

Choosing Health in Medway

The Annual Report of the Director of Public Health 2004



As Chair of Medway Teaching Primary Care Trust I welcome the first Annual Health Report of our Director of Public Health, Dr Anita Sims. As part of our National Health Service, Medway PCT has two major objectives:-

- to improve the health of the people of Medway, and
- to reduce health inequalities in our communities

If we are to achieve these objectives we need a base from which to start and an effective plan of action. This Annual Report forms the foundation on which this process is based and Dr Sims, as a member of Medway PCT's Board, will be instrumental in guiding the continuing development of our health policies by helping us ensure that priorities are determined by reference to it.

Healthy communities can only be achieved by consensus and with people and organisations working together effectively. We have achieved significant success already in this, particularly in terms of our integrated working with Medway Council. I am delighted with the support of Medway Council and the commitment of staff to this process in both organisations and look forward to the continuing development of these arrangements which are so crucial to the well-being of our community.

Eddie Anderson
Chairman Medway PCT



I am very pleased to have the opportunity to contribute to the first Annual Health Report of the Director of Public Health since 1991.

The importance of health, a feeling of well-being and an active, healthy lifestyle cannot be underestimated.

As Leader of the council I recognise the local authority's contribution to public health. Action on health inequalities is fundamental in promoting healthy communities. Our services begin to address the root causes of ill health through housing provision, benefit advice, lifelong learning, sports development, social services and environmental protection.

We must work with the NHS to have a more co-ordinated effort. This Annual Health Report provides us with an important start in this process as it paints a picture of the health of local people in Medway.

Cllr Rodney Chambers
Leader Medway Council



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Preface

I am pleased to present the Annual Public Health Report (APHR) for Medway for 2004. This year's report is looking at a wide range of issues which impact on and describe health and well being from infancy to old age. The report compares the local picture of the community in Medway with the national picture and examines how the Public Health White Paper, "Choosing Health" will support us to work with each other to improve the health of the community in Medway.

We have found unacceptable inequalities in health in some areas and have made recommendations to tackle them. These recommendations are for local health services, Medway Council, voluntary sector partners and everyone who lives or works in Medway. Introducing these recommendations will make a difference to health and social well being in Medway. The recommendations are consistent with, and add weight to the overall aims of the Medway Community Plan.

I am grateful to the Public Health Team and others who have worked together to produce this annual report. I hope it will be a valuable resource to all agencies and individuals working on health issues in Medway.

Dr. Anita Sims

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

September 2005



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Introduction

This is the first public health report of the Director of Public Health of Medway for some years. The last report was in 1991 when Medway Health Authority was one of four health authorities (the others were Tunbridge Wells, Maidstone and Dartford) which came together in 1992/3 to form the West Kent Commissioning Agency, the forerunner to West Kent Health Authority. Medway PCT was formed in April 2002 from three Primary Care Groups (PCGs), Rainham & Gillingham, Rochester & Strood and Chatham & Walderslade.

Following my appointment as joint Director of Public Health for Medway PCT and Medway Council in Summer 2004, a Public Health report is being presented for Medway once again.

What is Public Health?

'Public Health is the science and the art of preventing disease, prolonging life and promoting health through the organised efforts of society' (Acheson Report, 1998)

Public Health is concerned with improving the health of the population or community rather than treating individual patients,

'Society does not consist of individuals but expresses the sum of interrelations, the relations within which these individuals stand',

There are a number of strands to Public Health:

- Health protection and prevention, e.g. preventing disease by immunisation or helping to create safe clean environments for people
- Health promotion/ health improvement, tackling some of the underlying influences in health such as poverty and unemployment or more specific effects in health such as smoking and excessive drinking
- Maintaining or restoring health supporting, high quality social care and health services

For all this to happen Public Health needs to operate at many levels, from a local neighbourhood, to GP practice level, to a national or even international level. It also needs to involve a wide range of people and organisations. For some people it will be a large part of their role, and for some it will be a small part of their role, for others it will just be a case of their role benefiting from an awareness of Public Health. It is important to remember that it is not just people within health that have a role in Public Health but across organisations such as housing, education, transport, local business and the voluntary sector.

What is this Report?

The purpose of this report is to give a picture of the health of the people of Medway and highlight specific issues for those at higher risk of ill health i.e. local health inequalities. This information can then be used to shape services which will ensure effective action is taken which in turn ensures services are aimed at those most at risk. In following years the report will be used to check progress in improving local health and reducing health inequalities.

This report is important for all those who can make a difference to the health of local people and is especially aimed at the local NHS and Medway Council. It can be used by services to think about the health issues they affect and what they are doing that improves health or at least minimises any harm. More widely, the Annual Public



Health Report (APHR) could be used by anyone in Medway to understand local health issues and then think about what they can do to promote better health for themselves, their families and their communities.

What is health?

Different people and groups understand health in a variety of ways. In any planning for health it is important to have a clear and common understanding of what health is. A useful definition is:

Health is the extent to which an individual or group is able to:

- Satisfy basic human needs
- Change or cope with their environment
- Realise aspirations.

*So 'Health is a resource for everyday life and a positive concept emphasising social and personal resources as well as physical capabilities'*¹

Health allows people to 'be all they can be' irrespective of differing capabilities, experiences or cultures. It can apply to a person who uses a wheelchair, someone who has limited intellectual capacity or a world class athlete. This definition of health has some key aspects.

Being able to:	Aspect of health
Undertake your work or other regular daily activities e.g. cooking and cleaning, looking after the children	Role functioning
Join in social activities with family, friends, neighbours or other groups	Social functioning
Carry out basic physical tasks e.g. climbing the stairs, walk to the shops, bathing or dressing yourself	Physical activity
Not feel bodily pain or have pain interfere with daily life	Pain
Feel peaceful and happy rather than down in the dumps, sad or nervous	Mental health
Feel full of life rather than tired and worn out	Vitality

These aspects can only be interpreted by understanding the perceptions of a person about their limitations compared to their expectations. Health is personal to each one of us. The levels of health aspects in a population can only be known by asking people for their perceptions, through the types of surveys reported here, such as the Medway Young People's lifestyle survey and the 2001 Census.

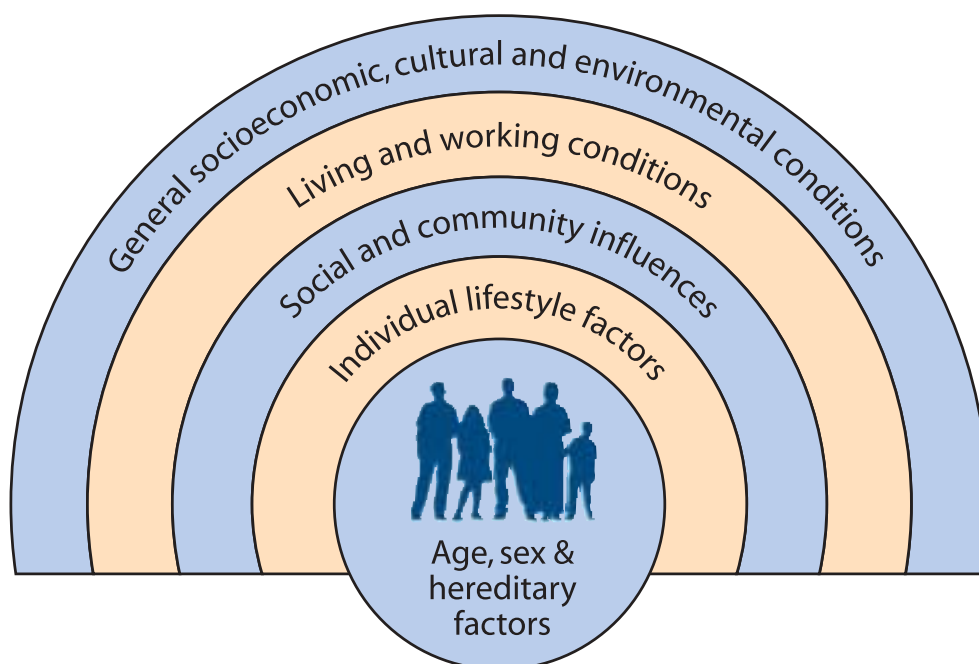
What are health inequalities?

It is well recognised that there are wide gaps in the levels of good health experienced by different groups. Where health differences are unnecessary and avoidable and considered unfair and unjust, then they are described as health inequalities.²

The crucial test of whether the gaps in health between people are health inequalities is the extent to which people have:

- control over factors that **prevent** their ill health
- **opportunities** to control such factors.

Research has repeatedly shown that good health relates to a range of factors as shown in the Rainbow Model ³



There are:

Biological factors which can be identified as psychological and physical factors e.g. genetic makeup, personality disorder, allergy, or high blood pressure.

Personal behaviours such as exercise, diet, smoking and use of mind altering drugs.

Social and community networks including friendships, family relationships, and some of the cultural aspects of the communities in which we live.

Living and working conditions are structural factors which include:

- *housing*: adequacy, overcrowding, affordable, heating
- *safety*: in homes, and on roads, workplaces and crime
- *physical environment*: air, water, noise, waste disposal, land use, quality of buildings, natural habitats, safe open spaces, leisure outlets, affordable shops (especially food items)
- *employment*: opportunities for jobs, working conditions, unemployment, different types of transport
- *health care*: easy and accessible
- *education*: information, availability of advice
- *wealth creation and distribution*; including levels of income.

Socio-economic, cultural and environmental policies that impact on health, both locally and nationally, affect the above local living and working conditions. Such factors tend to cluster together and reinforce each other. This makes some groups mentioned above very vulnerable to ill health and disease, (such as older people, people with a chronic disease and people with a lower than average income). These factors are important because many of them can be changed for better or worse by local or national action. In tackling the factors and diseases, it is

important to target three types of action to prevent ill health. These are called levels of prevention of ill health.

Levels of prevention

- | |
|---|
| 1. Preventing ill health occurring by reducing factors that can result in ill health e.g. not smoking, taking regular exercise. |
| 2. Detecting and treating ill health, so preventing it recurring. For example detecting hidden depression, treating it with drugs and tackling the other factors that contribute to the depression. |
| 3. Preventing the consequences of ill health by reducing the risk of negative factors or other diseases arising as a result of ill health. For example someone with heart disease is not able to carry out responsibilities either at work or at home. This could result in loss of income or getting into relationship difficulties and possibly depression. |

National policy context of health inequalities

A key national priority is to tackle health inequalities through a range of plans:

Independent inquiry into inequalities in health: The Acheson Report (1998). This reviewed the causes of health inequalities and set out 39 recommendations for tackling them, with four main priorities. It stated that all policies likely to have a direct or indirect effect on health should, be looked at and be formulated to favour less well-off people. Priority should be given to the health of women of childbearing age, expectant mothers and young children. And further steps should be taken to reduce income inequalities and improve the living standards of poor households.

Our Healthier Nation: A contract for health (1998) Saving Lives: Our Healthier Nation (1999). A Green Paper pledged to increase 'the length of people's lives and the number of years people spend free from illness' and to 'improve the health of the worst off in society and to narrow the health gap'. Targets to reduce premature deaths from cancer, coronary heart disease and stroke, accidents and mental health would be met through a 'contract' between individuals, local communities and national government, working in three settings - healthy workplaces, healthy schools and healthy neighbourhoods. A White Paper presented a strategy of NHS-related measures intended to meet the four targets set out in the earlier Green Paper, with numbers of deaths to be avoided and specific dates.

Tackling Health Inequalities: A Programme of Action (2003). This set out plans to achieve targets to reduce inequalities in health outcomes by 10 per cent by 2010, measured by infant mortality and life expectancy at birth. It identified a range of initiatives on education, welfare-to-work, housing, neighbourhoods, transport and the environment that will help improve health.

Securing Good Health for the Whole Population (2004).

The second of two reviews commissioned by the Treasury from former banker Derek Wanless, explored evidence-based ways of realising a 'fully engaged scenario' in which priority is given to preventing illness and individuals are

committed to safeguarding their own health. In his first review, Wanless had calculated that failure to shift towards this scenario would cost some £20 billion extra in annual healthcare costs by 2020.

Choosing Health? The Public Health White Paper 2004.

Early in 2004, just before the publication of the second Wanless review, Health Secretary John Reid announced a major consultation, entitled *Choosing Health*, which would lead to a public health White Paper later in the year. The Public Health White Paper was published in November 2004. In March 2005, the Government released its implementation plan for *Choosing Health*, its Public Health White Paper. It shows a new sense of urgency about the need to prevent illness, and a new focus on personal choice and changing individual lifestyles and behaviour.

What is in the White Paper?

Choosing Health signalled the Government's intention to refocus the NHS into a service for improving health as well as one that treats sickness. Health improvement and tackling health inequalities will become an integral part of NHS, mainstream planning and performance systems and will be at the core of its day-to-day business. *Choosing Health* highlights action over six key priorities for delivery which are based upon more people making healthy choices:

1. Tackling health inequalities
2. Reducing the numbers of people who smoke
3. Tackling obesity
4. Improving sexual health
5. Improving mental health and well-being
6. Reducing harm and encouraging sensible drinking

Action will be taken across Government on:

- Helping children and young people to lead healthy lives
- Promoting healthy and active life amongst older people

Delivering these priorities will depend on four supporting strategies:

- Promoting personal health
- Developing the workforce
- Building in research and development
- Using information and intelligence

Local and Central Government have already agreed 'shared priorities' where Local Government can make a real difference to communities and contribute to the Government's national priorities, including:

- Creating safer and stronger communities
- Improving the quality of life of older people and children, young people and families at risk
- Promoting healthier communities and narrowing health inequalities
- Promoting the economic viability of localities and getting people back into work
- Transforming the local environment



We have a national plan that clearly focuses on those most at risk and sets out priorities for national and local action. PCTs working in partnership with the local authority and many others now have the major role in tackling health inequalities using the priorities of Choosing Health. This report provides a first step by opening a view of the health of the local community. It can be used as a starting point for many local activities and initiatives in understanding local health inequalities and reducing them through working towards achieving the national targets.

What is in this Report?

This report gives information about the size and context of health issues in Medway and uses a life cycle approach i.e. it examines life and health in Medway for people during the three major stages of life:

- Children and young people
- The economically active (working age)
- Older people

Each chapter has information, analysis and interpretation about the following:

- 1 Demography, resources and environments, health and illness
- 2 Lifestyle
- 3 Current initiatives that support health improvement
- 4 Key 'Choosing Health' targets
- 5 Recommendations

The data comes from a variety of sources, either routinely collected or from local surveys.



Medway: the past and the future influences on health

Setting the annual public health report in context

*'A place has an influence on the people who live within its bounds, whilst these people leave their mark on a place's geography. The relationship between people and place changes with time, with humans being the main instrument of historical change. This influence of a population on its environment has the potential to be either positive or negative'*³

The understanding of how health is now in Medway can be improved if its history is examined, as it reveals the complex nature of the social, cultural, political and economic status that frame a particular problem or even a specific disease. This could inform tackling of many of these problems in a more efficient way, e.g. understanding a problem within a wider time span helps to explain the current situation.

Environment & Health:

The essential link between human health and well-being and the environment has long been recognised. The Hippocratic tradition, as early as the 5th century BC recognised that health and disease were affected by season and quality of environments. Environmental threats to human health have tended to arise from issues of underdevelopment (inadequate water quality, the lack of sanitation and poor housing). Whereas modern threats are a result of over consumption and pollution associated with unsustainable development. However, 'traditional' threats while generally adequately managed in the more affluent areas of developed countries can still exist for socially disadvantaged and disenfranchised sub-groups.⁴

The five key environmental determinants of health are:

- Air
- Water
- Land
- Food
- Biodiversity

The River in Medway

The social, and later, the industrial history of Medway has close links with the River Medway and, to a lesser degree, the River Thames and estuary. The River Medway stretches about 70 miles from the High Sussex Weald to the Thames Estuary. Over the ages the River Medway has provided access to the interior of Kent for various waves of invaders or settlers. Originally, the Medway valley was heavily wooded with dwellers living near the edge of the forest and beside the river. Lining the course of the River Medway are areas of coastal marshes and inter-tidal mud flats. Historically these have been an important resource for the area's residents, not only providing a rich and varied source of food, fish, eels, oysters and wildfowl but also serving as the location of early industrial activity such as salt making and pottery. It also provided an important area for sheep grazing, whilst the rich soil of the Medway valley provided an area for growing corn.

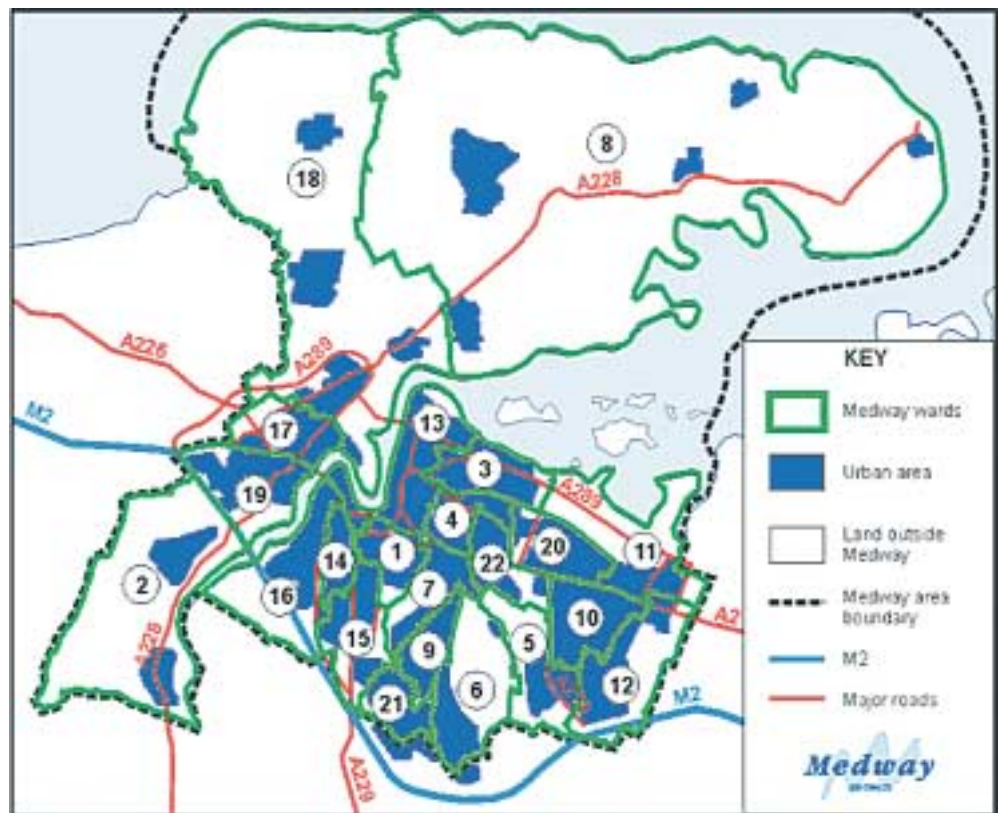


*'The crossing of the river at Rochester established its importance, whilst a regular waterborne trade on the river developed especially downstream where the accessible lower reaches provided safe anchorage of the English navy. The Storehouse was set up by Henry VIII in 1547 to serve the large number of ships moored in 'Jillingham Water'. Over the next hundred years this became transformed into the Chatham Dockyard with facilities for the building, refitting and provisioning of warships. Although employing hundreds of people in peacetime, work could be hard to find, and many Naval Commissioners refer to the near-starving condition of the men.'*⁵

An enormous extension into St Mary's Island was begun in 1864 and finally finished in 1885. The maximum total number of workers employed reached 11,000 men and 2,000 women during World War Two. Following the war the Dockyard was restricted to the building of submarines and of refitting ships. Despite the opening of facilities for nuclear submarines the Dockyard closed in 1984, meaning many thousands of people were out of work. However, by 1997 local unemployment seemed to have recovered and stood at 5.5%, which was below the UK average.

The Medway Towns

As industry and commerce expanded, the settlements in which people lived, worked and traded began to expand. The Medway towns may well have emerged as Britain's first conurbation during the period 1791-1850 with the amalgamation of Strood, Rochester, Chatham, Gillingham and Rainham. Along the River Medway the present landscape is a mosaic of dense urban development, commerce and industry interspersed with tracts of rural countryside and marshland.



The Medway Towns saw further rapid expansion during the latter half of the nineteenth century. The issues of health were of ever-increasing importance to urban populations during the nineteenth century. The establishment of asylums

and hospitals ran in parallel with the creation of other institutions such as prisons, workhouses and schools. They were ordered by Parliament to tackle increasing social problems.

Throughout the 19th century there had been proposals to join the Medway Towns under a single local authority. By 1903 this began to happen with the creation of the Borough of Gillingham. In 1928, the adjacent parish of Rainham was added. Following the Local Government Act 1974 the City of Rochester, the Borough of Chatham and Strood Rural District Council were amalgamated to form Medway District Council, with Gillingham remaining separate. The name of this new body was changed in 1982 to that of City of Rochester-upon-Medway. Finally, in 1998, Medway Council was created when The City of Rochester merged with Gillingham Borough Council.^{6,7,8}

Medical Officer of Health Annual Reports:

The Local Government Board Act 1871 transferred to Local Government the sanitary and Public Health functions of the previous Privy Council Medical Department. For the two Public Health Acts of 1872 and 1875 established rural and urban sanitary authorities and made it compulsory to appoint Medical Officers of Health to advise them. Later legislation in 1894 established urban and rural district councils as health administrations which required associated Medical Officers of Health to publish Annual Reports. Some extracts from the Medway reports over the last hundred years are included in the following pages.

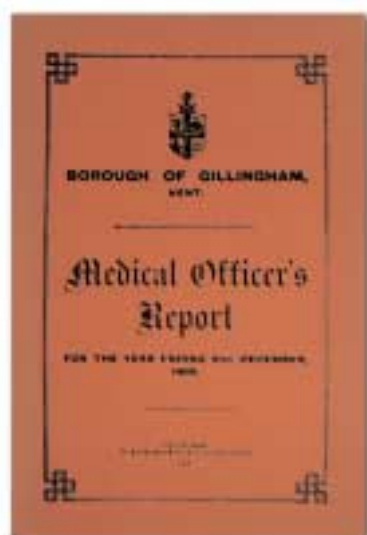
Medical Officer's Report to Gillingham Urban District - 1898

'It is my privilege to report to your council on the general sanitary condition of the Gillingham Urban District during the year ending December 31st 1898 to review the causes affecting the health of the locality and to summarise the action taken for preventing the spread of disease. It is gratifying to see the general desire amongst members of the council to rise to their responsibilities for the safeguarding of the public health.

The cardinal conditions of good sanitation are pure air, pure water, good drainage, wholesome food, proper clothing, suitable dwellings and a dry subsoil; and to endeavour to secure these benefits to the people whose interests they represent should be the prime aim of every council.

*Trusting your council will be satisfied with the information contained herein.
I remain, gentlemen, your obedient servant.*

E.C. Warren
Medical Officer for Health"



Borough of Gillingham, Kent Medical Officer's Report - 1905

Population estimate to middle 1905	49,600
Total deaths registered	599
Death rate per 1,000 population	12.0
Infant mortality per 1,000 population	3.9
Birth rate per 1,000 population	29.3

Number of deaths from zymotic (infectious) diseases

or those diseases which are caused by the reception into the system of a virus or poisonous principle and which acts like a ferment when diffused through the body.

Scarlet Fever	2
Typhoid (Enteric) Fever	9
Diarrhoea (including Enteritis)	59
Measles	6
Diphtheria	87

Zymotic death rate 1.7 per 1,000 population

Causes of, and age at, death

Cause	all ages	<1	year 1-5	5-15	15-25	25-65	>65
Measles	6	-	5	-	-	-	-
Whooping Cough	9	5	3	1	-	-	-
Diphtheria	9	-	5	4	-	-	-
Cancer	34	-	-	-	1	18	15
Alcoholism/ Cirrhosis of Liver	5	-	-	-	1	1	3
Venereal disease	1	-	-	-	-	-	1
Heart disease	21	1	-	3	2	10	5
Accidents	13	7	1	-	-	5	-
Suicides	3	-	-	-	-	-	3
All causes	5280						

'We have now but a very small proportion of houses not connected to main sewer, which is an immense improvement on the old cesspool system.'

'The underground urinal for both sexes in Gardiner Street is a great addition to the district and I trust in time is not far distant when the corporation will place more in various parts of the town.'

E.C. Warren, Medical Officer of Health'

Annual Report of the Medical Officer of Health Gillingham Borough Council 1955

Area in acres (land, inland and foreshore) 11,201

The birth rate remained the same as in the previous year, 13.9 per 1,000 of the civilian population.

The death rate was 8.4 per 1,000 of the civilian population and is the lowest recorded for the Borough.

The death rate for children under one year was 28.1 per 1,000 live births.

'As regards infectious diseases the year was a very healthy one. There were no cases of Diphtheria notified for the sixth successive year, Scarlet Fever cases showed a reduction on the previous year and there was one case of Poliomyelitis. Following the epidemic of Measles in 1953 only 11 cases were notified during the year and the number of Whooping Cough cases was fewer.'

Violence Deaths from motor vehicle accidents numbered 3
from Suicide 8
and from 'all other accidents' 12

Venereal Disease Special Clinic in Rochester

New Patients - Gillingham

	Male	Female	Total
Syphilis	4	6	10
Gonorrhoea	-	12	12
Non-venereal	38	17	55
Total	42	35	77

Malignant-Neoplasm lung, bronchus

	Male	Female	Total
	16	3	19

School Health Service

No. on School Roll	10,667
Periodic Cases examined	3,957
Total medical examinations	7,344

Nutrition

In accordance with the requirements of the Ministry of Education children examined at periodic medical inspections are classified as 'Good', 'Fair', or 'Poor'.

	Good %	Fair %	Poor %
1945	22.9	72.6	4.50
1954	71.39	26.49	2.12

Heights and Weights



Age	BOYS				GIRLS	
	No. Examined	Average Height	Weight	No. Examined	Average Height	Weight
		Inches	Lbs		Inches	Lbs
4-5 years	76	42.3	42.1	82	42.4	40.6
5-6	521	43.8	42.6	497	43.7	43.5
6-7	70	46.2	48.7	57	46.0	48.2
7-8	245	50.7	57.6	285	47.3	52.1
8-9	192	50.3	58.6	243	48.7	56.1
9-10	-	-	-	1	52.0	69.0
10-11	356	55.1	72.9	276	55.2	73.8
11-12	143	55.9	76.7	148	56.0	76.7
12-13	57	57.9	86.4	-	-	-
13-14	96	61.4	101.4	-	-	-
14-15	236	62.4	112.3	224	63.2	115.0
15-16	94	65.5	116.1	80	63.7	118.5

These figures show that in comparison with current measurements there were significantly lower levels of overweight children within a similar area for present day Medway.

Provision of Milk

Milk is provided free of charge to all school children. During December 8,496 children were supplied with milk each day. This represents 79.5% of the total number of children on the roll.

Annual Report on the health of the Rural District of Strood - 1955

Area of District 48,541 acres

Estimated mid-year resident population 22,190

The birth rate per 1,000 of the population shows a decrease to 15.09 compared with 16.4 for the previous year.

General death rate for 1955 was 9.19 per 1,000 of the population; the rate for 1954 was 8.2.

Infant Mortality for infants under one year of age was 23.89 and the rate for 1954 was 25.5.

Cancer and Smoking

NB Although fears about the effects of smoking were raised as early as 1858 in The Lancet, it was Sir Richard Doll, working with Austin Bradford Hill that made the first credible link between cigarettes and lung cancer in 1950. The first large-scale epidemiological study of the relationship between smoking and lung cancer was carried out by Professor Sir Richard Doll and Professor Sir Austin Bradford Hill and published in the British Medical Journal. Doll and Hill

interviewed 5,000 patients in British hospitals and found that of the 1,357 men with lung cancer, 99.5% were smokers. The discussion below illustrates the rising awareness and some early local investigation into the impact of smoking on health in Medway.

'Much publicity has recently been given to the connection between deaths from cancer of the lung and cigarette smoking. During 1955 11 people, all males, died from this cause. This compares with 1 in 1954 and 4 in 1953.'

4 were between 50 and 60

5 were between 60 and 70

2 were over 70

'I have been able to investigate the smoking habits of 10 of these people'

9 smoked cigarettes

3 were heavy smokers (more than 20 per day)

6 made their 'own' cigarettes

1 was a pipe smoker

Venereal Disease

Clinics

Rochester 36 New Road

New Cases

	Male	Female	Total
Syphilis	1	1	2
Gonorrhoea	4	4	8
Non-venereal	13	8	<u>21</u>
			31
Total no. of attendances			262

These figures are significantly lower than those for the current population for a similar area within present day Medway.

M.F. McDonnell, Medical Officer of Health

Sustainable Development:

Sustainable Development has been described as 'developments that meet the needs of the present without compromising the ability of future generations to meet their needs' - Our Common Future, Brundtland Commission Report 1987.

The central rationale for sustainable development is to increase people's standard of living and, in particular, the well-being of the least advantaged people in society but avoiding future damage and costs, i.e. it is a broad agenda which includes tackling social exclusion, and increasing prosperity, while improving and protecting the environment.

In February 2003 the Government published "Sustainable Communities: building for the future". This set out the policies, resources and partnerships that are needed to accommodate the economic success of London and parts of the south east as well as the need to alleviate the problems associated with the pressures on housing and services within existing towns and cities.

The Thames Gateway - is an area of land stretching from East London, 40 miles eastward towards the Thames estuary including parts of North Kent and South Essex, which has been identified as a national priority for urban regeneration.

Its boundary was drawn to capture the riverside strip that formerly hosted many land-extensive industries serving London and the south east, whose recent decline has left a large-scale dereliction and contaminated land. It contains some of the most deprived as well as affluent wards in the country and is characterised by mixed educational attainment. This reservoir of brownfield land has been recognised by successive Governments as having huge potential to act as a catalyst for regeneration and growth and for the social regeneration of the area, helping to alleviate some of the growth pressures on London and the south east and provide greater stability to the UK housing market and wider economy.

The task of co-ordinating the development of the Thames Gateway is organised under the direction of the Office of the Deputy Prime Minister. Today development will be largely delivered by the three Regional Development Agencies including the South East England Development Agency (SEEDA) as well as the national regeneration agency - English Partnership. In Medway the local council is the leading delivery unit.

Proposals for regeneration and responsible growth in the Thames Gateway identified strategic development locations which contain a high proportion of the Gateway's supply of brownfield land, and also offer good access to employment, supported by Government investment in transport and other infrastructure. Medway has been identified and included in this as an area, which has the capacity for significant housing and employment growth and will benefit from improved transport links with London from 2009.

In these Thames Gateway areas the focus for public sector investment will be on land assembly clearance and redevelopment - primarily in partnership with the private sector - to provide the infrastructure amenities and environment necessary to create sustainable communities for existing and new residents. Development will be based around anchor points - places such as schools and other community facilities, which provide a focus to the community.⁹

Medway Waterfront Renaissance Strategy - establishes the policy direction for the waterfront for the next 20 years. The Medway waterfront is to be the focus for Medway's regeneration activity, with more than 900 hectares of brownfield across 14 sites, spanning 11km of the River Medway. It extends from the M2 bridge in the west, encompassing Strood, Rochester, Chatham Historic Dockyard, Chatham Maritime and Universities, to Gillingham waterfront in the east. It aims to create a new linear waterfront city, composed of a series of urban quarters.

The regeneration priorities are:

- transform Chatham into Medway's strategic commercial, cultural and civic heart
- develop housing and employment at Rochester Riverside
- create a quarter from Star Hill to Sun Pier which has cultural vitality
- enable historic Rochester to continue as a key heritage and tourism location
- undertake environmental improvements within Medway City Estate

Implementing a sustainable communities Strategy -

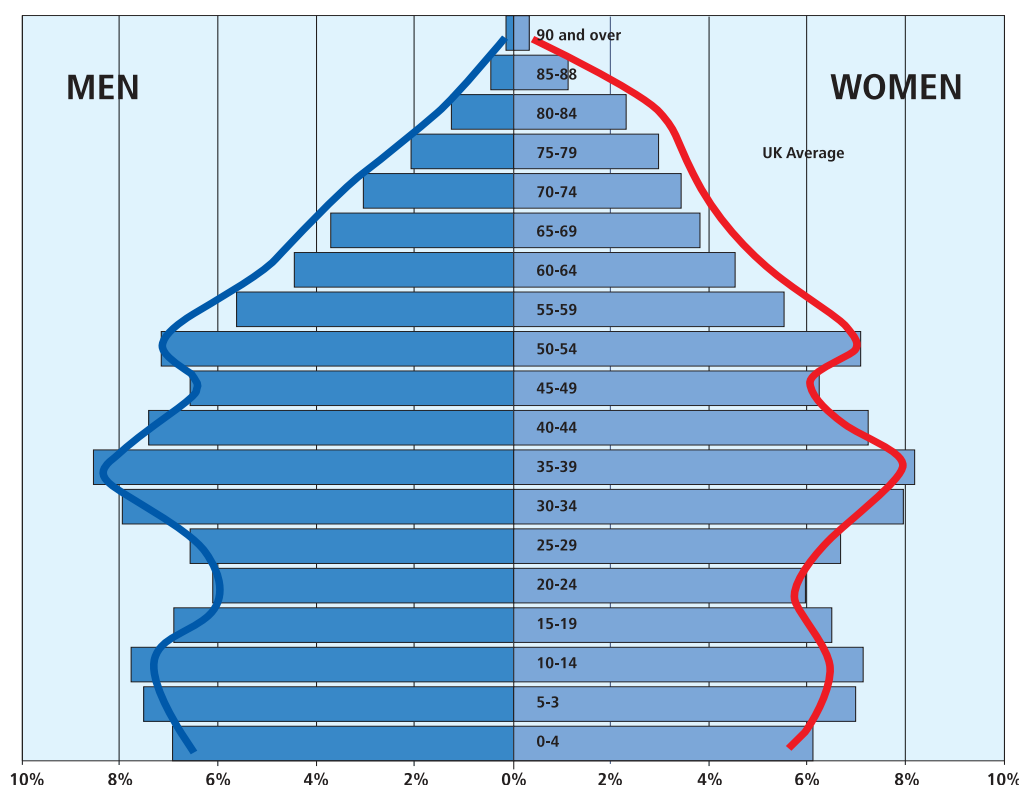
Urban renewal can be beneficial for health by the building of sustainable communities. There will opportunities for new and existing residents to adopt healthier lifestyles.

Assessment processes provide an opportunity to impose checks and balances on development proposals. The Government is committed to producing and delivering an integrated system of impact assessment and appraisal tools in support of sustainable development covering impacts on business, the environment, health and the needs of particular groups in society. In principle Environmental Impact Assessment (EIA) can be used for individual projects, whilst Strategic Environmental Assessment (SEA) are used on plans, programmes or policies i.e. EIA and SEA present opportunities to consider the potential health effects of planned developments, such as The Thames Gateway and the Medway Waterfront Renaissance.

Although human health is an explicit component of the SEA Directive, Health Impact Assessment (HIA) would provide a key opportunity to specifically address health issues of such development programmes. This process could be supported by utilising the “Healthy sustainable communities: A spatial planning checklist”.¹⁰

Who lives in Medway now?

The population graph gives the shape of an oak tree where the shape has a similar width all the way up.

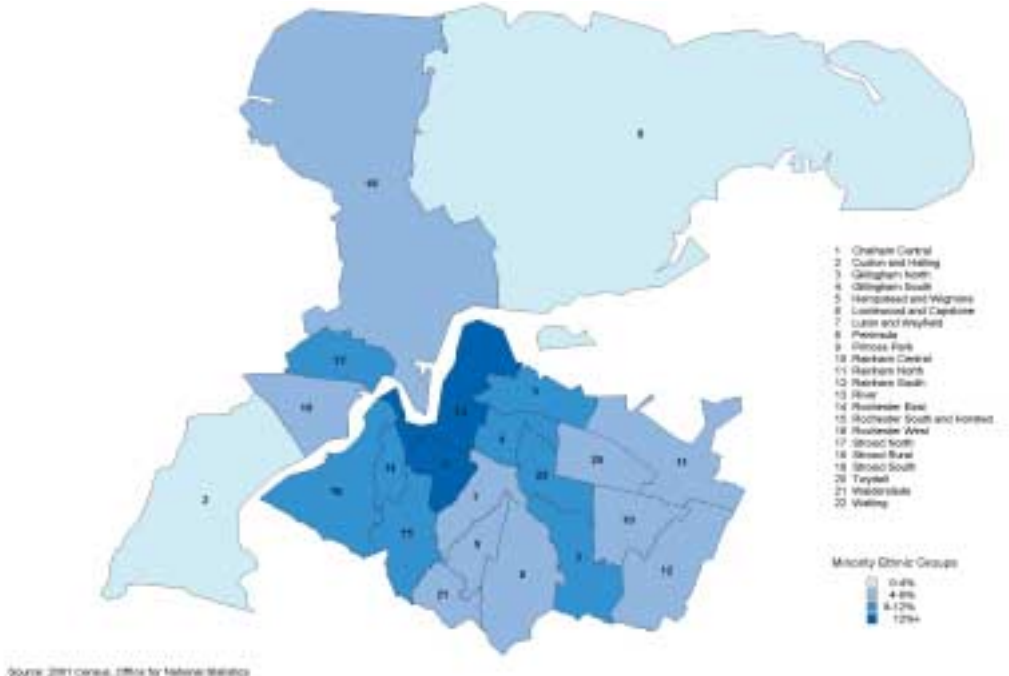


The oak tree emphasises that age groups remain similar in size up to about 60 years and then narrows as people begin to die. There were more women than men still alive well into old age, i.e. aged over 80 years. Overall, locally, the population is slightly younger than the national pattern. (Census 2001)

Minority ethnic groups in Medway

The distribution of Minority Ethnic Groups in Medway is shown in the map below. Similar to the national picture minority ethnic populations tend to be concentrated in urban areas and more in particular in the older “inner” urban areas, which are often associated with higher levels of deprivation.

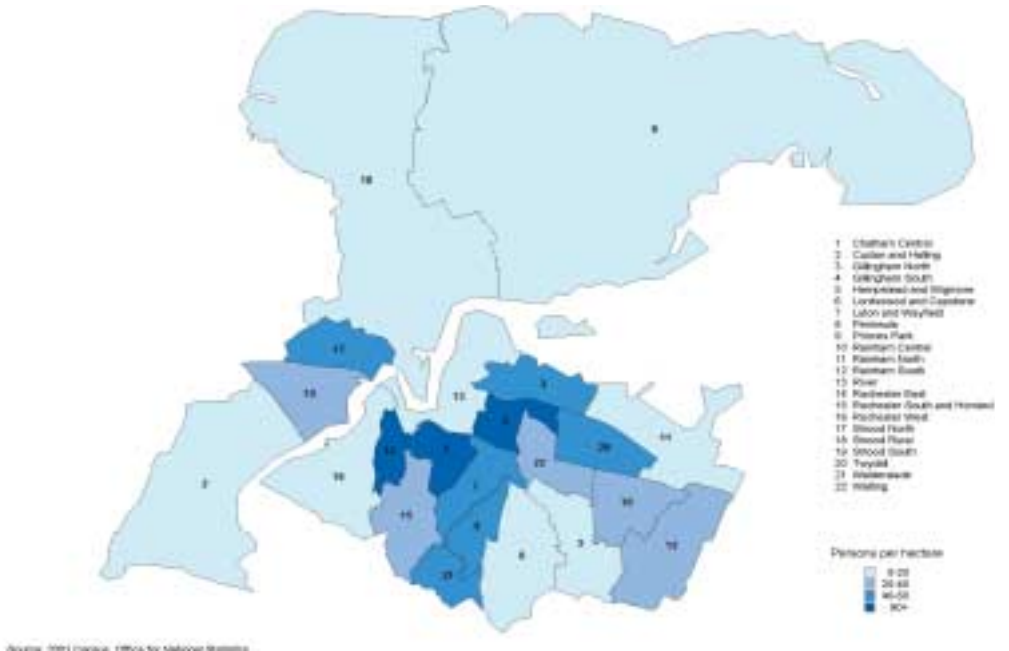
Distribution of Minority Ethnic Groups in Medway UA



The Population Density in Medway

The population density map shows the number of people per hectare for Medway electoral wards. The pattern demonstrates a historical distribution arising from the joining of free standing towns with areas developing as suburbs according to their geography in relation to these towns. As a result higher numbers are found in the older urban areas and in areas with higher levels of deprivation.

Population Density for electoral wards in Medway UA



Deprivation profile for Medway

The Index of Multiple Deprivation (2004) (IMD) is produced by the (ODPM) from new measures of deprivation made available from the Census 2001 data. It gives a detailed overview of the extent and types of deprivation in small areas termed “Lower Layer Super Output Areas” (LL-SOAs). LL-SOAs are at a lower level than electoral wards, and on average have a population size of 1,500 comprising similar types of dwelling and tenure.

The IMD (2004) is a combination of seven kinds of relative deprivation

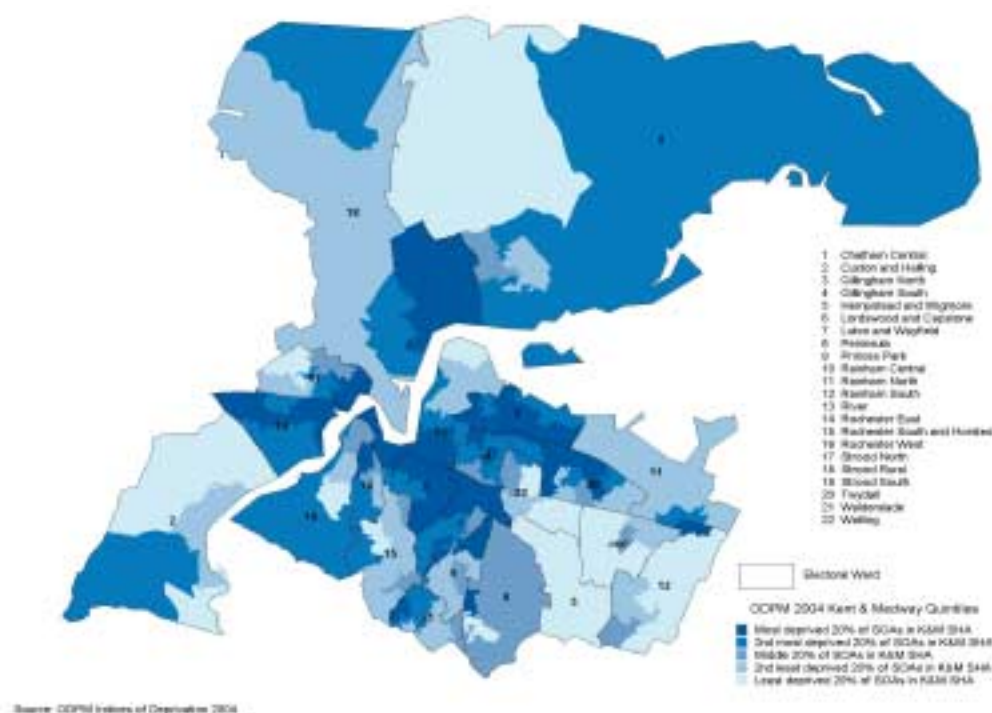
- Income deprivation
- Employment deprivation
- Health deprivation and disability
- Education, skills and training deprivation
- Barriers to housing and services
- Living environment deprivation
- Crime

Each score is calculated independently and then combined to produce the overall Index.

The map below shows the distribution of deprivation according to indices of IMD scores with reference to Kent & Medway Strategic Health Authority (SHA).

The mosaic pattern has areas of centrally located deprivation, again in the older urban areas, and sectors of deprivation representing more rural deprivation.

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



In the next sections the report examines closely the people, their environment and lifestyles and the local and external influences on people's health and well-being during the three distinct life stages.



Why is this group important for tackling health inequalities?

'Childhood is a period of rapid and uneven development; physical, psychological, intellectual, emotional and social. Illness, disability and problems of mental health, which develop during childhood, may remain with an individual throughout life, and it is during childhood that important choices are made and habits adopted which affect long-term health and well being. Traumatic effects in childhood such as divorce, unemployment, serious illness, disability or death of a parent or family breakdown may also have profound consequences not only at the time but also in adulthood'. (The Health Committee of the House of Commons. Health Services for Children and Young People in the Community, Home and School, 3rd report. London: The Stationery Office, 1997)

Overall, this country is still one where life chances are unequal. This damages not only those children born into disadvantage, but our society as a whole. We all stand to share the benefits of an economy and society with less educational failure, higher skills, less crime and better health. We all share a duty to do everything we can to ensure every child has the chance to fulfil their potential....by reducing levels of:

- Educational failure
- Illness
- Substance misuse
- Teenage pregnancy
- Abuse and neglect
- Crime and anti-social behaviour

(Dept. for Education & Skills. Every Child Matters: a green paper. London: The Stationery Office, 2004).

Such inequalities are shown by the following:

- In the mid 1990s, the death rate in the first year of life for social class V explain births was 70% higher than that of social class I births, i.e. eight compared to 4.9 per 1000 live births. (ONS)
- Babies weighing under 2,500 gm in 1991 accounted for 59% of all deaths in the first week of life. (ONS)
- In 1994, babies of fathers in social classes IV and V had a birth weight, on average, 130gms lighter than those from social classes I and II.¹¹

A cross Government review of issues affecting children at risk identified factors that children and young people may face,¹² examples are poor parental supervision and discipline, family conflict, low income, lack of commitment to school and truancy, low achievement beginning at primary school, disadvantaged and poor neighbourhoods and the involvement of friends in problem behaviour.

The main national policies and initiatives relating to children and young people:

Neighbourhood Renewal	National standards local action
Tackling health inequalities	Extended schools
Sure Start	NHS Plan
Connexions	Teenage Pregnancy Strategy
Children's Fund Standard	National Healthy Schools Standard Learning Disability Strategy
Food in schools	Education reform
Quality Protects (Looked-after children)	Children, young people and maternity services (National Strategic Framework)
Smoking kills	Health Inequalities: Programme for Action
Tomorrow's roads safer for everyone	Every Child Matters
Young Persons' Substance Misuse Plans	Child & Adolescent Mental Health care
Alcohol harm reduction strategy	

The above initiatives led to a series of programmes being implemented, such as:

- Reform of the Welfare Foods programme to ensure children in poverty have access to a healthy diet and increased support for breast feeding and parenting, including the School Fruit and 5 A DAY schemes.
- Development of a new sexual health and HIV strategy
- Effective screening programmes for women and children including ante-natal and neonatal screening programmes for haemoglobinopathies and sickle cell diseases; and immunisations
- Smoking cessation services especially for pregnant women.
- Child protection
- Joint registers for children with disabilities
- Development of coherent child and adolescent mental health services, linking to primary and secondary care
- Ensure all children looked after by the Local Authority have annual health assessments
- Improvements to drug misuse services

National policy for children and young people *Every Child Matters*. has clear outcomes set out, which are :



- *Being healthy*: enjoying good physical and mental health and living a healthy lifestyle
- *Staying safe*: being protected from harm and neglect
- *Making a positive contribution*: being involved with the community and society and not engaging in anti-social or offending behaviour
- *Economic well being*: not hampered by economic disadvantage from achieving their full potential in life
- *Enjoying and achieving*: getting the most out of life and developing the skills for adulthood

This sets out an ambitious review of services for children, which keeps the focus firmly on the child and their family rather than organisations and their boundaries. The agenda for change to improve life chances for children is huge. So it is crucial to focus on:

1. What is important locally
2. Doing what works
3. Working together with young people and across agencies

This chapter pulls together both local and national information to paint the picture of health of children and young people in Medway. The 'Rainbow Model' of health introduced in the first chapter is used to paint this picture. This is because health is so widely affected by all of those issues. The report concentrates on issues that we can do something about, and already are addressing to varying degrees. It also identifies those most at risk of ill health, i.e. health inequalities, starting with before we are born and including those up to 19 years and their families. It describes the priorities for children and young people in Medway that need to be addressed to fulfil the outcomes for policies such as *Every Child Matters*. The report makes recommendations for effective action that can be planned through services working together and involving local young people.

We can begin to focus on those most at risk through a number of different ways, e.g. through family health services, via schools, by specific services serving vulnerable groups such as looked after children, those with mental ill health, during pregnancy and in the early years of life.

Note

The information comes from:

1. Routine data sources
2. Local surveys such as the Medway young peoples' health and lifestyle survey, including 12 local Medway schools

Infant Health

Our future health is partly defined by the health of our parents, especially our mother, before we are born. Family attitudes and behaviours then become important influences as we are growing up. This section describes the importance of our parental health and some of the important childhood conditions.

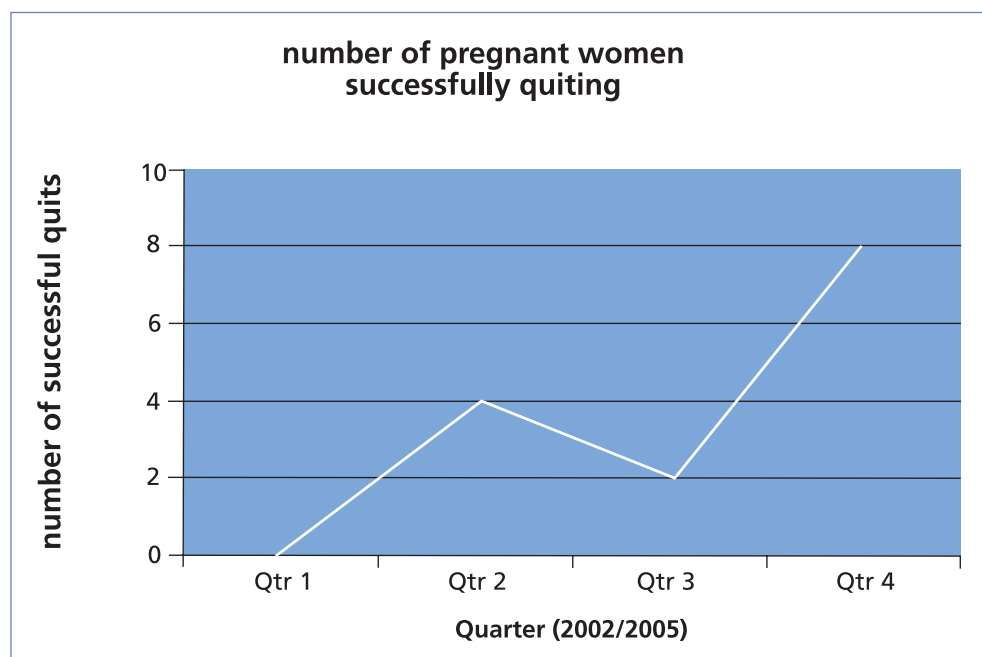
Locally

- There were 3100 live births to women resident in Medway in 2002. The birth rate for women aged between 15 and 44 years was 58.4 births per 1,000 women. This was a higher birth rate than the rate for England which was 54.78 per 1000. (Source: National Statistics)
- Locally there was a high rate of babies born with low birth weight (LBW) between 2001 and 2003 (less than 2500g), 81 per 1000 births. This was lowest in Peninsular electoral ward (44 per 1000) and highest in Gillingham South electoral ward (113 per 1000) compared to 75 per 1000 births in England. (Source: Annual District Birth Extracts & VS2 Statistics, ONS)
- The death rates for children dying in their first week of life and between 1 week and 1 year old (infant mortality) is the same as the national rate, 5.4 deaths per 1000 live births for the period 2000-2002. (Source: National Statistics)
- One in five women in Medway were smokers when they gave birth, between April 2003-March 2004. (Source: LDPR Quarterly figures)
- Sixty-six percent of women giving birth between April 2003-March 2004 were known to have started breastfeeding their babies.

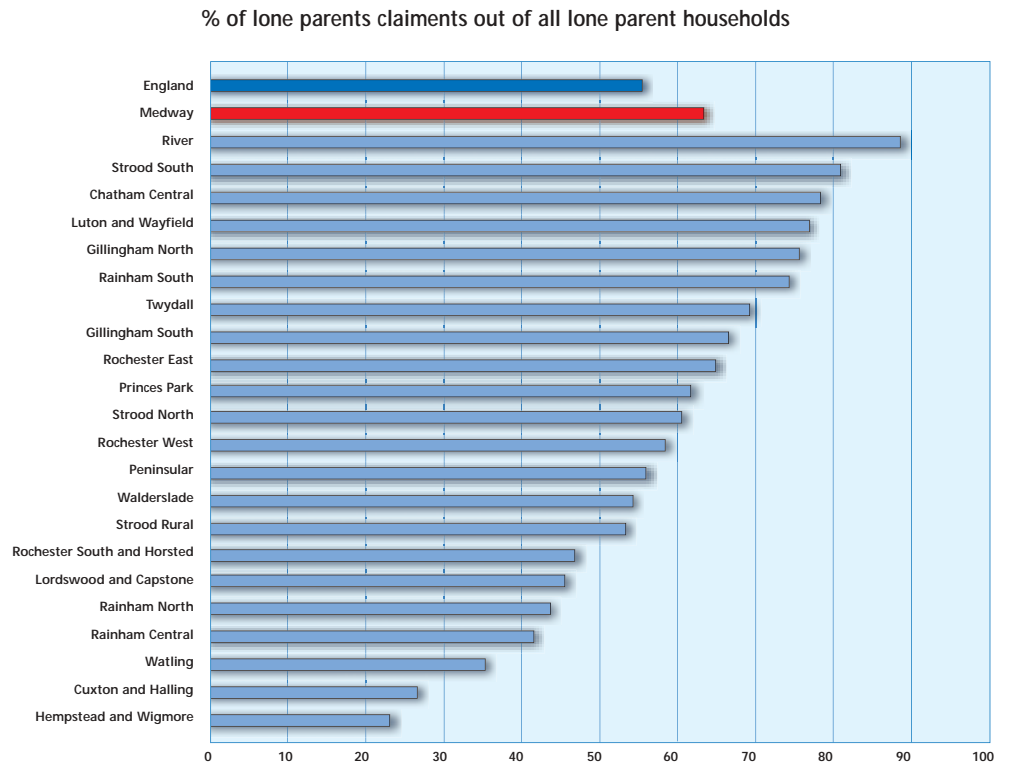
What does this mean for low birth weight and infant deaths?

The most relevant factors to the levels of low birth weight and many of the infant deaths are:

- *Smoking* is a major factor, with low birth weight being twice as high among babies of smokers as non-smokers.¹³ Stopping smoking as early as possible in pregnancy is important.¹⁴ The introduction of the smoking cessation services has had a significant impact on women who stop smoking during pregnancy. The 2004-5 data for Medway is shown in the graph below:



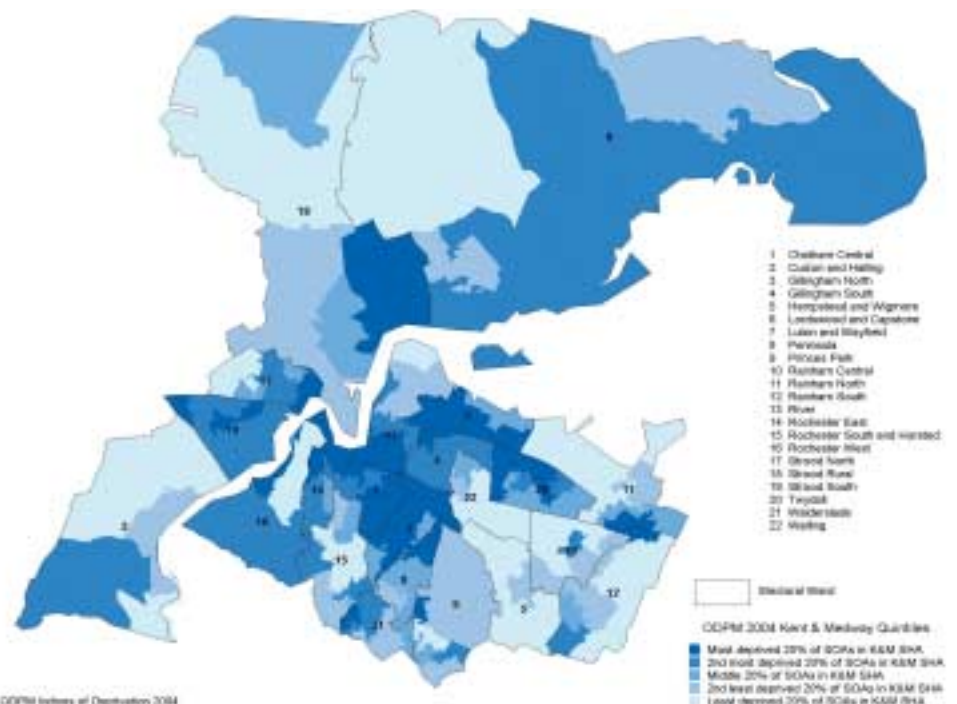
- *Low socio-economic background and access to material resources including poor housing, overcrowding and unemployment are also related to low birth weight babies and greater risk of a compromised 'start in life'. Local data shows that there is wide variation between different parts of Medway, stable incomes and housing, the following graphs and the map illustrate this variation:*



(Source: IAD information centre)

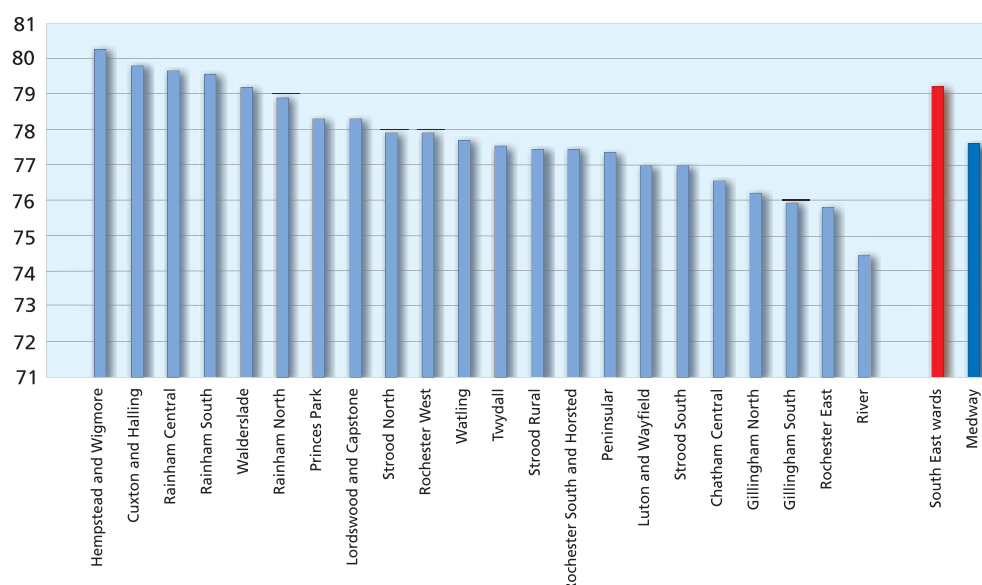
The ODPM commissioned the Social Disadvantage Research Centre (SDRC) in Oxford to update the Indices of Deprivation for England. The new Indices of Deprivation were produced in March 2004. The new Index of Multiple Deprivation 2004 (IMD 2004) is a measure of multiple deprivation and is made up of seven Domain Indices; There is a supplementary Index which measures Income Deprivation Affecting Children. The map below shows the distribution of this measure for Medway.

Rank of Income Deprivation Affecting Children Index for Medway UA LL-SOAs



It is clear that children born and living in different parts of Medway experience different levels of health as a result of the life chances they have. These differences are most starkly illustrated by looking at life expectancy by electoral ward i.e. the expected life span of babies born to families in different parts of Medway. The table below shows that there is a difference of nearly six years between life expectancy in Hempstead and Wigmore and River wards. The difference between the highest and lowest life expectancy within Medway is greater than the contrast between the highest and lowest life expectancy in the South East. (Guildford has a life expectancy of 81.1 and Portsmouth has a life expectancy of 77.2 years.) There are clearly significant health inequalities for children in Medway.

Life Expectancy at Birth



Sources:

Mortality data from Public Health Mortality Files 1998 - 2002, Census 2001 populations, calculated using an Adjusted Chiang method, described in: Evaluation of methodologies for small area life expectancy estimation, Eayres D and Williams ES. J Epidemiol Community Health 2004;58:243-249

Asthma

Asthma is a common condition where there is inflammation or swelling in the airways of the lung. The inflammation results in the airways becoming twitchy or irritable and can narrow easily in response to a wide range of triggers. The most common triggers for asthma are:

- Cold or warm air
- Exercise
- Allergies e.g. dogs, cats, house dust mites
- Irritants such as cigarette smoke, fumes, dusty atmospheres. Children whose parents smoke are 50% more likely to develop asthma. (National Asthma Campaign. UK Asthma Audit 2001.)
- The common cold
- Pollution especially from traffic is increasingly recognised as making existing asthma worse

Locally

- The age standardised admission rate (emergency admissions only) for asthma between 2001- 2004 (children aged birth -19) in Medway was 206 per 100,000.

Nationally

- One in eight of children and one in 13 adults are treated each year for asthma. (National Asthma Campaign. UK Asthma Audit 2001)

Trends in death rates show a decrease of about 48% in all age groups up to 65 in the years between 1993 and 2002. This is fortunately now a rare event in children, having dropped to 1 per million children aged birth-4 and for 5-14 year olds, to 3 per million. (Office of National Statistics)

What does this mean?

This is the most common chronic illness in children and young people. It has risen six times in this age group over the past 25 years, and four times in the whole UK population. The UK now has the 5th highest prevalence of asthma out of 56 countries. (National Asthma Campaign. UK Asthma Audit 2001). This is a real increase, not just better recognition. Asthma may get better or disappear completely during teenage years, but about half of children with asthma will continue to have problems as an adult. Asthma cannot be cured as yet but it can be controlled and attacks prevented. Many of the trigger factors are preventable:

- Not smoking in pregnancy. If the mother smokes, the risk of the baby being wheezy or having breathing difficulties is increased by 50 per cent
- Reducing exposure to dust e.g. in workplaces; or sources of allergies e.g. pollen or house dust mite residues
- Not smoking and not being exposed to second hand smoke

Asthma itself is very treatable for the vast majority of sufferers and is now a condition that is mainly managed in primary health care. Because of the wide varying factors that can make asthma worse it is important that sufferers understand and can treat themselves when they need to, including when at school. There is an active local asthma group, MASH (Medway Asthma Self Help).

A further major support will be tobacco policy both nationally and locally, focussing on the protection from second hand smoke or smoke free air.

Oral Health

Good oral health plays an important part in our quality of life. It allows us to eat, speak and socialise without discomfort or embarrassment. There have been marked improvements over the last 50 years but the most common oral diseases are still dental caries (tooth decay) and periodontal (gum) disease, both of which can result in pain, infection and loss of teeth. There are other secondary effects of poor oral health; such as taking time off work and school as well as the risks associated with general anaesthetic for tooth extraction.

The key contributing factors for tooth decay and gum disease are:

- Poor diet with frequent intakes of sugary foods and carbonated drinks
- Poor oral hygiene and lack of brushing with a fluoride toothpaste
- Levels of fluoride in the local drinking water
- Irregular visits to the dentist

Tooth decay in the population is quantified using an index that measures the number of decayed, missing (due to extraction) and filled teeth. For adult teeth this is the DMF index and for milk teeth the dmf index.

In 2003 the national target was 70 per cent of five year olds would be free from obvious tooth decay and would have an average dmf of 1.0. In Medway the target was achieved - five-year-old children in 2003 had a dmf of 0.83 and 70 per cent showed no signs of tooth decay. This compares well to the overall figure for the south of England which was 66 per cent with no obvious decay and a dmf of 1.18.

However, this does not give the full picture . Over the last eight years the proportion of children without any noticeable disease has improved from 58 per cent to 70 per cent, an increase of 12 per cent. Overall the reduction in tooth decay in five year-old children has on average fallen by 44 per cent but if we look only at the children who have experienced tooth decay their tooth decay levels have only reduced by 16 per cent. This suggests that whilst the oral health is improving in the majority of the population there is a small but worrying group of children who are not improving at the same rate. This is leading to inequalities within the population with tooth decay being confined to a smaller group of children.

This can be seen also in the 11 year old children with permanent teeth. The percentage of children with no apparent tooth decay has increased from 64 per cent in 2000 to 79 per cent in 2004. But again if we look at trends we are seeing the concentration of tooth decay in a smaller group of children.

It is more difficult to know what the oral health is like in the adult population. In national studies the situation has improved remarkably, as in children's oral health. This means we have an ageing population who are keeping their teeth for longer.

The other common oral disease, periodontal disease (gum disease), is age related. In the future an ageing population will therefore require more specialist care for more complex treatment.

Whilst diet is still important for maintaining healthy teeth in adults the level of gum disease is related to tobacco smoking rather than poor diet.

To tackle the problems of poor oral health it is important that the causes outlined above are recognised and appropriate preventive programmes are initiated. Dietary advice and smoking cessation would help improve oral health. It remains important that we try to identify those with higher levels of disease or groups within society that may well be at risk of developing tooth decay and gum disease and target them with helpful preventive programmes.



Some of these are in place for some children. The SureStart schemes contain a brushing-for-life element where fluoride toothpaste and brushes are given to 'at risk' children.

For those people who have already developed oral health problems, we need to ensure there are sufficient and appropriate dental services for them to access.

Accidents

Accidents are the greatest single threat to life for children and young people under 15 nationally (Office of National Statistics, Dept of Health. *Health Survey of England, 1996*. London: The Stationery Office, 1998.)

Children from poorer families are five times more likely to die from an accident, than from more affluent backgrounds. The word 'accident' suggests an unplanned or uncontrolled incident, but the factors that lead to an accident are clearly understood. It is impossible to stop all accidents happening, but they can be predicted and therefore some are preventable and the seriousness of many children's injuries could be reduced.

Locally

(Numbers of deaths between 1999-2003 inclusive age under 18 years)

- Ten Medway children and young people were killed between 1999-2003 in road traffic accidents
- Two Medway children drowned between 1999-2003

What does this mean?

Children are especially vulnerable to accidents, they are naturally curious, have lots of energy, and do not like to be confined. Due to their size and understanding of the world, they are not as aware of danger as adults, or become absorbed or easily distracted. Professionals, voluntary organisations and communities can work together on a wide range of activities that support parents in their caring role; teach children how to keep themselves safe; and make young people aware of the risks they take and the consequences of their actions.

Infectious Diseases

Communicable disease control has always been important, but with the return of old diseases and the appearance of new ones it has now become more important.

The Chief Medical Officer's report in 2002 'Getting ahead of the curve: A strategy for combating infectious diseases' set out a comprehensive range of proposals to reduce the burden of infectious diseases and improve health protection services. (Donaldson L. *Getting ahead of the curve: A Strategy for combating infectious diseases*. London: The Stationery Office, 2001.)

A new Health Protection Agency was set up in April 2003 to provide a joined up approach to protecting the public against infectious diseases, as well as chemical and radiological hazards.



Locally

Cases of Notifiable Diseases in Children in Medway 2004-5 (ref)

(Health Protection Unit, Kent and Medway)

Tuberculosis (TB)	2
Meningitis	10
Meningococcal Septicaemia	7
Food poisoning	32
Measles	22
Mumps	31
Rubella	9
Scarlet fever	16
Whooping cough	3

What does this mean?

Overall, the numbers of cases of notifiable diseases remained small, but it is likely that a substantial number of cases are not reported. Food poisoning stands out as being a commonly notified condition which is preventable. It is important to continue increasing knowledge about the hygienic practices that should be followed to prevent the spread of food poisoning.

Childhood immunisation and vaccine preventable diseases

Immunisation has proven to be one of the most effective, beneficial and cost-effective medical interventions we have to prevent disease. Immunisations currently save three million lives per year worldwide. Immunisation has made it possible to get rid of small-pox and polio, as well as the control of potentially life threatening diseases such as rubella, measles, mumps, diphtheria, whooping cough and some forms of meningitis. Routine immunisations can help to reduce or eliminate the impact of social inequalities for measles, whooping cough and meningitis. Every effort should be made to ensure that all children are immunised even if they are older than the recommended age. Children not immunised will be protected to a certain extent if population immunity is high, but they become vulnerable when general levels of immunisation fall or when travelling abroad. The national target for the uptake of childhood immunisation is 95% at two years, since sustained uptake by 95% of population provides good level of immunity for the population as a whole.

Immunisation Coverage

Percentage of children immunised by their fifth birthday, Medway 2003-04

	Diphtheria Tetanus Polio	Pertussis	Hib	MMR	Meningitis C	
	Primary and booster	Primary	Primary	first dose	first and second dose	
England	80	93	93	90	75	87
South East	83	92	93	90	75	88
Medway	83	94	94	93	77	92

Source: COVER

This suggests a need to reinforce the importance of childhood immunisations by health care professionals. It is crucial to promote the message that if general immunisation levels in the child population go down, we may see the return of childhood diseases such as rubella, measles and mumps that could easily be prevented.

Measles, Mumps and Rubella (MMR)

The measles, mumps and rubella vaccine was introduced as part of the routine childhood immunisation schedule in 1988. Vaccination coverage has fallen since 1998, largely because of the negative publicity associated with the vaccine followed by the publication of a later discredited article in the Lancet. Confidence in the vaccine is returning but it may take some time for vaccine coverage to get back to pre-scare levels.

There has been a dramatic reduction in cases of measles, mumps and rubella since the introduction of the MMR vaccine. However, more recently confirmed cases of measles and mumps have increased.

Nationally, the number of mumps cases notified has remained stable from 1995 to 1999 with less than 2,000 cases recorded annually. However, a resurgence of mumps occurred in 1999 and 2000 with outbreaks mainly affecting school children who had either never received a mumps containing vaccine or received only one dose of MMR.

Personal behaviours: what we do ourselves

What about food and nutrition?

Good nutrition in the early years of life is a major factor affecting future health. Growth and development are rapid during the teenage years, when the demand for energy and nutrients is high. In spite of confusing publicity, these guidelines have remained unchanged since the early 1990s. (Health Education Authority, Dept. of Health and Ministry of Agriculture, Fisheries and Food. *Eight guidelines for a healthy diet*. London: HEA, 1991, revised 1997.) These are:

- Enjoy your food
- Eat a variety of different foods
- Eat the right amount to be a healthy weight
- Eat plenty of foods rich in starch and fibre
- Eat plenty of fruit and vegetables
- Don't eat too many foods that contain a lot of fat
- Don't have sugary foods and drinks too often
- If you drink alcohol, drink sensibly

Locally

Forty seven per cent of 11-18 year olds agreed that they eat healthily; there were differences by gender, 65 per cent of males compared to 48 per cent of females agreed that they 'eat healthily'. (Medway young people's survey 2004).

Nationally

The Health Survey of England 2001 shows that the average number of portions of fruit and vegetable consumed by children aged 5-15 in a 24 hour period was 2.7. One in seven of 14 year olds ate five or more portions of fruit and vegetables daily, and two in three ate less than two portions, especially girls, in 2001.

What about weight?

Our body weight is a product of the balance between energy consumed and energy used. So the two main causes of being overweight are overeating and not doing enough physical activity. The ratio of weight to height, the Body Mass Index (BMI), is a standard measure of assessing a healthy weight. For children BMI is both gender and age-specific. This is because children's body fatness changes over the years as they grow. Girls and boys differ in body fatness as they mature. Occasionally, children who are both obese and short for their age could be suffering from hormone problems needing further investigations. Routine measurements of waist and hip circumferences of children and adolescents are not recommended given the uncertainty surrounding the usefulness of hip and waist measurements as a means of determining abdominal fat distribution in children and adolescents.

How common is obesity in children and young people?

Obesity has reached epidemic proportions in the western world. Though more common in adults, the rising number of overweight and obese children of all ages is a major cause for concern.



Locally

In 2003 the Child Health System data in Medway showed that eight per cent of five year olds in Medway were obese and 5% were overweight

Nationally

In England, in between 1995 and 2003, the prevalence of obesity among children aged 2 to 10 rose from 9.9 per cent to 13.7 per cent.

The percentage of children aged 2 to 10 who were overweight (including those who were obese) rose from 22.7per cent in 1995 to 27.7per cent in 2003

What does this mean?

Obese children are seven times more likely to become obese adults. The health risks of obesity are enormous:

- Children of obese mothers are at a higher risk of future heart disease and adult onset (type 2) diabetes. (ref Finch H, White C. *Physical activity at our time*. London; HEA, 1998.)
- Cases of adult-onset (type 2) diabetes in childhood is a great cause for concern
- Being overweight or obese are also known to have a significant impact on psychological well-being and social problems, with many children developing a negative self-image and experiencing low self-esteem due to being targets of persistent discrimination

What can we do to make a difference?

Reversing the trend in the rising number of overweight or obese children is a public health priority. The key focus for action is on activity and food patterns, combining physical activity, diet and changes in behaviours to achieve greater success. These programmes are often done independently, so reducing their effectiveness. The recent Medway Obesity Strategy, as part of the implementing Choosing Health Strategy plans to implement support in obesity reduction and prevention by taking a multi sectoral approach to tackling obesity in children and young people in many ways, including

- Early life influences such as breastfeeding, child nutrition, and active play
- Education and support in eating habits and physical activity patterns
- A whole school health promoting environment - curricular and non-curricular
- Encouraging active travel to and from school

Medway PCT has a local target, agreed with the Strategic Health Authority to:

'Halt the rise in obesity levels in children in Medway, targeting actions to promote physical activity, the modification of dietary intake and sedentary behaviours and weight management services available to children and their families'



Physical activity

This means any movement that leads to a marked increase in the use of energy. It can include day-to-day activities such as vacuuming, gardening, walking as well as formal exercise such as sport. All young people should participate in physical activity of at least moderate intensity for one hour per day.

Locally

- Fifty per cent agreed or strongly agreed that they take enough exercise (Medway Young People's Lifestyle Survey Medway 2004)
- Fifty seven per cent of those aged 11-15 felt that they take enough exercise compared to 33 per cent of those aged 16-18. 20 per cent of males agreed or strongly agreed with the statement 'I take enough exercise', compared to 30 per cent of females.

What does this mean?

Participating in physical activity in childhood can have many positive health outcomes for young people, now and in the future: optimise physical fitness, current health and well being and growth and development. An active child is more likely to be an active adult, increasing opportunities to mix with others and make friends. Physical activity in childhood reduces the risk of chronic disease in adulthood.

Boys are more active than girls from an early age and both sexes reduce their physical activity as they mature. This decline is more marked in girls than boys and is steeper in adolescence than in childhood. This is seen clearly in the local Young People's lifestyle survey.

Smoking tobacco

The burden of smoking in any population is well known, as being the greatest cause of ill health and death in the developed world. Nicotine replacement therapy (NRT) and Zyban are seldom prescribed to young smokers, though the evidence suggests that to do so would result in significant harm reduction and improved chances of quitting at a younger age.

An enthusiastically and aggressively promoted youth cessation service that was able to supply NRT to young smokers who are already addicted to tobacco could make use of text messaging, and youth-friendly protocols might well serve to encourage more young people to quit or at least reduce harm.

Locally

The Medway Young People's Lifestyle Survey showed that:

- Twenty three per cent of young people were already addicted to tobacco
- A higher proportion of females currently smoke (48 per cent) compared to males (39 per cent)
- Eighty four per cent of young people have thought about quitting smoking. If they wanted information about giving up smoking, 37 per cent would consult their friends and 35 percent their doctor
- Forty five per cent of young people indicated they had parents who smoked



- Fifty seven per cent of young people whose parents smoke would prefer it if they didn't
- Where the parents did smoke, there was a higher prevalence of smoking amongst their children than amongst the children of non smoking parents, 29 per cent of young people whose parents smoked were smokers
- Eighty one per cent of young people disagreed with the statement 'Smoking is unlikely to damage your health', 70 per cent of young people agreed that they were more likely to smoke if their friends smoked



Nationally

Data indicates 33 per cent of males aged 16-24 currently smoke, rising to 35 per cent for females (2002 Health Survey for England). Of these one in three were thinking about quitting.

What does this mean?

- High numbers of young people who report regular smoking means the creation of a new generation of smokers in Medway and that a change in thinking and practice is needed if we are to combat this future disease burden
- It is clear that young people understand the risks of smoking, but are still starting to smoke
- Reducing sales of cigarettes to children under 16 does not reduce smoking rates; children will find other ways of getting cigarettes
- If we want to get serious about reducing smoking and thus the burden of local diseases our priority should be a smoke-free environment .
- Smoke-free environments encourage adults to stop smoking and so reduces the adults' smoking behaviour role -model
- The message now is simple: smoking is not socially acceptable.

Alcohol

There are particular issues surrounding young people and alcohol use such as the health effects of drinking, the links between alcohol and crime, alcohol and exclusion from school and the links between alcohol consumption and unsafe sex.

Locally

The Medway Young People's Lifestyle Survey showed:

- Ninety-two per cent of young people had tried an alcoholic drink. Three per cent of 16-18 year olds and 11 per cent of 11-15 year olds had never tried alcohol
- Fifteen per cent of young people drink alcohol three or four days a week or more, 9 per cent don't drink alcohol at all
- Seventy-one per cent of young people agreed with the statement 'alcohol is likely to damage my own health'
- Seventy-three per cent of young people agreed that they were more likely to drink alcohol if their friends did
- Forty-six per cent agreed with the statement 'There is nothing wrong with getting drunk'

- Twenty-one per cent of young people indicated that they would like more information about the effects of alcohol on their health

Nationally

- Young people are drinking more and drinking more often. 11 -15 year olds who admitted to drinking consumed twice as much in 2000 (10.4 units a week) as they did in 1990 (5.3 units a week). This was slightly higher in boys
- In 2001, more than a quarter of 11-16 year olds drank alcohol at least once a week compared to 20 per cent in 1990. Drinking was more common in older adolescents with over a half of 15-16 year olds drinking at least once a week
- Young people drank mainly beer, cider, lager and wine. Consumption of alcopops has decreased since 1996 but young people were choosing stronger drinks such as white cider, strong brands of beer, fruit wines and vodka
- The age that young people begin to drink unsupervised is probably more significant than the age they first try alcohol as this signifies a shift to drinking with friends rather than parents
- Young people drink for a variety of reasons including; a rite of passage, to say that they have tried alcohol, to have fun and to get drunk and to show their maturity and experience
- Studies suggest that young people combine alcohol and sex, especially before their first sexual experience and that there is a link between drinking before sexual activity and unsafe sex
- There is also an association between alcohol and crime, 25 per cent of young prisoners had been drinking when they committed their crime
- Alcohol is linked to school exclusions. Twenty per cent of pupils excluded from school were excluded for drinking alcohol at school and 16 per cent of excluded pupils drank alcohol every day¹⁵

What does this mean? ^{16,17,18}

Children and young people who drink are vulnerable to a variety of health and social risks such as:

- Experiencing the intoxicating effects of alcohol and developing serious medical conditions, such as entering coma, at lower alcohol levels than adults
- Various effects from mixing alcohol with other drugs
- They are more likely to smoke
- Unprotected, unplanned or regretted sex
- Risk-taking activities, which raise the likelihood of criminal offences and having accidents

What needs to be done?

- Alcohol should be given equal status to illicit drugs in drug education
- Schools need to recognise the mixed messages children and young people

hear about the use and risks of alcohol

- Alcohol education should start in primary school and be needs led, including those with special educational needs
- Promote low alcohol and non-alcoholic drinks

Use of drugs by young people

Problem drug use is defined as drug use with serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them.

Locally (Medway Young People's Lifestyle Survey)

- The most common drug that young people had been offered and taken was Cannabis - 37 per cent had been offered, and 20 per cent of young people had taken Cannabis
- Eighty-one per cent of young people agreed with the statement 'Illegal drugs have a long term effect on my health'
- Seventy-one per cent of young people agreed that they were more likely to try drugs if their friends did
- Twenty-five per cent of young people agreed with the statement 'taking drugs isn't a big deal nowadays'

Nationally,

- National data indicates that 6 per cent of 11 year olds, and 36 per cent of 15 year olds had used drugs in the last year (National Statistics, Statistical Bulletin, 2003/4, July)
- In a survey of school children aged 11-15.¹⁹ Cannabis was the most likely drug to have been taken, by 20 per cent of all 14 year olds

What does this mean?

Experimental use of drugs is not linked to any particular factor such as low income. However, problematic drug use is linked to a range of risk factors such as truancy, school exclusion, family problems, youth offending, being a looked after child and other family members taking drugs.²⁰

Risks involved in illegal drug use:

- The user can never be sure of exactly what they are taking. What is bought is unlikely to be pure, and they won't know what it has been mixed with. Not knowing the strength of what has been bought could lead to accidental overdose
- If needles, syringes or other injecting equipments are shared, there is a serious risk of dangerous infections being spread such as HIV and Hepatitis B or C. Injecting can damage veins
- Unlawful possession of a controlled drug is a criminal offence

The Government launched an anti drug strategy in 1998 'Tackling drugs to build a better Britain'. It has four main elements focused around, **Young people, Communities, Treatment and Availability**. Multi agency and multi faceted

action is needed to tackle this complex issue. Nationally, it is recommended to focus early action on vulnerable groups, especially looked after children, those excluded from school, young offenders and children of drug users. ConneXions and other agencies are important in supporting these groups to have access to education, diversion and support. The local Drugs Action Team has a strategy to tackle drug use, which is a wide collaboration to act coherently.

Healthy sexual activity

The main issues about the impact of sex upon health are about the consequences of sex, in relation to:

- Unplanned pregnancy
- Age of first pregnancy
- Sexually transmitted infections

Locally

- Thirty-nine per cent of young people indicated they had, had sex, There were differences by age; 21 per cent of those aged 11-15 had sex, compared to 59 per cent of those aged 16-18
- Females were more likely to be have had sex in the past - 43 per cent of females compared to 36 per cent of males
- Seventy-one per cent of young people had always used contraception when having sex. Young women were less likely to always use contraception than young men - 68 per cent of women, 74 per cent of men
- Of those young people who had had sex: 82 per cent had used a condom, 36 per cent had used the pill, 5 per cent had used withdrawal
- Young people were asked about sex and relationship education classes (SRE) at school. Overall 88 per cent of young people had sex and relationships education at school
- Sixty- two per cent were aware that contraception was available legally to under 16's, 16 per cent thought that it was not, 41 per cent of young people thought they had to be 16 before they could visit a doctor or nurse without an adult being there
- Seventy-three per cent of young people were aware that information they told a doctor or nurse was confidential
- Eighty eight per cent of young people thought a condom could prevent a sexually transmitted infection, nearly a third of 11-15 year olds thought sexually transmitted infection could be prevented by the contraceptive pill
- 41per cent per 1000 young women in Medway aged 15 to 17 years conceived during 2003 compared to 42 per 1000 in this age group across England. There was an 11 per cent fall in teenage pregnancies in Medway between 1998-2003



What does this mean?

There are some young people aged under 16, the legal age, who have sexual relationships by choice. They need help to take the opportunities to have healthy sex. The impact of being under the legal age and fear of reprisal may deter some from asking for help and information, but clearly does not deter them from being sexually active. The long-term consequences of sexual health problems affect their future. Early intercourse without contraception carries an increased risk of sexually transmitted infections, including HIV.

Unintended pregnancy, which itself reduces the long-term opportunities for that young parent to finish their education, makes them less likely to find a good job and thus more likely to bring their children up on a low income. This continues the spiral of health inequalities for them into their adulthood, and potentially for their children, due to the consequences to health of having a low income.

Some young people may need advice and support to help them form positive and safe relationships as well as non-judgmental guidance to help them make positive and safe choices within their relationships. This does not mean advocating under age sexual activity but supporting those who want help. Sex and relationship education is ongoing throughout life, starting in childhood. Different places provide different opportunities for sex and relationship education. Parents and carers are the main provider of this education with schools complementing the learning through the personal, health, social and citizenship framework.

There is a Teenage Pregnancy Strategy Board across Medway to support action towards the target of reducing such pregnancies by 50 per cent by 2010 compared to 1998. There is a further requirement to provide support to teenage parents to maximise their, and their children's opportunities.

The following themes are important:

- Avoiding sexually transmitted infections and becoming pregnant
- Where to get information and help needs to be much more widely known, especially for young people
- Contraceptive clinics are more likely to be used if not in traditional health clinics
- Support is being given to teachers and other key professionals to talk to young people about their sexual health
- Development of peer and parent programmes which provide sex and relationship education
- The ways in which learning about sex and relationships should be redesigned after consultation with young people. This can be done using the findings of the Young People's Lifestyle Survey to target those groups which are most vulnerable to risky sexual behaviour

Children as carers

A young carer is any young person aged under 18 years who provides care or support for a parent, sibling or other relative. Young carers may miss out on some chances in life because of their caring role. Caring means physical and emotional



caring; doing things for the person in need of care or being emotionally available for them.

Locally

The 2001 census estimates that there are about 650 young carers in Medway.

Nationally

The 2001 census estimated there are more than 139,000 young carers nationally.

What does this mean?

Caring for a relative or family member can be both rewarding and difficult. Young carers usually provide care for an immediate family member, most often a parent. Caring can take a large amount of time and energy and can harm a young carer's development and life chances, particularly if their caring responsibilities are great and they have little support. Young carers in single parent families are especially likely to spend a large amount of their time providing support and care.¹⁰

Children and young people who care for others often achieve poorly in education, suffer from social isolation and lack time for leisure. They may experience emotional difficulties and be torn between the needs of the person they are caring for and their own needs, leading to feelings of guilt and resentment. The social isolation they experience can make it difficult for them to form relationships. If their parent suffers from mental illness, the young carer also has a greater risk of developing mental health problems. The full extent of care provided by young people is not known but seems to be significant. Many young carers have little or no support and do not know how to get help or access services. Young carers need:



- Recognition of their role
- Support with caring tasks
- Information about the support available to them
- Emotional support
- Time out from their caring role to care for their own needs and development

Well being and good mental health

Emotional well being is important for us to be able to live a full and creative life, and have the ability to deal with its 'ups' and 'downs'. With the right support most young people learn and develop effective problem solving skills. Without that support, emotional difficulties that develop in childhood can have lasting effects.

Worry and anxiety

Everyone experiences worry and anxiety at certain times, particularly in difficult situations. As they are growing up, young people face many new situations and become increasingly aware of themselves and the response of others to them. A desire to fit in with the group can create anxiety for them over a number of issues. Most learn to cope with the temporary discomfort that anxiety can bring but some may become overwhelmed. Anxiety that continues for a long time can have a serious effect on their ability to cope with everyday life.

Locally

- Young people were asked about whether they were worried about different aspects of their life. Thirty-eight per cent of young people have worried 'a lot' about school or exams, 35 per cent have worried 'a lot' about their appearance and 28 per cent worried 'a lot' about money problems
- The majority of young people 69 per cent would turn to a friend to seek help about a problem or worry, 53 per cent would speak to a parent/guardian and 33 per cent another family member. Fourteen per cent of young people wouldn't speak to anyone.

Self-image and self-esteem

Self-image is the picture you have in your mind about your size, shape and general appearance, and how you think and feel about it. Your self-image can be positive or negative depending on how you view yourself. Having a negative body image can be very upsetting, especially as it can reduce self-esteem and make you dislike yourself. Self-esteem is the opinion you have about yourself and is affected by your level of confidence in your abilities. How you feel about yourself has an effect upon the way you feel about others, and how they feel about you.

Locally

- Young people were asked how they feel about themselves.

Fifty-seven per cent indicated they 'liked themselves all or most of the time'

Fifteen per cent of young people 'didn't like themselves often at all'

Only seven per cent of females indicated they 'like themselves all of the time' Seven per cent of young women 'didn't like themselves at all'

What does this mean?

As young people begin to mature and their bodies begin to change at puberty, they become more aware of their self-image and may feel insecure about themselves as they search for an identity and begin to develop new relationships. A positive self-image is important for a sense of well-being. A number of influences can lead to a poor self-image including the reactions of parents and friends, or when young people develop unrealistic expectations through comparison to 'ideal' bodies portrayed in the media.²¹ Poor self-image is linked to and can contribute to low self-esteem leaving the young person feeling worthless. Low self-esteem can lead to feelings of helplessness, powerlessness and depression.

Our level of self-esteem can influence not only how we feel about ourselves and others and the relationships we develop but also the choices we make in life. There are indications that childhood self-esteem is associated with economic outcomes such as earnings and continuity of employment in early adulthood but the links involved remain unclear.²²

Poor self-image and low self-esteem are made worse by stressful situations and difficult social circumstances and can lead to emotional disorders including



depression, anxiety and with adolescent eating disorders. The early years are important for the development of positive self-esteem. Positive self-esteem in parents is necessary to nurture high self-esteem in children. The school environment also plays an important role in the development of self-esteem in young people. Young people who have a high regard for themselves are less likely to suffer emotional difficulties, become involved in crime or abuse alcohol or drugs. Girls with a positive self-esteem are less likely to become pregnant as teenagers.²³

Bullying

Bullying involves intentionally cruel behaviour to someone who is weaker or less powerful. Bullying can be physical, verbal, emotional, racial or sexual in nature. Bullying often involves the same children, in the same bully and victim roles. This does not mean that in order for bullying to occur there must be repeat offences. Bullying can consist of a single interaction.

Locally

Young people were asked about being bullied in school and how long ago if at all it happened to them.

- Fifty-seven per cent of young people indicated that they had bullied at school
- Sixteen per cent of young people had been bullied within the last month, 30 per cent had been bullied within the last six months
- 41 young people (five per cent) said they were bullied on the day this survey was administered

What does this mean?

Bullying is very common. Nearly everyone is bullied at some time in their lives but consistent bullying can leave victims feeling scared, vulnerable and alone and its effects can last a lifetime. There are many different reasons why a child may become a bully.

Children bully others as a way of coping with a difficult situation. Bullying causes distress and misery for victims and leaves a lasting impression on those individuals who have witnessed repeated bullying incidents. Children who are being bullied at school often show behaviour changes such as becoming disruptive or withdrawn. They may become fearful of attending school, have problems sleeping or concentrating on their work or complain of various physical symptoms. They may become anxious depressed or suicidal. Bullying can damage a child's self-esteem particularly, if it has been happening for some time. Bullying can have an effect on the child's emotional well being and health and consequently on the child's academic achievements. These problems can continue long after the bullying has stopped.²⁴

According to Kidscape:

- Each year 10-14 youth suicides nationally are directly attributed to bullying
- Bullied children are six times more likely to contemplate suicide than non-bullied children
- One in 12 children is badly bullied to the point that it affects their education, relationships and even their prospects for jobs in later life.

Crime

The most common forms of offending behaviour in young people are offences against property including theft, burglary and criminal damage. The risk factors associated with offending behaviour in young people include family conflict, social isolation, poor educational achievement, bullying, and drug misuse. Offending can have longterm significant impacts on both the offender and victims.²⁵ There is evidence that early intervention can have a positive effect in reducing offending behaviour and improving outcomes for young offenders.²⁶ Youth Offending Teams (YOT) are local teams which bring together professionals from organisations such as parents, social services, police, probation, education, Connexions and the NHS. They coordinate and provide youth crime prevention schemes to prevent re-offending, e.g. management of re-offending and work with young offenders to identify their reasons for offending and reduce their likelihood of re-offending.

Locally:

Respondents were asked about their perception and experiences of crime:

- Overall 77 per cent of the young people included in the survey disagreed that it was ok to steal small things from shops as long as nobody finds out
- Forty per cent of young people felt at risk of crime in school
- Forty-seven per cent of young people felt at risk of crime in the area they live
- One in three young people claimed to have been a victim of crime. Males were more likely to have been a victim of crime (38 per cent) compared to females (29 per cent)
- Respondents were asked what reasons prevent them from reporting crime. Around a half of young people indicated that 'not wanting to get involved' (54 per cent) and 'fear of those who committed the crime getting revenge' (50 per cent) were the most common reasons that would prevent them from reporting crime to the police

What does this mean?

Most young people had clear understanding of right and wrong. While young people are often feared by other groups as perpetrators of crime a significant number of young people felt at risk from crime and saw themselves as victims.

Education and aspirations

What type of job we have is important for both the level of income it can give us and how the nature of the job can affect us, whether physically, mentally or

emotionally. What is crucial is that children and young people have the opportunities to acquire skills and knowledge to have jobs.

Locally

- The average unauthorised absence rate in local secondary schools in 2004 was 0.6 per cent , ranging from 0 to 2.5 per cent - the England average is 1.2 per cent
- 1.6 per cent of school leavers in Medway in 2004 had no formal qualifications, compared to 4.1 per cent across England
- Fifty per cent of young people in Medway gained five GCSEs grade C or higher in 2004, compared to 54 per cent nationally
- Four per cent of Medway students aged 12-19 had statements of special educational needs
- Since 2001 the percentage of children permanently excluded from schools in Medway has dropped from 0.5 to 0.35 per cent
- Respondents were asked about careers, and their future plans. 72 per cent of respondents knew what career they wanted to pursue after they finished school
- Fifty-three per cent of young people wanted to go to University
- Of the young people who indicated they wouldn't go to university, the top reasons were, 'I don't think I will get good grades' (47 per cent), 'I can get a good job without going to Uni' (27 per cent), 'I don't think I can cope with the work load' (24 per cent), 'Not sure my parents could afford it' (22 per cent)

What does this mean?

Education so clearly influences future income it is one of the major impacts on health and health inequalities:

- Being able to read and write is a basic tool to cope with modern living, having vocational or academic knowledge and skills is now increasingly important in our higher technological world
- Education opens doors to types of jobs that are less risky or have a higher income and so gives more control to that person over the resources they need for daily living
- Those with higher educational attainment not only have greater opportunity for income but seem to go on to more healthy behaviours as an adult, such as eating healthy food, not smoking and being physically active
- Education has an impact on the basic skills for living such as budgeting and cooking as well as developing relationships and dealing with conflict
- The role of the school is a social one in preparing children to participate fully in society, from democratic rights and responsibilities to working together and having a greater understanding of the needs of others in society
- The school environment and culture should also be one that is safe, healthy and conducive to learning



Medway has a flourishing healthy schools programme, which supports schools in gaining the National Healthy Schools Standard. The standard aims to promote physical and emotional well-being in the whole school community and has been recently re-designed to ensure compatibility with the five outcomes of the strategy paper, EVERY CHILD MATTERS. To gain accreditation schools compile a portfolio of evidence, which demonstrates how they have met demanding standards in four aspects:

- Healthy eating
- Physical activity
- Personal, social and health education
- Emotional wellbeing

Successful accreditation as a healthy school demonstrates compliance with the minimum standards of the outcomes and will meet the criteria for Ofsted on “being healthy” and “staying safe.”

Local current services and initiatives that support health improvement for children and young people in Medway



- Big Lottery Bid for a Parenting Programme that will eventually be rolled out across all areas of Medway, with the initial pilot areas being North Gillingham and Twydall.

Email: maria.waters@medway.gov.uk

- The ‘Big Dig’ - Allotment bid in All Saints area. The four surrounding schools within this area and Sure Start Chatham are interested in establishing a pre-school/school age project, bringing children on site to learn how vegetables grow, understand seasons and produce and to ‘get their hands dirty’. The local adult community will engage with the scheme through ‘open day’ events, which highlight the benefits of home-grown vegetables and the learning opportunities available either through the allotment association or Medway Adult and Community Learning Service.

Email: bryan@stpaulwithallsaints.org.uk

- Medway Accident Prevention Scheme - selling low cost home safety equipment (e.g. stair gates) to parents and carers.
- Medway Asthma Self Help Group (MASH) helps with information and support locally working with health professionals.

Email: bridget@gales.u-net.com

- Medway Carers Centre (Young Carers) - The project supports children and young people who are affected by a family member’s long-term illness or disability in Medway. Information, peer support, group sessions and 1:1 key worker support is available.

Email: Andrea.Goddard@aol.com

- The Saturday Club - This club offers disabled children and their siblings positive fun experiences in a safe environment at the Parklands Resource Centre in Gillingham.

Email: angela.boyle@medway.gov.uk

- Medway Ethnic Minority Forum (Mother Tongue Language) - Mother tongue language tuition will be provided to children from various ethnic groups in many community settings in Medway.

Email: memforum@hotmail.co.uk

- Aloof/Sycamore Youth Clubs - Youth clubs work with local communities and established residents groups within the Chatham Central, North Gillingham, Rochester South and Horsted, Luton and Wayfield wards to initially identify the greatest need and the current provision of youth facilities for 8-13 year olds. Once the needs have been identified, local community members are recruited to assist with the running of the youth clubs, and eventual management and running of the youth clubs, to ensure sustainability.

Email: peter@sunlighttrust.org.uk

- Medway Mediation (Restorative Justice Conferencing in Schools) - Restorative justice in schools is a combination of peer mediation (a process in which students in conflict are guided by two trained peer mediators through a series of steps so that they can find their own way of resolving problems) and the Restorative Conferencing bringing together offending students with those affected by their behaviour to reach solutions which is delivered by trained facilitators from within school and the wider community). Both interventions provide a means of addressing offending and anti-social behaviour by young people in school and enable them to take responsibility for their actions, recognising the harm that has been caused and agreeing how that harm can be corrected. Peer mediation deals with the lower end of conflict whilst restorative conferencing aims to target those young people whose behaviour places them at risk of exclusion.

Email: mediationsue@btopenworld.com

- A young person's smoking cessation service has been set up, which takes self-referrals, as well as those from schools and Connexions.
- Place2be - enabling therapeutic and emotional support to children in primary schools, through talking, creative work and play
- Development of a SPEAKEASY course to help parents talk to their children about sex and relationships, which will be rolled out in schools across Medway. A similar programme for drug misuse is being developed.
- The Police, Kent County Council and Medway Council are working together to develop a joint drug education strategy across Kent and Medway. The aim is to involve local head teachers with the strategy to ensure ownership and increase the use of the drug screening tool (DUST) in youth clubs and schools. Professionals can use this tool, as a referral tool to appropriate services for young people in need. Contact details as above
- Development of a peer education programme for sex and relationship education (SRE) in schools. Email: Jo.Ferry@nhs.net



- The Pharmacy Emergency Hormonal Contraception Scheme provides emergency contraception to women under 24, free of charge, through community pharmacies in Medway. An accredited pharmacist may supply emergency contraception under a patient group direction. Medicine counter staff in pharmacies where the service is provided will be trained to refer each request for emergency contraception to the accredited pharmacist.
- Implementation of a Medway-wide SRE policy, involving statutory and community sector working with young people, to ensure that young people receive consistent messages about sexual health and relationship issues, and signposting to local services. This policy development will include a pilot condom distribution scheme provided by youth support workers.

Contact: **Jo Ferry**

- Project Esteem is an Interreg III funded initiative which promotes the mental health of young people between 12-18 years old in Medway, targeting those at risk of offending or at risk of exclusion.

Email: graham.gcreasey@medway.gov.uk

Key 'Choosing Health' targets for children and young people in Medway

- Simplify messages on what a portion of fruit or vegetables means for children and adults
- To provide eligible pregnant women, breastfeeding mothers and children in low-income families with vouchers that can be exchanged for fresh fruit and vegetables, milk and infant formula through a new scheme - Healthy Start
- As part of the School Fruit and Vegetable Scheme, all four - six year-old children in will be eligible for a free piece of fruit or vegetable every school day
- Improve nutrition in school meals by revising school meals standards. Ofsted inspectors will be looking at healthy eating in schools, and will take account of any school meals provided
- Building on existing progress, by 2010 all schools in England should have active travel plans
- Protect young people by giving information about responsible drinking, checking identification and refusing to sell alcohol to people who are under 18
- To support Teenage Pregnancy Partnership Boards to strengthen delivery of their strategy in neighbourhoods with high teenage pregnancy rates
- Nationally, there is a vision that half of all schools will be Healthy Schools by 2006, with the rest working towards Healthy School status by 2009
- The Department of Health will pilot health services dedicated to young people and designed around their needs and to make NHS services easy to use and trusted by young people
- Take action to prevent under age tobacco sales by looking at higher fines and improve education for retailers on better compliance
- The NHS and the council will be fully involved with the new Children and Young People's Plan arrangements in taking action to promote the health of children and young people



- The Government's longer-term ambition is for a children's centre to be in every community
- Central capital and revenue funding will be made available to tackle the high rate of sexually transmitted infections in England. This will support modernisation of the whole range of NHS sexual health services, to communicate better with people about the risks, offer more accessible services to provide faster and better prevention and treatment, and deliver these services in a different way
- National screening programme for Chlamydia, to cover the whole of England by March 2007
- Build on the commitments within the Alcohol Harm Reduction Strategy for England through: piloting approaches to targeted screening and brief intervention in both primary care and hospital settings, including A&E departments; and criminal justice settings with the aim of reducing repeat offending
- Voluntary social responsibility scheme for alcohol producers and retailers, to protect young people by placing information for the public on alcohol containers and in alcohol retail outlets and including reminders about responsible drinking on alcohol advertisements, checking identification and refusing to sell alcohol to people who are under 18.
- DH will pilot health services dedicated to young people and designed around their needs. These services will include primary care and specialist services in locations that are aimed at attracting young people, and will include facilities such as internet access.
- Nationally health and education will work closely to develop systems for recording lifestyle measures, such as obesity among school-age children



Recommendations

- Food initiatives and weight control interventions should be targeted at those communities in greatest need using the Medway Obesity strategy. Interventions should integrate physical activity with dietetic interventions
- Professionals, volunteers and community members should be appropriately trained to support communities and individuals to adopt health lifestyles relating to diet, exercise and non-smoking
- Adolescents, particularly girls should be targeted to increase opportunity and participation in physical activity. Emphasis should be on the immediate benefits such as enjoyment, fun and social aspects of physical activity rather than long-term health gains
- Use small area statistical information to further understand and raise the profile in Medway of areas of disadvantage and monitor and evaluate current and future initiatives to address these inequalities
- Use Health equity audit as a tool to support the reduction of health inequalities
- Establish a young people's cessation service which makes use of text messaging and youth friendly protocols

- Ensure that oral health promotion continues to link with programmes that aim to support the improvement of the diet of young children
- Continue to improve the access to support given to women to stop smoking in pregnancy
- Support local and national work to restrict smoking in enclosed public places and workplaces
- In the light of the Young People's Lifestyle Survey, review the quality and provision of contraception, advice and information relating to sexual health for young people to ensure that services are universal, equitable confidential, readily accessible
- Continue to work with young people and community partners to ensure that young people have the skills needed to negotiate when they have sex and the use of contraception



Working and living in Medway- the economically active population (adults)

What is the importance of this phase of life?

Social and economic constraints and opportunities affect health and disease risk during the adult working life period. This phase of life will build on the social and personal skills and coping techniques learnt in childhood and adolescence. The impact of experience and resources built up in childhood continue into adult life. There are still opportunities to take different pathways to alter course via different opportunity or lack of opportunity, such as education, learning experience and different lifestyles and types of behaviours.

Health, social and educational improvement chances influence where people live and what jobs they have. This middle part of life has an important impact on people and their families as they move into the later phases of ill health, loss of independence and old age. However, it is important to remember that this group of people will also have a fundamental effect on the experience of the children and young adults they are influencing and supporting.

The main national policies relating to the economically active population:

New deal	NHS Plan
NHS as a corporate citizen	National standards local action
Healthy workplace initiative	A new deal for transport
National strategy on neighbourhood renewal	Sustainable communities homes for all
Alcohol harm reduction strategy	Sustainable communities people, places and prosperity
Tackling drugs to make a better Britain	Smoking kills
Action on mental health: a guide to social inclusion	Health Inequalities: Programme for Action
	Neighbourhood Renewal

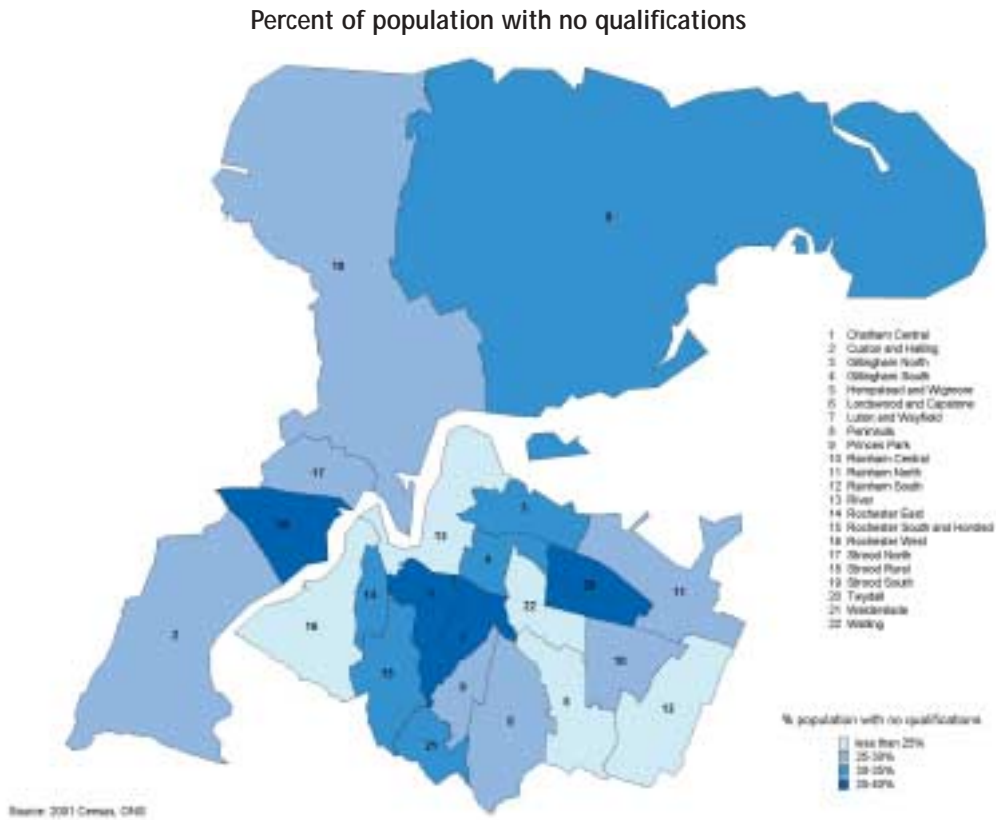


The labour market and the economy

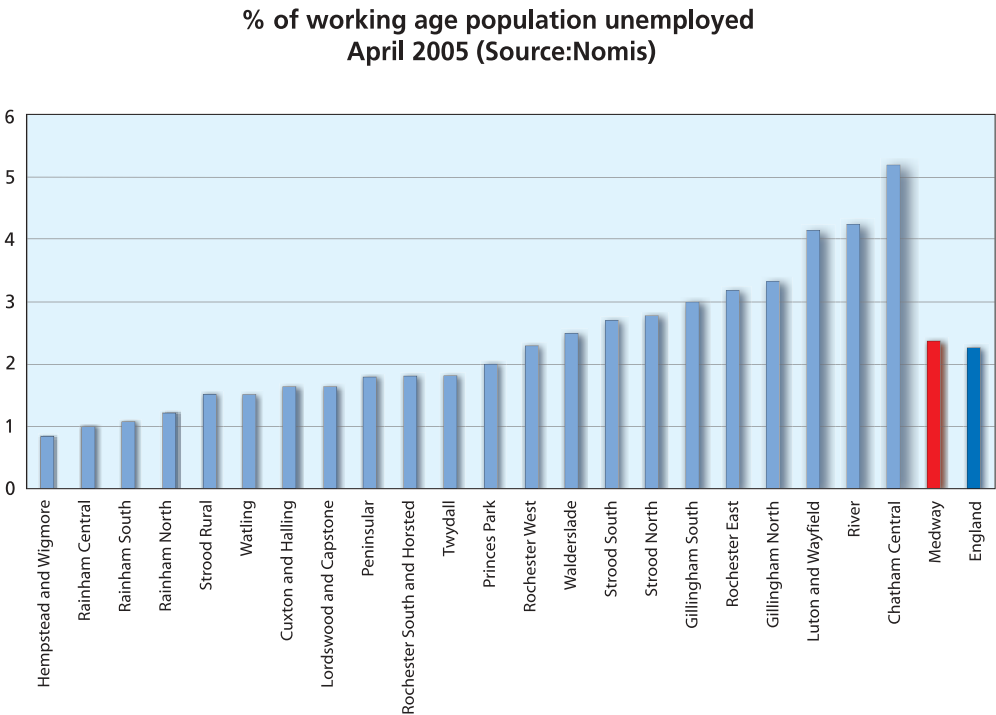
Medway is part of the south east region which has a prospering affluent economy with low levels of unemployment. However, there are significant numbers of people in Medway who are excluded from this wealth because of unemployment or low earnings perhaps due to low education or skill levels. These differences have an impact on health, as people are unable to afford good food, good housing and leisure, and are unable generally to participate in communities.

Locally

The lack of educational qualifications amongst the adult population varies across Medway, this is shown in the map below:

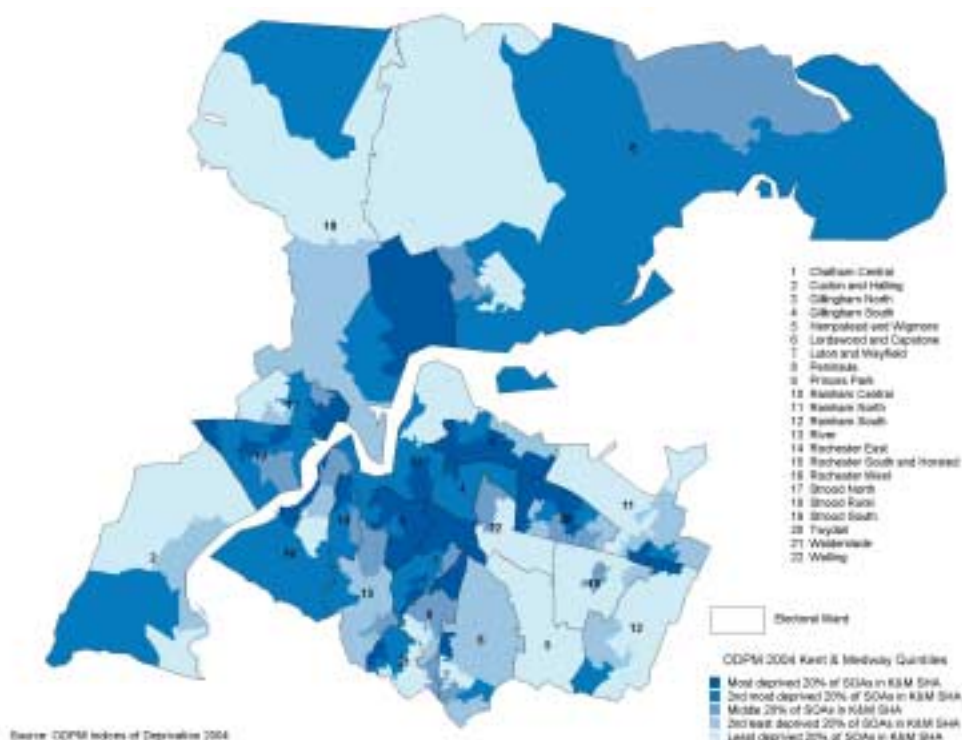


There are clear differences in access to work locally and this is reflected in unemployment levels in Medway, the graph below illustrates the contrasts across Medway.



The IMD 2004 index contains an income deprivation domain which shows at low geographical levels Standard Output Areas (SOAs) the difference in incomes

Rank of Income Deprivation for Medway UA LL-SOAs



What does this mean?

Inevitably there is a strong relationship between levels of deprivation and unemployment and the maps show that the highest levels of deprivation coincide with the lowest levels of educational achievement. This suggests very strongly that these areas are likely to be those with the greatest need for supporting individuals and communities to improve and retain health.

Housing

Shelter is a basic need that will contribute to maintaining and achieving good health. The opportunity of decent housing promotes strong communities well-being and independence. It has been estimated that, poor housing can increase the risk of severe ill-health or disability across the life course by 25 per cent on average.^{27, 28}

Locally

- the average cost a property in Medway was £153,000 in March 2005 (SOURCE:land registry)
- the average weekly local authority rent in Medway in April 2004 was £54

What does this mean?

There is a significant proportion of the population that will not be able to consider buying property. This confines their choice and freedom to make decisions about where they live and how they live their lives and of which communities they are a part . The cost of housing also presents issues for the recruitment and retention of workers in Medway - the cost of housing makes it unattractive for key workers such as care workers, teachers and health and education staff to come to work in Medway. This also has implications for running services locally.

Lifestyle

Lifestyle risk factors such as smoking, excess alcohol consumption, use of illegal drugs, inappropriate diet and lack of physical activity is associated with many diseases including mental illness, coronary heart disease, stroke and cancers.

Locally (source Kent and Medway healthy lifestyle survey 2001)

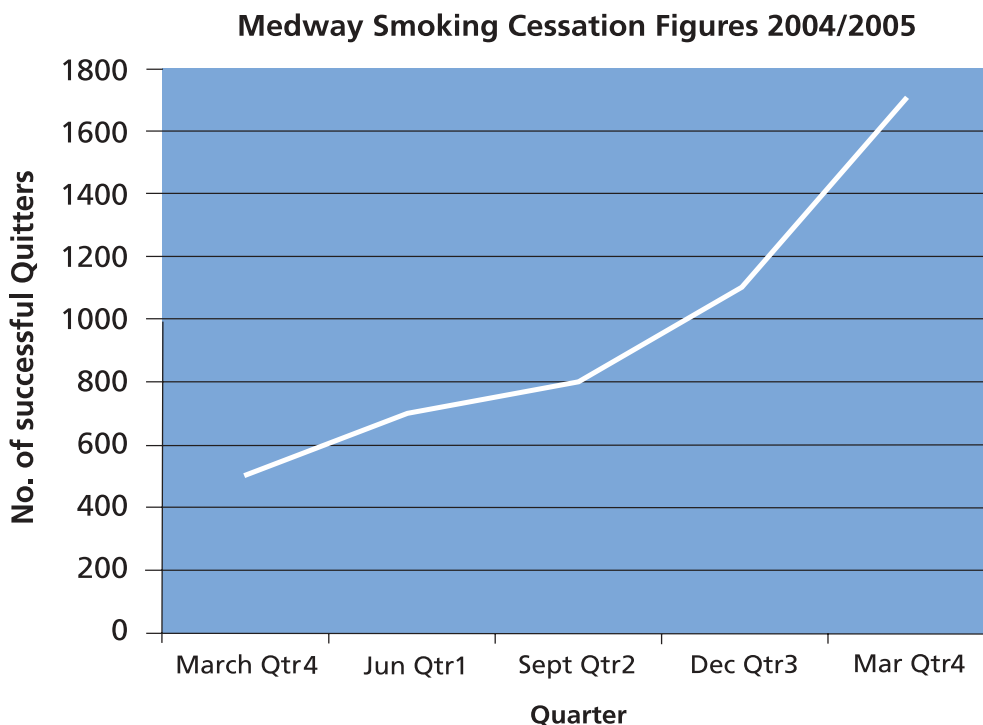
- Obesity: 48 per cent of women and 45 per cent of men in Medway had a BMI over 25, so were overweight or obese
- Illegal drug use: there were 20 deaths that were directly attributable to drug misuse in Medway in between 2001 and 2003
- Alcohol is also clearly a significant factor in many types of accidents, particularly road traffic accidents and has a significant societal 'cost' in terms of family life, mental health and economic position. Alcohol is an avoidable and unnecessary cause of early death in Medway, (see table below). This is higher than the rate for the South East and England and Wales. People die from mental and behavioural disorders due to use of alcohol, including dementia.

Area	Rate per 100,000 population
Medway	12.2
South East	9.5
England & Wales	10.9

The following table uses work done by Godfrey and Hardman²⁹ and subsequent updating of the work by Dept. of Health (EOR) 1999 and extrapolates the data to the Medway to create a broad estimate of the large costs of alcohol misuse per year to Medway

	£
1. The social cost to industry	
Sickness absence	6,000,000
Unemployment	1,400
2. Social costs to the NHS	
Inpatient costs - direct alcohol diagnosis	240,000
*Inpatient costs - other alcohol related diagnoses	700,000
General practice costs	30,000
3. Social cost of material damage	
Road traffic accidents- damage	780,000
4. Social costs of criminal activities	
Police involvement in traffic offences (excluding road traffic accidents)	30,000
Police involvement in road traffic offences (including judiciary and insurance admin)	120,000
Drink related court cases	150,000
Total	8,051,400

- Smoking: At least 48,000 adults in Medway smoke. More than 480 people a year in the Medway die from smoking
- In the UK we smoke more cigarettes per person than the European average and more deaths are caused by smoking in the United Kingdom than in other countries. Passive smoking kills hundreds every year. Smoking costs the NHS in the Medway up to £6 million each year
- Using the Health Survey of England 2000 we are able to estimate that in the Medway every day, nearly 660,000 cigarettes are smoked, and that is more than a 33,000 packets a day. In April 2005 the average cost of a packet of 20 cigarettes was £4.92, so £162,000 a day is spent on cigarettes in Medway over £59m a year
- Smoking cessation services collect 'quit data' on smokers who report having quit smoking at four weeks after the beginning of treatment. In Medway during 2004-5 more than 1,700 people in Medway used this support to stop smoking, this is shown in the graph below

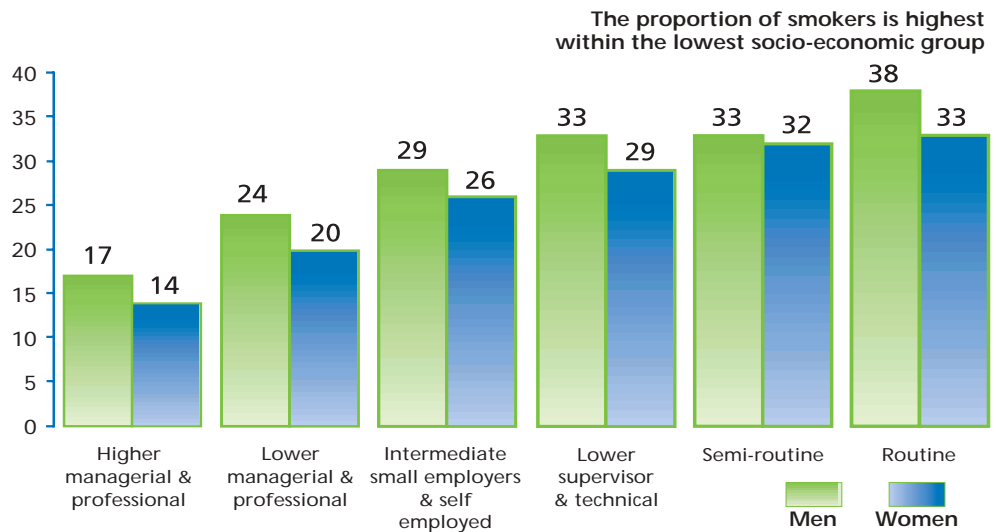


What does this mean?

Programmes to address these risk factors can potentially increase inequalities because they are accessed by more advantaged people. It is important that we acknowledge workplaces as an important environment to promote good health as those in work spend significant parts of their life at work. The White Paper identifies that the NHS should lead by example for its employees in this but locally we should be working closely with local employers to support people in healthy lifestyle changes to improve future health productivity.

We have seen overall rates of smoking decrease overall but there are disparities between how different groups in society take up these messages. This is illustrated in the graph below:

Prevalence of smoking
percentage of adult smokers
within each socio-economic group



Great Britain, 2001, aged 16 and over
Source: ONS Living in Britain (General Household Survey, 2001)

Smoking hits poorer people harder, widening inequalities in remaining disposable income and in health among social groups. Government will never completely ban smoking, because it is accepted that smokers have a right to choose to smoke, but *smokers do NOT have the right to impose their smoke on others. The statutory, voluntary sector and the community in Medway* has a responsibility to support policies to reduce smoking and save lives, *such as smokefree public spaces (with limited exemptions).*

Local services and initiatives that support health improvement for people of working age in Medway

- Active Life Scheme - continue to promote this scheme amongst Medway residents. It is planned to establish more outreach classes in poorer communities to develop the scheme further - All Saints, Twydall.

Email: hanife.dacosta@medway.gov.uk

- All Saints Housing Renewal Scheme - £350k available in housing grants to support properties in the All Saints area. The work is primarily aimed at tackling fuel poverty by replacing boilers, windows, fitting central heating etc. By making small changes to housing conditions, there is usually an impact on an individual's overall quality of life. None of the grants awarded are means tested as all qualifying criteria have been removed. The grant scheme is currently targeting about 800 homes in the All Saints area, and take up has improved by word of mouth amongst local residents.

As part of the All Saints Lifestyles' Group, this work will be developed further by for example, adding extra questions or listing extra services available regarding health and lifestyles, to the application form. Housing officers will

be trained to talk about these services with clients and possibly signpost them to other services as they work very closely with clients in their homes.

Email: joanne.lawson@medway.gov.uk

- Local Roots - Food Co-op - This fruit and vegetable scheme was established at the Sunlight Centre in Gillingham. Local residents pay £1 to join the scheme and £2.50 per week thereafter for a bag of fruit and vegetables. Members of the scheme either collect the bags direct from the Sunlight Centre or a home delivery service is also provided. It is planned to roll this programme out to other poorer communities in Medway (if there is a demand from local residents) - All Saints and Twydall areas.

Email: neil@sunlighttrust.org.uk

- All Saints Lifestyle Group - The key aims and objectives of the Lifestyles group are to take forward locally agreed actions to improve the health and well-being of the local residents, and to tackle any outstanding health inequalities. The healthy lifestyles group will report directly to the Neighbourhood Renewal Executive group. Key areas of work will focus on the main themes outlined in 'Choosing Health'.

Email: tracy.bishop@medwaypct.nhs.uk

Key 'Choosing Health' targets for people of working age in Medway

- Introduction of smoke-free places through a staged approach
- Shift the balance significantly in favour of smoke-free environments.
- Use health equity audits to build a better understanding of why some people or groups are less likely to use the range of available opportunities for screening, and then act to promote take-up
- Introduce a system that could be used as a standard basis for signposting foods. This will build on the nutrient criteria for the 5 A DAY logo
- Comprehensive 'care pathway' for obesity, providing a model for prevention and treatment
- A patient activity questionnaire which will be available by the end of 2005 to support NHS staff and others to understand their patients' need for interventions
- Capital and revenue funding to tackle the high rate of sexually transmitted infections in England. This will support the modernisation of the whole range of NHS sexual health services, by communicating better with people about the risks as well as offer more accessible services to provide faster and better prevention and treatment, and by delivering these services in a different way
- National screening programme for Chlamydia to cover the whole of England by March 2007
- Build on the commitments within the Alcohol Harm Reduction Strategy for England through developing a programme of improvement for alcohol treatment services, from April 2006, through additional funding provided through the Pooled Treatment Budget for Substance Misuse

- Piloting approaches to targeted screening and brief intervention for alcohol misuse in both primary care and hospital settings, including A&E departments. Similar initiatives can be used in criminal justice settings with the aim of reducing repeat offending
- Drive forward action to improve people's understanding of health issues,
- NHS-accredited health trainers will be giving support to people who want it
- Dentists will give a new focus to advise on the prevention of disease, lifestyle advice and the discussion of options for care
- Strategy for pharmaceutical public health demonstrates how pharmacists and their staff can contribute to improving health and reduce inequalities.
- The NHS will continue to develop employment policies and practices to make better healthier NHS workplaces
- Department for Health will continue to develop appropriate systems for recording lifestyle measures
- Develop and build capacity for health improvement at all levels of the system, with the backing of a national competency framework for health to support the development of the necessary education and skills

Recommendations

- Ensure disadvantaged areas are benefiting fully from universal publicly provided programmes through the use of locally defined targets aimed at poorer communities
- Undertake a health and lifestyle survey of the adult population in Medway to understand more clearly local needs and perceptions of aspects of health relating to diet, exercise, smoking, alcohol use, sexual health and wellbeing. This will enable monitoring and evaluation of current and planned interventions
- Support more people in Medway to stop smoking by increasing access to and awareness of stop smoking support in Medway
- Ensure that sustainable community- based interventions are developed to encourage take up of lifestyle focused activities based on local knowledge and needs in different areas of Medway
- Develop a strategy to reduce harm caused by alcohol misuse which is owned and supported by statutory and voluntary community sectors
- Set local targets to reduce alcohol related harm by March 2005⁶

Older people: Maintaining good health and independence

Overall life expectancy has increased dramatically over the last 100 years. In 1997, life expectancy at birth in the UK was 75 years for men and 80 years for women, compared with just 50 years for men and 54 years for women in 1911.³⁰ Ageing need not necessarily mean being unhealthy. As well as increasing life expectancy, we need to ensure that older people have sufficiently good health to be able to live active and independent lives.

The use of hospital care is generally heaviest in the last few months of life. Typically, until then, the majority of people, including the elderly, do not make great use of hospital inpatient care. However, there are a number of illnesses, such as cardiovascular disease, cancer and respiratory disease that are common amongst older people. Illnesses like these, in this older age group, result in the most significant dependence on health and social care systems by any of the three life cycle groups described in this report. 50 per cent of social services budgets and 40 per cent of health care budgets were spent on the over 65s in 1998/9.³¹

The main dependence is for treatment and care and, unlike the other two groups, there is far less potential and opportunity for prevention, although some schemes, do produce positive results.

Lifestyle has a major impact on the susceptibility of individuals to these illnesses, for example, through cigarette smoking and poor nutrition, as well as physical environment such as housing conditions. This chapter recognises that often these conditions are not confined to people in the older age group, and where appropriate, analysis of other age groups has been included.

Most of this chapter focuses on measurable and accessible profiles, such as physical disabilities, difficulties with housing and the impact of the environment. However, there are often factors underlying these that impact on older people but are more difficult to detect, particularly around mental illness.

*“Under-detection of mental illness in older people is widespread, due to the nature of the symptoms and the fact that many older people live alone... and mental health may be perceived... as an inevitable consequence of ageing, and not as health problems which will respond to treatment”.*³² These factors should not be overlooked and are considered to be key points for this group.

In order to maintain good health and independence, older people need to have straightforward accessible information about both preventive facilities and services, and more intensive services if their health has become poor. They also require easy means of accessing the services, which are relevant to their conditions. Many places are investing in new and imaginative ways of enabling people to help themselves to maintain good health.



The main national policies relating to older people:

National standards local action	NHS Plan
UK fuel poverty strategy	Coronary heart disease NSF
Older people NSF	Diabetes NSF
Preventing accidental injury - priorities for action	Cancer plan
Long term conditions	National Service Framework for Older People
Health Inequalities: Programme for Action	Mental health NSF

Inequalities in health of older people

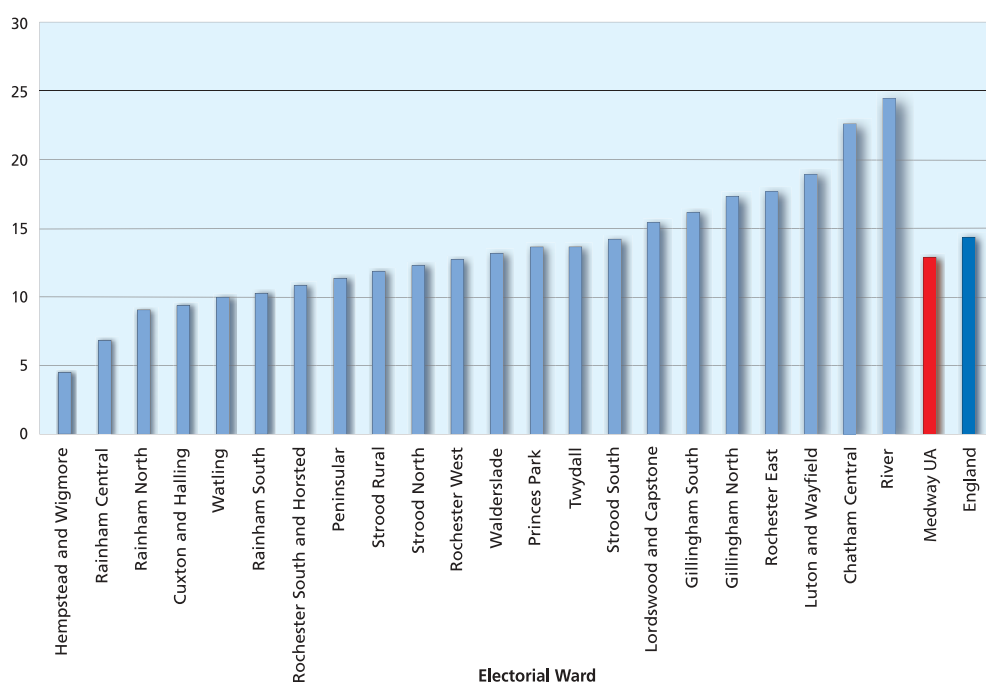
There are substantial inequalities in the health of older people in Medway, both compared to the general population in England and in Medway and between different groups of older people. This is reflected in differing life expectancies, disability and ill health.

The two largest preventable factors which could make a significant impact on reducing health inequalities are smoking and fuel poverty.

The other factors of inequalities in health for older people, (including gender, ethnicity, disability, sexuality, and socio-economic and geographical determinants), need to be addressed by ensuring mainstream approaches take account of the differing factors, and by ensuring targeted projects address inequalities.

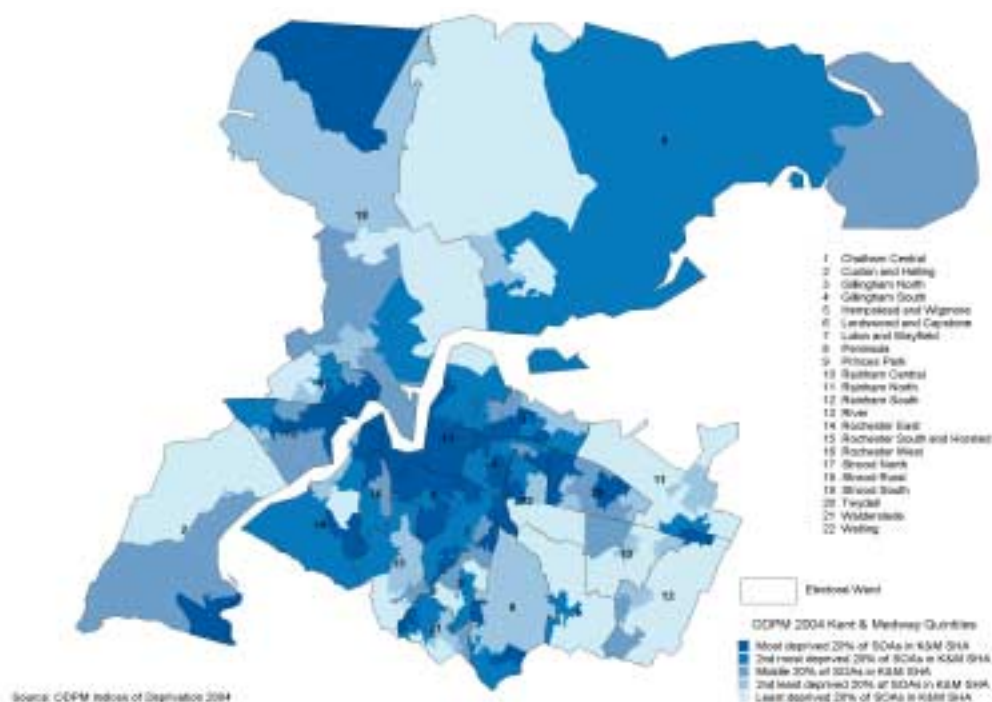
The proportion of the population over 60 claiming income support in addition to their pension is shown in the graph below. This means that in Medway more than 5,000 older people received these benefits to enable them to maintain a basic standard of living.

% over 60s claiming income support in Medway



The map below illustrates the areas of income deprivation measured by the IMD 2004 for older people and shows some geographical contrast with the general deprivation measure patterns and those of the pattern of deprivation relating to children and young people. This suggests that a health equity audit should be undertaken of older people's health and healthcare services in Medway to review whether there are health inequalities within this group to enable appropriate targeting of health and health care interventions.

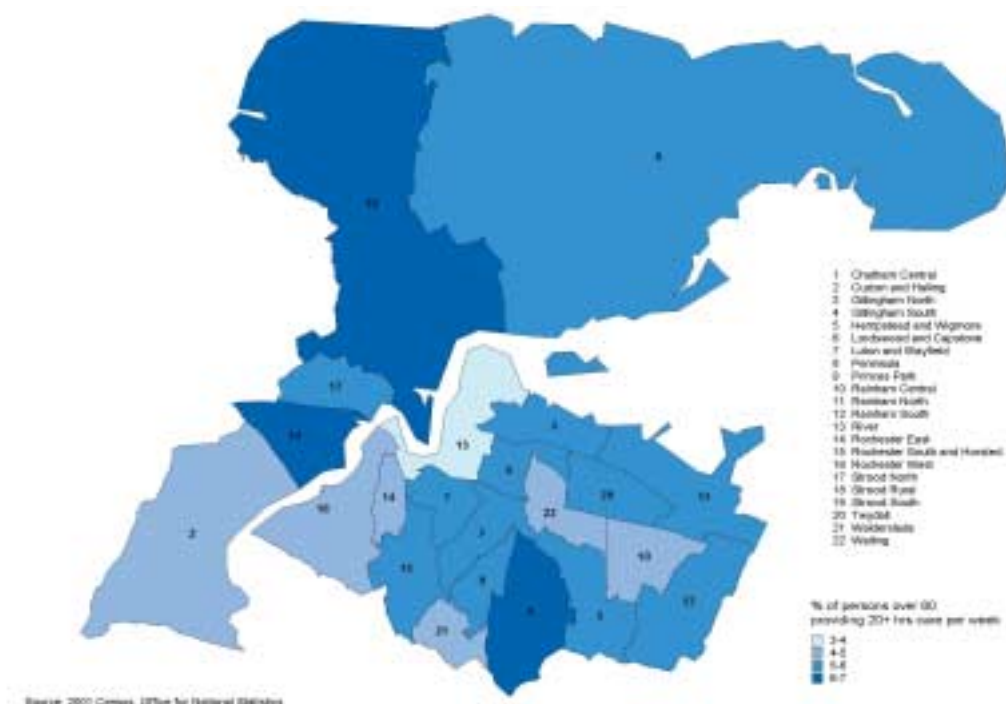
Rank of Income Domain Affecting Older People Index for Medway UA LL-SOAs



The following information is from the 2001 census, based on peoples' own descriptions of their health. Older people in Medway report worse levels of general health than the England average; 8,155 people aged 60 and over in Medway reported poor health.

Demands on health and social care are influenced by the demographic profile, including the health and social conditions in which people live. Longer life can lead to increased numbers of health interventions and need for long-term care. For example, it is estimated that there are 2,500 people aged over 75 suffering from dementia of varying degrees in Medway³². People aged 75 or over represent 10 per cent of the population of Medway compared to the general England average of six to eight per cent.

Older people provide substantial amounts of unpaid care to other people, to spouses and partners, but also as life expectancy increases to their own parents and often grandchildren. The following map summarises the patterns of unpaid care amongst older people in Medway:



Fuel Poverty

There are clear links³³ between cold, damp housing and an increased risk of ill health or even death. While it is likely that socio-economic deprivation is an indicator of poor housing conditions amongst older age groups and those with disabilities, it is likely that there are also significant numbers of previously affluent people who continue to live in large homes that they can no longer afford to heat. They are therefore experiencing fuel poverty.

Nationally, it has been estimated that more than four million British households are suffering from fuel poverty, and about half of the fuel poor households in Britain are occupied by individuals aged 60 or over. This would equate to about 15,000 people living in Medway who suffer fuel poverty. Fuel poverty is linked to excess winter deaths.

In Scandinavian countries population studies show that although winters are colder, houses are better heated and result in no excess winter mortality. Fuel poverty can be addressed by grants for improving insulation and heating in older people's houses and by providing advice and support on benefits and reducing fuel costs.

Main causes of disease in older people

Deaths in people aged less than 65 years

As the life expectancy locally is over 75 years, this means these people are dying before their time. Many of these deaths could be prevented, especially through not smoking, being physically active, eating a balanced diet and having local opportunities for good education and jobs.

Deaths from all causes

Medway has an indirectly standardised mortality ratio (SMR), a death rate of 108 for all causes for all ages for men and women. The national rate is 100, so a rate of eight lower means that locally eight per cent more people are dying than the national average. The rate for men is 107, i.e. seven per cent higher than average,

the rate for women is 108, i.e. eight per cent higher. (All of these are rates are statistically significant- i.e. not as result of chance variation in the data) (National statistics 2001-2)

Coronary heart disease:

Locally

- Males aged 65-74: 21.5 per cent prevalence (about 1800) men in Medway, with the highest rate in the 75+ age group, 26.4 per cent , about 1400 men in Medway.
- Females aged 65-74: 9.7 per cent prevalence, (about 900) women in Medway with the highest rate in the 75+ age group 18.4 per cent about 1700 women in Medway

(British Heart Foundation 2005)

- Medway has an (SMR), a death rate, of 107 for coronary heart disease for all ages for men and women, the national rate is 100, so a rate seven higher means that locally 7 per cent more people are dying of coronary heart disease than the national average, the rate for men is 103, i.e. three per cent higher than average (but is not statistically significant) the rate for women is 112, i.e. 12 per cent higher, which is statistically significant. (National statistics 2001-2)

Stroke:

Nationally

Each year 110,000 people in Britain will have their first stroke. It is the single biggest cause of severe disability and the third most common cause of death. The risk of stroke can be reduced by:

- Increasing physical activity
- Encouraging healthy eating
- Supporting people to stop smoking
- Identifying and managing high blood pressure

Locally

- Males: aged 65-74 7.6 per cent prevalence about 650 men in Medway; with the highest rate in the 75+ age group 13.3 per cent , about 690 men in Medway
- Females: aged 65-74 5.4 per cent prevalence about 500 women in Medway; with the highest rate in the 75+ age group 8.9 per cent, about 714 women in Medway

(British Heart Foundation 2005)

- Medway has an SMR, a death rate, of 90 for stroke heart disease for all ages for men and women, the national rate is 100, so a rate 10 lower means that locally 10% less people are dying of stroke than the national average, the rate for men is 72, i.e. 28per cent lower than average (but is not statistically significant) the rate for women is 101, i.e. one per cent higher. (National statistics 2001-2)

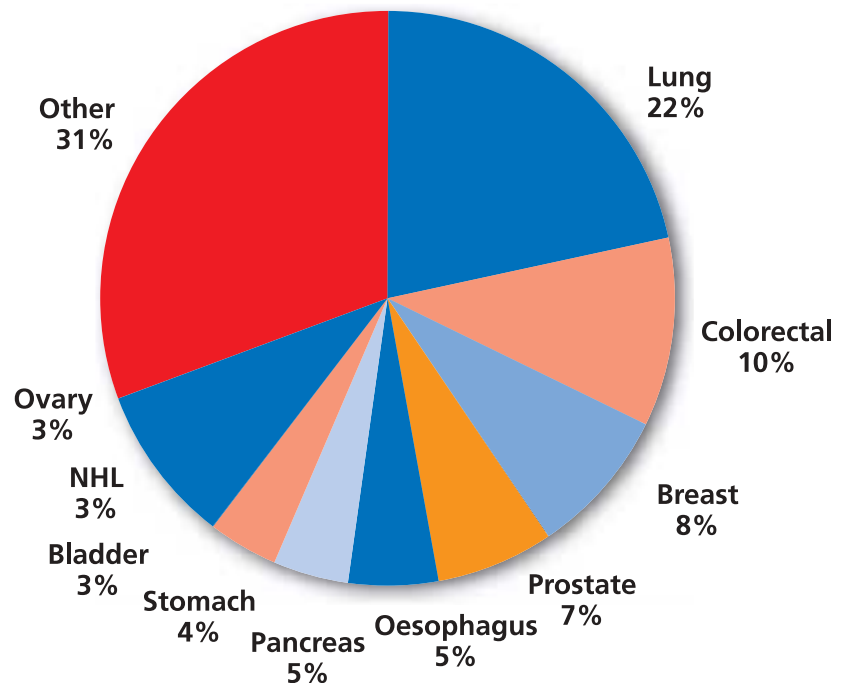
Diabetes

Locally

- Medway has an SMR, a death rate, of 90 for diabetes, 136 for all ages for men and women, the national rate is 100, so a rate 36 higher means that locally 36 per cent more people are dying of diabetes than the national average, the rate for men is 104, i.e. four per cent higher than average the rate for women is 165, i.e. 65 per cent higher. (the rates for women and persons are both statistically significant) (National statistics 2001-2)

Cancer

More than one fifth (22 per cent) of all cancer deaths are from lung cancer as shown in pie chart, Cancer of the large bowel (colorectal) was the second most common cause of cancer death (10 per cent). Although breast cancer is rare in men, the high rates among women place it as the third most common cause of cancer death in all persons (8 per cent).



All malignant neoplasms - 154,547

percentages may not add due to rounding

- **All cancers** Medway has an SMR, a death rate, of 109 for all cancers for all ages for men and women, the national rate is 100, so a rate 9 lower means that locally nine per cent more people are dying of cancer than the national average (and is statistically significant), the rate for men is 113, i.e. 13 per cent higher than average (and is statistically significant) the rate for women is 104, i.e. 4 per cent higher. (National statistics 2001-2)
- **Lung cancer** is the most common cancer; the five year survival rates for lung cancer are only about five per cent and the only prevention is not to smoke.
- **Breast cancer** The five year survival rates have risen from 73 per cent for women diagnosed in 1991-95 to 78% for those in 1996-99 across England

and Wales. Nationally death rates have fallen by at least 20 per cent compared to before screening started. The peak age of diagnosis was 50-64 years, the same age group as those originally targeted by the screening programme, which now extends to include women aged up to 70. The aim of screening is to reduce death rates by earlier detection. The screening rates for those aged 50-64 in 2003 were 79 per cent locally and 75 per cent across England.



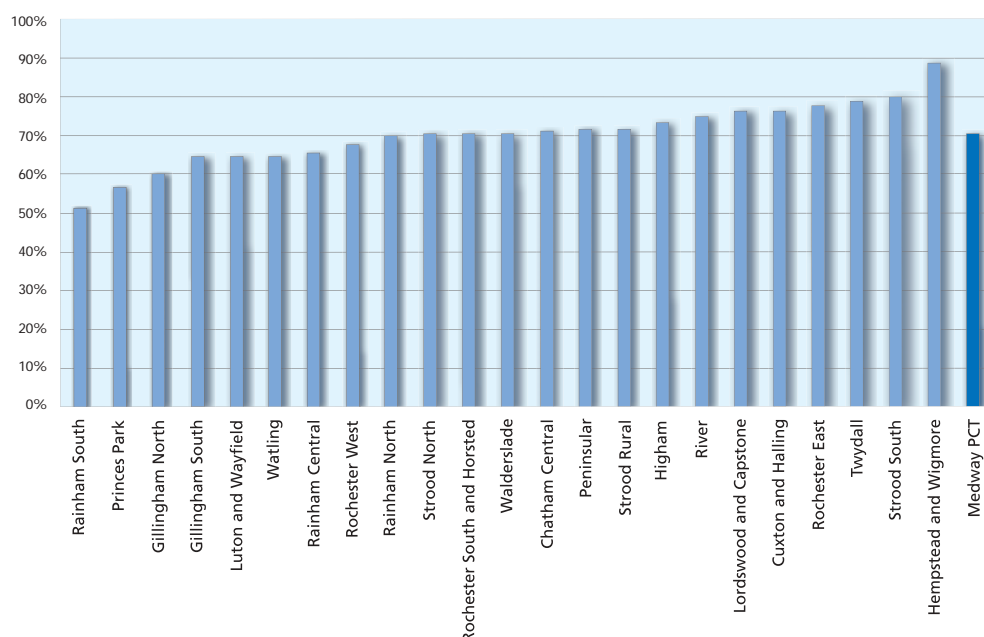
- **Colorectal (bowel) cancer** Medway has an SMR, a death rate, of 107 for bowel cancer for all ages for men and women, the national rate is 100, so a rate seven higher means that locally seven per cent more people are dying of cancer than the national average, the rate for men is 109, i.e. nine per cent higher than average the rate for women is 108, i.e. eight per cent higher. (National statistics 2001-2)

Excess winter deaths

Excess winter deaths are defined in any particular winter as 'the number of deaths in the four months December to March less the average of the numbers in the preceding autumn (August to November) and the following summer (April to July)³⁴. Excess winter deaths disproportionately affect older populations and those with existing chronic conditions. The Department of Health has published a report on 'Health Effects of Climate Change in the UK.³⁵ This estimates that, by the year 2050, excess winter deaths will have declined but there will be an increase in heat related deaths occurring in the summer. Therefore, while at present there is a high risk that older people may suffer adverse effects from cold weather, there will be an increasingly large percentage of the population in the future who may suffer due to warm weather. The current policy of combating fuel poverty³⁶ remains an important part of measures to reduce excess winter deaths. Poor nutrition may also be a problem for older people during the winter months, particularly in those who live in institutions.

It was estimated that in 1999/2000 there were 220 excess winter deaths in Medway. Pneumonia accounts for 33 per cent of deaths from respiratory illness, and influenza accounted for 1.2 per cent. It is clear that influenza vaccination reduces the number of deaths and hospital admissions. Older people and those with existing chronic conditions should continue to be encouraged to take up winter flu vaccination. Rates of uptake in the Medway are illustrated in the following graph.

% of over 65s vaccinated, winter 2004 (source:HPA)



Depression:

The prevalence of depressions in people 55 years old and over is around 13.5 per cent according to a study undertaken³⁷, this means that there will be more than 8,000 older people in Medway suffering from depression.

Disability:

The Health Survey for England 2000 estimates the following levels of disability in older people; numbers have been estimated for the Medway population:

Type of disability	estimated number in Medway (%) 65-79 years	estimated number in Medway (%) 80 years and over
Locomotor disability (e.g. Difficulty walking up and using stairs)	(26%) 629	(57%) 4620
Personal care disability	(12%) 2900	(29%) 2350
Sight disability	(5%) 1210	(17%) 1380
Hearing disability	(11%) 2660	(14%) 1130
Communication disability	(2%) 480	(8%) 650

Accidents

Nationally

Death rates from accidents are highest amongst older people, and more older people die from falls than from road traffic accidents. Hip fractures are the most common serious injury related to falls in older people resulting in a cost nationally to the NHS of about 1.7 billion pounds per year, of which 45 per cent is for acute care, 50 per cent for social care and long-term hospital care and five per cent for drugs and follow up care and treatment.

Locally

- In Medway there are about 260 admissions to hospital each year for people over 65 each year as a result of a fractured neck of femur. , This represents a higher rate than average in Kent and Medway particularly for women
- In Medway about 30 people over 65 die as a result of a fractured neck of femur, This represents a higher rate than average in Kent and Medway particularly for women and over twice as high as the rate for England

Individual risk and protective factors for health

Exercise and activity

Recent health survey of England data (2002) show that about 70 per cent of the general adult population are not sufficiently active to maintain good health, and this proportion increases as people get older. Nationally, an estimated 86 - 93 per cent of those over 65 were not active enough to benefit their health, (HSE 2001).

People who are physically inactive have twice the risk of coronary heart disease and three times the risk of stroke compared to those who are more physically active. Reduced physical activity results in a reduction in physical strength, co-ordination, balance and flexibility, which makes many older people susceptible to falling.

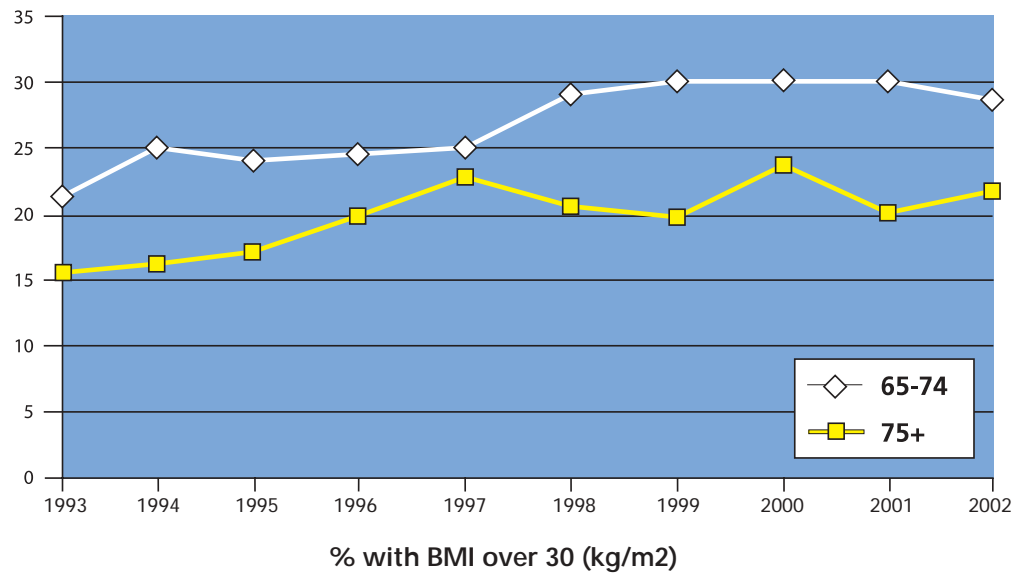
Physical activity has been found to have the following health benefits:

- Reduces the risk of Coronary Heart Disease
- Lowers total Cholesterol and triglycerides
- Lowers blood pressure
- Lowers the risk of developing type II diabetes
- Reduces the risk of developing colon cancer
- Helps maintain a healthy body weight
- Reduces stress and depression

Obesity

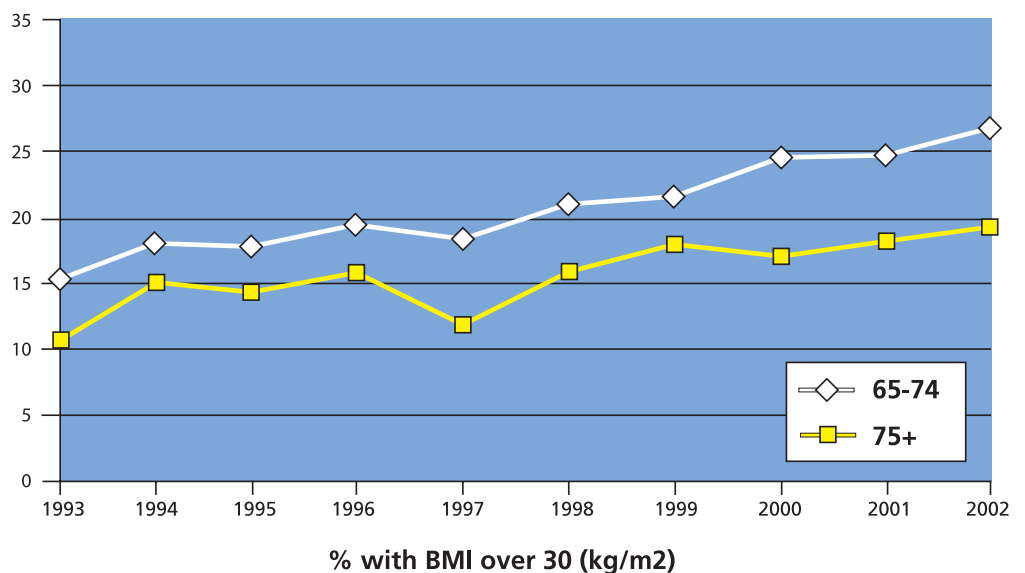
Obesity increases the risk of diabetes, coronary heart disease, stroke, cancer, respiratory disease, osteoarthritis, gall bladder disease and depression. Obesity is more common among older people and is increasing over time. An estimated 26 per cent of men and 28 per cent of women of 65-74 year olds are obese. The figures below illustrate the rising trend in obesity in over 65 year olds in the UK: (HSE 2004)

Obesity in Females over 65: 1993-2002



Source: Health Survey for England

Obesity in Males over 65: 1993-2002

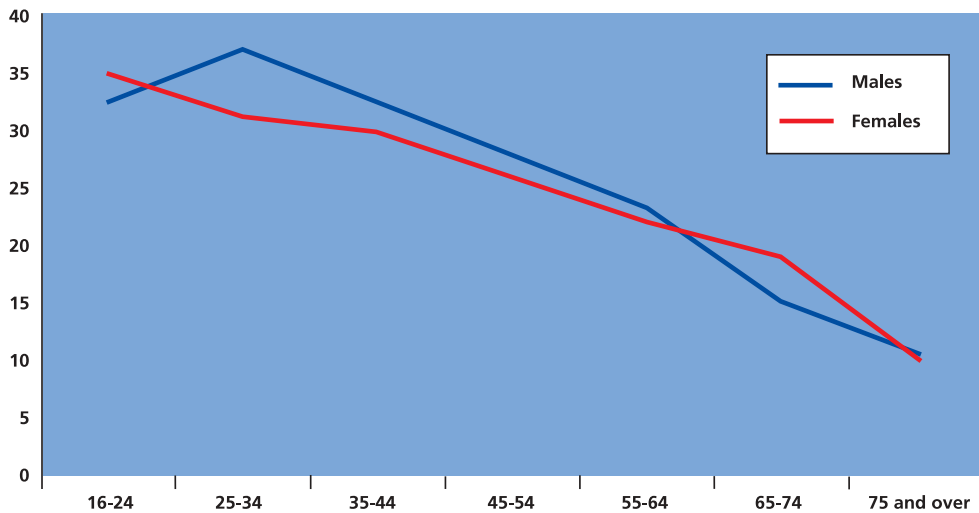


Source: Health Survey for England

Smoking

Smoking increases the risk of coronary heart disease, cancer, stroke, respiratory disease, dementia, blindness and osteoporosis. Smoking rates decrease with age, with only nine per cent of over 75 year olds smoking compared to 25 per cent of the general population. However, 71 per cent of men and 46 per cent of women over 65 used to smoke and many of the health effects are delayed. The figures below illustrate current and past smoking rates in people of different ages.

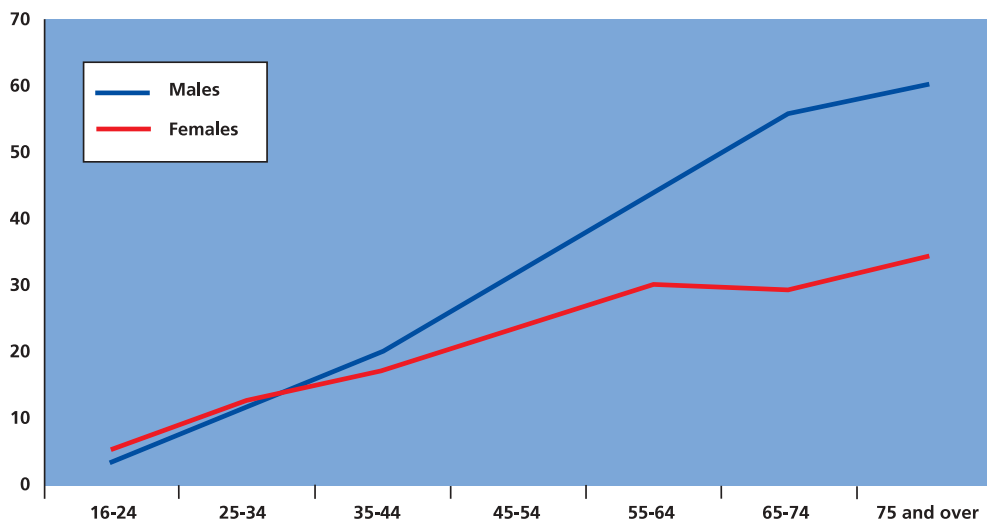
Current Smokers



Source: Health Survey for England 2000-2002

% of current smokers by age band

Ex-regular Smokers



Source: Health Survey for England 2000-2002

% of ex-regular smokers by age band

Locally these percentages are likely to be even higher. Figures from a health survey in Portsmouth which has a similar deprivation profile to Medway, shows that 79 per cent of males and 51 per cent of females aged over 65 used to smoke.

There is good evidence of effective measures to reduce smoking, including reduced advertising, tobacco control, medical advice, support groups and nicotine replacement medication. The evidence shows that older people are particularly well motivated to give up smoking, and have high success rates in quitter groups. However, targeting any age group for smoking cessation will benefit future groups of older people.

Alcohol

Nationally, there are increasing levels of alcohol consumption, with proportionate increases in health problems, including liver disease, high blood pressure and stroke, cancers, mental health problems and injuries. Alcohol consumption peaks in early adulthood and is relatively lower in older people. With age the volume of alcohol consumed tends to lessen, but the regularity increases, with those over 45 more likely to drink daily. National studies show the following percentage of men and women drink more than the recommended units per week in the table below:

Men and women drinking more than the 21/14 units of alcohol per week in the UK, 2001	Men	Women
65 and over	15%	6%

Although older people drink less than younger people, the long-term health effects of alcohol abuse are frequently seen in older people. In 1991 the peak age for alcohol related deaths was age 70; whilst in 2000 this had decreased to between 55 and 70, reflecting increasing consumption rates at younger ages. (Southampton Alcohol Strategy).

Preventing Falls

There is good evidence for the following physical activity interventions:

- Community- based exercise programme. These are especially effective when targeted at high risk groups
- Home Exercise Programmes. These are based on muscle strengthening and balance training of women over 80
- Exercise Programmes in Residential Homes this involves muscle strength and balance training programmes for high risk groups in supportive residential settings

There is also some evidence to support the following interventions for falls prevention:

- Medication reviews especially when people are prescribed several drugs or psychotropic drugs
- Home hazard assessment and correction when targeted at high risk populations (with a history of fall or frail elderly)
- Hip protectors in high risk individuals in residential settings
- Treatment of osteoporosis: reducing the risk of fracture following a fall.

Examples of current services and initiatives that support health improvement for older people in Medway

- Active Life Scheme-continuing to promote this scheme amongst Medway residents more outreach classes are planned in poorer communities focusing on particular local groups, e.g. older people. Appropriate activities, according to interest and ability, will be offered e.g. chair-based exercises.

Email: hanife.dacosta@medway.gov.uk



- In Twydall, following consultation with the local community as part of Medway Council's 'Community Futures Workshops', older residents requested more activities for their age group. On request old time dancing classes are starting in September

Email: churchinsocietytwydall@hotmail.co.uk

- Medway and Swale Falls Steering Group have developed a Falls Prevention Programme aimed at the over 65s at risk of falling., This includes carer training and initiatives aimed directly at older people

Email: Cathy.Steinmann@medwaypct.nhs.uk

Key 'Choosing Health' targets for older people in Medway

- Simplify messages on what a 'portion' of fruit or vegetable means
- Funding community food initiatives, focussing on poorer communities
- Healthcare professionals to support people to increase their fruit and vegetable consumption using a short 5 A DAY questionnaire as well as supporting work on obesity prevention and management
- Act on obesity as an issue in its own right using levers such as the new primary medical care contracting arrangements, enhanced services, and through negotiated changes which may be possible in the Quality and Outcomes Framework
- Develop a comprehensive 'care pathway' for obesity, providing a model for prevention and treatment
- Shift the balance significantly in favour of smoke-free environment; introduce smoke-free places through a staged approach: By the end of 2006, all government departments and the NHS will be smoke-free. By the end of 2007, all enclosed public places, other than licensed premises (and those specifically exempted) will be smoke-free
- Embedding an offer of stop smoking advice as part of clinical assessments in surgical care pathways
- Build on the commitments within the Alcohol Harm Reduction Strategy for England through developing a programme of improvement for alcohol treatment services
- If people want it, NHS-accredited health trainers will provide advice and support to develop a personal health guide, including help with defining the changes they want to make
- Strategy for pharmaceutical public health will demonstrate how pharmacists and their staff can contribute to improving health and reduce inequalities and how we can develop new services in the places they work
- Community matrons will take the lead in providing personalised care and health advice with support from health trainers
- Use health equity audits to build a better understanding of why some people or groups are less likely to use the range of available opportunities for screening, and then act to promote take-up




Recommendations

- The community and voluntary sector should be involved as partners in all public health developments
- Development of community infrastructure with particular emphasis on areas and communities where disadvantage is highest
- Reduce the gap between Coronary Heart Disease death rates in Medway and the rest of the country by improving diet, reducing smoking, and increasing physical activity
- A health equity audit should be undertaken of older people's health and healthcare services in Medway to review whether there are health inequalities within this group to enable appropriate targeting of health and health care interventions.

- 1 WHO Europe. Report of the working group on the concepts and principles of health promotion. Copenhagen: WHO: Regional Office for Europe 1984
- 2 Dahlgren, G and Whitehead, M. Policies and strategies to promote equity in health. Copenhagen; WHO: Regional Office for Europe 1992
- 3 Sonnabend, H. (1999), *Mensch und Landschaft in der Antike: Lexicon der historishcen Geographie*; J.B. Metzler: Stuttgart.
- 4 De Hollander, a. Bol, p. (2004), Friend and foe: health and the environment from an historical-epidemiological perspective; <http://www.library.uu.nl/digiarchief/dip/diss/2004-0511-152200/c1.pdf> accessed 24/06/05
- 5 Penn, R. (1981), *Portrait of the River Medway*, Robert Hale Ltd London.
- 6 Medway Council (no date given), *Local History: Tudor Medway 1485-1603: The Royal Dockyard*, www.medway.gov.uk/index/leisure/localhistory/timeline/17900/18071.htm (accessed 20/06/05)
- 7 English Heritage (2004), *The Historic Environment & the Thames Gateway 11092201R*, http://www.heritage.org.uk/upload/pdf/Final_report_textonly.pdf accessed 21/06/05
- 8 Medway Council (no date given) *Local History: Medway in the 20th Century 1901-2000*; www.medway.gov.uk/index/leisure/localhistory/timeline/17909. accessed 20/06/05
- 9 Office Of The Deputy Prime Minister (ODPM) (2003), *Sustainable Communities: building for the future*; www.odpm.gov.uk/stellent/groups/odpm_communities/documents/page/odpm_comm_0222184-02.hcsp#P35_2464 accessed 15/07/05
- 10 Ben Cave Associates (BCA) (2004), *Healthy Sustainable Communities: A spatial planning checklist*; Milton Keynes & South Midlands Health Care Group; <http://www.mksm.nhs.uk> accessed 10/06/05
- 11 BMA. *Growing up in Britain: a study of 0-5 year olds*. London: BMJ Books, 1999.
- 12 Dept. of Health. *Cross cutting review*. London: The Stationery Office, 2002.
- 13 Messecar D. *Smoking cessation interventions for pregnant women: what does the evidence show?* Journal of Academy of Nurse Practitioners 3 171-7, 2001.
- 14 Lumley J, Oliver S, Waters E. *Interventions for promoting smoking cessation during pregnancy* (Cochrane Review). The Cochrane Library Issue 3 Oxford: 2001
- 15 Dept. of Health. *Drug use, Smoking and drinking among young people in England in 2001*. London: The Stationery Office, 2002
- 16 www.alcoholconcern.org.uk
- 17 British Medical Association. *Adolescent health*. London: BMA, 2003.
- 18 Waller S, Naidoo B, Thom B. *Prevention and reduction of alcohol misuse*. London: HDA, 2002
- 19 Dept. of Health. *Drug use, Smoking and drinking among young people in England in 2001*. London: The Stationery Office, 2002.
- 20 British Medical Association. *Adolescent health*. London: BMA, 2003.
- 21 Costain L. *Our perception of ourselves*. BBCi Healthy Living. 2003. Available at http://www.bbc.co.uk/health/yourweight/bodyimage_perception.shtml#body
- 22 Emler N. *The costs and causes of low self-esteem*. 2001. www.jrf.org.uk/knowledge/findings/socialpolicy/n71.asp.
- 23 Turner T. *Self-esteem*. BBCi Your Health. 2003. Available at www.bbc.co.uk/health/mental/emotional_estimee.shtml
- 24 The Royal College of Psychiatrists. *Mental Health and Growing Up. The Emotional Cost of Bullying*. Fact sheet number 19. 2003.
- 25 NACRO. *Some facts about young people who offend 2000*. Youth Crime Briefing, March 2002. www.nacro.org.uk/data/briefings/nacro-2002030100-ycs.pdf
- 26 NACRO. *Effective Practice with Young People who Offend*. Youth Crime Briefing, August 1999. Available at www.nacro.org.uk/data/briefings/Nacro-1999080100-ycs.pdf
- 27 Marsh, A., Gordon, D., Pantazis, C. and Heslop, P. (1999)

- 28 Home sweet home: The impact of housing on poor health; The Policy Press
- 29 Godfrey C, Hardman G, Changing the social costs of alcohol. Final report to AREC. York: Centre for Health Economics, University of York 1994
- 30 <http://www.statistics.gov.uk/statbase/Product.asp?vlnk=8841&More=N>
- 31 <http://www.doh.gov.uk/nsf/olderpeople.htm>
- 32 <http://www.alz.co.uk/adi/pdf/3preval.pdf>
- 33 Collins KJ. Cold, cold housing and respiratory illness. In ed. Janet Roudge and Fergus Nicol 'Cutting the cost of cold' E&FN Spon (2000)
- 34 Curwen M. Excess winter mortality: a British phenomenon? Health Trend 1991; 22; 169-75.
- 35 <http://www.doh.gov.uk/hef/airpol/climatechange/001-20.pdf>
- 36 <http://www.dti.gov.uk/energy/fuelpoverty/>
- 37 Beekman, A. T., Copeland, J. R. and Prince, M. J. (1999). Review of community prevalence of depression in later life. British Journal of Psychiatry 174: 307-311





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7-8 Ambley Green, Bailey Drive, Gillingham Business Park, Gillingham ME8 ONJ, tel: 01634 382777,
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Civic Centre, Strood, Rochester, Kent ME2 4AU tel: 01634 333333