East Kent Health Needs Assessment
2025

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Contents

1. Executive Summary

1.1. Introduction

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

1.2. Preface

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

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

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

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

1.3. Key health indicators

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

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

1.4. JSNA cohort model simulation outputs

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

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

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

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

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

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

1.5. Health Inequalities

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

1.6. Recommendations

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

1.6.1. Planning for the future

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

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

Specific actions

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

1.6.2. Improving access

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

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

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

Specific actions

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

1.6.3. Health in all policies

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

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

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

Specific actions

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

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

1.6.4. Culturally competent services

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

Specific actions

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

1.6.5. Building analytical capabilities

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

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

Specific actions

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

2. Population

2.1. East Kent residents

2.1.1. Why population is important

The term 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 groups of people are more likely to have poor health due to a combination of physiological, genetic, socio-economic and environmental factors. Understanding the characteristics of a population helps to explain and predict differences in health and wellbeing outcomes.

Also, the size of the population is used to calculate rates to make comparisons with other areas and observe changes over time.

2.1.2. Population estimates

According to the Office for National Statistics mid-year population estimates, the total population of East Kent in 2023 is 694,976.9 [1]. This has increased by 5.7 percent since 2013.

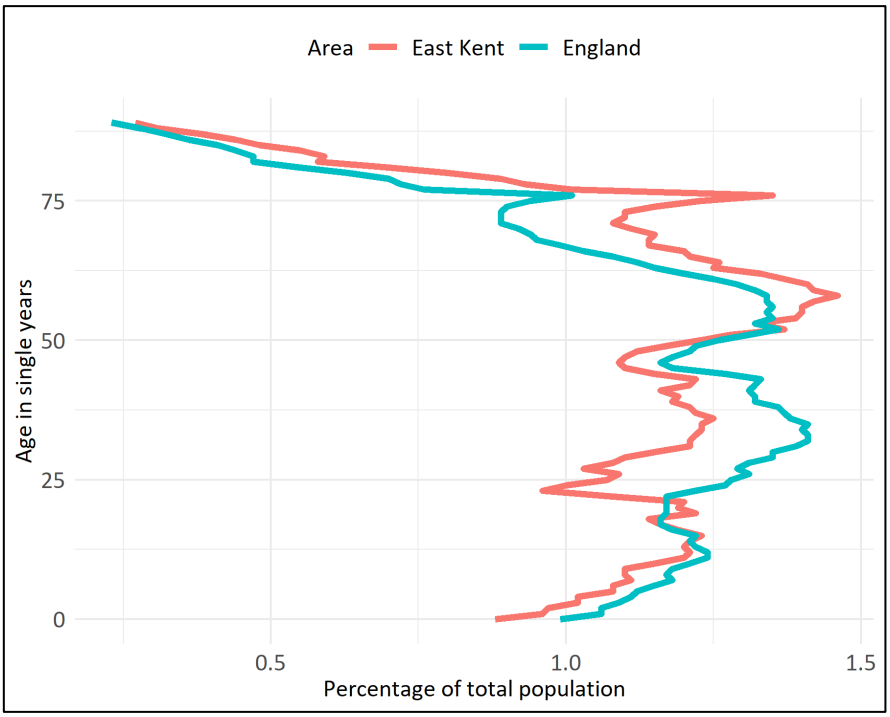


Figure 1 Population profile by single year or age

In East Kent there is a greater proportion of people aged 65 to 84 and a lower proportion aged 25 to 34 compared to England. Other broad age groups are within 1 percent. The median age in East Kent is 44 compared to 40 in England.

Among older people, there are more women than men.

2.1.3. Fertility

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 in 2023, Gravesham is highest (61 per 1,000), followed by Dartford (58) and Swale (57). The lowest district is Canterbury (38 per 1,000). Canterbury has been lower than all other Kent districts over previous years. This is partly due to the high number of university students [2].

2.1.4. 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. Period life expectancies use mortality rates from a specific year (or group of years) and assume these rates stay the same for the rest of a person's life. This means future changes in mortality rates aren't considered [3].

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. It has slightly increased in 2022 and 2023. In Kent, life expectancy is higher than the national average for England, but the gap has narrowed since 2012 [4].

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 [4].

At district level, life expectancy at birth is lowest in coastal areas, which are also the most deprived. These areas include Thanet, Folkestone and Hythe, Swale, Dartford, Gravesham, Dover, and Canterbury. The areas with the highest life expectancy are Sevenoaks, Tonbridge and Malling, Tunbridge Wells, Maidstone and Ashford [4].

The slope index of inequality measures the gap in life expectancy between the most and least deprived community segments. Between 2018 and 2020, this gap was 7.8 years for males and 5.6 years for females in Kent [5].

2.2. Geography

Figure 2 shows the location and population of the built-up areas in East Kent.

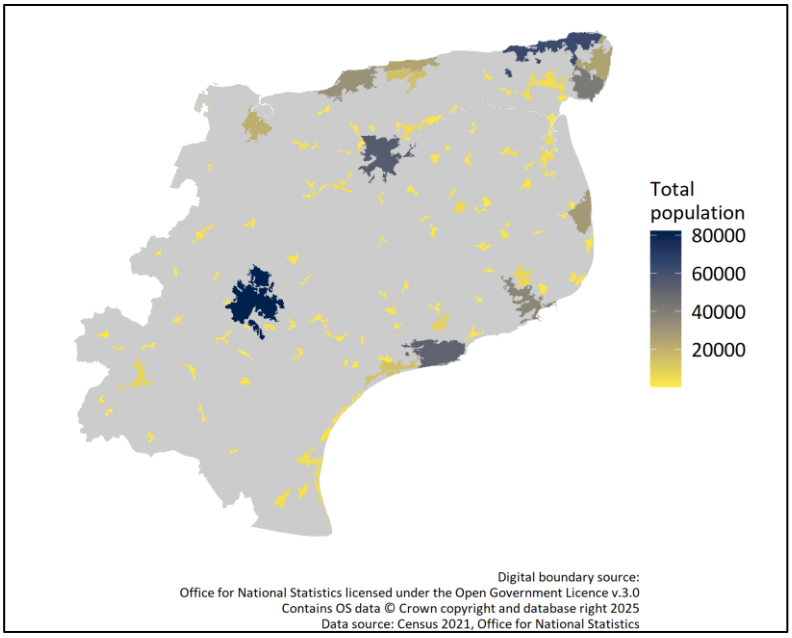


Figure 2 Map of built-up areas with population at time of Census 2021

Table 1 shows the 5 built-up areas with the largest population at the time of the Census 2021.

Table 1 Populations of largest built-up areas, Census 2021

Built-up area	Population
Ashford (Ashford)	82,140
Margate	63,320
Canterbury	55,090
Folkestone	51,995
Ramsgate	42,030

2.3. Projections and Forecasts

The latest population projections from the Office for National Statistics are based on the 2018 calendar year. ONS has consulted users about the frequency and format of future releases. Projections are not forecasts and do not attempt to predict the impact of future political and economic changes or local development policies. 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 [6]. Population growth is determined by the number of dwellings expected to be built in the county. It uses information provided by each Kent local authority planning department (including Medway) and includes some additional assumptions made at the county level.

By 2035, the total population of East Kent is expected to be about 818,000.

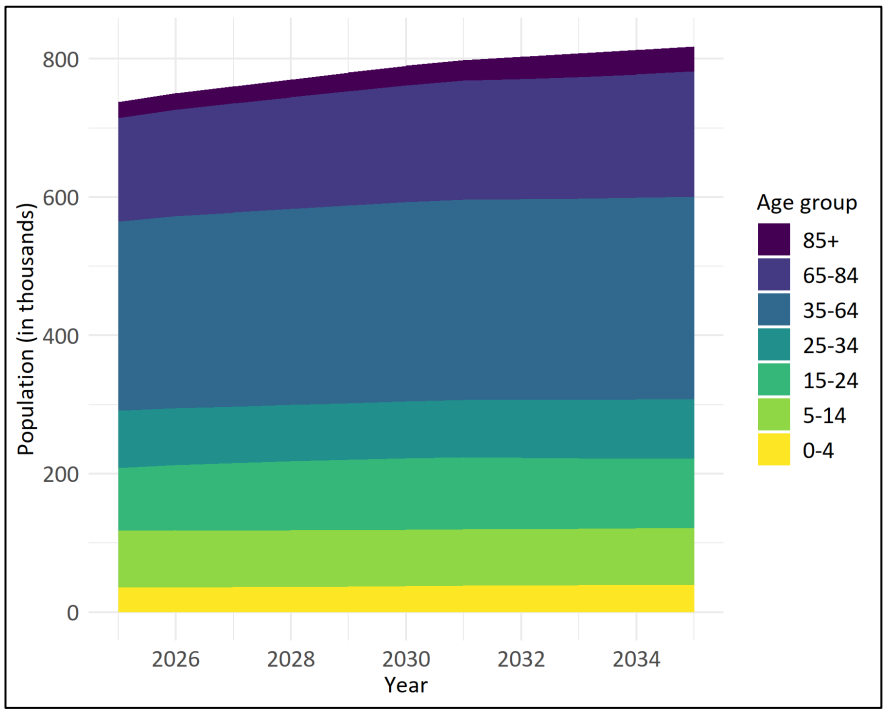


Figure 3 Population forecast by age group, KCC Housing led

Table 2 describes the forecast percentage change in population between 2025 and 2035.

Table 2 forecast percentage change in population

Age	East Kent
0-4	12.3
5-14	-0.1
15-24	9.8
25-34	4.8
35-64	7.0
65-84	20.8
85+	55.5

2.4. Identity

2.4.1. Ethnicity

In East Kent at the time of the Census in 2021, 85.9% of the population were classified as 'White: English, Welsh, Scottish, Northern Irish or British'. This compares to 73.5% in England.

Figure 4 shows the population profile of the other ethnic groups, comparing East Kent and England.

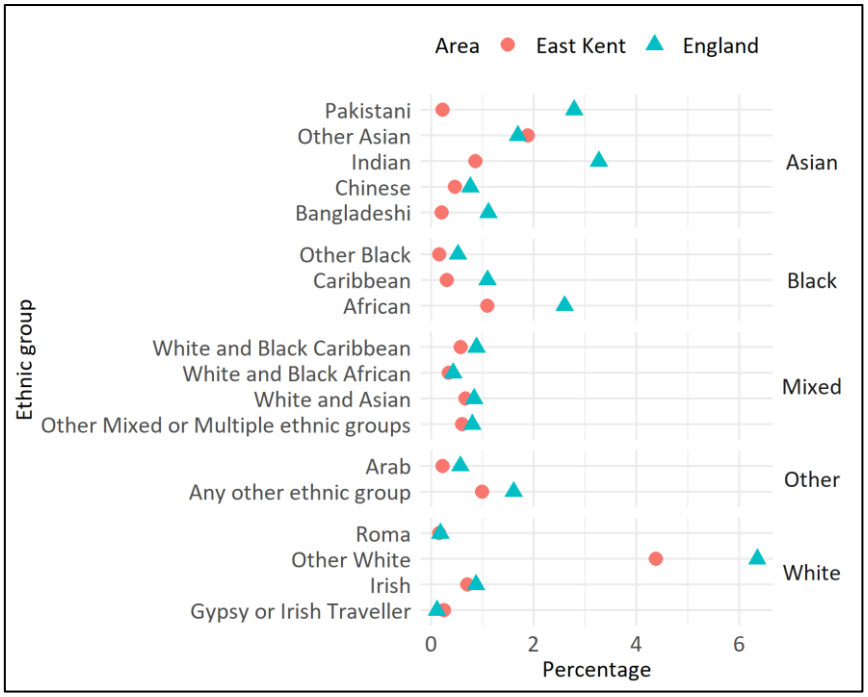


Figure 4 Percentage of the population in non-White British groups

Apart from White British, African (1.1%), Other Asian (1.9%) and Other White (4.4%) ethnic groups account for more than 1 percent of the population.

2.4.2. Gypsy Roma 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. Nationally there is a lack of focus on Gypsy, Roma and Traveller communities in Joint Strategic Needs Assessments which results in these communities being overlooked when planning services. In response to these issues, Public Health in Kent County Council carried out a Gypsy, Roma and Traveller Health Needs Assessment [7] to update the previous HNA of 2015.

2.4.3. Main language

There are 94 distinct main languages spoken by people in East Kent. 21 are spoken by at least 500 people. The top 5 languages are: English 91%, Nepalese 0.9%, Polish 0.5%, Romanian 0.4% and Slovak 0.2%.

2.4.4. Religion

In East Kent, 47.6 percent are Christian, 1.4 percent are Muslim and 1.1 percent Hindu. 42.2 percent declared no religion and 6 percent declined to answer.

Table 3 Religion, Census 2021

Religion	Value	Percent
Christian	312,685	47.6
No religion	277,335	42.2
Not answered	39,434	6.0
Muslim	8,955	1.4
Hindu	7,165	1.1
Other religion	5,166	0.8
Buddhist	4,565	0.7
Jewish	979	0.1
Sikh	648	0.1

2.4.5. 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 East Kent at the time of 2021 Census, 89.6 percent of residents aged 16 years and over responded that they were Straight or Heterosexual. 3.3 percent were Gay or Lesbian, Bisexual or another sexual orientation. This question was not answered by 7.1 percent of people.

Table 4 Sexual orientation, Census 2021

Sexual orientation	Value	Percent
Straight or Heterosexual	486,264	89.6
Not answered	38,339	7.1
Gay or Lesbian	8,581	1.6
Bisexual	7,626	1.4
All other sexual orientations	1,834	0.3

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 East Kent, 94.2 percent of residents responded that their gender identity was the same as their sex registered at birth. 0.5 percent identified as a different gender. This question was not answered by 5.3 percent of people.

2.5. Veterans

The Armed Forces and Veteran Community Needs Assessment [8] 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 26,865 veterans living in East Kent, approximately 5 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 12 percent and in those aged 85 years and over it is 26 percent. Figure 5 shows a map of electoral wards in Kent and Medway shaded corresponding to the percentage of the population which has served in the armed forces.

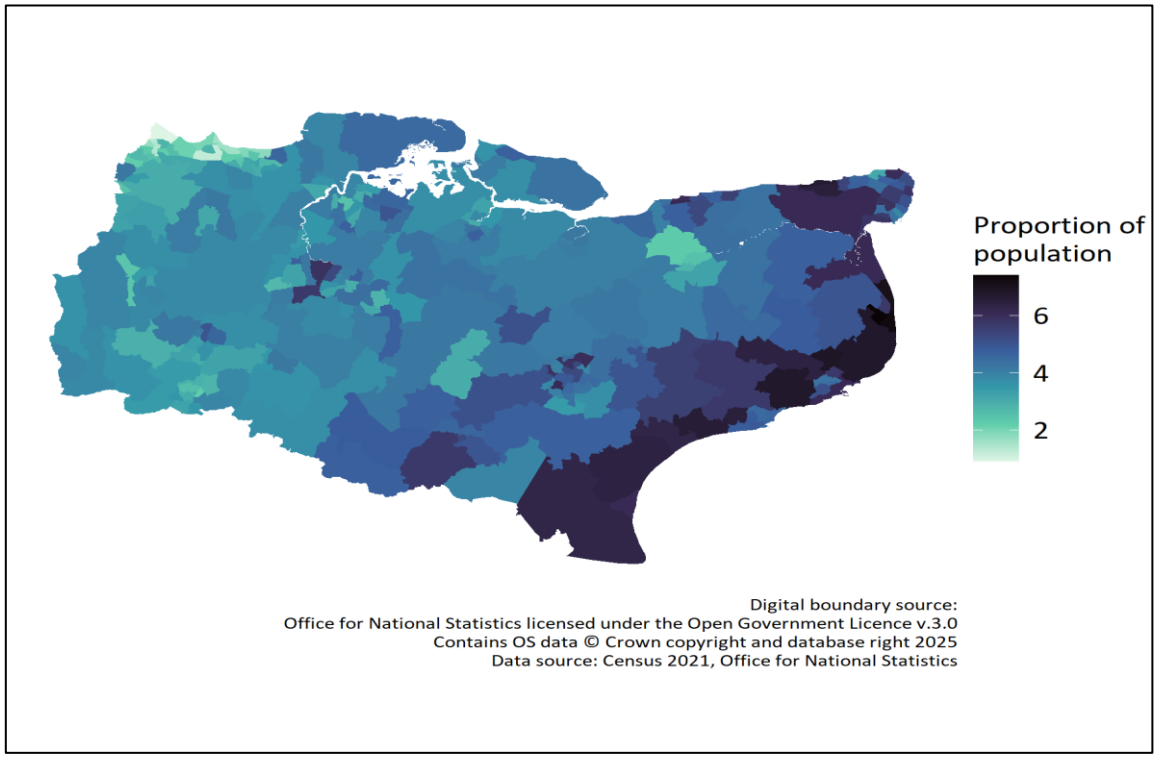


Figure 5 Percentage of the population who are military veterans by electoral ward

2.6. Disability

2.6.1. 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. There are five districts with higher rates than Kent and England average: Thanet (22.9%), Folkestone and Hythe (21.8%), Dover (21.2%), Canterbury (19.6%) and Swale (19.5%). Dartford, Tunbridge Wells, Sevenoaks, Tonbridge and Malling and Maidstone are all below 16% [9].

2.6.2. 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. It is highest in Thanet (5.4 per cent), Folkestone and Hythe (5 per cent), Dover (4.8 per cent) and Swale (4.5 per cent). Sevenoaks, Tunbridge Wells, Dartford and Tonbridge and Malling are all less than 3 per cent [10].

2.6.3. Unpaid carers

An unpaid carer may look after, give help or support to anyone who has long-term physical or mental ill-health conditions, 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 per cent). It is highest in Dover and Thanet (10.4 per cent), and Folkestone and Hythe (10.3 per cent). It is lowest in Dartford and Tunbridge Wells (about 8 per cent) [11].

2.7. Homeless and rough sleeping

2.7.1. 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.

2.7.2. 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 5 summarises homelessness statistics across Kent in 2023/24.

Table 5 Statutory Homeless statistics by local authority

Area	Threat homeless rate	Homeless rate
England	6.0	7.4
South East	5.9	5.4
Ashford	7.2	7.8
Canterbury	NA	NA
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

2.8. Students

Table 6 Full-time students by local authority of residence and academic year

Area	2017/18	2018/19	2019/20	2020/21	2021/22
Ashford	2,765	2,760	2,705	2,940	3,060
Canterbury	3,590	3,600	3,655	3,850	3,770
Dartford	2,120	2,170	2,270	2,550	2,675
Dover	2,050	2,015	2,045	2,220	2,280
Folkestone and Hythe	1,950	2,030	2,050	2,155	2,115
Gravesham	2,185	2,220	2,195	2,475	2,630
Maidstone	3,235	3,300	3,370	3,625	3,780
Sevenoaks	2,815	2,965	2,885	3,090	3,065
Swale	2,315	2,370	2,345	2,465	2,490
Thanet	2,550	2,490	2,490	2,625	2,660
Tonbridge and Malling	2,690	2,685	2,680	2,855	2,910
Tunbridge Wells	3,135	3,175	3,135	3,330	3,395

At the time of the 2021 Census, there were a total of 27,455 full-time students whose usual place of residence (term-time address) was in East Kent. This is approximately 5.2 percent of the total population aged 18 years and over, compared with 5.2 percent in England.

Please note, these figures include students aged 18 or more who are still in school or further education.

Table 7 Percentage of adult population who are full-time students, Census 2021

Area	Not a student	Student	Percent
East Kent	500,523	27,455	5.2
England	42,385,364	2,330,085	5.2

As shown in Figure 6 across Kent and Medway, there are six electoral wards in Canterbury in which the proportion of the adult population who are full-time students is between 13 and 53 percent. From largest to smallest, these are Blean Forest, St Stephen's, Northgate, Barton, Westgate and Wincheap. In Medway, Gillingham North and River ward have 11 percent and 8 percent student populations respectively.

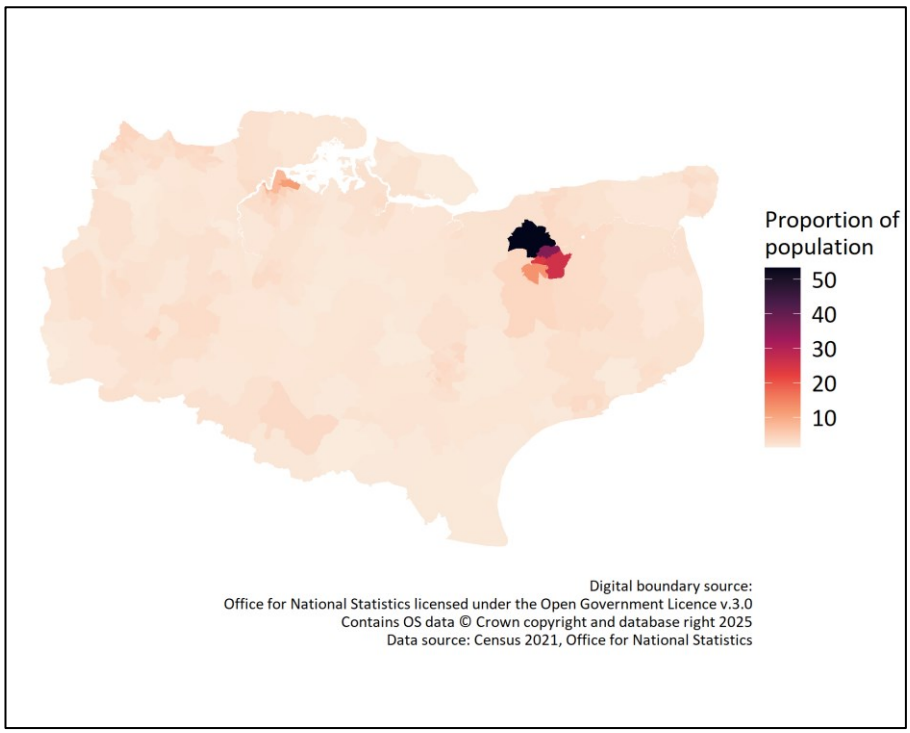


Figure 6 Percentage of the population aged 18 years and over who are full-time students by electoral ward, Census 2021

2.9. Deprivation

2.9.1. Indices of deprivation

The Indices of Deprivation 2019 (IoD2019) is based on 39 separate indicators, organised across seven distinct domains of deprivation which are combined and weighted to calculate the Index of Multiple Deprivation 2019.

This is an overall measure of multiple deprivation experienced by people living in an area and is calculated for every Lower-layer Super Output Area (LSOA), or neighbourhood, in England. All neighbourhoods in England are then ranked according to their level of deprivation relative to that of other areas. High ranking LSOAs or neighbourhoods can be referred to as the 'most deprived' or as being 'highly deprived' to aid interpretation. However, there is no definitive threshold above which an area is described as 'deprived'.

The IoD2019 measure 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 IoD2019 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 IoD2019 is designed to identify and measure specific aspects of deprivation, rather than measures of affluence [13].

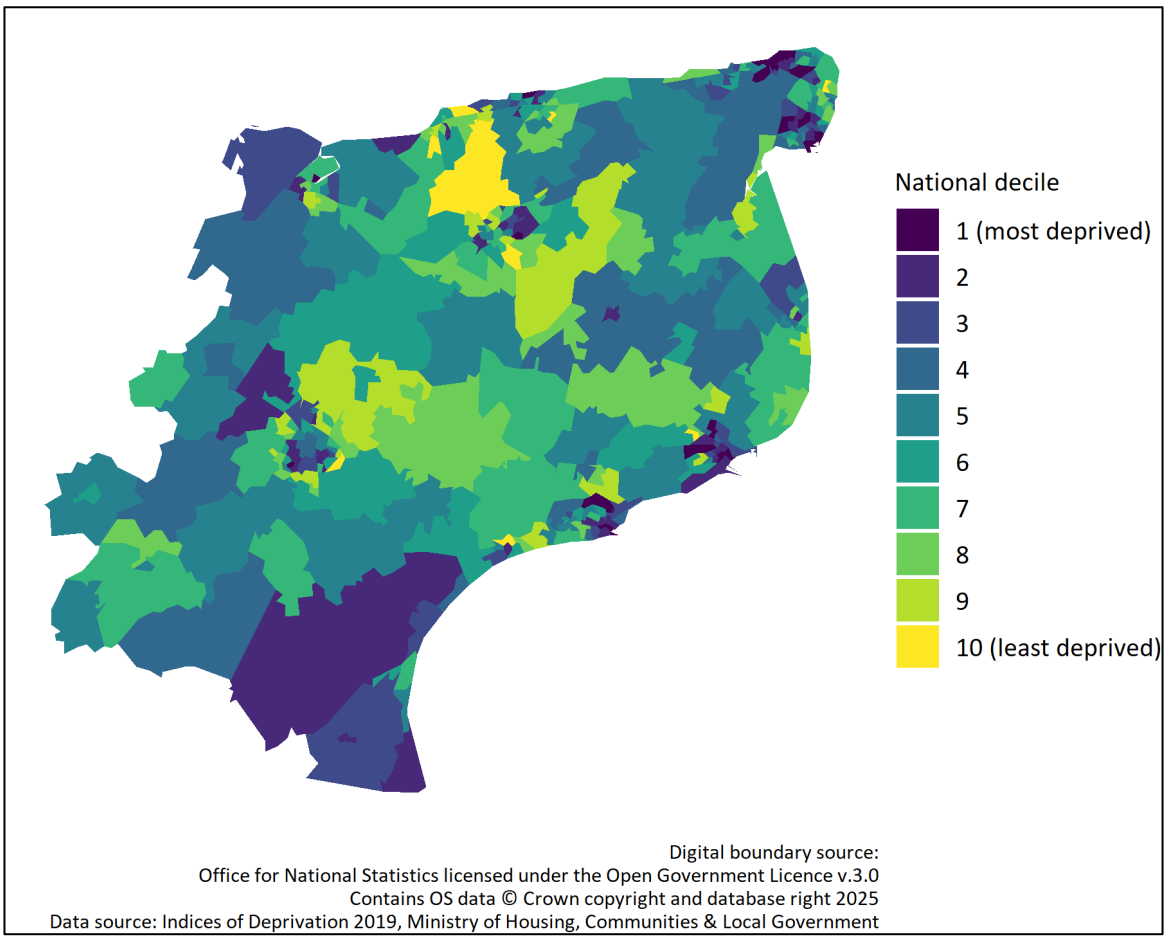


Figure 7 Index of Multiple Deprivation, 2019

The seven domains which comprise the overall index listed below with weighting in brackets:

- Income (22.5%)
- Employment (22.5%)
- Health deprivation and disability (13.5%)
- Education, skills training (13.5%)
- Crime (9.3%)
- Barriers to housing and services (9.3%)
- Living environment (9.3%)

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

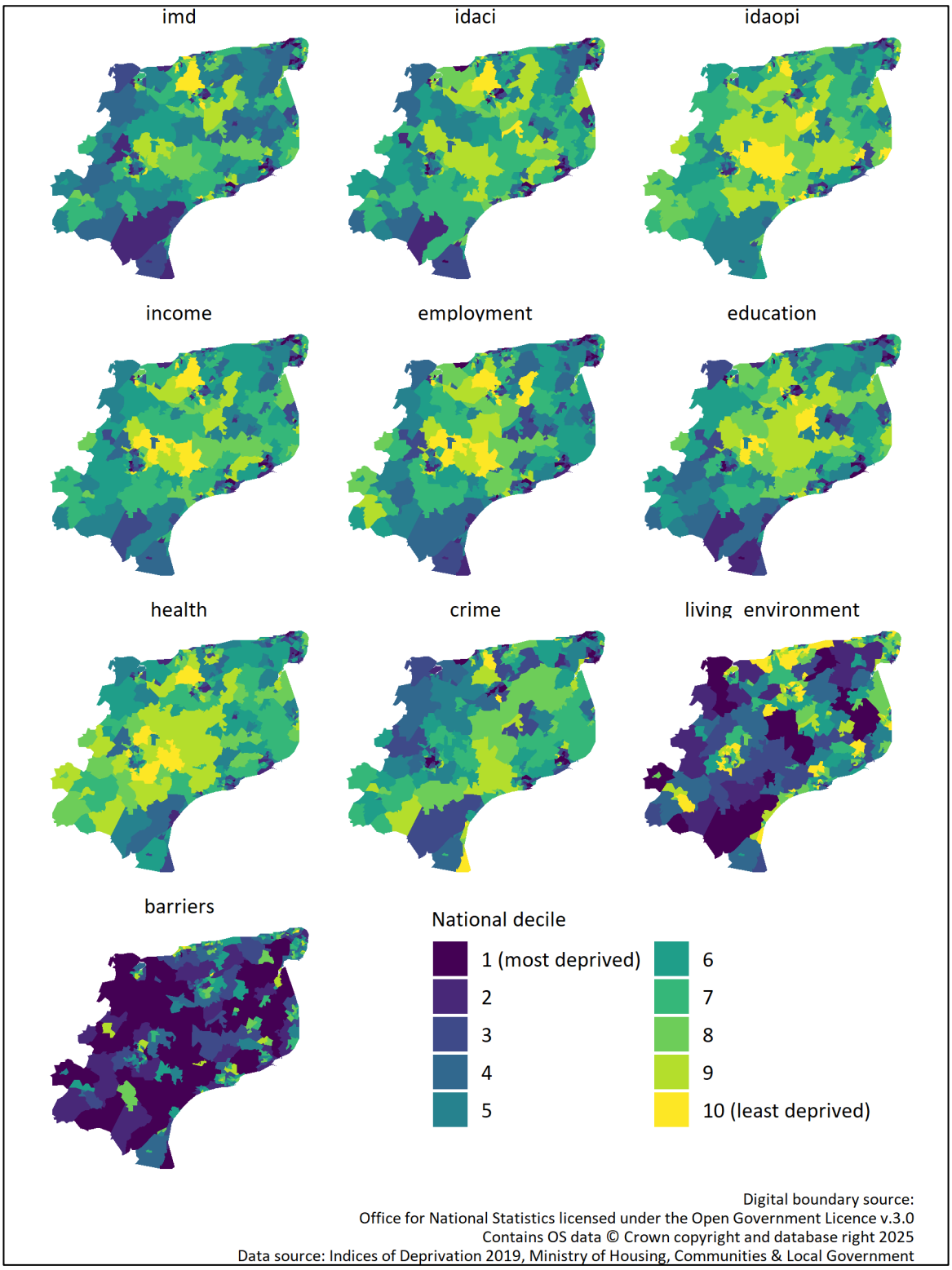


Figure 8 Deprivation deciles by domain of deprivation, 2019

2.9.2. Car or van availability

In Kent, 17.5 per cent of households do not own or a car or have one available. All districts within Kent are lower than the England average (23.5 per cent) apart from Thanet, which is 26.1 per cent [14].

2.10. References

1. Office for National Statistics. Population estimates for England and Wales: Mid-2023. 2024.
2. NOMIS. Live births in England and Wales : Birth rates down to local authority areas. 2024.
3. Buxton J. Period and Cohort life expectancy explained. Office for National Statistics; 2023.
4. ONS. Life expectancy for local areas of Great Britain. 2024.
5. OHID. Inequality in Life expectancy at birth - Slope index of inequality.
6. Kent Analytics. KCC Housing Led forecasts 2021. 2021.
7. Abbott M, Jolly A, Chapman S. Kent gypsy, roma and traveller populations joint strategic needs assessment. 2023.
8. Cochrane S, George A, Hopton H. Armed Forces and Veteran Community Needs Assessment 2024. Kent Public Health Department; 2024.
9. NOMIS. Day to day activities limited by long-term physical or mental health conditions or illnesses. 2021.
10. NOMIS. Economic activity status. 2021.
11. NOMIS. Unpaid carers. 2021.
12. HM Government. Homelessness data: Notes and definitions. 2018.
13. Ministry of Housing, Communities & Local Government. The English Indices of Deprivation 2019 - Statistical Release. 2019.
14. NOMIS. Car or van availability. 2021.

3. Wider Determinants of Health

3.1. Natural and Built Environment

3.1.1. Air Pollution

Air pollution remains a significant public health issue, both globally and in the UK [1]. The WHO has reported that air pollution is responsible for 4.2 million premature deaths a year. In the UK, there are estimated between 29,000 and 43,000 premature deaths per year [2], but many more suffer avoidable chronic ill health from air pollution. Air pollution disproportionally affects the most vulnerable in society — children, older adults, pregnant women, and those with existing health issues such as heart or lung conditions. Additionally, those from more deprived areas are also more likely to be exposed to higher levels of air pollution [3].

Both PM 2.5 and PM 10 (particulate matter at 2.5 and 10 microns in size, respectively) are linked to health issues such as lung cancer, heart attack and stroke. PM 2.5 and PM 10 are easier to monitor than other forms of air pollution, allowing them to be tracked and regulations to be implemented more easily.

It is thought that PM 2.5 is more harmful than PM 10. PM 2.5 is smaller than other forms of pollution and it is thought this can allow it to get deeper into the lungs and even the blood stream. This can damage organs and blood vessels, increasing the likelihood of stroke and heart attacks occurring.

Figure 9 shows the mean levels of PM 10 pollution by LSOA across Kent. Looking at East Kent specifically in 2024, all LSOAs were below the mean acceptable annual average set by the government which is 40 µg/m3 [4]. Dartford and Gravesham have the highest levels of PM 10 levels, likely due to the road traffic emissions, notably, near theA2, A30 and M25, but importantly, this was still below the 40 µg/m3 limit.

Figure 10 shows the concentration of PM 2.5 from 2018 to 2022 for the districts of East Kent. All of the districts in East Kent show decreasing levels of PM 2.5. Additionally, PM 2.5 concentration is well below the annual acceptable average set by the government which is 20 µg/m3. Thanet has the highest concentration of PM 2.5 for each year but has decreased 3.5 µg/m3 from 2018 to 2022 (a 30.8% reduction).

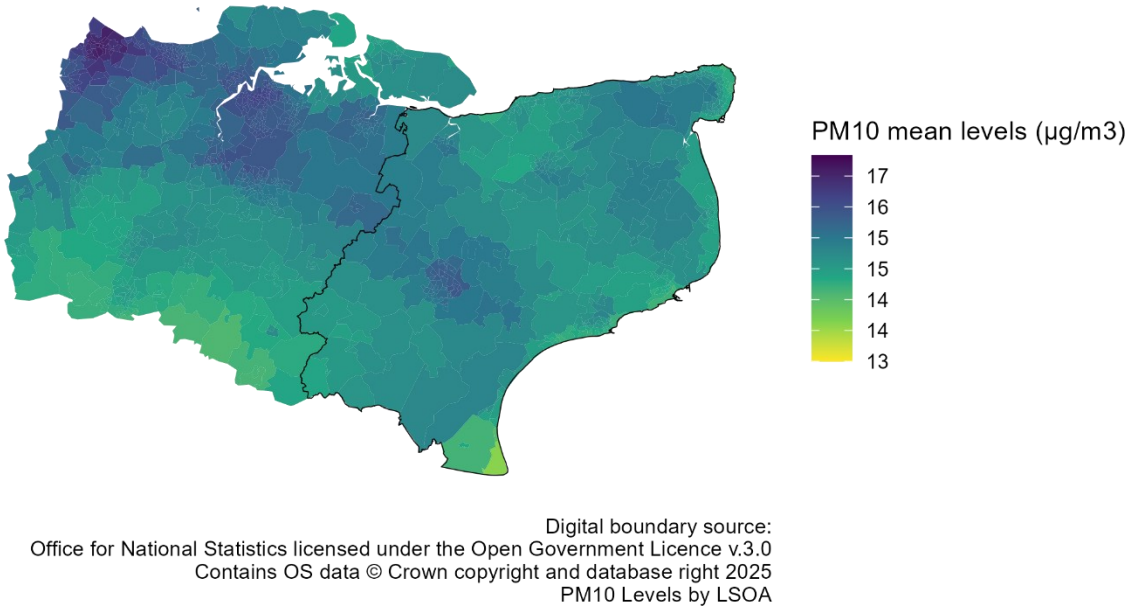


Figure 9. PM 10 Mean Yearly Levels by LSOA in Kent (2024).

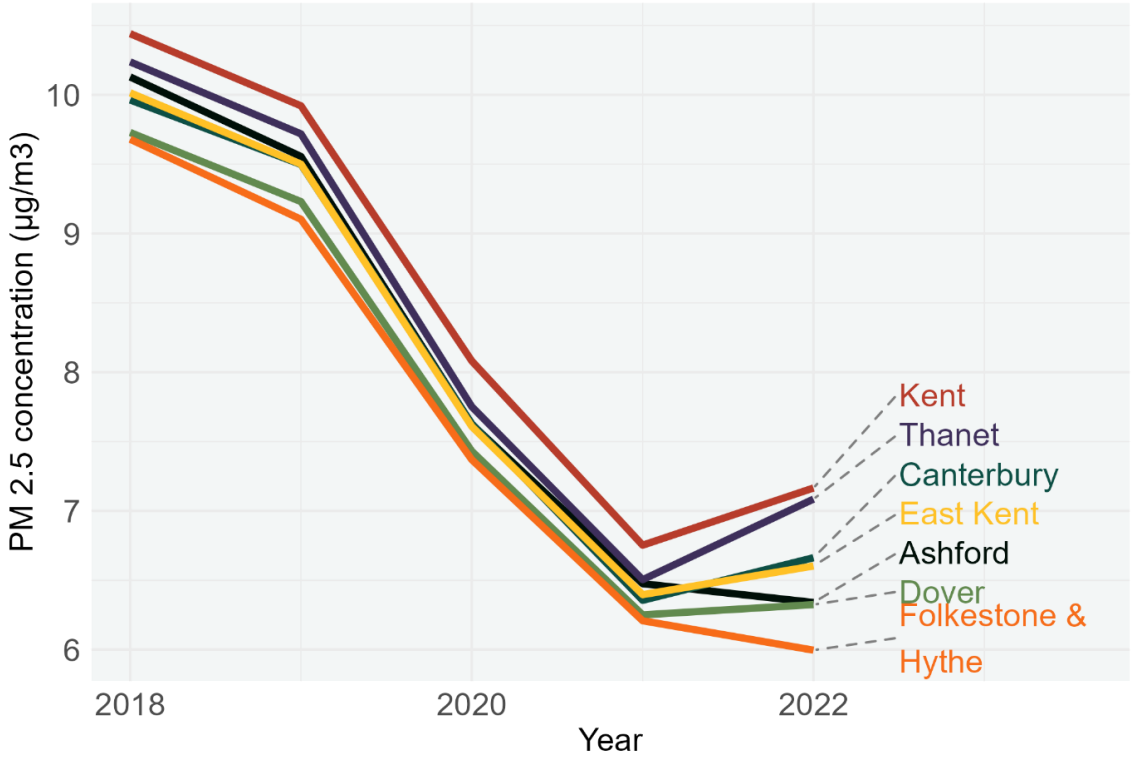


Figure 10. PM 2.5 Mean Yearly Levels in East Kent Districts Between 2018 and 2022.

3.1.2. Green Space

As traditional environmental risks to health have decreased, an increasing interest in the role the environment has in protecting health has emerged. Green space has become an emerging area of interest, especially in the built environment. Exposure to green space has been shown to improve mental health, increase social connections and improve physical activity [5]. Important connections have been made between childhood health and green space, notably a reduction in the numbers of low-birth-weight babies, an increase in physical activity, and lower risk of obesity and poor neurological outcomes [6].

Figure 11 shows the distance to green space by LSOA. Across East Kent, the average distance to green space is 0.61km, marginally below the Kent average of 0.62km. Dungeness in Folkestone and Hythe has the largest distance to green space (4.45km), however this is a large beach area which has also shown to share similar benefits to health as green space. While the government does not define an accepted distance to green space, Natural England suggest everyone should have a green space within 300 metres of their home, well below the East Kent average (620 metres).

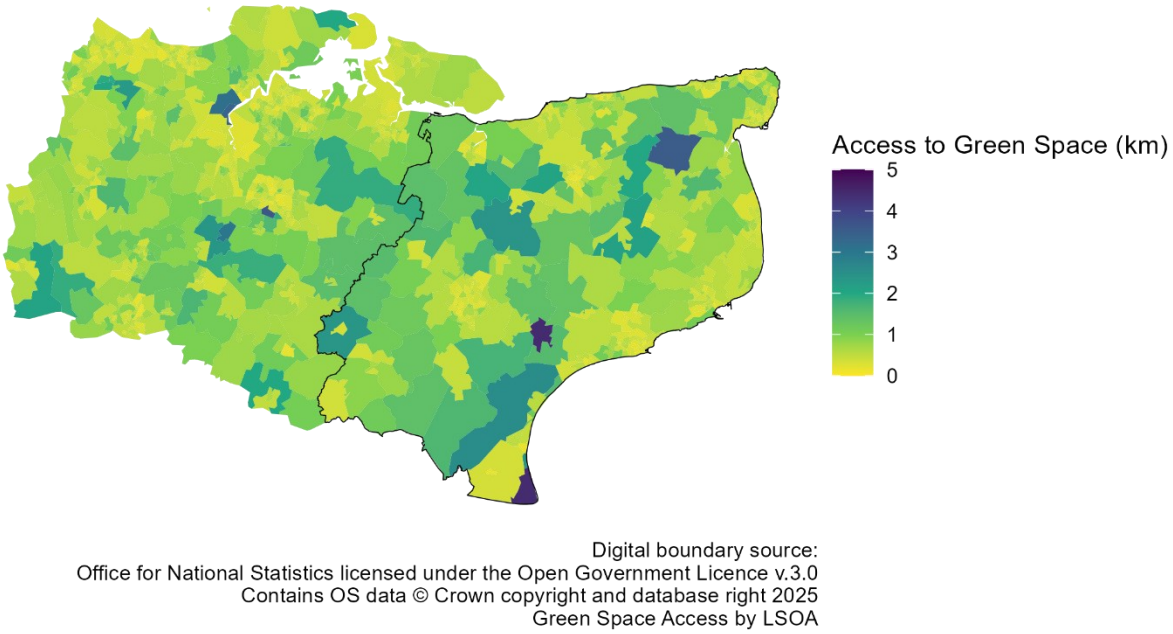


Figure 11. Distance to Green Space by LSOA in Kent for 2020.

3.2. Work and Labour Market

3.2.1. Free School Meals

Children are eligible for free school meals (FSM) if they are aged 4-16 and live in households which receive income related benefits. Additionally, all children in reception, year 1 and 2 are eligible for FSM. regardless of household income.

Figure 12 shows the percentage of children in East Kent districts who are eligible for FSM from 2017/18 to 2022/23. Thanet has the highest level of FSM eligibility for all time points, increase from 17.2% in 2017/18 to 31.9% in 2022/23 (a 14.7% increase in 6 years). Eligibility for FSM has doubled in Dover between 2017/18 to 2022/23 from 14.8% to 28%.

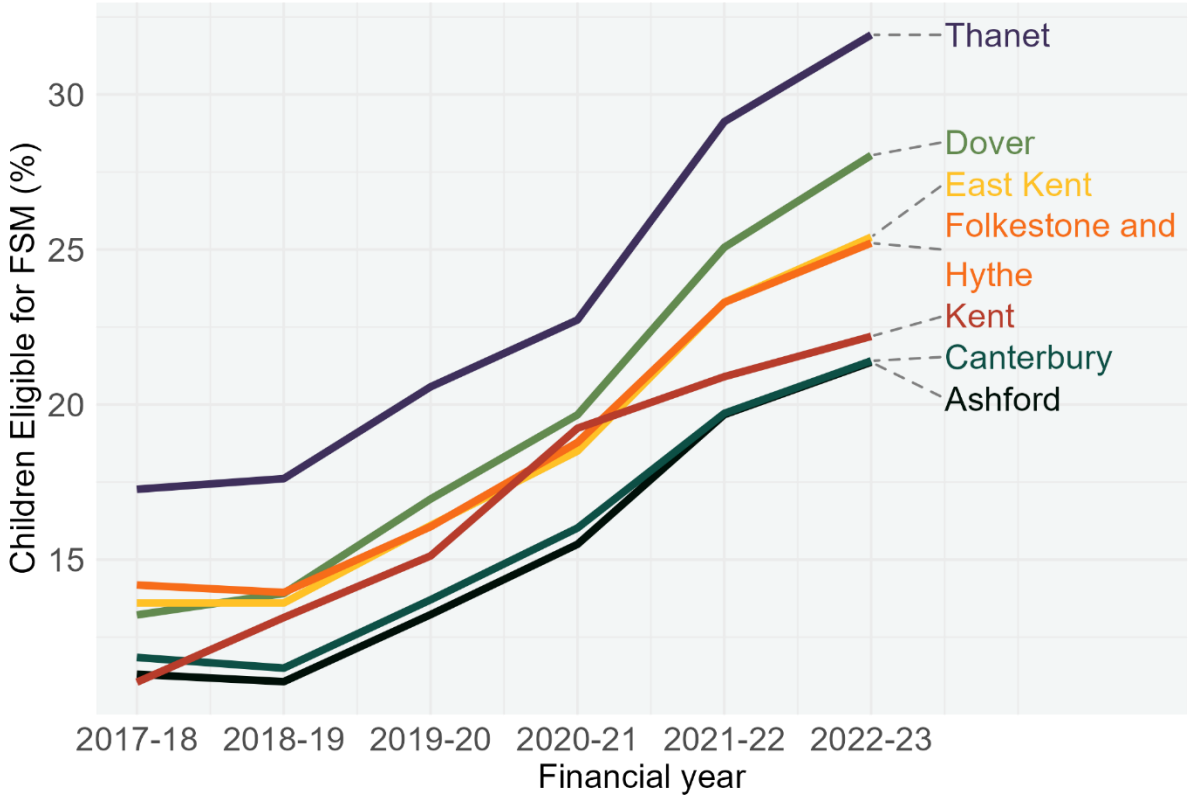


Figure 12. Proportion of Children Eligible for FSM in East Kent Districts between 2018 and 2023.

3.2.2. Economic Inactivity

Previous government budgets have cited economic inactivity as an increasingly significant issue, with 516,000 more people classed as economically inactive, compared with before the pandemic. Adults aged 60-64 represent the group with the largest number of inactive workers. This is typically driven by early retirement rather than ill health. However, changes to disability benefits have contributed to a rise in inactivity and a recent rise in people aged 18-24 becoming economically inactive, notably due to mental health issues [7]. It has also been reported that there is a large gender imbalance in economic activity, with men leaving the workforce at a rate three times greater than that of women [7]. Despite this, women are still more economically inactive in all districts other than Folkestone and Hythe in 2023, where 17.8% of women are economically inactive (compared to 27.8% of males). It is not known why this is.

Figure 13 shows the proportion of people aged 16-64 who are economically inactive in East Kent districts in 2022/23. Kent has seen a relatively steady level of economic inactivity at approximately 20%, despite significant fluctuation at the district level. While Thanet is one of the most deprived areas in Kent, in 2022/23 it had the lowest level of economic inactivity in East Kent, at 15.7%. It is possible that Thanet has less early retirees (who make up a large proportion of those who are economically inactive in the UK) and as such, both men and women in households are still working.

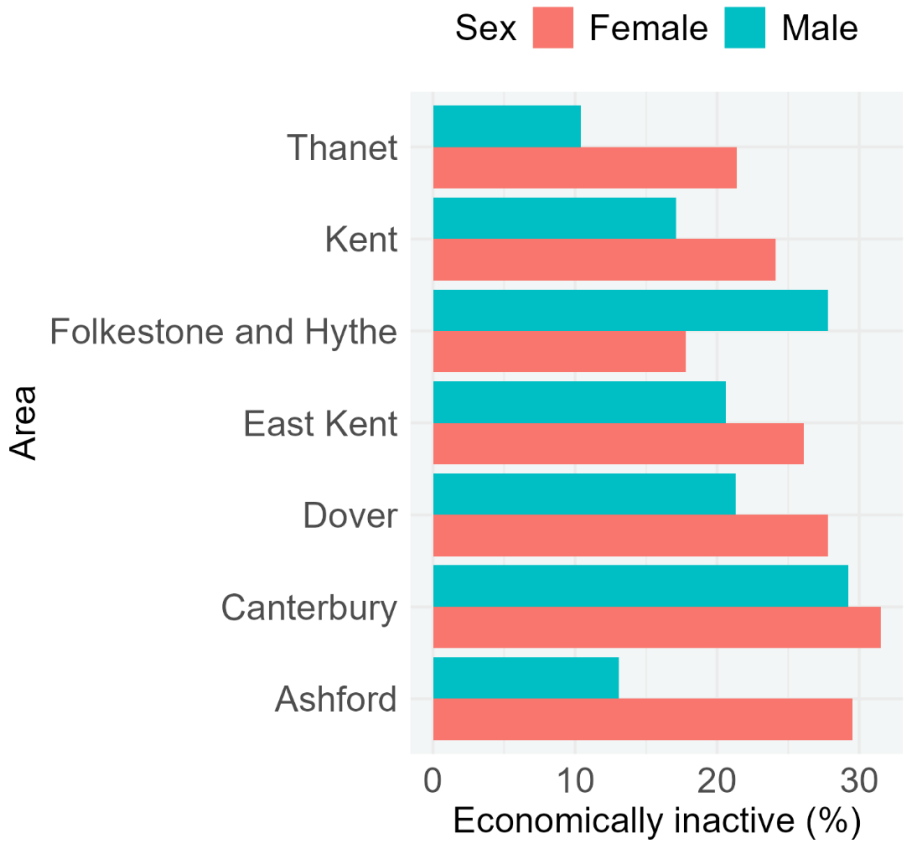


Figure 13. Proportion of People Classed as Economically Inactive in East Kent Districts Between 2018 and 2023.

Figure 14 shows the proportion of males and females who are economically inactive in 2017/18 to 2022/23 in East Kent and Kent. In 2019/20 the proportion of men who were economically inactive was 17.1%. In 2022/23 this had risen to 20.6%, an increase of 3.5%. The proportion of women in 2019/20 who were economically inactive was 26.1% which increased in 2021/22 but dropped back to 26.1% in 2022/23.

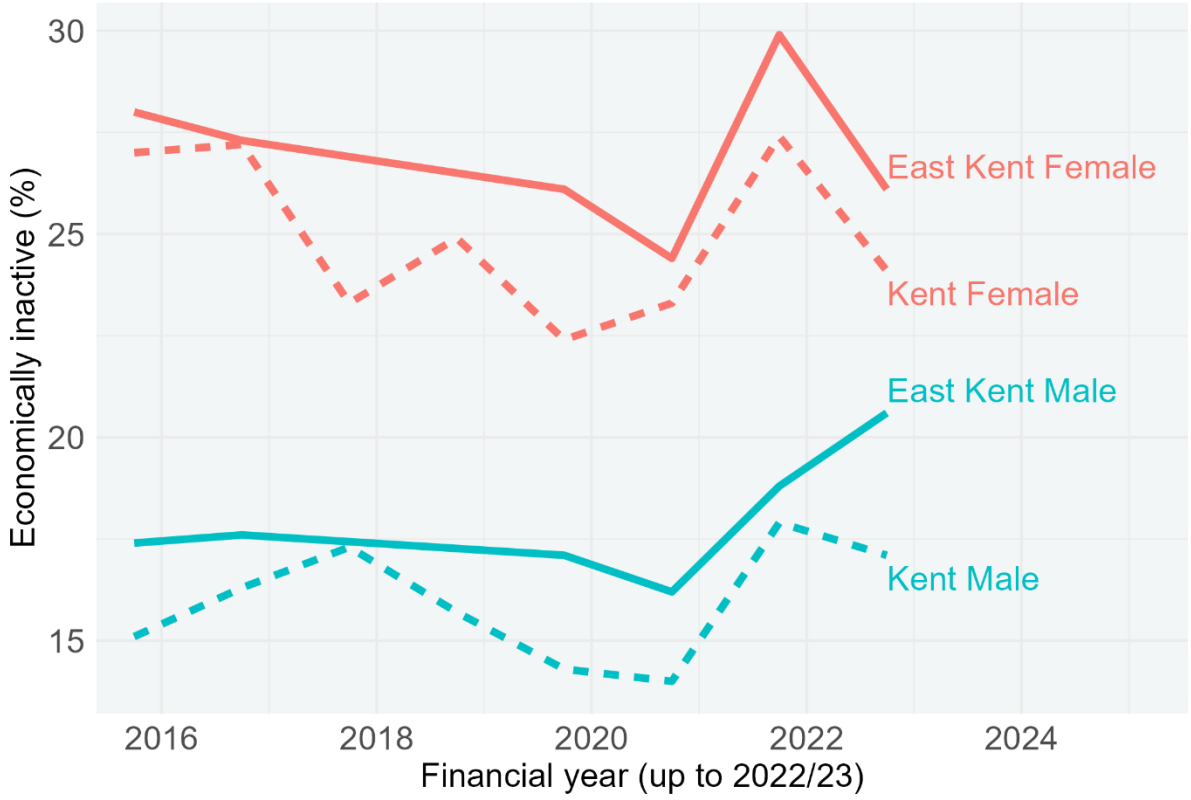


Figure 14. Proportion of males and Females Classed as Economically Inactive in East Kent Districts Between 2020 and 2023.

3.3. Income and Vulnerability

3.3.1. Overcrowded Housing

A household is considered overcrowded if it has fewer bedrooms than is required according to the number, ages and relationships of household members.

Overcrowded housing has been suggested as one mechanism linking deprivation to poor health outcomes. For example, 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 15 shows the proportion of overcrowded households by MSOA in 2021. Small pockets of overcrowded households are seen in Dover and Canterbury. It is possible that the student population in Canterbury, who often live in shared accommodation are contributing to a higher proportion of overcrowded houses.

Figure 16 shows the proportion of overcrowded households in 2011 and 2021 by district in East Kent. All districts have seen a decrease in the proportion of overcrowded households since 2011, however all districts in East Kent have higher proportions than the national average (4%) as reported in the 2021 census. Folkestone and Hythe has had the largest reduction in overcrowded housing, falling from 8% to 5%. Since 2011 the range between the districts has also reduced from 2.9% to 1.3%, suggesting initiatives to reduce this in the most deprived areas have had some impact. In these deprived areas it is likely that the government initiatives, e.g. to increase minimum room size have played a part in reducing the number of overcrowded households. Additionally, the number of affordable homes and affordability ration has increased in Kent, staying above the national average since 2013 [9]. In Kent in 2023/24, 25.1% of house completions are classified as ‘affordable homes’ which means their rent price is at least 20% below the average rent price for the area. It is possible that this drive has had an impact on overcrowded households as more people can afford larger dwellings [8].

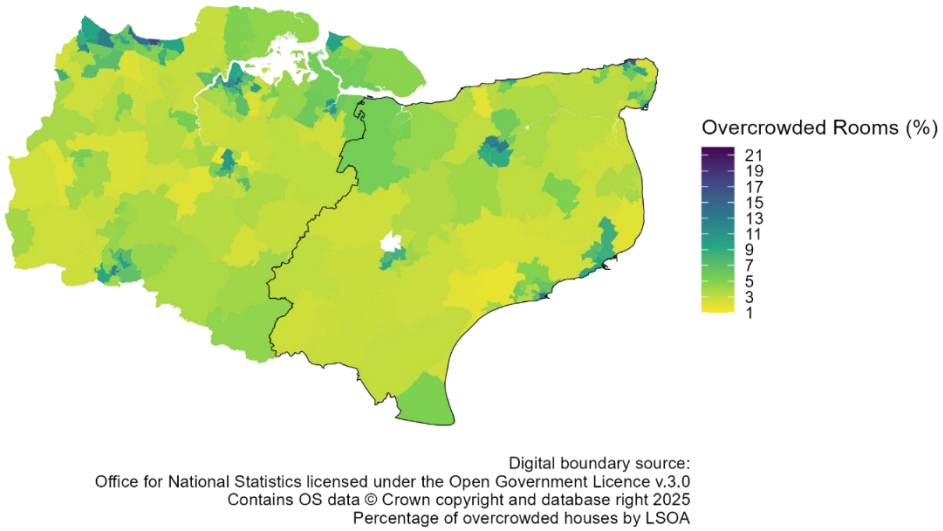


Figure 15. Proportion of People Living in Overcrowded Housing By LSOA in Kent in 2021.

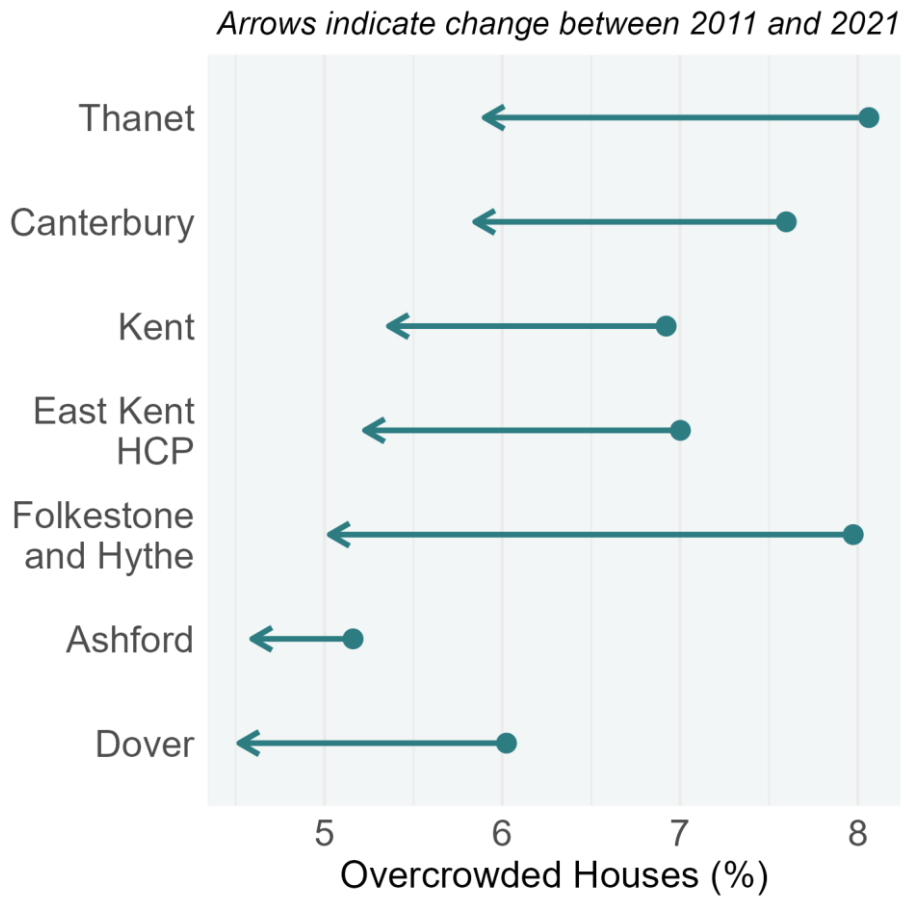


Figure 16. Proportion of People in East Kent Districts Living in Overcrowded Housing in 2011 and 2021 (census).

3.3.2. Claimant Count

Claimant count measures the number of people aged 16-64 years claiming unemployment related benefits. Due to broadening eligibility criteria this metric has become less useful as an economic indicator. To address this, the alternative claimant count, modelled for the introduction of universal credit, provides a more accurate economic understanding.

Figure 17 shows the proportion of individuals in East Kent claiming unemployment benefits from 2018 to 2024. The proportion has gradually been increasing year on year for nearly all districts with a large spike seen in 2021, most likely due to the Covid-19 pandemic. Thanet saw the largest increase during the pandemic with claimant count rising from 5.7% in 2020 to 9.8% in 2021, but this has since reduced, with 5.6% claiming unemployment benefit in 2024. Claimant count in Canterbury has grown nearly two and half times from 1.4% in 2018 to 3.5% in 2024, the largest relative increase seen in East Kent for this period.

Figure 18 shows the proportion of people claiming unemployment benefit by gender for 2024 in East Kent. In all districts, a higher proportion of males are claiming unemployment benefit. This gender difference is largest in Thanet, with a difference of 2.5% while the smallest difference is seen in Ashford at 0.7%.

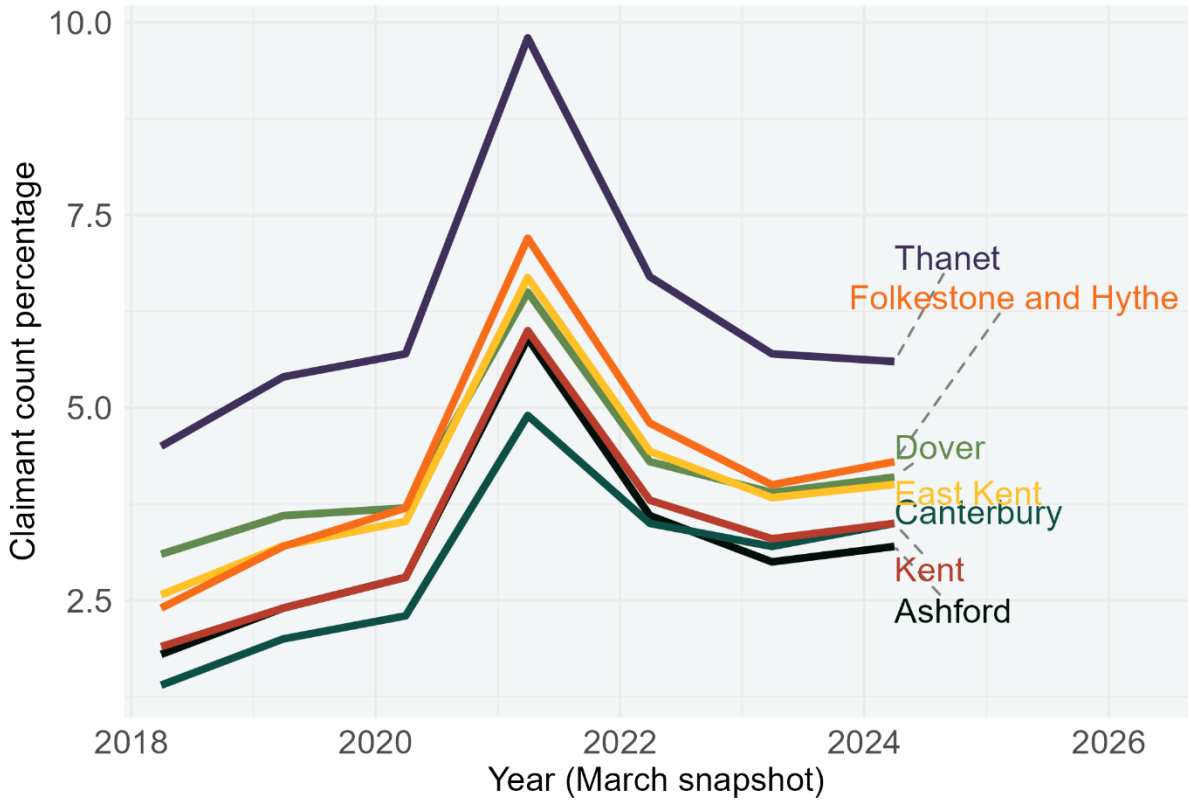


Figure 17. Proportion of People Aged 16-64 Claiming Unemployment Benefits in East Kent Districts from 2018 to 2024.

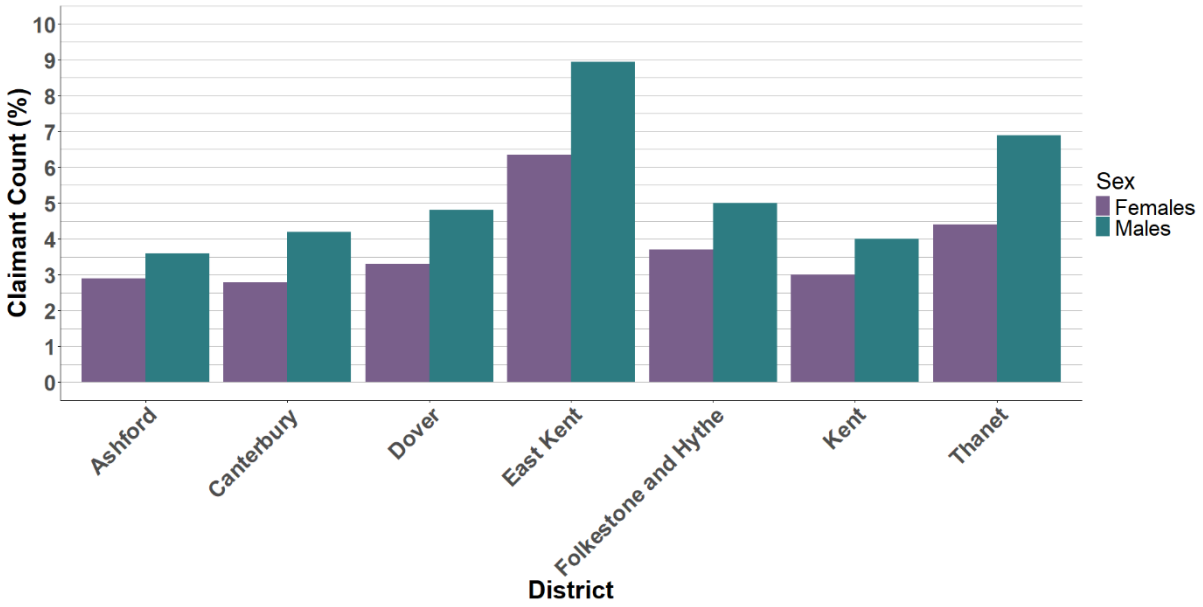


Figure 18. Proportion of Males and Females Aged 16-64 Claiming Unemployment Benefits in East Kent Districts from 2018 to 2024.

3.4. Crime

3.4.1. Crime Rates

Figure 19 shows the crude crime rate per 1000 population by MSOA in 2023. Generally rates are relatively consistent across East Kent, with higher rates seen in Dover, Canterbury, and Ashford, likely due to the higher number of town centres.

Figure 20 shows the crude crime rate per 1000 population for the districts of East Kent from 2018 to 2023. The rate has decreased between 2018 and 2023 but it should be noted that this indicator only tracks reported crimes. Thanet is consistely the highest district and Ashford is the lowest. In 2018, the rate in Ashford was 91.3/1000, decreasing to 81.1/1000 in 2023. In comparison, Thanet decreased from 154.2/1000 to 114.5 over the same period. Therfore, reported crime rates are reducing and the gap between districts in East Kent is also reducing.

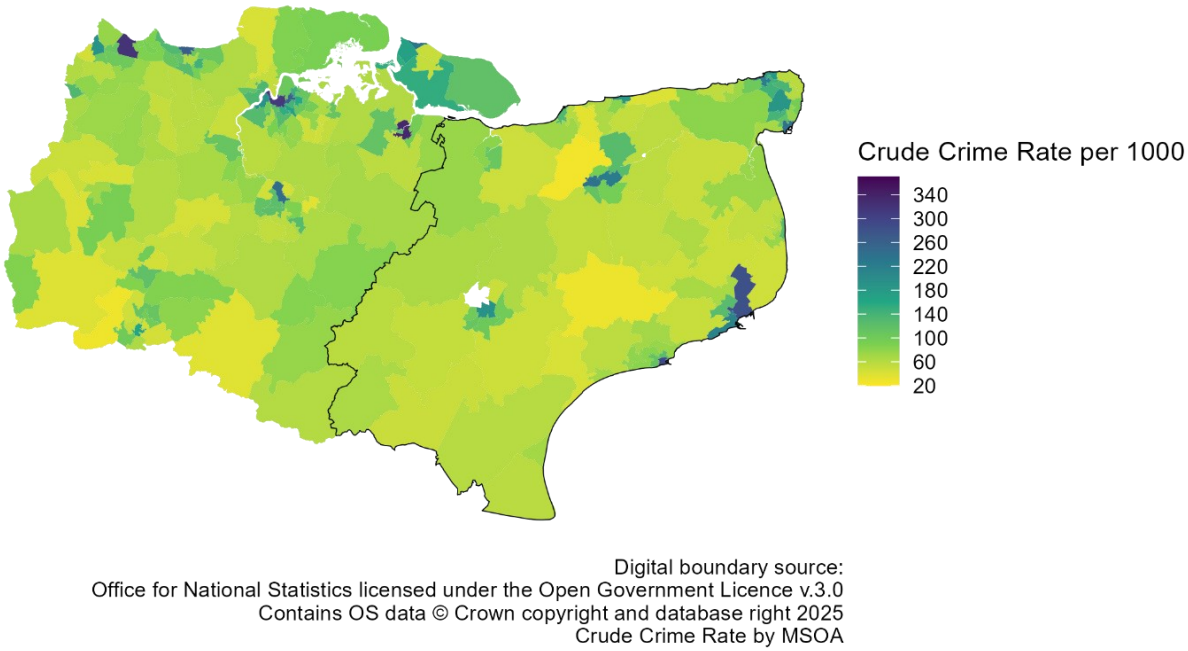


Figure 19. Crude Crime Rate Per 1000 Population by MSOA in Kent in 2023.

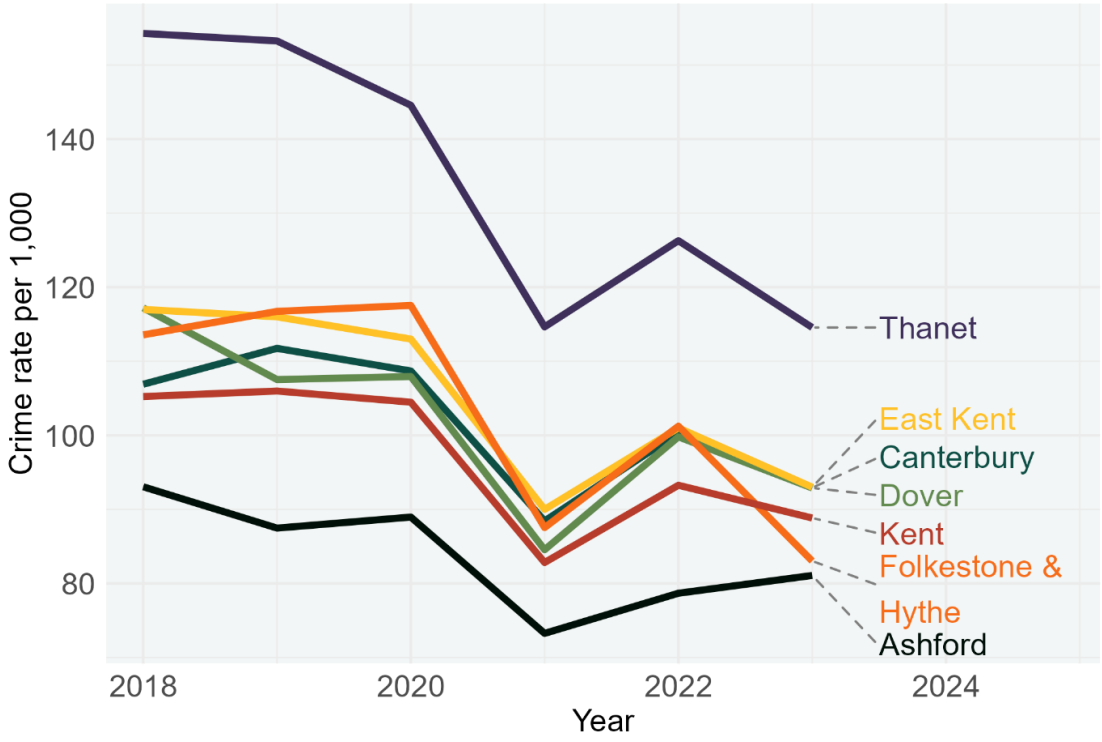


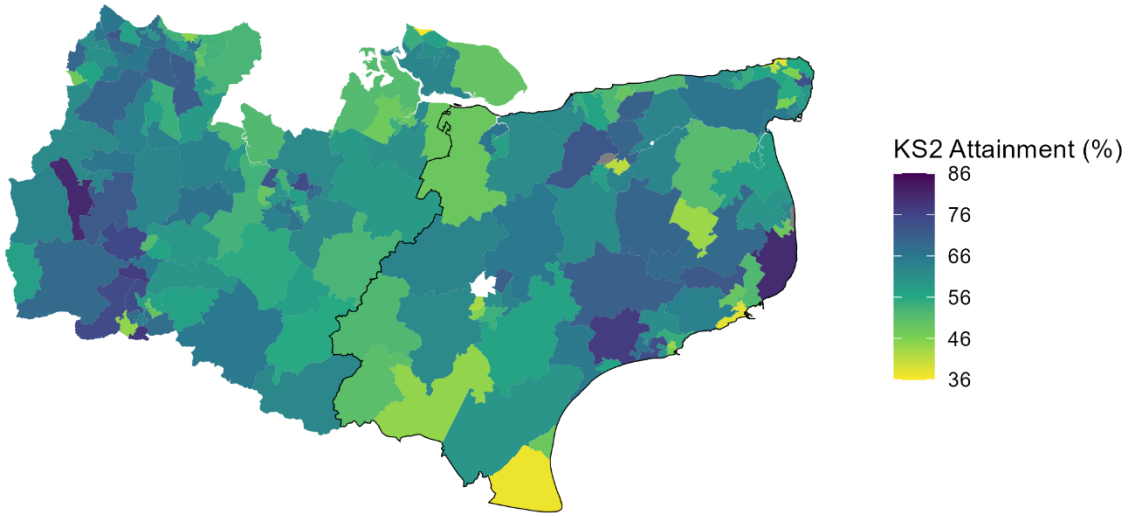
Figure 20. Crude Crime Rate Per 1000 Population in East Kent Districts from 2018 to 2023.

3.5. Education

3.5.1. Key Stage 2 (KS2) Outcomes

Figure 21 shows the proportion of children reaching the expected KS2 levels by Middle Super Output Area (MSOA) in 2023. A wide range of attainment is seen by MSOA with the lowest at 31.3% vs the highest attainment at 86.1%. Figure 23 shows the proportion by gender and district. In line with other educational outcomes, such as GCSE, in all districts the proportion of females achieving the required KS2 grades is higher than that of males (61.8% vs 55.4%). Despite this, females are less likely to attain 'high skilled' jobs and have reduced career earnings by 9% at graduation. This difference grows to over 30% a decade after graduation.

Figure 22 shows the proportion of children achieving the expected KS2 outcomes in 2022 and 2023 by district in East Kent. The average rate in East Kent is 58.8%, slightly below the UK average at 61%. While the national average marginally increased from 2022 to 2023 by 1%, East Kent has not seen a similar increase (<0.2%). In both 2022 and 2023, children in the least deprived quintile of East Kent had significantly higher attainment compared to the most deprived quintile (68.2% vs 44.4%).



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KS2 Outcomes by MSOA

Figure 21. Proportion of Children Reaching the Desired KS2 Attainment by MSOA in Kent for 2023.

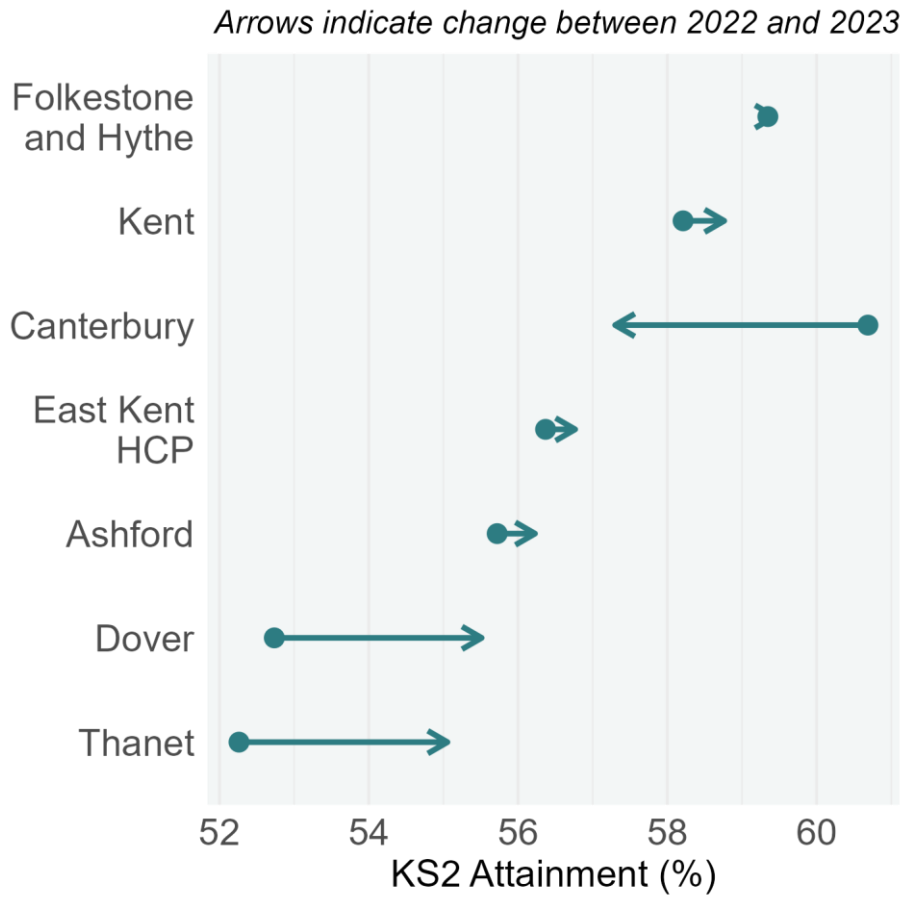

Figure 22. Proportion of Children Reaching the Desired KS2 Attainment by District in Kent for 2022 and 2023.

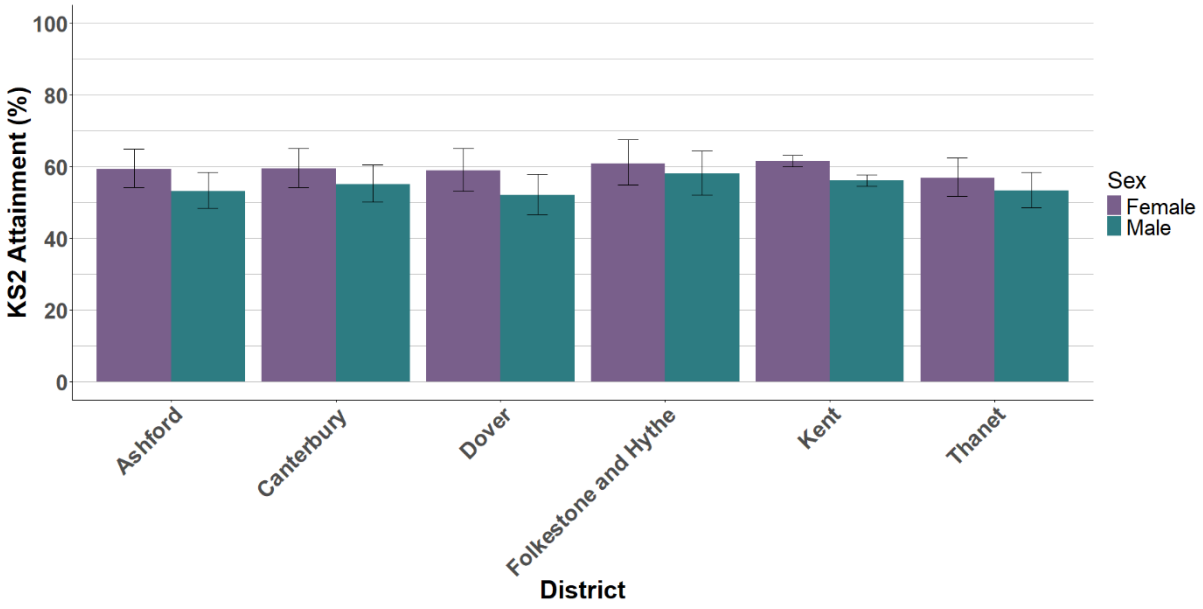

Figure 23. Proportion of Male and Female Children Reaching the Desired KS2 Attainment by District in Kent for 2022 and 2023.

References

1. Cohen AJ, Brauer M, Burnett R, Anderson HR, Frostad J, Estep K, et al. Estimates and 25-year trends of the global burden of disease attributable to ambient air pollution: an analysis of data from the Global Burden of Diseases Study 2015. Lancet. 2017 May 13;389(10082):1907–18.

2. Local Air Quality Management Technical Guidance (TG22) [Internet]. Department for Environment Food and Rural Affairs; 2022 Aug [cited 2025 Jun 26]. Available from: https://laqm.defra.gov.uk/wp-content/uploads/2022/08/LAQM-TG22-August-22-v1.0.pdf

3. Sharma S, Chandra M, Kota SH. Health Effects Associated with PM2.5: a Systematic Review. Curr Pollution Rep. 2020 Dec 1;6(4):345–67.

4. 2024 Air Quality Annual Status Report (ASR).

5. Van Den Berg AE, Custers MHG. Gardening promotes neuroendocrine and affective restoration from stress. J Health Psychol. 2011 Jan;16(1):3–11.

6. Islam MZ, Johnston J, Sly PD. Green space and early childhood development: a systematic review. Rev Environ Health. 2020 Jun 25;35(2):189–200.

7. Karl Williams. Where are the Workers? A new diagnosis of economic inactivity in Britain [Internet]. Centre for Policy Studies; 2023 Mar [cited 2025 Jun 26]. Available from: https://cps.org.uk/wp-content/uploads/2023/03/Where-are-the-Workers.pdf

8. Affordable Housing in Kent. Kent Analytics, Kent County Council; 2025 Jan.

4. Health Inequalities

"Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society" (NHS England). 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 forms of inequality, requiring a nuanced and tailored approach. Certain population groups typically experience multiple overlapping risk factors for poor health. These inclusion health groups include the homeless and rough sleepers, vulnerable migrants, sex workers, Gypsy, Roma, and Traveller, victims of modern slavery, people who are in prison or contact with the criminal justice system, and people with drug and alcohol dependence.

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.

Compared to Kent, East Kent has a higher rate of rough sleeping but lower rates of homelessness and Gypsy, Roma, and Traveller populations.

Table 8 Rates of rough sleeping, homelessness, and GRT for East Kent and Kent

Inclusion Health Group	East Kent	Rest of Kent
Rough sleepers (2023, rate per 10,000 households)	3.1*	0.9
Homelessness (2022/23, total assessments rate per 1,000 households)	8.4*	10.5
Gypsy, Roma, Traveller (2021, rate per 100,000 total population)	410.1	549

* Calculated from Ashford, Canterbury, Dover, Folkestone and Hythe, and Thanet district values

In Kent, several population groups are particularly adversely affected by health inequalities:

Socioeconomically Disadvantaged: Individuals in poorer communities experience worse health outcomes, including lower life expectancy and higher rates of chronic diseases

Elderly Population: Older adults often face multiple health challenges, including higher rates of disability and chronic illness

Ethnic Minorities: Certain ethnic groups are more likely to experience health disparities due to factors like socioeconomic status, access to healthcare, and cultural barriers

Coastal Populations: There is a health need greater than expected based the deprivation and demographics of the population. This is often associated with poorer access to health and social care facilities and a lack of employment opportunities. The analysis herein focuses on seven dimensions of inequality: age, sex, ethnicity, deprivation, rurality, household overcrowding and access to greenspace.

4.1. Socio-economic and Demographic Inequality

4.1.1. East Kent Population

Higher deprivation (as measured by the Index of Multiple Deprivation 2019) tends to cluster in and around the major towns. Deprivation across the HCP area tends to be generally higher than the rest of Kent and some of the most deprived Kent neighbourhoods are located in the coastal towns.

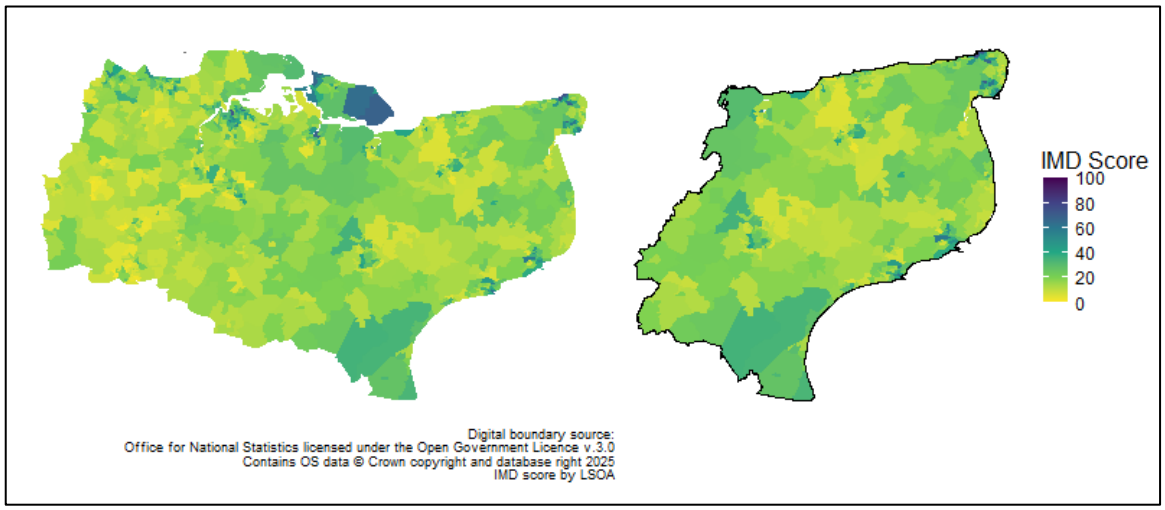

Figure 24 Deprivation (IMD 2019) by geography

Of all Kent HCPs, East Kent has the lowest percentage population aged 0-18 and highest percentage population aged 65+.

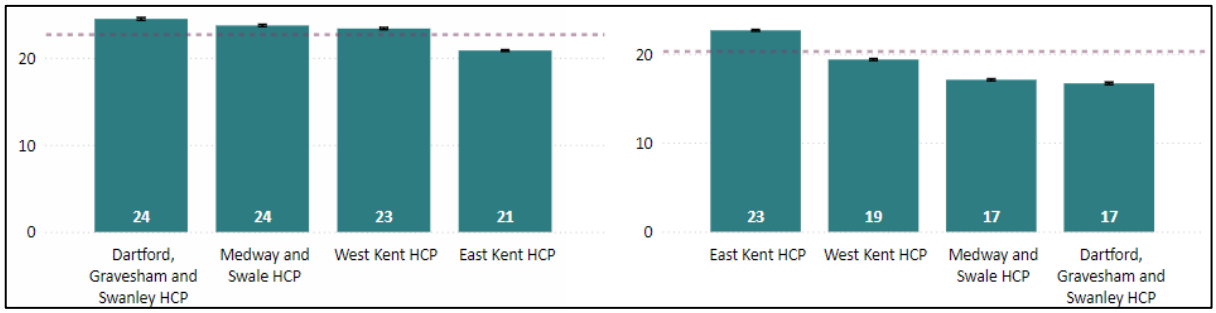

Figure 25 Percentage population aged 0-18 (left) and 65+ (right) by HCP

East Kent has the lowest percentage non-White population of all Kent HCPs.

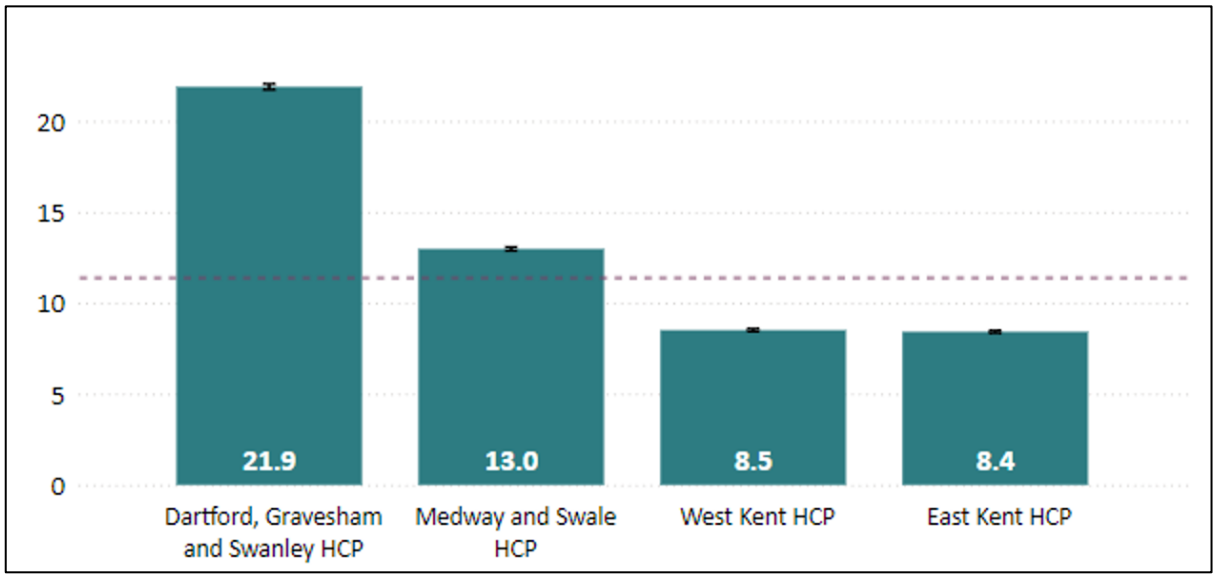

Figure 26 Percentage of non-white population by HCP

The proportion of people in each age group varies by ethnicity and deprivation quintile in the total East Kent population. The White ethnic group has a higher proportion of people in the 65+ age group. Over half of the Mixed ethnic group are aged below 30. By deprivation, the most deprived 20% of the population has an age profile most skewed towards younger age groups, followed by the second most deprived. The following three deprivation quintiles have a similar age profile.

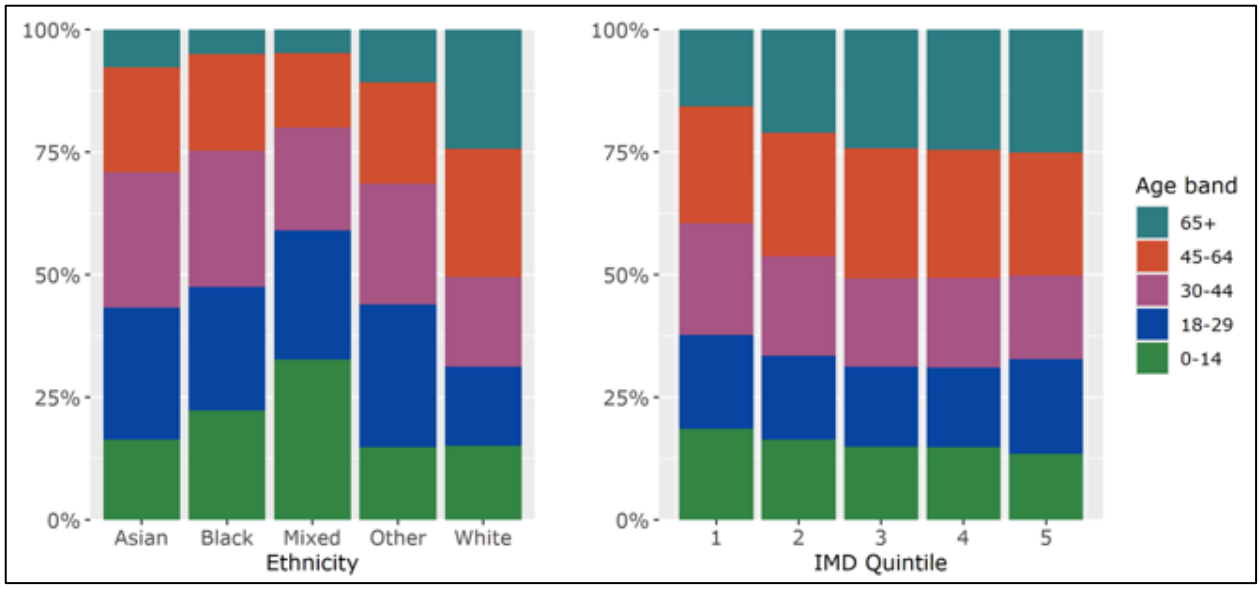

Figure 27 Age group distribution by Ethnicity and IMD Quintile

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 the Other ethnic group, there is over-representation in the most deprived 20% of the

population. The Asian ethnic group has the highest proportion in the least deprived 20% of the population. The Black ethnic group has over-representation both sides of the deprivation scale; the middle deprivation quintile is under-represented.

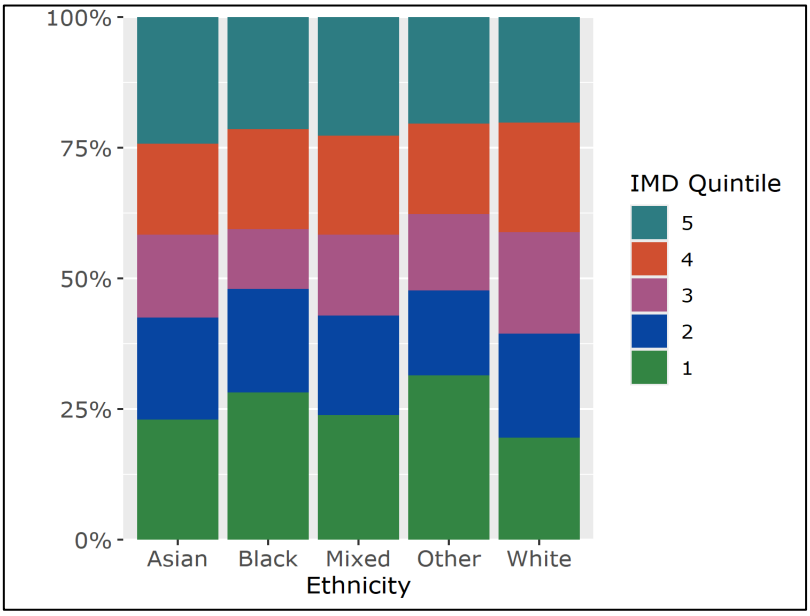

Figure 28 Deprivation (IMD quintile) distribution by ethnicity

4.1.2. Health Outcomes

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:

- People with two or more long-term conditions under the age of 65
- Emergency hospital admissions for chronic obstructive pulmonary disease
- Hospital admissions for respiratory conditions in children aged 0-19
- Excess weight in Year 6
- Smoking prevalence aged 16 plus
- Hospital admission episodes for alcohol-related conditions
- Depression prevalence aged 18 plus
- Diabetes prevalence
- Coronary heart disease (CHD) prevalence
- Hypertension prevalence

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).

4.1.2.1. Inequality by Deprivation

Deprivation has the strongest relationship with health outcomes; all health outcomes in this analysis are worse for the most deprived 20% of the population compared to the least deprived.

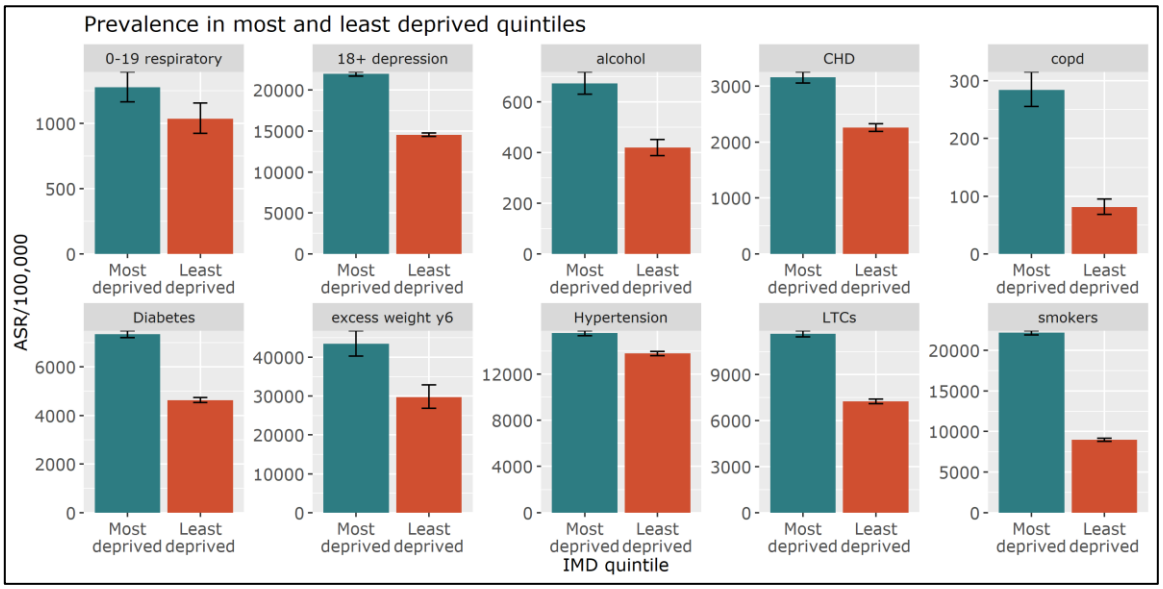

Figure 29 Prevalence of health outcomes for the most and least deprived quintiles

The graph below 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[1]. There is also a significant difference between males and females in the most and second most deprived that does not exist in the other deprivation quintiles.

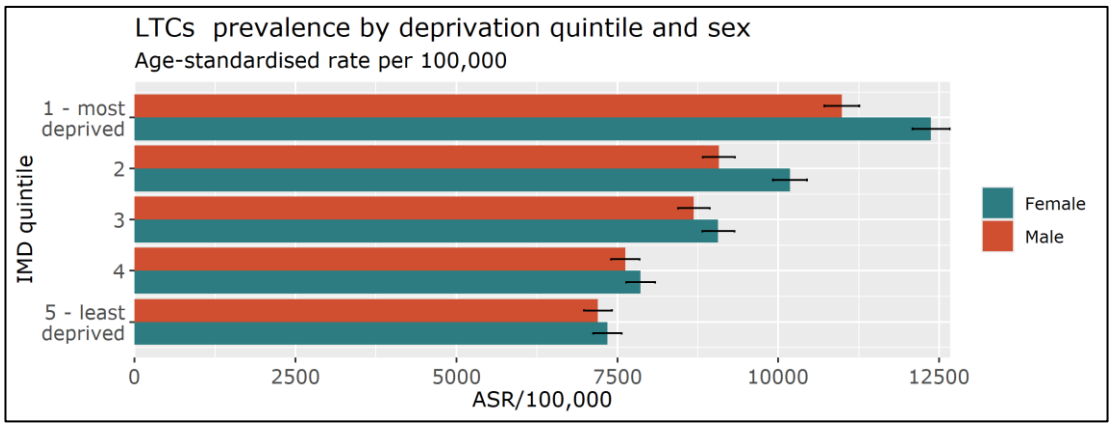

Figure 30 LTCs prevalence by deprivation quintile and sex

[1] The age-standardised rate (ASR) is a summary statistic which allows for the comparison of rates (e.g. dementia prevalence) between groups where the average age is not the same. This is important, as in this case, older adults are more likely to have multiple long-term conditions. Standardising for age allows us to compare differences in prevalence that are not due to differences in age.

The gap between males and females is wider and evident at a younger age group when deprivation is higher.

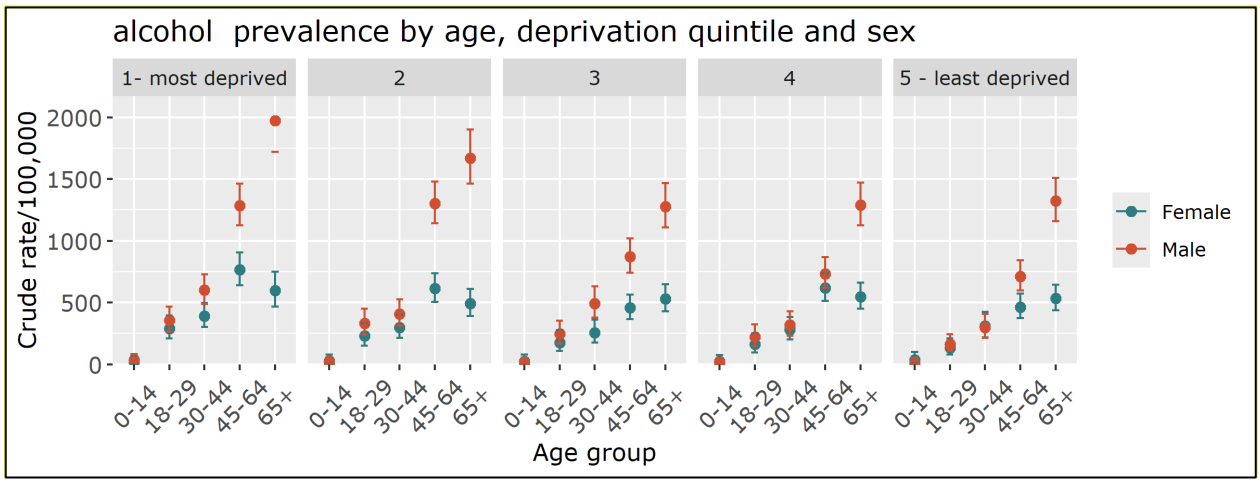

Figure 31 Prevalence of alcohol-related emergency hospital admissions by age, deprivation, and sex

When age is standardised, males have significantly higher rates of admission. Males in the most and second most deprived 20% of the population have significantly higher rates of admission compared to the least deprived.

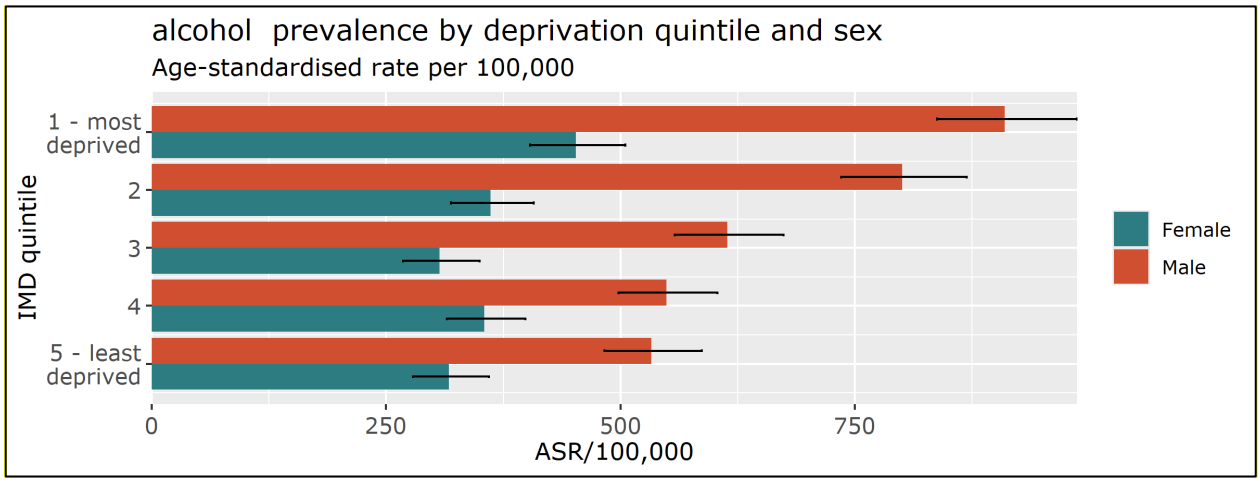

Figure 32 Prevalence of alcohol-related emergency hospital admissions by deprivation and sex

Males have significantly higher prevalence of hypertension in all deprivation groups and the gap between males and females increases as deprivation reduces. There is not a clear deprivation gradient but males and females in the most deprived 20% of the population have the highest rates of hypertension.

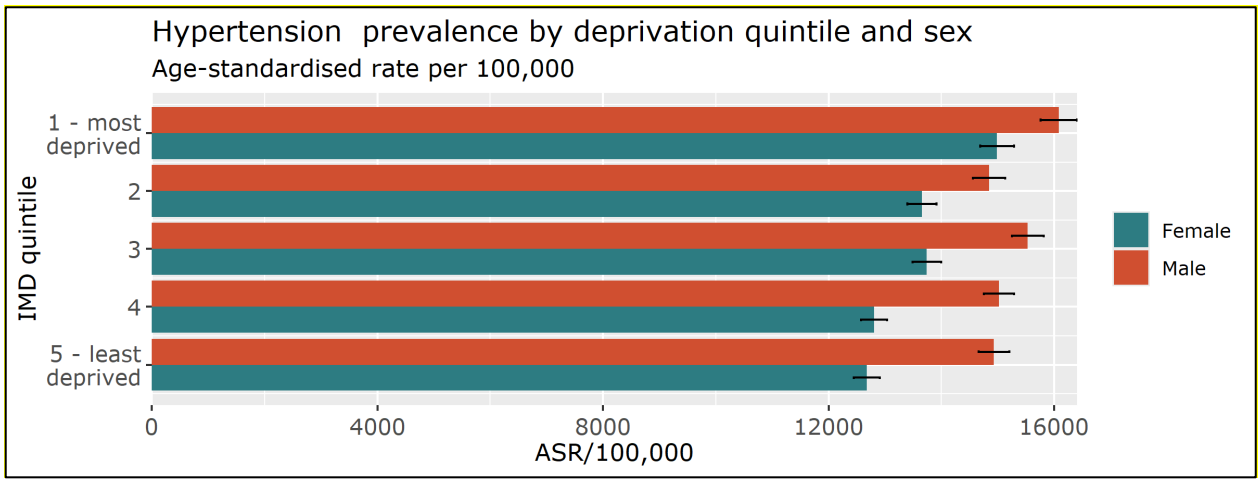

Figure 33 prevalence of hypertension by deprivation and sex

4.1.2.2. 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.

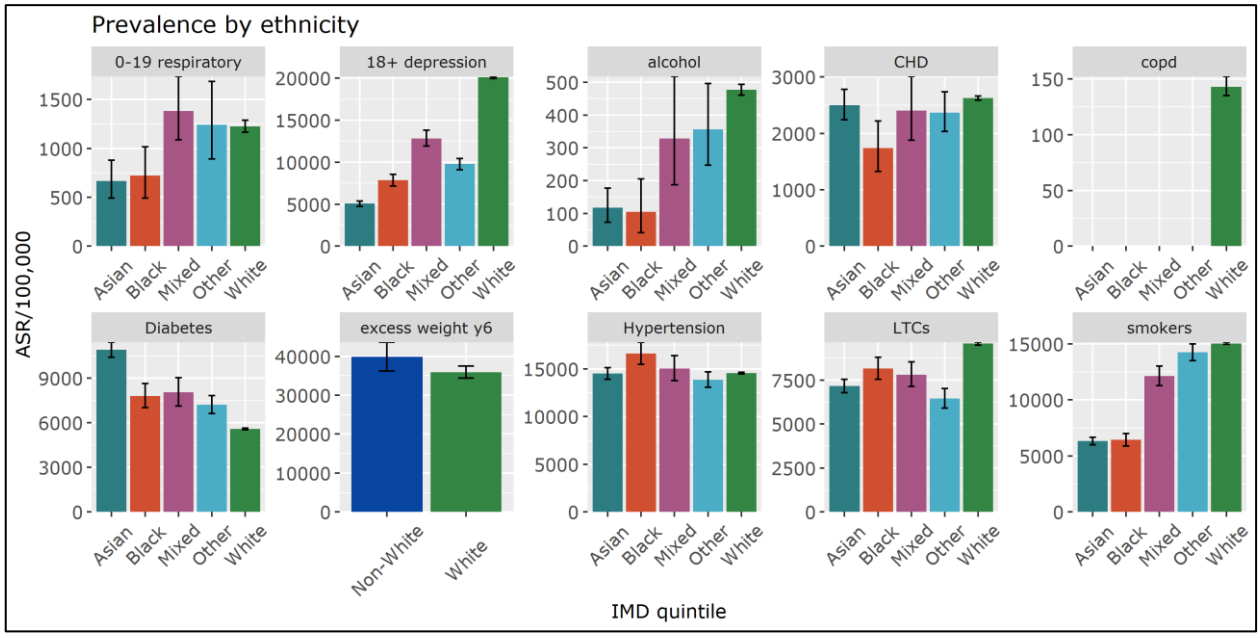

Figure 34 Prevalence of health outcomes by ethnicity

The rate of people with two or more long-term conditions before the age of 65 is higher in the White ethnic group at age 30-44 compared to the same age group in other ethnic groups suggesting that people in the White ethnic group become multi-morbid at a younger age. There is also a deprivation gradient in the White ethnic group that is not evident in other ethnic groups.

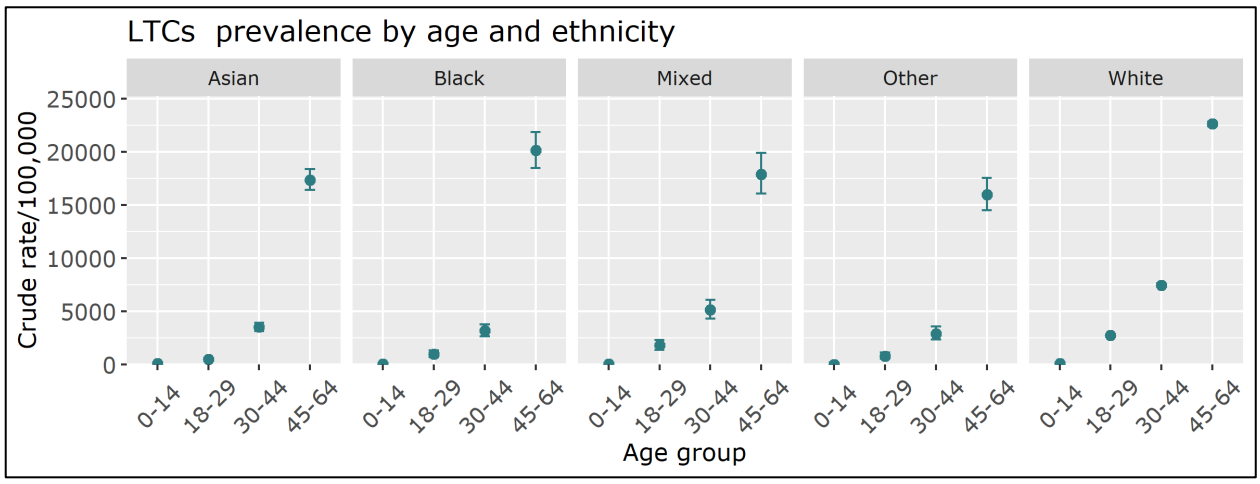

Figure 35 Prevalence of two or more long-term conditions by age and ethnicity

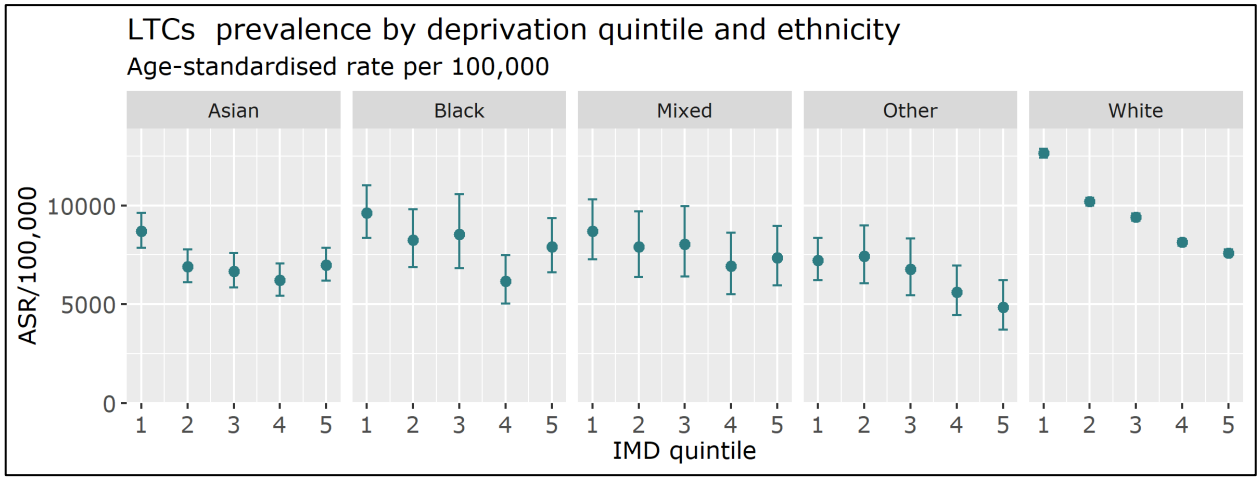

Figure 36 Prevalence of two or more long-term conditions by deprivation and ethnicity

In the Asian ethnic group, the rate of people with two or more long-term conditions before the age of 65 is higher for males compared to females. The rate is higher for females in the White ethnic group. In other ethnic groups, the rate is similar for males and females.

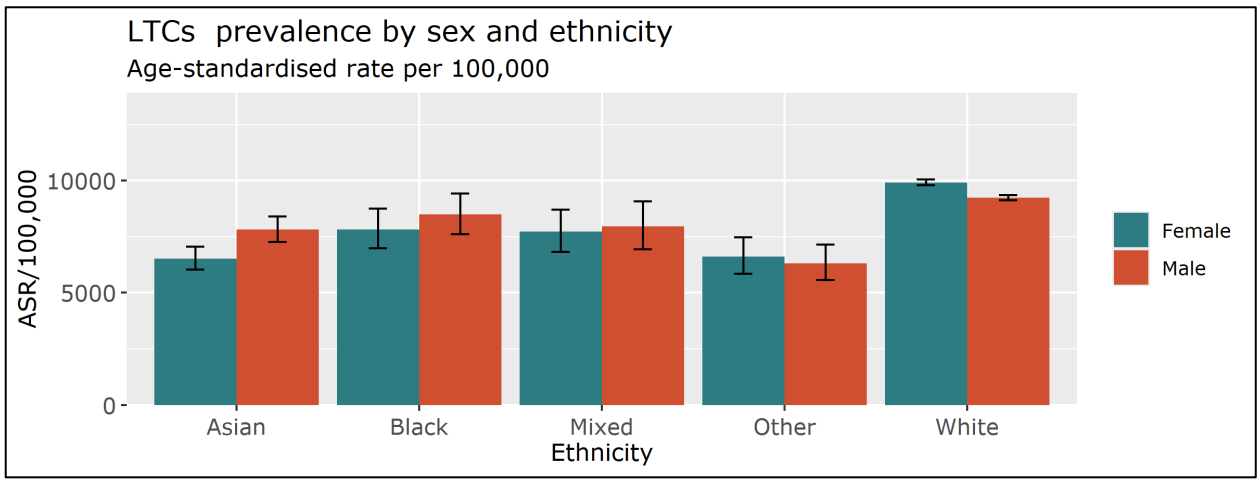

Figure 37 Prevalence of two or more long-term conditions by sex and ethnicity

In the Asian and Black ethnic groups, smoking prevalence does not vary as much by age as it does in other ethnic groups. In the Black ethnic group, smoking prevalence is highest in the 45-64 age group whereas in all other ethnic groups, prevalence is highest in the 30-44 age group.

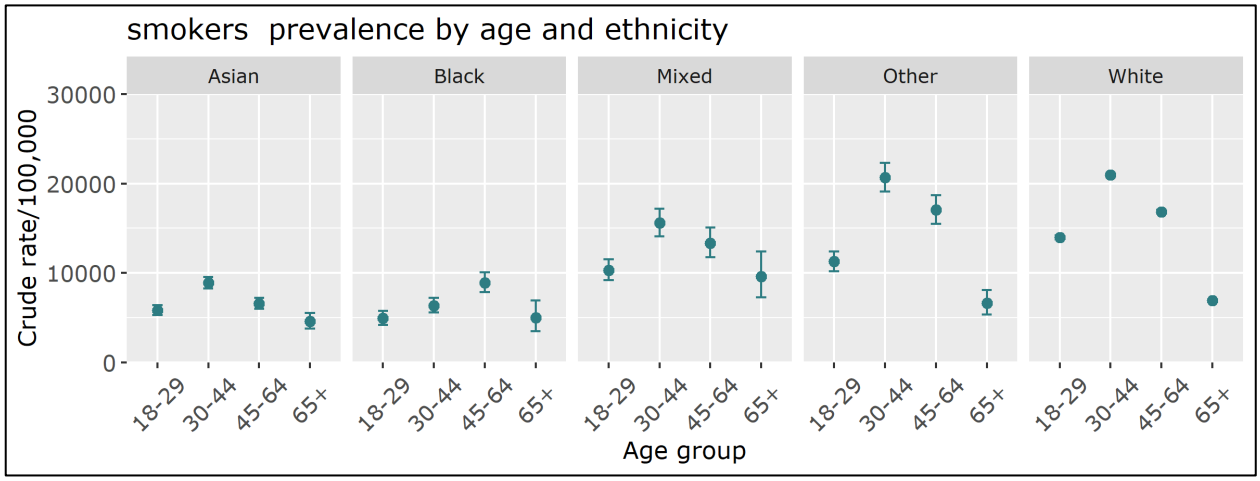

Figure 38 Prevalence of smoking by age and ethnicity

In the White ethnic group, smoking prevalence is approximately 40% higher for males. In the Black, Mixed and Other ethnic groups, prevalence is approximately twice as high for

males compared to females. In the Asian ethnic group, smoking prevalence is approximately four times higher for males.

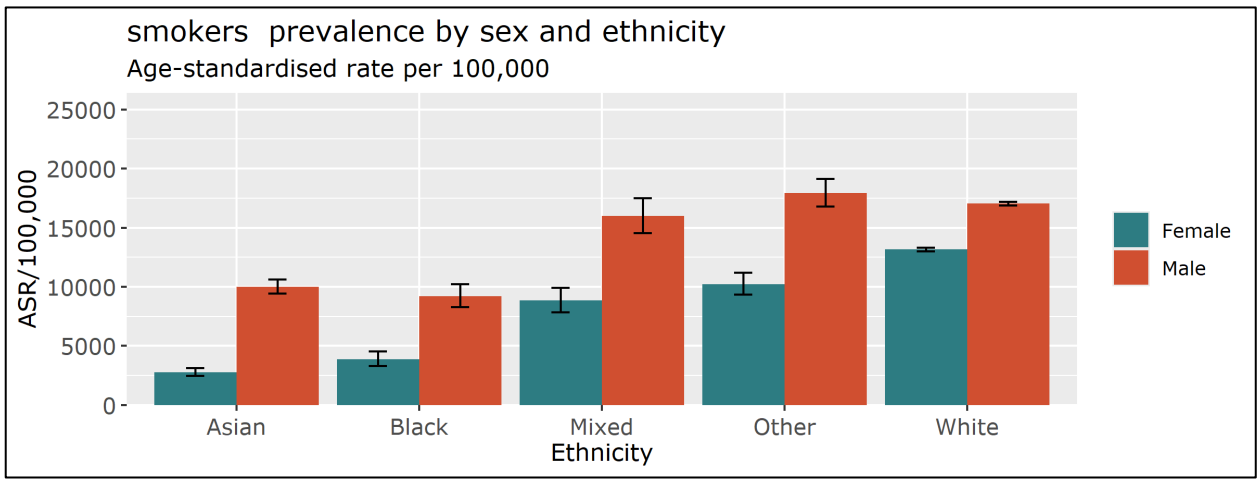

Figure 39 Prevalence of smoking by sex and ethnicity

Depression prevalence does not vary by age in the Asian ethnic group as it does in other ethnic groups. In the White ethnic group, depression prevalence is significantly lower in the 65+ age group compared to other age groups. This is not true for other ethnicity groups.

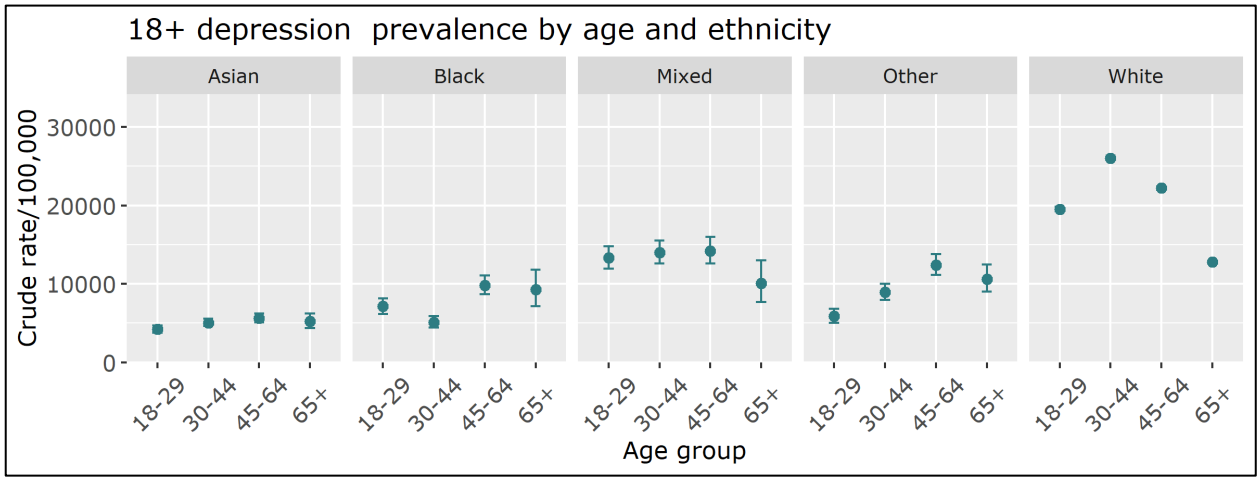

Figure 40 Prevalence of adult depression by age and ethnicity

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.

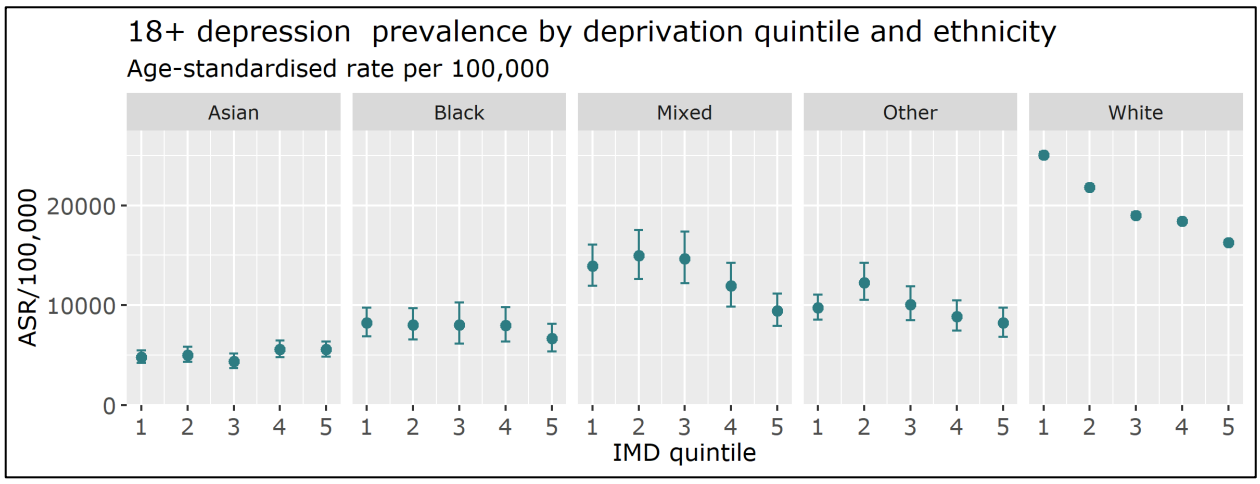

Figure 41 Prevalence of adult depression by quintile and ethnicity

Rates of depression are higher for females in all ethnic groups and the difference is most evident in the White ethnic group where the rate for females is 1.6 times higher than males.

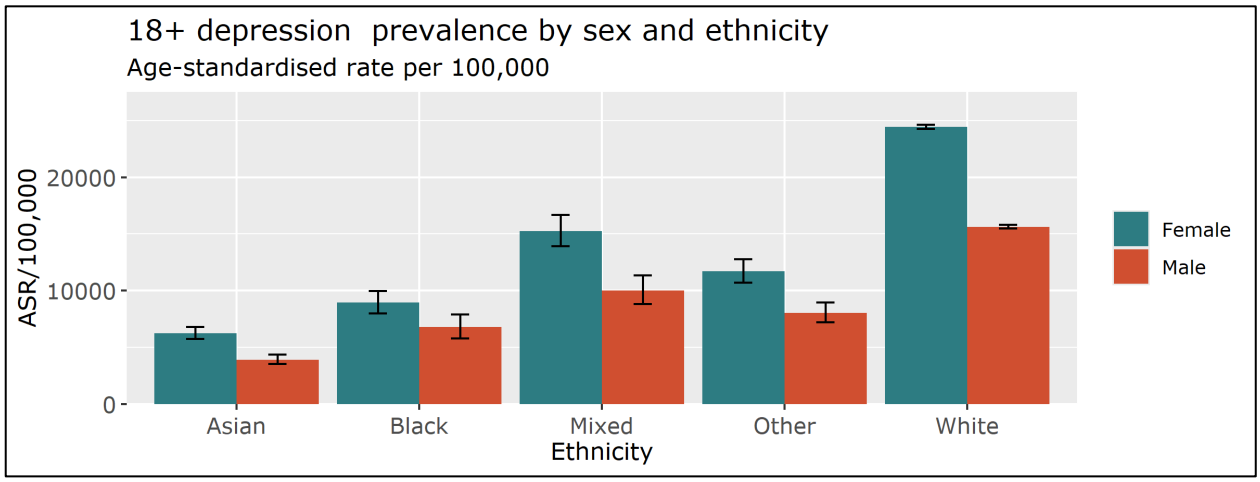

Figure 42 Prevalence of adult depression by sex and ethnicity

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 all other deprivation quintiles.

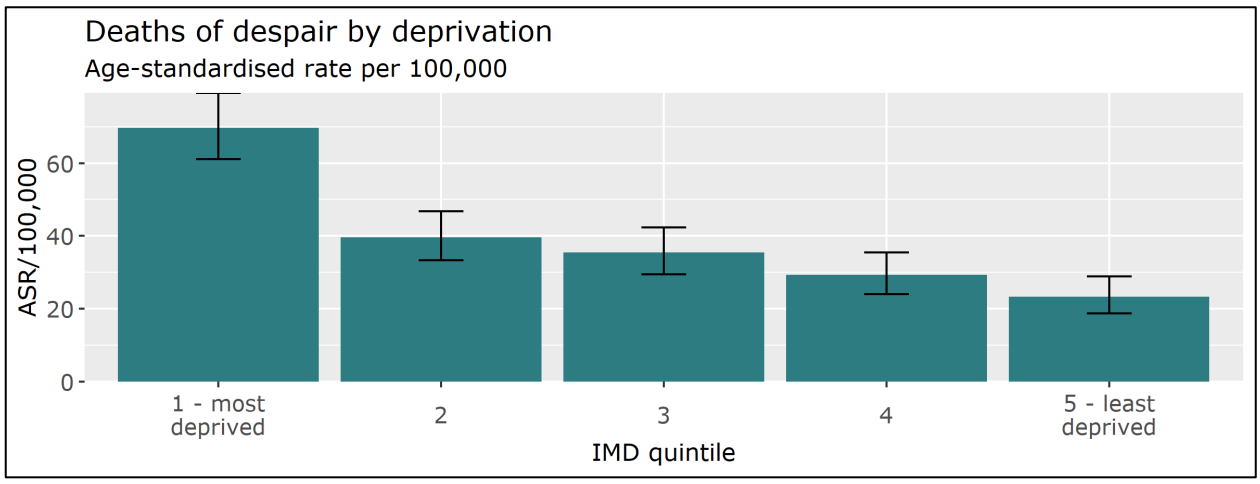

Figure 43 Prevalence of deaths of despair by deprivation quintile

4.2. Socio-environmental

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.

4.2.1. East Kent Population

The majority of the East Kent HCP area is rural, with large areas classified as rural village and dispersed. There are seven distinct areas classified as urban city and town, mostly located towards the coast.

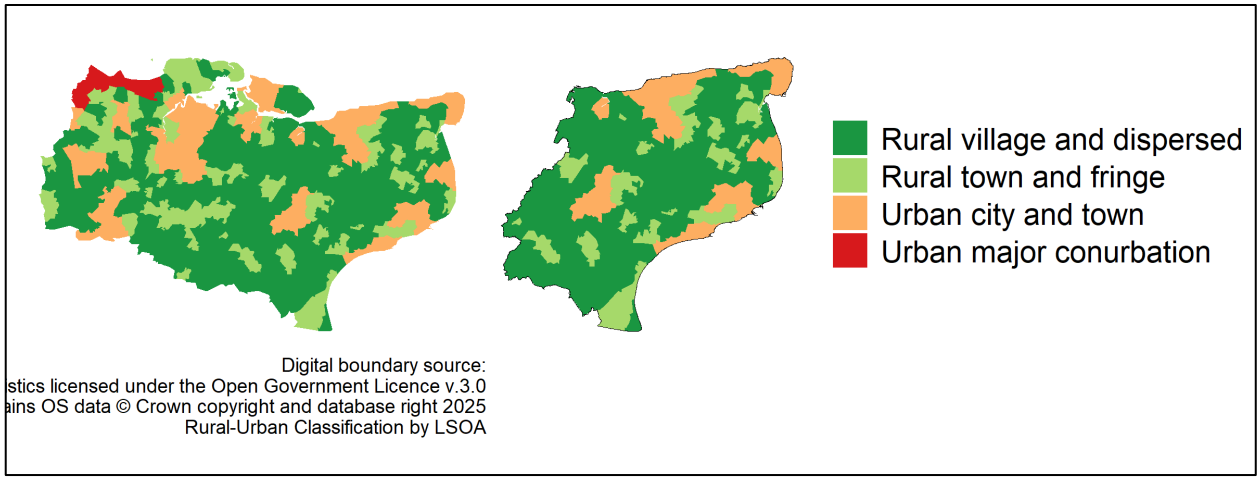

Figure 44 Area classifications across East Kent

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 5-minute walk).

Large areas in the east and west of the HCP area have very poor access to natural greenspace. There are small areas in urban settings and a larger area that extends beyond the town of Dover with very good access to greenspace.

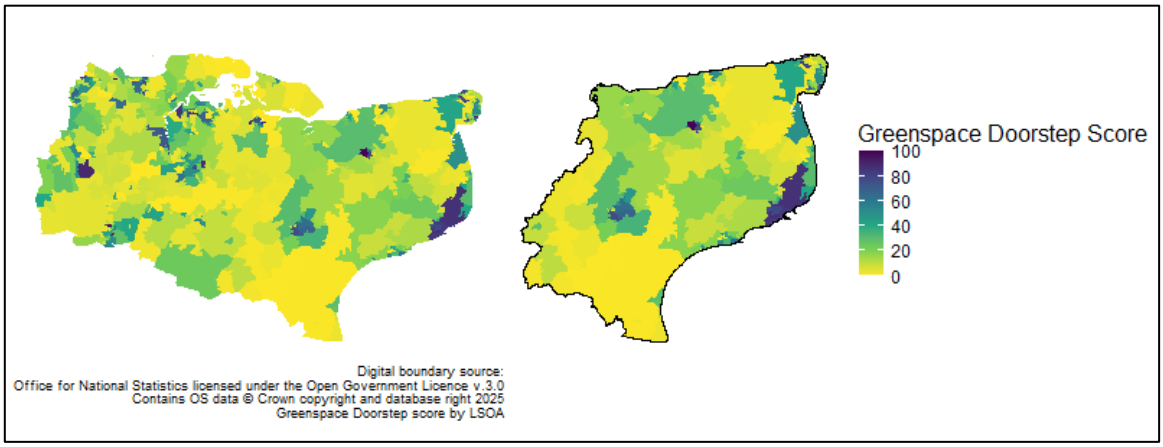

Figure 45 Greenspace Doorstep Scores across East Kent

LSOAs in the most deprived quintile have an average of 41% of the total LSOA area meeting the ANGSt doorstep standard. The percentage area meeting the ANGSt doorstep standard is similar across the four less deprived quintiles.

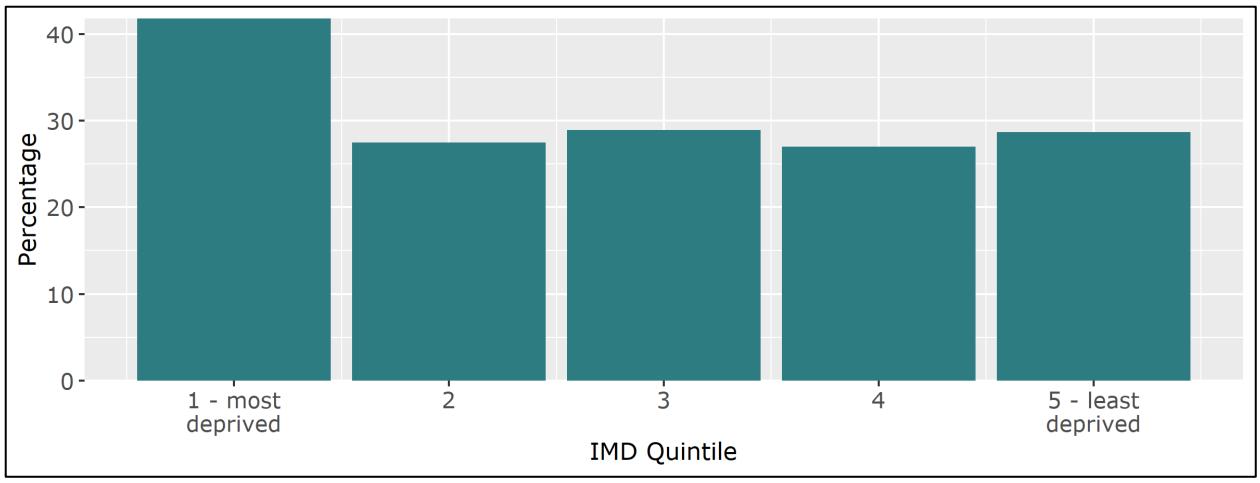

Figure 46 Percentage of total LSOA area meeting the ANGSt doorstep standard by IMD

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.

Overcrowding tends to be relatively low across the East Kent HCP. Higher rates are found within urban areas and there are two very small areas in Margate and Canterbury that have rates at the top of the scale.

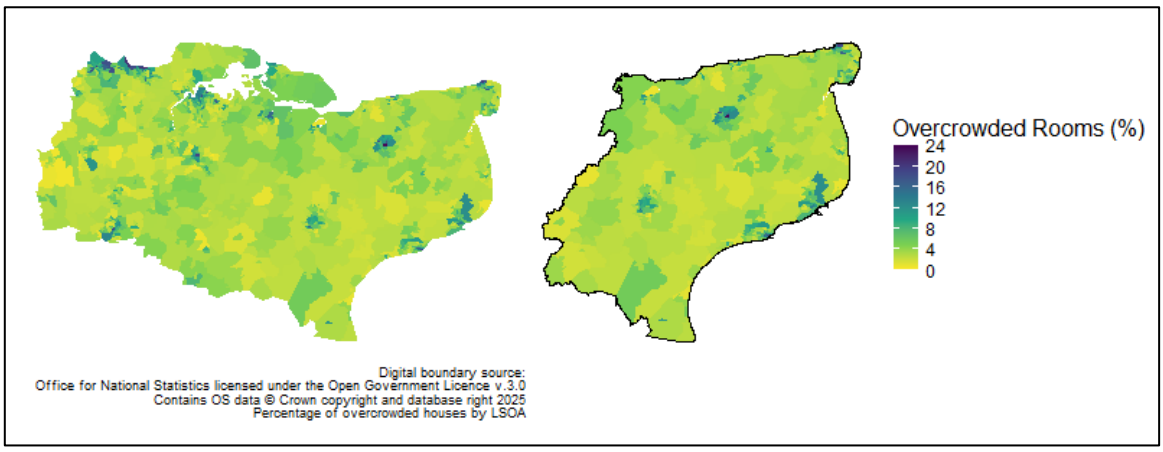

Figure 47 Overcrowding across East Kent

Household overcrowding follows a deprivation gradient: there is a greater proportion of overcrowded households in areas of higher deprivation.

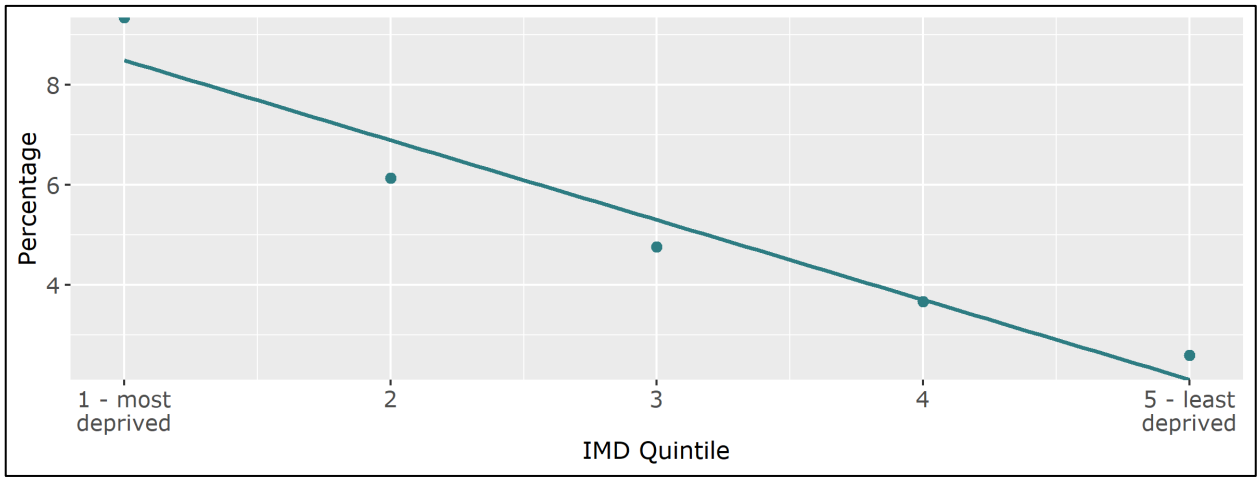

Figure 48 Household overcrowding by IMD

4.2.2. Health Outcomes

There is variation by health outcome and rates generally follow a similar pattern across the rural-urban spectrum, however, rural village and dispersed tends to have lower prevalence and hospital admission rates.

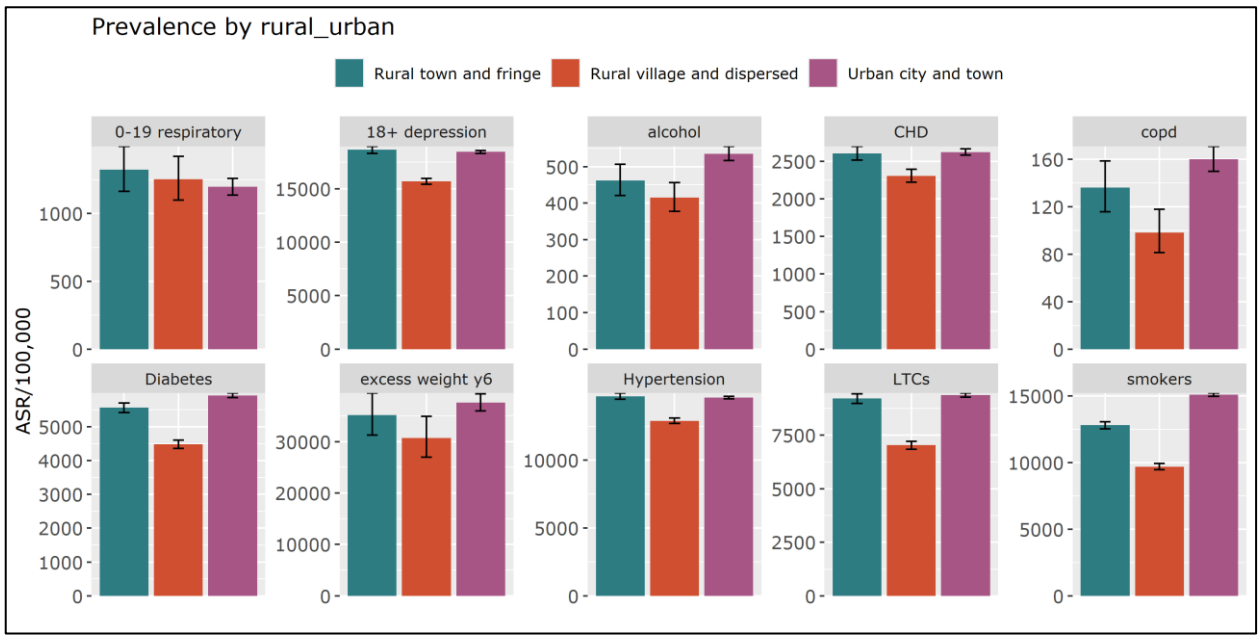

Figure 49 Prevalence of health outcomes by rural/urban divide

Coastal areas tend to have higher rates.

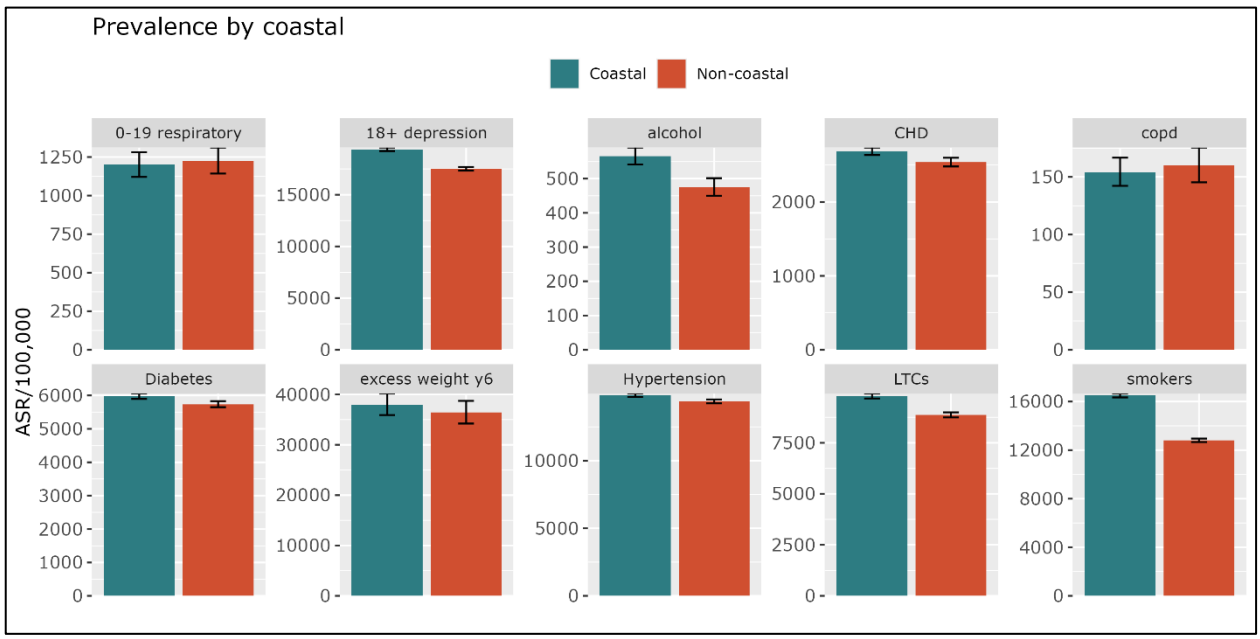

Figure 50 Prevalence of health outcomes by coastal/ non-coastal divide

Diabetes prevalence is higher in coastal areas. However, in the most deprived 20% of the population, prevalence is higher in non-coastal areas.

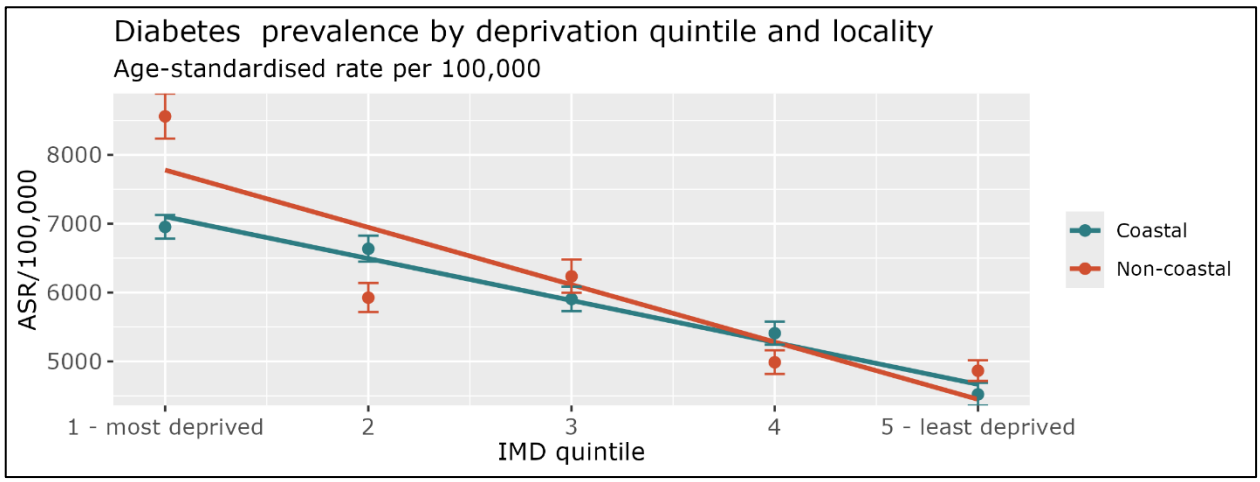

Figure 51 Prevalence of diabetes by deprivation and coastal/ non-coastal divide

The prevalence of excess weight in school year 6 is higher for males in non-coastal areas whereas in coastal areas, male and female rates are similar. By ethnic group, prevalence is higher in coastal areas for the White ethnic group but higher in non-coastal areas for the non-White ethnic group.

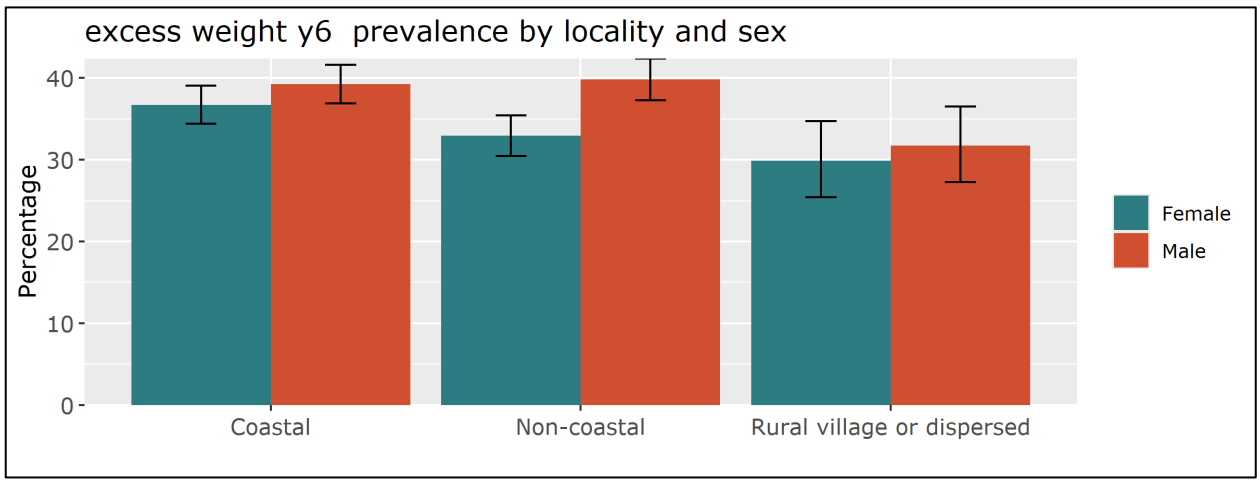

Figure 52 Prevalence of excess weight in school year 6 by locality and sex

The rate of hospital admissions for respiratory conditions in children aged 0-19 is higher for males compared to females but this is not evident in rural town and fringe.

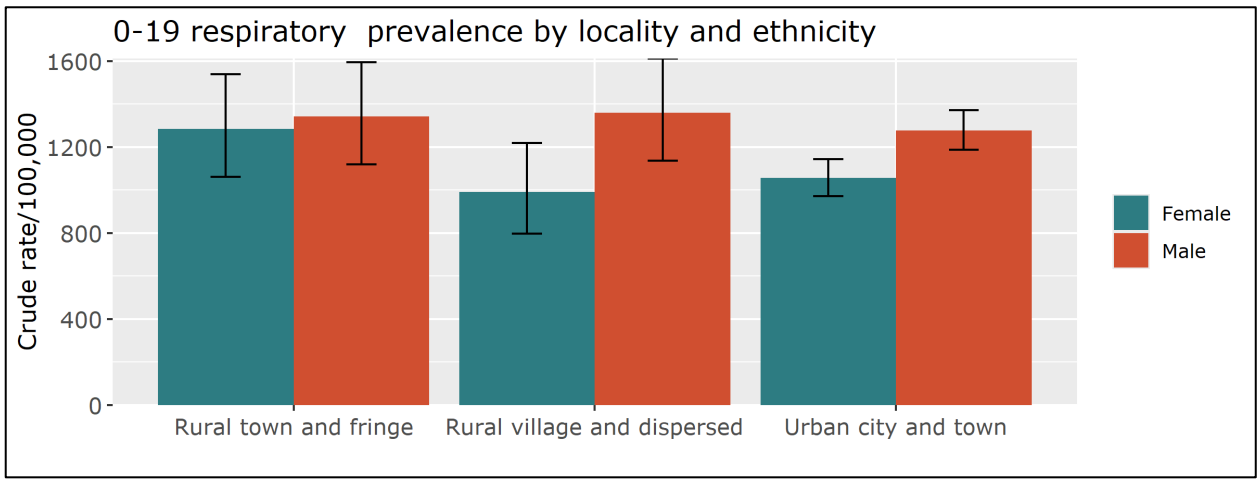

Figure 53 Prevalence of child respiratory conditions by locality and ethnicity

The difference between coastal and non-coastal areas in the prevalence of the following health outcomes appears to be modified by household overcrowding:

- People with two or more long-term conditions under the age of 65
- Smoking prevalence aged 16 plus
- Hospital admission episodes for alcohol-related conditions
- Depression prevalence aged 18 plus
- Emergency hospital admissions for diabetes

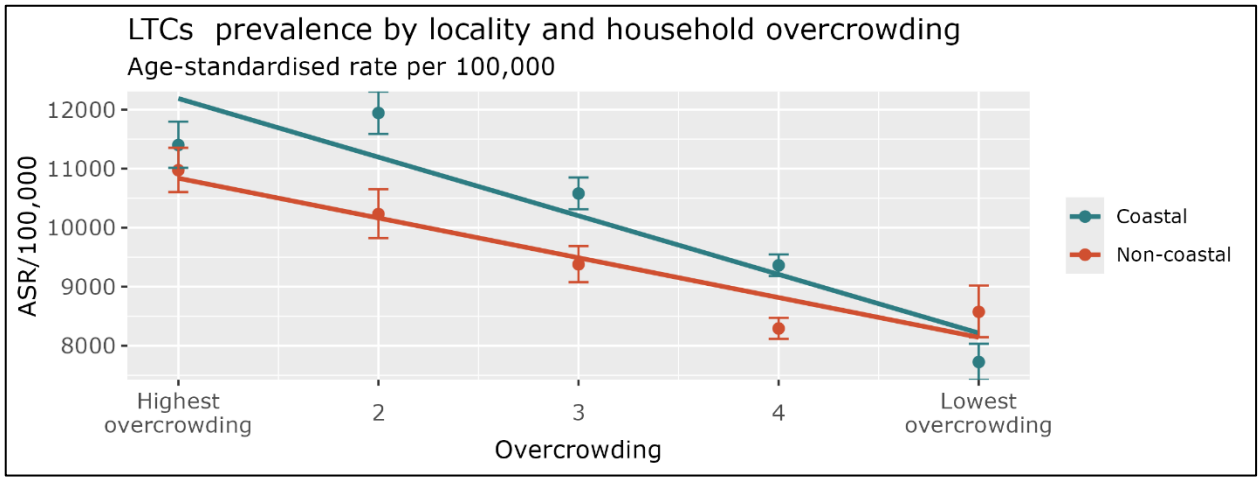

Figure 54 Prevalence of two or more long term conditions by locality and household overcrowding

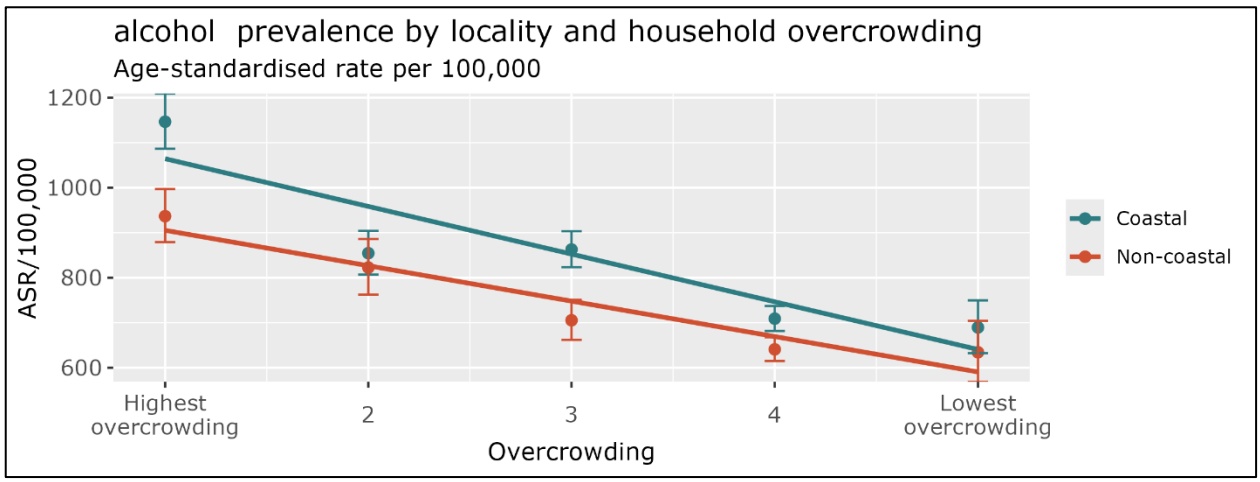

Figure 55 Prevalence of alcohol-related emergency hospital admissions by locality and household overcrowding

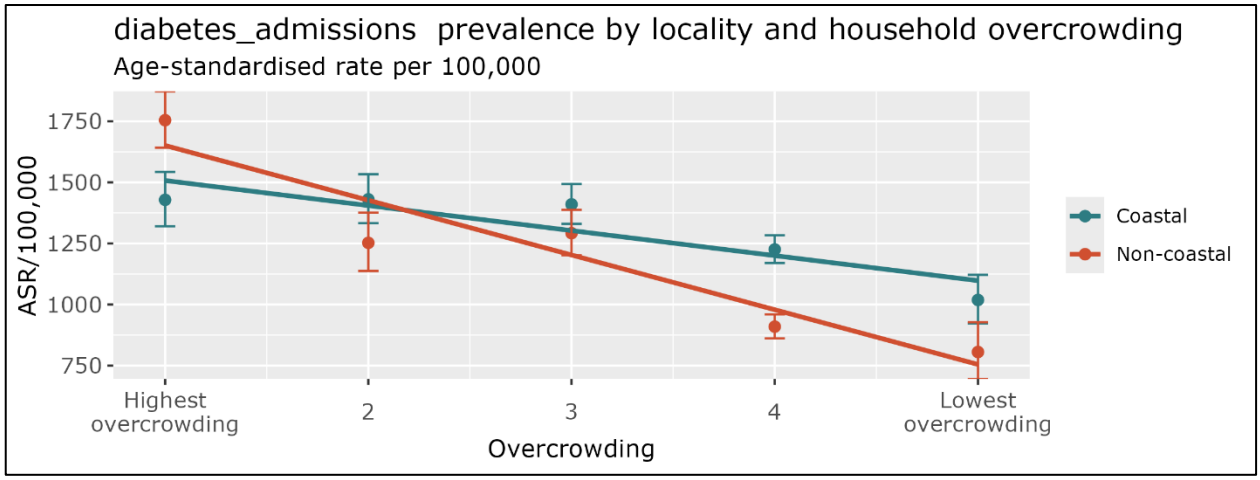

Figure 56 Prevalence of diabetes admissions by locality and household overcrowding

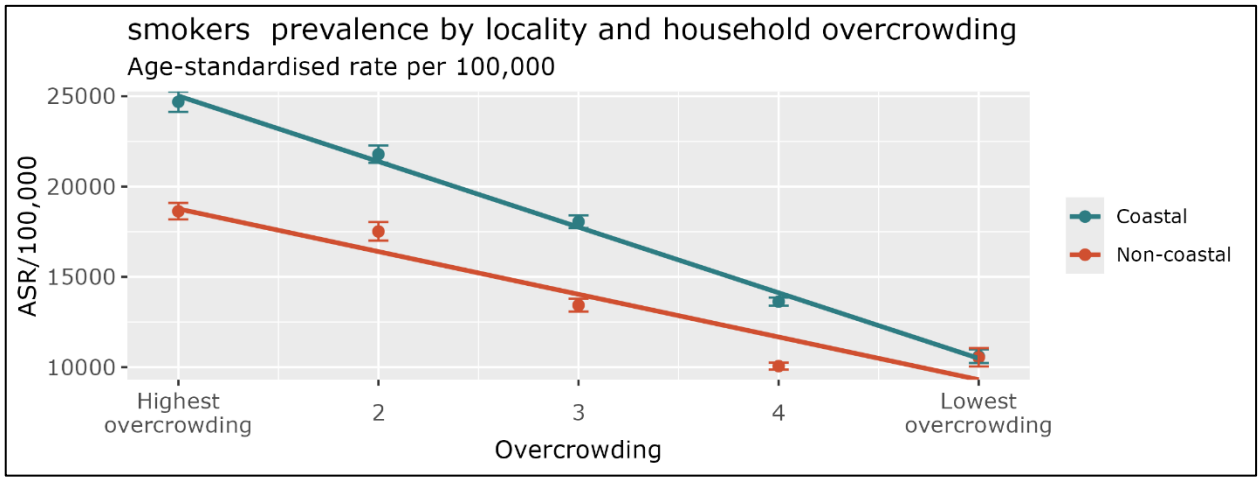

Figure 57 Prevalence of smoking by locality and household overcrowding

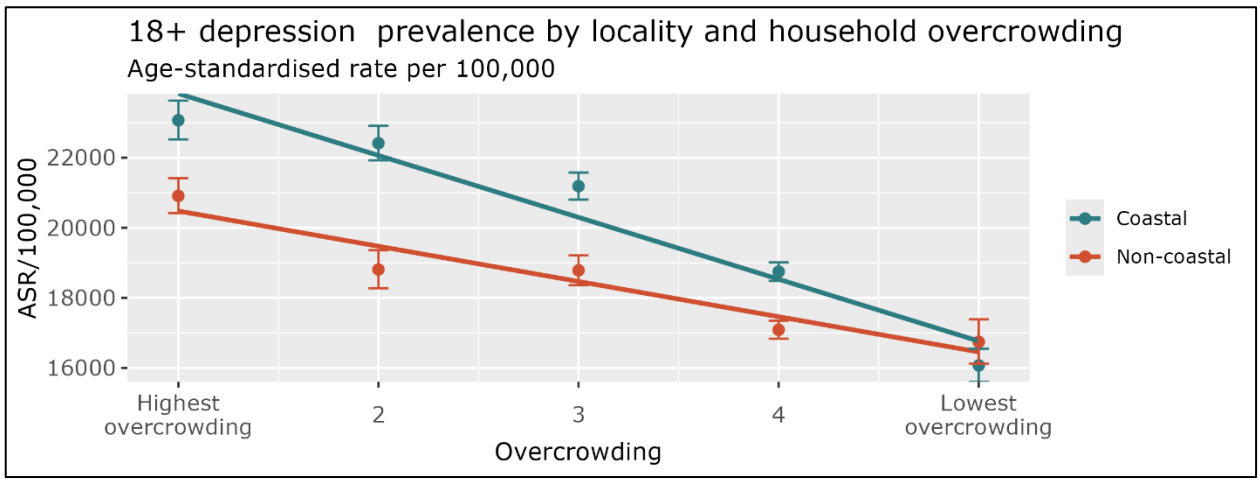

Figure 58 Prevalence of adult depression by locality and household overcrowding

The relationships between emergency hospital admissions for diabetes and household overcrowding and between depression prevalence and household overcrowding appear to be modified by rural-urban classification.

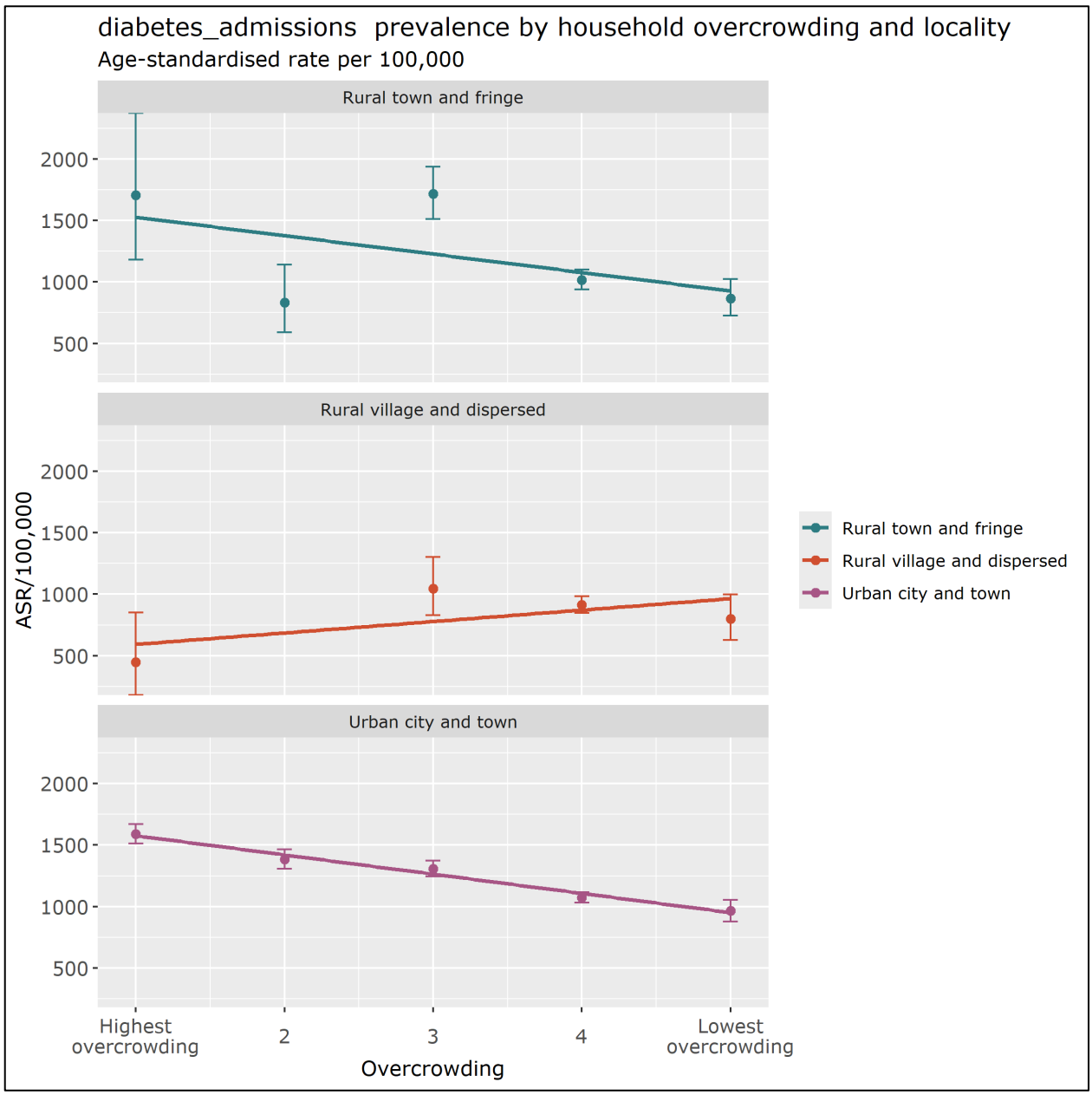

Figure 59 Prevalence of diabetes admissions by household overcrowding and locality

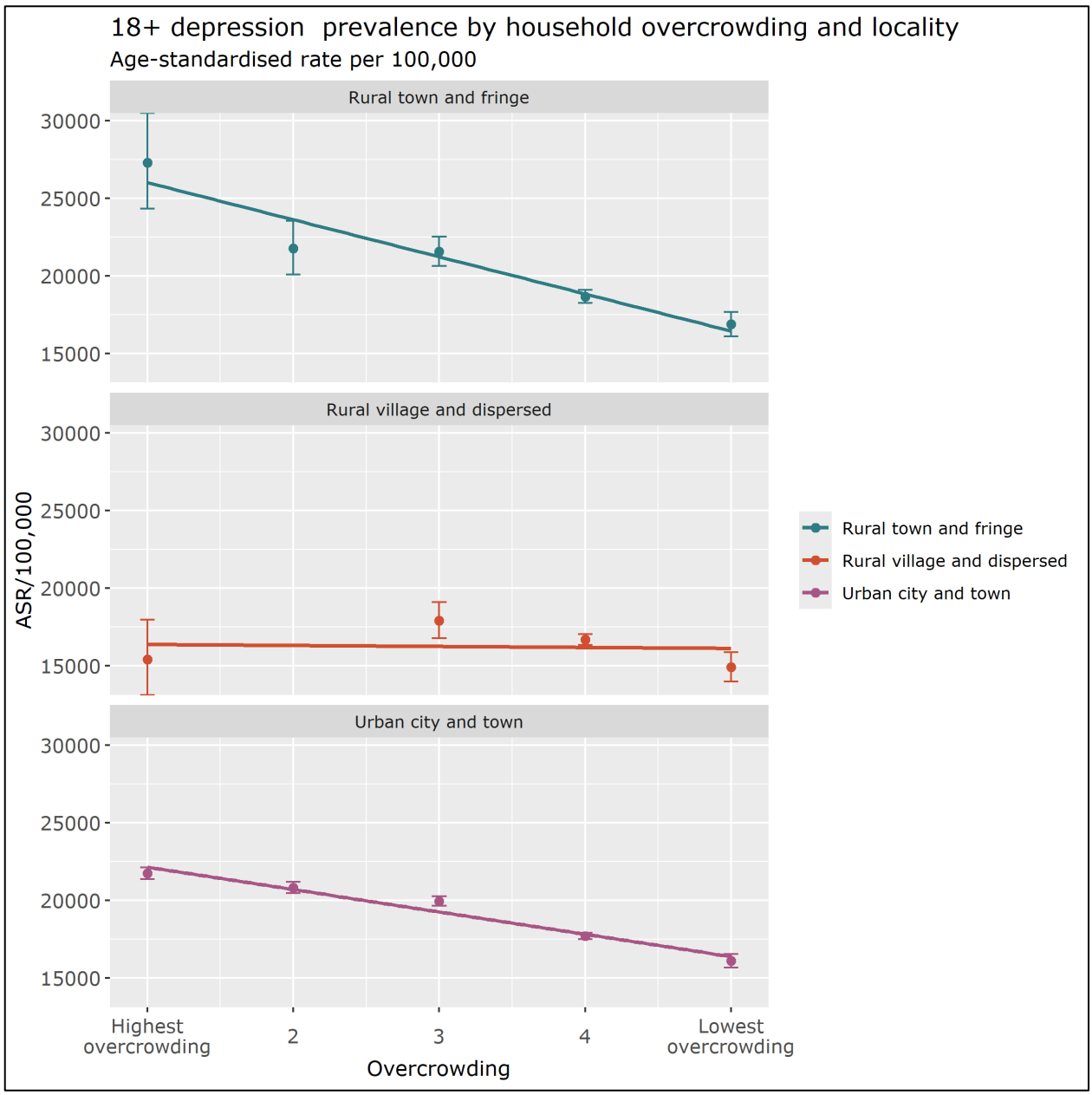

Figure 60 Prevalence of adult depression by household overcrowding and locality

4.3. Findings

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

4.4. Recommendations

- Interventions and services, especially those targeting the most deprived, should be culturally competent as a higher proportion of those in ethnic minority groups are also in the most deprived quintiles. Given poor health outcome rates tend to be higher in the most deprived groups, services need to be easily accessible by the most deprived in the population.
- Hospital admissions due to alcohol related conditions is a key concern in deprived men. This should be a focus of further inquiry. Interventions to reduce alcohol dependence should be focused on this group.
- Differences in rates of depression between ethnicities should be investigated. The reliability of data and consistency in how symptoms are reported, and diagnoses are made and recorded should be ascertained.
- Deaths of despair are an important focus for interventions, particularly in the most deprived. Existing services should be assessed to ensure that the most deprived people are both aware of, and can access, these services. Barriers to awareness and

access should be assessed, and steps taken to address any findings. This may include further cultural competency training, or targeted advertising of existing services.

5. Cohort Modelling

This section of the report summarises the findings of a system dynamic approach to understanding 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; people with multiple conditions or complex needs; and people who are frail. 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 East Kent 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.

5.1. Methods

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 position in which levels of risk factors do not change and demonstrate the contribution to the overall burden of health needs that improvements in risk factor prevalence could make.

To create outputs for East Kent, model outputs for Ashford, Canterbury, Dover, Folkestone and Hythe, Thanet and one third of Swale were summed to create East Kent. 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.

The ICS target on loneliness is to reduce it from 7.3% to less than 5% in Kent and Medway by 2028. For physical inactivity by 2028, the percentage of adults in Kent and Medway who are physically inactive should have fallen from 22.3% to 20%. By 2028, the

percentage of adults in Kent and Medway who are overweight or obese will have fallen from 64.1 per cent to 62 per cent.

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 9 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
Alcohol	0.3% yearly reduction

Table 10 Risk factors and the conditions they effect

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		

5.2. Outputs

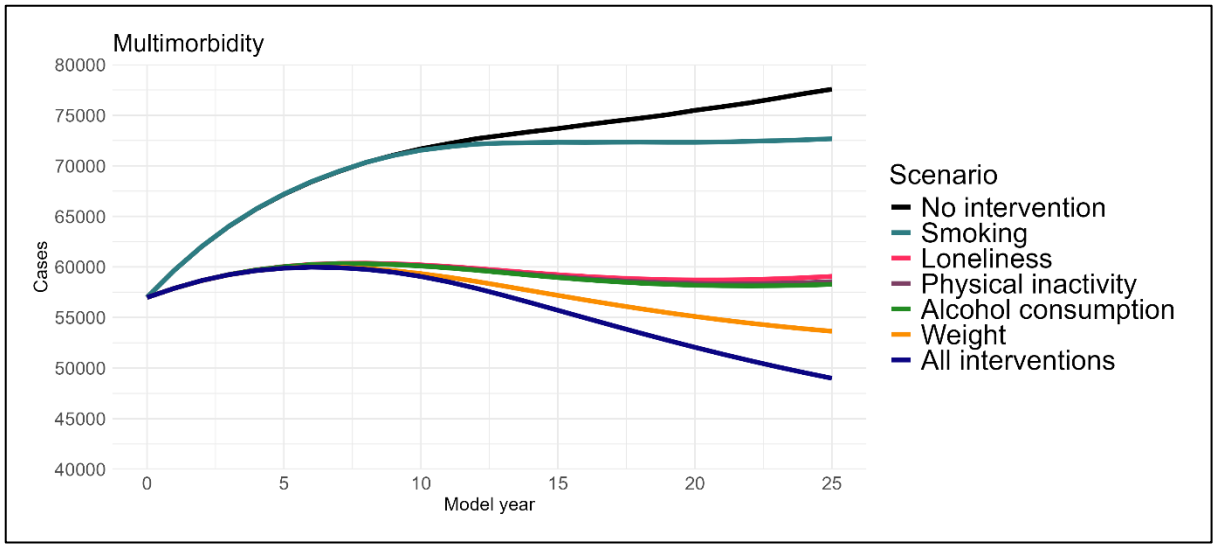

Figure 61 Modelled cases of multimorbidity across a range of hypothetical scenarios

Multimorbidity will be increasingly prevalent as the population ages and develops an increasing number of comorbidities. In the absence of interventions, multimorbidity is predicted to increase by approximately 27%. By implementing all five interventions, we instead see a reduction in multimorbidity within approximately 10 years. Due to the large incoming 'baby-boomer' generation who are expected to live into older age in high

numbers, we expect that the benefits of preventative action will be much more impactful if intervention is undertaken sooner, rather than later.

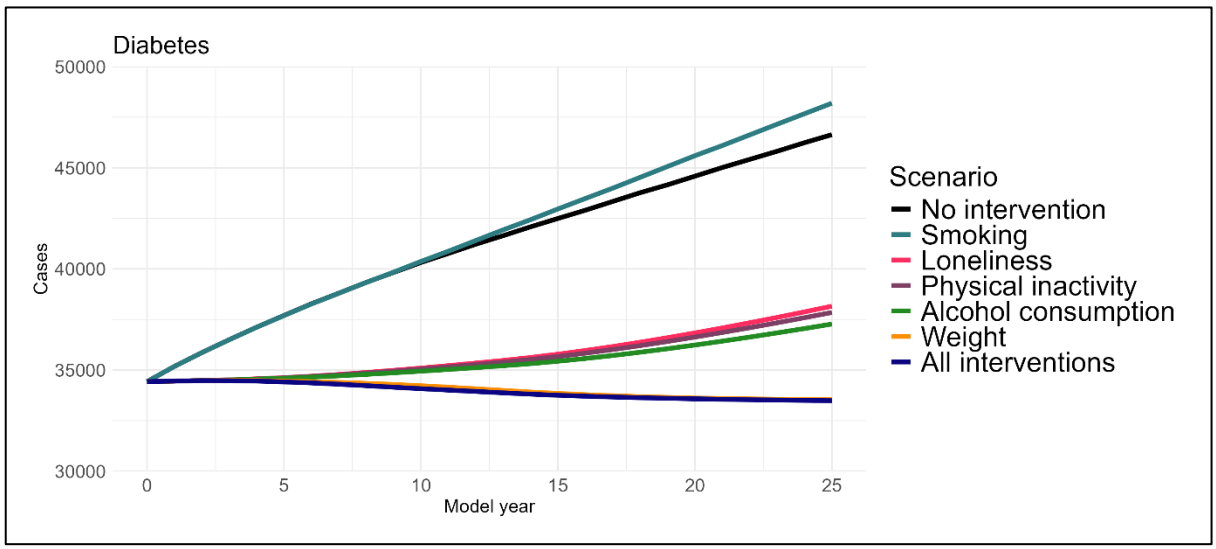

Figure 62 Modelled cases of diabetes across a range of hypothetical scenarios

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

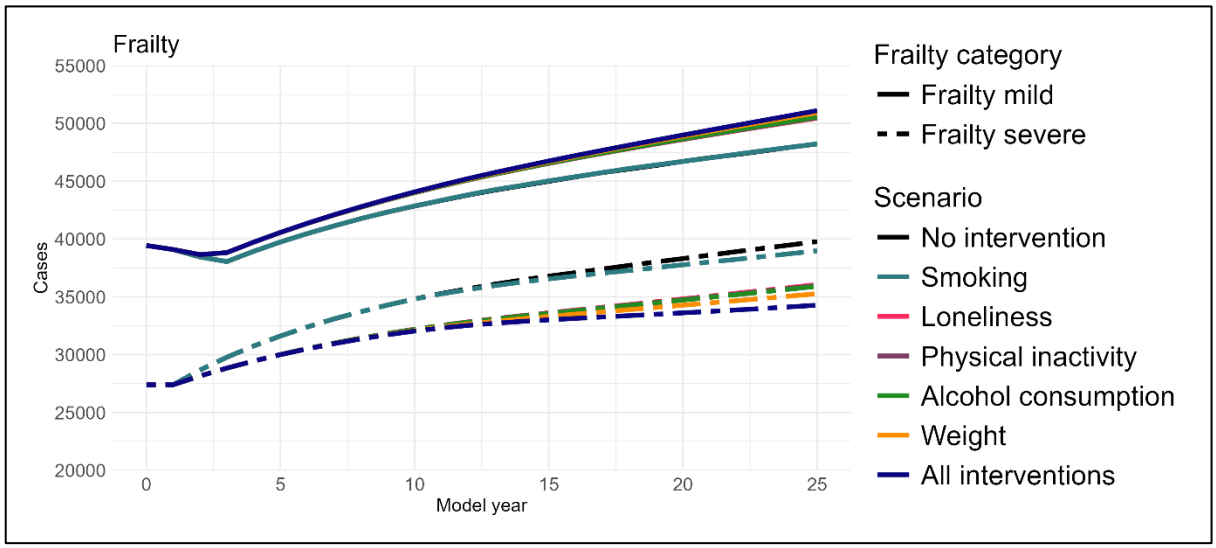

Figure 63 Modelled cases of frailty across a range of hypothetical scenarios

Frailty is an important target for public health interventions, as it will account for an increasing proportion of morbidity and mortality as the population ages. Cases of frailty are likely to increase, even in the scenario where all interventions are achieved. This is likely largely driven by the significant increase in the older population, who are at greater

risk of frailty. The difference in forecasted cases between the no-intervention and all-intervention scenarios is much greater when looking at severe frailty than mild frailty. This suggests to us that the modelled interventions result in people living longer, and ultimately still becoming frail, but that their frailty will be less severe with our interventions. The overall significant increase despite the interventions show that frailty represents a difficult target to address, and resources should be allocated to prepare for this increase over the next 25 years.

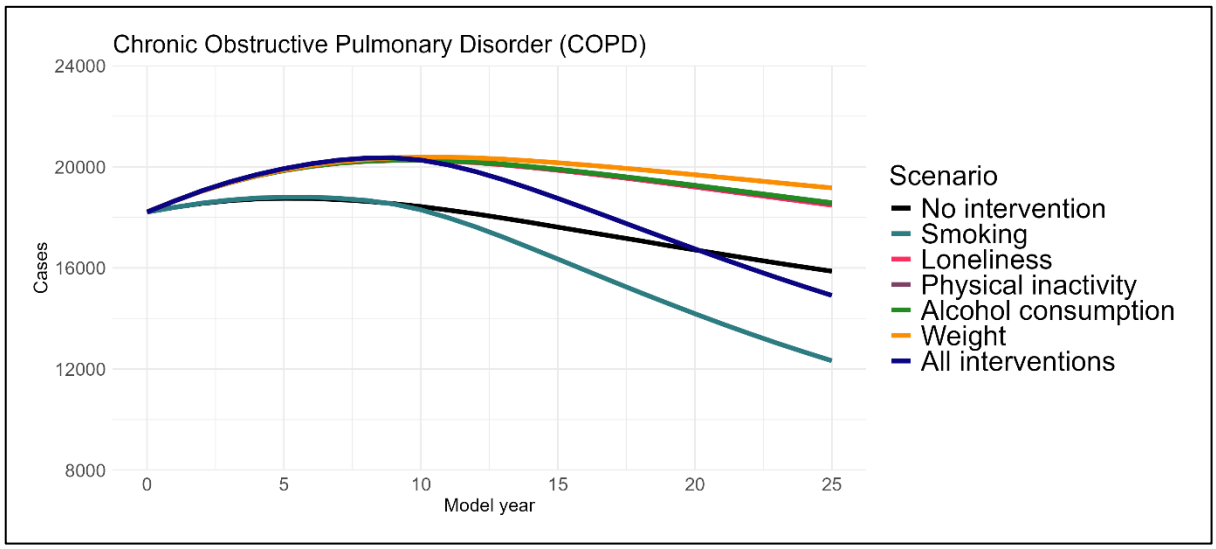

Figure 64 Modelled cases of COPD across a range of hypothetical scenarios

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

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

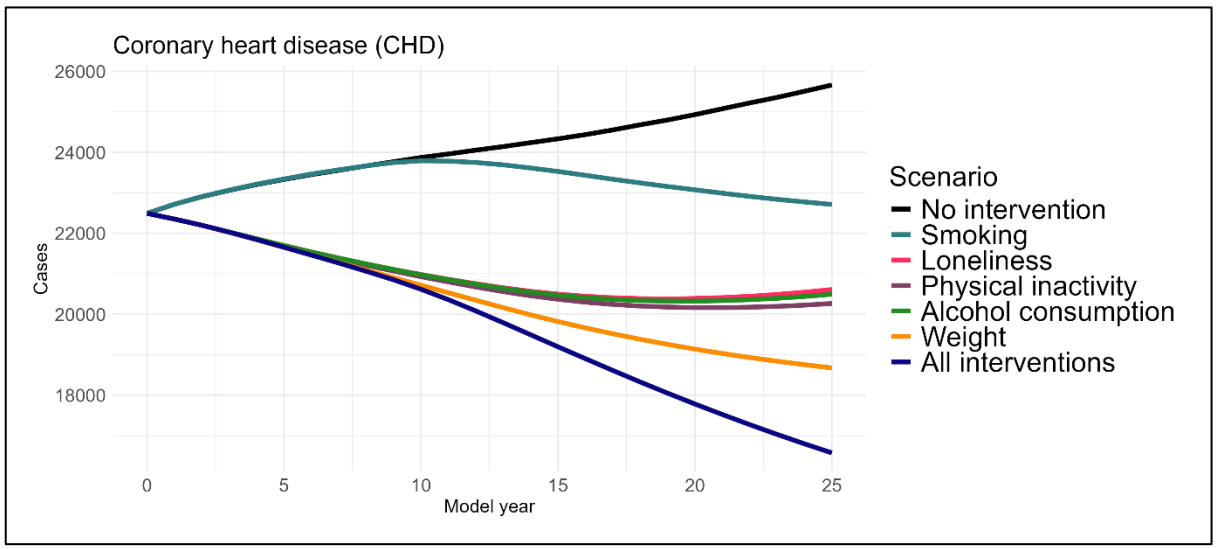

Figure 65 Modelled cases of CHD across a range of hypothetical scenarios

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

5.3. Summary

- Preventative action is of much greater value if taken sooner, rather than later.
- Smoking, physical inactivity, and weight loss are important interventions in this model.
- Some interventions may result in a paradoxical increase in cases for some conditions. This increase in morbidity is likely due to a decrease in mortality.
- Significant health improvements might be achieved through these public health interventions, most notably in reducing cases of CHD.
- Despite the effect of combined interventions, cases of some conditions, notably frailty, are still likely to rise significantly. As such, services should prepare to see greater demand over the next 25 years.

6. Child Health (Ages 0 to 4)

6.1. Introduction

The 1,001 days from conception until a baby's second birthday is a critical period for growth and 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.

More information can be found in the 2022 HNA for 0-4 year olds.

6.2. Best Practice

6.2.1. The Healthy Child Programme

The Healthy Child Programme launched in 2009. Is the national evidence-based universal programme for children aged 0-19. The programme 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 on health, wellbeing and parenting. The programme aims to bring together health, education, and other key partners to deliver an effective programme for prevention and support. Health Visitors lead the 0 to 5 elements of this programme. The programme has been supplemented by additional evidence over the last decade and there is national commitment to modernise the programme over the next few years.

In 2021, Public Health England published the revised Health Visiting model, commissioning guidance and high impact areas, updated with new evidence and emerging policy developments, based on feedback from service users, professionals working in this space and commissioners.

The High Impact Areas provide an evidence-based framework for those delivering maternal and child public health services and are central to the health visitor delivery model. The 6 early years high impact areas are listed below:

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

6.2.2. Legislation: Working Together to Safeguard Children 2023

In 2023, the government revised the Working Together to Safeguard Children, statutory guidance on multi-agency working to help, protect and promote the welfare of children. The revised guidance focuses on strengthening multi-agency working across the whole system, keeping a child-centred approach while bringing a whole-family focus, and embedding strong, effective and consistent multi-agency child protection practice. The updates include principles for working with parent and carers, expectations for multiagency working, and new national multi-agency child protection standards.

6.2.3. 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.

In April 2022, the government announced investment for 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's objective is 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. KCC is 1 of the 75 local authorities taking part in the scheme and are 1 of only 14 trailblazers for the programme.

6.2.4. No Child Left Behind

"No child left behind... a public health informed approach to improving outcomes for vulnerable children" is a Public Health England report that highlights the need for a focus on reducing vulnerabilities and addressing inequalities. The report sets out how adopting a public health informed approach offers substantial opportunities to reduce inequalities and improve health and wellbeing outcomes for the most vulnerable children.

6.2.5. 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. This was applied to adults and subsequently adapted for children and young people. The model for children highlights the need for focus on asthma, diabetes, epilepsy, oral health, and mental health

6.3. Epidemiological Findings

6.3.1. Infant Mental Health and Parent Infant Relationships

The time from conception until a baby's second birthday is an important period for development. Our experiences in this time lay the foundations for a wide range of future health and mental health outcomes. Experiences of warm, consistent, and loving care in this period supports a baby's development and wellbeing throughout childhood and

into adulthood. In contrast, experiencing adversity in this period is more associated with subsequent difficulties than adversity occurring in other periods over a lifetime.

There can be many reasons why parents and carers may struggle to provide the warm and consistent care that babies need. This can include mental health difficulties, experiencing stress such as financial, housing and relationship difficulties or having had difficult experiences and trauma earlier in life. It is estimated that 2,937 parent-infant relationships may need support in Kent each year between 2024 to 2029.

. The term perinatal mental health means the way a parent or carer may think or feel when they are expecting a baby or caring for an infant. 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. It is estimated that 6,663 parents and carers may need perinatal mental health support in Kent at a mild-to-moderate level each year between 2024 to 2029.

The Kent 0-4 Health Needs Assessment (2022) identified that the mental health and wellbeing of under 5-year-olds is largely unknown and that the understanding of the impacts are misplaced.

6.3.2. Deprivation

According to the Income Deprivation Affecting Children Index (IDACI) the top twenty most deprived Lower-layer Super Output Area (LSOA) within Kent are all in coastal areas (particularly in Thanet and Folkestone & Hythe). Please see the full report for more detail for LSOA and ward level data which identifies a number of East Kent wards/ LSOAs as 'most deprived'.

6.3.3. 0-4 years old living in low-income families

In 2022/23 Thanet, Dover and Folkestone and Hythe have had the highest proportion of all children aged 0-4 years old living in absolute low-income families and the proportion of all children aged 0-4 years old living in relative low-income families. In the same period, Thanet had the highest numbers of children aged 0-4 living in absolute (1,380) and relative low-income families. Almost a quarter of children aged 0-4 years in Thanet are living in relative low-income families.

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. Poverty has a significant impact on children's life chances. Children living in poverty are more likely to die in the first year of life, to breathe secondhand smoke, be bottle fed, become overweight, suffer from asthma, have tooth decay, perform poorly at school, and die in an accident.

6.3.4. 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."

In 2022/23, the proportion of babies born in EKHUFT whose first feed was breast milk was 64.5%, well under the number for England, at 72.9%. It was also the lowest across Kent. 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. 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.

Breastfeeding rates at 6-8 weeks vary by district across East Kent Thanet and Dover continue to have the lowest figures of any district in all of Kent.

Table 11 Breastfeeding prevalence (%) by district at the 6–8-week check, 2019/20 - 2022/23 (Source: KCHFT performance data)

	2019/20	2020/21	2021/22	2022/23	2023/24
Ashford	49.5%	48.7%	49.7%	54.4%	51.0%
Canterbury	51.6%	51.8%	52.2%	52.9%	59.8%
Dover	42.0%	45.1%	41.1%	45.4%	45.1%
Folkestone & Hythe	44.3%	48.5%	45.6%	49.7%	48.7%
Thanet	42.9%	43.5%	44.8%	44.8%	46.8%

6.3.5. Premature births

Between 2019-21 Thanet and Canterbury had among the highest rate of premature births in Kent (at 100.4 and 87.1 premature births per 1,000 births respectively).

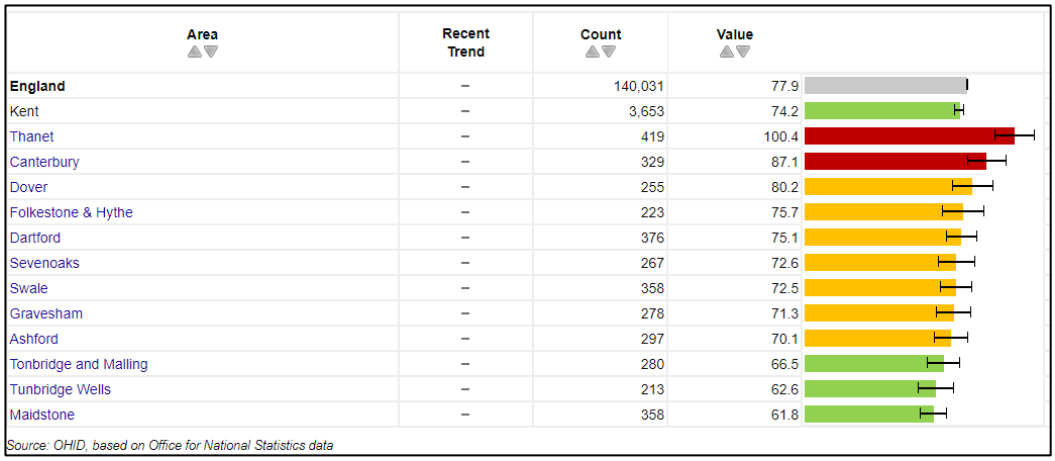

Figure 66 Premature births (less than 37 weeks gestation) 2019-21 crude rate per 1,000

6.4. Emergency Admissions in under 5-year-olds

There has been significant concern about the apparently high rate of emergency department attendances in young children (aged 0-4 years old) in East Kent. Data from the Hospital Episodes Statistics, analysed in the Health and Care Partnership profile, shows an attendance rate of 1,340 per 1,000 children per year (2023/24). This is approximately 1.7 times the figure for England, at 795 attendances per 1,000 children per year. As part of this needs assessment, we aimed to further investigate this figure.

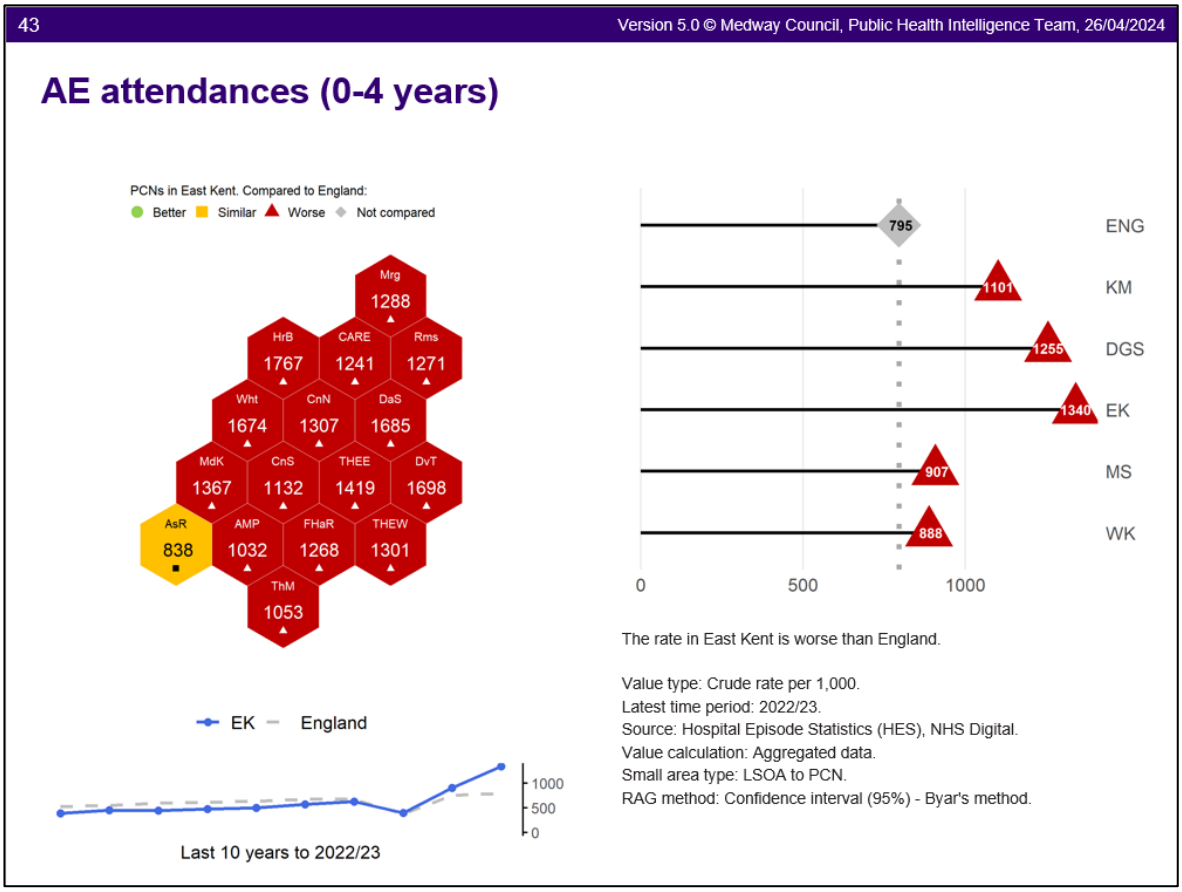

Figure 67 Accident and Emergency attendances (ages 0-4) by PCN and HCP

More granular analysis shows that for the year 22/23, ED attendances were recorded for each urgent care treatment centre (UCTC), while for all other years, the data was recorded at the hospital level. We believe that for this year, there was a set of cases that were not typically recorded in previous or subsequent years. As such, we believe this does not represent a real increase in attendances.

6.5. Relevant findings from the dedicated HNA

- The 2022 HNA found several concerns which do not fall neatly into a discussion of available and missing services. As such, they are summarised here.
- Kent has a Total Fertility Rate (TFR), above the England average. As such, children aged 0-4 are likely to be an increasingly important demographic for health planning in the coming years.
- There are stark inequalities experienced by children living in poverty and deprivation in their access and uptake of services and health outcomes. Proportionate universalism is required, targeted where need is greatest.
- The data presented in the HNA showed that between 2019 and 2021Thanet and Dover had particularly high rates of front door contacts meeting the threshold for the Kent Children's Social Work Services. The most common reasons for contact include domestic abuse and risk of harm or neglect.
- Mental health and wellbeing is an important issue in under 5-year-olds. It is acknowledged that childhood experiences in infancy and the first five years have a lasting impact on a child's mental wellbeing, but the mental health and wellbeing for this cohort is largely unknown.

6.6. Recommendations

- Invest in early identification and support for perinatal mental health and parent infant relationship challenges for pregnant women, new mums and their partners.
- Review and monitor the provision for parents and carers, involving families in the design and development of services and providing the support parent and carers need in order to parent their children well.
- Establish a systemwide approach to preventing poor health outcomes, ensuring provision and levels of support are flexible and responsive to meet needs.
- Utilise all opportunities to provide preventive interventions and messaging with pregnant women and families with children under 5 years of age.
- Ensure the provision of consistent information across the system on infant feeding and introduction to solid foods and portion sizes, with additional levels of support in response to need.
- Embed data sharing and data linkage, particularly between maternity care, family hubs, early help, health visiting, social care, and early years education.

7. Child Health (Ages 5 to 11)

7.1. Background

Children aged 5-11 years old are in a foundation period, in which they grow and develop. Recent published reports and policies have highlighted the importance of this age group and the challenges they face, particularly from the COVID-19 pandemic. All school communities have been impacted by the pandemic and national lockdowns and these in turn have affected children in different ways. There is evidence that shows that disadvantaged children and those who live in areas that were particularly hard hit by higher rates of COVID-19 are amongst those whose learning is most likely to have been affected.

For more information, please see the Primary School Aged HNA, published by KCC in 2024.

7.2. Best Practice

7.2.1. The Healthy Child Programme

Ensuring every child has the best start in life is one the key priorities of the OHID. The Healthy Child Programme is a universal programme of prevention and support for children which includes primary aged 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 main 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.

School nursing lead the healthy child programme across the school years. This includes four aims for primary school aged children to:

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

The programme suggests universal health reviews for primary aged children at key development stages:

- **Four to five-year-old health needs review-** this could include assessing immunisation status, speech and language skills and healthy weight.
- **Seven- to eight-year-old needs contact-** this could include brief interventions around supporting emotional and mental resilience.
- **10 to 11-year-old health needs assessment-** this could include supporting the transition to secondary school and providing information around healthy weight.

As with other stages of the healthy child programme the school nursing service also has high impact areas for consideration. In primary school aged children these will be reflective of work with the family, school or other agency support.

7.3. Epidemiological Findings

The health and wellbeing needs of 5- to 11-year-olds in East Kent are varied. Differences are driven by population, ethnicity, sex, health condition, nurturing, education, and living environment amongst other factors. Ethnicity varies across the districts in East Kent. The ethnic and cultural profile is becoming more diverse due to migration. There is a risk that inequalities will keep widening as cultural needs, language differences, interpretation, social norms are misunderstood or not heard. Ethnicity is not well recorded and reported through the NHS. The 2001 Census saw the introduction of the question on religion and country of birth; this was further expanded on in the 2011 Census with the introduction of questions about national identity.

7.3.1. Children in Care

Vulnerable Children are defined as 'any children at greater risk of experiencing physical or emotional harm and/or experiencing poor outcomes because of one or more factors in their lives'. Children come into care when it is the most appropriate arrangement for them and for most children, this happens in a planned and timely way. Some children are taken into care because of a legal order made by a court (such as a care order or emergency protection order) or are taken into care because someone with parental responsibility has made this request.

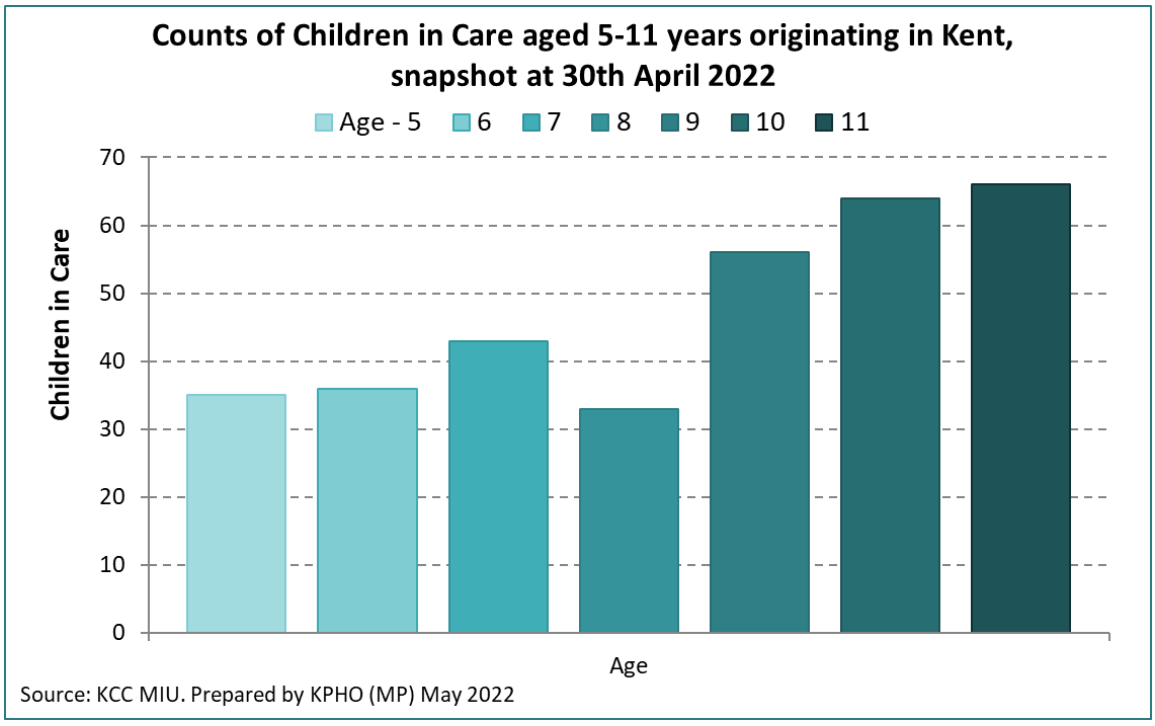

Figure 68 Counts of children in care aged 5-11 originating in Kent

7.3.2. Elective home educated children

The total number of Children and Young People (CYP) recorded with the Elective Home Education (EHE) team in Kent fluctuates. This is shown in the figure below which presents four academic years. At the end of Term 4 (2021-2022), 469 primary school aged children were recorded as home educated. In primary schools the highest number of children recorded with EHE were made in year 6 which is at end of key stage 2 when the children complete standardised assessment tests (SATs) examinations.

Table 12 Children and young people in elective home education in Kent

Year	Key stage 1		Key stage 2	
	Boys	Girls	Boys	Girls
2018/19	89	66	206	156
2019/20	86	55	163	141
2020/21	147	133	286	268
2021/22	93	76	137	163

Source: Elective Home Education Report KCC

7.3.3. Free School Meals

FSM is used as an indicator of inequality. If a child is under 19 and in full-time education, and their parent(s) receive certain benefits, they may be able to get free school meals. If eligible and registered a child will get:

- a choice of a healthy hot meal every school day at no cost – (worth £470 a year per child)
- meals to cater for cultural, dietary, and religious requirements
- the chance to develop social skills by sitting with friends for a school meal
- a £10 food voucher per eligible child each week during the school holidays

The school will also receive additional funding to cover the catering cost and school funding grants, such as the Pupil Premium, based on their take up of free school meals. Some schools and academies also offer reduced rates for school trips, clubs, after school care, and uniform to children registered for free school meals.

The following figure shows free school meal eligibility between 2018/19 to 2022/23 for state funded primary schools. Kent had 14.3% eligible in 2018/19, below the England figure of 15.8% but higher than the South-east region at 11.8%. By 2022/23 this had increased to 24% eligible, similar to England, while the South-east was lower at 19.5%.

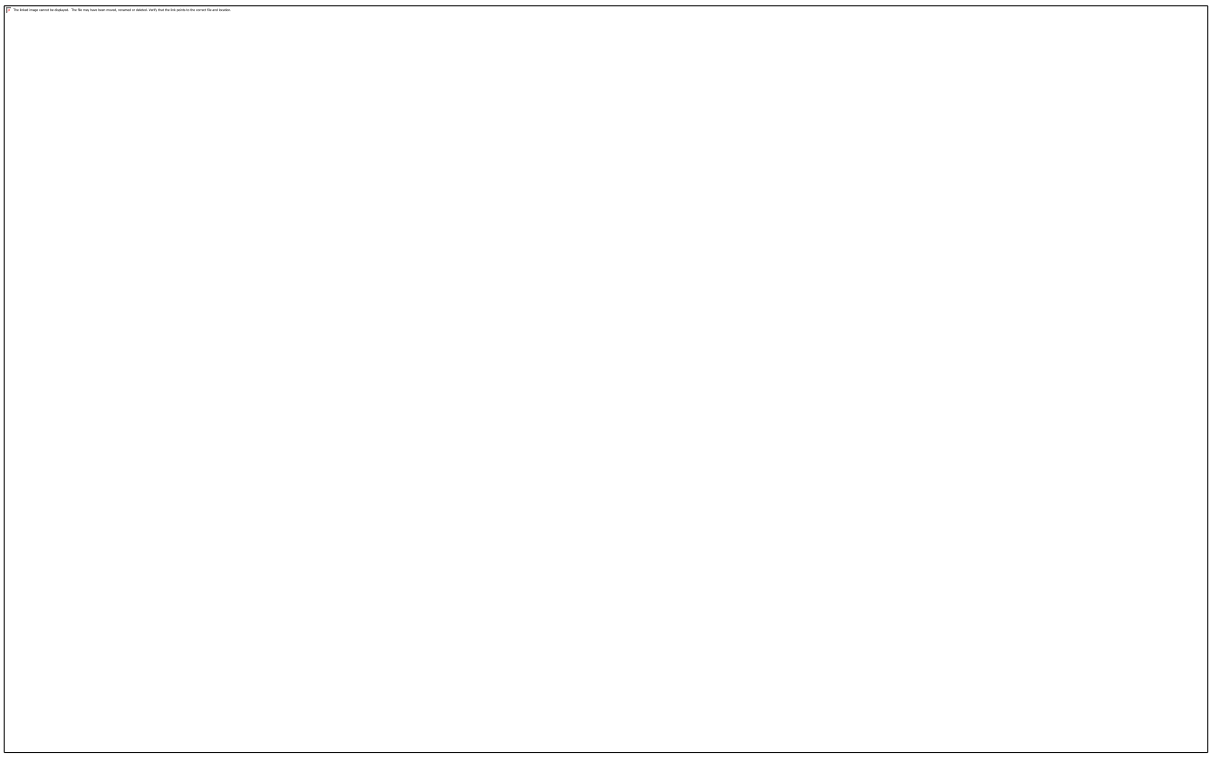

Figure 69 Free school meal eligibility

7.3.4. Disability living allowance

Disability and poverty are closely tied, with disability often increasing health care and related costs while simultaneously limiting entry or stay in the labour market. The Joseph Rowntree Foundation reported in 2018 that there were approximately 6.6 million people in families in poverty that include a disabled adult or child in the UK and that disability has also been linked with an increased risk of destitution, such as going without essentials such as a home, food, heating, lighting, clothing, shoes, and basic toiletries". Disability Living Allowance (DLA) is granted following an assessment qualification process and allocated to those who have extra care needs or mobility needs (difficulty getting around) because of a disability.

To qualify for DLA, the child's disability or health condition must mean at least one of the following apply:

- They need much more looking after than a child of the same age who does not have a disability
- They have difficulty getting about
- They must have had these difficulties for at least 3 months and expect them to last for at least 6 months.

DLA for children may help with the extra costs of looking after a child who:

- is under 16

- has difficulties walking or needs much more looking after than a child of the same age who does not have a disability

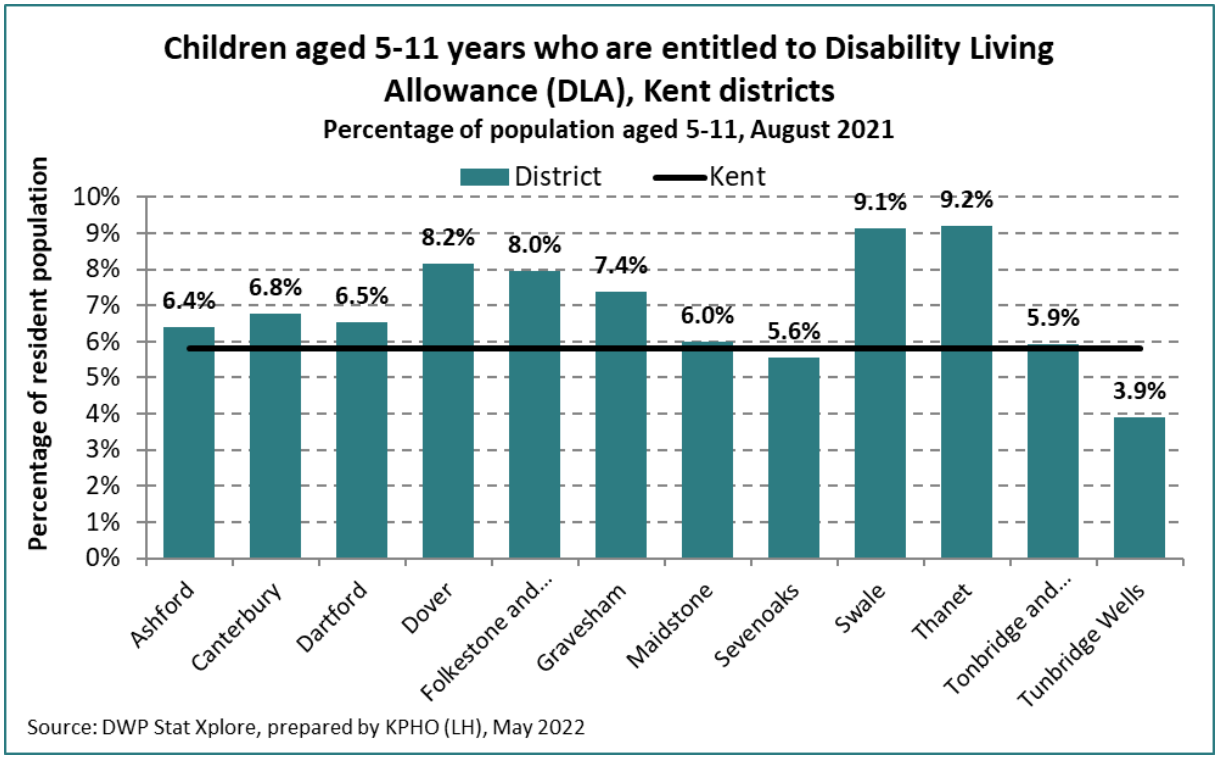

Figure 70 Children aged 5-11 who are entitled to Disability Living Allowance

7.3.5. A & E attendances

A and E attendance can provide an overview of health care needs. Access to urgent treatment centres or accident and emergency departments are included in the same hospital coding. Minor injury units can treat injuries that are not critical or life threatening. There are 10 minor injuries units throughout Kent.

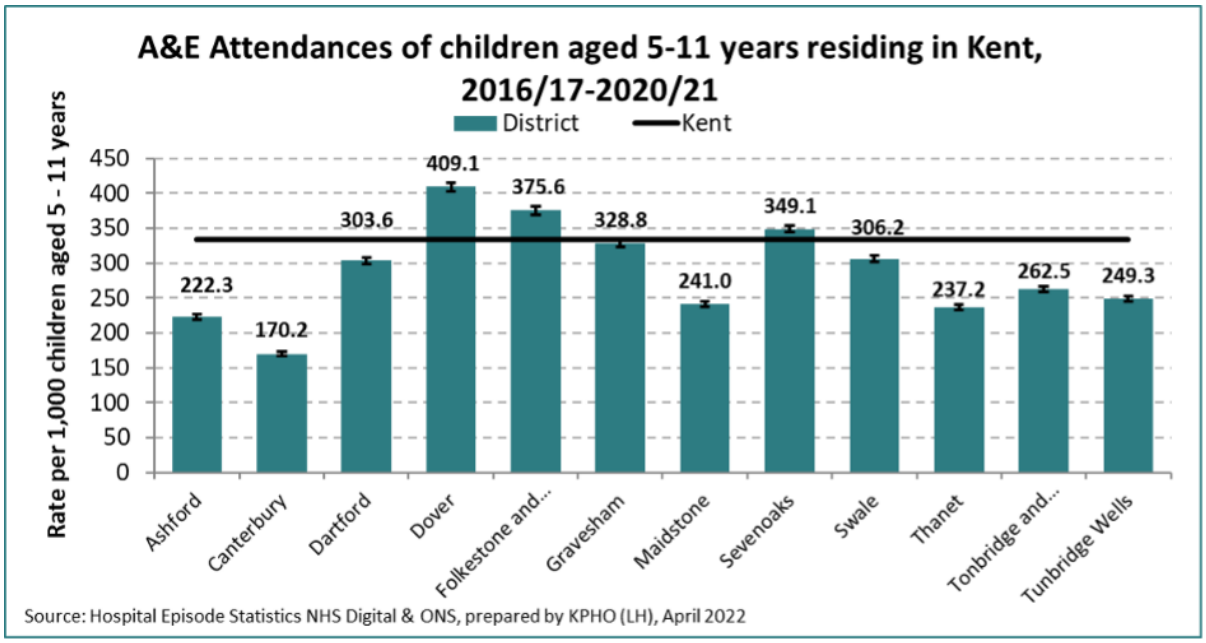

Figure 71 Accident and Emergency attendances in children aged 5-11 in Kent

7.3.6. Long term conditions

Three long term conditions are identified within the NHS long term plan. At a local level, observation of obesity amongst those children admitted to hospital with a long-term condition has received specific attention in Kent over the last 12 months.

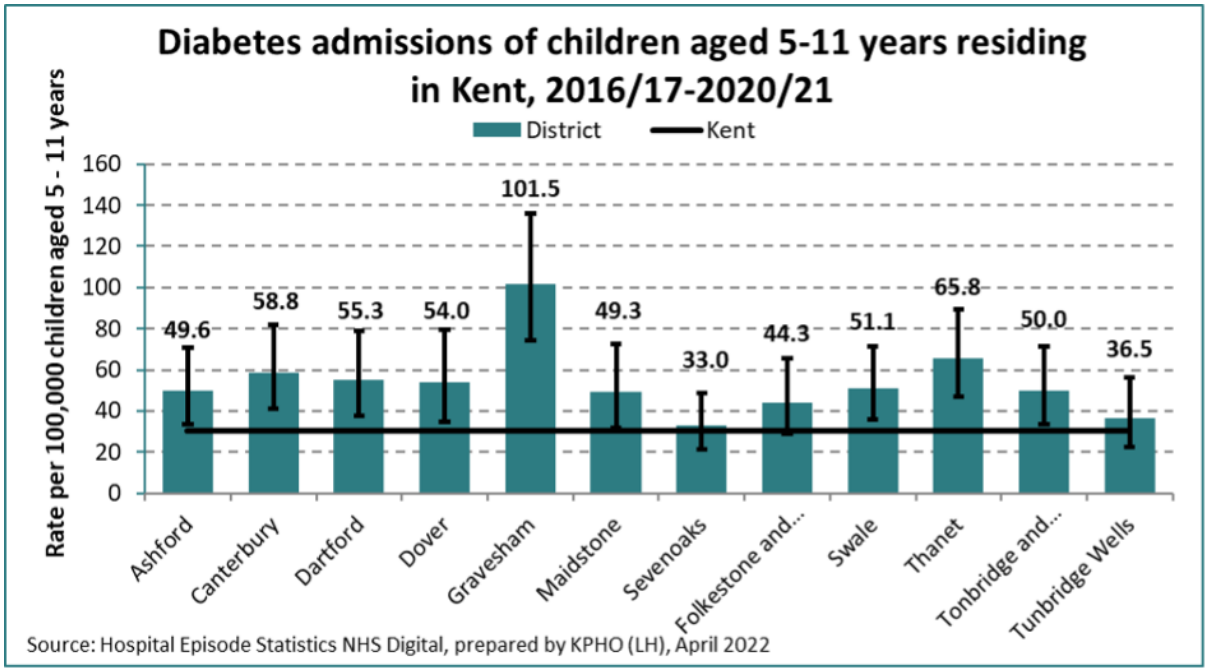

Figure 72 Diabetes admissions in children aged 5-11 in Kent

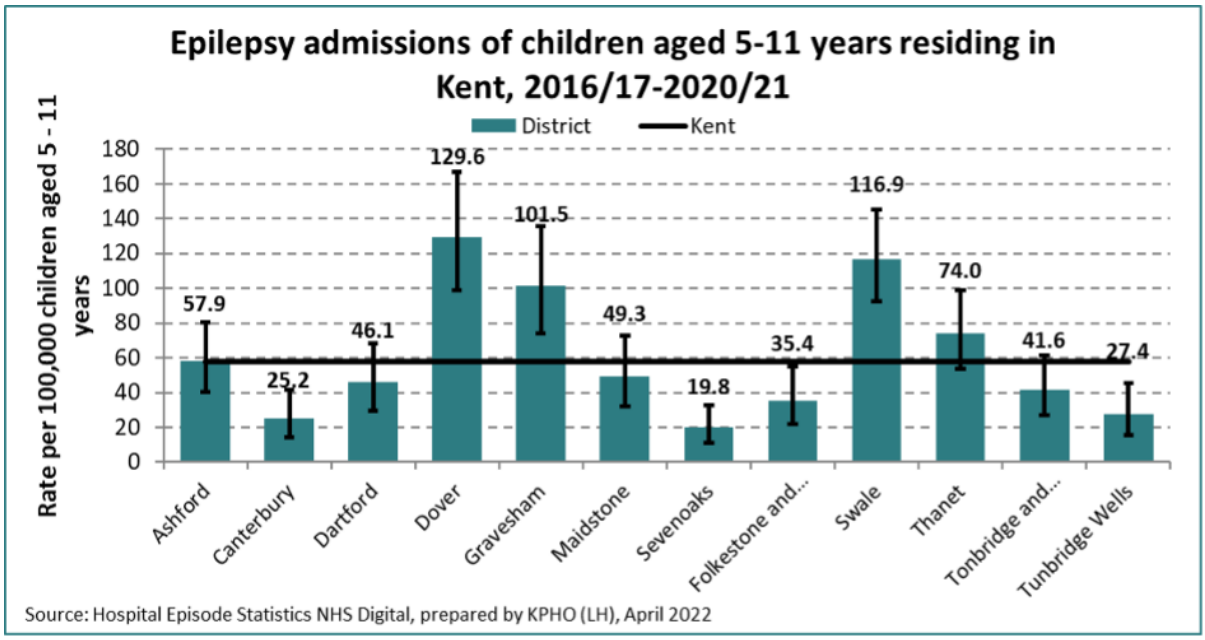

Figure 73 Epilepsy admissions in children aged 5-11 in Kent

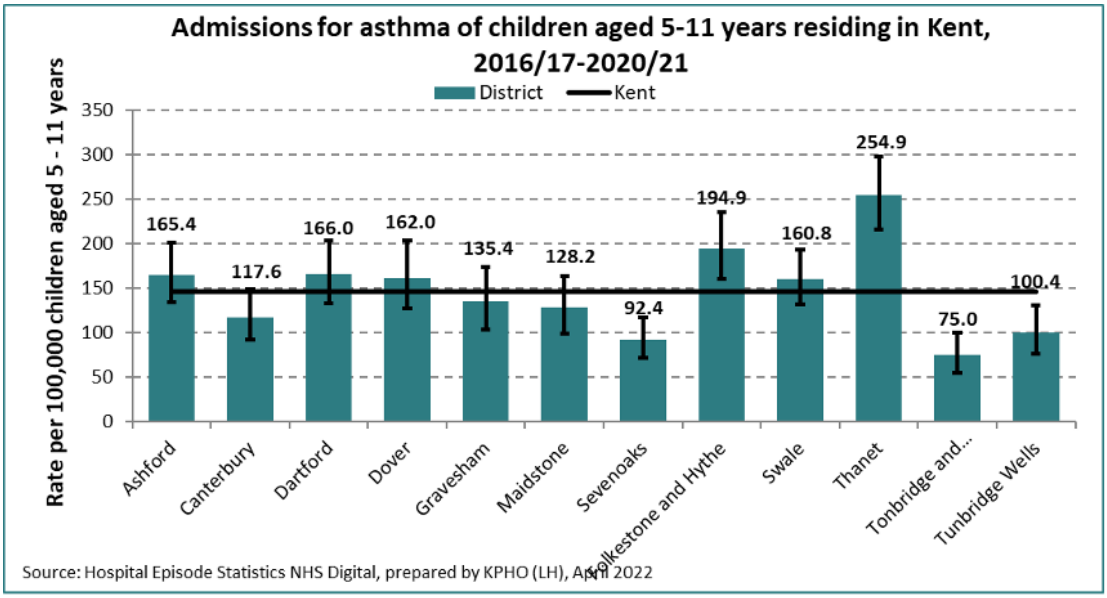

Figure 74 Asthma admissions in children aged 5-11 in Kent

7.3.7. Oral health

Tooth decay may lead to dental extraction. Looking at the crude rates of admissions for dental caries per 10,000 5 – 11-year-old population across the districts in Kent over a five-year period in the next figure shows Gravesham district were statistically significantly higher than other districts in Kent between 2016/17 - 2020/21.

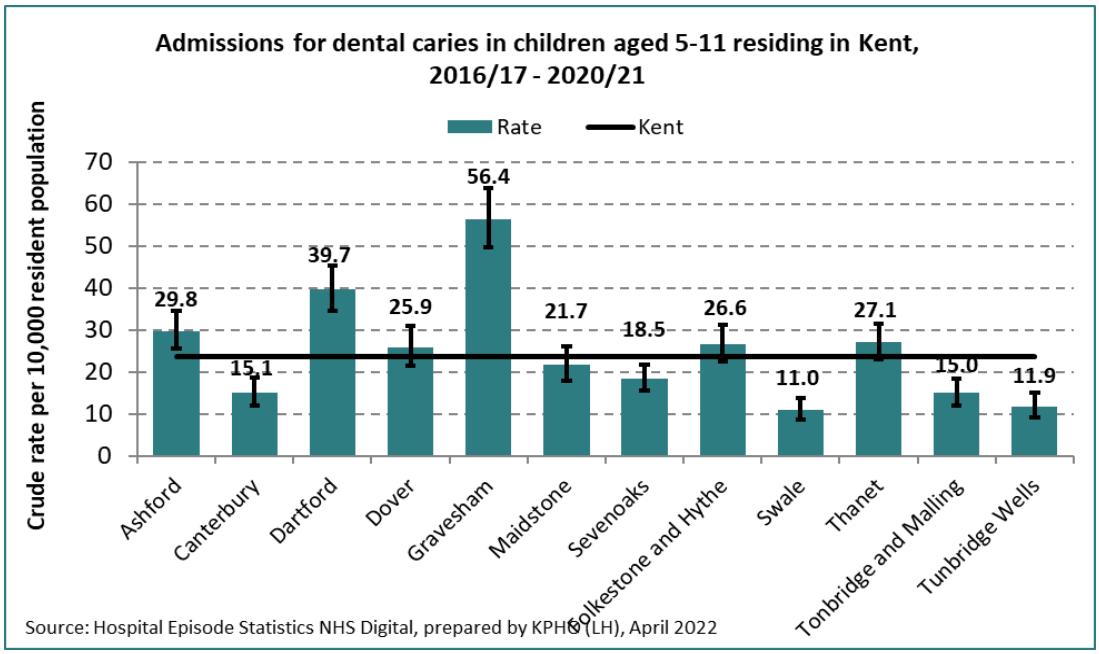

Figure 75 Dental caries admissions in children aged 5-11 in Kent

7.3.8. Injury: deliberate and unintentional

A PHE report in 2018 identified unintentional injuries as a major health inequality. 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.

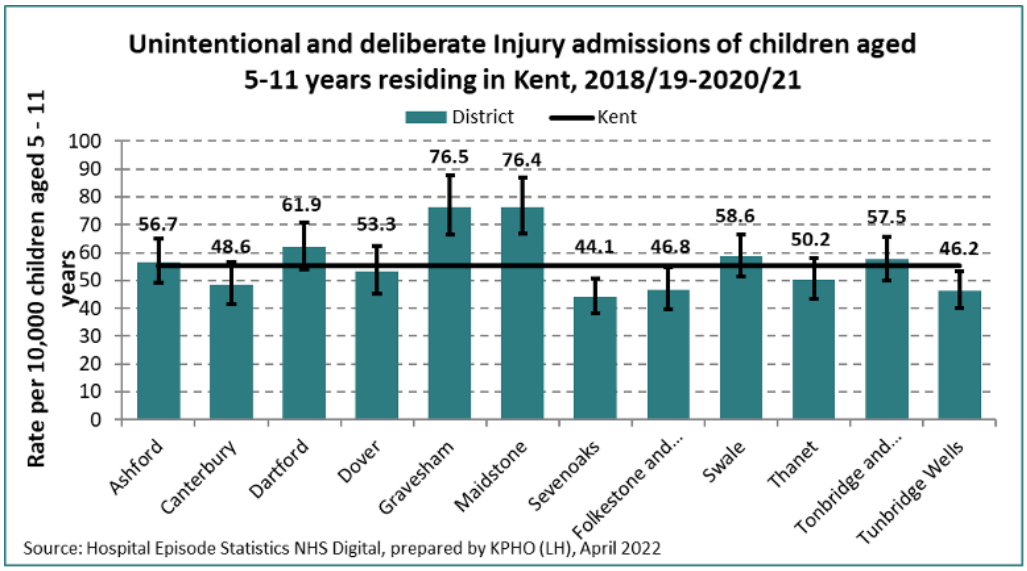

Figure 76 Injury admissions in children aged 5-11 in Kent

7.3.9. Mental health

A national longitudinal survey on children's mental health through NHS Digital has been conducted in 2017, 2020, 2021 and 2023. One in ten 5- to 10-year-olds were estimated to have at least one mental health disorder when assessed in 2017. The latest NHS digital longitudinal prevalence survey for England highlights the number of children with a diagnosable mental health condition. The prevalence of probable mental disorder in 6- to 10-year-olds increased between 2017 and 2021; from one in ten (9.9%) to approximately one in six (17.1%). In 2021, a further one in ten (9.0%) of 6 to 10 years have a possible mental disorder. The next figure provides illustration of probable mental disorders in 6- 10-year-olds.

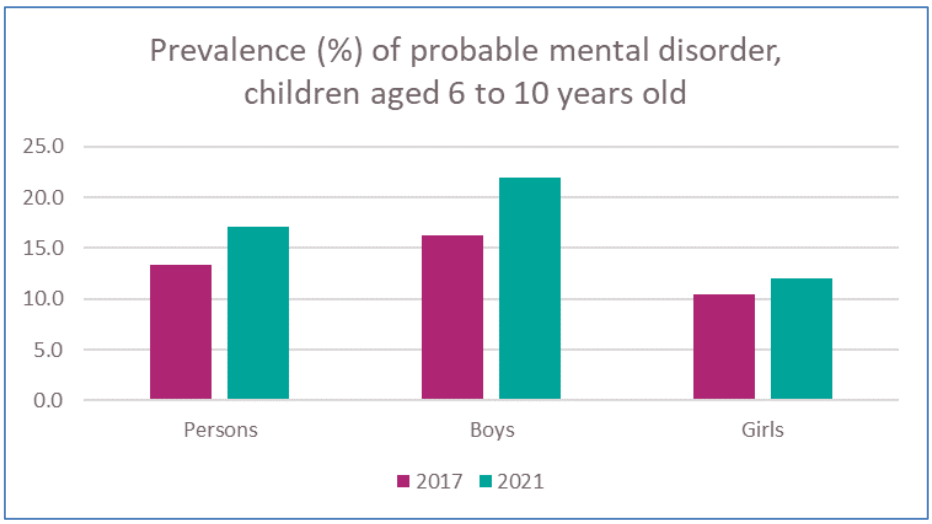

Figure 77 Prevalence of probable mental disorder in children ages 6-10

Applying the prevalence of a having a probable mental disorder (17.4%) to the Kent registered population aged 6 to 10 years would suggest that approximately 20,600 children may have a probable mental disorder and 10,900 may have a possible mental disorder. The findings through this longitudinal study suggest that probable mental disorders were nearly twice as likely amongst boys compared to girls aged 6 – 10 years in 2021 and that this affects 1 in 5 boys aged 6- 10 years.

7.3.10. Excess Weight

A Kent child weight health needs assessment was published in October 2020. This section provides update on subsequent policy, strategy, and surveillance.

The national child measuring programme (NCMP) is overseen by the Office for Health Improvement and Disparities, analysed, and reported by NHS Digital. This programme measures the height and weight of children in England annually. The NCMP is a longitudinal surveillance programme which provides information on the proportion of children in reception and year 6 who are identified as underweight, healthy weight, overweight, obese, or severely obese.

In the academic year 2020/21 there was delay to the commencement of the national child measuring programme as a consequence of the Covid-19 pandemic with measuring being undertaken during the summer term only. The national requirement was to measure 10% of the total cohort for the two age groups. The intention was to measure as many as possible in year R in Kent resulting in 89.4% being measured and nearly 9% from year 6 in 2020/21. Insufficient numbers of children aged 10-11 were measured to produce robust prevalence estimates. The NCMP found that over a quarter of children aged 4-5 years in Kent were overweight or obese with the prevalence of excess weight having increased from 25.2% in the academic year 2019/20 to 26.6% in 2020/21 with higher proportion identified as obese or severely obese as shown in the following figure.

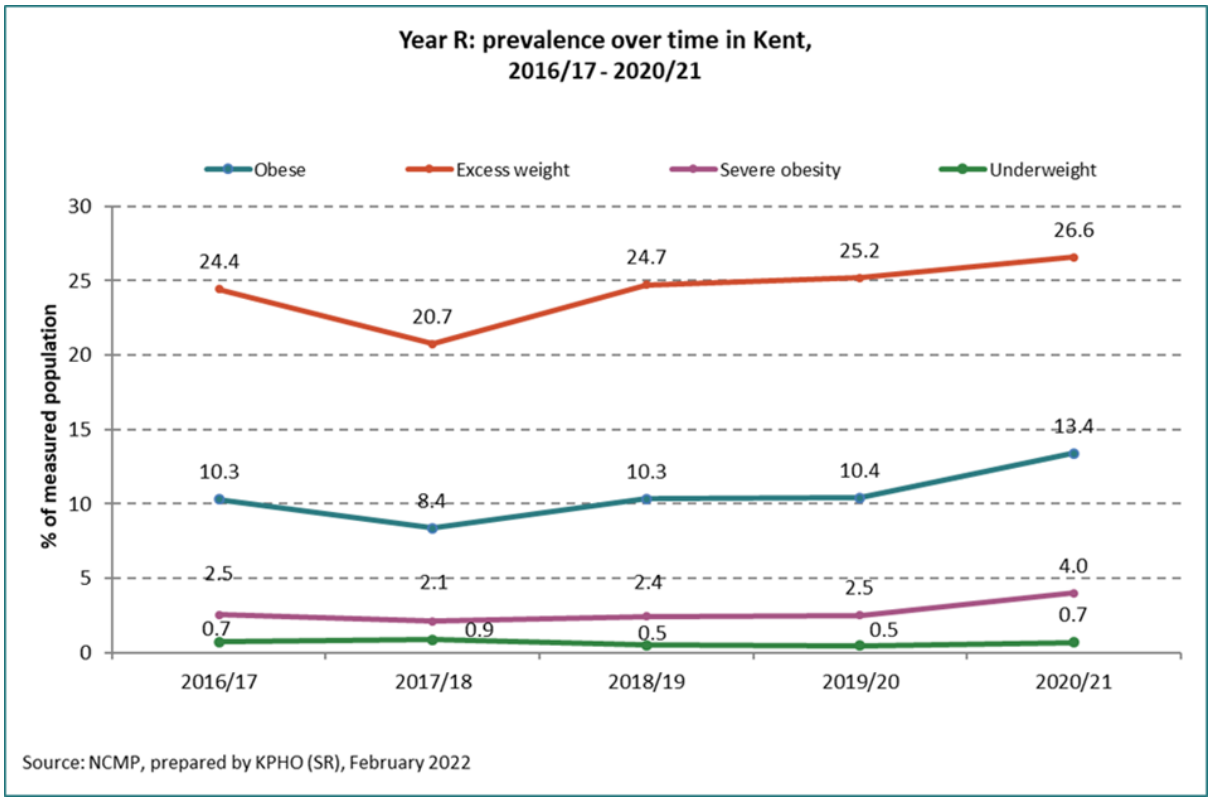

Figure 78 Prevalence of obesity, excess weight, and underweight in year R in Kent

7.4. Key findings from the dedicated HNA

The 2024 HNA found several concerns which do not fall neatly into a discussion of available and missing services. As such, they are summarised here.

Children who face the most adversity are least likely to have the resources needed to help build resources. Schools are an integral way of identifying and supporting these children. The impact of the pandemic on the emotional health and wellbeing of these children is not yet fully understood. There are concerns regarding the number of home-educated children, some of whom appear to be missing out on the support services available in schools, which are also available to home-educated children.

Developmental milestones in learning are not being met. Gypsy, Roma, and Traveller children are the most impacted, with the poorest attainment and attendance of any ethnicity category. Socioeconomic status and digital exclusion are likely contributors to this effect.

Increasing inequality is seen across Kent since the pandemic. For example, reduced access to dentistry and changes to family routines (e.g. toothbrushing) have exacerbated oral health inequalities.

7.5. Recommendations

- Further studies are needed to understand the extent of the effect of the pandemic on child health and wellbeing, and to develop effective interventions to target these effects.
- The understanding of personal, social, and emotional skills in families must improve in order to help children build emotional language skills. Earlier interventions for children in learning, understanding, and talking about how they feel, rather than just at crisis point, should be encouraged. Online parenting courses on “understanding your child” should be promoted.
- Parents who decide to home-educate their children should be made aware that they can still access support from school public health workforce support.
- Trauma informed approaches should be used more widely, and all professionals working with children in this age group should be trained in these approaches. In particularly, they are fundamental for children who have experience a traumatic event and should be used to manage wellbeing and prevent further traumatisation.
- System-wide efforts should be taken in the most deprived areas to support families access services, where needed, to improve their health and wellbeing.
- Activities which address wider determinants of health should be undertaken – e.g. addressing damp and mould in housing, which increases the risk of asthma.

8. Excess Weight

8.1. 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 also important to address excess weight in those with a BMI between 25 and 30. This is particularly important 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.

8.2. 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. 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. They are,

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

Kent County Council last conducted a dedicated health needs assessment on obesity in December 2015. 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.

8.3. Epidemiological Findings

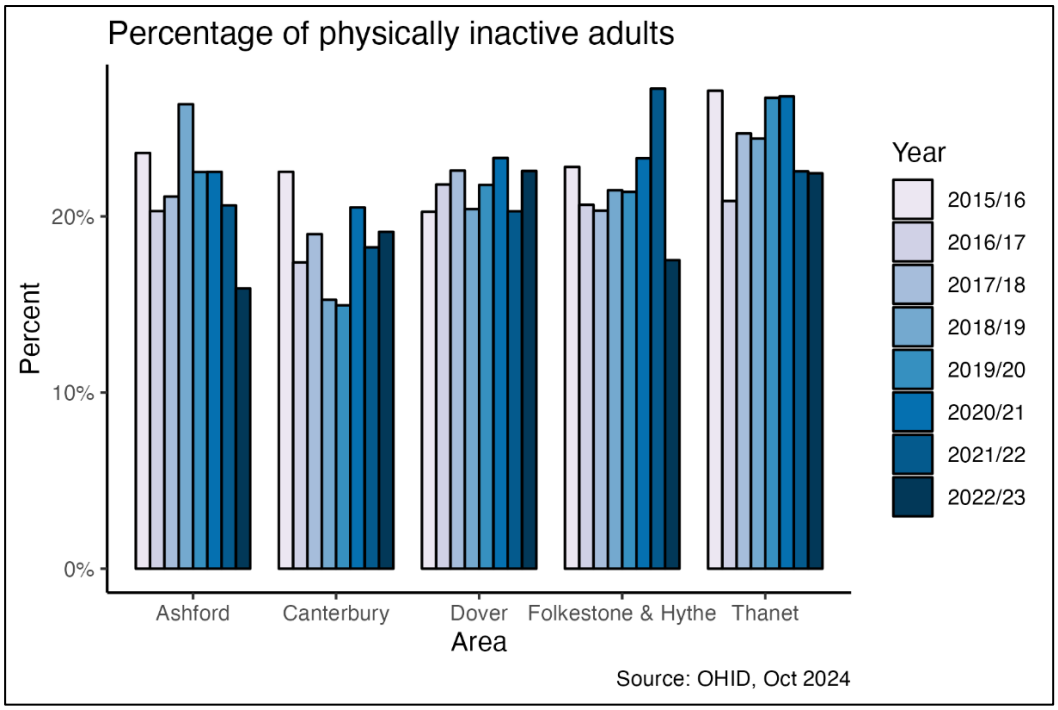

Figure 79 Percentage of physically inactive adults by district and year

The proportion of physically inactive adults is decreasing in Ashford but remains relatively static in the rest of East Kent.

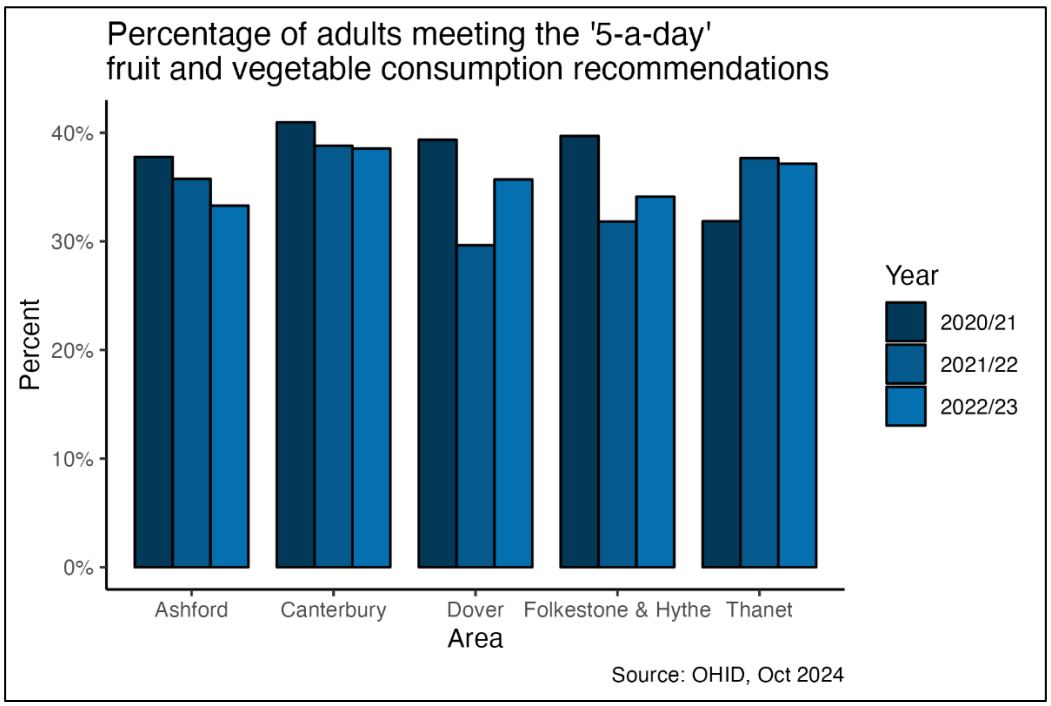

Figure 80 Percentage of adults meeting the 'five a day' fruit and vegetable consumption recommendations by district and year

Limited progress has been made in ensuring adults are consuming adequate fruit and vegetables.

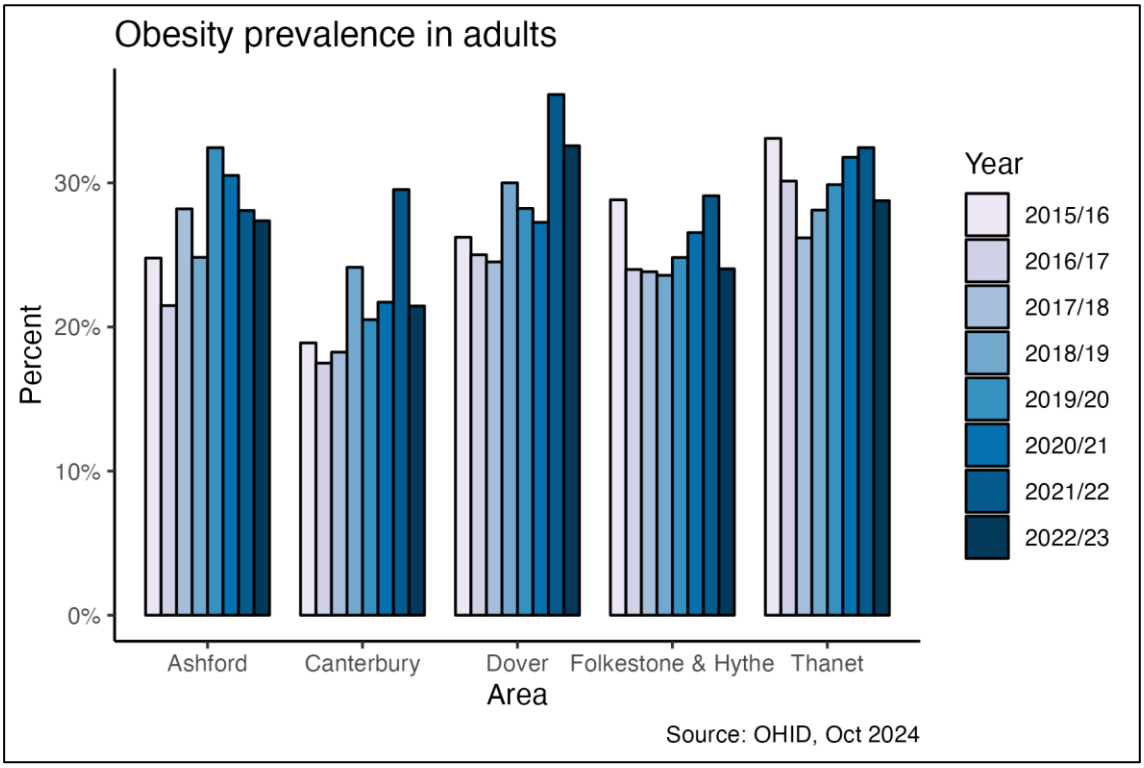

Figure 81 Obesity prevalence in adults by district and year

Obesity prevalence continues to rise across East Kent. Ashford is the only district which shows sustained improvements in prevalence.

8.4. Available services

Adult weight management services in East Kent are delivered is delivered as part of the One You programme by the Kent Community Health NHS Foundation Trust (KCHFT).

In 2023-2024, 11,160 individuals were active in the KCHFT programme. 6,303 (56%) of these were from deprivation quintiles 1 and 2.

4,527 people were referred to the Tier 2 weight management programme (WMP), of whom 1,560 were engaged on the programme. 752 (48.2%) were from deprivation quintiles 1 and 2. 1,116 attended at least one group session, but only 558 (50%) completed the twelve-week programme. 576 (51.6%) of participants had lost weight by the end of the programme, while 402 (72%) of those who had finished the programme had lost weight by the end of the programme. Of the completers, 188 (33.7%) had lost less than 3% of their baseline body weight, 103 (18.5%) had lost between 3% and 5%, and 111 (19.9%) had lost 5% or more.

Follow up data beyond this was limited, only 127 (22.8%) of completers provided a weight measure at 26 weeks after finishing the programme, and only 1 provided a weight measure 52 weeks after finishing the programme. The proportion of those engaged on the WMP from target groups (BAME, men, and those with learning disabilities) remains low – these groups represent 2.1%, 7.6%, and 0.4% of the total engaged cohort, respectively.

The whole system approach (WSA) to healthy weight has been in progress in East Kent 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.

8.5. 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 in East Kent.

8.6. Recommendations

- Increase capacity in the WMP to reduce the gap between demand and supply.
- Ensure that the service is made accessible to target groups.
- 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 which promote healthier environments such as banning the advertisement of high fat, sugar and salt (HFSS) foods, limiting the opening of fast-food outlets near schools and in areas of deprivation, and utilising planning regulations to create healthier spaces.

9. Smoking

9.1. 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 lung cancer, chronic obstructive pulmonary disease (COPD), heart disease and stroke.

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. Nationally, more than 77,000 people die each year from smoking, more than obesity, alcohol and illegal drugs together. There were 2,566 avoidable deaths caused by lung cancer, oral cancer and COPD in East Kent in 2022-23. Action on Smoking and Health (ASH) estimate that smoking costs the East Kent economy £493 million each year (See Figure 82). £284m of this is attributable to smoking related loss of economic productivity, £185.7m in social care costs and £21.5m healthcare costs every year in East Kent.

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

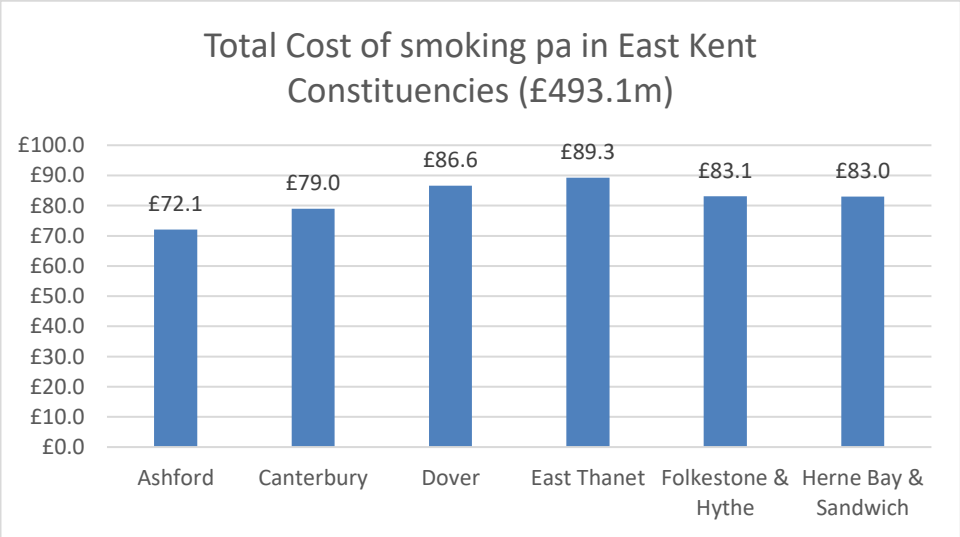

Figure 82 Total cost of smoking per annum in East Kent by district

Source: ASH ashresources.shinyapps.io/ready_reckoner/ (accessed 18/10/24)

9.2. 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 with the aim of increasing 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.

9.3. Epidemiological Findings

9.3.1. Smoking Prevalence

Smoking prevalence in Kent is similar to the England average (11.4% v 11.6%) and East Kent levels are estimated to be 10.96% which equates to 59,902 smokers. Coastal towns typically experience poorer health outcomes and lower life expectancy compared to similar inland towns, with higher smoking rates being a major risk factor in the most deprived communities. The Chief Medical Officer Report 2021 suggests an excess smoking prevalence of 6.71% in coastal towns, necessitating targeted interventions to high-risk groups and geographies.

The following charts show estimates of district level smoking prevalence with typically high rates in Thanet and Folkestone & Hythe, but at district level, these estimates should be treated with caution, with wide confidence intervals due to ONS survey response rates.

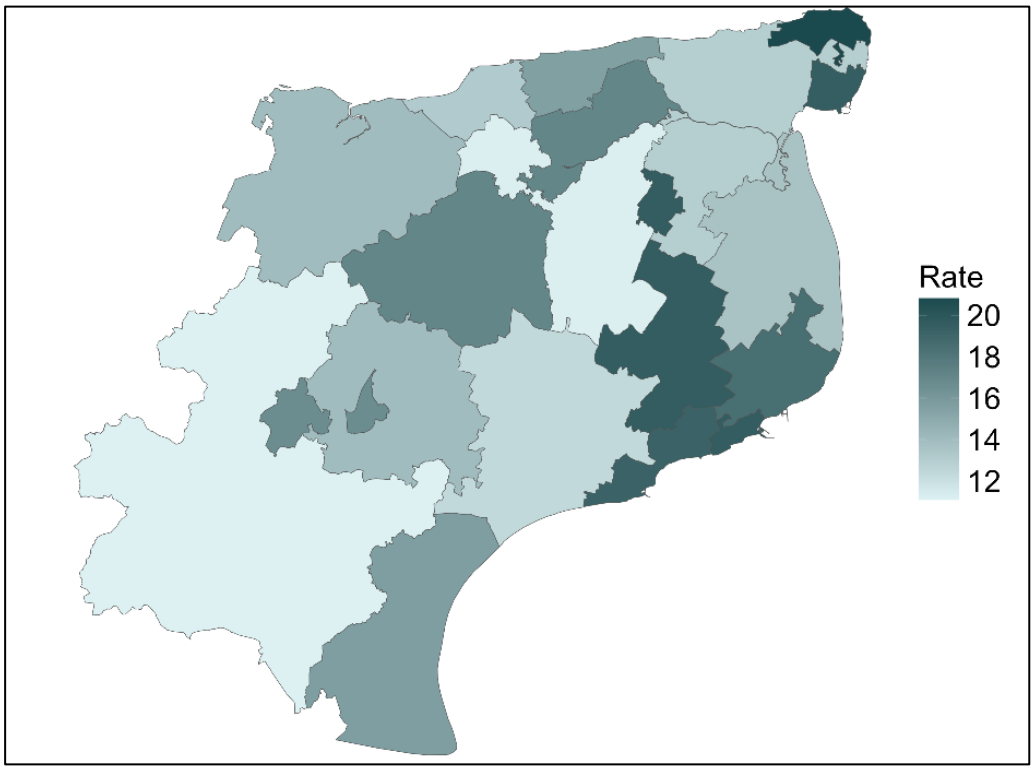

Figure 83 Smoking prevalence in East Kent PCNs, based on patients' GP as recorded in August 2024. Source: KMCR

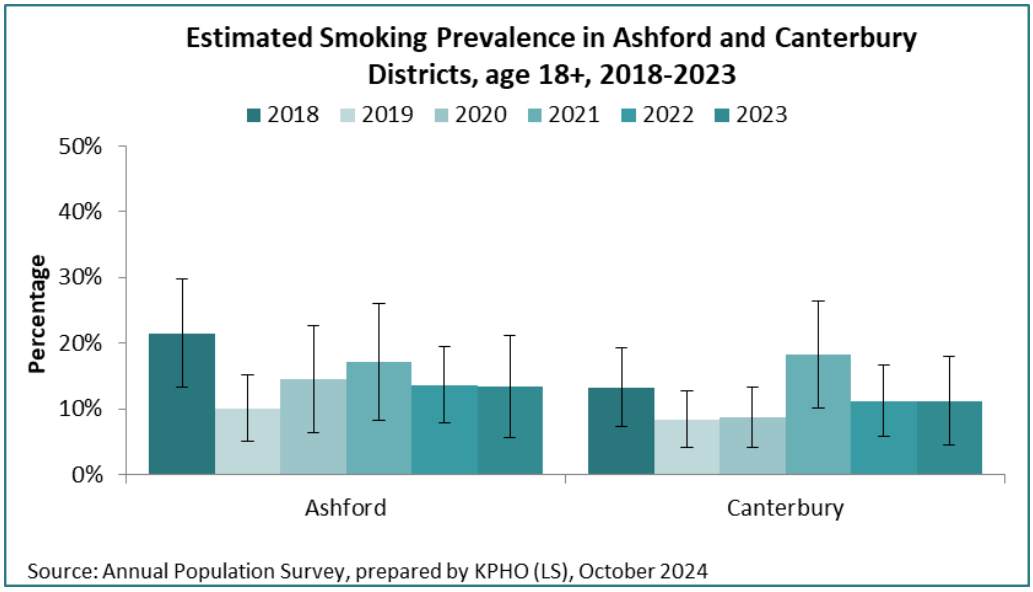

Figure 84 Estimated Smoking Prevalence: Ashford and Canterbury

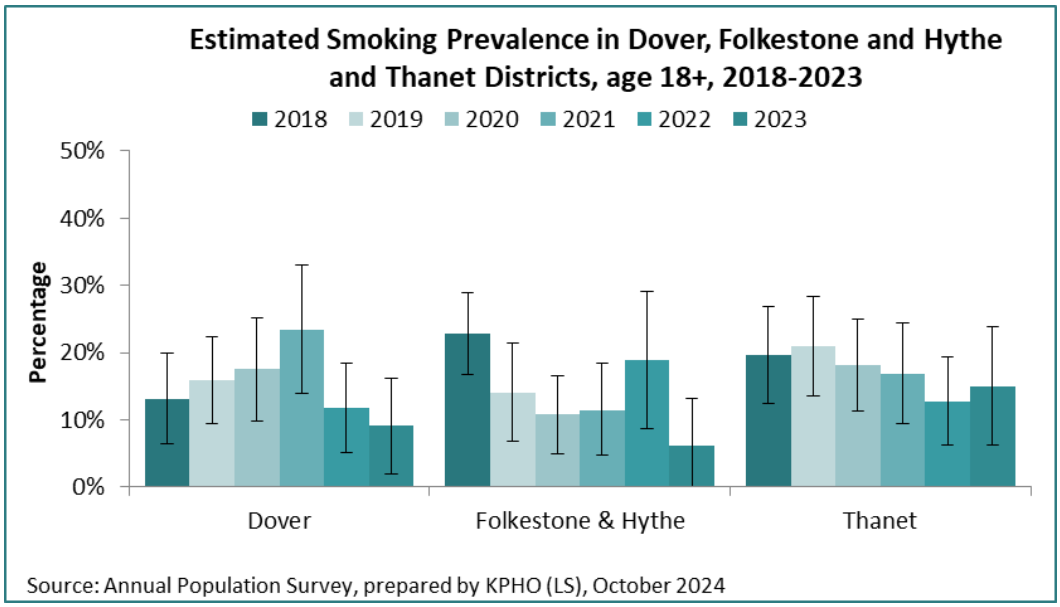

Figure 85 Estimated Smoking Prevalence: Dover, Folkestone and Hythe and Thanet Districts

Although the smoking trend 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 and 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.

9.3.1.1. Young People

The national NHS Digital, Smoking, Drinking and Drug Use Survey shows that 11% of pupils surveyed report having ever smoked, while 3% report to be current smokers and 1% said they smoke regularly. 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.

9.3.1.2. 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. It is estimated that 8.9% of women are recorded as smokers by the time their babies were delivered in East Kent. 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.

9.3.1.3. 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 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 (latest data published 2014/15). 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,

9.3.1.4. 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.

9.3.1.5. Sexual Orientation

Smoking prevalence is higher among lesbian, gay and bisexual people than in the general population, although data sources are limited.

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. 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.

9.3.1.6. Homelessness

Data on smoking prevalence among homeless people is not routinely collected in the UK but it is estimated that 77% of people experiencing homelessness smoke (2014 figures) 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. 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.

9.3.2. 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. 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. 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.

9.4. 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, 5231 smokers set a quit date with the stop smoking service and 2871 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. Although still in development in the East Kent Hospitals University Foundation Trust, the programme will provide support for smoking abstinence throughout the patient's hospital episode and will refer into community stop smoking services at the point of discharge from hospital.

9.5. 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.

9.6. Recommendations

Although prevalence rates have been declining, 10.96% of adults in East Kent smoke, costing east Kent £493m each year. 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. 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.

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.

10. Sexual Health

10.1. Introduction

Sexual Health is a key part of ensuring the overall health and wellbeing of our Kent 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, as well as to contributing to people's access to education, economic participation and increasing opportunities in the social and community spheres.

Trends are changing across Kent and England so we must be vigilant to ensuring that population and individual sexual health is protected. Sexual health is particularly pertinent recently due to key policy changes that have been implemented since the Covid-19 pandemic.

The sexual health landscape has changed since the last sexual health needs assessment in 2018. 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. Kent's population has also changed in this time, with a population increase of 14,600 from mid-2021 to mid-2022, of which, 95.7% has been because of migration.

There have been several changes to national policies affecting sexual health since 2020. Pre-exposure prophylaxis (PrEP) to reduce HIV transmission in those at a high risk was made available in sexual health clinics. An amendment in legislation during the pandemic allowing at-home early termination of pregnancy was made permanent, changing the way women access abortion services. 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. 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. 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. 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.

10.2. Best Practice

NICE have published the following Quality Standards for Sexual Health.

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

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

Additional best practice guidance and policies include

- Syphilis: Public Health England action plan - GOV.UK (www.gov.uk)
- Recommendations | Reducing sexually transmitted infections | Guidance | NICE
- A blueprint for the future: Sexual and reproductive health and HIV services in England | Local Government Association
- Women's Health Strategy for England - GOV.UK (www.gov.uk)
- STI Prioritisation Framework (publishing.service.gov.uk)

10.3. Epidemiological Findings

10.3.1. STI

Following the COVID-19 pandemic, the STI testing rate has increased across Kent and is now higher than pre-pandemic levels, with there being a 15.5% increase since 2018. 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.

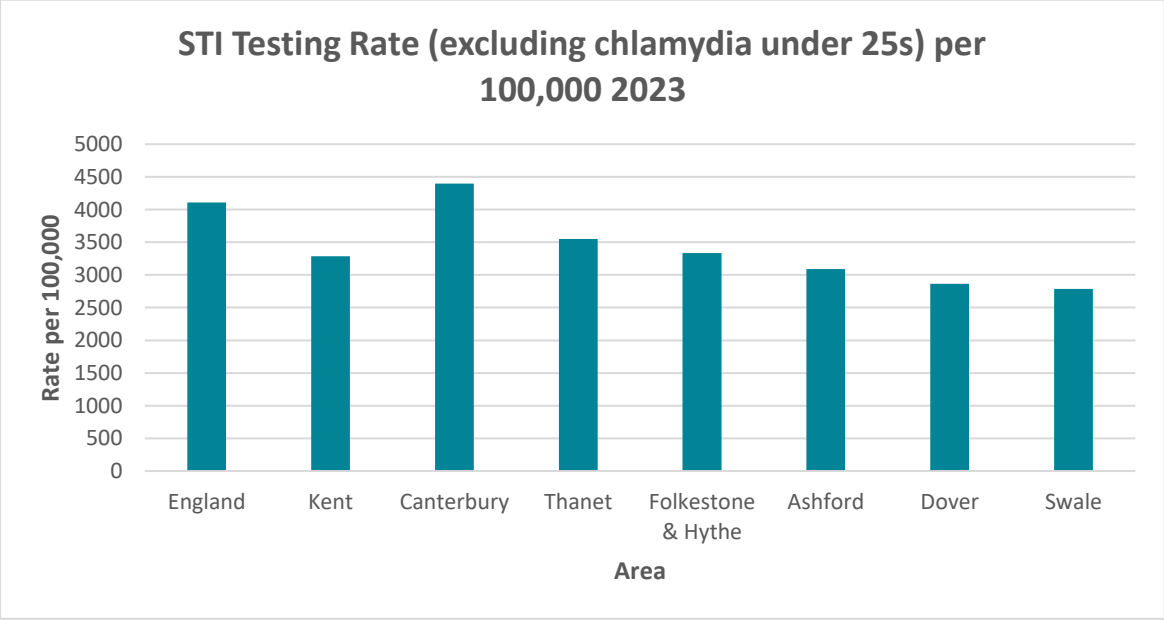

Figure 86 STI Testing Rate (excluding chlamydia under 25s)

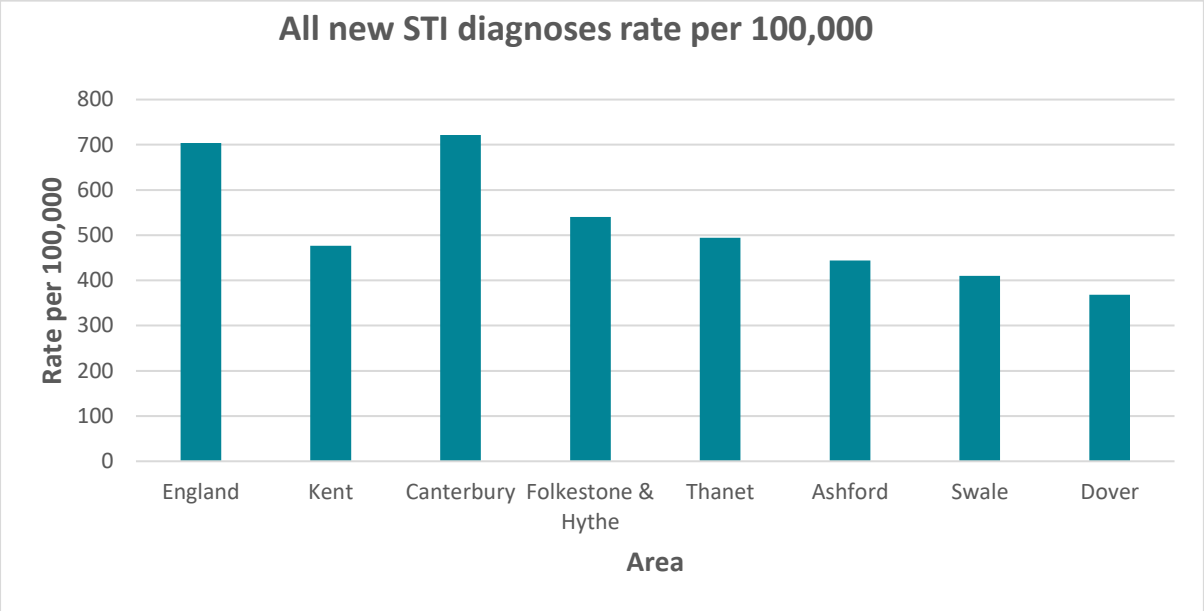

Figure 87 All new STI diagnoses rate per 100,000

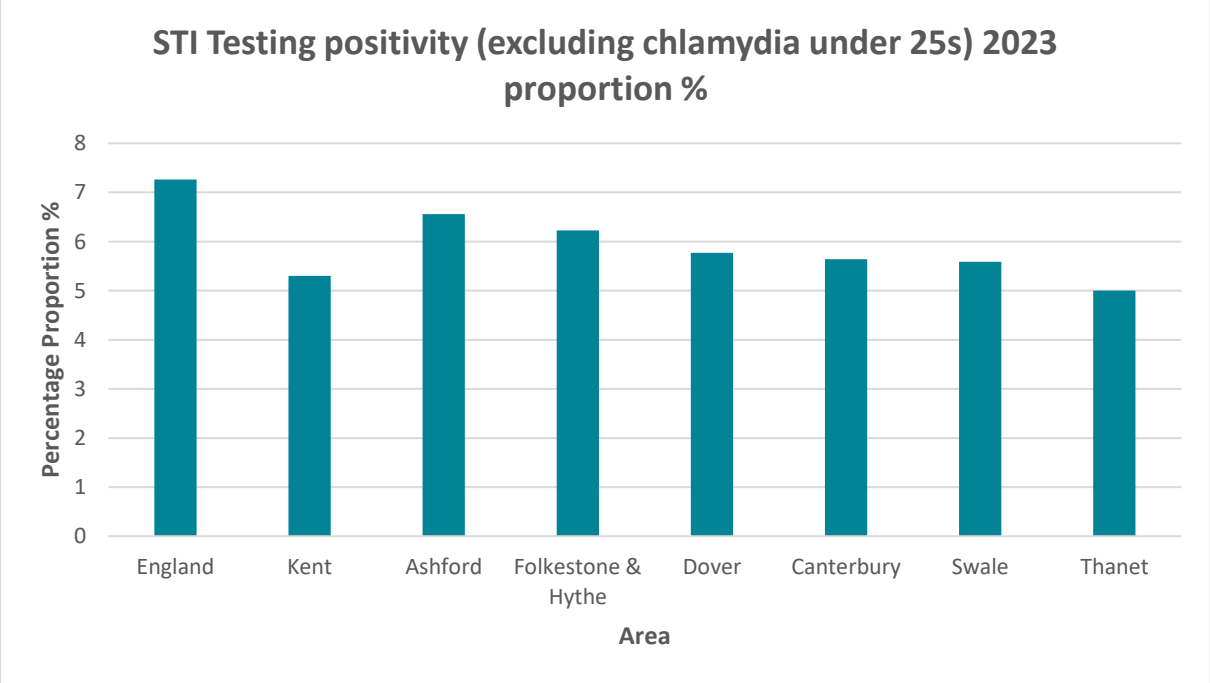

Figure 88 STI Testing positivity (excluding chlamydia under 25s) 2023 proportion %

Within Kent, Canterbury is the district with the highest number of young people aged 16 to 25 years, corresponding with being the second highest district for STI diagnoses rates. Canterbury has the also highest testing rate whereas Dover the lowest.

In 2023, Canterbury had the highest diagnosis of **Gonorrhoea** with a rate of 133 per 100,000. This is 156% higher than 2018. Gonorrhoea rates within each district have remained fairly stable except for Ashford and Folkestone and Hythe. In Ashford, there has been a 29.7% increase from a rate of 74 per 100,000 in 2022 to 96 in 2023 and

Folkestone and Hythe where there is an 8.2% increase from 98 per 100,000 in 2022 to 106 in 2023.

Herpes diagnosis was highest in Canterbury, Folkestone and Hythe, Dover and Thanet of all Kent districts in 2023.

Canterbury is also the highest district for diagnosis rates of **syphilis** (10.8 per 100,000), followed by Thanet (10 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, generally, North Kent has higher diagnosis rates of HIV than East Kent. Dartford is the highest district with a rate of 14.9 per 100,000, followed by Ashford (10.8 per 100,000) and Canterbury (10.6 per 100,000), all three of which are higher than the England rate of 10.4 per 100,000. Ashford's testing rate is proportionately lower than their diagnosis rate which could be indicative of higher levels of infection in the population, however, further analysis of this would be required. Dover has the lowest HIV new diagnosis rate in East Kent of 3.4 per 100,000 but it is only 5th lowest of all the Kent districts in terms of testing which would indicate genuinely lower disease in the population.

Positivity rates of STI diagnosis via the **online testing service** are generally higher in East Kent than in North and West Kent. The highest number of tests ordered in 2023/24 was Canterbury, with Thanet coming in third highest behind Maidstone.

10.4. Services

10.4.1. Contraception and reproductive health

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.

Canterbury has the highest rate per 1000 of prescribed LARC in 2022 at 56.6 per 1000, and in East Kent Folkestone and Hythe has the lowest at 36.1. The England rate is 44.1 per 1000.

Whilst **under-18 conception rates** have declined both in Kent and nationally, there is significant variation within the county with higher rates in Thanet, Swale, Dover and Ashford, all of which are East Kent districts.

There are few secondary schools that are 15 to 20 km away from a service, although in general, schools along the coastal regions appear to be a little further from services, typically between 10 to 20 km away. This is important to note given there is no sexual health clinic in Dover currently, and several coastal districts have higher rates of under 18 conceptions compared to the Kent average. Under 18 conceptions are associated

with deprivation and this is reflected in the higher rates found in the relatively more deprived districts of Thanet, Ashford, Swale and Dover.

The proportion of conceptions leading to **abortion** in teenagers under the age of 18 has increased 8% from 2020 to 2021. In Folkestone and Hythe, the proportion was 84.2%, highest of all the Kent districts. For females 15 to 44 years, in 2021, the total abortion rate per 1,000 of the population was 19.0 compared to 19.2 for England. Both Kent and England rates have increased since 2012, rising from 15.6 for Kent, and 16.5 for England.

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 longer periods of time. The rates of ectopic pregnancy in Kent are comparably high in Dartford (138 per 100,000), Ashford (122), Folkestone and Hythe (113.7), and Swale (107.3). The England rate per 100,000 is 89, and only 3 Kent districts fall below this rate, one of which is Canterbury.

Thanet and Swale are comparatively more affected by **violence** than other East Kent districts, with the wards that were most affected often found in the most deprived areas. This particularly impacted on women, with nearly 4 times as many women in the lowest income bracket experiencing domestic abuse in the last 12 months compared with those in the highest income bracket. In terms of sexual violence in 2022/23, 82% of victims were female and 90% of suspects were male, with the highest group of victims being girls aged 11 to 15 years. Women who experience sexual abuse are at a high risk of sexually transmitted infection.

Integrated sexual health services (ISHS) in East Kent are provided by KCHFT. KCHFT saw 33,140 in 2023/24, 12,034 (36.6%) males and 20,810 (63.4%) females.

In East Kent, services are in five of the six districts. The Gate Clinic in Canterbury offers level 3 provision for more specialist sexual health needs and is a very busy service due to Canterbury's student population. The new Flete clinic at QEQM in Margate opened in late 2023, with the aim of providing level 3 provision and reducing demand on the Canterbury clinic. There are also clinics in Folkestone, the Isle of Sheppey, and Ashford. There is no face-to-face service in Dover meaning residents would have to travel to Canterbury, Folkestone or Ramsgate using unreliable transport links which results in an inequality in access to services in East Kent. First-time patients are offered a full sexual health screen, including chlamydia, gonorrhoea, syphilis and HIV testing.

The service also provides long-acting reversible contraception (LARC), with a target of less than 6 weeks wait time from first consultation to insertion of the contraceptive device.

KCC has a section 75 agreement with NHSE for provision of HIV outpatient services through the ISHS.

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. Wait times for the KCHFT provided service are consistently above the target for waiting times, meaning people can access an ISH appointment when required.

People in East Kent are able to access at-home **STI testing service** 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. There may be potential inequalities in access however for those with poor internet connection, or those without a smart device or access to one. A map of wired broadband speeds in 2022 suggests East Kent and Canterbury have slower broadband speeds than other areas of Kent, but this does not account for internet access via smart phones and does not consider those without access to the internet or a smart phone.

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.

Psychosexual service is available to all residents in East Kent to support them through therapy sessions to support their good sexual wellbeing.

GP practices are located that deliver **LARC services** in Kent. This map shows good spread of availability across the county with the area of New Romney and Lydd in the Folkestone and Hythe district, as well as The Isle of Sheppey having a lower number of access points or further to travel to a practice.

10.5. Inequalities and Vulnerable Populations

10.5.1. 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.

10.5.2. People living in deprived areas

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

10.5.3. 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.

10.5.4. Migrant population

Barriers to accessing sexual health services, such as difficulty registering with NHS services remain, and in some cultures a perceived lack of risk of poor sexual health is present, preventing people from engaging with services. Outreach work of KCHFT and Metro have aimed to engage with migrant populations and regular sessions have been set up in some settings to give sexual health advice and support, for example Napier Barracks, and Milbank UASC Centre.

10.5.5. 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 East Kent in 2022/23, 78.6% of attendees were heterosexual, 13.5% gay or lesbian, 5% bisexual (with 2.9% other/not recorded/declined to answer) and 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).

10.5.6. 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.

10.5.7. Gypsy, Roma and Traveller populations

Kent has areas of high GRT populations, particularly the Isle of Sheppey, where it is not understood how well engaged ISHS are with this community. GRT populations should be a focus for sexual health to understand more about use of contraception, abortion rates, and identify opportunities to support with improving sexual health outcomes.

10.5.8. Alcohol and drug misuse

Alcohol and drug misuse can result in an increase in sexually risky behaviours including unprotected sex and inability to give consent to sexual activity. East Kent 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.

10.5.9. 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.

10.5.10. Homeless Population

The homeless population of East Kent 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.

10.5.11. 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 other council and other teams for this also.

10.5.12. Intersectionality

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

10.6. Recommendations

- Increase testing coverage given the marked drop in coverage from pre-pandemic levels, including via supporting promotional campaigns.
- Review gap in face-to-face service in Dover.
- Increase links with other services and stakeholders.
- Develop a peer support service for HIV, as recommended as best practice
- Review the options for strengthening of provision of HIV service provided to residents in Swale (Faversham) and Dover.
- Review the location of pharmacies offering the EoC and chlamydia treatment service to establish if there is an inequity in coverage of pharmacies across the county
- Insights data to understand awareness and effectiveness of pharmacy sexual health service
- Review outreach 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

11. Mental Health and Substance Misuse

11.1. 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 causes of death for drug users are more likely to be smoking-related illnesses than drug use.

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. 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.

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 had reduced slightly from 44% to 40%.

Approximately one quarter of people experiencing mental ill-health each year. Depressive disorders alone are one of the top five causes of death and disability combined in England. The cost of treating this is expected to continue to increase.

11.2. Best Practice

11.2.1. National policies

11.2.1.1. 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.

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.

11.2.1.2. 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.

11.2.2. 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
- Homelessness / Rough Sleeping Needs Assessment
- Children And Young People Drug & Alcohol Needs Assessment (0-25 Years Old)
- Mental Health Needs Assessment
- Domestic Abuse

11.2.3. Mental Health Needs Assessment

A health needs assessment specific to mental health in Kent is currently being complete, and will be available at the KPHO website page on mental health.

11.3. Epidemiological Findings

Deaths of despair are classified as deaths due to suicide, alcoholic live disease, and drug misuse. These are deaths from avoidable causes which occur disproportionately in those who are most deprived compared to those who are least deprived, both at a national and EK level. At a national level they are also associated with the following features: White British ethnicity, living alone, and education deprivation. Furthermore, in Kent, deaths of despair are around 2.5 times more likely to occur in men than women.

In EK rates of deaths of despair have been increasing since 2016 as shown in figure 89.

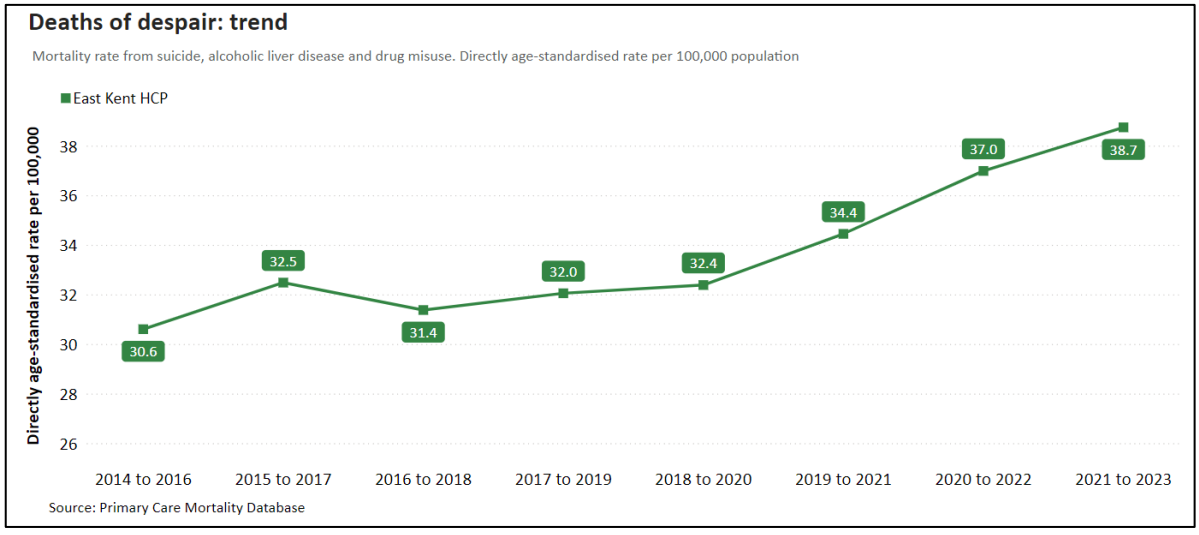

Figure 89 Age-standardised mortality rate for deaths of despair in East Kent, per 100,000.

When broken down the rise in rates of deaths of despair appears to be due to increases in mortality from alcoholic liver disease as shown in figure 90 and a slight increase in deaths related to drug misuse as shown in figure 91, whilst suicide rates in EK have remained relatively static.

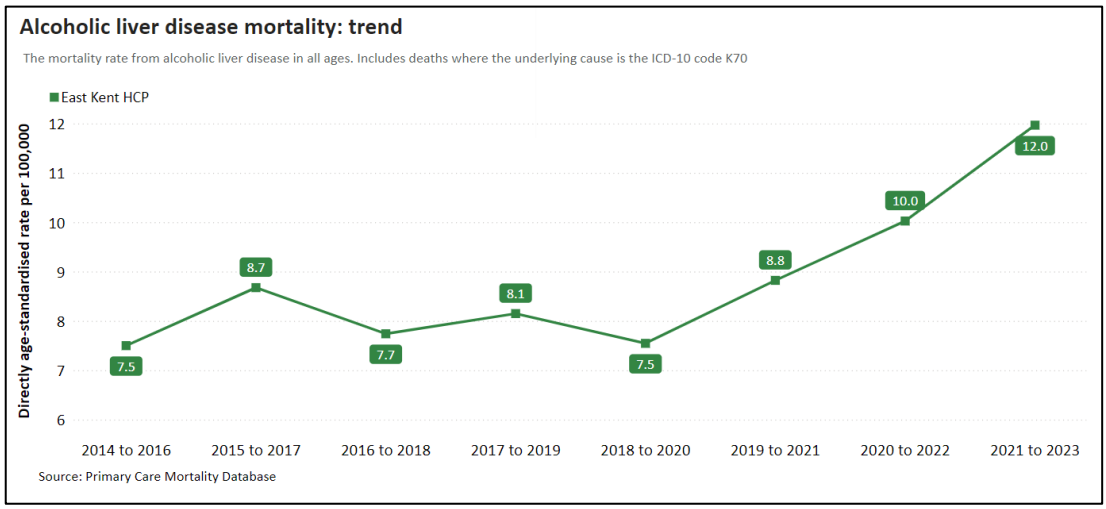

Figure 90 Age-standardised alcoholic liver disease mortality rates for East Kent, per 100,000

Alcoholic liver disease is twice as likely in men as it is in women in Kent. We know that at a national level those in the least affluent groups are more likely to die from alcohol related liver disease than those in the most affluent groups. Whilst those in the least affluent groups do tend to have higher risk drinking patterns, the difference in alcohol related harms persists between the most and least affluent groups when drinking patterns, smoking, and obesity are accounted for.

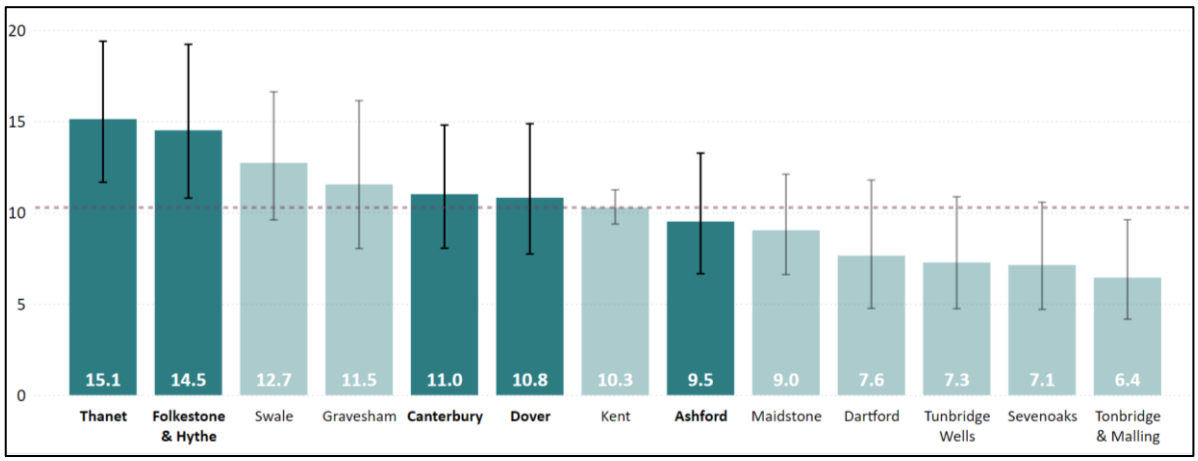

Figure 91 Age standardised alcoholic liver disease mortality rates by Kent district, per 100,000.

Drug misuse related deaths in East Kent are typically higher than both the England and Kent averages, 5.5 per 100,000 and 4.7 per 100,000 respectively. At district level, Ashford has slightly lower rates than Kent whilst the others are all higher than the Kent

average, a difference which is statistically significant for Folkstone and Hythe. Folkstone and Hythe is also statistically significantly higher than the English average.

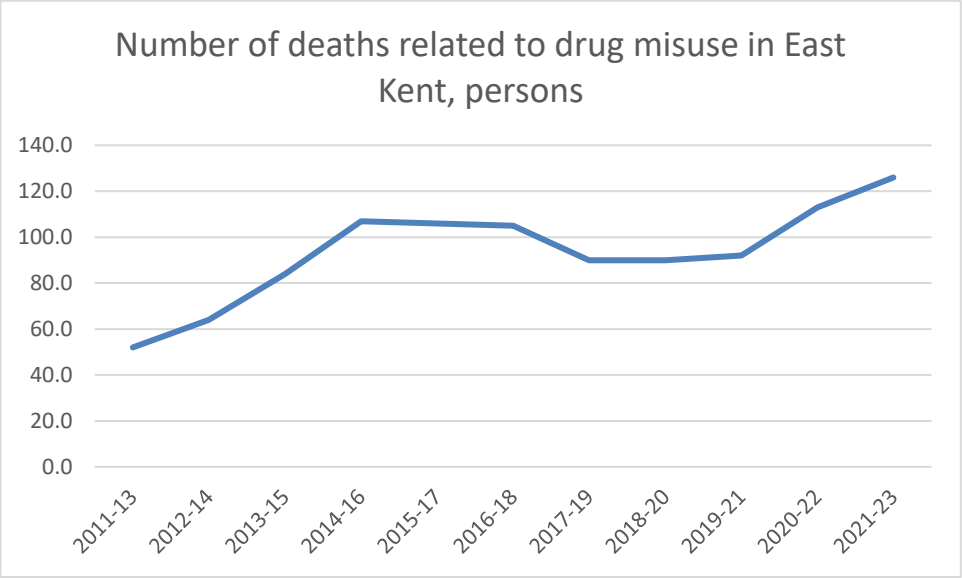

Figure 92 Number of deaths related to drug misuse in East Kent, persons (count)

Slight caution should be taken when assessing the overall trend in deaths related to drug misuse as they are given in crude numbers. However, age-standardised rates at district level appear to show a similar picture as shown in figure 93.

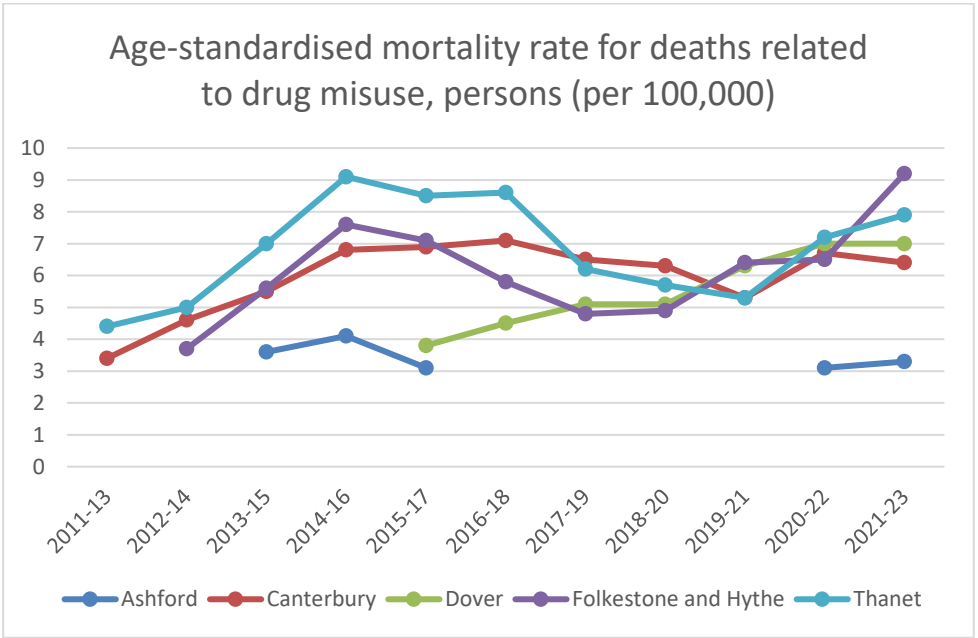

Figure 93 Age standardised mortality rate for deaths related to drug misuse by EK district, persons (per 100,000)

Rates of deaths related to drug misuse in EK are higher in consistently higher in men than women. However, the split across the districts of East Kent varies with the highest

rates of drug misuse related deaths in men occurring in Folkstone and Hythe whilst this district has the lowest rates of drug misuse related deaths in women.

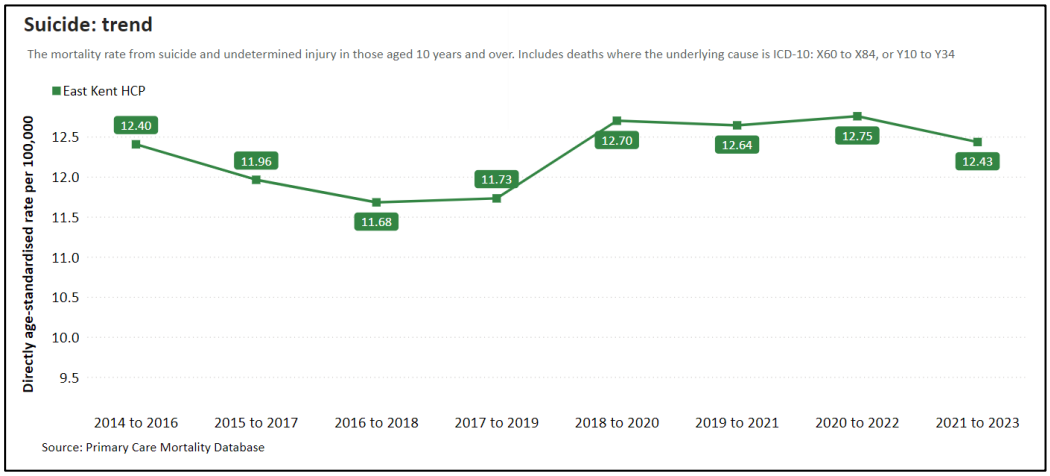

Figure 94 Age standardised suicide rate in EK, per 100,000

Within EK rates of suicide, self-harm, and mental health admissions have all remained static or declined despite an increase in the prevalence of depression, and severe mental illness which suggests that community-based interventions may be working well to ameliorate the rates of negative outcomes associated with rises in these conditions.

One key risk factor for both poor mental health and substance misuse is adverse childhood experiences, often referred to as ACEs. ACE 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. Exact numbers of ACEs experiences within Kent are unknown but research combining data from the police, social services, schools and other vital statistics, suggest that in EK Thanet appears to have the highest levels as shown in figure 95. Research suggests that 80% of those with 4 or more ACEs will have a serious mental or physical health condition by age 70.

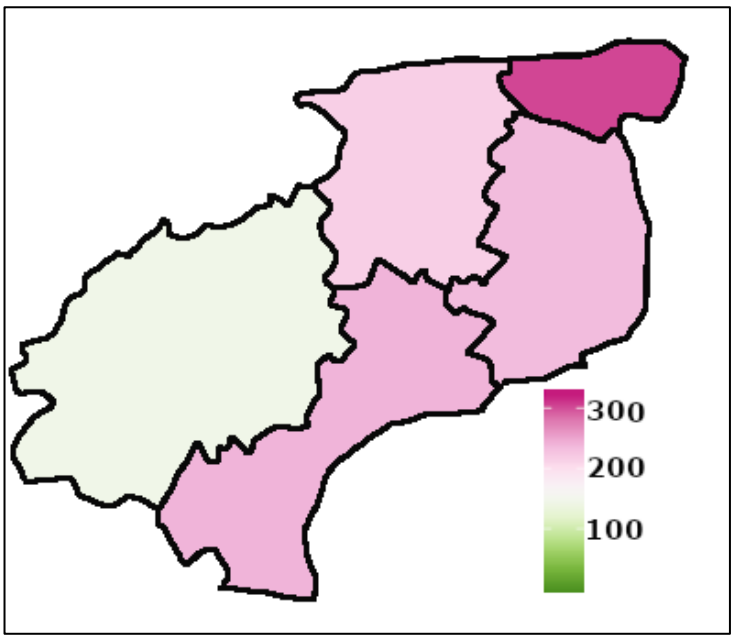

Figure 95 Rank of Adverse Childhood Experience index in EK Higher rank indicates that ACEs are more frequent [adapted from paper by Lewer et al].

Another key risk factor for mental ill-health and substance misuse is social isolation/loneliness. Social isolation can affect wellbeing, and research suggests that those experiencing it are 26% more likely to experience premature mortality.

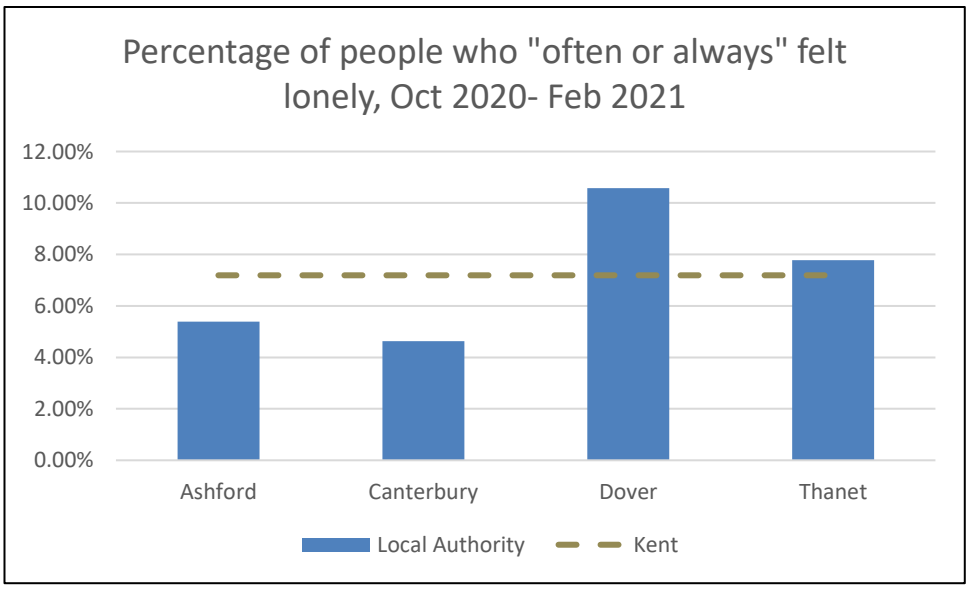

Figure 96 Percentage of people who "often or always" felt lonely, Oct 2020- Feb 2021, data not available for Folkstone and Hythe.

11.4. 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 their 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.

Adult substance misuse services in East Kent are provided by the Forward Trust. They provide a variety of services including facilities for safe needle exchange in Ashford, Canterbury, Dover, Folkestone, and Thanet, support through peer mentoring, and support for friends and families who are concerned about their loved one's substance misuse. Further Kent wide support for alcohol misuse is offered by One You Kent.

Support for young people in EK is provided by We Are With You who target 11–18-year-olds but also provide support for 18–24-year-olds, this service is offered across Kent.

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 better outcomes. All services for substance misuse offer mental health support.

The average waiting time for talking therapies in Kent is 18.8 days and completion rates of talking therapies in Kent is higher than the English average. There is a slight concern that only 19% of residents with severe mental illness receive physical health checks. This is a particular problem in DGS where only around 63% of people with severe mental illnesses have received a blood pressure check in the last 12 months, compared to the Kent average of 68%. This suggests that the proportion receiving a full physical health check may also be lower than the Kent average.

In East Kent 27.9% of individuals successfully completed drug misuse treatment in 2022/23-2023/24. Completion rates were lowest in Dover and Folkestone and Hythe.

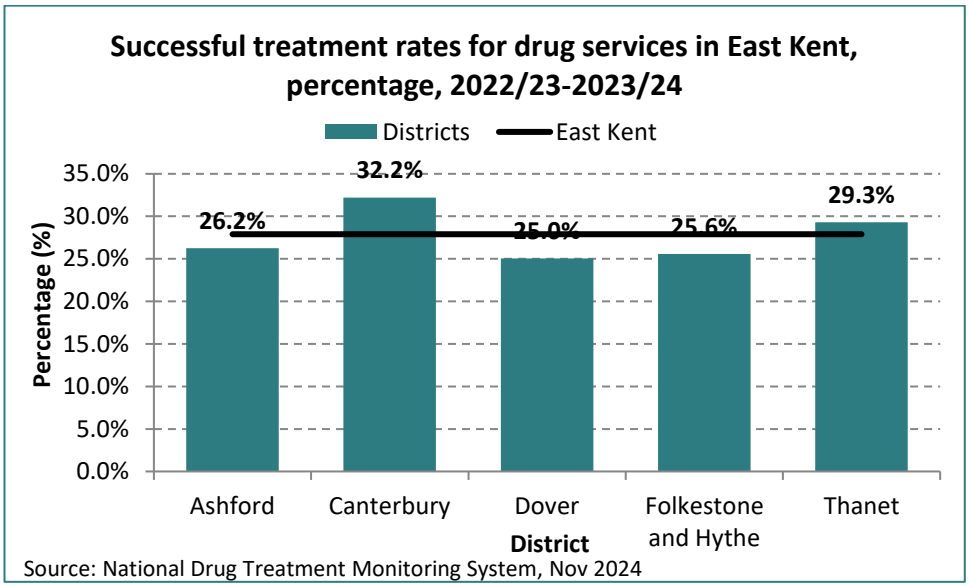

Figure 97 Successful treatment rates for drug services in East Kent

11.5. Gaps

- There is little known about rates of ACEs in Kent as a county or its districts, though research suggests these are higher in Thanet. As this is a key risk factor for both substance misuse and poor mental health, it may be a good area to review using more integrated data sources.
- Thanet has a high proportion of its population with risk factors for mental ill-health and substance misuse. For example, they have high levels of deprivation, potentially high levels of ACEs, and high levels of loneliness.

11.6. Recommendations

- Due to variation in need across East Kent, interventions should be targeted based on place-by-place need.
- A dedicated mental health needs assessment should be carried out to review services for mental health and evaluate the increase in depression seen in East Kent. This should include a focus on the comorbidities seen with depression and consider the provision of services more widely to this group.

12. Multimorbidity

The analysis of multimorbidity has been conducted using data using the Kent and Medway Care Record database, which for this analysis will largely draw 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, palliative care, rheumatoid arthritis (RA), and depression.

Figure 98 shows the distribution of morbidity across age groups in East Kent. 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 nationally. Approximately 19% of people of all ages are multimorbid, and by age 50 approximately 46% of people have at least 1 long term condition (LTC) and approximately 16% have 2.

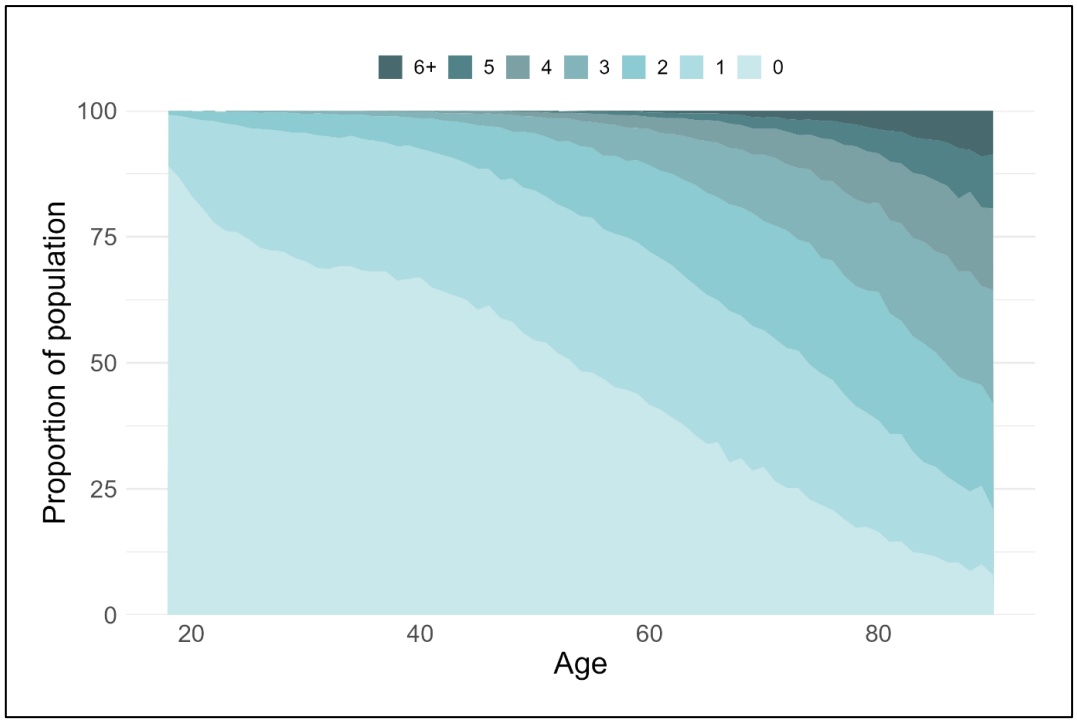

Figure 98 Count of long-term conditions by age of people in East Kent HCP aged 18, October 2024. Source: KMCR.

12.1. Demographics of multimorbid people

People in East Kent 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. People living in all other quintiles have significantly lower prevalence of multimorbidity. In the least deprived quintile, the prevalence of having 5+ conditions is approximately 1/3 lower than in the most deprived.

The prevalence of multimorbidity varies greatly between PCNs in East Kent, ranging from 13% in Canterbury South to 28% in The Marsh and 25.1% in Herne Bay PCN. Even after adjusting for age The Marsh and Herne Bay PCNs have the highest rates of multimorbidity, suggesting people living here may be in poorer health (figure 99).

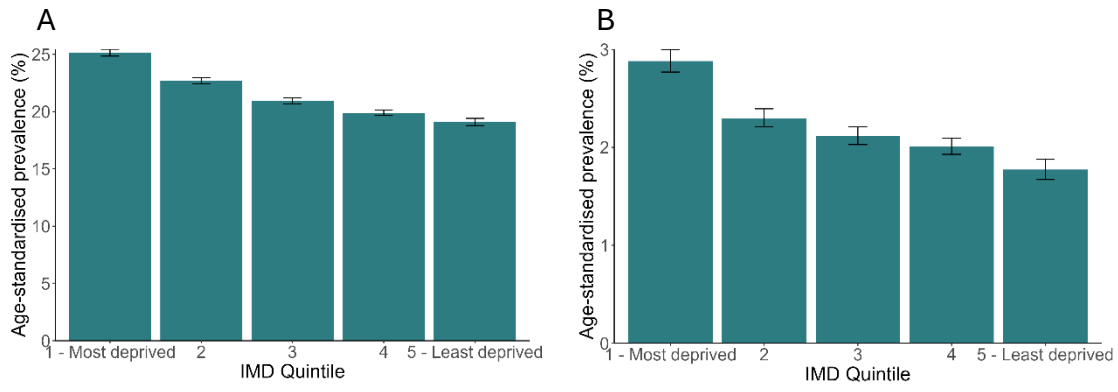

Figure 99 Age-standardised percentage of people who live in each deprivation quintile (Kent and Medway) who have A – two or more conditions, and B – five or more conditions, November 2024. Source: KMCR.

Figure 100 Proportion of people in East Kent PCNs who are multimorbid, October 2024. A –prevalence, B – age-standardised rate. Source: KMCR.

There is also a correlation between area type and the prevalence of multimorbidity (age-standardised). In coastal and non-coastal urban areas there is a higher rate than in rural or dispersed areas (22.3, 22.0 and 19.8 per 100 people, respectively).

Table 13 Prevalence of people who are multimorbid shown by area type, age-standardised, East Kent HCP, October 2024. Source: KMCR.

Area type	Age-standardised rate per 100 people	Confidence intervals (lower, upper)
Coastal	22.3	22.1 - 22.4
Non-coastal	22.0	21.8 - 22.2
Rural village or dispersed	19.8	19.5 - 20.2

Multimorbidity also varies by ethnicity. People who are Black/Black other, White or Multiple or mixed ethnic groups all had similar age-standardised rates of multimorbidity, at around 23%. People who are Asian/Asian British or Other ethnic groups had significantly lower rates of multimorbidity, at approximately 18% (figure 101).

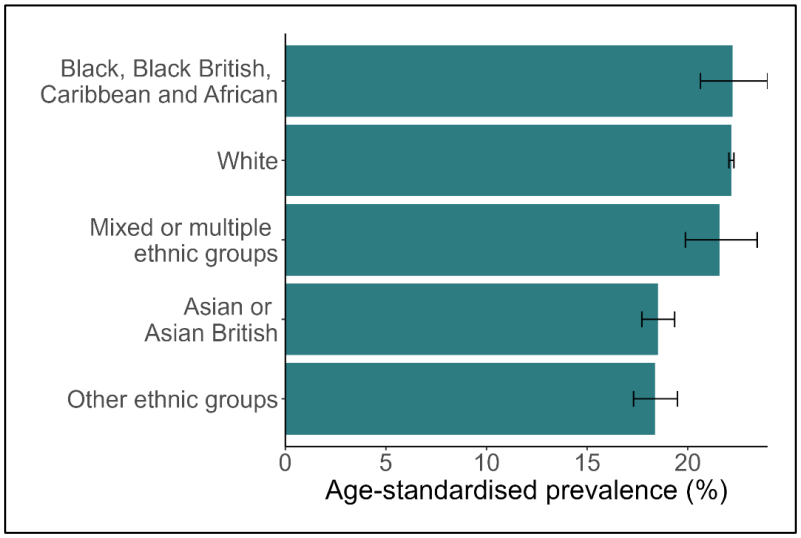

Figure 101 Proportion of people of each ethnic group who are multimorbid, age-standardised, East Kent HCP, October 2024. Source: KMCR.

12.2. 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.

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.

Table 14 The top 5 diagnosed first conditions in East Kent, October 2024. Source: KMCR.

Condition	% of conditions first diagnosed
Hypertension	37
Depression	14
Diabetes	9
Asthma	9
CHD	6

Table 15 The top 5 diagnosed second conditions in East Kent, October 2024. Source: KMCR.

Condition	% of conditions diagnosed second
Hypertension	22
Diabetes	13
Depression	12
CKD	9
Cancer	8

Table 16 The top 5 diagnosed third conditions in East Kent, October 2024. Source: KMCR.

Condition	% of conditions diagnosed third
Hypertension	14
CKD	13
Diabetes	12
Depression	9
Cancer	9

The median time between first and second diagnoses and second and third diagnoses in East Kent HCP and Kent and Medway are very similar (table 17). This indicates that people in East Kent 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 second condition half a year more quickly than the general cohort, and their third condition a year earlier than the general cohort. This could indicate that people who are diagnosed with depression are more vulnerable to developing further long-term conditions (table 17). People who are first diagnosed with a serious mental illness (SMI) generally acquire their second condition later. This is likely due to the lower typical age of diagnosis for these conditions (33 for SMI versus 44 for depression). This analysis excludes people who were diagnosed with multiple 'first' conditions on the same date and any conditions diagnosed before age 18 due to data quality concerns.

Table 17 Time delay between onset of first, second and third conditions in people in Kent and Medway and East Kent HCP, and people in East Kent who had a first diagnosis of hypertension, depression or serious mental illness. October 2024. Source: KMCR.

	First condition				
Median time delay (years)	Any (Kent and Medway)	Any (East Kent)	Hypertension (East Kent)	Depression (East Kent)	Mental Health (East Kent)
1st to 2nd diagnosis	5.8	5.8	7.3	5.3	9.4
2nd to 3rd diagnosis	3.7	3.7	4.1	2.7	4.0

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 (87%) of people had conditions which spanned several specialities. About 6% of people had diabetes with at least one of hypertension, LD or palliative care. About 5% of people had only cardiovascular diseases (possibly including LD or palliative care).

12.2.1. 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 – 8.3% of people with depression developed an SMI as their second condition, and 35% 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.

12.2.2. Trends in conditions acquired before age 50

A subset of more severely multimorbid people were identified – people aged 55 or over with 4 or more conditions. This amounted to about 22,400 people in East Kent. Approximately 7,000 of this cohort had diagnoses before age 50. Hypertension was the

most common diagnosis with 54% of this cohort having a diagnosis before age 50. 21% were diagnosed with diabetes, 18% with asthma and 15% with depression or CHD (table 18). In this cohort, the condition which they were diagnosed with first is similar to that of the general cohort, with hypertension being by far the most common, however diabetes and depression are noticeably less common first diagnoses (table 18 vs table 14). Of those who developed diabetes, it was only the first condition for half of them. This could suggest that there should be increased focus on people diagnosed with hypertension and an intervention at this point could slow the progression to multimorbidity.

In comparison, the conditions acquired by people who are currently aged under 50 have a different pattern. Approximately 70,000 people under the age of 50 in East Kent have at least one LTC and 11,000 have 2. About 75% of people in both of those groups have a depression diagnosis.

Table 18 Most common conditions acquired by people who are 55+ and have 4+ conditions when they were age under 50. East Kent, December 2024. Source: KMCR.

Condition	Percentage (%)	First condition diagnosed (%)
Hypertension	54	39.2
Diabetes	21.1	11.1
Asthma	17.5	11.3
Depression	15.3	5.9
CHD	15.2	9.3

Table 19 Most common conditions acquired by people who are currently aged under 50. East Kent, December 2024. Source: KMCR.

Condition	People with 1+ conditions (%)	People with 2+ conditions (%)
Depression	74.8	76.4
Asthma	15.9	37.9
Hypertension	11.9	28.4
Diabetes	6.5	24.6
SMI	4.3	18.4

13. Falls

13.1. Background

Falls represent a major cause of morbidity and mortality in older adults. Preventing falls, therefore, is an important mechanism of improving and maintaining health. Falls are associated with declines in physical and mental health, reduced function, and loss of confidence. Falls often result in serious injury, such as fractures and long lies, which can need hospital admission. They are a major cause of deconditioning, institutionalisation, escalation of care needs, and frailty. Many falls, particularly mild and moderately severe falls, go unreported. Identifying people who fall or are at risk of falling is important to adequately target services and prevent future morbidity and mortality. Falls are likely to be a significant driver of health and social care costs. As the population ages, this impact is likely to become even more significant.

Risk of both falling and having a poor outcome as a result of a fall is greater in those who

- Have a history of falls
- Have muscle weakness
- Have poor balance
- Have visual impairment
- Are taking several different medications (notably psychotropics and antiarrhythmic agents)
- Face environmental hazards
- Have other specific conditions associated with falls, e.g. arthritis, cognitive impairment, depression, diabetes, alcohol dependence, incontinence, Parkinson's disease, stroke, and syncope.

Fractures following a fall are more likely in those who

- Have low bone mineral density (osteoporosis)
- Have previously suffered a fracture
- Are older
- Are women
- Have a history of falls
- Use corticosteroids
- Have rheumatoid arthritis
- Smoke
- Consume high levels of alcohol
- Have a low BMI
- Have visual impairment

13.2. Best Practice

Public Health England published a consensus statement on falls and fractures in 2017, which advocates for a system wide approach.

This approach includes, among others,

- Promoting healthy ageing
- Optimising the reach of evidence-based case finding
- Actions to reduce risk in high-risk care environments
- Providing fracture liaison services in line with clinical standards
- Collaborative interdisciplinary

They recommend the commissioning of services that provide

- An appropriate response to people who have fallen
- Multifactorial risk assessment
- Timely and evidence based tailored interventions for those at high risk
- Evidence based strength and balance programmes for those at low to moderate risk
- Home hazard assessment and improvement programmes

Finally, they recommend having a strategic lead and governance body with oversight and assurance of falls, bone health, and related areas including frailty and multimorbidity.

A 2021 Cochrane review assessed interventions for preventing falls in older people living in the community. They noted that group and home-based exercise programmes, and home safety interventions, both reduced the rate of falls, and the risk of falling. Multifactorial assessment and intervention programmes reduced the rate of falls, but not the risk of falling. Tai Chi reduced the risk of falling. Further, they noted that several trials provided an economic evaluation of their interventions, of which three indicated cost savings - home based exercises in over 80-year-olds, home safety assessment and modification for those who had previously had a fall, and one multifactorial programme.

13.3. Epidemiological Findings

It is difficult to quantify the number and impact of falls for several reasons. Falls likely go underreported, particularly mild and moderate falls which are less likely to result in hospital admission. Additionally, falls are less likely to be reported by men. However, it is estimated that around a third of all people aged 65 and over will have a fall each year. This number rises to half of all people aged 80 and over.

Hospital Admissions provide one source of epidemiological data. However, they do not represent all falls in East Kent, or the associated need, as many falls (even those resulting in injury or other health harm) will not result in an ED attendance.

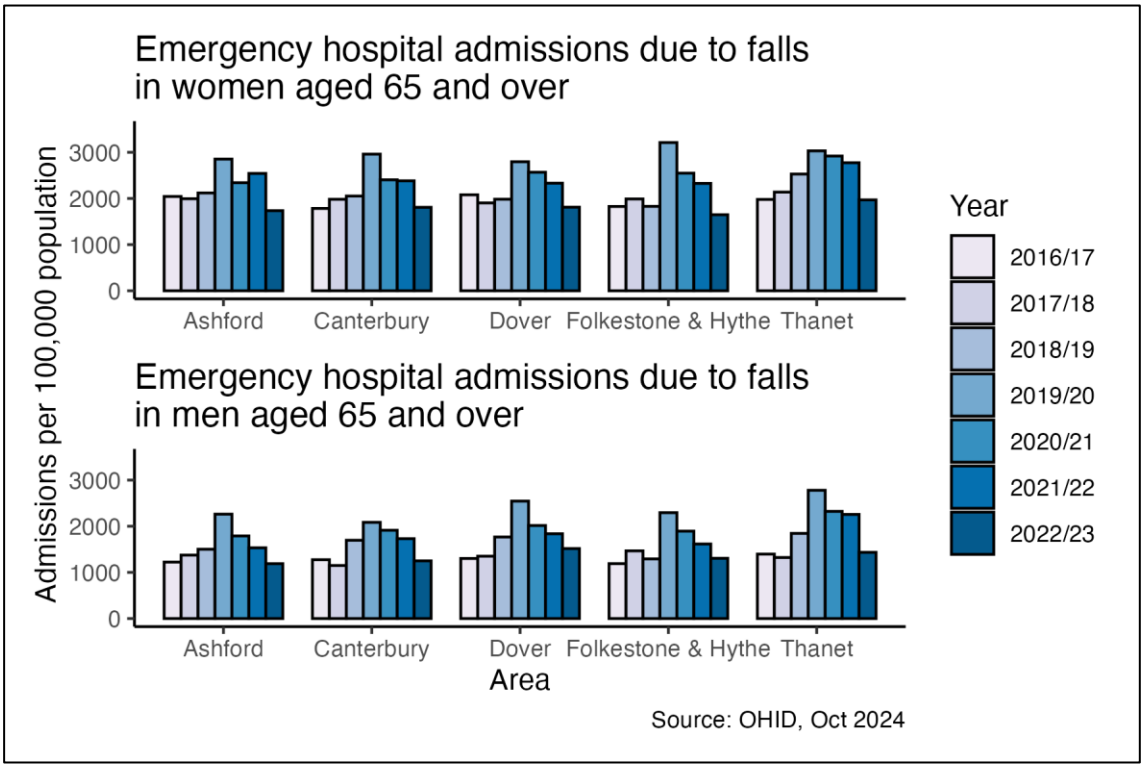

Figure 102 Emergency hospital admissions due to falls in women (top) and men (bottom) aged 65 and over by district and year

Admissions to emergency departments due to falls are more likely in women aged 65 and over than they are for men aged 65 and over. This is likely due to the increased prevalence of osteoporosis, an important risk factor for fractures. There does not appear to be any secular trend in these admission levels over time. There was a notable peak in admissions for the year 2020/21. This is potentially due to an increase in the number of serious falls, in the context of increased social isolation. However, the number of admissions due to falls has since decreased to a level similar to those before the Covid-19 pandemic. There does not appear to be any significant difference in the rate of admissions between districts within East Kent.

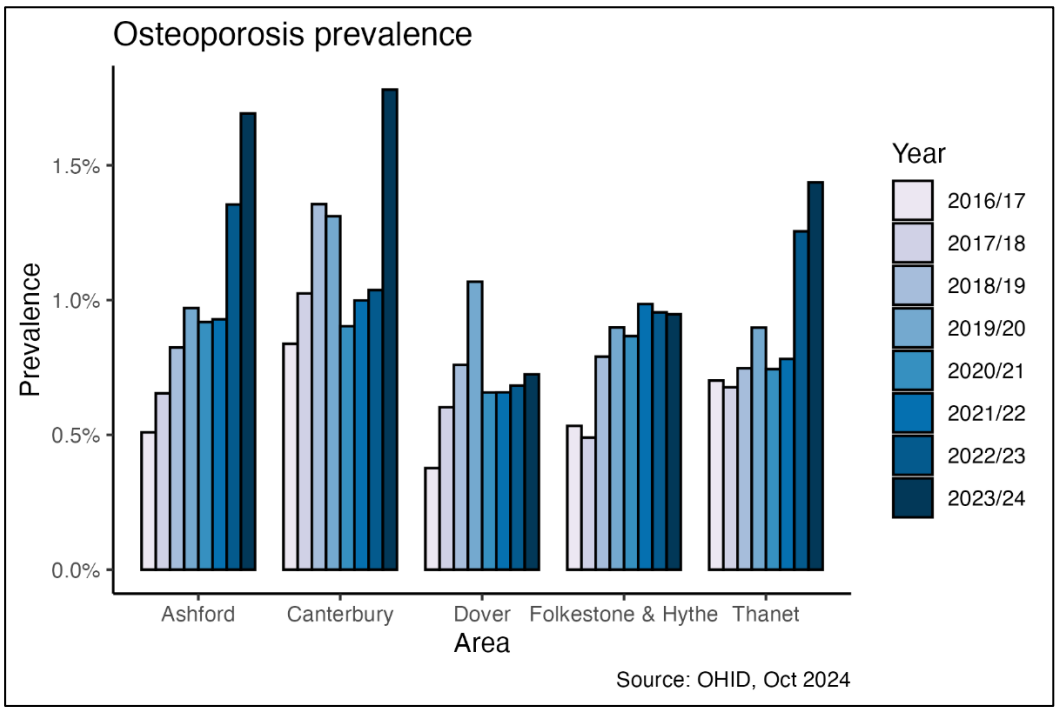

Figure 103 Prevalence of osteoporosis by district and year

The prevalence of osteoporosis is increasing over time, across all districts. This likely represents the impact of an ageing population. Notably, this increase is greatest in Ashford, Canterbury, and Thanet, and relatively modest in Dover and Folkestone & Hythe.

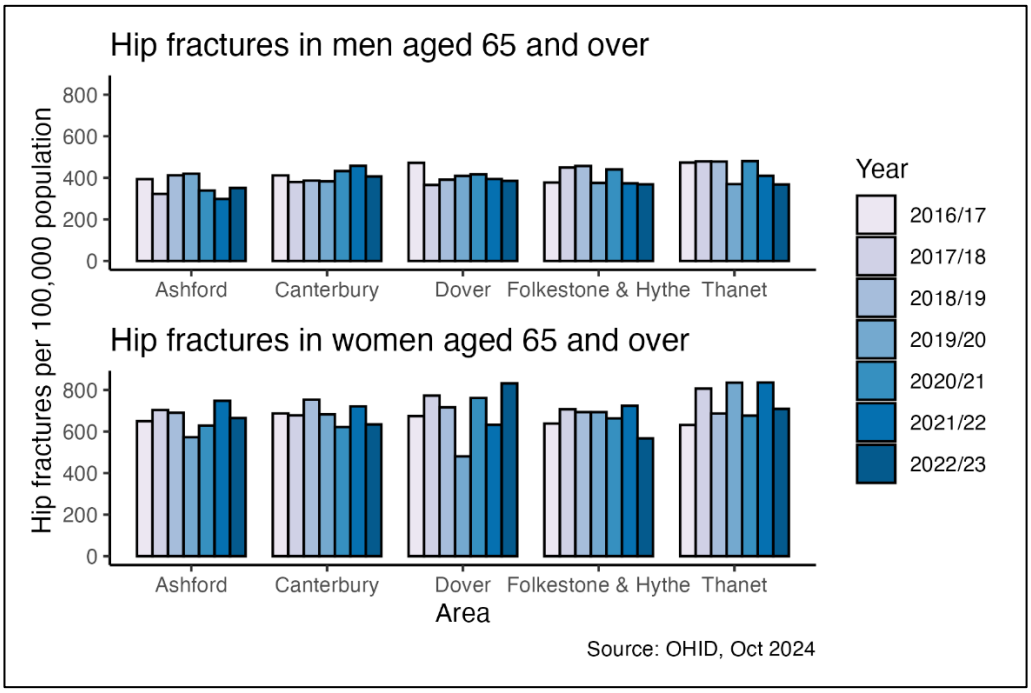

Figure 104 Hip fractures in men (top) and women (bottom) aged 65 and over by area and year

Hip fractures, like admissions to emergency departments due to falls, are more common in women than they are in men. Again, this likely represents increased levels of osteoporosis in women. Despite the increased levels of osteoporosis, there does not seem to be a resultant increase in hip fractures. It is not clear why this is.

13.4. Current Services

In East Kent, the following work is currently underway to reduce the risk of falls in older people.

13.4.1. Community Rehabilitation Team (Adults) – KCHT

The Community Rehabilitation Team at KCHT provide lower-level strength and balance classes for those unable to attend postural stability groups (i.e. housebound). They provide in depth assessment of falls risk, including physical, environmental and medical factors. They also provide advice, information, equipment, and support.

13.4.2. Falls Prevention Service/Postural Stability Team – KCHT

The Falls Prevention Service and Postural Stability Team at KCHT provide advice and encouragement to help reduce the risk of falling. They provide support and exercise through tailored group exercises. This covers areas such as coping after a fall, getting up after a fall, footwear and footcare, and medication. This also covers chair-based exercises to support with strength, balance, and mobility.

13.4.3. Buckland Day Hospital Falls Group – EKHUFT

Buckland Day Hospital has a Falls Group, which is aimed at people who have had a fall or have a fear of falling. They offer exercise groups to increase muscle strength, improve balance and stamina, co-ordination, and increase confidence and independence. They also provide education on what to do in the event of a fall.

13.4.4. Voluntary and Community Social Enterprise

Several services are provided by voluntary and community social enterprise. This includes housing assessment, decluttering, assistive technology, adaptations, home monitoring, fall detectors and alarms.

13.4.5. Falls prevention education to care homes

Various training and education resources are provided to care homes for falls prevention with options for both virtual and face-to-face delivery.

13.5. Recommendations

- Await the outcome of the KCC Falls Prevention Programme
- Continue to commission services which provide tailored interventions, strength and balance programmes and multifactorial risk assessment.
- Assess which interventions will have the greatest impact on health outcomes, and on demand and cost across the system.

- Adapt existing services as and when new evidence comes to light to maximise their effectiveness.
- Ensure that interventions are accessible to vulnerable populations and are culturally sensitive.
- Monitor and evaluate the impact of interventions on falls, particularly across different demographic groups.
- A targeted needs assessment, including dedicated analysis on the topics raised above, should be commissioned.

14. Dementia

14.1. Background

Dementia is a growing challenge that affects an estimated 24,000 people in Kent and Medway. There are estimated to be almost 950,000 people currently living with dementia in the UK. As the population ages and people live for longer, dementia has become one of the most important health and care issues facing the world.

Dementia describes a group of symptoms that include problems with memory, thinking or language, and changes in mood, emotions, perception and behaviour. Dementia is a progressive disease, which means symptoms may be relatively mild at first, but they get worse over time. There are many types of dementia, but Alzheimer's disease is the most common. The next most common is vascular dementia.

Dementia mainly affects older people, and after the age of 65 the likelihood of developing dementia roughly doubles every five years. However, dementia can develop earlier for some people, presenting different issues for the person themselves, their carer and their family.

14.2. Best Practice

NICE guideline NG97 covers the assessment, management and support for people living with dementia and their carers. It includes recommendations on involving people living with dementia in decisions about their care, interventions to promote cognition, independence and wellbeing, and on managing non-cognitive symptoms, as well as pharmacological interventions and staff training. It asserts the human value of people living with dementia, regardless of age or cognitive impairment.

Dementia: applying All Our Health is a 2022 guidance published by OHID. It is a resource which covers reducing the risk of getting dementia, as well as focusing on dementia in professional practice. It highlights evidenced based steps that can be taken to reduce the risk of dementia — increased physical activity, healthier eating and maintaining a healthy weight, drinking less alcohol, stopping smoking, being socially active, and controlling diabetes and hypertension.

The Lancet has published a 2020 report of their commission on the prevention, intervention, and care of dementia. It highlights the importance of modifiable risk factors for dementia and identifies evidence for three novel risk factors – alcohol consumption, head injury, and air pollution. Modifying the twelve risk factors identified by the commission might prevent or delay up to 40% of dementias. Further, it highlights the importance of care for family carers of people with dementia.

14.3. Epidemiological Findings

Dementia prevalence varies in East Kent. Folkestone and Hythe has the highest prevalence — 0.93% of the resident population in Folkestone and Hythe have a diagnosed dementia. Canterbury 0.92%, Dover 0.88%, Thanet 0.75%, and Ashford

0.73%. Kent as a whole has a prevalence of dementia at 0.78%. Age is the biggest risk factor for developing dementia and can't be modified. However, 40% of dementia cases could potentially be avoided by removing some risk factors. The largest impacts are made by hearing loss, education and smoking. Addressing social isolation and depression can also make a difference.

People with dementia are more likely to have comorbidities.

- 77% of people with dementia have comorbidities (vs 68% all patients)
- twice as likely to have 3+ comorbidities than the all-patient group (22% vs 11%)
- four times more likely to have 5+ comorbidities (2.3% vs 0.6%)
- Comorbid conditions become more difficult to diagnose resulting in under-diagnosis and unmet need as the severity of dementia increases
- Hospital admissions for those with dementia are rising and many are due avoidable illnesses and injuries such as infections, falls and dehydration

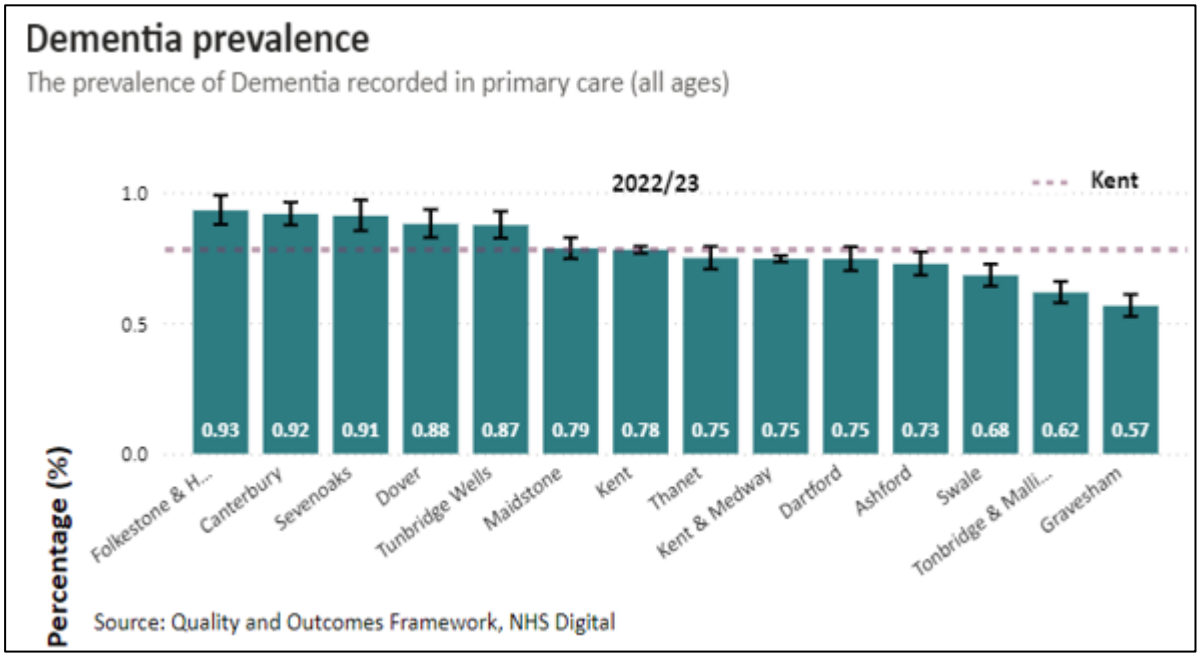

Figure 105 Prevalence of dementia by district

There is some evidence of a link between dementia prevalence and deprivation. Table 20 shows that prevalence is highest in those who live in an area with IMD quintile score of 4, however once adjusted for age, those in the most deprived quintile have the highest rate by a small margin. This suggests that living in a deprived area increases your risk of having dementia, however more older people live in less deprived areas and the higher burden of disease is there.

Table 20 Dementia prevalence in East Kent by IMD quintile, not age standardised. Source: KMCR.

IMD quintile	Prevalence (%)	Age-standardised rate (ASR)	Confidence intervals for ASR (lower, upper)
1 - Most deprived	0.73	1.62	1.51, 1.73
2	0.77	1.25	1.17, 1.33
3	0.84	1.17	1.10, 1.26
4	1.13	1.42	1.34, 1.50
5 - Least deprived	0.99	1.43	1.33, 1.54

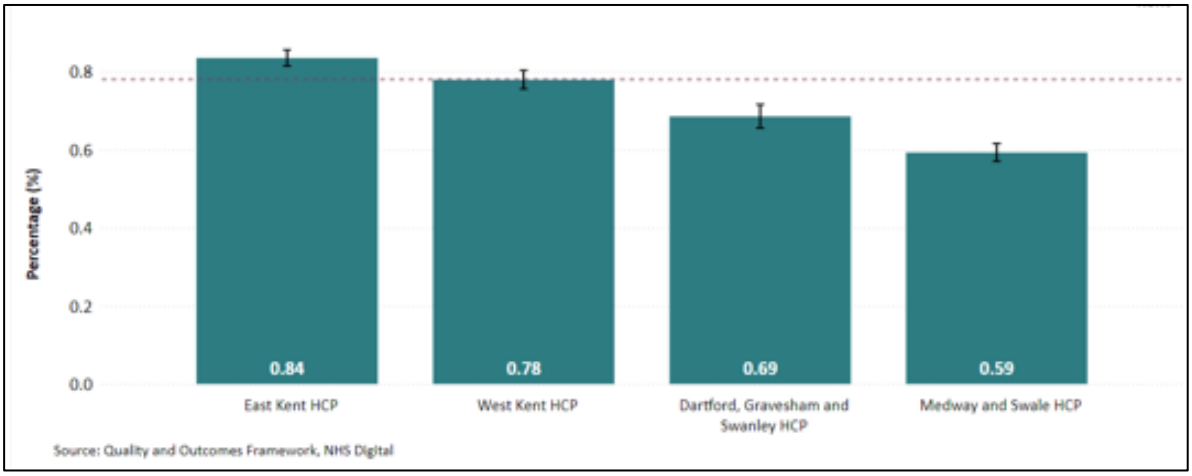

Figure 106 Estimated number of people age 60+ diagnosed and undiagnosed in East Kent HCP in 2024 and projected to 2030 and 2040. Source: KMCR prevalence by age applied to KCC population projections.

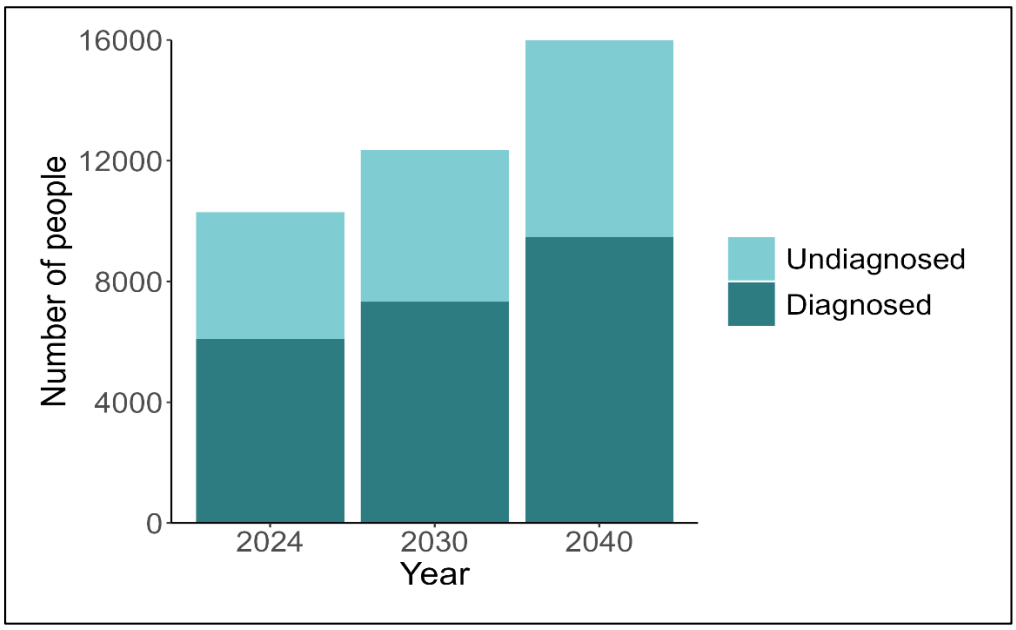

Figure 107 Projected dementia cases in 2030 and 2040 in East Kent.

From 2024 to 2030 we could expect an additional 1,200 dementia diagnoses, and from 2024 to 2040 an additional 3,300 (approximately 50% growth). Assuming the diagnosis rate remains at 59.3%, this would leave 6,500 people undiagnosed.

14.4. Available Services

14.4.1. KMPT Enhanced Memory Assessment and Intervention service

In summer 2022, KMPT introduced a new Enhanced Memory Assessment and Intervention service. Developed by Kent and Medway clinicians, it is now available to people with concerns about their memory who are referred by their GP or other healthcare professional. People are assessed and then diagnosed by clinicians on the same day where wanted and appropriate for the person.

The key benefits are:

- Single appointment for assessment and diagnosis
- Reduction in time to treatment and support
- Face to face consultation
- Opportunity to get answers to questions straight away
- Access to post diagnostic support service, including links to Living Well with Dementia toolkit and access to Cognitive Stimulation Therapy (CST) where appropriate

The service is part of a wider programme of work being delivered by KMPT and the Kent and Medway Integrated Care System (ICS) to improve dementia services in the county.

This includes work around raising dementia awareness and pre- and post-diagnostic support to enable people with dementia to live well. KMPT has also started a programme with GPs to train them to become dementia experts, which will see more people diagnosed in primary care settings in the future.

14.4.2. Admiral Nurses

KMPT works with family, loved ones and carers to support those with dementia. Admiral nurses are registered nurses who provide support for families affected by all forms of dementia and help families manage complex needs, considering the person living with dementia and the people around them.

14.4.3. KMPT Community Mental Health Service for Older People

KMPT Community Mental Health Service for Older People (CMHSOP) has six locations across East Kent. The community service is for both older people with mental health needs, which are complicated by age related needs, and for people, of all ages, who have needs related to dementia. The teams also provide support and advice to professionals, care homes and carers. KMPT Community Mental Health Service for Older People can be found in the following locations across East Kent

- Ashford CMHSOP
- Canterbury and Coastal CMHSOP
- Dover and Deal CMHSOP
- Shepway CMHSOP
- Swale CMHSOP
- Thanet CMHSOP

14.4.4. Dementia Engagement and Empowerment Groups

These are groups of people in East Kent living with dementia, who offer their time and knowledge to work with KMPT and others to improve services for people living with dementia.

- Phoenix in Ashford
- Forget-Me-Nots in Canterbury
- Pathfinders in Swale
- SUNShiners in Dover, Deal and Shepway area

Further information about additional DEEP groups can be found here: DEEP groups - DEEP (dementiavoices.org.uk)

14.5. Recommendations

- Increase public awareness of the steps individuals can take to reduce their risk of dementia
- Highlight the importance of systemic risk factors on dementia e.g. air pollution

- Target those at risk for hearing loss
- Ensure services are provided to support family carers of people with dementia

15. End of Life Care

15.1. Introduction

Death and dying are inevitable. In 2008 the first national strategy for end-of-life care in England focused the health and social care system towards three key insights: that people didn't die in their place of choice; that we needed to prepare for larger numbers of dying people; and that not everybody received high- quality care. 'Some people experience excellent care in hospitals; hospices; care homes and in their own homes. But the reality is that many do not'.

Approximately 1% of the UK's population die each year, and in East Kent the figure for 2022 is just above that at 1.05% at 7,600. Within that population the majority of deaths can be predicted. Evidence has found that 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.

15.2. Best Practice

The NICE guideline on end of life care for adults covers organising and delivering end of life care services, which provide care and support in the final weeks and months of life (or for some conditions, years), and the planning and preparation for this. It aims to ensure that people have access to the care that they want and need in all care settings. It also includes advice on services for carers. 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. NICE has also produced a guideline on end-of-life care for infants, children and young people with life-limiting conditions.

The Gold Standard Framework Prognostic Indicator Guidance, supported by the RCGP, 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 QOF/ GSF palliative care, hospital flagging system or locality register. This in turn can trigger specific support, such clarifying their needs, offering advance care planning discussions prevention of crises admissions and pro-active support to ensure they 'live well until they die'.

The Palliative And End Of Life Care Guidance has been developed by NHS England to support ICBs with their duty to commission palliative care services within integrated care systems (ICSs). 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.

NHS England have produced guidance on palliative and end of life care for ICBs. 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. NHS England have also produced a framework setting out what high quality

palliative and end of life care looks like, and the building blocks to implement this locally.

The Kent and Medway ICB also have a specific Palliative and End of Life Care (All age) five year strategy published in May 2022.

The RCGP and Marie Curie UK General Practice Core Standards for Advanced Serious Illness and End of Life Care, known as The Daffodil Standards, is an evidence-based framework to help practices self-assess and consistently offer the best end of life and bereavement care for patients. The standards offer a simple structure to enable practices to be proactive organisations in which continuous learning and simple quality improvement steps are an integral part of care.

15.3. Epidemiological findings

Table 21 Number of Deaths - All Ages, East Kent Districts (2022)

District of Residence	Deaths	Male	Female
Ashford	1,223.0	624.0	599.0
Canterbury	1,710.0	859.0	672.0
Dover	1,419.0	747.0	672.0
Folkestone & Hythe	1,493.0	748.0	745.0
Thanet	1,825.0	916.0	909.0
Total	7,670.0	3,894.0	3,597.0

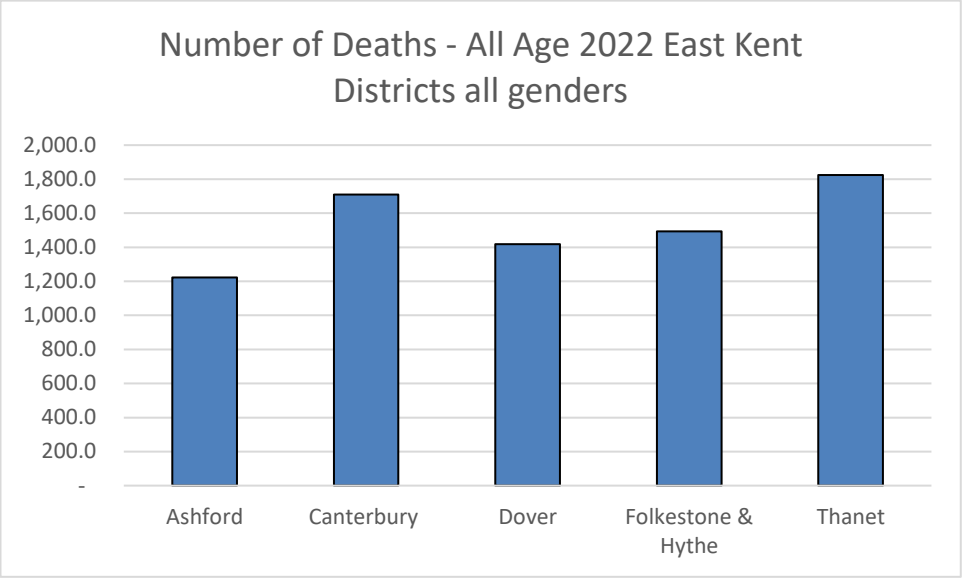

Figure 108 Number of Deaths - All Ages, East Kent Districts (2022)

15.3.1. Place of death

Death in a person's usual place of residence (home and care home) is recognised as one of the main markers for quality end of life care. The numbers dying at home or in a care home have remained largely the same, although apart from Canterbury the hospital is the single most common place for people to die, the majority die outside the hospital setting.

Table 22 Place of Death - All Age 2022 East Kent Districts Percentages all genders

District of Residence	Hospital	Own home	Care Home	Other places	Hospice
Ashford	36.0	30.7	21.0	4.3	8.0
Canterbury	31.7	34.1	23.2	3.0	8.0
Dover	35.1	29.5	24.5	4.2	6.7
Folkestone & Hythe	36.3	29.9	23.7	3.0	7.1
Thanet	35.7	29.4	21.8	3.1	10.0
ICB 2022	38.6	28.5	21.5	3.3	8.0
ICB 2023 (indicative)	38.4	28.5	21.7	3.0	8.4

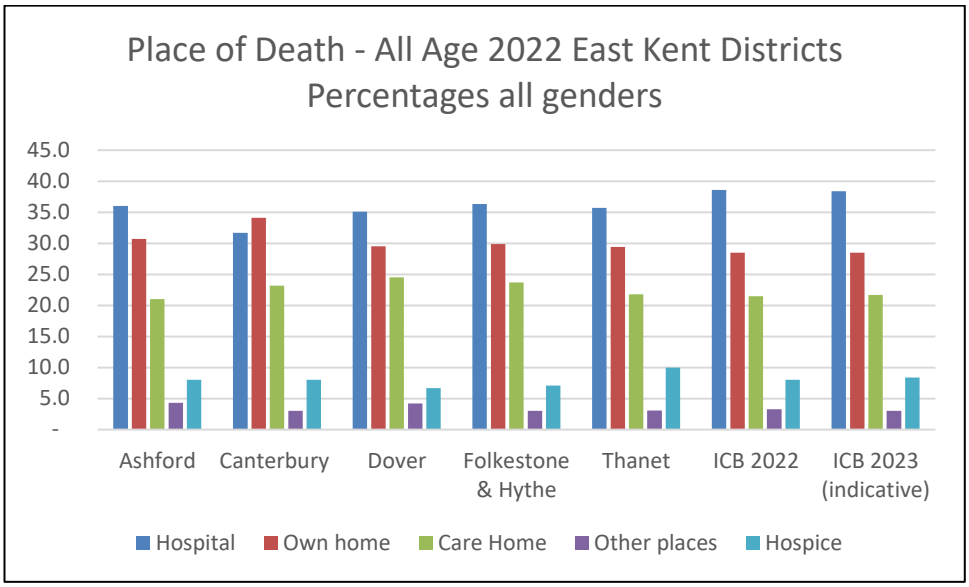

Figure 109 Place of Death by district (2022)

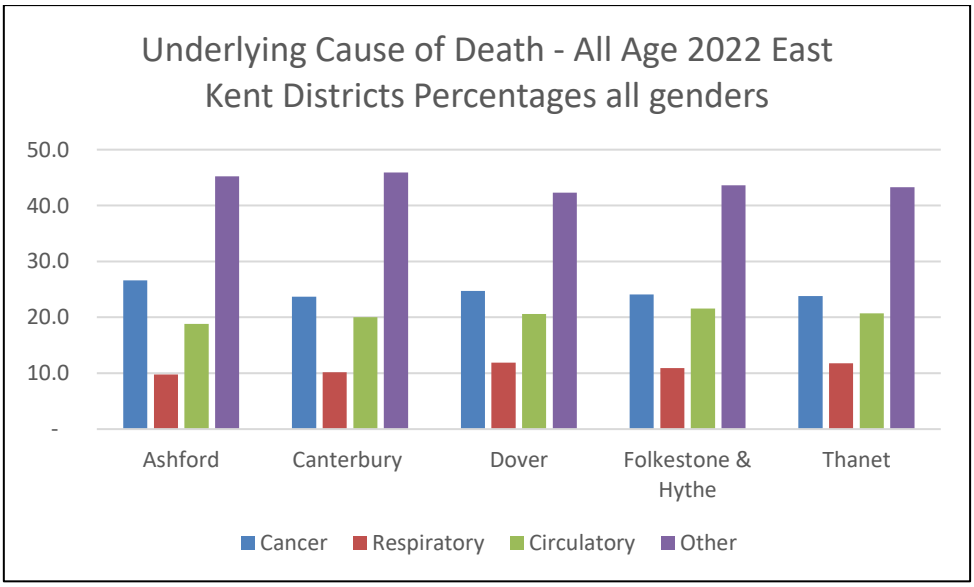

Figure 110 Underlying cause of death by district

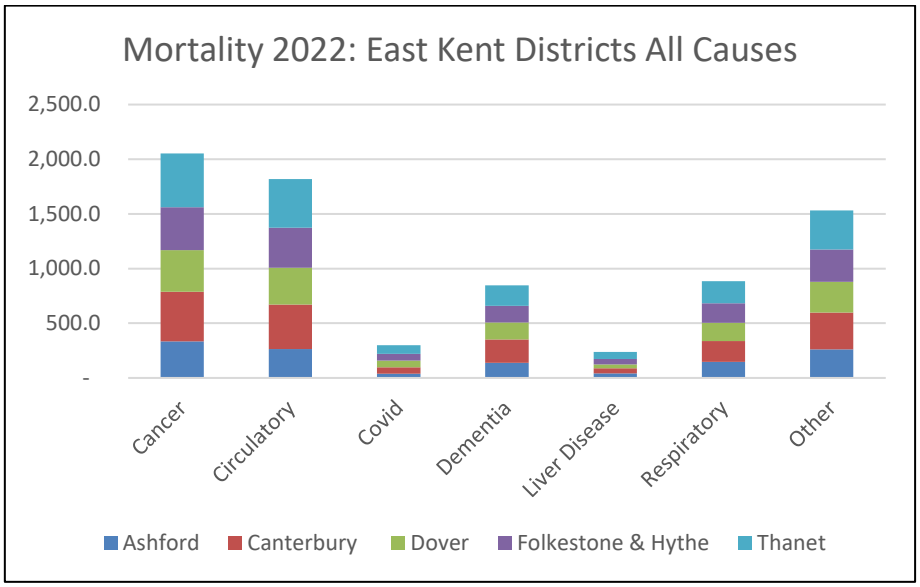

Figure 111 Mortality in East Kent (all causes) by district

15.3.2. End of life flag

Individuals can be flagged as being at the end of their life and noted on a register. At the end of February 2021, there were 632 unique individuals with this flag. The table below shows the spread of those who have a flag across the East Kent integrated health and care partnership (HCP) in Kent and the percentage of the Kent and Medway population in that HCP.

Table 23 End of life flags across East Kent and Kent & Medway

HCP	Individuals flagged for end-of-life care	Percentage of total flags the HCP	Approximate percentage of total population in the HCP
East Kent	137	22%	38%
Kent & Medway	632		

However, although not all individuals who die can be identified in advance, it is worth noting that roughly 15,000 to 17,000 people die each year in Kent and Medway and 7,600 in East Kent. Existing identification can, therefore, be improved upon.

15.3.3. ReSPECT care plans

The KMCR was queried for records containing the entry *Has Recommended Summary Plan for Emergency Care and Treatment* (ReSPECT care plan). 4,718 people were identified as having the care plan in Kent and Medway, of whom 4,345 were aged 70 or over and 3,556 were aged 80 or over. This only represents people who have the care plan recorded in primary care and may not include people who have an end-of-life care plan in place if it hasn't been recorded in this way.

In East Kent, approximately 1,786 people aged 70 or over have a ReSPECT care plan in place, representing 1.54% of the 70+ population. Of those aged 80 or over 1,443 have a care plan (3.26%). Across the HCPs, East Kent has a similar proportion of people with care plans to West Kent, with Dartford, Gravesham and Swanley having a much higher proportion and Medway and Swale having a relatively lower proportion.

Table 24 People aged 70+ with a ReSPECT care plan in Kent and Medway HCPs, captured on 04/11/2024. Source: KMCR.

HCP	Number of people with care plan	KMCR denominator 70+	Percentage with care plan (%)
Dartford, Gravesham and Swanley	960	30,190	3.18
East Kent	1,786	116,280	1.54
Medway and Swale	533	51,980	1.03
West Kent	1,066	67,580	1.58

Table 25 People aged 80+ with a ReSPECT care plan in Kent and Medway HCPs, captured on 04/11/2024. Source: KMCR.

HCP	Number of people with care plan	KMCR denominator 80+	Percentage with care plan (%)
Dartford, Gravesham and Swanley	794	11,960	6.64
East Kent	1,443	44,300	3.26
Medway and Swale	436	18,680	2.33
West Kent	883	27,380	3.22

15.4. Available Services

15.4.1. Hospices

There are six hospices in Kent and Medway, which provide holistic care and wellbeing services within their individual catchment areas:

- Pilgrims Hospice has 12 beds in three sites in Canterbury, Ashford and Thanet. There are 16 beds in each hospice, but funding only allows for 12 to be open.
- Ellenor Hospice has seven beds in Gravesend.
- Hospice in the Weald has 25 beds in Tunbridge Wells and provides care to people in west Kent, and northeast Sussex.
- Heart of Kent Hospice has ten beds in Aylesford, near Maidstone.
- Wisdom Hospice has 15 beds in Rochester.

- Demelza Hospice has nine beds for babies, children and young people up to 18 in Sittingbourne.

15.4.2. 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.

15.5. Recommendations

- A needs assessment on palliative care and end of life care should be commissioned to better inform the health and social care economy.
- Resources should be invested to increase the provision of ReSPECT forms.

16. Stakeholder Voice

Stakeholder and user views provide rich qualitative evidence for the needs assessment process and examples of evidence of engagement and its outcomes can validate recommendations to service commissioners. Kent and Medway Listens is the largest ever engagement project in relation to the mental wellbeing (MWB) of seldom heard communities in Kent and Medway.

16.1. Kent and Medway Listens

Kent County Council (KCC) worked in partnership with KMPT, NHS Kent and Medway and Medway Council to commission 'Kent and Medway Listens' which utilised a range of voluntary sector organisations to reach into local communities and hear the voices of individuals from a wide range of backgrounds. The aim was to hear the voices from communities and individuals who were unlikely to be known to any service in relation to their mental wellbeing.

KCC collaborated with Volunteer and Community Sector (VCS) partners across the four HCPs in Kent and Medway. In the East Kent HCP area, the partner was Social Enterprise Kent (SEK), and geographical area was East Kent HCP: Thanet, Dover, Folkestone and Hythe, Canterbury, Ashford and Faversham. They held listening events and in-depth meaningful dialogue with seldom heard individuals and client groups namely Older People, BAME, Care Leavers, LGBTQI+, and Men.

One common overwhelming finding from engagement with older people is that the majority of older people that attended the listening events reported they thrive on social interaction and are negatively affected by social isolation. It is not necessarily the activity they are undertaking or the venue that they are attending that supports their mental health and wellbeing but the opportunity for social interaction with others, particularly those with whom they have formed friendships and networks.

Some older people thought that even though they are resilient they do need social interaction to help them get through each day. Some older men SEK spoke to shared that society puts them on the 'rubbish pile' when they retire. They feel angry as they have lots of knowledge, skills and experience that their community aren't always encouraging them to utilise. They believe that there are not enough events and activities in their local communities for them to attend.

A common theme heard from the Black, Asian, and Minority Ethnic (BAME) community was that they find it hard to get a doctor's appointment, and impossible to talk to anyone about various health issues. This has left some people in very painful situations and with increased levels of anxiety. Those who reported this also said that these were the shared views of their friends and community. Some have become even more isolated and have felt marginalised due to racism. We heard reports of people removing themselves from social media due to racism and others who are experiencing harassment from their neighbours.

To increase wellbeing and promote positive mental health it was reported that BAME communities want the Local and National Government to tackle anti-social behaviour and address racism. They requested more access to counselling services, people to listen to them and for this to be offered in other languages.

Care Leavers felt that health services need to be more accessible in the community and be more proactive in identifying issues sooner, rather than later diagnosis leading to surgery. They described experiences of being passed around the system and wrongly diagnosed. Paperwork being lost, assessments being made during video calls with the GP, leading to a formal diagnosis of disorders, has left some Care Leavers not trusting of the health system.

Recommendations were to 'shake up' the Mental Health service and to provide a wider range of training to support health workers' professional development to better support the community. One request was for there to be more health professionals trained to support sexual health and general life skills for young adults. One person said, "I think there should be people in health services who tackle and provide guidance for 18+ to provide a more holistic support to young people".

Attendees at the listening events from the LGTBQI+ community want more opportunities to socialise in an informal way, feeling that there are too many 'party vibes' in the pride scene. They want more fulltime gay spaces and centres to socialise and be accepted, and less places where you get threatened or attacked, less toxic places.

They asked for more accessible spaces for mental health support that are not clinical spaces, and not activities, something in between to empower you to talk more and break the stigma. More awareness and consciousness around mental health and more people looking out for each other, including more awareness of alternative support such as books to read, etc. Opportunities to attend Mental Health First Aid Training and triage opportunities to help to normalise mental health discussions and take this awareness into schools.

From the listening events involving Men some felt that health services underestimated their needs by trying to implement 'quick fixes' and short courses of treatments. Some men echoed the views of some of the older people and their responses of feeling like a burden on the NHS, as the NHS had a lot to deal with during lockdown. There are views that other community services are needed prior to calling into more formal NHS services. Another reason for more outreach and community services was that some men shared that when they feel bad, they can't even leave their house, one man said he didn't leave his house for 18 months.

In conclusion, mental wellbeing is multifaceted, people of all backgrounds, ethnicities and ages have struggled to varying degrees and due to different pressures. COVID19 has given rise to further widening of health inequalities which has directly impacted mental wellbeing.

16.2. HealthWatch Kent Annual report 2023-2024

This report outlines some of the work managed by HealthWatch Kent

Included within this report are areas highlighted below.

16.2.1. Enhanced Health in Care Homes

In 2023, HealthWatch Kent published findings about care and support in care homes after talking to residents, family members, care home managers and primary care professionals across 15 care homes. Thanks to this insight, the NHS, Kent County Council, and local Health and Care Partnerships have made positive changes.

What did people tell them about their experiences in care homes?

- People shared their views on care and support provision, personalised care, wellbeing, activity offers, and integrated and joined-up care.
- Half of people's feedback was positive, around a third mixed or neutral, and approximately 14% was negative or suggestions for improvement.
- People also gave insights into the care provided by hospitals and GPs.

As a result in East Kent, the East Kent Health and Care Partnership have implemented daily, or twice daily if needed, health professional calls to homes.

16.2.2. East Kent Diabetes

In 2021, as part of a wider stakeholder group we supported East Kent Health and Care Partnership (HaCP) in their efforts to understand what was important for people who needed diabetes care. Healthwatch Kent were part of a working group, setting the direction of the engagement taking place. In total, 708 survey responses were completed in addition to focus groups which sought to gain deeper insights into the areas people felt needed to be improved. Along with NHS Elect we presented a summary of the findings to the East Kent HaCP board which highlighted that people wanted:

- Better advice and support pre-diagnosis
- More regular GP reviews, face-to-face consultations and check-ups Improved experience of hospital care
- Better signposting to support and guidance, particularly from community healthcare staff
- More joined-up working across healthcare staff
- Inclusion of carers and family in discussions about care
- Better access to foot care
- Access to better information about nutrition and diet What difference did it make? (As of September 2023)

- 100% of the 8 care processes for patients being seen in the clinics are being completed.
- At 3 month follow up 142 out of 171 patients have decreased their Hba1c score.
- There are improvements in all therapy outcome measure scores with particular increase in people reporting their impairment had got better (77.45%).

Feedback from people about their experience of the service has been positive. People have reported increased confidence in manging their condition and appreciated the ability to discuss the information being provided to them.

16.3. Recommendations

- Increase the focus on mental health and wellbeing
- Increase provision of community-based support and activities

17. Kent Marmot Coastal Region Programme

A key finding across our analysis of health inequalities and the wider determinants of health was the impact of living in a coastal community. Poor health and limited health life expectancy among people who live in coastal communities is often contributed to by education, employment, transport, housing, and environmental factors. The Kent Marmot Coastal Region Programme aims to improve health and reduce health inequities in these communities through sustained, joined-up, and effective action.

There are eight Marmot Principles which are highlight the mechanism by which a Marmot Place aims to improve health equity. They are:

- Give every child the best start in life.
- Enable all children, young people and adults to maximise their capabilities and have control over their lives.
- Create fair employment and good work for all.
- Ensure a healthy standard of living for all.
- Create and develop healthy and sustainable places and communities.
- Strengthen the role and impact of ill health prevention.
- Tackle racism, discrimination and their outcomes.
- Pursue environmental sustainability and health equity together.

Marmot places use these principles and commit to improving health equity by:

- Developing and delivering approaches, interventions and policies to improve health equity.
- Strengthening their health equity systems.
- Involving communities in the identification of the drivers of poor health and in the design and implementation of actions to reduce them.
- Broadening advocacy on health equity and engaging with other Marmot Places to share knowledge, roll out best practice alongside partners in local regions and nationally.

KCC Public Health aims to take a layered approach, beginning with two principles. These are *"Enable all children, young people and adults to maximise their capabilities and have control over their lives",* and *"Create fair employment and good work for all".* These are known locally as "work and employment", and "skills for work", respectively.

Work is increasingly being recognised as an important determinant of health. While working in supportive, rewarding and secure jobs is associated with improved health, unemployment, job precarity, low income, and stressful work are associated with poor health. Like many determinants of health, the negative impacts of work are found in higher proportions in coastal communities. The Marmot Coastal Region Programme therefore offers an opportunity to tackle work as a determinant of ill-health where it is most impactful.

The Kent Marmot Coastal Region Programme is particularly relevant for East Kent, as 5 of the 6 districts chosen for the programme comprise East Kent. There are four main objectives in achieving the aims of the programme. They are:

- To create strategic alignment between all the work being undertaken across various sectors and settings, so that we achieve maximal impact. This includes avoiding duplication, amplifying the work already underway and perhaps expanding the scope.
- To identify a set of new high impact actions: In addition to the actions already being undertaken, a set of new actions that will have a high impact on our efforts to address the two Marmot Principles being focussed on.
- To change the culture in Kent: Through the system-wide ownership and commitment towards the aims, objectives and actions in this programme, we wish to embed a prevention and an outcomes-based approach in everything we do. This includes making every contact count, person centred care planning and a whole person approach, thinking how we can optimise prevention in our strategic commissioning, and leveraging anchor institutions.
- To achieve critical mass: Through the effective implementation of the actions in this programme and the existing actions that will be amplified, we hope to generate a critical mass to deliver measurable impact to address 'work and employment', and 'skills for work', both in terms of improved outcomes and reducing health inequalities.

Within the two principles highlighted as a priority for East Kent, a specific focus will be on the role of health and care organisations as employers. These organisations have a role, as anchor institutions, to address gaps in the workforce while creating work. Young people (aged 16-24) and people who are not in education, employment, or education (NEET), and care leavers will be considered priority groups.

Adequate capacity, risk of duplication, lack of continuity, and lack of measurable impact have been identified and considered as risks for the programme. They will continue to be considered across all stages of the programme.

Collaborative working and strategic alignment, along with a commitment to robust evidence-based decision-making is core to this work. All findings and recommendations across this needs assessment should be viewed in the context of the Kent Marmot Coastal Region Programme.

18. Conclusions

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

18.1. Planning for the future

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

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

Specific actions

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

18.2. Improving access

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

Several of the aims of the 10 year plan will work to improve access and deliver more proximal care, including the role of neighbourhood health centres, ending the 8am scramble, and shifting health spending to out-of-hospital care. It is important that commissioners and local decision makers use this shift to maximally deliver benefits to

people in East Kent. Older adults should have their needs recognised and respected, across all services, not just those designed to exclusively serve their needs. Access should be made easy, with options for non-digital solutions. Appointments at times that are accessible to older adults should also be made available (e.g. due to transport needs), and older adults should be made aware that they can discuss their access needs with administrative staff. Services should also make sure that they are accessible to other demographics, and that anyone who might benefit from their work is made aware of their availability. For example, ensuring that parents who educate their children are aware that that can still access the support services that are available in schools.

Specific actions

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

18.3. Health in all policies

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

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

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

Specific actions

- Activities which address wider determinants of health should be undertaken – e.g. addressing damp and mould in housing, which increases the risk of asthma.
- Population-targeted programmes and interventions should be a focus for investment. Policies which promote healthier environments such as banning the advertisement of high fat, sugar and salt (HFSS) foods, limiting the opening of fast-food outlets near schools and in areas of deprivation, and utilising planning regulations to create healthier spaces.

18.4. Culturally competent services

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

Specific actions

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

18.5. Building analytical capabilities

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

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

Specific actions

- Embed data sharing and data linkage in services, particularly between maternity care, family hubs, early help, health visiting, social care, and early years education.
- Not all health and wellbeing providers routinely collect Information on client's smoking status. Partner organisations and stakeholders, such as mental health services, housing associations, Job Centres and treatment services have a role to collect smoking status and offer very brief advice on the health risks of smoking and

potential economic savings from quitting as well as providing information on local stop smoking services available.

Ensure that evaluation is considered in all services, with special focus on collecting data on health outcomes as well as process measures.

19. Appendix: All Recommendations

19.1. Health Inequalities

- Interventions and services, especially those targeting the most deprived, should be culturally competent as a higher proportion of those in ethnic minority groups are also in the most deprived quintiles. Given poor health outcome rates tend to be higher in the most deprived groups, services need to be easily accessible by the most deprived in the population.
- Hospital admissions due to alcohol related conditions is a key concern in deprived men. This should be a focus of further inquiry. Interventions to reduce alcohol dependence should be focused on this group.
- Differences in rates of depression between ethnicities should be investigated. The reliability of data and consistency in how symptoms are reported, and diagnoses are made and recorded should be ascertained.
- Deaths of despair are an important focus for interventions, particularly in the most deprived. Existing services should be assessed to ensure that the most deprived people are both aware of, and can access, these services. Barriers to awareness and access should be assessed, and steps taken to address any findings. This may include further cultural competency training, or targeted advertising of existing services.

19.2. Child Health (Ages 0 to 4)

- Invest in early identification and support for perinatal mental health and parent infant relationship challenges for pregnant women, new mums and their partners.
- Review and monitor the provision for parents and carers, involving families in the design and development of services and providing the support parent and carers need in order to parent their children well.
- Establish a systemwide approach to preventing poor health outcomes, ensuring provision and levels of support are flexible and responsive to meet needs.
- Utilise all opportunities to provide preventive interventions and messaging with pregnant women and families with children under 5 years of age.
- Ensure the provision of consistent information across the system on infant feeding and introduction to solid foods and portion sizes, with additional levels of support in response to need.
- Embed data sharing and data linkage, particularly between maternity care, family hubs, early help, health visiting, social care, and early years education.

19.3. Child Health (Ages 5 to 11)

- Further studies are needed to understand the extent of the effect of the pandemic on child health and wellbeing, and to develop effective interventions to target these effects.
- The understanding of personal, social, and emotional skills in families must improve in order to help children build emotional language skills. Earlier interventions for children in learning, understanding, and talking about how they feel, rather than just at crisis point, should be encouraged. Online parenting courses on "understanding your child" should be promoted.
- Parents who decide to home-educate their children should be made aware that they can still access support from school public health workforce support.
- Trauma informed approaches should be used more widely, and all professionals working with children in this age group should be trained in these approaches. In particularly, they are fundamental for children who have experience a traumatic event and should be used to manage wellbeing and prevent further traumatisation.
- System-wide efforts should be taken in the most deprived areas to support families access services, where needed, to improve their health and wellbeing.
- Activities which address wider determinants of health should be undertaken – e.g. addressing damp and mould in housing, which increases the risk of asthma.

19.4. Excess Weight

- Increase capacity in the WMP to reduce the gap between demand and supply.
- Ensure that the service is made accessible to target groups.
- 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 which promote healthier environments such as banning the advertisement of high fat, sugar and salt (HFSS) foods, limiting the opening of fast-food outlets near schools and in areas of deprivation, and utilising planning regulations to create healthier spaces.

19.5. Smoking

- Although prevalence rates have been declining, 10.96% of adults in East Kent smoke, costing east Kent £493m each year. 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. 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.

- 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.

19.6. Sexual Health

- Increase testing coverage given the marked drop in coverage from pre-pandemic levels, including via supporting promotional campaigns.
- Review gap in face-to-face service in Dover.
- Increase links with other services and stakeholders.
- Develop a peer support service for HIV, as recommended as best practice.
- Review the options for strengthening of provision of HIV service provided to residents in Swale (Faversham) and Dover.
- Review the location of pharmacies offering the EoC and chlamydia treatment service to establish if there is an inequity in coverage of pharmacies across the county.
- Insights data to understand awareness and effectiveness of pharmacy sexual health service.
- Review outreach 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.

19.7. Mental Health and Substance Misuse

- Due to variation in need across East Kent, interventions should be targeted based on place-by-place need.
- A dedicated mental health needs assessment should be carried out to review services for mental health and evaluate the increase in depression seen in East Kent. This should include a focus on the comorbidities seen with depression and consider the provision of services more widely to this group.

19.8. Falls

- Await the outcome of the KCC Falls Prevention Programme
- Continue to commission services which provide tailored interventions, strength and balance programmes and multifactorial risk assessment.
- Assess which interventions will have the greatest impact on health outcomes, and on demand and cost across the system.
- Adapt existing services as and when new evidence comes to light to maximise their effectiveness.
- Ensure that interventions are accessible to vulnerable populations and are culturally sensitive.
- Monitor and evaluate the impact of interventions on falls, particularly across different demographic groups.
- A targeted needs assessment, including dedicated analysis on the topics raised above, should be commissioned.

19.9. Dementia

- Increase public awareness of the steps individuals can take to reduce their risk of dementia.
- Highlight the importance of systemic risk factors on dementia e.g. air pollution.
- Target those at risk for hearing loss.
- Ensure services are provided to support family carers of people with dementia.

19.10. End of Life Care

- A needs assessment on palliative care and end of life care should be commissioned to better inform the health and social care economy.
- Resources should be invested to increase the provision of ReSPECT forms.