Alcohol

Summary

Introduction

Alcohol is a prominent commodity in our communities, with an increase in the number of premises licensed to sell alcohol, particularly shops, since 2005 [1]. For many it is associated with positive activities. However, 10 million or more people drink at levels which increase their risk of health harms, and alcohol consumption is a leading factor for ill-health. Among those aged 15 to 49 in England it is the leading cause for ill-health, early mortality and disability [2].

Increased affordability of alcohol in the 1980s and 1990s, a shift to higher strength products and an increase in consumption by women has led to an increase in sales in England and Wales of 42% since 1980. Most alcohol is now bought from shops and drunk at home [1].

Many indicators of alcohol-related harm have seen an upward trend over recent years. Alcohol related hospital admissions and mortality are increasing. This is particularly apparent in the most deprived third of the population. More working years of life are lost in England as a result of alcohol-related deaths than from cancer of the lung, bronchus, trachea, colon, rectum, brain, pancreas, skin, ovary, kidney, stomach, bladder and prostate, combined [2].

The annual economic burden of alcohol is estimated as being between 1.3% and 2.7% of annual GDP [2]. There is a considerable body of international literature showing that policy and treatment for alcohol issues is both effective and cost-effective [3].

This needs analysis considers alcohol issues in adults only.

Key issues and gaps

- Compared to the South East, Medway has high levels of hospital admissions for alcohol conditions and high levels of alcohol related mortality.
- Hospital admissions for alcohol related liver disease, mental and behavioural disorders and alcohol related conditions, are rising in Men.
- Males between 40 and 64 years are showing a rapid rise in alcohol related hospital admissions where an alcohol-specific illness is the main reason for admission.
- Females between 40 and 64 are also showing a growth in hospital admissions where an alcohol-specific illness is the main reason for admission.
• Overall mortality caused by deaths from alcohol-specific conditions for persons of all ages, is worse than the South East.

• There is a need for effective strategies to address alcohol misuse in hard to reach groups, such as the Eastern European community and the homeless.

• The provision of community rehabilitation and post treatment support needs to be improved.

• There is a need for improved mental health support for those in treatment.

• There is a need for a coherent and comprehensive approach to street drinking.

**Recommendations for commissioning**

Commissioning of the substance misuse and treatment service, which includes alcohol treatment services, was completed in 2018. Once the service is embedded a Health Impact Assessment should be conducted to identify remaining or new gaps.

**Who is at risk and why?**

**Alcohol and health harms**

The context of alcohol use and misuse as a public health issue is due to the complex relationships between alcohol and a range of issues. Alcohol has been identified as being a causal factor in more than 200 medical conditions[4], including:

• A range of cancers, including mouth, throat, stomach, liver and breast cancer[4][2].

• Cirrhosis of the liver[4][2].

• Heart disease[4][2].

• Mental Health issues, including depression[4][2].

• Stroke[4][2].

• Pancreatitis[4][2].

• Liver disease[4][2].

It is also an influence on a range of issues linked to the wider determinants of health, such as

• Crime and disorder[5][6].

• Relationship and family problems[5][6].

• Homelessness[5][6].

• Unemployment[5][6].

• Domestic abuse[5][6].

• Child safeguarding and child sexual exploitation[4][7].
Adult safeguarding[4].

All major body systems are affected by alcohol consumption. The effects vary according to a number of factors including age, gender, body mass index (BMI), pattern and volume of alcohol consumption and the length of time someone has been consuming alcohol[2].

General population

In 2016, among adults aged 16 years and above, 56.9% of respondents drank alcohol in the week before being interviewed for the Opinions and Lifestyle Survey, the lowest level seen since our time series began in 2005 (64.2%). This equates to around 29 million people in the population of Great Britain[8]. In 2014, over 10 million adults were regularly drinking more than the recommended maximum of 14 units of alcohol each week. Of these, 1.9 million were drinking at high-risk levels, defined as drinking more than 35 units per week for women and more than 50 units per week for men[2].

Men

31% of men in England drink alcohol in a way that presents increasing risk or potential harm to their health and wellbeing[4]. Gender and inequality gaps show that disproportionate levels of harm are impacting on men[9]. Among men, the prevalence of drinking more than 14 units a week increases with age and is most common among men aged 65 to 74 years. Thirty-nine per cent of men this age drink at this level[2].

Women

16% of women in England drink alcohol in a way that presents increasing risk or potential harm to their health and wellbeing[4]. Among women, the proportion who drink more than 14 units a week declines between the ages of 25 and 44 years, and is highest among women aged 55 to 64 years with 21% of women this age drinking at this level[2].

Unborn Children

During pregnancy alcohol can pass across the placenta to the foetus which is unable to process the alcohol in the same way as an adult. Drinking heavily can lead to Foetal Alcohol Syndrome (FAS), which is typified by restricted growth, facial abnormalities, learning and behavioural disorders. Data that would indicate incidence and prevalence are not routinely collected although numbers are likely to be low at a population level.

Age

Among those aged 15 to 49 in England, alcohol is now the leading risk factor for ill-health, early mortality and disability and the fifth leading risk factor for ill-health across all age groups[2]. Young people aged 16 to 24 years in Great Britain are less likely to drink than any other age group; when they do drink, consumption on their heaviest drinking day tends to be higher than other ages[8].

Socio economic factors

The highest earners, those earning £40,000 and above annually, are more likely to be frequent drinkers and “binge” on their heaviest drinking day when compared with the
lowest earners[8]. (Binge drinkers are defined as women who drink more than 6 units and men more than 8 units on their heaviest drinking day in the previous week.)

While those from lower socioeconomic groups report lower levels of average consumption, they experience greater or similar levels of alcohol-related harm. They are more likely to die or suffer from a disease relating to their alcohol use. In England rates of alcohol-specific and related mortality increase in line with higher levels of deprivation and alcohol-related liver disease is strongly related to the socioeconomic gradient. This gives rise to what has been termed the 'alcohol harm paradox' whereby disadvantaged populations who drink the same or lower levels of alcohol, experience greater alcohol-related harm than more affluent populations. There are a number of hypotheses which try to explain this issue, although the reasons are not fully understood. Possible factors may be:

- Different drinking patterns in different socioeconomic groups[2].
- Lower resilience and/or compounding effects with other risk factors or health conditions for those in lower socioeconomic groups[2].
- Differential access to health services between socioeconomic groups[2].

**Ethnicity**

The proportion of adults who do not drink varies between ethnic groups[2].

Asian groups are most likely to abstain from alcohol, particularly Asian women. About 40% of Black people do not drink compared to between 10 and 15% of White ethnic groups.

**The level of need in the population**

Local alcohol health data is available through the Public Health England (PHE) Fingertips[9].

There are two types of measure; broad and narrow. 'Broad' is an indication of the number of admissions to hospital where the primary diagnosis or any of the secondary diagnoses have alcohol as a contributory factor[9]. 'Narrow' shows the number of admissions where an alcohol-related illness was the main reason for admission or was identified as an external cause[10].

**Key indicators**

Compared to the South East, Medway has high levels of hospital admissions for alcohol related and alcohol specific conditions, alcohol related mortality and alcohol specific mortality[9].

**Hospital admissions for cardiovascular disease**

Coronary heart disease is the single most common cause of premature death in the UK. There is an increasing trend in Medway for the rate of alcohol related cardiovascular disease[9].
**Hospital admissions for liver disease**

Alcohol is the most common cause of liver disease in England. Alcohol-related liver disease accounts for over a third of liver disease deaths. The overall trend for alcohol related liver disease admission episodes in Medway is increasing, and is high compared to the South East region. The data shows a significant increase between 2013/14 to 2015/16 for males in this category[9].

**Admission episodes for mental and behavioural disorders due to use of alcohol condition**

Overall for both narrow and broad measures for this data Medway has a constant upward trend, and is generally similar to the South East region. However for males in both categories there has been a sharp increase from 2014/15 to 2015/16. Medway now has worse rates when compared to the South East region for males[9].

**Admissions episodes for alcohol related conditions (narrow) by age and gender**

Medway data for admission episodes for alcohol related conditions (narrow) has shown a rapid rise between 2014/15 to 2015/16 for males between 40 and 64 years following a period of constant to decreasing numbers. Females in this age group have shown a smaller growth over the same period of 2014/15 to 2015/16[9].

**Hospital admissions due to alcohol specific conditions**

Medway has been largely constant over the last few years for hospital admissions where the primary diagnosis or any of the secondary diagnoses, are alcohol specific conditions, but has shown a rapid rise for males between the period of 2014/15 to 2015/16[9].

**Alcohol specific mortality**

Overall, alcohol specific mortality, which refers to deaths from alcohol-specific conditions for persons of all ages, has shown a steady downward trend in Medway from 2006/08 to 2014/16. However, the rate of male specific mortality is greater than the rest of the South East region[9].

**Mortality from chronic liver disease**

While the rate for mortality in males from chronic liver disease in Medway decreased between 2013/15 and 2014/16, it is still significantly greater than the South East region[9].

**Alcohol related mortality**

There has been an increasing trend in alcohol related mortality in males of all ages, with rates significantly higher in 2015 to 2016 when compared to the South East region[9].

**Alcohol consumption**

The proportion of drinkers in Medway who can be categorised as engaging in increasing risk and higher risk drinking or possible dependence is 26.6%. 16.3% of drinkers consume alcohol on more than 4 or more days a week. 15.5% of drinkers binge drink[11].
**Current services in relation to need**

Community based specialist treatment for people who misuse alcohol has been available in Medway for over 10 years. Commissioning intentions have reflected national drug strategy changes, including a drive towards promoting and sustaining the recovery of adults from dependent and problematic substance misuse.

**Alcohol Treatment Services**

Adult alcohol treatment services are provided in Medway, with locations in Chatham and Gillingham. Services are available for anyone over the age of 18. Referrals can be made via professionals, such as GPs, as well as self referrals.

For the period 01/10/2016 to 30/09/2017, 224 adults were in treatment with 117 successful completions[12].

**Don’t Bottle It Up**

Don’t Bottle It Up[13] is a web based alcohol intervention promoted by Medway Public Health. Between October 2016 and October 2017 there were over 3275 visits to the website, with 1399 of these going on to complete the AUDIT self assessment tool[14].

**Intervention and Brief Advice (IBA)**

IBA is an alcohol brief intervention which typically involves using a validated screening tool to identify ‘risky’ drinking, and then the delivery of short, structured ‘brief advice’ aimed at encouraging a risky drinker to reduce their consumption to lower risk levels[15].

- IBA training has been given to a variety of people in different settings including:
  - Health professionals, such as pharmacies, GP’s, dentists and stroke services.
  - Partners, such as community wardens and KFRS.
  - Medway Champions.
  - Older adult groups.

**Projects**

- Blue Light Project - a national initiative to develop alternative approaches and care pathways for treatment resistant drinkers who place a burden on public services[16].
- Public Health participation in the alcohol licensing process.

**Projected service use and outcomes in 3–5 years and 5–10 years**

*Table 1: Medway population projections 2012 - 2026 (ONS sub-national population projections). Note: Figures are in thousands*

<table>
<thead>
<tr>
<th></th>
<th>15 - 24</th>
<th>25 - 34</th>
<th>35 - 49</th>
<th>50 - 64</th>
<th>65 +</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>36.4</td>
<td>40.7</td>
<td>55.3</td>
<td>53.0</td>
<td>45.4</td>
</tr>
</tbody>
</table>
The key indicators of hospital admissions for alcohol related and alcohol specific conditions and alcohol related mortality all show an increasing trend in Medway[9] but the contributing reasons are complex.

Factors that may contribute to a reduction in hospital admission episodes are:

- The ONS figures suggest that 15-24 year olds in Medway will actually decrease over the next ten years and then gradually increase again. Alcohol consumption trends among young people have shown they are drinking less frequently compared with a decade ago[17], and coupled with the decreasing population of this cohort, this may result in a decrease in interventions.

- Changes to treatment and recovery services, aimed at supporting substance misusers through the treatment phase and into a sustainable recovery may reduce the number of people re-presenting to treatment services.

- Increase in IBA interventions within the hospital setting in response to updated CQUIN indicators[18], due to start in 2018, identifying increasing risk and higher risk drinkers, will support and encourage healthier behaviour, with the intention of reducing alcohol harms.

- Decrease of the availability of alcohol due to the adoption of a more strategic Statement of Licencing Policy, including a Cumulative Impact Policy in those geographical areas of greatest alcohol related harms.

- Factors that may contribute to an increase in attendances

- Middle aged groups (40 - 64 years), particularly males, who are showing an increasing trend in all key indicators, are projected to grow at a faster rate than younger groups[9]. This older group may experience an increasing incidence of alcohol related harms in line with this trend, with increased associated hospital admission episodes.

- Increase in IBA interventions within the hospital setting in response to updated CQUIN indicators[18], identifying dependent drinkers with subsequent referrals to treatment services, may increase the number of those seeking treatment and recovery services.

**Evidence of what works**

PHE and NICE recommends a variety of measures to address alcohol related harm[2][6]:

- Taxation and price regulation.

- Regulating marketing.

- Regulating availability.
• Providing information and education.
• Managing the drinking environment.
• Brief interventions and treatment.

National measures
• Policies that reduce the affordability of alcohol are the most effective, and cost-effective, approaches to prevention and health improvement[2].

• Taxation and price regulation policies affect consumer demand. Minimum unit pricing (MUP) is highly targeted, ensuring any resulting price increases are passed on to the consumer. Combining an increase in taxation alongside MUP is estimated to lead to substantial gains in alcohol-related health, reductions in crime and work absence costs. This reduction is greater than that achieved by MUP in isolation[2].

• Marketing bans are highly effective and cost effective. Complete bans are more effective and cost-effective than partial bans[2].

• Lower legal alcohol limits for young drivers are effective and cost-effective at reducing casualties and fatalities[2].

Local measures
• Reducing the hours during which alcohol is available can reduce alcohol-related harm. When enforced and targeted at the most densely populated areas this policy is cost-effective[2].

• Regulating the availability of alcohol by reducing the density of licensed premises may reduce inequalities in specific areas with high levels of alcohol-related harm[2].

• Community programmes that are coordinated and implemented through multi-agency partnerships are effective and cost-effective[2].

• Enforcing legislation for reducing road traffic crashes, casualties and fatalities. Enforcement, using breath testing is cost-effective[2].

• Identification and brief advice is effective at addressing alcohol consumption for at risk drinkers, with specialist treatment for those who have harmful drinking patterns and are dependent. These show good returns on investment. Their success depends on large-scale implementation, dedicated treatment, staffing and funding streams[2].

• Effective treatment and recovery services[2].

User Views
In 2016/17 Medway Public Health commissioned an audit of local substance misuse needs, including a consultation with service users, treatment providers and partner agencies. 81 people with current or recent substance misuse issues, including alcohol dependence, were consulted, as well as 33 professionals working with both service providers and partner agencies[19].
In 2016/17 a consultation was undertaken with members of the public concerning their perception of alcohol harms linked to licensed premises in support of the licensing policy process. There were a total of 57 responses[20].

It is important to note that views expressed will reflect the opinions of the respondents only and may not accurately represent the views of the entire population.

Service users

The key messages from this group were:
- There was little rehabilitation support when back in the community, although the idea of community rehabilitation was advocated[19].
- There was a lack of mental health support[19].
- There was often a feeling of box ticking to keep funding going in treatment rather than a personalised approach[19].
- Those who were Eastern European believed their nationality was a barrier to support either through language problems or a right to accommodation[19].
- Lack of accommodation for the homeless was seen as a barrier to successful treatment[19].

Staff of treatment providers

The key messages from this group were:
- There are good links with agencies in Medway such as hospitals, the university, social services and police[19].
- Alcohol discharges from hospital needed more attention and immediate pick-up[19].
- Working individuals are a potentially neglected group and there should be more on offer to help their recovery[19].
- More emphasis is needed on aftercare[19].
- Issues such as housing threatened people's ability to change[19].

Partners

The key messages from this group were:
- A lack of accommodation, especially 'dry houses' was a barrier for change[19].
- The service provider was perceived to cater primarily for opiate users, which caused a barrier for users of other substances[19].
- Obtaining mental health support for clients could be problematic[19].
- There was a need for better transitioning support for young adults[19].
• A more holistic way of working for those in active addiction or recovery was needed[19].

Members of the public

The key messages from this group were:

• 86% felt that licensed premises in their area contributed towards issues of crime, disorder, nuisance, safety and harm to children[20].

• Most residents experienced alcohol related issues weekly or more often[20].

• The majority of the negative impacts from customers of licensed premises occurred during the evening and night. However, there was significant street drinking, littering, intimidation and begging and nuisance during the day impacting communities[20].

Equality Impact Assessments

Unmet needs and service gaps

Ethnic minorities

Those from ethnic minorities, particularly the Eastern European community, are underserved, with language and a lack of stable accommodation highlighted as barriers to treatment and recovery. Improved engagement and access to treatment services for this group would reduce inequality.

Homeless

There is a need for outreach, especially for the homeless community, who are difficult to reach and engage in treatment and support in recovery. One of the main barriers to support is the provision of suitable accommodation.

Street drinking

There is a need for a coherent and comprehensive approach to street drinking.

Peer mentors

The Saturday Club, run by peer mentors, could be further promoted and strengthened, providing a greater support for the recovery community.

Partnership working

Alcohol discharges from hospital need more attention and immediate pick-up by treatment and recovery services.

Treatment provision

Provision of community rehabilitation and post treatment support needs to be improved.
A lack of mental health support has been highlighted.

**Males in the 40 - 64 age group**

A sharp increase in admission episodes for alcohol related conditions in males aged 40 - 64 has been recorded, as well a smaller increase in females. Attention needs to be given to this specific group to address this issue.

**Area/community intervention**

Geographical areas or communities which have an identified need could be prioritised, such as wards with identified high volume of alcohol related harms.

**Intervention and Brief Advice training**

Further training will be given to health professionals in the hospital setting, to support proposed CQUIN indicators[18].

**Recommendations for Commissioning**

Commissioning of substance misuse services, including wellbeing and recovery services was completed in 2018.

Ensure accessibility of services to all hard to reach groups following mobilisation of commissioned services.

Outreach services to engage the difficult to reach populations, such as the homeless and ethnic minority groups.

**Recommendations for needs assessment work**

Assess the level of alcohol harms and barriers to engagement within migrant populations.

Assess the levels of need and service response for clients requiring both mental health and alcohol misuse services.

A substance misuse needs assessment/audit was carried out in 2016/17, which included alcohol misuse. This was carried out with the intention of informing the commissioning process for a new treatment and recovery service. An updated review would help to establish if gaps have been met and where needs still exist prior to the next commissioning process.

Complete a health impact assessment following mobilisation of substance misuse treatment and recovery services.
Healthy weight

Summary

Introduction
- Overweight and obesity are terms used to describe increasing degrees of excess body fat.
- Excess weight is a significant risk factor for a number of diseases, including type 2 diabetes, cancer and heart disease, and can also affect mental health and self-esteem.
- The prevention and treatment of overweight and obesity is a central public health policy goal.

Key issues and gaps
- Prevalence of excess weight in adults in Medway is estimated to be similar to the England average.
- Prevalence of childhood obesity in Medway is similar to the national average for both 4-5 year olds and 10-11 year olds.
- Prevalence of adult obesity (and therefore costs to the NHS and social care) are projected to rise without significant intervention.
- Obesity in adults is strongly correlated to obesity in children.
- Due to the high prevalence of overweight and obesity whole population approaches are required.
- National data and research suggests that groups at greatest health risk due to obesity are: pregnant women, women of African, Caribbean and Pakistani family origin, and people with physical and learning disability.
- National data shows that deprivation and low income is particularly related to higher prevalence of childhood obesity.

Recommendations for commissioning
- In line with NICE recommendations CCG to commission a tier 3 children’s weight management service.
- All Medway Council and Medway CCG contracts to take obesity into account where appropriate, embedding a minimum of one KPI related to obesity (e.g. healthy catering, active travel, etc.)
• Follow standard evaluation frameworks in all interventions and allocate a budget for evaluation.

• The NHS and local authority should act as exemplars in promoting healthy food and drink in their venues by adopting the Government Food Buying Standards in all food related contracts.

• As per NICE guidance all health and social care professionals should receive training on how to raise obesity related issues, and assess, discuss and take appropriate action on weight management with clients.

• All health and social care professionals should make every contact count by routinely advising on obesity related issues, including GP staff, midwives, health visitors, and school nurses.

• STP Local Maternity System weight management working group to create specialist midwifery provision to support women above a healthy weight.

**Introduction**

Overweight and obesity are terms used to describe increasing degrees of excess body fat. Excess weight is a significant risk factor for a number of diseases, including type II diabetes, cancer and heart disease. Overweight and obesity can also affect mental health and self-esteem. Obesity in adults is strongly correlated to obesity in children. The prevention and treatment of overweight and obesity is a central public health policy goal.

Excess weight is caused by an energy imbalance between ‘energy in’ (food consumption) and energy expenditure (energy used by the body during activity and metabolism). If there is greater energy intake than is required, the excess energy will become excess fat. However, the underlying causes of this energy imbalance, which result in weight gain, are complex. Behavioural, psychological, social, cultural and environmental factors are thought to determine the increasing prevalence of obesity seen throughout the world.

**Adult obesity classification**

Overweight and obesity in adults is measured and classified using Body Mass Index (BMI) according to table 1.

*Table 1: Classifying adults who are overweight and obesity using BMI (kg/m2)* [22]

<table>
<thead>
<tr>
<th>Body Mass Index</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Healthy weight</td>
<td>18.5 – 24.9</td>
</tr>
<tr>
<td>Overweight</td>
<td>25.0 – 29.9</td>
</tr>
<tr>
<td>Obesity I</td>
<td>30.0 – 34.9</td>
</tr>
<tr>
<td>Obesity II</td>
<td>35.0 – 39.9</td>
</tr>
<tr>
<td>Obesity III</td>
<td>40.0 or more</td>
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</tbody>
</table>
The BMI classifications may be less accurate in highly muscular people. For some ethnicities, risk factors for obesity may occur at a lower BMI. The Scottish guidance [23] recommends that until specific cut-offs are validated, South Asian, Chinese and Japanese individuals may be considered overweight at BMI >23 kg/m^2 and obese at BMI >27.5 kg/m^2. Waist measurements are also used to assess the health risks from overweight and obesity. Tables 2 and 3 detail the health risks associated with an increased BMI and waist circumference.

Table 2: Waist circumference classifications [22]

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>High</th>
<th>Very high</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>&lt;94</td>
<td>94–102</td>
<td>&gt;102</td>
</tr>
<tr>
<td>Female</td>
<td>&lt;80</td>
<td>80–88</td>
<td>&gt;88</td>
</tr>
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Table 3: Health risks associated with being overweight or obese in adults on BMI and waist circumference [22]

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>High</th>
<th>Very high</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overweight</td>
<td>No increased risk</td>
<td>Increased risk</td>
<td>High risk</td>
</tr>
<tr>
<td>Obesity I</td>
<td>Increased risk</td>
<td>High risk</td>
<td>Very high risk</td>
</tr>
</tbody>
</table>

The health problems associated with obesity are shown in table 4.

Table 4: Relative risks of health problems associated with obesity (Relative risk — risk measured against that of non-obese person of same age and sex)[21]

<table>
<thead>
<tr>
<th></th>
<th>Greatly increased risk(Relative risk much greater than 3)</th>
<th>Moderately increased risk(Relative risk 2-3)</th>
<th>Slightly increased risk(Relative risk 1-2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type II diabetes</td>
<td>Coronary heart disease</td>
<td>Hypertension</td>
<td>Cancer</td>
</tr>
<tr>
<td>Insulin resistance</td>
<td></td>
<td></td>
<td>Polycystic ovary syndrome</td>
</tr>
<tr>
<td>Gallbladder disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dyslipidaemia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breathlessness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleep apnoea</td>
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Childhood obesity classification

The National Child Measurement Programme (NCMP) measures the height and weight of children in reception class (aged 4 to 5 years) and year 6 (aged 10 to 11 years) to assess overweight and obesity levels in children within primary schools. This data can be used at a national level to support local public health initiatives and inform the local planning and delivery of services for children.

Children’s heights and weights are measured and used to calculate a Body Mass Index (BMI) centile. The measurement process is overseen by trained healthcare professionals in schools.

The method of assigning a BMI classification is different for children and adults. Defining children as overweight or obese is a complex process, given that their height
and weight change at the same time. Instead of using fixed BMI thresholds to classify individuals (as used for adults), children’s BMI is categorised using variable thresholds that take into account the child’s age and sex. The National Obesity Observatory has produced a simple guide for classifying BMI in children.[24]

Who’s at risk and why?

Adult prevalence

According to data from the 2016 Health Survey for England, 26.2% of adults in England are obese and a further 35.2% are overweight, making a total of 61.4% who are either overweight or obese.[25] Of obese adults, just over a tenth are morbidly obese (2.9% of all adults).

Some groups of the population are more at risk of developing obesity or its complications, and this contributes to inequalities in health. Obesity prevalence is influenced by factors such as age, gender and ethnicity.

The age group most likely to be overweight or obese is age 55-64, but only by a small margin. Prevalence of overweight and obesity is above 70% among all age groups from 45 upwards. The adult age group least likely to be obese is 16-24 year olds, with 59% at normal weight and only 34% overweight or obese.[26]

Ethnic differences also exist in the prevalence of obesity and the related risk of ill health. Compared with the general population, the prevalence of obesity is lower in men of Bangladeshi and Chinese family origin, whereas it is higher for women of African, Caribbean and Pakistani family origin.[22]

People living with learning disabilities, mental health problems, or a physical disability that limits mobility have been found to experience higher rates of obesity compared with people who do not have these conditions.[22]

During pregnancy and childbirth, obesity presents a series of health risks to the foetus, the infant and the mother. Obesity in pregnancy is associated with an increased risk of serious adverse outcomes including miscarriage, foetal congenital anomaly, thromboembolism, gestational diabetes, pre-eclampsia, dysfunctional labour, postpartum haemorrhage, wound infections, stillbirth and neonatal death. There is also a higher caesarean section rate and lower breastfeeding rate in this group of women compared with women with a healthy BMI.[27] Obesity in pregnancy also increases the risk of the child becoming overweight and of developing type 2 diabetes.

The National Obesity Observatory has published several briefing papers on obesity and health inequalities. They cover a range of topics including:

- Adult obesity and type 2 diabetes
- Obesity and the environment
- Social and economic inequalities in diet and physical activity
- Obesity and disability
Knowledge and attitudes towards healthy eating and physical activity

Obesity and mental health

Obesity and ethnicity

The National Obesity Observatory has also produced Obesity slide sets presenting key data and information on adult and childhood obesity.

**Childhood prevalence**

According to data from the 2016-17 National Child Measurement Programme (NCMP), in England, 9.6% of reception age children (age 4-5) are obese, with a further 13.0% overweight. These proportions are higher among year 6 children (age 10-11), with 20.0% being obese and 14.3% overweight.[28]

The most recent publication, Childhood Obesity: A Plan for Action (2016)[29] sets out the government’s plan to reduce England’s rate of childhood obesity within the next 10 years. This document acknowledges that the burden of childhood obesity is falling hardest on those children from low-income backgrounds. Obesity rates are highest for children from the most deprived areas and this is getting worse. Children aged 5 and from the poorest income groups are twice as likely to be obese compared to their most well off counterparts and by age 11 they are three times as likely.[29]

**Level of need in the population**

**Adult prevalence in Medway**

The Public Health Outcomes Framework uses an indicator from Sports England’s Active Lives survey to report the percentage of adults classified as overweight and obese (excess weight). The most recent data for Medway (2016/17) indicates that 64.6% of Medway adults are overweight or obese, which is statistically similar to the national average (England: 61.3%). The percentage of adults classified as overweight and obese in Medway has decreased since 2015/16 (67.8%). This indicator is based on self-reported measures of height and weight, which may be less accurate than measured data.

**Childhood prevalence in Medway**

The NCMP Local Authority Profile publishes annual overweight and obesity data for children from the National Child Measurement Programme. The most recent data for Medway (2016/17) shows that 10.2% of reception age children (4-5 years old) are obese, which is statistically similar to the national average (England: 9.6%). The prevalence of obesity in reception age children has been decreasing in Medway since 2008/09 (11.9%).

In 2016/17, 21.0% of year 6 children (10-11 years old) in Medway were classified as obese, which is statistically similar to the national average (England: 20.0%). The prevalence of obesity in year 6 children in Medway has increased since 2012/13 (17.2%).
Data from NCMP is likely to be more robust than the adult excess weight data, as the measurement process is overseen by trained healthcare professionals in schools.

**Current services in relation to need**

The Medway Council Public Health Team provide a range of prevention and treatment services to tackle obesity. The team also coordinate a network of private, public, voluntary and academic sector partners, who collectively make up the Medway Supporting Healthy Weight Network. This network provides a range of interventions to tackle obesity and share the same vision: *“Working together to support all Medway residents to adopt healthier lifestyles and achieve a healthy weight”*.  

A full list of interventions can be found below (as of December 2017), and for ease of presentation, have been categorised into 8 key areas. An intervention is defined as any project or initiative currently active in Medway, which has a key aim of tackling obesity, or promoting healthy eating and physical activity.

**Growing**
- Medway allotments scheme
- School food growing projects

**Healthy eating**
- Identification and Brief Advice (IBA) training to professionals, volunteers and champions
- Farmers markets in Rochester, Elm Court and Cliffe
- Free school meals for all years in key stage 1 and wider school food project
- Hot food takeaway planning guidance note
- Healthy start voucher and vitamin scheme
- Nursery and pre-school support project
- Medway cooks recipe programme
- Healthy cookery programme including 6 week courses, little chefs and little food explorers
- Tesco farm to fork project

**Breastfeeding**
- Beside You: normalising breastfeeding campaign and setting breastfeeding policies
- Breastfeeding support from midwives, health visitors, voluntary sector and peer support network
- Unicef UK Baby Friendly Initiative: accreditation for acute and community settings
- Tongue-tie and breastfeeding support clinic
**Healthy settings**
- Medway workplace health scheme

**Marketing**
- A Better Medway (ABM), Change4Life and One You campaign promotions

**Physical activity**
- Medway Council mass events: Medway Mile, Big Splash and Big Ride
- Active Medway Cycling Groups
- Medway Health Walks
- Nordic Walking
- Exercise Referral
- Greenspace offer of country parks, parks, green gyms and play areas
- Medway Council leisure centres
- Sport disability open day and community disability sport clubs
- Active retirement association clubs
- Bikeability in schools
- Bus routes, park and ride and concessionary bus fares
- Community activity providers (i.e. ski centre and Arethusa)
- Free swimming for under 16s and over 60s
- Gillingham FC community outreach
- School sports partnerships (Green acre Academy and The Howard School)
- Medway Adult Community Learning activity sessions
- Medway cycling routes
- Medway Festival of Sport
- Medway mini youth games
- Sport centre open days
- Parksport
- Walk and cycle to school initiative
- Parkrun
- Daily Mile
- Community health rehabilitation services
• Scouts, brownies and cub groups

**Weight management services**
• Healthy Way
• Tipping the Balance
• Tri for you and MEND (Mind, Exercise, Nutrition, Do it!)
• FitFix
• Weight Watchers
• Slimming World
• Bariatric surgery
• Orlistat prescriptions
• Community nutrition and dietetics service
• Change4Life schools club

**Workforce**
• A Better Medway champions training
• Health Visiting service
• Midwifery service
• School nursing service
• Make Every Contact Count project

Information for each intervention can be found on the [A Better Medway](#) website.

**Projected service use**
In 2016/17 the following number of people accessed these Public Health services:
• Medway Health Walks - 2,128
• Exercise Referral - 800
• Healthy Way: Diabetes Prevention Programme - 786
• Medway Breastfeeding Network - 413
• Tipping The Balance - 380
• Active Medway Cycling Groups - 293
• Little food explorers - 270
• Medway Cooks courses and workshops - 101
Projections show a steady increase in obesity rates in England until at least 2030. In England 35% of the population are expected to be obese in 2030.[30] It is therefore likely that prevalence of obesity in Medway will also increase, which will impact the number of people requiring access to services.

**Evidence of what works**

A wide range of evidence-based best practice guidelines have been read and interpreted, such as the NICE guidance on weight management[31] and obesity[32]. For ease of presentation, the best practice recommendations have been categorised into 10 subject areas and summarised.

**Commissioning and contracts**

- Embed the obesity agenda into all potential local authority and Clinical Commissioning Group (CCG) contracts (i.e. catering, transport)
- Follow standard evaluation frameworks in all interventions and allocate a budget for evaluation
- Ensure family-based, multi-component services are available

**Communication and community engagement recommendations**

- Gather local residents' views on priorities and recruit champions for the agenda
- Publicise interventions and services that are already underway and newly launched
- Identify barriers for taking up services and remove them where possible

**Environment**

- The NHS and local authority should act as exemplars in promoting healthy food and drink in their venues
- Utilise planning powers to create places that promote a healthy lifestyle
- Ensure events promote and provide a range of healthy food choices
- Ensure buildings are designed to promote healthy lifestyles
- Promote cycling and other active travel modes and ensure suitable infrastructure is in place
• Ensure the environment around schools promotes activity and healthy eating by addressing vehicle speed, parking and driving, whilst reducing exposure to high calorie foods

Health professionals
• All health professionals should receive training on how to raise obesity related issues, and assess, discuss and take appropriate action on weight management with clients
• All health professional should make every contact count by routinely advising on obesity related issues, including GP staff, midwives, health visitors, and school nurses
• Obesity related advice should be given at key life events by professionals, including pregnancy and child birth, long-term condition diagnosis, and treatment and recovery
• Screening should be routinely undertaken to identify people at risk, ensuring that weight management advice is given and services are signposted
• Care pathways should be modified to include routine obesity advice, support and signposting
• The NHS should support employees to be more active and lead healthier lifestyles
• Implement the Unicef Baby Friendly Initiative standards for breastfeeding in acute and community settings

Leadership and strategy
• Ensure the JSNA and all key Health and Wellbeing Board, CCG, local authority, and partner strategies support the obesity agenda
• Ensure elected members and senior leaders in key organisations champion the obesity agenda

Local authority
• Local assets that support the obesity agenda should be mapped and utilised
• Leisure services should offer an affordable and appropriate range of activity opportunities to all residents
• Establish links with local university colleagues to support the obesity agenda and evaluation

Local support services
• All areas should provide a comprehensive sport system, offering a range of opportunities at different times and locations
• Ensure a comprehensive walking programme is available through supported groups, 1-1 advice, maps and signage
• Provide a comprehensive set of weight management services at all tiers for children and adults
**Schools and young people settings**

- Early years settings should provide regular opportunities for active play and structured physical activity sessions
- Early years, schools and college settings should prioritise healthy food and create environments that promote physical activity
- Children and young people should learn skills to cycle through bikeability
- Head teachers and senior leaders should act as and identify further champions for the obesity agenda
- School facilities should be utilised as community assets before and after school hours
- Universal free school meals should be available in all schools, with access to free tap water for all
- Food-based and nutrient-based standards for England should be applied to all schools

**Training**

- Key system leaders and local champions should receive training on the obesity agenda
- Training should be provided for fitness professionals on how to engage priority groups
- Provide training on healthy food preparation to local catering staff and managers
- Provide basic training on healthy food and wider obesity issues to early years and other front line staff working with children
- Weight management delivery staff should continue to develop their professional skills

**Workplace health**

- The local authority and NHS should act as exemplars by ensuring the environment and internal policies help staff maintain a healthy weight, and offering lifestyle and weight management support to appropriate staff
- New workplaces should be designed to promote active travel
- Workplaces should provide facilities such as showers and bike racks to promote routine activity
- Champions should be identified in all workplaces to promote the obesity agenda

**User views**

Resident and potential service user views are particularly important when designing and implementing new services. A recent example of this is shown in the re-design of
the childhood obesity/family weight management projects, which conducted a large piece of insight work in 2014. Views of overweight children and young people, their parents, and healthcare professionals were collated. A combination of qualitative and quantitative data were collected, and resulted in a list of recommendations for the service to follow. This report identified eight barriers to professionals referring to and families accessing weight support services. Five area were recommended for change:

- Having the conversation about weight with clients
- Promoting service and facilities
- Re-framing the healthy weight issue
- Streamlining systems for consistency
- Devolving power to residents

In addition to service design insight, Medway Public Health ran a survey in 2016 and 2017 to hear from residents on how to help more local people achieve a healthy weight. In 2016, 740 people responded, sharing a range of views and ideas. The main points repeated most frequently were that we need to demonstrate how healthy eating can be achieved. Specifically, showing that it can be:

- Easy - giving people the skills, knowledge and ideas
- Quick
- Affordable - proving it can be cheaper than processed food or takeaways

Respondents were also clear that you must promote healthy eating and exercise together, and emphasis that the combination is important.

In 2017, the survey focused on male residents as they were under represented in the 2016 survey. Forty men from Medway took part in semi-structured interviews about their views and priorities with regards to healthy weight. In addition, we ran a survey that was completed by 213 males living in Medway. The following 7 areas for action were put forward:

1) Target the priority groups.
2) Give clear messages: Clearly define the key healthy weight messages for the different target markets.
3) Get the message across: Identify the most effective locations and communication vehicles through which to spread healthy weight information.
4) Educate: Develop and provide education and resources for residents.
5) Facilitate: Be a facilitator to help people have healthy lifestyles by creating opportunities and removing barriers.
6) Promote: Medway has many amenities and opportunities to help residents achieve and maintain a healthy weight, however we found a lack of awareness of what is available in parks, events, clubs, facilities, where to buy healthy food, etc.

7) Change the mindset: Look at encouraging a change of mindset and attitude.

Unmet needs and service gaps

A tiered-based system is recommended for weight management treatment services for children, with different tiers covering different activities. Usually tier 1 includes population-wide interventions largely focused on preventing obesity; tier 2 covers lifestyle interventions; tier 3 covers specialist weight management services; and tier 4 covers bariatric surgery.[31]

While Medway currently has services available at every tier for adults, children and young people who are overweight or obese only have access to services at tier 1 and tier 2. These services are not designed to provide the multi-disciplinary, holistic support that children with higher BMIs and/or more complex physical or mental health needs may require in order to achieve a sustainable change in weight trajectory. A tier 3 children’s weight management service is therefore a service gap in Medway.

There is also currently no formal service provision for supporting pregnant women with healthy weight related issues during pregnancy.

Recommendations for Commissioning

• In line with NICE recommendations CCG to commission a tier 3 children’s weight management service.

• All Medway Council and Medway CCG contracts to take obesity into account where appropriate, embedding a minimum of one KPI related to obesity (e.g. healthy catering, active travel, etc.

• Follow standard evaluation frameworks in all interventions and allocate a budget for evaluation.

• The NHS and local authority should act as exemplars in promoting healthy food and drink in their venues by adopting the Government Food Buying Standards in all food related contracts.

• As per NICE guidance all health and social care professionals should receive training on how to raise obesity related issues, and assess, discuss and take appropriate action on weight management with clients.

• All health and social care professionals should make every contact count by routinely advising on obesity related issues, including GP staff, midwives, health visitors, and school nurses.

• STP Local Maternity System weight management working group to create specialist midwifery provision to support women above a healthy weight.
Recommendations for needs assessment work

Evidence related to the cost-effectiveness of interventions to tackle obesity is lacking in terms of the return on investment for social care.

Diet and physical activity

Summary

Poor diet and lack of physical activity are risk factors for obesity which synthetic modelling predicts affects approximately 30% of adults in Medway.

Key issues and gaps

- Currently there are no suitable methods for collecting comprehensive local data on diet and nutrition and physical activity
- There are specific gaps in knowledge concerning intakes of fat, sugar and salt and issues relating to access to an affordable healthy diet.
- There are gaps in the knowledge regarding the uptake of targeted schemes to promote good nutrition such as Healthy Start vouchers and vitamins.
- Local planning levers such as Supplementary Planning Policies could be introduced to limit fast food takeaways in areas of existing high density and near schools, as highlighted in the Government’s Call to Action on Obesity [27] and Healthy Places Planning Resource

Who’s at risk and why?

Poor diet and lack of physical activity are risk factors for obesity which synthetic modelling predicts affects approximately 30% of adults in Medway. The Health Profile for Medway 2011 indicates that Medway is worse than the English average for healthy eating and physical activity amongst adults. Children are also less likely to be physically active compared to the English average.

The National Obesity Observatory has published briefing papers on obesity, physical activity and diet which can be accessed by following the links below.

Knowledge and attitudes towards healthy eating and physical activity

Environmental influences on physical activity and diet

Data sources:

Determinants of obesity: adult diet
Determinants of obesity: adult physical activity
Determinants of obesity: child diet
Determinants of obesity: adult physical activity
Statistics on obesity, physical activity and diet have been published by the Health and Social Care Information Centre using data from various national surveys.

**The level of need in the population**

Currently there are no suitable methods for collecting comprehensive local data on diet and nutrition.

The percentage of adults achieving at least 150 minutes of at least moderate intensity physical activity per week (in accordance with UK CMO recommended guidelines on physical activity), is 53.4% in Medway, compared to 56% across England [33].

Local Healthy Start data indicates that the uptake of vitamins for children and mothers are very low which reflects the national picture. Vouchers for fruits and vegetables are being used but the reason for the lack of vitamin uptake is unknown.

**Current services in relation to need**

The Healthy Weight Team offer the following services:

**Infant Feeding Programme**

Medway Breastfeeding Network is a peer support network made up of local mums who have breastfed their own babies and who have had additional training so that they can give information and support to other mums. Members of the Network are available at various locations including local baby clinics, children’s centres, breastfeeding drop-ins and at Medway Maritime Hospital.

A cross-organisation Infant Feeding Strategy has been adopted by local stakeholders to work towards the achievement of UNICEF Baby Friendly Initiative Award in both maternity and community settings.

**Early Years Support**

The Healthy Weight team work together with key partners to develop a range of initiatives to support the adoption of healthy lifestyle practices from a young age. The Obesity in Pregnancy and Early Years network meets 4 times a year to share activities, receive updates and develop plans to expand the range of opportunities families can access in Medway.

Early Years programmes include Mend 2–4, a lifestyle programme for families with children aged between 2–4 years, Start4life activities, Play days and support and training for early years practitioners.

Healthy Start is a national scheme, which provides pregnant mothers or families with children under four years old with Healthy Start vouchers to help purchase foods, which could benefit their health (milk and fruit and vegetables). The scheme is means-tested and actively promoted across Medway by health professionals and children’s centres. The Healthy Weight Team is involved in promotional activities to raise awareness of the scheme with particular regard to expanding access to vitamins for both mothers and children, and submission of uptake data to the Department of Health.
MEND Portfolio

Mend is a community based, family programme that delivers healthy lifestyle advice in a fun and informal way to encourage small changes to lifestyles. Programmes are age specific to ensure advice and delivery is appropriate for each age group.

Mend 2–4 is open to all 2–4 year olds regardless of BMI. Topics covered during the programme include general healthy eating, fussy eating, active play, mealtimes and label reading.

MEND 5–7 is a 10-week programme for families with children aged five to seven, whose weight is above the healthy range for their age. The course runs once a week after school.

Mend 7–13 is a 10-week programme for families with children aged seven to thirteen, whose weight is above the healthy range for their age. The course runs twice a week and includes regular activity sessions.

Mend Graduates is a local scheme that provides weekly groups and holiday activities to encourage Mend graduates (families who have completed Mend courses) to sustain their new lifestyle habits.

Community Food Programme

Medway's Community Food Programme aims to promote and sustain healthier food choices in communities, to increase the opportunity to enjoy a healthier diet. The programme provides healthy eating training, nutrition resources, guidance for existing food related projects and develops new initiatives to increase access to healthy eating. The Programme also has access to a community food allotment site where local community groups can learn how to grow and cook their own food.

Medway Dines

Medway Dines is Medway's healthy eating award for food businesses in partnership with Medway Environmental Health. It rewards businesses that promote healthy eating and who make it easier for consumers to find healthier food choices when eating out or taking away. The award is open to all types of establishments that cater for the general public including takeaways, cafés, sandwich shops and restaurants. Premises are usually considered for an award at the time of a satisfactory routine food hygiene or food standards inspection, partial inspection or audit. In addition, premises may also be assessed if requested by a proprietor.

It is not intended to apply to premises that cater for individuals with specific dietary requirements. These include care homes for older people, state schools and nurseries where there are already guidelines or measures in place to improve healthy eating.

The Award uses the Eat Well plate food groups to review food options and preparation methods offered by businesses. Successful businesses will receive bronze, silver or gold award.
**Medway Healthy Workplaces**

This is a free scheme open to businesses in Medway to help them implement health improvement initiatives in the workplace. Interested employers are encouraged to complete a staff needs assessment and to develop a local implementation plan with support from the Health Improvement Workplace Health Coordinator.

**Tipping the Balance**

Tipping the Balance is a community-based clinic designed to help people lead a healthier lifestyle. The main aims of the service are;

- To help patients work towards a healthy weight
- To encourage healthy eating and physical activity
- To boost the patient’s self-esteem and confidence

Patients are referred by their GP and have regular appointments with a Specialist Health Improvement Practitioner.

**Medway Health Walks**

Medway Health Walks is a volunteer lead programme that encourages people to use their natural environment, to achieve some regular physical activity. The walks take place across a range of urban, semi-rural and green spaces in Medway, and are free for residents to take part in. The schedule includes slower paced walks for families with young children to faster paced, longer duration walks for adults, so are an excellent opportunity for people to get some fitness gains and social interaction.

**Active Medway Cycling Groups**

Active Medway Cycling Groups aim is to provide cycling groups for adults, who have not been on their bikes for a number of years, and would like to rebuild their confidence in a safe and supportive group environment. These regular groups are facilitated by Ride Leaders (trained by British Cycling), with low traffic and less physically challenging routes chosen to cater for beginners.

**Medway Exercise Referral Programme**

Medway Exercise Referral programme is a 12-week programme for people diagnosed with a medical condition that would benefit from becoming more active. Patients are referred from a whole range of health professionals, who are then offered a choice of class or gym based opportunities. The scheme is hosted in the local authority leisure centres, where the exercise referral instructors assess, induct and provide supervised exercise sessions to people wanting to become more active.

**Bariatric Referrals**

NICE (2006) recommends surgery as a treatment option for patients that have a BMI of >= 40kg/m² or 35–40kg/m² with other significant diseases such as type II diabetes and hypertension. NICE states that surgery should only be offered when all appropriate non-surgical methods have been tried but failed to achieve or maintain adequate clinically
beneficial weight loss for at least 6 months. Individuals with a BMI > 50 kg/m2 should be considered for surgery as a first-line option if surgery is considered appropriate.

In Medway, patients can be referred to the Specialist Commissioning Panel by the community weight management service, Tipping the Balance or by their GP. Each individual is considered by the panel on a case-by-case basis.

**Other Interventions**

Other interventions and services promoting the healthy weight agenda are offered across Medway and include:

- **Change4Life**

  Change4Life has traditionally offered advice to families on achieving a healthy weight. The Government has now shifted towards a new life course approach to health improvement. Change4Life will expand to cover all nutrition-related messaging (including a new focus on the key area of calorie reduction) and to other topics that have relevance to target audiences, such as the harmful effects of drinking alcohol above the recommended daily limits. The Change4Life programme will continue its expansion into early years (via its sister brand, start4Life) and into advice for middle-aged adults.

- **Free swimming for adults aged 60+ in possession of a Medway City Card**

- **Children’s Centres** offer support with diet and exercise to families with children aged 5 years and under. All Children’s Centres have adopted a food policy, in partnership with the Healthy Weight team to improve the standard of food provision in that setting.

- **The Health Trainer programme provided by Sunlight Development Trust** programme can offer signposting and basic health improvement advice to those wanting to effect lifestyle change.

- **Medway Community Learning Service** provides courses to help people develop cooking skills and physical activity classes.

- **The Physical Activity Network**, facilitated by the Healthy Weight Team, is a collection of partners from across Medway who meet quarterly to identify opportunities to increase physical activity in the groups they work with.

**Projected service use and outcomes in 3-5 years and 5-10 years**

**Evidence of what works**

Relevant evidence and guidance includes:

**NICE (2008) PH11** Guidance for midwives, health visitors, pharmacists and other primary care services to improve the nutrition of pregnant and breastfeeding mothers and children in low income households.

**NICE (2010) PH27** Weight management before, during and after pregnancy.
Start Active, Stay Active: a report on physical activity for health from the four home countries’ Chief Medical Officers (DH, 2011)

NICE (2007) PH6 Behaviour change

NICE (2006) PH2 Four commonly used methods to increase physical activity

NICE (2008) PH6 Physical activity and the environment

NICE (2009) PH17 Promoting physical activity for children and young people

NICE (2008) PH13 Promoting physical activity in the workplace

NICE are currently developing a number of pieces of Public Health guidance related to obesity. Updates can be found by following the links below:

Obesity - working with local communities

Physical activity advice in primary care

Walking and cycling

User Views

A Community Food consultation was carried out across Medway in 2010/11. The Consultation used large visual questionnaires in accessible places such as on-street, in superstores, markets and interactive workshops in community venues.

- A total of 939 local people took part in the Consultation
  - 124 men
  - 482 women
  - 340 children and young people
- 39% of respondents felt that a healthy diet should be balanced and contain plenty of fruit and vegetables
- 16.8% were aware of the 5-a-day campaign
- 3% were aware of Change4Life without further prompting
- 36% always read food labels
- 56% of respondents ate three meals a day
- Breakfast was the meal that people were most likely to skip
- 52% regularly cook and prepare meals using all unprepared items every day
- On average it takes 16-30 minutes to prepare an evening meal
- 75% identified that a female parent/carer was responsible for cooking and choosing family meals
The results of the Consultation are being used to implement community food projects in communities with the greatest levels of obesity and deprivation.

**Equality Impact Assessments**

The Department of Health have published an Equality Analysis to accompany their Call to Action.[27]

- Currently there are no suitable methods for collecting comprehensive local data on diet and nutrition and physical activity.
- There are specific gaps in knowledge concerning intakes of fat, sugar and salt and issues relating to access to an affordable healthy diet.
- There are gaps in knowledge regarding the uptake of targeted schemes to promote good nutrition such as Healthy Start vouchers and vitamins.
- Local planning levers such as Supplementary Planning Policies could be introduced to limit fast food takeaways in areas of existing high density and near schools, as highlighted in the Government's Call to Action on Obesity and Healthy Places Planning Resource.

**Healthy Places Planning Resource**

**Recommendations for Commissioning**

- Ensure that evidence based messages and the 'Eatwell Plate' are used to promote consistent messages concerning a nutritionally adequate diet and healthy eating.
- Promote the Physical Activity Guidelines to all population groups to embed activity as a key part of a healthy lifestyle.

**Recommendations for needs assessment work**

- Evidence of effectiveness of interventions to tackle obesity is lacking and more research is required to understand the cost effectiveness of different interventions over the longer term.
- Currently there are no suitable methods for collecting comprehensive local data on diet and nutrition and physical activity.
- There are specific gaps in knowledge concerning intakes of fat, sugar and salt and issues relating to access to an affordable healthy diet.
- Potential for introduction of Supplementary Planning Resources to support healthy lifestyles.
Sexual health

Summary

Introduction

The health and economic wellbeing of any population and the wellbeing of individuals can be critically influenced by sexual health. The financial case for sexual health services has been made repeatedly; effective sexual health services and the prevention of sexually transmitted infections (STI) and unplanned conceptions are cost-saving.

Total new STI diagnosis rates have fallen in England since 2012. Chlamydia infection is the most common followed by genital warts, non-specific genital infection (NSGI), gonorrhoea, herpes and syphilis (PHE, 2017). Chlamydia detection among 15-24 year olds had increased in Medway as screening in GPs and pharmacies was extensively promoted but has recently seen a slight downward trend. Late diagnosis of HIV is above the England average and remains a priority area.

This chapter does not include teenage pregnancy specifically as this is addressed in the teenage pregnancy chapter.

Key issues and gaps

- Sexual ill health is not equally distributed among the population with the highest levels seen in men-who-have-sex-with-men (MSM), teenagers, young adults and some black and minority ethnic groups. It is therefore necessary to promote sexual health in a multifaceted manner as it is influenced by a number of issues including socio-economic and cultural issues.

- There is some correlation between deprivation and STI rates, with Chatham town centre having the highest concentration of GUM diagnoses per 100,000 population. The National Chlamydia Screening Programme (NCSP) has identified the highest rates of positivity in Strood North, Luton and Wayfield, and the Rochester wards; it should be noted that the Young Offenders Institution and the Secure Training Unit skew the data for Rochester West.

- The highest HIV prevalence rates are shown in Chatham with lower prevalence in rural areas.

- The Pelvic Inflammatory Disease rate is significantly higher in Medway than the England average.

- Although reducing, the total abortion rate in Medway is significantly above England average.

Recommendations for Commissioning

- A needs assessment should be conducted to identify existing or new gaps in service provision.

- HIV is of particular concern with late diagnosis of HIV posing serious problems at individual and community level. This increases the risk of onward transmission
and ultimately treatment costs. There is a need to improve HIV awareness training amongst secondary care medical disciplines to improve early diagnosis.

- As a large proportion of those affected by HIV in Medway are of black-African origin, it is important to review services to ensure that they are accessible to this population.
- Improve sexual health services delivered by GPs, in particular access to Long Acting Reversible Contraception (LARC), Chlamydia screening and referral for full STI screening.
- Improve chlamydia screening rates through core services to achieve the 2400/100,000 diagnosis rate.
- Reduce the number of women who have repeat abortions to the south East England average rate of 25.2%.
- Increase the uptake of LARC to achieve the South East average of 54/1,000.

Who's at risk and why?

All people who engage in sexual activity are at risk of sexual ill-health or unplanned pregnancy; however risk is not distributed evenly.

People from some Black and Ethnic Minority Communities

In the UK 34% of those receiving treatment for HIV are black African [34], due, in part, to the higher incidence of HIV infection in sub-Saharan Africa. Efforts to tackle HIV among high risk groups should be supported with work to reduce stigma.

Undiagnosed HIV, and therefore late diagnosis, is of concern among black Africans and in particular black African women [35]. People living with HIV who live outside London are at a higher risk of being undiagnosed than those living inside London. Black and black British ethnic groups are at higher risk of being diagnosed with an STI than the general population [36].

Men who have sex with men

Men-who-have-sex-with-men (MSM) face a range of health inequalities, including HIV and issues related to mental health and wellbeing, alcohol, drugs and tobacco [37].

It is estimated that 7% of the population are lesbian, gay or bisexual, but in England MSM accounts for 11% of all new STI diagnoses (81% of syphilis and 55% of new HIV diagnoses) [38].

While not relevant to all MSM, lifestyle factors including HIV sero-sorting, condomless sex, multi-partnering, chemsex, public sex environments all contribute to the risks of STI and HIV transmission. Increased extra-genital testing alongside improved laboratory testing are likely to have contributed to the increase in STI detection among MSM.
Given that MSM are disproportionately affected by STIs, the emergence of antibacterial resistant gonorrhoea is likely to have greatest impact on this group.

**Young people**

The National Survey of Sexual Attitudes and Lifestyles (NATSAL) survey (2013) indicates that just under a third of young people aged 16-24 at the time of the survey had had sex before age 16. Young people aged 16-24 are experimenting with a range of sexual practices: 71% have given or received oral sex, 19% males and 17% females have had anal sex. Anal sex among this group is higher than any other age range and unless participants observe safer sex messages this can increase health risks.

Young people are more likely to use contraception effectively if they are aware of the alternatives and are able to make their own choices. This group should be included in universal sexual health services, while acknowledging that those who are socially disadvantaged may require tailored support. Schools and other educational establishments have proven to be good sites to base contraceptive services. Due to the high prevalence of STIs condoms should be offered in addition to other forms of contraception [39].

**Looked-after children**

Looked-after children are at high risk of teenage pregnancy and while there is much policy and guidance to reduce teenage pregnancy, little of the guidance is directly focused on this group’s needs. The limitations of school-based programmes with this group are well recognised.

Consultations with this group are key if targeted interventions are going to be effective [40].

**Sex workers**

A literature review conducted by Balfour and Allen (2014) indicates that there are several factors that can adversely affect the health of sex workers [41]. The different types of sex work carry varying risk; for example, low risk activities such as stripping, web-casting and other forms of non-contact sex have significantly different impacts on health to on- or off-street sex work.

Even though some sex workers still engage in risky behaviour, research indicates that condom use among sex workers has increased over the last 30 years and incidence of HIV has decreased [41]. It should be noted that although potential for transmission is very high the actual rate of STI infection remains low. This may, in part, be due to the focus of support for sex workers being around sexual ill-health; prevention and support work should continue with this group.

**People subjected to sexual violence, abuse and exploitation**

A needs assessment for the Sexual Assault Referral Centre (SARC) for Kent & Medway has been carried out. Details of the SARC are available online on the Beech House webpage
NATSAL, one of the largest scientific studies of sexual behaviour, indicated that 1 in 71 males and 1 in 10 females have had non-volitional sex (2013). The median age for this in males was 16 and for females 18 years.

Sexual violence is often linked to domestic violence. The long-term health effects of sexual violence are associated with depression, anxiety, post-traumatic stress disorder, psychosis, substance misuse, self-harm and suicide.

Violence in all its forms are common for many sex workers but reporting of violent crimes to authorities by commercial sex workers is low.

Although the effects of sexual abuse on people are well documented, detection and prevention of Child Sexual Exploitation is a developing field. Victims are likely to be at increased risk of HIV, STIs and pregnancy.

It is widely acknowledged that reliable information on the volume of sexual offences is difficult to obtain as a significant proportion of offences are not reported to the police, although the number of reported incidents is increasing.

The level of need in the population

Local sexual health data is available through the Public Health England Fingertips website.

Chlamydia Detection in young people

After several years of increasing the proportion of the population screened and increasing detection Medway has seen a decrease in both. This may be in part to upheaval caused by the recommissioning, redesign and changes of services; the situation is being monitored through the performance management cycle.

Table 1: Chlamydia detection and screening rates (PHE)

<table>
<thead>
<tr>
<th></th>
<th>2016 detection rate aged 15-24 / 100,000 (PHOF indicator 3.02)</th>
<th>2016 Chlamydia proportion aged 15-24 screened</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medway</td>
<td>1754</td>
<td>20.50%</td>
</tr>
<tr>
<td>South East Region</td>
<td>1500</td>
<td>19.20%</td>
</tr>
<tr>
<td>England</td>
<td>1882</td>
<td>20.70%</td>
</tr>
</tbody>
</table>

Other STI prevalence

Overall STI prevalence in Medway has fallen each year since 2012. In 2014 the most commonly diagnosed STI in Medway was chlamydia (333 per 100,000) followed by genital warts at 123.9 per 100,000; genital herpes 68.6 per 100,000; gonorrhoea 28.0 per 100,000 and syphilis 3.3 per 100,000. Although reducing, the prevalence of genital herpes is higher in Medway than both the South East and England. Chlamydia detection has increased since 2012. Syphilis is almost exclusively diagnosed among MSM. Although not specifically an STI, Pelvic Inflammatory Disease (PID) can be caused by bacterial infections such as chlamydia and gonorrhoea; Medway has admission rates to hospital well in excess of regional and England rates [42].
Table 2: Pelvic Inflammatory Disease rates (PHE)

2015/16 Pelvic Inflammatory Disease (PID) rate / 100,000

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Medway</td>
<td>365.0</td>
</tr>
<tr>
<td>South East Region</td>
<td>272.4</td>
</tr>
<tr>
<td>England</td>
<td>237.0</td>
</tr>
</tbody>
</table>

Table 3: Rates of all new STI diagnoses (PHE)

2016 All new STI diagnoses (exc Chlamydia aged <25) / 100,000

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medway</td>
<td>652</td>
</tr>
<tr>
<td>South East Region</td>
<td>649</td>
</tr>
<tr>
<td>England</td>
<td>829</td>
</tr>
</tbody>
</table>

HIV

HIV prevalence in Medway has seen a slight decrease since 2014. However, late diagnosis is increasing, some of which may be attributable to increased testing opportunities. Across Medway the prevalence rate is 1.33/1,000 but that prevalence is not equally distributed. Data from the Survey of Prevalent HIV Infections Diagnosed (SOPHID) indicates that HIV diagnosis is highest in the ME4 and ME7 postcode areas. Adults aged 35-54 are more likely to be diagnosed with HIV in Medway than any other age group. The most common route of transmission was sex between men; the next more common was women who had heterosexual contact. Black Africans are the ethnic group at highest risk of HIV infection. However, the vast majority of UK HIV diagnoses are in people born in the UK as opposed to born overseas.

Table 4: HIV diagnosis rates (PHE)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>HIV late diagnosis (%) (PHOF indicator 3.04)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medway</td>
<td>1.33</td>
<td>50.00%</td>
</tr>
<tr>
<td>South East Region</td>
<td>1.77</td>
<td>43.50%</td>
</tr>
</tbody>
</table>

Unplanned pregnancy, Abortions and Repeat abortions

Not all unplanned pregnancies will lead to an abortion; outcomes for both mother and child are poorer than for a planned pregnancy [43]. Unplanned pregnancies are prevented by good access to all forms of contraception including long-acting reversible contraception (LARC). GPs are increasing the quantity of LARC they are prescribing but Medway is still below regional and England rates.

Table 5: Abortion rates (PHE)

<table>
<thead>
<tr>
<th></th>
<th>2016 Total abortion rate / 1,000</th>
<th>2016 Under 25s repeat abortions (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medway</td>
<td>18.0</td>
<td>29.4</td>
</tr>
<tr>
<td>South East Region</td>
<td>15.0</td>
<td>25.2</td>
</tr>
</tbody>
</table>
Other Needs

- Females aged 15-24 are at higher risk of STIs than males of the same age.[44](p31)
- Men-who-have-sex-with-other-men (MSM) are at greater risk of STIs than the general population and account of the majority of syphilis and gonorrhoea diagnoses in men. MSM are at higher risk of HIV. Diagnoses of chlamydia, syphilis and gonorrhoea are increasing among MSM.[44](p20, 21, 38)
- Individuals who are from the black and black British ethnic groups are disproportionately affected by STIs.[44](p44)
- Black Africans, and black African women, are disproportionately affected by HIV infections.[35]
- Heterosexuals are at far greater risk of a late HIV diagnosis than MSM.[35]
- There is insufficient data available to assess inequalities for those who have a physical or learning disability.

Current services in relation to need

Medway moved to an integrated model of service delivery in October 2017. This included the introduction of an online STI self-sampling scheme. Services are delivered by Hub and Spoke clinics; the hub is at 4 Clover Street Chatham and the spokes include GP Practices, Healthy Living Centres and other community settings. In the first year there were approximately 22,000 contacts in clinical settings and home sampling has proved popular with 1,657 users during the first year.

The service consists of the following elements:

1. Hub and Spoke clinics offering a full level 1-3 service and Self-managed care

   The aim is to:
   - Provide integrated clinics for contraceptive and genitourinary medicine.
   - Improve accessibility through extended opening hours.
   - Develop a range of self-managed care interventions, including online self sampling.

2. Outreach

   The aim of the outreach element is to:
   - Provide immediate and necessary support to prevent sexual ill-health for those not accessing universal services.
   - Identify and remove barriers to them accessing universal or targeted services.
   - Promote universal services and encourage their use.

3. Psychosexual therapies
• Provide help for patients presenting with sexual health aspects of psychosexual/sexual dysfunction for short to medium term therapy.

4. **National Chlamydia Screening Programme**

The aim of the Chlamydia screening element is to target 15-24 year olds to:

- Prevent and control chlamydia through early detection and treatment of asymptomatic infection.
- Reduce where possible onward transmission to sexual partners.
- Prevent the consequences of untreated infection.
- Raise awareness and skills of health professionals to screen for chlamydia and provide the information young adults need to reduce the risk of infection and transmission.
- The scheme gives rapid access to chlamydia screening through a range of settings including GP, Pharmacy, online, grab-bins, educational establishments and clinical settings.

5. **Get It condom scheme**

The aim of the condom distribution scheme is to target 13-24 to:

- Reduce STI transmission and HIV in young people.
- Reduce teenage pregnancy, especially among those identified as being most at risk and vulnerable.
- Achieve an increase in the percentage of the population screened for chlamydia and an increase in chlamydia detection.

Young people can register online or through a number of other venues such as clinics, pharmacies and educational establishments.

6. **LARC fitting and removal in primary care**

The aim of the Long Acting Reversible Contraception (LARC) fitting and removal in primary care scheme is to:

- Provide women with a choice of where to have LARC fitted to increase availability and uptake.
- Reduce unplanned pregnancy among all women of child-bearing age.
- Reduce teenage conceptions.
- Reduce abortions.
- Provide value for money contraception.
- Increase average LARC usage times so that it is comparable between GPs and Sexual Health Clinics.
7. EHC in Pharmacies

The aim of the EHC in Pharmacies scheme is to:

- Reduce unplanned pregnancy among women aged under 30.
- Reduce abortions especially repeat abortions.
- Reduce teenage conceptions.

8. Community based Targeted HIV screening

The aim of Community based targeted HIV screening is to target identified high risk groups, currently men who have sex with men (MSM) and Black Africans, to:

- Reduce the number of those infected with HIV who are undiagnosed and not on treatment.
- Reduce late diagnosis of HIV.
- Contribute to the reduction of stigma surrounding HIV.

9. HIV Adult services

The HIV adult services provides treatment and support for people living with HIV and is commissioned by NHS England but delivered through the Integrated Sexual Health Service.

Relationships and Sex Education

Medway Public Health supports Relationships and Sex Education (RSE) as part of Personal Health and Social Education (PHSE) by partnering with schools to ensure high quality delivery. RSE is operating in 12 of 18 secondary schools in Medway.

Projected service use and outcomes

*Table 1: Medway population projections 2012 - 2026 (ONS sub-national population projections). Note: Figures are in thousands*

<table>
<thead>
<tr>
<th></th>
<th>15 - 24</th>
<th>25 - 34</th>
<th>35 - 49</th>
<th>50 - 64</th>
<th>65 +</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>36.4</td>
<td>40.7</td>
<td>55.3</td>
<td>53.0</td>
<td>45.4</td>
</tr>
<tr>
<td>2022</td>
<td>36.3</td>
<td>41.9</td>
<td>55.6</td>
<td>56.1</td>
<td>49.4</td>
</tr>
<tr>
<td>2026</td>
<td>38.2</td>
<td>41.0</td>
<td>59.0</td>
<td>56.1</td>
<td>54.5</td>
</tr>
</tbody>
</table>

Older age groups, who have less contraceptive- or STI-related sexual ill-health, (50-64 and 65+) are projected to grow at a faster rate than younger groups. This older group may experience other forms of sexual ill-health but these are more likely to be age-related.

ONS figures suggest that the population of 15-24 year olds in Medway will decrease over the next ten years and then gradually increase again. This dip may result in a decrease in sexual health and contraception needs short term but the need is likely to increase back to current levels.
The net international migration component of these figures is fixed at about 500-600 people per year. Data from the 2011 census indicates that 1,953 Medway residents reported living outside the UK one year previously. The impact of the current migration trends is unclear.

Factors that may contribute to a reduction in attendances:

- Change to integrated sexual health services; service users will attend fewer appointments as they will be treated holistically.
- Increase in home sampling/self-managed care; cost effective solutions will reduce physical attendances at clinics for regular testers and asymptomatic service users.
- Increased focus on prevention is likely to reduce ill-health but may lead to an increase in lower level interventions such as contraception/contra-infection services.
- Accessibility of purchased ‘over-the-counter’ and ‘over-the-internet’ screening at affordable prices; as screening becomes more accessible some potential service users may choose to access private health care to maintain anonymity.

Factors that may contribute to an increase in attendances:

- Gonorrhoea or chlamydia with antimicrobial resistance; STIs that do not respond to current treatment programmes will lead to an increase in follow-up visits and increased drug costs.
- Improved accessibility of services will remove a barrier to asymptomatic clients, any anticipated increase should be met with cost-effective solutions such as online services.

HIV Pre-Exposure Prophylaxis (PrEP) trials have indicated the effectiveness of PrEP; this may be viewed as a cost effective preventive intervention and may be rolled out nationally.

**Evidence of what works**

Sexual health services should be viewed as a whole system and commissioned accordingly, across as many areas of responsibility as appropriate. [45][39]


- Build knowledge and resilience among young people.
- Improve sexual health outcomes for young adults.
- All adults have access to high quality services and information.
- People remain healthy as they age.
- Prioritise prevention.
- Reduce rates of STIs among people of all ages.
• Reduce onward transmission of and avoidable deaths from HIV.
• Reduce unwanted pregnancies among women of fertile age.
• Counselling for all women requesting an abortion (CCG responsibility).
• Continue to reduce the rate of under-16 and under-18 conceptions.

Young person friendly services, including contraception and emergency contraception, need to be easily accessible.[39]

Information for young people should be communicated using a variety of means through a variety of outlets.[39]

Services should seek consent and ensure confidentiality.[39]

Services should be based on the principle of progressive or proportionate universalism and tailored to the socially disadvantaged.[39]

Contraceptive services should be provided after a pregnancy or an abortion.[39]

Sexual health services should be provided in educational settings.[39]

Condoms should be provided in addition to other forms of contraception.[39]

Workforce and wider workforce should be trained in areas relating to sexual health.[39]

**User Views**

A programme of quantitative and qualitative primary research was conducted in April 2014 with over 300 respondents.

**Key messages**

Sexual health promotion and education; it was widely reported that the internet would be used as the primary source of additional information. ‘Official’ sites from recognised, trusted health bodies, such as NHS Choices, were used.

A broad cross-section of qualitative participants and almost all the stakeholders expressed concern that there was insufficient promotion of the local sexual health services. Students indicated that they would like campaigns based on local data.

Attitudes, motivators and barriers towards accessing services:

• The surveys revealed that people were most likely to attend services if they had genital discomfort or if their partner had an STI.

• There were several emotional barriers that people said would deter them from attending services. The most common of these was anxiety about confidentiality. People in the focus group explained that they were worried that they would be ‘spotted’ walking in/out of a clinic or sitting in the waiting room. Some said they would overcome this by attending a clinic in another locality. Having sexual health services placed alongside other health services was seen to be one way of avoiding the ‘embarrassment’ of being seen using the service.
• A few people also spoke very strongly, stating that they would feel anxious and put off attending because they wouldn’t know what was expected of them. The most commonly noted practical barrier was the lack of evening or weekend opening hours.

In response to the findings of the survey, the Integrated Sexual Health Service will provide services in the evenings and also on Saturday mornings. Webpages will be developed that will give service users an indication of what happens at the clinic and how testing is performed. Respondents wanted a degree of choice over the clinician they saw.

Of those surveyed 40% had sought information and support for sexual health issues from their GP. This was the most commonly used health service. Seventeen per cent had visited the chemist, 17% the CaSH service and 14% the Medway Maritime Hospital GUM service.

A smaller quantitative survey took place in youth settings in early 2015 that gave insight where the young people surveyed would prefer to attend services to improve their sexual health. Youth settings were popular for prevention and regular screening but for most other issues young people would prefer to access a Sexual Health Clinic.

Medway Sexual Health Network (MSHN) is open to all professional or voluntary organisations and is a forum to disseminate information and receive feedback from partner agencies in relation to sexual health. MSHN actively contributed to the writing of the integrated sexual health service specification.

Unmet needs and service gaps

HIV testing and diagnosis

Late diagnosis of HIV accounts for 39.5% of all diagnoses (CI 95% 23-63.3) which indicates individuals are not accessing regular testing. Heterosexual contact now accounts for a higher number of infections than among men who have sex with men; therefore the uptake of testing should be promoted and encouraged in all settings.

Chlamydia screening

Increased screening through core services and targeted outreach is required to reach the proposed Public Health Outcome diagnosis range of 2,400 positives per 100,000 15-24 year old population. Medway achieved a detection rate of 1,754/ 100,000 in 2016.

Easy access to STI screening

STI self-sampling kits have been made available through the Integrated Sexual Health Service. These have proved popular with younger adults and demand has outstripped supply, therefore additional resources should be made available to increase the number of tests taken by self-sampling.

Young peoples sexual health services

Accessibility to services for young people has improved, with onsite services available in educational establishments and online self-sampling is popular with adolescents and
young adults. Now that the integrated service has begun, young people should be asked for their views on the quality and accessibility of services.

**Local termination of pregnancy services:**

There has been a fall in women presenting at an early stage of pregnancy; this may have been in part to the disruption to the local Marie Stopes International clinic. A referral pathway has been developed to local SH services but the effectiveness of this pathway needs to be monitored.

**Provision of Long Acting Reversible Contraception (LARC)**

Promotion and uptake of LARC still require improvement to achieve the South East Average of 54/1000. Depo and oral contraception (which do not offer the same level of protection as a LARC method) still make up a large proportion of contraception issued through the clinical services.

**Sexual Assault Referral Centre (SARC)**

Whilst there is a sexual assault referral service located at Beech House, Armstrong Road, Maidstone there remain issues for wrap around services including STI testing and treatment, particularly for pediatric clients.

**Recommendations for Commissioning**

- A needs assessment should be conducted to identify existing or new gaps in service provision.
- HIV is of particular concern with late diagnosis of HIV posing serious problems at individual and community level. This increases the risk of onward transmission and ultimately treatment costs. There is a need to improve HIV awareness training amongst secondary care medical disciplines to improve early diagnosis.
- As a large proportion of those affected by HIV in Medway are of black-African origin, it is important to review services to ensure that they are accessible to this population.
- Improve sexual health services delivered by GPs, in particular access to LARC, Chlamydia screening and referral for full STI screening.
- Improve chlamydia screening rates through core services to achieve the 2400/100,000 diagnosis rate.
- Reduce the number of women who have repeat abortions to the south East England average rate of 25.2%.
- Increase the uptake of LARC to achieve the South East average of 54/1,000.

**Recommendations for needs assessment work**

The last Service review was conducted in 2014. A review of the sexual health system should be planned for 2018.
Smoking and tobacco control [Update in progress]

Summary

Cigarette smoking remains the leading cause of preventable death in England today; it is estimated to be responsible for up to 86,500 deaths per year.[47]

“Smoking has been identified as the single greatest cause of preventable illness and premature death in the UK. ...it is estimated that half the difference in survival to 70 years of age between social class I and V is due to higher smoking prevalence in class V.”[48] On average, those killed by smoking have lost 10–15 years of life.[49]

Smoking is a key driver of demand for the NHS, causing the majority of respiratory diseases, around 30% of cancers, and nearly one in five cases of cardiovascular disease, as well as being a contributory factor in diabetes and many other disease disorders.[50]

The local smoking prevalence in Medway has dropped from 31.8% in 2008 to 24.9% in 2010. These are based on national synthetic estimates and there is a need for more local data either through surveys or through an augmentation of the Annual Health Survey for England.

Smoking results in considerable use of NHS services—in 2007/08, an estimated 440,900 admissions to NHS hospitals in England among adults over the age of 35 were attributable to smoking.[51] This is nearly 1,200 per day and 5% of hospital admissions in that age group.

Stop smoking services should aim to treat a minimum of 5% of their local population of smokers in a year, but should take local needs into account. This is a minimum recommendation and the current national average is just under 10%.[52]

In 2010/11 the Medway Stop Smoking Service treated 7.5 % of the local population.

Key issues and gaps

Smoking prevalence in Medway is 24.9%, however, there is a significant variation across the Medway area and smoking is a major reason for health inequalities. Helping people to stop smoking is a key part of the business of NHS services across Medway and four-week quitting remains a challenging target.

Motivating people to stop smoking

- Currently there are no local data on the prevalence of smoking and there is a reliance on national synthetic estimates. This needs to be addressed through either local surveys or through an augmentation of the Health Survey for England.

- Continued focus on primary and secondary care is required, with an extension of this to frontline Council services, particularly in ensuring that sufficient and appropriate staff are trained in Brief Intervention, good quality Brief Advice/Intervention is given, and that referrals to stop smoking service are made proactively.

- Evidence has shown that mass media campaigns are effective in reducing smoking prevalence and are associated with stop smoking activity. The reduction in the
Department of Health-funded national mass media campaigns may result in a drop in activity/numbers accessing treatment.

- Increased working with General Practitioners (GPs) to continue to refer patients that smoke to the stop smoking service.

**Smoking cessation services**

- The stop smoking service currently offers the ‘abrupt quit’ model to smokers wanting to quit.

- It is unknown whether the current service provision adequately meets the needs of a certain groups with high smoking prevalence, such as those with mental health problems.

- The smoking status amongst some pregnant women at point of booking and point of delivery is not being recorded and is causing confusion and results in inaccurate recording.

- The lack of mobile technology and connectivity problems causes duplication in recording of patient outcomes. This is also causing an increase in use of financial and human resources. Improvements in this area will streamline processes, improve security and accuracy and enhance customer focus.

- Engaging midwives to carry out carbon monoxide testing (CO) as per NICE guidance and to participate in level 1 and level 2 training.

- The uptake of staff from Children’s centres to access training to enable them to offer professional advice on smoking cessation.

- IT systems at the acute trust not robust enough to support an electronic referral system.

- Releasing staff from duties at the acute trust in order for them to attend the 1-hour Brief Training Programme.

**Protection from tobacco-related harm**

- Continue to raise awareness of tobacco control beyond health partners and highlight the impact to other agencies and departments, including: fire and rescue; housing; social care; and Human Resources.

- Lack of understanding of the scale of illicit tobacco sales and counterfeit tobacco

- Challenging to enforce the legislation about smoking in cars

- Legislation for plain packaging of cigarettes not passed.

**Stopping Young People from starting to smoke**

- There is a lack of uptake of educational establishments working in partnership with the stop smoking service to design, deliver, monitor and implement stop smoking prevention activities.

- No power to influence, investigate or accountability to implement the five NICE guidance recommendations.
• Limited number of proactive schools supporting schools based interventions to prevent the uptake of smoking among children.

• Number of young people accessing the ‘go it alone programme’, indicate that the outcomes are un-measurable.

Improving evidence base
• There is little published evidence of the effects of interventions that focus on cessation activity in adolescence. In 2010/11 23,229 smokers aged under 18 set a quit date, achieving all self-reported quit rate of 32% (7,327) quitters. Proportionately on a national basis 3% of service users aged 18 or under set a quit date.

In Medway, 154 young people set a quit date in 2010/11 and of those, 54 quit successfully and achieved a 35% success rate. This equated to 4% of service users setting a quit date from the under 18 age group.

Who is at risk and why?
Smoking prevalence rates are highest in the poorest areas of England and Wales, demonstrating the strong link between smoking and deprivation. There are also differences in prevalence between genders, socio-economic groups, ethnicities and age groups [49][53][54]

Socio-Economic Status
• Smoking is higher than average in lower socio-economic status Mosaic Groups O, N, K, and I. These groups make up 31.1% of the Medway registered population.[55]

• Smoking prevalence in routine and manual workers continues to be higher at 29% than for those in the managerial and professional socio-economic group at 14%.[53]

• Smokers in lower socio-economic groups are less likely to succeed when trying to quit smoking, due in part to a stronger addiction to nicotine.

• At least 75% of lone parents in receipt of social security benefits smoke.

• People on low incomes (the bottom 15% in terms of material deprivation) have a significantly higher rate of smoking — 45% of men and 40% of women were current smokers.[56]

Gender
• Smoking in England is slightly higher in men (21%) than women (20%), contributing to the life expectancy gap between the sexes.[53]

• However, among children and young people in the South East more girls (8%) than boys (6%) smoke (2009 data).

Ethnicity
• Irish and Bangladeshi men have higher smoking levels than the general population, with Black Caribbean, Black African, Chinese, Pakistani and Indian men having
similar levels; Black Caribbean and Irish women have similar smoking levels to the general population; Black African, Chinese, Pakistani, Indian and Bangladeshi women have significantly lower levels of smoking.

Age
- Those aged 20 to 34 reported the highest prevalence of cigarette smoking (32% among 20–24 year olds and 27% among 25–34 year olds) while those aged 60 and over reported the lowest (12%).[53]
- Low Income Diet and Nutrition Survey 2007[56] found that older adults were much less likely to be current smokers than younger adults. Among men, the prevalence of current smokers was 54% for men aged 19–34, 58% for those aged 35–49, 52% for men 50–64 and 22% for men aged 65 and over. It is a similar pattern for women.

Young people and children
- Almost two thirds (65%) of current and ex-smokers who had smoked regularly at some point in their lives started smoking before they were 18.
- Across the South East Coast, 36% of girls and 33% of boys aged 11–15 will have smoked at least once. 8% of girls and 6% of boys aged 11–15 will be classed as regular smokers, defined as smoking at least once per week.[57] This is slightly higher than the national average.
- Nationally, 32% of pupils aged 11–15 have ever smoked, with a large variation by age: 55% of 15-year-olds have smoked at least once. The prevalence of regular smoking (at least once per week) also increases with age.
- The odds of being a regular smoker are higher if pupils live with other people who smoke, and also increase with the number of smokers in the household; children who live with two adult smokers are four times more likely to be regular smokers themselves than children who live with non-smokers.
- Smoking increases the risk of asthma in young people and aggravates asthma symptoms in those already diagnosed. It can also lead to impaired lung growth in children and young adults.[51]

Other groups

Pregnant women
- Prevalence of smoking in pregnancy across England is approximately 14% (Department of Health, 2010). In Medway it is higher at 20%.[58]
- Younger mothers are more likely to smoke throughout pregnancy than older mothers; 45% of mothers aged under 20 smoked throughout pregnancy compared with 9% of mothers aged 30 and over.
- Mothers classed as having ‘never worked’ are significantly more likely to smoke throughout pregnancy than mothers in managerial and professional occupations.
Prisoners

- Smoking prevalence among prisoners is estimated to be approximately 80%, with the 1997 psychiatric morbidity survey of prisoners in England and Wales [59] reporting 82% of male prisoners and 81% of female prisoners being current smokers.

- Smoking status should be routinely recorded in primary care records.

- Mental Health Trust staff, for example Wellbeing nurses, Occupational Therapists and Physical Activity co-ordinators should be trained to level 2 in Smoking Cessation.

- Patients who smoke should be offered referral to appropriate trained smoking cessation specialists on admission: or, if they do not wish to access this help at that time, a programme to promote readiness to quit should be agreed as soon as possible, and referral continue to be offered.

- The Medway Stop Smoking Service, the Mental Health Care provider and Medway Social Services should work together to develop plans to bring the Forensic and Secure Units, and eventually the Residential Care home environment for this patient population towards completely smoke free status. The GPCCs will be expected to actively support these plans. Commissioners of Forensic Secure Unit providers should use contract review as an opportunity to instigate change following consultation with staff, clinicians and patients/service users.

Mental Health

- Approximately 70% of people on mental health inpatient units are current smokers and 50% smoke heavily (more than 20-a-day).

- People with mental illness who are living in the community and who are less ill, smoke less, with up to 40% smoking and close to 30% smoking heavily.[60]

The level of need in the population

Smoking prevalence

Nationally, the prevalence of smoking among adults dropped from 24% in 2005 to 21% in 2008.[53] Smoking prevalence in Medway in 2010 was recorded at 24.9% higher than the national average. Smoking prevalence in Kent was higher than the national figure at 24.9%. The variation in prevalence across the Medway area is significant and varies between 16.2% in Rainham Central and 39.8% in Chatham Central (see Appendix -> Health and social care maps). There were around 54,344 smokers in Medway in 2010.

Figure 1: Smoking prevalence among over 18s in Medway and in England

A Health Equity Audit (HEA) carried out in July 2011 by the Kent Public Health Observatory [57] on the Medway Stop Smoking Service found that groups I, E, K and J had a good level of uptake. Smoking prevalence is highest in Mosaic group I, K, N and O.
and these groups make up 31% of the Medway population. Although the service is doing well at attracting smokers from Mosaic Group I and K, it is likely that there is a potential to target more smokers from group N and O.

The mosaic groups that are not well represented in Figure 21 are A, C and L, however smoking prevalence in these groups is lower than the England average so the number of smokers to target will be lower.

Smoking prevalence is strongly linked to deprivation. 45% of men and 40% of women in the most deprived 15% of households are current smokers.[56]

Routine and manual (R/M) smokers form the largest group of smokers among the general population and as stated, have higher smoking rates than other occupational groups in the general population (31% in R/M men and 27% in R/M women compared with 21% and 20% respectively in the general population).[52]

Age
• Those aged between 18 and 34 are setting the most quit dates. Those that are most successful in quitting are the older population aged 60 plus.

• Those aged 20 to 34 reported the highest prevalence of cigarette smoking (32% among 20–24 year olds and 26% among 25–34 year olds) while those aged 60 and over reported the lowest (12%).

• Low Income Diet and Nutrition Survey 2007 [56] found that older adults were much less likely to be current smokers than younger adults. Among men, the prevalence of current smokers was 54% for men aged 19–34, 58% for those aged 35–49, 52% for men 50–64 and 22% for men aged 65 and over. It is a similar pattern for women.

Figure 2: Numbers of Medway residents quitting smoking by age group in 2010/2011

Gender
• Males are more successful at quitting than females. Medway have been more successful at getting both men and women to quit and are better than the South East Coast and England average.

Figure 3: Numbers of Medway residents quitting smoking by gender in 2010/2011

Young people
• In recent years the proportions of young people smoking has declined. In 2006, the proportion of 11 to 15 year olds who said that they had smoked at least once in their lives was 39%; this fell to 33% in 2007 and 32% in 2008.[51] The survey defines regular smoking for this age group as usually smoking at least once a week. The proportion of this age group who were regular smokers was 9% in 2006, and 6% in both 2007 and 2008. Girls are more likely to smoke than boys and there is an increase in the prevalence of regular smoking with age.
In the south east 7% of young people between 11 and 15 years old smoke with more girls smoking than boys.[51] This is despite the increase in age at which it is legal to buy tobacco to 18.

Three in ten (29%) of pupils have tried smoking at least once. This proportion is the lowest measured since the survey began in 1982, when more than half of pupils (53%) had tried smoking. In the south east 35% of young people self-report ever smoking a cigarette, compared to 29% nationally. More girls have tried smoking at least once (36%) than boys (33%).

There are approximately 37% homes within England in which dependent children are living with smokers and potentially exposed to second-hand smoke.[61]

**Smoking in Pregnancy**

The number of maternities has been fairly steady in Medway and is currently around 3500 per year.[62]

The prevalence of smoking during pregnancy is high among the Medway residents compared to the England Average of 14%; it is currently around 20% in Medway.

This level equates to approximately 700 Medway resident mothers still smoking at the time of delivery each year. It also indicates that around half the women who smoke are stopping smoking during pregnancy.

**Prisoners**

The prevalence of smoking is much higher in the offender population than in the general population, for example it is estimated that at least 80% of prisoners smoke compared to 24% of the population of Medway.

The health needs of children and young people in the secure estate are noticeably higher than for those in contact with the YJS than they are in the community. Contact with the youth justice system (YJS) will produce positive health and well-being outcomes for children and young people. Early identification and attention to these needs should be considered integral to work to reduce youth crime and anti-social behaviour.[63]

**Current services in relation to need**

**The Stop Smoking Service in Medway**

The service has a range of support options across Medway including group, workplace, one to one, drop in and telephone support as well as specialist pregnancy support. They also offer specialist support whilst you are in hospital. They can provide these services in a wide range of venues including health centres, pharmacies, GP surgeries, community centres, libraries, hospitals and many more. Nicotine replacement therapy (NRT) is available for a one off prescription charge (exemptions apply) and prescription medication is also available via your local GP (prescription charges apply).

Staff are trained to deliver services within military, prisons, dental, young people’s settings. The service employs a polish worker, who speaks Slovak, Bulgarian and Roma who delivers stop smoking support in these languages.
All of the services recommend are provided by friendly trained stop smoking advisors, who offer a non-judgemental and supportive service. They will provide practical and expert advice on the most suitable treatment for you and give a wide range of coping strategies to help you be successful.

There is a website which is designed to be a further source of support for Medway residents who are either interested in quitting themselves, or helping a friend or family member to quit successfully. Registering for the website is free and those who register will not be contacted by any of the team unless requested to.

Registering as a member provides people with access to a wealth of information on how to quit smoking and the opportunity to join an online stop smoking group, so that they can receive specialist support from the comfort of their own home.

2010/2011 was a successful year for the stop smoking service in Medway. The service exceeded their vital signs target by 194%.

Projected service use and outcomes in 3–5 years and 5–10 years

We expect the current trend in prevalence in Medway to continue to follow England’s downward trend.

However, the prevalence and rate of reduction varies widely across Medway and between groups within Medway, for example there is a far lower prevalence in managerial and professional groups than routine and manual groups. The reduction in routine and manual groups therefore needs to be greater if the gap is to be narrowed.

Services will therefore need to be concentrated in areas that are most accessible for those groups that will continue to have a higher than average smoking prevalence, including routine and manual groups, geographical areas of high deprivation, offenders and mental health in-patients.

The Department of Health estimates nationally that 67% of smokers want to quit. As smoking is de-normalised in Medway, more people are likely to want to quit and there is therefore likely to be an increase in smoking cessation service need over the next 10 years.

As noted earlier, while the smoking cessation service is a highly cost-effective intervention, it is clear that this can only be one part of a comprehensive programme. A Smokefree Future: A Comprehensive Tobacco Control Strategy for England [64] describes the other two objectives as ‘stopping the inflow of young people recruited as smokers’ and ‘protecting families and communities from tobacco-related harm’.

Nationally, as the number of smokers reduces and there is less smoking-related morbidity, the average associated health care costs will fall. As smoking prevalence in Medway continues to reduce, there is likely to be a continued reduction in overall healthcare service use and costs associated with smoking if this continues. The cost to the NHS of smoking-related illnesses in the UK has been estimated at between £2.7 billion and £5.2 billion.[65][66]
Medway evidence

A Smoking Health Equity Audits for Medway has recently been produced. (ensure link is correct)

The service attracts more people from areas where smoking prevalence and deprivation are the highest and quit rates tend to be slightly higher in the least deprived areas. Stop smoking services in Medway are well distributed although possibly limited in some areas of high smoking prevalence. Most people who quit smoking used community groups, drop in sessions, GP practices or pharmacies for support. People quitting from the military achieved the highest success rates at 86%, however the numbers were relatively low for this setting. The community groups achieved an overall success rate of 73% with a higher proportion of numbers. Referral pathways and CQUIN targets have been set up with the Medway Community Health Care Trust and the Acute Trust in Medway and the service has seen an increase in the number of referrals to the service.

Figure 4: Numbers of Medway residents quitting smoking at 4 weeks 2005/2006 to 2011/2012

Research in Medway

Medway is committed to participating in local research and developing the evidence base for effective tobacco control and smoking cessation services. The following pieces of research are currently underway:

- Medway stop smoking service have supported Dr Michael Ussher (St Georges University London) with the LEAP Trial which investigated if physical activity was potentially effective and popular alongside behavioural support for smoking cessation during pregnancy.

- The service is taking part in a study that is aimed at investigating a new method of encouraging people to attend the NHS Stop Smoking Services by offering taster sessions. This Start 2 quit trial is a randomised control trial that is being directed by UCL.

National Evidence [links]

- The Centre for Disease Control Best Practices for Comprehensive Tobacco Control programme states: "A comprehensive state wide tobacco control programme is a co-ordinated effort to establish smoke free policies and social norms, to promote and assist tobacco users to quit and to prevent initiation of tobacco use.”

- The Health Inequalities National Support Team have published what works to improve uptake of SSS through their tobacco control visits Learning from National Support Team Visits Tobacco Control.

- Ten High Impact Changes to achieve tobacco control (Department of Health, 2008) should be used to plan the development and delivery of best practice tobacco
control interventions. These recommendations and identified gaps from the benchmarking exercise have been translated into 6 priority actions within the Tobacco Control Strategy and Action Plans. The document has been archived and is no longer accessible. The ten changes are as follows: (1) Work in partnership, (2) Gather and use the full range of data to inform tobacco control, (3) Use tobacco control to tackle health inequalities, (4) Deliver consistent, coherent and co-ordinated communication, (5) An integrated stop smoking approach, (6) Build and sustain capacity in tobacco control (7) Tackle cheap and illicit tobacco (8) Influence change through advocacy, (9) Helping young people to be tobacco free, (10) Maintain and promote smokefree environments.

• The Health Act 2009 requires tobacco products to be removed from display in shops. This new law will be implemented for large retailers in October 2011 and small retailers in October 2013. The Act also enables the prohibition of tobacco sales from vending machines, although this still subject to Parliamentary consideration of regulations.

• Beyond Smoking Kills (ASH, 2008) details a number of tobacco control priorities and contains new and useful research to support local priority setting.

• A Smokefree Future: A comprehensive tobacco control strategy for England (Department of Health, 2010) details the rationale and evidence-based policies for future tobacco control work under three objectives:

  • To stop the inflow of young people recruited as smokers.
  • To motivate and assist every smoker to quit.
  • To protect families and communities from tobacco-related harm.

• NICE public health guidance 10 (Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities), public health guidance 23 (School-based interventions to prevent smoking) and public health intervention guidance 1 (Brief interventions and referral for smoking cessation in primary care and other settings) details the guidance and recommendations for preventing uptake of smoking, engaging people and successful smoking cessation.

**User views**

**Desire to give up smoking**

67% of smokers say they would like to give up smoking, with 75% having tried to give up smoking in the past.[54]

**Equality Impact Assessments**

Medway Stop Smoking Service Equality Impact assessment: the service is providing evidence of equitable uptake relative to need by diverse population groups in terms of smoking cessation.
Unmet needs and service gaps

Recommendations for Commissioners

Motivating people to stop smoking

- Provide training and ensure wider delivery of brief advice/interventions across primary and secondary care and frontline Council work (e.g. social care). Ensure systems are in place for those staff to proactively refer to the stop smoking services.

- Consider a local survey to gain an accurate reflection of local smoking prevalence.

Smoking cessation services

- Continue the focus on: smoking in pregnancy; geographical areas of high prevalence; and routine and manual workers.

- To have an input into influencing the new service specification on maternity services and implement guidance from NICE.

- Review whether current provision meets the needs of groups with high smoking prevalence including: mental health in-patients; mental health patients in the community.

- Ensure CQUIN targets continue within the Acute and Community Healthcare trusts.

- Ensure robust service level agreements are in place with external providers, such as GP’s, Pharmacies and Prisons.

- Consider stop smoking interventions in any new commissioning contracts.

- Consider a patient group direction (PGD) for Champix to enable patients to gain access to smoking pharmacotherapies quicker and easier.

Protection from tobacco-related harm

- Engage wider partners with the tobacco control agenda to ensure a mutli-agency tobacco control alliance is established and implement a local tobacco control delivery plan.

- Formulate a clear communication approach, supported by community engagement activity.

- Continue with the development of smoke free initiatives.

- Continue development and implementation of workplace smoking policies for NHS and local authority organisations. Review policies of other partner organisations and Medway employers.

- Support the multi-agency illegal tobacco campaign to reduce supply and demand of illicit tobacco in Medway.

- Support Medway Maritime Hospital to achieve and maintain a Smokefree Hospital site.
Stopping Young People from starting to smoke

- Continue to support young people’s section of the website and investigate other social media methods to engage young people.

- The DH Tobacco Control Plan set out new national ambitions to reduce smoking prevalence among 15-year olds to 12% by the end of 2015. As the responsibility for public health moves to local authorities, it is important that elected members continue to play a key role and have access to the very strong evidence that exists to support continued local investment in tobacco control, to reduce the harms from smoking and tobacco use in their communities.

- Investigate the possibility of carrying out a young people’s survey to identify smoking prevalence among the 15 year olds to ensure that the 12% prevalence is met by 2015.

- Enforcing schools to adopt NICE guidance

Improving evidence base

- Continue to work with UCL and support the ‘start to quit’ study to assess whether ‘come and try it’ taster sessions will attract more smokers to attend stop smoking services.

Further needs assessment required

Substance misuse in children and young people [Update in progress]

Summary

Problematic risk behaviours such as smoking and drug misuse during youth are strongly associated with social deprivation.

However evidence of socio-economic variations in alcohol and drug misuse varies according to the definition of substance use that is adopted. Many UK surveys suggest a positive relationship between alcohol consumption and social status, young men and women from higher income groups drinking more frequently and in larger amounts. Similarly the use of cannabis and amphetamines does not appear to be strongly associated with social deprivation although young people who leave school at 16 appear more likely to have tried drugs than those who stay on to achieve higher qualifications. Against this highly problematic drug and alcohol use appear to be strongly associated with social disadvantage.

The close correlation between substance misuse and unplanned teenage pregnancy has been highlighted in many studies, as risk taking behaviour in one may easily lead to experimentation in the other. Use of substances may lead young people to intimate sexual contacts, having unprotected sex, having sex with someone they don’t know or becoming a victim of a sexual act.
Key issues and gaps

An increase in the number of young people presenting at specialist services who are injecting drug users.

Poor pathways of care between the secure estate and the Youth Offending Team (YOT) regarding substance misuse services, both inside and outside of Medway.

Looked after children (LAC) are not being referred from Children’s services but are being identified through schools or the Youth Offending Team (YOT) following a crisis. A more proactive approach is required.

No specifically funded work for children affected by someone else’s substance use

Recommendations for Commissioning

To continue to establish levels of need in relation to young people’s own substance use

- During 2011/12, re-tender young people’s substance misuse services within secure estates in line with new strategic direction and identified revised funding
- Commission systemic work for children affected by parental/family substance use
- Ensure that mechanisms continue to be in place to support workforce development within universal and targeted services.
- Develop and ratify a needle exchange policy for under 18’s
- Commission educational and skills training for foster carers

Who’s at risk and why?

All children and young people are potentially at risk of misusing drugs and / or alcohol.

There is evidence of a significantly increased propensity to misuse substances amongst certain vulnerable groups (as highlighted in Every Child Matters) including:

- Children in care;
- Persistent absentees;
- Excludees;
- Young offenders;
- Homeless young people; and
- Children affected by parental substance use.

Substance misuse has a negative impact on children and young people across each of the five Every Child Matters Outcomes. Effects include the impact of drugs and/or alcohol in relation to sexual health and teenage pregnancy; failing in education, employment and training; and involvement anti-social and criminal activity.
It should also be noted that children and young people may have multiple vulnerabilities, which are likely to increase the individual’s propensity to use drugs and/or alcohol.

Although consumption has increased for both boys and girls (25% of 16-24 year olds now drink more than the recommended weekly limit) a greater proportion of heavy drinkers (>50 units per week) are young men (9% compared with 6% of young women). It is important to note the increased potential risks and social costs associated with young women drinking heavily however. Alcohol can be toxic in pregnancy and may become an added complication in unplanned under 18 years conceptions.

Alcohol use is disproportionately concentrated in areas of high deprivation. In the most deprived areas, alcohol-related death rates amongst women are three times higher than those women in the least deprived areas, for men they are five times higher.

A recent study of 11,622 subjects from the 1970 British Birth Cohort Study, surveyed at aged 16 years (1986) and aged 30 years (2000) showed that binge drinking was reported in 17.7% of the cohort. It was associated with increased risk of drug/alcohol dependence, excessive regular consumption, illicit drug use, psychiatric morbidity, homelessness, convictions, school exclusions, lack of qualifications and lower adult social class. In short, adolescent binge drinking was a risk behaviour associated with significant later adversity and social exclusion and may contribute to the development of health and social inequalities during the transition from adolescence to adulthood.

There is a genetic predisposition (generational transmission) and a higher risk in families already affected by alcohol abuse, and early exposure to drinking alcohol increases the risk of problematic drinking in adolescence.

There is also strong association between parental substance misuse, domestic violence and mental health. The presence of any of these factors is likely to lead to an increase in emotional and behavioural difficulties and poor attachment impacting on current and future relationships. The presence of one or more of these factors has particular implications for safeguarding concerns and high numbers being referred into social care for these groups. Over 50% of serious case reviews include at least one of these factors. Given this correlation these factors, singularly or combined are seen as the ‘trilogy of risk’.

The level of need in the population

Medway has 28,000 10–17 year olds. 10.3 per cent of young people (in years 6, 8 and 10) reported either frequent misuse of drugs/volatile substances or alcohol or both.[67] There were 58 hospital admissions over a three year period of young people aged under 20 with mental and behavioural disorders due to substance misuse. During the same period there were 18 admissions of young people with poisoning by narcotics and psychodysleptics.[67] At any one time there are 66 young people engaged in structured treatment with KCA which offers a range of services to young people affected by their own or someone else’s drug or alcohol misuse.[68]

A range of research indicates that there is significantly increased drug use amongst vulnerable young people groups, including Children in Care, persistent absentees and truants, young offenders, young homeless and children whose parents misuse drugs
and/or alcohol. The children and young people’s plan for Medway estimates the number of children requiring Tier 3 level of intervention to be around 1,850 (this includes all children aged 0–19), with around 350 children in care with Medway Council. There were 526 first time entrants into the youth justice system in 2008.[67]

**Current services in relation to need**

- Screening Training for the wider Children’s Workforce to identify substance use/misuse and refer.
- Specialist input on diversionary programmes e.g. Fairbridge
- Drug Intervention Support Programme to reduce first time entrants into the criminal justice system for drug offences.
- Named Specialist Drug Worker with the Youth Offending Team (YOT) — screening 100% of YOT clients.
- Early Intervention worker — targeting links with sexual health and substance misuse, maintaining young people in educational settings, increasing protective factors for young people and reducing harm.
- Treatment services — for young people requiring 1-1 specialist treatment such as counselling and substitute prescribing.

Since the last JSNA the balance of work has shifted towards a more treatment focus due to ongoing restrictions to funding.

**Projected service use and outcomes in 3-5 years and 5-10 years**

- There has been a small increase in the incidence of Heroin use among under 18’s in Medway this year. The DAAT are considering needle exchange options for young people in the interests of public and personal safety.
- It is possible that if the population of Eastern Europeans increases over the coming years the prevalence of under 18 heroin use will also continue to increase. The users we have in services are known to each other and from the Eastern European community. This will increase demand on prescribing and needle exchange services which is costly. Translators are also sometimes required.
- ‘Feeder’ initiatives, such as Triage in custody (a targeted youth support intervention) is likely to increase the demand on services due to early identification. Commissioned services may need to be restructured should the skills balance need to shift.
- In the second quarter 86% of Medway’s young people in care had left in a planned way, compared to the national average of 79%. We would look to maintain this level.
Evidence of what works

National Guidance:

Every Child Matters: Change for Children Young People and Drugs
Young People's Specialist Substance Misuse Treatment: Commissioning Guidance
Young People's Specialist Substance Misuse Treatment: Exploring the Evidence
Young people's substance misuse treatment services – essential elements
Assessing Young People for Substance Misuse.
Hidden Harm Report Advisory Council Misuse of Drugs 2003
Drug Use Among Vulnerable Young People: developing a local picture Crime and Drugs Analysis and Research Home Office 2007
Healthy Child Programme

Summary of evidence base:

There must be targeted interventions within generic children and young people's services for those at risk around substances (particularly for those most at risk, such as children of problem drug users, persistent truants and school excludees, looked after children, young offenders, and homeless young people).

These interventions should include:

- early assessment around substance misuse issues;
- care management and appointment of a lead professional for all children and young people who need support and interventions around use;
- integrated information systems to help agencies work together to track interventions with individual children and young people;
- clear referral routes to specialist provision when needed.

(ECM: Young People and Drugs)

Service and workforce development is a key priority: all people working with young people have a key role to play in addressing substance misuse among children and young people. Substance misuse training should be available in every area and basis drugs awareness training should be incorporated into core professional training across the workplace (ECM: Young People and Drugs).

Children and adult services must adopt a Think Family approach: by taking a whole family approach and by working closely together, drug and alcohol services, dedicated young carer services and children, parenting and family services can meet the needs of parents whose substance misuse is adversely affecting the whole family. (Department for Children, Schools and Families (DCSF), Department of Health (DH) and National Treatment Agency for Substance Misuse (NTA): Joint Guidance on Development of Local
Protocols between Drug and Alcohol Treatment Services and Local Safeguarding and Family Services).

Specialist services must take a care planning approach to treatment and tailor effective and individualised packages of care to the young person’s specific needs.

Specialist treatment provision must be closely integrated with wider children and young people’s provision.

**User Views**

KCA consult with service users with regards to service provision.

Medway Council consulted with Medway residents when developing the children and young people’s plan and found that young people are really concerned about the effects of smoking, taking drugs and drinking alcohol and the fact you often see young people smoking and drinking in places like parks. There were real concerns about young people who drink alcohol and not knowing what they might do.[67]

**Equality Impact Assessments**

**Unmet needs and service gaps**

- There is a lack of detailed information available on the number and needs of children and young people with substance misuse needs that are not in specialist drug and alcohol treatment.

- Young people’s drug and alcohol provision is largely funded through external grant funding. This is likely to reduce with implications for the level and structure of substance provision. Significant reductions in provision are likely to have longer term implications for increased levels of offending behaviour, higher numbers requiring adult treatment and a range of health implications.

- As yet, no funding has been identified to ensure ongoing provision of targeted and specialist services for children affected by parental substance misuse. Lack of specialist provision is likely to have significant implications for safeguarding.

- Looked After Children are being identified through schools or Youth Offending Team (YOT) following a crisis and referred into services. Yet the number of referrals to specialist drug and alcohol services from Looked After Children Teams are low.

- The numbers of young people undertaking the transition into adult drug and alcohol services are very small.

- Transitional arrangements between the secure estate and YOT regarding substance misuse services, both inside and outside of Medway need to be developed.

- Needle Exchange Policy for under 18’s needs ratified with the increasing presentation of injecting heroin users.
Recommendations for Commissioning

- To continue to establish levels of need in relation to young people’s own substance use
- During 2011/12, re-tender young people’s substance misuse services within secure estates in line with new strategic direction and identified revised funding
- Commission systemic work for children affected by parental/family substance use
- Ensure that mechanisms continue to be in place to support workforce development within universal and targeted services.
- Develop and ratify a needle exchange policy for under 18’s
- Commission educational and skills training for foster carers

Recommendations for needs assessment work

Switch the focus to quality local data now that the National Treatment Agency (NTA) are not so prescriptive about data collection. Treatment is a small part of the work we commission and we need to focus more on how our work impacts on the wider agenda.

The NTA is about to provide us with needs assessment data capturing local activity and the complexity of the cohort within the specialist system. Later in the year the NTA will also be releasing an overview of data suitable for inclusion in the JSNA submission.

Substance misuse in adults

Summary

Introduction

Substance misuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and drugs. Drug misuse includes the harmful use illegal drugs, 'legal highs' and prescription-only medicines.

NB: Alcohol misuse is covered in a separate JSNA chapter: Lifestyle and wider determinants -> Alcohol

Substance misuse leads to ill health through both communicable and non-communicable disease. Those who participate in illicit drug use are more likely to share needles and increase the risk of acquiring blood borne viruses, such as HIV, hepatitis B and C. Drug users also have higher smoking and alcohol consumption rates, which contribute to an increased risk of premature death.

Nationally, and locally, the number of individuals in contact with specialist drug misuse services has decreased since numbers peaked in 2008-09. This is mainly due to the decline in the number of opiate users presenting to treatment. However, there is a
growing population of older opiate users, who commonly present to treatment services with cumulative physical and mental health problems due to long-term drug use.

In recent years there has been an increase in the use of synthetic drugs, especially new psychoactive substances (NPS), which is worrying as their availability and comparatively low price make them attractive. Several groups have been identified as being vulnerable to substance misuse, including young people, the homeless, some sex workers and individuals with pre-existing mental health problems.

**Key issues and gaps**

The level of unmet need (the estimated proportion of opiate users not in treatment) is higher in Medway compared to England.

In 2019, a needs assessment was carried out in Medway on common mental health disorders and non-dependent substance misuse (co-occurring conditions). This needs assessment highlighted a number of areas to consider taking action in Medway:

- Raise public awareness
- Targeted campaigns for key groups
- Improve screening and capacity to respond to need
- Enable self-help
- Agree (and implement) a pathway of care for co-occurring conditions
- Create a time-limited co-located “team” to kick start the pathway
- Encourage social prescribing to maximise available support

**Recommendations for Commissioning**

Medway Council commissioned Turning Point and Open Road to provide substance misuse treatment and recovery services in Medway from 1 April 2018. The aim is to provide a system that reduces the likelihood of lapse or individuals becoming ‘stuck in treatment’ by providing visible recovery to everyone entering treatment.

It is anticipated the new service will address: lack of mutual aid; co-occurring conditions; lack of engagement with treatment; substance misuse among rough sleepers; visible recovery; and low rates of blood borne viruses.

**Introduction**

Substance misuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and drugs.[69]

NB: Alcohol misuse is covered in a separate JSNA chapter: Lifestyle and wider determinants -> Alcohol

Drug misuse includes the harmful use illegal drugs, “legal highs” and prescription-only medicines.[70] Under the Misuse of Drugs Act 1971, illegal drugs are placed into one of
three classes: A, B or C. This is broadly based on the harms they cause either to the user or society when they are misused. Class A drugs are considered likely to cause the most serious harm.[71] Examples include:

- **Class A**: heroin, cocaine (including crack), methadone, ecstasy, and LSD.
- **Class B**: amphetamines, barbiturates, codeine, and cannabis.
- **Class C**: benzodiazepines, ketamine, pregabalin, and anabolic steroids.

In recent years there has been a growth in the use of synthetic drugs, especially new psychoactive substances (NPS) previously known as 'legal highs'. NPS are chemical substances that produce similar effects to 'established' drugs (like cocaine, cannabis and ecstasy).[72] They were originally created to side-step legislation,[72] but these drugs are now either under control of the Misuse of Drugs Act 1971 or subject the Psychoactive Substances Act 2016. The unknown purity and consistency of NPS is of particular concern in terms of both the short- and long-term effects, as well as their relative availability and comparatively low price.[73]

There is also concern regarding the dependence on, and withdrawal from, prescribed medicines, such as pain killers, and in 2018 Public Health England was commissioned to review the available evidence.[74]

**Health harms of drugs**

Substance misuse leads to ill health through both communicable and non-communicable disease.

Communicable disease: Those who participate in illicit drug use are more likely to engage in risky behaviours, which can increase their likelihood of poor health or drug-related deaths.5 Injecting illicit substances and participating in needle sharing not only increases the risk of overdose and dependency, but also the risk of acquiring blood borne viruses such as HIV, hepatitis B and C, alongside bacterial infections.[75], [76] Users of illicit substances are also at a greater risk of contracting sexually transmitted diseases by having unprotected sex.[75]

Non-communicable disease: Drug users have higher smoking and alcohol consumption rates than the wider population, which contributes to an increased risk of premature death. However, identifying whether the misuse of substances has been a direct or indirect cause of acute or chronic harm can be challenging.[75]

**Who’s at risk and why?**

**Prevalence**

The 2017/18 Crime Survey for England and Wales (CSEW) showed that around 1 in 11 (9.0%) adults aged 16 to 59 had taken an illicit drug in the last year.1 Cannabis was the most commonly used drug (7.2%; around 2.4 million people), followed by cocaine (in powder form: 2.6%) and ecstasy/MDMA (1.7%). Also, around 0.4 percent had used New Psychoactive Substances (NPS) in the past year.[77]
Medicines prescribed for the treatment of long-term pain include opioids, gabapentin and pregabalin.[78] The 2017/18 CSEW reported that 7.0 percent of adults aged 16 to 59 had taken prescription-only painkillers not prescribed to them for medical reasons, and a small proportion (0.2%) had taken them solely for the feeling or experience it gave them.[77]

There are three types of cocaine, all of which are Class A drugs; coke (fine white powder), crack (small lumps or rocks), and freebase (crystallised powder).[79] Crack is usually cheaper to purchase than powder cocaine,[78] making it a more affordable and accessible alternative. Collectively, opiate (e.g. heroin) and/or crack cocaine users (OCUs) have a significant impact on crime, unemployment, safeguarding children and long-term benefit reliance.[80] Table 1 shows the most recently published prevalence estimates of OCUs in England.[81] This gives an indication of the number in need of specialist drug treatment.[80]

Table 1: National opiate and/or crack prevalence estimates and rates, aged 15-64, 2016-17

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Rate per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiate users</td>
<td>261,294</td>
<td>7.37</td>
</tr>
<tr>
<td>Crack cocaine users</td>
<td>180,748</td>
<td>5.10</td>
</tr>
<tr>
<td>Opiate and/or crack users</td>
<td>313,971</td>
<td>8.85</td>
</tr>
</tbody>
</table>

While the estimated number of opiate users in England has remained relatively similar in recent years, there was a 10 percent increase in the estimated number of crack cocaine users between 2011-12 (166,640) and 2014-15 (182,828), and it remained at this increased level in 2016-17 (180,748).[81]

Deaths from drug misuse

Drug misuse is a significant cause of premature mortality in the UK.[82] The number and rate of drug misuse deaths increased between 2012 and 2016. There were nearly 2,400 drug misuse deaths in England in 2016, which was the highest figure on record; an increase of 60 percent since 2012.[83],[84]

This rise has been linked to heroin and opioid use, and the fact that heroin-related deaths doubled between 2012 and 2016. Two factors have been identified that may be responsible for the increase: the increased availability and purity of heroin, alongside an ageing population of heroin users in poorer health.[83],[84]

Data for 2017 shows that the number and rate of drug misuse deaths in England fell slightly from 2016; the first fall in 5 years.[83],[84]

Treatment

In 2017/18, there were 192,603 individuals in England, aged 18 and over, in contact with specialist drug misuse services, which is a 15 percent reduction since numbers in treatment peaked in 2008-09 (225,751).[72] This decrease is mainly due to the decline in the number of opiate users presenting to treatment.[85]

Overall, the most reported problematic substance in 2017/18 was opiates (73%; 141,189), followed by crack cocaine (36%; 70,040) and cannabis (28%; 53,446).
Age-related trends in treatment presentations

There has been a significant and steady fall in the number of under 25s presenting for treatment, which is primarily due to a decrease in the number of presentations for opiates and cocaine powder. Conversely, the proportion of those aged 40 years and over has continued to rise in the past decade, due to an increase in new opiate presentations in the over 40 age group.[85]

Opiate users

Although the number of new presentations for opiates is falling, there is an ageing population of opiate users (median age of 40),[72] many of whom would have started using drugs during the epidemics of the 1980’s and 1990’s.[86] This ageing population of opiate users commonly present to treatment services with cumulative physical and mental health problems from long-term drug use and are also at increased risk of overdosing.[86]

An individual may present with more than one problematic substance and nearly half (45%) of opiate clients also presented with problematic crack cocaine use.

Non-opiate users

Non-opiates are any drug other than those that act on opioid receptors, such as such as cannabis, crack and ecstasy.[72] Those who seek treatment for non-opiates tend to be younger. Within the 18-24 year old age group, the most reported drugs were cannabis (54%) and cocaine (29%). New treatment presentations for cannabis peaked in 2013/14, but have fallen by 17 percent over the last four years (30,422 to 25,169).[72]

New psychoactive substances

There were 1,223 people who had problems with new psychoactive substances (NPS) starting treatment in 2017/18, which is a 16 percent decrease on the previous year (1,450) and a 40 percent decrease on the year before that (2,042). This fall was mainly driven by a 36 percent reduction in those under 25 entering treatment for NPS problems (321 in 2016/17, dropping to 206 in 2017/18). This reduction may be attributable to the new legislation and the reduction on availability.

Vulnerable groups

The 2017 national Drug Strategy[87] identifies those most at risk of drug misuse in the UK:

Young people

Drug misuse in young people often overlaps with a range of other vulnerabilities, which can exacerbate their risk of abuse.[87] In 2016-17, of the young people accessing specialist substance misuse services:

• 21% were affected by domestic abuse
• 18% identified as having a mental health problem
• 16% were involved in self-harm
• 16% were not in education, employment or training (NEET)
• 12% were looked after children.[88]

Most young people who have developed a substance misuse problem are not at the stage where they are dependent on drugs, so the response should focus on preventing more problematic use.[87]

**Mental health**

Research suggests that up to 70 percent of people in community substance misuse treatment also experience mental illness. There is a high prevalence of drug use among those with severe and enduring conditions, such as schizophrenia and personality disorders.[87] The term co-occurring conditions is used when people experience mental health and drug and/or alcohol use conditions at the same time.[89]

**Offenders**

Around 45 percent of acquisitive crimes (e.g. burglary, robbery, shoplifting) are committed by regular heroin or crack cocaine users.[87], [90] The criminal justice system provides a prime opportunity to tackle substance misuse and ensure the individual has access to the support they need to stop.[87]

**Prisoners**

The use of new psychoactive substances (NPS) is problematic in prisons.[87] In 2017-18, almost one in ten adults in treatment stated they had a problem with NPS (8.5%).[91] The use of NPS in prisons is linked to violence, debt, organised crime and medical emergencies.[92]

**Families**

Parental drug dependence can limit the parent’s ability to care for their child(ren) and can increase the likelihood of children misusing drugs themselves.[87] Parent-child conflict can also lead to children disengaging from their family and choosing to take part in risky behaviours with peers.[93]

Intimate partner violence and abuse: Women with experience of extensive sexual or physical violence are more likely to be dependent on drugs.[87]

**Sex workers**

Those selling sex are at greater risk of drug misuse. Sex workers may use drugs as a way of coping with what they are having to do or because they are being coerced (into both prostitution and drug use). Alternatively, they may have become involved in prostitution to fund an existing drug dependence.[87]

**Homeless**

Homelessness can be both a cause and consequence of drug misuse.[87] The use of NPS is particularly problematic among the homeless population.[87] In 2017-18, people who started treatment with NPS problems were more likely to have an urgent housing problem compared to all individuals starting treatment (25% vs 8%).[72]
Veterans

Veterans sometimes use alcohol and/or drugs to cope with the physical and psychological effects of military service. These risks can be increased if their physical and/or mental health reduces their ability to find and hold long-term, fulfilling employment and secure accommodation.

Chemsex

Chemsex is a term for the use of drugs before or during sexual activity to sustain, enhance, disinhibit or facilitate the experience. Chemsex commonly involves crystal methamphetamine, GHB/GBL and mephedrone. These practices can have an adverse impact on the health and wellbeing of men who have sex with men (MSM), including the spread of blood borne infections and viruses.[87], [94]

The level of need in the population

Prevalence

Opiate and/or crack users (OCUs) collectively have a significant impact on crime, unemployment, safeguarding children and long-term benefit reliance.[95] Table 2 shows the most recently published prevalence estimates of OCUs in Medway[81], which gives an indication of the number in need of specialist drug treatment in the local area.[95]

Table 2: Local opiate and/or crack prevalence estimates and rates, adults aged 15-64, 2016-17.[81]

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Rate per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiate users</td>
<td>1,221</td>
<td>6.77</td>
</tr>
<tr>
<td>Crack cocaine users</td>
<td>913</td>
<td>5.06</td>
</tr>
<tr>
<td>Opiate and/or crack users</td>
<td>1,459</td>
<td>8.09</td>
</tr>
</tbody>
</table>

In 2016-17, the estimated prevalence rate of opiate and/or crack users in Medway (8.09 per 1,000) was lower, but statistically similar, to the national prevalence rate for England (8.85 per 1,000).[81]

Drug related deaths

Between 2015 and 2017, there were 35 deaths from drug misuse in Medway.[82] This is a rate of 4.4 per 100,000, which is statistically similar to the England rate (4.3 per 100,000).[95] Figure 1 shows that the rate of deaths from drug misuse in Medway has decreased since peaking between 2013 and 2015 (6.4 per 100,000).[82]
Figure 1: Age-standardised mortality rate from drug misuse per 100,000 population for England and Medway.[82]

**Treatment**

In 2017-18, 636 adults received structured drug treatment in Medway; 71 percent for opiates (450 adults), 18 percent for non-opiate and alcohol (117 adults) and 11 percent for non-opiates only (69 adults).[95] The number of adults in drug treatment in Medway has decreased by 13 percent since 2016-17 (731 adults). This appears to be driven by a reduction in opiate users in treatment; a 23 percent decrease from 581 opiate users in 2016-17.[95]

Detailed below are the characteristics of people who were in drug treatment in Medway in 2017-18:

- **Gender:** Seventy-one percent of adults in drug treatment in Medway were male and 29 percent were female, compared to 73 percent and 27 percent nationally, respectively.[95]

- **Age:** The age group with the largest proportion of adults in drug treatment in Medway was 30 to 39 (40%), followed by the 40 to 49 age group (31%), in line with the national picture.[95]

- **Sexuality:** Ninety-four percent of new presentations in Medway identified as heterosexual with a further one percent identifying as gay or lesbian, one percent as bi-sexual and four percent as not stated, not known or missing data.[95] Whilst this profile is similar to the national estimate of sexual identity,[96] it suggests that
LGBT communities could be under-represented in drug treatment services given studies which show that, on average, they have a higher level of need.[97]

**Co-occurring substance misuse and mental health**

Mental health problems are very common among those in treatment for drug use. In 2016/17, 22.5 percent of people who entered treatment for drug misuse in Medway were already in contact with mental health services, which is similar to the England average (24.3%).[98]

**Waiting times**

Drug users need prompt help if they are to recover from dependence. Keeping waiting times low will play a vital role in supporting recovery.[95] In 2016/17, the proportion waiting more than three weeks for drug treatment in Medway was 0.2 percent, which is lower than the England average (1.5%).[99]

**Successful completion**

In 2017/18, 6.8 percent of opiate users and 41.2 percent of non-opiate users successfully completed treatment in Medway; these figures are similar to the England averages (opiate users: 6.5%; non-opiate users: 36.9%).[95] Individuals achieving this outcome have overcome their drug dependence, which can lead to improvements in health and well-being, reduced mortality, reduced blood borne virus transmission risk, improved parenting, and improved physical and psychological health.[99]

The 2016-17 Medway Substance Misuse Needs Audit[19] highlighted that more than 50 percent of the opiate treatment population in Medway was assessed as having “high” or “very high” levels of complexity (higher than the local outcome comparator average). Those with higher levels of complexity are much less likely to successfully complete treatment.[19]

**Deaths in treatment**

Between 2014/15 and 2016/17, the number of deaths in drug treatment was higher than expected in Medway (Medway mortality ratio: 1.61; England mortality ratio: 1.00).[99] Analysis of service data indicates that overdoses and illness related to the liver were cited most frequently among those who died whilst in treatment.

**Current services in relation to need**

Provision of community-based treatment for drug and alcohol misusers has been available in Medway for over a decade. The primary focus of specialist services has been on engaging opiate and crack users (OCU’s), and people with a dependency on alcohol, to use effective treatment.[100]

**Turning Point and Open Road**

Medway Council currently commissions two providers to deliver an integrated specialist substance misuse treatment and recovery service for adults, aged 18 years and above, who live in the Medway area.
Turning Point delivers community-based treatment, detox and rehabilitation services. The service aims to address dependency issues through prescribing and psycho-social interventions. The service operates under the name of Medway Active Recovery Service (MARS) and uses a “phased and layered” approach[101] to ensure the treatment offer is most appropriate to the clients. In 2017-18, a total of 636 individuals used specialist drug treatment (excluding alcohol clients).[80]

A needle exchange scheme operates as part of the treatment service to reduce the likelihood of needle sharing and onward transmission of blood borne viruses.

Open Road has been commissioned by Medway Council to provide wellbeing and recovery services. Open Road accepts referrals from Turning Point, and other agencies, for individuals who have had issues with substances and would like ongoing support or targeted work to address issues such as training or employment. The purpose of this service is to reduce the likelihood of lapse and to present a visible recovery to those entering treatment services.

Windmill Clinic at Medway Hospital

Medway NHS Foundation Trust has a specialist clinic, Windmill Clinic, for women who use opiates prior or during their pregnancy. The clinic aims to provide individualised care and advice from both a midwife and obstetrician with specialist knowledge of substance misuse, as well as a drug worker within a friendly and non-judgemental environment. The service is in addition to normal midwifery care, although some women find it more appropriate to receive most of their care within the clinic.[102]

Mutual aid organisations

Mutual aid refers to the social, emotional and informational support provided by, and to, members of a community group at every stage of recovery. Groups often include people who are abstinent, and want help to remain so, as well as people who are thinking about stopping and/or actively trying to stop their drug and alcohol use.[103] There are a range of organisations in Medway providing mutual aid, including Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and Cocaine Anonymous (CA).[100]

Residential rehabilitation

While the majority of individuals in Medway received an intervention in the community (99%) in 2017-18, a small proportion of adults attended an intervention in a residential setting (2%).[80] Residential rehabilitation provides an opportunity for those who find community-based services ineffective at addressing the causes of addiction and prepare the individual for reintegration into the community. In Medway, Turning Point organises residential rehabilitation for clients when needed and finds the most appropriate programme for each case.

Locally

Medway Council Public Health is committed to the delivery of the current national Drug Strategy[87] through the commissioning of high quality local substance misuse services. The national plan aims to reduce demand, restrict supply, and build recovery in communities. The treatment provider, Turning Point, works collaboratively with
agencies including the police, housing providers, rough sleeper support workers, prison drug treatment providers and social care services to achieve those aims.

A key piece of collaborative working is the Blue Light Project, a multidisciplinary scheme to oversee a coordinated approach to supporting those facing the severe and multiple disadvantages (SMD) of substance misuse, homelessness and involvement with the criminal justice system. The quality of life reported by people facing SMD is much worse than that reported by many other low income and vulnerable people, especially with regard to their mental health and sense of social isolation.[104] The Blue Light Project has a rolling caseload of 20 individuals.

The Medway Council Public Health team engages with local primary and secondary schools to deliver quality PSHE on a variety of subjects, including building confidence and resilience, as well as providing drug and alcohol education.

Physical and mental health

Long-term drug use can affect the physical health of some people; this includes acquisition of blood borne viruses, unintentional overdose, respiratory problems and other health problems associated with self-neglect.

Medway Council Public Health has begun work to embed NHS Health Checks and stop smoking services into treatment and recovery services. Turning Point is working with Medway CCG to develop a chronic obstructive pulmonary disease (COPD) pathway and early identification of substance misuse issues at the acute hospital pre-admissions unit and other wards. It is anticipated that the Wellbeing and Recovery service delivered by Open Road will provide holistic support for all aspects of health.

To reduce the risk of opiate overdose, naloxone is made available through the needle exchange scheme and is offered (with appropriate training) to those working with high risk populations.

It is also acknowledged that substance misuse and mental ill-health are co-occurring conditions for some individuals (see the “Unmet needs and service gaps” section for further information). Services commissioned by Medway Council Public Health have been working to engage with mental health services to improve pathways.

Projected service use and outcomes


Overall, it is projected that the number of people in treatment for opiate misuse will decrease. The proportion aged under 30 is predicted to continue to fall considerably and, conversely, the proportion aged 40 and over is estimated to make up almost three-quarters of all those in treatment for opiate use. This will have significant implications for the health and mortality risks of older users. Drug treatment will need to respond to a range of age-related, long-term health conditions and actively support referrals for primary and specialist care.[85]
For non-opiate users, it is projected that the number in treatment will remain relatively stable, as has been the case in recent years. However, changes may be seen in the types of non-opiate substances that individuals are presenting for, with a rise in the use of New Psychoactive Substances (NPS) and the decline seen over the last 10 years in benzodiazepine and crack cocaine presentations. It is projected that the age profile of non-opiate clients will not change that much, with the majority of presentations continuing to come from the under 35 age group.[85]

It is unlikely that the trends predicted nationally will differ greatly from the local Medway picture. Although services will be adapted and scaled in line with the level of need, the continued commissioning of services for our opiate and crack users will continue to be important due to the impact this cohort can have on crime, unemployment, safeguarding children and long-term benefit reliance.[80]

**Evidence of what works**

**NICE guidelines**

The National Institute for Health and Care Excellence (NICE) provides several evidence-based guidelines on a range of topics related to drug misuse, such targeted interventions for drug misuse prevention (guideline NG64).[70]

**UK Clinical Guidelines 2017**

In 2017, the Department of Health published guidance for clinicians providing drug treatment for people who misuse or are dependent on drugs: Drug misuse and dependence - UK guidelines on clinical management.[101] This document offers guidelines on:

- Prison-based treatment
- New psychoactive substances and club drugs
- Mental health co-morbidity
- Misuse of prescribed and over-the-counter medicines
- Stopping smoking
- Preventing drug-related deaths, including naloxone provision

There is also a strong emphasis on recovery and a holistic approach to the interventions that can support recovery.[101]

**Drug Strategy 2017**

In July 2017, the Government published the 2017 Drug Strategy, which aims to reduce all illicit and other harmful drug use, and increase the rate of individuals recovering from their dependence. The Government aims to achieve this by adopting a balanced approach over four key themes:[87]

1. **Reducing demand**: Taking action to prevent the onset of drug use, and its escalation at all ages, through universal action combined with more targeted action
for the most vulnerable. This includes placing a greater emphasis on building resilience and confidence among our young people to prevent the range of risks they face (e.g. drug and alcohol misuse, crime, exploitation, unhealthy relationships).

2. **Restricting supply**: Taking a smarter approach to restricting the supply of drugs: adapting the approach to reflect changes in criminal activity; using innovative data and technology; taking coordinated partnership action to tackle drugs alongside other criminal activity.

3. **Building recovery**: Achieving a full recovery by improving both treatment quality and outcomes for different user groups; ensuring the right interventions are given to people according to their needs; and facilitating the delivery of an enhanced joined-up approach to commissioning and the wide range of services that are essential to supporting every individual to live a life free from drugs.

4. **Global action**: Taking a leading role in driving international action, spearheading new initiatives, e.g. on new psychoactive substances, sharing best practice and promoting an evidence-based approach to preventing drug harms.

**User Views**

In 2016 Medway Council Public Health commissioned a needs audit of local substance misuse needs.[19] The consultation heard the views of 81 people with current or recent substance misuse issues and 33 professionals working with partner agencies. Service user and partner views included:

- Recovery provision was felt to be underdeveloped due to high demand on treatment taking the majority of resources.

- Service users and partners do not want a ‘one size fits all’ approach - they want a ‘Both And’ approach - namely, both treatment and recovery.

- Sustainable recovery was felt to be limited by the lack of individual recovery capital and gaps in the current system to build individual and community recovery capital.

‘Recovery capital’ refers to the internal and external resources necessary for an individual to achieve and maintain recovery from substance misuse as well as make behavioural changes. Recovery Capital recognises that a variety of elements can support or jeopardise recovery; these include social networks, physical, human, cultural and community issues. Recovery capital differs from individual to individual, and may change over time.[105]

**Equality Impact Assessments**

**Unmet needs and service gaps**

Public Health England indicates the level of unmet need for drug treatment services by calculating the estimated proportion of local opiate users who were not in contact with
drug treatment services for an opiate problem. In 2016/17, it was estimated that 52.6 percent of opiate users were not in treatment in Medway.[99]

The 2016-17 Medway Substance Misuse Needs Audit[19] also highlighted the following issues:

- The current system appears to have a gap in the peer support and mutual aid available to clients. Data from 2015 shows that 3 percent in Medway receive peer support compared to 17 percent in Kent; these figures are the same for mutual aid support.
- Some groups are under-served; Eastern Europeans, homeless and lower level users.
- There is an apparent need for outreach, especially in the homeless community.
- The visibility of the service provider needs to be improved, so people know where to access help.
- There is lack of clear pathways out from services, so a number of people remain stuck in treatment.

Co-occurring conditions

The term co-occurring conditions, or dual diagnosis, is used when people experience mental health and drug and/or alcohol use conditions at the same time.3 Research shows that mental health problems are experienced by the majority of drug (70%) and alcohol (86%) users in community substance misuse treatment.[89]

Mental ill health and drug and/or alcohol use are both associated with physical health problems and early death.[89] Evidence suggests that people with co-occurring conditions are frequently unable to access the care they need from both mental health and addiction services. Individuals experiencing mental health crisis may experience difficulty in accessing care due to intoxication.[89]

Safeguarding is an issue, as some vulnerable groups of people with co-occurring conditions may be particularly at risk of losing contact with services, while also being at greater risk of harm.[89] Therefore importance is placed on individuals being assigned a named care worker in order to build a relationship and to help follow a Care Programme Approach (CPA).[106] NICE also recommends that individuals have contact with champions and supportive families who can encourage the use available mental health and substance misuse services.[107]

In 2019, a needs assessment was carried out in Medway on common mental health disorders and non-dependent substance misuse (co-occurring conditions). It was estimated that there are 6,227 individuals in Medway who have a common mental health disorder and use alcohol or other non-dependant substance misuse[108]. The numbers of those with more complex mental illness and dependant substance misuse are unknown, however it is safe to assume that harms will be far greater. This needs assessment highlighted a number of areas to consider taking action:

• **Targeted campaigns** for key groups such as young people, LGBTQ+, veterans, unpaid carers, women, those with dementia, and without GP access.

• **Improve screening and capacity to respond to need** for co-occurring conditions by choosing the most appropriate tools and training a range of professionals.

• **Enable self-help** by developing a comprehensive online offer and ensuring a better user journey for those experiencing co-occurring conditions.

• **Agree (and implement) a pathway of care for co-occurring conditions** to enable collaborative delivery of care by multiple agencies in response to individual need.

• **Create a time-limited co-located â€œteamâ€** to kick start the pathway of care for co-occurring conditions.

• **Encourage a social prescribing approach** as part of this pathway to maximise use of available support.

**Recommendations for Commissioning**

Medway Council commissioned Turning Point and Open Road to provide substance misuse treatment and recovery services in Medway from 1 April 2018. It is anticipated the new service will address the following:

• Lack of mutual aid: new support groups will be encouraged through peer support and the impact will be monitored.

• Co-occurring conditions: protocols will be checked, re-issued and monitored.

• Lack of engagement with treatment: improved links between criminal justice, general practice and treatment services.

• Substance misuse among rough sleepers: treatment experts will be embedded in the Rough Sleepers Initiative outreach, delivered by Medway Council’s Strategic Housing department, and will have rapid referral routes into treatment.

• Visible recovery: clear pathways between the treatment and recovery elements of the system.

• Low rates of blood borne viruses: needle exchange scheme will liaise with community wardens, etc. to reduce numbers of discarded sharps.

A pilot project is underway, Rough Sleepers Initiative delivered by Medway Council’s Strategic Housing department, to support vulnerable women, including those who sell sex. This builds on the strong partnerships between Public Health, Strategic Housing and the treatment service provider.

The data for deaths in treatment[99] and drug misuse deaths[82] in Medway were above the England average and higher than expected. This issue will be addressed, in part, by a multi-agency panel that will look at the circumstances around sudden and
unexpected drug related deaths through a root cause analysis process. The panel will disseminate the learning to other agencies.

To fill a gap in knowledge about Chemsex activity in Medway, Metro Charity have been commissioned to deliver a research project that will inform any future interventions.

In 2019, a needs assessment was carried out in Medway on common mental health disorders and non-dependent substance misuse (co-occurring conditions). This needs assessment highlighted a number of areas to consider taking action:

- Raise public awareness
- Targeted campaigns for key groups
- Improve screening and capacity to respond to need
- Enable self-help
- Agree (and implement) a pathway of care for co-occurring conditions
- Create a time-limited co-located team to kick start the pathway
- Encourage social prescribing to maximise available support

**Recommendations for needs assessment work**

Evaluate the impact of the new specialist substance misuse treatment service on key indicators by the end 2019.

**Housing and homelessness**

**Summary**

**Introduction**

Housing makes an important contribution to social and environmental objectives such as reducing health inequalities, improving educational attainment and community cohesion.

Medway has benefited, and continues to benefit, from considerable investment arising from its strategic location within the Thames Gateway. Recent infrastructure investment includes Chatham Bus Station and the High Speed Rail Link. This is resulting in a welcome diversification of the economic base towards creative industries, financial services, business services, education, environmental and energy technologies. This has added to Medway’s long-standing manufacturing strengths and important energy and port facilities located on the Hoo Peninsula. Good progress has been made in raising the skill levels, which are growing significantly faster than the regional and national averages. The unique cluster of universities and the Mid Kent College have contributed greatly to this. However, Medway remains a relatively low wage area with high numbers of people commuting out to work and skill shortages particularly at some levels.
In recent years, as part of the Thames Gateway regeneration area, Medway has undergone extensive regeneration particularly in the former derelict riverside areas of Rochester, Chatham and Gillingham, which have been transformed into thriving business, higher and further education and residential communities. Medway is now looking to continue its regeneration along the riverside, in the town centres and through the only new settlement in the Thames Gateway at Lodge Hill, Chattenden, which will accommodate approximately 5,000 homes.

The population of Medway is currently about 253,500 and is expected to grow to 280,000 by 2026. Overall, Medway is not a deprived area being ranked 150th most deprived local authority area out of 354 in England, but it has higher levels of deprivation than neighbouring local authorities in Kent and the South East. At ward level it has both some of the most affluent and some of the most deprived areas in the country. Within Medway are 25 neighbourhoods which fall into the 25% of most deprived areas in the country.

**Key issues and gaps**

The change of government in May 2010 has already seen a number of changes in housing policy introduced and others set for implementation over the coming months and years. Along with the Coalition’s various policy announcements, the medium term housing financial landscape was completely re-drawn with the outcome of the 2010 Spending Review. The Spending Review has seen a reduction in Government funding for affordable housing investment nationally, a move towards charging affordable rents for new schemes coupled with the ending of ‘tenancies for life’ and the introduction of the New Homes Bonus. The Government has also proposed greater local freedom for the way social housing is allocated and how the homelessness duty can be discharged, and seeks to give local communities greater control over planning outcomes as a further way of encouraging development.

Along with the Spending Review, the Coalition Government has introduced a number of other changes affecting housing. These include the abolition of a number of quangos including the Tenant Services Authority as the social housing regulator, with its powers being transferred to the Homes and Communities Agency (HCA); and the limiting of Local Housing Allowance payments from April 2011, with further changes to the Housing Benefit system to follow. Earlier cuts made to the Area Based Grant included the removal of the administration budget for delivering housing-related support services although the (Supporting People) funding for services themselves has largely been protected, as was the Homelessness Grant. Certain aspects of the previous government’s housing and related policy will, however, continue to be pursued by the current government, including the transformation of social care through personalisation of service delivery.

**Range and Affordability of Housing in Medway**

There is a whole range of housing options within Medway from Temporary Accommodation for those in priority housing need to traditional home ownership and everything in-between. The primary obstacle to providing these options for all residents is that the market does not provide the type of housing needed at a cost many can afford. A key element to housing markets being able to function effectively is to enable choices to be made when seeking housing, regardless of income and financial
circumstances. The housing offer of a community is one element to ensure that a
diversity of households have their housing needs met. These choices are best
represented through a continuum, depicted below.

Figure 1: The Housing Continuum

Traditionally the needs of those households unable to access the housing market have
been met through social rented housing. Intermediate housing is affordable housing
designed to assist those households not eligible for social rented housing but who are
priced out of the private housing market by a combination of low wages and/or high
house prices. The most common form of intermediate housing in Medway is shared
ownership; however the amount and distribution is sensitive to changes in house
prices. The credit crunch has lead to falling house prices in Medway. This was however
accompanied by a credit squeeze making mortgage availability scarcer and more
expensive. The credit crunch also led to the tailing off of private housing development
and Registered Providers selling fewer properties for shared ownership. Property
prices in Medway peaked in April 2008 and by May 2011 had fallen by an average
£26,835. Over the first five months of 2011, house prices have fallen by £5,703. In
June 2011, the Nationwide reported that there is uncertainty over whether house prices
will rise or fall over the remainder of 2011. They have reported that economic growth
looks set to gather pace but is likely to result in only modest gains in employment and
wage increases, which will continue to keep many potential buyers unable to purchase
property.

Delivery of affordable housing

Medway has a strong track record of delivering affordable housing, which has continued
despite the downturn in the market. These affordable homes not only leveraged in large
amounts of private finance toward the delivery of affordable housing but also have
enabled many regeneration sites to continue delivering units during the market
downturn. We have renegotiated through the planning system for key developments to
bring forward affordable housing and remove some risk for developers during the early
phases of development while the market recovers. However, we have taken a measured
approach to guard against an oversupply of social rented housing.

The recent Comprehensive Spending Review (CSR) announced a 60% reduction in the
levels of government grant available for affordable housing. The gap left by the
substantial cut in capital grant is expected to be met, in part, through revenue from the
introduction of a new proposed ‘affordable rent’, to be charged for most newly built
homes and many re-let properties. Despite these uncertainties, we are working in
partnership with our Registered Provider partners, developers, planners and the HCA to
ensure that where funding is needed and available this is secured. To date we have
supported firm bids that if successful would deliver an additional 562 affordable units
over the next 4 years. In addition to this, previously allocated funding (2008–11 NAHP)
is due to deliver 443 affordable units over the current 2011–15 NAHP. Almost all of the
units are currently under construction and will be delivered in the next couple of years.
We have identified a further 325 affordable homes that have the potential to be
delivered over the 2011–15 period without funding from the 2008–11 programme or
have not been included in bids in the 2011–15 programme.
Figure 2: Actual and Estimated Affordable Housing Delivery 2001–26

Figure 2 shows current estimates of what could be delivered in terms of affordable homes over the next four years. We estimate that a total of 1,325 new affordable homes could be delivered. This will be reliant on a range of factors, not least a significant pick up in house building from what are currently very low rates in Medway. Only 650 completions are expected to be reported for 2010–11. This would need to almost double for all of the anticipated affordable units to be delivered.

Making the best use of existing homes

Key Achievements 2008–11

- 454 empty properties brought back into use
- 50 empty properties brought back into use as affordable housing through the Purchase and Repair Scheme
- In 2010–11 we assisted 13 people to move to more suitable properties via our Mutual Exchange programme
- Joined Kent HomeChoice in May 2010 to achieve better economies of scale and provide a more equitable and efficient service to our clients

Empty homes represent economic, environmental and social costs to the community. As homes deteriorate they can become visually unattractive, therefore affecting the amenity of the local surrounding area as they create an impression of neglect and decline. This can encourage local property price devaluation, as an empty property can devalue neighbouring properties by as much as 20%. Empty homes can also be an attraction for vandalism and anti-social behaviour, which poses a risk for neighbouring properties and local residents, while increasing work for local fire and police services.

At the end of March 2011, there were 1,281 empty homes in the private sector. This represents 1.37% of the total private sector housing stock. Whereas this is good progress against the Government target of 3%, one less empty property is a home for a household and less likely to be a potential source of anti-social behaviour.

Ineffective use of the housing stock can result in overcrowding and underoccupation. Through our “Creating Space” initiative, we have identified households within the affordable housing stock whose current property does not meet their housing need.

Sustainable and Cohesive Communities

Key Achievements 2008–11

- All new affordable homes achieved Code for Sustainable Homes Level 3 and some homes achieved Level 4
- Nomination Rights were achieved for all new affordable homes
- Contributed to the Development Brief for Rochester Riverside and other regeneration sites to secure the delivery of affordable housing
Developed and delivered the In Focus project to target resources in a specific area

Sustainable communities are places where people want to live and work, now and in the future. They meet the diverse needs of existing and future residents, are sensitive to their environment and contribute to a high quality of life. This approach includes future proofing new properties to make sure they are adaptable to a household’s future needs, developing mixed tenure communities, ensuring high quality design and build and considering affordability.

Affordability in Rural areas can have an impact on the sustainability of a community. Young people may have to move away from the village they grew up in and older people may have to leave due to a lack of suitable housing which meets their needs.

Quality of the housing stock

Key Achievements 2008–11

- 8,391 people were given energy efficiency advice by the Energy Savings Advice Centre

The Housing Stock in Medway mainly comprises properties, which were built since 1945 (64%). 23% of the stock was built before 1919 and 13% between the wars. Aging properties generally require more work and investment to maintain them in good repair. In addition to this they present a challenge in terms of keeping them hazard free under the new Health and Housing Safety Rating System and meeting the Decent Homes Standard for vulnerable households.

The Housing Stock Condition survey highlighted a number of issues within the private housing stock in the Medway area and in particular that nearly 20% of homes fail the Decent Homes Standard, the majority doing so due to excess cold.

Recommendations for consideration by commissioners

Medway’s priorities for Housing for 2011–14 are:

Theme One: Bridging the Gap

Working to create a pathway into suitable housing and home ownership by increasing choice

Outcome One — Deliver a range of tenures, properties and locations to meet need

Outcome Two — Make the best use of existing housing

Outcome Three — Contribute to sustainable and cohesive communities

Theme Two: Early Prevention

Providing suitable, appropriate and timely housing advice to help people make the right housing choice

Outcome Four — Provide advice across agencies to prevent crisis and increase choice and access

Outcome Five — Improve housing offer to better meet a range of housing needs
Theme Three: Health and Housing

Improving health through quality housing and places

Outcome Six — Ensure good quality homes, which are energy efficient

Outcome Seven — Improve and maintain independence and inclusion by providing effective support

Who’s at risk and why

Vulnerable People

Key Achievements 2008–11

- Supported Housing Gateway system was set up, which since 1 April 2009 has placed 1,903 vulnerable people in supported accommodation or provided them with floating support.

Young People

Young people continue to be over-represented amongst those presenting as homeless and often have complex needs that require additional and on-going support. Of the people who were accepted as homeless in 2010-11, 38% were aged 16-24. This clearly shows that the younger generation in Medway are experiencing issues around accessing or maintaining accommodation or housing services. One of the main challenges we face is to help raise the profile of the advice and assistance that is available particularly for young people, who have raised this specific issue through our consultation work.

Figure 1: Homeless Applications in 2010–11 by Age Group

Reasons for Homelessness

The main reason for homelessness in 2010–11 was that parents/relatives were no longer willing to provide accommodation, with 81 approaches being made for this reason. Another 36 approaches were made due to rent arrears within private rented accommodation. Work should therefore be based around assisting people within these situations or facing housing barriers, whether it be better benefits advice and access to surgeries to apply for assistance or empowering people with the knowledge of their housing options so families are able to make decisions and choices to achieve suitable arrangements for their families in accessing their own homes.

In terms of the reasons for accepted households being in priority need, during 2010–11, households with a dependent child accounted for the greatest proportion (55%); mental illness or disability accounted for 11%, physical disability for 8% and households including pregnant women 8%.

Temporary Accommodation

Effective support is provided to people living in Temporary Accommodation. Starter packs are provided for those with few possessions and there is also support for those
leaving temporary accommodation. All tenants of social housing get a visit within two weeks of moving into their new homes and are then visited at least quarterly thereafter. A ‘move on’ protocol with social housing providers helps secure permanent accommodation and we target clients who have been in Temporary Accommodation the longest time. Over the last three years the number of people placed in Temporary Accommodation has reduced from 151 at the end of 2008-9 to 102 people at the end of 2010–11.

The level of need in the population

It is an urban area made up of five towns (Chatham, Gillingham, Rochester, Strood and Rainham) and extensive rural areas on the Hoo Peninsula and the area of Cuxton and Halling to the west of the M2. The population of Medway is younger than the average population age for England. However it has an increasing older person population. 15% of the total population have a long term illness. Single person households make up a third of all households in Medway and around 5% are from ethnic minority communities.

There are just over 110,000 dwellings in Medway at present, 85% of which are in the private sector. There are 16,328 affordable homes 3,056 of which are owned by the Council. Housing Associations own 13,272 with the majority being owned by mhs Homes (47%).

Housing Requirement and Delivery

The North Kent Strategic Housing Market Assessment (SHMA) provides an evidence base for Medway's housing requirement broken down by housing type and size. Although house prices have fallen since the peak in April 2008, the requirements still remain relevant due to the recovery in house prices to a similar level to November 2009.

Table 1: Housing requirement 2008–2026

<table>
<thead>
<tr>
<th></th>
<th>Total Housing Requirement 2008–26</th>
<th>Annual Housing Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market Housing</td>
<td>9522</td>
<td>529</td>
</tr>
<tr>
<td>Intermediate Housing</td>
<td>2979</td>
<td>166</td>
</tr>
<tr>
<td>Social Housing</td>
<td>3158</td>
<td>183</td>
</tr>
</tbody>
</table>

Figure 1: Demand for social housing

Figure 2: Demand for intermediate housing

In June 2011, 9,912 households had asked to be placed on the Housing Register. Households have their housing situation assessed and a suitable priority awarded. There are currently 1,066 households identified as having urgent or high housing needs.
and of these, nearly 90 are homeless households in Temporary Accommodation and 200 are living in overcrowded accommodation.

The demand for affordable housing in Medway outstrips the supply and it has been calculated that our housing need is for the delivery of 349 new affordable homes every year. However, we have estimated that our affordable housing programme will deliver 204 affordable homes each year. This leaves a shortfall of 145 homes per year, which will be addressed by using our existing stock more effectively.

Specialist Accommodation Need

We want to support people to remain in or work towards independent living, helping them to participate in mainstream society and make a contribution to the local economy. We hope to achieve this by looking at a range of opportunities to help improve access to different types of housing, delivering services to peoples homes and where appropriate developing purpose built specialist accommodation to meet needs. For the future we will focus our work on assisting people to live independently with support. We will also need to consider affordability issues for people to move into appropriate accommodation. We have identified a need to undertake further research into the housing and support needs of certain client groups - in particular people with learning disabilities, physical disabilities, mental health problems and people who are deaf and have sensory problems.

In regards to people with Learning Disabilities, we have used the Valuing People Now Housing Commissioning Toolkit to build up a picture of the current situation in terms of housing demand and supply. The toolkit is intended to assist local authorities with their partners to plan effectively for the housing requirements of local people with learning disabilities and to be able to deliver a wider range of housing options in practice. It is intended to assist local authorities to deliver the objective of more people with moderate to severe learning disabilities living in their own homes. A comprehensive understanding of the future housing needs of people with learning disabilities is a core component of having a plan to extend housing options and choices. It is hard to plan services and accommodation if the housing need is not known. We have been working with Adult Social Care to cross match clients known to them with those on the Housing Register. We are extending this work to look at clients with physical disabilities and mental health issues.

Actions 2011–14

- Deliver 10 fully wheelchair compliant homes per year
- Deliver 9 homes specifically designed for clients with Learning Disabilities
- Provide at least 150 households with major adaptations within their home through our Home Adaptations Service
- Through the HomeSafe scheme provide minor works, safety and security checks to allow 2,700 vulnerable people to feel safe within their own homes
- Assist 3,940 vulnerable households to undertake adaptations, repairs and improvements to their home
• Work with the Institute of Public Care and Adult Social Care to undertake housing needs analysis on a range of client groups including those with dementia and learning disabilities

• Deliver a minimum of 100 extra care units by 2013 and identify development opportunities to meet the additional demand.

**Older Persons’ Accommodation**

While residential care is the preferable option for some people, it is not the solution for everybody. As promoting choice and independence are key themes in national and local priorities, we are working to develop alternatives to residential care. By improving the housing offer in Medway we can enable people to make choices about the type of accommodation they would like to move into. In 2009–10, 289 people aged 65 and over were admitted to permanent residential or nursing care purchased or provided by Medway Council. The Older People Strategic Plan 2010–13 identifies the long-term objective to ensure that all appropriate people can access Extra Care Housing as an alternative to residential care. Although we have a number of schemes currently in the pipeline or on-site, there is currently no Extra Care Housing in Medway. Analysis carried out by the Institute of Public Care at Oxford Brookes indicated a need for between 445 and 453 units of Extra Care Housing to match the requirements of the current older population.

**Projected service use and outcomes**

*Outcome One*: Deliver a range of tenures, properties and locations to meet need

• Secure at least 25% of newly built homes as affordable on any site meeting the Council’s size threshold

• Deliver at least 204 additional affordable homes per annum

• Work with Registered Providers and the HCA to secure an annual investment in affordable housing of £20m

• Deliver a minimum of 85 new HomeBuy units per annum

*Outcome Two*: Make the best use of existing housing

• Report the void levels within the affordable housing stock on a quarterly basis

• Deliver the “Creating Space” initiative to help tackle overcrowding and improve the housing conditions of 15 households per annum

• Achieve 25 on-line mutual exchanges per annum

• Develop a range of options to help bring 100 empty homes back into use per annum

• Maintain the number of long term private sector empty homes below 1.6% of all private sector stock

• Consult, develop and implement a new Allocations Policy for Medway
• Develop a delivery programme for Extra Care and Sheltered Housing to meet demand

• Undertake a review of accommodation for older people in Medway

**Outcome Three**: Contribute to sustainable and cohesive communities

• Achieve a balanced approach with regards to tenure with 60% social rented homes and 40% intermediate homes

• 100% of affordable housing schemes to meet Secured by Design standard

• Lead on the development of the affordable element of Development Briefs for all major residential sites in Medway

• Ensure new affordable housing schemes meet the standards set out within the “Creating Sustainable Communities in Kent and Medway” protocol

• Adopt in association with Registered Providers Local Lettings Plans for all development of more than 10 units

*Continue to target resources to improve the worst housing conditions primarily in the All Saints, Luton and North Gillingham areas

• Work with partners to undertake proactive targeted multi agency operations to provide high profile interventions within target communities

**Outcome Four**: Provide advice across agencies to prevent crisis and increase choice and access

• Explore further ways of working with Medway Revenue and Benefits Service and the HRA to help prevent homelessness by ensuring that early warning is given of benefit refusals or suspension where eviction may ensue

• Review the advice and assistance available in cases of domestic abuse and to those in the Sanctuary scheme

• Consider the impacts of the Equality Duty 2011 and use analysis to tailor our services

• Continue to work in partnership to develop a clear Housing Pathway for clients with Learning Disabilities

• Review the range of debt and financial advice available and how these services are sign posted

• Work in partnership with agencies to improve young people and parents’ knowledge of housing issues

**Outcome Five**: Improve housing offer to better meet a range of housing needs

• In partnership with Registered Providers and Children’s Services implement an initiative which will deliver at least 10 homes for Looked After Children
• Maintain the Supported Housing Gateway with 1,200 referrals made per year to promote the most effective use of accommodation and support funded by Supporting People

• Work with HomeChoice to improve the move on of clients out of Temporary Accommodation

• In association with Children’s Services, identify the resources required to ensure young vulnerable persons are being offered suitable housing options and choices

• Maintain the Landlord Accreditation Scheme and Landlords’ Forum to encourage and support private landlords

• Review the use of the HomeBond scheme to help improve access to private rented accommodation

**Outcome Six: Ensure good quality homes, which are energy efficient**

• Continue to develop links with Health to assist in the delivery of an area based approach

• License or take legal enforcement action against 100% of licensable HMOs

• Maintain the program of inspections of non-licensable HMOs in accordance with the prioritisation scheme

• Review the site licensing arrangements of residential mobile home sites

• Reduce the number of vulnerable households living in non-decent sub-standard accommodation by 350 per annum

• Provide financial assistance to 250 vulnerable and low income homeowners and tenants to meet minimum standards

• Develop a scheme of professional development courses for accredited landlords to improve standards and professionalism

• Assist 35 households per year via energy efficiency loans and grants and give advice to 1,500 people via the Energy Savings Trust Advice Centre

**Outcome Seven: Improve and maintain independence and inclusion by providing effective support**

• Deliver 10 fully wheelchair compliant homes per year

• Deliver 9 homes specifically designed for clients with Learning Disabilities

• Provide at least 150 households with major adaptations within their home through our Home Adaptations Service

• Through the HomeSafe scheme provide minor works, safety and security checks to allow 2,700 vulnerable people to feel safe within their own homes

• Assist 3,940 vulnerable households to undertake adaptations, repairs and improvements to their home
• Work with the Institute of Public Care and Adult Social Care to undertake housing needs analysis on a range of client groups including those with dementia and learning disabilities

• Deliver a minimum of 100 extra care units by 2013 and identify development opportunities to meet the additional demand

**Evidence of what works**

**Living Independent Lives**

We aim to enable people to live independently in their existing homes, and the Council has supported this approach through a shift from institutional care to more individually tailored services to assist people to live in the community through the provision of aids and adaptations and assistive technology, as well as targeted specialist accommodation and accessible social care support based on individual need and choice.

The older population in Medway is increasing, with the numbers of people aged 65 and over projected to increase from 36,000 to 46,100 by 28% in the next ten years. The numbers aged 85 and over are projected to increase by 38% in the next ten years and more than double in the next 20 years. The steady overall growth in the population will put pressure on existing services. The Housing Strategy recognises that increasing proportions of the older population in future years are likely to own their own home. This has significant bearing on older people’s housing aspirations and their expectations. Broadly, many homeowners will seek to stay in their existing homes for as long as they can. There will however still be significant numbers of older people who may need specialist accommodation that mesh support, care and housing provision. The Council is working to adapt homes and provide support so that people can remain living independently rather than in more costly supported accommodation. We work in partnership with Hyde In Touch to provide a Home Improvement Agency service in Medway. The service supports older or disabled people who need a repair or adaptation to their home, helping people maintain their independence, safety and dignity. The service helps with things like:

• Organising repairs and adaptations

• Making sure people are receiving the right benefits

• A handyperson service to do small jobs around the home

• Finding organisations that can help with other problems

We work with the Occupational Therapy Service to help people with a disability to adapt their home to suit their needs. We provide advice that may be able to assist with the cost of funding the work via a Disabled Facilities Grant. Between 2008–9 and 2010–11 we assisted 445 vulnerable people to adapt their properties using a Disabled Facilities Grant.
**Key Achievements 2008–11**

Supported Housing Gateway system was set up, which since 1 April 2009 has placed 1,903 vulnerable people in supported accommodation or provided them with floating support.

**Recommendations**

Medway’s priorities for Housing for 2011–14 are:

**Theme One: Bridging the Gap**

Working to create a pathway into suitable housing and home ownership by increasing choice

Outcome One — Deliver a range of tenures, properties and locations to meet need

Outcome Two — Make the best use of existing housing

Outcome Three — Contribute to sustainable and cohesive communities

**Theme Two: Early Prevention**

Providing suitable, appropriate and timely housing advice to help people make the right housing choice

Outcome Four — Provide advice across agencies to prevent crisis and increase choice and access

Outcome Five — Improve housing offer to better meet a range of housing needs

**Theme Three: Health and Housing**

Improving health through quality housing and places

Outcome Six — Ensure good quality homes, which are energy efficient

Outcome Seven — Improve and maintain independence and inclusion by providing effective support

**Air Quality**

**Summary**

The impact of air quality upon health is unquestionable, and indeed has been a major driver in national and international attempts to reduce levels of air pollution. Long and short term exposure to poor air quality can have health impacts ranging from premature death due to cardiovascular disease and lung cancer, aggravation of asthma and other allergic illnesses, and reduced quality of life. Recent research has also linked air pollution to low birthweight.[109]
Medway's position between London, Kent and continental Europe brings health challenges associated with its unique pollution profile. Medway's extensive transport network carries a disproportionate number of HGVs, with their associated carcinogenic diesel emissions. Easterly winds can bring pollution, from continental Europe, which affects the whole of Medway, raising levels of particulate matter and/or ozone. Winds from the opposite westerly direction can bring London's urban pollution plume drifting across the area.

The Kent and Medway Air Quality Partnership provides strategic direction and support across the county, and has a health subgroup which provides advice to the respective partners on the health implications of air pollution.

Medway Council is currently producing an Air Quality Action Plan, updating the previous edition published in 2005.

Key issues and gaps

Medway's Air Quality Management Areas, i.e. where pollution levels are monitored because quality does not meet the objective set by the EU Directive and the UK's own Air Quality Strategy, are in some of its most deprived wards. This correlates with the literature, in which deprived communities are most likely to experience the worst air quality.\[110]\n
The possibility of providing air quality text alerts for vulnerable groups (the young, elderly, pregnant women and those with existing COPD and respiratory conditions) could be explored, based upon existing services in Greater London, Surrey, Sussex and Southampton, and using existing data collected by Kent Air.

The majority of air quality monitoring in Medway is focussed on measuring NO2 across 23 automatic monitoring sites. However, the Public Health Outcomes Framework provides data on PM2.5 as the pollutant most harmful to health. Medway has two sites that currently do so, but equipment to monitor this is expensive. The introduction of more affordable black carbon monitoring equipment, the data from which can be used as a proxy for PM2.5, may add greater detail to Medway’s air monitoring. To have sufficient detail to assess the health impact of air pollution in Medway, and make the case for evidence based measures to be implemented, it is important that PM2.5 is modelled in a range of locations.

There is arguably insufficient awareness across Medway of the impact of air pollution on the public's health. A balance needs to be struck between educating and informing the public to achieve behaviour change and adaptive action by those most at risk, and unnecessarily causing concern to vulnerable groups. The role of GPs and environmental health officers in developing and delivering these strategies is important.

Recommendations for commissioning

Work with Kent to provide a Kent and Medway air quality text alert service based on existing services in London, Surrey and Sussex, using the data already collected by Kent Air.

Provide information for GPs on air quality and its impact upon asthma and existing COPD conditions.
An integrated approach that maximises active transport and minimises people’s exposure to air pollution would multiple health benefits. Public health should work closely and collaboratively with environmental health, planning and transport to ensure that major developments and transport planning consider the impact upon air quality and by extension the public’s health.

**Who’s at risk and why?**

The impact of air quality upon health is unquestionable, and indeed has been a major driver in national and international attempts to reduce levels of air pollution. Long and short term exposure to poor air quality can have health impacts ranging from premature death due to cardiovascular disease\[111\] and lung cancer,\[112\] aggravation of asthma and other allergic illnesses,\[113\] and reduced quality of life.\[114\] Recent research has also linked air pollution to low birthweight.\[109\]

The human, and economic cost is considerable. The Committee on the Medical Effects of Air Pollutants (COMEAP) has calculated that in 2008, the long–term health effects on air pollution was the equivalent of 29,000 deaths at typical ages, and an associated loss of total population life of 340,000 life–years. This burden can also be represented as a loss of life expectancy from birth of approximately six months.\[115\] In economic terms, the Department for Environment, Farming and Rural Affairs (DEFRA) reports that the annual cost is £15 billion, within the range of £8–17 billion. To put this in perspective, they compare this to the economic costs of obesity and physical activity in urban areas, which is estimated as in excess of £10 billion per annum.\[114\]

The arguments for improving air quality on both public health and economic grounds are therefore strong, and European agreement on reduction of air pollution is predicated on analysis by the World Health Organisation. The 2008 ambient air quality directive (2008/50/EC) sets legally binding limits for concentrations in outdoor air of major air pollutants. At a national level, DEFRA monitors national air quality objectives,\[116\] and the Environment Act 1995 and Air Quality (Standards) Regulations 2010 provide a framework for local management of air quality and translate the EU directives into English legislation.

Both indoor and outdoor pollution impact upon people’s health. Indoor air pollution may include particulate matter from domestic gas combustion (cooking and heating), volatile organic compounds (VOCs) from cleaning and decoration products, wood and coal fires, and second-hand smoke.\[117\] It is more difficult to monitor and legislate, but significant health gains have been achieved through, for example, smokefree legislation in England since 2007.

Outdoor pollution includes nitrogen oxides (NOX), particulate matter (PM10, PM2.5), sulphur dioxide (SO2) and ozone (O3).

Nitrogen oxides (nitric oxide (NO) and nitrogen dioxide (NO2)) are produced by combustion of fossil fuels i.e. heating, power generation and the internal combustion in motor vehicles. The most harmful nitrogen oxide for human health is NO2, and short-term impacts include shortness of breath, and irritation of the eyes and respiratory system.
Particulate matter consists of those compounds which are emitted directly into the atmosphere and those which are formed within the atmosphere as a result of chemical reactions. Of greatest concern to public health are particles measuring less than 2.5 micrometres in diameter (PM2.5), small enough to be inhaled into the deepest parts of the lung. Studies link this fine particulate matter with asthma, bronchitis, acute and chronic respiratory symptoms such as shortness of breath and painful breathing, and premature deaths. The young and elderly are most at risk, the former because their lungs and respiratory systems are still developing, and the latter because of comorbidities and declining immune systems.[118] As a consequence, PM2.5 and its impact upon mortality is a new indicator in the Public Health Outcomes Framework (3.01).[119] Air Quality Objectives for local authorities are also in place for the protection of human health for PM2.5 and PM10 (particles of less than 10 micrometres in diameter).

Sulphur dioxide is an acidic gas which combines with water vapour to produce acid rain. It is associated with asthma and chronic bronchitis.

Ozone is a secondary pollutant and is formed by reactions between NO2, hydrocarbons and sunlight. Ozone can have an impact upon health in terms of respiratory irritation and airway inflammation, and can cause summer smog. However, formation of ozone can take place over several hours or days and may have arisen from emissions many hundreds of miles away. For this reason ozone is not considered to be a ‘local’ pollutant.

The overall health effects of air pollution by severity and incidence are helpfully summarised by the American Thoracic Society[120]:

Figure 1: Health effects of air pollution

Susceptibility to the adverse health effects of air pollution varies for different population groups. The young, older people, pregnant women, and those with pre-existing respiratory conditions and chronic illnesses such as asthma and chronic obstructive pulmonary disease are most at risk.

The risks to pregnant women and their unborn child(ren) of prolonged exposure to air pollutants include low birthweight, intrauterine growth retardation, and an increased risk of chronic diseases in later life.[121]

While two independent reviews by COMEAP[122] and the Health Effects Institute (HEI) of the evidence around onset of asthma and air pollution both concluded that there was insufficient evidence of a causative link, the latter reported a link with exacerbation of symptoms amongst asthmatic individuals, in particular children.[123]

Currently, there is insufficient evidence available to attribute outdoor air pollution as the causative factor for COPD due to the lack of long-term studies, but there is an association between air pollution and acute exacerbation of existing COPD. This includes increasing symptoms to A&E visits, hospital admissions and even mortality.[124]

Research conducted on behalf of the Environment Agency suggests a close link between air quality and deprivation. It concluded that in the 10 per cent of most deprived wards, the air quality was poorest (interestingly, the least deprived 10 per cent also experience
above average concentrations of pollutants, although not as acutely as the most deprived).[110] Sir Michael Marmot’s report on health inequalities, Fair Society, Healthy Lives reports that “Poorer communities tend to experience higher concentrations of pollution and have a higher prevalence of cardio-respiratory and other diseases â€¦ 66 per cent of carcinogenic chemicals emitted into the air are released in the 10 per cent most deprived wards.”[125]

**Level of need in the population**

Medway’s position between London, Kent and continental Europe brings health challenges associated with its unique pollution profile.

Medway’s extensive transport network carries a disproportionate number of HGVs, with their associated carcinogenic diesel emissions. Around the coast, shipping also brings an impact from marine diesel.

Easterly winds can bring pollution, from continental Europe, which affect the whole of Medway, raising levels of particulate matter and/or ozone. Winds from the opposite westerly direction can bring London’s urban pollution plume drifting across the area.

The Environment Act 1995 places a statutory duty on local authorities to monitor air quality across their area. This duty is informed by an European-wide commitment to reduce air pollution. These are transposed into English policy by the Air Quality Standards Regulations 2010.[126]

These Regulations include criteria for determining how achievement of the limit values should be assessed, including consideration of locations and length of exposure in relation to the averaging period of the limit values. Details of these obligations are available on the DEFRA website.

In areas where air quality objectives are not likely to be met by the relevant target date, local authorities are required to declare an Air Quality Management Area (AQMA) and develop an action plan in pursuit of the air quality objectives. In other words, these are areas where there are consistent exceptions to meeting the objectives. There are currently three AQMAs in Medway. They are Central Medway, High Street, Rainham, and Pier Road, Gillingham.

Medway has three continuous automatic air quality stations; one at an urban roadside location in Chatham, one at an urban background site at Luton and one at a rural location in Lower Stoke. Monitoring of NO2 and PM10 is undertaken at all three sites. Monitoring of PM2.5 is also carried out at the Chatham and Lower Stoke sites. The Lower Stoke and Luton sites also monitor sulphur dioxide. The latter site also monitors carbon monoxide.

Alongside these ‘automatic’ monitoring areas, there is also a network of 23 NO2 diffusion tubes sites across Medway. The following graph shows the levels of NO2 in the three automatic monitoring sites, against the regulatory objectives, and pollution levels against Medway-wide levels.
More detailed analysis of air quality has been produced by Environmental Health at Medway Council and the most recent progress report (June 2013, data from 2012), is available [here](#). This latest progress report concludes that “exceedences continue to occur in each of the three AQMAs [whilst] there were no exceedences of the annual mean NO2 objective outside of areas declared as AQMAs.” [127]

Alongside these Regulations, the impact of air pollution on health in upper tier and unitary local authority areas is measured as part of the Public Health Outcomes Framework. Indicator 3.01 is “Fraction of mortality attributable to particulate air pollution” and Medway’s rate is slightly higher than that of the English average, and its neighbouring local authority Kent, although caution is advised in comparing regions, the data being based upon estimates by COMEAP calculated from background levels of PM2.5. As mentioned above, local monitoring of PM2.5 is limited by cost which makes it currently impossible to produce accurate local data.
Kent and Medway Public Health Observatory have additionally carried out some more detailed analysis of mortality attributable to particulate matter across the Kent and Medway region, as well as background levels of PM2.5.

Figure 3: Number of deaths per 100,000 population attributed to pollution, 2011

Data collected via the primary care Quality and Outcomes Framework (QOF) also provides information on COPD and asthma prevalence in Medway.

There are 5,026 patients registered with a COPD condition, and this represents 1.8% of Medway patients (practice range 0.59%–3.14%). The following table illustrates mortality from COPD conditions over a four year period by ward. Again, it is striking that the wards within whose boundaries the AQMAs lie have the highest mortality over this period.
There are 15,800 patients with asthma registered at GP practices in Medway, which represents 5.6% of the population (practice range 3.54% – 7.15%).

**Current services in relation to need**

Kent Air provides air monitoring throughout Kent and Medway, providing daily contemporaneous data on air quality, and using the Daily Air Quality Index (DAQI). This provides recommended actions and health advice. The index is numbered 1-10 and divided into four bands, low (1) to very high (10), to provide detail about air pollution levels in a simple way, similar to the sun index or pollen index. The data is based upon the automatic monitoring sites across Kent and Medway, and dependent on the site, provides information on NO2, PM2.5, PM10, ozone and sulphur dioxide, collating this to provide a risk rating.

The following advice is given dependent on the risk rating.

Medway CCG made reduction of COPD emergency admissions a priority in 2013, and in pursuit of this, and in acknowledgement of environmental conditions as a contributing factor, a Met Office text alert service (Healthy Outlook® COPD Forecast Alert Service) was commissioned. However, the Met Office has now discontinued the service, in light of the recent changes in commissioning responsibilities in the NHS.

The Kent and Medway Air Quality Partnership provides strategic direction and support across the county, and has a health subgroup which provides advice to the respective partners on the health implications of air pollution.

Medway Council is currently producing an Air Quality Action Plan, updating the previous edition published in 2005.

**Projected Service Use**

AEA have produced estimates for Defra in 2012, providing projections on air pollution for 2015, 2020, 2025 and 2030, based on three different scenarios.[128] The following table details the third scenario, considered to be the most realistically ambitious, factoring in economic growth, fossil fuel prices, and transport activity.
In other words, it is expected that pollutants, and those most relevant to health such as fine particulate matter (PM2.5) will fall, or plateau over the next two decades.

Nonetheless, it is also worth noting that COMEAP comments that there are no ‘safe’ levels of PM2.5 so that even if the reduction of air pollution is encouraging, efforts still need to be redoubled to accelerate reductions.

Furthermore, Medway has higher levels of PM2.5 than many other places in the UK, and given its position between London, Kent and continental Europe, this is likely to continue.

Evidence of what works

Improving air quality and mitigating the health impacts of air pollution have many synergies with other important measures to improve the public’s health. Interventions addressing climate change adaptation and mitigation, increasing active travel and improving green spaces are all likely to have co-benefits for air quality.

In its guidance on walking and cycling, NICE mentions air quality as a key benefit of encouraging active travel and moving away from a society predominantly reliant on motor vehicles:

“Walking and cycling, like any form of transport, involve exposure to a certain level of risk. This includes the risk of injury from falls or from collisions and exposure to air pollution. These risks are not unique to transport involving physical activity. However, evidence shows that the health benefits of being more physically active outweigh these disbenefits. The whole population benefits from less exposure to polluted air and congested streets when there is a general shift away from motorised vehicles.”[129]

Defra has focused its policy on the interrelationship between climate change and air quality, with its 2010 publication Air Pollution: Action in a Changing Climate. It provided case studies in Greenwich and Perth and Kinross, which concentrated on creating Low Emission Zones, levers in planning policy and intelligent traffic management.

Defra has also provided specific advice to public health departments on the impact upon health and actions that can be taken.

The campaign group Clean Air in London, although primarily concerned with lobbying for improved air quality in the capital, has some useful advice for public health
departments everywhere, arguing that: "Most important, we need to warn people about the dangers of air pollution and give them advice about protecting themselves (i.e. adaptation) and reducing pollution for themselves and others (i.e. mitigation). For example, people can reduce their exposure to air pollution by up to 50% by walking or cycling down side streets rather than busy roads. People can also reduce air pollution by walking or cycling or using public transport rather than driving a diesel vehicle."[130]

Indeed, London is advanced in its adaptation strategies in that it has a text alert service AirText which provides free, localised advice by text message on environmental conditions for vulnerable groups and other interested parties that sign up via the website. There is a similar service available for Surrey, Sussex and Southampton, called AirAlert. This has recently been expanded to Sevenoaks in West Kent.

User views

Equality Impact Assessments

Unmet needs and service gaps

It is immediately noticeable that Medway’s AQMAs, i.e. where pollution levels are monitored because air quality does not meet the objective set by the EU Directive and the UK’s own Air Quality Strategy, are in some of its most deprived wards. This correlates with the literature, in which deprived communities are most likely to experience the worst air quality.

The possibility of providing air quality text alerts for vulnerable groups (the young, elderly, pregnant women and those with existing COPD and respiratory conditions) could be explored, based upon existing services in Greater London, Surrey, Sussex and Southampton, and using existing data collected by Kent Air.

The majority of air quality monitoring in Medway is focussed on measuring NO2 across 23 automatic monitoring sites. However, the Public Health Outcomes Framework provides data on PM2.5 as the pollutant most harmful to health. Medway has two sites that currently do so, but equipment to monitor this is expensive. The introduction of more affordable black carbon monitoring equipment, the data from which can be used as a proxy for PM2.5, may add greater detail to Medway’s air monitoring. To have sufficient detail to assess the health impact of air pollution in Medway, and make the case for evidence based measures to be implemented, it is important that PM2.5 is modelled in a range of locations.

There is arguably insufficient awareness across Medway of the impact of air pollution on the public’s health. A balance needs to be struck between educating and informing the public to achieve behaviour change (in terms of use of motorised vehicles) and adaptive action by those most at risk, and unnecessarily causing concern to vulnerable groups. The role of GPs and environmental health officers in developing and delivering these strategies is important.
To ensure an integrated approach to air pollution, public health needs to work closely and collaboratively with colleagues in environmental health, planning and transport. The air quality, and by extension health implications of travel (including active travel) and planning developments should be discussed with relevant colleagues in public health and environmental health before plans are approved and implemented. Similarly, public health can add value to active travel strategies, town planning decisions, and green space developments.

**Recommendations**

Work with Kent to provide a Kent and Medway air quality text alert service based on existing services in London, Surrey and Sussex, using the data already collected by Kent Air.

Provide information for GPs on air quality and its impact upon asthma and existing COPD conditions.

Public health should work closely and collaboratively with environmental health, planning and transport to ensure that major developments consider the impact upon air quality and by extension the public’s health.

**Recommendations for needs assessment work**

Explore the possibility of introducing black carbon monitoring equipment to enable a more sophisticated analysis of the effect of air pollution upon the Medway population’s health.

Produce more detailed analysis of the exposure to air pollution of different socioeconomic and age groups, similar to that conducted by Kings College London in South East London.

Identify particular groups at risk in Medway (COPD, asthma, young, elderly or pregnant).

**Key Contacts**

DEFRA leaflet on air quality and public health

Medway Council Air quality guidance for developers

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