The annual report of the Director of Public Health for Medway 2005

Minding the Gap

Published 2006




Medway Council
Serving You

Medway NHS
Teaching Primary Care Trust

Contents

Preface

Cllr Rodney Chambers, Leader Medway Council

Last year the first annual report of our Director of Public Health for Medway, described the health needs of our population, and our aspirations for improvement. This year Dr. Sims' is able to report some real progress in making those improvements, by empowering local people to make sensible choices about their lifestyle and helping them to improve their chances of healthy life expectancy by, for example, quitting smoking in greater numbers.

We are beginning to see the advantages of some excellent joint working between staff in the council and the NHS. I am pleased with the progress we are making and am determined that it should continue.

Eddie Anderson, Chairman, Medway Primary Care Trust

Last year our public health annual report outlined the challenges which faced us in achieving our key objective of improving the health of the community in Medway. The report set out an agenda which provided the foundation for the intensive programme of action that has unfolded and which is described in this report.

The success of this programme depended on the rapid development of an integrated joint public health team and I am delighted to say that this report provides evidence of this and of significant progress in terms of achieving our programme objectives. However, we need to go further as there are clearly still big challenges facing us and again the report makes this clear, not least in terms of the extent of some local health inequalities. It is crucial that this focus and investment in public health, which has provided demonstrable evidence of health improvement remains high on the agenda of the NHS, the council and with the community itself.

Foreword

Judith Armitt, Chief Executive, Medway Council

I am delighted to see this follow-up report on health in Medway. The work the NHS and Medway Council are doing locally will, I am confident, narrow the gap between the poorer health of some people locally and the national picture. The progress being made in quitting smoking, promoting exercise and improving diet is already showing gains.

Important developments this year that will bring further progress include:

- Healthier school meal menus coming in from September 2006
- The earlier start in Medway to a ban on public smoking
- The new integrated children's teams that are just starting work. These will put making sure every child in Medway is healthy and safe, as well as able to enjoy life and achieve, at the heart of our thinking. By 2008 health and council services will be provided together and genuinely joined up
- The appointment of Bob Dimond as Medway's Olympics co-ordinator. Bob's job will be about encouraging everyone in Medway, whatever their age, to improve their own personal health (Getting Fit for 2012) as well as promoting Medway as a potential economic and cultural beneficiary of the games.

There is a great deal to do but these are exciting times. The fruit of 'Minding the Gap' will be improved health for all in Medway.

Judith Armitt

Chief Executive, Medway Council

Foreword

Bill Gillespie, Chief Executive, Medway Primary Care Trust

"Stubborn, persistent and resistant to change." No, not the ubiquitous T-shirt stain of soap commercials but health inequalities as described in this, the second report from Medway's Director of Public Health. The former, if we are to believe the commercials, can be eradicated instantly with a magic formula; the latter, if we are honest, takes years of complex partnership working to make real in-roads.

This annual report highlights the major health inequalities in Medway and between Medway and the rest of the country. It is a sobering read for, by both measures, there is some catching up to do. Yet alongside those areas where there is a real need for concerted action to bring Medway into line with the rest of the country - in cervical cancer, in diabetes in women, in circulatory diseases, in heart disease in women - there is also acknowledgement of progress. Teenage pregnancy rates continue to decline, smoking cessation rates are up, there is multi-agency agreement that tackling obesity should be central to the forthcoming local area agreement between partners in Medway and central government and pump-priming funding is already going into implementing Medway's obesity strategy.

These have not been easy wins. They require a commitment to partnerships between public sector agencies, the voluntary sector, businesses and the community each with their own crowded agenda; and a steadfastness in pursuing actions with a long-term impact on the health of Medway in the face of a daily diet of media stories about today's health services. It is those strengths of partnership working in Medway, which should provide grounds for confidence that the major health challenges described in this report will continue to be tackled steadily and successfully.

Bill Gillespie

Chief Executive, Medway Primary Care Trust

Introduction

Dr. Anita Sims, Director of Public Health, Medway Council and Primary Care Trust

I am pleased to present my second annual report as Director of Public Health for Medway, 'Minding the Gap'. This year's report, as well as updating information from last year, focuses particularly on health inequalities in Medway and the planned and current action taking place to reduce these health inequalities.

The report is an independent assessment of the health of the people of Medway and is intended to help set and support an agenda for action for all groups and agencies whose decisions affect the health of the people of Medway. In the public sector, external inspectors such as the Audit Commission, and the Commission for Social Care Inspection, expect the NHS and local authorities to be able to demonstrate how they have taken the annual report of the Director of Public Health into account as they set their priorities. Indeed in Medway the 2004 annual report has been an important document used in both the older people's review and the joint area reviews which took place in Medway over the past year.

Medway's growth in the future will be associated with rapid changes in demography. All agencies will need to continue to build strong links with old and new communities to ensure services and lifestyle opportunities meet the needs of all those they serve.

It seems increasingly likely that a flu pandemic may emerge over the coming months or years. This poses not just a direct threat to health, but also the risk of many essential services being put under strain; potentially a quarter of the workforce may be absent at any one time. To anticipate this locally, extensive planning and testing of a local pandemic plan, working with many different agencies in Medway is taking place to ensure that essential services may continue to be delivered to people in Medway should a pandemic occur.

There are relatively high rates of death from respiratory disease in Medway, including lung cancer. Smoking is still the single largest avoidable cause of illness and death in Medway. It is responsible for around half of the difference in life expectancy that can be seen between different social groups and this emphasises the importance that all employers should attach to ensuring their employees are not exposed to tobacco pollution at work.

The decision by Medway Council, following the publication of the annual report public health report last year, to adopt local smoke free policies for Medway ahead of the national legislation coming into force is a significant contribution to the impact of reduction in smoking and ultimately health improvement in Medway.

There remain marked inequalities in experiences of life between most deprived and other parts of Medway, hence 'Minding the Gap'. Tackling this injustice must remain a long-term priority. This report explores some the issues relating to this and not only describes the issues and statistics but outlines some of the encouraging progress that is being made and the innovative work that is happening to ensure that we are 'Minding the Gap' in Medway. Much of the increasing rate of progress we see is due in no small part to the close joint working taking place in Medway between the council and the NHS and the community.

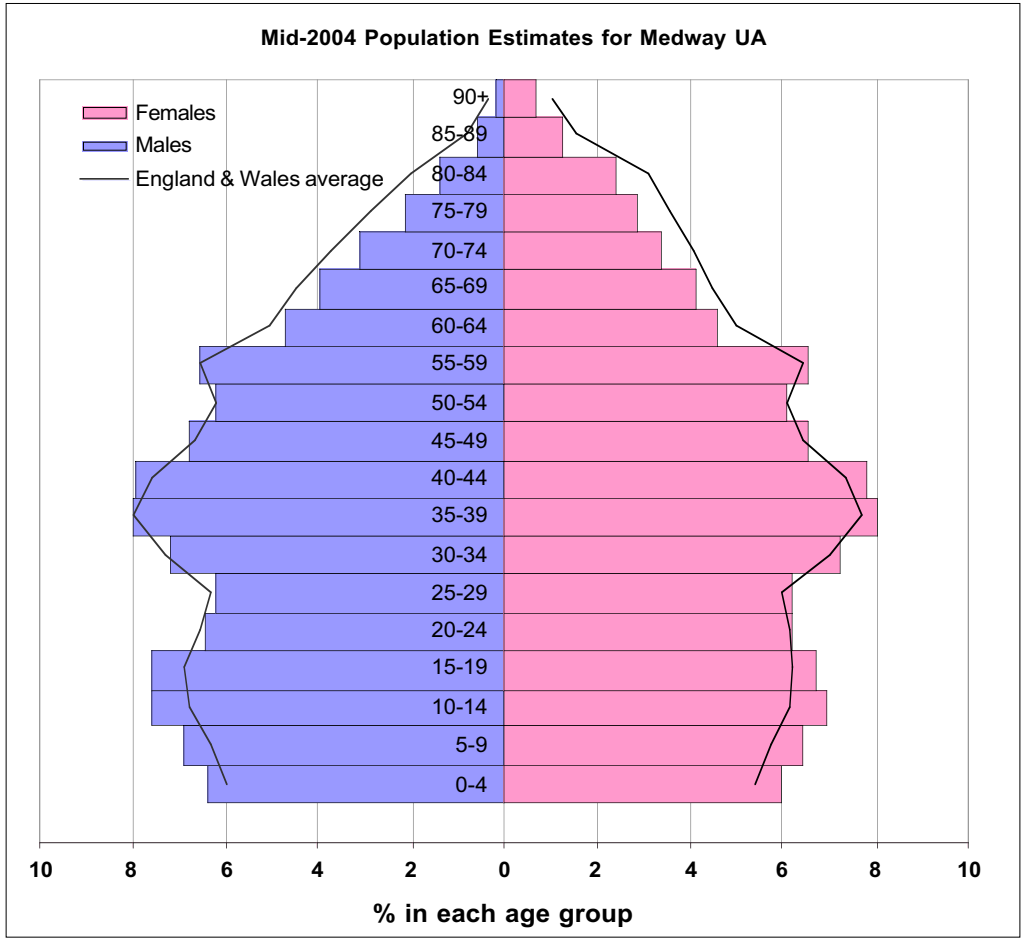
I would particularly like to thank Steve Wisher and Kate Marshall from IbyD for their work on this report.

An electronic version of this report can be found at the following websites:
www.medway.gov.uk,
www.medwaypct.nhs.uk

Dr. Anita Sims
Director of Public Health
Medway PCT and Medway Council

1. Health inequalities in Medway

The population of Medway is growing rapidly. It has a young population where there are significantly larger proportions of children and young adults than the average for England. This situation will continue for some years.



Mortality (death) rates

There are about 2,000 deaths per year in Medway each year, 38 per cent are among those aged under 75 and are considered to be premature deaths. The main causes of death in Medway are no different to those in the country as a whole: They are heart disease, stroke, cancer and respiratory disease. While these death rates are falling, the latest statistics indicate that Medway has higher rates than average for the following:

- Coronary heart disease for women, an SMR[1] of 112 - 12 per cent higher than the national average and statistically significant.
- Cervical cancer deaths, an SMR of 165 - 65 per cent higher than the national average and statistically significant.
- All circulatory diseases for men and women, an SMR of 108 - eight per cent higher than the national average and statistically significant.
- Diabetes for women, an SMR of 168 - 68 per cent higher than the national average and statistically significant.

Life expectancy

In Medway, the average life expectancy for men is 75.1 years, and for women 79.8 years. This is slightly lower than the national figure, and substantially lower than in the south-east overall, where life expectancy is 77.2 years for men and 81.5 years for women. Further details of the causes of these differences are explored within this report.

Life Expectancy (Years)

	Medway	South-East	England
Men	75.1	77.2	75.9
Women	79.8	81.5	80.6
Overall	77.5	79.4	78.3

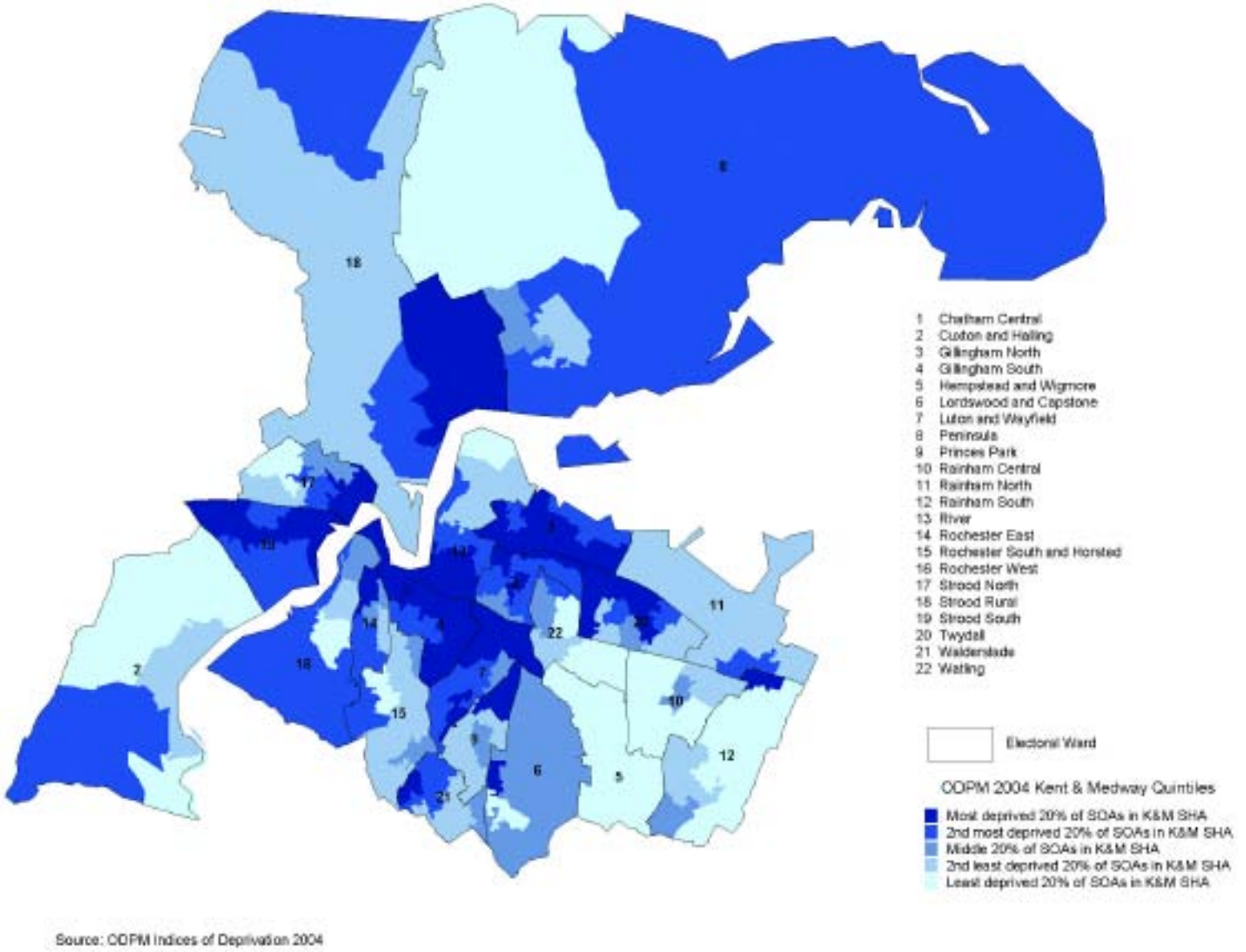
Source: National Statistics, June 2006

[1] *The explanation of SMR is given in the glossary*

The Index of Multiple Deprivation

The most common measure of socio-economic deprivation in England is the Index of Multiple Deprivation (IMD). In Medway there are large differences in deprivation across the wards of the area - Gillingham North had the highest level of deprivation, Hempstead and Wigmore the lowest.

Index of Multiple Deprivation 2004 ranks for Medway UA LL-SOAs

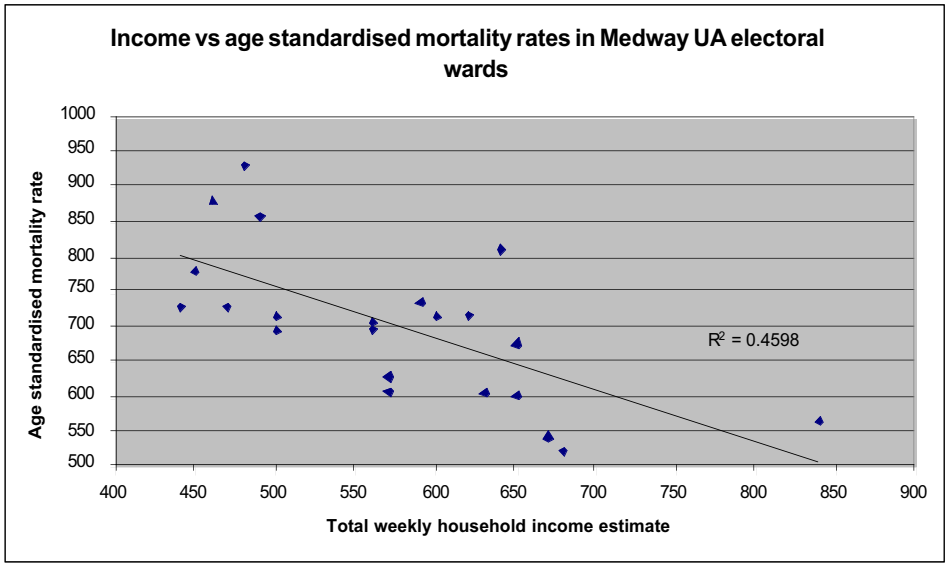


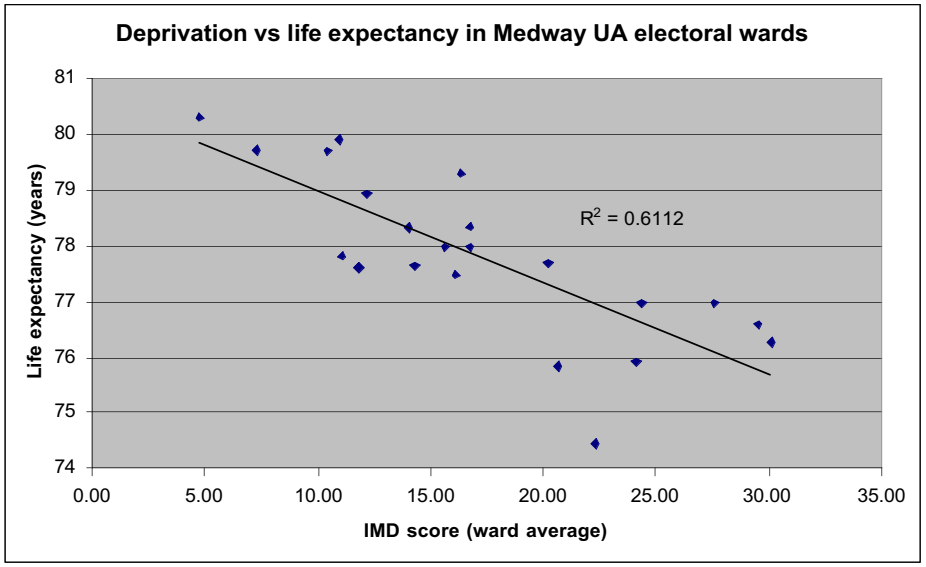
Source: COPM Indices of Deprivation 2004

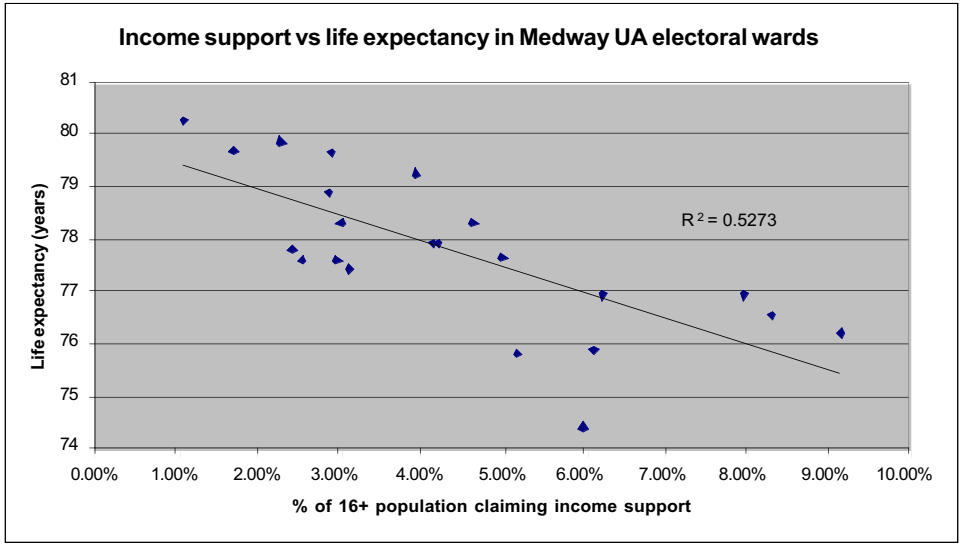
The figures below highlight the strong correlation between deprivation (IMD) and life expectancy. Overall, life expectancy ranges from just over 80 years in the most affluent ward, to around only 76 years in the most deprived.

There are similar links between income and standardised mortality rates and between the proportion claiming income support and life expectancy. These are shown in the following figures.

Sources: Income ONS Model-based estimates of income for wards 2001/02; Mortality - ONS annual district death extract 2000-2004







Avoidable deaths

In July 2003, the Government identified a programme of action[2] - noting once again the strong association between socio-economic deprivation and poor health. A number of areas are now key to improving the health of people in Medway and to reducing health inequalities.

Smoking is still the single largest avoidable cause of illness and death in Medway. It is responsible for around half of the difference in life expectancy that can be seen between different groups. Those working in public health in Medway have placed considerable effort behind reducing the prevalence of smoking. Medway Council has set an example by going smoke-free in advance of the impact of legislation next year.

Infant mortality is higher in Medway than the average for England and Wales. The infant mortality rates per 1,000, using 2002-2004 data were

- 7.3 in Medway
- 4.2 in the south-east and
- 5.2 in England and Wales.

The results emphasise the need to continue to both reduce the number of women who smoke during pregnancy and to increase breastfeeding rates.

Obesity has trebled in the UK over the past 25 years. This has a large impact on public health particularly for specific groups and geographical areas in Medway. Obesity can increase the risk of heart disease, cancer and other diseases.

Sexually transmitted diseases continue to increase, in line with the national picture, and there is rising demand for prevention and treatment.

A programme of action

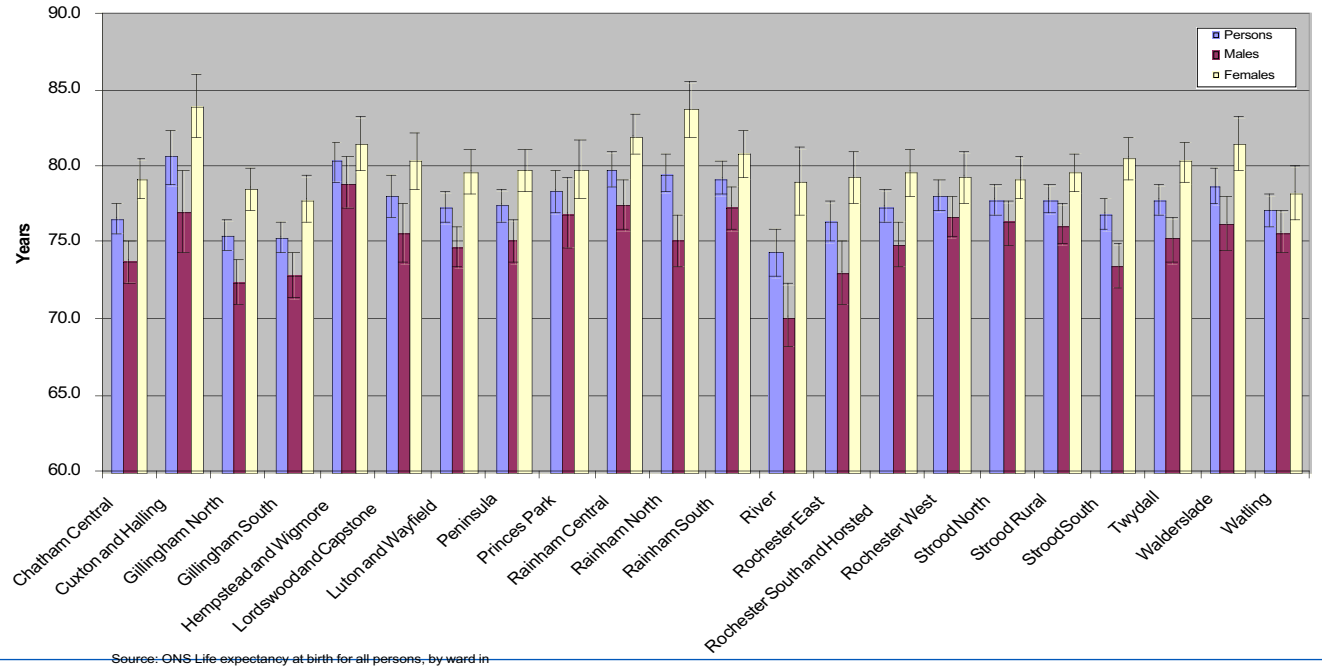
For each of the above aspects, data highlights inequalities between socio-economic groups in Medway. These inequalities and action needed to reduce such inequalities are discussed later in this report.

Income - life and death

Data suggests that people from deprived areas, where health needs are greater, may not be gaining access to services as readily as people from more affluent areas. In Medway, it has been estimated that the area is five per cent short of its' fair share of national resources - this would represent about £16 million of additional funding.

The following chart shows life expectancy for each of the wards of Medway (for all people, male and female). River ward has the lowest life expectancy at less than 75 years, with male life expectancy in the ward at only just over 70 years.

Life expectancy at birth for Medway UA electoral wards, 1999-2003



Source: ONS Life expectancy at birth for all persons, by ward in England and Wales, 1999 to 2003 (experimental statistics)

Source: ONS Life expectancy at birth for all persons, by ward in England and Wales, 1999 to 2003 (experimental statistics)

[2] *Tackling Health Inequalities: A Programme for Action. Department for health (2003) London.*

2. The National Health inequalities targets

In July 2003, the Government identified a programme of action[3] required to address the challenges set by the underlying causes of health inequalities and to meeting the national Public Service Agreement (PSA) target on reducing inequalities in health outcomes. The National Health inequalities targets were set, which focussed on infant mortality and life expectancy. The targets were:

THE NATIONAL HEALTH INEQUALITIES TARGETS

Infant mortality

"Starting with children under one year, by 2010, to reduce the gap in mortality by at least 10 per cent between routine and manual groups as a whole."

Life expectancy

"Starting with local authorities, by 2010, to reduce by at least 10 per cent the gap between the areas with the worst health and deprivation indicators and the population as a whole."

The targets were based on strong evidence of the association between health and deprivation. The priority the Government has given to tackling health inequalities is rooted in the fact that health and life expectancy are linked to social circumstances in adulthood and childhood and, despite overall improvement, the health gap between the top and bottom ends of the social scale remains large. For many people, these inequalities mean poorer health, reduced quality of life and avoidable early death.

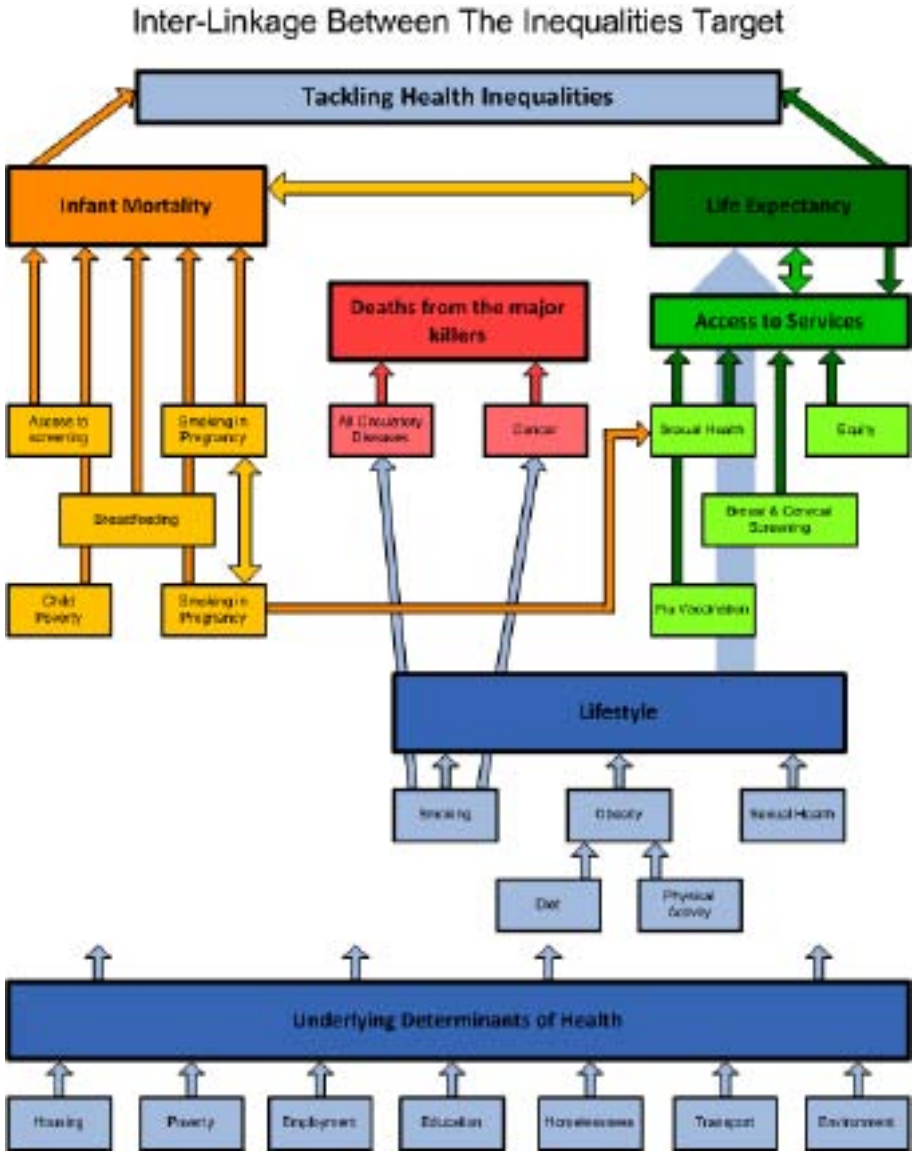
[3] *Tackling Health Inequalities: A programme for Action. Departmenyt for Health. London (2003)*

Linking the targets

There are strong inter-linkages between both of the targets and interventions from the NHS, the council and voluntary and community services groups. Individual and community lifestyle choices, both chosen and imposed, also impact on the two targets. This is illustrated in the diagram opposite.

To support progress towards the two targets, a set of national indicators were developed. They relate to the areas listed below and reflect the key interventions required to address health inequalities and feature in the diagram.

- Death rates from the big killers - cancer and heart disease
- Teenage conception rates
- Road accident casualty rates in disadvantaged communities
- Numbers of primary care professionals
- Uptake of flu vaccinations
- Smoking among manual groups and among pregnant women
- Educational attainment
- Consumption of fruit and vegetables
- Proportion in non-decent housing
- PE and school sport
- Children in poverty
- Homeless families living in temporary accommodation.

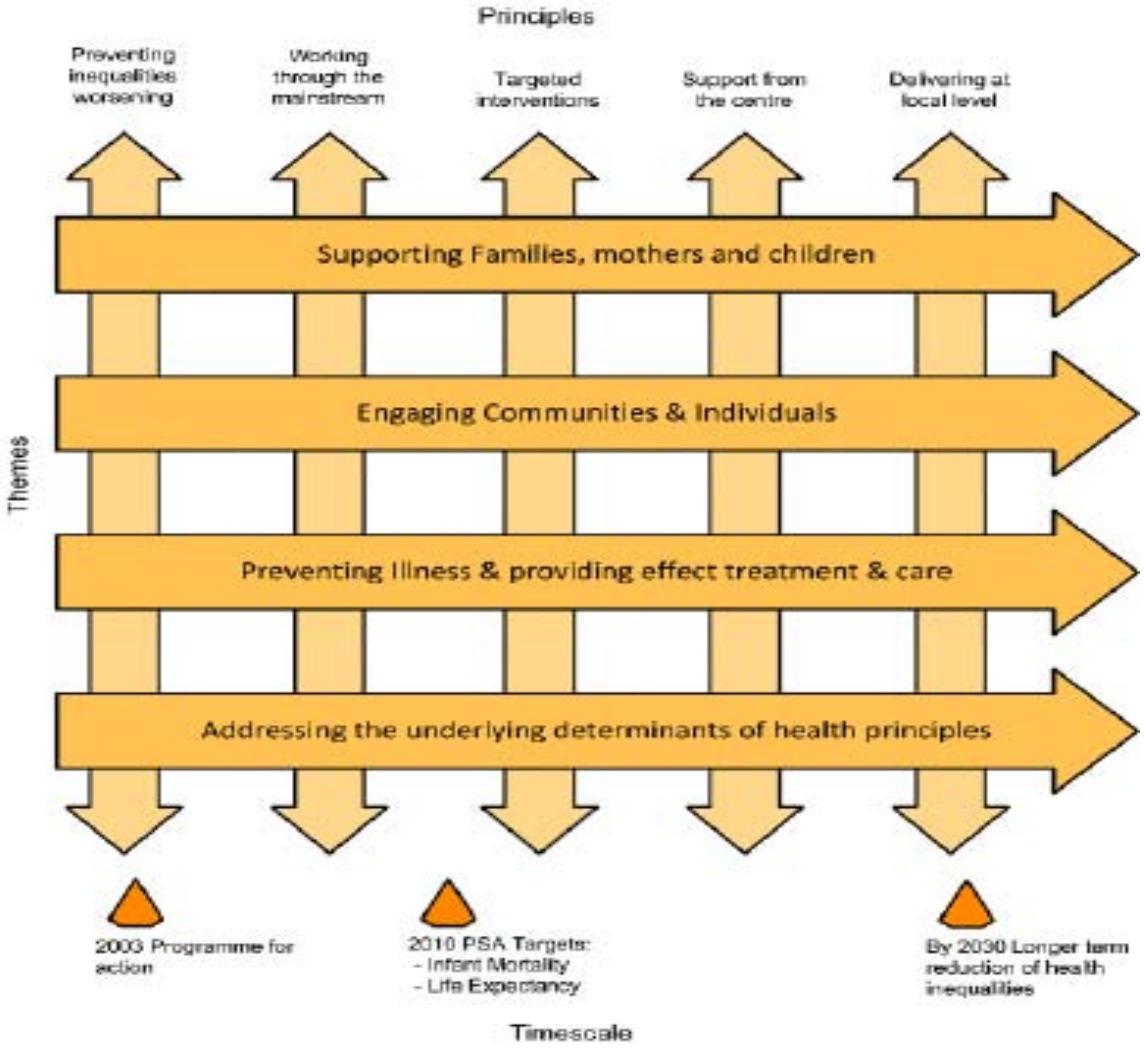


3. Narrowing the gap

There is a huge challenge to narrow the health gap. Health inequalities are stubborn, persistent and difficult to change. Targets and strategy will not by themselves start reversing accumulated trends of generations. Many programmes and interventions are already in place and will have an impact, especially where existing projects, which are known to work locally, are sustained and extended. While many of these developments are still at too early a stage to show an impact; the current position provides a baseline against which future progress will be shown.

The key themes and principles to deliver long-term sustainable change are summarised in the diagram opposite.

The following sections of this report build upon the various links between the two national targets on infant mortality and life expectancy and the interventions required to address health inequalities. They highlight the major issues affecting infant mortality and life expectancy and the wide-ranging interventions and work which will be our key priorities locally for the coming year.



Source:Tackling health inequalities: Status report on the programme for action, Department of Health 2005

4. Progress since last year

The Choosing Health White Paper was published in November 2004 and set out a comprehensive national strategy for local implementation with partners to support health improvement and tackle health inequalities. Delivery plans that provide supporting information were published in March 2005 and explain how identified key priorities will be taken forward and implemented.
The forthcoming local area agreement and the PSA2 targets will provide an opportunity to strengthen the focus on public health and the delivery of interventions and infrastructure that will support health improvement with the local authority.

The Medway public health team, in partnership with a range of NHS professionals, the council and the voluntary and private sector has made good progress in delivering Choosing Health priorities over the past year. Together with a focus on tackling inequalities in the specific health priorities various activities have been carried out in different areas. On the following pages we have listed some of the highlights of the progress made in our major work areas.

Visit of Caroline Flint MP, Minister for Public Health, to Step4ward, the young person led support group for teenage parents

WORK AREA	ACHIEVEMENTS
Health equity audits and health needs assessment	These have taken place in the following areas and are aimed at informing service delivery and commissioning: ● Coronary heart disease ● Mental health ● Diabetes in women ● Child health ● Alcohol
Health impact assessment	A health impact assessment (HIA) of the Sunlight Centre has been jointly carried out by the centre, the council and the PCT. This uses a combination of methods to judge the effects an intervention may have on the health of a population - both positive and negative. It is used subsequently to improve the quality of public policy decisions, by making recommendations that are likely to enhance positive predicted health impacts and minimise negative ones. The HIA report will be produced in Autumn 2006 and will provide important intelligence relating to the possible health improvement impacts of other developments in Medway such as LIFT and regeneration in Medway.
Health trainers	The public health team received pump priming funding from the Department of Health to roll out a pilot health trainer project. Working in partnership with Medway Council, the Voluntary Services Unit and the King's Family Practice, the All Saints area of Chatham has been designated as the main focus area. The aim of the pilot project is to recruit and train volunteer health trainers to provide help and support to anyone who lives in this area and wants to make positive changes to their lifestyle. The programme is being mainstreamed into other areas such as obesity.
Healthy schools	Medway has a very successful programme that is on track to achieve 100 per cent of the target number of schools to achieve healthy schools status by December 2006. There are strong links into the integrated public health team, particularly in the areas of teenage pregnancy work and tackling childhood obesity. The following initiatives have contributed to improved outcomes for Medway children: ● Production of water bottles (65,000) and lunch bags ● Production of resources such as leaflets on 'What makes a healthy lunch?' ● Training for school governors on the importance of personal health and social education ● Funding of initiatives such as 'Skip2beFit' for schools involvedin the programme ● Creation of a school nutrition co-ordinator role to act as independent advisor on school food ● Creation of Tier One drugs educator post. ● Pilot looking at improving emotional literacy ● Work with safer routes to school and walking buses

WORK AREA	ACHIEVEMENTS
Partnership with Connexions	The public health team has a successful partnership with the Connexions service, hosting four personal advisor posts for young people, promoting sexual health and mental health as well as support for teenage parents. The personal advisors work on an outreach basis, often with young people who are 'hard to reach'. The work is often upstream, engaging with young people who are socially excluded, aiming to get them to the stage where they might begin accessing services and considering employment, education or training. Successes include: ● Thriving multi-agency young parents group co-ordinated by Connexions personal advisor ● Regular drop-in sessions at young people's supported housing schemes to discuss sex and relationship issues ● Development and helping with anti-bullying workshops in secondary schools
Reducing the number of people who smoke	The Smoking Cessation Service provides group and one-to-one support for quitters in community, primary care, pharmacy, prisons and workplaces. The annual Quit Awards event in May 2006 celebrated the achievements of quitters and service providers and raised the service profile locally. Following on from the CHD Health Equity Audit, work has been carried out to map concentrations of smokers in high deprivation areas of Medway from data on lifestyle patterns and demographics. This revealed significant cluster patterns (e.g. in Strood and Gillingham). A trial of social marketing recruitment techniques took place. Initial results show phenomenal success in recruitment - 11 per cent compared with one per cent take-up when mailing out via GPs. Potential benefits are improved recruitment , effective targeting of smokers from key target groups/areas and enhanced success rates.
Tackling obesity	The Obesity Strategy was developed and consulted on in summer 2005, It influenced the development of the Choosing Health Implementation Plan and subsequent development of the Medway Council PSA2 target. It is being led by the Joint Council/PCT public health team to prevent and reduce childhood obesity in Medway.
Improving sexual health	A draft sexual health strategy for Medway has been developed to map and review current services in relation to local needs and national strategy and equitable access to services. This strategy has been developed by the integrated PCT/council Public Health team. It will provide a co-ordinated approach to sexual health promotion, tackling poor sexual health, and reducing health inequalities in Medway. Many of the target groups have already participated actively in recent consultation initiatives in Medway (i.e. young people, lesbian gay bisexual and transgender community, prison population and sex workers) and the findings of these initiatives have been incorporated into this draft strategy.
Chlamydia screening	The national chlamydia screening programme is being rolled out in Medway from August 2006 to provide screening to under 25s in line with the national targets by 2008.

WORK AREA	ACHIEVEMENTS
Teenage pregnancy	Medway has made comparatively good progress towards achieving its interim target to reduce the under-18 teenage conception rate by 15 per cent by 2004 and the rate has shown an overall decline of 11.9 per cent from the 1998 baseline. The teenage pregnancy programme has developed strengths in a number of key areas, including support for young parents, informal sex and relationships education, marketing services and programmes, and peripheral contraceptive services, namely the emergency hormonal contraceptive scheme and the condom distribution scheme. Key areas that the teenage pregnancy programme will focus on in the future include the development of sex and relationships education in schools, the improvement of young person-appropriate sexual health services and a review of supported housing. Some key initiatives include: ● The Young People's Health Action Project has recently begun, in partnership with youth services. The project aims to skill young people to deliver health promotion in their own communities and among their peers. ● The Step4ward programme is a weekly group for young parents and young parents-to-be. The group, which is young person led, offers a variety of activities including self-esteem courses, healthy eating, managing behaviour and first aid. The group is supported by health teams and other professionals including midwifery, health visiting and family planning. ● A young fathers' group, 'Dad's Army' was set up at the Sunlight Centre, Gillingham. 'Dad's Army' is an opportunity for fathers to develop their parenting and other skills. ● The One Stop, a joint initiative between midwifery and teenage pregnancy, means that young mums-to-be are booked in for their scan appointments at a set time, so that a number of other services can also be provided, including Connexions and health visiting. ● The pharmacy scheme, which provides free emergency hormonal contraception (EHC) to young people, is led by the PCT. The C-card scheme is an initiative to provide young people with condoms in non-health settings. Supported by the family planning/GUMservice, the pilot programme was launched in June 2006. The first training will permit about 30 youth support workers to provide condoms under the strict guidelines of the scheme. Following evaluation of the pilot, recommendations will be made about its appropriate roll out across Medway.

5. Infant mortality

The National Health inequalities target for infant mortality

'Starting with children under one year, by 2010, to reduce the gap in mortality by at least 10 per cent between routine and manual groups as a whole.'

Locally, our infant mortality target is:
'Starting at 5.27 deaths per 1,000 live births in 1998-2000 to reduce the rates to no more than 4.83 by 2010, this means saving the lives of at least another two children'

Data on Medway infant mortality rates and the impact of our local targets are shown below:

Year	No. live births	No. infant deaths	infant mortality rate
1998	3150	18	5.71
1999	3239	16	4.94
2000	3101	16	5.16
Three-year average	3163.33	17	5.27
2010	3151(est)	15	4.83

Infant mortality rates and causes

In 2001 the Government identified infant mortality (deaths in children under one-year-old) as a crucial headline target for reducing health inequality. This target was introduced because there is a significant variation between mortality rates among children of parents in manual and professional groups and between different areas. The target focuses on reducing this gap. However the data is not available locally to measure this inequality. Therefore, it is assumed that a general reduction in infant mortality will also lead to reduction in the gap in infant mortality between social classes and as a result help us meet this target.

Many infant deaths happen in the first few weeks of life. The main causes of death in these very young children are prematurity and congenital abnormalities and there is a strong relationship with smoking in pregnancy, poor nutrition and lack of ante-natal care. The infant mortality target aims to address infant mortality reduction through tackling some of these causes as well as improving the health of older babies. Infant mortality is usually expressed as a rate per 1,000 live births. The national baseline is based on 1998-2000 data. Three-year averages are used to smooth year on year fluctuations. In the case of ward level data, five-year averages have been used because of the small numbers involved.

How Medway compares

Nationally, the infant mortality rate is 5.2 per 1,000 live births (2002-04 data). While the rate for the south-east as a whole is lower, at 4.2 per 1,000, Medway has a higher infant mortality rate. This is shown in the table below.

Infant mortality rates per 1,000 live births and number of infant deaths - trend from 1997-1999 to 2002-2004

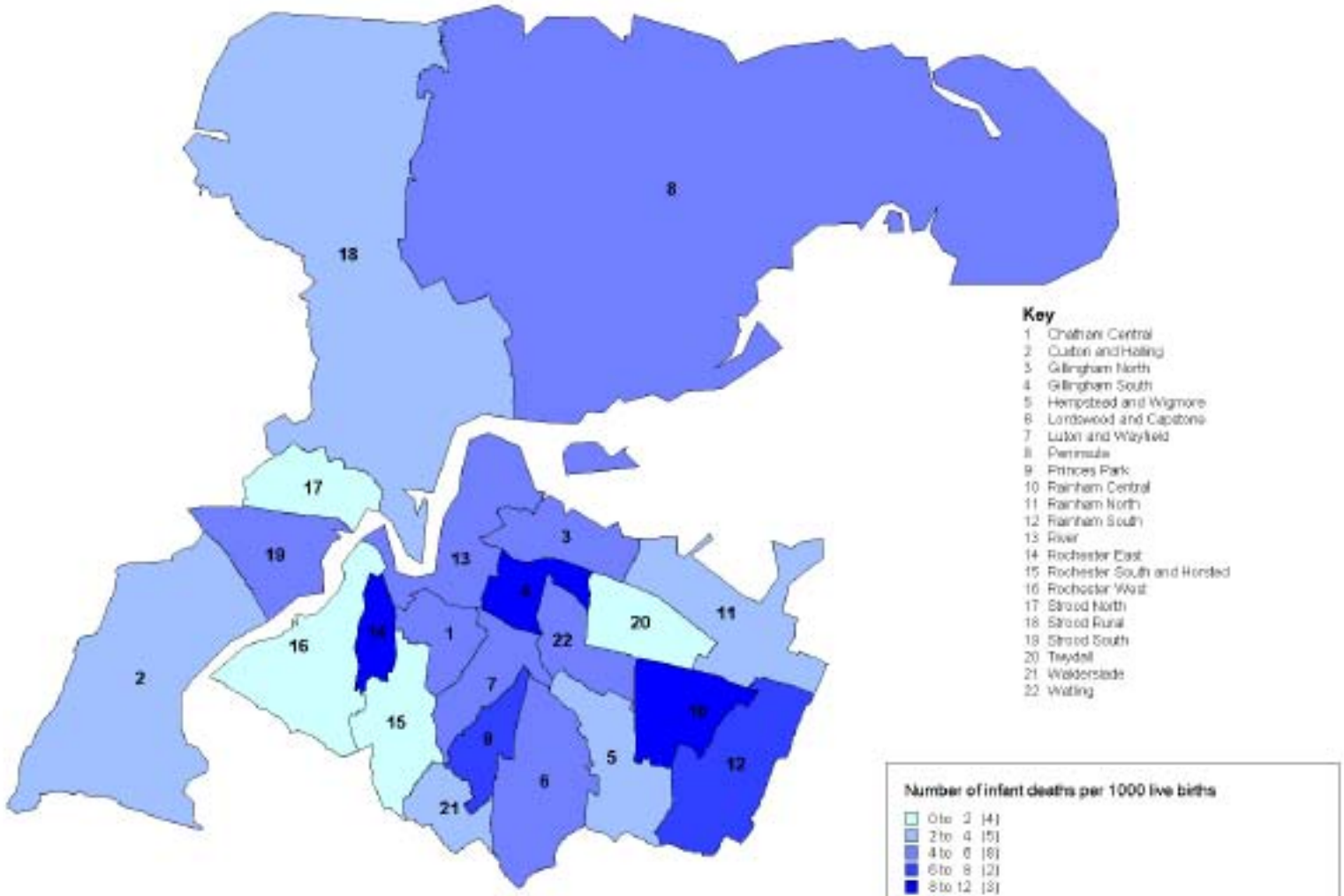
Year		Medway UA	England and Wales	South-east	New and growing towns (ONS area classification)
1997-1999	Rate	5.5	5.8	4.7	5.2
	Number	53	10941	1346	611
1998-2000	Rate	5.3	5.6	4.6	5.1
	Number	50	10512	1270	586
1999-2001	Rate	4.4	5.6	6.8	4.9
	Number	41	10184	1218	564
2000-2002	Rate	5.4	5.4	4.4	5.0
	Number	50	9742	1162	570
2001-2003	Rate	5.9	5.3	4.3	5.3
	Number	55	9650	1157	608
2002-2004	Rate	7.3	5.2	4.2	5.5
	Number	69	9652	1150	648

Source: Compendium of Clinical and Health Indicators, Health and Social Care Information Centre

Differences in infant mortality across Medway

Given the increasing trend in infant mortality in Medway since 1999-2001, the local target of 4.83 per 1,000 is a real challenge to achieve. It will mean saving the lives of a number of children over the period to 2010. Infant mortality rates vary across Medway; they vary across the wards of thearea. Some areas have particularly high infant mortality rates (for example Gillingham South), whereas others have much lower rates (for example, Rochester West).

Medway UA electoral wards average annual infant mortality rates, 2000-2004



Sources: ONS Annual District Death Extracts, ONS Annual District Birth Extracts, ONS Vital Statistics VS5 tables

Teenage conceptions

Nationally, teenage pregnancy targets also underpin the national the Public Service Agreement (PSA) target - shared jointly by the Department of Health (DH) and Department of Education and Skills (DfES) - to halve under 18 conceptions by 2010, within a broader strategy to improve sexual health. Teenage pregnancy targets are reinforced in the Public Health White Paper Choosing Health and the National Service Framework for Children, Young People and Maternity Services include clear outcomes for young people in relation to their sexual health.

Key targets:

To halve under 18 teenage conception rates by ensuring young people have access to accurate and up-to-date information, relevant sex and relationships education and readily available support to help them make informed choices about their health and well being.

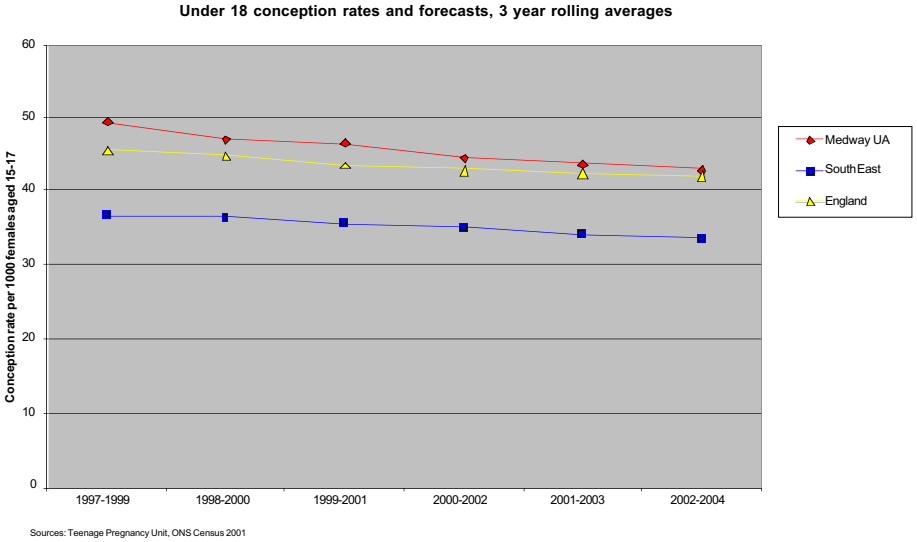
To increase to 60 per cent the proportion of teenage parents aged 16 to 19 in education, employment or training by 2010 and to support teenage parents in order to improve their life choices and outcomes for their children.

Within Medway, our targets are:

- 50 per cent reduction in under 18 teenage conception rate by 2010 from a 1998 baseline conception rate of 46.2 per 1,000 females under the age of 18 to 23.1 per 1,000

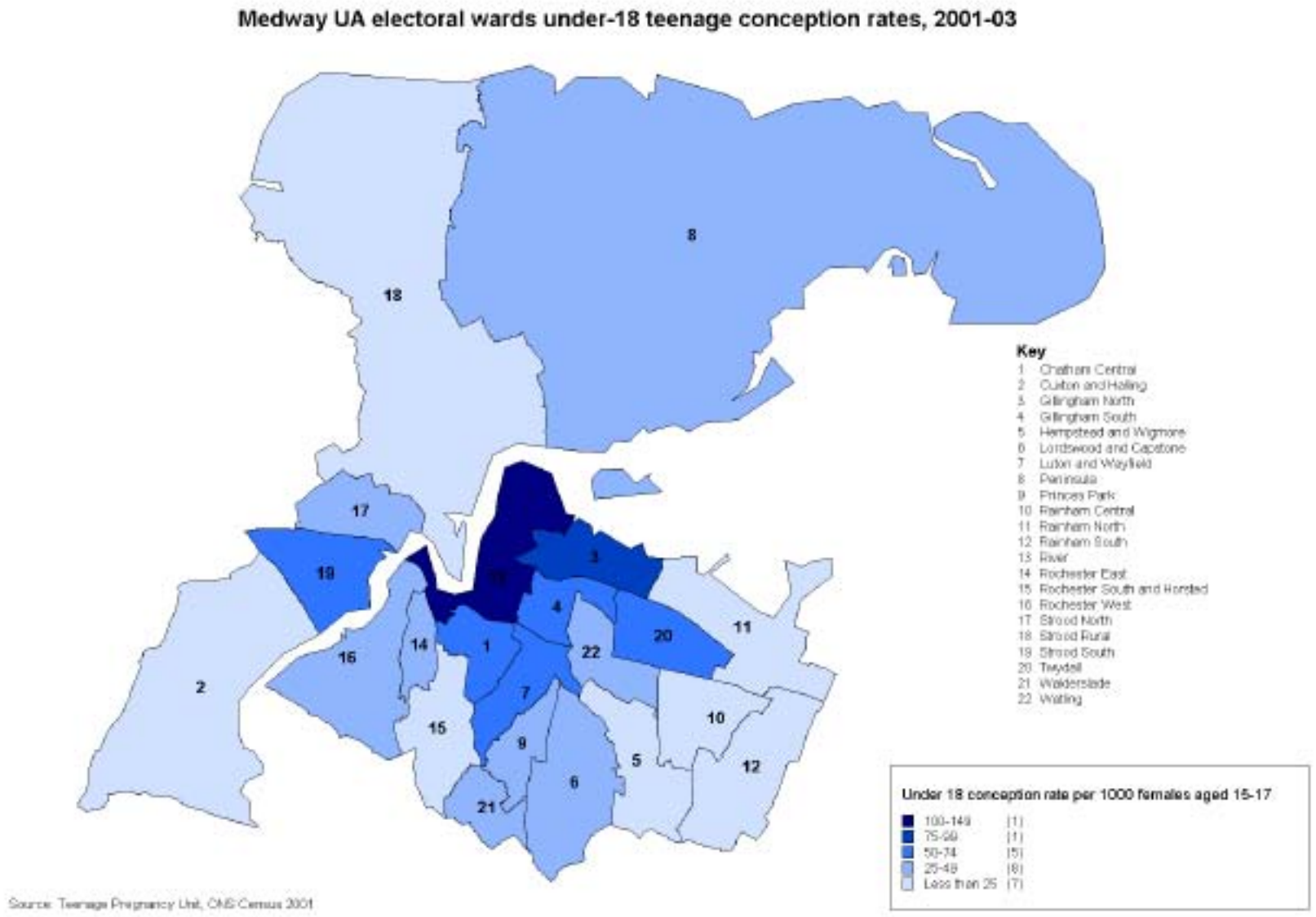
- 60 per cent increase in the participation of teenage parents in education, training or employment to reduce their risk of long-term social exclusion by 2010

Medway has made comparatively good progress towards achieving its interim target to reduce the under18 teenage conception from the 1998 baseline rate of 46.2 per 1,000 girls aged 15-17-years-old, particularly when compared with the national trend. The latest available under18 teenage conception rate figure is for 2004. Medway's under 18 conception rate for this period was 40.7 per 1,000 girls aged 15-17, a reduction of 5.5 percentage points. This rate represents an overall decline of 11.9 per cent from the 1998 baseline. Medway's under 18 conception rate for 2004 is higher than the regional rate of 33.5, but is comparable to the national rate of 41.5 for the same period.



Differences in teenage conception by ward

Looking at the differences across the area, there are differences in the teenage conception rate across the wards of Medway. The highest rate using 2001-03 data was in River ward.



Tackling the issues

Partnership working is at the heart of Medway's Teenage Pregnancy Strategy and has been significant in progressing local implementation. A range of local organisations both statutory and non-statutory continue to support local delivery of the strategy, including Connexions Kent and Medway, Sunlight Development Trust, midwifery, health visiting, school nursing, family planning and GUM, schools and children's services. The teenage pregnancy programme helps professionals network to improve communication and joined up working at a grass roots level in the areas of teenage pregnancy and young people's sexual health.

Significant achievements of the teenage pregnancy programme include the emergency hormonal contraceptive scheme and the condom distribution scheme. The forward plan for 2006/08 will prioritise the development of sex and relationships education in schools, the improvement of young person-appropriate sexual health services and a review of supported housing.

A young person's housing officer has been appointed by Medway Council. This post provides consistent support to young people, including young parents throughout the housing process, from application to placement in supported housing. Connexions personal advisors also advocate for young parents in the housing process and provide tenancy support.

Sex and relationship education (SRE)

Medway multi-agency sex and relationships education policy was endorsed by the Children and Young People's Strategic Partnership and will be implemented across agencies working with young people in Medway. The policy promotes consistent messages to young people about sexual health, relationships and local services.

The Living * Loving * Learning training team provides training and support to secondary schools to improve the quantity and quality of SRE and drugs education in schools. The programme is supported by changes in Ofsted inspections and the increased importance of personal, social, health education (PSHE) within the National Healthy Schools programme.

Source: NHS photo library

Source: NHS photo library

The ***Young People's Health Action Project*** has recently begun, in partnership with youth services. The project will provide young people with the necessary skills to deliver health promotion within their own communities and among their peers. Providing training and support, the programme (which is aimed at 16-19-year-olds) is an opportunity for young people to gain valuable volunteer experience and credits for both Duke of Edinburgh Awards and Millennium Volunteers, as well as providing a pool of young people able to deliver 'hands on' health promotion at young people's events.

The teenage pregnancy programme jointly funds a ***peer education project***, which is run by Kent Youth. The project trains young people to deliver sessions in schools on drugs and SRE. Young people are able to work towards a B-Tec qualification while taking part in the programme.

Media and Communications

The teenage pregnancy programme works closely with Medway Council's Communications Team to ensure that positive messages about teenage pregnancy and young people's sexual health are both frequent and consistent in local media.

The Communications Team has developed or updated a number of resources, which are used by services across Medway to promote positive relationships, good sexual health and use of appropriate services, these include:

- The young person's guide to visiting a sexual health clinic
- STIs the facts
- The parents guide to SRE in Medway

The Teenage Pregnancy Team developed the Medway Directory of Services for Young People, a professional's guide, and has launched its website that can be found at www.medway.gov.uk/yphealth

Smoking in pregnancy

Nationally, smoking in pregnancy is a key priority for Public Health services in the UK. The government is committed to reducing the percentage of women who smoke in pregnancy from 23 per cent to 15 per cent by the year 2010.

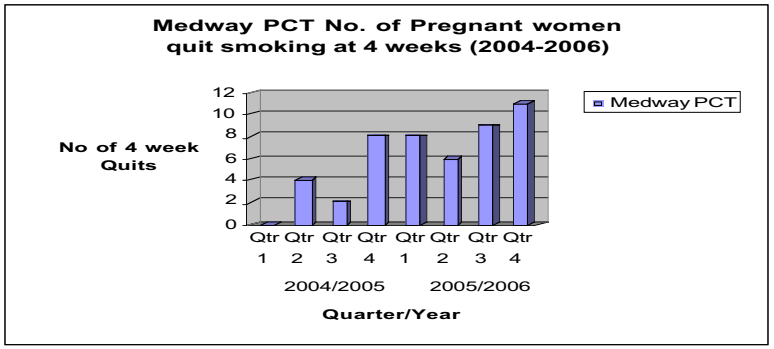
Smoking has detrimental effects on all stages of the reproductive process. It decreases the chance of conception in both men and women. In male smokers it is linked to reduced sperm count and in women it is associated with hormonal effects that make pregnancy less likely. Women who smoke are three times more likely to take more than a year to conceive than non-smokers.

It is widely recognised that cigarette smoking during pregnancy harms the foetus as well as the mother. The health risks posed by smoking during pregnancy are three-fold: to the mother, the unborn child and eventually to the newly born child. The ill effects of smoking before, during and after birth are as follows:

- Miscarriage
- Placental abruption (separation of placenta from uterus)
- Spontaneous abortion
- Ectopic pregnancy
- Placenta praevia (situated in the lower uterus and blocking uterine orifice)
- Premature rupture of the membranes
- Unexplained intra-uterine death
- Low birthweight
- Unborn babies small for gestational age (resulting in problems of hypothermia and hypoglycaemia)
- Sudden infant death syndrome (cot death)
- Respiratory problems in infants
- Cardiovascualr risk in adulthood
- Impaired intellectual development

The Local Target

In Medway the local target is for services to help 32 pregnant women to quit smoking successfully per annum (a one per cent reduction in the number of women known to be smoking at delivery)



Tackling the Issues

The Medway and Swale Stop Smoking Service provides a dedicated one to one service for pregnant smokers and their families, based at Medway Maritime Hospital. The service lead, works closely with midwives and hospital staff and the service has expanded during 2005/06 to help more pregnant smokers to quit successfully. Primary care staff also have an important role to play in encouraging pregnant smokers to make a quit attempt and referring them to the service.

Breastfeeding

The United Kingdom has one of lowest breastfeeding rates in Europe - one third of women never even try to breastfeed; although there is clear evidence that breastfeeding has short and longer term health benefits for both mother and baby. Breastfeeding has an important contribution to make towards meeting the national target to reduce infant mortality and health inequalities. Breastfeeding is associated with better cognitive development in childhood, less childhood obesity and a lower risk of cardiovascular disease.

The Infant Feeding Survey 2000

Data from the survey[4] shows that:

- Three-quarters of first-time mothers breastfeed their babies initially, compared with 65 per cent of mothers of subsequent babies.
- There is a steep social class gradient in breastfeeding initiation (breastfeed immediately after birth) rising from 57 per cent of mothers in social class V to 91 per cent of mothers in social class one.
- Mothers who left full-time education at age 16 or below were less likely to breastfeed than those educated longer (54 per cent of mothers educated to age 16 or below, compared to 88 per cent among mothers education to at least age 19).
- Ninety per cent of mothers who gave up breastfeeding within six weeks of birth would like to have breastfed for longer. Some of the reasons for stopping breastfeeding were found to include a lack of ante-natal information concerning breastfeeding, delays in the first feed and a lack of post-natal help with breastfeeding problems.

[4] *Infant Feeding 2000, Department of health, London, 2002*

Tackling the issues

Locally, the PCT has adopted, as a minimum standard for breastfeeding support, the best practice guide 'Good Practice and Innovation in Breastfeeding'. Information on breastfeeding must be timely, consistent and reflect best practice standards to deliver the Department of Health PSA target on improving the health of the population. Support for breastfeeding is a routine part of ante-natal care.

The PCT is also in the process of obtaining the UNICEF 'Baby Friendly Award', assessment criteria include all staff trained to support breastfeeding, welcoming facilities, and links with breastfeeding support groups. Locally, breastfeeding initiation rates have increased from 66.1 per cent in 2004/05 to 72.2 per cent in 2005/06.

Source: NHS picture library

Child poverty

National target for child poverty

- Starting with local authorities, by 2010 to reduce by at least 10 per cent the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole.
- Starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between routine and manual groups and the population as a whole.

Nationally, the number of children in poverty in the UK has increased threefold in the last 25 years[5]. Using 2002-03 data, 3.6 million children (28 per cent of all children) were living in income poverty. Specific groups of children are more at risk of poverty than others:

- 79 per cent of children in households where no adult is working were in income poverty.
- 52 per cent of children in lone parent households
- 48 per cent of children in a family with four or more children.

The health impact of child poverty is clear:
"Families living in poverty are less likely than other families to access health and other supportive services. Children from those families have higher than average rates of overweight and obesity, accidental injury and tooth decay. Although deaths in children under one are very rare, they happen more frequently among children living in deprivation"

Locally, using 2001 data, the estimated number of children under the age of 16 living in poverty was more than 11,000. This is about 20 per cent of children under the age of 16.

There are areas of Medway where there are high child poverty levels. Using 2000 data, nine of the wards in Medway were amongst the top 20 per cent of wards in England in terms of child poverty. In contrast some wards in the borough are amongst the 20 per cent of wards in England that have the lowest levels of child poverty.

[5] *Child Poverty in the UK, Second Report of Session 2003-04, House of Commons Work and Pensions Committee*

Tackling the issues

Medway Council has recently begun a review of both the Medway Community Plan and the Medway Local Strategic Partnership (LSP) structure designed to deliver the plan. Through its local area agreement (LAA), the LSP outlines the outcomes that it will achieve. These are under four broad headings:

- Children and young people
- Safer and stronger communities
- Healthier communities and older people
- Economic development

Economic development and, in particular, increasing local employment opportunities so that more local people can work in Medway, increasing vocational training opportunities and realising the potential of the Thames Gateway are a major strand of the LAA. In addition, the new community plan has highlighted a strand of 'A Young Medway' as a key element of the plan. This includes a focus on material well-being of young people, emphasising that deprivation and poverty directly affect the future prospects of children and young people.

It is widely accepted that the chief cause of child poverty is worklessness. There is strong evidence to support this, but other causes are also apparent. The Child Poverty Action Group (CPAG) highlights other broad causes which often interact with worklessness, such as marital and relationship breakdown, unstable parenting, inadequate levels of educational attainment and healthcare provision, and involvement in crime.

Medway has a lower than average proportion of young adults who achieve five or more GCSEs (grades A* to C) – 49 per cent in Medway, 55 per cent in the south-east and 54 per cent in England in 2004. It also has a lower proportion of young people who enter higher education - 9.33 per cent in Medway, 12.53 per cent in the south-east and 11.58 per cent in England in 2004.
Source: Department for Education and Skills

'Parentis', which is supported by the council and PCT, and run locally through the Sunlight Centre, is made up of a number of programmes aimed at parents of children of different age bands, from baby to teenager. This programme is being run through local providers and targets the most disadvantaged areas of the local community.

SureStart is a key resource in the area providing focused interventions to improve the lives of young people and to alleviate child poverty. It is committed to deliver:

* The best start in life for every child,
* Better opportunities for parents,
* Affordable, good quality childcare,
* Stronger and safer communities,
* The Government's commitment to halve child poverty by 2010.

SureStart

Medway Children and Young People's Plan

The Medway's Children and Young People's Plan 2006-2009 was written in partnership between the council, its statutory partners and the local community. Wide consultation with children and young people ensured that the plan accurately reflected their opinions, needs and aspirations.

Medway's plan sets out key targets for improving the health and well-being of children and young people in Medway.

The key partners

Responsibility for promoting health and well-being in young people, and for delivering the Children and Young People's Plan is shared between the statutory and non-statutory sectors. Community and voluntary groups are also important contributors to the work.

Key partners in Medway are:

- The Archdiocese of Southwark and the Diocese of Rochester
- Children's Fund Medway
- Community and voluntary sector
- Connexions Kent and Medway
- Kent Fire and Rescue Service
- Kent Police
- Kent Probation Service
- Learning and Skills Council
- Medway Council
- Medway Domestic Violence Forum
- Medway Drug and Alcohol Action Team
- Medway Ethnic Minority Forum
- Medway NHS Trust
- Medway Primary Care Trust
- Medway schools
- Medway Youth Parliament
- SureStart Medway

Source: NHS picture library

6. Life expectancy

The national target for life expectancy is:
'Starting with local authorities, by 2010, to reduce by at least 10 per cent the gap between the areas with the worst health and deprivation indicators and the population as a whole.

Life expectancy at birth is a way of expressing the all cause mortality for an area. It gives an estimate of how long someone is expected to live based on current mortality rates. Life expectancy varies considerably between the most affluent and most deprived groups and between different regions. The Government therefore introduced a target to increase life expectancy as one of their two headline inequalities targets. In order to increase life expectancy and achieve the national headline target a number of key areas need to be addressed. These include:

- reducing mortality rates from the major killer diseases
- improving access to services and
- changing to a healthier lifestyle.

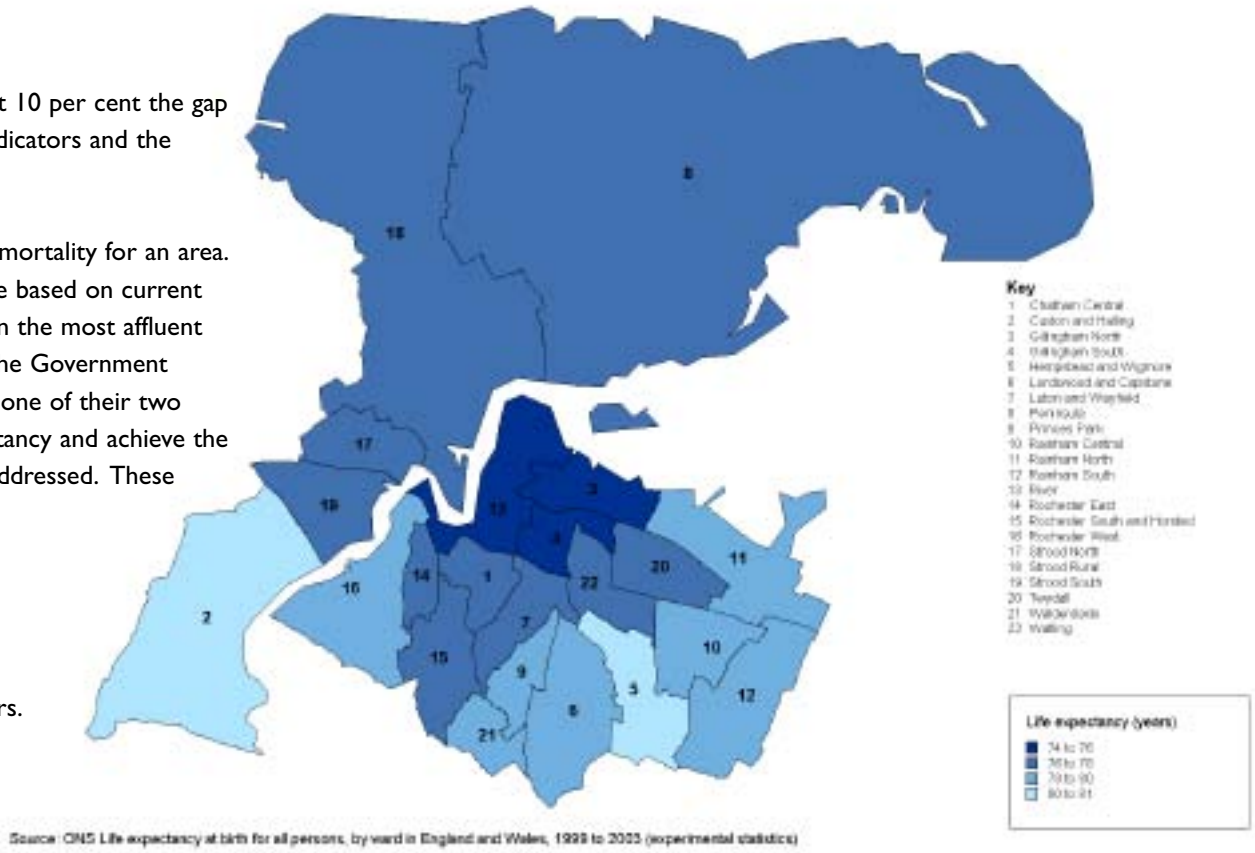
These are discussed in the next section of the report.
They include short term and long term targets and indicators.

Gap between the highest and lowest life expectancy in Medway

Within Medway, River ward has the lowest life expectancy.
In 2002, life expectancy here was 74.6 years.
The ward with the highest life expectancy
is Hempstead and Wigmore - where life expectancy in 2002
was 80.3 years.
The life expectancy gap between the two wards is 5.7 years.

Our local target is to reduce the gap between the life expectancy of River ward and the ward with the highest life expectancy by 15 per cent by 2010. This means that the life expectancy in the ward would increase by approximately one year to 75.4 years.

Life expectancy at birth in Medway UA electoral wards, 1999-2003



Source: ONS Life expectancy at birth for all persons, by ward in England and Wales, 1999 to 2003 (experimental statistics)

Life expectancy is being addressed by tackling key influencing factors such as mortality rates from the main killer diseases, access to services and lifestyle issues. Targets and indicators that address these issues and consequently life expectancy are outlined in the following sections.

Lifestyle

Having healthier lifestyles will have a major impact on life expectancy nationally. By making healthier choices, we can help avoid some of the major killers leading to premature death. The Government's white paper, Choosing Health[6] recognised that people need to be able to make informed choices and set out three key principles:

- Informed choice for all
- Personalisation of support to make healthy choices
- Working in partnership to make health everyone's business.

Choosing Health highlights action over six key priorities for delivery based upon more people making more healthy choices. These are:

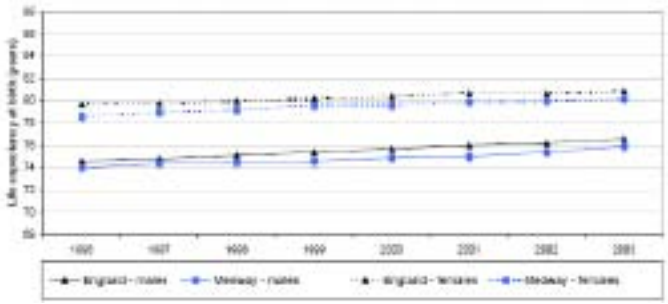
- Tackling health inequalities
- Reducing the numbers of people who smoke
- Tackling obesity
- Improving sexual health
- Improving mental health and well-being, and
- Reducing harm and encouraging sensible drinking.

These priorities are being addressed nationally and locally by engaging people in health decisions. As the Wanless Report emphasised, **'the prize includes longer, healthier lives, fewer working days lost, and reductions in the pressure on health services in the future.'**
Securing Good Health for the Whole Population, Derek Wanless, February 2004

Individuals are ultimately responsible for their own and their children's health and it is the aggregate actions of individuals, which will ultimately be responsible for whether or not such an optimistic scenario as "fully engaged" unfolds. People need to be supported more actively to make better decisions about their own health and welfare because there are widespread, systematic failures that influence the decisions individuals currently make. These failures include a lack of full information, the difficulty individuals have in considering fully the wider social costs of particular behaviours andengrained social attitudes not conducive to individuals pursuing healthy lifestyles and addictions.

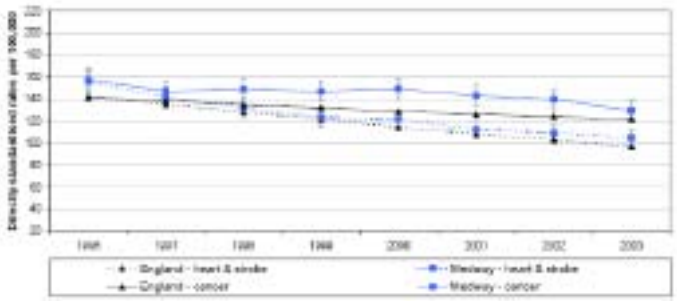
There are also significant inequalities related to individuals' poor lifestyles and they tend to be related to socio-economic and sometimes ethnic differences. These failures need to be recognised. They can be tackled not only by individuals but by wide ranging action by health and care services, government - national and local, media, businesses, society at large, families and the voluntary and community sector. Collective action must however respect the individual's right to choose whether or not to be "fully engaged".

Trend 1: Male and female life expectancy



This chart compares the trends in life expectancy at birth for men and women in this area with that for England.

Trend 2: Deaths from heart disease/stroke and cancer



This chart compares the trends in deaths for all persons under 75 years due to heart disease/stroke and cancer in this area with that for England.

Source community health profiles, (APHO and Department of Health). Produced by APHO with interpretation by SEPHO, (c) Crown Copyright 2006.

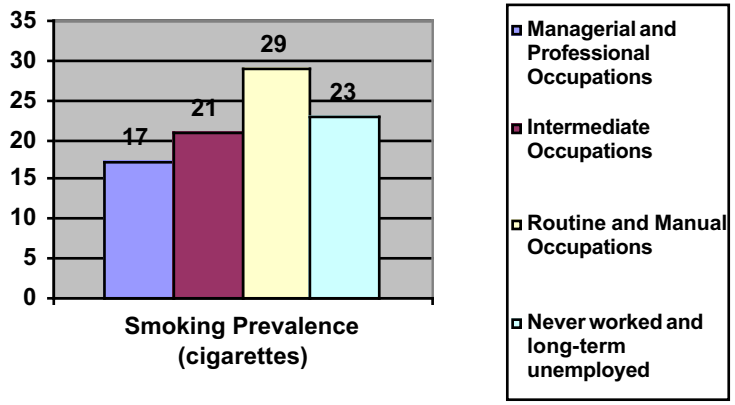
[6] *Choosing Health, Department of Health, 2004*

Smoking

Stopping smoking is the single most important thing a person can do to improve their current and future health. The government is committed to reducing adult smoking in all social classes so that the overall rate falls from 28 per cent to 24 per cent or less by the year 2010.

Smoking is also a major contributor to health inequalities. More people from socio-economically disadvantaged groups smoke, and fewer people smoke in more affluent groups.

Prevalence of Cigarette Smoking by Socio Economic Classification, 2004

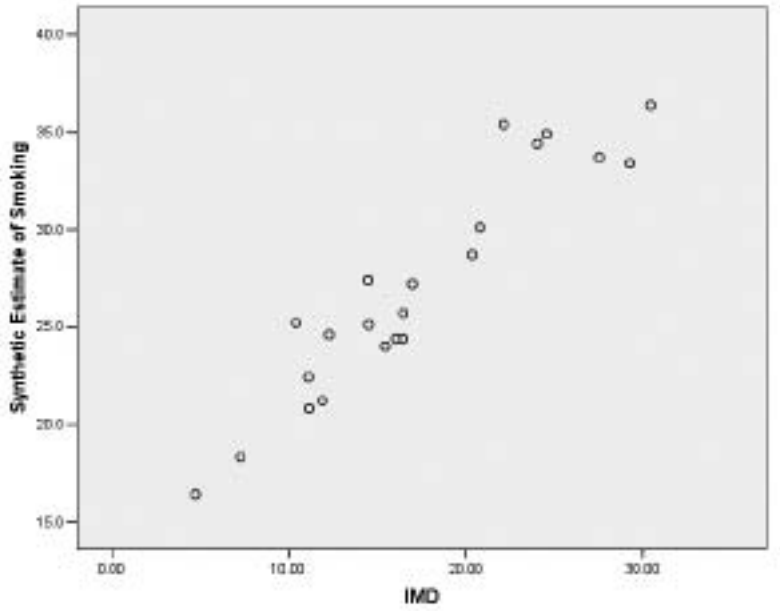


Source: health survey of England 2004

Source: NHS picture library

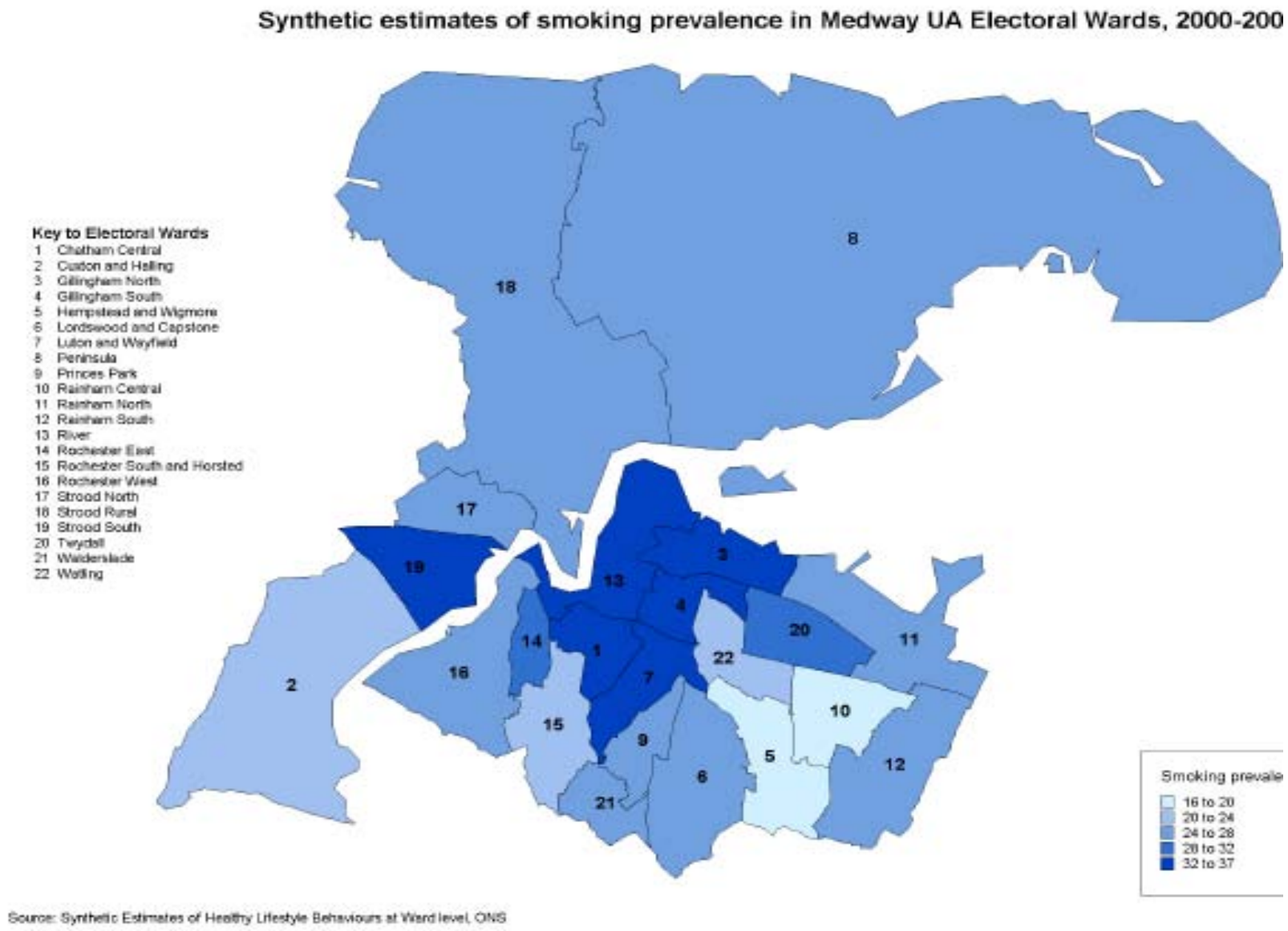
At least 48,000 adults in Medway smoke and more than 480 people a year die from smoking-related disease. There is a strong association between deprivation and the proportion of people who smoke: those in poorer areas are more likely to smoke. This is shown in the figure below.

Association between IMD 2004 and Synthetic Estimates of Smoking Prevalence in Medway UA Electoral Wards, 2000-2002



Source:Synthetic estimates of lifestyle behaviour at ward level, ONS

Across Medway, there are significant differences in the number of people who smoke, and in some areas prevalence rates are very high. If they are to target smokers effectively and work to reduce health inequalities, as emphasised in the 'Choosing Health' White Paper, services need to develop effective ways of reaching out to communities in which smoking rates are high.


Synthetic estimates of smoking prevalence in Medway UA Electoral Wards, 2000-200
Key to Electoral Wards
1 Chatham Central
2 Cuxton and Halling
3 Gillingham North
4 Gillingham South
5 Hempstead and Wigmore
6 Lordswood and Capstone
7 Luton and Wayfield
8 Peninsula
9 Princes Park
10 Rainham Central
11 Rainham North
12 Rainham South
13 River
14 Rochester East
15 Rochester South and Horsted
16 Rochester West
17 Strood North
18 Strood Rural
19 Strood South
20 Twydall
21 Walderslade
22 Watling
Smoking prevale
16 to 20
20 to 24
24 to 28
28 to 32
32 to 37
Source: Synthetic Estimates of Healthy Lifestyle Behaviours at Ward level, ONS

Tackling the issues

The Medway and Swale Stop Smoking Service has recently been developing new, more effective methods of reaching out to smokers in Medway. In early 2006, working with a social marketing organisation called 'Information by Design', the service carried out a promotional campaign in the Strood area. A total of 3,300 individual smokers in Strood were sent information about a comprehensive treatment package and were invited to attend for treatment over the following few weeks. The initial mailing was followed up by telephone calls from trained staff and as a result 190 smokers were booked onto the treatment programme. This initiative has already demonstrated that it is possible to target smokers in specific areas and social groups, thus helping to reduce health inequalities in the Medway area. A larger scale social marketing initiative is planned for smokers in the Gillingam area in autumn 2006.

Improving access to services

Easy access to services is vital if people are to be able to benefit from them and take steps to improve their health. The Medway and Swale Stop Smoking Service provides a number of treatment options in a wide variety of settings, in the interests of providing ready access for smokers from all walks of life and giving them the opportunity to choose and book their preferred service option.

Medway and Swale Stop Smoking Service options

- Group counselling courses are available across Medway in many locations and smokers are routinely offered a choice of daytime or evening sessions.
- One to one treatment delivered by trained staff is currently available in a number of pharmacies in the Medway area.
- One to one treatment delivered by trained medical staff is available at many GP surgeries.
- One to one or group treatment is also available in prison settings
- A training programme for dental practice staff is planned for 2006/07 leading to the provision of one to one services in some dental practices.

New developments

The Public Health White Paper 'Choosing Health: making healthier choices easier' sets out a number of measures which will encourage more smokers to quit. By the end of 2006, all government departments and the NHS will be expected to be smoke-free and by 2008 all enclosed public places and workplaces will be smoke-free. The Medway and Swale Stop Smoking Service is working on a number of new developments to help facilitate this process and extend treatment options in key areas. The initiatives currently under development are as follows:

- The service will be working to help employers and their staff to prepare for and adapt to the new legislation, by providing employers with staff training and treatment options for staff wishing to quit.
- A new service providing on-site stop smoking treatment for staff and patients at Medway Maritime Hospital will commence in summer 2006. The service Stop Smoking Advisor will be working with hospital staff to provide support for in-patients who wish to quit or manage their cravings whilst in hospital. The service will be available to provide one to one support for staff who wish to quit smoking.
- Stop smoking services for pupils in selected Medway schools will be introduced in 2006/07 following on from a successful pilot initiative in Minster College, Swale.

Celebrating success

Quitting smoking successfully is difficult for most people, but with the right help and support, many Medway smokers are managing to tackle their addiction and move on with their lives. The Medway and Swale Stop Smoking Service holds an annual event to celebrate their success and the dedication of the many staff involved in providing treatment and support.

Source: NHS picture library

Obesity

Obesity has trebled in the last decade, and over half of adults in England are now either obese or overweight. During this period, there has been an increase in the proportion of adults in England who are obese. In 1993, 13 per cent of men and 16 per cent of women aged 16 and over were classified as obese. By 2003, these proportions had risen to 23 per cent for both men and women. In addition, in 2003, a further 44 per cent of men and 33 per cent of women were classified as ***overweight***.

Obesity levels among the young population are at dangerous levels. Latest statistics show that prevalence in children aged 2-15 rose from 9.9 per cent to 14.3 per cent between 1999 and 2004. Obesity in both adults and children is more common among lower social groups. Obesity increases with age - almost 80 per cent of men over 45 are overweight or obese, and twice the proportion of women in unskilled manual groups are obese compared to those in professional groups.

Obesity is now a government priority. It has set a target to halt the rise in obesity amongst children by 2010, at the same time tackling obesity in the population in general.

The impact of obesity

Obesity can decrease life expectancy by up to nine years. Obesity can also lead to mental health problems - depression and low self esteem. People who are overweight or obese are more likely to be at risk from circulatory diseases (including heart disease and stroke) and diabetes.

The local position

The rate of obesity in children and young people in the south east is 4.5 per cent of boys and 4.9 per cent of girls aged 2-15 are obese, and a further 15 per cent of boys and 19 per cent of girls are overweight. Within Medway, almost a quarter of adults aged over 18 years old are obese. The rate of obesity in Medway is higher than the England average. Local estimates also point to an obesity gradient across the wards of Medway. Again, there is some correlation with deprivation - poorer wards generally have higher levels of obesity, more affluent wards tend to have lower levels.

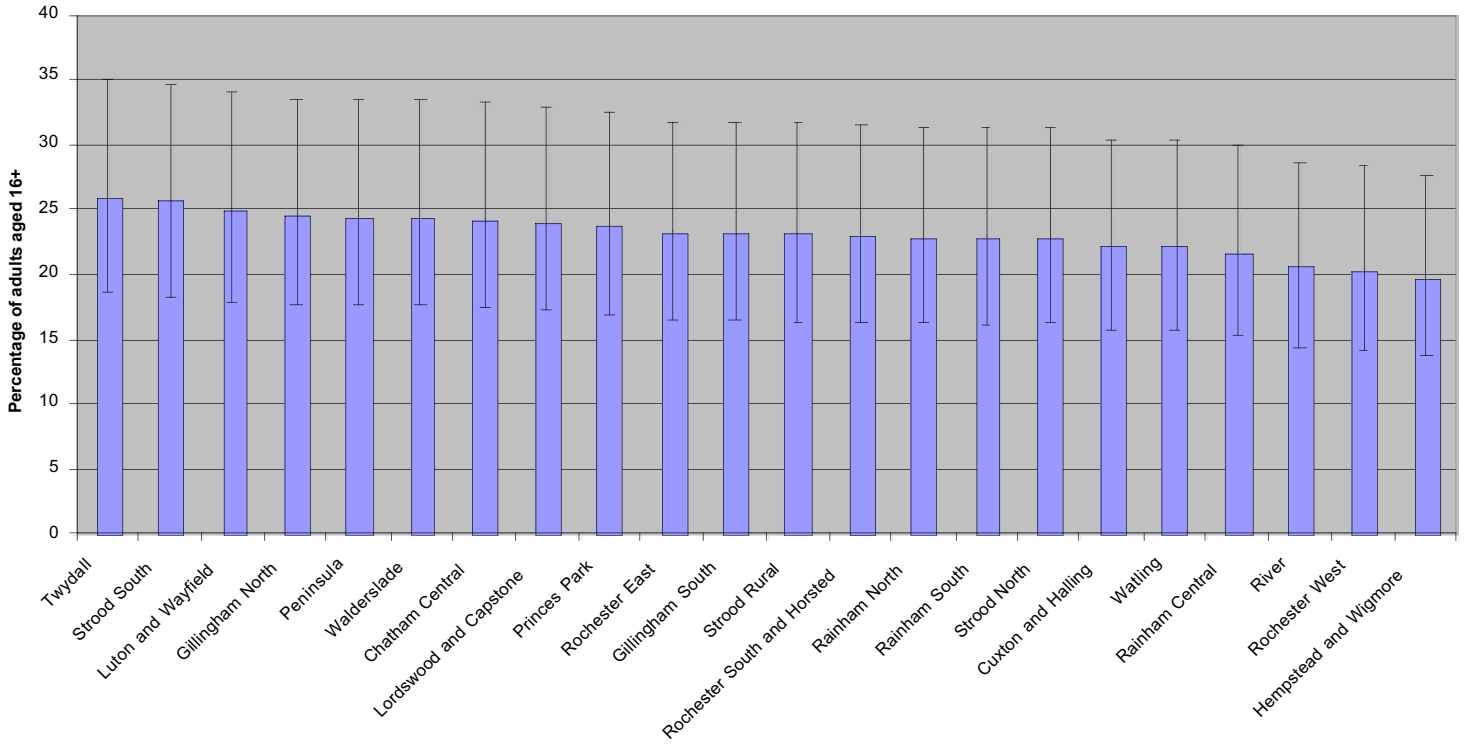
We take the Government Public Service Agreement (PSA) targets for obesity very seriously and are locked into the agreement to combat the obesogenic environment. Successful prevention strategies will need to address many aspects of lifestyle which

In Medway, we are implementing various programmes to address obesity levels, but are clear that the rise in obesity will not be reversed by any single approach. Healthy living clinics, such as those held at the Sunlight Centre, are designed to address the problem in adults. A wide range of activities seeks to improve the eating habits of children. We want young people and adults to look at their eating, drinking and smoking habits. Schemes include those which encourage physical activity in safe and comfortable surroundings, and support families to take part in more physical activity and hobbies together.

We are working to build long term partnerships with many organisations around Medway. As a team, we are dedicated to working with partners to develop services which will achieve the PSA2 target of halting the rise in obesity and an improved lifestyle for children and their families.

Sources: Synthetic Estimates of Healthy Lifestyle Behaviours at PCT Level, Health, Health and Social Care Information Centre, Health Surveys for England - National Centre for Social Research

Synthetic estimates of obesity for Medway UA electoral wards, 2000-2002



Diet

Eating well plays an important part in a healthy lifestyle. While many people in England eat well, a large percentage of the population does not. Among lower socio-economic groups, diet is often poor. Many people consume less than the recommended amount of fruit, vegetables and fibre, but their intake of fat, saturated fat, salt and sugar is excessive. However there is a worrying increase in poor diet among more advantaged groups of the population. Busy modern lifestyles lead people to eat more processed, convenience foods and fewer meals are prepared with freshly prepared ingredients. Another factor in poor diet is alcohol.

Nationally, men eat on average 3.0 portions of fruit and vegetables a day, and women 3.3 a day[7]. Both of these are well below the recommended five portions a day.

Source: NHS picture library

7 Median from Health Survey for England 2004, ONS, London.

Overall, 25 per cent of the adult population meet the five-a-day target – 23 per cent of men and 27 per cent of women[8]. Evidence from National Diet and Nutrition Survey (2004) suggests that men and women in households receiving state benefits ate fewer portions of fruit and vegetables (2.1 for men and 1.9 for women).

Locally, the proportion eating five portions of fruit and vegetables a day is lower than the national average, at approximately 22 per cent. Again there are large differences in the levels of fruit and vegetable consumption across the wards of Medway. Princess Park, Gillingham North and Strood North have less than one-in-five eating five portions of fruit and vegetables a day.

Tackling the issues

Following the adoption in 2005 of the Medway obesity strategy, an action plan to increase awareness of healthy diet has been developed. Locally, the overall aim is to improve diet through better information and access to healthier food. Our strategy Includes providing advice on healthier food for children, guidance on the marketing and advertising of foods, simpler labelling, and healthier meals in schools. Our five-a-day campaign encourages adults and children to eat five portions of fresh fruit or vegetables every day. Within schools the campaign has shown progress and children are encouraged to take a healthy message home.

We take the Government's advice on Choosing Healthy Diet seriously. Through our partnerships we are focusing heavily on raising awareness on this subject:

- Providing information on healthy food and cooking
- Running cookery classes in many centres e.g. SureStart. This enables young families to learn about the importance of a balanced diet.
- Supporting healthy eating cafes in various community centres - these enable people to come and eat a well balanced, healthy meal.
- Our courses give advice on reduction in sugar, fats and unsaturated fats. Teaching people to buy the right things, cook well and eat well is key priority.
- Part of our Healthy Schools programme promotes healthy diet. If we can reach children and educate them to eat well from an early age, it will become a lifelong habit.

8 *Health Survey for England, 2004. ONS, London*

Standards for foods in schools

In September 2006 new standards for food in schools were introduced across the country. These included:

- No fewer than two servings of fruit and vegetables per child per day;
- Oily fish to be served at least once every three weeks;
- Bread should be available every day;
- The only drinks to be served will be water, pure fruit juices, milk, yoghurt and milk drinks with less than 5 per cent added sugar, smoothies, low calorie hot chocolate, coffee and tea.

The Food in Schools toolkit has been issued to complement the new standards. Although it does not cover nutritional content the kit contains everything a school needs to improve the standard of healthy eating for its students.

Whilst the new standards apply to school meals, we still need to ensure that students can make healthy choices for tuck at breaks. The Medway Healthy Schools team is working with local businesses to offer healthy options at tuck shops - products which have been approved by the Health Education Trust. Many schools are working with their school council to trial the new products and publicise the new choices.

Adverse publicity around school meals has meant that more parents have decided to provide their child with a packed lunch. Whilst this can be an understandable reaction, it can have an adverse effect as packed lunches are rarely as nutritionally balanced as a school meal. However, this situation needs to be handled with sensitivity as many parents resent being told what they can and cannot provide for their child. The Food in Schools toolkit provides a sample food policy which schools can use to inform families about preferred food choices. It should be noted however that no school will forbid a child to eat his or her lunch, as we recognise the importance of a midday meal for learning and concentration.

Under the new standards, water is to be freely available throughout the day. Over the last two years the Medway Healthy Schools team has provided more than 65,000 water bottles to schools both here and in other parts of the country. Adequate hydration is linked to higher levels of concentration and improved behaviour. Medway bottles have been seen all over the world.

Physical activity

The scientific evidence on physical activity is compelling. Physical activity not only contributes to well-being, but is also essential for good health. People who are physically active reduce their risk of developing the major chronic diseases, such as coronary heart disease, stroke and type two diabetes - by up to 50 per cent, and the risk of premature death by about 20-30 per cent.
Sir Liam Donaldson, 2004

Recent evidence[9] clearly demonstrates that physical inactivity is a primary contributor to a broad range of chronic diseases such as coronary heart disease, stroke, diabetes and some cancers. To assist in increasing physical activity, the government recommend:

- For general health, a total of at least 30 minutes a day of at least moderate intensity physical activity on five or more days of the week.
- For children and young people, a total of at least 60 minutes of at least moderate intensity physical activity each day is needed, and at least twice a week, this should include activities to improve bone health, muscle strength and flexibility.

Nationally, only 37 per cent of men and 24 per cent of women are at the recommended level of at least five periods a week.

Locally, there is limited data available on the physical activity levels of local people. The 2001 Kent and Medway Lifestyle Survey[10] estimated that only 17 per cent of the total Kent and Medway population was exercising for 30 minutes five times a week - the Medway figure, although slightly higher, was less than 20%.

Physical activity targets for the United Kingdom

Adults
By 2020, 70 per cent of individuals to be undertaking 30 minutes of physical activity on at least five days a week, with an interim target of 50 per cent of individuals by 2011.
Children
To increase the proportion of school children in England who spend a minimum of two hours each week on high quality sport from 25 per cent in 2002, to 75 per cent by 2006 and 85 per cent in 2008.

Source: NHS picture library

Important projects to boost physical activity have been underway this year. These include school-based projects, such as Skip2beFit. Key elements of increasing community initiatives on physical activity include ensuring both a good quality environment for community activities and community safety.

Locally, the Health Trainers project will be the focal point for increasing physical activity levels of both adults and children. Also, as part of the interventions on obesity, new initiatives will be launched in the coming months.

9 *At least five a Week: Evidence on the impact of physical activity and its relationship to health, Chief Medical Officer, Department of Health, 2004.*

10 *A Survey of Health and Lifestyles in Kent and Medway, CHSS, 2002.*

Gold for Medway

The Olympic Games and Medway

by James Gibson (member of Medway Matters young people's editorial team)

Two things stood out for me when London won the rights to host the Olympic Games. First, we had beaten the French and second, the effects it would have. No doubt you have set yourself a target to be at the games, but have you considered how it will affect Medway?

Sport England has already given funding for potential medal winners at the games and clubs all over the country have sent in their applications for their own funding. It was one of Seb Coe's main policies. He emphasised the importance of Britain's youth having the Olympic Games as a legacy. This extra funding is a way of ensuring that the development of sport in Kent and Medway is as strong as possible.

But don't worry if you're not into sport or unable to compete. The Olympic Games will still benefit everyone living in Medway. Not only will you be able to sign up as a volunteer at the official website, but there will also be lots of jobs created in construction, hospitality and marketing as the new stadiums and venues are built. The high speed rail link will also mean that Kent and Medway's tourism levels will rise and it is a real possibility that some national teams will use Medway facilities for training in the run up to the event.
Also 10,000 of the 70,000 journalists reporting on the events are expected to use Kent and Medway as a base. This alone will generate about £20 million investment into local economies. The Thames Gateway (which includes Medway) will receive investment for a series of long-term development projects, including 90,000 new homes.

Access to services

The UK National Screening Committee (NSC) uses research evidence and the skills of multi-disciplinary expert groups to develop policies for screening. The NSC assesses proposed new screening programmes against a set of internationally recognised criteria. These criteria include the epidemiology of the condition, the screening test, any treatment options, and the acceptability of the screening programme. Their mission is to ensure that screening does more good than harm at a reasonable cost.

Breast screening

Nationally, incidence rates for breast cancer rose 47 per cent between 1980 and 2000, chiefly among more affluent women.
Mortality rates were broadly constant up until 1989 and fell by more than 25 per cent between 1989 and 2002. Survival and mortality rates are improving despite a significant rise in the level of incidence

The NHS Breast Screening Programme provides free breast screening every three years for all women in the UK aged 50 and over. Around 1.5million women are screened in the UK each year. Women aged between 50 and 70 are now routinely invited.

The national target for Breast Screening coverage for women aged 50-70 years is 70 per cent at 36 months in 2005. There have been great improvements in five-year breast cancer survival rates. For women diagnosed between 1971 and 1975 the five-year relative survival rate was 52 per cent, rising to 78 per cent for those diagnosed between 1996 and 1999.

Locally, in Medway, the incidence of breast cancer is similar to the national rate. The local five-year survival rate is 79 per cent (England rate is 78 per cent). Breast screening in Kent and Medway is managed by East Kent Hospitals Trust and is mainly carried out on mobile machines. If necessary, women are referred for assessment to one of three units based in Canterbury, Maidstone and Medway. Following the implementation of two view screening in 2003, plans are now in place to extend the programme from 65 up to 75 years. This has now started in Canterbury and Maidstone and will start shortly in Medway.

Medway has good a good performance record for breast screening:

- High uptake – 79 per cent of women invited to screening attend. This is higher than the southeast average (77 per cent) and England (75 per cent).
- Consistently high cancer detection figures in excess of national targets.
- Time from screening to assessment is 39 per cent within three weeks.

Although there have been delays in the service, these are now coming under control and achievement of 36 month target for coverage and extension to the programme in all the areas will be achieved by end July 2005.

In Medway, the programme faces challenges in extending coverage whilst addressing areas of low uptake. The aim is to improve access to breast screening for women in socially excluded and minority ethnic groups. This will possibly include the use the use of social marketing techniques, to target women in disadvantaged groups.

Cervical screening

The National Cervical Screening Programme coverage target for women aged 25-64 years is 80 per cent within last five years in 2005

Cervical screening is not a test for cancer. It is a method of preventing cancer by detecting and treating early abnormalities which, if left untreated, could lead to cancer in a woman's cervix. The first stage in cervical screening is either a smear test or Liquid based Cytology. Early detection and treatment can prevent 75 per cent of cancers developing.
The programme aims to reduce the number of women who develop invasive cervical cancer and the number of women who die from it. It does this by regularly screening all women at risk so that conditions which might otherwise develop into invasive cancer can be identified and treated. All women between the ages of 25 and 64 are eligible for a free cervical screening test every three to five years.

Local

Medway has a higher incidence of cervical cancer than England and the southeast. Cervical cancer five year survival rates for Medway (63.1 per cent) are similar to England (63.1 per cent) and the south east (62.5 per cent).

In Kent and Medway the requirements of the revised national cervical screening programme have been successfully introduced. Medway PCT's cervical screening coverage of the target age group (25-64) is 83 per cent.

Sexual health services

Nationally the Choosing Health priority is to modernise sexual health services and offer more accessible services, with a specific target that patients referred to genito urinary medicine (GUM) will be able to have an appointment within 48 hours (by 2008).

Locally Health Protection Agency data currently shows that 38 per cent of patients are offered an appointment within 48 hours (HPA, data for February 2006).

It is estimated the current waiting time for an appointment in specialist GUM clinic in Medway is seven days. The service combines an appointment system with walk-in clinics, making it difficult to manage and monitor the demand for the service.

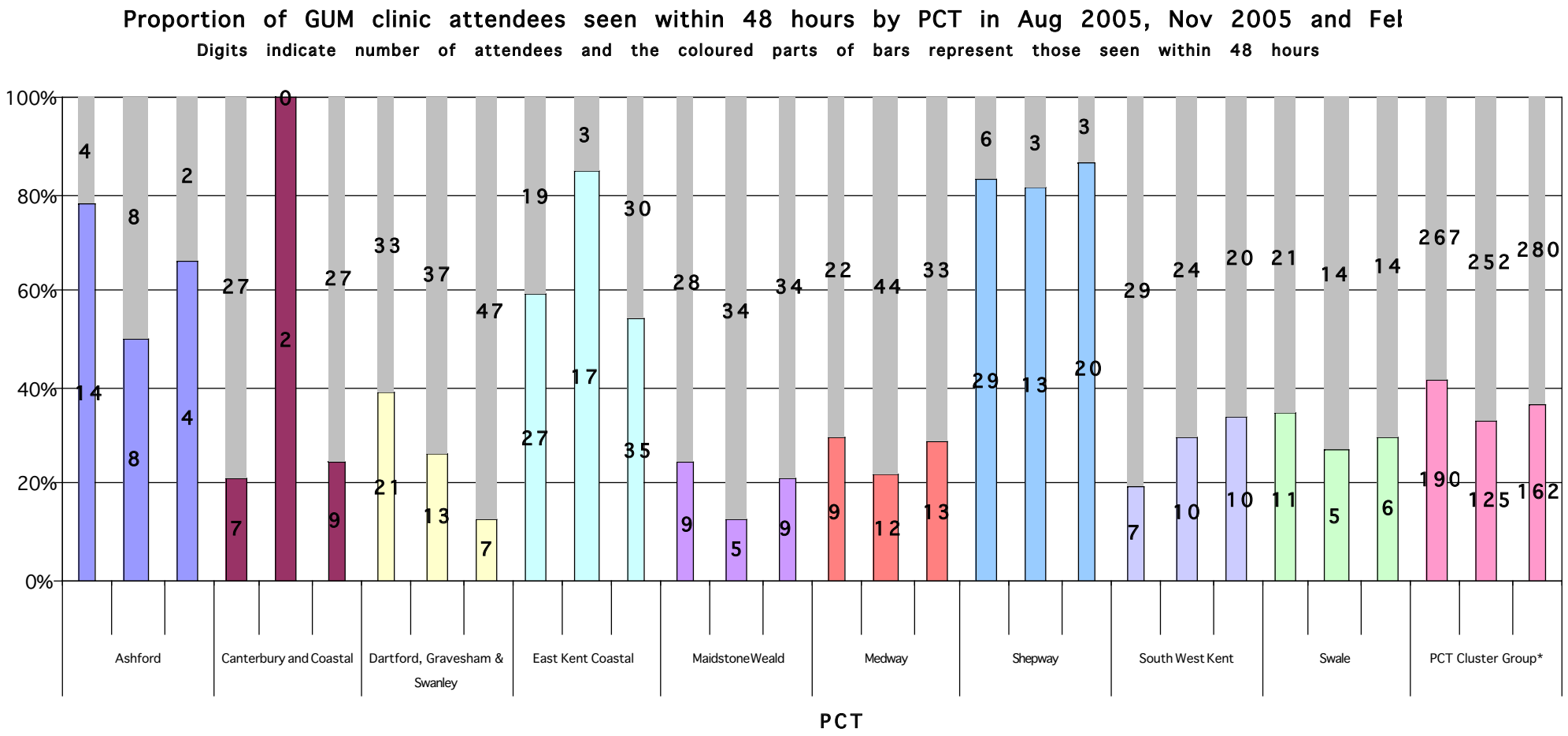
In the face of rapidly rising diagnosis of most sexually transmitted infections (STI's), it is essential that there is quick access to services where they can be diagnosed and treated.

There is currently a lack of consistency about how waiting times are measured. There is no national system for continuous monitoring of waiting times, and the Health Protection Agency undertakes quarterly audits to measure progress towards 48 hour access targets for GUM services.

Tackling the issues

The Medway Sexual Health Strategy details the requirements for sexual health services locally. The planned consultation and implementation of the strategy will facilitate the development of sexual health services in primary care settings. Current provision in primary care is not well documented, and its development will improve the capacity to meet the 48 hour target.

Medway data demonstrates a generally increasing trend; the pattern is consistent with other PCT areas across Kent.



Source: GUM Waiting Times Audit: A summary report of audits of access to Genitourinary Medicine Clinics in the South East Region May 2004 to February 2006, published June 2006,

* This includes Medway, Southampton, Milton Keynes, Brighton, Slough and Portsmouth

Vaccination

Nationally, the target for the uptake of childhood immunisation is 95 per cent at two years of age.

What is immunisation?

Immunisation is a way of protecting ourselves against serious disease. An immunisation programme protects people against specific diseases by reducing the number of people getting the disease and preventing it being passed on.

The childhood immunisation programme has been crucial in bringing about huge reductions in morbidity and mortality from a range of vaccine preventable diseases in childhood, including meningococcal diseases, whooping cough, measles, mumps and rubella. High levels of immunisation rates in the population are required to prevent epidemics of disease occurring.

Locally in Medway, the percentage of children immunised by their second birthday is higher than the southeast and England figures.

Across the country as a whole uptake of most childhood immunisations has remained close to the target of 95 per cent. Uptake of MMR, however, has declined as a consequence of adverse publicity around the supposed link to autism. The evidence disproving any link is compelling.

Flu

Influenza (flu) is a highly infectious disease caused by influenza viruses. There are three types of influenza virus: A, B and C. Influenza A and B viruses cause virtually all of the clinical illness. The symptoms of influenza C infection are usually mild. Flu occurs every year mainly during the winter months. The national target uptake of influenza immunisation is 70 per cent in people 65 years and over, targeting populations in the 20 per cent of areas with the lowest life expectancy.

Seasonal influenza

Flu is a respiratory illness associated with infection by influenza virus. Symptoms frequently include headache, fever, cough, sore throat, aching muscles and joints. There is a wide spectrum of severity of illness ranging from minor symptoms through to pneumonia and death. Influenza occurs most often in the winter months, and normally peaks between December and March in the northern hemisphere.

Source: NHS picture library

Avian influenza

Avian influenza (bird flu) is a bird disease caused by influenza viruses closely related to human influenza viruses. Economically it is an important disease for poultry farmers because of losses in poultry flocks. Transmission to humans in close contact with poultry or other birds occurs rarely and only with some strains of avian influenza.

Pandemic influenza

Pandemics arise when a new influenza virus emerges which is capable of spreading in the worldwide population. This was the situation during the influenza pandemic of 1918-19, when a completely new influenza virus subtype emerged and spread around the globe in around four to six months. There are concerns that the currently circulating H5N1 strain of avian influenza may give rise to the next pandemic influenza virus.

The influenza virus attacks the respiratory tract (the ear, nose and throat). The virus is mainly spread by respiratory droplets in the air produced by coughing or sneezing. It can also be spread by, for example, hand to eye contact after touching the respiratory droplets on another person or object. The incubation period before onset of symptoms is between one and three days.

Although most people recover from flu within a week, for some people the infection is more serious and leads to complications. These illnesses may require treatment in hospital and can be life-threatening especially in the elderly, people with heart or chest disease and those in poor health.

Influenza vaccine

The targeted risk groups for vaccination against influenza are people aged 65 and over, and those in clinical high risk groups, which include those with:

- chronic heart disease,
- lung disease (including asthma),
- renal disease or diabetes,
- chronic liver disease
- immunosuppression.

It also includes those who are the main carer for an elderly or disabled person whose welfare may be at risk if the carer falls ill

A new campaign to immunise persons aged 65 and over against influenza was introduced in 2000-01. Locally in Medway, HPA data is available for the Medway PCT area. This shows 76 per cent of those aged 65 and over received influenza vaccinations in 2005-6.

Tackling the issues

General practitioners are encouraged to improve on last year's uptake for those aged 65 and over and those in 'at risk' groups under 65 years of age.

Pneumococcal immunisation

The pneumococcal immunisation programme was launched in August 2003, to offer the 'pneumo' vaccine to older people. This vaccine offers protection against serious pneumococcal infections such as pneumonia, meningitis and septicaemia (blood poisoning), which can be particularly serious in older people.

Nationally the pneumococcal immunisation programme was first launched in August 2003, starting with people aged 80 years and over as at 1 April 2000. From 1 April 2004 it was extended to all people aged 75 years and over. The surveillance carried out in 2003 was to establish a baseline level of cover. Vaccine coverage data is now being collected annually to monitor the impact of the immunisation programme on pneumococcal disease and measure the effectiveness of the vaccine in preventing infection

Within Medway, 23.8 per cent of those aged 80+ received pneumococcal vaccinations in 2004-05.

Tackling the issues

All health professionals can promote the use of the vaccine in groups deemed eligible for the vaccination. The best way to ensure high uptake is for a health professional to advise on the need for the vaccine. GPs and practice nurses supported by other practice staff can promote the vaccine throughout the year and the practice should plan the campaign early. Community pharmacists could also encourage vaccination among patients receiving prescriptions for medicines that makes them eligible for the vaccination.

7. Deaths from the major killers

Cancer

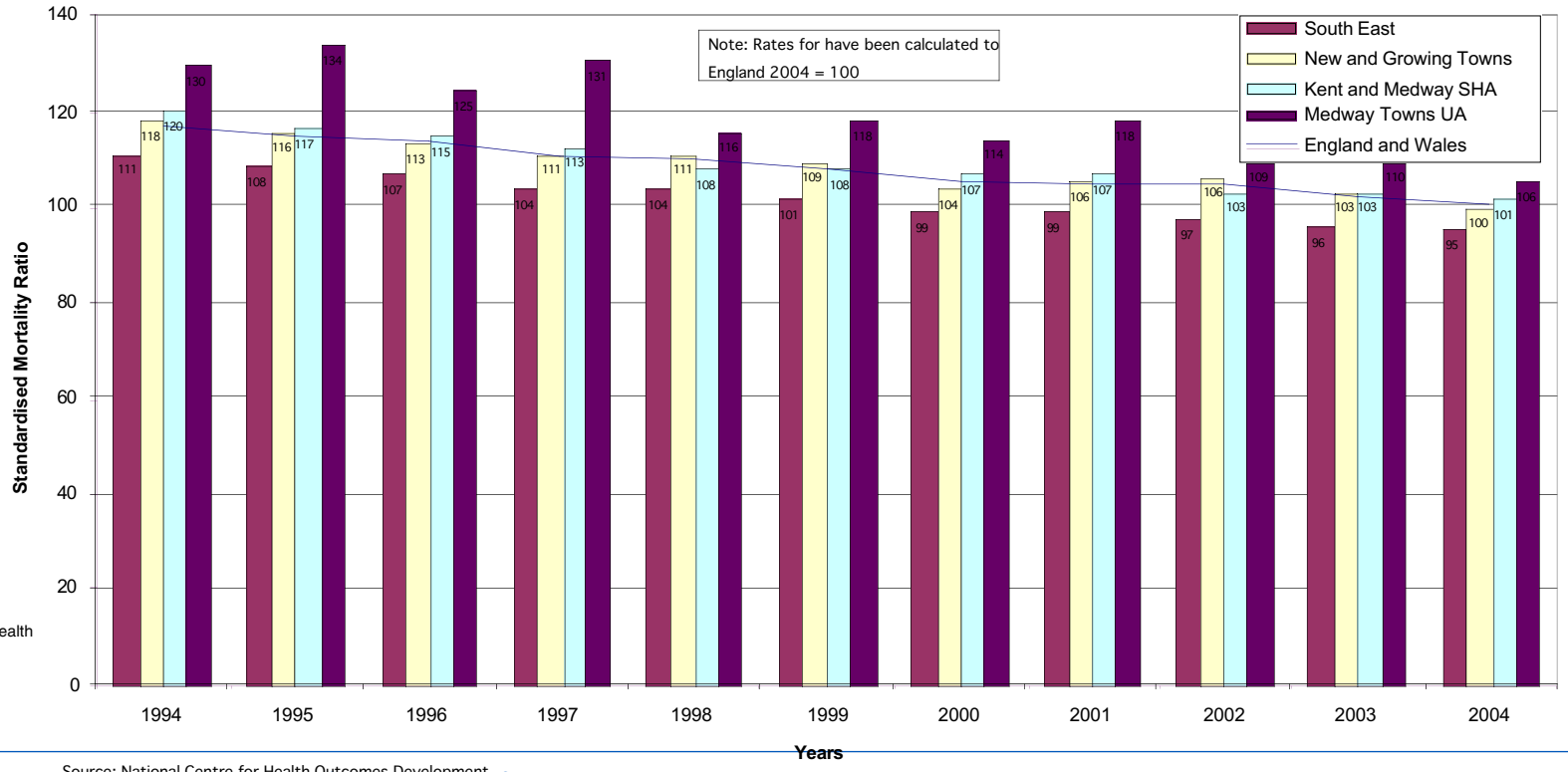
Nationally the death rate from all cancers has been falling year-on-year for the last decade. The Government has long recognised the importance of reducing cancer deaths, including cancer targets in Health of the Nation, Our Healthier Nation and the NHS Cancer Plan. There is a huge variation in cancer incidence, mortality and survival by gender, age, and deprivation.

In Medway about 311 people under 75 years of age die from cancer each year, representing about 37 per cent of all Medway deaths in this age group. Reducing the number of people dying from cancer will have a significant impact on increasing life expectancy. The SMR from all cancers is higher for Medway than both nationally and the southeast.

Medway PCT and hospitals are fully engaged in the Kent and Medway Cancer Network to ensure that National Cancer Plan targets are delivered. Deaths from both cancer and coronary heart disease (CHD) will be impacted by both prevention programmes and by interventions aimed at smoking reduction, healthy eating and exercise. As discussed earlier, these are major elements of activity for many agencies in Medway.

The Wisdom Hospice teams are involved in the care of many patients who have complex problems from any stage in their disease. Patients requiring specific types of chemotherapy are now able to have some of their care at home rather than in hospital, improving the quality of their lives.

Standardised Mortality Ratio, persons, all ages, from All Cancers (ICD9 140-208 adjusted, ICD10 C00-C97)
for Medway UA, Kent and Medway Strategic Health Authority, New and Growing Towns, South East and England and Wales
Years 1994-2004



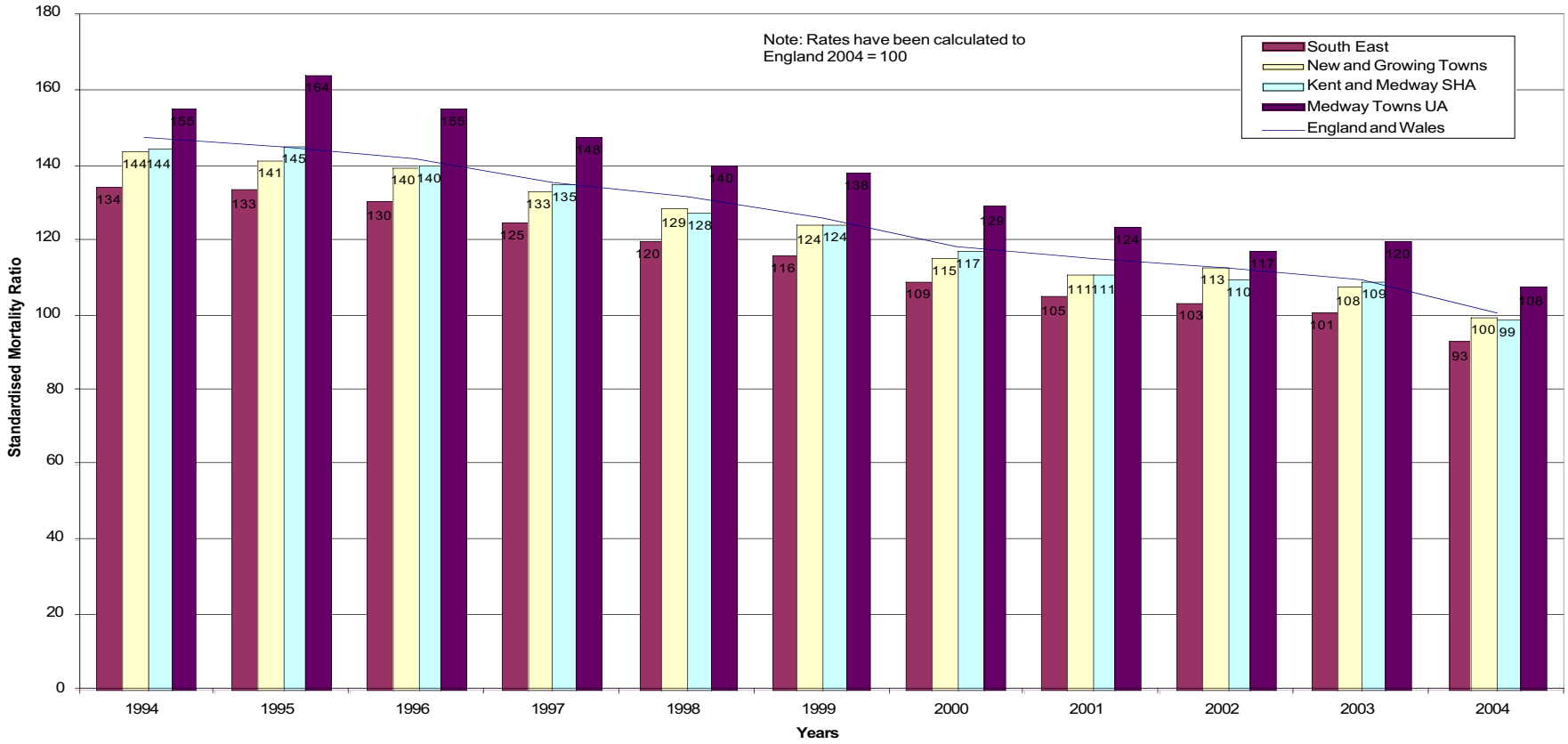
Source: National Centre for Health Outcomes Developments

Source: National Centre for Health Outcomes Development

Circulatory disease

The national target is to reduce death rates from circulatory disease (principally CHD and Stroke) by at least 25 per cent in people under 75. More than 800 people of all ages die of circulatory disease in Medway each year. About 255 people are under 75. Of these about 146 die from CHD and 45 die from stroke.

Standardised Mortality Ratios, persons, all ages, from all Circulatory Disease (ICD9 390-459 adjusted, ICD10 I00-I99)
for Medway UA, Kent and Medway Strategic Health Authority, New and Growing Towns, South East and England and Wales
Years1994-2004



Source: National Centre for Health Outcomes Development

Tackling the issues

Our Healthier Nation and the CHD National Strategic Framework highlight the significance of reducing CHD and stroke mortality to the government agenda to save lives and increase life expectancy.

The Medway death rate from all circulatory disease in people under 75 has reduced by over 33 per cent since 1995-97. The Medway SMR continues to be above the southeast and national rates.

Coronary heart disease (CHD)

A significant number of people in Medway have long-term conditions relating to CHD. A large part of the role of specialist teams in the community is tertiary prevention, as follows:

- CHD prevention programmes are currently running, comprising a wide range of initiatives aimed at reducing smoking prevalence, promoting healthy eating and encouraging people to take more exercise.
- Accurate and up to date CHD registers are being developed in primary care to improve secondary prevention among patients with established CHD.
- Appropriate and speedy access to diagnostics services for chest pain, angina, heart failure are in place.
- The cardiac rehabilitation service.
- The Kent and Medway CHD collaborative programme is being used to support further service improvement work in Medway

The PCT and other organisations support this work in a number of ways:

- ensuring referral protocols are followed
- maintaining accurate and up to date practice based CHD registers
- Rehabilitation programme - patients who have had heart attacks are encouraged to attend the programme which supports and encourages them to change their lifestyle and to self manage their condition and recovery.
- Heart failure team identify and support patients to better manage their disease
- Quality and Outcomes Framework encourages GPs to identify and register all patients with coronary heart disease
- Guidelines for GP practices to enable them to managed uncomplicated disease effectively

A more pro-active CHD prevention approach is required in order to identify people who wish to change their lifestyle behaviour.

Stroke

The recognition of the burden that Stroke illness places upon the individual is well documented in the NSF for Older People, Standard 5. The broad aim of standard 5 is to reduce the incidence of stroke in the population and ensure that those who have a stroke have prompt access to integrated stroke services. Medway stroke team already demonstrates many of the features required to achieve the NSF standard 5 milestones by working collaboratively.

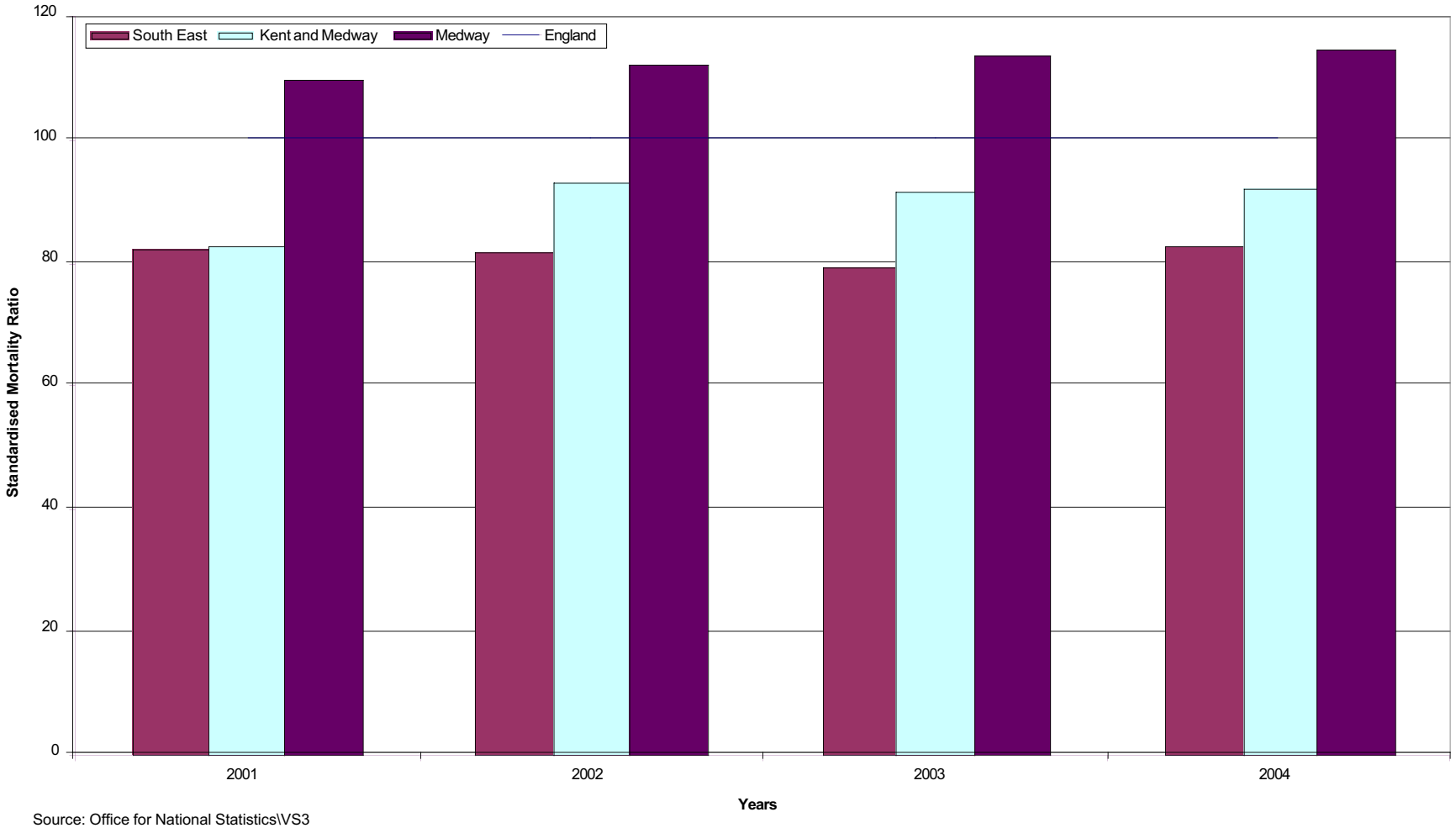
Four key components provide a framework to deliver the stroke agenda, prevention, immediate care, early and continuing rehabilitation and long term support. The risk factors for stroke are the same as those for CHD, and therefore the various CHD initiatives apply equally to stroke prevention.

In addition, there is a significant role for all primary care clinicians in the effective access and use of data collection and retrieval. We will continue to develop awareness of referral and treatment pathways

Respiratory disease

In Medway about 77 people under 75 years of age die from respiratory disease each year, representing about 9 per cent of all Medway deaths in this age group. Reducing the number of people dying from respiratory disease will have a significant impact on increasing life expectancy. There is a huge variation in respiratory disease incidence, mortality and survival by gender, age, and deprivation. Medway has an SMR for respiratory disease which is higher than both the South East and nationally.

Standardised Mortality Ratios, persons, ages under 75, from Respiratory Disease (ICD10 J00-J99)
for Medway UA, Kent and Medway Strategic Health Authority, South East and England
Years 2001-2004



Source: Office for National Statistics\VS3

The Quality and Outcomes Framework encourages GPs to identify and register all patients with respiratory disease. Guidelines for GP practices will enable them to manage uncomplicated disease effectively. The Respiratory team will identify and support patients with chronic respiratory disease to better manage their disease

Services across all areas

For all the major killers, the following are key service areas.

- End of Life - National project focusing on tools to improve quality of care in patients towards the end of their lives. The Liverpool Care Pathway focuses on the last few days of life, and has been implemented in most wards in acute hospital and several nursing homes

- A Gold Standard Framework focuses on the last few months of life, encouraging GP practices to overtly identify patients and employ multidisciplinary team decision making in managing their care

- The Expert Patient Programme (Staying Well) is a programme for people living with long term conditions that supports and enables them to self manage their condition and use health and social care services effectively.

- Community matrons are working with the specialist teams in relation to long-term conditions and enabling patients with multiple pathologies to access services and self manage their conditions and access services appropriately.

Source: NHS picture library

Recommendations

- We should strengthen health improvement awareness and skills across health and social care and other partnerships with voluntary and business sectors, schools and community organisations

- We should continue to work together with the wider workforce and the community in Medway to ensure we have the capacity and expertise to delivery and support the challenging health improvement agenda that will lead to significant decrease in ill health and reduction of health inequalities. This is needed particularly in the area of skill development to support prevention and reduction of obesity, mental health promotion and harm reduction from alcohol.
- We should continue the development of the concept and reality of health trainers, providing a sustainable local resource , embedded in the community, that supports and empowers individuals and groups to fully engage in taking personal responsibility for their own health and futures.

- We should aim to support the local substantial local NHS and council workforce to improve their health and well being through the provision of healthy lifestyle opportunities and encouragement in areas such as smoking cessation, weight management and physical activity, this is likely to have a significant effect on mental well being and subsequent capacity to reduce sickness rates.

- We should ensure that robust and effective monitoring and evaluation and public health research takes place to make sure we are confident that interventions are taking place are effective and targeted where they will not only make a difference to recipients but contribute to 'minding the gap'

- We should continue to increase the use of public health skills, information and intelligence to support commissioning and service delivery and particularly the operation and development of Practice Based Commissioning.

- We should utilise the opportunity offered by the LAA to bring together alliances and partnerships for cross sector and community working to improve health in Medway.

- We should use the opportunity of the regeneration and increasing economic development of Medway to synergise old and new communities, using this momentum for health improvement for all.

- The annual report of the Director of Public Health should continue to be promoted and used as an essential tool in Medway to inform planning, monitoring and development

Appendix 1 - Glossary of terms

Abortion
The expulsion or removal of an embryo or foetus from the uterus incapable of independent survival (ie at any time between conception and the 24th week of pregnancy).

Coronary artery bypass grafting (CABG)
A major surgical operation in which the blood supply to the heart is restored by replacing blocked arteries with arteries usually taken from the chest wall

Coronary heart disease (CHD)
Damage to the heart. Not enough blood flows through the vessels because they are blocked with fat or have become thick and hard, this harms the muscles of the heart.

Confidence intervals
A statistical measure which gives a range of values within which we expect the true variable in question to lie with a given level of certainty, e.g.95 per cen t

Incidence
The number of new cases of a disease that occur in a defined population within a specified time period, usually a year.

Indicators
An indicator suggests or shows something, for example the national indicator for teenage conceptions is the number of teenage conceptions per 1,000 women aged 15-17 years.

Infant mortality
Death in the first year following live birth; on or before the 365th day of life

Infant mortality rate
The number of deaths under the age of one year following live birth, per 1000 live births per year

Life expectancy at birth
This gives an estimate of how long someone is expected to live based on current mortality rates for an area.

Local strategic partnership
A non-statutory single body that operates at a level that enables strategic decisions to be taken. Includes health and local authorities but also the business, community and voluntary sectors.

Low birthweight
A child born weighing less than 2.5 kg

Neonatal
Period of infancy between birth and 27 completed days of life.

Neonatal mortality rate
The number of deaths in the first 27 completed days of life per1000 live births per

Mammography
The making of infrared ray photographs of the breast. It is used for the early detection of abnormal growths.

Mortality
The number of deaths caused by a disease that occur in a defined population within a specified time period, usually a year.

Obesogenic
Factors tending to create obesity, particularly in the sense of an obesogenic environment.

Perinatal
Period of infancy between 24 weeks of gestation and six completed days of life

Perinatal mortality rate
Number of stillbirths together with deaths up to six completed days of life per 1000 total births per year age group

Rehabilitation
The treatment of an ill, injured or disabled patient with the aim of restoring normal health and function or to percent the disability from getting worse.

Practice based commissioning (PBC)
PBC is about engaging practices in the commissioning of services.

Resident populations
Population residing in a defined geographical area

Revascularisation
Reestablishment of blood supply to the heart. The two most widely used techniques for restoring blood flow are coronary artery bypass surgery (CABG) and percutaneous transluminal coronary angioplasty (PTCA).

Screening
Screening aims to reduce the risk of disease, premature death or disability. Members of a defined group are asked a question or offered a test in order to identify those at risk of disease so further definitive tests can be offered.

Stillbirth rate
Number of stillbirths per 1000 total births per year

Stillbirths
The legal definition in England and Wales is 'a child which has issued forth from its mother after the 24th week of pregnancy and which did not at any time after being completely expelled from its mother breathe or show any signs of life'

Sudden infant death syndrome (SIDS)
May affect infants of any age, but some risk factors have been identified such as premature infants of low birth weight, siblings of infants who have succumbed to sudden infant death syndrome.

SureStart
This is a Government programme which aims to achieve better outcomes for children, parents and communities by increasing the availability of childcare for all children, improving health, education and emotional development for young children

Target
A goal or objective that has been set locally or nationally. We aim to meet the target within a specified time scale.

Uptake
The percentage of eligible women who attend for screening. The effectiveness of the breast screening programme is based on a minimum of 70 per cent

World Health Organisation (WHO)
WHO's objective is the attainment by all peoples of the highest possible level of health.

Appendix 2 - Community Health Profile: Medway

Health summary

How to interpret:
First look at the circle which shows how this local authority is doing, compared with the England average (central line), best (right side) and worst (left side). Look at the numbers, values and time periods in the columns. Some numbers shown are totalled over more than 1 year. Red is significantly worse and amber significantly better than the England average (95% confidence intervals used for the local data). Amber may still indicate a significant public health burden. A clear circle is not significantly different from the England average. Then, compare with the regional average (+ symbol), and the range for similar areas - New and growing towns (— ONS Group cluster range).

Domain	Indicator	No.	Value		Medway	Period	Notes
Our communities	Deprivation	16,300	6.5	%		2001	1,2
	Air quality*					2001	2
	Poor quality housing*	656	20.6	%		01.04.05	3,10
	Children in poverty*	11,179	20.0	%		2001	2
	GCSE achievement (5 A*-C)*	1,634	61.9	%		2004/05	
	Violent crime	4,160	16.6	CR1		2004/05	
	Older people supported at home*	2,626	80.1	CR2		31.03.05	4
Giving children and young people a healthy start	Smoking in pregnancy						5
	Breast feeding						5
	Obese children*						5
	Physically active children*						5
	Teenage pregnancy (under 18)*	681	43.8	CR3		2001-03	
The way we live	People who smoke*		27.4	%		2000-02	6
	Binge drinking		16.2	%		2000-02	6
	Healthy eating		22.1	%		2001-02	6
	Physically active adults						5
	Obese adults		23.2	%		2000-02	6
How long we live and what we die of	Life expectancy - Male*		75.9	yrs		2002-04	
	Life expectancy - Female*		80.2	yrs		2002-04	
	Deaths - smoking	1,142	136.6	DSR1		2002-04	
	Early deaths - heart disease & stroke*	766	104.7	DSR2		2002-04	
	Early deaths - cancer*	933	129.6	DSR2		2002-04	
	Infant deaths (under 1 year)*	69	7.3	CR4		2002-04	
	Road injuries and deaths*	193	7.2	CR5		2003-04	7
Health and ill health in our community	Feeling "in poor health"	18,286	7.2	DSR3		2001	
	Mental health treatment	812	0.3	%		2005	8
	Alcohol related hospital stays	1,392	111.2	DSR4		1998-03	
	Drug misuse treatment*	634	589.8	CR6		2004/05	9
	People with diabetes	8,604	3.3	%		2005	9
	Children's tooth decay		0.8	DMFT		2003/04	10,11
	Sexually transmitted infections						5

England Worst — England Average — England Best

+ Regional average — Cluster range

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

Notes

Full indicator information in metadata report, see www.communityhealthprofiles.info

Notes

1. No. and % of people in this area living in the 20% most deprived areas of England. **2.** No significance is calculated for this indicator. **3.** No data for authorities that have undertaken large scale voluntary transfer (LSVT). **4.** Data only available for County/Unitary Authorities/London Boroughs; data presented at District Authority level is County data. **5.** GAP indicator - no data currently available, but will be provided when it becomes available. **6.** Synthetic estimates derived from the Health Survey for England. **7.** New indicator - People killed or seriously injured per 100 million vehicle kilometres. **8.** High rates considered 'better' as reflects better service provision. **9.** High rates considered 'worse' as reflects high prevalence. **10.** Data incomplete or missing for some areas. **11.** DMFT: Average no. decayed, missing or filled teeth.

Key

* Supports PSA Targets 2005-2008.
DSR1 Directly age standardised rate / 100,000 population; **DSR2** Directly age standardised rate / 100,000 population under 75; **DSR3** Directly age standardised percentage; **DSR4** Directly age standardised rate / 100,000 population; **CR1** Crude rate / 1,000 population; **CR2** Crude rate / 1,000 population aged 65 or over; **CR3** Crude rate / 1,000 female population aged 15-17; **CR4** Crude rate / 1,000 live births; **CR5** Crude rate/ 100 million vehicle kilometres; **CR6** Crude rate / 100,000 resident population aged 15-44; **CR7** Crude rate / 100,000 resident population.

Source community health profiles, (APHO and Department of Health) Produced by APHO with interpretation by SEPHO, (c) Crown Copyright 2006.

Published by
Medway Primary Care Trust
7-8 Ambley Green, Bailey Drive,
Gillingham Business Park, Gillingham
ME8 ONJ, tel: 01634 382777,
and
Medway Council
Civic Centre, Strood, Rochester, Kent
ME2 4AU tel: 01634 333333

Medway NHS
Teaching Primary Care Trust

Medway Council
Serving You