KENT PUBLIC HEALTH OBSERVATORY

Dartford, Gravesham, and Swanley Needs Assessment

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Contents

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1 Executive Summary

1.1 Introduction

Since 2022 the Health and Care Act has made it easier for health and social care organisations to provide integrated care. Since then, the Kent and Medway Integrated Care Strategy has been developed which sets out six main outcomes, to give children and young people the best start in life, to tackle wider determinants of health to prevent ill-health, to support happy and healthy living, to empower people to best manage their health conditions, to improve health and care services, and to support and grow their workforce. This needs assessment has been produced as part of the Kent Joint Strategic Needs Assessment (JSNA) development process, managed by KCC Public Health, and provides further local information to the Dartford, Gravesham, and Swanley Health Care Partnership (HCP) and other partners to assist them in making their commissioning decisions.

1.2 Key health indicator results

- Smoking rates in Dartford, Gravesham, and Swanley have reduced from 14.4% to 12% between 2017 and 2022.
- The rate of admissions with Mental Health as a primary diagnosis has reduced by 44% over the last 10 years, from 297 per 100,000 to 165 per 100,000.
- Admissions for falls which have resulted in a leg or hip fracture in those over 65 have reduced by 16% in Dartford, Gravesham, and Swanley between 2013 and 2023.
- Dartford, Gravesham, and Swanley has higher rates of emergency admissions and gastroenteritis admissions in children aged 0-4 years old compared to Kent.
- Gravesham has the highest obesity rates in Kent for year 6 students, and the highest rates of admission for dental conditions for children aged 5-11.
- Hospital admissions where mental health is a secondary condition are higher in Dartford, Gravesham, and Swanley than in the rest of Kent. In addition, the rate of annual physical health checks in those with severe mental illnesses is lower in Dartford, Gravesham, and Swanley compared to the other health care partnerships in Kent. This is concerning due to the higher rates of premature mortality within this group.
- Alcohol related admissions are higher in Dartford, Gravesham, and Swanley than the rest of Kent, and are increasing.
- There are large disparities in the levels of smoking between ethnic groups with 36.4% of Gypsy/Irish traveller ethnicities smoking compared to 12% in the total Dartford, Gravesham, and Swanley population.
- Obesity rates in Dartford Model Primary Care Network (PCN) are significantly higher than in the rest of Dartford, Gravesham, and Swanley.
- Coverage of cervical cancer screening is below target in every PCN in Dartford, Gravesham, and Swanley.
- STI and HIV rates in Dartford are significantly higher than the rest of Kent.
- Flu and pneumonia admission rates in over 65 year olds are higher in Dartford, Gravesham, and Swanley than the rest of Kent, and are 70% higher in the most deprived areas compared to the least deprived.

- Dartford, Gravesham, and Swanley, and the rest of Kent and Medway, show persistently high rates of premature mortality from Cardiovascular Disease.

1.3 JSNA Cohort Model for scenario planning: Key findings

The factors which contribute to demographic change within the Dartford, Gravesham, and Swanley population, impact on the future health needs. They include;

- Continued growth in the total Dartford, Gravesham, and Swanley population.
- The significant contribution that is made to this growth by net inward migration.
- The changing nature of underlying risk factors that have the potential to lead to or exacerbate health and care needs
- The natural ageing process at a population level as the 'baby boom' generation approach old age.

A cautiously optimistic scenario was created based on the Kent and Medway Integrated Care Strategy. This included a 2% reduction in loneliness, a 0.3% yearly reduction in physical inactivity, alcohol misuse, overweight/obesity levels, and alcohol consumption, and a reduction in smoking, comprising of a 3.5% increase in smokers who attend smoking cessation services and a 50% reduction in new smokers. Findings suggest that if all interventions are performed, in Dartford, Gravesham, and Swanley there could be a:

- 11% reduction in all conditions
- 42% reduction in multimorbidity
- Prevalence of COPD increased with all scenarios which did not include smoking cessation, this is unlikely to reflect an increase in risk due to these interventions, but rather that the population is living long enough to develop COPD.
- There is predicted to be approximately a 6% increase in mild frailty and 17% reduction in severe frailty when all interventions are enacted compared to no interventions. However, frailty will continue to increase, by 33% for mild frailty and 22% for severe frailty between 2018 and 2043 due to an ageing population.

1.4 Health Inequalities Analysis

The health inequalities analysis for DGS explored multiple health outcomes by key domains of health inequalities. This analysis found the following:

- The rate of two or more long term conditions in under 65 year olds, COPD prevalence, and deaths of despair, all show a social gradient with higher rates in the most deprived compared to the least deprived.
- There is a significant difference in alcohol-related conditions, CHD, and hypertension prevalence by gender with the rates in males greater than rates in females. There is minimal variation by deprivation in men but both CHD and hypertension show a clear social gradient for females.
- There is a significant difference in diabetes and smoking rates by gender with higher rates in males compared to females. These both show a social gradient with higher rates in the most deprived compared to the least deprived. They also vary by ethnicity with higher rates of diabetes in Asian ethnicities and smoking in White ethnicities.
- Depression rates show a significant difference by gender with higher rates in females compared to males. Rates also vary by deprivation with higher rates in the most

deprived and by ethnicity with higher rates in the White ethnic group. Interestingly when different ethnic groups are arrayed by deprivation only the white ethnic group show variation in depression rates by deprivation. Rates also vary by access to green space with greater access associated with lower rates.

- Respiratory admissions in under 19 year olds vary by ethnicity with higher rates in the other ethnic group.

1.5 Stakeholder views

'Kent and Medway Listens' is an engagement project set up over 2021-2022 by Kent County Council, Medway Council, and Kent & Medway Partnership NHS Trust involving almost 4,000 participants across Kent and Medway to understand the pressures impacting mental wellbeing of the local population, particularly seldom heard communities. This found that the main concerns of the Dartford, Gravesham, and Swanley population were wider determinants of health such as growing financial concerns, poor housing, and pressure at work. Factors impacting the populations wellbeing were also explored, the key findings were a lack of trust in the system, a lack of GP access, inability to afford food or heating, and social isolation.

A consultation by the Safer Communities Alliance also offered access to the views of the Dartford, Gravesham, and Swanley population from diverse and marginalised communities. The key findings included, a desire for community-based health check hubs and localised services, improved cultural competency, easier and simplified access to healthcare providers including but not limited to GP services, mental health awareness, and support for social networks. The key areas for improvement include personalised care plans, collaboration among healthcare disciplines, help addressing social phobias, free educational classes, mental health and stigma reduction, and support for community groups.

1.6 Key Recommendations

Life stage and condition specific recommendations are included in chapters 6-16 of this HNA. The following recommendations summarise the specific recommendations into broader, strategic recommendations which overlap across life stages and conditions.

Integrated neighbourhood teams

Integrated neighbourhood teams are needed in Dartford, Gravesham, and Swanley to provide more personalised, multidisciplinary care for those with complex needs such as frailty, multimorbidity, and substance (including alcohol) misuse. Integrated neighbourhood teams could act as a bridge between acute and community care, helping to prevent unnecessary hospital admissions and reduce the length of hospital stays. The aim should be to reduce inequalities, reduce the health needs of the population, and improve patient and staff experience. This integration needs to be performed and evaluated using long-term goals to ensure that the positive impacts from integration have time to materialise. It will benefit from the inclusion of General Practice and patients in the design and development process and may require alterations to funding pathways.

Improving access

Access in certain groups, such as inclusion health groups, may require targeted interventions or a form of proportionate universalism. This includes health checks to ensure that risk factors for future ill-health are identified and treated. This would also benefit from treating those who may

have other risk factors for physical ill-health such as severe mental illness but have not been diagnosed.

There is a particular need in Dartford, Gravesham, and Swanley to improve the coverage of annual physical health checks in those with severe mental illnesses, to improve sexually transmitted infection testing coverage, and to improve the rate of identification of those with life-limiting conditions or who are nearing the end of their life.

Furthermore, there is potential for widening the role of discussing ReSPECT forms out to the wider multidisciplinary team, therefore reducing the strain on general practitioner capacity and reducing the need for discussions regarding emergency and end-of-life care to be had by hospital staff during an emergency admission.

Partnership working

Public Health to further their partnership work with districts, VCSE and other local anchor institutions to agree key priorities for action that would be developed under People, Place, Policy & Practice themes, ensuring focus on wider health determinants. Partnership arrangements should minimise duplication of existing work and must align with current local approaches. Key areas of partnership working include whole system efforts to delay ill health and maintain independence, especially though encouraging physical activity, improving air quality, reducing obesity, and reducing smoking rates.

Systems thinking

Utilisation of systems thinking would allow public health professionals to develop their understanding of the problems faced by the population, the surrounding context, and potential solutions. In addition, it allows for the relationships and dependencies within the systems to be considered. This is key for 'wicked' problems such as reducing obesity rates. Systems thinking should be implemented in all areas of work, be that partnership working or cultural competency, as the majority of changes will results in impacts on the interdependent elements of the systems which surround the population in DGS.

Vaccination and screening coverage

National vaccination and screening programmes aim to reduce the transmission of communicable diseases and to identify serious diseases at an earlier stage to improve outcomes. As such they are key features of protecting the health of the population. Coverage of both screening and immunisations across the life course should be improved in Dartford, Gravesham, and Swanley this may include improving access and improving reminders alongside educational campaigns. Particular focus should be placed on those with learning difficulties, severe mental illnesses, and ethnic minorities who tend to experience lower rates of screening coverage than the general population in Dartford, Gravesham, and Swanley.

Cultural competency

There is a need to ensure that services in Dartford, Gravesham, and Swanley are culturally competent to meet the needs of the diverse local population. Within this there is a need to ensure appropriate language services are readily available and utilised within local services so that care can be optimised for all residents. This is particularly key given the high rates of net inwards international migration in Dartford and Gravesham.

Research and innovation

There should be continued encouragement of data sharing and access, this would help ensure that accurate data is the basis of all health interventions. Data sharing would also allow for effective service planning, evaluation, targeting and measurement of success. Within this there should be further exploration of certain topics such as admissions for asthma and injuries in children, the rise in new HIV cases, increasing prevalence of osteoporosis, and the role of influenza and pneumonia admissions in the high emergency admission rates seen in older adults.

Insights research

There is a need to continue and develop stakeholder voices not only with patients/clients and carers but also with service providers, teaching staff, clinicians, local authorities, the voluntary sector, social care, and other health care staff to enable better insights into service delivery and quality. Particular focus is needed for specific issues e.g. vaccine uptake, screening coverage in those with learning disabilities and severe mental health conditions, and end of life care.

2 Introduction

The Health and Care Act 2022 made it easier for integrated care to be provided. Integrated care describes care that is joined up across multiple different services. A key element of providing integrated care is the integrated care system (ICS) which links a committee of system partners to the planning and funding of most local NHS service (1). The Kent and Medway ICS published their strategy in 2024 exploring how they would use the functions of the Integrated Care Board, partner local authorities or NHS England (NHSE) to tackle the local health needs identified in the Joint Strategic Needs Assessment (2). This strategy aims to;

- give children and young people the best start in life,
- tackle wider determinants of health to prevent ill-health,
- support happy and healthy living,
- empower people to best manage their health conditions,
- improve health and care services,
- support and grow their workforce.

Across Kent and Medway there is currently one ICS and four Health Care Partnerships (HCPs), namely Medway and Swale HCP, Dartford, Gravesham and Swanley HCP, East Kent HCP and West Kent HCP. This needs assessment builds on the Kent Joint Strategic Needs Assessment (JSNA) and provides further local information to the Dartford, Gravesham and Swanley (DGS) HCP to assist them in making their commissioning decisions.

In 2020 an update of the 2010 Marmot review was published exploring how the health needs of the UK population had changed over that time (3). The report found that life expectancy had stalled for the first time in 100 years and declined in the poorest 10% of women, health inequalities had widened with a growing north/south divide, mortality rates in those aged 45-49 had increased, child poverty had increased, and homelessness rates had increased (3). This report highlights the impact of wider determinants on the health of the population.

Whilst it is helpful to know the health needs of the national population when planning local service provision local data is crucial for making informed decisions. An exploration of local need is what this needs assessment aims to provide.

2.1 Methodology

This Health Needs Assessment takes a focused ‘exception based’ approach, highlighting areas where Dartford, Gravesham, and Swanley are outliers compared to the rest of Kent or compared to national rates. This also includes where there are emerging trends of need. Where possible analysis compares the level of needs in Dartford, Gravesham, and Swanley to the Kent average alongside exploring it at district or Primary Care Network (PCN) level.

Information has been assimilated from a variety of sources the Kent Public Health Observatory (KPHO) website, the Kent County Council website, from NHS Digital (including Hospital Episode Statistics (HES)), OHID, and the Office for National Statistics (ONS). Further analysis has been performed using local data sets and data kindly provided by local services. This includes a specific locally linked dataset made of GP and other Secondary Healthcare data which was developed for population segmentation trend analysis and health outcomes measurement, carried out by Outcomes Based Healthcare (OBH) (4).

In addition to analysis of present data, this needs assessment includes a Dartford, Gravesham, and Swanley specific run of the Kent JSNA Cohort Modelling tool which uses system dynamics modelling to generate predictions of the population health and health care needs in the future. The current model runs for 25 years from 2018, therefore makes predictions for up to 2043. This modelling structure allows different healthcare scenarios to be tested such as increasing rates of smoking cessation and reducing loneliness to show a picture of how different health care interventions will impact the health of the future local population, therefore providing guidance for commissioners during strategic decision making.

2.2 Index of Multiple Deprivation

The Index of Multiple Deprivation combines information from seven domains of deprivation to create an overall measure of relative deprivation for each small area (Lower-layer Super Output Areas) within England. These domains are Income Deprivation, Employment Deprivation, Education, Skills and Training Deprivation, Health Deprivation and Disability, Crime, Barriers to Housing and Services and Living Environment Deprivation (5). Each domain is weighted based on its robustness and relevance within academic literature. This can then be used to assess how all the different elements of deprivation combine to impact health.

The Indices of Deprivation 2019 measured deprivation on a relative rather than an absolute scale, so a neighbourhood ranked 100th is more deprived than a neighbourhood ranked 200th, but this does not mean it is twice as deprived.

At the neighbourhood-level, the Indices of Deprivation 2019 provides a place-based insight into deprivation. However, this description does not apply to every person living in these areas. Many non-deprived people live in deprived areas, and many deprived people live in non-deprived areas. It is important to note that the Indices of Deprivation 2019 is designed to identify and measure specific aspects of deprivation, rather than measures of affluence (5).

In addition, there are two supplementary indices of income deprivation; among children (IDACI) and older people (IDAOPI). The Income Deprivation Affecting Children Index (IDACI) measures the proportion of all children aged 0 to 15 living in income deprived families. The Income Deprivation Affecting Older People Index (IDAOPI) measures the proportion of all those aged 60 or over who experience income deprivation.

2.3 Wider Determinants of Health

Wider determinants of health are a range of factors which impact on an individual's health. These can be social, economic, and environmental factors. This is discussed further in the wider determinants chapter of this HNA.

3 Population

Population can refer to a collection of people living in the same geographical area, or who share a common characteristic such as being in the same age group, ethnicity, or with the same health condition. Some populations can be more likely to have poor health due to a combination of physiological, genetic, socio-economic and environmental factors. Examining the characteristics of the population can help explain and predict differences in health and wellbeing outcomes.

3.1 Dartford, Gravesham and Swanley residents

According to the Office for National Statistics mid-year population estimates, the total population of Dartford, Gravesham and Swanley in 2023 is 278,691 (6). This has increased by 11.7 percent since 2013.

In Dartford, Gravesham and Swanley there is a greater proportion of people aged 0 to 4, 5 to 14 and 35 to 64 and a lower proportion aged 15 to 24 and 65 to 84 compared to England. This variation is also seen when compared to the other HCPs in Kent, DGS has the greatest percentage of 0-18 year olds and the lowest percentage of over 65 year olds, as shown in figure 1.

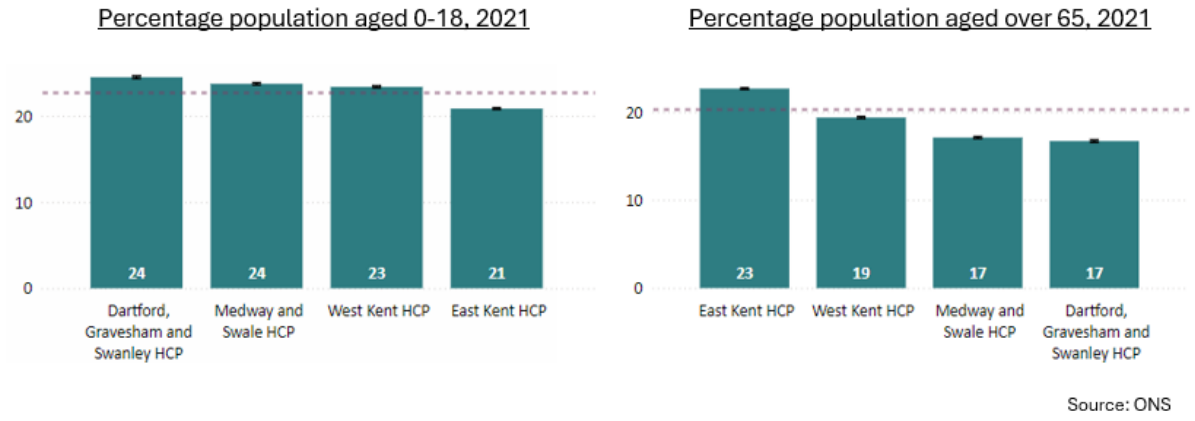


Figure 1: Percentage of residents aged 0-18 years (Left) and over 65 years (Right) by Kent HCP, 2021.

3.1.1 Fertility rates

The general fertility rate (GFR) is the ratio of live births divided by the number of women aged 15 to 44, multiplied by 1,000. Between 2013 and 2023, the GFR in Kent reduced from 61 per 1,000 to 53 per 1,000. Over the same period, the England rate reduced from 62 to 50. At a district level within Kent in 2023, Gravesham was highest (61 per 1,000), followed by Dartford (58) and Swale (57).

3.1.2 Life expectancy

Life expectancy is the average time a person is expected to live, based on their birth year, current age, and other factors like sex. Female life expectancy at birth is about four years higher than for males. Since 2001, life expectancy has increased for both genders. It remained stable from 2012 to 2019, then dropped in 2020 and 2021 due to the COVID-19 pandemic before increasing slightly from 2022 to 2023. From 2021 to 2023, the average female life expectancy in

Kent was 83.3 years, compared to 83.1 years across England. For males, it was 79.3 years in Kent, compared to 79.1 years in England (7).

3.1.3 Geographical spread

Figure 2 shows the geographical spread of the DGS population across the HCP with the highest population density in urban areas.

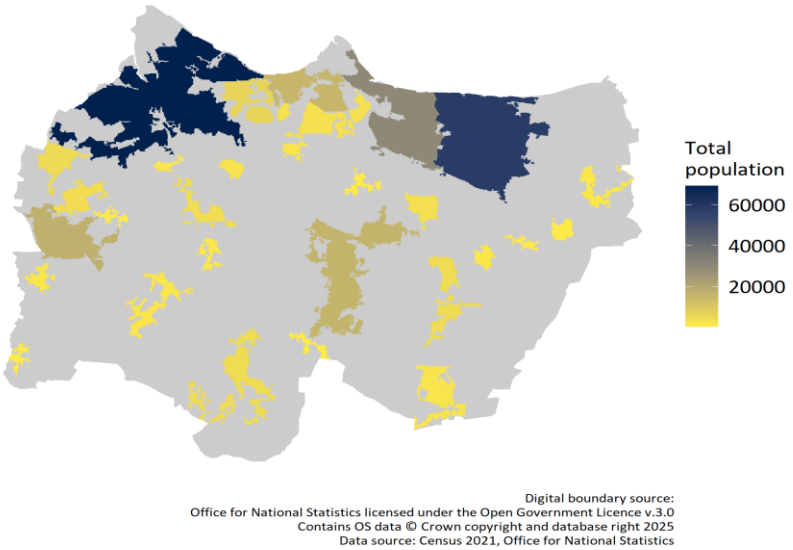


Figure 2: Map of built up areas with population at time of Census 2021

3.1.4 Population predictions

The latest population projections from the Office for National Statistics are based on the 2018 calendar year. The methodology is based on assumptions made about three major components of population change: natural change (births, deaths and ageing), migration and special populations using recent trends. Kent County Council produces complementary housing-led population forecasts which determines growth based on the number of dwellings planned to be constructed and other county level assumptions (8). The predictions from this can be seen in figure 3 which shows that by 2035, the total population of Dartford, Gravesham and Swanley is expected to be about 314,000.

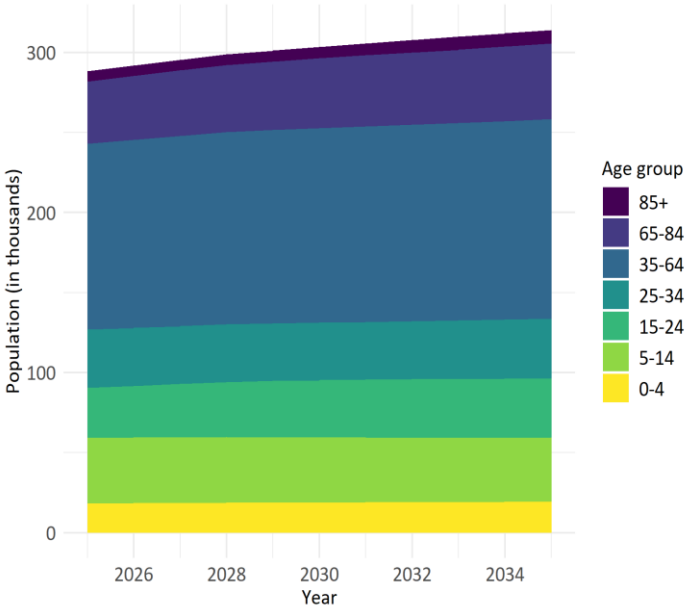


Figure 3: Population forecast by age group in Dartford, Gravesham, and Swanley, KCC Housing led

3.2 Identity

3.2.1 Ethnicity and Main Languages

In DGS at the time of the Census in 2021, 67.8% of the population were classified as 'White: English, Welsh, Scottish, Northern Irish or British'. This compares to 73.5% in England. This translates to DGS having the highest percentage of non-white residents in Kent, as shown in figure 4. Apart from White British, African (6.7%), Any other ethnic group (2.3%), Indian (5.9%), Other Asian (2.4%) and Other White (6.5%) ethnic groups account for more than 1 percent of the population.

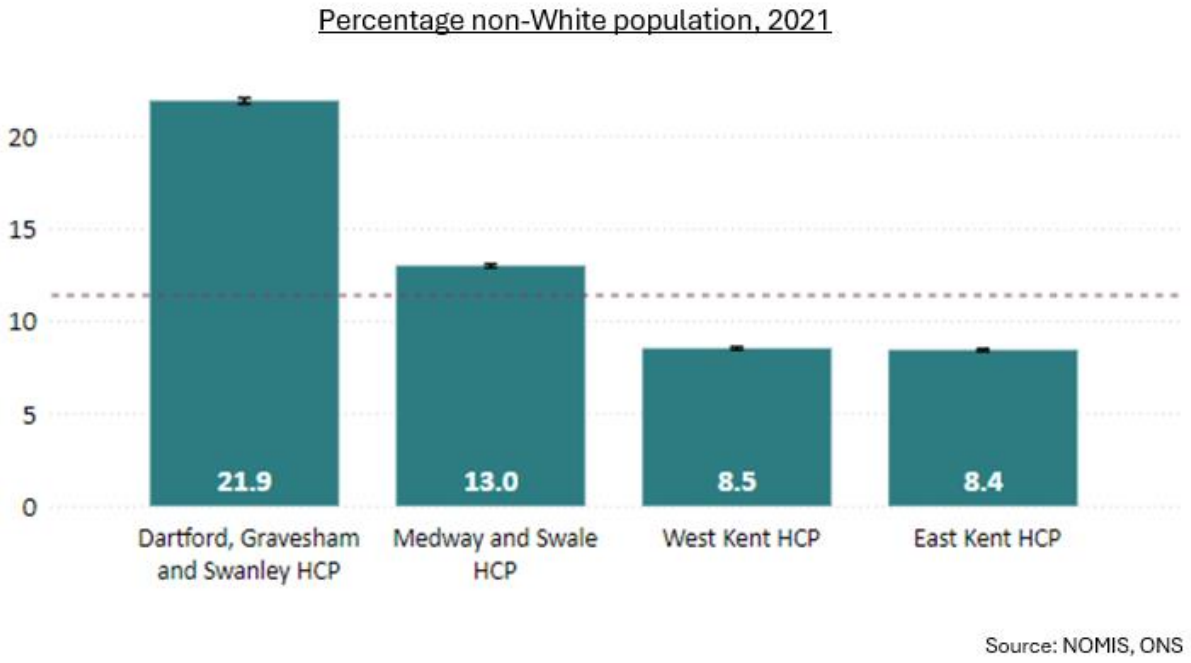


Figure 4: Percentage of the population who are non-white by HCP in Kent, 2021.

There are 90 distinct main languages spoken by people in Dartford, Gravesham and Swanley. 10 are spoken by at least 500 people. The top 5 languages are: English 81.7%, Panjabi 1.9%, Romanian 1.2%, Polish 1% and Lithuanian 0.6%.

3.2.2 Gypsy, Roma, and Traveller communities

It is recognised nationally that Gypsy, Roma and Traveller people have significantly poorer health outcomes than the general population of England and these inequalities in health are a result of interactions between adverse environments (living, working and social), lifestyle behaviours and poor access to health, care and wider support services.

Kent has a higher percentage of Gypsy and Traveller people than the England average and many Roma communities too. In 2021 DGS had 554.5 per 100,000 Gypsy, Roma and Traveller residents compared to the Kent average of 480.1 per 100,000. More information can be found in the Gypsy, Roma and Traveller Health Needs Assessment.

3.2.3 Religion

In DGS, 48.6% of residents are Christian, 4.7% are Sikh, 3.3% are Muslim, 2.6% Hindu, 0.5% Buddhist, 0.5% Other religion, and 0.1% Jewish. 34.4% declared no religion and 5.2% declined to answer.

3.2.4 Sexual orientation and Gender identity

Sexual orientation is an umbrella term covering sexual identity, attraction, and behaviour. Census 2021 was the first census in England and Wales to ask about people's sexual orientation and gender identity. These were voluntary questions for those aged 16 years and over. In Dartford, Gravesham and Swanley at the time of 2021 Census, 91.1 percent of residents aged 16 years and over responded that they were Straight or Heterosexual. 2.3 percent were Gay or Lesbian, Bisexual or another sexual orientation. This question was not answered by 6.6 percent of people.

Gender identity refers to a person's sense of their own gender, whether male, female or another category such as non-binary. This may or may not be the same as their sex registered at birth. In Dartford, Gravesham and Swanley, 94.1 percent of residents responded that their gender identity was the same as their sex registered at birth. 0.6 percent identified as a different gender. This question was not answered by 5.3 percent of people.

3.3 Veterans

The Armed Forces and Veteran Community Needs Assessment focuses on the needs of armed forces and veterans living in Kent. It looks at the Armed Forces Covenant, governance in Kent and Medway, and the support structures that connect various organisations.

People who have previously served in the regular or reserve UK armed forces are often known as the veteran population and form part of the armed forces community (along with those who currently serve in the armed forces or Merchant Navy and their families). At the time of the 2021 Census, there were 4,679 veterans living in Dartford, Gravesham and Swanley, approximately 2.7 percent of the population aged 16 years and over. This compares to 3.8 percent in England.

The proportion of the population who are veterans increases with age. Among those aged 75 to 84 it is 9 percent and in those aged 85 years and over it is 25 percent.

3.4 Disability

3.4.1 Limited day-to-day activities

In response to the Census 2021, people who assessed their day-to-day activities as limited by long-term physical or mental health conditions or illnesses are considered disabled. This definition of a disabled person meets the harmonised standard for measuring disability and is in line with the Equality Act (2010).

In Kent, 17.9 percent of residents are disabled using this definition, compared to 17.3% in England. Rates in Gravesham are similar to Kent and rates in Dartford and Sevenoaks are below 16 (9).

3.4.2 Economic inactivity

Questions about economic activity were part of the Census 2021. It should be noted that the Census took place during the COVID-19 pandemic which will have affected the responses.

Economically inactive are those aged 16 years and over who did not have a job between 15 March to 21 March 2021 and had not looked for work between 22 February to 21 March 2021 or could not start work within two weeks. It includes those who are retired. A subgroup of economically inactive is those who are long-term sick or disabled.

In Kent, 3.7 per cent are economically inactive due to long-term sickness or disability which is lower than the England average 4.1 per cent. Rates were below 3% in Dartford and Sevenoaks (10).

3.4.3 Unpaid carers

An unpaid carer may look after or give help or support to anyone who has a long-term physical or mental ill-health condition, illness or problems related to old age. This does not include any activities as part of paid employment.

Of all Kent residents aged 5 years and over, just over 9 per cent provide some form of unpaid care. This is slightly higher than the England average (8.8 percent). It is highest in Dover and Thanet (10.4 percent), and Folkestone and Hythe (10.3 percent). It is lowest in Dartford and Tunbridge Wells (about 8 percent) (11).

3.5 Homeless and rough sleeping

3.5.1 Rough sleeping

Every Autumn, local authorities in England carry out an annual estimate of rough sleeping on a single night between 1 October and 30 November which includes some basic demographics details (age, gender, nationality). The results are submitted to the Ministry of Housing, Communities and Local Government.

People sleeping rough are defined as those sleeping or about to bed down in open air locations and other places including tents and makeshift shelters. The snapshot does not include people

in hostels or shelters, or those in recreational or organised protest, squatter or traveller campsites. The snapshot can be carried out using either a count-based estimate, evidence-based estimate meeting with local partners or an evidence-based estimate with spotlight count. It does not include everyone in an area with a history of sleeping rough, or everyone sleeping rough in areas from October to November.

According to the Rough sleeping data dashboard, the 2023 snapshot shows that there are an estimated 126 people sleeping rough (7.9 per 100,000 population) across Kent districts which compares to 6.8 per 100,000 across England. 75 percent are from the UK, 13 percent from the European Union and 7 percent outside the EU. Four-fifths are male, and 83 percent are over the age of 25. No under 18s were identified.

3.5.2 Homeless

Each local housing authority is required to consider housing needs within its area, including the needs of homeless households, to whom local authorities have a statutory duty to provide assistance. The definition of homeless includes statutorily homeless, which are those households which meet specific criteria of priority need set out in legislation, and to whom a homelessness duty has been accepted by a local authority. Such households are rarely homeless in the literal sense of being without a roof over their heads but are more likely to be threatened with the loss of, or are unable to continue with, their current accommodation (12). Table 1 summarises homelessness statistics across Kent in 2023/24.

Table 1: Statutory Homeless statistics by local authority in Kent, 2023/24

Area	Threat homeless rate	Homeless rate
England	6.0	7.4
South East	5.9	5.4
Ashford	7.2	7.8
Canterbury		
Dartford	6.4	6.0
Dover	4.1	6.0
Folkestone & Hythe	4.7	4.1
Gravesham	6.3	6.7
Maidstone	8.2	6.9
Sevenoaks	3.9	3.1
Swale	4.0	5.1
Thanet	5.9	6.4
Tonbridge & Malling	4.8	4.0
Tunbridge Wells	5.1	3.8

3.6 Students

At the time of the 2021 Census, there were a total of 5,134 full-time students (including students aged 18 or more who are still in school or further education) whose usual place of residence (term-time address) was in Dartford, Gravesham and Swanley. This is approximately 3 percent of the total population aged 18 years and over, compared with 5.2 percent in England.

3.7 Green space and Housing

The majority of DGS is rural, however a large swathe in the north and west of the HCP is classified as urban major conurbation, as shown in figure 5. As a large part of DGS is urban, it is important to also consider the access residents have to green space.

The Accessible Natural Green Space Standards (ANGSt) is a set of guidelines developed in the United Kingdom to ensure that urban residents have access to natural green spaces. There are different levels of the standards according to the size of accessible green spaces and the time taken to access them. This analysis focuses on the doorstep standard: accessible greenspace at least 0.5 hectares in size within 200 metres (less than a 5-minute walk). There are a few tightly clustered patches in the HCP where access to greenspace is best. These tend to be in more densely populated areas but not within all of the urban areas, as shown in figure 6.

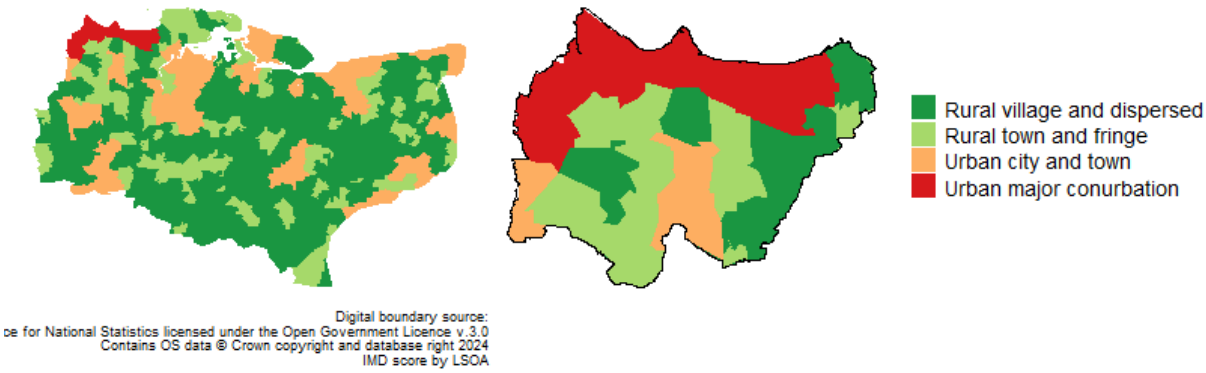


Figure 5: Map of the rural-urban composition of Dartford, Gravesham, and Swanley.

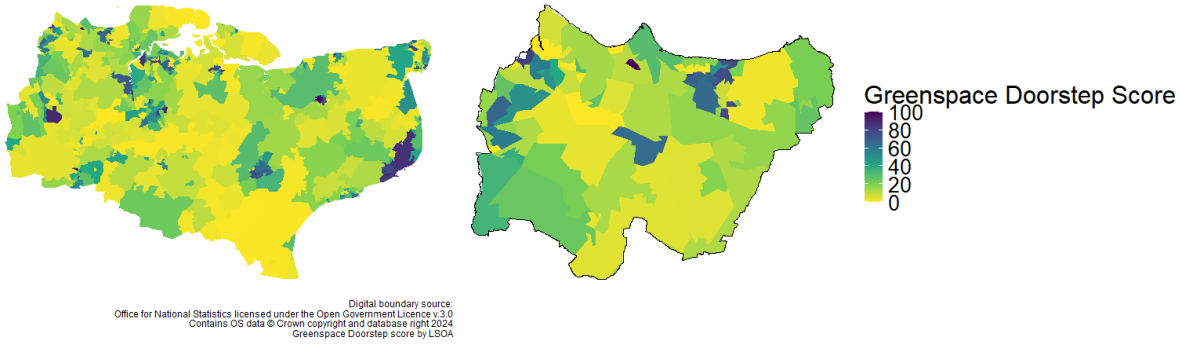


Figure 6: Map of the Greenspace Doorstep score for Dartford, Gravesham, and Swanley

Census 2021 provides a measure of household overcrowding. A household is considered overcrowded if it has fewer bedrooms than is required according to the number, ages and

relationships of household members. Within DGS the highest rates of overcrowded homes tend to be in urban areas in the north of the HCP area, as shown in figure 7.

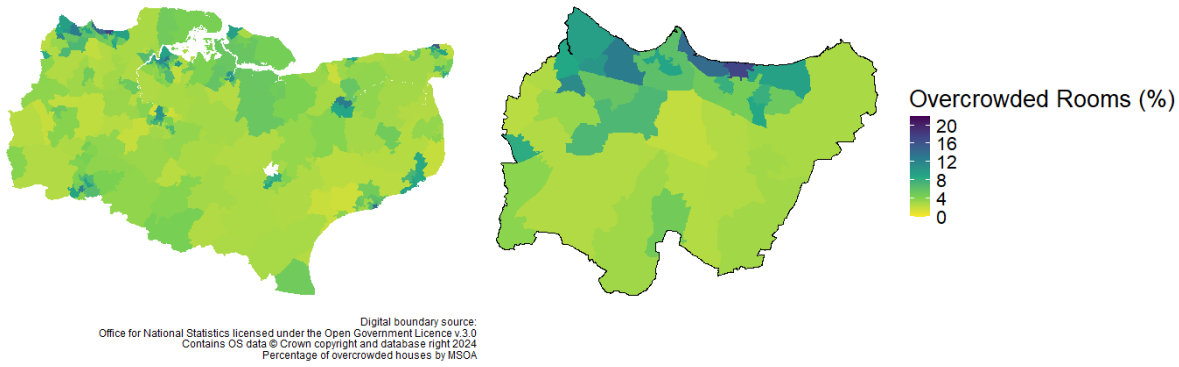
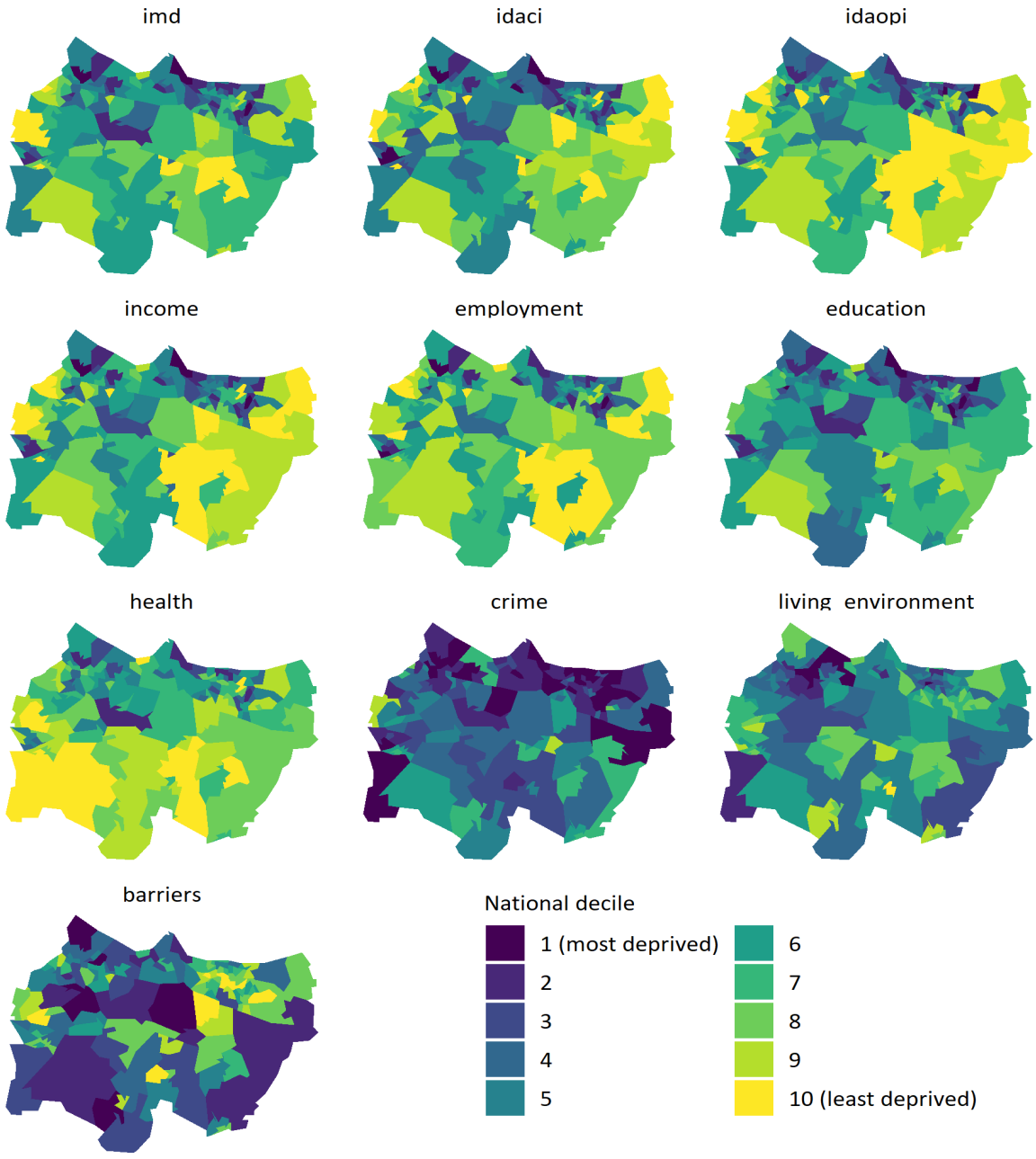


Figure 7: Map of overcrowded rooms in Dartford, Gravesham, and Swanley

3.8 Deprivation

As discussed previously in this report the Index of Multiple Deprivation (IMD) comprises of multiple indices to provide a relative measure of deprivation in small areas. Figure 8 shows the IMD, Income Deprivation Affecting Children Index (IDACI), Income Deprivation Affecting Older People Index (IDAOPI) and the individual domains of deprivation. Deprivation typically is higher in the north-west of the HCP area and in urban areas of Dartford, Gravesend and Swanley.



Digital boundary source:
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Data source: Indices of Deprivation 2019, Ministry of Housing, Communities & Local Government

Figure 8: Deprivation deciles by domain of deprivation in Dartford, Gravesham, and Swanley, 2019

3.9 Population Views

The views of the population in Dartford, Gravesham, and Swanley have been ascertained in two different ways. The first was through the Kent and Medway Listens engagement programme. During this programme Kent County Council (KCC) collaborated with Voluntary and Community Sector partners across Kent and Medway. This allowed KCC to benefit from the pre-existing trusted relationships with seldom heard communities in their area that their Voluntary and Community Sector partners had nurtured.

Within this programme, five hundred and twenty-six people (526) were consulted across DGS, with community groups, community events and listening activities from a diverse range of respondents. Mental health was the focus of these talks and from them the following features were drawn out at key concerns. Pressure at work, financial pressure, family and friend pressures, health, child wellbeing, education, and bereavement. Of these, pressure at work was the most frequently mentioned which encapsulated issues at work, maintaining work life balance and being out of work.

This programme also explored what was negatively impacting on the participants wellbeing. From this the key findings were a lack of trust in the system, inability to afford food or heating, cost of living crisis, inability to get a GP appointment, loneliness and isolation, and relationship breakdowns. These have been categorised into five main categories as shown in figure 9.

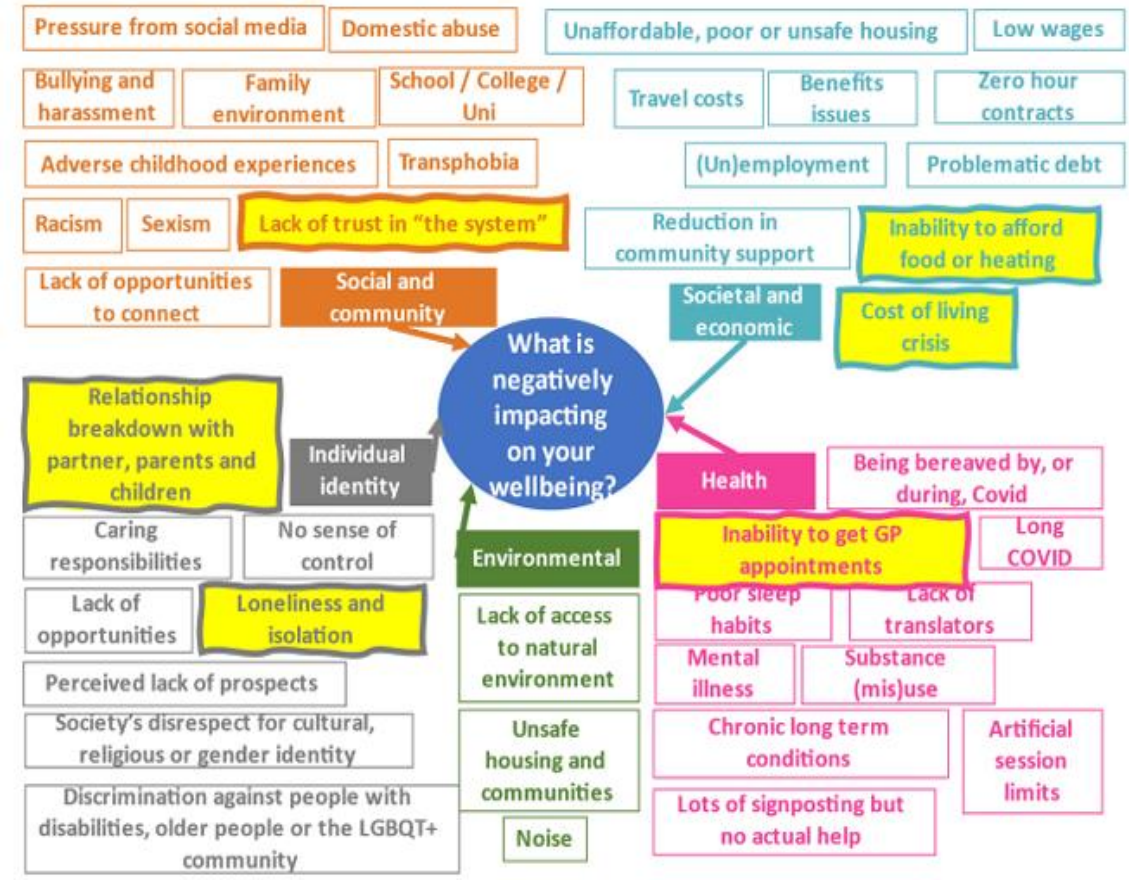


Figure 9: Issues raised by Kent and Medway listens as impacting on people's wellbeing.

The second way individual's views were garnered was through a consultation conducted by the Safer Communities Alliance. This involved twenty participants from marginalised, diverse communities, and low-income backgrounds.

Key findings included: a desire for community-based health check hubs and localised services, improved cultural competency, easier and simplified access to healthcare providers including but not limited to GP services, free fitness classes, dental care for low-income families and children, recognition of NHS limitations, improved education and awareness in schools, improved understanding of rare diseases, and easier inpatient meal access, mental health awareness, support for social networks, and assistance with employment.

Key areas for improvement include personalised care plans, collaboration among healthcare disciplines, help addressing social phobias, free educational classes, mental health and stigma reduction, and support for community groups.

4 Wider determinants

Wider determinants of health describe the factors outside of access to healthcare and the quality of care with influence individuals' health. As shown by the Robert Wood Johnson Foundation model below (figure 10) only 50% of health is driven by clinical care and an individual's health behaviours, whilst the remaining 50% is from socio-economic factors such as education and employment, and the built environment (13). The following wider determinants of health have been explored for the DGS population; education, income, crime, housing, loneliness, green-blue spaces, air pollution, and climate change risks.

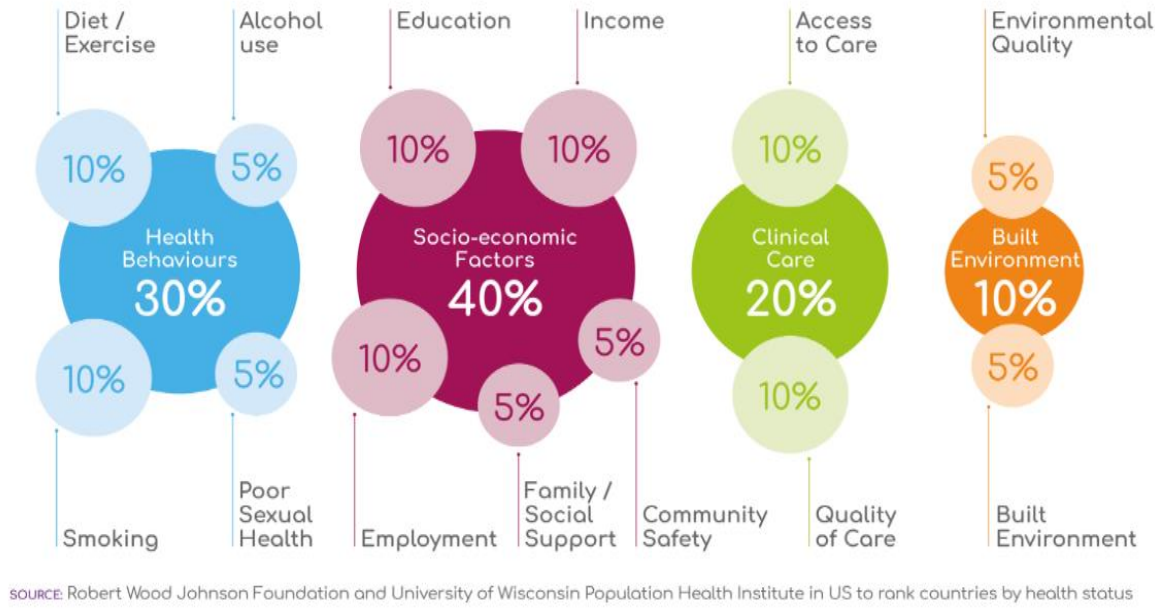


Figure 10: Robert Wood Johnson Model (13)

4.1 Education

A strong link exists between educational attainment and health behaviours and outcomes. Better educated individuals tend to have lower rates of mental and physical ill-health. Furthermore, higher qualification levels tend to be linked to better employment opportunities and higher incomes which is then associated with better health.

Concerningly a socio-economic achievement gap exists which shows differential attainment between socio-economic groups. This is further influenced by parental education, and parental occupation (14–16). There is also an association between educational attainment and eligibility of free school meals (FSM), whereby non-eligible pupils outperformed eligible pupils academically (17). In 2022, 47% of FSM-eligible pupils achieved a standard pass (grades 4-9 or A*-C) in GCSE English and Mathematics, compared to 75% of ineligible pupils, highlighting the importance of FSM on other health and educational outcomes (18). These attainment gaps persist from early childhood into adolescence and given the link between education and employment opportunities, income, and health the impact of this attainment gap resonates throughout the life course.

Within DGS the proportion of children reaching the expected KS2 level has remained stable in 2022-2023, as shown by figure 11. The average proportion of children reaching their expected KS2 level is similar in DGS compared to the Kent average by 5.6% in 2022 and 5.5% in 2023.

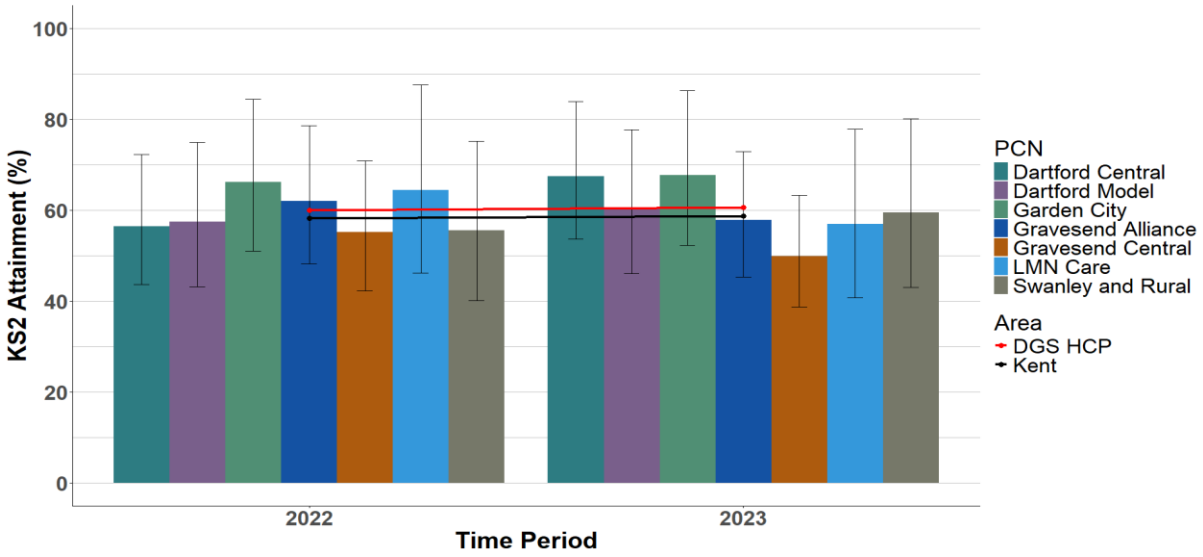


Figure 11: Proportion of children reaching the expected KS2 level in DGS compared to Kent by PCN, percentage, 2022 and 2023.

The impact of deprivation on the proportion of children reaching the expected KS2 levels is seen when rates in the most and least deprived quintiles in DGS are compared, as shown in figure 12. 10.2% more pupils in the least deprived areas achieve the required KS2 attainment compared to the most deprived. DGS had better attainment in the most deprived group compared to Kent.

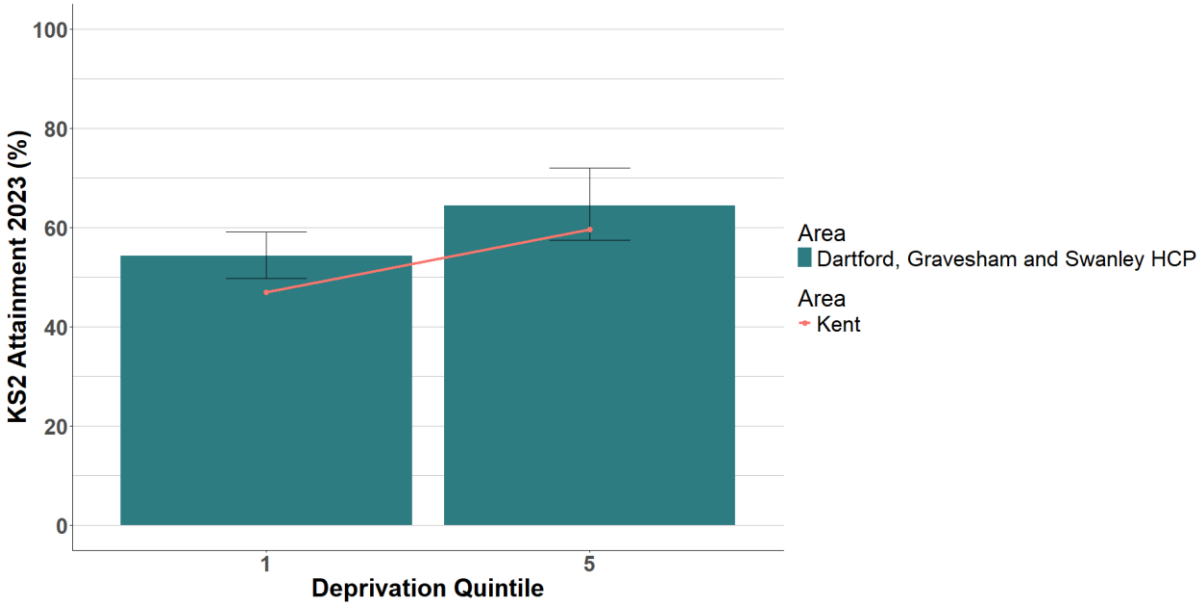


Figure 12: Proportion of children reaching the expected KS2 level in DGS compared to Kent by most and least deprived quintile, percentage, 2022 and 2023.

The proportion of children eligibile for free school meals in Dartford, Gravesham and Sevenoaks has grown from 2018 to 2023, as shown in figure 13. However, rates remain below the Kent

average. Gravesham has the highest level of free school meal eligiblity at all time points with 21.2% of children eligible in 2022/23. Unfortunately Swanley level data is not available and it is possible that Sevenoaks data masks the level of need in Swanley, better coverage of data is required to unpack this.

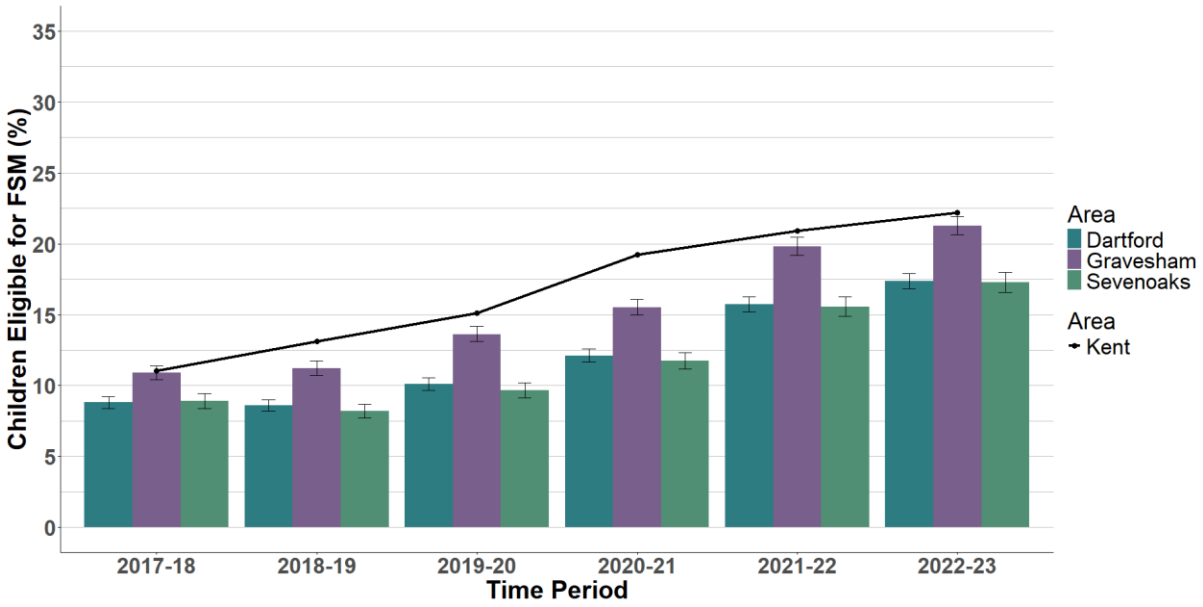


Figure 13: Proportion of children eligible for free school meals (FSM) in Dartford, Gravesham, and Sevenoaks, 2017-2023, percentage.

4.2 Income and Employment

Income positively correlates to many physical and mental health outcomes. Income influences the ability of individuals to purchase goods and services both helpful and harmful for health, to participate in social activities, and affects self-worth.

In Dartford, Gravesham, and Sevenoaks income varies with median annual gross pay per employee in 2024 highest in Dartford and below the Kent average in Gravesham as shown in figure 14.

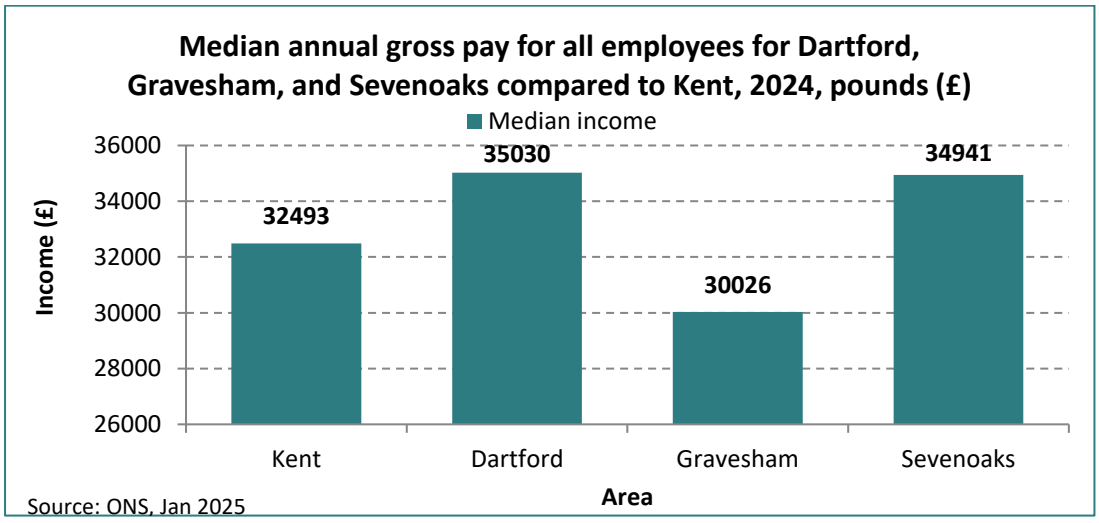


Figure 14: Median annual gross pay for all employees for Dartford, Gravesham, and Sevenoaks compared to Kent, 2024, pounds (£)

In addition to the financial benefits of receiving an income, employment also provides social interaction, a sense of contributing to society, and a place to grow skills, all of which benefit health (19). Provision of benefits for those who are unemployed only replaces the financial support of employment.

In DGS the claimant count, a measure of the number of people aged 16-64 years claiming unemployment related benefits, has risen from 2018 to 2024. This peaked in 2021, likely due to the pandemic but has remained stable since then, as shown in figure 15. There is variation across the PCNs in DGS with the highest rates consistently in Gravesend Central PCN. Claimant count rates tend to be slightly higher in men than women in DGS, as shown in figure 16. Gravesend Central has the highest proportion of claimants for both males and females and also has the greatest gender difference of all the PCNs (5.5%).

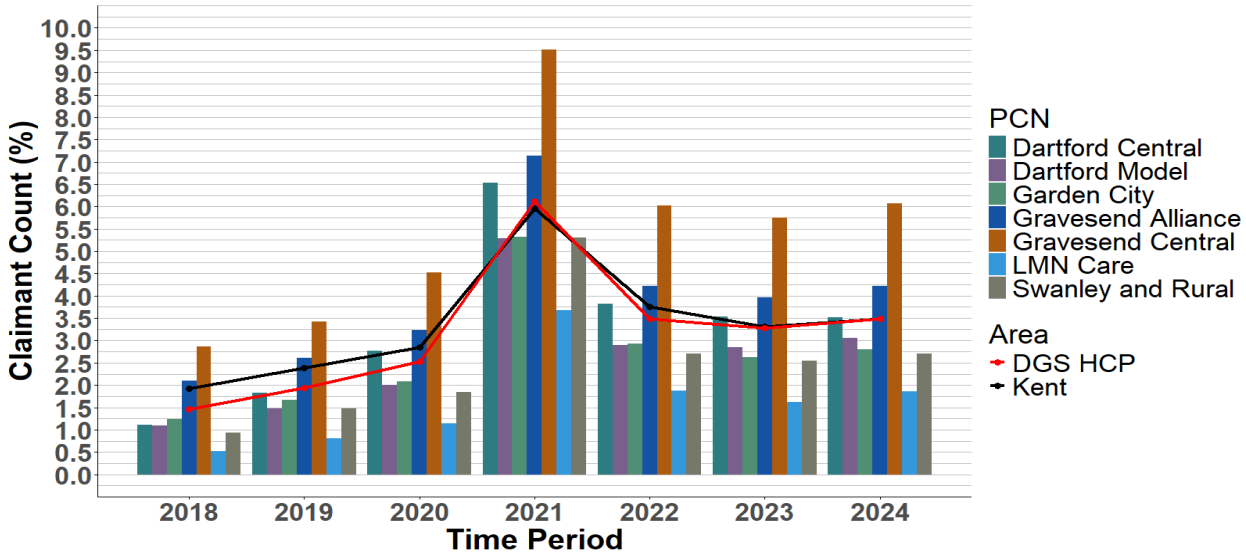


Figure 15: Claimant count (using the alternative claimant count measure which was modelled for the introduction of universal credit) by Primary Care Network (PCN) in Dartford, Gravesham, and Swanley, 2018-2024, percentage.

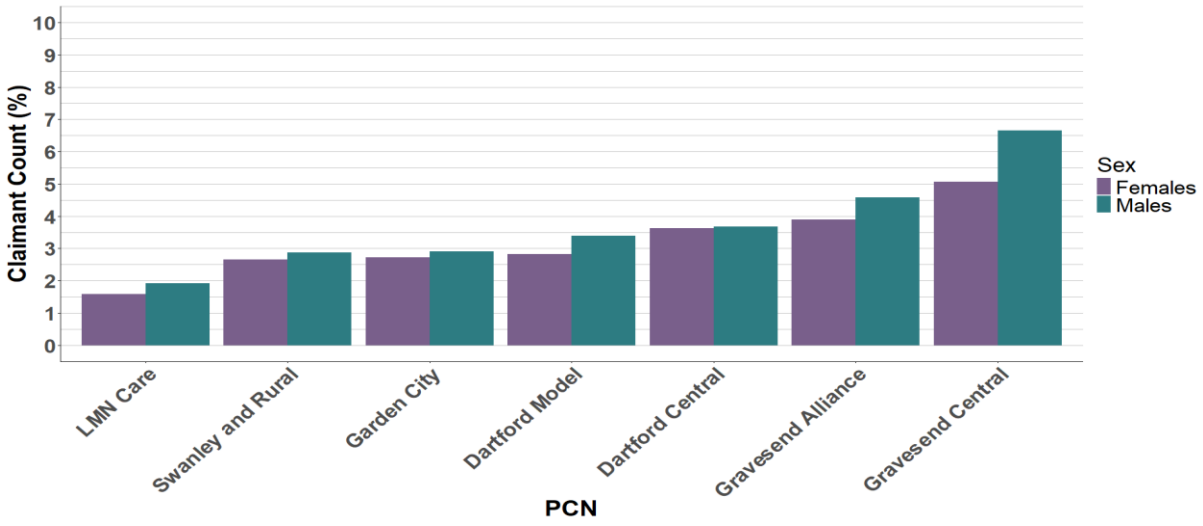


Figure 16: Claimant count (using the alternative claimant count measure which was modelled for the introduction of universal credit) by Primary Care Network (PCN) and gender in Dartford, Gravesham, and Swanley, 2024, percentage.

The health impacts of income and financial benefits are also impacted by its purchasing power, this is the amount of goods that can be purchased with a given amount of currency. Internal purchasing power of the pound has declined from 1975 with a pound in 2015 able to buy the same as 49p in 1990 (20). An example of this relevant to health is the affordability of housing.

Poor housing affordability is associated with both homelessness and poor health outcomes (21,22). Keeping people stably and affordably housed is increasingly recognised as a priority for both public health and health care. However, this is a growing problem as housing becomes less affordable. This is measured using an affordability ratio which compares average house prices in an area to the average income within that area. Rates for 2024 have been modelled using the median weekly wages published by the ONS and house prices in 2024. By using the weekly wages at a MSOA level in 2024, a median household income has been calculated based on an average of 2.1 people per household. This was then used against the average houseprices at a MSOA level to produce a likely affordability ratio in 2024. It should be stated that as these figures are based on weekly wages, total household income is subject to change as and when the ONS publish them, however, every step to check and validate these modelled results has been taken.

In DGS the affordability ratio tends to be lower than the rest of Kent, as shown in table 2.

Table 2: Affordability ratio for Health and Care Partnerships (HCPs) in Kent, 2020 and 2024.

HCP / Region	Affordability Ratio 2020	Higher or Lower than Kent Average	Affordability Ratio 2024	Higher or Lower than Kent Average	Change in Ratio	Higher or Lower than Kent Average
Kent	6.23	-	7.27	-	1.04	-
DGS	**6.07**	↓	**7.13**	↓	**1.06**	↑
East Kent	6.38	↑	7.55	↑	1.17	↑
West Kent	6.92	↑	7.76	↑	0.85	↓

However, this has risen from 2020 to 2024 in every PCN in DGS with the affordability ratio in areas such as LMN PCN rising by over 25%, from 7.7 in 2020 to 9.92 in 2024, as shown in table 3. The UK government has previously suggested that the affordability ratio should be no more than 5, all PCNs in DGS are higher than this.

Table 3: Affordability ratio for Dartford, Gravesham and Swanley Primary Care Networks (PCN) in Kent, 2020 and 2024

PCN	Affordability Ratio 2020	Affordability Ratio 2024	Change in Ratio
Dartford Central	5.91	6.56	**0.65**
Dartford Model	5.69	6.73	**1.04**
Garden City	6.39	7.49	**1.10**
Gravesend Alliance	5.42	6.32	**0.90**
Gravesend Central	5.02	5.81	**0.79**
LMN Care	7.77	9.92	**2.15**
Swanley and Rural	6.52	7.58	**1.06**

4.3 Housing

Multiple elements of housing affect health, as shown in the Decent Homes Standard which assesses multiple elements of a dwelling (23). The minimum standard of accommodation under the social rented sector is guided by the Decent Homes Standard, however this does not currently apply to the private rental sector (23). Private renters are more likely to live in poor quality homes which do not meet the decent home standard and suffer from damp and mould (24). These hazards can lead to development or worsening of asthma, allergies, and respiratory infections alongside poor mental health (25). Rural homes are more likely to be classified as non-decent or contain damp and mould (25).

One element of the Decent Homes Standard is the energy efficiency of homes. Energy efficient homes require less gas or electricity to remain warm. This is crucial due to the large number of excess deaths experienced in the UK due to the cold, discussed in the 4.8 climate change section of this HNA. Having more energy efficient homes could help prevent excess winter deaths due to cold.

Figure 17 shows the mean energy efficiency scores by MSOA in Kent and DGS for 2022 with a score of 100 representing a more energy efficient home. In England the median score was 68 while in DGS this is 66.9, 1.1 lower. Dartford Central PCN had the highest median energy efficiency score of 71 in 2022, while LMN PCN had the lowest at 63.7. Interestingly, LMN PCN had the highest affordability ratio in DGS HCP and has the lowest energy efficiency rating, making this an area that may need further investigation and understanding. It is possible that homes in this area are older, and larger, making them more expensive while harder to equip with double glazing, new insulation and efficient heating.

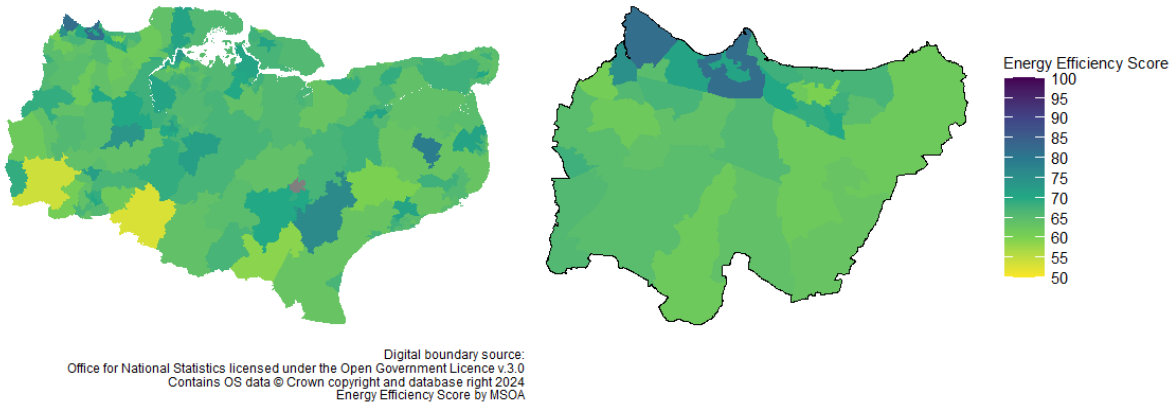


Figure 17: Map of energy efficiency scores for houses in Kent (Left) and Dartford, Gravesham, and Swanley (Right), 2022

In addition, overcrowding within houses is linked to poorer health outcomes. Overcrowded housing has been suggested as one mechanism linking deprivation to poor health outcomes. Overcrowding plays a role in child and adult health, with higher rates of respiratory problems seen in poorer quality housing that have issues with damp and mould.

Figure X shows the proportion of overcrowded rooms by MSOA in 2021. Higher rates are seen in city regions such as Dartford and Gravesend. As shown in figure 18, this has changed little from 2011 with rates high in Gravesend PCN and Dartford model and Dartford Central PCNs. One positive note is that rates of overcrowding have fallen from 2011 to 2021, as shown in figure 19, suggesting initiatives to reduce landlord loopholes and minimum room sizes have improved. Interestingly, when compared to the affordability ratio, areas with a lower ratio also have a higher percentage of overcrowded rooms. While it would be expected that a lower affordability ratio would mean fewer overcrowded rooms, it is possible that built up areas in Dartford and Gravesham do not have the capacity to build enough homes for the demands.

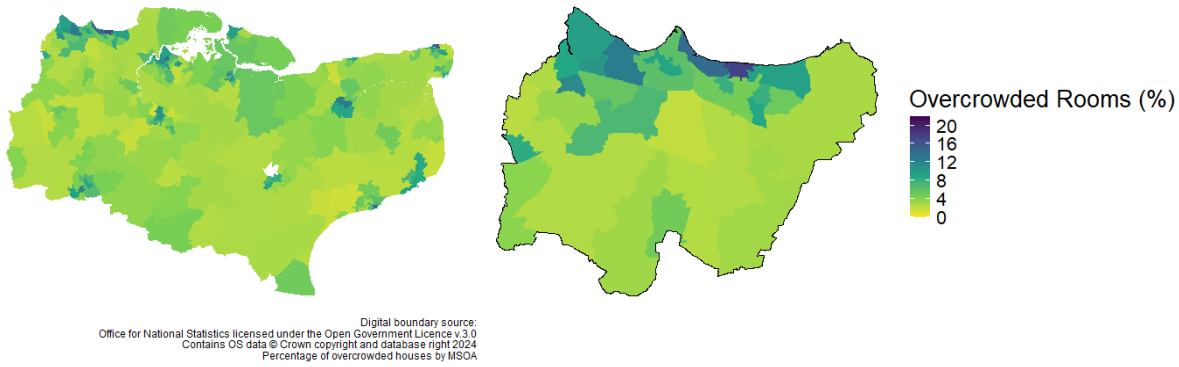


Figure 18: Map of Overcrowding in Kent (Left) and Dartford, Gravesham, and Swanley (Right) in 2021, percentage

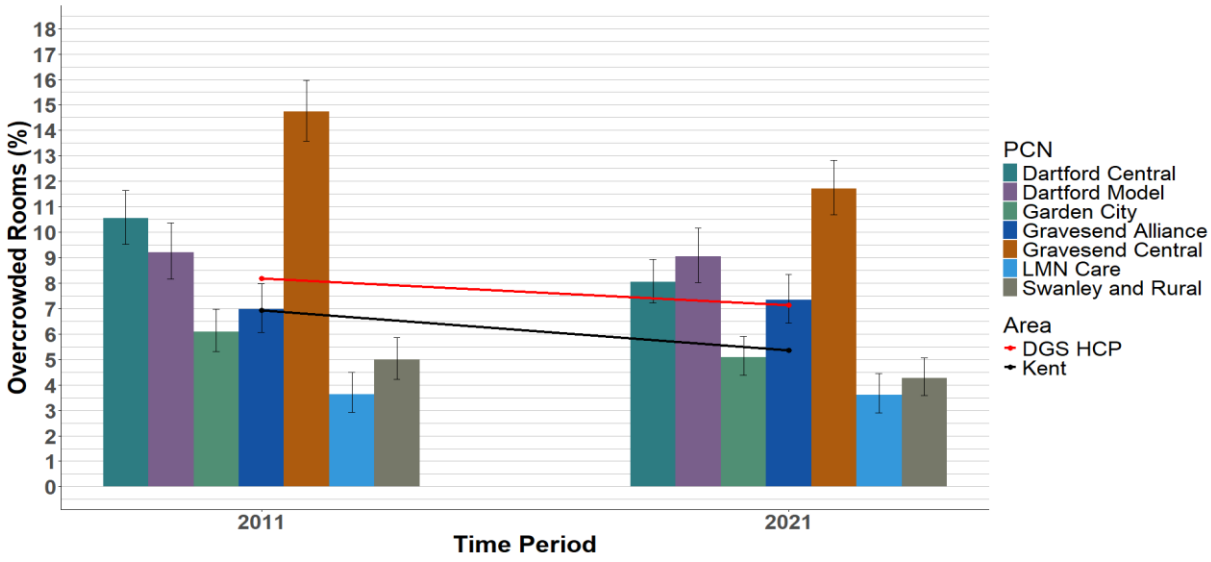


Figure 19: Percentage of overcrowded rooms in Primary Care Networks (PCN) in Dartford, Gravesham, and Swanley, 2011 and 2021, percentage.

4.4 Crime

Crime affects health through multiple pathways such as direct harm from violent crimes like assault and indirect harms from a fear of crime like anxiety and a lack of physical activity (26). Rates of crime in DGS are similar to the rest of Kent. However, there is variation across the MSOAs in DGS with a high of 263 crimes per 1000 population in Stone and Crossways and a low of 39 crimes per 1000 population in Heath in 2023, as shown in figure 20. Within DGS crime rates have remained stable since 2018 with a very slight reduction by 2023, as shown in figure 21. Rates tend to be higher in Gravesend Central PCN and Dartford Model PCN which may reflect the relationship between crime and deprivation seen nationally and the association between crime and urban locations (27,28).

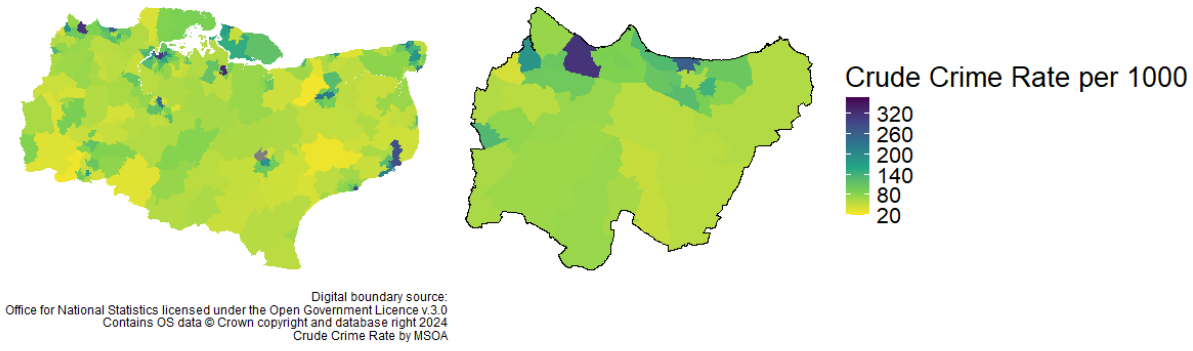


Figure 20: Map of Crude Crime Rate per 1000 population by Primary Care Network in Kent (Left) and Dartford, Gravesham, and Swanley (Right), 2023.

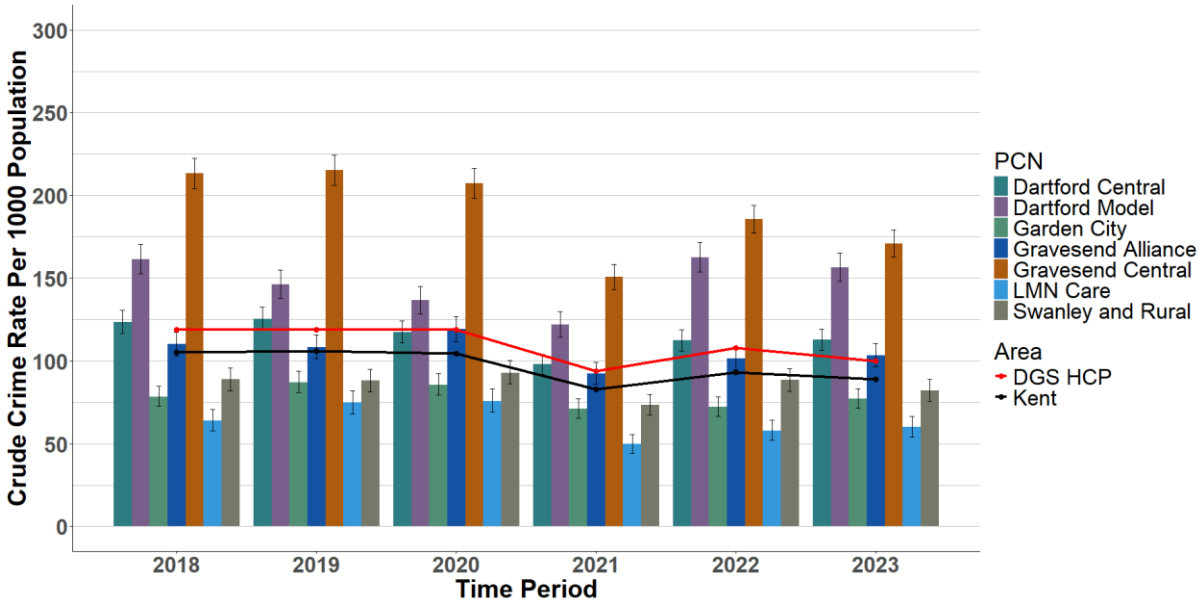


Figure 21: Crude Crime Rate per 1000 population by Primary Care Network in Dartford, Gravesham, and Swanley, 2018-2023.

4.5 Loneliness

Social connections can provide a buffer against disease and help to build resilience in individuals (27). In contrast living alone is linked to higher levels of most mental health problems. Self-reported feelings of loneliness, often defined as a "subjective, unwelcome feeling of lack or loss of companionship", is one indicator that can be measured to examine the social connections and support within the population (29). The latest data from an Active England survey in 2019/20 shows that rates of loneliness in Dartford, Gravesham, and Swanley are similar to the Kent average, as shown in figure 22.

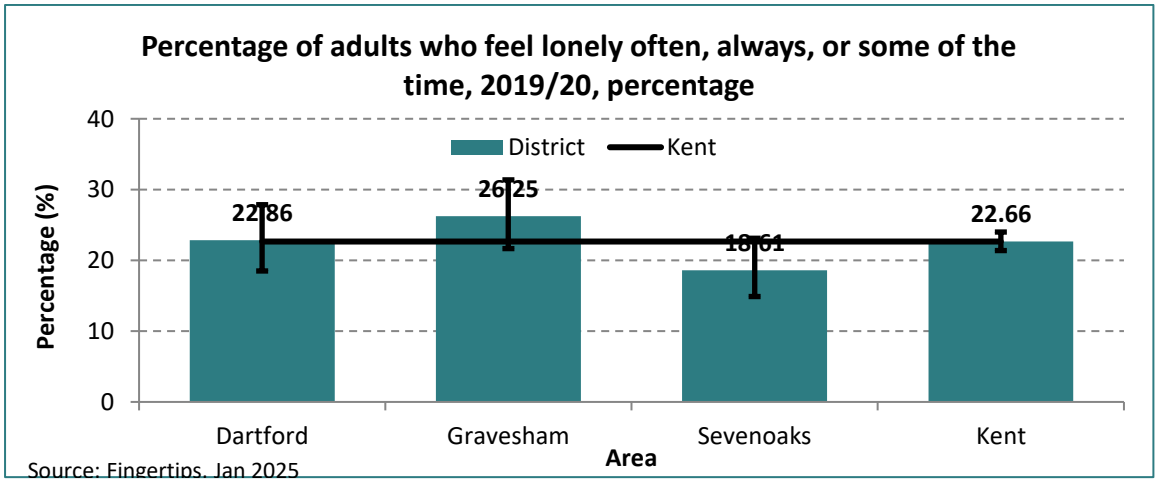


Figure 22: Percentage of adults who feel lonely often, always, or some of the time, 2019/20, percentage

4.6 Green/Blue Space

Access to green space is linked to both physical and mental health benefits in many ways, for example through the reduction in cortisol from being among nature, and the physical health benefits of physical activity (30,31).

Figure 23 shows the Green / Blue space domain score by MSOA in Kent and DGS for 2024. The score for this domain is calculated based on the proximity and accessibility of these spaces to the population within a given area. Higher scores indicate better access to green and blue spaces. It is thought that domain score is a better metric for green / blue space as a simple distance measure does not consider the quality and accessibility of the spaces. Furthermore, it is thought that high quality of green / blue spaces has better mental and physical health benefits than low quality areas. The average green / blue space domain score for DGS is 0.05, better than the overall Kent average at 0.019. The max value in DGS is 0.79 which was in Dartford central.

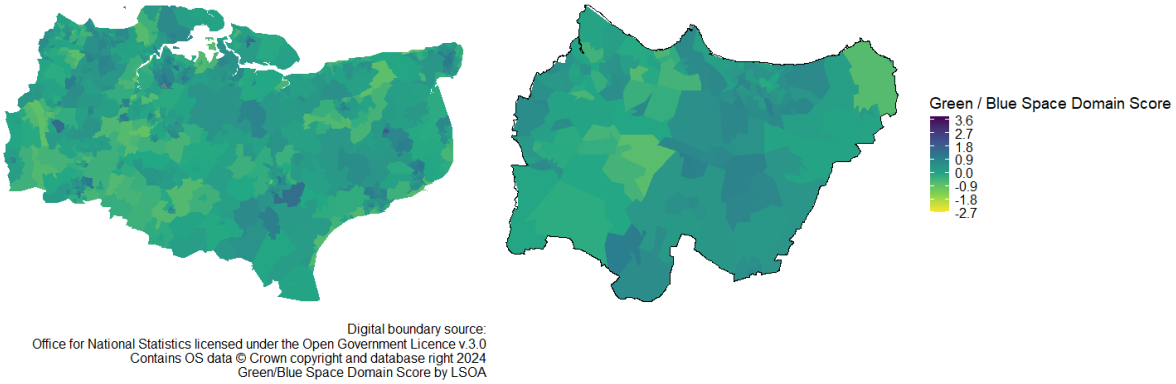


Figure 23: Map of Green/Blue Space Domain Score in Kent (Left) and Dartford, Gravesham, and Swanley (Right), 2024.

Another means through which to explore access to green space is the doorstep standard, accessible greenspace at least 0.5 hectares in size within 200 metres (less than a 5-minute walk). There are a few tightly clustered patches in the HCP where access to greenspace is best, as shown in figure 24. These tend to be in more densely populated areas but not within the urban centres of Dartford and Gravesend.

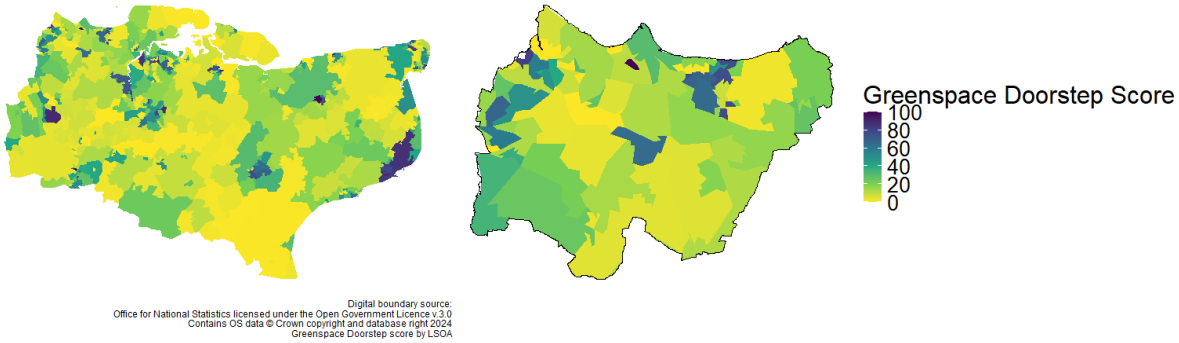


Figure 24: Map of Green Space Doorstep Score in Kent (Left) and Dartford, Gravesham, and Swanley (Right), 2024.

4.7 Air Pollution

The WHO has reported that air pollution is responsible for 4.2 million premature deaths a year. In the UK it is estimated between 29,000 and 43,000 per year, but many more suffer avoidable chronic ill health from air pollution (32). Air pollution disproportionally affects the most vulnerable in society, children, the elderly, pregnant women, and those with existing health issues such as heart or lung conditions. Additionally, those from a less affluent area are also more likely to be exposed to higher levels of air pollution (33).

Particulate matter (PM) is thought to be more harmful than other pollutants, especially PM10 and PM2.5 which refers to particulate matter with a diameter smaller than 10 micrometres and 2.5 micrometres respectively. This is because it can get further into the lungs (34). Annual emissions of PM10 have reduced since 1970 in the UK (32). Current government targets are for PM10 levels to be below 40 µg/m^3 (35). All areas in DGS were below this target in 2024, however, rates are higher in areas such as around the Dartford Tunnel, and Queen Elizabeth II bridge, as shown by figure 25.

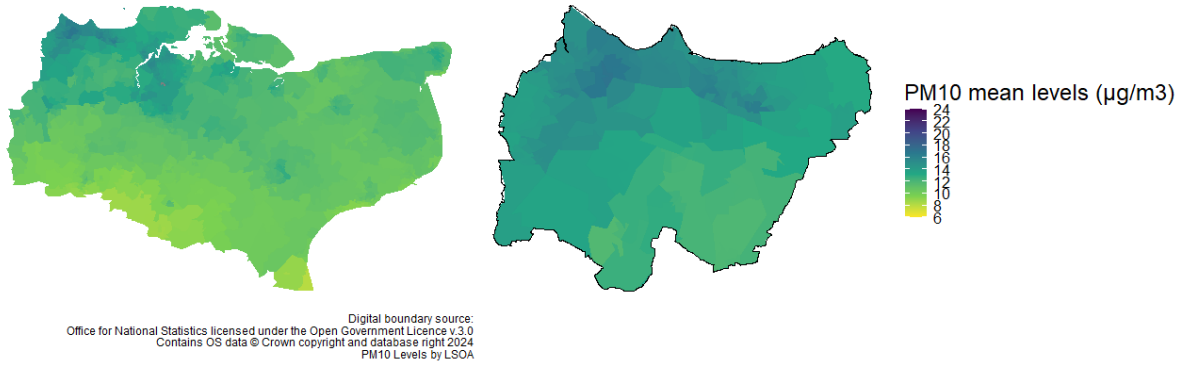


Figure 25: Map of mean Particulate Matter 10 (PM10) levels, moelled by MSOA in Kent (left) and Dartford, Gravesham, and Swanley (right), 2024.

4.8 Climate Change risks

There are many consequences of climate change. The two covered within this HNA are flooding and temperature-related excess deaths.

4.8.1 Flooding

Flooding typically causes more psychological harm due to loss of belongings and abodes, than physical harm (36). However, it can lead to disruptions to services and therefore have a secondary impact on health due to closures (37,38). It can also impact the ability for health care to respond to health crises due to flooding of roads, and impact of chronic condition care do to limiting access to medications (36).

In DGS the flood risk can be assessed using a metric which combines the number of people, critical services (including electricity and water), and the number of non-residential properties to determine a flood risk threshold. A higher number presents a greater risk to infrastructure and people while a lower number presents a lower / no risk if the annual mean surface water level is met. Unsurprisingly areas in DGS that are situated near the river and city centres are at a higher risk of flooding than areas more inland, as shown by figure 26.

Figure 27 shows areas predicted to be below the annual flood level if the current trojectory of climate change continues by 2030. This means that these areas could be at risk of flooding if the same annual rain fall occurs. It is important to note that these predictions are based on current flood risk and the predicted rate of sea level rising due to climate change. Crucially, when compared to figure 26 some of the areas at risk of high harms from flooding overlap woth those areas predicted to have a higher risk of flooding such as north of Dartford town, and east of Gravesend.

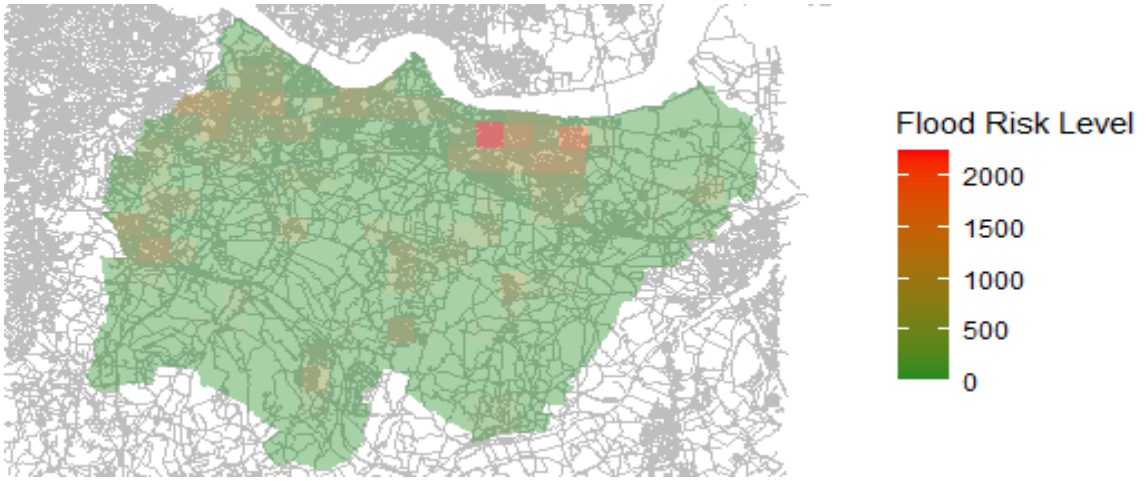


Figure 26: Map of Flood Risk Level for Dartford, Gravesham, and Swanley.

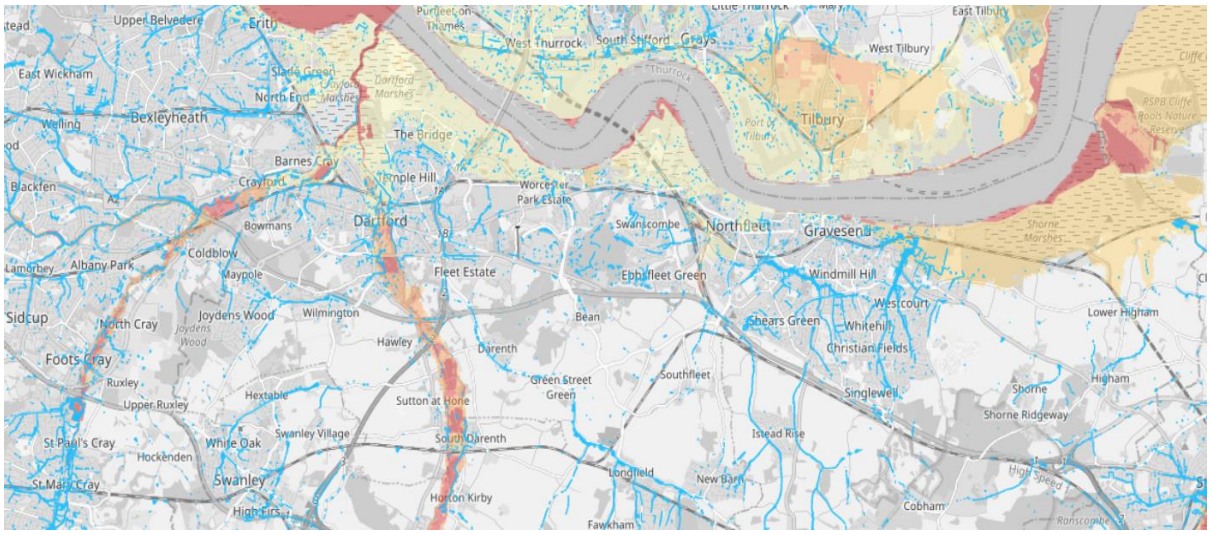


Figure 27: Map of areas predicted to be below the annual flood level by 2030 in Dartford, Gravesham, and Swanley.

4.8.2 Temperature-related excess mortality

Both heat and cold cause excess deaths, deaths beyond the expected number of deaths during a set time period. As shown in table 4, in 2018-2022 low tempteratures caused a higher rate of deaths across the UK than high temperatures. However, due to climate change heat-waves are increasing in intensity, frequency and duration in the UK (39,40). As such, heat-related excess deaths are likely to increase over time and cold-related excess deaths are set to reduce (41). However, as shown in figure 28, this is predicted to be a slow change and deaths due to moderate cold are not predicted to start reducing until 2070 (42). A degree of this may be due to the ageing population, as older adults, particularly those in nursing homes, are more vulnerable

to temperature-related deaths(43). As such, efforts will be required to reduce harms from both low and high temperatures.

Table 4: Number and rate of cold and heat related deaths for regions in England, 2018 – 2022.

English Region	*Estimated cold-related deaths*	*Cold-related deaths per 100,000*	*Estimated heat-related deaths*	*Heat-related deaths per 100,000*
East of England	2,900	9	1,600	5
East Midlands	1,800	7	900	4
London	3,000	7	2,200	5
North East	1,200	9	700	5
North West	3,200	9	800	2
South East	**3,800**	**8**	**1,900**	**4**
South West	2,800	10	1,100	4
West Midlands	2,400	8	1,200	4
Yorkshire & the Humber	1,800	7	900	3

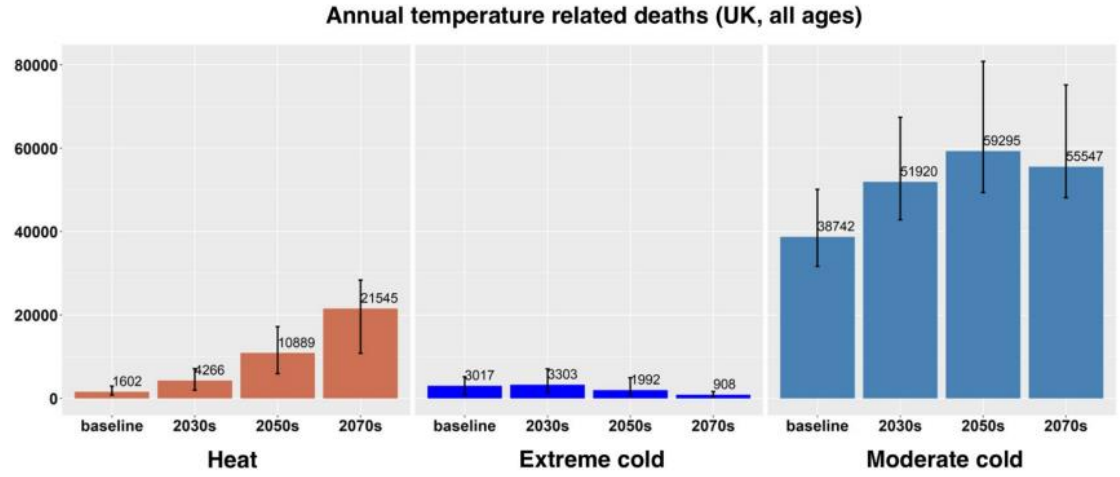


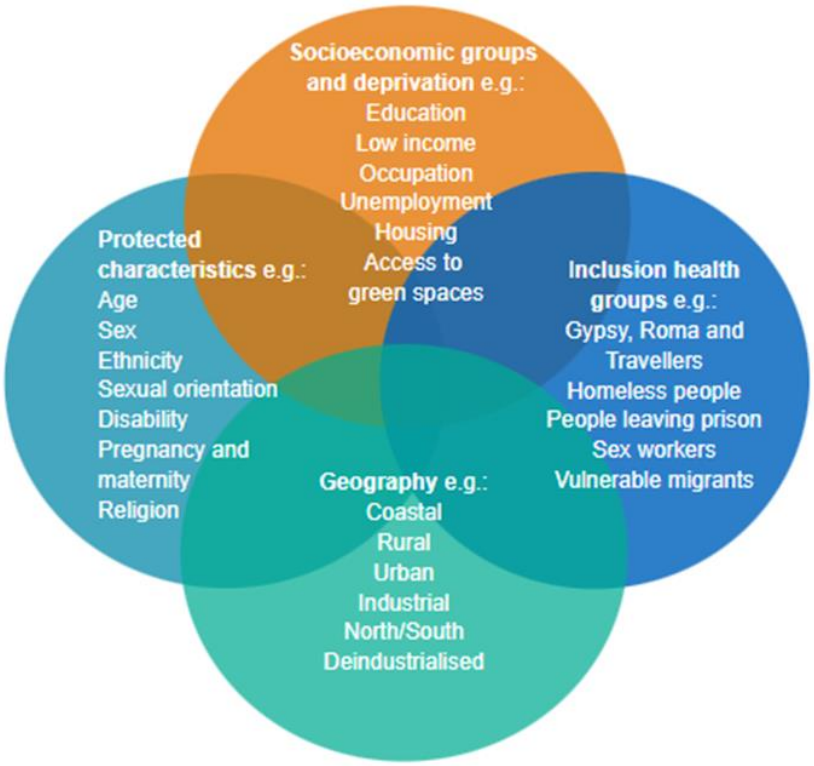
Figure 28: Predicted annual temperature-related deaths in UK, all ages (42).

5 Health Inequalities

Health inequalities encompass variations in health status, life expectancy, and the prevalence of diseases among different socioeconomic groups, ethnicities, and geographic locations.

Inequalities are often rooted in wider determinants of health such as education, employment/income, access to greenspace, and housing. The combination of socio-economic, environmental and demographic factors affects an individual's behaviour and access to care, which ultimately affects health outcomes.

Individuals may experience multiple and intersecting dimensions of inequality, requiring a nuanced and tailored approach. Figure 29 shows the different dimensions of health inequality and how they might overlap.



Source: PHE, LGA and ADPH. COVID-19 Place-based approach to reducing health inequalities. 2020.

Figure 29: The overlapping dimensions of health inequalities (44)

Inclusion health groups typically experience multiple overlapping risk factors for poor health. However, individuals from inclusion health groups are often not accounted for in electronic records; meaning specific, detailed analysis of health inequalities in these groups is not possible unless improvements are made to data capture protocols.

Available data for inclusion health groups shows that compared to the rest of Kent, DGS appears to have a lower rate of rough sleeping and homelessness but a higher rate of Gypsy, Roma, and Traveller populations (Table 5).

Table 5: Rates of rough sleeping, homelessness, and Gypsy, Roma, Traveller population

Inclusion Health Group	DGS	Rest of Kent
Rough sleepers (2023, rate per 10,000 households)	1.1*	1.9
Homelessness (2022/23, total assessments rate per 1,000 households)	14.1*	9.5
Gypsy, Roma, Traveller (2021, rate per 100,000 total population)	554.5	480.1

* Data only available for Dartford and Gravesham districts

Source: Kent Analytics, ONS

The analysis herein focuses on seven dimensions of inequality: age, sex, ethnicity, deprivation, rurality, household overcrowding and access to greenspace.

The following analysis of health inequalities uses a selection of health outcomes to demonstrate how health varies by different dimensions of inequality.

It is important to note that not all dimensions of inequality are considered in this analysis. The availability of data to form a sufficiently sized dataset to enable detailed analysis was an important consideration. It should not be overlooked that there are population groups outside of this analysis that face significant inequality; for example, women with a learning disability die, on average, 23 years younger than women in the general population (45).

The first part of this analysis focuses on socio-economic and demographic dimensions of inequality and how they interact to affect health outcome. For example, depression prevalence is higher in deprived communities, but it is unclear if that is true for males and females, all ethnic groups and all age groups. Deprivation inequality may be moderated by another inequality dimension.

In this first part of the analysis, the interaction between deprivation, age and sex is presented before going on to include ethnicity as a fourth dimension.

The second part of the analysis focuses on socio-environmental dimensions of inequality to explore how deprivation, sex and ethnicity interact with household overcrowding and access to natural greenspace.

There are other interactions between dimensions of inequality as well as with other confounding factors that are beyond the scope of this analysis.

5.1 Socio-economic and Demographic Inequality

5.1.1 Demographics

The composition of the DGS population has previously been discussed in the population chapter of this report. This showed that DGS has a higher proportion of residents from ethnic minority groups compared to the rest of Kent and a younger population. Interestingly, certain dimensions of inequality interact. For instance, the proportion of people in each age group varies by ethnicity and deprivation quintile in the total DGS population, as shown in figure 30. For example, the White ethnic group has a higher proportion of people in the over 65 years age group but over half of the Mixed ethnic group are aged below 30 years old. By deprivation, the least deprived 20% of the population has an age profile skewed more towards older age.

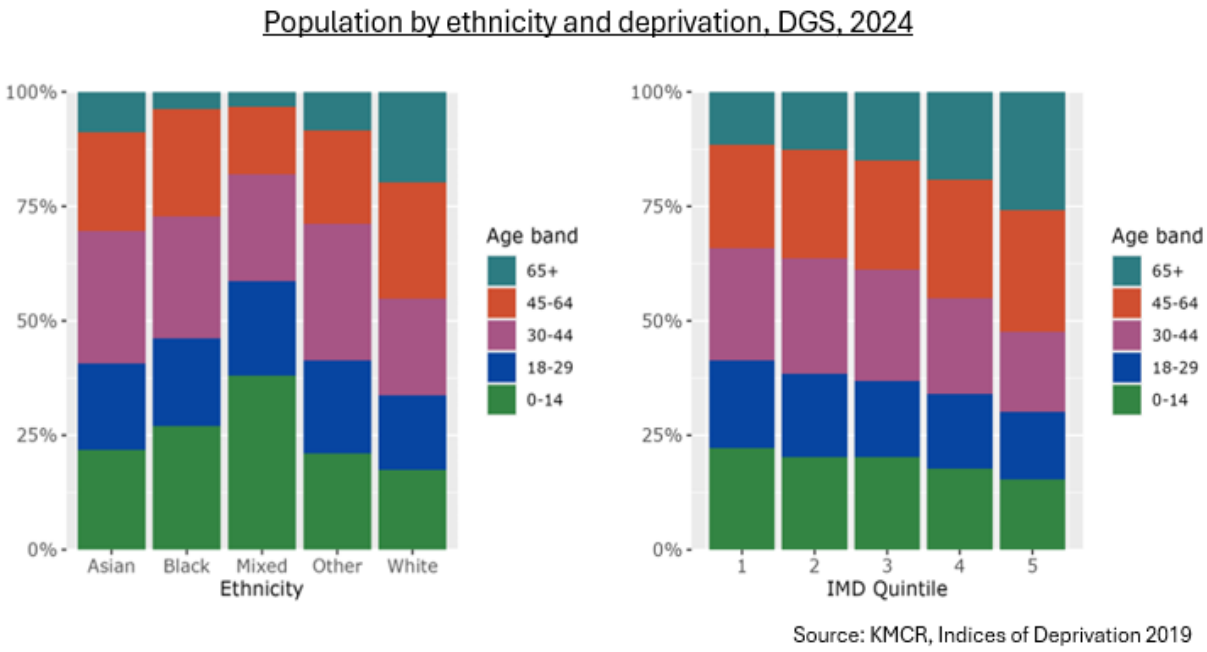


Figure 30: Dartford, Gravesham, and Swanley population proportions by age and ethnicity (left), and age and IMD quintile (right), 2024

There is also an interaction between ethnicity and deprivation. In the White ethnic group, the proportion of the population in each deprivation quintile is roughly equal. In other ethnic groups, a greater proportion of the population is in more deprived quintiles, most notably in the Black ethnic group where 60% of the population is in the two most deprived quintiles, as shown in figure 31.

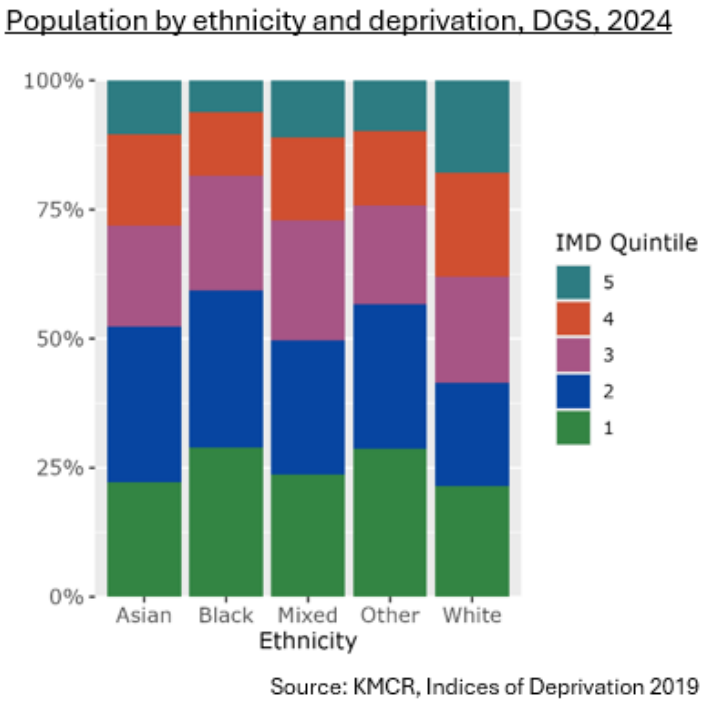


Figure 31: Dartford, Gravesham, and Swanley population proportions by ethnicity and IMD quintile, 2024

5.1.2 Socio-environmental Circumstances

Variations in the socio-environmental circumstances in which people live can affect health outcomes. Rurality, access to natural greenspace and household overcrowding are considered in this analysis, where possible, the interaction with socio-economic and demographic inequality is explored. As discussed previously in this HNA much of the DGS area is rural, however a large swathe in the north and west of the HCP is classified as urban major conurbation. In addition, household overcrowding follows a deprivation gradient: there is a greater proportion of overcrowded households in areas of higher deprivation.

5.1.3 Health Outcome Measures

To measure the inequality in health outcomes for different population groups, a set of outcomes were chosen to represent different segments of the population, different inequality trends, conditions/behaviours more or less amenable to change, and with consideration to the NHS Core20PLUS5 approach to reducing health inequalities. The outcomes used in this analysis are presented in Table 6. A single year of data was used for each outcome.

Table 6: Health outcomes analysed, sources and year of data

Health Outcome	Data Source	Year
People with two or more long-term conditions under the age of 65 years	Kent & Medway Care Record (KMCR)	2024
Emergency hospital admissions for chronic obstructive pulmonary disease (COPD)	NHS Digital	2022/23
Hospital admissions for respiratory conditions in children aged 0-19 years	NHS Digital	2022/23
Excess weight in Year 6	NHS Digital	2022/23
Smoking prevalence aged 16 years plus	KMCR	2024
Hospital admission episodes for alcohol-related conditions	NHS Digital	2022/23
Depression prevalence aged 18 years plus	KMCR	2024
Diabetes prevalence	KMCR	2024
Coronary heart disease (CHD) prevalence	KMCR	2024
Hypertension prevalence	KMCR	2024
Emergency hospital admissions for myocardial infarction (MI)	NHS Digital	2022/23

The analysis of health outcomes by deprivation also includes “deaths of despair” (a combination of deaths from drug misuse, alcoholic liver disease mortality and suicides sourced from primary care mortality database, 2022/23). Patient ethnicity is not recorded in the mortality database, but future analysis of this indicator will include all other inequality dimensions.

5.2 Health Outcomes by Inequality Domain

5.2.1 Inequality by Deprivation

Deprivation has the strongest relationship with health outcomes compared to the other dimensions of inequality; many health outcomes in this analysis are worse for the most deprived 20% of the population compared to the least deprived 20% (Figure 32).

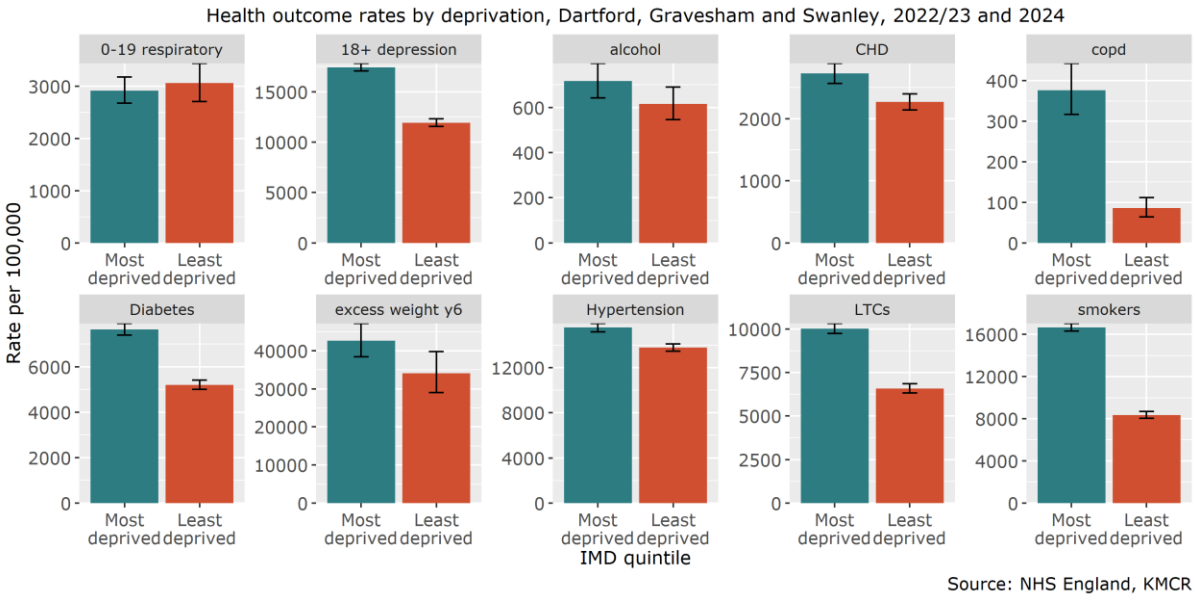


Figure 32: Health outcome rates in most and least deprived quintiles of Dartford, Gravesham, and Swanley HCP, 2022/23 and 2024

Depression prevalence aged 18 years plus

Depression prevalence is higher in females than males in all age groups and peaks in age 45-64 in women in quintiles 1-3 and men in quintiles 2 and 3, as shown in figure 33. The rates of depression are higher in the most deprived than the least deprived, following a social gradient.

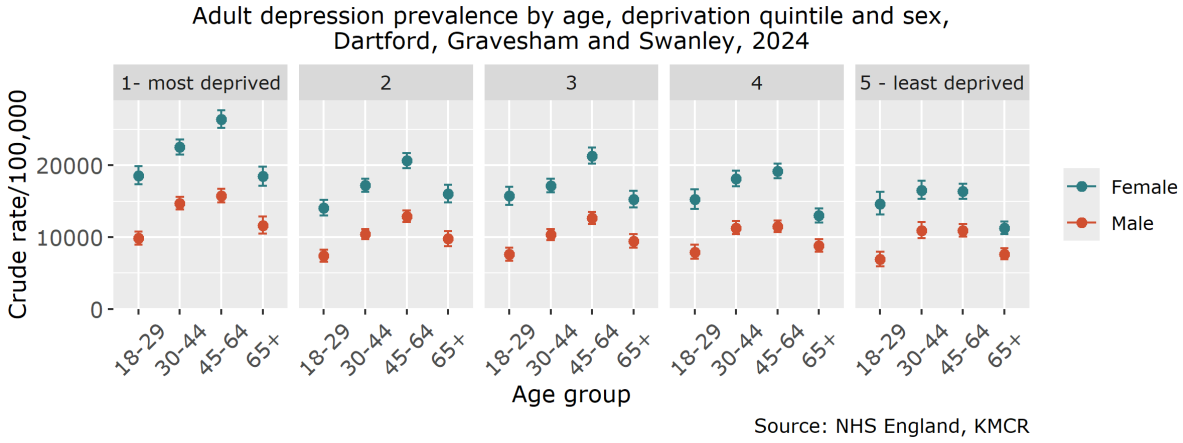


Figure 33: Crude rate of depression prevalence in people aged 18 years plus by age, deprivation, and sex in Dartford, Gravesham, and Swanley HCP, 2024

When the data is standardised for age, the difference in depression prevalence by deprivation and sex become more pronounced, as shown in figure 34, with higher rates in females compared to males, and in the most deprived groups compared to the least deprived groups.

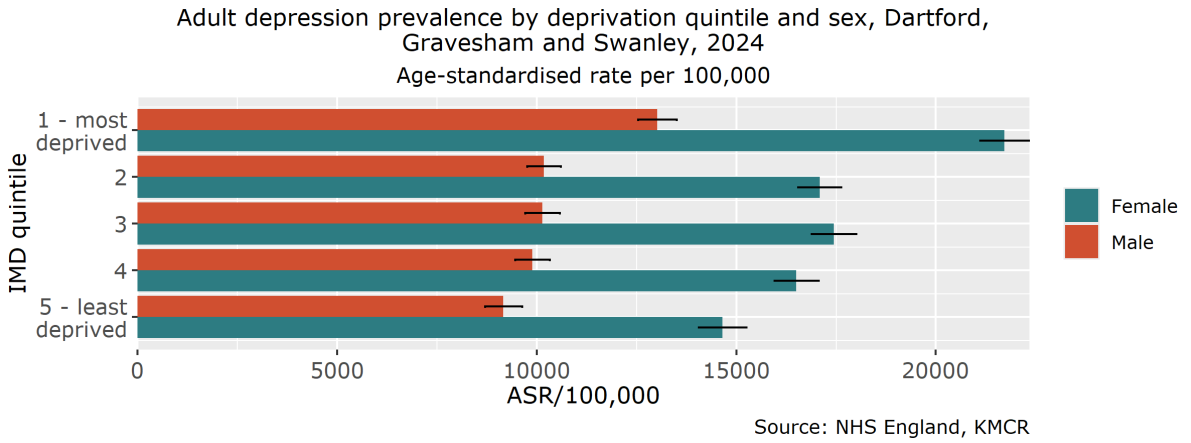


Figure 34: Age-standardised rate of depression prevalence in people aged 18 years plus by deprivation, and sex in Dartford, Gravesham, and Swanley HCP, 2024

Hospital admission episodes for alcohol-related conditions

Admission rates for alcohol-related conditions tend to increase with age for both sexes but this progression occurs at a faster rate for males compared to females, as shown in figure 35. Overlapping confidence intervals reduce the certainty of this observation but it is clear that older age groups and males have higher rates.

Figure 35: Crude rate of hospital admissions for alcohol-related conditions in Dartford, Gravesham, and Swanley HCP, 2022/23

As figure 36 shows, when age is standardised, males tend to have higher rates of admission but there is no significant difference in admission rates by deprivation.

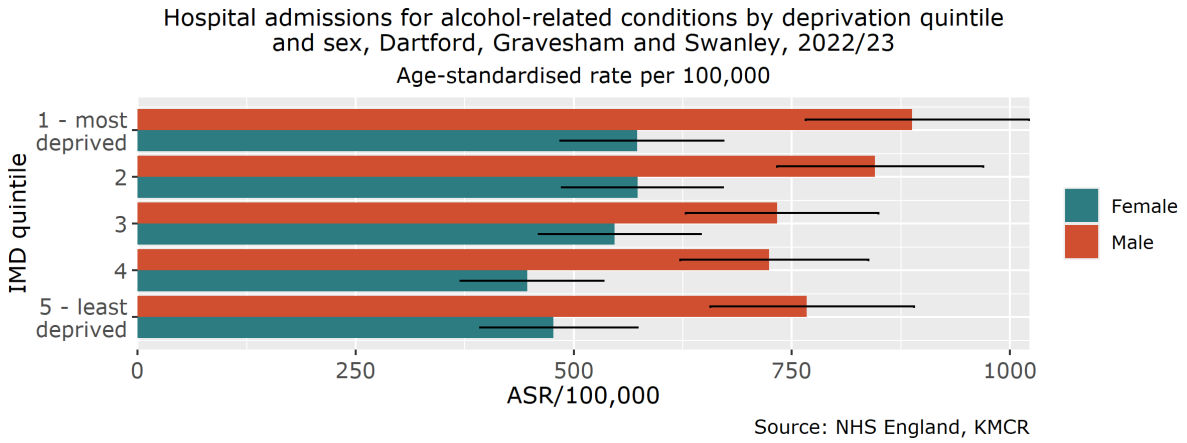


Figure 36: Age-standardised rate of hospital admissions for alcohol-related conditions by deprivation and sex in Dartford, Gravesham, and Swanley HCP, 2022/23

Coronary heart disease (CHD) prevalence

The prevalence of coronary heart disease increases significantly from age 45 and is significantly higher in the 65+ age group. This is true for males and females and all deprivation and ethnic groups. Prevalence in males is approximately three times higher than females and similar across all deprivation groups, as shown in figure 37.

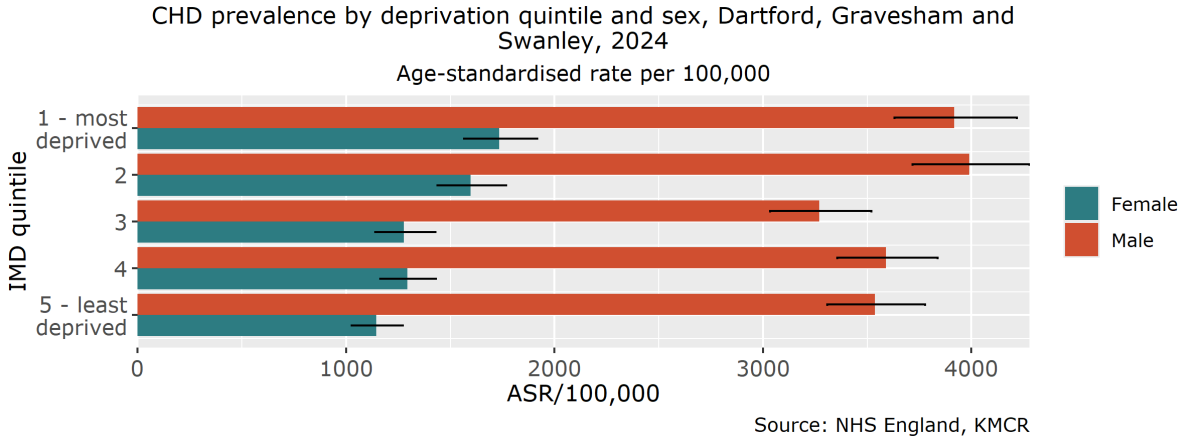


Figure 37: Age-standardised coronary heart disease (CHD) prevalence by deprivation and sex in Dartford, Gravesham, and Swanley HCP, 2024

Emergency hospital admissions for chronic obstructive pulmonary disease (COPD)

Emergency hospital admissions for COPD are almost four times higher in the most deprived 20% of the population compared to the least deprived, as shown in figure 38. This relationship does not appear to be modified by sex or age.

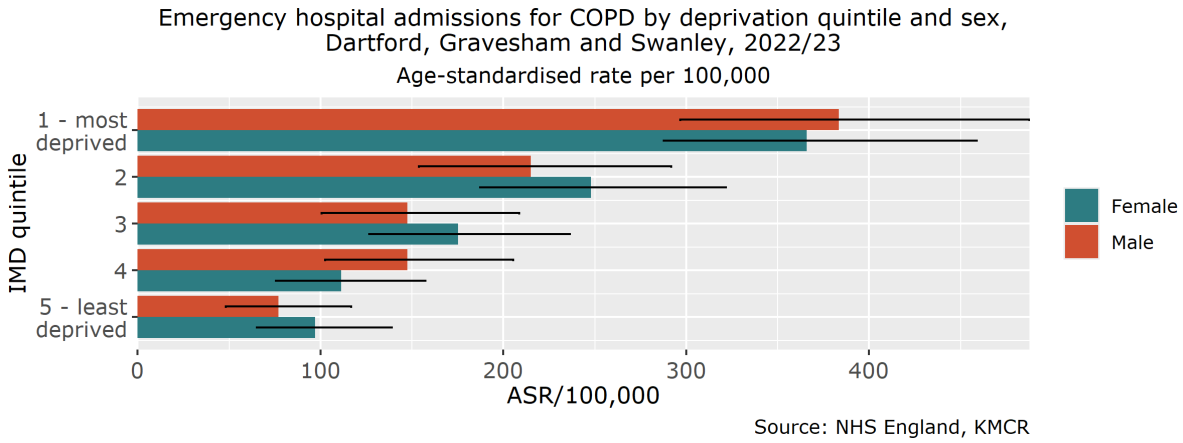


Figure 38: Age-standardised emergency hospital admissions for chronic obstructive pulmonary disease (COPD) by deprivation and sex in Dartford, Gravesham, and Swanley HCP, 2022/23

Diabetes prevalence

Figure 39 shows that people in the most deprived 20% of the population have higher rates of diabetes compared to the least deprived. In addition, males have higher rates than females in every quintile of deprivation.

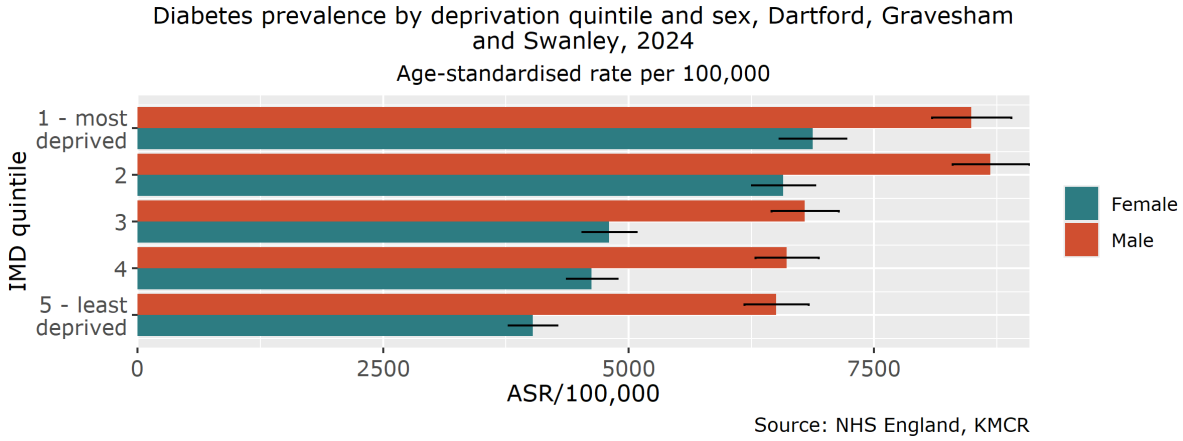


Figure 39: Age-standardised rates of diabetes prevalence by sex and deprivation in Dartford, Gravesham, and Swanley HCP, 2024

Excess weight in Year 6

The proportion of overweight and obese children is higher in the most deprived 20% of the population compared to the least deprived, as shown in figure 40. This relationship is not modified by age or sex.

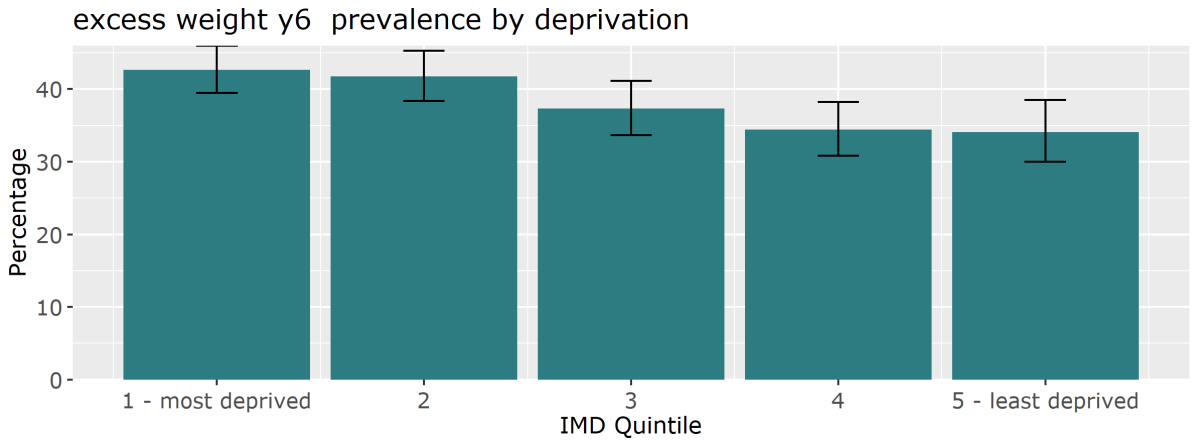


Figure 40: Prevalence of excess weight in Year 6 by deprivation in Dartford, Gravesham, and Swanley HCP, 2022/23

Hypertension prevalence

As shown in figure 41, hypertension prevalence increases with age but rates are similar across deprivation groups and by gender.

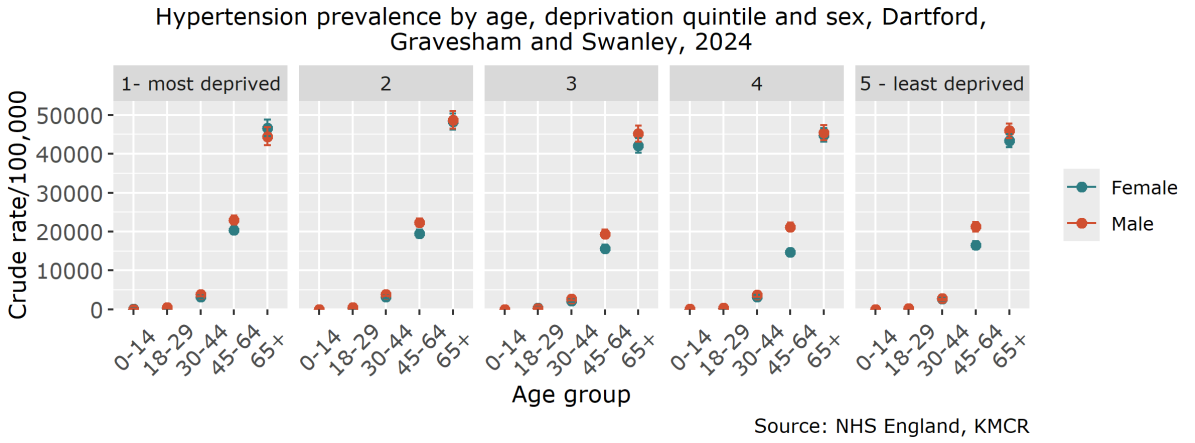


Figure 41: Crude rate of hypertension by age, deprivation and sex in Dartford, Gravesham, and Swanley HCP, 2024

Although hypertension prevalence is similar across deprivation groups, this relationship is modified by gender: rates are similar across all deprivation groups for males but females in the most deprived 20% of the population have significantly higher rates compared to females in the least deprived 20%, as shown in figure 42.

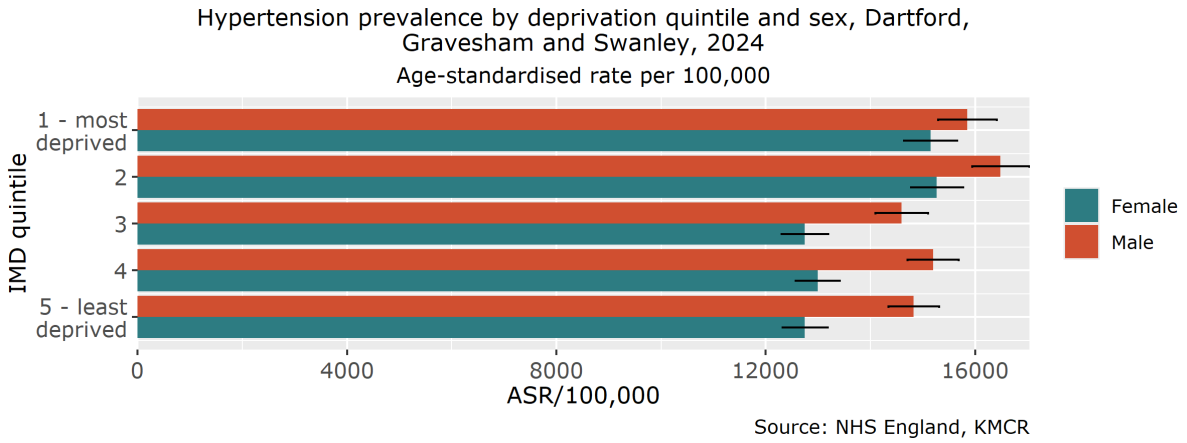


Figure 42: Age-standardised prevalence of hypertension by deprivation and sex in Dartford, Gravesham, and Swanley HCP, 2024

People with two or more long-term conditions under the age of 65

People in the most deprived 20% of the DGS population tend to develop at least two long-term conditions at an early age, as shown in figure 43. In the 45-64 age group, the number of people with at least two long-term conditions is approximately 50% higher in the most deprived compared to the least deprived. The number of females with at least two long-term conditions is higher than males in every age and deprivation group apart from the 45-64 age group where the number of males is higher.

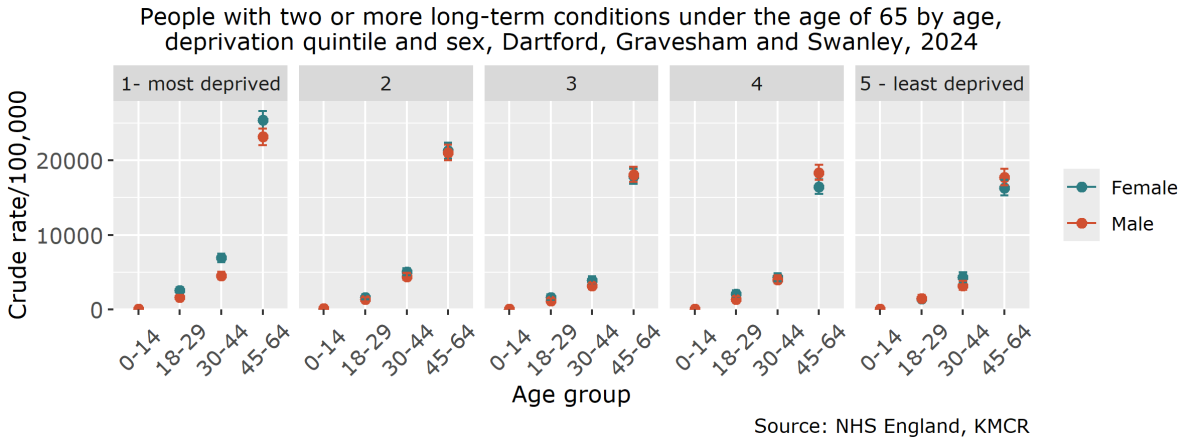


Figure 43: Crude rate of long-term conditions by age, deprivation, and sex, Dartford, Gravesham, and Swanley HCP, 2024

Figure 44 shows that when age is standardised, the number of people with at least two long-term conditions below the age of 65 is considerably higher in the most deprived 20% of the population. There is also a significant difference between males and females in the most deprived that does not exist in the other deprivation quintiles.

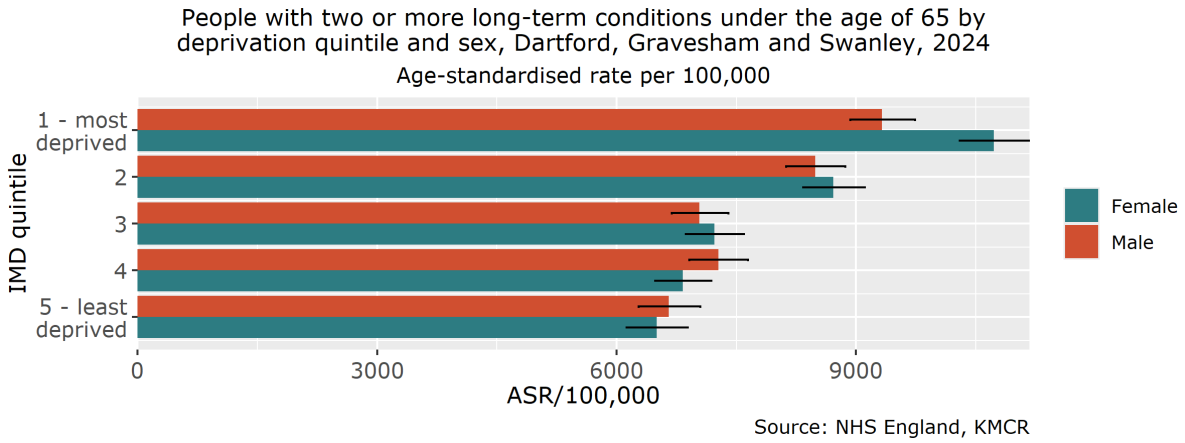


Figure 44: Age-standardised prevalence of long-term conditions by deprivation and sex, Dartford, Gravesham, and Swanley HCP, 2024

Smoking prevalence aged 16 years plus

As shown in figure 45, when smoking prevalence is standardised for age, rates are higher in males than females in every deprivation quintile. In addition, figure 45 shows a clear social gradient with rates in the most deprived 20% of the population nearly double rates in the least deprived 20% of the population.

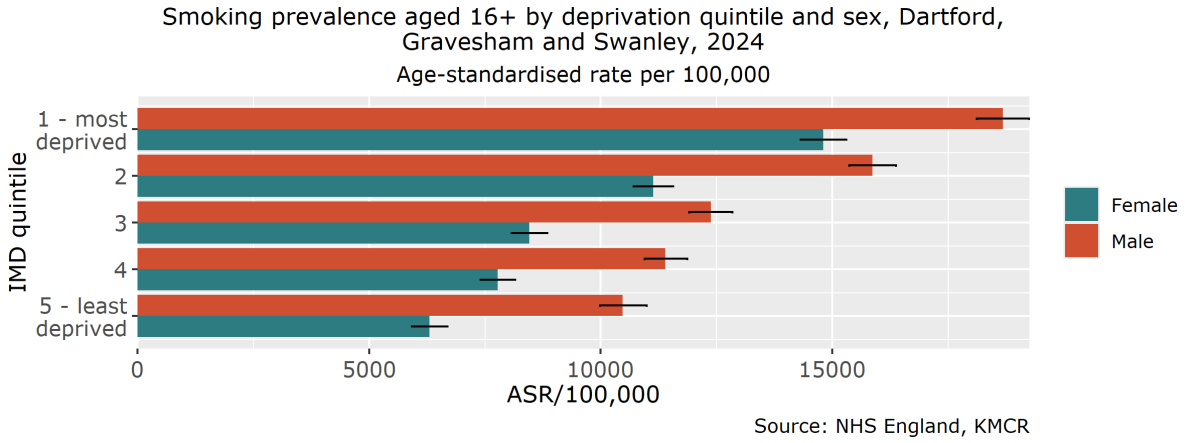


Figure 45: Age-standardised smoking prevalence in those aged 16 years plus by deprivation and sex, Dartford, Gravesham, and Swanley HCP, 2024

Deaths of Despair

There is not a clear deprivation gradient in the rates of deaths of despair but the most deprived 20% of the population has significantly higher rates than the least deprived, as shown in figure 46.

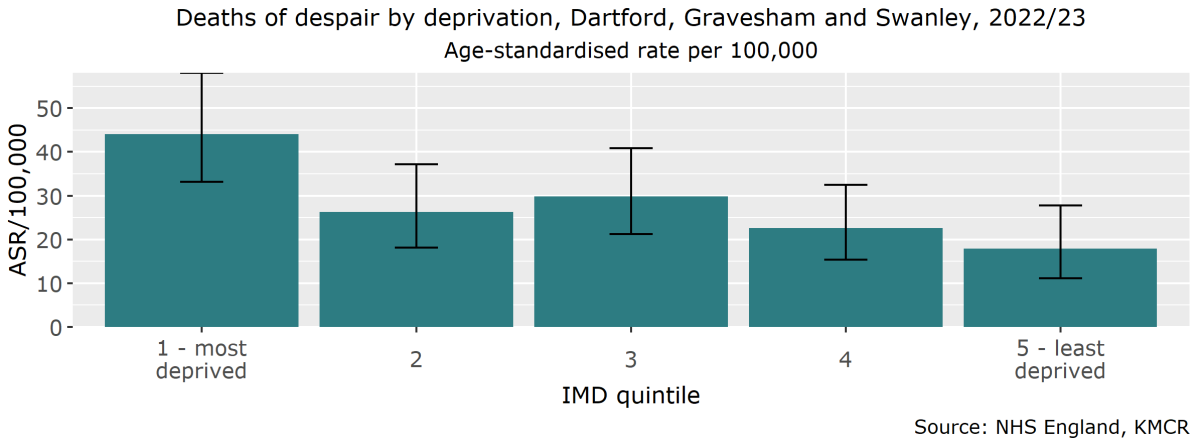


Figure 46: Deaths of despair by deprivation in Dartford, Gravesham, and Swanley HCP, 2022/23

5.2.2 Inequality by Ethnicity

The relationship between health outcomes and ethnicity is not as clear and consistent as it is with deprivation. There are clear differences in rates of some diseases between ethnic groups but there is no consistency in which ethnic group has better or worse rates (Figure 47). Health outcomes for ethnic groups are sometimes modified by deprivation, age and or/sex.

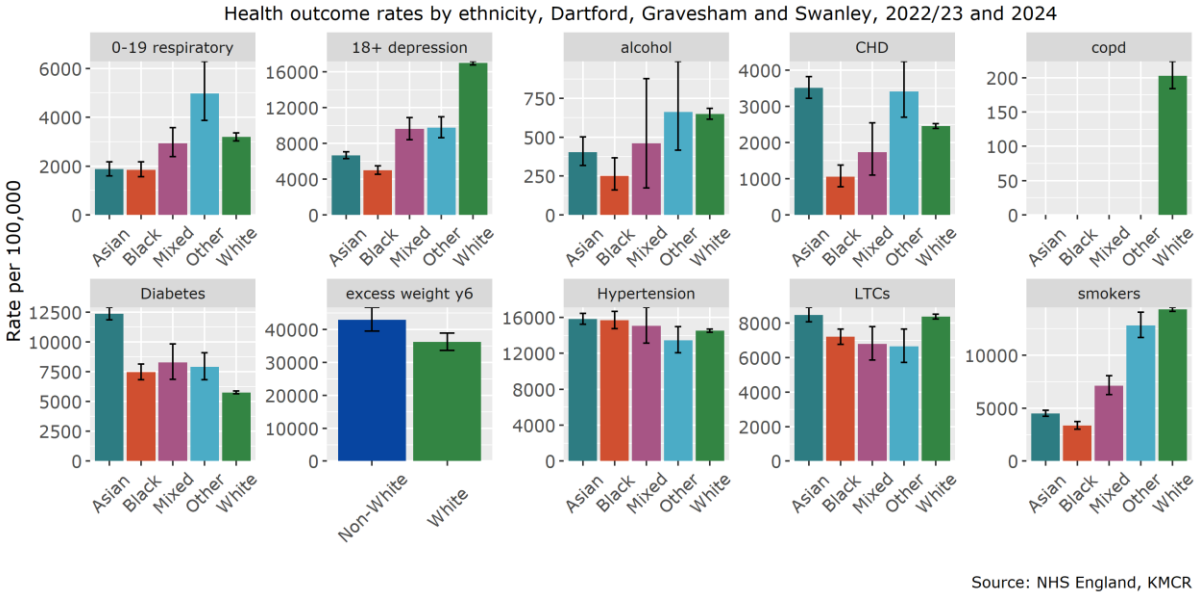


Figure 47: Health outcomes rates by ethnic groups in Dartford, Gravesham, and Swanley HCP, 2022/23 and 2024

<u>Hospital admissions for respiratory conditions in children aged 0-19 years</u>

Emergency admissions for respiratory conditions in children aged 0-19 vary by ethnicity, as shown in figure 48. Children from Other ethnic groups have the highest rates and children from Asian and Black groups have the lowest rates. This relationship is not modified by deprivation, age or sex.

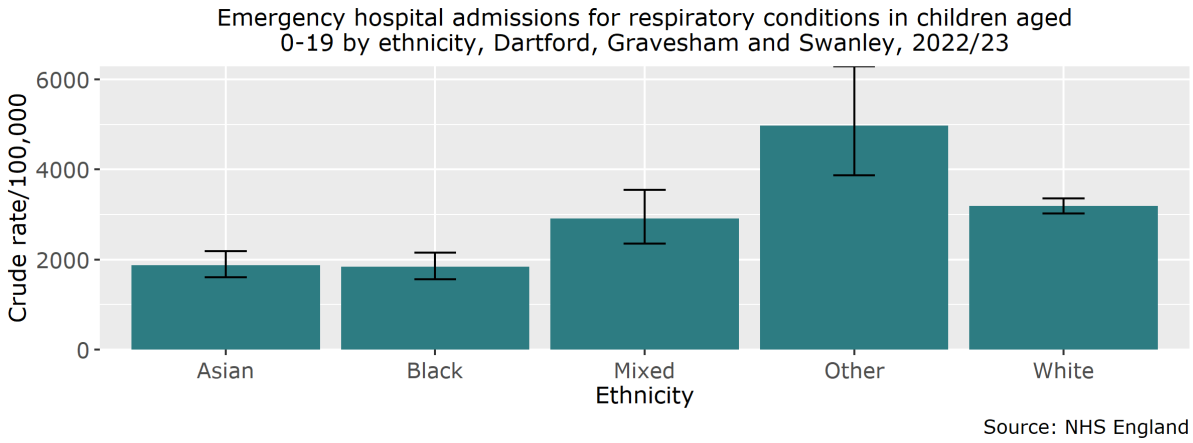


Figure 48: Crude rate of Hospital admissions for respiratory conditions in children aged 0-19 years by ethnicity in Dartford, Gravesham, and Swanley HCP, 2022/23

Depression prevalence aged 18 years plus

Rates of depression are higher in the most deprived 20% of the population but a clear deprivation gradient only appears in the White ethnic group, as shown in figure 49.

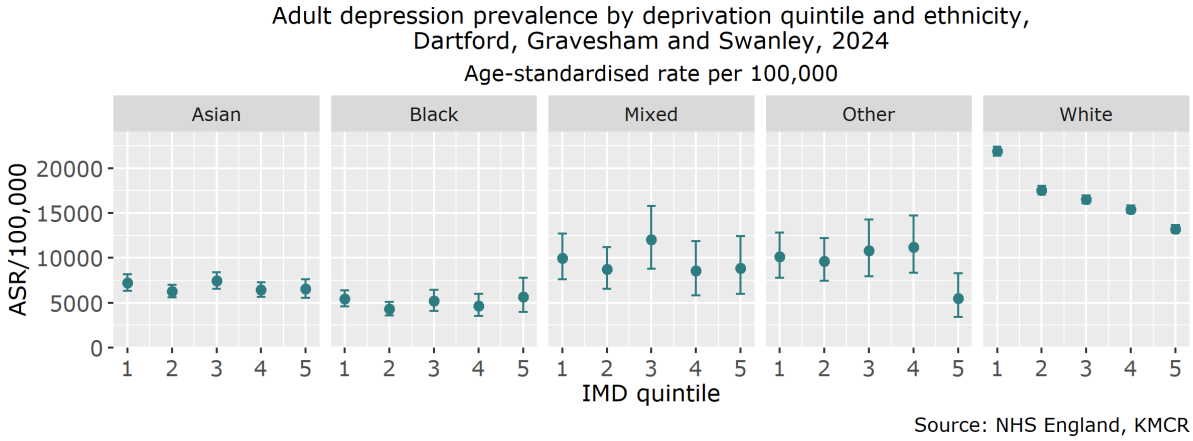


Figure 49: age-standardised rate of depression prevalence aged 18 years plus by deprivation and ethnicity in Dartford, Gravesham, and Swanley HCP, 2024

Rates of depression by age are also modified by ethnicity and deprivation. There are no clear differences in rates for different age groups in the Black, Mixed and Other ethnic groups, as shown in figure 50. The clear progressive change in rates with age that appears in the most deprived group reduces as deprivation reduces such that in the least deprived group, rates are similar across all age groups.

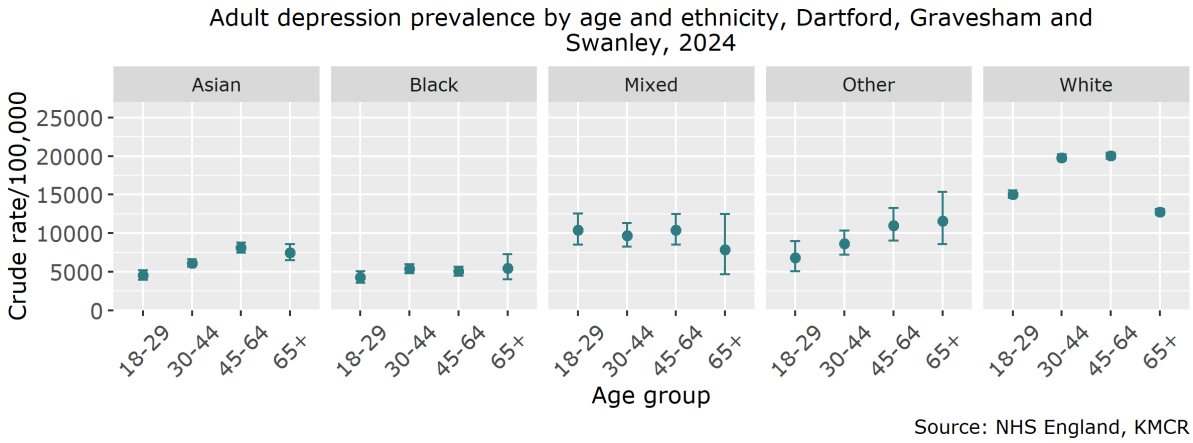


Figure 50: Crude rate of depression prevalence aged 18 years plus by age and ethnicity in Dartford, Gravesham, and Swanley HCP, 2024

Hospital admission episodes for alcohol-related conditions

Figure 51 shows that rates of admissions for alcohol-related conditions are higher in the White ethnic group compared to the Asian and Black groups. This relationship does not appear to be modified by other dimensions of inequality.

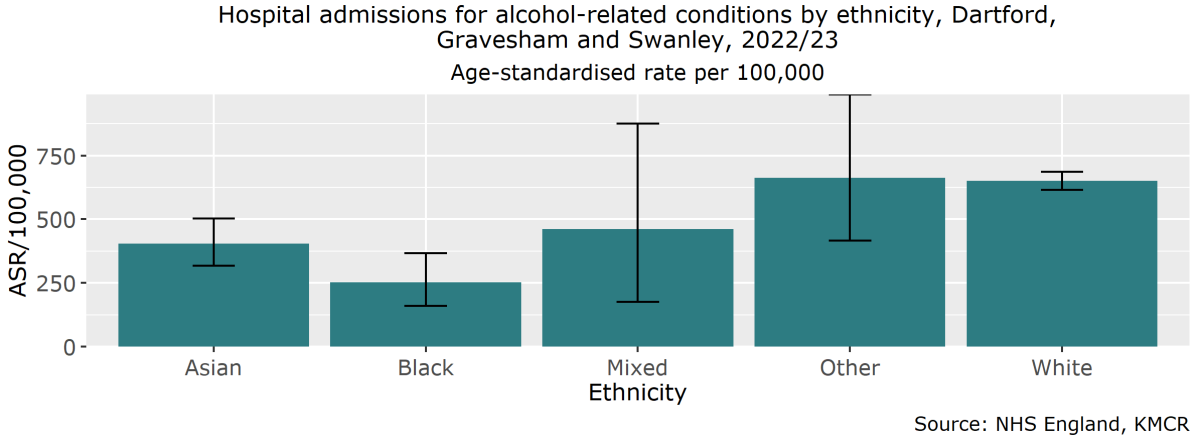


Figure 51: Age-standardised rates of hospital admission episodes for alcohol-related conditions by ethnicity in Dartford, Gravesham, and Swanley HCP, 2022/23

Coronary heart disease (CHD) prevalence

Coronary heart disease prevalence in the Asian ethnic group is higher than the Black and White groups, as shown in figure 52. Males have a much higher prevalence in the Asian and White ethnic groups but in the Black ethnic group, males and females have similar rates. There does not appear to be any interactions with the other dimensions of inequality.

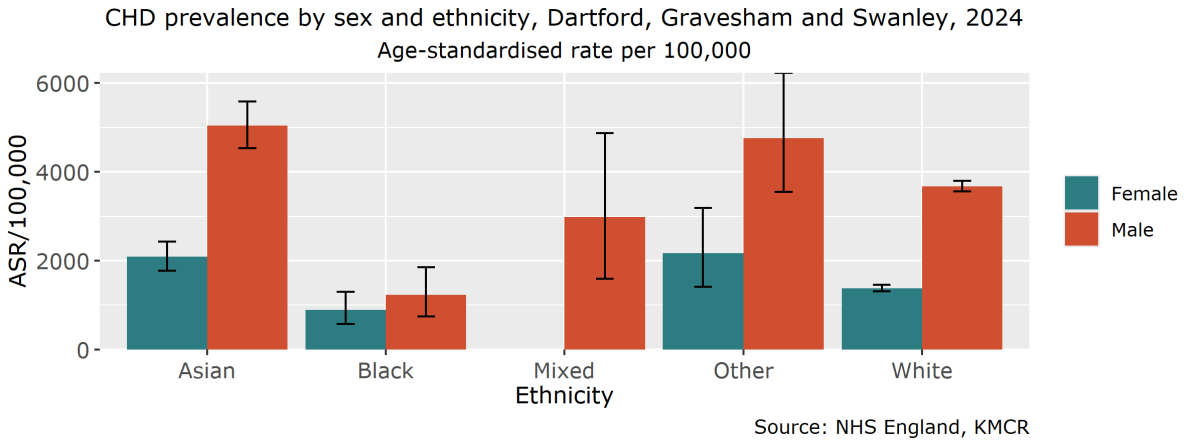


Figure 52: Age-standardised rates of coronary heart disease (CHD) prevalence by sex and ethnicity in Dartford, Gravesham, and Swanley HCP, 2024

Emergency hospital admissions for chronic obstructive pulmonary disease (COPD)

95% of emergency admissions for COPD were for people of White ethnicity. There were fewer than 10 emergency admissions in each of the other ethnic groups. Patient ethnicity was recorded for 97% of COPD admissions.

Diabetes prevalence

The relationship between diabetes prevalence and gender is modified by ethnicity. Males have higher rates than females in the Asian and White ethnic groups but both sexes have similar rates in other ethnic groups, as shown in figure 53.

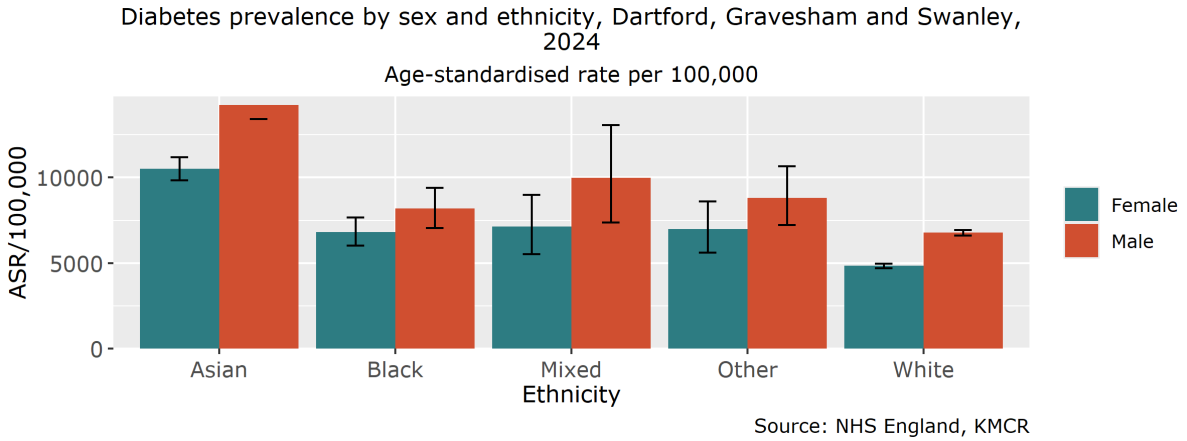


Figure 53: Age-standardised rates of diabetes prevalence by sex and ethnicity in Dartford, Gravesham, and Swanley HCP, 2024

Figure 54 shows that in the White ethnic group, people in the most deprived 20% of the population have higher rates of diabetes compared to the least deprived. However, this deprivation gradient is not clear in other ethnic groups. Rates are highest in the Asian ethnic group.

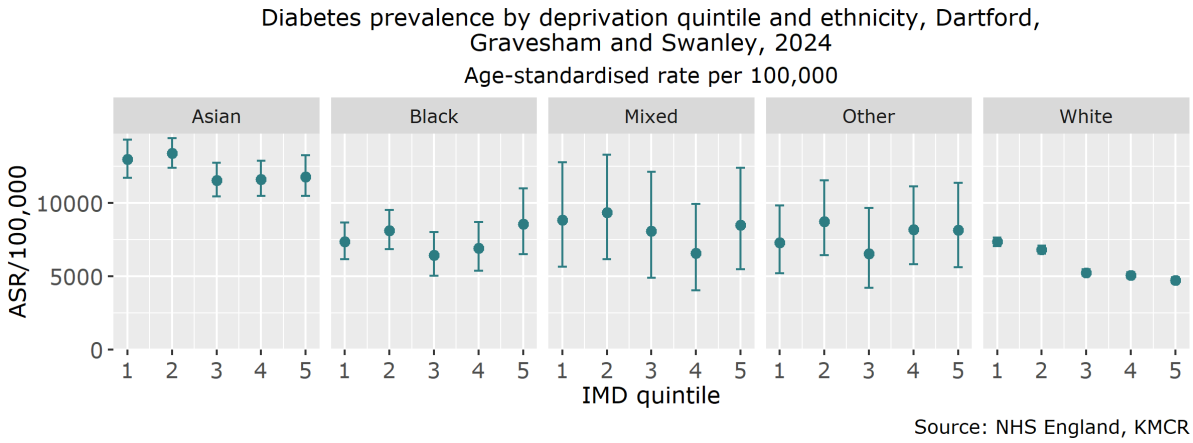


Figure 54: Age-standardised rates of diabetes prevalence by deprivation and ethnicity in Dartford, Gravesham, and Swanley HCP, 2024

Excess weight in Year 6

The proportion of overweight and obese children is higher in non-White ethnic groups compared to White, as shown in figure 55. This relationship is not modified by deprivation, age or sex.

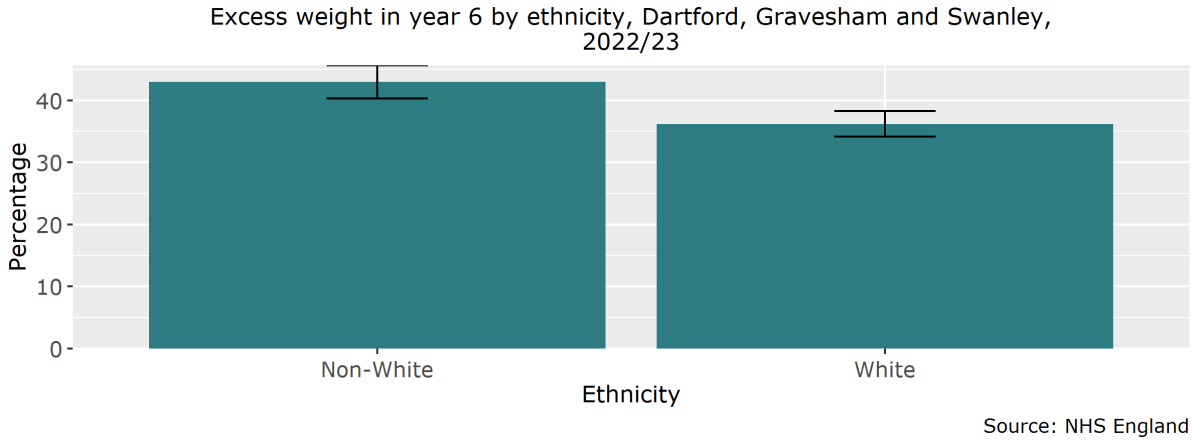


Figure 55: Prevalence of excess weight in Year 6 by ethnicity in Dartford, Gravesham, and Swanley HCP, 2022/23

Hypertension prevalence

Hypertension prevalence does not appear to be modified by ethnicity.

People with two or more long-term conditions under the age of 65 years

White and Asian ethnic groups have slightly higher rates of people with at least two long-term conditions under the age of 65, as shown in figure 56. Ethnicity appears to modify the male-female relationship for the Asian and White ethnic groups. Males have higher rates in the Asian ethnic group whereas females have higher rates in the White ethnic group.

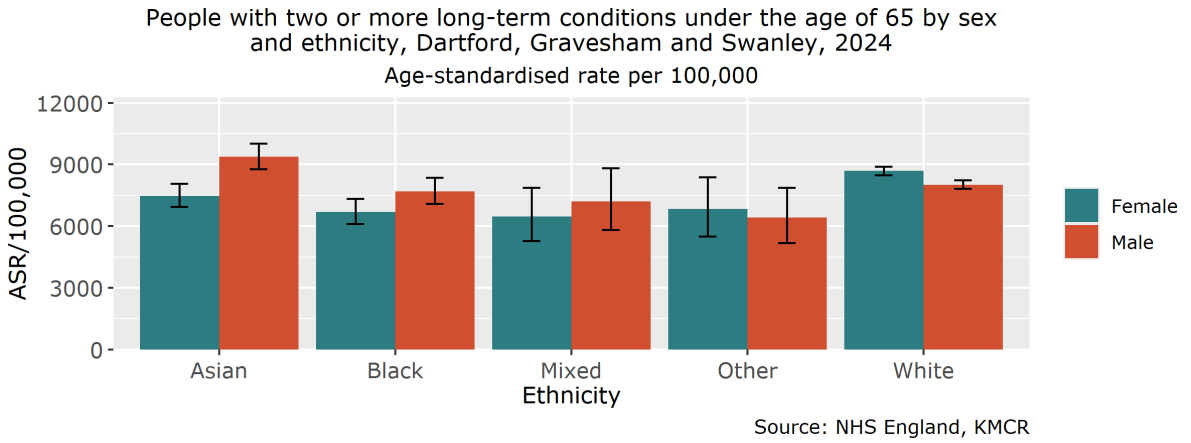


Figure 56: Age-standardised rates of two or more long-term conditions in people under the age of 65 years by sex and ethnicity in Dartford, Gravesham, and Swanley HCP, 2024

Smoking prevalence aged 16 years plus

Smoking prevalence shows similar patterns by age and gender across all deprivation groups, however, ethnicity appears to modify prevalence by age and deprivation. All ethnic groups apart from Black have a significant drop in prevalence in the 65+ age group, as shown in figure 57. In all other age groups, prevalence rates are similar within the Black, Mixed and Other ethnic groups whereas in the Asian and White groups, there are significant differences between age groups.

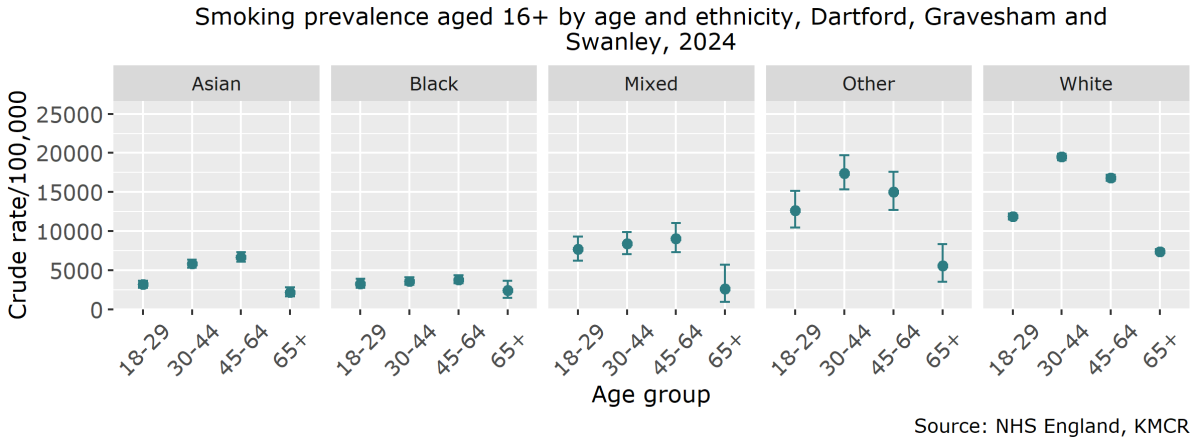


Figure 57: Crude rates of smoking prevalence aged 16 years plus by age and ethnicity in Dartford, Gravesham, and Swanley HCP, 2024

When standardised for age, smoking prevalence is highest in the Other and White ethnic groups, as shown in figure 58. Prevalence is higher in males across all ethnic and deprivation groups. However, the difference between males and females is much lower in the White ethnic group compared to the other ethnic groups.

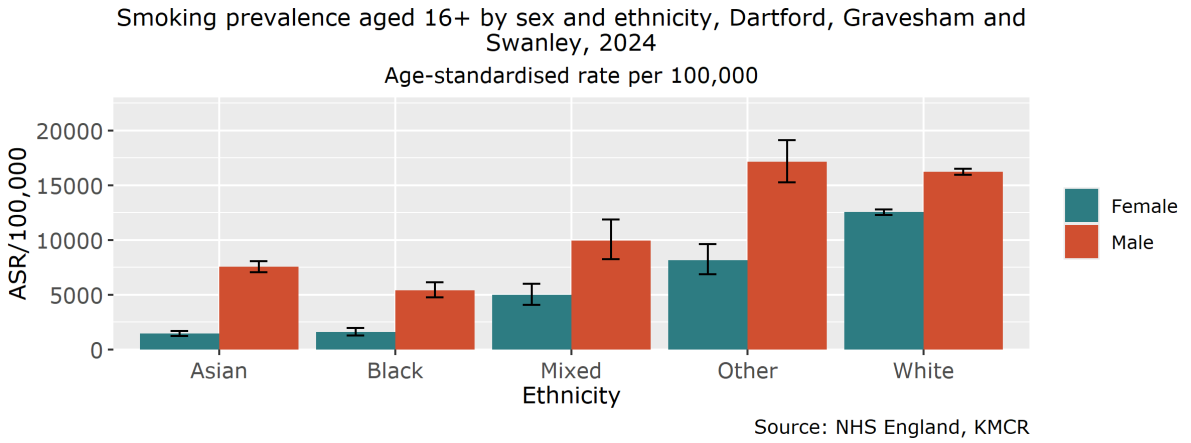


Figure 58: Age-standardised rates of smoking prevalence aged 16 years plus by sex and ethnicity in Dartford, Gravesham, and Swanley HCP, 2024

5.2.3. Inequality by rural-urban classification

There is no clear pattern in health outcomes by rural-urban classification, however, as shown in figure 59, rural village and dispersed tends to have lower prevalence and hospital admission rates than other area types.

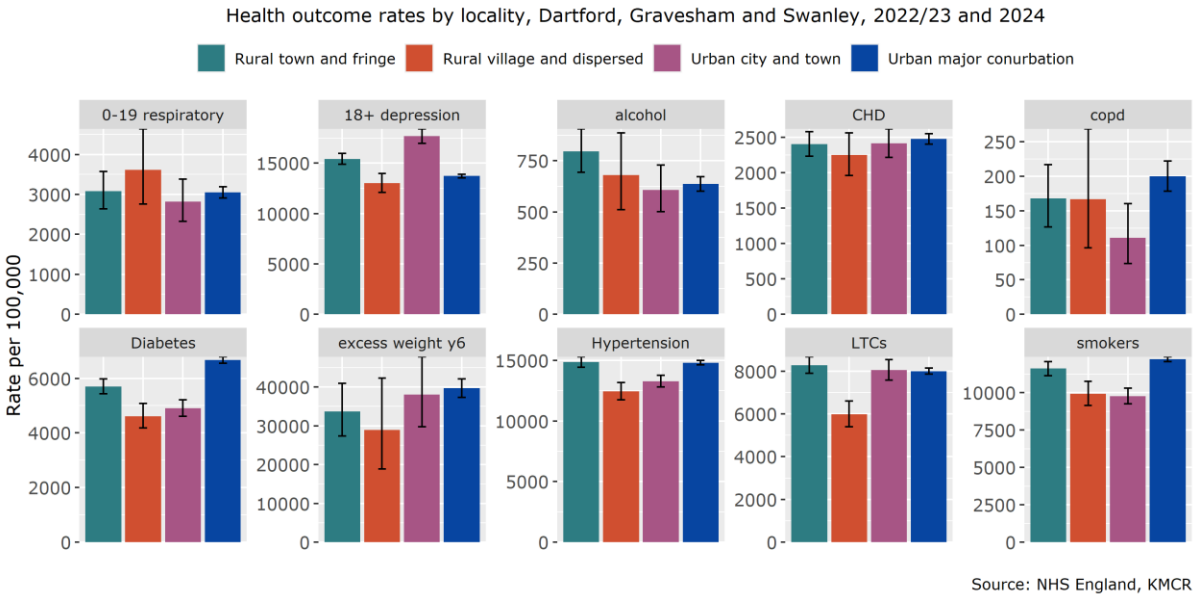


Figure 59: Health outcomes rates by rural-urban classification in Dartford, Gravesham, and Swanley HCP, 2022/23 and 2024

Compared to urban major conurbations, rural town and fringe have higher rates of alcohol-related admissions and depression. However, urban city and town has the highest rates of depression.

There is no variation in rates by rural-urban classification for children's health outcomes (excess weight in year 6 and emergency admissions for respiratory conditions).

For hypertension prevalence, deprivation seems to have a greater effect on prevalence in rural town and fringe populations compared to urban major conurbation populations. This is seen in figure 60 where rates in the most deprived 20% of the population are higher than the least

deprived in rural town and fringe whereas in urban major conurbation populations rates are similar in the most and least deprived.

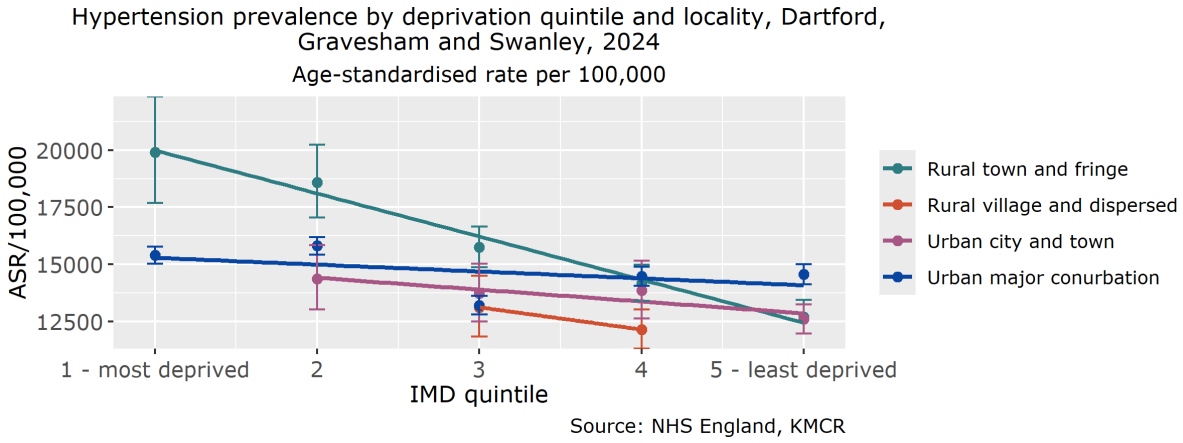


Figure 60: Age-standardised rates of hypertension prevalence by deprivation and rural-urban classification in Dartford, Gravesham, and Swanley HCP, 2024

Most health outcomes show either no relationship with access to greenspace or the expected relationship given the relationship with deprivation i.e. health outcomes that are worse in most deprived areas are also worse in areas with highest greenspace access because greenspace access is highest in more deprived areas.

However, rates of depression are slightly lower where greenspace access is highest despite rates being higher in more deprived areas, as shown in figure 61. This supports the notion that access to greenspace is beneficial for mental health.

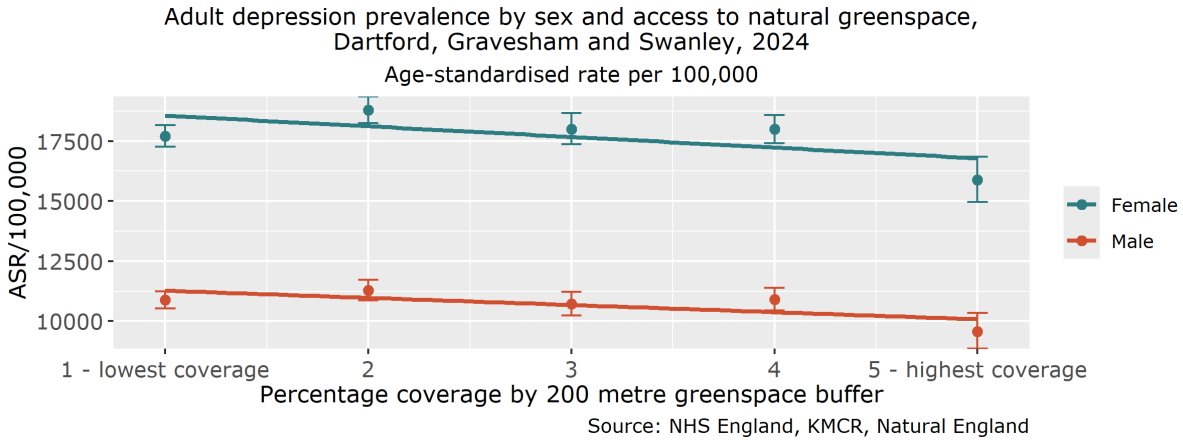


Figure 61: Age-standardised rates of depression prevalence in people aged over 18 years by sex and access to greenspace in Dartford, Gravesham, and Swanley HCP, 2024

This analysis did not find that socio-environmental inequality is modified by ethnicity.

Starting well – overview

Starting well

High fertility rates in Gravesham

General fertility rate (live births/1,000 reproductive aged women):
Gravesham = 61.1, Dartford = 52.6, Kent = 52.6

14.4% 0-4 year olds in absolute low-income

in Gravesham in 2022/23.
Kent = 13.1%
Dartford = 10.3%
Sevenoaks = 8.6%

15.3% 0-19 year olds in absolute low-income

in Gravesham in 2022/23. Statistically significantly higher than **Kent average at 13.6%**
Dartford = 11.6%
Sevenoaks = 10.3%

Gastroenteritis admissions 0-4s higher in 6/7 PCNs

Compared to the Kent average 2020/21-2022/23. This difference is statistically significant. No clear variation by deprivation is seen

Higher rates of emergency admissions in 0-4 year olds

In every PCN in DGS compared to Kent

91.5 per 100,000

Injury related admissions in 0-14, 2020/21-2022/23 significantly higher than the **Kent and Medway average of 71.6 per 100,000**

225 per 10,000

Respiratory admissions in children and young people (0-19), 2018/19- 2022/23
Kent = **128 per 10,000**

Influenza vaccine coverage only around 41%

In 2 and 3 year olds in DGS compared to approximately 48% in Kent and Medway

Significantly higher rates of dental fillings and sealant restorations

in 5-10 year olds in Gravesham and Sevenoaks and in 11-18 year olds in Dartford, Gravesham, and Sevenoaks compared to the Kent average for 2024/25

Highest obesity rates in year 6 students

Gravesham has the highest obesity rates in Kent for Year 6 students and the second highest in reception aged children.

Rates of obesity in Year 6 pupils in the most deprived groups are 300% higher than in the least deprived groups across Kent

Rates of obesity in year 6 are increasing

Vaccine coverage significantly below the WHO target

For every routine childhood vaccine across DGS for 2021/22-2022/23 except

- the pneumococcal vaccine in 12 month olds and,
- all PCNs except LMN and Swanley and Rural PCN in 2 and 5 year olds

Key recommendations

- **Perinatal mental health support**
- **Continuation of a whole systems approach to obesity**
- **Assessment of emergency admissions in 0-4 year olds and high rates of diabetes, epilepsy, and injury-related admissions children and young people**
- **Local insight data on drivers and barriers to breastfeeding, dental care, and vaccine uptake.**
- **Data sharing/linkage**
- **Exploration of asthma medication provision and encourage asthma friendly schools**

6 Starting well – Maternity and Early Child Health (0-4 years)

6.1 Introduction

The 1,001 days from conception until a baby's second birthday is a critical period for growth and cognitive, emotional and physical development. During this period, babies are uniquely susceptible to their environment and are completely reliant on their caregivers. Our experiences in this time shape the adults we will become.

Good parent-infant relationships nurture 'secure attachments' and supports the baby's development and wellbeing throughout childhood and into adulthood. Whereas exposure to adversity, particularly in the absence of good parent-infant relationships, in the 1,001 critical days have negative impact on a baby's development and can have lifelong effects on wellbeing. It is therefore very important that parents and carers get the support they need to help give their babies the best start for life.

6.2 National policies

6.2.1 The Healthy Child Programme

The Healthy Child Programme [HCP], launched in 2009 (46). This remains the national evidence based universal programme for children aged 0-19. The HCP for the early life stages focuses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting

In 2021, Public Health England published the revised Health Visiting model, highlighting high impact areas (46). For early years these are:

1. supporting transition to parenthood and the early weeks
2. supporting maternal and infant mental health
3. supporting breastfeeding (initiation and duration)
4. supporting healthy weight and healthy nutrition
5. improving health literacy; reducing accidents and minor illnesses
6. supporting health, wellbeing and development: Ready to learn, narrowing the 'word gap'

6.2.2 Family Hubs and Start for Life

The Leadsom review 'The Best Start for Life: A vision for the 1,001 Critical Days' recommended focusing policy on the first 1001 days of life, from conception to age two, introducing family hubs, strong leadership, as well as information and support available for families when needed (47).

In April 2022, the government announced investment into family hubs and the Start for Life programme for the creation of a network of family hubs in 75 upper-tier local authorities identified across England. The programme aims to join up and enhance services delivered through transformed family hubs and to ensure that all parents and carers can access the support they need when they need it (48). KCC is 1 of the 75 local authorities taking part in the scheme and are 1 of only 14 trailblazers for the programme.

6.2.3 Core20PLUS5 model

Core20PLUS5 is a national NHS approach to support the reduction of health inequalities at both national and system level. The approach defines a target population group – the 'Core20PLUS' – and identifies 'five' focus clinical areas requiring accelerated improvement. The model for children highlights the need for focus on asthma, diabetes, epilepsy, oral health, and mental health

Further relevant policies can be found in the full 0-4 health need assessment, these include:

- No child left behind… a public health informed approach to improving outcomes for vulnerable children
- Legislation: Working Together to Safeguard Children 2023

6.3 Best Practice

NICE publish a range of guidance for maternal care and care of neonates, infants, children, and young people (49,50). Due to the range of care requirements within these groups no single guidance can be used to encapsulate best practice for this group.

6.4 Epidemiological findings

6.4.1 Mortality rates

Infant (0-1) and child (1-17) mortality rates are only available to Kent level. Infant mortality rates in Kent were similar to England rates from 2014-16 to 2019-21 but in 2020-2022 they were significantly below national rates at 3.3 per 1,000 compared to 3.9 per 1,000. Child mortality rates in Kent have been similar to national rates since 2017-19. In 2020-22 child mortality rate in Kent were 10.7 per 1,000 compared to 10.4 per 1,000 in England.

6.4.2 Fertility rates and Maternity services

Fertility rates have been previously discussed in the population section of this report. As discussed, fertility rates in Gravesham and Dartford are higher than the rest of Kent, therefore maternity service provision needs to be sufficient to match demand. On top of this, services need to be engaging and accessible to those with need. Within DGS just under a third of Gravesham's (31.7%) and Dartford's (32.7%) population did not identify as White British. This is important as women from ethnic minorities experience disparities in maternal and infant mortality rates, perinatal mental health, and receipt of optimum care. In addition, women who live in areas of high deprivation experience higher maternal and neonatal morality.

MBRRACE- UK highlighted that in 2020-22, the risk of maternal death was statistically significantly almost three times higher among women from Black ethnic minority backgrounds and continued to be higher for women from Asian backgrounds when compared to White women (51). In 2022, babies of black ethnicity were more than twice as likely to be stillborn than babies of White ethnicity. Babies of both Asian and Black ethnicity continued to have much higher rates of neonatal mortality than babies of White ethnicity (52).

Perinatal mental health disparities persist among diverse racial and ethnic groups in the UK. Evidence suggests that access to perinatal mental health services varies significantly between women from different ethnic groups (53). This may occur for many reasons, with a variety of barriers identified in the literature which may prevent women from ethnic minorities accessing appropriate care (54,55). For example, women might present with mental health difficulties in different ways to white women and so they remain unacknowledged. Women might experience

stigma and fear of disclosing any mental health difficulties even with family, due to fear of being seen to not be coping and difficulties in medication adherence (54,55).

Women of ethnic minorities, especially migrants, may experience language as a barrier in their maternal care. A report by MBRRACE-UK highlighted that 50% of all contacts with expectant migrant women took place with no documented interpreter provision (56). Consequently, there were missed opportunities for optimal care. This is pertinent to DGS as from 2011/12 – 2020/21 both Dartford and Gravesham had relatively consistent rates of net positive international migration, at around 250 and 400 respectively, with Dartford seeing a peak of 900 in 2021/22.

Finally, national data from MRRACE-UK shows that women in the most deprived areas have a maternal mortality rate over double that of women living in the least deprived areas (51). This difference in outcome by deprivation is also seen for stillbirth and neonatal mortality rates. In 2022 in the UK still birth rates in the most deprived were 4.6 per 1,000 compared to 2.61 per 1,000 in the least deprived. In this same time period neonatal mortality rates (the number of deaths during the first 28 days of life) were 2.38 per 1,000 in the most deprived compared to1.18 per 1,000 in the least deprived (52). This is pertinent for DGS as deprivation and ethnicity appear to interact to impact maternal outcomes and higher rates of deprivation are experienced in those in ethnic minority groups within DGS (52). In addition, higher rates of deprivation are experienced by younger age groups, as shown in the health inequalities section of this HNA. Younger people are also more likely to experience fertility as they are within their fertile years.

6.4.3 Infant Mental Health and Parent Infant Relationships

As discussed, the first 1001 days is a critical period for growth and development which shapes the adults we will become (57). Neuroscientific research has shown that high quality parent-infant relationships with experiences of warm, consistent, and loving care, lead to healthy brain development, the establishment of good immune systems and stress response systems (58,59). In contrast, experiencing adversity in this period is more associated with subsequent difficulties than adversity occurring in other periods over a lifetime (60).

In Kent, approximately 2,937 parent-infant relationships need support each year (61). This need can be influenced by many factors such as housing, poverty, or domestic abuse. One particularly important factor is perinatal mental health difficulties. If parents or carers are experiencing low mood, anxiety, or other mental health difficulties when they are expecting a baby or caring for a baby, this can make it hard for them to meet their baby's social and emotional needs. In Kent it is estimated that 6,663 parents and carers may need perinatal mental health support at a mild-to-moderate level each year (61).

6.4.4 Infant Feeding

The World Health Organization (WHO) and UNICEF recommend that "children initiate breastfeeding within the first hour of birth and be exclusively breastfed for the first 6 months of life – meaning no other foods or liquids are provided, including water. Infants should be breastfed on demand – that is as often as the child wants, day and night. No bottles, teats or pacifiers should be used. From the age of 6 months, children should begin eating safe and adequate complementary foods while continuing to breastfeed for up to two years of age or beyond."(62)

Breastfeeding protects mothers and babies against many illnesses, including breast and ovarian cancer and heart disease in the mother and infectious diseases in infancy such as

gastrointestinal and respiratory infection, diabetes, asthma, heart disease and obesity, as well sudden infant death syndrome (63). In addition to the health benefits of breastfeeding, individuals who were breastfed as babies have stay in school for longer, have a higher academic attainment and a higher income at age 30. The longer a child is breastfed, the greater these effects (64).

In Dartford and Sevenoaks, the percentage of babies who receive breast milk as their first feed is significantly higher than the average for Kent, as shown in figure 62. The percentage in Gravesham is similar to the Kent average at 65% compared to 66%, as such the rate in Gravesham is lower than the other districts in DGS.

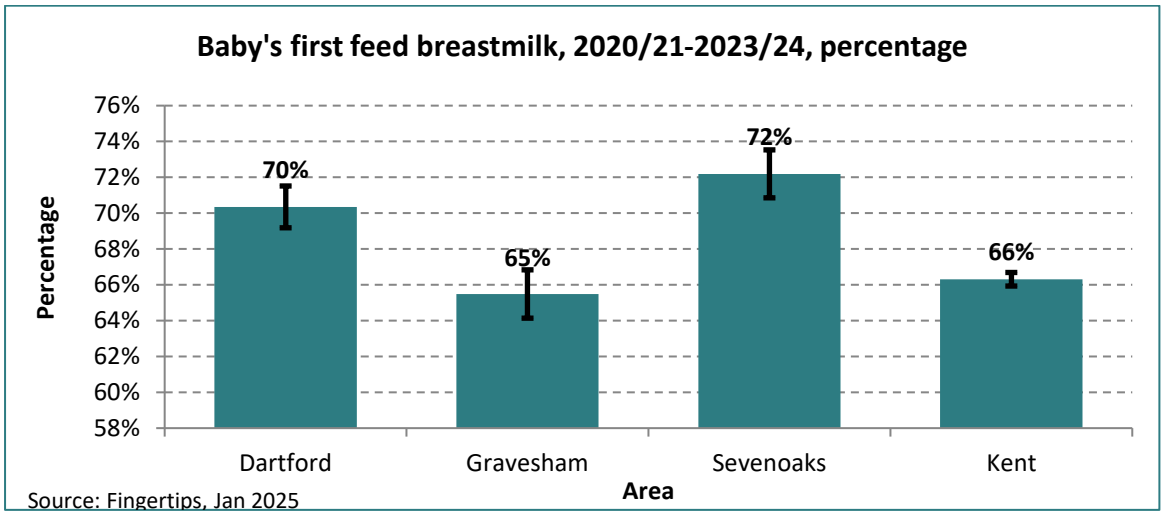


Figure 62: Percentage of babies who received breast milk as their first feed in Dartford, Gravesham, and Swanley compared to Kent, 2020/21 – 2023/24

At 6-8 weeks the prevalence of breast feeding in infants in Dartford, Gravesham, and Sevenoaks appears higher than the Kent average of 51% and the national average of 53%, as shown in Figure 63. Gravesham has seen a relatively steady increase in the proportion of infants who are being breastfed at 6-8 weeks from 2019/20 – 2023/24, whilst rates in Dartford and Sevenoaks have remained stable.

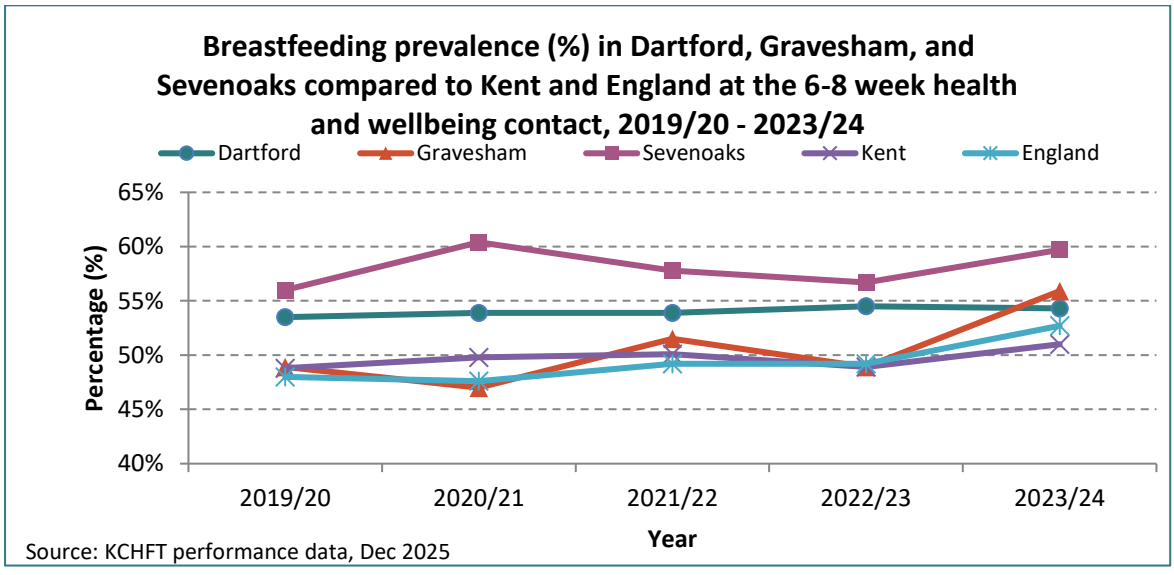


Figure 63: Breastfeeding prevalence (%) in Dartford, Gravesham, and Sevenoaks compared to Kent and England at the 6-8 week health and wellbeing contact, 2019/20 - 2023/24

6.4.5 Child Poverty

Children born into poverty are more likely to suffer from greater health and social inequalities and experience a wide range of health problems including poor nutrition, chronic disease, and mental health issues. Furthermore, children living in poverty are more likely to: die in the first year of life, breathe second-hand smoke, be bottle fed, become overweight, suffer from asthma, have tooth decay, perform poorly at school, and die in an accident. The Kent 0-4 health needs assessment (2022) highlighted the inequalities in uptake of different service provision, service need and health outcomes across Kent for children experiencing income deprivation.

Gravesham has higher rates of childhood poverty than the rest of DGS. 14.4% of children aged 0-4 years lived in absolute low income households in 2022/23, compared to 10.3% in Dartford and 8.6% in Sevenoaks. The rate in Gravesham also appears to be higher than the Kent average of 13.1% during the same time period.

Data for Swanley for 0–4-year-olds is not available, however it is likely that the data for Sevenoaks hides the true picture experienced by children in Swanley. When rates of children in absolute poverty aged 0-19 years are examined for 2020/21-2022/23, as shown in Figure 64, rates in Swanley are similar the Kent average at 14.6% compared to 14.1% respectively. Rates remain highest in Gravesham at 16%.

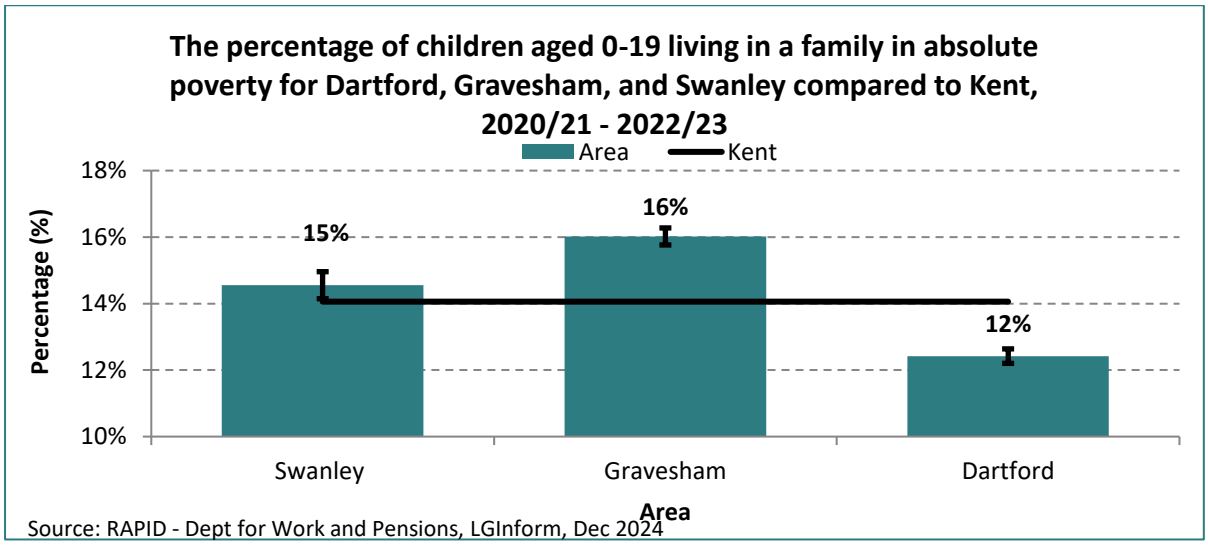


Figure 64: The percentage of children aged 0-19 living in a family in absolute poverty for Dartford, Gravesham, and Swanley compared to Kent, 2020/21 - 2022/23

6.4.6 Vaccine uptake

WHO recommend a 95% target for immunisation coverage to ensure protection from the communicable diseases they aim to prevent (65). Vaccines prevent many potentially fatal diseases such as meningitis and rotavirus and reduce strain on services which occurs during outbreaks (66).

In DGS rates of childhood vaccines for 0–4-year-olds can be assessed at 12 months and 24 months. In 12-month-olds every vaccine except the pneumococcal vaccine (PCV1) are below

the WHO target. In addition, Dartford Model PCN and Gravesend Central PCN have coverage below the Kent and Medway average for every vaccination at 12 months, as shown in figure 65.

Immunisation coverage at 24 months shows a similar picture, only the 6-in-1 vaccine (DTaP/IPV/Hib(Hep)) had rates statistically similar to the 95% WHO target and this is restricted to the LMN PCN and Swanley and Rural PCN, as shown in figure 66. All other vaccines in every PCN in DGS are below the 95% target. In addition, Dartford Model PCN remains significantly below the Kent average for all vaccines monitored at 24 months.

In addition to routine vaccines, influenza vaccines should be offered to all children aged 2 and 3 unless contraindicated. The WHO target for influenza vaccine coverage is lower at 75% (67). Across DGS coverage was approximately 41% from 2021/22-2023/24 in both 2 and 3-year-olds, as shown in figure 67.

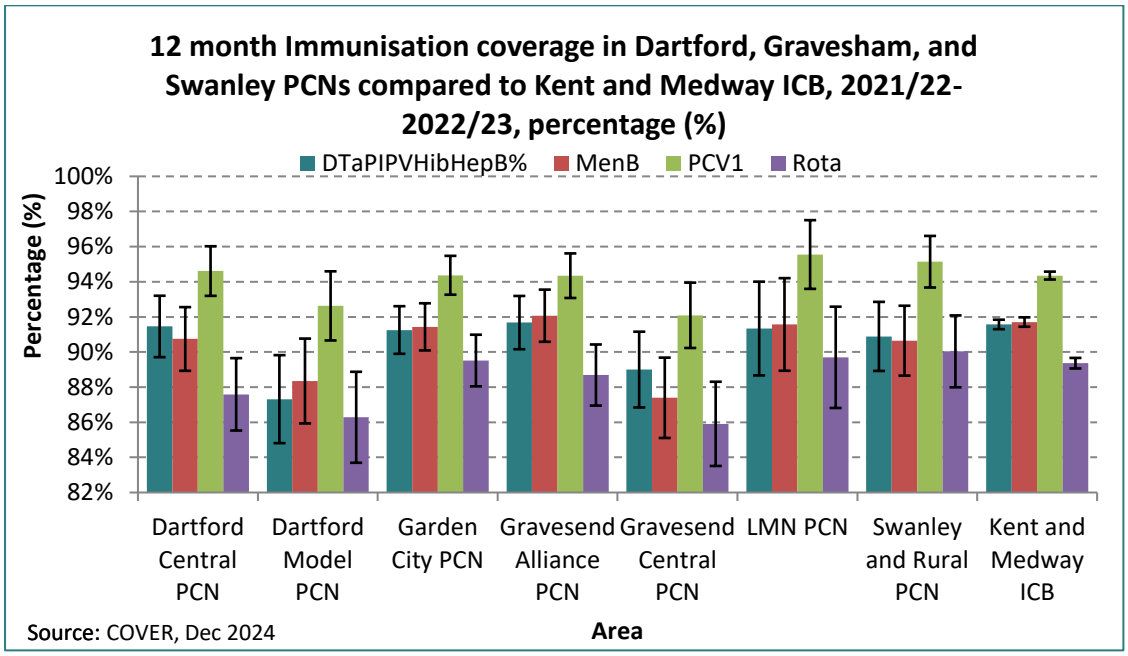


Figure 65: 12 month Immunisation coverage in Dartford, Gravesham, and Swanley PCNs compared to Kent and Medway ICB, 2021/22-2022/23, percentage (%)

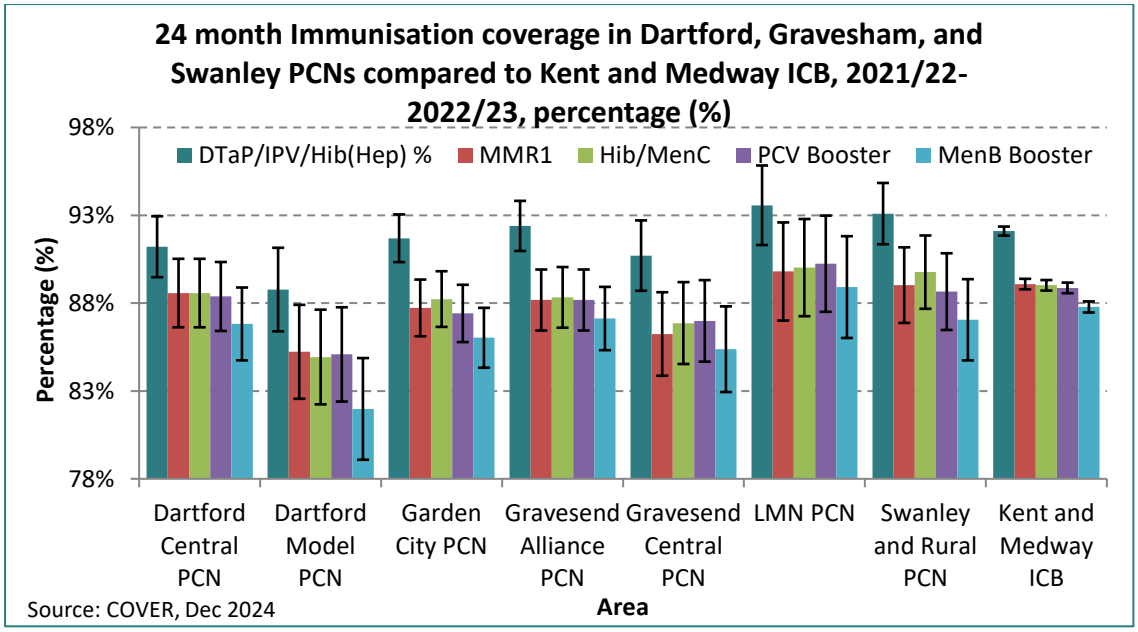


Figure 66: 24 month Immunisation coverage in Dartford, Gravesham, and Swanley PCNs compared to Kent and Medway ICB, 2021/22-2022/23, percentage (%)

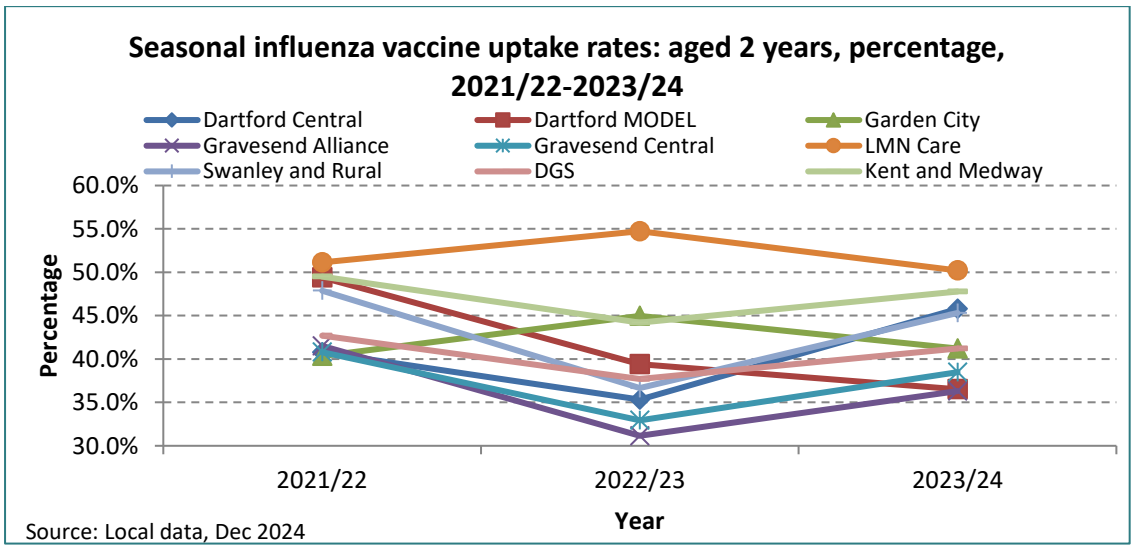


Figure 67: Seasonal influenza vaccine uptake rates in Dartford, Gravesham, and Swanley compared to Kent: aged 2 years, percentage, 2021/22-2023/24

6.4.7 Emergency department attendances and emergency admissions

Figure 68 shows that in DGS rates of Emergency Department (ED) attendance in 0–4-year-olds appears to be highest in Gravesend central PCN at 9084 per 100,000.

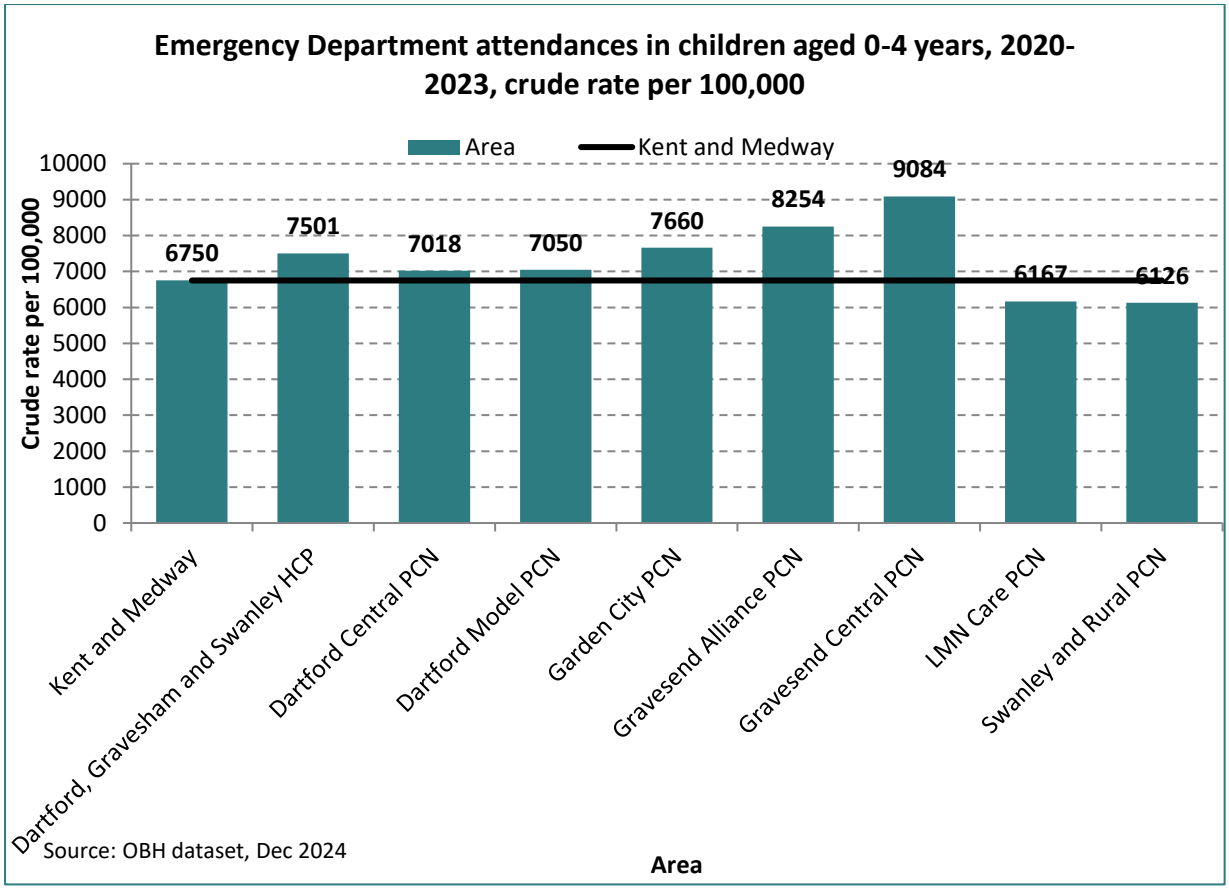


Figure 68: Emergency Department attendances in children aged 0-4 years, 2020-2023, crude rate per 100,000

All PCNs in DGS had significantly higher rates of emergency admissions than the Kent and England average, as shown in figure 69. Interestingly the rate of emergency admissions was Garden City PCN and Dartford Central PCN at 224 per 1,000 and 209 per 1,000 respectively. Admissions in Gravesend Central PCN were actually one of the lowest out of DGS. This difference may indicate differing service use rather than high emergency need in Gravesend Central PCN. This may be due to parents being unable to access their GP in a timely manner, or self-referring directly to ED.

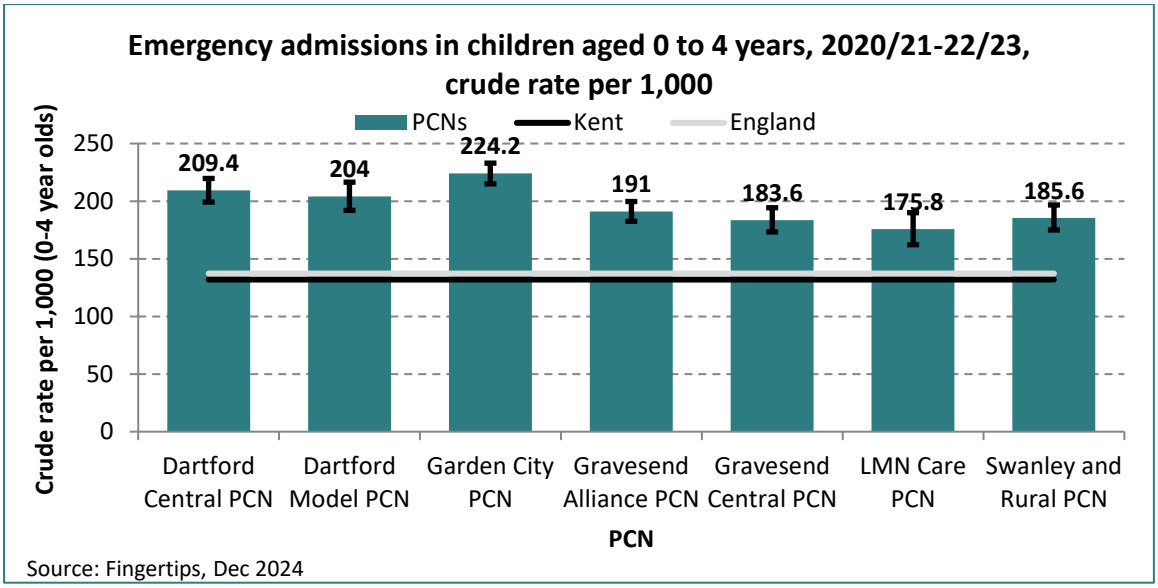


Figure 69: Emergency admissions (0 to 4 years) - registered population 2020/21-22/23, crude rate per 1,000

6.4.8 Emergency admissions for respiratory conditions

Respiratory admissions in children aged 0-19 years have been discussed in the 5-19 year olds section of this HNA.

6.4.9 Emergency admissions for gastroenteritis

Gastroenteritis is a transient infection of the digestive tract which can cause diarrhoea and vomiting. Infants and young children are at a higher risk of complications from gastroenteritis, these include dehydration, meningitis, and sepsis (68). Systematic reviews link gastroenteritis to overcrowding, and children from Asian ethnic groups (69,70). In addition, one of the main causative agents is rotavirus, therefore low vaccination levels may lead to the population being vulnerable to gastroenteritis (71).

In DGS the rate of emergency admissions for gastroenteritis amongst 0–4-year-olds over a three-year time period (2020/21-2022/23) is higher than the Kent average in every PCN except LMN PCN, as shown in figure 70. Little variation is seen across deprivation quintiles within DGS with no clear social gradient.

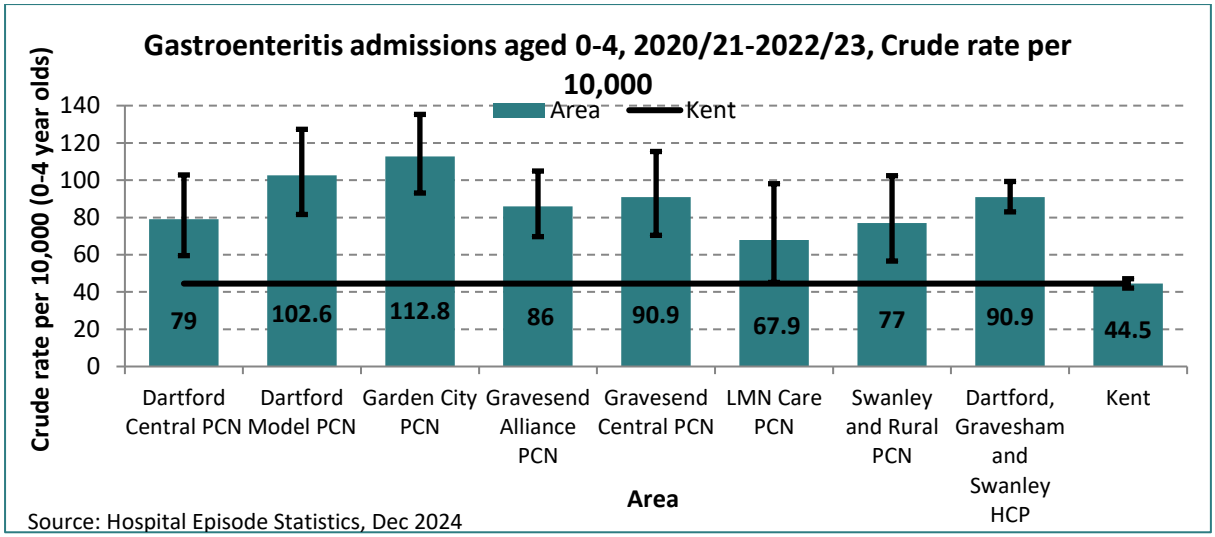


Figure 70: Gastroenteritis admissions aged 0-4, 2020/21-2022/23, Crude rate per 10,000

6.4.10 Oral Health

Tooth decay is preventable but continues to be the most common oral disease in children. Primary teeth offer less protection from bacteria compared to permanent teeth and decay can be associated with recurrent consumption of sugary drinks through bottles or supping cups. Once poor oral health occurs it can affect a child's ability to eat, speak, sleep and socialise due to pain or discomfort. To prevent this and protect oral health, it is key that children brush with fluoride toothpaste, attend appropriate dental care, and have restriction on their intake of sugary foods and drinks.

In DGS, especially in Gravesham, the rate of dental treatment and extractions in children aged 0-4 appears to have improved from 2021/22 to 2024/25 with rates now similar to Kent, as shown in figures 71 and 72.

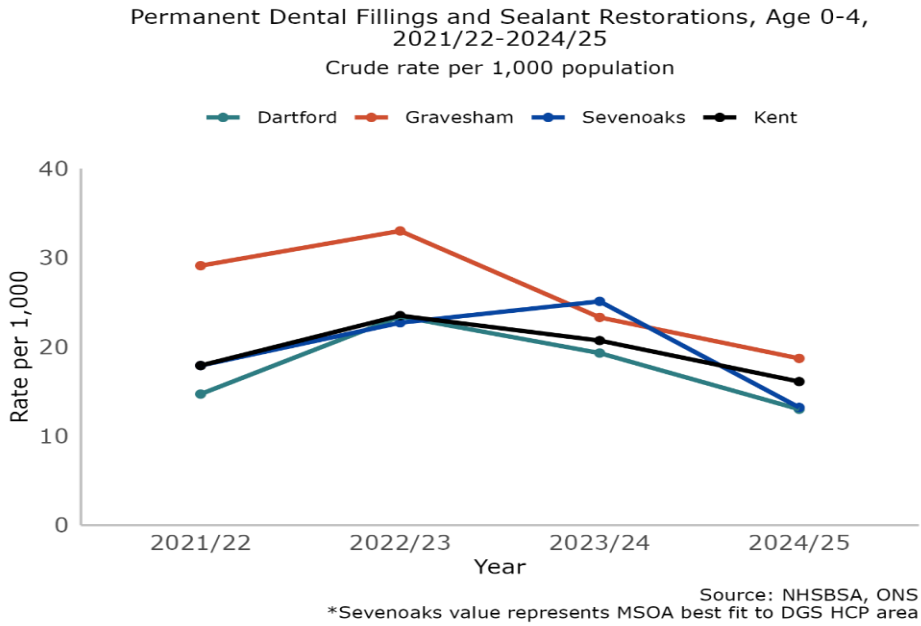


Figure 71: Rate of Permanent Dental Fillings and Sealant Restorations in Dartford, Gravesham and Swanley HCP and Kent, 0 to 4 Year Olds, 2021-22 to 2024-25

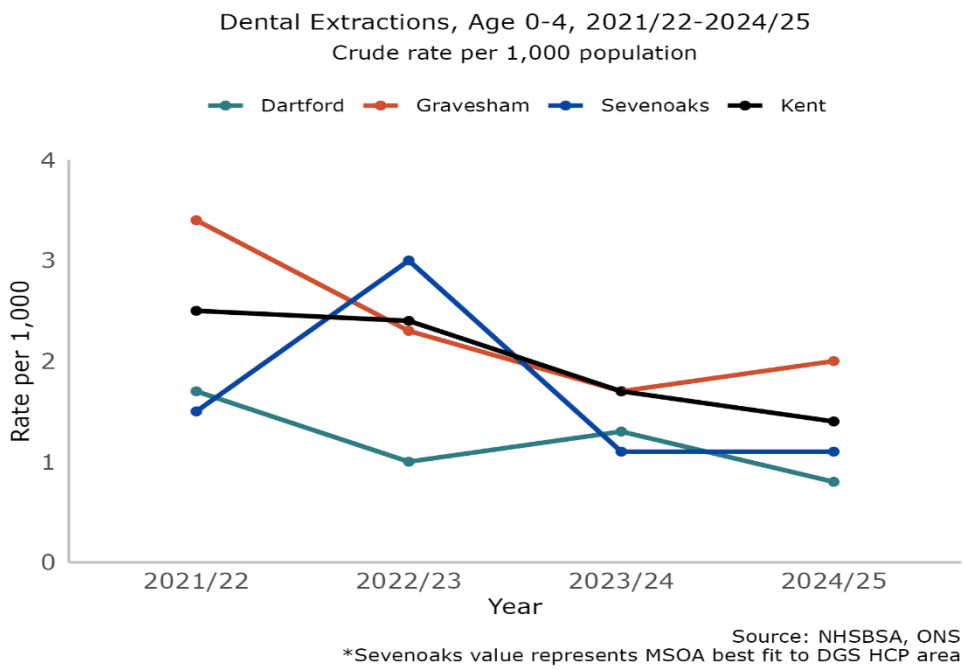


Figure 72: Rate of Dental Extractions in Dartford, Gravesham and Swanley HCP and Kent, 0 to 4 Year Olds, 2021-22 to 2024-25

6.5 Available services

More details on the available services for 0-4 years olds can be found in the maternal health and 0-4 HNA. In summary this includes:

- Maternity care provided through acute trusts.
- Health Visiting service including:
  - Family Partnership Programme
  - Specialist Infant Feeding Service
  - Universal Infant Feeding support
  - Perinatal mental health programme
- Perinatal Mental Health Helpline
- Early Years Education
- Integrated Children's Services including:
  - Family Hubs
  - Early Help and Preventative Services
  - Children's social work services
- Speech, language and communication services

6.6 Key findings

- Fertility rates in DGS are higher than elsewhere in Kent.
  - Those in deprived and ethnic minority groups have worse outcomes from maternity care than those from less deprived and White ethnic backgrounds.
- Rates of childhood poverty in Gravesham are high compared to the Kent average.
- Vaccination coverage is below WHO targets in nearly every PCN in DGS across all vaccines.

- Gastroenteritis admissions in ages 0-4 are higher in 6/7 PCN compared to the Kent average
- Crude rates of emergency admission in 0-4 are higher in each PCN in DGS compared to Kent.

6.7 Recommendations

- Invest in early identification and support of poor perinatal mental health for pregnant women and their partners. Continuation of postnatal mental health identification and support for women and their partners.
- Maternity and child health services should be planned and distributed across Kent to meet the highest needs, this should be a part of commissioning decisions when planning services and service providers should work to ensure jobs in these areas are appealing.
- Local hospital admission data should be assessed to explore the degree at which the high rates of emergency admissions in 0-4year olds are driven by coding differences in DGS compared to elsewhere in Kent.
    - If rates remain high then local insight data could be collected to identify drivers for high rates of emergency admissions in 0-4 to identify targets for interventions to reduce them.
- Whole system efforts should be made to promote and support good health through interventions such as breastfeeding, dental care, and vaccine uptake. These efforts should be culturally competent and provide translation services and information in alternative languages.
    - Local insight data may be beneficial to review local drivers and barriers to such behaviours, from which targeted interventions can be produced such as providing vaccines at nurseries or outpatient appointments if parents struggle to access GP appointments.
- Continue work to improve data sharing and data linkage, particularly between maternity care, early help, health visiting, social care, and early years education.
- Trauma informed approaches should be used more widely, and all professionals working with children and families should be trained.
- Cultural competence and intersectionality training should be mandatory as part of Diversity, Equity and Inclusion (DEI) training for healthcare providers, including those within the NHS Integrated Care Board (ICB) and Health Care Partnerships (HCP), to improve equitable care delivery to diverse patients.

7 Starting well – Child and Young People Health (5-19 years)

7.1 Introduction

Ensuring that every child has the best start in life is one of the key priorities of the Office for Health Improvement and Disparities (OHID). Delays in identifying and meeting the health and wellbeing needs of children can have far reaching effects, impacting their chance of reaching their full potential and having healthy fulfilling lives.

7.2 National policies

7.2.1 The Healthy Child Programme

The Healthy Child Programme is a universal programme of prevention and support for children. It is delivered as part of the local authority's statutory responsibility to commission public health services for children. It aims to bring together health, education, and other key partners to deliver an effective programme for prevention and support for children. Investing in children and families and enabling children to thrive is a crucial part of achieving the Governments 'Levelling Up' agenda to reduce inequalities seen across the country.

The healthy child programme is led by school nurses during school years, they have four main aims:

- reduce inequalities and risk
- ensure readiness for school at 5 years old
- support autonomy and independence
- increase life chances and opportunity

The programme suggests that school aged children should receive universal health reviews at key development stages with certain aspects considered as high impact areas. In primary school aged children these will be reflective of work with the family, school, or other agency support. In secondary school aged children, the focus switches to substance misuse prevention and maintaining healthy relationships including sexual health (72).

7.2.2 Core20PLUS5 model

Core20PLUS5 is a national NHS approach to support the reduction of health inequalities at both national and system level. The approach defines a target population group – the 'Core20PLUS' – and identifies 'five' focus clinical areas requiring accelerated improvement. The model for children highlights the need for focus on asthma, diabetes, epilepsy, oral health, and mental health.

7.3 Best Practice

NICE publish a range of guidance for the care of children and young people (50). Due to the range of care requirements within these groups no single guidance can be used to encapsulate best practice for this group. However, trauma informed practice is a consistent theme. All care to children and young people should be trauma- informed. This builds on evidence showing that traumatic events in childhood are a key factor associated with increased prevalence of poor social, emotional and mental wellbeing (73,74). Trauma-informed care aims to prevent re-traumatisation and has moved to focus on healing -centred approaches for trauma (73,75). This is particularly pertinent to neurodivergent children and children with special educational needs or disabilities due to their increased vulnerability (74).

7.4 Epidemiological findings

The health and wellbeing needs of 5-19-year-olds in Kent are varied. Differences are driven by population, ethnicity, sex, health condition, nurturing, education, and living environment amongst other factors. Due to increasing migration health inequalities may worsen, as cultural needs, language differences, interpretation, social norms are misunderstood or not heard. This is especially a concern in the DGS area where a large proportion of the population are from ethnic minority groups.

7.4.1 Emergency department attendances

Observational research shows that approximately 20% of Emergency Department (ED) attendances in children are non-urgent and may be best treated elsewhere (76). Assessing whether this is an issue in DGS is complicated by that fact that urgent treatment centre and ED access are included in the same hospital coding. However, the data we do have indicates that ED attendances have increased in the last three years in DGS, from 4.67 per 1,000 in 2021 to 6.46 per 1,000 in 2023. This change may be reflecting the drop in ED usage seen during the COVID pandemic. There is also variation in ED usage within DGS. From 2021-2023, age-standardised rates in the most deprived groups and White ethnic groups with higher than the least deprived and all other ethnic groups. In addition, there appears to be higher rates of ED attendance in Gravesend Alliance PCN and Gravesend Central PCN, as shown in figure 73.

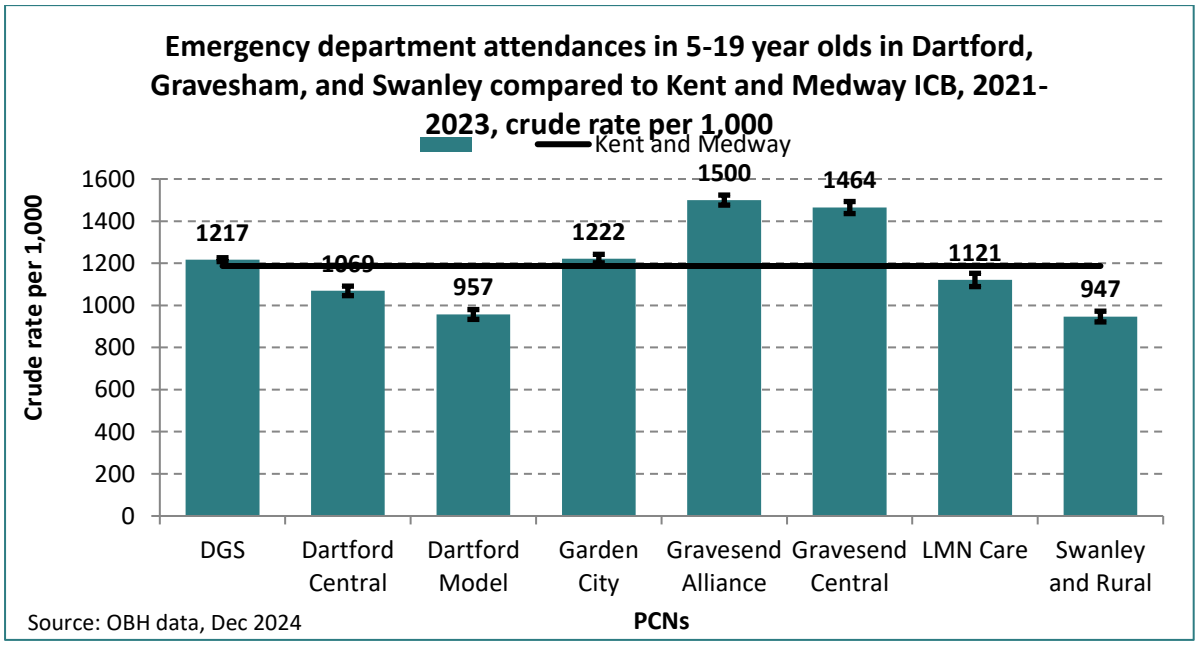


Figure 73: Emergency department attendances in 5–19-year-olds in Dartford, Gravesham, and Swanley compared to Kent and Medway ICB, 2021-2023, crude rate per 1,000

7.4.2 Emergency admissions

From 2021-23 the age-standardised rate of emergency admissions in DGS was 0.56 per 100,000, very similar to the 0.55 per 100,000 for the rest of Kent and Medway. The rate of admissions is highest in those of White ethnicity compared to other ethnic groups and in the most deprived groups compared to the least deprived. The variation across DGS is minimal.

7.4.3 Injury-related admissions

A proportion of these admissions are injury-related emergency admissions. Rates of these are higher in DGS than the rest of Kent for children aged 0-14 years, as shown in figure 74, and are higher in males than females for this age. The prevalence of injury related admissions reduces to Kent average or lower for the 15-24 years age band, and have been reducing over time for both age brackets from 2013-2023.

The risk of unintentional injury is greatest for those living in the most deprived circumstances, for example children of parents who have never worked or are long-term unemployed are 13 times more likely to die from unintentional injury than those whose parents are in managerial or professional occupations. The risks are not solely linked to income but complex and interrelated factors, such as gender, age, culture, ethnicity, and control over the home environment (77).

Furthermore, research suggests that a proportion of injury-related admissions may be sports related injuries such as trampoline-related injuries and target sport-related injuries (78). A better understanding of what feeds into the high rates of injury-related admissions in DGS children aged 0-14 years is needed to allow targeting of interventions.

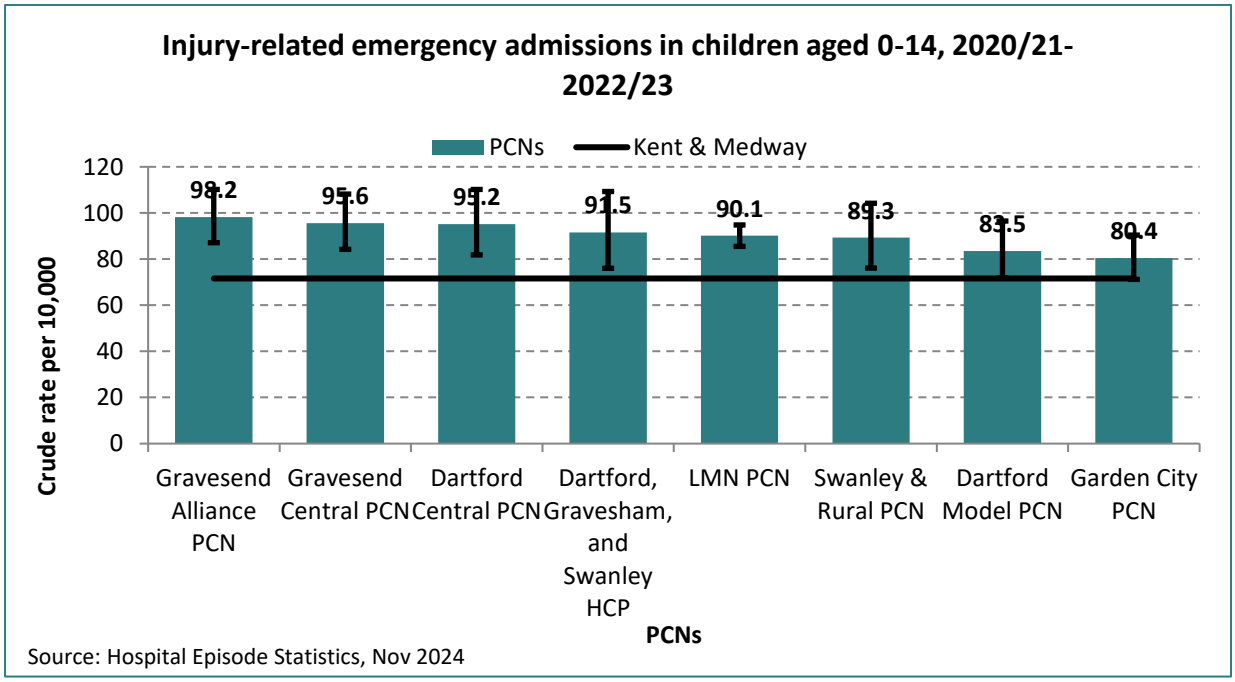


Figure 74: Injury related emergency admissions in children aged 0-14, 2022/21-2022/23

7.4.4 Long term conditions

Diabetes, asthma, and epilepsy are all mentioned in the NHS long term plan as examples of longstanding illnesses affecting children and are key clinical areas for children and young people within the CORE20PLUS5 model.

7.4.4.1 Diabetes admissions

In DGS from 2019-23 rates of emergency admissions for diabetes were higher than the Kent and Medway average at 4.99 per 100,000 compared to 4.77 per 100,000. The highest rates were seen in Gravesend Alliance and Garden City PCN. Rates were 56% higher in the most deprived groups compared to the least deprived groups. Data suggests that within DGS, children aged 5-11 years in Gravesham have higher rates of diabetes related admissions than Kent but similar rates of

admissions as the South East for children aged 11-18 years. In contrast Dartford district has similar rates of diabetes admissions as Kent for 5–11-year-olds but higher rates than the South East for 11-18 year olds, as shown in figure 75 and 76.

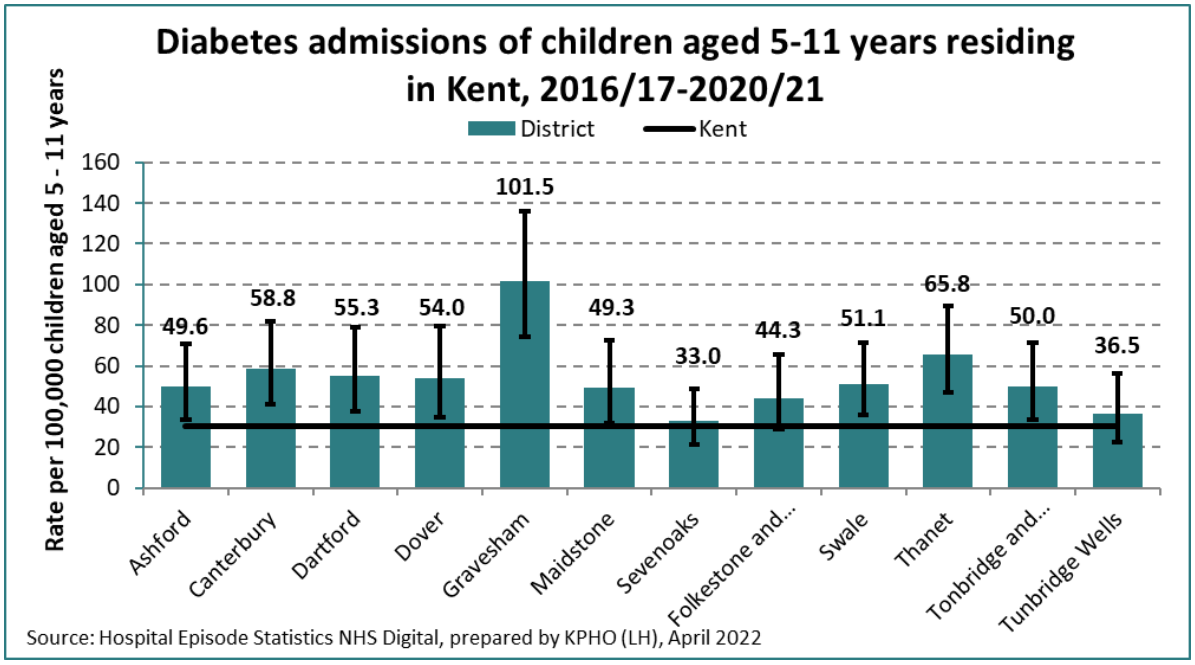


Figure 75: Diabetes admissions of Children aged 5-11 years by district, 2016/17-2020/21

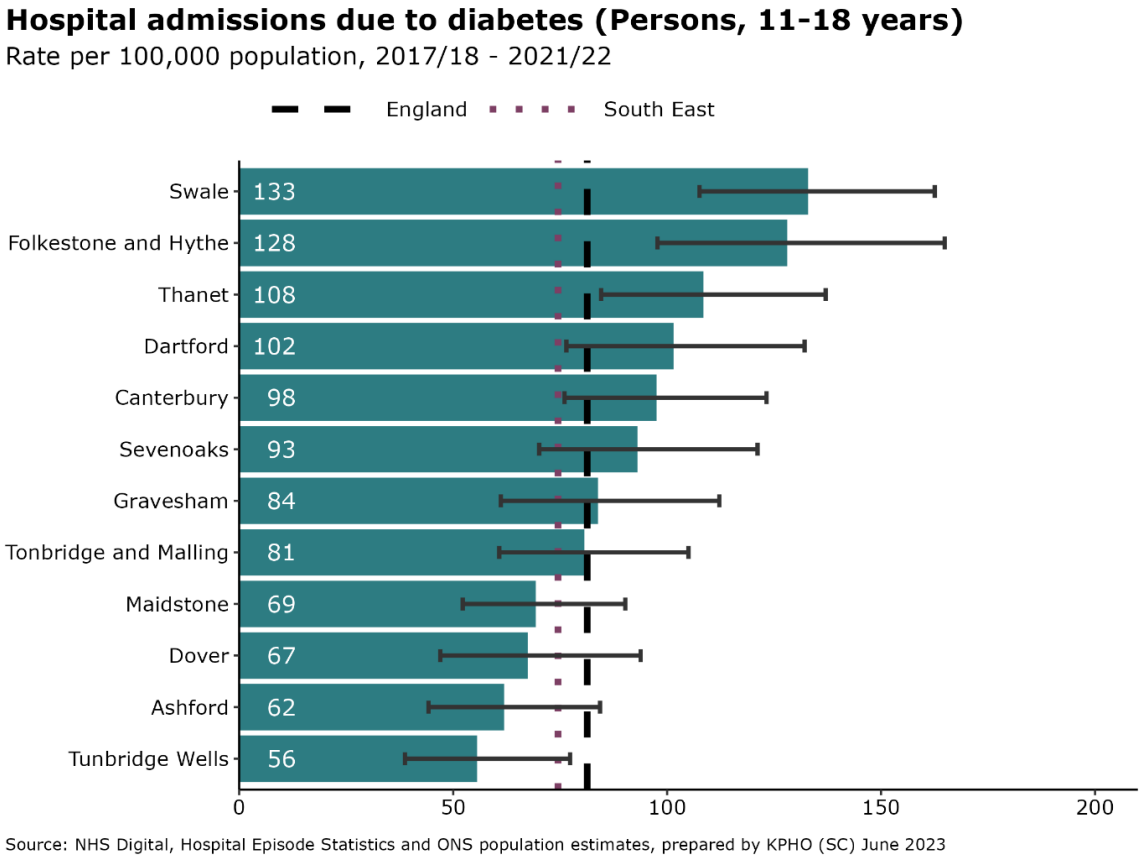


Figure 76: Diabetes admissions of Children aged 11-18 years by district, 2017/18-2021/22

This may reflect a switch from care being primarily provided by parents to be managed by adolescents, which research shows increases the risk of complications such as Diabetic Ketoacidosis, driving up admissions (79–81). This area switch may also reflect a change in support for these different population groups which would benefit from exploration. Understanding the drivers for diabetes admissions is key in preventing unnecessary complications from diabetes.

7.4.4.2 Respiratory admissions

From 2018-2023, respiratory admission rates in children aged 0-19 years were higher in all PCNs in DGS compared to Kent, as shown in figure 77. These rates are higher in the most deprived three quintiles, with a peak in quintile 3, compared to the least deprived quintiles.

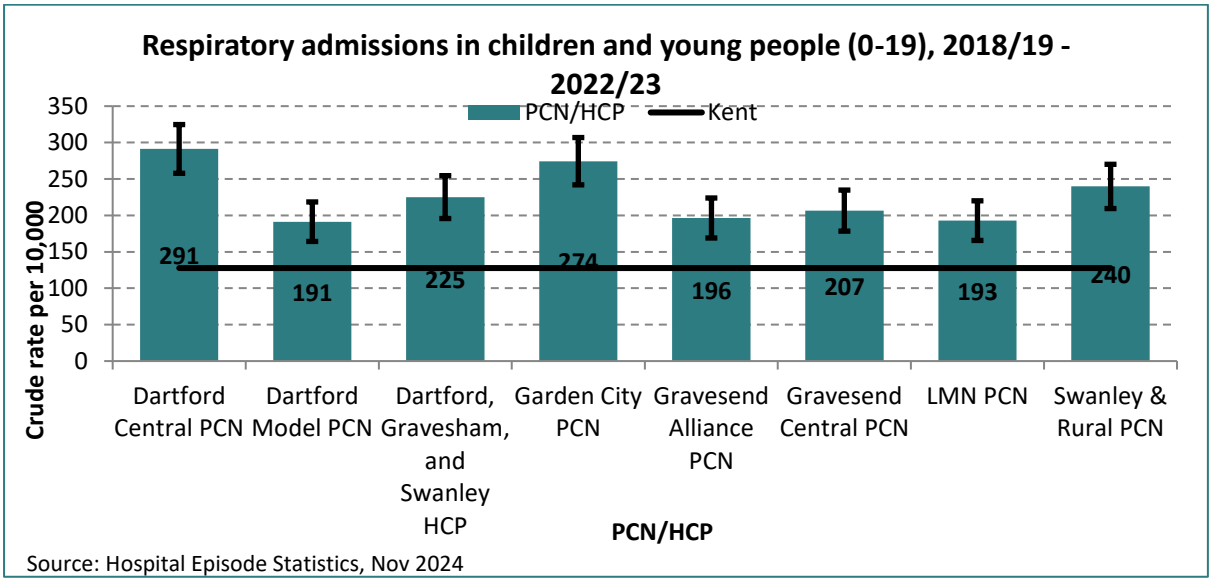


Figure 77: Respiratory admissions in children and young people (0-19), 2018/19-2022/23

For asthma in particular, rates similar to Kent and Medway in most PCNs in DGS except Garden City PCN where rates are significantly higher than the Kent and Medway average, as shown in figure 78.

Emergency admissions due to asthma is an important marker because this is an ambulatory care sensitive condition where the majority of admissions are preventable (82). The NHS long-term plan raises the need for appropriate medication and training for those with asthma which is key to prevent admissions and complications (83). Furthermore, wider determinants such as housing play a key role in preventing child deaths from asthma and respiratory infections (84). As such, the implementation of asthma friendly schools will help support families and their child in the knowledge that the care of their asthma health is identified on a plan

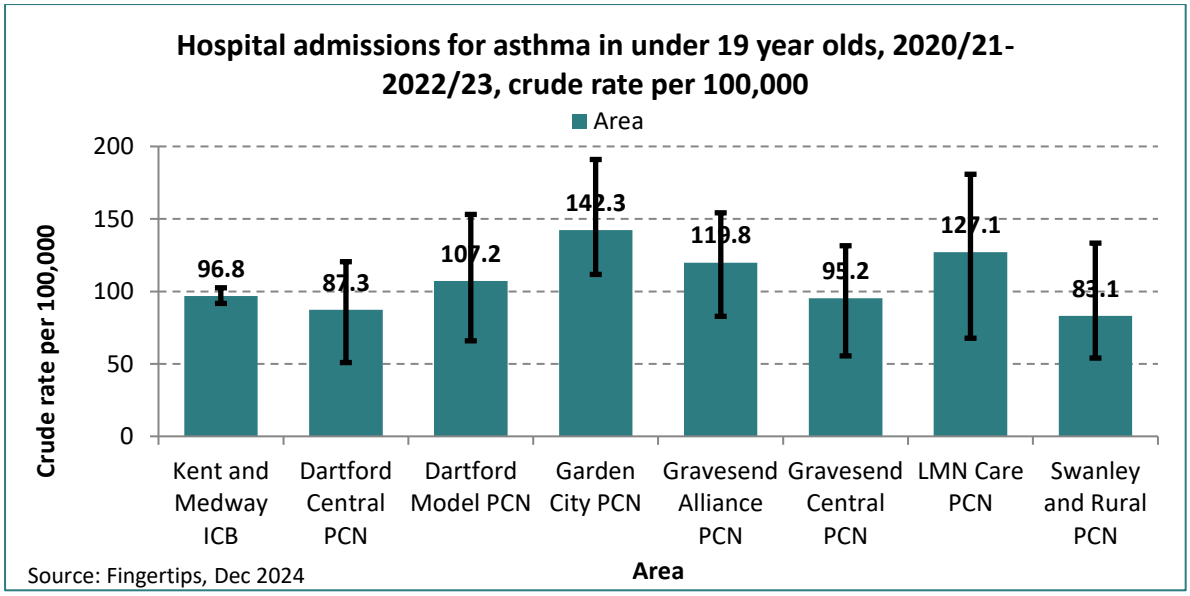


Figure 78: Hospital admissions for asthma in under 19-year-olds, 2020/21-2022/23, crude rate per 100,000

7.4.4.3 Epilepsy admissions

Epilepsy emergency admissions in Gravesham are higher than Kent average in children aged 5-11 years but are similar to the Kent average in children aged 11-18 years, as shown in figure 79 and 80. Rates are similar to Kent in Dartford and lower than Kent in Sevenoaks for both age groups.

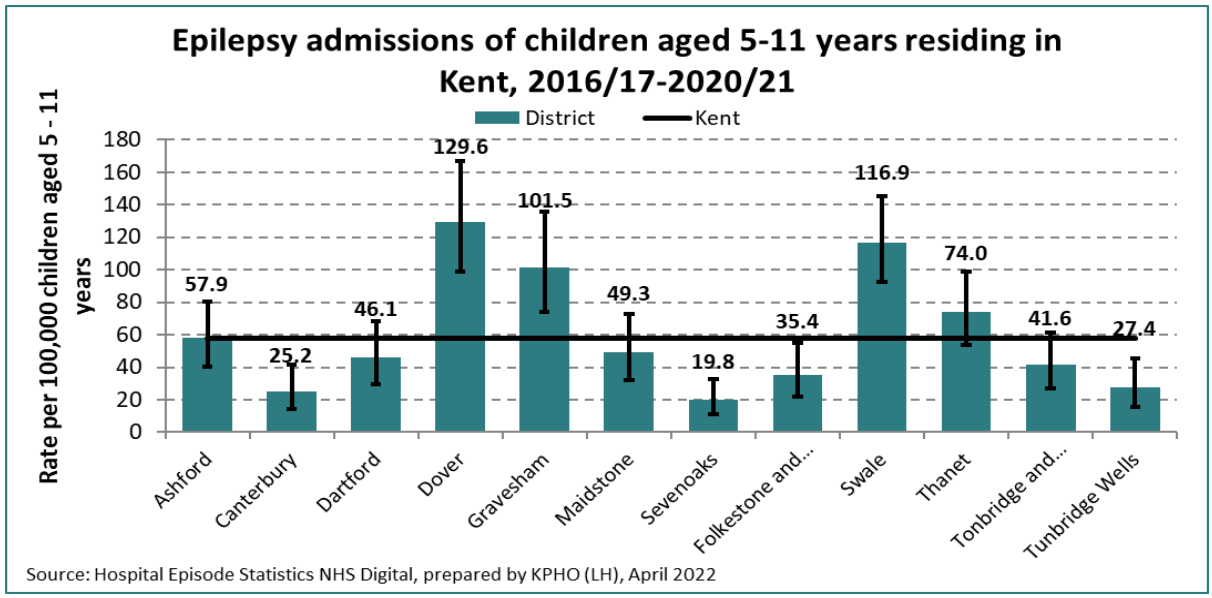


Figure 79: Epilepsy related hospital admissions in children aged 5-11 years by Kent District, 2016-2021

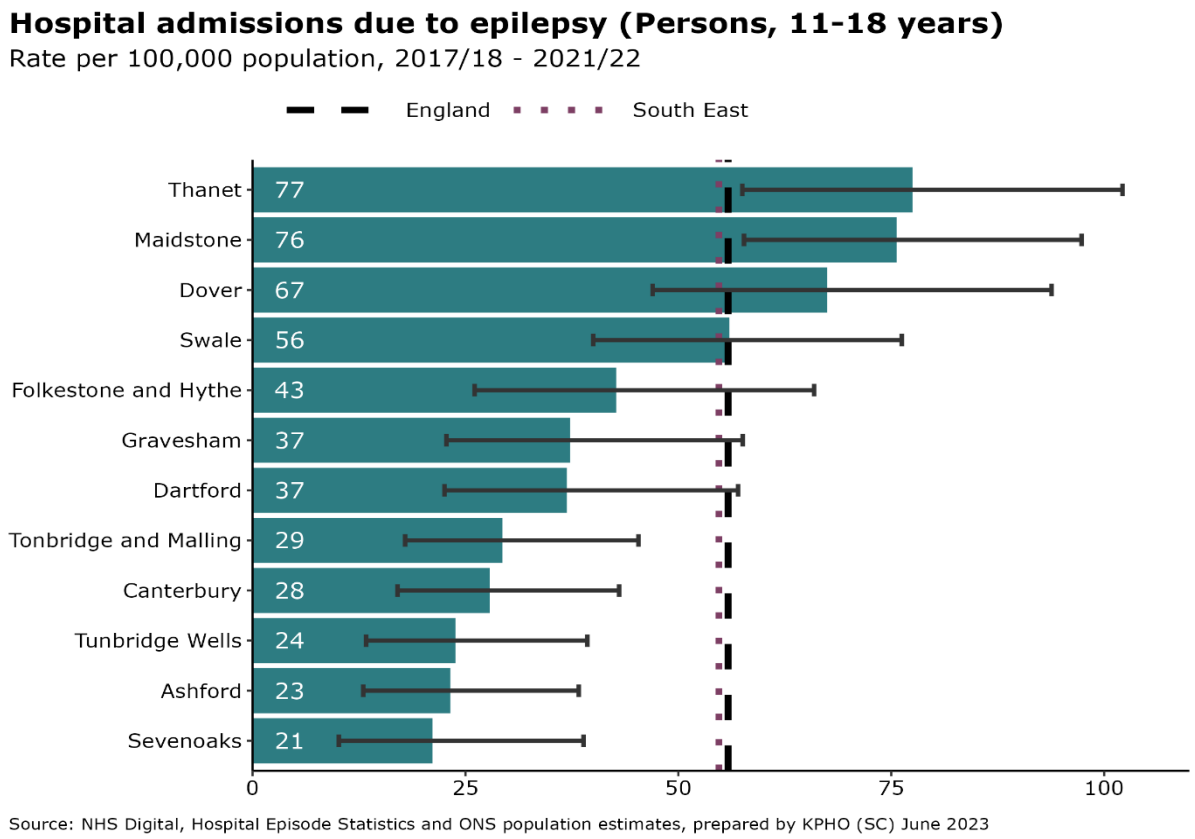


Figure 80: Epilepsy related hospital admissions in children aged 11-18 years by Kent District, 2016-2021

7.4.5 Mental health

In 2023 approximately 1 in 5 children in England had a probable mental health disorder. This reflects 20.3% of 8–16-year-olds and 23.3% of 17–19-year-olds (85). The association between mental health conditions and gender appears to alter throughout childhood. Rates appear to be higher in young boys aged 6-10 than young girls but become similar in both sexes for 10–16-year-olds before rates in females rise to double that of males in 17–25-year-olds (85).

Hospital admissions for children aged 11-18 with primary diagnosis codes of F00 to F99 (Mental and behavioural disorders) for 2017-22 were lower in Dartford and Gravesham compared to the rest of Kent. Hospital admissions as a result of self-harm in people aged 10-24 were significantly below Kent and Medway ICB average in DGS HCP for 2022/23, as shown in figure 81, with variation across the PCNs. Reassuringly rates in DGS have declined from 181 per 100,000 to 142 per 100,000 from 2013-2023.

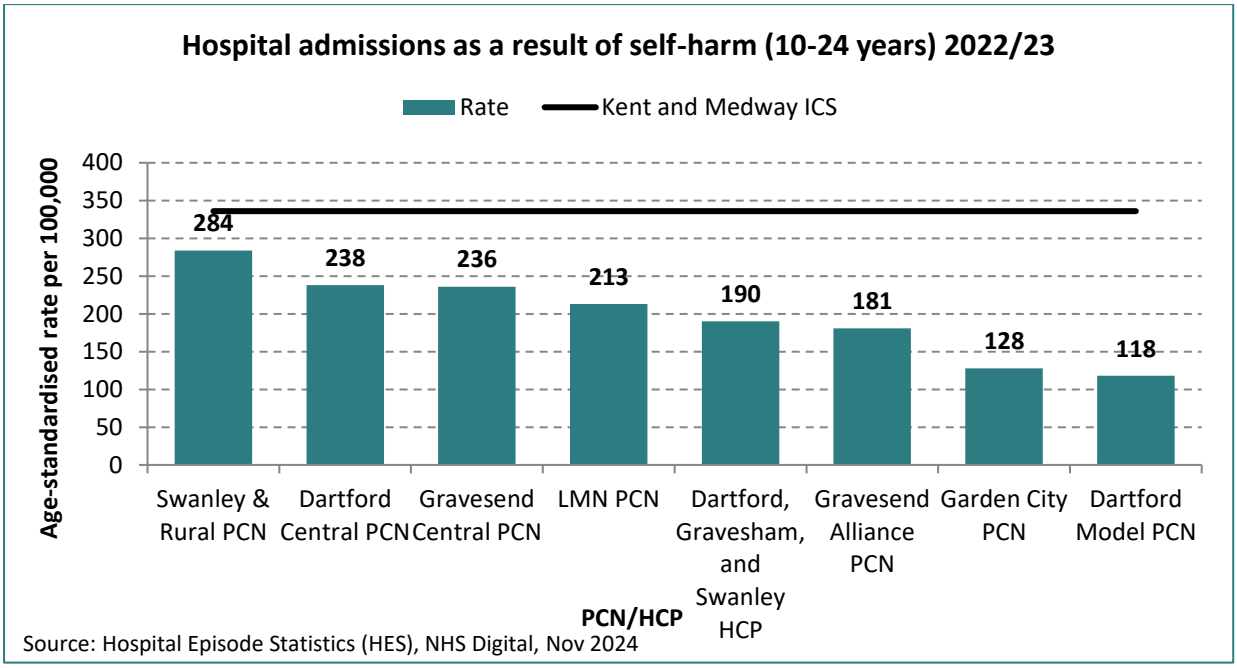


Figure 81: Hospital admissions as a result of self-harm (10-24 years), 2022/23, per 100,000.

7.4.6 Obesity

Children's height and weight is measured in reception and year 6 as part of the national child measurement programme. From 2018/19-2022/23 the proportion of reception and year 6 aged children in Dartford, Gravesham, and Sevenoaks who are either overweight or obese has remained stable from 2019/20-2023/24 (86). 3 year average rates for 2021/22-2023/24 for overweight or obesity prevalence in reception aged children in Gravesham was higher than the English average at 23.3% compared to 21.9%. Rates in Dartford were similar to England at 22.8% whilst rates in Sevenoaks are below the English average at 18.5%. However, rates in Sevenoaks may not show a true representation of Swanley where rates are higher, as shown in figure 82.

For year 6 aged children, in 2021/22-2023/24, both Dartford and Gravesham had higher rates of overweight and obesity prevalence than the English average at 38.4% and 39.9% compared to 36.7%. Sevenoaks remains below the English average at 29.5%, again this likely hides Swanley rates as shown in figure 83. In addition, Gravesham as a district has the highest rates of childhood severe obesity for year 6 aged children in the whole of Kent.

Obesity rates in Kent vary with deprivation. Rates of excess weight were 60% higher in reception years and rates of severe obesity were 300% higher in year 6 in the most deprived compared to the least deprived in Kent. Gender is also an important factor; rates of excess weight tend to be similar in reception but males experienced higher levels of obesity by age 11 onwards (87).

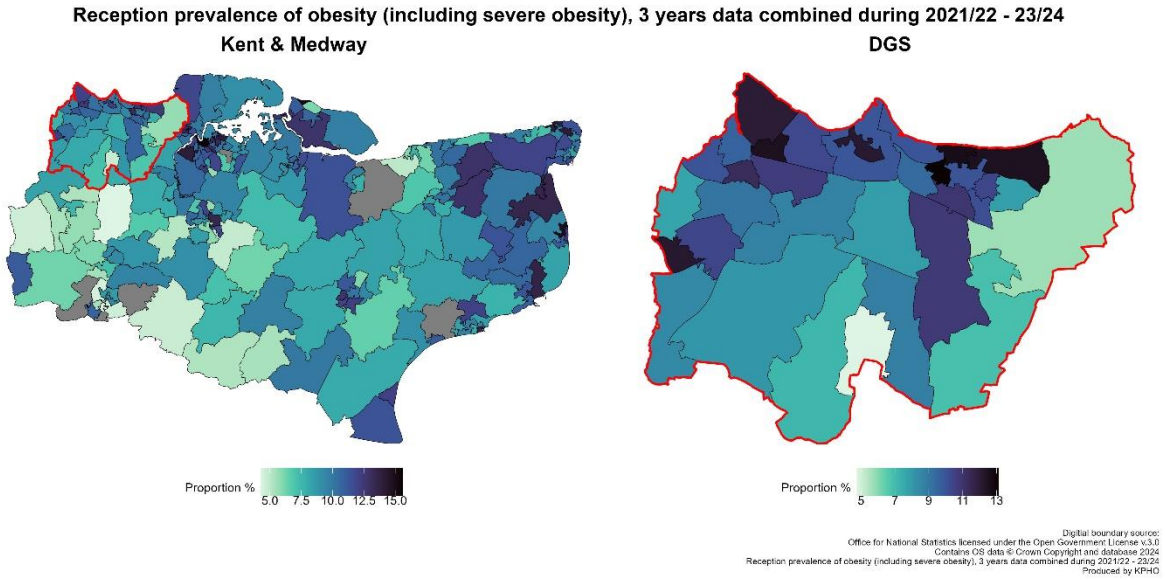


Figure 82: Reception prevalence of obesity, 3 year combined 2021/22-2023/24

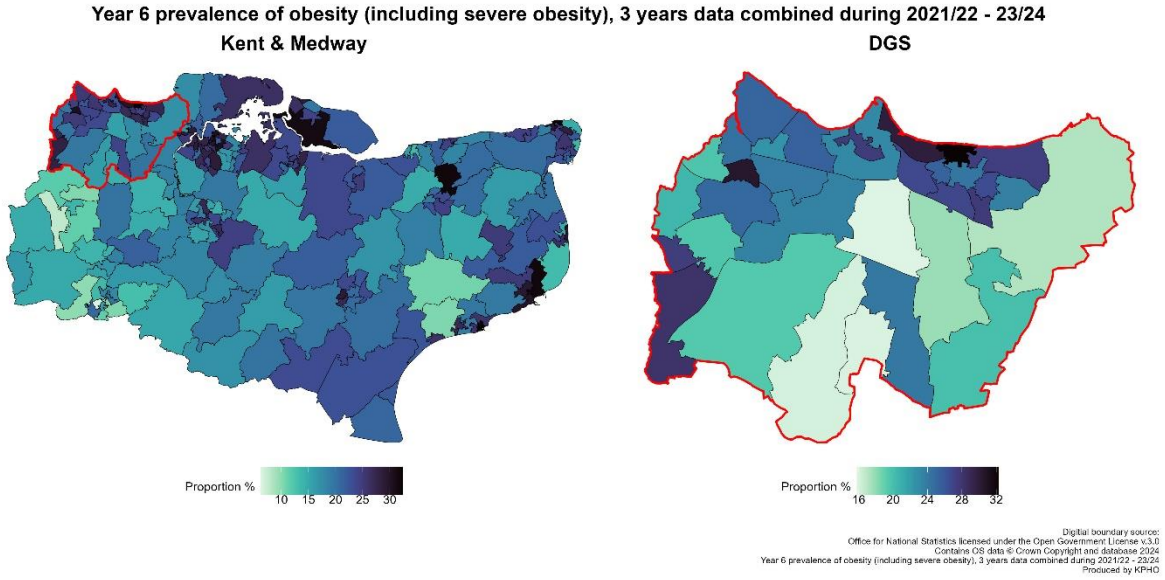


Figure 83: Year 6 prevalence of obesity, 3 year combined 2021/22-2023/24

There are a multitude of risk factors for childhood obesity, as displayed in figure 84.

Figure 84: Risk factors linked to childhood obesity (88–97).

Tackling all these risk factors requires a whole-system, life-course approach. Children of parents who are obese are more likely to develop obesity, therefore the inclusion of parents in any intervention seems sensible.

7.4.7 Special educational needs and disability (SEND)

Many children in Dartford and Gravesham with special educational needs require speech, language, and communication support. Good provision for children with SEND requires co-operation between services and joint commissioning arrangements between local authorities and the health systems that are informed by assessment of local need.

7.4.8 Vaccinations

As discussed in the 0-4 years chapter of this HNA, vaccinations help protect children from morbidity and mortality by preventing the transmission of communicable diseases. This also reduces the burden of said diseases on the health system.

In DGS rates of vaccination coverage in children aged 5 years is below the WHO recommended target of 95% coverage in every PCN for most vaccines. The only vaccines with statistically similar rates to the target is the DTaP/IPV/Hib vaccine in three PCNs, and the first MMR vaccine (MMR1) in LMN PCN, as shown in figure 85.

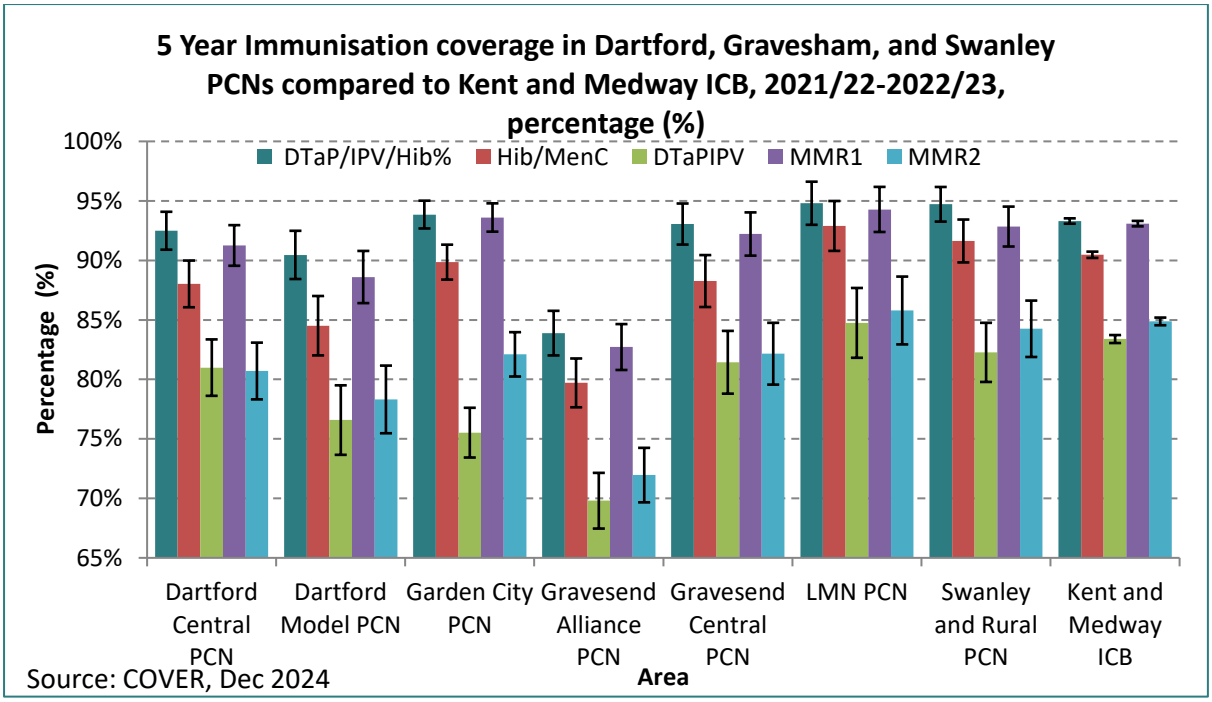


Figure 85: 5 Year Immunisation coverage in Dartford, Gravesham, and Swanley PCNs compared to Kent and Medway ICB, 2021/22-2022/23, percentage (%)

7.4.9 Oral health

Tooth decay may lead to dental extraction, pain, difficulty eating, and impact on a child's development. Rates of dental treatment and fillings in DGS are higher than Kent rates in both the 5-10 years and 11-19 years age groups as shown in figures 86 and 87. Fo 2024/25, this is due to significantly higher rates of dental treatment and fillings in Gravesham and Sevenoaks in 5-10 year olds and significantly higher rates in 11-18 year olds in Dartford, Gravesham, and Sevenoaks. Rates of dental extractions have reduced from 2021/22-2024/25 in both age groups and are statistically similar to Kent rates.

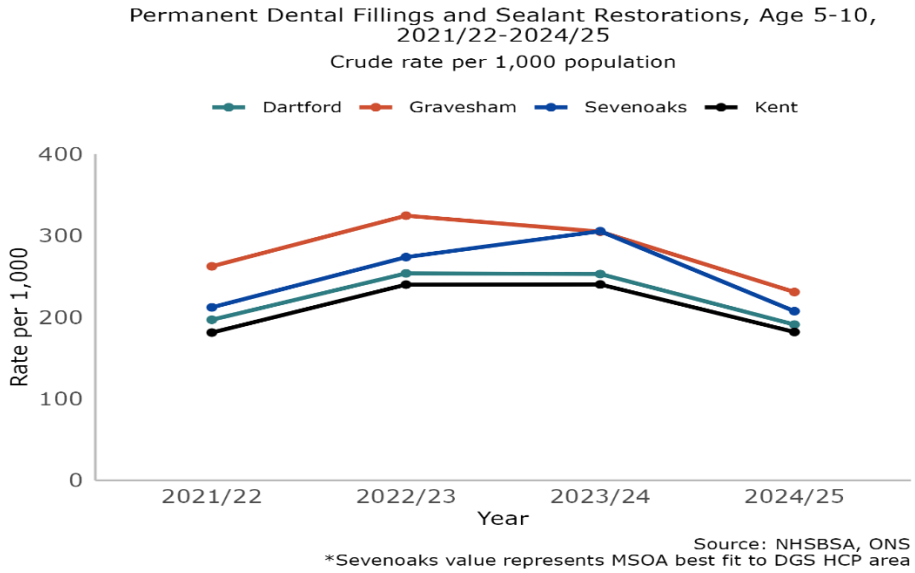


Figure 86: Rate of Permanent Dental Fillings and Sealant Restorations in Dartford, Gravesham and Swanley HCP and Kent, 5 to 10 year olds, 2021-22 to 2024-25

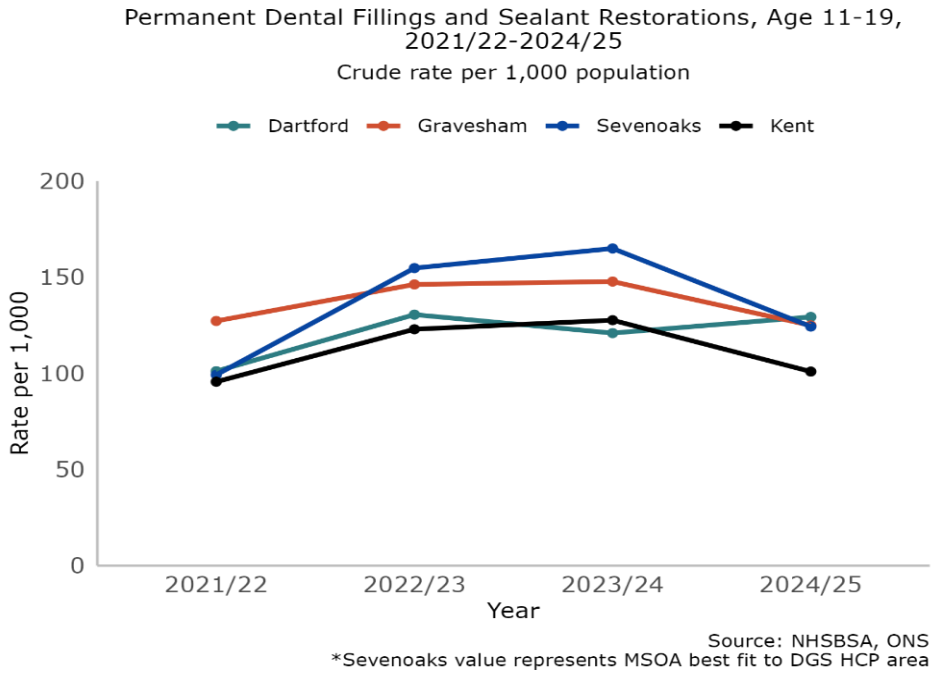


Figure 87: Rate of Permanent Dental Fillings and Sealant Restorations in Dartford, Gravesham and Swanley HCP and Kent, 11 to 19 year olds, 2021-22 to 2024-25

7.4.10 Alcohol related admissions

Rates of alcohol related admissions in secondary school aged children are lower in Dartford, Gravesham, and Sevenoaks than the South East average, as shown in figure 88.

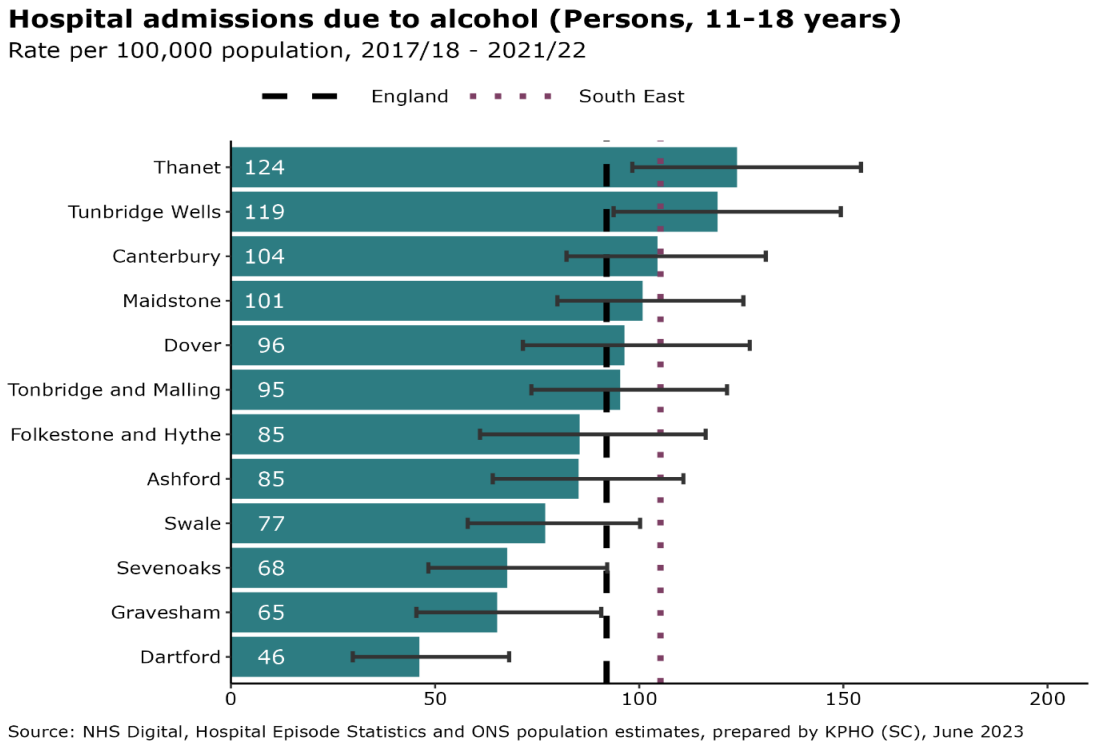


Figure 88: Alcohol related admissions by Kent district, 2017/18-2021/22

7.4.11 Conceptions in under 18s

From the latest available data, which is from 2021, rates of conceptions in under 18 years old across Dartford (9.8 per 1,000), Gravesham (10.7 per 1,000), and Sevenoaks (9.9 per 1,000) are similar to Kent (13.9 per 1,000) and England (13.1 per 1,000) rates. However this has dropped significantly from 2006.

7.5 Available services

- One you Kent for young people over 16 years.
- Active Kent app
- Better health app
- Kooth app - an online mental health and wellbeing service for children and young people
- Yearly influenza vaccines for primary aged children
- Parenting courses
    - Kent Community Healthcare Foundation Trust [KCHFT] offer free online parenting courses
    - Kent adult education offer online parenting programmes
- Family hub support
- Additional support from the children's social work team for children in need and children with a child protection plan. Also Early Help for vulnerable children and their families.
- Evidence- based supervised toothbrushing programme in nurseries and with reception year children piloted last year and continuing with another cohort in this academic year

7.6 Gaps

- Obesity
    - No level two provision for weight management.
    - The uptake of available interventions and support is low and there is no clear evaluation on why this is.

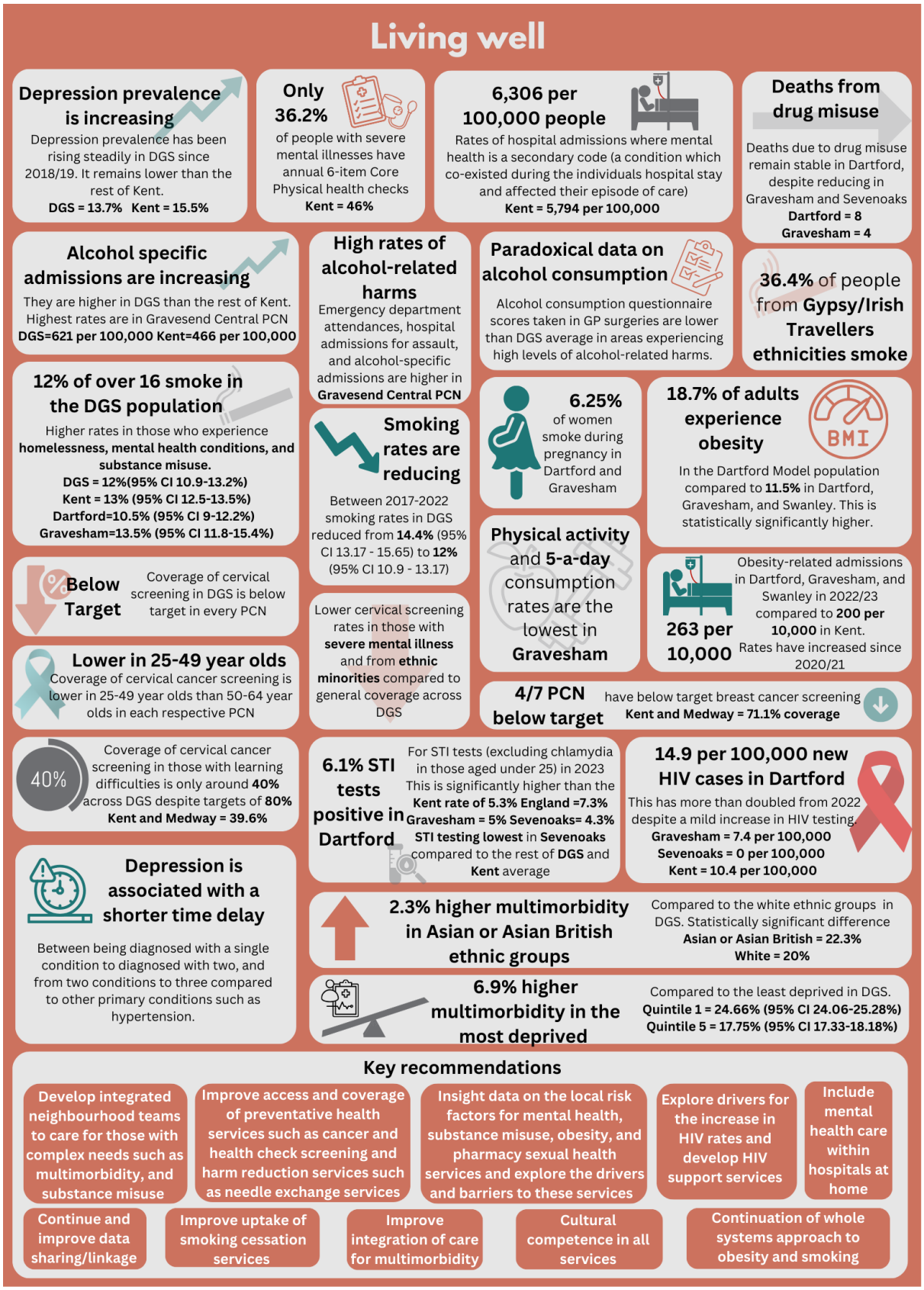
7.7 Key findings

- Obesity rates in Gravesham for Year 6 students are the highest in Kent compared to the other districts.
    - Obesity rates are 300% higher in the most deprived compared to the least deprived in Kent.
- Rates of dental treatments and extractions appear consistently higher in DGS than the rest of Kent from 2021/22 – 2024/25.
- Respiratory admissions in 0-19 year olds are higher in DGS compared to the Kent average at 225 per 10,000 compared to 128 per 10,000.
- There were 91.5 per 100,000 injury related admissions in 0-14 year olds in DGS compared to 71.7 per 100,000 in Kent in 2020/21-2022/23.
- The majority of vaccines in every PCN in DGS are significantly below the WHO target of 95% coverage.

7.8 Recommendations

- Explore the difference in diabetes admissions rates within DGS, the drivers for this and how services may be best suited to reduce the increased admission rates in DGS and the variation of increased emergency admission with age.
    - Given the variation in admission rates by area and by age, it may be pertinent to ensure services and support available across Dartford and Gravesham meet demand.
- Evaluate the medication provision for children with asthma in DGS and whether this is appropriate. This could involve either an analysis of the children presenting with asthma exacerbations and if they have care plans and the number of salbutamol prescriptions they have received, or an analysis on the percentage of children with asthma having more than 6 SABAs per year.
- Partnership working to encourage the implementation of asthma friendly schools should help support families and their child with the knowledge that the care of their asthma health is as identified on a plan.
- Explore the drivers for high epilepsy admissions in children aged 5-11 in Gravesham to identify if any can be attenuated.
- Rates of obesity in year 6 students in Gravesham are high and appear to be rising, as such a whole-system approach to obesity should be continued, taking in a mixture of perspectives, involving views of council, parents, children, education, transport, and air pollution specialists.
- Insights data is needed to gain a better understanding of what feeds into the high rates of injury-related admissions in DGS children aged 0-14 years and allow targeting of interventions.
- Vaccine uptake needs to be improved, this can be bolstered through opportunistic vaccines within outpatient services.

Living well – overview



8 Living well – Mental Health

8.1 Introduction

Approximately one quarter of people experience mental ill-health each year (98). Mental illness is often a chronic, relapsing condition and therefore support may be needed at various stages and levels throughout an individual's lifetime. Depressive disorders alone are one of the top five causes of death and disability in England (99). Often depression occurs alongside anxiety with a prevalence of around 13.2% in England (100). Severe mental illness such as bipolar disorder or schizophrenia is less common, with a prevalence of just under a 1% across all ages (101).

The risk of mental health conditions tends to be higher in those who identify as LGBTQIA+, young women between 16-24, those of Black or Black British and Asian ethnicities, and those experiencing homelessness, substance misuse, and contact with the criminal justice system (98,102).

In 2021/22 the NHS spent £12 billion on mental health in England (103). The majority of this was spent on inpatient and community mental health services (103). Planned commitments have led to mental health services receiving better funding, however due to previously unforeseen circumstances such as the COVID pandemic and high inflation rates, the cost of treating mental health conditions is expected to increase beyond the planned budget (103,104).

8.2 National policies

8.2.1 The NHS Long Term Plan

This plan highlights the key priorities for the next ten years. These include increased funding for mental health services, expanding maternal mental health services, delivering mental and physical health care for those with severe mental health in the community, improvements to co-ordinated care, and improving access to talking therapy for depression and anxiety (83).

8.3 Best Practice

Best practice guidance can be found in the relevant subject-based Health Needs Assessments.

- Mental Health Needs Assessment
- Domestic Abuse
- Homelessness / Rough Sleeping Needs Assessment

NICE guidance recommends low intensity psychosocial interventions, such as CBT, for depression and anxiety (105). For severe mental health conditions such as bipolar disorder and schizophrenia they recommend pharmacological treatment options alongside psychological and psychosocial interventions (105).

8.4 Epidemiological findings

8.4.1 Mortality

Local mental health mortality data is not available. However national evidence shows that individuals with a severe mental illness (SMI) are 5 times more likely to die prematurely (before the age of 75) compared to those who do not have an SMI (106). In Kent there was a 374% excess premature mortality in those with SMI compared to those without in 2020-22, this was just lower than the English average of 386% (107). There are also rising rates of deaths linked to mental and behavioural disorders related to alcohol use, such as alcohol dependence and

withdrawal symptoms. Furthermore, in 2024/25 38% of drug and alcohol-related deaths involved individuals with co-occurring mental health issues.

8.4.2 Suicides

Rates of suicide and deaths from undetermined injuries in those over 10 years old in DGS are slightly lower than the rest of Kent at 10.7 per 100,000 compared to 11.9 per 100,000, as shown in figure 89. Rates in Gravesham appear to be slightly higher than rates in Dartford, however due to wide confidence intervals this cannot be said with certainty. Data for Swanley is not available, however given the trend in DGS compared to Dartford and Gravesham, Swanley rates have potentially become higher than the rest of DGS for 2021-2023.

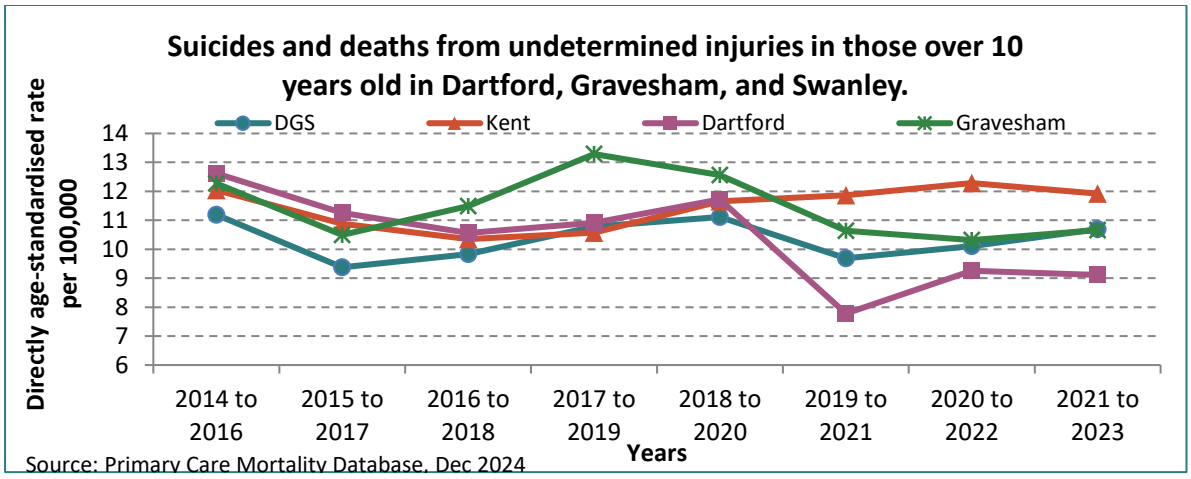


Figure 89: Suicides and deaths from undetermined injuries in those over 10 years old in Dartford, Gravesham, and Swanley, directly age-standardized per 100,000, 2014-16 to 2021-23.

8.4.3 Depression

Depression is defined as a prolonged period of low mood which affects daily life. Rates of depression in adults, individuals over 18 years old with an active diagnosis of depression on their GP record, have been increasing in DGS since 2018/19. They have been slightly higher than national levels since 2020/21. However, the rates remain lower than the rest of Kent, as shown by figure 90. Swanley levels are not available but given the comparison between DGS rates and those for Dartford and Gravesham, they potentially follow a similar trend.

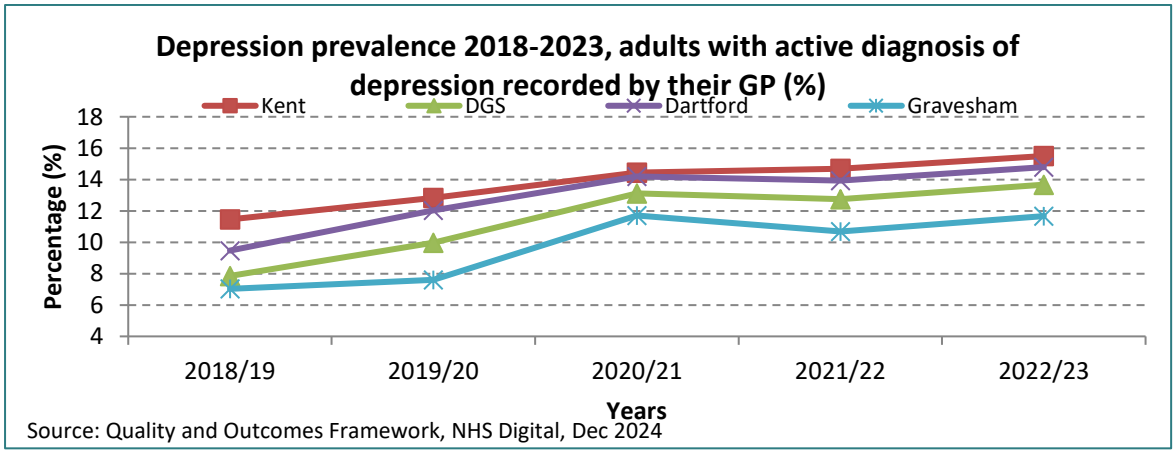


Figure 90: Prevalence of depression in adults in DGS, 2018-2023 (%)

Depression is a risk factor for self-harm, suicide, and alcohol misuse (98,108). In DGS rates of emergency admissions for self-harm have decreased over the last 10 years. However, in DGS, the rate of harm from alcohol misuse has also seen an increase, this is discussed further in the substance misuse chapter.

Research shows that low-intensity psychosocial interventions such as cognitive behavioural therapy are beneficial for common mental health disorders such as less severe depression to reduce the risk of suicide and progressing into severe depression, as such they are recommended by NICE (109).

8.4.4 Serious/severe mental illness

Serious or severe mental illness (SMI) refers to conditions which greatly impact on the ability of individuals to engage in functional and occupational activities. They tend to be chronic but are less prevalent than common mental disorders such as depression and anxiety.

In DGS prevalence of SMI is around 0.96%, similar to the Kent and Medway average of 1.17%, as shown in figure 91. In both locations SMI is associated with deprivation with the existence of a clear social gradient. Additionally, rates appear higher in younger years with a peak in those aged 30-39 and appear higher in men than women. In DGS a greater percentage of those with SMI appear to be from ethnic minorities than in Kent overall, which is potentially due to the underlying population structure of DGS. Of the ethnic minority groups the highest rates are in unknown, and then Asian/Asian British.

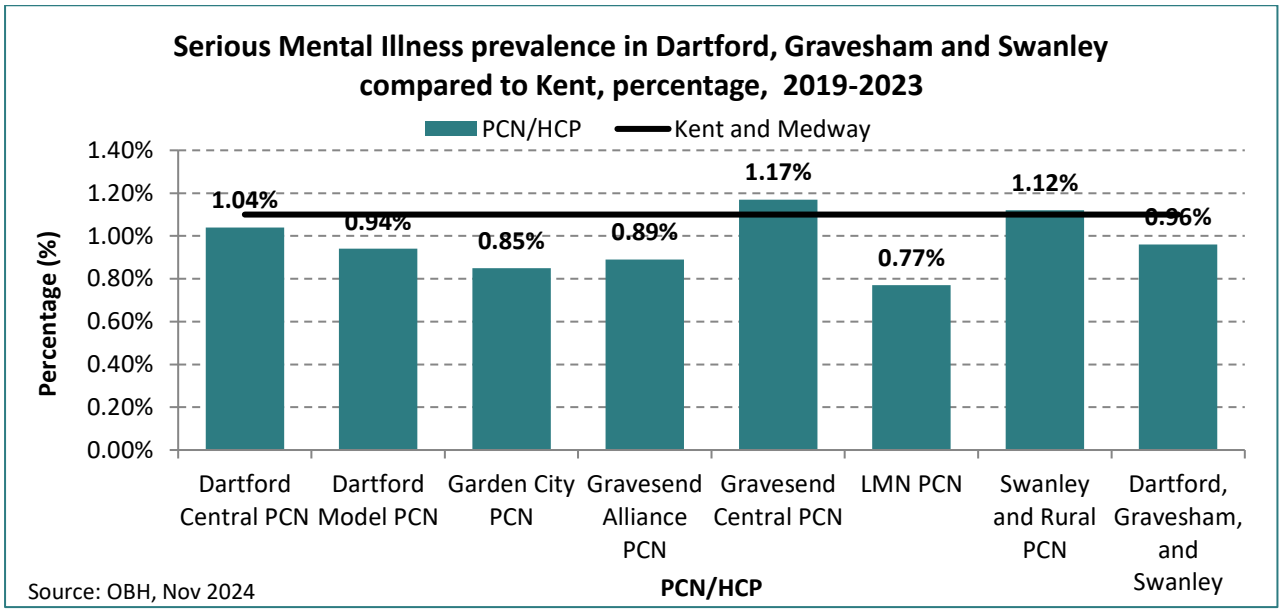


Figure 91: Prevalence of serious mental illness in DGS (%)

8.4.5 Comorbidities

Research shows that individuals with SMI experience higher rates of long-term physical health conditions compared to all patients (110). Physical health conditions in those with SMI are of concern because research suggests that people with SMI are less likely to receive the standard level of care and checks for these physical health conditions compared to individuals without mental health concerns (111). As a consequence of these physical health conditions, they experience higher levels of excess mortality and subsequent shorter life expectancy, as discussed above (111).

One potential measure for the rate of physical health in those with mental health conditions is the rate of hospital admissions with admissions where mental health is a secondary code. A secondary code is a condition which co-existed during the individual's hospital stay and affected their episode of care. Rates of these are significantly higher in DGS compared to the rest of Kent, age-standardised rates of 6,306 per 100,000 and 5,794 per 100,000 respectively, as shown in figure 92. Therefore, it appears that mental health conditions are impacting on the hospital care of more patients in DGS than they are in in the rest of Kent. This disproportionately affects the most deprived of the DGS population.

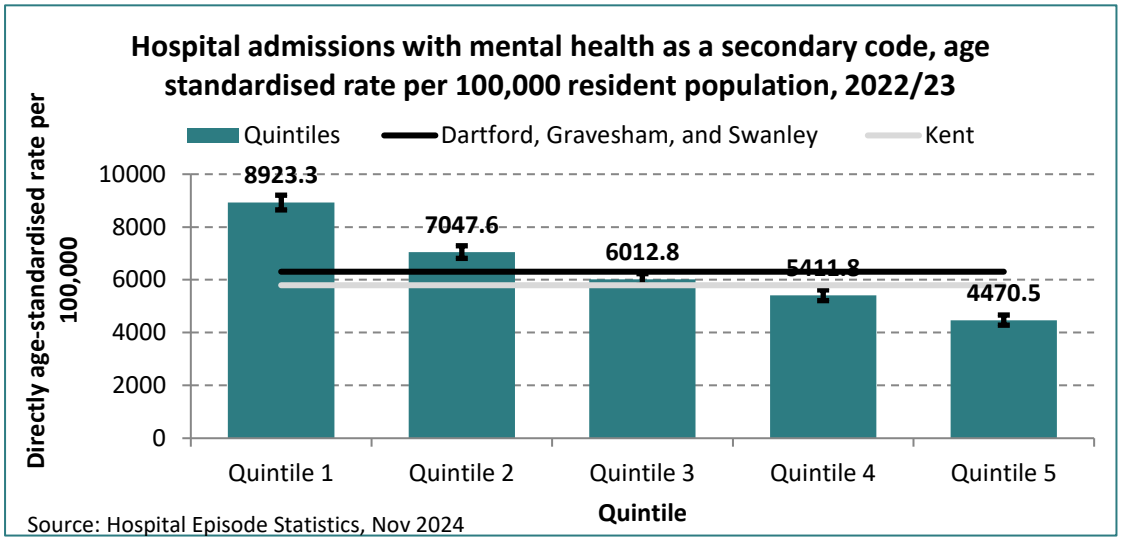


Figure 92: Hospital admissions with mental health as a secondary code, age standardised rate per 100,000 resident population, 2022/23

Research in Australia by Roberts et al suggests that public health interventions such as smoking cessation, vaccines, and health screening may reduce preventable deaths by 0.1% and 25% (112). Current NHS and NICE guidance advise that patients with SMI should receive an annual 6-item Core Physical Health Check (113,114). However, in DGS the proportion of people with SMI who have received this health check appears to be lower than the other HCPs in Kent, at 36.2% compared to a 46% Kent average, as shown in table 7. DGS has the lowest coverage rates in all areas of this check compared to the rest of Kent, especially for assessing blood lipid levels and alcohol consumption.

Table 7: Coverage of Annual Core Physical Health Checks for those with SMI, %, 2022/23.

	Average of percentage of SMI patients with Weight Measurement	Average of percentage of SMI patients with Blood pressure and Pulse check	Average of percentage of SMI patients with blood lipid check	Average of percentage of SMI patients with blood glucose check	Average of percentage of SMI patients with alcohol consumption assessment	Average of percentage of SMI patients with smoking status assessment	Average of percentage of SMI patients who have received the Core Physical Health Check
Dartford, Gravesham, and Swanley HCP	64.9%	71.1%	57.7%	69%	59.3%	70.5%	36.2%
East Kent HCP	68.5%	73.7%	70.1%	73.3%	66.5%	77.5%	47.2%
Medway and Swale HCP	71.9%	75.2%	67.9%	74%	66.9%	80.7%	49.2%
West Kent HCP	69.1%	73.6%	68.9%	74%	64.3%	72%	45.8%
Kent and Medway average	69.1%	73.7%	67.6%	73.1%	65.1%	75.9%	46%

8.4.6 Risk factors

Adverse childhood events (ACEs) are a risk factor for poor mental health and substance misuse. ACEs include experiences such as being a victim of childhood abuse or being a young carer. They affect a huge swath of the population with 48% of the population in England expected to have experienced at least one ACE. Research suggests that 80% of those with 4 or more ACEs will have a serious mental or physical health condition by age 70 (115). Rates of ACEs appear to be higher in Dartford and Gravesham in DGS, but data is only available at local authority level and therefore Swanley data may be masked by more general Sevenoaks findings (116). Care for those who have experienced ACEs or trauma at other points in life should be trauma-informed to prevent re-traumatisation and support healing (75).

Loneliness and social isolation are also a risk factors for mental ill-health and substance misuse, with those who experience isolation 26% more likely to experience premature mortality (117). In Dartford, Gravesham, and Sevenoaks rates of those who always or often feel lonely are similar than the Kent average with wide confidence intervals, as should in figure 93. Due to the nature of the data available, Sevenoaks has been presented as a proxy for Swanley.

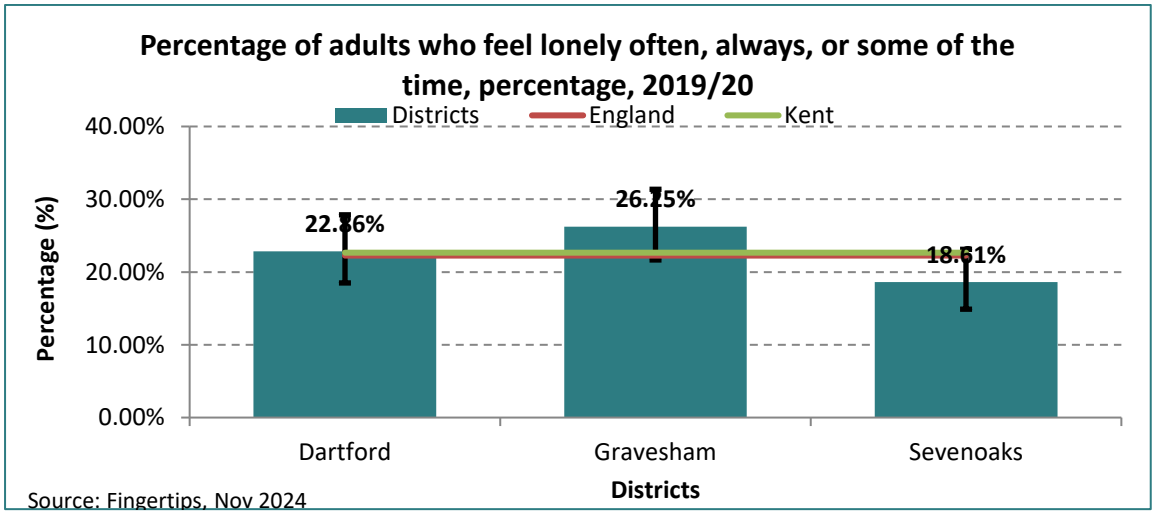


Figure 93: Percentage of adults who feel lonely often, always, or some of the time, percentage, 2019/20

8.5 Current services

8.5.1 Mental health services

Mental health services include Kent wide Adults Autism Team, Live Well Kent, Kent and Medway Safe Havens, and helplines. In addition, NHS mental health services are provided by NHS Kent and Medway, for example the Community Mental Health Team. It is recommended that those with specialist mental health needs such as psychosis receive a Care Programme Approach which coordinates their care and that all people with a SMI and complex needs have a care plan and care co-ordinator wherever their care is located. Currently those with SMI should receive annual physical health checks.

Talking therapy is provided for those with common mental health disorders in DGS. This is a form of low-intensity psychosocial intervention. In DGS, the average wait times to be assessed for talking therapy has reduced throughout 2024 from 40 days in May to 15 days in September-November. The number of referrals has remained around 600. From April-November 2024 the

rates of reliable recovery following talking therapy are around 48%, and rates of reliable improvement is around 70%. Overall, patient feedback shows that talking therapy treatment provided help that mattered to patients the majority of the time.

Ecology island is also available in DGS to provide green space work to use the benefits of the natural environment to help improve mental health, they hold weekly sessions.

8.6 Gaps

- There is a lack of formal evaluation of mental health services. Without this it is difficult to fully assess how well services are matching need.

8.7 Main findings

- Suicide rates appear to be slightly increasing whilst rates in the rest of Kent remain static. At present they remain lower in DGS than Kent as a whole.
- Depression prevalence is increasing.
- 6306 per 100,000 people in DGS are admitted with mental health as a secondary code – compared to 5,794 per 100,000 in Kent.
- Only 36.2% of people in DGS with SMI had a full annual Core Physical Health check in 2022/23 compared to 46% in Kent.

8.8 Recommendations

- Ensure that those with mental health conditions have access to the same level of basic health screening as the general population. This may include targeting inclusion health groups for health checks (to capture those without a diagnosis) and increasing the rate of annual physical health checks within those with severe mental illness to match the Kent average, with special focus on assessment of blood lipid levels and alcohol consumption. As per WHO guidance this may involve coordination of care, and the use of SMI specific resources (118).
- HCPs could work to include mental health care within all care, with particular focus on hospital at home care. This would allow those with secondary mental health concerns to receive the correct support but still be able to receive care in their own home if this is felt to be beneficial for them through a shared decision-making process.
- The Public Health team should review the mental health burden of both common and serious mental health in Kent & Medway, highlight inequalities by age, sex and ethnicity, and evaluate whether the current mental health services meet the needs of the population and are being accessed by those groups with higher need such as inclusion health groups. Within this, there should be exploration of whether the services are in the right place, with cultural and language appropriate care. This can be performed via the Mental Health needs assessment.
- Exploration of the risk factors for mental health (and substance misuse) within the Swanley area, such as a review of loneliness and ACEs to identify any population groups who may benefit from interventions, for example trauma informed care, to reduce their risk of substance misuse and mental health conditions. Utilisation of the KMCR linked dataset may facilitate this analysis.

9 Living well - Substance misuse

9.1 Introduction

Misusing drugs is linked to high rates of health and socioeconomic inequalities. For instance, those who misuse drugs face higher rates of premature morbidity and mortality. Research also suggests that nearly all opioid dependant users smoke tobacco, and this causes a significant proportion of the mortality seen in this group.

Alcohol-related deaths account for approximately 3% of all mortality. About one third of these are alcohol-specific deaths, such as alcohol poisoning, alcoholic liver disease or acute pancreatitis, liver cancer, and SMI associated with alcohol misuse. Rates of which increased in England during the COVID-19 pandemic, rising from 10.9 per 100,000 in 2017-19 to 13.8 per 100,000 in 2020-22 (119).

Young people are particularly vulnerable to the harms of alcohol, and it is recommended that no one under the age of 15 should consume alcohol. Fortunately, the proportion of young people aged 11-15 who drink alcohol has reduced slightly from 44% to 40% between 2016-2021(120).

9.2 National policies

9.2.1 National Drug Strategy 2021 – From harm to hope: A 10-year drugs plan to cut crimes and save lives

This 10-year plan aims to disrupt drug supply chains, provide world-class drug treatment and recovery services, and reduce the demand for recreational drugs. This follows all the key recommendations from Dame Carol Black's Independent Reviews of Drugs and commits £3 million over 3 years to see these to fruition (121). The Dame Carol Black report also highlights the importance of services to treat alcohol misuse and states that there should be no further cuts to drug and alcohol services. Furthermore, this report highlights the importance of joined up services, a concept further supported by a peer review of Kent in 2020.

9.2.2 Kent's Drug and Alcohol Strategy 2023-2028 (122)

This local strategy reflects local need on the national 'from harm to hope' strategy. It focuses on prevention, improving treatment and recovery, and community safety.

9.2.3 The NHS Long Term Plan

This plan highlights the key priorities for the next ten years. These include better support for children and young people transitioning to adult services, improvements to co-ordinated care, psychiatric liaison, lifestyle advice, and support for alcohol treatment and improved access to psychological services and urgent/crisis care.

9.3 Best Practice

Best practice guidance can be found in the relevant subject-based Health Needs Assessments and NICE guidance.

- Alcohol needs assessment
- Drug Needs assessment
- Inpatient Detox Needs Assessment
- Homelessness / Rough Sleeping Needs Assessment
- Children and Young People Drug & Alcohol Needs Assessment (0-25 years old)

- Domestic Abuse Needs Assessment

9.4 NICE Guidance

NICE guidance recommends that:

- Needle and syringe programmes should be available at a range of different locations which account for the geography of the area. This could utilise other settings such as pharmacies.
    - A mixture of service levels should be available with some services offering blood-borne virus testing, vaccinations, and referral to specialist services.
- Care pathways should be integrated
- Advice on reducing the risk of blood-borne viruses should be given.
- Opportunistic brief interventions should be provided for those who are not in contact with drug services
- Brief advice or psychological treatment should be offered for those with mild alcohol dependence
- Treatment for moderate or severe alcohol dependence should occur through planned withdrawal programmes with psychological treatment following successful withdrawal.

9.5 Epidemiological findings

9.5.1 Mortality - Drug misuse

A severe consequence of substance misuse is drug related deaths. Fortunately, these appear to show a slight decline in the last ten years, as shown by figure 94, though the number of deaths in Dartford have been persistent. Due to data restraints this figure uses Sevenoaks data as a proxy measure for Swanley.

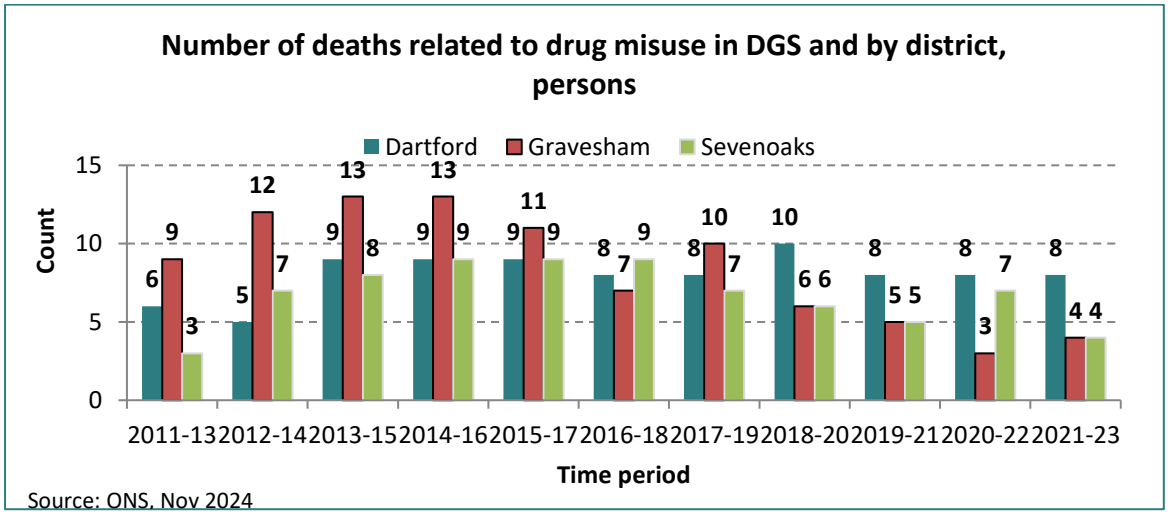


Figure 94: Number of deaths related to drug misuse in DGS and by district, persons (2011/13-2021/23)

9.5.2 Mortality - Alcohol

In 2023/24 Gravesham had the second highest rate of drug and alcohol-related deaths in Kent, at 45 per 100,000. This is approximately 11% of the drug and alcohol-related deaths within the whole of Kent. Rates in Dartford appeared lower at 23 per 100,000 and rates in Sevenoaks were

15 per 100,000. Unfortunately, these rates are not available at Swanley level but the crude number of deaths within Sevenoaks was the lowest within Kent.

Alcoholic liver disease mortality in DGS has remained stable, with a slight decrease since 2019-21, as shown in figure 95. Rates in Gravesham appear slightly higher than in Dartford but this is not a statistically significant difference. Overall rates in DGS are similar to Kent. In Kent alcoholic liver disease mortality rates are approximately 5.5 times higher in the most deprived compared to the least deprived, and over two times as high in men as they are in women.

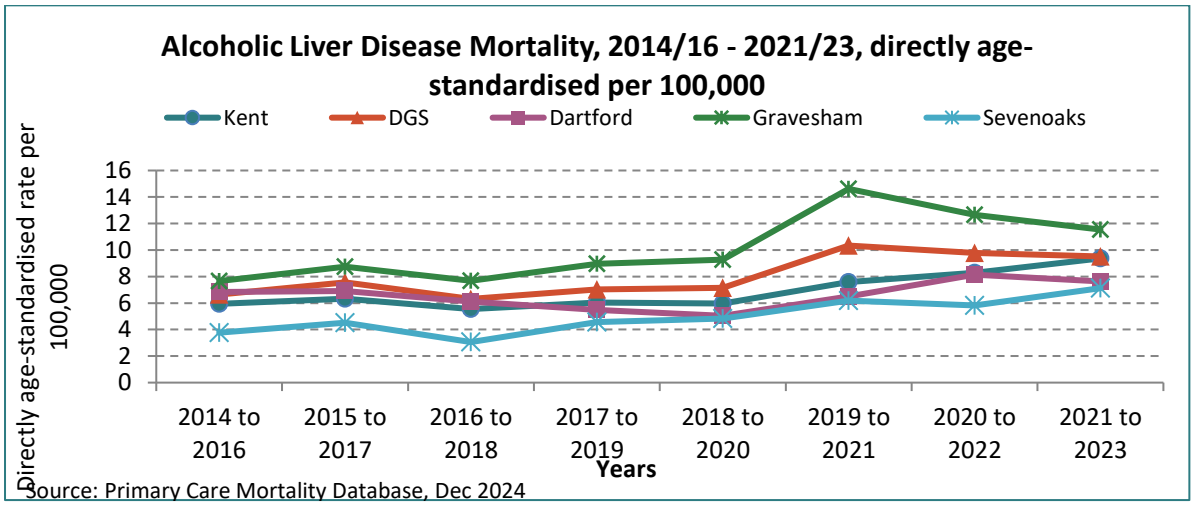


Figure 95: Alcoholic Liver Disease Mortality, 2014/16 - 2021/23, directly age-standardised per 100,000

9.5.3 Substance misuse

Admissions where substance misuse is recorded as the primary or secondary diagnosis have been stable in Dartford, Gravesham, and Sevenoaks between 2017-2022, as shown in figure 96. Within Kent as a whole substance misuse rates are higher in the most deprived quintiles than the least deprived quintiles. Furthermore, rates also tend to be higher in males than females. Within Sevenoaks Substance misuse rates are highest in Swanley.

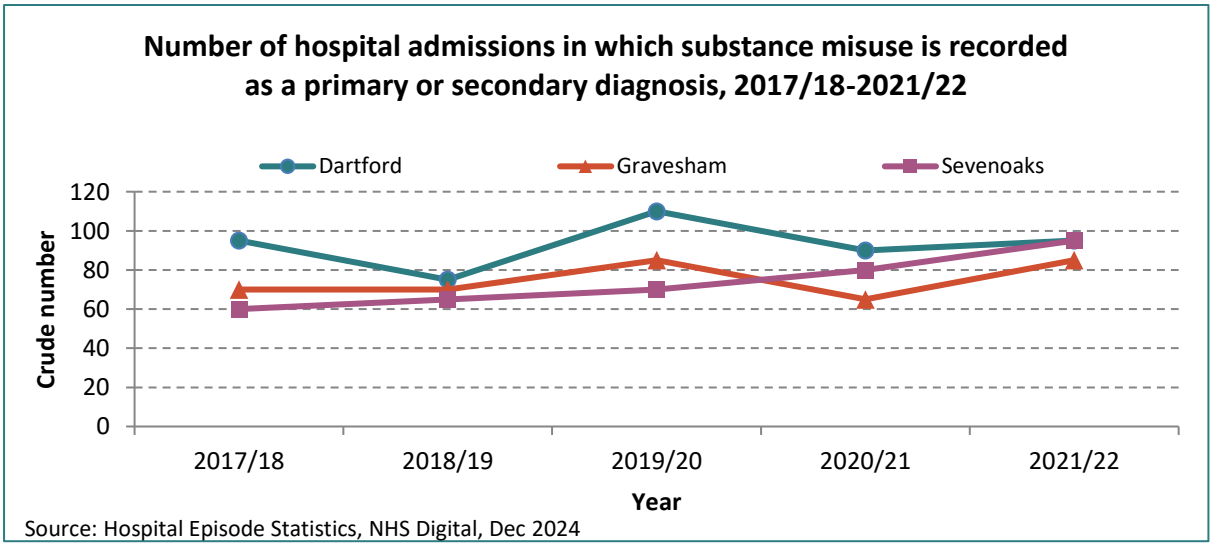


Figure 96: Number of hospital admissions in which substance misuse is recorded as a primary or secondary diagnosis, 2017/18-2021/22

9.5.4 Alcohol specific admissions

Rates of alcohol specific admissions in DGS have been growing in the last 5 years and are now significantly higher than the Kent average, as shown in figure 97. This has occurred despite DGS as a whole reporting significantly lower levels of alcohol consumption, as shown in figure 98.

This may indicate that the alcohol-specific admissions are due to a smaller number of high risk, treatment resistant clients, sometimes referred to as 'blue light' clients, or that the alcohol consumption data is not representative of the population (123). The data may not be representative of the population due to low access to services such as GP alcohol consumption assessment in certain population groups. Local data shows that members of the BAME communities struggle to access substance misuse services, including their GP, and therefore this data may not be an accurate representation of the alcohol consumption in DGS (124).

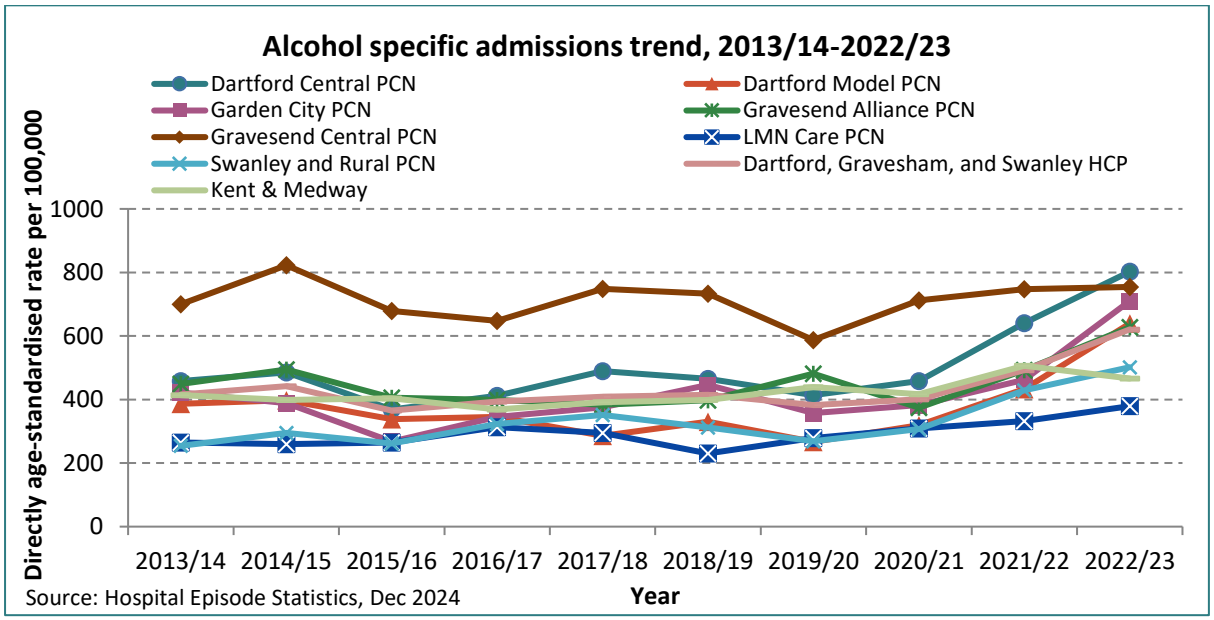


Figure 97: Alcohol specific admissions trend in Dartford, Gravesham and Swanley, 2013/14-2022/23, per 100,000.

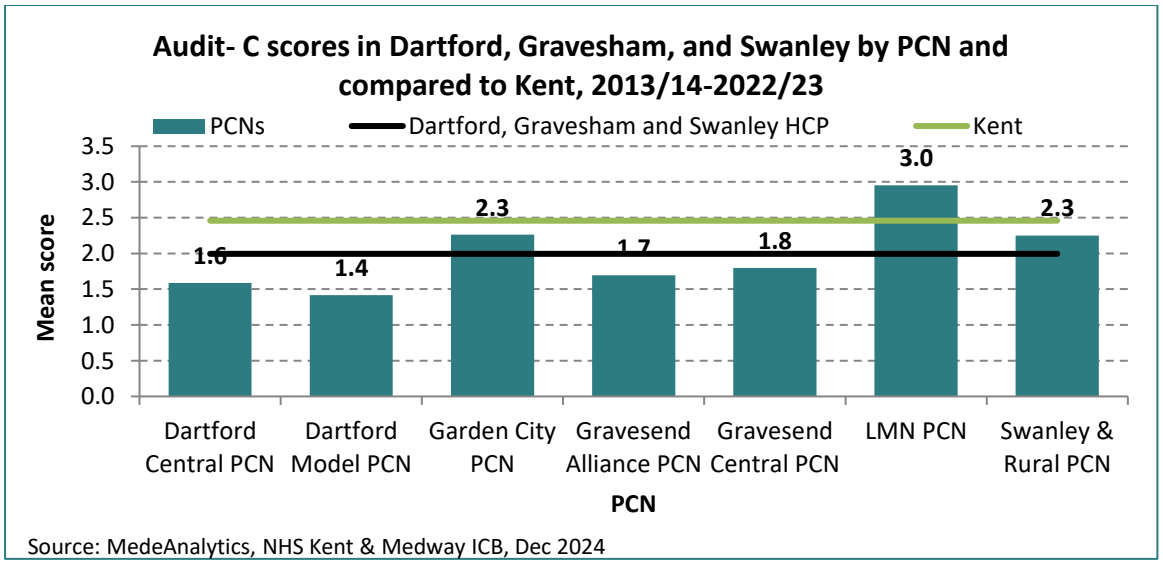


Figure 98: Alcohol consumption Audit-C score in DGS by PCN, mean score, 2013/14-2022/23.

Within DGS, alcohol specific admissions disproportionately affect those in lower socioeconomic groups, with rates in the most deprived quintile over 2.5 times higher than the rates in the least deprived quintile. Alcohol specific admissions are also higher in Gravesend Central PCN, as shown in figure 99. Lastly, alcohol specific admissions tend to occur in those aged 15-65, with higher rates in those in the older end of this age bracket. This aligns with the latest alcohol specific mortality trends in Kent as a whole. Alcohol misuse in the BAME population rose during the COVID pandemic, local research shows that these communities tend to face barriers such as language, access, and stigma preventing access to services.

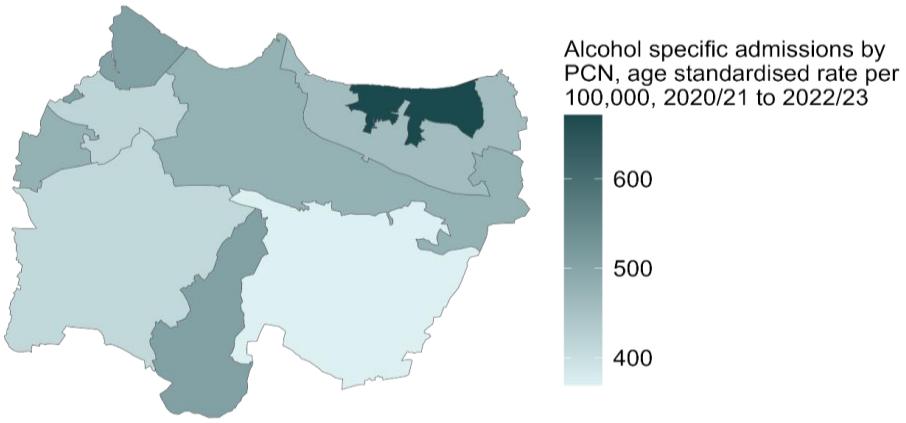


Figure 99: Alcohol specific hospital admissions, 2020/21 to 22/23, age-standardised rate per 100,000 residents.

9.5.5 Emergency Department Attendances

Evidence suggest that in the UK 12-15% of patients attending the Emergency Department (ED) are intoxicated and that accidents, including road traffic accidents, are more common when people are intoxicated (125,126). As such, there may be a link between alcohol consumption and increasing rates of ED attendances in DGS. In DGS the highest ED attendance rates are in Gravesend Central, as shown by figure 100. In DGS, ED attendance rates are 50% higher in the most deprived compared to the least deprived and in Kent as a whole they tend to be slightly higher in females compared to males.

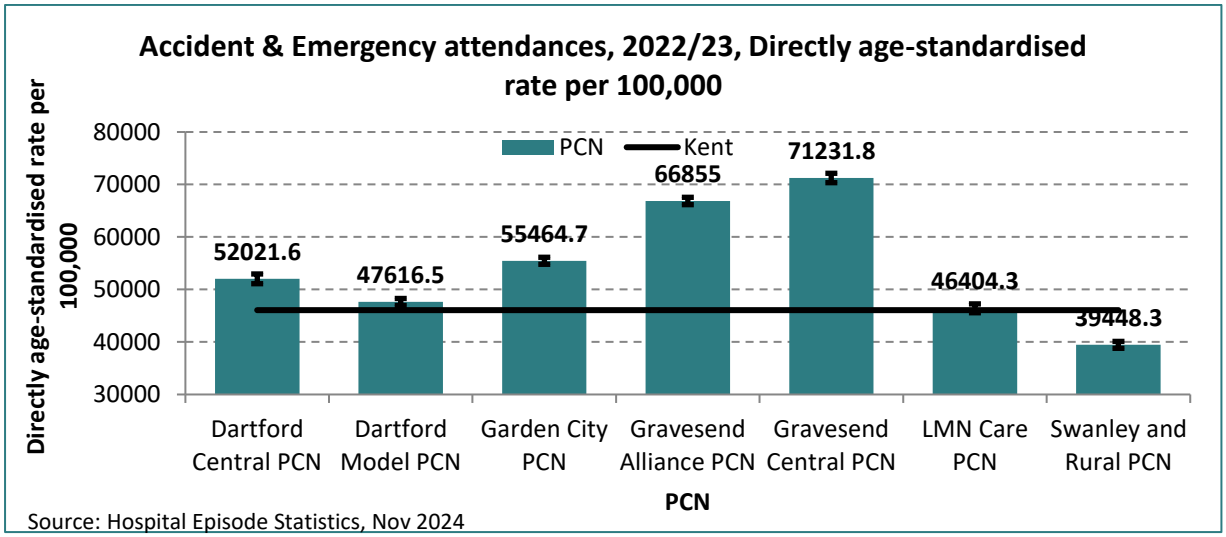


Figure 100: Accident & Emergency attendances, 2022/23, Directly age-standardised rate per 100,000

9.5.6 Crime

Nearly half of all violent crime in the UK is thought to be related to alcohol use (127). As such, this may be a driving factor in the high rates of crime and admissions for assaults in DGS.

Within DGS over the five years from 2018-2023 crime rates have been higher than the Kent average of 96.7 per 1,000 (95% CI 96.5-96.8 per 1,000) in Gravesham and Dartford, at 120.2 (95% CI 119.4-121 per 1,000) and 108.8 (95% CI 108-109.5 per 1,000) respectively. Rates in Swanley were below the Kent average at 85.2 (95% CI 84.2-86.2 per 1,000).

Admissions for assault tend to be higher in Gravesend Central than the rest of DGS, as shown by figure 101. Crime rates and assault admissions within Kent are associated with socioeconomic deprivation and are more common in men than women.

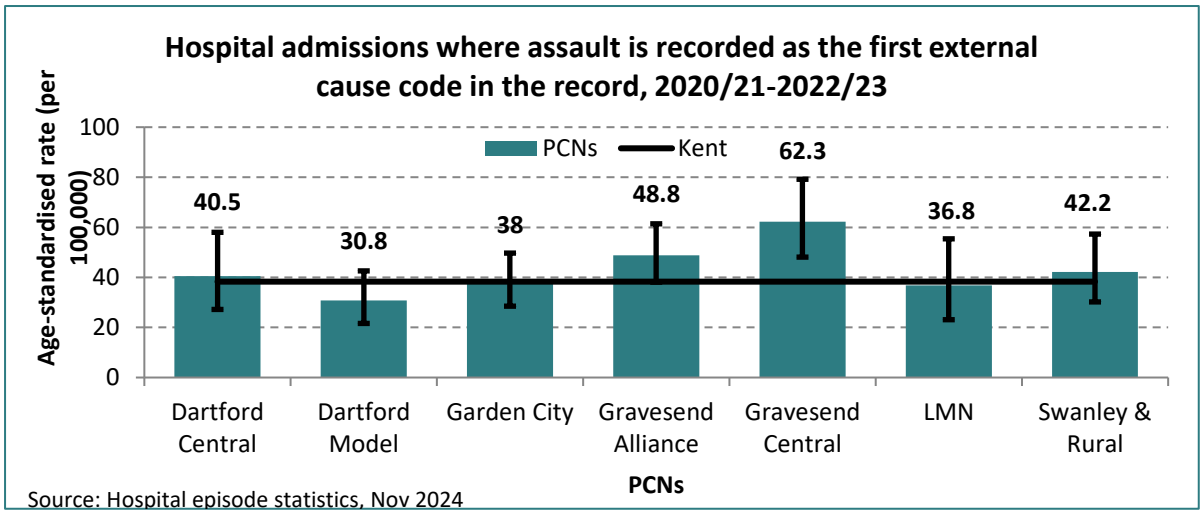


Figure 101: Hospital admissions where assault is recorded as the first external cause code in the record, 2020/21-2022/23, per 100,000.

Gravesend Central PCN shows high rates of alcohol specific admissions, admissions related to assaults, and ED attendances. As research shows alcohol is linked to all these indicators this may benefit from a co-ordinated whole system approach.

9.5.7 Risk Factors

The risk factors for substance misuse and mental health conditions are similar and therefore have been discussed in the mental health section of this HNA.

9.6 Current services

Adult substance misuse services in DGS are provided by Change, Grow, Live (CGL). They provide a variety of services including facilities for safe needle exchange in Gravesend, support through peer mentoring, and Complex Case Workers for those experiencing co-occurring conditions. Further Kent wide support for those at a hazardous level of alcohol consumption (as per the AUDIT score (128)) is offered via more widespread intervention and brief advice during medical consultations and by One You Kent.

Inpatient detoxification services for adults in the DGS area are provided by Bridge House in Maidstone and the Dame Carol Unit in Farham, Hampshire. Patients are referred by CGL to these services which are commissioned by Kent County Council.

Supplemental Substance Misuse Treatment & Recovery Housing is a joint service between Kent County Council, Kent Substance Misuse Services, and District Housing Teams which aims to support individuals with a housing need who are currently in or willing to engage with structured substance misuse treatment.

Support for young people in DGS is provided by We Are With You who target 11–18-year-olds but also provide support for 18–24-year-olds. Opioid substitution treatment is only offered by adult services.

Substance misuse services in Kent follow NICE guidelines and have been rated well by both users and regulators. In general Kent spends less per head on substance misuse services than relevant comparators but tends to have better outcomes. All substance misuse services offer mental health support.

Approximately 26% of people successfully exited drug misuse treatment in Dartford and Gravesham from 2022/23-2023/24. Data is not available at Swanley level but successful completion rates in Sevenoaks were around 26% during this period.

9.7 Gaps

Substance misuse data stratified by ethnicity is not readily available. Therefore, identifying if any ethnic groups are at greater risk of substance misuse and the consequences of this is difficult.

Alcohol increases the risk of accidents but there is little analysis on the degree of which alcohol is linked to falls in the DGS area. This may be a developing problem as the data suggests that a greater proportion of those misusing alcohol are in the later years of the 15-65 age bracket and therefore may be at an increased risk of fragility fractures, the risk of which increases with age.

It is unclear if the alcohol consumption data within DGS accurately represents the consumption behaviours within the population.

Evidence for risks for substance misuse and deaths from substance misuse are not available at Swanley level and therefore the level of need is more difficult to ascertain for this population.

9.8 Key findings

- Deaths from drug misuse are stubbornly persistent in Dartford despite reductions in Gravesham and Sevenoaks
- Alcohol specific admissions in DGS are rising despite falling rates in Kent as a whole.
    - This is despite paradoxical data on alcohol consumption showing consumption rates in DGS as the lowest of the HCPs in Kent.
- Gravesend Central PCN and Gravesend Alliance PCN have high rates of alcohol related harms – this includes alcohol-specific admissions, crime, ED attendances, and admissions for assault.
- Local data shows that people from ethnic minorities (which make up a larger proportion of DGS than the other HCPs in Kent) find it difficult to access substance misuse services.

9.9 Recommendations

Given the district level variation in substance misuse, mental health, and demographics including ethnicity, deprivation, and age structure in Kent all interventions within the following recommendations should be place based.

- Extend services such as needle exchange locations and naloxone provision in Dartford to combat persistently high numbers of deaths from drug misuse
- Public Health and substance misuse services should provide BAME community specific substance misuse support groups as these communities tend to be very private.
- Given the interlinking nature of substance misuse, crime, and emergency department attendances, especially for assault, within DGS, a population health management approach may be appropriate.
    - This approach could bring together relevant partners to undertake the appropriate risk stratification assessment to identify the correct groups and align the priorities and strategies for management of these patients.
    - This may then be actioned by the ICB and HCP utilising integrated neighbourhood teams involving mental health, substance misuse, public health, and community nursing. Integrated neighbourhood teams would provide the additional benefit of acting as a bridge between acute and community care.
    - In addition, partners such as Criminal Justice and Social Care could continue to ensure care is integrated by continuing and improving data sharing.
- To prevent substance misuse information regarding the risks of substance misuse should be available in areas frequented by those at risk, such as night clubs (129). This should also include information on local services.
- Identification and brief advice should be provided by all settings.
- The Public Health team should analyse the data for the last three years to review the relationship between ethnicity and substance misuse risk and consequences. This is needed to understand the scope of need in these communities, especially given local insight research shows that those from ethnic minority groups can struggle to access substance misuse support services.
- Exploration of the risk factors for substance misuse (and mental health) within the Swanley area, such as a review of loneliness and ACEs to identify any population groups who may benefit from interventions, for example trauma informed care, to reduce their risk of substance misuse and mental health conditions.

10 Living well – Smoking and Respiratory Health

10.1 Introduction

Smoking rates have declined steadily since 2017 and yet smoking remains one of the main causes of preventable diseases in the UK; accountable for 1 in 6 of all deaths in England. It is a major risk factor for 16 different cancers and 18 other health conditions, such as chronic obstructive pulmonary disease (COPD), heart disease and stroke (130).

Mortality rates due to smoking are 3 times higher in the most deprived areas than the most affluent areas, demonstrating that smoking is intrinsically linked to inequalities (131). Nationally, more than 77,000 people die each year from smoking, more than obesity, alcohol and illegal drugs together (132). There were 547 avoidable deaths from lung cancer, oral cancer and COPD in Dartford and Gravesham alone in 2022-23. Action on Smoking and Health (ASH) estimate that smoking costs the Dartford and Gravesham economy £142.4 million each year, as shown in figure 102. £88.8m of this is attributable to smoking related loss of economic productivity, £46.9m in social care costs and £6.7m healthcare costs every year.

Smoking prevalence is particularly high among routine and manual workers, those who are unemployed, people with mental health illness and across some ethnic groups. The cost of smoking can very often exacerbate their financial problems. Motivating smokers within these groups to quit can be particularly challenging as they tend to smoke more and are less likely to want to quit.

Effective tobacco control measures can reduce smoking prevalence in the population. Preventing ill health through smoking cessation can significantly reduce premature mortality and morbidity, relieve some of the burden on NHS resources, and help reduce inequalities.

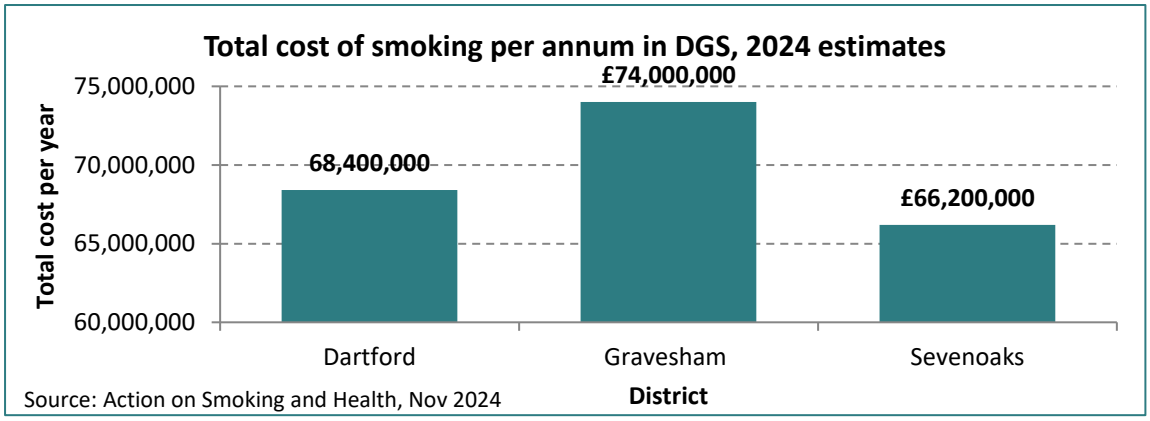


Figure 102: Total cost of smoking in Dartford, Gravesham, and Sevenoaks per year (133)**.**
Due to data restraints Sevenoaks data has been used as a proxy for Swanley.

10.2 Best Practice

In October 2023, the government issued 'Stopping the start: our new plan to create a smokefree generation'. The plan sets out ambitious proposals recommended by the Khan Review in 2022 which concluded that the national agenda to reduce smoking prevalence to 5% or less is not on track and that, if we do not act, nearly half a million more people will die from smoking by 2030. Through the national plan, the government intends to introduce legislation to increase the legal age of sale of tobacco to stop young people from ever starting to smoke. In addition, the government has committed an additional £70m per year to invest in local stop smoking

services. This aims to increase the number of people who set a commitment to quit smoking with stop smoking service support (measured by set quit dates) and to ensure that all local stop smoking services are in line with quality standards and recommendations set out in the National Centre for Smoking Cessation and Training guidance and NICE Guidance (NG209). Kent has received £1.94m funding in 2024/5 under a Section 31 grant agreement to achieve an additional 1,347 set quit dates. Grant funding will be awarded annually for 5 years with an overall Kent target of 26,937 additional set quit dates in 5 years.

10.3 Epidemiology

10.3.1 Smoking Prevalence

Smoking prevalence in Kent is similar to the England average (11.4% compared to 11.6%) and Dartford and Gravesham levels are estimated to be 11.75% which equates to 19,442 smokers.

The following charts, figures 103 and 104, show estimates of district level smoking prevalence. Note the wide confidence intervals at district level and fluctuating rates are likely to be due to ONS survey and GP survey response rates. The data is for two slightly different age groups, 16+ and 18+ but the differences between the two datasets highlight the problems with providing accurate estimates of smoking prevalence at a district level. Swanley level data, is unfortunately not available, therefore Sevenoaks data has been supplied for the 16+ age bracket with the caveat that it is likely an inaccurate representation of Swanley given HCP estimates.

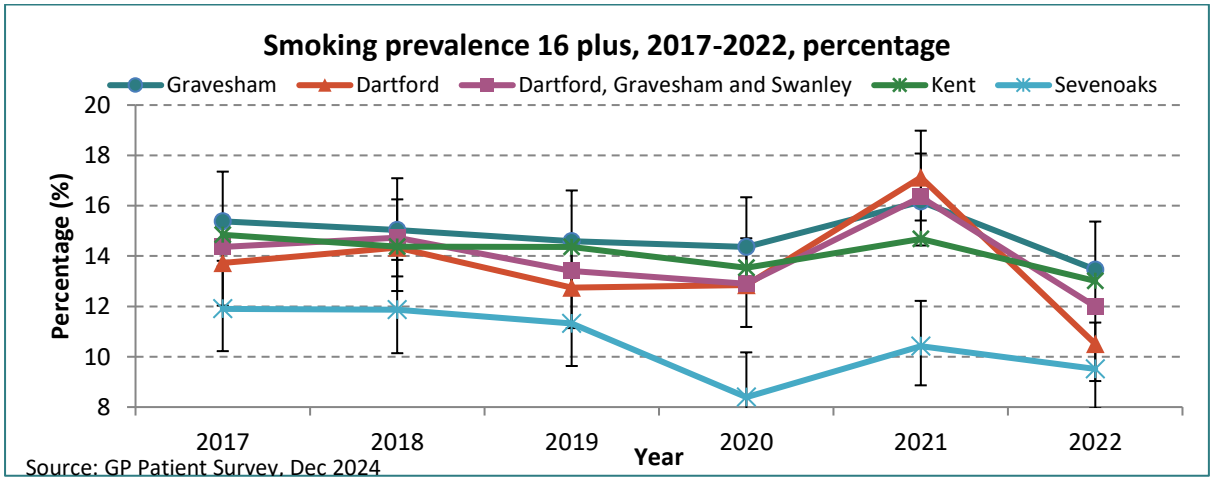


Figure 103: Smoking prevalence 16 plus, 2017-2022, percentage.

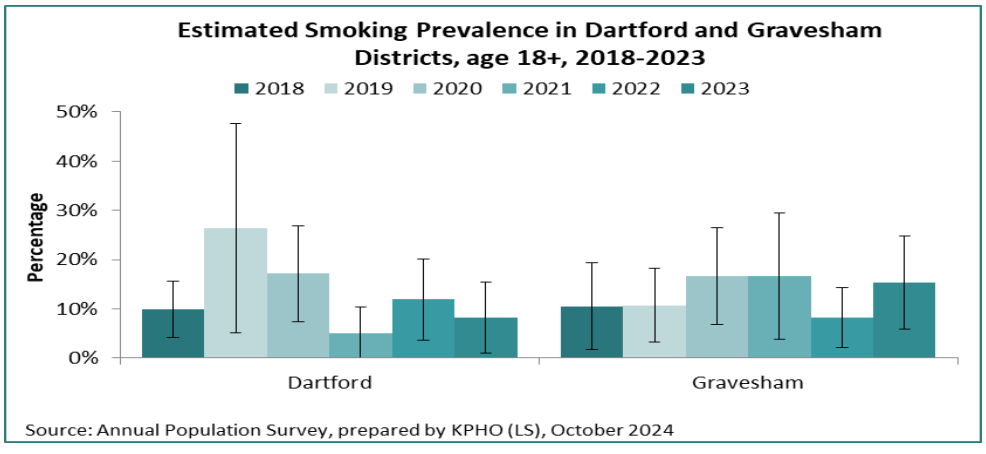


Figure 104: Estimated Smoking Prevalence: Dartford and Gravesham

Although the smoking trend in general has reduced year on year, smoking rates are still stubbornly high among routine and manual workers (17%) and other lower socio-economic groups including those who live in social housing. People living with social and economic hardship tend to smoke more, be more addicted and find it harder to quit, although they may try just as often. The cost of smoking is more likely to perpetuate poverty among those who are least likely to be able to afford it. Households where people smoke tend to be poorer because of an addiction which usually started in childhood. This exposes children to the harms of second-hand smoke and statistically increases the likelihood of children taking up smoking. Two thirds of adult smokers started before they reached 18 and most of them go on to become regular adult smokers. There is also a strong association with children taking up smoking and smokers from low socio-economic groups engaging with the illicit tobacco trade .

The sale of illicit tobacco compromises public health policies encouraging smokers to quit. It adversely impacts Revenue and Customs tax increases aimed at reducing the demand for tobacco products by supplying cheaper, unregulated alternatives. Much of the trade is led by criminal gangs supplying merchandise to local sellers and often responsible for initiating children into smoking at affordable 'pocket money' prices.

10.3.2 Young People

The national NHS Digital, Smoking, Drinking and Drug Use Survey shows that 11% of pupils reported having ever smoked, while 3% report to be current smokers and 1% said they smoke regularly (134). However, 1 in 4 pupils surveyed (25%) said they have tried vaping. Vaping among under 18-year-olds poses potential health risks and can initiate a nicotine addiction. Reducing vaping among under 18s and adults who are not using vapes to support a quit attempt is a public health priority and government legislation to reduce the sale and accessibility of vapes to under 18s is expected to be announced in the Autumn 2024.

10.3.3 Smoking in Pregnancy

Smoking during pregnancy is associated with health risks and birth abnormalities such as premature birth and low birth weight and increased risk of stillbirth, miscarriage, and sudden infant death (135). It is estimated that 6.25% of women are recorded as smokers by the time their babies are delivered in Dartford and Gravesham*. Pregnant women who smoke are more likely to be younger and live in poorer communities. Regional differences in smoking in pregnancy rates reflect the area's general smoking prevalence, so activities that reduce the adult smoking population are likely to also reduce smoking in pregnancy.

**these estimates are calculated using district level data and there may be some discrepancies with geographical boundaries*

10.3.4 Adults with a Mental Health Condition

Smoking rates are higher among people with a mental health illness compared to the general population, with smoking prevalence increasing relative to the severity of the mental health condition. In Kent, it is estimated that 25% of adults with anxiety or depression smoke compared to 11.4% of the general population. This rises to 40% among those with a serious mental illness (132). Access to accurate smoking status data is often problematic as it is not always routinely collected and yet we know that smoking rates are higher among people with mental health concerns. Smoking is very often used to manage levels of stress and anxiety and nicotine withdrawal symptoms can heighten further feelings of stress thus perpetuating

nicotine dependency which can be more pronounced for smokers with a mental health condition (136).

10.3.5 Ethnicity

GP Primary Care data reports slightly higher smoking estimates than the ONS but provides a breakdown of smoking rates by ethnicity. In 2022 GP data showed a 16.5% smoking prevalence among White British people in Kent. Groups with higher rates are:

- Gypsy/Irish Travellers (36.4%) – highest smoking rate
- Other White (24%)
- Arab (21.9%)
- White and Black Caribbean (19.4%)

Ethnic groups with a lower smoking rate than White British are Bangladeshi, Indian, Pakistani, and other Asian, ranging from 6.7% to 13.1% prevalence. It is important for stop smoking support to be accessible and commensurate to the needs of different ethnic groups and mindful that different cultures may hold different attitudes to smoking and propensity or inclination to want to quit. Further targeted community support is also needed to explain the benefits of quitting smoking and to support different and effective ways to motivate smokers to want to quit.

10.3.6 Sexual Orientation

Smoking prevalence is higher among lesbian, gay and bisexual people than in the general population, although data sources are limited (137). NICE guidance (NG209) emphasises the need for vulnerable groups, including LGBTQ+ smokers to be targeted and prioritised in smoking cessation services.

Although the reason for higher smoking prevalence among the LGBT community is not known, managing stress associated with transphobia, prejudices and attitudes of some non-LGBT people is one possible theory (138). Other factors associated with higher smoking prevalence are being single, homeless and being part of other groups with higher smoking rates.

The LGBT Foundation suggest that visibility of LGBT people (as a high smoking prevalence group) should be included in campaign communications and offering drop-in stop smoking sessions in voluntary sector premises.

10.3.7 Homelessness

Data on smoking prevalence among homeless people is not routinely collected in the UK but it was estimated in 2014 that 77% of people experiencing homelessness smoke (139). Riskier smoking behaviours, such as sharing cigarettes with other people or using discarded cigarette butts and poor mental health issues are disproportionately high among people experiencing homelessness.

The Groundswell Report (2016) estimates that more than 50% of homeless people want to quit smoking and recommends that local authorities, public health teams and homelessness support should collaborate to ensure stop smoking support is provided to people experiencing homelessness (140). Very often, factors such as transient residencies and staff training pose challenges in homeless shelters and support to quit smoking is often not regarded as a priority. National trials have shown that quit support can be deliverable and beneficial (141).

10.3.8 Smoking and Substance Misuse

Some drug use, particularly cannabis, is administered by smoking. 7.4% of 16–59-year-olds in the UK report to be cannabis users (142). Smoking prevalence is likely to be higher among drug users in accordance with risk taking behaviours. The UK government estimates that nearly 100% of opioid dependent users also smoke and suggests that drug users are more likely to die from smoking-related illnesses than drug use (143). Adverse Childhood Experiences (ACEs) also increase the risk of smoking, drug and alcohol addiction later in life.

Smoking prevalence is shown to be higher among adults admitted into substance misuse treatment services using the National Drug Treatment Monitoring System (NDTMS). Smoking status among non-opiate users is considered to be particularly high, with two thirds of those admitted identified as smokers.

Intervention strategies to treat drug dependency should identify smoking status and offer effective harm reduction or cessation support to all clients who smoke either as part of or alongside their drug treatment. All smokers should be encouraged and motivated to quit. It may be worth exploring whether clients engaged in treatment services would benefit from quit smoking support from the drug dependency services or from locally commissioned stop smoking services.

Further information about the factors associated with smoking among high smoking prevalence groups and how these are being addressed are detailed in the Kent Tobacco Control Needs Assessment.

10.4 Available services

In Kent, local authority commissioned stop smoking services, Kent Community Health NHS Foundation Trust (KCHFT) deliver quit support under the One You branding. The service comprises behavioural support, additional resources and the offer of pharmacotherapy and/or vape products over a seven-week intervention. Some GPs and pharmacies are sub-contracted to deliver stop smoking services in the community which increases the reach and accessibility of stop smoking services. Smokers are four times more likely to quit with the support of commissioned stop smoking services, making them cost effective. In 2023/4, 5,231 smokers set a quit date with the stop smoking service and 2,871 successfully quit (55%). Although this is slightly higher than the England average (54%), only 3.6% of the estimated number of smokers in Kent try to quit using stop smoking services support. Successful quit rates are higher among retired smokers, managerial and intermediate groups (67.1%, 59.9% and 61.6% respectively), reflecting the difficulty of quitting among disadvantaged groups.

The NHS Long Term Plan provides NHS funding to maternity trusts to deliver new-in house stop smoking services for pregnant women who smoke throughout the duration of their maternity. This dedicated quit support aims to identify smokers at an early stage in pregnancy and provides continual support to increase quit successes and reduce relapses into smoking. The Long Term Plan also funds a dedicated tobacco dependency service delivered to inpatients in acute trusts. The programme provides support for smoking abstinence throughout the patient's hospital episode and refers into community stop smoking services at the point of discharge from hospital.

10.5 Gaps

- One of the main gaps in tobacco control is the absence of smoking status data. Health, wellbeing and care providers should routinely collect and report on client's smoking status. This will provide opportunities to offer very brief advice on reducing ill health and promoting healthy behaviours to people who need it. It also provides an opportunity to offer smokers access into stop smoking support.
- Many smokers may feel disinclined to quit or feel they are unlikely to succeed in quitting. There needs to be more opportunities for smokers to be motivated to quit smoking in their daily lives.
- Quit services offer a range of support but further insight is needed to develop more flexible, tailored quit services that meet the needs of high smoking prevalence groups. Harm reduction and extended 12-week programmes should be considered and greater engagement is needed to co-design services with specific groups to ensure that quit support is engaging and accessible.
- There needs to be greater promotion of quit services, explaining the service offer and ensuring that stop smoking support is equitable and accessible.

10.6 Key findings

- 12% of over 16s smoke in the DGS population
- Smoking rates are reducing slightly in DGS and Kent but 11.75% of adults in Dartford and Gravesham smoke, costing £142.4m each year.
- 36.4% of the Gypsy/Irish traveller population smoke
- 6.25% of women smoke during pregnancy in Dartford and Gravesham.

10.7 Recommendations

- To reduce smoking prevalence rates more smokers need to quit smoking and further prevention measures are needed to reduce the uptake of smoking in the first place. Stop smoking services offer the greatest chance of successful quitting so need to be promoted widely and campaigns targeted to high smoking prevalence groups. Local Authority and Health partners and the voluntary/community sector have a role in identifying smokers within their client groups and promoting opportunities to help people quit.
- Increasing take-up of stop smoking services will require increased engagement with specific community groups and key touchpoints (such as workplaces) to increase motivation and encourage smokers to want to quit.
- 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.
- Lastly, vaping uptake among young people needs to be addressed to ensure that vaping does not become a new gateway into smoking. Public Health and Trading Standards are currently working together to tackle underage sales of vape products, but legislation needs to be introduced to make vapes less appealing and inaccessible to children.

11 Living well – Adult Obesity

11.1 Introduction

Obesity is a significant public health concern, with profound implications for individual health, healthcare systems, and society. Defined as a body mass index (BMI) of 30 or higher, obesity increases the risk of chronic conditions such as type 2 diabetes, cardiovascular disease, and certain cancers. It also contributes to mental health disorders, reduced quality of life, and increased mortality rates.

It is important to also address excess weight in those with a BMI between 25 and 30. This is particularly key in people from Black and Asian backgrounds, as they may develop cardiometabolic disease at a lower BMI cutoff.

Nationally, obesity prevalence among adults in England has risen steadily, with 28% classified as obese in 2022, and an additional 36% overweight.

Obesity is particularly driven by social and commercial determinants of health. It disproportionately affects those who are more deprived, who are more likely to be exposed to unhealthy foods and drinks, and more likely to have poor access to an environment that can promote physical activity in their daily lives.

11.2 National policies and Best Practice

The 2020 policy paper, "Tackling obesity, empowering adults and children to live healthier lives" is the most recent national publication on addressing obesity (144). It highlights that many people who are overweight want to lose weight but struggle to do so. In particular, it highlights the role of commercial determinants of health as a key driver of obesity, through advertisements and promotions for food. Simply, it is made hard to eat healthily and made easy to eat unhealthily.

The NIHR themed review "How can local authorities reduce obesity? Insights from NIHR research" defines 9 areas for action from local authority (145). They are,

1. Influencing what people buy and eat
2. Encouraging healthy schools
3. Expanding access to public sports and leisure services
4. Promoting active workplaces
5. Providing weight management programmes
6. Designing built and natural environments
7. Enabling active travel and public transport
8. Preventing obesity in children and families
9. Embracing system-wide approaches

Kent County Council last conducted a dedicated health needs assessment on obesity in December 2015 (146). The Kent Public Health Observatory published an analysis of family weight management programmes in 2018, and a report on adult lifestyle weight management in 2017 (147,148).

11.3 Epidemiological findings

11.3.1 Obesity prevalence

Obesity prevalence is assessed using Quality & Outcomes Framework data which may underestimate the prevalence as obesity is often only recorded for those with long term conditions. Prevalence of obesity in DGS is similar to the Kent average. The prevalence of obesity has increased significantly above the rest of DGS and Kent average in the population covered by Dartford Model PCN, but is relatively static across the rest of DGS, as shown in figure 105.

In Kent as a whole, rates of obesity in the most deprived quintiles are nearly twice that of the least deprived quintiles, this shows a social gradient.

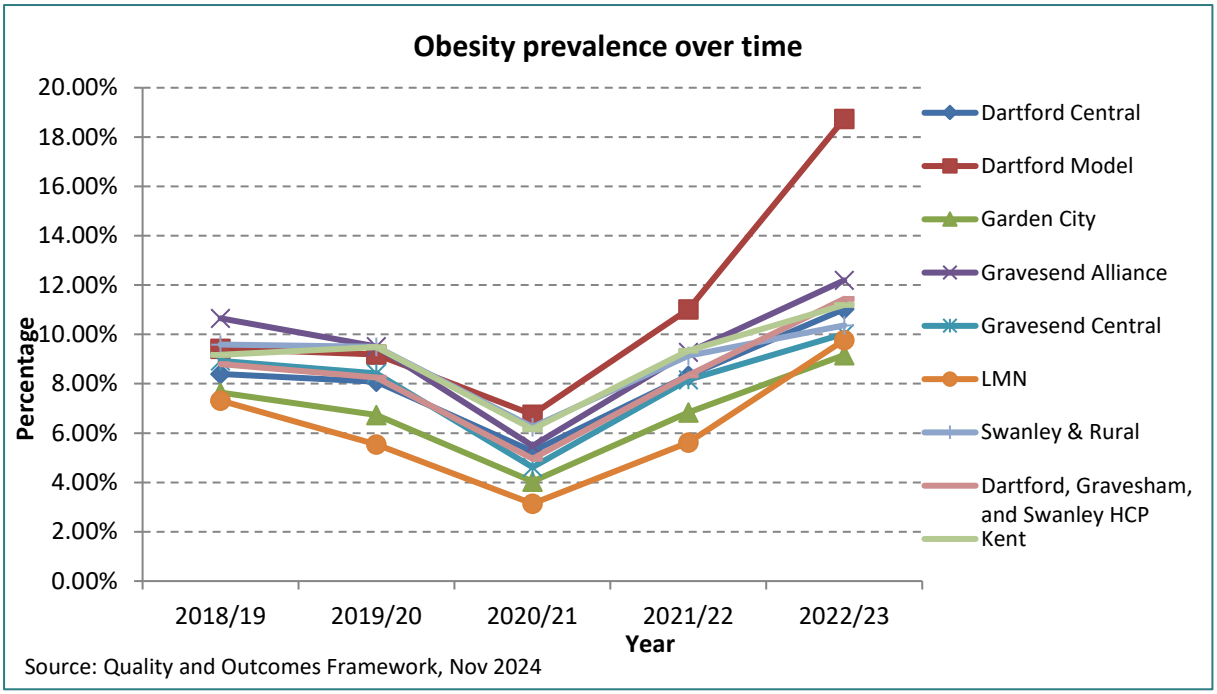


Figure 105: Obesity prevalence over time, 2018/19-2022/23, (%)

Within DGS a greater proportion of the population with obesity are from ethnic minorities. This is mostly comprised of Asian or Asian British, and Black, Black British, Caribbean or African groups. Within these Indian and African ethnicity subgroups were the most prevalent.

11.3.2 Physical activity and Diet

Physical activity and diet play a key role in obesity prevalence. Diets high in sugar and fat increase the risk of obesity as do low levels of physical activity (149). There are other risk factors for obesity, as discussed in the Child Health (5-18) chapter.

Data from the active lives survey in 2021/22 shows that the proportion of adults who are physically active for 150+ minutes per week in DGS is lowest in Gravesham, with Swanley showing the highest proportion of physically active adults, as shown in figure 106.

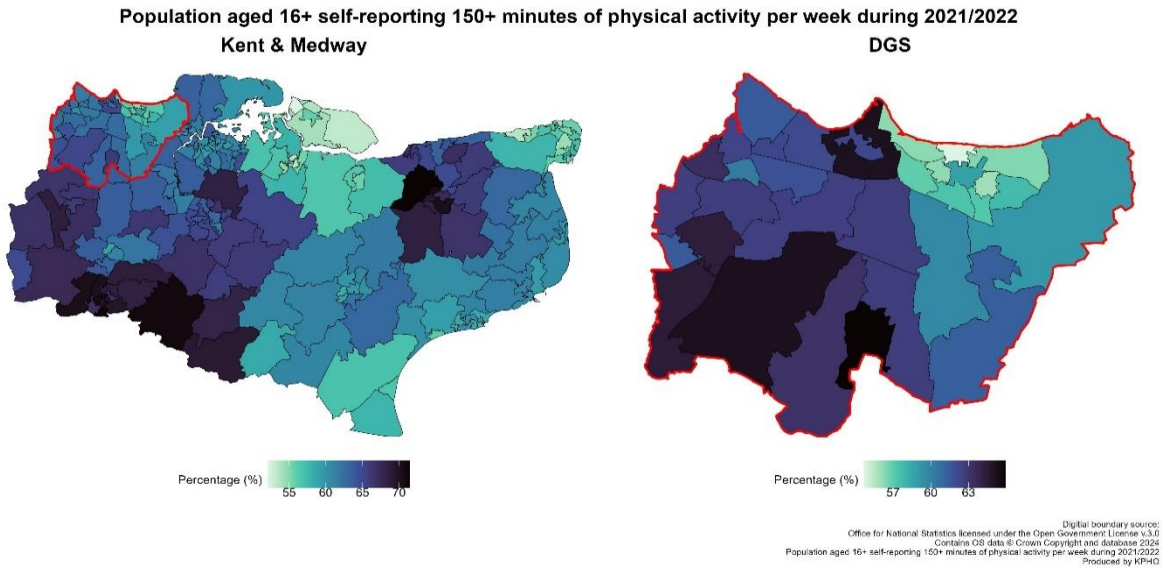


Figure 106: Map of physical activity levels in Dartford, Gravesham, and Swanley, 2021/22 (%)

Physical activity levels in Kent are approximately 16% higher in the least deprived compared to the most deprived residents. The levels are also higher in males than females. Compared to the Kent average rates of physical activity are lower in Black, Chinese, Asian (excluding Chinese), and Other ethnic groups. Rates were higher than the Kent average in Mixed ethnic groups.

Active transport is an excellent means through which to increase physical exercise and protect the environment. In England the National Travel Survey shows that in 2023 approximately 11.7% of commutes per person were through walking, 4.2% were via cycling, and 17.7% were through public transport which is also effective at increasing rates of physical activity (150,151). However, the majority of commutes, 66.4%, remained via private transport (150).

Limited progress has been made in ensuring adults are consuming adequate fruit and vegetables. In fact, the percentage of adults consuming five portions of fruits and vegetables a day has seen a slight decline across DGS, as shown in figure 107. Dartford and Gravesham have rates which are statistically significantly below the Kent average for 2020/21 and 2022/23. A degree of this may be related to cost. Research by the ONS shows that 11% of households in the South East of England reported buying less fruit and vegetables due to the increases in cost of living (152). Healthy foods in particular have seen a large increase in price (153).

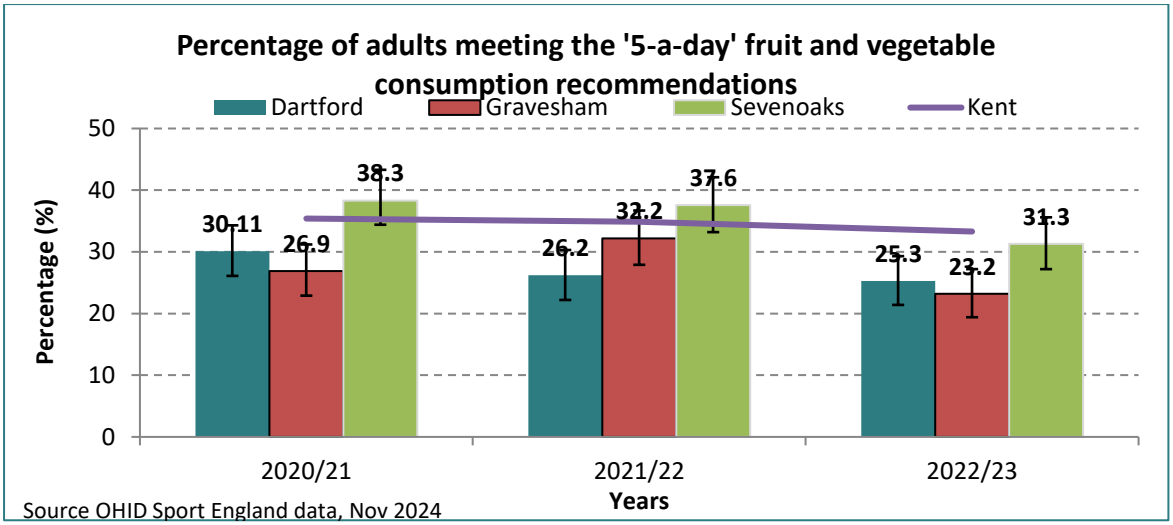


Figure 107: Percentage of adults meeting the '5-a-day' fruit and vegetable consumption recommendations 2020/21-2022/23 (%). *Due to data restrictions Sevenoaks data has been used as a proxy for Swanley data.*

11.3.3 Obesity-related admissions

Obesity-related admissions can refer to a variety of admission types. This can be admissions with a primary diagnosis of obesity, of which a large proportion involve bariatric surgery procedures (154). They can also include admissions where the primary or secondary diagnosis was obesity where obesity was either a contributing factor to the admissions or a factor relevant to the episode of care (154). Examples of this type of obesity-related admission include maternal care, arthrosis of the knee, cholelithiasis (gall stones), and chronic ischaemic heart disease. This data may be skewed as not every admission where obesity has been a contributing factor will be coded as such and variation may occur by coding practices.

Rates of obesity-related hospital admissions are significantly higher in DGS than the Kent average, as shown in figure 108. Furthermore, these rates have increased dramatically in the last two years following the COVID-19 pandemic.

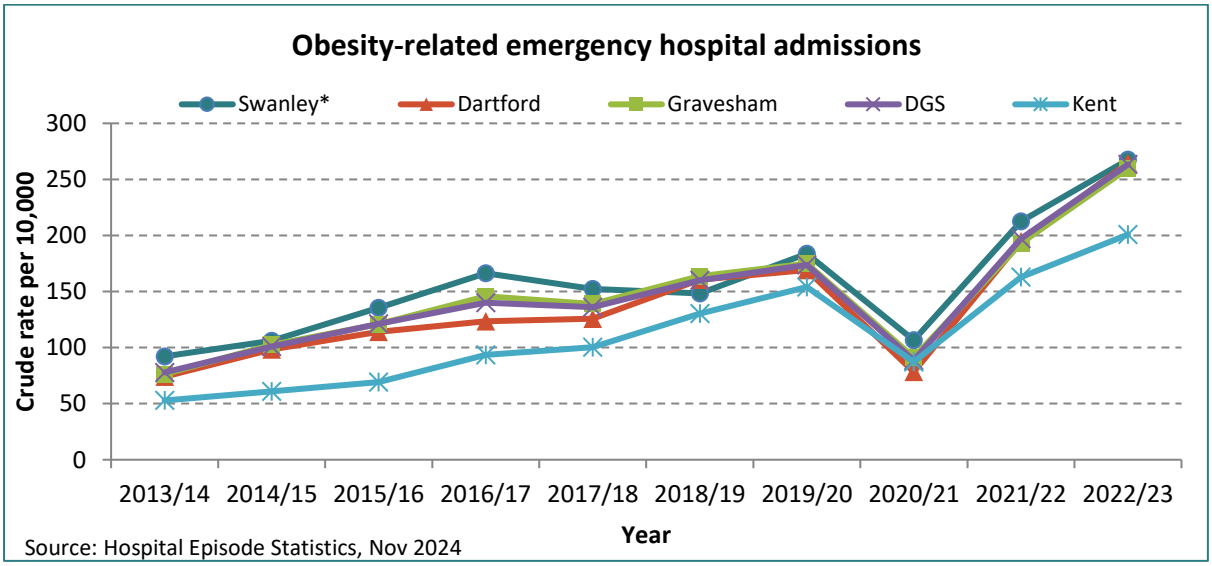


Figure 108: Obesity-related emergency hospital admissions, 2013/14-2022/23, crude rate per 10,000 *created using Swanley MSOA level data.

11.4 Current services

Adult weight management services in Kent follow a tiered system. Tier 1 involves universal prevention services, Tier 2 is lifestyle and multicomponent weight management services, Tier 3 is specialist weight management services, and tier 4 involves bariatric surgery.

Tier 1 and 2 services are commissioned by KCC and delivered by Kent Community Health Foundation Trust, Sevenoaks District Council, Dartford District Council, and Gravesham Borough Council in DGS.

In DGS tier 1 services are delivered as part of the One You programme by The Grand across DGS as part of a Healthy Lifestyles service. They focus on prevention and not just treatment of obesity. This involves programmes such as cooking classes to improve dietary intake of fruits and vegetables. In addition, physical activity initiatives are ran via Active Kent. In 2023-2024, 1,789 individuals were active in the One You Kent programme in DGS. 934 (52.2%) of these were from deprivation quintiles 1 and 2.

One You Kent weight management services include face-to-face and online group sessions, and some users may receive one-on-one sessions based on their individual needs. 894 people were referred to the Tier 2 WMP, of whom 585 were engaged on the programme. 273 (46.7%) were from deprivation quintiles 1 and 2. 558 attended at least one group session, but only 427 (76.5%) completed the twelve-week programme (This was highest in Gravesham, at 81%, and lowest in Sevenoaks, at 77%). 354 (63.4%) of participants had lost weight by the end of the programme, while 382 (89.5%) of those who had completed the programme had lost weight by the end of the programme. Of the completers, 148 (34.7%) had lost less than 3% of their baseline body weight, 139 (32.6%) had lost between 3% and 5%, and 93 (21.8%) had lost 5% or more.

Follow up data beyond this was limited, only 166 (38.9%) of completers provided a weight measure at 26 weeks after finishing the programme, and only 138 (32.3%) provided a weight measure 52 weeks after finishing the programme. Of those that provided a weight measure at 52 weeks, 52.9% had a body weight lower than their initial baseline weight.

Tier 3 services are specialised and commissioned by the ICB. They are delivered by TBC Healthcare for eligible people in Kent and involve multidisciplinary care. Tier 4 services are provided by 4 London NHS trusts and Maidstone and Tunbridge Wells NHS Trust as the only local provider.

The whole system approach (WSA) to healthy weight has been in progress in DGS since 2022. It focuses on collaborative working and sharing good practices across Kent in a range of areas, including Early Years and Education, Physical Activity, and Healthy Communities. An initial evaluation of the WSA implementation concluded in June 2024. It found that local stakeholders felt the WSA positively impacted knowledge about services and initiatives in local communities, and that it legitimised the view that obesity requires collective action. However, the evaluation highlighted that funding and resources represents a potential barrier to the WSA's work and the WSA's partners in delivering services.

11.5 Gaps

- There is a large gap between the number of referrals to tier 2 weight management and number of people engaged in the programme. Capacity in the WMP should be increased to match demand.

- Efforts to ensure rigorous evaluation of this service should be a priority, with a focus on long term sustained weight loss. The WMP in Dartford has a 59% 52 week follow up rate - efforts should be made to analyse the reasons for their success and emulate them across the rest of DGS.
- Little is known about the local drivers and barriers for behaviours such as eating more fruit and vegetables and being physically active.
- There is a lack of evaluation on the weight management impacts of the Tier 1 One You service which makes it difficult to evaluate their effectiveness. Furthermore, this makes it difficult to align them with social prescribing processes within GP practices.

11.6 Key Findings

- A higher proportion of adults experience obesity in the Dartford Model PCN population, 18.7% versus a DGS average of 11.5%
- Physical activity and 5-a-day consumption rates are the lowest in Gravesham
- Obesity-related admissions in DGS are higher than Kent (263 per 10,000 verses 200 per 10,000) and have increased since 2020/21

11.7 Recommendations

- Increase capacity in the tier 2 WMP to reduce the gap between demand and supply.
- Given the higher rates of obesity in Dartford Model PCN population a project created with the local GPs, patients, weight management services, and relevant stakeholders may be beneficial to bring the prevalence of obesity into line with the Kent and DGS average.
- Increase 52 week follow-up to ensure the service is adequately evaluated.
- Continue to support the whole systems approach to obesity.
- Population-targeted programmes and interventions should be a focus for investment. Policies should 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. This can be performed via active participation in the new planning applications for food establishments at district council level.
- Analysis of the obesity-related hospital admissions in DGS to identify the types of admissions driving the increase in rates and therefore the groups who may benefit from support in the community, prevention, or proactive treatment to lower the emergency admission rates.
- Inclusion of system dynamic modelling to predict the future burden of obesity in the DGS and Kent population and the effect of interventions on this to help with strategic planning.
- Improved data sharing and sharing of good practices for obesity prevention and treatment so that interventions can be focused based on local need and the effectiveness of local practices. Within this to make sure the data is robust and well recorded such as obesity prevalence and obesity coding in hospital admissions.
- Explore the feasibility of performing a local Kent survey on attitudes to obesity and the barriers and facilitators for eating 5-a-day and being physically active to identify local targets for initiatives to support these behaviours. This would give more robust local data than currently available via national surveys. Given the high rates of childhood obesity and growing levels of adult obesity in DGS this may make a good pilot area.

12 Living well – Women's health

12.1 Introduction

Throughout this section the term 'women' mostly refers to the female sex, purely to highlight some physiological sex-based differences in disease and care. This will capture some of the physical health needs of some transgender men and some non-binary people, such as breast and cervical cancer screening, and is not aimed to diminish the challenges faced by all women.

Women spend a significantly longer proportion of their lives with ill health and disability than men (155). This issue is compounded by the historical impact of healthcare research, education, and services being designed by men, for men (156). For example, there is a lack of knowledge on the effect of sex-related differences to long-term conditions, such as dementia and cardiovascular disease. Furthermore, there is a lack of knowledge on conditions which only impact women such as endometriosis and menopause (156).

12.2 National policies

12.2.1 Women's Health Strategy for England 2022 (156)

This strategy builds on the views of women on the healthcare they receive. It details a 6-point long-term plan for how it will achieve better health for women. These are:

- Ensuring women's voices are heard – by tackling stigma, taboo, and improving representation.
- Improving access to services - prioritising services for women's conditions and ensuring they can access such services across their lives. Ensuring conditions which affect both sexes consider the needs of both sexes by default.
- Addressing disparities in outcomes among women.
- Better information and education.
- Greater understanding of how women's health affects their experience in the workplace.
- Supporting more research, improving the evidence base and spearheading the drive for better data.

In 2024 the following were made into key priorities: better care for menstrual and gynaecological conditions, creating and expanding women's health hubs, tackling disparities and improving support for vulnerable women, bolstering maternity care, and further increasing research.

12.3 Best Practice

Women's health is broad and therefore there is a variety of NICE guidance that can be found on this topic (157). The majority of current guidelines on this topic focus on fertility.

12.4 Epidemiological findings

12.4.1 Contraception

Contraception access and use is discussed in detail within the sexual health chapter of this HNA.

12.4.2 Fertility services

Fertility service access and use is discussed in the maternity and 0-4 chapter of this HNA.

12.4.3 Cancer

Cervical and breast cancer primarily affect the female sex. Screening programmes exist for both cancers, these assess asymptomatic women with the aim of identifying cancer earlier as earlier detection is shown to lead to better health outcomes. For cervical cancer screening runs from 25-64 and for breast cancer it runs from 50-71 years.

12.4.3.1 Cervical cancer

Coverage refers to the proportion of the eligible population who are up to date with screening, therefore it reflects both the offer of screening and the uptake of screening (158). In DGS coverage of cervical cancer screening falls below the national target of 80% for both 25–49-year-olds and 50-64 year olds. Rates are lowest in Gravesend Central PCN in both age groups and highest in LMN PCN, with rates in the majority of PCNs falling below the Kent and Medway average as shown by figures 109 and 110. Rates across DGS tend to be lower in younger women, aged 25-49.

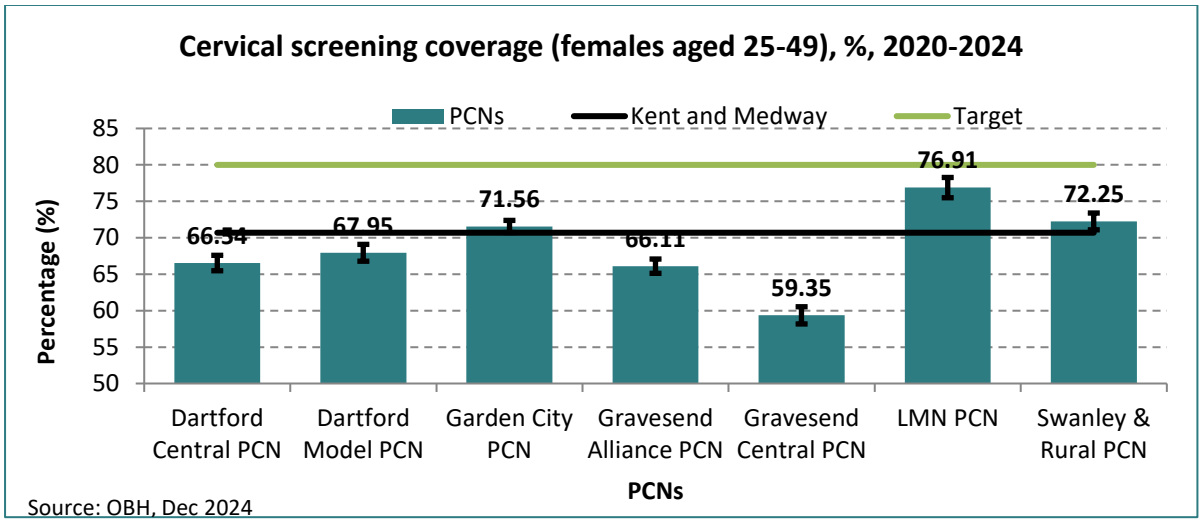


Figure 109: Cervical screening coverage (females aged 25-49), %, 2020-2024

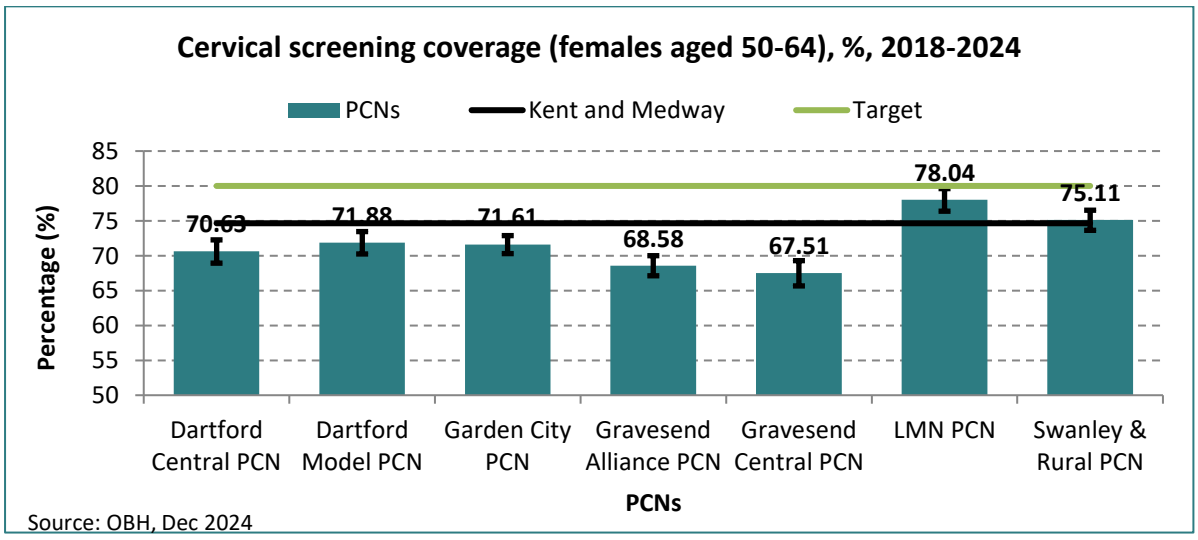


Figure 110: Cervical screening coverage (females aged 50-64), %, 2018-2024

Cervical cancer screening coverage is lowest in those with learning disabilities, with rates of below 50% in every PCN in DGS, though this appears to be a problem across the whole of Kent and Medway, as shown by figure 111. These values have large confidence intervals, likely due to small numbers, but given the picture within the whole of Kent it is unlikely that they are significantly inaccurate.

Cervical cancer screening coverage for those with severe mental illness and in ethnic minority groups are both slightly lower than general coverage for the respective PCNs but these differences are far less dramatic than the reduction seen for those with learning disabilities. Disparities in coverage of cervical cancer screening in ethnic minority groups are crucial to reduce as those in ethnic minority groups, especially black women, are more likely to get certain types of cervical cancer and have worse survival at 5 years when they do develop these cancers (159).

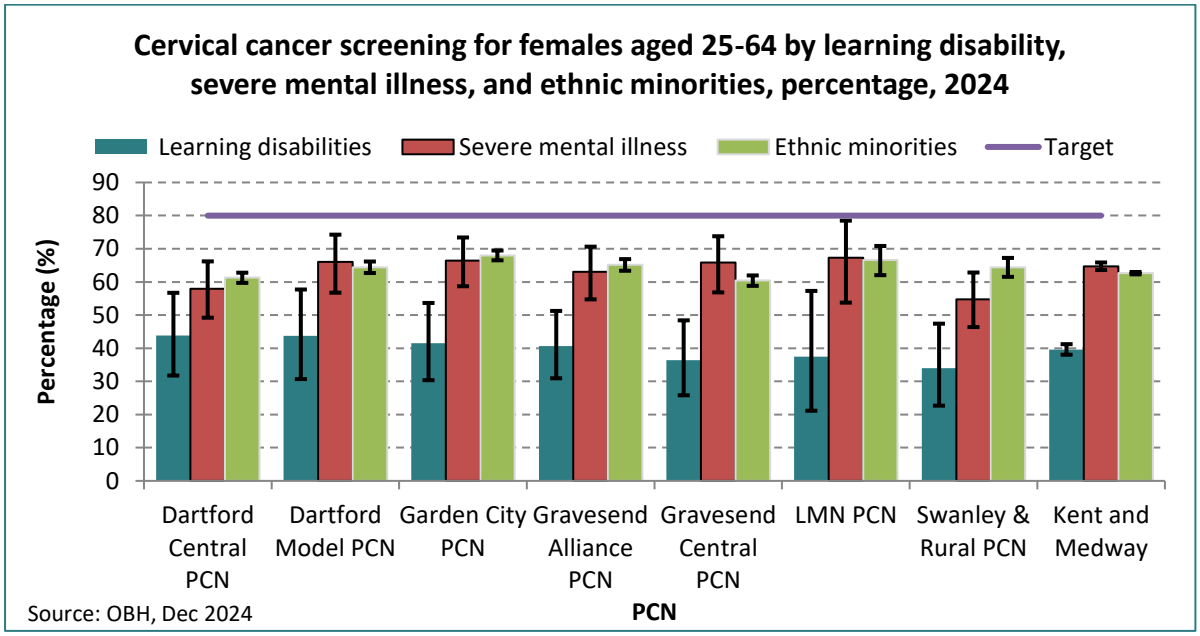


Figure 111: Cervical cancer screening for females aged 25-64 by learning disability, severe mental illness, and ethnic minorities, percentage, 2024

12.4.3.2 Breast cancer

Nationally, coverage of breast cancer screening aims to hit 70% and nearly half of the PCNs in DGS meet this target, as shown in figure 112. Kent and Medway as a whole are above this target rate. Rates of coverage are lowest in Gravesend Central PCN which highlights a potential target for interventions. Again, LMN PCN has the highest coverage of screening. This may be a location where best practice for encouraging uptake can be drawn from.

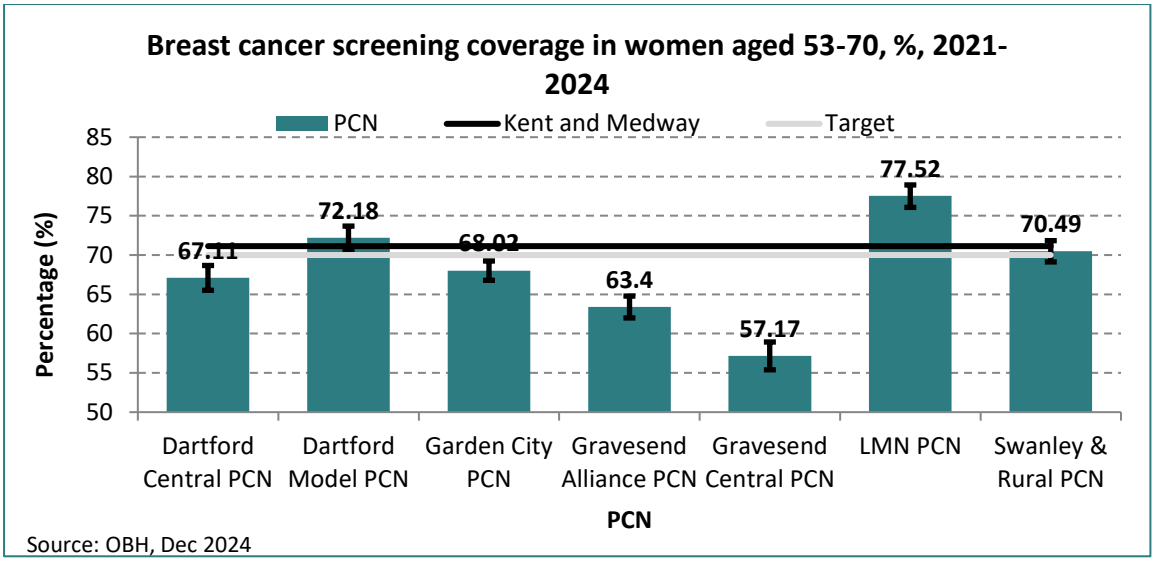


Figure 112: Breast cancer screening coverage in women aged 53-70, %, 2021-2024

12.4.4 Violence

30% of respondents to a public survey report that the health impacts of violence against women and girls are a key topic for health strategies for women. Violence in women tends to be higher in those with disabilities compared to without disabilities and in those who are lesbian and bisexual compared to those who are heterosexual.

Within Dartford, Gravesham, and Sevenoaks rates of referrals to the Referral, Assessment and Triage (RAT) service for domestic abuse are lower than the majority of districts in Kent. In fact, combined rates in 2022/23 for Dartford and Gravesham only comprised 13.1% of the referrals in Kent. When Sevenoaks (used as a proxy for Swanley due to data constraints) is added this becomes 17.3%. If an equal distribution was seen across the districts of Kent these numbers would be expected to be 16.7% and 25% respectively. Further details regarding domestic about in DGS can be found in the domestic abuse needs assessment for Kent and the Serious Violence Strategic Needs Assessment. In addition, violent crime is further discussed in the sexual health chapter of this HNA.

12.4.5 Healthy ageing

Physiologically women are at a greater risk of conditions such as osteoporosis and related fragility fractures compared to males. This risk is further discussed in the ageing well section of this HNA.

12.5 Current services

Cancer screening services for breast and cervical cancer are ran nationally through NHS England.

Menopause and gynaecological services available via primary care and secondary services via the acute trusts in DGS.

Safe accommodation is provided by Clarion in North Kent (for Dartford and Gravesham) and Look Ahead for West Kent (Swanley) for survivors of domestic abuse.

12.6 Gaps

- There is a lack of local data on gynaecological conditions and menopause, therefore it is difficult to ascertain the size of this problem in DGS.

12.7 Key Findings

- Coverage of cervical cancer screening in DGS is below target in every PCN
- Coverage of cervical cancer screening is lower in 25–49-year-olds than 50-64 year olds in each PCN in DGS.
- Coverage of cervical cancer screening in those with learning difficulties is only approximately 40% across DGS despite the target of 80% coverage. Rates in Kent & Medway are similar at 39.6%
- There are lower rates of cervical cancer screening in those with serious mental illness and ethnic minority groups compared to general coverage rates in DGS
- 4/7 PCNs are below the breast cancer screening coverage target in DGS.

12.8 Recommendations

- Creation and development of women's health hubs in line with government strategy.
- There is need to improve coverage of cervical screening in those with learning disabilities, severe mental illness and from ethnic minorities to at least match the PCN average.
    - This may require working with local communities, such as through faith leaders, and the voluntary sector to identify any barriers to access and educate individuals and communities on the importance of cancer screening.
- Increase coverage of cervical cancer screening and breast cancer screening to meet the national targets. This process may benefit from working with the Gravesend Central PCN to improve rates in this PCN, with learning then shared across the HCP.
- Explore the potential of Women's health hubs to provide access to insights on women's experiences and needs during menopause, especially within various cultures.

13 Living well – Sexual Health

13.1 Introduction

Sexual Health is a key part of ensuring the overall health and wellbeing of the population. Good sexual health and wellbeing can improve fundamental aspects of people's lives including protection from long term consequences of disease and risks to physical and psychological health. In addition, it can contribute to people's access to education, economic participation, and access to opportunities in the social and community spheres.

Trends have changed across Kent and England since the last sexual health needs assessment in 2018 so we must be vigilant to ensuring that population and individual sexual health is protected. Significant changes to services were seen in the COVID-19 pandemic resulting in reduced access to sexual health clinics and a shift to using online services (160). The population of Kent has also changed in this time, with a population size increase of 14,600 from mid-2021 to mid-2022, of which, 95.7% has been because of migration (161).

13.2 National policies

Changes in key national policy surrounding sexual health have been implemented since 2020.

- Pre-exposure prophylaxis (PrEP) to reduce HIV transmission in those at a high risk was made available in sexual health clinics (162).
- An amendment in legislation during the pandemic allowing at-home early termination of pregnancy was made permanent, changing the way women access abortion services (163).
- Relationship and Sex Education (RSE) became a mandatory subject on schools' curriculum in 2020, aiming to improve young people's knowledge about safer sex and sexual health (164).
- The Women's Health Strategy was published in 2022, highlighting the disparities in women's health and setting out an approach to improve this within several priority areas (156).
- Pharmacies are now able to prescribe oral contraception and licences for certain intrauterine devices (IUDs) were extended, changing the way women access and use contraception services (165,166).
- In September 2024, 'A blueprint for the future: Sexual and reproductive health and HIV services in England' was published by the Local Government Association (LGA) aiming to lobby the new Labour Government to prioritise focus on improving the sexual health of the UK population through a 10-year strategy (167).

13.3 Best Practice

13.3.1 NICE Quality Standards for Sexual Health (168):

This NICE standard sets out 6 statements about standards for sexual health services:

1. People are asked about their sexual history at key points of contact.
2. People identified as being at risk of sexually transmitted infections have a discussion about prevention and testing.
3. Local authorities provide a range of condom distribution schemes tailored to the needs of their populations.

4. People contacting a sexual health service about a sexually transmitted infection are offered an appointment that is within 2 working days.
5. Men who have sex with men have repeat testing every 3 months if they are at increased risk of sexually transmitted infections.
6. People diagnosed with a sexually transmitted infection are supported to notify their partners.

13.4 Epidemiological findings

13.4.1 Prevalence (169)

Following the COVID-19 pandemic, the STI testing rate has increased across Kent and is now higher than pre-pandemic levels, with a 15.5% increase since 2018. Rates in Dartford and Gravesham are higher than the Kent average, as shown in figure 113. Higher rates of testing will usually correspond with higher detection rates and therefore testing is actively encouraged to ensure that disease is found and treated within the population. However, high positivity rates can indicate that there are higher levels of infection in the population and therefore alongside increases in testing, health promotion messaging is normally required to increase good sexual health practices within the population.

Unfortunately, sexual health data is not available at Swanley level, therefore data for Sevenoaks has been used as a proxy. However, this may not reflect the true picture of the health needs of the Swanley population.

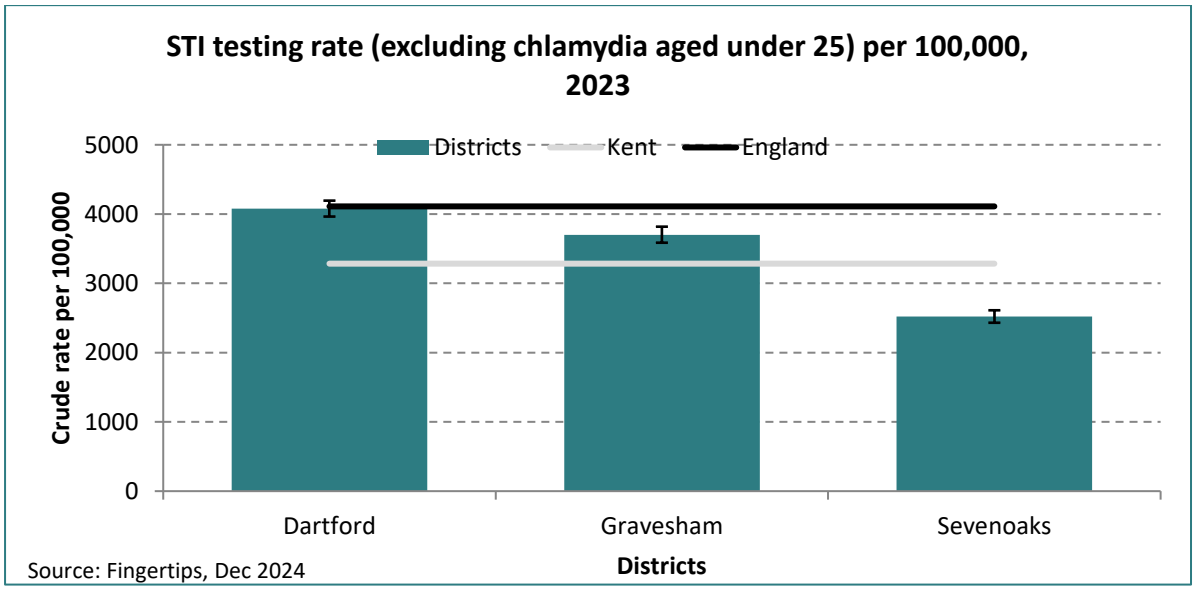


Figure 113: STI testing rate (excluding chlamydia aged under 25) per 100,000, 2023

Dartford has the highest rate of all new STI diagnosis and new STI diagnoses (excluding chlamydia aged under 25) in Kent, as shown in figures 114 and 115. This corresponds with being the second highest district for STI testing (excluding chlamydia aged under 25) in Kent, as shown in figure 113.

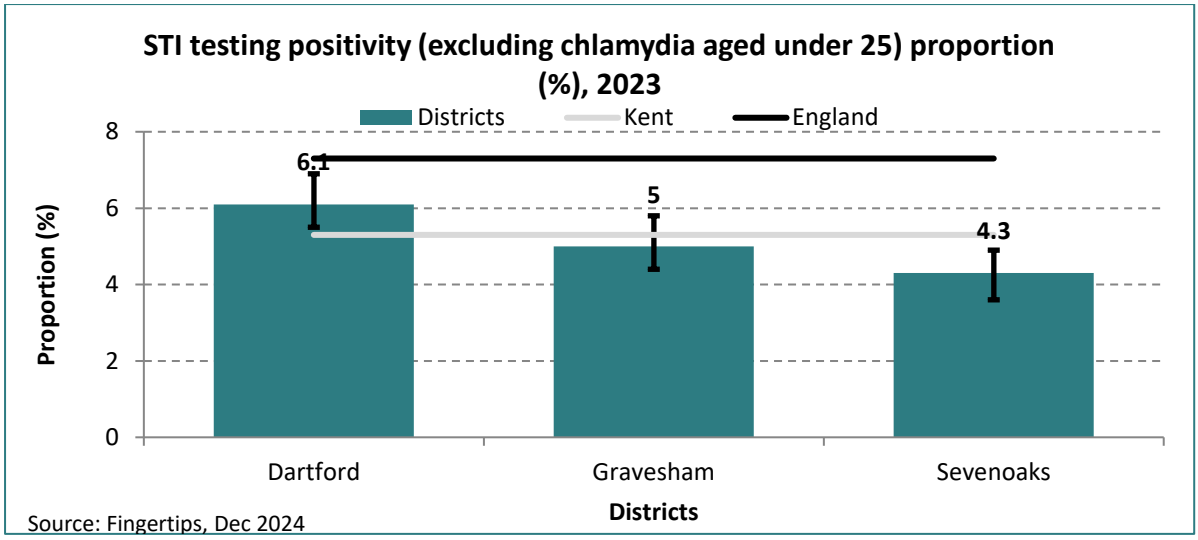


Figure 114: STI testing positivity (excluding chlamydia aged under 25) proportion (%), 2023

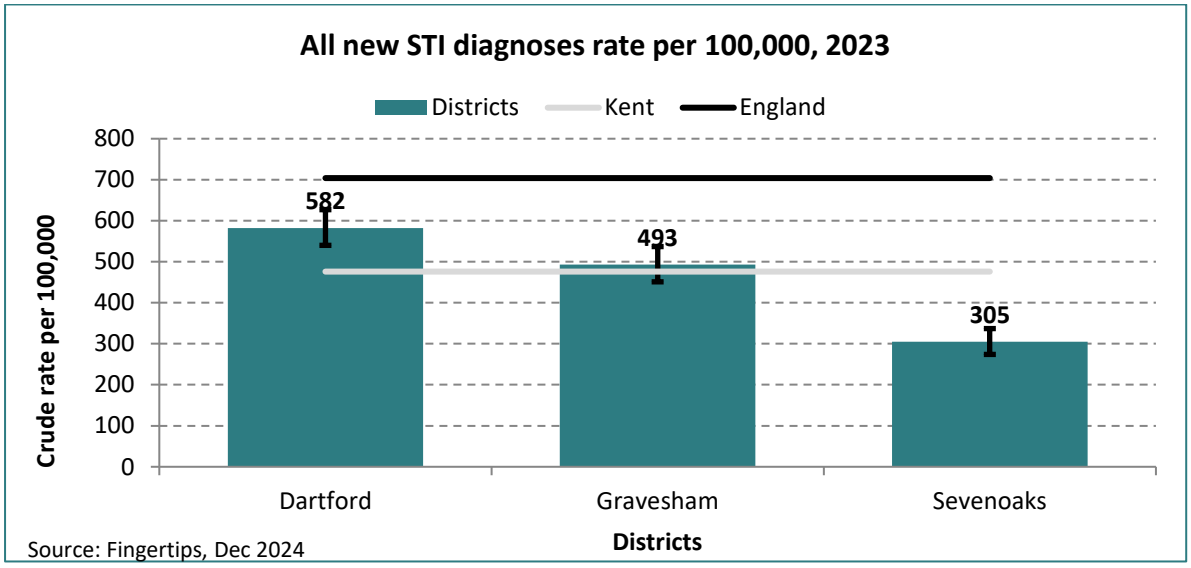


Figure 115: All new STI diagnoses rate per 100,000, 2023

In 2023, Dartford had the highest diagnosis of Gonorrhoea with a rate of 98 per 100,000 within DGS and the third highest in Kent. This has risen back to pre-pandemic rates. Rates in Sevenoaks have also risen, increasing to the highest rate seen in the last 12 years of 54 per 100,000. Rates in Gravesham have shown a slight drop since 2022, of approximately 9.7%.

Herpes diagnosis was highest in Gravesham within DGS, at 43.9 per 100,000 and higher than the Kent average of 41.9 per 100,000. Rates in Gravesham and Dartford have been relatively stable over the last three years. Rates in Sevenoaks have been increasing since 2021 but remain below pre-pandemic levels.

Gravesham is also the highest district for diagnosis rates of syphilis (9.3 per 100,000), followed by Dartford (7.6 per 100,000) in 2023. However, it should be noted that all of Kent has a lower diagnosis rate than England (16.7 per 100,000) for syphilis and isn't currently experiencing the same concerns as have been seen nationally.

HIV testing is too low in Kent; however, North Kent typically has higher diagnosis rates of HIV than East Kent. Dartford has the highest new HIV diagnosis rate of 14.9 per 100,000 in Kent. This rate has increased by more than double since 2022 despite rates of HIV testing experiencing only a mild increase. Rates in Gravesham remain stable and were 7.4 per 100,000 in 2023, and rates in Sevenoaks have declined and were 0 per 100,000 in 2023. HIV testing rates in both districts have steadily increased since 2020.

13.4.2 Contraception and reproductive health

Rates of women prescribed short-acting combined contraceptives at GP services in 2022 was higher in Gravesham and Dartford than the English average at 131 per 1,000 and 127 per 1,000 respectively compared to 117 per 1,000 in England. In Sevenoaks rates were similar to national rates at 115 per 1,000. However, rates of combined oral contraception prescription are reducing in Dartford, Gravesham, Sevenoaks, and nationally. Rates of progesterone only contraception prescriptions in GP surgeries are slightly more stable and rates are similar in Gravesham to national rates, though they are lower in Sevenoaks and Dartford.

Total prescribed Long Acting Reversible Contraception (LARC) decreased during the pandemic and has not yet returned to the pre-pandemic levels. The use of LARC has been steadily declining. This declining trend in use of both short and long-acting contraception should be monitored, given the possible impact on unplanned pregnancy.

Gravesham had the highest rate of prescribed LARC in 2022, at 44.1 per 1,000, matching the England rate. This has increased past pre-pandemic levels of 43.1 per 1,000 in 2019. In Dartford rates are increasing but remain below pre-pandemic levels at 39.6 per 1,000. Rates in Sevenoaks have remained stubbornly low at around 31.5 per 1,000 from 2020.

13.4.3 Ectopic pregnancies

Ectopic pregnancies are a medical emergency and one of the causes of this type of pregnancy are sexually transmitted infections, especially if they are undetected and untreated for long periods of time. The rates of ectopic pregnancy in Kent (99.1 per 100,000) are comparably high in Dartford at 138 per 100,000 compared to the England rate of 89 per 100,000. Rates of ectopic pregnancies in Gravesham have varied considerably from 2014/15-2022/23 between 96.8 per 100,000 and 146.5 per 100,000 but have been consistently above the English average. Rates in Sevenoaks are also higher than the English average at 122.9 per 100,000 in 2022/23. Ectopic pregnancy rates within Dartford, Gravesham, and Sevenoaks are higher than the English average despite rates of STI detection being lower, this may benefit from further investigation to detect the driving factors and therefore reduce rates.

13.4.4 Sexual Violence

Rates of sexual violence in Dartford (2.9 per 1,000) and Gravesham (2.9 per 1,000) are similar to the English average (3 per 1,000). Rates in Sevenoaks are lower at 1.8 per 1,000. Rates across the districts have remained relatively static from 2018/19 – 2022/23. It is important to note that self-reported rates of sexually violent crime are likely to be higher than the rate of sexual violence reported to the police and therefore this data is likely to underrepresent rates. Young women are disproportionately affected by sexual violence and women who experience sexual abuse are at a high risk of sexually transmitted infection (170).

13.5 Available services

Sexual health clinics in DGS are provided by Maidstone and Tunbridge Wells NHS trust. They provide The Rubin Clinic in Dartford and the Riverside Clinic in Gravesham. These clinics offer Asymptomatic Screening, symptomatic STI testing, STI treatment, HIV post exposure prophylaxis, HIV testing and management, Hepatitis vaccines, emergency contraception, general contraception, and LARC.

HIV treatment is a level 3 service, with service delivery throughout Kent and on multiple days of the week, in Dartford, Gravesham, Maidstone, Tunbridge Wells, Ashford, Margate, Canterbury and Folkestone. There are no clinics in the districts of Swale, Dover, Sevenoaks or Tonbridge & Malling.

An integrated model means that people who need to access sexual health support can be offered more services in one place.

People in DGS are able to access at-home STI testing services via Home testing for sexually transmitted infections (STIs) - Kent County Council. Online STI testing is available for HIV, syphilis, hepatitis B and C, chlamydia, gonorrhoea and trichomonas vaginalis (TV). The service aims to maximise equitable access to STI testing across Kent, reducing the need for patients to travel to a clinic site. However, there may be potential inequalities in access for those with poor internet connection, or those without a smart device or access to one.

The pharmacy service includes provision of emergency oral contraception (EoC) for women under 30 years, simple genital chlamydia consultation and treatment, signposting and referral to other sexual health services and sexual assault services and sexual health promotion including raising awareness of the Get It condom distribution programme. Service availability can vary from location to location.

Metro offers a free condom service for all people under the age of 24, which can be distributed either via an online order and delivery service, or collection point pick up at various open access locations across each district.

13.6 Gaps

13.6.1 Young People

Young people are at a higher risk of STIs and unplanned pregnancy, making this group a key focus for sexual health services. Young people have raised a lack of awareness of services and a need to improve education around healthy relationships.

13.6.2 People living in deprived areas

Deprived areas in DGS should be a targeted focus to reduce under 18 conceptions and find and treat STIs

13.6.3 Black and ethnic minority populations

Evidence suggests black and ethnic minority populations can be more at risk of some STIs, although local data for Kent is required. Understanding of sexual health issues specific to local communities is key for good sexual health service provision.

13.6.4 Migrant population

Barriers to accessing sexual health services, such as difficulty registering with NHS services remain. In addition, in some cultures a perceived lack of risk of poor sexual health is present, preventing people from engaging with services. Outreach work from Metro has aimed to engage with migrant populations and offers regular sessions in some settings to give sexual health advice and support.

13.6.5 LGBTQ+

LGBTQ+ people make up a greater proportion of those accessing sexual health services in Kent, compared to the population demographics. An increased risk of poor sexual health relating to STIs and chemsex exists, along with the need for better education around healthy relationships and addressing barriers such as stigma and the use of inappropriate language. In North and West Kent, 86.9% were heterosexual, 8.3% gay or lesbian, 4.2% bisexual (with 0.5% other/not recorded/declined to answer).

13.6.6 People who have experienced sexual abuse and violence

Young people, in particular women and girls in deprived areas of Kent are more at risk of violence, including sexual violence.

13.6.7 Gypsy, Roma and Traveller populations

Kent has areas of high GRT populations. GRT populations should be a focus for sexual health to understand more about use of contraception, abortion rates, and to identify opportunities to support with improving sexual health outcomes.

13.6.8 Alcohol and drug misuse

Alcohol and drug misuse can result in an increase in sexually risky behaviours including unprotected sex and the inability to give consent to sexual activity. DGS should seek to make links between sexual health and drug and alcohol services to minimise compounded risks between the two factors on sexual health outcomes.

13.6.9 People in Contact with the Justice System

People in contact with the justice system are at a higher risk of poor sexual health and this is often underreported in national datasets. More understanding is required of sexual health service provision in prisons, along with what support is available to reduce sexual health risks on release from prison.

13.6.10 Homeless Population

The homeless population of DGS are particularly affected by changes to services, such as shifts to online or virtual services requiring an address. This population should remain a key focus of outreach work.

13.6.11 Women's Health

Women experience poorer sexual health consequences than men and are also more likely to experience sexual abuse and violence. Women's health hubs are anticipated to be set up in Kent and aim to improve access and outcomes in services for women. KCC should continue to work with the ICB on the development of the hubs as well as work with the wider system to reduce violence against women and girls. As young people, in particular women and girls in

deprived areas of Kent are more at risk of violence, including sexual violence, it will be important to engage with wider partners for this.

13.6.12 Intersectionality

Whilst these factors have been considered individually in the sections above, the reality is that people in our communities can be part of more than one group at any one time.

13.7 Key Findings

- 6.1% of STI tests (excluding chlamydia in those aged under 25) were positive in Dartford in 2023 compared to 5% in Gravesham and 5.3% in Kent.
- There were 14.9 per 100,000 new HIV cases in Dartford in 2023 which is nearly double from 2022. In comparison there were 7.4 per 100,000 in Gravesham and 10.4 per 100,000 in Kent. This is despite minimal changes in HIV testing rates.

13.8 Recommendations

- Develop a peer support service for HIV, as recommended as best practice
- Increase links with other services and stakeholders.
- Review ectopic pregnancy cases in DGS to identify targets for interventions to reduce rates.
- Review the location of pharmacies offering the emergency oral contraceptive and chlamydia treatment service to establish if there is an inequity in coverage of pharmacies across the county
- Review outreach in order to optimise utilisation for population need alongside system thinking approach. There is an overlap with the outreach service in ISH, and it isn't clear what impact outreach are having on sexual health
- Patient insights into ease of access alongside further analysis of the map of LARC providing GPs in the county to explore areas of low or distant access
- Increase knowledge of at-risk groups and those with vulnerabilities to deepen knowledge of population needs
- Increase testing coverage given the marked drop in coverage from pre-pandemic levels, including via supporting promotional campaigns.
- Insights data to understand awareness and effectiveness of pharmacy sexual health service
- Explore the drivers for the increase in HIV diagnosis in Dartford, which have risen dramatically despite similar testing rates.

14 Living well – Multimorbidity

14.1 Introduction

Multimorbidity is defined as having two or more concurring long-term health conditions (171). These can include both mental health and physical health conditions and physical conditions can be infectious and non-communicable (171). Multimorbidity occurs in approximately 23-42% of the population with increasing prevalence with advancing age (172). However, a large Scottish study found that the majority of people with multimorbidity were under 65 years old (172). In addition, the age of onset for multimorbidity is earlier in those who experience socioeconomic deprivation compared to those who do not (172).

Multimorbidity is important as it is linked to higher rates of mortality, polypharmacy and related adverse drug events, and high disease burden and service use (173). It is also linked to lower quality of life (173). A degree of this may be due to increased burden from multiple treatment regimens and often disjointed care (173). The extent at which care is disjointed in multimorbidity often depends on the mixture of conditions which are co-occurring. For instance, less fragmented care is seen when diabetes, hypertension, and angina occur together compared to when angina and psychosis occur together, this is because the treatments, and systems affected, differ more for the latter (173).

The polypharmacy seen in multimorbidity is often comprised of preventative medications (173). However, the benefits seen from these medications potentially drops both as the life expectancy of the person using them declines due to their multiple conditions, and additional medications are added, lessening the individual effect (173).

14.2 National policies

Within his 2023 annual report the Chief Medical Officer, Professor Chris Whitty, highlights the growing prevalence of multimorbidity (174). This report discusses the sometimes synergistic effect of multimorbidity on independence, that whilst one condition alone may allow for the continuation of independence, two or more may not (174).

Multimorbidity is also problematic because our services are not designed to treat it. NHS services tend to be single disease or system focused (174). Therefore, they lead to patients being forced to see multiple clinicians about their co-occurring medical conditions resulting in more time off work, more transport costs, and more NHS costs overall (174). As such, the CMO report suggests that clinicians and services should maintain their generalist skill sets (174).

14.3 Best practice

The National Institute for Health and Care Excellence (NICE) recommend that care of people with multimorbidity should take into account their multimorbidity (173). This therefore includes assessing the severity of their disease and treatment burden, their goals, values, and priorities, and reviewing their medications and treatments (173). From this an individualised treatment plan can be created (173).

14.4 Epidemiology

This analysis of multimorbidity has been conducted using data from the Kent and Medway Care Record database and largely draws on primary care data. Patients were considered multimorbid if they had two or more of the following 18 long term conditions: atrial fibrillation (AF),

hypertension, heart failure (HF), peripheral artery disease (PAD), stroke, diabetes, asthma, chronic obstructive pulmonary disease (COPD), coronary heart disease (CHD) dementia, serious mental illness (SMI), cancer, chronic kidney disease (CKD), epilepsy, learning difficulties (LD), osteoporosis, rheumatoid arthritis (RA), depression, or required palliative care.

Figure 116 shows the distribution of morbidity across age groups in Dartford, Gravesham and Swanley. It starts at age 18 and people over age 90 have been grouped together so clear trends can be seen. It is similar to the whole of Kent and Medway and the national picture. Approximately 15% of people of all ages are multimorbid, and by age 50 approximately 42% of people have at least 1 long term condition (LTC) and approximately 14% have 2 or more.

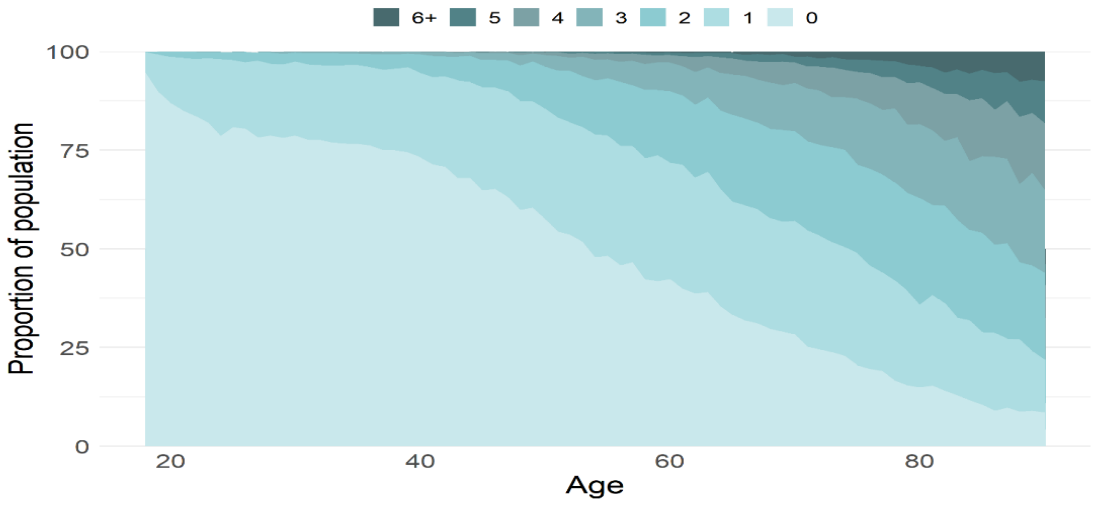


Figure 116: Count of long term conditions by age of people in Dartford, Gravesham and Swanley HCP aged 18, January 2025. Source: KMCR.

12.4.1 Demographics of multimorbid people

People in Dartford, Gravesham and Swanley who live in the most deprived areas have the highest prevalence of multimorbidity with 25% having two or more conditions and approximately 3% having 5 or more conditions (Figure 117a and 117b). People living in all other quintiles have significantly lower prevalence of multimorbidity (Figure 117a), in fact rates of multimorbidity in the most deprived quintile are 6.9% higher than in the least deprived quintile. The 3 least deprived quintiles have significantly lower prevalence of 5+ conditions than the 2 most deprived quintiles (figure 117b).

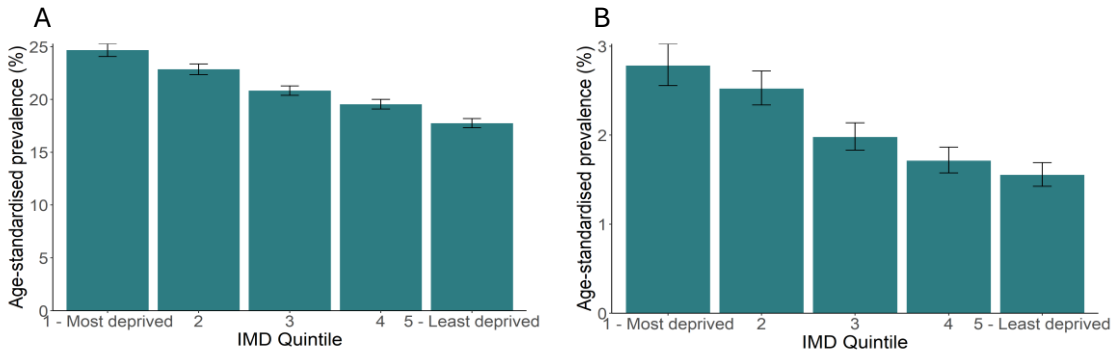


Figure 117: Age-standardised percentage of people in each deprivation quintile who have A – two or more conditions, and B – five or more conditions, Jan 2025 (source: KMCR)

The prevalence of multimorbidity varies between PCNs in Dartford, Gravesham and Swanley, ranging from 12.9% in Garden City to 19.1% LMN Care and 18.7% in Swanley and Rural PCN. However, after adjusting for age Dartford Model and Dartford Central PCNs have the highest rates of multimorbidity, suggesting people living here may be younger but in poorer health (figure 118). This variation is also found when multimorbidity is considered by deprivation, showing that in more deprived areas people are facing multimorbidity at a younger age compared to less deprived areas.

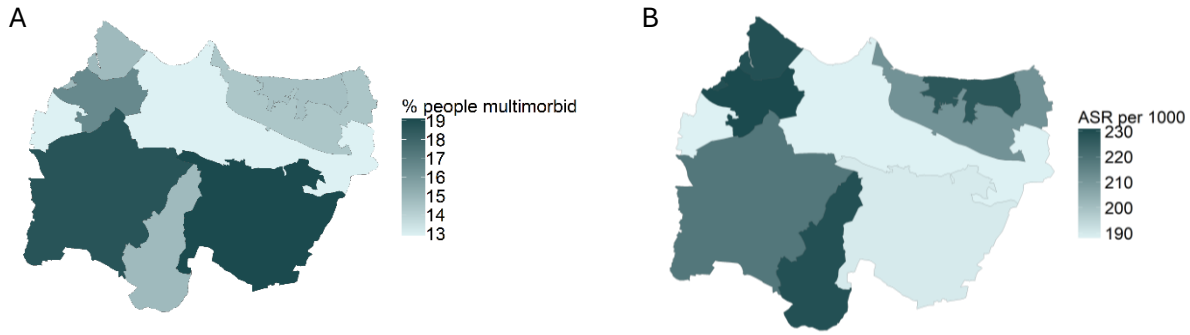


Figure 118: Proportion of people in Dartford, Gravesham and Swanley PCNs who are multimorbid, January 2025. A –prevalence, B – age-standardised rate. Source: KMCR

Multimorbidity also varies by ethnicity. People over 15 years old who are White, Multiple or mixed ethnic groups, Black or Black British or Other ethnic groups all had similar age-standardised rates of multimorbidity, at around 20%. People who are Asian or Asian British had significantly higher rates of multimorbidity than White people, at approximately 22.3% (figure 119).

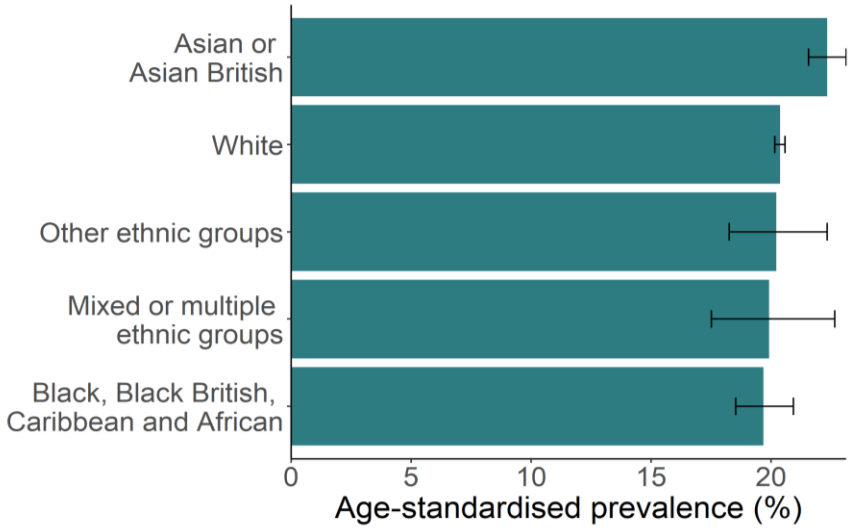


Figure 119: Proportion of people aged 15+ who are multimorbid by ethnic group, age-standardised, Dartford, Gravesham and Swanley HCP, January 2025. Source: KMCR.

12.4.2 Trends in conditions diagnosed

The Kent and Medway Care Record also allows us to see the date of diagnosis of a particular condition. The database is being continually improved and made more accurate, so while this allows more complex analysis of disease trends, these statistics should be considered

experimental at this stage due to some data quality concerns. For the analysis of trends in this document some adjustments have been made to account for these concerns. In particular, this analysis excludes anyone who had a diagnosis of the aforementioned conditions before age 18. This means that some conditions which are commonly diagnosed in childhood, like asthma or epilepsy, may not be included and/or be underestimated. This analysis is therefore more representative of trends in conditions acquired in adulthood due to lifestyle factors. In addition, this analysis excludes people who were diagnosed with multiple 'first' conditions on the same date for data quality assurance.

Trends in which conditions are commonly diagnosed first, second and third were investigated in people who had two or more conditions. Hypertension was the most common at all time points, and diabetes and depression were in the top 4 most common conditions at all time points as well. Another notable finding is that chronic kidney disease becomes more common with subsequent diagnoses; it is the second most commonly diagnosed third condition (tables 8-10).

Table 8: The top 5 diagnosed first conditions in Dartford, Gravesham and Swanley, January 2025. Source: KMCR.

Condition	% of conditions first diagnosed
Hypertension	38
Depression	13
Diabetes	11
Asthma	8
CHD	5

Table 9: The top 5 diagnosed second conditions in Dartford, Gravesham and Swanley, January 2025. Source: KMCR.

Condition	% of conditions diagnosed second
Hypertension	23
Diabetes	15
Depression	12
CKD	10
Cancer	7

Table 10: The top 5 diagnosed third conditions in Dartford, Gravesham and Swanley, January 2025. Source: KMCR.

Condition	% of conditions diagnosed third
Hypertension	14
CKD	13
Diabetes	13
Depression	10
Cancer	8

The median time between first and second diagnoses and second and third diagnoses in Dartford, Gravesham and Swanley HCP and Kent and Medway are very similar (table 11). This

indicates that people in Dartford, Gravesham and Swanley HCP do not acquire long term conditions at a different rate to those in the rest of the county.

We hypothesised that hypertension as an initial diagnosis could act as a gateway to developing more conditions at an increased rate, however the median time delay between the diagnosis of subsequent conditions was longer than for all conditions combined i.e. when hypertension was the first condition diagnosed, progression to multimorbidity was slower. Conversely, people who were diagnosed with depression first got their third condition one year more quickly than the general cohort. This could indicate that people who are diagnosed with depression are more vulnerable to developing further long-term conditions (table 11). People who are first diagnosed with a serious mental illness (SMI) generally acquire their second condition later. This may be partly due to the lower typical age of diagnosis for these conditions (46 for SMI versus 49 for depression).

Table 11: Time delay between onset of first, second and third conditions in people in Kent and Medway and Dartford, Gravesham and Swanley HCP, and people in Dartford, Gravesham and Swanley who had a first diagnosis of hypertension, depression or serious mental illness. January 2025. Source: KMCR.

	First condition				
Median time delay (years)	Any (Kent and Medway)	Any (Dartford, Gravesham and Swanley)	Hypertension (Dartford, Gravesham and Swanley)	Depression (Dartford, Gravesham and Swanley)	Mental Health (Dartford, Gravesham and Swanley)
1st to 2nd diagnosis	5.8	5.5	7.3	5.4	8.7
2nd to 3rd diagnosis	3.7	3.9	4.2	2.6	4.3

Multimorbid patients were categorised to attempt to understand how many people have conditions which cross over multiple specialities and may make their care more complex. The vast majority (84%) of people had conditions which spanned several specialities. About 9% of people had diabetes with at least one of hypertension, LD or palliative care. 5% of people had only cardiovascular diseases (possibly including LD or palliative care).

12.4.3 Trends in conditions in those with depression or SMI

The subsequent conditions acquired by people who had depression or SMI as their first condition were also analysed. The most notable finding was that depression and SMI were correlated – 8% of people with depression developed an SMI as their second condition, and 38% of those with SMI got depression as their second condition. Beyond this, hypertension, asthma and diabetes were the most common conditions subsequently acquired in both groups.

14.5 Current services

Multimorbidity in DGS, like elsewhere in the UK, is treated in systems designed for single conditions and single organ systems. As such, the services specifically for multimorbidity are minimal. However, much has been done to highlight how best to provide care for those experiencing multimorbidity, as discussed in the best practice section of this chapter. This care should include prevention of multimorbidity through the commissioning of services that reduce

risk factors, and provision of community resources such as green spaces and active transport links.

14.6 Gaps

- The DGS population is due to expand with just over 2,000 new homes planned to be built in Ebbsfleet. As such, the population living in the area is due to expand and with this will likely be an expansion of the number of those living with multimorbidity requiring services. The scale of this is unclear.
- Furthermore, there appears to be little guidance on systems-based management of multimorbidity which, given the range of conditions encapsulated within multimorbidity, may be difficult but potentially beneficial.
- We know that socioeconomically deprived populations tend to have higher rates, and earlier onset, of multimorbidity, but how best to reduce this inequality is unclear.

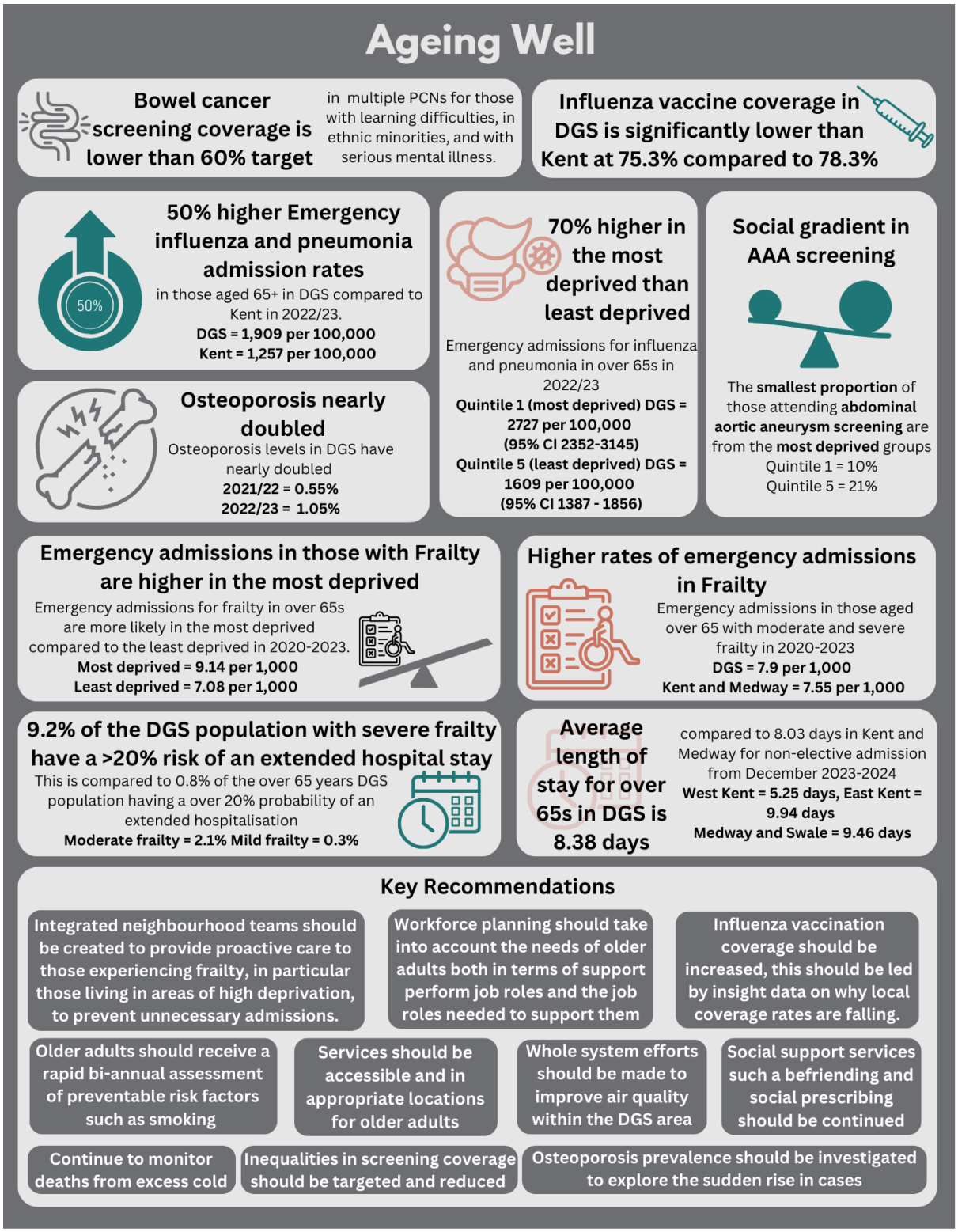
14.7 Key Findings

- Rates of multimorbidity are 6.9% higher in the most deprived compared to the least deprived.
- Rates of multimorbidity are 2.3% higher in Asian or Asian British ethnic groups compared to White ethnic groups.
- Depression is associated with a shorter time delay between being diagnosed a single condition and multiple conditions compared to other primary conditions such as hypertension.

14.8 Recommendations

- Multimorbidity management requires better integration of services and improved generalisable skills within the medical teams providing care. This may require better allowances for joint care within the organisation of services, for example by altering service funding to reflect integrated work. It may also include embedding generalist and specialist skills within teams, organisations and individual clinicians.
- Ensuring that integrated care includes both physical and mental health services, this should be provided by strategic planning and working in partnerships across the HCP.
- Reducing the risk factors for multimorbidity, such as obesity and smoking, will require a whole system approach. This is especially pertinent in the most disadvantaged groups within which rates of multimorbidity are higher and the onset of multimorbidity is earlier. Joint work and strategic planning is needed to provide a whole systems approach within the DGS area.
- Patients with multimorbidity are at an increased risk of polypharmacy which is associated with a range of adverse health outcomes (175). This should be assessed within primary care and the benefits from treatment maximised and the risks from treatment limited.
- A holistic assessment in the community for those who cannot leave their home due to being frail, housebound, or a nursing home resident should be provided. Integrated neighbourhood teams may be well suited to provide this care.
- Research, including local health service research in DGS, should include people with multimorbidity in their trials.

Ageing well – overview



15 Ageing well

15.1 Introduction

One of the positive markers of modern times is that people are living longer and able to witness and experience the growth of their families and society. However, the ability of an individual to enjoy and participate in these changes is largely determined by their health. Maintaining this health is a social responsibility which offers not only benefits to older adults, by allowing them to enjoy their later years as independently as possible, but to society as a whole. This is through lower levels of health and social care needs and the availability of older adults to impart their skills and knowledge garnered over years of experience.

15.2 National policies

15.2.1 NHS long term plan (83)

This national plan aims to support people to age well by providing more funding to community and primary care, making care more co-ordinated, and helping people to live independently at home for longer. In addition, it's goals include improving care services to allow faster discharges home from hospital, improving recognition for carers and improving patient involvement in decisions about the care they receive.

15.2.2 Chief Medical Officer's annual report 2023: health in an ageing society (176)

This report by Professor Chris Whitty focuses on means through which the quality of life in later years can be improved. These improvements can be made by maintaining independence through a combination of reducing disease and adapting the environment. The aim of which is to delay disease onset and reduce inequalities in both life expectancy and healthy life expectancy, the average years spent in good health. The recommendations from this report include planning services and infrastructure to meet the needs of the growing elderly population, primary prevention of risk factors such as smoking, secondary prevention of risk factors such as high cholesterol, improve care for multimorbidity, improve data collection of the health and care needs of older adults, and improve research into the health needs of older adults.

15.3 Best Practice

The NHS long term plan advises that care for older adults should promote an MDT approach which gives patients a say in the care they receive, offers support for carers for elderly loved ones, develops more community response teams, and offers more NHS support in care homes (177).

Age-friendly communities is an approach established by the WHO in consultation with older adults from around the world. This approach focuses on adapting our built and social environments to suit the current and future needs of our ageing populations. Examples of this include public seating and sanitary facilities, barrier-free access to buildings and houses, and safe and accessible transport infrastructure (178). To guide the development of age-friendly communities the WHO have created a Four-Step Programme Cycle through which Eight Domains should be acted upon (179). These are as follows:

1. Outdoor spaces and buildings
2. Transport

3. Housing
4. Social participation
5. Respect and social inclusion
6. Civic partnership and employment
7. Communication and information
8. Community support and health services

15.4 Epidemiology – Wider determinants

15.4.1 Demographics

As of 2021, 16.8% of the population in Dartford, Gravesham and Swanley were over 65 years old. This equates to 13.7% in Dartford, 17.2% in Gravesham, and 23.5% in Swanley. The population aged over 65 in Kent is expected to grow dramatically in this next fifteen years, rising from around 350,000 in 2024 to approximately 470,000 in 2040. The spread of older adults in DGS is shown in figure 120.

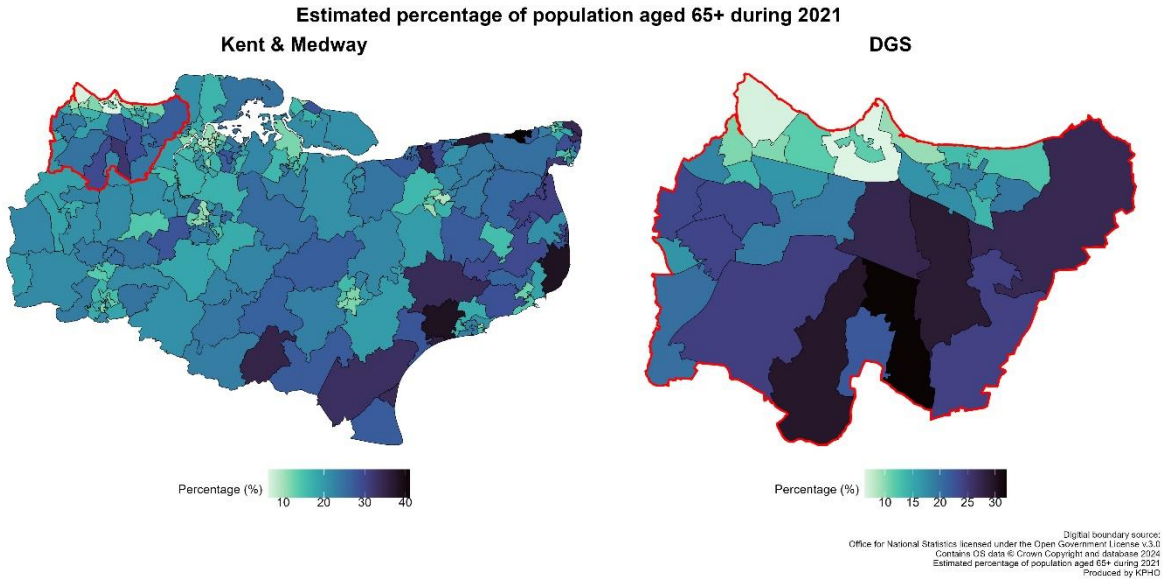


Figure 120: map of population aged 65+ in DGS at MSOA level, 2021 (%).

15.4.2 Outdoor space and buildings

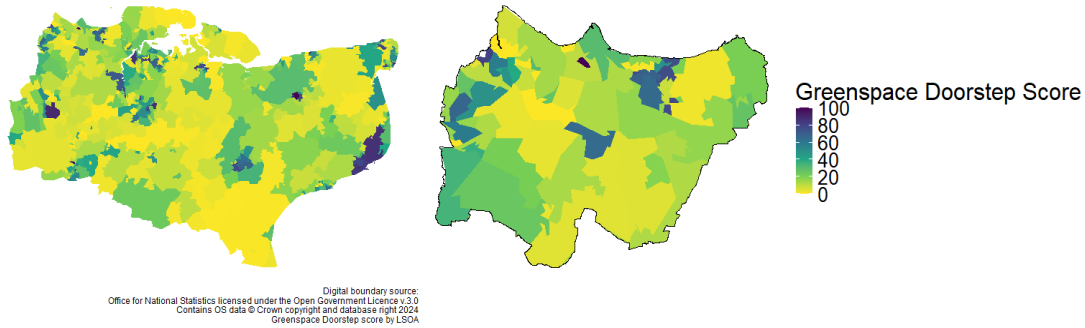


Figure 121: Greenspace Doorstep score in Kent and Dartford, Gravesham and Swanley.

When compared to figure 120, the availability of nearby greenspaces (figure 121) is lower in areas with a higher proportion of older adults such as southern part of Gravesham. The Greenspace doorstep standard was chosen for comparison as older adults may not be able to access transport to travel to further away green spaces or walk long distances to them. Unfortunately, this data only shows the access to green spaces, it does not show how accessible this space itself is, such as the availability of benches and public toilets.

15.4.3 Transport

Transport allows older adults to access services, which therefore allows them to continue participating in their communities and access healthcare. In 2022 Age UK reported that older people made up 13.6% of all licenced drivers in England (180). Surveys by the ONS show that within Dartford and Gravesham around 50% of over 65s in single person households have one or more cars, a rate which increases significantly to 63% within Sevenoaks (181). Unfortunately, data is not available for the Swanley area. Given over half of the DGS population aged over 65 years possess cars and therefore the potential ability to drive themselves, it is important that the built environment suits their needs, such as through provision of disabled car parking spaces and blue badge cards.

However, this data also means that around half of the households with a single resident aged over 65 years in DGS do not own a car and therefore would be reliant on public transport or people around them for transport. Within Kent there have been dramatic bus cuts following the COVID-19 pandemic due to falls in use (182). Understandably efforts have been made to preserve routes transporting school-aged children, however this means that routes for older adults may have not been prioritised (182).

Other transport options include community transport, however within DGS this is often transport to and from certain groups rather than to appointments or other activities (183).

15.4.4 Housing

Housing and the risk of cold-related deaths has been discussed separately within the wider determinants section of this HNA. The quality of housing, both in terms of temperature and damp, impact on the health of older adults and can increase the risk of respiratory infections and cardiovascular events such as heart attacks (176). Within older residents it is important to also note that a higher proportion of individuals have complex care needs and are unable to perform their normal activities of daily living and therefore require care homes. Adult social care is under heavy strain and some providers may be forced to close due to financial pressures (184). As such, this is an area which may struggle to meet the growing needs of the ageing society. Therefore, actions which reduce the dependence of older adults are key in ensuring both older adults enjoy their later years and social care services have capacity to be accessed if needed.

15.4.5 Social participation & respect and social inclusion

Social participation is key for mental health and wellbeing and helps encourage activities such as physical activity and health seeking behaviour (185). A lack of social participation can lead to adverse feelings of loneliness which in turn is associated with an increased risk of cardiovascular disease, hypertension, diabetes, infectious diseases, impaired cognitive function, depression, and anxiety (186). In 2019/20 in Dartford, Gravesham, and Sevenoaks districts the proportions of adults who felt lonely often, always, or some of the time were

statistically similar to Kent but tended towards being higher in Gravesham and lower in Sevenoaks, as shown in figure 122. Social isolation has also been explored for adult social care users aged over 65 years in Kent which found that in 2022/23 rates had returned to pre-pandemic levels at 47.1% and were similar to national rates of 41.5% (187).

Certain groups can aim to improve the social participation of older adults, this includes groups such as Men's Sheds and Befrienders who are volunteers who can visit individuals' homes, call, or run group sessions (188). A recent review of systematic reviews on interventions to reduce loneliness in older adults found that interventions which included animals, psychological therapies, or skill-building tended to be more effective than groups focused on social facilitation or health promotion (189). This fits with the international success of Men's Sheds at reducing loneliness given their basis in skill-building (190). A wide range of groups and activities for over 55-year-olds in DGS are provided by Involve Kent (191).

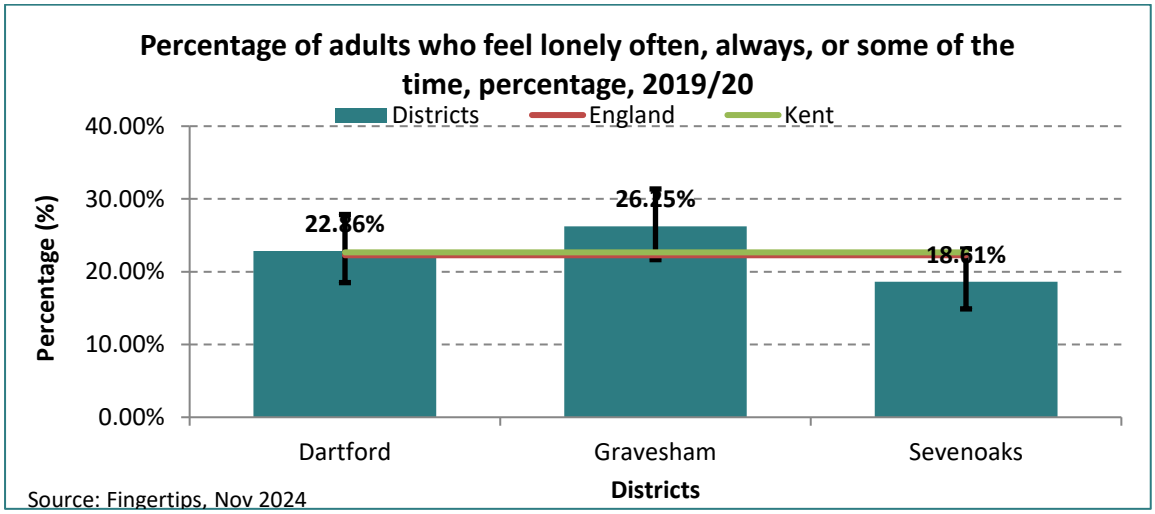


Figure 122: Percentage of adults who feel lonely often, always, or some of the time in Dartford, Gravesham, and Sevenoaks, percentage, 2019/20

15.4.6 Civic partnership and employment

Nationally rates of over 65s in employment has seen a steady increase from 5% in 2001 to around 12% in 2024 (192). The WHO age-friendly community guidance suggests that working in later life can contribute to wellbeing as well as benefiting finances, however the degree at which the continuation of work is performed by choice and is offering benefit is unclear.

Concerningly 13.1% of older adults in DGS experience income deprivation, this is similar to the Kent average of 12.9% however there is wide variation across the HCP, as shown by figure 123. As a district, Gravesham has the third highest rates of older adults facing income deprivation in Kent. There are also areas of high deprivation affecting older adults in Dartford.

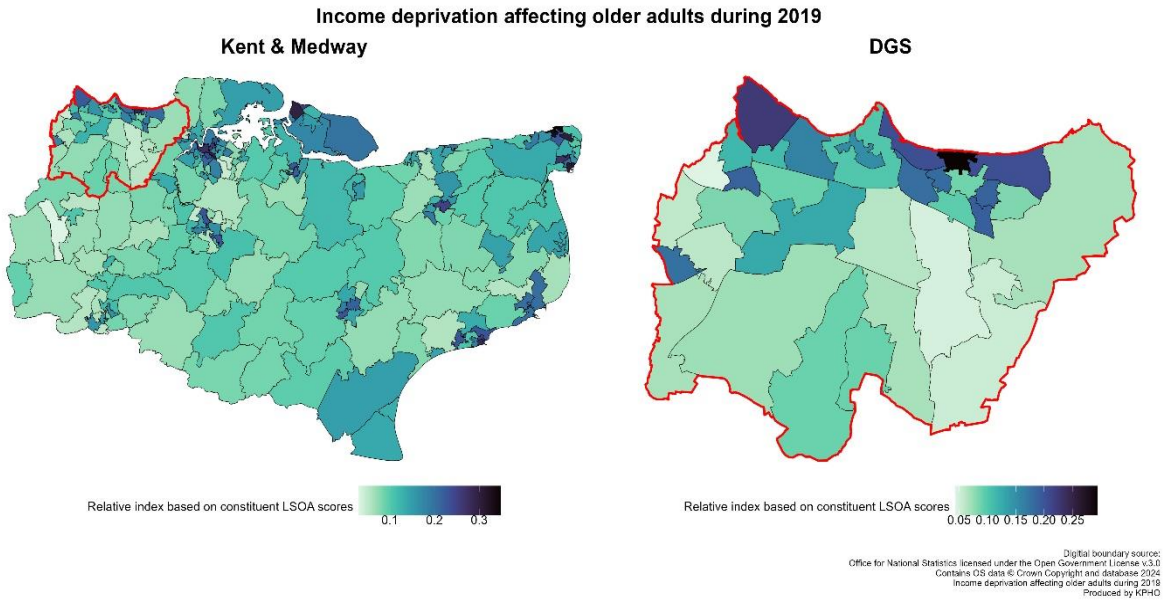


Figure 123: Income deprivation affecting older adults, 2019: relative index based on LSOA scores, reported at MSOA level.

Winter fuel payments help ensure older adults, who are more vulnerable to cold-related deaths, have sufficient funds to warm their houses. Research suggests that approximately half of the reduction in excess winter deaths between 1999–2012 are attributable to winter fuel payments. As discussed within the wider determinants section of this HNA, winter deaths due to cold are likely to not start declining until 2070 due to the large vulnerable population of older adults. In 2023/24, around 70% of over 65s received winter fuel payments in Dartford and Gravesham, and 68% in Sevenoaks, as shown in table 12. This number is likely to be lower from 2024 due to changes in eligibility (193).

Table 12: Proportion of over 65 year olds receiving winter fuel allowance in Kent, 2023/24.

Area	Proportion of over 65s receiving winter fuel allowance 2023/24
Ashford	69%
Canterbury	68%
Dartford	**69%**
Dover	69%
Folkestone and Hythe	69%
Gravesham	**70%**
Maidstone	68%
Sevenoaks	**68%**
Swale	70%
Thanet	70%
Tonbridge and Malling	69%
Tunbridge Wells	69%

15.4.7 Communication and information & Community support and health services

All communications to older adults, and residents in general, should be accessible for everyone regardless of their first language and their ability to use digital devices. The status of this within DGS is difficult to ascertain but advances in accessibility guidelines should have helped improve this.

Older adults receive various forms of health and social care, their access to which affects their ability to be independent in society. In terms of physical health, this can include assessment of vision and hearing, and support for physical activity.

Sensory loss can hinder basic activities such as cooking or cleaning and can lead to or worsen social isolation and loneliness (194). Higher rates of sensory loss are seen in those experiencing deprivation and in those with learning disabilities (194). Sensory loss is also associated with an increased risk of cognitive impairment and reduced mobility (195,196). In Kent 484 per 100,000 adults aged 65-74 years old were blind or partially sighted in 2022/23. This rises to 3,561 per 100,000 in those aged over 75 years old. In the UK around one in three adults are deaf, have hearing loss or tinnitus (197). This rises to 50% for those aged over 55 years old (197).

Physical activity protects from disease. A large systematic review of reviews showed that physical activity reduced the risk of "all-cause and cardiovascular mortality, breast and prostate cancer, fractures, recurrent falls, ADL disability and functional limitation and cognitive decline, dementia, Alzheimer's disease, and depression", it also delays the need for physical care support (198). In DGS rates of physical activity are lowest in more urban areas, especially around Gravesend, as shown in figure 124. Physical activity interventions can include services such as the postural stability courses or education on simple ways in which physical activity can be increased by older adults such as walks or chair exercises.

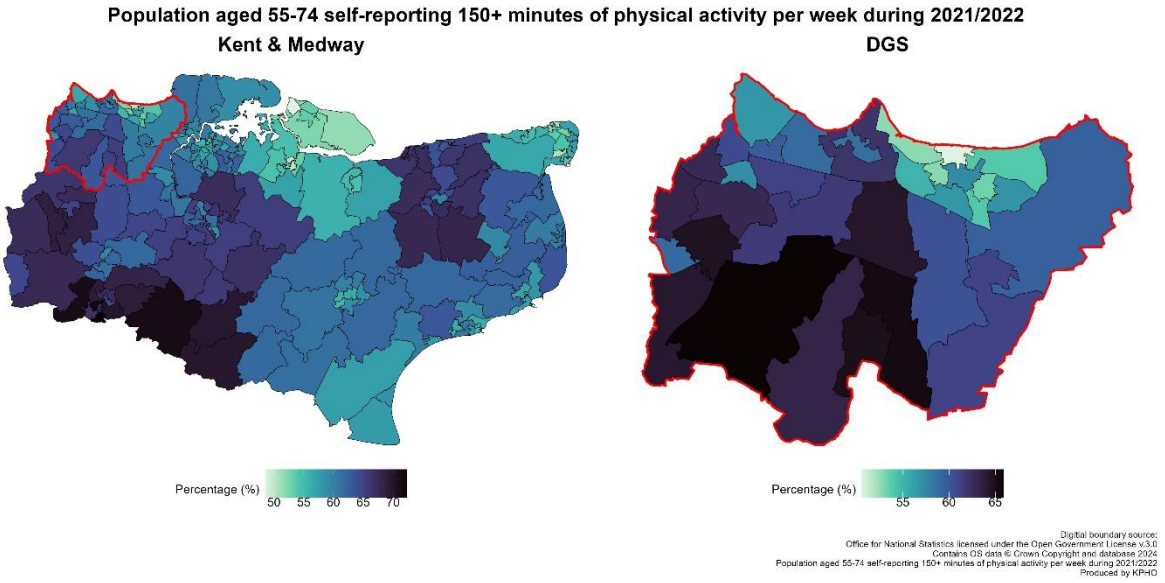


Figure 124: Map of physical activity level in older adults (150+ minutes a week), 2021/22

Older adults make up a large proportion of those receiving some form of care, this may be either formal care via carers or living in a care home resident, or informal care from family members and loved ones. From 2023-2024 86% of care home beds in Kent were full, this equates to 11,495 individuals residing in care homes in December 2024. However, not all of those who

require long-term adult social care support reside in care homes, some merely require support to remain at home. From April 2020-September 2020, much of the care requested, approximately 82%, was for Physical support. The majority of those accessing adult social care services were White. The largest minority group, if those where ethnicity is unknown are excluded, was Asian/Asian British.

Informal care impacts on the health of the individuals providing care. Findings from the Eurocare project found that older carers who provided over 20 hours of care per week experienced deterioration in their mental and physical health (199). In addition, older carers were more likely to experience loneliness despite higher levels of social interactions (199). Provision of unpaid care by older adults also exhibits gender and socioeconomic inequalities. Women are more likely to provide care than men, though the gender gap in the UK is narrowing. In addition, more intensive unpaid care (over 20 hours of care per week) is seen in those experiencing higher levels of deprivation (199). Interestingly the opposite relationship is seen for the general likelihood of being a carer at aged 65+, which increases with household incomes (199). In Dartford, Gravesham, and Sevenoaks the proportions of older adults providing unpaid care are 13%, 13.2%, and 12.5% respectively which is around the Kent average of 12.9%. In 2021 in DGS the majority of those over 50 years old who are providing unpaid care were from southern parts of Gravesham and Dartford, as shown in figure 125.

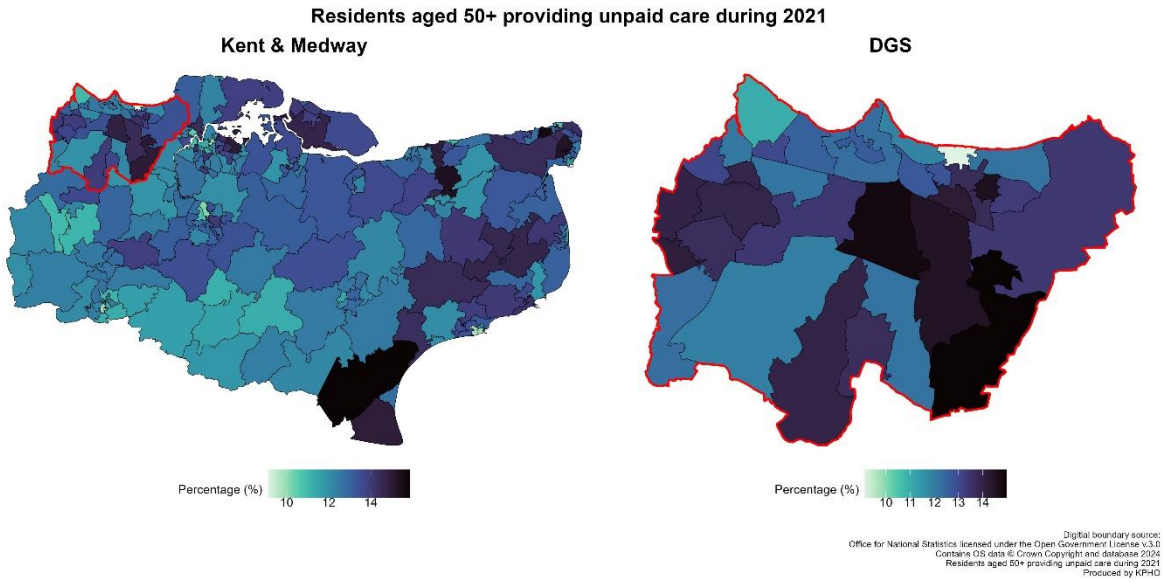


Figure 125: Map of unpaid carers in those aged over 50 years in Dartford, Gravesham, and Swanley, 2021.

15.5 Epidemiology - Prevention

Preventative care aims to reduce the incidence of disease. This report focuses on vaccine uptake, bowel cancer screening, abdominal aortic aneurysm screening, and wellbeing.

15.5.1 Influenza

Vaccine uptake in older adults is an integral way to prevent diseases such as influenza. By November 2024, the 2024/25 influenza vaccine data showed that three of the ten GP practices in Kent with the lowest uptake of influenza vaccines in the over 65 population were located within DGS. Between 2021/22- 2023/24 influenza vaccination coverage in DGS has been

significantly lower than the Kent and Medway average, as seen in figure 126. Coverage in DGS reduced from 79.3% in 2021/22 to 75.3% in 2023/24 which represents a statistically significant drop in 2022/23 and then little change between 2022/23 and 2023/24, as shown in figure 126.

Influenza vaccine coverage is important because in 2022/23 influenza was responsible for 44% of excess winter deaths (200). Influenza infection can lead to complications such as secondary bacterial pneumonia, or exacerbations of pre-existing conditions such as COPD (201). In DGS rates of emergency hospital admissions with influenza and pneumonia in those aged 65+ are 50% higher than the Kent average. These admissions in DGS are 70% higher in those in the most deprived quintile than the least deprive quintile, a difference which is statistically significant. Within Kent admissions for influenza and pneumonia are 37% higher in men than women.

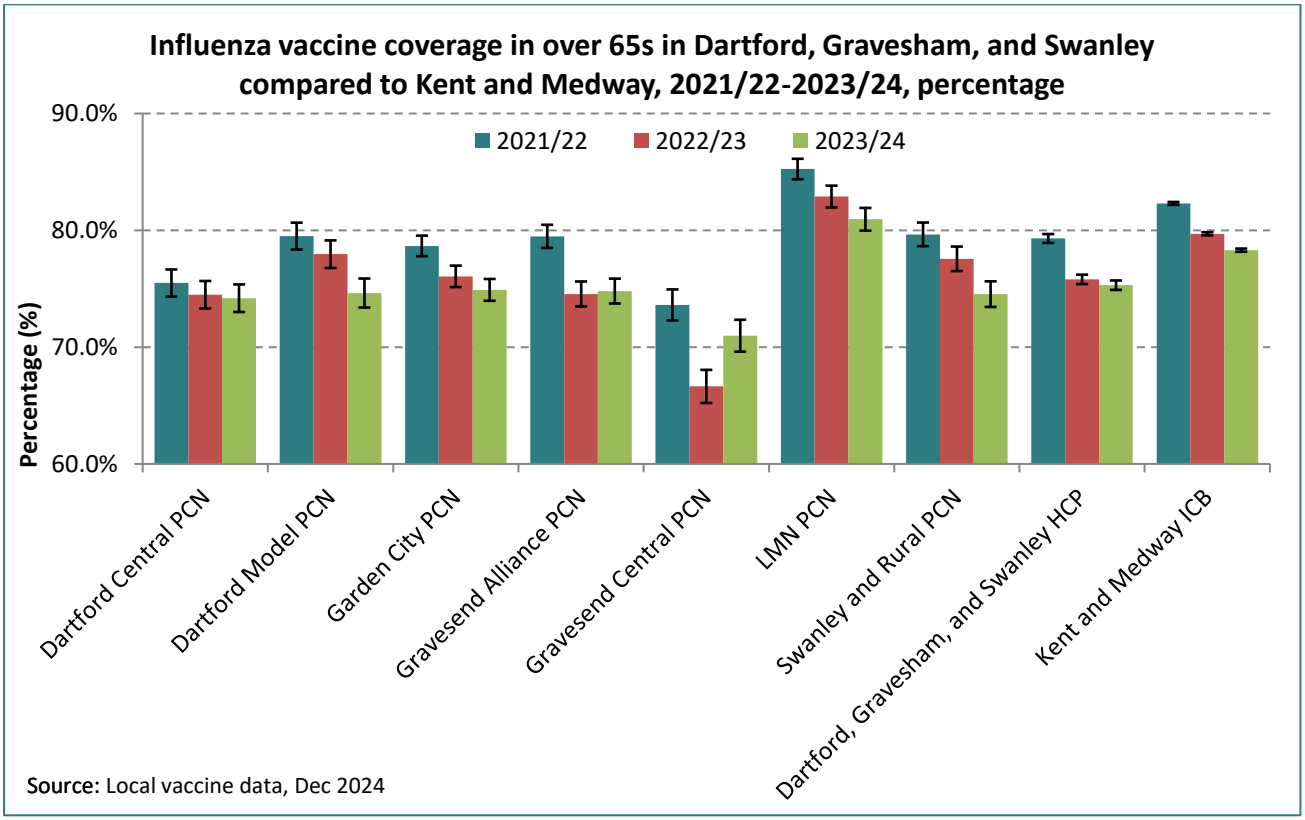


Figure 126: Influenza vaccine coverage in over 65s in Dartford, Gravesham, and Swanley compared to Kent and Medway, 2021/22-2023/24, percentage.

In DGS, the highest rates of admissions with influenza and pneumonia are in Gravesend Alliance PCN, Swanley and Rural PCN, and Dartford Model PCN, as shown in Figure 127. A degree of this may be due to the underlying income deprivation affecting older adults in these areas, as shown in figure 127, but this does not appear to explain the full picture.

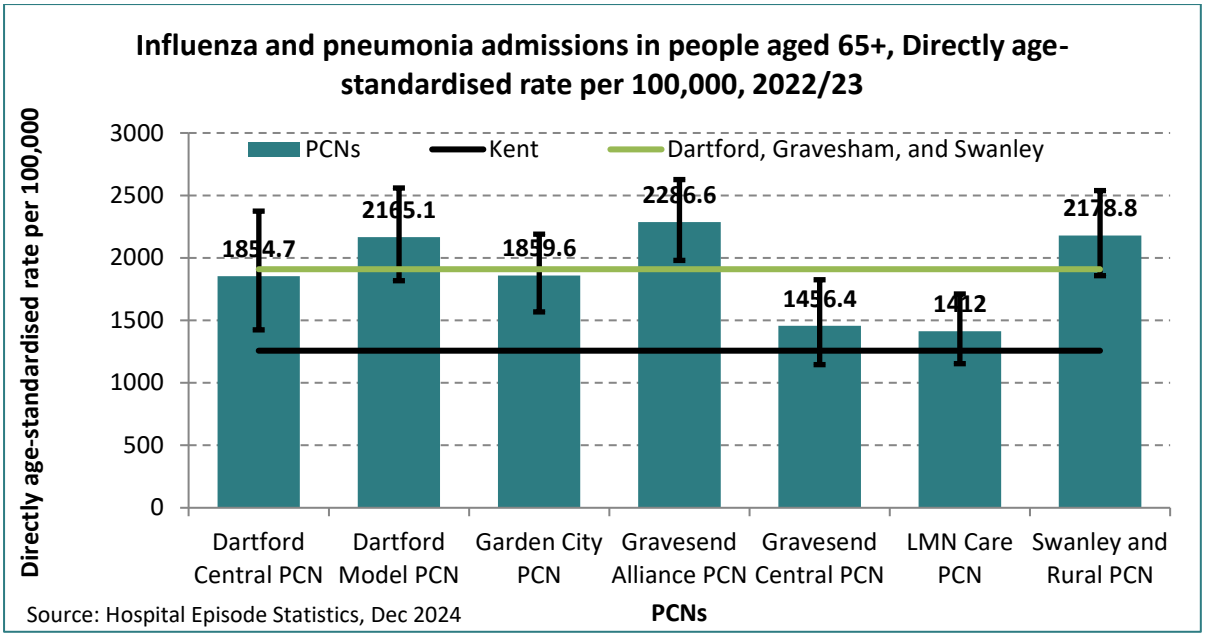


Figure 127: rates of influenza and pneumonia admissions in people aged 65+, 2022/23 (per 100,000)

Another key respiratory virus for older adults is COVID-19. Though far less cases are seen of this compared to during the pandemic, annual vaccines are still provided to protect vulnerable members of the population from severe disease. Rates of COVID-19 vaccine coverage for over 65 year olds across all PCNs in DGS have been falling since 2022/23 as shown in table 13, making the population more vulnerable to severe disease from this virus.

Table 13: COVID-29 vaccine coverage by PCN in Dartford, Gravesham, and Swanley 2022/23-2024/25, percentage.

PCN	COVID-19 vaccine coverage		
	AW 22/23	AW 23/24	AW 24/25
Dartford Central PCN	80.10%	68.40%	56.30%
DARTFORD MODEL PCN	83%	64.20%	48.80%
Garden City PCN	83.70%	68.50%	56.50%
GRAVESEND ALLIANCE PCN	83.40%	70.50%	59.10%
Gravesend Central PCN	77.70%	61.30%	45%
LMN PCN	88.70%	80.40%	70.30%
Swanley & Rural PCN	84.70%	73.60%	61.10%

15.5.2 Bowel cancer screening

Coverage for bowel cancer screening refers to the proportion of the eligible population who are up to date with screening, therefore it reflects both the offer of screening and the uptake of screening (158). In DGS Bowel cancer screening coverage is lower than the Kent and Medway

average in four PCNs, as shown in figure 128. Reassuringly these values are all above the national target of 60% coverage.

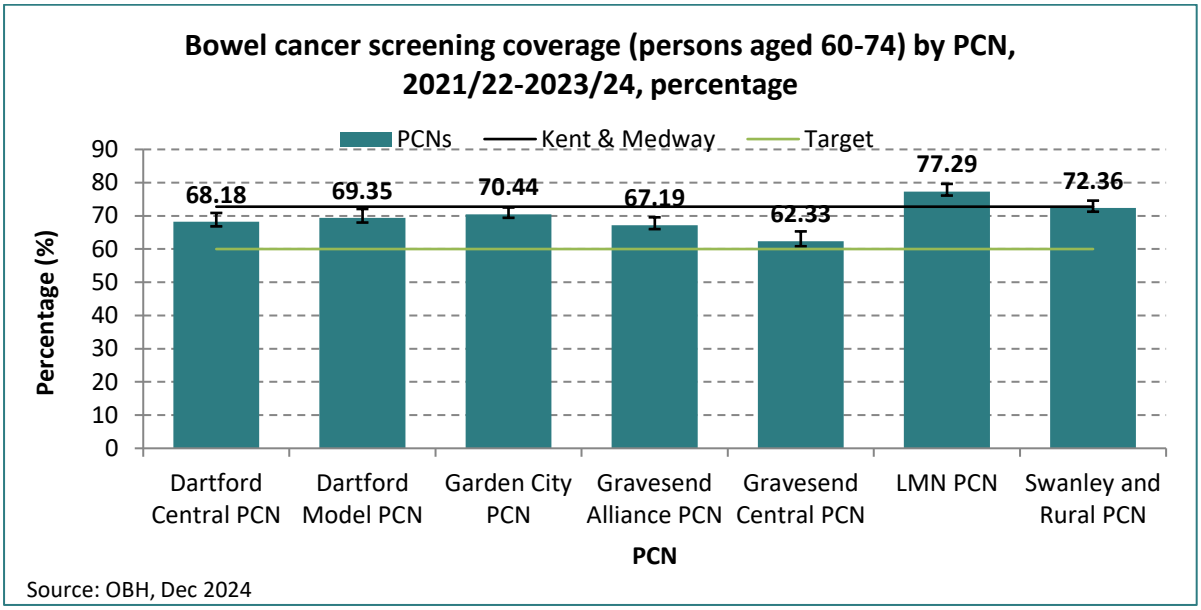


Figure 128: Bowel cancer screening coverage (persons aged 60-74), 2021/22-2023/24, percentage

Bowel cancer screening coverage varies across DGS in individuals with learning disabilities, severe mental illness, and from ethnic minorities, as shown in table 14. In DGS LMN PCNs has coverage rates significantly below the target of 60% for people with learning disabilities. The remaining PCNs have rates that are around the 60% target. This is concerning because individuals with learning disabilities are at an increased risk of bowel cancer due to various factors such as diet, obesity, and physical inactivity (202).

Bowel cancer screening coverage in DGS is around 60% in ethnic minority groups. However, coverage in ethnic minority groups is significantly below that of the general coverage for each respective PCN except for Gravesend Central PCN and LMN PCN.

Lastly, in those with severe mental illness bowel cancer screening coverage rates are significantly below target in three out of the seven PCNs in DGS. In a similar picture to ethnic minority groups, coverage is significantly below that of the general coverage for four of the PCNs. On a more positive note, coverage in the LMN PCN for those with severe mental illnesses is the highest of all the PCNs in Kent and Medway and therefore may be a location where best practice can be drawn from.

Table 14: Bowel cancer screening coverage (persons aged 60-74) by PCN and domain of inequality, 2021/22-2023/24, percentage (95% CIs)

	Bowel cancer screening coverage (persons aged 60-74) by PCN and domain of inequality, 2021/22-2023/24, percentage (95% CIs)		
	Learning disability	Ethnic minorities	Severe mental illness
Dartford Central PCN	66.67 (47.82-81.36)	62.48 (58.47-66.32)	50 (37.92-62.08)
Dartford Model PCN	75 (56.64-87.32)	61.37 (57.55-65.06)	60 (47.37-71.43)
Garden City PCN	51.52 (35.22-67.5)	62.84 (59.47-66.08)	46.51 (36.35-56.98)
Gravesend Alliance PCN	63.33 (45.51-78.13)	60.85 (56.93-64.63)	42.5 (32.26-53.43)
Gravesend Central PCN	57.78 (43.3-71.03)	59.92 (57.23-62.56)	48.91 (38.95-58.96)
LMN PCN	20 (5.67-50.98)	73.33 (65.74-79.76)	77.08 (63.46-86.69)
Swanley and Rural PCN	47.62 (28.34-67.63)	65.34 (60.23-70.12)	67.35 (57.56-75.82)
Kent & Medway	60.72 (58.47-62.93)	66.25 (65.55-66.95)	59.17 (57.67-60.65)

15.5.3 Abdominal Aortic Aneurysm Screening

An abdominal aortic aneurysm (AAA) occurs when the aortic artery within the abdomen expands to more than 3cm in diameter. AAAs are concerning due to the risk of rupture which carries a 80% mortality rate. Screening for AAAs aims to identify those at increased risk and offer surgical management to reduce the risk of rupture. It also allows advice on cardiovascular risk factors such as smoking cessation advice to be given. Men are offered screening when they are 75 years old.

In DGS, 83% of men attended their offered AAA screening from January 2023 – November 2024. This showed variation across the PCNs within DGS and with deprivation. The lowest attendance rate appears to be in Gravesend Central PCN at 73%. Typically, the PCNs where a larger proportion of those attending screening were from ethnic minorities had lower attendance rates, as shown in figure 129. Unfortunately, data on ethnicity is not available for those who did not attend as it is collected during the screening appointment. A lower proportion of those attending appeared to be from the most deprived quintiles in DGS, as shown by the social gradient in figure 130. This shows that only 26% of attendees were from the most deprived two quintiles despite this making up around 41% of the population. In comparison a higher percentage of the DGS population are rom the most

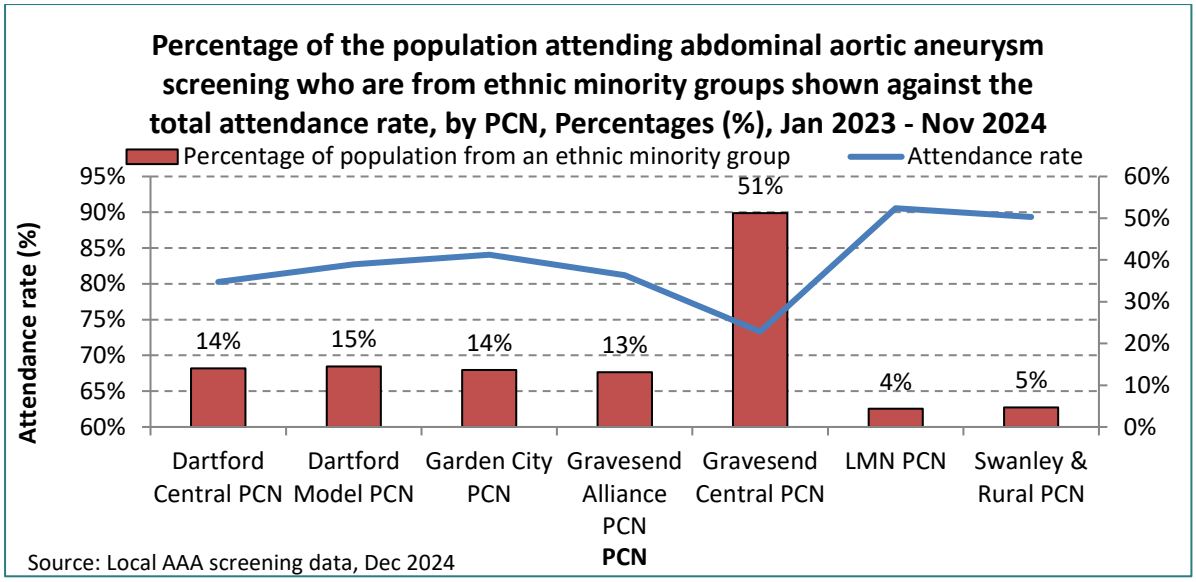


Figure 129: Percentage of the population attending abdominal aortic aneurysm screening who are from ethnic minority groups shown against the total attendance rate, by PCN, Percentages (%), Jan 2023 - Nov 2024

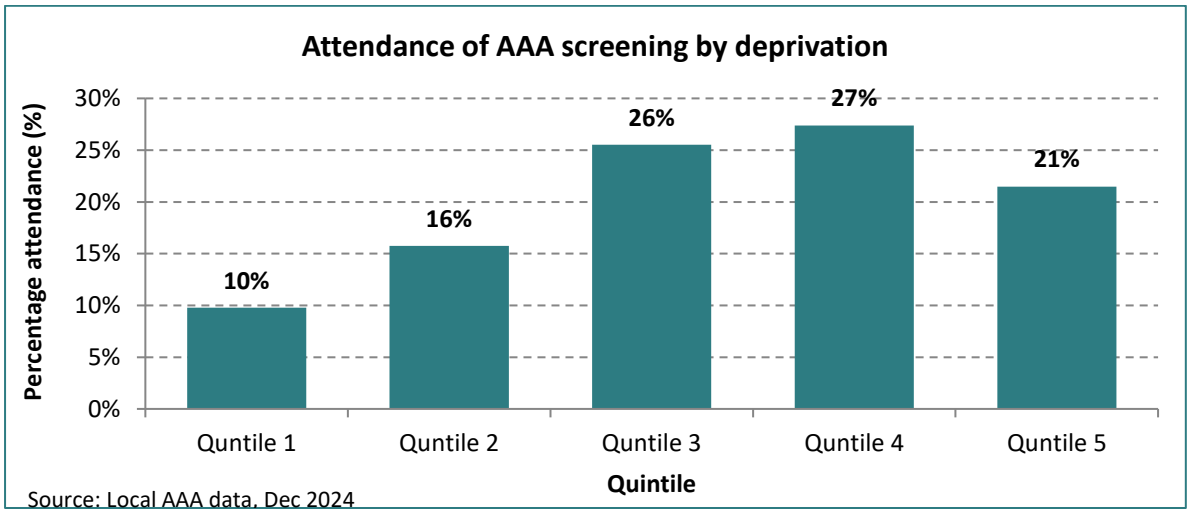


Figure 130: Attendance of AAA screening by deprivation

15.5.4 Prevention of cardiovascular disease

Cardiovascular disease has a significant impact on the lives of older adults. It is a leading cause of death in England and Wales but around 85% of cardiovascular disease is estimated to be preventable (203,204). Prevention includes primary prevention through reductions in risk factors such as alcohol, smoking, obesity, physical inactivity, and secondary prevention through treatment of hypertension and atrial fibrillation.

In 2021-23 Gravesham had the highest rate of deaths from cardiovascular disease in under 75-year-olds in Kent at 93.1 per 100,000 (95% CI 81.7-105.6 per 100,000), compared to 69.3 per 100,000 (95% CI 66.8-71.8 per 100,00) in Kent. This is significantly higher than the national average of 77.1 per 100,000. Rates in Dartford and Sevenoaks were significantly lower than the national average during this time at 61.4 per 100,000 and 55.8 per 100,000 respectively.

Within DGS in 2023 rates of hypertension in over 65-year-olds were significantly higher in Dartford Central PCN, Dartford Model PCN, and Gravesend Central PCN compared to Kent and Medway, as shown in figure 131. Figure 131 also shows that rates of obesity in over 65-year-olds were significantly higher in Dartford Model and Gravesend Alliance PCN compared to Kent and Medway, and rates of smoking were significantly higher in Gravesend Central PCN compared to Kent and Medway. Due to data restrictions levels of high cholesterol within the DGS population cannot be reported on.

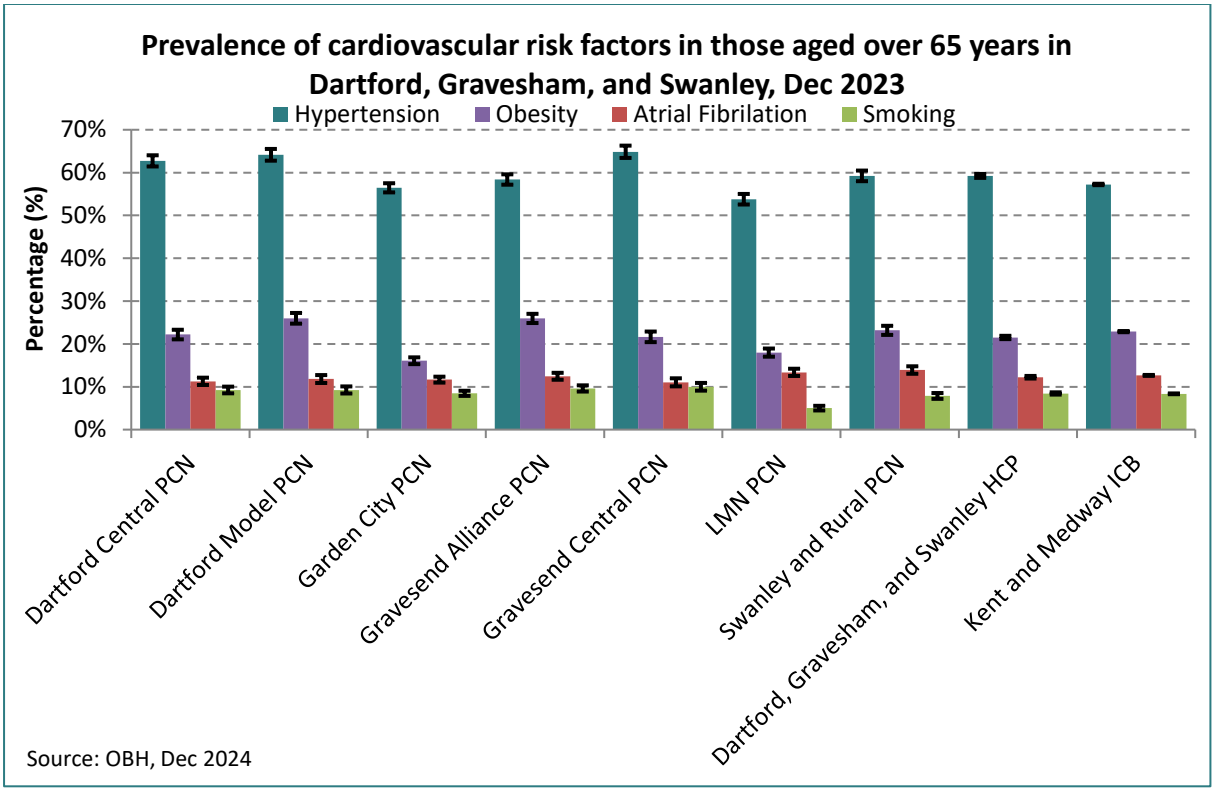


Figure 131: Prevalence of cardiovascular risk factors in those aged over 65 years in Dartford, Gravesham, and Swanley, Dec 2023

15.5.5 Wellbeing

The most recent data from the Annual Population Survey shows that life satisfaction, as a proxy for wellbeing has been relatively stable across DGS, as shown in figure 132. As this data is collected nationally it is not available at Swanley level and therefore Sevenoaks data has been reported. Concerningly the life satisfaction for adults in Gravesham dropped in 2020/21. Presently more recent data is not available. This data is also only available for all ages of adults. Research by Age UK in 2017 showed that when assessed using their index of wellbeing in later years score the wellbeing of older adults in the UK was only around 50% (205). Therefore, it is likely that the wellbeing of older adults in DGS is lower but due to data constraints this is difficult to truly define.

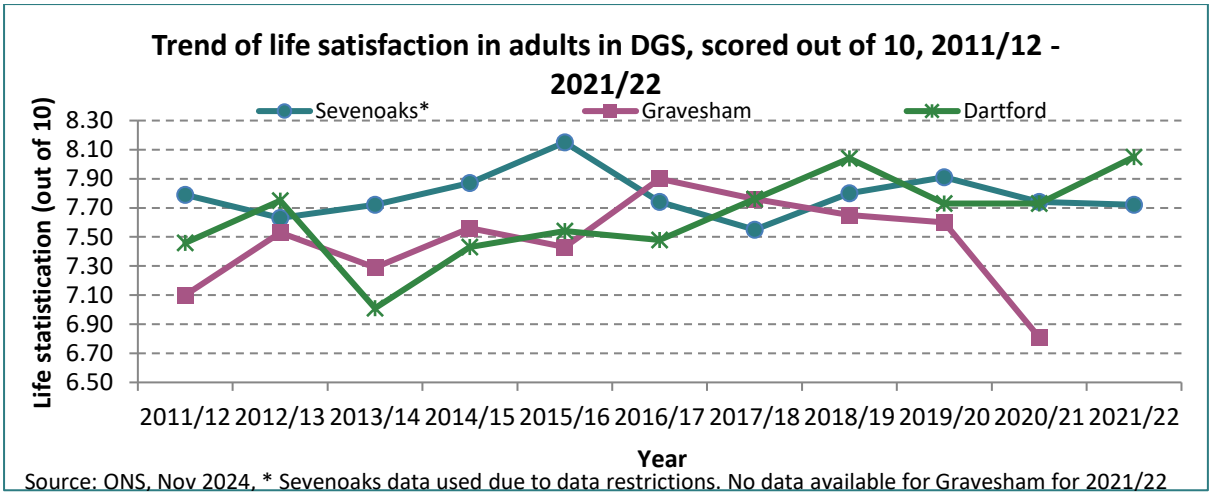


Figure 132: Trend of life satisfaction in adults in DGS, scored out of 10, 2011/12 - 2021/22

15.6 Epidemiology – Pro-active care

Pro-active care focuses on identifying those with health and care needs earlier so that appropriate care can be put in place. This section of the needs assessment includes osteoporosis, falls (especially those resulting in fractures), and dementia.

15.6.1 Osteoporosis

Osteoporosis rates in Kent are highest in Dartford and lowest in Gravesham compared to the other districts. Rates in Sevenoaks are lower than the Kent average. Osteoporosis levels in DGS nearly doubled from 0.54% to 1% between 2021/22-2022/23. When explored at PCN level this appears to be due to increases in prevalence in LMN PCN and Dartford Central PCN, as shown in figure 133. This may reflect changes in data collection, an increase in the diagnosis rate, or a true increase in cases. If it is the latter, this will be associated with an increased risk of fractures within the population of DGS. Research suggests that half of women over 50 and a third of men over 60 will develop an osteoporosis-related fracture (206). These fractures, in particular hip fractures, can be extremely costly both in terms of loss of life, with 18-33% of patients dying in the year following a hip fracture, and monetary costs, costing the UK £2 billion per year (207)

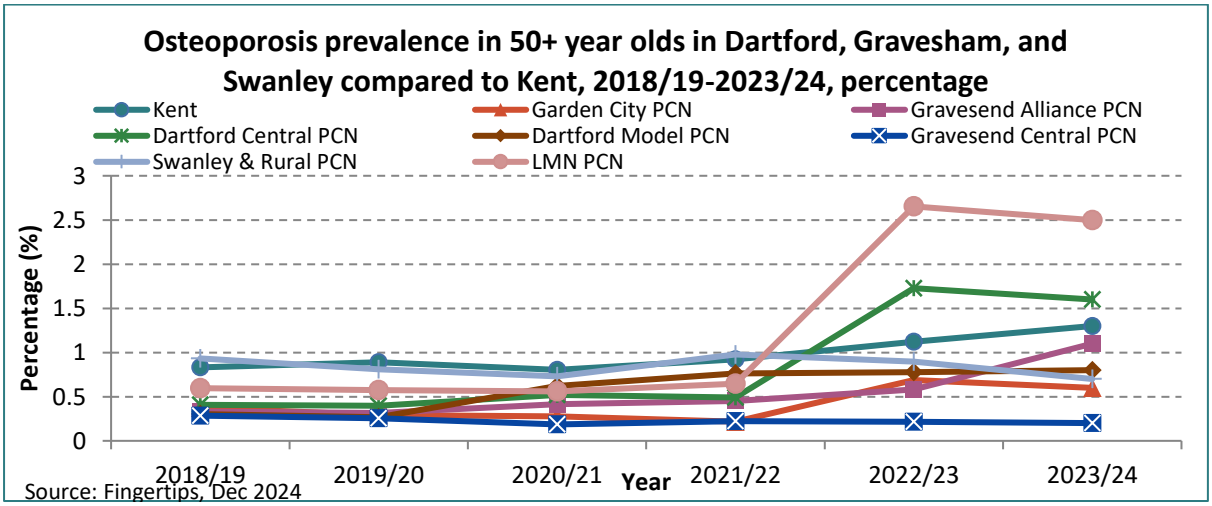


Figure 133: Prevalence of osteoporosis in DGS in those >50 years as per primary care records, 2018/19-23/24, percentage

15.6.2 Falls

Falls are defined as an event which "causes a person to, unintentionally, rest on the ground or lower level which is not due to a stroke or extreme hazard" (207). Local data shows that within DGS ambulances were called to 509 falls between April 2023-July 2024. This translates to 18.7 falls per 10,000 people which is lower than the Kent and Medway average rate of 20.6 per 10,000. As shown in figure 134, rates of emergency hospital admissions due to falls in over 65-year-olds are similar to the Kent and England averages in Dartford and Gravesham but significantly higher in Sevenoaks.

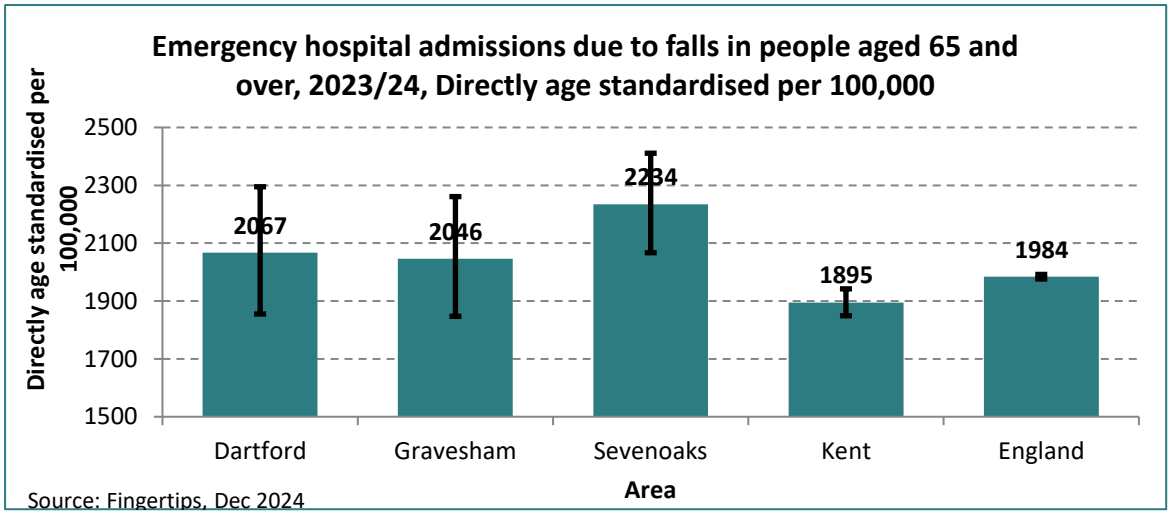


Figure 134: Emergency hospital admissions due to falls in people aged 65 and over, 2023/24, Directly age standardised per 100,000

Falls resulting in leg or hip fractures in those over 65 occur less frequently in DGS than elsewhere in Kent. Within DGS they occur with the highest frequency in northern Dartford as shown in figure 135. This fits with Dartford having the highest rates of Osteoporosis in Kent which would increase the risk of fractures occurring with a fall (207). These falls also have important consequences for social care, around 20% of individuals require long-term care facilities within the first year following a hip fracture (208).

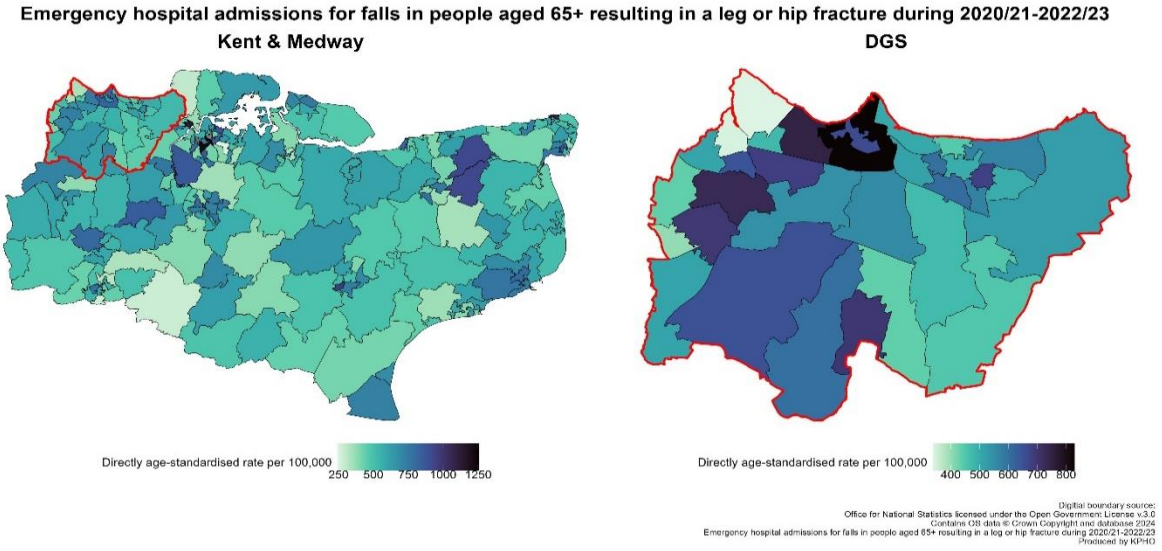


Figure 135: Map of emergency admissions in people aged 65+ for a fall resulting in a leg or hip fracture, 2020/21.

One way to help reduce the risk of falls is to encourage physical activity, including strength and balance exercises, into the later years of life (207). Tools that can be used include the evidence guide by the chartered society of physiotherapists and Age UK (209).

15.6.3 Dementia

Dementia is an umbrella term for multiple diseases which affect memory, thinking, and the ability to perform tasks (210) . Its prevalence in DGS is significantly lower than the Kent average by approximately 12%, see figure 136, as may be expected given the age demographics of the two populations.

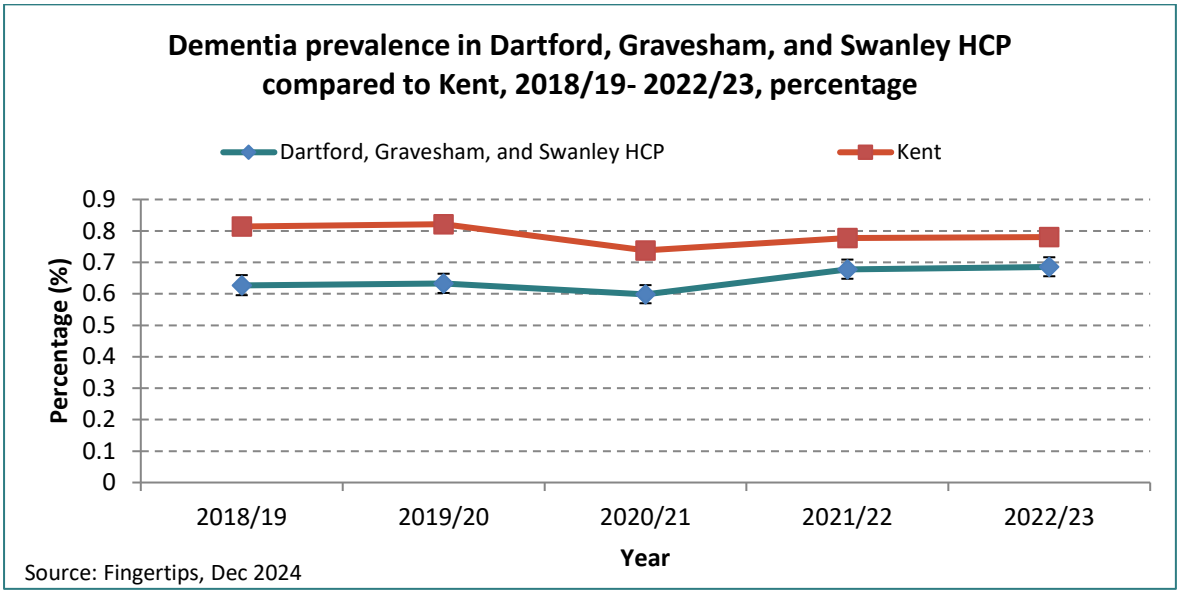


Figure 136: Dementia prevalence in Dartford, Gravesham, and Swanley HCP compared to Kent, 2018/19- 2022/23, percentage

Those with dementia in DGS tend to be female and are more likely to be aged 85-89 than the rest of Kent. The majority of dementia cases in DGS occur in those who are moderately to least deprived, with only 37.3% occurring in the five more deprived quartiles. However, a higher proportion of those in the most deprived quartiles are from ethnic minorities either Asian or Asian British, or Unknown. Research suggests that rates of dementia diagnosis tend to be lower in ethnic minority groups which may mask the expected rise in groups experiencing higher levels of socioeconomic deprivation (211). Furthermore, rates in deprived areas may be missed due to low diagnostic rates.

In DGS around 63% of expected cases have a diagnosis which appears to be higher than the rest of Kent and Medway but below the national target of 66.7%, as shown in figure 137. Gravesend Alliance and Dartford Model PCNs both appear above the target whilst the remaining PCNs have rates which appear below the target level. Dementia diagnostic rates appear to be particularly low in Gravesend Central, Swanley & Rural, and Dartford Central which are all below 60%, these PCNs cover areas of high deprivation. In addition to population surveillance, is important for those with dementia to get diagnosed so they can access relevant support systems and medication if relevant for their cause (212). Research by the Alzheimer's society suggests that most people receive at least one benefit from being diagnosed (212).

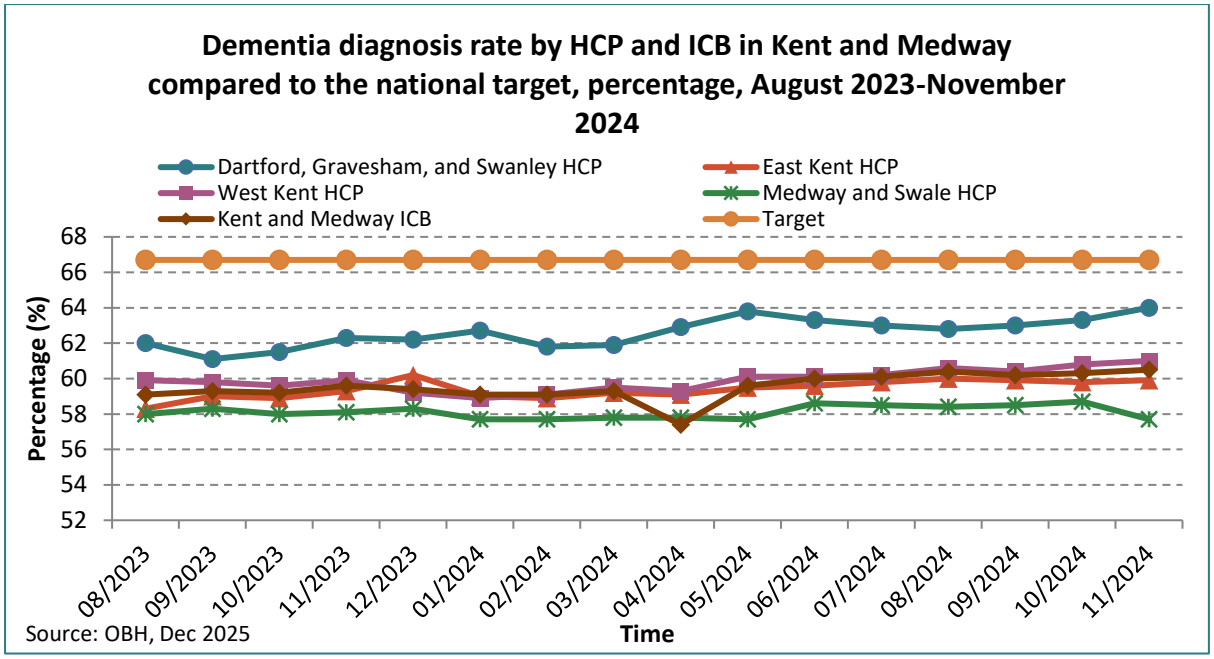


Figure 137: Dementia diagnosis rate by HCP and ICB in Kent and Medway compared to the national target, percentage, August 2023-November 2024

Whilst it is key to identify those with dementia and ensure they have the correct support and care, preventing dementia cases is equally, if not more important. Dementia may seem inevitable, but only 1 in 10 of those aged 80-84 and 3 in 10 of those aged 90-94 years will have dementia (176). If dementia incidence is delayed by 5 years, the prevalence could be nearly halved. To lower these rates, there are a slew of potentially modifiable risk factors which if targeted, may lead to a delay in onset of disease. These, as shown in research by Livingston et al, include common risk factors such as smoking, hypertension, and physical inactivity (213). Alongside these are risk factors which are not considered as frequently such as midlife hearing loss. This is thought to attribute 20% of the known, and potentially modifiable, risk of dementia (213).

People with dementia are also more likely to have multimorbidity. Approximately 77% have comorbidities compared to 68% of all patients (214). This can make their care more complex. Concerningly, across the nation, hospital admissions for those with dementia are rising (215). Many of these are due to preventable causes such as infections, falls, and dehydration. Emergency department attendances and emergency admissions for over 65s with dementia have been explored. In DGS the rate of ED attendances in those with dementia from 2019-2023 was 20.42 per 1,000 compared to 18.41 per 1,000 in Kent and Medway. The highest rate appeared to be in Swanley and Rural PCN at 25.76 per 1,000.

Emergency admissions from 2019-2023 occurred at an age-standardised rate of 11.99 per 1,000 in DGS compared to 9.76 per 1,000 in Kent and Medway. These rates appear higher in care home residents compared to non-care home residents at 14.66 per 1,000 and 10.97 per 1,000, respectively. Emergency admissions in dementia appeared to follow a slight social gradient with age-standardised rates appearing higher in the most deprived quintile compared to the least deprived quintile at 13.15 per 1,000 and 10.26 per 1,000, respectively.

15.7 Epidemiology – Reactive care

Reactive care includes providing urgent health and social care when appropriate. Within this section the following topics will be discussed, unplanned admissions for ambulatory sensitive conditions, length of stay, and frailty.

15.7.1 Ambulatory care sensitive conditions

Admissions for ambulatory care sensitive conditions describes emergency admissions for conditions which if appropriately managed in the community may avoid admissions. DGS has 19% higher rates of this than in Kent as a county and those who are most deprived have nearly double the rates of those who are least deprived. Within DGS these rates are highest in the more urban areas, as shown in figure 138.

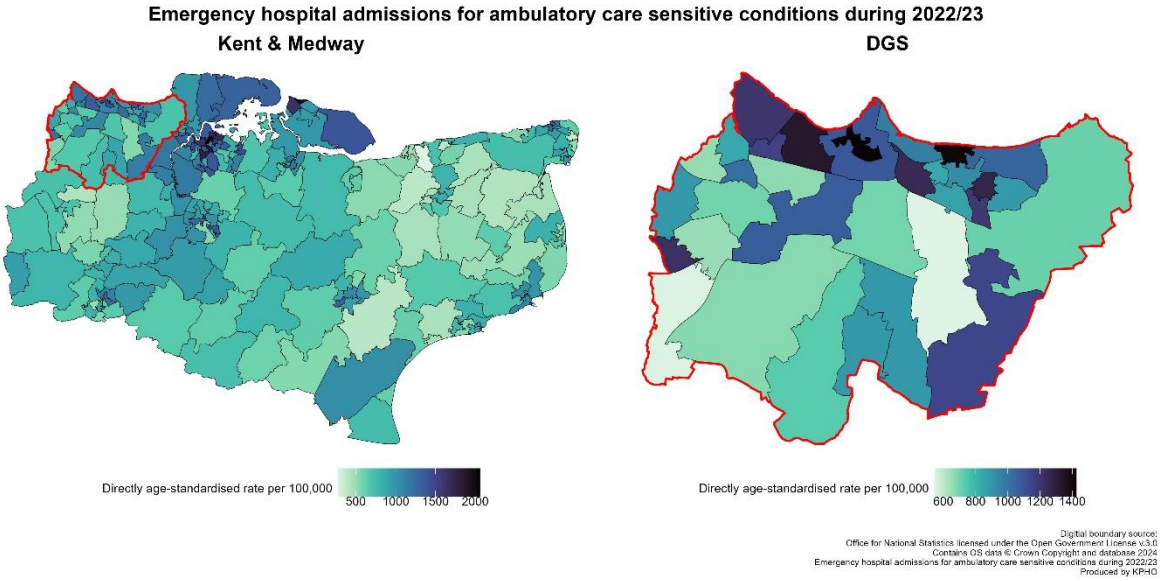


Figure 138: Map of emergency admissions for ambulatory sensitive conditions 2022/23 at MSOA level for DGS (per 100,000)

Emergency admissions are undesirable due to the related increased risk of infections, reduced mobility and subsequent increase in frailty (216). These risks are exacerbated in those who are vulnerable such as older adults (216). In addition, emergency admissions cost the NHS £18 billion in 2017/18, a number which has likely risen given inflation and increases in the rate of emergency admissions (216,217). Research suggests that ambulatory sensitive conditions make up around 14% of emergency admissions and that emergency admissions are more common in those aged over 65 years old (216,218). As such, there are potentially large gains from optimising ambulatory care in the community both for patients and healthcare services.

15.7.2 Length of stay

Length of stay as an indicator in older adults can reflect both the complexity of acute healthcare needs and the availability of social care to support the hospital discharge process. In DGS the 12 month rolling average length of stay for non-elective admissions in December 2024-2025 was 8.38 days in adults over 65 years old. This appears longer than West Kent and the Kent and Medway average, 5.25 and 8.03 days respectively, but appears shorter than the Medway and Swale and East Kent averages which were 9.46 and 9.94 respectively. Variation is seen across

the PCNs with longer lengths of stay appearing to occur in Dartford Central PCN, as shown in figure 139.

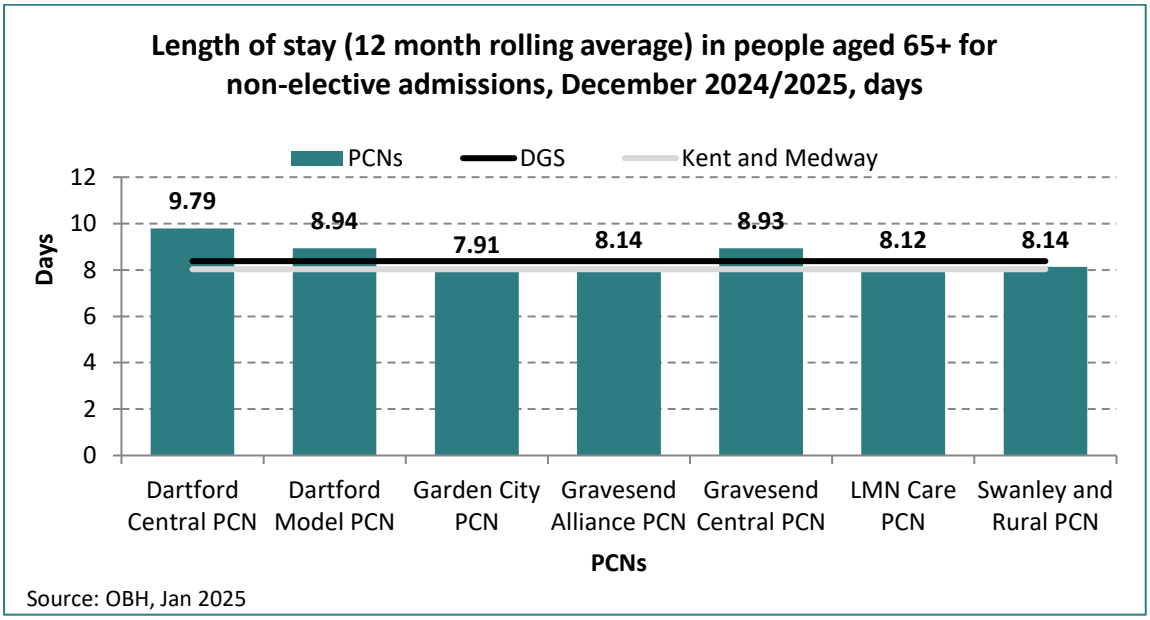


Figure 139: Length of stay (12 month rolling average) in people aged 65+ for non-elective admissions, December 2024/2025, days

15.7.3 Frailty - Demographics

The British geriatrics society define frailty as the 'distinctive health state related to the ageing process in which multiple body systems lose their in-built reserves' (219). Frailty is typically measured using a frailty index. This comprises of 60 variables which typically increase with age and can lead to disability, impairments, cognitive decline, and chronic illnesses (220).

Frailty can be assessed using the electronic frailty index, a validated tool which collates routinely collected primary care data to identify those at risk of frailty on a population level. As this is a electronic tool rather than a clinical tool and has high sensitivity and low specificity, it may overestimate the burden of frailty, however it does an estimate at the population level. It shows that in DGS approximately 48% of the population aged over 65 year is classified as frail. This is broken down into 31.2% experiencing mild frailty, 12.2% with moderate frailty, and 4.5% experiencing severe frailty. Individuals with severe frailty tend to be older with a higher proportion within the 80+ age bracket. The majority of those experiencing frailty are female, which may be expected given that females tend to have a longer life expectancy and therefore experience a higher proportion of the diseases associated with older age. Geographically higher rates of frailty are recorded in LMN PCN and Swanley & Rural PCNs which likely reflects the age spread of the population as shown in figure 120.

In DGS those of Asian or Asian British ethnicity appear to make up a greater percentage of those with frailty than the rest of Kent and Medway, 7% versus 2% respectively. The majority of this group in DGS tends to comprise of Indian and 'other' Asian backgrounds. Much of the ethnic minority population experiencing frailty in DGS appear to be located in Gravesend Central PCN.

More people in the least deprived deciles tend to experience frailty in DGS compared to the rest of Kent and Medway, as shown in figure 140. This is the opposite of what has been found in research by Maharani et al using the English Longitudinal Study of Ageing (ELSA), which found

that frailty showed a social gradient with those in the most deprived groups experiencing higher levels of frailty (220). Why this difference occurs in difficult to ascertain, for example this difference may be due to differences in assessment rates between those experiencing high and low levels of deprivation which would typically not affect those in the ELSA study (220,221). It also may be due to those in more deprived quintiles experiencing premature mortality from alternative causes and therefore not reaching an age at which they would experience and be diagnosed with frailty. It could also be a true finding; however, further analysis is required to ascertain this.

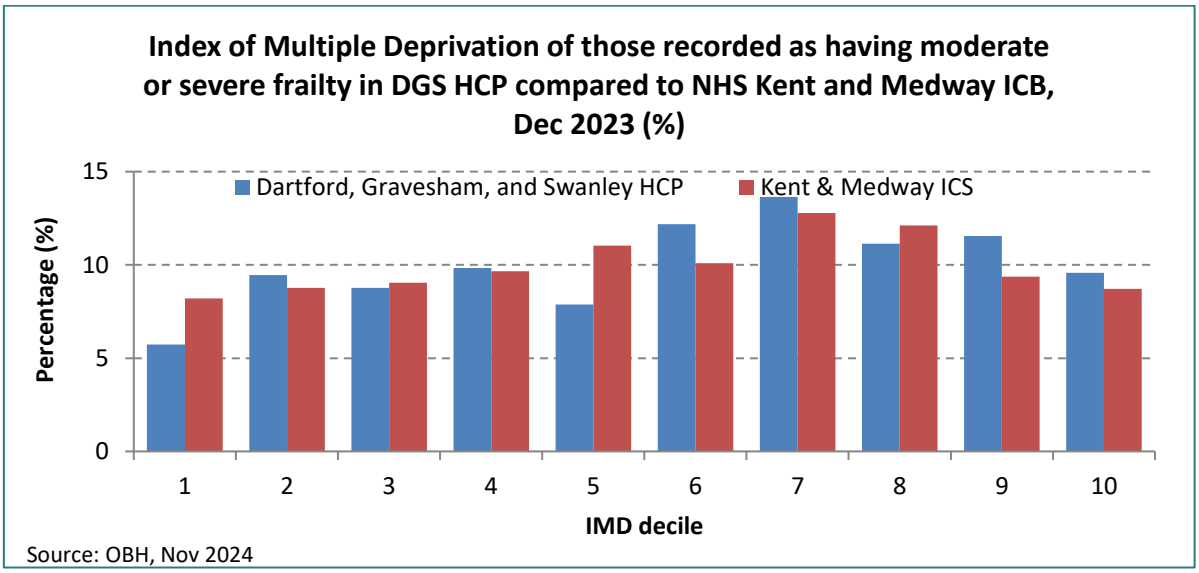


Figure 140: Index of Multiple Deprivation of those recorded as having moderate or severe frailty in DGS HCP compared to NHS Kent and Medway ICB, Dec 2023 (%)

The proportion of DGS residents aged over 65 experiencing frailty is similar across DGS, as shown in figure 141.

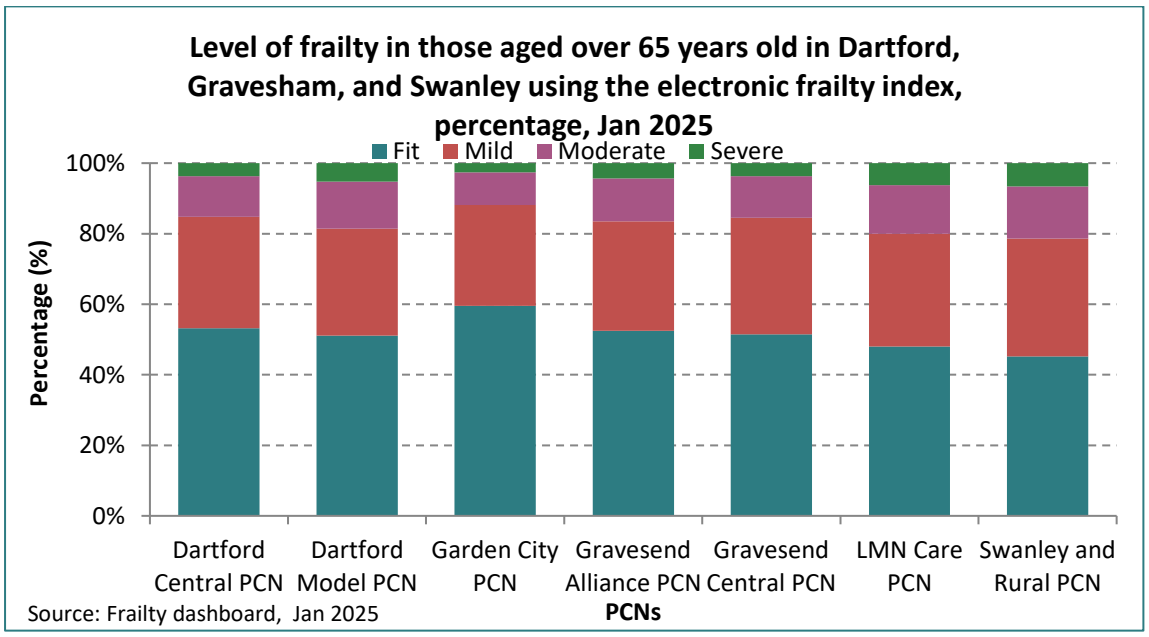


Figure 141: Level of frailty in those aged over 65 years old in Dartford, Gravesham, and Swanley using the electronic frailty index, percentage, Jan 2025

Frailty is associated with an increased risk of an extended hospitalisation, as shown in figure 142 and 143. In general, in residents aged over 65 years less than 15% have an over 5% chance of an extended hospital stay. However, in those aged over 65 years old with severe frailty this increases to around a 70% of the population having an over 5% chance of a prolonged hospitalisation.

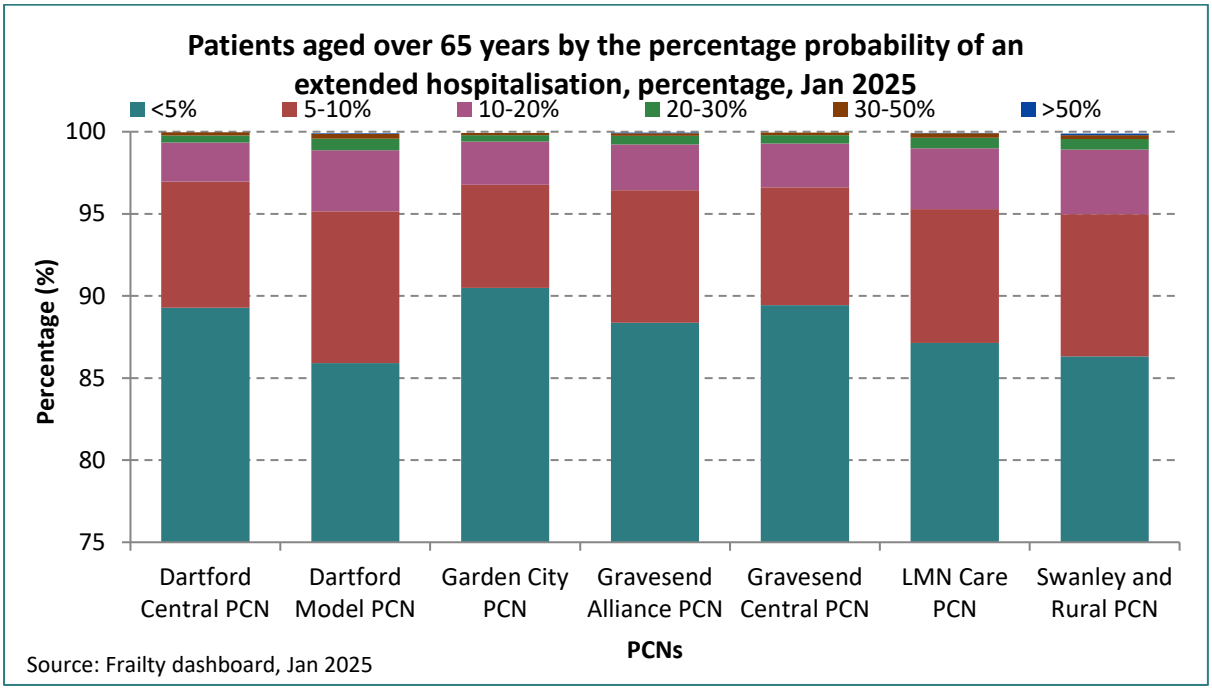


Figure 142: Patients aged over 65 years by the percentage probability of an extended hospitalisation, percentage, Jan 2025

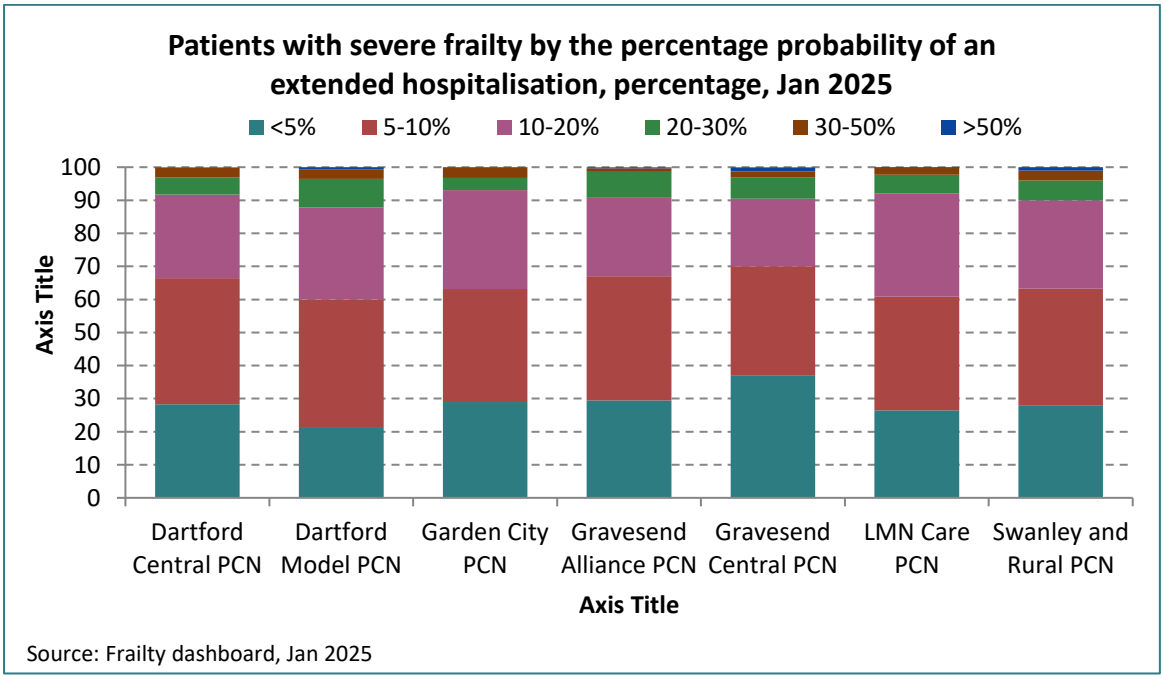


Figure 143: Patients with severe frailty by the percentage probability of an extended hospitalisation, percentage, Jan 2025

15.7.4 Frailty - Emergency admissions and Emergency Department attendances

Emergency admissions, as discussed, can be detrimental in those who are vulnerable due to the increased risk of infections and loss of mobility. Emergency admissions can also lead to increased risk of delirium, defined as disturbed consciousness, attention, cognition, and perception (222). Delerium can lead to prolonged hospital stays and increase the risk of older patients requiring long-term care (223). Those who are frail are more vulnerable to delirium (224). In addition, those who are frail are already at a higher risk of mortality with emergency admissions, prolonged length of stays in hospital, and being discharged to locations other than their home (225). Even if frail patients have a short hospital stay, they appear to be at an increased risk of mortality and high resource utilisation (226).

Within DGS rates of emergency admissions in those classified as moderately or severely frail appear similar to Kent and Medway ICB at 7.9 per 1,000 in DGS compared to 7.55 per 1,000 from April 2019-Dec 2023. The rate of emergency admissions across DGS shows little variation from the Kent and Medway average, as shown in figure 144. Interestingly LMN PCN tends towards slightly lower age standardised emergency admission rates despite having slightly higher rates of individuals experiencing frailty.

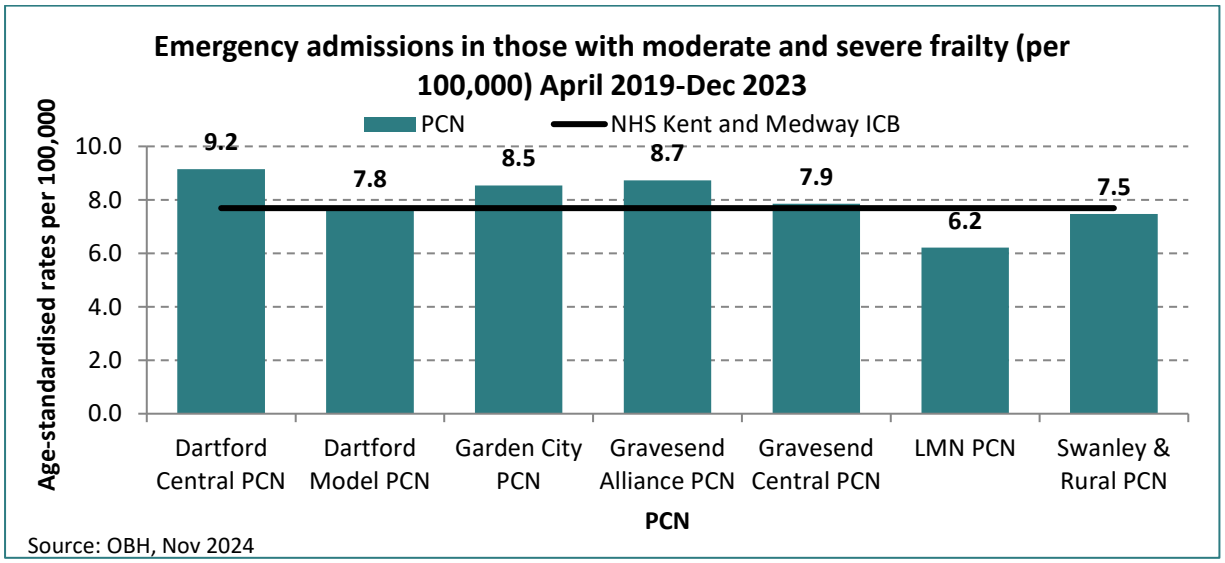


Figure 144: Emergency admissions in those with moderate and severe frailty (per 100,000), 2019-2023

Emergency admissions also appear more likely in the most deprived compared to the least deprived at 9.14 per 1,000 and 7.08 per 1,000 respectively. This variation follows a social gradient from most to least deprived. Variation in emergency admissions also occurs by ethnicity. Those in the Asian or Asian British groups tend to have lower rates of emergency admissions at 5.67 per 1,000. However, rates appear higher in 'other' and unknown ethnic groups, at 9.51 per 1,000 and 10.44 per 1,000 respectively. Furthermore, rates of emergency admissions in those with frailty are 2.5 times higher in care home residents than those who are non-residents.

Emergency department attendances within DGS for those experiencing frailty show a similar picture, with higher rates appearing to be associated with deprivation, other and unknown ethnic groups, and being a care home resident. Geographical variation also appears to occur, as shown in figure 145.

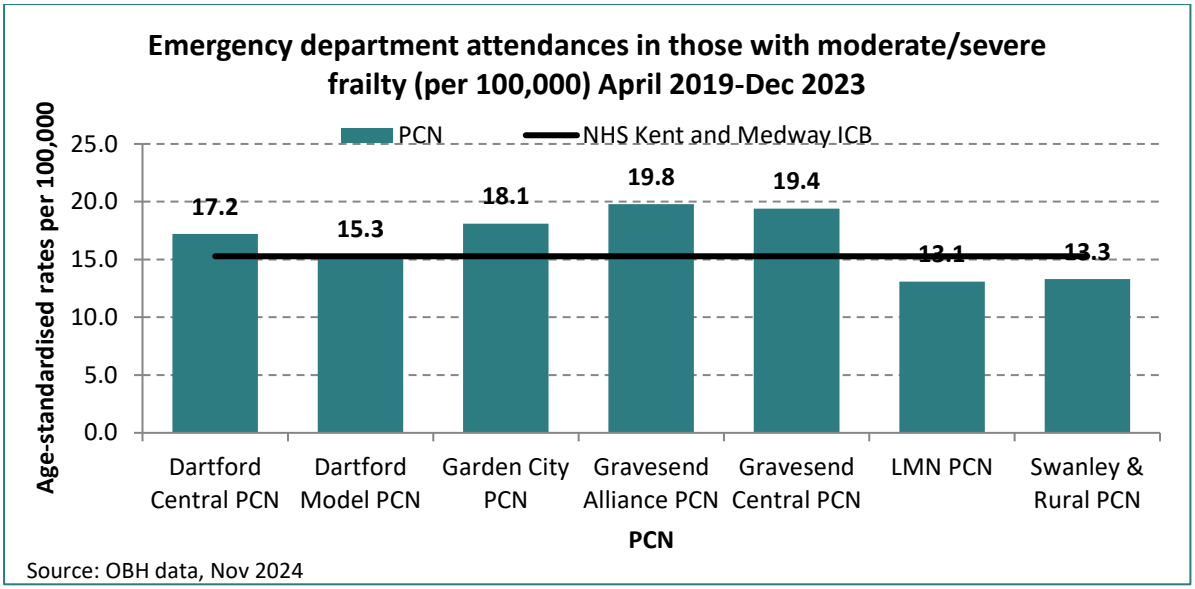


Figure 145: Emergency department attendances in those with moderate/severe frailty (per 100,000), 2019-2023

15.8 Available services

Many of services in DGS for older adults are ran via GP services such as health checks, vaccines, and osteoporosis assessment, therefore supporting primary care services is crucial for their continued success. Additional services are as follows:

- West and North Kent Postural Stability Service from Involve
    - This service is currently undergoing a public consultation for potential changes such as providing the service for those aged 50 and above and shortening the service to an intense 12 week programme rather than 36 weeks.
- Bowel cancer and AAA Screening via the NHS Screening and Immunisations Team
- Influenza and Covid-19 Vaccines via the NHS Screening and Immunisations Team
- Stop the start – smoking cessation
- Weight management services
- Active Kent & Medway
- Education, employment and training services

15.9 Gaps

- There is little data available on wellbeing in older adults in DGS. NICE guidance recommends ways to maintaining independence and wellbeing of older adults, but little appears to have been done to measure this in the local area.
- There are clear inequalities in bowel cancer screening coverage in DGS for those from ethnic minorities and for those with severe mental illnesses or learning disabilities.
- It remains unclear why rates of osteoporosis in DGS are increasing.
- There appears to be a potential gap in the available data on frailty demographics. At present it appears that a greater proportion of those with frailty are from the least deprived deciles in DGS than in Kent and Medway. This deviates from the nationally seen association between frailty and deprivation. It is unclear if this is a true finding or due to differing rates of assessment for frailty dependant on deprivation.

- There is a lack of data on the number of those experiencing hearing of visual loss in DGS, this is important given the associated increased risk of dementia and poor health.

15.10 Key Findings

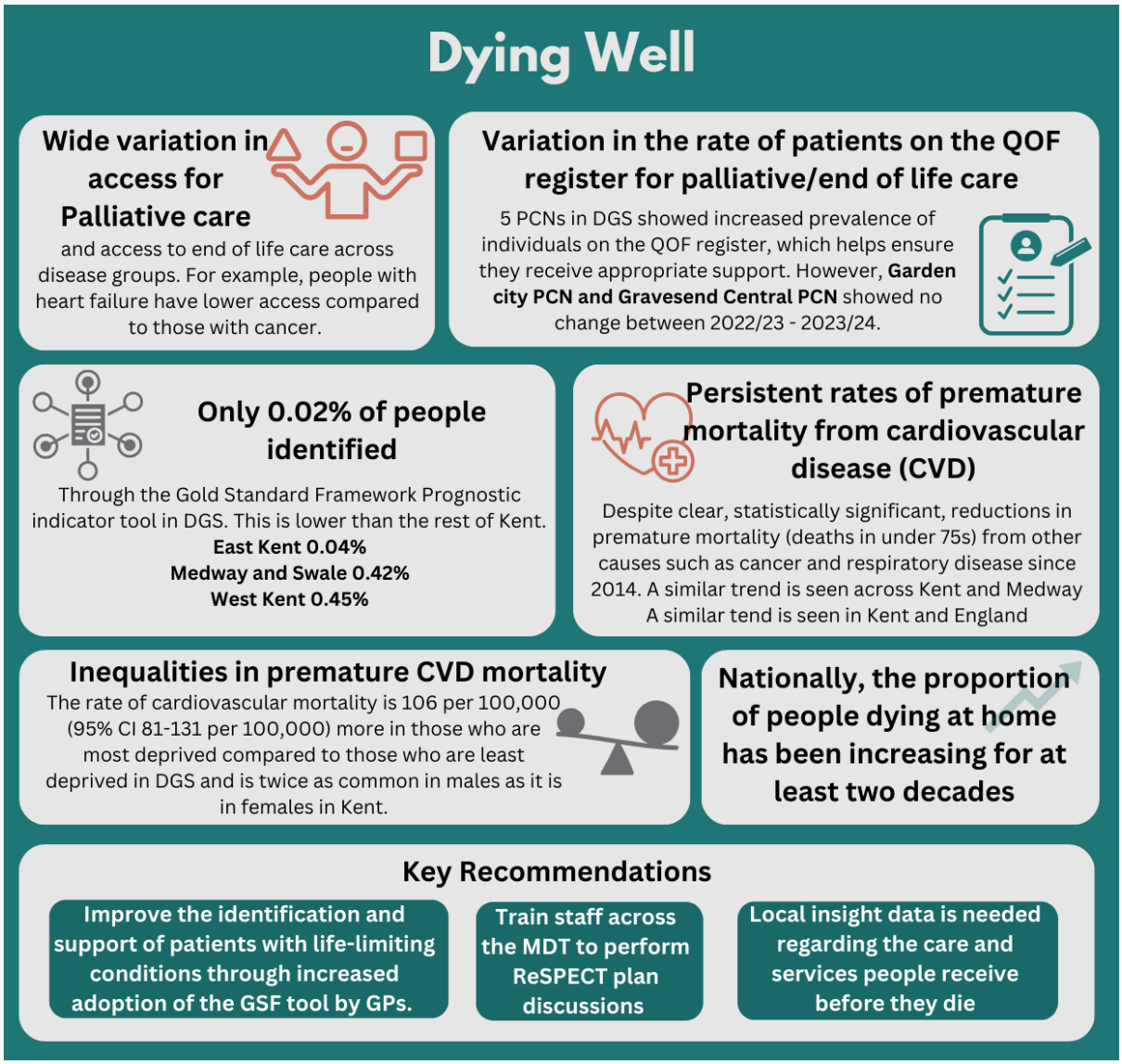
- Coverage of the influenza vaccine in 2023/24 was significantly lower in DGS compared to Kent at 75.3% compared to 78.3% respectively.
- Emergency admissions rates for influenza and pneumonia in over 65-year-olds are 50% higher in DGS compared to Kent - 1,909 per 100,000 versus 1,257 per 100,000.
    - These are 70% higher in the most deprived than the least deprived – 2,727 per 100,000 and 1,609 per 100,000 respectively.
- There is a social gradient to the coverage of abdominal aortic aneurysm screening in DGS with only 10% of attendees from quintile 1 versus 21% from quintile 5.
- Osteoporosis prevalence nearly doubled from 0.55% to 1.05% between 2021/22 and 2022/23.
- Emergency admission rates for ambulatory care sensitive conditions (ACSC) in DGS were 19% higher compared to the Kent average, 963 per 100,000 compared to 779 per 100,000 respectively.
    - ACSC admissions rates are twice as high in the most deprived in DGS compared to the least deprived, 1,345 per 100,000 versus 707 per 100,000.
- Emergency admission rate in those with frailty appear higher in DGS compared to Kent at 7.9 per 1,000 and 7.55 per 1,000 respectively.
    - These appear higher in the most deprived at 9.14 per 1,000 in the most deprived and 7.08 per 1,000 in the least deprived.
- A larger proportion of older adults in DGS with severe frailty have an increased risk of an extended hospitalisation compared to all adults aged over 65 years old.

15.11 Recommendations

- Over the next five years all buildings providing services to older adults should be accessible, including lifts if over multiple floors, slops in addition to outdoor stairs, and access to public toilets. This should be through a joint effort from town planning, district councils, and service providers.
    - All such services for older adults should also be provided in locations which can be accessed via public transport for at least 60% of the population local (within 10 miles) to the service. This should be through a joint effort from public transport services, service providers, and district councils.
- Workforce planning of services for older adults should consider the likely growth in demand for support due to the ageing population. Efforts should be made by service providers and commissioners to create a strategy to make local jobs appealing, especially within DGS due to its proximity to London. An element of this may be providing training for older adults who wish to remain in the workforce so they can perform a job role suited to their life stage.
- Continue to monitor excess deaths due to cold, especially over the next two years, to monitor for any variation following the changes to winter fuel allowances. This will help identify communities who may require further support following changes, such as through the maximisation of their eligible benefits from district councils and help from voluntary organisations.

    - In addition, through utilisation of the decent housing standard, district councils should ensure that all rented housing for older adults, aged 60 years and above, should provide a 'reasonable degree of thermal comfort'.
- Alcohol use, smoking status, and physical inactivity should be assessed bi-annually within routine GP appointments or annual chronic condition reviews for at least 70% of older adults aged over 65 years old using rapid assessment tools such as the Alcohol Use Disorders Identification Test (AUDIT-C) and General Practice physical activity questionnaire (GPPAQ) and if appropriate brief advice should be provided.
    - In addition, physical activity levels should be improved within older people in DGS by the Kent County Council Public Health team commissioners working with one you Kent and Active Kent.
- Whole system efforts should be made to improve air quality, this should be focused on the Dartford crossing and the planned Lower Thames Crossing as areas of high pollution and may be tackled through development of clean air zones in the surrounding areas.
- Services such as befriending and activity groups within DGS should be continued with encouragement and advertisement of such services within local health and social care services, for example GP surgeries.
    - This could be performed with the assistance of link workers so that advertisement of services is up to date and relevant to the area.
- To reduce health inequalities, it is essential that the coverage bowel cancer screening and AAA screening is improved to match the general local rates, and at least meet national targets, for all groups within DGS including those with SMIs, those with learning disabilities, those from ethnic minority groups. This can be performed by national screening providers utilising local voluntary organisations or faith leaders to access individuals from these groups to improve their trust and knowledge of and access to these services.
- Local action should be taken to increase the coverage of the influenza vaccine in over 65s-year-olds in every PCN in DGS to at least meet the WHO target of 75% coverage over the next two years. Given the high rates of admissions for influenza and pneumonia, there may be benefit from aiming for an aspirational coverage level of 80%.
    - This should be performed by identifying those who have not had their influenza vaccines, sending appropriate reminders, and improving accessibility to vaccines to improve uptake.
    - In addition, local insight data can be collected to explore why vaccination coverage rates are falling.
    - All of this should be performed through collaboration with local GPs, immunisation teams, and relevant stakeholders.
- The sudden rise in osteoporosis needs to be investigated to clarify if this is a sudden rise in prevalence or reflects a change in practice. Either way, where appropriate treatment and relevant follow up to prevent fragility fractures should be provided.
- Integrated neighbourhood teams within DGS should be utilised to provide proactive care to those experiencing frailty, with particular emphasis on supporting those experiencing deprivation.
    - Within this there should be provision effective services to prevent unnecessary emergency admissions in those experiencing frailty.

Dying well – overview



16 Dying well – End of life care

16.1 Introduction

The Kent and Medway palliative and end of life care strategy for adults and children 2022-2027 sets out goals to realise the national ambition: ***"****I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer(s).****"*** (227)

End of life care ensures that individuals who are in the last stages of their lives and dying receive the care they need to preserve their dignity and wellbeing, to keep them independent for as long as possible and to be comfortable, dying in a place of their choosing.

Approximately 1% of the UK's population die each year, and evidence suggests that the majority of those deaths can be predicted (228). Early identification of patients who are likely to die within the next 12 months often enables well-coordinated, pro-active quality care, and allows healthcare professionals to focus on better meeting patients' end of life care needs.

16.2 Policy

16.2.1 Palliative and end of life care

Statutory guidance for integrated care boards (ICBs) has been developed by NHS England to support ICBs with their duty to commission palliative care services within integrated care systems (ICSs) (229). ICSs have a key role to play in ensuring that people with palliative and end of life care needs can access and receive high quality personalised care and support. The guidance is statutory and ICBs must have regard to it. It also contains links to resources and good practice for ICSs when planning locally and working collaboratively with local partners.

16.2.2 Ambitions for Palliative and End of Life Care

A national framework for local action 2021-2026 sets out what high quality palliative and end of life care looks like, and the building blocks to implement this locally (230).

16.2.3 Kent and Medway ICB Palliative and End of Life Care strategy

This five year strategy covers local plans for Palliative and End of life care and was published in May 2022 (227).

16.3 Best practice guidance

16.3.1 NICE guidance

The main guidance from NICE associated with palliative and end of life care is the 'End of life care for adults: service delivery' (NG142) which recommends applying a systematic process of identifying people preparing for the end of their life (231).

This guideline is intended to be used alongside - The NICE guideline on care of dying adults in the last days of life, which covers clinical care for people who are considered to be in the last days of life (232). It aims to improve end of life care by communicating respectfully and involving individuals, and the people important to them, in decisions and by maintaining their comfort and dignity. The guideline covers how to manage common symptoms without causing unacceptable side effects and maintain hydration in the last days of life.

NICE has also produced a guideline on end of life care for infants, children and young people with life-limiting conditions (2016) This guideline covers the planning and management of end of life and palliative care for infants, children and young people (aged 0 to 17 years) with life-limiting conditions (233). It aims to involve children, young people and their families in decisions about their care, and improve the support that is available to them throughout their lives (233).

16.3.2 The Gold Standard Framework (GSF) Prognostic Indicator Guidance (228)

This guidance is supported by the Royal College of General Practitioners (RCGP) and aims to help GPs, clinicians, and other professionals in earlier identification of those adult patients nearing the end of their life who may need additional support. Once identified, they can be placed on a register such as the GP's Quality and Outcomes Framework (QOF) / GSF palliative care, hospital flagging system or locality register. This in turn can trigger specific support, such as clarifying their particular needs, offering advance care planning discussions, prevention of crises admissions, and pro-active support to ensure they 'live well until they die'.

16.3.3 The Daffodil Standards for General Practice (234)

The Daffodil Standards are the RCGP and Marie Curie UK General Practice Core Standards for Advanced Serious Illness and End of Life Care. They provide a free, evidence-based framework to help practices self-assess and consistently offer the best end of life and bereavement care for patients.

16.3.4 Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)

ReSPECT is a UK advance care planning (ACP) initiative aiming to standardise the process of creating personalised recommendations for a person's clinical care in a future emergency and therefore improve person-focused care.

ReSPECT can be used by anyone who wishes to record their preferences but is particularly relevant for people with complex health needs, people nearing the end-of-life or at risk of sudden deterioration or cardiac arrest.

16.4 Epidemiological findings

16.4.1 Causes of death

There are approximately 2800 deaths occurring each year in Dartford, Gravesham and Swanley HCP. Nationally the leading causes of death in 2023 were Dementia and Alzheimer's disease (11.5%); replacing coronavirus (COVID-19), which was the leading cause in 2020 and 2021. The second was ischaemic heart diseases (10.3%) and third was chronic lower respiratory diseases (5.2% of all deaths).

It is important to note that there is disparity in access to palliative/supportive care between life limiting conditions. For example, the NHS England (2023) revised framework for integrated care systems states that there is inequity in access to palliative and end of life care in people with heart failure compared to those with cancer (235). Those with heart failure are less likely to have their needs identified and managed early and they are less likely to be referred to specialist services (235).

16.4.2 Premature mortality

Premature mortality (deaths in under 75s) from cardiovascular disease in DGS is higher than the rest of Kent, though this difference is not statistically significant. Interestingly, rates in DGS and across Kent have been relatively static for the last 10 years as shown in figure 146. The rate of cardiovascular mortality is 106 per 100,000 (95% CI 81-131 per 100,000) more in those who are most deprived compared to those who are least deprived in DGS and is twice as common in males as it is in females in Kent. Within DGS, and Kent as a whole, cardiovascular disease is the highest in Gravesham, where the difference in rates between most and least deprived is larger, at 131 per 100,000 (95% CI 104-158 per 100,000).

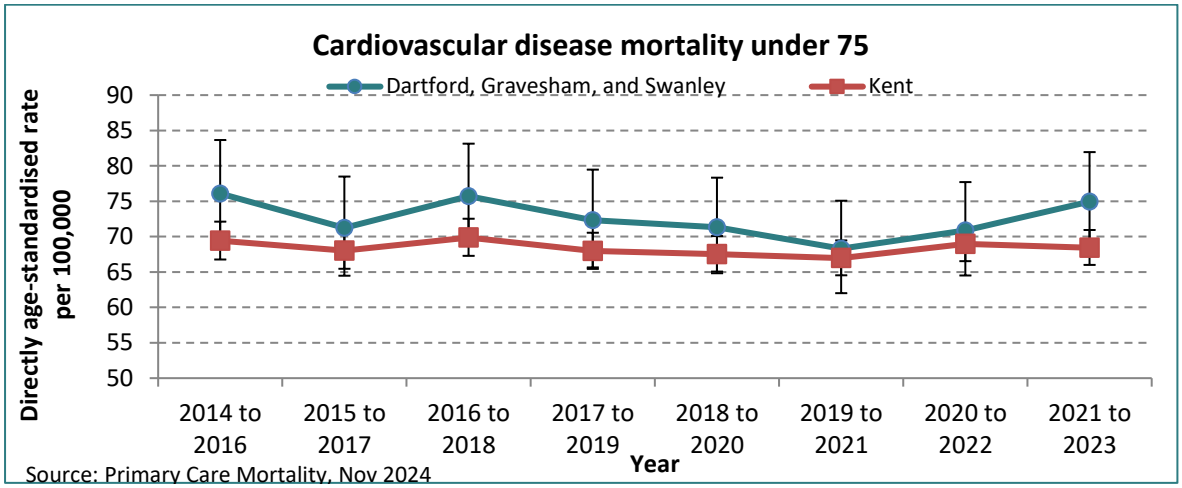


Figure 146: rates of cardiovascular disease mortality in under 75s 2014/16 to 2021/23 (per 100,000)

Cardiovascular disease mortality is linked with well-known risk factors such as smoking, hypertension, obesity and physical inactivity. As such, reductions in these risk factors may result in reductions in cardiovascular disease mortality. In Gravesham in particular physical activity rates are low with only around 57% of adults self-reporting that they do 150+ hours of physical exercise per week compared to 62% in Dartford.

Cancer mortality in under 75s in DGS has steadily reduced from 147 per 100,000 in 2014 to 114 per 100,000 in 2023 as shown in figure 147. This puts DGS rates as the same as East Kent but slightly higher than West Kent which sits at 103 per 100,000. Rates of cancer mortality in under 75s is 51 per 100,000 (95% CI 30 per 100,000) higher in the most deprived quintiles than the least deprived in DGS.

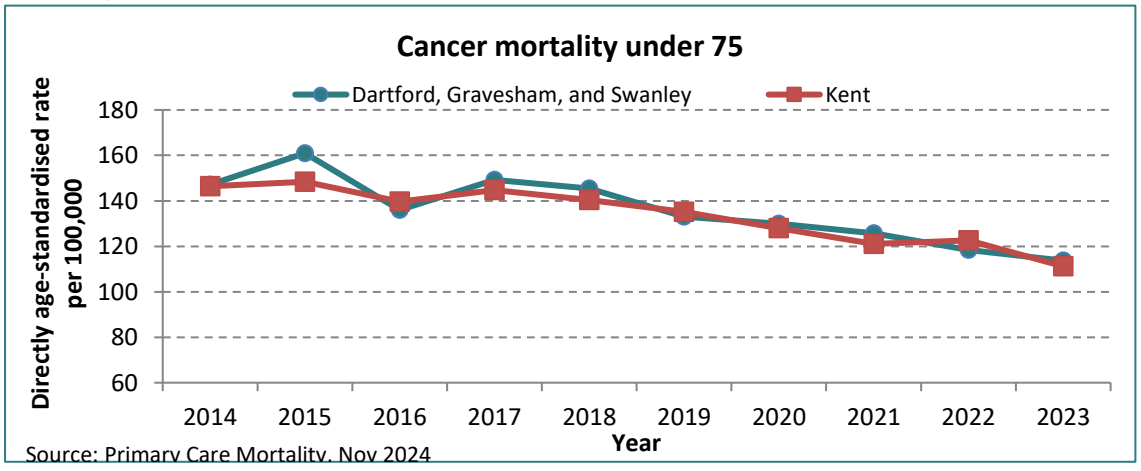


Figure 147: rates of all cancer mortality in under 75s in DGS 2014-2023 (per 100,000)

Within DGS rates of premature cancer mortality are highest in Gravesham, particularly in Westcourt, Northfleet, and Gravesend town. However, the difference in rates between Gravesham, Dartford, and Swanley are not statistically significant and therefore may be due to chance.

Premature mortality from respiratory disease (including COPD, asthma, pneumonia and influenza, lung cancer, and mesothelioma) in DGS has also reduced from 2014 to 2023 as shown by figure 148 (236).

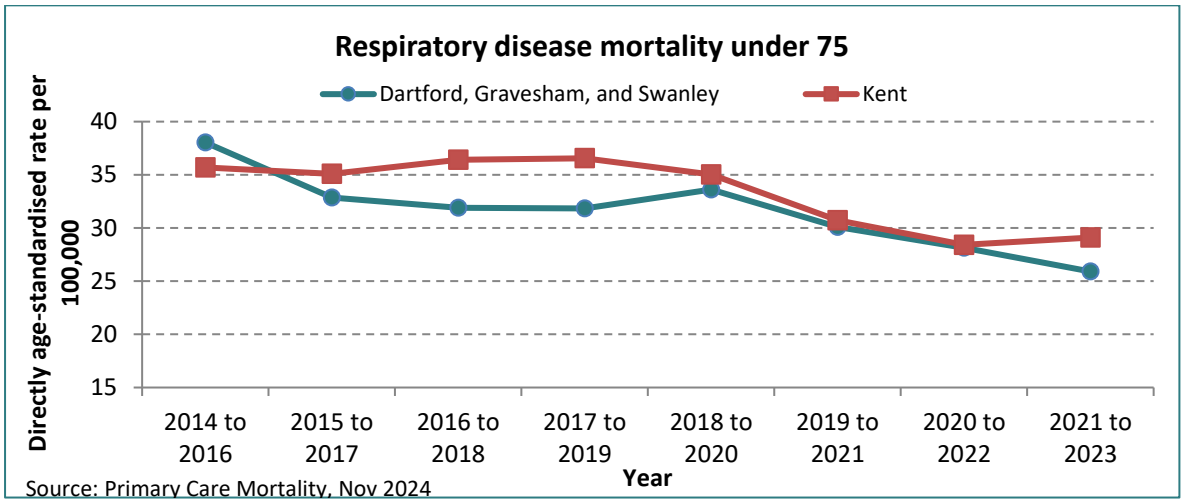


Figure 148: rates of respiratory disease mortality in under 75s in DGS 2014-2023 (per 100,000)

Premature respiratory mortality rates are lower in DGS than the Kent average of 29.1 per 100,000 and are close to West Kent rates of 22.4 per 100,000. The difference between those in the most and least deprived quintiles is significant at 42 per 100,000 (95% CI 15 per 100,000), in other words it is 5.6 times higher in the most deprived than the least deprived. Within Kent men have statistically significantly higher rates of premature respiratory mortality than women, 34.3 per 100,000 compared to 24.2 per 100,000. A degree of these inequalities is likely due to tobacco smoking – as discussed previously in this needs assessment rates of smoking in DGS are higher in the most deprived. Some may also be due to exposure to air pollution, a risk which will potentially increase due to the new Thames crossing, and poor-quality housing such as damp and cold, a risk also previously discussed in this needs assessment. As such, a systems-based approach may stand in better stead to reduce the inequalities associated with premature respiratory mortality than a single system approach.

16.4.3 Palliative care

Identifying patients in need of palliative care, assessing their needs and preferences and proactively planning their care, are the key steps in the provision of high quality care at the end of life in general practice. Kent and Medway has seen an upward trend in the number of patients on the QOF register for palliative/supportive care in line with national efforts (Kent and Medway 0.4% and national average 0.5%). There's wide variation across DGS as shown in figure 149.

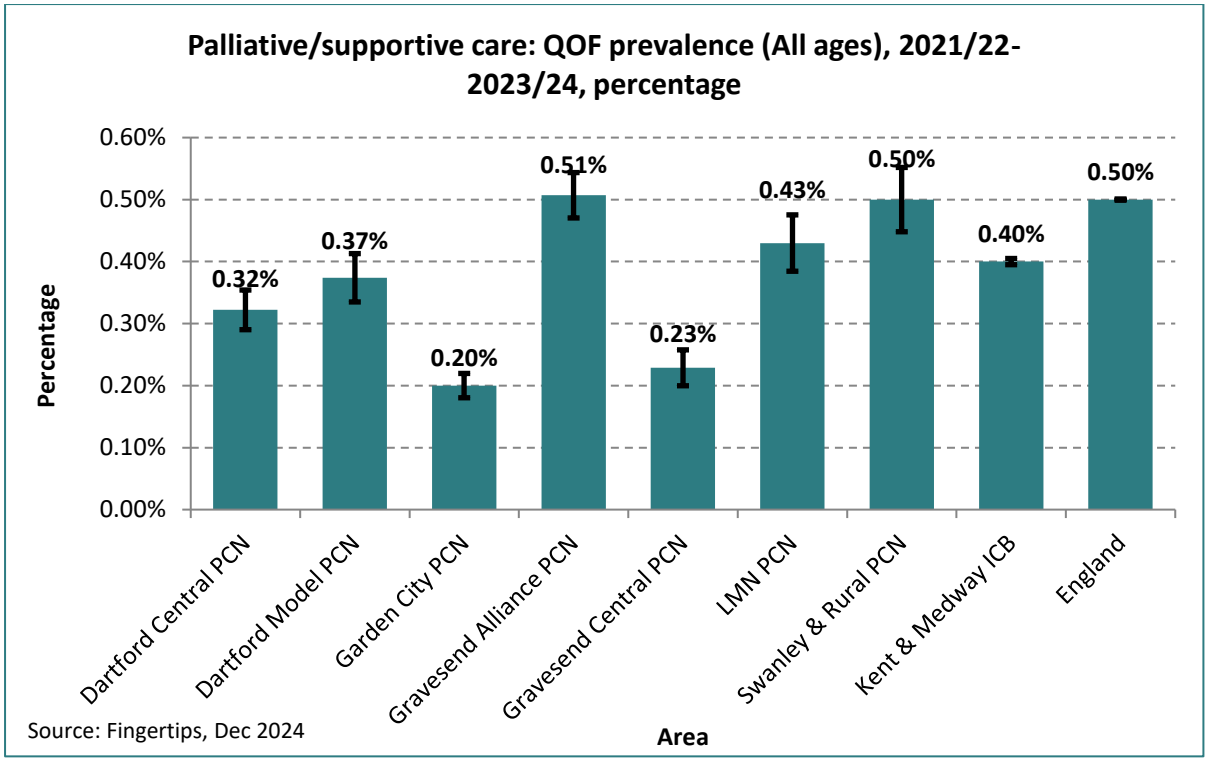


Figure 149: Prevalence of individuals on the palliative/supportive care Quality and Outcomes Framework register in Dartford, Gravesham, and Swanley compared to Kent and Medway and England, percentage, 2021/22-2023/24

The table below (table 15) presents the QOF prevalence indicator by each PCN in Dartford, Gravesham and Swanley for 2022-23 and 2023-24. The prevalence for some PCNs has remained the same, Garden City PCN (0.2%) and Gravesend Central PCN (0.2%). Others have shown an increase in that same period.

Table 15: Prevalence of individuals on the palliative/supportive care Quality and Outcomes Framework register in Dartford, Gravesham, and Swanley compared to Kent and English averages, percentage, 2022/23-2023/24

Prevalence – Palliative/supportive care (QOF)						
	2022-23			2023-24		
	List size	Register	Prevalence (%)	List size	Register	Prevalence (%)
Dartford Model PCN	33,394	105	0.3	34,144	174	0.5
Garden City PCN	57,848	131	0.2	59,673	142	0.2
Gravesend Central PCN	34,287	71	0.2	35,569	90	0.2
Dartford Central PCN	38,401	93	0.2	39,444	183	0.5
Gravesend Alliance PCN	48,903	139	0.3	49,515	192	0.4
Swanley & Rural PCN	25,960	208	0.8	31,468	273	0.9
LMN PCN	25,892	111	0.4	25,930	119	0.5
England average			***0.5%***			***0.5%***
Kent average			***0.4%***			***0.4%***
DGS HCP		***858***	***0.32***		***1,173***	***0.43***

The count of ReSPECT care plans is slightly lower than the number of patients on the QOF register for Palliative/supportive care, but largely reflective of the registered population. In addition, rates are higher in DGS than the other HCPs in Kent, as shown in table 16 below.

Table 16: People with a ReSPECT care plan by HCP, queried on 21/11/2024. Source: KMCR.

HCP	Count of people	KMCR Population	Percentage with a ReSPECT care plan (%)
Dartford, Gravesham and Swanley	1009	284475	0.36
East Kent	1966	734833	0.27
Medway and Swale	588	438060	0.13
West Kent	1155	519619	0.22

However, the numbers of people who have been identified through the GSF Prognostic indicator tool in DGS (0.02%) is markedly lower than the neighbouring HCP areas: East Kent (0.04%), Medway and Swale (0.42%) and West Kent (0.45%), as shown in the table 17 below.

Table 17: People with a GSF Prognostic Indicator by HCP, queried on 21/11/2024. Source: KMCR.

HCP	Number of People with a GSF Prognostic Indicator	KMCR Population	Percentage with GSF Prognostic Indicator (%)
Dartford, Gravesham and Swanley	53	284475	0.02
East Kent	258	734833	0.04
Medway and Swale	1839	438060	0.42
West Kent	2318	519619	0.45

16.4.4 Place of death

National figures suggest that less than half of all deaths occur in hospital (for all ages), this downward trend has been seen nationally and locally (Kent and Medway ICB) over the past 10 years. Similarly, the percentage of deaths that occur in hospices has also seen a downward trend.

The proportion of people dying at home has been increasing for at least two decades (237). This trend is projected to continue, with deaths at home and in care homes expected to overtake the number of deaths in hospitals and hospices by the 2030s, and account for more than three-quarters of all deaths by 2040.

Death in a person's usual place of residence (home and care home) is recognised as one of the main markers for good quality end of life care. Table 18 shows that in Dartford, Gravesham, and Sevenoaks approximately 44-52% of residents died in their own home or care homes in 2023.

Table 18: Place of Death for individuals of all aged, in Dartford, Gravesham, and Sevenoaks compared to England, 2023. Source: Office of National statistics

District of Residence	Hospital	Own home	Care Home	Other places	Hospice
Dartford	46% (416)	24% (220)	22% (201)	2% (14)	6% (54)
Gravesham	47% (465)	30% (295)	14% (138)	3% (25)	6% (64)
Sevenoaks	38% (469)	28% (351)	24% (305)	2% (26)	7% (96)
England	**43%**	**29%**	**21%**		**5%**

Place of death is an important measure, unfortunately, there is no further data available to deduce to what extent the place of death was the preference of individuals in DGS.

One other measure of quality of life prior to death is the percentage of deaths with three or more emergency admissions in the last 90 days of life. Within Kent and Medway this is lower than the national average at 5.6% compared to 6.2%. Unfortunately, there are no other indicators available to show the quality of palliative care services within DGS from a patient perspective.

16.5 Available Services

16.5.1 Hospices

There are six hospices in Kent and Medway, which provide holistic care and wellbeing services

Ellenor is a specialist palliative care provider for adults and children in Dartford, Gravesham and Swanley. The Ellenor Hospice has seven beds in Gravesend.

19.5.2 Other service providers

There are four NHS acute trusts in Kent and Medway:

- East Kent Hospitals University NHS Foundation Trust
- Maidstone and Tunbridge Wells NHS Trust
- Medway NHS Foundation Trust
- Dartford and Gravesham NHS Trust

There is also one mental health trust - Kent and Medway NHS and Social Care Partnership Trust and one community trust - Kent Community Health NHS Foundation Trust supporting end of life care.

16.6 Gaps

- It is a legal requirement for ICBs to commission palliative care services that meet their population needs. Yet, there is little detailed data that is routinely available about the services people received before they died, the quality of those services, whether care provided was in line with need, how decisions were taken about place of death, and the experiences of individuals and carers

16.7 Key Findings

- Premature mortality (deaths in under 75s) rates from cardiovascular disease in DGS are persistently high despite other causes of premature mortality, such as cancer and respiratory disease showing clear, statistically significant, reductions since 2014.

- The rate of cardiovascular mortality is 106 per 100,000 (95% CI 81-131 per 100,000) more in those who are most deprived compared to those who are least deprived in DGS and is twice as common in males as it is in females in Kent.
- There is wide variation in access to palliative and end of life care across disease groups, for example people with heart failure have lower access compared to those with cancer.
- Most PCNs in DGS have seen an increase in the rate of patients on the QOF register which helps ensure they receive appropriate support. However, two PCNs in DGS have seen little change from 2022/23 – 2023/24.
- The number of people who have been identified through the Gold Standard Framework Prognostic indicator tool in DGS (0.02%) is markedly lower than the neighbouring HCP areas: East Kent (0.04%), Medway and Swale (0.42%) and West Kent (0.45%).
- The proportion of people dying at home has been increasing for at least two decades

16.8 Recommendations

- There is an opportunity to identify additional patients with life-limiting conditions through the adoption of the GSF tool by GPs. This will help improve patient care and uplift QOF figures. Information sessions should be held with targeted GP practices to raise awareness of the tool and to understand barriers to uptake.
- Staff across the MDT should be trained to facilitate and support ReSPECT plan discussions. This could increase the communicability of the contents of the ReSPECT form to other healthcare professionals and care staff, reduce the demand on GP time, and help ensure patients have a say in their care.
- Insight data is needed about the care and services people receive before they die, the quality of those services, whether care provided was in line with need, how decisions were taken about place of death, and the experiences of individuals and carers. Local data of this nature should be collected using local surveys, to help commissioners to identify disparities in service provision and explore areas for improvement

17 System Dynamics Modelling of Future Health Needs

17.1 Systems dynamic modelling

A system dynamic modelling approach aids in the understanding of local adult health and care needs in terms of 'population cohorts.' In broad terms, these cohorts are the healthy population, those with a single condition, and people with multiple conditions. The approach uniquely identifies the rates of progression of need using an evidence base rooted in the English Longitudinal Study of Ageing (ELSA) and other sources. These form a dynamic modelling environment that is able to respond to different 'what-if' questions regarding health and wellbeing interventions, taking into account the complex nature of population change. Briefly, the model can take into account phenomena such as the following:

- Continued growth in the total DGS population.
- The significant contribution that is made to this growth by net inward migration.
- The changing nature of underlying risk factors that have the potential to lead to or exacerbate health and care needs
- The natural ageing process at a population level as the 'baby boom' generation approach old age.

In this project, we have developed a cautiously optimistic scenario based on the Kent and Medway Integrated Care Strategy (ICS) targets and KCC public health strategies. Briefly, this includes reductions in levels of smoking, a reversal of the current trends in levels of obesity, and reduced harmful and hazardous alcohol intake, physical inactivity and loneliness. These are all proven contributors to the incidence of conditions that lead to poor health and reduced life expectancy. We compare the effect of these interventions against a hypothetical situation in which levels of risk factors do not change to demonstrate the contribution to the overall burden of health needs that improvements in risk factor prevalence could make.

To create outputs for DGS HCP, model outputs for Dartford, Gravesham and one third of Sevenoaks were summed. Seven scenarios were run. The first represents a baseline with no interventions. This shows predictions for this population if things continue as they are. To model the effects of 6 different interventions, 5 risk factors were adjusted. A scenario was run changing each risk factor in turn and then the final scenario was the effect of running all interventions simultaneously. The chosen risk factors and scenarios were as follows: loneliness, physical inactivity, excess weight/obesity, smoking, and alcohol misuse.

The Kent and Medway ICS targets for 2028 are for loneliness to reduce from 7.3% to less than 5%, for physical inactivity rates to fall from 22.3% to 20%, and for the percentage of adults who are overweight or obese to fall from 64.1% to 62%

For loneliness we have reduced the prevalence by 2% and kept it at that level for the model's 25 year period. This is because the prevalence of loneliness is already quite low, and we feel it may be particularly difficult to reduce it any further. For physical inactivity and BMI, we have applied a 0.3% reduction in risk factor prevalence each year, to reflect the more dynamic nature of changes in the population. This 0.3% reduction would result in a 1.2% reduction by 2028, which is less than the ICS target, however we assume that the trend can be continued indefinitely, resulting in approximately a 7% reduction in the risk factor prevalence after 25 years.

Separate to the ICS which has not specified an indicator for smoking, colleagues in public health have set a target of increasing the percentage of smokers who attend smoking cessation

services by 3.5% within 10 years. We also expect that the number of new smokers will fall each year to a maximum reduction of 50% after 14 years in light of the policy to increase the legal age limit to buy tobacco by one year every year. Alcohol consumption was also a risk factor of interest. There are no published targets for Kent and Medway on alcohol consumption, so we chose a similar percentage reduction to the other risk factors; 0.3% reduction each year.

Given the interventions vary in the magnitude of change on the risk factors, their outcomes shouldn't be used to compare the effectiveness of an intervention on one risk factor over another. Rather, this can provide insight into the possible benefits of achieving reductions in risk factors similar to the ICS targets.

The outputs of interest were cases of coronary heart disease (CHD), chronic obstructive pulmonary disease (COPD), diabetes and stroke, prevalence of multimorbidity, and cases of mild and severe frailty.

Table 19: Percentage reductions used for each risk factor.

Intervention	Change in risk factor
Smoking	3.5 additional smokers and 50% reduction in new smokers, over 14 years
Loneliness	2% reduction
Physical inactivity	0.3% yearly reduction
Alcohol misuse	0.3% yearly reduction
Overweight/Obese	0.3% yearly reduction

Table 20: Risk factors and the conditions they have an effect on.

Condition	Smoking	Physical inactivity	Loneliness	Alcohol	BMI
Asthma	Y				Y
CHD	Y	Y	Y	Y	Y
COPD	Y				
Diabetes		Y	Y		Y
Heart failure	Y	Y		Y	Y
Stroke	Y	Y	Y	Y	Y
SMI			Y		
Dementia			Y		
Neuro			Y		

17.2 Effects on Prevalence

17.2.1 All conditions

As shown by figure 150, the combined prevalence of all included conditions is predicted to increase from the baseline value over 25 years regardless of the interventions in place. This is likely due to the ageing nature of the population and therefore, the increased prevalence of disease within the population. However, providing all the discussed interventions is predicted to reduce cases by 10,000 in DGS compared to no intervention.

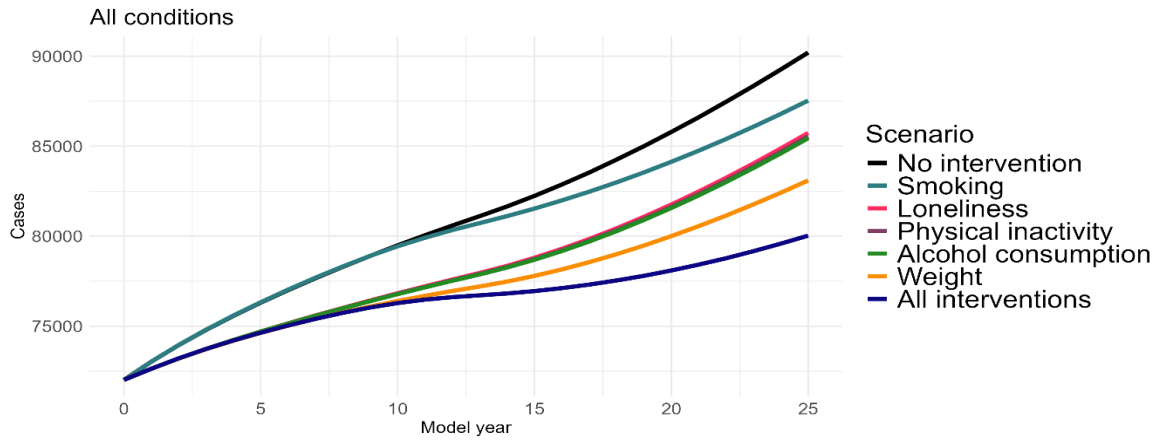


Figure 150: Modelled prevalence of all conditions over 25 years, by scenario.

17.2.2 Coronary Heart Disease

Prevalence of coronary heart disease is predicted to increase by 11.5% when no interventions are in place. As shown in figure 151, this rate should reduce to be lower than the baseline prevalence with all the interventions performed separately and together. When all interventions are performed together this shows a reduction of 45.3% from baseline.

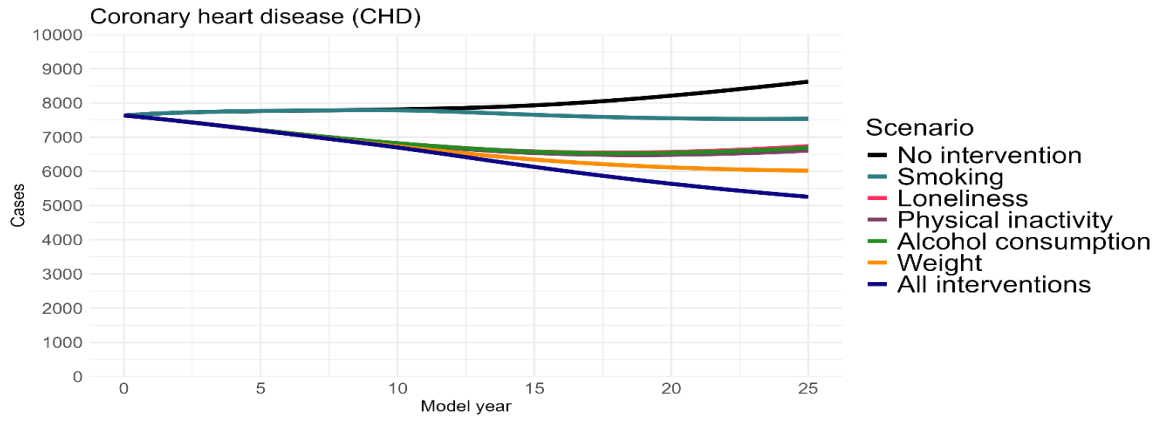


Figure 151: Modelled prevalence of coronary heart disease over 25 years, by scenario.

17.2.3 Chronic Obstructive Pulmonary Disease

Rates of COPD reduced for all interventions other than weight, as shown in figure 152. A reduction of 62% from baseline levels is seen from smoking interventions. It is worth noting that the increase in cases of COPD for all interventions which do not involve smoking cessation, compared to no interventions, is likely reflective of an increase in life expectancy and therefore increased ability to develop COPD, rather than these interventions increasing the risk of COPD.

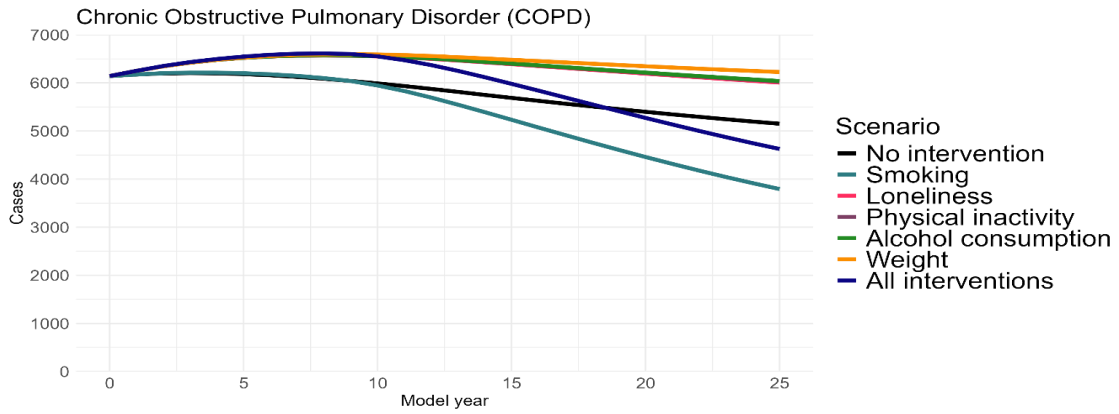


Figure 152: Modelled prevalence of chronic obstructive pulmonary disease over 25 years, by scenario.

17.2.4 Stroke

As shown in figure 153, rates of stroke decreased for all interventions compared to baseline. This decrease, of 10.3%, is also seen when no interventions were modelled. However, larger reductions are seen when interventions are in place compared to no interventions.

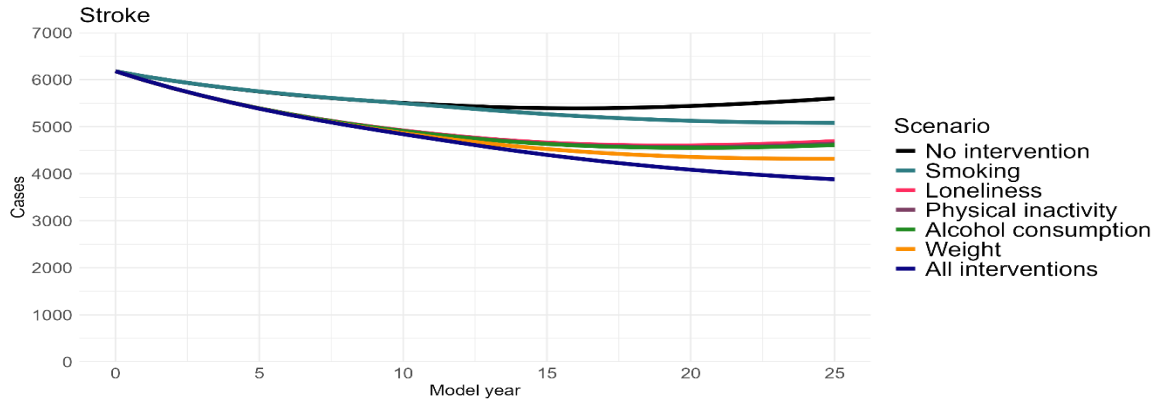


Figure 153: Modelled prevalence of stroke over 25 years, by scenario.

17.2.5 Diabetes

Figure 154 shows that providing no interventions is predicted to lead to a 28% increase in cases of diabetes. Providing smoking cessation interventions increased cases by a further 2.1%. Again, it is likely that the increase in cases of diabetes with smoking-related interventions reflects changes in life expectancy and therefore more people living long enough to develop diabetes, rather than smoking cessation increasing the risk of diabetes.

All other interventions saw reductions in the prevalence of diabetes compared to no intervention. Weight management interventions are predicted to lead to a reduction in prevalence compared to current rates, as is providing all interventions together.

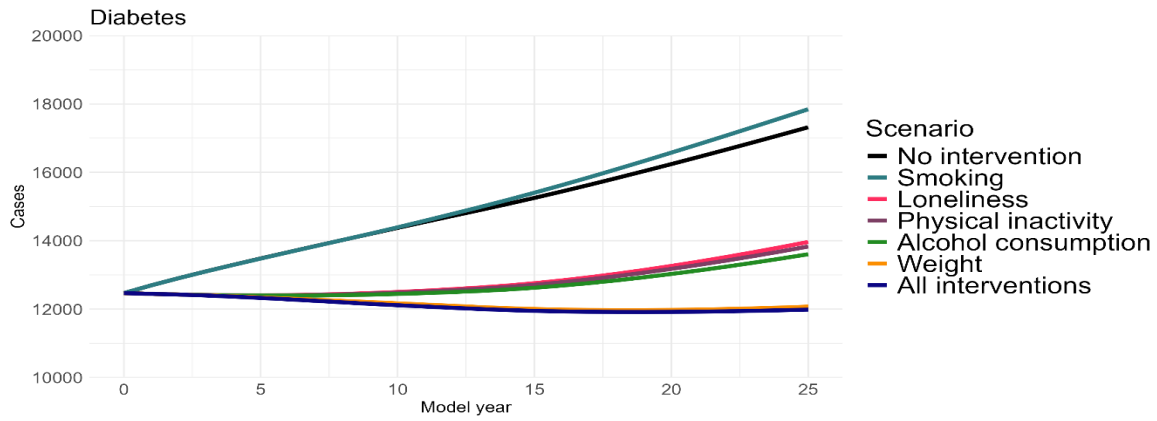


Figure 154: Modelled prevalence of diabetes over 25 years, by scenario.

17.2.6 Multimorbidity

Providing all the discussed interventions had the largest percentage impact on multimorbidity compared to all other modelled health outcomes. As shown in figure 155, there is predicted to be a 34.2% reduction in multimorbidity cases when all interventions are provided compared to baseline rates. All interventions both alone and combined lead to lower rates of multimorbidity compared to no interventions.

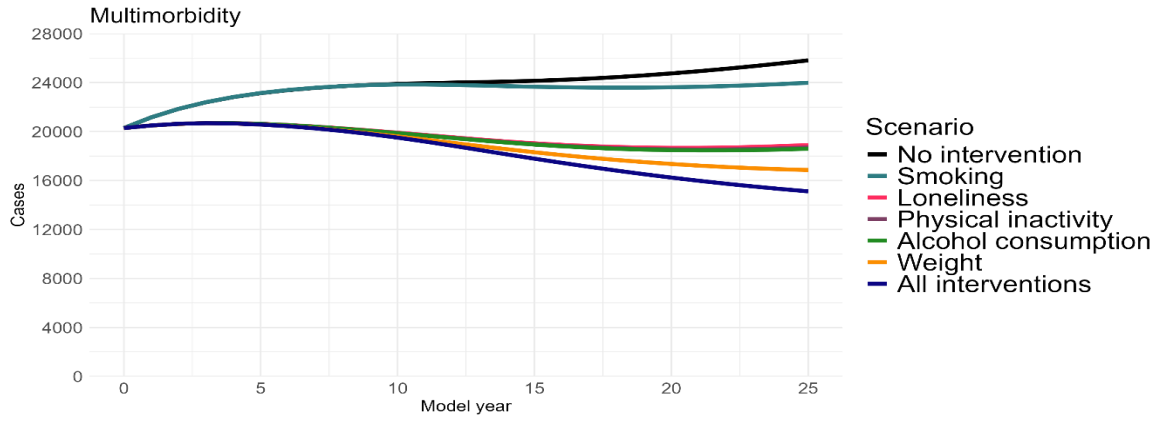


Figure 155: Modelled prevalence of multimorbidity over 25 years, by scenario.

17.2.7 Frailty

Regardless of the intervention type, prevalence of both mild and severe frailty is predicted to increase compared to current rates, as shown in figure 156. when all the interventions are modelled together (reducing obesity, smoking, loneliness, physical inactivity, and alcohol consumption) then severe frailty rates are predicted to reduce by 12.1% and mild frailty is predicted to increase by 4.1% compared to no interventions. However, due to the higher number of those with mild frailty, providing all interventions is predicted to reduce frailty rates over all by 2.5%. The increase in mild frailty is likely due to a combination of individuals living longer and therefore developing frailty and a slower rate of transmission into moderate or severe frailty. Currently Severe frailty results in higher resource utilisation, however given the growing number of individuals expected to have mild frailty the reverse may become true, therefore services in DGS need to be targeted at both mild and severe frailty.

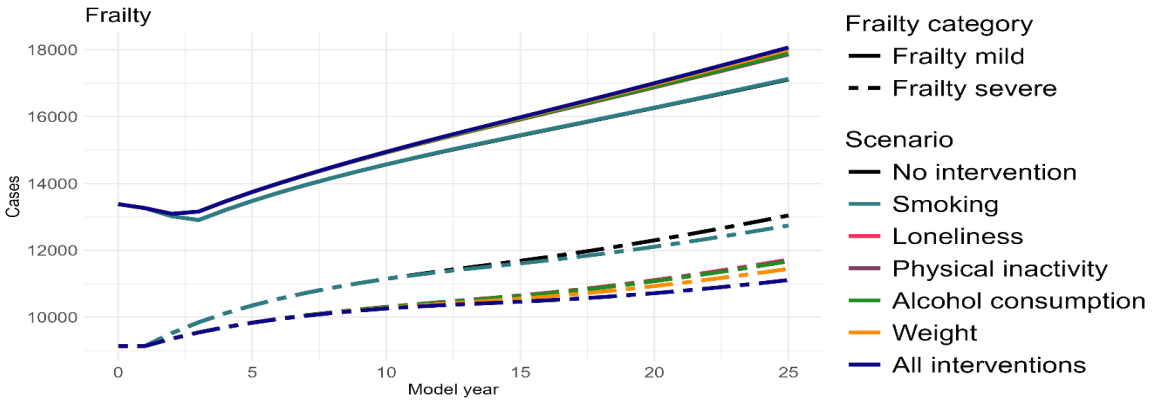


Figure 156: Modelled prevalence of frailty over 25 years, by scenario.

18 Conclusions

18.1 Key Health Indicators

- Smoking rates in Dartford, Gravesham, and Swanley have reduced from 14.4% to 12% between 2017 and 2022.
- The rate of admissions with Mental Health as a primary diagnosis has reduced by 44% over the last 10 years, from 297 per 100,000 to 165 per 100,000.
- Admissions for falls which have resulted in a leg or hip fracture in those over 65 have reduced by 16% in Dartford, Gravesham, and Swanley between 2013 and 2023.
- Dartford, Gravesham, and Swanley has higher rates of emergency admissions and gastroenteritis admissions in children aged 0-4 years old compared to Kent.
- Gravesham has the highest obesity rates in Kent for year 6 students, and the highest rates of admission for dental conditions for children aged 5-11.
- Hospital admissions where mental health is a secondary condition are higher in Dartford, Gravesham, and Swanley than in the rest of Kent. In addition, the rate of annual physical health checks in those with severe mental illnesses is lower in Dartford, Gravesham, and Swanley compared to the other health care partnerships in Kent. This is concerning due to the higher rates of premature mortality within this group.
- Alcohol related admissions are higher in Dartford, Gravesham, and Swanley than the rest of Kent, and are increasing.
- There are large disparities in the levels of smoking between ethnic groups with 36.4% of Gypsy/Irish traveller ethnicities smoking compared to 12% in the total Dartford, Gravesham, and Swanley population.
- Obesity rates in Dartford Model Primary Care Network (PCN) are significantly higher than in the rest of Dartford, Gravesham, and Swanley.
- Coverage of cervical cancer screening is below target in every PCN in Dartford, Gravesham, and Swanley.
- STI and HIV rates in Dartford are significantly higher than the rest of Kent.
- Flu and pneumonia admission rates in over 65-year-olds are higher in Dartford, Gravesham, and Swanley than the rest of Kent, and are 70% higher in the most deprived areas compared to the least deprived.
- Dartford, Gravesham, and Swanley, and the rest of Kent and Medway, show persistently high rates of premature mortality from Cardiovascular Disease.

18.2 JSNA Cohort Model for scenario planning: Key findings

The factors which contribute to demographic change within the Dartford, Gravesham, and Swanley population, impact on the future health needs. They include;

- Continued growth in the total Dartford, Gravesham, and Swanley population.
- The significant contribution that is made to this growth by net inward migration.
- The changing nature of underlying risk factors that have the potential to lead to or exacerbate health and care needs
- The natural ageing process at a population level as the ‘baby boom’ generation approach old age.

A cautiously optimistic scenario was created based on the Kent and Medway Integrated Care Strategy. This included a 2% reduction in loneliness, 0.3% yearly reduction in physical inactivity, alcohol misuse, overweight/obesity levels, and alcohol consumption, and a reduction in smoking, comprising of a 3.5% increase in smokers who attend smoking cessation services and a 50% reduction in new smokers. Findings suggest that if all interventions are performed, in Dartford, Gravesham, and Swanley there could be a:

- 11% reduction in all conditions
- 42% reduction in multimorbidity
- Prevalence of COPD increased with all scenarios which did not include smoking cessation, this is unlikely to reflect an increase in risk due to these interventions, but rather that the population is living long enough to develop COPD.
- There is approximately a 6% increase in mild frailty and 17% reduction in severe frailty when all interventions are enacted compared to no interventions. However, frailty will continue to increase, by 33% for mild frailty and 22% for severe frailty between 2018 and 2043 due to an ageing population.

18.3 Health Inequalities Analysis

The health inequalities analysis for DGS explored multiple health outcomes by key domains of health inequalities. This analysis found the following:

- The rate of two or more long term conditions in under 65-year-olds, COPD prevalence, and deaths of despair, all show a social gradient with higher rates in the most deprived compared to the least deprived.
- There is a significant difference in alcohol-related conditions, CHD, and hypertension prevalence by gender with the rates in males greater than rates in females. There is minimal variation by deprivation in men but both CHD and hypertension show a clear social gradient for females.
- There is a significant difference in diabetes and smoking rates by gender with higher rates in males compared to females. These both show a social gradient with higher rates in the most deprived compared to the least deprived. They also vary by ethnicity with higher rates of diabetes in Asian ethnicities and smoking in White ethnicities.
- Depression rates show a significant difference by gender with higher rates in females compared to males. Rates also vary by deprivation with higher rates in the most deprived and by ethnicity with higher rates in the White ethnic group. Interestingly when different ethnic groups are arrayed by deprivation only the White ethnic group show variation in depression rates by deprivation. Rates also vary by access to green space with greater access associated with lower rates.
- Respiratory admissions in under 19-year-olds vary by ethnicity with higher rates in the 'other' ethnic group.

18.4 Stakeholder views

'Kent and Medway Listens' is an engagement project set up over 2021-2022 by Kent County Council, Medway Council, and Kent & Medway Partnership NHS Trust involving almost 4,000 participants across Kent and Medway to understand the pressures impacting mental wellbeing of the local population, particularly seldom heard communities. This found that the main concerns of the Dartford, Gravesham, and Swanley population were wider determinants of

health such as growing financial concerns, poor housing, and pressure at work. Factors impacting the populations wellbeing were also explored, the key findings were a lack of trust in the system, a lack of GP access, inability to afford food or heating, and social isolation.

A consultation by the Safer Communities Alliance also offered access to the views of the Dartford, Gravesham, and Swanley population from diverse and marginalised communities. The key findings included a desire for community-based health check hubs and localised services, improved cultural competency, easier and simplified access to healthcare providers including but not limited to GP services, mental health awareness, and support for social networks. The key areas for improvement include personalised care plans, collaboration among healthcare disciplines, help addressing social phobias, free educational classes, mental health and stigma reduction, and support for community groups.

19 Recommendations

Life stage and condition specific recommendations are included in chapters 6-16 of this HNA. The following recommendations summarise the specific recommendations into broader, strategic recommendations which overlap across life stages and conditions.

19.1 Integrated neighbourhood teams

Integrated neighbourhood teams are needed in Dartford, Gravesham, and Swanley to provide more personalised, multidisciplinary care for those with complex needs such as frailty, multimorbidity, and substance (including alcohol) misuse. Integrated neighbourhood teams could act as a bridge between acute and community care, helping to prevent unnecessary hospital admissions and reduce the length of hospital stays. The aim should be to reduce inequalities, reduce the health needs of the population, and improve patient and staff experience. This integration needs to be performed and evaluated using long-term goals to ensure that the positive impacts from integration have time to materialise. It will benefit from the inclusion of General Practice and patients in the design and development process and may require alterations to funding pathways.

19.2 Improving access

Access in certain groups, such as inclusion health groups, may require targeted interventions or a form of proportionate universalism. This includes health checks to ensure that risk factors for future ill-health are identified and treated. This would also benefit from treating those who may have other risk factors for physical ill-health such as severe mental illness but have not been diagnosed.

There is a particular need in Dartford, Gravesham, and Swanley to improve the coverage of annual physical health checks in those with severe mental illnesses, to improve sexually transmitted infection testing coverage, and to improve the rate of identification of those with life-limiting conditions or who are nearing the end of their life.

Furthermore, there is potential for widening the role of discussing ReSPECT forms out to the wider multidisciplinary team, therefore reducing the strain on general practitioner capacity and reducing the need for discussions regarding emergency and end-of-life care to be had by hospital staff during an emergency admission.

19.3 Partnership working

Public Health to further their partnership work with districts, VCSE and other local anchor institutions to agree key priorities for action that would be developed under People, Place, Policy & Practice themes, ensuring focus on wider health determinants. Partnership arrangements should minimise duplication of existing work and must align with current local approaches. Key areas of partnership working include whole system efforts to delay ill health and maintain independence by making it easy and attractive to increase and maintain physical activity levels throughout the life course, improving air quality, reducing obesity, and reducing smoking rates.

19.4 Systems thinking

Utilisation of systems thinking would allow public health professionals to develop their understanding of the problems faced by the population, the surrounding context, and potential solutions. In addition, it allows for the relationships and dependencies within the systems to be

considered. This is key for 'wicked' problems such as reducing obesity rates. Systems thinking should be implemented in all areas of work, be that partnership working or cultural competency, as the majority of changes will results in impacts on the interdependent elements of the systems which surround the population in DGS.

19.5 Vaccination and screening coverage

National vaccination and screening programmes aim to reduce the transmission of communicable diseases and to identify serious diseases at an earlier stage to improve outcomes. As such they are key features of protecting the health of the population. Coverage of both screening and immunisations across the life course should be improved in Dartford, Gravesham, and Swanley this may include improving access and improving reminders alongside educational campaigns. Particular focus should be placed on those with learning difficulties, severe mental illnesses, and ethnic minorities who tend to experience lower rates of screening coverage than the general population in Dartford, Gravesham, and Swanley.

19.6 Cultural competency

There is a need to ensure that services in Dartford, Gravesham, and Swanley are culturally competent to meet the needs of the diverse local population. Within this there is a need to ensure appropriate language services are readily available and utilised within local services so that care can be optimised for all residents. This is particularly key given the high rates of net inwards international migration in Dartford and Gravesham.

19.7 Research and innovation

There should be continued encouragement of data sharing and access, this would help ensure that accurate data is the basis of all health interventions. Data sharing would also allow for effective service planning, evaluation, targeting and measurement of success. Within this there should be further exploration of certain topics such as admissions for asthma and injuries in children, the rise in new HIV cases, increasing prevalence of osteoporosis, and the role of influenza and pneumonia admissions in the high emergency admission rates seen in older adults.

19.8 Insights research

There is a need to continue and develop stakeholder voices not only with patients/clients and carers but also with service providers, teaching staff, clinicians, local authorities, the voluntary sector, social care, and other health care staff to enable better insights into service delivery and quality. Particular focus is needed for specific issues e.g. vaccine uptake, screening coverage in those with learning disabilities and severe mental health conditions, and end of life care.

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