

HEALTH AND WELLBEING BOARD

17 JUNE 2014

JOINT HEALTH AND WELLBEING STRATEGY MONITORING REPORT

Report from: Dr Alison Barnett, Director of Public Health

Author: Dr Saloni Zaveri, Consultant in Public Health

Summary

The purpose of this report is to provide an update to the Board on JHWS indicators and to provide finalised delivery plans for 2014/15 for consideration and discussion by the Board.

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 and the strategy outcomes are on-going.

2. The Medway JHWS Monitoring and Outcomes Framework

- 2.1. The HWB has responsibility to ensure that robust 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 taken from the National Outcomes Frameworks for the NHS, Social Care, Public Health and Children which are aligned to the Medway Joint Health and Wellbeing Strategy 2012-17. A report on key JHWS outcome indicators is attached as Appendix 1.
- 2.2. Finalised delivery plans for 2014/15 are attached as Appendix 2 a-e for consideration by the Board. A briefing paper on social isolation and loneliness is included in Appendix 3 as background information for the corresponding delivery plan for this priority action.

3. Board level Theme Leads and Lead Officers for 2014/15 priority actions

Theme	Theme Leads	Key Priority Action	Lead Officer
1: Give every child a good start	Cllr. Mike O'Brien & Barbara Peacock	1. Promote maternal physical and emotional health in pregnancy and in the early months of life through high quality antenatal and postnatal services. (Focus on increasing levels of breastfeeding and reducing smoking in pregnancy).	Scott Elliott (Senior Public Health Manager (Supporting Healthy Weight), Medway Council)
2: Enable our older population to live independently and well	Cllr David Brake & Dr Gill Fargher	2.1. Improve early diagnosis, treatment and care for people with dementia in line with increasing population need.	Mark Goodman (Partnership Commissioning Manager, Medway Council)
	Cllr Kelly Tolhurst & David Quirke-Thornton	2.2. Falls prevention and management	Ben Keeble (Project Manager, Medway CCG)
3: Prevent early death and increase years of healthy life	Cllr Les Wicks & Dr Pete Green	3. Reduce death rates from cancer (bowel, breast and lung). (Focus on improving prevention, awareness and increasing early diagnosis).	Dr Julia Duke Macrae (Consultant in Public Health, Medway Council)
4: Improve mental and physical health and wellbeing	Cllr Andrew Mackness & Alison Burchell	4.1. Increase awareness of MH conditions and support for prevention, early diagnosis and treatment. (Focus on MH promotion).	Sally-Ann Ironmonger (Head of Health Improvement, Medway Council)
	Cllr Howard Doe & Dr. Mark Beach	4.2. Reduce social isolation through a social isolation strategy developed and delivered jointly with key partners.	Colin Thompson (Consultant in Public Health, Medway Council)
5: Reduce health inequalities	Cllr Vince Maple & Dr Alison Barnett	5. Increase targeting of disadvantaged groups for promotion of healthy lifestyles. (Focus on promoting healthy eating and physical activity and tobacco, drugs and alcohol control).	Rachael Horner (Public Health Programme Manager (Health Inequalities), Medway Council)
		Watching Brief: Improve uptake of screening and health checks in most disadvantaged areas.*	David Whiting (Senior Public Health Intelligence Manager)

**Watching Brief: Two priority actions for 2013/14 have been assigned Watching Brief status. These are priority actions for which good progress was made in local outcomes during 2013/14. The HWB's role will be to continue monitoring and intervene should outcomes deteriorate.*

4. Risk management

Risk	Description	Action to avoid or mitigate risk
Delivery plans are not implemented	Due to lack of resource and commitment plans are not fully implemented	Lead officers have been nominated for each area
Lack of clarity as to progress on health and wellbeing outcomes	Monitoring and outcomes framework not sufficiently robust so unclear if progress is being made	Regular progress reports to the Board.

5. Financial and legal implications

- 5.1 There are no financial or legal implications arising directly from the contents of this report

6. Recommendations

- 6.1 The HWB are asked to consider progress updates and facilitate progress to the successful implementation of the priority action delivery plans

Lead officer

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Background papers

Medway Clinical Commissioning Group, NHS Commissioning Board and Medway Council, 2012. *Joint Health and Wellbeing Strategy for Medway 2012-2017*

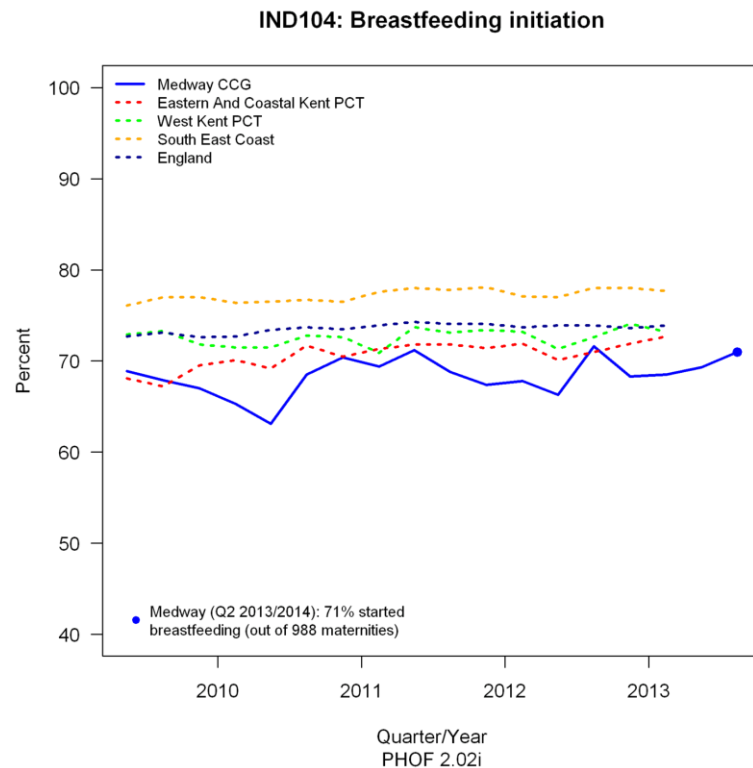
Public Health Indicators for Medway Health & Wellbeing board 17th June 2014

Contents

Breastfeeding initiation	3
Breastfeeding continuation	4
Smoking at time of delivery (SATOD)	5
Children aged 4-5 classified as obese	7
Children aged 10-11 classified as obese	8
Five-year olds achieving a good level of development	9
Discharged into reablement/rehab services	10
Falls admissions 65+	11
Flu vaccination 65+	12
Flu vaccination 'at risk'	13
Estimated diagnosis rate for people with dementia	14
Circulatory disease mortality (under 75)	15
Cancer mortality rate (under 75)	16
Experience of community mental health services	17
People using green spaces for exercise	19

Adults achieving 150 minutes of exercise	20
Households in temp accommodation	21
Smoking prevalence (18+)	22
Mental Illness employment rate	23
Invited to NHS Health Check	24
Children in poverty	25
Not in Education, Employment or Training	26

Breastfeeding initiation



Current status

Medway (Q2 2013/2014): 71% started breastfeeding (out of 988 maternities)

Additional information

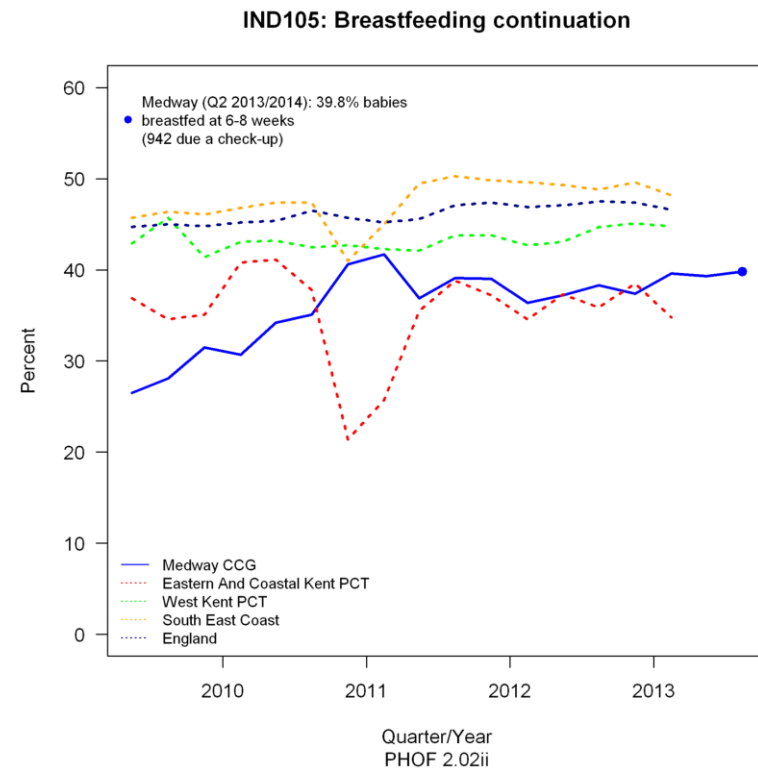
Item	Detail
Description:	IND104: Breastfeeding initiation
Definition:	Women who initiate breastfeeding in the first 48 hours after delivery
Source:	Department of Health, breastfeeding quarterly statistics
Reporting frequency	Quarter/Year
Last review	2014-05-28

Breastfeeding initiation in Medway has remained at a consistent level of around 70% for the past 3 years. This is slightly below the England average, and significantly less than for the South East Coast area. Breastfeeding continuation to six weeks has however shown a steady rise from below 30% to almost 40% over the same time period, although it still remains below national and regional rates. Medway Breastfeeding Network provides breastfeeding support and advice through local drop-ins held in Children's Centres, one-to-one meetings and support through existing family services e.g. Health Visitor clinics, libraries, Family Nurse Partnership and on the maternity wards at Medway Foundation NHS Trust (MFT).

The Infant Feeding Strategy Group which has representation from Medway Community Healthcare (MCH), MFT and Medway Council (Early Years and Public Health) was re-launched in July 2013. The previous action plan was updated and revised, and undertakings concerning working together to increase both initiation and continuation were given.

Medway Foundation Trust has confirmed that their data submission for quarters 1 to 3 was unsuccessful so they have been asked to resubmit the data with the quarter 4 submission

Breastfeeding continuation



Current status

Medway (Q2 2013/2014): 39.8% babies breastfed at 6-8 weeks (942 due a check-up)

Additional information

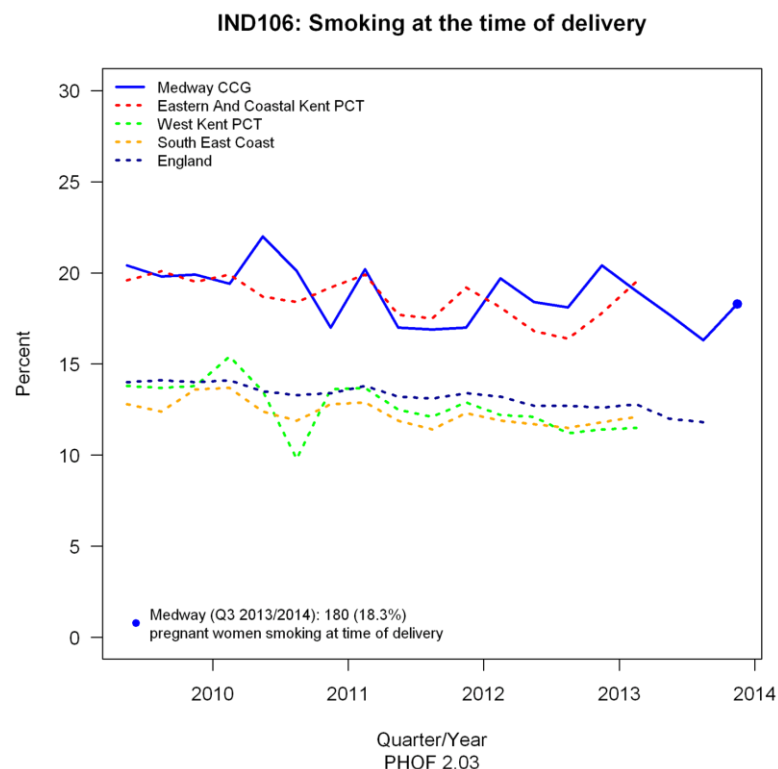
Item	Detail
Description:	IND105: Breastfeeding continuation
Definition:	Infants who are totally or partially breastfed at 6-8 week check
Source:	Department of Health, breastfeeding quarterly statistics
Reporting frequency	Quarter/Year
Last review	2014-05-28

Breastfeeding initiation in Medway has remained at a consistent level of around 70% for the past 3 years. This is slightly below the England average, and significantly less than for the South East Coast area. Breastfeeding continuation to six weeks has however shown a steady rise from below 30% to almost 40% over the same time period, although it still remains below national and regional rates. Medway Breastfeeding Network provides breastfeeding support and advice through local drop-ins held in Children's Centres, one-to-one meetings and support through existing family services e.g. Health Visitor clinics, libraries, Family Nurse Partnership and on the maternity wards at Medway Foundation NHS Trust (MFT).

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Smoking at time of delivery (SATOD)



Current status

Medway (Q3 2013/2014): 180 (18.3%) pregnant women smoking at time of delivery

Additional information

Item	Detail
Description:	IND106: Smoking at the time of delivery
Definition:	Rate of smoking at time of delivery per 100 maternities
Source:	HSCIC, SATOD data collection
Reporting frequency	Quarter/Year
Last review	2014-05-28

These data supplement the national information available from the Infant Feeding Survey (IFS) conducted every five years. The 2010 IFS states that just over a quarter of mothers (26%) in England smoked at some point in the 12 months immediately before or during their pregnancy. Of these, just over half (55%) in England gave up at some point before the birth.

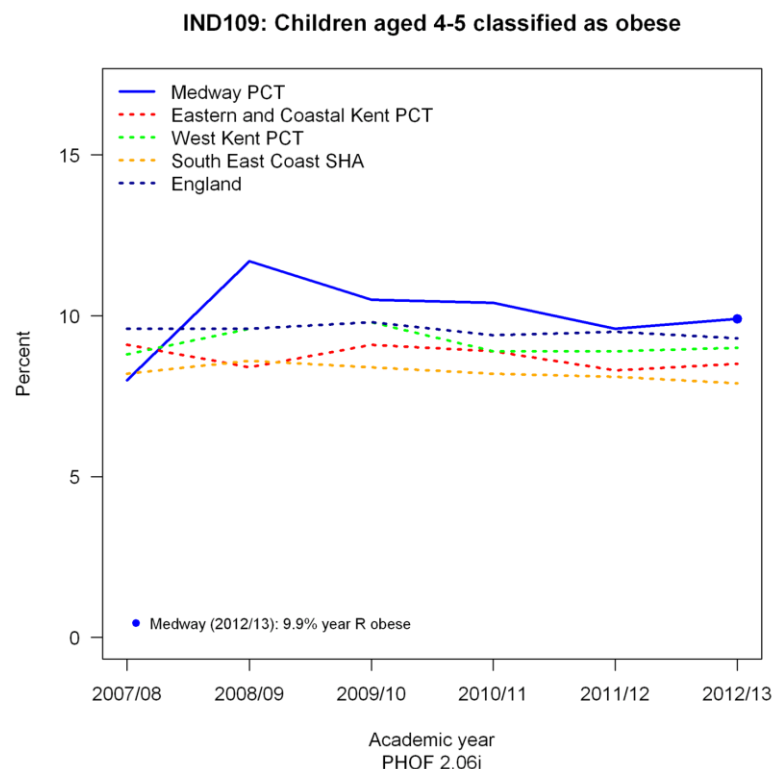
Smoking in pregnancy remains a problem in Medway, with 18.3% women smoking at time of delivery (SATOD). The prevalence fell 16.3% in quarter two, however, this remains consistently higher than the rate in England at 11.8% and in the South East Coast area.

Smoking is one of the few modifiable risk factors in pregnancy. It can cause a range of serious health problems, including lower birth weight, pre-term birth, placental complications and perinatal mortality. In Medway, the CQUIN (Commissioning for Quality and Innovation) payment framework which enables reward for excellence has been set to target midwives on the accurate recording of the smoking status of women at time of delivery. NICE guidance says all pregnant women should have their carbon monoxide level measured at booking and smoking cessation should be integrated into the antenatal care pathway. Midwives should refer all women who smoke for help to quit and check if the woman took up the referral at the next antenatal appointment. Specialist training has been provided to the midwives to support them through raising the issue of smoking, explaining carbon monoxide testing and the

referral processes. This has been delivered via a project called 'Babyclear' The training also re-enforces the importance of accurately recording smoking at time of booking and at time of delivery. Whilst the Trust is looking at improving data quality, variances will be expected until the new improved processes are fully implemented.

Medway Stop Smoking Service provides a specialist service for pregnant women wanting to stop smoking, providing a relaxed and discreet environment where women can go to discuss their smoking habits and the challenges involved in quitting.

Children aged 4-5 classified as obese



Current status

Medway (2012/13): 9.9% year R obese

Additional information

Item	Detail
Description:	IND109: Children aged 4-5 classified as obese
Definition:	Percentage of children aged 4-5 classified as overweight or obese
Source:	HSCIC NCMP
Reporting frequency	Academic year
Last review	2014-02-20

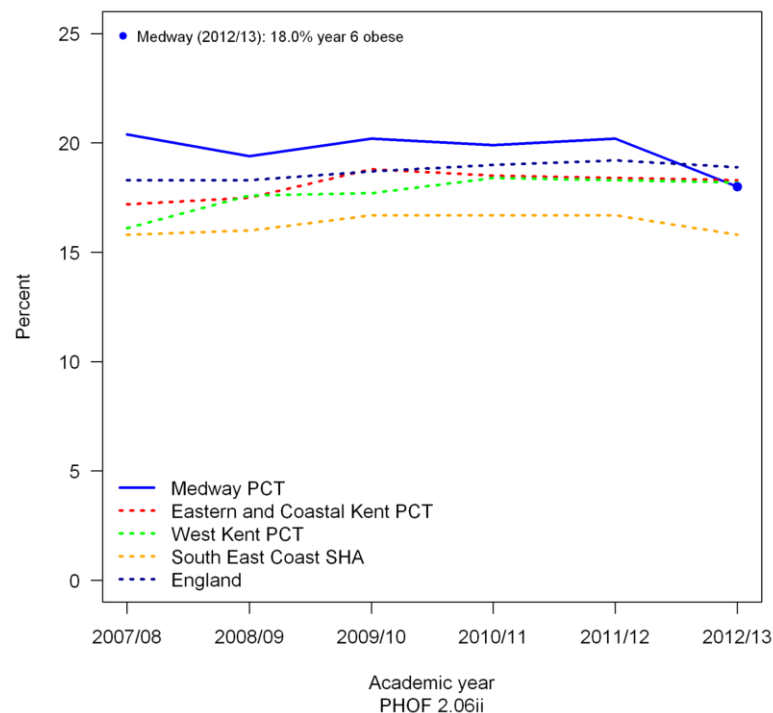
Rates of children classified as "overweight" and "obese" are monitored through the National Child Measurement Programme (NCMP), which is delivered through schools. Children's weight and height are measured in reception class (ages 4-5) and again in year 6 (ages 10-11).

For children in reception year, the rates of those classified overweight has fallen to 13.3% in Medway in 2012/13, while those classified as obese has risen since 2011/12 to 9.9% in 2012/13. Both of these most recent rates are slightly above those for England. Nationally, there has been a plateau or, at best, slight decline in this age group of children classified as overweight and obese.

In Medway, there are established services for children and young people to achieve and maintain healthy weight. Mind, Exercise, Nutrition, Do it (MEND) has a number of free courses for families with children up to 13 years old. These include MEND 2-4, MEND 5-7 and MEND 7-13, which works with children and their families for these age ranges, and a MEND graduate programme, which offers continuing support after the 10-week course has been completed. There are also a range of other community initiatives aimed at promoting healthy eating.

Children aged 10-11 classified as obese

IND111: Children aged 10-11 classified as obese



Current status

Medway (2012/13): 18.0% year 6 obese

Additional information

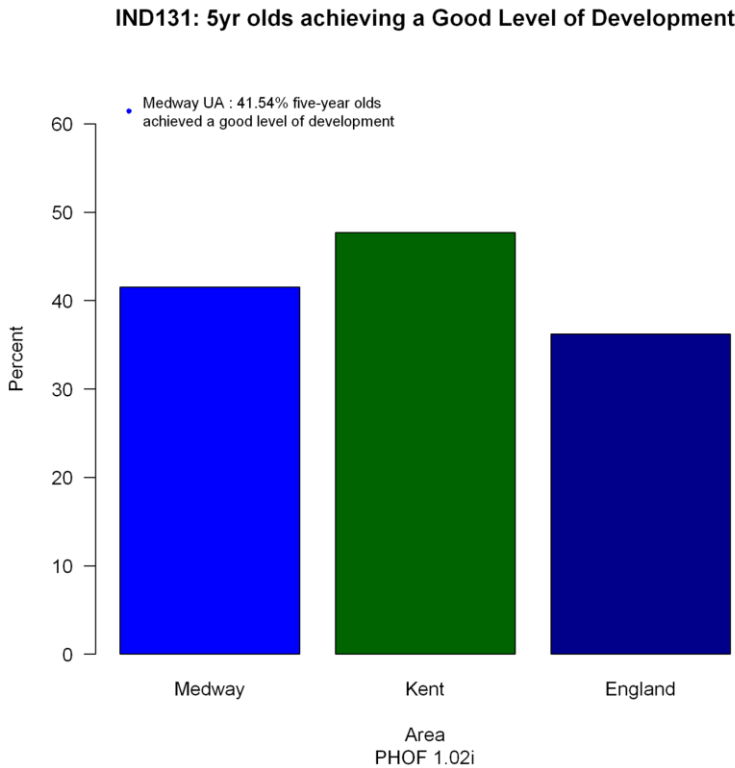
Item	Detail
Description:	IND111: Children aged 10-11 classified as obese
Definition:	Percentage of children aged 10-11 classified as overweight or obese
Source:	HSCIC NCMP
Reporting frequency	Academic year
Last review	2014-05-13

Rates of children classified as "overweight" and "obese" are monitored through the National Child Measurement Programme (NCMP), which is delivered through schools. Children's weight and height are measured in reception class (ages 4-5) and again in year 6 (ages 10-11).

For children in the year 6 age group, the rate of those classified as overweight has risen since 2011/12, to 14.3% in 2012/13. This is marginally below the national average of 14.4%. On a positive note, there has been a recent drop in children in Medway classified as obese, which had previously plateaued at around 20% between 2009/11 and 2011/12. The new figure of 18.0% in 2012/2013 takes Medway below the National average of 18.9%.

In Medway, there are established services for children and young people to achieve and maintain healthy weight. Mind, Exercise, Nutrition, Do it (MEND) has a number of free courses for families with children up to 13 years old. These include MEND 2-4, MEND 5-7 and MEND 7-13, which works with children and their families for these age ranges, and a MEND graduate programme, which offers continuing support after the 10-week course has been completed. There are also a range of other community initiatives aimed at promoting healthy eating.

Five-year olds achieving a good level of development



Current status

Medway UA : 41.54% five-year olds achieved a good level of development

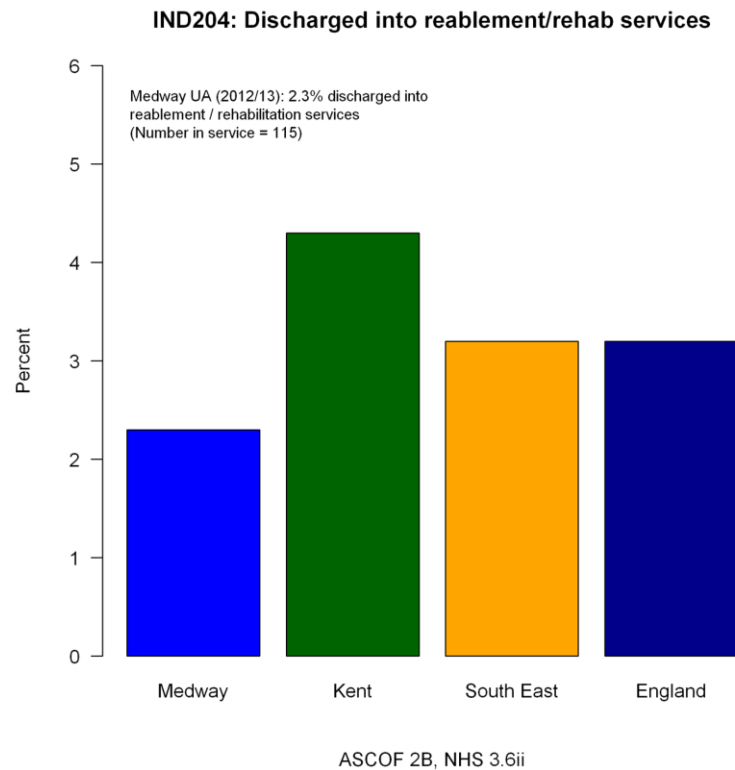
Additional information

Item	Detail
Description:	IND131: 5yr olds achieving a Good Level of Development
Definition:	The percent of children from each local authority achieving a Good Level of Development by the end of the Early Years Foundation Stage (EYFS). A Good Level of Development is defined as achieving the expected level within the three prime areas of learning (communication and language, physical development and personal, social and emotional development) and the early learning goals in the specific areas of mathematics and literacy.
Source:	Department for Education
Reporting frequency	Area
Last review	2014-05-19

This indicator relates to the residents of Medway.

A new indicator for Good Level of Development was introduced in September 2012. This new indicator has a stronger emphasis on the three prime areas which are most essential for children's healthy development: communication and language; physical; and personal, social and emotional development. For each child the Level of Development is now assessed against 17 early learning goals at a newly revised EYFS (the end of the academic year in which the child turns five). Teachers indicate whether children are "meeting" , "exceeding" or "not reaching" expected levels.

Discharged into reablement/rehab services



Current status

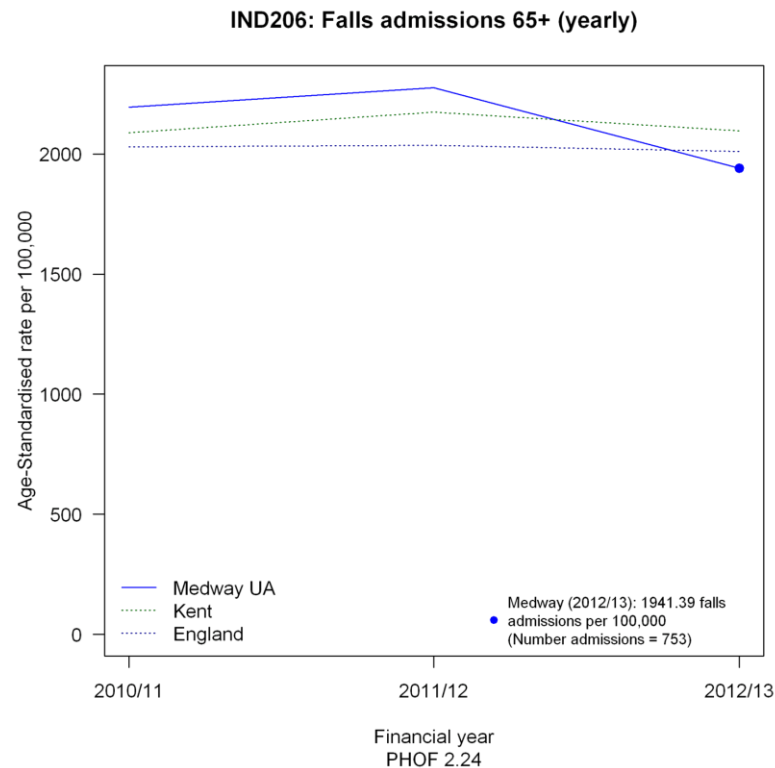
Medway UA (2012/13): 2.3% discharged into reablement / rehabilitation services (Number in service = 115)

Additional information

Item	Detail
Description:	IND204: Discharged into reablement/rehab services
Definition:	Percentage of older people (aged 65 and over) offered rehabilitation following discharge from acute or community hospital
Source:	NHS Information Centre NASCIS
Reporting frequency	
Last review	2014-05-28

This indicator relates to the residents of Medway.

Falls admissions 65+



Current status

Medway (2012/13): 1941.39 falls admissions per 100,000 (Number admissions = 753)

Additional information

Item	Detail
Description:	IND206: Falls admissions 65+ (yearly)
Definition:	Number of emergency admissions for falls or fall related injuries in persons aged 65 and over
Source:	http://www.phoutcomes.info/
Reporting frequency	Financial year
Last review	2014-05-28

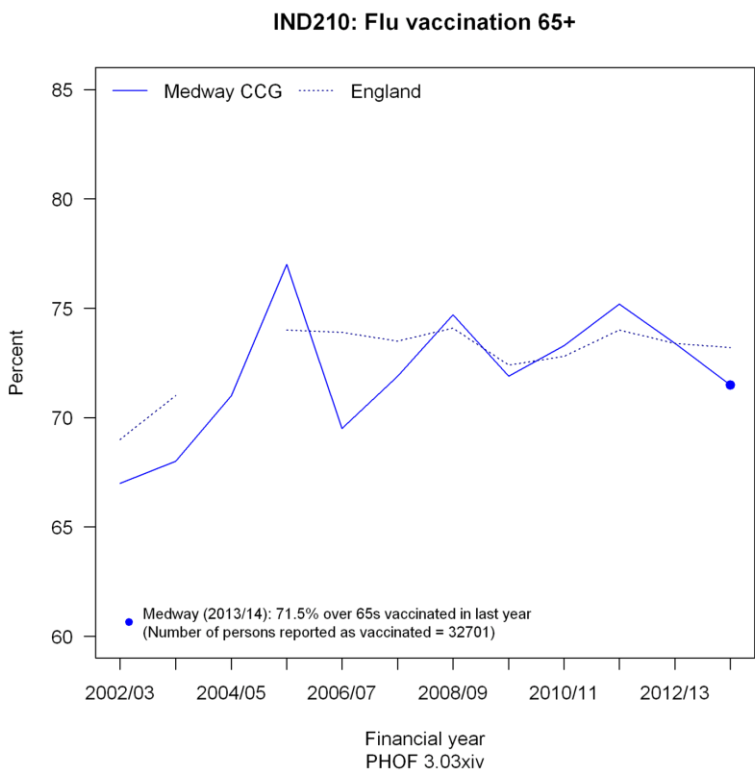
A fall is defined as 'an event whereby an individual comes to rest on the ground or another lower level with or without the loss of consciousness' (American Geriatric Society, 2001).

Falls are an increasingly significant public health issue due to our ageing population. Older people have the highest incidence of falls and the greatest susceptibility to injury. Up to 35% of people aged 65 and over fall each year increasing to up to 42% for those aged 70 years and above

Falls may result in loss of independence, injuries such as fractures and head injuries (20% of fallers sustain serious injury such as hip fracture), mobility loss, pressure related injuries, infection and sometimes injury-related death.

In the UK there were 647,721 Accident and Emergency (A&E) attendances and 204,424 hospital admissions for falls-related injuries in those aged 60 years or above in 1999. Falls and fractures in the >65s account for four million hospital bed days/year in England.

Flu vaccination 65+



Current status

Medway (2013/14): 71.5% over 65s vaccinated in last year
(Number of persons reported as vaccinated = 32701)

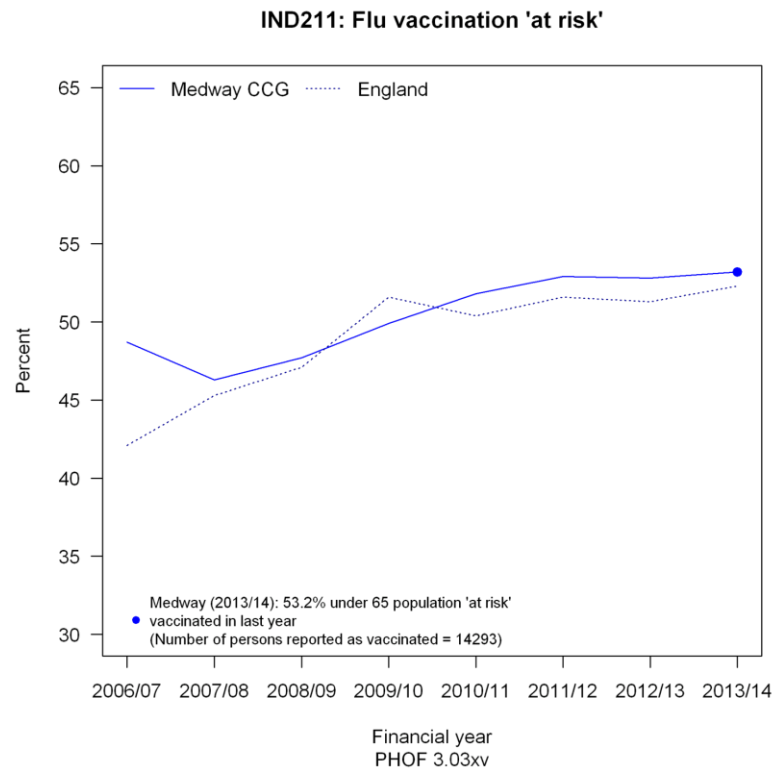
Additional information

Item	Detail
Description:	IND210: Flu vaccination 65+
Definition:	Flu vaccination coverage in population aged 65+
Source:	Department of Health
Reporting frequency	Financial year
Last review	2014-04-28

Influenza is a viral infection of the respiratory tract. Symptoms include fever, dry cough, sore throat, headache, muscle pain and fatigue. Those with underlying health problems, pregnant women and children under 6 months are at an increased risk of serious illness as are those aged 65 and over. Uptake is measured from September to January each year.

In 2013/14, Medway achieved a lower uptake in adults aged 65 or over than England and has had a downward trend since 2011/12.

Flu vaccination 'at risk'



Current status

Medway (2013/14): 53.2% under 65 population 'at risk' vaccinated in last year
(Number of persons reported as vaccinated = 14293)

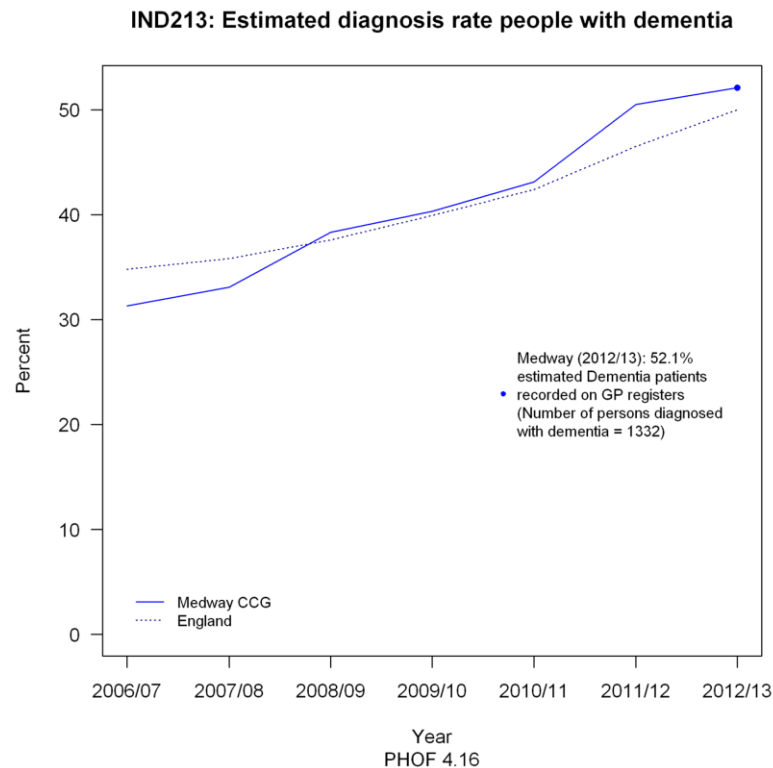
Additional information

Item	Detail
Description:	IND211: Flu vaccination 'at risk'
Definition:	Flu vaccination coverage in at risk population aged 6 months to 64 years
Source:	Department of Health
Reporting frequency	Financial year
Last review	2014-04-28

Influenza is a viral infection of the respiratory tract. Symptoms include fever, dry cough, sore throat, headache, muscle pain and fatigue. Those with underlying health problems, pregnant women and children under 6 months are at an increased risk of serious illness as are those aged 65 and over. Uptake is measured from September to January each year.

In 2013/14, Medway achieved a higher uptake in those in an at risk group than England.

Estimated diagnosis rate for people with dementia



Current status

Medway (2012/13): 52.1% estimated Dementia patients recorded on GP registers (Number of persons diagnosed with dementia = 1332)

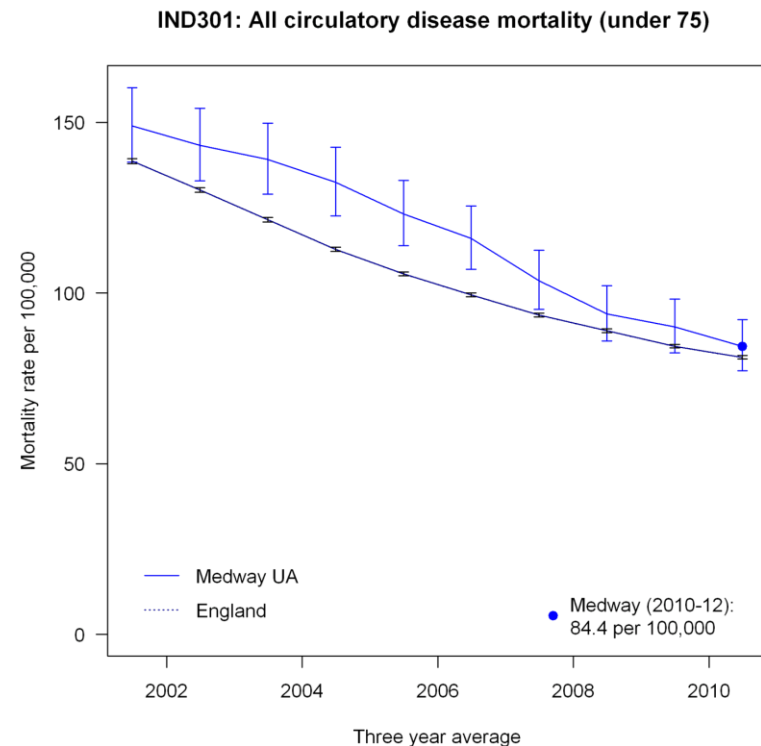
Additional information

Item	Detail
Description:	IND213: Estimated diagnosis rate people with dementia
Definition:	Proportion of total population diagnosed with dementia according to Quality and Outcomes framework as a percentage of estimated dementia prevalence according to Dementia UK report (2007)
Source:	Quality and Outcomes Framework , Health & Social Care Information Centre and Dementia UK report (2007)
Reporting frequency	Year
Last review	2014-04-28

The estimated rate of diagnosis of dementia in Medway was 52.1% in 2012/13. This figure refers to the number of people diagnosed with dementia as recorded in the Quality and Outcomes Framework, compared with prevalence estimates based upon the findings of a Dementia UK report in 2007. In other words, approximately half of the population one would expect to have developed dementia in Medway were successfully diagnosed and had their condition recorded. This has risen, alongside the England average, from approximately a third diagnosed in 2006/7. Medway's performance in this indicator now outstrips the England average.

Some caution should be exercised in interpreting this data however, both because the rate is based on an estimate of prevalence, and because the nature of the condition may make early diagnosis difficult. The CCG had a focus for 2013/14 on increasing dementia diagnosis rates through redesign of diagnostic pathway linked to Payment by Results (PbR) for dementia.

Circulatory disease mortality (under 75)



Current status

Medway (2010-12):
84.4 per 100,000

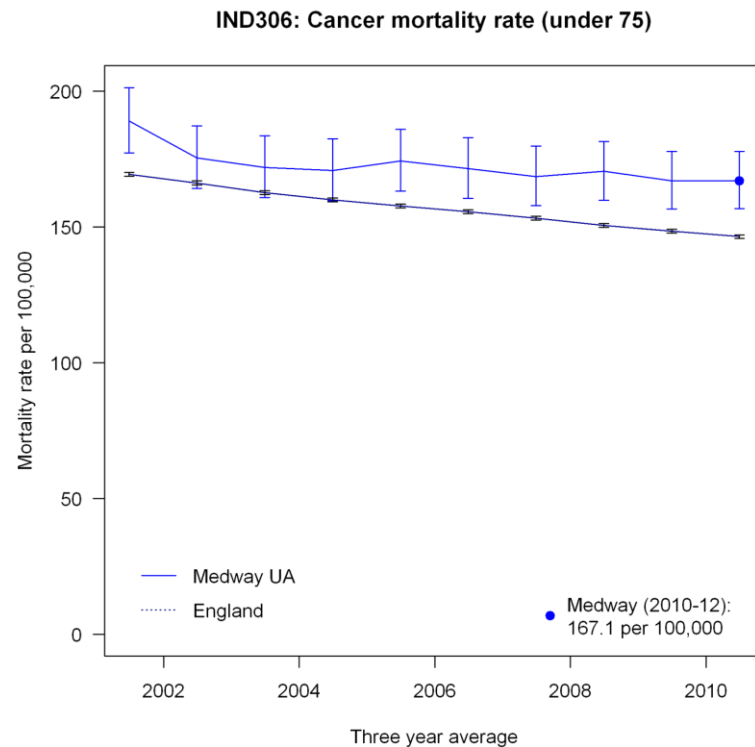
Additional information

Item	Detail
Description:	IND301: All circulatory disease mortality (under 75)
Definition:	Age-standardised rate of mortality from all circulatory diseases(including heart disease and stroke) in persons less than 75 years of age per 100,000 population
Source:	Public Health England
Reporting frequency	Three year average
Last review	2014-05-09

There have been significant improvements in premature mortality rates for cardiovascular disease (including heart disease and stroke). In 2010-12, the difference between Medway and England was not statistically significant demonstrating that the gap has been closed. The Medway rate was 84.4 and the England rate was 81.2.

Medway GP practices participate in the NHS Health Checks programme, which focuses on checks for type 2 diabetes, heart disease, stroke and kidney disease for people aged between 40 and 74. Nationally, both the NHS and Public Health Outcomes Frameworks have a strong focus on helping people to live well for longer, and reducing premature mortality (deaths under 75). Public Health England have produced a [Longer Lives](#) map for upper and unitary authorities in which local authorities' premature mortality is comparable in an accessible format.

Cancer mortality rate (under 75)



Current status

Medway (2010-12):
167.1 per 100,000

Additional information

Item	Detail
Description:	IND306: Cancer mortality rate (under 75)
Definition:	Age-standardised rate of mortality from all cancers in persons less than 75 years of age per 100,000 population
Source:	Public Health England
Reporting frequency	Three year average
Last review	2014-05-09

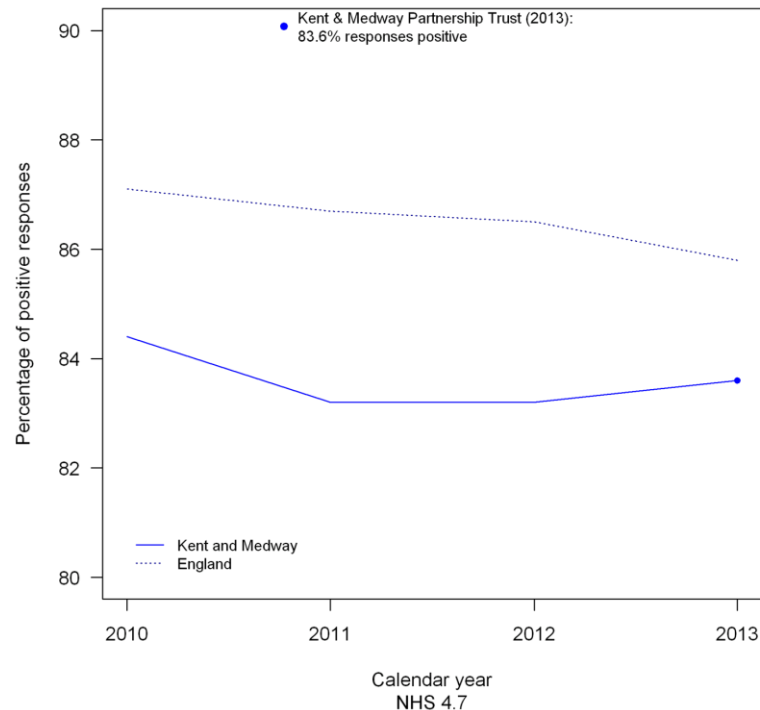
Premature mortality due to cancer has fallen from a rate of 189.03 per 100,000 pre 2002 to its current (2010-12) figure of 167.1 age-standardised deaths per 100,000. Nonetheless, cancer remains the leading cause of premature deaths for both genders, accounting for almost half of deaths in women and a third of deaths in men before the age of 75.

Medway has one of the highest cancer mortality rates of all areas in the South East, significantly higher than the England average, [see PHOF indicator 4.5i](#). The England average shows a steady downward trend over time, whereas Medway has remained roughly stable meaning that the gap between is widening.

Medway has well-established screening programmes for breast, cervical and bowel cancers. Nationally, both the NHS and Public Health Outcomes Frameworks have a strong focus on helping people to live well for longer, and reducing premature mortality (deaths under 75). Public Health England has produced a "[Longer Lives](#)" map for upper and unitary authorities in which local authorities' premature mortality is comparable in an accessible format.

Experience of community mental health services

IND313: Experience of community mental health services



Current status

Kent & Medway Partnership Trust (2013):
83.6% responses positive

Additional information

Item	Detail
Description:	IND313: Experience of community mental health services
Definition:	Figures are based on the community mental health survey, which is completed by a sample of patients aged 16 and over who received care or treatment for a mental health condition, including services provided under the Care Programme Approach (CPA)
Source:	National patient survey programme, Health & Social Care Information Centre
Reporting frequency	Calendar year
Last review	2014-05-13

Just under 84% of service users of community mental health services in Medway rated their care positively in 2013, and this rate has increased from the previous year. However, this value is still below the England average of 85.8% in 2013.

This figure is based upon the community mental health survey which asks service users (aged over 16) four questions about their experience of the last time that they had contact with a mental health or social care worker. Patients seen only once for an assessment, current inpatients or anyone primarily in receipt of learning disability, drug and alcohol, or forensic services were not eligible to take part in the survey.

The indicator is calculated as the average of four survey questions from the community mental health survey. The questions are:

Thinking about the last time you saw this NHS health worker or social care worker for your mental health condition.

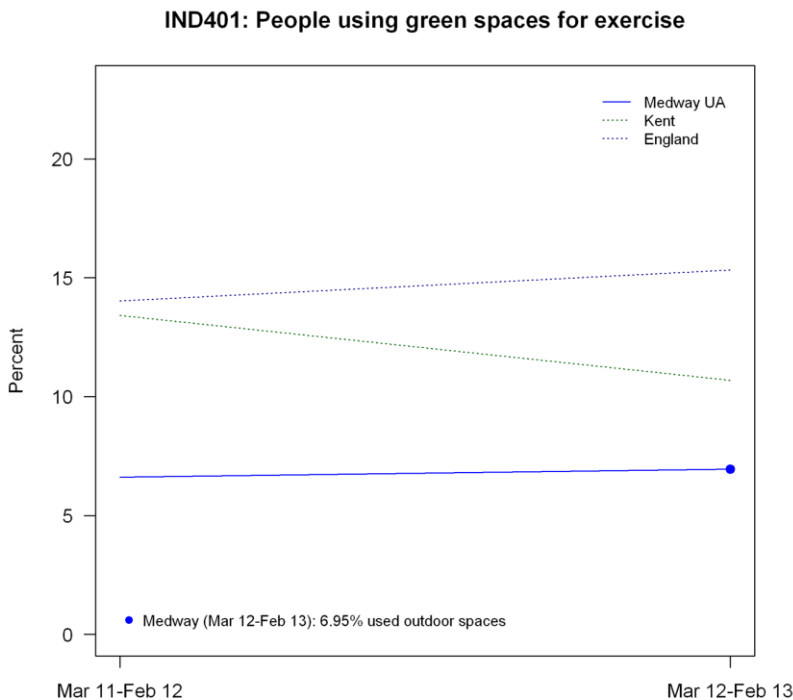
- Did this person listen carefully to you?
- Did this person take your views into account?
- Did you have trust and confidence in this person?

- Did this person treat you respect and dignity?

For each Provider an average weighted score (by age and sex) is calculated for each of the questions. Overall Trust scores are calculated as a simple average of the 4 question scores. National scores are calculated by a simple average of the overall trust scores. Only the overall score is used as the high level outcome measure.

Community mental health services in Medway are provided by Kent and Medway Partnerships NHS Trust. Medway CCG has a programme focus on improving the experience of mental health service users, including closer monitoring of experience along the care pathway, development of Patient Reported Outcome Measures (PROMs) and enhancing shared decision-making.

People using green spaces for exercise



PHOF 1.16

Current status

Medway (Mar 12-Feb 13): 6.95% used outdoor spaces

Additional information

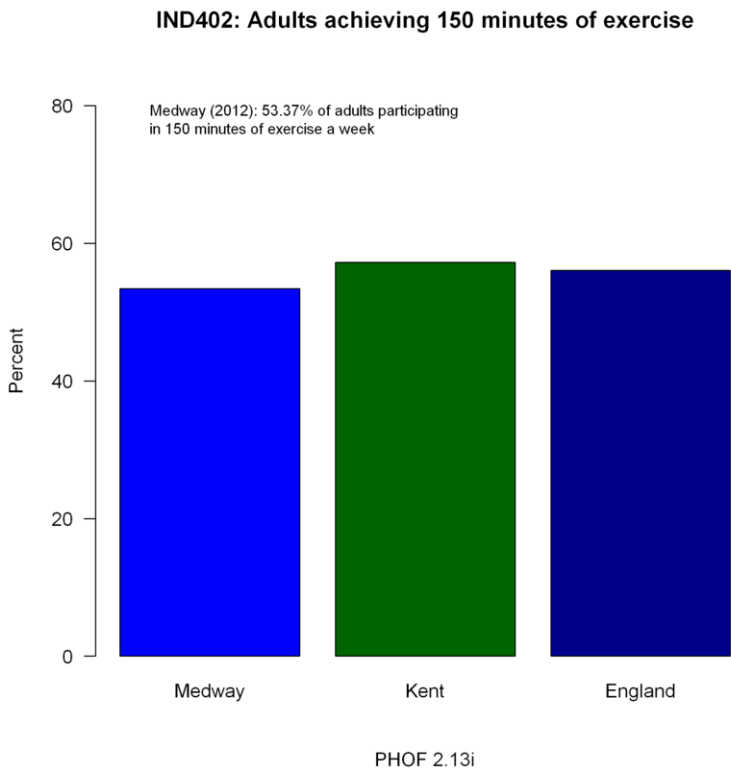
Item	Detail
Description:	IND401: People using green spaces for exercise
Definition:	Percentage of people using green space for exercise / health reasons. The value is a weighted estimate of the proportion of residents in each area taking a visit to the natural environment for health or exercise purposes
Source:	Monitor of Engagement with the Natural Environment Survey, Natural England
Reporting frequency	
Last review	2014-05-14

Every year at least 45,000 people aged 16 years and over are interviewed about their use of the natural environment in the last seven days.

This indicator is a weighted estimate of the proportion of residents in each area taking a visit to the natural environment for health or exercise purposes. Visits to the natural environment are defined as time spent "out of doors" e.g. in open spaces in and around towns and cities, including parks, canals and nature areas; the coast and beaches; and the countryside including farmland, woodland, hills and rivers. This could be anything from a few minutes to all day. It may include time spent close to home or workplace, further afield or while on holiday in England.

During each survey interview, respondents are asked how many visits they have taken to the natural environment in the last 7 days. If any visits have been taken in this period, they are then asked to provide details of one visit (if more than one has been taken, the visit asked about is randomly selected).

Adults achieving 150 minutes of exercise



Current status

Medway (2012): 53.37% of adults participating in 150 minutes of exercise a week

Additional information

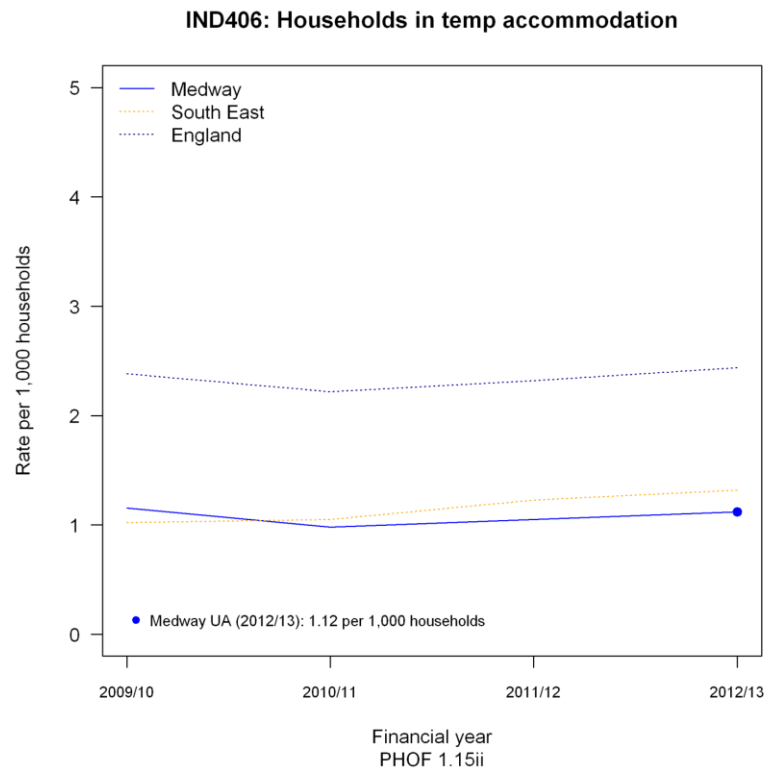
Item	Detail
Description:	IND402: Adults achieving 150 minutes of exercise
Definition:	Proportion of adults achieving at least 150 minutes of physical activity per week in accordance with UK CMO recommended guidelines on physical activity
Source:	Active People Survey, Sport England
Reporting frequency	Financial year
Last review	2014-05-14

This indicator is based on the residents of Medway. The definition for this indicator has changed compared to past data collected as part of Sport England's Active People Survey. It represents respondents aged 16 and over, with valid responses to questions on physical activity, doing at least 150 "equivalent" minutes of at least moderate intensity physical activity per week in bouts of 10 minutes or more in the previous 28 days.

The counts were weighted to be representative of the whole population at each level of geography. Approximately 500 people are contacted in each district and single tier local authority during the survey.

Medway Council has a range of physical activity interventions that it provides for local residents including leisure centres, sporting legacy projects and public health programmes. The community and third sector also play a crucial role in providing sport and exercise opportunities in Medway.

Households in temp accommodation



Current status

Medway UA (2012/13): 1.12 per 1,000 households

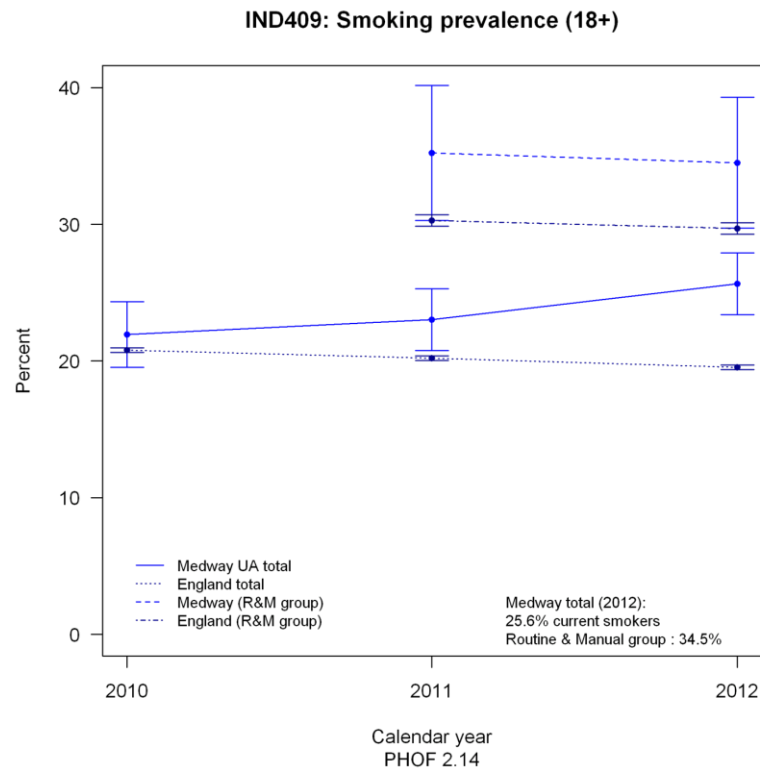
Additional information

Item	Detail
Description:	IND406: Households in temp accommodation
Definition:	Households in temporary accommodation (per thousand households)
Source:	Department of Communities and Local Government
Reporting frequency	Financial year
Last review	2014-05-20

Medway Council places people in temporary accommodation if they are homeless (as defined by legislation), have nowhere to stay and have been accepted as being in priority need. The increase in homeless applications and acceptances has had an impact on the number of clients placed into temporary accommodation. At the end of February 2014, there were 140 households living in temporary accommodation against a target of 135.

However, since September 2013, the number of households in temporary accommodation has fallen despite the increase in households approaching the Council as homeless. This is due to the service quickly sourcing and moving clients in to permanent accommodation and discharging duties on cases. Where the Council has no other option but to place households in temporary accommodation it will ensure that vulnerable people have targeted support to help them move on into settled accommodation.

Smoking prevalence (18+)



Current status

Medway total (2012):
25.6% current smokers
Routine & Manual group : 34.5%

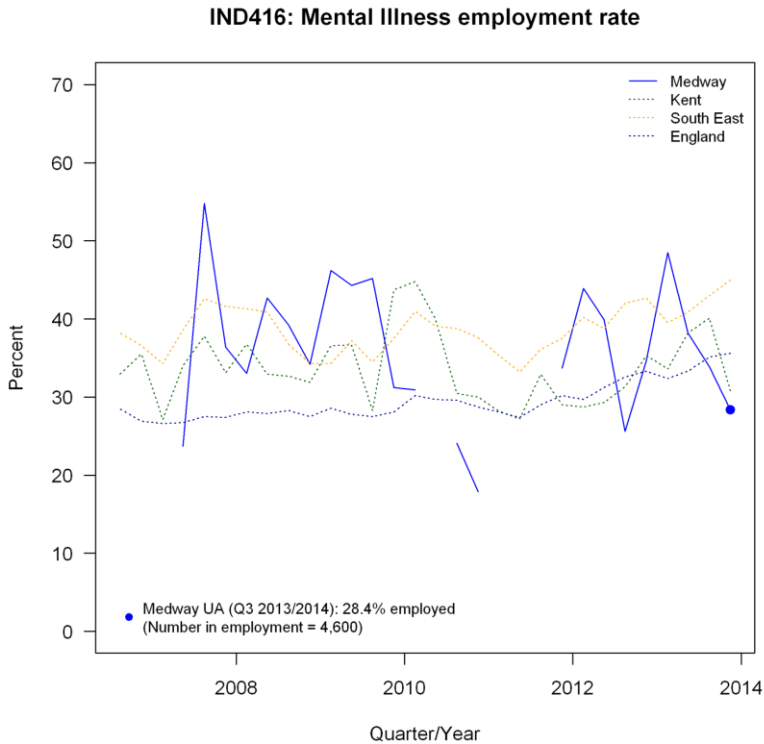
Additional information

Item	Detail
Description:	IND409: Smoking prevalence (18+)
Definition:	Prevalence of smoking among persons aged 18 years and over - persons aged 18+ who are self-reported smokers in the Integrated Household Survey
Source:	Public Health England
Reporting frequency	Calendar year
Last review	2014-05-28

The smoking prevalence among adults in Medway is significantly higher than the England average. The percentage has increased from 2010 to 2012 although the difference between 2010 and 2012 is not significant. The prevalence in routine and manual sub-group is over 34% (England is 29.7%). The difference is not significant.

The data has been published on the PH Outcomes website with the definitions and supporting information (indicator number 2.14). The original data is from the quarterly Labour Force Survey conducted by ONS. This is combined with other surveys to form the 'Integrated Household Survey'. These estimates have been updated to include the whole of 2012 and the number of respondents has been weighted in order to improve representativeness of the sample. The weights take into account survey design and non-response.

Mental Illness employment rate



Current status

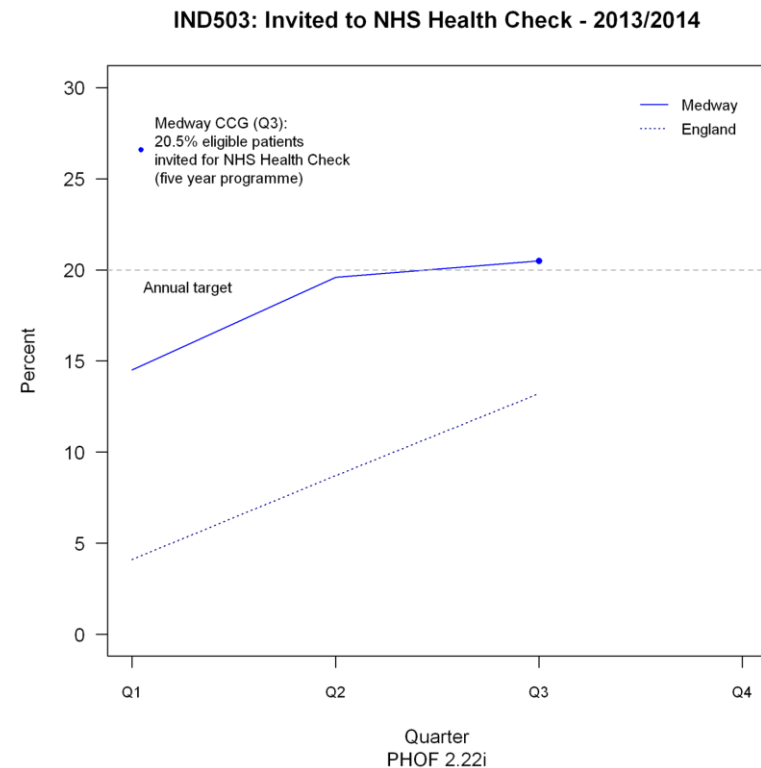
Medway UA (Q3 2013/2014): 28.4% employed
(Number in employment = 4,600)

Additional information

Item	Detail
Description:	IND416: Mental Illness employment rate
Definition:	Proportion of people with a mental illness in employment. Number of people with mental illness in employment are those where the respondent has a health problem or disabilities that they expect will last for more than a year AND has Depression, bad nerves or anxiety or Severe or specific learning difficulties (mental handicap), or Mental illness, or suffer from phobia, panics or other nervous disorder AND is in employment - either an employee, self-employed, in Government employment & training programmes, or and unpaid family worker (this is the ILO definition of Basic economic activity) AND is of working age (ages 16-64)
Source:	NHS IC Indicator Portal
Reporting frequency	Quarter/Year
Last review	2014-05-28

This indicator only covers those aged 18-69 in contact secondary mental health services on the Care Programme Approach.

Invited to NHS Health Check



Current status

Medway CCG (Q3):
20.5% eligible patients
invited for NHS Health Check
(five year programme)

Additional information

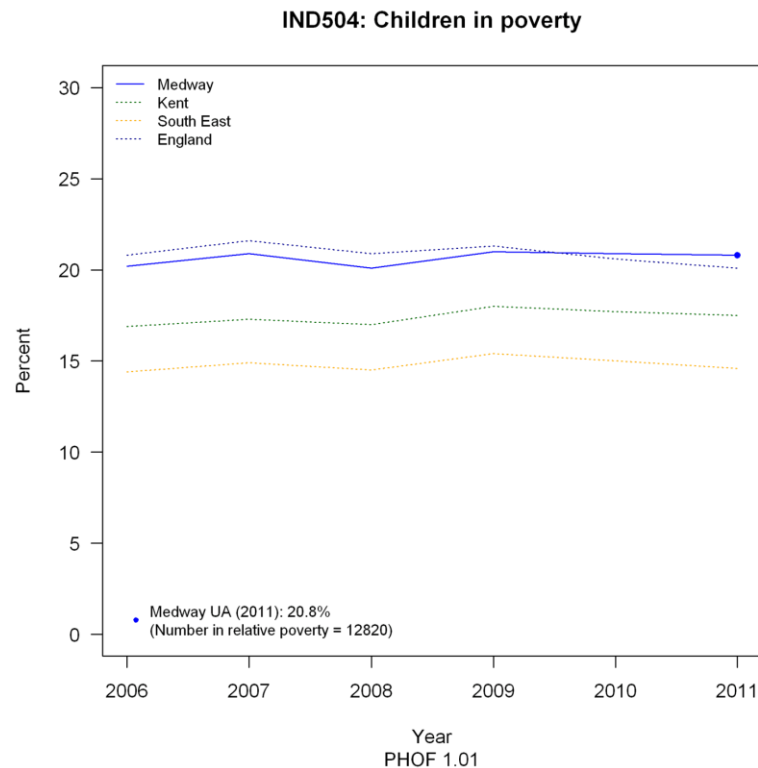
Item	Detail
Description:	IND503: Invited to NHS Health Check
Definition:	Percentage of eligible people who receive an NHS Health Check invite
Source:	Department of Health
Reporting frequency	Quarter
Last review	2014-03-19

The Medway NHS Health Check programme was first implemented in April 2010. All Medway registered patients aged 40-74 without existing cardiovascular disease are eligible for screening once every five years, this equates to 75,400 individuals.

Methods of invitation in Medway include telephone calls and letters (roll out is based on date of birth). The GP practices use an IT system to produce the letters and send out batches based on their practice capacity. GPs are encouraged to carry this work out at the beginning of the financial year when other work streams are lower, so that invitations generally peak in quarter one. There has been an increase each year where the programme has become embedded into the practices.

Because of the IT system used in GP practices in Medway, we can be assured that all patients eligible for an NHS health check will receive an invitation by the end of the financial year.

Children in poverty



Current status

Medway UA (2011): 20.8%
(Number in relative poverty = 12820)

Additional information

Item	Detail
Description:	IND504: Children in poverty
Definition:	Percentage of children in relative poverty (living in households where income is less than 60 per cent of median household income before housing costs)
Source:	HM Revenue & Customs http://www.hmrc.gov.uk/stats/personal-tax-credits/child_poverty.htm
Reporting frequency	Year
Last review	2014-05-28

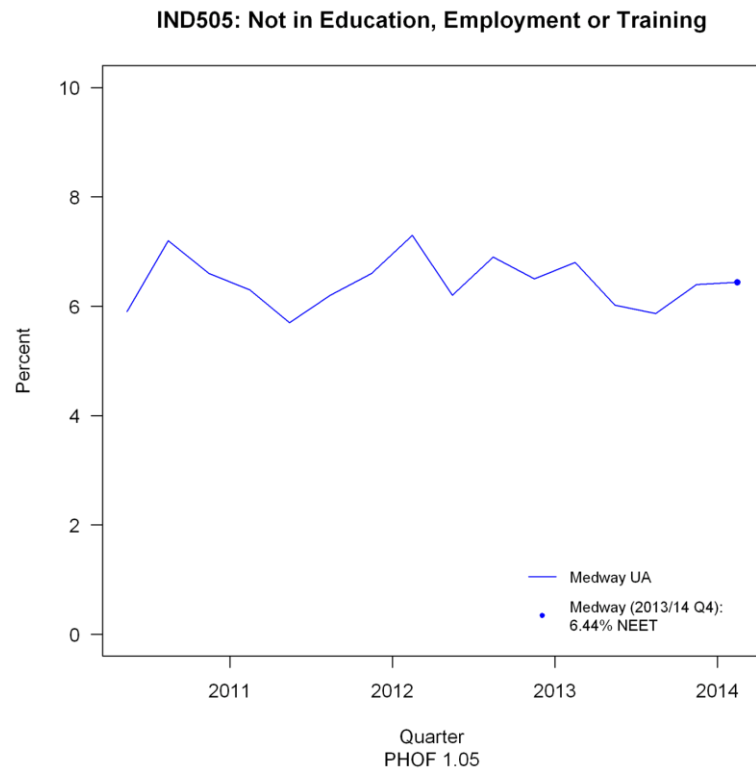
"Previously known as the Revised Local Child Poverty Measure or National Indicator 116, this publication has been renamed Children in Low-Income Families Local Measure to help distinguish these statistics from the Households Below Average Income (HBAI) publication, which provides the definitive national measure of relative child poverty as set out in the Child Poverty Act 2010.

Under the Child Poverty Act 2010 a child is defined as being in relative poverty if they live in a household where income is less than 60 per cent of the national median income. The Children in Low-Income Families Local Measure is based on administrative tax credits and benefit data sources and includes children who are living in families in receipt of out-of-work benefits, or in receipt of tax credits with reported income less than 60 per cent of median income."

Source: [Commentary](#) accompanying the Children in Low-Income Families Local Measure, HMRC

In 2011, a greater proportion of children were living in poverty in Medway than the England average. Gillingham North has the highest level of child poverty.

Not in Education, Employment or Training



Current status

Medway (2013/14 Q4):
6.44% NEET

Additional information

Item	Detail
Description:	IND505: Not in Education, Employment or Training
Definition:	Percentage of 16-18 year olds not in education, employment or training (NEET)
Source:	Medway Youth Trust
Reporting frequency	Quarter
Last review	2014-05-30

The percentage of young people aged 16-18 years not in education, employment or training (NEET) reflects skill development during school years and indicates those at greater risk of a range of negative outcomes, including poor health and early parenthood.

This trend data shows quarterly percentages based on data provided by Medway Youth Trust and has been used in Council performance reporting.

European Social Fund programmes are run throughout Kent and Medway and target young people aged 14 to 19 who are classed as NEET or are likely to become so.

MEDWAY JOINT HEALTH AND WELLBEING STRATEGY DELIVERY PLAN 2014/15

THEME	1. Give every child a good start	LEAD HWB MEMBER	Cllr Mike O'Brien and Barbara Peacock
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PRIORITY ACTION	1. Support to mothers to have good physical and emotional health in pregnancy and in the early months of life: Focus on increasing levels of breastfeeding and reducing smoking in pregnancy.	LEAD OFFICER	Scott Elliott
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No.	ACTION	Who responsible	Completion date	Outputs and measures	Outcomes	Contributing toward national outcome indicators	Progress commentary plus RAG
1	Achieve the next available stage of UNICEF UK Baby Friendly Initiative (BFI) Accreditation for women and childrens services in the acute (stage 2) and community (stage 3) settings	Medway Public Health, Medway Foundation Trust and Medway Community Healthcare	Mar-15	Medway Foundation Trust to have achieved stage 2 for UNICEF UK Baby Friendly Initiative (BFI) Accreditation for acute settings Medway Community Health Care to have achieved stage 3 for UNICEF UK Baby Friendly Initiative (BFI) Accreditation for community settings	Increased prevalence and duration of exclusive breastfeeding and improved cognitive outcomes for children	1,4,5,A and B	
2	Reduce number of women who smoke during pregnancy. Implement Medway Smoking in Pregnancy Action Plan which includes implementing carbon monoxide (CO) testing to all patients at booking and improving on recording methods of smokers at time of booking and delivery. Implement C.O. environmental testing pilot project.	Public Health, Medway Community healthcare, Medway Foundation Trust & Medway Council	Mar-15	Implement action plan, Number and % of pregnant women CO tested and smoking status recorded at time of delivery	Reduction in the rate of smoking at time of delivery to 14%	1,2,3 and 6	
3	Improved early detection and treatment of perinatal mental health disorders through delivery of universal healthy child programme (Antenatal contact and maternal mood assessment)	Dave Smith; Sheena Bolland	Apr-15	% of health visitors trained in early detection and treatment of maternal mental health issues. Numbers/% women seen antenatally by a health visitor; numbers/% of women offered a maternal mood assessment at 6-8 weeks and 3-4 months; numbers of women receiving a health visiting package of care for maternal mental health.	Improved early detection of maternal mental health problems and more effective management; Long term impact on children by improved early attachment increasing emotional resilience and better health outcomes	1,4,5, A and B	
4	Increase the identification and attendance rates at Medway children's centres of families with a new birth, as identified in data shared by Medway Foundation Trust.	Medway Council Early Years	Mar-15	(a) Increased % of identification of children in CACI CCM system from corresponding MFT new birth data (b) Increased % of attendance of children identified from corresponding MFT new birth data (c) Increased total number of attendances of children identified from corresponding MFT new birth data	Improved access and uptake of early childhood services provided by Sure Start Children's Centres across Medway		Baseline: January 2013 - December 2013 (a) Identified = % ; (b) Attending = % ; (c) Attendances =

No.	ACTION	Who responsible	Completion date	Outputs and measures	Outcomes	Contributing toward national outcome indicators	Progress commentary plus RAG
5	Continue to develop Medway Breastfeeding network to allow more people to access the peer support service.	Public Health	Mar-15	Train 12 new peer supporters Increase presence of peer supporters at routine midwife and health visitor appointments and contacts, to maximise opportunity for people to be aware of peer support service	Increased prevalence and duration of exclusive and partial breastfeeding and improved cognitive outcomes for children	1,4,5, A and B	

MEDWAY JOINT HEALTH AND WELLBEING STRATEGY DELIVERY PLAN 2014/15

Appendix 2b i

THEME	2: Enable older people to live independently and well	LEAD HWB MEMBER	Cllr David Brake & Dr Gill Fargher
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PRIORITY ACTION	2.2. Improve early diagnosis treatment and care for people with dementia in line with increasing population need	LEAD OFFICER	Mark Goodman
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No.	ACTION	Who responsible	Completion date	Outputs and measures	Outcomes	Contributing toward national outcome indicators	Progress commentary plus RAG
1	Make Medway a Dementia Friendly Community	Partnership Commissioning Team & Public Health	Mar-15	Develop awareness across Council departments Support the PHE Dementia Friends Campaign Increase the number of Dementia Friends Champions Achieve 6,000 Dementia Friends (pro rata to PM's target of 1 million) Run a campaign to support Dementia Awareness Week Achieve DFC status with Alzheimer's Society Sign up to the National Dementia Declaration Join the national Dementia Action Alliance Support the development of a local Dementia Action Alliance	People with dementia are able to 'live well' and feel empowered to have high aspirations, confidence and know they can contribute	ASCOF 1A, 1H, 1I, 3D PHOF 1.18, 4.13 NHSOF 2.6	
2	Understand the current health and social care needs of people in Medway living with dementia	Public Health & Partnership Commissioning Team	Jul-14	A revised JSNA A map of current services A record of the expressed needs and aspirations of people living with dementia and their carers An analysis of good practice An identification of gaps in current care and support Recommendations for improvement	Ensure commissioning processes are evidence based and reflect current need	ASCOF 1A,D,H; 3A,B,C,D PHOF 2.23; 4.13; 4.16 NHSOF 2.4; 2.6; 4.7	
3	Develop a Medway Dementia Strategy	Partnership Commissioning Team	Sep-14	A set of partnership commissioning options	A clear partnership commissioning strategy upon which intelligent and responsive services are created, maintained and developed to ensure an enhanced quality of life for people living with dementia and their carers	ASCOF 1A,D,H; 2C; 3A,B,C,D PHOF 2.23; 4.13; 4.16 NHSOF 2.1, 2.4; 2.6; 4.7	

No.	ACTION	Who responsible	Completion date	Outputs and measures	Outcomes	Contributing toward national outcome indicators	Progress commentary plus RAG
4	Develop an Implementation Plan	Partnership Commissioning Team	Sep-14	A range of agreed commissioning options Timescales for implementation Improved diagnosis rates (national aspiration is 67%) A focus on early and earliest care and support Care and support which develops sensitively from prevention to responsive intervention A reduction in the length of stay in acute settings Improved diagnosis rates Reduction in inappropriate admissions from nursing home to hospital Supported transitions from specialist facilities to residential and nursing homes Standardised training in dementia care	A dementia pathway that will provide timely interventions that focus on early diagnosis reducing admissions to hospital and mental health units and averts crises Improved quality of care for patients with dementia in acute hospitals and supported early discharge High quality care for adults with dementia at	ASCOF 1A,D,H; 2C; 3A,B,C,D PHOF 2.23; 4.13; 4.16 NHSOF 2.1, 2.4; 2.6; 4.7	

MEDWAY JOINT HEALTH AND WELLBEING STRATEGY DELIVERY PLAN 2014/15

THEME	2. Enable our older population to live independently and well	LEAD HWB MEMBER	Cllr Kelly Tolhurst & David Quirke-Thornton
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PRIORITY ACTION	2.2. Falls prevention and management	LEAD OFFICER	Ben Keeble/ Saloni Zaveri
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No.	ACTION	Who responsible	Completion date	Outputs and measures	Outcomes	Progress to date	Contribution towards national outcome indicators
1	To raise public and professional awareness around falls prevention.						
1.1.	GP Education for falls prevention (reference document for use by GPs to enable rapid assessment of possible causes of patient falls in Primary Care and recommendations for referral pathways to prevent further falls).	Medway CCG	Mar-15	1. Reference document prepared by Consultant Geriatrician and Community Falls Service for support from Urgent Care PMG in February 2014. 2. Consultant Geriatrician and Community Falls Service to present reference document at GP Monthly - in spring of 2014.	1. Aim to improve knowledge of potential causes of falls in Primary Care, resulting in reductions in recurrent falls and increases in falls prevention advice and appropriate referrals to other services aimed at reducing falls. 2. Reduction in ED attendances for falls.	Dr Sanjay Suman, Consultant Geriatrician at MFT presented the Falls assessment tool (assessment & management of falls) for GPs at the recent Medway CCG GP Monthly educational event on the 22nd May 2014. There was also a presentation from Medway Community Healthcare, reminding GPs of referral pathways for Falls. This project is now completed and pathway and referrals in place. Ongoing monitoring and evaluation.	NHS 1.22 PH 2.24 4.14
1.2.	Falls prevention and management training for care homes- pilot project	Medway Council (MCSC/ Public Health)	Dec-14	1. Briefing event for all care homes to be held. 2. Number of training events delivered. 3. Number of care home: a. managers b. other staff attending training events. 4. Number of care homes taking up bespoke package of support. 5. Evaluation of pilot programme	Consistent approach across Medway care homes to falls prevention and management leading to reduction in falls and falls related injury in care home settings.	Briefing event held on 29th May 2014. Excellent attendance from Medway care home managers who were briefed about the importance of falls prevention and management and about the course. Bookings have now been invited. Pre-course questionnaire to be completed for all attendees to get baseline outcome information.	NHS 3.6 PH 4.14 4.13,
2	Commission and develop appropriate services to reduce the risk of falls and falls related injury.						
2.1.	Fast access falls clinic at Medway Foundation Trust	Medway CCG	Mar-15	1. Six monthly review of patients attending clinic to ensure clinic is identifying, treating and referring appropriate patients. 2. Review of patients ED attendances before and after attending clinic to measure impact on falls prevention. 3. CQUIN in place to increase ED assessments completed. Continued review during 2014/15	1. Ongoing falls prevention for identified patients at high risk of further falls. 2. Reduction in ED attendances as a direct impact of the falls clinic. 3. Increasing awareness of falls assessments leading to onward referral to appropriate services for intervention and prevention.	Review of repeat ED attendances completed. 2. Performance is 33% better than the expected 50 % re-attendance rate. 17% was achieved. Falls Assessment Tool for GPs to be presented at GP monthly on 22nd May by Dr Suman, Consultant Geriatrician (MFT) and MCH. This project is now completed and falls clinic running. Ongoing monitoring and evaluation. Falls project April 2013/March 2014 Aim: To increase Falls Assessments completed in ED and reduce repeat attendances for falls. Triage of Falls Assessments completed by Dr Suman and MFT Falls Specialist Nurse and appropriate referrals made	NHS 1.22 4.2 PH 2.24 4.14

No.	ACTION	Who responsible	Completion date	Outputs and measures	Outcomes	Progress to date	Contribution towards national outcome indicators
2.2.	SECamb/ MCH Falls Service- Rapid Access	Medway CCG	Mar-15	1. Development of a rapid access falls pathway from SECamb to MCH Community Falls Service, able to respond to urgent requests with an appropriate falls service and assessment process, including meeting urgent equipment needs. 2. Reduction in conveyance to ED. 3. Increased speed of access to falls prevention advice, including links to social care.	1. Enabling patients to stay at home and improve their experience. 2. Reduction in repeat falls reducing falls related injuries, including fractured neck of femur. 3. Improved interaction with care homes and community falls service	This pilot started as planned in May 2014. Expecting initial data in 1 month.	NHS 1.22 PH 2.24 4.14
2.3.	Specialist Falls Response Vehicles	Medway CCG	Mar-15	1. Medway to utilise the falls response model used in Hertfordshire to reduce unnecessary acute admissions and the social issues that accompany prolonged stays in the acute sector. 2. Two falls vehicles would be available 24 hours a day with a social care professional and Emergency Care Practitioner on board to assess the patient in their home and where it is safe to do so, provides support to enable the patient to remain at home, as well as referring the person into the falls liaison service to receive further support. 3. This service would draw on an equipment store/ equipment support and install any equipment as needed to prevent an attendance or	1. Preventing unnecessary conveyance to hospital for people aged 65 and over who have fallen at home. 2. Minimising the disruption and the risk of disorientation and subsequent lessening in confidence for the older person. 3. Operating falls prevention and offering training, advice and guidance to the management of falls in care homes. 4. To make efficiencies across the health economy by reducing the costs of conveyance to hospital, triage and treatment, transfer home and potential admission.	Undertaking a review of data/evidence from Hertfordshire and other CCGs. Awaiting initial data from South East Coast Ambulance Service. A meeting is arranged for July to include Medway Council Occupational Therapy Team Manager and other stakeholders to start Medways model of development.	NHS 1.22 PH 2.24 4.14
3	To consider the wider environment in the context of falls prevention						
3.1	Improve the safety of the home environment to reduce the likelihood of older people falling at home.	Medway Council	Mar-15	1. Scope the feasibility of a collaboration with Kent Fire & Rescue to include delivery of falls risk assessments with routine home safety checks for older people.	Reduction in frailty and preservation of independent living	Partnerships Manager, Samantha Jones, at Kent Fire & Rescue contacted. Meeting to be arranged at Gun Wharf in June to discuss this further.	PH 2.24 4.14

No.	ACTION	Who responsible	Completion date	Outputs and measures	Outcomes	Progress to date	Contribution towards national outcome indicators
3.2.	Promote healthy lifestyles for older people: ensure access to falls specific exercise classes that can improve their posture, balance and muscle strength.	Medway Council	Ongoing	2.1. Increase the number of older people referred for falls prevention. 2.2. % of people referred to the service who attend an initial assessment. 2.3. % of those attending an initial assessment who complete the 12 week programme. 2.4. % of patients reporting an increase in their physical activity level on completion/ discharge compared with baseline. 2.5. Change in self-reported wellbeing score on completion of course compared with baseline score	Reduction in frailty and preservation of independent living		PH 2.24 4.14

MEDWAY JOINT HEALTH AND WELLBEING STRATEGY DELIVERY PLAN 2014/15

THEME	3:PREVENT EARLY DEATH AND INCREASE HEALTHY YEARS OF LIFE	LEAD HWB MEMBER			Cllr Les Wicks & Dr Peter Green	
PRIORITY ACTION	3. Reduce death rates from cancer (bowel, breast and lung). Focus on improving prevention, awareness and increasing early diagnosis	LEAD OFFICER			Julia Duke-MacRae	
No.	ACTION	Who responsible	Completion	Outputs and measures	Contributing toward national outcome indicators	Progress reporting plus RAG
1	Liaise with health improvement intervention programmes (smoking cessation, physical activity, weight management and nutrition programmes and alcohol project programmes) in raising awareness of risk factors for cancer. Ensure local campaigns within Healthier Medway align with national campaigns	RG/PL	Feb-15	No. responding to advice on lifestyle behaviour changes re: diet, physical activity, smoking through the health improvement services.	15	
2	Identify and collate a list of DNAs (patients who "did not attend") bowel and breast screening for each GP practice through Audit Plus and/or in collaboration with Breast & Bowel screening units to recall patients and encourage attendance at screening programme.	LM/PC	Jul-Aug 14	Produce a list of DNA by GP practice		
3	MOSAIC segmentation of DNA's to examine and apply best communication methods based on previous findings from Cancer Awareness Measure and behavioural insight studies.	PC/PHIT	Sep-14	DNA postcodes collated. Communication methods identified		
4	Promote cancer prevention services within primary care. Run Cancer screening session on the GP educational event- invite Prof Stephen Holloran. Invite GPs to provide feedback on patients' experience of screening programme	PG/JDM	Nov-14	GP supportive of cancer screening programmes and willingness to encourage uptake of screening programme		
5	Identify GP practices with low uptake or who have expressed interest to send endorsement letter with screening invitation or following a notification list to validate patients within the practice in Collaboration with Prof Holloran.	PC/PHIT /LM	Nov-14	Interested GP practices identified and endorsement letter produced		
6	Increase public awareness of early cancer signs and symptoms (breast, bowel and lung) in line with national campaigns- tailored to different audiences using various media. Collaborating with community leaders from BME groups, voluntary groups (Age concern). Collaborating with Outreach NHS Health Checks programme	PL/HH	Mar-15	Be clear on cancer (bowel, lung and breast) symptom campaign including women over 70 breast cancer campaign sustained throughout the year. Cancer symptoms and screening programmes promoted inside the Health Checks mobile van	14	
7	Utilise Macmillan trainer to offer a training package to equip health trainers and volunteers with key cancer awareness message to work with the public, supporting, encouraging people to attend screening programmes when invited and to seek help quickly when there are concerns.Targeting specific groups	PC/LM	Mar-15	Increase in uptake of cancer screening programmes	14	

No.	ACTION	Who responsible	Completion	Outputs and measures	Contributing toward national outcome indicators	Progress reporting plus RAG
8	Produce practice level data on uptake of breast, bowel cancer screening programme and share with primary care	PHIT/MJ	Aug 14 - May 15	Practice level data on breast, bowel cancer screening produced annually		
9	Monitoring uptake and outcomes of bowel and breast cancer screening programme to identify areas of concern for further targeted actions to achieve maximum uptake	JDM/PHIT	Aug 2014-March 2015	Areas with low cancer screening uptake identified and targetted	16,17	
10	Monitoring cancer survival and staging for breast, lung and bowel cancer,	PHIT	March 2015	Produce data for Mortality Working group	18,19,20,21	
11	Evaluate impact of interventions after 12 months	PHIT/LM	Apr-15	Cancer Report produced		

Key

Reference plan for priority three				NB. QOF data annual	
Code	No.	outcomes framework	Text	Data source	Frequency
14	1.4vii (4.5i)	NHS (PH)	Under 75 mortality rate from cancer	ONS	annual
15	2.14	PH	Smoking prevalance 18+	Integrated household survey	annual
16	2.20i	PH	Percentage of eligible women who were adequately breast-screened	PHE	yearly
17	2.20ii	PH	Percentage of eligible women who were adequately	PHE	yearly
18	1.4i	NHS	one year survival from colorectal cancer	PHE	annual
19	1.4iii	NHS	one year survival from breast cancer	PHE	annual
20	1.4v	NHS	one year survival from lung cancer	PHE	annual
21	2.19	PH	cancer diagnosed at stage 1 and 2 as a proportion of cancers	PHE	annual

KEY	
RG	Richard Griffith
PL	Phil Lewis
LM	Lisa Marshall
PC	Peder Clark
PHIT	PH Intelligence Team
HS	Hollie Snelson
PG	Pete Green
JDM	Julia Duke-MacRae

MEDWAY JOINT HEALTH AND WELLBEING STRATEGY DELIVERY PLAN 2014/15						
THEME	4. Improve physical and mental health and wellbeing		LEAD HWB MEMBER	Cllr Andrew Mackness & Alison Burchell		
PRIORITY ACTION	4.1. Increase awareness of Mental Health conditions and support for prevention, early diagnosis and treatment. (Focus on MH promotion).		LEAD OFFICER	Sally-Ann Ironmonger		
No.	ACTION	Who responsible	Completion date	Outcome and output measures	Contributing to national outcomes	Progress to date
1	Training and awareness: Develop and deliver a range of training programmes for decision makers, partners and community members, to raise awareness of mental health promotion and suicide prevention.	Colin Thompson/Julia Thomas	Mar-15	No of GPs trained in suicide prevention; No. of partners receiving mental health awareness training No. of partners receiving mental health first aid training No. of ABM champions offered Mental Health module	NHSOF 4.7 PHOF 2.23	
2	Develop outcome based interventions to promote mental health undertaken by Community Development Workers in Medway	Colin Thompson/CCG	June 204 and ongoing (timelines determined by specific projects)	Detailed proposal completed in June 2014, which will determine deliverables.	NHSOF 4.7 PHOF 2.23,	
3	Raise awareness of mental health support services network available for residents in Medway					
3.1.	Undertake mapping of Tier 1 mental health services	CCG/ Julia Thomas	TBC	1. Task group convened 2. Scoping undertaken for mapping exercise 3. Mapping completed 4. Gap analysis undertaken 5. Recommendations reported	NHSOF 2.5 1.8, 1.18, 2.8, 2.23 QS14 PHOF NICE	
3.2	Improve the availability of resources and information about services, support and choices for vulnerable people	Sara Moreland/Julia Thomas	Oct-14	Design and produce information resources for targeted populations at high risk of poor mental wellbeing		
4	Identification of patients at high risk of suicide and ensure appropriate signposting or referrals.	CCG	Mar-15	Training completed in primary care Pathways in place	NHSOF 1.5 4.9, 4.10 PHOF	

MEDWAY JOINT HEALTH AND WELLBEING STRATEGY DELIVERY PLAN 2014/15

THEME	Improve mental and physical health and wellbeing	LEAD HWB MEMBER	Cllr Howard Doe & The Very Rev. Dr. Mark Beach
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PRIORITY ACTION	Reduce social isolation through a social isolation strategy developed and delivered jointly with key partners.	LEAD OFFICER	Colin Thompson
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No.	ACTION	Who responsible	Completion date	Outcome and output measures	Progress to date	Contributing toward national outcome indicators
1	Production of Joint Strategic Needs Assessment chapter for social isolation	Colin Thompson	Early July 2014	JSNA chapter is available via Medway JSNA website outlining data on need, current mapping, evidence base and recommendations for future	Briefing paper has been produced and circulated to Health and Wellbeing Board. Quantitative data is complete. Focus groups are in the process of being undertaken	ASCOF 1A, 1B, 1.D, 1.I, 3D PHOF 1.16, 1.18, 1.19, 2.23, 4.13
2	Consultation with a range of partners and community groups as to what would work in Medway in terms of ensuring that the barriers for social isolation are minimised for different communities in Medway	Colin Thompson	Sep-14	Outcomes from focus groups and scoping work will inform JSNA and strategy development	Scoping with different partners is being undertaken. Focus groups planned in June/July.	
3	Development of strategy and action plan for Social Isolation in medway.	Colin Thompson	Sep-14	Production of Strategy and action plan	The JSNA chapter and consultation with different agencies and communities will inform the development of the strategy, along with the research evidence base.	
4	Setting up of strategy implementation group to ensure that strategic priorities are implemented to reduce social isolation in Medway following the production of the strategy	Colin Thompson	Sep-14	Strategy group will report progress to the Health and Wellbeing Board		
5	Working with different providers about linking in current available activity (ie leisure, arts) to different community groups and settings to ensure barreirs to access are minimised	Colin Thompson	Sep-14	Increases in the number of people attendng sessions in leisure centres, adult eduction etc.	Scoping activity currently being undertaken	

MEDWAY JOINT HEALTH AND WELLBEING STRATEGY DELIVERY PLAN 2014/15							
	THEME	5. Reduce health inequalities		LEAD HWB MEMBER	Cllr Vince Maple Dr A Barnett		
	PRIORITY ACTION	5. Increase targeting of disadvantaged groups for promotion of healthy lifestyles. (Focus on promoting healthy eating and physical activity and the control of tobacco, drugs and alcohol).		LEAD OFFICER	Rachael Horner		
No.	Action	Who responsible	Completion date	Outputs and measures	Outcomes	Contributing toward national outcome indicators	Progress reporting plus RAG
1	Healthy Eating - To advertise nutrition education sessions (teaching cookery skills and increasing confidence in cooking healthy recipes) more heavily in areas with higher prevalence of obesity. Delivering workshops within schools, areas with high deprivation and specifically targeting adults at high risk of developing type two diabetes. To expand documentation to improve monitoring of at risk groups. To investigate access to equipment. To ensure social landlords tied in.	PH Health Improvement team and local and community organisations	Mar-15	<ul style="list-style-type: none"> No. of nutrition education workshops delivered per area No. of people participated. (service data) improved documentation to enable closer monitoring of participants 	<ul style="list-style-type: none"> *Improved knowledge and ability of healthy eating in at risk populations * Improved focussing of programme on at risk groups. 	A, B, C, 1, 2, 6, 7, 14, 15, 18	
2	Training and awareness - Obtain RSPH accreditation for four training programmes for decision makers, partners and community members that promote healthy lifestyles - Let's talk weight, Alcohol IBA, Smoking Cessation level 2 and A Better Medway Champions.	Public Health, H&WB board members, community members and health professionals	Mar-15	<ul style="list-style-type: none"> Number of training programmes developed Number of key decision makers, community members and health professionals attended training. Training recruitment strategy 	PH awareness disseminated widely to key members of the community	all	
3	Contribute to increasing the physical activity and improving the wellbeing levels of more deprived populations by promoting and developing transport corridors that encourage personal movement by walking, cycling and bus travel.	RCC Integrated travel team	Mar-15	<ul style="list-style-type: none"> number of road traffic accidents in pedestrians and cyclists trends of cycle usage on the strategic cycle network; number of walking buses and approximate number of children number of bikeability training sessions delivered / pupils achieving Leve 	<ul style="list-style-type: none"> Accessible bus services Encouraged walking Encouraged cycling Green Grid Improved air quality 	B, C, 1, 2, 3, 4, 5, 7, 8, 13, 15, 16, 17, 19, 20, 24	The number, type and extent of projects that affect public highway landscape and furniture will be documented in quarterly reports.
4	Develop targeting of smoking cessation services to vulnerable groups	PH, benefits team, housing, other council programmes as evolves	Ongoing	<ul style="list-style-type: none"> * increased knowledge of vulnerable groups * increased number of vulnerable groups accessing smoking cessation services 	Reduced smoking prevalence in vulnerable groups	A, B, C, 1, 2, 9, 10, 18, 19, 20,	Julia and Rachael to brainstorm action plan by end May. Linked to welfare reform work.
5	Piloting a treatment programme focussing on reducing smoking in adult patients with moderate to severe mental health needs.	KMPT, PH	May-15	<ul style="list-style-type: none"> specialised training course for KMPT staff #KMPT staff trained a set of tools and resources for staff to use with patients 	a greater understanding of the support needed by patients with mental health needs in quitting smoking that can inform future service delivery	A, B, C, 1, 2, 9, 10, 18, 19, 20,	

HEALTH AND WELLBEING BOARD

17 JUNE 2014

SOCIAL ISOLATION AND LONELINESS: BRIEFING PAPER

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Summary

This paper provides an overview of social isolation and loneliness, the potential health effects and interventions that are effective in reducing it and ways in how we can move forward in developing a strategy and delivering an action plan.

1 Background

- 1.1 The concepts of social isolation and loneliness are frequently used interchangeably but are defined as two distinct concepts. Loneliness' is a subjective negative feeling of a lack or loss of meaningful social relationships (e.g. loss of a partner or children relocating), while 'social isolation' is an objective measurement to indicate a lack of social interaction and relationships caused by loss of mobility or deteriorating health (Biordi and Nicholson, 2008).
- 1.2 It is possible to have very few social contacts or relationships without feeling lonely and conversely individuals can live a seemingly rich social life and feel lonely nevertheless (Coyle and Dugan, 2012).
- 1.3 There are a number of population groups that have an increased vulnerability to social isolation. Older people are significantly more likely to suffer from social isolation with contributing factors being 'loss of friends and family, loss of mobility or loss of income'. Other population groups at risk include carers, refugees and those with mental health problems. (Social Care Institute for Excellence 2011).
- 1.4 It is estimated that across the present population aged 65 and over, that 5%-16% are lonely (O' Luanaigh and Lawlor 2008) and 12% feel socially isolated (Greaves and Farbus 2006). If this estimate was applied to Medway this would result in an estimate of 4,698 people over 65 years old being socially isolated and between 1,958 and 6,264 people being lonely. The Medway JSNA highlights that the rapid increase in the ageing population, the need to plan for this across all areas of health and social care and the importance of feeling safe within the home to reduce social isolation.

2 Policy context

- 2.1 The National Service Framework for Older People (2001) acknowledged isolation in relation to falls and depression and linked the differential access to services between rural and urban areas to social isolation.
- 2.2 Putting People First (Department of health, 2007) prioritised the alleviation of loneliness and isolation and recognised the importance of strong social relationships.
- 2.3 The Marmot Review (2010) highlighted the importance of loneliness and social isolation in the promotion of health and wellbeing and in tackling inequalities.
- 2.4 The Adult Social Care Outcomes Framework for 2013/4 contains a new measure of social isolation, shared with the Public Health Outcomes Framework, which draws on self-reported levels of social contact to provide an indicator of social isolation. There are two indicators that are directly related to social isolation in the framework. These are the percentage of adult social care users who have as much social contact as they would like and the percentage of adult carers who have as much social contact as they would like. The values for Medway are 43.1% and 44% for the respective indicators which are similar to the England average.

3 Health effects of social isolation and loneliness

- 3.1 Loneliness and social isolation can have a considerable impact on the health and wellbeing of an individual. Loneliness is associated with a range of negative health outcomes including mortality, dementia, high blood pressure, increased stress levels and suppression of the immune system (Holt-Lunstead et al. 2010).
- 3.2 People with stronger social relationships have a 50% increased likelihood of survival than those with weaker social relationships. This mortality difference is comparable with well-established risk factors for mortality such as smoking, obesity and physical inactivity (Holt-Lunstead et al. 2010).
- 3.3 A study by Steptoe et al. (2013) identified that both social isolation and loneliness were associated with increased risk of death but argued that the objective nature of social relationships may be more crucial to older people's health rather than individual perceptions of loneliness. Social isolation was assessed in terms of contact with family and friends and participation in civic organizations and loneliness was assessed using a validated questionnaire in 6,500 men and women aged 52 and older who took part in the English Longitudinal Study of Ageing in 2004–2005. The results showed that mortality was statistically higher for social isolation after taking account of baseline health and demographic factors, such as wealth, ethnicity, marital status and education. Loneliness was not statistically significant associated with increased mortality once the baseline health and demographic factors were taken into account.

4 Interventions that are effective in reducing social isolation and loneliness

- 4.1 Reducing social isolation and loneliness can reduce the demand for health and social care interventions and the evidence shows that there are a number of interventions that can have a positive impact on reducing social isolation or loneliness, although the quality of the relationships in the interventions is a vital component. Also, some caution is needed when interpreting the research outcomes because there are a variety of populations that may have a different response to interventions (ie those who are very frail, those from different cultural backgrounds).
- 4.2 Butler (2006) found that befriending schemes can have a positive impact on reducing loneliness. Befriending schemes are an intervention that introduce an individual to one or more individuals with the aim of increasing additional social support through the development of sustaining an emotion-focused relationship over time. They can include home visits by volunteers or paid workers or telephone or group support and often provided by community or voluntary organisations such as Age UK.
- 4.3 Community Navigators are usually volunteers who provide 'hard-to-reach' or vulnerable people with emotional, practical and social support, acting as an interface between the community and public services and helping individuals to find appropriate interventions. There is evidence that people who used community navigator schemes became less lonely and socially isolated following such contact (Windle et al 2008).
- 4.4 Supportive group services (such as lunch clubs, bereavement support groups), and social group schemes which aim to help people widen their social circles can be effective in reducing loneliness and social isolation. A study by Savikko et al. (2010) showed a support group that offered social group activities ('art and inspiring activities', 'group exercise and discussion' and 'therapeutic writing and group therapy') reported that 95 per cent of the participants (mean age 80) felt that their feelings of loneliness had been alleviated during the intervention. Pitkala et al. (2009) found that group based interventions that included art and cultural activities (eg music sessions, cultural events and sights, and production of their own art) and exercise and health discussion groups, (eg walking, strength training, swimming, or senior dancing) had a significant reduction in measured hospital bed days, physician visits and outpatient appointments. A systematic review by Dickens et al (2011) found that sessions offering social activity and/or support within a group format were effective in alleviating social isolation.
- 4.5 Mentoring schemes involve working with people with the goal of providing clients with the necessary skills and abilities to ensure that they are able to continue and sustain any achieved change following withdrawal of the service. There is evidence that mentoring schemes can have a positive impact in improving symptoms of depression and after 12 months follow-up (Greaves and Farbus 2006)

- 4.6 There is very limited evidence on the cost-effectiveness of interventions to reduce social isolation or loneliness and it is relatively complex to measure accurately. Knapp et al (2010) demonstrated the economic impact of Befriending Interventions and Community Navigators, compared with what might have happened in the absence of any such service. Along with the costs of 'formal' service provision, those unpaid 'resources' and 'opportunity costs' provided by family and/or informal carers were included. They found that a typical service for befriending would cost around £80 per older person within the first year and provides about £35 in 'savings' due to the reduced need for treatment and support for mental health needs. Pitkala et al. (2009) estimated cost-savings of supportive closed groups and found that there was a saving of €62 per person due to a reduction of hospital bed days, physician visits and outpatient appointments. This saving took the cost of the intervention into account.

5 How we can make progress in reducing Social Isolation and Loneliness in Medway

- 5.1 A web toolkit for Health and Wellbeing Boards has been developed to reduce loneliness and social isolations. It recommends that there should be a four step approach that includes; 1)Gathering information, 2)Strategy development, 3)Strengthening partnerships, 4)Monitoring and evaluation
- 5.2 A Joint Strategic Needs Assessment (JSNA) of social isolation and loneliness should be undertaken in order to inform the development of a strategy. An estimate 'isolation index' could be constructed from Mosaic data to identify clusters of households that are potentially vulnerable to loneliness and isolation at Lower Super Output Area (LSOA) level. The JSNA should also include data on risk factors such as sensory impairment and caring. It could include qualitative data that takes account of the views and experience of older people and other population risk groups in relation to social isolation and loneliness. The JSNA should include information from stakeholders and mapping of current services that are available that may alleviate social isolation or loneliness.
- 5.3 Development of a strategy to alleviate social isolation and loneliness should follow from the JSNA highlighting the priorities based on the need identified from the data, current services, utilisation of good practice from other areas and research evidence. The strategy should be produced with input from a range of stakeholders such as Medway Older Peoples Partnership (MOPP), Age UK Medway, Medway Pensioners Forum, Sunlight Development Trust. Development of the strategy should include the consultation and involvement of older people and other population groups at risk across Medway.
- 5.4 Health and social care services need to work in close partnership with the voluntary sector in determining priorities and designing realistic evidence based service interventions that offer flexibility within the Medway population. For example, it is important to ensure that befriending schemes are not too rigid in terms of times and days.

5.5 Evaluation is a key component of any future programmes in Medway. Self-reporting is regarded as the best means of measuring social isolation and loneliness amongst older people. Measurements using valid scales such as De Jong Gierveld Scale should be utilised. In order to assess whether specific programmes are able to change individuals' quality of life, or impact on their care pathway, participants need to be asked their views before the start of the intervention as well as following it. Validated quality of life tools should be used in the evaluation process (eg EQ-5D).

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