AGENDA

WEST KENT CCG HEALTH AND WELLBEING BOARD MEETING

Date: Tuesday 16 September 2014
Time: 4.00 p.m.
Venue: Rooms 1B & 1C - The Gateway, King Street, Maidstone

Membership:

Gail Arnold, William Benson, Councillor Annabelle Blackmore, Dr Bob Bowes (Chairman), Lesley Bowles, Alison Broom, Councillor Alison Cook, Councillor Roger Gough, Jane Heeley, Fran Holgate, Dr Caroline Jessel, Dr Tony Jones, James Lampert, Mark Lemon, Reg Middleton, Councillor Mark Rhodes, Dr Sanjay Singh, Penny Southern, Malti Varshney and Councillor Lynne Weatherly

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Page No.

1. Welcome and Introductions
2. Apologies for Absence
3. Declaration of Disclosable Pecuniary Interests
4. Minutes of the Meeting held on 15 July 2014 - to follow
5. Board Development and COG Update - Dr Bob Bowes

Continued Over/:

Issued on 8 September 2014

The reports included in Part I of this agenda can be made available in **alternative formats**. For further information about this service, or to arrange for special facilities to be provided at the meeting, **please contact MARK LEMON** on 01622 696252

Kent County Council, Policy and Strategic Relationships, Room 2.65, Sessions House, Maidstone, ME14 1XQ

6. Kent Joint Health and Wellbeing Strategy; West Kent Health and Wellbeing Board's Partner Organisations' Plans for Public Engagement, Identification of Gaps and Plans to Close Them - Dr Bob Bowes

7. Kent Joint Health and Wellbeing Strategy; West Kent Health and Wellbeing Board's Partner Organisations' Plans for Implementation, Identification of Gaps and Plans to Close Them - Dr Bob Bowes

8. West Kent Tobacco Control and Smoking Cessation Working Group - Jane Heeley 1 - 8

9. Alcohol Strategy for Kent 2014-2016 - Linda Smith 9 - 23

10. Better Care Fund Update, CCG - Gail Arnold/Louise Matthews

11. Teenage Pregnancy Strategy Consultation - Malti Varshney

12. Any Other Business

13. Date of Next Meeting

By: Jane Heeley, Malti Varshney and Debbie Smith

To: West Kent CCG Health and Wellbeing Board

Date: 16th September 2014

Subject: West Kent Tobacco Control and Smoking Cessation Working Group

Classification: Unrestricted

Summary

Following the presentation of the action plan developed by the Tobacco Control Task and Finish Group at the April meeting of this Board it was evident that the meetings of this Group had enabled partners working across the system to come together to integrate approaches to dealing with this priority area. The Board agreed to the continuation of the Group with the aims of delivering its action plan.

1. Background

1.1 In brief the recommendations of the April report were:

- Delivery of the action plan ;
- "Make every contact count" by developing ways for staff throughout partner organisations to promote the tobacco control agenda;
- Review how partners contribute to the return on investment figures; and
- That West Kent Partners would demonstrate their strategic leadership and commitment to this area of work by becoming signatories to the Local Declaration on Tobacco Control.

1.2 In April the Board also held a development session focussing on how all partners can collectively work to address population needs. During this session six principles were identified, which were:

Problem-based approach – this was around focusing on a topic and getting to grips with it, rather than spreading too thin;

Articulate ambition – this was getting the narrative of the story of change around the topic area agreed and then clarity across all HWB members about

how they communicate this in their organisation; also using social media and off-the-wall approaches to get the message across

Population level – recognising that the topic will play out at population level, to tackle health and wellbeing both in the short and long term;

Audiences – carrying out segmentation of the target audiences and getting the message across to each in the most appropriate way; for instance working with schools as a target group for some of the change topics

Risk sharing – shared ownership of the changes and the implications on organisations and their services from these changes, including shifting resources;

Holding to account – this gets down to the 'conductor' role of the HWB in getting action across the West Kent system, and then holding organisations to account for implementation

1.3 This report illustrates how the above approach has been used to implement the findings of the work of Tobacco control Task and Finish Group and provides an update on the progress being made in the delivery of those aims.

2. Problem based approach

2.1 Smoking continues to be one of the main causes of preventable early death in West Kent. Although smoking rates have fallen from 135,000 in 2007 to 115,000 in 2010 there is a reported increase of 5% in 16 to 19 year old males, which is equivalent to 800 more teenage male smokers.

2.2 Additionally smoking is a key contributor to higher death rates in people from more deprived areas, as a greater proportion of people living in those areas smoke, compared to their more affluent counterparts, most notably in Park Wood and Shepway areas of Maidstone (West Kent Smoking Health Equity Audit 2011). This equity gap is widened by the fact that people from more affluent backgrounds are more likely to access Stop Smoking Services (SSS) than smokers from deprived areas.

2.3 With regards to ethnicity the prevalence across different ethnic groups follows the national picture, with the most notable examples of high prevalence being in male Bangladeshis at 40% and male Irish at 30% prevalence rates.

2.4 In developing the action plan the Group were mindful of this data and aim to implement actions consistent with the Kent Tobacco Control Strategy to tackle this priority area:

- Encouraging smokers to quit;
- Harm reduction, through both encouraging smokers to cut down their intake of tobacco and looking at initiatives to reduce exposure to second hand smoke;
- Preventing people taking up smoking; and
- Controlling sales of cheap and illegal tobacco

3. Articulate ambition

3.1 A recommendation of the report to this Board in April was that partners should demonstrate commitment to this area of work by signing up to the local Government Declaration on Tobacco control. It is our aspiration that all partner organisations will sign up to the declaration and in doing so promote/ show their support for the main messages around the Tobacco Control agenda.

3.2 An important step in promoting messages around quitting and harm reduction is ensuring that partners have as broad a pool of people able to deliver Very Brief Advice (VBA) interventions on a variety of settings. Districts have been asked to identify officers that are able to promote tobacco control messages through their day to day work, when interacting with members of the public, for example Housing or Leisure officers. When this has been done the SSS will provide the necessary training. It is intended that the first sessions will be delivered before the end of the year.

4. Population level

4.1 Kent prevalence for smoking is 20.9 % and across West Kent prevalence at district level ranges between 16 % in Sevenoaks to 20.4% (Source:2014 Health Profiles) in Maidstone. However smoking prevalence at ward level may be more than 35% as in Parkwood Park in Maidstone.

4.2 The overarching aim of the Group is to bring about a reduction in this prevalence, promote harm reduction strategies and reduce the number of new people taking up smoking. The Task and Finish group members appreciate that this will involve both short term and long term activity. In particular this will require a disproportionately high level of intervention with our priority

communities, where the prevalence of smoking is higher and the consequential health impacts are more significant.

4.3 Last year there was a 10% increase in referrals to the stop smoking service. However the number of people who successfully quit smoking over this period reduced by 27%. The National Institute of Clinical Excellence (NICE) evidence suggests that harm reduction ('cutting down to quit') programmes may be better deployed to support heavy smokers who are not able to quit smoking completely. **Table 1** below shows this year's data from the SSS on people quitting smoking.

West Kent CCG Data - 1 April 14 to 5 Sept 14

	Babyclear	GP	Pharmacy	Core	TOTALS
Referrals					0
Quit dates set	12	432	43	156	643
Quits	8	184	13	82	287
Lost to Service	0	77	10	14	101
Not Quit	1	66	7	28	102
Awaiting outcome	3	105	13	32	153
				Grand Total	1286

5. Audience segmentation

5.1 It is clear from reviewing how each of the four themes are tackled, the fact that smoking is an issue right across our population and in a wide variety of settings, that agencies would benefit from a range of measures, and interventions for addressing all aspects of this agenda. One of the functions of this group should be to develop a toolbox of interventions that can be used to target specific audiences that are included based on evidence of their success, either locally or nationally.

5.2 An example of how this might work in practice is illustrated through the recent pilot lead by Kent County Council Trading Standards, working in collaboration with Maidstone BC and Public Health. Through the identification of young persons smoking hotspots in Maidstone the Trading Standards Service was able to address potential tackle the sale of underage sales with four retailers in the locality. Following a test purchasing exercise the businesses were engaged with informally and were offered advice and support. A further exercise will be carried out in due course to monitor their compliance; failures on this occasion may result in formal action. The next steps required complete the objectives of this initiative will involve engagement with young persons, through youth workers, the development of tobacco support sessions for community groups and the preparation of local media groups to promote the initiative. These next steps are best achieved through other partners in the pilot, recognising the relative skill sets of each agency.

5.3 There will need to be more effective targeting of stop smoking services to the most vulnerable groups where smoking is a heavily entrenched way of life and where people are less likely to quit (such as routine and manual workers and smoking in pregnancy where prevalence rates for smoking in Kent are above the national average) and support for people with Learning Disabilities and Mental Health issues.

5.4 There are a number of areas of current activity across West Kent which include:

- Districts and the SSS are currently reviewing a more strategic approach to local collaborative working to improve outcomes from the work being delivered through the health inequalities action plans, the KCC commissioned work that Districts are delivering through their Healthy Living Centres, and workplace health programmes, of which one priority is making referrals into the SSS.

- Smokefree homes initiative in priority communities targeting, homes with children, which is a joint initiative with Kent Fire and Rescue, the Districts and Stop Smoking Service.

- The Baby clear programme, the aim of which is to support pregnant women give up smoking, is being delivered by the midwifery service, with support through VBA training provided by the Tobacco Control Control Collaborating Centre. The SSS take up the referrals and have recently set up a dedicated telephone line and bespoke programme to handle these specific referrals. Kent Baby

Clear is based on the evidence-based national programme and is currently being evaluated locally.

- KCHT Stop Smoking Service is in the process of working with Housing providers and District Housing Teams, linking Quitting with recovery from debt.

- KCHT are also working with Kent Fire and Rescue Fire Fit programme and providing VBA training to officers carrying out home visits.

6. Risk Sharing

6.1 It was evident from the work that has been done through the Tobacco Control Task and Finish Group to date that there are a number of agencies directly involved in the challenges of delivering population level improvements in relation to tobacco control. In the previous report to this Board it was explained that we identified that there were some significant gaps in integrated working and opportunities for this to be improved.

6.2 There is a national decline in reported quitters and Kent has seen a 27% reduction in the number of people who have quit smoking in the last year. Referrals to stop smoking services remain high however, so the outcomes of a current Rapid Review of stop smoking services will help identify where further action can be taken to address these missed opportunities. The Rapid Review will also highlight where further resources are required to support vulnerable groups who are not currently accessing stop smoking services (eg. Young smokers below 18 years of age).

6.3 Through commissioning processes it would be helpful if the contribution that individual agencies and work programmes could be made explicit and used to underpin the need for collaborative working. This is also being addressed at the Kent Tobacco Control Stakeholder group.

6.4 The aim here is that all partners/agencies have a sense of shared ownership and take collective responsibility for improving the “problem”. There is an outstanding piece of work that would help this sense of shared responsibility and that is around the area of return on investment, and the identification of the contribution that individual partners make to the delivery of the strategy.

6.5 This will require all partners to identify opportunities for tobacco control through the routine business of their organisations. For instance Board members can work with their respective organisations to identify commissioned services which will as part of their service level agreement have sign posting to stop smoking services.

7. Holding to Account

7.1 The Board has a leadership role in providing strategic direction and expects individual commissioners and stakeholder organisations to implement that through their commissioning plans. Once this has been implemented then the Board holds commissioners to account for implementing strategy.

By each organisation within the system taking collective responsibility for the delivery of this agenda it is important to be clear what each of our roles are:

7.2 West Kent Health and Wellbeing Board

- Ensure commissioners report at agreed intervals on the outcomes of delivery associated with this agenda

7.3 West Kent CCG

- Sign up to the NHS Statement of Support for Tobacco Control
- Include in commissioning plans for pharmacies and GP's the requirements to make provide VBA's to smokers and referrals to the SSS – targets to be agreed

7.4 Kent County Council

- Sign up to the Local Government Declaration on Tobacco Control
- Identify ways of contributing to this agenda through the range of front line services that are provided e.g. social care, education, trading standards
- Identify Tobacco Control related activity in commissioning intentions
- Monitor the outcomes of those intentions

7.5 Districts

- Sign up to the Local Government Declaration on Tobacco Control
- Review how each District can contribute to this agenda through the range of front line services it delivers e.g. leisure and housing services
- Identify opportunities for working with voluntary partners that will promote this agenda

- Work with the SSS and Housing providers to deliver referrals
- Identify key officers that trough their contacts with the public can deliver VBA's.

8. Conclusions

8.1 Whilst there has been a reduction in the numbers of people quitting in Kent in the last twelve months, commissioners and providers have a number of clear measures that are in place to reverse this trend. The on-going work of the Tobacco Control Task and Finish Group will support the delivery of some of these initiatives through its continuing efforts to improve collaborative working and develop a toolbox of resources to complement these work streams.

8.2 It is recognised that the marketing and use of e-cigarettes is affecting referrals and numbers of quits. Further work is needed to understand these impacts more clearly and this will be an on-going process by the SSS.

8.3 Finally, we believe that the West Kent Health and Wellbeing Board has a clear role to play in providing advocacy and leadership around this priority area, as well as challenging those involved in both the commissioning and delivery of this agenda.

By: Linda Smith Public Health Specialist, KCC
Jess Mookerjee, Public Health Consultant, KCC

To: West Kent Health and Wellbeing Board

Date: 16 September 2014

Subject: Alcohol Strategy for Kent 2014-2016

Classification: Unrestricted

Summary

Although the majority of people drink alcohol responsibly, there are still a proportion of people for whom alcohol misuse is a problem. Liver disease is on the increase and alcohol misuse can also lead to violence and family disruption. In Kent it is estimated that alcohol harm accounts for approximately £108m of Health commissioning resource each year.[1]

The National Alcohol Strategy makes key recommendations on enforcement and disorder that are echoed in the Kent Strategy. The Kent Strategy for 2014-16 goes further by pledging action to improve the current prevention and treatment arrangements in Kent.

Currently there is evidence that not enough people are being referred for Alcohol Treatment and that too few people are aware of the harm that alcohol misuse is causing them. There are also a number of vulnerable groups, whose needs must be addressed.

This Alcohol Strategy has six pledges for action to reduce alcohol-related harm and seven evidence-based steps that we will take to reduce harm from alcohol consumption. Each local Health and wellbeing Board is asked to consider developing local action plans for implementation of the Kent strategy.

Recommendations

The West Kent Health and Wellbeing Board is asked to:

1. note this report and consider key actions from the strategy to be taken
2. develop a Local Alcohol Action Plan to implement the Kent Alcohol Strategy
3. consider creating a multi-partner Task and Finish Group to address the six pledge areas of the Kent Alcohol Strategy

[1] Data Extracted from NHIS Alcohol Impact Model

1. Purpose

1.1 To inform the West Kent Health and Wellbeing Board about the Kent Alcohol Strategy 2014-2016 that was approved by Kent Adult Social Care and Health Cabinet Committee earlier this year. Appendix 1

2. Background

2.1 Although the majority of people in West Kent and the UK consume alcohol responsibly, excessive consumption of alcohol is a growing problem in Kent and across the country and contributes to health issues such as liver disease and obesity. Alcohol also contributes to crime and disorder, is linked to domestic violence, mental distress and family disruption.

2.2 Liver disease is almost wholly attributed to alcohol misuse and is the fifth largest cause of death in England. Liver disease is the only chronic condition that is increasing rapidly in the UK, with a five-fold increase in the development of cirrhosis in 35-55 year olds over the last 10 years. The average age of death from liver disease is 59 years, compared to 82-84 years for heart and lung disease or stroke.

3. Local Needs

District level information on a number of indicators is available through Local Alcohol Profile (LAPE). Some key points from LAPE (2013) are:

- In Maidstone female mortality is highest in West Kent and higher than the South East region
- Sevenoaks has the highest alcohol related sexual offences in West Kent and higher than the South East region
- Tonbridge and Malling has the lowest rate of abstainers of the West Kent localities and South East region
- Tunbridge Wells has the highest number of those drinking at lower risk levels of the localities and South East region
- Tunbridge Wells has the highest number of those drinking at increasing risk drinkers of the localities and South East region
- The overall admission trend at ward level has reduced by 295 2011-2013 for West Kent
- Admissions of those under 18 years continues to decline over the last seven years: *n=23 in 2012/13 for West Kent*

  Further information relating to alcohol profiles is available both at ward and CCG level (please see appendix 2 for an example selection)

4. Kent Alcohol Strategy 2014-2016

The National Alcohol Strategy focuses on the importance of preventing and reducing the impact of alcohol on crime and disorder across the UK.

The New Kent Alcohol Strategy builds on the previous Alcohol Strategy for Kent 2010-2013.

4.1 The Key aims of the Alcohol Strategy for Kent 2014-2016 are to:

a) Reduce alcohol-related specific deaths
b) Continue to reduce alcohol-related disorder and violence year on year
c) Raise awareness of alcohol-related harm in the population
d) Increase pro-active identification and brief advice at primary care
e) Increase numbers referred into treatment providers as appropriate

4.2 The new strategy will strengthen many of the positive actions of the 2010-13 strategy: namely in the area of trading standards and local alcohol partnerships. The Kent Community Action Partnerships (KCAP) were identified nationally as best practice and showed how local action between police, trading standards, industry and the community could have good results in tackling under-age sales, town centre disruption and irresponsible licence holding. The new 2014-16 strategy will expand on this by enabling more KCAP sites across Kent.

4.3 The 2014-16 Kent Alcohol Strategy goes further than the previous strategy in a number of areas, notably the health prevention and treatment pathways. Currently there is capacity in the existing Alcohol Treatment Services which is not being utilised fully.

The development of an Integrated Care Pathway for alcohol and the introduction of a Locally Enhanced Service for Primary Care and pharmacy will help to provide the preventative element and increase earlier access to specialist treatment services.

4.4 A section has been developed for each key area (pledge element) which explores current action, the planned activity for the future and how we will know it has been successful (Table 1).

Table 1

Alcohol Strategy Pledge area	**Priority Actions to Address**
Prevention and Identification	Identification and Brief Advice (IBA) in Primary Care and pharmacies, Training, Social Marketing and targeted promotion. The development of an integrated care pathway for alcohol, increasing access/earlier access into specialist treatment provider services. Proactive case-finding for IBA screening in Primary Care especially those with mental health conditions and vulnerable populations

Treatment	Improve liaison at A&E, Pro-active care into and away from hospital, Creating a liaison team and after-care packages, better signposting. Better joint working and pathways into primary care.
Enforcement and responsibility	Tackling night-time economy, reduction of violence, use of crime & community partnerships, spot checks on traders, working with industry.
Local Action	Continue good practice using KCAP model and expand into areas where there is no KCAP. Improve data and needs assessment. Widen the partnerships. Support local schemes like street pastors and Alcohol Zones.
Vulnerable groups and inequalities	Prioritise dual diagnosis by improving the links between mental health workers and substance misuse treatment providers, domestic violence awareness campaigns and working with perpetrators. Work with the military covenant groups to increase awareness in ex-military/ veteran population.
Children and Young People	Continue with RisKit, lead a Kent-wide campaign, co-ordinate hidden harm strategy linked to KIASS, systematic screening in A&E.

4.5 The development of the Alcohol Strategy for Kent 2014-16 commenced in 2013, and took account of good practice being developed, and therefore many of the actions identified within the strategy are already underway.

- An improved 'in reach' system from the community treatment provider into the A&E in Maidstone and Tunbridge Wells Hospitals is in place.
- Agreement has been reached with many Kent Clinical Commissioning Groups (CCGs) to provide improved access to 'Identification & Brief Advice', where GPs are incentivised to pro-actively screen patients for alcohol misuse and then provide advice and/ or referral to treatment providers.

5 Implementation

5.1 A strategy implementation group will monitor progress on Kent Alcohol Strategy. This group will meet on a quarterly basis to monitor progress and will review the strategy on an annual basis. The implementation group will include a range of partners.

5.2 Each Health and Wellbeing Board should consider developing a detailed local action plan with a timeline and agreed responsibilities to ensure that actions developed will be focussed on achieving the outcomes within the Kent strategy.

5.3 Each locality will be provided with the widest range of alcohol profiles at Ward and CCG level as available. This will enable each area to target areas for action and

provide information to monitor progress against aims and inform commissioning intentions. [2]

6. Conclusion

Whilst much progress has been made in some areas, notably the reduction of admissions in those under 18 years, there is much work to be done to address the actual and predicted trend in hospital admissions across all ages.

By using the clear action 'road-map' of the Kent Alcohol Strategy 'Six Pledges' and 'Seven High Impact steps' and building upon the work to date and willingness to tackle alcohol related harm in our communities, it is anticipated that Kent will make good progress against the aims of the Kent Alcohol Strategy provided that:

- The importance of addressing and implementing the Kent Alcohol Strategy should be (and be seen to be) of high priority amongst organisations
- There should be a willingness to extend data capture and share data
- There should be support for workforce training
- Organisations should work together to avoid duplication and work flexibly to facilitate an integrated and comprehensive approach to tackling alcohol harm in Kent

7 Recommendations:

Members of the West Kent Health and Wellbeing Board are asked to:

1. note this report and consider key actions from the strategy to be taken
2. develop a Local Alcohol Action Plan to implement the Kent Alcohol Strategy
3. consider creating a multi-partner Task and Finish Group to address the six pledge areas of the Kent Alcohol Strategy

8. Background Documents

Appendix 1 Kent Alcohol Strategy
Appendix 2 Summary local alcohol data profiles

9. Contact details

[2] Will be made available electronically given the size of the data file

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Appendix 1 Kent Alcohol Strategy 2014-2016

Kent Alcohol Strategy 2014_16.pdf

Appendix 2 Local alcohol data profiles

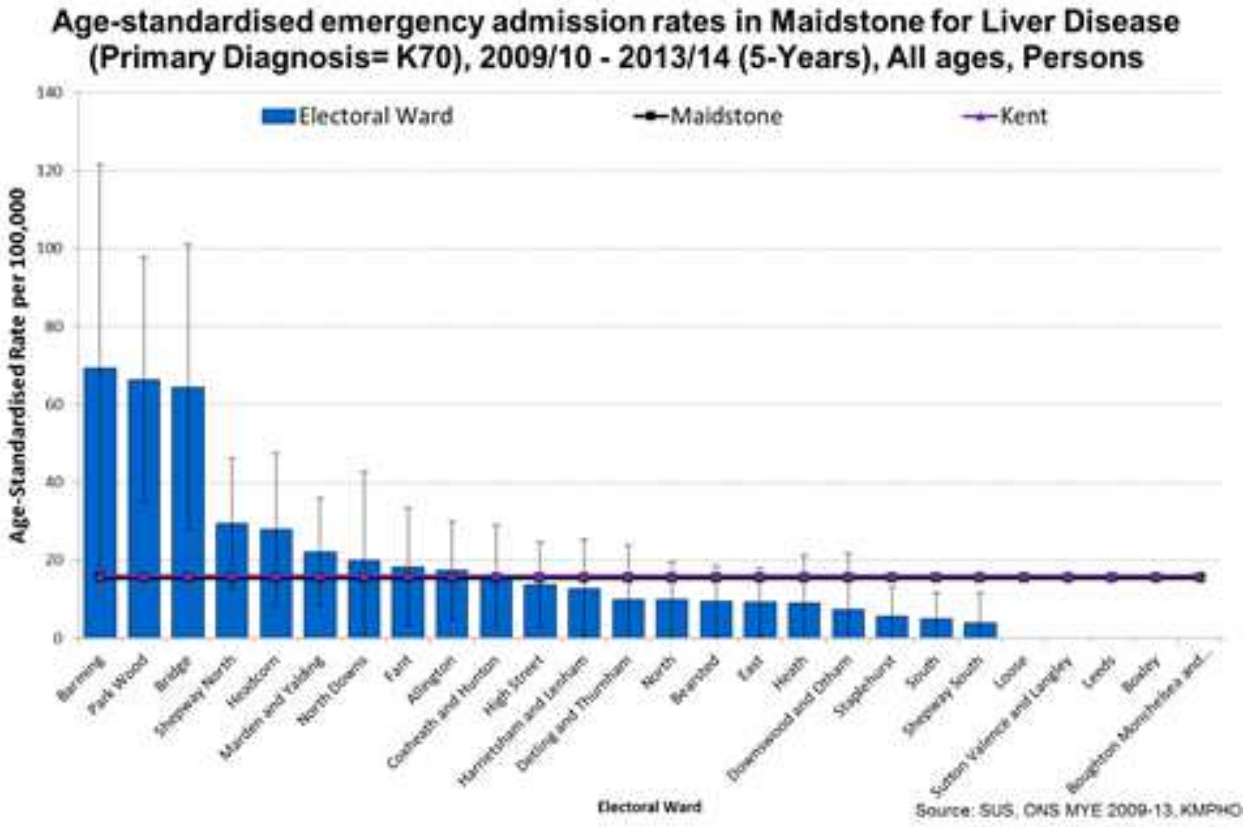
Table 1 Summary of LAPE profile Indicators, 2013 (Source: NWPHO, KMPHO)

Indicators	Maidstone	Sevenoaks	Tonbridge and Malling	Tunbridge Wells	South East region
Months of life lost - males	8.18	8.50	8.29	7.22	**9.89**
Months of life lost - females	4.80	3.86	4.35	4.19	**4.72**
Alcohol-specific mortality - males	9.89	7.25	5.06	6.27	**11.78**
Alcohol-specific mortality - females	6.39	4.13	2.68	4.07	**5.35**
Mortality from chronic liver disease - males	9.75	8.35	9.35	5.53	**12.94**
Mortality from chronic liver disease - females	7.65	5.46	4.95	4.66	**6.92**
Alcohol-related mortality - males	50.95	61.16	59.87	46.35	**58.49**
Alcohol-related mortality - females	*32.41	29.61	21.04	19.95	**25.95**
Alcohol-specific hospital admission - under 18s	25.73	28.64	40.87	37.44	**37.30**
Alcohol-specific hospital admission - males	370.90	240.78	337.96	356.64	**375.53**
Alcohol-specific hospital admission - females	151.53	143.71	132.04	216.57	**188.37**
Alcohol-related hospital admission (Broad) - males	1399.31	1228.20	1290.45	1241.49	**1409.59**
Alcohol-related hospital admission (Broad) - females	628.51	609.36	598.74	664.22	**705.48**
Alcohol-related hospital admission (Narrow) - males	500.75	442.61	457.00	489.03	**495.95**
Alcohol-related hospital admission (Narrow) - females	247.74	245.63	235.85	254.90	**267.25**
Admission episodes for alcohol-related conditions (Broad)	1469.74	1371.05	1359.91	1406.06	**1615.65**
Admission episodes for alcohol-related conditions (Narrow)	468.65	473.49	440.80	469.72	**513.12**
Alcohol-related recorded crimes	4.96	3.80	3.66	4.09	**4.90**
Alcohol-related violent crimes	3.73	2.07	2.51	3.14	**3.60**
Alcohol-related sexual offences	0.09	*0.15	0.08	0.08	**0.11**
Abstainers synthetic estimate	13.37	13.32	*13.15	13.44	**14.73**
Lower Risk drinking (% of drinkers only) synthetic estimate	72.36	72.69	72.82	*71.78	**72.71**
Increasing Risk drinking (% of drinkers only) synthetic estimate	20.86	20.85	20.69	*21.25	**20.54**
Higher Risk drinking (% of drinkers only) synthetic estimate	6.79	6.46	6.50	6.97	**6.75**
Binge drinking (synthetic estimate)	17.80	17.10	16.90	17.70	**18.10**
Employees in bars - % of all employees	1.58	2.09	1.30	1.41	**1.59**

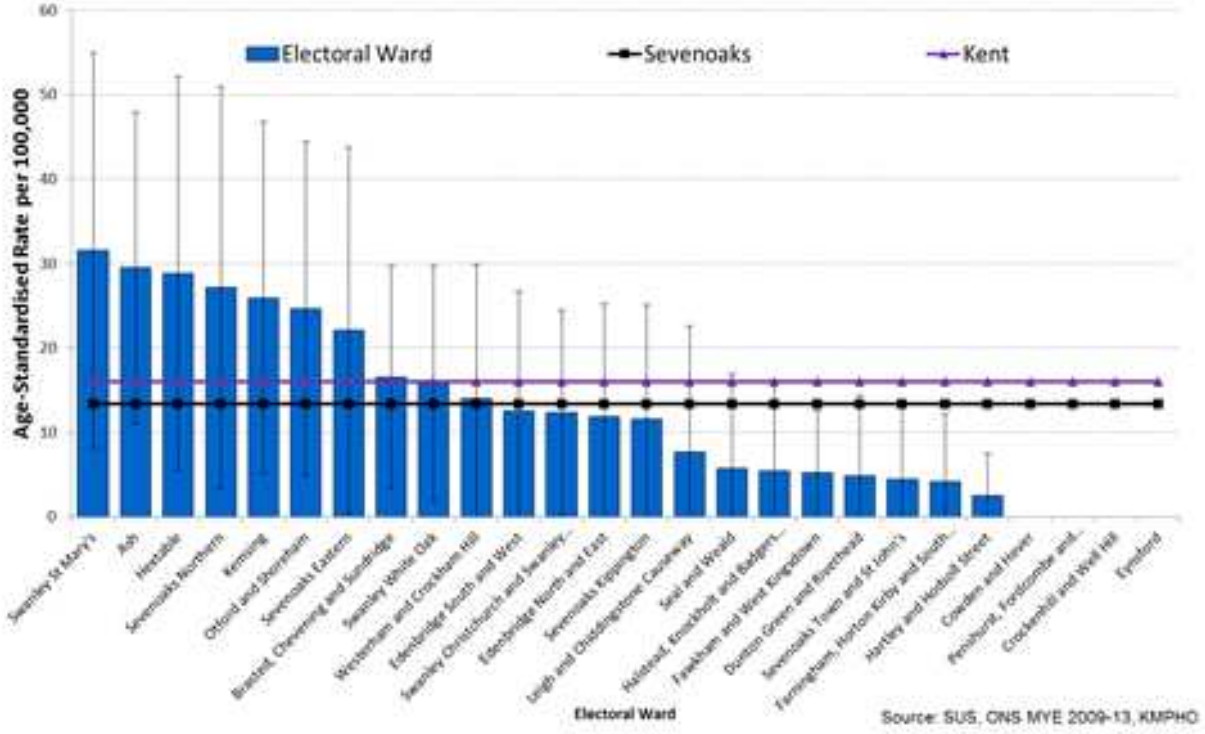
	Best locally
	Better performance than regional average
	Worse performance than regional average
	Worst locally

Tables 2 LAPE locality profile with definitions

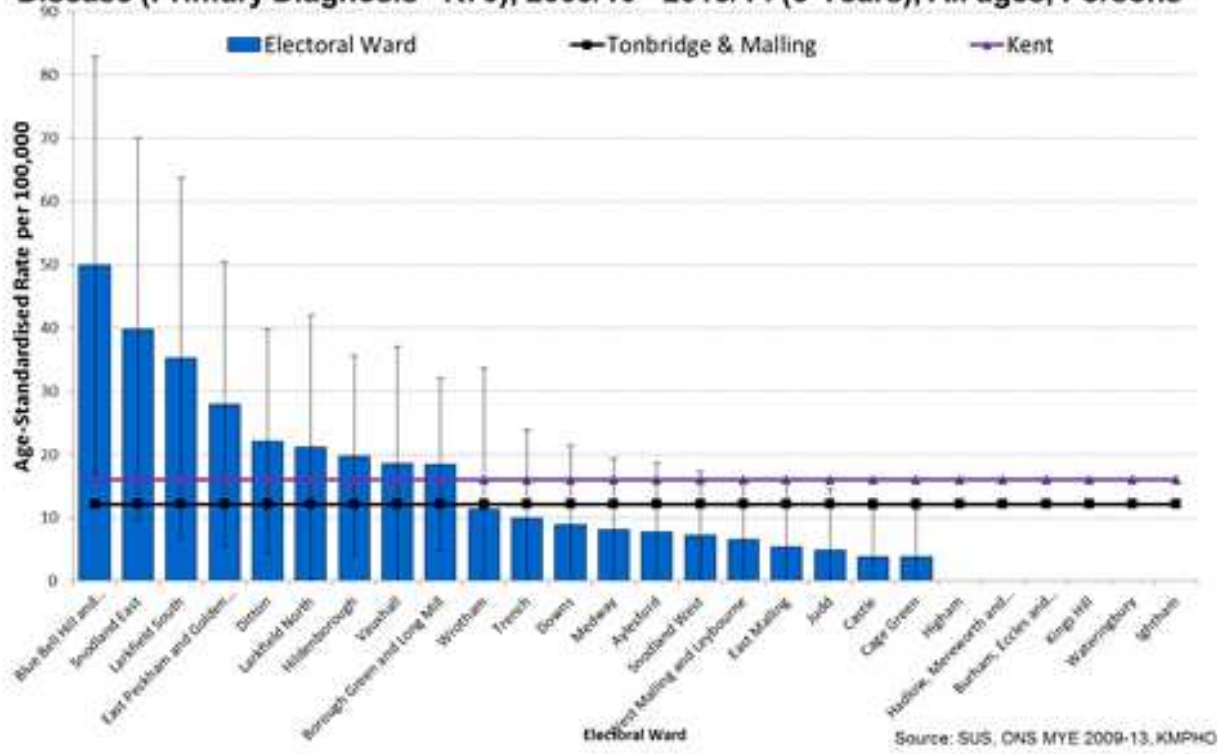
(278902863)
MaidstoneLAPEProfile2



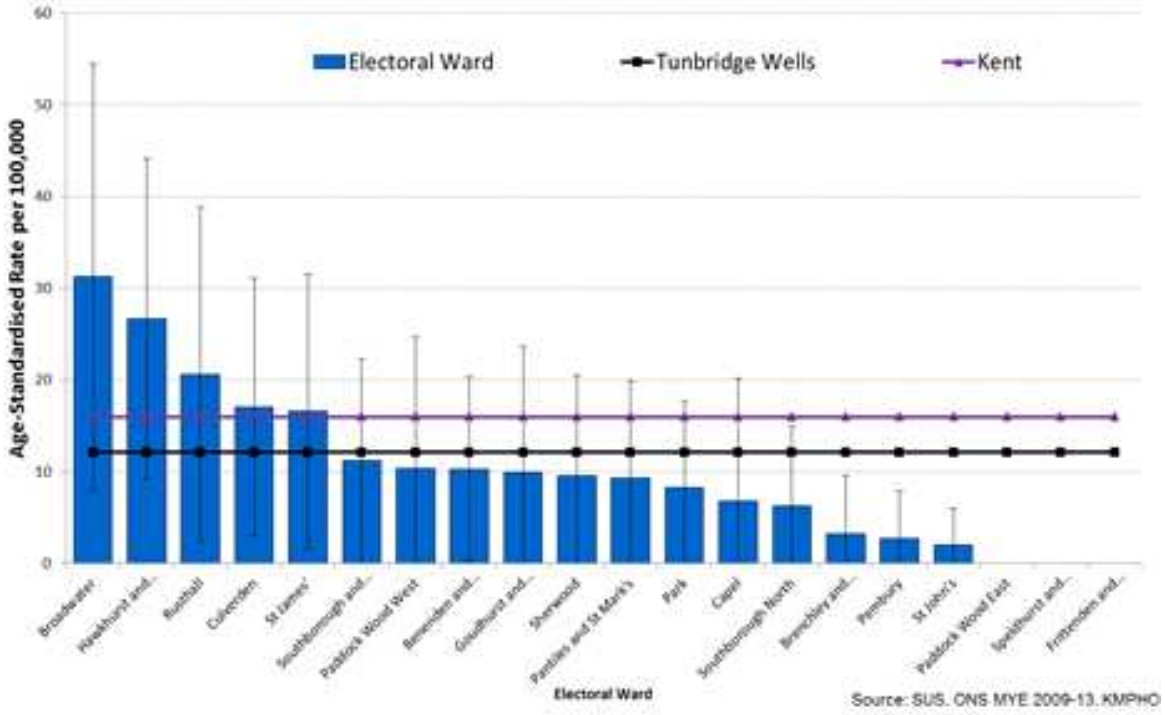
Age-standardised emergency admission rates in Sevenoaks for Liver Disease (Primary Diagnosis= K70), 2009/10 - 2013/14 (5-Years), All ages, Persons



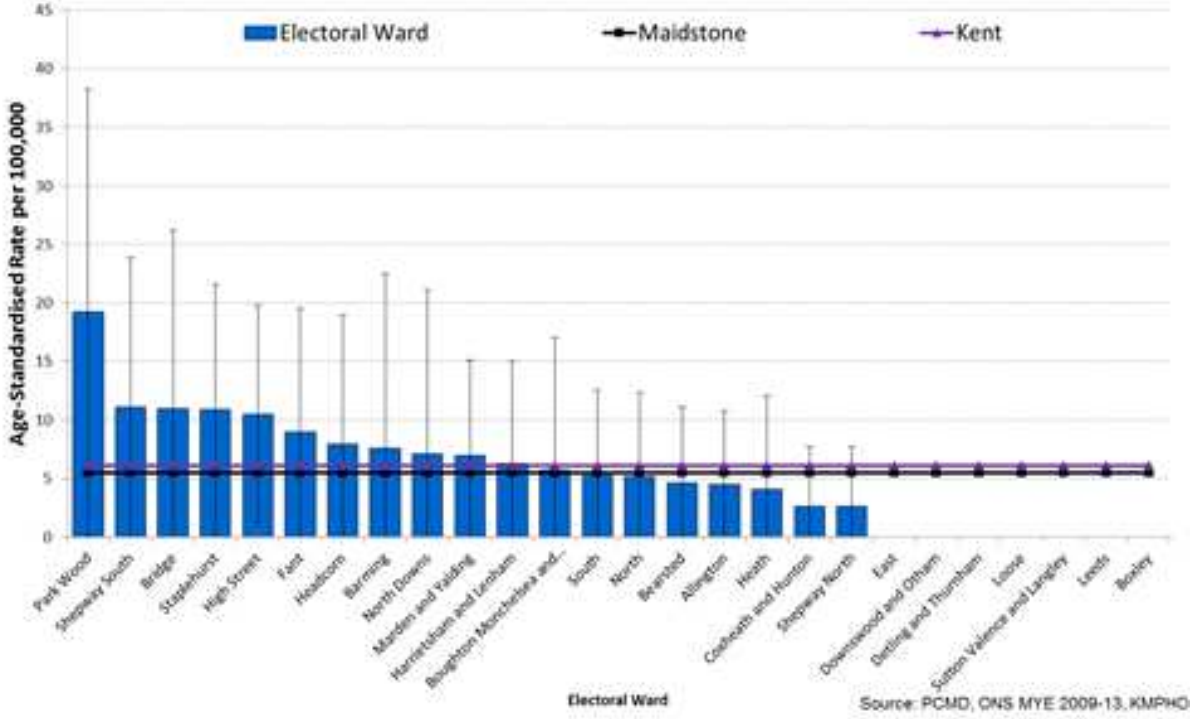
Age-standardised emergency admission rates in Tonbridge & Malling for Liver Disease (Primary Diagnosis= K70), 2009/10 - 2013/14 (5-Years), All ages, Persons



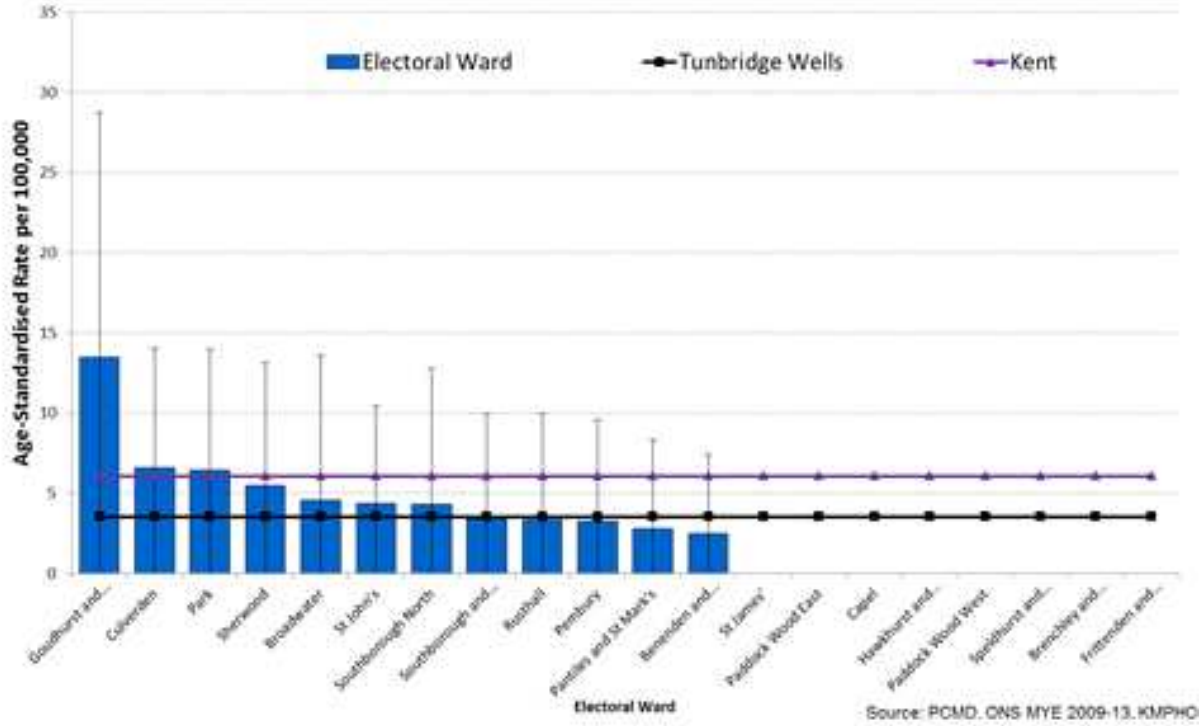
Age-standardised emergency admission rates in Tunbridge Wells for Liver Disease (Primary Diagnosis= K70), 2009/10 - 2013/14 (5-Years), All ages, Persons

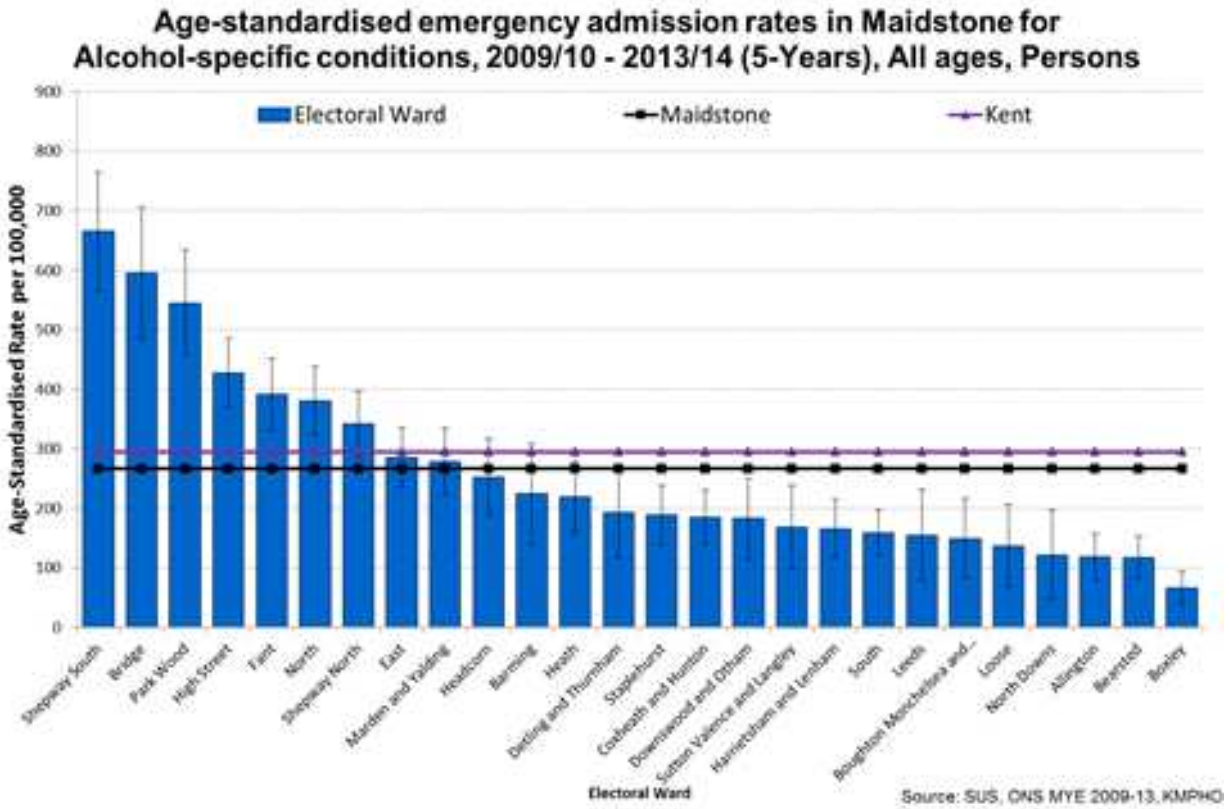


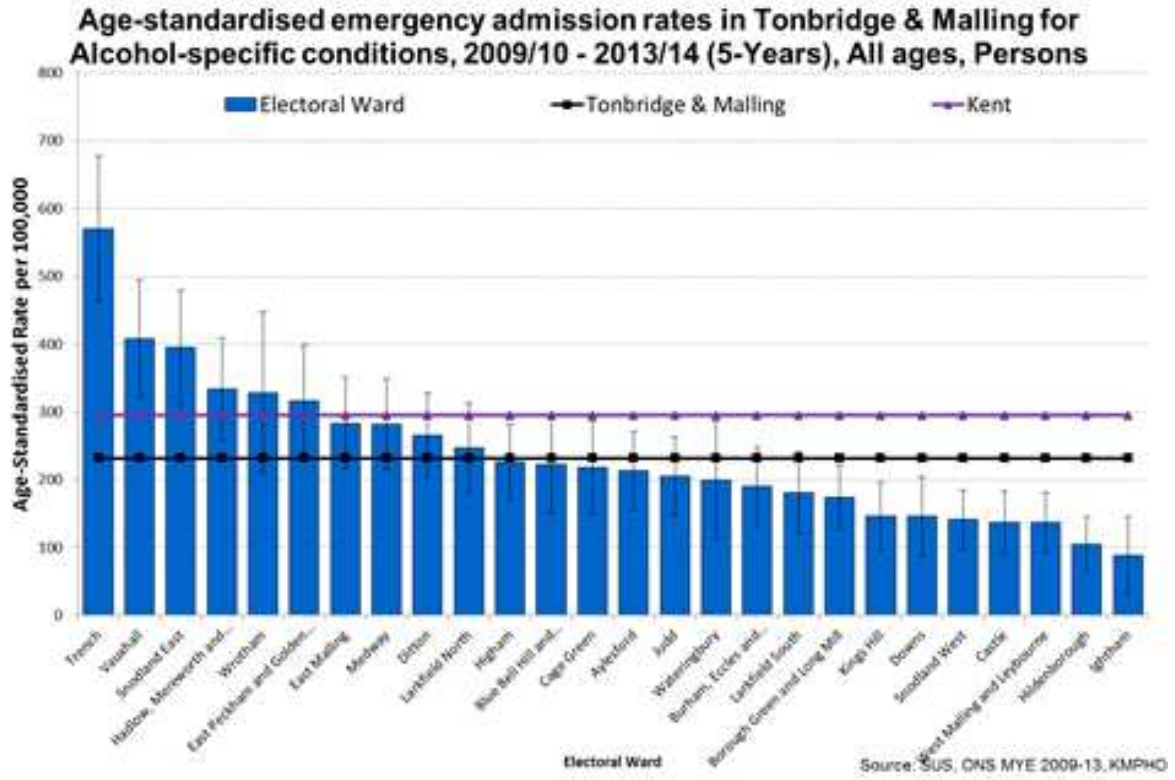
Age-standardised mortality rates in Maidstone for Liver Disease, 2009/10 - 2013/14 (5-Years), All ages, Persons

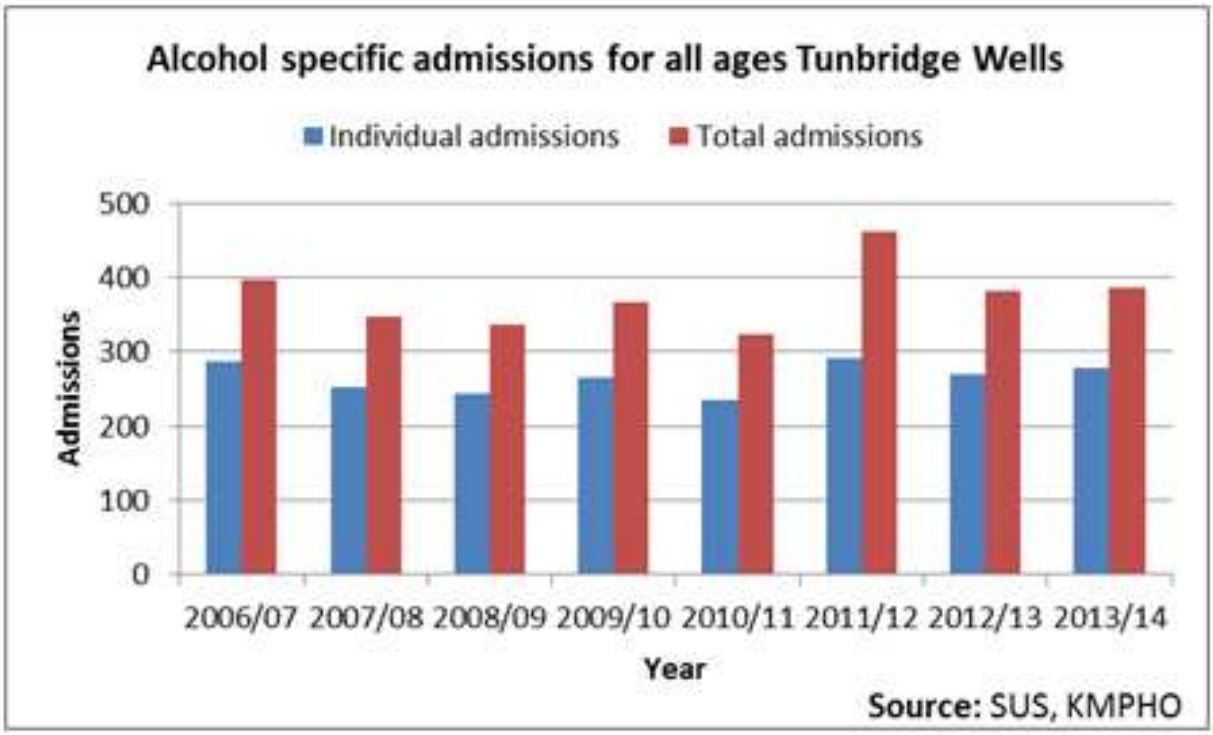


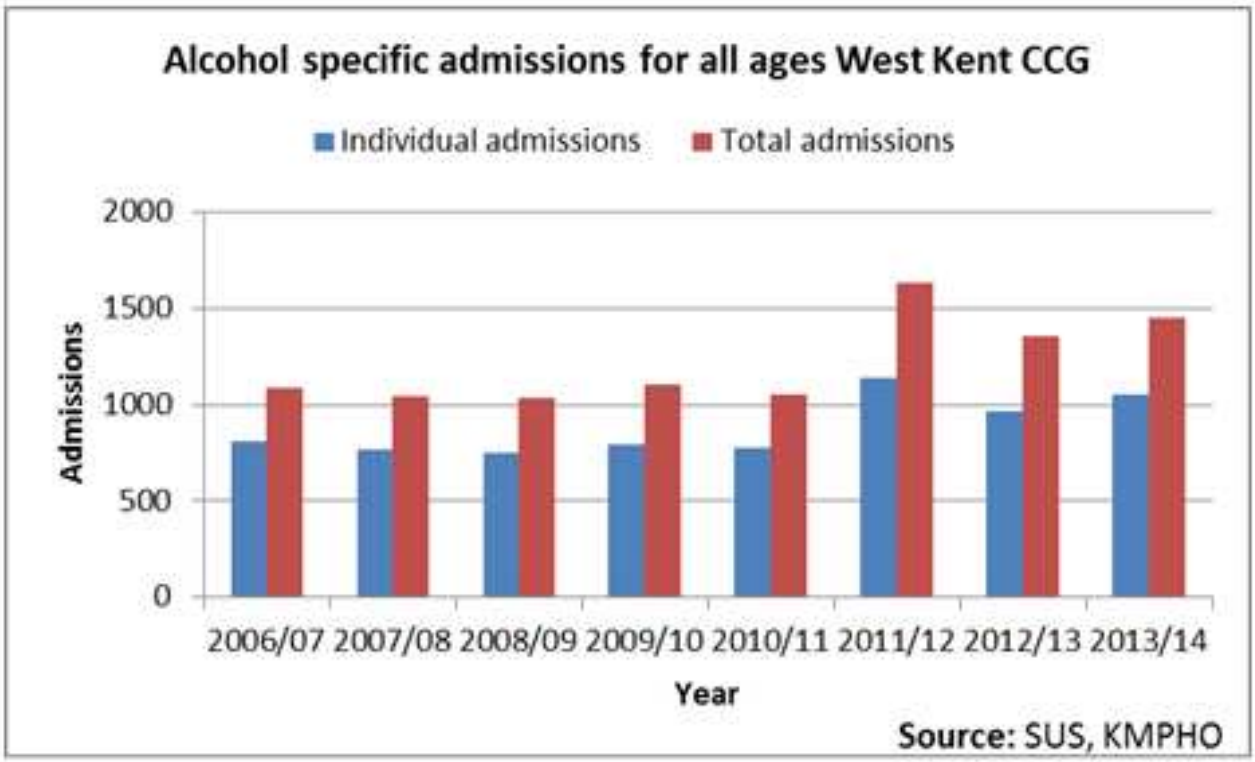
Age-standardised mortality rates in Tunbridge Wells for Liver Disease, 2009/10 - 2013/14 (5-Years), All ages, Persons

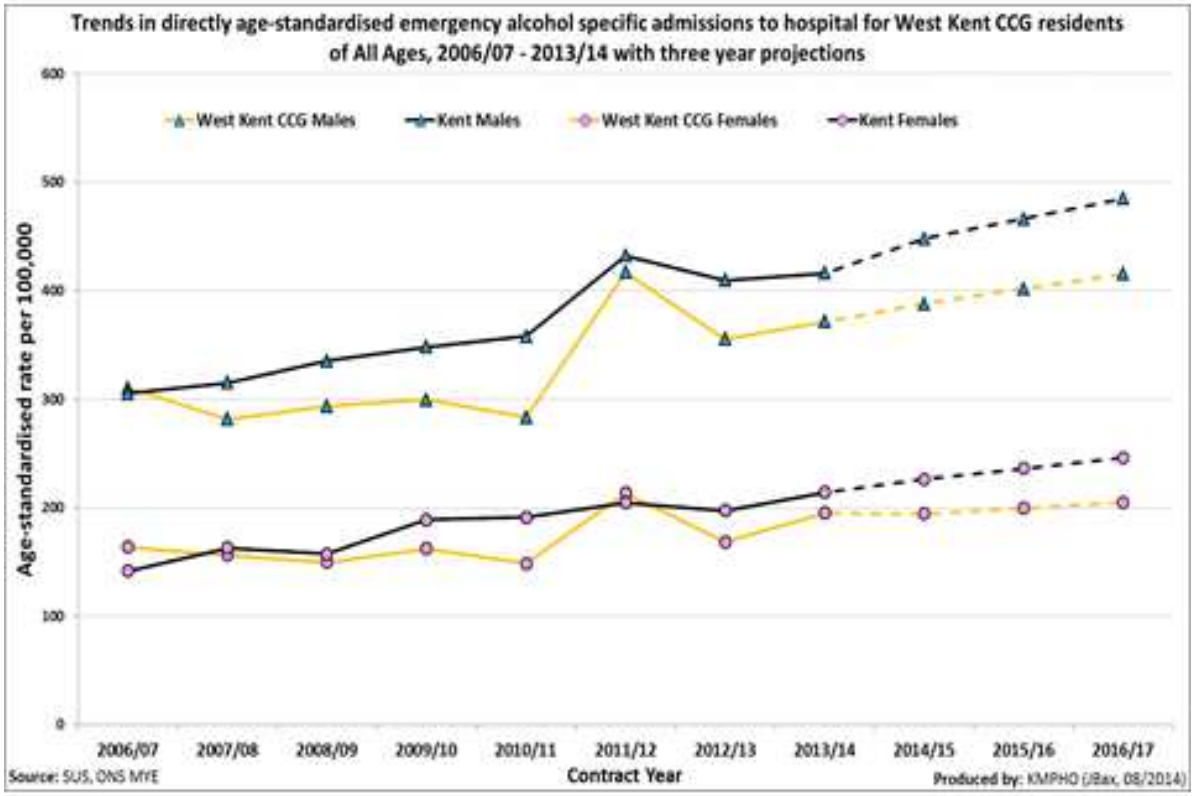


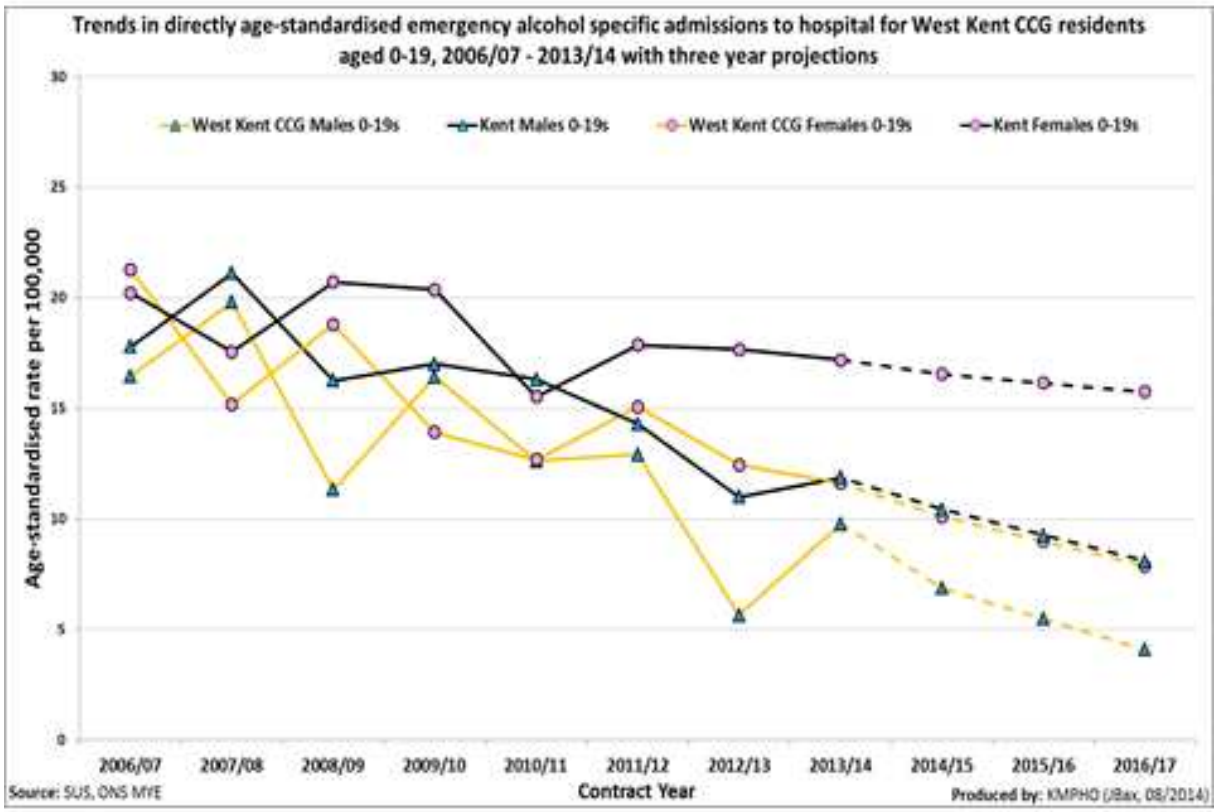

Age-standardised emergency admission rates in Maidstone for Alcohol-specific conditions, 2009/10 - 2013/14 (5-Years), All ages, Persons
Electoral Ward
Maidstone
Kent
Age-Standardised Rate per 100,000
900
800
700
600
500
400
300
200
100
0
Shepway South
Bridge
Park Wood
High Street
Fant
North
Shepway North
East
Marden and Yalding
Headcorn
Barming
Heath
Detling and Thurnham
Staplehurst
Coxheath and Hunton
Downswood and Otham
Sutton Valence and Langley
Harrietsham and Lenham
South
Leeds
Boughton Monchelsea and...
Loose
North Downs
Allington
Bearsted
Bowley
Electoral Ward
Source: SUS, ONS MYE 2009-13, KMPHO


Age-standardised emergency admission rates in Tonbridge & Malling for Alcohol-specific conditions, 2009/10 - 2013/14 (5-Years), All ages, Persons
Electoral Ward
Tonbridge & Malling
Kent
Age-Standardised Rate per 100,000
800
700
600
500
400
300
200
100
0
Trench
Vauxhall
Snodland East
Hadlow, Mereworth and...
Wrotham
East Peckham and Golden...
East Malling
Medway
Ditton
Larkfield North
Higham
Blue Bell Hill and...
Cage Green
Aylesford
Judd
Wateringbury
Burham, Eccles and...
Larkfield South
Borough Green and Long Mill
Kings Hill
Downs
Snodland West
Castle
West Malling and Leybourne
Hildenborough
Ightham
Electoral Ward
Source: SUS, ONS MYE 2009-13, KMPHO


Alcohol specific admissions for all ages Tunbridge Wells
Individual admissions
Total admissions
Admissions
500
400
300
200
100
0
2006/07 2007/08 2008/09 2009/10 2010/11 2011/12 2012/13 2013/14
Year
Source: SUS, KMPHO


Alcohol specific admissions for all ages West Kent CCG
Individual admissions
Total admissions
Admissions
2000
1500
1000
500
0
2006/07 2007/08 2008/09 2009/10 2010/11 2011/12 2012/13 2013/14
Year
Source: SUS, KMPHO


Trends in directly age-standardised emergency alcohol specific admissions to hospital for West Kent CCG residents of All Ages, 2006/07 - 2013/14 with three year projections
West Kent CCG Males
Kent Males
West Kent CCG Females
Kent Females
Age-standardised rate per 100,000
0
100
200
300
400
500
600
2006/07
2007/08
2008/09
2009/10
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17
Contract Year
Source: SUS, ONS MYE
Produced by: KMPHO (JBax, 08/2014)


Trends in directly age-standardised emergency alcohol specific admissions to hospital for West Kent CCG residents aged 0-19, 2006/07 - 2013/14 with three year projections
West Kent CCG Males 0-19s
Kent Males 0-19s
West Kent CCG Females 0-19s
Kent Females 0-19s
Age-standardised rate per 100,000
0
5
10
15
20
25
30
2006/07
2007/08
2008/09
2009/10
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17
Contract Year
Source: SUS, ONS MYE
Produced by: KMPHO (JBax, 08/2014)