






# Rural Health profile for Kent

Action with Communities in Rural England (ACRE) Rural Evidence project

20 November 2013



This rural health profile brings together quantitative data on rural health issues for your area, to help you with the evidence you need to strengthen and influence local health services. The profile is structured around the five themes shown below, alongside links to the more detailed subsections under each theme.

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This report was commissioned by Action with Communities in Rural England (ACRE) and the Rural Community Councils from Oxford Consultants for Social Inclusion (OCSI), [www.ocsi.co.uk](http://www.ocsi.co.uk) / 01273 810 270.

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### *The importance of robust local evidence on rural health issues*

The shift in how local health programmes are commissioned and delivered raises challenges and opportunities for rural health services. With new roles for Health and Wellbeing Boards, Clinical Commissioning Groups and local council public health teams, it is more important than ever that ACRE Network members can evidence the importance of rural health issues. This rural health profile provides robust data to help underpin effective planning, prioritisation and commissioning decisions for rural health services.

### *How this profile is intended to help you*

This profile brings together quantitative data on rural health issues for your area, to help you with the evidence you need to strengthen and influence local health services. Each of the sections shows data for rural areas in Kent, comparing with other areas (local authority and national averages), and with trends over time where data is available.

The information is organised under the five themes shown on the previous index page, and is intended to help you discuss questions like:

- Where are we now?
- What change has taken place in the past?
- What are the strengths (and weaknesses) in our community?
- What changes would we like to see in future, and what needs to be done?

Of course, we cannot show all the data for all the issues that you might be interested in, so in each section we have highlighted more detailed information that may be available, such as data held by local organisations and/ or published in public health reports.

The report has been designed so that you can work through each of the sections, or jump straight to the most useful parts using the index on page 2. More detailed data tables for Kent are in Appendix A, with details on the sources of the data in Appendix B.

### *How we have created this rural health profile*

This report covers the Local Economic Partnership (LEP) of Kent, in the area served by Action with Communities in Rural Kent. Appendix A shows all data for the local area compared against England (and rural and urban comparisons), while Appendix B shows details of the indicators.

To create this profile, OCSI have collected and aggregated health datasets for all rural and urban areas in England. To do this, we have used the Countryside Agency and Office for National Statistics (ONS) definitions of rural areas which were first created in 2004, and updated in summer 2013 based on 2011 Census data (see Appendix C for details).

You can access this and the other area profiles through the Rural Evidence website, [www.rural-evidence.org.uk](http://www.rural-evidence.org.uk) (you will need a login from ACRE to access the reports).

### *About the Rural Evidence programme and other available support*

Evidencing Rural Need shows the real picture of socio-economic issues across rural areas of England, and enables organisations to influence decisions about policies and services more effectively. Building on the pioneering work with the Rural Community Councils, ACRE commissioned Oxford Consultants for Social Inclusion (OCSI) to further develop a set of the reports for all rural areas across England.

Evidencing Rural Need comprises a series of reports, prepared for a range of geographies, initially highlighting the incidence of deprivation in rural communities throughout England but now including the rural economy, rural health and access to services. Although there is a great deal of data available for villages, hamlets and smaller towns, this information has not been brought together so succinctly in a single resource for all settlements and parishes in rural England.

The reports are available through Rural Community Council members but the full range and background information can be viewed at [www.rural-evidence.org.uk](http://www.rural-evidence.org.uk).



Health is defined by the World Health Organisation as “a state of physical, mental and social wellbeing and not only the absence of disease and disability”. In other words, it is important to understand public health in a broader sense than just measures of mortality (deaths), morbidity (illnesses) or disability.

In this report, we therefore look at a wide set of physical, mental and social wellbeing indicators. We start in this section by looking at the traditional indicators of health and wellbeing, such as life expectancy and mortality, disability, mental health and mortality rates due to common causes. Later sections go on to look at the local population (p11), social place & wellbeing (p17), healthy lifestyles and behaviours (p24) and service use (p27).

The table below shows the indicators we explore in this introductory health and wellbeing section.

Theme	Indicators
Overall wellbeing	People with a limiting long-term illness, Indices of Deprivation Health domain
Life expectancy and mortality	Healthy life expectancy, Total life expectancy, Standardised mortality ratios, Indices of Deprivation Years of Potential Life Lost
Disability	Disability free life expectancy at birth, Attendance Allowance claimants, Disability Living Allowance claimants, Indices of Deprivation Comparative Illness and Disability Ratio,
Mental health	Incapacity Benefit claimants for mental health reasons, Indices of Deprivation Mood and Anxiety Disorder indicator
Cancers, cardiovascular & respiratory health	Standardised mortality ratios for cancer, coronary heart disease, stroke, circulatory disease and respiratory disease

### *What other data may be available?*

As with all analysis in this report, we have used data published for all small areas across the country, aggregated to local rural areas. Additional detailed local datasets may be available from organisations such as the local authority, while some useful data is published nationally only for larger geographies (so cannot be broken-down for local rural areas). Other relevant data includes:

- Morbidity data: prevalence of non-fatal (possibly recurrent) health conditions may be available from Clinical Commissioning Groups for local areas
- Data on maternity related health outcomes, including infant mortality, still births and low birth weight are collected by the ONS at Local Authority level <http://www.statistics.gov.uk/hub/population/births-and-fertility/live-births-and-stillbirths/>
- Prevalence of mental health issues, including dementia, and numbers of people with learning disabilities are collected by the Projecting Adult Needs and Services information system (PANSI) for upper-tier Local Authorities <http://www.pansi.org.uk/>
- A range of sexual health indicators are collected and published by the Health Protection Agency at Local Authority level <http://www.data4nr.net/resources/health--disability/1469/>
- Office for National Statistics: Measuring National Well-being – Health publication <http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/health/index.html>



We start by looking at indicators of overall wellbeing, including people with limiting long-term illness, and local levels of health deprivation.

### What information is shown here?

The data highlight boxes display the number of people in Kent who have a limiting long term illness, for all people and for people aged 16-64. The Indices of Deprivation Health domain shows the number of LSOA's in the most deprived 20% on this measure. The domain measures morbidity, disability and premature mortality but not aspects of behaviour or environment that may be predictive of future health deprivation.

Figure 1 shows the share of people with a limiting long term illness who are living in urban and rural areas in Kent. Figure 2 shows the proportion of all people with poor health in rural and urban areas in Kent.

Fig 1. People with a limiting long-term illness

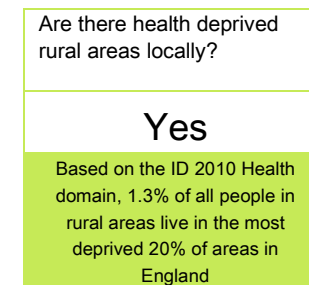
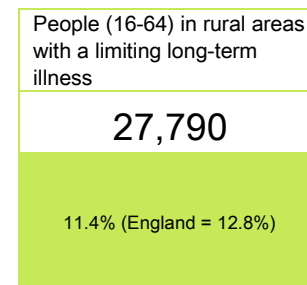
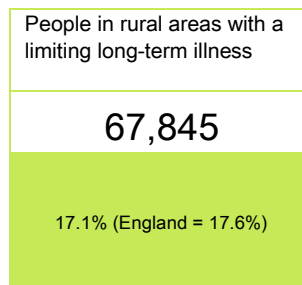
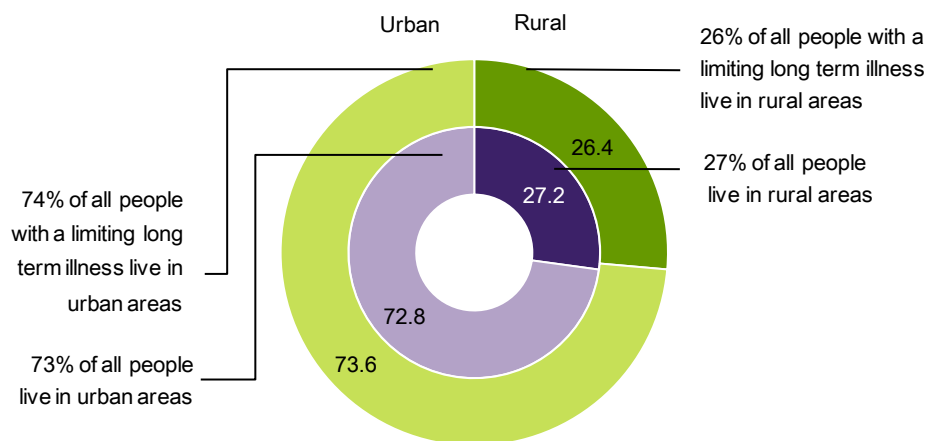
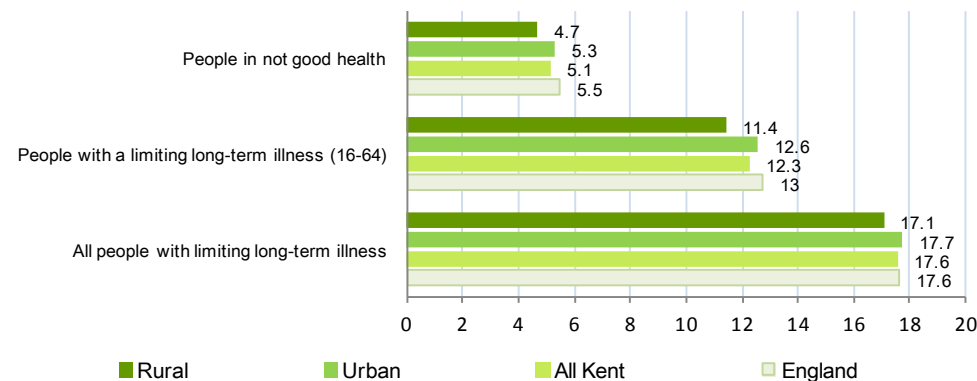


Fig 2. People with health problems



In rural Kent a lower % of 16-64 year olds have a limiting long term illness compared with urban areas

Sources: Census 2011, Indices of Deprivation 2010



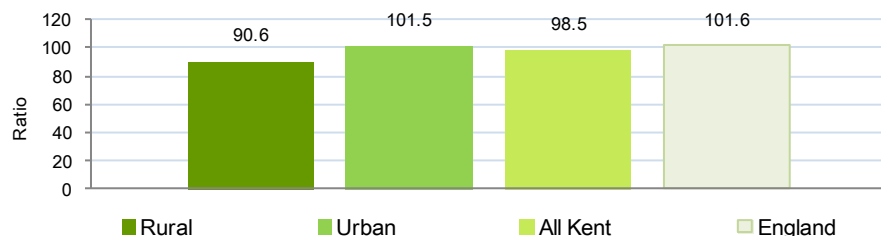
The expected and actual life outcomes of people in the local area are important indicators to take into account by health commissioners and providers looking to both improve services and tackle health inequalities.

### What information is shown here?

The data highlights show life expectancy and healthy life expectancy for females and males in Kent from 1999-2003 (this is the most recent data published nationally for small areas, local health agencies may hold more up-to-date data for small areas).

Figure 3 shows healthy life expectancy from birth for females, males and both sexes for rural and urban areas locally. Figure 4 shows the standardised mortality ratio for all causes and all ages for urban and rural areas locally. This indicator highlights the ratio of observed to expected deaths (given the age profile of the population)<sup>1</sup>.

Fig 4. Standardised Mortality ratio (all causes and ages)

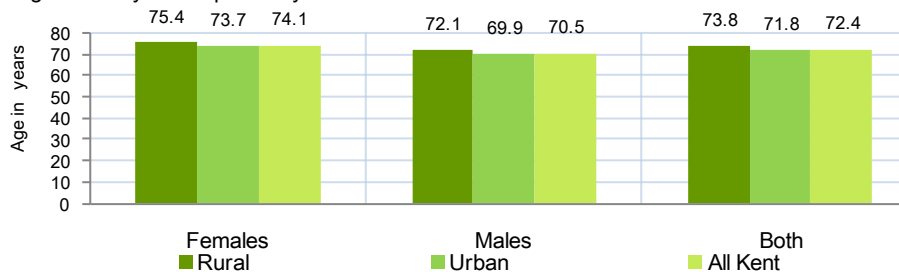


The standardised mortality ratio is lower in rural Kent compared to urban areas

Healthy life expectancy for females in rural areas	Healthy life expectancy for males in rural areas	Total life expectancy for females in rural areas	Total life expectancy for males in rural areas
<b>75 years</b>	<b>72 years</b>	<b>82 years</b>	<b>78 years</b>
74 years in urban areas	70 years in urban areas	81 years in urban areas	76 years in urban areas

Source: ONS life expectancy estimates at ward level (1999-2003). ONS standardised mortality (2005-2009) - Population weighted aggregation from SOA to rural urban areas.

Fig 3. Healthy Life Expectancy



Healthy life expectancy is higher in rural Kent compared with urban areas

<sup>1</sup> A mortality ratio of 100 indicates an area has a mortality rate consistent with the age profile of the area, a mortality rate of more/ less than 100 indicates that the mortality rate is higher/ lower than expected given the overall age profile of the area. Note a mortality rate of 100 does not equal the national average mortality rate (it represents the average mortality rate for an area with that age profile).



Understanding the level of disability in the local area can help ensure both sufficient provision of (and equity of access to) health care, and also that the right support mechanisms are in place to prevent further inequalities as a result of disability, e.g. in education, employment, housing, service use and so on. In addition, due to the distance people can live from services, mobility and isolation are key concerns for public health providers in rural areas; this becomes even more the case when considering disability as a factor.

### What information is shown here?

There is a limited amount of data available at small area levels on the types of disabilities in rural areas, but the proportion of people claiming disability related benefits provides an overview of levels of disability in the area.

Figure 5 shows disability free life expectancy at birth (1999-2003) for rural and urban areas in Kent.

Figure 6 shows the Indices of Deprivation 2010 Comparative Illness and Disability Ratio. This is an age and sex standardised measure of the number of people receiving health related benefits (Disability Living Allowance, Severe Disablement Allowance, Incapacity Benefit, Attendance Allowance and the disability premium of Income Support)<sup>2</sup>.

Figures 7-10 (on the following page) show people receiving Disability Living Allowance (a benefit payable to people who become disabled before the age of 65) and Attendance Allowance (for people aged 65+ with social care needs). Figures 7 and 8 show the change in the proportion of people claiming these benefits from 2002-2013 in rural and urban Kent and figures 9 and 10 compare the age breakdowns of these people.

Older people with social care needs (Attendance Allowance)
<b>10,525</b>
13% of older people claim Attendance Allowance in rural areas and 16% claim in urban areas

People with a disability (Disability Living Allowance)
<b>16,685</b>
4% of people claim Disability Living Allowance in rural areas and 5% claim in urban areas

Fig 5. Disability Free Life Expectancy

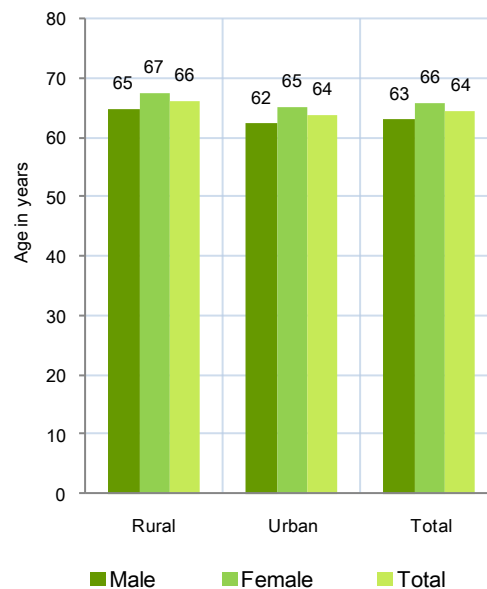
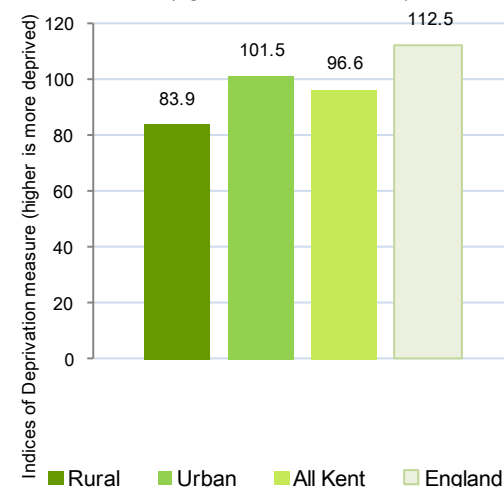


Fig 6. Indices of Deprivation: People receiving health benefits (age standardised score)



Sources: DWP (Feb-13), ONS (1999-2003), Indices of Deprivation 2010.

<sup>2</sup> Data is standardised by calculating the numbers receiving health benefits by five year age-sex band, divided by the total population by five year age-sex band (note shrinkage is applied so the score is not a rate out of 100, but a relative score, with higher scores indicating a higher level of illness and disability).



Fig 7 People with a disability (receiving Disability Living Allowance)

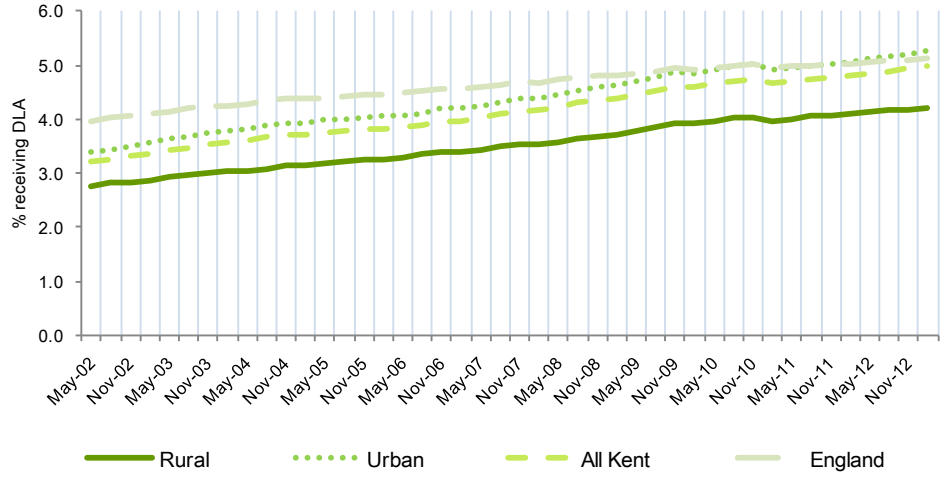


Fig 8. Older people with social care needs (receiving Attendance Allowance)

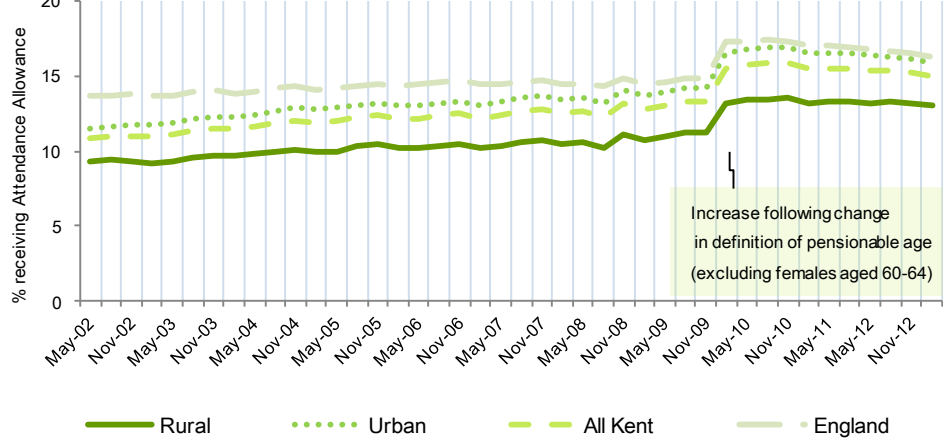
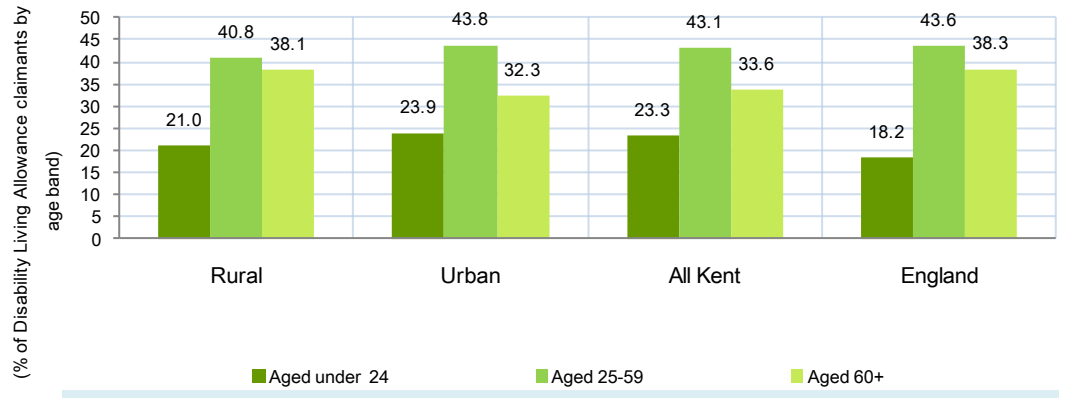
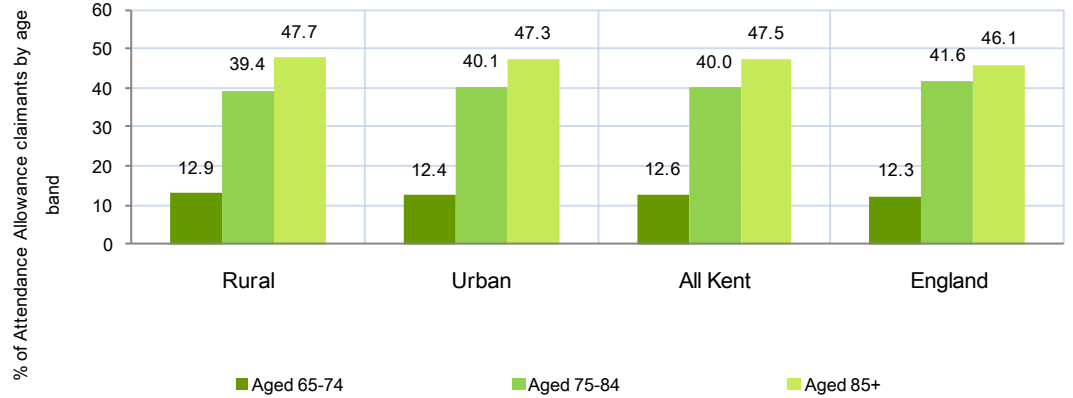


Fig 9. Age breakdown of people claiming Disability Living Allowance



In rural Kent a lower proportion of Disability Living Allowance claimants are aged under 16 and a higher proportion are aged 65+ compared with local urban areas

Fig 10. Age breakdown of people claiming Attendance Allowance



A similar proportion of Attendance Allowance claimants are aged 85 and over in rural Kent compared with urban areas

Source: DWP (Feb-13). Population weighted aggregation from SOA to rural urban areas.





The far-reaching impact of mental health issues costs the NHS an estimated £77 billion a year. However, recent research has suggested that 75% of people suffering mental health problems go untreated<sup>3</sup>. Mental health issues can affect people to varying degrees, and have a range of possible causes; as a result, mental health relates in some way to most of the indicators highlighted in this report.

Studies on rural inequalities have shown that mental health is a major component affecting wellbeing in rural areas, for example showing that suicide rates amongst farmers are particularly high. With certain groups more vulnerable to mental health problems, and the high levels of untreated mental health issues, it is important to ensure that adequate mental health services and support are available to people living in rural areas.

### What information is shown here?

Figure 11 shows the Indices of Deprivation measure for mood and anxiety disorders, for rural and urban areas in Kent. This is composite measure using a number of mental health measures<sup>4</sup> combined into an overall score, with a higher positive score indicating higher levels of mood and anxiety disorders and a lower negative score indicating low levels of mood and anxiety disorders. Figure 12 shows the change in the proportion of people claiming Incapacity Benefit (IB) for mental health reasons from 1999-2013 for rural and urban areas in Kent. From November 2009 IB was no longer provided for new claimants; people who are out of work for mental health reasons were now eligible for Employment Support Allowance<sup>5</sup>.

Number claiming Incapacity Benefit for Mental Health reasons in rural areas

**1,580**

0.7% of people in rural areas, compared with 0.9% in urban areas

Fig 11. Indices of Deprivation 2010 mood and anxiety levels score (higher = more deprived)

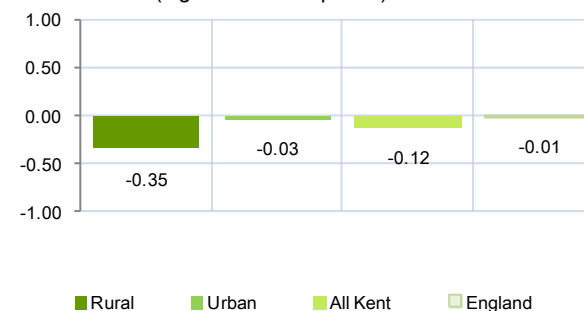
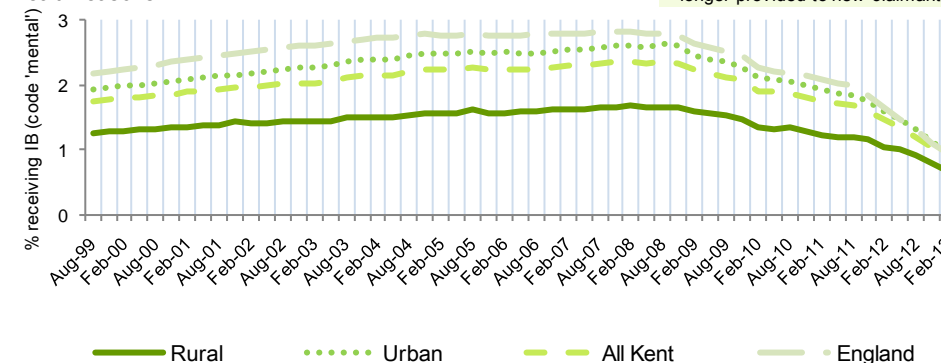


Fig 12. People receiving Incapacity Benefits (IB) for mental health reasons



The % claiming IB for mental health reasons is similar in rural areas compared with urban areas

Sources: DWP (Feb-13), Indices of Deprivation 2010. Population weighted aggregation from SOA to rural urban areas.

<sup>3</sup> Centre for Performance, Mental Health Policy Group, 2012, "How mental illness loses out in the NHS" (Available Online: <http://bit.ly/QOLwbn>)

<sup>4</sup> Prescribing data for 2005 from NHS Prescription Services, hospital episode data for 2006-07 and 2007-08 from the NHS Information Centre, suicide mortality data for 2004-2008 from the ONS and health benefits data for 2008 from the DWP

<sup>5</sup> Figures on the number of people receiving Employment Support Allowance due to mental health reasons are not published for rural areas and cannot be reported here.



Mortality rates are an immediate and direct measure of the levels of health in local areas, and a key indicator of the need for particular local services and support. The types of illnesses people suffer are affected by a variety of lifestyle and physical factors, and because of this are likely to vary between different communities. For example, cancer and asthma outcomes have been highlighted as poor in some rural areas.

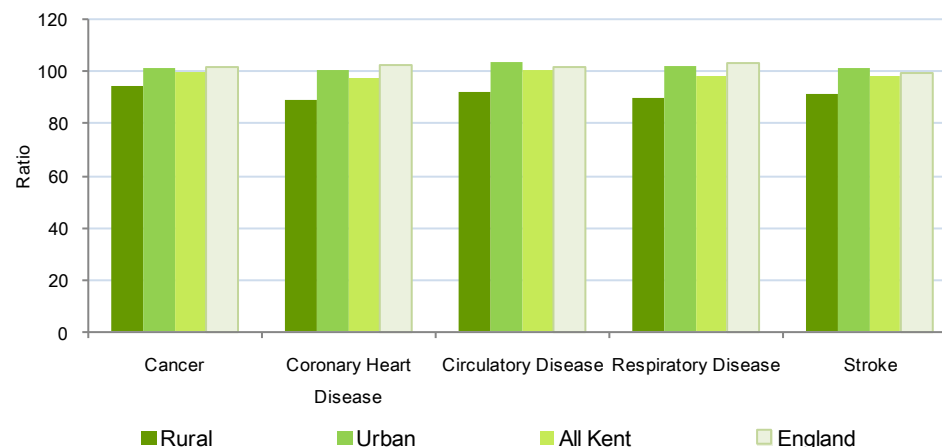
### *What information is shown here?*

There is a limited amount of material available to form a local rural health analysis. Morbidity measures (prevalence and incidence rates) for select illnesses are likely to be the most useful indicators of rural health outcomes; but the data is relatively incomplete for small areas and so generally not assessable for rural areas. This is for a number of reasons but includes confidentiality and the worry that anonymity may not be preserved due to the sparsity of many rural communities.

Mortality rates can be used as proxy indicators of health status amongst rural populations; however it is important to recognise that mortality rates are influenced by the age profile of the population in rural areas.

Figure 13 shows the standardised mortality ratio for five select causes, for rural and urban Kent. The standardised mortality ratio measures the level of observed deaths for each condition against 'expected' deaths for each condition ('expected' deaths' are the level of deaths that would be expected in an area given the area's age profile)<sup>6</sup>.

Fig 13. Standardised Mortality Ratio (select causes)



Sources: ONS Standardised Mortality Ratios (2005-2009), ONS 2010. Population weighted aggregation from MSOA to rural urban areas.

<sup>6</sup> A mortality ratio of 100 indicates an area has a mortality rate consistent with the age profile of the area, a mortality rate of more/less than 100 indicates that the mortality rate is higher/lower than expected given the overall age profile of the area. Note a mortality rate of 100 does not equal the national average mortality rate (it represents the average mortality rate for an area with that age profile).



A detailed understanding of the local population is important information for rural health services, as population size and structure is a major driver of health need and demand. This information also sets a benchmark against which other data can be compared, helping to identify inequalities and modelling service requirements.

This section looks at the following key issues:

Theme	Indicators
Age and gender	Total population, population by five year age band, population by broad age band
Ethnicity	Population in non-white ethnic groups, population by broad ethnic group
Births and deaths	Number of live births, crude death rate
Groups with specific needs	People providing unpaid care, single pensioner households, full time students and school children, lone parents, households with no car or van, households with multiple needs

### *What other data may be available?*

Additional detailed local datasets may be available from organisations such as the local authority, while some useful data is published nationally only for larger geographies (so cannot be broken-down for local rural areas). Other relevant data includes:

- More detailed breakdowns of population sizes by age and gender are published by government: [www.data4nr.net/resources/527](http://www.data4nr.net/resources/527)
- Population projections data by age and gender to 2033 are available at Local Authority level: [www.data4nr.net/resources/797](http://www.data4nr.net/resources/797)
- GPs hold information on number of people registered with GP practices that can be used to inform local measures of population and migration
- Data on births by ethnicity of baby and age / country of birth of mother are also published at Local Authority level, [www.data4nr.net/resources/436](http://www.data4nr.net/resources/436).
- Data on pupil ethnicity at Local Authority level, [www.data4nr.net/resources/247](http://www.data4nr.net/resources/247).
- Data on pupils with English as an Additional Language are published for upper-tier Local Authority level, see [www.data4nr.net/resources/249](http://www.data4nr.net/resources/249).
- There is a range of more detailed birth data at Local Authority level including birth rates by age of mother [www.data4nr.net/resources/1429](http://www.data4nr.net/resources/1429)
- There is a range of communities of interest data for larger geographies, including: Children on the child protection register ([www.data4nr.net/resources/528](http://www.data4nr.net/resources/528)), children with statements of Special Educational Needs ([www.data4nr.net/resources/250](http://www.data4nr.net/resources/250)), Gypsies and Travellers ([www.data4nr.net/resources/250](http://www.data4nr.net/resources/250)), homeless people ([www.data4nr.net/resources/1334](http://www.data4nr.net/resources/1334)), looked-after children and those leaving care ([www.data4nr.net/resources/512](http://www.data4nr.net/resources/512)), migrant workers ([www.data4nr.net/resources/1111](http://www.data4nr.net/resources/1111)), refugees and asylum seekers ([www.data4nr.net/resources/375](http://www.data4nr.net/resources/375)), teenage parents ([www.data4nr.net/resources/803](http://www.data4nr.net/resources/803)), NEETs ([www.data4nr.net/resources/1020](http://www.data4nr.net/resources/1020))



Information on the age and gender of the local population can help commissioners and providers target services to those areas and communities most in need of such services.

### What information is shown here?

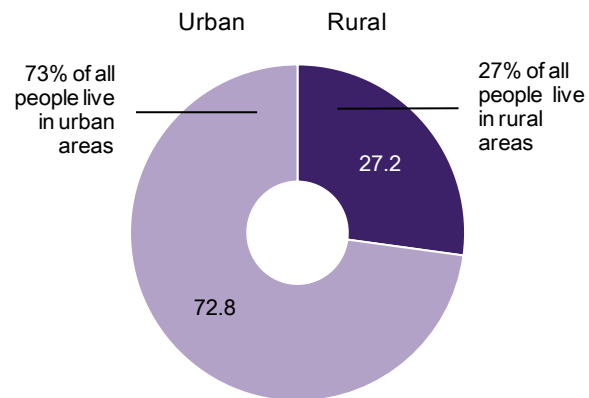
The information on the right shows the number of people living in rural Kent (figures are taken from Census 2011). Also shown is the breakdown of the population by sex and age and the dependency ratio (the ratio of non-working age to working age population).

Figure 14 shows the proportion of the population living in rural and urban areas. Figure 15 shows a population pyramid comparing the proportion of males and females in rural Kent by five year age band. Figure 16 shows how the proportion of the population is changing over time in rural and urban areas in Kent. Figure 17 shows the age breakdown of the population in rural and urban Kent.

How many people live in rural areas	How many people are aged 0-15 in rural areas	How many people are aged 65+ in rural areas	Dependency ratio (in rural areas)
<b>397,665</b>	<b>74,235</b>	<b>80,440</b>	<b>63.65</b>
27% of all people locally; 49.0% male; 51.0% female	18.7% (Urban = 19.7%)	20.2% (Urban = 17.1%)	Urban = 58.03

The dependency ratio is an age-population ratio of those typically not in the labour force (the *dependency* part) and those typically in the labour force. For example, the population aged 0-15 or over 65 expressed as a ratio of the working age population

Fig 14. People living in rural and urban areas



Sources: Census 2011



Fig 15. Population estimates by 5 year age band

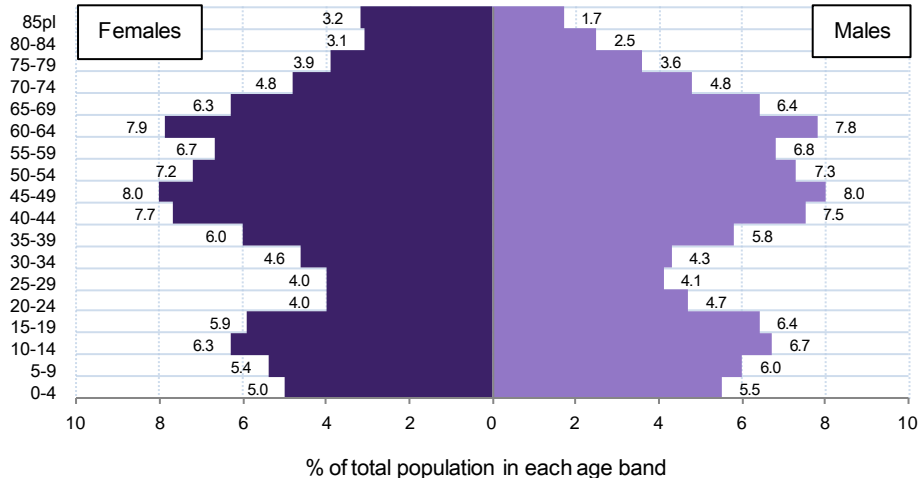


Fig 17 Population by age

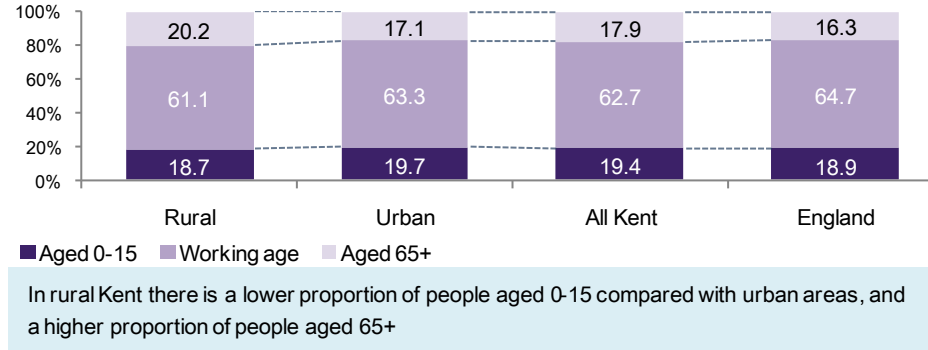
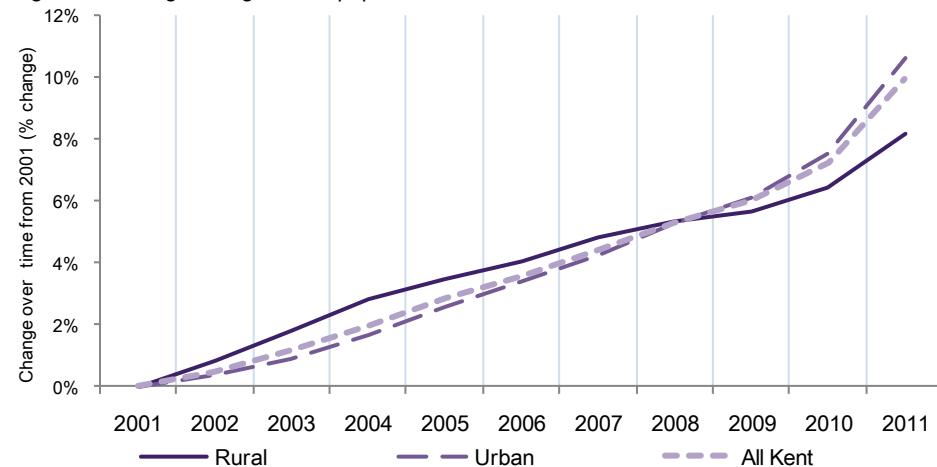


Fig 16 Percentage change in total population from 2001-2010



Sources: Census 2011



There is evidence that people from ethnically diverse backgrounds – particularly patients with low English language proficiency – can receive poorer quality services compared to others, and are more likely to experience adverse events in their journey through the health system.

Ethnicity can also influence exposure to particular risks or health behaviours that impact on health, e.g. chewing betel liquid and paan among some Asian men, is strongly associated with mouth cancer. Some genetic conditions are more strongly associated with particular ethnic groups e.g. diabetes among south Asian men. These factors will impact on how best to design health services for specific populations, whilst also aiming to reduce any inequalities in health outcomes and service access.

### What information is shown here?

The data tables and Figure 18 on the right show the proportion of people by ethnic group in rural and urban Kent.

The data table on the far right shows the total number of people from areas locally registering for a National Insurance number. This is a measure of the level of overseas migration into the local area; recently published by DWP to small area.

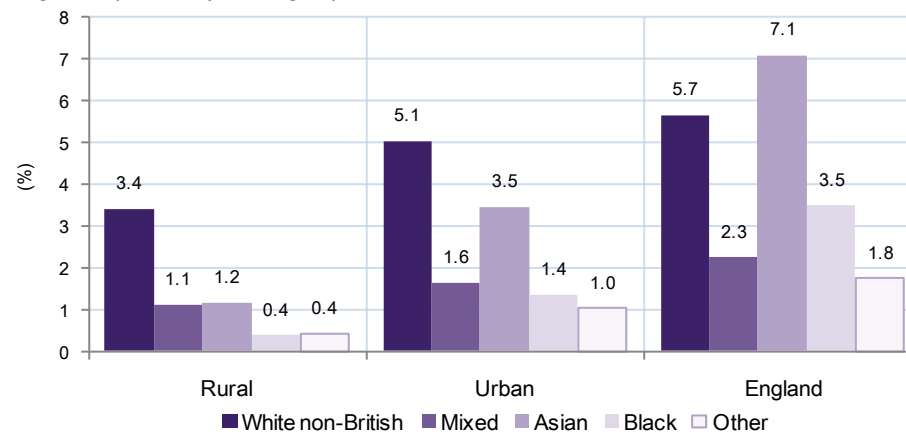
People of White British ethnicity in rural areas
<b>371,510</b>
93.4% (Urban average = 87.4%)

People from Black or Minority Ethnic groups in rural areas
<b>26,155</b>
6.6% (Urban average = 12.6%)

Overseas migrants* in rural areas (as % of working age population)
<b>2,820</b>
1.2% (Urban average = 1.1%)

\*Based on the number of people from overseas registering locally for a National Insurance number

Fig 18. Population by ethnic group



The % of BME groups is lower in rural areas compared with urban areas

Source: Census 2011. DWP (2011-12) population weighted aggregation from ward to rural urban areas.



### What information is shown here?

Figures on the number of birth and deaths in the local area are collected by the Office for National Statistics (ONS). The data highlight tables (right) show the number of births and deaths in rural areas in Kent in 2010 (the most recent year for which data was collected). Figure 19 shows the percentage of births to people living in rural areas. Figure 20 shows the percentage of deaths occurring in rural and urban areas. Figure 21 compares the crude death rate (per 100,000 population) in rural and urban areas in Kent.

Source: ONS 2010. Population weighted aggregation from MSOA to rural urban areas.

Number of births in rural areas (2010)	Number of deaths in rural areas (2010)
<b>3,830</b>	<b>3,645</b>
51.2% male; 48.8% female	48.3% male; 51.7% female

Fig 19. Births

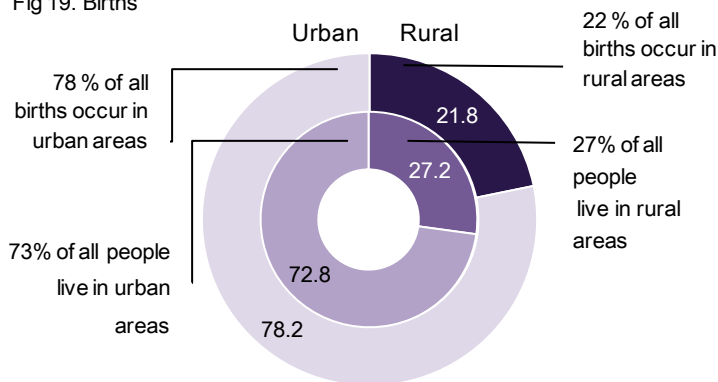
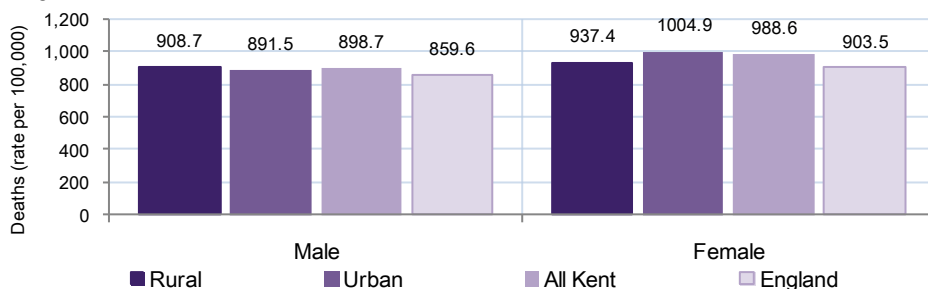


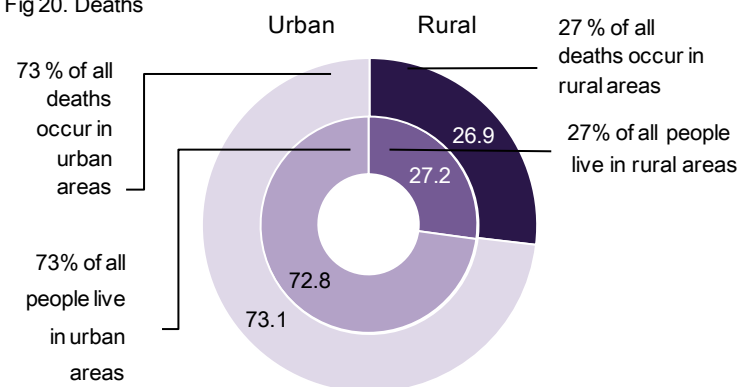
Fig 21. Crude death rate



Male death rates are higher in rural areas compared with urban areas

Female death rates are lower in rural areas compared with urban areas

Fig 20. Deaths





Tackling health inequalities requires information on the actual or estimated number of people in particular population groups. Understanding the population composition can help answer the question; what about the local population might require a different approach to local services?

### What information is shown here?

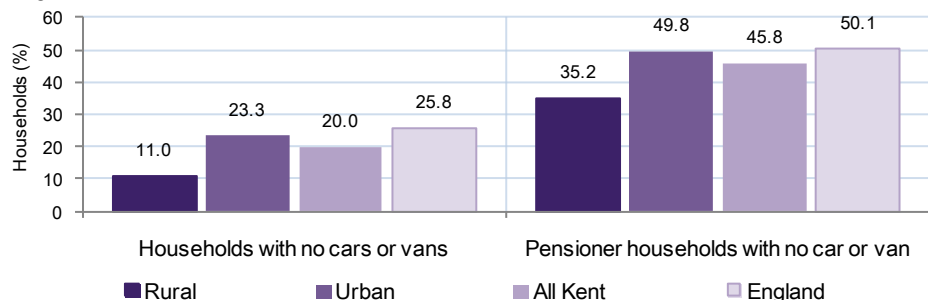
The data highlight tables (below) shows the size of particular groups in rural Kent: people providing unpaid care; pensioners living alone, students, lone parents, households with no car, households with multiple needs (see Appendix B).

Figure 22 looks at households with no access to a car (an important issue in rural areas) and Figure 23 looks at people providing informal (unpaid) care by level of care provision. People providing informal care are a key community of interest for health practitioners, playing an important role in health and social care provision.

People providing unpaid care in rural areas <b>44,550</b> 11.2% of all people (Urban areas = 10.1%)	People providing 50+ hours unpaid care in rural areas <b>9,570</b> 2.4% of all people (Urban areas = 2.5%)	Single Pensioner households in rural areas <b>21,305</b> 52.6% of pensioner households (Urban areas = 59.6%)	Full time students (aged 16-74) in rural areas <b>17,365</b> 5.4% of all people (Urban areas = 7.5%)
Lone parents with dependent children in rural areas <b>8,145</b> 17.5% of households with dependent children (Urban areas = 24.8%)	Households with no car or van in rural areas <b>17,715</b> 11.0% of all households (Urban areas = 23.3%)	Households with multiple needs in rural areas <b>400</b> 0.2% of all households (Urban areas = 0.6%)	

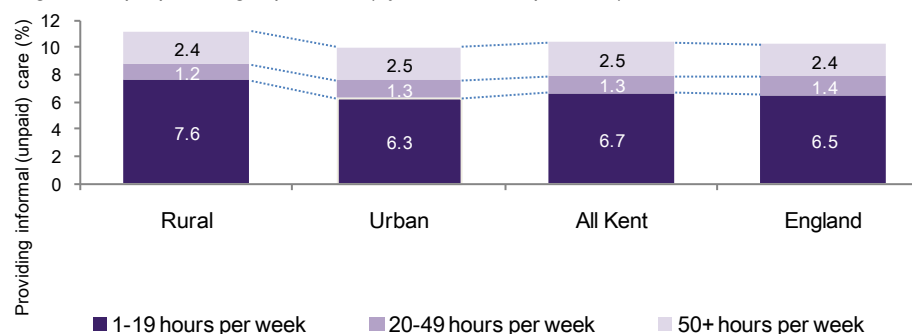
Source: Census 2011

Fig 22. Households with no car or van



A higher proportion of pensioner households have no car compared with the average across all households, and a lower proportion of households have no car in rural areas compared with urban areas

Fig 23. People providing unpaid care (by hours of care provided)



Locally, a higher % provide unpaid care in rural areas compared with urban areas, and a similar % provide intensive informal care (50+ hours per week)





This section looks at the wider determinants of health and well-being. Individual and community experience is affected by many different factors that together contribute to social and place wellbeing.

The Social place & wellbeing section looks at the following key issues:

Theme	Indicators
Community wellbeing, economy and income	Index of Multiple Deprivation (IMD) 2010, Working-age DWP benefit claimants, Economically active adults, Children in out-of-work families, Pension Credit claimants, Incapacity benefits/Employment Support Allowance claimants
Environment, accessibility and transport	Road distance to GP and Dental services, Travel time to the nearest hospital by method of transport
Education	Adult qualifications, pupil attainment at Key Stage 1, 2 and 4
Housing	Fuel poverty, households living in overcrowded conditions, households lacking central heating

### *What other data may be available?*

Additional detailed local datasets may be available from organisations such as the local authority, while some useful data is published nationally only for larger geographies (so cannot be broken-down for local rural areas). Other relevant data includes:

- The Place Survey contains a number of key wellbeing indicators including people's perceptions of their local area, civic participation in the local area, participation in regular volunteering. Data is available at Local Authority level <http://www.data4nr.net/resources/environment/1336/>
- Another key factor in overall wellbeing is overall crime levels, with counts of offences, fear of crime and anti-social behaviour regularly feature in priorities for local areas. The police now publish maps of recorded crime offences and anti-social behaviour – enter your postcode into the website at [www.police.uk](http://www.police.uk) to see this for your local area, as well as details of your local community policing team and events.
- Data on wage levels is published at local authority district level, but your Local Authority may have access to commercial data on local area wages such as CACI Paycheck data.
- The Department for Communities and Local Government (DCLG) publishes annual data on housing through the Housing Strategy Statistical Appendix, including the condition of private sector housing: [www.communities.gov.uk/housing/housingresearch/housingstatistics/housingstatisticsby/localauthorityhousing/dataforms/hssabpsa1011/hssadatareturns1011/](http://www.communities.gov.uk/housing/housingresearch/housingstatistics/housingstatisticsby/localauthorityhousing/dataforms/hssabpsa1011/hssadatareturns1011/) .
- DCLG also compile a code for sustainable homes measuring the energy efficiency of homes, [www.data4nr.net/resources/housing--households/1412/](http://www.data4nr.net/resources/housing--households/1412/)
- The Annual Population Survey contains estimated data on the levels of job-related training and work based learning in the area. Because of the sample size of the survey, figures are only available at Local Authority level, see [www.data4nr.net/resources/226](http://www.data4nr.net/resources/226).



This section looks at the social and economic factors that promote or damage wellbeing in rural areas in Kent.

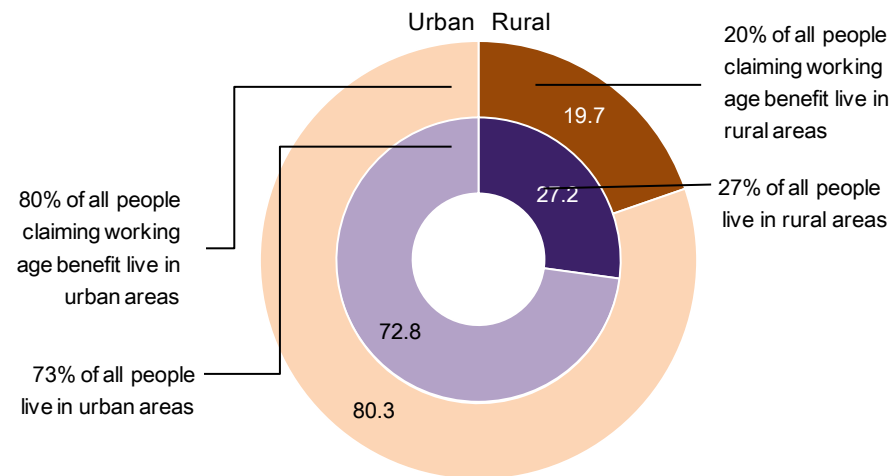
### What information is shown here?

The data highlights on the right show whether any local areas are highly deprived, and if so identifies how many people are living in such areas based on the national Index of Multiple Deprivation 2010. Data also shows the number and proportion of people locally who are economically active or receiving benefits related to low income or employment.

Figure 24 shows the proportion of benefit claimants (Feb-13) in Kent that live in rural areas. Figure 25 (over page) shows the proportion of working-age people receiving benefits in rural and urban areas locally, showing the trend over time. Figure 26 compares specific groups receiving benefits across rural and urban areas locally.

Are there deprived rural areas locally?	Working-age DWP benefit claimants in rural areas	Economically active adults in rural areas
<b>Yes</b>	<b>23,410</b>	<b>199,000</b>
Based on the IMD 2010, 1.7% people in the rural areas in Kent live in the most deprived 20% of areas in England	9.6% of working age people (Urban areas = 14.2%)	69.3% of working age people (Urban areas = 70.1%)
Children in out-of-work families in rural areas	Pension Credit claimants in rural areas	Incapacity benefits claimants in rural areas
<b>9,285</b>	<b>13,305</b>	<b>10,445</b>
11.0% of dependent children (Urban areas = 19.0%)	16.5% of working age people (Urban areas = 22.1%)	4.3% of working age people (Urban areas = 5.9%)

Fig 24. Working age DWP benefit claimants



Sources: Indices of Deprivation 2010, DWP (Feb-13), HMRC 2011, Census 2011.



Fig 25. Working age population claiming DWP benefits

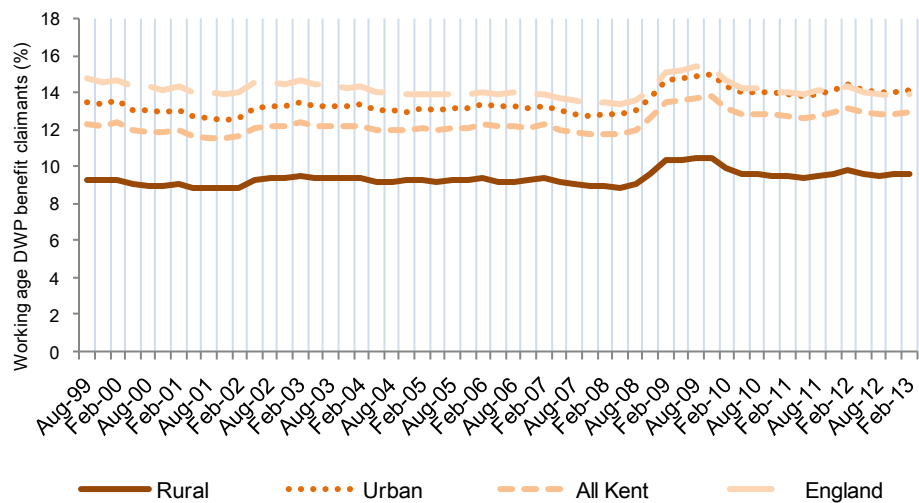
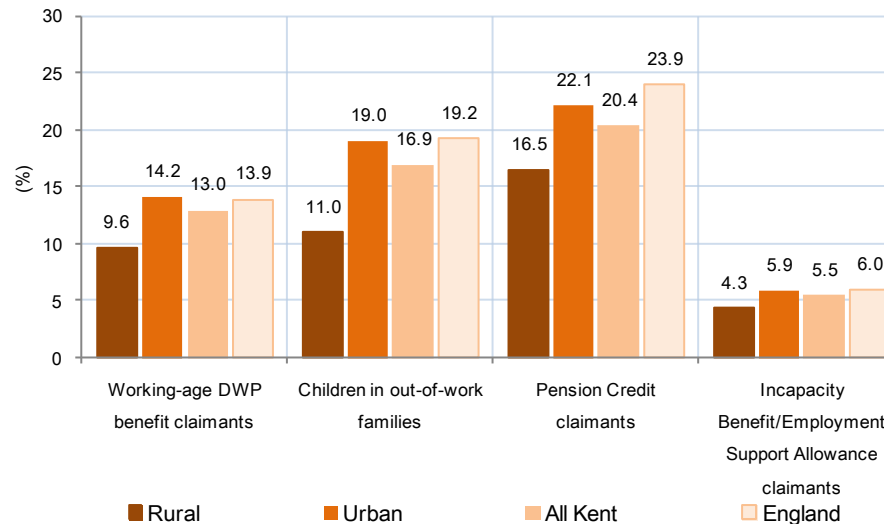


Fig 26. Specific groups receiving benefits



Sources: Indices of Deprivation 2010, DWP (Feb-12), HMRC 2011, Census 2011.



This section focuses on access to health services in rural areas. Poor access can pose a significant challenge to promoting health and wellbeing. Many smaller cottage-style hospitals have been closed for reasons of economies of scale and in favour of specialist centres of excellence. This has led to increased travel distances for accident and emergency and outpatient services and for those visiting patients. In rural areas, access to hospital services can involve very lengthy trips.

More than ten per cent of rural households outside the south east live over 7.5 miles from their nearest hospital. Poor access to health facilities can mean that people miss health appointments or suffer delays in being discharged from hospital – both of which incur significant costs to the NHS. Over the course of a year, more than 1.4 million people say they have missed, turned down, or chosen not to seek medical help over the last 12 months because of access and transport problems.

### What information is shown here?

This section shows data on travel times to hospitals and distances to GPs.

The travel time data is from the DfT, and shows travel times (in minutes) by car, cycle and public transport/ foot. Figure 27 shows how travel times from rural and urban areas in Kent to the nearest hospital (figures are for 2010, the most recently published data).

The road distance data shown in the data highlight box and Figure 28 is taken from Commission for Rural Communities data on rural services, and shows average road distances from houses in the rural Kent to the nearest GPs (2010) compared with urban areas.

Average road distance from the nearest GP in rural areas (2010)  
**2.0km**  
Urban area average: 0.9km

Fig 27. Travel time to the nearest Hospital

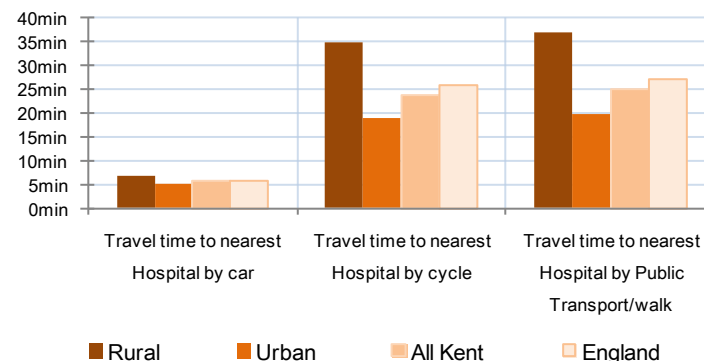
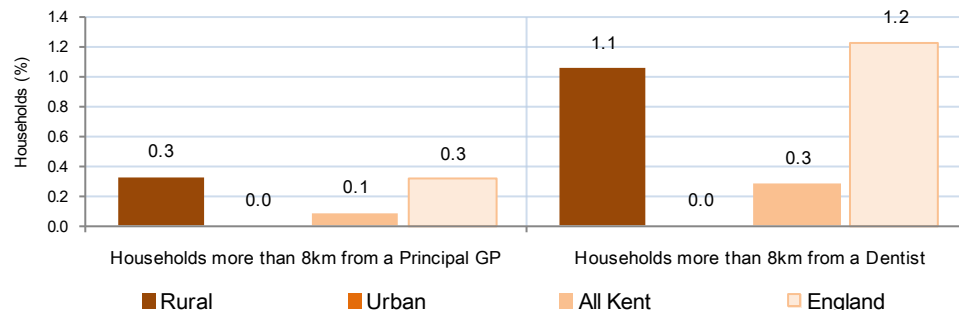


Fig 28. Households more than 8km from health practitioners



Locally, a similar % of households in rural areas are 8km+ from a GP compared with urban areas, and a higher % of households are 8km+ from a Dentist

Sources: Department for Transport (2010), Commission for Rural Communities 2010



Education levels in the local population can be an important indicator of community wellbeing. In general, those with low or no skills are more likely to experience exclusion, and be vulnerable to changes in the economy and more likely to experience job insecurity and associated stress.

### What information is shown here?

This section looks at education data for pupils and adults. Published data on qualifications is available from Census 2011. The data on the right shows the number and proportion of people in rural Kent by their level of qualification, and compared to urban areas.

Figure 29 shows how rural and urban Kent areas compare for the number of people with no qualifications, as well as degree level (and higher) qualifications.

Figure 30 (over page) compares pupil attainment at Key Stage 1 and 2 across rural areas and urban areas in Kent. Pupil attainment is measured by comparing the Average Point Score achieved per pupil across Key Stage 1 and 2 tests (2011/12).

Figure 31 compares the gap in Average Point Score at Key Stage 4 (GCSE) per pupil between rural and urban areas in Kent between 2004 and 2012. The gap is measured as the point difference against the Local Authority average. Areas with a score of greater than zero are performing better than the Local Authority average, while areas with less than zero are performing below the Local Authority average. See Appendix B for details of the Average Point Score measure.

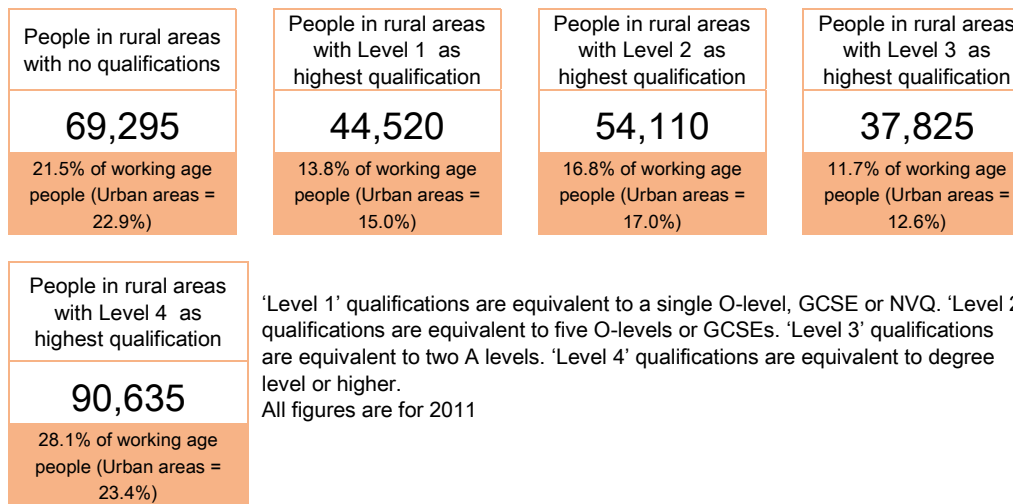
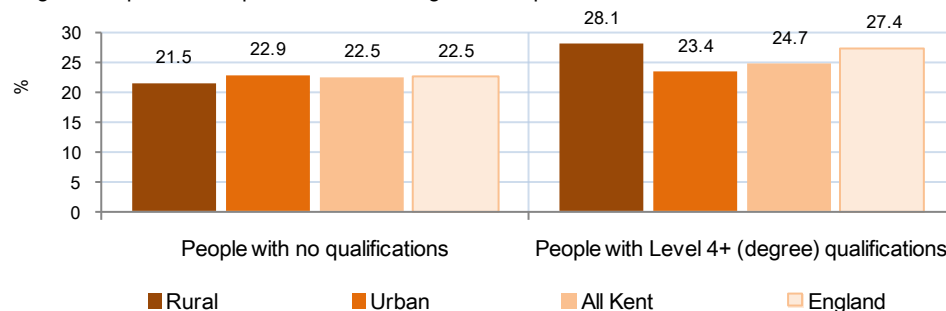


Fig 29. People with no qualifications and degree level qualifications

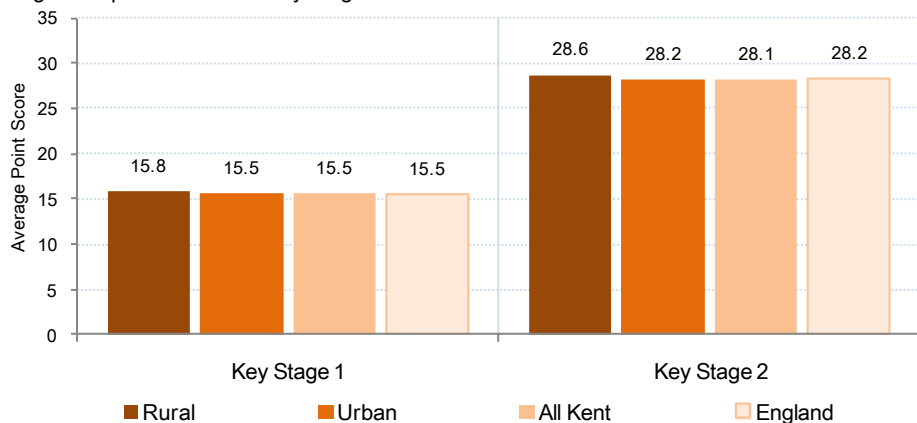


A lower proportion of people in rural Kent have no qualifications compared with people living in urban areas, and a higher proportion of people have degree level qualifications

Source: Census 2011

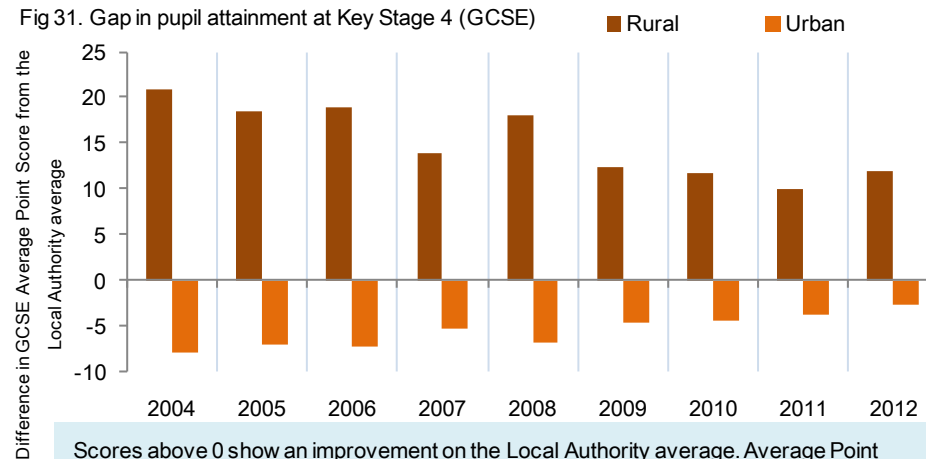


Fig 30. Pupil attainment at Key Stage 1 and 2



Compared to pupils in urban areas, those in rural Kent perform better at Key Stage 1, and perform better at Key Stage 2

Fig 31. Gap in pupil attainment at Key Stage 4 (GCSE)



Scores above 0 show an improvement on the Local Authority average. Average Point Score is made up of all GCSE examinations sat, with a point score of 58=A\*, 52=A, 46=B, 40=C, 34=D, 28=E, 22=F, 16=G.

Source: Department for Education (DfE) 2011/12



Housing condition is an important determinant of health and wellbeing in rural areas. The highest levels of non-decent homes (that do not pass the Housing Health & Safety rating system) are found in smaller rural communities, particularly those more isolated areas. This is often due to the age of properties, with older housing (more common in rural areas) most likely to be in this condition.

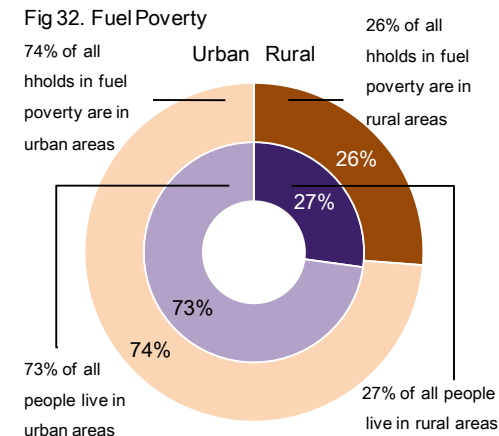
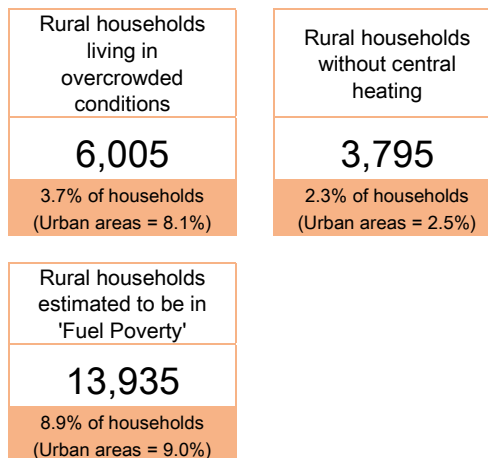
Housing conditions can indicate other issues. For example overcrowded housing can highlight areas with pressing needs for more affordable housing. Where central heating is not present, fuel poverty is significantly more likely.

### What information is shown here?

Whether a household is 'overcrowded' is based on a standard definition using the number of inhabitants, and number of rooms. The data shown is taken from Census 2011. Housing without central heating is self-reported, also taken from Census 2011.

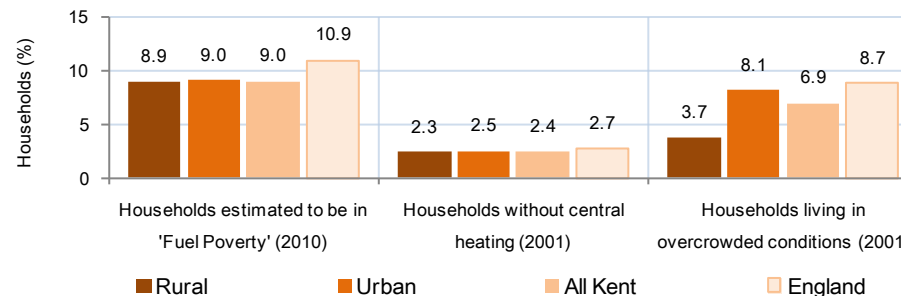
The definition of fuel poverty is based on the Low Income High Costs (LIHC) framework. Under this definition, a household is said to be in fuel poverty if they have required fuel costs that are above average (the national median level) were they to spend that amount they would be left with a residual income below the official poverty line. It is calculated using the income of households, the cost of fuel they need for heating, and the ability of their home to retain heat (which tends to be worse for older / detached properties, both more common in rural areas). The data shows the number and proportion of households in the local area estimated by the Department for Energy and Climate Change to be in fuel poverty (2011).

Figure 33 shows how local rural and urban areas compare on these three housing indicators.



Sources: Census 2011, Department for Energy and Climate Change (2011)

Fig 33. Key housing condition indicators



Locally, households in rural areas are as likely to be in fuel poverty, as likely to lack central heating, and less likely to be overcrowded, compared with urban areas



Many lifestyles and behaviours have an impact on health and wellbeing. They are often affected by the socio-economic factors outlined in the previous domain and can therefore exhibit sharp inequalities. Improving lifestyle behaviours can have very substantial long-term health benefits, but research shows that a multi-faceted approach that also tackles the ‘causes of the causes’ is likely to be most effective.

The ‘Lifestyles & health improvement’ section looks at the following key issues:

Themes	Breakdowns
Lifestyles and health improvement	Walking and cycling to work
	Healthy eating
	Obesity
	Binge drinking
	Smoking

## What other data may be available?

Additional detailed local datasets may be available from organisations such as the local authority, while some useful data is published nationally only for larger geographies (so cannot be broken-down for local rural areas). Other relevant data includes:

- The Health Survey for England asks key questions relating to lifestyle behaviours. This survey has a small sample size so results are only available at regional level. Local surveys of healthy lifestyle behaviours are likely to produce more representative estimates of lifestyle habits in rural and urban areas.
- The TellUs surveys conducted between 2006 and 2009 on all school pupils in years 6, 8 and 10 ask questions relating to smoking, drinking and drug use. Because it covers all pupils it has a larger sample size than the Health Survey so it would be potentially possible to publish this data with rural and urban breakdowns; however, data is not currently published at this level
- Data on mortality rates from ‘lifestyle’ related conditions e.g. alcohol attributable mortality, liver disease, lung cancer, drug induced deaths, type 2 diabetes is available at Local Authority level (but not published for rural areas within each Local Authority).
- Locally, it may be possible to obtain indicators relating to the impact of health improvement interventions. Examples of these indicators include figures relating to vaccinations, screening for key conditions, contraception services, smoking cessation, post natal checkups and prevention activities in primary care. Many of these datasets are collected at Primary Care Trust level. It is not yet confirmed whether these indicators will be collected for GP commissioning groups or at Local Authority level.





Lifestyle choices play a major part in an individual's health outcomes and will have varying physical and psychological consequences. Studies into rural deprivation at small area levels have suggested that lifestyle choices vary between urban and rural populations.

Whilst it is important to address the problems associated with these outcomes, it is just as important to consider the causes leading to these choices e.g. the link between socio-economic background and lifestyle choice (see earlier section on social place & wellbeing for details of deprivation levels). Varying causes can lead to high levels of inequality between those leading healthy and unhealthy lives.

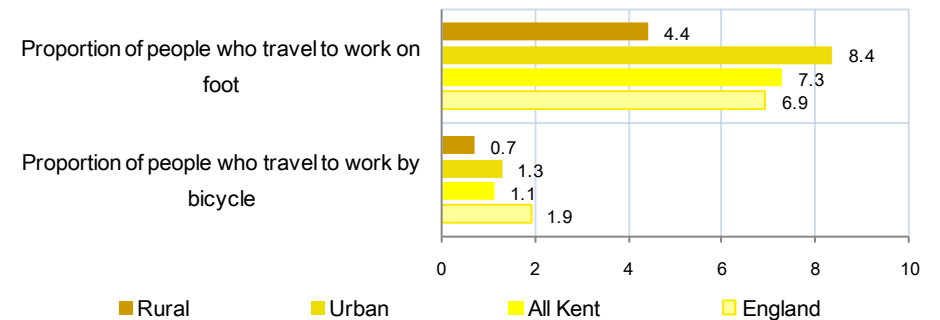
### What information is shown here?

Mobility is a major issue in rural areas, with many people living a fair distance from public transport, services, local amenities and the work place. The way in which they travel to work can therefore be a useful indicator of their levels of physical activity.

Figure 34 shows the proportion of people who travel to work on foot or by bicycle in rural and urban areas in Kent (figures are taken from the 2011 Census).

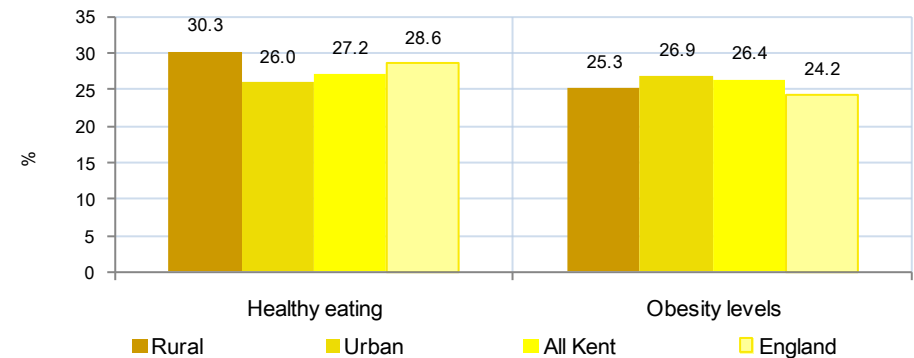
Figure 35 shows the healthy eating levels (consumption of 5 or more portions of fruit and vegetables a day among adults) in rural and urban Kent (figures are for 2007-2008). It also shows the obesity levels (%) in these areas, allowing a consideration of the relationship between these two indicators.

Fig 34. People travelling to work on foot and by bicycle



People in rural Kent are less likely to travel to work by bicycle, and less likely to travel to work on foot compared with urban areas

Fig 35. Healthy eating (consumption of 5+ portions of fruit and vegetables a day) and obesity



People in rural Kent are more likely to engage in healthy eating, and less likely to be obese compared with urban areas

Sources: Census 2011, ONS (2007/08). Population weighted aggregation from MSOA to rural urban areas.



As much as healthy lifestyle choices can be used as an indicator of a community's wellbeing, areas with high levels of unhealthy behaviours are likely to have lower standards of overall health. For example, smoking accounts for 1 in 4 UK cancer deaths and nearly a fifth of all cancer cases (Cancer Research UK).

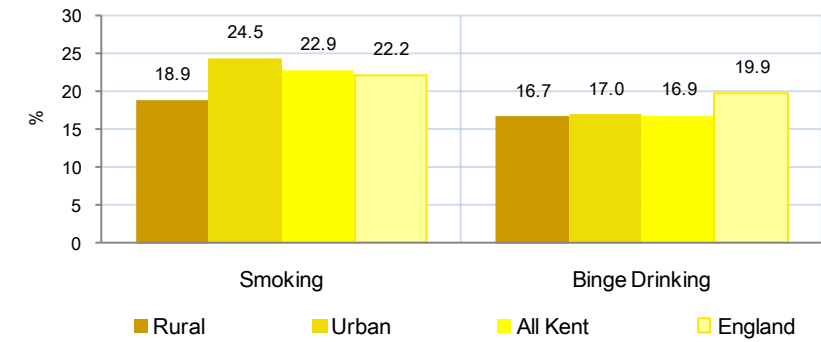
As this statistic suggests, unhealthy lifestyle behaviours can destroy people's health and consequently cost the NHS millions of preventable pounds a year. Prevention is likely to be more effective than intervention so knowing which areas have the highest levels of unhealthy behaviours will allow service providers to respond accordingly.

### *What information is shown here?*

There is only a limited set of data published for small areas on unhealthy lifestyle behaviours (see 'Lifestyles & health improvement: Introduction' above for details). However, levels of smoking and binge drinking can provide good indications of which areas have less healthy lifestyles.

Figure 36 shows the percentage of people engaged in binge drinking and smoking in rural and urban Kent (figures are for 2007-2008).

Fig 36. Smoking and binge drinking levels



People in rural Kent are less likely to be smokers, and as likely to binge drink compared with urban areas

Source: ONS (2007/08). Population weighted aggregation from MSOA to rural urban areas.



Use of services is affected by not only the health and wellbeing status of the population, but also by other factors such as the location and availability of services, as well as community expectations and referral pathways.

The 'Service use' section looks at the following key issues:

Themes	Breakdowns
Hospital admissions for selected causes	Cerebrovascular disease Falls Coronary Heart Disease (CHD) Cataract Operation Cancer
Emergency hospital admissions	
Acute morbidity	

### *What other data may be available?*

Additional detailed local datasets may be available from organisations such as the local authority, while some useful data is published nationally only for larger geographies (so cannot be broken-down for local rural areas). Other relevant data includes:

- Social care datasets collected at upper-tier Local Authority level, identified in the Joint Strategic Needs Assessment (JSNA) data inventory under the 'service use' theme. These indicators are not published below upper-tier geography, but more detailed data may be held locally to enable rural breakdowns.
- Data on health service providers, including indicators on waiting times, early access to services, re-admissions, and outpatient attendances. These measures are primarily published at PCT/CCG level, and are assessments of the performances of the particular health providers. Analysis comparing service quality in rural and urban areas is complicated by the fact that large health providers are typically located in urban areas, and provide services to people living in both rural and urban areas.



A person's use of services can be influenced by a number of factors including their health status, the location and availability of services, and the process of health referrals in the local area.

In rural areas, mobility will also play a major part due to the distance people may live from their closest health care provider (see p20 for details on distances to services). Studies have identified the impact that distance can have on rural health outcomes, with rural residents less likely to seek medical help.

### What information is shown here?

It is important to use caution when exploring data on service use in rural areas, as the way in which people use primary, hospital and emergency health services will vary between rural and urban areas. Greater distances to local casualty departments for example, mean that minor injuries will be more likely seen in primary care in rural areas and not recorded by Accident and Emergency Departments in the locality.

However, looking at trends in hospital admission data and use of hospital services for select causes provides some insight into how and why services are used (see next page for more detail on other data related to service use at Local Authority level).

Figure 37 shows the proportion of all hospital admissions that occurred in urban and rural areas (figures are for 2007-2008, the most recently published data).

Figure 38 shows hospital admissions for select causes (per 1,000 population) in urban and rural Kent (again, figures are for 2007-2008).

Fig 37. Share of hospital admissions in rural and urban areas

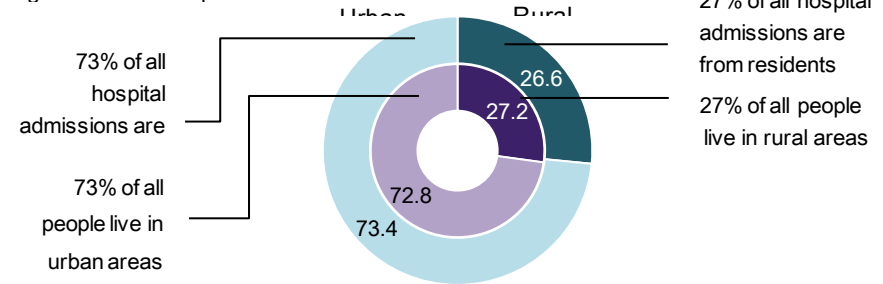
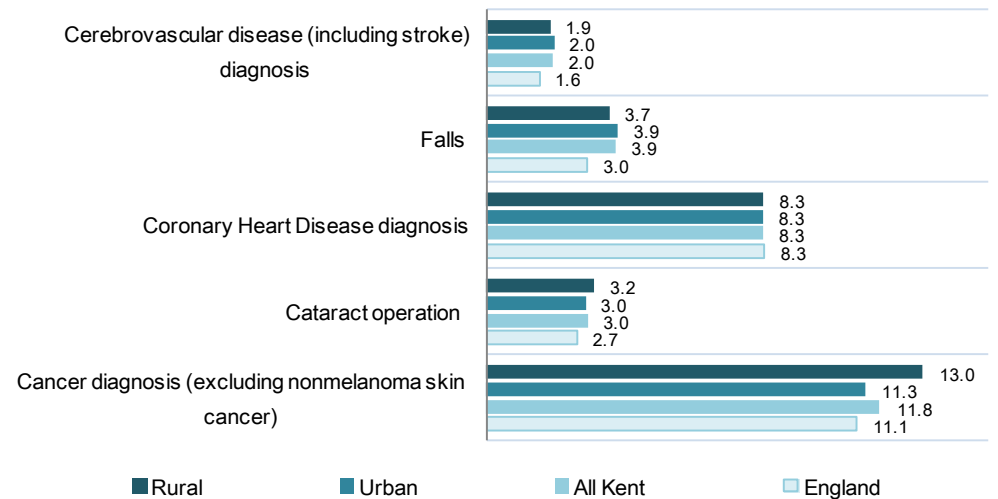


Fig 38. Hospital admissions for select causes



Source: Hospital Episode Statistics, Information Centre for Health and Social Care (2007/08). Population weighted aggregation from MSOA to rural urban areas.

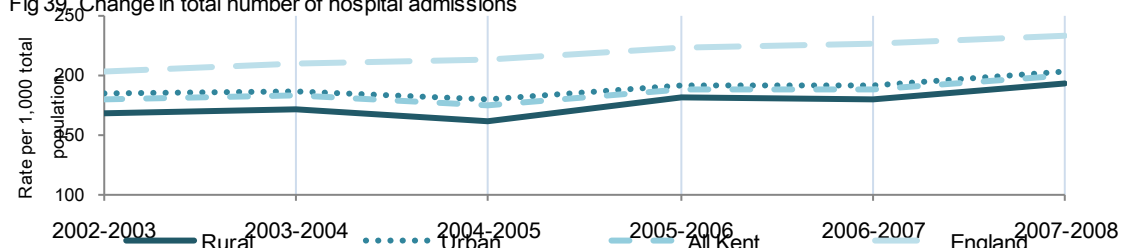


Figure 39 shows the change in the proportion of hospital admissions (per 1,000 population) from 2002-2008, comparing rural and urban areas in Kent.

Figure 40 shows the rate of emergency admissions to hospital for rural and urban Kent (2003-2007). Figures are presented as a ratio benchmarked against the national figure (a ratio of greater than 100 indicates an area has a higher than average level of emergency hospital admissions, a ratio of under 100 indicates an area has a lower than average level of emergency hospital admissions than the national average).

Figure 41 shows the Indices of Deprivation 2010 Acute Morbidity indicator across rural and urban Kent. This is an age-standardised measure of rate of emergency admissions to hospital (per 1,000)<sup>7</sup>.

Fig 39. Change in total number of hospital admissions



Hospital admissions have increased in rural areas from 2002 to 2008

Fig 40. Hospital emergency admissions

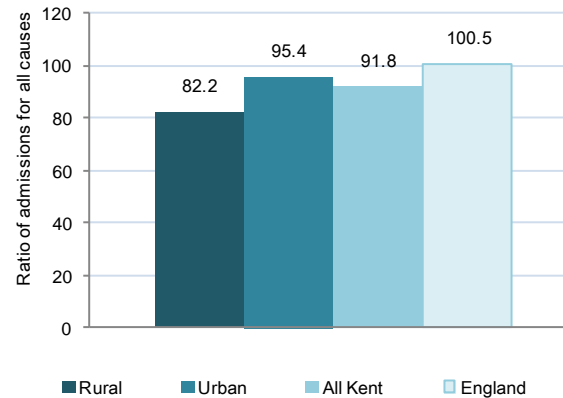
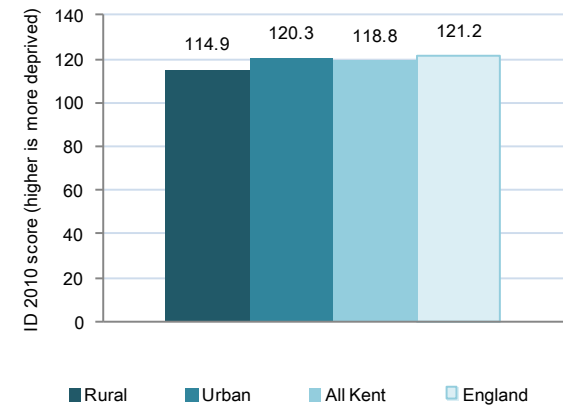


Fig 41. Acute Morbidity Indicator



Sources: Hospital Episode Statistics, Information Centre for Health and Social Care (2007/08), Indices of Deprivation 2010. Population weighted aggregation from SOA to rural urban areas.

<sup>7</sup> The numerator is the number of hospital spells starting with admission in an emergency and lasting more than a calendar day in five year age-sex bands for 2006-07 and 2007-08. The denominator is the total population in five year age-sex bands for 2008 (each band is multiplied by three to match the three years of numerator data)

Indicator	Kent (Rural)		Kent (Urban)		Kent		England
	N	Rate	N	Rate	N	Rate	Rate
All People (2011)	397,665		1,066,075		1,463,740		
Males (2011)	194,850	49.0	520,765	48.8	715,615	48.9	49.2
Females (2011)	202,815	51.0	545,310	51.2	748,125	51.1	50.8
Aged 0-15 (2011)	74,235	18.7	209,590	19.7	283,825	19.4	18.9
Working age (2011)	242,990	61.1	674,615	63.3	917,605	62.7	64.7
Aged 65+ (2011)	80,440	20.2	181,865	17.1	262,305	17.9	16.3
White British (2011)	371,510	93.4	932,045	87.4	1,303,555	89.1	79.8
White non-British (2011)	13,635	3.4	53,910	5.1	67,545	4.6	5.7
Non-white (2011)	12,520	3.1	80,115	7.5	92,635	6.3	14.6
White Irish (2011)	2,370	0.6	7,870	0.7	10,240	0.7	1.0
Other White (2011)	9,270	2.3	43,350	4.1	52,620	3.6	4.6
Mixed White and Black Caribbean (2011)	1,195	0.3	5,070	0.5	6,265	0.4	0.8
Mixed White and Black African (2011)	520	0.1	2,480	0.2	3,000	0.2	0.3
Mixed White and Asian (2011)	1,740	0.4	5,780	0.5	7,520	0.5	0.6
Other Mixed (2011)	1,070	0.3	4,255	0.4	5,325	0.4	0.5
Indian (2011)	1,745	0.4	16,395	1.5	18,140	1.2	2.6
Pakistani (2011)	320	0.1	2,085	0.2	2,405	0.2	2.1
Bangladeshi (2011)	395	0.1	2,990	0.3	3,385	0.2	0.8
Other Asian (2011)	2,215	0.6	15,500	1.5	17,715	1.2	1.5
Black Caribbean (2011)	505	0.1	2,790	0.3	3,295	0.2	1.1
Black African (2011)	885	0.2	10,640	1.0	11,525	0.8	1.8
Other Black (2011)	195	0.0	1,205	0.1	1,400	0.1	0.5
Chinese (2011)	885	0.2	5,095	0.5	5,980	0.4	0.7
Other ethnic group (2011)	615	0.2	4,550	0.4	5,165	0.4	0.6
Live Births, total (2010)	3,830		13,730		17,560		
Live Births, female (2010)	1,855	48.4	6,670	48.5	8,525	48.5	48.6
Live Births, male (2010)	1,950	51.0	7,060	51.3	9,010	51.3	51.3

Indicator	Kent (Rural)		Kent (Urban)		Kent		England
	N	Rate	N	Rate	N	Rate	Rate
All deaths (2010)	3,645	931.0	9,925	958.0	13,570	950.7	882.1
Female deaths from all causes (2010)	1,870	937.4	5,350	1004.9	7,220	988.6	903.5
Male deaths from all causes (2010)	1,745	908.7	4,490	891.5	6,235	898.7	859.6
People not providing unpaid care (2001)	353,120	88.8	958,845	89.9	1,311,965	89.6	89.8
People providing unpaid care, 1-19 hours per week (2011)	30,145	7.6	67,320	6.3	97,465	6.7	6.5
People providing unpaid care, 20-49 hours per week (2011)	4,835	1.2	13,600	1.3	18,435	1.3	1.4
People providing unpaid care, 50+ hours per week (2011)	9,570	2.4	26,310	2.5	35,880	2.5	2.4
Full-time students and schoolchildren aged 16-74 (2011)	17,365	0.0	64,525	0.0	81,890	0.0	0.0
Households of one pensioner (as % of all pension households) (2011)	21,305	52.6	58,005	59.6	79,310	57.5	59.6
Households of one lone-parent family with dependent children (as % of households with dependent children) (2011)	8,145	17.5	32,925	24.8	41,070	22.9	24.5
Pensioner households with no car or van (2011)	13,595	35.2	50,880	49.8	64,475	45.8	50.1
Household members are deprived in four dimensions (2011)	400	0.2	2,460	0.6	2,860	0.5	0.5
Households with no cars or vans (2011)	17,715	11.0	103,375	23.3	121,090	20.0	25.8
Index of Multiple Deprivation 2010, Number of LSOAs in the most deprived 20%	5	1.7	85	14.1	90	10.6	20.0
Working-age DWP benefit claimants (Feb-13)	23,240	9.6	94,540	14.0	117,780	12.8	13.8
Economically active (working age) (2011)	199,000	69.3	538,910	70.1	737,910	69.9	69.9
Economically inactive (working age) (2011)	88,050	30.7	229,435	29.9	317,485	30.1	30.1
Children in out-of-work families (small area) (2011)	9,285	11.0	44,555	19.0	53,840	16.9	19.2
Pension Credit claimants (Feb-13)	13,525	16.8	40,735	22.4	54,260	20.7	24.2
Incapacity Benefit claimants (Feb-13)	4,985	2.1	17,360	2.6	22,345	2.4	2.6
Employment Support Allowance claimants Total (as % of working age 16-64) (Feb-13)	5,690	2.3	22,835	3.4	28,525	3.1	3.5
Travel time to nearest Hospital by car (2009)		7.0		5.0		6.0	6.0
Travel time to nearest Hospital by cycle (2009)		35.0		19.0		24.0	26.0
Travel time to nearest Hospital by Public Transport/walk (2009)		37.0		20.0		25.0	27.0
Road distance (meters) from the nearest GP (2010)	2,030		910		2,940		
Households more than 8km from a Principal GP (2010)	530	0.3	0	0.0	530	0.1	0.3
Households more than 8km from a Dentist (2010)	1,705	1.1	0	0.0	1,705	0.3	1.2

Indicator	Kent (Rural)		Kent (Urban)		Kent		England
	N	Rate	N	Rate	N	Rate	Rate
People with no qualifications (2011)	69,295	21.5	196,030	22.9	265,325	22.5	22.5
People with Level 1 qualifications (2011)	44,520	13.8	128,645	15.0	173,165	14.7	13.3
People with Level 2 qualifications (2011)	54,110	16.8	145,515	17.0	199,625	16.9	15.2
People with Level 3 qualifications (2011)	37,825	11.7	107,695	12.6	145,520	12.3	12.4
People with Level 4+ (degree) qualifications (2011)	90,635	28.1	200,575	23.4	291,210	24.7	27.4
Average Point Score - Key Stage 1 pupils (2012)		15.7		15.3		15.5	15.5
Average Point Score at Key Stage 2 for all pupils (2012)		28.0		27.6		27.7	28.0
Average Point Score at GCSE for all pupils (2012)		477.3		461.2		465.7	452.5
Overcrowded housing (2011)	6,005	3.7	35,915	8.1	41,920	6.9	8.7
Households without central heating (2011)	3,795	2.3	10,965	2.5	14,760	2.4	2.7
Households living in Fuel Poverty (2011)	13,935	8.9	39,225	9.0	53,160	9.0	10.9
People who travel to work by Bicycle (2011)	2,045	0.7	9,900	1.3	11,945	1.1	1.9
People who travel to work On Foot (2011)	12,705	4.4	64,350	8.4	77,055	7.3	6.9
Binge Drinking levels, 2007-2008		16.7		17.0		16.9	19.9
Healthy eating, 2007-2008		30.3		26.0		27.2	28.6
Obesity levels, 2007-2008		25.3		26.9		26.4	24.2
Smoking levels, 2007-2008		18.9		24.5		22.9	22.2
People with limiting long-term illness (2011)	29,780	7.5	86,630	8.1	116,410	8.0	8.3
People in not good health (2011)	18,635	5	56,570	5	5	4	4
ID 2010 Health Domain, Number of LSOAs in the most deprived 20%	5	1.3	70	11.2	75	8.5	20.0
All People with a limiting long-term illness - aged 0-64 (2011)	27,790	11.4	84,890	12.6	12	9.8	10.7
Healthy Life Expectancy at birth, all people (1999-2003)		72.1		73.6		72.4	
Healthy Life Expectancy at birth, females (1999-2003)		74.8		75.3		75.0	
Healthy Life Expectancy at birth, males (1999-2003)		68.8		71.6		70.2	
Life Expectancy at birth, all people (1999-2003)		77.3		79.8		78.6	
Life Expectancy at birth, females (1999-2003)		80.5		82.3		81.4	
Life Expectancy at birth, males (1999-2003)		74.1		77.1		75.6	



Indicator	Kent (Rural)		Kent (Urban)		Kent		England
	N	Rate	N	Rate	N	Rate	Rate
Standardised mortality ratio for all causes, for people aged under 75 (2005-2009)		83.1		99.7		95.1	103.0
Standardised mortality ratio for all causes (all ages) (2005-2009)		90.6		101.5		98.5	101.6
ID 2010 Years of Potential Life Lost		58.7		62.9		61.7	67.2
ID 2010 Comparative Illness and Disability Indicator		83.9		101.5		96.6	112.5
Attendance Allowance claimants (Feb-13)	10,625	13.2	29,360	16.1	39,985	15.2	16.5
Disability Living Allowance claimants (Feb-13)	16,655	4.2	55,580	5.2	72,235	4.9	5.1
Disability Free Life expectancy at birth (1999-2003)		68.0		66.0		67.0	
Disability Free Life expectancy at birth, females (1999-2003)		67.4		67.3		67.3	
Disability Free Life expectancy at birth, males (1999-2003)		62.6		64.7		63.6	
Incapacity Benefit claimants, disease code is 'Mental' (Feb-13)	1,940	0.8	7,540	1.1	9,480	1.0	1.1
ID 2010 Mood and anxiety disorders indicator		-0.3		0.0		-0.1	0.0
Standardised mortality ratio for cancer (all ages), (2005-2009)		94.8		101.7		99.8	101.4
Standardised mortality ratio for coronary heart disease (all ages) (2005-2009)		89.0		100.3		97.2	102.8
Standardised mortality ratio for circulatory disease (all ages) (2005-2009)		92.4		103.3		100.3	101.6
Standardised mortality ratio for respiratory disease (all ages) (2005-2009)		89.5		101.7		98.3	103.0
Standardised mortality ratio for strokes (all ages) (2005-2009)		91.2		101.3		98.5	99.4
All hospital admission episodes (2007-2008)	74,330	191.9	205,550	202.6	279,880	199.7	233.2
Hospital elective admissions ratio, all causes (2003-2007)		74.3		78.9		77.6	99.9
Hospital emergency admissions, all causes (2003-2007)		82.2		95.4		91.8	100.5
ID 2010 Acute Morbidity Indicator		114.9		120.3		118.8	121.2

The main datasets used in this report are shown below. Full details of each indicator and data sources are available at <http://www.rural-evidence.org.uk/pages/metadata/>

## Population

- Total population; Population aged 0-15; Working-age population; Pensionable age population; Male/Female population (Census 2011)
- Population by ethnic group (Census 2011)
- Births and Deaths (ONS, 2010)
- People providing unpaid care, lone parents, lone pensioners, full-time students, households with no car, households with multiple needs<sup>8</sup> (Census 2011)

## Social place & wellbeing

- Working-age people receiving any DWP benefit, Pension Credit, Jobseekers Allowance; Incapacity Benefit/Employment Support Allowance (DWP, Feb-13)
- Children in out-of-work families (HM Revenue and Customs, 2011)
- Economic activity, Qualifications (Census 2011)
- Pupil attainment – Average Point Score Key Stages 1-4, A\*=58 points, A=52, B=46, C=40, D=34, E=28, F=22, G=16 (Department for Education, 2004-2012)
- Core Accessibility Indicators: travel times to key services by public transport (Department for Transport, 2009)
- Rural services data series: Road distance to key services (Commission for Rural Communities: 2010)
- Overcrowded households; Households lacking central heating (Census 2011)
- Fuel poverty (Department for Energy and Climate Change, 2011)

<sup>8</sup> Households with multiple needs refers to households with each of the following four deprivation characteristics: a) Employment: Any member of the household aged 16-74 who is not a full-time student is either unemployed or permanently sick; b) Education: No member of the household aged 16 to pensionable age has at least 5 GCSEs (grade A-C) or equivalent AND no member of the household aged 16-18 is in full-time education c) Health and disability: Any member of the household has general health 'not good' in the year before Census or has a limiting long term illness d) Housing: The household's accommodation is either overcrowded; OR is in a shared dwelling OR does not have sole use of bath/shower and toilet OR has no central heating.

## Lifestyles & health improvement

- Travelling to work by walking/cycling (Census 2011)
- Prevalence of smoking, binge drinking, obesity and healthy eating (ONS: modelled healthy lifestyle behaviours, 2007/08)

## Health & Wellbeing

- Indices of Deprivation (ID) Health domain, Years of Potential Life Lost, Comparative Illness and Disability Ratio, Mood and anxiety disorders indicator (Communities and Local Government (CLG), 2010)
- Limiting long-term illness aged 16-64 (Census 2011)
- Life Expectancy, Healthy Life Expectancy and Disability Free Years (ONS 1999-2003)
- Standardised mortality ratio by key cause (all causes, cancer, coronary heart disease, circulatory disease, stroke, respiratory disease) (ONS, 2005-2009)
- Crude death rates per 100,000 by key cause (ONS, 2010)
- Disability Living Allowance, Attendance Allowance, Incapacity Benefit claimants: disease code 'mental' (DWP, Feb-13)

## Service Use

- Hospital admissions by key causes (Hospital Episode Statistics, Information Centre for Health and Social Care, 2002/03 to 2007/08)
- Emergency admissions to hospital, standardised ratio (ONS, 2005-2009)
- Indices of Deprivation (ID) Acute Morbidity Indicator (CLG, 2010)

### *The rural-urban classification 2011*

To create this profile report, OCSI have collected and aggregated health datasets for all rural and urban areas in England. To do this, we have used the Office for National Statistics (ONS) definitions of rural areas which were created in 2013, based on Census 2011 data, and an update of the 2004 Countryside Agency definitions.

The classifications are categorised into eight categories: 'Urban major conurbation' (part of largest cities in England – Greater London, Birmingham/West Midlands, Greater Manchester, Leeds/West Yorkshire, Liverpool and Newcastle/Tyneside); 'Urban minor conurbation' (part of large city conurbations – Sheffield and Nottingham city regions); 'Urban city and town in a sparse setting' (settlements over 10,000 population that are far surrounded by sparsely populated areas); 'Urban city and town' based on all settlements over 10,000 population not in the major conurbations or in a sparse setting; 'Rural town and fringe' 'Rural town and fringe in a sparse setting'; 'Rural village and dispersed' and 'Rural village and dispersed in a sparse setting'. For the analysis in this project, we have combined the four rural town and fringe and village and dispersed categories into a single non-urban 'rural' category. In other words, our rural area analysis is based on all areas outside settlements with populations of more than 10,000 people. Local areas may use different definitions of 'rural'.

The classifications are available for a range of geographical scales, including Output Areas, Super Output Areas (both Lower and Middle layer), and Wards. The classification can be used to analyse and report on the very wide range of data sets that are now geographically referenced.

### *2011 Lower layer Super Output Areas*

2011 Lower layer Output Areas (2011 LSOAs) are a statistical geography created for the purpose of presenting the 2011 Census, and other neighbourhood statistics. There are two layers to the SOA geography: 'lower layer' and 'middle layer'. All SOA level data presented within this report is based on 'lower layer' SOA boundaries (LSOAs).

Unlike wards, LSOAs are designed to produce areas of approximately equal population size, with the mean population of LSOAs being approximately 1,500 people. Although there remains a degree of variation around this mean of 1,500 persons (the smallest LSOA population in England is just under 1,000 whilst the highest population is over 6,000), the large majority of lower layer SOAs have populations close to 1,500. This standardised population size makes the lower layer SOA geography well suited to identifying smaller pockets of deprivation that may be averaged out over large wards.

One of the main strengths of LSOAs is that they are relatively static over time (unlike wards, which change for electoral purposes). However, a small proportion of LSOAs have been changed in the 2011 Census to ensure consistent population size.



### *About Action with Communities in Rural England (ACRE)*

Action with Communities in Rural England (ACRE) is the national umbrella body of the Rural Community Councils, which operates at national, regional and local level in support of rural communities across the country. We aim to promote a healthy, vibrant and sustainable rural community sector that is well connected to policy and decision-makers who play a part in delivering this aim. ACRE is nationally recognised for its expertise in ensuring rural community-led solutions are central to public policy debate. For contact details and more information go to [www.acre.org.uk](http://www.acre.org.uk).

### *About the Rural Evidence programme*

The Rural Evidence programme has developed a series of reports on key issues, for each of the rural communities in England: parish and settlement profiles; the rural economy; access to services; rural daytime populations; and rural deprivation.

All reports are available through ACRE Network members, and the full range and background information can be viewed at [www.rural-evidence.org.uk](http://www.rural-evidence.org.uk).

### *About Action with Communities in Rural Kent*

Action with Communities in Rural Kent works to try and ensure that nobody is disadvantaged because they live or work in a rural location. The organisation provides guidance, information and networking opportunities to help communities identify, articulate and address their needs. Core areas of work include Community-led and Neighbourhood Planning, Community Asset Management, Local Needs Housing and Access to Services (including economic development, healthcare and leisure provision).

