Health and Wellbeing Board – Supplementary agenda No.1

A meeting of the Health and Wellbeing Board will be held on:

Date: 3 November 2020

Time: 3.00pm

Venue: Virtual Meeting

Items

8 Joint Health and Wellbeing Strategy and Joint Strategic Needs Assessment Monitoring Report **(Pages 3 - 98)**

This report will provide an update on key Joint Health and Wellbeing Strategy (JHWS) indicators.

This item has been circulated separately to the main agenda. The Chairman of the Board is of the opinion that it should be considered at this meeting as a matter of urgency as permitted under section 100B of the Local Government Act 1972 to enable the Board to consider the matter at the earliest opportunity and to avoid adding to the volume of business programmed for the next meeting of the Board. The report was not available in time for despatch with the main agenda due to other COVID-19 related response activity in the Public Health team which had to take priority.

9 Joint Health and Wellbeing Strategy Theme 3 Review **(Pages 99 - 104)**

This report asks the members of the Health and Wellbeing Board to identify how they and the organisations that they represent can encourage the system to improve health and wellbeing with respect to the future state describe for theme 3 of the Joint Health and Wellbeing Strategy: Prevent early death and increase years of healthy life.

This item has been circulated separately to the main agenda. The Chairman of the Board is of the opinion that it should be considered at this meeting as a matter of urgency as permitted under section 100B of the Local Government Act 1972 to enable the Board to consider the matter at the earliest opportunity and to avoid adding to the volume of business programmed for the next meeting of the Board. The report was not available in time for despatch with the main agenda due to other COVID-19 related response activity in the Public Health team which had to take priority.

For further information please contact Jade Hannah, Democratic Services Officer on Telephone: 01634 332008 or Email: democratic.services@medway.gov.uk

Date: 28 October 2020

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HEALTH AND WELLBEING BOARD

3 NOVEMBER 2020

JOINT HEALTH AND WELLBEING STRATEGY AND JOINT STRATEGIC NEEDS ASSESSMENT MONITORING REORT

Report from: James Williams, Director of Public Health

Author: Dr David Whiting, Consultant in Public Health

Summary

The purpose of this report is to provide an update to the Board on key Joint Health and Wellbeing Strategy (JHWS) indicators.

1. Budget and policy framework

1.1. The Health and Social Care Act 2012 places a duty on Health and Wellbeing Boards to produce a Joint Health and Wellbeing Strategy for their local area. Implementation and monitoring of the strategy outcomes are on-going.

1.2. This item has been circulated separately to the main agenda. The Chairman of the Board is of the opinion that it should be considered at this meeting as a matter of urgency as permitted under section 100B of the Local Government Act 1972 to enable the Board to consider the matter at the earliest opportunity and to avoid adding to the volume of business programmed for the next meeting of the Board. The report was not available in time for despatch with the main agenda due to other COVID-19 related response activity in the Public Health team which had to take priority.

2. Background

2.1. The HWB has a responsibility to ensure that performance and quality monitoring measures are in place with regard to the implementation and outcomes for the JHWS. The monitoring and outcomes framework for Medway's JHWS includes monitoring of outcomes related to the National Outcomes Frameworks for the NHS, Social Care, Public Health and Children.

2.2. The JHWS for 2018–2023 is based on five themes, each with a set of priorities. Appendix 1 to this report shows indicators that relate to the five themes of the Strategy that permit comparison with other local authorities in

England. In the narrative below, indicators in the Appendix are referred to by the ID number, e.g. IND106.

3. Advice and analysis

3.1. Theme 1: Giving every child a good start

3.2. Priorities

- Reduce childhood obesity
- Reduce smoking in pregnancy
- Ensure that childhood vaccination rates are high enough to provide herd immunity
- Improve the emotional well-being of looked after children

3.3. Key points

3.3.1. There is good evidence that investment in the early years of life (0–5 years) is highly effective in terms of the impact on future health and wellbeing and is highly cost-effective. What happens during these early years, starting in the womb, has lifelong effects on many aspects of health and wellbeing, from obesity, heart disease and mental health, to educational achievement and economic status.

3.3.2. Ensuring that every child in Medway has a good start in life is essential for the future success of Medway and the health and wellbeing of people in Medway.

3.3.3. Smoking while pregnant harms the developing child. Rates of smoking during pregnancy in Medway have been in the worst quartile for many years, however, in recent quarters we have seen an improvement with rates falling and we are the closest we have ever been to breaking into the second quartile (see IND106). This improvement has been achieved even though the Public Health team had to suspend face-to-face interventions and close the smoke-free advice centre for a substantial amount of time due to COVID. All interventions can now be delivered either by telephone or through other digital methods. Staff were re-deployed to deliver pharmacotherapy to those quitting in the community. To reduce rates further the public health team is developing a holistic Healthy Pregnancy version of its successful Blooming Bumps programme.

3.3.4. During the COVID period there has been a 45% increase in the number of referrals of women who are smoking while pregnant, and the rate of those who did not attend has decreased by 16%. With more women engaging with smoking cessation while pregnant, rates should continue to fall.

3.3.5. The last data available relating to the year 2018/19 (IND132) highlights that further improvement is required to improve the emotional well-being of looked-after children. Action to address this issue has been prioritised as part of the Medway Childrens Services Improvement Plan. System partners are working together to improve the outcomes for looked-after children. A thresholds pathway has been agreed with the provider (NELFT) to aid professionals in

using the Strengths and Difficulties Questionnaires (SDQ) scores to make decisions about when to contact the single point of access for advice, consultation and referral.

3.3.6. After several years of decreases in the proportion of children who are overweight or obese, there has been an increase in the most recent year in the proportion of children in Year 6 who are overweight or obese (IND137). The number of referrals to Medway's obesity-related health improvement programmes has reduced significantly as the National Childhood Measurement Programme (NCMP) has been suspended due to COVID. However, there has been good engagement through social media which is helping referral numbers. The Public Health team has been developing a digital offer which commenced in September. This is particularly important while lives are affected by COVID-19 because of the potential impact of COVID-19 restrictions on physical activity.

3.3.7. High immunisation rates are important to maintain "herd immunity", whereby the number of people who are immunised is large enough to make transmission of disease much less likely. For a period of four years reported immunisation rates fell below the national average. Action was taken to conduct catch-up and data cleaning exercises and as a result rates have risen to the national average (see IND127).

3.4. Theme 2: Enable our older population to live independently and well

3.5. Priorities

- Support work to identify and support those who are socially-isolated
- Support work to develop local care and ensure co-ordination with adult social care
- Support the development of the new strategy for carers and the delivery of its actions

3.6. Key points

3.6.1. From 2018 to 2023 the number of people aged over 65 years will increase by over four thousand (10%) and the number aged over 85 years is expected to increase by 900 (18%). Increasing numbers of older people mean that there will be increasing numbers of people developing chronic conditions who become intensive users of services (assuming age-specific rates remain constant). This ageing of the population is likely to result in a substantial increase in costs to the health and social care system. Therefore, primary and secondary prevention of conditions such as diabetes, chronic obstructive pulmonary disease (COPD) and heart disease (see next theme), combined with improved care for people with conditions such as dementia, is essential to reduce or limit the numbers of high-intensity users of services and reduce the costs to the health and social care system.

3.6.2. Many older people prefer to stay in their own home for as long as they can and to do so they may need additional support. There have also been increasing numbers of older people who need specialist accommodation that

combines support, care and housing provision. Carers play an essential role in supporting older people and their role will become increasingly important as the size of the older population increases.

3.6.3. One area that has become recognised in recent years as being important in improving outcomes for this group is social isolation. There are no national indicators that report on this, so we cannot compare outcomes in Medway with other local authorities, however, there a number of initiatives that have been implemented in Medway to reduce social isolation, following our member deep dive. These include the Better Medway Together Chatty Bench Tour which visited a number of locations including Chatham, Hoo, Rainham and Strood. It consisted of using a wooden bench that was commissioned from Men in Sheds, a service funded by Medway Council Public Health to help local men to stay well and healthy by getting together to share their interests and skills. The bench was a metaphor, prop and prompt to start conversations and raise awareness of the impact on health and wellbeing of loneliness and social isolation. In total, 320 people were spoken to and offered advice on stopping smoking, nutrition and health checks.

3.6.4. The social isolation team is also working with Arriva bus company to explore the introduction of 'Chatty Buses'. This is in response to the National Loneliness Strategy to help raise awareness of social isolation and loneliness. Arriva staff will also be offered training around raising awareness of loneliness and social isolation. The first chatty bus excursion was planned for March, but was cancelled because of COVID-19.

3.6.5. When measures were implemented nationally on 23 March 2020 to reduce the transmission of coronavirus, Medway Council moved rapidly to set up a vulnerable people's hub to provide support to people who may have difficulty obtaining food or medicines. People who were socially-isolated were supported through this work during this period.

3.6.6. To develop local care, Medway and Swale Integrated Care Partnership (ICP), the membership of which includes the Medway organisations represented on the Health and Wellbeing Board, is transforming primary and local care. GP-led Primary Care Networks (PCNs), serving a registered population of 30,000 to 50,000, act as the provider and delivery vehicle for local care. There are nine PCNs in the Medway and Swale ICP, seven of which are in Medway. Each Medway PCN has a named public health lead to help inform the development of local priorities.

3.6.7. From 2017, Medway saw a large rise in the percentage of people discharged into reablement/rehabilitation to having one of the highest rates in the country (IND204). Over the same period the proportion of patients who were at home 91 days post-discharge fell from being one of the highest in the country to one of the lowest (IND203). Work has been undertaken recently by Medway and Swale ICP to improve the process for patients who are medically-fit for discharge from Medway NHS Foundation Trust. This has included the introduction of a single point of access with packages of care, in which a key factor has been the creation of joint pathways with health and social care

and/or clear community pathways. This work has been undertaken working closely with Medway Council and community providers.

3.6.8. To improve support for carers the members of the Better Together Consortium, led by Healthwatch Medway and a wider initiative across Kent and Medway, have worked together to ensure carers of all ages, from all parts of the community, are identified and offered support.

3.7. Theme 3: Prevent early death and increase years of healthy life

3.8. Priorities

- Determine the drivers behind Medway's consistently high cancer mortality rates (IND306)
- Promote cancer screening, including supporting the Time to Test campaign (IND501, IND502)
- Support action being taken to reduce variation in quality of primary care across Medway

3.9. Key points

3.9.1. This theme focuses on preventing early death and improving quality of life through improving healthcare, including increasing the number of people who are diagnosed early, thereby allowing more timely intervention which can significantly improve outcomes in some diseases.

3.9.2. The leading causes of early death and illness in Medway include cancer, circulatory disease (e.g. heart attack, stroke and heart failure) and respiratory disease, conditions that share many common causes. Over recent decades public health action and improved health care have led to dramatic reductions in the number of deaths from these causes. For example, the mortality rate from heart attacks in Medway fell 85 per cent from 108 to 17 per 100,000 between 1993 and 2010, with about half of this reduction due to improved health care and half due to public health measures, such as reductions in smoking.

3.9.3. Most people with long-term conditions have a single condition and can be helped to manage their condition at relatively low cost. However, as people age, and if prevention and treatment are not optimal, people develop other conditions. As the number and severity of these conditions increases the complexity and cost of managing them becomes much greater.

3.9.4. The most recent premature cancer mortality rate (deaths from cancer in those under the age of 75 years) shows an improvement over previous years, although the rate is higher than the England average (IND306). These data are, however, from before the COVID-19 pandemic. There will be a need to monitor whether the pause in access to cancer screening and diagnostic services associated with the COVID-19 pandemic, impacts on future outcomes for patients. The Medway and Swale ICP has a programme to improve cancer outcomes, which includes improving access to screening, and increasing endoscopy capacity for detecting bowel cancer and will review

these issues.

3.9.5. Cervical cancer screening remains higher than the national average (IND502), however, breast cancer screening has seen a small fall and is now at the same level as the national average in the most recently published data (IND501). Community work to improve bowel cancer screening has been paused due to the COVID-19 pandemic.

3.9.6. Variation in primary care is being addressed directly by the creation of Medway and Swale Integrated Care Partnership (ICP) and its constituent primary care networks (PCNs), small groups of GP practices that work together to deliver services for their local communities. Medway and Swale ICP has a clinical variation programme that works with primary care networks PCNs to reduce variation in care. Two important workstreams within this programme focus on mental health, dementia and people with learning disabilities; and on stroke and cardiovascular disease. The work of this programme includes developing systems to identify patients who need to be reviewed to improve their outcomes, training where required, and reviewing progress regularly to improve processes.

3.9.7. The Medway Council Public Health Intelligence team produces profiles for each ICP and each PCN to support the identification of variation and inequalities (see Appendix 2). These profiles are being used by Medway and Swale ICP and the PCNs to inform the development of local plans to improve outcomes and reduce variation.

3.10. Theme 4: Improving mental and physical health and well-being

3.11. Priorities

- Support actions to make Medway a Dementia Friendly Community
- Influence the shaping of the environment in Medway to make healthy choices the easy choices (IND401, IND402, IND429)
- Encourage initiatives to improve self-management of long-term conditions
- Support people with mostly good mental wellbeing to consciously maintain a good mental health
- Support the implementation of the suicide prevention plan (IND408, IND430)
- Support work to reduce domestic abuse
- Reduce drug-related deaths (IND422)

3.12. Key points

3.12.1. It is now well-recognised that it is not only important how long people live, but also how well they live. Mental and physical health and wellbeing are affected by many broader issues, including crime and the perception of crime, proximity to green spaces, housing, unemployment, the quality of employment for those who are in work, debt and income level, the ability to live independently and autonomously, and freedom from pain and ill-health.

3.12.2. In addition to these wider determinants of health and wellbeing, the Joint Strategic Needs Assessment identifies key individual-level risk factors that affect health and wellbeing on which we need to take action:

- tobacco use, both preventing people from starting smoking and helping people to stop smoking;
- harmful use of alcohol and drugs;
- physical inactivity;
- poor diet;
- high stress levels and poor mental wellbeing;
- poor sexual health.

3.12.3. Changing behaviour is difficult and behaviours are shaped by experiences and where we live. People who are isolated or are experiencing stressful circumstances in their lives find it very difficult to make lifestyle changes.

3.12.4. Improving mental and physical health and wellbeing therefore involves broader changes to the wider determinants that influence us all and specific changes for those with particular needs.

3.12.5. One of the most important and preventable threats to health and wellbeing is smoking. Medway has run a successful smoking cessation programme for a number of years, and over the last eight years the percentage of the population who smokes has fallen from around 25% in 2012 to 14.1% in 2019 (see IND409), approximately 20,000 fewer smokers.

3.12.6. As part of the drive to make Medway more dementia friendly work has been undertaken by Medway Park to become dementia friendly and as a result Medway Park was accredited as being dementia friendly by the Medway Dementia Action Alliance. This assessment coincided with the launch of new physical activity sessions for people living with dementia held at Medway Park.

3.12.7. The Dementia Action Alliance (DAA) has reviewed its membership processes and aims of the group. A greater emphasis will now be placed on promoting and creating opportunities for individuals who live with dementia to visit. Where appropriate this will also result in the assessment and creation of new dementia friendly places.

3.12.8. A Rainham GP practice has led the pilot work of making Medway's first dementia friendly GP surgery.

3.12.9. While action is being taken to make Medway more dementia friendly, the rate of diagnosis of dementia is low relative to most other local authority areas and has become worse over the last two years (see IND213). More work to understand why this is the case is required.

3.12.10. Some public health services were suspended as a result of the COVID-19 pandemic and to provide support for the vulnerable people hub, however, where possible the Public Health team has developed digital or remote versions of its health improvement programmes to make it as easy as possible for people in Medway to make healthier choices. Some of these have made use of technology, such as Microsoft Teams to provide live online sessions, others have been through the production of digital materials that people can access when it is convenient for them.

3.12.11. In further work to make Medway a healthy place, the healthy settings programme is working with over 100 local business to make work places healthier. Connect 5 training has been delivered to people within the programme. Connect 5 is an accredited mental health training programme for front line staff that draws on cognitive behavioural therapy to promote self-help. Staff learn how to manage conversations with clients so that clients are better able to understand, manage and improve their own mental health.

3.12.12. “Time to Change champions” are people with lived experience of mental health problems who campaign to change the way people think and act about mental health. The Medway Council “Time to change” (TTC) employer pledge resulted in a number of champions signing-up. They have received a bespoke TTC champions induction, and some have also had Mental Health First Aid/Connect 5 training and are active in their roles. Implementation of the Medway Council TTC action plan is on track and has been reviewed and updated by the Task and Finish group. Work has started with frontline services to develop mental health support.

3.12.13. Medway also has a Time to Change Hub and activity is underway with a number of projects being delivered with funding from the Bright Ideas Champions fund. The hub has continued to operate virtually during the COVID-19 epidemic to support local people and has links with other hubs across the South East.

3.12.14. The published suicide rate for Medway has fluctuated over the last 15 years with the most recent figure in the lowest quartile (IND430). In supporting the delivery of the suicide prevention plan Kent and Medway suicide prevention partnership were highly commended at the Health Service Journal award finals for the Health and Local Government Partnership section.

3.12.15. A successful expression of interest to the Local Government Association (LGA) has resulted in Medway Council being one of twelve local authorities to receive bespoke expert to support to deliver suicide prevention programmes. Support consists of a one-day workshop of two half-day sessions that will focus on developing Postvention/Bereavement support pathways.

3.12.16. A working group was established to review an apparent increase in suicide in Children and Young people during lockdown. Data from NELFT and acute trusts indicated that the numbers of suicides were in line with

previous years data. However, lessons were learnt and schools and primary care were informed about high risk categories so vulnerable children could be identified and supported.

3.12.17. The Communications team supported work with the Public Health team on a campaign to raise awareness of local services for domestic abuse and ensure people knew where to signpost and how to access services. The service is now looking at venues to provide face-to-face services as well as ensuring domestic abuse champions within their own organisations feel equipped to signpost and support colleagues around domestic abuse.

3.12.18. Drug-related deaths rose to a high level relative to many other local authorities in 2013–15, however, after a review of the service and changes to the way the service is delivered rates have since fallen and for the last two reporting periods to 2016–18 the rate has fallen to the national average (see IND436). Commissioned services continued to operate throughout the COVID-19 pandemic, moving to a virtual offer and supporting clients with their prescriptions.

3.12.19. Turning Point, the service provider for substance misuse, is working with CCG commissioners, community mental health and the public health team to improve pathways in readiness for a second wave of COVID-19.

3.13. Theme 5: Reduce health inequalities

3.14. Priorities

- 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

3.15. Key points

3.15.1. In Medway rates of long-term illness, emergency hospital admissions and death are higher in those who are more disadvantaged. Health outcomes are not only worse in those who are the most disadvantaged; the inequalities follow a gradient and as such the response also needs to follow a gradient. This means that health and social care provisions need to be made available to all, with increasing effort needed for those who are increasingly disadvantaged. For example, individuals with a learning disability and individuals with mental illnesses have, on average, a significantly lower life expectancy compared to the general population.

3.15.2. Other groups at risk of health inequalities include those in the criminal justice system and former members of the armed forces. For these groups national strategies and policies apply, and the local Public Health team works with these groups and national teams where appropriate.

3.15.3. Taking action through tackling the wider determinants of health, behavioural factors and improved health and social care to reduce health inequalities will result in reduced costs for the health and social care system. Some interventions will have a rapid effect, while others will take longer to affect health inequalities.

3.15.4. The publication Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010 (Marmot Review) reviewed the evidence on what is effective in tackling health inequalities. This focuses largely on the social determinants of health and is based around six key policy recommendations for the most effective ways to reduce the health inequalities gap. These policy recommendations are woven into the JHWS and are as follows: give every child the best start in life; enable all children, young people and adults to maximise their capabilities and have control over their lives; create fair employment and good work for all; ensure a healthy standard of living for all; create and develop healthy and sustainable places and communities and strengthen the role and impact of ill health prevention.

3.15.5. The proportion of children receiving schools meals who are ready for school (IND510) was increasing in Medway and nationally, however, it has levelled-off more rapidly in Medway than in other parts of the country and while it has declined in the most recently reported period (2018/19) it has not fallen below the national average. As noted in theme one above, the first years of life are of critical importance for future health and wellbeing, and the economy of Medway.

3.15.6. To reduce health inequalities, the Medway Public Health team has been working closely with colleagues in the Medway and Swale ICP to explore and address how services can be delivered differently to reduce variation, using health and wellbeing profiles to identify variation in outcomes in different primary care networks (see Appendix 2).

3.15.7. Variation in health and wellbeing leads to differences in life expectancy. These differences have fallen in males across Medway (IND508) and remained level at below the national average in females (IND509). Life expectancy is a summary measure of current mortality experience and can take time to improve in an area. The fall in inequality in males in Medway is encouraging.

3.15.8. Variation and inequalities in a number of other key health outcomes has been addressed above in other themes.

3.16. Learning from COVID-19

3.17. The national impact of COVID-19 was devastating in terms of excess deaths in the first wave. The potential impact on health and wellbeing through direct effects on health, and indirect effects mediated via loss of earnings, increased social isolation, and disruption to education, for example, is hard to calculate now, and will only really be known some time

after the epidemic is over, but it is clear that the impact will be significant.

3.18. As well as the negative impacts there are some changes that the pandemic has brought about or enabled that have the potential to improve health and wellbeing for the population of Medway. For example, it has led to the rapid adoption of digital technology for consultations and interventions and it is likely that once the pandemic is over this new way of working will remain; both professionals and the public have found that it can be more convenient than travelling to a consultation and can be just as effective in many circumstances.

3.19. Systems have been implemented to make it easier for health professionals to consult with each other about complex cases using remote technology.

3.20. Recent years have seen a fall in the proportion of people in at-risk groups who have had the flu vaccine, however, this year uptake seems to be much higher, to the extent that supplies of vaccine have been stretched. It is possible that greater awareness of the importance of these groups being vaccinated will last into future years, thereby reducing mortality from flu.

4. Risk management

Risk	Description	Action to avoid or mitigate risk	Risk rating
Lack of clarity as to progress on health and wellbeing outcomes.	Monitoring and outcomes frame work not sufficiently robust so unclear if progress is being made.	Regular progress reports to the Board.	D3

5. Consultation

5.1. Consultation with the public was undertaken as part of the creation of the Joint Health and Wellbeing Strategy.

6. Financial implications

6.1. There are no financial implications arising directly from the contents of this report.

7. Legal implications

7.1. It is a function of the HWB to provide robust measures for monitoring performance and quality in respect of the implementation and outcomes of the JHWS.

7.2. The Health and Social Care Act 2012 (HSCA 2012) amends the Local Government and Public Involvement in Health Act 2007 ('the 2007 Act') to introduce duties and powers for HWBs in relation to Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs).

7.3. Section 116 of the 2007 Act (as amended by s. 192 HSCA 2012) and Section 116A of the 2007 Act (inserted by s.193 HSCA 2012) require a responsible local authority and each of its partner CCGs to prepare JSNAs and JHWSs.

7.4. Section 196(i) HSCA 2012 provides that these functions under s.116 and s. 116A of the 2007 Act are to be exercised by the HWB established by the local authority."

8. Recommendations

8.1 The Health and Wellbeing Board is asked to consider and comment on the indicator updates.

Lead officer contact

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Appendices

1) Joint Health and Wellbeing Strategy indicators
2) Medway and Swale ICP profile

Background Papers

None

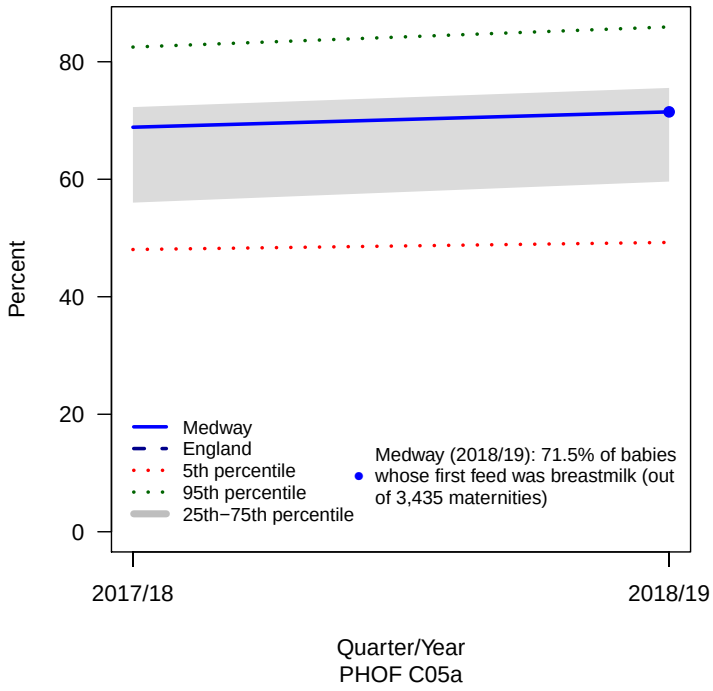
Joint Health and Wellbeing Strategy indicators

October 2020

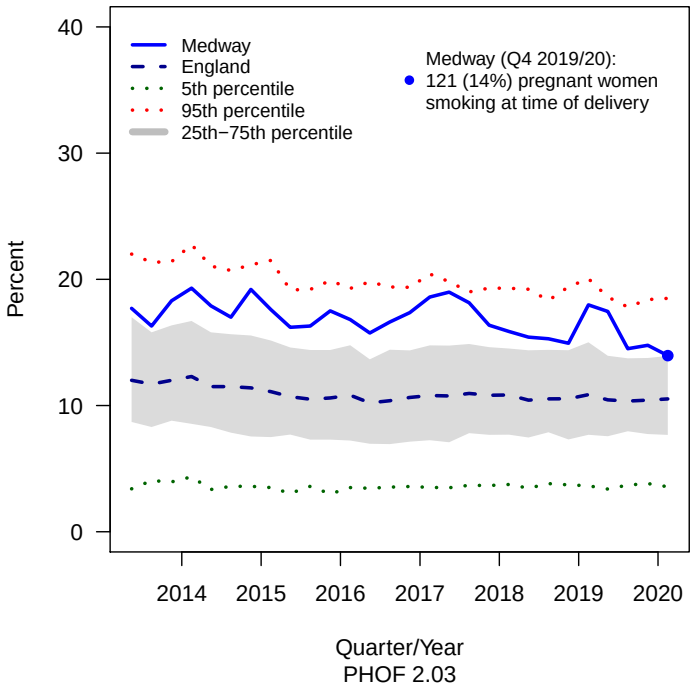
Theme 1

Give every child a good start

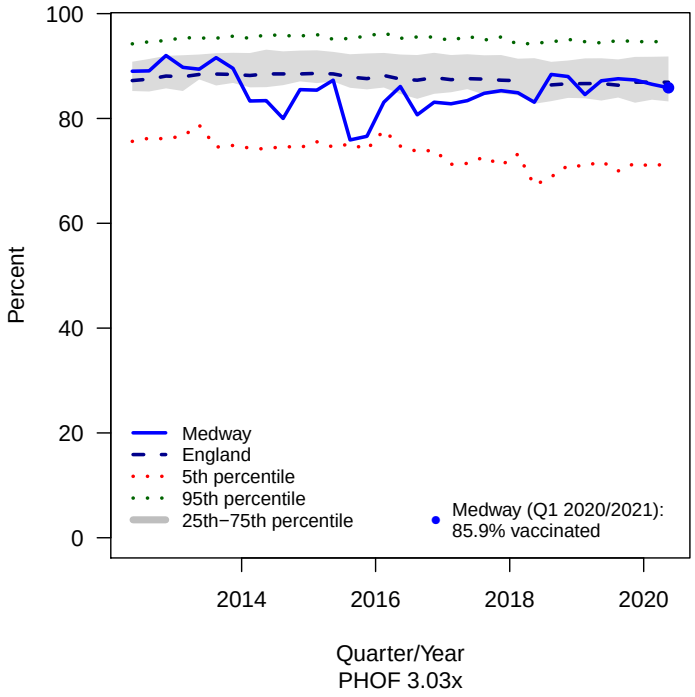
IND104: Baby's first feed breastmilk



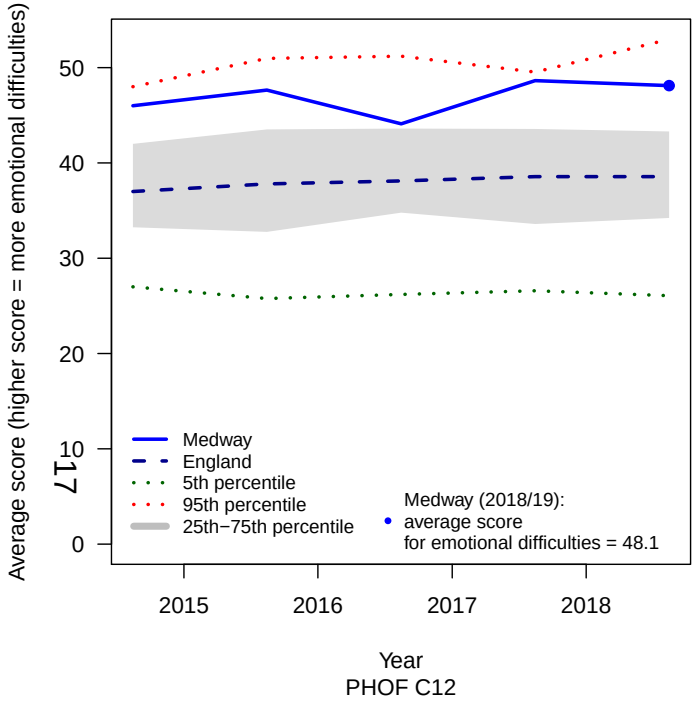
IND106: Smoking at the time of delivery



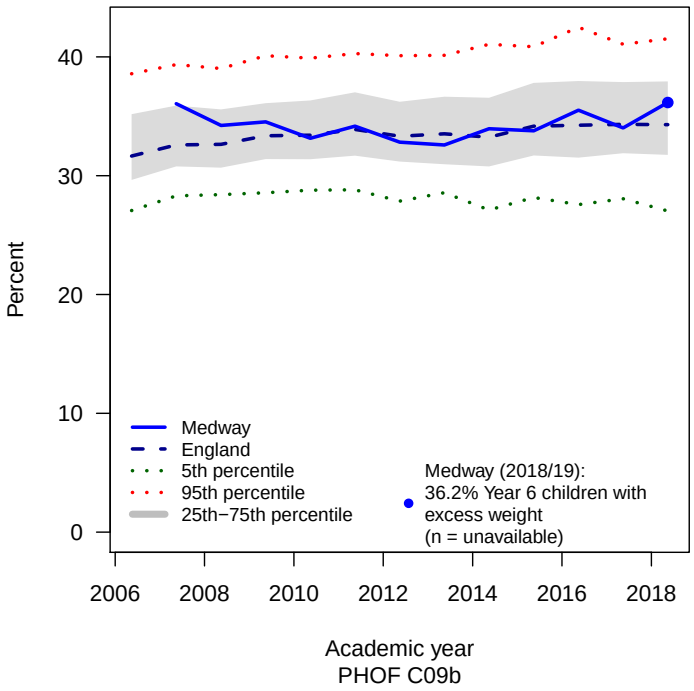
IND127: Second MMR 5 years



IND132: Emotional well−being of looked after children



IND137: Year 6: Prevalence of overweight (including obesity)



NOTES

IND104: Baby's first feed breastmilk

Percentage of babies whose first feed is breastmilk

IND106: Smoking at the time of delivery

Rate of smoking at time of delivery per 100 maternities

IND127: Second MMR 5 years

MMR vaccination coverage for two doses (5 year olds)

IND132: Emotional well−being of looked after children

Average score for looked after children for whom a Strengths and Difficulties Questionnaire (SDQ) was completed. A higher score on the SDQ indicates more emotional difficulties. A score of 0−13 is considered normal, a score of 14−16 is considered borderline cause for concern and a score of 17 and over is a cause for concern.

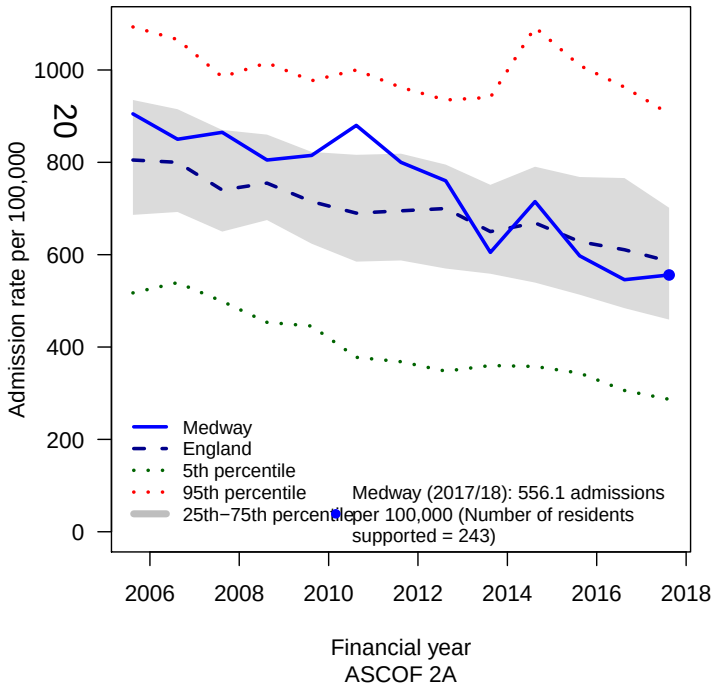
IND137: Year 6: Prevalence of overweight (including obesity)

Proportion of children aged 10−11 classified as overweight or obese. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex

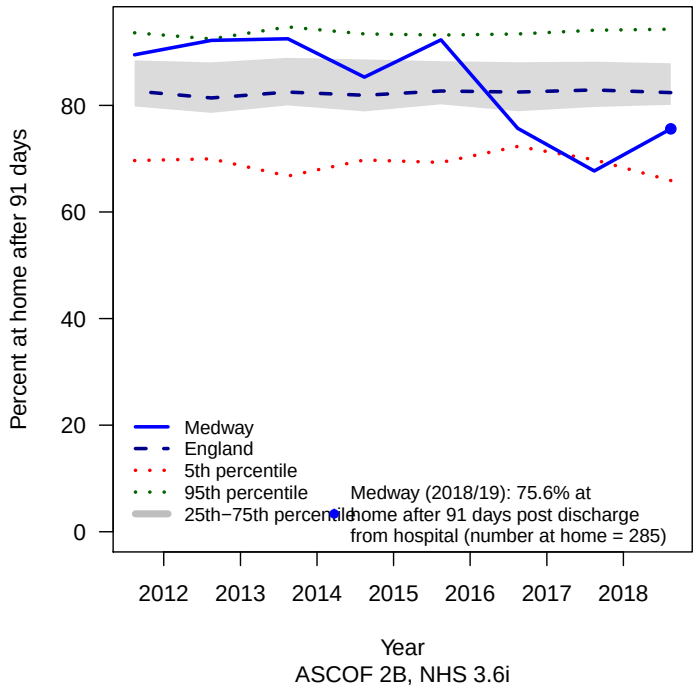
Theme 2

Enable our older population to live independently and well

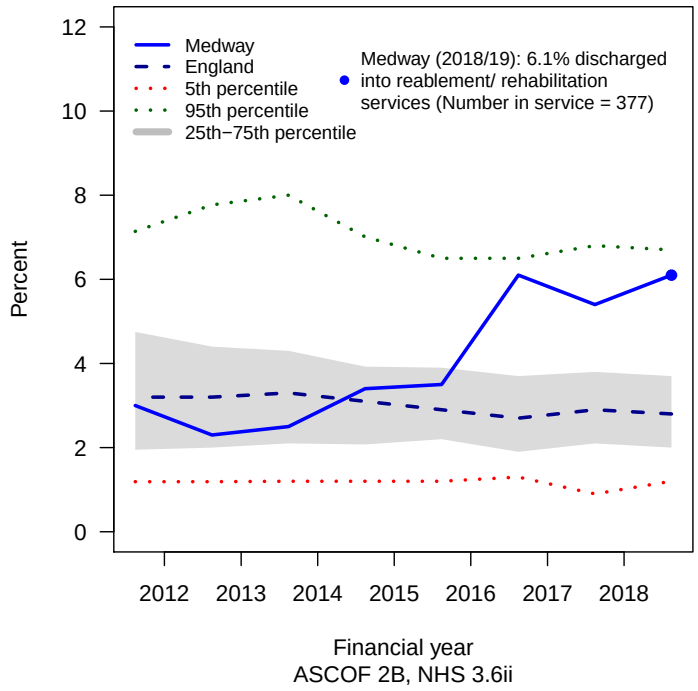
IND202: Care home admissions aged 65+



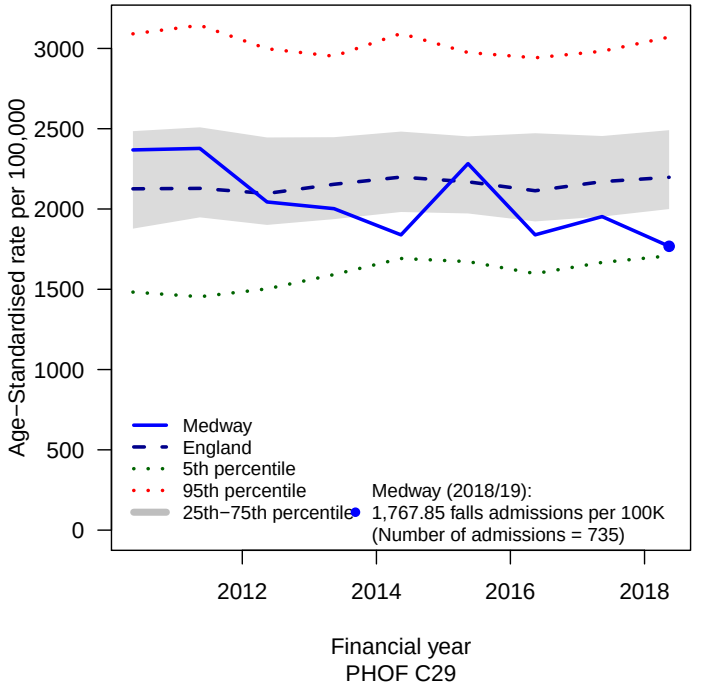
IND203: Reablement/rehab services success rate



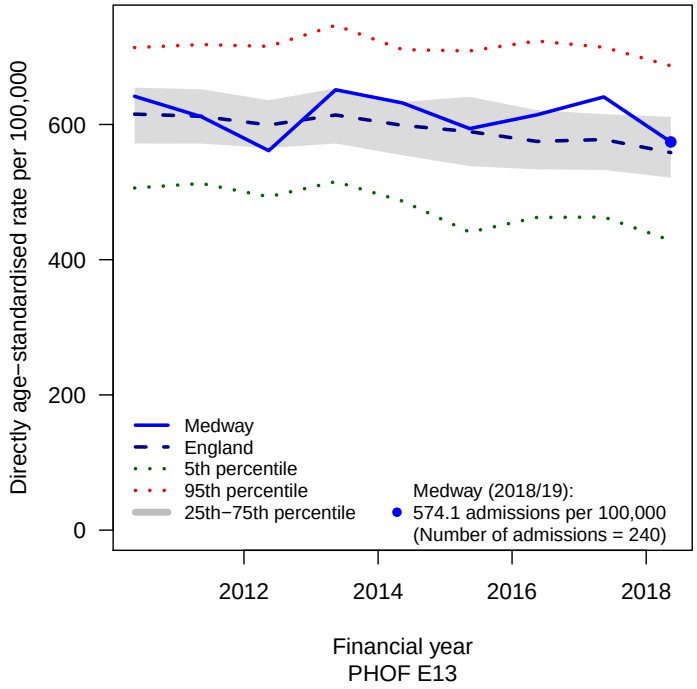
IND204: Discharged into reablement/rehab services



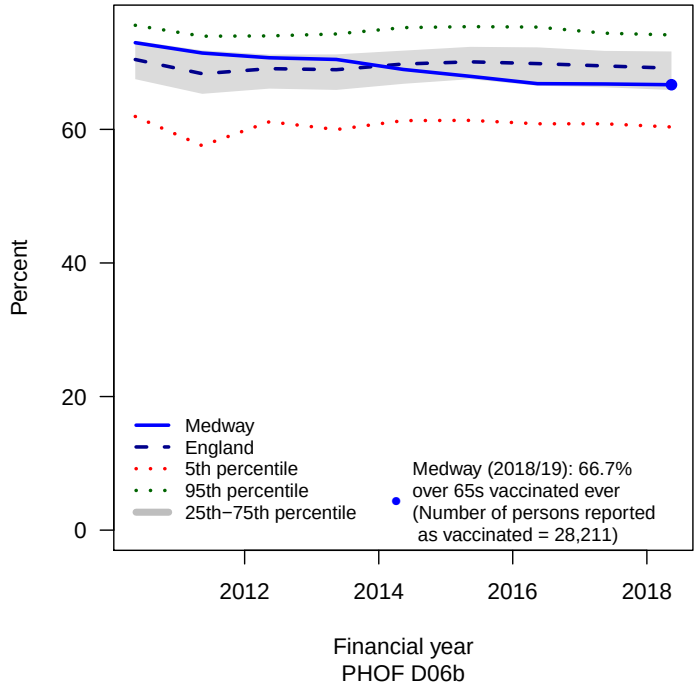
D206: Emergency hospital admissions due to falls in people aged 65 a



IND207: Hip fractures in people aged 65 and over



IND209: Population vaccination coverage − PPV



NOTES

IND202: Care home admissions aged 65+

Permanent admissions to residential and nursing care homes (65+), per 100,000 population

IND203: Reablement/rehab services success rate

Percentage of older people (aged 65 and over) discharged from hospital into reablement/rehabilitation services, at home after 91 days

IND204: Discharged into reablement/rehab services

Percentage of older people (aged 65 and over) offered rehabilitation following discharge from acute or community hospital

IND206: Emergency hospital admissions due to falls in people aged 65 and over

Emergency hospital admissions for falls injuries in persons aged 65 and over, directly age standardised rate per 100,000

IND207: Hip fractures in people aged 65 and over

Emergency Hospital Admission for fractured neck of femur in persons aged 65 and over, directly age standardised rate per 100,000

IND209: Population vaccination coverage − PPV

These data describe pneumococcal polysaccharide vaccine (PPV) uptake for the survey year, for those aged 65 years and over

IND210: Population vaccination coverage − Flu (aged 65+)

Flu vaccine uptake (%) in adults aged 65 and over, who received the flu vaccination between 1st September to the end of February in a primary care setting (GPs) The February collection has been adopted for our end of season figures going forwards to take into account data returning from outside the practice and later in−practice vaccinations

IND211: Population vaccination coverage − Flu (at risk individuals)

Flu vaccine uptake (%) in at risk individuals aged 6 months to 65 years (excluding pregnant women), who received the flu vaccination between 1st September to the end of February in a primary care setting (GPs). The February collection has been adopted for our end of season figures going forwards to take into account data returning from outside the practice and later in−practice vaccinations

IND213: Estimated diagnosis rate people with dementia

Proportion of total population diagnosed with dementia as a percentage of estimated dementia prevalence according to NHS Outcomes Framework

IND214: Emergency hospital admissions due to falls in people aged 65 and over (females)

Emergency hospital admissions for falls injuries in persons aged 65 and over, directly age standardised rate per 100,000

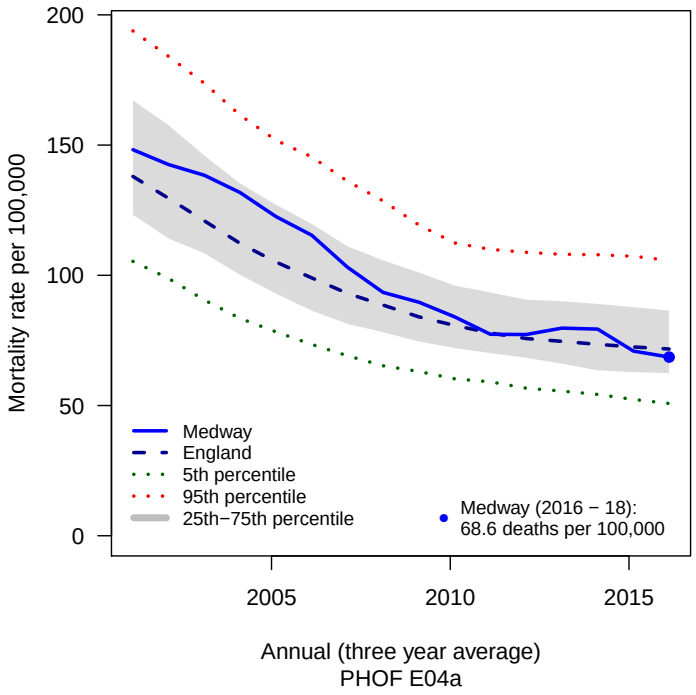
IND215: Emergency hospital admissions due to falls in people aged 65 and over (males)

Emergency hospital admissions for falls injuries in persons aged 65 and over, directly age standardised rate per 100,000

Theme 3

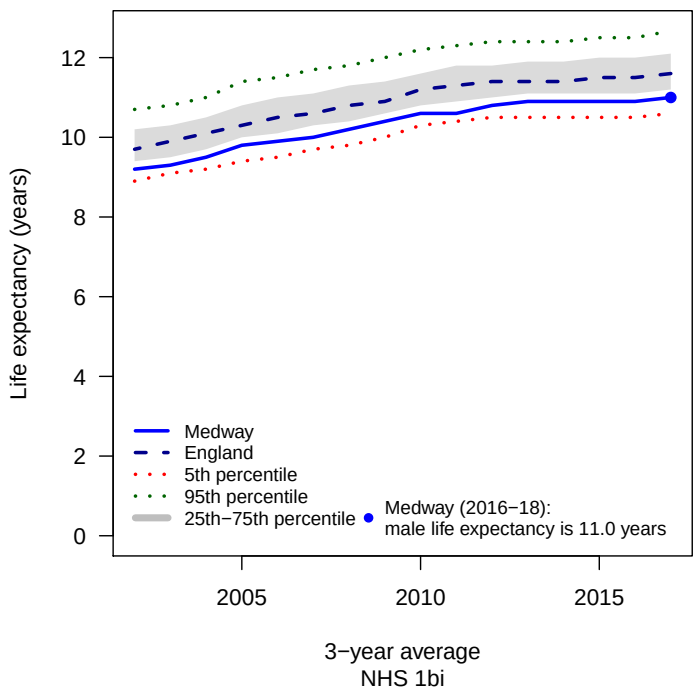
Prevent early death and increase years of healthy life

IND301: Under 75 mortality rate from all cardiovascular diseases



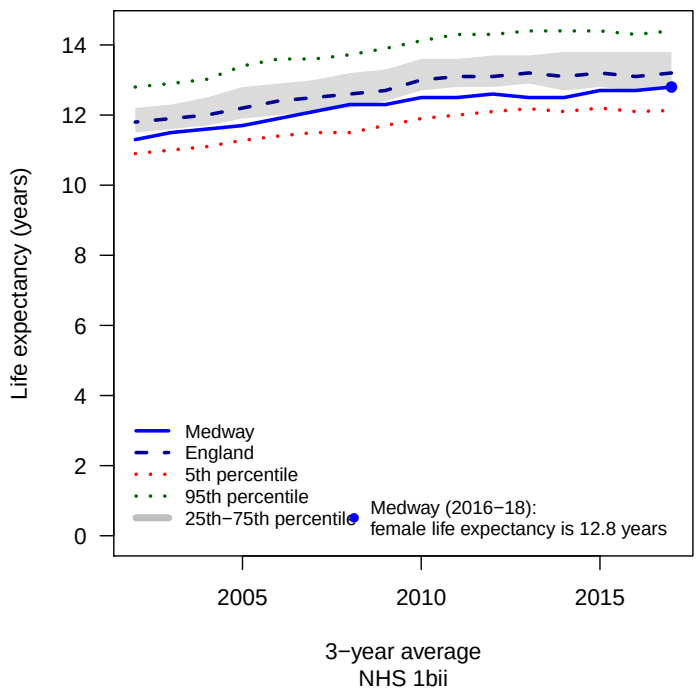
Annual (three year average)
PHOF E04a

IND302: Life expectancy at 75 − Male



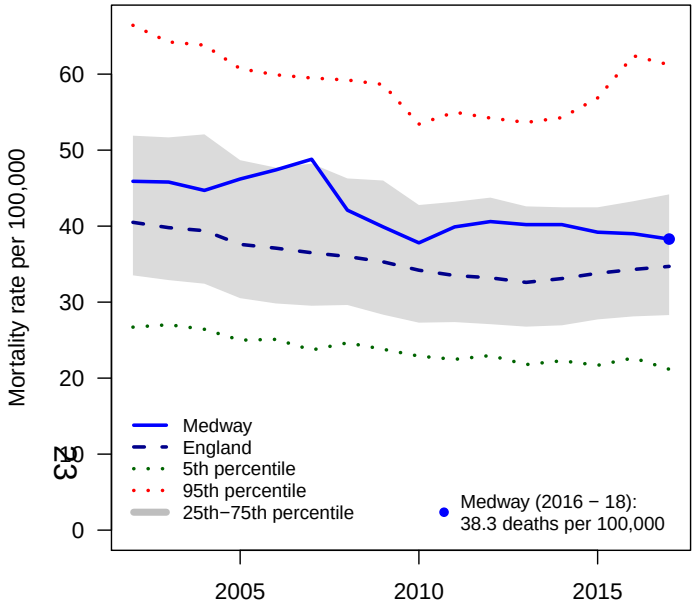
3−year average
NHS 1bi

IND303: Life expectancy at 75 − Female



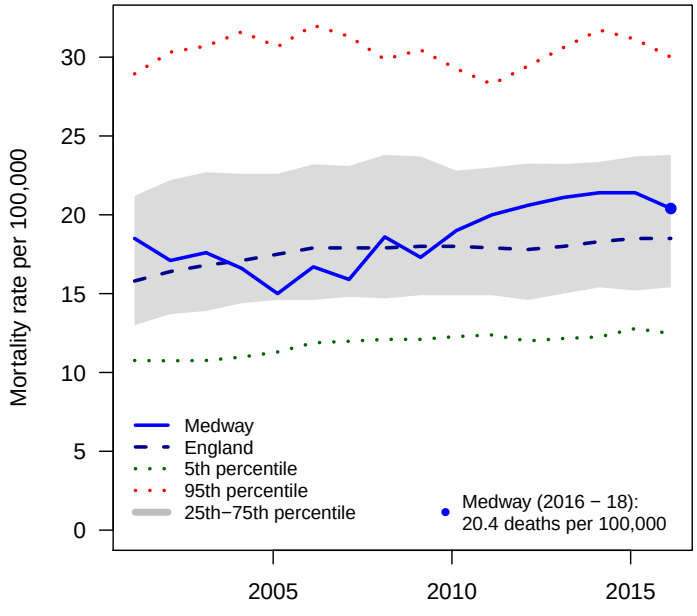
3−year average
NHS 1bii

IND304: Under 75 mortality rate from respiratory disease



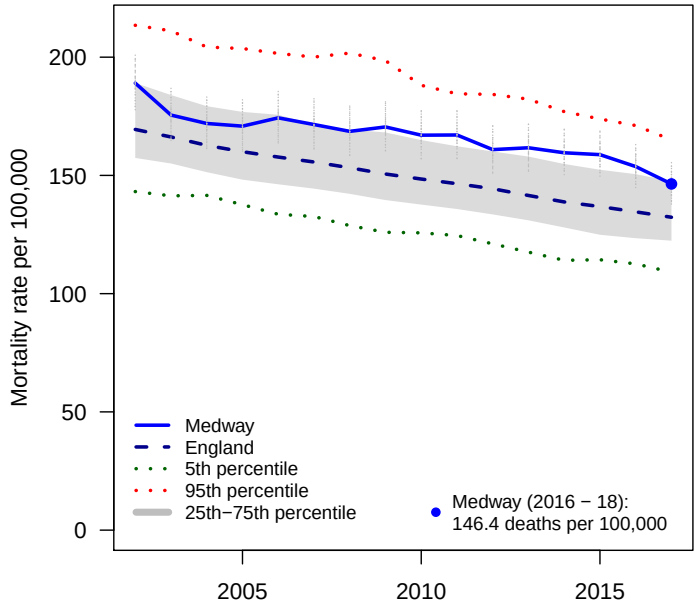
Three year average
NHS 1.2, PHOF E07a

IND305: Under 75 mortality rate from liver disease



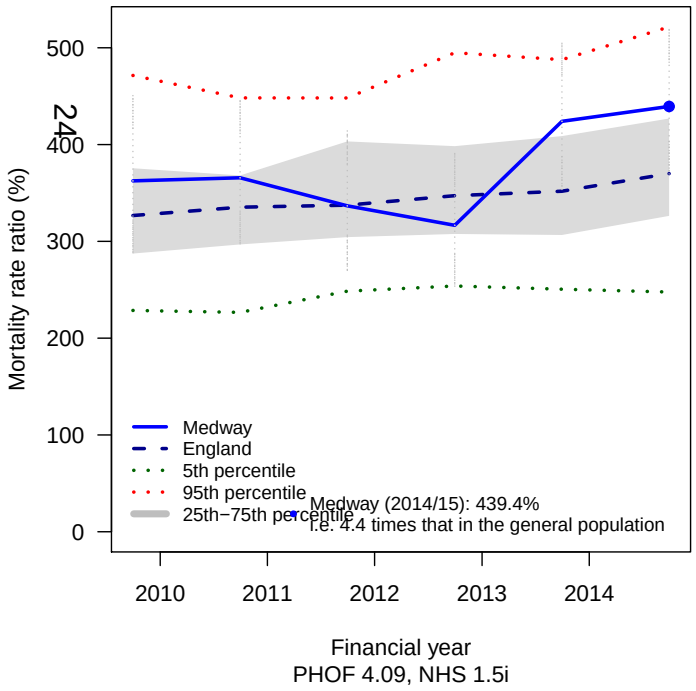
Three year average
NHS 1.3, PHOF E06a

IND306: Cancer mortality rate (under 75)

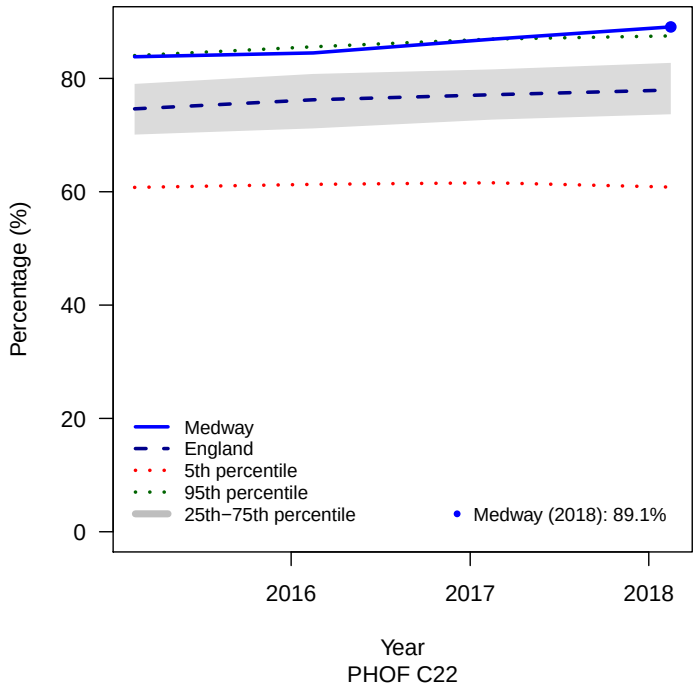


Annual (three year average)
PHOF E05a

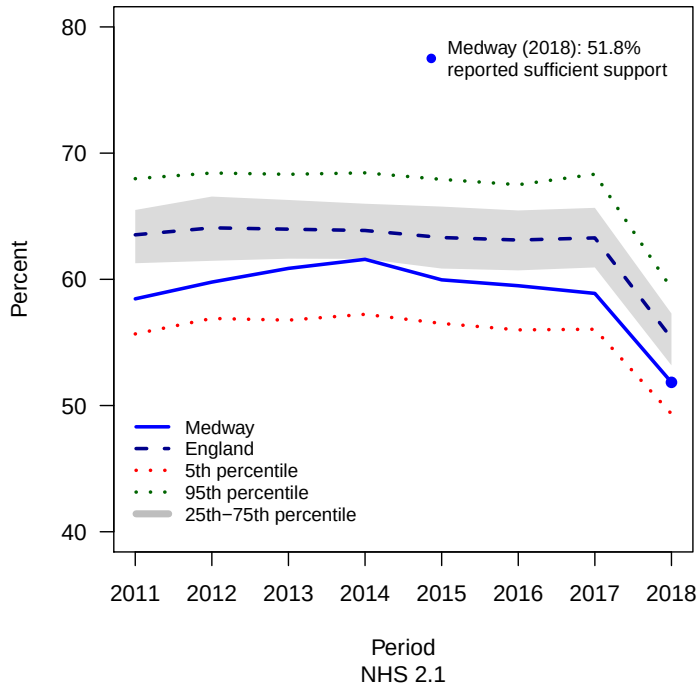
IND307: Serious mental health illness excess deaths



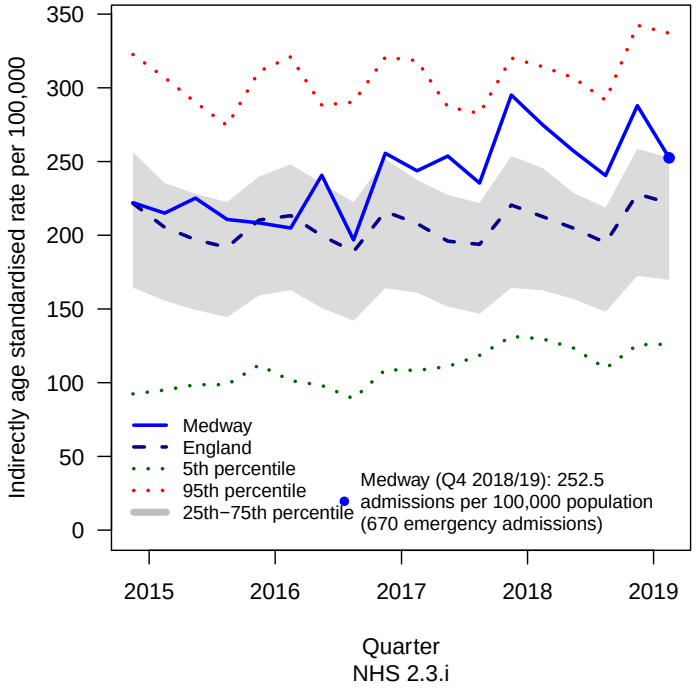
IND308: Estimated diabetes diagnosis rate



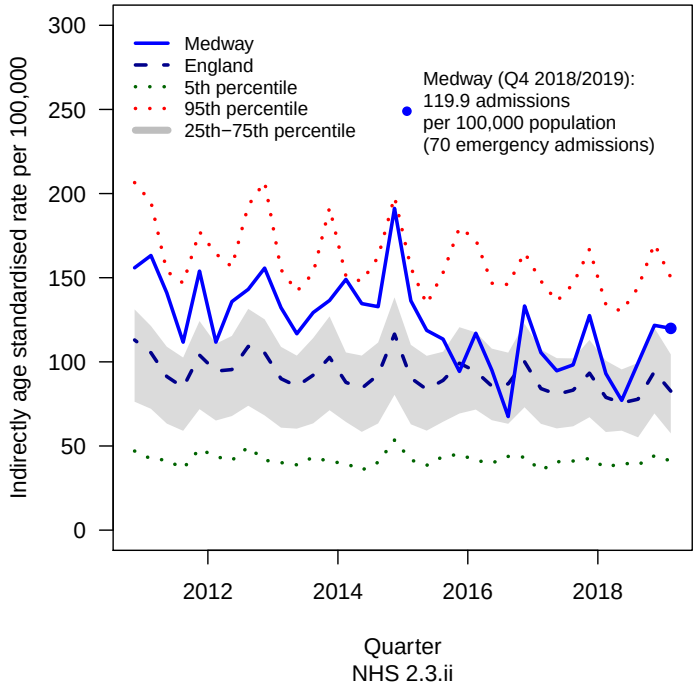
IND310: Long−term condition support



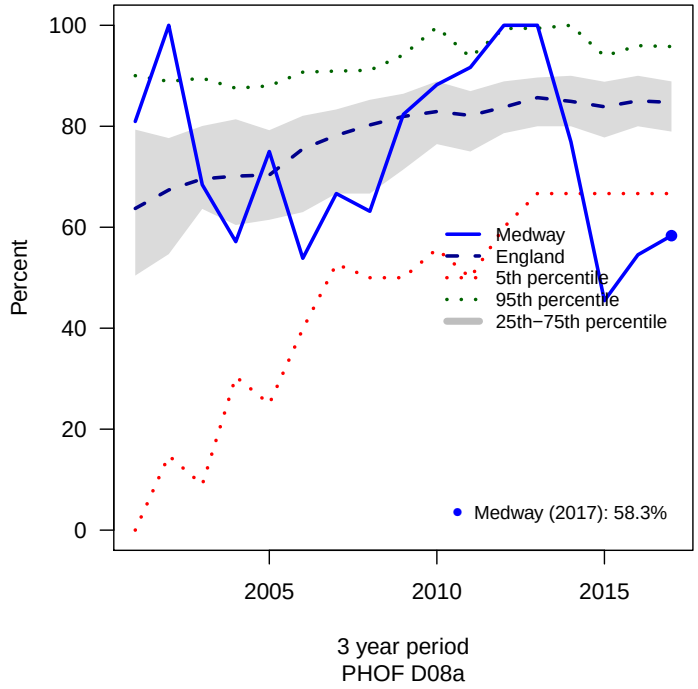
IND311: Chronic ambulatory care admissions



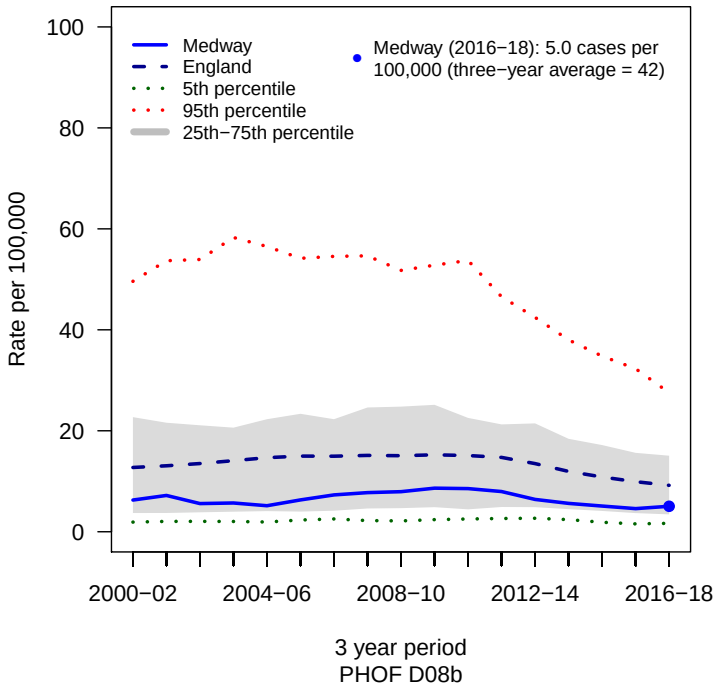
IND312: Asthma diabetes & epilepsy admissions (under 19s)



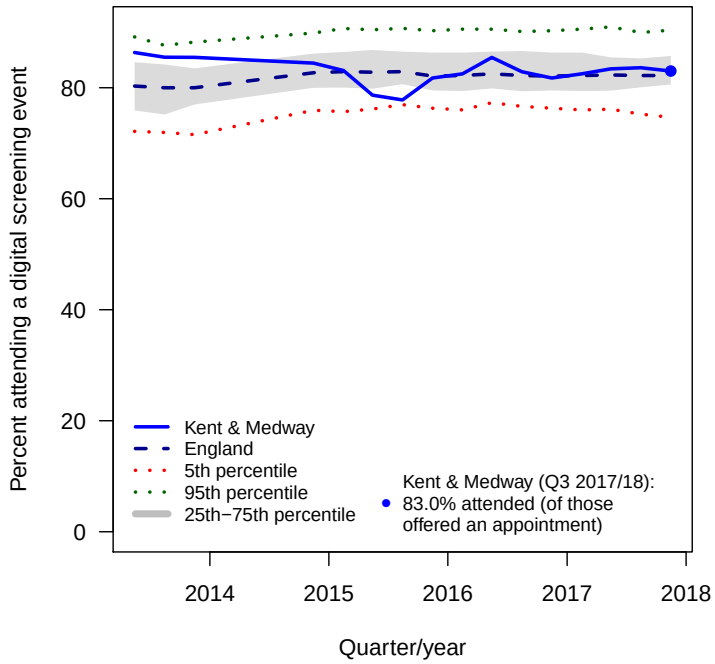
IND314: Percentage completing treatment for TB



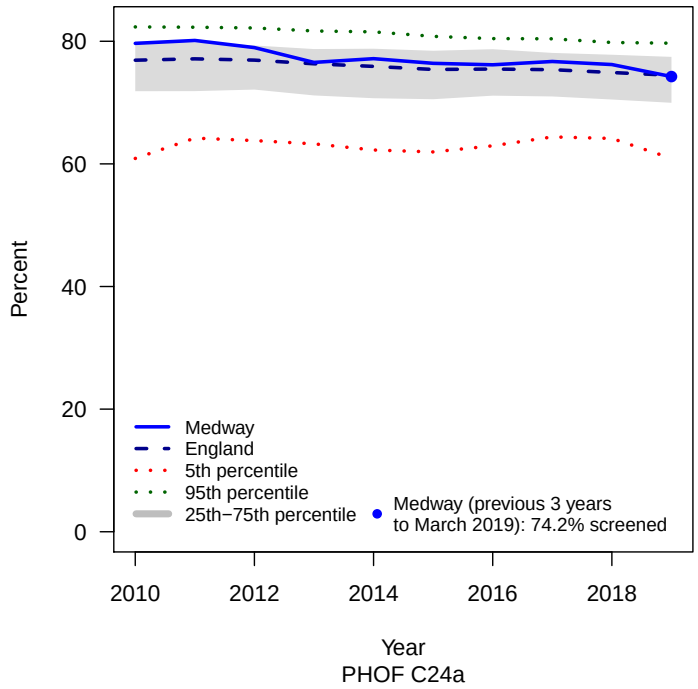
IND315: Rate of reported new cases of TB per year



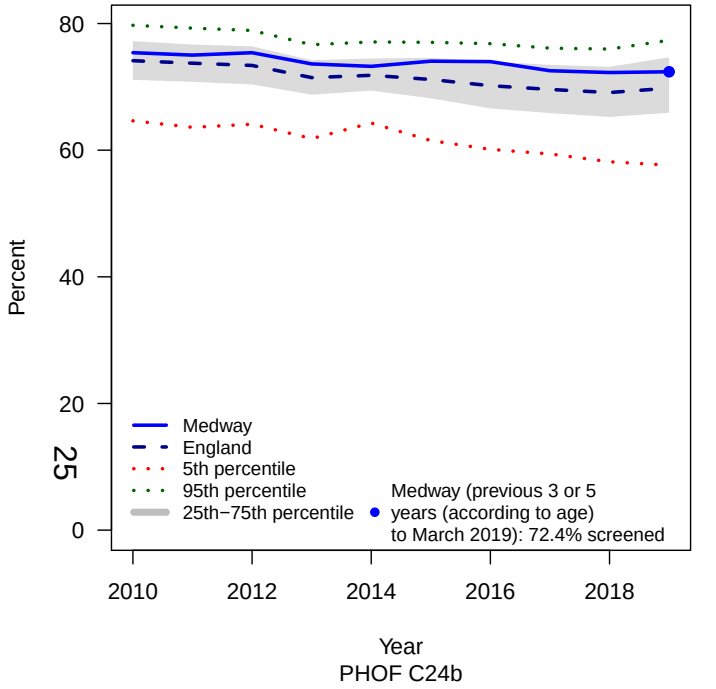
IND316: Diabetic retinopathy screening



IND501: Breast screening 53−70 years



IND502: Cervical screening 5 to 49 years



NOTES

IND301: Under 75 mortality rate from all cardiovascular diseases

Age−standardised rate of mortality from all cardiovascular diseases (including heart disease and stroke) in persons less than 75 years per 100,000 population

IND302: Life expectancy at 75 − Male

Period life expectancy at age 75 for males

IND303: Life expectancy at 75 − Female

Period life expectancy at age 75 for females

IND304: Under 75 mortality rate from respiratory disease

Age−standardised rate of mortality from respiratory disease in persons less than 75 years per 100,000 population

IND305: Under 75 mortality rate from liver disease

Age−standardised rate of mortality from liver disease in persons less than 75 years per 100,000 population

IND306: Cancer mortality rate (under 75)

Age−standardised rate of mortality from all cancers in persons less than 75 years of age per 100,000 population

IND307: Serious mental health illness excess deaths

The ratio of the directly age standardised mortality rate for people aged 18 to 74 in contact with Secondary Mental Health Services to the directly age−standardised mortality rate for the general population of the same age expressed as a percentage.

IND308: Estimated diabetes diagnosis rate

The observed number of people with a formal diagnosis of diabetes as a proportion of the estimated number with diabetes

IND310: Long−term condition support

People aged 18 and over suffering from a longterm condition feeling supported to manage their condition

IND311: Chronic ambulatory care admissions

Unplanned hospitalisation for chronic ambulatory care sensitive conditions

IND312: Asthma diabetes & epilepsy admissions (under 19s)

Unplanned hospitalisation for asthma, diabetes and epilepsy (under 19)

IND314: Percentage completing treatment for TB

The percentage of drug susceptible people completing treatment for tuberculosis within 12 months prior to 31st December, of all those who were notified the previous year.

IND315: Rate of reported new cases of TB per year

The three−year average number of reported new cases per year (based on case notification) per 100,000 population

IND316: Diabetic retinopathy screening

The percentage of those offered screening for diabetic eye screening who attend a digital screening event

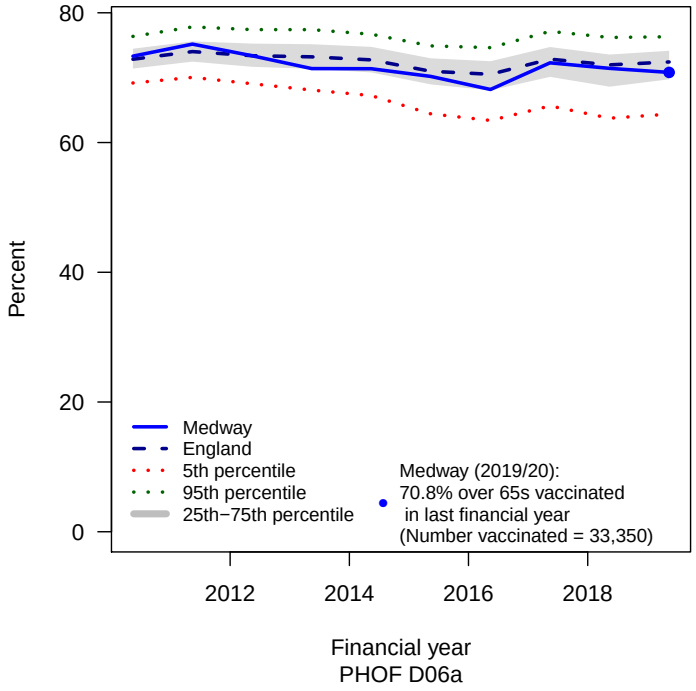
IND501: Breast screening 53−70 years

The percentage of women in the resident population eligible for breast screening who were screened adequately within the previous three years on 31 March

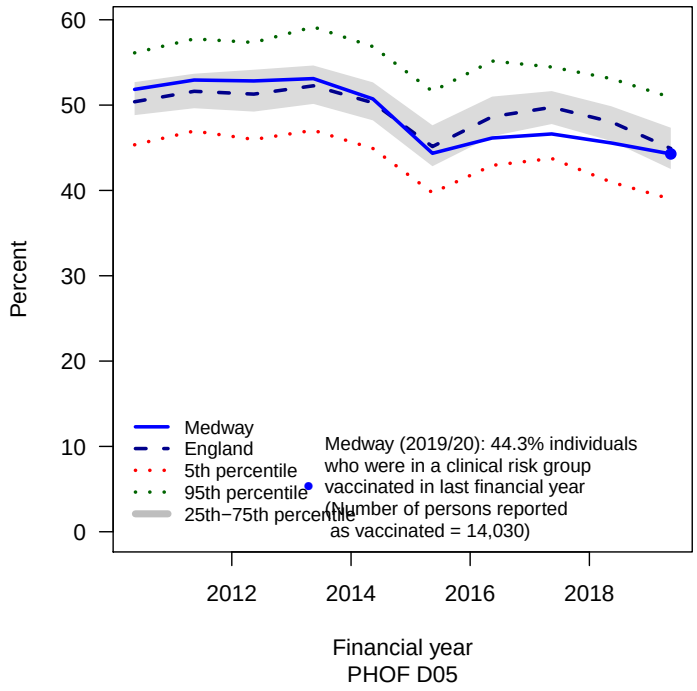
IND502: Cervical screening 5 to 49 years

The proportion of women in the resident population eligible for cervical screening aged 25 to 49 years at end of period reported who were screened adequately within the previous 3.5 years.

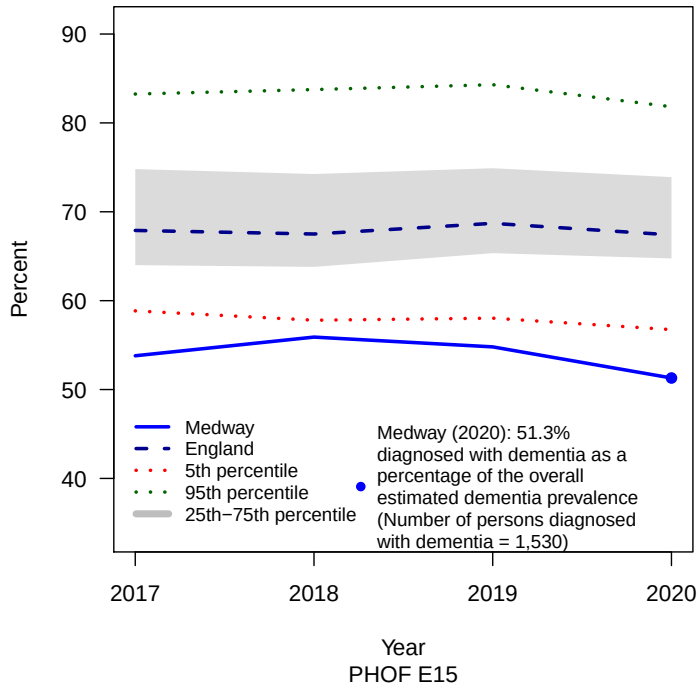
IND210: Population vaccination coverage − Flu (aged 65+)



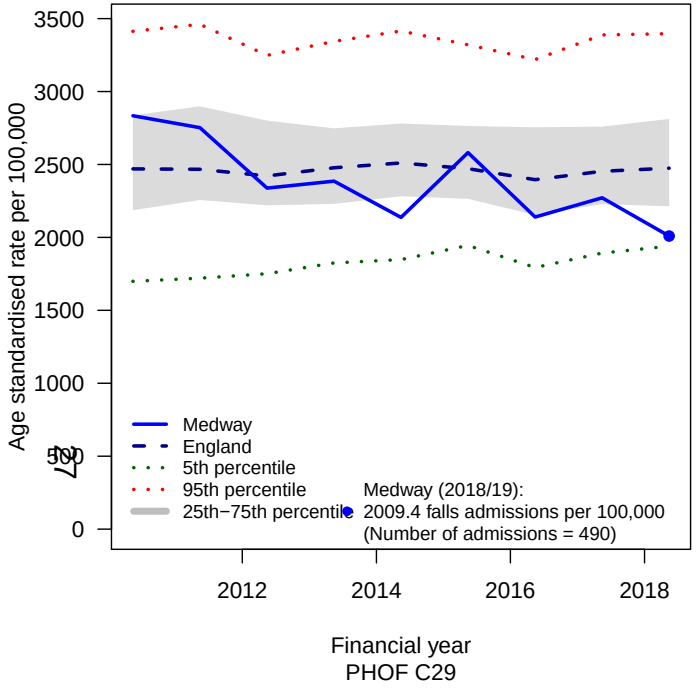
IND211: Population vaccination coverage − Flu (at risk individuals



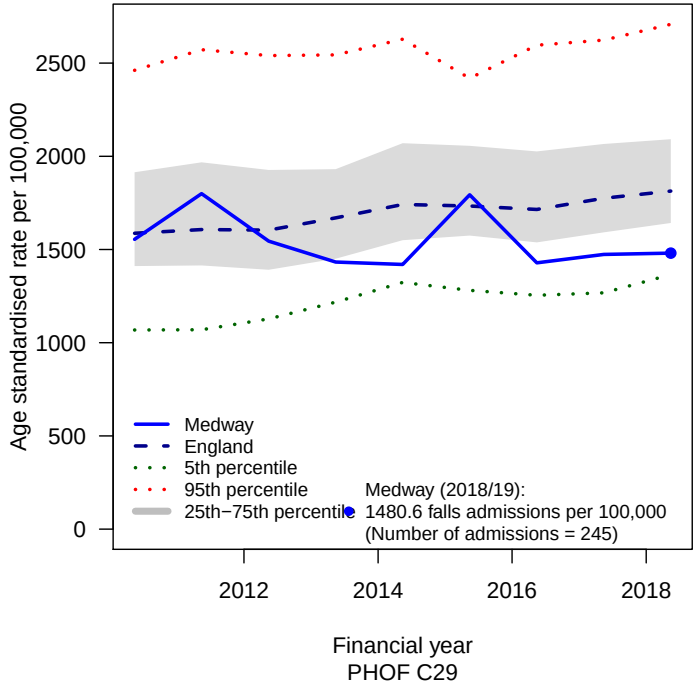
IND213: Estimated diagnosis rate people with dementia



IND214: Emergency hospital admissions due to falls in people aged and over (females)



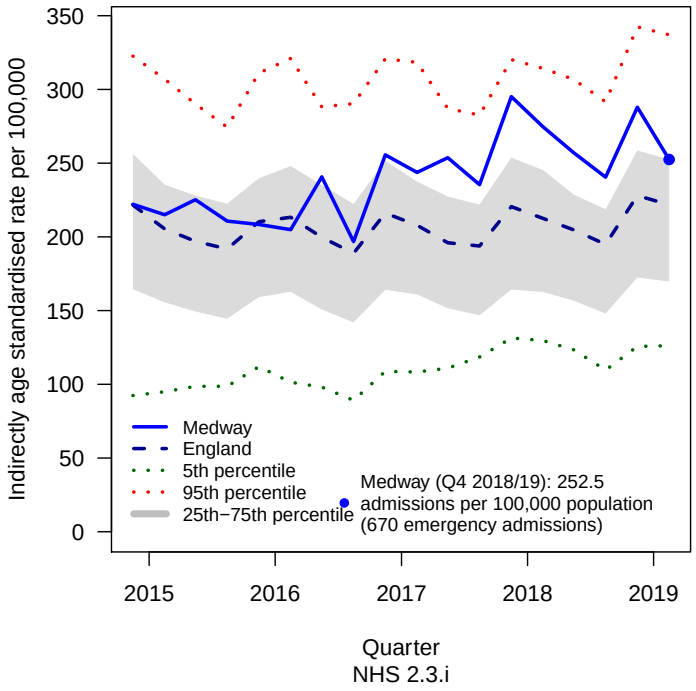
IND215: Emergency hospital admissions due to falls in people aged and over (males)



Theme 4

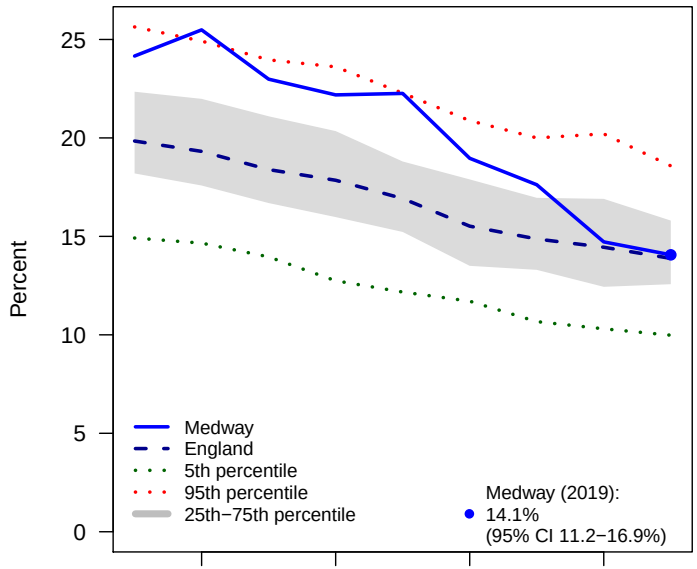
Improve mental and physical health and well-being

IND311: Chronic ambulatory care admissions



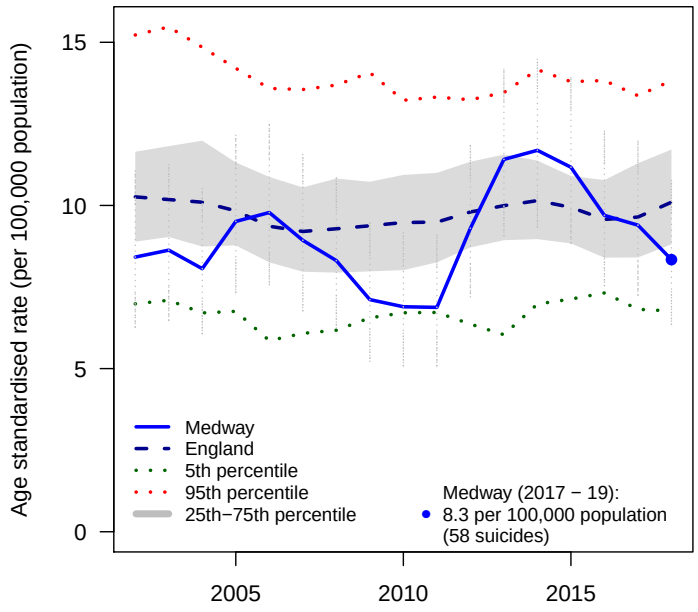
Quarter
NHS 2.3.i

IND409: Smoking % (18+)



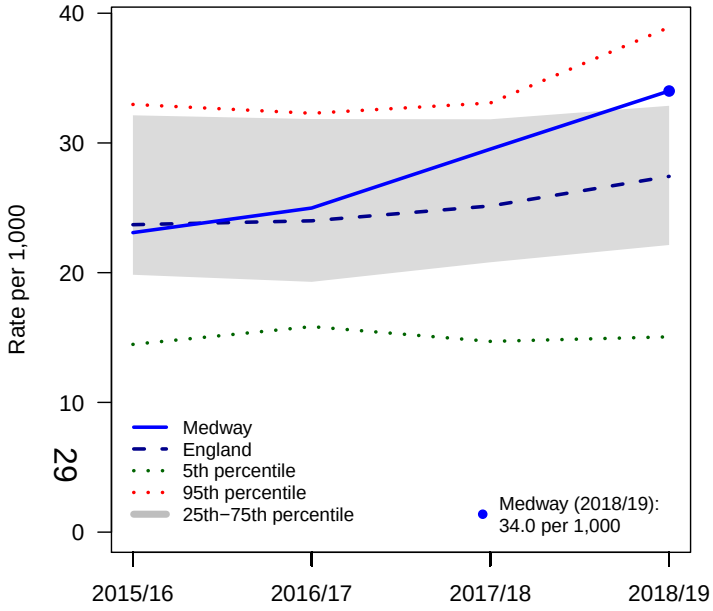
Calendar year
PHOF C18

IND430: Suicide rate (persons)



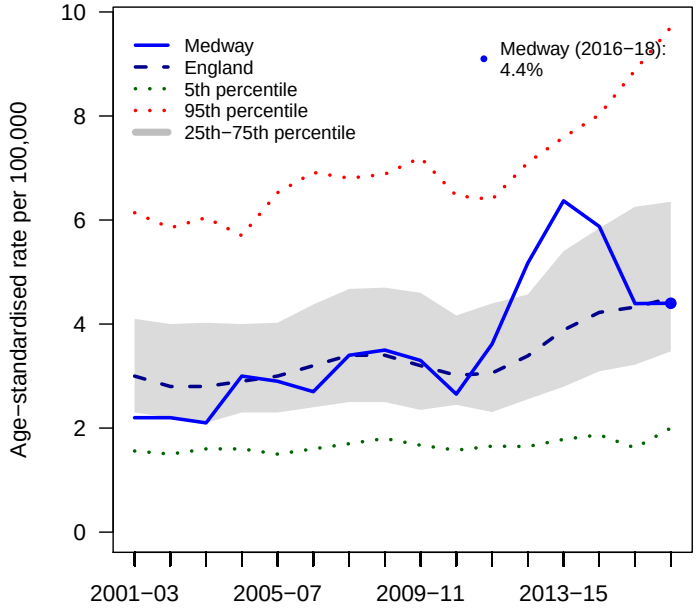
PHOF E10 (rolling average)

IND435: Domestic abuse−related incidents and crimes



Financial year
Fingertips Indicator ID 92863

IND436: Deaths from drug misuse



Year
PHOF C19d

NOTES

IND311: Chronic ambulatory care admissions

Unplanned hospitalisation for chronic ambulatory care sensitive conditions

IND409: Smoking % (18+)

Prevalence of smoking among people aged 18 years and over − persons aged 18+ who are self−reported smokers in the Annual Population Survey

IND430: Suicide rate (persons)

Age−standardised mortality rate from suicide and injury of undetermined intent per 100,000 population

IND435: Domestic abuse−related incidents and crimes

Domestic abuse−related incidents and crimes recorded by the police, crude rates per 1,000

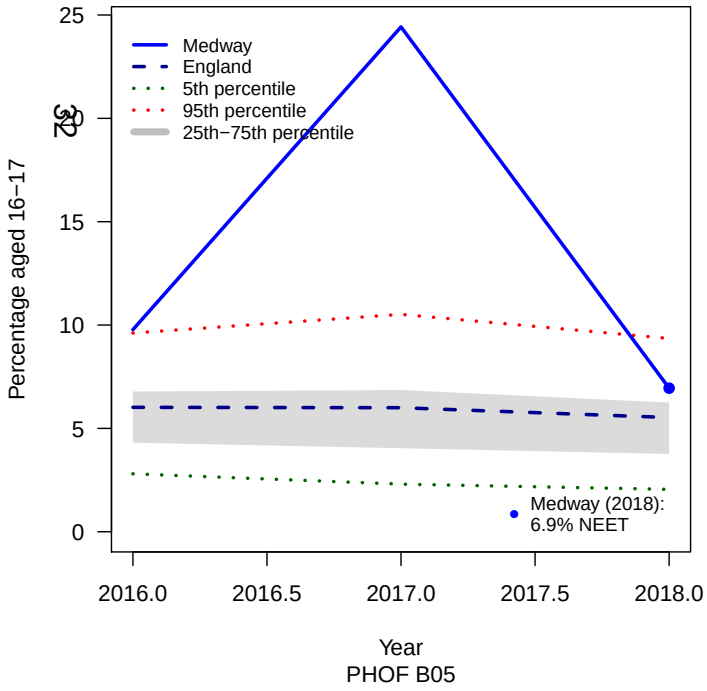
IND436: Deaths from drug misuse

Age−standardised mortality rate from drug misuse per 100,000 population

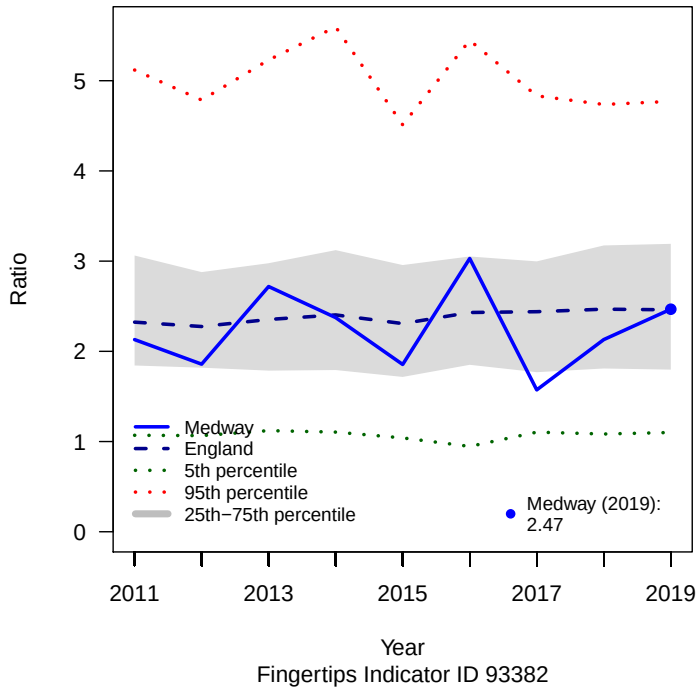
Theme 5

Reduce health inequalities

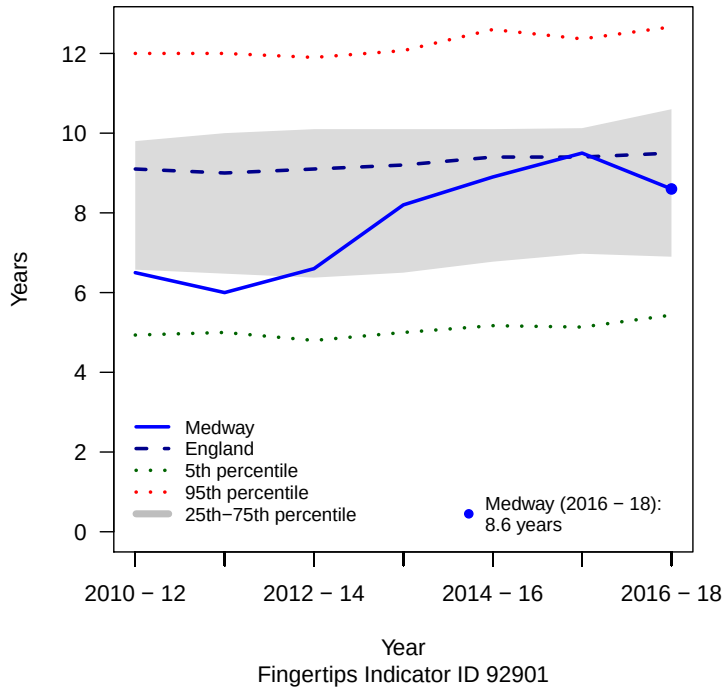
IND505: Not in Education, Employment or Training



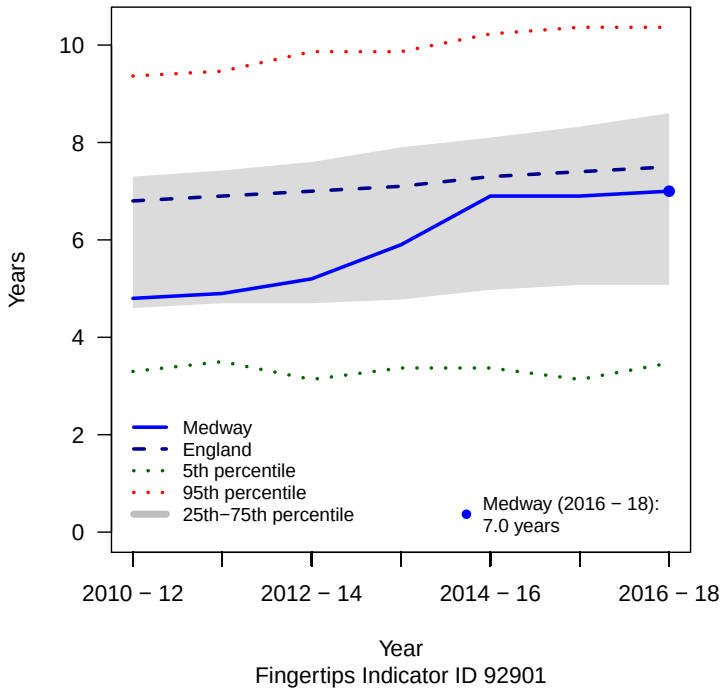
IND507: Socio−economic gap in current smokers (18−64)



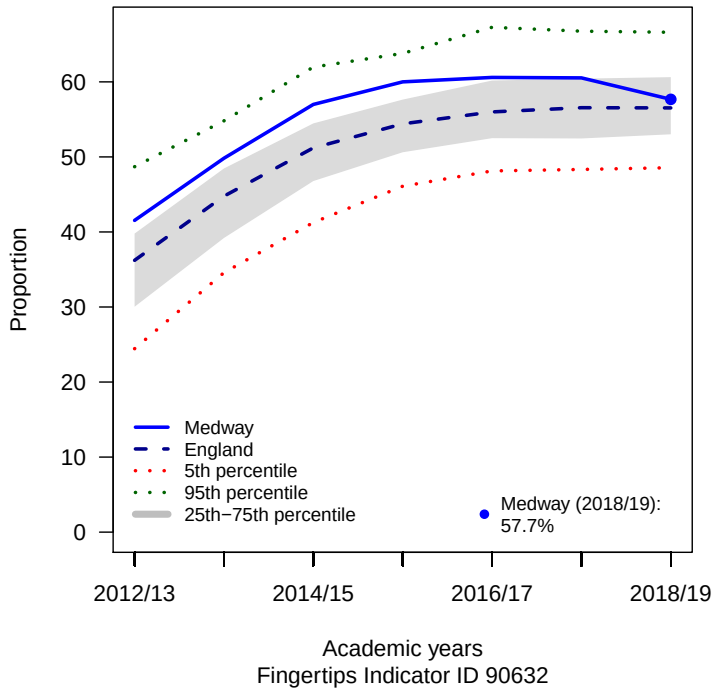
IND508: Inequality in life expectancy at birth (Male)



IND509: Inequality in life expectancy at birth (Female)



IND510: School readiness in children receiving free school meals



NOTES

IND505: Not in Education, Employment or Training

Percentage of 16−17 year olds not in education, employment or training (NEET) or whose activity is not known

IND507: Socio−economic gap in current smokers (18−64)

Smoking prevalence in adults (age 18−64 years) − gap between current smokers in routine and manual occupations and other occupations

IND508: Inequality in life expectancy at birth (Male)

The slope index of inequality in life expectancy at birth (Male), which represents the absolute difference in life expectancy across the social gradient from most to least deprived.

IND509: Inequality in life expectancy at birth (Female)

The slope index of inequality in life expectancy at birth (Female), which represents the absolute difference in life expectancy across the social gradient from most to least deprived.

IND510: School readiness in children receiving free school meals

Children with free school meal status defined as having reached a good level of development at the end of the early years foundation stage (Reception) as a percentage of all eligible children with free school meal status.

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Appendix 2

Transforming health and social care in Kent and Medway

Medway and Swale Integrated Care Partnership profile

Created by Medway Council Public Health Intelligence Team and Kent Public Health Observatory

Transforming health and social care in Kent and Medway is a partnership of all the NHS organisations in Kent and Medway, Kent County Council and Medway Council. We are working together to develop and deliver the Sustainability and Transformation Plan for our area.

Summary part 1: Medway and Swale

36

Indicator	Compared to England
Life expectancy at birth (Male)	Similar
Life expectancy at birth (Female)	Similar
Smoking Prevalence in adults (18+) - current smokers (APS)	Similar
Percentage of adults (aged 18+) classified as overweight or obese	Worse
Children with excess weight Year 6, three year average	Similar
Percentage of physically inactive adults	Worse
Hospital stays for alcohol-related harm (Narrow definition)	Better
Air pollution: fine particulate matter	Not compared
Total number of prescribed antibiotic items per STAR-PU	Similar
Breast cancer screening coverage (females aged 50-70)	Better
Cervical cancer screening coverage (females aged 25-64)	Better
Bowel cancer screening coverage (persons aged 60-74)	Worse
Infant mortality rate	Similar
Low birth weight of term babies	Better
Stillbirth rate	Similar
Smoking status at time of delivery	Worse
Baby's first feed breastmilk	Better
AE attendances (0-4 years)	Better

Summary part 2: Medway and Swale

Indicator	Compared to England
Percentage of 5 year olds with experience of visually obvious dental decay	Similar
Under 18s conception rate / 1,000	Worse
Emergency hospital admissions for asthma (< 19 yrs)	Similar
Emergency hospital admissions for epilepsy (< 19 yrs)	Worse
Emergency hospital admissions for diabetes (< 19 yrs)	Similar
Hospital admissions for mental health conditions (0-17 years)	Similar
Hospital admissions as a result of self-harm (10-24 years)	Better
Hospital admissions due to substance misuse (15-24 years)	Better
Hypertension: QOF prevalence (all ages)	Higher
Diabetes: QOF prevalence (17+)	Higher
CHD: QOF prevalence (all ages)	Lower
CKD: QOF prevalence (18+)	Lower
Stroke: QOF prevalence (all ages)	Lower
Deaths from circulatory disease, under 75 years	Similar
Deaths from all cancer, under 75 years	Worse
Cancer diagnosed at early stage (experimental statistics)	Not compared
Unplanned hospitalisation for chronic ACSC	Worse
Depression: Recorded prevalence (aged 18+)	Higher

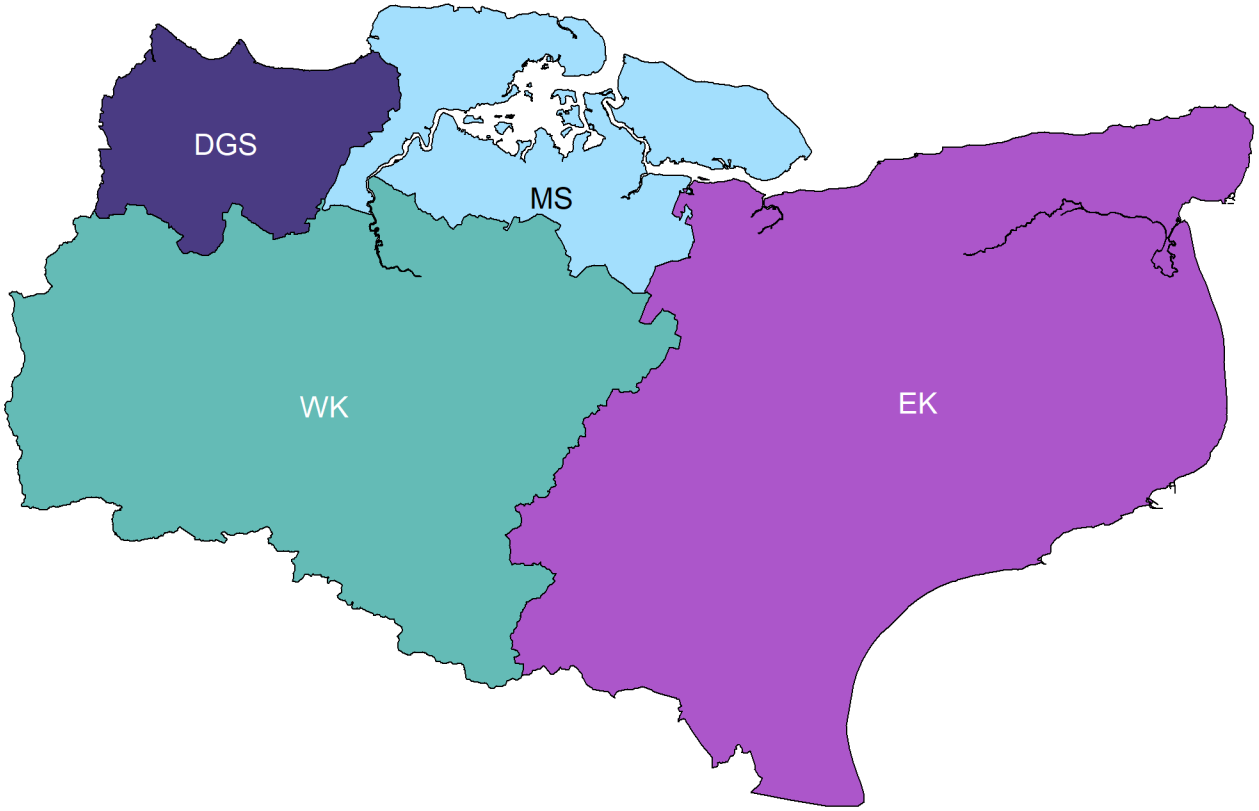
Summary part 3: Medway and Swale

Indicator	Compared to England
Serious Mental Illness: QOF prevalence (all ages)	Lower
Suicide rate (Persons)	Similar
Suicide rate (Male)	Worse
Estimated dementia diagnosis rate (aged 65 and over)	Not compared
Emergency hospital admissions due to falls (persons aged 65 and over)	Better
Emergency hospital admissions for hip fracture (persons aged 65 and over)	Similar
Osteoporosis: QOF prevalence (50+)	Lower

Purpose

- Profiles have been created for each of the Integrated Care Partnerships (ICPs) in the Kent and Medway Integrated Care System (ICS).
- 1) Dartford, Gravesham and Swanley; 2) East Kent; 3) Medway and Swale; 4) West Kent.
- The aim of the profiles is to allow comparison between each of the ICPs and identify priority areas to focus work.

Kent and Medway ICPs



Integrated Care Partnerships

Dartford, Gravesham and Swanley ICP | East Kent ICP | Medway and Swale ICP | West Kent ICP

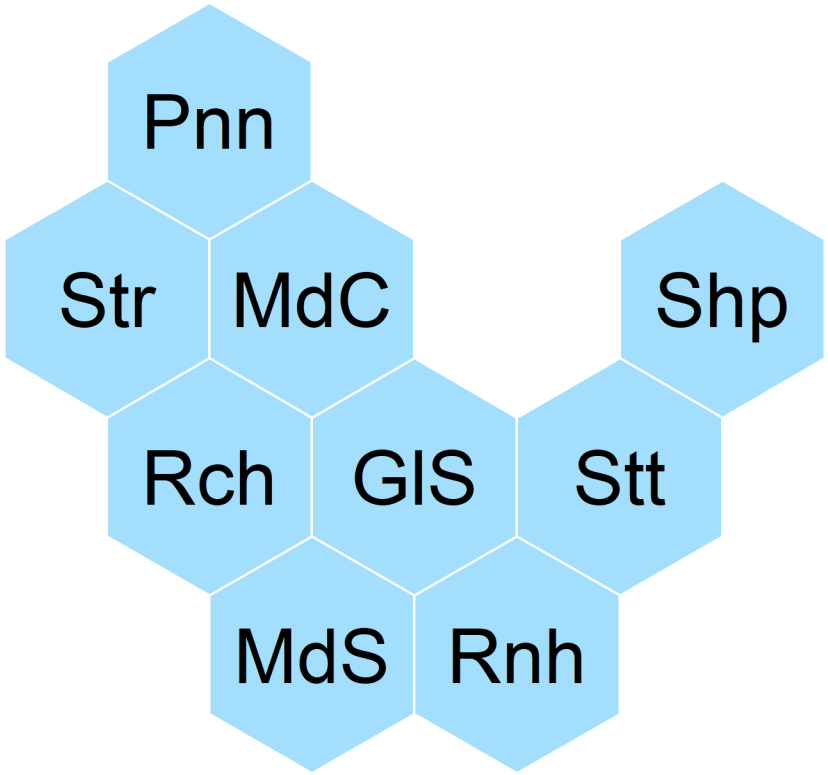
Produced by Medway Public Health Intelligence Team, Medway Council 2020-08-14

Rationale

- The profiles contain five sections, which are based on key themes identified in the NHS Long Term Plan.
- 1) Demographics; 2) Prevention and Health Inequalities; 3) Best Start in Life; 4) Major Health Conditions; 5) Ageing Well.
- Key stakeholders were consulted to identify the indicators that should be included.
- Due to limitations in the available data, some indicators could not be included for all the priorities identified at this time.

PCN hex map explained

- Some slides contain a hex map, which displays the indicator value at PCN level.
- Each hexagon represents a PCN, arranged according to its relative geography within the ICP.
- The PCN abbreviations used in the hex map are displayed below.

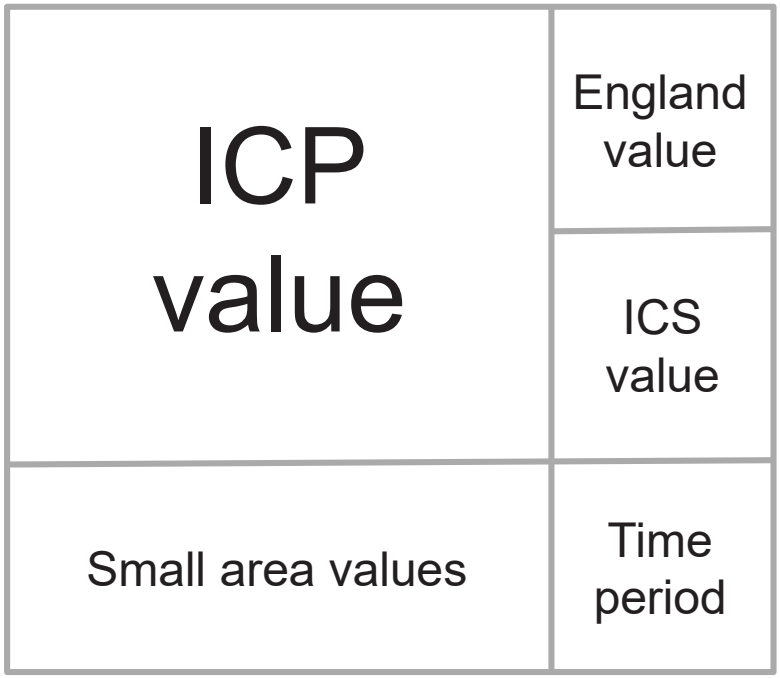


PCN abbreviations

- Pnn: Peninsula
- Shp: Sheppey
- MdC: Medway Central
- Str: Strood
- Stt: Sittingbourne
- GIS: Gillingham South
- Rch: Rochester
- Rnh: Rainham
- MdS: Medway South

Number grid explained

- Some slides contain a number grid, which displays the indicator value at different levels of geography.
- England -> Kent and Medway ICS -> ICP -> Small area.
- The small area type displayed depends on the data available for the indicator.



- Either District & Unitary Authority (UA) or Clinical Commissioning Group (CCG).

Small areas

- District & UA and CCG data have been mapped to the ICP boundaries as per the table below.
- Caveat: District & UA data does not align with the ICP areas exactly.
- For the purpose of this profile, data for whole District & UAs have been assigned to the ICP where the majority of residents reside.

Integrated Care Partnership	District & Unitary Authority	Clinical Commissioning Group
Dartford, Gravesham and Swanley	Dartford Gravesham	Dartford, Gravesham and Swanley CCG
East Kent	Ashford Canterbury Dover Folkestone & Hythe Thanet	Ashford CCG Canterbury and Coastal CCG South Kent Coast CCG Thanet CCG
Medway and Swale	Medway Swale	Medway CCG Swale CCG
West Kent	Maidstone Sevenoaks Tonbridge and Malling Tunbridge Wells	West Kent CCG

Small areas

- Data at several small area levels has been used as building blocks to calculate the PCN values: Lower Super Output Area (LSOA), ward, general practice and school.
- LSOAs have a defined geographical boundary. On average the population is about 1,700 people so they can be thought of as representing a neighbourhood. There are 1,065 LSOAs within Kent and Medway.
- LSOAs and wards were assigned to PCNs on a first passed the post basis, e.g. LSOAs or wards were mapped to PCNs based on which PCN has the highest count of registered patients living in that LSOA/ward.
- School level data was assigned to PCNs based on the ward the school was located in. Only primary and nursery school data was used as this more likely reflects the child profile of the local area due to the larger catchment areas of secondary schools.

ICP value and comparison

- The ICP values have been calculated from either LSOA, ward, general practice, school, District & UA or CCG level data using one of two methods:
- 1) Aggregated data: ICP values are created from aggregated counts and denominators, where data is available.
- 2) Small areas averaged: Where count and/or denominator data is not available, the ICP value is the median of the small area values.
- A RAG rating (red, amber, green) has been applied to the majority of indicators to show how well an area is performing compared to a benchmark (England). The RAG rating is assigned by comparing an area's value to a reference range, which was created using either confidence intervals (CIs) or a range around the England average (usually 5%). Green corresponds to a value that is better than England, red to a value that is worse, and amber indicates that there is no difference.
- Where it is inappropriate to label high or low values as 'better' or 'worse', for example osteoporosis prevalence, the terms 'higher' and 'lower' have been used with neutral colouring: shades of blue from light to dark. Such labelling does not imply that high values of these indicators, for example, are 'worse'.
- An indicator is shaded grey where it is inappropriate to apply a RAG rating due to the methods used in the calculation or the count is less than 10.

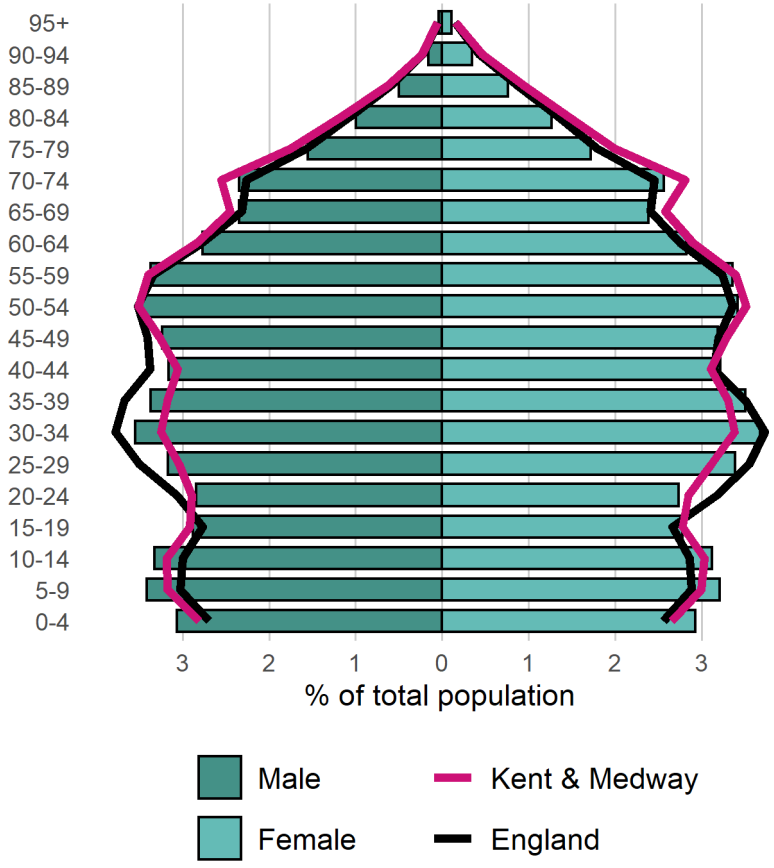
DEMOGRAPHICS

Population

48

Age Profile for Medway and Swale

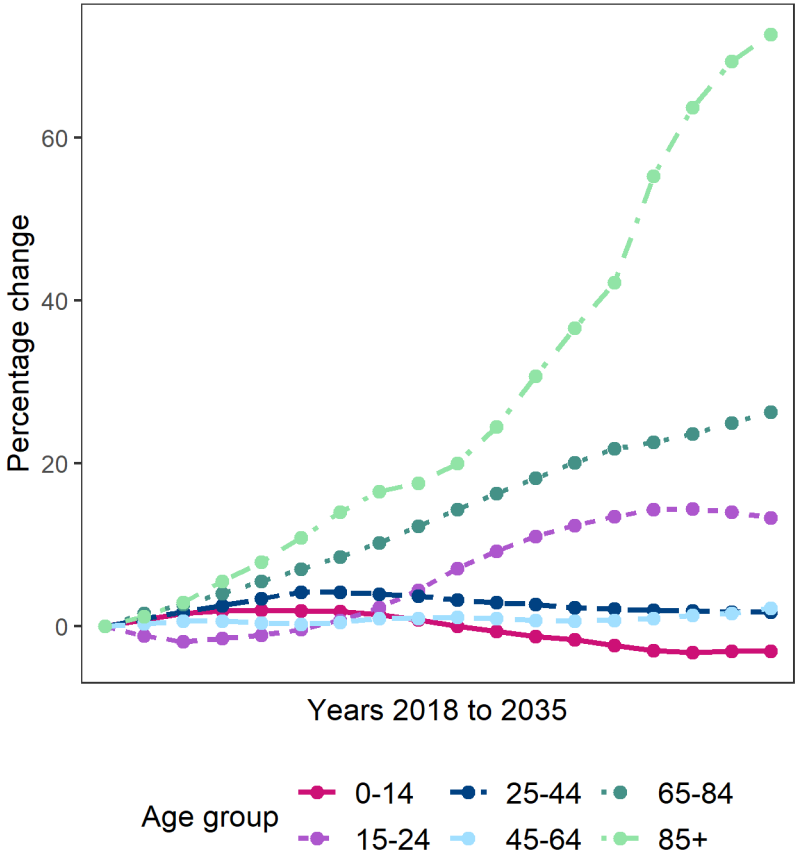
Total population: 402,657



Source: NHS Digital. Patients Registered at a GP Practice. 01JUL2020

Projected population for MS

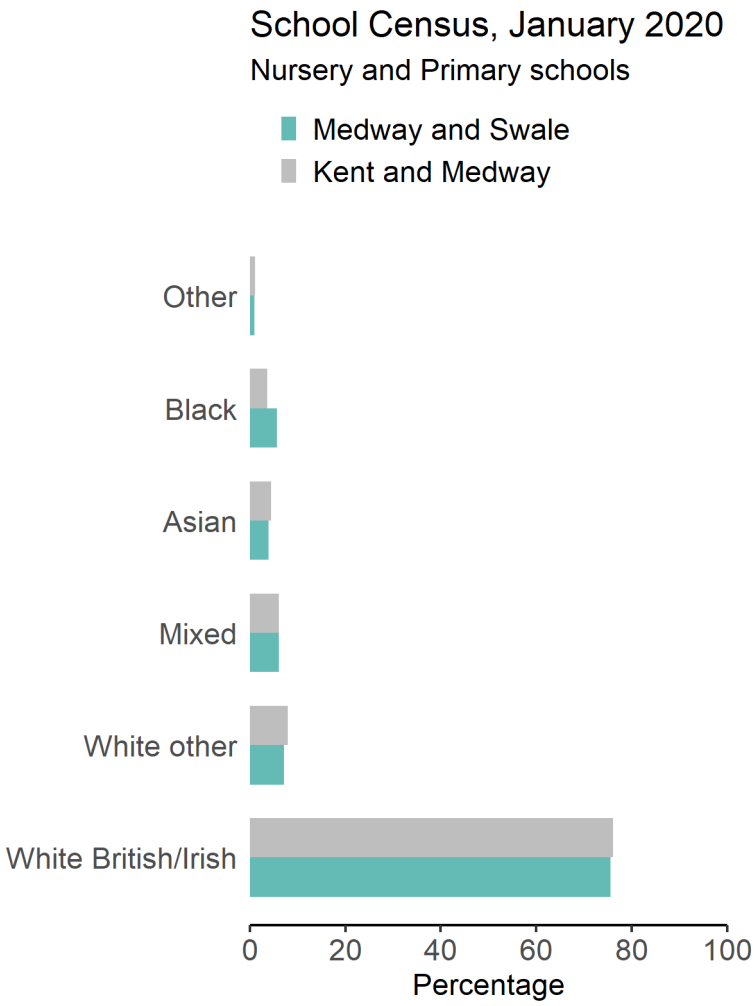
Percentage change from 2018

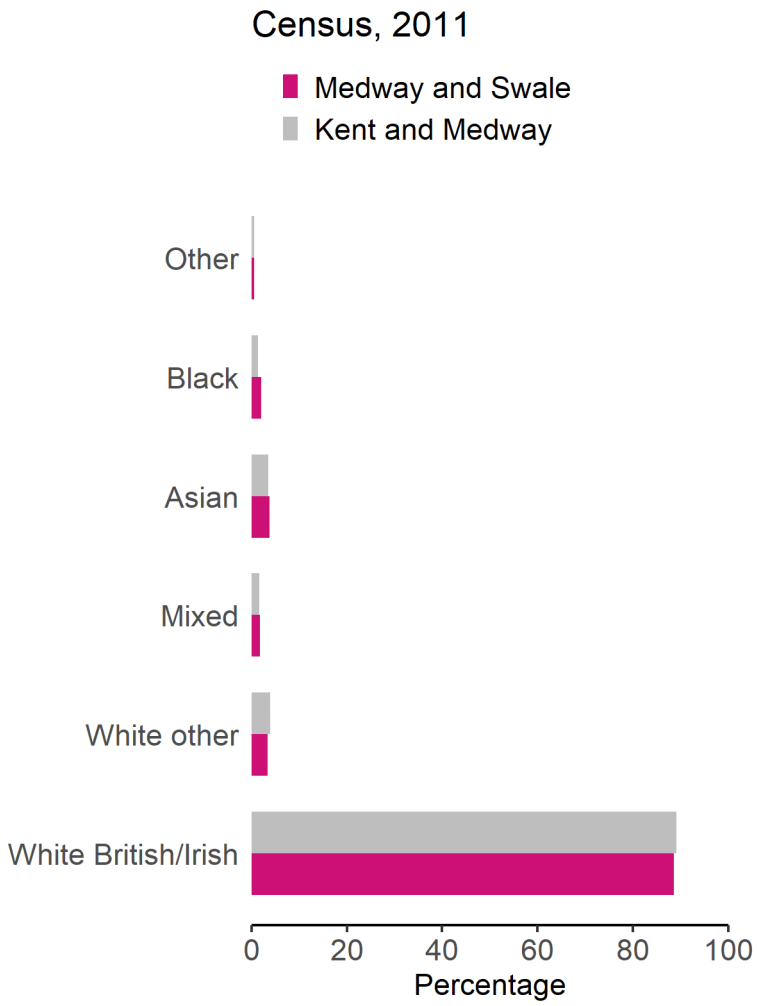


Source: ONS. Population projections for local authorities. 2018 based.

Note: Population projections have been calculated by aggregating the local authority districts assigned to the ICP.

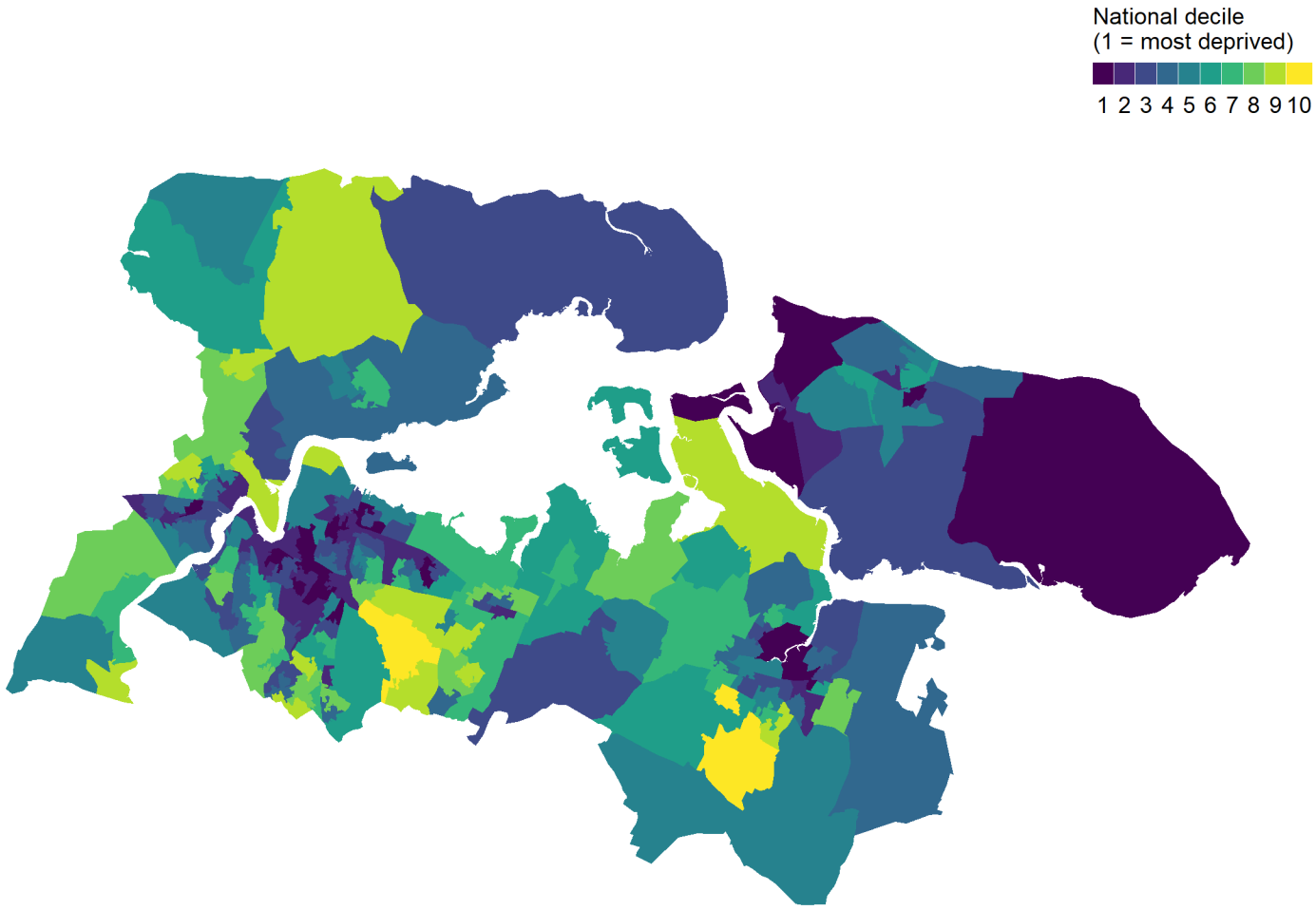
Ethnicity





Census source: NOMIS. 2011 Census. KS201EW)) - Ethnic group.
School Census source: GOV.UK. Department for Education. (2019). Schools, pupils and their characteristics: January 2020.

Deprivation

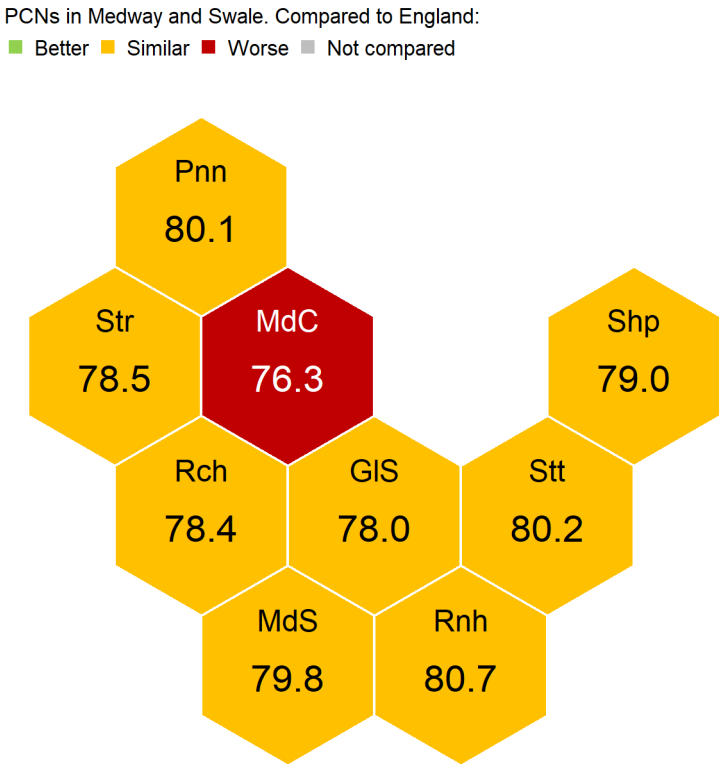


Produced by Medway Public Health Intelligence Team, Medway Council 2020-08-14

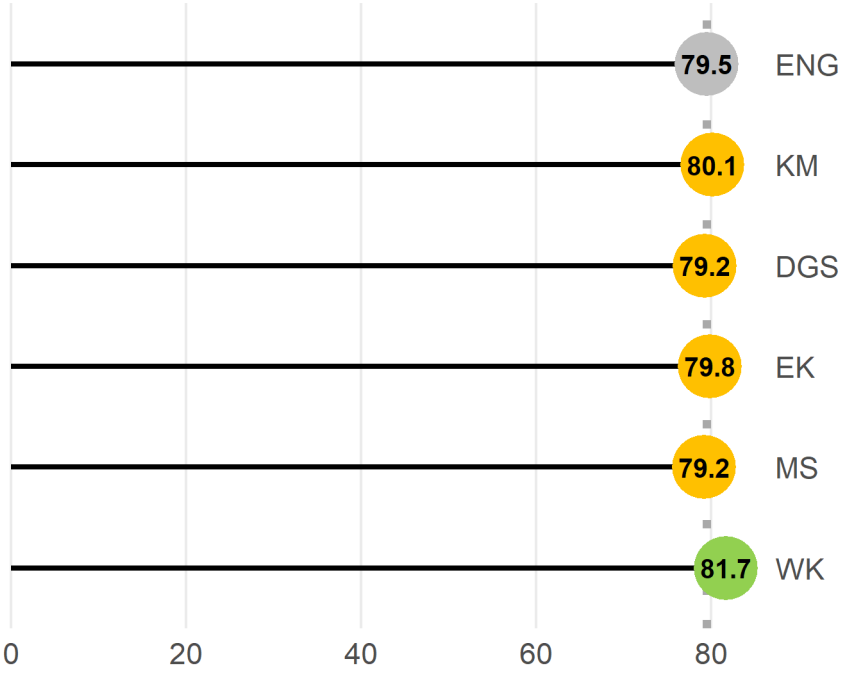
PREVENTION AND HEALTH INEQUALITIES

52

Life expectancy at birth (Male)



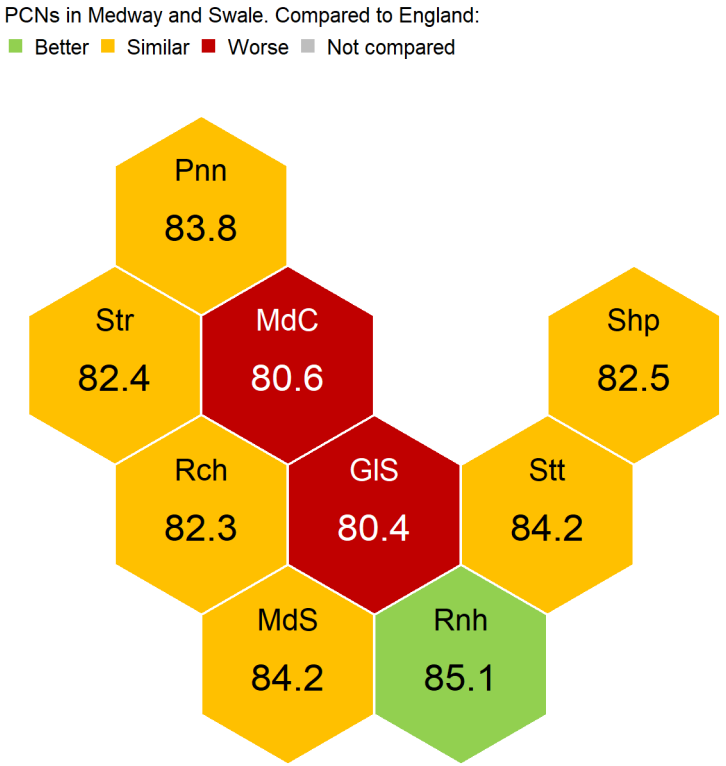
Trend data not available.



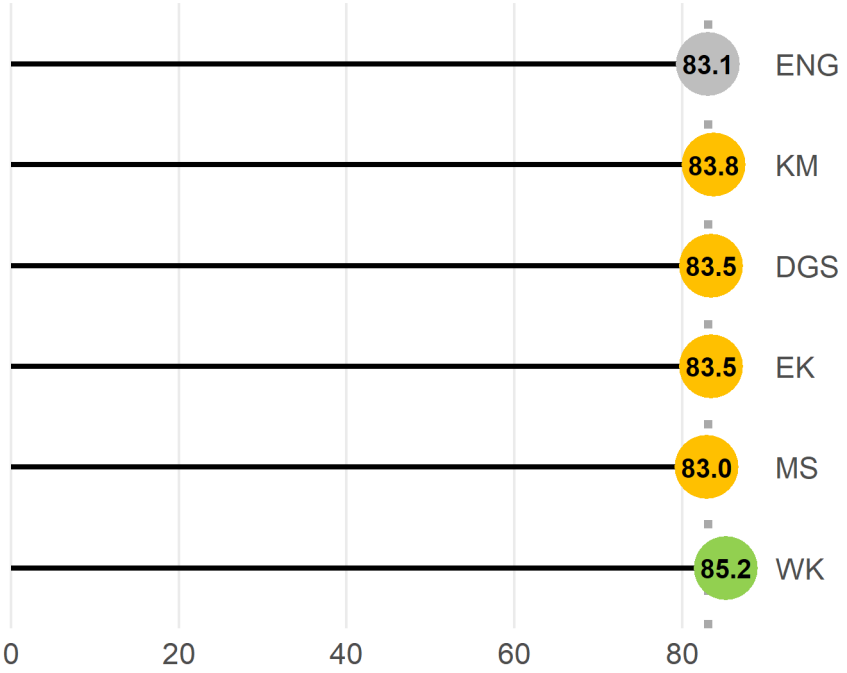
The rate in Medway and Swale is similar to England.

Value type: Years
Latest time period: 2013 - 17
Source: PHE, Fingertips, Indicator ID: 93283
ICP value calculation: Small areas averaged
Small area type: Ward to PCN
ICP RAG method: England plus/minus 2%

Life expectancy at birth (Female)



Trend data not available.



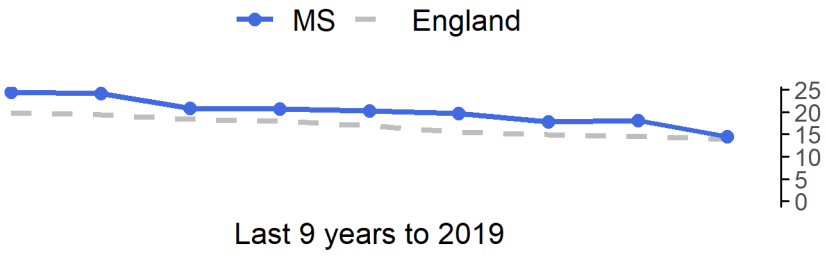
The rate in Medway and Swale is similar to England.

Value type: Years
Latest time period: 2013 - 17
Source: PHE, Fingertips, Indicator ID: 93283
ICP value calculation: Small areas averaged
Small area type: Ward to PCN
ICP RAG method: England plus/minus 2%

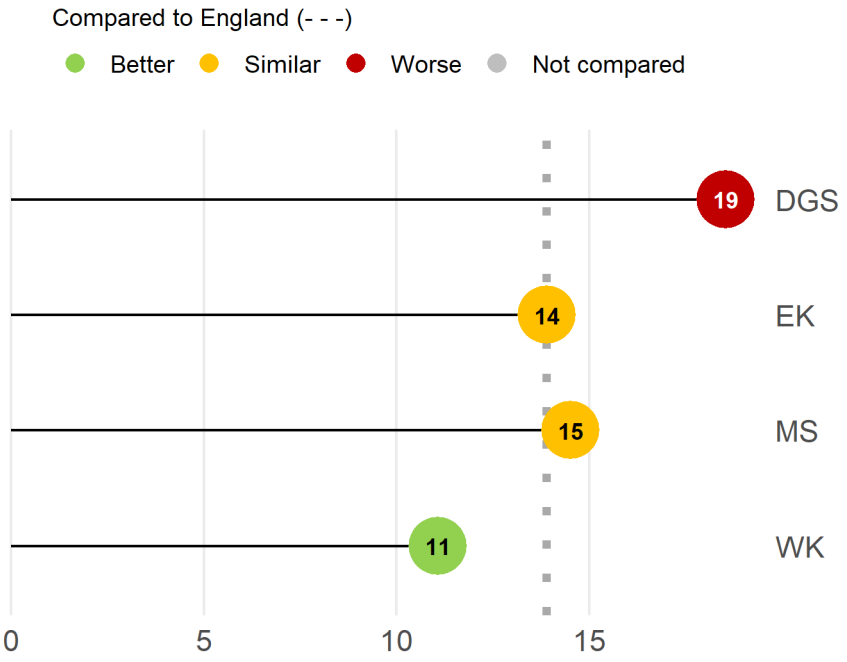
54

Smoking Prevalence in adults (18+) - current smokers (APS)

15		14
ICP: Medway and Swale		England
		14
		Kent and Medway
14	15	2019
Medway	Swale	



Last 9 years to 2019



The rate in Medway and Swale is similar to England.

Value type: Proportion - %
Latest time period: 2019
Source: PHE, Fingertips, Indicator ID: 92443
ICP value calculation: Small areas averaged
Small area type: District & UA (4/19-3/20)
ICP RAG method: England plus/minus 5%

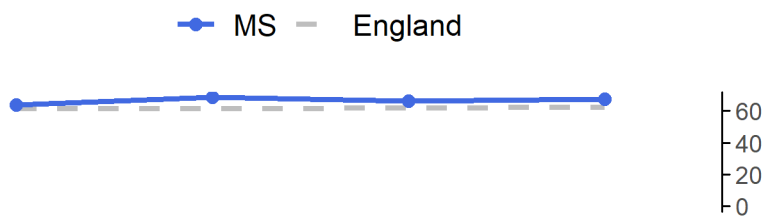
There are data quality concerns with the figure for Dartford LA (see notes on the next slide).

Smoking Prevalence in adults (18+) - current smokers (APS)

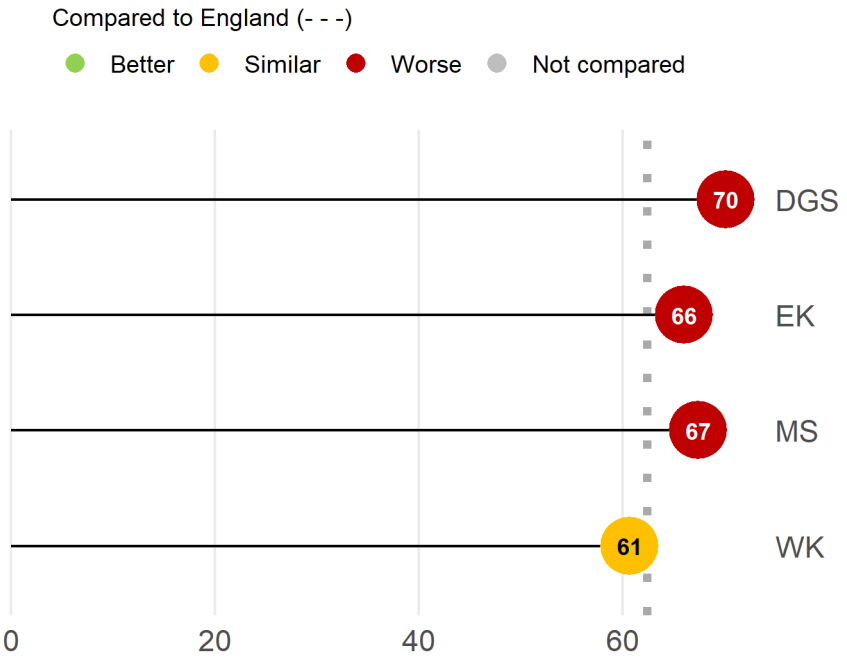
- Smoking prevalence is an estimate based on a sample of the population questioned in the Annual Population Survey run by the Office for National Statistics.
- The figure for Dartford LA in 2019 was high (26.4%) but with a very wide degree of uncertainty.
- This is most likely due to a small sample of people.
- Therefore the aggregate figure for DGS ICP should be interpreted with caution.

Percentage of adults (aged 18+) classified as overweight or obese

67 ICP: Medway and Swale		62 England
		65 Kent and Medway
70 Medway	65 Swale	2018/19



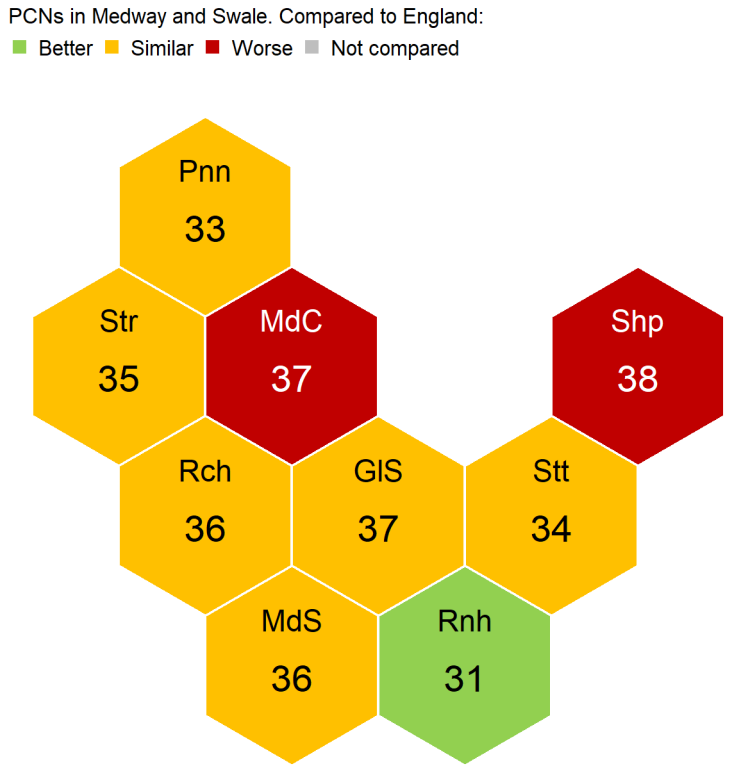
Last 4 years to 2018/19

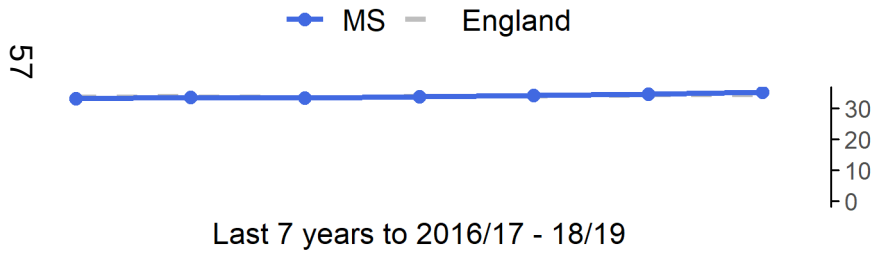


The rate in Medway and Swale is worse than England.

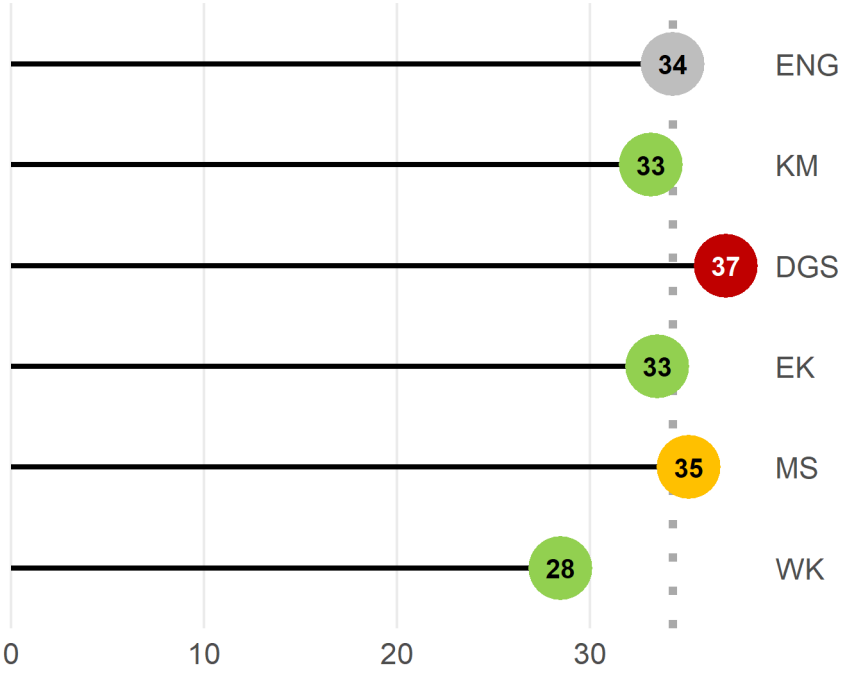
Value type: Proportion - %
Latest time period: 2018/19
Source: PHE, Fingertips, Indicator ID: 93088
ICP value calculation: Small areas averaged
Small area type: District & UA (4/19-3/20)
ICP RAG method: England plus/minus 5%

Children with excess weight Year 6, three year average





Last 7 years to 2016/17 - 18/19



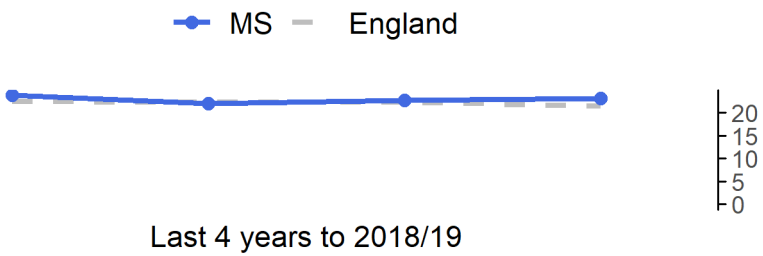
The rate in Medway and Swale is similar to England.

Value type: Proportion - %
Latest time period: 2016/17 - 18/19
Source: PHE, Fingertips, Indicator ID: 93108
ICP value calculation: Aggregated data
Small area type: Ward to PCN
ICP RAG method: Confidence interval (95%) - Wilson Score method

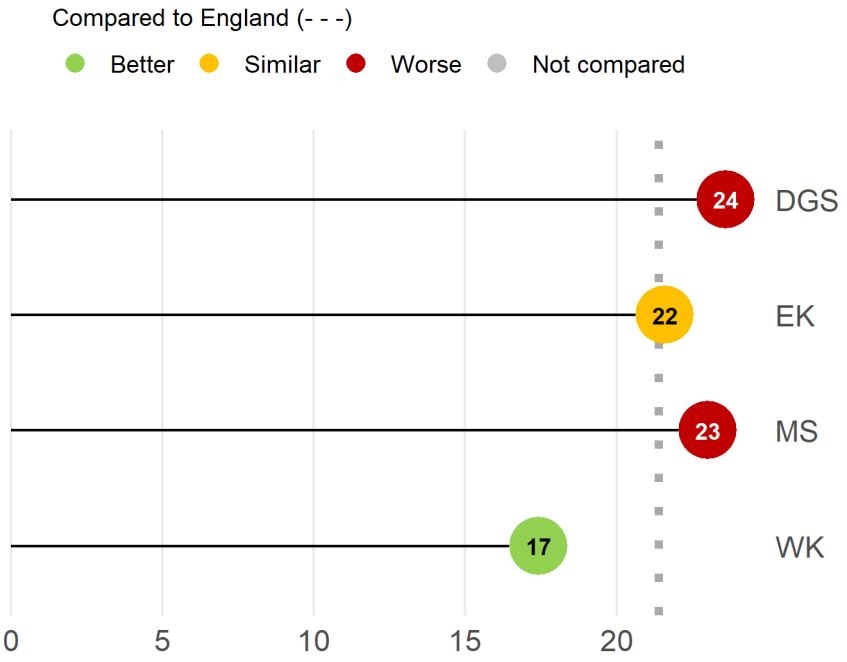
58

Percentage of physically inactive adults

23 ICP: Medway and Swale		21 England
		21 Kent and Medway
23 Medway	23 Swale	2018/19



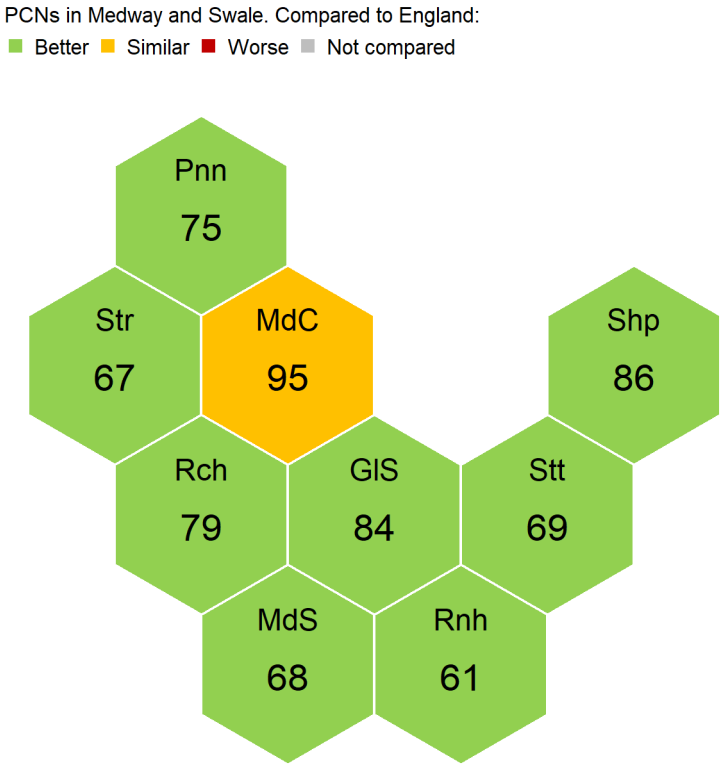
Last 4 years to 2018/19

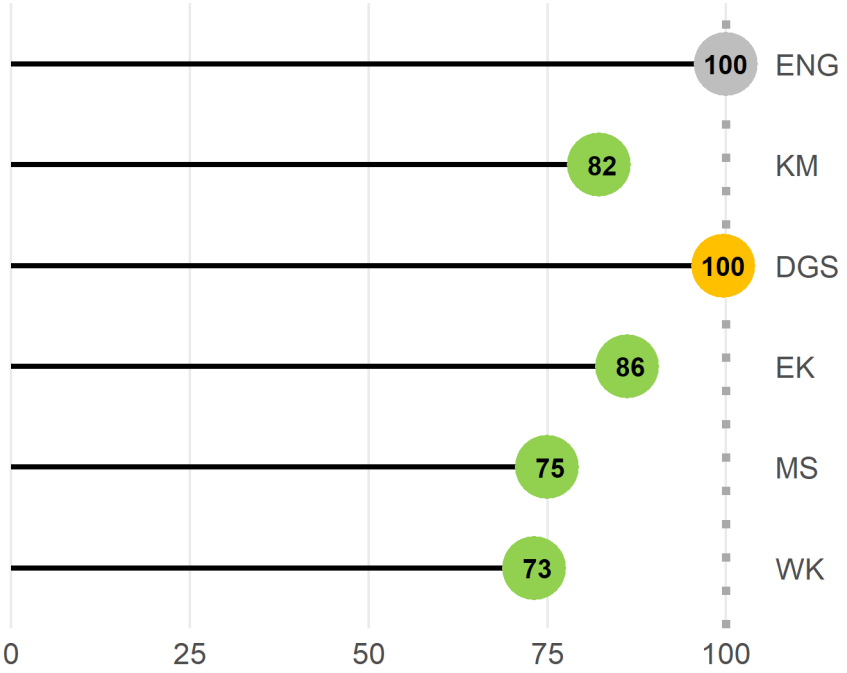


The rate in Medway and Swale is worse than England.

Value type: Proportion - %
Latest time period: 2018/19
Source: PHE, Fingertips, Indicator ID: 93015
ICP value calculation: Small areas averaged
Small area type: District & UA (4/19-3/20)
ICP RAG method: England plus/minus 5%

Hospital stays for alcohol-related harm (Narrow definition)





The rate in Medway and Swale is better than England.

Value type: Indirectly standardised ratio per 100
Latest time period: 2013/14 - 17/18
Source: PHE, Fingertips, Indicator ID: 93240
ICP value calculation: Aggregated data
Small area type: Ward to PCN
ICP RAG method: Confidence interval (95%) - Byar's method

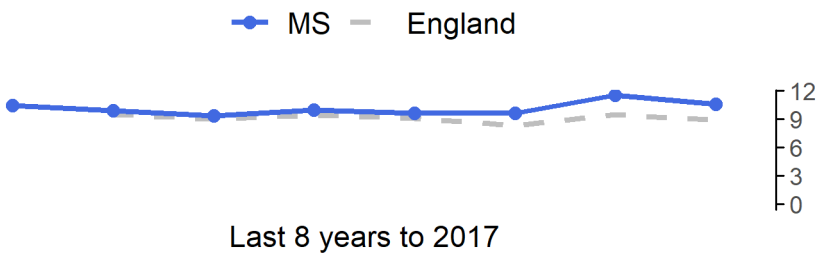
No trend data available.

59

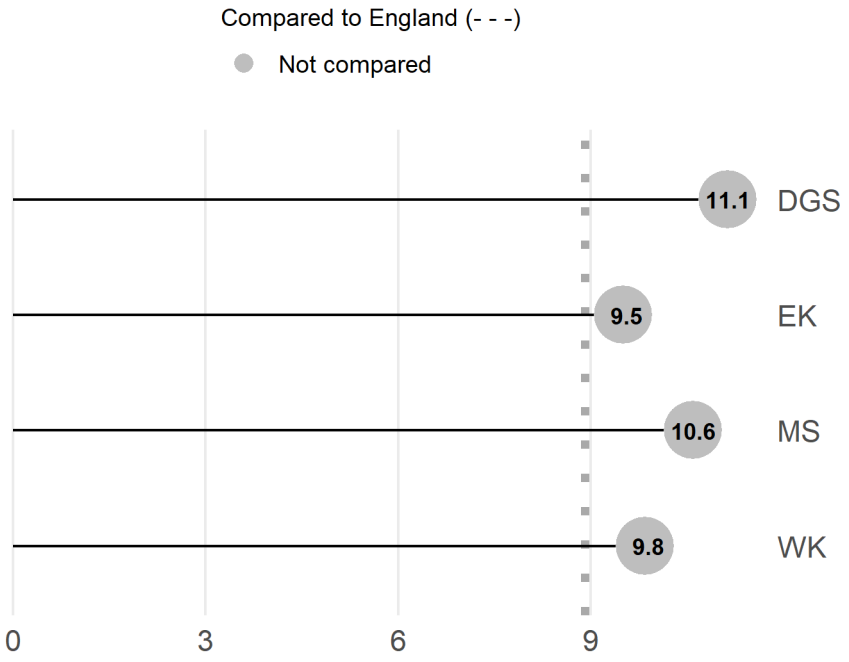
Narrow definition: Admissions to hospital where the primary diagnosis is an alcohol-related condition, or a secondary diagnosis is an alcohol-related external cause.

Air pollution: fine particulate matter

10.6 ICP: Medway and Swale		8.9 England
		10.0 Kent and Medway
11.2 Medway	10.0 Swale	2017



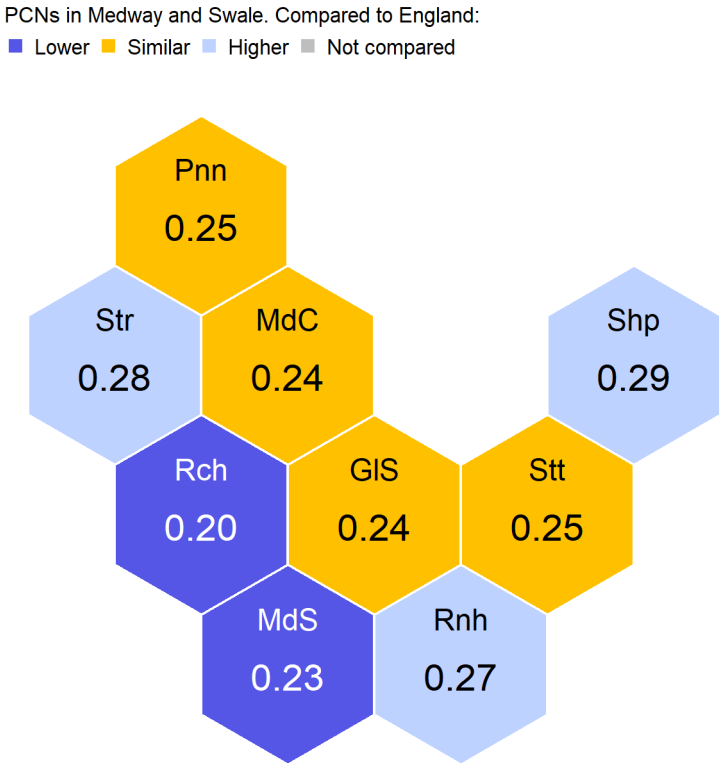
Last 8 years to 2017

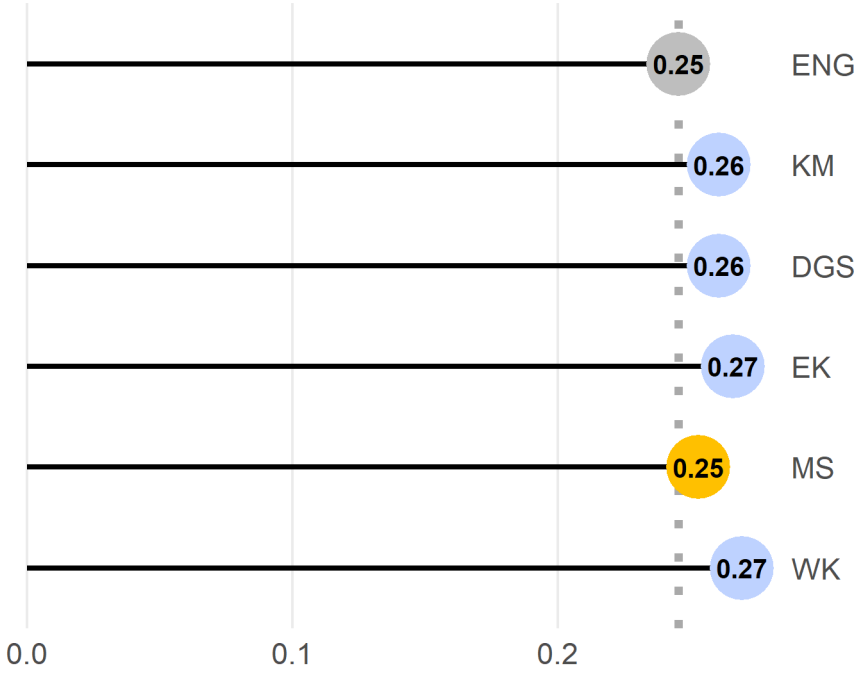


Medway and Swale cannot be compared to England statistically.

Value type: Mean - µg/m3
Latest time period: 2017
Source: PHE, Fingertips, Indicator ID: 92924
ICP value calculation: Small areas averaged
Small area type: District & UA (4/19-3/20)
ICP RAG method: None applied

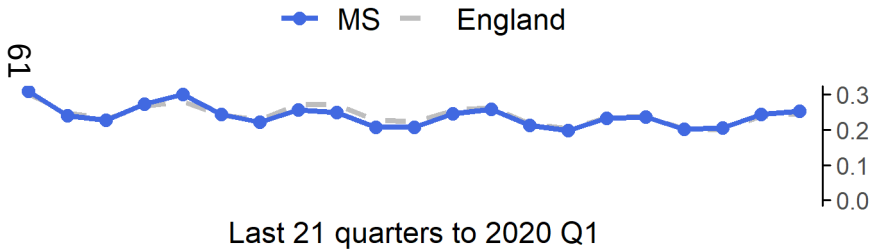
Total number of prescribed antibiotic items per STAR-PU





STAR-PU: Specific Therapeutic group Age-sex weightings Related Prescribing Unit

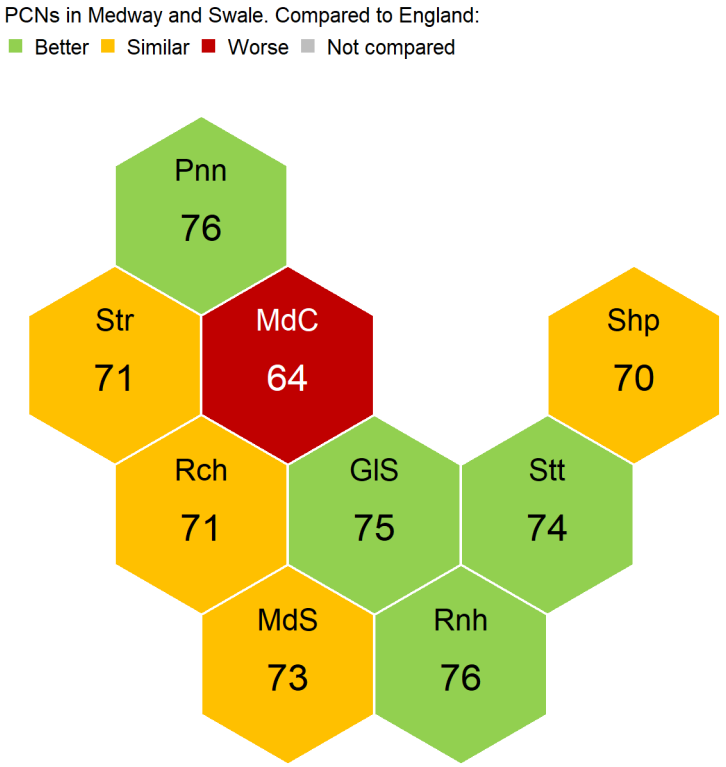
The rate in Medway and Swale is similar to England.

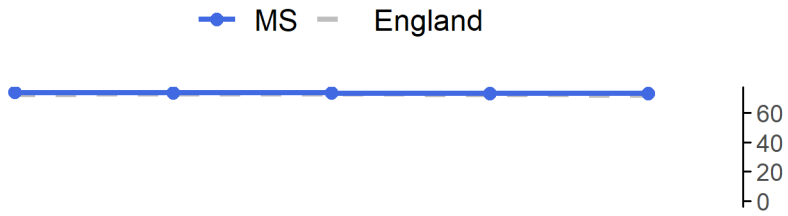


Value type: Indirectly standardised ratio - per STAR-PU
Latest time period: 2020 Q1
Source: PHE, Fingertips, Indicator ID: 91900
ICP value calculation: Small areas averaged
Small area type: Practice to PCN
ICP RAG method: England plus/minus 5%

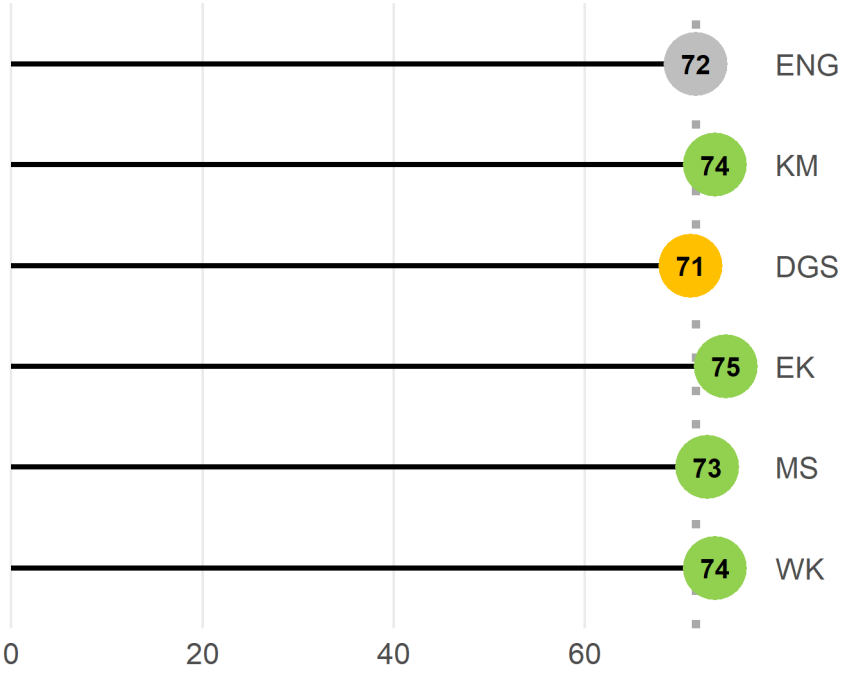
62

Breast cancer screening coverage (females aged 50-70)





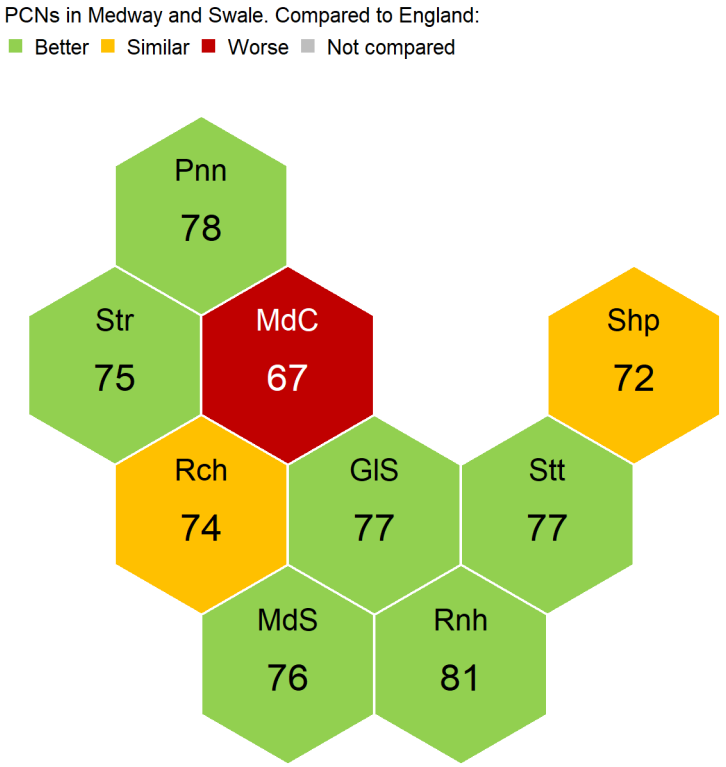
Last 5 years to 2018/19

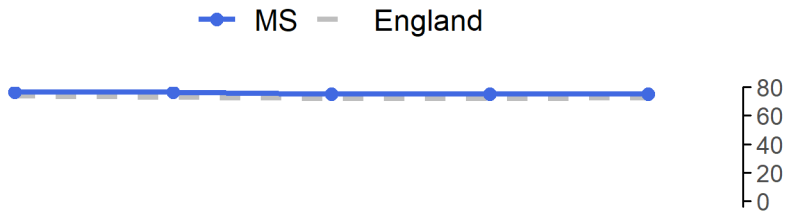


The rate in Medway and Swale is better than England.

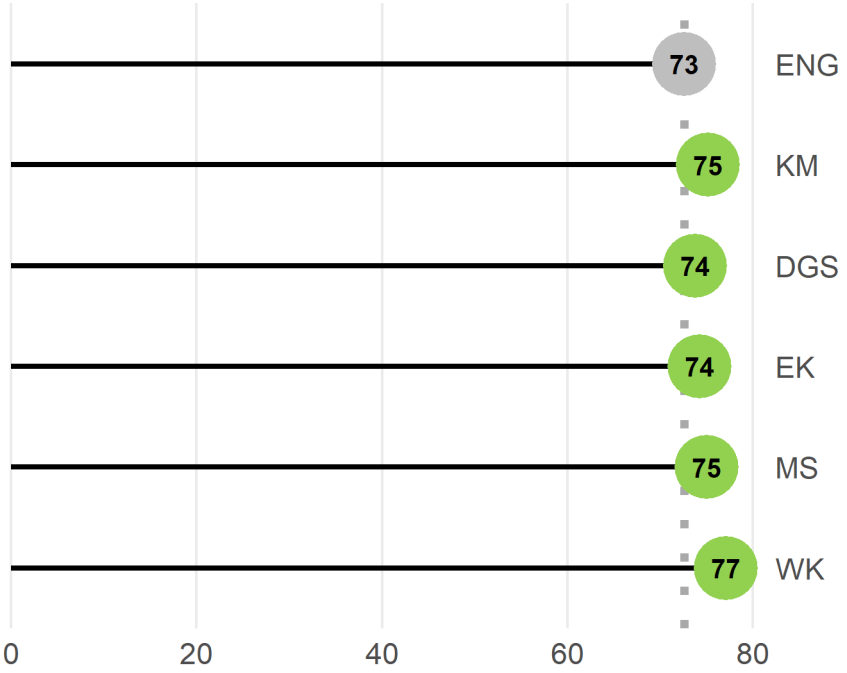
Value type: Proportion - %
Latest time period: 2018/19
Source: PHE, Fingertips, Indicator ID: 91339
ICP value calculation: Aggregated data
Small area type: Practice to PCN
ICP RAG method: Confidence interval (99.8%) - Wilson Score method

Cervical cancer screening coverage (females aged 25-64)





Last 5 years to 2018/19

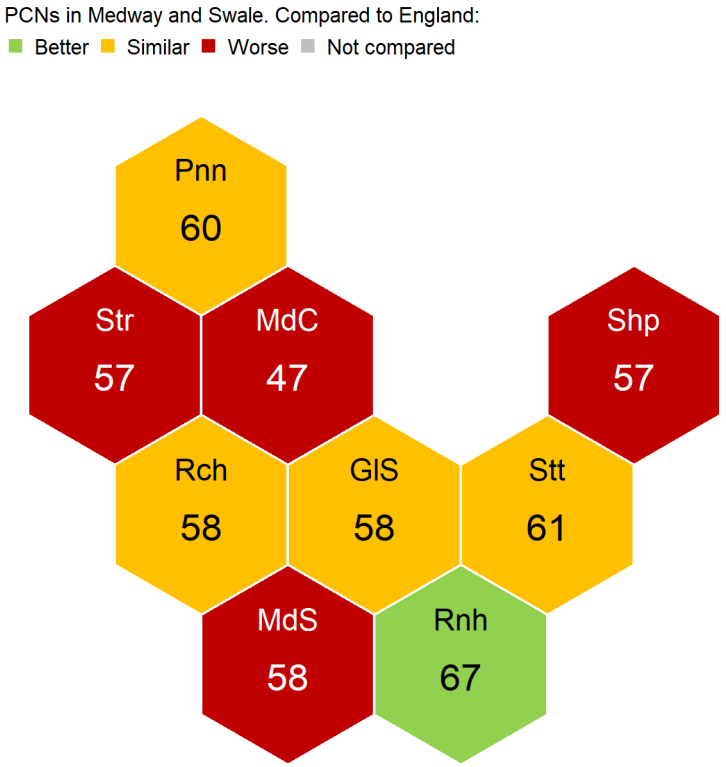


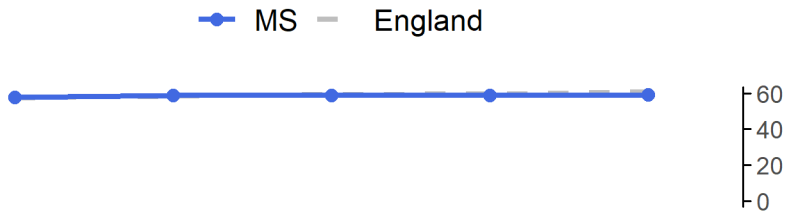
The rate in Medway and Swale is better than England.

Value type: Proportion - %
Latest time period: 2018/19
Source: PHE, Fingertips, Indicator ID: 91341
ICP value calculation: Aggregated data
Small area type: Practice to PCN
ICP RAG method: Confidence interval (99.8%) - Wilson Score method

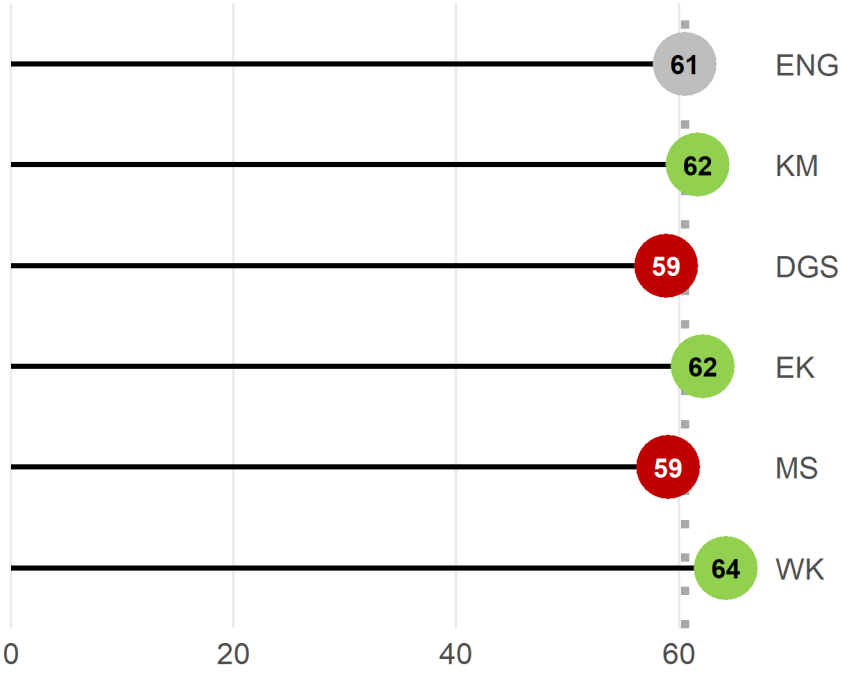
64

Bowel cancer screening coverage (persons aged 60-74)





Last 5 years to 2018/19



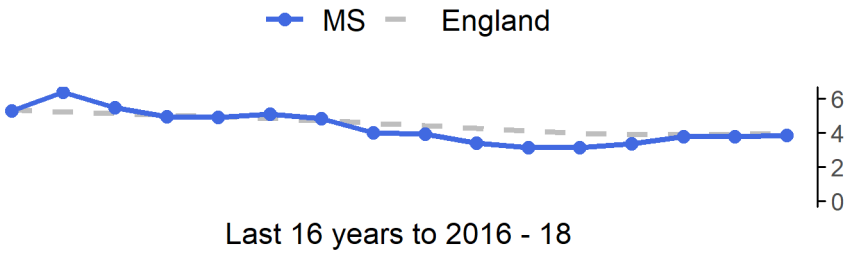
The rate in Medway and Swale is worse than England.

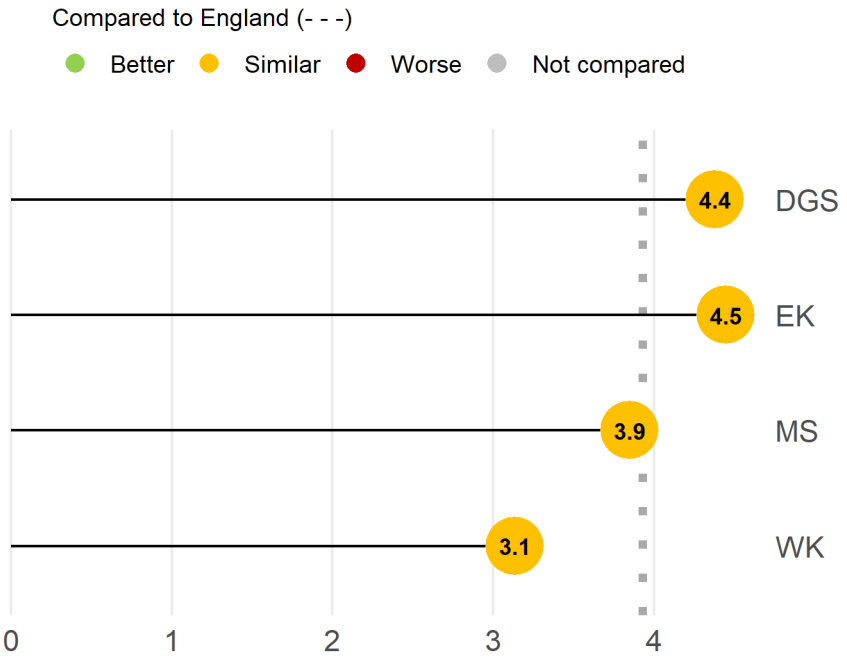
Value type: Proportion - %
Latest time period: 2018/19
Source: PHE, Fingertips, Indicator ID: 92600
ICP value calculation: Aggregated data
Small area type: Practice to PCN
ICP RAG method: Confidence interval (99.8%) - Wilson Score method

BEST START IN LIFE

Infant mortality rate

3.9 ICP: Medway and Swale		3.9 England
		3.9 Kent and Medway
3.6 Medway	4.3 Swale	2016 - 18



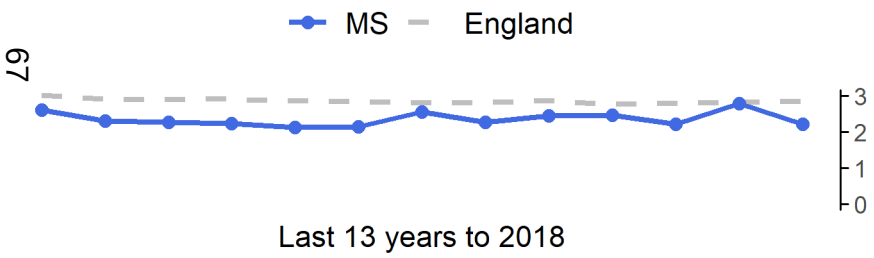


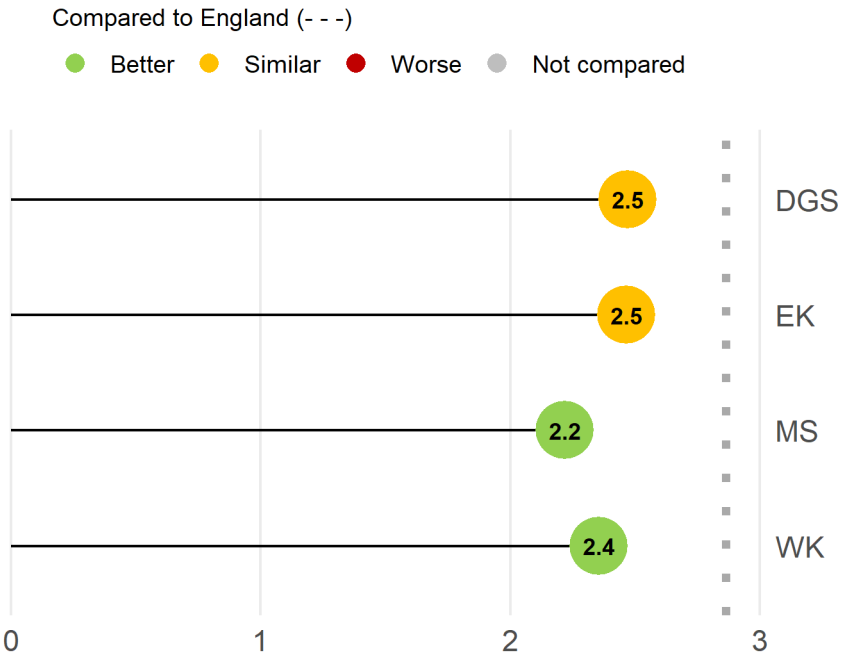
The rate in Medway and Swale is similar to England.

Value type: Crude rate - per 1,000
Latest time period: 2016 - 18
Source: PHE, Fingertips, Indicator ID: 92196
ICP value calculation: Aggregated data
Small area type: District & UA (4/19-3/20)
ICP RAG method: Confidence interval (95%) - Byar's method

Low birth weight of term babies

2.2 ICP: Medway and Swale		2.9 England
		2.4 Kent and Medway
2.4 Medway	1.8 Swale	2018



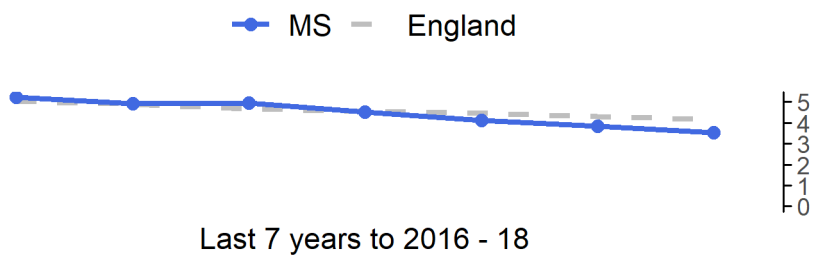


The rate in Medway and Swale is better than England.

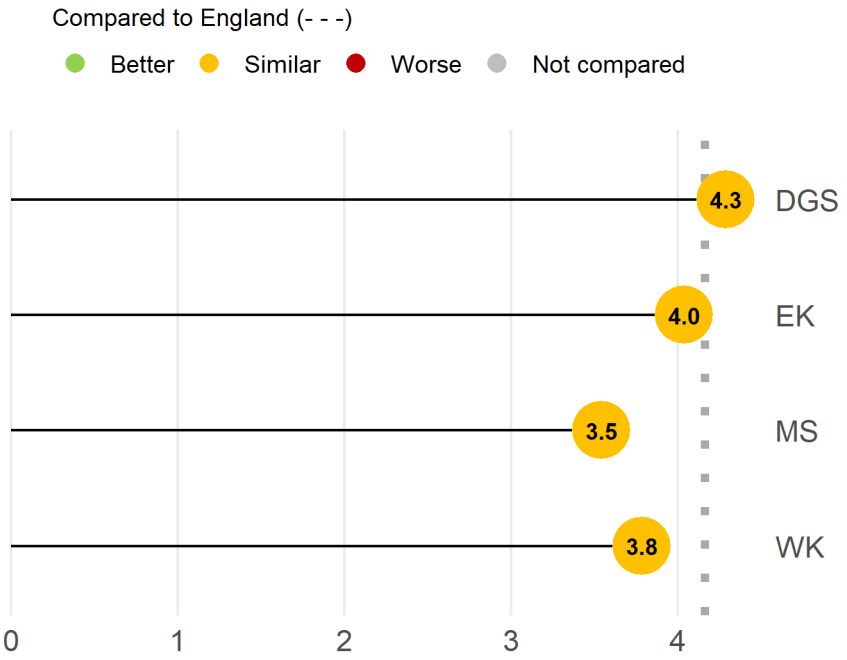
Value type: Proportion - %
Latest time period: 2018
Source: PHE, Fingertips, Indicator ID: 20101
ICP value calculation: Aggregated data
Small area type: District & UA (4/19-3/20)
ICP RAG method: Confidence interval (95%) - Wilson Score method

Stillbirth rate

3.5 ICP: Medway and Swale		4.2 England
		3.9 Kent and Medway
4.1 Medway	2.2 Swale	2016 - 18



Last 7 years to 2016 - 18

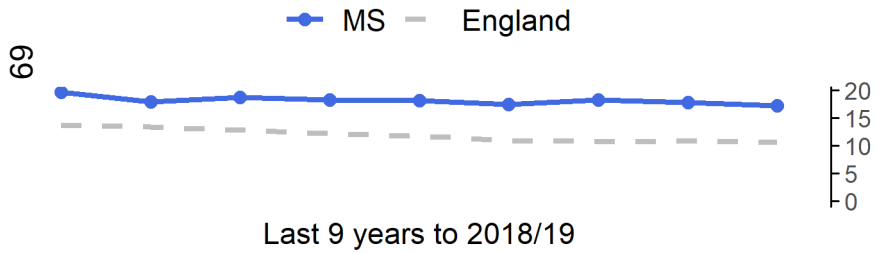


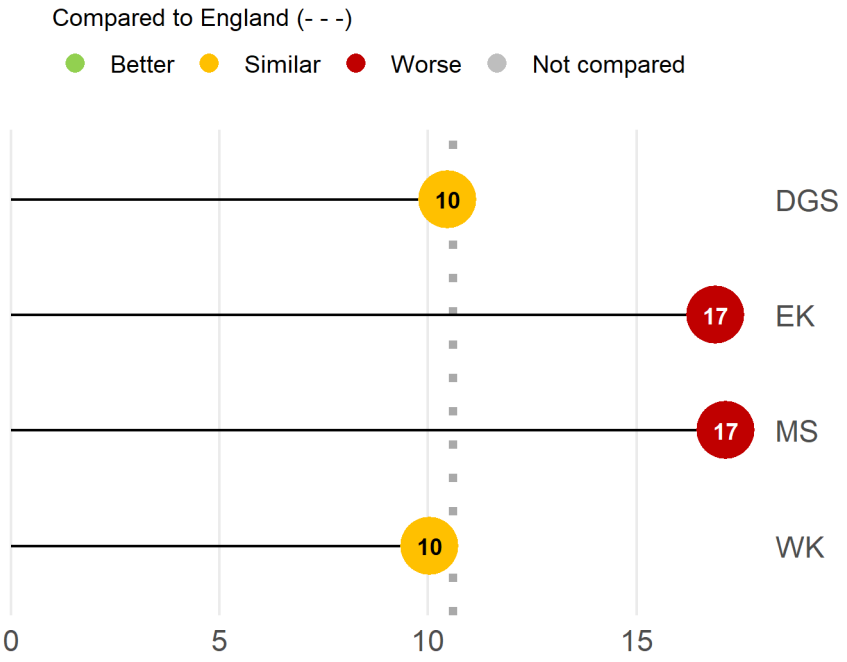
The rate in Medway and Swale is similar to England.

Value type: Crude rate - per 1,000
Latest time period: 2016 - 18
Source: PHE, Fingertips, Indicator ID: 92530
ICP value calculation: Aggregated data
Small area type: CCGs (2019/20)
ICP RAG method: Confidence interval (95%) - Byar's method

Smoking status at time of delivery

17		11
ICP: Medway and Swale		England
		14
		Kent and Medway
16	20	2018/19
Medway	Swale	



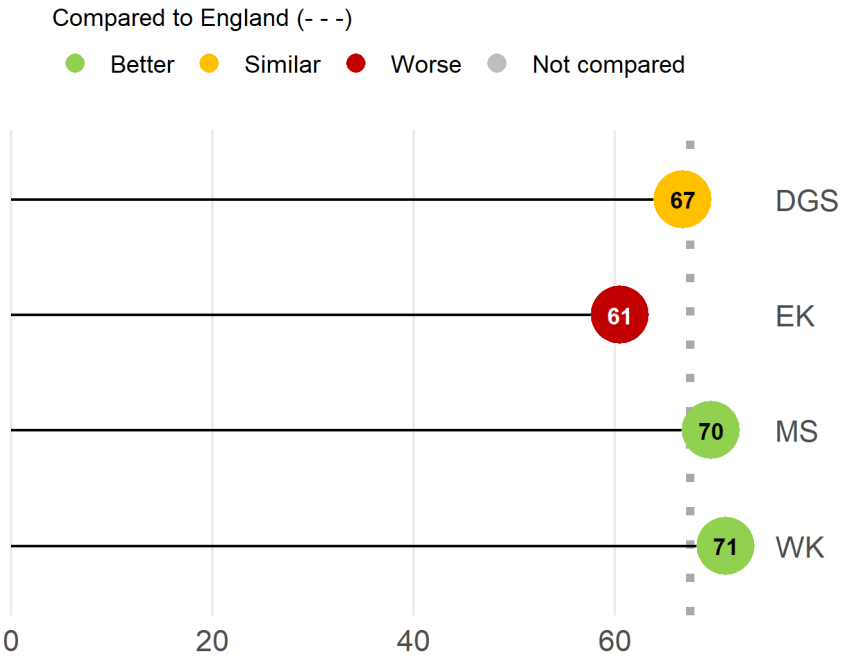


The rate in Medway and Swale is worse than England.

Value type: Proportion - %
Latest time period: 2018/19
Source: PHE, Fingertips, Indicator ID: 93085
ICP value calculation: Aggregated data
Small area type: District & UA (4/19-3/20)
ICP RAG method: Confidence interval (95%) - Wilson Score method

Baby's first feed breastmilk

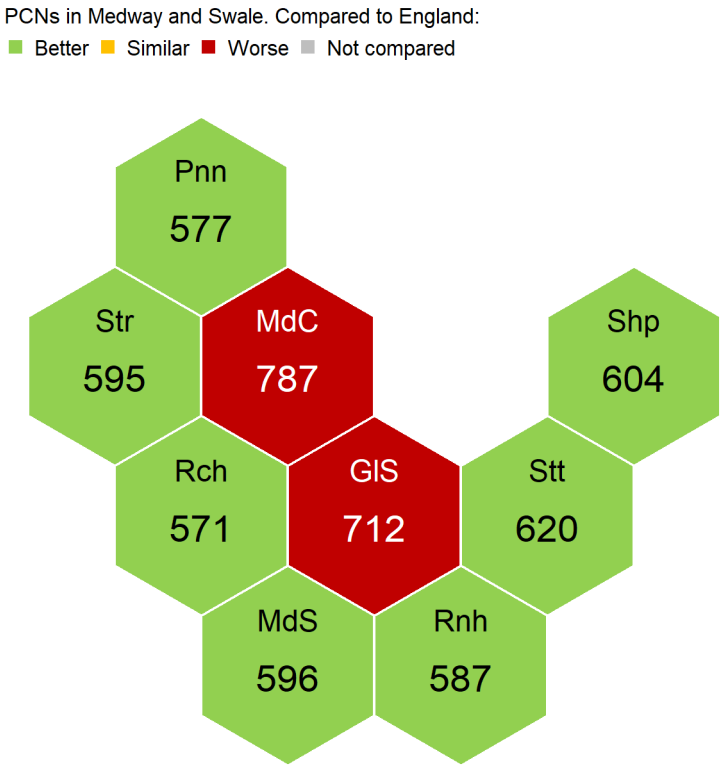
70 ICP: Medway and Swale		67 England
		67 Kent and Medway
71 Medway	65 Swale	2018/19

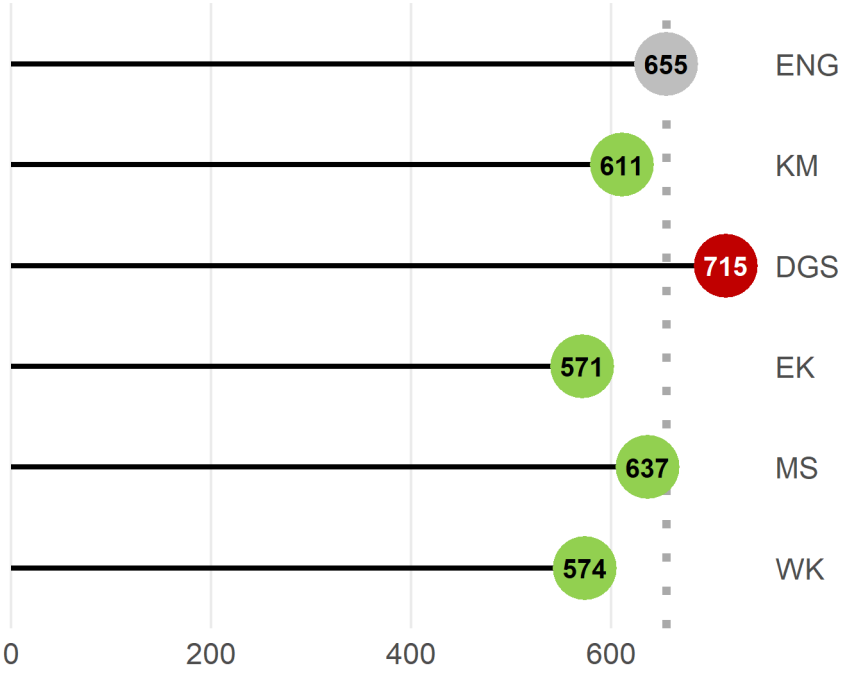


The rate in Medway and Swale is better than England.

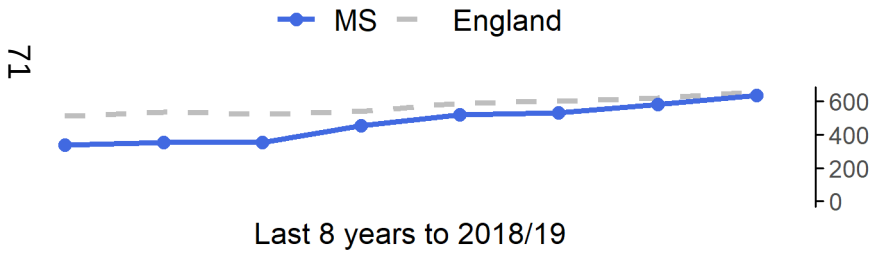
Value type: Proportion - %
Latest time period: 2018/19
Source: PHE, Fingertips, Indicator ID: 93614
ICP value calculation: Aggregated data
Small area type: CCGs (2019/20)
ICP RAG method: Confidence interval (95%) - Wilson Score method

AE attendances (0-4 years)





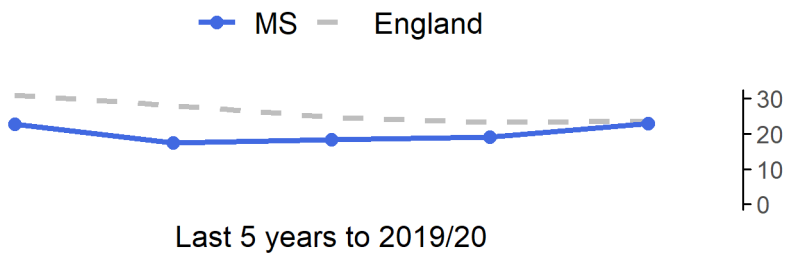
The rate in Medway and Swale is better than England.

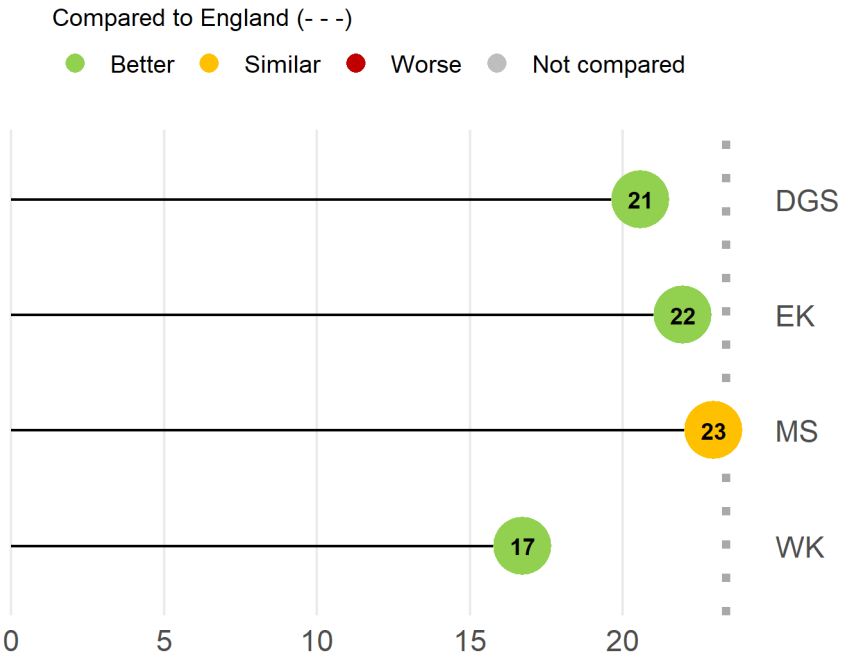


Value type: Crude rate per 1,000
Latest time period: 2018/19
Source: Hospital Episode Statistics (HES), NHS Digital
ICP value calculation: Aggregated data
Small area type: LSOA to PCN
ICP RAG method: Confidence interval (95%) - Byar's method

Percentage of 5 year olds with experience of visually obvious dental decay

23 ICP: Medway and Swale		23 England
		20 Kent and Medway
25 Medway	20 Swale	2019/20



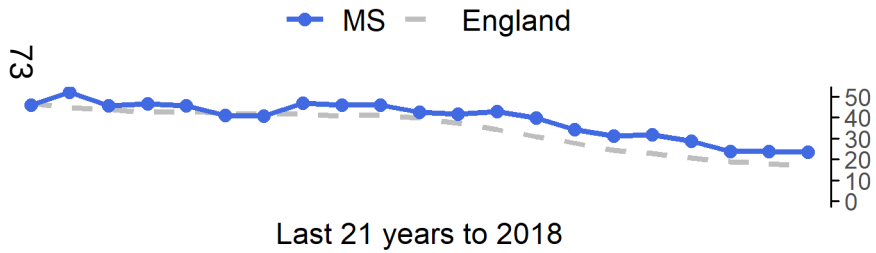


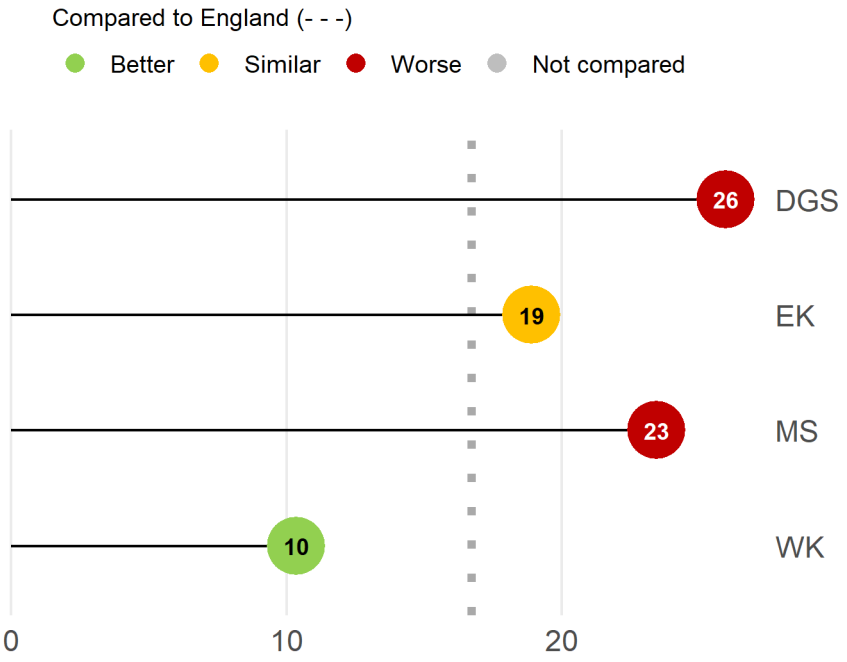
The rate in Medway and Swale is similar to England.

Value type: Proportion - %
Latest time period: 2019/20
Source: PHE, Fingertips, Indicator ID: 93563
ICP value calculation: Small areas averaged
Small area type: District & UA (pre 4/19)
ICP RAG method: England plus/minus 5%

Under 18s conception rate / 1,000

23 ICP: Medway and Swale		17 England
		18 Kent and Medway
23 Medway	24 Swale	2018



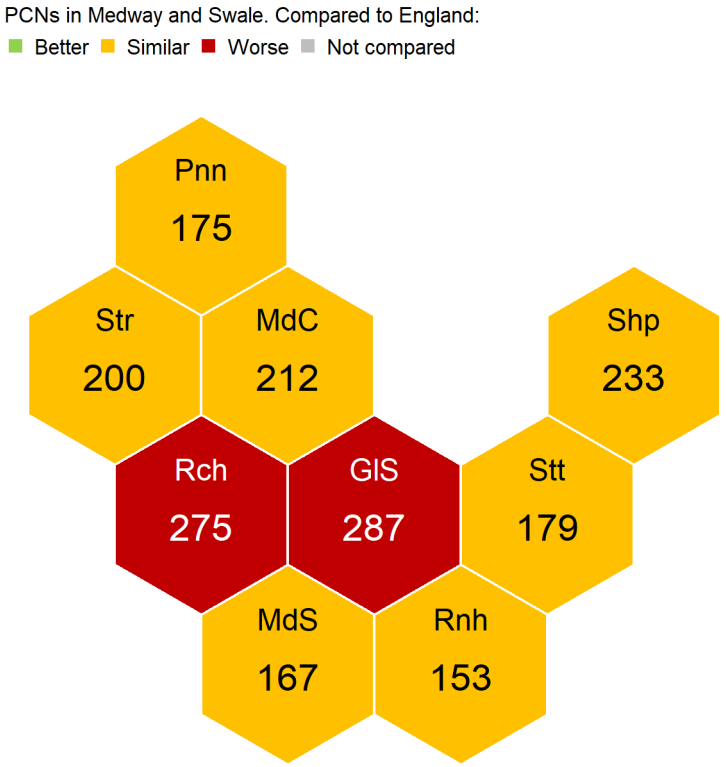


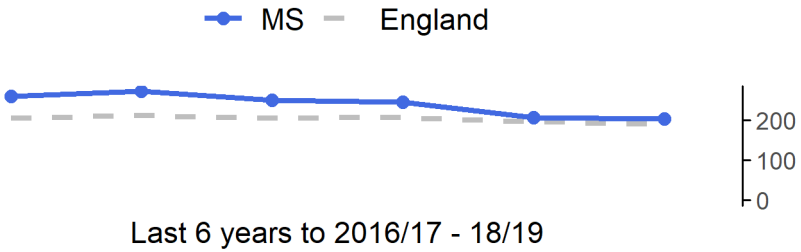
The rate in Medway and Swale is worse than England.

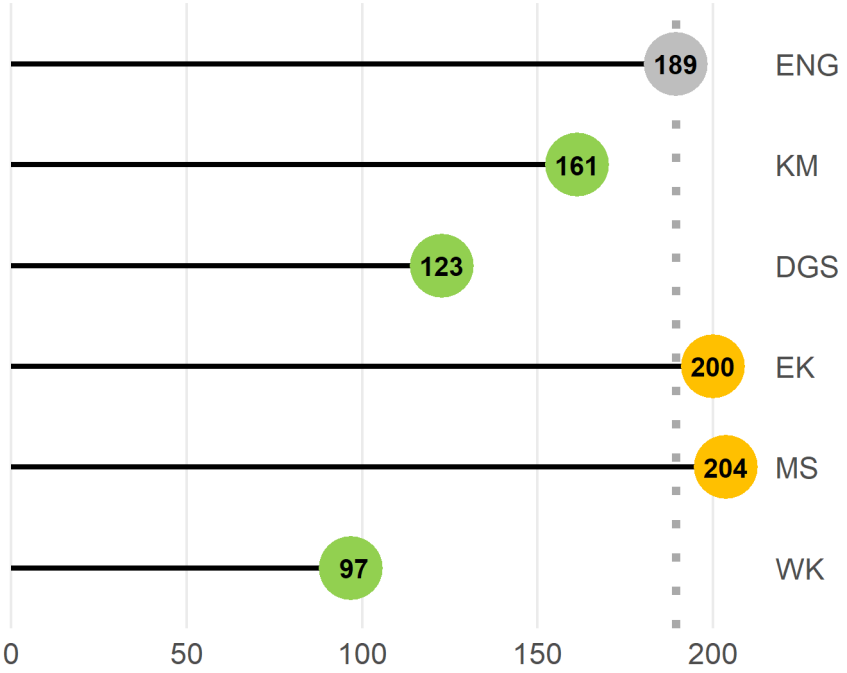
Value type: Crude rate - per 1,000
Latest time period: 2018
Source: PHE, Fingertips, Indicator ID: 20401
ICP value calculation: Aggregated data
Small area type: District & UA (4/19-3/20)
ICP RAG method: Confidence interval (95%) - Byar's method

74

Emergency hospital admissions for asthma (< 19 yrs)





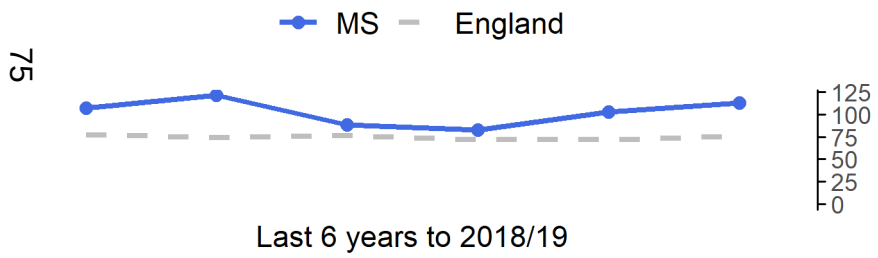


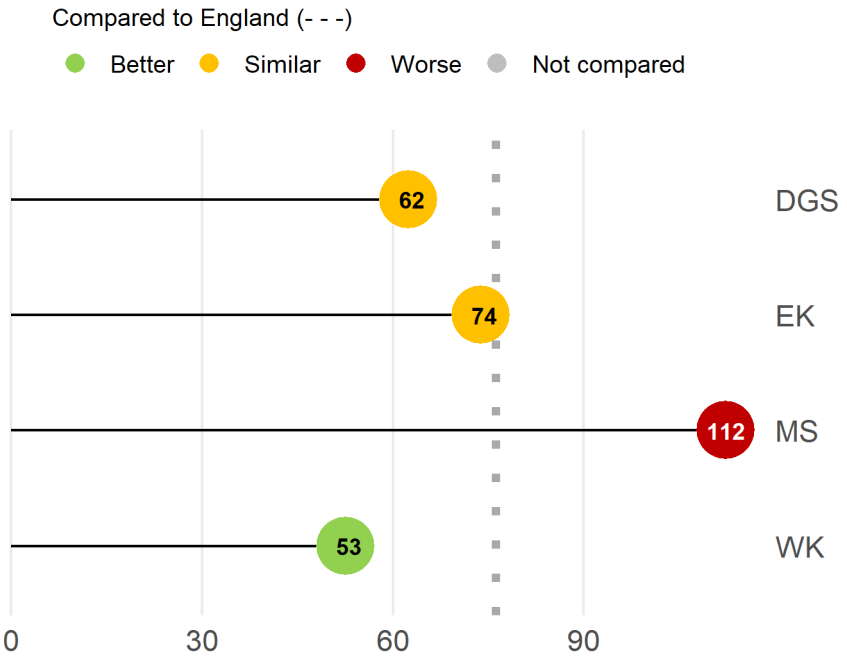
The rate in Medway and Swale is similar to England.

Value type: Crude rate - per 100,000
Latest time period: 2016/17 - 18/19
Source: Hospital Episode Statistics (HES), NHS Digital
ICP value calculation: Aggregated data
Small area type: LSOA to PCN
ICP RAG method: Confidence interval (95%) - Byar's method

Emergency hospital admissions for epilepsy (< 19 yrs)

112		76
ICP: Medway and Swale		England
		75
		Kent and Medway
105	131	2018/19
Medway	Swale	



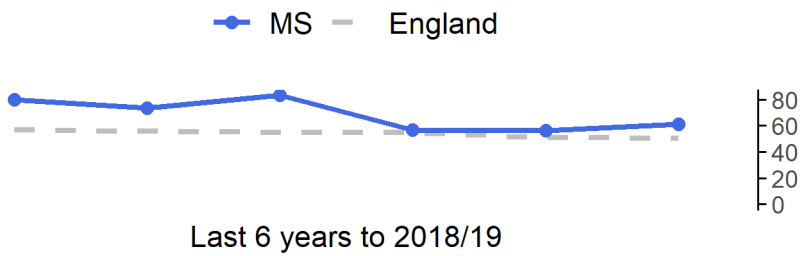


The rate in Medway and Swale is worse than England.

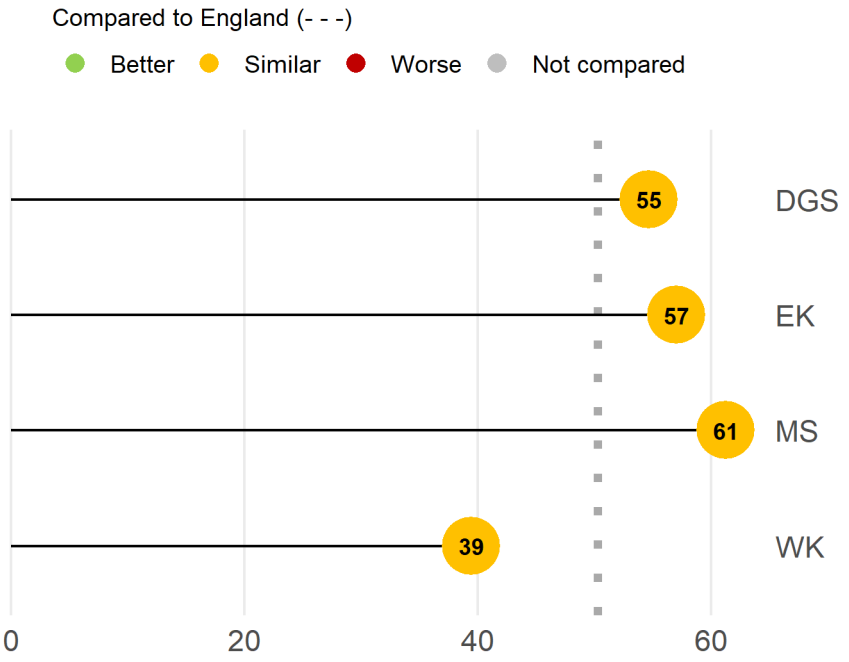
Value type: Crude rate - per 100,000
Latest time period: 2018/19
Source: PHE, Fingertips, Indicator ID: 93142
ICP value calculation: Aggregated data
Small area type: CCGs (2019/20)
ICP RAG method: Confidence interval (95%) - Byar's method

Emergency hospital admissions for diabetes (< 19 yrs)

61 ICP: Medway and Swale		50 England
		53 Kent and Medway
56 Medway	75 Swale	2018/19



Last 6 years to 2018/19

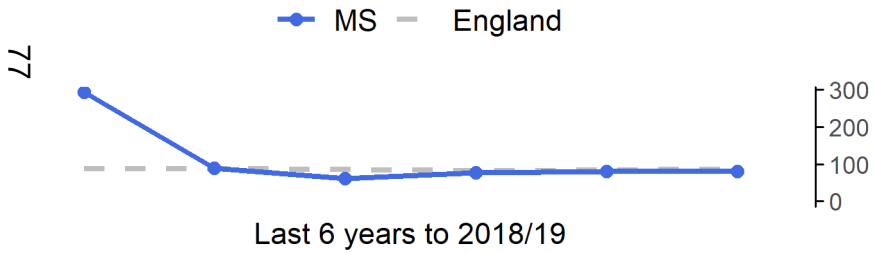


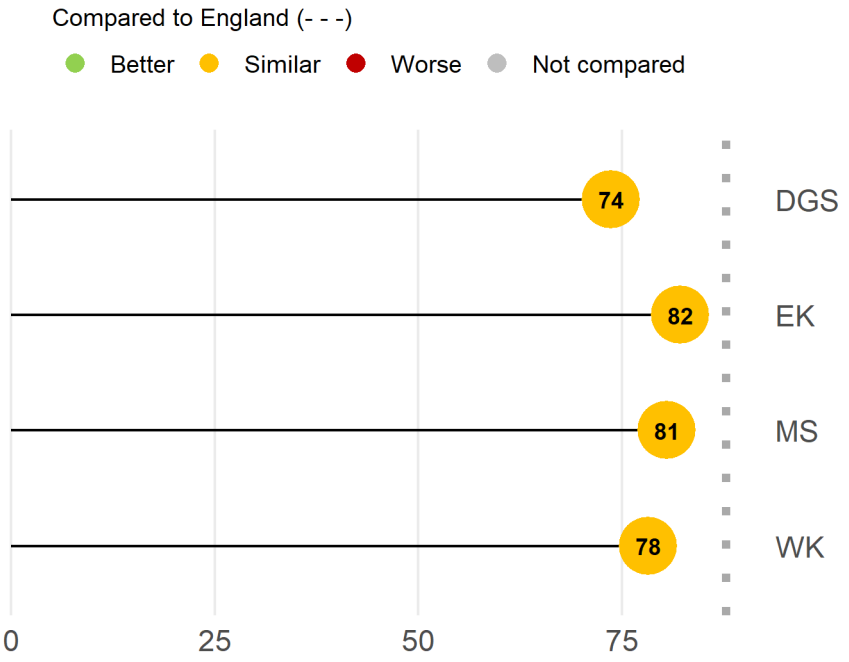
The rate in Medway and Swale is similar to England.

Value type: Crude rate - per 100,000
Latest time period: 2018/19
Source: PHE, Fingertips, Indicator ID: 93140
ICP value calculation: Aggregated data
Small area type: CCGs (2019/20)
ICP RAG method: Confidence interval (95%) - Byar's method

Hospital admissions for mental health conditions (0-17 years)

81 ICP: Medway and Swale		88 England
		79 Kent and Medway
81 Medway	78 Swale	2018/19

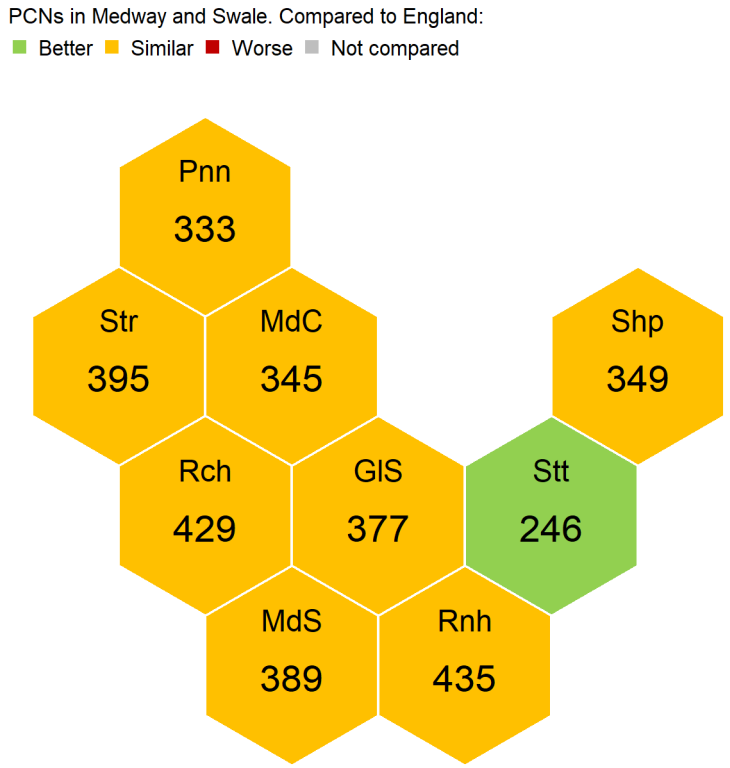


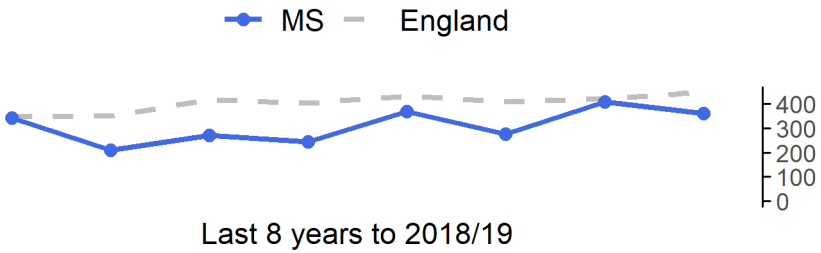


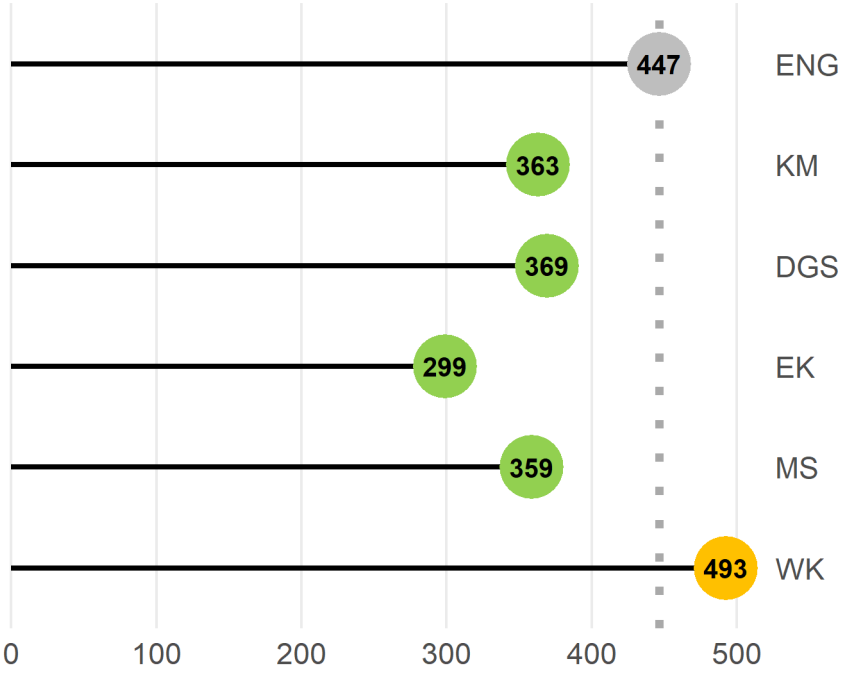
The rate in Medway and Swale is similar to England.

Value type: Crude rate - per 100,000
Latest time period: 2018/19
Source: PHE, Fingertips, Indicator ID: 92761
ICP value calculation: Aggregated data
Small area type: CCGs (2019/20)
ICP RAG method: Confidence interval (95%) - Byar's method

Hospital admissions as a result of self-harm (10-24 years)





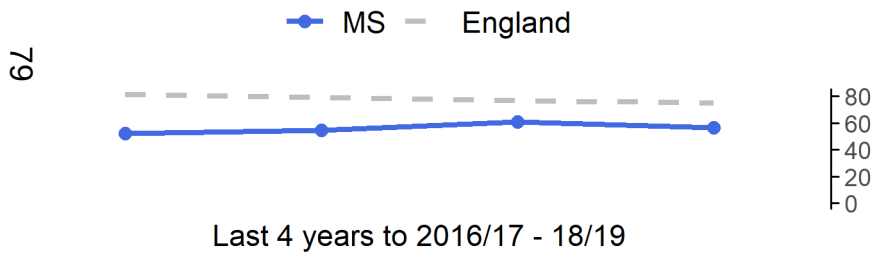


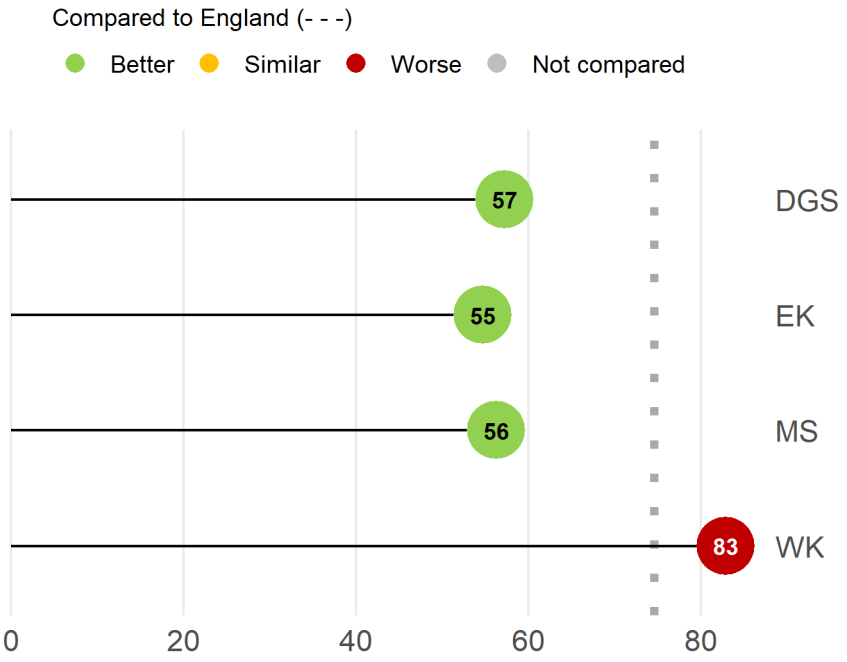
The rate in Medway and Swale is better than England.

Value type: Directly standardised rate
Latest time period: 2018/19
Source: Hospital Episode Statistics (HES), NHS Digital
ICP value calculation: Aggregated data
Small area type: LSOA to PCN
ICP RAG method: Confidence interval (95%) - Dobson's method

Hospital admissions due to substance misuse (15-24 years)

56		75
ICP: Medway and Swale		England
		59
		Kent and Medway
64	49	2016/17 - 18/19
Medway	Swale	



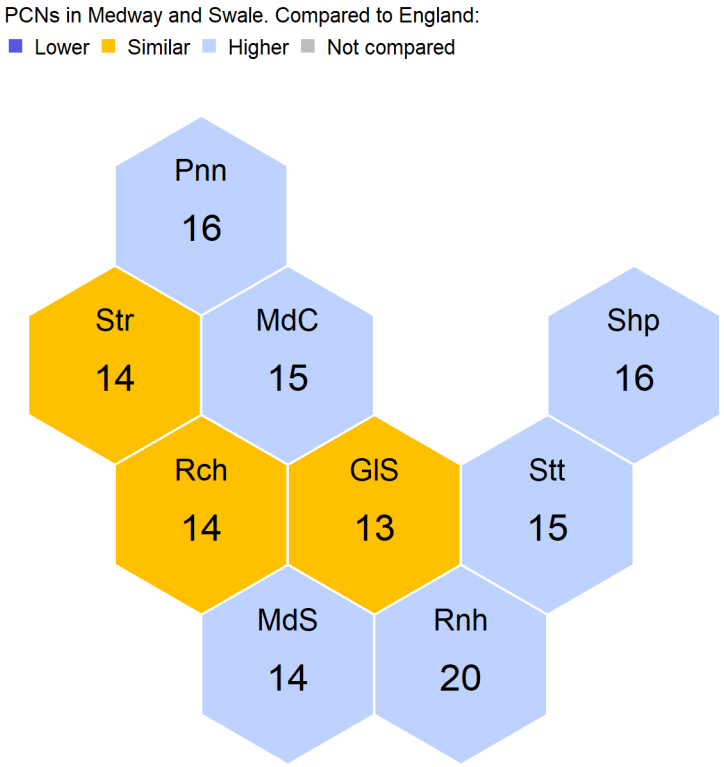


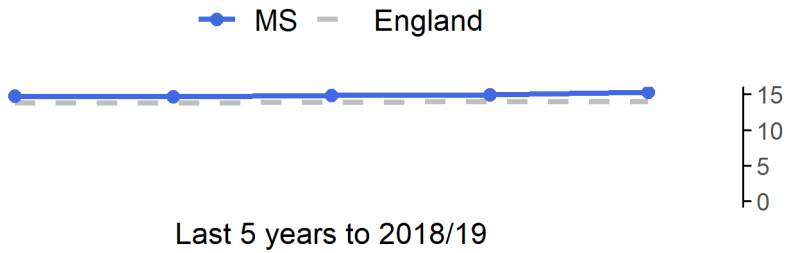
The rate in Medway and Swale is better than England.

Value type: Directly standardised rate - per 100,000
Latest time period: 2016/17 - 18/19
Source: PHE, Fingertips, Indicator ID: 92755
ICP value calculation: Small areas averaged
Small area type: CCGs (2019/20)
ICP RAG method: England plus/minus 5%

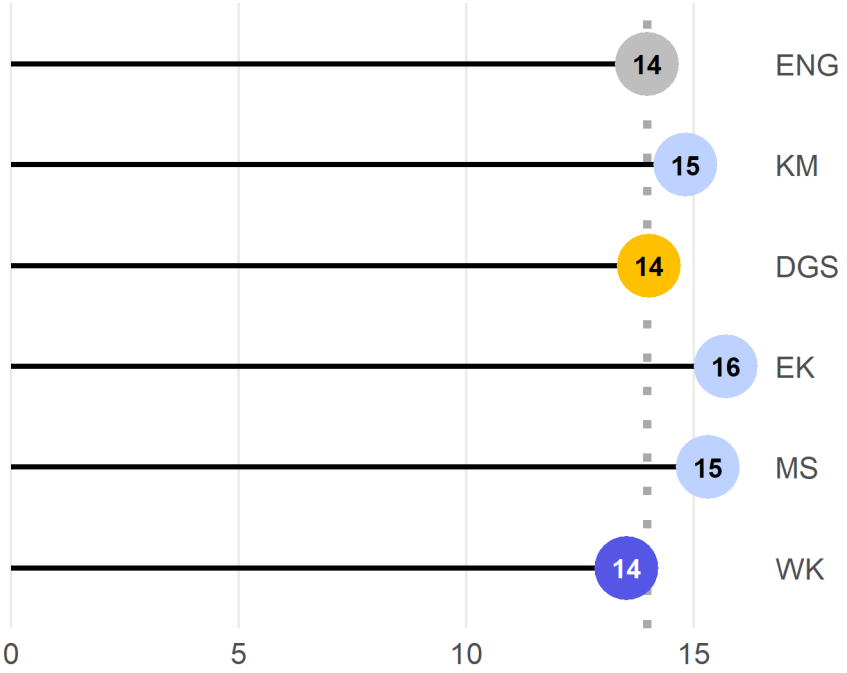
MAJOR HEALTH CONDITIONS

Hypertension: QOF prevalence (all ages)





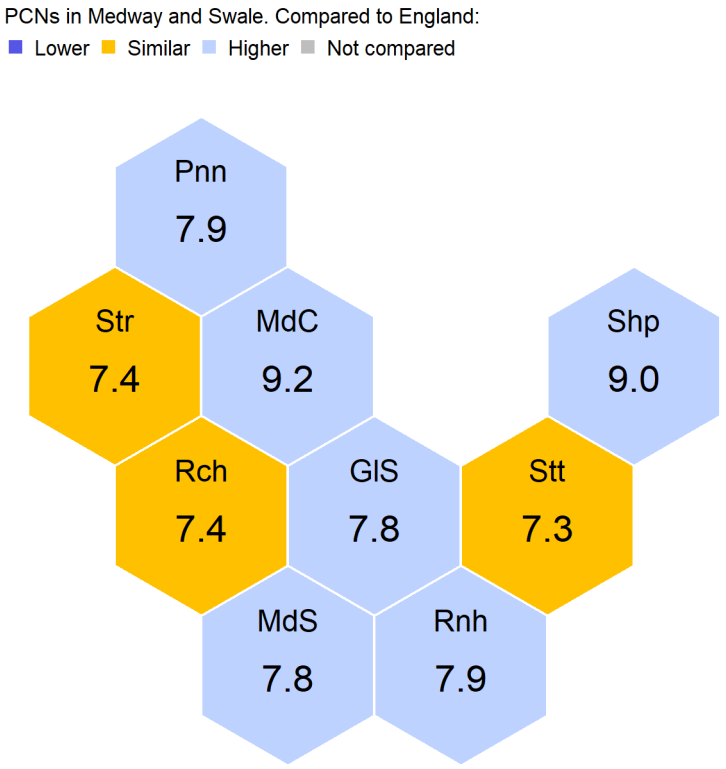
Last 5 years to 2018/19

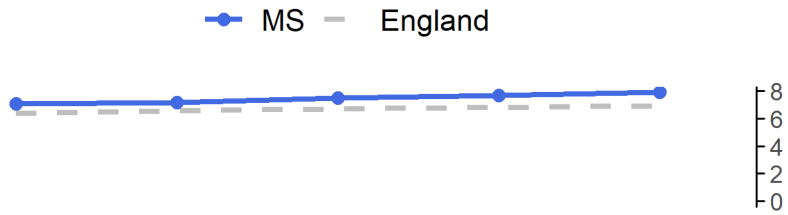


The rate in Medway and Swale is higher than England.

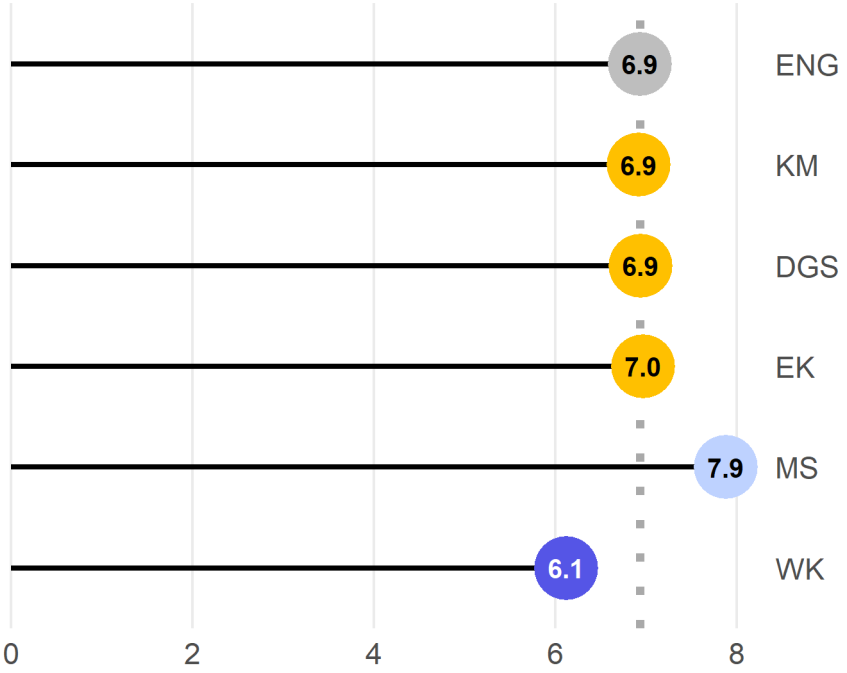
Value type: Proportion - %
Latest time period: 2018/19
Source: PHE, Fingertips, Indicator ID: 219
ICP value calculation: Aggregated data
Small area type: Practice to PCN
ICP RAG method: Confidence interval (99.8%) - Wilson Score method

Diabetes: QOF prevalence (17+)





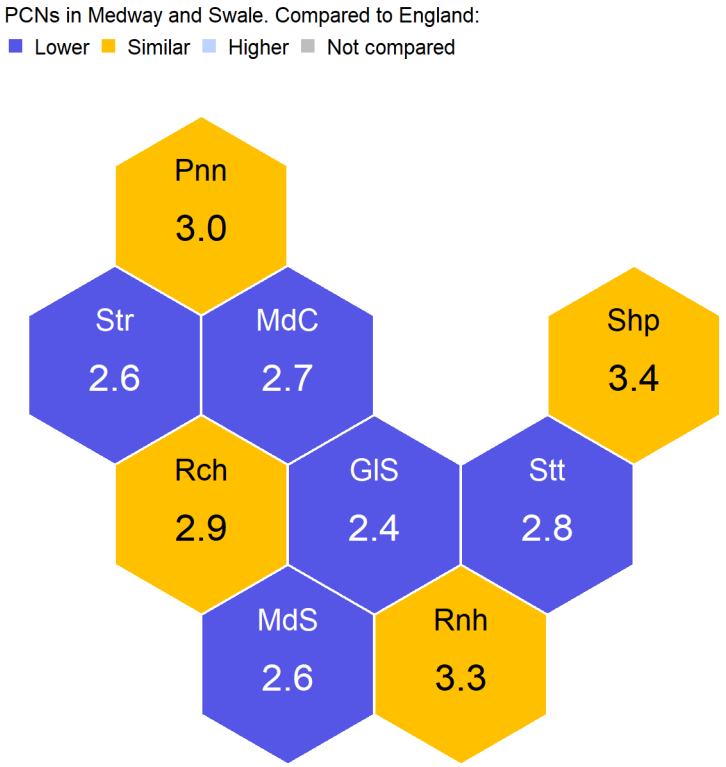
Last 5 years to 2018/19

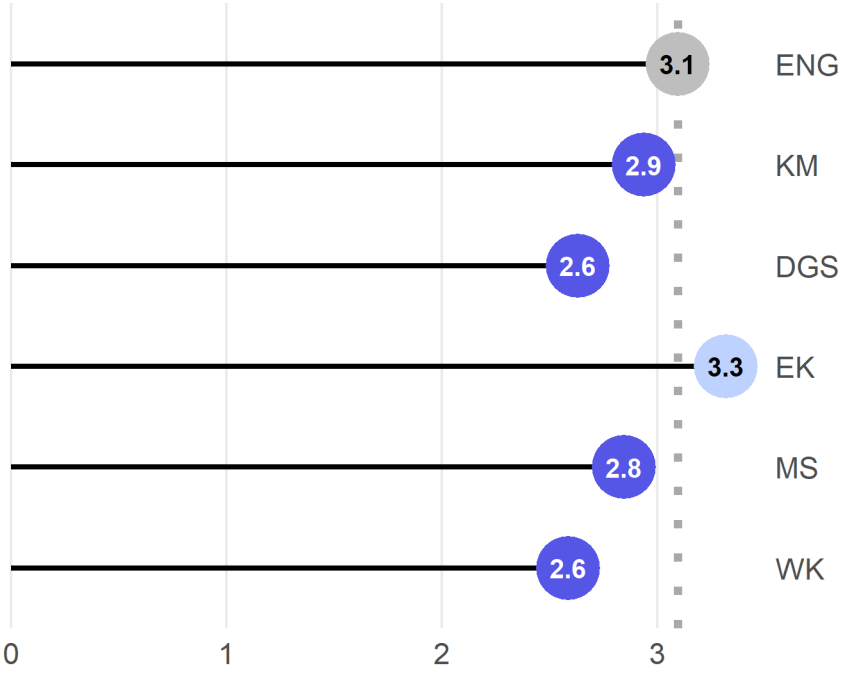


The rate in Medway and Swale is higher than England.

Value type: Proportion - %
Latest time period: 2018/19
Source: PHE, Fingertips, Indicator ID: 241
ICP value calculation: Aggregated data
Small area type: Practice to PCN
ICP RAG method: Confidence interval (99.8%) - Wilson Score method

CHD: QOF prevalence (all ages)



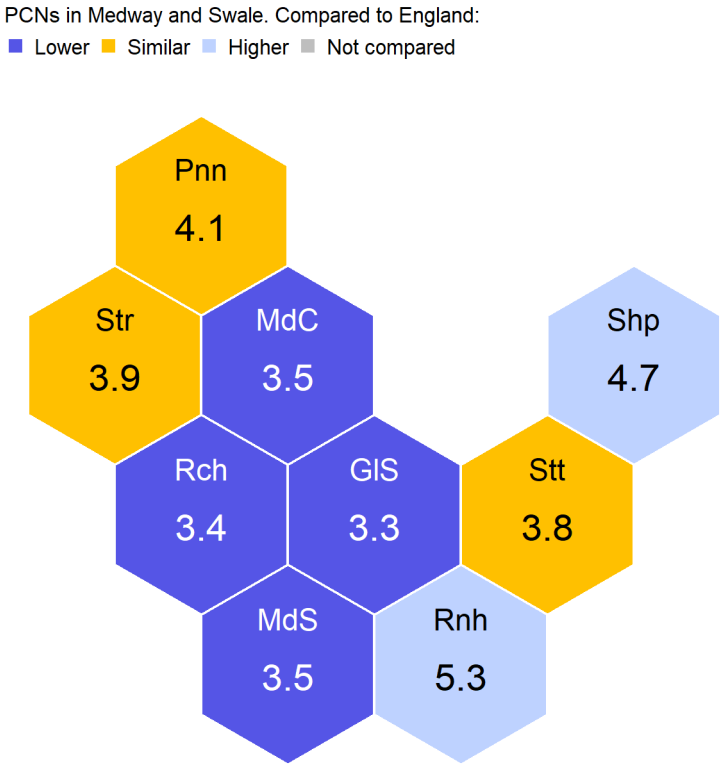


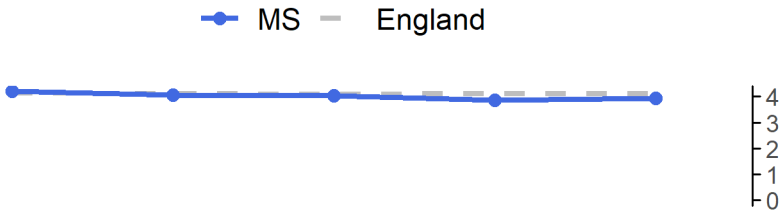
The rate in Medway and Swale is lower than England.

Value type: Proportion - %
Latest time period: 2018/19
Source: PHE, Fingertips, Indicator ID: 273
ICP value calculation: Aggregated data
Small area type: Practice to PCN
ICP RAG method: Confidence interval (99.8%) - Wilson Score method

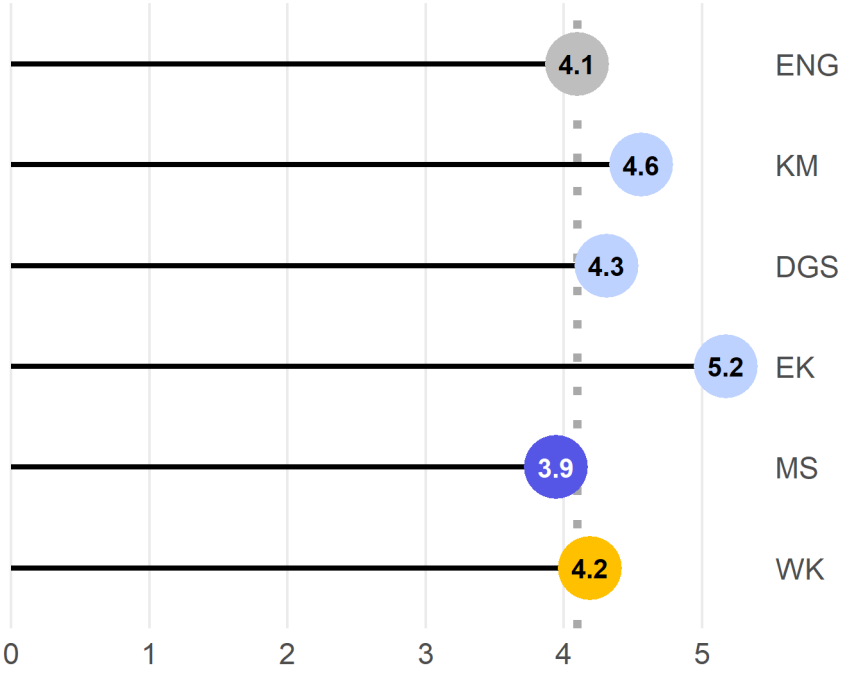
84

CKD: QOF prevalence (18+)





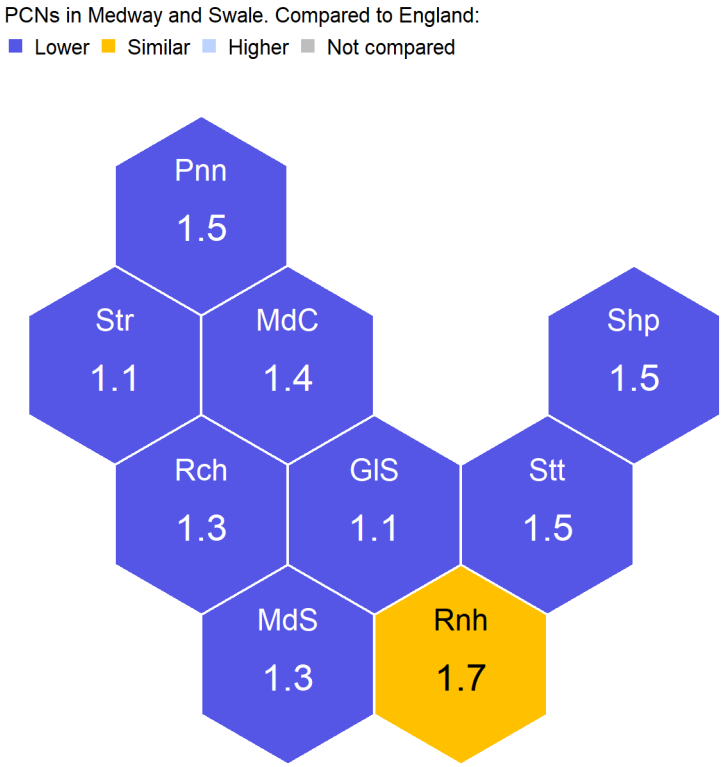
Last 5 years to 2018/19

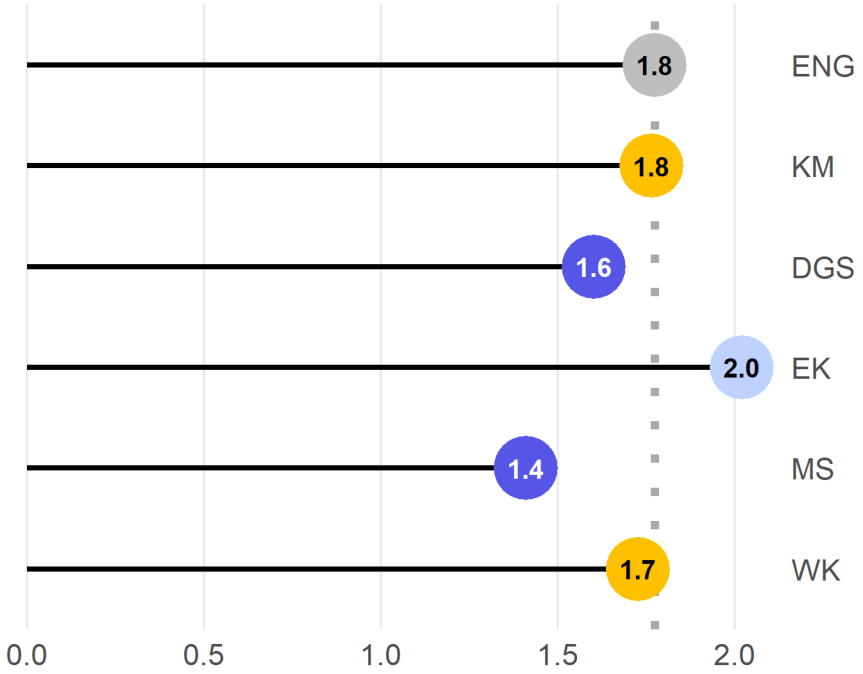


The rate in Medway and Swale is lower than England.

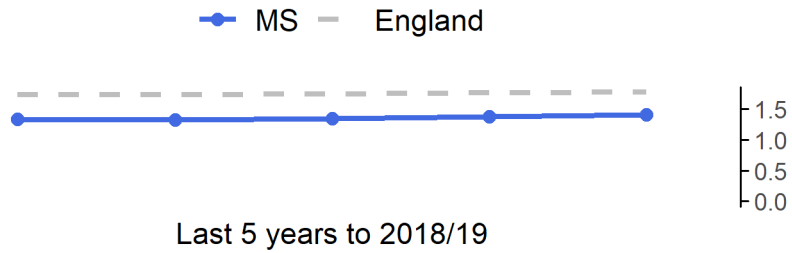
Value type: Proportion - %
Latest time period: 2018/19
Source: PHE, Fingertips, Indicator ID: 258
ICP value calculation: Aggregated data
Small area type: Practice to PCN
ICP RAG method: Confidence interval (99.8%) - Wilson Score method

Stroke: QOF prevalence (all ages)



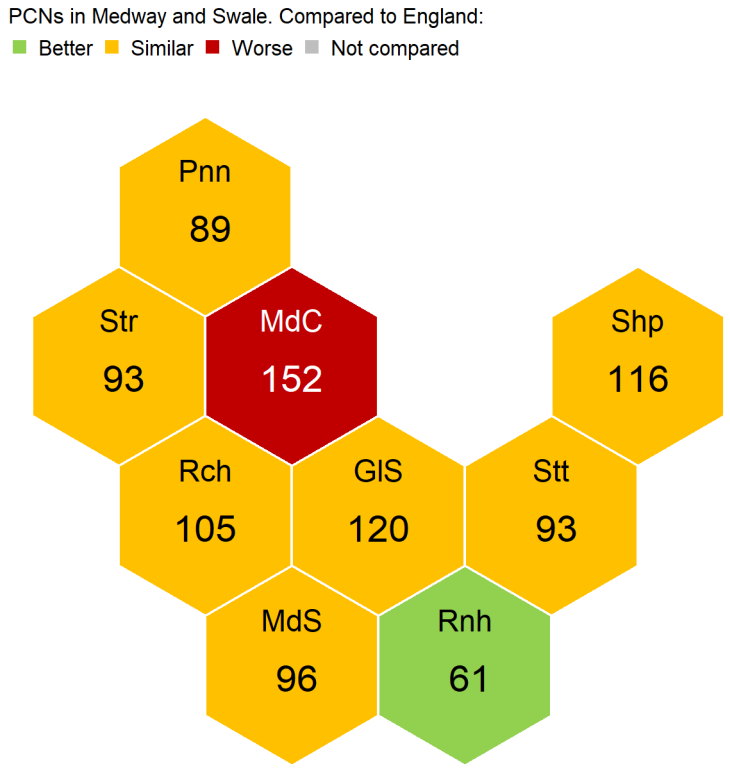


The rate in Medway and Swale is lower than England.

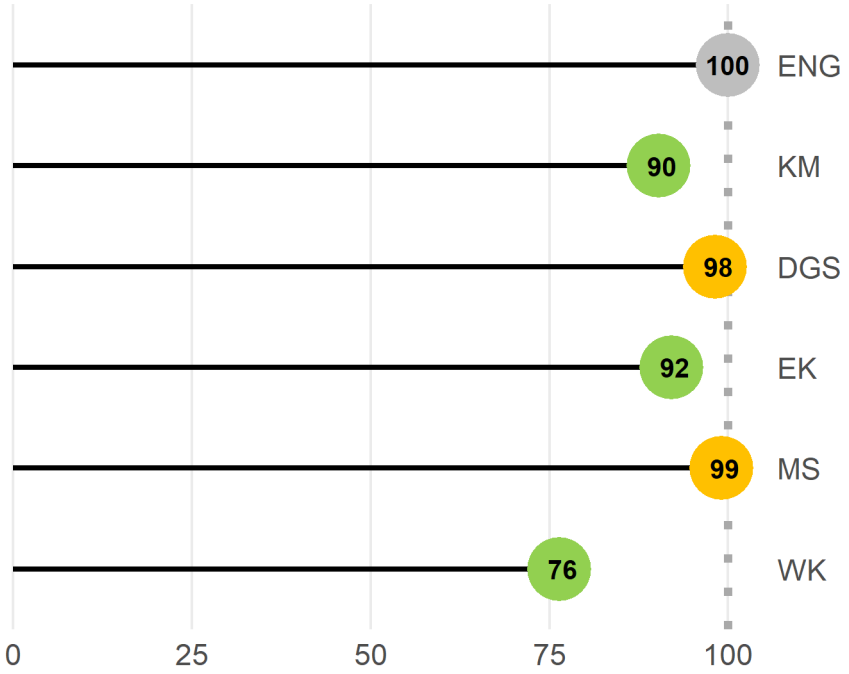


Value type: Proportion - %
Latest time period: 2018/19
Source: PHE, Fingertips, Indicator ID: 212
ICP value calculation: Aggregated data
Small area type: Practice to PCN
ICP RAG method: Confidence interval (99.8%) - Wilson Score method

Deaths from circulatory disease, under 75 years



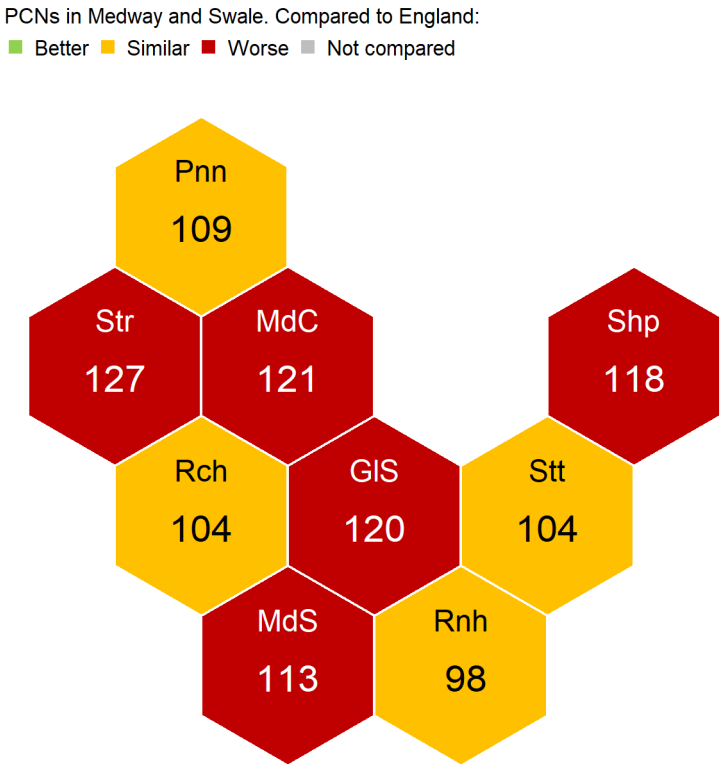
Trend data not available.

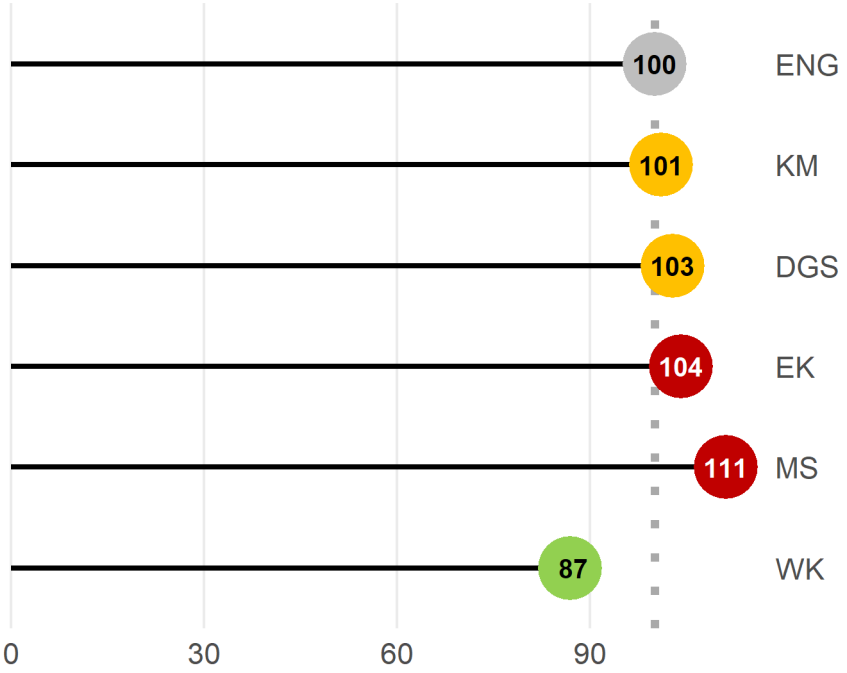


The rate in Medway and Swale is similar to England.

Value type: Indirectly standardised ratio per 100
Latest time period: 2013 - 17
Source: PHE, Fingertips, Indicator ID: 93256
ICP value calculation: Aggregated data
Small area type: Ward to PCN
ICP RAG method: Confidence interval (95%) - Byar's method

Deaths from all cancer, under 75 years





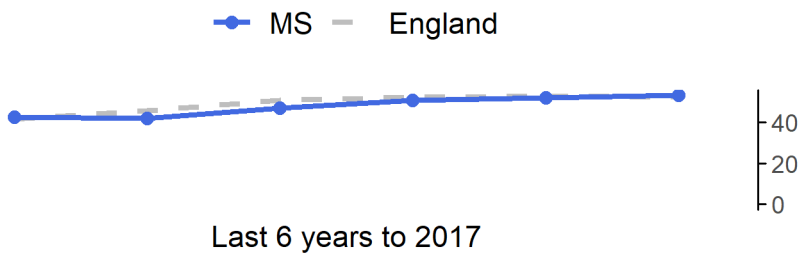
The rate in Medway and Swale is worse than England.

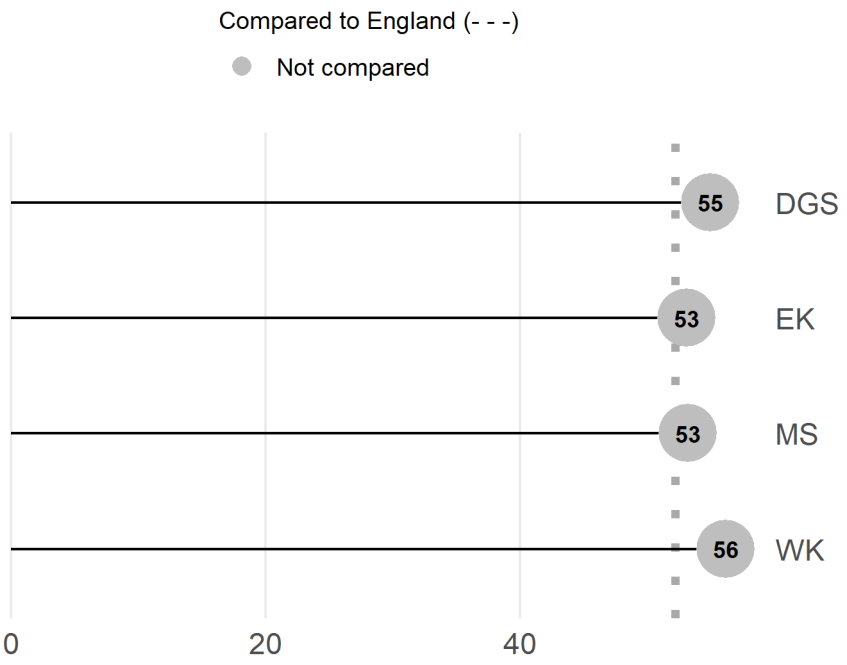
Trend data not available.

Value type: Indirectly standardised ratio per 100
Latest time period: 2013 - 17
Source: PHE, Fingertips, Indicator ID: 93254
ICP value calculation: Aggregated data
Small area type: Ward to PCN
ICP RAG method: Confidence interval (95%) - Byar's method

Cancer diagnosed at early stage (experimental statistics)

53 ICP: Medway and Swale		52 England
		54 Kent and Medway
49 Medway	59 Swale	2017

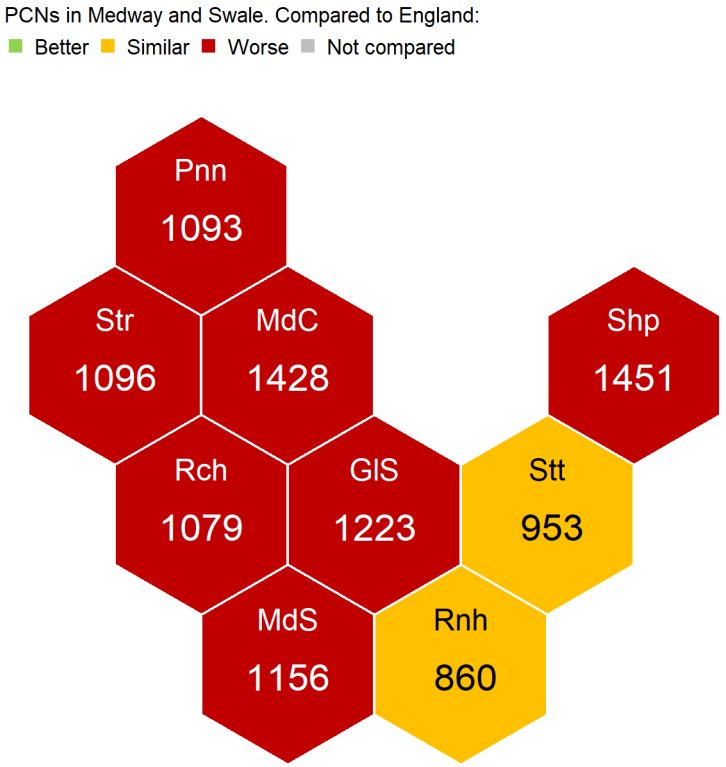


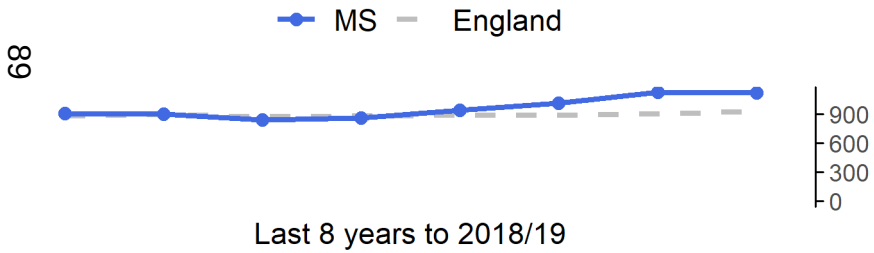


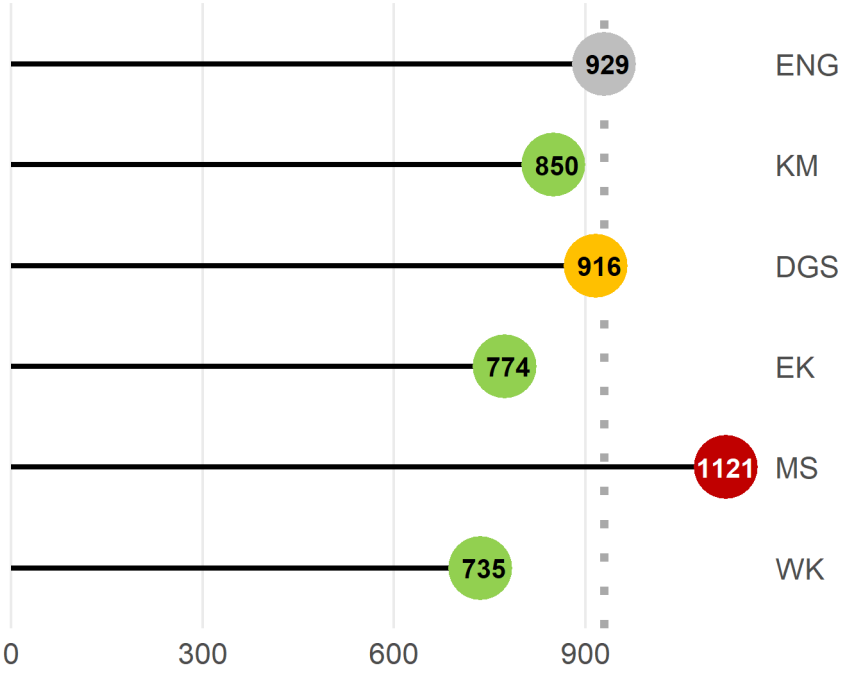
Medway and Swale cannot be compared to England statistically.

Value type: Proportion - %
Latest time period: 2017
Source: PHE, Fingertips, Indicator ID: 90834
ICP value calculation: Aggregated data
Small area type: District & UA (4/19-3/20)
ICP RAG method: None applied

Unplanned hospitalisation for chronic ACSC



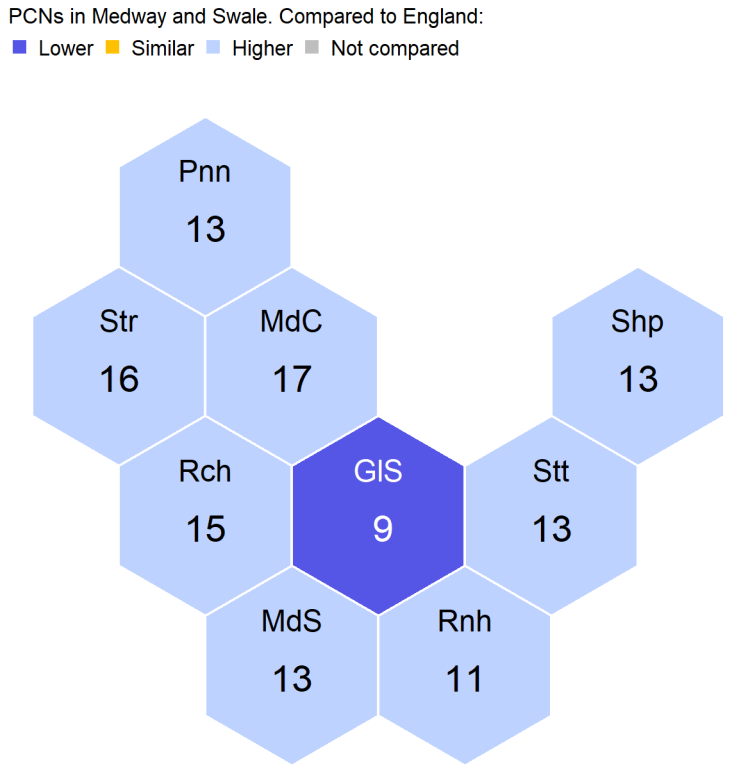


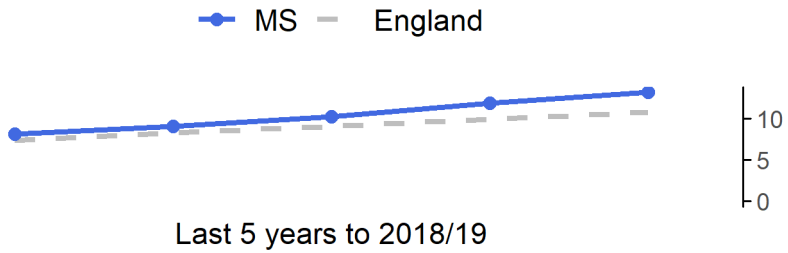


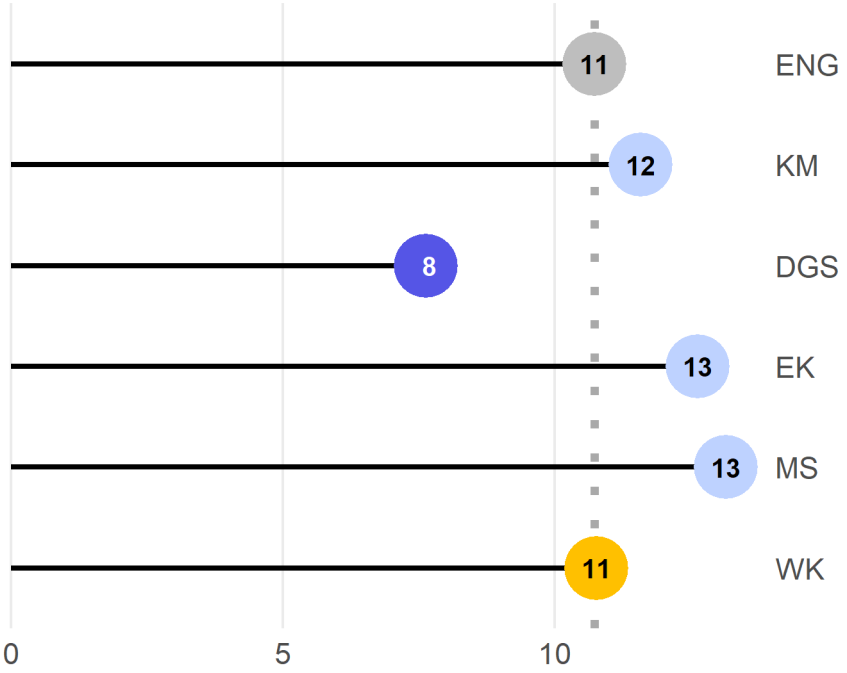
The rate in Medway and Swale is worse than England.

Value type: Directly standardised rate per 100,000
Latest time period: 2018/19
Source: Hospital Episode Statistics (HES), NHS Digital
ICP value calculation: Aggregated data
Small area type: LSOA to PCN
ICP RAG method: Confidence interval (95%) - Dobson's method

Depression: Recorded prevalence (aged 18+)



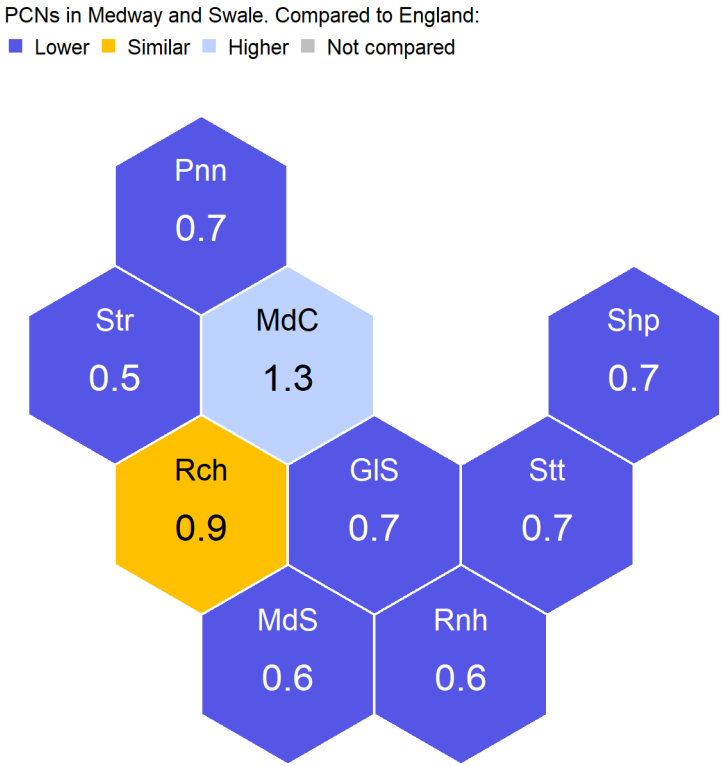


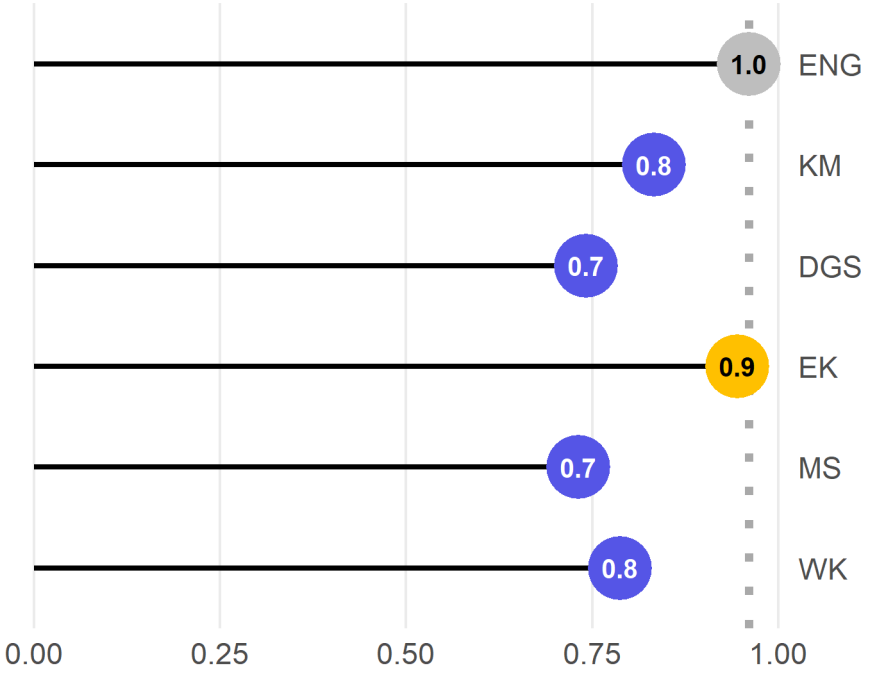


The rate in Medway and Swale is higher than England.

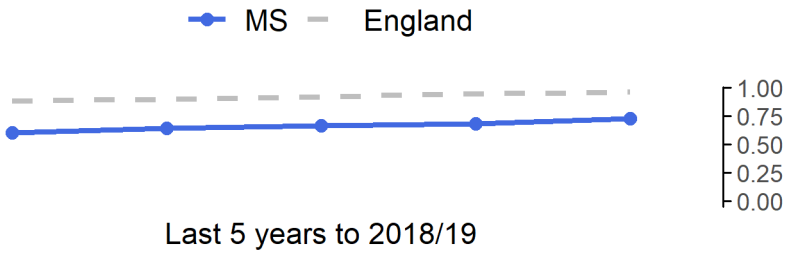
Value type: Proportion - %
Latest time period: 2018/19
Source: PHE, Fingertips, Indicator ID: 848
ICP value calculation: Aggregated data
Small area type: Practice to PCN
ICP RAG method: Confidence interval (99.8%) - Byar's method

Serious Mental Illness: QOF prevalence (all ages)





The rate in Medway and Swale is lower than England.

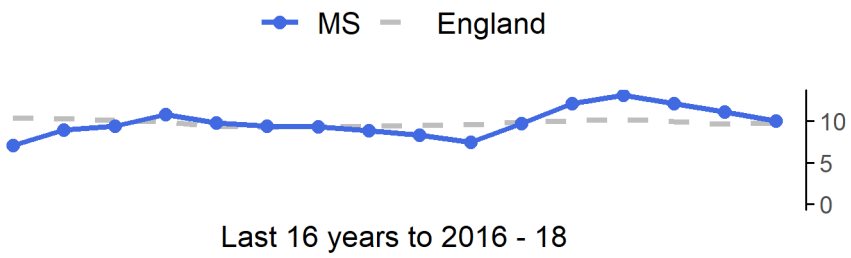


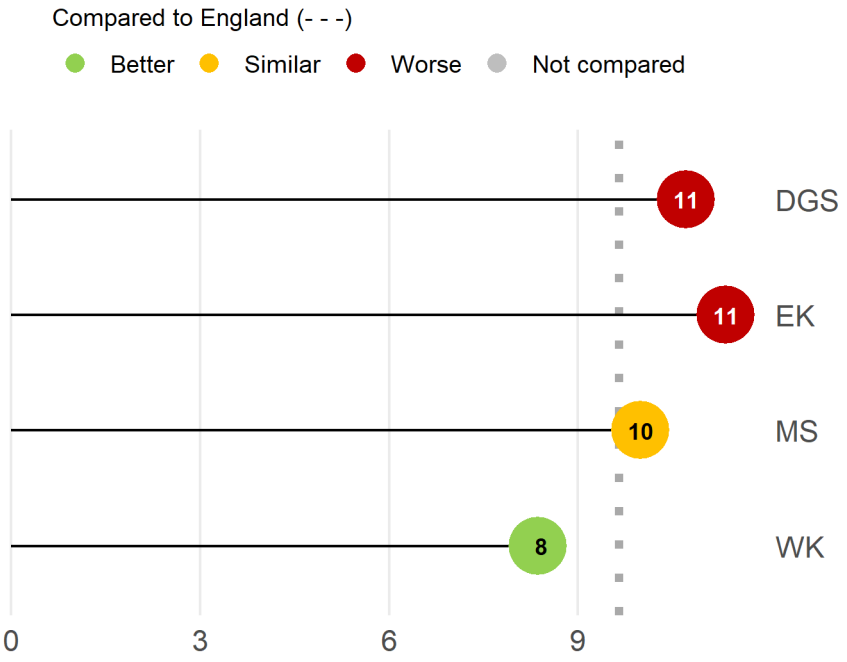
Value type: Proportion - %
Latest time period: 2018/19
Source: PHE, Fingertips, Indicator ID: 90581
ICP value calculation: Aggregated data
Small area type: Practice to PCN
ICP RAG method: Confidence interval (99.8%) - Wilson Score method

92

Suicide rate (Persons)

10		10
ICP: Medway and Swale		England
		10
		Kent and Medway
9	11	2016 - 18
Medway	Swale	



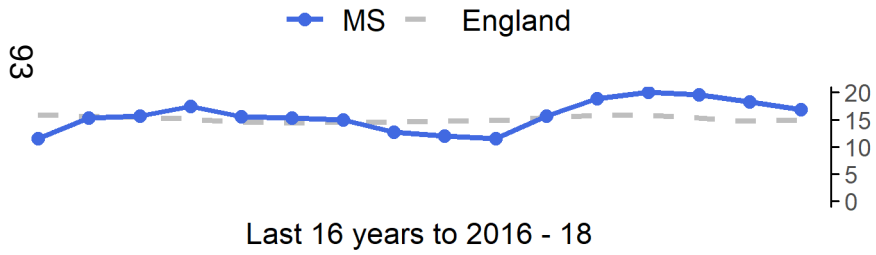


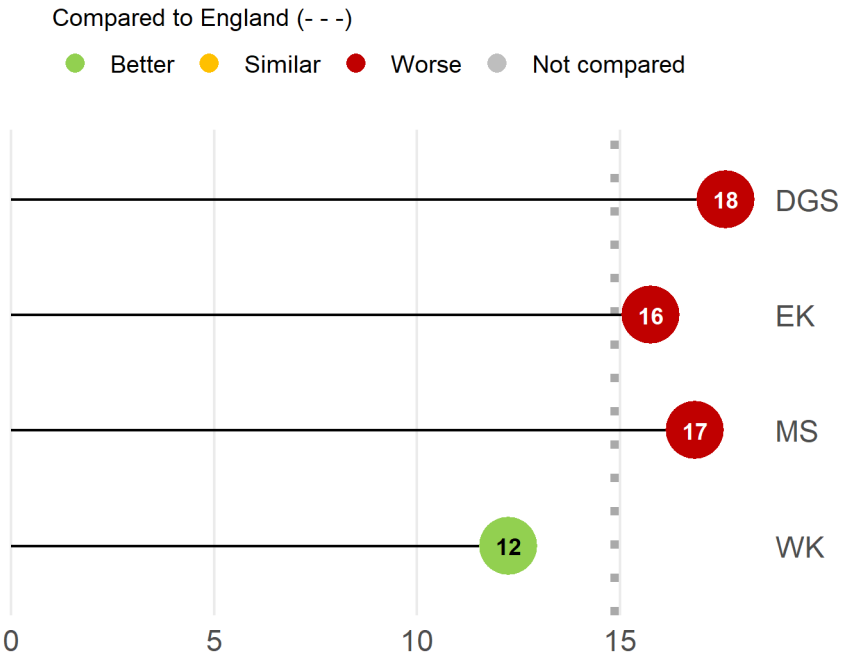
The rate in Medway and Swale is similar to England.

Value type: Directly standardised rate - per 100,000
Latest time period: 2016 - 18
Source: PHE, Fingertips, Indicator ID: 41001
ICP value calculation: Small areas averaged
Small area type: District & UA (4/19-3/20)
ICP RAG method: England plus/minus 5%

Suicide rate (Male)

17 ICP: Medway and Swale		15 England
		15 Kent and Medway
17 Medway	16 Swale	2016 - 18





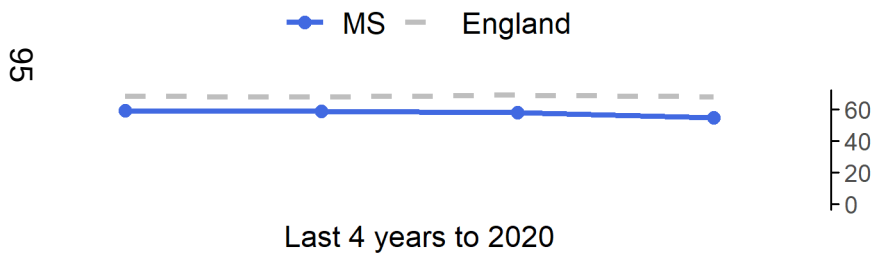
The rate in Medway and Swale is worse than England.

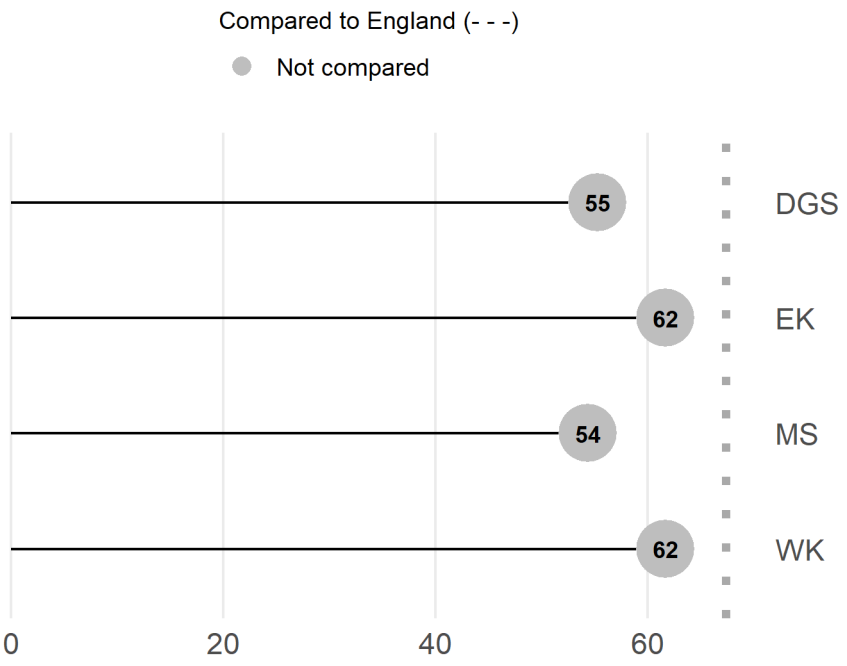
Value type: Directly standardised rate - per 100,000
Latest time period: 2016 - 18
Source: PHE, Fingertips, Indicator ID: 41001
ICP value calculation: Small areas averaged
Small area type: District & UA (4/19-3/20)
ICP RAG method: England plus/minus 5%

AGEING WELL

Estimated dementia diagnosis rate (aged 65 and over)

54	67	
ICP: Medway and Swale	England	
	60	
	Kent and Medway	
51	60	2020
Medway	Swale	



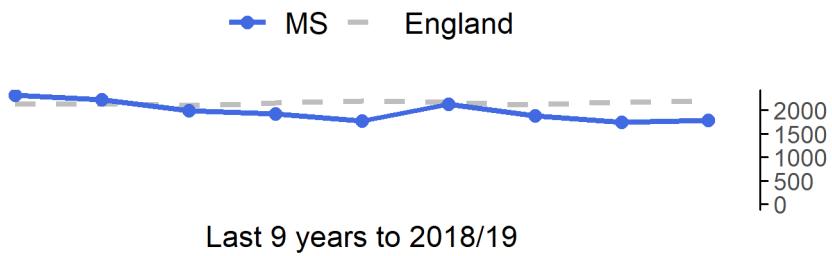


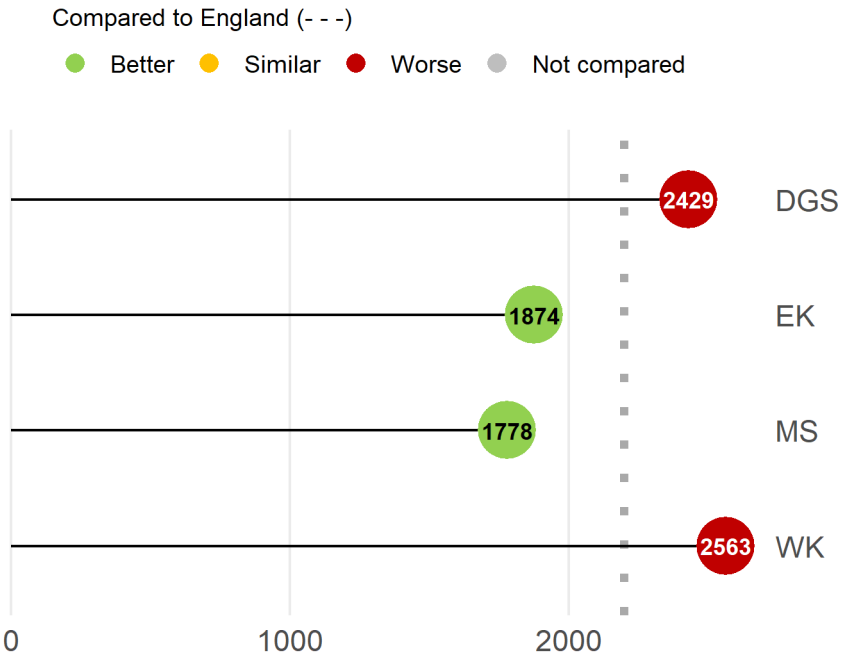
Medway and Swale cannot be compared to England statistically.

Value type: Proportion - %
Latest time period: 2020
Source: PHE, Fingertips, Indicator ID: 92949
ICP value calculation: Aggregated data
Small area type: District & UA (4/19-3/20)
ICP RAG method: None applied

Emergency hospital admissions due to falls (persons aged 65 and over)

1778		2198
ICP: Medway and Swale		England
		2157
		Kent and Medway
1768	1788	2018/19
Medway	Swale	

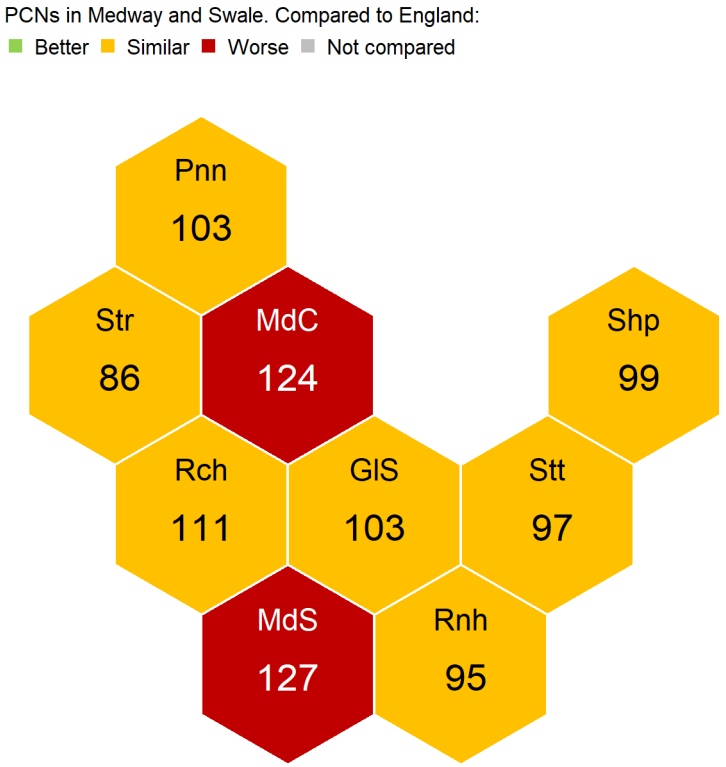


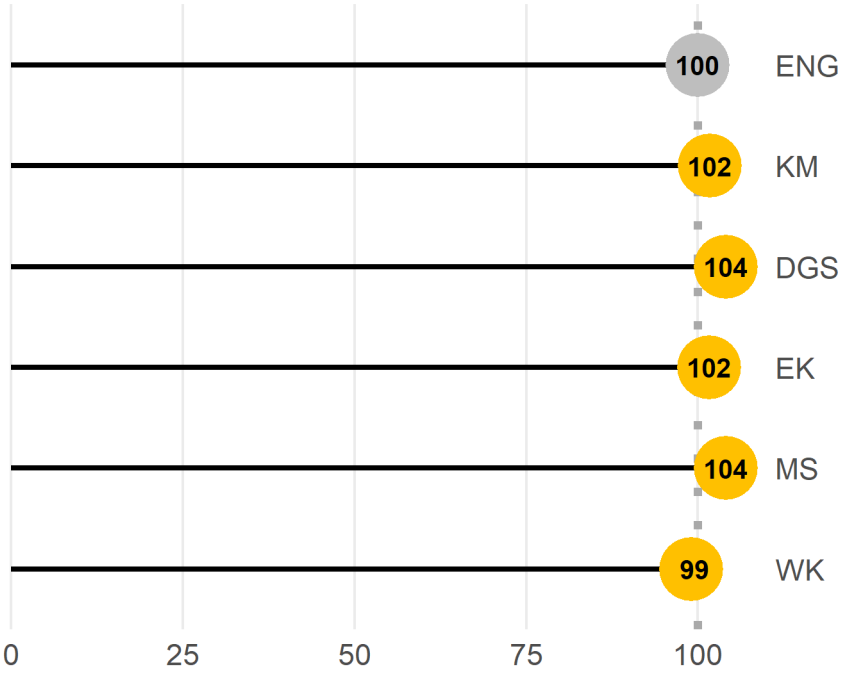


The rate in Medway and Swale is better than England.

Value type: Directly standardised rate - per 100,000
Latest time period: 2018/19
Source: PHE, Fingertips, Indicator ID: 22401
ICP value calculation: Small areas averaged
Small area type: District & UA (4/19-3/20)
ICP RAG method: England plus/minus 5%

Emergency hospital admissions for hip fracture (persons aged 65 and over)



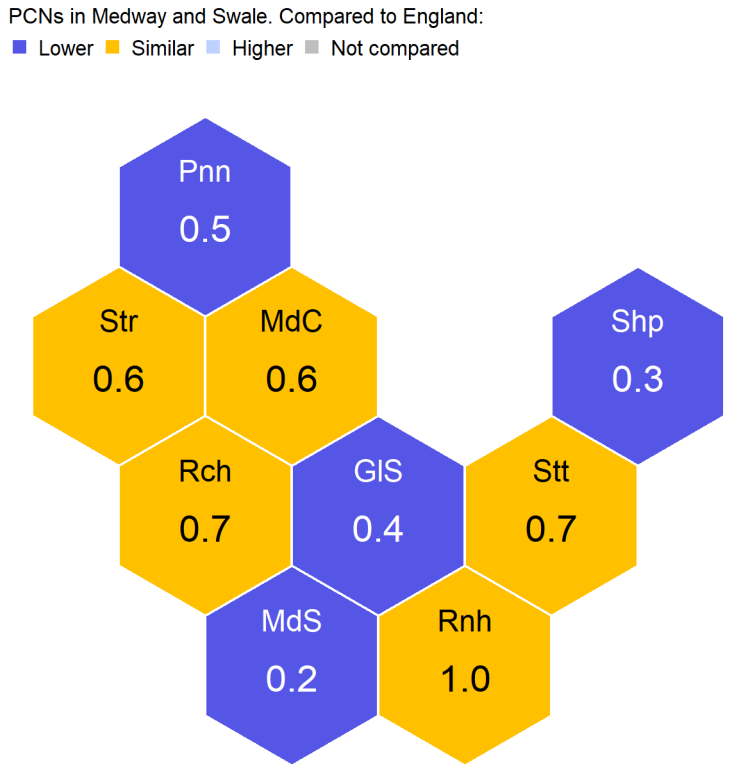


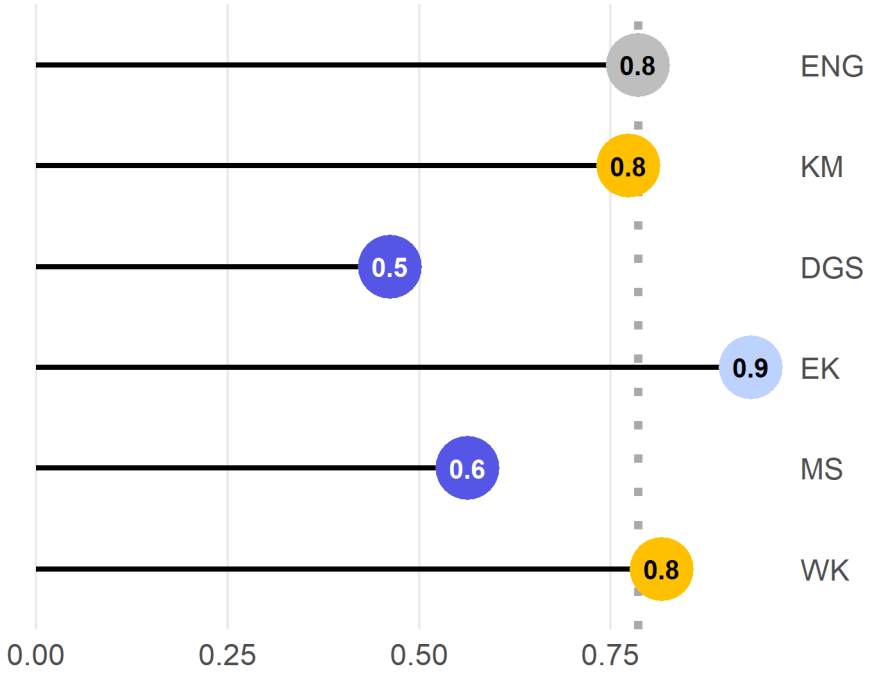
The rate in Medway and Swale is similar to England.

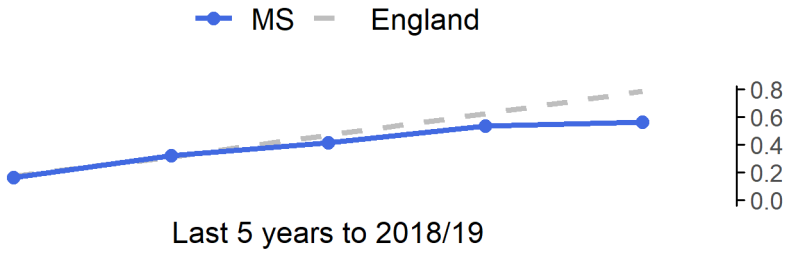
Trend data not available.

Value type: Indirectly standardised ratio per 100
Latest time period: 2013/14 - 17/18
Source: PHE, Fingertips, Indicator ID: 93241
ICP value calculation: Aggregated data
Small area type: Ward to PCN
ICP RAG method: Confidence interval (95%) - Byar's method

Osteoporosis: QOF prevalence (50+)







The rate in Medway and Swale is lower than England.

Value type: Crude rate - %
Latest time period: 2018/19
Source: PHE, Fingertips, Indicator ID: 90443
ICP value calculation: Aggregated data
Small area type: Practice to PCN
ICP RAG method: Confidence interval (99.8%) - Wilson Score method

Medway Council
Serving You

HEALTH AND WELLBEING BOARD

3 NOVEMBER 2020

JOINT HEALTH AND WELLBEING STRATEGY THEME 3 REVIEW

Report from: James Williams, Director of Public Health

Author: Dr David Whiting, Consultant in Public Health

Summary

This report asks the members of the Health and Wellbeing Board to identify how they and the organisations that they represent can encourage the system to improve health and wellbeing with respect to the future state describe for theme 3 of the Joint Health and Wellbeing Strategy: Prevent early death and increase years of healthy life.

1. Budget and policy framework

1.1. The Local Government and Public Involvement in Health Act 2007 and the Health and Social Care Act 2012 place a statutory duty on upper tier Local Authorities and NHS Clinical Commissioning Groups (CCGs), to develop a Joint Health and Wellbeing Strategy (JHWS). The priorities within a JHWS are derived from a range of sources. The primary source of evidence is generally the area's Joint Strategic Needs Assessment (JSNA). Additional information to assist in the development of JHWS priorities comes from a range of partners and key stakeholders and the specific views of local people. National guidance does not specify how long a JHWS should stay in force. It is up to the Local Authority and CCG to determine the period to be covered by a JHWS.

1.2. The Health and Wellbeing Board is a statutory committee of the Council whose role is to build strong and effective partnerships to improve the commissioning and delivery of services across NHS and local government.

1.3. In practice the Council, the NHS and Healthwatch work together to improve population health and wellbeing and reduce health inequalities.

1.4. The Health and Wellbeing Board agrees priorities based on need and promotes integrated working between health and social care commissioners.

1.5. This item has been circulated separately to the main agenda. The Chairman of the Board is of the opinion that it should be considered at this meeting as a matter of urgency as permitted under section 100B of the Local Government Act 1972 to enable the Board to consider the matter at the earliest opportunity and to avoid adding to the volume of business programmed for the next meeting of the Board. The report was not available in time for despatch with the main agenda due to other COVID-19 related response activity in the Public Health team which had to take priority.

2. Background

2.1. The Joint Health and Wellbeing Strategy is based around five themes:

- Giving every child a good start;
- Enabling our older population to live independently and well;
- Preventing early death and increase years of healthy life;
- Improving physical and mental health and well-being; and
- Reducing health inequalities.

2.2. At the Health and Wellbeing Board briefing on 2 July 2019 sub-groups of members of the board considered each of the themes and began to explore ways in which actors in the system can collaborate to improve the situation with respect to each theme.

2.3. Through June to September 2019 Medway Council's internal audit team conducted an audit of the Joint Health and Wellbeing Strategy. A summary of the report was presented to the Audit Committee on 7 January 2019. One recommendation was made which relates to introducing a process whereby the Board are advised of individual strategy outcomes.

3. Advice and analysis

3.1. There are many factors that influence the health and wellbeing of the population of Medway and changes in different areas are required to improve health and wellbeing. The JHWS listed a number of existing key strategies or action plans that contribute to each theme.

3.2. Members of the Health and Wellbeing Board are in a unique position to be able to encourage key stakeholders in the system to improve health and wellbeing.

3.3. Regular review of each theme of the strategy will help to ensure that the focus is maintained on the key areas of the strategy so that members of the Board, as key system leaders, are able to identify how they and the organisations they represent can encourage the system to make changes that will improve health and wellbeing.

3.4. Appendix A contains a summary of information about theme 3: Prevent early death and increase years of healthy life. The "future state" section contains the priorities from the Strategy rephrased to describe how these priorities will

look in a successful future state.

4. Risk management

Risk	Description	Action to avoid or mitigate risk	Risk rating
Focus is not maintained on five themes	If focus is not maintained on the key areas of the strategy the HWB may not drive change as effectively as it could	The HWB will regularly review each theme as per this paper	D-II

5. Consultation

5.1. Engagement with members of the public about the health and wellbeing needs of different areas of Medway took place through a series of community listening events. These events took place in six localities across Medway and formed part of a wider initiative to engage with local people and inform them about future developments taking place in the provision of health and social care services in Medway.

6. Climate change implications

6.1. Many of changes that will improve health and wellbeing will also result in positive improvements in the environment and will contribute to reducing the adverse effects of climate change. For example, increasing active travel, such as cycling and walking, as an alternative to using private cars will reduce emissions from cars. Moving to a more healthy diet that has more vegetables and fruit and less meat will help to drive a shift to more sustainable agriculture.

7. Financial implications

7.1. There are no direct resource implications that arise from this paper. Funding of delivery actions is contained within relevant organisational budgets. Specific projects will be funded through the submission of business plans using the existing financial governance arrangements.

8. Legal implications

8.1. S. 116A(vi) of the Local Government and Public Health Involvement Act 2007 as inserted by s.193 of the Health and Social Care Act 2012 places a statutory duty on Medway Council and NHS Medway CCG, through the Health and Wellbeing Board, to publish a Joint Health and Wellbeing Strategy. The period that a JHWS must cover is not defined, however, the current JHWS covers 2018-2023.

9. Recommendations

9.1 Members of the Health and Wellbeing Board are asked to consider how they and the organisations they represent can encourage the system to make changes that will improve health and wellbeing with respect to theme 3 of the Joint Health and Wellbeing Strategy.

Lead officer contact

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Appendices

Appendix A — JHWS theme 3 overview

Background papers

None

THEME 3: Prevent early death and increase years of healthy life

1) CURRENT STATE

- 146.4 deaths from cancer per 100,000 (2016 – 18)
- 68.6 deaths from circulatory disease per 100,000 (2016 – 18)
- 38.3 deaths from respiratory disease per 100,000 (2016 – 18)
- 74.2% of eligible women screened for breast cancer (previous 3 years to March 2019)
- 72.4% of eligible women screened for cervical cancer (previous 3½ or 5½ years (according to age) to March 2019)
- 51.8% of adults with a long-term condition reported sufficient support (2018)

3) FUTURE STATE

- Medway is a place where the health system works well, key drivers of mortality and morbidity are detected early and appropriate action is taken to improve outcomes and prevent complications
- The drivers behind Medway's consistently high cancer mortality rates have been identified and are being addressed
- Screening rates for bowel, breast and cervical cancer are high
- All Medway residents have the same high quality of primary care

2) BACKGROUND

- Improving healthcare to prevent early death and improve quality of life. Includes improving early diagnosis and therefore allowing more timely intervention which can significantly improve outcomes in some diseases.
- The leading causes of early death and illness in Medway include cancer, circulatory disease (e.g. heart attack, stroke and heart failure) and respiratory disease, conditions that share many common causes. Over recent decades public health action and improved health care have led to dramatic reductions in the number of deaths from these causes. About half of this reduction was due to improved health care and half was due to public health measures, such as reductions in smoking.
- Most people with long-term conditions have a single condition and can be helped to manage their condition at relatively low cost. However, as people age, more people begin to develop other conditions
- Addressing these conditions requires well-integrated health and social care systems.

4) How will we collaborate to create this future state, in the context of the Integrated Care System, Integrated Care Partnership (Medway and Swale) and Primary Care Networks?

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