East Kent Health Needs Assessment
2025

Executive Summary

Dr Joseph Deegan, Public Health Registrar, Kent County Council

Stephen Cochrane, Public Health Specialist, Kent County Council

Dr Abraham George, Consultant in Public Health, Kent County Council

Enquiries to: kpho@kent.gov.uk

Executive Summary

1.1. Introduction

Health needs in East Kent are changing. This needs assessment sets out those needs, relevant services, and recommendations to improve health, across several health domains. This executive summary highlights the key findings across health indicators, modelling outputs, and our recommendations.

1.2. Preface

This is a high-level overview of health status and need in East Kent across a range of health domains. These health domains were chosen by a steering group at the outset of the work, as they were felt to have particular relevance to the needs of East Kent. As such, the scope of this work focused on breadth rather than depth.

Findings, analysis, and recommendations can be found in greater depth for several domains in the focused health needs assessments available on the Kent Public Health Observatory website. Omissions are not indicative of lack of importance or need — rather, they are due to the necessarily limited scope of this high-level assessment.

Many of the findings and recommendations from some domains are broadly applicable across domains and services. Commissioners and service-planners can find useful findings and insights across the report, not just confined to chapters related to their work. Analysis of the findings and recommendations are provided here in the executive summary and at the end of the report. Recommendations from each chapter have been extracted in their entirety and are available in the included appendix.

At the time of finalising this report, the 10 Year Health Plan for England has just been published. Several of the findings in the report reflect the strategic aims outlined in the 10 year plan. These are discussed in the recommendation section of this executive summary.

1.3. Key health indicators

- Deaths related to drug misuse is higher than the average for England and for Kent.
- The age-standardised suicide rate has been relatively static since 2018, at approximately 12.5 deaths per 100,000.
- Obesity rates are increasing in East Kent, while the rate of physical activity remains static.
- Osteoporosis rates are rising across East Kent. While hip fractures occur at a greater rate in women than in men, neither group is seeing an increase in their fracture rate as a result of greater osteoporosis prevalence.
- The crude prevalence of dementia in East Kent is greatest in the least deprived IMD quintile, but the age standardised rate is greatest in the most deprived IMD quintile.

- Folkestone and Hythe has the greatest prevalence of dementia in East Kent, at 9.3 cases per thousand population. Ashford has the lowest prevalence, at 7.5 cases per thousand population.
- Smoking rates remain high in routine and manual workers, at 17%. 11% of adults in East Kent are smokers.
- Canterbury has the highest diagnosis rate of gonorrhoea, at 133/100,000 in 2023 — 1.5 times higher than in 2018.
- The positivity rate of STI diagnosis via online testing services are higher in East Kent than in North or West Kent.
- Canterbury sees the highest proportion of deaths occurring at home, at 34.1%. The proportion for the rest of the East Kent is roughly similar, at approximately 30%.

1.4. JSNA cohort model simulation outputs

Multimorbidity will be increasingly prevalent as the population ages and develops an increasing number of comorbidities. In the absence of interventions, multimorbidity is predicted to increase by approximately 27%. By implementing all five interventions, we instead see a reduction in multimorbidity within approximately 10 years. Due to the large incoming 'baby-boomer' generation who are expected to live into older age in high numbers, we expect that the benefits of preventative action will be much more impactful if intervention is undertaken sooner, rather than later.

Most of our interventions see a slowing or decrease in the number of cases of diabetes. A reduction in smoking sees an increase in cases of diabetes, likely due to a greater number of people living longer, allowing for more time to develop the disease. All interventions combined, or the weight loss scenario alone, result in a decrease in cases. This highlights the importance of tackling excess weight through prevention and investment in weight loss services.

Frailty is an important target for public health interventions, as it will account for an increasing proportion of morbidity and mortality as the population ages. Cases of frailty are likely to increase, even in the scenario where all interventions are achieved. This is likely largely driven by the significant increase in the older population, who are at greater risk of frailty. The difference in forecasted cases between the no-intervention and all-intervention scenarios is much greater when looking at severe frailty than mild frailty. This suggests to us that the modelled interventions result in people living longer, and ultimately still becoming frail, but that their frailty will be less severe with our interventions. The overall significant increase despite the interventions show that frailty represents a difficult target to address, and resources should be allocated to prepare for this increase over the next 25 years.

Smoking cessation represents the most important tool in reducing cases of COPD. The forecast shows an apparent increase in case numbers when other scenarios are employed. As with other target conditions, this is likely due to an increase in the population due to increased survivorship of other conditions. As such, there are more people at risk of developing COPD. This is an important reminder that interventions

which aim to reduce mortality will still likely see an increase in morbidity, particularly in the context of an ageing population.

In the absence of intervention, we expect cases of CHD to rise by 12% over the next 25 years. All the interventions show a reduction compared with no intervention. The intervention reducing BMI is particularly effective, however the largest reduction comes from all the interventions together: in this combined scenario we could see 9,000 fewer cases of CHD in 25 years, with a downward trend. The smoking intervention has a large effect but as our intervention does not reach full impact until year 10, we cannot see the full effect of smoking cessation in this model. Smoking cessation may be more important than this chart shows for long-term CHD prevention.

1.5. Health Inequalities

- East Kent's population is older and ethnically diverse than the rest of Kent.
- Age distributions are broadly consistent across deprivation quintiles but vary starkly by ethnicity — Black people and people from mixed ethnicities tend to be younger than Asian and white people.
- Poor health outcomes are disproportionately impacting the most deprived quintile of the population. This is true for several high-impact diseases, as well as for the likelihood of multimorbidity in those under 65 years old.
- While the rate of alcohol related hospital admission is relatively static across deprivation quintiles in women, it varies starkly by deprivation in men - the most deprived men are far more likely to be admitted to hospital for an alcohol-related condition than their least deprived counterparts.
- Depression in adults is more likely in women than it is in men. While true across ethnicities, this relationship is most stark in the white population. However, this may represent differences in the reporting of depressive symptoms by individuals, and in the recording of depression by their medical professionals, rather than true population differences.
- Deaths of despair are far more prevalent in the most deprived people in East Kent than in their least deprived counterparts.
- Those who live in rural villages and dispersed settings see the lowest rates of several conditions. Rural towns and urban cities see higher rates. Coastal areas also tend to see high rates of several health conditions, although the differences are smaller than those seen in the urban and rural divide.
- The strongest difference between coastal and non-coastal communities is in the rate of smokers - those who live in coastal areas are far more likely to smoke.

1.6. Recommendations

This section identifies recommendations and specific actions from across the work carried out during this needs assessment. While specific actions are given as examples from relevant health domains and chapters, the broader learnings are likely relevant for all services. As such, the headline recommendations should be considered across health-planning.

1.6.1. Planning for the future

Our simulation modelling shows that both the population and their health needs are set to grow, even in the face of our most optimistic estimate of the impact of public health interventions. This reality should be recognised, and service adaptation should begin now – expanding their reach and capacity to best serve the population.

The NHS 10 year plan highlights the steps necessary to adapt to this increasing demand, including a focus to the importance of prevention, and devolving power to local places. As a result, expansion of services, local investment in prevention, and further developing services for older adults are made all the more important. While outside the scope of this report, economic modelling (including social return on investment) should be used to plan services and recognise the inevitable demographic shift.

Specific actions

- Investing in early identification and support for perinatal mental health and parent infant relationship challenges for pregnant women, new mums and their partners.
- Reviewing and monitoring the provision for family and carers, across services for both children and older adults.
- Continuing to commission falls services which provide tailored interventions, strength and balance programmes and multifactorial risk assessment.
- Targeting those at risk for hearing loss
- Increasing public awareness of the steps individuals can take to reduce their risk of dementia
- Ensuring services are provided to support family carers of people with dementia

1.6.2. Improving access

The population is increasingly older and more diverse – services should acknowledge this and adapt to provide the best service to all users.

Several of the aims of the 10 year plan will work to improve access and deliver more proximal care, including the role of neighbourhood health centres, ending the 8am scramble, and shifting health spending to out-of-hospital care. It is important that commissioners and local decision makers use this shift to maximally deliver benefits to people in East Kent. Older adults should have their needs recognised and respected, across all services, not just those designed to exclusively serve their needs. Access should be made easy, with options for non-digital solutions. Appointments at times that

are accessible to older adults should also be made available (e.g. due to transport needs), and older adults should be made aware that they can discuss their access needs with administrative staff. Services should also make sure that they are accessible to other demographics, and that anyone who might benefit from their work is made aware of their availability. For example, ensuring that parents who educate their children are aware that that can still access the support services that are available in schools.

Specific actions

- Ensuring parents who home-educate their children are aware of support available to them from school public health workforce.
- Supporting family access services in the most deprived areas to improve health and wellbeing
- Investing to increase capacity in the weight management programme to reduce the gap between demand and supply.
- Ensuring that services, such as the weight management programme, continue to identify high priority target groups, and make services accessible to those groups.
- Increase engagement with specific community groups to increase uptake of stop smoking services
- Reviewing the gap in face-to-face sexual health services in Dover.
- Identifying high risk and comorbid groups across services, and continuing to provide specialised services, e.g. those with complex and treatment resistant diabetes with concomitant mental illness.

1.6.3. Health in all policies

We recognise that good health is created across all policies, not just those labelled as related to health and wellness. The 10 year plan highlights the importance of tackling harmful alcohol consumption through standards for alcohol labelling, Expanding free school meals, and joining up support from across work, health, and skills systems. Placing a focus on the importance of work as a determinant of health is a priority for the Kent Marmot Coastal Programme as well as the 10 year plan.

Downstream demand can be reduced and prevented through appropriate planning and investment in resources which promote good health. For example, public transport should allow people to access health services. Active lifestyles should be made easy to practice, to prevent frailty and other downstream ill-health. Tackling loneliness should be a priority across departments and organisations.

“Health in All Policies” should be a widely practiced mantra.

Specific actions

- Activities which address wider determinants of health should be undertaken – e.g. addressing damp and mould in housing, which increases the risk of asthma.

- Population-targeted programmes and interventions should be a focus for investment. Policies which promote healthier environments such as banning the advertisement of high fat, sugar and salt (HFSS) foods, limiting the opening of fast-food outlets near schools and in areas of deprivation, and utilising planning regulations to create healthier spaces.

1.6.4. Culturally competent services

We recognise cultural sensitivity as an important capability of organisations and services. Organisations should be aware of, and avail of, training to help them deliver the best possible services to all users. This includes cultural competence training on working with people from ethnic minorities, LGBTQ+, neurodiverse, and Gypsy, Roma, Traveller backgrounds, among others.

Specific actions

- Trauma informed approaches should be used more widely, and all professionals working with children should be trained in these approaches. In particularly, they are fundamental for children who have experience a traumatic event and should be used to manage wellbeing and prevent further traumatisation.
- Develop a peer support service for HIV, as recommended by best practice.
- Identify patient insights into ease of access for LARC services, alongside further analysis of the map of LARC providing GPs in the county to explore areas of low or distant access.

1.6.5. Building analytical capabilities

A key finding across all domains was the relative paucity of high-quality evaluation to guide service planning. Existing evaluation capabilities should be expanded in all services, led by national best practice – e.g. The Magenta Book. Evaluation should aim to address both estimates of service impact, through quantitative and qualitative methods. Evaluations should also aim to develop understanding of how services, programmes and interventions work, who they work for, and under what circumstances.

Advances in data sharing and linked data is needed to make the best use of evidence, to best plan services and deliver best value to the population.

Specific actions

- Embed data sharing and data linkage in services, particularly between maternity care, family hubs, early help, health visiting, social care, and early years education.
- Not all health and wellbeing providers routinely collect Information on client's smoking status. Partner organisations and stakeholders, such as mental health services, housing associations, Job Centres and treatment services have a role to collect smoking status and offer very brief advice on the health risks of smoking and potential economic savings from quitting as well as providing information on local stop smoking services available.
- Ensure that evaluation is considered in all services, with special focus on collecting data on health outcomes as well as process measures.