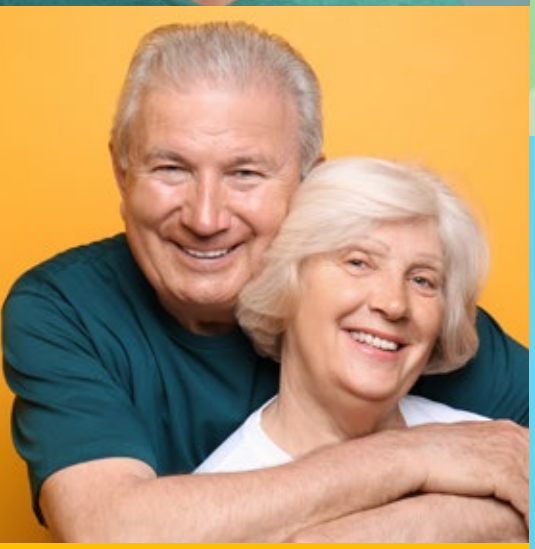
Health Inequality in Medway

Annual Public Health Report 2019/20

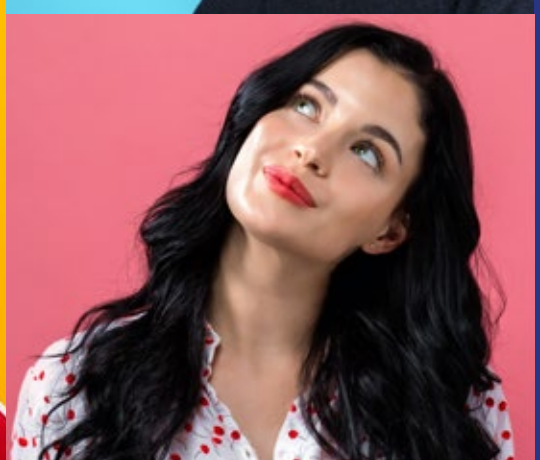












A BETTER MEDWAY
Easier ways to be healthy

Medway Council
Serving You

Healthy Minds, Healthy People: Wellbeing across the life course in Medway

Director of Public Health for Medway's Annual Report 2019-20

A BETTER MEDWAY
Easier ways to be healthy

Medway Council
Serving You

Contents

Foreword

James Williams
Director of Public Health
Medway Council

The SARS-CoV-2 (COVID-19) global pandemic has caused significant morbidity and loss of life, worldwide and in the UK. The manner in which different segments of our population have been affected by the pandemic has led many observers to suggest that societal disadvantage and health inequalities may be key factors that inform whether a person infected with COVID-19 has a positive or negative clinical outcome overall. The decision to explore the impact of health inequalities on the population of Medway in the 2019/2020 Annual Public Health Report (APHR) had been made prior to the COVID-19 pandemic. This was primarily because 2020 was the 10-year anniversary of one of the most pivotal investigations into health inequalities in England.

In 2010 Professor Michael Marmot published 'Fair Society Healthy Lives' (The Marmot Review)[1]. This ground-breaking work, commissioned by central government, aimed to provide a deeper understanding of the contemporary issues that gave rise to health inequalities in England. It provided much needed insight into the circumstances that contributed to the widening gap in terms of life expectancy and disability-free life expectancy seen at the time both within and across regions and communities in England.

The initial 2010 review found people living in the poorest neighbourhoods in England died, on average, seven years earlier than those living in the richest neighbourhoods and spent more of their lives contending with some form of disability – an average total difference of 17 years[1]. It was clear that wealth had become a key determinant for both the quality and quantity of life a person could expect.

There was an extremely positive response to the Marmot Review's findings at both national and local level; Marmot's concept of 'proportionate universalism', whereby actions taken to rectify inequalities should be of the same magnitude as the inequalities themselves, was especially popular. In practice, this means working with all segments of a community (from the most affluent to the most disadvantaged and all who lie in-between) to 'raise the bar' of living standards across the board. Marmot believed this was the best way to address entrenched disadvantage; previous efforts that only focussed on improving outcomes for one specific group (generally the poorest) had not been sustainable or successful. The Marmot review also introduced a range of inequality indicators that are key to the public servant's toolbox to this day; these can be applied within forums such as Health and Wellbeing Boards to determine whether actions taken to narrow the 'health gap' first identified by Marmot are being effective.

In February 2020, 'The Marmot Review: 10 years on' was published[2]. The updated findings suggest that the gap in health inequalities in England have not decreased substantially. In fact, there have been increases for some groups and the previous gains made to life expectancy seen in England over the

> “...smoking prevalence in adults in Medway was at its lowest recorded level since records began at 14.1%”

past decade have since stalled. When discounting for age, these findings potentially help explain why the impact of the COVID-19 pandemic appears to be more significant in areas of disadvantage; evidence suggests people infected with COVID-19 are more likely to become seriously ill, or die, if they have underlying health conditions such as diabetes, high blood pressure or obesity. These same long-term conditions are generally more prevalent in areas of disadvantage and play a significant role in increasing the gaps in life expectancy seen nationally. Other factors associated with the increased risk of transmission of COVID-19 that are linked to social disadvantage include housing tenure and type. For example, transmission rates have appeared higher in multigenerational households and more urban, densely-packed areas.

Public Health England (PHE) has undertaken extensive work (which is ongoing) to understand how factors such as these affect an individual's chances of both contracting COVID-19 and experiencing worse outcomes as a result[3]. Asthis is well-trodden terrain, it is not the intention of this report to undertake a specific review into the impact of the COVID-19 pandemic on Medway at this time. As Director of Public Health, I would however, like to commend the officers and members of Medway Council for their focus on continuing to deliver services to vulnerable members of our community. Examples include:

- The establishment of the **Medway Wellbeing Hub.** This hub has coordinated support, including free food, shopping and medicines delivery for our needy and most vulnerable residents of our community
- The provision of **food vouchers** for children of low-income families during school holidays
- **Grants to local business and the wavier of fees** for a range of council services
- The establishment of **the first asymptomatic test-at-scale programme** in the South East of England, dedicated to mitigating the impact of the second wave on Medway residents.

These examples demonstrate that Medway Council has used the Marmot principles to safeguard the local economy during the pandemic, essential for creating wealth and supporting the disadvantaged amongst us.

Whilst the overall summation of the 'Marmot Review: 10-years On'[2] is that there is still so much more to do to reduce health inequalities, it is important to note the local pre-pandemic successes we have had in Medway - successes that we will do our utmost to protect and build upon now and in the future. For example, in 2019, smoking prevalence in adults in Medway was at its lowest recorded level since records began at 14.1 per cent[4], with a continued downward trajectory in sight. New figures from Public Health England estimate that this change represents nearly half (44 per cent) of that seen just eight years ago[5]. The number of women smoking at the time of delivery had also fallen considerably; as smoking is one of the major causes of premature death (associated with increased risk of dying from cancer and cardiovascular disease). Both of these are great success stories for Medway. Furthermore, while still above the England average, rates of unintended teenage pregnancy in Medway had also fallen to their lowest recorded levels by 2019[6]. Though time will tell how the events of 2020 will impact the ground we have made in these areas, we should be heartened by these wins and confident that pre-pandemic levels are only the start of what we can aspire to.

This APHR will review the progress Medway has made to address some of the key determinants of health and health inequalities. It will identify and make recommendations in terms of the system-wide actions that are required to offset the potential impact the COVID-19 pandemic may have had on pre-existing efforts to improve public health.

Chapter one will explore the ways in which the impact of COVID-19 has served to highlight and heighten national health inequalities. The

remainder of the report, however, will outline what Medway Council has been doing at the local level to meaningfully address these long-standing issues and bolster the wellbeing of its residents. The report will close by outlining our priorities in this area, relevant during the pandemic and in the rebuilding that will come thereafter.

While no one was fully prepared for the full impact of this novel coronavirus pandemic, Medway Council and local stakeholders have rallied to protect the local community from harm. Responding to COVID-19 has been, and will remain, a collective effort. I am extraordinarily proud of the way in which the Medway community has come together during this crisis. I have seen the sacrifices that many have had to make and the creative ways in which people from all segments of the community have supported one other. My heartfelt thanks go out to all those volunteers and community champions who have selflessly come forward to protect their communities. I would also like to celebrate the efforts of local NHS workers, our military, our police force, our blue light services and of my colleagues within Medway Council. By aligning our efforts,both lives and livelihoods have been saved.

Medway is a unique and vibrant place. I have full confidence that our community can overcome the challenges posed by COVID-19 and maintain the solid progress we have been making to improve the life chances of our children and young people and reduce health inequalities at large. While undoubtedly the year ahead will bring new difficulties, the vital lessons learned over the reporting period of 2019/20 will be applied to protect our community today, tomorrow and for generations to come.

Councillor David Brake, Portfolio Holder for Adults' Services:

I am delighted that the Director of Public Health has chosen the vital topic of health inequalities for his annual report. Tackling health inequalities underpins the key policies of Medway Council and is central to the work of the Health and Wellbeing Board. This annual report provides a welcome summary of all the excellent work underway in Medway that is focussed on tackling the root causes of ill health. It also helps identify areas where more needs to be done, particularly in light of the impact of the COVID-19 pandemic on the Medway population. Whilst significant improvements in health and wellbeing had been made before the pandemic struck, it is essential that we learn lessons from how well we have come together as a community during these troubled times. We need to build on the new and existing partnership working arrangements to address the emerging and existing threats to human health.

As the Portfolio Holder and Lead Member for Public Health, I am tasked to create the environment in which every resident is able to fulfil their potential and have equal access to opportunities that will improve their health and wellbeing. This annual public health report provides a framework to help further narrow the health gap in Medway. It offers examples of the work we have done and our future plans to tackle the wider determinates of health. Our skills agenda to improve access to employment together with our approach to facilitate lifelong learning and excellence in education with our economic and regeneration programmes is an example, to ensure ongoing investment and wealth creation.

Medway Council is ambitious for our community. By implementing the recommendations set out in this report, we will deliver improved life chances for local people and drive down the issues that affect our most disadvantaged communities.

I am extraordinarily proud of the way in which the Medway community has come together during this crisis

I have full confidence that our community can overcome the challenges posed by COVID-19

We will deliver improved life chances for local people

1. The health gap

1.1. What are health inequalities?

Defining what health inequalities are can be a challenge given the subjective nature of the concept of health for each individual. For many developing nations, enabling all members of a population to receive regular access to clean drinking water, shelter and food could be considered the primary aim. The challenge of addressing health inequalities in developed countries such as the UK is subtly, but still noticeably, different.

NHS England defines health inequalities as 'unfair and unavoidable differences in health across the population, and between different groups in society [arising] because of the conditions in which we are born, grow, live, work and age'[7]. These inequalities exist within or between different population groups and are the result of systemic differences in factors that determine our health and wellbeing.

Average life expectancy in Medway is lower than that of the England average for both sexes (79.1 years vs 79.8 years amongst men and 82.6 years vs 83.4 years amongst women)[8]. Life experience within Medway varies greatly across the unitary authority. For example, within the reporting period of 2016-2018, male life expectancy at birth in Medway was lowest in its most deprived areas (75.4 years) and highest in its least deprived areas (83.1 years), equivalent to an absolute difference of 7.7 years[8]. The same trend was replicated amongst female residents whereby life expectancy at birth was lowest within most deprived areas (78.7 years) and highest in the least deprived areas (85.6 years), amounting to a total difference of 6.9 years[8]. This social gradient in life expectancy is a key symptom of health inequalities in a given population; tackling this inequity is therefore a key priority for Medway Council and all local decision-makers.

The Marmot Review summarised the benefits that come with addressing avoidable disparities in population health outcomes: it is clear that healthy people are better able to contribute to the economic output of a community, leading to increased economic growth and overall prosperity[1]. Furthermore, improvements in local quality of life reduce morbidity and mortality, increase life expectancy and ease the burden on local healthcare, education and wider social support systems[1]. No matter what your vantage point, addressing health inequalities make sense.

1.2. What contributes to health inequalities?

The quality of a person's health is determined by a series of complex interactions. These include inherited genetic factors, lifestyle, social and community networks, and general socio-economic, cultural and environmental conditions. Health

inequalities, however, emerge from underlying inequalities in society. There is a clear relationship between inequitable access to education, employment opportunities, adequate living conditions and negative health outcomes[1].

Rather than focus on a specific disease or single condition, a life course approach tackles complex underlying factors that may lead to an individual contracting the disease or being affected by a condition. Using this life course approach, it's possible to identify factors that affect an individual's conception, birth, growth, work and later years and how these phases of life are influenced by wider determinants that impact on health and wellbeing. Coordinating efforts to tackle these wider determinants of health at a population-wide scale can have profound impacts. This strategy is supported by the National Institute for Health and Care Excellence (NICE), who state that tackling health inequalities "requires a combination of both universal (population-wide) and targeted interventions"[9]. Key determinants can be divided into the following categories:

A. Living and working conditions

Living and working conditions, most notably those surrounding access to paid employment, housing, education and welfare services, are significant contributors to our physical and mental health. Unemployment is associated with a lower life expectancy and poorer physical and mental wellbeing[1]. Life expectancy can be further reduced by living in poor-quality/overcrowded accommodation[1].

B. Social and community networks

Having a strong social support network and feeling embedded in a community has proven benefits for an individual's health. For example, self-reported wellbeing scores are lower in the most disadvantaged areas[10]. This may be due to the absence of social support structures in these communities. A household's work patterns, housing type and tenure can also create barriers that prevent individuals from accessing or making use of local social networks[1]. As a result, by better understanding the social context of local neighbourhoods, we can work with communities to improve their resilience and enhance their support networks.

C. Individual lifestyle factors

The manner in which an individual lives their life can have significant ramifications for their physical and mental wellbeing. Smoking, physical inactivity, obesity and drinking alcohol to excess all increase the risk of premature mortality associated with cancer, heart disease or stroke[11]. It is, however, an oversimplification to believe that people always choose to engage in behaviours that affect their health. The lifestyle choices people make are often informed by the wider determinates of health and economic constraints and other factors that may influence[1]. In order to support these individuals, it is necessary to fully understand the context of local communities they reside within.

D. Age, sex and constitutional factors

The age and sex of an individual can be major determinants of the health inequalities they might experience[12]. The prevalence of many health conditions that have a negative bearing on wellbeing increase with age. The older a person is, the more likely they will be affected by long-term chronic conditions that impact on their physical and mental health[13]. An individual's sex also plays a part in life expectancy: evidence suggests that males have a shorter life expectancy than females and the gap in life expectancy between the most and least deprived deciles (10 per cent of a given population) is smaller for women than it is for men[14].

Ethnicity can also be an important indicator of premature mortality and inequality. While the disproportionate impact of COVID-19 on Black and Minority Ethnic communities (BAME) has recently become the focus of considerable research15 and public inquiry, there is evidence to suggest that BAME communities have historically experienced higher rates of mortality and morbidity associated with major diseases (cancer, cardiovascular disease, coronary heart disease, diabetes, etc.)[16].

E. General socioeconomic, cultural and environmental conditions

There is a clear relationship between a person's wealth and the quality of health they can expect over their life course. Although NHS services remain free at the point of care, disposable income and employment status both have a major bearing on health status[1]. People from disadvantaged communities often present late to clinical care or do not attend preventative appointments[17]. Late presentation can lead to significantly worse health outcomes as the disease or illness in question may have progressed to a stage that requires more invasive treatment.

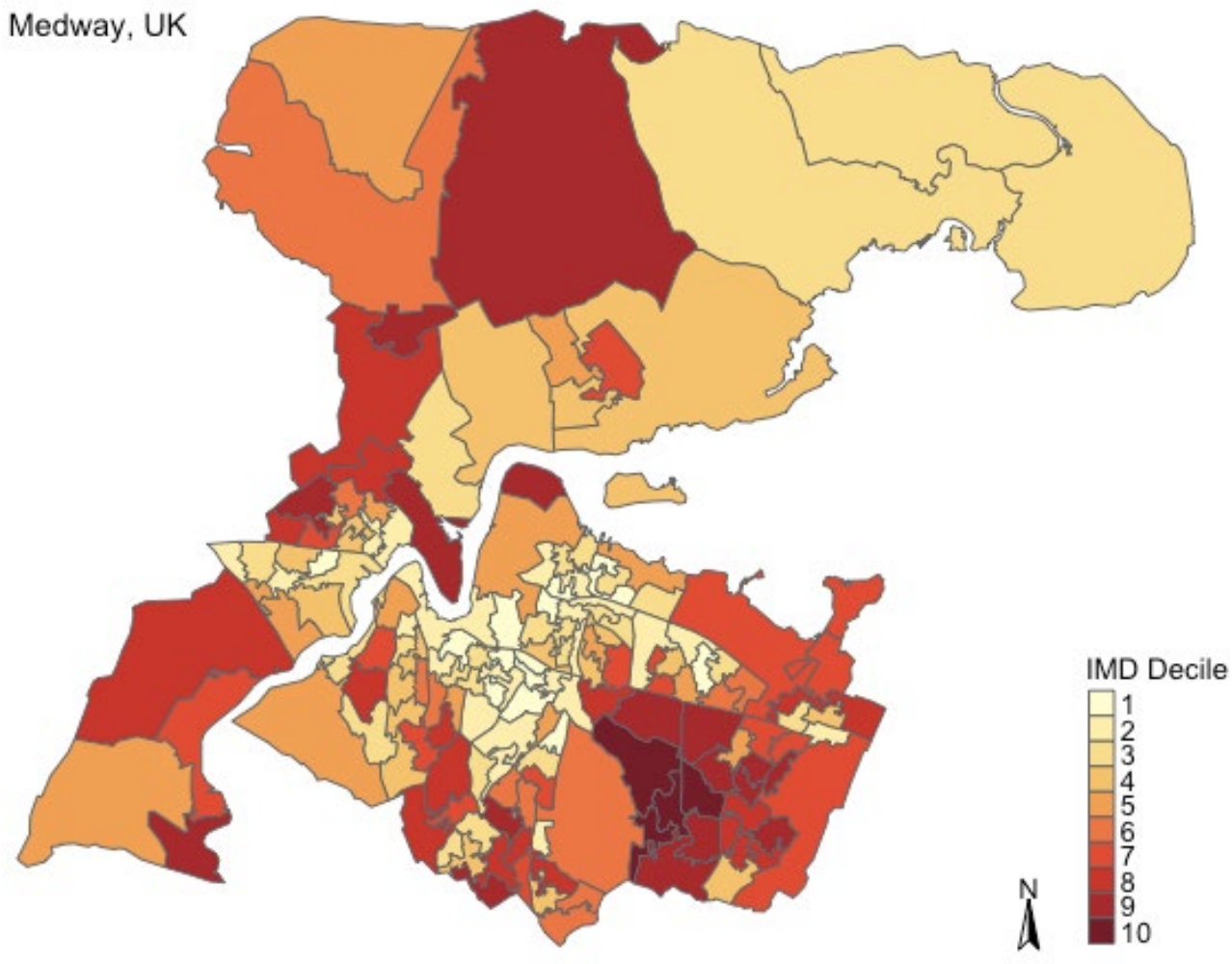
There is also strong evidence the level of education a person has attained is directly linked to their employment prospects. Being in stable, paid employment has a major bearing on an individual's ability to feed, clothe and house themselves and their dependents[18].

1.3. Understanding deprivation

Deprivation is a term used to describe an environment where individuals do not have access to the things commonly considered to be basic necessities[19]. There are several indicators for deprivation; these include (but are not limited to) low income, high crime rates, poor housing and restricted access to, or limited availability of, key services such as health, education and basic amenities[20]. Living in a deprived area has been linked to poor cardiovascular health, higher mortality and elevated rates of mental illness and risky health behaviours (substance and alcohol misuse for example)[17].

The English Indices of Deprivation refer to metrics that represent relative deprivation across LowerLayer Super Output Areas (LSOAs) in England[20]. These are made up of 39 separate indicators, organised across 7 distinct domains of deprivation, that collectively reflect all facets of an individual's living conditions. Combining information from these 7 domains produces the overall relative measure known as the Index of Multiple Deprivation (IMD)[21]. This is the official measure of relative deprivation used for small areas in England; it ranks every neighbourhood in England from 1 (most deprived) to 32,844 (least deprived)[21]. IMD scores are always comparative, meaning neighbourhood scores can be directly compared with one another. These scores can then be organised into deciles whereby 1 would represent an LSOA in the top 10 per cent of deprivation nationally and 10 would represent an LSOA in the bottom 10 per cent for deprivation nationally. Figure 1 provides an overview:

Figure 1: Index of Multiple Deprivation across LSOAs in Medway by decile

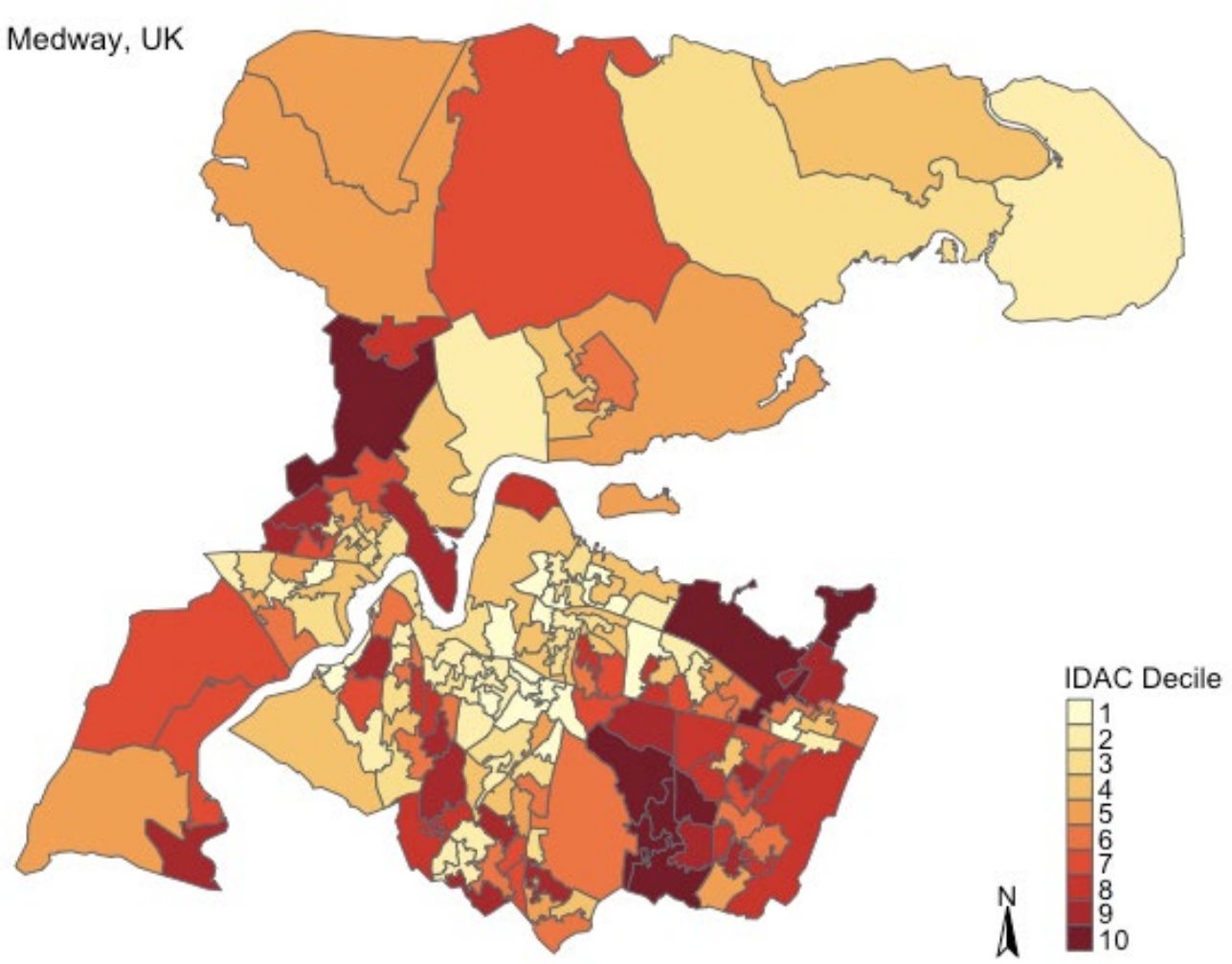


Source: English Indices of Deprivation at the LSOA level, Ministry of Housing, Communities & Local Government (2019)

Although health inequalities can exist within a given area, the most marked differences in wellbeing are generally observed between the most affluent and most disadvantaged areas. For example, 14 LSOAs in Medway are represented within the top 10 per cent most deprived areas nationally; this equates to nearly 9 per cent of all LSOAs in the unitary authority[22].

In addition to the IMD, there is a supplementary index specifically focussed on the deprivation experienced by children. This is called the Income Deprivation Affecting Children Index (IDACI). The IDACI measures the proportion of all children aged 0 to 15 who live in financially insecure families. According to recent estimates, nearly 11 per cent of Medway's LSOAs are classified as belonging to the most deprived decile of income deprivation affecting children[23]. Figure 2 illustrates how IDACI levels differ across LSOAs in Medway.

Figure 2: Income Deprivation Affecting Children Index (IDACI) across LSOAs in Medway



Source: English Indices of Deprivation at the LSOA level, Ministry of Housing, Communities & Local Government (2019)

1.4. Key indicators of health inequality

There are several key indicators used to monitor health inequalities:

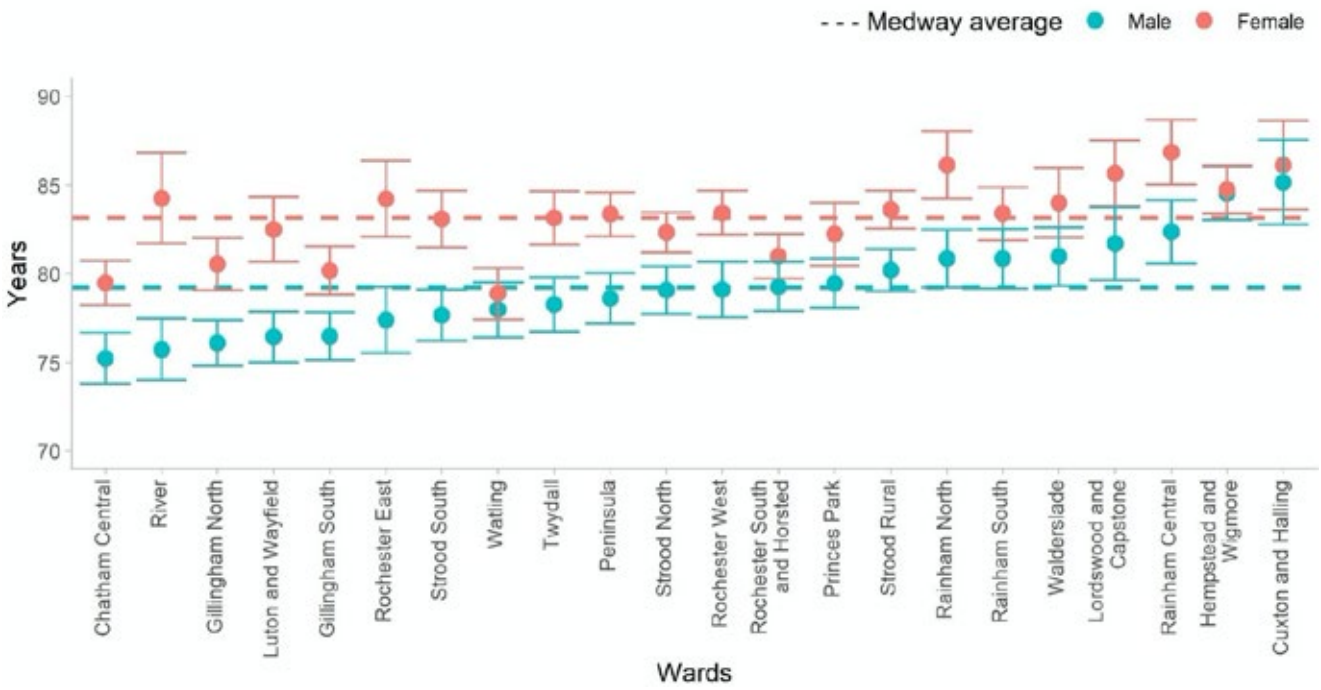
1. **Life expectancy:** the average number of years that an individual is expected to live (based on current mortality rates)[24]
2. **Healthy life expectancy:** the average number of years that an individual is expected to live in a state of self-assessed good or very good health (based on current mortality rates and prevalence of good or very good health)[25]
3. **Average number of years lived in poor health:** the difference between life expectancy and healthy life expectancy[25]
4. **Avoidable mortality:** deaths from causes considered avoidable if timely and effective health care or public health interventions had been applied[25].

1.5. What health inequalities currently exist in Medway?

Life expectancy

According to data presented on Public Health England's Fingertips tool, between 2017-2019 Medway's average life expectancy at birth for males was 79.1 years and was 82.6 years for females[8]. This is statistically worse than the England average of 79.8 years and 83.4 years respectively[8]. However, there is considerable variance in life expectancy at birth between wards in Medway; this is represented in Figure 3. People living in more affluent areas live significantly longer than those living in areas of greater disadvantage[26].

Figure 3: Life expectancy at birth by ward, Medway, 2015-19; error bars indicate 95 per cent confidence interval



Source: Primary Care Mortality Database and ONS mid-year population estimates. 2015-19

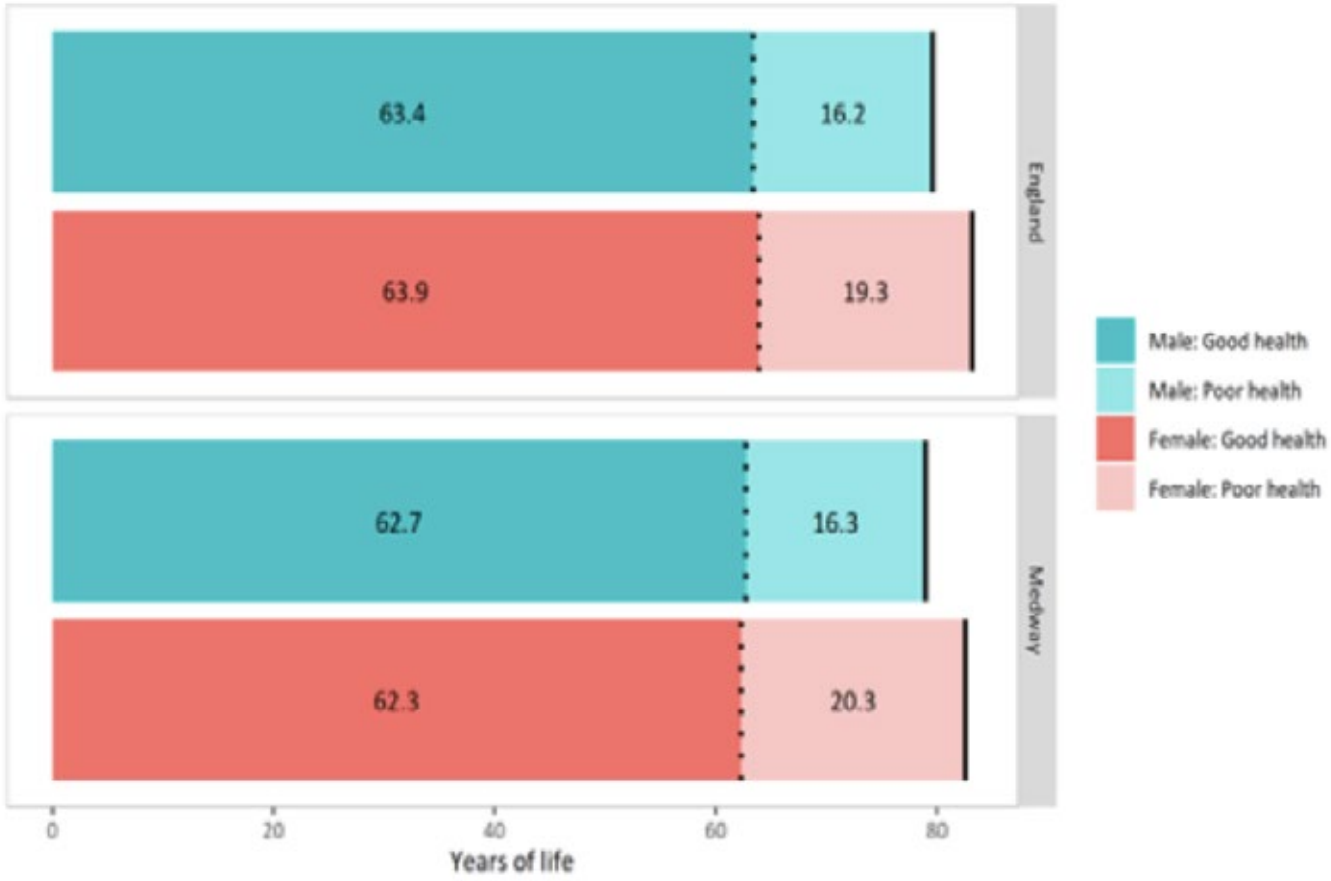
Although women in Medway live on average around 3.5 years longer than men, this gender life expectancy gap has narrowed in recent years[8]. This is likely due to an increase in the prevalence of unhealthy lifestyle behaviours amongst women in Medway (excessive alcohol consumption and obesity, for example).

Healthy life expectancy & years lived in poor health

Between 2016-18, healthy life expectancy in Medway was 62.7 years in males and 62.3 years in females, less than the national average of 63.4 years and 63.9 years, respectively[27].

Despite living longer, evidence suggests women living in Medway spend an average of 0.4 fewer years in good health than males (see Figure 4)[28] and spend a greater proportion of their lives in poor health (24.6 per cent) compared to males (20.6 per cent).

Figure 4: Life expectancy, healthy life expectancy and years spent in poor health for males and females in England and Medway (2016-2018)



Source: Public Health England, Fingertips, Indicator IDs: 90366 & 90362

20.6% of their lives that men spend in poor health

24.6% of their lives that women spend in poor health

Avoidable mortality

This term refers to deaths that could have been prevented through timely clinical care or public health intervention. For example, deaths attributable to certain cancers, respiratory disease, circulatory disease, alcohol and drugs. According to ONS data, approximately 22 per cent of all UK deaths are considered avoidable. The standardised metric for measuring avoidable mortality is known as the avoidable mortality rate; in the UK, this currently sits at 237.9 per 100,000 population – statistically significantly lower than that of all years as far back as 200125. In 2016-2018, Medway's avoidable mortality rate was 240.7 per 100,000, with 1,645 avoidable deaths occurring in that 3-year period alone[30]. This represents a significant improvement on previous years. In 2001-2003 the avoidable mortality rate in Medway was 364.4 per 100,000 with 1,913 avoidable deaths recorded[30].

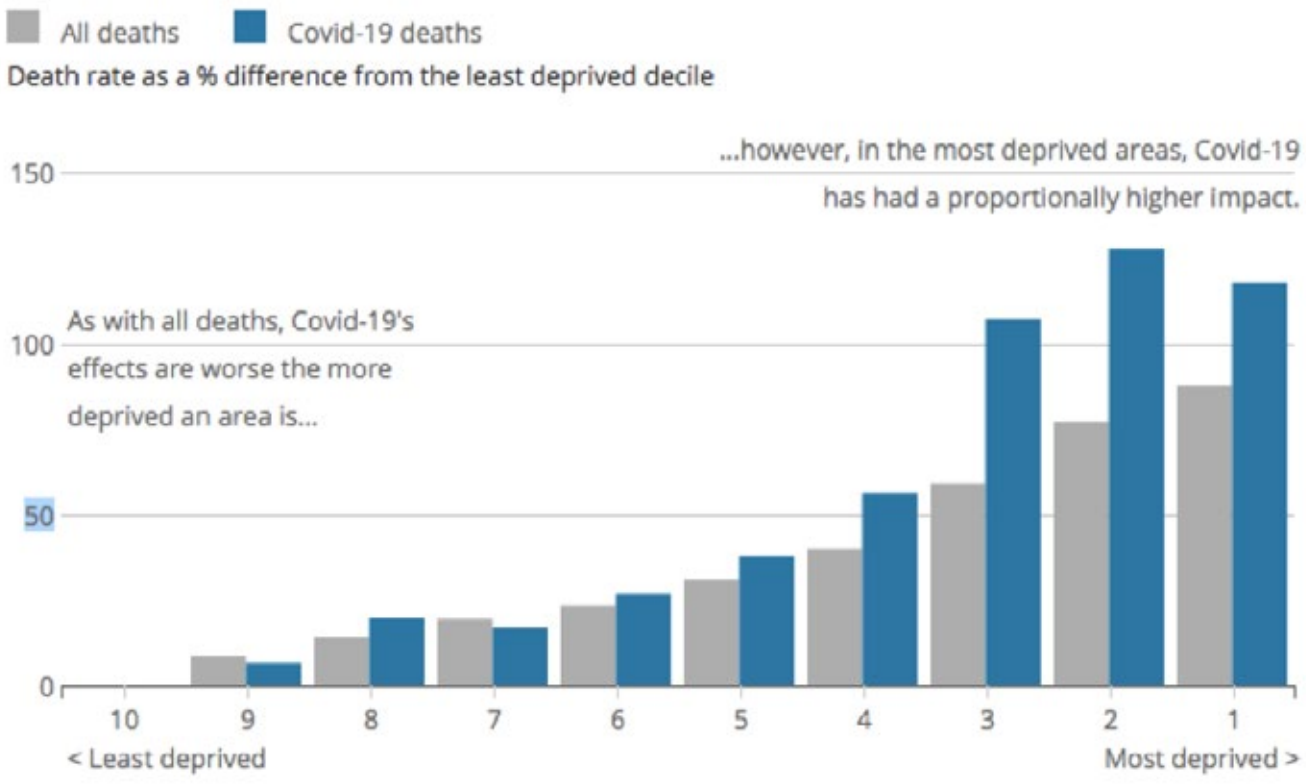
Although the avoidable mortality rate has reduced in Medway, there is still room for improvement. There remains a substantial gender difference in avoidable mortality. For example, the latest recorded avoidable mortality rate for men (198.5 per 100,000) is considerably higher than that for women (105.8 per 100,000 women)[30]. Furthermore, avoidable mortality is strongly associated with deprivation: ONS data from 2018 revealed that the proportion of total deaths that were avoidable in England was substantially larger in the most deprived areas than the least deprived areas[29]. Avoidable deaths accounted for 39.4 per cent of all male deaths and 26.2 per cent of all female deaths in most deprived areas in England compared to 17.7 per cent and 12.2 per cent of all male and all female deaths respectively in least deprived areas31. The absolute inequality in the rate of avoidable mortality indicated that in 2018, there were 396.7 additional deaths per 100,000 males and 234.8 additional deaths per 100,000 females living in the most deprived regions of England compared to the least deprived areas[31]. Although, at least prior to the pandemic, these numbers represent a sizable reduction in the avoidable mortality gap since 2001, the speed of this improvement has declined considerably since 2013, particularly amongst avoidable deaths attributed to alcohol-related and drug-related disorders and respiratory conditions which remain far more prevalent amongst those from deprived backgrounds[31]. Understanding these nuances are essential for informing efforts to further reduce the avoidable mortality rates seen in Medway today.

1.6. What was the impact of COVID-19 on health inequalities?

The national picture

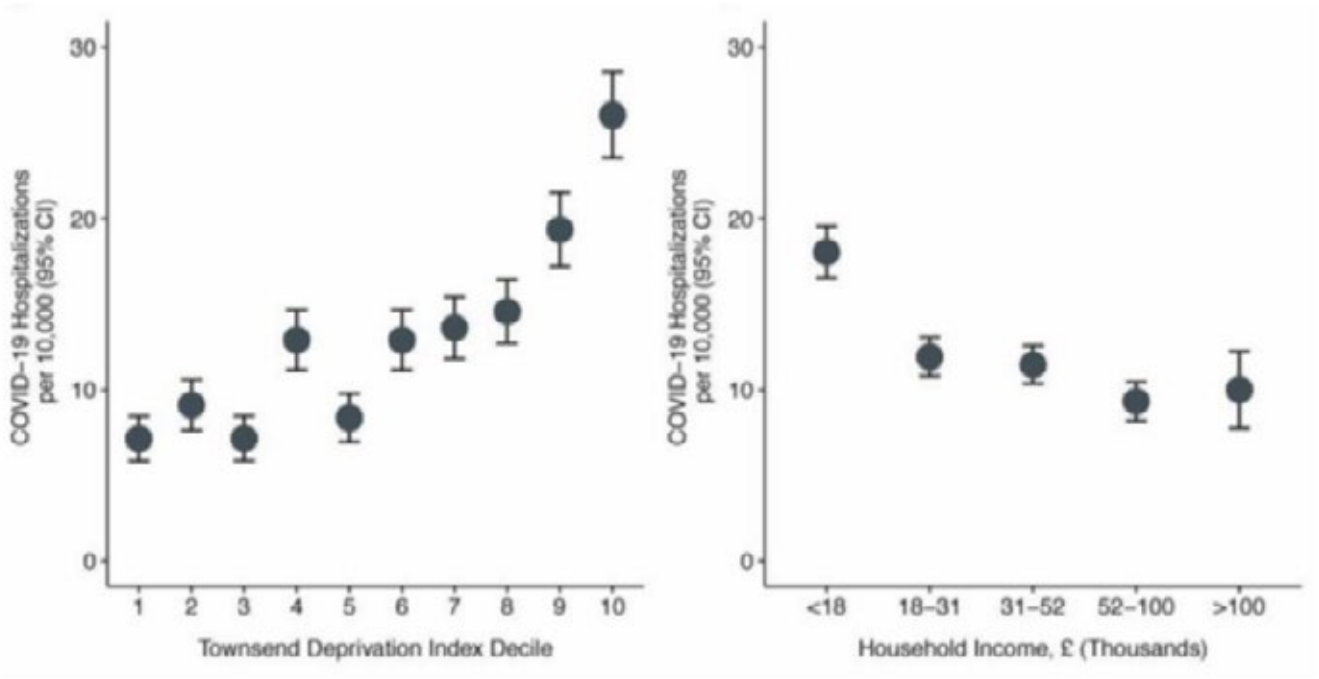
The COVID-19 pandemic has shone a spotlight on the long-standing health inequalities experienced by the UK's most disadvantaged communities. Public Health England have undertaken an initial review into morbidity and mortality associated with COVID-19. They found an association between socio-economic disadvantage and increased rates of virus transmission, hospitalisation and death[3]. For example, death rates associated with COVID-19 infections were found to be twice as high in the poorest areas of the UK than the most affluent[30]. Figure 5 provides an overview of the findings of this initial review and Figure 6 demonstrates how hospitalisation rates varied across household income groups during the first wave of the pandemic.

Figure 5: Standardised Mortality Rates of Deaths Involving COVID-19 in England (1st March to 17th April 2020) by Area Deprivation Deciles (IMD)



Source: ONS People, Population and Community, Births, Deaths and Marriages, Deaths involving COVID-19 by Local Areas and Deprivation (2000)

Figure 6: Hospitalisation Rate for COVID-19 Infections by Townsend Deprivation Index and Pre-tax Household Income Amongst the 0.5 Million Biobank Participants in England



Source: Patel, A.P., Paranjpe, M.D., Kathiresan, N.P., Rivas, M.A. & Khera, A.V. (2020) Race, Socioeconomic Deprivation, and Hospitalisation for COVID-19 in English participants of a National Biobank

A key factor associated with the elevated COVID-19 related mortality and morbidity rates in disadvantaged communities is the greater prevalence of underlying long-term health conditions seen in these localities[31]. These communities are more affected by diseases likes chronic obstructive pulmonary disease, diabetes and cardiovascular disease than those living in wealthier areas - conditions that have been shown to exacerbate the risks of COVID-related complications[32].

The elevated impact of COVID-19 on the BAME community, a community that is in turn disproportionately represented within the UK's most deprived communities, has been especially significant this year. Excess deaths (the number of deaths that exceed those expected for a given time period) have been higher in BAME populations than in any other ethnic group[3]. Public Health England's review[3] into the reasons for these disparities has led to a renewed focus on the wider societal factors that contribute to health inequality. For example, disadvantaged groups are more likely to live in multigenerational households (making social distancing more difficult to maintain)[33] and work in occupations that come with a higher risk of workplace exposure to COVID-19 (NHS, Social Care, Transport etc.)[34].

However, age is the primary risk factor associated with complications from COVID-19; this is especially true of the elderly living in socially deprived areas[35]. A survival analysis of those with a positive test discovered that those aged 80 and older were seventy times more likely to die of COVID-19 than those under 40 years of age[3]. The majority (75 per cent) of excess deaths recorded by Public Health England occurred in those aged 75 years and over[3]. Although the social gradient in COVID-19 complications narrows across the lifespan, it is still essential that targeted wraparound support is provided to older adults, particularly those who may be challenged financially, to enable them to maintain their social networks and wellbeing as well as their physical health during the pandemic.

The local picture

In the absence of longitudinal and local data, the impact of COVID-19 on health inequalities in Medway remains largely anecdotal. That said, it is evident from the high demand for local authority services, food supplies and NHS and social care services, that the events of 2020 have had a significant impact on the Medway community[36]. Research is underway to quantify the exact magnitude of this; these findings will inform Medway Council's whole-systems response to similar events that may occur in the future.

Impact on the local economy

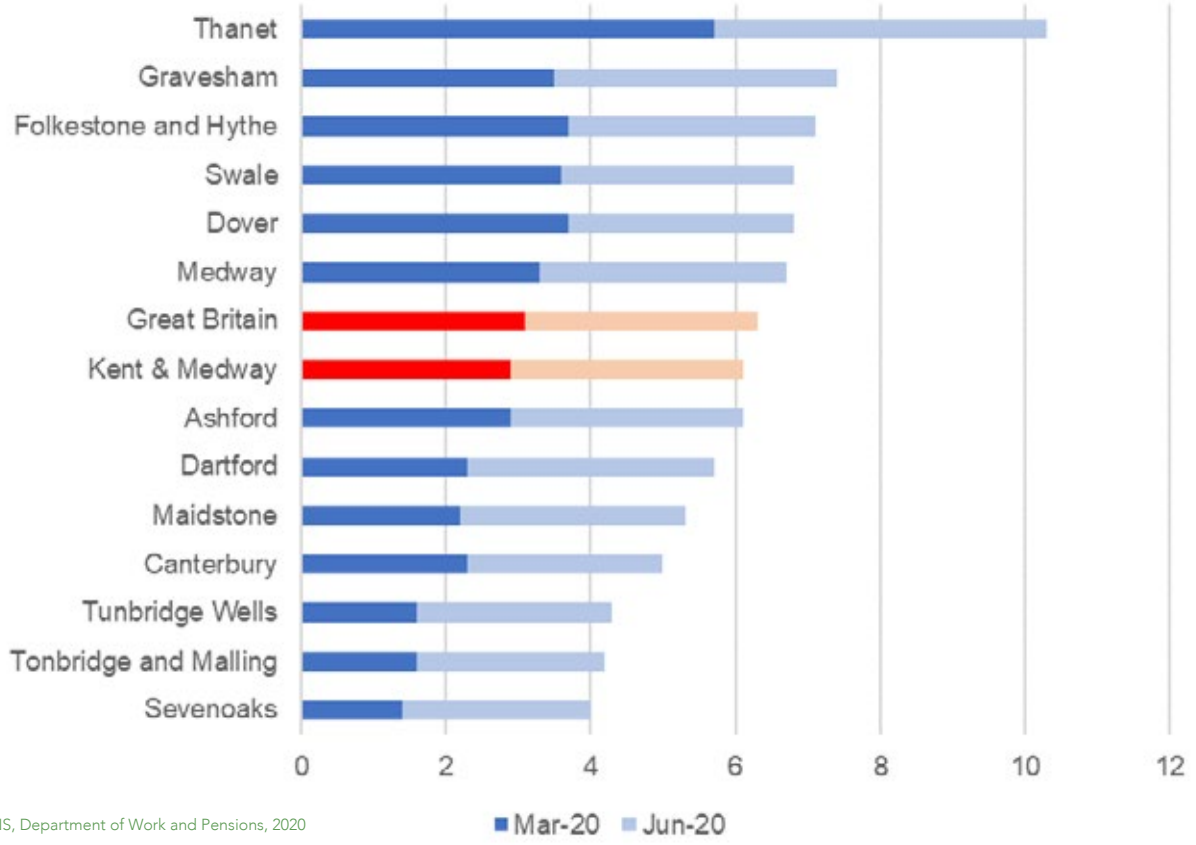
The economic burden associated with COVID-19 has been significant at the local level; sectors such as retail, hospitality, education and leisure, arts and culture have been especially disrupted. Whilst Medway may not have been impacted as gravely as other local authority areas who may be more reliant on income from these specific sectors, the economic fall-out of the pandemic has been felt by everyone to some degree. According to Kent and Medway's Economic Renewal and Resilience Plan, a document dedicated to offsetting three potential economic scenarios of varying severity after the pandemic, economic output in the region shrank by 20 per cent between March and May in 2020[38]. Although no Gross Domestic Product (GDP) estimates exist below the national level, modelling suggests Kent and Medway may have seen a loss of some £2.3 billion in the three months between March and May in 2020[38]. This equates to a 20 per cent loss to Gross Value Added (GVA) - a metric used to calculate economic output by individual producers, industries, sectors or regions. Applying this estimate to the Medway economy results in an estimated loss of economic output in 2020 amounting to circa £0.59 - £0.75bn (based on total GVA in 2018 of £5.362bn). The GVA loss in Kent and Medway is slightly greater than the UK average.

Unemployment has also risen rapidly in Kent and Medway, with benefit claimants increasing by 110 per cent since March 2020[38]. Although this is only slightly higher than the UK average, given the link between employment and inequality, it is still an issue of concern. Figure 7 provides an overview of the increase in claimant counts in Medway as of November 2020 compared with lower tier local authorities in Kent.

75%

of excess deaths occurred in people over 75

Figure 7: Claimant count as percentage of population aged 16-64 (March to June 2020)



Source: ONS, Department of Work and Pensions, 2020

While all sectors have experienced some reduction in output during the pandemic (summarised in Figure 8 below), the hospitality and tourism sectors continue to be most affected. It is likely that people working in these sectors have less employment security. They may therefore be more vulnerable to loss of income and consequently impacted by health inequalities associated with low income. It is also important to note there may be an increase in unemployment when the national government COVID furlough scheme winds down. Data from 31 October 2020 highlighted 7,800 Medway residents on the furlough scheme. Medway Council is doing its upmost to support the local economy. To date, it has allocated over £75 million to help businesses retain their workforce during the pandemic.

Sector	Output loss (%)	Kent & Medway output loss, £m
Accommodation and food services	-71.7	-208
Education	-37.8	-292
Other services	-37.6	-171
Construction	-29.8	-350
Transport and storage	-29.5	-180
Administrative & support services	-28.3	-181
Human health & social work	-24.2	-203
Wholesale, retail and motor trades	-23.7	-326
Manufacturing	-18.0	-151
Professional, scientific & technical	-15.5	-100
Information and communication	-10.8	-42
Mining, energy & water supply	-8.0	-35
Agriculture	-6.3	-7
Financial and insurance services	-2.5	-12
Real estate	-2.1	-41
Public administration & defence	0.2	10
Total	-19.9	-2,288

Figure 8: Estimated output change, March to May 2020 (estimate for Kent & Medway, based on UK monthly GDP data)

Source: Office for National Statistics, GDP Monthly Estimate, May 2020, SQW analysis

Impact on health and social care

This year, our NHS has been called upon to respond to one of the most significant events in recent history. Local NHS providers are working in a unified way, collaborating to share personnel, facilities, and resources. The manner in which care and support is provided has changed dramatically. For example, digital technologies are being embraced in primary and community care. Hospital beds are being freed up wherever possible to bolster critical care capacity. Elective (planned) procedures have had to be modified to reduce risks to staff, patients and visitors while still ensuring the NHS is able to deliver critical services and save lives. There is, however, significant demand being placed on both adult and children's social care services that will require a coordinated response to address this (even after the pandemic has subsided).

The pandemic has weighed heavily on social care resources; there have been increasing demands for support at both the family and individual level in Medway. While both adult and children's social care services are still being provided, there is a growing recognition that the longer this pandemic goes on, the harder it will be to maintain the delivery of our full range of care services. Health and social care staff are on the frontline and many have been personally affected by COVID-19. There is a need to ensure the future resilience of this workforce given the pivotal role they play in supporting the most disadvantaged and vulnerable people in our community.

The long-term implications of COVID-19 on the wider health care system are currently difficult to quantify. It is predicted that delays to routine or planned treatments will lead to negative health outcomes in the short to mid-term, for example. Medway Council is monitoring this and is doing all it can to support the NHS to offset any future negative impact on the health of the population.

Impact on education

Educational attainment is a key determinant of long term physical and financial health. The education sector makes both a direct and indirect impact on economic growth and tackling inequality. Strengthening Medway's skill base will

help to increase the employability of local people and attract external investment. Regrettably, the pandemic has been incredibly disruptive for both teaching and student learning.

The longer-term impact on learning and outcomes for those children and young people whose education has been affected by this pandemic is of major concern for parents and the Council alike. Supporting the wider education system to secure the future of the children and young people in Medway will be a priority for all stakeholders.

2. Tackling health inequalities

2.1. How can we achieve health equality?

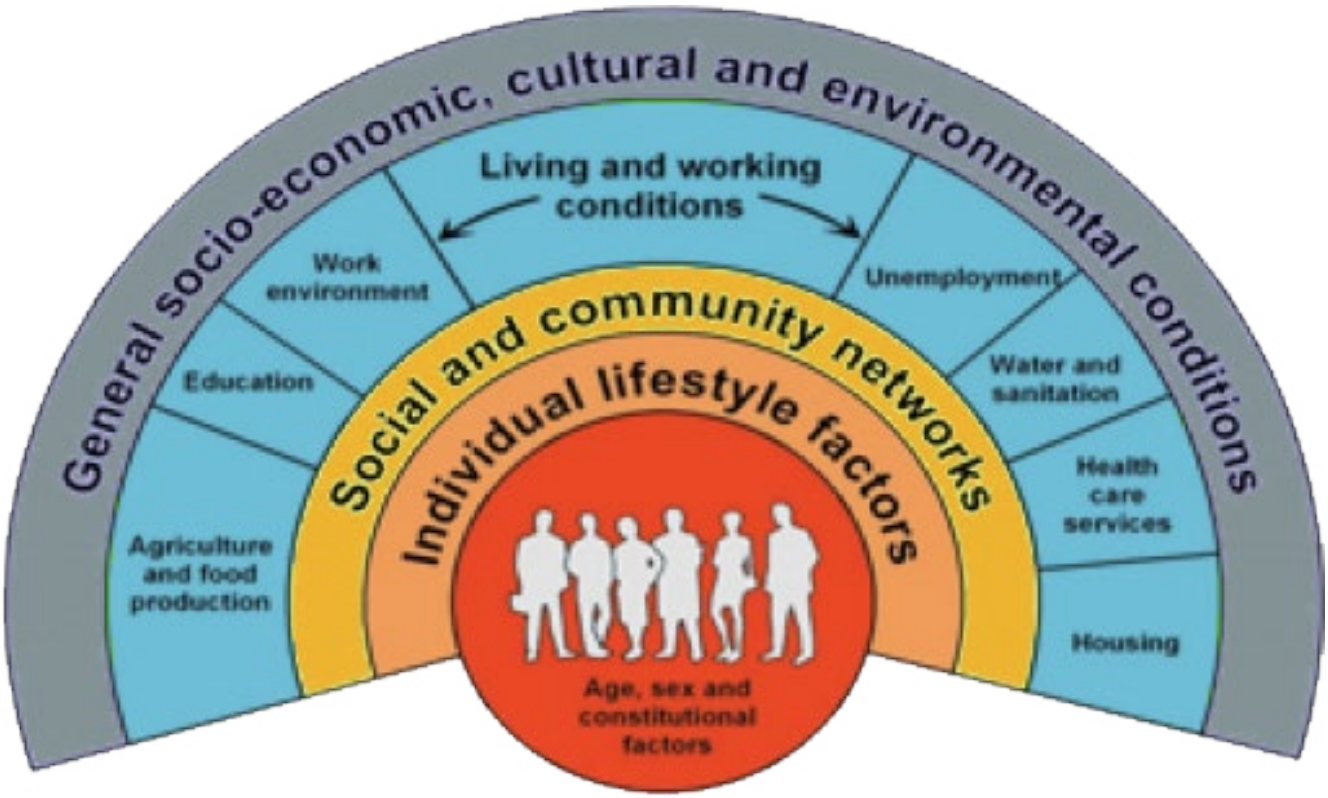
To reduce health inequalities, it is important to start with a clear framework to enable root causes to be identified, targeted action to be taken and outcomes to be monitored. There are many models available to quantify health inequalities, each with their own merits. Three concepts that have most inspired Medway Council's approach to addressing health inequalities are set out in this chapter.

A holistic approach

Whitehead and Dahlgren[37] (1991) mapped the relationships that exist between an individual, the environment they live in and their health status. They created a model to illustrate the range of factors that impact on health and wellbeing (Figure 9). This model is often referred to as the Dahlgren-Whitehead Rainbow. It has been widely adopted by change-making systems as it provides a standardised framework for interventions and underpinning or resultant policy.

Figure 9: The Dahlgren-Whitehead model

Source: Dahlgren and Whitehead (1991)

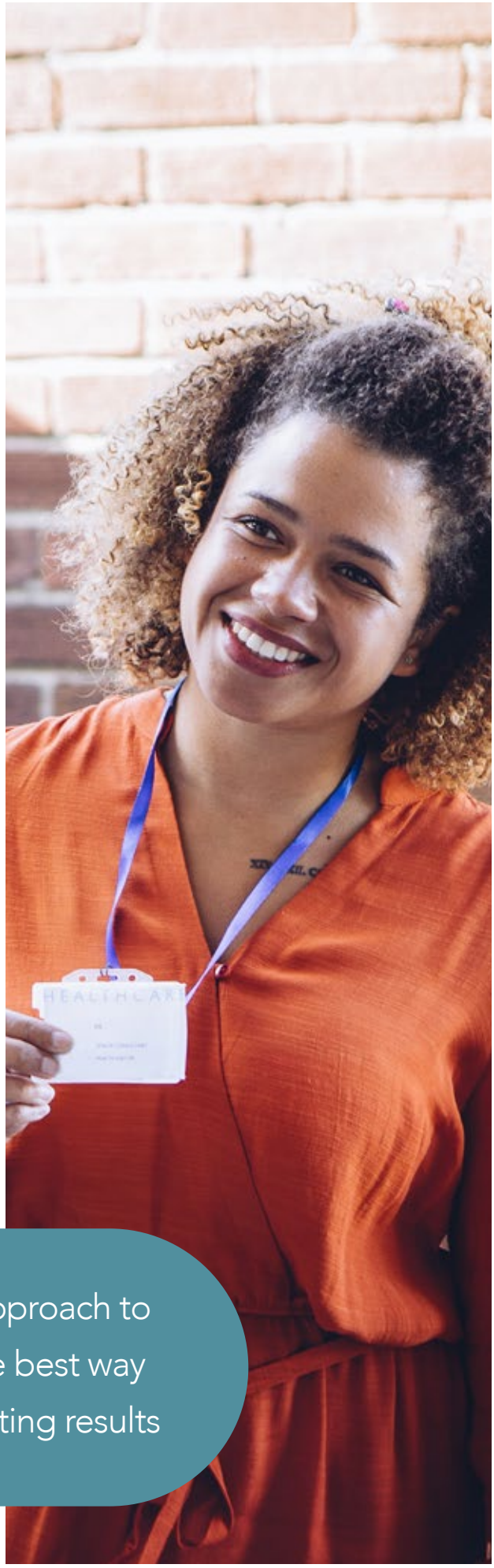


A place based approach

Ronald Labonté, an eminent Canadian epidemiologist, created a model to acknowledge the complex relationship that exists between protective factors (e.g., isolation, social support, self-esteem, meaning/purpose) and the wider determinants of health (Figure 10). His research established that individuals and populations do not have equal opportunities to be healthy[38]. Health interventions must therefore prioritise place-shaping (building and shaping the local infrastructure) to enable more people to take advantage of opportunities. Key elements of this place-based approach are summarised below:

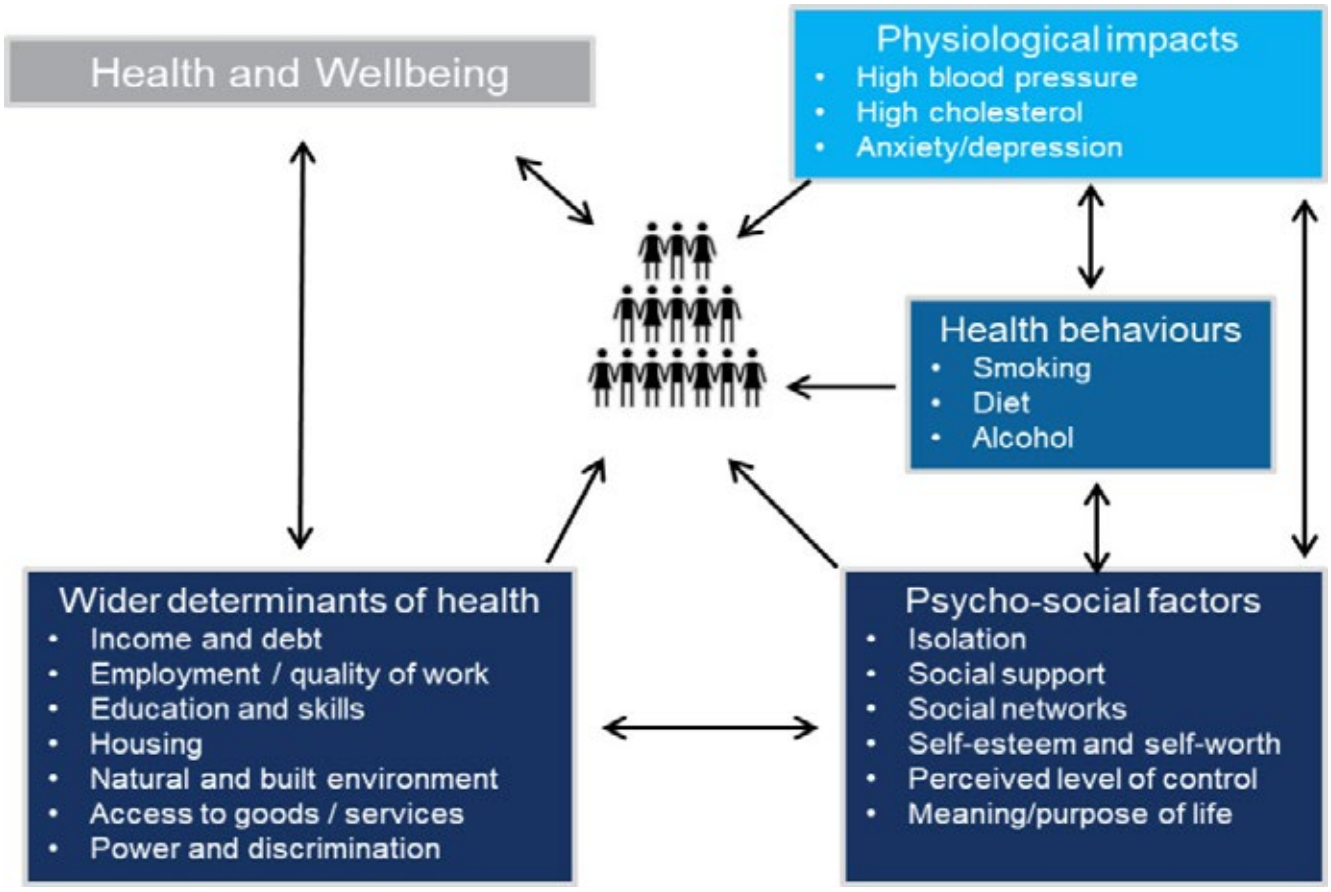
1. While action aimed at changing behaviours and conditions is a necessary step to reducing health inequalities, these need to be addressed within the wider context of their root causes
2. Resources should be allocated proportionately to address the levels of need for specific communities or populations to achieve equitable outcomes for all
3. Interventions that solely rely on individual behaviour change are likely to widen inequalities as they do not consider the social context that impacts behaviour change
4. Local authorities have a critical role to play in addressing health inequalities; providing local leadership, expertise and infrastructure

Labonté believes a community development approach to public health challenges is the best way to achieve sustainable long-lasting results. The person-centred principles that inform this model have been incorporated in previous programmes in Medway (most notably Medway City of Culture, Medway Local Plan and Housing Infrastructure programme). This approach will help inform the local place-shaping work, critical to tackling health inequalities in the longer term.



A community development approach to public health challenges is the best way to achieve sustainable long-lasting results

Figure 10: System map of the causes of health inequalities inspired by Labonté principles



Source: Context and causes of health inequalities, PHE

A life course approach

The Marmot Review emphasised the importance of taking a life course approach to tackle inequality and improving health and wellbeing outcomes1. Marmot found disadvantage sets before birth that accumulates throughout a person's life. Figure 11 provides an overview of the framework Marmot developed and the proposed actions that would reduce health inequalities and address disparity throughout the life course.

The Marmot Review is underpinned by the principle of proportionate universalism – the assertion that actions taken to reduce health inequalities must be at the same scale and intensity of the level of disadvantage being tackled (illustrated in Figure 12). Marmot emphasised that these actions must also prioritise improving the lives of those with the most disadvantage and with the worst health. The ultimate aim of proportionate universalism is to equalise health outcomes.

Marmot proposed six key recommendations and policy objectives in his original review. These were:

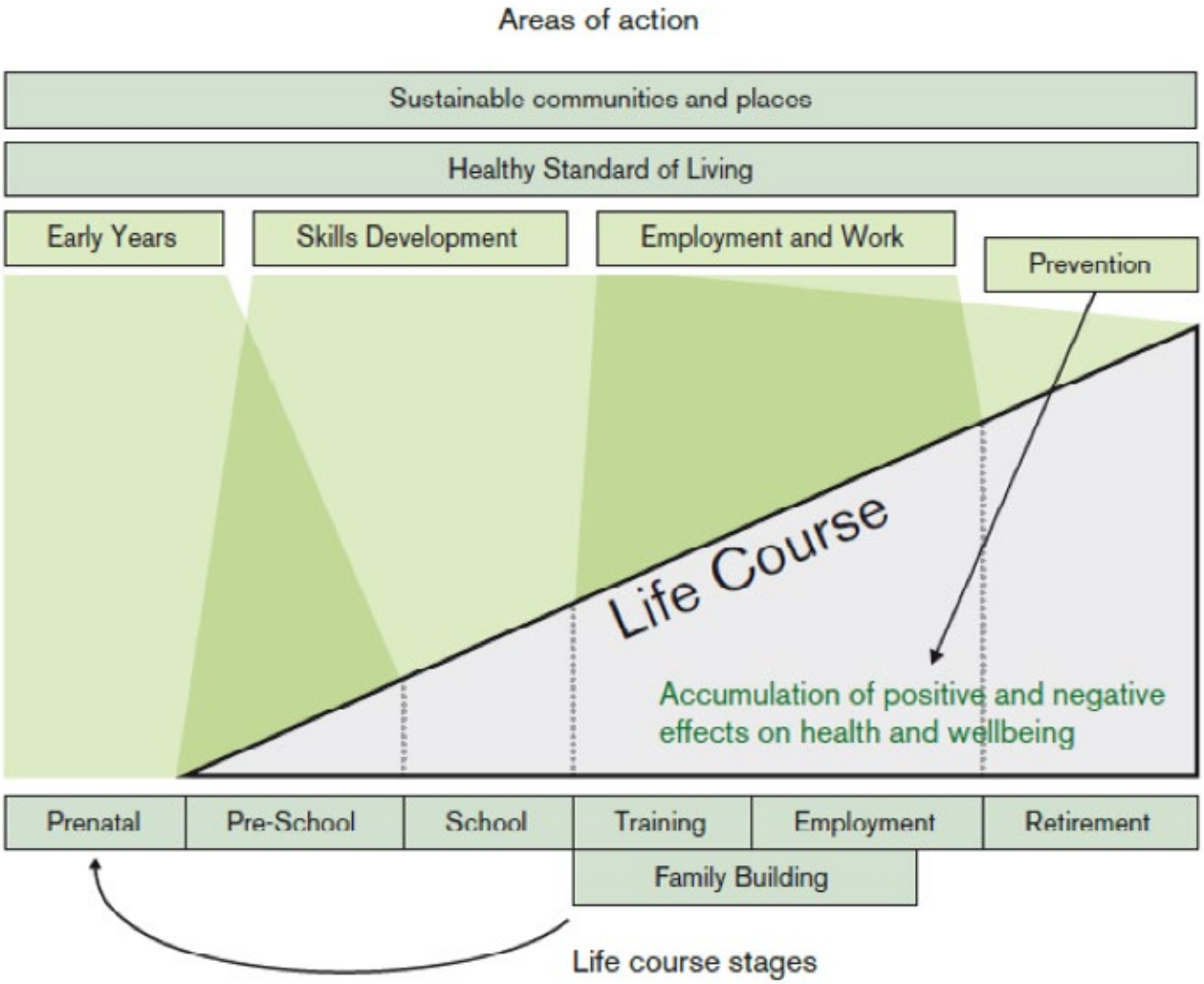
1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention

These principles have been embedded in a large number of Council initiatives including the Joint Health and Wellbeing Strategy for Medway, The Council Plan, The Children's Plan, The Local Plan and a range of key place-based and public health programmes. We ensure that, wherever possible, our programmes consider the underlying

contributors to health inequalities in both their design and delivery. For example, women who smoke during their pregnancy often do so to counteract the emotional burden of housing and financial insecurity[39]. As such, our bespoke initiative to help women stop smoking during pregnancy, 'Blooming Bumps', links all key agencies together to facilitate access to broader financial support services, housing or social care support for pregnant women and their households.

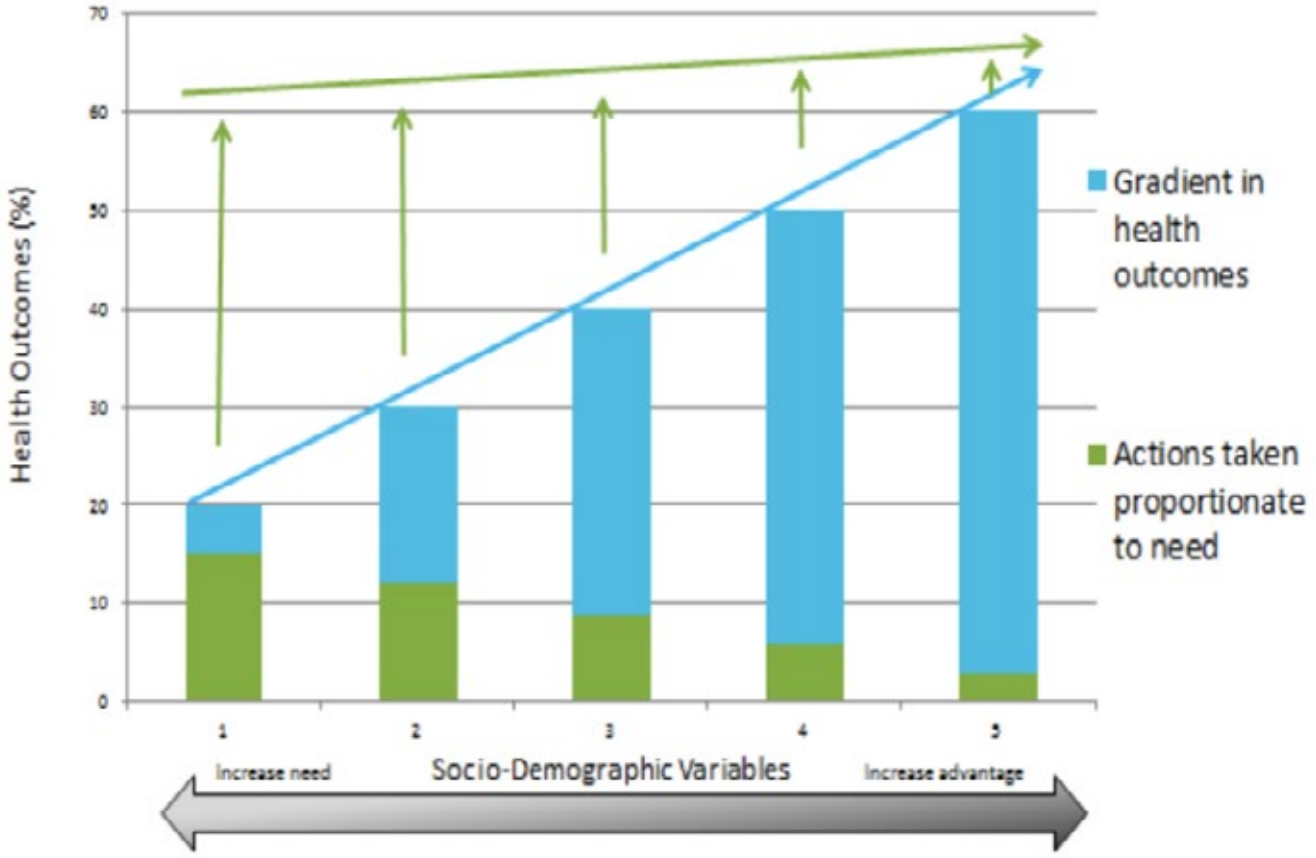
It is also important to reflect on the findings of 'The Marmot Review: 10 years on', which this report has already touched upon in part[2]. Published at the start of 2020, this report summarised the significant barriers to financial and physical health that persist within the UK and prevent the narrowing of health inequalities. In keeping with both Marmot's original review and most recent call to action, the Medway unitary authority is deploying all available resources to create a local environment that enables young people to thrive. Our ongoing commitment to our residents includes creating investment and employment opportunities in tandem with providing support for our most vulnerable families and communities.

Figure 11: Marmot Review: Areas of preventative action across the life course



Source: Fair Society, Healthy Lives. The Marmot Review Strategic Review of Health Inequalities in England post-2010 (2010)

Figure 12: Schematic illustration of proportionate universalis



Source: Ontario Agency for Health Protection and Promotion (Public Health Ontario), Lu D, Tyler I. Focus on: A proportionate approach to priority populations. Toronto, ON: Queen's Printer for Ontario; 2015.

3. Starting well

3.1. Why is this important?

Health inequalities can persist from generation to generation. Pregnancy and the first years of life are crucial for setting us up for long and healthy lives, influencing an individual's physical, cognitive and even emotional development[40]. Exposure to adverse life experiences in this sensitive developmental period (including homelessness, abuse and neglect) has been linked to negative health outcomes, both physically and mentally, and economic difficulty across the entire lifespan[42]. By intervening to narrow health inequalities as early on in a child's life as possible, this inter-generational transfer of adversity can be disrupted[42]

Nutrition in the early years

Meeting the nutritional needs of children is key to ensuring they meet their developmental milestones; supporting children's nutritional intake starts with the mother at conception, however, as studies show a mothers' nutritional profile has a direct impact on the healthy development of the foetus[41]. Furthermore, supporting women to breastfeed sets a child up for healthy physical and emotional development. Breastfeeding has been proven to provide the best possible nutritional start for babies and helps to enable early attachment between mother and child[42]. There is strong evidence of the shortand long-term benefits of breastfeeding for mother and infant. These include lower rates of hospital admissions associated with gastrointestinal infections for breastfed babies, reduced incidence of diabetes and obesity, and improved cognitive function for the child and protection from breast

cancer, ovarian cancer and type 2 diabetes for the mother[43]. While breastfeeding may not always be possible or appropriate, when it is, mothers should be supported in their breastfeeding journeys and given all the information they need to make the experience as stress-free and nurturing as possible.

Rising levels of childhood obesity are another worrying trend in the UK today. Childhood obesity tends to extend into adulthood and can cause a host of physical and psychological health problems. As well as elevating risks of high blood pressure and type 2 diabetes, obesity amongst children can exacerbate breathing problems (such as asthma and sleep apnoea) and negatively affect self-esteem[44].

Smoking during pregnancy

Preventing women (and others in their households) from smoking during their pregnancy is a public health priority. Evidence suggests babies born to mothers who smoke are more likely to have worse health outcomes across the entire course of their lives compared to those born to non-smoking mothers[45]. As well as having detrimental effects on the growth and development of the baby in the womb, smoking in pregnancy has been linked to low birth weight, a range of childhood illnesses, lower educational attainment (potentially impairing onward employment opportunities) and, unfortunately in some cases, infant death47.

Smoking during pregnancy is not just a risk for the unborn child. Expectant mothers who smoke are at significantly higher risk of experiencing complications during pregnancy; some, such as ectopic pregnancy, can be life-threatening46. Investing in initiatives that reduce smoking during pregnancy deliver both long- and short-term tangible benefits to the mother, her child, the NHS and community at large. For example, addressing the impacts of smoking during pregnancy in mothers costs the NHS somewhere between £8.1m and £64m per annum. Costs associated with treating and caring for babies and infants adds a further £12m to £23.5m to the cost[47].

Early cognitive development

Children's cognitive development is particularly susceptible to disruption in the earliest years of life and determines their potential to succeed at school[48]. Transition to school can be affected by a range of factors. These include household income, support available for parents, and children's pre-school linguistic, behavioural, social and problem-solving skills. The School Readiness metric is a key measure of the success of early cognitive development. It has been associated with future educational attainment and employment prospects[50]. Children are assessed for school readiness after completing Reception class at around 5 years of age.

The first years of life are crucial for setting us up for long and healthy lives

Children's cognitive development is particularly susceptible to disruption in the earliest years

3.2. Work underway in Medway

Levels of child poverty

According to the United Nations Children's Fund (UNICEF), the term child poverty refers to 'those who experience deprivation of the material, spiritual and emotional resources needed to stay alive, develop and thrive, leaving them unable to enjoy their rights, achieve their full potential, and participate as full and equal members of society.'[49]

It is estimated that as many as 18.8 per cent of under 16s in Medway resided in low-income families in 2018/19; however, this represents a decrease from the level of 14.8 per cent that was seen in 2014/1550. Furthermore, this proportion varies greatly across wards in Medway, ranging from 7.6 per cent in Hempstead and Wigmore to 30.3 per cent in Luton and Wayfield[52].

Medway Council wishes to enable a 'child-focused future', where all children and young people in Medway are supported to overcome the obstacles they face and realise their personal potential. There is still a significant amount of work that needs to be done to get us there, however. At present, there are approximately 95,000 children and young people aged between 0-25 living within Medway[51]; of these, 2,058 are classified as Children in Need, 2,147 have an Education Health and Care Plan and 356 are on Child Protection Plans[53]. We know that specialist, universally accessible and targeted services will be key to supporting the most vulnerable and disadvantaged children within our community – this is the standard that Medway Council is committed to providing.

As a result of a major recruitment drive, we are happy to report that vacancies for social workers in Medway have reduced from 29 per cent to 25 per cent. These new staff members will help to build our capacity and capability to provide early intervention and prevention services for at-risk families and help us to achieve our wider ambitions for reducing child poverty and increasing child safety. Through these efforts, more and more families will be empowered and supported to reach the position of economic security that will enable them to live independently and will allow their children to thrive.

Childhood obesity

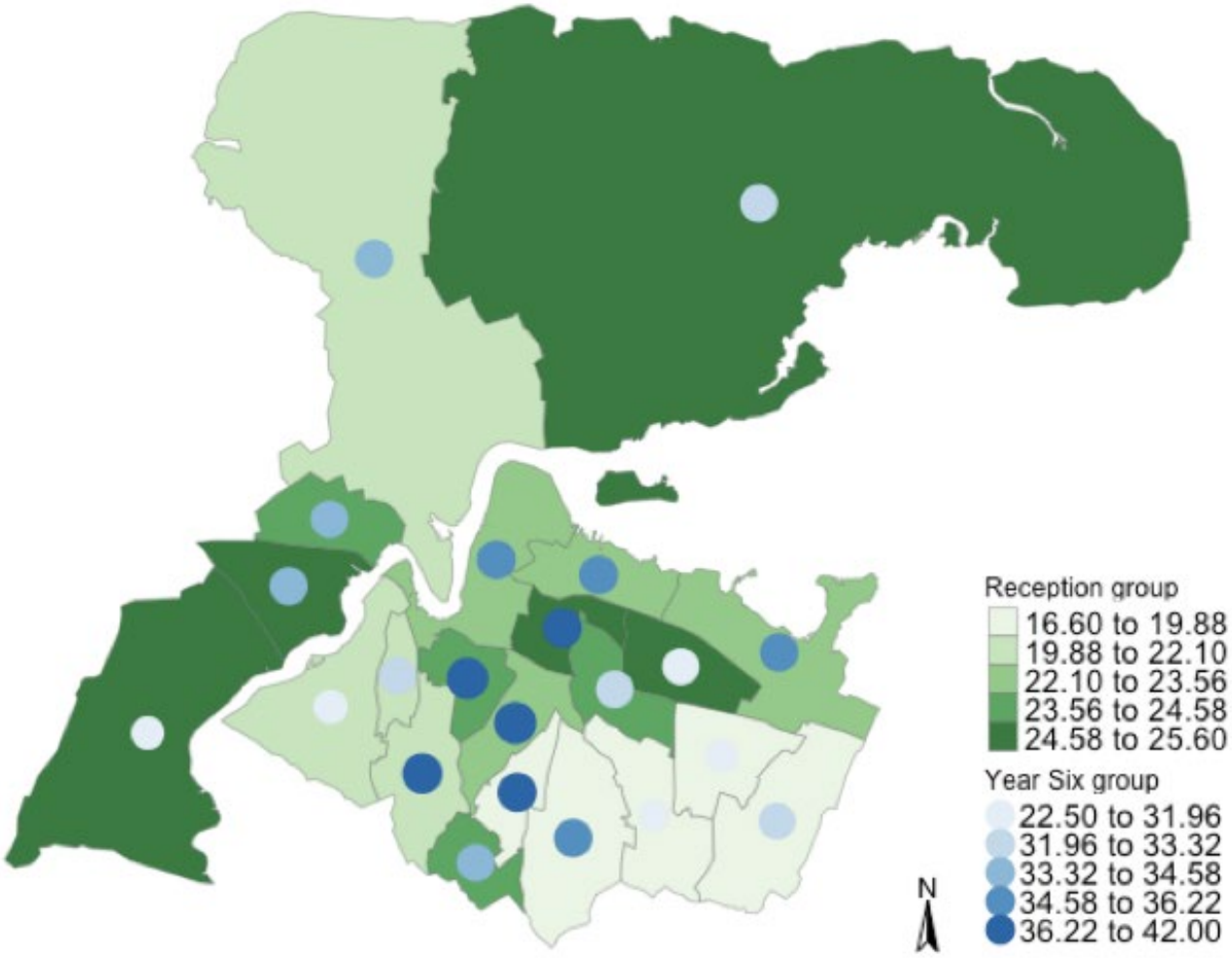
Between 2015/16 and 2017/18, 22.6 per cent of children in Medway aged 4-5 years (Reception class) were classified as overweight or obese (excess weight)[52]. This was not significantly different to the national average which was (22.4 per cent)[54]. That said, as illustrated in Figure 13, rates vary from ward to ward. For example, Hempstead and Wigmore has comparatively low levels of childhood excess weight (16.6 per cent) compared to Strood South (25.6 per cent)[54]. This pattern is replicated in older children: 34.5 per cent of children in Medway aged 10-11 (Year 6) were classified as overweight or obese during the same time period which was in line with national trends (34.2 per cent)[53]. There is local variance, however: the prevalence of excess weight in Year 6 children in Luton and Wayfield was 42.0 per cent, which is nearly double that in Hempstead and Wigmore (22.5 per cent[55]).

To address the rising levels of obesity amongst children, Medway Council has implemented a 'Whole-Systems Approach' as advocated by Public Health England[54]. This includes the roll-out the following interventions:

- A comprehensive range of adult and children weight management services
- Adult and family cookery classes
- Breastfeeding support services
- Hot Food Takeaway planning guidance note
- Healthy Early Years award supporting nurseries and pre-schools
- Family-oriented mass participation sporting events (e.g. Medway Mile)
- Active travel to school projects (e.g. Walking buses and Bikeability)
- Effective health promotion campaigns (e.g. Sugar Smart and Beside You)
- Ommissioning 0-19 child health services and other forms of support within schools
- Coordination of the Medway Healthy Weight Network

Medway has begun to assess the feasibility of new evidence-based interventions ranging from banning advertisements for junk food to replacing all vending machines on Council sites with healthier options. Our recently published 'Childhood Obesity Deep Dive'[55] outlines our intentions for comprehensive and radical action on childhood obesity reduction and prevention in Medway.

Figure 13: Proportion of children classified as overweight or obese in Medway wards, 2015/16 to 2017/18



Source: National Child Measurement Programme. (2019). Childhood obesity and excess weight: small area level data.

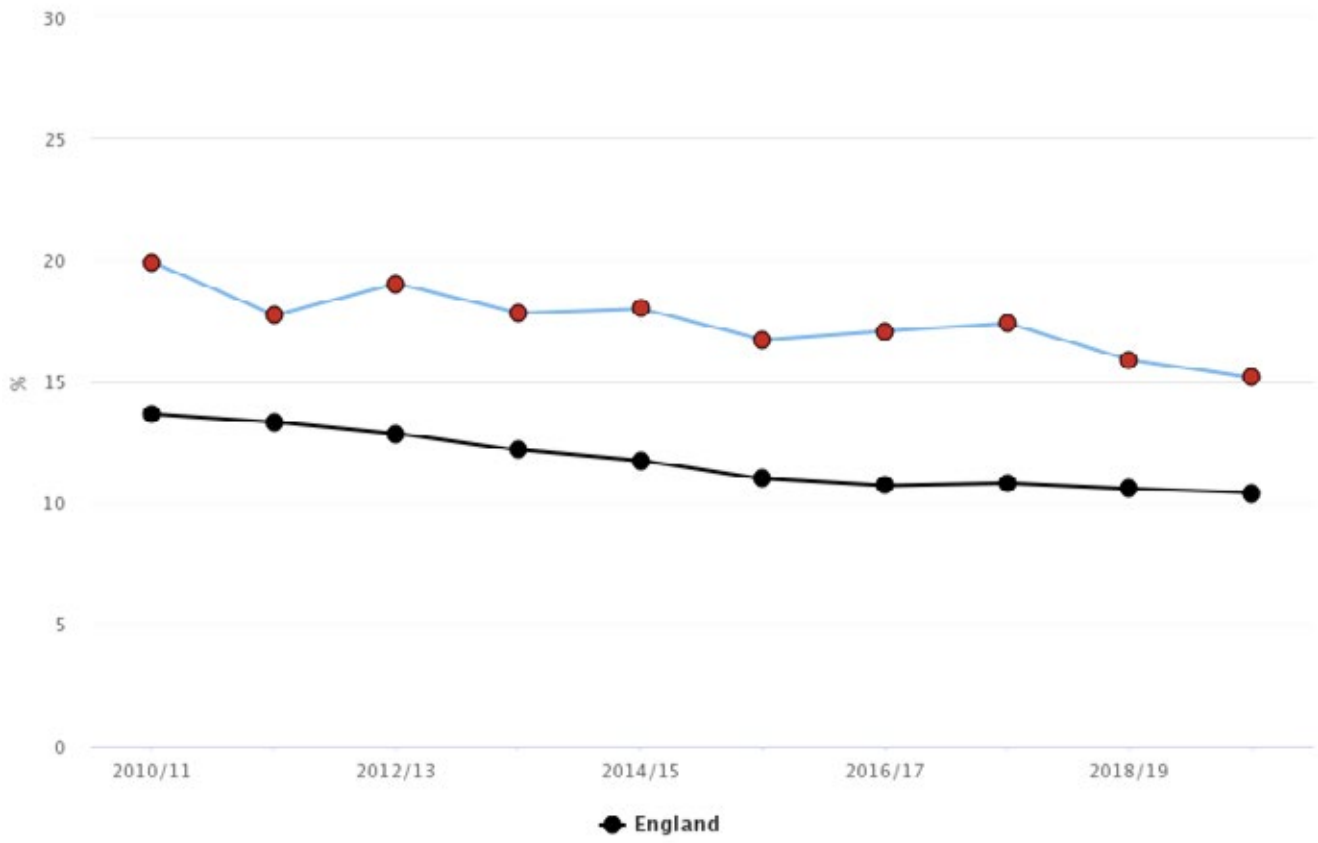
A closer look: 'Family and schools together'

Medway's 'Family and Schools Together' initiative has been particularly successful at raising awareness of childhood obesity across the local authority and in encouraging healthy eating amongst primary and secondary school children. Taking a 'whole school' approach, this programme offers schools healthy eating resources, staff and volunteer training and family workshops on lunchbox preparation, breakfast ideas and healthy eating and snacking and organises a dedicated healthy eating school assembly. With support from this programme, all schools enrolled are empowered to host their own all-year-round gardening clubs and accredited cookery groups for students and parents. Upon completion of the programme, the Council continues to monitor and support schools' progress, and funds and co-delivers a 6-week family cooking course for all those interested in taking part.

Smoking during pregnancy

In the 2019/20 period, smoking status at time of delivery in Medway was 15.2 per cent[4]. Although higher than the England average (10.4 per cent)[4], this is a reduction since 2010/11 (19.9 per cent) and, as illustrated in Figure 14, represents a major improvement from levels seen just a decade ago.

Figure 14: Smoking status at time of delivery for Medway compared to England



Source: Calculated by PHE from the NHS Digital return on Smoking Status At Time of delivery (SATOD)

We attribute this success to our concerted effort to provide mothers with the resources and support they need to quit for the good of their unborn child and their long-term health. **The Medway Stop Smoking Service (MSSS)** now offers a range of targeted interventions to support pregnant women and their wider family members who want to stop smoking. The combination of 1-to-1 support and home visits ensures staff have a full picture of a mother's smoking habits and the barriers they may face when trying to quit. The **Blooming Bumps** programme is a bespoke model created to help women, predominantly those from disadvantaged communities, stop smoking when pregnant. This programme has achieved national acclaim and is currently being expanded.

In Medway, smoking cessation continues to feature on the mandatory training provided for midwives. We ensure the results of carbon monoxide testing (a key marker for smoking in pregnancy) are routinely recorded in all patients' notes. Those with high readings are automatically referred to the stop smoking service. The MSSS provides local midwives with a range of specialist training packages to help them tackle smoking cessation amongst the women they support.

The Council's new live online breastfeeding information sessions have also begun to generate a strong following

Maintaining our momentum during COVID-19: Supporting eating in early years (remotely)

Guiding mothers through the breastfeeding process doesn't lend itself well to social distancing measures; hands-on instruction and face-to-face support were the cornerstones of our Blooming Bumps programme. However, the pandemic has given us the opportunity to experiment with new delivery methods and build upon our existing digital programmes. For example, Blooming Bumps has since taken its sessions online and the expansive resources available on our Beside You website have become increasingly popular amongst expecting and new mothers in Medway. The Council's new live online breastfeeding information sessions have also begun to generate a strong following.

We are also looking at suitable COVID-19-safe methods of supporting parents as they transition their infants to solid foods. In addition to moving our current offerings online, we have invested in new training programmes for health professionals to help them oversee this delicate process remotely. Little Food Explorers - an initiative designed to encourage healthy eating amongst our children who are a little further along in their feeding journey – has also had to make the digital leap this year. Face-to-face cooking classes have been replaced with live online cookalongs and we are exploring the option of providing healthy food packages direct to beneficiaries free of charge. For the fussier eaters amongst us, Food Adventures – a programme dedicated to reducing toddlers' anxiety of new, healthful foods – is being finalised for delivery next year.

As the second wave of COVID-19 moves into 2021, we are also planning to invest in fortifying our food banks. In the beginning of 2020, Medway Council ran an effective emergency food parcel service for vulnerable residents who should not leave their home and could not easily get food themselves. Each food parcel contained enough non-perishable food to feed a family or isolating resident for 2 weeks, alongside information on how to stay fit, well and connected during this difficult time. While this service wrapped up over the summer months, we are still providing services during the pandemic for those who need our support and will return to full operation if demand surges. Similarly, Medway Food Bank provides 3 days of nutritionally balanced emergency food for those who are in financial crisis – an increasingly common occurrence as the pandemic goes on.

Breastfeeding

Medway has traditionally had much lower rates of breastfeeding initiation and continuation compared to the England average[56]. Medway Council launched the Beside You breastfeeding awareness campaign in 2016 to better understand this trend. We established there was a perception amongst some women that Medway was not a welcoming place to breastfeed in public. Furthermore, the negative attitudes that grandmothers held towards breastfeeding were seen to influence the feeding choices of new mothers.

The Medway Infant Feeding Strategy was launched to tackle these and many other barriers to breastfeeding. For example, the Medway Breastfeeding Peer Support Network has gone from strength to strength and we continue to pursue UNICEF Baby Friendly Accreditation across Council sites and services. The Council has an Infant Feeding Strategy Group which has set the following goals for the coming years:

- A year-on-year increase in breastfeeding initiation and continuation rates, aiming for a 1 per cent uplift per year
- 80 per cent of babies discharged from the neonatal unit receive some breast milk
- All parents are supported to build close relationships with their babies
- Parents are satisfied with the support they receive and able to follow their chosen method of infant feeding
- Breastfeeding is an achievable option for all families, but parents who choose to formula feed are supported to do so responsively
- Medway as a place becomes a more infant feeding friendly environment
- Solid food is offered to infants after 6 months of age, with continued breastfeeding for the first year and beyond
- Increased uptake of Healthy Start vitamins from 2017 baseline

School Readiness, Attendance and Follow-On Opportunities

According to the school readiness assessment, 73.7 per cent of children were recorded as having achieved a good level of development at the end of reception in Medway in the 2018/19 academic year57. This compares positively to the England average which is 71.8 per cent[59]. There is, however, further room for improvement. For example, the proportion of children not achieving a good level of development at the end of the reception year was 42.3 per cent amongst those eligible for free meals, compared to 24.1 per cent amongst those not in receipt of free school meals - an absolute difference of 18.3 per cent[58].

The local authority continues to work in partnership with all our schools to support them to ensure our young people enter into schooling prepared and excited for the journey ahead. As well as following advice included in the government's Healthy Child Programme (providing guidance on screening, immunisation, health and development over the first 5 years of life), Medway Council has created its own unique tool to screen the cognitive and physical development of its youngest residents at 3 and a half years of age. When local parents fill in the online paperwork necessary for registering their children for reception classes, a pop-up invites them to complete a series of interactive questions about their child's development. If any areas of concern are identified, children are invited to a follow-up physical health screen. This level of observation helps identify those at greater risk of encountering difficulties when attending school for the first time. This process can pre-empt any behavioural or performance issues even before a child gets to the classroom setting. **Medway's Virtual School** has also recently been established. It ensures no child is left behind when it comes to school readiness and attainment. The Virtual School provides schools, social workers and foster carers with a range of resources to address any attainment gap that children currently or previously looked after might experience compared to their peers.

Ensuring children attend school is vitally important to improving learning outcomes and addressing inequality in the long term. All children of compulsory school age (5 to 16 years) must receive a full-time education by law. **Medway Council's Attendance Advisory Service to School and Academies (AASSA)** does its absolute best to ensure attendance issues are addressed before criminal charges are ever contemplated. By intervening early, every young person in Medway is able to receive the education their future deserves and depends upon.

Medway Council has created its own unique tool to screen the cognitive and physical development of its youngest residents

73.7%
of children were recorded as having achieved a good level of development

Ensuring children attend school is vitally important

4. Living well

4.1. Why is this important?

Living well depends on three factors: healthy bodies, healthy minds and healthy communities. It is difficult to thrive when one or all of these three components are missing or out of balance. People in disadvantaged communities often find it more difficult to live well and balance the three key elements.

Healthy bodies

Maintaining good physical health should not be complicated, yet making healthy choices isn't always easy. As well as daily exercise and a balanced diet, there are other factors to consider when attempting to live well. A healthy diet combined with the sensible consumption of alcohol and the avoidance of smoking tobacco products can help to improve mental and physical wellbeing. This in turn reduces our risk of long-term health complications and, consequently, increases life expectancy.

Obesity increases the risk of developing a wide range of diseases, notably cancer. People who are obese are three times more likely to be diagnosed with colon cancer[59]. They are two and half times more likely to be diagnosed with high blood pressure and five times more likely to be diagnosed with type 2 diabetes[61].

From 1993 to 2015, the proportion of those in England categorised as obese increased from 13.2 per cent of men and 16.4 per cent of women to 26.9 per cent of men and 26.8 per cent of women respectively[61].

Although the rate of increase has slowed in recent years, there is still an upward trend[61].

An increased prevalence of obesity both nationally and locally places a significant burden on the NHS and social care system as a whole. The costs to society of tackling obesity-related conditions are greater than the amount spent on the police, the fire service and the judicial system combined[60]. Between 2015 and 2016, the NHS spent as much as £6.1 billion on overweight and obesity-related ill health alone; this figure is projected to increase to as much as £9.7 billion by 2050 with wider costs to society reaching close to £50 billion per year[61].

Tobacco products, such as cigarettes, are also detrimental to health and wellbeing. The World Health Organisation (WHO) estimates that half of all smokers die as a result of tobacco use[60]. Although cigarette smoking is fortunately becoming less and less popular, it remains a major burden on public health and cause of inequality. Evidence suggests that people living in the most deprived areas of England are four times more likely to smoke than those from the least deprived[61]. Smoking increases the risk of developing cancers of the lungs, head and neck, as well as cardiovascular and respiratory diseases[62 63]. Furthermore, the current available evidence also suggests that smoking is associated with an increased severity of COVID-19[64].

Although drinking in moderation can be an enjoyable part of adulthood, when done frequently and in excess it can become problematic and

even life-destroying. Alcohol, like nicotine, has addictive properties. Drinking more than the daily recommended amount (for units of alcohol) on a regular basis damages physical health and social wellbeing. Alcoholism can also cause relationships to break down, job losses and serious mental health problems. Alcohol is also severely damaging to the liver and can cause a process called cirrhosis, or scarring, to occur[65]. This can have long-term health implications, such as chronic liver disease, cancer and premature death[66].

In line with trends seen amongst smokers, alcohol-related deaths are also strongly aligned with levels of deprivation. Although those living in poverty tend to not be able to afford alcohol and therefore consume less of it then their wealthier counterparts, they are still likelier to die as a result of consumption. Known as 'the alcohol harm paradox' the causes of this relationship are not yet fully understood. Scientists suggest the unique combination of poor diet, excessive consumption of poor-quality alcohol and precarious living conditions most commonly seen in deprived regions may create the 'perfect environment' for physical harm[67].

Finally, it is also important to emphasise that negative lifestyle choices are often pursued as an attempt to cope with the disturbing and debilitating symptoms of mental illness. Comorbidities between drug addiction, alcohol abuse, problematic eating, gambling and mental illness are incredibly common. Those at greatest risk of experiencing these comorbidities are likely to be from underprivileged or marginalised groups including the unemployed, veterans, offenders, the homeless, young people, those from the LGBTQ+ community and women[68].

Healthy minds

Everyone has their own mental health and we are all capable of suffering from mental health problems at some point. Evidence suggests that, in the UK, one in every four adults will experience a mental illness in any given year[69]. Mental illness can occur at any stage, but frequently begins in early life. Over half of all mental illnesses begin before the age of 14 and three quarters before the mid-twenties[70]. Despite this prevalence, suffering from a mental illness still comes with significant stigma attached.

Mental illness is multifactorial and cannot always be contributed to a single cause. Ordinarily, it is a combination of genetic, biological, environmental and social factors that give rise to poor mental health. However, it is possible to identify those who are most at risk of struggling with their mental health and to intervene early for optimal outcomes.

For example, it is typically the most disadvantaged in our society who are at greatest risk of poor mental health. The precariousness of their lives combined with exposure to adverse childhood experiences (i.e. abuse, poverty, unemployment, institutional upbringing, homelessness, incarceration and discrimination from an early age) heightens their risk of developing a diagnosable mental health condition[71].

Rates of mental illness are especially elevated in minority and social ethnic groups[72]. These groups include, but are not limited to, those from a low socio-economic background, Black, Asian and Minority Ethnic communities, members of the LGBTQ+ community and people with disabilities. These communities are often subjected to disproportionate societal and individual adversities that make suffering from a mental illness more likely and accessing appropriate support more difficult[73].

Social isolation and poor physical health have also been identified as risk factors for poor mental health[74]. Older adults, those with long-term physical conditions and those who receive care or depend upon carers, are most vulnerable to social isolation and poor mental health outcomes. Social isolation and poor mental health are strongly associated with poor physical health[76].

Those with diagnosed mental illnesses are also more likely to engage in risky lifestyle choices including poor dietary intake, substance abuse and increased incidences of smoking[75]. For example, roughly 40 per cent of people diagnosed with a serious mental illness in England also smoke, increasing the likelihood of shorter life and poor quality of life[76].

The NHS spent as much as £6.1 billion on overweight and obesity-related ill health

Healthy communities

Medway has a population of 278,556; 49.6 per cent are males, 50.4 per cent are females[77]. Medway's population has increased considerably since the 2011 census. The ethnic make-up of Medway is also broad, with approximately 15 per cent of our residents coming from BAME backgrounds[78]. As discussed, it is this ethnic group that has been disproportionately affected by the pandemic and will require the most ongoing support to reduce health inequalities.

A strong sense of community is an asset for health at both the individual and population level. Societal exclusion and discrimination are typically key factors in creating or further exacerbating health disparities[79]. There is a real need to balance and align the economic development and regeneration of communities with the needs and aspirations of local people. Undertaken effectively, community development approaches can lift people out of poverty and break the cycle of being disadvantaged.

In July 2019, Medway also announced its intention to compete for recognition as the **Next City of Culture** - the winner of which will be announced in 2025. We firmly believe that Medway's cultural heritage, business background and strong track record for staging sporting events makes it a fierce competitor for this title. Infinitely more important than prestige, we see this bid as an opportunity to galvanise and unite the local community; over the next few years we will continue to invest in Medway's cultural offerings and will call upon local talent and innovation to help elevate our application.

Medway is also a growing urban area that is projected to increase to over 330,000 people by 2035[80]. New housing brings new residents and, with that, new demands on local services including schools, parks and transport. Medway's Planning system recognises the need to take a holistic approach to ensuring that these pressures do not affect the quality of life of those who have lived in the area for several years or, perhaps, all their lives. It is Medway Council's responsibility to carefully monitor house prices in the area to ensure that a growing population does not outprice its existing one.

4.2. Work underway in Medway

Healthy bodies: Obesity

More adults in Medway are overweight or obese (69.6 per cent) compared to the national average (62.3 per cent)[81]. Evidence suggests that those most at risk of obesity are male, disabled, unemployed (or in precarious working arrangements), under-educated, from deprived regions or are from White British and Black ethnic groups[57]. Building on this initial analysis will be essential for tackling growing obesity levels in Medway, thereby curbing a major source of health inequality in the area.

In keeping with our whole-system approach to reducing levels of obesity (leveraging the collective expertise of public, private, voluntary and academic partners), Medway Council has a variety of weight management programmes available for residents. For example, **Tipping the Balance** was created to help support people to work towards a healthy weight, to encourage healthy eating and physical activity and to improve self-esteem and confidence. This 1-to-1 service can also provide access to support from psychologists and dietitians on a case-by-case basis. Alternatively, residents can be referred to our **Healthy Way** lifestyle programme. This programme brings clients together to create a community around positive lifestyle change. Users are encouraged to make small lifestyle changes to improve their health via 12 weeks of dedicated guidance and support.

Medway Council also offers support to workplaces as they try and incentivise healthy choices amongst their own staff. Open to all workplaces in Medway, regardless of size and sector, the **Medway Healthy Workplaces** programme provides those enrolled with the policies, training and guidance they need to make their workplaces as health-conscious as possible.

Smoking

The dramatic reductions in smoking rates we have seen across the unitary authority mark a significant step towards tackling health inequalities at large. We attribute our success in curbing smoking rates in Medway to our impressively diverse cessation services. At this moment in time, the Medway Stop Smoking Service offers 1-2-1 specialist support, online support, a free quit smoking app (My Quit Route) and a text-to-quit messaging service. While face-to-face options have had to take a backseat during the pandemic, the service's digital resources have brought free support to those in need.

Alcohol consumption and drug abuse

It is estimated that there are approximately 23,000 severely dependent drinkers in Medway, roughly 4 per cent of the entire population[82]. An estimated 1 per cent of residents would be classified as having a severe and complex dependency[84]. Over 19 per cent of residents are classified as binge drinkers[84]. While these estimates are helpful for targeting public health interventions, they are likely to be an underestimate of the true nature of alcohol consumption patterns in Medway.

It is similarly difficult to measure illicit drug use in Medway. Data correct as of 2017 placed the number of opiate and crack users at 1,100 adults[83], and survey data from 2019 suggests that around 9 per cent of Medway residents had taken an illicit drug in the previous 12 months[84].

Drinking and substance abuse are common coping mechanisms for many during both acute and extended periods of stress. It is no surprise, therefore, that the number of people using alcohol and illicit substances have increased nationally and potentially locally, during the COVID-19 pandemic. Fortunately, Medway entered the pandemic well-resourced in terms of alcohol and substance abuse services. Local treatment and support services provided by **Turning Point** and **Open Road** are widely available. Medway Council has also designed and deployed its own public health interventions and support programmes dedicated to supporting people with drink and/or drug problems. The **Medway Active Recovery Service (MARS)**, run by Turning Point, and **Think Differently** (an alcohol and substance abuse education programme for young people aged 11-18), are good examples of services focussed on local people.

Medway Council's own **Lower My Drinking** service remains as accessible and effective as ever. Designed to help residents monitor and moderate their drinking levels, this website and accompanying app service measures alcohol intake. It provides users with tailored recommendations in terms of how they can meet their health goals. **The Lower My Drinking Quiz** has been particularly helpful during quarantine periods where social isolation has seen so many increase their consumption without real awareness.

Healthy minds: Mental wellbeing

As illustrated in Figure 15, self-reported wellbeing data collected in 2018/19 suggests that Medway has lower levels of wellbeing on average than the rest of England. Nearly 10 per cent of Medway's population reported a low happiness score. While this has decreased since 2016/17 (11.1 per cent), it remains higher than the England average of 7.8 per cent[85]. Worryingly, 23.7 per cent of the population in Medway reported a high anxiety score, substantially higher than the England average of 19.7 per cent and the highest level since records began[86]. It remains to be seen how this anxiety score will have been impacted by the events of the COVID-19 pandemic.

Figure 15: Self-reported wellbeing in Medway, the South East and England, 2018/19

Source: Public Health England, Fingertips, Indicator ID: 22301 (2018)

Like so many of our multi-variate public health challenges, we have applied a life course approach when promoting mental wellbeing services in Medway Council; we have utilised targeted messaging services, campaigns and programmes to fit the needs of local people as and where they are.

Last year's annual public health report, **Healthy Minds Healthy People**, is an excellent summary of this work[87]. The majority of the services and programmes it describes are still supporting our residents today. We are also currently in the process of actioning our **Adult Mental Health Strategy (2018-2023)**. This sets out our plan to invest in high-quality response and crisis services and initiatives that promote the importance of mental hygiene and support residents with diagnosed mental illnesses to maintain their quality of life while managing symptoms.

Medway has also been striving to improve mental wellbeing within the workplace. For example, the Council has rolled out the **Medway Healthy Workplace** programme across local businesses to great effect. In addition to supporting businesses' efforts to improve the physical wellbeing of their staff members, this programme addresses any work-based causes of mental distress. As a sign of our commitment to combatting mental health stigma in the workplace, Medway Council also signed the **Time to Change Employer Pledge** in 2019. Changing the ways in which mental health issues are discussed and managed in the workplace enables more people to come forward and request support when they need it.

We have also increased our support for our older residents' mental wellbeing. For example, our **Men in Sheds** programme provides retired or out of work men with the chance to learn new skills and to connect with others. Our **Wellbeing Navigation Service** aims to link isolated residents with a whole host of life-improving services including befriending and housing options. **Age UK** also provides a Medway-specific information and advice service, offering residents guidance on welfare benefits, housing options and leisure and social activities across the Council. These interventions are all focussed on offering residents with bespoke support options to 'raise the bar' on the quality of life in Medway.

Treating mental illness and preventing suicide

Common Mental Disorders (CMD) include depression, anxiety disorders, panic disorders, obsessive compulsive disorders and phobias. Population estimates in the UK suggest that women are more likely to suffer from a CMD than men[88]. It is estimated that 21,370 women and 12,230 men had CMD symptoms in Medway in 201779. There is also a slightly higher rate of adult depression in Medway than the England average, with 11.9 per cent of over-18-year-old patients registered to a GP in Medway having a diagnosis of depression compared to the national average of 9.9 per cent[89]. Given the robust relationship that exists between having a diagnosed mental health condition and experiencing a great number of health inequalities, supporting those with mental health issues and preventing them from arising in the first place (where possible) is a major priority for Medway Council.

The Kent and Medway NHS and Social Care Partnership Trust provides specialised mental health services for Medway residents. There are a range of services on offer, including the **Mental Health Single Point of Access Service** for urgent mental health support and the **Medway Community Mental Health Team** which supports diagnosis and treatment of severe, long-term and complex conditions. Other services include the **Crisis Resolution and Home Treatment Team** that offers at-home support as an alternative to hospitalisation. **The Medway Liaison Psychiatry Service** provides advice, assistance and formal assessment for those presenting at Medway hospital. Mental health support is also offered to mothers and expectant mothers through the **Mother and Infant Mental Health Service.**

The suicide rate in Medway has decreased in recent years. It has reduced from a rate of 11.7 per 100,000 in 2013-15 to 8.3 per 100,000 in 2017-1990. This rate is similar to the England average of 10.1 per 100,000[93]; however, we are still striving to prevent any person from taking their own life. We will continue to develop suicide awareness and prevention campaigns to help those in need and crisis; for example, through the multi-agency suicide prevention steering group, we continue to offer grants and resources to local community groups and organisations who are working with vulnerable members of the Medway community.

Medway's **Release the Pressure campaign** has gone from strength to strength as a result of Public Health England and NHS England's 2018 funding. This year the Kent and Medway Sustainability and Transformation Partnership (STP) allocated funds to this campaign to launch a mental health text service for the Kent and Medway area to offset the immense mental health toll of the pandemic. Thanks to technical support from SHOUT and The Crisis Line, by texting the words 'Kent' or 'Medway' to 85258, residents can now be connected to experienced volunteers for mental health support at any time. This text service runs in conjunction with Release the Pressure's 24/7 mental health support hotline and can provide confidential help for issues relating to anxiety, depression, low self-esteem, money worries, relationship troubles, stress and suicidal thoughts.

The text line has been promoted across local media and communication outlets, primary care facilities, schools and colleges as well as across Council service channels and websites. This service has already impacted many lives for the better; several case studies of how local volunteers have helped residents manage their mental health during the pandemic are included on the Release the Pressure website.

A range of testimonials are available on the campaign site (https://www.kent.gov.uk/social-care-and-health/health/release-the-pressure), including a testimonial from Joe who encourages those struggling with their mental health to turn to Release the Pressure: "Don't be scared to reach out; you aren't going to be judged and hopefully, like me, you'll feel a million times better."

Residents can now be connected to experienced volunteers for mental health support at any time

Healthy communities: Reducing criminality

Criminality – either from the perspective of the victim or the perpetrator - has major repercussions for a person's physical and mental health and is a significant contributor to health inequalities at a national and local level. For example, those brought up in violent homes are more likely to either experience or perpetrate violence themselves later on in life[91]. People recovering from victimisation may be unable to work for a considerable period of time and those who fear crime in their communities may engage in less physical or social activities, leading to poorer self-rated physical and mental health[92].

Addressing both the health and wellbeing of those at risk of offending, and of those who have already offended, is a pragmatic and cost-effective way of improving outcomes for the individual, the victims and the community[93]. In the long term, improving an at-risk child's family environment can reduce the risk of them developing mental health issues and risky patterns of behaviour in the future[96]. This would reduce the gap in health inequalities experienced by this group, reduce their offending and re-offending rates and ultimately make Medway a safer place to live for the whole community.

Looking across all age groups, the rate of first-time offenders in Medway was 278 per 100,000 population in 2018, statistically higher than the England average of 211 per 100,000[94]. However, the rate of first-time offenders in Medway has shown an overall decrease since its highest recorded level in 2010[97]. This has been attributed to the variety of programmes dedicated to youth crime and reoffending prevention that are currently active in Medway. For example, the **Children's Services and the Youth Offending Team (YOT)** use integrated case management to address children who may be on a pathway into crime.

Strategic collaboration with the office of the police and crime commission through the **Kent and Medway's Violence Reduction Unit**, has enabled additional funding to flow into Kent and Medway to tackle youth crime and the causes of youth crime. **The Medway Task Force** combines a holistic model of policing and family support, with proactive engagement to address the critical issues in our communities. Our 3-year **Medway Youth Justice Partnership Strategic Plan (2020-2023)** sets out the manner in which we will continue to deliver high quality, high performing services that incorporate wider determinates of health. Preventing young people from entering the criminal justice system will improve their life chances in the long term and reduce health inequalities.

Domestic abuse related crime remains an issue within Medway. There are currently 34.0 domestic abuse related crimes per 1,000 reported in Medway, compared to the national average of 27.4 per 1,000[95]. To address this particularly challenging issue, **Medway's Domestic Abuse and Sexual Violence Executive Group** was established. The strategic assessments produced by this group informs the domestic violence interventions and public awareness campaigns that are active in Medway today. Medway Council also offers residents access to specialised services, refuges and **independent domestic violence advisers (IDVAs)** that respect, understand and meet the unique needs of victims.

To crackdown on the inter-generational effects of domestic violence, Medway Council is investing heavily in programmes and services that support and rehabilitate children brought up in violent homes. For example, **Operation Encompass**, a national initiative aiming to support children affected by domestic abuse, is currently being rolled out across Medway and Kent in coordination with local **HeadStart Services** (a non-profit dedicated to boosting children's mental wellbeing and job prospects). Thanks to the hard work of those involved in this programme, schools are now notified within 24 hours if one of their students is affected by a domestic abuse incident that the police have attended. This early engagement means schools can act to safeguard pupils and protect their education from being disrupted as much as possible.

Medway's 'Family Matters' counselling practice continues to provide support for victims of sexual abuse. Their helpline and 1-to-1 support options help to mitigate issues that can follow sexual abuse and rape, such as depression, anxiety, post-traumatic stress, trauma, bereavement, substance abuse, sexual confusion, low self-esteem and anger management.

Schools are now notified within 24 hours if one of their students is affected by a domestic abuse incident

Providing adequate housing

Medway Council is also aware that more investment has to go into providing adequate housing for our elderly residents. Medway's **Homes for Independent Living** is a Council scheme aimed at providing those over 60 with more manageable homes to help them maintain their dignity, privacy and independence. Alternatively, the **Extra Care Scheme** is open to residents aged over 55 who require additional support during daily tasks. Extra Care Housing has a permanent care team in the building to meet the needs of those who live there, any time night or day.

Place-shaping to increase urban green spaces, reduce traffic movements and facilitate job creation is at the very centre of Medway's strategy for urban development. The Council is also absolutely committed to securing safe and stable accommodation for those in need. Recent investments and improvements to local social care services and community support initiatives have allowed us to place unprecedented numbers of homeless residents into long-term accommodation[96].

Fuel poverty refers to households who would be placed below the poverty line after paying their energy bills. Fuel poverty can trigger incredibly hard decisions, typically revolving around whether a person should prioritise their heating bills over their food bills. Compromising on either of these will have consequences on a person's physical and mental health over time[97]. Whilst levels of fuel poverty in Medway are below that of the national average (standing at 9.0 per cent locally vs 10.3 per cent in England), the Council continues to support those who struggle to pay their energy bills. For example, our **Warm Homes Scheme** offers financial aid and provides support for loft and cavity wall insulation to slow down heat loss from the home and reduce fuel bills overall. This programme is open to both homeowners and renters.

Maintaining our momentum during COVID-19: Shielding the homeless

Rough sleepers typically live and sleep in close quarters and are three times likelier to have a pre-existing respiratory condition; taken collectively, these factors make them exceptionally vulnerable to COVID-19. At the very start of the pandemic, Medway Council committed itself to finding temporary accommodation for all our rough sleepers. By repurposing the empty King Charles Hotel and providing new shelters and interim forms of accommodation, we were able to offer socially distanced living options for all those without a permanent residence. Though some refused, for the most part these emergency forms of accommodation were well-received by their users and the community at large, especially as established shelters were forced to temporarily close.

Beyond re-housing, this project also attempted to foster a community spirit amongst this disparate community; whilst respecting social distancing measures, we really encouraged residents try to form connections with one another – holding each other responsible for maintaining sobriety rules, developing independent living skills and for maintaining common living spaces. One resident, a former military veteran who continues to struggle with post-traumatic stress disorder (PTSD), explained that having others depend upon him to cook meals was an enormous boost for his mental wellbeing: 'Thinking of others instead of yourself is important, it makes you feel good'. This client has since gone on to seize every opportunity offered by this initiative including signing up to become a peer mentor at local substance misuse support groups.

5. Staying well

5.1. Why is this important?

Fair, equitable and timely access to health and social care services is central to maintaining good health, vitality and wellbeing. An effective health care system is also absolutely key to tackling health inequalities. Many conditions can be treated or improved by early intervention. This is not only beneficial to the individual, but also reduces the demand on more specialist services to ensure there is sufficient capacity to treat others quickly. Given that they provide residents' first point of contact for formal medical support, primary care services, such as general practices, community pharmacies, dentists and optometry (eye health), are key targets for improving local health inequalities. A cautious but comprehensive programme of local health and social care reforms are still needed to better resource the primary, secondary and tertiary services we all depend upon to stay well. Such improvements would also help to reduce the health inequalities that persist in the unitary authority.

An effective healthcare system is also absolutely key to tackling health inequalities

5.2. Work underway in Medway

Improving uptake of screening services

Screening services have a significant role to play in reducing health inequalities: early identification of killer diseases is key to improving patient outcomes. Increasing uptake of screening services in Medway is a priority.

Our work to improve cervical cancer screening exemplifies this commitment to enhance screening services in Medway. Data from 2019 shows the percentage of eligible women aged 50 to 64 screened for cervical cancer was 75.2 per cent in Medway[98]. This is lower than the national average (76.2 per cent) and much lower than 2010 when 81.4 per cent were screened[101]. Furthermore, the percentage of younger women aged 25 to 49 screened for cervical cancer was 72.4 per cent in 2019[99]. This is similar to the national average (69.8%)[102], but also lower than the proportion screened in 2010 (75.4 per cent). It is recognised that a number of factors affect screening uptake. Women from the most deprived groups in society are currently the least likely to attend cervical screening despite having the greatest chance of being diagnosed with or dying from cervical cancer[100]. Sincere efforts are being made to address this disparity, including the introduction of P**ublic Health England's Screening Inequalities Strategy**[101]. The Council will continue to work with NHS England and Public Health England to increase cervical cancer screening uptake and apply key lessons learned to enhance community engagement with other screening services available.

Bringing care into the community

Offering care options closer to home is a prime strategy for reducing health inequalities in a given population. Such an approach seeks to empower patients to make decisions about their own care, health and wellbeing. **The Sustainability and Transformation Plan for Kent and Medway** encourages health and social care providers to better align services and look for opportunities to provide more outpatient services in community settings.

Recruitment

The only way of delivering our ambitious goals for narrowing health inequalities in Medway is to have the right people behind us. We have therefore built upon our presence at careers fairs and have invested heavily into health and social care-related pre-employment courses and work placements to give local young talent a taste of the rewarding careers that can be found in both these sectors.

Going digital

The COVID-19 pandemic has highlighted the value of digital technologies in health and social care. However disrupted it has been, the continuity of care we have seen in both these sectors has only been possible thanks to the broader use of digital solutions including telemedicine, online booking systems and remote monitoring. These technologies have allowed clinical care to enter the home directly, removing inequalities of access altogether. Remote monitoring has also allowed doctors to catch and address early signs of the major killers in Medway and Kent including cancer and cardiovascular disease.

Prevention rather than cure

Preventative medicine and care have key roles to play in narrowing health inequalities. Intervening early in either a patient's disease trajectory or a client's adversity can curb the negative health outcomes that would have occurred otherwise. Though representing a major investment from the outset, it is clear from both financial modelling and comparative case studies that preventative actions reap dividends for the Council and community at large. That said, the **Make Every Contact Count (MECC) scheme** demonstrates how inexpensive preventative care can be when leveraging existing institutions and opportunities. Here we leverage the millions of day-to-day interactions we all have as a vehicle for delivering pertinent health information. MECC training empowers those who have brief contact with the general public to use brief and very brief interventions (spanning 30 seconds to a couple of minutes) during routine interactions or appointments to signpost individuals to local public health services and plant a seed of behaviour change. This MECC approach has the capacity to help individuals tackle their problematic lifestyle choices before they escalate into chronic disease. While we have suspended this programme of work until training can be done in a COVID-19 compliant manner, Medway Council will continue to invest in this approach in the near future.

6. Aging well

6.1. Why is this important?

Although healthcare innovations such as vaccinations and modern therapeutics have given us access to increased longevity, there is still a long way to go before these added years are guaranteed to bring added quality of life. The longer we live, the greater our likelihood of experiencing disability and multiple morbidities. More than half of adults suffer from two or more chronic health conditions in their old age[102]. The risk of long-term conditions is not the same for everyone. The lower a person's socio-economic status, the greater their mortality risk and likelihood of suffering from conditions that affect their health. Those from deprived areas are also more likely to smoke and have poor nutritional intake, leading to higher incidences of conditions, such as obesity, coronary heart disease, stroke and cancer, than the more affluent.[63]

Living and managing several comorbidities can be complex and often requires continuous oversight and support from medical professionals. It can also reduce patients' ability to carry out daily activities. Evidence suggests that

those with active social lives may be protected from the elevated levels of anxiety, depression, dementia, high blood pressure, obesity and even premature death that is seen amongst those who self-identify as being lonely or isolated in their old age.

6.2. Work underway in Medway

While Medway has a smaller percentage of residents aged over 65 years (16.1 per cent) than the national average (18.4 per cent)[103], this demographic is set to expand in the coming years; it is estimated that as many as one in every five Medway residents will be over 65 years of age by 2029[104]. While the population's longevity is a real cause for celebration from a public health perspective, an aging population comes with some unique challenges.

Accessible and aligned care options

Medway Council is working hard to ensure that health and social care services are more seamlessly linked for this population. Older people should be confident that their doctor, community nurse, social worker or warden in their supported housing are all in agreement with their treatment plan and are regularly updated on its progress. This multi-disciplinary, locally accessible approach is the surest way of optimising health outcomes and convenience for the elderly patient. We are also expanding the number of ways in which we support our elderly residents via home-care services and assistive technologies. For example, our **integrated joint equipment store** provides a range of mobility aids, equipment and adaptations for our

residents to help them stay safe with maximum independence at home. We are also investing heavily into accident prevention schemes (to help reduce the number of falls people experience in their own homes) and telehealth and telecare systems.

In keeping with these ambitions, Medway Community Healthcare and Kent County Council has partnered with T**ICC (Transforming Integrated Care in the Community)**, an Interreg, '2 Seas' initiative that pilots novel service models to better suit our aging population and their holistic needs. As a result of €4.8 million in European funding, this programme will allow Kent and Medway communities to experiment with the 'Buurtzorg Integrated Care at Home' model which consists of self-managing teams of 12 staff working at the neighbourhood level to handle every aspect of both care and business. This approach provides better outcomes for patients (via reduced unplanned hospital admissions, convenience and consistency of care) and for healthcare providers (via reduced costs and improved staff productivity, patient satisfaction and communication between health and social care organisations). We will be piloting this scheme in Edenbridge, Ashford and Medway over the next 4 years.

Social interaction

Loneliness should not have to be a fact of life as we age. While physical distancing has been central to the COVID-19 pandemic response, we have not allowed our past efforts in tackling feelings of loneliness and isolation in Medway to be compromised during the pandemic.

For example, we have continued to build upon the social prescribing programmes that have been so effective in the past. Social prescribing refers to the process when a client or patient is referred or signposted by GPs, nurses and other primary care professionals into non-clinical services to support or improve their health and wellbeing in a holistic way. In 2019, Medway Council and Medway Voluntary Action partnered with Simply Connect to deliver a whole population social prescribing service across the Council. **Simply Connect Medway** now supports cross referrals from the NHS, adult social care and the voluntary sector into community service options. Link Workers and Care Navigators use the Simply Connect case management system to store client data, record case notes and monitor health and wellbeing improvements. This platform has already proven itself to be well worth the investment with special value for the most isolated and vulnerable in our community; over 92 per cent of its users would recommend the social activities advertised to others[105].

Taking things offline, **Better Connected**, a 12-week social prescribing course, was launched in August of this year to help our older population make new connections. This programme supports them to get out, reconnect and be more socially active, even if at a social distance.

Respect in the community

We do not tolerate any form of abuse towards the elderly in Medway and are quick to respond to any such accusations. Adult abuse can be reported to Medway Council directly via the telephone and email information provided on our website; an official adult social care safeguarding alert form is also included here. In line with our **Safeguarding Adults protocol**, when we receive a report that someone is being neglected, harmed or is in any way at risk, it is our duty as a Council to decide if a formal safeguarding enquiry needs to take place and if any other support should be provided. Generally speaking, this process involves either an informal conversation with the adult at risk but can escalate to a more formal multi-agency discussion. An official, Statutory S42 Safeguarding Enquiry can only be made if a person meets the criteria included within Section 42 of the Care Act.

Finally, we also encourage elderly residents to participate in our **'Safer Stronger Partnership'** and co-create plans and actions to ensure a safer environment for everyone.

Adult abuse can be reported to Medway Council directly via the telephone and email information provided on our website

7. Recommendations and next steps

This report has highlighted Medway's progress in addressing key sources of health inequality in the unitary authority. Although the COVID-19 pandemic has emphasised the urgency of these issues and how they increase a person's likelihood of experiencing negative health outcomes, the strides Medway has made in this area show every sign of resilience. As such, the recommendations listed below are intended to both preserve and build upon progress made.

7.1. Job creation and upskilling

As summarised within the local authority's **Skills and Employability Plan for Medway 2035**, Medway is a vibrant and growing community that will require considerable dedication and talent to unlock its ambitions for economic recovery and growth. With 30,000 new homes and 17,000 new jobs originally projected for the year 2035[106], the Council should invest in upskilling schemes and other programmes to nurture local talent and offset job losses experienced this year. However, if Medway is to become a city of the future, it is essential that it looks to future-proofing residents' jobs. Plans to create an **Innovation Park** in Medway are well underway; this, alongside greater subsidisation of digital and robotics skillsets and local talent accelerators, will help the Council to achieve its goals for a truly modern Medway.

Beyond the immediate aftermath of COVID-19, upskilling programmes will also prove essential for protecting all workers from the growing threat of job automation. It is essential that older workers are not excluded from new opportunities. In addition, Medway's economy and infrastructure recovery cell is working across a number of areas to promote employment, job creation and reduce inequalities. An example of this is combatting escalating carbon emissions in Medway, and the negative health outcomes associated. This aligns with the Council's decision to **declare a climate change emergency** in April 2019, and also taps into the future employment markets.

7.2. Investment in prevention

Medway Council must continue to pursue preventative public health interventions. To achieve its goals, it is essential to proactively identify those most at risk for experiencing health inequalities and to intervene at the earliest stage possible before negative health outcomes are experienced or risky behaviours become entrenched. The Council will therefore continue to build upon pre-existing **Make Every Contact Count** and **Community Champions programmes** to preserve the flow of information between health influencers and the public, even if from afar. The immediate future must involve actioning new funds for suicide prevention across

Medway and setting ambitious new goals for the Medway faction of the **NHS Diabetes Prevention Programme, Healthier You** and other initiatives to reduce the rising obesity levels in Medway.

Prioritising the continued delivery of children's health services along with effective smoking cessation, obesity prevention, weight management, physical activity and alcohol and drug treatment programmes is essential. While digitally-enabled solutions have allowed many of Medway's pre-existing programmes to go ahead relatively undisrupted, it is important not to lose sight of residents who are digitally excluded and have been left out from these new outreach efforts. From this point onwards, the Council must endeavour to ensure all new health programmes operate according to a blended model of digital and in-person teaching or support, where possible.

7.3. Emphasise care in the community

Increased community participation and broader accountability for healthcare provision is required to improve the efficiency, effectiveness and economic viability of Medway's health and social care services. **Medway Community Healthcare** exemplifies exactly the type of initiative the Council should aim to replicate looking to the future. This social enterprise provides both NHS and non-NHS services directly to the people of Medway via partnerships with the Council, local GPs, Medway NHS Foundation Trust and other key local stakeholders. Established in 2011, this Community Interest Company demonstrates how impactful social enterprise can be for 'raising the bar' in community services. Any profit generated is directly reinvested back into the communities this organisation serves.

Further investment into telemedicine and the subsidisation of personal medical devices is also required, particularly for those who are digitally excluded. The Council should continue to leverage its recently established **Telecare/Telemedicine Network** and **The Design and Learning Centre (DLC) for Clinical and Social Innovation** to develop safer, efficient and highly cost-effective solutions for the delivery of health and social care in Medway, working through the Joint Commissioning Management Group to ensure NHS digital aspirations are aligned with the Council's. **The Digital Care Homes scheme** and **RETHINK Alliance** are two assistive digital technology initiatives that have emerged out of this pandemic

The immediate future must involve actioning new funds for suicide prevention across Medway

and will likely go on to prove central to achieving the Council's broader ambitions for integrated and community-based care options. Finally, the Council must continue to invest in social marketing and behavioural insight programmes to gather insights around addressing cancer and cardiovascular risk factors in the unitary authority.

7.4. Integration, integration, integration

Integrating services where this adds value has long been a strategic priority for both local and national governments. The main benefit of integration is generally improved efficiency, lower costs and better service outcomes for customers or services users. Working collaboratively will allow the wider determinants of health to be more visible to local practitioners and healthcare providers when making clinical decisions.

Integrating services is not straightforward. Appropriate solutions will need to be explored to prevent any disruption to services while reforms are going ahead. The partnership between **IC24 and South East Coast Ambulance Service NHS Foundation Trust (SECAmb)** is best practice for what private-public partnerships can achieve here. Thanks to their joint efforts, an enhanced NHS[111] service connecting users to GPs, paramedics, nurses, mental health professionals, dental nurses and pharmacists is now available to all residents within Kent, Medway and Sussex.

Medway Council and its stakeholders must continue to explore where natural alliances can be formed amongst both health and social care providers to help those most disadvantaged benefit from more tailored and person-centred services. The opportunity that the **Medway Integrated Care Partnership Board** brings for this localised integration is one that cannot be missed.

7.5. Elevate hardest hit communities

The pandemic has made it clear that, when it comes to public health, we are all only ever as strong as our weakest links. All public health interventions and wider regeneration activity must focus (proportionately) on the needs of communities worst affected by COVID-19.

Building on **Medway's Community Champions programme**, steps should be taken to gain insight from community stakeholders in Medway's most disadvantaged localities to inform new models of service delivery. Once the pandemic has reached a point of containment, all local efforts around 'Building Back for Better' must incorporate ample time and opportunities for public consultation, particularly amongst the communities hardest hit by COVID-19.

7.6. Make mental health a commissioning priority

As the pandemic progresses, it is important that the Council continues to support the mental health of those self-isolating. These individuals should be directed to NHS-approved mental wellbeing apps to develop new, healthy coping mechanisms and relaxation methods.

In order to mitigate the adverse psychological effects of COVID-19 in the Medway population, it is essential that mental health services are both accessible and equitable. The Council must look for new ways of improving access to short courses of cognitive behavioural therapy and other forms of psychological support for residents, either online or face-to-face (when safe to do so), for those most psychologically harmed by the pandemic and

In order to mitigate the adverse psychological effects of COVID-19 in the Medway population, it is essential that mental health services are both accessible and equitable

unable to self-fund treatment otherwise. Front line workers should be prioritised initially – preventing burnout is absolutely essential as COVID-19 fatigue sets in and the second wave gathers pace. **Medway Talking Therapies** should be considered as a possible implementation partner for these efforts.

7.7. Leverage existing research and frameworks

Actioning the Joint Health and Wellbeing Strategy for Medway

Reducing health inequalities is one of the five strategic themes in the **Medway Joint Health and Wellbeing Strategy (JHWS) 2018-2023**. The JHWS provides a high-level framework for improving health and wellbeing in Medway and is used to inform commissioning decisions across the Council's health and care system.

The key priorities for reducing health inequalities in Medway include:

- Monitor the variation in key outcomes across Medway, including school readiness
- Influence the delivery of services to reduce variation across Medway
- Reduce variation in healthy life expectancy
- Support early help to families

The JHWS acts as the critical framework to align system priorities to tackle health inequalities. The Council must therefore continue to ensure all its strategic partners align their priorities to the issues set out in the JSNA.

Actioning the health inequalities review

In 2014, the Medway Council Overview and Scrutiny Committee Task Group produced a **Health Inequalities Review**. This in-depth review focused on health inequalities across Medway wards and, based on the insights that emerged over the course of its investigations, produced recommendations for the Council and its partners. Suggested actions centred around embedding an understanding of health inequalities in Medway, achieving buy-in to the commitments around narrowing health inequalities made within the JHWS, and ensuring stakeholders always have access to guidance on how they can effectively impact health inequalities in their jurisdiction.

The Task Group produced a key set of principles to assist the Council and its partners when investing in measures or initiatives to narrow health inequalities in Medway:

1. **Principle 1:** Actively seek ways of working in partnership across teams and agencies to tackle health inequalities and direct resources.
2. **Principle 2:** Assess the impact of investment decisions on health inequalities before decisions are made.
3. **Principle 3:** Review and evaluate how equitable services are, e.g. through health equity audit, and adjust service delivery to address any health inequalities found.

These principles should inform the design of new policies and strategic decisions we make as a system. This will enable the Council and its partners to align decision making to improve community outcomes over the longer term.

7.8. Looking ahead

As an extension to preventative medicine, the Council should look to learn from the lessons of the COVID-19 pandemic and maintain its own pandemic preparedness resources and strategies, even when the public's attention has moved on. Robust, retrospective research studies should be undertaken to identify where the Council might be able to improve its pandemic response in the future. The Council might consider tapping into the research capabilities offered by **The Universities at Medway collaboration** (University of Greenwich, University of Kent and Canterbury Christ Church University) to undertake this vital work.

The Joint Health and Wellbeing Strategy acts as the critical framework to align system priorities to tackle health inequalities

Indices/references

1. Marmot, M. (2010). Marmot Review report– 'Fair society, healthy lives' London, United Kingdom: University College London.
2. Marmot, M., Allen, J., Boyce, T., Goldblatt, P. and Morrison, J. (2020). Health equity in England: The Marmot Review 10 years on. London: Institute of Health Equity.
3. Public Health England. (2020). Disparities in The Risk and Outcomes Of COVID-19. London. Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf
4. Public Health England. Fingertips. Local Tobacco Control Profiles. Indicator ID: 92443.
5. A Better Medway. (2020). More Medway smokers are stubbing out the habit. Medway Council.
6. Public Health England. Fingertips. Indicator ID: 20401.
7. NHS England. Definitions for Health Inequalities. Retrieved from: https://www.england.nhs.uk/ltphimenu/definitions-for-health-inequalities/
8. Public Health England. Fingertips. Local Authority Health Profiles. Indicator ID: 90366.
9. NICE. (2016). Community engagement: improving health and wellbeing and reducing health inequalities. Retrieved from: https://www.nice.org.uk/guidance/ng44
10. National Statistics. (2017). Health Survey For England 2016 Well-Being And Mental Health. [eBook] London: p.1. Available at: http://healthsurvey.hscic.gov.uk/media/63763/HSE2016-Adult-wel-bei.pdf
11. Williams, R., Aspinall, R., Bellis, M., Camps-Walsh, G., Cramp, M., Dhawan, A., and Hickman, M. (2014). "Addressing liver disease in the UK: a blueprint for attaining excellence in health care and reducing premature mortality from lifestyle issues of excess consumption of alcohol, obesity, and viral hepatitis", The Lancet. 384(9958), 1953-1997.
12. Dahlgren G, Whitehead M. (1991). "Policies and strategies to promote social equity in health", Stockholm: Institute for future studies.
13. Department of Health. (2012). Long-term conditions compendium of Information: 3rd edition. Report.
14. Leon, D. A., Jdanov, D. A., and Shkolnikov, V. M. (2019). "Trends in life expectancy and age-specific mortality in England and Wales, 1970–2016, in comparison with a set of 22 high-income countries: an analysis of vital statistics data", The Lancet Public Health, 4(11), 575-582.
15. Paton, A., Fooks, G., Maestri, G., & Lowe, P. (2020). "Submission of evidence on the disproportionate impact of Covid 19, and the UK government response, on ethnic minorities and women in the UK".
16. Chaturvedi, N. (2003). "Ethnic differences in cardiovascular disease", Heart, 89(6), 681-686.
17. The King's Fund. (2020). What are health inequalities. Retrieved from https://www.kingsfund.org.uk/publications/what-are-health-inequalities#access
18. OECD. (2012). How does education affect employment rates?, in Education at a Glance 2012: Highlights, OECD Publishing, Paris.
19. Townsend, P. (1987). "Deprivation", Journal of Social Policy 16(1): 125–146.
20. McLennan, D., Noble, S., Noble, M., Plunkett, E., Wright, G., and Gutacker, N. (2019). "The English Indices of Deprivation 2019", London: Ministry of Housing, Communities and Local Government. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/833951/IoD2019_Technical_Report.pdf

21. Strategic Commissioning Statistical Bulletin. (2020). The Index of Multiple Deprivation (IMD2019): Headline findings for Kent.

22. LG Inform. (2020). IMD – Income Deprivation Affecting Children Index (IDAC) – proportion of LSOAs in most deprived 10% nationally (from 2015 to 2019) for Medway.

23. Public Health England. (2017). Health Profile for England: 2017. Chapter 1: life expectancy and healthy life expectancy.

24. Office for National Statistics. (2020). Avoidable Mortality in the UK. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/avoidablemortalityinenglandandwales/previousReleases

25. Medway Health and Wellbeing Board. Joint Strategic Needs Assessment. http://medwayjsna.info/downloads/Medway%20JSNA%20Executive%20Summary.pdf

26. Public Health England. Fingertips. Indicator ID: 90362.

27. Public Health England. Fingertips. Indicator ID: 90366 and 90362.

28. Office for National Statistics. (2020). Socioeconomic inequalities in avoidable mortality in England: 2018. Retrieved from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/socioeconomicinequalitiesinavoidablemortalityinengland/2018

29. Zoe. (2020). COVID Symptom Study. https://covid.joinzoe.com/data

30. Patel, A.P., Paranjpe, M.D., Kathiresan, N.P., Rivas, M.A. & Khera, A.V. (2020). "Race, Socioeconomic Deprivation, and Hospitalisation for COVID-19 in English participants of a National Biobank", Int J Equity Health. https://doi.org/10.1101/2020.04.27.20082107.

31. Centers for Disease Control and Prevention. (2020). COVID-19 (Coronavirus Disease). https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html

32. Cabinet Office. (2020). Overcrowded households. Retrieved from: https://www.ethnicity-facts- figures.service.gov.uk/housing/housing-conditions/overcrowded-households/latest

33. Office for National Statistics. (2020). Which occupations have the highest potential exposure to the coronavirus (COVID-19). Retrieved from: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/articles/whichoccupationshavethehighestpotentialexposuretothecoronaviruscovid19/2020-05-11

34. House of Commons Library. (2020). Poverty in the UK: statistics [eBook].

35. Kent and Medway Economic Partnership. (2020). Kent and Medway Economic Renewal and Resilience Plan-Economic Impact Evidence Base [eBook]. Retrieved from: http://kmep.org.uk/documents/Economic_Impacts_Evidence_Base_August_2020.pdf

36. Whitehead, M., & Dahlgren, G. (1991). "What can be done about inequalities in health?"

37. Labonte R. (1993). "Health Promotion and Empowerment Practice Frameworks."

38. Askew, D.A., Guy, J., Lyall, V. et al. (2019). "A mixed methods exploratory study tackling smoking during pregnancy in an urban Aboriginal and Torres Strait Islander primary health care service", BMC Public Health 19, 343.

39. Public Health England. (2016). Health matters: giving every child the best start in life. https://www.gov.uk/government/publications/health-matters-giving-every-child-the-best-start-in-life/health-matters-giving-every-child-the-best-start-in-life

40. Veena, S.R., Gale, C.R., Krishnaveni, G.V. et al. (2016). "Association between maternal nutritional status in pregnancy and offspring cognitive function during childhood and adolescence; a systematic review", BMC Pregnancy Childbirth 16, 220.

41. RCPCH. (2017). Position Statement. Breastfeeding in the UK. https://www.rcpch.ac.uk/resources/breastfeeding-uk-position-statement

42. Horta, B. & Victora, G. (2013). "Long-term effects of breastfeeding: A systematic review", WHO Library Catalogue.

43. Lang J. E. (2012). "Obesity, Nutrition, and Asthma in Children. Pediatric allergy, immunology, and pulmonology", 25(2), 64–75.

44. Wehby, G. L., Prater, K., McCarthy, A. M., Castilla, E. E., & Murray, J. C. (2011). "The Impact of Maternal Smoking during Pregnancy on Early Child Neurodevelopment", Journal of human capital, 5(2), 207–254.

45. Marufu, T. C., Ahankari, A., Coleman, T., & Lewis, S. (2015). "Maternal smoking and the risk of still birth: systematic review and meta-analysis", BMC public health, 15(1), 239.

46. Maternal and Early Years. (2013). Costs to the NHS of smoking in pregnancy for pregnant women and infants. http://www.maternal-and-early-years.org.uk/costs-to-the-nhs-of-smoking-in-pregnancy-for-pregnant-women-and-infants

47. Ettinger, A. S. (2004). "Children's health, the Nation's wealth: Assessing and improving child health".

48. UNICEF.(2004). The State of the World's Children 2005: Childhood under threat, New York.

49. Department for Work and Pensions and HM Revenue & Customs. (2020). Children in low income families: local area statistics.

50. Medway Council. (2018). Medway Children and Young People's Plan 2019-2024 [Ebook]. https://democracy.medway.gov.uk/mgconvert2pdf.aspx?id=46579

51. Public Health England. Fingertips. Indicator ID: 93105.

52. Public Health England. Fingertips. Indicator ID: 93108.

53. Public Health England. (2020). Whole Systems Approach to obesity and promoting a healthy weight- A report on the opportunities to strengthen place-based systems approaches to consider and address associated health inequalities. London. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/943643/Opportunities_to_strengthen_placebased_systems_approaches_to_consider_and_address_associated_health_inequalities.pdf

54. Kent and Medway Joint Health and Wellbeing Board. (2018). Obesity Deep Dive [eBook]. https://democracy.medway.gov.uk/mgconvert2pdf.aspx?id=44928

55. Medway Council. (2018). Medway Infant Feeding Strategy.

56. Public Health England. Fingertips. Indicator ID: 90631

57. Public Health England. (2020). Health Inequalities Dashboard.

58. Public Health England. (2017). Health matters: Obesity and the food environment. https://www.gov.uk/government/publications/health-matters-obesity-and-the-food-environment/health-matters-obesity-and-the-food-environment--2

59. World Health Organisation. (2020). Tobacco. Retrieved from: https://www.who.int/news-room/fact-sheets/detail/tobacco

60. Office for National Statistics. (2018). Likelihood of smoking four times higher in England's most deprived areas than least deprived - Office for National Statistics.

61. Argiris A, Karamouzis MV, Raben D, Ferris RL. (2008). "Head and neck cancer", Lancet; 371(9625):1695–1709.

62. IARC Working Group on the Evaluation of Carcinogenic Risks to Humans. (2004). Tobacco smoke and involuntary smoking. IARC monographs on the evaluation of carcinogenic risks to humans, 83, 1–1438.

63. Gülsen, A., Yigitbas, B. A., Uslu, B., Drömann, D., and Kilinc, O. (2020). "The effect of smoking on COVID-19

symptom severity: Systematic review and meta-analysis", Pulmonary medicine.

64. Centers for Disease Control and Prevention. Alcohol and Public Health. Retrieved from: https://www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm

65. Campbell, A. (2017). "Alcohol-related deaths in the UK - Registered in 2015", Office for National Statistics. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/alcoholrelateddeathsintheunitedkingdom/registeredin2015

66. Bellis, M. A., Hughes, K., Nicholls, J., Sheron, N., Gilmore, I., & Jones, L. (2016). "The alcohol harm paradox: using a national survey to explore how alcohol may disproportionately impact health in deprived individuals", BMC public health, 16(1), 111.

67. Plus Project. (2016). Homelessness, substance use and equalities briefing from frontline staff. Retrieved from: https://www.homeless.org.uk/sites/default/files/site-attachments/Substance%20Misuse%20Equalities%20briefing%20-%20April%202016.pdf

68. NHS Mental Health Taskforce. (2016). The Five Year Forward View for Mental Health. Retrieved from: https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

69. Kessler, R. C., Amminger, G. P., Aguilar-Gaxiola, S., Alonso, J., Lee, S., & Ustün, T. B. (2007). "Age of onset of mental disorders: a review of recent literature", Current opinion in psychiatry, 20(4), 359–364. https://doi.org/10.1097/YCO.0b013e32816ebc8c

70. The long shadow of adverse childhood experiences. (2017). American Psychological Association. Retrieved from: https://www.apa.org/science/about/psa/2017/04/adverse-childhood

71. Race Equality Foundation. (2019). Racial disparities in mental health: Literature and evidence review.

72. Mental Health Foundation. (2019). Black, Asian and Minority Ethnic (BAME) Communities. https://www.mentalhealth.org.uk/a-to-z/b/black-asian-and-minority-ethnic-bame-communities

73. National Institute on Aging. (2019). Social isolation, loneliness in older people pose health risks.

74. Atzendorf J, Apfelbacher C, Gomes de Matos E, et al. (2018). "Patterns of multiple lifestyle risk factors and their link to mental health in the German adult population: a cross-sectional study", BMJ Open.

75. Act on Smoking and Health. (2019). Fact sheet No. 12: Smoking and Mental Health [eBook]. Retrieved from: https://ash.org.uk/wp-content/uploads/2019/08/ASH-Factsheet_Mental-Health_v3-2019-27-August-1.pdf

76. Office for National Statistics. Mid-2018 population estimate. Retrieved from: www.ons.gov.uk

77. Office for National Statistics. (2011). Medway 2011 Census Report.

78. World Health Organisation. (2010). Poverty, social exclusion and health systems in the WHO European Region. Copenhagen, WHO Regional Office for Europe.

79. Medway Council. (2018). Future Medway. London. Retrieved from http://medway.gov.uk/futuremedway

80. Public Health England. Fingertips. Obesity Profile. Indicator ID: 93088.

81. Kent And Medway Joint Health And Wellbeing Board. (2019). Reducing Alcohol Consumption Deep Dive. Retrieved from: https://democracy.medway.gov.uk/mgconvert2pdf.aspx?id=46777

82. Medway Cabinet. (2017). Gateway 3 Contract Award: Adult Substance Misuse Specialist Treatment Services Recommissioning. Retrieved from: https://democracy.medway.gov.uk/mgconvert2pdf.aspx?id=39393

83. Medway Council. (2019). Common Mental Health Disorders and Non-Dependent Substance Misuse In Medway. Co-occurring conditions: A Health Needs Assessment Executive Summary.

84. Public Health England. Fingertips. Indicator ID: 22301.

85. Public Health England. Fingertips. Indicator ID: 22304.

86. Medway Council. (2019). Healthy Minds, Healthy People 2018-2019. Retrieved from:

https://democracy.medway.gov.uk/mgconvert2pdf.aspx?id=49255

87. McManus, S., Bennington, P., Jenkins, R., and Brugha, T. (2016). "Mental Health and Wellbeing in England: Adult Psychiatric Morbidity Survey 2014", Leeds: NHS Digital.

88. Public Health England. (2018). Depression: Recorded prevalence (aged 18+). Retrieved from: https://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna/data#page/4/gid/1938132922/pat/6/par/E12000008/ati/102/are/E06000035/iid/848/age/168/sex/4

89. Public Health England. Fingertips. Indicator ID: 41001.

90. Local Government Association. (2018). The Relationship Between Family Violence and Youth Offending.

91. UNICEF. (2006). Behind Closed Doors The Impact of Domestic Violence on Children [eBook]. Retrieved from: https://www.unicef.org/media/files/BehindClosedDoors.pdf

92. Rolf L., David P. F., David P. (2003). "Child Delinquency: Early Intervention and Prevention," Office of Juvenile Justice and Delinquency Prevention.

93. Public Health England. Fingertips. Indicator ID: 92456.

94. Public Health England. Fingertips. Indicator ID: 92863.

95. Medway Council. (2019). Homelessness and rough sleeper strategy. Retrieved from: https://www.medway.gov.uk/download/downloads/id/1499/strategic_housing_homelessness_prevention_strategy.pdf

96. World Health Organisation. (2018). WHO Housing and Health Guidelines. Geneva, 4, Low indoor temperatures and insulation. Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK535294/

97. Public Health England. Fingertips. Indicator ID: 93561.

98. Public Health England. Fingertips. Indicator ID: 93560.

99. Tanton, C., et al. (2015). "High-risk human papillomavirus (HPV) infection and cervical cancer prevention in Britain: Evidence of differential uptake of interventions from a probability survey", Cancer Epidemiology, Biomarkers, and Prevention, Volume 24, pp. 842-853.

100. Public Health England. (2020). PHE Screening Inequalities Strategy Guidance. Retrieved from: https://www.gov.uk/government/publications/nhs-population-screening-inequalities-strategy/phe-screening-inequalities-strategy

101. Kingston, A., Robinson, L., Booth, H. Knapp, M.& Jagger, C. (2018). "Projections of multi-morbidity in the older population in England to 2035: estimates from the Population Ageing and Care Simulation (PACSim) model", Age and Ageing, 47 (3), 374-380.

102. Office for National Statistics. (2020). Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland. Retrieved from: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland

103. Office for National Statistics. (2020). Population Projections for local Authorities. Retrieved from: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandtable2

104. Simply Connect Medway. (2020). Simply Connect Medway - Connecting you to your local Community. Retrieved from: https://medway.simplyconnect.uk

105. Medway Council. (2019). Skills and Employability Plan for Medway 2035 [eBook]. Retrieved from: https://democracy.medway.gov.uk/mgconvert2pdf.aspx?id=47795