Introduction

One in six adults in England has a common mental disorder at any one time. The proportion of people with a common mental disorder accessing mental health treatment has increased from one in four (24%) in 2007 to one in three (39%) people in 2014.[1]

People with mental illness are more likely to experience physical illness and have a lower life expectancy than people without mental illness.[2] It is estimated that people living with severe mental illness may die up to 20 years earlier than the general population.[3]

A wide range of variable factors can affect people’s mental wellbeing both positively and negatively throughout their lives, e.g. age, gender, housing tenure, employment status or life events.[4]

Key issues and gaps

- The physical health and lifestyle of people with serious mental illness in Medway needs to be brought closer to that of people without serious mental illness.

- Professionals and service users report that support for those with co-occurring conditions (both substance misuse and mental health problems) could be improved through a more joined up approach and exploring opportunities for integrated service provision.

- Professionals who work with vulnerable homeless people report that it is challenging to identify ways for these individuals to receive mental health assessments. Outreach mental health provision would help to address this gap, as professionals could undertake mental health assessments for homeless people in the community.

- Further work is needed to increase the proportion of people in mental health services who refer into the smoking cessation service.

Recommendations for Commissioning

- Work to increase the uptake of physical health checks among those with severe mental illness should continue, including an audit of this area to identify any areas for improvement.
• To address the concerns around access to mental health services and waiting times, work should be undertaken to ensure there is a clear pathway for mental health provision, including crisis support.

• Medway CCG will continue to review the Community Mental Health Team waiting times against KPIs through performance management processes and work with the provider to identify any areas for improvement.

• Public Health should continue to raise awareness of the smoking cessation service within mental health settings, increasing understanding of the referral process.

• It is recommended that partners in Medway continue to increase the capacity of frontline workers in health and social care to deliver brief mental wellbeing interventions through training such as Connect 5.

Introduction

Being mentally healthy is not just about the absence of mental illness, but is a state of wellbeing where an individual can cope with the normal stresses of life, be productive, reach their potential and make a contribution to their community. [5] People with higher wellbeing are more likely to have better physical and mental health. [4] A wide range of variable factors can affect people's mental wellbeing both positively and negatively throughout their lives, e.g. age, gender, housing tenure, employment status or life events. [4]

Common mental health disorders (CMDs) include depression, anxiety disorders, post-traumatic stress disorder, panic disorder, obsessive compulsive disorder and phobias. [6] Severe mental illness (SMI) is where mental health issues substantially interfere with daily living, and may involve psychosis (losing touch with reality) or require a high level of care which may include hospital treatment. [7] This can include conditions such as schizophrenia, bipolar disorder and personality disorders.

One in six adults in England has a common mental disorder at any one time. The proportion of people with a common mental disorder accessing mental health treatment has increased from one in four (24%) in 2007 to one in three (39%) people in 2014. [1]

People with mental illness are more likely to experience physical illness and have a lower life expectancy than people without mental illness. [2] People with long-term physical health conditions are also more likely to experience mental health conditions than those without health conditions. [8] It is estimated that people living with severe mental illness may die up to 20 years earlier than the general population. [3] There are multiple factors that lead to this inequality in life expectancy. High risk lifestyle behaviours, such as smoking and substance misuse, are often associated with the isolation and loneliness caused by living with a severe mental illness. This is also coupled with risks to physical health caused by medication, such as cardiac arrest and weight gain. [9]

Mental health problems impact individuals, families, communities and society as a whole. [4] The growing cost of mental health problems to the economy in England have
been estimated at £105 billion and mental health treatment costs are expected to double in the next 20 years.[4]

Half of all lifetime mental health problems arise by the age of 14 and three quarters arise by the age of 24.[10] Further information on children and young peoples’ mental health can be found in the JSNA chapter on this topic: Children -> Emotional health and wellbeing of children and young people. There is also a separate JSNA chapter on social isolation, which is a risk factor for mental illness.

Who is at risk and why

Mental illness can affect anyone, however a wide range of factors can affect people’s mental wellbeing both positively and negatively throughout their lives. Some of these are individual factors, such as age or genetics, and some are wider social, economic and environmental factors, such as unemployment, isolation, deprivation or exposure to crime. Below are some examples of the factors that may impact the mental health and wellbeing of residents in Medway.

Factors that support mental health and wellbeing

Having access to green spaces, opportunities for regular physical activity and access to good education are all examples of wider determinants that can help support mental health and wellbeing.[11]

- Medway has over 200 parks and open spaces. From March 2015 to February 2016, the proportion of individuals using open spaces for exercise in Medway was 17.2%, which is similar to both the England (17.9%) and South East (18.2%) averages.[12]

- In 2017/18, the average Attainment 8 score for Medway was 45.3%, which is significantly lower compared to the England (46.7%) and South East (47.8%) averages.[13]

Further data for Medway about the protective factors that support good mental wellbeing can be found on Public Health England’s Fingertips tool.[11]

Factors that increase the risk of poor mental health and wellbeing

Some factors can increase risk of poor mental health. Some examples include:

**Deprivation**

Individuals living in higher levels of deprivation are more likely to experience mental health problems.[4][14]

In Medway, 20.3% of the population live in areas which are among the 20% most deprived nationally. This is significantly higher than the South East average (7.7%), but similar to the England average (20.2%).[15]

**Unemployment**

Unemployment can increase the risk of mental illness, but mental illness can also increase risk of unemployment.[4][16]
In 2017, unemployment in Medway was similar to the England and South East averages with 4.4% of people in Medway unemployed (compared to 4.4% nationally and 3.2% in the South East).[17]

In 2017, the rate of people aged 16-64 years claiming job seekers allowance for more than twelve months in Medway was 4.9 per 1,000 population, which is significantly higher compared to England (3.5 per 1,000 population) and the South East (1.9 per 1,000 population).[18]

In Medway, the gap in employment between those with and without a mental illness has recently increased from 65.8% in 2016/17 to 69.0% in 2017/18.[19]

Further data for Medway about risk factors for poor mental health and wellbeing can be found on Public Health England’s Fingertips tool.[20]

**Population groups at higher risk of poor mental health and wellbeing**

There are a number of population groups that are at higher risk of developing mental health problems, including asylum seekers and refugees, black and minority ethnic groups, carers, offenders, looked after children, those with long-term physical illnesses, people with learning disabilities, lesbian, gay, bisexual and transgender adults, drug-users, and homeless people.[4][21]

In 2011, 2.53% of the population of Medway were reported to be unpaid carers.[22]

Isolation is a risk factor for poor mental health[23] and in 2016/17 the percentage of adult carers in Medway who have as much social contact as they would like was 29.5%, which is similar compared to the South East region (33.2%), but lower than the England average (35.5%).[24]

**Level of need in the population**

There are several sources for mental health and wellbeing prevalence.

**Self-reported wellbeing**

The Annual Population Survey (APS) captures four self-reported measures of personal wellbeing: 1) life satisfaction; 2) worthwhile; 3) happiness; and 4) anxiety. Figure 1 shows the APS personal wellbeing data for Medway, the South East region, and England for 2017/18.[25]

- The proportion of people in Medway who report having low life satisfaction (4.9%) is similar to the South East region (3.9%) and England (4.4%).
- A similar proportion of people in Medway report not feeling the things they do in life are very worthwhile (4.4%) compared to the South East region (3.1%) and England (3.6%).
- The proportion of people in Medway with a low happiness score (10.0%) is similar to the England average (8.2%), but significantly higher than the South East region (7.6%).
In Medway, the proportion of people reporting high levels of anxiety (21.8%) is similar to the South East region (20.4%) and England (20.0%) averages.

Common mental health disorders (CMDs) include depression, anxiety disorders, panic disorder, obsessive compulsive disorder and phobias.[6] CMDs are conditions which are often treated by a person’s GP, however they can be more severe and need specialist treatment. In England, women were more likely than men to have been diagnosed with CMD.[1]

Table 1 shows the estimated number of Medway residents, aged 16 and over, with common mental disorder symptoms. These estimates were calculated by applying the 2014 Adult Psychiatric Morbidity Survey data [1] to the 2017 local mid-year population estimates.[26]

**Figure 1: Self-reported measures of personal wellbeing from the Annual Population Survey [25]**
Table 1: Estimated number of Medway residents with common mental health disorder symptoms by gender [1] [26]

<table>
<thead>
<tr>
<th>Percentage of the population with CMD symptoms in England</th>
<th>Estimated number of Medway residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women 19.1%</td>
<td>21370</td>
</tr>
<tr>
<td>Men 12.2%</td>
<td>12230</td>
</tr>
</tbody>
</table>

In September 2017, around 40% of patients aged 18-64 registered at a GP practice in Medway had been recorded as having a mental health condition in the last 12 months.[27]

- Of patients aged 18 or over registered at a GP practice in Medway, 11.9% were recorded as having depression in 2017/18, which is significantly higher than both the South East region (10.1%) and England (9.9%).[28]
- When comparing the six geographic localities in Medway, the locality with the highest GP registered prevalence of depression is found in Strood.[29]
- In 2016/17, 14.0% of people who completed the GP Patient Survey in Medway reported having depression and anxiety, which is higher compared to the South East region (12.5%), but similar to England (13.7%).[30]

Severe Mental Illness

Severe mental illness (SMI) is where mental health issues substantially interfere with daily living, and may involve psychosis (losing touch with reality) or require a high level of care which may include hospital treatment.[7] This can include conditions such as schizophrenia, bipolar disorder and personality disorders.

- The prevalence of serious mental illness (aged 18 or over) recorded on GP practice registers in Medway (0.73%) is lower than the South East region (0.85%) and England (0.94%).[31]
- The rate of new cases of psychosis in people aged 16-64 in Medway (21.1 per 100,000 population) is similar to the South East region (19.8) and England (24.2).[32]
- In 2017/18, the proportion of people in Medway (all ages) reporting they have a long-term mental health problem (9.4%) is similar to the South East region (8.6%) and England (9.1%) averages.[33]

Table 2 shows the number of patients registered at a GP practice in Medway with a serious mental illness in September 2017:

Table 2: Patients registered at a GP practice in Medway with a serious mental illness, September 2017. [27]

<table>
<thead>
<tr>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients aged 18-64 registered with GP</td>
</tr>
<tr>
<td>Patients with a SMI or personality disorder recorded in the last 12 months</td>
</tr>
</tbody>
</table>
Patients whose latest diagnosis is bipolar affective disease 571
Patients whose latest diagnosis is psychosis 317
Patients whose latest diagnosis is schizophrenia 714
Patients recorded as possibly having 2 or more psychiatric conditions 10549
Patients whose latest diagnosis is a personality disorder 769

Physical health and lifestyle of people with serious mental illness in Medway

Mental health and physical health are related. People with mental illness are more likely to experience physical illness. [2]

- In 2014/15, the excess under 75 mortality rate in adults with serious mental illness, measured as the ratio of observed to expected mortalities (expressed as a percentage), was 439.4% in Medway, which is higher compared to England (370.0%). [34]

Poor mental health and wellbeing are also associated with high levels of health risk behaviours, such as smoking, alcohol and drug misuse.

- In 2014/15, 44.3% of people with a serious mental illness in Medway smoked, which is significantly higher than the South East region (38.5%) and England (40.5%). [35]

- In 2015, among the general adult population in Medway, 22.3% of people smoked, suggesting that smoking prevalence among those with serious mental illness in Medway is twice as high compared to the general population. [36]

The National Institute for Health and Care Excellence (NICE) recommends that GPs and other primary care professionals should monitor the physical health of people with certain types of mental health problems, including schizophrenia, psychosis and bipolar disorder at least once a year. [9]

- In 2017/18, 79.1% of patients with SMI had a blood pressure check in the last 12 months, which is significantly lower compared to England (81.5%). [37]

- In 2017/18, the proportion of patients with SMI that had a record of alcohol consumption in the last 12 months was 73.4% in Medway, which is significantly lower compared to England (80.6%). [38]

Current services in relation to need

Mental health and wellbeing promotion

A range of partners deliver services which contribute to mental wellbeing. Medway Council has an important role in population mental wellbeing, and the Public Health team delivers the following:

- Mental wellbeing training - overseeing the delivery of a programme of training across health and care organisations, which enables staff to identify and talk to people who may be experiencing mental health issues and signpost them to
services. This also includes delivering mental wellbeing training to “A Better Medway” champions, which includes members of the local community.

- **Workplace health programme** - supporting workplaces to improve the health of employees, including support and training around mental wellbeing.

- **Medway Council Public Health commissions the Medway Men in Sheds scheme delivered by the Sunlight Trust. The scheme provides user led activities to improve wellbeing, reduce isolation and promote good mental health. In 2018, approximately 200 people were registered with the scheme.**

### Services for those with common mental health disorders

Medway Clinical Commissioning Group (CCG) is responsible for commissioning and overseeing mental health services in Medway, including Talking Therapies and secondary (specialist) care. In Medway, services which support people with mental health problems include:

- **Support from primary care** - GPs and other members of primary care teams can provide support with a range of mental health issues. This may include advice, treatment/medicines or referrals to more specialised services. In Medway there are three Primary Mental Health Workers who work with GP practices across Medway to support people with mental health issues.

- **Medway Talking Therapies** - this service is aimed at people with common mental health disorders, including low mood, depression, anxiety, stress and phobias, as well as bereavement and relationship problems. The service provides a range of talking therapies, either face-to-face, over the phone or digitally via apps and online services. Access to the service is by GP or self-referral. The service also has dedicated employment advisors who can provide advice and support around employment to those using the service. In Medway this service is delivered by Insight Healthcare, in partnership with North Kent Mind and IESO digital health.

### Support for people with severe mental health needs

Kent and Medway NHS and Social Care Partnership Trust is the local provider of secondary (specialised) mental health services for Medway. Some of these services are outlined below:

- **Mental Health Single Point of Access** - is available 8am to 10pm, 7 days a week. The service is for people who need urgent mental health support and who are not already under the care of the Community Mental Health Team. The service can provide advice and help accessing support and services.

- **Medway Community Mental Health Team** - assess, diagnose and treat adults with severe, long-term and complex mental health needs who are living in the community. Referrals can be made by a GP. In exceptional circumstances they can be received from Social Services and other agencies.

- **Crisis Resolution and Home Treatment Team** - this team provides an alternative to a hospital admission by supporting individuals who are acutely mentally unwell in
their own homes. Support can include home visits, problem solving and talking therapy, carers support and medication management.

- **Medway Liaison Psychiatry service** - sometimes people with acute psychiatric illness need specific care that can only be provided in hospital or cannot be managed safely at home, and therefore may require admission to hospital for treatment. The liaison psychiatry service provides mental health advice, assistance and formal assessments for adults presenting at Medway Hospital (both people attending the accident and emergency department and people who have been admitted to hospital).

- **Early Intervention for Psychosis Service** - psychosis is a mental health disorder that can cause problems such as hallucinations and delusions. This team works with people between 14 and 65 years old who are experiencing their first episode of psychosis (symptoms started within the last 3 years). The team offers advice, assessment and support, including practical activities such as social or vocational.

- **The Mother and Infant Mental Health Service** - specialises in the assessment, diagnosis and short-term treatment of pregnant women with a pre-existing mental illness or those at risk, and women who encounter mental health problems for the first time during or after their pregnancy. Medway residents also have access to a specialist mother and baby unit which is commissioned by NHS England for the whole of the South East and located in nearby Dartford.

Additional support is also available for rough sleepers. Since July 2018 work has been taking place in Medway as part of the rough sleeper initiative, led by Medway Council. A mental health practitioner has been working with housing teams to provide extra support to rough sleepers and former rough sleepers who have been placed into accommodation. The practitioner’s role is to support with mental health needs and to give guidance and advice to housing staff working with this client group. This post is funded until March 2020.

**Social care support for people with mental health problems**

People with mental health problems who meet the criteria for Adult Social Care services, as set out in the Care Act, receive support from one of Medway Council’s three generic locality teams. These comprise Social Workers, Occupational Therapists and Assistant Integrated Practitioners who work with service users using the Three Conversations model. This model of practice focuses on making the best use of the particular strengths of people, their families and communities before considering the use of traditional social care provision.

Wherever possible Adult Social Care staff work with people to utilise their own resources and support networks to make the positive changes they wish to achieve. Those who require long-term support are also provided with a range of care services. Users can receive a direct payment to arrange their support packages. Alternatively, packages are commissioned from home care agencies, day services and care homes.

The Council also directly provides community outreach support, visiting people in their homes initially, to assess individual needs and signpost to other services where appropriate. Wellbeing services and practical life skills support are also delivered from the 147 Day Resource Centre for individuals who meet eligibility criteria, ranging from
short to longer term support. The social care team is responsible for undertaking safeguarding adult enquires when concerns are raised.

Peer support, advocacy and wellbeing support for people with mental health problems

- Mental Health Advocacy services are commissioned by Medway Council and delivered by POhWER. Free, confidential and independent advocacy services to help people understand their rights. Referrals are via adult social care and eligibility criteria are determined by guidelines as set out for the provision of statutory advocacy services.

- Carers First is also commissioned by Medway Council to provide advice and emotional or practical support to carers, including those who care for people with a mental health issue.

- Medway CCG commissions a Wellbeing Cafe which runs at a local community centre to provide out-of-hours and weekend support to people experiencing mental health issues. The service offers a range of facilitated social activities that promote mental wellbeing, such as arts and crafts, along with one-to-one support and advice.

- The CCG, in partnership with Medway Council, commissions the service user group, MEGAN CIC, to provide a range of peer support groups in Medway, such as a personality disorder support group and a depression and anxiety support group. The group aims to reduce mental health stigma and provides a forum for service user engagement.

- Mental Health Matters is a helpline which is available 24/7. Callers are able to access online or telephone support from trained counsellors who offer emotional guidance, information and prevent mental health crises.

- The voluntary sector in Medway also provides support to those with mental health problems, for example through art groups and informal peer support.

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

Depression contributes 12% of the total burden of non-fatal global disease and by 2020 is set to be second after cardiovascular disease in terms of the world’s disabling diseases.[39]

Table 1 shows the projected prevalence of mental health problems to 2020. Prevalence rates from the Adult Psychiatry Mobility Survey (2007) have been applied to ONS population projections for the 18-64 population to give estimated numbers predicted to have a mental health problem in 2020.[26]

Table 1: People aged 18-64 predicted to have a mental health problem in Medway by gender, projected to 2020. [26]

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>People aged 18-64 predicted to have a common mental disorder</td>
<td>28012</td>
<td>28599</td>
</tr>
<tr>
<td>People aged 18-64 predicted to have a borderline personality disorder</td>
<td>783</td>
<td>799</td>
</tr>
</tbody>
</table>
Evidence of what works

Mental health services: cost-effective commissioning

Public Health England has recently published an updated version of work previously carried out by the London School of Economics in 2011: “Commissioning cost-effective services for promotion of mental health and wellbeing and prevention of mental ill-health”. This document looks at the most cost-effective interventions for mental health promotion and is accompanied by a Mental Health Promotion return on investment tool. The work focuses on eight key interventions for preventing the development of mental health problems and finds that there is a strong case for investing in these different actions. The following activities provide a return on investment, which varies between £1.26 and £39.11 per £1 spent on these activities.[40]

- School-based programmes to prevent bullying and initiatives to prevent depression in children and young people.
- Workplace programmes to promote mental health and initiatives to help adults at risk of stress, anxiety and depression.
- Mental health support integrated into the pathways and interventions for people with long-term physical health problems, e.g. diabetes and heart disease.
- Group-based social activities, including volunteering, to address loneliness as a way of promoting mental health.
- Financial advice services for people with debt problems located in primary care.
- Initiatives to identify and support people who have self-harmed and are potentially suicidal.

NICE pathways and guidelines

There are a range of evidence-based pathways and guidelines about effective ways of preventing, identifying and treating mental health problems published by the National Institute for Health and Care Excellence.[41]

Mental Health Forward View

The independent Mental Health Taskforce published its Five Year Forward View [2] in February 2016 which set out the current state of mental health service provision in England and made recommendations in all service areas.[42]

NHS England accepted all the recommendations in the report for which it held responsibility and it was agreed with the Government that to support this transformation, mental health services will benefit from additional investment of
£1bn per year by 2020/21.[42]

In July 2016, NHS England published an Implementation Plan detailing how it will deliver the recommendations made by the Taskforce working with its partner arms-length bodies.[42]

Immediate priorities for service redesign are:

• to increase access to specialist perinatal care
• to reduce the number of out of area placements for children, young people and adults through the provision of more care closer to and at home
• to increase access to crisis care liaison services in emergency departments and inpatient wards
• suicide prevention.[42]

**User Views**

In October 2017 service users at a World Mental Health Day event in Medway were asked their views of what was working well in mental health services.

• Overnight crisis provision from voluntary organisation IMHP (Improve Mental Health Provision) is working well, but funding is short-term.
• A good range of public health initiatives are available in Medway.
• Service users reported better awareness and attitude of mental health in society generally. There is much less stigma around mental illness.
• The role of the voluntary sector is vital for service users in their recovery. MEGAN and Fairbridge were cited as examples of engaging and relaxing places to access support.
• The Early Intervention Service at Canada House (which has been rated as outstanding).
• Services are beginning to listen more to the people in the community and are engaging better.

A service user forum event, run by MEGAN CIC, was also held in March 2018 and a snapshot of the views of those who attended is represented below. More details on the service user forum are available on the MEGAN CIC website.

• Waiting lists for allocations to a care coordinator in the Community Mental Health Team are too long and service users do not feel those in primary care understand their medication requirements well, particularly around ADHD. Staffing is an issue with secondary care teams and there is a lack of consultant psychiatrists.
• Service users and carers reported feeling dissatisfied with crisis/out-of-hours provision often meaning individuals are presenting at A&E to access crisis support.
When a hospital admission is required, patients are often discharged too soon before they are well enough and quickly become unwell again.

- There are issues where there is a dual diagnosis and no dedicated services that tackle dual diagnosis. Services users report a lack of treatment and support for mental health and/or drug and alcohol.
- People with a diagnosis of personality disorder require a quicker response to their support needs and faster access to talking therapies. Waiting times for talking therapies in secondary care requires improvement.

In addition, Partnership Commissioning set up an advisory group consisting of service users, carers and community organisations which provide peer support. Feedback from consultation with this group was presented in Medway’s 2017 Mental Health Needs Assessment and Gap Analysis[27] and a sample of this feedback is listed below.

- Recent experiences of accessing acute services were not perceived as helpful. Long waiting times for secondary care services.
- Expressed lack of continuity of care. Staff turnover described as a barrier to engaging with services. Makes trust building difficult.
- Expressed lack of support for adults with additional diagnosis or awaiting diagnostic assessment, such as ASD/ADHD.
- People with personality disorder reported a lack of supportive services.
- Peer support gained through community groups was identified as a major form of support.

**Unmet needs and service gaps**

**Public health and mental health promotion**

There could be additional work undertaken by all partners to further raise awareness of the 5 ways to wellbeing and other ways of maintaining good mental wellbeing among the general population.

**Primary care**

The proportion of those with serious mental illness having annual health checks could be improved to address the physical health needs of this population group and reduce their existing health inequalities. The introduction of specialist primary care mental health nurses in Medway localities may help to achieve improvements in this area.

**Secondary care**

Waiting times for support from community mental health teams could be improved. It is recognised that both in Medway and nationally there are challenges with mental health workforce capacity.

Professionals and service users report that support for those with co-occurring conditions (both substance misuse and mental health problems) could be improved
through a more joined up approach and exploring opportunities for integrated service provision.

Professionals who work with vulnerable homeless people report that it is challenging to identify ways for these individuals to receive mental health assessments. Outreach mental health provision where professionals could undertake mental health assessments for homeless people in the community would help to address this gap.

Further work is needed to increase the proportion of people in mental health services who refer into the smoking cessation service.

**Recommendations for commissioning**

It is recommended that partners continue to explore opportunities to integrate mental health support into new ways of working in primary care (locality working and the Medway model).

Work to increase the uptake of physical health checks among those with severe mental illness should continue, including an audit of this area to identify any areas for improvement.

To address the concerns around access to mental health services and waiting times, work should be undertaken to ensure there is a clear pathway for mental health provision, including crisis support. Partners need to work together to implement urgent care redesign and have a clear communication plan for the public on how to access support when it is required.

Medway CCG should continue to review Community Mental Health Team waiting times against KPIs through performance management processes and work with the provider to identify any areas for improvement.

The Public Health team should continue to raise awareness of the smoking cessation service within mental health settings, increasing understanding of referral processes and support available, such as one-to-one support and stress management techniques. Targeting is recommended for staff who are in regular contact with mental health service users, such as social workers, residential care homes, voluntary sector providers and acute settings.

It is recommended that partners in Medway continue to increase the capacity of frontline workers in health and social care to deliver brief mental wellbeing interventions through training such as Connect 5.

It is recommended that partners identify ways of promoting mental wellbeing campaigns, such as the five ways to wellbeing, to achieve improvements in population mental wellbeing.

Further partnership working and action around mental health promotion and prevention of mental health conditions is recommended. Social prescribing schemes should ensure that improved mental wellbeing is an outcome. Services aimed at improving mental wellbeing and preventing mental illness need to identify ways of targeting those who have the worst health outcomes to reduce health inequalities.
Recommendations for needs assessment work

It is recommended that a separate JSNA chapter on suicide prevention be developed. This is to inform strategic commissioning and future service provision in order to achieve the target set out in the Five Year Forward View for Mental Health to reduce suicides by 10% nationally by 2020/21.

Needs assessment work to understand the needs of and support for those with co-occurring conditions (dual diagnosis) is recommended.

Additional work to understand the needs of and support for those with mental health issues around employment, financial management (including debt) and housing is recommended.

Perinatal mental health (mental health during pregnancy) is also identified as an area for further local needs assessment to inform production of a JSNA chapter.

Cancer

Summary

Cancer is the second leading cause of morbidity and mortality in Medway. Each year approximately 1,300 people are diagnosed with cancer [43] and around 650 people die from cancer in Medway, accounting for about 31% (nearly 1 in 3) of all deaths in Medway. Lifestyle factors such as smoking, obesity, poor diet and alcohol play an important role in determining an individual’s risk of developing cancer. Although there are over 200 types of cancer in the UK, over half of cancer deaths are due to the top four most common cancers: lung, bowel, breast and prostate[43]. Cancer is one of the largest contributors to excess mortality in Medway.

The incidence of cancer is rising and is expected to increase from nearly 300,000 cases in the UK in 2007 to over 430,000 by 2030[44]. This increase will have a significant additional demand on health and social care services. The one year survival rate from all cancers combined has risen gradually over time. This trend is due to a number of factors, notably earlier detection of cancer and continued improvements in treatment and is expected to continue over the coming years. However, cancer mortality in Medway has remained consistently higher than the England average.

Key issues and gaps

The NHS Outcome Framework 2015/16 sets out improvement areas for reducing premature mortality from cancer.

- One and five-year survival rate from all cancers
- One and Five year survival from breast, lung and colorectal cancers combined
- Proportion of cancers diagnosed early at stages one and two.

The risk of not delivering in other areas, such as smoking, physical activity, diet and obesity will have impact on cancer outcomes.
- Smoking prevalence in Medway remains higher than the national average, especially in pregnant women and young people

- Attitudes and beliefs about cancer impact on late presentation; cancer signs and symptoms awareness campaigns need to continue and be sustained

- Variation in cancer screening coverage and uptake between GP practices

- Variation in access to cancer services - cancer waiting time standards not met.

**Who’s at risk and why?**

A number of factors play a part in determining an individual’s risk of developing cancer and the outcome if they do develop it. Some of these are fixed such as age, sex and genetics. Others relate to the individual’s lifestyle. Smoking is the single biggest cause of cancer and it is estimated that around 50% of all current smokers are likely to be killed by their smoking habits. Smoking increases the risk of cancers of the lung, bladder, cervix, kidney, larynx, lip, mouth and pharynx, oesophagus, pancreas, stomach and some types of leukaemia.[45] Alcohol has been linked to increased risk of cancer of the mouth, larynx, oesophagus, liver, breast and bowel.

Diets high in fats and proteins and low in fruits, vegetables and fibre increase the risk of colorectal (bowel) cancer.[46] Being overweight or obese are the most important known avoidable causes of cancer after tobacco.[47] Other risk factors for cancer include: lack of exercise and excessive exposure to ultraviolet light.

*Table 1: Lifestyle related risk factors [48][49]*

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<tr>
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</thead>
<tbody>
<tr>
<td>Medway</td>
<td>22.3</td>
<td>65.6</td>
</tr>
<tr>
<td>England</td>
<td>16.9</td>
<td>64.8</td>
</tr>
</tbody>
</table>

Table 1 shows the estimated prevalence of cancer risk factors in Medway in comparison with England. The prevalence of smoking and excess weight (obesity and overweight categories combined) is higher in Medway than the England average.

**Issues of inequality**

Smoking prevalence is significantly higher in the routine and manual groups in Medway (29.7%) compared with England (26.5%) [48]. Higher cancer mortality rates in BME communities than the general population explained by the lower levels of awareness of major risk factors for cancer and cancer symptoms and lower help seeking behaviour amongst this group. This phenomenon has been observed nationally.[50]

**The level of need in the population**

**Incidence of all cancers**

There were 3,992 new cases of cancer registered in Medway between 2012 and 2014. The majority of these, 2,668 (67%), were in people aged under 75 years.
Over time, the incidence of all cancers has increased in both Medway and England as a whole. Figure 1 shows that, over the last decade, cancer incidence in Medway amongst people aged under 75 years has been similar to that of England.

**Figure 1: Trends in number of new cancer cases diagnosed in people aged under 75**

**Prevalence**

In 2016, 6,238 people in Medway were registered with their GP as having a cancer diagnosis. This equates to a prevalence of 2.1% of the registered population and compared with England prevalence of 2.4%.

**All cancer mortality**

Although the mortality rate from all cancers has been falling over time nationally, cancer still remains the leading cause of premature death for both males and females, accounting for almost half of deaths in women (47%) and two-fifths of deaths in men (40%) before the age of 75 years.
Figure 2 shows that over recent years, cancer mortality rates for Medway have remained consistently higher than the England average. There has been no significant increase in the gap in all cancer mortality rates between Medway and England over this period.

![Cancer deaths in people aged under 75](image)

**Figure 2: Trends in number of cancer deaths in people aged under 75[43]**

**Lung cancer incidence**

Between 2012 and 2014, 519 new cases of lung cancer were registered in Medway, 319 (61%) of which were in people aged under 75 years. Figure 3 shows that the lung cancer incidence rate for under 75s in Medway has remained fairly similar to the England average over recent years.
Lung cancer mortality

Lung cancer is the most common cause of all cancer deaths in England and in Medway. For the period between 2012 and 2014, lung cancer deaths accounted for 21% (Medway) and 21% (England) of all cancer deaths. Amongst under-75s, lung cancer deaths accounted for 21% (Medway) and 26% (England) of all cancer deaths amongst under-75s over the same period.

Between 2012 and 2014, 424 people died from lung cancer in Medway. Of these, 260 (61%) were deaths in people aged under 75 years.
The lung cancer mortality rate amongst people aged under 75 years in Medway has fluctuated on or above the England average since 2001 (figure 4). Several of these recent ‘peaks’ have been significantly higher than the national average.

**Breast cancer incidence**

Nationally, one in three women who develop breast cancer are aged 70 and over.

Between 2012 and 2014, 584 new cases of breast cancer were registered in Medway, 433 (74%) of which were in people aged under 75 years. There is a clear pattern over the last two decades in the incidence rate for breast cancer, with a three-year cycle of peaks and troughs rising above and falling below the England rate and with a slight upward trend (figure 5). This cyclical pattern reflects breast screening activity (which follows a three-yearly cycle) and is a known, national phenomenon.
Breast cancer mortality

Breast cancer is now the second most common cause of death from cancer in women after lung cancer. Nationally, the number of women dying from breast cancer has fallen. This decline has in part been due to screening and improvements in treatment.

Between 2012 and 2014, 137 women died from breast cancer in Medway. Of these, 82 (60%) were deaths in women aged under 75 years. As shown in figure 6, there is a slight downward trend in breast cancer mortality amongst under-75s in Medway but with a lot of fluctuation above and below the national average.
Colorectal cancer incidence

Between 2012 and 2014, 474 new cases of colorectal cancer were registered in Medway, 271 (57%) of which were in people aged under 75 years.

Figure 7 shows that a peak in the incidence rate of bowel cancer occurred for Medway in 2010. This peak coincides with the start of bowel cancer screening in 2009 in Medway, and suggests that cancers were being detected earlier than they would have been without screening. Since 2010, bowel cancer incidence has been falling in Medway and is currently similar to the England rate.
Figure 7: Trends in number of new colorectal cancer cases diagnosed in people aged under 75[43]

Colorectal cancer mortality

Colorectal (also known as Bowel) cancer is the second most common cause of cancer death in the UK after lung cancer.

Between 2012 and 2014, 198 people died from colorectal cancer in Medway. Of these, 93 (47%) were deaths in people aged under 75 years.

Figure 8 shows that there is a slight downward trend in bowel cancer mortality in Medway. The rate is consistently higher than the England average but has reduced since peak in 2010.
Avoidable cancer deaths

During 2013-15, there were 1,019 cancer deaths in the under 75s, of which 625 (61%) could have been prevented, an average of 208 per year. Expressed as a rate per 100,000, this is the highest in the South East and fourth highest among other local authorities in the Chartered Institute of Public Finance and Accountancy (CIPFA) comparator group[48].

A death is considered to be preventable by the Office for National Statistics “if, in the light of understanding of the determinants of health at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided by public health interventions in the broadest sense”[51]. In practice this definition includes the following cancers: lip, oral cavity, pharynx, oesophagus, stomach, colorectal, anus, liver, trachea, broncus and lung, skin, mesothelioma, breast and cervical.
Cancer survival

Net or relative survival in a population of cancer patients is their survival from the cancer of interest after adjustment for other causes of death. It is defined as the ratio of the observed survival and the survival that would have been expected if the cancer patients had experienced the same background mortality by age and sex as the general population. Net survival varies with age, sex and type of cancer and all of these factors can vary with time and between geographical areas, so the estimates are age, sex and cancer standardised to facilitate comparison.

Despite the one-year survival rate for all cancers rising every year in Medway since 1998, it is still one of the lowest in the country. Furthermore, Medway has the lowest lung cancer survival in the country and one of the lowest rates of colorectal cancer survival[52].

Current services in relation to need

Prevention

Prevention remains the best method of tackling cancer, reducing the burden caused by the disease and improving outcomes. Over half of all cancers can be prevented. Smoking is the single largest preventable risk factor for cancer. See chapter on smoking in ‘Lifestyle and Wider determinants’ section.

Poor diet and obesity are linked to cancer. The prevention work done in Medway is closely aligned to local and national strategies.

Excessive alcohol consumption is strongly linked to an increased risk of several cancers. A Medway alcohol strategy aims to promote sensible drinking and to reduce the impact of alcohol misuse.

The human papillomavirus (HPV) national childhood vaccination programme was introduced in 2008 for secondary school year 8 girls (12 to 13 years of age) as a three-dose schedule given within a six-month period. In 2014/15 the schedule changed to two doses; one in the Autumn term and the second in the Summer.

For 2014/15, HPV vaccination uptake for Medway of two doses was 80.7%, lower than the coverage for England (84.9%)[53]. This data excludes HPV vaccination given in general practice but will be included from 2015/16 onwards.

Improving awareness and earlier presentation

Improving cancer outcomes in line with the best cancer outcomes in Europe requires better awareness of cancer signs and symptoms to ensure earlier diagnosis and treatment.

A range of surveys conducted between 2010-2012 by the Kent and Medway Cancer Network in partnership with Cancer Research UK, highlighted low levels of awareness of cancer risk factors and cancer signs and symptoms in Medway. A cancer delivery plan to improve cancer symptom awareness and cancer screening uptake was developed jointly with Public health, Medway Clinical Commissioning Group and the Communications Team from both Medway Council and the CCG was approved by the
Health and Wellbeing Board in 2014. The plan focused on lung, breast and colorectal cancers and was implemented in 2015.

Public Health England leads and runs various national cancer symptoms awareness campaigns aimed at both the public and health professionals.

**Earlier diagnosis - cancer screening**

Cancer screening is a vital tool for the early detection of cancers and pre-cancerous changes. There are three national screening programmes in the UK: breast, cervical and bowel.

**Breast cancer screening**

Women aged between 50 and 70 are routinely invited to breast screening once every three years. The programme was extended to include women aged 47 to 73 years in 2011.

Although, there has been a slight decline in screening coverage over the last few years in Medway, coverage is above the minimum standard (>70%) and above the average for England[54]. However, there are variations across general practices in Medway and Medway is yet to achieve the national target (80%).

An action plan was developed and implemented jointly with Medway CCG in 2014 through to 2015, to improve cancer screening uptake as part of a wider cancer mortality reduction plan in Medway.

**Cervical cancer screening**

All women between the ages of 25 and 64 years are eligible for cervical screening every three to five years depending on their age.

At the end of March 2016, the coverage for eligible women in Medway was 75.4%, above the average for England. However, there are variations across general practices in Medway. Coverage remains lower (74.0%) for eligible women aged 25-49 years in Medway, as in the rest of the country[55].

**Bowel cancer screening**

The NHS Bowel Cancer Screening Programme offers screening to all men and women aged 60 to 69 every two years. The programme started in West Kent and Medway in 2009 and was extended to include those aged 70 to 74 years in West Kent and Medway in January 2012.

In 2015, the percentage of eligible people aged 60-74 years in Medway screened for bowel cancer was 56%[48], above the minimum standard of 52% target.

In 2013, West Kent and Medway was one of six national pilot sites chosen to launch the Bowel Scope Programme (BSP) - a one off test for 55 year olds, which uses a camera on a flexible scope to look for and remove surgically, pre-cancerous growths in the lower part of the bowel. The roll out of the BSP has been phased across three years, with the final lists rolled out in early 2016. The uptake in Medway is 47%.
More recently, Public Health, Medway Council, Medway CCG, PHE and Macmillan Cancer Support have jointly developed an action plan in line with the recently published National cancer strategy.

**Improved access to diagnostic**

The review of access to diagnostic in line with the four national priority areas across Kent and Medway has commenced. These areas include: chest x-ray to support diagnosis of lung cancer; non-obstetric ultrasound for the diagnosis of ovarian cancer; flexible sigmoidoscopy/colonoscopy for the diagnosis of colorectal cancer and Magnetic resonance imaging (MRI) brain for diagnosis of brain cancer. GPs now have direct access to chest x-ray to support diagnosis of lung cancer and non-obstetric ultrasound to support diagnosis of ovarian cancer.

**Completeness of cancer staging**

The completeness of cancer staging in Medway in 2013, has improved from the previous year with three-quarters (75.7%) of newly diagnosed cancers having a valid stage recorded at time of diagnosis[56]. The proportion presenting at an early stage (stage 1 or 2 as opposed to 3, 4 or unknown) was 44% in 2014 compared to 50% England average[48].

**Ensuring better treatment**

Table 2 shows the national targets for cancer waiting times with comparable figures for Medway and England. Please note, all figures are percentages.

*Table 2: Cancer waiting times (Q2 2016-17)[48]*

<table>
<thead>
<tr>
<th>Operational standard</th>
<th>Medway</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two week wait from GP urgent referral to first consultant appointment</td>
<td>93</td>
<td>84.9</td>
</tr>
<tr>
<td>One month wait from a decision to treat to a first treatment for cancer</td>
<td>96</td>
<td>95.4</td>
</tr>
<tr>
<td>Two month wait from GP urgent referral to a first treatment for cancer</td>
<td>85</td>
<td>75.0</td>
</tr>
</tbody>
</table>

The monitoring of cancer waiting time targets remains a priority. During Q2 2016-17, Medway was below the operational standard for two week waits, 31 day wait (diagnosis to treatment) and 62 day wait (referral to first treatment).

Medway CCG is supporting Medway NHS Foundation Trust in driving improvements in cancer waits and referrals. An action plan has been developed and the implementation of this plan is overseen by the Cancer Board.

**Living with and beyond cancer**

A Macmillan Information Centre and the Macmillan Chemotherapy unit is available at Medway Maritime Hospital to support people living with and beyond cancer.

Medway CCG, Macmillan Cancer support and Medway Council are working jointly to improve and provide access to advice and support on welfare benefits to people with
cancer. Medway CCG is implementing the top tips guide to improve one-year survival for cancer produced by Macmillan Cancer Support.

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

Cancer incidence is expected to increase with an ageing population. Even though Medway has a slightly younger population than the national average, projections from 2015 to 2025 suggest that the number of people 65 years of age or over will increase by 24% to 53,000 and the number of people over 85 years will grow by 44% to 6,900[57]. Nationally, the predicted increase in the incidence of cancer from nearly 300,000 in 2007 to over 430,000 by 2030 in the UK[44] and is likely to result in the need and demand for new cancer drugs and treatment as well as other health and social care services.

With ongoing national cancer awareness campaigns, it is expected that this would also increase the detection of cancer as well as the need for treatment.

More people are surviving cancer or living longer with the disease. These groups have different needs which are not provided by the usual cancer services.

**Evidence of what works**

- Department of Health (2007) *Cancer Reform Strategy*
- National Institute for Clinical Excellence (NICE)
  - Prostate Cancer Diagnosis and Treatment (*CG58 February 2008*)
  - Early and locally Advanced Breast Cancer Diagnosis and Treatment (*CG80 February 2009*)
  - Diagnosis and Treatment of Lung Cancer (*CG121, April 2011*)
  - Referral Guidelines for Suspected Cancer (*CG27 June 2005, updated April 2011*)

**User Views**

The National Cancer Patient Experience Survey 2015[58] Programme was undertaken by Quality Health, on behalf of NHS England to understand patients’ experience of cancer services.

- 76% of respondents said that they were definitely involved as much as they wanted to be in decisions about their care and treatment
• 91% of respondents said that they were given the name of a Clinical Nurse Specialist who would support them through their treatment
• when asked how easy or difficult it had been to contact their Clinical Nurse Specialist, 87% of respondents said that it had been ‘quite easy’ or ‘very easy’
• 84% of respondents said that, overall, they were always treated with dignity and respect they were in hospital
• 94% of respondents said that hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital
• 61% of respondents said that they thought the GPs and nurses at their general practice definitely did everything they could to support them while they were having cancer treatment.

There were two areas in which the Trust scored lower than expected:
• Patient told they could bring a family member or friend when first told they had cancer (70% compared to 79% national average)
• All staff asked patient what name they preferred to be called by (47% compared to 67%)

There were two areas in which the Trust scored higher than expected:
• Hospital staff gave information on getting financial help (68% compared to 55%)
• Hospital staff told patient they could get free prescriptions (87% compared to 80%)

**Unmet needs and service gaps**

The NHS Outcome Framework identifies the reduction in cancer mortality and fewer people dying prematurely from cancers before the age of 75. The risk of not delivering in other areas, such as smoking, physical activity, diet and obesity will have impact on cancer outcomes.

• Smoking prevalence remains higher than the national average especially in pregnant women and young people.
• Attitudes and beliefs impact on late presentation- Social marketing combined with community engagement and empowerment approaches needs to be continued and sustained.
• Mortality from all cancer has been consistently higher than the England average
• One year lung cancer survival is significantly lower than the England average.
• Cancer screening coverage and uptake: variation between GP practices needs to be reduced.
Recommendations for Commissioning

- Conduct a detailed investigation into why the mortality rate from the most common cancers in Medway has remained higher when compared with England.

- The quality of cancer data had led to significant difficulties in interpreting trends and drawing conclusions. Where possible, further analyses should be conducted once data quality issues have been addressed.

- Ensure continuous improvement of GP access to diagnostic tests for cancer.

- Continued investment in prevention and early diagnosis is important. It is recommended that there is support to:
  - Ensure that prevention strategies focus on reducing risk factors for cancer such as smoking, drinking too much alcohol and being overweight/obese.
  - Continue and sustain public awareness of the signs and symptoms of cancer, an understanding of when and how to seek help (campaigns especially targeting older people, who often present late) and the link between lifestyle behaviour and cancer.
  - Ensure that all those eligible have access to existing cancer screening programmes, using evidence based interventions to encourage attendance.
  - Support on going work with primary care to reduce practice variations in screening coverage, uptake and access to services
  - Commissioners should encourage providers to improve data collection, in particular record tumour staging and that this is uploaded on info flex database system.
  - The number of new cancer patients presenting as emergencies should be monitored through the national cancer intelligence network and reduction incentivised as these have very poor outcomes.

- The recommendations set out in the Achieving World Class Cancer Outcomes: A strategy for England 2015-20, should be considered and implemented.

COPD

Summary

Chronic Obstructive Pulmonary Disease (COPD) is the name for a collection of diseases including chronic bronchitis, emphysema, and chronic obstructive airways disease. This condition is characterised by difficulty breathing, known as airflow obstruction, and can lead to profound difficulties carrying out the activities of daily life, and so a significantly impaired quality of life.

The airflow obstruction is usually progressive, not fully reversible (unlike in asthma) and does not change markedly for several months at a time. It is treatable, but not
curable. Early diagnosis and treatment can slow down the progression of the disease and make it easier for individuals to carry out usual daily activities.

Smoking is the main cause of COPD. It usually affects people aged 35 and over who are or have been heavy smokers. Deprivation is linked to high smoking and COPD prevalence.

The total annual cost of COPD to the NHS is estimated to be over 800 million GBP for direct healthcare costs, which equates to 1.3 million GBP per 100,000 people.[59]

Key issues and gaps

The present way services are utilised in the treatment and management of COPD may not be cost effective, in particular the high rates of hospital admissions and of long-length hospital stays. For emergency admissions relating to COPD, the average length of stay is longer in Medway than other local comparators (7.9 days compared to an average of 6 days).[60]

Opportunities to reduce costs include:

- Compliance with NICE guidance [61] to support COPD patients who smoke to stop, by providing smoking cessation advice, and/or referring to stop smoking services.
- Compliance with NICE guidance to refer patients with an abnormally high or low body mass index (BMI) for dietetic advice, which may include referral to healthy weight or physical activity services.

Other gaps include:

- Low proportion of COPD patients who had a review and breathlessness assessment and low rates of FEV1 recorded compared to local comparators.[60]
- Lower proportion of COPD sufferers administered with the flu vaccination compared to local comparators.[60]

Who’s at risk and why?

Current and ex-smokers are most at risk of developing COPD. Chemicals found in tobacco smoke stimulate inflammation in the lungs, leading to destruction of the alveoli and narrowing of the airways, which can cause COPD.

Other people at risk of COPD are those who have been exposed to inhaled dusts and gases in the workplace, those who have an inherited genetic problem that leads to the early onset of emphysema or those who may have previously been diagnosed with asthma.

Occasionally COPD may be the result of inadequate lung development in childhood that can be trans-generational, or damage caused by infections in childhood that affect lung growth and development.

Levels of deprivation and levels of smoking are linked, with higher levels of smoking found in more deprived groups. This leads to a higher prevalence of COPD in the most deprived quintiles, as shown in Figure 1:
Current and ex-smokers are most at risk of contracting COPD. Chemicals found in tobacco smoke stimulate inflammation in the lungs, leading to destruction of the alveoli and narrowing of the airways, which can cause COPD. Other people at risk of contracting COPD are those who have been exposed to inhaled dusts and gases in the workplace, those who have an inherited genetic problem that leads to the early onset of emphysema or those who may have previously been diagnosed with asthma. Occasionally COPD may be the result of inadequate lung development in childhood that can be trans-generational, or damage caused by infections in childhood that affect lung growth and development.
COPD mainly affects people over the age of 45 and is more prevalent in older age groups. Figure 3 shows that approximately half the cases of COPD are found in people aged over 65 years.

![Bar chart showing prevalence of COPD by age](image)

**Figure 3: Estimated prevalence of COPD in Medway by age[64]**

Prevalence of COPD is on average higher in males than females, as shown in Figure 4.

**Figure 4: Number of people per 100,000 ever diagnosed with COPD, by sex, 2004-2012[62]**

**Figure 4: Number of people per 100,000 ever diagnosed with COPD, by sex, 2004-2012[62]**

**The level of need in the population**

As at March 2016, the number of people with a COPD diagnosis in Medway was 5,368. This represents a prevalence of 1.82%. The prevalence for the whole of England is 1.85%[65].
Whilst mortality attributable to respiratory causes has declined (Figure 6), Figure 5 shows, that the prevalence of COPD has in fact increased in Medway and England since 2006.

Figure 5: Recent trends in COPD prevalence[65]

There is a strong consensus of opinion that COPD prevalence is higher than suggested by recorded diagnoses. Modelled estimates of COPD, using a model developed by Imperial College London, suggest that the true prevalence in Medway could be 2.78% among those aged 16 years and over. (as opposed to 1.8% recorded), which equates to 6,347 people with COPD (as opposed to 5,368 recorded).

This gap, often described as the “missing millions” when considered nationally, represents people with COPD who have not been diagnosed. These people may not be aware they have a condition that needs treatment and are therefore likely to experience poorer outcomes. Thus reducing the gap between estimated and recorded COPD is an important public health issue.

Based on these data, it is estimated that 85% of COPD cases in Medway have been detected. This compares to an estimated 63% of cases detected in England.
Based on an analysis of non-elective hospital admissions for COPD using data available from Dr Foster[66], Medway has a similar admission rate to England adjusting for the age structure of the population.

COPD is the fifth leading cause of death in the UK, killing approximately 25,000 people in England and Wales every year[67]. Figure 6 shows a downward trend in mortality rates from respiratory diseases, to which COPD is a key contributor. This pattern has been observed in England overall, South England, and in Medway.

![Figure 6: Recent trends in respiratory mortality (under 75)](image)

Overall, there is a downward trend in mortality attributed to respiratory conditions. Medway has a higher premature (under 75 years) mortality rate from respiratory diseases (40.2 per 100,000) compared to England (33.1 per 100,000).

Preventable mortality rates give an indication of the number of deaths that could potentially be avoided by the implementation of public health interventions. In Medway, 149 deaths from respiratory diseases could have been prevented in 2013-2015. The rate of respiratory disease deaths considered preventable in Medway (24.4 per
100,000) is significantly higher than the preventable mortality rate in England (18.1 per 100,000)[68].

**Current services in relation to need**

Medway currently offers a number of services for people with COPD. In the early stages of disease, the majority of care takes place in primary care settings. Care is provided by both GPs and practice nurses, though there is some variation in the availability of practice nurses with specific training in the management of COPD.

For patients with a greater level of need, there is a Community Respiratory Team (CRT). The CRT provides a number of services including routine clinics, an urgent “unwells” service, and pulmonary rehabilitation. The CRT also carries out all home oxygen assessments, ensuring that the drug is dispensed and used appropriately. Medway was one of the first trusts in the UK to establish a dedicated Community Respiratory Team and many other authorities have since adopted this model.

For patients with the most severe disease, or specialist requirements, Medway Maritime Hospital provides acute services led by consultants in respiratory medicine.

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

Modelled estimates and projections of COPD prevalence carried out in 2008 by the Eastern Region Public Health Observatory (ERPHO), projected an increase in the prevalence of COPD. An increase in COPD prevalence has been observed. The model provides a projection up to 2020, which predicts a continuation of this trend.

The prevalence is estimated to be 0.2% higher in males and 0.1% higher in females in 2020 compared to 2015. The projected prevalence for males in 2020 is 4.3% and 2.5% in females.

A rise in the number of people with COPD will likely lead to an increase in demand for services such as those provided by the Community Respiratory Team over the next 4 years to 2020.

There is a risk that if the need for community-based, multidisciplinary care is not met, individuals with COPD may go on to require emergency services and/or acute secondary care.

However, prevention, early diagnosis, and effective intervention and treatment by primary care and community services should in time result in a decrease in the demand on acute hospital care and social services.

**Evidence of what works**

National guidelines and strategies have been developed to inform the treatment and management of COPD, ensuring that services and interventions are based on up to date evidence. The guidelines include:
The Five Year Forward View (FYFV) provides guidance on the treatment and management of COPD as part of its objective to reduce premature mortality[69].

Services and interventions that have been shown to be effective include:

### Prevention

Smoking is the leading cause of COPD. Reducing tobacco use, through intervention such as Stop Smoking Services and tobacco control initiatives, will help to prevent cases of COPD occurring.

### Early Diagnosis

The earlier COPD is diagnosed the more quickly it can be treated to slow the decline in lung function. It is estimated that as many as 2 million undiagnosed cases of COPD exist nationally[70]. Finding these ‘missing millions’ through targeted case finding is likely to improve outcomes for COPD patients and reduce emergency hospital admissions. The FYFV reports that between 10% and 34% of emergency admissions for acute exacerbation of COPD are in people whose COPD is undiagnosed, suggesting that successful case-finding and management could reduce COPD emergency admissions by up to one third.

### Management of COPD

Providing appropriate treatment and supporting patients to manage their condition will prevent the worsening of the disease, enabling people to carry out their usual daily activities for longer. Interventions should include supporting COPD patients to stop smoking and providing pulmonary rehabilitation services.

Supported discharge scheme piloted in Medway Hospital in 2015, was effective in reducing the length of stay from 8 to 4.8 days for patients with COPD exacerbations.

The FYFV provides comprehensive evidence-based guidance for the clinical management of COPD, with factsheets on Non-invasive ventilation (NIV); Home oxygen; controlled oxygen dosing, and pulmonary rehabilitation[71].

### User Views

Not available at this time.
**Equality Impact Assessments**

An equality impact assessment was carried out in 2011 looking at the impact of increasing access to Pulmonary Rehabilitation (PR) it identified that increasing access to PR would not have a negative impact on equality and showed a positive impact in disability, socioeconomic status and age.

**Unmet needs and service gaps**

Estimates suggest that 15% of COPD cases in Medway are undiagnosed. Closing the gap between recorded and estimated prevalence, and recognising people’s treatment needs, is vitally important to meeting the needs of people living with COPD.

Current patterns of service use are unlikely to be the most cost effective or best for patients, in particular the high hospital admission rates and long lengths of stay.

Opportunities to improve patient care and to reduce costs include:

- Further development of community services to improve case-finding.
- Improved and sustained support and training for primary care practitioners to enable successful community-based management of patients’ conditions, reducing the need for acute or secondary services.
- A more systematic evidence based approach to COPD care management in primary care in line with NICE quality standards and the Five Year Forward View.
- A full roll-out of the early discharge pilot scheme, which has been shown to reduce the length of hospital stay for COPD patients.

**Recommendations for Commissioning**

- Implement strategies for targeted case-finding to find Medway's share of the ‘missing millions’ and reduce the gap between recorded and estimated prevalence.
- Improve access to accredited spirometry services at diagnosis
- Implement Personal Care Plans (to include COPD information, self-management, and signposting to other relevant services).
- Improve referral and uptake of smoking cessation services for COPD patients.
- Redesign the urgent care pathway for confirmed COPD patients to ensure quicker access to secondary care assessment thereby avoiding unnecessary hospital admission.
- Improve and increase access to pulmonary rehabilitation.
- A COPD audit should be undertaken for case-finding and hospital admissions to assess the impact of the implementation of the recommendations and highlight areas in the COPD pathway where further improvements can be made.
CVD

Summary
Cardiovascular disease (CVD) encompasses diseases of the heart and blood vessels and includes conditions such as coronary heart disease (CHD), stroke, heart failure, peripheral vascular disease and some other less common conditions.

Lifestyle factors such as smoking, unhealthy diet and lack of physical activity and their consequences such as obesity, high cholesterol, high blood pressure and diabetes, are major risk factors for CVD.

CVD causes more than a quarter (27%) of all deaths in the UK, or around 155,000 deaths each year[72] - an average of 425 people each day or one every three minutes.

The main forms of CVD are coronary heart disease (CHD) and stroke; just under half (45%) of CVD deaths were from CHD and a quarter were from stroke (25%)[72]. Deaths from CVD in those under 75 years old are considered premature because most are preventable. Tackling premature death and ill health, including CVD, has been identified as a priority in the Medway Joint Health and Wellbeing Strategy.

Key issues and gaps
- Prevalence of CVD is similar to or lower than the national average in Medway; however, there are gaps between the recorded and estimated CVD prevalence.
- CVD is no longer the biggest killer in Medway; in 2015 23.6% of deaths are caused by CVD, compared to 30.2% caused by cancer.
- Overall CVD mortality rates for under-75s are 79.6 per 100,000 population and are similar to the national average. However, mortality rates from CVD considered preventable (< 75 years) in Medway are significantly higher (55.7 per 100,000) than the national average (48.1 per 100,000).
- Mortality from CVD is higher in men and in the most deprived areas in Medway.
- Deaths from CVD are the greatest contributor to the life expectancy gap between the most deprived and least deprived areas in Medway; 24% in men and 27% in women.
- Emergency hospital admissions for CVD among those aged under 75 have increased in Medway over the past three years.
- A higher proportion of the eligible population aged 40-74 in Medway have been offered an NHS Health Check compared to England. However the proportion who have actually received an NHS Health Check is lower.

Who’s at risk and why?
There are multiple risk factors for CVD, which can be classified as unmodifiable and modifiable risks.
Unmodifiable risk factors include age, sex, family history and ethnicity. The risk of CVD increases with age, is more common in men (until women reach the menopause) and in people from South Asian descent. People of African-Caribbean descent have a 25-50% lower risk of CHD than the White population, however, black people have the highest stroke mortality rates. The proportion of the population from the black and minority ethnic groups in Medway is estimated to be 10.4%[73].

Modifiable risk factors for CVD include smoking, obesity, inactivity, excessive alcohol intake and stress. These factors lead to hypertension, diabetes and hyperlipidaemia, which are key causes of CVD. It is estimated that 74% of the population between 35 and 74 who do not have existing CVD have a low risk of experiencing a cardiovascular event in the next 10 years. A further 18% are estimated to have a moderate risk, and 8% a high risk of CVD[74].

The level of need in the population

Prevalence

Overall CVD Prevalence

There are 21,409 people estimated to have CVD in Medway, based on the Eastern Region Public Health Observatory (ERPHO) modelling. This represents 10.4% of the population aged 16 years and over in 2011 in Medway and is lower than the prevalence estimate for the South East (11.8%) and England (11.7%).[75] Table 1 shows the recorded and modelled prevalence estimates of CVD for 2016.

Table 1: Recorded and modelled prevalence estimates of CVD[75],[76],[65]

<table>
<thead>
<tr>
<th>Condition</th>
<th>Estimated prevalence (Medway)</th>
<th>Recorded prevalence 2016 (Medway)</th>
<th>Recorded prevalence 2016 (South region)</th>
<th>Recorded prevalence 2016 (England)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atrial Fibrillation</td>
<td>n/a</td>
<td>1.46</td>
<td>2.00</td>
<td>1.71</td>
</tr>
<tr>
<td>Coronary Heart Disease</td>
<td>4.76</td>
<td>2.62</td>
<td>3.16</td>
<td>3.20</td>
</tr>
<tr>
<td>Heart failure</td>
<td>n/a</td>
<td>0.75</td>
<td>0.74</td>
<td>0.76</td>
</tr>
<tr>
<td>Hypertension</td>
<td>23.55</td>
<td>14.05</td>
<td>14.05</td>
<td>13.81</td>
</tr>
<tr>
<td>Peripheral Arterial Disease</td>
<td>n/a</td>
<td>0.45</td>
<td>0.59</td>
<td>0.61</td>
</tr>
<tr>
<td>Stroke and Transient Ischaemic Attack (TIA)</td>
<td>2.09</td>
<td>1.22</td>
<td>1.87</td>
<td>1.74</td>
</tr>
</tbody>
</table>

Inequalities in life expectancy

Over the period 2012-2014, the life expectancy at birth of both males and females in Medway is lower than the England average by -0.9 and 1.0 years respectively[77].
The mortality rate from CVD is slightly lower in Medway females than England females so does not contribute to this gap. In contrast, in males the mortality rate is higher and contributes just over 4% of the gap in life expectancy. For information, the main causes of death which contribute to the gap in both sexes are cancer and respiratory disease[77].

However, deaths from CVD are a much greater contributor to the life expectancy gap between the most deprived and least deprived areas in Medway; 24% in men and 27% in women. This is the most significant contribution of a single disease group to the life expectancy gap. In 2012–14, 103 deaths in the most deprived quintile in Medway due to circulatory disease were considered excess deaths[77].

Mortality

Overall mortality

CVD is the second most common cause of mortality in Medway. In 2015, 23.6% of deaths in Medway were caused by CVD, representing a decrease of 37.1% from 2004 (Figure 1). The proportion in 2015 is significantly lower than the England average (26.2%), and is the second lowest proportion across all local authorities in the South East[78]. This is whilst the proportion caused by cancer has increased slightly and is now the most common cause of death in Medway (rising from 27.3% in 2004 to 30.2% in 2015)[78].
Premature mortality

CVD is the also the second largest cause of premature mortality. Eighteen per cent of premature deaths in women and 28% in men are due to circulatory disease. In Medway, the CVD mortality rate for all persons under 75 is 79.6 per 100,000 (2013–2015). This is not significantly different from the CVD mortality rate in England (74.7 per 100,000).[48] The under 75 CVD mortality rate in Medway is significantly higher for males (108.8 per 100,000) than for females (51.3 per 100,000).[48] The trend with the latest available data is shown in Figure 2.

---

**Figure 1: Trends in proportion of all deaths where underlying cause is CVD[78]**

---

**Figure:** Proportion of deaths caused by CVD

- **Medway**
- **England**
- 5th percentile
- 95th percentile
- 25th-75th percentile

Calendar year

Percent


Proportion of deaths caused by CVD
Preventable mortality

Preventable mortality rates give an indication of the number of deaths that could potentially be avoided by the implementation of public health interventions. During the period 2013–2015, the under 75 mortality rate from CVD considered preventable in Medway was 55.7 per 100,000, representing 357 deaths. This is significantly greater than the England average figure of 48.1 per 100,000[48].

Hospital admissions

All CVD

In 2015/16, there were 4,616 CVD admissions among Medway residents; 1,950 elective (42.2%) and 2,666 (57.8%) emergency admissions. Overall, admissions have increased by 25.4% between 2006/07 and 2015/16. The increase in elective admissions is 25.6%, compared to 25.3% in emergency admissions. There has been a sharp increase in emergency admissions for CVD over the past three years. Figure 3 highlights the trends
in the five most common types of CVD in patients aged less than 75 years. Table 2 shows the breakdown of these five types for the latest year (2015/16).

Table 2: Emergency hospital admissions for cardiovascular disease 2015/16

<table>
<thead>
<tr>
<th>Condition</th>
<th>Overall number of emergency admissions</th>
<th>Percentage aged under 75</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atrial fibrillation</td>
<td>271</td>
<td>57.9</td>
</tr>
<tr>
<td>Coronary heart disease</td>
<td>686</td>
<td>67.1</td>
</tr>
<tr>
<td>Heart failure</td>
<td>315</td>
<td>38.7</td>
</tr>
<tr>
<td>Peripheral arterial disease</td>
<td>31</td>
<td>54.8</td>
</tr>
<tr>
<td>Stroke / TIA</td>
<td>408</td>
<td>54.7</td>
</tr>
</tbody>
</table>

Figure 2: Under-75 emergency hospital admissions[79]
**Current services in relation to need**

**Prevention and Detection**

Primary prevention concentrates on altering modifiable lifestyle factors including diet, exercise, obesity, smoking and alcohol intake. For example, Medway Exercise Referral programme accepts patients with diagnoses of stroke and CHD for a 12-week programme of support and access to activity sessions to increase levels of physical activity.

The NHS Health Checks programme allows the systematic detection of risk factors of CVD; high BP, atrial fibrillation, non-diabetic hyperglycaemia (‘pre-diabetes’), type 2 diabetes mellitus, chronic kidney disease, high cholesterol and overall CVD risk. The programme is offered to people without CVD aged 40-74 years at any Medway GP practice to identify those who have a CVD risk score of 20% or higher. This is followed by personalised lifestyle advice, individually tailored management and treatment. The cumulative percentage (Q1 2013/14 - Q3 2016/17) of the eligible population aged 40-74 offered an NHS Health Check in Medway is 78.6%, which is significantly higher than the England average (69.7%). However, the cumulative percentage of people who have received a Health Check is slightly lower in Medway (33.7%), than England (33.8%).[80]

Of the 41,507 people on the hypertension disease register in Medway in 2016, 83% had a blood pressure less than 150/90[65], and a further estimated 28,000 people remain undiagnosed[76].

**Secondary Care**

Cardiology services are provided from the Cardiac Care Unit and Cardiology Ward at Medway Maritime Hospital. They include the following:

**Cardiac imaging and diagnostics**

A number of imaging and diagnostic test are performed in Medway, including angiograms and echocardiograms, however, there is a need for cardiac MRI, cardiac CT and stress imaging locally as this is currently being referred to London hospital trusts.

**Revascularisation**

Revascularisation encompasses any intervention that would improve blood flow. This includes thrombolysis (breaking up the blood clots), angioplasty (including primary Percutaneous Coronary Intervention, pPCI) and coronary artery bypass graft (CABG). The MINAP (Myocardial Ischaemia National Audit Project) clinical audit of the management of heart attack, including information on the performance of Medway Foundation NHS Trust can be seen here: [http://www.ucl.ac.uk/nicor/audits/minap/reports](http://www.ucl.ac.uk/nicor/audits/minap/reports).

**Cardiac Devices**

The following devices are fitted and replaced in Medway Maritime Hospital:

- Permanent Pacemaker implantation and follow up
• Internal Cardiac Defibrillator implantation and follow up
• Cardiac Resynchronisation Device Therapy and follow up

Historically, ICD implants for Medway residents were performed in London, but increasing numbers are being done locally. Implantation of left atrial appendage ocluders and implantation of atrial septal defect closure devices are not performed locally.

Community services

Medway Community Healthcare CIC provides community cardiology services, including cardiac rehabilitation, arrhythmia service, diagnostic services and heart failure services. For more information, visit: https://www.medwaycommunityhealthcare.nhs.uk/our-services/heart-services/

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

Based on Projecting Adult Needs and Service Information (PANSI), it is estimated that in 2016 1,502 people aged 18 years and over will be left with a long-standing health condition caused by a stroke in Medway. This number is estimated to rise to 1,532 in 2017 and 1,561 in 2018, reaching 1,960 by 2030, a 33% increase[81]. Similarly, the number of heart attacks in those aged 65 years and over in 2015 is projected to increase from 2,073 to 3,003 in 2030.

Other sources of projections are too old to be considered for inclusion.

Evidence of what works

The following guidelines provide evidence to support the prevention and treatment of CVD:

Department of Health, Treatment of heart attack national guidance: final report of the National Angioplasty project (NIAP) (2008)


NHS, National Service Framework for Coronary Heart Disease (2007)

NICE, Identifying and supporting people most at risk of dying prematurely (2008)

NICE, Prevention of cardiovascular disease at population level (2010)


User views

There has been limited local research conducted to collect the views of patients with CVD in Medway. A systematic review of qualitative research about the barriers to and facilitators for successful CVD prevention programmes addressing multiple risk factors
found that community and familial norms can make it difficult to engage in and commit to lifestyle changes. At an individual level, being ill or receiving physiological test results or experiences which affect self-image may be most likely to motivate individuals to alter their lifestyles to prevent CVD[82].

A review of hyper acute services for stroke (care in the first 72 hours) is currently underway in Kent and Medway. This has involved collecting the views and experiences of patients and their families who have experienced stroke and received care locally and will be used to shape future services.

Unmet needs and service gaps

- Prevalence of CVD is similar to or lower than the national average in Medway; however, there are gaps between the recorded and estimated CVD prevalence.

- Overall CVD mortality rates for under-75s are 79.6 per 100,000 population and are similar to the national average. However, mortality rates from CVD considered preventable (< 75 years) in Medway are significantly higher (55.7 per 100,000) than the national average (48.1 per 100,000).

- Mortality from CVD is higher in men and the most deprived areas in Medway.

- Deaths from CVD are the greatest contributor to the life expectancy gap between the most deprived and least deprived areas in Medway; 24% in men and 27% in women.

- Emergency hospital admissions for CVD among those aged under 75 have increased in Medway over the past three years.

- A lower than expected number of people have received an NHS Health Check given the high number of people invited.

Recommendations for Commissioning

- Raise public awareness about CVD within Medway to address inequity, with particular focus on communication to men and those in the most deprived areas, ensuring that this is aligned with already existing programmes which focus on healthy lifestyles.

- Intensive behavior change can reduce type 2 diabetes risk substantially. Targeting programmes for these individuals will therefore reduce their risk of CVD.

- Prioritise smoking cessation and continue to target young people and pregnant women.

- Improve joint health and social care commissioning arrangements to effectively target high risk groups, applying evidenced based social marketing techniques and evaluation.

- Work with primary care to ensure that patients with hypertension are given lifestyle advice in order to reduce the risk of CVD.
• Cardiac MRI, cardiac CT and stress imaging should be provided locally as this is currently being referred to London hospital trusts.

• Conduct an audit of all CVD deaths considered preventable in Medway to investigate the possible causes for mortality rates being significantly higher in Medway than in England.

• Conduct an audit of NHS Health Checks programme delivery in order to identify groups or GP practices where low levels of uptake exist, and conduct targeted promotion accordingly.

• Detection and management of hypertension: through implementation of local leadership and action planning for system change, to tackle particular areas of local variation; health professional support (communication, tools and incentives) to bring professional practice nearer to treatment guidelines where this falls short; and support adherence to drug therapy and lifestyle change, particularly through self-monitoring of blood pressure and pharmacy medicine support.[83]

• Detection and management of type 2 diabetes: encouraging people to have a risk assessment for type 2 diabetes and identifying those at risk, local action to prevent type 2 diabetes, including strategy, policy and commissioning. Population and community interventions developed by local public health services working with other local authority departments: develop a local plan; convey healthy lifestyle messages to the local community; promoting a healthy diet; tailor interventions and target communities at high risk of type 2 diabetes; ensure local planners use existing mechanisms to promote physical activity, address service gaps in service provision and encourage employers to develop physical activity policies.

• Ensure GPs are aware of the correct anticoagulant therapy for the treatment of atrial fibrillation in line with 2014 NICE guidelines; takes into account the introduction of non-vitamin K oral anticoagulants, and associated technology appraisal guidance for recommending them as therapy options.[84]

Dementia

Summary

Dementia is a global term used to describe a range of neurological disorders characterised by a decline in intellectual and other mental functions. It can affect people of any age, but is most common in older people and age is the greatest risk factor for dementia.

Dementia affects one in fourteen people over the age of 65 and one in six over the age of 80. However, dementia is not restricted to elderly people: there are 15,000 people under the age of 65 with dementia in the UK, although this figure is likely to be an underestimate[85].
Dementia costs the UK economy £23 billion pounds per year. This is more than cancer and heart disease combined. The average care costs per person are £29,000 per year[86].

In the Medway local authority area in 2012, there were estimated to be 2,587 people living with dementia with 2,523 being over 65 years old. The number estimated for the registered population for Medway CCG is 2,783. Data from the Quality and Outcomes Framework primary care dementia registers in 2012/13 have only identified 1,332 patients in Medway as having dementia. The diagnosis rate of dementia for Medway CCG population is 47.87%, which is higher than the Kent and Medway average of 42.94% and the South of England average of 45.65%.

Key issues and gaps
1. Between 2012 and 2037, the number of older people living in Medway with Dementia is expected to increase from approximately 2,500 to 5,600. This is driven by projected changes in the age structure of the population. This will represent a huge challenge as current services will have to nearly double in capacity if in their present form or different approaches will need to be found. 45% of these will be likely to have moderate to severe dementia.

2. Development of a clearly described integrated care pathway for dementia would assist both people living with the condition and professionals supporting people to access services without increasing the stresses and anxieties already likely to be present in people's lives.

3. Current under-reporting in primary care (which is an issue nationally) and variation in primary care in quality of dementia care needs to be addressed to improve early diagnosis and intervention.

4. Improving professional understanding and appropriate management of dementia is an ongoing need. This is the case for all health and social care professionals, including doctors, care staff and acute hospital staff.

5. There is still stigma associated with dementia which means that people may be reluctant to seek help for themselves or their loved ones. Further campaigns (e.g. Dementia Friends) to change public perception and reinforce the importance of early diagnosis need to be supported locally.

6. 24/7 practical support to carers needs to be further developed to ensure that people living with dementia are supported to remain in their own homes for as long as possible and for any admissions to acute settings can be as short as possible.

7. Local stakeholder events have indicated that some support services are working well but there is a need for more support to carers, better information, earlier diagnosis but with additional support, clear pathways to services and better integration and coverage of what is available to ensure equality of opportunity across Medway. The absence of services for people with a learning disability who also develop a dementia illness was highlighted as a significant issue.
Recommendations for Commissioning

• The aims of the Dementia Strategy are being developed to take into account the growing needs within the Medway population and in recognition of changing priorities within health and social care. The Dementia Strategy when complete should inform commissioning activity on behalf of both Adult Social Care and the CCG.

• Public awareness about dementia and its effect on people's lives should be the focus of attention within the community of Medway and the creation and support of a local Dementia Action Alliance is seen as the most effective was of becoming a dementia friendly community.

• The role of the GP is central to meeting people's needs and there should be a continued development of understanding for the importance of early diagnosis, treatment through medication, and the care and support that is available through social care services including those provided by the independent sector.

• The role and importance of the carer should be incorporated into the Strategy and supported by the commissioning options selected for implementation. A focus of attention will need to be given to ensuring that services are available to avoid and manage crises that might lead to avoidable hospital or care home admissions.

• The Dementia Strategy should set out in the form of clear pathways the journey that people with a developing dementia disease are expected to take. Together with clear pathways there is a need to develop ways that information, guidance and support can be understood and available in easy to understand formats. Options being considered for practitioner and patient signposting should continue to be explored.

• Achieving a dementia friendly community is one where people living with dementia can do so in a way that promotes a sense of value and ability to make a continued meaningful contribution to the community. The strategy will need to be developed from an understanding of the needs and aspirations heard from listening carefully to people living with dementia, both the person with the condition and their carers.

• To ensure services provide quality at each point on a person’s dementia journey, support and development will be necessary within the care home sector.

Who’s at risk and why?

Dementia is a clinical syndrome characterised by a widespread loss of mental function, including memory loss, language impairment, disorientation, change in personality, self-neglect and behaviour which is out of character. [87]

Risk factors

The most important risk factor is age. Other risk factors are learning disabilities, socio-economic status and alcohol.
**Age and sex**

The table below shows estimated prevalence rates from the most recent consensus exercise [85] broken down by age group. Most dementia is late onset (affecting people aged 65 and over) with about 1 in 40 cases being early onset (up to the age of 64 years).

*Table 1: Prevalence of early onset dementia in the UK by age and gender [85]*

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Female Rate per 100,000 Population</th>
<th>Male Rate per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-34</td>
<td>9.5</td>
<td>8.9</td>
</tr>
<tr>
<td>35-39</td>
<td>9.3</td>
<td>6.3</td>
</tr>
<tr>
<td>40-44</td>
<td>19.6</td>
<td>8.1</td>
</tr>
<tr>
<td>45-49</td>
<td>27.3</td>
<td>31.8</td>
</tr>
<tr>
<td>50-54</td>
<td>55.1</td>
<td>62.7</td>
</tr>
<tr>
<td>55-59</td>
<td>97.1</td>
<td>179.5</td>
</tr>
<tr>
<td>60-64</td>
<td>118.0</td>
<td>198.9</td>
</tr>
</tbody>
</table>

*Table 2: Prevalence of late onset dementia in the UK by age and gender [85]*

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Female Percent</th>
<th>Male Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-69</td>
<td>1.0</td>
<td>1.5</td>
</tr>
<tr>
<td>70-74</td>
<td>2.4</td>
<td>3.1</td>
</tr>
<tr>
<td>75-79</td>
<td>6.5</td>
<td>5.1</td>
</tr>
<tr>
<td>80-84</td>
<td>13.3</td>
<td>10.2</td>
</tr>
<tr>
<td>85-89</td>
<td>22.2</td>
<td>16.7</td>
</tr>
<tr>
<td>90-94</td>
<td>29.6</td>
<td>27.7</td>
</tr>
<tr>
<td>95+</td>
<td>34.4</td>
<td>30.0</td>
</tr>
</tbody>
</table>

Tables 1 and 2 highlight the importance of age as the key risk factor for dementia. 1–1.5% of 65–69 year olds are likely to have dementia compared with 30–35% of adults over 95. The prevalence of dementia increases significantly with age. A higher proportion of females experience dementia than males.

**Learning disabilities**

Early onset dementia can be linked to learning disabilities and there is a suggestion of increasing levels of alcohol related dementia. Not only can people with learning disabilities have an increased risk of developing dementia but the early stages of the condition can be missed or misinterpreted. As people with learning disabilities are living longer there is an increasing need for awareness and early detection of the condition. A study of people with Down’s syndrome found the following prevalence of Alzheimer’s disease: [88]

- 30–39 years: 1 in 50
- 40–49 years: 1 in 10
- 50–59 years: 1 in 3
• 60–69 years: more than half

Studies have also shown that in later life almost all people with Down’s syndrome develop the changes in the brain associated with Alzheimer’s disease, although not all develop the symptoms of Alzheimer’s.

Studies suggest the numbers of people with learning disabilities other than Down’s syndrome who have dementia are approximately: [88]

• 50–65 years: 1 in 10
• 65–75 years: 1 in 7
• 75–85 years: 1 in 4
• 85+ years: nearly three-quarters

These numbers indicate a risk about three to four times higher than in the general population.

Socio-economic status

The rate of cognitive problems has been found to be higher in people of lower social class and lower educational achievement. [89]

Alcohol

This is important particularly with respect to Korsakoff’s dementia which is reported to affect 12.5% of dependent drinkers.

Types of dementia

There are a number of types of dementia which are caused by different diseases of the brain. These different types of dementia are associated with different risk factors.

The most common type is Alzheimer’s disease, affecting about 62% of those with dementia. Vascular dementia (17%), including multi-infarct dementia and Lewy Body dementia, are the next most common forms as well as mixed presentations. About 10% of people with dementia have both Alzheimer’s disease and vascular dementia.

Table 3: Types of dementia [85]

<table>
<thead>
<tr>
<th>Types of dementia</th>
<th>Proportion of people with dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alzheimer’s disease</td>
<td>62</td>
</tr>
<tr>
<td>Vascular dementia</td>
<td>17</td>
</tr>
<tr>
<td>Mixed (AD and VD)</td>
<td>10</td>
</tr>
<tr>
<td>Dementia with Lewy bodies</td>
<td>4</td>
</tr>
<tr>
<td>Frontotemporal dementia</td>
<td>2</td>
</tr>
<tr>
<td>Parkinson’s dementia</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
</tr>
</tbody>
</table>
**Alzheimer’s**

A physical disease affecting the brain leading to the death of brain cells. It is a progressive disease that becomes more severe over time. It is characterised by confusion and memory loss, mood swings, social withdrawal and poor social functioning.

The primary risk factor is age. There is some evidence of genetic factors and also smoking and hypotension have been linked to increased risk of getting Alzheimer’s.

People with Downs Syndrome have increased risk of getting Alzheimer’s due to chromosomal abnormalities.

**Vascular Dementia**

Certain factors can increase a person’s risk of developing vascular dementia. These include:

- a medical history of stroke, high blood pressure, high cholesterol, diabetes (particularly type II), heart problems, or sleep apnoea (where breathing stops during sleep)
- a lack of physical activity, drinking more than recommended levels of alcohol, smoking, eating a fatty diet, or leaving conditions such as high blood pressure or diabetes untreated
- a family history of stroke or vascular dementia
- gender - men are slightly more likely to develop vascular dementia
- an Indian, Bangladeshi, Pakistani, Sri Lankan or African Caribbean ethnic background

**Mixed dementia — Alzheimer’s and Vascular**

It is estimated that this form of dementia consists of 10% of the total number of people diagnosed with a dementia.

**Dementia with Lewy Bodies (DLB) and Parkinson’s Disease Dementia (PDD)**

If symptoms of dementia are noted with a year of the person being diagnosed with Parkinson’s, a diagnosis of DLB will be made. This is caused by tiny spherical protein deposits that develop inside nerve cells in the brain. These interrupt the brains normal functioning affecting the person’s memory, concentration and language skills. If the symptoms appear over a year after the Parkinson’s diagnosis, a diagnosis of PDD will be given.

**Korsakoff’s / Alcohol-related dementia**

Those affected tend to be men between the ages of 45 and 65 with a long history of alcohol abuse. Although numbers affected by Korsakoff’s are small (component of ‘other’ forms of dementia which make up 3% total cases), it is reported to affect 12.5% of dependent drinkers and has implications for health and social care services as it affects a younger age group where dementia support is targeted at older people.
Other dementias

Included in this are Fronto-Temporal Dementia (2% of total) along with less common types such as CJD.

The level of need in the population

Local prevalence

In the Medway local authority area in 2012, there were estimated to be 2,587 people living with dementia with 2,523 being over 65 years old. The number estimated for the registered population for Medway CCG is 2,783. Data from the Quality and Outcomes Framework primary care dementia registers in 2012/13 have only identified 1,332 patients in Medway as having dementia. The estimated prevalence of dementia for Medway CCG population is 47.87%, which is higher than the Kent and Medway average of 42.94% and the South of England average of 45.65%.

Figure 1: Estimated prevalence of Dementia in people aged 65 years and over [90] Notes: Age-sex prevalence estimates have been taken from Dementia UK 2007 report produced.
The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers of people predicted to have dementia in 2012. These numbers are shown above the bars.

**Severity of need**

The severity of dementia is normally classified as mild, moderate or severe. At any one time about 55% of the population who have dementia will have mild dementia, 32% moderate dementia and 13% severe dementia. [85] The table below shows this in more detail broken down by age group. Applying the estimates in the first column to the Medway population numbers the second column shows the estimated total number of people in 2012 with mild, moderate and severe dementia.

*Table 1: Measures of subjective wellbeing in Medway compared with the southeast and England 2012. Source: Office for National Statistics*

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Mild.num</th>
<th>Mild.pc</th>
<th>Mod.num</th>
<th>Moderate.pc</th>
<th>Sev.num</th>
<th>Severe.pc</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-69</td>
<td>101</td>
<td>62</td>
<td>52</td>
<td>32</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>70-74</td>
<td>157</td>
<td>63</td>
<td>75</td>
<td>30</td>
<td>17</td>
<td>7</td>
</tr>
<tr>
<td>75-79</td>
<td>244</td>
<td>57</td>
<td>133</td>
<td>31</td>
<td>51</td>
<td>12</td>
</tr>
<tr>
<td>80-84</td>
<td>349</td>
<td>57</td>
<td>196</td>
<td>32</td>
<td>67</td>
<td>11</td>
</tr>
<tr>
<td>85-89</td>
<td>318</td>
<td>54</td>
<td>194</td>
<td>33</td>
<td>77</td>
<td>13</td>
</tr>
<tr>
<td>90+</td>
<td>226</td>
<td>47</td>
<td>158</td>
<td>33</td>
<td>91</td>
<td>19</td>
</tr>
</tbody>
</table>

**Level of need for care**

Many of those with severe dementia, especially those over 85, have a combination of mental and physical problems. [91] On average, people with dementia live for seven or eight years after the problem has been first diagnosed, although there are wide individual variations [91]

The Dementia UK 2007 report [85] estimates that 63.5% of people with late onset Dementia (aged 65 years and over) live in private households (the community) and 36.5% live in care homes. Applying these percentages to current Medway estimates, suggests that about 1,590 people with dementia are living in the community and 932 in care homes.
Another way of understanding the level of need for care is to use the concept of “interval of care” [92] developed for use with older people.

Using these classifications the table below shows the number of people in Medway aged 65 and over currently in these groups.

**Table 1: Care intervals [93]**

<table>
<thead>
<tr>
<th>Care interval/description</th>
<th>Requirement</th>
<th>Proportion of people with dementia</th>
<th>Number of people in Medway</th>
</tr>
</thead>
<tbody>
<tr>
<td>critical (critical interval)</td>
<td>constant care or supervision needed</td>
<td>34%</td>
<td>858</td>
</tr>
<tr>
<td>substantial (short interval)</td>
<td>care needed at regular intervals during the day for dressing, meals etc</td>
<td>48%</td>
<td>1211</td>
</tr>
<tr>
<td>Care Level</td>
<td>Frequency</td>
<td>Number</td>
<td></td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-----------</td>
<td>--------</td>
<td></td>
</tr>
<tr>
<td>Moderate (long interval) care</td>
<td>11%</td>
<td>278</td>
<td></td>
</tr>
<tr>
<td>Low (independent) care considered</td>
<td>6%</td>
<td>151</td>
<td></td>
</tr>
</tbody>
</table>

**Carers needs**

- Many of the carers of older people with dementia are themselves fairly old.
- Carers of people with dementia generally experience greater stress than carers of people with other kinds of need, nearly one-half having some kind of mental health problem themselves.

As can be seen above the majority of people living with dementia live at home. Supporting carers needs is essential if this situation is to continue especially as number of people with dementia increase.

**Current services in relation to need**

**Primary care**

The number estimated for the registered population for Medway CCG is 2,783. Data from the Quality and Outcomes Framework primary care dementia registers in 2012/13 have only identified 1,332 patients in Medway as having dementia. The estimated diagnosis rate for Medway CCG population is 47.87%, which is higher than the Kent and Medway average of 42.94% and the South of England average of 45.65%. The diagnosis rate has fewer than half of the population who are estimated to have dementia receiving a diagnosis. This could be due to a number of factors including late presentation and underdiagnoses. Nationally late diagnosis has been recognised as a problem and earlier diagnosis could be more cost effective in that it could slow progression of the disease and reduce costs. There are a number of actions being undertaken to improve the diagnosis rate. These include:

- Medication analysis — using Audit Plus to identify patients who have been prescribed dementia medication but who do not have a recorded diagnosis
- Coding cleansing — based on work undertaken at Waltham Forest CCG to support GPs to identify problems in coding, which are contributing to low rates of dementia diagnosis on practice registers.
- Care Home Population analysis — Liaison with care homes to identify residents who clearly have dementia and liaise with practices to check that formal diagnoses have been made.

The central role of GPs is recognised in the Dementia Strategy and initiatives are being developed to develop a greater understanding and awareness of the importance of early diagnosis, treatment and providing patients and carers with meaningful information about care and support services that are available through the NHS, Adult Social Care and the independent sector.

An overriding approach adopted by the Dementia Strategy will see integration with the CCG’s key clinical strategies and the Partnership Commissioning themes within the
Better Care Fund. Knitting together the various strands that make up the communities complex needs is vital to ensuring those needs are met.

Statutory services are trying hard to work together to ensure that the services they provide offer people a coherent pathway as their dementia illness develops and needs become more complex. Most people will approach their GP when they feel that something is not right and support is being provided to local Practices to help Doctors and other professionals gain a better understanding of dementia and the importance of obtaining an early diagnosis.

Secondary care

Medway Foundation Trust have made dementia the focus of much work in the last year and opened the dedicated Bernard unit to support people with dementia whilst they receive treatment. The Trust has also adopted the Butterfly scheme which allows people with memory impairments to request a particular person centred approach to their care – this operates throughout the hospital. In addition to these initiatives dementia awareness training for staff working in the hospital has also been given a priority.

Kent and Medway NHS and Social Care Partnership Trust (KMPT) take referrals from GPs where there is an indication of a dementia disease and support people through an assessment process with both pre and post diagnostic counselling as part of their memory assessment service. This support is provided through a multi-disciplinary team which includes Admiral Nurses, who are mental health nurses that specialise in dementia. KMPT provide on-going support and guidance with the aim of working in a shared care approach with a person’s GP.

Community care

Current services to support people living with dementia are wide and varied but are not always known about and those that operate in one area may not be present in another. There are dementia cafes run by voluntary sector organisations that provide an opportunity for those people with dementia and their carers to come together in an informal setting for mutual support and guidance. Organisations such as the Alzheimer’s Society, Age Concern and the Sunlight Trust provide valuable support by telephone and face to face to help people deal with daily lives that are affected by dementia.

Medway Community Healthcare (MCH) provide community based services and are registered to run Darland House a specialist residential facility providing nursing care to older people with mental health needs which are predominantly associated with dementia. Darland House offers people with complex needs an opportunity for careful assessment and for care plans to be developed that will help people live with needs that are often felt as very challenging to less specialist facilities.

Medway Community Healthcare (MCH) provide a Dementia Support Service with a multidisciplinary team lead by an Admiral Nurse which responds to and works to prevent crises that might occur in people’s homes where the main support for a person with dementia is being provided by a carer. It is the aim of the service to avoid, where possible and appropriate, an admission to hospital or care home. A move away from a familiar setting can be a highly traumatic experience which may exacerbate a decline in the person’s wellbeing. Where a person is admitted to hospital it is important that where possible and appropriate that a return to home is arranged as early as possible.
and the hospital’s new Integrated Discharge Team will work with the Dementia Support Service and Adult Social Care to ensure this is achieved.

MCH are also overseeing a scheme that employs two Carer Support Coordinators from Carers First, with one being based with the Dementia Support Service in the community and the other based with the Integrated Discharge Team at Medway Maritime Hospital. This scheme provides support to carers to reduce the risk of crisis leading to avoidable hospital admissions or to support an earliest possible discharge.

Medway’s Council for Voluntary Service has been commissioned by Medway Council to achieve the following outcomes in the local area: Capacity Building; Co-ordination, Networking and Engagement; Encouragement and Development of Volunteering; Representation; Information, Support and Training

A crisis support team has provides 24/7 support for people in dementia and their carers in the home when this support is needed.

Residential care

Medway Community Healthcare (MCH) provide community based services and are registered to run Darland House a specialist residential facility providing nursing care to older people with mental health needs which are predominantly associated with dementia. Darland House offers people with complex needs an opportunity for careful assessment and for care plans to be developed that will help people live with needs that are often felt as very challenging to less specialist facilities.

In Medway, there are twelve independent sector nursing homes registered with the Care Quality Commission and most of these will support older people many of whom are likely to have varying degrees of dementia. However there are few dedicated nursing homes providing care to people with complex and often challenging needs arising from their dementia. A pilot scheme will provide these homes with additional support through a multi-disciplinary team in the form of the Integrated Care Home Model. The aim of this scheme is to support homes to achieve an equal and improved standard of care and reduction on secondary care services.

Acute inpatient care at Medway Foundation Trust

A psychiatric liaison team is in place at Medway Maritime Hospital who are also able to support appropriate management of Emergency Department attenders and inpatients with dementia. MFT and KMPT are currently developing a dementia pathway within Enhancing Quality Programme. This will include appropriate screening on entry during any stay and onward referral into dementia services and/or primary care or a return home with additional support services.

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

The most significant challenge with respect to the provision of dementia care is the increase in the ageing population over the next 20 years. The graph below illustrates the expected growth.
Figure 1: Trends in estimated number of people living in Medway with Dementia aged 65 years and over [90]

Table 1: Trends in estimated number of people living in Medway with Dementia aged 65 years and over [90] Please note, figures may not sum due to rounding

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2017</th>
<th>2022</th>
<th>2027</th>
<th>2032</th>
<th>2037</th>
</tr>
</thead>
<tbody>
<tr>
<td>Females</td>
<td>1629</td>
<td>1798</td>
<td>2056</td>
<td>2495</td>
<td>2904</td>
<td>3359</td>
</tr>
<tr>
<td>Males</td>
<td>893</td>
<td>1068</td>
<td>1304</td>
<td>1583</td>
<td>1916</td>
<td>2224</td>
</tr>
<tr>
<td>Persons</td>
<td>2522</td>
<td>2866</td>
<td>3360</td>
<td>4078</td>
<td>4820</td>
<td>5583</td>
</tr>
</tbody>
</table>

Notes: Age-sex prevalence estimates have been taken from Dementia UK 2007 report produced for the Alzheimer's society by King's College London and the London School of Economics. The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers of people predicted to have dementia.
Between 2012 and 2037, the number of older people living in Medway with Dementia is expected to increase from approximately 2,500 to 5,600. This is driven by projected changes in the age structure of the population.

Using the information in previous sections the proportions of the population expected to have mild, moderate or severe dementia the following table illustrates the expected changes over the next 25 years.

Table 2: Trends in estimated number of people living in Medway with Dementia aged 65 years and over by level of severity [90] [85]

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2017</th>
<th>2022</th>
<th>2027</th>
<th>2032</th>
<th>2037</th>
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<tbody>
<tr>
<td>Mild</td>
<td>1387</td>
<td>1576</td>
<td>1848</td>
<td>2243</td>
<td>2651</td>
<td>3071</td>
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<tr>
<td>Moderate</td>
<td>807</td>
<td>917</td>
<td>1075</td>
<td>1305</td>
<td>1542</td>
<td>1787</td>
</tr>
<tr>
<td>Severe</td>
<td>328</td>
<td>373</td>
<td>437</td>
<td>530</td>
<td>627</td>
<td>726</td>
</tr>
<tr>
<td>Total</td>
<td>2522</td>
<td>2866</td>
<td>3360</td>
<td>4078</td>
<td>4820</td>
<td>5583</td>
</tr>
</tbody>
</table>

Notes: These predictions are based on prevalence rates in a report by Eric Emerson and Chris Hatton of the Institute for Health Research, Lancaster University, entitled Estimating Future Need/Demand for Supports for Adults with Learning Disabilities in England, June 2004. The authors take the prevalence base rates and adjust these rates to take account of ethnicity (i.e. the increased prevalence of learning disabilities in South Asian communities) and of mortality (i.e. both increased survival rates of young people with severe and complex disabilities and reduced mortality among older adults with learning disabilities). Therefore, figures are based on an estimate of prevalence across the national population; locally this will produce an over-estimate in communities with a low South Asian community, and an under-estimate in communities with a high South Asian community.

This means there will also be an increase in the number of older people with learning disabilities which will also affect the need for services.

‘Department of Health (2009) Living Well with Dementia: a national dementia strategy’: This strategy provides a strategic framework within which local services can; deliver quality improvements to dementia services and address health inequalities relating to dementia; provide advice and guidance and support for health and social care commissioners and providers in the planning, development and monitoring of services provide a guide to the content of high-quality services for dementia.

‘Department of Health (2013) Dementia: A state of the nation report on dementia care and support in England’: This Dementia report, with its accompanying map of variation, available at http://dementiachallenge.dh.gov.uk/map/, shines a light on the quality of dementia care in England. The very best services are excellent and show what is possible. But the worst show that we still have some way to go. The message is clear: we can and must do better.
‘Dementia Challenge (2012)’: The Prime Minister’s Dementia Challenge launched in March 2012. It sets out plans to go further and faster in improving dementia care, focusing on raising diagnosis rates and improving the skills and awareness needed to support people with dementia - and their carers. It also has details of plans to improve dementia research.

‘Dementia Partnerships (2012)’: Dr Edana Minghella, proposes a new understanding of the dementia journey and a revised model of care for dementia, aimed at improving experiences and outcomes, and informing service redesign and commissioning.

‘The Prime Minister’s Challenge on Dementia (2012): delivering major improvements in dementia care and research by 2015: Annual report of progress’: The progress of the Dementia Challenge is overseen by three groups of ‘champions’. This is their latest progress report.

‘NICE/Social Care Institute for Excellence (2006) CG42 Dementia: supporting people with dementia and their carers in health and social care’: This guideline makes recommendations for the identification, treatment and care of people with dementia and the support of carers. Settings relevant to these processes include primary and secondary healthcare, and social care. Wherever possible and appropriate, agencies should work in an integrated way to maximise the benefit for people with dementia and their carers.

‘NICE (2010) End of life care for people with dementia: commissioning guide: implementing NICE guidance’: This commissioning guide has been developed to help support the local implementation of NICE clinical guidelines to commission integrated end of life care services for people with dementia. The guide makes the case for commissioning end of life care for people with dementia, highlighting key benefits.


‘SCIE (2012) End of life care for people with dementia living in care homes’: This research briefing is about the care provided in care homes to people with dementia in the period leading up to the end of their lives. It aims to provide an overview of a range of issues important to care home residents, carers and providers.

‘Alzheimers Society (2011) Optimising treatment and care for people with behavioural and psychological symptoms of dementia’: This best practice guide was developed in consultation with an advisory group of leading clinicians specialising in dementia. It is aimed at a wide range of health and social care professionals caring for people with dementia who have behavioural and psychological symptoms to provide evidence-based support, advice and resources.

‘Dementia Partnerships (2014) Dementia: 10 key steps to improving timely diagnosis’: This Briefing is designed to support GPs and primary health care teams to improve the recognition, diagnosis and management of dementia.

**Pharmacological Interventions**

There are no drug treatments available that can provide a cure for Alzheimer’s disease. Although there are medicines have been developed that can improve symptoms, or
temporarily slow down their progression. Medicines will not be effective for all individuals though. The brains of people with Alzheimer’s disease show a loss of nerve cells that use a chemical called acetylcholine as a chemical messenger. The loss of these nerve cells is related to the severity of symptoms that people experience. Donepezil, Rivastigmine and Galantamine prevent an enzyme known as acetylcholinesterase from breaking down acetylcholine in the brain. Increased concentrations of acetylcholine lead to increased communication between the nerve cells that use acetylcholine as a chemical messenger, which may in turn temporarily improve or stabilise the symptoms of Alzheimer's disease.

**Non-Pharmacological Interventions**

An increasing number of non-pharmacological therapies are now available for people with dementia. These include standard therapies such as behavioural therapy, alternative therapies such as art or music therapy and brief psychotherapies such as cognitive behavioural therapy[94]. Each approach is rarely used in isolation, therefore a combination of treatments tailored to the individual requirements of the patient may be necessary.

**Receiving and early diagnosis**

Obtaining an early diagnosis enables a person with dementia and their family to receive help in understanding and adjusting to the diagnosis and to prepare for the future in an appropriate way. This might include making legal and financial arrangements, changes to living arrangements, and finding out about aids and services that will enhance quality of life for people with dementia and their family and friends. Early diagnosis can allow the individual to have an active role in decision making and planning for the future while families can educate themselves about the disease and learn effective ways of interacting with the person with dementia. There is evidence that the currently available medications for Alzheimer’s disease may be more beneficial if given early in the disease process[95]. These medications can help to maintain daily function and quality of life as well as stabilise cognitive decline in some people. Early diagnosis allows for prompt access to medications and medical attention.

**Dementia Friendly communities**

A dementia-friendly community is one in which people with dementia are empowered to have aspirations and feel confident, knowing they can contribute and participate in activities that are meaningful to them. Many villages, towns and cities are already taking steps towards becoming dementia-friendly communities. One area that has successfully utilised this model is Motherwell in Scotland. It has involved working with shop assistants, public service workers, religious groups, businesses, police, transport and community leaders.

Outcomes have been positive and included a range of activities undertake to increase community awareness of dementia including; promotional materials being distributed widely throughout the town, a successful Football Memories event held at Motherwell FC, awareness sessions with local fire fighters, Training of police officers and arrangement with Boots to distribute Alzheimer Scotland helpline cards.
User Views

In March 2012 a report was produced for Medway LINK by Lake Market Research. The executive summary of this report identifying the four key themes coming out of this report is inserted below. The report attempted to ascertain views of carers, providers and people with dementia but struggled to access views from people with dementia. 14 Medway carers were interviewed as part of this work and 10 providers of care. The findings from the report remain relevant and are being tackled by the development of the Dementia Strategy.

There are some strong themes emerging from this piece of research which were echoed by both carers and providers:

1. A lack of continuity throughout the dementia journey from diagnosis to end of life
2. Services fragmented - too many different services not working together
3. Greater professional understanding and awareness with more personalised care / attention to those with dementia
4. More public awareness about dementia and reducing the stigma associated with the disease.

1. A lack of continuity throughout the dementia journey from diagnosis to end of life

The general consensus here, amongst carers and providers, is that the services on offer are not consistent and do not adapt as the condition worsens. Post diagnosis people generally felt that the services were adequate and it was possible to cope, however this was more to do with the condition being relatively early in its stages and therefore much easier psychologically and physically to access the services on offer. Furthermore with the sufferer being more aware this meant the effectiveness of the service was higher and there was less demand on the carer. As the condition worsened, the general feeling was that it became more difficult to access the types of services which would have made a difference. Furthermore, in the later stages people felt there was limited emergency help and advice twenty four/seven and that practical help is sometimes needed at all times, to quote “dementia is not 9.00am to 5.00pm”.

An extension to this theme addressed early onset dementia. Those with this condition often fell into “no man’s land” because they were not considered elderly enough to access some of the dementia services on offer to them, or the services on offer were not appropriate due to the age of the person.

“There appears to be a need to address the gap in service provision from early stages to later stages when the condition is more demanding as well as age considerations in terms of younger people getting dementia and offering services more appropriate for their age”.

2. Fragmented - too many different services not working together

Both carers and providers felt that there were lots of services out there but that none of them were joined up. This results in confusion because people are either passed from pillar to post or they don’t know where to start asking for help. The variety of services available is not the issue; it is the lack of communication between them which makes
the process patchy. It does not necessarily matter where the person enters the system, as long as that person knows to pass them onto the most appropriate service. Alternatively, people felt there should be a central office / contact that can then refer them onto the most appropriate service or individual.

Ambivalence can be seen in some of the scoring of the provision of dementia services locally, with scores hovering around the midpoint and tipping slightly towards dissatisfaction. This seems to be more associated with the process one has to go through to get into the system, rather than the quality of the service itself once you are there.

“More co-ordinated provision of services is needed - a central office or greater communication between services to guide carers / people with dementia through the system to the most appropriate service”.

3. Greater professional understanding and awareness with more personalised care / attention to those with dementia

Overall, people felt more training was needed amongst professional staff across the board, this included hospital staff, doctors and care staff. As an example, a person may require medical attention that is separate to their dementia illness and often carers felt the staff did not recognise or understand that a dementia patient will act differently to patients who do not have dementia on the ward. In addition to this, people felt dementia care cannot be generalised; it needs to be specific to the person who has dementia.

“More recognition of dementia within the professional environment and greater understanding of behavioural changes. Provision of services which offer more personalised activities tailored to individuals rather than generalised day centres to cater for all. Clearly this needs to be balanced with the feasibility of bespoke servicing but a greater understanding of the disease could highlight the benefits of providing more stimulating social activities and improving the quality of life for both carer and patient”.

4. More public awareness about dementia and reducing the stigma associated with the illness

There still appears to be a stigma associated with dementia which influences the effectiveness of the services on offer because people are not yet willing to admit they need help or their loved one needs help. Coupled with this, there is limited knowledge of the condition which makes it a daunting prospect to tackle and often problems are kept hidden as a result.

There is also a sense of determination to just “get on and cope with it”; that it is “part and parcel” of one’s commitment to their loved one to care for them. Whilst this is commendable, it seems people cope until it reaches crisis point and then it starts to break down. Acceptance of help earlier on could go some way to preventing it reaching this stage which would require a change in people’s perception of dementia and recognition that these services are there to enhance the quality of life for both them and their loved one.
Unmet needs and service gaps

1. Between 2012 and 2037, the number of older people living in Medway with Dementia is expected to increase from approximately 2,500 to 5,600. This is driven by projected changes in the age structure of the population. This will represent a huge challenge as current services will have to nearly double in capacity if in their present form or different approaches will need to be found. 45% of these will be likely to have moderate to severe dementia.

2. Development of a clearly described integrated care pathway for dementia would assist both people living with the condition and professionals supporting people to access services without increasing the stresses and anxieties already likely to be present in people's lives.

3. Current under-reporting in primary care (which is an issue nationally) and variation in primary care in quality of dementia care needs to be addressed to improve early diagnosis and intervention.

4. Improving professional understanding and appropriate management of dementia is an ongoing need. This is the case for all health and social care professionals, including doctors, care staff and acute hospital staff.

5. There is still stigma associated with dementia which means that people may be reluctant to seek help for themselves or their loved ones. Further campaigns (e.g. Dementia Friends) to change public perception and reinforce the importance of early diagnosis need to be supported locally.

6. 24/7 practical support to carers needs to be further developed to ensure that people living with dementia are supported to remain in their own homes for as long as possible and for any admissions to acute settings can be as short as possible.

7. Local stakeholder events have indicated that some support services are working well but there is a need for more support to carers, better information, earlier diagnosis but with additional support, clear pathways to services and better integration and coverage of what is available to ensure equality of opportunity across Medway. The absence of services for people with a learning disability who also develop a dementia illness was highlighted as a significant issue.

Recommendations for Commissioning

- The aims of the Dementia Strategy are being developed to take into account the growing needs within the Medway population and in recognition of changing priorities within health and social care. The Dementia Strategy when complete should inform commissioning activity on behalf of both Adult Social Care and the CCG.

- Public awareness about dementia and its effect on people's lives should be the focus of attention within the community of Medway and the creation and support of a local Dementia Action Alliance is seen as the most effective way of becoming a dementia friendly community.
• The role of the GP is central to meeting people’s needs and there should be a continued development of understanding for the importance of early diagnosis, treatment through medication, and the care and support that is available through social care services including those provided by the independent sector.

• The role and importance of the ‘carer’ should be incorporated into the Strategy and supported by the commissioning options selected for implementation. A focus of attention will need to be given to ensuring that services are available to avoid and manage crises that might lead to avoidable hospital or care home admissions.

• The Dementia Strategy should set out in the form of clear pathways the journey that people with a developing dementia disease are expected to take. Together with clear pathways there is a need to develop ways that information, guidance and support can be understood and available in easy to understand formats. Options being considered for practitioner and patient signposting should continue to be explored.

• Achieving a dementia friendly community is one where people living with dementia can do so in a way that promotes a sense of value and ability to make a continued meaningful contribution to the community. The strategy will need to be developed from an understanding of the needs and aspirations heard from listening carefully to people living with dementia, both the person with the condition and their carers.

• To ensure services provide quality at each point on a person’s dementia journey, support and development will be necessary within the care home sector.

Recommendations for needs assessment work

• Further research in relation to support and information needs of BME groups in relation to dementia and the resource implications of dementia prevalence in older people with learning disability.

• Further research is also required around the dementia needs and the effects on personal identity for Lesbian, Gay, Bisexual and Transgender (LGBT) populations.

Dental health in adults

Summary

Oral health refers to the condition of gums, teeth, surrounding bone and soft tissues of the mouth enabling function and being free of disease and pain. Although oral health in England has improved significantly over the past 30 years, not all have benefited from these improvements. According to the national Adult Dental Health Survey of 2009/10, one in five South East Coast adults has untreated tooth decay, most of whom are likely to be from lower socio-economic backgrounds. In addition, some 7% of adults reported experiencing some pain from their teeth or gums at the time of the survey. A significant minority of older adults also suffer from gum disease.
Tooth decay is largely preventable. The risk factor is a frequent and high sugar diet, which is also common to diabetes and obesity. The availability of topical fluoride such as in toothpastes, varnishes and mouth rinses helps to prevent tooth decay.

**Key issues and gaps**
- Inequality in uptake of primary care dental services
- Current available data suggest 20% of adults in South East Coast have active tooth decay and 25% of older adults have severe gum disease, with 7% reporting pain
- The need for specialist dental services needs to be reviewed.

**Recommendations for consideration by commissioners**
- Promote orientation of primary care dental services to focus on prevention in line with Delivering Better Oral Health — a toolkit for prevention (Department of Health, 2009)
- Improve uptake of services by local residents through provision of information to support uptake
- Improving access to specialist services
- Promote development of an appropriate skills–mix workforce in order to meet the dental needs of the population effectively and efficiently
- Review the provision of domiciliary services according to evolving need
- Develop oral health promotion initiatives for the elderly and other vulnerable adult groups
- Develop stronger links between dental services and quit smoking services
- Robust, annual monitoring and evaluation of dental practices

**Who is at risk and why**
Marked inequalities in oral health are evident, with people living in areas of material and social deprivation having much higher levels of tooth decay. They are more likely to have high and frequent sugar diets and less likely to brush their teeth. Vulnerable groups of society such as those with a learning disability and mental illness also have poorer oral health.

Other groups at risk include people in long–term institutional care (such as residential homes, psychiatric hospitals and prisons), homeless people and some refugee and asylum seeker groups. Some minority ethnic groups more likely to be living in areas of disadvantage may encounter language and cultural barriers to accessing care and advice.

Young men from semi–skilled or unskilled manual backgrounds are less likely to use dental services in the transition from childhood to adult life. Expectant mothers and nursing mothers require special consideration. Elderly people living in residential care tend to have a poorer diet than those living in their own homes. Other vulnerable
groups include people requiring palliative care and people undergoing chemotherapy, radiotherapy or a bone marrow transplant.

**Level of need in the population**

Dental need may be estimated from the latest national Adult Dental Health Survey undertaken in 2009/10.[96] The findings indicate that oral health has improved significantly over the past few decades; for example, 6% of adults were assessed as having no natural teeth in 2009/10 compared to 28% in 1978 (Figure 1). However, as people retain their teeth for longer, the potential for dental diseases increases and the need for maintenance can be substantial. In 2009/10, one in five adults in the South East Coast SHA has active tooth decay and may need fillings, and over two in ten of those aged 55 years and older have severe gum disease that requires periodontal treatment.

![Figure 1: Oral health of adults in the South East Coast SHA compared to the England population. *LOA=loss of attachment, PUFA=pain, ulceration, fistula or abscess.[96]](image)

The findings of the Medway Adult Oral Health Survey 2009 provide a local indication of dental need. In Medway, the proportion of adults with at least one tooth was higher than in England but the proportion with 21 or more teeth was lower, i.e. there may be more people with teeth but the number of teeth present may not be adequate to enable acceptable social functioning.

A significant 7%, compared to 10% for England, reported experiencing pain from their teeth or gums at the time of the national survey. Current pain was less common in the South East Coast although pain in the last 12 months was more prevalent. It is likely that people who experienced pain in the last 12 months had been able to access services for pain relief and therefore did not experience current pain. Medway adults were more likely than South East Coast adults to report having pain in the past 12 months.

Experience of dental restorations was similar between South East Coast and England. However, in Medway the proportion having restorations was lower, as was the number of teeth filled or crowned. This comparison is made with caution as the England data were collected clinically whereas the Medway data were self-reported.

Most adults brushed their teeth at least twice a day. The England ADHS reported that two in ten were current smokers, whereas in the Medway Adult Oral Health Survey, the prevalence of smoking was over 30%. Within Medway, smoking was more prevalent in Chatham, a recognised risk factor in incidence of oral cancer.

Most adults visited their dentists regularly for check–ups, but a significant minority visited only when in trouble. In Medway a relatively high proportion had never been to the dentist. Among those who had not visited the dentist in the past two years, three in ten in the South East Coast had difficulties finding a dentist.
**Current services in relation to need**

Most NHS dental services are provided in the primary care setting. Dental services are commissioned geographically, but individuals may access any dentist they wish. Since the introduction of the new dental contract in 2006, primary care dental services have been procured in areas of need as identified in PCT’s oral health needs assessments (OHNAs). There is some variation in commissioned dental activity across Kent and Medway, however the activity commissioned in Medway is relatively higher than in neighbouring PCT areas. In Medway, 1.9 Units of Dental Activity (UDA) is commissioned per resident compared to 1.2 UDAs per resident in West Kent.

The use of dental services as measured by numbers of patients seen as a proportion of the population also suggests that Medway is relatively well served compared to neighbouring areas (Figure 1). For example, NHS dental access in Medway is higher than in West Kent. In the 24 months previous to 31 March 2011, the number of patients treated in Medway represented 70% of the Medway adult population (Figure 1). In Medway, there is generally good availability of services however the challenge in Medway is mainly uptake of services. Uptake of services may be improved by raising awareness and improving the information available about the provision of services.

**Figure 1: Dental access of residents in the South East Coast PCTs**

**Projected service use**

Although oral health of adults is improving, there remain social and geographical inequalities in its distribution. Due to falling disease patterns and growing reluctance to have extractions and dentures, people are keeping their teeth longer. This may mean that there are more teeth at risk of decay and large numbers of heavily restored teeth which need expensive long term maintenance by dental services.

In the report NHS Dental Services in England (2009)[97], Steele recognises the difficulty accessing an NHS dentist is a localised issue, but where it exists it is severe. Improving future capacity is a priority, but this alone will not lead to improved access. Empowering patients with information on how to access dental services through social marketing and ensuring the services are of a high quality are also essential.

Population projections in Kent and Medway suggest dramatic increase in the elderly population. By 2020, 21% of the local population will be over 65 years, which suggests a high service need for dental care for this age group, and very likely a need for more complex maintenance care because of replacement of existing restorative work. There will be an increase in patients who are housebound or in residential care, meaning an increased need for domiciliary dental services.

**Evidence of what works**

Valuing People’s Oral Health provides guidance on the development of services for those with a disability (Department of Health, 2007).

Dental recall: Recall interval between routine dental examinations provides guidance on the recall of dental attendance based on individual risk (NICE, 2004)

Unmet needs

Although oral health of adults in Kent and Medway has improved, services are needed for those with active tooth decay and older adults with severe gum disease. Additionally, dental access rates are variable across Kent and Medway. Further capacity is needed in some areas, and action is needed to promote equitable access to dental services.

The changing patterns of dental disease distribution, with older adults experiencing more disease compared to younger adults, means the need for services that are appropriate for complex dental need in those who are likely to be medically compromised and unable to leave their homes because of immobility. Young adults will need prevention services in order to maintain their level of oral health. There is therefore a need to develop specialist or special care dental services in the community setting.

Recommendations

- Promote orientation of primary care dental services to focus on prevention in line with Delivering Better Oral Health — a toolkit for prevention[98]
- Improve uptake of services by local residents through provision of information to support uptake
- Improve access to specialist services
- Promote development of an appropriate skills–mix workforce in order to meet the dental needs of the population effectively and efficiently
- Review the provision of domiciliary services according to evolving need
- Develop oral health promotion initiatives for the elderly and other vulnerable adult groups
- Develop stronger links between dental services and stop smoking services
- Robust, annual monitoring and evaluation of dental practices

Further needs assessment

- Dental need of adults with a disability that limits their mobility
- Dental need of older adults in residential and care homes
Diabetes

Summary

Diabetes is a disease in which the amount of glucose in the blood is too high because the body cannot use it properly. There are two main types of diabetes:

• Type 1 diabetes — where the body fails to produce insulin, accounting for 10% of people with diabetes

• Type 2 diabetes — where the body cannot produce enough insulin and is resistant to what is produced, accounts for the remaining 90% of people with diabetes.

Type 2 diabetes is often associated with being overweight and usually appears in people over 40, or over 25 in south Asian and African Caribbean people. More recently, a greater number of children are being diagnosed with Type 2 diabetes.

Diabetes can have profound effects on health. People with diabetes are at increased risk of developing various forms of cardiovascular disease (e.g. angina, heart attacks, heart failure, strokes, pain in the legs on walking and foot ulcers that may result in the need for amputation).[99] Approximately 75% of people with diabetes develop cardiovascular disease. Prolonged exposure to raised blood glucose levels can also damage the eyes, kidneys and nerves. Diabetes is the leading cause of blindness in people of working age, the largest single cause of end stage renal failure and the second most common cause of lower limb amputation. This places a significant burden on health and social services.

Life expectancy is reduced, on average, by more than 20 years in people with Type 1 diabetes and by up to 10 years in people with Type 2 diabetes.[99]

Key issues and gaps

• Diabetes is on the increase in Medway. This might be explained by the increasing prevalence of obesity and an ageing population.

• There are over 14,065 adults aged over 17 (6.3%) known to have diabetes in Medway (QOF March 2011)

• By 2030, it is estimated that over 19,000 will have diabetes in Medway. Most of these cases will be Type 2 diabetes mainly because of our ageing population and the rising numbers of people who are overweight or obese

• Proportion of people with diabetes receiving all 9 care processes

• There is variation in the management of diabetes in primary care

• Care for adults with Type 1 on insulin pump is patchy

• Information on the provision of diabetes services for children and young people

• Information is on the provision of diabetes services for women with gestational diabetes
**Recommendations for Commissioning**

Commissioning plans for all services for people with diabetes should include:

- The projected growth in the number of people with diabetes

**Prevention and early intervention**

- Proactively identify people with undiagnosed diabetes and promote timely and appropriate access to services
- Address increasing incidence of diabetes by targeting high risk groups, promoting prevention, and increasing detection
- Continue the roll out of Health Checks Outreach programme focusing on men and young age groups. The early detection and active management through the NHS Health Check, tackling: obesity, smoking, poor diet, blood pressure and physical activity should contribute towards prevention of diabetes.
- Raise public awareness of diabetes and the importance of the screening programme and ensure the service is commissioned to provide at least 80% screening uptake and that appropriate activity is commissioned in secondary care for ongoing treatment and monitoring of people with diabetic eye disease

**Primary care and Community services**

- Implement agreed local pathways for patients’ care that would reduce fragmentation and delay
- Ensure appropriate training and education for health professionals
- Ensure structured integrated care between primary care, community, acute care and self management
- Addressing the variations in clinical outcomes between practices will contribute to the reductions in complications and related hospital admissions
- Review prescribing of drugs for diabetes with a view to discouraging excess prescription of the newly available drugs for diabetes
- Ensure the provision of a seamless personalised patient centred care plan

**Hospital services**

- Review current service provision for children, young adults and pregnant women
- Review the commissioning of insulin pumps

Diabetes is becoming more common in all age groups including children and young people. Type 1 diabetes is not preventable, but Type 2 diabetes is linked with behavioural factors such as being overweight and physically inactive.

The small but increasing number of children developing Type 2 diabetes at a very early age is linked to their weight and physical inactivity. The maps below show the findings...
from the National Child Measurement Programme 2009/10. Areas in red indicate places in Kent and Medway, where children are above the South East Coast average for being overweight or obese.

Figure 1: Proportion of pupils in reception year classified as ‘Obese or Overweight’ in National Child Measurement Programme 2009/10 by electoral ward in Kent and Medway compared with south east region average

Figure 2: Proportion of pupils in year 6 classified as ‘Obese or Overweight’ in National Child Measurement Programme 2009/10 by electoral ward in Kent and Medway compared with south east region average

It is estimated that 31.4% of adults living in NHS Medway were obese in 2006–08. This is statistically significantly higher than the whole of England (25%).[100] People living in more deprived neighbourhoods in England are 56% more likely to have diabetes than those in the least deprived areas.

There is good evidence that lifestyle changes can reduce the risk of progression to Type 2 diabetes in overweight people with impaired glucose tolerance.[101] Once diabetes is present, good management of blood sugar levels and blood pressure can reduce the risk of complications.

The main risk factors for developing Type 2 diabetes are:

**Age**

The risk of developing Type 2 diabetes increases with age; most cases of Type 2 diabetes develop in people aged over 40. Currently 47% of the population of Medway are aged 40 or over; this is projected to increase to around 51% by 2030. The proportion of the population aged over 65 is predicted to increase from 13.6% to 20.3% by 2030. This means that a greater proportion of the population of Medway will be at risk of developing diabetes.

**Ethnicity**

Type 2 diabetes is up to six times more common in people of South Asian descent and up to three times more common in those of African and African-Caribbean descent, compared with the white population. These groups are likely to develop the condition at a younger age. It is also more common in people of Chinese descent and other non-white groups.[99]

**Weight**

Over 80% of people diagnosed with Type 2 diabetes are overweight. The more overweight and the more inactive a person is, the greater their risk of developing diabetes. Information on the prevalence of obesity in Medway and levels of physical activity are presented in the healthy weight section (Appendices —> Background papers: Lifestyle and wider determinants —> Healthy weight).

**Waist Circumference**

The greater the waist circumference, the higher the risk of developing diabetes. For women, a waist measurement of 80cm (31.5in) or more confers an increased risk. Amongst men, a waist circumference of 94cm (37in) or more gives an increased risk of
developing diabetes; this figure is lower for Asian men where a measurement of 90 cm (35 in) or more confers increased risk.[102]

**The level of need in the population**

**Prevalence**

Table 1 shows an increasing trend in the number of people diagnosed with diabetes in Medway, the South East Coast SHA and England as a whole.

*Table 1: General Practice recorded Diabetes prevalence (patients aged 17 years and over) [103]*

<table>
<thead>
<tr>
<th>Year</th>
<th>Region</th>
<th>Number</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006/07</td>
<td>Medway PCT</td>
<td>1037</td>
<td>5.0</td>
</tr>
<tr>
<td></td>
<td>Medway PCT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2007/08</td>
<td>Medway PCT</td>
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<td>5.3</td>
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<td></td>
<td>Medway PCT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008/09</td>
<td>South Coast SHA</td>
<td>1527</td>
<td>4.3</td>
</tr>
<tr>
<td></td>
<td>South Coast SHA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009/10</td>
<td>South Coast SHA</td>
<td>1631</td>
<td>4.5</td>
</tr>
<tr>
<td></td>
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<tr>
<td>2010/11</td>
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</tr>
<tr>
<td></td>
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<td></td>
</tr>
<tr>
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<td>2088</td>
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<tr>
<td></td>
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<tr>
<td>2010/11</td>
<td>England</td>
<td>2455</td>
<td>5.5</td>
</tr>
</tbody>
</table>

**Recorded and Expected prevalence**

Figure 1 shows the proportion of potentially undiagnosed people for each general practice in Medway.

*Figure 1: Recorded prevalence of Diabetes by general practice as at March 2011 [103] [104]*

The Long Term Condition modelling suggests that for people in Medway with a diagnosis of diabetes, 11,252 (80%) should be able to achieve blood glucose control (Table 2).

*Table 2: Calculated using APHO prevalence model which is adjusted for age, sex, ethnicity and deprivation [105]*
From QOF data, 6500 (46%) people have achieved glucose control, implying that 4,752 of the 5,326 poorly controlled patients would require additional support to achieve blood glucose control.

**Diabetes complications**

The complications of diabetes are the final outcomes of care. Of all aspects of diabetes they have the greatest costs to the patient and the health service. Complication prevalence is defined as the number of people who have had one or more records of a specific complication over the defined time period.

Diabetes is associated with a range of complications including eye and foot problems, heart attacks, angina, stroke, kidney disease, nerve damage, sexual dysfunction and short term complications such as hypoglycaemia or diabetes ketoacidosis.

These complications can lead to an increased need for secondary care (including, emergency services) and social care services. Diabetes data to support this are limited, mainly because the patient’s primary diagnosis or cause of mortality is a complication due to diabetes, so it is unlikely that diabetes will be diagnosed or coded. Therefore, only a small number of cases of complications are recorded with a primary diagnosis of diabetes (Figure 2).

Figure 2: Prevalence of Diabetic Complications [106]

**Hospital admissions for diabetes**

Between 91–93% of patients with diabetes are admitted as emergencies. Poor diabetes control further contributes to the need for emergency admissions. In Medway, non-elective admissions have remained persistently higher compared to elective admissions (Figure 3). This is because most admissions are for short term complications such as diabetic ketoacidosis and hypoglycaemia. This is consistent with the variation in inpatient activity: diabetes tool, which showed that more people in Medway with diabetes (48.8%) are more likely to be readmitted as an emergency after a period of care than those without diabetes. [107]

Figure 3: Trends in hospital admissions by admission method all ages (2006/07–2010/11 ) [108]

**Diabetes Retinopathy**

Diabetes retinopathy is the damage to the retina due to complications from the condition and it affects up to 80% of those who have had diabetes for 10 years or more.

**Table 3: Diabetic Retinopathy screening [109]**

<table>
<thead>
<tr>
<th></th>
<th>Medway PCT Percentages offered</th>
<th>Medway PCT Percentages uptake</th>
<th>South East Coast Percentages offered</th>
<th>South East Coast Percentages uptake</th>
<th>England Percentages offered screening</th>
<th>England Percentages uptake</th>
</tr>
</thead>
</table>
Between October 2009 and June 2011, the percentage of people with diabetes offered retinopathy screening in Medway PCT has remained consistently high and has been 100% for the past fifteen months. Over the same period, the percentage attending an appointment has shown a downward trend from 87% to 72%.

### Diabetes and psychological health

Depressive symptoms affect one in four people with diabetes and it is associated with poor outcomes, lower levels of self care, more days off work and significantly higher medical costs. This group may need significant psychological support. [110]

### Changes in need since last JSNA

- Increasing trend in diabetes prevalence: In 2010/11, 14,065 people with diabetes were registered with Medway GPs. An additional 2,503 people have been added onto the diabetes register since 2008/09, implying improved identification of people with diabetes as well as increasing trend in diabetes prevalence

- Establishment of an integrated diabetes service model: An integrated diabetes service is currently being developed for people with diabetes in Medway

### Current services in relation to need

The NHS guidance encourages commissioners and service providers (community services, GPs, secondary services, public health, social care and voluntary sector) to
agree local pathways for patient care to improve efficiency in care, reduce fragmentation of services and delay.[111]

**Primary care**

The majority of people with diabetes are managed in primary care. In general practice there is considerable variation between practices in the management of diabetes. Many people with Type 1 diabetes who can be managed in the community are being managed by the acute trust.

NHS Health Checks are offered through a Local Enhanced Service (LES) contract to all Medway General Practitioners to identify people at risk of heart disease, diabetes and stroke, supporting them in making healthier lifestyle choices and also identifying and treating those with undiagnosed conditions. Between 2010/11 to 2011/12, the programme probably accounted for a significant proportion of the 644 newly diagnosed patients with diabetes in Medway. An outreach Health Check programme was also set up to target those on job seekers allowance, people from Asian origin and manual workers, identified from the evaluation of the programme undertaken in 2010.

Evaluation of this programme showed that men and younger individuals within the target age group were less likely to attend. This suggests that, further work is required to increase awareness of the Health Check programme within the male and younger population aged 40–59 years.

**Community and Specialist Diabetes Service**

Adult specialist diabetes services in Medway are provided by both Medway NHS Foundation Trust (MFT) and Medway Community Healthcare (MCH). MFT provides a consultant led service with specialist nurse support for inpatients only. MCH provides a specialist nurse service. Both teams have access to podiatry and dietetic support. The care of patients provided between the community and hospital teams is not well coordinated however.

Patients requiring support from the diabetes specialist nurse in the community are referred to the consultant diabetologists at MFT. Currently, patients who need insulin pumps have to travel to London to receive this service.

**Structured Education Programme**

The PCT has developed a structured education programme for people newly diagnosed with Type 2 diabetes and for those with Type 1 diabetes. It is unclear how many people were seen in this programme, what proportion of them were newly diagnosed cases or what proportion were referred for dietetic support and advice in 2010/11.

**Diabetes Retinopathy Screening Programme**

The PCT commissioned Paula Carr Trust in April 2011 to deliver two main targets:

- 100% of people with diabetes aged 12 years and over offered screening, using only digital photography within the previous 12 months
- 80% uptake of screening
This service is offered from both static and mobile clinics in Medway and patients are referred to the service from GP practices. In Quarter 2, 2011/12, although screening was offered to all eligible patients, 81% attended the service. Uptake of this service has been on the decline since 2009. The service is working with GP practices to improve the accuracy of the screening list, promote the importance of eye screening and the key role of primary care in raising awareness amongst patients.

Podiatry services

All newly diagnosed patients have an initial assessment with a podiatrist. The recall of patients with diabetes is arranged by their GP surgery, where annual foot screening is undertaken. This will usually include: foot sensation testing, Doppler foot pulses, foot deformity and footwear inspection and foot risk assessment.

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

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medway</td>
<td>6.8%</td>
<td>7.4%</td>
<td>8.0%</td>
<td>8.5%</td>
<td>9.0%</td>
</tr>
<tr>
<td>South East Coast</td>
<td>7.2%</td>
<td>7.8%</td>
<td>8.3%</td>
<td>8.8%</td>
<td>9.4%</td>
</tr>
<tr>
<td>England</td>
<td>7.4%</td>
<td>8.0%</td>
<td>8.5%</td>
<td>9.0%</td>
<td>9.5%</td>
</tr>
</tbody>
</table>

The prevalence of diabetes in Medway in 2010 was estimated to be around 6.8% of the population aged 16 years and over. These estimates are modelled to take account of age, sex, ethnic group and deprivation and are, therefore, subject to a certain amount of uncertainty. For example, the 2010 figure is thought to lie somewhere between 4.9% and 9.8%. Therefore the differences in prevalence between areas in the table above are not statistically significant. By taking into account projected changes in the age structure of the population, combined with observed trends in obesity, the prevalence in Medway is expected to increase to 9% by 2030.

In contrast, the average prevalence of diabetes recorded by general practices in Medway is 6.3% (approximately 14,000 patients) as at March 2010 according to the Quality and Outcomes Framework which is limited to patients aged 17 years and over. This suggests that approximately 0.5% of the population have undiagnosed diabetes in comparison with estimates of the underlying prevalence in the table above.

Evidence of what works

National Service Framework for Diabetes 2001

Type 2 Diabetes Clinical Guideline: The management of Type 2 diabetes (update) 2008 Guidance 66 Guidance 43

NICE, primary prevention of Type 2 diabetes mellitus among high risk black and minority ethnic groups (in progress)
User views

A Health Care Commission survey in 2006 of patients with diabetes found that knowledge of their condition, self-management and involvement in care planning was inadequate.

Evaluation of the NHS Health Checks programme in 2011 showed that people were generally satisfied with the outreach Health Checks programme and would attend again when invited in 5 years time. A few (21%) said they would have preferred having a glucose test included as part of the screening test.

A stakeholder workshop was held on 11th March 2011, involving health care professionals and patient representatives. Some of the suggestions from the users were as follows:

- Improved staff education
- More and improved cross-boundary working
- Improved patient education (especially structured education)
- A high quality seamless diabetes service;
- Local access to insulin pump therapy for adults;
- Improved management of in-patient stays.

Following the workshop, two working groups (Primary Care Working group and the Specialist/Community Care Working Group) were set up to progress the establishment of an integrated diabetes service in Medway to meet the needs of people with diabetes.

The Medway Diabetes Strategic Change Group have incorporated the views of stakeholders in developing a proposal for the redesign of the local diabetes service towards the provision of an integrated and more efficient model.

There has been a drive to improve patient experience through better IT systems, developing and enhancing the use of Audit Plus in primary care, improving the use of patient choice and encouraging participation in the National Diabetes Audit.

Unmet needs and service gaps

- Undiagnosed people with diabetes and also the increasing prevalence of diabetes in Medway
- Variation in care provided in primary care
- Some newly diagnosed patients in Medway are undertaking a structured education programme, with only a small proportion of all patients with diabetes having been
on a structured education programme. According to NICE this should be offered to everyone with diabetes and their carers at the time of diagnosis and thereafter annually.[112]

- Inadequate provision of Insulin pumps for adults with diabetes
- Diabetes retinopathy programme- 28.5% did not attend their annual screening.
- There is currently no provision of psychological support for people with diabetes. NICE recommends that diabetes care teams should have appropriate access to mental health professionals to support them in assessment of psychological dysfunction and the delivery of psychological support[113] and psychological support for Type 2 diabetes, especially for those with complications such as erectile dysfunction and diabetes neuropathy.[114]
- There is limited information on the extent and quality of care planning for diabetes in Medway. Care planning involves clinicians and patients working together to support diabetes self management. This may include prior notification of test results to patients before their annual review to enable patients enough time to think about the questions they would wish to ask the GP.

**Recommendations for Commissioning**

Commissioning plans for all services for people with diabetes should include:

- The projected growth in the number of people with diabetes

**Prevention and early intervention**

- Proactively identify people with undiagnosed diabetes and promoting timely and appropriate access to services
- Address increasing incidence of diabetes by targeting high risk groups, promoting prevention and increasing detection
- Continue the roll out of NHS Health Checks outreach programme focusing on men and young age groups. The early detection and active management through the NHS Health Check, tackling obesity, smoking, poor diet, blood pressure and physical activity should contribute towards prevention of diabetes.
- Raise public awareness of diabetes and the importance of the screening programme and ensure the service is commissioned to provide at least 80% screening uptake and that appropriate activity is commissioned in secondary care for ongoing treatment and monitoring of people with diabetic eye disease

**Primary care and Community services**

- Implement agreed local pathways for patients’ care that would reduce fragmentation and delay.
- Ensure appropriate training and education for health professionals
- Ensure structured integrated care pathways between primary care, community, acute care and self management
• Addressing the variations in clinical outcomes between practices will contribute to the reductions in complications and related hospital admissions

• Review prescribing of drugs for diabetes with a view to discouraging excess prescriptions of the newly available drugs for diabetes

• Ensure the provision of a seamless personalised patient centred care plan

**Hospital services**

• Review current service provision for children, young adult and pregnant women

• Review the commissioning of insulin pumps

**Recommendations for needs assessment work**

• Diabetes and pregnancy

• Provision of service for children and young adults with diabetes

• Provision of insulin pumps for adults with Type 2 diabetes

**End of life**

**Summary**

End-of-life care helps people with advanced, progressive, incurable illness and the elderly live as well as possible until they die. It includes care provided in the last year of life, e.g. pain management and control of other symptoms, as well as provision of social, psychological, spiritual and practical support for patients and their carers. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. Care can be provided in all settings (home, residential and nursing care homes, acute hospital, community hospitals, hospices, prisons and any other institutions).[115][116]

People approaching end-of-life often have complex needs, requiring support from different agencies in various locations. The National End-of-Life Care Strategy indicates that the majority of people would prefer to die at home.[116] In 2016, there were 2,142 deaths in Medway, of which 47.6% (1020) occurred in hospital, 24.7% (529) at home and 10.4% (222) in care homes. The national strategy highlights the opportunities for health and social care systems to work together to provide coordinated care and support; opportunity for patients to discuss their personal needs; choice of where to be cared for and to die; and appropriate advice and support for carers at every stage.

**Key issues and gaps**

• In 2015/16, only 554 people in Medway were on the General Practice palliative care register, implying poor identification of patients with end-of-life care. Identification is known to be worse in non-cancer patients.
• The ‘My Wishes’ register is an important secure record of how patients wish to be cared for as they approach the end of their life, but it is not being used consistently.

• The majority of people in England would prefer to die at home; however, lack of timely access to appropriate community services prevents more people dying in their place of choice. In Medway, nearly half of the deaths (48%) occur in hospital.

• There is no existing mechanism for identifying the needs, wishes and preferences for end-of-life care for people with learning disabilities and dementia.

• In Medway, it is estimated that the number of people aged 85 or above will rise by 17% from 2015 to 2020. The projected increase of the ageing population in Medway points to the future needs in developing skills in the community if admissions, in particular emergency admissions, are to be avoided.

• Patients and carers that come under the specialist palliative care service receive pre-bereavement but other end-of-life care patients do not receive this service.

• There is a lack of training and support for staff to ensure good end-of-life care is provided in all residential and care homes.

• There is a lack of information and data to inform decisions regarding the end-of-life care needs specific to black and minority ethnic groups, including spiritual and cultural needs.

• Coordination of care and communication between existing end-of-life care providers is inadequate and needs to be addressed.

**Recommendations for commissioning**

• Encourage the use of the Gold Standard Framework’s (GSF) Prognostic Indicator Guidance in primary care to ensure early identification of people approaching the end stages of their disease.

• Medway CCG needs to encourage the GP/primary care team to work closely with other professionals in hospitals, hospices and specialist teams to help to provide the highest standard of care possible for patients and their families.

• Given the generally ageing population and the likely increase over time in percentage of people over the age of 75 from a Black, Asian and minority ethnic (BAME) background, it is recommended that Medway CCG looks at their demographic projections and works accordingly with their clinicians, community groups and SPCS to develop, fund and evaluate appropriate, cost-effective services.

• A gap has been identified in pre-bereavement in Medway. Commissioners should consider the provision of the service through a suitable provider or developing alternative models for providing this service.

• Continued commitment is needed to provide high quality care to enable people in Medway to die in the place of their choice.
• Ensure workforce development (training and education) around the core competencies as outlined in the End-of-Life Strategy: Assessment of needs and preferences, communication, advanced care planning and symptom management.

• Encourage joint working and shared resources across all providers, with an identified lead provider coordinating all services that support the end-of-life pathway.

• Support the development of a single point of access to services to improve the coordination of end-of-life services.

• Voluntary sector organisations should be involved appropriately, especially around issues relating to culture and religion.

• Disseminate information on integrated health and social care end-of-life teams to the public, to ensure timely access to continue care funding.

• Develop a shared IT system to facilitate a more streamlined service through data sharing.

**Who’s at risk and why?**

The National Audit Office’s report on end-of-life care suggests that approximately 40% of patients dying in acute hospitals do not have medical needs requiring a hospital stay.[117] In Medway, this equates to about 408 people annually. The report suggests that people approaching end-of-life and their families may be at risk of a poor end-of-life experience if their needs are not being met because they are in an inappropriate setting at the time and therefore not receiving the right and appropriate level of care and support. Early recognition of end-of-life is particularly problematic for patients with non-cancer diagnosis as, traditionally, end-of-life services have been provided to only cancer patients.

**Inequalities**

The national End-of-Life Care Strategy highlights that, although much has been done already, inequalities still exist in the care that different groups of people receive at the end of their life.[116] The groups experiencing less favourable outcomes include: older people, those with dementia and learning disabilities, those with non-cancer diagnosis and black and minority ethnic (BME) groups.[118] Deprivation is a known risk factor for health inequalities and has been identified as a risk indicator for poor end-of-life care outcomes.[119]

Death rates increase steeply with age, with 81.9% (1,755) of deaths occurring in people aged over 65 years and 62.3% (1,335) in people over 75 in Medway. Older patients have complex needs due to their frailty, comorbidities and increased reliance on support from older carers. It is estimated that, for those over 85, the prevalence of dementia is 21%.[120] This represents a significant group with unmet needs, people whose preferences for end-of-life care may not have been identified earlier and then provided appropriate support.
According to the 2011 census, the BME group is around 10.4% of the Medway population.[121] During 2013, Public Health England published a report called ‘Palliative and end-of-life care for Black, Asian and Minority Ethnic (BAME) groups in the UK’,[122] which provides an evidence-base to understand the profile of BAME populations living in the UK and identifies their unmet needs regarding palliative and end-of-life care. The report highlighted that BAME groups had lower access to palliative and end-of-life care services when compared with white British people. This was associated with lack of awareness of relevant services, lack of information in relevant language and previous bad experiences when accessing care also contributed to the gap. Poor communication between the healthcare professional providing end-of-life care and the patient or patient's family also contributed to the inequalities observed by the BAME groups. Lack of referrals to the end-of-life care services also contributed to the gap.

In 2016, only 38.6% of non-sudden deaths were attributed to cancers in Medway, suggesting a large proportion of patients with non-cancer diagnosis. The majority of deaths not attributable to cancer are in patients who are older and frailer than those with cancer and thus requiring more support for longer periods.[123]

Social factors such as deprivation (lower income), increased age, and coming from a minority ethnic descent, were also associated with fewer home deaths. This may be explained by the lower income and resources available to afford adequate care at home.[124]

The level of need in the population

The majority of deaths (n = 1778) in 2016, were predictable (i.e. non-sudden (see definition below), occurring following a period of chronic illness), where deaths could have been anticipated and care properly planned.

Definition of sudden deaths: Sudden deaths are defined as those occurring due to the following causes: acute myocardial infarction; pulmonary embolism; aneurysm of pulmonary artery; sudden cardiac death; cerebrovascular diseases; aortic aneurysm and dissection; influenza and pneumonia; other acute lower respiratory infections; suppurative and necrotic conditions of lower respiratory tract; other diseases of the pleura; post-procedural respiratory disorders; respiratory failure; injury, poisoning and certain other consequences of external causes; external causes of morbidity and mortality.

Table 1 shows that the proportion of non-sudden deaths has increased over the last 10 years, implying that the number of people in Medway who could benefit from end-of-life care is increasing.

Table 1. Total number of deaths and proportion of non-sudden deaths in Medway 2007-2016 [125]

<table>
<thead>
<tr>
<th>Sudden death</th>
<th>Non-sudden death</th>
<th>Total number of deaths</th>
<th>% non-sudden death</th>
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In 2016, the four main underlying causes of non-sudden death in Medway were: cancers (neoplasms) - 687 deaths (38.6%); circulatory diseases - 292 deaths (16.4%); mental and behavioural - 231 deaths (13.0%); respiratory diseases - 207 deaths (11.6%). With active case finding and good disease management the majority of these deaths could be anticipated and the end-of-life adequately planned for.

**Place of death**

Most people die in hospital, although their preferred place of death would be at home, as long as high quality care is received with minimal burden to their families and carers.[126] Figure 1 shows the place of death recorded for Medway residents in 2016 for non-sudden deaths (hospital includes deaths in an acute or community hospital, not psychiatric).[125]
Figure 2 shows that in Medway, the proportion of deaths in hospital has risen from 44.7% in 2011/12 to 47.0% in 2015/16 (hospital deaths include deaths occurring in a community hospital) while in England during the same period, the proportion of deaths in hospital has fallen from 50.4% to 48.2%. The proportion of deaths occurring at people’s homes in this time frame has stayed approximately the same at around 25% for Medway, however the proportion of deaths occurring in a hospice or care home has decreased. This suggests further work is still needed to ensure equality in access to services for all relevant conditions.
There are about 2000 deaths per year within the Medway area. It is recognised that the number of deaths per year is about 1% of a GP practice caseload and there is a national campaign to encourage GPs to identify these patients called **Find Your 1%**. A register of palliative care patients is held within GP practices. In 2015/16, 554 people in Medway were on the General Practice palliative care register.[65] Patients on this register should be reviewed on a 3-monthly basis by the practice health care team. A DS 1500 form should be issued if requested by a patient (or their representative) if it is identified that the patient may be suffering from a potentially terminal illness. The DS 1500 is a form used by GPs in the UK allowing the immediate release of funds to aid a patient with a terminal illness. Identifying patients who are coming to the end of life is key to better palliative care, allowing for coordination and planning of care, prevention of crisis and support for families and carers. A well-maintained register of patients who are approaching the end of life is a tool to allow for better care planning and coordination.

**‘My Wishes’ register**

The ‘My Wishes’ register is an important secure record of how patients wish to be cared for as they approach the end of their life. It ensures people caring for them know what they want. The process for end-of-life care coordination in Medway is dependent on ‘My Wishes’. This is a formal record of patients’ preferred priorities for care and is held by Medway Community Healthcare (MCH). GPs, MCH and staff at the acute trust can view
patient preferences held on ‘My Wishes’. However, ambulance staff are required to telephone the out-of-hours service in order to access the same information.

Provider data, as reported to the Medway CCG, shows that in 2015/16, 451 patients were added to the ‘My Wishes’ register. Of this number, 207 had either confirmed their preferred place of death or were undecided at the time they were asked. Overall, 174 of these patients died during the course of the year and of this number, 130 (74%) died in their preferred place of choice. Given that the overall number of deaths in Medway is on average 2,140 per year for the five-year period 2010-2016, an increase in the number of patients on the ‘My Wishes’ register would support health and social care colleagues to make decisions about care provision that reflect the wishes expressed by the patient.

**Primary Care**

GPs provide generalist support for end of life patients according to their needs in line with the Gold Standards Framework, including pain management, emotional support and coordination of care dependent on the patient and carers needs.

The Palliative Care Helpline is in place to provide patients at the end of life, including their carers and family, access to 24/7 crisis support. GPs and nurses consult, visit patients, provide telephone advice, and refer to community and specialist teams where appropriate.

**Community Nursing Service**

The Community Nursing Service, provided by Medway Community Health Care, delivers 24/7 nursing services to patients registered with a Medway GP who are over the age of 18 years and are either permanently or temporally housebound. The service functions as part of an integrated health and social care model and works collaboratively with stakeholders to deliver high quality patient care. Community nursing provides the majority of the palliative and end-of-life care for patients living in their own homes or residential care.

**Secondary Palliative Care Service**

The Secondary Palliative Care Service is provided by Medway Community Health Care. This service provides support alongside community nursing to palliative care patients over the age of 18 years who have complex care needs that are difficult to manage, such as pain, nausea, vomiting, dyspnoea, constipation, anxiety, and agitation. The service also supports patients, their families and carers who have complex psychological needs including concerns about children or vulnerable individuals, and spiritual or religious concerns.

For a detailed breakdown of the components of the Secondary Palliative Care Service, and other services that support end of life care, please refer to Medway’s End of Life Care Strategy for Adults 2017-2020.
Projected service use and outcomes

It is predicted that by 2020, the ageing population will increase globally, with more people dying from chronic rather than acute diseases[127] and health care will increasingly focus on achieving the best possible quality of life for patients and their families and providing palliative care. Part of this includes meeting their wishes with regards to place of care and of death. Population projections for Medway from 2015 suggest that by 2020, there will be an increase in the size of population aged 85 and over by 17% to 5,600, and by 2030 it will increase by 85% to 8,900.[128] Based on current trends, it is expected that the prevalence of major causes of death in Medway will continue to rise over the next 5 to 10 years. This increase in prevalence and an ageing population will have an impact on end-of-life care services within health and social care.

In a study of multimorbidity by Melzer et al. (2015), the percentage of the population in England aged over 85 years with three or more long-term conditions was estimated at 55.1% (95% CI: 52.6%-57.5%).[129] Based on the national estimate, it can be predicted that in Medway, by 2020 over 3,000 people and by 2030 nearly 4,900 people aged 85 and over will be living with three or more long-term conditions.

Evidence of what works

- The National [Gold Standard Framework](http://www.goldstandardsframework.org.uk/) (GSF) aims to support best implementation of the GSF in all settings, using a common framework and toolkit of resources so that generalist frontline staff can provide quality of care for people nearing end-of-life, whatever their illness and wherever the setting.


- Department of Health End of Life Care Strategy – promoting high quality care for all adults at the end of life. DH. London. (2008)

- Department of Health Our Health, Our Care, Our Say: a new direction for community services. DH. London. (2006)


- The Preferred Priorities of Care, National End of Life Programme (2011)

- The National Carers Strategy emphasises the need for mental wellbeing and support for carers. (2008)

Unmet needs and service gaps

- More training is required for the wider workforce on end-of-life care. Need to educate professionals to initiate end-of-life conversations and advance care planning.
There is a need for a proactive identification of people approaching end-of-life, better coordination of care and communication between services.

There is inequity in end-of-life care for non-cancer patients especially those with mental health problems e.g. dementia and patients with long-term conditions and learning disabilities.

There is a gap in pre bereavement, only patients with complex needs receive the service.

The majority of people in England would prefer to die at home, however lack of timely access to appropriate community services prevent more people dying in their place of choice. In Medway, nearly half of the deaths (48%) occur in hospital.

There is no existing mechanism for identifying the needs, wishes and preferences for end-of-life care for people with dementia and learning disabilities.

There is currently no systematic approach to capturing patients' views in the use of the service, although there is patient representation within the End-of-Life Care Group.

The main barrier to the delivery of good quality end-of-life care is because people are not identified early enough to provide this care as they are approaching end-of-life.

The projected increase in the ageing population in Medway, points to the future needs in developing skills in the community if admissions, especially emergency admissions, are to be avoided.

Lack of information and data to inform decisions regarding the end-of-life care needs specific to BME groups, including spiritual and cultural needs.

**Recommendations for commissioning**

Encourage the use of the Gold Standard Framework's (GSF) Prognostic Indicator Guidance in primary care to ensure early identification of people approaching the end stages of their disease.

Medway CCG needs to encourage the GP/primary care team to work closely with other professionals in hospitals, hospices and specialist teams to help to provide the highest standard of care possible for patients and their families.

Given the generally ageing population and the likely increase over time in percentage of people over the age of 75 from a Black, Asian and minority ethnic (BAME) background, it is recommended that Medway CCG looks at their demographic projections and works accordingly with their clinicians, community groups and secondary palliative care services to develop, fund and evaluate appropriate, cost-effective services.

There should be a standardised advance care plan, which can be used across whole system and to be recognised and staff supported.
• A gap has been identified in pre-bereavement in Medway. Commissioners should consider the provision of the service through a suitable provider or developing alternative models for providing this service.

• Continued commitment is needed to provide high quality care to enable people in Medway to die in the place of their choice.

• Use local population data available from National End-of-Life Intelligence Network, Hospital Episode Statistics, QOF and end-of-life care analytical tool which is published by Public Health England.

• Ensure workforce development (training and education) around the core competencies as outlined in the End-of-Life Strategy: Assessment of needs and preferences, communication, advanced care planning and symptom management.

• Encourage joint working and shared resources across all providers, with an identified lead provider coordinating all services that support the end-of-life pathway.

• Support the development of a single point of access to services to improve the coordination of end-of-life services.

• Voluntary sector organisations should be involved appropriately, especially around issues relating to culture and religion.

• Disseminate information on integrated health and social care end-of-life teams to the public, to ensure timely access to continue care funding.

• Develop a shared IT system to facilitate a more streamlined service through data sharing.

Recommendations for needs assessment work
• Review of patients’ place of death, cause of death and their preferred place of death in Medway.

Excess winter deaths

Summary

In common with other areas, Medway experiences higher levels of mortality in the winter than in the summer. Studies have found that mortality increases as mean daily temperatures fall (below 18 degrees) and, in England and Wales, the total excess winter mortality is estimated to be around 30,000 per annum. Although excess winter mortality (EWM) is associated with low temperatures, conditions directly relating to cold, such as hypothermia, are not the main cause of EWM. The majority of additional winter deaths are caused by cerebrovascular diseases, ischaemic heart disease and respiratory diseases. Mortality in England and Wales however, increases more than in other European countries with colder climates, suggesting that factors other than
temperature also contribute. There is no clear cut explanation for excess winter mortality. It would appear to be due to a variety of factors. Consequently, the response needs to be similarly multi-faceted.

**Key issues and gaps**

Medway sees highest levels of excess winter mortality in Gillingham South, Watling and Strood North wards.

**Knowledge and research gaps:**

There is a relatively limited local understanding around excess winter death and morbidity, from the epidemiological standpoint, through to individual clinicians on the ground.

**Service gaps:**

Besides the seasonal flu vaccination programme, specific measures to tackle EWM are in their infancy. As such the main gap is the lack of a strategic, systematic partnership based approach with relevant measures beneath it.

**Who’s at risk and why?**

Many studies demonstrate links between winter mortality and climate, even quantifying the increase in mortality per degree drop in temperature, yet outdoor temperature alone cannot explain all excess winter mortality (EWM). The Eurowinter study showed that percentage increases in mortality per degree fall in temperature were surprisingly greatest in countries with more mild climates. [130] The rate of EWM in the UK also appears higher than in countries with lower winter temperatures such as Finland and Denmark. [131] Such findings have led many to conclude that there is a great potential in the UK to reduce excess winter deaths.

Some argue that the high levels in the UK relate to poor insulation and housing standards resulting in low indoor temperatures, [132] [133] whilst others stress the importance of outdoor exposure. [134] Keatinge, [135] has argued strongly that campaigns remain overly fixated on indoor heating, when the cold stress experienced from minutes spent at a windy bus stop can exceed anything experienced indoors.

It is likely that both these variables play important roles in EWM. Research has also demonstrated that there is no clear link between these deaths and the usual measures of deprivation or social class. [136] [137] [138] In fact, it was found in one study that people in the lowest socio-economic groups do not necessarily live in cooler homes as housing association and local authority dwellings tend to be well heated and well-insulated, whereas large owner-occupier houses tend to be those which are harder to heat. [139] However, the present policy focus on fuel poverty or affordable warmth acknowledges that socio-economic factors do play a role in the health inequalities associated with EWM, even if this cannot be easily demonstrated by the available data. Reliance on public transport however (a feature of deprivation), is thought to increase exposure to outdoor cold.
Recent research has suggested a relationship between hospital admission rates and poverty using the fuel poverty risk index [140] and the Meteorological Office has done considerable work looking at temperature as a predictor of hospital admissions.

The strongest risk factor is age, with most studies showing EWM concentrated in people over 75. This would suggest that interventions to tackle winter deaths should focus on this age group — although there is a rationale for also focusing on the very young, and those with specific circumstances and conditions that make them more vulnerable to cold-related illness. The research also suggests that future activities should focus on the private housing sectors — both owner-occupiers and private rented accommodation. Older people living in older housing, are particularly at risk. [141]

Respiratory illness has a significantly higher excess winter death index than other illnesses and there is some national evidence that having an existing respiratory condition significantly increases the risk of winter death. A recent Nottingham Health Needs Assessment found that deaths from respiratory disease have an EWM index of around 43%, and that this was significantly higher than the indices of other disease categories. [142]

A report has shown that asthma patients without a written personal asthma action plan are four times more likely to have to be admitted to hospital, due to an asthma attack, than those who do. At the time of report’s writing, only 16% of people with asthma in England have a written personal asthma action plan. [143]

The South East Public Health Observatory (SEPHO) report into EWM notes that there is a significantly greater increase in EWM ratios for care home residents. As care home residents generally lead a sheltered existence, protected from exposure to outdoor temperatures, damp housing or difficulties with heating their homes, it might be expected that EWM would be low for this group, when in fact, the opposite is true (another Winter mortality paradox). It is the case however, that people in care homes are likely to be the very oldest older people, many will have pre-existing conditions and they live in an enclosed space where infection can easily spread. Greater excess mortality amongst this group may also reflect seasonal patterns in care home use, for example, more patients being admitted to care homes shortly before death in the winter period. Whatever the explanation (and there are many), figures do demonstrate that the seasonal increase in mortality has a strong impact on care home residents. The report notes that guidance for care homes has been developed on dealing with heatwaves, and suggests that similar guidance for winter might also be beneficial. [141]

A range of research has argued that vaccination of health care workers is important to limit spread of flu amongst vulnerable patients in hospitals and other healthcare settings. [144] [145]

Figure 1: Epidemic curve of confirmed influenza cases, Royal Liverpool University Hospital, and influenza-like illness rates in Liverpool between week 47/2008 and week 2/2009

A report from the North West Health Protection Unit (2009) [146] notes the importance of vaccination of staff. An outbreak of influenza occurred amongst patients and staff at
an acute hospital in the North West of England in early December 2008. Over a three-week period in November/December 2008, rates of influenza-like illness in Liverpool increased from 26.7 per 100,000 population (in week 47) to 102.7 per 100,000 (in week 50). At the same time cases of influenza started presenting at the Royal Liverpool University Hospital. On 25th November a confirmed case of influenza, acquired in the hospital, was diagnosed on the haematology ward. The number of infections increased quickly until infection control and immunisation measures were put in place (Figure 1).

The outbreak illustrated how easily influenza can spread in a health care setting when virus is circulating in the community and staff vaccination levels are low. It was a notable success in the management of the outbreak that high levels of vaccination were achieved in a short period of time, helping to reduce the exposure of vulnerable patients in hospital despite the ongoing seasonal influenza activity in the community.

Level of need in the population

Although analysis at a small area level can be problematic, the local picture of who is at risk and why is broadly similar to the national picture. Medway sees highest levels of excess winter mortality (EWM) in the wards of Gillingham South, Watling and Strood North (Figure 1 and Table 1).

Key definitions

EWM is calculated as the number of winter deaths (deaths occurring in December to March) minus the average of non-winter deaths (April to July of the current year and August to November of the previous year)

\[ \text{EWM} = \text{Number of winter deaths} - \frac{\text{(number of non-winter deaths)}}{2} \]

The Excess Winter Deaths Index (EWD Index), 2006–2009 is the excess of deaths in winter compared with non-winter months from 01.08.2005 to 31.07.2010 expressed as a percentage.

The year runs from August to July. Winter months are classified as December to March, Non-Winter months are August to November and April to July.

Figure 1: Medway excess winter mortality by Ward 2005–2009

*Table 1: Medway excess winter deaths by ward*

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Kent
West Kent  18.9  18.8  16.0  13.0  14.3  16.3  16.3  17.1
Kent &  16.8  18.4  17.0  14.4  16.6  17.3  17.3  16.8
Medway

Figure 2 (below) shows how the excess winter deaths ratio has fluctuated in recent years. As has been alluded to earlier patterns of such death are affected by a range of factors and colder winters will generate fluctuation. Given the data period below however, it is possible that excess winter deaths in Medway have increased.

Figure 2: Trends in Excess Winter Death indices, 2002/04–2007/09 for Kent and Medway

Housing

As has been noted earlier, cold homes are a risk factor for EWM. For more information on housing, please see Appendices —> Background papers: Lifestyle and wider determinants —> Housing and homelessness

A Housing Stock Survey was undertaken in 2007. In summary, 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. Most Medway stock is privately owned.

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.

Current services in relation to need

Influenza Immunisation

As has already been noted, immunising those at risk can reduce excess winter mortality (EWM). The topic of Immunisation and Vaccination is covered in another chapter and can be found in Appendices —> Background papers: Children/Adults —> Immunisations and vaccinations. In summary, the influenza immunisation programme in Medway is well established and largely surpasses England and South East Coast Strategic Health Authority uptake averages (Table 1), although healthcare staff immunisation rates remain relatively low.

<table>
<thead>
<tr>
<th>Table 1: Seasonal Influenza vaccine uptake Winter Season, 2010-11 (Medway, SHA and England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seasonal influenza vaccine uptake in those aged</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>73.3%</td>
</tr>
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</table>
65 years and over
Seasonal influenza vaccine uptake in those aged 6 months to under 65 at risk

|            | 51.8% | 47.9% | 50.4% |

Seasonal influenza vaccine uptake in Carers (aged under 65 years and not considered at risk)

|            | 54.5% | 40.7% | 42.7% |

All frontline healthcare workers

|            | 25.0% | 28.2% | 34.7% |

Data coverage shows end of campaign cumulative vaccine uptake data for England, for seasonal flu vaccinations administered from 1st September 2010 to 28th February 2011.

Data Source: DH ImmForm website: Registered Patient GP practice data Influenza Immunisation Vaccine Uptake Monitoring Programme.

Seasonal influenza vaccine uptake amongst frontline healthcare workers (HCWs) in England

**Housing**

Medway Council has put initiatives in place to help residents reduce fuel poverty by supporting residents in their energy use. Between 2008 and 2011, 8,391 people were given energy efficiency advice by the Energy Savings Advice Centre.

In addition, a joint scheme (between Medway Council and NHS Medway) which draws upon existing models (e.g. Clearing House model Greater Manchester) is being due to be piloted. This will use clinical systems in GP practices to identify those at most risk and create referrals for those individuals into a service which assesses houses, carries out improvements for eligible homes and offers advice on energy use or benefits entitlement. If successful this model may be extended to other GP Practices.

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

In common with the rest of the UK, Medway has an ageing population. This could mean that excess winter mortality (EWM) will increase when risk factors are conducive. As few services exist which specifically tackle EWM, it is difficult to model how this demographic change will affect those services. It is likely that the demand for influenza immunisation will increase.

The importance of managing those risk factors which are within the ambit of the NHS and Local Authority will grow as morbidity associated with excess cold will place greater winter pressures on NHS acute capacity. The monthly pattern of respiratory admissions, influenza admissions, influenza and pneumonia admissions combined and influenza laboratory tests, show winter peaks similar to the all-cause mortality pattern.[147]

In addition, it can be expected that the current economic climate, combined with the rising costs of fuel will increase fuel poverty and limit the amount of home maintenance undertaken.
Evidence of what works

Evidence on this topic suggests many different interventions may be beneficial, but stops short of quantifying what level of reduction in mortality might be expected by introducing various interventions. Risk reductions for example, are not calculated.

It is widely accepted that pre-seasonal vaccination is effective in reducing the more serious manifestations of influenza, as has vaccination of health care workers. Campaigns to increase uptake of immunisation have been relatively successful amongst target groups in Medway, but uptake amongst health care workers remains poor. There is some evidence that early use of anti-virals amongst the very aged in residential and care home settings could limit the spread of influenza in institutional environments.[148]

The large, cross-European study found robust relationships between energy efficiency levels and excess winter deaths, although they were still significant at the 5% level (cavity wall insulation p=0.02, double glazing p=0.02 and floor insulation p=0.03). The four countries with the poorest standard of housing in this respect (Portugal, Greece, Ireland and the UK) all score highly for excess winter deaths. The authors suggest that their findings support the theory that EWM can be reduced through not just targeted improvement of energy efficiency, but also socioeconomic progress (such as looking at poverty, income inequalities, fuel poverty and deprivation).[130]

The research also suggests that interventions will be most effectively focused on the private housing sectors — both owner occupiers and private rented accommodation. Older people living in older housing, particularly those without central heating are particularly at risk.[141]

National research has also shown that as well as the energy efficiency of the house, the way a householder uses the house (e.g. use of heating system, opening windows at night etc) is of crucial importance in maintaining a healthily warm home.

There is some evidence to suggest that the Met Office runs a ‘Healthy Outlook’ service which is a preventative measure, aimed at helping people with Chronic Obstructive Pulmonary Disease (COPD) to stay well in cold weather is effective in reducing hospital admissions. It is operated through GP practices.

User views

No user views have yet been elicited locally for this aspect of public health. It is envisaged that public engagement with appropriate groups should be sought as planning develops for reducing excess winter deaths.

Equality Impact Assessments

Equality impact assessments will need to be completed as future services are planned. The Medway population is diverse and plans which affect health services and housing need to take account of this.
Unmet needs and service gaps

- Other than the influenza vaccination programme and dedicated work carried out by Medway Council’s housing department, systematic approaches to the reduction of excess winter mortality (EWM) are in their infancy and need to develop.

- There are insufficient knowledge and tools to be able to identify Medway households most at risk of EWM.

- There is currently no formalised system to generate referrals to energy efficiency services of vulnerable householders from frontline health staff.

- There is currently no identified resource to operate targeted energy advice services in the homes of the most vulnerable householders across the Medway area.

- There is a lack of public and professional awareness of the health problems associated with cold exposure and services available to tackle these.

Recommendations

Measures should concentrate on vulnerable people (those living in care homes, those aged over 65, those with respiratory or cardiovascular conditions, older women, people reliant on public transport, sedentary people and older people who live alone). The CCG should develop procedures and systems to ensure that the referral of vulnerable older households to appropriate energy service happens systematically.

Measures to reduce both indoor and outdoor cold stress are necessary to reduce levels of winter mortality. Warning people about outdoor cold exposure and protective measures is as important as messages about keeping their home adequately heated.

Early use anti-virals amongst the very aged in residential and care home settings should be considered.

The proportion of health care workers vaccinated should be increased to limit spread of flu to vulnerable patients in hospitals and other healthcare settings.

As with many public health issues, the wider determinants (i.e. the ‘causes of the causes’) need to be considered. A strategic approach supported by the emerging Medway Health and Wellbeing Board, which maintains general aims to reduce poverty, increase economic development etc should run concurrently with more targeted programmes.

Current mainstream commissioning programmes which seek to manage winter service pressures and acute admissions should include support preventative measures which seek to reduce excess winter death as these measures will also reduce morbidity.

Guidance for care homes has been developed on dealing with heat waves, similar guidance for winter may be beneficial.

The introduction of asthma plans for affected patients should be considered, to reduce admissions for the condition.
The possibility of introducing heated waiting rooms/seating, wind-proof bus shelters and similar could be investigated, especially in areas populated by high numbers of older people who are reliant on public transport.

Commissioning the Met Office’s “Healthy Outlook” service for Medway should be considered.

**Recommendations for needs assessment work**

More detailed analysis which combines housing and health data would allow for more appropriate development and targeting of interventions related excess winter mortality.

Further assessment should be undertaken to examine the impact of cold homes on morbidity (illness) as well as deaths. This should include work to understand the impact of cold homes on mental health and wellbeing.

**Immunisations and vaccinations**

**Summary**

Immunity is the ability of the human body to protect itself against infectious disease. Active immunity is protection that is produced by an individual’s own immune system and is usually long lasting — it can be acquired by natural disease or via vaccination. Passive immunity is protection provided from the transfer of antibodies from immune individuals, most commonly across the placenta or less often from the transfusion of blood or blood products including immunoglobulin. Passive immunity is temporary but provides immediate short-term protection against disease.[149]

After clean water, vaccination is the most effective public health intervention in the world for saving lives and promoting good health.[150] Vaccination generally provides a similar immunity to that provided by natural infection, but without the risk of complications of the disease. Vaccinations work by producing immunological memory, so that when the immune system is subsequently exposed to natural infection it is able to recognise and respond to it, thus preventing or modifying the disease. In some cases more than one dose of the vaccine may be required initially to produce this response and/or booster doses may be required to maintain it. While the main aim of vaccination is to protect the individual who receives it, high levels of immunity in a population mean those who cannot be vaccinated, for example because they are too young, are also at reduced risk of being exposed to a disease. This is known as herd immunity. When vaccine coverage is high enough a disease may be eliminated from a community, however if this is not maintained the disease may return.[149] Vaccine coverage is evaluated against World Health Organization (WHO) targets of 95% coverage annually for each vaccine (except Meningitis C) at the national level, and at least 90% in each Strategic Health Authority.[151]

**Who’s at risk and why**

There are no vaccinations that are routinely offered by the NHS to all adults. However, there are several vaccinations that are available on the NHS to adults in certain ‘at risk’ groups. These are:

- annual seasonal flu vaccination if aged 65 and over, if in a clinical risk group and under 65 and all pregnant women
- pneumococcal vaccination if aged 65 and over in an at risk group
- hepatitis B vaccination if at increased risk of hepatitis B because of lifestyle, occupation or other factors e.g. a household contact of someone who is infected with hepatitis B
- measles, mumps and rubella (MMR) post delivery — for women who do not have immunity against rubella identified via the antenatal screening programme
- BCG vaccination if at increased risk

Healthcare and laboratory staff should be offered appropriate vaccination in addition to those offered as part of the childhood vaccination as they are at higher risk e.g. hepatitis B, BCG (protects against tuberculosis), seasonal flu, varicella (protects against chickenpox and shingles). It is the employer’s responsibility to provide these vaccinations.

Travel vaccinations are generally not funded by the NHS although there are some exceptions.

**The level of need in the population**

Uptake rates in adults are only routinely collected for seasonal flu, pneumococcal disease and the BCG vaccinations given.

**Seasonal flu**

Uptake of seasonal flu vaccination is measured as those who have been vaccinated from when the vaccine becomes available in September each year until the end of January the following year. In 2011/12 uptake in NHS Medway was:

- 75.2% in those aged 65 and older (73.3% in 2010/11)
- 52.9% in those aged under 65 years within a clinical risk group (51.8% in 2010/11)
• 33.3% in all pregnant women (38.3% in 2010/11). There were some data problems with the denominator for pregnant women nationally in 2011/12 so this figure needs to be treated with caution.

Table 1: Uptake for seasonal flu vaccination in patients Medway compared with the South East Coast (SEC) region and England (provisional data) 2011/12 [154]

<table>
<thead>
<tr>
<th></th>
<th>65 years and over</th>
<th>Under 65 and in at risk group</th>
<th>Pregnant women</th>
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</thead>
<tbody>
<tr>
<td>NHS Medway</td>
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<td>52.9</td>
<td>33.3</td>
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<td>SEC SHA</td>
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<td>England</td>
<td>74.0</td>
<td>51.6</td>
<td>27.4</td>
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</table>

NHS Medway uptake rates were the highest in South East Coast (SEC) for all these categories but there were considerable differences between practices as can be seen in Figures 1–3.

Figure 1: The percentage uptake of flu vaccine in over 65s [154]

Figure 1: The percentage uptake of flu vaccine in over 65s [154]

Figure 2: The percentage uptake of flu vaccine in those under 65 but in an at risk group [154]

Figure 2: The percentage uptake of flu vaccine in those under 65 but in an at risk group [154]

Figure 3: The percentage uptake of flu vaccine in pregnant women [154]

Figure 3: The percentage uptake of flu vaccine in pregnant women [154]

The graphs show that half of Medway practices met the target for those aged 65 and over (70%). A much lower number met the targets for those aged under 65 years within a clinical risk group (60%) and for pregnant women (60%)

Tables 2–4 show the improvements that some practices have made compared to 2010/11.

Table 2: Uptake of flu vaccine in over 65s by Medway GP [154]

<table>
<thead>
<tr>
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<th>Percentage point difference</th>
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Table 3: Uptake of flu vaccine in those under 65 but in an at risk group by Medway GP [154]

<table>
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<th>2010/11</th>
<th>2011/12</th>
<th>Percentage pointdifference</th>
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Table 4: Uptake of flu vaccine in pregnant women by Medway GP [154]
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A staff seasonal flu programme occurs every year. Uptake in 2011/12 was improved in healthcare provider organisations in Medway in 2011/12 compared to 2010/11.

Table 5: Staff uptake of flu vaccine 2011/12 compared to 2010/11 [154]

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Pneumococcal Vaccination

See Figure 4 and Table 6.

Figure 4: The percentage uptake of pneumococcal vaccine up to 31st March 2011 by Medway GP [154]

Table 6: Uptake of pneumococcal vaccine up to 31st March 2011 compared to 31st March 2010 by Medway GP [154]

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Figure 4: The percentage uptake of pneumococcal vaccine up to 31st March 2011 by Medway GP [154]

Table 6: Uptake of pneumococcal vaccine up to 31st March 2011 compared to 31st March 2010 by Medway GP [154]
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<td>66.0</td>
<td>72.5</td>
<td>6.5</td>
</tr>
<tr>
<td>G82679</td>
<td>Apex Medical Centre, Dr Premeratne &amp; Partners</td>
<td>70.5</td>
<td>72.1</td>
<td>1.6</td>
</tr>
<tr>
<td>G82139</td>
<td>Maidstone Road Surgery, Dr Qureshi</td>
<td>79.6</td>
<td>70.2</td>
<td>-9.4</td>
</tr>
<tr>
<td>G82622</td>
<td>The Surgery, Dr Bhasme</td>
<td>70.8</td>
<td>70.2</td>
<td>-0.6</td>
</tr>
<tr>
<td>G82077</td>
<td>Elms Medical Practice, Dr Lee &amp; Partners</td>
<td>71.5</td>
<td>70.1</td>
<td>-1.4</td>
</tr>
<tr>
<td>G82744</td>
<td>Halfway Surgery, Dr Ali</td>
<td>59.0</td>
<td>70.1</td>
<td>11.1</td>
</tr>
<tr>
<td>G82095</td>
<td>Dame Sybil Thorndike Healthcare, Dr Tanday &amp; Partners</td>
<td>70.4</td>
<td>70.0</td>
<td>-0.4</td>
</tr>
<tr>
<td>G82727</td>
<td>Malling Health, Malling Health</td>
<td>60.9</td>
<td>70.0</td>
<td>9.1</td>
</tr>
<tr>
<td>G82600</td>
<td>Eastcourt Surgery, Dr Nandini</td>
<td>64.8</td>
<td>69.7</td>
<td>4.9</td>
</tr>
<tr>
<td>G82821</td>
<td>Bryant Street Surgery, Dr Kanekal</td>
<td>60.8</td>
<td>69.0</td>
<td>8.2</td>
</tr>
<tr>
<td>G82721</td>
<td>Parkwood Family Practice, Dr Selvan</td>
<td>70.2</td>
<td>68.4</td>
<td>-1.8</td>
</tr>
<tr>
<td>G82106</td>
<td>Riverside Medical Centre, Dr Sastry &amp; Partners</td>
<td>36.3</td>
<td>68.2</td>
<td>31.9</td>
</tr>
<tr>
<td>G82123</td>
<td>Balmoral Gardens, Dr Karim &amp; Partners</td>
<td>7.4</td>
<td>68.2</td>
<td>60.8</td>
</tr>
<tr>
<td>G82109</td>
<td>Railside Surgery, Dr Ramesh</td>
<td>66.0</td>
<td>67.8</td>
<td>1.8</td>
</tr>
<tr>
<td>G82233</td>
<td>Hoo St Werburgh, Dr Davies &amp; Partners</td>
<td>66.2</td>
<td>67.6</td>
<td>1.4</td>
</tr>
<tr>
<td>G82753</td>
<td>Kings Family Practice, Dr Huxham &amp; Partners</td>
<td>78.4</td>
<td>67.6</td>
<td>-10.8</td>
</tr>
<tr>
<td>G82762</td>
<td>Upper Canterbury Street Surgery, Dr Silhi</td>
<td>68.3</td>
<td>67.5</td>
<td>-0.8</td>
</tr>
<tr>
<td>G82162</td>
<td>Rainham Healthy Living Centre, Dr Ferrin &amp; Partners</td>
<td>65.1</td>
<td>66.3</td>
<td>1.2</td>
</tr>
<tr>
<td>G82741</td>
<td>Princes Park Medical Centre, Dr Aslam</td>
<td>10.2</td>
<td>63.8</td>
<td>53.6</td>
</tr>
<tr>
<td>Y02462</td>
<td>DMC Health Centre - Canterbury Street, DMC Healthcare</td>
<td>45.9</td>
<td>62.9</td>
<td>17.0</td>
</tr>
<tr>
<td>G82014</td>
<td>Woodlands Family Practice, Dr Rishi &amp; Partners</td>
<td>63.5</td>
<td>61.9</td>
<td>-1.6</td>
</tr>
<tr>
<td>G82011</td>
<td>Sunlight Centre Surgery, Medway</td>
<td>62.9</td>
<td>61.8</td>
<td>-1.1</td>
</tr>
</tbody>
</table>
The BCG (Bacillus Calmette–Guérin) programme

Data are not collected in a form that allows uptake rates to be calculated in adults only.

Table 7: The number of BCG vaccinations per 1,000 population over the past 3 years in Medway compared to SEC SHA and England [155] [156]

<table>
<thead>
<tr>
<th></th>
<th>2008/09 All ages</th>
<th>2008/09 age under 1</th>
<th>2008/09 age 1 and over</th>
<th>2009/10 All ages</th>
<th>2009/10 age under 1</th>
<th>2009/10 age 1 and over</th>
<th>2010/11 All ages</th>
<th>2010/11 age under 1</th>
<th>2010/11 age 1 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medway</td>
<td>582</td>
<td>321</td>
<td>261</td>
<td>560</td>
<td>339</td>
<td>221</td>
<td>447</td>
<td>292</td>
<td>155</td>
</tr>
<tr>
<td>South East Coast</td>
<td>12761</td>
<td>7988</td>
<td>4773</td>
<td>11986</td>
<td>9383</td>
<td>2603</td>
<td>6727</td>
<td>5547</td>
<td>1180</td>
</tr>
<tr>
<td>England</td>
<td>23924</td>
<td>14894</td>
<td>90293</td>
<td>22316</td>
<td>11561</td>
<td>67556</td>
<td>22531</td>
<td>15325</td>
<td>72063</td>
</tr>
</tbody>
</table>

Current services in relation to need

Vaccination of adults is undertaken in general practice.

The HPU also provide a two day training programme on immunisation and vaccination for all new vaccinators and a half annual update for all others as per Health Protection Agency guidelines.
Projected service use

The population of those aged 65 and over resident in Medway has increased by 8.6% over the past few years from 33,299 people (2006) to 36,172 (2010). It is predicted to increase to 41,900 by 2015 and 46,100 by 2020. This means that more people will be eligible for seasonal flu and Pneumococcal vaccination.

Evidence of what works

Joint Committee for Vaccinations and Immunisations:

The Joint Committee on Vaccination and Immunisation (JCVI) is an independent expert advisory committee first set up in 1963 to advise the Secretaries of State for Health, Scotland, Wales and Northern Ireland on matters relating to communicable diseases, preventable and potentially preventable through immunisation. JCVI gives advice to Ministers based on the best evidence reflecting current good practice and/or expert opinion. The process involves a robust, transparent, and systematic appraisal of all the available evidence from a wide range of sources. The committee is appointed by the Appointments Commission and is independent of the Department of Health.

Health Protection Agency (HPA):

The Health Protection Agency is an independent UK organisation that was set up by the government in 2003 to protect the public from threats to their health from infectious diseases and environmental hazards. It does this by providing advice and information to the general public, to health professionals such as doctors and nurses and to national and local government and includes specific information about immunisations and vaccinations.

NHS choices immunisation website:

A comprehensive, up-to-date and accurate source of information on vaccines, disease and immunisation for the UK for the public can be found here.

Department of Health Immunisation against Infectious Disease:

'The Green Book':

The most recent printed version was published in 2006, but the website is regularly refreshed with updated chapters. Each chapter gives details on the disease, vaccine available, efficacy of the vaccine, contraindications, side effects and the correct dosage etc.
User views

Equality Impact Assessment

Unmet needs - service gaps

This year 2012/13 there has been confusion concerning the responsibility of providing flu vaccination to health care students — while this does not appear to have been an issue in Medway, this needs to be resolved nationally.

Recommendations

Ensure that all those who vaccinate are adequately trained and aware of issues such as the cold chain guidance and what to do if there is an incident

Review the staff seasonal flu programme which has historically been led by Kent HPU and offered to all NHS staff in Medway with the coordination being led by public health in the light of changes within public health as a result of the Health and Social Care Bill

Further needs assessment required

Long term neurological conditions

Summary

A long term neurological condition (LTNC) results from disease of, injury or damage to the body’s nervous system. Many LTNCs severely affect quality of life and cause lifelong disability, with a range of co-morbidities that affect patients, carers and family members. This places a considerable burden on the health and social care sector.

LTNCs affect individuals, families and carers in many different ways, physically, psychologically and socially. Many LTNCs severely affect quality of life and cause lifelong disability. People can experience a range of co-morbidities such as depression and anxiety, physical or motor problems, sensory problems, cognitive/behavioural problems, and communication problems.[157][158][159]

Exclusions and relevance to existing work

- Migraine is the most common neurological complaint. Its management has been addressed by the outpatient improvement programme at Medway Foundation Trust (MFT) so it has not been considered in detail in this work.

- Acquired brain injury (ABI) has not been considered in detail, nor has stroke been included, on the advice of the CCG.
• Specialist in-patient neuro-rehab has been a CCG focus since 2012, centred mainly on facilities and number of in-patient beds required for this function. For this reason it has not been considered in detail here.

**Key issues and gaps**

• Specialist nurses and multi-disciplinary teams — Specialist nurses (SN) are felt to be important in ensuring continuity of care. There is a lack of consistency nationally in the provision of SN support and the way in which services are designed around them. NICE recommends that every patient with epilepsy should have access to an ESN. There is only one ESN clinic a week in Medway at present.

• Transition — Managing child to adult transition is an issue for both health and social care services. Transition is common for conditions such as epilepsy, which affects both children and adults, and increasingly for conditions such as Duchenne Muscular Dystrophy (DMD), for which medical advances have meant that more children are surviving into adulthood.

• Palliative care — specialist palliative care services are needed for patients with advanced Parkinson’s disease and the rapidly progressive ‘Parkinson-Plus’ syndromes (MSA and PSP). Their needs are similar in nature and severity to people with terminal cancer yet much of the burden of care of this group tends to fall on informal care givers. Motor Neurone Disease is such that serious patient episodes often occur outside of normal GP practice hours, and where out of hours services are unable to provide an acceptable level of care, the result is unnecessary and expensive hospital admissions, underlining the importance of appropriate specialist palliative care.

**Recommendations for commissioning**

• Develop a strategy for neurology that is jointly owned and developed by health services, social care and relevant third sector organisations

• Improve community neuro-rehab to meet the on-going needs of people with LTNCs

• Improve management of epilepsy through provision of epilepsy specialist nurse(s)

• Provide appropriate emotional and psychological support to people with LTNCs

• Establish arrangements for secure on-going provision of palliative and pre-palliative care

**Who is at risk and why**

A long term neurological condition (LTNC) results from disease of, injury or damage to the body’s nervous system. LTNCs are numerous and varied. Some may be present at birth and lead to learning disability. Some appear in childhood and others have an adult onset. The time course of different conditions also varies considerably, ranging from a few months to decades between diagnosis and death.

Broadly speaking there are four categories of LTNC:
• Sudden onset conditions – followed by a partial recovery, e.g. spinal cord injury
• Intermittent and unpredictable conditions – causing variation in the level of care needed, e.g. epilepsy, or early multiple sclerosis (MS)
• Progressive conditions – with increasing dependence on others for help as the condition deteriorates, e.g. motor neurone disease (MND), Parkinson’s disease (PD) or late stages MS.
• Stable neurological conditions – for which the needs change with development or ageing, e.g. post-poliomyelitis syndrome or cerebral palsy in adults.

Approximately 10 million people across the UK have a LTNC (migraine accounts for 8 million of these). The impact on the health and social care sector is considerable — it is estimated that LTNCs account for 19% of acute hospital admissions, 10% of visits to A&E and 17% of GP consultations (being the third most common reason for seeing a GP). They also make up 25% of the burden of chronic disability in people aged 16–64, affecting one in fifty of the UK’s population. Approximately 350,000 people need assistance with daily living and around 850,000 people provide care for someone affected by a LTNC. Thirty-three percent of disabled people living in residential care have a LTNC.[157][160]

A small number of LTNCs have relatively high prevalence. There are other conditions that are much rarer, but which collectively impose a large burden of illness on the population. People with LTNCs require support from a range of services, with much of the care for some conditions coming from specialties other than neurology, such as geriatrics and general medicine.[161]

Studies have found it challenging to get a clear local picture of healthcare activity due to LTNCs. Routine data usually centre on hospital admissions, which are likely to underestimate the true level of overall activity. Admissions tend to be most concentrated around the time of diagnosis and/or changes with the stages of disease trajectory.

Summary profiles can be found in a 2010 HNA for Oxfordshire,[158] providing 2–3 page summaries of a range of LTNCs. The information provided for each condition includes age of onset, symptoms, diagnosis, treatment, longer term support, and end of life care.

**Level of need in the population**

**Prevalence and incidence**

National estimates of prevalence and incidence for a range of conditions have been applied to the Medway population and summarised in Table 1, listed in order of prevalence (highest to lowest). Also included in the table are local estimates based on data from GP practice records and Quality Outcomes Framework (QOF) data, including numbers of people with Parkinson’s Disease, Multiple Sclerosis and Muscular Dystrophy who also have a possible diagnosis of depression.
Table 1: Estimates of incidence and prevalence of LTNCs in Medway

<table>
<thead>
<tr>
<th>Condition</th>
<th>Incidence per 100,000 (based on national estimate)</th>
<th>Incidence (No.)</th>
<th>Prevalence per 100,000 (based on national estimate)</th>
<th>Prevalence (no. based on national estimate)</th>
<th>Prevalence (no. based on local data)</th>
<th>No. with possible depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Migraine</td>
<td>400</td>
<td>1,150</td>
<td>15,000</td>
<td>43,113</td>
<td>No data</td>
<td></td>
</tr>
<tr>
<td>Traumatic brain injury leading to LTC</td>
<td>175</td>
<td>503</td>
<td>1,200</td>
<td>3,449</td>
<td>No data</td>
<td></td>
</tr>
<tr>
<td>Essential tremor</td>
<td>unknown</td>
<td>unknown</td>
<td>850</td>
<td>2,443</td>
<td>328</td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td>80</td>
<td>230</td>
<td>500-1,000</td>
<td>1,437-2,874</td>
<td>2,065</td>
<td></td>
</tr>
<tr>
<td>Parkinson’s disease</td>
<td>17</td>
<td>49</td>
<td>200</td>
<td>575</td>
<td>489</td>
<td>254</td>
</tr>
<tr>
<td>Cerebral palsy</td>
<td>unknown</td>
<td>unknown</td>
<td>144</td>
<td>414</td>
<td>235</td>
<td></td>
</tr>
<tr>
<td>Multiple sclerosis</td>
<td>4</td>
<td>11</td>
<td>144</td>
<td>414</td>
<td>475</td>
<td>285</td>
</tr>
<tr>
<td>Post-polio syndrome</td>
<td>unknown</td>
<td>unknown</td>
<td>100-300</td>
<td>287-862</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Dystonia</td>
<td>unknown</td>
<td>unknown</td>
<td>65</td>
<td>187</td>
<td>No data</td>
<td></td>
</tr>
<tr>
<td>Muscular dystrophy</td>
<td>unknown</td>
<td>unknown</td>
<td>50</td>
<td>144</td>
<td>39</td>
<td>32</td>
</tr>
<tr>
<td>Spinal chord injury</td>
<td>2</td>
<td>6</td>
<td>50</td>
<td>144</td>
<td>No data</td>
<td></td>
</tr>
<tr>
<td>Charcot-Marie Tooth</td>
<td>unknown</td>
<td>unknown</td>
<td>37</td>
<td>106</td>
<td>No data</td>
<td></td>
</tr>
<tr>
<td>Spina bifida and congenital hydrocephalus</td>
<td>unknown</td>
<td>unknown</td>
<td>24</td>
<td>69</td>
<td>No data</td>
<td></td>
</tr>
<tr>
<td>Huntingdon’ s disease</td>
<td>unknown</td>
<td>unknown</td>
<td>14</td>
<td>39</td>
<td>No data</td>
<td></td>
</tr>
<tr>
<td>Myasthenia gravis</td>
<td>unknown</td>
<td>unknown</td>
<td>10</td>
<td>29</td>
<td>71</td>
<td></td>
</tr>
<tr>
<td>Hereditary Ataxia</td>
<td>unknown</td>
<td>unknown</td>
<td>10</td>
<td>28</td>
<td>No data</td>
<td></td>
</tr>
</tbody>
</table>
Motor neurone disease 2 6 7 20 38
CNS infections 7 21 unknown unknown No data

Notes on table 1
• National estimates — All conditions based on various sources, applied to Medway’s resident population of 287,417 (PCIS 2013 Q1 estimates).
• Local estimates (epilepsy) — of all the LTNCs, QOF data is only available for epilepsy, and provides figures for adults (aged 18+) of 1,882 (QOF 2011/12). An estimate for Medway prevalence among children and young people is 183 (based on estimate produced by NICE).
• Local estimates (all other conditions) — taken from clinical records of 54 of the 58 Medway GP practices. The registered population across these practices is 277,994, almost 10,000 people fewer than the resident population used to extrapolate from national estimates. The figures above were taken from an existing audit called ‘Medway Prevalence’ and were correct as at 28th August 2013.
• Possible depression — taken from ‘Medway Prevalence’ audit with data for the three conditions shown.

Differences between local and national estimates of prevalence
Discrepancies exist between estimates of prevalence extrapolated from national figures and local data from GP records. Despite being one of the most prevalent conditions nationally, GP records show essential tremor to be less prevalent in Medway than epilepsy, PD and MS. Cerebral palsy is also far less prevalent than estimated from national figures and post-polio syndrome appears to be entirely absent in the local population.

To some extent these differences are to be expected since Medway’s population may not be representative of the national population. However, it possible that the large relative differences between national and local estimates for post-polio syndrome, essential tremor and muscular dystrophy are due to under- or misdiagnosis or people not being known to GPs.

It is noteworthy that local numbers of patients registered with Motor Neurone Disease (for which misdiagnosis is less likely given its severity and rapid progression) are almost double that of the national estimates. This has potential implications when planning services, particularly palliative care, for this condition. The number of patients registered with myasthenia gravis is also much higher than the national estimates. There is a slight genetic predisposition towards developing this condition [162] and it is possible that this is partly responsible for the high numbers in Medway.

Mental health co-morbidities
It is clear from Table 1 that a large proportion of people with MS (60%), muscular dystrophy (82%) and PD (52%) may also have depression. This has implications for the way in which services for people with LTNC need to be integrated with mental health
services to ensure that their needs are met holistically. Work is planned by Medway CCG to identify more fully the level of depression associated with long term conditions in general.

**Multiple Sclerosis and Parkinson’s Disease prevalence**

Table 2 shows estimates of the number of people with these conditions by stage of progression.

*Table 2: Prevalence breakdown by phase of progression for MS and PD. Source Neuronavigator, breakdown calculated using total prevalence from GP records*

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Multiple sclerosis</th>
<th>Parkinson’s disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum-moderate impairment (MS)/ Maintenance (PD)</td>
<td>22 199</td>
<td>53 198</td>
</tr>
<tr>
<td>Complex</td>
<td>243 164</td>
<td></td>
</tr>
<tr>
<td>Palliative</td>
<td>11 74</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>475 489</td>
<td></td>
</tr>
</tbody>
</table>

**Adult epilepsy prevalence**

As mentioned above, adult epilepsy is the only LTNC included within QOF. Figure 1 shows that Medway had a much higher prevalence in 2011/12 than England and all of the ONS cluster towns.

*Figure 1: Estimated prevalence per 1,000 of adult epilepsy in 2011/12, comparing Medway with England and the ONS cluster. Source: QOF 2012, based on data collected for QOF indicator Epilepsy 5*

**Mortality**

Standardised Mortality Ratios (SMR) associated with a neurological condition (as the underlying cause of death) are presented in figure 2 for the last ten years (2002–12). This shows an increasing trend in mortality in Medway to 2008 followed by a decreasing trend since. Compared to the Kent SMR for this period of 100, the SMR in DGS is the same (100), while it is higher in Medway (113) and Swale (114).
Table 3 shows condition specific mortality for the same period. There is also a description of the age distribution of deaths in 2012 across Kent and Medway to give a picture of where the overall mortality burden lies.

**Table 3: Number of deaths due to selected underlying LTNCs. Source: Office for National Statistics**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Number of deaths in Medway (2002-2012)</th>
<th>2012 deaths in Kent and Medway</th>
<th>Description of age distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parkinson’s</td>
<td>178</td>
<td>136</td>
<td>All adults aged 60+</td>
</tr>
<tr>
<td>Motor neurone disease and spinal muscular atrophy with most in those aged 65+</td>
<td>70</td>
<td>68</td>
<td>Heavily skewed towards older adults</td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td>44</td>
<td>49</td>
<td>Approximate bell</td>
</tr>
</tbody>
</table>
between the ages 35-39 and 85+

Epilepsy 71 34 Very few children, fairly even distribution

across adult ages until an increase in those 85+

Cerebral palsy 13 8 Deaths in both children and young adults

Huntingdon’s disease 30 9 All in adults aged 45+

CNS infections 6 sup All in adults 75+

Muscular dystrophy 9 sup

Spinal chord injury sup sup

Spina bifida and congenital hydrocephalus sup sup Most in adults 70+

Myasthenia gravis 6 sup All in adults 75+

Guillain Barre syndrome sup sup All in adults 65+

Total deaths (any underlying neurological condition) 437 324 Heavily skewed towards adults 65+

Deaths due to epilepsy in Medway accounted for 21% of the total mortality due to epilepsy across K&M in the period 2002–12, compared with DGS (11%) and Swale (7%). Deaths due to Huntington’s Disease in Medway were also disproportionately high, although this is expected given the presence of two homes in Medway dedicated to the care of people with advanced HD that take patients from outside the area. For PD, MS and MND, Medway has lower numbers of observed deaths than DGS, despite having a higher expected prevalence due to its larger population.

Admissions

There is an increasing trend in rates of both elective and emergency hospital admissions, where neurological conditions were the main reason for admission, since 2006, as shown in figures 3 and 4.
Figure 3: Elective admission rates due to LTNCs, 2006/07–2012/13
Figure 4: Emergency admission rates due to LTNCs, 2006/07–2012/13

There is more variation shown in figure 4 between areas than figure 3.

Age specific rates of emergency hospital admissions, where a neurological condition was the primary cause for admission, across Kent and Medway CCGs in the period 2010–13 are shown in figure 5. Medway CCG has the highest rates in the 65–84 and 85+ age bands and the second highest rate in the 0–19 age band. The emergency hospital admission rate for the 20–64 age band is relatively low. This could be of significance for provision of both palliative and paediatric care.
For elective admissions, the highest percentages of admissions in Medway are for patients aged 40 to 54 and 60 to 64. For emergency admissions, the highest percentages are for patients aged 0 to 4 and then over 40.

Conditions for which emergency admissions made up at least 80% of all admissions in 2010/11–2012/13 are epilepsy, migraine, PD, CNS infections, Guillain Barre syndrome, and HD. There were a large number of emergency epilepsy admissions, which accounted for 31% of all admissions due to a LTNC in the period. There is scope to greatly reduce this figure through better management or self-management of this condition.

The high proportion of elective MS admissions observed is due mainly to the presence of the Tysabri clinic at MFT, for which people with MS are admitted for a few hours so that they can be closely monitored during treatment.
There is a strong downward trend in emergency admissions for neurological conditions from the most to least deprived quintiles. For elective admission rate, there is not such a clear pattern. This is shown in figure 6.

![Figure 6: Directly standardised rates of hospital admissions by deprivation quintile, Medway CCG, 2010–13](image)

**Current services in relation to need**

**Community services**

Community neuro—physiotherapy: a neuro-phyiotherapist holds outpatient clinics at St Barts, MFT and the Walter Brice Centre for 130–150 patients.

**Specialist neurology services**

- PD and MS specialist nurses: MFT has two full time nurses for each condition, providing home visits, clinics, education and training.
- Epilepsy specialist nurses: One clinic a week is held in Lordswood by the ESN who also covers Dartford and Gravesham. MFT has submitted a business plan to recruit an ESN to increase provision and improve links with consultants.

- Tysabri clinic for MS: MS patients who stop responding to disease modifying therapies can be screened for suitability for Tysabri treatment, which takes place at Kings (London). Tysabri appointments occur every 4 weeks, with each one lasting a minimum of 90 minutes.

- Huntington’s disease specialist care in nursing homes: There are two nursing homes in Medway specialising in providing care for people with advanced HD, including many patients from outside of Medway.

- Emotional support and psychological therapies: The CCG is providing training for staff to recognise anxiety and to ensure appropriate support pathways are in place.

**Social services**

Support from social services for people with LTNC comes mainly for people with associated physical disabilities that are severe enough to qualify for social care. People will often enter the system once their condition is quite far advanced. The exception to this is the large number of people receiving support from the learning disabilities team who also happen to have epilepsy.

Social services at Medway Council is also diverting more resources into support for carers. They have started to implement a strategy for increasing the number of carer’s assessments completed and increasing the amount of support available, with a dedicated care manager and care manager’s assistant based at the council.

**Palliative and end of life care**

- MCH specialist palliative care service: MCH provides a specialist palliative care service, including Wisdom Hospice (15 beds), a day hospice and a home care team of nurses that care for about 350 patients in their homes at any one time. Outpatient clinics are provided at the Disablement Service Centre.

- Multi-disciplinary team for MND: A multi-disciplinary team provides a service for patients with MND which is unfunded and reliant on the goodwill of its members to function. The team comprises a palliative care consultant, Wisdom Hospice, home care nurse, social worker, MND association rep, Occupational Therapist (OT) from MCH and speech and language therapists. The team is usually involved from diagnosis of the condition, since the prognosis is usually 2–3 years. Joint clinics are held for people requiring non-invasive ventilation. These clinics are also due to start with a nutrition nurse for people who may need percutaneous endoscopic gastrostomy (PEG) feeding.

**Third sector services**

- The Huntington’s Disease Association: This is a small charity with one person working across Kent & Sussex and Bromley, Bexley and Dartford as a non-medical advisor, providing advice for individuals with HD, signposting them to services and also supporting professionals. The representative’s support extends to families and she makes home visits in Medway as well as visiting nursing homes and clinics.
• Parkinson’s UK: A large charity which has had active involvement in Medway, notably through pump–priming of the two PD specialist nurse posts. It has a local branch which meets monthly in Chatham, offering information and support to individuals, families and carers.

• MS Society: The MS Society has a local development support officer who works with branches as a volunteer. The Medway branch is quite active, organising social meetings and signposting people if they need support for advocacy. It also runs a drop in centre, has a helpline number and an active website. It organises speakers at its events such as the MS specialist nurse, who is also the charity’s main interface with the health service. Support for carers is provided from support volunteers and the national centre, and in 2014 a big push in this area is planned, including appointing strategic national lead for carers.

• Carers First: Support to carers is available primarily through Carers First in Gillingham, although each of the condition-specific charities offer support to carers too.

Evidence of what works

The National Service Framework (NSF) for LTNCs[159] is a comprehensive resource that, while out of date, outlines the key issues in this area. Its 11 quality requirements (QR) remain a useful gold standard for service provision for LTNCs across the health and social care sectors. A 2011 review of the NSF by the National Audit Office[163] was partly based on a systematic review of 146 documents. Included within these are fairly recent published audits of compliance with clinical guidance for a range of LTNCs.

The QRs in the NSF have the common theme of ‘integration’ running across them, but very limited advice is given about how to implement this in practice nor how to evaluate whether the outcome of continuity of care has been achieved.[164] Continuity of care should comprise good continuity in healthcare and social care, but also improved social and economic inclusion. Three types of service are highlighted that have the various factors identified as being necessary to promote continuity of care:

1. community interdisciplinary neurological rehabilitation teams (CINRT)
2. specialist nurses (SN)
3. proactive, holistic day opportunities services[165]

Common blockages to accessing these services include eligibility criteria, poorly-defined pathways and a lack of local availability or capacity. Third sector organisations also play an important role by improving access and promoting continuity of care.[164]

It is clear is that specialist nurses play a crucial role within a multi-disciplinary team (MDT), which is felt to be the best way of ensuring patient–centred services are delivered. SNs can act as a catalysts for change, lead service development and be a constant figure for the patient.[160]

An implementation framework now exists for end of life care in LTNCs. It notes that well delivered palliative care services, particularly if they are delivered holistically with
pain and symptom management, can improve patients’ quality of life as conditions progress.[166]

NICE has published comprehensive clinical guidance (CG) on the diagnosis and management of MS (CG8, 2003), PD (CG35, 2006) and epilepsy (CG137, 2012). NICE quality standards (QS) have also been published for epilepsy in adults (QS26) and children and young people (QS27). Quality standards are also being developed for MS, MND, cerebral palsy, PD, and for ‘relatively uncommon neurological problems e.g. muscular dystrophy’.

The Association of British Neurologists has guidelines on the management of MND, viral encephalitis in adults and the treatment of MS.

Map of Medicine has maps for a range of conditions: Bell’s palsy in adults, epilepsy in adults, headache in adults, HD, MS, PD.

Neurological Commissioning Support has also published care pathways for Progressive Supranuclear Palsy (PSP) and PD.

User Views

It was not possible to meet with consultants at Medway Foundation Trust (MFT), nor have direct contact with patients as part of this work. The views of these key groups should be included as part of the process of implementing the recommendations.

Unmet needs and service gaps

- At present on person from the Huntington’s Disease Association works across Kent, Sussex, Bromley, Bexley and Dartford as a non-medical advisor, but given the limited resources of one individual, it is not possible to support all people with HD in Medway, nor provide a service whereby she proactively contacts people on a regular basis.

- There is no GP with a Special Interest in neurology in Medway, resulting in frequent referrals to specialist nurses and consultant neurologists

- Provision of an epilepsy specialist nurse is limited with the one clinic a week in Medway being run by an ESN from Darent Valley Hospital.

Services in development

- Community neuro–rehabilitation pathway: MCH is in the early stages of developing a community pathway to ensure people with LTNCs receive the right therapy from the right provider and to minimise duplication. This will create a single point of access for patients who will have their treatment or rehabilitation plan coordinated and supported.

- Case management approach: MCH is liaising with the CCG regarding the restructuring of its services into a case management approach in order to give a holistic overview of complex cases.
• Shared electronic patient record: this is being developed by MCH to contain MyPlan, which is filled in as part of an assessment and contains an individual’s care plan, treatment and goals, which could then be viewed by all MCH services.

• Proposed neuro rehabilitative palliative care service: A business case has been developed for a neuro rehabilitative palliative care service, comprising a doctor, community nurse, neuro nurse, physio, counsellor/social worker, speech and language therapist and OT. Having such a team in place would enable more regular visits to places such as Millstream and Frindsbury care homes, which provide support for patients with advanced HD. The team would also work with the MS specialist nurse to proactively identify and assess patients whose condition is deteriorating, and with the PD specialist nurse to support patients with MSA/PSP. This team could also be tasked with identifying the small numbers of people with rarer LTNCS that exist in the community. It was estimated that there are 20–30 people with these conditions in Medway and almost no expertise to cover them currently.

**Recommendations for commissioning**

The following recommendations are those that are likely to be locally practicable and have the biggest impact, in terms of numbers involved, severity of the condition(s), risk and costs associated. The recommendations have tried to build upon or further inform existing opportunities and initiatives.

1. **Develop a strategy for neurology that is jointly owned and developed by health services, social care and relevant third sector organisations**
   • Improved integration for patient-focused services
   • Ownership within healthcare to include different medical specialties
   • Inform service planning through better use of data and existing estimates

2. **Improve community neuro-rehab to meet the on-going needs of people with LTNCS**
   • Appoint a community neurology specialist nurse to work closely within or alongside Medway Community Health’s emerging community neuro-rehab pathway, case management approach, condition-specific specialist nurses and palliative care team.
   • Develop a structured programme of training for community physios with the aim of having at least two physios with confidence in dealing with specific LTNCS. Additional neuro-physio capacity is likely to be required in the short term to achieve this.

3. **Improve management of epilepsy through provision of ESN(s)**
   • Pursue the plan to appoint an epilepsy specialist nurse at MFT as soon as possible
   • Closely monitor this nurse’s caseload/performance and plan for the appointment of at least one additional ESN, based either at MFT or in the community.
   • Determine optimal configuration of ESNs via discussion with the current ESN at DVH/Lordswood and investigation of the model used in Canterbury
4. Provide appropriate emotional and psychological support to people with LTNCs

- Build a more complete picture of the need: a) run a complete audit of GP records combining all main LTNCs with a range of relevant mental co-morbidities; b) consider this alongside priorities expressed by SNs, charities and patients.
- Explore opportunities for vocational rehab for people with LTNC such as MS to ensure they reap the mental health benefits of being in employment.

5. Establish arrangements for secure on-going provision of palliative and pre-palliative care

- Consider and negotiate proposed arrangements for a neuro-rehab palliative care team and ensure that sustainable funding is available for the existing MDT for MND.
- Facilitate more proactive and regular assessment of people in the complex phase of MS that might require transition to palliative services.
- Pilot a MDT for advanced PD cases, coordinated by the PD specialist nurse. One major focus would be to ensure care is arranged for people with multiple morbidities that might not, taken individually, warrant referral to a specialist.

Maternity and pregnancy

Summary

The health of a pregnant woman directly affects the health of her unborn child. What happens in the early years of life, starting in the womb, has lifelong effects on many aspects of health and well-being — from obesity, heart disease and mental health, to educational achievement and economic status. Giving every child the best start in life is crucial to reducing health inequalities across the life course.[167]

In 2008 a maternity needs assessment was undertaken in Medway.[168] This provided a detailed snapshot of the needs and services within Medway and compliance with standards within the Department of Health 2007 publication Maternity Matters[169] using data mainly up to 2007.

The Medway Annual Public Health Report 2009/10[152] also contained 2 chapters relating to maternity and the outcome of pregnancy. This chapter of the JSNA updates relevant information.

Who’s at risk and why?

While most births occur following an uneventful pregnancy, occasionally there are complications and rare tragedies which good antenatal care seeks to minimise. A maternal death is defined as ‘the death of a woman while pregnant or within 42 days of termination of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes’. There have been five maternal deaths in the last 10 years (that is with an underlying cause of death in chapter ‘O’ of the ICD 10 codes).[170]
Babies may also die – in utero, during labour or in the early days, weeks and months of life.

- Still births are deaths after 24 or more weeks of completed gestation — death may occur in utero or during labour.
- Perinatal deaths are deaths from the 24th week of gestation up to 6 completed days of life (i.e. include still births)
- Early neonatal deaths are deaths between birth and 6 completed days of life.
- Late neonatal deaths are deaths from 7–27 completed days of life.
- Neonatal deaths are deaths in the first 27 completed days of life.
- Post neonatal deaths are deaths at 28 days but under one year of life.
- Infant deaths are deaths between birth and under one year of life.

Still births and deaths in infancy are fortunately relatively rare events. Confidential enquiries into still births and neonatal deaths have been undertaken in the UK for many years and risk factors for these events have been identified.[171] They are:

- Maternal age – greater risk if less than 20 or 40 years and over
- Maternal Body Mass Index (BMI) – greater risk if underweight, overweight, obese or very obese.
- Maternal smoking
- BME ethnicity
- Maternal country of birth is outside the UK
- Maternal social deprivation – greater risk if living in more deprived area
- Booking for antenatal care after 12 weeks gestation
- Prematurity – greater risk if born before 37 weeks
- Low birthweight – greater risk if less than 2,500g and even higher risk if less than 1,500g
- Parity

Smoking in pregnancy has significant health consequences. Babies of women who smoke during pregnancy are more likely to be born prematurely, have twice the risk of being low birthweight and are up to three times more likely to die from sudden unexpected death in infancy (SUDI).[171]

*Multiple births*

Twins are at a higher risk of stillbirth (2.5 times higher) and neonatal deaths (6.4 times higher) than singletons but more research is needed to determine whether this is due to prematurity and growth restriction rather than specific twin factors.[171]
**Causes of prematurity**

The causes of prematurity are complex and in many premature births are unidentifiable. However risk factors in addition to smoking are maternal pre-eclampsia (a condition causing hypertension, severe headaches, vision problems etc, the risk of which itself is increased by obesity), cervical incompetence (where the cervix begins to thin and dilate before the pregnancy has reached term), multiple births, infections, a previous preterm delivery, low BMI and domestic violence. Preterm babies often have low birth weights which is associated with inhibited growth and cognitive development, and chronic diseases later in life.

**Level of need in the population**

**Demographics and fertility rates**

Population estimates for 2012 indicate there are 54,972 women of childbearing age (15–44 years) residing in Medway. This represents 20.5% of the total (male and female) population, a slightly higher proportion than the national estimate of 20.0% and South East estimate of 19.2%.

It is estimated that the number of women of this age group in Medway will increase in 2021 compared to 2011, by around 2,000 as shown in table 1.

### Table 1: Projections based on mid 2011 estimates of the population aged 15–44 years [172]

<table>
<thead>
<tr>
<th></th>
<th>2011 No</th>
<th>2016 No</th>
<th>Difference (%)</th>
<th>2021 No</th>
<th>Difference (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medway</td>
<td>54600</td>
<td>55000</td>
<td>0.7</td>
<td>56500</td>
<td>3.5</td>
</tr>
<tr>
<td>South East</td>
<td>1679900</td>
<td>1665400</td>
<td>-0.9</td>
<td>1675100</td>
<td>-0.3</td>
</tr>
<tr>
<td>England</td>
<td>10725400</td>
<td>10711900</td>
<td>-0.1</td>
<td>10821300</td>
<td>0.9</td>
</tr>
</tbody>
</table>

Some areas in Medway have a larger percentage of women in this age group than others. Figure 1 shows where the highest proportions of women aged 15–44 live in Medway.

**Figure 1: Percentage of female population aged 15 to 44 years, by lower layer super output area, with ward boundaries**

Figure 2 shows which wards in Medway have the highest number of women aged 15–44 residing of BME ethnicity.

**Figure 2: Number of females aged 15-44 with ethnicity other than White British, Irish or Irish/gypsy traveller**
In 2012, there were 3,693 live births to mothers usually resident in Medway. Table 2 shows the year on year increase since 2006. The increase between 2006 and 2012 is 436 (13.4%).

Table 2: Live births to Medway residents, 2006 to 2012 [173]

<table>
<thead>
<tr>
<th>Year</th>
<th>Medway</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>3257</td>
</tr>
<tr>
<td>2007</td>
<td>3345</td>
</tr>
<tr>
<td>2008</td>
<td>3419</td>
</tr>
<tr>
<td>2009</td>
<td>3515</td>
</tr>
<tr>
<td>2010</td>
<td>3538</td>
</tr>
<tr>
<td>2011</td>
<td>3564</td>
</tr>
<tr>
<td>2012</td>
<td>3693</td>
</tr>
</tbody>
</table>

The distribution of live births in 2012 by age of mother suggests that women in Medway are choosing to have babies younger than in the South East and England (figure 3).

Figure 3: The percentage of 2012 live births per age band [173]

This is supported by analysing the general fertility rate by age group. Figure 4 shows that women aged under 30 resident in Medway have consistently had a higher general fertility rate than for the South East and England. For women aged 30 and over, however, this pattern reverses.
The overall general fertility rate for Medway residents in 2012 was 67.2 per 1,000 females aged 15-44, higher than for England (64.9 per 1,000). In line with national trends, this has increased over recent years (figure 5). In 2012, Medway’s rate was significantly higher than for the South East.

Figure 4: General fertility rate (live births per 1,000 females aged 15-44) trend, by age band, 2003 to 2012 [173]
Figure 5: General fertility rate (live births per 1,000 females aged 15-44) trend, 2003 to 2012 [173]

The total period fertility rate (the average number of children a woman is expected to have during her reproductive life if she experiences the current age specific fertility rates) in Medway has been consistently higher than the England rate over recent years with the exception of 2008 when it was the same as the national rate of 1.97.

Table 3: Total period fertility rate, Medway and England 2006 to 2011 [174] [173]

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medway</td>
<td>1.92</td>
<td>1.98</td>
<td>1.97</td>
<td>2.07</td>
<td>2.07</td>
<td>2.00</td>
</tr>
<tr>
<td>England</td>
<td>1.86</td>
<td>1.91</td>
<td>1.97</td>
<td>1.96</td>
<td>2.00</td>
<td>1.93</td>
</tr>
</tbody>
</table>

Abortions

Some pregnancies are unplanned to the extent that they result in terminations. Figure 6 shows that the rate of terminations is significantly higher in Medway than in England. In 2012, there were 1,094 terminations in Medway resident women. The highest age
group was 20-24 years old with 349 terminations. This suggests there is a need for more effective sexual health and contraceptive services in Medway.

Figure 6: The rate of abortions per 1,000 Medway resident women, 2012 [175]

Booking

Women are encouraged to contact midwifery services as soon after they are aware they are pregnant as possible. Medway NHS Foundation Trust (MFT) offers “early bird group sessions” where women in the early stages of pregnancy have the opportunity to receive information and advice from community midwives prior to their booking appointment which is ideally at 8–10 weeks gestation (measured from the first day of a woman’s last menstrual period). Data from MFT of the week of booking in is shown in Table 4. Owing to the number of unknown/blank entries, definite conclusions cannot be drawn, but it seems most women are booking in prior to 12 weeks gestation and the number of unknown entries is reducing year on year.

Table 4: Gestation of women booking at MFT, 2009 to 2013 [176]
Where do women booking at Medway hospital live?

The majority of women registered with Medway GP practices are booked for maternity care with MFT. This hospital also provides maternity care for a large proportion of women in Swale. Table 5 shows the local authority of residence of women giving birth at MFT. The number of women from Maidstone district has almost doubled in 2012 compared to 2009. This could be partly due to the consultant-led maternity provision moving to Pembury hospital in Tunbridge Wells, although the number has reduced again in 2013. Figure 7 shows the same data, but hotspots by lower super output area (LSOA) the areas with the highest numbers of women booking into MFT.

Table 5: Local authority of residence of women booking at MFT

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medway</td>
<td>3,274</td>
<td>3,284</td>
<td>3,387</td>
<td>3,488</td>
<td>3,279</td>
</tr>
<tr>
<td>Swale</td>
<td>1,263</td>
<td>1,351</td>
<td>1,284</td>
<td>1,361</td>
<td>1,339</td>
</tr>
<tr>
<td>Maidstone</td>
<td>78</td>
<td>94</td>
<td>104</td>
<td>141</td>
<td>102</td>
</tr>
<tr>
<td>Tonbridge and Malling</td>
<td>76</td>
<td>65</td>
<td>77</td>
<td>95</td>
<td>85</td>
</tr>
<tr>
<td>Gravesham</td>
<td>34</td>
<td>22</td>
<td>34</td>
<td>36</td>
<td>38</td>
</tr>
<tr>
<td>Canterbury</td>
<td>5</td>
<td>6</td>
<td>11</td>
<td>19</td>
<td>6</td>
</tr>
<tr>
<td>Dartford</td>
<td>6</td>
<td>5</td>
<td>7</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>Bexley</td>
<td>5</td>
<td>7</td>
<td>5</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>28</td>
<td>31</td>
<td>26</td>
<td>34</td>
<td>26</td>
</tr>
<tr>
<td>Total</td>
<td>4,769</td>
<td>4,865</td>
<td>4,935</td>
<td>5,197</td>
<td>4,891</td>
</tr>
</tbody>
</table>

Figure 7: Lower super output area of residence of women booking at MFT, 2009 to 2012

Table 6 shows that, of the women living in Medway and booking in at MFT, nearly 10% live in the Gillingham North ward. A high proportion of women also live in Chatham Central, Gillingham South and Luton and Wayfield. These 4 wards represent a third of women living in Medway and booking in at MFT.
Table 6: The ward of residence of Medway women booking at MFT, 2009 to 2013 [176]

<table>
<thead>
<tr>
<th>Ward</th>
<th>Number</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gillingham North</td>
<td>1,535</td>
<td>9.3</td>
</tr>
<tr>
<td>Chatham Central</td>
<td>1,488</td>
<td>9.1</td>
</tr>
<tr>
<td>Gillingham South</td>
<td>1,316</td>
<td>8.0</td>
</tr>
<tr>
<td>Luton and Wayfield</td>
<td>1,199</td>
<td>7.3</td>
</tr>
<tr>
<td>Strood South</td>
<td>1,077</td>
<td>6.6</td>
</tr>
<tr>
<td>Princes Park</td>
<td>770</td>
<td>4.7</td>
</tr>
<tr>
<td>Strood Rural</td>
<td>758</td>
<td>4.6</td>
</tr>
<tr>
<td>Rainham South</td>
<td>739</td>
<td>4.5</td>
</tr>
<tr>
<td>Rochester East</td>
<td>734</td>
<td>4.5</td>
</tr>
<tr>
<td>Strood North</td>
<td>739</td>
<td>4.5</td>
</tr>
<tr>
<td>Twydall</td>
<td>721</td>
<td>4.4</td>
</tr>
<tr>
<td>Peninsula</td>
<td>614</td>
<td>3.7</td>
</tr>
<tr>
<td>Rochester South and Horsted</td>
<td>586</td>
<td>3.6</td>
</tr>
<tr>
<td>Rochester West</td>
<td>584</td>
<td>3.6</td>
</tr>
<tr>
<td>Lordswood and Capstone</td>
<td>554</td>
<td>3.4</td>
</tr>
<tr>
<td>Walderslade</td>
<td>538</td>
<td>3.3</td>
</tr>
<tr>
<td>Rainham Central</td>
<td>516</td>
<td>3.1</td>
</tr>
<tr>
<td>Rainham North</td>
<td>508</td>
<td>3.1</td>
</tr>
<tr>
<td>River</td>
<td>503</td>
<td>3.1</td>
</tr>
<tr>
<td>Watling</td>
<td>435</td>
<td>2.6</td>
</tr>
<tr>
<td>Hempstead and Wigmore</td>
<td>315</td>
<td>1.9</td>
</tr>
<tr>
<td>Cuxton and Halling</td>
<td>207</td>
<td>1.3</td>
</tr>
</tbody>
</table>

Table 7 contains data for all women booking into MFT (not just those living in Medway) and so the deprivation quintiles used are for England. There is a reduction across the quintiles in 2013 compared to 2012 due to the lower number of births, with the exception of quintile 5 (least deprived).

Table 7: Deprivation quintile (England) of women booking at MFT, 1 = most deprived [176]

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quintile 1</td>
<td>928</td>
<td>1,027</td>
<td>1,017</td>
<td>1,122</td>
<td>1,082</td>
</tr>
<tr>
<td>Quintile 2</td>
<td>1,639</td>
<td>1,583</td>
<td>1,648</td>
<td>1,729</td>
<td>1,603</td>
</tr>
<tr>
<td>Quintile 3</td>
<td>795</td>
<td>791</td>
<td>812</td>
<td>809</td>
<td>729</td>
</tr>
<tr>
<td>Quintile 4</td>
<td>612</td>
<td>703</td>
<td>635</td>
<td>775</td>
<td>691</td>
</tr>
<tr>
<td>Quintile 5</td>
<td>568</td>
<td>518</td>
<td>558</td>
<td>502</td>
<td>527</td>
</tr>
</tbody>
</table>

The number of women booking in at MFT with ethnicity ‘Any other white background’ has risen by 70% between 2009 and 2012 (table 8).
Table 8: Ethnicity of women booking in at MFT [176]

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>4047</td>
<td>4087</td>
<td>4172</td>
<td>4304</td>
<td>4040</td>
</tr>
<tr>
<td>White Irish</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Any other White</td>
<td>209</td>
<td>275</td>
<td>279</td>
<td>355</td>
<td>343</td>
</tr>
<tr>
<td>background Indian</td>
<td>106</td>
<td>114</td>
<td>114</td>
<td>123</td>
<td>99</td>
</tr>
<tr>
<td>Pakistani</td>
<td>26</td>
<td>28</td>
<td>26</td>
<td>22</td>
<td>28</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>38</td>
<td>26</td>
<td>22</td>
<td>29</td>
<td>27</td>
</tr>
<tr>
<td>Any other Asian</td>
<td>32</td>
<td>51</td>
<td>46</td>
<td>48</td>
<td>65</td>
</tr>
<tr>
<td>background White and</td>
<td>&lt;5</td>
<td>14</td>
<td>6</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>Asian</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White and black</td>
<td>6</td>
<td>&lt;5</td>
<td>7</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>African</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White and black</td>
<td>7</td>
<td>11</td>
<td>9</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td>Caribbean</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any other mixed</td>
<td>20</td>
<td>15</td>
<td>17</td>
<td>19</td>
<td>15</td>
</tr>
<tr>
<td>background Black</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African</td>
<td>110</td>
<td>142</td>
<td>128</td>
<td>140</td>
<td>130</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>24</td>
<td>25</td>
<td>24</td>
<td>16</td>
<td>25</td>
</tr>
<tr>
<td>Any other Black</td>
<td>15</td>
<td>11</td>
<td>8</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>background Chinese</td>
<td>18</td>
<td>18</td>
<td>21</td>
<td>23</td>
<td>17</td>
</tr>
<tr>
<td>Any other ethnic group</td>
<td>98</td>
<td>51</td>
<td>59</td>
<td>62</td>
<td>63</td>
</tr>
<tr>
<td>Not collected/Not</td>
<td>34</td>
<td>17</td>
<td>10</td>
<td>13</td>
<td>15</td>
</tr>
<tr>
<td>stated/blank</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Parity and Gravidity

Parity is the number of children previously born at a gestation of 24 weeks or more, regardless of whether they were live or stillborn, and gravidity is the number of times a woman has been pregnant. As mentioned in the last section, parity can be a factor in infant mortality. The number ‘unknown’ has fallen significantly in 2013.

Table 9: The number of births with the following parity [176]

<table>
<thead>
<tr>
<th>Parity</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>2,048</td>
<td>2,152</td>
<td>2,201</td>
<td>2,240</td>
<td>2,120</td>
</tr>
<tr>
<td>1</td>
<td>1,526</td>
<td>1,595</td>
<td>1,564</td>
<td>1,809</td>
<td>1,734</td>
</tr>
<tr>
<td>2</td>
<td>709</td>
<td>664</td>
<td>756</td>
<td>745</td>
<td>710</td>
</tr>
<tr>
<td>3</td>
<td>271</td>
<td>282</td>
<td>268</td>
<td>304</td>
<td>234</td>
</tr>
<tr>
<td>4</td>
<td>86</td>
<td>98</td>
<td>87</td>
<td>99</td>
<td>110</td>
</tr>
<tr>
<td>5</td>
<td>36</td>
<td>40</td>
<td>38</td>
<td>25</td>
<td>34</td>
</tr>
<tr>
<td>6</td>
<td>18</td>
<td>16</td>
<td>15</td>
<td>14</td>
<td>18</td>
</tr>
<tr>
<td>7 and over</td>
<td>12</td>
<td>16</td>
<td>15</td>
<td>19</td>
<td>18</td>
</tr>
<tr>
<td>Unknown</td>
<td>173</td>
<td>120</td>
<td>88</td>
<td>57</td>
<td>16</td>
</tr>
</tbody>
</table>

Table 10: The number of births with the following gravidity [176]

<table>
<thead>
<tr>
<th>Gravidity</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 and over</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 11 shows the main languages spoken by women aged 16-49 resident in Medway and the five wards with the highest numbers of women of child bearing age. Women in these wards account for just over 31% of all women aged 16-49 in Medway, but they account for 60% of speakers of languages other than English. 78% with a main language of 'other South Asian language' live in these five wards along with 66% of Gujarati and 'other European language (non EU)' speakers. Please note this is a table of the main language spoken and English may be a second language for anyone not having it as their primary language.

<table>
<thead>
<tr>
<th>Languages</th>
<th>Medway</th>
<th>Chatham</th>
<th>Gillingham Central</th>
<th>Gillingham North</th>
<th>Gillingham South</th>
<th>Luton and Wayfield</th>
<th>River</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>58,399</td>
<td>3,581</td>
<td>4,569</td>
<td>3,702</td>
<td>3,110</td>
<td>2,276</td>
<td></td>
</tr>
<tr>
<td>French</td>
<td>134</td>
<td>18</td>
<td>15</td>
<td>15</td>
<td>8</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Portuguese</td>
<td>101</td>
<td>20</td>
<td>11</td>
<td>7</td>
<td>8</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Spanish</td>
<td>91</td>
<td>15</td>
<td>6</td>
<td>3</td>
<td>5</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Polish</td>
<td>589</td>
<td>124</td>
<td>58</td>
<td>77</td>
<td>78</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>Other European language (EU)</td>
<td>1,145</td>
<td>255</td>
<td>112</td>
<td>145</td>
<td>149</td>
<td>91</td>
<td></td>
</tr>
<tr>
<td>Other European language (non EU)</td>
<td>383</td>
<td>79</td>
<td>31</td>
<td>39</td>
<td>46</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>Arabic</td>
<td>70</td>
<td>5</td>
<td>10</td>
<td>6</td>
<td>3</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>West/Central Asian language</td>
<td>88</td>
<td>14</td>
<td>6</td>
<td>15</td>
<td>7</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Panjabi</td>
<td>302</td>
<td>59</td>
<td>13</td>
<td>32</td>
<td>15</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Urdu</td>
<td>115</td>
<td>12</td>
<td>13</td>
<td>32</td>
<td>11</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Bengali (with 207)</td>
<td></td>
<td></td>
<td>11</td>
<td>31</td>
<td>13</td>
<td>8</td>
<td></td>
</tr>
</tbody>
</table>
Sylheti and Chatgaya)

Gujarati 76 16 7 12 6 9
Tamil 71 6 8 7 6 13
Any other South Asian language 234 30 21 60 4 68
Chinese 209 25 23 15 7 44
Any other East Asian language 283 34 31 75 17 13
African language 236 32 31 24 19 26
Other language 28 4 6 3 2 2
Total 62,761 4,386 4,982 4,300 3,514 2,673

Delivery

Place of delivery

The Birth Place opened in October 2011 and it can be seen in table 12 the impact this has had on the number of deliveries in the Delivery Suite. The number of deliveries in theatre has gone up however, in line with the increase in emergency caesarean sections shown in table 13. The number of planned homebirths decreased by nearly 40% between 2011 and 2012.

Table 12: Number of births at each location between 2009 and 2013 [176]

<table>
<thead>
<tr>
<th>Location</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery Suite</td>
<td>3036</td>
<td>3122</td>
<td>3067</td>
<td>2430</td>
<td>2374</td>
</tr>
<tr>
<td>Theatre</td>
<td>1437</td>
<td>1472</td>
<td>1448</td>
<td>1696</td>
<td>1576</td>
</tr>
<tr>
<td>The Birth Place</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>152</td>
<td>882</td>
<td>770</td>
</tr>
<tr>
<td>Planned homebirth</td>
<td>187</td>
<td>157</td>
<td>145</td>
<td>89</td>
<td>87</td>
</tr>
<tr>
<td>Unknown</td>
<td>121</td>
<td>140</td>
<td>131</td>
<td>87</td>
<td>57</td>
</tr>
<tr>
<td>Unplanned homebirth</td>
<td>56</td>
<td>52</td>
<td>46</td>
<td>72</td>
<td>73</td>
</tr>
<tr>
<td>Other ward/ triage/hospital</td>
<td>29</td>
<td>27</td>
<td>29</td>
<td>31</td>
<td>44</td>
</tr>
<tr>
<td>In ambulance on route to hospital</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>12</td>
<td>&lt;5</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>6</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>5</td>
<td>6</td>
<td>&lt;5</td>
<td>6</td>
</tr>
</tbody>
</table>

Type of delivery

There has been a 19% increase in emergency c-sections between 2009 and 2012 (+149). The number of normal vaginal deliveries has also increased (7.5%, +234). ‘Breech’ means a breech vaginal delivery. The majority of breech presentations are likely to be delivered by caesarean. Despite the lower number of births in 2013, the number requiring forceps continues to rise.
Table 13: Method of delivery [176]

<table>
<thead>
<tr>
<th>Method of Delivery</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery Suite</td>
<td>3036</td>
<td>3122</td>
<td>3067</td>
<td>2430</td>
<td>2374</td>
</tr>
<tr>
<td>Theatre</td>
<td>1437</td>
<td>1472</td>
<td>1448</td>
<td>1696</td>
<td>1576</td>
</tr>
<tr>
<td>The Birth Place</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>152</td>
<td>882</td>
<td>770</td>
</tr>
<tr>
<td>Planned homebirth</td>
<td>187</td>
<td>157</td>
<td>145</td>
<td>89</td>
<td>87</td>
</tr>
<tr>
<td>Unknown</td>
<td>121</td>
<td>140</td>
<td>131</td>
<td>87</td>
<td>57</td>
</tr>
<tr>
<td>Unplanned homebirth</td>
<td>56</td>
<td>52</td>
<td>46</td>
<td>72</td>
<td>73</td>
</tr>
<tr>
<td>Other ward/atriage/hospital grounds</td>
<td>29</td>
<td>27</td>
<td>29</td>
<td>31</td>
<td>44</td>
</tr>
<tr>
<td>In ambulance on route to hospital</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>12</td>
<td>&lt;5</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>6</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>5</td>
<td>6</td>
<td>&lt;5</td>
<td>6</td>
</tr>
</tbody>
</table>

Figure 8 is data taken from nationally published tables and shows that the proportion of elective caesarean sections has decreased slightly over the last four years; Medway is not significantly different to England. However, the proportion of emergency caesarean sections is increasing in Medway, whilst England is approximately stable meaning that Medway is significantly higher.
Figure 8: The proportion of deliveries that are elective or emergency caesarean sections [178]

Pain relief

Table 14 shows the number of deliveries using the main types of pain relief. It is common for women to use more than one type of relief during labour and delivery. Regional anaesthesia is also known as a spinal block and is used for caesareans.

Table 14: The number of births involving each type of pain relief in 2012 and 2013 [176]

<table>
<thead>
<tr>
<th></th>
<th>Pethidine</th>
<th>Epidural</th>
<th>Entonox</th>
<th>None</th>
<th>Other</th>
<th>Regional Anaesthesia</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>912</td>
<td>790</td>
<td>3,022</td>
<td>1,145</td>
<td>101</td>
<td>67</td>
</tr>
<tr>
<td>2013</td>
<td>798</td>
<td>782</td>
<td>2,867</td>
<td>733</td>
<td>85</td>
<td>47</td>
</tr>
</tbody>
</table>

Smoking at time of delivery (SATOD)

Smoking in pregnancy has significant health consequences. Babies of women who smoke are more likely to be born prematurely, have twice the risk of being low
birthweight and are up to three times more likely to die from Sudden Unexpected Death in Infancy (SUDI). Figure 9 shows the percentage of women smoking at time of delivery in Medway is significantly higher than in England.

![Figure 9: The percentage of women smoking at time of delivery][179]

Accurate recording of smoking status at time of delivery has now been implemented as a CQUIN (Commissioning for Quality and Innovation) indicator meaning that, as of April 2013, more women have their smoking status accurately recorded at time of delivery.

**Table 15: Number of mothers smoking at time of delivery [176]**

<table>
<thead>
<tr>
<th></th>
<th>Number of mothers</th>
<th>Number smoking at delivery</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr 2013</td>
<td>298</td>
<td>57</td>
<td>19.1</td>
</tr>
<tr>
<td>May 2013</td>
<td>264</td>
<td>42</td>
<td>15.9</td>
</tr>
<tr>
<td>Jun 2013</td>
<td>281</td>
<td>50</td>
<td>17.8</td>
</tr>
<tr>
<td>Jul 2013</td>
<td>339</td>
<td>48</td>
<td>14.2</td>
</tr>
<tr>
<td>Aug 2013</td>
<td>310</td>
<td>54</td>
<td>17.4</td>
</tr>
</tbody>
</table>
Mortality rates

Still births and deaths in infancy are rare events so three year rolling averages are used for the presentation of this data. Figure 10 shows that the still birth rate for 2010-12 was 4.8 per 1,000 total births.

Figure 10: Stillbirth rate in Medway and England, 3 year pooled data, 2001 to 2012 [173]

The neonatal mortality rate in Medway for 2010-12 was 2.1 per 1,000 live births, the lowest rate since 2001-03, but not significantly lower than England. The trend is shown in figure 11.
Figure 11: Neonatal mortality rate in Medway and England, 3 year pooled data, 2001 to 2012 [173]

Table 16 shows the causes of neonatal deaths in England and Wales in 2011. The most common causes are conditions related to prematurity. This is supported when considering mortality rates by birthweight. In 2011, babies with birthweight <1,500 grams had a neonatal mortality rate of 145.4 per 1,000 live births in England and Wales. For babies with birthweight <2,500 grams, the neonatal mortality rate was 28.9 per 1,000 births compared to 0.7 per 1,000 live births with birthweight at least 2,500 grams.

Table 16: Causes of neonatal deaths in England and Wales, 2011 [180]

<table>
<thead>
<tr>
<th>Cause</th>
<th>Number</th>
<th>Proportion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immaturity related conditions</td>
<td>1207</td>
<td>57.6</td>
</tr>
<tr>
<td>Congenital anomalies</td>
<td>553</td>
<td>26.4</td>
</tr>
<tr>
<td>Asphyxia, anoxia or trauma (intrapartum)</td>
<td>185</td>
<td>8.8</td>
</tr>
<tr>
<td>Antepartum infections</td>
<td>40</td>
<td>1.9</td>
</tr>
</tbody>
</table>
Other conditions 33  1.6  
Infections 31  1.5  
Sudden infant deaths 22  1.1  
Other specific conditions 17  0.8  
External conditions 7  0.3  
Total 2095  

Infant mortality rates have decreased nationally and in Medway over the past decade. Figure 12 shows that Medway’s rate is lower than England, but not significantly so. The infant mortality rate in Medway for 2010-12 was 3.3 per 1,000 live births.

![Graph showing infant mortality rates in Medway and England, 2001 to 2012.]

*Figure 12: Infant mortality rate in Medway and England, 3 year pooled data, 2001 to 2012 [173]*

**Birth weight**

Preterm babies often have low birth weights which is associated with inhibited growth and cognitive development, and chronic diseases later in life. Low birth weight also
increases the risk of stillbirth. Figure 13 shows that the most common weight category is 3-3.5kg and most babies weighed between 3 and 4kg. Babies with a high birth weight are at higher risk of injuries during the birth and problems with blood sugar control. High birthweight is classified as more than 4.5kg (9lb 15oz).

**Figure 13: Weight distribution of live births, 2009 to 2012 [173]**

**APGAR**

The APGAR score was devised to quickly assess the health of a newborn baby by scoring 0 to 2 for: appearance/complexion, pulse rate, reflex irritability, activity and respiratory effort. Table 17 shows the APGAR scores of babies 5 minutes after birth. Babies with a 0 recorded have been excluded from table 17 due to uncertainty in recording practices.

**Table 17: The number of babies with the following APGAR scores at 5 minutes, 2009 to 2013 [176]**

<table>
<thead>
<tr>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
</tr>
<tr>
<td>8</td>
</tr>
</tbody>
</table>
Breastfeeding

Increasing breastfeeding initiation rates is an important target for the NHS in Medway. Breastfeeding is a key indicator of child health and wellbeing, which contributes to reducing infant mortality, health inequalities and obesity. There is evidence that babies who are breast fed experience lower levels of gastro-intestinal and respiratory infection. Observational studies have shown that breastfeeding is associated with lower levels of child obesity.

The UK Infant Feeding Survey 2010 [181] showed that 81% of women in the UK breastfed their babies after birth. By 6 weeks, this was down to 55% of mothers, 7 percentage points higher than in the 2005 survey. However, 85% of women stopping breastfeeding between 1 and 2 weeks said they would have preferred to breastfeed for longer. This suggests that much more could be done to support and help them to exclusively breastfeed up to 6 months of age, with continued breastfeeding along with appropriate complementary foods up to two years of age or beyond as per World Health Organisation guidance.

Breastfeeding rates in Medway are well below the national average and have remained at that rate for several years. The percentage of mothers initiating breastfeeding in Medway was 71% in Q2 of 2013/14. Medway has consistently been below the national and regional level each quarter. By the age of 6–8 weeks, 39.8% of babies were still receiving breast milk in Medway. [182] This represents a significant fall in breastfeeding rates during the first two months after birth.
Figure 14: Percentage of women initiating breastfeeding, 2009/10 – 2013/14 [182]

Figure 15 shows the percentage of babies either totally or partially breastfed at 6–8 weeks of age. Totally breastfed is defined as infants who are exclusively receiving breast milk - that is, they are not receiving formula milk, any other liquids or food. Partially breastfed is defined as infants who are receiving breast milk and who are also receiving formula milk or any other liquids or food. [183]
Breastfeeding can contribute significantly towards reducing health inequalities amongst those in the UK least likely to breastfeed. These groups were identified in the Infant Feeding Survey 2010 as white, under 20 years old, having left school at sixteen or younger, never worked, and living in the most deprived quintile.

In Medway, breastfeeding rates are highest among older mothers and those from the least deprived areas. White women are less likely to initiate breastfeeding than BME groups. Continuation of exclusive breastfeeding is lowest among younger mothers and White women. At the time of the Maternity Matters Needs Assessment (2007), only 25% of babies born to White women locally were receiving any breast milk at 6 to 8 weeks compared with 62% of babies born to women from Black/ Black British background.

Funding from the Department of Health in 2009 has enabled a programme of interventions to be put in place to increase breastfeeding in Medway. These interventions include:

Figure 15: Percentage of women breastfeeding at 6–8 weeks, 2009/10 – 2013/14 [182]
• Development of a cross-organisation Infant Feeding Strategy (see appendices) and a group which meets quarterly to implement it.

• Implementation of the UNICEF UK Baby Friendly Initiative (BFI) as routine practice in maternity and community services.

• Maternity services achieved the Certificate of Commitment for BFI in August 2011 and the Level 1 award in 2012.

• Community services achieved the UNICEF UK BFI Level 2 Award in September 2011 and are working towards the Level 3 award with the assessment in summer 2014.

• Introduction of a peer support network (Medway Breastfeeding Network) to support local mothers.

• Implement workforce training and development in all maternity and early years settings to increase knowledge of infant feeding. The Infant Feeding Strategy Group is working on a training matrix to assess the level of breastfeeding knowledge and skill amongst the workforce. Training in introducing solids is now being delivered to Children’s Centre staff.

Current services in relation to need

Ideally women should plan their pregnancies — this enables them to conceive a baby when they are physically as fit as possible — having given up smoking if they are smokers and gained a normal healthy weight. Planning a pregnancy also enables women to take a low dose of folic acid which has been proven to reduce neural tube defects such as spina bifida during the time when they are trying to conceive, vitamin D (deficiency impairs the absorption of dietary calcium and phosphorus, which can give rise to bone problems such as rickets in children, and bone pain and tenderness as a result of osteomalacia in adults) [184] and to discuss any changes in medication with their doctor if they have a chronic disease such as hypertension, epilepsy or diabetes so that they are not taking any drugs which might prove harmful to the baby and receive optimal care.

Medway hospital has a range of maternity services:

Consultant Led Unit — Primarily for women with complications identified in their previous medical history, previous birth experiences or their current pregnancy or labour. All aspects of intrapartum care can be provided within Medway NHS Trust without the need to transfer women to a neighbouring Trust or specialist unit.

Midwifery Led Unit (MLU) — The Birth Place is staffed and led by midwives and is designed for women experiencing low risk pregnancies. It is a co-located unit at Medway Hospital and has been open since October 2011. The unit contains five birth rooms two of which also contain birth pools as well as a 4-bedded postnatal bay. If an unforeseen complication occurs or there is a change in risk status, there is direct and instant access to the consultant led unit along the corridor.
Home Births — All four community teams offer a home birth service. A planned home birth is a safe option for women with low risk pregnancies. A midwife will help in preparation for the birth and two midwives will attend the birth to assist with labour and delivery. In the case of any concerns during labour or birth, the woman will be transferred to the local consultant-led unit by ambulance accompanied by the attending midwife.

There are three wards that provide postnatal care.

**Specialist maternity services**

In every society there are some groups who are more vulnerable than others, brought about by societal factors and the environments in which people live. There are some common challenges across all vulnerable groups including the risk of stigma and discrimination, restricted access to educational opportunities and exclusion from income generation. Within these groups there are varying levels of vulnerability.

This section illustrates the needs of some (it is not exhaustive) of the vulnerable groups in Medway and Swale. The intention here is to show how vulnerability is an important issue to consider in the design and implementation of services and programmes.

**Smoking**

The smoking status of the woman and her partner is assessed at booking and updated throughout her pregnancy. The effects of smoking on the fetus and new born baby are discussed. Smoking in pregnancy has significant health consequences. Babies of women who smoke are more likely to be born prematurely, have twice the risk of being low birthweight and are up to three times more likely to die from Sudden Unexpected Death in Infancy (SUDI). Carbon monoxide (CO) levels have been assessed at booking since April 2011 and smoking cessation clinic services are offered to couples in collaboration with Medway Public Health.

**Breastfeeding**

The benefits of breastfeeding for both mother and baby are widely recognised, however the choice of feeding for mothers in Medway and Swale doesn’t reflect this (for current breastfeeding levels, see Level of Need). Peer support workers attend the post natal wards voluntarily to offer help and advice to all women. Those women with particular breastfeeding issues that cannot be addressed by the ward staff are referred to the breastfeeding midwifery specialist who assesses their needs, makes a plan of care in collaboration with the mother and supports both her and the staff to achieve success. Breastfeeding promotion needs to be continued throughout the first six months following delivery. A specialist clinic for 1:1 advice and assessment of breastfeeding is run on a weekly basis by the breastfeeding midwifery specialist and the Medway Public Health breastfeeding lead. There are 26 breastfeeding support groups throughout Medway, available for all mothers to attend, run by the same peer support workers who attend the wards to provide continuity for the women. The Trust has achieved the UNICEF accreditation in breast feeding standards
**Infectious Diseases and Haemoglobinopathy**

There are on average 10 HIV cases per year, 35 Hepatitis B cases per year, 10 Hepatitis C cases per year and 6 syphilis cases per year. Clients require Genito-Urinary Medicine (GUM) input, specialist referral for the Hepatitis B and C to gastroenterology and lead consultant input.

There are 90 haemoglobinopathy (genetic defect that results in abnormal structure of one of the globin chains of the hemoglobin molecule, a common example being sickle-cell disease) carriers per year requiring partner testing. On average 10% will be carriers and require counselling from the Antenatal Screening Co-ordinator for Infectious Diseases and Haemoglobinopathies who has received additional training, to decide whether they wish invasive prenatal diagnosis followed by referral to fetal medicine. Around 50% choose prenatal diagnosis.

**Substance Misuse**

The Windmill Clinic is a joint midwifery and drug service clinic that is held on Tuesday afternoons alongside the Antenatal Clinic of the lead Obstetric Consultant for substance misuse. Any pregnant women with significant substance misuse issues including alcohol misuse can access care from a specialist midwife in substance misuse and a keyworker from KCA or Medway Alcohol Services.

The aim of the clinic is not to replace normal midwifery care – it is an extra service to provide specialist input under one roof. Clients with recognised high risk pregnancies (as recognised by NICE [185]) have access to Consultant obstetric care, specialist midwifery care, drug service care and access to obstetric ultrasound, phlebotomy and neonatal input in one place. As part of the clinic a weekly multidisciplinary meeting is held where the drug and alcohol keyworkers, specialist midwives in substance misuse, safeguarding and mental health, the liaison midwife from the transitional care ward as well as the neonatal liaison sister can meet to discuss clients.

*Table 1: The number of women seen with substance misuse issues*

<table>
<thead>
<tr>
<th></th>
<th>Heroin</th>
<th>Alcohol</th>
<th>Cannabis</th>
<th>Amphetamine</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>18</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
<tr>
<td>2011</td>
<td>5</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
<tr>
<td>2012</td>
<td>9</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
<tr>
<td>2013</td>
<td>11</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
</tbody>
</table>

**Antenatal and Postnatal Mental Health**

Women experiencing mental health problems during pregnancy or after birth are referred to the mental health specialist midwife who will offer them a one hour appointment to discuss their mental health needs, talk to them about how best to manage their psychological difficulties, advise them on the support available locally, and make referrals to specialist services if needed. Referrals come from other midwives, as well as GPs, obstetricians, social workers and health visitors.

There is a clear robust pathway to ensure women are referred to the obstetric lead and Mother and Infant Mental Health Service (MIMHS). There is a weekly multidisciplinary
team meeting to review all cases. Participants include the specialist midwife, the specialist obstetrician, the perinatal psychologist, the specialist nurse and a midwife from the antenatal department. Since the development of this position, women and their families have experienced much more coordinated support to help them to improve their mental health.

Table 2: The number of women receiving advice from the specialist midwife

<table>
<thead>
<tr>
<th>Advice by letter</th>
<th>Received a consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>700</td>
</tr>
<tr>
<td>2010</td>
<td>850</td>
</tr>
<tr>
<td>2011</td>
<td>780</td>
</tr>
<tr>
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<td>900</td>
</tr>
<tr>
<td>2013</td>
<td>800</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Advice by letter</th>
<th>Received a consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>527</td>
</tr>
<tr>
<td>2010</td>
<td>1000</td>
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<tr>
<td>2011</td>
<td>1428</td>
</tr>
<tr>
<td>2012</td>
<td>600</td>
</tr>
<tr>
<td>2013</td>
<td>626</td>
</tr>
</tbody>
</table>

**Teenage Pregnancy**

The Swale community team has a lead midwife who looks after young parents. The teenagers would benefit from multiple services being offered in one location on the same day. Liaison with representatives from Health Visiting, support for finances, education and other Medway Public Health services would be essential. There is a Family Nurse Partnership scheme available if the young women agree to engage with them. The Family Nurse Partnership is a maternal and early years public health programme. It provides on-going, intensive support to young, first-time mothers and their babies (and fathers/other family members, if mothers want them to take part). Structured home visits are delivered by highly trained nurses and start in early pregnancy, continuing until the child’s second birthday. [186]

A seamless service of care is provided by ensuring that the community midwives work closely with the clinical lead for safeguarding and mental health issues and Medway Public Health services.

**Diabetes**

Women with diabetes or those who develop diabetes in pregnancy are seen in a specialist clinic supported by lead midwives for diabetes. They are monitored closely throughout their pregnancy, owing to the associated risks, in the fetal medicine department and at a specialist antenatal clinic. The multi-disciplinary clinic includes the obstetric lead, the specialist midwife and a dietician all working collaboratively to ensure the best care for the women.

The specialist midwife for diabetes will accompany the woman to theatre, if an elective caesarean section has been decided upon, to provide continuity of care. During the postnatal period the clinical leads review the plans of care and support the ward staff to give the appropriate care.

Training of all staff is a priority to ensure continuity of practice and the safe wellbeing of both the woman and her new baby.
The number of women booking in with diabetes was 120 in 2011, 130 in 2012 and 165 in 2013. Of those booking in 2013, 122 had gestational diabetes, 25 had Type 1 diabetes and 18 had Type 2 diabetes.

**Obesity**

Maternal obesity is a significant challenge for maternity services. According to the national audit of obesity during pregnancy by the Centre for Maternal and Child Enquiries (CMACE), the UK prevalence of women with a known BMI >35 at any point in pregnancy, who give birth at 24+ weeks’ gestation, is 4.99%. This equates to approximately 38,478 maternities each year. The prevalence of women with a pregnancy BMI >40 (Class III obesity) in the UK is 2.01%, while super-morbid obesity BMI >50 is 0.19% of all women giving birth.

It is a challenge not only because of the increasing prevalence of the problem as almost one in five of pregnant women in the UK are obese, but also because of the impact that obesity has on women’s reproductive health and the health of their babies. There are higher rates of miscarriage, fetal abnormality, blood pressure problems, diabetes, thrombosis, difficulty in delivery leading to higher caesarean rates and infection following delivery. Obesity also predisposes women to diabetes during pregnancy.

Care provision has been enhanced for women with issues of obesity with the introduction of a clinical midwifery specialist since June 2012. The lead midwife for obesity runs a clinic with an obstetrician and a support group for the women in her care with assistance from Medway Public Health (IC Mum). CNST requires the provision of support services for all women with a BMI of 30kg/m2. A healthy living clinic is run for women with a BMI of 35-44kg/m2 with no medical conditions. A preconception clinic would be valuable.

In 2013, 1,413 women booked in with a BMI 27–35 and 487 with a BMI over 35. In 2013, 252 new referrals attended who were then followed up in subsequent clinics. Five support group sessions were held with 20 couples at each.

**Learning Disabilities**

Working with colleagues at Medway Public Health has ensured that the Antenatal access pathway has appropriate and adequate steps in it for women with learning disabilities so that they are able to access maternity services. At booking the community midwives assess the women’s needs and refer to other health professionals and care support as necessary. The women are assessed at each antenatal appointment to ensure that all risks are being addressed and that needs are met. Support from the specialist midwife for safeguarding and collaboration with social services will ensure that the mother and baby will be fully supported on discharge from the hospital and will have a safe transition into community care.

**Safeguarding Children**

The Trust has a specialist midwife who works collaboratively within a multidisciplinary team within health and social care, to assess risk factors and the needs of complex families. Through collaboration with the named community midwife, the specialist midwife will ensure that the care pathway is monitored throughout the antenatal period. All safeguarding referrals are alerted to the hospital staff to ensure continuity of
information especially if circumstances change. The specialist midwife meets regularly with the women on the wards, during child protection conferences and pre discharge planning meetings in the community.

Training is high on the agenda for the maternity directorate, Trust-wide and for the Local Safeguarding Children’s Board (LSCB). All maternity staff are required to update on safeguarding issues on a three yearly basis. The training for this update is bespoke to the needs of maternity staff and is mainly delivered by the specialist midwife. This is an area within the maternity directorate that will be improved so that more in-house training sessions can be offered on a regular basis, with a stronger focus on other vulnerable groups, for example, those with learning difficulties and teenage pregnancy.

The role has a responsibility to co-ordinate all cases. For child protection concerns, this is effective through ongoing supervision of each case and there is an essential bi-monthly meeting with the community midwives. For all other cases, for example concerns and vulnerability, there is a monthly meeting with each community team to monitor progress of the cases. The specialist midwife attends the child death overview panel meetings and contributes to investigations as necessary in order to support staff to learn from incidents, embed change and review policy.

There is now a new role of a Band 6 midwife support which will relieve the lead from a lot of the clinical aspects and allow time to develop the role.

**Antenatal and newborn screening**

There are 6 antenatal and newborn screening national programmes in England which are offered to women as part of routine antenatal care and to newborns.

The UK National Screening Committee (NSC) defines screening as

“a process of identifying apparently healthy people who may be at increased risk of a disease or condition. They can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition”

Whilst screening has the potential to save lives or improve quality of life through early diagnosis of serious conditions, it is not a foolproof process. Screening can reduce the risk of developing a condition or its complications but it cannot offer a guarantee of protection. In any screening programme, there is a minimum of false positive results (wrongly reported as having the condition) and false negative results (wrongly reported as not having the condition). The UK NSC is increasingly presenting screening as risk reduction to emphasise this point.

The NHS screening agenda is driven by a range of NHS and Department of Health policies and standards. These can be viewed at www.screening.nhs.uk

The current UK National Screening Committee (UK NSC) programmes for antenatal and newborn screening are:

**Antenatal:**

- Sickle Cell and Thalassaemia
- Fetal Anomaly (Down’s syndrome and fetal anomaly ultrasound)
• Infectious Diseases (Hepatitis B, HIV, Syphilis, Rubella)

Newborn screening:
• Newborn Blood Spot (Phenylketonuria, Medium Chain Acyl CoA Dehydrogenase Deficiency (MCADD), Cystic Fibrosis, Congenital Hypothyroidism, Sickle Cell)
• Newborn and Infant Physical Examination
• Newborn Hearing

Figure 1 shows the optimum time for the various screening tests

Figure 1: Antenatal and newborn screening timeline

*Sickle Cell & Thalassaemia Screening Programme*

Sickle Cell disorders are a group of heritable genetic conditions in which there is an abnormality of the haemoglobin. Haemoglobin carries oxygen to the various organs of the body and is contained in the red blood cells. In the sickle cell disorders, some of the red blood cells assume a sickle shape following the release of oxygen. This abnormal shape causes the cells to clump together making their passage through smaller blood vessels difficult, which may lead to blockage of these small blood vessels, death of tissues and an associated inflammatory reaction.

Sickle Cell Disease is now the most common serious genetic condition in England, affecting more than 1 in 2,000 live births.

Thalassaemia major is a life threatening, genetically inherited, progressive anaemia common in the Mediterranean, Asian, South East Asian and Middle Eastern countries.

The screening for Sickle Cell and thalassaemia is offered to women between 10 to 12 weeks of pregnancy. The antenatal screening policy has been defined into two categories, high and low prevalence, based on a fetal prevalence of sickle cell disorders. High prevalence is defined as a fetal prevalence of more than 1.5 babies with sickle cell disorders per 10,000 births.

Kent and Medway were low prevalence areas until April 2011 when maternity units at Darent Valley Hospital (part of Dartford and Gravesham NHS Trust) were classified as high prevalence. In these sites all pregnant women are offered screening for sickle cell, thalassaemia and other haemoglobin variants rather than just those identified as high risk using a screening questionnaire asking about family history.

*Fetal Anomaly Screening Programme*

This programme offers screening for Down’s syndrome and a minimum of two ultrasound scans during pregnancy to screen for physical (structural) abnormalities

Down’s Syndrome is a genetic disorder, therefore present at birth and lifelong. It affects approximately one in every 1,000 babies. This figure is similar in all ethnic populations and is an overall population risk, though it increases markedly with maternal age. Down’s Syndrome is caused by the presence of an extra copy of chromosome 21 in a
baby’s cells. It affects the physical appearance and the ability to learn. The severity of Down’s syndrome symptoms can vary from person to person. There is currently no cure for the condition. However, there are treatments that can help someone with the syndrome to lead an active and independent life and the average life expectancy of someone with Down’s syndrome is now 60–65 years of age.

There are about 600 babies with Down’s Syndrome born each year in the UK. The condition tends to affect male and female babies equally. It is estimated that there are approximately 60,000 people with Down’s Syndrome currently living in the UK.

The recommended screening strategy for Down’s Syndrome is for the combined test (blood test and nuchal translucency scan) undertaken between 10 and 14 weeks. Looking at two proteins in the blood test and measuring the thickness of the fluid in the back of the baby’s neck calculates the risk of the women having a child with Down’s Syndrome at her present age. If this is missed, a quadruple blood test can be done between 14 and 20 weeks which looks at four proteins.

As part of the NHS Fetal Anomaly screening programme, all women in England should be offered a minimum of two ultrasound scans during their pregnancy to screen for physical (structural) abnormalities in their unborn babies.

The first is an early scan, undertaken after eight weeks gestation and used mainly for dating the pregnancy and confirming viability. The second ultrasound scan is undertaken between 18+0 to 20+6 weeks of pregnancy and screens for major structural anomalies. In 2012/13, 3,647 women booking in Medway had a second ultrasound scan, of which 84 revealed a confirmed fetal anomaly (24 revealed serious cardiac abnormality).

**Infectious Diseases Screening Programme**

The Infectious Diseases in Pregnancy Screening (IDPS) Programme is responsible for ensuring that women with hepatitis B, HIV, syphilis and susceptibility to rubella infection are identified early in pregnancy, ideally between eight to twelve weeks. The tests can usually be taken from one blood test.

The four infections screened for are:

- **Hepatitis B** is a serious viral disease, which affects the liver. It is blood borne and may cause acute illness. Mothers can pass on their infection to their baby. An infected baby may develop liver problems later in life. To reduce the risk of infection, the newborn baby will be vaccinated within the first 24 hours of life and then given three further doses within the first 12 months.

- **HIV**, human immunodeficiency virus (HIV) results in progressive destruction of the immune system. As a result of this, an infected individual becomes susceptible to a number of different infections and is also liable to become wasted and also to develop neurological problems. It can be passed on to the baby and risk of this can be reduced by, for example, drug treatment and elective caesarian section.

- **Rubella** is no longer a common disease of childhood in the UK. This is a result of the Mumps, Measles and Rubella (MMR) vaccination programme. Rubella infection usually presents as a mild disease, often without symptoms. However, if the
infection occurs during pregnancy it can cross the placenta and pass to the fetus with serious consequences.

- Syphilis is a bacterial infection that is typically passed on through sexual contact. However, it can be passed on by intravenous drug use (injecting drugs directly into the vein), blood transfusions and from an infected mother to her unborn child.

Table 3: The number of women tested and found to have an infectious disease in Medway Foundation Trust in 2012/13 [187]

<table>
<thead>
<tr>
<th></th>
<th>No. of tests completed</th>
<th>No. positive results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B</td>
<td>5505</td>
<td>21</td>
</tr>
<tr>
<td>HIV</td>
<td>5500</td>
<td>6</td>
</tr>
<tr>
<td>Syphilis</td>
<td>5502</td>
<td>8</td>
</tr>
<tr>
<td>Rubella Negative</td>
<td>5502</td>
<td>319</td>
</tr>
</tbody>
</table>

Of the women booking at Medway hospital in 2012/13, 140 women were administered MMR vaccination prior to leaving the hospital. The GP practice of each of these women was informed so that a second dose could be arranged subsequently.

Newborn Bloodspot Screening Programme

Parents of every newborn baby are offered a Newborn Screening Test. A heel prick blood sample, routinely taken between day five and eight is currently screened for Sickle Cell disorder as described earlier and five other conditions:

MCADD – 1 in 10,000 babies born in the UK has Medium Chain Acyl CoA Dehydrogenase Deficiency (MCADD).

Babies with this inherited condition have problems breaking down fats to make energy for the body. This can lead to serious illness, or even death.

Screening means that most babies who have MCADD can be recognised early, allowing special attention to be given to their diet, including making sure they eat regularly. This care can prevent serious illness and allow babies with MCADD to develop normally.

Phenylketonuria – 1 in 10,000 babies born in the UK has phenylketonuria (PKU).

Babies with this inherited condition are unable to process a substance in their food called phenylalanine. If untreated, they will develop serious, irreversible, mental disability.

Screening means that babies with the condition can be treated early through a special diet, which will prevent severe disability and allow them to lead a normal life.

If babies are not screened, but are later found to have PKU, it may be too late for the special diet to make a real difference.

Congenital Hypothyroidism – 1 in 4,000 babies born in the UK has congenital hypothyroidism (CHT).
Babies with CHT do not have enough of the hormone thyroxine. Without this hormone, they do not grow properly and can develop serious, permanent, physical and mental disability.

Screening means that babies with CHT can be treated early with thyroxine tablets, which will prevent serious disability and allow them to develop normally. If babies are not screened and are later found to have CHT, it may be too late to prevent them becoming seriously disabled.

Cystic Fibrosis – 1 in 2,500 babies born in the UK has cystic fibrosis (CF)

The condition is characterised by early onset of severe intestinal malabsorption, failure to thrive and recurrent chest infections and pneumonia, which, if untreated, leads to death from malnutrition and respiratory failure in infancy or early childhood.

Newborn Hearing Screening Programme

The early identification of hearing loss is known to be important for a child's development.

One to two babies in every 1,000 are born with a hearing loss in one or both ears. Most of these babies are born into families with no history of hearing loss.

The aim of the NHS Newborn Hearing Screening Programme (NHSP) is to identify all children born with moderate to profound permanent bilateral deafness within four to five weeks of birth and to ensure the provision of safe, high quality age-appropriate assessments and world-class support for deaf children and their families.

Table 4: Babies born in Medway and Swale screened by West Kent NHSP

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of babies screened</td>
<td>5202</td>
<td>4984</td>
</tr>
<tr>
<td>Bilateral referrals</td>
<td>29</td>
<td>41</td>
</tr>
<tr>
<td>Unilateral referrals</td>
<td>174</td>
<td>168</td>
</tr>
</tbody>
</table>

The Newborn and Infant Physical Examination Programme (NIPE)

Newborn and Infant Physical Examination Programme (NIPE) offers parents the opportunity of a head to toe physical examination for their baby to check for problems or abnormalities.

The examination is carried out within 72 hours of birth and then again at six to eight weeks of age, as some conditions can develop later and includes a general all over physical check, as well as specific examination of the baby's:

- eyes
- heart
- hips
- and testes, in boys.
Quality Assurance

National Quality Assurance teams have been developed and commissioning frameworks for antenatal and newborn screening programmes are now in place.

Locally, Kent and Medway's Antenatal and Newborn Screening committee meet quarterly to review performance and promote compliance with national guidelines. Sub-groups have also been tasked to review individual programmes to ensure standards are met.

Antenatal and Newborn Midwifery Screening coordinators, Child Health Record Departments and the Newborn Screening Laboratory now report key performance indicators on a quarterly basis; this will improve understanding of the programmes and provide relevant and accurate data to manage performance and track trends.

Projected Service Use

It is difficult to project use of maternity services. Over the last seven years looked at in this report, there has been a year on year increase of live births to Medway resident women, a total increase of 13% between 2006 and 2012.

Evidence of what works

There have been several pieces of NICE guidance issued on maternity care in recent years, in addition to Maternity Matters[169] and standards for antenatal and newborn screening.

User views

The percentage of women using the following services in December 2013 who would either highly or likely recommend them to friends and family:

Delivery Suite – 87.5%
The Birth Place – 93.3%
Emergency Department – 59.5%
Kent Ward – 89.5%
Pearl Ward – 86.6%

Equality Impact Assessments

Unmet needs and service gaps

There is a significant increase in women with an ethnicity of ‘other white background’ and the associated language and cultural needs must be addressed. A specialist midwife
for teenage pregnancies is an area that needs to be reviewed. All other services must be reviewed regularly to ensure we are providing the most appropriate level of service.

Recommendations

The information in this section is to be reviewed quarterly to address any issues, with a specific focus on ensuring that the community teams are aware of any changes in the demography and epidemiology of the women in their area so that adjustments to workload and demand can be implemented as necessary. Focus needs to remain on delivering a high standard of care according to the specific needs of the women and at the same time remain open and adaptable to new innovative ways of thinking when opportunities arise.

Recommendations for needs assessment work

Safeguarding

Summary

‘No Secrets’ (2000) guidance gave local authorities the lead responsibility for developing and implementing local multi-agency processes for coordinating systems, polices and procedures to protect vulnerable adults from abuse. A review of No Secrets in 2009 highlighted that adult safeguarding systems were underdeveloped in the NHS and detailed guidance in safeguarding adults was published in 2011.

Government has pointed to three key concepts involved in safeguarding: protection, justice and empowerment (Minister of State 2010).

‘Vulnerable adults’ are not a homogenous group but are individuals who because of certain vulnerabilities or circumstances are disproportionately likely to be victims of abuse. The work of the Kent and Medway Safeguarding Adults Executive Board is to coordinate agencies to safeguard these adults who are at risk of being abused. The Kent & Medway Safeguarding Vulnerable Adults Board takes a strategic lead on safeguarding matters and is co-chaired by the Assistant Director of Social Care in Medway.

Safeguarding Vulnerable Adults work is concerned with the multi-agency approach to responding to and preventing the abuse of ‘vulnerable adults’. Across Kent and Medway, there are multiagency policy, protocols and guidelines in place, which are updated twice a year. They are available to organisations and the public via the Kent and Medway Safeguarding Vulnerable Adults Executive Board’s website.

Key issues and gaps

It is likely that there is considerable under reporting of adult abuse, whether in the community, residential or hospital settings and improved awareness raising and reporting may put pressure on the local authority and the wider partner agencies. There is a need to ensure the accessibility of main stream services that address domestic
abuse and sexual abuse, to disabled people and in particular older women and create services that meet the need of disabled and older people who have been abused.

Although there has been public awareness work, this now need to extend support and awareness to Black and Minority Ethnic (BME) and Lesbian, gay, bisexual and transgender (LGBT) groups in Medway.

Current emphasis is on supporting individuals to remain living in their own homes and enable more people with Learning Difficulties to live more independently in the community. The move to individual budgets and greater use of, for example Direct payments by individuals and carers, are intended to increase peoples choice and control and to ensure that services are better matched to individual needs. This also brings challenges in terms of safeguarding to ensure that the alternative solutions to meet the needs of people are achieved safely.

**Recommendations for Commissioning**

Commissioners have a key role in ensuring that multiagency capacity is sufficient to ensure that safeguards are effectively monitored and embedded across the region.

Commissioners need to ensure that health and social care services are effectively resourced to respond, as the number of referrals continues to rise and support vulnerable people in reducing repeat referrals.

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Commissioners have a key role in ensuring that all providers, including personal assistants and independent contractors, are working in adherence with the Multiagency Adult Protection Policy, Protocols and Guidance for Kent and Medway.

**Who’s at risk and why?**

Vulnerable adults are defined by government guidance called No Secrets (2000) as people (a) who or may be in need of community care services because of mental or other disability, age or illness, and/or (b) who are unable to care for themselves or unable to protect themselves from significant harm or exploitation. The guidance refers to harm in terms of ‘abuse’.

Abuse is a violation of an individual’s human and civil rights by any other person or persons.

Abuse of a vulnerable adult may consist of a single act or repeated acts. It may occur as a result of a failure to undertake action or appropriate care tasks. It may be an act of neglect or an omission to act, or it may occur where a vulnerable person is persuaded to
enter into a financial or sexual transaction to which they have not, or cannot, consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the individual. However for some clients the issues of abuse relate to neglect and poor standards of care. They are ongoing and if ignored may result in a severe deterioration in both physical and mental health and even death.

Abuse might be physical, sexual, psychological, financial or material, neglect and acts of omission, discriminatory or institutional.

This could include people with learning disabilities, mental health problems, older people and people with a physical disability or impairment. It also includes people whose condition and subsequent vulnerability fluctuates. It may include an individual who may be vulnerable as a consequence of their role as a carer in relation to any of the above (on average, 20% of the referrals in Medway, cite the main carer as the alleged perpetrator). It may also include victims of domestic abuse, hate crime and anti-social abuse behavior. The persons' need for additional support to protect themselves may be increased when complicated by additional factors, such as, physical frailty or chronic illness, sensory impairment, challenging behaviour, drug or alcohol problems, social or emotional problems, poverty or homelessness.

Many vulnerable adults may not realise that they are being abused. For instance an elderly person, accepting that they are dependent on their family, may feel that they must tolerate losing control of their finances or their physical environment. They may be reluctant to assert themselves for fear of upsetting their carers or making the situation worse.

**The level of need in the population**

Over the last three years the number of reported and subsequently investigated referrals of alleged abuse in Medway has increased. In 2008/09, 2009/10 and 2010/11 there were 245, 277 and 324 referrals respectively. There has been a 17% increase in the number of referrals since 2009/10. It is believed that it is not the amount of adult abuse that has increased, but the level of reporting of incidents and concerns. This reflects the continuing efforts made to raise awareness of adult abuse. However, compared to other unitary authorities (The Health and Social Care Information Centre 2011) Medway Towns referrals are below average by approximately 30%.

Within Medway, the primary client categories of the alleged victims of abuse, for the period of April 2009 to March 2011 are presented in Figure 1.
Within the physical disability category, 65% of the alleged victims were over the age of 65 years and 30% were over the age of 85 years.

It is widely recognized that individuals with learning difficulties or complex needs, such as mental health issues or drug and alcohol dependency, are at a heightened risk because they face additional barriers in disclosing abuse and neglect. Abuse and neglect can happen to anyone regardless of race or ethnicity.

Although referrals regarding non-white citizens are increasing, from 2.2% (2010/11) to 13% in the first quarter of 2011/12, it is accepted that in order to continue to protect vulnerable adults, awareness raising must continue to reach all sections of Medway’s diverse communities.

Women are disproportionately more likely to be the victims of abuse. Of the 601 referrals during the period April 2009 to March 2011, 406 (68%) of the alleged victims were female and 195 (32%) male. The gender proportion varies by age, as 60% of the alleged victims were female in the group 16-64 years, and this increases to 80% in the over 85 year group.
Research by Hague et al on behalf of Women’s Aid (2008) also drew out important links between domestic abuse and safeguarding. The research revealed that people with disabilities are more vulnerable to domestic abuse and will often face additional difficulties in attempting to access support. While one in four adult women and one in 13 adult men will experience domestic violence during their lifetimes, findings from the research found that vulnerable women and men are at increased risk of abuse; 50% of disabled women have experienced domestic abuse compared with a quarter of non-disabled women.

Any ‘vulnerable adult’ can be the victim of abuse regardless of sexuality. However, gay, lesbian, bisexual and transsexual ‘vulnerable adults’ are likely to face additional concerns about homophobia and gender discrimination. They may be concerned that they will not be recognised as victims or believed and taken seriously. Abusers may also be able to control their victims further through the threat of ‘ outing’. Currently, sexual orientation is not recorded as part of the referral process.

Figure 2. Numbers types of alleged abuse (2008–2011)
In 2010, Kent police recorded 75 reports of sexual orientation and gender hate crime compared to 56 cases in 2009. Disability hate crime reporting had also increased from 21 to 51 cases respectively from 2009 to 2010.

The victim’s home is the primary location of the alleged abuse however 30% of referrals are regarding people who live in residential care settings. The majority of these allegations implicate the staff working in these settings but will also include family and visitors as the alleged perpetrators.

The primary types of alleged abuse are physical, financial and neglect. In the current economic climate, it is predicted that the incidence of financial abuse will increase.

**Current services in relation to need**

Medway Council Adult Social Care is the lead coordinating agency for safeguarding adults. Joint working with other organisations with safeguarding responsibilities is essential. These agencies include National health Services (NHS), independent (private and voluntary) social and health care providers, housing providers, the police, the Crown prosecution Service (CPS), the Probation Service and the Benefits Agency.

Over the last 3 years there has been investment of safeguarding services within the NHS. This has resulted within the Kent & Medway Cluster Primary Care Trust, the identification of nominated safeguarding adults lead oficers with responsibility for Medway, East and West Kent, and within this team there are also specialist advisors for care homes and domestic abuse. In Medway, both Medway Community HealthCare and Medway Foundation NHS Trust have nominated Safeguarding Vulnerable Adults leads/advisors.

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

As there is a steady increase in the percentage of allegations of abuse where it is happening in the vulnerable adult’s own home. While we must continue with adult abuse awareness training for staff working in domiciliary care settings, we must ensure that service users, carers and other agencies visiting people at home and the wider community know how to identify and report abuse or concerns about abuse.

**Evidence of what works**

Although the local authority leads on safeguarding vulnerable adults the current good partnership arrangements for conducting investigations, information sharing, training and supporting staff has been recognised in a recent independent audit of safeguarding arrangements in Medway.

Following public awareness campaigns the number of referrals from the victim, family or friends has slowly increased. Medway Council is ranked second, in its comparator group, for the highest number of referrals from this source. This is a good indicator that safeguarding awareness is good in the community and routes for reporting are known.
User Views

The views of service users who have experienced abuse need to be captured and fed back to develop improved safeguarding practices. Medway Council are developing these systems currently. Users and carers also have membership of the Medway Safeguarding Community Network (see website).

Equality Impact Assessments

Unmet needs and service gaps

It is likely that there is considerable under reporting of adult abuse, whether in the community, residential or hospital settings and improved awareness raising and reporting may put pressure on the local authority and the wider partner agencies.

It is recognised that younger people using mental health services are under represented in safeguarding adult’s figures nationally and locally.

Current emphasis is on supporting individuals to remain living in their own homes and enable more people with Learning Difficulties to live more independantly in the community. The move to individual budgets and greater use of, for example Direct payments by individuals and carers, are intended to increase peoples choice and control and to ensure that services are better matched to individual needs. This also brings challenges in terms of safeguarding to ensure that the alternative solutions to meet the needs of people are achieved safely.

There is a very low rate of prosecution of crimes towards ‘vulnerable adults’. The police need the capacity to repond to the complexity of cases where victims are often unable to give a clear and reliable account of what has happened to them.

The views of service users who have experienced abuse need to be captured and fed back to develop improved safeguarding practices.

We need to ensure the accessibility of main stream services that address domestic abuse and sexual abuse, to disabled people and in particular older women and create services that meet the need of disabled and older people who have been abused.

We need to ensure that services meet the needs of vulnerable adults from LBGT and BME groups.

We need to develop services that enable disabled people and those with impaired mental capacity to recover from abuse.

There is a need for independent health contractors such as general practitioners and dentists etc require support and training in understanding their role and responsibilites in protecting vulnerable adults from abuse.
Recommendations for Commissioning

Commissioners have a key role in ensuring that multiagency capacity is sufficient to ensure that safeguards are effectively monitored and embedded across the region.

Commissioners need to ensure that health and social care services are effectively resourced to respond, as the number of referrals continues to rise and support vulnerable people in reducing repeat referrals.

Joined up working across health, social care and the criminal justice agencies is needed to ensure that each agencies can respond in partnership to allegations of abuse of a vulnerable adult.

Commissioners need to ensure that support, advice, advocacy and information are readily available for service users and their carers to ensure, that as they take on more responsibility for their own packages of care, that they know how to protect themselves from abuse and who to raise concerns with. Information should be available in multiple formats and languages.

Commissioners have a key role in ensuring that all providers, including personal assistants and independent contractors, are working in adherence with the Multiagency Adult Protection Policy, Protocols and Guidance for Kent & Medway.

Recommendations for needs assessment work

Within the context of adult safeguarding referrals there is a need to identify the incidence and needs of the Medway BME and LGBT population in Medway.

Offenders

Summary

For many years it has been clear that individuals who come in contact with the criminal justice agencies are far more likely to come from some of our most vulnerable and disadvantaged groups in society, with the worst outcomes and greatest inequalities in health. Many of the factors that impact on poor health are the same as those leading to increased criminality such as poor housing, unemployment and poor educational attainment.

Offenders and their families are more likely to have learning difficulties and disabilities, with poor educational attainment.[188] In a recent survey of young prisoners, most had been excluded from school with many failing to receive full time education after the age of 14 years.[189] Once they have been excluded it is easier to become part of groups who are engaged in disruptive and criminal behaviour, where taking drugs and abusing alcohol are commonplace. Risk taking behaviour will also include early sexual activity, with many becoming parents in their teenage years, continuing the cross generational cycle of disadvantage. It should not be surprising to find that this group is far more likely to suffer from mental health problems, which contribute to their problems.
Families of offenders can often be chaotic with high levels of substance misuse, alcohol problems, and mental health issues and higher than normal levels of domestic violence. Young offenders are more likely to have been taken into the care of local authorities at some point in their childhood, and are more likely to have other members of the family known to criminal justice agencies. Medway PCT has already identified some of their most challenged families and are starting to work with them to try and break the cycle of disadvantage and criminality.

Young men rarely take advantage of mainstream health services and are not commonly seen in primary care. Schools provide an important source of information on lifestyle choices, which lead to positive health outcomes, missed by those outside the mainstream schools. Contact with criminal justice agencies may provide the first opportunity for some of these young people to have their health needs assessed and addressed. It also could provide the opportunity to leave them, and their families, positive messages about how to improve their health in the future. NHS Medway is already contributing to this through their work with the Medway Youth Offending Team.

**Key issues and gaps**

The commissioning of healthcare in prisons should be equivalent level to that of the rest of the population, and Improving Health, Supporting Justice (November 2009)[190] sets very clear aims for each locality in terms of its offender health population.

This coupled with Lord Bradley's recommendations (April 2009)[191] refers to the ability for a strong commissioning structure to contribute to reducing inequalities and support the justice system in reducing reoffending through the provision of an integrated and dynamic model of health care.

- Commission the same range and quality of services for offenders as it does for general public
- Target resources at reducing health inequalities in order to improve morbidity and mortality rates in this vulnerable group
- Ensure that prison health services are appropriately reflected in the development and implementation of wider government policies, and the wider criminal justice system
- Ensure that there is continuous service development for offender health services
- Make the best use of available resources and ensure value for money in the commissioning of offender health services

**Who’s at risk and why?**

The cyclical nature of disadvantage is well recognised, culminating in the government paper Breaking the Cycle[192] which stresses the inability for one agency to tackle all of the issues and the great need for organisations, including health agencies, to work together to protect society, reduce criminal activity and improve the life chances for individuals. Medway has some of the most deprived communities in the South East of
England, but partnership working has helped reduce re-offending. Medway is home to two prisons, HMP Rochester and HMYOI Cookham Wood.

Information from the local criminal justice agencies and the prison service indicates that approximately 46,000 people are detained in custody each year within the Kent and Medway area. According to the probation service, there are approximately 1,300 individuals under supervision of the probation service across Kent and Medway at any one time. There are about 150–160 young people under the care of the Youth Offending Team at any one time and there are about 560 families in Medway with complex and chaotic lives that lead them to be in contact with criminal justice agencies. The highest proportions of offenders live in Chatham. Approximately 10% of offenders are women, but they tend to have complex needs.

**Prisons in Medway**

**HMP Rochester**

- Operational capacity: 649
- There are currently 565 prisoners between the age of 18 and 21 years old and 94 between the age of 22 and 68 years old (November 2011).
- The prison holds convicted sentenced male offenders. It has some old accommodation and new purpose built accommodation which opened in 2008. The Chief Inspector of prisons commented[189][191] that the large area of the prison and some of the behavioural challenges encountered made this a difficult prison to operate.

**HMYOI Cookham Wood**

- Operational capacity: 143
- The age range of prisoners is 15–18 years
- Cookham Wood takes young men on remand or convicted, but not deemed suitable for secure local authority accommodation. There is a 60/40 split between sentenced and remanded prisoners. The turnover of population is estimated to be over 70%.
- Proposals to build two new wings on the site are being actively considered, and it is anticipated that the prison roll is likely to increase from 143 to approximately 200 within the next 18 months

**High Risk of Suicide**

- Prisoners have higher rates of suicide whilst in prison compared to the general population. Young offenders aged 15–17 are 18 times more likely to commit suicide.[193]
- Female ex-offenders are 35.8 times more likely, and male ex-offenders are 8.3 times more likely to commit suicide. The risk is especially high in the first month after release for older ex-offenders.[194]
• Some of these deaths are related to loss of tolerance upon returning to drug misuse, but the majority are related to high psychiatric morbidity combined with a high stress situation.

• Foreign National Prisoners (FNP) also experience high rates of suicide. There were over 20 apparently self-inflicted deaths of FNPs in prisons during 2007 compared to a historical annual average of 6. The Prisons and Probation Ombudsman (PPO) investigations into the deaths have not identified any clear link with immigration status (CSIP data 2007).

• The suicide rate for offenders in custody and recently released is nine times the rate found among similar population in the community.

• Hanging is the most common method (80%) associated with self-inflicted deaths in prison.[195]

### Poor Mental Health

Prisoners and ex-offenders are a group at particular risk of mental health problems.

• Men and women in prison have a higher proportion of serious mental health problems, including psychosis.

• The majority of prisoners have some degree of learning difficulty, with over one in 10 remand prisoners having an IQ under 65.[196]

• For male and female prisoners, 27% have been in care as a child, compared to 2% in the general population.[197]

• Many prisoners are released without mental health support, drug service throughcare, housing or income support.

• Ex-offenders are more likely to suffer rejection and discrimination from families and wider society.

• Prisoners generally have higher rates of mental illness and self harm and other associated risk factors, such as drug and alcohol misuse.

• A high proportion of offenders have been found to suffer from drug and alcohol addiction.

• In the young offender population, alcohol misuse is often of greater significance than drug misuse.

### Other conditions[198]

• The incidence of sexual health problems is known to be significant among young offenders.

• Chronic diseases such as heart disease and diabetes form a high proportion of the health care needs of prisoners. Incidence of such conditions is lower among young offenders. Early recognition and appropriate management of conditions such as asthma, epilepsy and diabetes are vital in preventing progression of these chronic conditions.
• The prevalence of learning disabilities, including autism and Asperger’s syndrome, and such conditions such as attention deficit hyperactivity disorder (ADHD) may require particular interventions in the under 21 population.

• Poor oral health and dental disease is also a feature of prisoners, which requires the provision of a high standard and volume of care.

**The level of need in the population**

Contact with the criminal justice system may provide the first point of contact with healthcare services for an individual offender. In 2011, 125 individuals who came into contact with the criminal justice system, aged between 40 and 74 years, agreed to undergo an NHS Health Check. Fifty of these were referred back to their GP for advice or treatment. The results showed that 57% were smokers and the same proportion were drinking alcohol at unsafe levels. Five were serious drinkers requiring referral to the alcohol treatment service and 13% were found to have a BMI which indicated obesity.

The data obtained from the probation systems demonstrated that 922 offenders have a need related to alcohol; of those 35% have an alcohol treatment order. Alcohol misuse is linked to offending behaviour and risk of harm. There are also high needs for accommodation amongst those people accessing the probation service which may influence their health needs. Only 2.6% of offenders have a GP address recorded in the system.

Nationally, there is a high prevalence of mental health conditions amongst offenders under the probation service. Twenty seven per cent of offenders currently have a mental health condition. Many young offenders are fathers; their health worker is able to liaise with the local family nurse practitioner, health visitors and safeguarding nurses to consider any child protection measures. As well as pre-existing health needs, offenders are also at risk of health problems created as a consequence of imprisonment: through overcrowding, isolation and exposure to violence and access to illicit drugs.[199]

**Mental Health**

A Mental Health Needs Assessment[200] carried out in both Medway prisons between June 2005 and November 2006 identified:

• 17.9% of participants reported contact with the Mental Health Services whilst in custody

• 15.4% reported prior contact with Mental Health Services

• Of those interviewed, the majority left school under 16 years old

• 35.9% had previously attended a special school

• 38.2% were found to have an IQ score which suggested learning difficulties

• 38.5% scored within the 'low IQ' range
The most common needs being reported as unmet needs were ‘safety to others’ (46.2%) and ‘psychological distress’ (28.2%).

The Psychiatric Diagnostic Screening Questionnaire indicated a range of features where participants scored on or above the threshold.

Drug abuse/dependence was found to be 64.1%
Alcohol abuse/dependence was reported to be 51.3%
Obsessive Compulsive Disorder was also reported as 51.3%

Therefore it is likely that prisoners will have high mental health needs.

Learning Disability

Learning disability is not adequately screened at reception and is grossly under reported in prisons in the UK. There is an estimation that 23% of offenders under 18 years of age have an IQ of less than 70 and a further 25% have an IQ of less than 80. Below 80 is thought to be borderline intellectual functioning.[201]

A reception screen for learning disability has been piloted by Offender Health. This screen is based on a simple seven question screen and will identify in a crude way any young man who may have a learning disability, although further assessment would be required to assess the disability fully.

Having a learning disability whilst being in prison comes with many difficulties for the individual, from not being able to cope with the prison regime to bullying from other offenders. Therefore it is essential that offenders with a learning disability are identified at reception via screening and then adequately assessed as to the degree of their disability and an appropriate care/support plan drawn up.

It should be noted that this does not include learning difficulties, which is a much wider issue that needs to be addressed. As the prisons do not currently have a measure of learning difficulties it has been challenging to quantify the scale of the issue.

Substance misuse needs

In the young offender population alcohol misuse is often of greater significance than drug misuse.

In November 2011, the assessment data from HMP Rochester indicates:

- Opiates used in 10% of prisoners
- Hazardous levels of alcohol used in 14%
- Cocaine was used by 12%
- Crack was used by 9%
- Cannabis was used by 8%

In November 2011, the assessment data from HMYOI Cookham Wood indicates:

- Opiates used in 10% of prisoners
- Hazardous levels of alcohol used in 14%
- Cocaine was used by 12%
- Crack was used by 9%
- Cannabis was used by 8%
- Opiates used in less than 5% of prisoners
- Alcohol used in more than 75% of prisoners, with binge drinking being a key feature
- Club drugs (Ecstasy, amphetamines and cocaine) were used by 25–30%
- Benzodiazepine and Ketamine use was found to be very rare
- Cannabis was used by 80–90% of prisoners

**Smoking Cessation**

Offenders display high levels of smoking prevalence as identified in the police cells, YOT and the prison service. In September 2011, there were 659 smokers across the two prisons, which represent 79% of the prison population (source: HMP Cookham Wood and HMP Rochester); the young age groups have the highest number of smokers however they represent the biggest proportion of the prison population. Stop Smoking Support in HM Prisons offers a best practice checklist for smoking cessation in prisons which should be incorporated in any future health promotion strategy.

**Immunisations and Blood Borne Viruses**

Many of the young people in the prison had irregular attendance at school and have often missed standard vaccinations and health interventions. There were three patients who tested positive for hepatitis C and as yet no patients have been diagnosed with Hepatitis B or HIV. Both hepatitis B and C are reported each quarter to the Health Protection Agency.

**Sexual Health**

Sexual health needs are relatively high with a disproportionate number requiring the services of an external Genito-Urinary Medicine Clinic.

**Chronic Diseases**

The incidence of chronic diseases is lower among young offenders, however early recognition and prevention of smoking is essential to reduce the future burden of disease and reduce inequalities. Information from both prisons indicates that the proportion and number of prisoners suffering from long term conditions is small, but good management is vital in preventing deterioration in conditions such as asthma, epilepsy and diabetes.

**Heart Disease**

There were 12 patients with heart disease at the time of this report (source: HMP Rochester, November 2011), but the population at this time was mostly young offenders under 21. It is expected that this number will increase with the population becoming older. In the UK prison population, chronic diseases such as heart disease and diabetes form a high percentage of the health care needs. The Prison and Probation Ombudsmen produced a report in 2010[202] which looked at 115 deaths from circulatory disease, and they found:
• The average age at death from all circulatory diseases was 53 years. Thirty per cent of these deaths were of prisoners aged less than 45 years (34 of 115).

• Of those who died as a result of ischemic heart diseases (82 cases), 35% had been diagnosed with ischemic heart diseases (most commonly angina) prior to death.

• A further 19 were receiving medication for high blood pressure and/or high cholesterol (23%). Thirty-four were neither diagnosed with nor receiving treatment to prevent development of heart disease (41 per cent).

**Diabetes**

The expected prevalence for diabetes for Rochester Prison will change compared to historic prevalence. This is because the prison population will include a greater proportion of older people. It is estimated that 5.1% of the population of England has diabetes of either type. In September 2011, there were four people at HMP Rochester who were diabetic (0.6%). Therefore further work needs to be carried out to identify whether there are true differences in the populations or whether identification needs to be improved.

**Asthma and Respiratory Disorders**

The number of people receiving treatment for asthma in the UK is reported to be 5.4 million people of which 4.3 million are adults; this is almost 10% of the UK population. It has previously been reported that the prevalence of asthma amongst prisons is 13%, of which 5% will require treatment.[203] The local prison data indicates that 78 patients had a diagnosis of asthma which is 12% of the September 2011 population. In HMP Rochester, three patients were identified with COPD who are all aged between 35 and 50. The prevalence generally increases with age and long term smoking.

**Epilepsy**

The expected prevalence of epilepsy in the prison population is approximately 1% of the population.[203] According to NICE guidance, the age-standardised prevalence of epilepsy in the UK is estimated to be 7.5 per 1,000 population. This would suggest that at least seven patients at Rochester will have epilepsy. Local data indicates that seven prisoners had a diagnosis of epilepsy, although there is no chronic disease register for this disorder.

**Injuries**

The populations of both prisons are at risk from minor illness and injuries related to fights. Injuries are common reasons that necessitate external hospital appointments.

**Parenting Skills**

As with the experience in the YOT, many of the prisoners are young fathers, with poor experience of parenting and for whom parenting skills training would be potentially reduce the generational cycle of criminogenic activity.
Current services in relation to need

HMYOI Cookham Wood

Her Majesty’s Chief Inspector of Prisons (HMCIP) has not reported any serious concerns with the provision of healthcare. The most recent report comments on improvements in the service for young men with mental health problems. All offenders who are new in to custody, or are returning to the prison after a change of status, have to be assessed by the health team on admission.

In 2008, HMP Cookham Wood changed from managing adult women to young teenage men. This presented a number of challenges for staff and concerns were noted by HMIP in 2009. The Inspectorate considered the accommodation unsuitable for young teenage men. The follow up inspection in 2010 identified considerable improvement with reduction in bullying and use of force. However, a survey in 2010 showed significant difference in the experiences for black and minority ethnic young men who were more negative about the relationship with staff.

Healthcare is provided from a dedicated suite on the Cookham Wood site with a responder for unplanned incidents in the prison. These incidents have varied between 10 and 44 per month and remain largely unpredictable. Incidents include illness, accidents, use of force, fights and self-harm. The majority of activities take place by appointment, however there is a very high failure to attend rate. The healthcare delivery team is made up of a high number of long term agency staff and one challenge will be to develop a sustainable workforce to deliver high quality services.

Funding for substance misuse is now channelled through the NHS and locally this is managed by Medway DAAT. Drug services are currently provided at Cookham Wood by three staff members who deliver the Substance Misuse Service. These individuals are part of the broader casework team and take the lead on substance misuse. The services that are provided are non-clinical and cover the psychological and social aspects of drug use. Clinical management and detoxification of opiates are undertaken at HMYOI Feltham.

The core tasks for the service include:

- Administration of medication
- Immunisations and phlebotomy
- Reception screening and secondary screening
- Wellman clinic, Access clinic and Asthma clinic
- Emergency response for the core
- Pre/discharge/release assessment
- Health promotion

Most medicines are not given in-possession with the exception of antibiotics and inhalers for the treatment of asthma. Additionally, the following services are offered through providers working in association with the prison health team.
• GP clinics
• Out of hours GP cover
• Optometry
• Dentistry
• Podiatry

**HMP Rochester**

Healthcare at HMP Rochester is a well-established and well-integrated service. The prison was inspected in February 2011 during which the healthcare service received a generally good review. The inspection team noted that “Prisoners had access to a wide range of health services. Health staff were well trained, highly motivated and prisoner-staff relationships were good.”[204]

All new receptions are seen on the day of arrival for an initial reception assessment and they are all offered a follow up Wellman appointment within a week. Over a six month period there were 950 consultations for young men under 21 and 69 for prisoners aged between 22 and 72. There were on average 10 lost appointments a day through failure to attend. Most consultations were for minor illness or injury.

Healthcare is now shared as the prison has integrated services for Young Offenders and Adults. This represents the recent re-rolling of the prison as a partial Category C Adult prison. The original healthcare site is now used to deliver services to the Young Offender population, whilst a new healthcare facility is dedicated to the adult population. The complement of staff provides healthcare to offenders at all stages of their stay at HMP Rochester.

Core tasks for healthcare include:

• Administration of medication
• Risk assessment for in-possession medication
• Twice daily dispensing of medication at both health care centres
• Immunisations and phlebotomy
• Reception screening and secondary screening
• Wellman clinic, access clinic, smoking cessation and asthma clinic
• On-call GP services
• Pre-discharge for/release assessment, fitting forward/adjudication assessments
• Mental health care
• Emergency and contingency planning for healthcare specific issue, e.g. endemic flu planning
In addition to this, the following services are also delivered to the prison by other providers,

- GP clinics
- Optometry
- Dentistry
- Podiatry
- Mental health in-reach
- Phlebotomy

**Sexually Transmitted Infections**

A sexual health clinic is run once a week at Rochester with Chlamydia being the most commonly diagnosed condition. It is difficult to establish the exact numbers of those diagnosed as the current information systems do not separate this information. During a nine month period for which data is available, 17 patients attended GUM clinics in the community for testing and diagnosis.

**Mental Health and substance misuse**

Health agencies in Medway have recognised the higher levels of mental health and substance misuse for offenders and services have improved through adult and CAMHS services. A high proportion of offenders have dual problems and it is not clear how the need for alcohol services is to be addressed though it is identified as a key priority in almost all of the local strategies.

**Substance Misuse**

HMP Rochester has been a clinical Integrated Drug Treatment Service (IDTS) site since 2008. Medway PCT commissions services in partnership with the prison and Medway DAAT.

A newly commissioned IDTS (clinical) and psychosocial Counselling, Assessment, Referral, Advice and Through care teams (CARATs) service will commence in October 2012.

The IDTS aims to expand the quantity and quality of drug treatment available at HMP Rochester by:

- Increasing the availability and range of treatment options, particularly substitute prescribing
- Integrating clinical substance misuse care with the services offered by the Drug Strategy/CARAT team with this including psychosocial treatment
- Develop joint working between Healthcare and CARAT teams
- Develop treatment delivery and joint care planning working to standards of care and models of treatment that integrate services and are agreed
• Integrating prison and community treatment to prevent damaging interruptions to treatment either on reception into custody or on release back home

Current Service Provision for Alcohol Reduction

Rochester currently operates the COVAID (Control of Violence for Angry Impulsive Drinkers) programme. The programme provides ten sessions that are each two hours in length that follow a prescribed timetable. The sessions can be either individual or group. The sessions are structured within a cognitive-behavioural treatment programme. Over an 18 month period 91 young offenders attended the COVAID programme and from the results of the Alcohol Use Disorders Identification Test (AUDIT), we can see that the 91 offenders who completed the programme have scored highly; a score of more than 8 requires intervention.

Chronic Diseases and their Management

Chronic disease management is essential to primary health care and is monitored through performance indicators. There are currently two sessions that are set aside for chronic disease management, which are general clinics rather than disease specific clinics. There is good evidence that supports the notion that imprisonment is not conducive for good health outcomes. Currently there is limited need for chronic disease management but this will change as the establishment has greater number of older offenders. The two sessions currently available for chronic disease management may not be adequate if the prison population increases and there is an increased number of older prisoners.

Outpatient Appointments in Hospital

Over an 18 month period between February 2010 and August 2011, a total of 280 patients attended hospitals as outpatients (source: HMP Rochester). Diagnostic imaging for radiography is the most common reason for attendance at the local hospital. Most patients who required a radiograph were due to suspected hand or face injuries sustained during fights. The reports from the healthcare staff indicate that most of these were soft tissue injuries. It was reported by staff that a high number of the emergency calls were for fights or self-injury. A large proportion of the patients required ultrasound for investigation of testicular lumps, which may be related to the increased awareness due to health promotion during induction. The number of patients requiring escorts has increased and may represent the higher healthcare needs of the adult population. It is anticipated that the number of patients requiring escorts could increase even further as the adult population of HMP Rochester also increases.

Failure to Attend

The number of failed appointments appears to be generally problematic; this was previously identified in the last health needs assessment that was undertaken in 2009. The service providers report that approximately half of all appointments are lost due to failure to attend.

The failed appointments during the period 1st October 2011 to 17th November 2011 totalled 510 appointments, which equated to an average of almost 10 failed appointments per day. These missed appointments represent 109 hours of clinical
activity over the 48 days period assessed, excluding failed appointments within mental health.

If prisoners do not arrive at either of the Health Care Centres via the “free flow system” then it is impossible for them to attend their appointment unless they are given an escort; access to an escort is dependent on the availability of prison officers. Prisoners do not get flexible access to clinics as they often arrive at the same time and have to wait together in the waiting room until they are seen. This can lead to prisoners having to wait in the waiting area for long periods of time which can become problematic from an order and control perspective.

The prison will be changing its regime - the free flow period will be available all morning and during the unlock period in the afternoon. This will enable patients to attend their appointments without the need to wait for escorts. This should improve access to services.

Projected service use

The offender and ex-offender health population will change over the next 10 years. There are changes that will be brought about from tackling the wider determinants of health and aimed at reducing the number of people coming into contact with the criminal justice system. There will also be those system wide changes that are designed to reduce the number of people reoffending. Better recognition of the association between Looked After Children and the likelihood of contact with the criminal justice system may help local authorities implement preventative measures much earlier on. Disease patterns and health needs are also likely to change in the prison population, in part this will be due to the change in age profile of prisoners. Greater emphasis on mental health and improved access to services for children and young people may result in fewer people entering the criminal justice system.

Table 1: Estimated service use over the next 12 months for HMP Rochester

<table>
<thead>
<tr>
<th>Service</th>
<th>Frequency</th>
<th>Indicative activity for 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access clinics</td>
<td>Daily</td>
<td>2819</td>
</tr>
<tr>
<td>Chiropodist</td>
<td>6 Weekly</td>
<td>8</td>
</tr>
<tr>
<td>Chlamydia screens</td>
<td>On demand</td>
<td>199</td>
</tr>
<tr>
<td>Dentist</td>
<td>Weekly</td>
<td>185</td>
</tr>
<tr>
<td>GP (appointments)</td>
<td>Daily</td>
<td>1147</td>
</tr>
<tr>
<td>GUM referrals</td>
<td>As required</td>
<td>19</td>
</tr>
<tr>
<td>Health promotion</td>
<td>Twice weekly</td>
<td>444</td>
</tr>
<tr>
<td>Immunisation and vaccination</td>
<td>Twice weekly</td>
<td>206</td>
</tr>
<tr>
<td>Optician</td>
<td>4-6 weekly</td>
<td>57</td>
</tr>
<tr>
<td>Physio</td>
<td>On demand</td>
<td>9</td>
</tr>
<tr>
<td>Receptions</td>
<td>Daily</td>
<td>444</td>
</tr>
<tr>
<td>Wellman</td>
<td>Twice weekly</td>
<td>444</td>
</tr>
</tbody>
</table>
The Ministry of Justice has estimated prison population projections for the period 2011–2017 which are considered alongside legislation and sentencing activity on the prison population.[205] The three projected trends reflect the cumulative impacts of the various circumstantial, sentencing, legislative and procedural assumptions and are modelled on ‘lower’, ‘medium’ and ‘higher’ scenarios in 2011 projections. Recent public disorder impacts on prison population trends.

Following the medium projection, the prison population rises gradually (between 0.0 and 0.7% year on year) to 2017, which is an increase from 85,200 in 2011 to 88,900 in 2017. This gradual rise is principally due to a steady rise in the indeterminate sentence population, but is also influenced by a rise in the non-criminal population over the first year of the projection and a later rise in the determinate sentence population. The exception to this is a projected 2.0% rise from June 2011 to June 2012 which is partly a consequence of the August 2011 public disorder events. This brings the projected prison population to 86,900 by June 2012. There is 0% growth in the projected prison population in the following year as the majority of public disorder prisoners complete their sentence and the total projected prison population remains at 86,900.

Table 2: Estimated service use over the next 12 months for HMYOI Cookham Wood

<table>
<thead>
<tr>
<th>Access clinics</th>
<th>Frequency</th>
<th>Indicative activity for 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access clinics</td>
<td>Daily</td>
<td>2819</td>
</tr>
<tr>
<td>Chiropodist</td>
<td>6 Weekly</td>
<td>8</td>
</tr>
<tr>
<td>Chlamydia screens</td>
<td>On demand</td>
<td>199</td>
</tr>
<tr>
<td>Dentist</td>
<td>Weekly</td>
<td>185</td>
</tr>
<tr>
<td>GP (appointments)</td>
<td>Daily</td>
<td>1147</td>
</tr>
<tr>
<td>GUM referrals</td>
<td>As required</td>
<td>19</td>
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<tr>
<td>Health promotion</td>
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</tr>
<tr>
<td>Immunisation and vaccination</td>
<td>Twice weekly</td>
<td>206</td>
</tr>
<tr>
<td>Optician</td>
<td>4-6 weekly</td>
<td>57</td>
</tr>
<tr>
<td>Physio</td>
<td>On demand</td>
<td>9</td>
</tr>
<tr>
<td>Receptions</td>
<td>Daily</td>
<td>444</td>
</tr>
<tr>
<td>Wellman</td>
<td>Twice weekly</td>
<td>444</td>
</tr>
</tbody>
</table>

Following the lower projection, the prison population generally falls (between 0.2 and 0.6% year on year) to 2015 due to a projected decrease in the level of immediate custodial conviction. After 2015 it rises slightly as the indeterminate sentence population continues to rise against a background of levelling determinate sentence, remand and recall populations. Following the higher projection, the prison population generally rises (initially at around 2% year on year, reducing to less than 1% year on year by 2015) throughout the modelled period. At the end of June 2011 the published prison population was within 0.2% (200 in 85,400) of the medium projection, and within -0.9% of the high projection. At the end of September 2011 the published prison population was within 0.7% (600 in 87,500) of the medium projection, and within -0.9% of the high projection. Based on medium and high projections, service use within prisons is likely to increase. A low projection would indicate a possible reduction in service use.
**HMP Rochester**

The current total operational capacity is 664 offenders, and current population is 577 (June 2012). A refurbishment is currently taking place which will result in the capacity increasing to 724. Once the A wing opens (estimated to open in July 2013) the capacity will increase to 804. It is expected that 60% of the prisoners will be older adults and 40% will be younger males. The average length of stay is 4.5 months. The indicative service use over the next 12 months has been estimated for this prison to help plan health services (table 1)(source: HMP Rochester and NHS Medway).

**HMYOI Cookham Wood**

Current total operational capacity is 143 people and the current population is 110. There is a proposed new build at the prison which will increase the population capacity to 179 in the future. The average length of stay is 3–4 months (table 2).

**Evidence of what works**

**Crime and Offending**

**Breaking the cycle: Effective Punishment, rehabilitation and Sentencing of offenders[192]**

The Ministry of Justice identifies the need to bring together agencies involved in criminal justice to provide a more coherent and coordinated approach, including engagement of health services for offenders with mental health, alcohol and substance misuse problems. It focuses on the increasing role of the police in turning offenders away from crime and the importance of the court system in protecting the public and reducing reoffending through the use of community orders for drug treatment. Police, probation and other agencies are already working closely together in Medway in the management of prolific offenders. There is an Offender Management Unit that brings together police and probation. The Medway Drug and Alcohol Team is actively involved in supporting offenders with substance misuse problems and there is a Forensic Mental Health Team that works with the police to divert mentally ill offenders into appropriate treatment and provide court reports to support appropriate sentencing. Locally, West Kent is a pilot site, leading to the commissioning of a new service to provide an integrated drugs and alcohol service based on payment by results, which if successful may be rolled out across Kent and Medway.

**Mental health and substance misuse**

**No health without mental health. A cross government mental health outcomes strategy for people of all ages[206]**

This strategy aims to improve the mental health and well-being of the population and improve outcomes for people with mental health problems through high-quality services that are equally accessible to all. The incidence of mental health problems can increase in times of economic and employment uncertainty, and there are indications that behavioural and emotional problems are now more prevalent in young people. The strategy promotes early intervention as it can improve health and well-being and prevent mental illness, but also reduce costs incurred by ill health, unemployment and crime. There are critical priorities in the strategy which are relevant to the lives of offenders such as supporting young people and their families, improving parenting skills to reduce the generational cycle of offending, improving access to psychological
therapies, reducing drug use, supporting the positive mental health from employment and improving access to services for those who are homeless. It is estimated that 90% of all prisoners have a diagnosable mental health problem with or without a substance misuse problem. The strategy aims to reduce this by recommending that more individuals with mental health and learning difficulties are diverted away from criminal justice agencies and into treatment and social support.

**Anti-social personality disorder**

Many offenders can be identified as having an anti-social personality disorder. The National Institute for Clinical Excellence estimates that half of the prison population has such a disorder. Following consultation on offender personality disorders, the government’s response [207] indicates the need for criminal justice agencies and the NHS to work more closely together to ensure patients get access to the services, recognising that the affected individuals may be in prison or in the community. The protection of the public from the more serious cases would fall to the prison service. The National Offender Management Service (NOMS) and NHS are encouraged to work together to develop services along the offender pathway, providing psychological support by appropriately qualified staff. There was a particular focus on the needs of young people to prevent reoffending and the intergenerational cycle of crime. Agencies should ensure that services are targeted with an emphasis on screening and assessment. Appropriate treatment programmes should be provided within prisons or NHS secure estate supported by psychologically informed planned environments. The existing MAPPA (Multi Agency Public Protection Arrangements) programmes should have extra support to manage offenders in the community. The National Institute for Clinical Excellence has produced guidelines on the treatment, management and prevention of anti social personality disorder for adults over 18 years of age.[208]

**The Drug Strategy 2010: Reducing demand, restricting supply, building recovery [209]**

Drug use by young people has fallen by a third in the last decade, but the UK still has the highest rates of cannabis use and binge drinking amongst young people in Europe. This strategy focuses particularly on the impact of drugs and alcohol on young people and especially vulnerable groups, such as those in contact with criminal justice agencies, excluded from school or with parents with drug and alcohol problems who need targeted support and early intervention. Early drug and alcohol use is related to a host of educational, health and social problems.

The strategy requires that young people will get rapid access to specialist support for both drug and alcohol problems. The service should be recovery based both in the community and in treatment based accommodation, supported by CAMHS (Child and Adolescent Mental Health Services), the Public Health grant and the Early Intervention grant. There is particular emphasis on liaison and diversion from police and courts.

A third of the adult treatment (drug or alcohol) population has parental responsibility for a child, but there are family focused interventions, which provide evidence of reduction in anti social behaviour, crime, truanting and domestic violence. There is also a need to develop recovery-based services in prisons.
The Patel Report[210]

The Patel report reviewed substance misuse therapies available in the prison and community setting by looking at reduction in drug use and reoffending. It also looked at how current regimes improved social functioning and relationships or improved employment or workforce skills. However it found a need for greater continuity in management for substance misusers between prisons and community agencies including housing.

Children and young people

Healthy children, safer communities - a strategy to promote the health and well-being of children and young people in contact with the youth justice system[211]

Many children and young people in the YJS (Youth Justice System) come from vulnerable families living in disadvantaged areas where health outcomes are noticeably worse than for other children; particularly so for children from black and minority ethnic (BME) groups. High numbers of children and young people in the YJS experience domestic violence, neglect, and physical and sexual abuse within their family. These are risk factors for the development of mental health problems as well as for offending. For those in the secure estate there are particular concerns in relation to restraint, bullying, self-harm and the risk of suicide.

Many are not registered with a GP, increasing the risk that screening and developmental checks for children will be missed. In addition, many of these children and young people suffer from physical health problems such as poor oral health, respiratory problems, smoking, sexually transmitted diseases and pregnancy.

The strategy recognises the need to identify mental health problems, learning disabilities and communication problems when children and young people are in police custody, because such problems increase children’s vulnerability. Understanding a child’s health problems will also help the police, the Crown Prosecution Service (CPS) and the Youth Offending Team (YOT) to decide the most appropriate action to take and wherever possible divert them from criminal justice agencies towards more appropriate treatment and support services.

Looked After Children and Young People (NICE Guideline 28)[212]

The guidance covers children and young people from birth to age 25, wherever they are looked after. The guideline applies to secure settings such as young offenders institutions (e.g. Cookham Wood and Rochester), recognising the constraints of working with some of the most challenging behaviour and attitudes. It is recommended that services are commissionned which are dedicated to looked after children and young people that are integrated, preferably on the same site, and have expert resources to address physical and emotional health needs. These services should have links with universal services, be friendly, accessible and non-stigmatising.

Unmet needs and service gaps

The prisons undertake an assessment of their performance using the Prison Health Performance and Quality Indicators. The results for HMP Rochester and HMYOI
Cookham Wood indicate that there are some unmet needs and service gaps that require development.

**HMP Rochester**
- Improving services for the management of chronic disease and long term conditions
- Developing prison dental services
- Developing services for older adults
- Improving services for those with learning disabilities
- Implementing the Care Programme Approach Audit
- Developing health promotion
- Improving health services in accordance with the Equality Act and Human Rights Act
- Increasing service user involvement
- Developing corporate governance and information governance
- Working with providers to plan the healthcare workforce

**HMYOI Cookham Wood**
- Improving health services in accordance with the Equality Act and Human Rights Act
- Implementing alcohol screening, intervention and support
- Developing services for children and younger people
- Improving services for those with learning disabilities
- Developing health promotion
- Improving communicable disease control services

**Recommendations for consideration by commissioners**

**Engagement**
- Links need to be developed with the Health and Wellbeing Board to ensure the greater needs of offenders are taken into account when tackling health inequalities
- Engagement with Clinical Commissioning Groups to ensure that primary care services are aware of the risks and opportunities in the management of offenders and their families

**Working with external agencies**
- Services need to be developed that allow early identification of health needs in conjunction with the probation service and court service. These services need to
enable access to wider health and social services working with the wider criminal justice system.

- The probation services and the courts should be assisted to make better use of Alcohol Treatment Orders for those people known to be suffering from alcohol related problems to help prevent them reoffending

**Developing Services**

- Ensure that all new receptions have their peak flow taken as part of the Wellman clinic. Ensure that spirometry is available at the establishment to aid diagnosis of respiratory conditions.

- All future chronic disease management clinics should be run in line with best clinical practice and complies with the relevant National Institute for Health and Clinical Excellence guidance. The new service provider to improve the data quality, clinical coding and to ensure that chronic disease registers are in place.

- Focus on the development of positive relationships between staff and offenders, especially BME offenders

- Substance misuse services at Cookham Wood should be developed to meet National Service Specifications

- Identify health services and preventative services that can be more easily delivered in the ‘wings’ to improve access for prisoners

- Improve collaboration between prisons to share health resources and improve access to specialised services

- Introduce a screen for diabetes as part of Wellman clinics

- Increase uptake of smoking cessation at HMP Rochester

- Identify health promotion needs and develop a health promotion plan

- Develop services for those with learning difficulties across both HMP Rochester and HMYOI Cookham Wood

- Consider developing the workforce to deliver services equitable to a minor injury unit to deal with fights

- Reduce failed appointments - Consider for the new model of care and the employment of a nursing assistant/porter to act as a movements officer to ensure patients can get to their appointments and are returned to work/wing without delay

- The commissioner should consider the possibility of providing onsite Diagnostic Imaging (Ultrasound and Radiography), GUM and Dermatology clinics for both Cookham Wood and Rochester
Further needs assessment required

- Further needs assessment is required to compare the service utilisation and needs in these prisons with similar prisons and with other prisons in the area

- User involvement should be encouraged as part of future needs assessment with better mechanisms to collate service user views

- As systems develop, incidence and prevalence of disease conditions needs to be gathered

- The effectiveness and cost-effectiveness of services that are currently provided need to be considered

- Service use projections should be calculated over 3-5 years and 10 years. This will be needed to consider the increasing prison population and increase in the age range of the prisoners.

- Further analysis needs to be included of all unplanned admissions to hospital

Carers

Summary

Summary

The term “unpaid carer” encompasses individuals of any age who provide unpaid support to a relative partner, a child or friend who could not manage without this help.[213] This could include the provision of support to someone who is ill, frail, disabled or has mental health or substance misuse problems. In Medway there are an estimated 25,000 unpaid carers,[121] although many carers do not make themselves known to services, and as such this number is likely to underrepresent the actual value. Caring can have detrimental effects on the health of the carer and also in their ability to remain financially independent, as many have to give up work in order to provide care. It is important that carers are identified and supported early to ensure that the health and wellbeing of the carer, and the person being cared for, are protected. Those particularly vulnerable are carers that are very young or elderly.

Key issues and gaps

The Care Act 2014 came into force in April 2015 and, for the first time, allows carers the same rights to assessment and support as the persons they care for.[214] This shift in focus has highlighted the need for change nationally, to put legislation from the health and social care reforms into action. This includes the increased monitoring of the impact on carers, to ensure that future priorities for action to support carers are identified. In response to the Care Act 2014, Medway has formed a new strategy entitled “NHS Medway and Medway Council Joint Carers’ Strategy”,[215] which sets out to identify carers in need of help and put in place the structures necessary to deliver advice and support. This support is hoped to maximise the carers’ potential through the delivery of
training, identification of resources already available to them in their family and community networks and, in some instances, provision of financial assistance.

**Who’s at risk and why?**

In any one year an adult has a 6.6% chance of becoming a carer; this likelihood is greater in women than it is in men (7.3% and 5.8% respectively). By the time a woman has reached the age of 59 she has a 50% chance of having had significant caring responsibilities at least once; for a man the equivalent age is 74 years.[216]

Caring may have a substantial negative economic impact as a significant number of carers also either give up or reduce their hours of work in order to care. There is also a cost to society in terms of both reduced income from taxation and increased benefits payments. It has been estimated that carers in the UK miss out on between £750 million and £1.5 billion a year in earnings.[217] A Carers UK survey found that one third of carers were unable to afford their utility bills and almost half were cutting back on essentials such as food and heating.[218]

Caring is associated with an increase in health problems in those providing the care. Common problems include physical injuries and mental health problems such as depression and anxiety.[218] Among older people mortality rates may also be higher in carers than in non-carers.[219] However, carers do not visit the doctor any more than non-carers, suggesting that they may not be accessing the services that they require.[220] If carers are struggling with the demands of caring this may also have consequences on the health of the person being cared for. In one study, the carer’s inability to cope was found to be the principal reason for re-admission of patients in 14% of cases, but problems with the carer were felt to contribute to as many as 62% of re-admissions.[221]

Nationally, we are seeing an ageing population and correspondingly the number of carers over the age of 65 is increasing more rapidly than the general carer population; increases of 35% and 11% respectively seen in England between 2001 and 2011 Census surveys.[222] See table below for breakdown of increases in elderly carers by age. Elderly carers may have health problems of their own, so developing adequate support for this group of carers is essential.

*Table 1: Breakdown of elderly carers in England from 2001 and 2011 Census data.* [222]

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number of older carers 2001</th>
<th>Number of older carers 2011</th>
<th>% increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged 65 to 74</td>
<td>582,287</td>
<td>725,251</td>
<td>25%</td>
</tr>
<tr>
<td>Aged 75 to 84</td>
<td>261,240</td>
<td>377,923</td>
<td>45%</td>
</tr>
<tr>
<td>Aged 85 and older</td>
<td>38,291</td>
<td>87,346</td>
<td>128%</td>
</tr>
<tr>
<td>Total</td>
<td>881,818</td>
<td>1,190,520</td>
<td>35%</td>
</tr>
</tbody>
</table>

Anyone under the age of 18 who is in some way affected by the need to take physical, practical and/or emotional responsibility for the care of another person is termed a 'young carer'. Young carers can be particularly vulnerable as they are often undertaking
a level of responsibility that is inappropriate to their age or development and for this reason may also be reluctant to seek help.

The level of need in the population

Although it is difficult to measure the current overall level of unpaid care provided by Medway's residents, the most recent Census data provides us with our best indication. In 2011, the number stood at approximately 25,000, accounting for 9.5% of the total population.[121] Overall, this places Medway below the national and regional averages in terms of unpaid care provision, with England and South East revealing values of 10.2% and 9.8% respectively.[121] The breakdown of unpaid carers within Medway by age and gender can be seen below in Figure 1. The largest group of unpaid carers were women aged 55-59, of which 22.0% were providing unpaid care. Using figures from the 2011 Census, there are an estimated 661 children and young people in the age range 0 - 15 provided unpaid care in Medway, with an additional 1,632 in the 16 - 24 age range.

Figure 1: Percentage of the population in each age group in Medway who are providing unpaid care, 2011 census.
National trends reveal an overall increase in the level of reported unpaid care, with an increment of 11.3% in England between the 2001 and 2011 Census surveys. In Medway, the number of unpaid carers increased by 16.5% from that recorded in the previous (2001) Census; including a 51.1% increase in unpaid care provision by those aged 65 and over. Changes to the age ranges displayed at Local Authority level mean that direct comparisons for the younger age ranges cannot be made with previous surveys. However, national figures in the 2011 Census show a 2.1% rise in young carers identified as providing unpaid care compared with the preceding survey.[223]

If we look at the level of care provided, slightly fewer carers in Medway provide the lower (1 to 19 hours per week) and medium (20 to 49 hours) levels of care than the national average, whilst there are slightly more carers in Medway than the national average providing higher (50+ hours) levels of unpaid care.[121] Unpaid carers reported poorer health than those not delivering unpaid care (4.7% and 6.5% respectively); with carers delivering 50 hours or more of care revealing the highest levels of poor health (11.7%).[224]

At ward level Peninsula, Gillingham North and Gillingham South have the greatest proportions of unpaid carers; Cuxton & Halling, River and Lordswood & Capstone have the lowest.[225] There is no obvious correlation between the level of deprivation in a ward and the percentage of the population who are carers. Similarly to the general population, the majority of carers in Medway were of white ethnicity; in this group 9.8% provided unpaid care.[226] Most unpaid carers are still economically active (65.7%). However, a higher proportion of part-time workers, working in an employed or self-employed capacity, undertake caring responsibilities than those working in a full-time role.[227] It is likely this is due to the requirement of carers to reduce work hours in order to provide care.

**Current services in relation to need**

For an up-to-date list of current services please contact Caroline Friday.

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

It is estimated that 3 in 5 people will act as a carer at some point in their lives.[216] However, carers are not a static population, every year millions of people take on caring responsibilities, whilst for millions of carers caring comes to an end as the person they care for recovers, moves into residential care or passes away.[228] As such, it is very difficult to calculate the number of carers that will be required in subsequent years.

Table 2 shows projected carer provision required in the years 2017 to 2037. These projections assume that the proportion of the population providing care in the future, by age, remains the same as in 2011.[121] This assumption is unlikely to be accurate as it does not take into account changes in the prevalence of age-related conditions, such as dementia, which has shown a rapid increase in prevalence. In addition, the proportion recognised as providing care is likely to increase due to better identification of unpaid carers. Thus we are likely to see much higher numbers recorded in the future than those estimated in Table 2.
Table 2: Estimated number of carers in Medway, by age, 2017 to 2037. Projections calculated using Census 2011 carer numbers and 2012-population projections (ONS).

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2017</th>
<th>2022</th>
<th>2027</th>
<th>2032</th>
<th>2037</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 15</td>
<td>701</td>
<td>740</td>
<td>759</td>
<td>765</td>
<td>770</td>
</tr>
<tr>
<td>16 to 24</td>
<td>1,548</td>
<td>1,495</td>
<td>1,577</td>
<td>1,697</td>
<td>1,749</td>
</tr>
<tr>
<td>25 to 34</td>
<td>2,680</td>
<td>2,800</td>
<td>2,673</td>
<td>2,626</td>
<td>2,793</td>
</tr>
<tr>
<td>35 to 49</td>
<td>6,851</td>
<td>6,851</td>
<td>7,428</td>
<td>7,755</td>
<td>7,780</td>
</tr>
<tr>
<td>50 to 64</td>
<td>9,387</td>
<td>10,040</td>
<td>9,913</td>
<td>9,677</td>
<td>9,768</td>
</tr>
<tr>
<td>65 and over</td>
<td>5,680</td>
<td>6,343</td>
<td>7,196</td>
<td>8,151</td>
<td>8,890</td>
</tr>
<tr>
<td>Total</td>
<td>26,605</td>
<td>27,800</td>
<td>28,938</td>
<td>29,991</td>
<td>30,987</td>
</tr>
</tbody>
</table>

Using figures from the 2011 Census, Carers UK predict that there will be a 40% rise in the number of carers needed by 2037, resulting in an estimated 9 million carers nationally.[228] If we were to crudely (with no age-standardisation) apply this 40% increase in the number of Medway carers, we would expect to see 35,004 unpaid carers by 2037. However, the methodology used by Carers UK has not been published and as such cannot be verified.

A recent paper looking at the supply of unpaid care for older people by their adult children, suggests that demand for unpaid care will begin to exceed supply by 2017 and that the unpaid ‘care gap’ will grow rapidly from then onwards.[229] Estimates by POPPI suggest that the number of older carers (aged 65 years and over) in England is set to increase to over 1.8 million by 2030.[230]

**Evidence of what works**

The literature on support interventions for carers shows a wide range of interventions have been tried to support carers of people with a variety of different conditions, with mixed results. The provision of short breaks to carers has been shown to have beneficial effects; one particular intervention showed that short breaks for families of disabled children led to a positive impact on the wellbeing of most disabled children and their families.[231] There is also evidence to show that cognitive reframing can have some effect on anxiety, depression and subjective stress in dementia carers.[232]

Providing primary care teams with training and awareness of issues faced by carers can be successful. Options to increase identification of carers may include routinely asking about whether someone is a carer at new registrations and routine health checks, or on repeat prescriptions. Carer support workers may be helpful in providing carers with advice and signposting to relevant agencies.[233] For hospital patients, comprehensive discharge planning, which includes both patients and their carers has been found to be related to shorter hospital stays and reduced re-admissions.[234]

**User Views**

In 2012 four focus groups were held with carers from across Medway, with adult carers, young carers, carers from black and minority ethnic groups and carers for people with
mental health problems. One of the key points raised was identification. Carers felt that there was often a delay in recognition of their role as a carer, by authorities and the carer themselves. Carers felt that GPs and hospitals were in an ideal position to recognise that they were carers and offer support and felt that the carer should be identified as soon as the person being cared for received their diagnosis.

There was felt to be a lack of training for unpaid carers in the skills they needed in their caring role, for example using a hoist. Carers also expressed that they would like more information about the condition of the person they cared for as well as clear information relating to available support. Carers felt that a single information booklet with necessary information and contact details would help greatly.

In order to keep themselves healthy, carers highlighted a need for support to take breaks from their caring responsibilities in addition to respite care, which was deemed too costly for some. In addition, counselling was mentioned as something that could be useful in helping carers maintain their mental health. Carers also expressed the desire for free travel and other treatments, such as free swimming.

Further consultation will be undertaken in the 2017 leading up to review of the carers’ strategy.

Unmet needs and service gaps

Out of the estimated 25,000 carers identified in the 2011 census, only a small proportion of carers in Medway appear to be known to services. This would suggest that there is a need to improve the way in which carers are identified in order that they are provided with appropriate support. The discussion of a carers’ lead role in GPs surgeries is planned to take place shortly will assist in raising the awareness and better identification of carers and carers’ issues within primary care settings. Once identified carers should be given the correct information and training for their needs to support them in their caring role.

Anecdotally, working age carers do not appear to be well engaged with the Medway Carers’ Centre. Further work needs to take place to identify how best to support this group of carers.

Recommendations for Commissioning

Medway Council and Medway NHS CCG value their adult, parent and young carers. As such, there is the recommendation to ensure that carers should be recognised by the wider community and receive appropriate support where necessary to help them provide care safely and maintain a balance between their caring responsibilities and a life outside caring. This includes assisting them in achieving their potential, maintaining mental and physical health and wellbeing, ensuring access to training and employment and supporting them to be as independent as possible.[215]

A list of principles underpinning ‘Medway’s Commitment to Carers’ can be found under section 7 of the NHS Medway and Medway Council Joint Carers’ Strategy 2015–2017. The ongoing development and testing of the new Citizen’s Portal, MyMedway.org, will
carry a full suite of information, advice and guidance as well as an “E-Marketplace” which is being developed to ensure that those looking for support can research appropriate solutions for themselves.[215]

In line with the requirements of the new Care Act 2014, Medway Council will offer assessments for carers who request them. This will enable the council to determine the carers’ level of need, including whether or not they are eligible for any additional funding from adult social care.

Recommendations for needs assessment work
A detailed needs assessment was carried out and published in October 2012.

Falls

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

Falls are an increasingly significant public health issue due to our ageing population. Older people have the highest incidence of falls and the greatest susceptibility to injury. Up to 35% of people aged 65 and over fall each year increasing to up to 42% for those aged 70 years and above. [235]

Falls may result in loss of independence, injuries such as fractures and head injuries (20% of fallers sustain serious injury such as hip fracture), mobility loss, pressure related injuries, infection and sometimes injury–related death. The most common serious consequence of falling is a hip fracture (fractured neck of femur). Often the elderly will require hospital admission and rehabilitation following a fall. In the UK there were 647,721 Accident and Emergency (A&E) attendances and 204,424 hospital admissions for falls–related injuries in those aged 60 years or above in 1999. [236] Falls and fractures in the >65s account for four million hospital bed days/year in England.

Older people who fall are likely to fall again, usually requiring further use of health and social care services. Recurrent fallers are also more likely to have a fall–related fracture. [237] Half of people suffering a hip fracture never return to their previous level of independence and experiencing falls is a strong predictor of needing placement in a nursing or care home in the future. [238]

Osteoporosis, a condition characterised by a reduction in bone mass and density, increases fracture risk when an older person falls. Osteoporotic fractures are increasing in the UK, a trend which is likely to continue as the elderly population increases. It is estimated that 3 million people in the UK have osteoporosis and that around 230,000 osteoporotic fractures occur in the UK each year. In 2001, the combined NHS and social care costs for a single hip fracture in the UK were estimated to be £20,000 with an estimated total of more than £1.73 billion per year for all UK hip fractures.
The financial impact of falls and fractures on health and social care is substantial. As the rate of falls is expected to rise with an ageing population, developing effective interventions to prevent falls becomes increasingly important as they will have significant implications for health and social services.

The Department of Health published “Falls and Fractures. Effective interventions in health and social care” in 2009, the aim of which was to improve NHS falls and fracture services and care for older people. Four key objectives were set out within the document, prioritised in the size of health gain, which commissioners should consider in the context of local services for falls, falls prevention and fractures (figure 1).

Figure 1: Department of Health: Systematic Approach to Falls and Fracture Prevention—Four Key Objectives.

Key issues and gaps

- Falls are a public health problem nationally due to an ageing population. Medway’s 50+ population is expected to increase by 16% from 2013 to 2021. The number of people over 85 will grow by 27% over the same time period.

- Osteoporosis is common, especially in older females, and is a major cause of fractures in fallers. Osteoporosis prevalence is likely to increase with Medway’s ageing population.

- Hospital admissions for hip fractures following falls are expected to rise by 29% from the 2010–2012 baseline by 2021 in those aged 50 years and above. For all falls–related admissions in Medway patients aged 50 years and above the expected increase from baseline is 27% by 2021. By far the greatest burden in Medway of hip fracture following falls occurs within the 85+ age group.

- The highest rates of falls related Medway admissions in 2012 were for non–hip fractures (“other fracture”) and injuries other than fractures (“other injury”). In 2012, Hip fractures accounted for just 11.4% of all falls–related admissions in Medway compared to 52.6% of admissions where no fracture took place. The remaining 36% of falls related admission in 2012 were for non–hip fractures.

- Directly standardised hospital admission rates for all falls in those aged over 50 years saw a general upward trend from 2007–2011, with a similar trend in admission rates for hip fractures following falls. An unexpected situation can be noted for Medway where admissions for all falls and for hip fractures has declined over the last couple of years following the earlier rise. Although data from subsequent years is required in order to determine whether this decline is an enduring trend, its possible causes are worthy of further investigation.

- Mean length of stay for hip fracture admissions was 16.1 days (median 12 days) for Medway in 2012: lower than the 2012 national mean of 20.2 days. [239]

- The total number of admissions coded as “other diagnoses” involving no injury such as Senility, Urinary Tract Infections, Pneumonia etc. saw a striking increase of...
51% from 2007 to 2011, followed by a fall of 53% from 2011 to 2012. The cause of this pattern is unclear and needs further investigation.

**Recommendations for commissioning**

- Projected increases in the burden of falls and falls–related injury together with fewer resources available for health and social care mean that falls and falls prevention should be a priority issue for commissioners and providers.
- A Medway Falls Strategy should be developed and implemented as a framework for consideration of the whole falls care pathway by commissioners.
- Falls should continue to be included as a topic within the JSNA and the findings should be brought to the attention of the Health and Wellbeing Board.
- Effective falls prevention schemes can be implemented at little cost with the involvement of professionals working in health, social care and in the community. The majority of falls in Medway occur in the home or in residential care settings, highlighting the need to examine the existing provision of home safety information in the community and the need for a better understanding of falls prevention activities within care settings. All care homes should have falls prevention strategies in place, the objectives of which should include more robust recording and reporting of data on falls.
- Commissioning of the enhanced falls pathway and falls fast track clinic
- Service users should have greater involvement in service development and monitoring.
- Audit of the accuracy/ appropriateness of coding for falls related admissions
- Further in depth analysis of falls data, including data on A&E attendances and locations of falls in the community, is required in order to achieve a better understanding of the pattern of falls across different groups and different settings in Medway.
- Detailed mapping of all falls services delivered across all sectors and organisations in Medway, including the voluntary sector, should be undertaken.
- Falls Prevention should also consider the wider environment, for example, through partnership working with town planners to ensure that the risk of falls to older people is taken into account.

**Who is at risk and why**

The risk of falling increases with age and frailty for a number of reasons. Risk factors for falls include:

- Balance or mobility problems including those due to degenerative joint disease and motor disorders such as stroke and Parkinson’s disease
- Taking four or more medications, particularly sedating or blood pressure lowering drugs.
• Certain drugs, e.g., alcohol, psychotropic drugs, benzodiazepines and antidepressants [240]

• Visual impairment

• Impaired cognition or depression

• Postural hypertension

• Risk factors at home such as poor lighting, steep stairs, loose carpet, slippery/rough floors and obstacles can cause falls for all people but particularly for older people who may already have other risk factors [241]

• Certain demographic groups, e.g., older populations (aged 85+), females, those from the least advantaged social groups [242]

These risk factors become more common with age and there is therefore a high prevalence of falls related injury amongst older people: more than 30% of people aged <65 and 50% of people aged >80 fall each year. Multiple factors, many of which are modifiable, can combine to cause falls. Identifying and modifying risk factors is therefore vital to falls prevention.

Older people who experience a fall are also more likely to fall again. Figure 1 shows that Medway’s hospital admission rates for all falls increased with age in 2012. It should be noted that calendar year, rather than financial year, has been used throughout this needs assessment due to the availability of more current data with this method. A particularly rapid acceleration in the rate occurred from age 70–74 years onwards, with the rate for females aged 85+ reaching almost 12%.

Figure 1: Falls related hospital admission rate (all falls) in Medway by age and gender, 2012 Source: Secondary Uses Service via KMHS data warehouse and Office for National Statistics.

Osteoporosis is most common in older white women. After the menopause, osteoporosis prevalence in women increases markedly with age from approximately 2% at 50 years to more than 25% at 80 years. [239] The most common osteoporotic fractures resulting from a fall occur in the hip, spine and wrist. These often result in substantial morbidity and mortality: the risk of death in older people following a hip fracture is approximately 11–23% at six months and 22–29% at a year after injury. [240] In the UK, 1 in 2 women and 1 in 5 men will suffer a fracture after the age of 50. [243]

Figure 2 shows that the Medway hospital admission rate in 2012 for hip fractures in both men and women increased with age and was by far the highest in those aged 85 years and above.
Falls in older persons are around three times more common in residential care settings than in the community, reflecting a higher incidence of risk factors such as poor mobility, visual impairment and dementia in these settings. [244] Up to 75% of nursing home residents fall annually — twice as high as older people living in the community. An estimated 10–25% of falls in institutional settings result in fracture or injury requiring hospital attention, compared with 5% in the community. [245]

Level of need in the population

Demographics

Increasing life expectancy and a reduction in fertility is leading to an ageing of England’s population. Medway’s population is currently younger than the national average but population projections (please see ‘Our People and Place’) suggest that the number of people 50 years or above will increase from 88,000 in 2013 to 102,000 by 2021 and the number of people over 85 years will grow by 27% to 5,800.

This expected growth in the older population has important implications for falls prevention strategies, healthcare and social care services.

There are differences in the age distributions of Medway’s wards. Rainham Central, Hempstead & Wigmore and Rainham North have the largest proportions of older people with one fifth or more of their population aged 65 years and above.

51% of falls amongst Medway residents aged 50 years and above which required hospital admission in 2012 occurred at the patient’s home. 9% occurred within a residential institution. Table 1 gives a breakdown of place of occurrence of these falls.

Table 1: Place of occurrence of falls requiring hospital admission, Medway residents aged 50+ (n = 1260), 2012 Source: Secondary Uses Service via KMHIS data warehouse

<table>
<thead>
<tr>
<th>Place of Occurrence</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>50.7%</td>
</tr>
<tr>
<td>Residential/nursing institutions</td>
<td>8.9%</td>
</tr>
<tr>
<td>School, other institution and public administrative area</td>
<td>4.4%</td>
</tr>
<tr>
<td>Sports and athletics area</td>
<td>0.4%</td>
</tr>
<tr>
<td>Street and highway</td>
<td>5.9%</td>
</tr>
<tr>
<td>Trade and service area</td>
<td>2.5%</td>
</tr>
<tr>
<td>Industrial and construction area</td>
<td>0.1%</td>
</tr>
<tr>
<td>Farm</td>
<td>0.1%</td>
</tr>
</tbody>
</table>
Table 1 shows that in over a quarter of cases the place of occurrence is coded as ‘unspecified’. Although this proportion has decreased compared to previous years, the reliability of the data is limited.

**Hospital admissions**

Figure 1 shows that the falls admission rate for Medway residents (males and females combined) aged 50 years and above rose by 23% from 2007 to 2011 when a peak of 1488.2 per 100,000 was reached in before falling again from 2011–2012. A similar pattern to that seen in figure 1 applies to admission rates for falls amongst those aged over 65 years. Further surveillance of falls–related admissions will determine whether or not this decline is an enduring trend.

In 2012, neck of femur (NOF) fractures accounted for 11.4% of all falls–related admissions in Medway compared to 52.6% of admissions where no fracture took place. Falls–related admissions for hip fractures made up 24.1% of admissions for all fractures following falls in 2012. Figure 2 shows that the highest rates of falls related Medway admissions in 2012 were for non–hip fractures (‘other fracture’) and injuries other than fractures (‘other injury’). Over the period from 2007–2012, admission rates for ‘other fractures’, ‘other injury” and ‘other diagnoses’ have been consistently higher than for ‘neck of femur fracture’ and ‘other femur fracture’. The admission rates for all primary diagnosis categories apart from ‘other fracture’ have declined over 2007–2012: the rate for ‘other fracture’ has seen an increase from 2010–2012 (although not statistically significant). Admission rates for ‘other diagnoses’ (i.e., diagnoses without injury or fracture) rose steeply from 2008–2011 and then declined sharply.

Table 2 shows the change in numbers of falls related hospital admissions for each of the five diagnosis categories over the period 2007–2012.
Table 2: Numbers of falls related hospital admissions, Medway residents aged 50 years and above, by year of occurrence and primary diagnosis code, 2007–2012 Source: Secondary Uses Service via KMHIS data warehouse.

<table>
<thead>
<tr>
<th>Year</th>
<th>Fractured neck of femur</th>
<th>Other femur fracture</th>
<th>Other fracture</th>
<th>Other injury</th>
<th>Other diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>120</td>
<td>102</td>
<td>302</td>
<td>420</td>
<td>273</td>
</tr>
<tr>
<td>2008</td>
<td>131</td>
<td>84</td>
<td>304</td>
<td>409</td>
<td>270</td>
</tr>
<tr>
<td>2009</td>
<td>145</td>
<td>85</td>
<td>378</td>
<td>505</td>
<td>383</td>
</tr>
<tr>
<td>2010</td>
<td>168</td>
<td>79</td>
<td>331</td>
<td>461</td>
<td>451</td>
</tr>
<tr>
<td>2011</td>
<td>155</td>
<td>83</td>
<td>373</td>
<td>445</td>
<td>557</td>
</tr>
<tr>
<td>2012</td>
<td>144</td>
<td>69</td>
<td>384</td>
<td>400</td>
<td>263</td>
</tr>
</tbody>
</table>

Figure 3 shows that the admission rates for hip fractures following falls rose steadily from 2007 to 2010 and then saw an overall decline from 2010–2012 which was most marked amongst females. Further surveillance of falls–related admissions will determine whether or not this decline is an enduring trend.

Admissions for “other diagnoses” (i.e., involving no falls related injury) saw a striking increase of 51% in their total number from 273 in 2007 to 557 in 2011 (an increase in the rate of admissions of 48% from 253.5 to 489.0 per 100,000) followed by a fall of 53% in numbers of admissions from 557 in 2011 to 263 in 2012 (a decrease in the rate of admissions of 53% from 489.0 to 228.9 per 100,000). The pattern of admission rates for “other diagnoses” is shown in figure 7.

The International Classification of Diseases (ICD) is used to classify diseases and other health problems recorded on many types of health and vital records including death certificates and health records. The ICD–10 is the 10th revision of the classification and is the version which is currently in use.

The steep drop from 2011–2012 in admissions for “other diagnoses” represents a fall in actual numbers of these admissions of 294 between 2011 and 2012: admissions coded as senility account for 61% of the total drop in admissions.
Table 3 shows the breakdown of the top eight diagnosis codes within the “other diagnosis” category which were most frequently used to classify falls–related hospital admissions in Medway for 2011 and 2012.

Table 3: Number of falls–related hospital admissions without an injury or fracture recorded in primary diagnosis, 2011 & 2012, Medway residents aged 50 years and above

<table>
<thead>
<tr>
<th>ICD 10 description</th>
<th>2011</th>
<th>2012</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>R54 Senility</td>
<td>177</td>
<td>39</td>
<td>-78%</td>
</tr>
<tr>
<td>N39 Other disorders of urinary system</td>
<td>47</td>
<td>27</td>
<td>-43%</td>
</tr>
<tr>
<td>M25 Other joint disorders, not elsewhere classified</td>
<td>42</td>
<td>25</td>
<td>-40%</td>
</tr>
<tr>
<td>J18 Pneumonia, organism unspecified</td>
<td>32</td>
<td>17</td>
<td>-47%</td>
</tr>
<tr>
<td>M54 Dorsalgia</td>
<td>25</td>
<td>11</td>
<td>-56%</td>
</tr>
<tr>
<td>R55 Syncope and collapse</td>
<td>14</td>
<td>7</td>
<td>-50%</td>
</tr>
<tr>
<td>J63 Cerebral infarction</td>
<td>7</td>
<td>7</td>
<td>0%</td>
</tr>
<tr>
<td>J22 Unspecified acute lower respiratory infection</td>
<td>10</td>
<td>6</td>
<td>-40%</td>
</tr>
<tr>
<td>Other Further separate diagnoses</td>
<td>203</td>
<td>124</td>
<td>-39%</td>
</tr>
<tr>
<td>Total</td>
<td>557</td>
<td>263</td>
<td>-53%</td>
</tr>
</tbody>
</table>

Median length of stay for falls–related hospital admissions in people aged over 65 years (all falls) was 7 days (mean 12.1) in 2012. The median length of stay for admissions for hip fractures was 12 days (mean 16.1). Median length of stay was longest for the "other femur fracture category at 17 days (mean 24.5).

Ambulance callouts

Data on ambulance callouts was obtained from the South East Coast Ambulance Service (SECAMB). SECAMB classify callouts by problem nature and response using NHS Pathways, a clinical triage system, which replaced the Advanced Medical Priority Dispatch System (AMPDS) triage software in 2011.

Callouts to Medway residents classified as either ‘fall <12ft’ or ‘falls–assistance only’ have been included in the following analyses.

2,746 emergency calls were made to SECAMB in 2012/13 based on the inclusion criteria above. Of those, 150 were removed as they were either duplicates or call–backs from a clinician. A total of 2,596 incidents were analysed.

Figure 5 shows the age and gender distribution for all Medway residents who called for an ambulance following a fall in 2012/13. Patients represented by the bars labelled “unknown” represent those where age and/or sex had not been recorded.
Figure 5 shows that numbers of callouts for falls increased with age of patient (median age of patient 80 years, range 4 months – 105 years). The 80–90 year age group made up a third of all incidents throughout last year. The over 50's group (target audience) accounts for 85% (2,208/2,596) of all SECAMB callouts for falls. The proportion of falls-related callouts for female patients aged 50 years and over (66%) was almost double that of males for 2012/13.

Increases in falls-related callouts occurred during the winter months of 2012/13 — these monthly differences are in-line with overall SECAMB activity during those periods.

Of the 2,596 falls-related callouts, 371 (14%) falls had occurred in a public place.

The response rate was 95% (2,477/2,596) with 119 incidents being cancelled before the ambulance arrived. The conveyance rate was 39% (962/2,477) with 1,515 patients not being conveyed to hospital. Of those patients who were conveyed to hospital, the final destination for 99% (952/962) was Medway Foundation Trust.
Falls related mortality

The falls-related mortality rates provided by the Kent & Medway Public Health Observatory (KMPHO) are based on the underlying cause of death between ICD-10 codes W00 and W19, registered anytime over the five year period from 2008–2012. The Clinical Commissioning Group populations have been sourced from the Exeter database via the Primary Care Information System.

Deaths following falls across Kent CCGs are presented in figure 6 as pooled data (age standardised mortality rates) for 2008–2012 as the numbers of deaths recorded in each year were small. In total, 55 deaths were recorded in Medway for 2008–2012 for male and female patients aged 65 years and above. The reliability of the rates presented here may be affected by the small numbers of deaths due to falls.

Figure 6: Mortality rates from falls, Kent & Medway CCGs, 2008–2012, males and females aged over 65 years (D,G and S = Dartford, Gravesham and Swanley) Source: Public Health Mortality File, PCIS populations

For males aged 65 years and above, the age standardised mortality rate for Dartford and Gravesham CCG is significantly lower than all other Kent CCGs for 2008–2012. For all
other Kent CCGs, including Medway, the falls–related mortality rates are not significantly different, and although Medway CCG’s rate appears to be higher than Kent & Medway as a whole, the difference is not statistically significant.

For females aged 65 years and above, the age standardised mortality rate for Medway CCG for 2008–2012 is not significantly different to the other Kent CCGs and is similar to the overall rate for Kent & Medway as a whole.

**Current services in relation to need**

*Medway Foundation Trust Falls Emergency Department Pilot*

The Falls Emergency Department pilot commenced following identification of the need for a clear pathway for fallers presenting at Medway Foundation Trust (MFT) Emergency Department (ED). The pilot initially ran for one and a half months from January 2012 and then resumed for 6 months from October 2012 following agreement from the Urgent Care Programme Management Group and MFT.

The objectives of the pilot were to:

- Identify the numbers of fallers presenting to ED
- Establish the percentage of patients already known to the MCH Community Falls Service
- Understand the impact of the enhanced falls assessment process and new fast track clinic

The project scope comprised:

- Mapping the desired ED Falls pathway
- Developing assessment criteria and tools for use in ED to identify fallers for triage
- Triage process in place to refer patients to most appropriate service — GP, MCH Community Falls Service or MFT Fast Track Clinic
- Undertaking of comprehensive medical review at the fast track clinic on appropriate patients to reduce the risk of recurrent falling and prevent further ED attendance and emergency admissions. Once seen within the fast track clinic, a patient may be referred by the Consultant Geriatrician to Medway’s Community Falls Service if required.

Presentations were given to GPs during GP Protected Learning Times, clarifying the GP pathway and assessment tool for fallers. Prompts are currently being considered for GP clinical IT systems to help identify existing and potential new fallers in primary care, who can then be assessed using the Falls Assessment Tool and managed appropriately thereby reducing further ED attendances and non–elective admissions.

Evaluation of the pilot demonstrated that the proposed pathway change yields significant improvements in patient care, providing rapid access for complex patients to be reviewed and prevents avoidable re–attendance to ED. The Falls ED pilot review has
been presented to the Urgent Care Programme Management Group (UCPMG) and the Medway Clinical Commissioning Group Commissioning Committee who supported a permanent pathway change.

**Fracture Liaison Service (Medway Foundation Trust)**

A Fracture Liaison Service (FLS) is a multidisciplinary service which ensures that every person over the age of 50 who suffers a fragility fracture is identified, recorded and given an assessment for their future fracture risk. The fracture liaison nurse then helps to ensure that patients are prescribed bone protecting treatments where appropriate, reducing their risk of suffering further fractures later on in life. A comprehensive FLS will also ensure that high standards of post-fracture care are delivered, and that the complex range of health and social care services that patients need following a fragility fracture, including falls services, are co-ordinated.

Medway Foundation Trust provides a comprehensive FLS led by a dedicated Nurse Specialist, working under the guidance of a Specialist Consultant. The service aims to identify all patients over the age of 50 years presenting with a new fragility fracture and to offer the opportunity to have Bone Density Measurement (DXA) if considered at risk.

Fracture clinics, trauma wards, Occupational Health and Physiotherapy departments and the Emergency Department are all targeted for case finding. Outpatients are invited by letter to attend for DXA and Bone Health assessment. In–patients are visited by one of the Osteoporosis team, assessed and invited for DXA and Bone Health assessment. An individual management plan is then produced for implementation in primary care. In all cases, the GP is alerted that the patient has had a recent fracture.

**Medway Community Healthcare Community Falls Service**

The MCH Falls Prevention Service is provided by a multiprofessional team which can take referrals from any health professional as well as self-referrals.

On initial referral the patient is contacted by Falls Multi Professional team member, who could be either a Nurse, Occupational Therapist or, Physiotherapist. Each patient will then be triaged and assessed according to clinical need and a personalised treatment plan will be agreed with the patient. Patients can be seen in either their own home environment or in a clinical setting according to their individual circumstances.

Complex cases are referred to a secondary care geriatrics consultant.

**Rapid Response**

The Rapid Response Team is jointly funded by Medway Community Healthcare and Medway Council and consists of two teams:

1. Admission Avoidance (hospital-based) team
2. Community based team

The teams assists patients who have fallen or are at risk of falls and help to assemble a care package that may involve integrated working with other health and social care professionals. The care package is tailored to the individual needs of each patient, and can include:
• Social care arranged through a care manager
• Nursing care
• Rehabilitation from occupational and physiotherapists
• Group exercise programme

The Rapid Response team can be involved in patients’ care for up to six weeks, in the patient’s own home or place of residence. The Rapid Response service does not accept patients who have been diagnosed with dementia or who are confused—Medway Community Healthcare provides a separate dementia support service for people with dementia who live at home and their carers.

**Exercise programmes**

**Medway Community Healthcare Falls Service**

Following an initial assessment by the Medway Community Healthcare Falls Team, appropriate patients may be considered to commence a tailored programme of exercise classes which aim to build strength, balance and confidence. The course consists of 12 sessions over a 12 week period, with the opportunity to attend a further class if deemed to be required following assessment or progressed to the next level of programme if appropriate. For house bound patients a tailored programme based upon the same principles of the taught group sessions will be provided in the patient’s own home.

- Chair Based Exercise
- Otago
- Postural Stability

Exercise programmes are currently held at various locations across Medway, including:

- Lordswood Healthy Living Centre
- Rochester Healthy Living Centre
- St. Bartholomew’s Hospital, Rochester
- Twydall church hall

**Medway Council Health Improvement Team Exercise Referral Scheme**

The Health Improvement Team within Medway Council’s Public Health Directorate offer an exercise referral programme to which residents of Medway with a wide range of medical conditions can be referred by their GP, practice nurse or other health professionals (such as the MCH Falls Team). People living with a long-term health condition are eligible for the programme, which is delivered across Medway Council’s leisure centres. A risk classification tool is used to determine eligibility for the programme, with individuals classified as medium or high risk being deemed suitable. Low risk clients are referred directly to a host of community activity sessions, including walking and cycling groups, exercise, sport and dance classes.
The programme consists of a 12-week course of physical activity sessions. There is a small charge for each activity session, with participants offered the choice of gym or class-based sessions.

Since the service was launched in 2010, 29 referrals have been received with the primary referral reason being stated as ‘falls prevention’, with 13 referrals coming directly from MCH’s Falls Prevention Team, 7 referrals from Primary Care and the remainder from social care, physiotherapy and other public health colleagues.

A large proportion of individuals referred to the programme are older people and often state falls prevention as a key reason for attending. Balance training is therefore built in, where possible, into the gym and class-based programmes.

Projected service use

The projected number of falls admissions has been calculated by applying the admission rates (by five-year age band and gender) observed over 2010–2012 to ONS population projections for 2013–2021. This methodology assumes that admission rates in the baseline period will remain constant in future years.

*Table 1: Projected numbers of hospital admissions for fractured neck of femur resulting from falls and for all falls, Medway patients aged 50 years and above Source: Medway Public Health Intelligence Team, April 2013.*

<table>
<thead>
<tr>
<th>Year</th>
<th>Admissions for fractured neck of femur</th>
<th>Admissions for all falls</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>120</td>
<td>1217</td>
</tr>
<tr>
<td>2008</td>
<td>131</td>
<td>1198</td>
</tr>
<tr>
<td>2009</td>
<td>145</td>
<td>1496</td>
</tr>
<tr>
<td>2010</td>
<td>168</td>
<td>1490</td>
</tr>
<tr>
<td>2011</td>
<td>155</td>
<td>1613</td>
</tr>
<tr>
<td>2012</td>
<td>144</td>
<td>1260</td>
</tr>
<tr>
<td>2013</td>
<td>163</td>
<td>1519</td>
</tr>
<tr>
<td>2014</td>
<td>165</td>
<td>1544</td>
</tr>
<tr>
<td>2015</td>
<td>169</td>
<td>1579</td>
</tr>
<tr>
<td>2016</td>
<td>173</td>
<td>1614</td>
</tr>
<tr>
<td>2017</td>
<td>179</td>
<td>1662</td>
</tr>
<tr>
<td>2018</td>
<td>185</td>
<td>1708</td>
</tr>
<tr>
<td>2019</td>
<td>190</td>
<td>1755</td>
</tr>
<tr>
<td>2020</td>
<td>195</td>
<td>1801</td>
</tr>
<tr>
<td>2021</td>
<td>201</td>
<td>1852</td>
</tr>
</tbody>
</table>

Table 1 shows that the overall percentage change from the 2010–2012 baseline in projected number of hospital admissions for hip fractures resulting from falls in Medway patients aged 50 years and above is 29% by 2021. For all falls related admissions in Medway patients aged 50 years and above the percentage change from baseline is 27%. Years beyond 2012 are projected numbers.
**Evidence of what works**


**User views**

**Community Falls Service (Medway Community Healthcare)**

A survey was carried out in 2012 by Medway Community Healthcare with the aim of assessing the patient experience of the Community Falls Service. The survey response rate was 33%. The overall rating of the service was 96%. 95% of service users reported that they had been treated fairly by the service.

The friends and family test is a national validated patient experience outcome measure which enables local and national comparisons to be made across services. The test produces a percentage score between -100 to +100. Medway’s Community Falls Service scored 60% (“excellent”) for quarter 2 of 2012.

The overall percentage positive experience score for 2011/12 and 2012/13 was over 96%.

The following comments were made by service users completing the survey and have led to Action Plan recommendations:

- Inadequate information given to patients regarding the service before their appointment
- Patients are not offered a copy of their treatment plan
- Patients are finding it difficult to contact the service

Plans are now in place to address the above comments.

**Exercise Referral Service (Medway Council, Public Health Directorate)**

All patients using the service, including falls patients, are asked to complete a patient experience survey on completion or discharge from the service. A general review of
survey responses is undertaken quarterly with a detailed review taking place annually. Key performance indicators used by the service include the following:

- Adherence (% of patients attend the first session who complete the course)
- % of patients reporting an increase in their physical activity level on completion/discharge compared with baseline
- Change in self-reported wellbeing score on completion of course compared with baseline score

For 2012/13:

- Adherence was 50%
- 79% of people were more physically active on discharge from the course compared with baseline
- 62% patients had an increase in their wellbeing score on discharge from the course compared with baseline.

Recommendations from service users for improvement in 2012 focused mainly on issues relating to the venues used for the exercise classes. These recommendations have been actioned where possible by the Exercise Referral Team.

**Recommendations**

- Projected increases in the burden of falls and falls-related injury together with fewer resources available for health and social care mean that falls and falls prevention should be a priority issue for commissioners and providers.
- A Medway Falls Strategy should be developed and implemented as a framework for consideration of the whole falls care pathway by commissioners.
- Falls should continue to be included as a topic within the JSNA and the findings should be brought to the attention of the Health and Wellbeing Board.
- Effective falls prevention schemes can be implemented at little cost with the involvement of professionals working in health, social care and in the community. The majority of falls in Medway occur in the home or in residential care settings, highlighting the need to examine the existing provision of home safety information in the community and the need for a better understanding of falls prevention activities within care settings. All care homes should have falls prevention strategies in place, the objectives of which should include more robust recording and reporting of data on falls.
- Commissioning of the enhanced falls pathway and falls fast track clinic
- Service users should have greater involvement in service development and monitoring.
- Audit of the accuracy/appropriateness of coding for falls related admissions
Further in depth analysis of falls data, including data on A&E attendances and locations of falls in the community, is required in order to achieve a better understanding of the pattern of falls across different groups and different settings in Medway.

Detailed mapping of all falls services delivered across all sectors and organisations in Medway, including the voluntary sector, should be undertaken.

Falls Prevention should also consider the wider environment, for example, through partnership working with town planners to ensure that the risk of falls to older people is taken into account.

### Learning disabilities

#### Summary

The Learning Disabilities Observatory describes learning disabilities as “significant and widespread difficulty in learning and understanding that has been present since childhood.” The term learning disabilities does not include specific learning disabilities such as dyslexia, specific social/communication difficulties such as Asperger’s syndrome or significant and widespread difficulty in learning and understanding that are acquired in later life.

#### Who’s at risk and why?

There is much published evidence relating to the poorer health and health outcomes faced by those with LD.

Within information provided to support the national Joint Health and Social Care Self Assessment Framework (as published by the Public Health Observatory) it is referenced that people with learning disabilities are 58 times more likely to die before the age of 50 than the general population (Hollins et al 1999). Continuing to explain some of the history behind this the Observatory highlights that people with learning disabilities are disadvantaged by:

1. Greater risk of exposure to social determinants of poorer health such as poverty, poor housing, unemployment and social disconnectedness.

2. Increased risk of health problems associated with specific genetic, biological and environmental causes of learning disabilities.

3. Communication difficulties and reduced health literacy.

4. Personal health risks and behaviours such as poor diet and lack of exercise.

5. Deficiencies relating to access to healthcare provision.
The level of need in the population

Work is currently being undertaken in Medway to look at learning disabilities in depth. The new Joint Health and Social Care Self-Assessment Framework (JHSCSAF) replaces the Valuing People Now Self-Assessment and the Learning Disability Health Self-Assessment. All Local Authority areas are required to complete the self-assessment working with their local partners including Clinical Commissioning Groups. Please follow the link to the Joint Health and Social Care Self-Assessment Framework for more information.

There is good evidence that, across the country, patients with learning disabilities have more health problems and die at a younger age than the rest of the population.

Since April 2008 GP practices have been supported to identify Learning Disability patients aged 18 or over with the most complex needs and to offer them a health check. The rationale is to target people with the most complex needs and, therefore, at highest risk from undetected conditions (usually people with moderate to severe learning disabilities) and to develop a health action plan for them. From the prevalence figures available, it is estimated that approximately 240,000 patients fall into this category across the country.

In January 2014 there were 901 patients aged 18 years and over with a learning disability in Medway of whom 585 were identified as benefiting from eligibility for an annual healthcheck. In 2012/13 43% of eligible learning disability patients received a healthcheck. A range of actions are in place to increase uptake in 2013/14 including automatic prompts when a patient’s record is opened at their GP practice and an easy read invite letter is under development.

People with learning disability have been identified as attending national screening programmes (bowel/breast/cervical/abdominal aortic aneurysm/diabetic retinopathy) less often where compared to the general population. A Kent and Medway policy is in place to support equitable access, reasonable adjustment and good access to cervical screening services. This good practice should be duplicated for other screening programmes also.

For more information on national screening programmes, click here

Current services in relation to need

Primary service provision for people who have a learning disability is the same provision as for the general Medway population, but with the expectation that providers make reasonable adjustment to the way that service is provided to enable equal access. Two examples of reasonable adjustments are allowing longer appointment times for patients with learning disability and providing information in "Easy Read". This approach defines much of the focus with regard to learning disabilities to ensure that those with learning disability are supported to access care services and that they are not disadvantaged as a result of their learning disability.

In support of the above Medway Community Healthcare adult learning disability (health) team supports access to health care for people who have a learning disability
and a Medway GP, and who can't manage adequate access to health care by themselves or through their carers. The team works closely with mental health learning disability professionals locally, and with social services and hospital teams. The teams support includes expert assessment of needs, advice and therapy training, and practical support too.

A Learning Disability Liaison Nurse (LDLN) has been in post at Medway NHS Foundation Trust since April 2010. The LDLN's work is focussed in areas where care of patients with learning disabilities is high. Medway NHS Foundation Trust actively identify learning disability patients admitted for care enabling the LDLN to focus support where it will be of greatest benefit. The LDLN also delivers training to improve awareness of learning disabilities amongst all ward staff.

A Partnership Commissioning Team has been established between Medway Council and Medway Clinical Commissioning Group which works across health and social care in order that a whole systems approach to commissioning can be adopted to deliver improved outcomes, risk management and effective investment to meet local need. The Partnership Commissioning Team leads on learning disability services.

Medway Council provides a free bus pass scheme for those with specified disabilities to travel off-peak, not just within the Council area, but around England. The Council also provides home to school transport which supports those wanting to remain in education.

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

The Learning Disabilities Observatory highlights the expectation that over the next 20 years we will see an increase in the number of people with learning disabilities and that by 2030 the number of people aged 70 and over with learning disabilities will more than double. This is expected to be accompanied by an increase in the complexity of needs as young people with learning disabilities with extremely complex needs are now living well into adulthood.

**Evidence of what works**

The Public Health Observatory has published a number of reports investigating the health inequalities faced by people with learning disability that can be accessed here.

Key recommendations from these reports are to:

- Reduce exposure to health harms for people with learning disabilities
- Increase the uptake of annual health checks
- Ensure there is equitable access to screening (eg cervical)
- Support carers in understanding the health needs of people with learning disabilities
- Make reasonable adjustments to health services
• Address avoidable death inequalities

**User Views**

During 2013, Medway Clinical Commissioning Group (MCCG) held three engagement events to gain the views of those with learning disabilities/parents or carers of those with learning disability. The events gave MCCG an opportunity to explain what they do and to seek views of the attendants regarding what is working well and what needs to be improved in Medway. The key messages from attendants were:

• People were keen to understand more regarding mental capacity, decision making, equality and reasonable adjustments

• It was felt that greater use should be made of easy to read information/letters

• The importance of making reasonable adjustments was flagged with regard to longer appointments, time to talk, reminders/texts

• Improve the availability of healthcare checks

• Communication about learning disabilities can be improved across all providers

Engagement with Medway LD representatives identified the desire for and the potential to increase the use of easy read appointment letters.

In the 2012/13 Adult Social Care Survey, 48% of participants with learning disabilities said they had adequate control over their daily lives and 52% said they had as much control as they would like. Nobody said they were dissatisfied overall. In response to the question on feelings of safety, 83% said they felt as safe as they would like to feel, 15% said they felt generally safe and 2% said they felt less than adequately safe. 100% agreed that Adult Social Care services help them to feel safe though.

In the 2012/13 Carer's survey, of those who care for someone with a learning disability:

• 64% were extremely, very or quite satisfied with the support or services they receive. 12% were fairly, very or extremely dissatisfied.

• The ratio of carers responding positively or negatively to the ease of finding information was exactly 50:50, indicating an area for improvement.

**Unmet needs and service gaps**

Medway participates in the learning disability self assessment framework that enables health and social care organisations to review how well learning disability services reflect best practice recommendations. Medway’s 2013 Self Assessment Review identified key areas as the focus for change in 2014, namely:

• Developing Clinical Commissioning Group capture of demographic/needs information.
• Ensuring that GPs notify other healthcare providers of a patient’s learning disability status when referring them. This is key in enabling receiving healthcare providers to make reasonable adjustments in advance of patients attending for care.

• Support increased uptake of health checks and associated health action plans to improve the way that GPs pro-actively manage patients’ health needs to try and avoid medical problems from developing and/or to offer earliest intervention to prevent medical conditions from worsening.

• Reduce inequalities in access to national screening programmes between those with a learning disability and those without.

Recommendations
• Consider the recommendations from ‘Health Inequalities and People with Learning Disabilities in the UK: 2010’ and the views of the MCCG engagement, combined with the findings of the JHSCSAF.

• Address the unmet needs detailed in the Unmet Needs and Service Gaps section.

Further needs assessments
Intend to continue participating in the annual self-assessment framework.

Domestic Abuse

Summary
Domestic abuse is defined by the Home Office as any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 years old or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

• psychological
• physical
• sexual
• financial
• emotional

The definition from the Home Office includes so called ‘honour’ based violence, female genital mutilation (FGM) and forced marriage. It does not confine victims to gender or a particular ethnic group.
More than 1 in 4 women and more than 1 in 7 men have experienced domestic abuse since the age of 16 in England and Wales [246]. Women are more likely than men to experience domestic abuse. This was true for all types of domestic abuse, other than non-sexual family abuse (year ending March 2017) [246]. National research has found that nearly 1 in 4 young people witnessed at least one type of domestic violence during childhood [247].

Under-reporting makes it difficult to gain a complete picture of the extent of domestic abuse. The most comprehensive national data comes from dedicated sections of the Crime Survey for England and Wales. Findings from the year ending March 2017 estimated that there were 1.2 million female victims of domestic abuse and 713,000 male victims [246].

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NICE guidance on domestic violence and abuse was published in February 2014, which covers planning and delivering multi-agency services for domestic violence and abuse. It aims to help identify, prevent and reduce domestic violence and abuse among women and men in heterosexual or same-sex relationships, and among young people [248].

The Kent and Medway Domestic Abuse Strategy (2016-2020) has been developed and the key objectives are listed on page 22. A Kent and Medway domestic abuse strategic group exists and oversees the implementation of the strategy. The strategy group is a multi-agency partnership that has the aims of reducing domestic abuse and changing attitudes. The group plans on meeting these aims by increasing knowledge and understanding of the impact of domestic abuse across communities and agencies, highlighting the fact that it is everyone’s responsibility to tackle domestic abuse whilst emphasising the effectiveness of early identification and intervention.

Table 1: Key objectives of Kent and Medway Domestic Abuse Strategy

<table>
<thead>
<tr>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing violence and abuse</td>
</tr>
<tr>
<td>Provision of services</td>
</tr>
<tr>
<td>Partnership working</td>
</tr>
</tbody>
</table>
Pursuing perpetrators, supported by commissioning frameworks

Take effective sanctions against perpetrators and support sustainable behaviour change, to reduce re-offending.

Risk assessment is based on structured professional judgement. It structures and informs decisions that are already being made. It is only a guide/checklist and should not be seen as a scientific predictive solution. Its completion is intended to assist professionals in the decision making process on appropriate levels of intervention for victims of domestic violence.

The Domestic Abuse, Stalking and Harassment and Honour Based Violence Risk Identification, Assessment and Management Model (DASH) was established in 2009 and allows relevant agencies to use a common checklist for identifying and assessing risk, which will save lives. The tool allows different levels of risk to be identified. These include high, medium and standard:

- **High Risk:** There is imminent risk of serious harm. The potential event is more likely than not to happen imminently and the impact could be serious. There may be need for immediate intervention. It may be necessary for agencies to notify the Police and/or Children and Young People’s Services immediately, without the consent of the victim. Where any agency assesses risk as ‘High’ an immediate referral to multi-agency risk assessment conference (MARAC) is normally required, with or without consent.

- **Medium Risk:** There are identifiable features of risk or serious harm. This level of risk should be referred to the local specialist domestic violence and abuse ‘Outreach’ services with the consent of the individual.

- **Standard Risk:** While risk indicators may be present, it is deemed neither imminent, nor serious. Action should involve advice stating that nobody needs to live with domestic violence and abuse and that there is support out there.

**Key issues and gaps**

- A rolling programme of training that is quality assured and embedded within organisations to ensure frontline staff in services are trained to recognise the indicators of domestic violence and abuse and can ask relevant questions to help people disclose their past or current experiences of such violence or abuse.

- Implement a risk assessment tool that considers the needs of children and promotes a think family approach.

- Interventions for perpetrator need to be more widely available in Medway.

- DASH tool is victim focused and as such does not consider the needs to children who may be living with domestic abuse.

- Help people who may find domestic violence and abuse services inaccessible or difficult to use. This includes people from black and minority ethnic groups or with disabilities, older people, transgender people and lesbian, gay or bisexual people. It also includes people with no recourse to public funds.
• Improve the level of support to victims of domestic abuse. This should include ensuring that multiple needs are also taken into account (i.e. mental health, substance misuse, parental/child disabilities).

• The need to ensure that learning from domestic homicide reviews is disseminated to frontline practitioners.

**Recommendations for commissioning**

• Community based perpetrator programmes need to be prioritised in Medway.

• Ensure that the needs of children affected by domestic violence perpetrated by parents as well as within their own relationships are identified and met.

• Quality assured training package to be rolled out as part of domestic abuse champions programme to ensure consistency across single agencies.

• An integrated pathway should be developed for identifying, referring (either externally or internally) and providing interventions to support people who experience domestic violence and abuse, and to manage those who perpetrate it.

**Who’s at risk and why**

**Gender**

Women are much more likely than men to experience domestic abuse. The findings from the year ending March 2017 Crime Survey for England and Wales (CSEW) estimated that there were 1.2 million female victims of domestic abuse and 713,000 male victims [246]. Nationally, women are much more likely to be high-risk victims, indicated by the fact that they account for 95% of all multi-agency risk assessment conference (MARAC) referrals [249].

For male and female victims of partner abuse, there was no significant difference between being abused once or more than once (18% and 14% respectively for males and 17% and 16% respectively for females). The level of repeat victimisation is not statistically different between men and women. It is likely that any difference between men and women are now being masked, as 70% of respondents did not provide an answer when asked how many times they had experienced abuse in the last year [250].

In England and Wales, the most prevalent age group for male victims is 16-24 year olds, with 16-19 year olds at greatest risk [246].

Pregnant women can be particularly vulnerable to domestic abuse. McWilliams and McKiernan (1993)[251] found that 30% of domestic violence cases start during pregnancy and mothers who suffer domestic abuse during pregnancy are at an increased risk of having low birth weight infants, miscarriage or stillbirth, and are more likely to have abortions.

**Age**

Younger women: Women aged between 16 and 19 and between 20 and 24 were more likely to be victims of any domestic abuse (10.5% and 9.6% of the respective
population) compared with those aged between 50 and 54 and between 55 and 59 (6.4% and 5.6% respectively)[246].

Children and young people: Domestic abuse is a child protection issue and children can experience abuse both directly and indirectly. Nearly 1 in 5 11-17 year olds were exposed to domestic violence in 2009 [252]. The Home Office estimate that three quarters of a million children witness domestic abuse every year and that three quarters of children living with a child protection plan live in households where domestic violence occurs [253]. Domestic abuse can have an impact upon a child’s emotional, behavioural and cognitive development. Its effects can include anxiety, fear, withdrawal, highly sexualised and aggressive behaviour, reduced educational attainment, failure to acquire social competence, anti-social behaviour and also, in some cases, the use of substances.

Older people: Older people may become more vulnerable due to a range of factors that include poor quality long-term relationships, a carer’s inability to provide the level of care required, and a carer with mental or physical health problems who feels under stress within the caring relationship. Elder abuse can present in several different forms including physical abuse, sexual abuse, emotional abuse, financial exploitation and neglect.

Lesbian, Gay, Bisexual and Transgender (LGBT)

Lesbian and bisexual women experience domestic violence and abuse at a similar rate to women in general (1 in 4), although a third of this is associated with male perpetrators [254]. Compared with 17% of men in general, 49% of gay and bisexual men have experienced at least one incident of domestic violence and abuse since the age of 16. This includes domestic violence and abuse within same-sex relationships [255].

Ethnicity

National data from the year ending March 2017 CSEW shows no significant difference in the risk of domestic abuse by ethnicity [246]. However, women from ethnic minorities may have greater difficulties in accessing services due to language, inter-generational issues, and cultural differences. It is difficult to estimate the prevalence of so-called 'honour' based violence and forced marriage, but we do know that the incidences of both are under-reported. Both can occur in Christian, Jewish, Sikh, Hindu, Muslim and other communities. They are probably more common in some groups, for example, some Pakistani, Kurdish, and Gypsy and Traveller communities, reflecting a more oppressive patriarchal ideology [256][257].

Socio-economic Status

Domestic abuse occurs across society in all social classes. However, reported domestic abuse is more closely associated with those in the more deprived communities. Domestic violence can also lead to poverty as it can create instability, difficulties in maintaining employment and increases in ill health.

Disability

Those with a long-term illness or disability were more likely to be victims of any domestic abuse in the last 12 months than those without a long-term illness or
disability. This was true for both men (7.3% compared with 3.9%) and women (15.7% compared with 6.2%) in the year ending March 2016 [258]. Issues facing disabled women can make it harder for them to access support. They may be more physically vulnerable and socially isolated than other women relying heavily on the abuser for basic care needs and access to the wider community [259].

**Substance misuse**

A UK study showed that 51% of respondents from domestic violence agencies claimed that either themselves or their partners had used drugs, alcohol and/or prescribed medication in problematic ways in the last five years [260]. A number of studies have found that the perpetrators use of alcohol, particularly heavy drinking, was likely to result in more serious injury to their partners than if they had been sober [261].

A victim’s substance misuse may effect or be affected by their experience of domestic abuse. This may also lead them to become a perpetrator of domestic abuse or cause them to suffer from further domestic abuse in the future.

Gilchrist et al, 2003 [262] found that from 336 convicted offenders of domestic violence, alcohol was a feature in 62% of offences and 48% of offenders were alcohol dependent.

**Level of need in the population**

The Violence Against Women and Girls ‘Ready Reckoner’ uses findings from the British Crime Survey to estimate the prevalence of domestic violence, sexual violence and stalking in an area [263]. Using ONS mid-year 2016 population estimates [264], the numbers of women likely to have been affected in Medway in 2016 have been calculated (Table 1) out of a population of 140,280 females.

Table 1: Estimated domestic abuse numbers for women aged 16-59 in Medway using ONS mid-year 2016 population estimates

<table>
<thead>
<tr>
<th>Estimated number</th>
<th>Margin of error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women and girls aged 16-59 have been a victim of domestic abuse 9118 1830</td>
<td></td>
</tr>
<tr>
<td>Women and girls aged 16-59 have been a victim of sexual assault 4629 1</td>
<td>472</td>
</tr>
<tr>
<td>Women and girls aged 16-59 have been a victim of stalking 11307 2</td>
<td>251</td>
</tr>
</tbody>
</table>

These estimates are necessary because of the relatively high proportion of domestic abuse that is not reported. These estimates are only for women, but national data suggests that around one third of victims are male. Using the data from Table 1, it is estimated that there were around 11,800 male victims in Medway in 2016.
In 2017/18 there were 5,162 crimes and 2,770 secondary incidents (not amounting to a notifiable offence) related to domestic abuse, resulting in a total of 7,932 reports. There were 3,498 female victims and they accounted for 74% of the total reports. There were 1,458 male victims and they accounted for 26% of the total reports. 1,911 of the reports were repeat victims (24%).

Table 2: Medway Domestic Abuse Service Data [265]

<table>
<thead>
<tr>
<th></th>
<th>Qtr 4 2016/17</th>
<th>Qtr 1 2017/18</th>
<th>Qtr 2 2017/18</th>
<th>Qtr 3 2017/18</th>
<th>Qtr 4 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of cases</td>
<td>157</td>
<td>127</td>
<td>161</td>
<td>137</td>
<td>157</td>
</tr>
<tr>
<td>discussed at MARAC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of repeat cases</td>
<td>48%</td>
<td>45%</td>
<td>32%</td>
<td>26%</td>
<td>38%</td>
</tr>
<tr>
<td>seen at MARAC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of clients</td>
<td>155</td>
<td>145</td>
<td>143</td>
<td>169</td>
<td></td>
</tr>
<tr>
<td>seen at One Stop Shop</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| The proportion of females seen at the One Stop Shop is over 90%. The proportion of repeat victims in the preceding 12 months varies in different quarters and ranges between 17.3%-31.4%. For the year 2017/18, the overall percentage of repeat incidents is just below 35%. The number of cases discussed at MARAC ranged between 127-161 per quarter.

In 2017/18, there were 531 victims of domestic abuse referred to Independent Domestic Violence Advisors (IDVAs) in Medway. They have engaged 89% of all referrals which is higher than the benchmark set by Coordinated Action Against Domestic Abuse (CAADA).

- In the year ending June 2017, for every 100 domestic abuse crimes recorded, there were 58 arrests in Kent and Medway. Compared to 40 other forces, Kent Police ranked as having the 6th highest rate [266].

- Kent and Medway recorded 20,969 domestic abuse-related crimes between in the year ending March 2017 [266].

Current service in relation to need

Multi Agency Risk Assessment Conferencing (MARAC)

The role of the MARAC is to facilitate, monitor and evaluate effective information sharing to enable appropriate actions to be taken to increase public safety. It combines up to date risk information with a comprehensive assessment of the victim’s needs and links those directly to the provision of services for all those involved in a case: victim, children and perpetrator. The victim does not attend the meeting, nor does the perpetrator or the crown prosecution service. The victim will be represented by the Independent Domestic Violence Advisor (IDVA).
The MARAC coordinator is currently funded by Kent Police. The Medway MARAC is supported by multi agency partners across Medway including Kent Police, Children’s Social Care, Kent Probation, Adult Social Care, Mental Health, Housing and both statutory and voluntary partners. They provide joint multi-agency, safety planning for victims assessed as being high risk. The MARAC is overseen by a Kent Police employed MARAC Supervisor and governed by the multi-agency Domestic Abuse Tactical Group.

The MARAC receives multi-agency referrals, this fluctuates during the year but on average Kent Police referrals account for 78% of them. In 2017/18, the repeat victimisation rate was 34%, which is above the benchmark set by Coordinated Action Against Domestic Abuse (CAADA) of 28% but within the range of 28-40% repeat cases suggested by SafeLives nationally. The MARAC is at capacity, discussing on average 145 cases per quarter for 2017/18 - this is significantly higher than the 2013/14 figures of 87 cases per quarter. The higher numbers may be reflecting the change in delivery model whereby Medway moved to a weekly meeting rather than the monthly meetings that take place across Kent.

The MARAC in Medway, unlike other MARACs in the county, are held on a weekly basis. This change was implemented in 2015 after multi-agency workshops and consultations with partner agencies were held. The core principals of these workshops and consultations were to explore how to improve the overall efficiency and accountability of MARAC, whilst also addressing the ever increasing case load. The MARAC in Medway is extremely well attended and multi-agency representation is appropriately diverse, leading to the Medway MARAC being considered an example of best practice to other MARACs.

**Independent Domestic Violence Advisors (IDVAs).**

Choices deliver the Medway IDVA contract. The IDVAs support victims of domestic abuse through the MARAC process as the independent voice of the victim and provide support through the Specialist Domestic Violence Court (SDVC), One Stop Shops (OSS) providing risk assessments, individual safety support plans (ISSP), multi-agency working and developing action plans for both the victim and children. The IDVAs also support a newly established Kent Police domestic abuse board which works to support medium risk victims not eligible for MARAC referral.

In 2017/18, the IDVA service received 531 referrals which resulted in an 89% engagement rate. In 2017/18, 84% of clients reported a feeling of reduction in risk, which is a successful outcome against the CAADA benchmark of 63%.

**One Stop Shop (OSS)**

The OSS is overseen by Medway Domestic Abuse Forum and is part funded by Medway Community Safety Partnership. Based at the Sunlight Centre and well established within the community, this offers anonymity for clients and offers free, practical support from a range of agencies. Operating on a Tuesday morning, any victim of domestic abuse can access the service and speak to multi-agency partners. These include an IDVA, Health Visitor, Floating Support Worker, Solicitor and Citizens Advice Worker for welfare, housing and debt. Further agencies are currently being identified to support the OSS. The Kent Fire and Rescue Service now support the OSS, providing advice and direct
referrals to their home safety assessment. This is a strength-based approach, promoting empowerment of individuals and providing practical and emotional support.

**Freedom Programme**

The freedom programme is a 12-week nationally recognised programme, which offers an insight into the behaviour and tactics of the abuser. Medway has consistently offered all victims of domestic abuse a place on a course, currently funded by Medway Council and operated through All Saints Children’s Centre.

**Support2Court**

Sateeda successfully bid for a Tampon Tax grant. This will provide funding to deliver a Support2Court programme, which includes Medway courts, and supports those who are attending family court without a legal representative. This reduces the need for a support worker or IDVA to attend, therefore reducing their workload.

**Domestic Homicide Reviews**

Lessons Learnt Seminars take place to share learning from some of the Domestic Homicide Reviews (DHRs) that have been commissioned and completed by the Medway and Kent Community Support Partnership (CSP), since they became a statutory requirement in April 2011. These events are aimed at frontline practitioners and/or those agencies that may come into contact with or deal with victims of domestic abuse. The seminars enable attendees to have the chance to hear from the Independent Chairs, who present their key findings and discuss the recommendations from each review and any lessons learnt. Multi-agency partners also hear from some of the key agencies who have contributed to the reviews about what they have done in response to the recommendations.

Three seminars took place in 2017/18. The most recent DHR Lessons Learnt Seminar was well attended by multi-agency partners across Medway and Kent and provided an opportunity to share good practice as well as learn from previous lessons. The Kent and Medway Domestic Homicide Review Steering Group retains ownership of all county DHR’s and is attended by, and part funded through, the Medway and Kent CSP. The learning from DHRs are disseminated through events across the county and always include a Medway setting.

**Domestic Abuse Notification**

The Domestic Abuse Notification (DAN) was piloted in 2013 and, due to its success, was rolled out in February 2014 throughout Medway. The DAN is received from Kent Police and all domestic abuse is screened by Kent Police staff in the central referral unit. The criteria for this are as follows:

- **High risk domestic abuse**: Children up to the age of 17 are shared via an urgent DAN direct to children’s social services.
- **Medium risk domestic abuse**: Children up to the age of 17 years are shared via DAN.
- **Standard risk domestic abuse**: Children unborn and up to 1 year are shared via DAN.
The information on the notification includes the child and siblings' details, parental details and others involved in the situation, details of the incident, any additional information or concerns, previous relevant history and the current situation.

**Domestic abuse Awareness for Youth (DAY) programme**

DAY is a unique multimedia programme that uses short films, advertisements and chart music to raise awareness and provide education about domestic abuse and child sexual exploitation in a relevant and exciting way. It challenges detrimental mindsets about abuse and exploitation, explores how beliefs inform behaviour, and looks at the role of the media in reinforcing unhealthy beliefs.

It is based on the Freedom Programme and is designed to be used with young people over the age of 14, although it can be adapted for use with young people over 11 years. DAY is delivered by Medway Council Integrated Family and Youth Support Service.

**Victim Support**

Victim Support has specialist teams that deliver tailored support to help people recover from the effects of crime and traumatic events. Victim Support helps anyone affected by crime, not only those who experience it directly, but also their friends, family and any other people involved. Victim Support is an independent charity, so clients can talk to Victim Support whether or not they reported the crime to the police, and their support is free and confidential.

**Training**

Multi-agency training on domestic abuse is delivered by the MCSB (Medway Safeguarding Children Board). A full day’s multi-agency training focuses on domestic abuse, prevalence, elder abuse, children witnessing domestic abuse, teenage domestic abuse and forced marriage and honour based violence. Following on from this training, participants can opt for a further half a day training on using the DASH domestic abuse, stalking, harassment and honour based violence risk assessment tool.

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

Domestic abuse-related incidents and crimes for Kent and Medway appears to have increased over the last three years from 19.8 cases per 1,000 population (14/15) to 24.9 per 1,000 population (16/17). However the most recent figure represents a new way of calculating the data and is therefore not directly comparable to previous figures. The rate for Medway is in line with peer comparator areas which range from 18.8 (Plymouth) to 34.3 (Stockton-on-Tees)[267].

Services are currently working at full capacity and this is set to continue with domestic abuse rates rising. Several factors indicate that there could be an increase in the demand for domestic abuse services over the next few years. These include:

- Improved screening and training within various settings is likely to increase the identification of domestic abuse and subsequently the increase need for support.

- Continued changes to welfare including, legal aid, child benefit, housing benefit, universal credit, under-occupancy rules and disability living allowance will have an
impact on women and children affected by domestic abuse, but the extent has not been fully assessed.

- Local authorities across the country are increasingly trying to manage reduced budgets and this is directly affecting the services available to support women and children.
- Technology is increasingly being used as a tool to stalk, harass and psychologically abuse victims.

Local actions should help to mitigate against the potential increase in domestic abuse services. These include:

- Improved early help and interventions for victims, children and perpetrators will counter balance the traditional 'hierarchy of seriousness' which has led to cases categorised as 'low risk' being unable to access statutory services unless they escalate.
- Improved partnership working in relation to Domestic Abuse will result in limited resources being applied more effectively.
- Outcome based commissioning of services will provide an integrated care pathway for victims of Domestic Abuse.

**Evidence of what works**

**Multi-Agency Risk Assessment Conferences (MARAC)**

These are regular meetings at which information about people experiencing domestic violence or abuse and who are at high risk of homicide or serious harm, is shared between local agencies. Whenever possible, the person who experiences the violence is represented by an independent domestic violence adviser or advocate (IDVA). Participants from the various agencies aim to develop a coordinated safety plan to support the person. It was established originally in Cardiff and the evaluation showed that at the six month stage 63% of people were living free from violence and harm and at the twelve month stage this figure had fallen to 42%[268].

**Independent Domestic Violence Advisors (IDVA)**

IDVAs work primarily with people at high risk of domestic violence and abuse, independently of any one agency, to secure their safety and the safety of their children. Serving as the primary point of contact, IDVAs normally work with their clients from the point of crisis to assess the level of risk, discuss the options and develop plans that address their immediate safety, as well as longer-term solutions. A multi-site evaluation of Independent Domestic Violence Advisors[269] found that abuse stopped completely in two-thirds of cases where there was intensive support from an IDVA service including multiple interventions.

**Children affected by domestic abuse**

It is important for agencies to work concurrently with both the non-abusive parent or carer and child, rather than just focusing on the parent. It is also important to ensure
that services are appropriate to the age, gender and developmental stage of the child or young person. For example, teenagers may not want to be seen at the same time as their non-abusive parent or carer.

**Perpetrator programmes**

There is a lack of consistent evidence on the effectiveness of programmes for people who perpetrate domestic violence and abuse. Some evaluations take account of the partner’s health and wellbeing and include their perception of any changes in the perpetrator’s behaviour, but these tend to be small-scale, uncontrolled studies.

**The Rotterdam Code of Conduct for Reporting Domestic Violence and Child Abuse**

This is a step-by-step action plan for care providers and institutions that can be followed where domestic violence or child abuse are suspected or detected[270]. The action plan offers support to carers by making clear what is expected of them. This clarity is not only important for the care provider, but also for providing effective help to the victim and the perpetrator. The reporting code involves five key steps:

**Step 1: Identifying the signs**

**Step 2: Peer consultation and, if necessary, consultation with the relevant counselling body**

**Step 3: Interview with the client**

**Step 4: Assess the information and the risk**

**Step 5: Reaching a decision: organising or reporting assistance**

It was introduced to all care providers and institutions that offered education, shelter, assistance, care or support (e.g. teachers, social workers, doctors, nurses and psychiatric nurses, childcare employees, carers). These organisations became legally required to sign the ‘Code of Conduct’ assigning responsibility onto themselves and their staff to report cases of abuse and suspected abuse. As soon as a care provider started work at an institution that had signed the protocol, the employer was required to ensure that their new employee was capable of effectively following the protocol. Before 2006, approximately 1,200 cases of domestic abuse were recorded each year in the City of Rotterdam. Following implementation of the ‘Code of Conduct’, the number of cases increased to around 6,000 to 7,000 per year. This confirmed that, previously, domestic abuse cases had been severely under-reported and more abuse cases were now being realised. Excluding the increased levels in reporting, the true extent of the effectiveness of the new ‘Code of Conduct’ policy has still yet to be clarified.

**User views**

National research[271] shows that all women think that the NHS (health visitors, GPs, hospitals, dentists, sexual health services, practice nurses) has a vital role in early identification and response to violence – particularly for those who are isolated and therefore more vulnerable – and also should have a key role in supporting and safeguarding women and children. Survivors saw the main issues and barriers to getting the help they needed as:
• healthcare staff not having time to let them disclose violence and see how to meet their needs;
• healthcare staff not knowing what to do with the problems of women who have experienced domestic violence, whether currently or in the past;
• healthcare staff not believing they had a problem, thinking it was part of their lifestyle or culture; and
• healthcare staff listening to accompanying abusive partners or family members instead of to the woman herself, or not understanding violence issues for lesbian and transgender women. Similar issues exist for other groups of women who might have had difficulty in communicating them: older women, women with learning disabilities or mental health issues, and women with language barriers, particularly if dependent on violent partners for translation.

Unmet needs and service gaps
• A consistent programme of training within agencies will ensure frontline staff in services are trained to recognise the indicators of domestic violence and abuse and can ask relevant questions to help people disclose their past or current experiences of such violence or abuse.
• Community based perpetrator programmes need to be in place in Medway.
• Implement risk assessment tools which consider the needs of children living with Domestic Abuse.
• Help people who may find domestic violence and abuse services inaccessible or difficult to use. This includes: people from black and minority ethnic groups or with disabilities, older people, transgender people and lesbian, gay or bisexual people. It also includes people with no recourse to public funds.
• Improve the level of support to victims of domestic abuse. This should include ensuring that multiple needs are also taken into account (ie mental health, substance misuse, parental/child disabilities)
• The need to ensure that learning from domestic homicide reviews is disseminated to front line practitioners.

Recommendations for commissioning
• Community based perpetrator programmes need to be prioritised in Medway.
• Ensure that the needs of children affected by domestic violence perpetrated by parents as well as within their own relationships are identified and met.
• Quality assured training package to be rolled out as part of DA champions programme to ensure consistency across single agencies.
• An integrated pathway should be developed for identifying, referring (either externally or internally) and providing interventions to support people who experience domestic violence and abuse, and to manage those who perpetrate it.

**Recommendations for needs assessment work**

• A detailed needs assessment should be undertaken to fully understand the Medway picture. This could include information regarding the views of service users in terms of how appropriate the current services are in meeting need and exploration of volume of local needs in Black and Minority (BME) groups across Medway and the extent to which cultural issues can act as a barrier in victims seeking support. This should also improve local understanding of specific types of domestic abuse that may be more prevalent in certain communities such as honour based violence and forced marriage.

• Extent of the hidden harm needs experienced by children.

• Greater understanding of the needs in certain vulnerable populations (e.g. veterans and ex-offenders)

**Social Isolation [Update in progress]**

**Summary**

Social isolation occurs when a person has little or no social interaction with other people and society. It is different from loneliness, which is concerned with negative feelings that an individual may have due to of a lack or loss of meaningful social relationships.

Social isolation can affect anyone, although, older people are one group of the population at particular risk. Older people may experience a reduction in household income, loss of a partner and deterioration of physical health. All of which can have an impact on social contact.

The concepts of social isolation and loneliness are frequently used interchangeably but are defined as two distinct concepts. Loneliness’ is a subjective negative feeling of a lack or loss of meaningful social relationships (e.g. loss of a partner or children relocating), while ‘social isolation’ is an objective measurement to indicate a lack of social interaction and relationships caused by loss of mobility or deteriorating health.[272]

It is possible to have very few social contacts or relationships without feeling lonely and conversely individuals can live a seemingly rich social life and feel lonely nevertheless.[273]
Who is at risk and why

Loneliness and social isolation can have a considerable impact on the health and wellbeing of an individual. Loneliness is associated with a range of negative health outcomes including mortality, dementia, high blood pressure, increased stress levels and suppression of the immune system.\[274\] Research has shown that people with stronger social relationships have a 50% increased likelihood of survival than those with weaker social relationships. This difference on survival is comparable with well-established risk factors for mortality such as smoking, obesity and physical inactivity.\[274\]

There are a number of population groups that have an increased vulnerability to social isolation. Older people are significantly more likely to suffer from social isolation with contributing factors being “loss of friends and family, loss of mobility or loss of income”. Other population groups at risk include, carers, refugees and those with mental health problems.\[275\]

Level of need in the population

It is estimated nationally that across the present population aged 65 and over, that 5%–16% are lonely \[276\] and 12% feel socially isolated.\[277\] If this estimate was applied to Medway this would result in an estimate of 4,698 people over 65 years old being socially isolated and between 1,958 and 6,264 people being lonely. Population projections for Medway highlight that the rapid increase in the ageing population, the need to plan for this across all areas of health and social care and the importance of feeling safe within the home to reduce social isolation.

In order to identify the areas within Medway where social isolation is more likely to occur, one data source to consider is the census. A crude way to do this is to use the 2011 Census to calculate the proportion of the population living alone, which can be done separately for those under 65 and those aged 65 years and over. This is a reliable source of data but does not take account of people’s circumstances in terms of health, mood, mobility and engagement with social networks.

Another way to identify areas within Medway where social isolation is more likely to occur is to use modelled estimates based on other data. MOSAIC Public Sector is a tool designed to help understand the characteristics and distribution of different types of people living within an area. It is produced by Experian Ltd and is one of a number of social-segmentation products available on the market today. The classification is built by drawing on a large database of Census and consumer demographic variables. Statistical analysis is used to identify clusters of associated variables to form distinct person types which have similar needs, attitudes or behaviours. Every household and residential postcode in the UK has been classified into a number of ‘groups’ which sub-divide into ‘types’. The underlying premise is that similar people live in similar places, do similar things and have similar lifestyles, although it is important to take account that every individual has a unique set of circumstances and values and not all of the population within a given area may have similar characteristics.
The MOSAIC social segmentation system from October 2013 has been used as the basis of this report. Although updated in 2014, the older version has been used for two main reasons:

1. The background indicators are more relevant to social isolation and therefore provide a better set of proxy measures.

2. The number of households of each MOSAIC type living in Medway was not available at the time of writing the report.

The results are highlighted in figures 2 and 3.

Figure 1: Medway ward map
Figure 2: Relative social isolation per household at lower super output area level of persons under 65.
Figure 3: Relative social isolation per household at lower super output area level of persons aged 65 and over.

Figure 3 shows the estimated proportion of households for people aged 65 years old or over in Medway who are estimated to be socially isolated according to the developed composite index. Areas estimated to have the highest proportion of households that contain socially isolated people aged 65 years old or older include parts of Chatham Central, Peninsula, Princes Park, Rainham South, River, Rochester East, Rochester South and Horsted, Rochester West, Strood Rural, Strood South, Twydall and Walderslade. The map shows the specific communities where the highest proportion of households estimated to be socially isolated are located.

Figure 4 shows the distribution of a measure of health and disability for Medway. The measure includes reduced quality of life that is a result of poor mental and physical health. The areas that have the highest deprivation of health and disability are similar to ones that high levels of overall deprivation and those estimated to have relatively high levels of social isolation per for people aged below 65 years old.
Current services in relation to need

Medway men’s health group

The focus of the group is on reducing the isolation of men. It was established in November 2013 and is supported and facilitated by Rethink. The group meets weekly at the Sunlight Centre, in Gillingham and usually over 20 men attend. The men attending the session feel that they are in a comfortable environment where they can discuss any problems or concerns that they have, receive peer support, and receive health promotion information.

Flexicare housing

Flexi-care housing in Medway is a model of supported accommodation which provides 24 hour care on site and allows older people to live as independently as possible. Flexi-care housing provides an opportunity to preserve or rebuild independent living skills.
which makes independent living possible for people with a range of abilities. Flexi-care is available to older people aged 55 and over including those with sensory needs, mental disorder including dementia, short- or long-term illnesses, and those who require end of life care.

**Befriending schemes**

The Hands & Gillingham Volunteer Centre and Rochester Hands Volunteer Bureau offer befriending schemes to provide support and information to the community and to develop the involvement of other voluntary and statutory organisations. It is offered primarily to elderly or disabled people who have difficulty leaving the house due to their infirmity, and therefore can become isolated.

Suitable befrienders are matched to clients and visit them at home. During the visit, they can chat about everyday issues, enjoy a game of cards or encourage the client to contact old friends again. Befrienders are also able to take clients on days out to local amenities, such as the park or shops, giving them the opportunity to meet others and enjoy the fresh air. Regular contact between the client and befriender can establish a strong bond and encourage participation in community activities to encourage independence.

**Leisure, arts and cultural activities delivered by Medway Council**

There is currently a wealth of activities being offered across Medway including leisure (including physical activity) and education sessions delivered by Medway Adult and Community Learning Service. Medway Sport is working with partner organisations to launch initiatives such as boccia coaching for care home staff and afternoon tea dances. Medway Sport provide the Sports centre senior offer. The over 60s can enjoy a comprehensive timetable of activities at sport and leisure sites ranging from badminton, short tennis and table tennis to short mat bowls, chirobics, walking football and senior step. Most sites also offer a friendly social element with external trips and activities. The Senior Sports programme is also offered to help older people to live better, healthier lives.

Medway Libraries’ host regular groups which bring together a wide range of people who enjoy reading and talking about books

**Activities delivered by volunteer organisations in Medway**

Medway Voluntary Action provides a range of support to help not-for-profit organisations in Medway to assist them to be sustainable and connected. Both the voluntary sector and Medway Council offer a wide range of volunteering opportunities in local communities. Many other voluntary sector organisations such as Carers First and Age UK also support the reduction of social isolation.

The Women’s Royal Voluntary Service (WRVS) has recently opened an information centre for people over 55 in Medway. This is funded mainly by Medway Council, with a contribution from WRVS, the centre offers information and signposting on a range of issues that older people identify as being important to them. The centre is based in Central Chatham and is staffed by a team of local volunteers, led by a centre manager. In addition to the provision of information, the centre also provides the opportunity for older people to learn how to use computers. It has a small community cafe and will
provide the opportunity for other organisations to hold regular ‘surgeries’ when older people can get expert advice on specific issues.

**Projected service use**

**Evidence of what works**

Reducing social isolation and loneliness can reduce the demand for health and social care interventions and the evidence shows that there are a number of interventions that can have a positive impact on reducing social isolation or loneliness, although the quality of the relationships in the interventions is a vital component. Also, some caution is needed when interpreting the research outcomes because there are a variety of populations that may have a different response to interventions (ie those who are very frail, those from different cultural backgrounds).

1. **Befriending schemes**

Butler (2006) found that befriending schemes can have a positive impact on reducing loneliness.[278] Befriending schemes are an intervention, that introduce an individual to one or more individuals, with the aim of increasing additional social support through the development of sustaining an emotion-focused relationship over time. They can include home visits by volunteers or paid workers or telephone or group support and often provided by community or voluntary organisations such as Age UK.

2. **Community Navigators**

Community Navigators are usually volunteers who provide ‘hard-to-reach’ or vulnerable people with emotional, practical and social support, acting as an interface between the community and public services and helping individuals to find appropriate interventions. There is evidence that people who used community navigator schemes became less lonely and socially isolated following such contact (Windle et al 2008).[279]

3. **Supportive group services**

Supportive group services (such as lunch clubs, bereavement support groups), and social group schemes which aim to help people widen their social circles can be effective in reducing loneliness and social isolation. A study by Savikko et al. (2010) showed a support group that offered social group activities (‘art and inspiring activities’, ‘group exercise and discussion’ and ‘therapeutic writing and group therapy’) reported that 95 per cent of the participants (mean age 80) felt that their feelings of loneliness had been alleviated during the intervention.[280] Pitkala et al. (2009) found that group based interventions that included art and cultural activities (eg music sessions, cultural events and sights, and production of their own art) and exercise and health discussion groups, (eg walking, strength training, swimming, or senior dancing) had a significant reduction in measured hospital bed days, physician visits and outpatient appointments.[281] A systematic review by Dickens et al (2011) found that sessions offering social activity and/or support within a group format were effective in alleviating social isolation.[282]
4. Mentoring schemes

Mentoring schemes involve working with people with the goal of providing clients with the necessary skills and abilities to ensure that they are able to continue and sustain any achieved change following withdrawal of the service. There is evidence that mentoring schemes can have a positive impact in improving symptoms of depression and after 12 months follow-up.[277]

There is very limited evidence on the cost-effectiveness of interventions to reduce social isolation or loneliness and it is relatively complex to measure accurately. Knapp et al (2010) demonstrated the economic impact of Befriending Interventions and Community Navigators, compared with what might have happened in the absence of any such service.[283] Along with the costs of ‘formal’ service provision, those unpaid ‘resources’ and ‘opportunity costs’ provided by family and/or informal carers were included. They found that a typical service for befriending would cost around £80 per older person within the first year and provides about £35 in ‘savings’ due to the reduced need for treatment and support for mental health needs. Pitkala et al. (2009) estimated cost-savings of supportive closed groups and found that there was a saving of €62 per person due to a reduction of hospital bed days, physician visits and outpatient appointments.[281] This saving took the cost of the intervention into account.

User views

A total of seven focus groups were undertaken to find out more about the views of population groups in Medway at risk of social isolation. Focus groups were undertaken with older people (Age UK day centre in Gillingham), carers (Carers First support group), mental health service users (MEGAN support group), black and minority ethnic communities (two groups were undertaken, one with the Medway BME Forum and the other with the Medway African and Caribbean Association), residents from Peninsula ward (parents at Grain Sure Start group) and a men’s health support group (weekly group, based at the Sunlight Centre, Gillingham facilitated by Rethink Mental Illness).

A number of key themes emerged from the focus groups that included access barriers influencing isolation, transport, involvement of communities, information, what works well currently and solutions. Key points from these themes were utilised in the development of the first social isolation strategy for Medway 2014-2018.

Equality Impact Assessments

Unmet needs and service gaps

- Identifying people at risk of loneliness can be difficult, but targeting those disproportionately affected by loneliness – lower socio-economic groups, the widowed, the physically isolated, people who have recently stopped driving, those with sensory impairment and the very old – has proven most effective.

- Individuals within local communities should be encouraged to take some responsibility for identifying, ‘reaching out’ and supporting potentially isolated
people within their own area. In order to achieve this, statutory, voluntary and community organisations need to work in partnership to build greater community capacity and better social outcomes for risk populations. The DERIC project which is being piloted in Medway and looks to do this should be supported.

- Reducing social isolation needs to be built into care pathways for a range of different conditions. Health professionals should be mindful of the effects that social isolation have on health and refer into a befriending group or community group.

- We will ensure that we will continue to offer the wide range of high quality services that are currently available across Medway in leisure centres, libraries and adult education centres.

- Ensuring that social isolation is embedded in any relevant future strategies and JSNA chapters.

- There is a need to undertake marketing and promotional work to raise the profile of social isolation in the Medway population.

- There is a need to improve awareness of social isolation via training among frontline professionals that include; health professionals, social care workers, community safety wardens, housing officers, community development workers and floating support staff. The increased knowledge will help them to have an increased awareness of the risks of social isolation and knowledge of how to address it.

- It is important to ensure we utilise opportunities to work with faith groups as partners to identify and support people at risk of being isolated.

- There is a need to utilise the opportunity from public health programmes to target raising awareness for social isolation and signpost people to support and activities. Examples of programmes include health checks, stop smoking, substance misuse.

- It is important to improve the availability of information and advice on existing services and activities that reduce loneliness and isolation. Local authority websites, book and social network groups, sports clubs, art groups, transport links and volunteering opportunities can all help reduce social isolation. It is important to ensure that information on these activities are available in day centres, health centres, schools, youth projects, housing offices and other settings within the local community.

- Evaluation is a key component of any future programmes in Medway. Self-reporting is regarded as the best means of measuring social isolation and loneliness amongst older people. Measurements using valid scales such the Friendship Scale should be utilised. In order to assess whether specific programmes are able to change individuals’ quality of life, or impact on their care pathway, participants need to be asked their views before the start of the intervention as well as following it.
**Recommendations**

- Interventions that have an evidence base of being effective to reduce social isolation, such as befriending programmes, should be considered for further commissioning support.

- Frontline health and social care workers should receive training and information that will help them to have an increased awareness of the risks of social isolation and find ways to connect people to activities or organisations that can help.

- There should be an emphasis to support people to engage with the wide range of opportunities (i.e., leisure facilities, drama groups) in Medway which would address social isolation. A greater understanding of people’s behaviour in terms of what would make them utilise facilities is needed. This could be undertaken via action research.

- To ensure the development of the care navigator programme appropriately signposts the population in Medway to improve the interface between the community and public services in helping socially isolated individuals to find appropriate interventions.

- There is a need to increase the number of supportive groups in Medway, such as the men’s health group operating at the Sunlight Centre to support vulnerable populations at risk of being socially isolated.

**Further needs assessment required**

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