__Index - Investment, jobs and regeneration.pdf

i. **Investment, jobs and regeneration.pdf**

- **Jobs** – These high quality jobs, many with career structures are desperately needed – a quarter of the new unemployment in the last year was in Thanet.
- **East Kent and Thanet in particular are very deprived areas**, and the investment and jobs will help greatly.
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TR020002 – Manston Airport - Written Representation Ref:20011948

Investment, Jobs and Regeneration

Socio-Economic Issues SEi, SEiii, SEiv, SE v, SE vi, SE viii.

Introduction

I am writing as Vice Chair of Save Manston Airport Association, which supports the RSP DCO application in full, and as such agree with all aspects of the application [APP-001 to APP-087].

Save Manston Airport Association (SMAa) are working with the applicant and Kent Needs Manston Airport (KNMA) to find the best ways of providing the appropriate training and education to enable as many local people as possible to be employed. KNMA will be submitting a detailed Written Representation concerning the training aspects. SMAa, through this Written Representation, will concentrate on the educational opportunities presented by the application.

Data, methodology and assumptions

I have tried to access information/data from reputable sources and quoted relevant passages using quotation marks. In each case I have used a footnote which indicates the name of the relevant appendix and, where possible the page number, paragraph or table/figure number. I have then submitted these appendices as PDF attachments. In some cases, such as data from web pages I have taken screenshots and then converted to PDFs.

If I have referred to documents in the Examination Library, I used the appropriate document reference from the EL and put it in square brackets with a footnote. The footnote will indicate the relevant page number and paragraph number, table, diagram or figure where possible.

N.B. Some documents, for example audio recordings, are not yet in the EL so I have used their full name in the footnote with the approximate start time indicated.

I have tried to avoid using assumptions by applying the methods described above but on occasions I have used my personal experience as a teacher of 34 years.

I would also like to thank other members of SMAa for their contributions towards this document.

Executive Summary

Evidence makes it clear that Thanet continues to be the most deprived local authority[1] in Kent and has the highest 18-24 year old unemployment in the South East. The situation is not much better in Canterbury, Dover and Swale. [2]

The majority of enterprises in East Kent employ 0-4 people and very few employ over 250 people.[3] A reopened airport, by the applicant, will be a significant employer in the area even by year two of operation.[4]

This application brings real hope to the area because it will be transformational in so many ways. It will give employment prospects for many hundreds of local people in a wide range of jobs, with many being highly paid skilled jobs. This drastic fall in unemployment in Thanet and East Kent will help to reduce deprivation, improve both physical and mental health and raise life expectancy. The area will become more attractive for other investors thus increasing local employment and give a further boost to the local economy. The positive affects of a reopened airport will also be reflected by the large contribution to GDP.

[1] Appendix 1 – page 1
[2] Appendix 2 – page 2
[3] Appendix 3 – page 6 table 3 and table 4
[4] [APP – 085] – Volume IV page 28 table 4

Background

a) Deprivation

According to figures produced by the Office for National Statistics (ONS) and published by Kent County Council (KCC) looking into the index of multiple deprivation (2015):

"Thanet continues to rank as the most deprived Local Authority in Kent"[5]

Out of 326 Local Authorities, Thanet is now ranked 28th, which is 21 places worse than in 2010.[6] Thanet is within the top (worst) 10% most deprived Authorities in England.

N.B. The lower the ranking number the more deprived the area.

England is divided into 32,844 Lower Super Output Areas (LSOA) each with a population of 1,500. Cliftonville West 001A (in Thanet) is 4th out of 32,844 LSOAs. Thanet has 14 LSOAs within the top 10% most deprived LSOAs in England.[7]

b) Unemployment

Using information from the Office for National Statistics Claimant Count (Dec 2018) published by KCC:

Thanet has the highest unemployment rate (in Kent) at 5.2%. That compares very poorly with the Kent figure of 2.2% and Great Britain 2.4%.[8]

The situation for the young is even worse. "Thanet has the highest 18-24 year old unemployment rate in the South East at 8.0%." In Canterbury, 1.5%, Dover 5.9%, Swale 6.1%, Kent 3.4% and Great Britain 3.2%.[9]

It is clear from the information above that Thanet and neighboring authorities desperately need jobs that are accessible to local people, particularly the young.

Referring to information from the Office for National Statistics published by KCC, it shows there are very few enterprises that employ more than 250 people:

Canterbury District 30 out of 3,990 (0.6%)
Dover District 5 out of 2,530 (0.1%)
Swale District 15 out of 3,670 (0.3%)
Thanet District 5 out of 2,935 (0.1%)[10]

In contrast most enterprises employ 0-4 people, Canterbury 75.8%, Dover 75.1%, Swale 76.1% and Thanet 75.9%.[20]

Unemployment in Kent increased by 3,875 from December 2017 to December 2018 with a quarter of that, 965, being in Thanet alone. Thanet desperately needs jobs.

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[5] Appendix 1 – page 1
[6] Appendix 1 – page 3 table 2
[7] Appendix 1 – page 4
[8] Appendix 2 – page 1
[9] Appendix 2 – page 2
[10] Appendix 3 – page 6 table 3 and table 4

By any standard, a reopened airport will be a very significant enterprise with the number of jobs projected. By year two, direct jobs projected by the applicant (856) will exceed the 250-job threshold making it one of the major employers in the area. [11]

Table 4 Forecast job creation

	Freight tonnage	Passenger numbers	Direct jobs	Indirect/ induced jobs	Catalytic jobs	Total job creation
Y1	0	0	116	0	0	**116**
Y2	96,553	0	856	1,542	0	**2,398**
Y3	108,553	662,768	1,551	2,791	6,203	**10,545**
Y4	167,092	679,868	2,085	3,753	8,341	**14,179**
Y5	173,741	686,672	2,150	3,870	8,601	**14,621**
Y6	181,436	965,295	2,466	4,438	9,862	**16,766**
Y7	192,908	975,591	2,576	4,638	10,306	**17,520**
Y8	200,673	975,591	2,645	4,762	10,581	**17,988**
Y9	203,245	975,591	2,668	4,803	10,673	**18,143**
Y10	212,351	975,591	2,749	4,948	10,996	**18,693**
Y11	222,377	1,011,587	2,812	5,062	11,249	**19,124**
Y12	234,508	1,049,022	2,890	5,202	11,561	**19,653**
Y13	244,690	1,087,954	2,947	5,305	11,789	**20,042**
Y14	256,989	1,128,444	3,018	5,432	12,072	**20,522**
Y15	270,579	1,170,553	3,094	5,570	12,378	**21,042**
Y16	283,904	1,214,347	3,164	5,695	12,656	**21,515**
Y17	296,594	1,259,892	3,224	5,802	12,894	**21,920**
Y18	312,344	1,307,259	3,301	5,942	13,205	**22,448**
Y19	324,838	1,356,521	3,349	6,029	13,397	**22,775**
Y20	340,758	1,407,753	3,417	6,151	13,668	**23,235**

[11] [APP – 085] – Volume IV page 28 table 4

Diversity of Jobs

Airports provide employment for large numbers of people both directly and indirectly in a wide variety of roles. At a reopened Manston the following is projected:[12]

- Pax – passenger services
- Frei't – Freight services
- ATS – Air Traffic Services
- RFFS – Rescue and Fire Fighting Services
- Ops – Airport operations
- Maint – Maintenance
- MT- Motor Transport
- Sec – Site and freight security
- Adm – Administration

Estimated job creation by the Manston Airport operator by function

	Pax	Frei't	ATS	RFFS	Ops	Maint	MT	Sec	Adm	Total
Y1	0	49	6	14	6	8	8	11	14	**116**
Y2	0	196	25	57	24	31	31	45	14	**423**
Y3	99	215	25	57	29	38	38	55	15	**571**
Y4	102	302	25	57	31	41	41	59	15	**673**
Y5	103	322	25	57	32	41	41	60	16	**697**
Y6	145	256	25	57	33	43	43	62	16	**680**
Y7	146	288	25	57	33	43	43	63	16	**714**
Y8	146	307	25	57	33	43	43	63	16	**733**
Y9	146	357	25	57	34	44	44	64	16	**787**
Y10	146	331	25	57	34	44	44	64	16	**761**
Y11	152	347	25	57	34	44	44	64	16	**783**
Y12	157	361	25	57	34	45	45	65	16	**805**
Y13	163	376	25	57	35	45	45	66	16	**828**
Y14	169	391	25	57	35	46	46	67	16	**852**
Y15	176	413	25	57	36	46	46	68	16	**883**
Y16	182	430	25	57	36	47	47	68	16	**908**
Y17	189	447	25	57	36	47	47	69	16	**933**
Y18	196	469	25	57	37	48	48	70	17	**967**
Y19	203	488	25	57	37	48	48	71	17	**994**
Y20	211	507	25	57	38	49	49	71	17	**1,024**

The diversity of roles available means that there is something to suit all abilities and, coupled with the appropriate education and training, will be transformational for the area. It will give local people real hope that they can obtain a worthwhile, well-paid job right on their doorstep.

[12] [APP – 085] – Volume IV page 30 table 6

Many of the jobs will be high quality with clearly defined career structures to enable progression within the industry. For an area of such high unemployment and deprivation the beneficial effect of a reopened airport cannot be over emphasised.

Not only will there be direct jobs available but airports generate indirect jobs:

"5.1.2 Indirect employment includes jobs in the supply chain such as wholesalers providing food for in-flight catering, aviation fuel supply, travel agents, cleaning and maintenance contractors, for example. Induced employment covers a wide range of jobs created as a result of those connected to the airport spending their income in the local or national economy."[13]

With more local people in employment spending their money locally the knock on effect to Thanet and East Kent will be extremely positive. Businesses seemingly unrelated to the airport will benefit from the upturn in the local economy. This in turn will encourage further investment in an area that will be seen as up and coming.

Effect on the Local Economy

A reopened airport will have an affect on both GDP and GVA. Within 5 years it is projected that direct jobs will contribute between £1,000,000 and £150,000,000 towards GDP. [14] In terms of GVA:

"8.1.8 In order to estimate GVA from Manston Airport's operations, the Stansted Airport figure, as used in their March 2018 Planning Application, has been applied (RPS, 2018). GVA per person in employment for the Stansted Airport operational study area was shown to be £60,500 (RPS, 2018, section 11.59). Applying this figure to the Manston direct job forecast only would generate GVA of £166 million in Year 10 and almost £207 million in Year 20."[15]

What other businesses in Thanet and East Kent generate these kind of figures?

Deprivation, Unemployment and Health

There have been many studies done over the years looking at the relationship between deprivation, unemployment and health:

"Unemployment affects both physical and mental health and is an important determinant of health inequalities in adults of working age. Unemployed people have a higher risk of morbidity and premature mortality. They also have a higher risk of lower levels of psychological wellbeing ranging from symptoms of depression and anxiety to self-harm and suicide. Unemployment affects family income levels that impact on other health determinants, for example, housing and nutrition."[16]

"There is a social gradient in lifespan; people living in the most deprived areas in England have on average the lowest life expectancy and conversely, life expectancy is higher on average for those living in areas with lower deprivation. Males living in the most deprived tenth of areas can

[13] [APP – 085] – Volume IV page 27
[14] [APP – 085] – Volume IV page 51 table 11
[15] [APP – 085] – Volume IV page 50
[16] Health Impacts of Employment – page 27

expect to live 9 fewer years compared with the least deprived tenth, and females can expect to live 7 fewer years."[17]

However, it is not just physical health that is affected by deprivation and sustained unemployment but also mental health:

"Major risk factors for mental health problems include poverty, poor education, unemployment, social isolation/exclusion and major life events. A review of large-scale studies of mental health problems reported that such problems are more common among people who are unemployed, have fewer educational qualifications, have been looked after or accommodated, are on a low income or have a low standard of living."[18]

Since Thanet is the most deprived Local Authority in Kent and has 14 of the most deprived LSOAs within the (worst) top 10% most deprived LSOAs in England,[19] it follows that the physical health, mental health and life expectancy within Thanet will be greatly affected. A reopened airport will reduce unemployment levels, reduce deprivation in Thanet and will improve the health and wellbeing of the Thanet population.

It could, possibly, also have a knock on effect on the ability of Local Health trusts to attract and retain staff and this is an area that is covered in another document "Estimates of significance of RSP funding to local healthcare" which is part of the overall SMAa submission.

Investment and Viability

The proposed increase in stands and hangerage at Manston will make a huge difference to the viability of the site.

One of the main reasons that the site was not used to its full potential was the lack of investment...The proposed £300 plus Millions by RSP, is something that was never available prior to 2014.

The increase in Cargo Stands (19 by year 20)[20], will permit a lot of Aircraft to be handled during operating hours 07:00 - 23:00, thus negating the need for Night Flights, which everyone wants to avoid if possible. The Aircraft can be serviced, unloaded and reloaded overnight, ready for the next day. This of course adds to the job creation so badly needed.

Most other UK Airports have insufficient stands reserved primarily for Freight Aircraft, which is a contributing reason why those Airports use Night Flights so much. Manston, being designed and purpose-built primarily as a Freight Hub will be very attractive to operators with quick turnarounds, and more available "slots".

As we get closer to Brexit, this massive investment in reopening Manston airport will enable high value and /or time critical goods to be moved to and from the emerging markets such as the Far East, South Africa and South America.

SMAa firmly supports the application by RSP to reopen Manston Airport.

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[17] Inequality in Health – page 1
[18] Mental Health and deprivation – page 1
[19] Appendix 1 – page 4
[20] [APP – 012] – page 2

The English Index of Multiple Deprivation (IMD 2015): Headline findings for Kent

Related information

The Deprivation and Poverty web page contains more information which you may find useful.

- *Fuel poverty*
- *Households in poverty*
- *Children in Poverty*
- *Homelessness*
- *Unemployment and benefits claimants*

***NOTE**: within this bulletin 'Kent' refers to the Kent County Council (KCC) area which excludes Medway*

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The English Index of Multiple Deprivation 2015 (IMD2015) was released 30 September 2015 by The Department for Communities and Local Government. This bulletin presents the initial findings for Kent.

Summary

- On the National rank of the IMD2015 Kent is ranked at 100th out of 152 Counties and Unitary Authorities in England. This places Kent within the least deprived 50% of all counties and unitary authorities in England.
- Within the 19 Counties and Local Authorities in the South East, Kent is ranked at 9. This places Kent just within the most deprived 50% of all Counties and Unitary Authorities in the South East.
- The level of deprivation in eight out of 12 Kent local authority districts has increased since ID2010 relative to other areas in England.
- Thanet continues to rank as the most deprived local authority in Kent.
- Tunbridge Wells ranks as the least deprived local authority in Kent
- Ashford and Swale have experienced the largest increase in deprivation relative to other areas.
- Tunbridge Wells has experienced the largest decrease in deprivation relative to other areas.

Introduction

The Index of Multiple Deprivation 2015 (IMD 2015) is the official measure of relative deprivation for small areas (or neighbourhoods) in England.

The IMD ranks every small area in England from 1 (most deprived area) to 32,844 (least deprived area).

The small areas used are called Lower-layer Super Output Areas, of which there are 32,844 in England. They are designed to be of a similar population size with an average of 1,500 residents each and are a standard way of dividing up the country. They do not have descriptive place names (in the way that local wards do), but are named in a format beginning with the name of the local authority district followed by a 4 character code eg Ashford 001A.

It is common to describe how relatively deprived a small area is by saying whether it falls among the most deprived 10 per cent, 20 per cent or 30 per cent of small areas in England (although there is no definitive cut-off at which an area is described as 'deprived').

To help with this, deprivation 'deciles' are published alongside ranks. Deciles are calculated by ranking the 32,844 small areas in England from most deprived to least deprived and dividing them into 10 equal groups. These range from the most deprived 10 per cent of small areas nationally to the least deprived 10 per cent of small areas nationally.

The Index of Multiple Deprivation is part of the Indices of Deprivation and it is the most widely used of these indices. It combines information from seven domain indices (which measure different types or dimensions of deprivation) to produce an overall relative measure of deprivation. You can use the domain indices on their own to focus on specific aspects of deprivation. There are also supplementary indices concerned with income deprivation among children (IDACI) and older people (IDAOPI).

The Index of Multiple Deprivation is designed primarily to be a *small-area* measure of deprivation. But the Indices are commonly used to describe deprivation for higher-level geographies including local authority districts. A range of summary measures are available allowing you to see where, for example, a local authority district is ranked between 1 (the most deprived district in England) and 326 (the least deprived district in England). Summary measures are also available for upper tier local authorities, local enterprise partnerships and clinical commissioning groups.

All of the Indices of Deprivation measure relative deprivation at small area level as accurately as possible, but they are not designed to provide 'backwards' comparability with previous versions of the Indices (2010, 2007, 2004 and 2000). However, because there is a broadly consistent methodology between the Indices of Deprivation 2015 and previous versions, you can compare the rankings as determined at the relevant time point by each of the versions.

When looking at changes in deprivation between the Indices of Deprivation 2015 and previous versions, users should therefore be aware that changes can only be described in relative terms, for example, the extent to which an area has changed rank or decile of deprivation.

This bulletin presents the IMD 2015 for Kent, Kent local authorities and the 10% most deprived LSOAs in Kent. A comparison with the IMD2010 (and IMD2007 at County level) is also presented.

County Level

The overall IMD2015 ranks Kent at 100 out of 152 local authorities in England This places Kent within the least 50% deprived local authorities in England.

This position is two places higher than the IMD2010 and six places higher than the IMD2007 which indicates that Kent has become more deprived in 2015 relative to all other areas.

Kent's position amongst the local authorities within the South East region is nine out of 19. This position has not changed between the IMD2007 and IMD2010. This places Kent just within the 50% most deprived areas in the region.

Table 1: South East Counties and Unitary Authorities by national and regional ranks: IMD2007, IMD2010, IMD2015

South East Counties and Unitary Authorities by national and regional ranks: IMD2007, IMD2010, and IMD2015
Source: Indices of Deprivation 2007; 2010; and 2015 Communities and Local Government
Table presented by Strategic Business Development & Intelligence, Kent county Council
A rank of 1 is the most deprived

	IMD2007		IMD2010		IMD2015		Change in rank* 2010 to 2015	
Authority	National rank (out of 152)	South East rank (out of 19)	National rank (out of 152)	South East rank (out of 19)	National rank (out of 152)	South East rank (out of 19)	National position	South East position
Portsmouth U.A.	67	3	60	2	50	1	10	1
Southampton U.A.	66	2	65	3	54	2	11	1
Brighton and Hove U.A.	59	1	53	1	74	3	-21	-2
Isle of Wight U.A.	88	5	86	5	76	4	10	1
Slough U.A.	79	4	69	4	78	5	-9	-1
Medway U.A.	92	6	88	7	81	6	7	1
Reading U.A.	94	7	87	6	93	7	-6	-1
East Sussex	95	8	90	8	99	8	-9	0
Kent	**106**	9	**102**	9	**100**	9	**2**	0
Milton Keynes	118	10	119	10	106	10	13	0
West Sussex	132	11	130	11	131	11	-1	0
Hampshire	141	13	141	13	141	12	0	1
Oxfordshire	139	12	135	12	142	13	-7	-1
Bracknell Forest U.A.	147	15	148	16	145	14	3	2
West Berkshire U.A.	149	17	147	15	146	15	1	0
Buckinghamshire	146	14	145	14	148	16	-3	-2
Surrey	150	18	150	18	150	17	0	1
Windsor & Maidenhead U.A.	148	16	149	17	151	18	-2	-1
Wokingham U.A.	152	19	152	19	152	19	0	0

Table sorted by ID2015 lowest rank

* A minus change in rank illustrates that an area has moved down the rankings and is therefore less deprived in ID2015 than ID2010 relative to other areas

*A positive change in rank illustrates an area is more deprived in ID2015 than ID2010 relative to other areas

Local Authority Level

Thanet was the most deprived local authority in the IMD2010 and remains Kent's most deprived local authority district in IMD2015. Nationally, Thanet is ranked at 21 out of 326 authorities placing it within England's 10% most deprived of authorities.

Kent's least deprived local authority district in the IMD2015 is Tunbridge Wells with a rank of 282 out of 326 authorities. This rank places Tunbridge Wells within the least 20% deprived areas in England.

Deprivation levels have increased in eight out of the 12 local authority districts relative to all other areas between IMD2010 and IMD2015.

Ashford and Swale have seen the greatest change in national rank, both moving up 22 places between 2010 and 2015. This indicates that these areas are more deprived in 2015 than in 2010 relative to all other local authorities in England.

Canterbury, Shepway, Tonbridge & Malling and Tunbridge Wells have all moved down in the rankings which indicates that levels of deprivation have reduced between 2010 and 2015 relative to other local authorities in England.

Table 2: Kent Local Authorities by national and Kent ranks: IMD2010, IMD2015

Kent local authorities by national and Kent ranks: IMD2010 and IMD2015

Source: Indices of Deprivation 2010 and 2015, Communities and Local Government
Table presented by Strategic Business Development & Intelligence, Kent county Council
A rank of 1 is the most deprived

	IMD2010			IMD2015			Change in rank* 2010 to 2015	
Authority	IMD2010 national rank (out of 326)	Kent Rank (out of 12)		IMD2015 national rank (out of 326)	Kent Rank (out of 12)		National position	Kent position
Thanet	49	1		28	1		21	0
Swale	99	3		77	2		22	1
Shepway	97	2		113	3		-16	-1
Gravesham	142	5		124	4		18	1
Dover	127	4		126	5		1	-1
Dartford	175	7		170	6		5	1
Ashford	198	8		176	7		22	1
Canterbury	166	6		183	8		-17	-2
Maidstone	217	9		198	9		19	0
Sevenoaks	276	12		268	10		8	2
Tonbridge & Malling	268	11		274	11		-6	0
Tunbridge Wells	249	10		282	12		-33	-2

Table ranked by highest IMD 2015 Score

* A minus change in rank illustrates that a district has moved down the rankings and is therefore now less deprived relative to other areas in England.

*A positive change in rank illustrates an area is more deprived in ID2015 thank ID2010 relative to other areas

Deprivation at small area level in Kent's Lower Super Output Areas

Kent has 902 Lower Super Output Areas, 51 (6%) fall within the top 10% most deprived LSOAs in England in the IMD2015. In the IMD2010 the number of LSOAs within the most deprived 10% nationally was 32 (4%).

These LSOAs are spread within seven of Kent's local authorities with Thanet having the highest number and proportion of LSOA within the top10% most deprived LSOAs in England.

Ashford, Canterbury, Sevenoaks, Tonbridge & Malling and Tunbridge Wells do not have any LSOAs ranked within the top 10% most deprived in England.

Table 3: The number and proportion of LSOAs in Kent Authorities within the 10% most deprived Lower Super Output Areas in England

IMD2015 Number and proportion of LSOAs in Kent authorities within the top 10% most deprived in England

Source: Indices of Deprivation 2010 and 2015, Communities and Local Government
Table presented by Strategic Business Development & Intelligence, Kent county Council

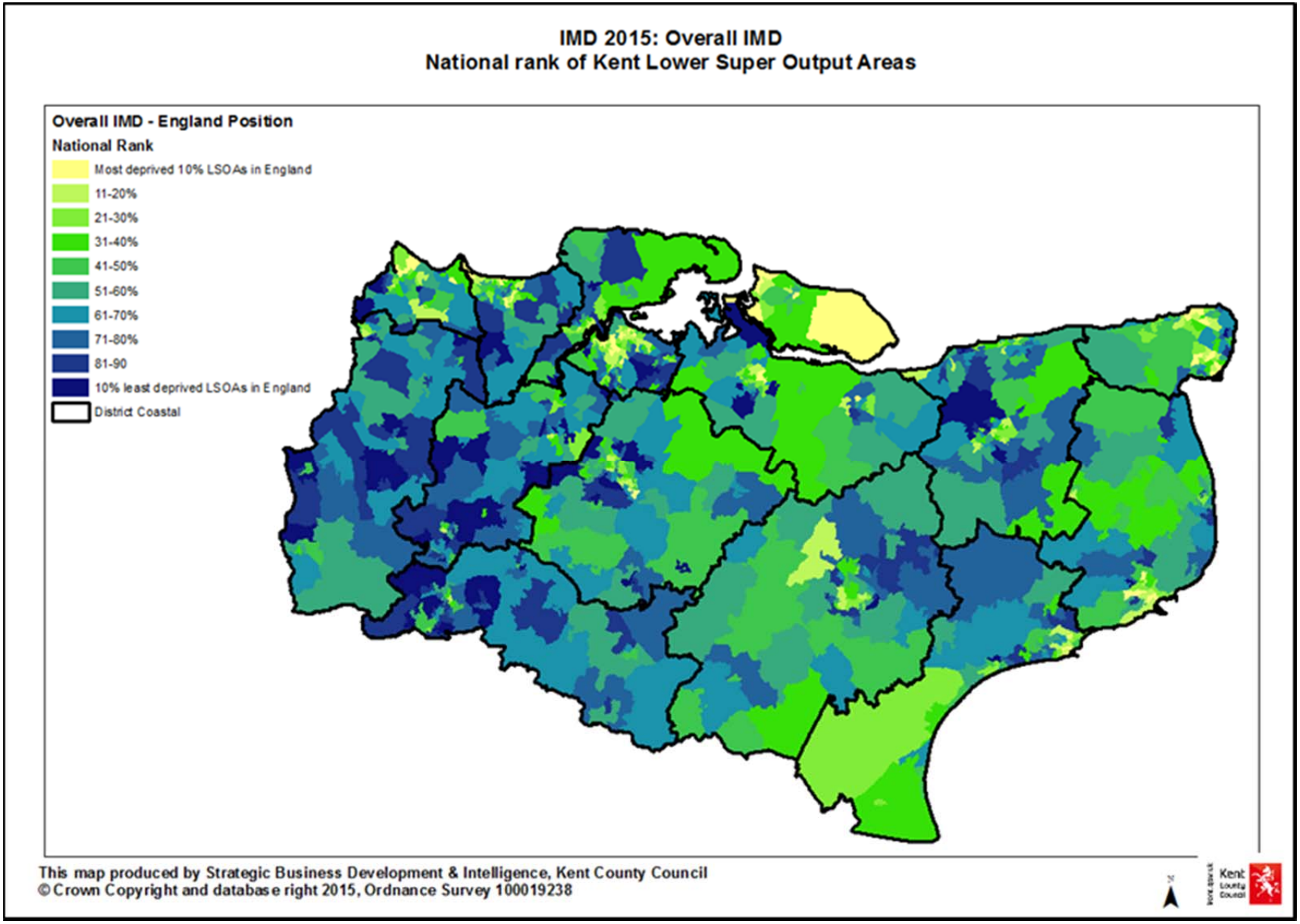
Authority	Total LSOAs in each Local Authority	Top 10% most deprived National Rank:IMD 2010			Top 10% most deprived National Rank:IMD 2015			Change
		Number of LSOAs	%		Number of LSOAs	%		Number of LSOAs
Thanet	84	14	*16%*		18	*20%*		4
Swale	85	8	*9%*		14	*16%*		6
Gravesham	64	3	*3%*		6	*7%*		3
Dover	67	1	*1%*		4	*4%*		3
Shepway	67	5	*6%*		4	*4%*		-1
Dartford	58	0	*0%*		3	*3%*		3
Maidstone	95	1	*1%*		2	*2%*		1
Canterbury	90	0	*0%*		0	*0%*		0
Ashford	78	0	*0%*		0	*0%*		0
Sevenoaks	74	0	*0%*		0	*0%*		0
Tonbridge & Malling	72	0	*0%*		0	*0%*		0
Tunbridge Wells	68	0	*0%*		0	*0%*		0
Kent	902	32	*36%*		51	*57%*		19

Table ranked by highest number of LSOAs in top 10% most deprived by IMD 2015 Score

The highest ranking LSOA in Kent is in Thanet District, within Cliftonville West ward. This LSOA is ranked 4th out of 32,844 LSOAs in England placing it within England's most deprived 1% of small areas.

The lowest ranking LSOA in Kent is in Tunbridge Wells Borough, within Speldhurst & Bidborough ward. This LSOA is ranked 32,728th out of 32,844 LSOAs in England placing it within England's most deprived 1% of small areas.

Map 1 illustrates the pattern of deprivation across Kent at LSOA level. The map shows there is an east/west divide, with the east of the county having higher levels of deprivation than the west.


IMD 2015: Overall IMD
National rank of Kent Lower Super Output Areas
Overall IMD - England Position
National Rank
Most deprived 10% LSOAs in England
11-20%
21-30%
31-40%
41-50%
51-60%
61-70%
71-80%
81-90
10% least deprived LSOAs in England
District Coastal
This map produced by Strategic Business Development & Intelligence, Kent County Council
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Kent County Council

A ward level measure of deprivation is not published as part of the official IMD2015. However, there is high demand for a ward level measure and we will issue ward level ranks based on averages of LSOA scores at a later date. Table 4 indicates the wards in which the top 10% most deprived LSOAs in Kent are situated. This table also shows the national rank and South East rank.

Table 4: The 10% most deprived Lower Super Output Areas in Kent

The 10% most deprived Lower Super Output Areas in Kent: (Rank 1 to 45 out of 90)

Source: Indices of Deprivation 2015, Communities and Local Government

A rank of 1 is the most deprived

Table presented by Strategic Business Development & Intelligence, Kent county Council

		National rank		South East rank		Kent Rank	
2011 LSOA Name	2011 Ward Name	position out of 32,844 LSOAs	Within top 10% most deprived	position out of 5,382 LSOAs	Within top 10% most deprived	Position out of 902 LSOAs	Within top 10% most deprived
Thanet 001A	Cliftonville West	4	Yes	1	Yes	1	Yes
Thanet 001E	Margate Central	21	Yes	2	Yes	2	Yes
Thanet 003A	Margate Central	35	Yes	3	Yes	3	Yes
Swale 001A	Sheerness East	46	Yes	4	Yes	4	Yes
Thanet 001D	Cliftonville West	117	Yes	7	Yes	5	Yes
Thanet 001B	Cliftonville West	233	Yes	10	Yes	6	Yes
Swale 010C	Murston	329	Yes	14	Yes	7	Yes
Swale 006A	Leysdown and Warden	366	Yes	18	Yes	8	Yes
Thanet 016D	Eastcliff	423	Yes	22	Yes	9	Yes
Thanet 006D	Dane Valley	452	Yes	24	Yes	10	Yes
Thanet 013B	Newington	486	Yes	26	Yes	11	Yes
Shepway 014A	Folkestone Harbour	572	Yes	29	Yes	12	Yes
Swale 002C	Sheerness West	626	Yes	31	Yes	13	Yes
Swale 002A	Sheerness West	674	Yes	32	Yes	14	Yes
Thanet 003E	Westbrook	692	Yes	33	Yes	15	Yes
Swale 002B	Sheerness West	739	Yes	36	Yes	16	Yes
Thanet 013E	Northwood	968	Yes	42	Yes	17	Yes
Swale 006D	Sheppey Central	1013	Yes	44	Yes	18	Yes
Swale 004E	Sheppey Central	1036	Yes	46	Yes	19	Yes
Swale 005C	Queenborough and Halfway	1053	Yes	48	Yes	20	Yes
Thanet 006E	Dane Valley	1065	Yes	52	Yes	21	Yes
Thanet 004A	Cliftonville West	1171	Yes	54	Yes	22	Yes
Shepway 014B	Folkestone Harvey Central	1343	Yes	63	Yes	23	Yes
Dover 011F	St Radigunds	1358	Yes	64	Yes	24	Yes
Swale 015D	Davington Priory	1649	Yes	74	Yes	25	Yes
Shepway 003C	Folkestone East	1751	Yes	76	Yes	26	Yes
Gravesham 011D	Singlewell	1876	Yes	81	Yes	27	Yes
Gravesham 001C	Northfleet North	1877	Yes	82	Yes	28	Yes
Dartford 001A	Joyce Green	1951	Yes	85	Yes	29	Yes
Maidstone 013A	Park Wood	1979	Yes	86	Yes	30	Yes
Gravesham 002E	Riverside	2017	Yes	89	Yes	31	Yes
Dover 012F	Castle	2065	Yes	94	Yes	32	Yes
Swale 006B	Leysdown and Warden	2109	Yes	97	Yes	33	Yes
Thanet 003D	Salmestone	2224	Yes	102	Yes	34	Yes
Swale 001B	Sheerness East	2240	Yes	104	Yes	35	Yes
Thanet 016E	Eastcliff	2319	Yes	107	Yes	36	Yes
Dover 013B	Maxton, Elms Vale and Priory	2330	Yes	108	Yes	37	Yes
Gravesham 011C	Singlewell	2533	Yes	118	Yes	38	Yes
Swale 001C	Sheerness East	2564	Yes	121	Yes	39	Yes
Thanet 013A	Newington	2633	Yes	123	Yes	40	Yes
Gravesham 007A	Westcourt	2730	Yes	128	Yes	41	Yes
Thanet 001C	Cliftonville West	2739	Yes	129	Yes	42	Yes
Thanet 016C	Central Harbour	2751	Yes	130	Yes	43	Yes
Thanet 015D	Eastcliff	2850	Yes	134	Yes	44	Yes
Maidstone 013B	Park Wood	2857	Yes	137	Yes	45	Yes

Table 4 continued: The 10% most deprived Lower Super Output Areas in Kent

The 10% most deprived Lower Super Output Areas in Kent: (Rank 46 to 90 out of 90)

Source: Indices of Deprivation 2015, Communities and Local Government

A rank of 1 is the most deprived

Table presented by Strategic Business Development & Intelligence, Kent county Council

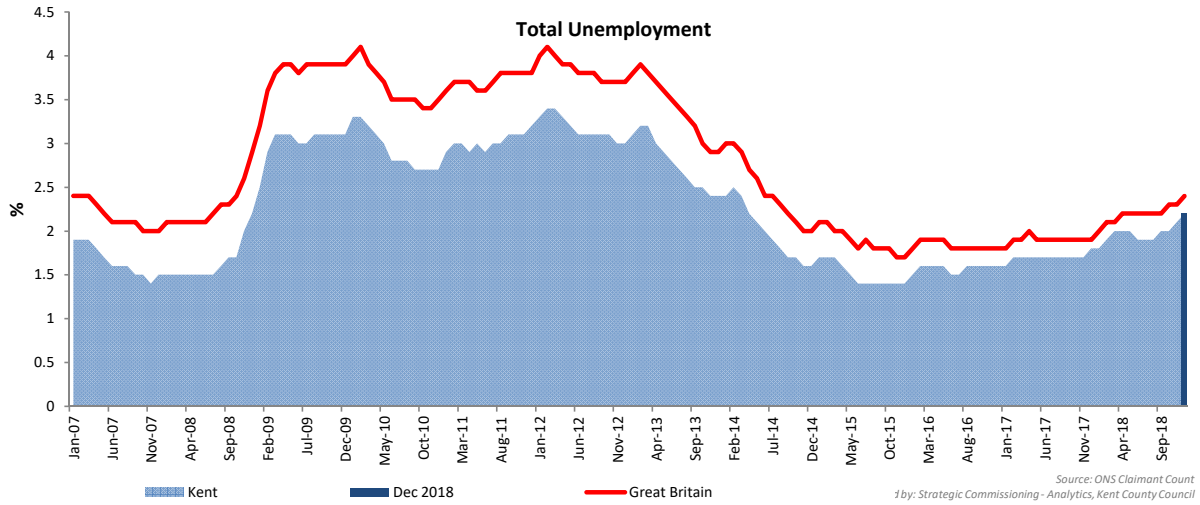
		National rank		South East rank		Kent Rank	
2011 LSOA Name	2011 Ward Name	position out of 32,844 LSOAs	Within top 10% most deprived	position out of 5,382 LSOAs	Within top 10% most deprived	Position out of 902 LSOAs	Within top 10% most deprived
Swale 001D	Sheerness East	2887	Yes	140	Yes	46	Yes
Dartford 004C	Swanscombe	3010	Yes	147	Yes	47	Yes
Dover 011D	Buckland	3071	Yes	151	Yes	48	Yes
Shepway 014D	Folkestone Harvey Central	3125	Yes	154	Yes	49	Yes
Dartford 001D	Littlebrook	3199	Yes	156	Yes	50	Yes
Gravesham 002A	Central	3222	Yes	158	Yes	51	Yes
Ashford 008C	Stanhope	3285	No	163	Yes	52	Yes
Shepway 014C	Folkestone Harvey Central	3296	No	164	Yes	53	Yes
Ashford 008B	Stanhope	3315	No	165	Yes	54	Yes
Thanet 005A	Garlinge	3332	No	167	Yes	55	Yes
Swale 002D	Sheerness West	3474	No	174	Yes	56	Yes
Swale 010B	Milton Regis	3609	No	183	Yes	57	Yes
Dover 012D	Tower Hamlets	3627	No	185	Yes	58	Yes
Thanet 006C	Dane Valley	3643	No	188	Yes	59	Yes
Canterbury 019A	Wincheap	3751	No	195	Yes	60	Yes
Maidstone 013D	Shepway South	3768	No	198	Yes	61	Yes
Thanet 012C	Sir Moses Montefiore	3779	No	199	Yes	62	Yes
Canterbury 007B	Gorrell	3814	No	202	Yes	63	Yes
Sevenoaks 002A	Swanley St Mary's	3820	No	203	Yes	64	Yes
Thanet 003B	Margate Central	3834	No	204	Yes	65	Yes
Thanet 004B	Dane Valley	3884	No	208	Yes	66	Yes
Maidstone 013E	Shepway South	3928	No	212	Yes	67	Yes
Shepway 004E	Folkestone Harbour	3953	No	214	Yes	68	Yes
Canterbury 001B	Heron	3968	No	215	Yes	69	Yes
Dover 013A	Maxton, Elms Vale and Priory	4019	No	218	Yes	70	Yes
Dover 013D	Tower Hamlets	4137	No	225	Yes	71	Yes
Dover 011A	Buckland	4155	No	226	Yes	72	Yes
Sevenoaks 002B	Swanley St Mary's	4324	No	234	Yes	73	Yes
Dover 013E	Town and Pier	4397	No	241	Yes	74	Yes
Dartford 009A	Princes	4464	No	245	Yes	75	Yes
Canterbury 001C	Heron	4469	No	246	Yes	76	Yes
Maidstone 009C	High Street	4490	No	249	Yes	77	Yes
Gravesham 002F	Pelham	4555	No	253	Yes	78	Yes
Canterbury 009D	Seasalter	4715	No	263	Yes	79	Yes
Canterbury 001A	Heron	4726	No	266	Yes	80	Yes
Dover 011H	Tower Hamlets	4848	No	271	Yes	81	Yes
Canterbury 011A	Northgate	4869	No	273	Yes	82	Yes
Shepway 003A	Folkestone East	4936	No	279	Yes	83	Yes
Thanet 016A	Central Harbour	5057	No	288	Yes	84	Yes
Ashford 007F	Victoria	5083	No	290	Yes	85	Yes
Shepway 004B	Folkestone Foord	5084	No	291	Yes	86	Yes
Ashford 005A	Aylesford Green	5117	No	294	Yes	87	Yes
Dover 006C	Aylesham	5134	No	296	Yes	88	Yes
Swale 014F	Watling	5242	No	301	Yes	89	Yes
Swale 003A	Minster Cliffs	5251	No	302	Yes	90	Yes

Further information about the English Indices of Deprivation can be found from the Department for Communities and Local Government website

Unemployment in Kent

Last updated: 22 Jan 2019

Using information from the Office for National Statistics Claimant Count this bulletin looks at the total number of people claiming either Jobseekers Allowance or Universal Credit **principally for the reason of being unemployed**. It also looks at the age profile of claimants, in particular at youth unemployment which is defined as those aged 18 to 24.



	Dec 2018		Change since Nov 2018		Change since Dec 2017	
Unemployment	**Number**	**% Rate**	**Number**	**%**	**Number**	**%**
Kent	20,400	2.2%	550	2.8%	3,875	23.4%
Great Britain	956,745	2.4%	19,485	2.1%	184,150	23.8%

	Dec 2018		Change since Nov 2018		Change since Dec 2017	
	Number	**% Rate**	**Number**	**%**	**Number**	**%**
Ashford	1,710	2.2%	70	4.3%	410	31.5%
Canterbury	1,850	1.8%	140	8.2%	495	36.5%
Dartford	930	1.4%	70	8.1%	165	21.6%
Dover	2,405	3.5%	70	3.0%	470	24.3%
Folkestone & Hythe	1,885	2.9%	65	3.6%	445	30.9%
Gravesham	1,595	2.4%	15	0.9%	260	19.5%
Maidstone	1,180	1.1%	0	0.0%	-30	-2.5%
Sevenoaks	575	0.8%	60	11.7%	45	8.5%
Swale	2,780	3.1%	5	0.2%	805	40.8%
Thanet	4,275	5.2%	65	1.5%	965	29.2%
Tonbridge and Malling	660	0.8%	5	0.8%	-90	-12.0%
Tunbridge Wells	555	0.8%	-15	-2.6%	-65	-10.5%
Medway	4,145	2.3%	230	5.9%	880	27.0%
Kent	20,400	2.2%	550	2.8%	3,875	23.4%

Kent unemployment headlines December 2018

The unemployment rate in Kent is 2.2%. This is below the rate for Great Britain (2.4%).

20,400 people were claiming unemployment benefits in Kent.This has increased since last month.

Thanet has the highest unemployment rate at 5.2%. Sevenoaks has the lowest unemployment rate at 0.8%.

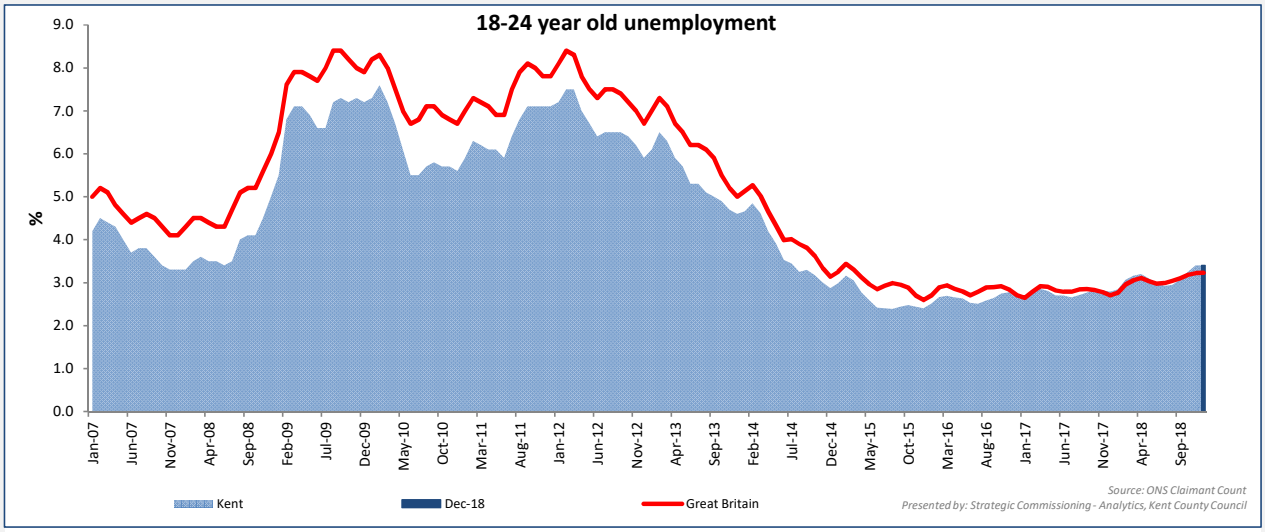
The 18-24 year old unemployment rate in Kent is 3.4%. They account for 21.1% of all unemployed people in the area

Thanet has the highest 18-24 year old unemployment rate in the South East at 8%.

Unemployment by age group

Kent	Dec 2018		Change since Nov 2018		Change since Dec 2017	
	Number	%	Number	%	Number	%
18-24	4,305	3.4%	5	0.1%	780	22.1%
25-49	10,335	2.1%	380	3.8%	2,150	26.3%
50-64	5,705	1.9%	165	3.0%	920	19.2%

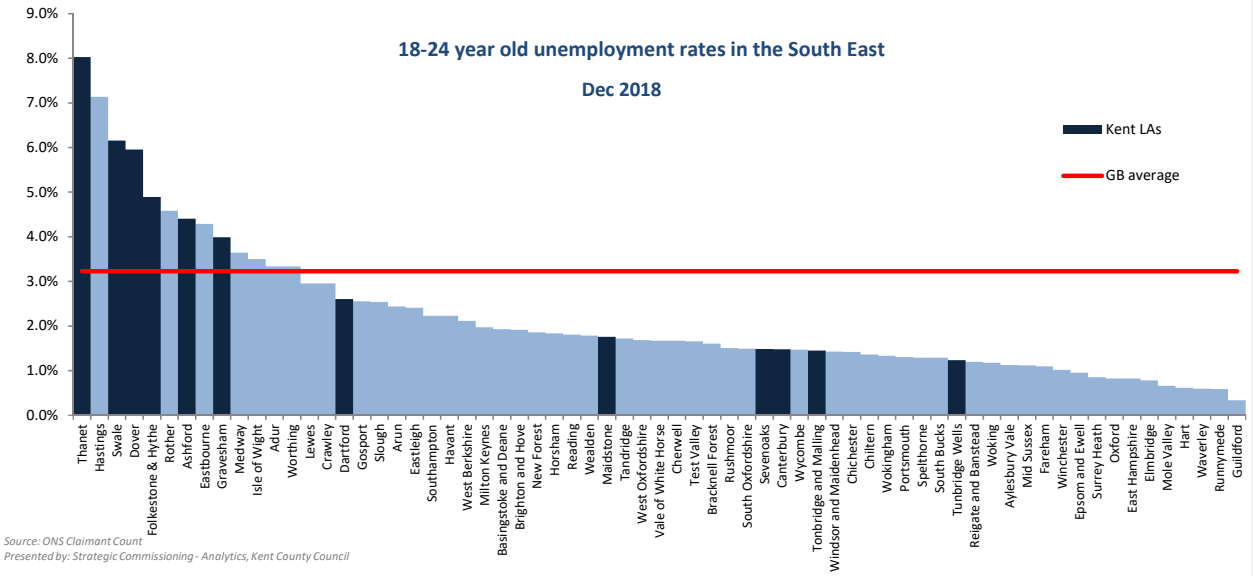
December 2018	Number			Rate		
	18-24	25-49	50-64	18-24	25-49	50-64
Ashford	395	835	470	4.4%	2.1%	1.9%
Canterbury	410	925	510	1.5%	2.0%	1.8%
Dartford	200	515	210	2.6%	1.3%	1.1%
Dover	500	1200	695	5.9%	3.7%	2.8%
Folkestone & Hythe	375	915	595	4.9%	2.8%	2.6%
Gravesham	320	825	445	4.0%	2.3%	2.3%
Maidstone	210	625	340	1.8%	1.1%	1.1%
Sevenoaks	110	280	180	1.5%	0.8%	0.7%
Swale	705	1340	730	6.1%	2.9%	2.5%
Thanet	860	2275	1140	8.0%	5.7%	4.1%
Tonbridge and Malling	130	315	215	1.4%	0.8%	0.9%
Tunbridge Wells	90	290	170	1.2%	0.8%	0.7%
Kent	4305	10335	5705	3.4%	2.1%	1.9%
Medway	885	2195	1055	3.6%	2.3%	2.1%

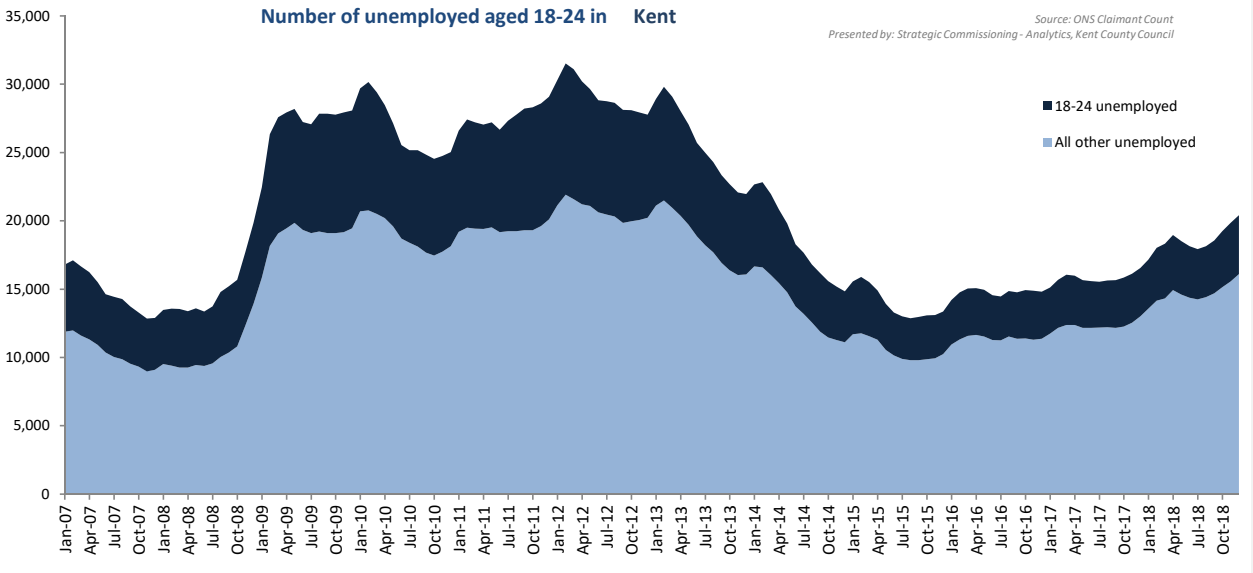


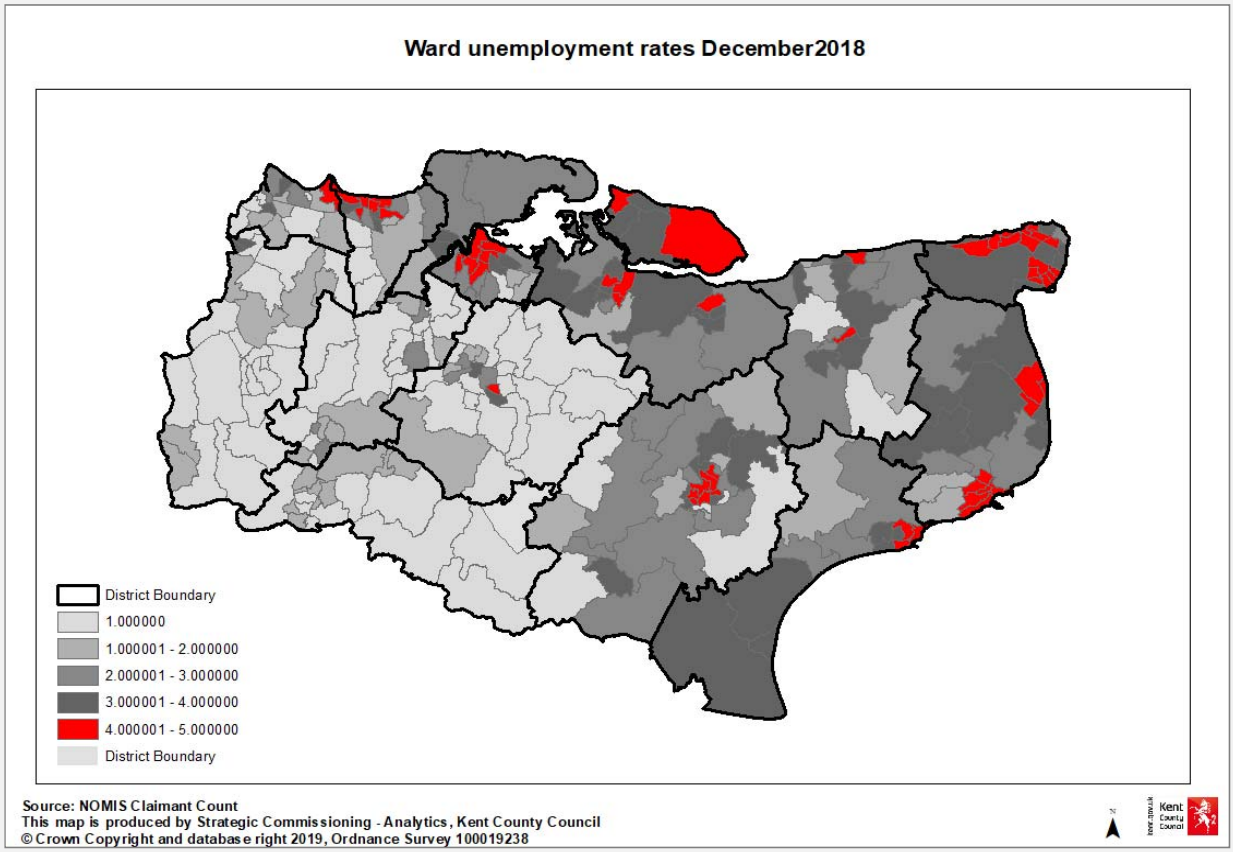
18-24 Unemployment	Number	Rate	Change since Nov 2018 Number	Change since Nov 2018 %	Change since Dec 2017 Number	Change since Dec 2017 %
Kent	4,305	3.4%	5	0.1%	780	22.1%
Great Britain	180,715	3.2%	385	0.2%	29,135	19.2%

Unemployment by age group - % of all unemployed

December 2018	Kent		Great Britain	
	Number	% of all unemployed	Number	% of all unemployed
18-24	4,305	21.1%	180,715	18.9%
25-49	10,335	50.7%	519,815	54.3%
50-64	5,705	28.0%	253,250	26.5%







This workbook looks at the total number of people claiming either Jobseekers Allowance or Universal Credit principally for the reason of being unemployed. It also looks at the age profile of claimants, in particular at youth unemployment which is defined as those aged 18 to 24.

This workbook uses information from a dataset called The Claimant Count by Sex and Age. This experimental series counts the number of people claiming Jobseeker's Allowance plus those who claim Universal Credit who are out of work. The dataset currently includes some out of work claimants of Universal Credit who are not required to look for work; for example, due to illness or disability. Therefore this dataset is considered experimental and the results should be interpreted with caution.

Unemployment rates are calculated using the Office for National Statistics Mid-year Population Estimates 2001-2017. The resident working age population is defined as all males and females aged 16-64. These denominators will be updated annually with the ONS mid-year population estimates.

Data back to December 2014 were revised by ONS on 18th October 2017. This bulletin contains these revisions and therefore supersedes any previously released data.

Introduction of Universal Credit
Since 2013 the roll out of Universal Credit has progressed across across the UK. Universal Credit will replace a number of means-tested benefits including the means-tested element of Jobseeker's Allowance (JSA).

From April 2015 Universal Credit started to be rolled out within Kent. It is now available in all Jobcentre areas in Kent & Medway. Initially it was only available to single claimants without a partner and without child dependents however in 2017 the full roll out of Universal Credit to all claimant types began. The following table shows the planned roll out within Kent districts.

As announced in June 2018 the government will start to migrate existing claimants of the benefits that are being replaced to Universal Credit early in 2019. It hopes to migrate all existing benefit claimants to Universal Credit by March 2023.

Date of roll

out	Job Centre Plus Office	District Served
May-17	Dover	Dover
Jul-17	Margate	Thanet
Jul-17	Ramsgate	Thanet
Dec-17	Sheerness	Swale
Dec-17	Sittingbourne	Swale
Feb-18	Gravesend	Gravesham
Feb-18	Gravesend	Sevenoaks (part)
Feb-18	Folkestone	Folkestone & Hythe
Feb-18	Chatham	Medway
Mar-18	Ashford	Ashford
Apr-18	Canterbury	Canterbury
Apr-18	Hernebay	Canterbury
Apr-18	Whitstable	Canterbury
May-18	Dartford	Dartford
May-18	Dartford	Sevenoaks (part)
Aug-18	Maidstone	Maidstone
Aug-18	Tonbridge	Tonbridge & Malling
Aug-18	Tonbridge	Tunbridge Wells

For more information on Universal Credit: https://www.gov.uk/universal-credit

Produced by:
Strategic Commissioning - Analytics,
Strategic & Corporate Services,
Kent County Council

Tel: 03000 417444

kent.gov.uk Kent County Council

UK Business Counts 2018

Information on businesses in Kent

Related documents

Business Demography – Looking at the counts business activity during the course of the whole of the financial year

Construction Industries in Kent – the number of construction businesses in Kent and the people employed in the sector

Creative Industries in Kent - the number of creative businesses in Kent and the people employed in the sector

Further information

Strategic Commissioning - Analytics
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Email: research@kent.gov.uk

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The UK Business data is published annually by the Office for National Statistics (ONS) and is based on output from the VAT and PAYE administrative systems.

The information provided by the UK Business dataset gives a snap shot of businesses and is broken down by size band, industry, turnover and age of business.

An additional dataset from ONS is the Business Demography dataset. This is also based on VAT and PAYE data but this information measures any activity during the course of the year, so leads to slightly higher counts of businesses. It provides information on business births, deaths and survival rates. Information on this dataset can be found in the bulletin "Business Demography"

Kent Summary

- As at March 2018 there were 61,255 enterprises in Kent
- Kent has a significantly higher proportion of enterprises (16.3%) in the wholesale industry than is seen nationally (12.4%)
- The highest proportion of enterprises in Kent (17.6%) are within the Professional, scientific and technical sector
- The majority of enterprises in Kent (89.7%) are micro enterprises (with 0-9 employees)
- The majority of enterprises in Kent (99.3%) are classed as companies which operate within the private sector.
- 62.7% of enterprises in Kent have a turnover of over £100k

Introduction

The UK Business data is produced from a snapshot of the Inter Departmental Business Register (IDBR) - usually taken during March - and provides the basis for the Office for National Statistics (ONS) to conduct surveys of businesses.

The main administrative sources for the IDBR are VAT trader and PAYE employer information passed to the ONS by HM Revenue & Customs under the Value Added Tax Act 1994 for VAT traders and the Finance Act 1969 for PAYE employers; details of incorporated businesses are also passed to ONS by Companies House. ONS Survey data and survey information from the Department of Enterprise, Trade and Investment – Northern Ireland (DETINI) and the Department for Environment, Food and Rural Affairs (DEFRA) farms register provide auxiliary information. Construction statistics formerly produced by the Department for Business Innovation & Skills are now produced by ONS.

The IDBR combines the information from the three administrative sources with this survey data in a statistical register comprising over two million enterprises. These comprehensive administrative sources combined with the survey data contribute to the coverage on the IDBR, which is one of its main strengths, representing nearly 99 per cent of UK economic activity.

The latest data is published for 2018 and is based upon the 2007 revision to the Standard Industrial Classification UKSIC (2007). Detailed information about the types of industry which make up each of the industrial sectors is available from the UK Standard Industrial Classification of Economic Activities published by the Office for National Statistics.

This bulletin looks at the main tables available from the UK Business data, which relate to VAT/PAYE enterprises.

This bulletin will be updated in Autumn 2019.

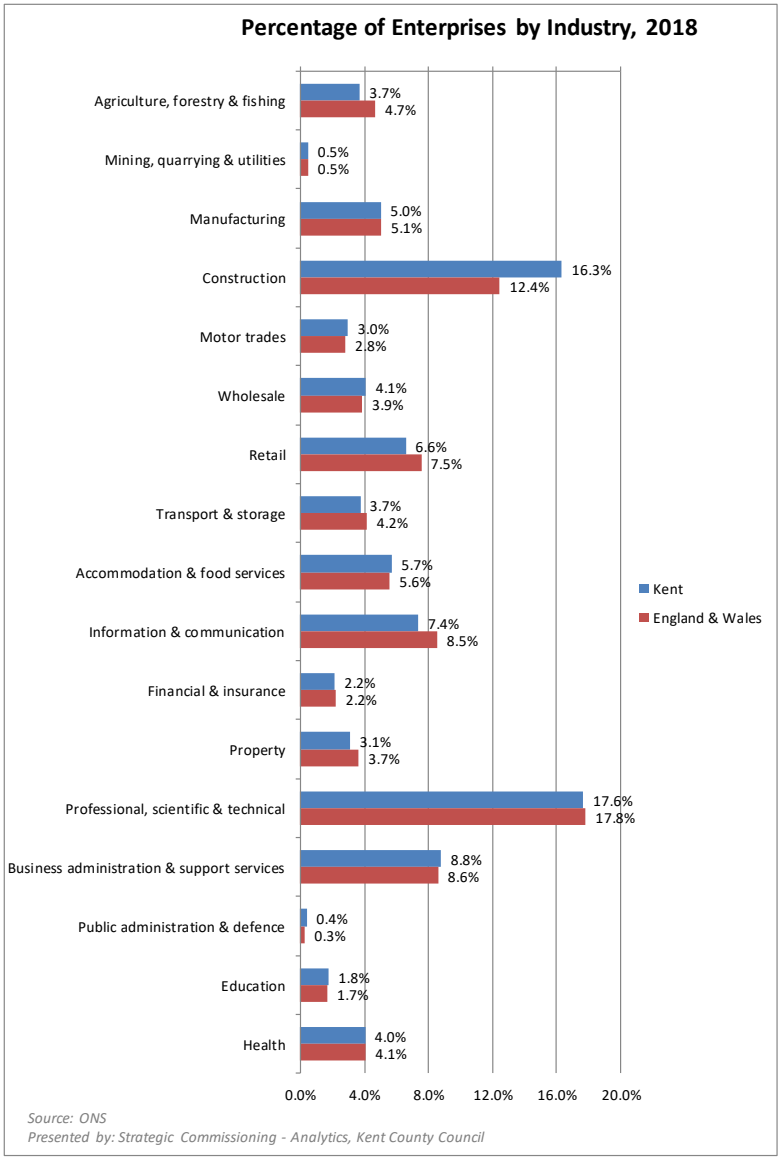
Analysis

Enterprises by Industry

The UK Business data shows us the number of enterprises by broad industrial group.

Overall Kent has a similar profile to England and Wales although does show a significantly higher proportion of enterprises in the Construction Industry and lower proportions in Agriculture and Fishing, Retail and Information & Communications industries. This is shown in Chart 1.

Chart 1: Enterprises by Industry



Tables 1 and 2 show the number and percentage of businesses by industry in Kent local authority districts and Kent as a whole. Regional and national figures are also presented for comparison.

Table 1: Number Of Vat And/or Paye Based Enterprises In 2018 By Broad Industrial Group

	UK SIC 2007																	
	Agriculture, forestry & fishing	Mining, quarrying & utilities	Manufacturing	Construction	Motor trades	Wholesale	Retail	Transport & storage	Accommodation & food services	Information & communication	Financial & insurance	Property	Professional, scientific & technical	Business administration & support services	Public administration & defence	Education	Health	Arts, entertainment, recreation & other services	Total
Ashford	410	30	330	870	170	475	370	160	250	405	345	210	975	535	40	85	240	305	6,205
Canterbury	175	20	230	765	150	205	440	130	410	355	85	195	905	425	15	105	255	395	5,265
Dartford	30	20	220	850	135	170	245	245	200	425	70	110	750	360	10	60	150	195	4,240
Dover	195	20	170	545	115	100	275	150	280	165	40	75	510	240	40	80	165	215	3,370
Folkestone & Hythe	205	10	165	575	120	110	295	120	335	210	40	125	610	295	15	60	155	235	3,670
Gravesham	45	15	195	805	115	105	260	320	235	250	45	105	545	340	5	70	165	205	3,830
Maidstone	300	40	370	1,360	235	295	395	390	320	465	125	230	1,260	620	30	125	305	420	7,295
Sevenoaks	200	25	310	990	200	275	370	135	250	625	160	245	1,390	655	25	115	205	400	6,580
Swale	230	40	325	920	185	170	315	250	325	250	60	135	655	385	25	80	195	275	4,820
Thanet	75	25	240	670	125	110	380	130	400	215	60	110	475	290	10	85	175	285	3,865
Tonbridge and Malling	135	30	270	935	165	245	280	170	235	515	150	165	1,200	570	25	105	230	320	5,745
Tunbridge Wells	285	20	245	700	115	255	410	95	265	635	145	210	1,525	670	20	120	245	410	6,365
Kent	2,280	300	3,075	9,990	1,830	2,515	4,035	2,295	3,500	4,515	1,320	1,915	10,800	5,380	260	1,095	2,480	3,660	61,255
Medway	75	40	450	1,785	275	320	615	505	475	575	110	210	1,260	685	10	170	410	450	8,410
Kent + Medway	2,355	340	3,525	11,770	2,105	2,835	4,645	2,805	3,975	5,085	1,430	2,125	12,060	6,065	270	1,270	2,890	4,110	69,660
South East LEP	6,010	800	9,020	29,865	5,330	6,780	11,370	6,750	8,930	12,740	3,325	5,500	28,460	14,520	585	3,055	6,805	10,085	169,930
South East Region	11,830	1,715	18,725	54,485	11,045	15,005	27,200	12,615	19,080	44,650	8,100	13,475	81,230	35,265	1,200	7,475	15,475	25,985	404,555
ENGLAND AND WALES	113,520	12,145	122,650	301,145	68,585	94,070	182,665	101,105	135,270	206,985	54,130	88,610	430,910	208,365	7,210	41,345	99,120	153,755	2,421,590

Source: ONS

Presented by: Strategic Commissioning - Analytics, Kent County Council

Table 2: Percentage Of Vat And/or Paye Based Enterprises In 2018 By Broad Industrial Group

	UK SIC 2007																	
	Agriculture, forestry & fishing	Mining, quarrying & utilities	Manufacturing	Construction	Motor trades	Wholesale	Retail	Transport & storage	Accommodation & food services	Information & communication	Financial & insurance	Property	Professional, scientific & technical	Business administration & support services	Public administration & defence	Education	Health	Arts, entertainment, recreation & other services
Ashford	6.6	0.5	5.3	14.0	2.7	7.7	6.0	2.6	4.0	6.5	5.6	3.4	15.7	8.6	0.6	1.4	3.9	4.9
Canterbury	3.3	0.4	4.4	14.5	2.8	3.9	8.4	2.5	7.8	6.7	1.6	3.7	17.2	8.1	0.3	2.0	4.8	7.5
Dartford	0.7	0.5	5.2	20.0	3.2	4.0	5.8	5.8	4.7	10.0	1.7	2.6	17.7	8.5	0.2	1.4	3.5	4.6
Dover	5.8	0.6	5.0	16.2	3.4	3.0	8.2	4.5	8.3	4.9	1.2	2.2	15.1	7.1	1.2	2.4	4.9	6.4
Gravesham	5.6	0.3	4.5	15.7	3.3	3.0	8.0	3.3	9.1	5.7	1.1	3.4	16.6	8.0	0.4	1.6	4.2	6.4
Maidstone	1.2	0.4	5.1	21.0	3.0	2.7	6.8	8.4	6.1	6.5	1.2	2.7	14.2	8.9	0.1	1.8	4.3	5.4
Sevenoaks	4.1	0.5	5.1	18.6	3.2	4.0	5.4	5.3	4.4	6.4	1.7	3.2	17.3	8.5	0.4	1.7	4.2	5.8
Shepway	3.0	0.4	4.7	15.0	3.0	4.2	5.6	2.1	3.8	9.5	2.4	3.7	21.1	10.0	0.4	1.7	3.1	6.1
Swale	4.8	0.8	6.7	19.1	3.8	3.5	6.5	5.2	6.7	5.2	1.2	2.8	13.6	8.0	0.5	1.7	4.0	5.7
Thanet	1.9	0.6	6.2	17.3	3.2	2.8	9.8	3.4	10.3	5.6	1.6	2.8	12.3	7.5	0.3	2.2	4.5	7.4
Tonbridge and Malling	2.3	0.5	4.7	16.3	2.9	4.3	4.9	3.0	4.1	9.0	2.6	2.9	20.9	9.9	0.4	1.8	4.0	5.6
Tunbridge Wells	4.5	0.3	3.8	11.0	1.8	4.0	6.4	1.5	4.2	10.0	2.3	3.3	24.0	10.5	0.3	1.9	3.8	6.4
Kent	3.7	0.5	5.0	16.3	3.0	4.1	6.6	3.7	5.7	7.4	2.2	3.1	17.6	8.8	0.4	1.8	4.0	6.0
Medway	0.9	0.5	5.4	21.2	3.3	3.8	7.3	6.0	5.6	6.8	1.3	2.5	15.0	8.1	0.1	2.0	4.9	5.4
Kent + Medway	3.4	0.5	5.1	16.9	3.0	4.1	6.7	4.0	5.7	7.3	2.1	3.1	17.3	8.7	0.4	1.8	4.1	5.9
South East LEP	3.5	0.5	5.3	17.6	3.1	4.0	6.7	4.0	5.3	7.5	2.0	3.2	16.7	8.5	0.3	1.8	4.0	5.9
South East Region	2.9	0.4	4.6	13.5	2.7	3.7	6.7	3.1	4.7	11.0	2.0	3.3	20.1	8.7	0.3	1.8	3.8	6.4
ENGLAND AND WALES	4.7	0.5	5.1	12.4	2.8	3.9	7.5	4.2	5.6	8.5	2.2	3.7	17.8	8.6	0.3	1.7	4.1	6.3

Source: ONS

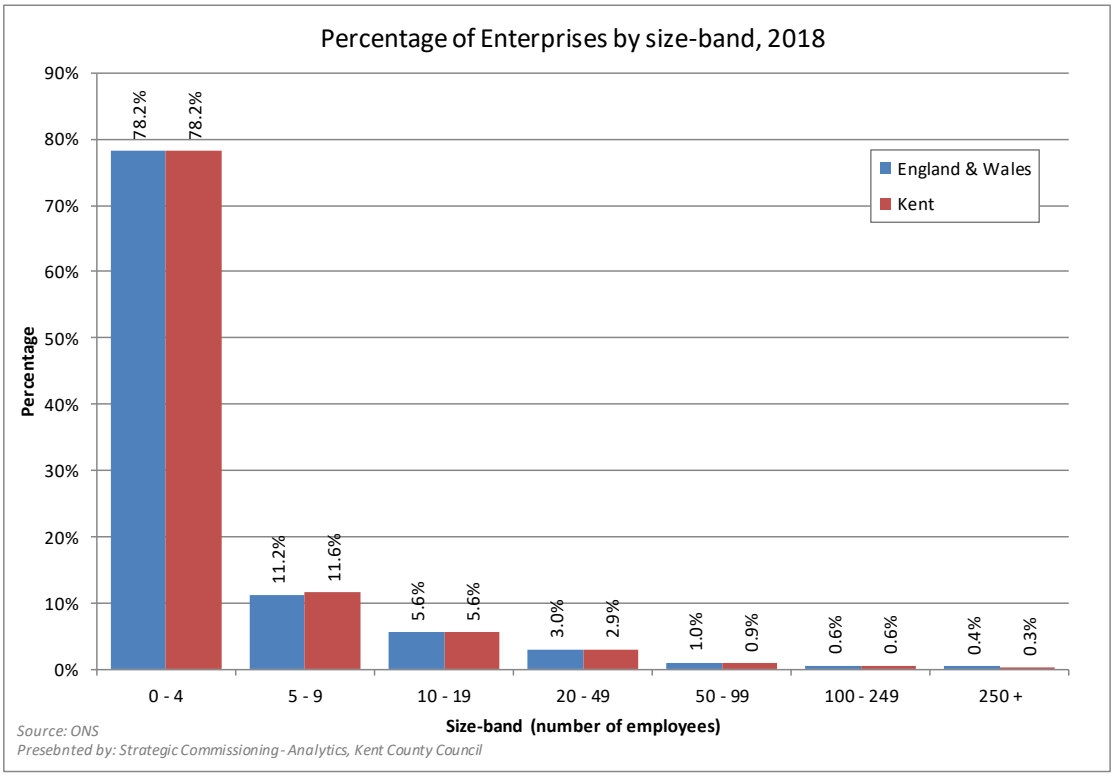
Presented by: Strategic Commissioning - Analytics, Kent County Council

Enterprises by employee size

The majority of enterprises are classed as micro businesses i.e. they have 0 - 9 employees. In Kent 89.7% of enterprises are classed as micro, 89.5% in England and Wales.

Chart 2 shows the proportion of enterprises in Kent and England and Wales by employment size.

Chart 2: Enterprises by sizeband



Tables 3 and 4 show an even greater breakdown of the number and percentage of enterprises by the number of employees.

The data shows that while the majority of enterprises are micro businesses employing up to 9 people, most of these actually have 0 - 4 employees (87.1% of micro businesses in Kent).

Kent has the same proportion of enterprises with 0 – 4 employees, and a slightly higher proportion with 5 – 9 employees than is seen nationally.

Table 3: Number Of Vat And/or Paye Based Enterprises In 2016 By Employment Size

	Employment size							
	0 - 4	5 - 9	10 - 19	20 - 49	50 - 99	100 - 249	250 +	TOTAL
Ashford	4,995	670	285	160	50	25	20	6,205
Canterbury	3,990	670	320	175	55	25	30	5,265
Dartford	3,395	415	210	120	50	30	20	4,240
Dover	2,530	460	215	105	35	25	5	3,370
Folkestone & Hythe	2,800	490	205	120	30	15	10	3,670
Gravesham	3,050	450	170	100	25	20	10	3,830
Maidstone	5,690	820	435	200	70	50	30	7,295
Sevenoaks	5,230	725	345	180	55	25	20	6,580
Swale	3,670	610	300	135	45	40	15	4,820
Thanet	2,935	505	230	125	30	30	5	3,865
Tonbridge and Malling	4,495	610	335	195	60	30	25	5,745
Tunbridge Wells	5,090	645	350	190	55	25	10	6,365
Kent	54,540	7,995	3,875	2,000	635	390	230	61,255
Medway	47,875	7,080	3,400	1,795	565	340	200	8,410
Kent + Medway	6,665	915	475	205	70	50	35	69,660
South East LEP	133,990	18,970	9,280	4,775	1,540	865	510	169,930
South East Region	321,210	42,680	21,610	11,480	3,765	2,270	1,535	404,555
ENGLAND AND WALES	1,893,935	272,190	136,415	72,265	23,995	13,490	9,305	2,421,590

Source: ONS
Presented by: Strategic Commissioning - Analytics, Kent County Council

Table 4: Percentages Of Vat And/or Paye Based Enterprises In 2018 By Employment Size

	Employment size							
	0 - 4	5 - 9	10 - 19	20 - 49	50 - 99	100 - 249	250 +	TOTAL
Ashford	80.5	10.8	4.6	2.6	0.8	0.4	0.3	100
Canterbury	75.8	12.7	6.1	3.3	1.0	0.5	0.6	100
Dartford	80.1	9.8	5.0	2.8	1.2	0.7	0.5	100
Dover	75.1	13.6	6.4	3.1	1.0	0.7	0.1	100
Gravesham	76.3	13.4	5.6	3.3	0.8	0.4	0.3	100
Maidstone	79.6	11.7	4.4	2.6	0.7	0.5	0.3	100
Sevenoaks	78.0	11.2	6.0	2.7	1.0	0.7	0.4	100
Shepway	79.5	11.0	5.2	2.7	0.8	0.4	0.3	100
Swale	76.1	12.7	6.2	2.8	0.9	0.8	0.3	100
Thanet	75.9	13.1	6.0	3.2	0.8	0.8	0.1	100
Tonbridge and Malling	78.2	10.6	5.8	3.4	1.0	0.5	0.4	100
Tunbridge Wells	80.0	10.1	5.5	3.0	0.9	0.4	0.2	100
Kent	89.0	13.1	6.3	3.3	1.0	0.6	0.4	100
Medway	569.3	84.2	40.4	21.3	6.7	4.0	2.4	100
Kent + Medway	9.6	1.3	0.7	0.3	0.1	0.1	0.1	100
South East LEP	78.9	11.2	5.5	2.8	0.9	0.5	0.3	100
South East Region	79.4	10.5	5.3	2.8	0.9	0.6	0.4	100
ENGLAND AND WALES	78.2	11.2	5.6	3.0	1.0	0.6	0.4	100

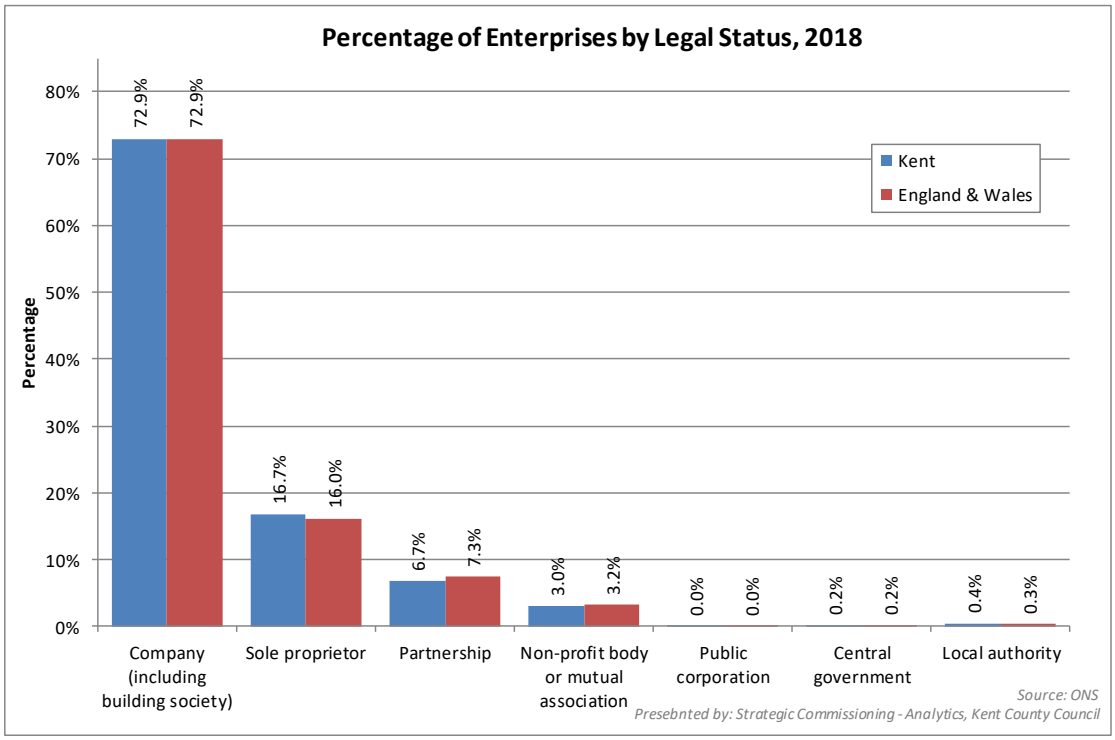
Source: ONS
Presented by: Strategic Commissioning - Analytics, Kent County Council

Enterprise by status

The data also shows the number of enterprises by legal status. The legal status of units is classified by ONS in accordance with National Accounts Sector Classifications. All enterprises engage in financial transactions, paying out and receiving money for reasons such as buying and selling goods and services, paying taxes, or collecting tax revenues. Using information received from Companies House and the administrative sources from HM Revenue & Customs, the National Accounts Sector Classification determines whether a body or enterprise is in the private or public sector, and if public, whether they are government bodies or public corporations, and whether certain transactions count as taxes or service fees.

Chart 3 shows the proportion of enterprises by legal status in Kent compared to England and Wales in 2018.

Chart 3: Enterprises by legal status



The majority of enterprises are private sector companies. In Kent they account for 72.9% of all enterprises, the same as England and Wales as a whole.

Kent has a slightly higher proportion of sole proprietor enterprises (16.7%) than is seen nationally and a slightly lower proportion of partnerships (6.7%).

Tables 5 and 6 show the legal status of enterprises in Kent local authority districts and Kent as a whole. They also present information at regional and national level for comparison.

Table 5: Number Of Vat And/or Paye Based Enterprises In 2018 By Employment Status

	Private sector				Public sector			
	Company (including building society)	Sole proprietor	Partnership	Non-profit body or mutual association	Public corporation	Central government	Local authority	TOTAL
Ashford	4,250	985	500	420	0	10	40	6,205
Canterbury	3,625	990	440	180	0	10	20	5,265
Dartford	3,455	505	140	115	0	15	10	4,240
Dover	2,015	815	385	105	5	10	40	3,370
Folkestone & Hythe	2,450	780	325	90	0	10	15	3,670
Gravesham	3,020	555	160	75	0	10	10	3,830
Maidstone	5,415	1,170	485	175	0	10	35	7,295
Sevenoaks	5,085	970	345	145	0	5	30	6,580
Swale	3,400	900	350	125	0	15	30	4,820
Thanet	2,630	800	310	100	0	15	10	3,865
Tonbridge and Malling	4,480	795	285	150	0	5	30	5,745
Tunbridge Wells	4,820	950	400	175	0	5	20	6,365
Kent	44,655	10,215	4,130	1,855	5	120	275	61,255
Medway	6,380	1,360	410	215	0	30	10	8,410
Kent + Medway	51,035	11,570	4,540	2,070	5	150	290	69,660
South East LEP	126,590	26,935	11,105	4,315	10	360	620	169,930
South East Region	307,465	59,780	23,950	11,440	15	550	1,350	404,555
ENGLAND AND WALES	1,766,460	388,100	177,770	76,910	160	3,890	8,300	2,421,590

Source: ONS
Presented by: Strategic Commissioning - Analytics, Kent County Council

Turnover

Turnover figures provided to ONS for the majority of traders is based on VAT returns for a 12 month period. For 2018 this relates to a 12 month period covering the financial year 2017/2018. For other records, in particular members of VAT group registrations, turnover may relate to an earlier period or survey data.

For traders who have registered more recently, turnover represents the estimate made by traders at the time of registration.

The turnover figures on the register generally exclude VAT but include other taxes, such as the revenue duties on alcoholic drinks and tobacco. They represent total UK turnover, including exempt and zero-rated supplies.

Turnover bands shown in the analyses relate to the latest year for which information is available. Traders may be registered below the VAT threshold or may choose not to de-register should their turnover fall below the threshold.

Table 7 shows the VAT registration thresholds since 2004/05.

Table 7 - VAT registration thresholds

Operative dates	VAT Registration Threshold
1 Apr 2004 - 31 Mar 2005	£58,000
1 Apr 2005 - 31 Mar 2006	£60,000
1 Apr 2006 - 31 Mar 2007	£61,000
1 Apr 2007 - 31 Mar 2008	£64,000
1 Apr 2008 - 31 Mar 2009	£67,000
1 Apr 2009 - 31 Mar 2010	£68,000
1 Apr 2010 - 31 Mar 2011	£70,000
1 Apr 2011 - 31 Mar 2012	£73,000
1 Apr 2012 - 31 Mar 2013	£77,000
1 Apr 2013 - 31 Mar 2014	£79,000
1 Apr 2014 - 31 Mar 2015	£81,000
1 Apr 2015 - 31 March 2016	£82,000
1 Apr 2016 - 31 March 2017	£83,000
1 Apr 2017 - 31 March 2018	£85,000
1 Apr 2018 onwards	£85,000

Source: HMRC

33.2% of enterprises in Kent have a turnover of between £100k and £249k. In Kent a higher proportion of enterprises have a turnover of over £100k than is seen nationally. This is shown in chart 4.

Tables 8 and 9 present the turnover data for Kent local authority districts and Kent as a whole. Regional and national figures are also presented for comparison.

Chart 4

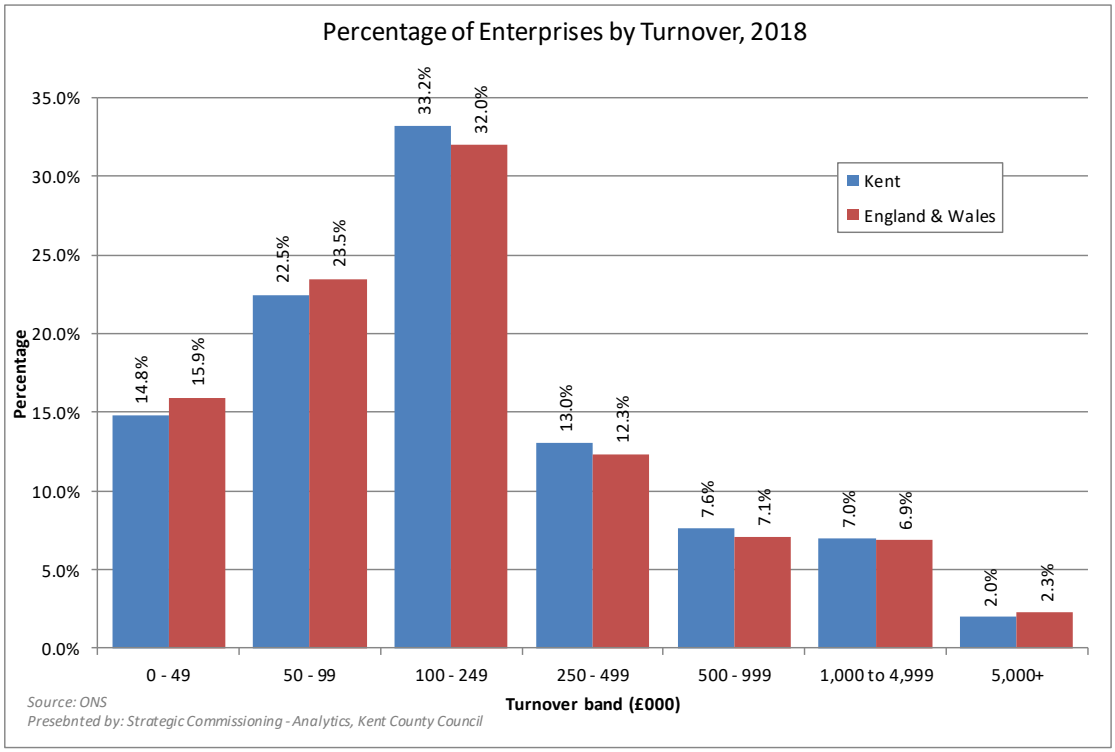


Table 8: Number Of Vat And/or Paye Based Enterprises In 2018 By Turnover Sizeband

	Turnover size (£ thousand)							
	0 to 49	50 to 99	100 to 199	200 to 499	500 to 999	1,000 to 4,999	5,000+	TOTAL
Ashford	1,225	1,295	1,850	810	525	405	95	6,205
Canterbury	735	1,195	1,780	685	415	360	95	5,265
Dartford	575	1,080	1,395	485	275	310	120	4,240
Dover	510	720	1,095	475	285	240	50	3,370
Folkestone & Hythe	570	845	1,275	460	245	230	45	3,670
Gravesham	585	970	1,245	480	250	250	55	3,830
Maidstone	1,115	1,605	2,330	975	585	525	160	7,295
Sevenoaks	875	1,370	2,320	845	515	495	165	6,580
Swale	675	1,150	1,495	665	400	340	90	4,820
Thanet	485	905	1,355	545	280	245	55	3,865
Tonbridge and Malling	800	1,235	1,930	740	420	460	160	5,745
Tunbridge Wells	920	1,390	2,235	825	450	415	130	6,365
Kent	9,070	13,760	20,310	7,980	4,650	4,270	1,220	61,255
Medway	1,245	2,145	2,610	1,030	660	565	160	8,410
Kent + Medway	10,315	15,900	22,920	9,010	5,310	4,835	1,370	69,660
South East LEP	24,545	39,210	56,695	21,850	12,525	11,740	3,365	169,930
South East Region	62,330	92,600	135,775	49,070	28,370	27,375	9,040	404,555
ENGLAND AND WALES	386,205	568,870	774,035	298,325	171,895	166,485	55,770	2,421,590

Source: ONS
Presented by: Strategic Commissioning - Analytics, Kent County Council

Table 9: Percentage Of Vat And/or Paye Based Enterprises In 2018 By Turnover Sizeband

	Turnover size (£ thousand)							
	0 to 49	50 to 99	100 to 199	200 to 499	500 to 999	1,000 to 4,999	5,000+	TOTAL
Ashford	19.7	20.9	29.8	13.1	8.5	6.5	1.5	100
Canterbury	14.0	22.7	33.8	13.0	7.9	6.8	1.8	100
Dartford	13.6	25.5	32.9	11.4	6.5	7.3	2.8	100
Dover	15.1	21.4	32.5	14.1	8.5	7.1	1.5	100
Gravesham	15.5	23.0	34.7	12.5	6.7	6.3	1.2	100
Maidstone	15.3	25.3	32.5	12.5	6.5	6.5	1.4	100
Sevenoaks	15.3	22.0	31.9	13.4	8.0	7.2	2.2	100
Shepway	13.3	20.8	35.3	12.8	7.8	7.5	2.5	100
Swale	14.0	23.9	31.0	13.8	8.3	7.1	1.9	100
Thanet	12.5	23.4	35.1	14.1	7.2	6.3	1.4	100
Tonbridge and Malling	13.9	21.5	33.6	12.9	7.3	8.0	2.8	100
Tunbridge Wells	14.5	21.8	35.1	13.0	7.1	6.5	2.0	100
Kent	14.8	22.5	33.2	13.0	7.6	7.0	2.0	100
Medway	14.8	25.5	31.0	12.2	7.8	6.7	1.9	100
Kent + Medway	14.8	22.8	32.9	12.9	7.6	6.9	2.0	100
South East LEP	14.4	23.1	33.4	12.9	7.4	6.9	2.0	100
South East Region	15.4	22.9	33.6	12.1	7.0	6.8	2.2	100
ENGLAND AND WALES	15.9	23.5	32.0	12.3	7.1	6.9	2.3	100

Source: ONS
Presented by: Strategic Commissioning - Analytics, Kent County Council

Public Health England

Research and analysis

Chapter 5: inequality in health

Published 13 July 2017

Contents

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3. Patterns in health inequality
4. Trends in health inequality
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1. Main messages

Health inequalities are differences in health between people or groups of people that may be considered unfair. There is a social gradient in lifespan; people living in the most deprived areas in England have on average the lowest life expectancy and conversely, life expectancy is higher on average for those living in areas with lower deprivation. Males living in the most deprived tenth of areas can expect to live 9 fewer years compared with the least deprived tenth, and females can expect to live 7 fewer years.

Males and females living in the most deprived areas can also expect to spend nearly 20 fewer years in good health compared with those in the least deprived areas: they spend nearly a third of their lives in poor health, compared with only about a sixth for those in the least deprived areas. For males living in the 5 most deprived tenth of areas, and females living in the 4 most deprived, average healthy life expectancy falls below the age of 65 years (current state pension age for men).

Although deprived areas can be found in all regions of England, there is a higher concentration of more deprived authorities in the north. In addition, life expectancy in local authorities within the same deprivation group is generally lower among authorities in the north than those in the south.

As a consequence, there is a persistent 'north-south' divide in life expectancy and healthy life expectancy. Those in southern regions can on average expect to live longer and with fewer years in poor health than those further north.

Almost half of the gap in life expectancy between the most and least deprived areas in England is due to excess deaths from heart disease, stroke, and cancer in the most deprived areas. These are also the causes that make up a large proportion of the burden of premature death in England overall.

As well as lower life expectancy, there is a higher prevalence of many behavioural risk factors among the more deprived areas compared with the less deprived areas. These health inequalities are underpinned by inequalities in the broad social and economic circumstances which influence health.

2. Introduction

As described in previous chapters, there are differences in health outcomes for men and women, for different age groups and for different countries. As described in this chapter, there are also differences in outcomes relating to socioeconomic status, ethnicity, geographical region and other social factors. These health inequalities, differences in health between people or groups of people that may be considered unfair, reflect historic and present-day social inequalities in our population. Reducing inequalities should allow everyone to have the same opportunities to lead a healthy life.

This chapter provides an overview of inequality in health in England, concentrating primarily on deprivation. Inequalities by other socioeconomic characteristics are explored in more depth in the report Public Health Outcomes Framework: health equity report, focus on ethnicity which presents analysis and commentary on inequalities for 18 indicators from the Public Health Outcomes Framework (PHOF).

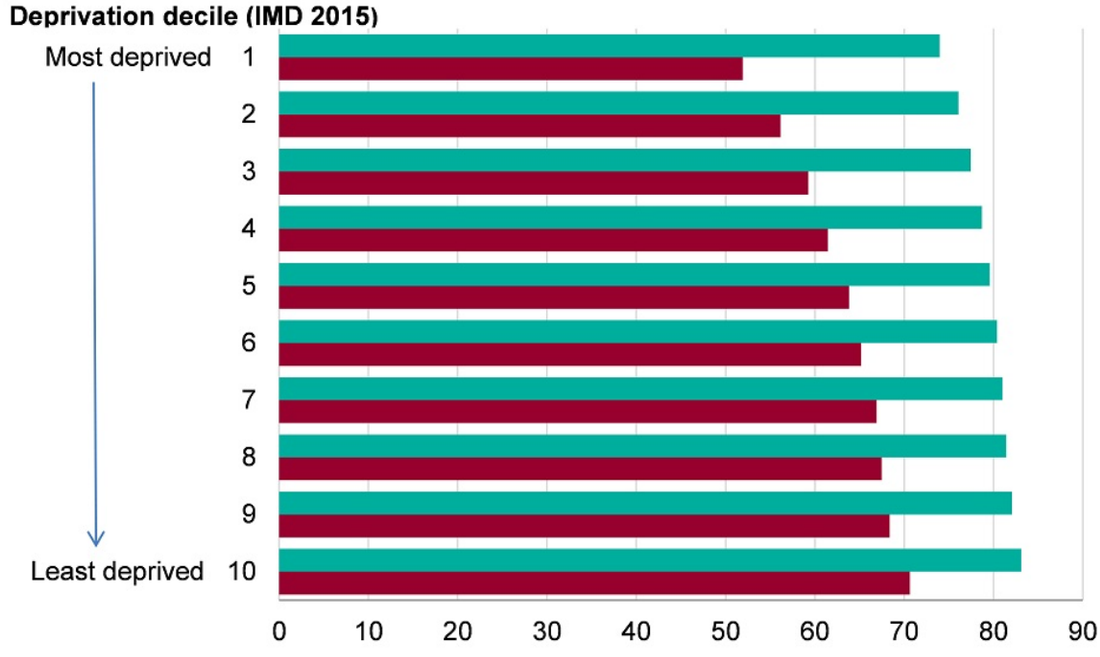
3. Patterns in health inequality

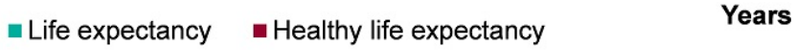
Life expectancy at birth in England has generally increased in recent decades and provisional data for 2016 show that it has reached 79.5 for males and 83.1 for females (chapter 1). However, life expectancy is not uniform across England and inequalities exist. On average, individuals living in more deprived areas live the fewest years, while those in the least deprived areas have the longest lives (figure 1, 2).

If England's population is ranked from most to least deprived and then divided into 10 groups (deprivation decile groups), life expectancy increases in each decile group as the level of deprivation decreases (figure 1, 2). In other words, there is a 'social gradient' in health [1]. Between the most and least deprived tenths of England, the absolute difference in life expectancy is 9 years for males and 7 years for females (figure 1, 2).

3.1 Figure 1: male life expectancy and healthy life expectancy at birth by deprivation decile, England, 2013 to 2015

For males, both life expectancy and healthy life expectancy were highest in the least deprived areas and lowest in the most deprived areas





Source: Public Health Outcomes Framework

Note: Index of Multiple Deprivation (IMD) 2015 deprivation deciles at lower super output area (LSOA).

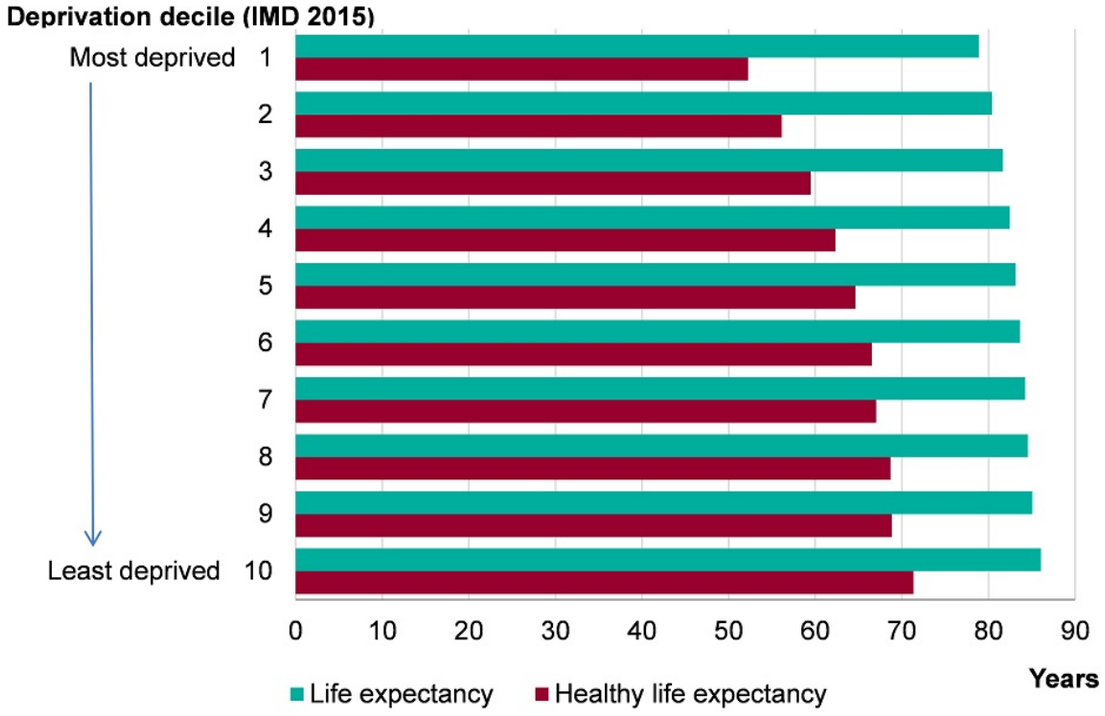
This shows:

- the least deprived areas had the highest male life expectancy (83.1 years) while the most deprived areas had the lowest life expectancy (74.0 years)
- healthy life expectancy (years in good health) was highest in the least deprived areas (70.6 years) and lowest in the most deprived areas (51.9 years)
- while there was a sizeable difference in outcome between the most and least deprived, there was also a gradient whereby there were incremental decreases in life expectancy and healthy life expectancy between each decile group as deprivation increased. The level of inequality or 'gap' is 9 years for life expectancy and 19 years for healthy life expectancy[2]
- from the most deprived tenth of areas (decile group 1), up to and including decile group 5, the average healthy life expectancy was lower than the current male state pension age of 65 years

See how your area compares

3.2 Figure 2: female life expectancy and healthy life expectancy at birth by deprivation decile, England, 2013 to 2015

For females, both life expectancy and healthy life expectancy were highest in the least deprived areas and lowest in the most deprived areas



Source: Public Health Outcomes Framework

Note: Index of Multiple Deprivation (IMD) 2015 deprivation deciles at lower super output area (LSOA).

This shows:

- the least deprived areas had the highest female life expectancy (86.1 years) while the most deprived areas had the lowest life expectancy (78.9) years
- healthy life expectancy was highest in the least deprived areas (71.3 years) and lowest in the most deprived areas (52.2 years)
- while there was a sizeable difference in outcome between the most and least deprived, there was also a gradient whereby there were incremental decreases in life expectancy and healthy life expectancy between each decile group as deprivation increased. The level of inequality or 'gap' is 7 years for life expectancy and 20 years for healthy life expectancy [2]
- from the most deprived tenth of areas (decile group 1), up to and including decile group 4, healthy life expectancy was lower than 65 years

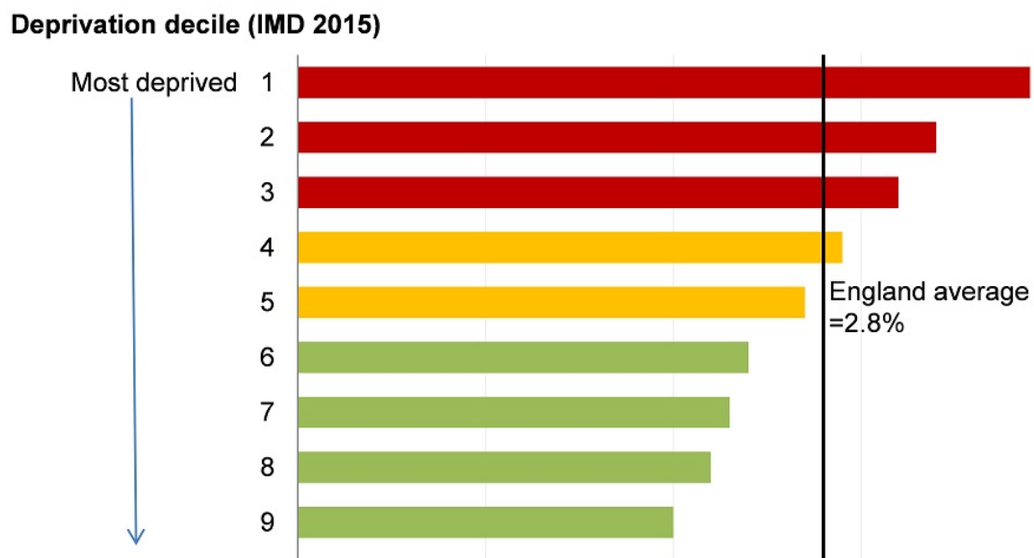
See how your area compares

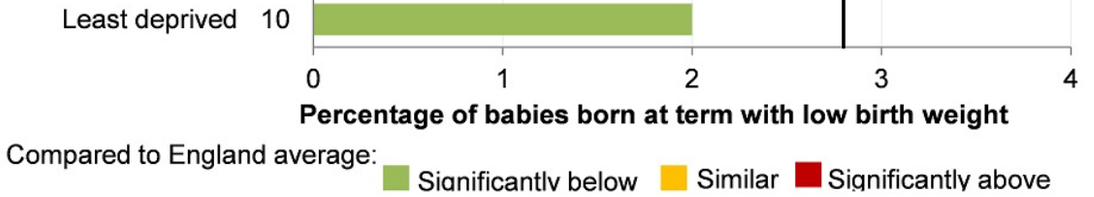
This difference in outcomes between the most deprived and least deprived begins early in life. Of all live births at full term, a higher percentage are born at a low birth weight in the 3 most deprived decile groups than on average in England (figure 3). Furthermore, the infant mortality rate is highest in the most deprived areas and lowest in the least deprived areas (figure 4).

If the most deprived decile group had the same infant mortality rate as the least deprived, there would have been 780 fewer infant deaths in 2013 to 2015. And if all decile groups had the same infant mortality rate as the least deprived, there would have been 2,051 fewer infant deaths in England as a whole.

3.3 Figure 3: the proportion of live births at term with low birth weight (<2500g) by deprivation decile, England, 2012 to 2014

A higher percentage of babies are born at term with a low birth weight in the 3 most deprived decile groups





Source: Public Health Outcomes Framework: Health Equity Report. Focus on Ethnicity (2017)

Note: Index of Multiple Deprivation (IMD) 2015 deprivation deciles at lower super output area (LSOA).

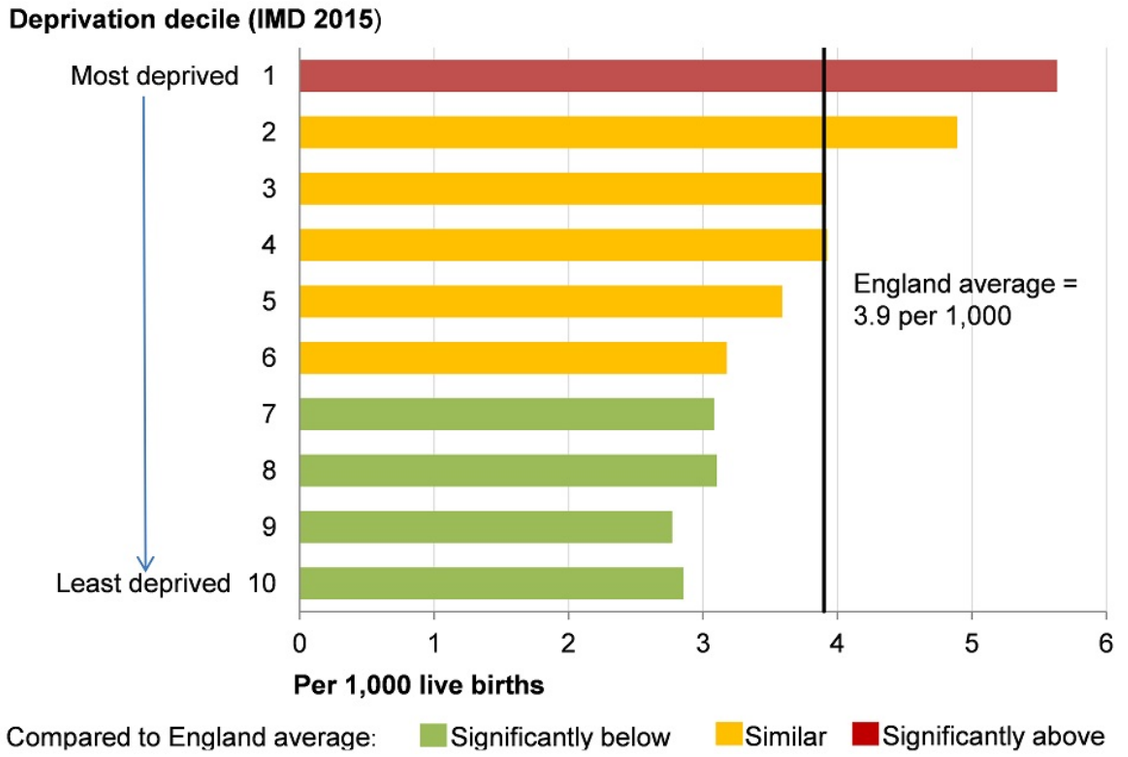
This shows:

- in the 3 most deprived decile groups, significantly more babies born at term had a low birthweight than the England average (2.8%)

See how your area compares

3.4 Figure 4: infant mortality rate by deprivation decile, England, 2013 to 2015

The infant mortality rate is highest in the most deprived decile group and lowest in the least deprived



Source: Public Health Outcomes Framework

Note: Index of Multiple Deprivation (IMD) 2015 deprivation deciles at lower super output area (LSOA).

This shows:

- in the most deprived decile group there was a significantly higher infant mortality rate than the England average
- in the 4 least deprived decile groups there was a significantly lower infant mortality rate than the England average

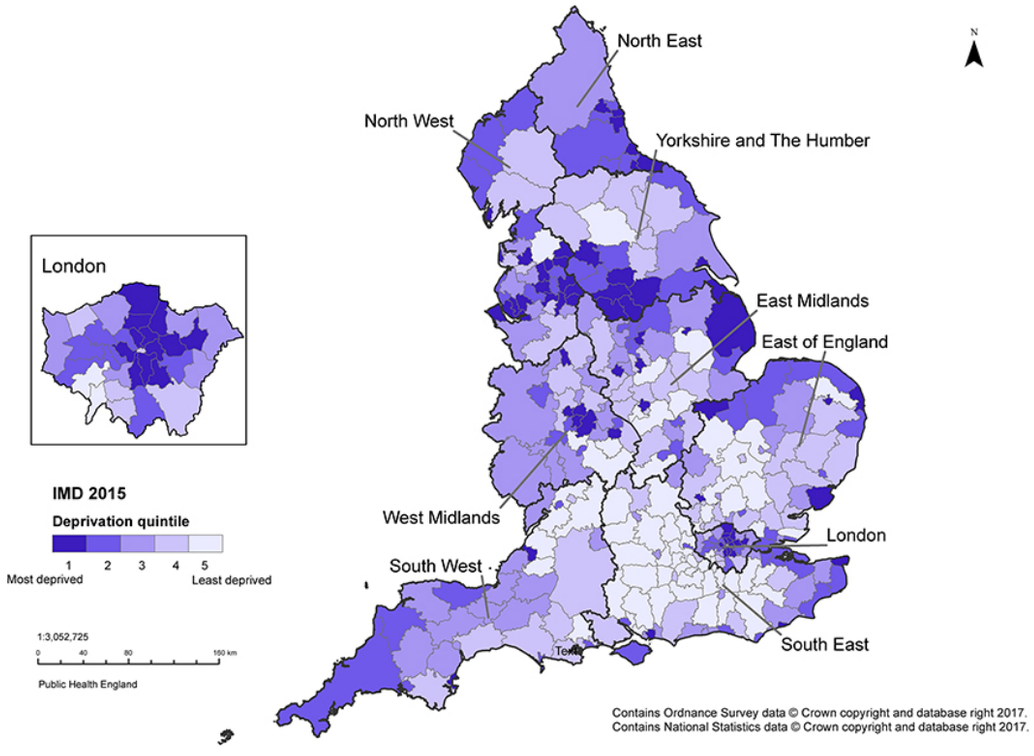
See how your area compares

Figure 5 shows the geographical distribution of England's local authorities according to their level of deprivation. More of the authorities in the most deprived group are in the north of England than in the south, but there are deprived authorities in all regions (figure 5).

In addition to this, as shown in the PHOF, life expectancy in local authorities within the same deprivation group is generally lower among authorities in the north than those in the south. As a consequence, there is a persistent north-south divide in life expectancy. Those in southern regions can expect to live longer than those further north (figure 6, 7).

3.5 Figure 5: lower tier local authorities (districts and unitary authorities) by Index of Multiple Deprivation (IMD) 2015

Districts and unitary authorities in the most deprived quintile in England are concentrated in the North, Midlands and London



Source: Department for Communities and Local Government, 2015

This shows:

- by mapping the level of deprivation for local authorities using IMD 2015, it can be seen that levels of deprivation vary around the country and pockets of deprivation are found in all regions
- the local authorities that fall within the most deprived quintile are concentrated in the north of England, the Midlands and London
- the local authority districts in the least deprived quintile are concentrated in the south of England

See how your area compares

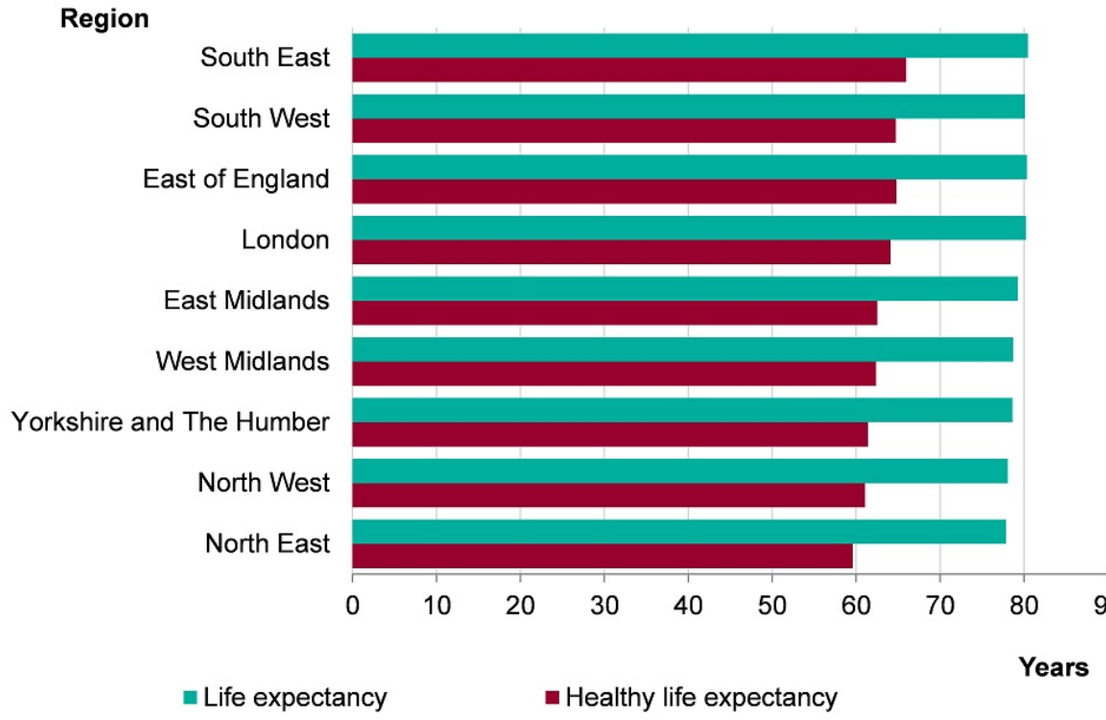
Healthy life expectancy also varies between areas, reflecting both the level of deprivation and geographical location. The most deprived areas have the lowest healthy life expectancy while the least deprived areas have the highest (figure 1, 2).

For both males and females in the most deprived areas, there is almost a 20-year difference in healthy life expectancy compared with those living in the least deprived areas. Healthy life expectancy across England is also characterised by the same north-south divide that exists for life expectancy: it is highest in the southern regions and lowest in the north (figure 6, 7).

In addition, for males living in the lowest 5 deprivation decile groups, and females living in the lowest 4 groups (more deprived), their healthy life expectancy falls below the age of 65 years, the current state pension age for men (figure 1, 2). In the most deprived decile group, healthy life expectancy falls short of the current state pension age for men by more than 10 years for both males and females (figure 1, 2).

3.6 Figure 6: male life expectancy and healthy life expectancy at birth by region, England, 2013 to 2015

For males, there is a north-south divide in life expectancy and healthy life expectancy where the highest life expectancy is found in the southern regions and the lowest in the north



Source: Public Health Outcomes Framework

This shows:

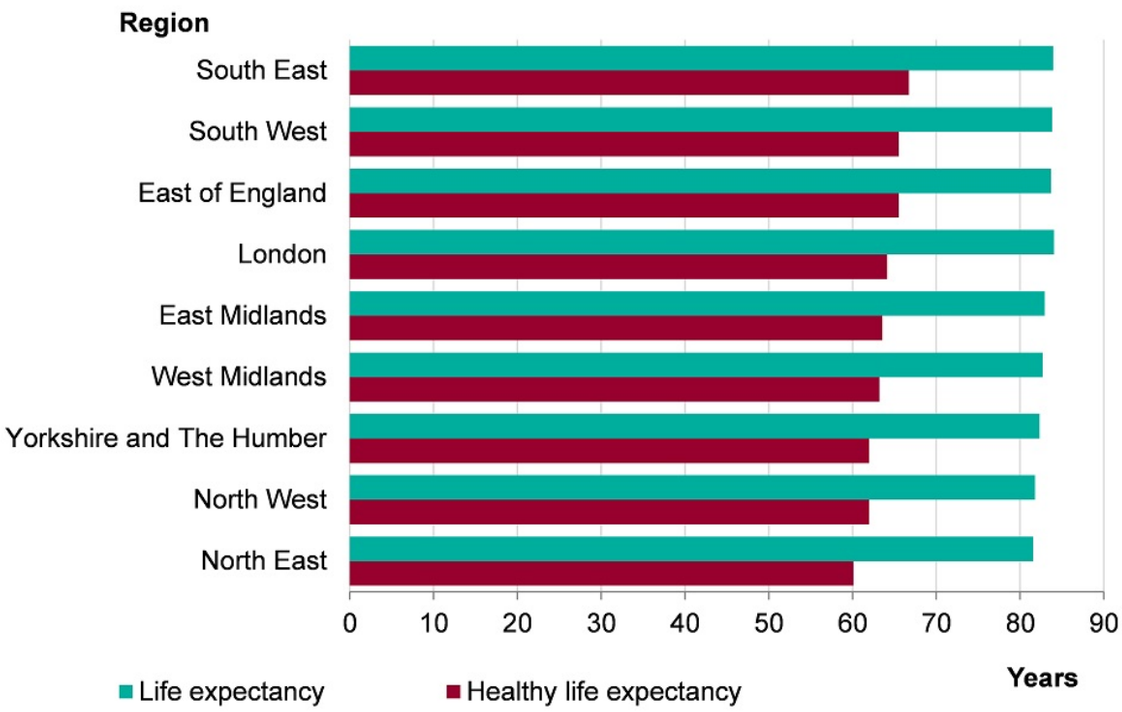
- male life expectancy was highest in the southern regions of England and lowest in the northern regions

- the South East had the highest life expectancy (80.5 years) while the North East had the lowest life expectancy (77.9 years)
- there was a similar north-south divide in male healthy life expectancy with the lowest healthy life expectancies being in the north of England and the highest in the south
- the highest healthy life expectancy was in the South East (66.0 years) and the lowest was in the North East (59.6 years)

See how your area compares

3.7 Figure 7: female life expectancy and healthy life expectancy at birth by region, England, 2013 to 2015

For females, there is a north-south divide in life expectancy and healthy life expectancy; the highest life expectancy is in the southern regions and the lowest in the north



Source: Public Health Outcomes Framework

This shows:

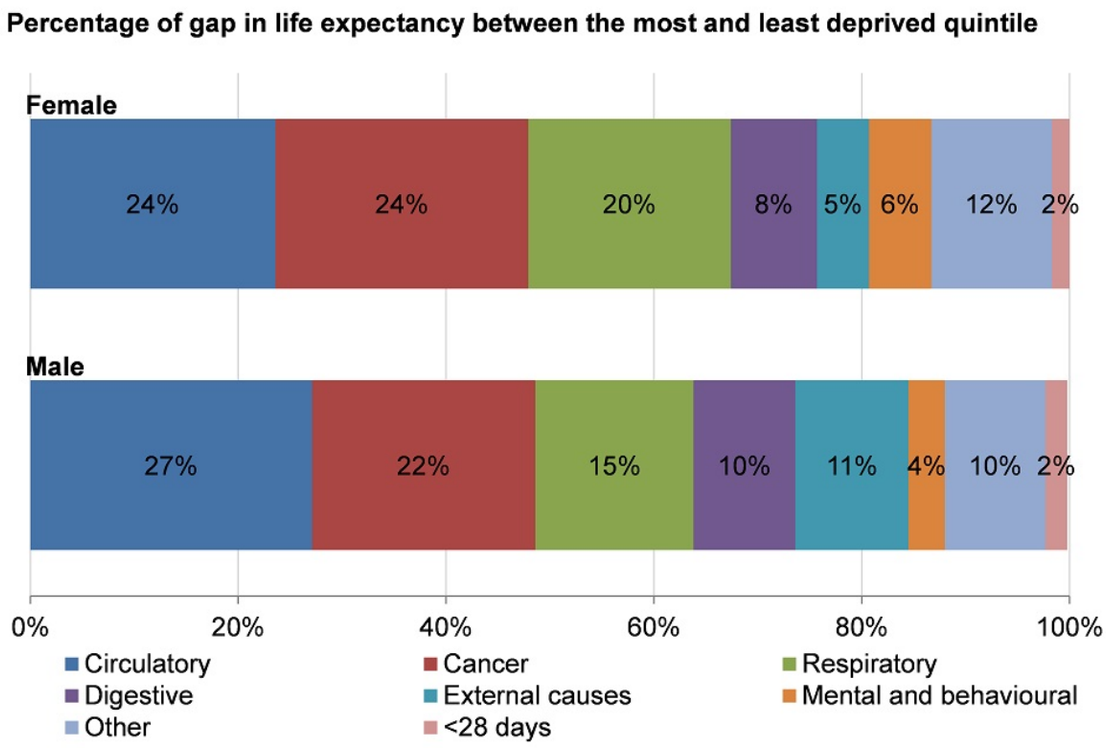
- female life expectancy was highest in the southern regions of England and lowest in the northern regions
- London had the highest life expectancy (84.1 years) while the North East had the lowest life expectancy (81.6 years)
- there was a similar north-south divide in female healthy life expectancy with the lowest healthy life expectancies being in the north of England and the highest in the south
- the highest healthy life expectancy was in the South East (66.7 years) and the lowest was in the North East (60.1 years)

See how your area compares

The gap in life expectancy between the most and least deprived areas in England can be broken down by the broad causes of death that contribute to the years of difference (figure 8). Almost half of the gap in life expectancy between the most and least deprived areas in England is due to excess deaths from circulatory disease (heart disease and stroke) and cancer in the most deprived areas. This means that if people in the most deprived fifth of areas in England had the same mortality rate for these causes as the least deprived fifth, the gap in life expectancy between the most and least deprived fifths would reduce by almost a half.

3.8 Figure 8: the breakdown of the life expectancy gap between the most deprived and least deprived quintiles, by broad cause of death for males and females, England, 2012 to 2014

Deaths caused by heart disease, stroke and cancers made up half of the gap in life expectancy between the most and least deprived quintiles in England



Source: PHE Segment tool: England PDF

Note: Due to rounding, numbers may not add to 100%. England was divided into quintiles based on Lower Super Output Area (LSOA) level IMD 2015 scores.

This shows:

- in both males and females, circulatory (heart disease and stroke), cancer and respiratory causes of death are the top 3 contributors to the difference in life expectancy between the most and least deprived quintiles
- circulatory disease deaths account for 24% of the difference in life expectancy in females and 27% in males between the most and least deprived quintiles
- cancer deaths contribute to 24% of this gap in females and 22% in males
- respiratory causes of death contribute 20% to the gap in females and 15% to the gap in males

- digestive, external, mental and behavioural, deaths in those under 28 days, and deaths due to other causes also contribute to the gap in life expectancy

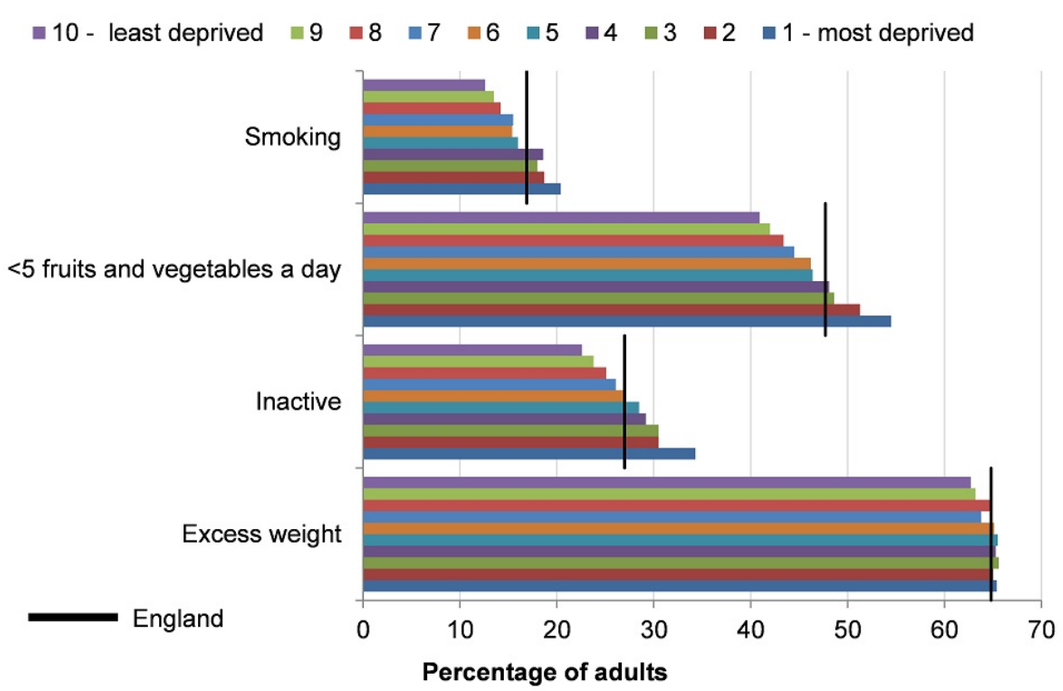
See how your area compares

As well as lower life expectancy, there is a higher prevalence of many behavioural risk factors in the more deprived areas compared with the less deprived areas. For example, in more deprived areas, the prevalence of inactivity and the prevalence of smoking are both highest, while the proportion of people eating the recommended 5-a-day of fruits and vegetables is lowest (figure 9). These are among the key behavioural risk factors for cardiovascular, cancer and respiratory disease deaths (chapter 2).

Those in the most deprived areas are also more likely to suffer the harms associated with alcohol consumption, one of the risk factors associated with the highest proportion of deaths in the 15 to 49 age group [3], (chapter 2).

3.9 Figure 9: the prevalence of selected risk factors in adults by deprivation decile, England

The prevalence of risk factors varies across upper tier local authorities grouped into deprivation deciles, whereby the least deprived areas had the lowest prevalence of risk factors



Source: Public Health Outcomes Framework

Note:

- excess weight in adults (aged 16 or over), 2013 to 2015
- physically inactive adults (aged 16 or over), 2015
- eating fewer than 5 portions of fruits and vegetables a day (aged 16 and over), 2015
- smoking prevalence in adults (aged 18 or over), 2015

The indicator presented as ‘eating fewer than 5 portions of fruit and vegetables a day’ is an inversion of the indicator ‘proportion of the adult population meeting the recommended ‘5-a-day’ available on the PHOF.

Only statistically significant differences are described as ‘higher’, ‘lower’, ‘more’, ‘less’ or ‘fewer’. If not statistically significant they are described as ‘similar’.

Index of Multiple Deprivation (IMD) 2015 deprivation deciles at upper tier local

HEALTH IMPACT ASSESSMENT GUIDANCE

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2009

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Investing for Health

Department of Health & Children
AN ROINN SLÁINTE AGUS LEANAÍ

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contents

1. Introduction

This guidance manual explains what Health Impact Assessment (HIA) is and the stages involved in conducting it. It has been revised and updated based on the experience of HIA practitioners and includes new tools which have been developed to assist each step of the HIA process. It aims to provide a user friendly and practical framework to guide policy-makers and practitioners in undertaking HIA. All HIA tools contained in this guidance and further information on HIA may be found at http://www.publichealth.ie/hia

The guidance has been endorsed by the Department of Health, Social Services and Public Safety in Northern Ireland and the Department of Health and Children in the Republic of Ireland.

In Northern Ireland HIA is supported from a policy perspective by the *Investing for Health Strategy*[1] which was developed by all government departments through the Ministerial Group on Public Health (MGPH) and chaired by the Minister of Health, Social Services and Public Safety (DHSSPS). *Investing for Health* contains a commitment to develop a methodology to enable all government departments to identify and evaluate the health impacts of new policy developments.

In the Republic of Ireland HIA is supported from a policy perspective by the health strategy *Quality and Fairness: a health system for you*[2]. This strategy contains a commitment to develop HIA methodology and to support other government departments and agencies to conduct HIAs.

2. Health and health inequalities

2.1 Definition of health

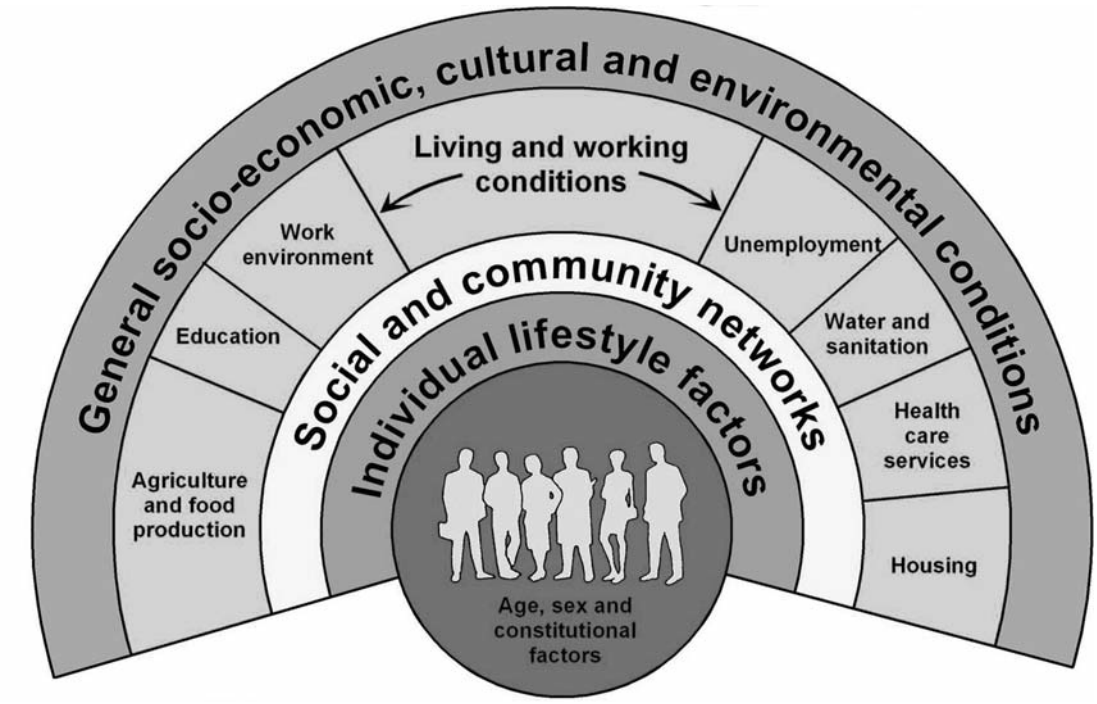
The World Health Organization (WHO) defines health as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'. In keeping with this definition, HIA includes consideration of the potential impacts of a proposal on physical, mental and social health.

2.2 Social determinants of health

Health is determined not only by access to quality healthcare services and lifestyle choices but also by the social and economic conditions in which people live. These include many factors which lie outside the healthcare sector, such as housing, employment, transport and access to fresh food. Policies and actions formulated in these non-healthcare sectors have a significant impact on people's health and wellbeing. For example, a housing sector scheme on damp proofing is likely to significantly improve respiratory health, particularly for vulnerable residents such as the elderly and young children. Similarly, a transport sector policy to promote active forms of travel is likely to improve levels of physical activity with subsequent health benefits.

Figure 1 below illustrates the many determinants of health. Further information on the social determinants of health can be found in Appendix 1.

Figure 1 Social determinants of health[3]



2.3 Health inequalities

Health inequalities refer to the avoidable and unjust gap in health outcomes between those at the top and bottom ends of the social scale. People in higher socioeconomic groups are more likely to live longer and enjoy more years of good health than those in lower socioeconomic groups. There are also notable differences in the health experiences of men and women. As health inequalities often mirror social inequalities, addressing the social determinants of health can impact positively on health inequalities.

3. Health Impact Assessment

3.1 Definition

HIA is a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population[4].

3.2 Rationale

Policies, programmes and projects from many areas affect health and should take into account their impact on health and health inequalities. HIA is a tool which can be used to achieve this by assessing potential health impacts of proposals in a systematic and transparent way.

3.3 Background

HIA has been developing internationally since the early 1990's. It is now used in many European countries, Australasia, North America, Africa and Asia.

In the European Union, the Amsterdam and subsequent Treaties[5] support the consideration of health in policy making across all sectors. This is reflected in the EU Health *Strategy Together for Health 2008 – 2013*[6] *and the second programme of Community action in the field of health (Health Programme) 2008 – 2013*[7].

WHO has developed a HIA programme and set targets for member states to develop HIA mechanisms by 2010. The report of WHO's *Commission on Social Determinants of Health*, recommends Health Equity Impact Assessment as a tool to build policy coherence for health equity[8].

3.4 Aims of HIA

HIA seeks to inform and enhance the decision-making process in favour of health and health equity. It aims to maximise potential positive health impacts and minimise potential negative health impacts of a proposal.

HIA can contribute to improved health by:

- raising awareness among decision makers of the relationship between health and the physical, social and economic environments
- demonstrating how a proposal may affect the health of a population
- providing recommendations on how a proposal could be modified to maximise opportunities for health gain and minimise chances of health loss.

HIA can contribute to reducing health inequalities by:

- raising awareness among decision makers of the unequal distribution of health and illness
- demonstrating how a proposal may affect the health of particular groups within a population
- providing recommendations on how a proposal could be modified to reduce health inequalities or prevent existing inequalities being exacerbated.

HIA can contribute to better decision-making by:

- following a clear, transparent process
- ensuring recommendations are evidence based
- helping those affected by the proposal to participate in policy formation and contribute to decision-making.

3.5 Values of HIA

WHO has outlined the values which provide a sound ethical framework for conducting a HIA. These values are:

- Democracy – HIA allows people to participate in the development and implementation of proposals that may impact on their lives
- Equity – HIA assesses the distribution of impacts of a proposal on the whole population, with a particular reference to how the proposal will affect vulnerable people (in terms of age, gender, ethnic background and socioeconomic status)
- Sustainable development – Where appropriate, HIA considers both long and short term impacts
- Ethical use of evidence – HIA uses the best available evidence from different disciplines and methodologies and places an emphasis on using transparent and rigorous processes to synthesise and interpret this evidence.

3.6 HIA and other assessments

There are considerable parallels between HIA and other impact assessments including Environmental (EIA), Poverty (PIA), Human Rights (HRIA) and Equality Impact Assesment (EqIA). HIA derives its approach and framework from EIA but was developed partly as a consequence of EIA not placing sufficient emphasis on human health. Strategic Environmental Assessment (SEA) goes some way towards addressing this deficit at policy level as there is a requirement to consider effects on population and human health.

In Northern Ireland Integrated Impact Assessment has been developed by the Office of the First Minister and Deputy First Minister (OFMDFM) and health forms an important component of this.

4. Conducting Health Impact Assessment

4.1 Issues to consider

The following issues should be considered:

4.1.1 Support

At the outset it is useful to identify the support that is likely to be available for HIA. This can be a critical factor in commencing or in determining the ease with which HIA can be conducted and recommendations implemented. This may include reviewing relevant government or political processes and the identification of resources available to conduct the HIA.

4.1.2 Ensuring a broad understanding of health and its determinants

Health in HIA is understood to encompass physical, mental and social wellbeing. It also emphasises the social, economic and environmental determinants of health (see Figure 1). This perspective is essential in helping to decide where a HIA might be appropriate, the type of research needed and if any specialist assistance is required. A growing number of resources are available which demonstrate clear links between many non-healthcare sectors and health (see Appendix 1).

4.1.3 Timing

It is important to be clear about what stage the policy, programme or project is at when undertaking HIA. This will impact upon the level of influence the HIA recommendations may have. HIA may be undertaken prospectively, concurrently or retrospectively:

Prospective HIA: Ideally HIA should be carried out prospectively, i.e. when the proposal is being developed, so that HIA recommendations have the potential to influence decisions being made.

Concurrent HIA: A concurrent HIA takes place while the policy, programme or project is being implemented. This can be particularly useful to inform a review process. It overcomes the problems sometimes faced in prospective HIA in accessing detailed information about the proposal.

Retrospective HIA: A retrospective HIA is carried out on a policy, programme or project that has already been implemented. This can be useful when a similar proposal is being planned to ascertain health impacts of the one already in existence. Retrospective HIA differs from

evaluation as it focuses on how health has been affected which may not have been an explicit objective of the policy, programme or project.

In deciding when to undertake a HIA, it is important to be clear about who is making key decisions and to identify key decision points in a given proposal for a new policy, programme or project.

4.1.4 Level

HIA can be conducted at different levels depending on a range of factors including:

- the status and complexity of the policy, programme or project
- locally determined health priorities and targets
- the potential scale and severity of health impacts
- the quality of the evidence base and availability of data
- the support for HIA at regional and local level
- the resources available to conduct HIA.

The terms desktop, rapid and comprehensive are used to describe the different levels of a particular HIA:

Desktop HIA: This is conducted quickly and with limited resources. Only evidence which is easily accessible is used. A desktop HIA is usually conducted when there is only a short timeframe available or if the scale of the proposal does not warrant more in-depth investigation.

Rapid HIA: This type of HIA includes a broader range of evidence but is still conducted within tight time and resource constraints.

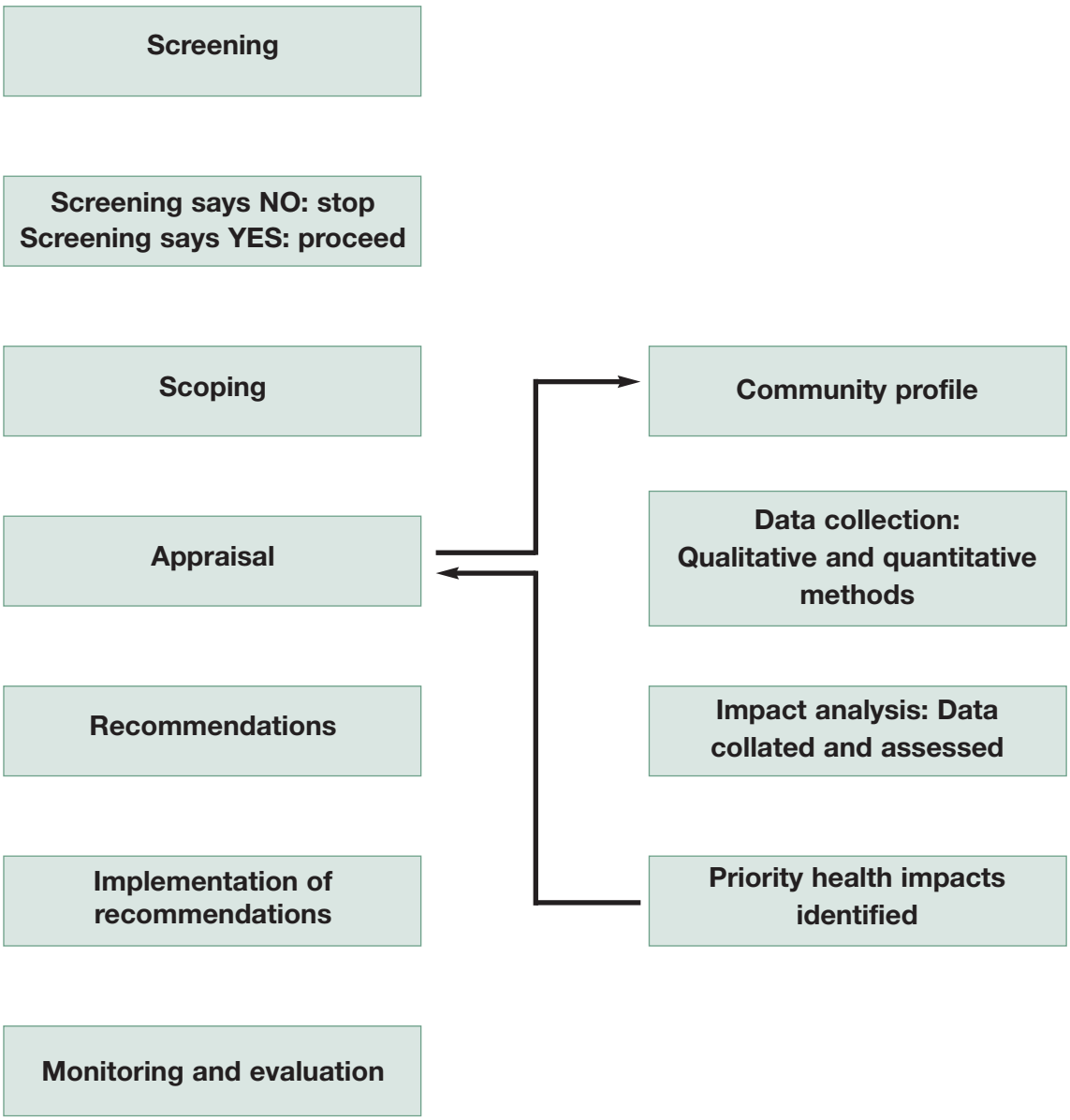
Comprehensive HIA: This is undertaken over a longer period of time and involves more resources. It is useful when the potential scale and severity of health impacts warrant an in-depth investigation.

The HIA process, described in the next section, should be followed whichever level of HIA is undertaken.

4.2 HIA process

The HIA process consists of a series of steps which are described here as discrete stages. However experience shows that the different stages can overlap with each other, for example, screening and scoping are sometimes carried out as one exercise.

Figure 2 The HIA process



4.2.1 Screening

Screening quickly and systematically establishes whether a HIA is appropriate or necessary. It can indicate:

- potential health impacts of a policy, programme or project
- potential impacts on vulnerable sections of the population
- if there is a need for a more detailed assessment
- if HIA is the best way to effectively address health and equity issues.

If a decision is made to proceed with HIA, this stage provides an outline of areas of concern to be considered when conducting the HIA. If it is decided not to proceed with HIA, screening provides a record of why that decision was reached. Additionally, conducting screening can raise awareness of health impacts among decision makers and prompt them to consider these in the future.

Use a screening tool

Using a screening tool (see Appendix 2) helps with the tasks involved in screening. The main purpose of the screening tool is to give a structure to discussions or meetings with stakeholders. It aims to prompt consideration of health impacts that may otherwise be overlooked.

Who should be involved in screening?

It is strongly recommended that screening is carried out by more than one person. Involving key informants and major stakeholders can help ensure a broader perspective and promote ownership of the process at an early stage. Members may include, for example, someone with health knowledge, the initiator of the policy, representatives from relevant government, non-government and voluntary sectors and a representative from the community likely to be affected by the proposal. Keeping the number of people involved fairly small at this stage (perhaps 5 or 6 people) will make it easier to manage.

Understand the proposed policy, programme or project

Study the proposal and its background and context. Understand its rationale and aims and objectives. Consider the health impacts of similar policies elsewhere.

Prepare for the screening meeting

Prior to the meeting it might be useful to circulate the following information:

- a summarised description of the policy, programme or project
- aspects of the policy, programme or project open to negotiation and those which are not
- any easily accessible information on the population affected by the proposal
- sections of the population likely to be particularly vulnerable to the proposal.

Establish health impacts and affected population groups

At the meeting have a brainstorming session to get the stakeholders' and key informants' perspectives on what the health impacts might be and what population groups might be affected and how. Out of a list of potential health impacts identified, attempt to prioritise them. This will help to focus resources on the most significant impacts on which to conduct the HIA. The screening tool can help to structure this exercise.

Make the process transparent

The screening tool also provides transparency for the process, enabling the recording of decisions and demonstrating thorough consideration of the health implications.

4.2.2 Scoping

The scoping stage produces the blueprint for the HIA and how it is managed. It establishes a foundation for the rest of the assessment. Appendix 3 provides a scoping tool which lists items to consider when developing a work plan for the HIA.

Proposal analysis

Proposal analysis identifies which elements of the proposal will be subject to HIA. It is important to read and fully understand the aims of the proposal in order to identify which sections the HIA should focus on. Engaging with those responsible for developing the proposal at an early stage may provide easier access to information as it becomes available.

Establish a steering group

A HIA steering group is usually set up at this stage or may evolve from the group who conducted the screening. The nature and size of the group depends on the complexity of the proposal, the resources available and the time available to conduct the HIA.

Who should be on the steering group?

Identify the main stakeholders and get them involved. Community participation forms an important part of HIA. Professionals from the relevant policy areas, representatives from affected communities, the voluntary sector and other stakeholders should be represented. Their input will contribute to informed and balanced results at the end of the process.

Attempt to get a good mix of skills on the steering group

Useful skills include community involvement, public health knowledge and understanding of evidence, research skills (such as literature review, data analysis, qualitative research, stakeholder consultation), negotiation skills, project management and policy analysis. Representatives with access to relevant data could be very useful. Other skills required vary according to the proposal type and the depth of the assessment but could include specialist skills in social sciences, epidemiology and health economics.

Who will manage the HIA process?

The group should decide this. In some cases it may be the person with lead responsibility for developing the policy, in other situations it may be the person who initiated the HIA process or another organisation interested in health.

Develop a work plan

The steering group should develop a work plan for the HIA which includes clearly defined deadlines and measurable outputs. The scope of the work plan will be dictated by the amount of time and other resources available. It is essential to find out at an early stage when key decisions will be made about the proposal so that HIA recommendations are delivered in advance of this. The contents of the work plan will be largely dictated by the following:

Aims and objectives of the HIA

Use SMART (Specific, Measurable, Achievable, Realistic and Timely) principles to develop the aims and objectives.

Values

Consider what values the HIA steering group will adopt for conducting the HIA. These may include for example, transparency, equity, sustainability, participation and inclusiveness.

Non-negotiable issues

There may be aspects of the policy, programme or project that are not open to negotiation. These should be clearly identified at the outset.

Boundaries

What geographical area and what communities or population groups will the HIA consider?

Resources

Assess financial and human resources available to conduct the HIA. The London Health Observatory has developed a HIA calculator which can be used to estimate how much the HIA will cost, available at http://www.lho.org.uk/viewResource.aspx?id=9735. Consider what additional resources may be available from organisations represented on the steering group.

Methods

Decide on the methods which will be used to gather evidence from the literature and from the community and other stakeholders. A detailed description of methods used to gather evidence is contained in section 4.2.3.

Monitoring and evaluation

The steering group should also include monitoring and evaluation arrangements in the HIA work plan.

Decide whether or not to engage an external HIA consultant

It may be advantageous to engage an external consultant. This person could be used to coordinate the process from beginning to end or to undertake one aspect of it. They could be used for a number of resource intensive tasks such as documenting decisions, recording the results of appraisal, identifying the impacts missed by stakeholders, finding evidence, prioritising health impacts and helping frame recommendations. An external HIA consultant should have public health knowledge and skills and expertise in conducting HIAs. It is important for the HIA steering group to keep control of the process and ensure its quality.

Record decisions for transparency

A record of all activity should be documented and archived. This is important to ensure that the assessment is transparent.

4.2.3 Appraisal

The appraisal stage is where evidence of potential health impacts is gathered, considered and prioritised. The methods used for data collection and analysis will vary according to the level of HIA.

Gathering information on potential health impacts of the proposal

A range of information is needed to ensure that HIA recommendations are evidence based. Consideration needs to be given to evidence from a range of sources, which are relevant to the proposal and also the population. In some cases information may already have been collected and this should be used when it is relevant and appropriate to the issues under investigation. The depth of information obtained from the following areas will depend on the level of HIA being conducted.

Community profile

Building a community profile helps to better understand the population affected by the proposal, identify potentially vulnerable groups and establish a baseline against which possible future health impacts can be assessed. Belfast Healthy Cities has produced guidance on developing a community profile, available at http://www.belfasthealthycities.com/images/stories/PDFs/guidelines.pdf

A community profile might include:

- general attributes of the population including size, density, distribution, age and sex, birth rate, ethnicity, socioeconomic status
- health status of the population, particularly the at-risk groups
- levels of employment or unemployment
- health behaviour indicators
- environmental conditions such as transport infrastructure, housing make-up, details on air, water and soil
- geographical location of at-risk groups.

Information for community profiling is available from a number of agencies including:

- The Northern Ireland Statistics and Research Agency (NISRA) http://www.nisra.gov.uk/
- Northern Ireland Neighbourhood Information Service (NINIS) http://www.ninis.nisra.gov.uk/

- The Central Statistics Office in the Republic of Ireland
  http://www.cso.ie/
- Ireland and Northern Ireland's Population Health Observatory (INIsPHO)
  http://www.inispho.org

Government departments, local authorities and community/voluntary groups may also be able to provide useful data.

Policy analysis

The policy environment into which the proposal is being introduced needs to be understood by those conducting the HIA. Understanding where the proposal sits in the wider social, economic, political and cultural policy context will help to inform the appraisal and ensure recommendations are appropriate. Policy analysis involves reviewing government and other relevant agency policy related to the proposal. Having a good mix of skills and knowledge represented on the HIA steering group can help to ensure that the policy context for the proposal is understood. A policy analysis tool is available in Appendix 4.

Literature review

A literature review should be undertaken to find evidence which supports or refutes the assumptions made at the screening stage about the potential health impacts of the proposal. It is important when conducting a literature review that questions are clear and focused and relevant to the local context of the HIA. Further information on reviewing the literature is available at:
http://www.publichealth.ie/whatishealthimpactassessment/hiamethodology

It may be useful to check with colleagues and topic experts to identify key databases, websites and other sources of information. Systematic reviews should be used where these are available. Additionally, it can be useful to review other HIAs which have been conducted on similar proposals. HIA Gateway website provides links to a number of HIAs conducted internationally, available at http://www.hiagateway.org.uk

Quantitative and qualitative evidence

Quantitative evidence is evidence, data or information which is expressed in numerical terms. The objective of quantitative research is to develop and employ mathematical models, theories and/or hypotheses pertaining to natural phenomena. The process of measurement is central to quantitative research because it provides the fundamental connection between empirical observation and mathematical expression of quantitative relationships.

Qualitative evidence is evidence, data or information that is expressed in terms of the meaning of acts or events, which distinguishes between data in terms of quality or form rather than quantity. Qualitative research places emphasis on understanding through looking closely at people's words, actions and records. The task of the qualitative researcher is to find patterns within those words (and actions) and to present those patterns for others to inspect while at the same time staying as close to the construction of the world as the participants originally experienced it.

Both types of evidence are important in HIA. The HIA should focus on the quality of the evidence regardless of whether it is quantitative or qualitative. The crucial test of the validity of evidence for HIA should be the robustness of the research design and the validity of its conclusions.

Stakeholder information

The local community and other stakeholders are valuable sources of evidence and can provide insight not available elsewhere on how the proposal might affect health. Engagement with key informants and stakeholders can take place through a variety of means including interviews, focus groups and stakeholder workshops. A task based approach to gathering evidence from stakeholders is available at http://www.publichealth.ie/eventsandresources/hiatools

Assessing the quality of evidence

The HIA aims to provide a number of evidence-based recommendations but there may be disagreement over what constitutes acceptable evidence. These are some of the issues encountered with collecting evidence and suggested ways of dealing with them.

Lack of evidence
It may be difficult to find evidence to show the direct health impacts of public policy decisions, particularly at a local level. For this reason evidence from other similar geographical areas is frequently used and extrapolated to apply to local conditions.

Time constraints on gathering evidence
There may not be enough time to carry out local research so readily available existing evidence will have to suffice.

Speculative nature of evidence
Where evidence exists, much of it shows associations rather than direct causal connections between policy actions and health impacts. For example, there is an association between poor housing conditions and certain types of illness but there is disagreement about the strength of the association and whether one directly causes the other.

Apply the precautionary principle
To address this issue, HIA adopts the WHO approach and applies the precautionary principle when dealing with evidence. This means that where there are threats of serious damage to health, a lack of full scientific certainty should not be used as a reason for postponing measures to minimise this damage.

Decision makers' views on evidence
If the crucial decision makers on the policy, programme or project want to see particular types of evidence used, then highlighting this evidence will improve the chances of the recommendations to maximise health being accepted.

Collating information

The next step in appraisal is to assemble all the information that has been gathered to date in preparation for prioritising impacts. It may be useful to insert information into a table (see Appendix 5) which links the potential health impacts identified in the proposal with the evidence gathered.

Prioritising potential health impacts

Depending on the complexity of the proposal and level of HIA undertaken, there may be a large number of potential health impacts identified. Some groups choose to form recommendations for each impact identified however it is advisable to agree some form of ranking system to help decide where most efforts should be made in ensuring certain recommendations are implemented. Prioritised impacts should reflect the aims, objectives and values of the HIA. Furthermore appropriate consideration should be given to different types of evidence.

Issues which may influence prioritisation include:

- the likelihood of the impact occurring (likely, speculative or unlikely)
- the scale of the impact if it does occur (severe, moderate or minimal)
- the number of people likely to be affected (many, some or few)
- the timescale in which the impact may occur (short, medium or long term)
- whether the impact will affect some groups within the population more than others (inequalities)
- issues highlighted as areas of concern by stakeholders (stakeholder concerns).

All the evidence used to support prioritisation of potential health impacts should be documented by referencing, for example, studies, quotes from stakeholders or policy documents. The strength of evidence used should also be easily identifiable.

Appendix 5 provides a tool to assist in prioritising potential health impacts.

4.2.4 Recommendations

Forming recommendations

The steering group develops one or more recommendations for each (prioritised) health impact on how this aspect of the proposal could be modified to maximise health gain and/ or minimise health loss. Recommendations should:

- be practical and achievable
- identify a lead agency and others who may play a role
- specify timeframes where possible
- be wide ranging
- aim to be cost effective
- be relatively few in number.

Appendix 6 provides a tool in which recommendations can be documented.

Examples of recommendations from HIAs conducted in the Republic of Ireland and Northern Ireland are contained in Appendix 8.

Disseminating recommendations

Recommendations should be sent to the relevant lead agencies. This may require a period of negotiation where decision makers plans to implement recommendations are agreed. Ideally discussions will have begun in advance of this stage. A report describing the process, findings and policy revision options may also be produced for the proposal developers. Summary reports and other mechanisms of dissemination may also be produced to meet the different needs of stakeholders and target audiences. A tool has been developed to guide this stage of the process (see Appendix 6).

4.2.5 Monitoring and evaluation

Monitoring and evaluation is an essential part of the HIA. As well as assessing actual impacts on health in the longer term, it can help inform whether the aims and objectives set at the beginning of the HIA were achieved and whether the methodology used was effective or suitable. The following issues should be considered:

Process

Assess how the HIA process was undertaken, who was involved, and how useful

and valuable the process was. This can help determine whether the HIA added value to the decision-making process. Monitoring and evaluation of the process and methodology can be conducted by reading output documents, minutes, agendas and other material and obtaining steering group members' points of view through a survey or interview.

Impact
Assess the impact of the HIA in terms of whether recommendations are subsequently accepted and implemented by the decision makers and if not, why not. The tool in Appendix 7 can assist with the process.

Outcome
Monitoring and evaluation should also consider the health outcomes of a proposal after a HIA has been conducted. It should aim to assess whether the anticipated positive effects on health, wellbeing and equity were in fact enhanced and whether negative ones were minimised.

The health impacts of a policy may take many years to become apparent and the HIA steering group may not be available to measure these impacts once the assessment is complete. For this reason, indicators to measure the longer term health impacts of the proposal should be framed while doing the HIA and these should be included as a discrete strand of the ongoing monitoring of the policy or project.

4.3 The HIA report

A brief report describing the process, findings and policy revision options may be produced. It may be appropriate to also produce a full HIA report for decision makers and other stakeholders involved in the HIA. Other feedback mechanisms such as newsletters and posters may also be considered.

Appendix 1: Further information on social determinants of health

The Institute of Public Health in Ireland (IPH) has produced review documents in four areas, education, the built environment, employment and transport, illustrating the connections between these policy areas and health. A brief overview of key health impacts identified in each review is given below. The full reports, together with supporting 'sources of information' documents, can be accessed at http://www.publichealth.ie/hiaresources.

Health impacts of education

Health outcomes associated with education

Evidence shows that those with lower levels of education die younger, experience higher rates of illnesses such as cardiovascular disease and strokes and are also less likely to engage in healthy behaviours such as physical activity.

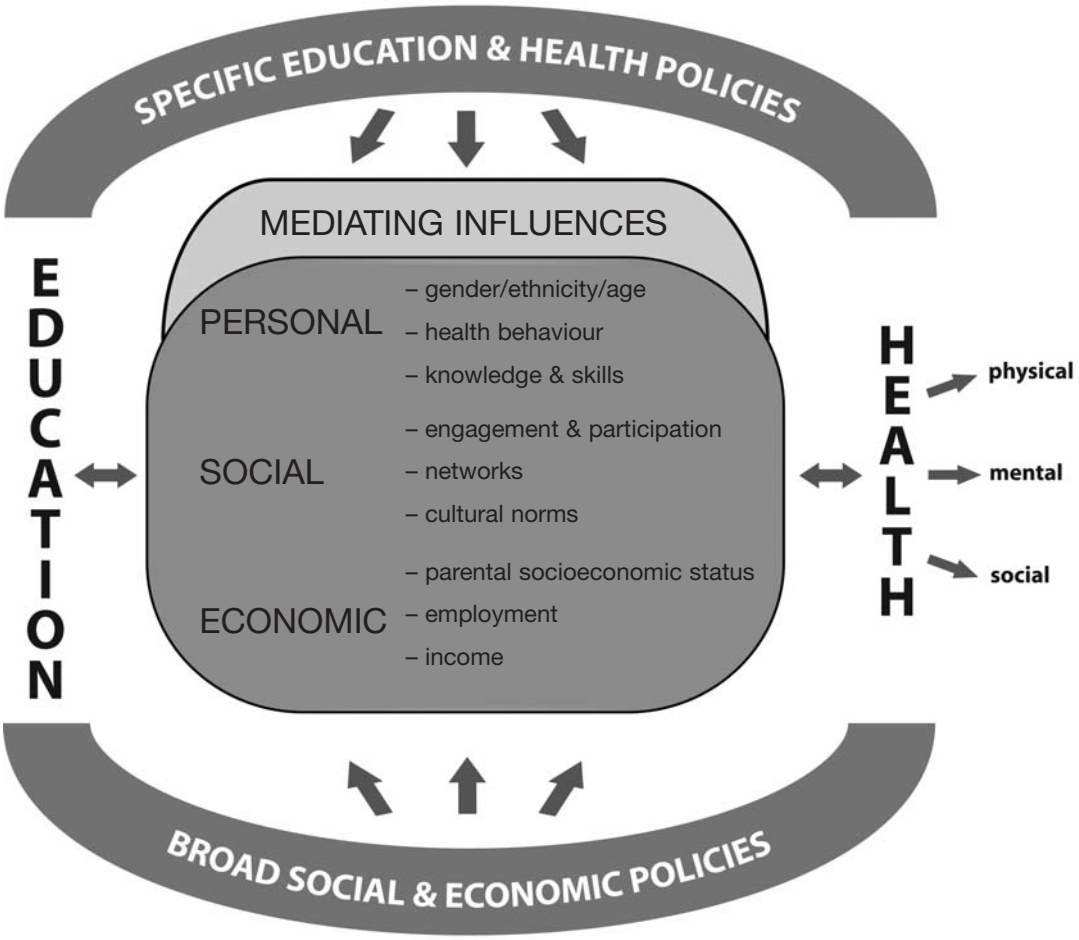
Route to health through education

Education provides opportunities for employment and potentially higher income levels. It enhances individuals' social skills and levels of social capital, both of which are associated with better health. Personal development and attitudes are enhanced with higher levels of education which can lead to a greater sense of control and an increased likelihood that healthier behaviours will be adopted.

Supporting healthy behaviours and attitudes in the school environment

The school environment can support health through school settings approaches to healthier lifestyles for young people. Physical education (PE) and travel to school patterns such as walking or cycling are important for health. Exercise habits established in childhood are a key indicator of levels of physical activity in adulthood and therefore the education system can support the development of such habits.

Figure 3 Health impacts of education[9]



Health impacts of the built environment

Acknowledging the historic links between public health and planning, this review considers how modern illnesses are affected by the built environment.

Buildings

The way in which buildings are designed and used has many impacts on health. Adequate space, light, temperature and noise control are all essential for good health. This has been demonstrated across a wide range of building types including schools, hospitals and homes. Cold, damp homes can lead to respiratory and cardiovascular health problems, especially for vulnerable groups such as the elderly, chronically ill and very young. Children living in buildings with limited space for play are more likely to suffer behavioural problems and multi-occupational dwellings are associated with mental health issues. Well designed and maintained buildings can reduce the likelihood of injuries, for example falls amongst the elderly.

Public spaces and networks

Public spaces and networks influence physical, mental and social health in a number of ways. Access to good quality, well-maintained public spaces, efficient, modern public transport systems and walkable neighbourhoods can encourage physical activity, increase the likelihood of social interaction and contribute to better air quality.

Figure 4 Health impact of the built environment[10]

Health impacts of employment

Unemployment and low income

Unemployment affects both physical and mental health and is an important determinant of health inequalities in adults of working age. Unemployed people have a higher risk of morbidity and premature mortality. They also have a higher risk of lower levels of psychological wellbeing ranging from symptoms of depression and anxiety to self harm and suicide. Unemployment affects family income levels that impact on other health determinants, for example, housing and nutrition.

Job insecurity

Job insecurity is associated with negative attitudes to work and negative impacts on health. For example, mild depression and self-reported health status tends to deteriorate among those anticipating a job loss. Insecure jobs also tend to involve high exposure to work hazards of various kinds. Less skilled, manual workers tend to be most exposed to low paid, temporary or insecure jobs. Downsizing, which can lead to increased job insecurity, has been shown to be associated with long periods of sick leave due to musculo-skeletal disorders and trauma.

Type of work

Jobs involving a high psychological demand but with low control over working conditions are associated with health-related harm. High demand, low control work is more common among lower socioeconomic groups and non-permanent workers and is associated with increased risk of heart disease, musculo-skeletal disorders, mental illness and sickness absence. Social support in the workplace has been shown to mitigate this job strain.

Health impacts of transport

Air pollution

Motor vehicles are responsible for nitrogen dioxide, carbon dioxide and Particulate Matter (PM) emissions. Air pollution episodes are associated with rises in death and hospital admissions. Ambient levels of air pollution are associated with raised morbidity and mortality. Air pollution also contributes to climate change.

Road traffic injuries

Effects of road traffic injuries include mortality and injury for bicycle users, pedestrians, motorists and passengers. Perceived danger from traffic restricts

children's independent mobility and reduces the amount children exercise, with long term implications for children's physical and mental wellbeing.

Physical activity
Physical activity reduces the risk of heart disease, stroke, diabetes, hypertension, depression, cancer and osteoporosis. A transport policy that encourages exercise through cycling or walking will maximise health.

Community severance
This is caused by major roads being built through a community, with residents cut off from safe access to shops, schools and other parts of their social network. Social contact is beneficial to health but studies in the USA show that social contact tends to fall as traffic increases.

Noise
Traffic noise contributes to stress-related health problems such as hypertension and minor psychiatric illness. It can also cause loss of sleep and may interfere with concentration.

Access/Mobility
Access to education, work, shops, health care and social networks are important determinants of health. A transport policy needs to ensure that access is enabled for all sectors of the community, not just car users.

Inequalities
The effects of a transport policy do not fall evenly on all sectors of society. Pedestrians and cyclists are more prone to injuries than drivers. People with higher incomes can live away from a main road and will not suffer as much from air pollution, noise or community severance. Those with easier access to leisure facilities are more likely to exercise more.

Appendix 2: Screening tool

Available online at http://www.publichealth.ie/hia

Section one: Background and context

Title of proposal being screened	
Date screening conducted	
Person(s) involved in the screening process (name, organisation represented and job title if applicable)	
What stage of development is the proposal at?	
Briefly outline the importance of the proposal from: *An economic/ business perspective* *A political perspective* *A community perspective*	
What resources are available to conduct a HIA? (Consider both human and financial)	
Are decision makers likely to be open to recommendations to amend the proposal?	

Section two: Potential impacts on health determinants

Instructions for completing the table

The first column contains a list of issues that are known to influence health (health determinants). These are grouped into social and economic conditions, structural issues and individual and family issues.

STEP 1: Assess the likelihood of the proposal impacting on this health determinant and record as:

- **Likely** (it is likely that the proposal will impact on this health determinant). **Code as L**
- **Unlikely** (it is unlikely that the proposal will impact on this health determinant). **Code as U**
- **Not known** (there is insufficient information in the proposal to assess whether or not it will impact on this health determinant). **Code as NK**

*If the health impact is considered **likely**, continue to step 2. If the health impact is considered **unlikely** or is **not known**, proceed to step 3 or move on to the next health determinant.*

STEP 2: List the groups most likely to be affected by the proposal. Examples of different population groups are given below (this is not intended to be a complete list).

- Infants and toddlers
- Children and young people
- Working age people
- Older people
- Rural population
- Urban population
- Males/ females
- Single/ married people
- Gay/ lesbian people
- People with dependants
- Racial and ethnic groups (particularly minority groups)
- People with particular religious beliefs
- People with particular political opinions
- People with disabilities
- Chronically ill people
- Homeless people
- Unemployed people
- Economically disadvantaged people
- Others

Social and economic conditions that influence health		
Likelihood that the proposal will impact on this health determinant (L/ U/ NK)		***Groups most likely to be affected by the proposal***
Education		
Employment		
Childcare		
Crime and fear of crime		
Community interaction		
Access to fresh food		
Access to sports and other opportunities for physical activity		
Access to cultural and other recreational activities		
Access to healthcare services		
Access to social welfare services		
Access to other community services		
Access to public transport		
Other social or economic conditions (list)		

Structural issues that influence health		
Likelihood that the proposal will impact on this health determinant (L/ U/ NK)		***Groups most likely to be affected by the proposal***
Housing		
Public buildings		
Commercial buildings		
Green space (including parks)		
Other public spaces		
Road safety *Transport infrastructure*		
Communications infrastructure (internet/telephone)		
Energy sources		
Waste management infrastructure		
Water quality		
Air quality (indoor and outdoor)		
Soil quality		
Noise		
Light		
Other structural issues (list)		

Individual and family issues that influence health		
Likelihood that the proposal will impact on this health determinant (L/ U/ NK)		***Groups most likely to be affected by the proposal***
Diet		
Physical activity		
Substance use (legal and illegal)		
Sexual activity		
Household income		
Family cohesion		
Other individual and family issues (list)		

Section three: Screening outcome

Tick the appropriate outcome

Overall, health impacts are unlikely or relatively minor and easy to address.	Where appropriate, make recommendations to decision makers on how such impacts may be addressed. Do not proceed with HIA.	
Overall, health impacts are likely or unknown.	Taking into account issues raised in section one, proceed with HIA.	

Appendix 3: Scoping tool[1]

Available online at http://www.publichealth.ie/hia

Title of the proposal on which the HIA is being conducted	
Aim of the HIA	
Values underpinning the HIA	
Objectives of the HIA (Consider core values)	
Boundaries of the HIA (e.g. geographical, population)	
Time scale for the HIA	
Non-negotiable aspects of the proposal	
Steering group membership • Suggest maximum of 12 members • include decision makers of the policy, programme or project on the group	
Main stakeholders: • Who is likely to be affected? • Are key stakeholders represented on the steering group?	
Key informants for the HIA: • Who can provide useful information on how the proposal is likely to impact on health?	
Who will be responsible for gathering evidence in the following areas? • Literature review • Community profile • Stakeholder workshops • Proposal and policy analysis	

[1] Adapted from a tool developed by E. Ison

Who will be responsible for appraising the evidence and forming recommendations?	
How will the results of the HIA be presented and disseminated?	
What measures will be put in place to facilitate evaluation of the HIA?	
How will the HIA budget be spent? Consider: • Human resources • Venue hire, catering and travel costs for meetings and workshops • Costs associated with dissemination of the results • Evaluation costs	
Operating arrangements for the steering group including: • Chair • Date and location of meetings • Secretariat	

Appendix 4: Policy analysis tool

Available online at http://www.publichealth.ie/hia

This tool provides a framework to record information obtained relating to the policy environment. In the following table record:

- Policy – overview of the policy being analysed, including title and lifespan
- Organisation – who is responsible for implementation
- Aspects relevant to HIA – identify key areas of the policy relevant to the HIA.

Policy	Organisation(s)	Aspects relevant to HIA

Appendix 5: Tools for collating information and prioritising impacts

Available online at http://www.publichealth.ie/hia

Collating information

This tool can be used as a structure to collate the information gathered as part of the HIA process. The tool enables the steering group to systematically record the evidence supporting or negating potential health impacts identified in the proposal.

In the following table:
Record the potential health impact identified in the proposal in column 1.
Place evidence from various sources in columns 2-5.

Potential health impact identified in proposal	Community profile	Policy analysis	Evidence from literature	Evidence from stakeholders

Prioritising health impacts tool

This tool suggests one approach to prioritising potential health impacts identified. A prioritisation column may be inserted into the collating information tool to record decisions.

The criteria for prioritisation potential health impacts identified. A prioritisation column may be inserted into the collating information tool to record decisions. The criteria for prioritisation will depend on the specific circumstances of the HIA and some of the following could be used to assist this process:

- the severity of the impact if it does occur (severe, moderate or minimal)
- the number of people likely to be affected (many, some or few)
- the timescale in which the impact may occur (short, medium or long term)
- whether the impact will affect some groups within the population more than others (inequalities)
- issues highlighted as areas of concern by stakeholders (stakeholder concerns).
- the likelihood of the impact occurring (likely, speculative or unlikely)

Codes may be assigned to assist the steering group e.g. use L, S or U to document likelihood of the impact occurring.

Potential health impact identified in proposal	Community profile	Policy analysis	Evidence from literature	Evidence from stakeholders	Prioritisation

Appendix 6: Tools for forming and disseminating recommendations

Available online at http://www.publichealth.ie/hia

The following tools provide templates to record the recommendations and how they will be implemented by the decision maker.
Step 1 Forming recommendations
Step 2 Disseminating HIA recommendations

Step 1 Forming recommendations

Record the recommendations agreed by the steering group to maximise health gain or minimise health loss.

Prioritised Health Impact	Recommendation to maximise health gain

In Appendix 8 there are examples of recommendations from completed health impact assessments.

Step 2 Disseminating HIA recommendations

This tool can be used to approach each decision maker who is responsible for implementing the identified recommendations. This will provide an overview of how they intend to implement the recommendations relevant to their organisation.

The organisation conducting (or responsible for) the HIA should insert the relevant recommendation(s) into column 1 and the suggested timescale for implementation into column 2 prior to sending this to the identified organisation/decision maker who then completes column 3.

This report provides details of recommendations arising from the HIA conducted on

_____

Please review each recommendation and its suggested timescale for implementation. In right-hand column, please indicate your organisation's intentions regarding implementation, which may include:

- Likelihood of the recommendation being implemented
- Appropriateness of the suggested timescale for implementation
- Any other comments.

Recommendation	Suggested timescale for implementation	Organisational response re intention to implement

Please return the completed form to_____ by _____

Appendix 7: Reviewing the implementation of HIA recommendations

Available online at http://www.publichealth.ie/hia

This tool may be used as part of the evaluation stage of the HIA and be presented to decision makers responsible for implementing identified recommendations.

The organisation conducting (or responsible for) the HIA should insert the relevant recommendation(s) into column 1 prior to sending this to the identified organisation/decision maker.

This report assesses the progress made towards implementing recommendations arising from the HIA conducted on _____

Please review the recommendations listed.
For each recommendation, please select the outcome which best describes its current status from the options listed below:

- insert √ if the recommendation has been fully implemented
- insert ? if the recommendation has been partially implemented or implemented with modifications
- insert O if the recommendation has provided the stimulus for additional actions (including unintended ones) for example an agency other than the one specified took some action
- insert X if there is no evidence to suggest that the recommendation has been taken on board.

Please note any available supporting evidence in the right hand column.

Recommendation	Outcome	Supporting evidence

Please return the completed form to_____ by _____

Appendix 8: Examples of recommendations from HIAs conducted in the Republic of Ireland and Northern Ireland

Listed below are examples of recommendations from HIAs completed in the Republic of Ireland and Northern Ireland. They demonstrate how HIAs can support healthy public policy to maximise health gains and minimise health loss from a proposal. Copies of all HIAs listed and others conducted across Ireland may be sourced at http://www.publichealth.ie/hia

A HIA of Traffic and Transport in Ballyfermot, Eastern Region Health Authority, 2005

- A key recommendation is that a local action group be convened in Ballyfermot to identify how the issues identified in the HIA may be addressed locally.
- It is recommended that Dublin City Council (DCC) endeavour to target resources to promote active transport, i.e. walking and cycling in Ballyfermot, within the agreed priorities of the South Central Area Committee and in line with DCC policy.
- It is recommended that the Health Promotion Department continue to seek resources to develop local health promotion teams and services and work with the General Manager of the Community Health Services in relation to this.
- It is recommended that a member of staff with a broad understanding of public health be assigned from the local Community Care Area Dublin West to the local implementation group to promote health and physical activity in Ballyfermot. The General Manager of Dublin West, who is a member of the URBAN II Board, is supportive of this.

Health Impact Assessment - Dove Gardens, Co-operation and Working Together (CAWT), 2005

- Traffic calming, signage and pedestrian areas should be designed into the new scheme (including 'welcome' sign).
- Achieve 'secure by design' certification for individual homes and the estate layout.
- Hold regular social meetings to update residents on developments and maintain social contacts and networks.
- Incorporate principles of a safe play environment within the whole area to allow children to play on the streets.

Health Impact assessment of the Draft Air Quality Action Plan for Belfast, Belfast City Council, 2006

- To increase safety, and decrease crime and fear of crime, it is suggested that Belfast City Council and Translink consider building cycle shelters the design of which takes into account access, security and location and reduces the likelihood of vandalism, e.g. roofless.
- To encourage the uptake of public transport, it is suggested that Translink considers improving coordination among bus services and between bus and train services to facilitate interchange within and between modes of transport.
- To maintain the reductions in air pollution that may be achieved through strategic highway network capacity improvements, it is suggested that DRD Roads Service and Translink consider the simultaneous introduction of bus lanes/corridors to improve service quality and reliability and thereby encourage the uptake of public transport.

West Tyrone Area Plan (WTAP) 2019, Health Impact Assessment, Stage 1 – Interim report, Western Investing for Health, 2008

- Significant consideration needs to be given to facilitate rural economic development to provide employment opportunities and a source of income for those in the local area.
- WTAP should encourage the provision of walking and cycling routes in the countryside.
- The WTAP should ensure that accommodation needs of the Travelling community are given adequate consideration.
- Renewable energy targets should be set by the WTAP to ensure adequate zoning is allocated to assist Northern Ireland to achieve the target of 12% of all electricity consumed coming from indigenous, renewable energy sources as identified by the Strategic Energy Framework.

Health Impact Assessment of Doneraile Traveller accommodation proposal, Traveller Health Unit HSE South & HIA Ireland, 2008

- Provide internet access in homes to encourage education and home study for both children and adults.
- Develop a joint neighbourhood watch scheme between Travellers and the settled community supported by the Gardaí.
- Provide an opportunity for Traveller community to rename their neighbourhood (suggest name from Traveller language which relates to the local area).
- Put in place a traffic management plan which deals with anticipated increased traffic and makes provision for Traveller families pulling in and out of transient site.

Limerick Regeneration HIA: Phase 1: Physical regeneration, HSE West, 2008

- Develop a Communication Strategy that considers a wide variety of methods of communication with the aim of encouraging maximum participation from all residents. Hard to reach groups which may need particular attention are young people, older adults, travellers, those with a disability and those with low literacy.
- Give consideration to the development of a network of safe cycling and walking routes throughout the estates.
- Green areas should be surrounded by small attractive walls/hedging or other border that prevents access to the green by motorised vehicles with the aim of reducing joy riding on the green and burning out of cars.
- Involve older adults at all stages of the planning, including the planning and design of their home.

Limerick Regeneration HIA: Phase 2: Early school leaving, absenteeism and truancy, HSE West 2008

- Build upon and enhance the capacity of current Department of Education and Science and community initiatives to promote more positive parent-school - parent-teacher relationships.
- Give consideration to a first year transition or induction period, to facilitate the smooth transition from primary to post-primary school, particularly for vulnerable / marginal young people.
- Schools and local statutory and voluntary agencies should support the work of the local Drugs Task Force in the Limerick area.
- Limerick City should develop a communication strategy and an action plan that challenges national and local media practice to work in a balanced and responsible fashion – one that is mindful of people who have to live in 'disadvantaged'/'troubled' estates.

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Mental health: deprivation

Major risk factors for mental health problems include poverty, poor education, unemployment, social isolation/exclusion and major life events. A review of large-scale studies of mental health problems reported that such problems are more common among people who are unemployed, have fewer educational qualifications, have been looked after or accommodated, are on a low income or have a low standard of living (Mental Health and Social Exclusion 2004 (1.11MB)).

The Scottish Burden of Disease Study report on deprivation shows the stark inequalities in mental health outcomes across Scotland.

Further evidence of the link between deprivation and psychiatric morbidity can be seen in Practice Team Information (PTI) for Scotland. Table 1 presents estimates of the number and rate of people in each Scottish Index of Multiple Deprivation (SIMD) quintile (fifth of the population) consulting their GP or practice nurse for anxiety or depression in 2012/13. It shows that:

- For anxiety, the estimated rate of patients who consulted a GP or practice nurse ranged from 39 per 1000 males and 76 per 1000 females in the most deprived quintile, down to 20 per 1000 males and 37 per 1000 females in the least deprived quintile.
- For depression, the rates were all a little lower but the pattern was broadly similar.

Table 1. PTI data on anxiety and depression(1,2), by gender and Scottish Index of Multiple Deprivation (SIMD) quintile(3): Scotland, 2012/13

		Anxiety			Depression		
			95% confidence intervals			95% confidence intervals	
Sex	Quintile	Rates per 1000 population(1)	Lower	Upper	Rates per 1000 population(1)	Lower	Upper
Males	1- most deprived	38.8	34.6	43.0	24.3	20.1	28.5
	2	28.9	25.0	32.8	20.1	17.4	22.8
	3	24.8	21.5	28.1	21.6	18.6	24.6
	4	22.0	19.1	25.0	17.2	14.9	19.4
	5 - least deprived	19.6	16.9	22.3	14.3	12.8	15.7
	All categories	26.4	22.9	30.0	20.1	17.4	22.7
Females	1 - most deprived	76.2	67.5	84.9	44.4	37.6	51.2
	2	58.0	50.6	65.4	41.3	35.5	47.2
	3	48.2	42.4	54.0	38.7	33.5	43.9
	4	45.4	38.8	52.0	33.7	30.1	37.3
	5 - least deprived	36.7	32.2	41.1	30.9	27.8	33.9
	All categories	52.8	45.6	59.9	37.7	33.0	42.4
Persons	ALL	39.7	34.5	44.9	29.0	25.5	32.5

Source: ISD Practice Team Information.
(1) The rates for quintiles are standardised for age, the rates for 'All categories' are standardised for age and SIMD quintile, and the rates for Persons are standardised for age, gender and SIMD quintile. (2) Based on 60 PTI practices that submitted complete GP and practice nurse data for the year ending 31 March 2013. A patient may have a diagnosis of both anxiety and depression. (3) The SIMD 2012 release was used.

Note that the PTI measure does not reflect prevalence of particular mental health problems: PTI data captures active as opposed to lifelong or previous conditions.

As of September 2013, PTI data were no longer collected. 2012/13 is the last year for which ISD can publish annual PTI data. A new national GP information system known as the Scottish Primary Care Information Resource (SPIRE) is in development which will supersede and build on the data collected for PTI.

Please note: If you require the most up-to-date data available, please check the data sources directly as new data may have been published since these data pages were last updated. Although we endeavour to ensure that the data pages are kept up-to-date, there may be a time lag between new data being published and the relevant ScotPHO web pages being updated.

Page last updated: 14 December 2018

TR020002 – Manston Airport - Written Representation Ref:20011948

Investment, Jobs and Regeneration

Socio-Economic Issues SEi, SEiii, SEiv, SE v, SE vi, SE viii.

Introduction

I am writing as Vice Chair of Save Manston Airport Association, which supports the RSP DCO application in full, and as such agree with all aspects of the application [APP-001 to APP-087].

Save Manston Airport Association (SMAa) are working with the applicant and Kent Needs Manston Airport (KNMA) to find the best ways of providing the appropriate training and education to enable as many local people as possible to be employed. KNMA will be submitting a detailed Written Representation concerning the training aspects. SMAa, through this Written Representation, will concentrate on the educational opportunities presented by the application.

Data, methodology and assumptions

I have tried to access information/data from reputable sources and quoted relevant passages using quotation marks. In each case I have used a footnote which indicates the name of the relevant appendix and, where possible the page number, paragraph or table/figure number. I have then submitted these appendices as PDF attachments. In some cases, such as data from web pages I have taken screenshots and then converted to PDFs.

If I have referred to documents in the Examination Library, I used the appropriate document reference from the EL and put it in square brackets with a footnote. The footnote will indicate the relevant page number and paragraph number, table, diagram or figure where possible.

N.B. Some documents, for example audio recordings, are not yet in the EL so I have used their full name in the footnote with the approximate start time indicated.

I have tried to avoid using assumptions by applying the methods described above but on occasions I have used my personal experience as a teacher of 34 years.

I would also like to thank other members of SMAa for their contributions towards this document.

Executive Summary

Evidence makes it clear that Thanet continues to be the most deprived local authority[1] in Kent and has the highest 18-24 year old unemployment in the South East. The situation is not much better in Canterbury, Dover and Swale. [2]

The majority of enterprises in East Kent employ 0-4 people and very few employ over 250 people.[3] A reopened airport, by the applicant, will be a significant employer in the area even by year two of operation.[4]

This application brings real hope to the area because it will be transformational in so many ways. It will give employment prospects for many hundreds of local people in a wide range of jobs, with many being highly paid skilled jobs. This drastic fall in unemployment in Thanet and East Kent will help to reduce deprivation, improve both physical and mental health and raise life expectancy. The area will become more attractive for other investors thus increasing local employment and give a further boost to the local economy. The positive affects of a reopened airport will also be reflected by the large contribution to GDP.

[1] Appendix 1 – page 1
[2] Appendix 2 – page 2
[3] Appendix 3 – page 6 table 3 and table 4
[4] [APP – 085] – Volume IV page 28 table 4

Background

a) Deprivation

According to figures produced by the Office for National Statistics (ONS) and published by Kent County Council (KCC) looking into the index of multiple deprivation (2015):

"Thanet continues to rank as the most deprived Local Authority in Kent"[5]

Out of 326 Local Authorities, Thanet is now ranked 28th, which is 21 places worse than in 2010.[6] Thanet is within the top (worst) 10% most deprived Authorities in England.

N.B. The lower the ranking number the more deprived the area.

England is divided into 32,844 Lower Super Output Areas (LSOA) each with a population of 1,500. Cliftonville West 001A (in Thanet) is 4th out of 32,844 LSOAs. Thanet has 14 LSOAs within the top 10% most deprived LSOAs in England.[7]

b) Unemployment

Using information from the Office for National Statistics Claimant Count (Dec 2018) published by KCC:

Thanet has the highest unemployment rate (in Kent) at 5.2%. That compares very poorly with the Kent figure of 2.2% and Great Britain 2.4%.[8]

The situation for the young is even worse. "Thanet has the highest 18-24 year old unemployment rate in the South East at 8.0%." In Canterbury, 1.5%, Dover 5.9%, Swale 6.1%, Kent 3.4% and Great Britain 3.2%.[9]

It is clear from the information above that Thanet and neighboring authorities desperately need jobs that are accessible to local people, particularly the young.

Referring to information from the Office for National Statistics published by KCC, it shows there are very few enterprises that employ more than 250 people:

Canterbury District 30 out of 3,990 (0.6%)
Dover District 5 out of 2,530 (0.1%)
Swale District 15 out of 3,670 (0.3%)
Thanet District 5 out of 2,935 (0.1%)[10]

In contrast most enterprises employ 0-4 people, Canterbury 75.8%, Dover 75.1%, Swale 76.1% and Thanet 75.9%.[20]

Unemployment in Kent increased by 3,875 from December 2017 to December 2018 with a quarter of that, 965, being in Thanet alone. Thanet desperately needs jobs.

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[5] Appendix 1 – page 1
[6] Appendix 1 – page 3 table 2
[7] Appendix 1 – page 4
[8] Appendix 2 – page 1
[9] Appendix 2 – page 2
[10] Appendix 3 – page 6 table 3 and table 4

By any standard, a reopened airport will be a very significant enterprise with the number of jobs projected. By year two, direct jobs projected by the applicant (856) will exceed the 250-job threshold making it one of the major employers in the area. [11]

Table 4 Forecast job creation

	Freight tonnage	Passenger numbers	Direct jobs	Indirect/ induced jobs	Catalytic jobs	Total job creation
Y1	0	0	116	0	0	**116**
Y2	96,553	0	856	1,542	0	**2,398**
Y3	108,553	662,768	1,551	2,791	6,203	**10,545**
Y4	167,092	679,868	2,085	3,753	8,341	**14,179**
Y5	173,741	686,672	2,150	3,870	8,601	**14,621**
Y6	181,436	965,295	2,466	4,438	9,862	**16,766**
Y7	192,908	975,591	2,576	4,638	10,306	**17,520**
Y8	200,673	975,591	2,645	4,762	10,581	**17,988**
Y9	203,245	975,591	2,668	4,803	10,673	**18,143**
Y10	212,351	975,591	2,749	4,948	10,996	**18,693**
Y11	222,377	1,011,587	2,812	5,062	11,249	**19,124**
Y12	234,508	1,049,022	2,890	5,202	11,561	**19,653**
Y13	244,690	1,087,954	2,947	5,305	11,789	**20,042**
Y14	256,989	1,128,444	3,018	5,432	12,072	**20,522**
Y15	270,579	1,170,553	3,094	5,570	12,378	**21,042**
Y16	283,904	1,214,347	3,164	5,695	12,656	**21,515**
Y17	296,594	1,259,892	3,224	5,802	12,894	**21,920**
Y18	312,344	1,307,259	3,301	5,942	13,205	**22,448**
Y19	324,838	1,356,521	3,349	6,029	13,397	**22,775**
Y20	340,758	1,407,753	3,417	6,151	13,668	**23,235**

[11] [APP – 085] – Volume IV page 28 table 4

Diversity of Jobs

Airports provide employment for large numbers of people both directly and indirectly in a wide variety of roles. At a reopened Manston the following is projected:[12]

- Pax – passenger services
- Frei't – Freight services
- ATS – Air Traffic Services
- RFFS – Rescue and Fire Fighting Services
- Ops – Airport operations
- Maint – Maintenance
- MT- Motor Transport
- Sec – Site and freight security
- Adm – Administration

Estimated job creation by the Manston Airport operator by function

	Pax	Frei't	ATS	RFFS	Ops	Maint	MT	Sec	Adm	Total
Y1	0	49	6	14	6	8	8	11	14	**116**
Y2	0	196	25	57	24	31	31	45	14	**423**
Y3	99	215	25	57	29	38	38	55	15	**571**
Y4	102	302	25	57	31	41	41	59	15	**673**
Y5	103	322	25	57	32	41	41	60	16	**697**
Y6	145	256	25	57	33	43	43	62	16	**680**
Y7	146	288	25	57	33	43	43	63	16	**714**
Y8	146	307	25	57	33	43	43	63	16	**733**
Y9	146	357	25	57	34	44	44	64	16	**787**
Y10	146	331	25	57	34	44	44	64	16	**761**
Y11	152	347	25	57	34	44	44	64	16	**783**
Y12	157	361	25	57	34	45	45	65	16	**805**
Y13	163	376	25	57	35	45	45	66	16	**828**
Y14	169	391	25	57	35	46	46	67	16	**852**
Y15	176	413	25	57	36	46	46	68	16	**883**
Y16	182	430	25	57	36	47	47	68	16	**908**
Y17	189	447	25	57	36	47	47	69	16	**933**
Y18	196	469	25	57	37	48	48	70	17	**967**
Y19	203	488	25	57	37	48	48	71	17	**994**
Y20	211	507	25	57	38	49	49	71	17	**1,024**

The diversity of roles available means that there is something to suit all abilities and, coupled with the appropriate education and training, will be transformational for the area. It will give local people real hope that they can obtain a worthwhile, well-paid job right on their doorstep.

[12] [APP – 085] – Volume IV page 30 table 6

Many of the jobs will be high quality with clearly defined career structures to enable progression within the industry. For an area of such high unemployment and deprivation the beneficial effect of a reopened airport cannot be over emphasised.

Not only will there be direct jobs available but airports generate indirect jobs:

"5.1.2 Indirect employment includes jobs in the supply chain such as wholesalers providing food for in-flight catering, aviation fuel supply, travel agents, cleaning and maintenance contractors, for example. Induced employment covers a wide range of jobs created as a result of those connected to the airport spending their income in the local or national economy."[13]

With more local people in employment spending their money locally the knock on effect to Thanet and East Kent will be extremely positive. Businesses seemingly unrelated to the airport will benefit from the upturn in the local economy. This in turn will encourage further investment in an area that will be seen as up and coming.

Effect on the Local Economy

A reopened airport will have an affect on both GDP and GVA. Within 5 years it is projected that direct jobs will contribute between £1,000,000 and £150,000,000 towards GDP. [14] In terms of GVA:

"8.1.8 In order to estimate GVA from Manston Airport's operations, the Stansted Airport figure, as used in their March 2018 Planning Application, has been applied (RPS, 2018). GVA per person in employment for the Stansted Airport operational study area was shown to be £60,500 (RPS, 2018, section 11.59). Applying this figure to the Manston direct job forecast only would generate GVA of £166 million in Year 10 and almost £207 million in Year 20."[15]

What other businesses in Thanet and East Kent generate these kind of figures?

Deprivation, Unemployment and Health

There have been many studies done over the years looking at the relationship between deprivation, unemployment and health:

"Unemployment affects both physical and mental health and is an important determinant of health inequalities in adults of working age. Unemployed people have a higher risk of morbidity and premature mortality. They also have a higher risk of lower levels of psychological wellbeing ranging from symptoms of depression and anxiety to self-harm and suicide. Unemployment affects family income levels that impact on other health determinants, for example, housing and nutrition."[16]

"There is a social gradient in lifespan; people living in the most deprived areas in England have on average the lowest life expectancy and conversely, life expectancy is higher on average for those living in areas with lower deprivation. Males living in the most deprived tenth of areas can

[13] [APP – 085] – Volume IV page 27
[14] [APP – 085] – Volume IV page 51 table 11
[15] [APP – 085] – Volume IV page 50
[16] Health Impacts of Employment – page 27

expect to live 9 fewer years compared with the least deprived tenth, and females can expect to live 7 fewer years."[17]

However, it is not just physical health that is affected by deprivation and sustained unemployment but also mental health:

"Major risk factors for mental health problems include poverty, poor education, unemployment, social isolation/exclusion and major life events. A review of large-scale studies of mental health problems reported that such problems are more common among people who are unemployed, have fewer educational qualifications, have been looked after or accommodated, are on a low income or have a low standard of living."[18]

Since Thanet is the most deprived Local Authority in Kent and has 14 of the most deprived LSOAs within the (worst) top 10% most deprived LSOAs in England,[19] it follows that the physical health, mental health and life expectancy within Thanet will be greatly affected. A reopened airport will reduce unemployment levels, reduce deprivation in Thanet and will improve the health and wellbeing of the Thanet population.

It could, possibly, also have a knock on effect on the ability of Local Health trusts to attract and retain staff and this is an area that is covered in another document "Estimates of significance of RSP funding to local healthcare" which is part of the overall SMAa submission.

Investment and Viability

The proposed increase in stands and hangerage at Manston will make a huge difference to the viability of the site.

One of the main reasons that the site was not used to its full potential was the lack of investment...The proposed £300 plus Millions by RSP, is something that was never available prior to 2014.

The increase in Cargo Stands (19 by year 20)[20], will permit a lot of Aircraft to be handled during operating hours 07:00 - 23:00, thus negating the need for Night Flights, which everyone wants to avoid if possible. The Aircraft can be serviced, unloaded and reloaded overnight, ready for the next day. This of course adds to the job creation so badly needed.

Most other UK Airports have insufficient stands reserved primarily for Freight Aircraft, which is a contributing reason why those Airports use Night Flights so much. Manston, being designed and purpose-built primarily as a Freight Hub will be very attractive to operators with quick turnarounds, and more available "slots".

As we get closer to Brexit, this massive investment in reopening Manston airport will enable high value and /or time critical goods to be moved to and from the emerging markets such as the Far East, South Africa and South America.

SMAa firmly supports the application by RSP to reopen Manston Airport.

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[17] Inequality in Health – page 1
[18] Mental Health and deprivation – page 1
[19] Appendix 1 – page 4
[20] [APP – 012] – page 2

The English Index of Multiple Deprivation (IMD 2015): Headline findings for Kent

Related information

The Deprivation and Poverty web page contains more information which you may find useful.

- *Fuel poverty*
- *Households in poverty*
- *Children in Poverty*
- *Homelessness*
- *Unemployment and benefits claimants*

***NOTE**: within this bulletin 'Kent' refers to the Kent County Council (KCC) area which excludes Medway*

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The English Index of Multiple Deprivation 2015 (IMD2015) was released 30 September 2015 by The Department for Communities and Local Government. This bulletin presents the initial findings for Kent.

Summary

- On the National rank of the IMD2015 Kent is ranked at 100th out of 152 Counties and Unitary Authorities in England. This places Kent within the least deprived 50% of all counties and unitary authorities in England.
- Within the 19 Counties and Local Authorities in the South East, Kent is ranked at 9. This places Kent just within the most deprived 50% of all Counties and Unitary Authorities in the South East.
- The level of deprivation in eight out of 12 Kent local authority districts has increased since ID2010 relative to other areas in England.
- Thanet continues to rank as the most deprived local authority in Kent.
- Tunbridge Wells ranks as the least deprived local authority in Kent
- Ashford and Swale have experienced the largest increase in deprivation relative to other areas.
- Tunbridge Wells has experienced the largest decrease in deprivation relative to other areas.

Introduction

The Index of Multiple Deprivation 2015 (IMD 2015) is the official measure of relative deprivation for small areas (or neighbourhoods) in England.

The IMD ranks every small area in England from 1 (most deprived area) to 32,844 (least deprived area).

The small areas used are called Lower-layer Super Output Areas, of which there are 32,844 in England. They are designed to be of a similar population size with an average of 1,500 residents each and are a standard way of dividing up the country. They do not have descriptive place names (in the way that local wards do), but are named in a format beginning with the name of the local authority district followed by a 4 character code eg Ashford 001A.

It is common to describe how relatively deprived a small area is by saying whether it falls among the most deprived 10 per cent, 20 per cent or 30 per cent of small areas in England (although there is no definitive cut-off at which an area is described as 'deprived').

To help with this, deprivation 'deciles' are published alongside ranks. Deciles are calculated by ranking the 32,844 small areas in England from most deprived to least deprived and dividing them into 10 equal groups. These range from the most deprived 10 per cent of small areas nationally to the least deprived 10 per cent of small areas nationally.

The Index of Multiple Deprivation is part of the Indices of Deprivation and it is the most widely used of these indices. It combines information from seven domain indices (which measure different types or dimensions of deprivation) to produce an overall relative measure of deprivation. You can use the domain indices on their own to focus on specific aspects of deprivation. There are also supplementary indices concerned with income deprivation among children (IDACI) and older people (IDAOPI).

The Index of Multiple Deprivation is designed primarily to be a *small-area* measure of deprivation. But the Indices are commonly used to describe deprivation for higher-level geographies including local authority districts. A range of summary measures are available allowing you to see where, for example, a local authority district is ranked between 1 (the most deprived district in England) and 326 (the least deprived district in England). Summary measures are also available for upper tier local authorities, local enterprise partnerships and clinical commissioning groups.

All of the Indices of Deprivation measure relative deprivation at small area level as accurately as possible, but they are not designed to provide 'backwards' comparability with previous versions of the Indices (2010, 2007, 2004 and 2000). However, because there is a broadly consistent methodology between the Indices of Deprivation 2015 and previous versions, you can compare the rankings as determined at the relevant time point by each of the versions.

When looking at changes in deprivation between the Indices of Deprivation 2015 and previous versions, users should therefore be aware that changes can only be described in relative terms, for example, the extent to which an area has changed rank or decile of deprivation.

This bulletin presents the IMD 2015 for Kent, Kent local authorities and the 10% most deprived LSOAs in Kent. A comparison with the IMD2010 (and IMD2007 at County level) is also presented.

County Level

The overall IMD2015 ranks Kent at 100 out of 152 local authorities in England This places Kent within the least 50% deprived local authorities in England.

This position is two places higher than the IMD2010 and six places higher than the IMD2007 which indicates that Kent has become more deprived in 2015 relative to all other areas.

Kent's position amongst the local authorities within the South East region is nine out of 19. This position has not changed between the IMD2007 and IMD2010. This places Kent just within the 50% most deprived areas in the region.

Table 1: South East Counties and Unitary Authorities by national and regional ranks: IMD2007, IMD2010, IMD2015

South East Counties and Unitary Authorities by national and regional ranks: IMD2007, IMD2010, and IMD2015
Source: Indices of Deprivation 2007; 2010; and 2015 Communities and Local Government
Table presented by Strategic Business Development & Intelligence, Kent county Council
A rank of 1 is the most deprived

	IMD2007		IMD2010		IMD2015		Change in rank* 2010 to 2015	
Authority	National rank (out of 152)	South East rank (out of 19)	National rank (out of 152)	South East rank (out of 19)	National rank (out of 152)	South East rank (out of 19)	National position	South East position
Portsmouth U.A.	67	3	60	2	50	1	10	1
Southampton U.A.	66	2	65	3	54	2	11	1
Brighton and Hove U.A.	59	1	53	1	74	3	-21	-2
Isle of Wight U.A.	88	5	86	5	76	4	10	1
Slough U.A.	79	4	69	4	78	5	-9	-1
Medway U.A.	92	6	88	7	81	6	7	1
Reading U.A.	94	7	87	6	93	7	-6	-1
East Sussex	95	8	90	8	99	8	-9	0
Kent	**106**	9	**102**	9	**100**	9	**2**	0
Milton Keynes	118	10	119	10	106	10	13	0
West Sussex	132	11	130	11	131	11	-1	0
Hampshire	141	13	141	13	141	12	0	1
Oxfordshire	139	12	135	12	142	13	-7	-1
Bracknell Forest U.A.	147	15	148	16	145	14	3	2
West Berkshire U.A.	149	17	147	15	146	15	1	0
Buckinghamshire	146	14	145	14	148	16	-3	-2
Surrey	150	18	150	18	150	17	0	1
Windsor & Maidenhead U.A.	148	16	149	17	151	18	-2	-1
Wokingham U.A.	152	19	152	19	152	19	0	0

Table sorted by ID2015 lowest rank

* A minus change in rank illustrates that an area has moved down the rankings and is therefore less deprived in ID2015 than ID2010 relative to other areas

*A positive change in rank illustrates an area is more deprived in ID2015 than ID2010 relative to other areas

Local Authority Level

Thanet was the most deprived local authority in the IMD2010 and remains Kent's most deprived local authority district in IMD2015. Nationally, Thanet is ranked at 21 out of 326 authorities placing it within England's 10% most deprived of authorities.

Kent's least deprived local authority district in the IMD2015 is Tunbridge Wells with a rank of 282 out of 326 authorities. This rank places Tunbridge Wells within the least 20% deprived areas in England.

Deprivation levels have increased in eight out of the 12 local authority districts relative to all other areas between IMD2010 and IMD2015.

Ashford and Swale have seen the greatest change in national rank, both moving up 22 places between 2010 and 2015. This indicates that these areas are more deprived in 2015 than in 2010 relative to all other local authorities in England.

Canterbury, Shepway, Tonbridge & Malling and Tunbridge Wells have all moved down in the rankings which indicates that levels of deprivation have reduced between 2010 and 2015 relative to other local authorities in England.

Table 2: Kent Local Authorities by national and Kent ranks: IMD2010, IMD2015

Kent local authorities by national and Kent ranks: IMD2010 and IMD2015

Source: Indices of Deprivation 2010 and 2015, Communities and Local Government
Table presented by Strategic Business Development & Intelligence, Kent county Council
A rank of 1 is the most deprived

	IMD2010			IMD2015			Change in rank* 2010 to 2015	
Authority	IMD2010 national rank (out of 326)	Kent Rank (out of 12)		IMD2015 national rank (out of 326)	Kent Rank (out of 12)		National position	Kent position
Thanet	49	1		28	1		21	0
Swale	99	3		77	2		22	1
Shepway	97	2		113	3		-16	-1
Gravesham	142	5		124	4		18	1
Dover	127	4		126	5		1	-1
Dartford	175	7		170	6		5	1
Ashford	198	8		176	7		22	1
Canterbury	166	6		183	8		-17	-2
Maidstone	217	9		198	9		19	0
Sevenoaks	276	12		268	10		8	2
Tonbridge & Malling	268	11		274	11		-6	0
Tunbridge Wells	249	10		282	12		-33	-2

Table ranked by highest IMD 2015 Score

* A minus change in rank illustrates that a district has moved down the rankings and is therefore now less deprived relative to other areas in England.

*A positive change in rank illustrates an area is more deprived in ID2015 thank ID2010 relative to other areas

Deprivation at small area level in Kent's Lower Super Output Areas

Kent has 902 Lower Super Output Areas, 51 (6%) fall within the top 10% most deprived LSOAs in England in the IMD2015. In the IMD2010 the number of LSOAs within the most deprived 10% nationally was 32 (4%).

These LSOAs are spread within seven of Kent's local authorities with Thanet having the highest number and proportion of LSOA within the top10% most deprived LSOAs in England.

Ashford, Canterbury, Sevenoaks, Tonbridge & Malling and Tunbridge Wells do not have any LSOAs ranked within the top 10% most deprived in England.

Table 3: The number and proportion of LSOAs in Kent Authorities within the 10% most deprived Lower Super Output Areas in England

IMD2015 Number and proportion of LSOAs in Kent authorities within the top 10% most deprived in England

Source: Indices of Deprivation 2010 and 2015, Communities and Local Government
Table presented by Strategic Business Development & Intelligence, Kent county Council

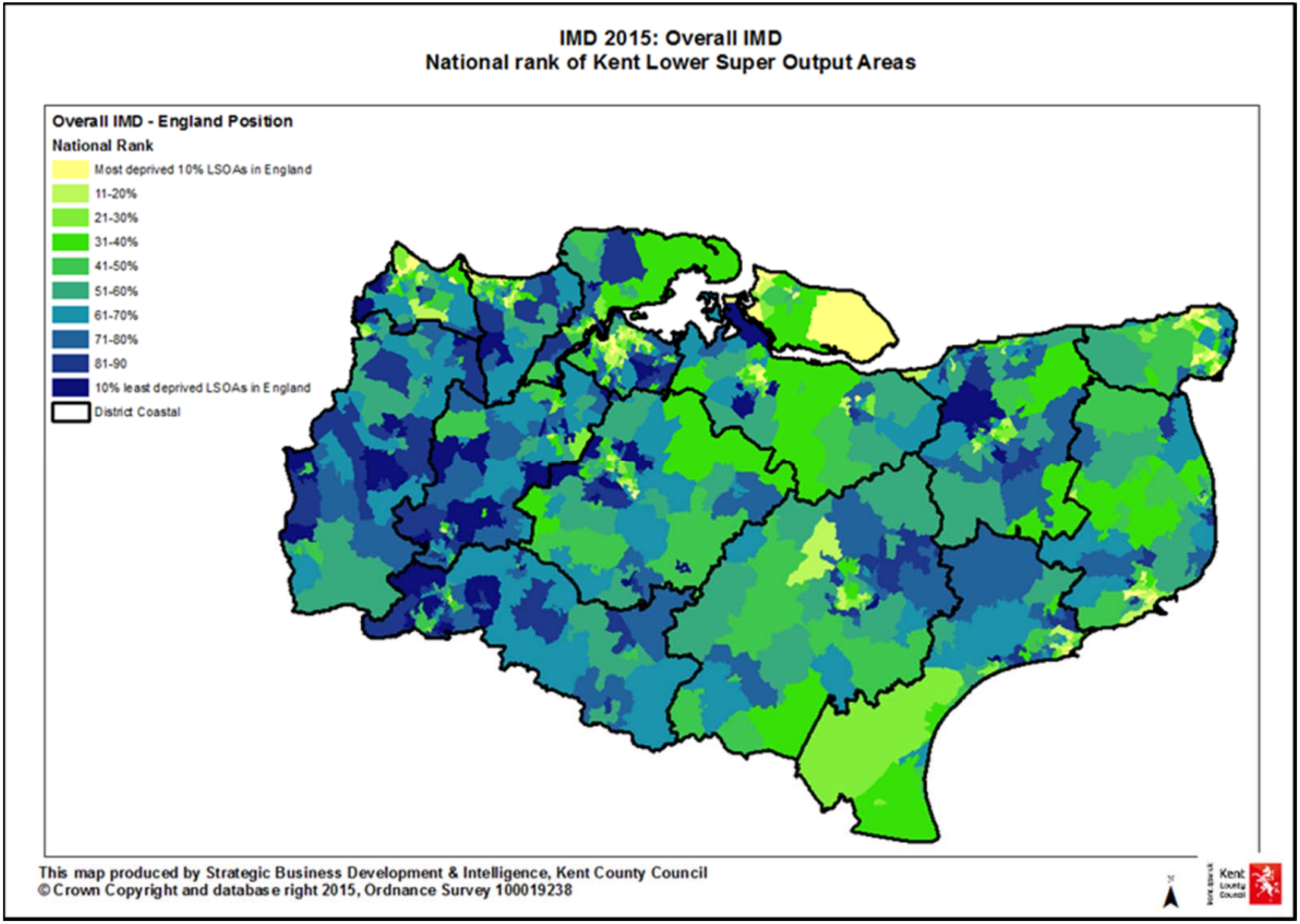
Authority	Total LSOAs in each Local Authority	Top 10% most deprived National Rank:IMD 2010			Top 10% most deprived National Rank:IMD 2015			Change
		Number of LSOAs	%		Number of LSOAs	%		Number of LSOAs
Thanet	84	14	*16%*		18	*20%*		4
Swale	85	8	*9%*		14	*16%*		6
Gravesham	64	3	*3%*		6	*7%*		3
Dover	67	1	*1%*		4	*4%*		3
Shepway	67	5	*6%*		4	*4%*		-1
Dartford	58	0	*0%*		3	*3%*		3
Maidstone	95	1	*1%*		2	*2%*		1
Canterbury	90	0	*0%*		0	*0%*		0
Ashford	78	0	*0%*		0	*0%*		0
Sevenoaks	74	0	*0%*		0	*0%*		0
Tonbridge & Malling	72	0	*0%*		0	*0%*		0
Tunbridge Wells	68	0	*0%*		0	*0%*		0
Kent	902	32	*36%*		51	*57%*		19

Table ranked by highest number of LSOAs in top 10% most deprived by IMD 2015 Score

The highest ranking LSOA in Kent is in Thanet District, within Cliftonville West ward. This LSOA is ranked 4th out of 32,844 LSOAs in England placing it within England's most deprived 1% of small areas.

The lowest ranking LSOA in Kent is in Tunbridge Wells Borough, within Speldhurst & Bidborough ward. This LSOA is ranked 32,728th out of 32,844 LSOAs in England placing it within England's most deprived 1% of small areas.

Map 1 illustrates the pattern of deprivation across Kent at LSOA level. The map shows there is an east/west divide, with the east of the county having higher levels of deprivation than the west.


IMD 2015: Overall IMD
National rank of Kent Lower Super Output Areas
Overall IMD - England Position
National Rank
Most deprived 10% LSOAs in England
11-20%
21-30%
31-40%
41-50%
51-60%
61-70%
71-80%
81-90
10% least deprived LSOAs in England
District Coastal
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Kent County Council

A ward level measure of deprivation is not published as part of the official IMD2015. However, there is high demand for a ward level measure and we will issue ward level ranks based on averages of LSOA scores at a later date. Table 4 indicates the wards in which the top 10% most deprived LSOAs in Kent are situated. This table also shows the national rank and South East rank.

Table 4: The 10% most deprived Lower Super Output Areas in Kent

The 10% most deprived Lower Super Output Areas in Kent: (Rank 1 to 45 out of 90)

Source: Indices of Deprivation 2015, Communities and Local Government

A rank of 1 is the most deprived

Table presented by Strategic Business Development & Intelligence, Kent county Council

		National rank		South East rank		Kent Rank	
2011 LSOA Name	2011 Ward Name	position out of 32,844 LSOAs	Within top 10% most deprived	position out of 5,382 LSOAs	Within top 10% most deprived	Position out of 902 LSOAs	Within top 10% most deprived
Thanet 001A	Cliftonville West	4	Yes	1	Yes	1	Yes
Thanet 001E	Margate Central	21	Yes	2	Yes	2	Yes
Thanet 003A	Margate Central	35	Yes	3	Yes	3	Yes
Swale 001A	Sheerness East	46	Yes	4	Yes	4	Yes
Thanet 001D	Cliftonville West	117	Yes	7	Yes	5	Yes
Thanet 001B	Cliftonville West	233	Yes	10	Yes	6	Yes
Swale 010C	Murston	329	Yes	14	Yes	7	Yes
Swale 006A	Leysdown and Warden	366	Yes	18	Yes	8	Yes
Thanet 016D	Eastcliff	423	Yes	22	Yes	9	Yes
Thanet 006D	Dane Valley	452	Yes	24	Yes	10	Yes
Thanet 013B	Newington	486	Yes	26	Yes	11	Yes
Shepway 014A	Folkestone Harbour	572	Yes	29	Yes	12	Yes
Swale 002C	Sheerness West	626	Yes	31	Yes	13	Yes
Swale 002A	Sheerness West	674	Yes	32	Yes	14	Yes
Thanet 003E	Westbrook	692	Yes	33	Yes	15	Yes
Swale 002B	Sheerness West	739	Yes	36	Yes	16	Yes
Thanet 013E	Northwood	968	Yes	42	Yes	17	Yes
Swale 006D	Sheppey Central	1013	Yes	44	Yes	18	Yes
Swale 004E	Sheppey Central	1036	Yes	46	Yes	19	Yes
Swale 005C	Queenborough and Halfway	1053	Yes	48	Yes	20	Yes
Thanet 006E	Dane Valley	1065	Yes	52	Yes	21	Yes
Thanet 004A	Cliftonville West	1171	Yes	54	Yes	22	Yes
Shepway 014B	Folkestone Harvey Central	1343	Yes	63	Yes	23	Yes
Dover 011F	St Radigunds	1358	Yes	64	Yes	24	Yes
Swale 015D	Davington Priory	1649	Yes	74	Yes	25	Yes
Shepway 003C	Folkestone East	1751	Yes	76	Yes	26	Yes
Gravesham 011D	Singlewell	1876	Yes	81	Yes	27	Yes
Gravesham 001C	Northfleet North	1877	Yes	82	Yes	28	Yes
Dartford 001A	Joyce Green	1951	Yes	85	Yes	29	Yes
Maidstone 013A	Park Wood	1979	Yes	86	Yes	30	Yes
Gravesham 002E	Riverside	2017	Yes	89	Yes	31	Yes
Dover 012F	Castle	2065	Yes	94	Yes	32	Yes
Swale 006B	Leysdown and Warden	2109	Yes	97	Yes	33	Yes
Thanet 003D	Salmestone	2224	Yes	102	Yes	34	Yes
Swale 001B	Sheerness East	2240	Yes	104	Yes	35	Yes
Thanet 016E	Eastcliff	2319	Yes	107	Yes	36	Yes
Dover 013B	Maxton, Elms Vale and Priory	2330	Yes	108	Yes	37	Yes
Gravesham 011C	Singlewell	2533	Yes	118	Yes	38	Yes
Swale 001C	Sheerness East	2564	Yes	121	Yes	39	Yes
Thanet 013A	Newington	2633	Yes	123	Yes	40	Yes
Gravesham 007A	Westcourt	2730	Yes	128	Yes	41	Yes
Thanet 001C	Cliftonville West	2739	Yes	129	Yes	42	Yes
Thanet 016C	Central Harbour	2751	Yes	130	Yes	43	Yes
Thanet 015D	Eastcliff	2850	Yes	134	Yes	44	Yes
Maidstone 013B	Park Wood	2857	Yes	137	Yes	45	Yes

Table 4 continued: The 10% most deprived Lower Super Output Areas in Kent

The 10% most deprived Lower Super Output Areas in Kent: (Rank 46 to 90 out of 90)

Source: Indices of Deprivation 2015, Communities and Local Government

A rank of 1 is the most deprived

Table presented by Strategic Business Development & Intelligence, Kent county Council

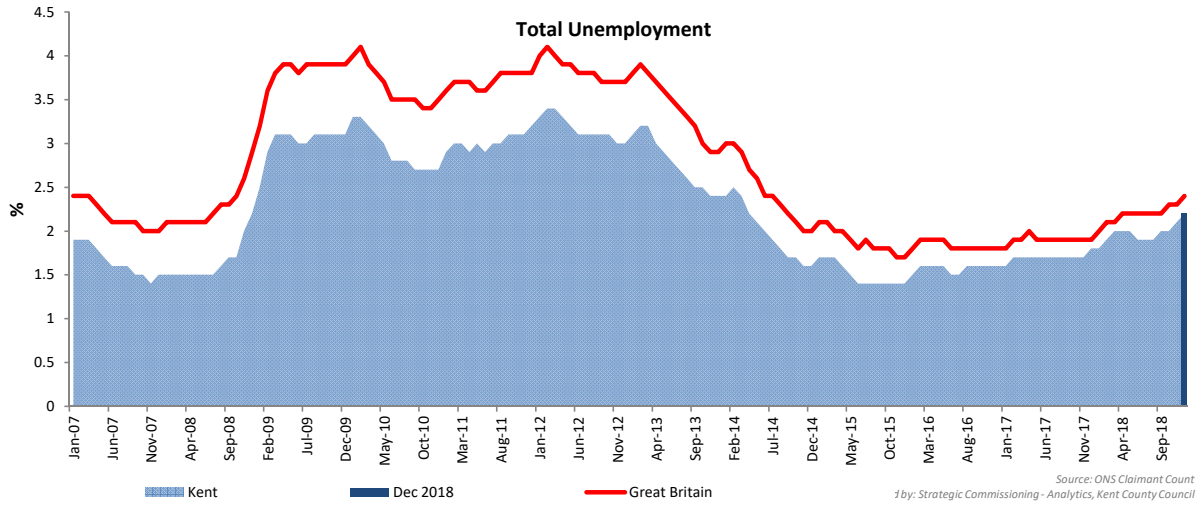
		National rank		South East rank		Kent Rank	
2011 LSOA Name	2011 Ward Name	position out of 32,844 LSOAs	Within top 10% most deprived	position out of 5,382 LSOAs	Within top 10% most deprived	Position out of 902 LSOAs	Within top 10% most deprived
Swale 001D	Sheerness East	2887	Yes	140	Yes	46	Yes
Dartford 004C	Swanscombe	3010	Yes	147	Yes	47	Yes
Dover 011D	Buckland	3071	Yes	151	Yes	48	Yes
Shepway 014D	Folkestone Harvey Central	3125	Yes	154	Yes	49	Yes
Dartford 001D	Littlebrook	3199	Yes	156	Yes	50	Yes
Gravesham 002A	Central	3222	Yes	158	Yes	51	Yes
Ashford 008C	Stanhope	3285	No	163	Yes	52	Yes
Shepway 014C	Folkestone Harvey Central	3296	No	164	Yes	53	Yes
Ashford 008B	Stanhope	3315	No	165	Yes	54	Yes
Thanet 005A	Garlinge	3332	No	167	Yes	55	Yes
Swale 002D	Sheerness West	3474	No	174	Yes	56	Yes
Swale 010B	Milton Regis	3609	No	183	Yes	57	Yes
Dover 012D	Tower Hamlets	3627	No	185	Yes	58	Yes
Thanet 006C	Dane Valley	3643	No	188	Yes	59	Yes
Canterbury 019A	Wincheap	3751	No	195	Yes	60	Yes
Maidstone 013D	Shepway South	3768	No	198	Yes	61	Yes
Thanet 012C	Sir Moses Montefiore	3779	No	199	Yes	62	Yes
Canterbury 007B	Gorrell	3814	No	202	Yes	63	Yes
Sevenoaks 002A	Swanley St Mary's	3820	No	203	Yes	64	Yes
Thanet 003B	Margate Central	3834	No	204	Yes	65	Yes
Thanet 004B	Dane Valley	3884	No	208	Yes	66	Yes
Maidstone 013E	Shepway South	3928	No	212	Yes	67	Yes
Shepway 004E	Folkestone Harbour	3953	No	214	Yes	68	Yes
Canterbury 001B	Heron	3968	No	215	Yes	69	Yes
Dover 013A	Maxton, Elms Vale and Priory	4019	No	218	Yes	70	Yes
Dover 013D	Tower Hamlets	4137	No	225	Yes	71	Yes
Dover 011A	Buckland	4155	No	226	Yes	72	Yes
Sevenoaks 002B	Swanley St Mary's	4324	No	234	Yes	73	Yes
Dover 013E	Town and Pier	4397	No	241	Yes	74	Yes
Dartford 009A	Princes	4464	No	245	Yes	75	Yes
Canterbury 001C	Heron	4469	No	246	Yes	76	Yes
Maidstone 009C	High Street	4490	No	249	Yes	77	Yes
Gravesham 002F	Pelham	4555	No	253	Yes	78	Yes
Canterbury 009D	Seasalter	4715	No	263	Yes	79	Yes
Canterbury 001A	Heron	4726	No	266	Yes	80	Yes
Dover 011H	Tower Hamlets	4848	No	271	Yes	81	Yes
Canterbury 011A	Northgate	4869	No	273	Yes	82	Yes
Shepway 003A	Folkestone East	4936	No	279	Yes	83	Yes
Thanet 016A	Central Harbour	5057	No	288	Yes	84	Yes
Ashford 007F	Victoria	5083	No	290	Yes	85	Yes
Shepway 004B	Folkestone Foord	5084	No	291	Yes	86	Yes
Ashford 005A	Aylesford Green	5117	No	294	Yes	87	Yes
Dover 006C	Aylesham	5134	No	296	Yes	88	Yes
Swale 014F	Watling	5242	No	301	Yes	89	Yes
Swale 003A	Minster Cliffs	5251	No	302	Yes	90	Yes

Further information about the English Indices of Deprivation can be found from the Department for Communities and Local Government website

Unemployment in Kent

Last updated: 22 Jan 2019

Using information from the Office for National Statistics Claimant Count this bulletin looks at the total number of people claiming either Jobseekers Allowance or Universal Credit **principally for the reason of being unemployed**. It also looks at the age profile of claimants, in particular at youth unemployment which is defined as those aged 18 to 24.



	Dec 2018		Change since Nov 2018		Change since Dec 2017	
Unemployment	**Number**	**% Rate**	**Number**	**%**	**Number**	**%**
Kent	20,400	2.2%	550	2.8%	3,875	23.4%
Great Britain	956,745	2.4%	19,485	2.1%	184,150	23.8%

	Dec 2018		Change since Nov 2018		Change since Dec 2017	
	Number	**% Rate**	**Number**	**%**	**Number**	**%**
Ashford	1,710	2.2%	70	4.3%	410	31.5%
Canterbury	1,850	1.8%	140	8.2%	495	36.5%
Dartford	930	1.4%	70	8.1%	165	21.6%
Dover	2,405	3.5%	70	3.0%	470	24.3%
Folkestone & Hythe	1,885	2.9%	65	3.6%	445	30.9%
Gravesham	1,595	2.4%	15	0.9%	260	19.5%
Maidstone	1,180	1.1%	0	0.0%	-30	-2.5%
Sevenoaks	575	0.8%	60	11.7%	45	8.5%
Swale	2,780	3.1%	5	0.2%	805	40.8%
Thanet	4,275	5.2%	65	1.5%	965	29.2%
Tonbridge and Malling	660	0.8%	5	0.8%	-90	-12.0%
Tunbridge Wells	555	0.8%	-15	-2.6%	-65	-10.5%
Medway	4,145	2.3%	230	5.9%	880	27.0%
Kent	20,400	2.2%	550	2.8%	3,875	23.4%

Kent unemployment headlines December 2018

The unemployment rate in Kent is 2.2%. This is below the rate for Great Britain (2.4%).

20,400 people were claiming unemployment benefits in Kent.This has increased since last month.

Thanet has the highest unemployment rate at 5.2%. Sevenoaks has the lowest unemployment rate at 0.8%.

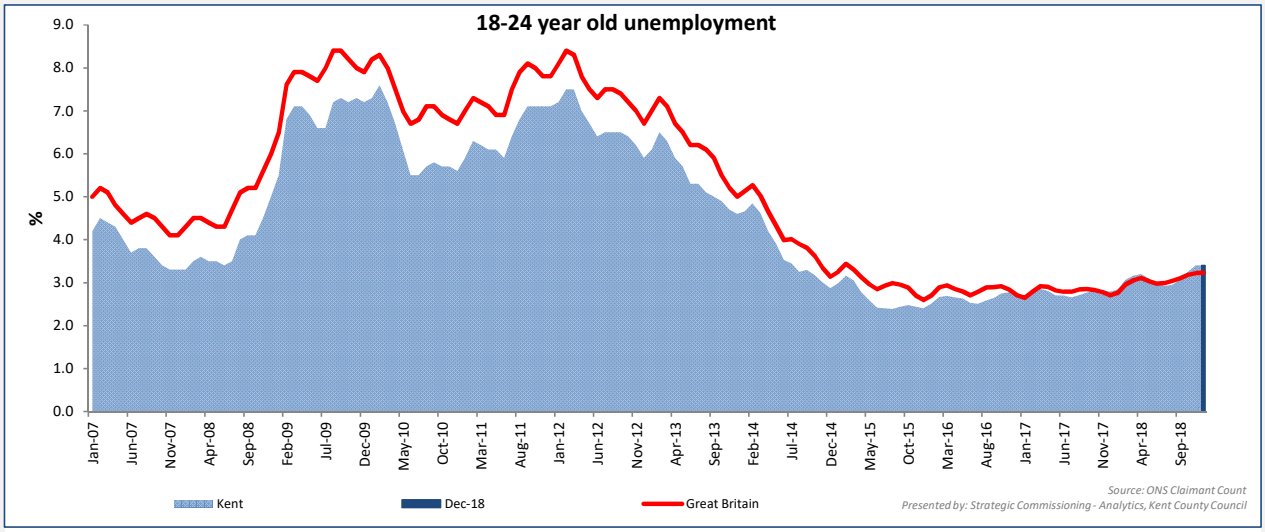
The 18-24 year old unemployment rate in Kent is 3.4%. They account for 21.1% of all unemployed people in the area

Thanet has the highest 18-24 year old unemployment rate in the South East at 8%.

Unemployment by age group

Kent	Dec 2018		Change since Nov 2018		Change since Dec 2017	
	Number	%	Number	%	Number	%
18-24	4,305	3.4%	5	0.1%	780	22.1%
25-49	10,335	2.1%	380	3.8%	2,150	26.3%
50-64	5,705	1.9%	165	3.0%	920	19.2%

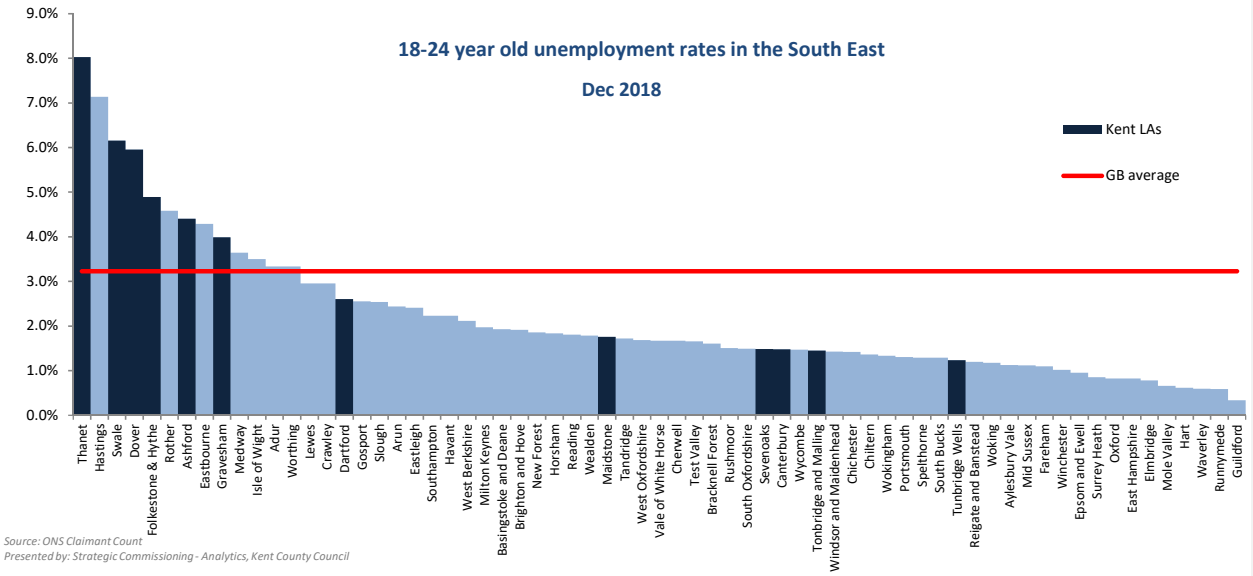
December 2018	Number			Rate		
	18-24	25-49	50-64	18-24	25-49	50-64
Ashford	395	835	470	4.4%	2.1%	1.9%
Canterbury	410	925	510	1.5%	2.0%	1.8%
Dartford	200	515	210	2.6%	1.3%	1.1%
Dover	500	1200	695	5.9%	3.7%	2.8%
Folkestone & Hythe	375	915	595	4.9%	2.8%	2.6%
Gravesham	320	825	445	4.0%	2.3%	2.3%
Maidstone	210	625	340	1.8%	1.1%	1.1%
Sevenoaks	110	280	180	1.5%	0.8%	0.7%
Swale	705	1340	730	6.1%	2.9%	2.5%
Thanet	860	2275	1140	8.0%	5.7%	4.1%
Tonbridge and Malling	130	315	215	1.4%	0.8%	0.9%
Tunbridge Wells	90	290	170	1.2%	0.8%	0.7%
Kent	4305	10335	5705	3.4%	2.1%	1.9%
Medway	885	2195	1055	3.6%	2.3%	2.1%

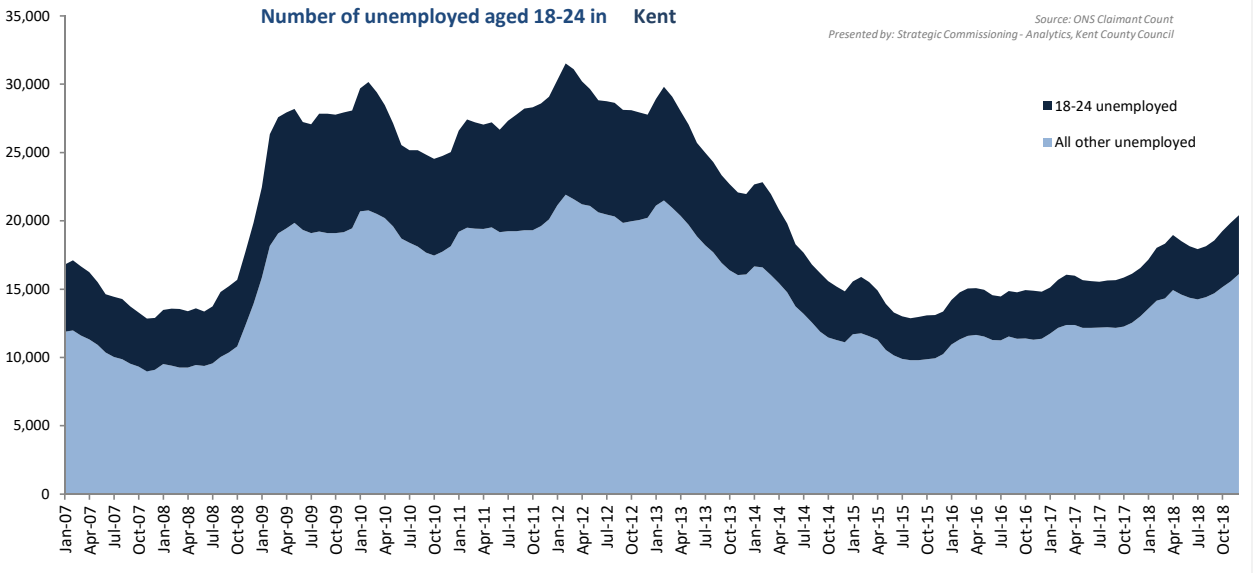


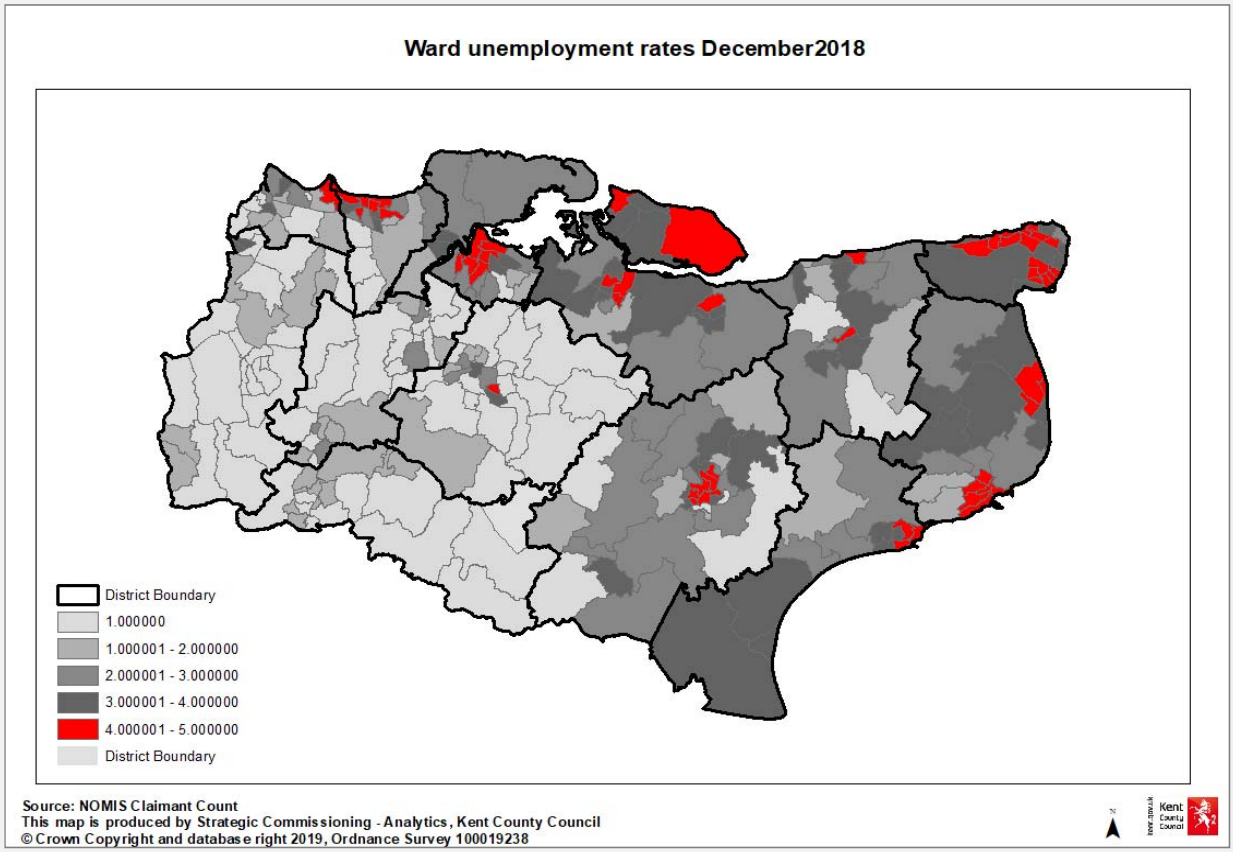
18-24 Unemployment	Number	Rate	Change since Nov 2018 Number	Change since Nov 2018 %	Change since Dec 2017 Number	Change since Dec 2017 %
Kent	4,305	3.4%	5	0.1%	780	22.1%
Great Britain	180,715	3.2%	385	0.2%	29,135	19.2%

Unemployment by age group - % of all unemployed

December 2018	Kent		Great Britain	
	Number	% of all unemployed	Number	% of all unemployed
18-24	4,305	21.1%	180,715	18.9%
25-49	10,335	50.7%	519,815	54.3%
50-64	5,705	28.0%	253,250	26.5%







This workbook looks at the total number of people claiming either Jobseekers Allowance or Universal Credit principally for the reason of being unemployed. It also looks at the age profile of claimants, in particular at youth unemployment which is defined as those aged 18 to 24.

This workbook uses information from a dataset called The Claimant Count by Sex and Age. This experimental series counts the number of people claiming Jobseeker's Allowance plus those who claim Universal Credit who are out of work. The dataset currently includes some out of work claimants of Universal Credit who are not required to look for work; for example, due to illness or disability. Therefore this dataset is considered experimental and the results should be interpreted with caution.

Unemployment rates are calculated using the Office for National Statistics Mid-year Population Estimates 2001-2017. The resident working age population is defined as all males and females aged 16-64. These denominators will be updated annually with the ONS mid-year population estimates.

Data back to December 2014 were revised by ONS on 18th October 2017. This bulletin contains these revisions and therefore supersedes any previously released data.

Introduction of Universal Credit
Since 2013 the roll out of Universal Credit has progressed across across the UK. Universal Credit will replace a number of means-tested benefits including the means-tested element of Jobseeker's Allowance (JSA).

From April 2015 Universal Credit started to be rolled out within Kent. It is now available in all Jobcentre areas in Kent & Medway. Initially it was only available to single claimants without a partner and without child dependents however in 2017 the full roll out of Universal Credit to all claimant types began. The following table shows the planned roll out within Kent districts.

As announced in June 2018 the government will start to migrate existing claimants of the benefits that are being replaced to Universal Credit early in 2019. It hopes to migrate all existing benefit claimants to Universal Credit by March 2023.

Date of roll

out	Job Centre Plus Office	District Served
May-17	Dover	Dover
Jul-17	Margate	Thanet
Jul-17	Ramsgate	Thanet
Dec-17	Sheerness	Swale
Dec-17	Sittingbourne	Swale
Feb-18	Gravesend	Gravesham
Feb-18	Gravesend	Sevenoaks (part)
Feb-18	Folkestone	Folkestone & Hythe
Feb-18	Chatham	Medway
Mar-18	Ashford	Ashford
Apr-18	Canterbury	Canterbury
Apr-18	Hernebay	Canterbury
Apr-18	Whitstable	Canterbury
May-18	Dartford	Dartford
May-18	Dartford	Sevenoaks (part)
Aug-18	Maidstone	Maidstone
Aug-18	Tonbridge	Tonbridge & Malling
Aug-18	Tonbridge	Tunbridge Wells

For more information on Universal Credit: https://www.gov.uk/universal-credit

Produced by:
Strategic Commissioning - Analytics,
Strategic & Corporate Services,
Kent County Council

Tel: 03000 417444

kent.gov.uk Kent County Council

UK Business Counts 2018

Information on businesses in Kent

Related documents

Business Demography – Looking at the counts business activity during the course of the whole of the financial year

Construction Industries in Kent – the number of construction businesses in Kent and the people employed in the sector

Creative Industries in Kent - the number of creative businesses in Kent and the people employed in the sector

Further information

Strategic Commissioning - Analytics
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The UK Business data is published annually by the Office for National Statistics (ONS) and is based on output from the VAT and PAYE administrative systems.

The information provided by the UK Business dataset gives a snap shot of businesses and is broken down by size band, industry, turnover and age of business.

An additional dataset from ONS is the Business Demography dataset. This is also based on VAT and PAYE data but this information measures any activity during the course of the year, so leads to slightly higher counts of businesses. It provides information on business births, deaths and survival rates. Information on this dataset can be found in the bulletin "Business Demography"

Kent Summary

- As at March 2018 there were 61,255 enterprises in Kent
- Kent has a significantly higher proportion of enterprises (16.3%) in the wholesale industry than is seen nationally (12.4%)
- The highest proportion of enterprises in Kent (17.6%) are within the Professional, scientific and technical sector
- The majority of enterprises in Kent (89.7%) are micro enterprises (with 0-9 employees)
- The majority of enterprises in Kent (99.3%) are classed as companies which operate within the private sector.
- 62.7% of enterprises in Kent have a turnover of over £100k

Introduction

The UK Business data is produced from a snapshot of the Inter Departmental Business Register (IDBR) - usually taken during March - and provides the basis for the Office for National Statistics (ONS) to conduct surveys of businesses.

The main administrative sources for the IDBR are VAT trader and PAYE employer information passed to the ONS by HM Revenue & Customs under the Value Added Tax Act 1994 for VAT traders and the Finance Act 1969 for PAYE employers; details of incorporated businesses are also passed to ONS by Companies House. ONS Survey data and survey information from the Department of Enterprise, Trade and Investment – Northern Ireland (DETINI) and the Department for Environment, Food and Rural Affairs (DEFRA) farms register provide auxiliary information. Construction statistics formerly produced by the Department for Business Innovation & Skills are now produced by ONS.

The IDBR combines the information from the three administrative sources with this survey data in a statistical register comprising over two million enterprises. These comprehensive administrative sources combined with the survey data contribute to the coverage on the IDBR, which is one of its main strengths, representing nearly 99 per cent of UK economic activity.

The latest data is published for 2018 and is based upon the 2007 revision to the Standard Industrial Classification UKSIC (2007). Detailed information about the types of industry which make up each of the industrial sectors is available from the UK Standard Industrial Classification of Economic Activities published by the Office for National Statistics.

This bulletin looks at the main tables available from the UK Business data, which relate to VAT/PAYE enterprises.

This bulletin will be updated in Autumn 2019.

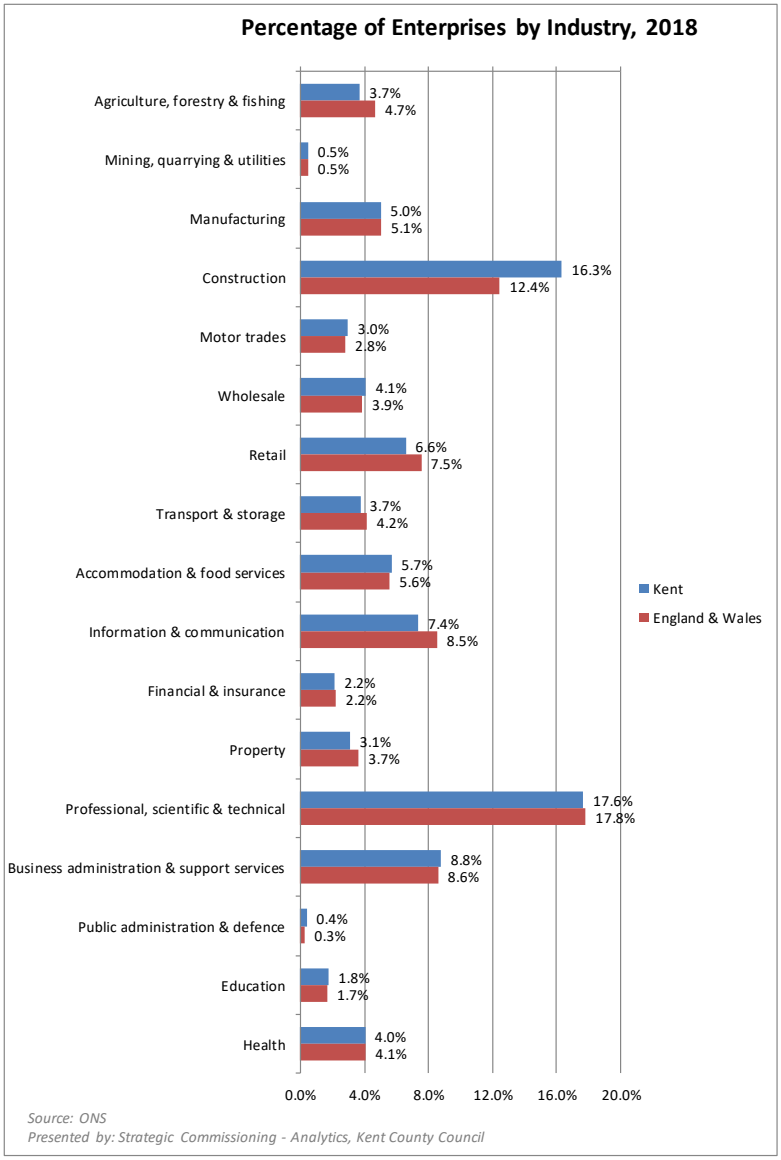
Analysis

Enterprises by Industry

The UK Business data shows us the number of enterprises by broad industrial group.

Overall Kent has a similar profile to England and Wales although does show a significantly higher proportion of enterprises in the Construction Industry and lower proportions in Agriculture and Fishing, Retail and Information & Communications industries. This is shown in Chart 1.

Chart 1: Enterprises by Industry



Tables 1 and 2 show the number and percentage of businesses by industry in Kent local authority districts and Kent as a whole. Regional and national figures are also presented for comparison.

Table 1: Number Of Vat And/or Paye Based Enterprises In 2018 By Broad Industrial Group

	UK SIC 2007																	
	Agriculture, forestry & fishing	Mining, quarrying & utilities	Manufacturing	Construction	Motor trades	Wholesale	Retail	Transport & storage	Accommodation & food services	Information & communication	Financial & insurance	Property	Professional, scientific & technical	Business administration & support services	Public administration & defence	Education	Health	Arts, entertainment, recreation & other services	Total
Ashford	410	30	330	870	170	475	370	160	250	405	345	210	975	535	40	85	240	305	6,205
Canterbury	175	20	230	765	150	205	440	130	410	355	85	195	905	425	15	105	255	395	5,265
Dartford	30	20	220	850	135	170	245	245	200	425	70	110	750	360	10	60	150	195	4,240
Dover	195	20	170	545	115	100	275	150	280	165	40	75	510	240	40	80	165	215	3,370
Folkestone & Hythe	205	10	165	575	120	110	295	120	335	210	40	125	610	295	15	60	155	235	3,670
Gravesham	45	15	195	805	115	105	260	320	235	250	45	105	545	340	5	70	165	205	3,830
Maidstone	300	40	370	1,360	235	295	395	390	320	465	125	230	1,260	620	30	125	305	420	7,295
Sevenoaks	200	25	310	990	200	275	370	135	250	625	160	245	1,390	655	25	115	205	400	6,580
Swale	230	40	325	920	185	170	315	250	325	250	60	135	655	385	25	80	195	275	4,820
Thanet	75	25	240	670	125	110	380	130	400	215	60	110	475	290	10	85	175	285	3,865
Tonbridge and Malling	135	30	270	935	165	245	280	170	235	515	150	165	1,200	570	25	105	230	320	5,745
Tunbridge Wells	285	20	245	700	115	255	410	95	265	635	145	210	1,525	670	20	120	245	410	6,365
Kent	2,280	300	3,075	9,990	1,830	2,515	4,035	2,295	3,500	4,515	1,320	1,915	10,800	5,380	260	1,095	2,480	3,660	61,255
Medway	75	40	450	1,785	275	320	615	505	475	575	110	210	1,260	685	10	170	410	450	8,410
Kent + Medway	2,355	340	3,525	11,770	2,105	2,835	4,645	2,805	3,975	5,085	1,430	2,125	12,060	6,065	270	1,270	2,890	4,110	69,660
South East LEP	6,010	800	9,020	29,865	5,330	6,780	11,370	6,750	8,930	12,740	3,325	5,500	28,460	14,520	585	3,055	6,805	10,085	169,930
South East Region	11,830	1,715	18,725	54,485	11,045	15,005	27,200	12,615	19,080	44,650	8,100	13,475	81,230	35,265	1,200	7,475	15,475	25,985	404,555
ENGLAND AND WALES	113,520	12,145	122,650	301,145	68,585	94,070	182,665	101,105	135,270	206,985	54,130	88,610	430,910	208,365	7,210	41,345	99,120	153,755	2,421,590

Source: ONS

Presented by: Strategic Commissioning - Analytics, Kent County Council

Table 2: Percentage Of Vat And/or Paye Based Enterprises In 2018 By Broad Industrial Group

	UK SIC 2007																	
	Agriculture, forestry & fishing	Mining, quarrying & utilities	Manufacturing	Construction	Motor trades	Wholesale	Retail	Transport & storage	Accommodation & food services	Information & communication	Financial & insurance	Property	Professional, scientific & technical	Business administration & support services	Public administration & defence	Education	Health	Arts, entertainment, recreation & other services
Ashford	6.6	0.5	5.3	14.0	2.7	7.7	6.0	2.6	4.0	6.5	5.6	3.4	15.7	8.6	0.6	1.4	3.9	4.9
Canterbury	3.3	0.4	4.4	14.5	2.8	3.9	8.4	2.5	7.8	6.7	1.6	3.7	17.2	8.1	0.3	2.0	4.8	7.5
Dartford	0.7	0.5	5.2	20.0	3.2	4.0	5.8	5.8	4.7	10.0	1.7	2.6	17.7	8.5	0.2	1.4	3.5	4.6
Dover	5.8	0.6	5.0	16.2	3.4	3.0	8.2	4.5	8.3	4.9	1.2	2.2	15.1	7.1	1.2	2.4	4.9	6.4
Gravesham	5.6	0.3	4.5	15.7	3.3	3.0	8.0	3.3	9.1	5.7	1.1	3.4	16.6	8.0	0.4	1.6	4.2	6.4
Maidstone	1.2	0.4	5.1	21.0	3.0	2.7	6.8	8.4	6.1	6.5	1.2	2.7	14.2	8.9	0.1	1.8	4.3	5.4
Sevenoaks	4.1	0.5	5.1	18.6	3.2	4.0	5.4	5.3	4.4	6.4	1.7	3.2	17.3	8.5	0.4	1.7	4.2	5.8
Shepway	3.0	0.4	4.7	15.0	3.0	4.2	5.6	2.1	3.8	9.5	2.4	3.7	21.1	10.0	0.4	1.7	3.1	6.1
Swale	4.8	0.8	6.7	19.1	3.8	3.5	6.5	5.2	6.7	5.2	1.2	2.8	13.6	8.0	0.5	1.7	4.0	5.7
Thanet	1.9	0.6	6.2	17.3	3.2	2.8	9.8	3.4	10.3	5.6	1.6	2.8	12.3	7.5	0.3	2.2	4.5	7.4
Tonbridge and Malling	2.3	0.5	4.7	16.3	2.9	4.3	4.9	3.0	4.1	9.0	2.6	2.9	20.9	9.9	0.4	1.8	4.0	5.6
Tunbridge Wells	4.5	0.3	3.8	11.0	1.8	4.0	6.4	1.5	4.2	10.0	2.3	3.3	24.0	10.5	0.3	1.9	3.8	6.4
Kent	3.7	0.5	5.0	16.3	3.0	4.1	6.6	3.7	5.7	7.4	2.2	3.1	17.6	8.8	0.4	1.8	4.0	6.0
Medway	0.9	0.5	5.4	21.2	3.3	3.8	7.3	6.0	5.6	6.8	1.3	2.5	15.0	8.1	0.1	2.0	4.9	5.4
Kent + Medway	3.4	0.5	5.1	16.9	3.0	4.1	6.7	4.0	5.7	7.3	2.1	3.1	17.3	8.7	0.4	1.8	4.1	5.9
South East LEP	3.5	0.5	5.3	17.6	3.1	4.0	6.7	4.0	5.3	7.5	2.0	3.2	16.7	8.5	0.3	1.8	4.0	5.9
South East Region	2.9	0.4	4.6	13.5	2.7	3.7	6.7	3.1	4.7	11.0	2.0	3.3	20.1	8.7	0.3	1.8	3.8	6.4
ENGLAND AND WALES	4.7	0.5	5.1	12.4	2.8	3.9	7.5	4.2	5.6	8.5	2.2	3.7	17.8	8.6	0.3	1.7	4.1	6.3

Source: ONS

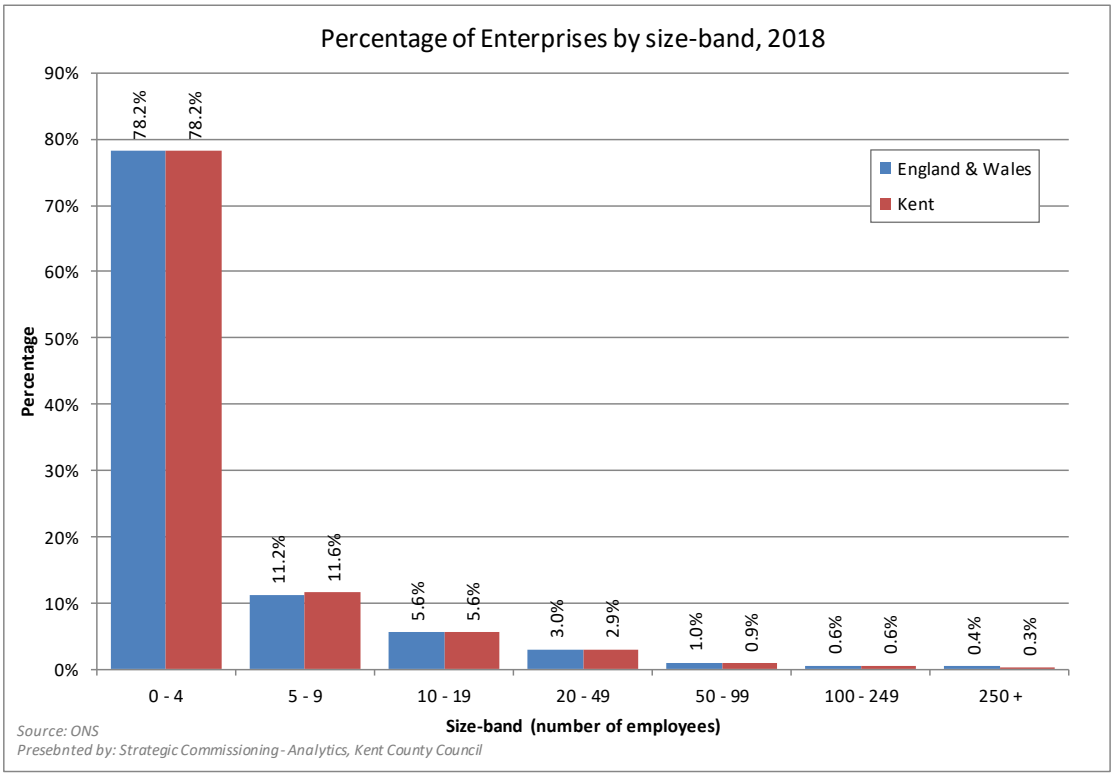
Presented by: Strategic Commissioning - Analytics, Kent County Council

Enterprises by employee size

The majority of enterprises are classed as micro businesses i.e. they have 0 - 9 employees. In Kent 89.7% of enterprises are classed as micro, 89.5% in England and Wales.

Chart 2 shows the proportion of enterprises in Kent and England and Wales by employment size.

Chart 2: Enterprises by sizeband



Tables 3 and 4 show an even greater breakdown of the number and percentage of enterprises by the number of employees.

The data shows that while the majority of enterprises are micro businesses employing up to 9 people, most of these actually have 0 - 4 employees (87.1% of micro businesses in Kent).

Kent has the same proportion of enterprises with 0 – 4 employees, and a slightly higher proportion with 5 – 9 employees than is seen nationally.

Table 3: Number Of Vat And/or Paye Based Enterprises In 2016 By Employment Size

	Employment size							
	0 - 4	5 - 9	10 - 19	20 - 49	50 - 99	100 - 249	250 +	TOTAL
Ashford	4,995	670	285	160	50	25	20	6,205
Canterbury	3,990	670	320	175	55	25	30	5,265
Dartford	3,395	415	210	120	50	30	20	4,240
Dover	2,530	460	215	105	35	25	5	3,370
Folkestone & Hythe	2,800	490	205	120	30	15	10	3,670
Gravesham	3,050	450	170	100	25	20	10	3,830
Maidstone	5,690	820	435	200	70	50	30	7,295
Sevenoaks	5,230	725	345	180	55	25	20	6,580
Swale	3,670	610	300	135	45	40	15	4,820
Thanet	2,935	505	230	125	30	30	5	3,865
Tonbridge and Malling	4,495	610	335	195	60	30	25	5,745
Tunbridge Wells	5,090	645	350	190	55	25	10	6,365
Kent	54,540	7,995	3,875	2,000	635	390	230	61,255
Medway	47,875	7,080	3,400	1,795	565	340	200	8,410
Kent + Medway	6,665	915	475	205	70	50	35	69,660
South East LEP	133,990	18,970	9,280	4,775	1,540	865	510	169,930
South East Region	321,210	42,680	21,610	11,480	3,765	2,270	1,535	404,555
ENGLAND AND WALES	1,893,935	272,190	136,415	72,265	23,995	13,490	9,305	2,421,590

Source: ONS
Presented by: Strategic Commissioning - Analytics, Kent County Council

Table 4: Percentages Of Vat And/or Paye Based Enterprises In 2018 By Employment Size

	Employment size							
	0 - 4	5 - 9	10 - 19	20 - 49	50 - 99	100 - 249	250 +	TOTAL
Ashford	80.5	10.8	4.6	2.6	0.8	0.4	0.3	100
Canterbury	75.8	12.7	6.1	3.3	1.0	0.5	0.6	100
Dartford	80.1	9.8	5.0	2.8	1.2	0.7	0.5	100
Dover	75.1	13.6	6.4	3.1	1.0	0.7	0.1	100
Gravesham	76.3	13.4	5.6	3.3	0.8	0.4	0.3	100
Maidstone	79.6	11.7	4.4	2.6	0.7	0.5	0.3	100
Sevenoaks	78.0	11.2	6.0	2.7	1.0	0.7	0.4	100
Shepway	79.5	11.0	5.2	2.7	0.8	0.4	0.3	100
Swale	76.1	12.7	6.2	2.8	0.9	0.8	0.3	100
Thanet	75.9	13.1	6.0	3.2	0.8	0.8	0.1	100
Tonbridge and Malling	78.2	10.6	5.8	3.4	1.0	0.5	0.4	100
Tunbridge Wells	80.0	10.1	5.5	3.0	0.9	0.4	0.2	100
Kent	89.0	13.1	6.3	3.3	1.0	0.6	0.4	100
Medway	569.3	84.2	40.4	21.3	6.7	4.0	2.4	100
Kent + Medway	9.6	1.3	0.7	0.3	0.1	0.1	0.1	100
South East LEP	78.9	11.2	5.5	2.8	0.9	0.5	0.3	100
South East Region	79.4	10.5	5.3	2.8	0.9	0.6	0.4	100
ENGLAND AND WALES	78.2	11.2	5.6	3.0	1.0	0.6	0.4	100

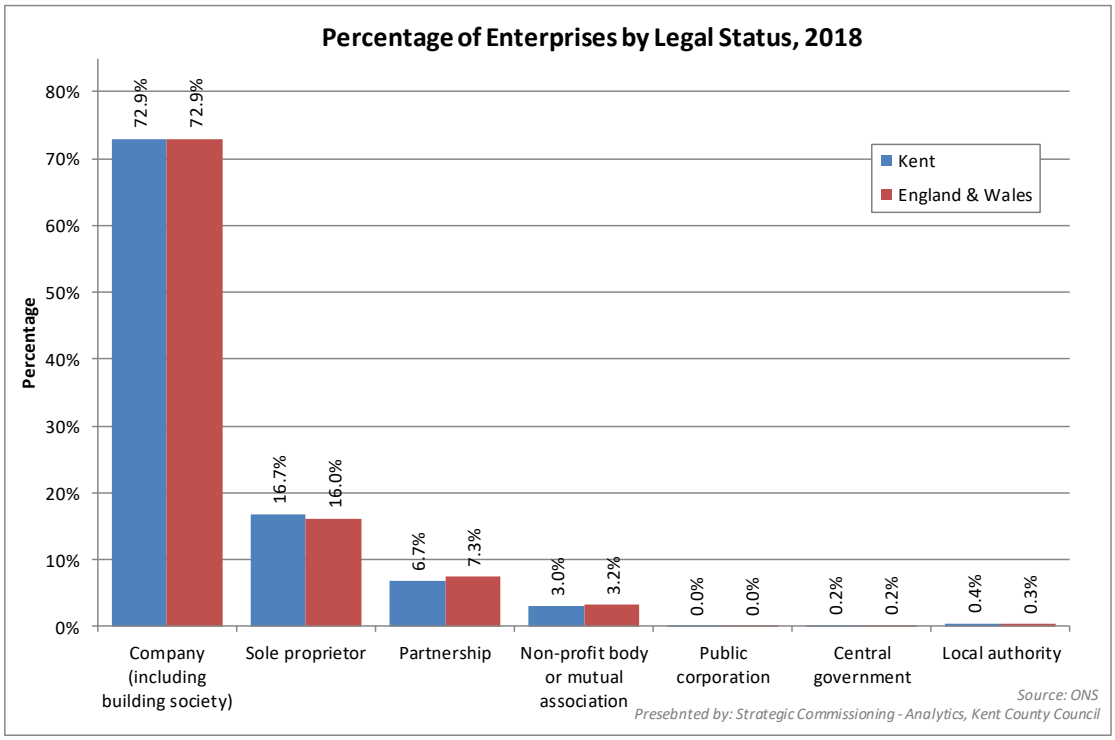
Source: ONS
Presented by: Strategic Commissioning - Analytics, Kent County Council

Enterprise by status

The data also shows the number of enterprises by legal status. The legal status of units is classified by ONS in accordance with National Accounts Sector Classifications. All enterprises engage in financial transactions, paying out and receiving money for reasons such as buying and selling goods and services, paying taxes, or collecting tax revenues. Using information received from Companies House and the administrative sources from HM Revenue & Customs, the National Accounts Sector Classification determines whether a body or enterprise is in the private or public sector, and if public, whether they are government bodies or public corporations, and whether certain transactions count as taxes or service fees.

Chart 3 shows the proportion of enterprises by legal status in Kent compared to England and Wales in 2018.

Chart 3: Enterprises by legal status



The majority of enterprises are private sector companies. In Kent they account for 72.9% of all enterprises, the same as England and Wales as a whole.

Kent has a slightly higher proportion of sole proprietor enterprises (16.7%) than is seen nationally and a slightly lower proportion of partnerships (6.7%).

Tables 5 and 6 show the legal status of enterprises in Kent local authority districts and Kent as a whole. They also present information at regional and national level for comparison.

Table 5: Number Of Vat And/or Paye Based Enterprises In 2018 By Employment Status

	Private sector				Public sector			
	Company (including building society)	Sole proprietor	Partnership	Non-profit body or mutual association	Public corporation	Central government	Local authority	TOTAL
Ashford	4,250	985	500	420	0	10	40	6,205
Canterbury	3,625	990	440	180	0	10	20	5,265
Dartford	3,455	505	140	115	0	15	10	4,240
Dover	2,015	815	385	105	5	10	40	3,370
Folkestone & Hythe	2,450	780	325	90	0	10	15	3,670
Gravesham	3,020	555	160	75	0	10	10	3,830
Maidstone	5,415	1,170	485	175	0	10	35	7,295
Sevenoaks	5,085	970	345	145	0	5	30	6,580
Swale	3,400	900	350	125	0	15	30	4,820
Thanet	2,630	800	310	100	0	15	10	3,865
Tonbridge and Malling	4,480	795	285	150	0	5	30	5,745
Tunbridge Wells	4,820	950	400	175	0	5	20	6,365
Kent	44,655	10,215	4,130	1,855	5	120	275	61,255
Medway	6,380	1,360	410	215	0	30	10	8,410
Kent + Medway	51,035	11,570	4,540	2,070	5	150	290	69,660
South East LEP	126,590	26,935	11,105	4,315	10	360	620	169,930
South East Region	307,465	59,780	23,950	11,440	15	550	1,350	404,555
ENGLAND AND WALES	1,766,460	388,100	177,770	76,910	160	3,890	8,300	2,421,590

Source: ONS
Presented by: Strategic Commissioning - Analytics, Kent County Council

Turnover

Turnover figures provided to ONS for the majority of traders is based on VAT returns for a 12 month period. For 2018 this relates to a 12 month period covering the financial year 2017/2018. For other records, in particular members of VAT group registrations, turnover may relate to an earlier period or survey data.

For traders who have registered more recently, turnover represents the estimate made by traders at the time of registration.

The turnover figures on the register generally exclude VAT but include other taxes, such as the revenue duties on alcoholic drinks and tobacco. They represent total UK turnover, including exempt and zero-rated supplies.

Turnover bands shown in the analyses relate to the latest year for which information is available. Traders may be registered below the VAT threshold or may choose not to de-register should their turnover fall below the threshold.

Table 7 shows the VAT registration thresholds since 2004/05.

Table 7 - VAT registration thresholds

Operative dates	VAT Registration Threshold
1 Apr 2004 - 31 Mar 2005	£58,000
1 Apr 2005 - 31 Mar 2006	£60,000
1 Apr 2006 - 31 Mar 2007	£61,000
1 Apr 2007 - 31 Mar 2008	£64,000
1 Apr 2008 - 31 Mar 2009	£67,000
1 Apr 2009 - 31 Mar 2010	£68,000
1 Apr 2010 - 31 Mar 2011	£70,000
1 Apr 2011 - 31 Mar 2012	£73,000
1 Apr 2012 - 31 Mar 2013	£77,000
1 Apr 2013 - 31 Mar 2014	£79,000
1 Apr 2014 - 31 Mar 2015	£81,000
1 Apr 2015 - 31 March 2016	£82,000
1 Apr 2016 - 31 March 2017	£83,000
1 Apr 2017 - 31 March 2018	£85,000
1 Apr 2018 onwards	£85,000

Source: HMRC

33.2% of enterprises in Kent have a turnover of between £100k and £249k. In Kent a higher proportion of enterprises have a turnover of over £100k than is seen nationally. This is shown in chart 4.

Tables 8 and 9 present the turnover data for Kent local authority districts and Kent as a whole. Regional and national figures are also presented for comparison.

Chart 4

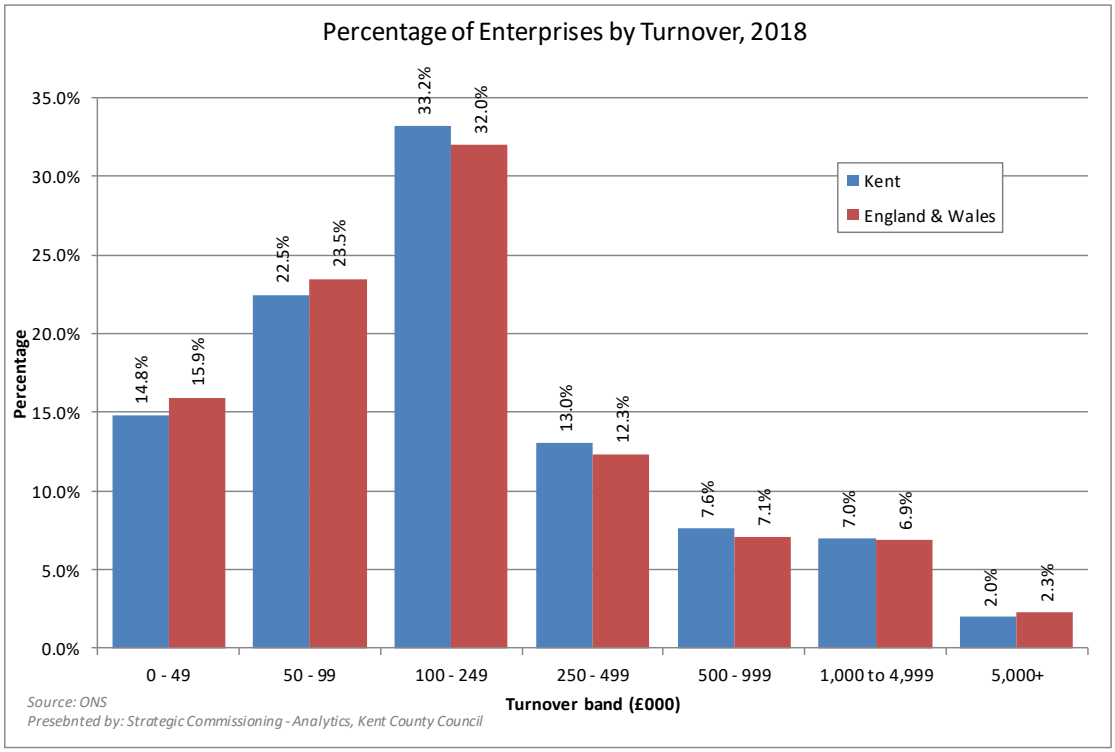


Table 8: Number Of Vat And/or Paye Based Enterprises In 2018 By Turnover Sizeband

	Turnover size (£ thousand)							
	0 to 49	50 to 99	100 to 199	200 to 499	500 to 999	1,000 to 4,999	5,000+	TOTAL
Ashford	1,225	1,295	1,850	810	525	405	95	6,205
Canterbury	735	1,195	1,780	685	415	360	95	5,265
Dartford	575	1,080	1,395	485	275	310	120	4,240
Dover	510	720	1,095	475	285	240	50	3,370
Folkestone & Hythe	570	845	1,275	460	245	230	45	3,670
Gravesham	585	970	1,245	480	250	250	55	3,830
Maidstone	1,115	1,605	2,330	975	585	525	160	7,295
Sevenoaks	875	1,370	2,320	845	515	495	165	6,580
Swale	675	1,150	1,495	665	400	340	90	4,820
Thanet	485	905	1,355	545	280	245	55	3,865
Tonbridge and Malling	800	1,235	1,930	740	420	460	160	5,745
Tunbridge Wells	920	1,390	2,235	825	450	415	130	6,365
Kent	9,070	13,760	20,310	7,980	4,650	4,270	1,220	61,255
Medway	1,245	2,145	2,610	1,030	660	565	160	8,410
Kent + Medway	10,315	15,900	22,920	9,010	5,310	4,835	1,370	69,660
South East LEP	24,545	39,210	56,695	21,850	12,525	11,740	3,365	169,930
South East Region	62,330	92,600	135,775	49,070	28,370	27,375	9,040	404,555
ENGLAND AND WALES	386,205	568,870	774,035	298,325	171,895	166,485	55,770	2,421,590

Source: ONS
Presented by: Strategic Commissioning - Analytics, Kent County Council

Table 9: Percentage Of Vat And/or Paye Based Enterprises In 2018 By Turnover Sizeband

	Turnover size (£ thousand)							
	0 to 49	50 to 99	100 to 199	200 to 499	500 to 999	1,000 to 4,999	5,000+	TOTAL
Ashford	19.7	20.9	29.8	13.1	8.5	6.5	1.5	100
Canterbury	14.0	22.7	33.8	13.0	7.9	6.8	1.8	100
Dartford	13.6	25.5	32.9	11.4	6.5	7.3	2.8	100
Dover	15.1	21.4	32.5	14.1	8.5	7.1	1.5	100
Gravesham	15.5	23.0	34.7	12.5	6.7	6.3	1.2	100
Maidstone	15.3	25.3	32.5	12.5	6.5	6.5	1.4	100
Sevenoaks	15.3	22.0	31.9	13.4	8.0	7.2	2.2	100
Shepway	13.3	20.8	35.3	12.8	7.8	7.5	2.5	100
Swale	14.0	23.9	31.0	13.8	8.3	7.1	1.9	100
Thanet	12.5	23.4	35.1	14.1	7.2	6.3	1.4	100
Tonbridge and Malling	13.9	21.5	33.6	12.9	7.3	8.0	2.8	100
Tunbridge Wells	14.5	21.8	35.1	13.0	7.1	6.5	2.0	100
Kent	14.8	22.5	33.2	13.0	7.6	7.0	2.0	100
Medway	14.8	25.5	31.0	12.2	7.8	6.7	1.9	100
Kent + Medway	14.8	22.8	32.9	12.9	7.6	6.9	2.0	100
South East LEP	14.4	23.1	33.4	12.9	7.4	6.9	2.0	100
South East Region	15.4	22.9	33.6	12.1	7.0	6.8	2.2	100
ENGLAND AND WALES	15.9	23.5	32.0	12.3	7.1	6.9	2.3	100

Source: ONS
Presented by: Strategic Commissioning - Analytics, Kent County Council

HEALTH IMPACT ASSESSMENT GUIDANCE

IPH

Institute of Public Health in Ireland

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Owen Metcalfe
Claire Higgins
Teresa Lavin

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2009

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Investing for Health

Department of Health & Children
AN ROINN SLÁINTE AGUS LEANAÍ

Health Impact Assessment Guidance

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contents

1. Introduction

This guidance manual explains what Health Impact Assessment (HIA) is and the stages involved in conducting it. It has been revised and updated based on the experience of HIA practitioners and includes new tools which have been developed to assist each step of the HIA process. It aims to provide a user friendly and practical framework to guide policy-makers and practitioners in undertaking HIA. All HIA tools contained in this guidance and further information on HIA may be found at http://www.publichealth.ie/hia

The guidance has been endorsed by the Department of Health, Social Services and Public Safety in Northern Ireland and the Department of Health and Children in the Republic of Ireland.

In Northern Ireland HIA is supported from a policy perspective by the *Investing for Health Strategy*[1] which was developed by all government departments through the Ministerial Group on Public Health (MGPH) and chaired by the Minister of Health, Social Services and Public Safety (DHSSPS). *Investing for Health* contains a commitment to develop a methodology to enable all government departments to identify and evaluate the health impacts of new policy developments.

In the Republic of Ireland HIA is supported from a policy perspective by the health strategy *Quality and Fairness: a health system for you*[2]. This strategy contains a commitment to develop HIA methodology and to support other government departments and agencies to conduct HIAs.

2. Health and health inequalities

2.1 Definition of health

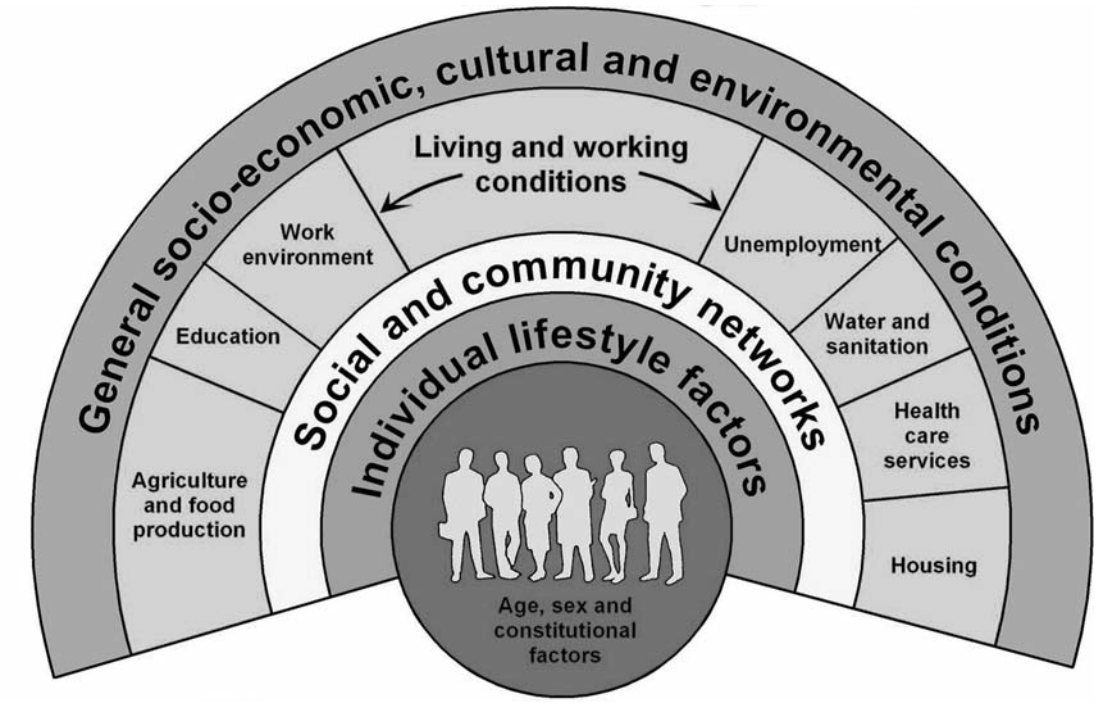
The World Health Organization (WHO) defines health as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'. In keeping with this definition, HIA includes consideration of the potential impacts of a proposal on physical, mental and social health.

2.2 Social determinants of health

Health is determined not only by access to quality healthcare services and lifestyle choices but also by the social and economic conditions in which people live. These include many factors which lie outside the healthcare sector, such as housing, employment, transport and access to fresh food. Policies and actions formulated in these non-healthcare sectors have a significant impact on people's health and wellbeing. For example, a housing sector scheme on damp proofing is likely to significantly improve respiratory health, particularly for vulnerable residents such as the elderly and young children. Similarly, a transport sector policy to promote active forms of travel is likely to improve levels of physical activity with subsequent health benefits.

Figure 1 below illustrates the many determinants of health. Further information on the social determinants of health can be found in Appendix 1.

Figure 1 Social determinants of health[3]



2.3 Health inequalities

Health inequalities refer to the avoidable and unjust gap in health outcomes between those at the top and bottom ends of the social scale. People in higher socioeconomic groups are more likely to live longer and enjoy more years of good health than those in lower socioeconomic groups. There are also notable differences in the health experiences of men and women. As health inequalities often mirror social inequalities, addressing the social determinants of health can impact positively on health inequalities.

3. Health Impact Assessment

3.1 Definition

HIA is a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population[4].

3.2 Rationale

Policies, programmes and projects from many areas affect health and should take into account their impact on health and health inequalities. HIA is a tool which can be used to achieve this by assessing potential health impacts of proposals in a systematic and transparent way.

3.3 Background

HIA has been developing internationally since the early 1990's. It is now used in many European countries, Australasia, North America, Africa and Asia.

In the European Union, the Amsterdam and subsequent Treaties[5] support the consideration of health in policy making across all sectors. This is reflected in the EU Health *Strategy Together for Health 2008 – 2013*[6] *and the second programme of Community action in the field of health (Health Programme) 2008 – 2013*[7].

WHO has developed a HIA programme and set targets for member states to develop HIA mechanisms by 2010. The report of WHO's *Commission on Social Determinants of Health*, recommends Health Equity Impact Assessment as a tool to build policy coherence for health equity[8].

3.4 Aims of HIA

HIA seeks to inform and enhance the decision-making process in favour of health and health equity. It aims to maximise potential positive health impacts and minimise potential negative health impacts of a proposal.

HIA can contribute to improved health by:

- raising awareness among decision makers of the relationship between health and the physical, social and economic environments
- demonstrating how a proposal may affect the health of a population
- providing recommendations on how a proposal could be modified to maximise opportunities for health gain and minimise chances of health loss.

HIA can contribute to reducing health inequalities by:

- raising awareness among decision makers of the unequal distribution of health and illness
- demonstrating how a proposal may affect the health of particular groups within a population
- providing recommendations on how a proposal could be modified to reduce health inequalities or prevent existing inequalities being exacerbated.

HIA can contribute to better decision-making by:

- following a clear, transparent process
- ensuring recommendations are evidence based
- helping those affected by the proposal to participate in policy formation and contribute to decision-making.

3.5 Values of HIA

WHO has outlined the values which provide a sound ethical framework for conducting a HIA. These values are:

- Democracy – HIA allows people to participate in the development and implementation of proposals that may impact on their lives
- Equity – HIA assesses the distribution of impacts of a proposal on the whole population, with a particular reference to how the proposal will affect vulnerable people (in terms of age, gender, ethnic background and socioeconomic status)
- Sustainable development – Where appropriate, HIA considers both long and short term impacts
- Ethical use of evidence – HIA uses the best available evidence from different disciplines and methodologies and places an emphasis on using transparent and rigorous processes to synthesise and interpret this evidence.

3.6 HIA and other assessments

There are considerable parallels between HIA and other impact assessments including Environmental (EIA), Poverty (PIA), Human Rights (HRIA) and Equality Impact Assesment (EqIA). HIA derives its approach and framework from EIA but was developed partly as a consequence of EIA not placing sufficient emphasis on human health. Strategic Environmental Assessment (SEA) goes some way towards addressing this deficit at policy level as there is a requirement to consider effects on population and human health.

In Northern Ireland Integrated Impact Assessment has been developed by the Office of the First Minister and Deputy First Minister (OFMDFM) and health forms an important component of this.

4. Conducting Health Impact Assessment

4.1 Issues to consider

The following issues should be considered:

4.1.1 Support

At the outset it is useful to identify the support that is likely to be available for HIA. This can be a critical factor in commencing or in determining the ease with which HIA can be conducted and recommendations implemented. This may include reviewing relevant government or political processes and the identification of resources available to conduct the HIA.

4.1.2 Ensuring a broad understanding of health and its determinants

Health in HIA is understood to encompass physical, mental and social wellbeing. It also emphasises the social, economic and environmental determinants of health (see Figure 1). This perspective is essential in helping to decide where a HIA might be appropriate, the type of research needed and if any specialist assistance is required. A growing number of resources are available which demonstrate clear links between many non-healthcare sectors and health (see Appendix 1).

4.1.3 Timing

It is important to be clear about what stage the policy, programme or project is at when undertaking HIA. This will impact upon the level of influence the HIA recommendations may have. HIA may be undertaken prospectively, concurrently or retrospectively:

Prospective HIA: Ideally HIA should be carried out prospectively, i.e. when the proposal is being developed, so that HIA recommendations have the potential to influence decisions being made.

Concurrent HIA: A concurrent HIA takes place while the policy, programme or project is being implemented. This can be particularly useful to inform a review process. It overcomes the problems sometimes faced in prospective HIA in accessing detailed information about the proposal.

Retrospective HIA: A retrospective HIA is carried out on a policy, programme or project that has already been implemented. This can be useful when a similar proposal is being planned to ascertain health impacts of the one already in existence. Retrospective HIA differs from

evaluation as it focuses on how health has been affected which may not have been an explicit objective of the policy, programme or project.

In deciding when to undertake a HIA, it is important to be clear about who is making key decisions and to identify key decision points in a given proposal for a new policy, programme or project.

4.1.4 Level

HIA can be conducted at different levels depending on a range of factors including:

- the status and complexity of the policy, programme or project
- locally determined health priorities and targets
- the potential scale and severity of health impacts
- the quality of the evidence base and availability of data
- the support for HIA at regional and local level
- the resources available to conduct HIA.

The terms desktop, rapid and comprehensive are used to describe the different levels of a particular HIA:

Desktop HIA: This is conducted quickly and with limited resources. Only evidence which is easily accessible is used. A desktop HIA is usually conducted when there is only a short timeframe available or if the scale of the proposal does not warrant more in-depth investigation.

Rapid HIA: This type of HIA includes a broader range of evidence but is still conducted within tight time and resource constraints.

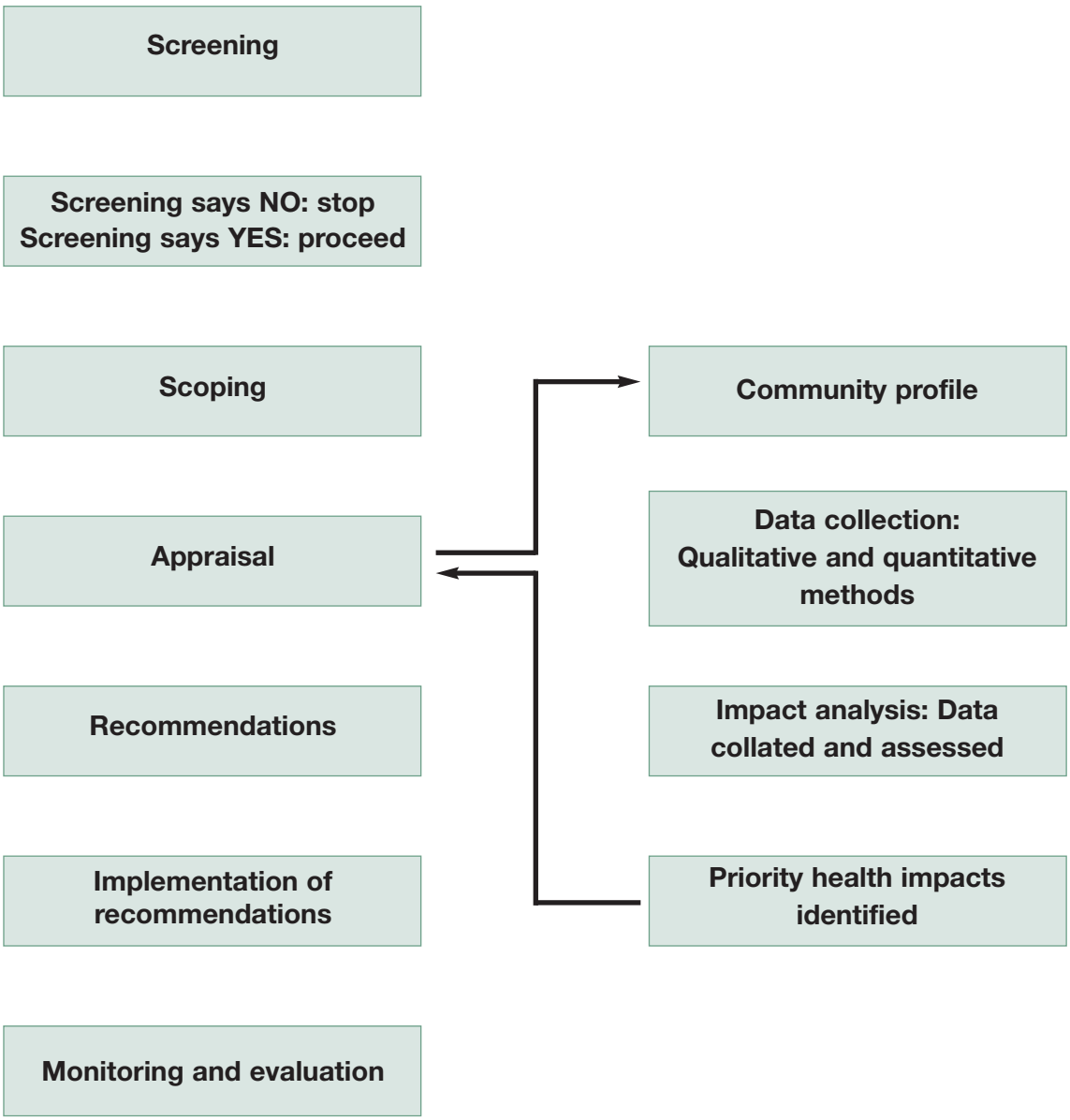
Comprehensive HIA: This is undertaken over a longer period of time and involves more resources. It is useful when the potential scale and severity of health impacts warrant an in-depth investigation.

The HIA process, described in the next section, should be followed whichever level of HIA is undertaken.

4.2 HIA process

The HIA process consists of a series of steps which are described here as discrete stages. However experience shows that the different stages can overlap with each other, for example, screening and scoping are sometimes carried out as one exercise.

Figure 2 The HIA process



4.2.1 Screening

Screening quickly and systematically establishes whether a HIA is appropriate or necessary. It can indicate:

- potential health impacts of a policy, programme or project
- potential impacts on vulnerable sections of the population
- if there is a need for a more detailed assessment
- if HIA is the best way to effectively address health and equity issues.

If a decision is made to proceed with HIA, this stage provides an outline of areas of concern to be considered when conducting the HIA. If it is decided not to proceed with HIA, screening provides a record of why that decision was reached. Additionally, conducting screening can raise awareness of health impacts among decision makers and prompt them to consider these in the future.

Use a screening tool

Using a screening tool (see Appendix 2) helps with the tasks involved in screening. The main purpose of the screening tool is to give a structure to discussions or meetings with stakeholders. It aims to prompt consideration of health impacts that may otherwise be overlooked.

Who should be involved in screening?

It is strongly recommended that screening is carried out by more than one person. Involving key informants and major stakeholders can help ensure a broader perspective and promote ownership of the process at an early stage. Members may include, for example, someone with health knowledge, the initiator of the policy, representatives from relevant government, non-government and voluntary sectors and a representative from the community likely to be affected by the proposal. Keeping the number of people involved fairly small at this stage (perhaps 5 or 6 people) will make it easier to manage.

Understand the proposed policy, programme or project

Study the proposal and its background and context. Understand its rationale and aims and objectives. Consider the health impacts of similar policies elsewhere.

Prepare for the screening meeting

Prior to the meeting it might be useful to circulate the following information:

- a summarised description of the policy, programme or project
- aspects of the policy, programme or project open to negotiation and those which are not
- any easily accessible information on the population affected by the proposal
- sections of the population likely to be particularly vulnerable to the proposal.

Establish health impacts and affected population groups

At the meeting have a brainstorming session to get the stakeholders' and key informants' perspectives on what the health impacts might be and what population groups might be affected and how. Out of a list of potential health impacts identified, attempt to prioritise them. This will help to focus resources on the most significant impacts on which to conduct the HIA. The screening tool can help to structure this exercise.

Make the process transparent

The screening tool also provides transparency for the process, enabling the recording of decisions and demonstrating thorough consideration of the health implications.

4.2.2 Scoping

The scoping stage produces the blueprint for the HIA and how it is managed. It establishes a foundation for the rest of the assessment. Appendix 3 provides a scoping tool which lists items to consider when developing a work plan for the HIA.

Proposal analysis

Proposal analysis identifies which elements of the proposal will be subject to HIA. It is important to read and fully understand the aims of the proposal in order to identify which sections the HIA should focus on. Engaging with those responsible for developing the proposal at an early stage may provide easier access to information as it becomes available.

Establish a steering group

A HIA steering group is usually set up at this stage or may evolve from the group who conducted the screening. The nature and size of the group depends on the complexity of the proposal, the resources available and the time available to conduct the HIA.

Who should be on the steering group?

Identify the main stakeholders and get them involved. Community participation forms an important part of HIA. Professionals from the relevant policy areas, representatives from affected communities, the voluntary sector and other stakeholders should be represented. Their input will contribute to informed and balanced results at the end of the process.

Attempt to get a good mix of skills on the steering group

Useful skills include community involvement, public health knowledge and understanding of evidence, research skills (such as literature review, data analysis, qualitative research, stakeholder consultation), negotiation skills, project management and policy analysis. Representatives with access to relevant data could be very useful. Other skills required vary according to the proposal type and the depth of the assessment but could include specialist skills in social sciences, epidemiology and health economics.

Who will manage the HIA process?

The group should decide this. In some cases it may be the person with lead responsibility for developing the policy, in other situations it may be the person who initiated the HIA process or another organisation interested in health.

Develop a work plan

The steering group should develop a work plan for the HIA which includes clearly defined deadlines and measurable outputs. The scope of the work plan will be dictated by the amount of time and other resources available. It is essential to find out at an early stage when key decisions will be made about the proposal so that HIA recommendations are delivered in advance of this. The contents of the work plan will be largely dictated by the following:

Aims and objectives of the HIA

Use SMART (Specific, Measurable, Achievable, Realistic and Timely) principles to develop the aims and objectives.

Values

Consider what values the HIA steering group will adopt for conducting the HIA. These may include for example, transparency, equity, sustainability, participation and inclusiveness.

Non-negotiable issues

There may be aspects of the policy, programme or project that are not open to negotiation. These should be clearly identified at the outset.

Boundaries

What geographical area and what communities or population groups will the HIA consider?

Resources

Assess financial and human resources available to conduct the HIA. The London Health Observatory has developed a HIA calculator which can be used to estimate how much the HIA will cost, available at http://www.lho.org.uk/viewResource.aspx?id=9735. Consider what additional resources may be available from organisations represented on the steering group.

Methods

Decide on the methods which will be used to gather evidence from the literature and from the community and other stakeholders. A detailed description of methods used to gather evidence is contained in section 4.2.3.

Monitoring and evaluation

The steering group should also include monitoring and evaluation arrangements in the HIA work plan.

Decide whether or not to engage an external HIA consultant

It may be advantageous to engage an external consultant. This person could be used to coordinate the process from beginning to end or to undertake one aspect of it. They could be used for a number of resource intensive tasks such as documenting decisions, recording the results of appraisal, identifying the impacts missed by stakeholders, finding evidence, prioritising health impacts and helping frame recommendations. An external HIA consultant should have public health knowledge and skills and expertise in conducting HIAs. It is important for the HIA steering group to keep control of the process and ensure its quality.

Record decisions for transparency

A record of all activity should be documented and archived. This is important to ensure that the assessment is transparent.

4.2.3 Appraisal

The appraisal stage is where evidence of potential health impacts is gathered, considered and prioritised. The methods used for data collection and analysis will vary according to the level of HIA.

Gathering information on potential health impacts of the proposal

A range of information is needed to ensure that HIA recommendations are evidence based. Consideration needs to be given to evidence from a range of sources, which are relevant to the proposal and also the population. In some cases information may already have been collected and this should be used when it is relevant and appropriate to the issues under investigation. The depth of information obtained from the following areas will depend on the level of HIA being conducted.

Community profile

Building a community profile helps to better understand the population affected by the proposal, identify potentially vulnerable groups and establish a baseline against which possible future health impacts can be assessed. Belfast Healthy Cities has produced guidance on developing a community profile, available at http://www.belfasthealthycities.com/images/stories/PDFs/guidelines.pdf

A community profile might include:

- general attributes of the population including size, density, distribution, age and sex, birth rate, ethnicity, socioeconomic status
- health status of the population, particularly the at-risk groups
- levels of employment or unemployment
- health behaviour indicators
- environmental conditions such as transport infrastructure, housing make-up, details on air, water and soil
- geographical location of at-risk groups.

Information for community profiling is available from a number of agencies including:

- The Northern Ireland Statistics and Research Agency (NISRA) http://www.nisra.gov.uk/
- Northern Ireland Neighbourhood Information Service (NINIS) http://www.ninis.nisra.gov.uk/

- The Central Statistics Office in the Republic of Ireland
  http://www.cso.ie/
- Ireland and Northern Ireland's Population Health Observatory (INIsPHO)
  http://www.inispho.org

Government departments, local authorities and community/voluntary groups may also be able to provide useful data.

Policy analysis

The policy environment into which the proposal is being introduced needs to be understood by those conducting the HIA. Understanding where the proposal sits in the wider social, economic, political and cultural policy context will help to inform the appraisal and ensure recommendations are appropriate. Policy analysis involves reviewing government and other relevant agency policy related to the proposal. Having a good mix of skills and knowledge represented on the HIA steering group can help to ensure that the policy context for the proposal is understood. A policy analysis tool is available in Appendix 4.

Literature review

A literature review should be undertaken to find evidence which supports or refutes the assumptions made at the screening stage about the potential health impacts of the proposal. It is important when conducting a literature review that questions are clear and focused and relevant to the local context of the HIA. Further information on reviewing the literature is available at:
http://www.publichealth.ie/whatishealthimpactassessment/hiamethodology

It may be useful to check with colleagues and topic experts to identify key databases, websites and other sources of information. Systematic reviews should be used where these are available. Additionally, it can be useful to review other HIAs which have been conducted on similar proposals. HIA Gateway website provides links to a number of HIAs conducted internationally, available at http://www.hiagateway.org.uk

Quantitative and qualitative evidence

Quantitative evidence is evidence, data or information which is expressed in numerical terms. The objective of quantitative research is to develop and employ mathematical models, theories and/or hypotheses pertaining to natural phenomena. The process of measurement is central to quantitative research because it provides the fundamental connection between empirical observation and mathematical expression of quantitative relationships.

Qualitative evidence is evidence, data or information that is expressed in terms of the meaning of acts or events, which distinguishes between data in terms of quality or form rather than quantity. Qualitative research places emphasis on understanding through looking closely at people's words, actions and records. The task of the qualitative researcher is to find patterns within those words (and actions) and to present those patterns for others to inspect while at the same time staying as close to the construction of the world as the participants originally experienced it.

Both types of evidence are important in HIA. The HIA should focus on the quality of the evidence regardless of whether it is quantitative or qualitative. The crucial test of the validity of evidence for HIA should be the robustness of the research design and the validity of its conclusions.

Stakeholder information

The local community and other stakeholders are valuable sources of evidence and can provide insight not available elsewhere on how the proposal might affect health. Engagement with key informants and stakeholders can take place through a variety of means including interviews, focus groups and stakeholder workshops. A task based approach to gathering evidence from stakeholders is available at http://www.publichealth.ie/eventsandresources/hiatools

Assessing the quality of evidence

The HIA aims to provide a number of evidence-based recommendations but there may be disagreement over what constitutes acceptable evidence. These are some of the issues encountered with collecting evidence and suggested ways of dealing with them.

Lack of evidence
It may be difficult to find evidence to show the direct health impacts of public policy decisions, particularly at a local level. For this reason evidence from other similar geographical areas is frequently used and extrapolated to apply to local conditions.

Time constraints on gathering evidence
There may not be enough time to carry out local research so readily available existing evidence will have to suffice.

Speculative nature of evidence
Where evidence exists, much of it shows associations rather than direct causal connections between policy actions and health impacts. For example, there is an association between poor housing conditions and certain types of illness but there is disagreement about the strength of the association and whether one directly causes the other.

Apply the precautionary principle
To address this issue, HIA adopts the WHO approach and applies the precautionary principle when dealing with evidence. This means that where there are threats of serious damage to health, a lack of full scientific certainty should not be used as a reason for postponing measures to minimise this damage.

Decision makers' views on evidence
If the crucial decision makers on the policy, programme or project want to see particular types of evidence used, then highlighting this evidence will improve the chances of the recommendations to maximise health being accepted.

Collating information

The next step in appraisal is to assemble all the information that has been gathered to date in preparation for prioritising impacts. It may be useful to insert information into a table (see Appendix 5) which links the potential health impacts identified in the proposal with the evidence gathered.

Prioritising potential health impacts

Depending on the complexity of the proposal and level of HIA undertaken, there may be a large number of potential health impacts identified. Some groups choose to form recommendations for each impact identified however it is advisable to agree some form of ranking system to help decide where most efforts should be made in ensuring certain recommendations are implemented. Prioritised impacts should reflect the aims, objectives and values of the HIA. Furthermore appropriate consideration should be given to different types of evidence.

Issues which may influence prioritisation include:

- the likelihood of the impact occurring (likely, speculative or unlikely)
- the scale of the impact if it does occur (severe, moderate or minimal)
- the number of people likely to be affected (many, some or few)
- the timescale in which the impact may occur (short, medium or long term)
- whether the impact will affect some groups within the population more than others (inequalities)
- issues highlighted as areas of concern by stakeholders (stakeholder concerns).

All the evidence used to support prioritisation of potential health impacts should be documented by referencing, for example, studies, quotes from stakeholders or policy documents. The strength of evidence used should also be easily identifiable.

Appendix 5 provides a tool to assist in prioritising potential health impacts.

4.2.4 Recommendations

Forming recommendations

The steering group develops one or more recommendations for each (prioritised) health impact on how this aspect of the proposal could be modified to maximise health gain and/ or minimise health loss. Recommendations should:

- be practical and achievable
- identify a lead agency and others who may play a role
- specify timeframes where possible
- be wide ranging
- aim to be cost effective
- be relatively few in number.

Appendix 6 provides a tool in which recommendations can be documented.

Examples of recommendations from HIAs conducted in the Republic of Ireland and Northern Ireland are contained in Appendix 8.

Disseminating recommendations

Recommendations should be sent to the relevant lead agencies. This may require a period of negotiation where decision makers plans to implement recommendations are agreed. Ideally discussions will have begun in advance of this stage. A report describing the process, findings and policy revision options may also be produced for the proposal developers. Summary reports and other mechanisms of dissemination may also be produced to meet the different needs of stakeholders and target audiences. A tool has been developed to guide this stage of the process (see Appendix 6).

4.2.5 Monitoring and evaluation

Monitoring and evaluation is an essential part of the HIA. As well as assessing actual impacts on health in the longer term, it can help inform whether the aims and objectives set at the beginning of the HIA were achieved and whether the methodology used was effective or suitable. The following issues should be considered:

Process

Assess how the HIA process was undertaken, who was involved, and how useful

and valuable the process was. This can help determine whether the HIA added value to the decision-making process. Monitoring and evaluation of the process and methodology can be conducted by reading output documents, minutes, agendas and other material and obtaining steering group members' points of view through a survey or interview.

Impact
Assess the impact of the HIA in terms of whether recommendations are subsequently accepted and implemented by the decision makers and if not, why not. The tool in Appendix 7 can assist with the process.

Outcome
Monitoring and evaluation should also consider the health outcomes of a proposal after a HIA has been conducted. It should aim to assess whether the anticipated positive effects on health, wellbeing and equity were in fact enhanced and whether negative ones were minimised.

The health impacts of a policy may take many years to become apparent and the HIA steering group may not be available to measure these impacts once the assessment is complete. For this reason, indicators to measure the longer term health impacts of the proposal should be framed while doing the HIA and these should be included as a discrete strand of the ongoing monitoring of the policy or project.

4.3 The HIA report

A brief report describing the process, findings and policy revision options may be produced. It may be appropriate to also produce a full HIA report for decision makers and other stakeholders involved in the HIA. Other feedback mechanisms such as newsletters and posters may also be considered.

Appendix 1: Further information on social determinants of health

The Institute of Public Health in Ireland (IPH) has produced review documents in four areas, education, the built environment, employment and transport, illustrating the connections between these policy areas and health. A brief overview of key health impacts identified in each review is given below. The full reports, together with supporting 'sources of information' documents, can be accessed at http://www.publichealth.ie/hiaresources.

Health impacts of education

Health outcomes associated with education

Evidence shows that those with lower levels of education die younger, experience higher rates of illnesses such as cardiovascular disease and strokes and are also less likely to engage in healthy behaviours such as physical activity.

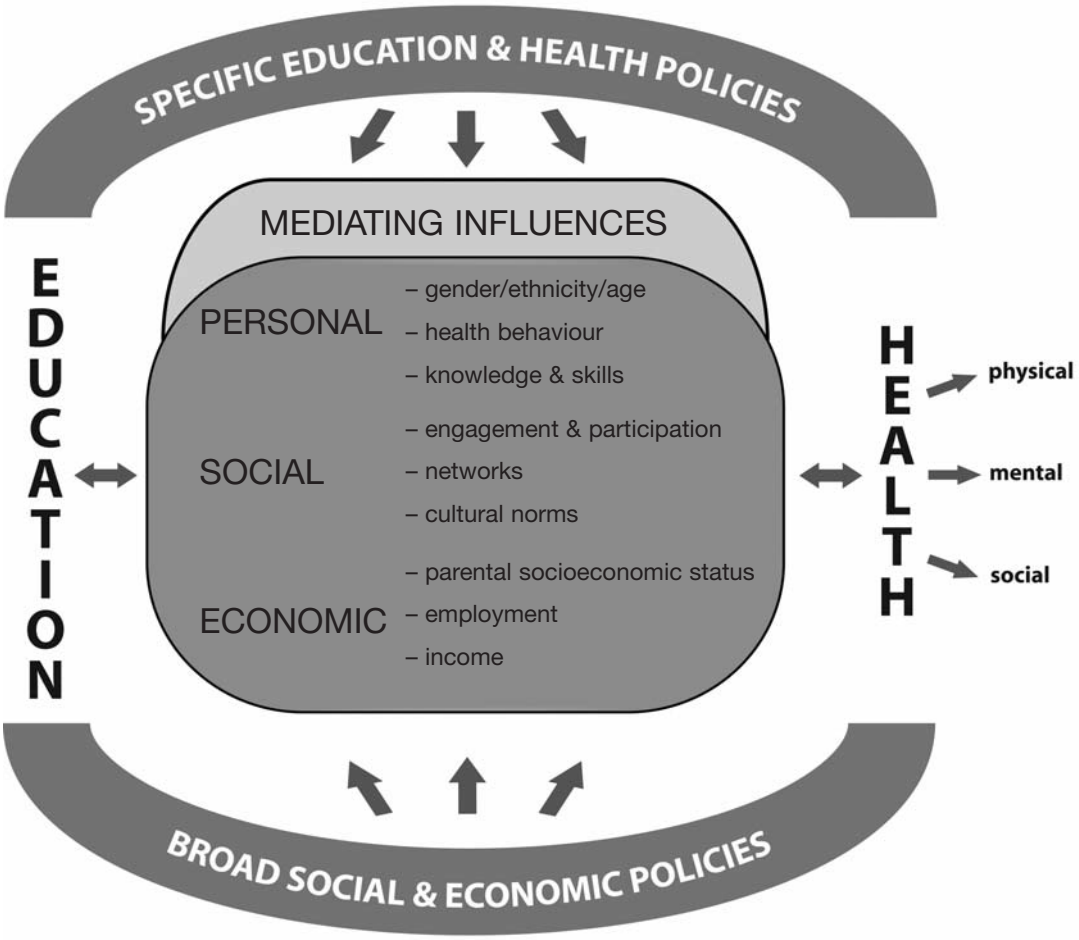
Route to health through education

Education provides opportunities for employment and potentially higher income levels. It enhances individuals' social skills and levels of social capital, both of which are associated with better health. Personal development and attitudes are enhanced with higher levels of education which can lead to a greater sense of control and an increased likelihood that healthier behaviours will be adopted.

Supporting healthy behaviours and attitudes in the school environment

The school environment can support health through school settings approaches to healthier lifestyles for young people. Physical education (PE) and travel to school patterns such as walking or cycling are important for health. Exercise habits established in childhood are a key indicator of levels of physical activity in adulthood and therefore the education system can support the development of such habits.

Figure 3 Health impacts of education[9]



Health impacts of the built environment

Acknowledging the historic links between public health and planning, this review considers how modern illnesses are affected by the built environment.

Buildings

The way in which buildings are designed and used has many impacts on health. Adequate space, light, temperature and noise control are all essential for good health. This has been demonstrated across a wide range of building types including schools, hospitals and homes. Cold, damp homes can lead to respiratory and cardiovascular health problems, especially for vulnerable groups such as the elderly, chronically ill and very young. Children living in buildings with limited space for play are more likely to suffer behavioural problems and multi-occupational dwellings are associated with mental health issues. Well designed and maintained buildings can reduce the likelihood of injuries, for example falls amongst the elderly.

Public spaces and networks

Public spaces and networks influence physical, mental and social health in a number of ways. Access to good quality, well-maintained public spaces, efficient, modern public transport systems and walkable neighbourhoods can encourage physical activity, increase the likelihood of social interaction and contribute to better air quality.

Figure 4 Health impact of the built environment[10]

Health impacts of employment

Unemployment and low income

Unemployment affects both physical and mental health and is an important determinant of health inequalities in adults of working age. Unemployed people have a higher risk of morbidity and premature mortality. They also have a higher risk of lower levels of psychological wellbeing ranging from symptoms of depression and anxiety to self harm and suicide. Unemployment affects family income levels that impact on other health determinants, for example, housing and nutrition.

Job insecurity

Job insecurity is associated with negative attitudes to work and negative impacts on health. For example, mild depression and self-reported health status tends to deteriorate among those anticipating a job loss. Insecure jobs also tend to involve high exposure to work hazards of various kinds. Less skilled, manual workers tend to be most exposed to low paid, temporary or insecure jobs. Downsizing, which can lead to increased job insecurity, has been shown to be associated with long periods of sick leave due to musculo-skeletal disorders and trauma.

Type of work

Jobs involving a high psychological demand but with low control over working conditions are associated with health-related harm. High demand, low control work is more common among lower socioeconomic groups and non-permanent workers and is associated with increased risk of heart disease, musculo-skeletal disorders, mental illness and sickness absence. Social support in the workplace has been shown to mitigate this job strain.

Health impacts of transport

Air pollution

Motor vehicles are responsible for nitrogen dioxide, carbon dioxide and Particulate Matter (PM) emissions. Air pollution episodes are associated with rises in death and hospital admissions. Ambient levels of air pollution are associated with raised morbidity and mortality. Air pollution also contributes to climate change.

Road traffic injuries

Effects of road traffic injuries include mortality and injury for bicycle users, pedestrians, motorists and passengers. Perceived danger from traffic restricts

children's independent mobility and reduces the amount children exercise, with long term implications for children's physical and mental wellbeing.

Physical activity
Physical activity reduces the risk of heart disease, stroke, diabetes, hypertension, depression, cancer and osteoporosis. A transport policy that encourages exercise through cycling or walking will maximise health.

Community severance
This is caused by major roads being built through a community, with residents cut off from safe access to shops, schools and other parts of their social network. Social contact is beneficial to health but studies in the USA show that social contact tends to fall as traffic increases.

Noise
Traffic noise contributes to stress-related health problems such as hypertension and minor psychiatric illness. It can also cause loss of sleep and may interfere with concentration.

Access/Mobility
Access to education, work, shops, health care and social networks are important determinants of health. A transport policy needs to ensure that access is enabled for all sectors of the community, not just car users.

Inequalities
The effects of a transport policy do not fall evenly on all sectors of society. Pedestrians and cyclists are more prone to injuries than drivers. People with higher incomes can live away from a main road and will not suffer as much from air pollution, noise or community severance. Those with easier access to leisure facilities are more likely to exercise more.

Appendix 2: Screening tool

Available online at http://www.publichealth.ie/hia

Section one: Background and context

Title of proposal being screened	
Date screening conducted	
Person(s) involved in the screening process (name, organisation represented and job title if applicable)	
What stage of development is the proposal at?	
Briefly outline the importance of the proposal from: *An economic/ business perspective* *A political perspective* *A community perspective*	
What resources are available to conduct a HIA? (Consider both human and financial)	
Are decision makers likely to be open to recommendations to amend the proposal?	

Section two: Potential impacts on health determinants

Instructions for completing the table

The first column contains a list of issues that are known to influence health (health determinants). These are grouped into social and economic conditions, structural issues and individual and family issues.

STEP 1: Assess the likelihood of the proposal impacting on this health determinant and record as:

- **Likely** (it is likely that the proposal will impact on this health determinant). **Code as L**
- **Unlikely** (it is unlikely that the proposal will impact on this health determinant). **Code as U**
- **Not known** (there is insufficient information in the proposal to assess whether or not it will impact on this health determinant). **Code as NK**

*If the health impact is considered **likely**, continue to step 2. If the health impact is considered **unlikely** or is **not known**, proceed to step 3 or move on to the next health determinant.*

STEP 2: List the groups most likely to be affected by the proposal. Examples of different population groups are given below (this is not intended to be a complete list).

- Infants and toddlers
- Children and young people
- Working age people
- Older people
- Rural population
- Urban population
- Males/ females
- Single/ married people
- Gay/ lesbian people
- People with dependants
- Racial and ethnic groups (particularly minority groups)
- People with particular religious beliefs
- People with particular political opinions
- People with disabilities
- Chronically ill people
- Homeless people
- Unemployed people
- Economically disadvantaged people
- Others

Social and economic conditions that influence health		
Likelihood that the proposal will impact on this health determinant (L/ U/ NK)		***Groups most likely to be affected by the proposal***
Education		
Employment		
Childcare		
Crime and fear of crime		
Community interaction		
Access to fresh food		
Access to sports and other opportunities for physical activity		
Access to cultural and other recreational activities		
Access to healthcare services		
Access to social welfare services		
Access to other community services		
Access to public transport		
Other social or economic conditions (list)		

Structural issues that influence health		
Likelihood that the proposal will impact on this health determinant (L/ U/ NK)		***Groups most likely to be affected by the proposal***
Housing		
Public buildings		
Commercial buildings		
Green space (including parks)		
Other public spaces		
Road safety *Transport infrastructure*		
Communications infrastructure (internet/telephone)		
Energy sources		
Waste management infrastructure		
Water quality		
Air quality (indoor and outdoor)		
Soil quality		
Noise		
Light		
Other structural issues (list)		

Individual and family issues that influence health		
Likelihood that the proposal will impact on this health determinant (L/ U/ NK)		***Groups most likely to be affected by the proposal***
Diet		
Physical activity		
Substance use (legal and illegal)		
Sexual activity		
Household income		
Family cohesion		
Other individual and family issues (list)		

Section three: Screening outcome

Tick the appropriate outcome

Overall, health impacts are unlikely or relatively minor and easy to address.	Where appropriate, make recommendations to decision makers on how such impacts may be addressed. Do not proceed with HIA.	
Overall, health impacts are likely or unknown.	Taking into account issues raised in section one, proceed with HIA.	

Appendix 3: Scoping tool[1]

Available online at http://www.publichealth.ie/hia

Title of the proposal on which the HIA is being conducted	
Aim of the HIA	
Values underpinning the HIA	
Objectives of the HIA (Consider core values)	
Boundaries of the HIA (e.g. geographical, population)	
Time scale for the HIA	
Non-negotiable aspects of the proposal	
Steering group membership • Suggest maximum of 12 members • include decision makers of the policy, programme or project on the group	
Main stakeholders: • Who is likely to be affected? • Are key stakeholders represented on the steering group?	
Key informants for the HIA: • Who can provide useful information on how the proposal is likely to impact on health?	
Who will be responsible for gathering evidence in the following areas? • Literature review • Community profile • Stakeholder workshops • Proposal and policy analysis	

[1] Adapted from a tool developed by E. Ison

Who will be responsible for appraising the evidence and forming recommendations?	
How will the results of the HIA be presented and disseminated?	
What measures will be put in place to facilitate evaluation of the HIA?	
How will the HIA budget be spent? Consider: • Human resources • Venue hire, catering and travel costs for meetings and workshops • Costs associated with dissemination of the results • Evaluation costs	
Operating arrangements for the steering group including: • Chair • Date and location of meetings • Secretariat	

Appendix 4: Policy analysis tool

Available online at http://www.publichealth.ie/hia

This tool provides a framework to record information obtained relating to the policy environment. In the following table record:

- Policy – overview of the policy being analysed, including title and lifespan
- Organisation – who is responsible for implementation
- Aspects relevant to HIA – identify key areas of the policy relevant to the HIA.

Policy	Organisation(s)	Aspects relevant to HIA

Appendix 5: Tools for collating information and prioritising impacts

Available online at http://www.publichealth.ie/hia

Collating information

This tool can be used as a structure to collate the information gathered as part of the HIA process. The tool enables the steering group to systematically record the evidence supporting or negating potential health impacts identified in the proposal.

In the following table:
Record the potential health impact identified in the proposal in column 1.
Place evidence from various sources in columns 2-5.

Potential health impact identified in proposal	Community profile	Policy analysis	Evidence from literature	Evidence from stakeholders

Prioritising health impacts tool

This tool suggests one approach to prioritising potential health impacts identified. A prioritisation column may be inserted into the collating information tool to record decisions.

The criteria for prioritisation potential health impacts identified. A prioritisation column may be inserted into the collating information tool to record decisions. The criteria for prioritisation will depend on the specific circumstances of the HIA and some of the following could be used to assist this process:

- the severity of the impact if it does occur (severe, moderate or minimal)
- the number of people likely to be affected (many, some or few)
- the timescale in which the impact may occur (short, medium or long term)
- whether the impact will affect some groups within the population more than others (inequalities)
- issues highlighted as areas of concern by stakeholders (stakeholder concerns).
- the likelihood of the impact occurring (likely, speculative or unlikely)

Codes may be assigned to assist the steering group e.g. use L, S or U to document likelihood of the impact occurring.

Potential health impact identified in proposal	Community profile	Policy analysis	Evidence from literature	Evidence from stakeholders	Prioritisation

Appendix 6: Tools for forming and disseminating recommendations

Available online at http://www.publichealth.ie/hia

The following tools provide templates to record the recommendations and how they will be implemented by the decision maker.
Step 1 Forming recommendations
Step 2 Disseminating HIA recommendations

Step 1 Forming recommendations

Record the recommendations agreed by the steering group to maximise health gain or minimise health loss.

Prioritised Health Impact	Recommendation to maximise health gain

In Appendix 8 there are examples of recommendations from completed health impact assessments.

Step 2 Disseminating HIA recommendations

This tool can be used to approach each decision maker who is responsible for implementing the identified recommendations. This will provide an overview of how they intend to implement the recommendations relevant to their organisation.

The organisation conducting (or responsible for) the HIA should insert the relevant recommendation(s) into column 1 and the suggested timescale for implementation into column 2 prior to sending this to the identified organisation/decision maker who then completes column 3.

This report provides details of recommendations arising from the HIA conducted on

_____

Please review each recommendation and its suggested timescale for implementation. In right-hand column, please indicate your organisation's intentions regarding implementation, which may include:

- Likelihood of the recommendation being implemented
- Appropriateness of the suggested timescale for implementation
- Any other comments.

Recommendation	Suggested timescale for implementation	Organisational response re intention to implement

Please return the completed form to_____ by _____

Appendix 7: Reviewing the implementation of HIA recommendations

Available online at http://www.publichealth.ie/hia

This tool may be used as part of the evaluation stage of the HIA and be presented to decision makers responsible for implementing identified recommendations.

The organisation conducting (or responsible for) the HIA should insert the relevant recommendation(s) into column 1 prior to sending this to the identified organisation/decision maker.

This report assesses the progress made towards implementing recommendations arising from the HIA conducted on _____

Please review the recommendations listed.
For each recommendation, please select the outcome which best describes its current status from the options listed below:

- insert √ if the recommendation has been fully implemented
- insert ? if the recommendation has been partially implemented or implemented with modifications
- insert O if the recommendation has provided the stimulus for additional actions (including unintended ones) for example an agency other than the one specified took some action
- insert X if there is no evidence to suggest that the recommendation has been taken on board.

Please note any available supporting evidence in the right hand column.

Recommendation	Outcome	Supporting evidence

Please return the completed form to_____ by _____

Appendix 8: Examples of recommendations from HIAs conducted in the Republic of Ireland and Northern Ireland

Listed below are examples of recommendations from HIAs completed in the Republic of Ireland and Northern Ireland. They demonstrate how HIAs can support healthy public policy to maximise health gains and minimise health loss from a proposal. Copies of all HIAs listed and others conducted across Ireland may be sourced at http://www.publichealth.ie/hia

A HIA of Traffic and Transport in Ballyfermot, Eastern Region Health Authority, 2005

- A key recommendation is that a local action group be convened in Ballyfermot to identify how the issues identified in the HIA may be addressed locally.
- It is recommended that Dublin City Council (DCC) endeavour to target resources to promote active transport, i.e. walking and cycling in Ballyfermot, within the agreed priorities of the South Central Area Committee and in line with DCC policy.
- It is recommended that the Health Promotion Department continue to seek resources to develop local health promotion teams and services and work with the General Manager of the Community Health Services in relation to this.
- It is recommended that a member of staff with a broad understanding of public health be assigned from the local Community Care Area Dublin West to the local implementation group to promote health and physical activity in Ballyfermot. The General Manager of Dublin West, who is a member of the URBAN II Board, is supportive of this.

Health Impact Assessment - Dove Gardens, Co-operation and Working Together (CAWT), 2005

- Traffic calming, signage and pedestrian areas should be designed into the new scheme (including 'welcome' sign).
- Achieve 'secure by design' certification for individual homes and the estate layout.
- Hold regular social meetings to update residents on developments and maintain social contacts and networks.
- Incorporate principles of a safe play environment within the whole area to allow children to play on the streets.

Health Impact assessment of the Draft Air Quality Action Plan for Belfast, Belfast City Council, 2006

- To increase safety, and decrease crime and fear of crime, it is suggested that Belfast City Council and Translink consider building cycle shelters the design of which takes into account access, security and location and reduces the likelihood of vandalism, e.g. roofless.
- To encourage the uptake of public transport, it is suggested that Translink considers improving coordination among bus services and between bus and train services to facilitate interchange within and between modes of transport.
- To maintain the reductions in air pollution that may be achieved through strategic highway network capacity improvements, it is suggested that DRD Roads Service and Translink consider the simultaneous introduction of bus lanes/corridors to improve service quality and reliability and thereby encourage the uptake of public transport.

West Tyrone Area Plan (WTAP) 2019, Health Impact Assessment, Stage 1 – Interim report, Western Investing for Health, 2008

- Significant consideration needs to be given to facilitate rural economic development to provide employment opportunities and a source of income for those in the local area.
- WTAP should encourage the provision of walking and cycling routes in the countryside.
- The WTAP should ensure that accommodation needs of the Travelling community are given adequate consideration.
- Renewable energy targets should be set by the WTAP to ensure adequate zoning is allocated to assist Northern Ireland to achieve the target of 12% of all electricity consumed coming from indigenous, renewable energy sources as identified by the Strategic Energy Framework.

Health Impact Assessment of Doneraile Traveller accommodation proposal, Traveller Health Unit HSE South & HIA Ireland, 2008

- Provide internet access in homes to encourage education and home study for both children and adults.
- Develop a joint neighbourhood watch scheme between Travellers and the settled community supported by the Gardaí.
- Provide an opportunity for Traveller community to rename their neighbourhood (suggest name from Traveller language which relates to the local area).
- Put in place a traffic management plan which deals with anticipated increased traffic and makes provision for Traveller families pulling in and out of transient site.

Limerick Regeneration HIA: Phase 1: Physical regeneration, HSE West, 2008

- Develop a Communication Strategy that considers a wide variety of methods of communication with the aim of encouraging maximum participation from all residents. Hard to reach groups which may need particular attention are young people, older adults, travellers, those with a disability and those with low literacy.
- Give consideration to the development of a network of safe cycling and walking routes throughout the estates.
- Green areas should be surrounded by small attractive walls/hedging or other border that prevents access to the green by motorised vehicles with the aim of reducing joy riding on the green and burning out of cars.
- Involve older adults at all stages of the planning, including the planning and design of their home.

Limerick Regeneration HIA: Phase 2: Early school leaving, absenteeism and truancy, HSE West 2008

- Build upon and enhance the capacity of current Department of Education and Science and community initiatives to promote more positive parent-school - parent-teacher relationships.
- Give consideration to a first year transition or induction period, to facilitate the smooth transition from primary to post-primary school, particularly for vulnerable / marginal young people.
- Schools and local statutory and voluntary agencies should support the work of the local Drugs Task Force in the Limerick area.
- Limerick City should develop a communication strategy and an action plan that challenges national and local media practice to work in a balanced and responsible fashion – one that is mindful of people who have to live in 'disadvantaged'/'troubled' estates.

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Research and analysis

Chapter 5: inequality in health

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1. Main messages

Health inequalities are differences in health between people or groups of people that may be considered unfair. There is a social gradient in lifespan; people living in the most deprived areas in England have on average the lowest life expectancy and conversely, life expectancy is higher on average for those living in areas with lower deprivation. Males living in the most deprived tenth of areas can expect to live 9 fewer years compared with the least deprived tenth, and females can expect to live 7 fewer years.

Males and females living in the most deprived areas can also expect to spend nearly 20 fewer years in good health compared with those in the least deprived areas: they spend nearly a third of their lives in poor health, compared with only about a sixth for those in the least deprived areas. For males living in the 5 most deprived tenth of areas, and females living in the 4 most deprived, average healthy life expectancy falls below the age of 65 years (current state pension age for men).

Although deprived areas can be found in all regions of England, there is a higher concentration of more deprived authorities in the north. In addition, life expectancy in local authorities within the same deprivation group is generally lower among authorities in the north than those in the south.

As a consequence, there is a persistent 'north-south' divide in life expectancy and healthy life expectancy. Those in southern regions can on average expect to live longer and with fewer years in poor health than those further north.

Almost half of the gap in life expectancy between the most and least deprived areas in England is due to excess deaths from heart disease, stroke, and cancer in the most deprived areas. These are also the causes that make up a large proportion of the burden of premature death in England overall.

As well as lower life expectancy, there is a higher prevalence of many behavioural risk factors among the more deprived areas compared with the less deprived areas. These health inequalities are underpinned by inequalities in the broad social and economic circumstances which influence health.

2. Introduction

As described in previous chapters, there are differences in health outcomes for men and women, for different age groups and for different countries. As described in this chapter, there are also differences in outcomes relating to socioeconomic status, ethnicity, geographical region and other social factors. These health inequalities, differences in health between people or groups of people that may be considered unfair, reflect historic and present-day social inequalities in our population. Reducing inequalities should allow everyone to have the same opportunities to lead a healthy life.

This chapter provides an overview of inequality in health in England, concentrating primarily on deprivation. Inequalities by other socioeconomic characteristics are explored in more depth in the report Public Health Outcomes Framework: health equity report, focus on ethnicity which presents analysis and commentary on inequalities for 18 indicators from the Public Health Outcomes Framework (PHOF).

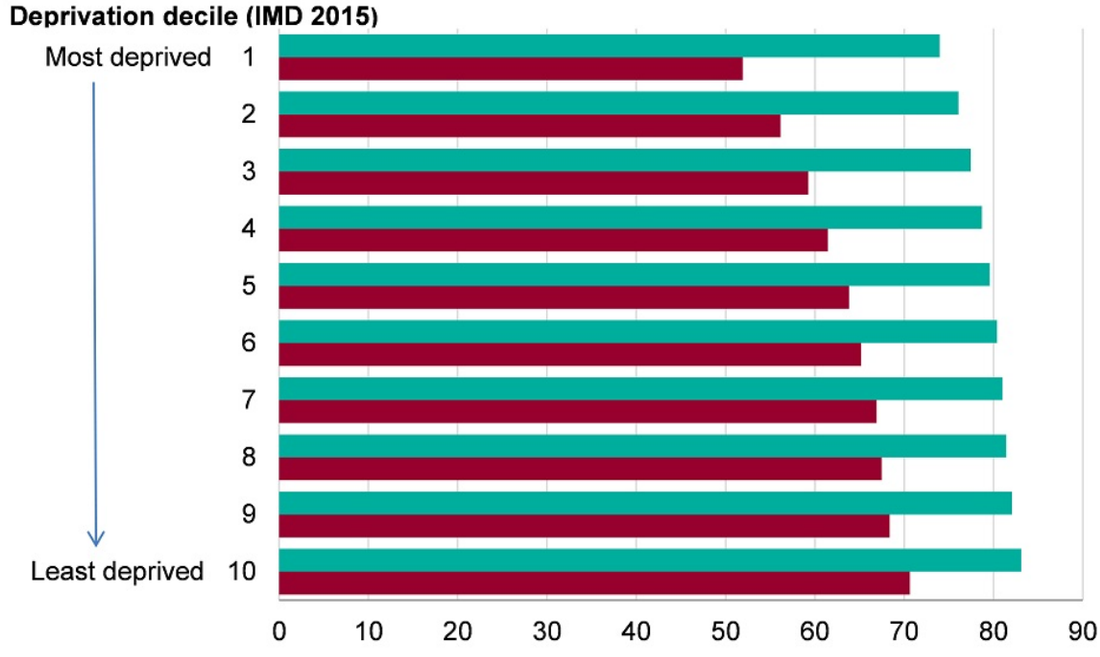
3. Patterns in health inequality

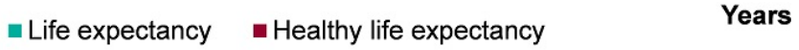
Life expectancy at birth in England has generally increased in recent decades and provisional data for 2016 show that it has reached 79.5 for males and 83.1 for females (chapter 1). However, life expectancy is not uniform across England and inequalities exist. On average, individuals living in more deprived areas live the fewest years, while those in the least deprived areas have the longest lives (figure 1, 2).

If England's population is ranked from most to least deprived and then divided into 10 groups (deprivation decile groups), life expectancy increases in each decile group as the level of deprivation decreases (figure 1, 2). In other words, there is a 'social gradient' in health [1]. Between the most and least deprived tenths of England, the absolute difference in life expectancy is 9 years for males and 7 years for females (figure 1, 2).

3.1 Figure 1: male life expectancy and healthy life expectancy at birth by deprivation decile, England, 2013 to 2015

For males, both life expectancy and healthy life expectancy were highest in the least deprived areas and lowest in the most deprived areas





Source: Public Health Outcomes Framework

Note: Index of Multiple Deprivation (IMD) 2015 deprivation deciles at lower super output area (LSOA).

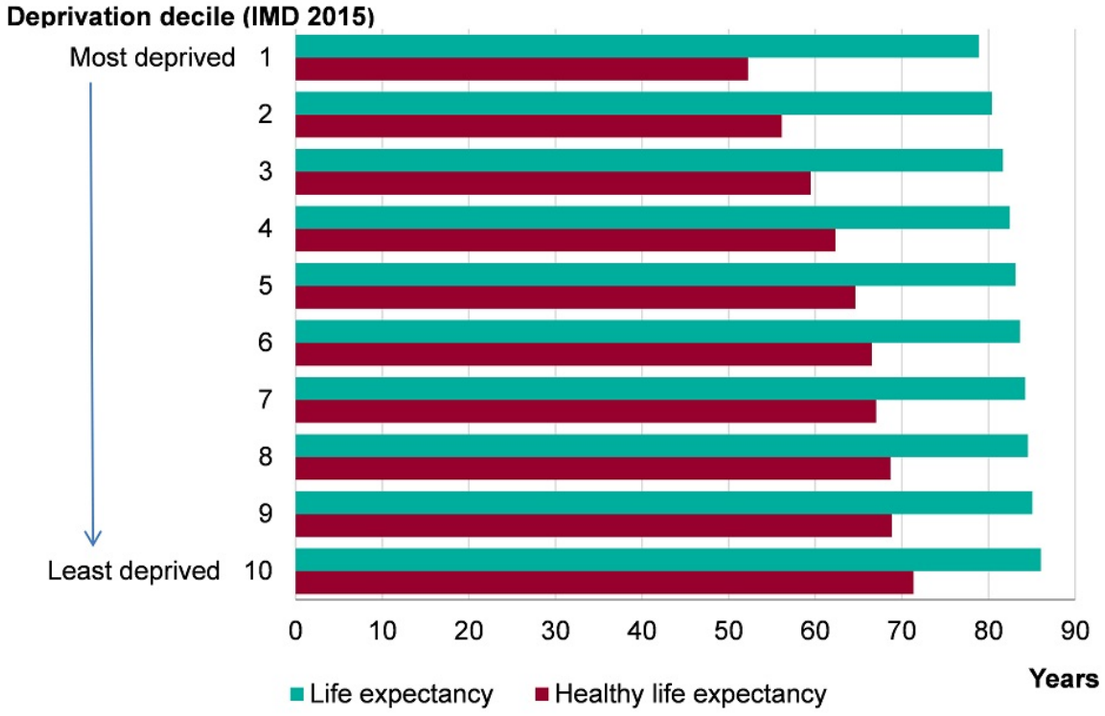
This shows:

- the least deprived areas had the highest male life expectancy (83.1 years) while the most deprived areas had the lowest life expectancy (74.0 years)
- healthy life expectancy (years in good health) was highest in the least deprived areas (70.6 years) and lowest in the most deprived areas (51.9 years)
- while there was a sizeable difference in outcome between the most and least deprived, there was also a gradient whereby there were incremental decreases in life expectancy and healthy life expectancy between each decile group as deprivation increased. The level of inequality or 'gap' is 9 years for life expectancy and 19 years for healthy life expectancy[2]
- from the most deprived tenth of areas (decile group 1), up to and including decile group 5, the average healthy life expectancy was lower than the current male state pension age of 65 years

See how your area compares

3.2 Figure 2: female life expectancy and healthy life expectancy at birth by deprivation decile, England, 2013 to 2015

For females, both life expectancy and healthy life expectancy were highest in the least deprived areas and lowest in the most deprived areas



Source: Public Health Outcomes Framework

Note: Index of Multiple Deprivation (IMD) 2015 deprivation deciles at lower super output area (LSOA).

This shows:

- the least deprived areas had the highest female life expectancy (86.1 years) while the most deprived areas had the lowest life expectancy (78.9) years
- healthy life expectancy was highest in the least deprived areas (71.3 years) and lowest in the most deprived areas (52.2 years)
- while there was a sizeable difference in outcome between the most and least deprived, there was also a gradient whereby there were incremental decreases in life expectancy and healthy life expectancy between each decile group as deprivation increased. The level of inequality or 'gap' is 7 years for life expectancy and 20 years for healthy life expectancy [2]
- from the most deprived tenth of areas (decile group 1), up to and including decile group 4, healthy life expectancy was lower than 65 years

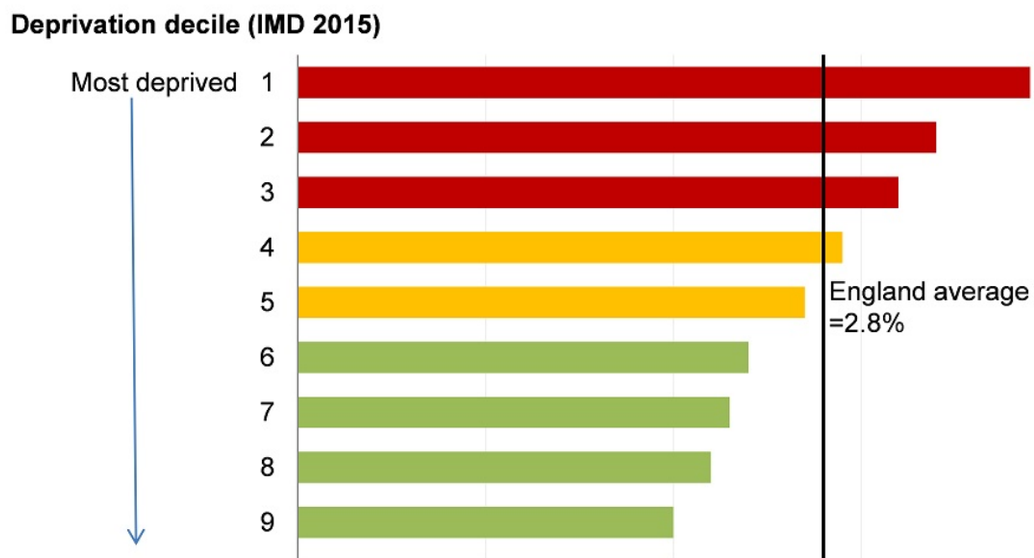
See how your area compares

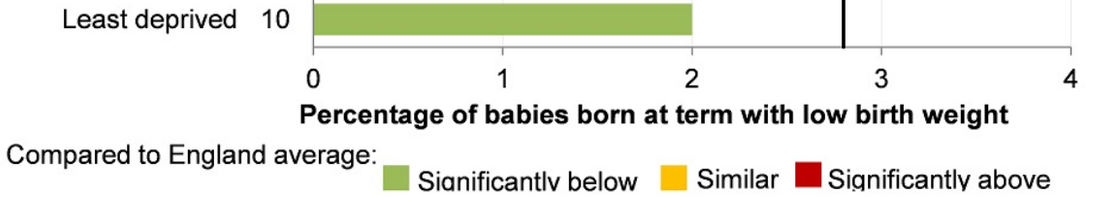
This difference in outcomes between the most deprived and least deprived begins early in life. Of all live births at full term, a higher percentage are born at a low birth weight in the 3 most deprived decile groups than on average in England (figure 3). Furthermore, the infant mortality rate is highest in the most deprived areas and lowest in the least deprived areas (figure 4).

If the most deprived decile group had the same infant mortality rate as the least deprived, there would have been 780 fewer infant deaths in 2013 to 2015. And if all decile groups had the same infant mortality rate as the least deprived, there would have been 2,051 fewer infant deaths in England as a whole.

3.3 Figure 3: the proportion of live births at term with low birth weight (<2500g) by deprivation decile, England, 2012 to 2014

A higher percentage of babies are born at term with a low birth weight in the 3 most deprived decile groups





Source: Public Health Outcomes Framework: Health Equity Report. Focus on Ethnicity (2017)

Note: Index of Multiple Deprivation (IMD) 2015 deprivation deciles at lower super output area (LSOA).

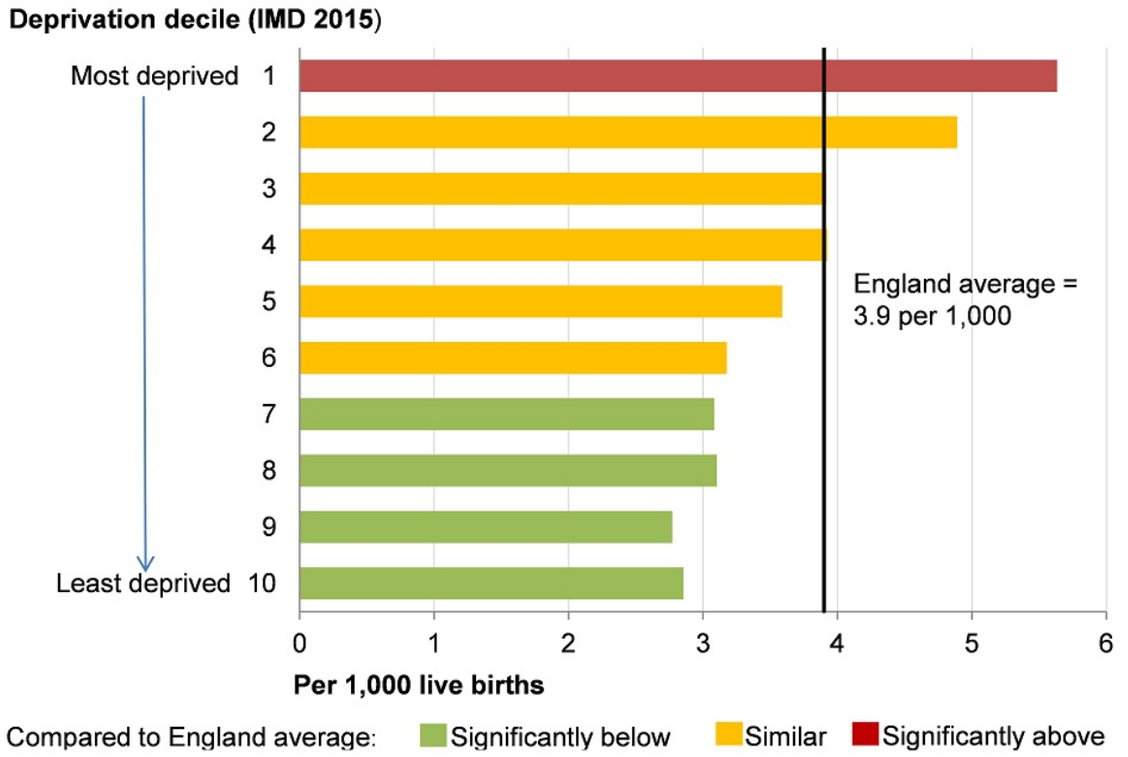
This shows:

- in the 3 most deprived decile groups, significantly more babies born at term had a low birthweight than the England average (2.8%)

See how your area compares

3.4 Figure 4: infant mortality rate by deprivation decile, England, 2013 to 2015

The infant mortality rate is highest in the most deprived decile group and lowest in the least deprived



Source: Public Health Outcomes Framework

Note: Index of Multiple Deprivation (IMD) 2015 deprivation deciles at lower super output area (LSOA).

This shows:

- in the most deprived decile group there was a significantly higher infant mortality rate than the England average
- in the 4 least deprived decile groups there was a significantly lower infant mortality rate than the England average

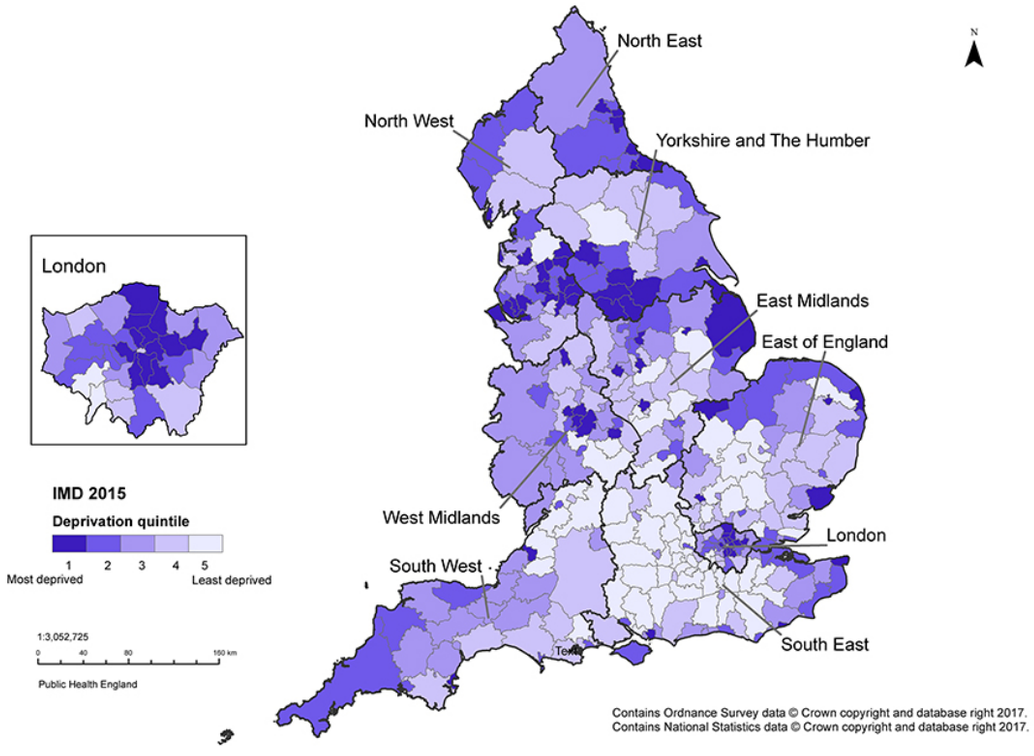
See how your area compares

Figure 5 shows the geographical distribution of England's local authorities according to their level of deprivation. More of the authorities in the most deprived group are in the north of England than in the south, but there are deprived authorities in all regions (figure 5).

In addition to this, as shown in the PHOF, life expectancy in local authorities within the same deprivation group is generally lower among authorities in the north than those in the south. As a consequence, there is a persistent north-south divide in life expectancy. Those in southern regions can expect to live longer than those further north (figure 6, 7).

3.5 Figure 5: lower tier local authorities (districts and unitary authorities) by Index of Multiple Deprivation (IMD) 2015

Districts and unitary authorities in the most deprived quintile in England are concentrated in the North, Midlands and London



Source: Department for Communities and Local Government, 2015

This shows:

- by mapping the level of deprivation for local authorities using IMD 2015, it can be seen that levels of deprivation vary around the country and pockets of deprivation are found in all regions
- the local authorities that fall within the most deprived quintile are concentrated in the north of England, the Midlands and London
- the local authority districts in the least deprived quintile are concentrated in the south of England

See how your area compares

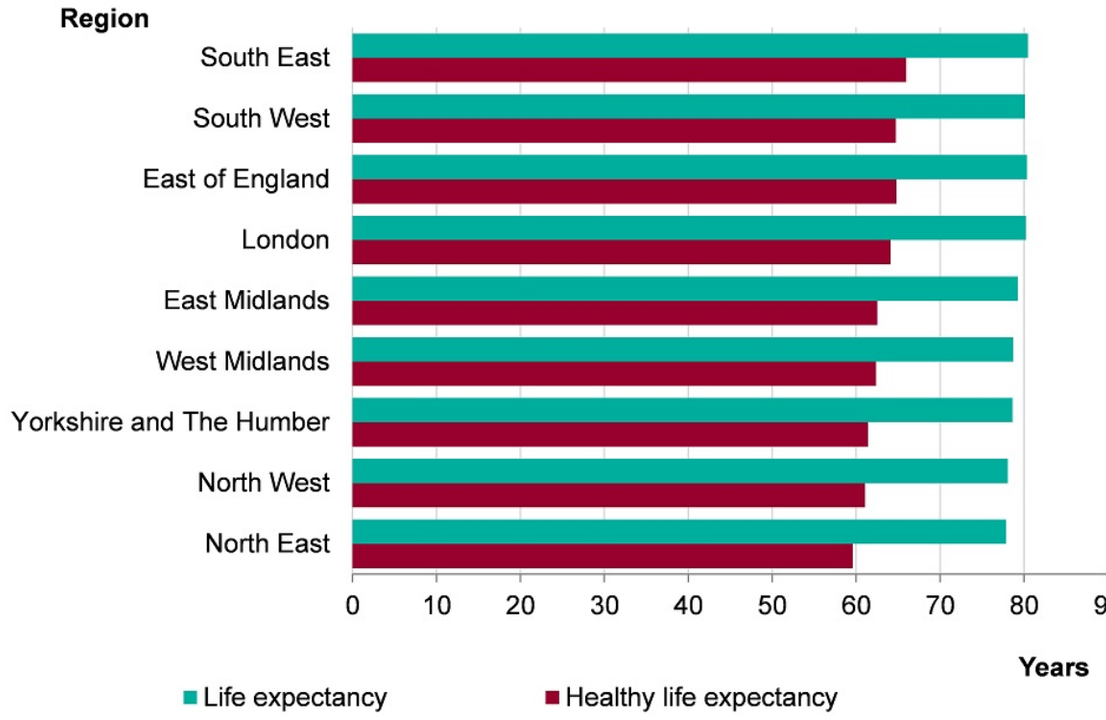
Healthy life expectancy also varies between areas, reflecting both the level of deprivation and geographical location. The most deprived areas have the lowest healthy life expectancy while the least deprived areas have the highest (figure 1, 2).

For both males and females in the most deprived areas, there is almost a 20-year difference in healthy life expectancy compared with those living in the least deprived areas. Healthy life expectancy across England is also characterised by the same north-south divide that exists for life expectancy: it is highest in the southern regions and lowest in the north (figure 6, 7).

In addition, for males living in the lowest 5 deprivation decile groups, and females living in the lowest 4 groups (more deprived), their healthy life expectancy falls below the age of 65 years, the current state pension age for men (figure 1, 2). In the most deprived decile group, healthy life expectancy falls short of the current state pension age for men by more than 10 years for both males and females (figure 1, 2).

3.6 Figure 6: male life expectancy and healthy life expectancy at birth by region, England, 2013 to 2015

For males, there is a north-south divide in life expectancy and healthy life expectancy where the highest life expectancy is found in the southern regions and the lowest in the north



Source: Public Health Outcomes Framework

This shows:

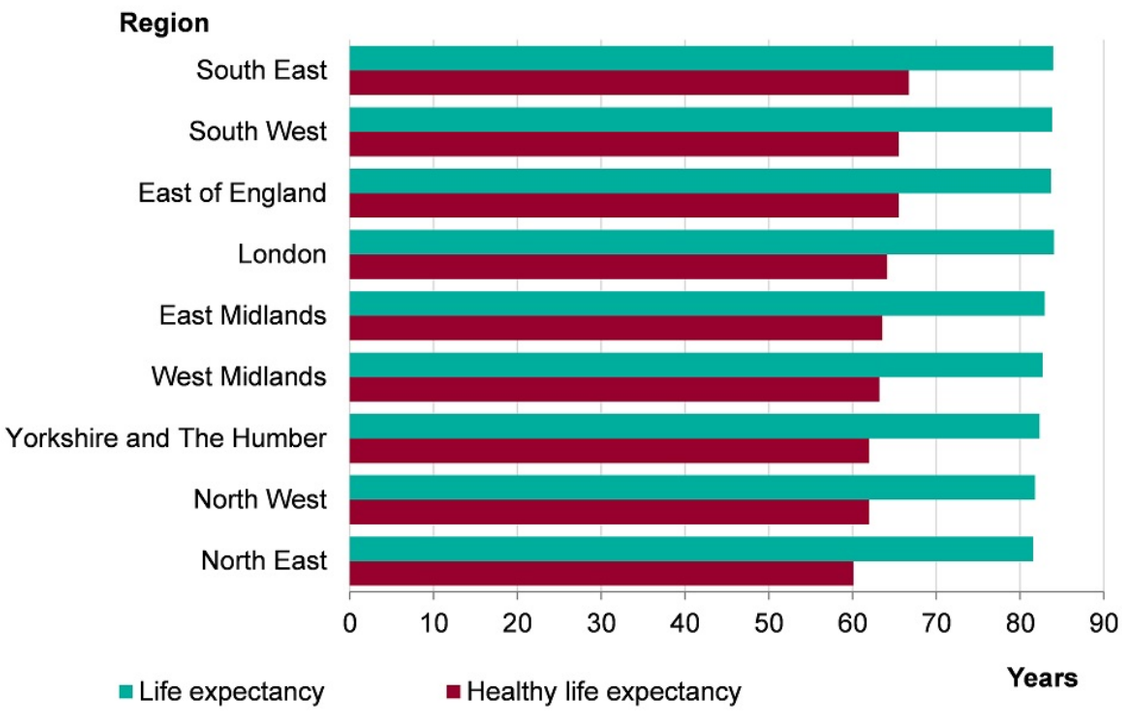
- male life expectancy was highest in the southern regions of England and lowest in the northern regions

- the South East had the highest life expectancy (80.5 years) while the North East had the lowest life expectancy (77.9 years)
- there was a similar north-south divide in male healthy life expectancy with the lowest healthy life expectancies being in the north of England and the highest in the south
- the highest healthy life expectancy was in the South East (66.0 years) and the lowest was in the North East (59.6 years)

See how your area compares

3.7 Figure 7: female life expectancy and healthy life expectancy at birth by region, England, 2013 to 2015

For females, there is a north-south divide in life expectancy and healthy life expectancy; the highest life expectancy is in the southern regions and the lowest in the north



Source: Public Health Outcomes Framework

This shows:

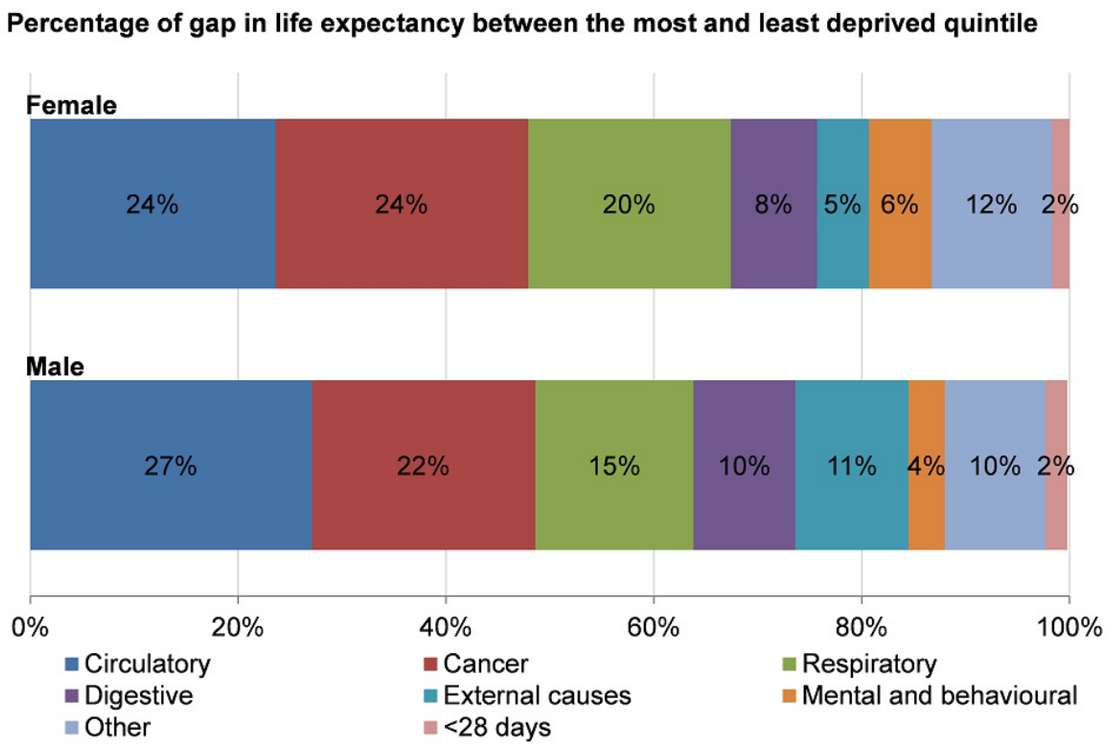
- female life expectancy was highest in the southern regions of England and lowest in the northern regions
- London had the highest life expectancy (84.1 years) while the North East had the lowest life expectancy (81.6 years)
- there was a similar north-south divide in female healthy life expectancy with the lowest healthy life expectancies being in the north of England and the highest in the south
- the highest healthy life expectancy was in the South East (66.7 years) and the lowest was in the North East (60.1 years)

See how your area compares

The gap in life expectancy between the most and least deprived areas in England can be broken down by the broad causes of death that contribute to the years of difference (figure 8). Almost half of the gap in life expectancy between the most and least deprived areas in England is due to excess deaths from circulatory disease (heart disease and stroke) and cancer in the most deprived areas. This means that if people in the most deprived fifth of areas in England had the same mortality rate for these causes as the least deprived fifth, the gap in life expectancy between the most and least deprived fifths would reduce by almost a half.

3.8 Figure 8: the breakdown of the life expectancy gap between the most deprived and least deprived quintiles, by broad cause of death for males and females, England, 2012 to 2014

Deaths caused by heart disease, stroke and cancers made up half of the gap in life expectancy between the most and least deprived quintiles in England



Source: PHE Segment tool: England PDF

Note: Due to rounding, numbers may not add to 100%. England was divided into quintiles based on Lower Super Output Area (LSOA) level IMD 2015 scores.

This shows:

- in both males and females, circulatory (heart disease and stroke), cancer and respiratory causes of death are the top 3 contributors to the difference in life expectancy between the most and least deprived quintiles
- circulatory disease deaths account for 24% of the difference in life expectancy in females and 27% in males between the most and least deprived quintiles
- cancer deaths contribute to 24% of this gap in females and 22% in males
- respiratory causes of death contribute 20% to the gap in females and 15% to the gap in males

- digestive, external, mental and behavioural, deaths in those under 28 days, and deaths due to other causes also contribute to the gap in life expectancy

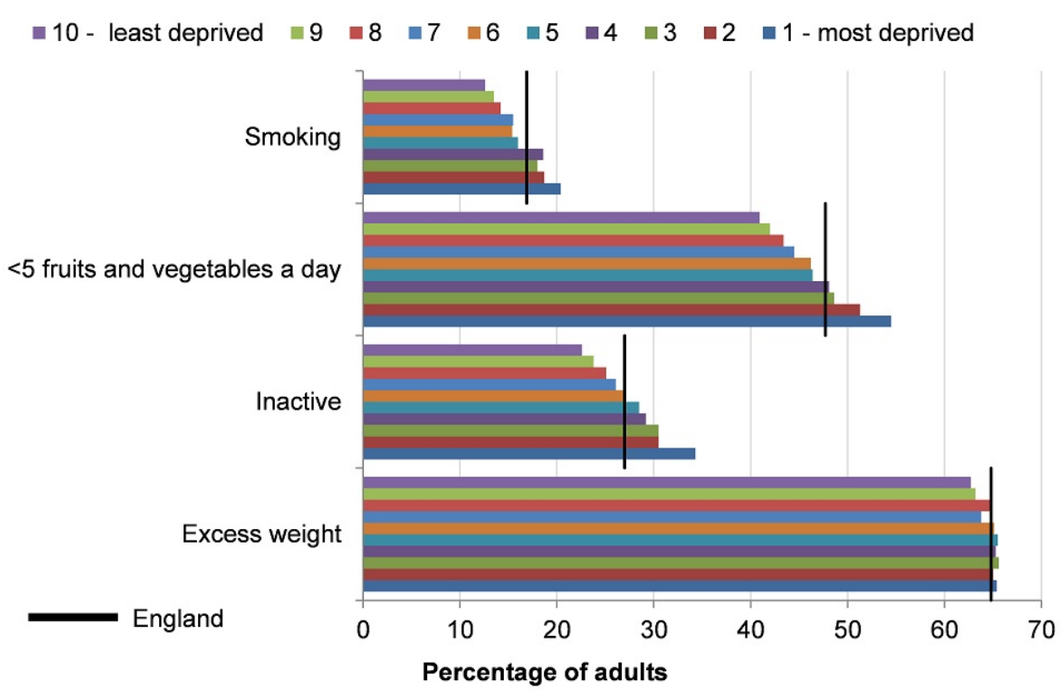
See how your area compares

As well as lower life expectancy, there is a higher prevalence of many behavioural risk factors in the more deprived areas compared with the less deprived areas. For example, in more deprived areas, the prevalence of inactivity and the prevalence of smoking are both highest, while the proportion of people eating the recommended 5-a-day of fruits and vegetables is lowest (figure 9). These are among the key behavioural risk factors for cardiovascular, cancer and respiratory disease deaths (chapter 2).

Those in the most deprived areas are also more likely to suffer the harms associated with alcohol consumption, one of the risk factors associated with the highest proportion of deaths in the 15 to 49 age group [3], (chapter 2).

3.9 Figure 9: the prevalence of selected risk factors in adults by deprivation decile, England

The prevalence of risk factors varies across upper tier local authorities grouped into deprivation deciles, whereby the least deprived areas had the lowest prevalence of risk factors



Source: Public Health Outcomes Framework

Note:

- excess weight in adults (aged 16 or over), 2013 to 2015
- physically inactive adults (aged 16 or over), 2015
- eating fewer than 5 portions of fruits and vegetables a day (aged 16 and over), 2015
- smoking prevalence in adults (aged 18 or over), 2015

The indicator presented as ‘eating fewer than 5 portions of fruit and vegetables a day’ is an inversion of the indicator ‘proportion of the adult population meeting the recommended ‘5-a-day’ available on the PHOF.

Only statistically significant differences are described as ‘higher’, ‘lower’, ‘more’, ‘less’ or ‘fewer’. If not statistically significant they are described as ‘similar’.

Index of Multiple Deprivation (IMD) 2015 deprivation deciles at upper tier local

Mental health: deprivation

Major risk factors for mental health problems include poverty, poor education, unemployment, social isolation/exclusion and major life events. A review of large-scale studies of mental health problems reported that such problems are more common among people who are unemployed, have fewer educational qualifications, have been looked after or accommodated, are on a low income or have a low standard of living (Mental Health and Social Exclusion 2004 (1.11MB)).

The Scottish Burden of Disease Study report on deprivation shows the stark inequalities in mental health outcomes across Scotland.

Further evidence of the link between deprivation and psychiatric morbidity can be seen in Practice Team Information (PTI) for Scotland. Table 1 presents estimates of the number and rate of people in each Scottish Index of Multiple Deprivation (SIMD) quintile (fifth of the population) consulting their GP or practice nurse for anxiety or depression in 2012/13. It shows that:

- For anxiety, the estimated rate of patients who consulted a GP or practice nurse ranged from 39 per 1000 males and 76 per 1000 females in the most deprived quintile, down to 20 per 1000 males and 37 per 1000 females in the least deprived quintile.
- For depression, the rates were all a little lower but the pattern was broadly similar.

Table 1. PTI data on anxiety and depression(1,2), by gender and Scottish Index of Multiple Deprivation (SIMD) quintile(3): Scotland, 2012/13

		Anxiety			Depression		
			95% confidence intervals			95% confidence intervals	
Sex	Quintile	Rates per 1000 population(1)	Lower	Upper	Rates per 1000 population(1)	Lower	Upper
Males	1- most deprived	38.8	34.6	43.0	24.3	20.1	28.5
	2	28.9	25.0	32.8	20.1	17.4	22.8
	3	24.8	21.5	28.1	21.6	18.6	24.6
	4	22.0	19.1	25.0	17.2	14.9	19.4
	5 - least deprived	19.6	16.9	22.3	14.3	12.8	15.7
	All categories	26.4	22.9	30.0	20.1	17.4	22.7
Females	1 - most deprived	76.2	67.5	84.9	44.4	37.6	51.2
	2	58.0	50.6	65.4	41.3	35.5	47.2
	3	48.2	42.4	54.0	38.7	33.5	43.9
	4	45.4	38.8	52.0	33.7	30.1	37.3
	5 - least deprived	36.7	32.2	41.1	30.9	27.8	33.9
	All categories	52.8	45.6	59.9	37.7	33.0	42.4
Persons	ALL	39.7	34.5	44.9	29.0	25.5	32.5

Source: ISD Practice Team Information.
(1) The rates for quintiles are standardised for age, the rates for 'All categories' are standardised for age and SIMD quintile, and the rates for Persons are standardised for age, gender and SIMD quintile. (2) Based on 60 PTI practices that submitted complete GP and practice nurse data for the year ending 31 March 2013. A patient may have a diagnosis of both anxiety and depression. (3) The SIMD 2012 release was used.

Note that the PTI measure does not reflect prevalence of particular mental health problems: PTI data captures active as opposed to lifelong or previous conditions.

As of September 2013, PTI data were no longer collected. 2012/13 is the last year for which ISD can publish annual PTI data. A new national GP information system known as the Scottish Primary Care Information Resource (SPIRE) is in development which will supersede and build on the data collected for PTI.

Please note: If you require the most up-to-date data available, please check the data sources directly as new data may have been published since these data pages were last updated. Although we endeavour to ensure that the data pages are kept up-to-date, there may be a time lag between new data being published and the relevant ScotPHO web pages being updated.

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