

I write to oppose the proposed Air Cargo Hub at Manston.

70,000 people's health, wellbeing and quality of life is at risk if this proposal gains consent. I'm a Ramsgate resident and live under the proposed flight path. I am an asthma sufferer and garden lover and I feel that my home and quality of life is under threat from the extreme levels of pollution and noise that will bellow from the number of aircraft necessary to fulfil the economic potential of RSPs proposal.

I've read the documents that RSP distributed via their website during the consultation period in 2018 and was amazed at the lack of specific information with regard to the number, frequency and type of aircraft that would be used. The lack of clarity on the environmental effects to humans and wildlife is woefully inadequate and shocking.

There are wild assumptions and contradictions in the consultation documents including the generalised mitigation statements, particularly where the most significant effects to wildlife and human health were concerned. However, in other areas stark warnings were made clear;

...by year 2020 [the operational airport] will have "significant adverse effects due to the increase in noise on the communities of Ramsgate, Manston, Wade, West Stourmouth and Pegwell Bay". This is indicated in 1.1.82 of the which goes on to summarise in 1.1.83 " In these communities aircraft noise would increase to the point where there would be a perceived change in quality of life for occupants of buildings in these communities or a perceived change in the acoustic character of shared open spaces within these communities".

As the UK Charity for [REDACTED] state on their website, the Government has repeatedly been taken to court by "ClientEarth for failing to comply and breaching EU Air Quality Directive ...and to produce an adequate National Plan." Environmental Protection go on to say:

"The 2017 National Plan has been deemed inadequate by the High Court, which required: '*...the Secretary of State... must aim to achieve compliance by the soonest date possible; he must choose a route to that objective which reduces exposure as quickly as possible; and that he must take steps which mean meeting the value limits is not just possible, but likely.*'"

In early 2018 a ruling by the High Court of Justice concluded the policy inadequate stating in Item 5.²

... a failure to comply with these legal requirements exposes the citizens of the UK to a real and persistent risk of significant harm. The 2017 Plan says that "poor air quality is the largest environmental risk to public health in the UK. It is known to have more severe effects on vulnerable groups, for example the elderly, children and

1 [REDACTED]

2 [REDACTED]

people already suffering from pre-existing health conditions such as respiratory and cardiovascular conditions”.

Whilst I appreciate this is in relation to road traffic pollution and NO₂ particularly, pollution from planes also delivers a multitude of harmful pollutants including nitrogen oxides and sulfur dioxides which are additive to the road traffic problem and significant in terms of increased output with little hope for any other form of fuel for the aviation industry in the future, unlike road traffic.

Only last month (January 2019) the mother of young Ella who lived in Lewisham and died from Asthma linked to unlawful levels of air pollution, won an appeal to a fresh inquest. As reported in the Telegraph on 12 January 2019:

“... expert report by Prof Stephen Holgate, quoted in a submission to the Attorney General, concluded that it was likely that unlawful levels of air pollution contributed to Ella’s fatal asthma attack.”³

In 2015/2016 Thanet has a higher rate than the rest of Kent for hospital admission for respiratory problems. In particular, Newington (a ward in Ramsgate very near to the proposed runway) has the highest hospital admissions for respiratory problems (See Appendix 3: Kent Public Health Observatory Report, April 2017 p.40).

Thanet is seeing a rise in tourism, independent businesses blossoming and young families moving here for a better quality of life. There is greater interest in our unique natural environment (eg. Pegwell Nature Reserve), which the airport would decimate.

I urge the Examining Authority to assess further the extreme detrimental effect that a Air Cargo Hub at Manston would have on the health and wellbeing of the thousands of people that live in close proximity to it.

Attached are 3 Appendices.

1. Webpage from Environmental Projection.org.uk
2. Client Earth Final Judgement from Judiciary.uk
3. Kent Public Health Observatory Report, Thanet CCG Locality Profile for Ramsgate, April 2017

Cathy Rogers

³ [REDACTED]

Ramsgate.

NATIONAL AIR QUALITY LAW AND POLICY

The Air Quality Strategy for England, Scotland, Wales and Northern Ireland 2007 sets out UK air quality standards and objectives for reducing levels of health-threatening pollutants. The Government are currently developing a new Clean Air Strategy focusing on reducing total emissions and protecting health.

The UK Government are subject to infraction proceedings for breaching the EU Air Quality Directive and have been repeatedly taken to Court by campaign group ClientEarth for failing to comply with the Air Quality Directive, and failing to produce an adequate National Plan to reduce NO₂ pollution.

The 2017 National Plan has been deemed inadequate by the High Court, which required:

'...the Secretary of State... must aim to achieve compliance by the soonest date possible; he must choose a route to that objective which reduces exposure as quickly as possible; and that he must take steps which mean meeting the value limits is not just possible, but likely.' See [judgment here](#).

In the recent consultation on the draft Clean Air Strategy, we raised a number of points, welcoming the government's recognition of a wider range of sources, and calling for more action.

- [EPUK response to the Clean Air Strategy Consultation](#) – 14 August 2018 (PDF)

We wrote to the government about the most recent National Plan on NO₂ on National Clean Air Day 2017, to raise concerns over their lack of ambition and lack of action.

- [EPUK response to the 2017 National Plan Consultation](#) – 15 June 2017 (PDF)

To support this, our President, Lord Whitty, wrote to the new Secretary of State for the Environment, Food and Rural Affairs, Michael Gove, about this national plan and our proposed commission.

- [Letter from Lord Whitty to Michael Gove – June 2017](#) (PDF)

We also submitted written evidence to the Joint Select Committee Inquiry on Air Pollution, outlining the key issues of concern.

- [Submission to Joint Select Committee Inquiry on Air Pollution](#) – 9 November 2017 (PDF)

The UK Government had been previously required, by the Supreme Court, to produce a National Plan by the end of 2015 which would allow the UK to meet the NO₂ limit values as soon as possible. The government consulted on the draft National Plan. We submitted a robust response raising concerns over the plans, their evidence and the lack of support for the local measures included, and calling for more government action by Defra and other government departments.

- [EPUK response to the 2015 NO₂ National Plan Consultation](#) – November 2015 (PDF)

The Government also consulted on guidance for Clean Air Zones, a key pillar of both National Plans. Again, there were significant concerns about these. This consultation coincided with the High Courts decision that the 2015 National Plan was inadequate, so we addressed some wider issues within this response.

- [EPUK response to Clean Air Zones Consultation](#) – December 2016 (PDF)

The 2007 National Strategy addresses benzene, 1,3-butadiene, carbon monoxide, lead, nitrogen dioxide, particles, sulphur dioxide, ground level ozone, and PAH. The levels of reduction have been set on the basis of scientific and medical evidence on the health effects of each pollutant, and according to practicability of meeting the standards. All of these standards, except those for ozone and polyaromatic hydrocarbons (PAH), are subject to regulations made under the Environment Act 1995, and many are the result of UK incorporation of European law.

LOCAL AIR QUALITY MANAGEMENT

Part IV of the Environment Act 1995, which covers England, Scotland and Wales, and the Environment (Northern Ireland) Order 2002, requires all local authorities in the UK to review and assess air quality in their area. If any standards are being exceeded or are unlikely to be met by the required date, then that area should be designated an Air Quality Management Area (AQMA) and the local authority must draw up and implement an action plan aimed at reducing levels of the pollutant. Local authorities are required to make copies of their reviews and assessments of local air quality available to the public, as well as any orders designating an AQMA, and to consult locally on the action plan. In many areas, traffic is likely to be the main contributor to excessive levels of pollution.

In December 2015 the government launched a third consultation on Local Air Quality Management, this time on the proposed Technical and Policy Guidance. Whilst we welcomed the updated guidance for Local Air Quality Management, and the aims to streamline reporting, introduce a role for local authorities in reducing emissions of PM2.5, and clarify roles and responsibilities, there were a number of places where the guidance (and the underlying LAQM system) could be strengthened, to achieve more effective action and earlier compliance with the national objectives and the EU directive. We raised these in our response to the consultation.

- [EPUK response to the 2015 Consultation on Local Air Quality Management](#) – January 2016 (PDF)

In the government's second consultation on the future of the Local Air Quality Management Framework, although the main consultation report included some good ideas, the detail was either lacking (as it will be added through guidance at a later stage) or alarming, with the Impact Assessment including some extreme assumptions when assessing costs and benefits. We raised these concerns with Defra in our consultation response.

- [EPUK response to the 2014 Consultation on Local Air Quality Management](#) – January 2015 (PDF)

In 2013, the government consulted on the future of the Local Air Quality Management Framework. We submitted a robust response as we thought their preferred option would have a catastrophic impact

on air quality and public health, as it removed the duty on local authorities to assess and act on areas of poor air quality.

Environmental Protection UK submitted an initial letter outlining an alternative option to those proposed by government, as none of the four options are appropriate and adequate to deliver benefits to air quality and public health. We invited others to support this option in their consultation responses or in writing to Defra.

We subsequently also submitted a response to the government's consultation questionnaire.

- [EPUK initial letter to the Consultation on Local Air Quality Management](#) – August 2013 (PDF)
- [EPUK questionnaire response to the Consultation on Local Air Quality Management](#) – September 2013 (PDF)

Defra have also consulted on the need for Further Assessments (one of the reports required from Local Authorities in the LAQM Framework). Our response to this consultation is below:

- [EPUK response to the Consultation on Further Assessments](#) – February 2013 (PDF)

BY-LAWS

Some local authorities have adopted specific by-laws to control sources of air pollution and nuisance. However, these can be hard to enforce as surveillance is often difficult and the culprit hard to track down. Often the nuisance has ceased by the time an official can get to the scene.

WHERE TO FIND OUT ABOUT AIR QUALITY

Your local authority environmental health department should be able to advise you on air quality in your area. The UK National Air Quality Information Archive also monitors air quality nationally, on a daily basis:

<http://www.airquality.co.uk/>

Tel: 0800 556677 or visit Teletext page 156.

Similar websites are available specifically covering:

Northern Ireland – <http://www.airqualityni.co.uk/>

Scotland – <http://www.scottishairquality.co.uk/>

Wales – <http://www.welshairquality.co.uk/>

ROAD TRANSPORT

EXHAUST EMISSIONS

The Road Vehicles (Construction and Use) Regulations govern the standards to which new motor vehicles must be manufactured, including standards for exhaust emissions. Vehicle exhaust testing

has been included in the annual MOT since 1991. The Vehicle & Operator Services Agency (VOSA) carries out roadside tests on heavy goods vehicles and can ban further use of a smoking vehicle until it has been adjusted or repaired. However, only the police have the powers to stop a vehicle on the road if it is producing so much smoke as to be a hazard to other drivers.

You can report smoky buses, coaches and lorries to the Vehicle and Operator Services Agency (VOSA (0870 606 0440). Following a complaint the operator is notified and requested to clean up their vehicle. There is no mechanism for reporting privately owned vehicles.

FIXED PENALTY NOTICES

Where an AQMA has been declared, local authorities in England and Wales can apply for powers to carry out roadside emissions testing under the Road Traffic (Vehicle Emissions) (Fixed Penalty) (England) Regulations 2002 and the Road Traffic (Vehicle Emissions) (Fixed Penalty) (Wales) Regulations 2003. In Scotland all local authorities have these powers available to them, under the Road Traffic (Vehicle Emissions) (Fixed Penalty) (Scotland) Regulations 2003.

Authorised and adequately trained persons can then carry out an emissions test on a vehicle being driven through, or about to pass through, an AQMA and if an offence has been committed a fixed penalty of £60 can be issued. A driver can also be required to submit their vehicle to a test and to produce a test certificate. If the fixed penalty is not paid within the given timeframe it can rise to £90.

STATIONARY IDLING

Fixed penalty notices of £20 can also be issued by an authorised local authority officer in England, Wales and Scotland to motorists who leave their engines running unnecessarily (e.g. waiting outside school/station), having asked them to switch them off. This rises to £40 if it is not paid within the given timeframe.

LEADED FUEL

All new petrol vehicles now run on unleaded fuel and the sale of leaded petrol was banned in January 2000. For the small amount of older vehicles that will not run on unleaded fuel, special lead replacement petrol is available from some filling stations. Petrol producers and importers wishing to make leaded petrol available for use in classic and historic vehicles must apply for a permit from the Department for Transport.

DOMESTIC FIRES

Under the Clean Air Act 1993 (or Clean Air (Northern Ireland) Order 1981 local authorities can declare the whole or part of their district to be a Smoke Control Zone. This means that it is an offence to cause smoke from a chimney, and for any person or company to obtain or deliver unauthorised fuel to a building, unless the appliance in use is exempt. Ordinary bituminous coal and wood are not authorised fuels. Around 50% of households live in Smoke Control Areas, and those using solid fuel must therefore ensure that they use an authorised smokeless fuel and/or an exempt appliance.

For more information go to [Using Wood and Coal for Home Heating](#).

The Clean Air Act is currently under review, and Environmental Protection UK is keen to ensure that this continues to protect air quality, especially in light of the increased use of solid fuels in urban environments. Please see our response to the Government's consultations on the Clean Air Act 1993 Review below:

- [EPUK questionnaire response for the Clean Air Act 1993 Review](#) – February 2013 (PDF, the main content of our response is included in response to question 27)
- [EPUK response to the Call for Evidence on the Clean Air Act 1993](#) – October 2013 (PDF)

Breach of a smoke control order can lead to prosecution by the local authority. Your local environmental health department will be able to tell you if your area is smoke controlled and advise you on authorised fuels and appliances. Smoke control orders do not apply to domestic bonfires – these are covered by nuisance legislation.

NUISANCES

Under the Environmental Protection Act 1990 (England, Scotland and Wales) a statutory nuisance can be any dust or effluvia from any trade or business premises or smoke, fumes or gases emitted from premises so as to be prejudicial to health or a nuisance. For a nuisance action to succeed the offence also has to be a cause of material harm or to be persistent or likely to recur. Nuisances may include smoke from bonfires, unpleasant odours, grit and dust. (In Northern Ireland statutory nuisances are currently regulated under the Public Health (Ireland) Act 1878, as amended, which includes powers for local authorities to serve abatement notices. The Clean Neighbourhoods and Environment Bill introduced into the NI Assembly in June 2010 makes provision for similar controls to those applying in the rest of the UK.)

In many cases a friendly approach to a neighbour or business can resolve the problem. If this fails, complaints should be made to your local environmental health department. If they are satisfied that a nuisance exists steps will be taken to abate the nuisance. This may involve serving a legal notice, which, if ignored, can result in proceedings in the Magistrates Court (Scotland – Sheriff Court). The Courts may impose an order to prevent the nuisance and a fine. Continued non-compliance can lead to further fines. The local authority also has power to abate the nuisance itself and recover costs.

If for any reason your local authority is unwilling to act on your behalf you may apply directly to the Magistrates Court (Scotland – Sheriff Court) for a nuisance order. In such cases it is essential to compile a proper record of occurrence of the nuisance and its effect on you. The support of independent witnesses will also help. In any event it is possible that the complainants may be called upon to give evidence in nuisance proceedings.

INDUSTRIAL AIR POLLUTION

Industrial processes have been regulated for Integrated Pollution Prevention and Control (IPPC) for some time now, introduced by the Pollution Prevention and Control Act 1999. These regulations were phased in sector-by-sector up to October 2007, taking over from mechanisms established in the Environmental Protection Act 1990. This has now been subsumed into the Environmental Permitting Regulations which will also implement the EC's new Industrial Emissions Directive (IED). The IED consolidates IPPC with other sector-specific Directives such as for Large Combustion Plant, Waste Incinerators etc. In Northern Ireland a similar regime is in operation with regulations made under the Environment (Northern Ireland) Order 2002. More details below.

SMOKE

It is an offence for factories and trade premises to emit dark smoke from their chimneys under the Clean Air Act 1993 (or Clean Air (Northern Ireland) Order 1981), except when it is unavoidable (e.g. or lighting up). Current technology should allow efficient combustion, free of dark smoke at all times. Dark smoke emissions from open burning (bonfires) on industrial or trade premises (including demolition sites) or agricultural land is also prohibited, except in very limited circumstances. 'Dark' smoke is a shade of grey defined by law.

GRIT AND DUST

The amount of grit and dust emitted from the chimney of non-domestic boilers and some furnaces is also controlled by the Clean Air Act 1993 (NI – 1981 Order). This legislation ensures that newly installed industrial plants have adequate arrestment equipment and that where emissions from a plant appear excessive a local authority can require measurements to be made of emissions to the atmosphere.

INTEGRATED POLLUTION PREVENTION CONTROL/ ENVIRONMENTAL PERMITTING

The system of Integrated Pollution Prevention and Control (IPPC) replaced the previous Local Authority Pollution Control and Integrated Pollution Control systems. IPPC was implemented through separate Pollution Prevention and Control Regulations 2000 in England and Wales and in Scotland, and in Northern Ireland through separate 2003 Regulations. The transferral process to the new system was completed in October 2007. In England and Wales the PPC Regulations have been replaced by the Environmental Permitting Regulations (EPRs).

The EPRs cover a wide range of industries, including fuel production and power generation, metal production and processing, mineral industries, chemical industries, waste disposal and recycling, food and drink processing and intensive livestock installations. All industries covered by the EPRs must obtain a permit to operate from the appropriate regulator. This covers all aspects of an installation's activities, including noise and vibration, heat, energy efficiency and accident prevention policy. For new installations an environmental impact assessment must also be available.

Permit conditions are based on the use of Best Available Techniques (BAT), which balances the cost to the operators against benefits to the environment. Where a breach of legally binding EU air quality

limit values is caused by a particular industrial installation more stringent permit limits than BAT must be imposed.

In England and Wales certain installations are regulated for emissions to air, water and land by the Environment Agency and from 1 April 2013, Natural Resources Wales, respectively. A lesser number of smaller, or less complex, installations regulated by local authorities. All such installations in Scotland and Northern Ireland are regulated by either the Scottish Environment Protection Agency or the Northern Ireland Environment Agency (as appropriate).

A number of smaller installations are regulated for their emissions to air only. These installations include many solvent using processes, timber activities and crematoria, and are regulated by local authorities in England, Wales and Northern Ireland, and by SEPA in Scotland.

Copies of applications and other documentation for all permits, subject to certain exemptions, are put in the Public Register maintained by the regulator. Various other statutory bodies will also be consulted (representing, for example, health interests, sites of special scientific or other local interest etc). A copy of all comments is put in the Register, although members of the public may request that their comments are not recorded on the register.

Complaints about any process or installation should in the first instance be made to the operator. If no satisfactory solution can be reached the regulator should be contacted. You can contact your environmental health (or pollution control) department at your local authority offices.

The Environment Agency has seven regional offices. Their head office is at:

Environment Agency
Horizon House, Deanery Road
Bristol BS1 5AH
Tel: 0117 934 4001

Emergency hotline: 0800 807060
Email: enquiries@environment-agency.gov.uk
<http://www.environment-agency.gov.uk/>
<http://www.environment-agency.wales.gov.uk/>

Natural Resources Wales (NRW) has regional offices across Wales (details can be found on its website). The head office is at:

Natural Resources Wales
Tŷ Cambria
29 Newport Road
Cardiff
CF24 0TP

Tel: 0300 065 3000

Email: enquiries@naturalresourceswales.gov.uk

<http://naturalresourceswales.gov.uk>

The Scottish Environment Protection Agency (SEPA) has regional offices across Scotland (details can be found on its website). The head office is at:

Scottish Environment Protection Agency

Erskine House

The Castle Business Park

Stirling FK9 4TR

Tel: 01786 457700

Email: info@sepa.org.uk

<http://www.sepa.org.uk/>

The Northern Ireland Environment Agency is an executive agency of the Department of Environment (NI), with main offices in Belfast and Lisburn.

Klondyke Building

Cromac Avenue

Gasworks Business Park

Lower Ormeau Road

Belfast

BT7 2JA

Pollution hotline 0800 80 70 60

Email: ipri@doeni.gov.uk

<https://www.doeni.gov.uk/>

The Industrial Pollution and Radiochemical Inspectorate is part of NIEA and can be contacted through the details already listed above.

PLANNING AND POLLUTION CONTROL

Most new industrial developments require planning permission; certain types of developments will also need to carry out an environmental impact assessment as part of the planning procedure. The public have a right to comment on planning applications, which are advertised in the local press and copies placed on the local planning register.

When drawing up their development plans (now known as Local Development Frameworks) and making decisions on individual applications local authorities must have regard to Government guidance on pollution control. In England the relevant document is the National Planning Policy

Framework 2012; in Scotland Planning Advice Note 51, Planning, Environmental Protection and Regulation provides supplementary advice in support of Scottish Planning Policy which sets out the national framework.. Planning Policy Wales sets out land use policies of the Welsh Assembly Government and in Northern Ireland PPS 1 sets out general principles for land use.

The planning system in England is changing, and Environmental Protection UK are keen that this continues to protect and improve air quality. Our response to the consultation on Planning Guidance following the Taylor Review is available here.

- [EPUK Response to the Planning Guidance Consultation](#) – February 2013 (PDF)

FURTHER CONTACTS

If your air pollution problem is caused by a neighbour and legal action is not appropriate, mediation may help. Your local authority or the Citizens Advice Bureau will be able to tell you if there is a mediation service in your area.

Citizens Advice Bureau

<http://www.citizensadvice.org.uk/>

If you have a specific pollution problem and the appropriate regulatory authority does not appear to be taking sufficient action, the Environmental Law Foundation can offer consultation with legal and technical experts.

The Environmental Law Foundation

Tel: 020 7404 1030

Email: info@elflaw.org

<http://www.elflaw.org/>



Neutral Citation Number: [2018] EWHC 315 (Admin)

Case No: CO/4922/2017

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 21/02/2018

Before :

MR JUSTICE GARNHAM

Between :

**The Queen (on the application of
ClientEarth) No.3**

Claimant

- and -

**(1) Secretary of State for Environment, Food and
Rural Affairs**

Defendants

**(2) Secretary of State for Transport
(3) Welsh Ministers**

And

Mayor of London

**Interested
Party**

Nathalie Lieven QC & Ravi Mehta (instructed by ClientEarth) for the Claimant
Kassie Smith QC & Julianne Morrison (instructed by Government Legal Department)
for the First Defendant
Jonathan Moffett QC (instructed by Government Legal Department) for the Welsh Ministers

Hearing date: 25th January 2018

Approved Judgment

Mr Justice Garnham:

Introduction

1. On 26 July 2017 the Department for Environment, Food and Rural Affairs (“DEFRA”) published the “UK plan for tackling roadside nitrogen dioxide concentrations” and associated documents (hereafter “the 2017 Plan”). This was the third attempt by the UK Government to provide an Air Quality Plan (“AQP”) that met its obligations in law.
2. The first AQP, produced in 2011, was quashed by order of the Supreme Court in 2015. The Government was made the subject of a mandatory order requiring the Secretary of State to prepare new air quality plans in accordance with a defined timetable (see R (on the Application of ClientEarth) v The Secretary of State for the Environment, Food and Rural Affairs [2015] UKSC 28, 4 All ER 724). The second AQP, produced in purported compliance with the order of the Supreme Court, was published on 17 December 2015.
3. In a judgment dated 2 November 2016 ([2016] EWHC 2740 (Admin), (“the November 2016 judgment”), I held that the 2015 plan was also deficient. I made a direction that DEFRA must publish a new AQP, which complied with the relevant EU Directive and domestic Regulations, by 31 July 2017. It was in purported compliance with that order that DEFRA published the 2017 Plan.
4. The Claimant in these proceedings is “ClientEarth”, a registered charity, whose objects include promoting and encouraging the “*enhancement, restoration, conservation and protection of the environment, including the protection of human health, for the public benefit*”. By these proceedings, the Claimant challenges the 2017 Plan on the ground that it too failed to meet DEFRA’s legal obligation. ClientEarth was also the claimant in the two previous judicial review cases. The Defendants are the Secretaries of State for Food, Environment and Rural Affairs, and for Transport, and the Welsh Ministers. The Secretary of State for Food, Environment and Rural Affairs has taken the lead for the Defendants in this case (and I refer to him hereafter as “the Secretary of State”).
5. Proper and timely compliance with the law in this field matters. It matters, first, because the Government is as much subject of the law as any citizen or any other body in the UK. Accordingly, it is obliged to comply with the Directive and the Regulations and with the orders of the court. Second, it matters because, as is common ground between the parties to this litigation, a failure to comply with these legal requirements exposes the citizens of the UK to a real and persistent risk of significant harm. The 2017 Plan says that “*poor air quality is the largest environmental risk to public health in the UK. It is known to have more severe effects on vulnerable groups, for example the elderly, children and people already suffering from pre-existing health conditions such as respiratory and cardiovascular conditions*”. As I pointed out in the November 2016 judgment, DEFRA’s own analysis has suggested that exposure to nitrogen dioxide (NO₂) has an effect on mortality “*equivalent to 23,500 deaths*” every year.

The Legislative Scheme

6. At paragraphs 6-15 of the November 2016 judgment, I set out and explained the legislative background relevant to the arguments in that case. That background remains

relevant to this challenge but it is not necessary to repeat all that detail here. It suffices for me to note the following provisions, all of which are cited in the November 2016 judgment:

7. Article 13 of Directive 2008/50/EC (“the 2008 Directive”) imposes limit values and alert thresholds for the protection of human health. It provides:

“1. Member States shall ensure that, throughout their zones and agglomerations, levels of sulphur dioxide, PM10, lead and carbon monoxide in ambient air do not exceed the limit values laid down in Annex XI.

In respect of nitrogen dioxide and benzene the limit values, specified in Annex XI may not be exceeded from the date specified therein.”

8. Article 23 provides that:

“Where, in given zones or agglomerations, the levels of pollutants in ambient air exceeds any limit value...member states shall ensure that air quality plans are established for those zones and agglomerations in order to achieve the related limit value...specified in Annexes XI and XIV.

In the event of exceedances of those values for which the attainment deadlines have already expired the air quality plan shall set out appropriate measures, so that the exceedance period can be kept as short as possible.”

9. Annex XI to the 2008 Directive imposes a limit value for nitrogen dioxide of an average of 200ug/m³ in any given hour (which is not to be exceeded more than 18 times in a calendar year) and an average of 40ug/m³ which applies to each calendar year.
10. Annex XV sets out information to be included in the local, regional or national air quality plans for improvement in ambient air quality. Amongst the information required is detail of those measures or projects adopted with the view to reducing pollution. The Plan must list and describe all the measures set out in the project, set out a timetable for implementation, provide an estimate of the improvement of air quality planned and the expected time required to obtain that objective.
11. The 2008 Directive was brought into domestic law in the UK by means of four sets of regulations, one for each of the home nations. Regulation 26 of the English Regulations (the Air Quality Standards Regulations 2010 (2010/1001)) requires the Secretary of State, when the levels of nitrogen dioxide (amongst other pollutants) exceeds any limit value, to draw up and implement an AQP so as to achieve that limit value.
12. Regulation 26 also specifies that the AQP must “include measures intended to ensure compliance with any relevant limit value within the shortest possible time....” and “must include the information listed in Schedule 8.”

13. In addition to the provisions referred to in the November 2016 judgment, it is material to note the following five additional provisions.

14. First, paragraph 8 of Schedule 8 (which, as noted above, is referred to in Regulation 26 of the English Regulations) specifies, as part of the information which must be included in air quality plans, the following:

“Details of those measures or objectives adopted with a view to reducing pollution following 11 June 2008 - (a) listing and description of all the measures set out in the project; (b) the timetable for implementation; (c) estimate of the improvement of air quality planned and of the expected time required to attain these objectives”

15. Second, the Air Quality Standards (Wales) Regulations 2010 (2010/1433) impose, on the Welsh Ministers, duties in respect of Wales equivalent to those imposed on the Secretary of State in respect of England. In particular, regulations 13 and 20 of those Regulations provide:

“13.(1) ...the Welsh ministers must ensure levels of ...nitrogen dioxide...do not exceed the limit values set out in Schedule 1 in any zone...”

(Schedule 1 imposes the same limit values as are imposed in England.)

20. Where the level of ...nitrogen dioxide...in ambient air exceeds any of the limit values in Schedule 1 in any zone...the Welsh Ministers must draw up and implement an air quality plan to achieve the relevant limit value...in that zone.”

16. Third, Articles 6-7 of the 2008 Directive makes provision for assessment criteria and sampling points in order to ensure consistent monitoring of ambient air quality across the EU.

17. Fourth, in December 2011, the European Commission published a Commission Implementing Decision laying down rules for the 2008 Directive as regards reporting of ambient air quality. Paragraph 1 of Article 13 of that decision provides that:

“Member States shall make available the information set out in Parts...K of Annex II to this Decision on air quality plans as required by Article 23 of Directive 2008/50/EC including (a) the mandatory elements of the air quality plan as listed pursuant to Article 23 of the Directive 2008/50/EC in Section A of Annex XV to Directive 2008/50/EC...”

18. Part K requires the provision of information as to matters including:

“(14) Planned implementation: start and end date

(15) Date when the measure is planned to take full effect

- (16) Other key implementation dates*
- (17) Indicator for monitoring progress*
- (18) Reduction in annual emissions due to applied measure...*

19. Finally, s85 of the Environment Act 1995 provides, as material:

“(3) If it appears to the [the Secretary of State]

(a) that air quality standards or objectives are not being achieved, or are not likely within the relevant period to be achieved, within the area of a local authority...

the appropriate authority may give directions to the local authority requiring it to take such steps as may be specified in the directions...

(7) It is the duty of a local authority to comply with any direction given to it under or by virtue of this Part.”

20. It is against that statutory framework that the new AQP was developed.

Developing the 2017 Air Quality Plan

- 21. Shortly after the November 2016 judgment, DEFRA set about the task of preparing a new AQP.
- 22. I was provided with a detailed and helpful statement from Mr Andrew Jackson, Deputy Director of a unit established by DEFRA and the Department for Transport and known as the Joint Air Quality Unit (“JAQU”). It is apparent from the statement that very considerable time and effort was devoted to the preparation of the plan by officials and ministers.
- 23. A long list of potential policy options to tackle nitrogen dioxide emissions was identified; strategy papers analysing the problem were produced; proposals were discussed with the Greater London Authority, other local authorities and the devolved administrations. Amongst the options was a wider deployment of clean air zones (“CAZs”) than that contemplated by the 2015 plan.
- 24. In 2016 the Government had published a “Clean Air Zone Framework in England” which set out the principles for the operation of a CAZ. As was subsequently to be explained in paragraph 103 of the 2017 Plan, CAZs fall into two categories:

“a. Non-charging Clean Air Zones – These are defined geographic areas used as a focus for action to improve air quality. This action can take a range of forms including, but not limited to, those set out in Section 2 of the Framework but does not include the use of charge based access restrictions.

b. Charging Clean Air Zones – These are zones where, in addition to the above, vehicle owners are required to pay a

charge to enter, or move within, a zone if they are driving a vehicle that does not meet the particular standard for their vehicle type in that zone. Clean Air Zone proposals are not required to include a charging zone, and local authorities may consider alternatives to charging such as access restrictions for certain types of vehicles.”

25. As a result of the work described above it was determined, consistent with the analysis referred to in the November 2016 judgment, that “Charging Clean Air Zones” (or “Charging CAZs”) were the preferred option for reducing roadside NO₂ emissions.
26. By the middle of April 2017, a draft AQP was nearing completion. DEFRA sought an extension of time from the Court for the production of the draft plan because of the approach of local, and then national, elections. I granted a modest extension to cover the local election, but refused a much longer one in respect of the general election ([2017] EWHC 1618 (Admin)). The date of the publication of the final report was maintained at 31 July 2017.
27. In accordance with the amended order of the Court, a draft air quality plan and supporting technical report were published on 5 May 2017. Those documents were then put out to consultation. In June 2017 ClientEarth sought an order that the Secretary of State should produce a supplement to the draft published in May 2017. I refused that application ([2017] EWHC 1966 (Admin)).
28. The consultation process ended on 15 June by which time some 743 substantive responses had been received. The responses included a substantive one from ClientEarth and a number of pro forma responses from members of the public who were encouraged to respond by ClientEarth. A summary of the responses to the consultation was published subsequently.
29. The period between the end of the consultation period and production of the final AQP was marked by high level meetings between officials and ministers at which decisions were made as to the final shape of the report. On 26 July 2017 the Government and the devolved administrations published 3 documents. First, the “UK plan for tackling roadside nitrogen dioxide concentrations: an overview” (also known as “the Overview Document”). Second, the “UK plan for tackling roadside nitrogen dioxide concentrations: Detailed plan” (“the Detailed Plan”). Third, the technical report.
30. On 27 July 2017 the Government published a Direction to 23 local authorities under s85(5) of the Environment Act 1995. This Direction, entitled “The Environment Act 1995 (feasibility study for nitrogen dioxide compliance) air quality direction 2017”, required the 23 authorities to undertake a feasibility study to identify the option which will deliver compliance with legal limits for nitrogen dioxide in the area for which the authority is responsible, in the shortest possible time.

The 2017 Air Quality Plan

31. Identification of what are the critical elements of the new air quality plan is not contentious and I am able to summarise the position in relatively short compass.

Zones, Local Authorities and National Measures

32. Section 3 of the Detailed Plan explains that the UK is divided into 43 zones for air quality reporting. In all but two zones, the UK is achieving the statutory hourly mean limit value for NO₂. However, 37 zones exceeded the statutory annual mean limit value for NO₂ in 2015.
33. These zones are not co-terminal with local authority areas; many zones incorporate more than one local authority area. For the purposes of its operation, however, the 2017 Plan is directed to local authorities, who are to have a central role in bringing the plan into effect. Section 7.4.1 of the Detailed Plan outlines the requirement for local authority-led action plans in England. Paragraph 90 of the Detailed Plan provides that:

“Given the local nature of the problem, local action is needed to achieve improvements in air quality. As the UK improves air quality nationally, air quality hotspots are going to become even more localised and the importance of action at a local level will increase. Local knowledge is vital to finding air quality solutions that are suited to local areas and the communities and businesses affected. A leading role for local authorities is therefore essential.”
34. It is acknowledged that locally-led solutions will need to be implemented within a national framework designed to ensure that compliance will be achieved within the shortest possible time.
35. The 2017 Plan identifies a range of existing actions that were already being taken to tackle local NO₂ exceedances and reduce overall emissions. First, there is action taking place across the UK, including, for example, improvements to emissions testing for vehicles. Second, there is action being taken in England: for example, action by Highways England to improve air quality on the strategic road network in England, and action to update Government procurement policy to encourage the purchasing of cleaner vehicles by Government.

Non-Compliant Areas and Annex K

36. The 2017 Plan explains that on 31 July 2017 the Government published 37 individual zone plans for each non-complaint zone in the UK. I return to the contents of the local plans below.
37. The degree of non-compliance exhibited and forecast for different local areas varies widely. Annex K to the Detailed Plan sets out these different forecasts by reference to local authorities. Different approaches are adopted in the Plan depending on the degree of non-compliance forecast.
38. First, there are 23 local authorities representing areas with the greatest problem, i.e. those with exceedances projected beyond the next three to four years. Second, there are the five cities that were previously the focus of the 2015 AQP (Birmingham, Leeds, Nottingham, Derby and Southampton). Third, there are 45 local authorities which currently have air quality exceedances, but which are expected to achieve compliance with the NO₂ limit values by 2021.

39. Although different measures are planned for each of these groups, the plan explains that “*the UK government has identified Clean Air Zones that include charging as the measure it is able to model nationally which will achieve statutory NO₂ limit values in ... the shortest possible time*”. Accordingly, this measure is to be used as “*the benchmark for assessing locally-led solutions*”.
40. For the first group, those areas with exceedances projecting beyond the next three to four years, local authorities are required to develop local plans in order “*to achieve the statutory NO₂ limit values within the shortest possible time*”. Paragraph 111 of the Detailed Plan explains that if local authorities adopt a Charging CAZ, modelling suggests that they could achieve statutory NO₂ limit values in most cases by 2021. That allows for the time needed to design, commission and install CAZs and bring them into operation.
41. Given the potential impacts on individuals and businesses of CAZs and other measures, the Plan provides that if local authorities can identify measures other than Charging CAZs, which are *at least as* effective at reducing NO₂, then such measures are to be preferred. However, the local authority must demonstrate that these will deliver compliance as quickly as a Charging CAZ. The Government will only approve local authority plans if the local authority can show that its plan is likely to cause NO₂ levels in the area to reach legal compliance within the shortest time possible (and that it provides a route to compliance which reduces exposure as quickly as possible). By virtue of the July 2017 Direction, these local authorities are subject to legal duties to develop and implement such local plans.
42. The relevant 23 local areas are required to develop local plans and implement them “at pace” so that air quality limits are achieved within the shortest possible time. Specifically, they are required to set out initial plans by the end of March 2018, at the latest, and final plans by the end of December 2018 at the latest.
43. A somewhat different approach is taken to the second group, the five cities that were previously the focus of the 2015 AQP. That AQP anticipated that the five cities would be mandated to implement Charging CAZs which would achieve compliance by 2020. Consequently, paragraph 112 of the 2017 Plan makes clear that:

“The UK government continues to expect local authorities in the five cities named above to deliver their Clean Air Zones by the end of 2019, with a view to achieving statutory NO₂ limit values within the shortest possible time, which the latest assessment indicates will be in 2020.”
44. The 2017 Plan provides that the five cities are working to the same timetable as they were under the 2015 AQP. A more detailed breakdown of the proposed timetable was set out in the draft Technical Report published in May 2017. The Secretary of State contends that JAQU and Defra have been engaging, and continue to engage, intensively with each of the five cities and have been closely supporting them in the development of their plans for achieving compliance. JAQU has provided feedback on the Outline Business Cases submitted by the five cities to date.
45. On 19 December 2017, new Directions were issued to each of the five cities under s85(5) of the Environment Act 1995 requiring the relevant local authority to prepare,

as part of its feasibility study, a full business case for the area for which it is responsible, which was to be submitted to the Secretary of State as soon as possible, and by 15 September 2018 at the latest. JAQU has indicated to the cities that it is intended subsequently to use Ministerial Directions to direct each local authority to implement its local plan (full business case) once it has been approved by the Secretary of State.

46. The third group are the 45 local authorities which currently have air quality exceedances, but which are expected to achieve compliance with the NO₂ limit values by 2021. The 2017 Plan proceeds on the basis that these local authorities are not required to develop further local plans or undertake a feasibility study benchmarked against a Charging CAZ.
47. The situation as regards these local authority areas is not homogenous. Of these 45 local authorities, 12 are expected to achieve compliance in 2018, a further 10 are expected to achieve compliance in 2019, a further 13 are expected to achieve compliance in 2020, and the remaining 10 are expected to achieve compliance in 2021.
48. The Detailed Plan explains that the implementation of a CAZ is expected to take up to three years. Paragraph 116 provides that the government

“will only require local authorities to develop plans where evidence suggests measures could be put in place to bring forward achievement of statutory NO₂ limit values”.
49. However, the Plan says that the government is conscious that some local authorities, namely these 45, are forecast to have air quality exceedances *“which are close to, but below air quality limits in 2021”* and therefore it

“will consider further steps to ensure that air quality in these areas improves and to ensure that forecast levels remain compliant. These steps could include preferential access to funding and government support to access and build on best practice.”
50. The Technical Report also explains that:

“Those areas with the greatest problem, with exceedances projected beyond the next three to four years, will be required to develop local plans. Other areas will also be expected to take steps now to reduce emissions if there are measures they could take to bring forward the point where they meet legal limits and government will take steps to support them.”
51. The Secretary of State asserts that, depending on the extent and source of the exceedances, different local authorities are adopting different policies and measures to address air quality issues. He says that JAQU has undertaken a review of the situation in these areas which the unit proposes to share with them to help them to focus their efforts. It is said that all 45 local authorities can also access support from DEFRA as

part of the Local Air Quality Management (LAQM) framework, including a dedicated LAQM helpdesk.

Wales

52. The Welsh Ministers are responsible for those parts of the 2017 Plan which fall within their devolved competence and for which they have been designated the competent authority for the purposes of Directive 2008/50/EC. The Welsh AQP primarily consists of the Detailed Plan and the zone plans for the four Welsh air quality zones.
53. For reasons that will become apparent, I need to say no more about background to the claim against the Welsh Ministers.

The Competing Arguments

54. I had the benefit of detailed skeleton arguments from Nathalie Lieven QC and Ravi Mehta on behalf of the Claimant, and Kassie Smith QC and Julianne Morrison for the Secretary of State. I also heard careful and well-structured oral submissions from Ms Lieven and Ms Smith. I am grateful to all Counsel and to those who instruct them for the manner in which this case has been prepared and argued. I do not intend to do more here than summarise the parties' respective arguments; the skeletons provide a more detailed overview of their cases.
55. Ms Lieven advanced two principle grounds in support of her contention that the 2017 Plan is unlawful in respect of England.
56. In her skeleton argument she summarised her first argument by saying that "*a substantial number of local authority areas in England are unaccounted-for.*" She went on to develop that argument in rather less bald terms. She says that in relation to 45 local authority areas in England, the AQP "*includes no concrete, impact-assessed measures to ensure compliance in the 'shortest possible time', nor any requirement for responsible local authorities to "carry out feasibility studies or to identify such measures, despite identifying ongoing breaches of limit values"*.
57. Ms Lieven says that the adoption of a benchmark provided by Charging CAZs is misplaced in the case of these areas because it avoids the obligation to ensure compliance in the "*shortest possible time*". She says that the 45 Local Authorities will not have the same access to funding as the local authorities who are included in the Direction. She says that the Individual Zones Plans contain lists of measures designed to ensure compliance with legal limit values, but with "*largely unquantified impacts*". She says that no timeline is given for additional measures to be taken in the 45 local authority areas, no concrete measures are identified and no indication is given of the likely improvements from those steps. She says that in any event projected compliance is based on over-optimistic modelling.
58. Ms Lieven's second ground relates to provision made in the 2017 Plan for the five cities alongside London that were previously to be mandated to introduce CAZs (Birmingham, Leeds, Nottingham, Derby and Southampton). She contends that the Detailed Plan originally imposed no legal requirement for the timing or scope of their introduction of Charging CAZs. She says that "*the 2017 Directions effectively concede part of this claim*". Nonetheless she argues that these directions do not meet the

requirements of EU law for a clear and legally enforceable timetable for implementation of the necessary measures.

59. In response, Ms Smith argues that the first complaint is “*misconceived*”. The 45 local authority areas are not “*unaccounted-for*”. In each area, action is being taken to address air quality issues. The individual zone plans for the areas covered by the 45 local authorities set out the measures that have been implemented to date, or are planned and being taken in each area to reduce NO₂ levels within a reporting Zone.
60. She says that the government has identified Charging CAZs as the measure that will achieve compliance with the NO₂ limit values in the shortest possible time and the benchmark against which any local authority plans will be assessed. Given the projected timeframe for compliance in each of these areas, the introduction of CAZs would not bring forward compliance. Consequently, she argues it would be disproportionate and inappropriate for these areas to be mandated to take steps towards introducing one. In particular, she contends, the preparation of feasibility studies and necessary local consultation is not expected to identify measures that could be worked up and introduced in time to bring forward compliance.
61. This does not mean, Ms Smith contends, that no further action will be taken in these areas. In particular, in those areas which are forecast to have air quality exceedances which are close to, but below air quality limits in 2021, as well as the matters set out in the individual zone plans, the Government “*will consider further steps to ensure that air quality in these areas improves and to ensure that forecast levels remain compliant. These steps could include preferential access to funding and government support to access and build on best practice.*” She says that JAQU is already engaging with relevant authorities in order to identify what further steps can be taken to support them.
62. Ms Smith says that the national monitoring and modelling used for the purposes of the 2017 Plan has been undertaken in accordance with the criteria set out in and the requirements of the Air Quality Directive.
63. According to Ms Smith, ClientEarth’s second complaint is also misconceived. The Joint Air Quality Unit, she says, is working intensively with the five cities to ensure that they deliver their CAZs to the timetable anticipated by the 2017 Plan (i.e. CAZs to be in place by the end of 2019, achieving compliance in 2020). She argues that ClientEarth is wrong to contend that the Plan can only be effective if the Secretary of State imposes mandatory timetabling requirements, addressing all stages of the process, on the five cities from the outset.
64. In any event, she says, that is not required by the Air Quality Directive. Moreover, she says, the 2017 Plan always envisaged mandating authorities to act to implement their measures in accordance with the timetable outlined in the 2015 AQP. Legally binding Ministerial Directions have now been issued to the five cities to submit their full business cases to the Secretary of State by 15 September 2018, and Directions will subsequently be issued requiring each of the five cities to implement its local plan, as set out in its full business case, once it has been approved by the Secretary of State.
65. Ms Smith disputes ClientEarth’s contention that the decision to issue the December Directions concedes part of its claim. Instead, the issuing of the 2017 Directions demonstrates that the Secretary of State is continuing to work to ensure that the five

cities achieve compliance as soon as possible. She says that the change in the means of applying obligations (a move from a Statutory Instrument to legally binding Directions) does not assist the Claimant's case. The use of Directions is predicated on the need for a tailored, timely and focused approach.

Discussion

66. Central to the argument as it was developed at the hearing was Table 1 of Annex K to the Detailed Plan, which provides a summary of proposed remedial measures. That table identifies local authorities in England "*with roads with concentrations of NO₂ forecast above legal limits and assuming no additional measures*". It is possible to identify from that table three categories of local authority.
67. The first consists of the Greater London Authority (the plans in respect of which are not challenged in this case) and the five cities of Birmingham, Derby, Leeds, Nottingham and Southampton (excluding a single stretch of road in the New Forest). The 2015 Plan assumed a Clean Air Zone was required in each of these areas. The second consists of 23 local authorities (including New Forest District Council but excluding Halton Borough Council where the opening of the Mersey Gateway Bridge was thought likely to solve the problem), which are to be "*required to produce local action plans by March 2018*". The third is the 45 local authorities which are "*not required to conduct a feasibility study*". Ms Lieven's first ground focuses on the third category and her second on the first category.

The 45

68. It is perfectly plain that the 45 local authorities are not "*unaccounted for*" as Ms Lieven's skeleton asserted. On the contrary, they are expressly identified in Table 1 and discussed in paragraph 116 of the Detailed Plan which I have set out above.
69. It is equally apparent, however, that the fact that these 45 local authority areas are expected to achieve compliance with the statutory NO₂ limit values by 2021 has led the Government to impose on them less onerous obligations than is the case for the 28, namely the five cities and the 23 other authorities (plus London) in respect of which compliance will not be achieved until after 2021. It is also plain that the reason for this distinction is the Government's assessment that these 45 will become compliant, without further measures being taken, within the period of three years which it would take to design, install and bring into operation a Charging CAZ.
70. Whilst no concession is made, no real point is taken on the assertion that it would take three years to introduce a Charging CAZ, nor on the assertion that Charging CAZs are the most effective means of addressing NO₂ exceedances. Nor can it be said that there is any error of approach in the government adopting Charging CAZs as the yardstick against which any alternative scheme is to be tested. In consequence, there is no challenge in this regard to the proposals in the 2017 plan in respect of the 23 authorities or to the plan to introduce CAZs in the five cities.
71. But where, in my judgment, the Government's plan is flawed, and seriously flawed, is in its application of the 3 year benchmark to the 45 local authority areas where compliance is anticipated within 3 years in any event. Plainly, it would be pointless to

require these local authorities to embark on the expensive and time consuming enterprise of establishing a CAZ in an area where compliance will be achieved within the same period without a CAZ. But the Government cannot sensibly, or lawfully, substitute the application of its benchmark, however rational in respect of areas where a CAZ is the most efficacious solution, for the requirements of the Directive and the Regulations in areas where it is not.

72. The obligation imposed by Article 23 of the 2008 Directive is specific to each and every zone or agglomeration. The obligation to devise air quality plans applies “*where, in given zones or agglomerations, the levels of pollutants in ambient air exceed any limit value*” (emphasis added). When the obligation arises the Article requires Member States to ensure that AQPs are established “*for those zones*”.
73. As I explained in the November 2016 judgment, the proper construction of Article 23 imposes a three-fold obligation on the Secretary of State; he must aim to achieve compliance by the soonest date possible; he must choose a route to that objective which reduces exposure as quickly as possible; and that he must take steps which mean meeting the value limits is not just possible, but likely. It follows that the Secretary of State must ensure that there is in place a plan for each zone which meets the three-fold obligation.
74. Because the obligation is zone-specific, the fact that each of the 45 local authority areas will achieve compliance in any event by 2021 is of no immediate significance. The Secretary of State must ensure that, in each of the 45 areas, steps are taken to achieve compliance as soon as possible, by the quickest route possible and by a means that makes that outcome likely. The CAZ benchmark cannot be treated as a means of watering down those obligations.
75. Nor is it an answer to this point to say, as Ms Smith does, that the current plan, with its careful application of the CAZ benchmark, is a “proportionate” response by the government to the issue raised by NO₂ emissions. Implicit in that submission is a suggestion that cost may play a part in determining the national AQP; that when viewed as a whole, the 2017 Plan is reasonable because it demands expenditure and action where there are exceedances that will persist, but demands less when the effluxion of time will bring zones into compliance without such costs. I reject that argument.
76. For the reasons I explained at paragraph 50 of the November 2016 judgment, the obligations imposed by the 2008 Directive are not qualified by reference to their cost:

“I reject any suggestion that the state can have any regard to cost in fixing the target date for compliance or in determining the route by which the compliance can be achieved where one route produces results quicker than another. In those respects the determining consideration has to be the efficacy of the measure in question and not their cost. That, it seems to me, flows inevitably from the requirements in the Article to keep the exceedance period as short as possible.”
77. In consequence, the expression “proportionate” has a very particular meaning in the present context. I stand by the definition of that word offered in the November 2016 judgment: “the measures a Member State may adopt should indeed be “proportionate”,

but they must be proportionate in the sense of being no more than is required to meet the target". I note that DEFRA chose not to appeal the 2016 decision. Because the target in view is compliance with the 2008 Directive in all zones, the expense of doing so promptly in any one zone is of no relevance to the need for, or the content of, a plan in that zone. Cost might be taken into account if there were two equally effective means of achieving the objective in view in one particular zone or one local authority area within that zone, but it is illegitimate to decline properly to design or fund the necessary measures in that zone because the benefit to be gained is modest or of limited duration compared with other zones. All that matters is whether such a plan will hasten the achievement of compliance.

78. Furthermore, there is, in respect of the 45 local authorities, no mechanism for enforcing the local plan. On 15 November 2017, the DEFRA Parliamentary Under Secretary of State, Dr Thérèse Coffey, wrote to 33 of the 45 local authorities (those who are not expected to achieve compliance in 2018) encouraging them to bid for the annual air quality grant; stressing the importance of taking action to achieve compliance in the shortest time possible; offering training and materials; and requesting further information on the steps they are taking to achieve compliance. On 19 January 2018, a week before the hearing, a similar letter was sent to the 33. In effect, these local authorities are being urged and encouraged to come up with proposals to improve air quality over the next three years but are not being required to do so.
79. In my judgment, that sort of exhortation is not sufficient. The obligation placed on Member States by Article 23 is to *ensure* that air quality plans are established; the competent authority in the UK for the purposes of the 2008 Directive is the Secretary of State (see Regulation 3 of the English Regulations); and polite letters from the Government urging additional steps by individual local authorities are not enough. Whilst I see no obligation on the Secretary of State to impose legal directions on local authorities covering every stage in the process of achieving compliance, in my view the failure to make mandatory any step in the case of the 45 means that the Government cannot show either that it is taking steps to "*ensure*" compliance or, as a result, that compliance is "*likely*".
80. It follows that the 2017 Plan, in its application to the 45 local authority areas, does not contain measures sufficient to ensure substantive compliance with the 2008 Directive and the English Regulations.
81. Furthermore, each plan must comply with the requirements of the 2008 Directive and the Regulations as to its form. As noted above, Annex XV of the Directive sets out information to be included in local (and other) AQPs. That includes information which identifies the measures being adopted, which sets out a timetable for implementation and provides an estimate of the improvement of air quality planned and the expected time required to attain that objective. Schedule 8 of the English Regulations mirrors those requirements and requires the plans to include details of the measures or objectives adopted, with a description of all the measures set out in the project; the timetables for implementation; an estimate of the improvement of air quality planned and the expected time required to attain those objectives.
82. The local plans produced as part of the 2017 Plan do not meet those requirements. Little time was devoted to the text of the local plans at the hearing but it is apparent that each local plan follows a similar template. After an introduction and general

information about the zone (or agglomeration), there is a description of the “overall picture for the 2013 reference year”, a section identifying measures that address the exceedances of the NO₂ limit value in the zone and then an analysis of “baseline model projections”.

83. In section 4 of each template words to the following effect appear:

“Relevant Local Authority measures within this exceedance situation are listed in Table C.1 (see Annex C). Table C.1 lists measures which a local authority has carried out or is in the process of carrying out, plus additional measures which the local authority is committed to carrying out or is investigating with the expectation of carrying out in the future.”

84. A list of measures which have been carried out, are underway, are promised or are being investigated, does not constitute compliance with Annex XV or Schedule 8; it does not amount to a plan describing the measures set out in a project; with timetables for implementation; estimates of the improvement of air quality that will follow and an indication of the expected time required to attain the objectives.

85. Ms Lieven suggests that “feasibility studies” ought to have been required for the 45; Ms Smith counters that these were needed for CAZ but not otherwise. The 2008 Directive and the English Regulations do not specify the development of “feasibility studies”, but they do, in my judgment, require the Secretary of State, if he is not to carry out the task himself, to devise some mechanism by which the 45 local authorities can be required to develop plans to address NO₂ exceedances in their areas in a manner that is consistent with the three-fold obligation. “Feasibility studies” is as good a name as any for the first stage of that process.

86. It follows that, as regards those 45 local authority areas, the 2017 Plan does not include the information required by Annex XV of the Directive and Schedule 8 of the English Regulations.

87. As noted above, the circumstances of the 45 local authorities are not homogenous. In particular, 12 are expected to achieve compliance this year. I will hear submissions on relief when this judgment is handed down, but it does not seem to me sensible to require (and I did not understand Ms Lieven to demand) any form of feasibility study in respect of the 12 authorities anticipated to achieve compliance this year. Feasibility studies for measures less complicated than CAZs will undoubtedly take significantly less time than the year or so I understand is required for CAZs. But they will take some time. And thereafter, there will need to be a process by which the outcome of the study is approved and the necessary work commissioned. In those circumstances, it seems to me that the prospect of making any difference to the outcome in these 12 areas is so remote as to make the exercise pointless.

88. For those reasons, and to that extent, this element of the challenge must succeed. Ms Lieven advanced further argument to the same end which it is not strictly necessary for me to address, but in deference to the quality of the argument deployed on this issue, particularly in writing, I set out my conclusions, albeit briefly.

Modelling and Monitoring

89. First, it is said that the 2017 Plan does not sufficiently take into account the results of Local Authority modelling and monitoring in the 45 local authority areas, relying instead on DEFRA's national model. Second, it is argued, the modelling used in the 2017 Plan does not take account of the risk of displacement, i.e. the risk that air quality could be made worse in these 45 local authorities as a result of the displacement of older, more polluting vehicles from the areas that do introduce Charging CAZs. Third, it is argued that the 2017 Plan places reliance on various national measures that it announces, which it appears to assume will have a positive effect on air quality in these Local Authorities, but which have not been modelled. It is said that in consequence the projected compliance of these 45 local authority areas rests on unspecified, un-timetabled measures which have not been modelled. Ms Lieven relies on the witness statements of Dr Claire Holman in support of these arguments.
90. In my judgment none of those points adds anything of substance to the argument.
91. As to the first, I accept the evidence that national monitoring and modelling used for the purposes of the 2017 Plan has been undertaken in accordance with the criteria set out in the Air Quality Directive. I fail to see how that can be criticised on the basis of different results obtained by others that may or may not have been conducted in accordance with the Directive. Further, as Ms Smith contends, "*the fact that local modelling may produce different results from those produced by national modelling does not mean that the latter is wrong or "overoptimistic"*".
92. As to the second, the evidence demonstrates that the possible effect of displacement was expressly drawn to the attention of local authorities who are to conduct feasibility studies. Both Mr Jackson and Mr Roald Dickens, a senior adviser in DEFRA's Environmental Quality Directorate, make that point. It is right to say that the same point was not made about the 45 local authorities. But that, undoubtedly, is a consequence of the fact that the 45 have not been required to implement feasibility studies to address NO₂ exceedances in their areas in the manner I have now ruled is necessary. I have no doubt that now studies are to be required in the 33 areas, the same point will be made to their local authorities.
93. As to the third, it is plain that the modelling in the 2017 Plan does *not* rely upon the benefits expected to flow from the non-modelled measures. That means that there are in place additional measures which might reduce exceedances but which are not factored into the calculations. To that extent at least DEFRA's modelling is conservative.
94. I would add that, in my judgment, modelling future compliance with NO₂ limit values is pre-eminently a matter of technical judgement upon which expert opinion is likely to be decisive. DEFRA established an independent panel of experts to provide guidance on this issue. As Ms Smith submits, any challenge to such modelling must show clear legal error or irrationality. I see no such legal error or irrationality here.

The 5 Cities

95. The criticism of the plans for the five cities in the Claimant's Grounds was the lack of any *obligation* on the cities to comply with the Plan.

96. It was noted that the 2015 AQP had proposed that Charging CAZs would be introduced in Birmingham, Leeds, Nottingham, Derby and Southampton in order to address serious exceedances there; and that the 2017 Plan noted the expectation that they would deliver compliance by 2020. But, it was asserted, no legal requirement to enforce such a timeline was imposed by the 2017 Plan. It was pointed out that the individual AQPs for each of these five cities simply records an *expected* timeline or an intention for CAZs to be introduced by particular dates, but no obligation to do so.
97. In my judgment, for the reasons set out above in relation to the 45 local authorities, there was some merit in that argument. However, on 19 December 2017, in exercise of the power conferred by s85(5) of the Environment Act 1995 the Secretary of State issued Ministerial Directions to the five cities, (the “Environment Act 1995 (Feasibility Study for Nitrogen Dioxide Compliance) Air Quality Direction 2017”). As submitted by Ms Smith, these impose requirements on the five to submit full business cases to the Secretary of State by 15 September 2018. In my judgment, those Ministerial Directions meet the primary point advanced by Ms Lieven. The critical first step of detailed business cases is now a legal obligation.
98. Ms Lieven complains that there is still no legally mandated timetable for implementation after the business cases are produced. Ms Smith responds that there is no legal obligation to mandate a timetable. She says the timetable is set out in the Plan, and the Ministerial Directions are the first step in ensuring that timetable will be complied with. Further Directions will follow once the business cases have been reviewed.
99. In my view, Ms Smith’s analysis on this issue is to be preferred. The Directive and the Regulations require that there must be a timetable, but not that the timetable is itself mandated in law. The Plan as regards the five cities is clear. Paragraph 111 provides:
- “The UK government continues to expect local authorities in the five cities named above to deliver their Clean Air Zones by the end of 2019, with a view to achieving statutory NO₂ limit values within the shortest possible time, which the latest assessment indicates will be in 2020.”*
100. The obligation on the Secretary of State is to ensure that that plan is followed so as to meet the obligations on him imposed by the 2008 Directive and the English Regulations. The issuing of the Ministerial Directions in December 2017 demonstrates how the Secretary of State intends to ensure the Plan will be adopted. Ms Smith made clear that further targeted and tailored Ministerial Directions will be issued in order to require implementation of those measures.
101. In my judgment, the Secretary of State’s approach to this issue is a sensible, rational and lawful one. Furthermore, in my view, the clear indication from the Secretary of State as to the next step of the process, is sufficient; were the Secretary of State to fail to act as he has indicated, it is unlikely that this Court would hesitate in requiring him to do so.

Wales

102. Mr Moffett QC told me that, from the outset of these proceedings, the Welsh Ministers have accepted that the Welsh AQP does not satisfy the requirements of either the Directive or the Welsh Regulations and were prepared to give an undertaking that they will correct the position.
103. Accordingly, the only discrete issue that arises in the context of the claim against the Welsh Ministers is that of what remedy, if any, the Court should grant. As to that, it was agreed between Ms Lieven and Mr Moffett that they would seek to agree an appropriate order having seen this judgment in draft. That seemed to me a sensible way to proceed and I will hear submissions from them on relief when this judgment is handed down.

Conclusions

104. For the reasons set out above I conclude that the 2017 Air Quality Plan is unlawful in that:
- i) in its application to the 45 local authority areas, it does not contain measures sufficient to ensure substantive compliance with the 2008 Directive and the English Regulations (see paragraph 80);
 - ii) the 2017 Plan does not include the information required by Annex XV to the Directive and Schedule 8 to the English Regulations, in respect of those same local authority areas (paragraph 86); and
 - iii) it contains no compliant AQP for Wales (paragraphs 103).
105. I will hear counsel further on the precise details of the relief that is appropriate. But I indicate now that I would be minded:
- i) to make a declaration that the 2017 Plan is unlawful in those respects;
 - ii) to grant a mandatory order requiring the urgent production of a Supplement to the 2017 Plan containing measures sufficient to rectify the deficiencies identified above; and
 - iii) to direct that the 2017 Plan remains in force whilst the Supplement is produced in order to avoid any delay in its implementation.
106. As indicated above, I will also hear submissions as to the position of the Welsh Ministers.
107. I have given permission to the Defendants to enlarge the group of persons who, upon appropriate undertakings to the Court, may have sight of the embargoed judgment; if a similar application is made by the Claimants I will give it consideration.
108. I end this judgment where I began, by considering the history and significance of this litigation. It is now eight years since compliance with the 2008 Directive should have been achieved. This is the third, unsuccessful, attempt the Government has made at devising an AQP which complies with the Directive and the domestic Regulations. Each successful challenge has been mounted by a small charity, for which the costs of

such litigation constitute a significant challenge. In the meanwhile, UK citizens have been exposed to significant health risks.

109. It seems to me that the time has come for the Court to consider exercising a more flexible supervisory jurisdiction in this case than is commonplace. Such an application was made to me when the November 2016 judgment was handed down. I refused it on that occasion, opting for a more conventional form of order. Given present circumstances, however, I would invite submissions from all parties, both in writing and orally, as to whether it would be appropriate for the Court to grant a continuing liberty to apply, so that the Claimant can bring the matter back before the court, in the present proceedings, if there is evidence that either Defendant is falling short in its compliance with the terms of the order of the Court.

Thanet CCG Locality Profile for Ramsgate

April 2017



Produced by

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| Contents

1. Introduction	5
2. Demographics	6
2.1 Location.....	6
2.2 Population (registered)	7
2.3 Ethnicity.....	8
3. Socio-Economic	9
3.1 Deprivation.....	9
3.2 Unemployment	11
4. Maternity	12
4.1 General fertility rate.....	12
4.2 Breastfeeding	13
4.3 Low birth weight	14
5. Education	15
5.1 School Readiness.....	15
5.2 Key Stage 4 attainment	15
5.3 Special Educational Needs	16
6. Lifestyles	17
6.1 Modelled adult smoking prevalence.....	17
6.2 Modelled adult obesity prevalence	17
6.3 Childhood obesity.....	18
6.3.1 Reception year	18
6.3.2 Year 6	19

7. Quality Outcomes Framework	20
7.1 Recorded prevalence	20
Ramsgate Locality and General Practices	21
7.1 Clinical achievement	24
Ramsgate Locality and General Practices	25
8. Mental Health	27
8.1 Contact rates (16-64 years)	27
8.2 Contact rates (65+)	27
9. Hospital Admissions	29
9.1.1 Under 18	29
9.1.2 Ages 18 to 64	30
9.1.3 Age 65 and above	32
9.2 Emergency admissions	33
9.2.1 Under 18	33
9.2.2 Ages 18 to 64	34
9.2.3 Ages 65 and above	35
9.3 Cancer	37
9.4 Acute myocardial infarction	38
9.5 Respiratory disease	39
9.6 Stroke	40
9.7 Diabetes	42
9.8 Falls (over 65)	43
9.9 Alcohol-specific	44
9.10 Drug-specific	46
9.11 Assaults	47
9.12 Deliberate self-harm and unintentional injury (under 18)	48
10. Mortality	50

10.1	Cancer (under 75).....	51
10.2	Circulatory (under 75)	52
10.3	Respiratory (under 75).....	53
11.	Life Expectancy.....	54
11.1	Male Life Expectancy	54
11.2	Female Life Expectancy	55

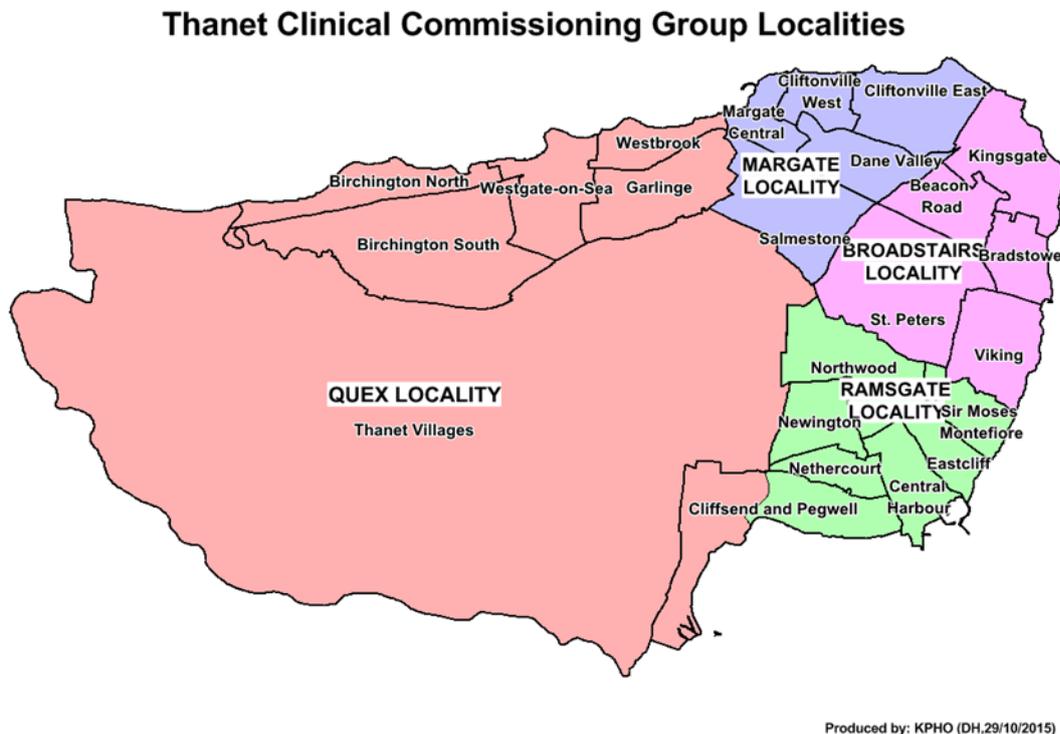
| 1. Introduction

This report outlines the key indicators of health for the Ramsgate locality in Thanet Clinical Commissioning Group (CCG) and will be used by Thanet CCG to form the update of their Operational Plan.

2. Demographics

2.1 Location

The map below shows Thanet CCG split into the four different localities (Quex, Margate, Broadstairs and Ramsgate) based on Thanet wards.



The Ramsgate locality consists of seven electoral wards in the south of Thanet CCG:

- Eastcliff
- Central Harbour
- Nethercourt
- Newington
- Northwood
- Sir Moses Montefiore
- Cliffsend and Pegwell¹

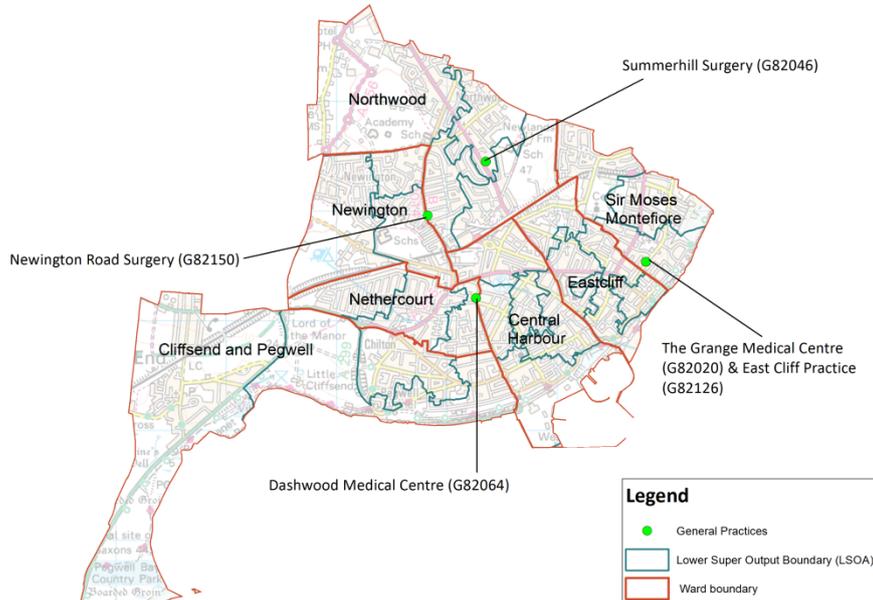
Cliffsend and Pegwell ward also borders the Quex locality. The ward has been split by the coverage of LSOAs contained with Ramsgate and Quex localities.

The map below shows the breakdown of the Ramsgate locality into wards and lower super output areas (LSOAs). An LSOA is a geographical region which has a minimum population of

¹ Cliffsend and Pegwell ward spans both the Quex and Ramsgate localities. It has been included in the analysis of both Quex and Ramsgate.

1,000 and an average population of 1,500. The Ramsgate locality has five general practices² located in Northwood, Sir Moses Montefiore, Eastcliff and Nethercourt wards.

General practice* locations in Ramsgate Locality



*Wickham Surgery in Ramsgate has now closed.

Source: PCIS, ArcGIS, prepared by: KPHO (LLY), 11/16

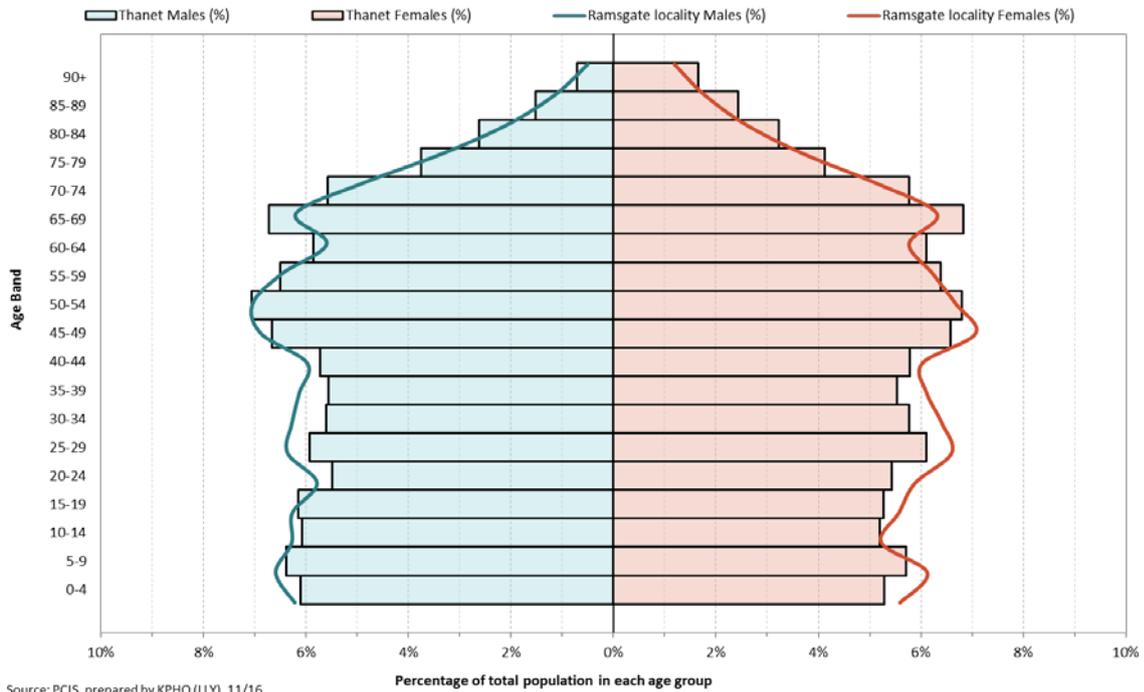
2.2 Population (registered)

As of 30.09.16, the chart overleaf shows the population of Ramsgate locality compared to Thanet CCG³. Approximately 51,700 persons are registered to the general practices within the Ramsgate locality. The locality has a slightly higher proportion of younger adults (aged 20-39) and very young children (aged 0-4) than Thanet CCG as a whole.

² This map features only live (open) general practices in Ramsgate locality.

³ The registered population includes population for Wickham Surgery as this surgery was open as of 30.09.2016.

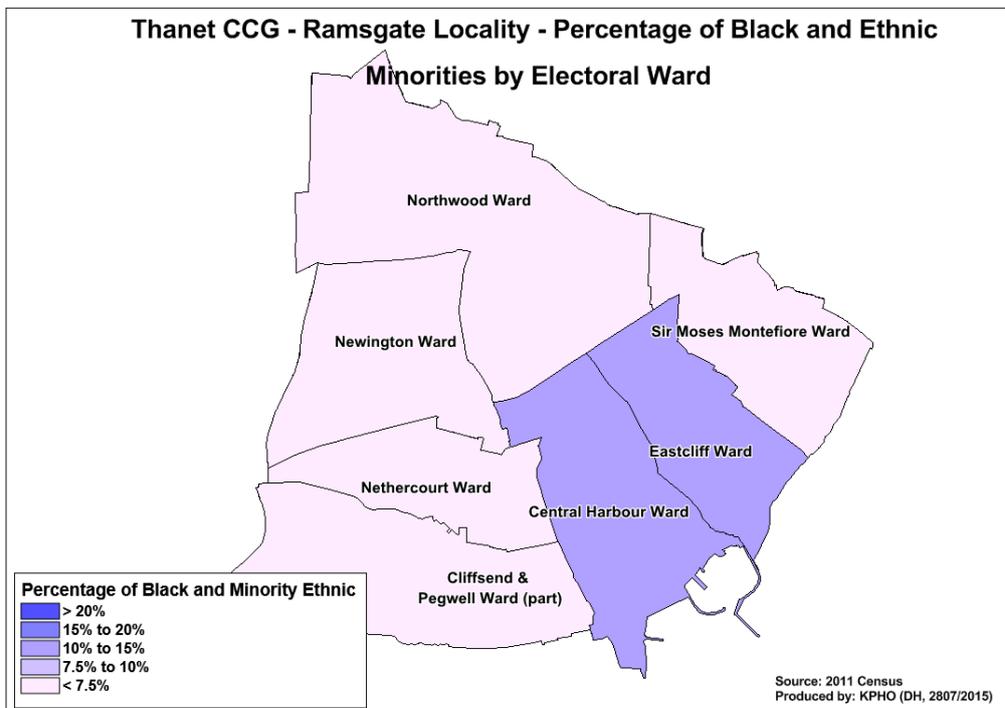
September 2016 registered population in Thanet compared to Ramsgate locality



Source: PCIS, prepared by KPHO (LLY), 11/16

2.3 Ethnicity

The map below shows the black and minority ethnic (BME⁴) population of wards within the Ramsgate locality. Five of the seven wards have a BME population of less than 10%, rising to a maximum of 15% in Central Harbour and Eastcliff.



Source: 2011 Census
Produced by: KPHO (DH, 2807/2015)

⁴ BME population refers to all ethnicities except White British.

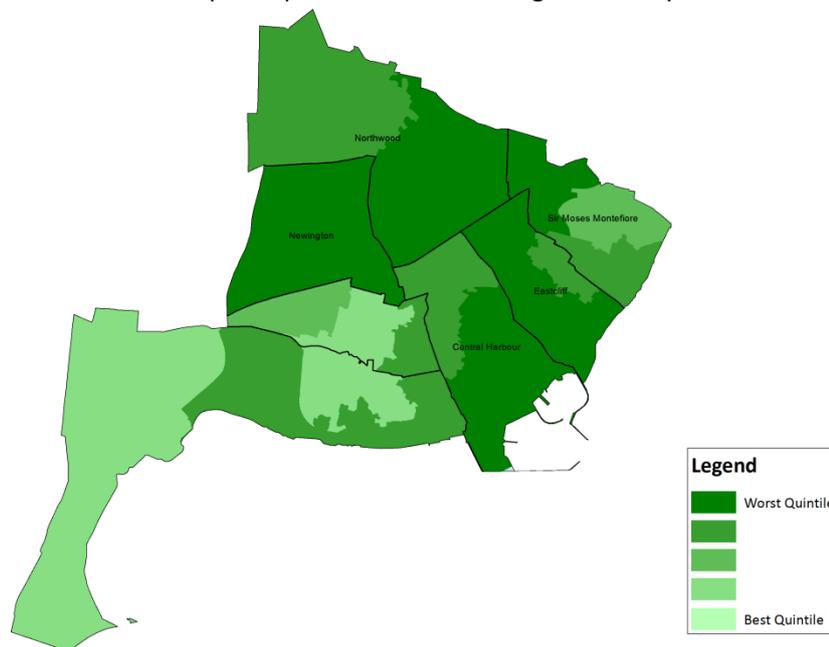
3. Socio-Economic

3.1 Deprivation

The local authority of Thanet has some of the most deprived areas in the country within its boundaries. The electoral wards of Margate Central and Cliftonville West are among the 10% most deprived wards in England and Wales. Areas of high deprivation have long been associated with poorer population health outcomes.

The map below shows the relative deprivation in the Ramsgate locality. Five out of the seven wards have LSOAs which are in the most deprived quintile in Kent. The Ramsgate locality has 9 of the 88 most deprived LSOAs in Kent⁵.

Indices of Multiple Deprivation 2015: Ramsgate Locality

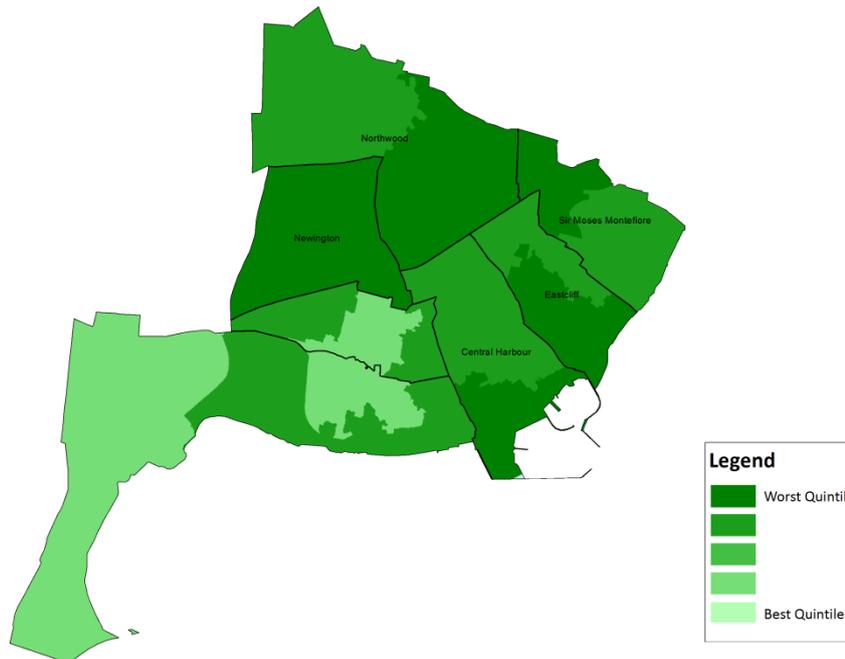


Source: Department for Communities and Local Government, prepared by: KPHO (LLY), 11/16

The map below shows child poverty measured by the income deprivation affecting children index and shows a broadly similar pattern to overall deprivation.

⁵ <http://www.kpho.org.uk/health-intelligence/inequalities/deprivation/mind-the-gap-analytical-report>

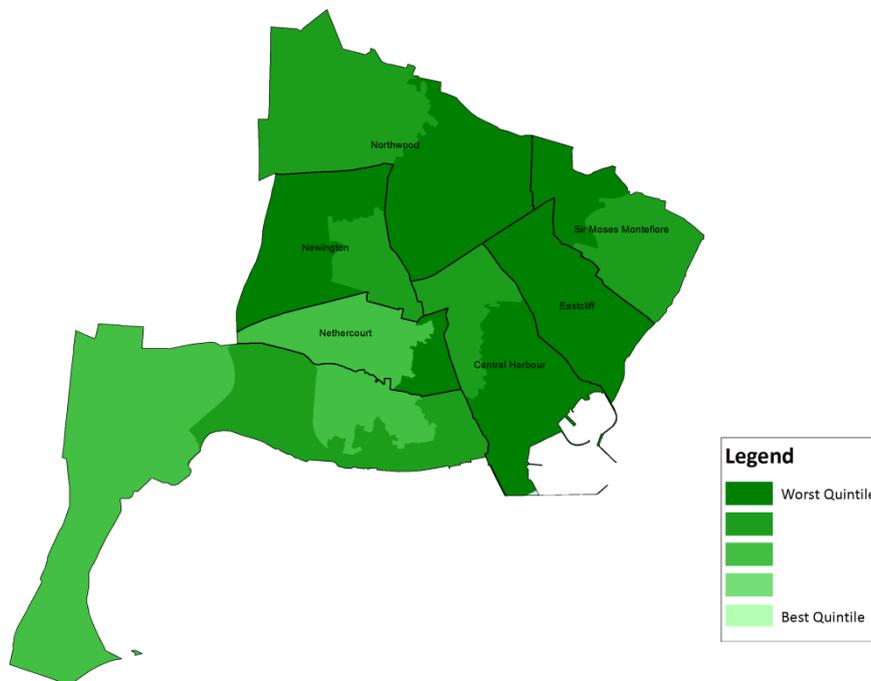
Income Deprivation Affecting Children Index 2015: Ramsgate Locality



Source: Department for Communities and Local Government, prepared by: KPHO (LLY), 11/16

The last map in this section shows the income deprivation affecting older people index. This too has a similar profile to the overall deprivation however now all of the LSOAs in Eastcliff are in the most deprived quintile in Kent. Nethercourt ward now also has a LSOA within the most deprived quintile.

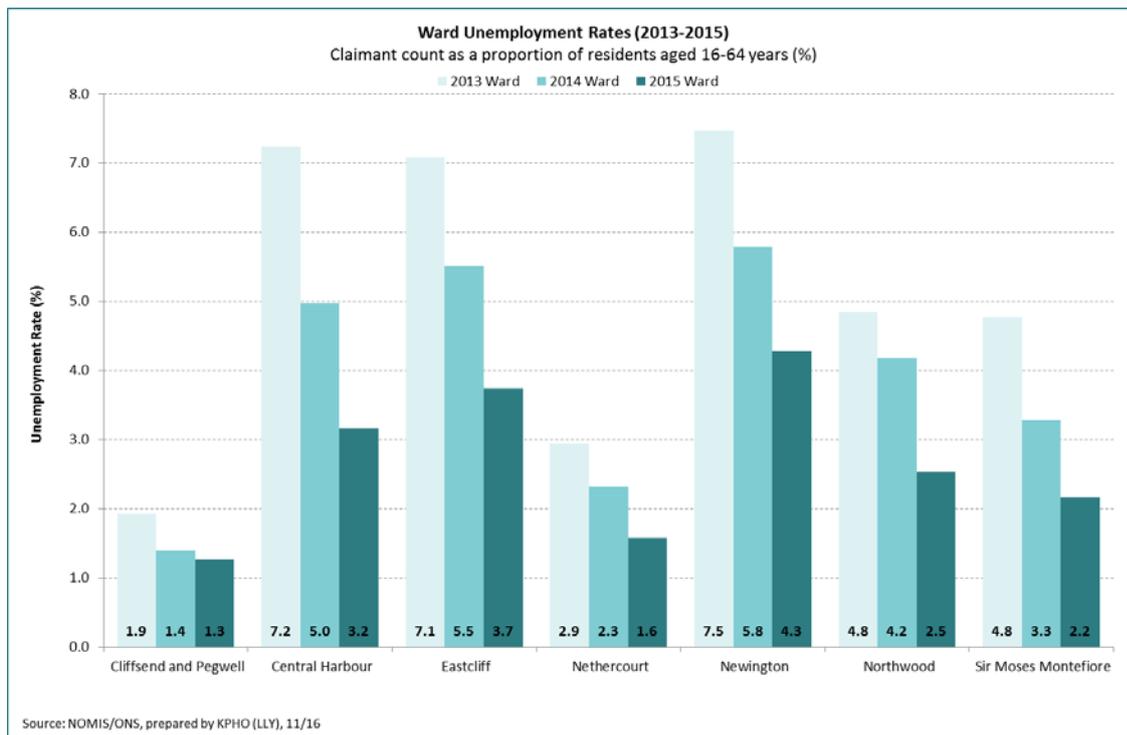
Income Deprivation Affecting Older People Index 2015: Ramsgate Locality



Source: Department for Communities and Local Government, prepared by: KPHO (LLY), 11/16

3.2 Unemployment

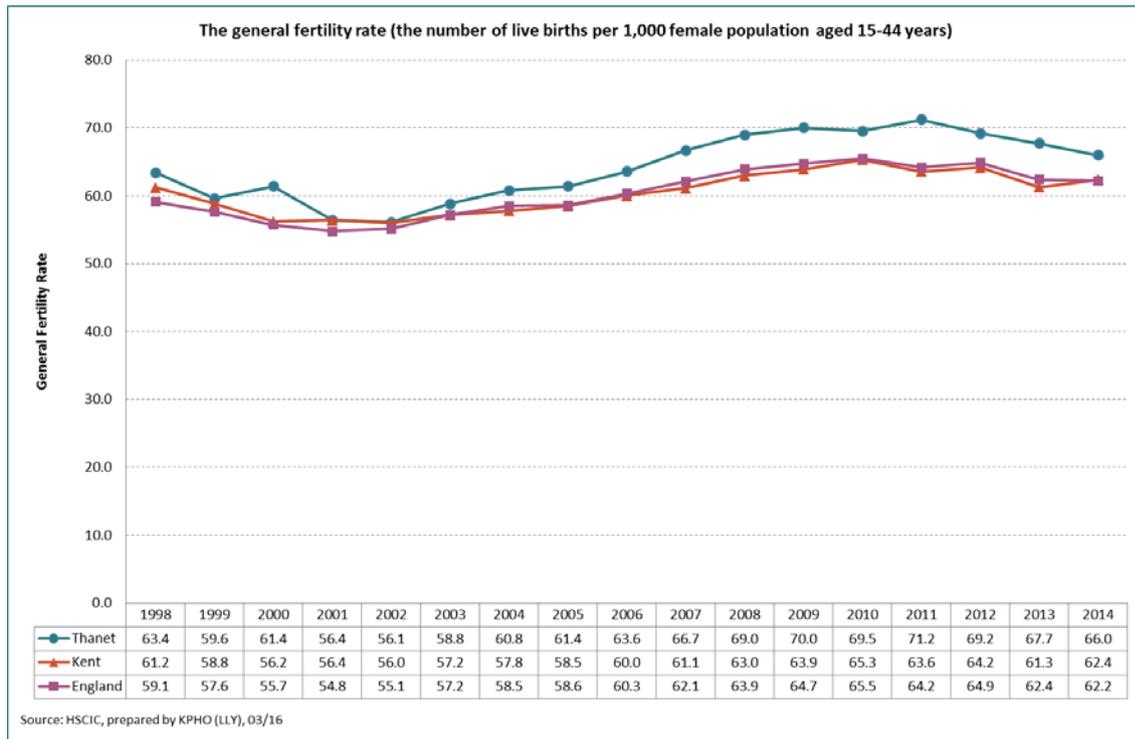
Presented at ward level within the Ramsgate locality, unemployment rates are given as a proportion (%) of residents aged 16-64 years. All wards show a decrease in unemployment rates between 2013 and 2015. The lowest recorded unemployment rate (1.3%) was in Cliffsend and Pegwell in 2015. Of the wards within the Ramsgate locality Central Harbour, Eastcliff and Newington have the highest unemployment rates.



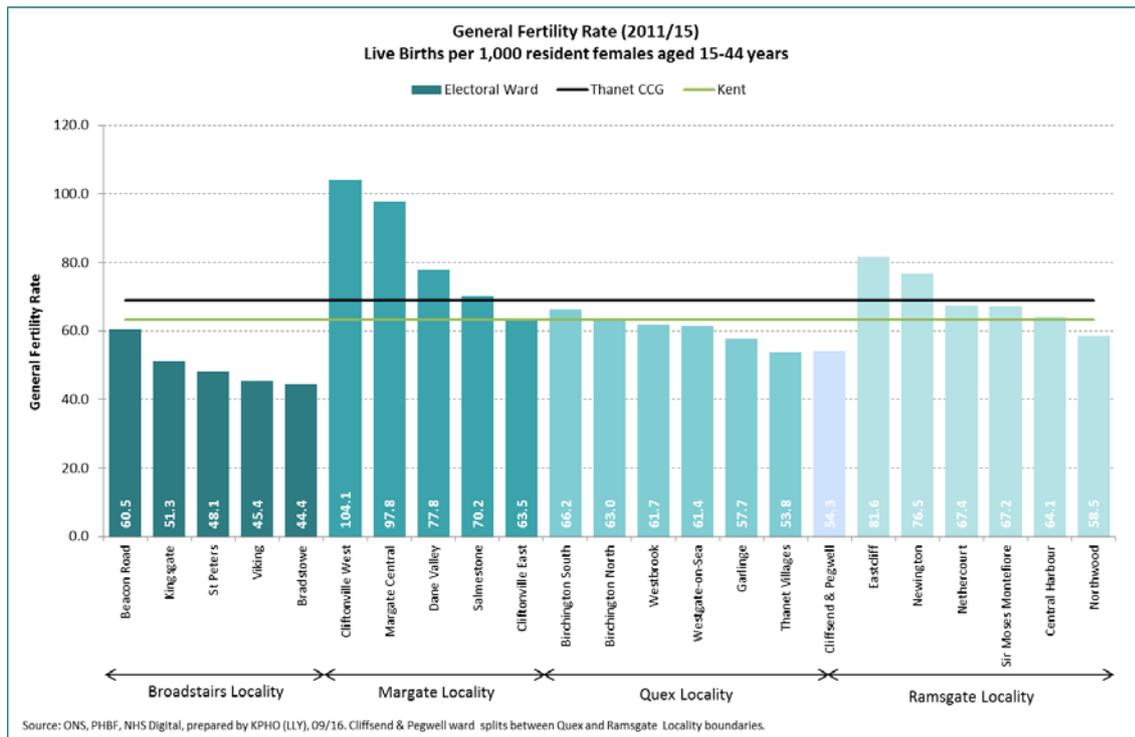
4. Maternity

4.1 General fertility rate

The general fertility rate (GFR) is the number of live births per 1,000 women aged 15-44 years. In Thanet the fertility rate rose steadily between 2000 and 2011, but has begun to fall over recent years; a trend that is also seen across Kent and nationally. Rates rose to over 70, per 1,000 women aged 15-44 in 2011 before decreasing in recent years. The fertility rate for Thanet however has remained consistently higher than Kent and England.



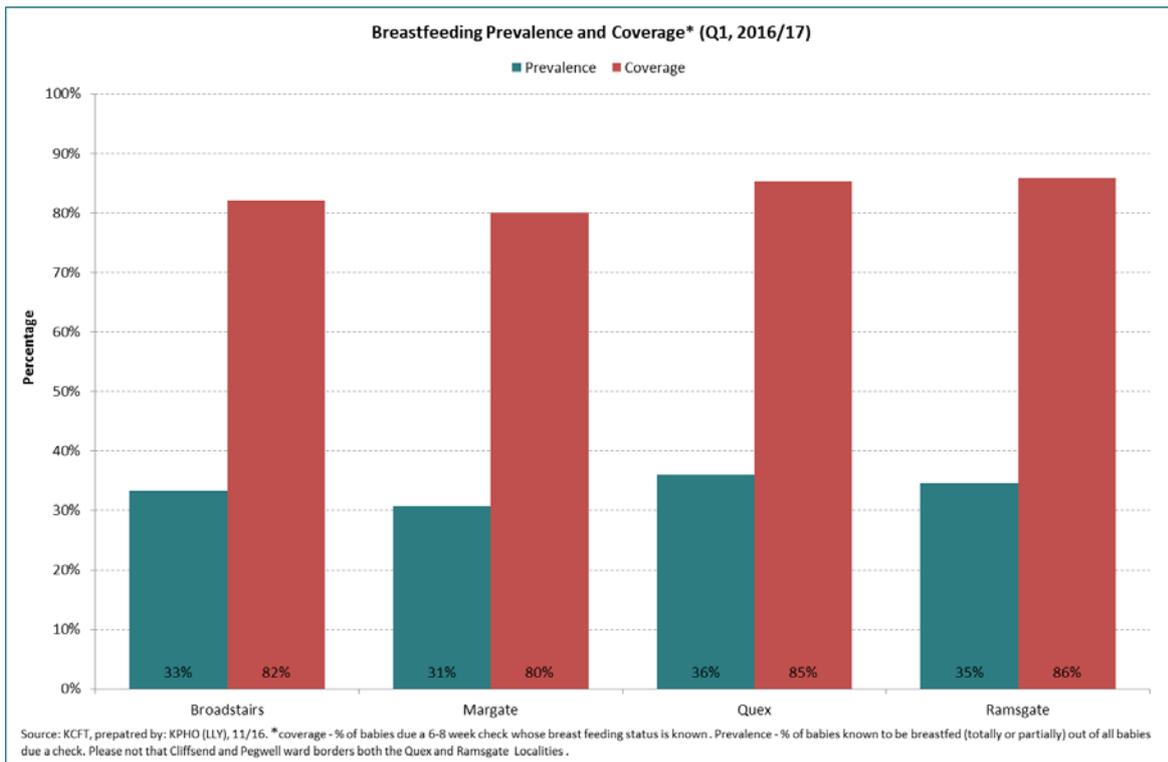
Shown at ward level, the fertility rates for the Ramsgate locality are above both the Kent and Thanet rates (of 69.0 and 63.2, per 1,000 women aged 15-44 years respectively) in Eastcliff and Newington.



4.2 Breastfeeding

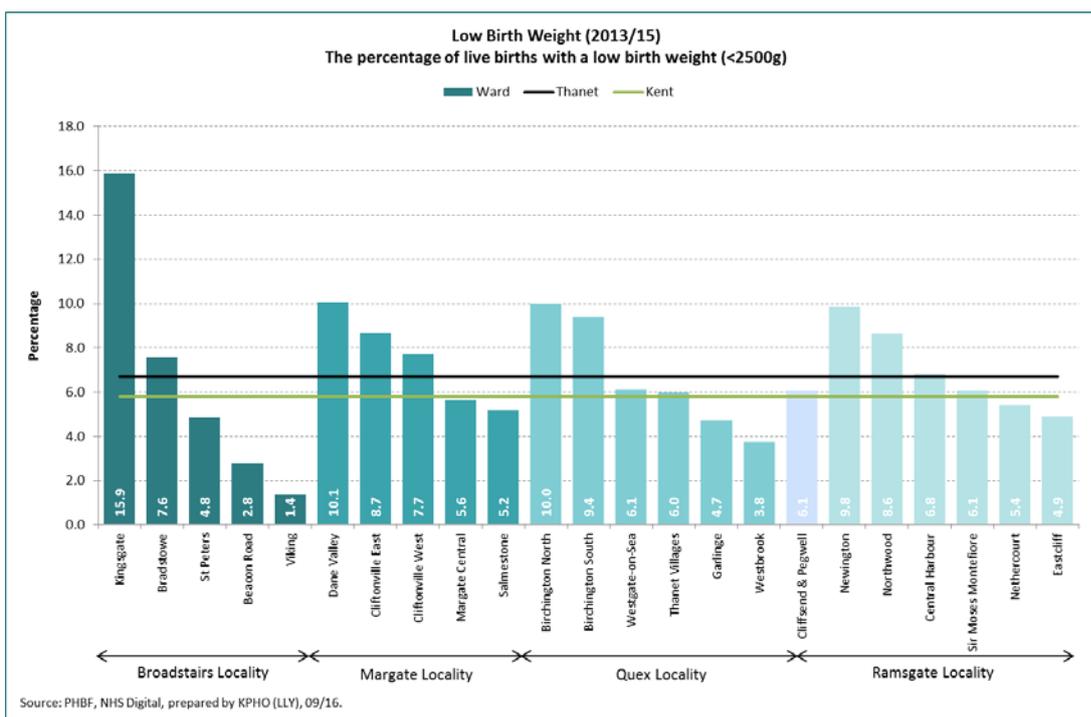
One important public health area, with regard to maternity and related child health is breast-feeding continuation. The following chart shows both the coverage of breast feeding status as well as the prevalence.

Breastfeeding continuation status is recorded at the 6-8 week check. The prevalence of breastfeeding is similarly low across the four Thanet localities, at around 1 in 3.



4.3 Low birth weight

Low birth weight (LBW) shows the percentage of babies with a birth weight of less than 2500 grams. The low birth weight indicator is a good predictor of future childhood health. The low birth weight indicator is a good predictor of future childhood health. Newington and Northwood appear to have high rates of low birth weights, but these values are not statistically significantly different to the Thanet or Kent averages (of 6.7% and 5.8%).

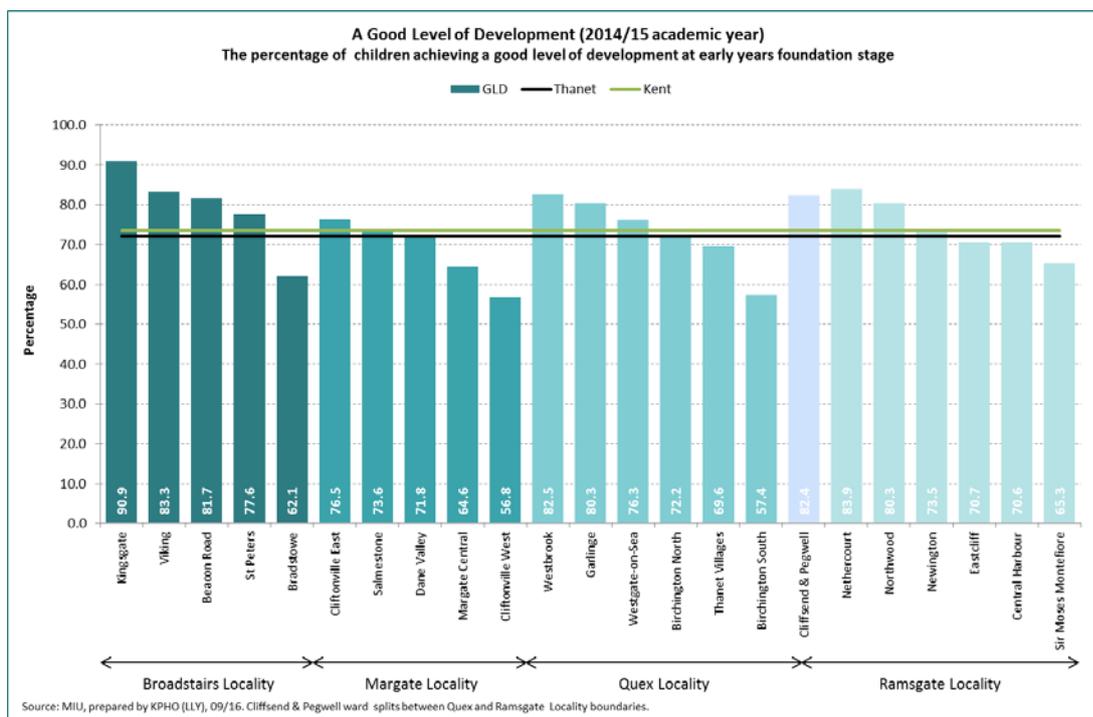


5. Education

Education has long been identified as one of the wider determinants of health; poor educational outcomes often lead to poor health outcomes.

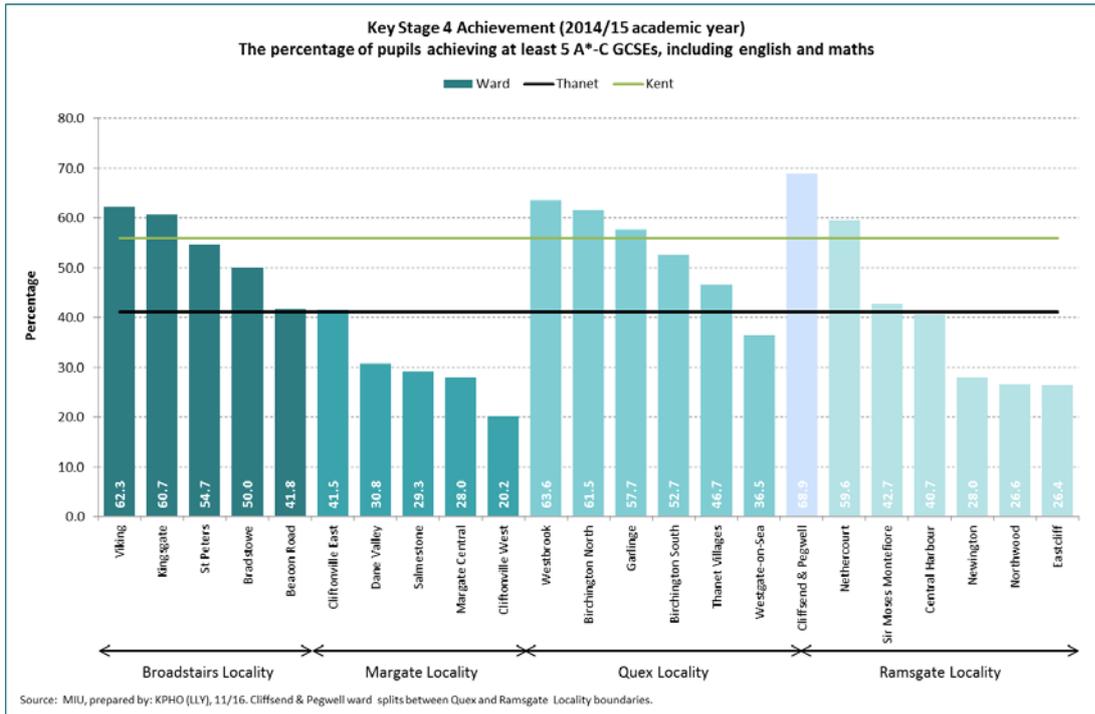
5.1 School Readiness

School readiness can be measured using the proportion of children who achieve a good level of development at the early years foundation stage (reception year). Attainment varies from 83.9 in Nethercourt to 65.3 in Sir Moses Montefiore.



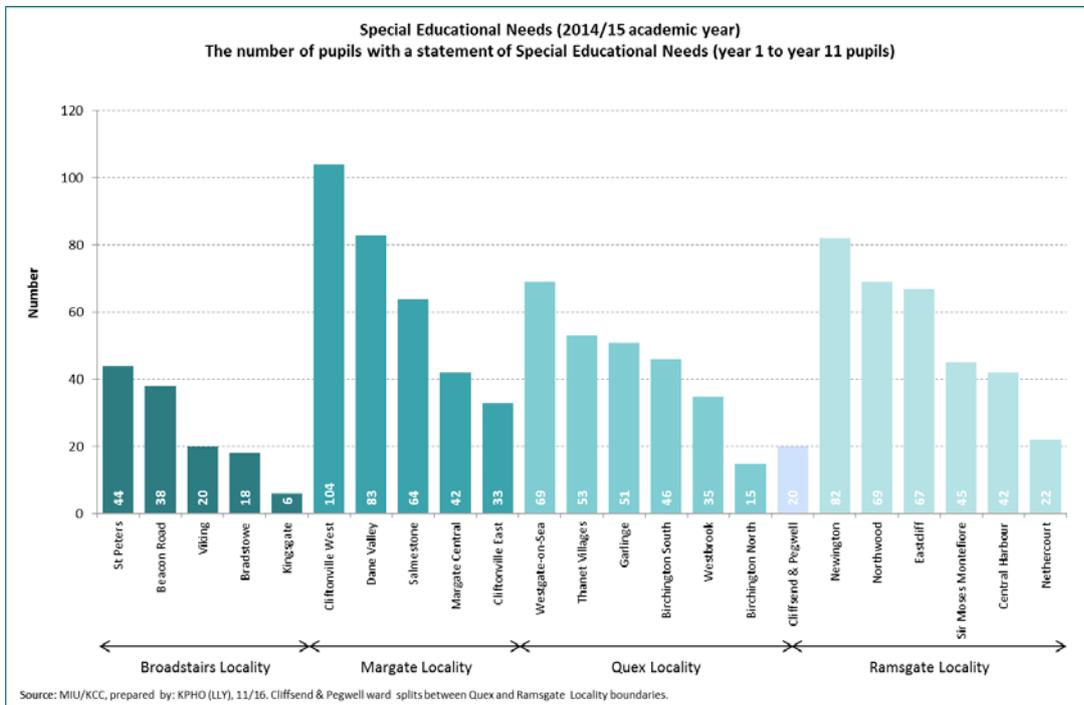
5.2 Key Stage 4 attainment

Attainment at Key Stage 4 is measured as the proportion of pupils who achieve A*-C grades, including in English and Maths, and varies considerably across the Ramsgate locality. Whilst Newington, Northwood and Eastcliff all have lower attainment rates than both the Kent and Thanet averages, attainment is better than the Thanet average in Cliffsend & Pegwell and in Nethercourt.



5.3 Special Educational Needs

The chart below shows the numbers of pupils within each ward with a statement of special educational needs. Within the Ramsgate locality, SEN pupil numbers range from 82 pupils in Newington to 20 pupils in Cliffsend and Pegwell, and 22 pupils in Nethercourt.



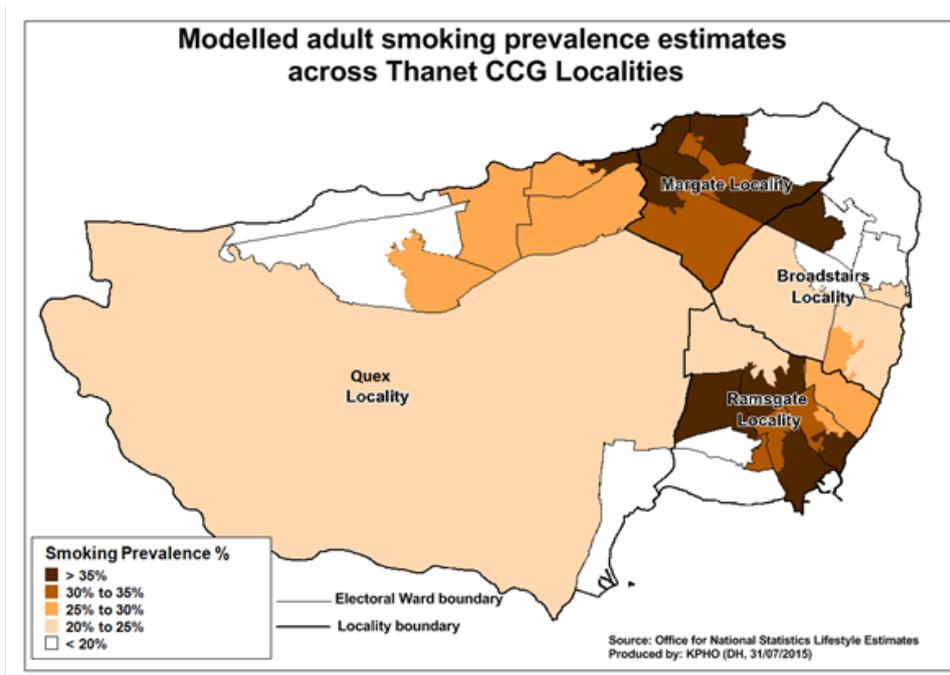
6. Lifestyles

The measurement of lifestyle factors is very difficult, since we do not routinely weigh and measure adults for obesity prevalence, and we do not regularly check on everyone's smoking status for population smoking prevalence. Estimates of population prevalence for these lifestyle factors are modelled from national surveys such as The Health Survey for England.

The following maps show modelled adult smoking and obesity prevalence estimates applied locally at a Mid Super Output Area (MSOA) level with electoral wards overlaid for all of Thanet.

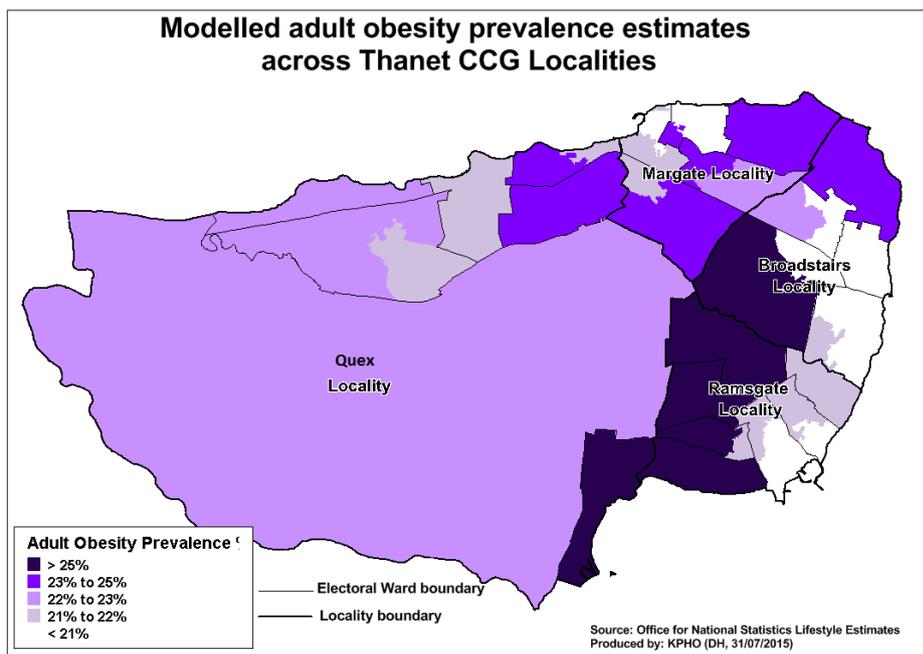
6.1 Modelled adult smoking prevalence

Modelled smoking prevalence is highest in parts of Eastcliff, Central Harbour, Northwood and Newington, where smoking prevalence is estimated to be over 35%. Modelled smoking prevalence in Nethercourt and Cliffsend & Pegwell however are amongst the lowest in Thanet (estimated to be lower than 20%).



6.2 Modelled adult obesity prevalence

Modelled adult obesity prevalence appears to be higher in the western part of the Ramsgate locality where it is estimated that more than 1 in 4 adults are obese.

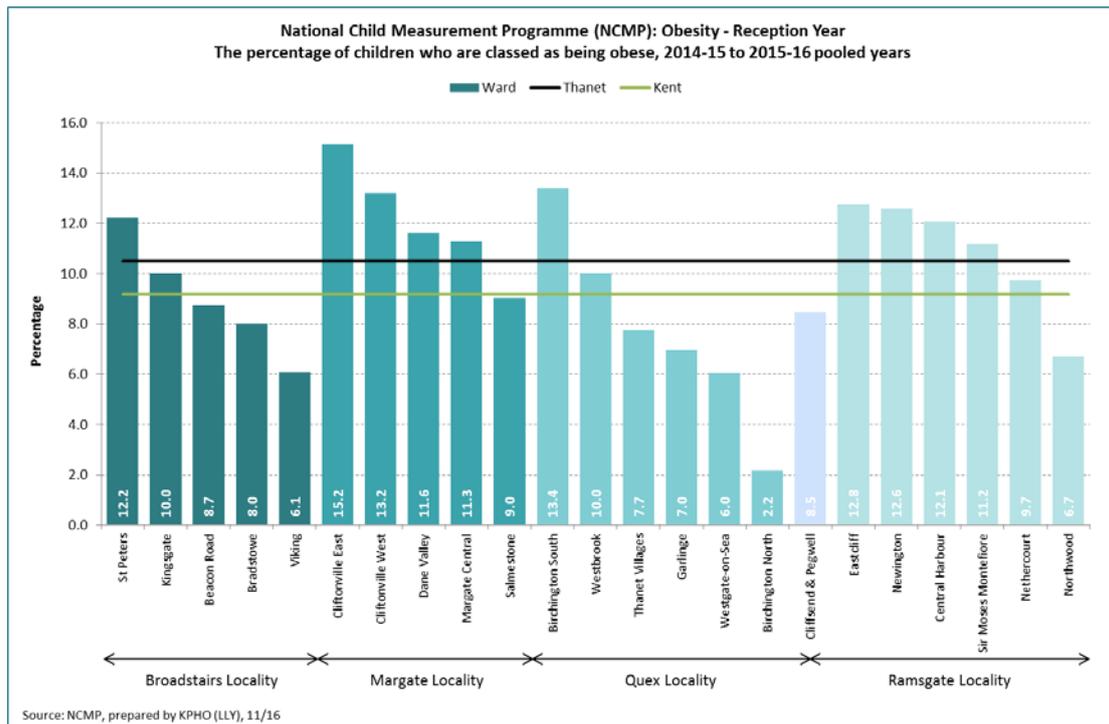


6.3 Childhood obesity

The National Child Measurement Programme measures the height and weight of each child in reception year and year 6. This analysis considers the proportion of children classified as being obese.

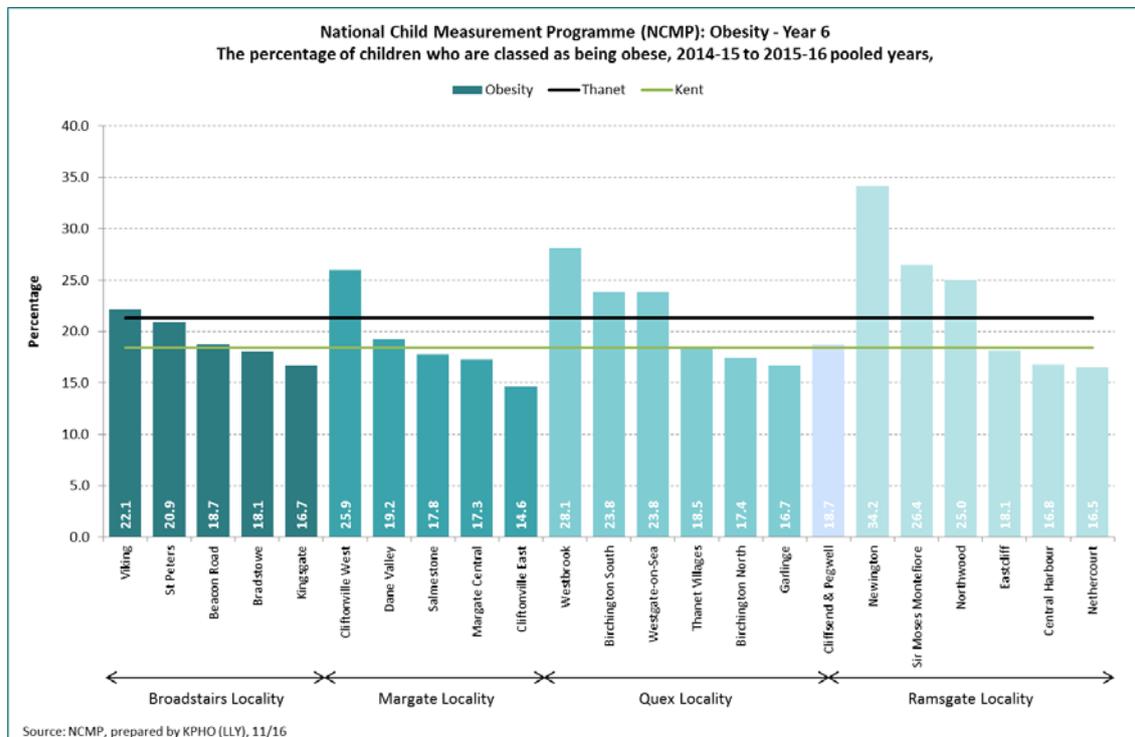
6.3.1 Reception year

Within the Ramsgate locality, reception year obesity rates range from 6.7% in Northwood to 12.8% in Eastcliff. There are no statistically significant differences between the wards in the Ramsgate locality, or compared within the Thanet and Kent averages.



6.3.2 Year 6

Obesity levels are higher in year 6 compared to reception year. Levels of obesity amongst year 6 pupils in Newington are significantly higher than the Kent average.



| 7. Quality Outcomes Framework

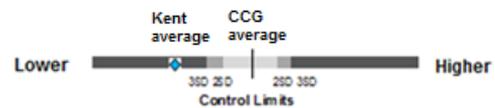
7.1 Recorded prevalence

The prevalence of Quality & Outcome Framework recorded long term conditions has been explored and spine charts have been produced for each general practice.

- Each spine chart presents the general practice and Kent estimate for 2015/16. Statistical significance has been presented in comparison to Thanet CCG.
- The horizontal line represents the Thanet CCG average and the shaded bars represent the distribution of general practice, long term condition recorded prevalence, within Thanet CCG. If the data are normally distributed there should be equal amounts of the shaded bars on each side of the CCG average.
- Trend analysis explores the general practice rate of change in long term condition recorded prevalence; recent trend analysis explores the two latest years 2014/15 and 2015/16, as well as, long term trend analysis explores 2006/07 to 2015/16.

Key:

●	Significantly much lower than CCG	↓	Decreasing
○	Significantly lower than CCG		
●	Not significantly different from CCG	↔	Stable
○	Significantly higher than CCG		
●	Significantly much higher than CCG	↑	Increasing
○	No significance can be calculated		



Ramsgate Locality and General Practices

Overall the key findings for the Ramsgate locality:

- Lower recorded prevalence of dementia can be observed across the locality, largely driven by practices G82150 and G82064.
- For the locality, the remainder of the long term conditions were similar to the average recorded prevalence for the CCG. However, higher recorded prevalence can be observed for practice G82046 for asthma, cancer, chronic kidney disease, chronic obstructive pulmonary disease and hypertension.
 - Of the long term conditions, hypertension represents the highest numbers across the locality. An increasing hypertension trend of 0.23% with each passing year was observed for the locality, higher than the 0.07% increase for Thanet CCG.
 - Based on past trends, total Kent and locality hypertension patient registers could be projected to grow by 382 and 20 persons respectively with each passing year.

Ramsgate locality, Quality & Outcomes Framework: recorded prevalence

Indicator	Locality prevalence		Trend		CCG prevalence			
	Number	%	Recent	Long	Average	Low	Range	High
Asthma	2975	6.0	↔	↑	5.8	4.6		7.5
Atrial fibrillation	998	2.0	↔	↑	2.2	0.9		3.9
Cancer	1422	2.9	↔	↑	3.0	1.4		5.0
Chronic Kidney Disease	2478	6.4	↔	↑	6.3	2.2		9.7
Chronic Obstructive Pulmonary Disease	1577	3.2	↔	↑	3.1	1.7		4.8
Coronary Heart Disease	1757	3.5	↔	↔	3.7	1.8		5.7
Dementia	359	0.7	↔	↑	0.9	0.3		1.7
Diabetes	2822	7.1	↔	↑	7.5	5.5		9.0
Epilepsy	379	1.0	↔	↔	0.9	0.5		1.2
Heart Failure	379	0.8	↔	↔	0.9	0.3		1.4
Hypertension	8340	16.7	↔	↑	16.9	8.6		23.2
Learning Disabilities	293	0.6	↔	↔	0.6	0.2		1.1
Mental Health	503	1.0	↔	↑	1.1	0.6		1.6
Obesity	3906	10.0	↑	↔	10.2	5.5		14.9
Palliative Care	117	0.2	↔	↑	0.3	0.0		0.8
Stroke	951	1.9	↔	↑	2.1	1.1		3.2

The Quality Outcomes Framework for the Locality has been based on data from the five general practices listed below.

Practice G82046, Quality & Outcomes Framework: recorded prevalence

Indicator	Practice prevalence		Trend		CCG prevalence				
	Number	%	Recent	Long	Average	Low	Range	High	
Asthma	460	7.4	↔	↑	5.8	4.6		7.5	
Atrial fibrillation	146	2.4	↔	↑	2.2	0.9		3.9	
Cancer	248	4.0	↔	↑	3.0	1.4		5.0	
Chronic Kidney Disease	416	8.5	↔	↑	6.3	2.2		9.7	
Chronic Obstructive Pulmonary Disease	298	4.8	↔	↑	3.1	1.7		4.8	
Coronary Heart Disease	257	4.1	↔	↑	3.7	1.8		5.7	
Dementia	45	0.7	↔	↑	0.9	0.3		1.7	
Diabetes	411	8.3	↔	↑	7.5	5.5		9.0	
Epilepsy	51	1.0	↔	↑	0.9	0.5		1.2	
Heart Failure	62	1.0	↔	↔	0.9	0.3		1.4	
Hypertension	1267	20.4	↔	↑	16.9	8.6		23.2	
Learning Disabilities	44	0.7	↔	↑	0.6	0.2		1.1	
Mental Health	73	1.2	↔	↑	1.1	0.6		1.6	
Obesity	270	5.5	↓	↓	10.2	5.5		14.9	
Palliative Care	20	0.3	↔	↑	0.3	0.0		0.8	
Stroke	128	2.1	↔	↔	2.1	1.1		3.2	

Practice G82020, Quality & Outcomes Framework: recorded prevalence

Indicator	Practice prevalence		Trend		CCG prevalence				
	Number	%	Recent	Long	Average	Low	Range	High	
Asthma	643	5.4	↓	↔	5.8	4.6		7.5	
Atrial fibrillation	282	2.4	↔	↑	2.2	0.9		3.9	
Cancer	341	2.9	↔	↑	3.0	1.4		5.0	
Chronic Kidney Disease	428	4.6	↔	↑	6.3	2.2		9.7	
Chronic Obstructive Pulmonary Disease	365	3.1	↔	↑	3.1	1.7		4.8	
Coronary Heart Disease	488	4.1	↔	↑	3.7	1.8		5.7	
Dementia	89	0.8	↔	↑	0.9	0.3		1.7	
Diabetes	677	7.1	↔	↑	7.5	5.5		9.0	
Epilepsy	108	1.2	↔	↔	0.9	0.5		1.2	
Heart Failure	109	0.9	↔	↔	0.9	0.3		1.4	
Hypertension	1966	16.5	↔	↑	16.9	8.6		23.2	
Learning Disabilities	45	0.4	↔	↔	0.6	0.2		1.1	
Mental Health	129	1.1	↔	↑	1.1	0.6		1.6	
Obesity	986	10.5	↑	↑	10.2	5.5		14.9	
Palliative Care	39	0.3	↔	↑	0.3	0.0		0.8	
Stroke	247	2.1	↔	↔	2.1	1.1		3.2	

Practice G82064, Quality & Outcomes Framework: recorded prevalence

Indicator	Practice prevalence		Trend		CCG prevalence				
	Number	%	Recent	Long	Average	Low	Range	High	
Asthma	476	5.4	↔	↔	5.8	4.6		7.5	
Atrial fibrillation	151	1.7	↔	↔	2.2	0.9		3.9	
Cancer	262	3.0	↔	↑	3.0	1.4		5.0	
Chronic Kidney Disease	396	5.8	↔	↑	6.3	2.2		9.7	
Chronic Obstructive Pulmonary Disease	237	2.7	↔	↑	3.1	1.7		4.8	
Coronary Heart Disease	262	3.0	↔	↓	3.7	1.8		5.7	
Dementia	41	0.5	↔	↔	0.9	0.3		1.7	
Diabetes	414	6.0	↔	↑	7.5	5.5		9.0	
Epilepsy	70	1.0	↔	↔	0.9	0.5		1.2	
Heart Failure	64	0.7	↔	↔	0.9	0.3		1.4	
Hypertension	1410	15.9	↔	↑	16.9	8.6		23.2	
Learning Disabilities	61	0.7	↔	↔	0.6	0.2		1.1	
Mental Health	101	1.1	↔	↔	1.1	0.6		1.6	
Obesity	830	12.2	↑	↔	10.2	5.5		14.9	
Palliative Care	16	0.2	↔	↔	0.3	0.0		0.8	
Stroke	156	1.8	↔	↔	2.1	1.1		3.2	

Practice G82126, Quality & Outcomes Framework: recorded prevalence

Indicator	Practice prevalence		Trend		CCG prevalence				
	Number	%	Recent	Long	Average	Low	Range	High	
Asthma	955	6.3	↔	↓	5.8	4.6		7.5	
Atrial fibrillation	312	2.1	↔	↑	2.2	0.9		3.9	
Cancer	434	2.9	↔	↑	3.0	1.4		5.0	
Chronic Kidney Disease	794	6.6	↔	↑	6.3	2.2		9.7	
Chronic Obstructive Pulmonary Disease	395	2.6	↔	↑	3.1	1.7		4.8	
Coronary Heart Disease	541	3.6	↔	↓	3.7	1.8		5.7	
Dementia	131	0.9	↔	↑	0.9	0.3		1.7	
Diabetes	854	7.0	↔	↑	7.5	5.5		9.0	
Epilepsy	100	0.8	↔	↔	0.9	0.5		1.2	
Heart Failure	85	0.6	↔	↔	0.9	0.3		1.4	
Hypertension	2451	16.3	↔	↔	16.9	8.6		23.2	
Learning Disabilities	124	0.8	↔	↔	0.6	0.2		1.1	
Mental Health	140	0.9	↔	↑	1.1	0.6		1.6	
Obesity	1171	9.7	↑	↔	10.2	5.5		14.9	
Palliative Care	29	0.2	↔	↑	0.3	0.0		0.8	
Stroke	315	2.1	↔	↔	2.1	1.1		3.2	

Practice G82150, Quality & Outcomes Framework: recorded prevalence

Indicator	Practice prevalence		Trend		CCG prevalence				
	Number	%	Recent	Long	Average	Low	Range	High	
Asthma	441	5.7	↔	↔	5.8	4.6		7.5	
Atrial fibrillation	107	1.4	↔	↑	2.2	0.9		3.9	
Cancer	137	1.8	↔	↑	3.0	1.4		5.0	
Chronic Kidney Disease	444	7.5	↔	↑	6.3	2.2		9.7	
Chronic Obstructive Pulmonary Disease	282	3.6	↔	↑	3.1	1.7		4.8	
Coronary Heart Disease	209	2.7	↔	↓	3.7	1.8		5.7	
Dementia	53	0.7	↔	↑	0.9	0.3		1.7	
Diabetes	466	7.7	↔	↑	7.5	5.5		9.0	
Epilepsy	50	0.8	↔	↔	0.9	0.5		1.2	
Heart Failure	59	0.8	↔	↔	0.9	0.3		1.4	
Hypertension	1246	16.0	↔	↑	16.9	8.6		23.2	
Learning Disabilities	19	0.2	↔	↓	0.6	0.2		1.1	
Mental Health	60	0.8	↔	↔	1.1	0.6		1.6	
Obesity	649	10.9	↔	↔	10.2	5.5		14.9	
Palliative Care	13	0.2	↔	↔	0.3	0.0		0.8	
Stroke	105	1.4	↔	↑	2.1	1.1		3.2	

Source: QOF, produced by KPHO (ZC), December 2016.

7.1 Clinical achievement

The prevalence of Quality & Outcome Framework clinical achievement has been explored and spine charts have been produced for each general practice.

- Each spine chart presents the general practice and Kent estimate for 2015/16. Statistical significance has been presented in comparison to Thanet CCG.
- The horizontal line represents the Thanet CCG average and the shaded bars represent the distribution of general practice, long term condition clinical achievement, within Thanet CCG. If the data are normally distributed there should be equal amounts of the shaded bars on each side of the CCG average.
- Trend analysis explores the general practice rate of change in long term condition clinical achievement; recent trend analysis explores the two latest years 2014/15 and 2015/16.
- The exception rate per 100 has also been presented.



The following clinical indicators, representing the percentage of patients, have been included:

- Patients with asthma (diagnosed on or after 1 April 2006) aged 8 or over, with **measures of variability or reversibility** recorded between 3 months before or any time after diagnosis.
- Patients with asthma, who have had an **asthma review** in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions.
- Patients with cancer, diagnosed within the preceding 15 months, who have a **patient review** recorded as occurring within 6 months of the date of diagnosis.
- Patients with coronary heart disease in whom the last **blood pressure reading** (measured in the preceding 12 months) is **150/90 mmHg or less**.
- Patients with COPD with a **record of FEV1** in the preceding 12 months.
- Patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months.
- Patients with hypertension in whom the last **blood pressure reading** (measured in the preceding 12 months) is **150/90 mmHg or less**.
- Patients with diabetes, in whom the last IFCC-HbA1c is **59 mmol/mol or less** in the preceding 12 months.

Ramsgate Locality and General Practices

Overall the key findings for the Ramsgate locality:

- Generally average achievement for the majority of clinical indicators, as well as, slightly lower clinical achievement for blood pressure management in hypertension.
- The majority of practices similarly showed average clinical achievement for the majority of clinical indicators except for the following; practice G82046 long term diabetes control, practice G82020 and G82064 blood pressure control in hypertension, as well as, practice G82126 measures of variability or reversibility in asthma.

Ramsgate locality, Quality & Outcomes Framework: clinical achievement

Indicator	Locality achievement		Recent trend	Exception rate per 100	CCG achievement			
	Number	%			Average	Low	Range	High
Variability/ reversibility measures, asthma	629	87.6	↔	4.9	87.4	76.5		96.0
Review, asthma	1936	72.2	↔	9.8	72.6	42.3		97.7
Review, cancer	177	92.7	↔	17.7	90.2	35.3		100.0
Blood pressure 150/90mmHg or less, CHD	1561	92.8	↔	4.2	92.0	77.0		97.0
Record of FEV1, COPD	1184	85.2	↔	11.9	84.4	59.1		95.2
Review, dementia	280	82.6	↔	5.6	80.5	10.7		100.0
HbA1c 59mmol/mol or less, diabetes	1683	70.4	↔	15.3	72.0	53.1		85.1
Blood pressure <= 150/90mmHg, hypertension	6407	79.9	↔	3.9	80.9	65.6		93.4

The Quality Outcomes Framework for the Locality has been based on data from the five general practices listed below.

Practice G82046, Quality & Outcomes Framework: clinical achievement

Indicator	Practice achievement		Recent trend	Exception rate per 100	CCG achievement			
	Number	%			Average	Low	Range	High
Variability/ reversibility measures, asthma	117	83.6	↔	6.0	87.4	76.5		96.0
Review, asthma	285	73.6	↔	15.9	72.6	42.3		97.7
Review, cancer	32	91.4	↔	27.1	90.2	35.3		100.0
Blood pressure 150/90mmHg or less, CHD	229	93.9	↔	5.1	92.0	77.0		97.0
Record of FEV1, COPD	233	85.0	↓	8.1	84.4	59.1		95.2
Review, dementia	36	81.8	↔	2.2	80.5	10.7		100.0
HbA1c 59mmol/mol or less, diabetes	243	63.3	↔	6.6	72.0	53.1		85.1
Blood pressure <= 150/90mmHg, hypertension	986	80.0	↔	2.8	80.9	65.6		93.4

Practice G82020, Quality & Outcomes Framework: clinical achievement

Indicator	Practice achievement		Recent trend	Exception rate per 100	CCG achievement			
	Number	%			Average	Low	Range	High
Variability/ reversibility measures, asthma	149	94.9	↑	9.2	87.4	76.5		96.0
Review, asthma	361	72.1	↔	22.1	72.6	42.3		97.7
Review, cancer	42	91.3	↔	16.4	90.2	35.3		100.0
Blood pressure 150/90mmHg or less, CHD	427	92.8	↑	5.7	92.0	77.0		97.0
Record of FEV1, COPD	230	83.0	↑	24.1	84.4	59.1		95.2
Review, dementia	66	77.7	↔	4.5	80.5	10.7		100.0
HbA1c 59mmol/mol or less, diabetes	421	70.5	↔	11.8	72.0	53.1		85.1
Blood pressure <= 150/90mmHg, hypertension	1428	76.6	↔	5.1	80.9	65.6		93.4

Practice G82064, Quality & Outcomes Framework: clinical achievement

Indicator	Practice achievement		Recent trend	Exception rate per 100	CCG achievement			
	Number	%			Average	Low	Range	High
Variability/ reversibility measures, asthma	97	86.6	↔	3.4	87.4	76.5		96.0
Review, asthma	303	72.7	↔	12.4	72.6	42.3		97.7
Review, cancer	24	88.9	↔	25.0	90.2	35.3		100.0
Blood pressure 150/90mmHg or less, CHD	240	93.4	↔	1.9	92.0	77.0		97.0
Record of FEV1, COPD	194	91.9	↑	11.0	84.4	59.1		95.2
Review, dementia	27	75.0	↔	12.2	80.5	10.7		100.0
HbA1c 59mmol/mol or less, diabetes	245	67.7	↑	12.6	72.0	53.1		85.1
Blood pressure <= 150/90mmHg, hypertension	1040	75.4	↔	2.2	80.9	65.6		93.4

Practice G82126, Quality & Outcomes Framework: clinical achievement

Indicator	Practice achievement		Recent trend	Exception rate per 100	CCG achievement			
	Number	%			Average	Low	Range	High
Variability/ reversibility measures, asthma	119	80.4	↔	2.6	87.4	76.5		96.0
Review, asthma	668	70.4	↔	0.6	72.6	42.3		97.7
Review, cancer	57	93.4	↔	7.6	90.2	35.3		100.0
Blood pressure 150/90mmHg or less, CHD	475	91.2	↔	3.7	92.0	77.0		97.0
Record of FEV1, COPD	324	85.0	↔	3.5	84.4	59.1		95.2
Review, dementia	100	82.0	↔	6.9	80.5	10.7		100.0
HbA1c 59mmol/mol or less, diabetes	530	73.1	↔	15.1	72.0	53.1		85.1
Blood pressure <= 150/90mmHg, hypertension	1920	82.4	↔	4.9	80.9	65.6		93.4

Practice G82150, Quality & Outcomes Framework: clinical achievement

Indicator	Practice achievement		Recent trend	Exception rate per 100	CCG achievement			
	Number	%			Average	Low	Range	High
Variability/ reversibility measures, asthma	147	91.3	↔	2.4	87.4	76.5		96.0
Review, asthma	319	74.5	↔	2.9	72.6	42.3		97.7
Review, cancer	22	100.0	↔	18.5	90.2	35.3		100.0
Blood pressure 150/90mmHg or less, CHD	190	94.5	↔	3.8	92.0	77.0		97.0
Record of FEV1, COPD	203	82.2	↔	12.4	84.4	59.1		95.2
Review, dementia	51	98.1	↔	1.9	80.5	10.7		100.0
HbA1c 59mmol/mol or less, diabetes	244	75.5	↔	30.7	72.0	53.1		85.1
Blood pressure <= 150/90mmHg, hypertension	1033	85.5	↔	3.0	80.9	65.6		93.4

Source: QOF, produced by KPHO (ZC), December 2016

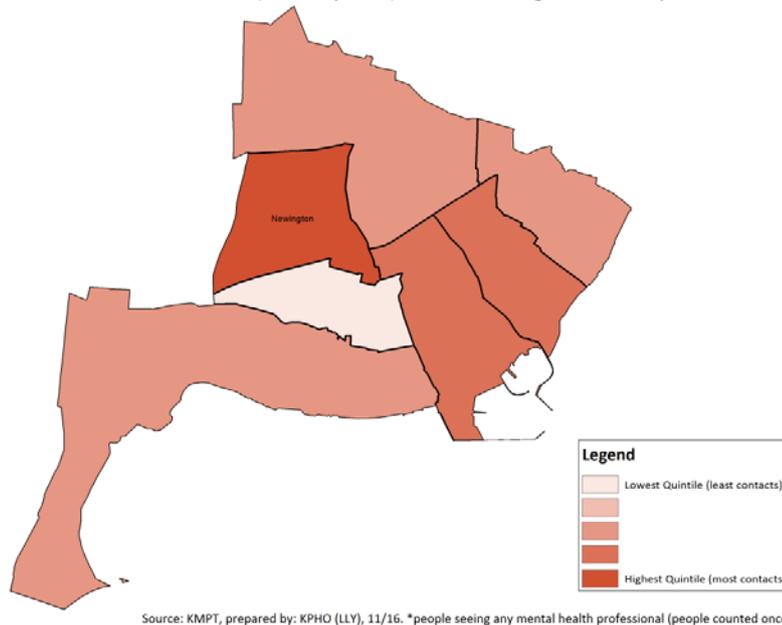
| 8. Mental Health

The following maps show the mental health contact rates for people aged 16-64 and 65 years plus respectively. Contact rates are defined as the proportion of the population seeing a mental health professional (with individuals counted only once, regardless of the frequency of contact).

8.1 Contact rates (16-64 years)

Mental health contact rates amongst those aged 16-64 are high in Newington.

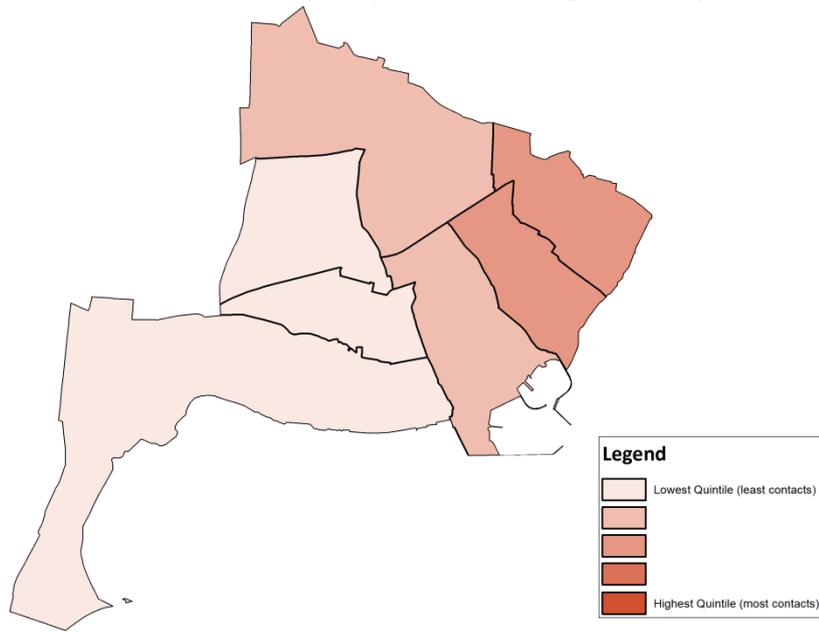
Mental Health Contact Rates (16-64 years) 2015: Ramsgate Locality



8.2 Contact rates (65+)

Mental health contact rates amongst those aged 65 years and over are low across the Ramsgate locality.

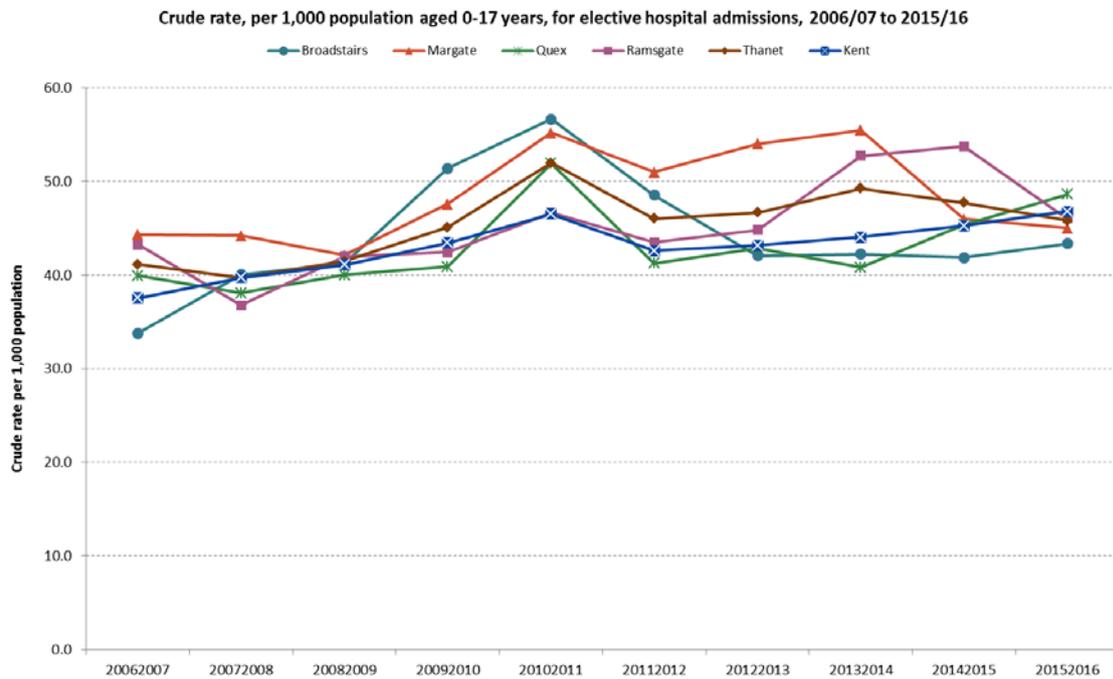
Mental Health Contact Rates (65 years plus) 2015: Ramsgate Locality



Source: KMPT, prepared by: KPHO (LLY), 11/16. *people seeing any mental health professional (people counted once)

9. Hospital Admissions

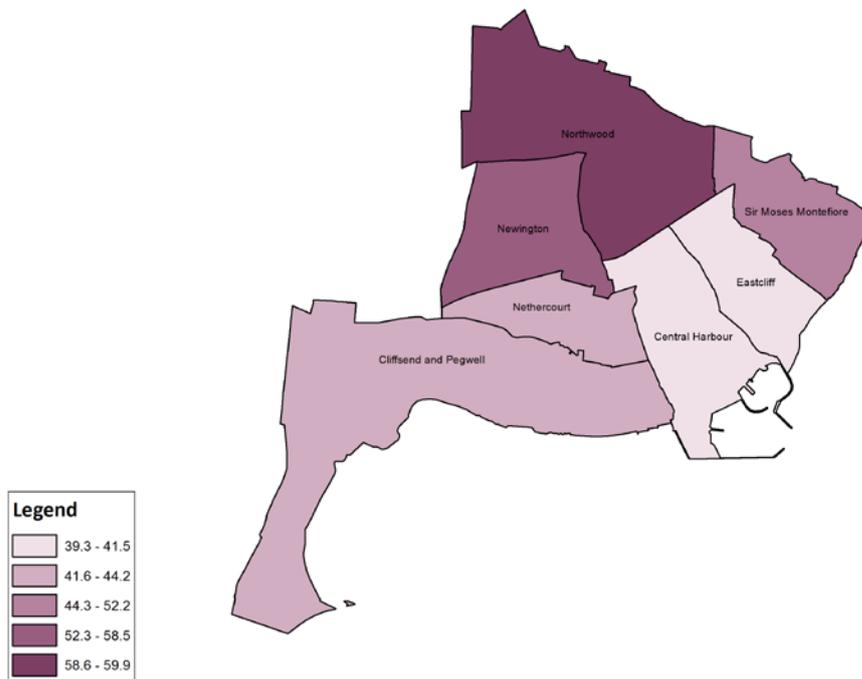
9.1.1 Under 18



Source: SUS/ONS, prepared by KPHO (RK), 03/17

The under 18 elective admission trend has increased over the period 2006/07 to 2015/16 with the localities following a similar trend to Thanet and Kent. There were no significantly different rates to Kent in 2015/16.

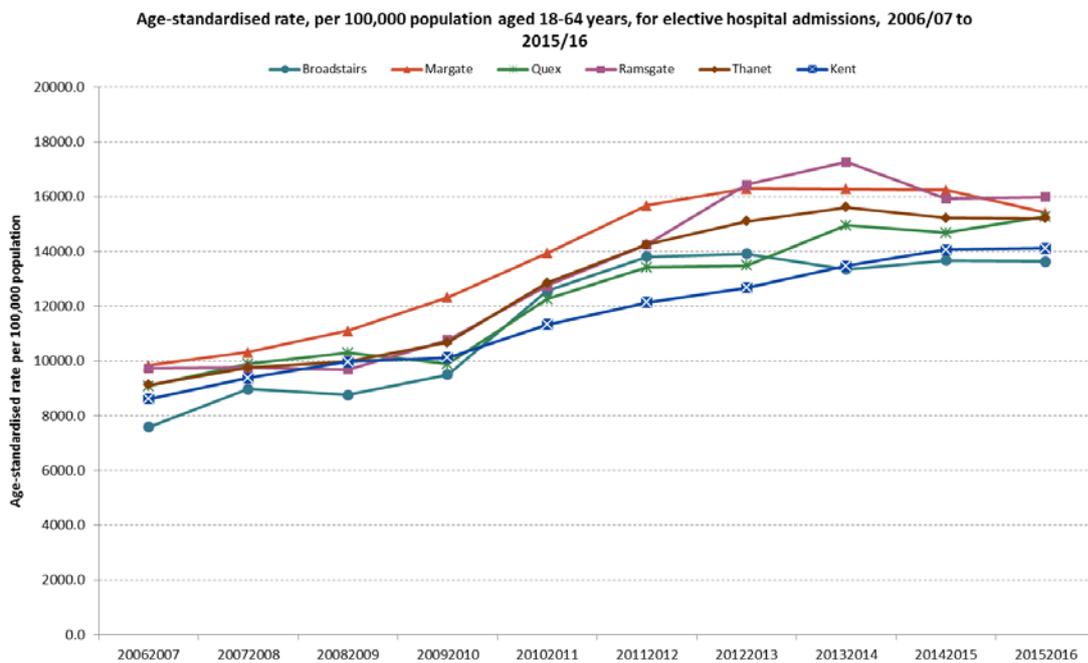
Crude rate per 10,000 population for elective hospital admissions for those aged under 18 years, 2011/12-2015/16



Source: SUS, prepared by: KPHO (LLY), 03/17

Northwood has the highest rate of elective hospital admissions for those aged under 18 years (ranging from 58.6 to 59.9 per 10,000 population).

9.1.2 Ages 18 to 64

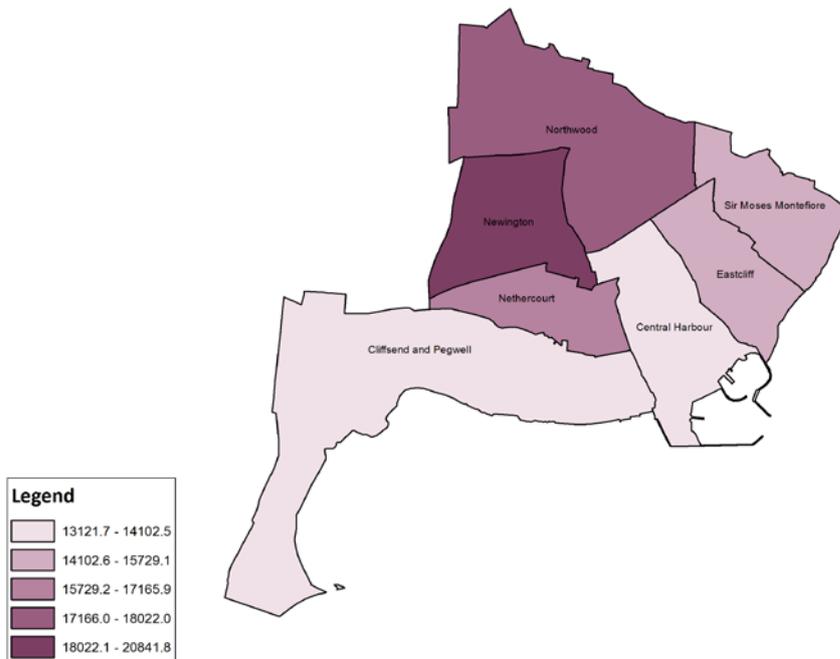


Source: SUS/ONS, prepared by KPHO (RK), 03/17

The rates for elective admissions aged 18-64 years have steadily increased from 2006/07 to 2015/16 for all localities, Thanet as a whole and Kent. During 2015/16, Margate (15,412.2

per 100,000 population), Quex (15,277.8) and Ramsgate (15,994.1) localities all had a significantly higher rate than Kent (14,115.9). All the localities had a significantly higher rate than Thanet (15,210.1).

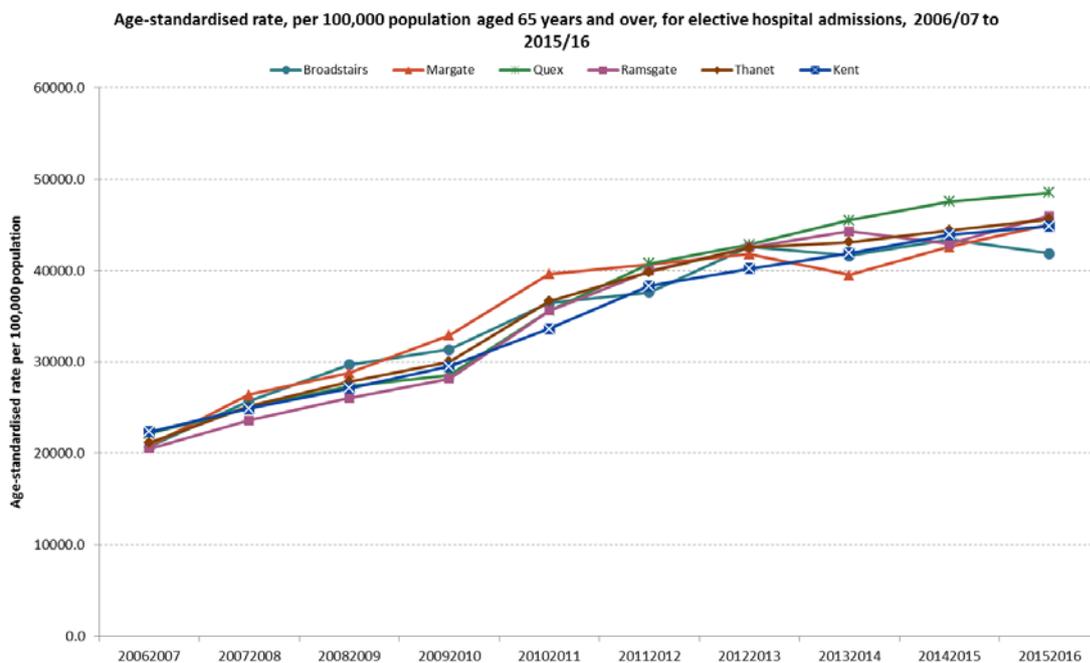
Age standardised rate per 100,000 population for elective hospital admissions for those aged 18-64 years, 2011/12-2015/16



Source: SUS, prepared by: KPHO (LLY), 03/17

Newington falls within the top quintile for the highest rate of elective admissions amongst those aged 18-64 years.

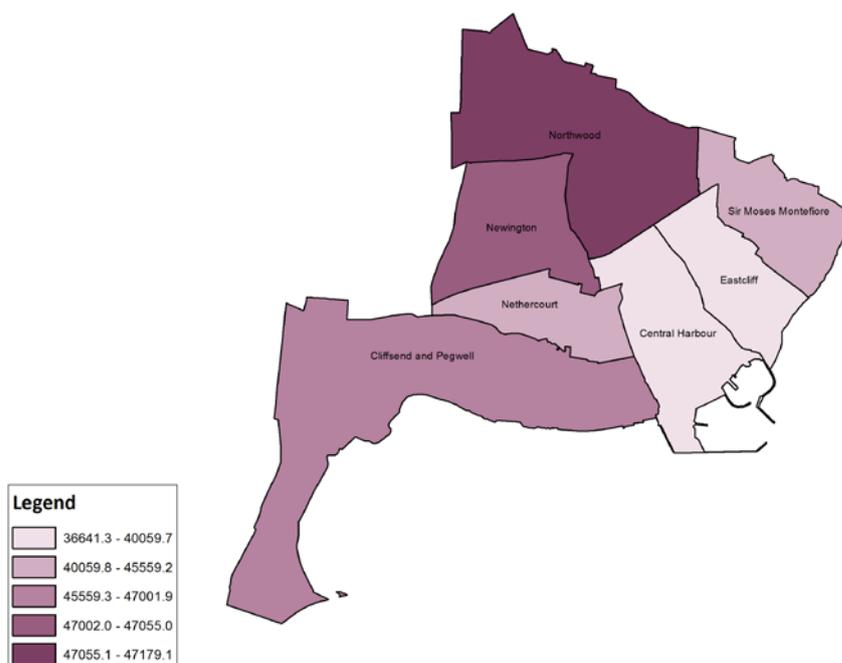
9.1.3 Age 65 and above



Source: SUS/ONS, prepared by KPHO (RK), 03/17

Elective admissions for those aged 65 years and over follow the same pattern of elective admissions aged 18-64 years by increasing from 2006/07 to 2015/16. Only Broadstairs (41,881.4 per 100,000 population) had a rate significantly lower than Kent (44,861.4) whereas Ramsgate (45,997.5) was significantly higher than Kent (44,861.4) and Thanet (45,631.8).

Age standardised rate per 100,000 population for elective hospital admissions for those aged 65 years and over, 2011/12-2015/16

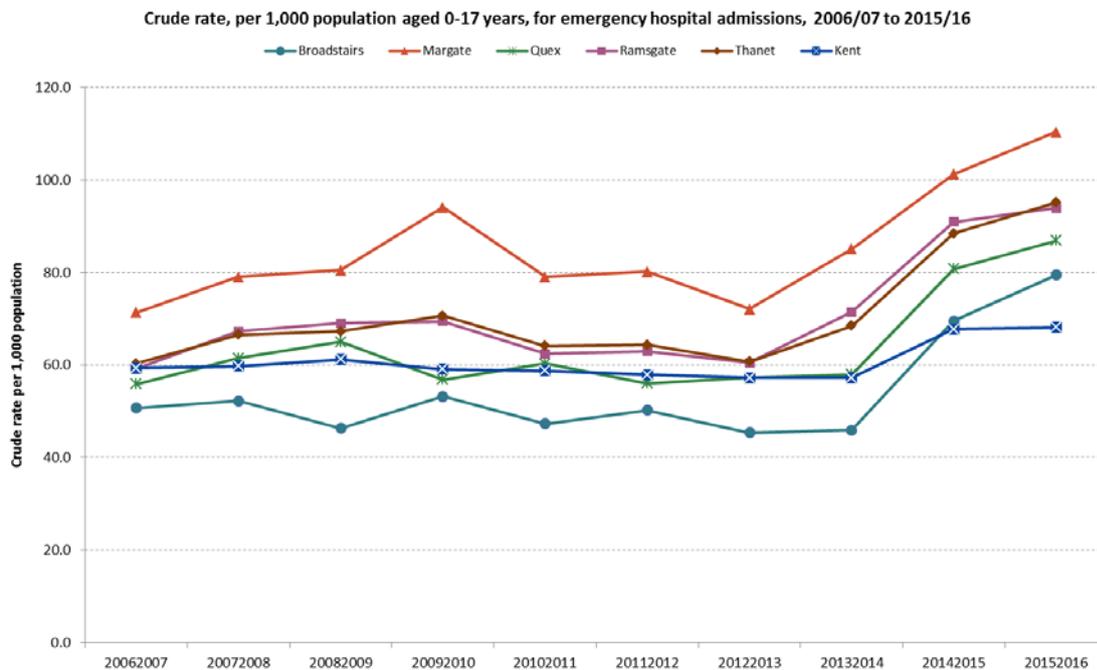


Source: SUS, prepared by: KPHO (LLY), 03/17

Similar to elective admissions under 18 years, Northwood has the highest rate of elective admissions in the 65 years and over population also.

9.2 Emergency admissions

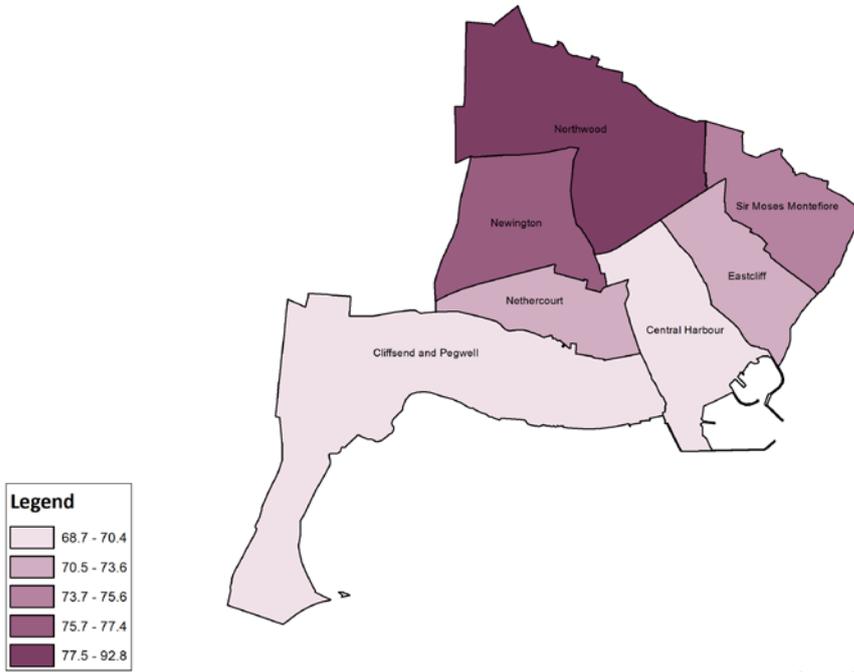
9.2.1 Under 18



Source: SUS/ONS, prepared by KPHO (RK), 03/17

The under 18 emergency admission trend remained fairly static from 2006/07 to 2013/14 before sharply increasing in recent years. All localities had a significantly higher rate than Kent (68.1 per 100,000 population) in 2015/16.

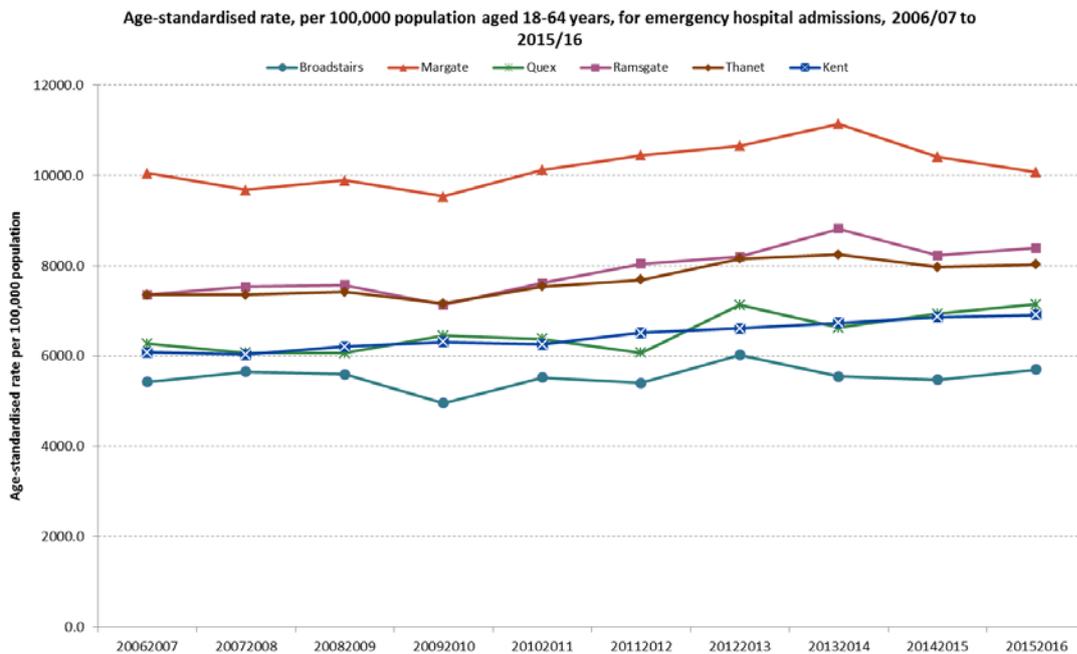
Crude rate per 10,000 population for emergency hospital admissions for those aged under 18 years, 2011/12-2015/16



Source: SUS, prepared by: KPHO (LLY), 03/17

Again, Northwood has the highest rate of emergency admissions for those aged under 18 years.

9.2.2 Ages 18 to 64

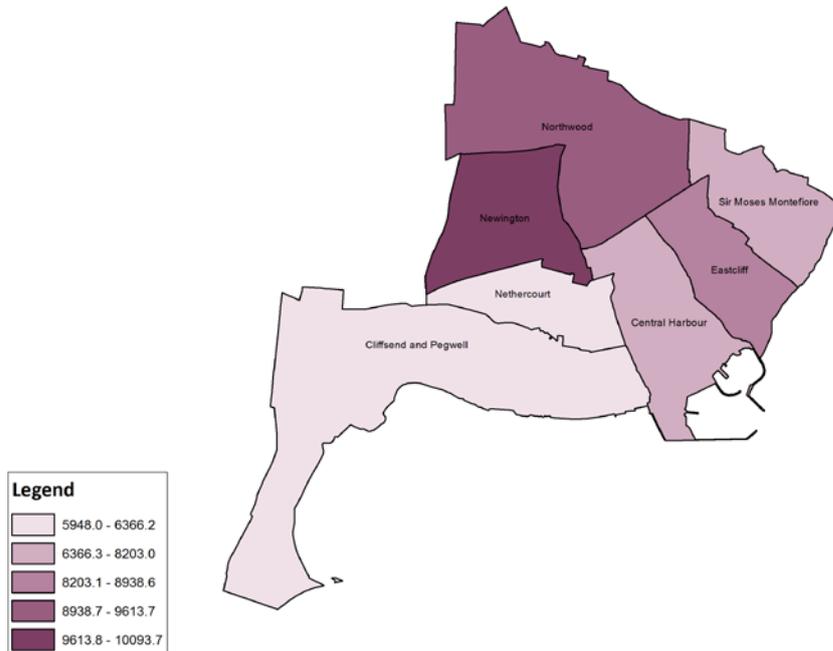


Source: SUS/ONS, prepared by KPHO (RK), 03/17

There has been a marginal increase for emergency admissions aged 18-64 years from 2006/07 to 2015/16. In 2015/16, Margate (10,081.3 per 100,000 population) and Ramsgate

(8,386.6) had a significantly higher rate than Kent (6,914.0). The rate for Thanet (8,027.7) in 2015/16 was also significantly higher than Kent.

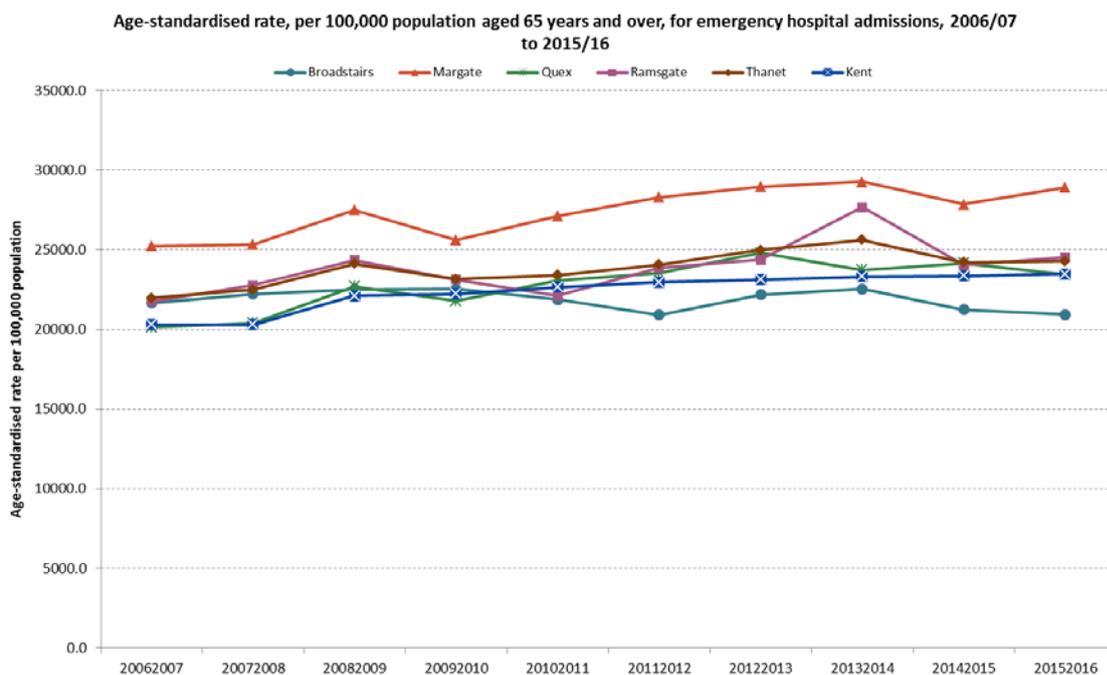
Age standardised rate per 100,000 population for emergency hospital admissions for those aged 18-64 years, 2011/12-2015/16



Source: SUS, prepared by: KPHO (LLY), 03/17

Newington has the highest admission rate elective admissions for those aged between 18-64 years (9,613.8 to 10,093.7 per 100,000 population).

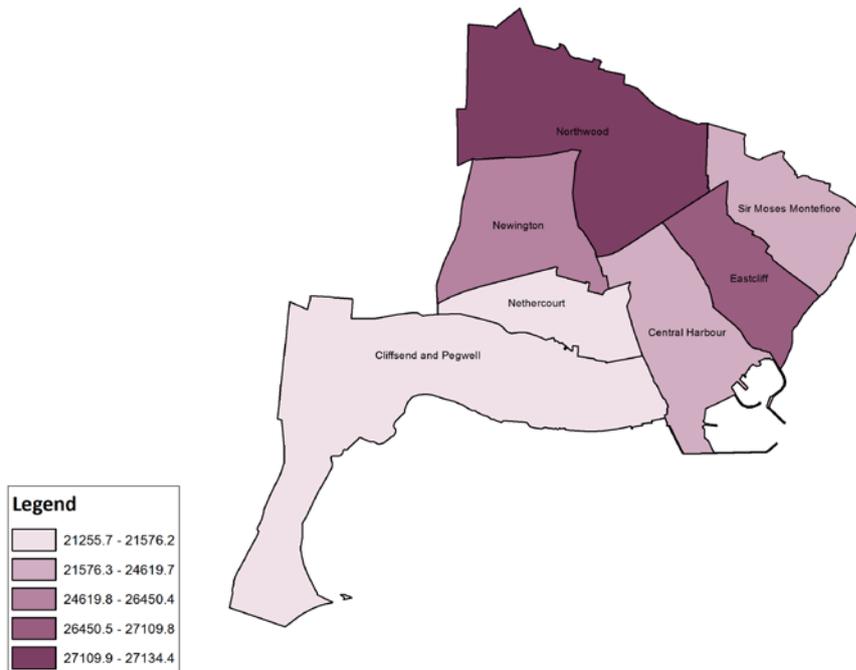
9.2.3 Ages 65 and above



Source: SUS/ONS, prepared by KPHO (RK), 03/17

Emergency admissions aged 65 years and over have increased for all localities (apart from Broadstairs), Thanet as a whole and Kent from 2006/07 to 2015/16. During 2015/16, only Margate (28,909.7 per 100,000 population) had a significantly higher rate than Kent (23,479.9). Thanet (24,268.8) also had a significantly higher rate than Kent.

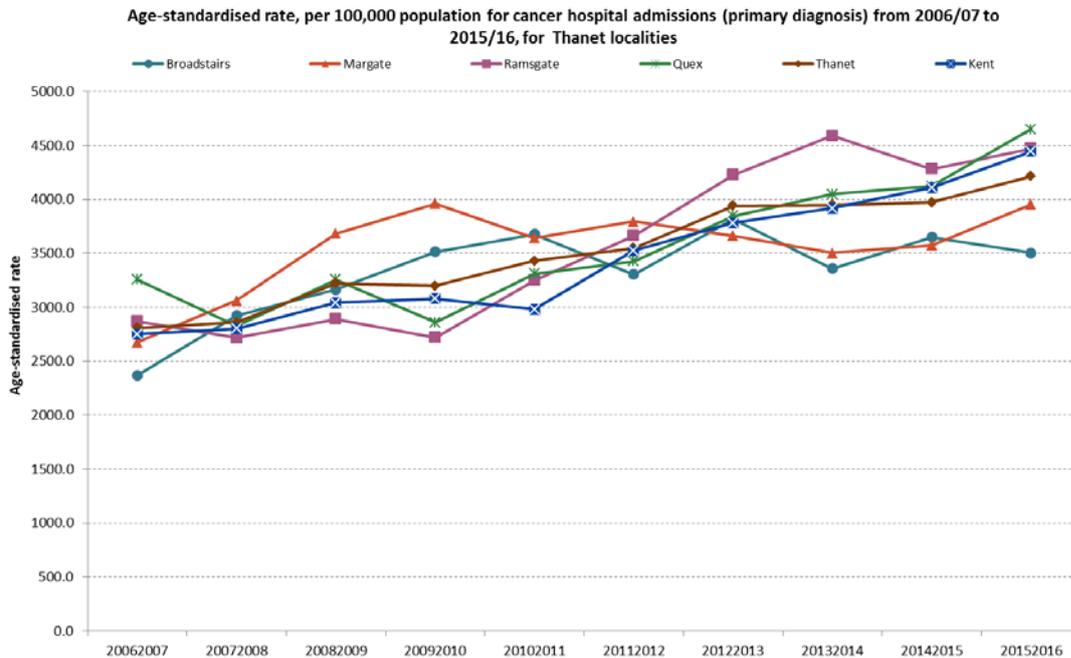
Age standardised rate per 100,000 population for emergency hospital admissions for those aged 65 years and over, 2011/12-2015/16



Source: SUS, prepared by: KPHO (LLY), 03/17

Again, Northwood falls within the top quintile for emergency admissions in those aged 65 years and over.

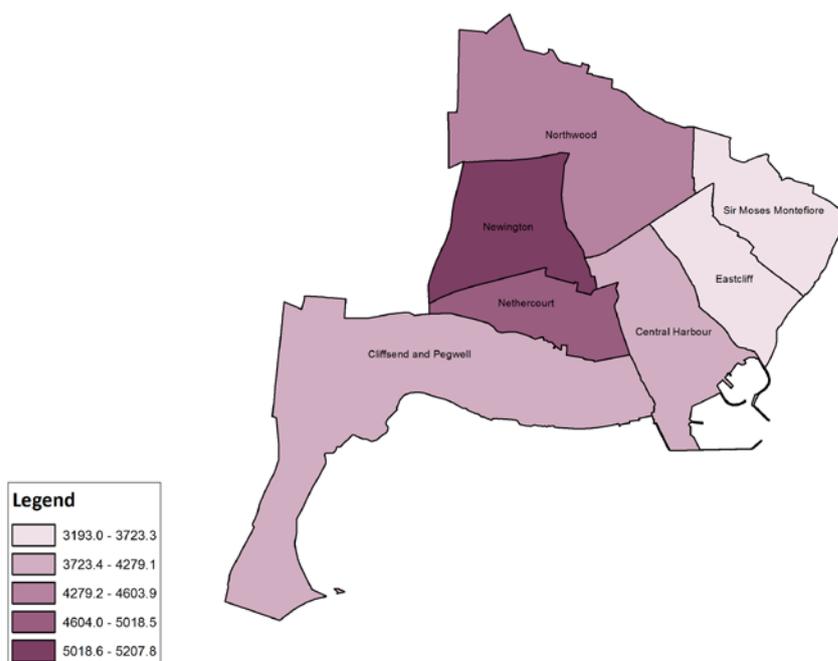
9.3 Cancer



Source: SUS, ONS, prepared by KPHO (RK), 03/17

The rate for cancer hospital admissions has increased steadily from 2006/07 to 2015/16 for all localities, Thanet as a whole and Kent. During 2015/16, Broadstairs (3,503.6 per 100,000 population), Margate (3,955.5) and Thanet (4,214.7) all had a rate which was significantly lower than Kent (4,442.8).

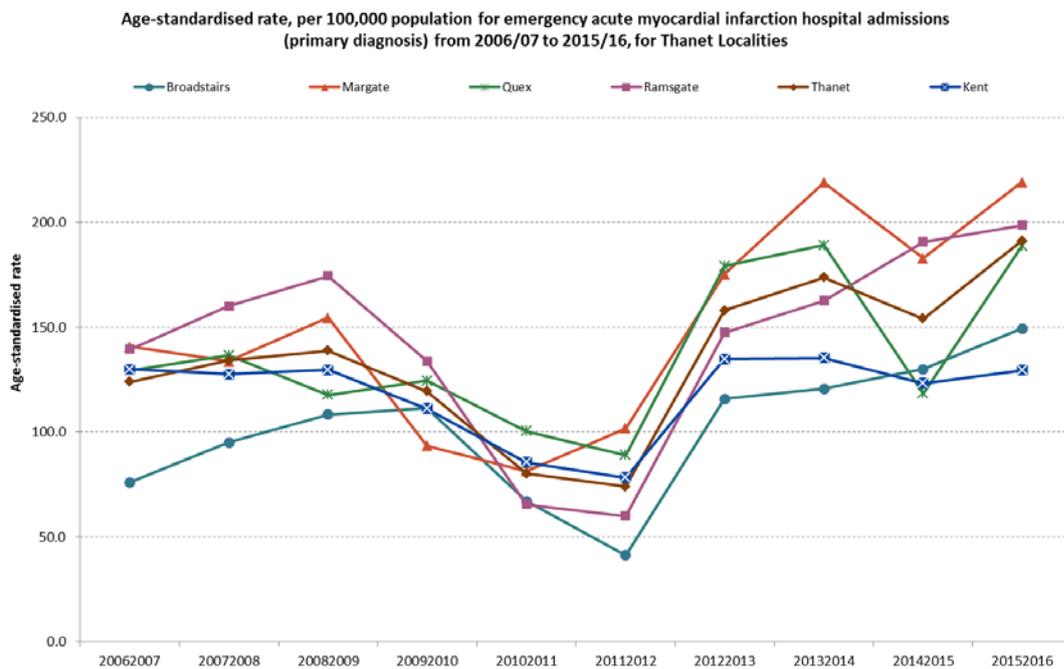
Age standardised rate per 100,000 population for cancer (primary diagnosis) hospital admissions, 2011/12-2015/16



Source: SUS, prepared by: KPHO (LLY), 03/17

Hospital admissions due to cancer are highest in Newington.

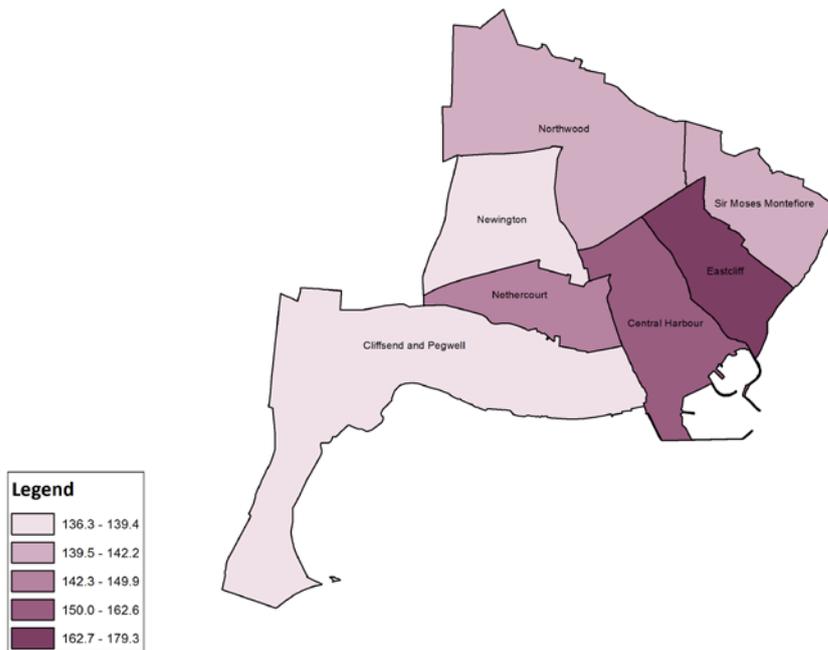
9.4 Acute myocardial infarction



Source: SUS, ONS, prepared by KPHO (RK), 3/17

The rate for acute myocardial infarction hospital admissions declined between 2006/07 to 2011/12 but has since increased again in more recent years. During 2015/16, Broadstairs (149.3 per 100,000 population) was the only locality that did not have a significantly different rate to Kent (129.4).

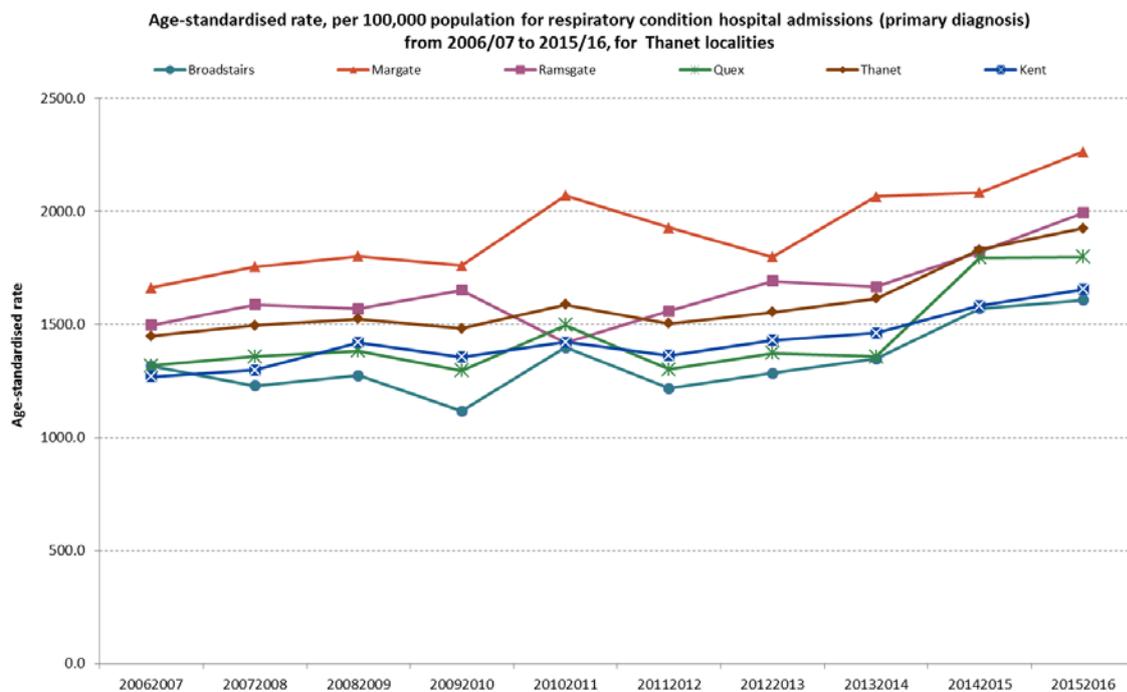
Age standardised rate per 100,000 population for acute myocardial infarction hospital admissions, 2011/12-2015/16



Source: SUS, prepared by: KPHO (LLY), 03/17

Eastcliff has the highest rate of admissions due to acute myocardial infarction (between 162.7 to 179.3 per 100,000 population).

9.5 Respiratory disease

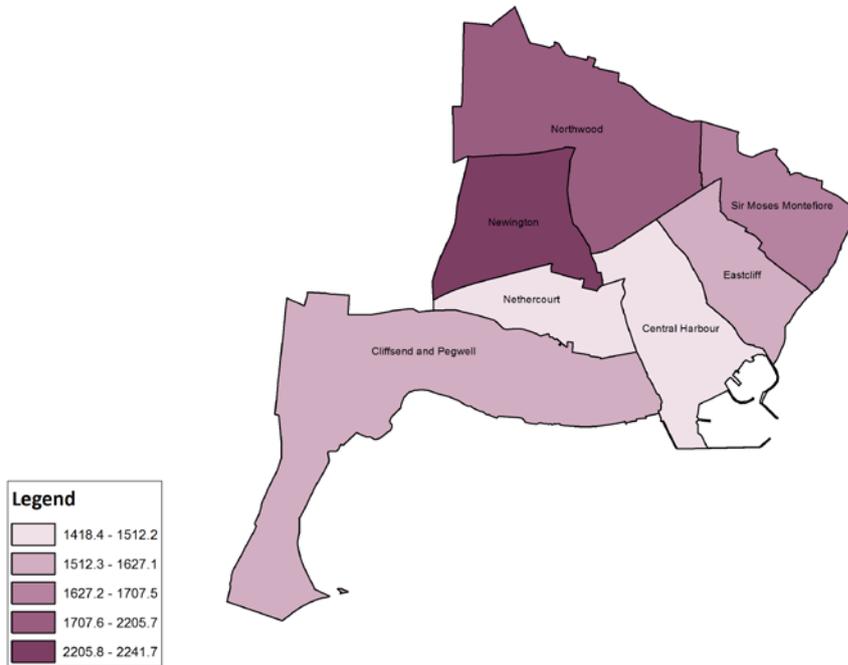


Source: SUS, ONS, prepared by KPHO (RK), 03/17

The rate for respiratory condition hospital admission has increased from 2006/07 to 2015/16. During 2015/16, Margate (2,263.2 per 100,000 population) and Quex (1,799.1) have rates

significantly higher than Kent (1,654.5). Thanet (1,925.9) also has a rate higher than Kent for the same time period.

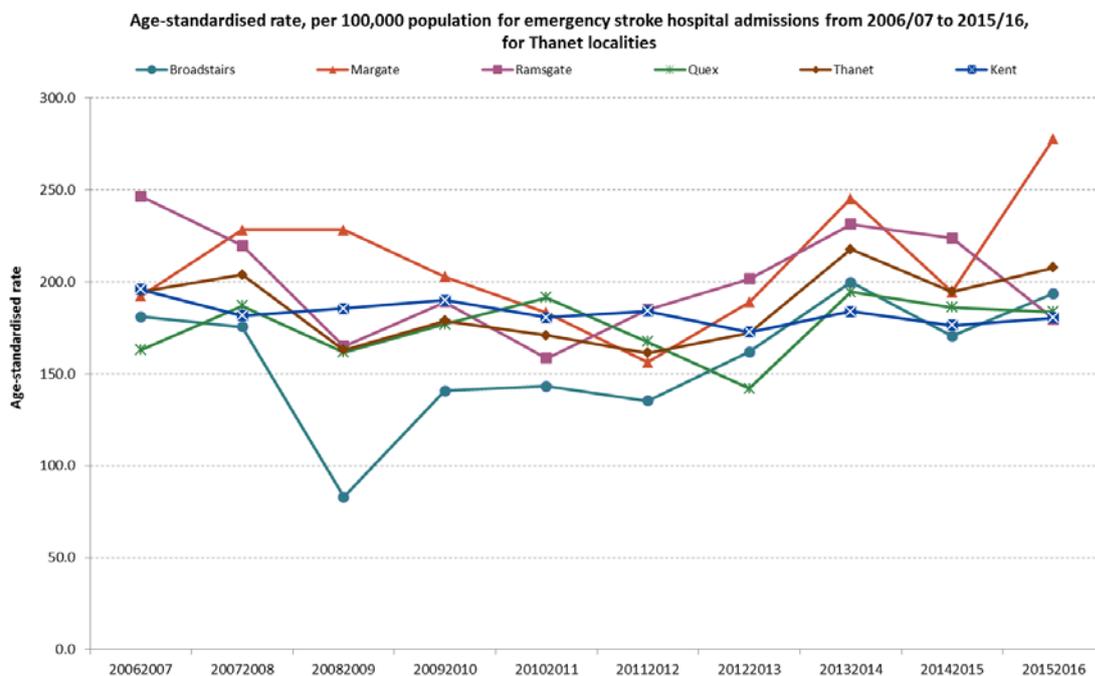
Age standardised rate per 100,000 population for respiratory hospital admissions, 2011/12-2015/16



Source: SUS, prepared by: KPHO (LLY), 03/17

Hospital admissions are highest in Newington for respiratory conditions.

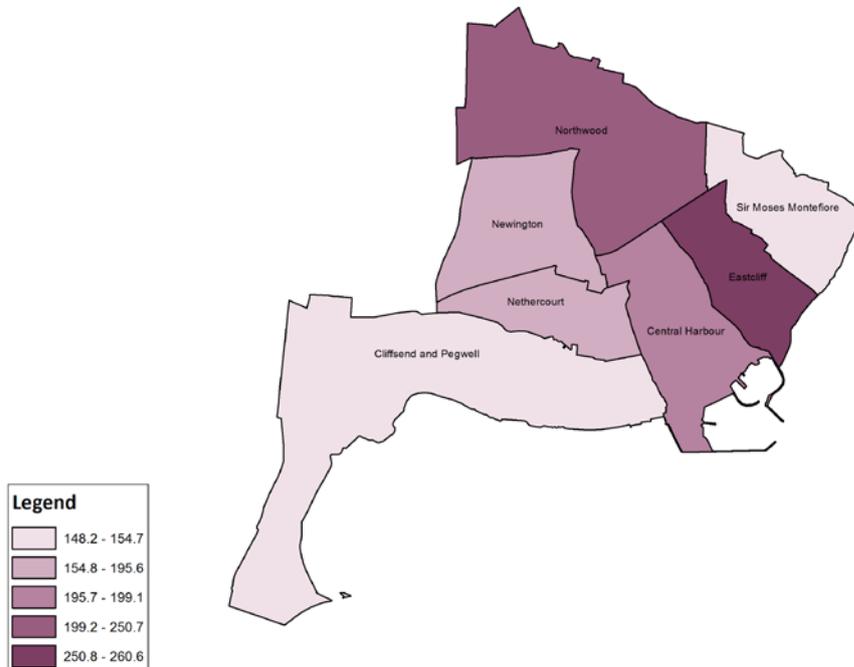
9.6 Stroke



Source: SUS, ONS, prepared by KPHO (RK), 03/17

The rate for stroke hospital admissions has remained fairly similar to Thanet and Kent for the four localities, with the exception being Margate locality in 2015/16 where it increased to 277.8 per 100,000 population and was significantly higher than Kent (180.4).

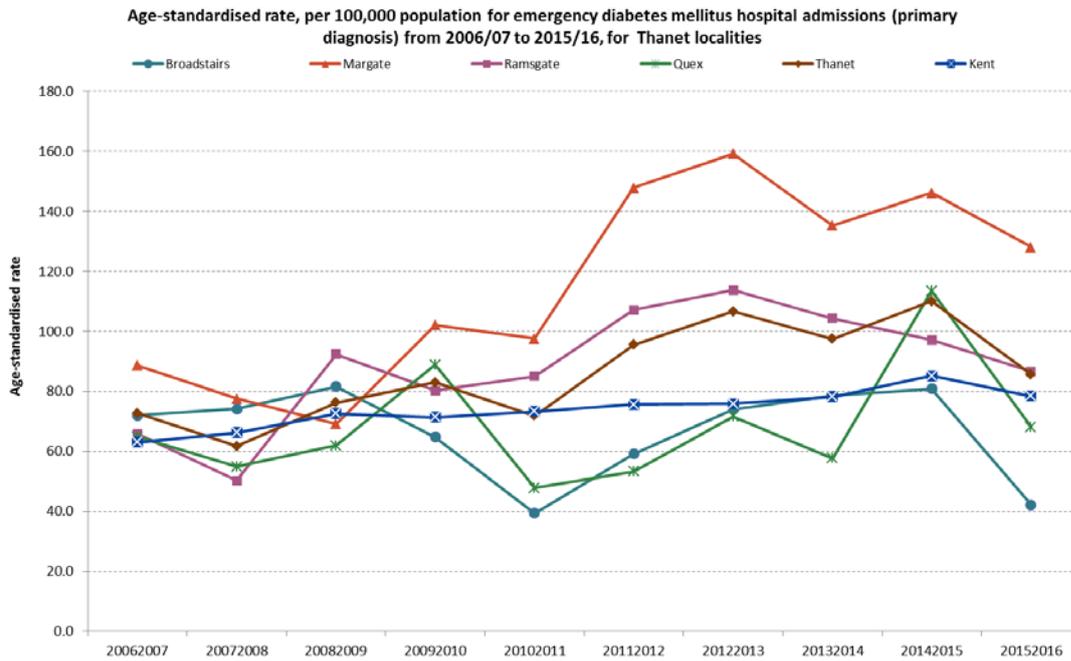
Age standardised rate per 100,000 population for stroke hospital admissions, 2011/12-2015/16



Source: SUS, prepared by: KPHO (LLY), 03/17

Eastcliff has the highest rate of hospital admissions due to stroke (250.8 to 260.6 per 100,000 population).

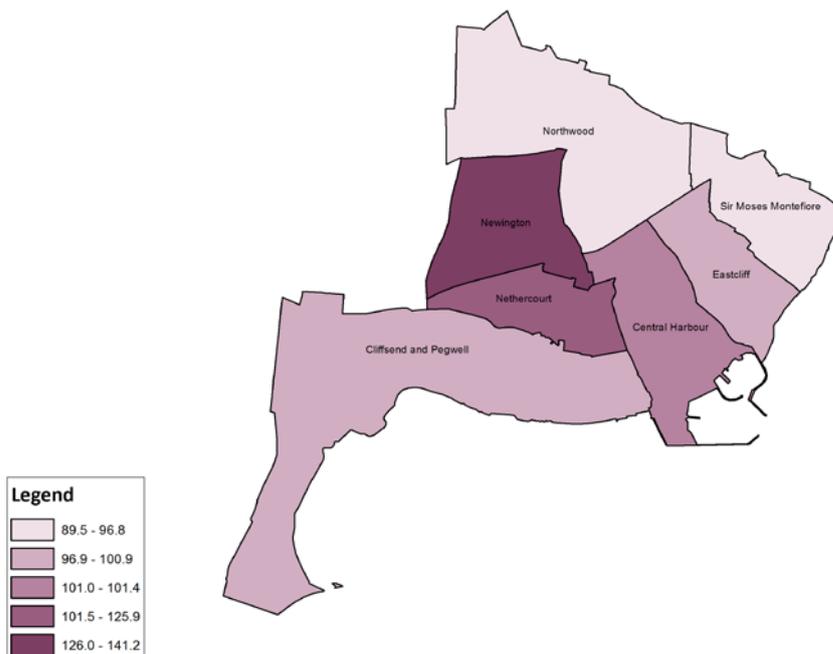
9.7 Diabetes



Source: SUS, ONS, prepared by KPHO (RK), 03/17

The rate of emergency hospital admissions for diabetes mellitus has increased for all localities apart from Broadstairs, Thanet and Kent from 2006/07 to 2015/16. During 2015/16 however there was a decrease across all areas but only Broadstairs locality (42.2 per 100,000 population) was significantly lower than Kent (78.4).

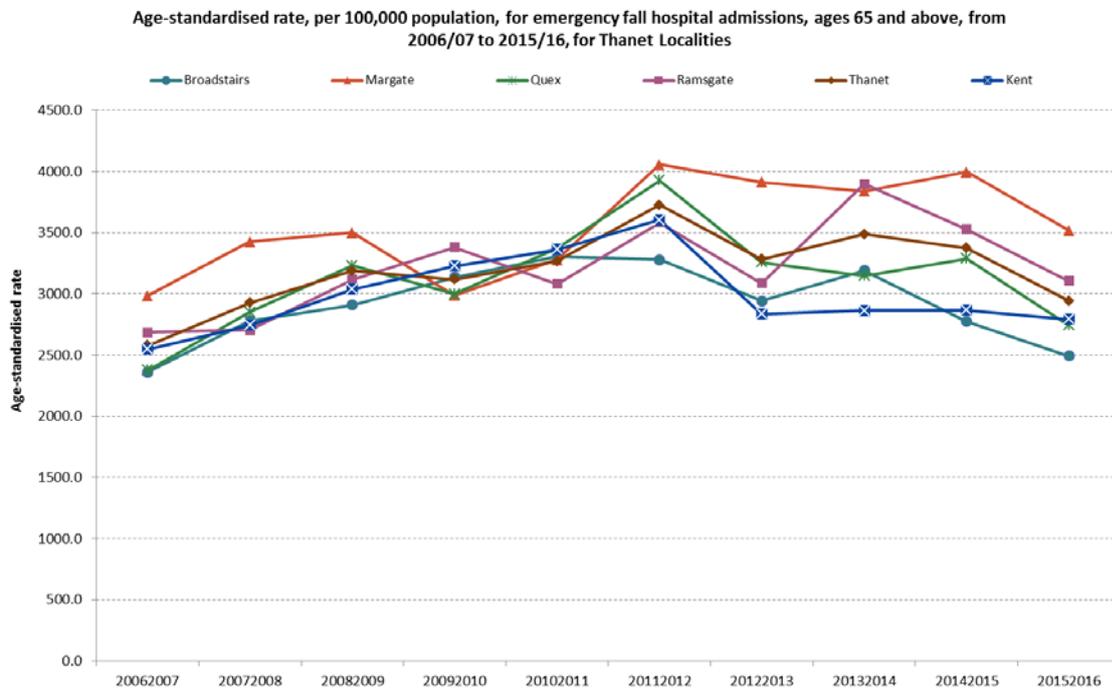
Age standardised rate per 100,000 population for diabetes (primary diagnosis) hospital admissions, 2011/12-2015/16



Source: SUS, prepared by: KPHO (LLY), 03/17

Newington also has the highest rate of hospital admissions for diabetes.

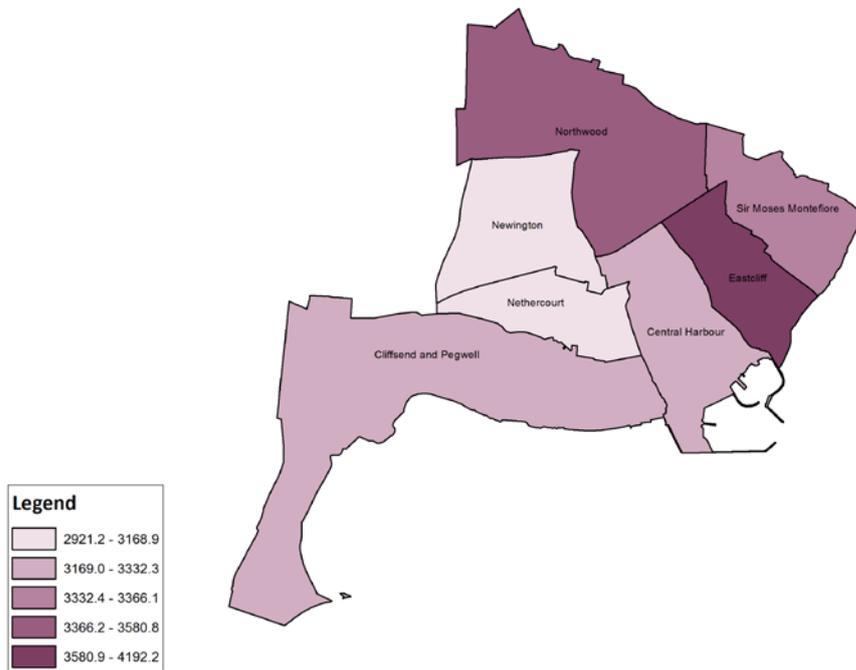
9.8 Falls (over 65)



Source: SUS, ONS, prepared by KPHO (RK), 3/17

The rate for hospital admissions due to falls increased from 2006/07 to 2011/12 before decreasing in recent years. During 2015/16 only Margate locality (3,518.0 per 100,000 population) had a rate that was significantly higher than Kent (2,791.2).

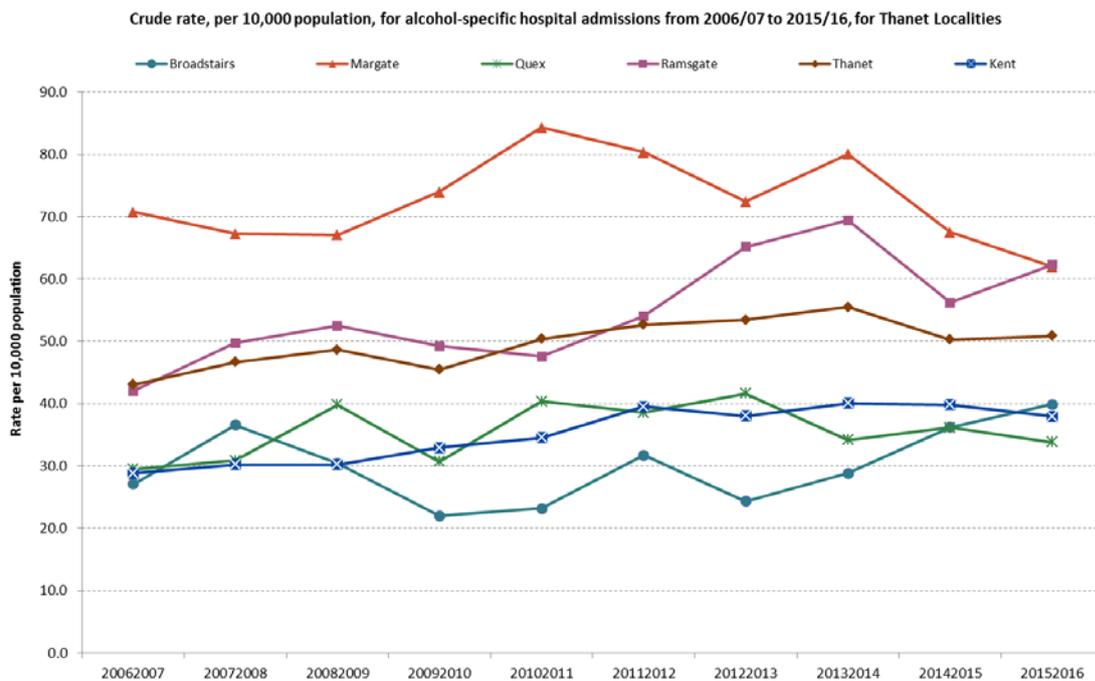
Age standardised rate per 100,000 population (aged 65 years and over) for falls hospital admissions, 2011/12-2015/16



Source: SUS, prepared by: KPHO (LLY), 03/17

Like for acute myocardial infarction admissions, Eastcliff also has the highest rate of falls admissions for those aged 65 years and over.

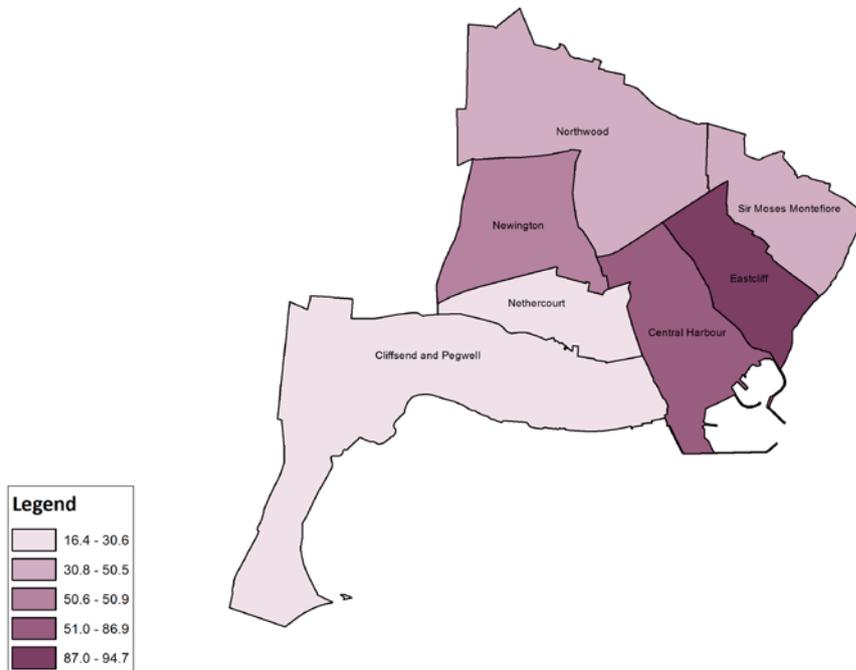
9.9 Alcohol-specific



Source: SUS, ONS, prepared by KPHO (RK), 3/17

The rate of alcohol-specific hospital admissions has remained fairly similar; the Broadstairs and Quex localities have followed a similar pattern to the Kent rate from 2006/07 to 2015/16 with the Ramsgate rate mirroring that of Thanet. There is no statistical difference between the rates.

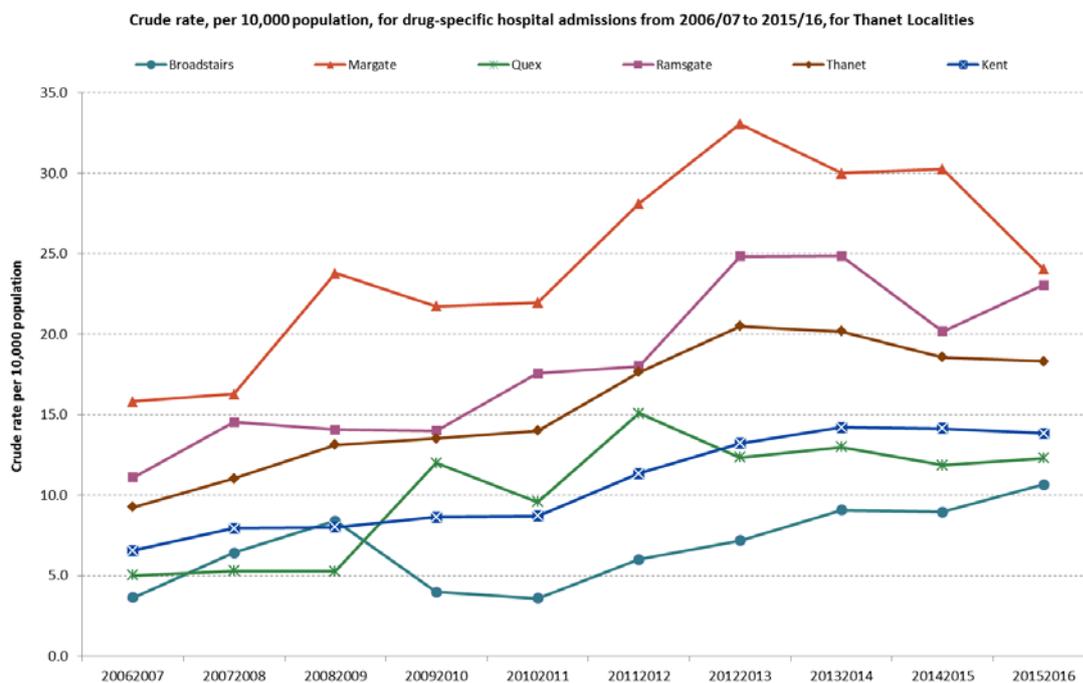
Crude rate per 10,000 population for assaults hospital admissions, 2011/12-2015/16



Source: SUS, prepared by: KPHO (LLY), 03/17

Again, Eastcliff falls within the top quintile for hospital admissions relating to assaults (ranging between 87.0 and 94.7 per 10,000 population).

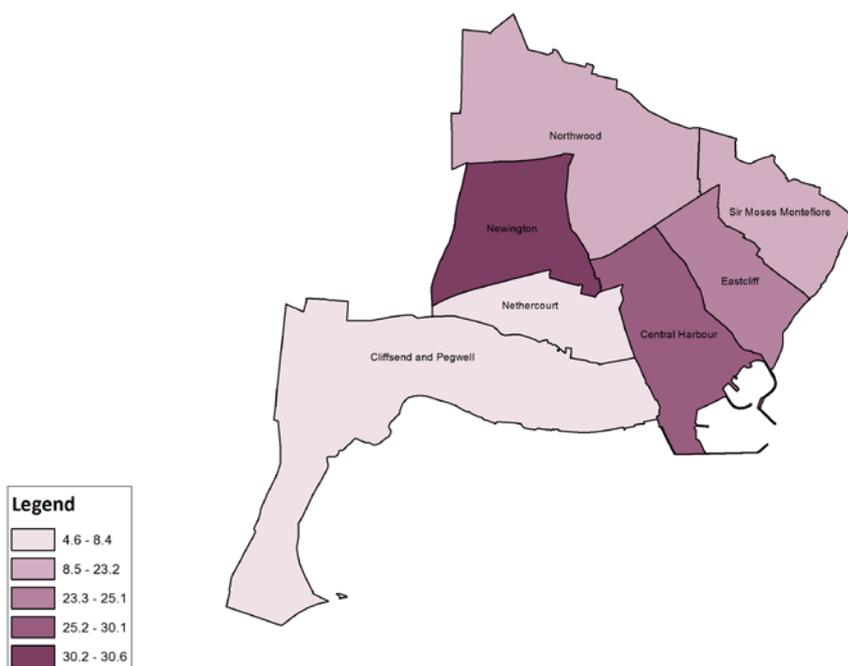
9.10 Drug-specific



Source: SUS, ONS, prepared by KPHO (RK), 3/17

The rate for drug-specific hospital admissions has increased for all localities, Thanet as a whole and Kent from 2006/07 to 2015/16. Thanet (18.3 per 100,000 population) had a significantly higher rate compared to Kent (13.8) for 2015/16 but all localities were not significantly different to Kent.

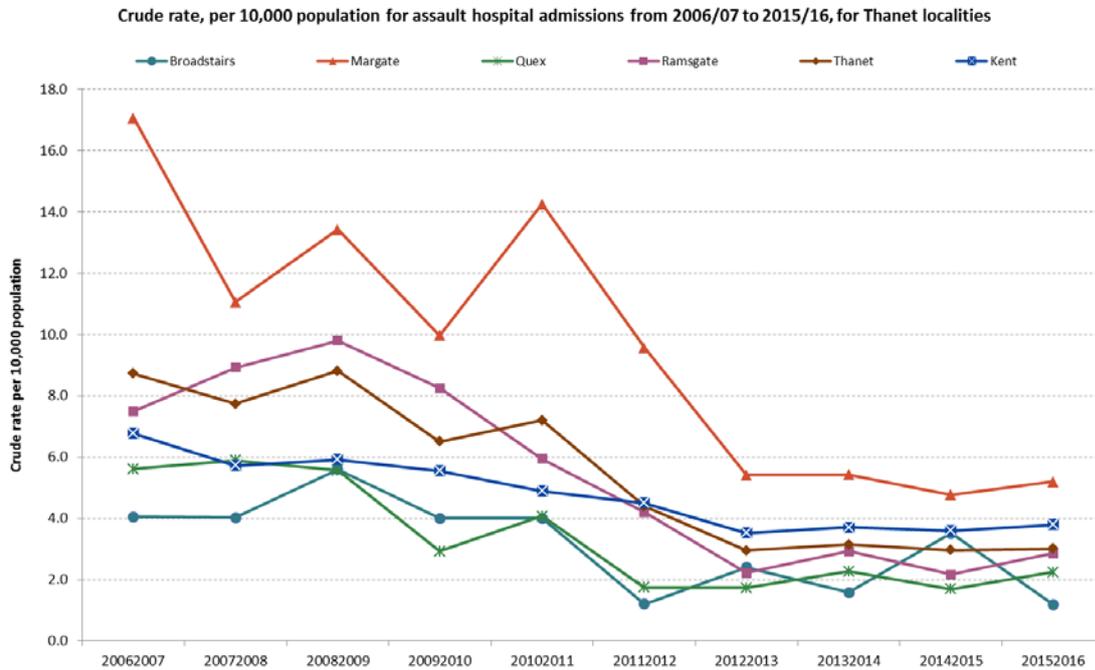
Crude rate per 10,000 population for drug abuse hospital admissions, 2011/12-2015/16



Source: SUS, prepared by: KPHO (LLY), 03/17

Newington has the highest rate of hospital admissions relating to drug abuse (30.2 to 30.6 per 10,000 population).

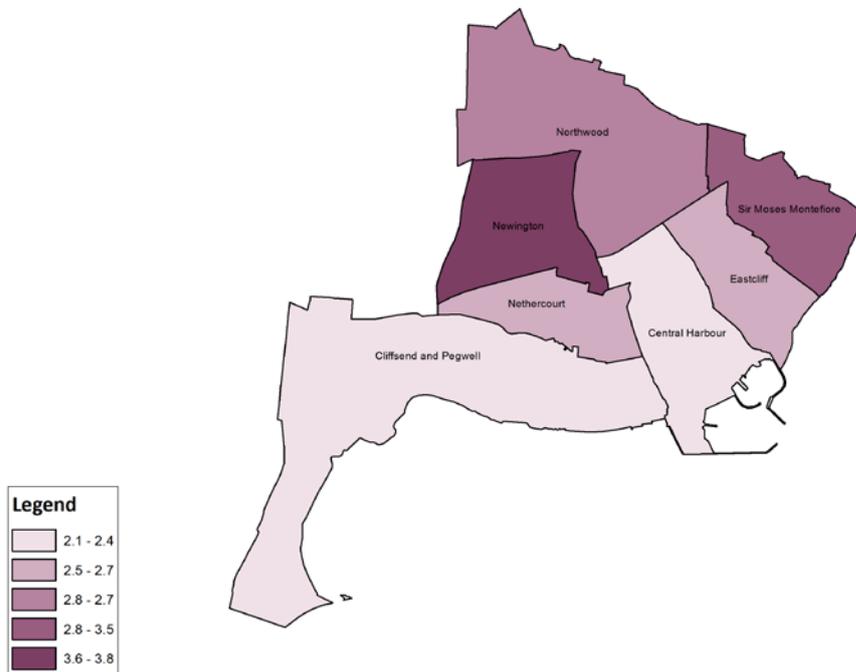
9.11 Assaults



Source: SUS, ONS, prepared by KPHO (RK), 3/17

The rate for hospital admissions relating to assaults have substantively decreased from 2006/07 to 2015/16. There was no significant difference between the localities to Thanet and Kent comparators.

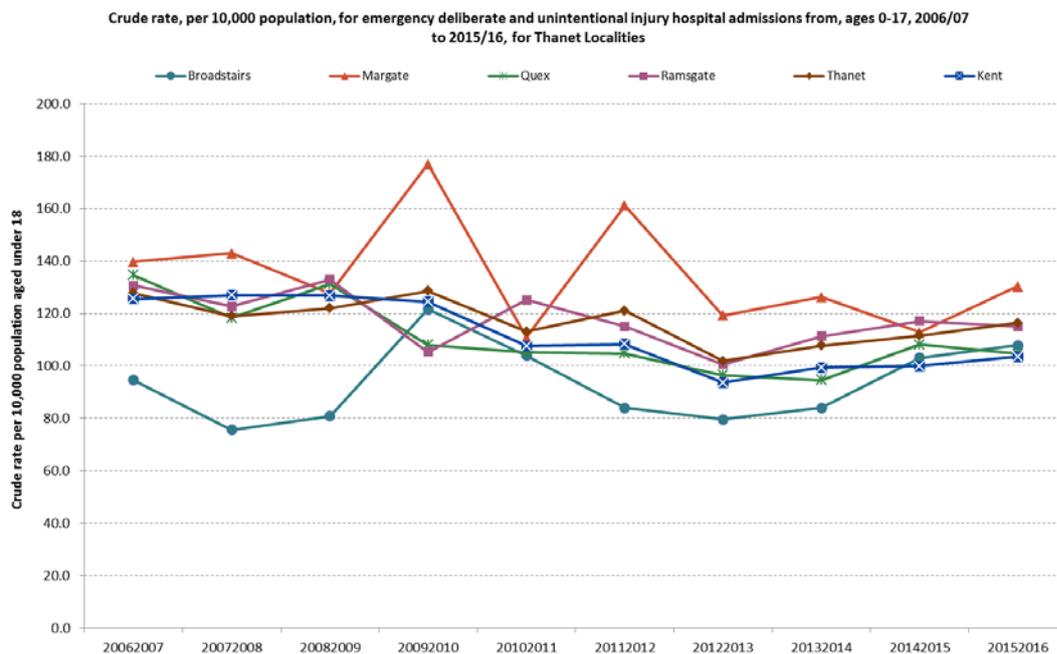
Crude rate per 10,000 population for assault hospital admissions, 2011/12-2015/16



Source: SUS, prepared by: KPHO (LLY), 03/17

Newington also has the highest rate of hospital admissions due to assaults.

9.12 Deliberate self-harm and unintentional injury (under 18)

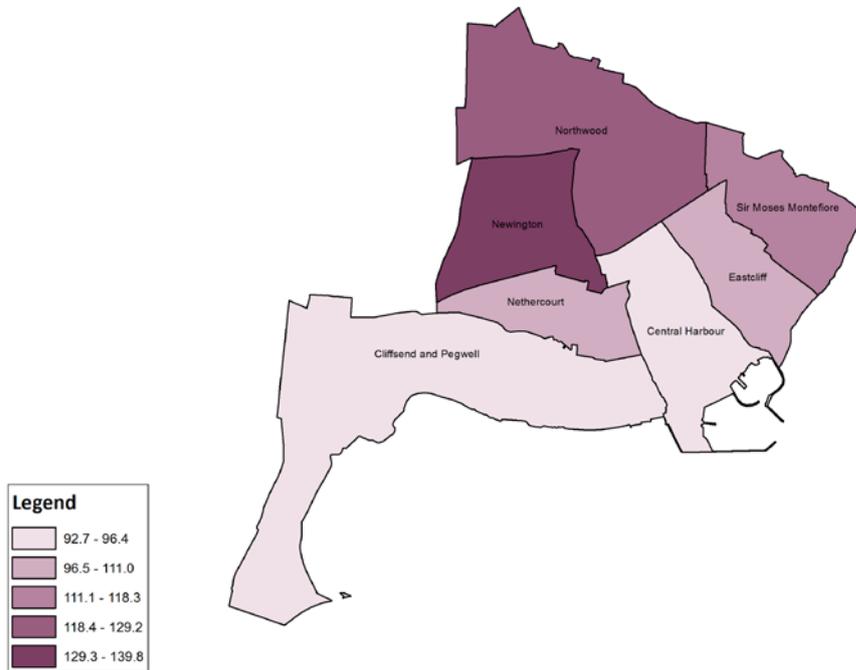


Source: SUS, ONS, prepared by KPHO (RK), 3/17

Emergency deliberate and unintentional injury admissions for the under 18s have decreased from 2006/07 to 2015/16 for all localities (apart from Broadstairs), Thanet as a whole and

Kent. Only Margate (130.3 per 10,000 population) had a significantly higher rate than Kent (103.5) in 2015/16.

Crude rate per 10,000 population for deliberate and unintentional injury hospital admissions, 2011/12-2015/16



Source: SUS, prepared by: KPHO (LLY), 03/17

The deliberate and unintentional injury admission rate is highest in Newington (between 129.3 to 139.8 per 10,000 population).

10. Mortality

The mortality rate has been calculated using pooled data from 2006 to 2015 and has been shown for cancer, circulatory disease and respiratory conditions for the under 75 population of Thanet CCG. The following list of general practices have been included in the analysis. Some of these general practices may not be open, however were open during 2006 to 2015.

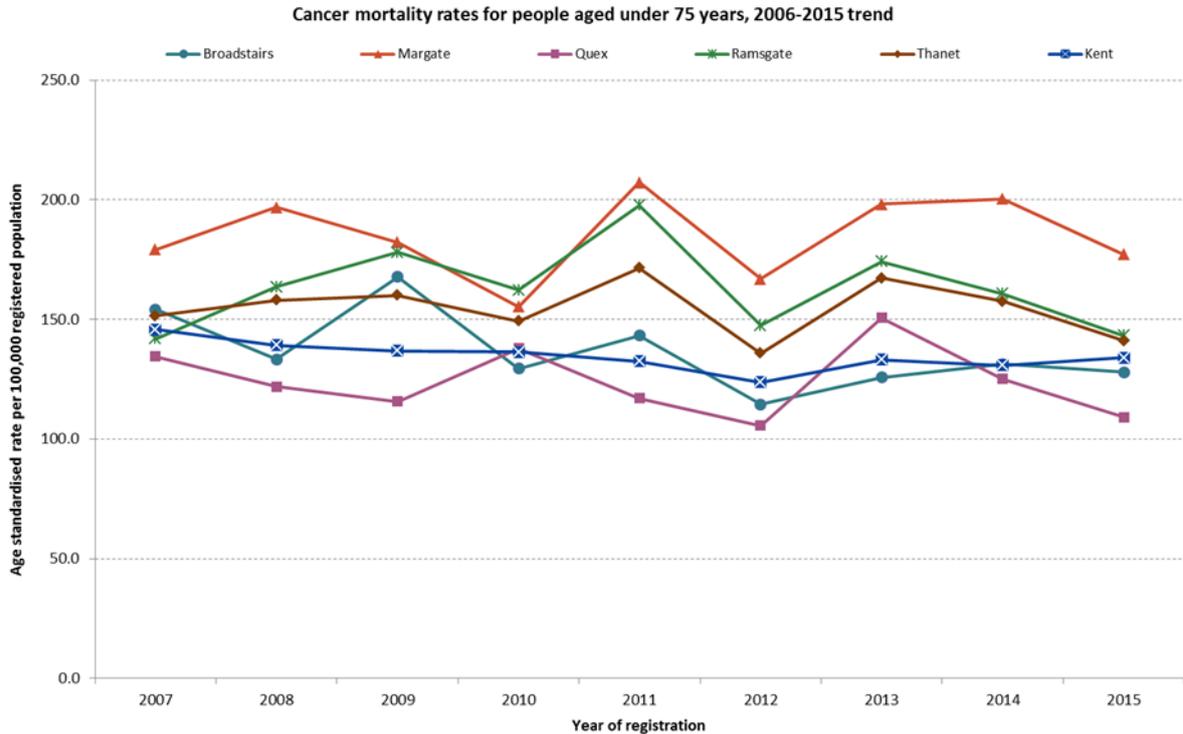
General Practices in Thanet	
G82210*	Osborne Road Surgery
G82219	St Peters Surgery
G82630*	The Broadway Practice
G82650	Mocketts Wood Surgery
G82796	Broadstairs Medical Practice
G82052	The Limes Medical Centre
G82066	Northdown Surgery
G82105	The Bethesda Medical Centre
G82649	Union Row Surgery
G82674*	Cliftonville Surgery
G82769*	Cecil Square Surgery
G82810**	Garlinge Surgery
G82079	Westgate Surgery
G82107	Minster Surgery
G82666	Birchington Medical Centre
G82020	The Grange Medical Practice
G82046	Summerhill Surgery
G82064	Dashwood Medical Centre
G82126	East Cliff Practice
G82150	Newington Road Surgery
G82812*	Wickham Surgery

Source: PCIS, prepared by: KPHO (LLY), 01/17

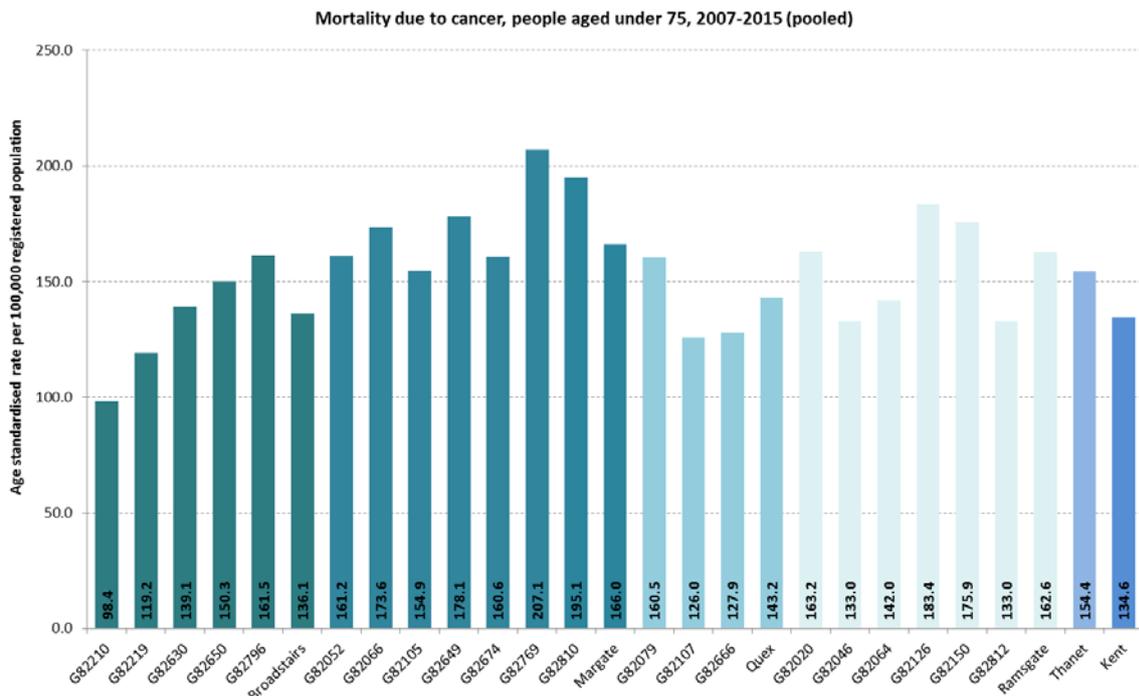
*General practices have since closed however were included in the analysis as they were open during 2006 to 2015.

**General practice has closed but has been taken over by The Limes Medical Practice and is now known as the The Limes Surgery (Garlinge Site).

10.1 Cancer (under 75)

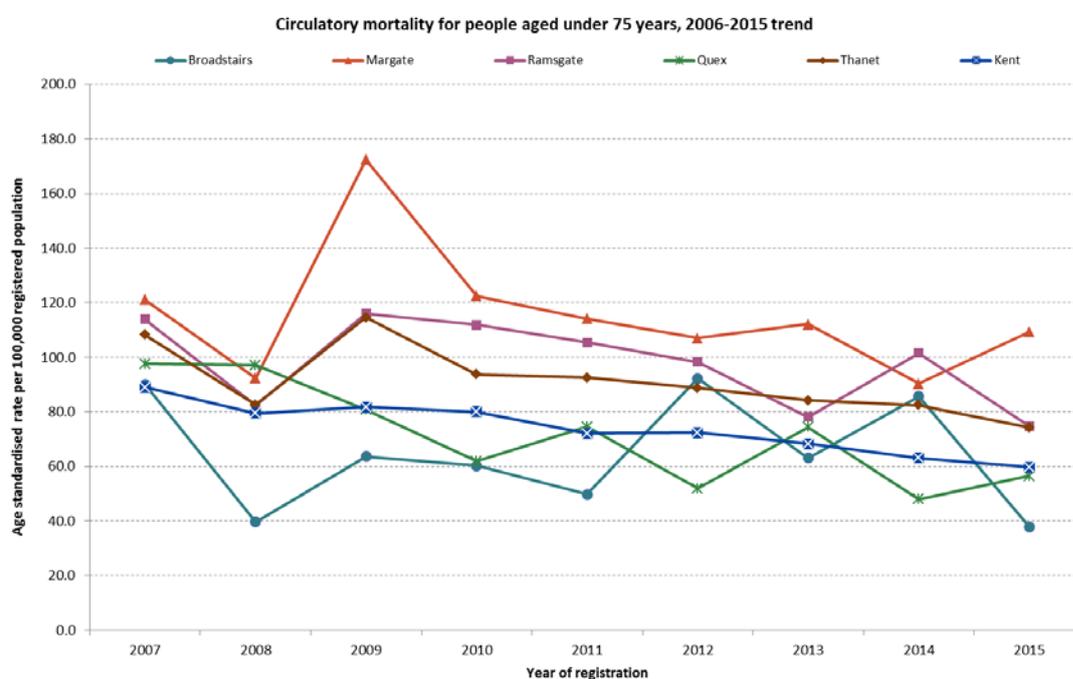


Mortality rates have remained at a similar level in all localities, Thanet as a whole and Kent from 2007 to 2015. The Ramsgate locality was recorded as 143.3 per 100,000 population in 2015, which is not statistically significantly different to the 141.0 recorded for Thanet or Kent (134.1).

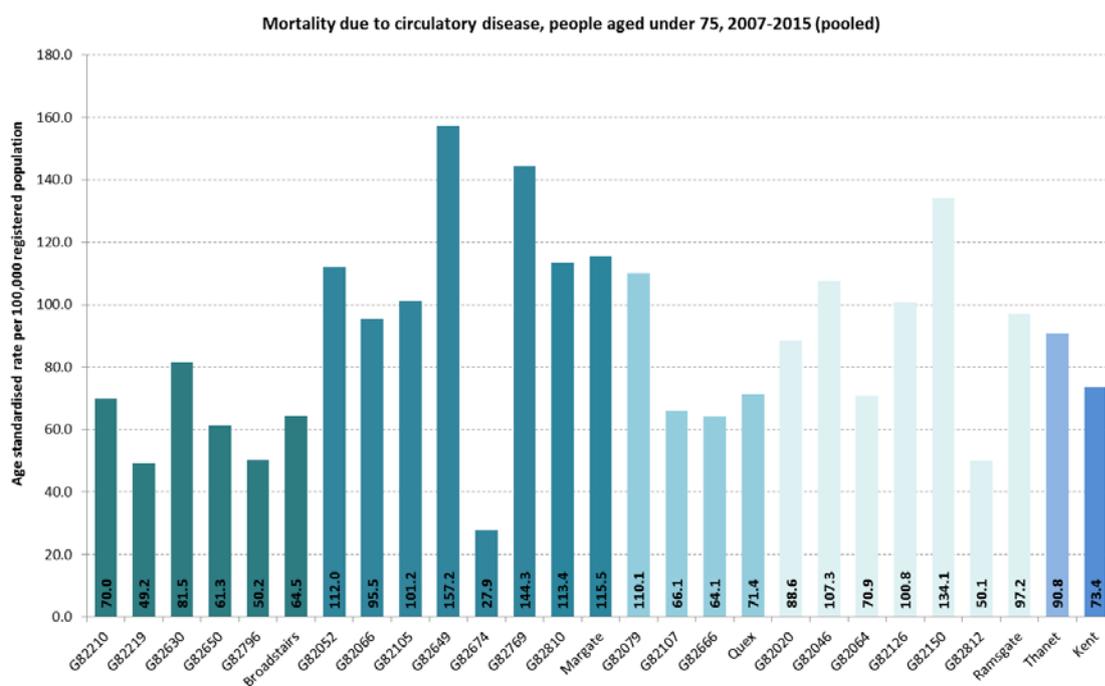


GP-level mortality rates in Ramsgate vary from 133.0 per 100,000 population to 183.4.

10.2 Circulatory (under 75)

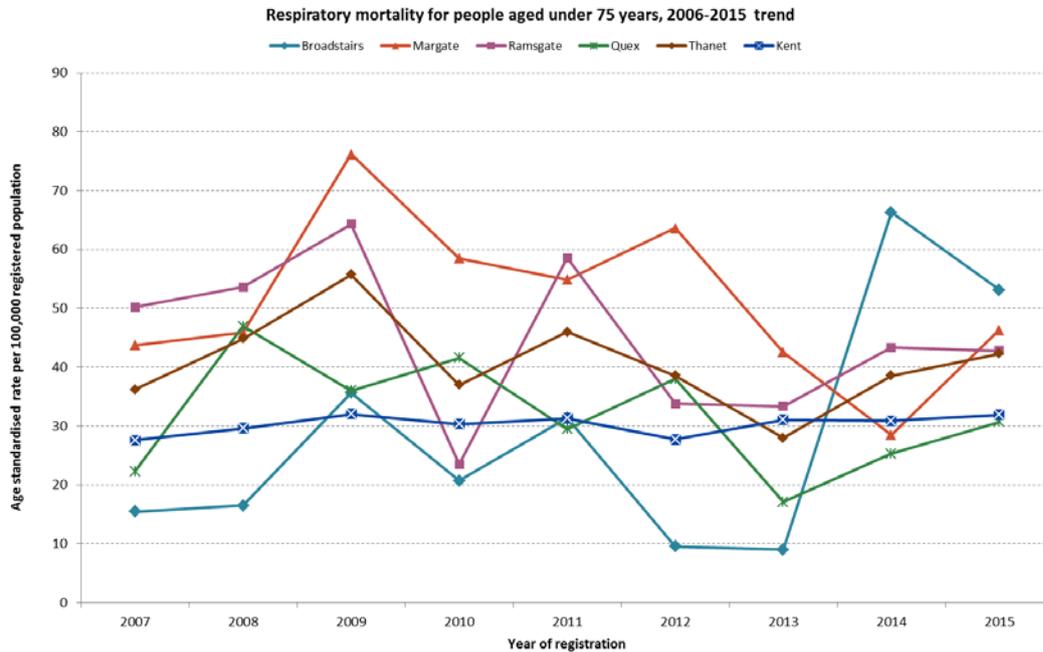


Premature mortality rates for circulatory disease in Thanet have decreased between 2007 and 2015. The Ramsgate locality (74.7 per 100,000 population) is similar to the Thanet average (74.2).



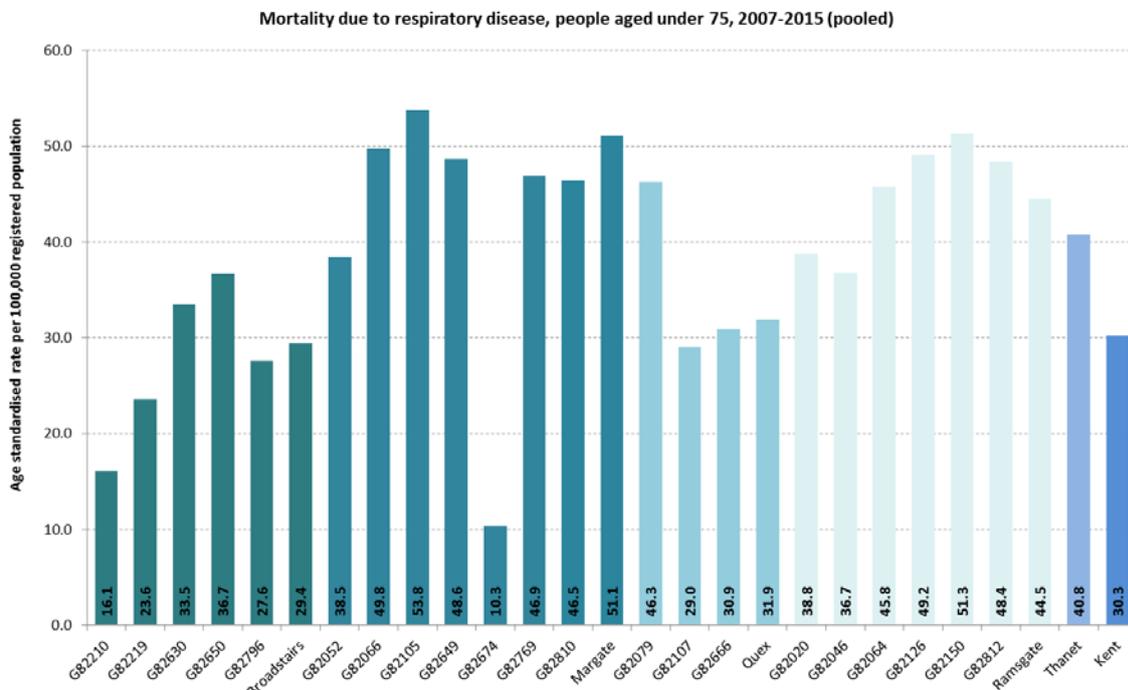
GP-level mortality rates in Ramsgate vary from 50.1 per 100,000 population to 134.1.

10.3 Respiratory (under 75)



Source: PCMD, PCIS, prepared by KPHO (LLY), 01/17

There is substantial variation year-on-year in premature mortality rates from respiratory conditions both at locality and Thanet level. There is no statistically significant difference in premature mortality rates between 2007 and 2015.



Source: PCMD, PCIS, prepared by KPHO (LLY), 01/17. General practices: G82210, G82630, G82674, G82769, G82810 and G82812 have closed since 2015. General practice G82810 closed but was taken over by The Limes Medical Practice and is now known as The Limes Surgery (Garlinge Site).

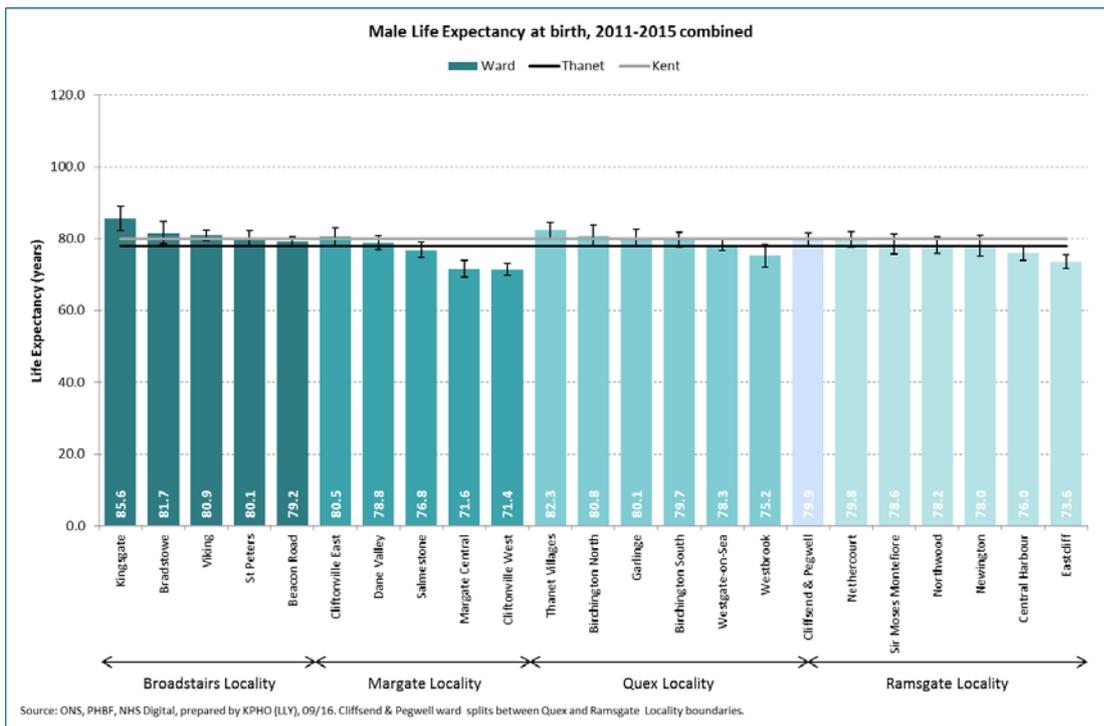
GP-level mortality rates in Ramsgate vary from 36.7 per 100,000 population to 51.3.

11. Life Expectancy

The life expectancy of Thanet CCG residents at birth has been calculated using pooled data from 2011 to 2015.

11.1 Male Life Expectancy

Male life expectancy within the Ramsgate locality ranges from 73.6 years in Eastcliff to 79.9 years in Cliffsend and Pegwell. Within the Ramsgate locality only Eastcliff has an estimated life expectancy significantly lower than the Thanet average.



11.2 Female Life Expectancy

Female life expectancy is higher compared with males. Female life expectancy within the Ramsgate locality ranges from 81.0 years in Newington to 85.2 years in Nethercourt.

