Agenda Item No:	6(ii)
Report To:	**Ashford Health & Wellbeing Board**
Date:	19th July 2017
Report Title:	**Priorities 2018-23**
Report Author:	Sheila Davison
Organisation:	Ashford Borough Council

Summary:	This paper proposes priorities for the Ashford Health and Wellbeing Board for the period 2018-23.

Recommendations:	**The Ashford Health & Wellbeing Board is asked to discuss and agree priorities for the period 2018-23.**

Policy Overview:	The priorities are set against the developing Kent Health and Wellbeing Strategy and Kent & Medway Sustainability and Transformation Plan. They are relevant to all organisations represented on the Ashford Health and Wellbeing Board and will support those organisations to delivery their core public health responsibilities.
Financial Implications:	No specific costs identified. Identified activity will need to be commissioned and / or delivered collaboratively, flexibly and creatively within existing resources where possible.
Risk Assessment	No
Equalities Impact Assessment	No
Other Material Implications:	None
Background Papers:	None

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Agenda Item No.

Report Title: Priorities 2018-23

Purpose of the Report

1. At the last Ashford Health and Wellbeing Board meeting, the Lead Officer Group were asked to consider priorities for the coming year and to take into account progress against the current priorities of reducing smoking prevalence and reducing obesity and excess weight rates. See complimentary reports on the agenda for this meeting.

2. This paper presents the outcome of the discussions by the Lead Officer Group and outlines a number of health indicators that can be considered relevant to the setting of future priorities for the Board.

3. It is suggested that the priorities are set for a longer period in order to align with the developing Kent Health and Wellbeing Strategy as presented to the April Board meeting (reference AHWB 260417 minute 8). The draft Strategy identified a broad aim of extending years lived in good health and extended life expectancy. Priorities, outcomes and measures were also proposed.

4. Finally this papers suggests that the number of priorities are increased and that the scrutiny role of the Board be expanded in order to give oversight of a wider range of health indicators and opportunity to address an expanded range of health related subjects.

Background

5. In order to set future priorities the Lead Officer Group reviewed a range of data but for the purpose of this paper focused primarily on the 2016 Ashford Health Profile as benchmarked to the South East Region. Since this meeting the 2017 Health Profiles have been published and this paper has been prepared having reference to the most up to date information.

6. The 2017 Health Profile, which is provided in full at Appendix 1, provides a snapshot overview of health for the Borough. The aim of the Health Profile is to:

    - provide a consistent, concise, comparable and balanced overview of the population's health
    - inform local needs assessment, policy, planning, performance management, surveillance and practice
    - be primarily of use to joint efforts between local government and the health service to improve health and reduce health inequalities
    - empower the wider community

Priorities under consideration

7. The more detailed information provided by the 2017 Health Profile suggests that the following indicators are appropriate to consider as priority areas / indicators to monitor:

    a. Children in low income families (under 16s)

b. Statutory homelessness
c. GCSEs achieved
d. Violent crime (violent offences)
e. Long term unemployment
f. Smoking status at time of delivery
g. Breastfeeding initiation
h. Obese children
i. Excess weight in adults
j. Recorded diabetes
k. Hip fractures in people 65 and over
l. Killed and seriously injured on roads
m. Smoking related deaths

8. These indicators have been selected on the basis of a comparison with the England and/or South East regional data. They are selected when the Ashford position is worse or the recent trend indicates a static or worsening situation. The data as bench marked to the South East region is provided below:

Compared with benchmark Better Similar Worse Lower Similar Higher Not Compared

Benchmark Value
Worst/Lowest 25th Percentile 75th Percentile Best/Highest

Indicator	Period	Ashford			Region England		South East region		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Deprivation score (IMD 2015)	2015	–	-	17.3	-	21.8	-	-	-
Children in low income families (under 16s)	2014	↑	4,180	17.2%	14.7%	20.1%	28.7%		6.6%
Statutory homelessness	2015/16	→	12	0.2	0.8*	0.9	-	*Insufficient number of values for a spine chart*	-
GCSEs achieved	2015/16	–	761	55.3%	60.3%	57.8%	45.0%		78.7%
Violent crime (violence offences)	2015/16	↑	1,822	14.8	16.8	17.2	35.4		7.2
Long term unemployment	2016	↓	204	2.7*	2.0*	3.7*	8.4		0.4
Smoking status at time of delivery	2015/16	↓	166	11.3%	9.7%	10.6%*	19.0%		4.4%
Breastfeeding initiation	2014/15	–	1,017	71.3%	78.0%	74.3%	63.8%		89.2%
Obese children (Year 6)	2015/16	→	262	19.1%	17.1%	19.8%	24.2%		10.4%
Hospital stays for alcohol-specific conditions (under 18s)	2013/14 - 15/16	–	24	28.0	36.5	37.4	121.3		13.2
Under 18 conceptions	2015	↓	44	18.7	17.1	20.8	35.7		5.4
Smoking prevalence in adults	2016	–	-	17.4%	14.6%	15.5%	25.7%		4.9%
Percentage of physically active adults	2015	–	-	58.5%	60.2%	57.0%	49.8%		69.4%
Excess weight in adults	2013 - 15	–	-	66.6%	63.3%	64.8%	70.6%		52.0%
Cancer diagnosed at early stage	2015	–	274	51.2%	52.1%	52.4%	39.0%		59.8%
Hospital stays for self-harm	2015/16	–	192	158.7	211.8	196.5	350.6		70.9
Hospital stays for alcohol-related harm	2015/16	–	524	440	527	647	753		374
Recorded diabetes	2014/15	↑	5,876	6.1%	5.7%	6.4%	8.4%		3.8%
Incidence of TB	2013 - 15	–	32	8.7	7.6	12.0	47.8		1.2
New sexually transmitted infections (STI)	2016	↓	321	419	648	795	1,387		223
Hip fractures in people aged 65 and over	2015/16	–	137	589	562	589	708		312
Life expectancy at birth (Male)	2013 - 15	–	-	80.2	80.5	79.5	77.2		82.5
Life expectancy at birth (Female)	2013 - 15	–	-	84.0	84.0	83.1	82.0		86.7
Infant mortality	2013 - 15	–	16	3.6	3.2	3.9	6.0		1.3
Killed and seriously injured on roads	2013 - 15	–	193	52.2	49.1	38.5	85.1		22.9
Suicide rate	2013 - 15	–	36	11.6	10.2	10.1	15.2		6.0
Smoking related deaths	2013 - 15	–	-	-	249.4	283.5	-	*Insufficient number of values for a spine chart*	-
Under 75 mortality rate: cardiovascular	2013 - 15	–	183	56.7	62.3	74.6	104.7		43.1
Under 75 mortality rate: cancer	2013 - 15	–	442	137.3	129.4	138.8	166.2		98.6
Excess winter deaths	Aug 2012 - Jul 2015	–	214	22.0	18.8	19.6	29.4		6.9

Source: https://fingertips.phe.org.uk/profile/health-profiles/data#page/1/gid/1938132701/pat/6/par/E12000008/ati/101/are/E07000105

9. Clearly it would be unrealistic for the Board to focus on so many indicators, therefore, it is suggested that priority could be given to the following which are most closely aligned to the work of the Board and its membership:

    a. Homelessness
    b. Smoking and pregnancy
    c. Breastfeeding initiation
    d. Obesity in children and excess weight in adults
    e. Diabetes
    f. Hip fractures in people 65 and over
    g. Smoking related deaths

10. Additionally the Board could decide to have oversight of the other indicators supporting the work of related groups that have a greater ability to implement programmes and projects that would improve the relevant indicators. The Board could consider other indicators as part of its forward plan and receive updates from relevant organisations or groups. For example, Ashford is significantly worse than the England average with regard to the number killed and seriously injured on roads. A focused review of our road safety activity in collaboration with the Ashford Community Safety Partnership would be beneficial.

11. It is suggested that the current smoking and obesity working groups should continue. Further consideration by the Lead Officer Group is necessary with regard to the support that can be provided by the Board for the various work streams relevant to breastfeeding initiation, diabetes and hip fractures.

12. It is appropriate, however, for lead organisations to be agreed for each of the priority areas and the following is proposed:

    a. Homelessness – Ashford Housing Sub Group
    b. Smoking and pregnancy – Ashford Local Children's Partnership Group
    c. Breastfeeding initiation – Ashford Local Children's Partnership Group
    d. Obesity in children and excess weight in adults - HWB via its specific working group
    e. Diabetes – Ashford Clinical Commissioning Group
    f. Hip fractures in people 65 and over – Ashford Housing Sub Group
    g. Smoking related deaths - HWB via its specific working group

13. While it is suggested that the above priorities are set for the next five years, the Lead Officer Group will review relevant health data and other health information on an annual basis. Where appropriate recommendations will be made to the Board to change the priorities. This is particularly relevant to the Kent and Medway Sustainability and Transformation Plan (STP) and the work undertaken by the STP Partnership Board.

Areas not covered by the Health Profiles

14. There is a danger in only focusing on the indicators highlighted by the Health Profiles. It is important to remember that health and wellbeing are primarily shaped by factors outside the direct influence of health services, and we need to constantly look at this bigger picture. As we know the gaps of almost 20

years in health expectancy between people living in the most and least deprived areas of the UK is not explained by the ability to access health care but by our experience of the factors that make us healthy including safe and rewarding work, education, housing, resources, our physical environment and social connections.

15. The Board needs to bear this in mind and where necessary scrutinise a far wider range of services.

16. A useful infographic on 'What Makes Us Health?' has been published recently by The Health Foundation and is provided at Appendix 2. More information on this is available at http://www.health.org.uk/blog/infographic-what-makes-us-healthy.

Risk Assessment

17. A risk assessment will be undertaken when relevant for each of the activities as this work progresses. All partners will need to work collaboratively to achieve successful outcomes.

Equality Impact Assessment

18. All activities will be subject to an Equality Impact Assessment (EIA). They may be universally offered to Ashford residents, but specific target groups and areas of highest prevalence will be targeted with the aim to reduce the gap in inequalities. The Board will be updated on the EIA process as appropriate.

Other Options Considered

19. The Board could continue to focus on a smaller number of priorities as it has for the last year. This would, however, miss the opportunity to give attention to the broader health indicators that are worse within Ashford. It will be important for the Board to be open to further proposals for additional or alternative options as they arise throughout the course of the next five years.

Consultation

20. The Lead Officer Group has discussed the priorities considered in this paper. Any specific activity undertaken will be conducted in consultation with specific target groups in the local community and co-designed with target groups where possible.

Implications Assessment

21. The progress and outcomes of this work will be submitted to Health and Wellbeing Board and where necessary to the Kent Board.

Handling

22. The Lead Officer Group will report progress and performance to the Ashford Health and Wellbeing Board as a regular agenda item for the smoking and obesity priorities at each of the HWB meetings. Further updates will also be made available on request of the Board as relevant to all other agreed priorities.

Conclusion

23. This paper provides the Board with an opportunity review the current picture of people's health in Ashford so that it can help members to understand the community's needs and support joint working to improve health and reduce inequalities.

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Public Health England

Protecting and improving the nation's health

Ashford

District

This profile was published on 4th July 2017

Health Profile 2017

Health in summary
The health of people in Ashford is varied compared with the England average. About 17% (4,200) of children live in low income families. Life expectancy for both men and women is higher than the England average.

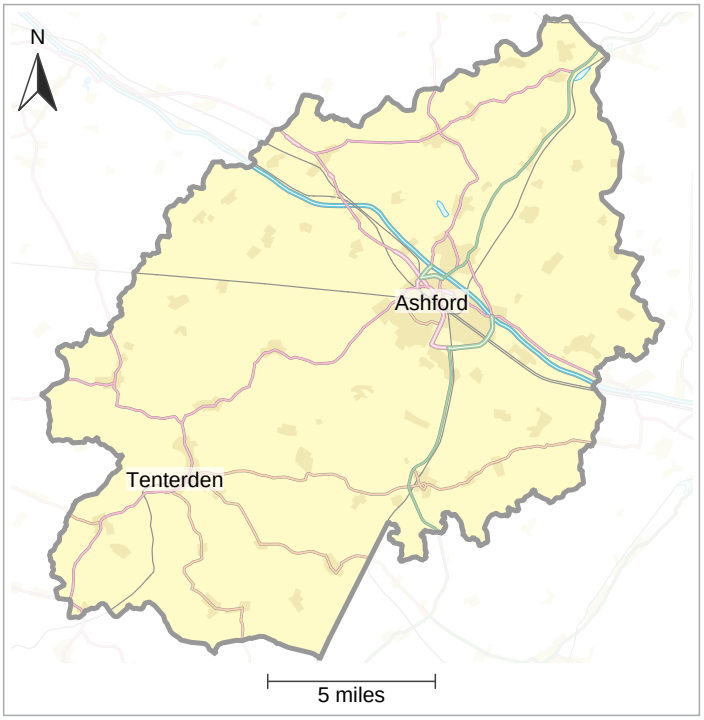
Health inequalities
Life expectancy is 4.0 years lower for men in the most deprived areas of Ashford than in the least deprived areas.

Child health
In Year 6, 19.1% (262) of children are classified as obese. The rate of alcohol-specific hospital stays among those under 18 is 28*. This represents 8 stays per year. Levels of breastfeeding initiation are worse than the England average.

Adult health
The rate of alcohol-related harm hospital stays is 440*, better than the average for England. This represents 524 stays per year. The rate of self-harm hospital stays is 159*, better than the average for England. This represents 192 stays per year. The rate of people killed and seriously injured on roads is worse than average. The rate of sexually transmitted infections is better than average. Rates of statutory homelessness, violent crime, long term unemployment and early deaths from cardiovascular diseases are better than average.

Local priorities
Priorities in Ashford include improving levels of healthy weight among adults and children through increasing physical activity, addressing health inequalities (heart disease), and addressing smoking prevalence and smoking in pregnancy. For more information see www.ashfordccg.nhs.uk and www.kpho.org.uk

* rate per 100,000 population

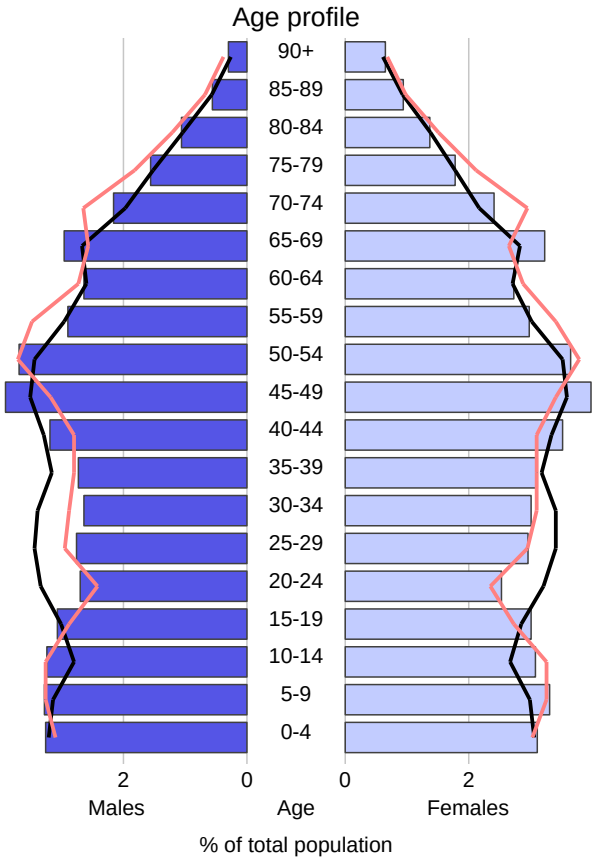


This profile gives a picture of people's health in Ashford. It is designed to help local government and health services understand their community's needs, so that they can work together to improve people's health and reduce health inequalities.

Visit www.healthprofiles.info for more profiles, more information and interactive maps and tools.

Follow @PHE_uk on Twitter

Population: summary characteristics



	Males	Females	Persons
Ashford (population in thousands)			
Population (2015):	60	64	124
Projected population (2020):	64	68	132
% people from an ethnic minority group:	5.4%	7.0%	6.2%
Dependency ratio (dependants / working population) x 100			68.3%
England (population in thousands)			
Population (2015):	27,029	27,757	54,786
Projected population (2020):	28,157	28,706	56,862
% people from an ethnic minority group:	13.1%	13.4%	13.2%
Dependency ratio (dependants / working population) x 100			60.7%

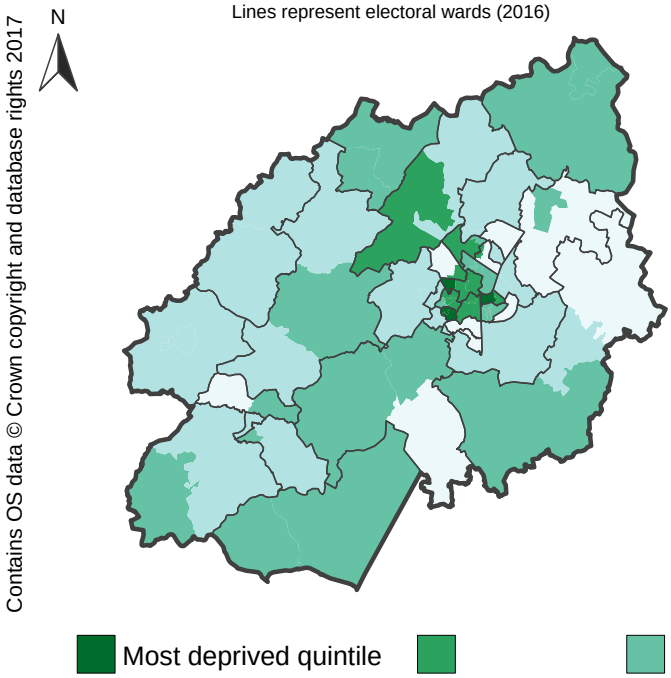
The age profile and table present demographic information for the residents of the area and England. They include a 2014-based population projection (to 2020), the percentage of people from an ethnic minority group (Annual Population Survey, October 2014 to September 2015) and the dependency ratio.

The dependency ratio estimates the number of dependants in an area by comparing the number of people considered less likely to be working (children aged under 16 and those of state pension age or above) with the working age population. A high ratio suggests the area might want to commission a greater level of services for older or younger people than those areas with a low ratio.

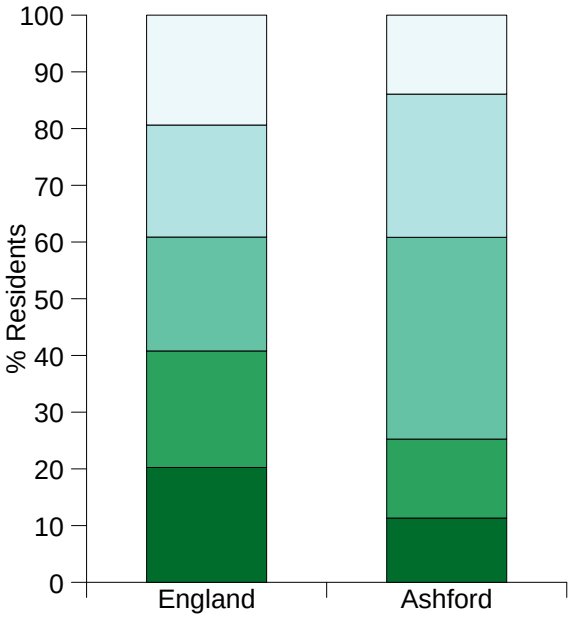
Ashford 2015 (Male)
Ashford 2015 (Female)
England 2015
Ashford 2020 estimate

Deprivation: a national view

The map shows differences in deprivation in this area based on national comparisons, using national quintiles (fifths) of the Index of Multiple Deprivation 2015 (IMD 2015), shown by lower super output area. The darkest coloured areas are some of the most deprived neighbourhoods in England.



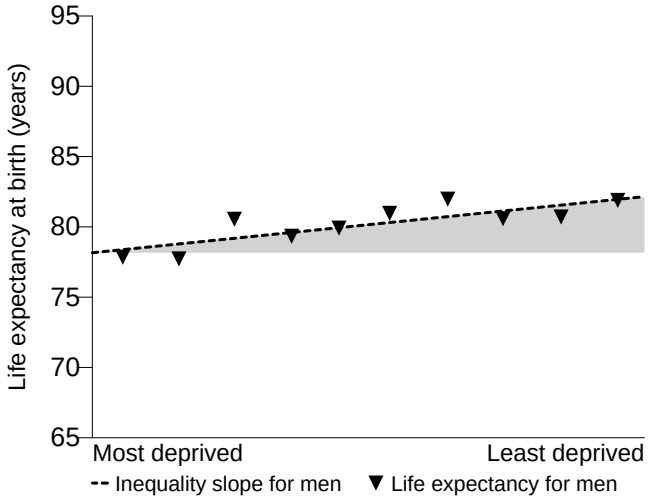
This chart shows the percentage of the population who live in areas at each level of deprivation.



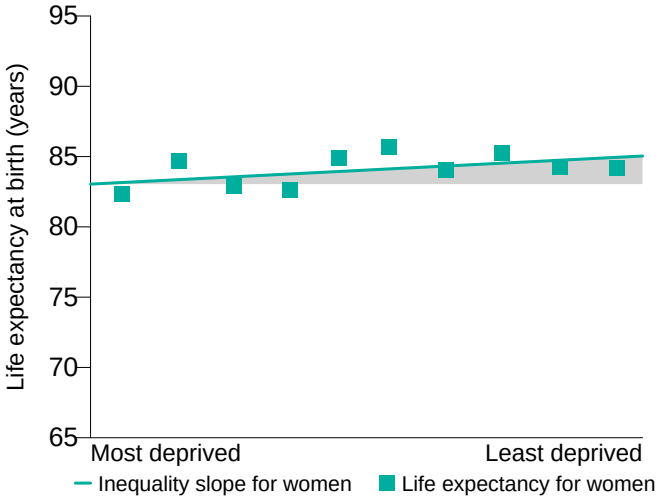
Life expectancy: inequalities in this local authority

The charts show life expectancy for men and women in this local authority for 2013-15. The local authority is divided into local deciles (tenths) by deprivation (IMD 2015), from the most deprived decile on the left of the chart to the least deprived decile on the right. The steepness of the slope represents the inequality in life expectancy that is related to deprivation in this local area. If there was no inequality in life expectancy the line would be horizontal.

Life expectancy gap for men: 4.0 years



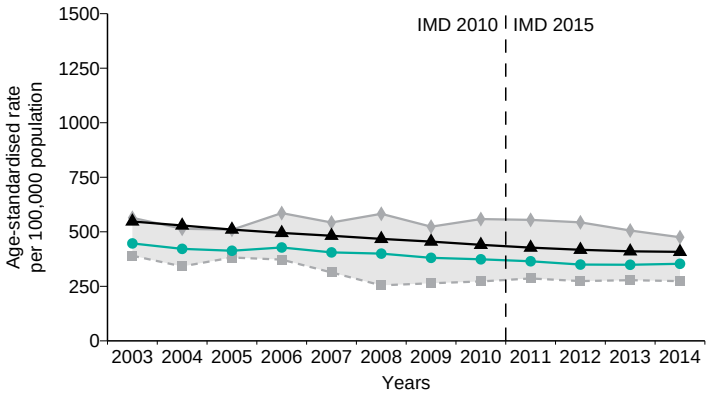
Life expectancy gap for women: 2.0 years



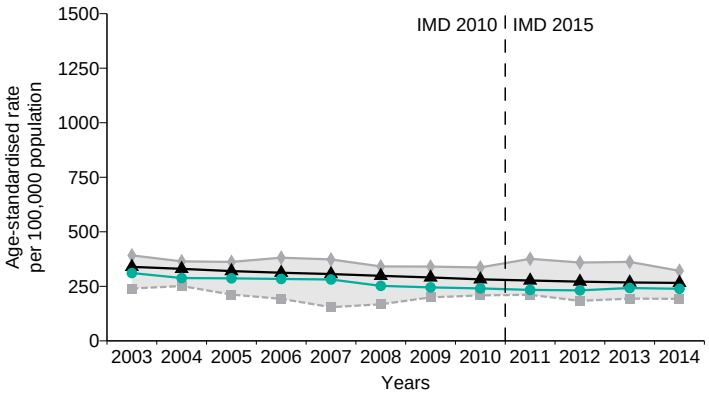
Health inequalities: changes over time

These charts provide a comparison of the changes in death rates in people under 75 (early deaths) between this area and England. Early deaths from all causes also show the differences between the most and least deprived local quintile in this area. Data from 2010-12 onwards have been revised to use IMD 2015 to define local deprivation quintiles (fifths), all prior time points use IMD 2010. In doing this, areas are grouped into deprivation quintiles using the Index of Multiple Deprivation which most closely aligns with time period of the data. This provides a more accurate way of discriminating changes between similarly deprived areas over time.

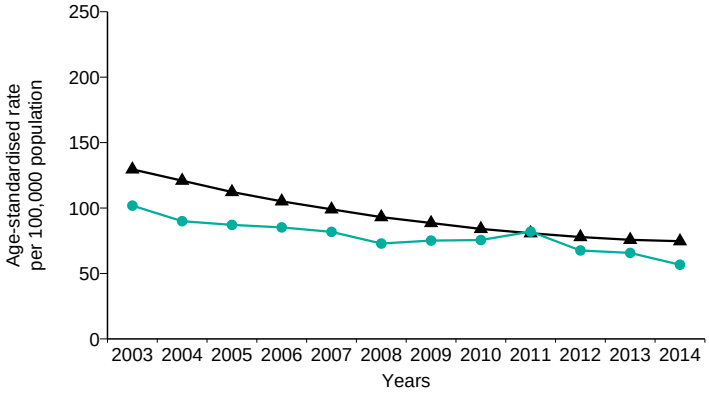
Early deaths from all causes: men



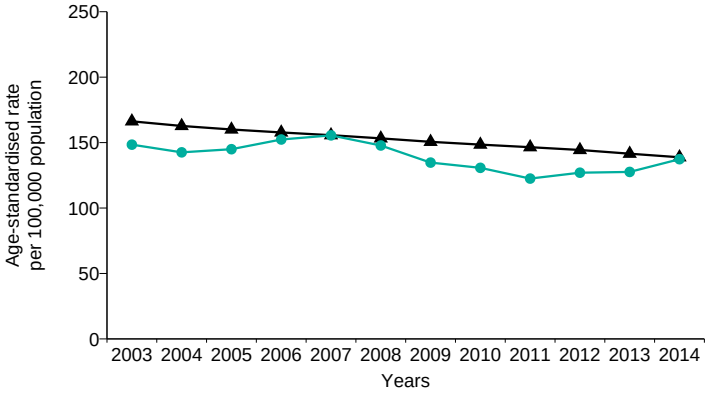
Early deaths from all causes: women



Early deaths from heart disease and stroke



Early deaths from cancer



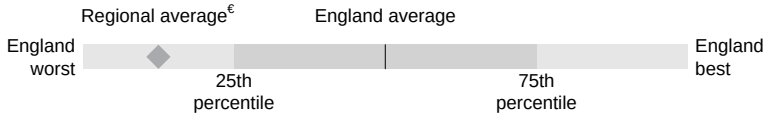
Data points are the midpoints of three year averages of annual rates, for example 2005 represents the period 2004 to 2006. Where data are missing for local least or most deprived, the value could not be calculated as the number of cases is too small.

England average | Local average | Local least deprived | Local most deprived | Local inequality

Health summary for Ashford

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- Not compared



Domain		Indicator	Period	Local count	Local value	Eng value	Eng worst	England range	Eng best
Our communities	1	Deprivation score (IMD 2015)	2015	n/a	17.3	21.8	42.0		5.0
	2	Children in low income families (under 16s)	2014	4,180	17.2	20.1	39.2		6.6
	3	Statutory homelessness	2015/16	12	0.2	0.9			
	4	GCSEs achieved	2015/16	761	55.3	57.8	44.8		78.7
	5	Violent crime (violence offences)	2015/16	1,822	14.8	17.2	36.7		4.5
	6	Long term unemployment	2016	204	2.7 ^20	3.7 ^20	13.8		0.4
Children's and young people's health	7	Smoking status at time of delivery	2015/16	166	11.3	10.6 $1	26.0		1.8
	8	Breastfeeding initiation	2014/15	1,017	71.3	74.3	47.2		92.9
	9	Obese children (Year 6)	2015/16	262	19.1	19.8	28.5		9.4
	10	Admission episodes for alcohol-specific conditions (under 18s)†	2013/14 - 15/16	24	28.0	37.4	121.3		10.5
	11	Under 18 conceptions	2015	44	18.7	20.8	43.8		5.4
Adults' health and lifestyle	12	Smoking prevalence in adults	2016	n/a	17.4	15.5	25.7		4.9
	13	Percentage of physically active adults	2015	n/a	58.5	57.0	44.8		69.8
	14	Excess weight in adults	2013 - 15	n/a	66.6	64.8	76.2		46.5
Disease and poor health	15	Cancer diagnosed at early stage	2015	274	51.2	52.4	39.0		63.1
	16	Hospital stays for self-harm†	2015/16	192	158.7	196.5	635.3		55.7
	17	Hospital stays for alcohol-related harm†	2015/16	524	440.2	647	1,163		374
	18	Recorded diabetes	2014/15	5,876	6.1	6.4	9.2		3.3
	19	Incidence of TB	2013 - 15	32	8.7	12.0	85.6		0.0
	20	New sexually transmitted infections (STI)	2016	321	418.5	795	3,288		223
	21	Hip fractures in people aged 65 and over†	2015/16	137	589.2	589	820		312
Life expectancy and causes of death	22	Life expectancy at birth (Male)	2013 - 15	n/a	80.2	79.5	74.3		83.4
	23	Life expectancy at birth (Female)	2013 - 15	n/a	84.0	83.1	79.4		86.7
	24	Infant mortality	2013 - 15	16	3.6	3.9	8.2		0.8
	25	Killed and seriously injured on roads	2013 - 15	193	52.2	38.5	103.7		10.4
	26	Suicide rate	2013 - 15	36	11.6	10.1	17.4		5.6
	27	Smoking related deaths	2013 - 15	n/a	n/a	283.5			
	28	Under 75 mortality rate: cardiovascular	2013 - 15	183	56.7	74.6	137.6		43.1
	29	Under 75 mortality rate: cancer	2013 - 15	442	137.3	138.8	194.8		98.6
	30	Excess winter deaths	Aug 2012 - Jul 2015	214	22.0	19.6	36.0		6.9

Indicator notes

1 Index of Multiple Deprivation (IMD) 2015 **2** % children (under 16) in low income families **3** Eligible homeless people not in priority need, crude rate per 1,000 households **4** 5 A*-C including English & Maths, % pupils at end of key stage 4 resident in local authority **5** Recorded violence against the person crimes, crude rate per 1,000 population **6** Crude rate per 1,000 population aged 16-64 **7** % of women who smoke at time of delivery **8** % of all mothers who breastfeed their babies in the first 48hrs after delivery **9** % school children in Year 6 (age 10-11) **10** Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population **11** Under-18 conception rate per 1,000 females aged 15 to 17 (crude rate) **12** Current smokers (aged 18 and over), Annual Population Survey **13** % adults (aged 16 and over) achieving at least 150 mins physical activity per week, Active People Survey **14** % adults (aged 16 and over) classified as overweight or obese, Active People Survey **15** Experimental statistics - % of cancers diagnosed at stage 1 or 2 **16** Directly age sex standardised rate per 100,000 population **17** Admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause (narrow definition), directly age standardised rate per 100,000 population **18** % people (aged 17 and over) on GP registers with a recorded diagnosis of diabetes **19** Crude rate per 100,000 population **20** All new diagnoses (excluding chlamydia under age 25), crude rate per 100,000 population aged 15 to 64 **21** Directly age-sex standardised rate of emergency admissions, per 100,000 population aged 65 and over **22, 23** The average number of years a person would expect to live based on contemporary mortality rates **24** Rate of deaths in infants aged under 1 year per 1,000 live births **25** Rate per 100,000 population **26** Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population (aged 10 and over) **27** Directly age standardised rate per 100,000 population aged 35 and over **28** Directly age standardised rate per 100,000 population aged under 75 **29** Directly age standardised rate per 100,000 population aged under 75 **30** Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths (three years)

† Indicator has had methodological changes so is not directly comparable with previously released values. € "Regional" refers to the former government regions.
^20 Value based on an average of monthly counts $1 There is a data quality issue with this value

If 25% or more of areas have no data then the England range is not displayed.

Please send any enquiries to healthprofiles@phe.gov.uk

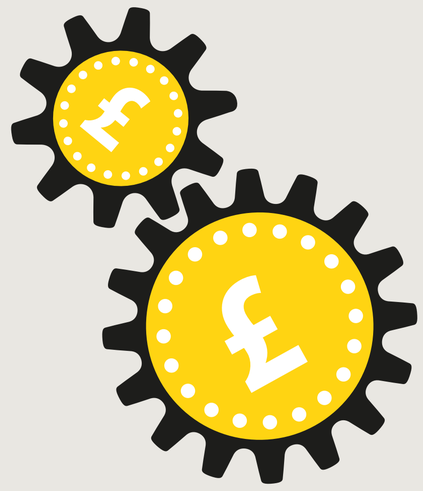
What makes us healthy?

AS LITTLE AS
10% of a population's health and wellbeing is linked to access to health care.

We need to look at the bigger picture:

Good work

Our surroundings



Money & resources

Housing

The food we eat

Transport

Education & skills

Family, friends & communities

But the picture isn't the same for everyone.

The healthy life expectancy gap between the most and least deprived areas in the UK is: **19** YEARS

The Health Foundation

References available at www.health.org.uk/healthy-lives-infographics