

# **Kingston JSNA 2023**

## **(Main Document)**

**Prepared by the Kingston  
JSNA Steering Group**

**August 2023**

<b>Introduction</b>	<b>7</b>
<b>Methodology</b>	<b>8</b>
<b>Demography</b>	<b>9</b>
Age breakdown	9
Healthy Life Expectancy and Disability Free Life Expectancy:	11
Ethnicity	11
Figure 1: Languages in Kingston Census data from 2011, 2021	12
Deprivation - Index of Multiple Deprivation (IMD 2019)	12
Figure 2: Small area (LSOA) map (left) showing IMD deciles (2019) and neighbourhood map (right)	12
Neighbourhoods:	13
Student Population and Children Looked After	13
Carers and Care Homes in Kingston:	14
Disability: data from Census 2021	14
Figure 3: Levels of disability affecting daily living, all ages, by ward (post-2022 boundaries), Census 2021	15
See the latest Census 2021 Kingston data:	15
<b>Top 5s (Health, risks, hospitalisation)</b>	<b>16</b>
Top five reasons for ill-health, hospitalisation and mortality: Young Children	17
Figure 4: Ill-health 0-4 years	17
Figure 5: Risks for ill-health 0-4 years	18
Figure 6: Hospitalisation 0-4 years	18
Top 5 Long Term Conditions (LTC), Children aged 0-4 years, Kingston, 2022	19
Figure 7: Top 5 Long Term Conditions (LTC), Children aged 0-4 years, Kingston, 2022	19
Mortality 0-4 years	20
Top five reasons for ill-health, hospitalisation and mortality: Older Children	20
Figure 8: Ill-health (5-19 years)	20
Risks for ill health 5-19 years	21
Figure 9: Top 5 Risk Factors for ill health in Kingston, 5-19 years (2019)	21
Figure 10: Hospitalisation (5-19 years)	21
Top 5 Long Term Conditions (LTC), Older Children aged 5-19 years, Kingston, 2022	22
Figure 11: Top 5 Long Term Conditions (LTC), older children aged 5-19 years, Kingston, 2022	22
Mortality (5-19 years)	22
Top five reasons for ill-health, hospitalisation and mortality: Adults (20-69 years)	23
Figure 12: Ill-health 20-69 years	23
Risks for ill-health 20-69 years	23
Figure 13: Risks for ill-health, Kingston, 20-69 years, 2019	24
Figure 14: Hospitalisation 20-69 years	24
Figure 15: Mortality 20-69 years	26
Risk factors for premature mortality 20-69 years	26

Figure 16: Top 5 Risk Factors for Death (20-69 years) (Premature Mortality), Kingston, 2019	27
Primary Care Network (PCN) Mortality:	27
Top five reasons for ill-health, hospitalisation and mortality: Older Adults (70 years and older)	28
Ill-health 70 years and older	28
Figure 17: Top 5 causes of ill health, Kingston, people aged 70 years and over, 2019	28
Risk factors for ill health in people aged 70 and above	29
Figure 18: Top Five Risk Factors for Ill Health, people aged 70 years, Kingston (2019)	29
Hospitalisation 70 years and older	30
Mortality 70 years and older	30
Figure 19: Top 5 causes of death in Kingston, age 70 years and older	31
Mortality Summary (cause, and rate per 100,000 residents), Kingston, 2019	31
Figure 20: Mortality Summary (cause, and rate per 100,000 residents), Kingston, 2019	31
Health patterns by Primary Care Network (PCN)	32
Figure 21: Overview of Kingston Primary Care Networks (PCNs):	32
Figure 22: PCN data - The Top 5 QoF recorded conditions in Kingston age 15-64 yrs, 2022 (% prevalence)	33
<b>Inequalities in the Top 5s</b>	<b>33</b>
Inequalities: Young Children (0-4 years)	33
Figure 23: Long Term Condition Prevalence, Ethnicity, Children in Kingston aged 0-4 years, 2022	34
Figure 24: Long Term Condition (LTC) Prevalence in Children in Kingston aged 0-4 years, by deprivation, 2022	34
Figure 25: Asthma and other respiratory condition prevalence, by ward, Children in Kingston 0-4 years, 2022	35
Inequalities: Children and young people aged 5-19 years	36
Figure 26: Children aged 5-19 years, Inpatient Hospitalisations, Ethnicity, 2018-2021	36
Figure 27: Long Term Conditions, Deprivation, Children 5-19 years in Kingston, 2022	36
Figure 28: Children aged 5-19 years, asthma and other respiratory conditions by ward, 2022 (using pre-2022 ward geographies )	37
Figure 29: Children 5-19 years, Hospitalisation Rate for Dental Caries, by ward, 2022 (using pre-2022 ward geographies)	39
Inequalities: Adults (20-69 years)	39
Figure 30: Long Term Conditions (LTC) prevalence in Kingston, 2022, by ethnicity	39
Figure 31: Long Term Conditions (LTC) prevalence in Kingston, 2022, by deprivation	41
Figure 32: Mental Health Long Term Conditions, Prevalence by ward, Adults 20-69 years, Kingston, 2022	42
Figure 33: Cancer (breast cancer, colorectal cancer), 2015-2019, all ages, by ward	43

Figure 34: Emergency hospital admissions for Coronary Heart Disease (CHD), all ages, 2016 - 2017 to 2020 - 2021 (SAR)	43
Figure 35: Deaths from Coronary Heart Disease (CHD), all ages, Indirectly standardised ratio, 2016 to 2020 (SMR)	44
Figure 36: COPD and emergency hospital admissions, 2016-2021, all ages, Kingston by ward	45
Inequalities in Risk Factors for Ill Health 20-69 years	45
Figure 37: Hospital admissions for alcohol attributable conditions (Broad definition), 2016-2021	45
Primary Care Network (PCN) Health Inequalities	46
Figure 38: PCN Health Inequalities, 2022, QoF data, top 5 causes of morbidity and % prevalence, age 15-64 years:	46
Figure 39: PCN Health Inequalities, 2022, QoF data, top 5 causes of morbidity and % prevalence, age 65+ years:	46
Inequalities and In-patient hospitalisation reasons	47
Figure 40: Adults 20-69 years, inpatient hospitalisations, ethnicity, 2018-2021	47
Figure 41: Inpatient hospitalisations, 20-69 years, Kingston, Deprivation	48
Figure 42: Hospitalisation, Top Five Hospitalisation Reasons combined, Ward (Old Geographies), 2018-2021	49
Inequalities and Older Adults (70+ years)	49
Figure 43: Long Term Condition prevalence, Ethnicity, Kingston, 70 years and above, 2022	50
Figure 44: Long term conditions, people aged 70 years and over, deprivation, Kingston, 2022	51
Figure 45: Diabetes and Cancer, people aged 70 and over, Kingston, wards, 2022	51
Figure 46: In patient hospitalisation, people aged 70 years and over, ethnicity, Kingston, 2018-2021	52
Figure 47: In patient hospitalisation, people aged 70 years and over, deprivation, Kingston 2018-2021	53
Figure 48: In patient hospitalisation rate, falls, people aged 70 years and above, ward (old geographies), Kingston, 2018-2021	54
Overall reasons for the gap in life expectancy between most and least deprived in Kingston	54
Figure 49: Breakdown of the life expectancy gap between the most and least deprived quintiles of the Kingston by cause of death, 2020-2021	55
<b>How residents report their own health</b>	<b>55</b>
Wider Determinants	56
Natural and Built Environment	56
Figure 50: Natural and Built Environment Wider Social determinants	57
Education	57
Figure 51: Education Wider determinants of health, school outcome measures	58
Figure 52: School Readiness: percentage of children with free school meal status achieving a good level of development at the end of Reception, 2021/22	58
Figure 53: School readiness: percentage of children with free school	



meals achieving the expected level in the phonics screening check in Year 1 2021/22	59
Work and the Labour Market	60
Figure 54: Work and the Labour Market, Kingston and England as a whole	61
Housing	61
Figure 55: Housing and Vulnerability, Kingston and other London boroughs	61
Income	63
Figure 56: Income, Kingston, compared to other London boroughs	63
Crime	64
Figure 57: Crime as a wider determinant of health, Kingston and other London boroughs	64
Figure 58: Violent crime - sexual offences per 1,000 population, 2021/22	66
<b>Climate</b>	<b>67</b>
Reducing carbon emissions and mitigation for health and care:	69
<b>Health Protection</b>	<b>70</b>
1. Childhood vaccination uptake - focus on Measles and Poliovirus	71
Figure 59: MMR vaccination uptake, Kingston at 5 years, 2022	73
2. Adult vaccinations, decline in whooping cough vaccination coverage in pregnant women, flu vaccination and COVID-19	73
Figure 60: Flu Vaccination in 'at risk' individuals 2021/22	74
3. Adverse Weather and associated health risks	75
Heat-periods and health risks:	75
Cold and health risks	76
4. Below Target National Cancer Screening Programme Uptake	76
Figure 61: Breast cancer and colorectal cancer in Kingston, 2015-2019	77
Figure 62: Adults 20-69 Years - mortality	78
5. Sexual Health	79
Figure 63: Rates per 100,000 population by STI diagnosis by year in Kingston upon Thames compared to rates in London UKHSA Region and England, 2012-2021.	80
Figure 64: Kingston (blue line) HIV testing coverage, proportion of eligible attendees accepting a test	81
<b>COVID-19</b>	<b>82</b>
Kingston COVID-19 data 2020-2022	82
Figure 65: COVID-19 testing, Kingston, 2020-2022	83
Figure 66: COVID-19 cases recorded in Kingston, 2020-2022	83
Figure 67: Proportion of Kingston's population testing positive for COVID-19 2020-2022	84
Figure 68: Rank of London boroughs by proportion ever testing positive for COVID-19, to 2022	84
Figure 69: COVID-19 weekly rate per 100,000 population, July 2020-Aug 2022	84
Figure 70: COVID-19 Hospitalisations in Kingston, 2020-2022	85
Figure 71: COVID-19 deaths recorded in Kingston 2020-February 2022	85

Figure 72: Total COVID-19 death rate, London boroughs, to Oct 2022	85
The impact of COVID-19 on healthcare utilisation	86
<b>Cost of Living</b>	<b>87</b>
Kingston data on benefit claimants, deprivation data	87
Figure 73: Universal Credit claimants in Kingston, Jan 2016 to Mar 2023	87
Kingston data on 'Cost of Living Risk Factors':	88
Figures 74: Households claiming Housing Benefit and Universal Housing Credit Entitlement, Deprivation:	88
Partnership approach to the cost of living	90
<b>Communications</b>	<b>90</b>
Media Use:	91
News Consumption:	91
Digital exclusion:	92
Tailoring communications for our residents:	93
<b>Commissioner and Resident Survey</b>	<b>94</b>
<b>Discussion and themes</b>	<b>96</b>
<b>Recommendations:</b>	<b>96</b>
Glossary	106

# Introduction

The Kingston JSNA 2023 was produced in unusual times. Drafting started during the COVID-19 pandemic (since declared no longer a pandemic by WHO on 4th May 2023<sup>1</sup>). Other unusual Health Protection events arose over the drafting period including a large [Mpox](#) outbreak, [Polio](#) virus being found in the London wastewater, a record heatwave and other climate concerns, and the welcome of many thousands of Ukrainians and Afghans into the UK among other international responses with local health and care implications. As a result of the COVID-19 pandemic, the health system has been challenged by a large backlog of people awaiting care that had been postponed (or illnesses not diagnosed) during the pandemic. The challenges of the pandemic came on top of existing pressures on health and care systems and exacerbated some of the widespread risk factors resulting in many of the health and care pressures - such as obesity and tobacco use. The current 'Cost of Living' challenges have added to these pressures on the health and care system.

In this JSNA, an approach was taken to look at the 'Top 5s' of ill health, risk factors, hospitalisation and wider determinants of health. The main data on causes of ill health, mortality and risks to health comes from a large 2019 data set<sup>2</sup>, the latest data available for these areas. Thus, these are the best indicators for some of the key underlying and main ongoing health risks in the borough. A separate section covers COVID-19 data. While there are many other conditions and issues for health and care, this approach gives a chance to review some of the main factors leading to the use of health and care systems - and some of the underlying risks that could be addressed to reduce health and care needs and help people keep themselves healthier for longer.

All of the 'Top 5' causes of ill health and premature mortality, hospitalisations and long term conditions have at least one element that is preventable. Tobacco, obesity and alcohol all feature as key risks for ill health and premature mortality in adulthood in Kingston. National data shows that smokers require social care 10 years earlier than non smokers - so the impacts of these risk factors are felt across the health and care system. Poor dental health is the main reason for hospital admissions for children and young people - a largely preventable condition - and is linked to poor diet and being overweight in young people. Children also face factors such as drug abuse and bullying as risk factors. Lower back pain, the number one cause of ill health in adults in Kingston, may also have some links to the low levels of activity of many residents and the overweight in over 50% of residents. The high levels of reported poor mental health across the age groups may also have some connections to the high levels of overweight and some of the wider determinants covered in this report.

By focusing on health challenges and related risk factors, this JSNA also considers and highlights climate change as a major and exacerbating factor on people's health and wellbeing in the borough. In fact, according to the World Health Organisation (WHO), climate change is currently the single biggest health threat facing humanity.

Climate change is already impacting health worldwide in a myriad of ways. These include death and illness resulting from increasingly frequent extreme weather events, such as heatwaves, droughts, storms and floods, the disruption of food systems, increases in zoonoses and food-borne, water-borne and vector-borne diseases, and mental health

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<sup>1</sup> World Health Organisation Website: [link](#).

<sup>2</sup> GBD, <https://ghdx.healthdata.org/record/ihme-data/global-burden-disease-study-2019-gbd-2019-reference-life-table>

issues. Furthermore, climate change is undermining many of the social determinants for good health, such as livelihoods, clean air, safe drinking water, sufficient food and equality and access to health care and social support structures ([WHO](#)).

Not all of these impacts are being felt in Kingston, but this is likely to change in the future with the effects of climate change gradually worsening. Even with action worldwide to mitigate emissions, we expect to see significant changes affecting wide areas of our lives.

The current and future health, care and wellbeing needs of the local community are therefore going to be closely linked to the impacts of climate change but are also linked to the potential to reduce carbon emissions. Reducing being overweight and increasing physical activity through active travel can also help decrease our carbon footprint while also keeping people healthier for longer.

The Kingston data shows that good health is not found equally in all. Some of the 'Top 5' conditions show a link with deprivation - with higher levels found as deprivation increases. These conditions contribute to the actual shorter length of life of residents in the most deprived areas of the borough - with male residents in these areas living around five years less than those in the least deprived, and women around three years less. There are some geographical 'hotspots' for poor health, most notably the Cambridge Road Estate (CRE) but some other locations also. Some health conditions are found at higher rates in some ethnic groups, compared with others. Education, a key 'wider determinant' of health, shows that children in Kingston in the lowest income groups (eligible for Free School Meals) do less well than not only other more well off children in Kingston, but also children eligible for Free School Meals in other parts of London.

In terms of climate, we know that climate-sensitive health risks are disproportionately felt by the most vulnerable and disadvantaged in our communities ([WHO](#)). In the longer-term, the health effects from climate change will increasingly depend on the extent to which transformational action is taken now to reduce emissions and avoid the breaching of dangerous temperature thresholds and potential irreversible [tipping points](#). ([WHO](#)).

According to UK Government [guidance](#), the climate crisis affects our efforts to safeguard the health of the population and therefore tackling it as a determinant of health is a crucial aspect of health and care professionals' roles. Integrated health and care sectors need to adopt a decisive role in climate change mitigation and adaptation (see [NASA](#)) with a focus on protecting the most vulnerable and carbon reduction in areas where it brings additional health co-benefits, for example air quality improvement or health benefits of active travel and improved access to nature.

## Methodology

The production of a Joint Strategic Needs Assessment (JSNA) is a requirement for Health and Wellbeing Boards and guidance is set out for their production<sup>3</sup>. JSNAs are assessments of the current and future health and social care needs of the local community. These are needs that could be met by the local authority, Integrated Care Board (ICB), or the NHS Commissioning Board (CB). JSNAs are unique to each local area. The policy intention is for Health and Wellbeing Boards to also consider wider factors that impact on their communities' health and wellbeing, and local assets that can help to improve outcomes and reduce inequalities. CCGs, the NHS CB, and local authorities' plans for commissioning services will be expected to be informed by relevant JSNAs and JHWSs. Where plans are

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<sup>3</sup> <https://www.gov.uk/government/publications/jsnas-and-jhws-statutory-guidance>

not in line with JSNAs and JHWSs, ICB, the NHS CB and local authorities must be able to explain why. The purpose of Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs) is to improve the health and wellbeing results of the local community and reduce inequalities for all ages.

Local authorities and Integrated Commissioning Boards (which replaced Clinical Commissioning Groups in July 2022) have equal and joint duties to prepare JSNAs and 'Joint Health and Wellbeing Strategies' (JHWSs), through the Health and Wellbeing Board (HWB). The responsibility falls on the Health and Wellbeing Board as a whole, and so success will depend upon all members working together throughout the process. The Kingston HWB agreed in March 2022 that a 'Kingston JSNA Steering Group' would produce the new Kingston JSNA on behalf of the HWB. The production of the JSNA 2023 follows the 2020 COVID-19 pandemic, which delayed the possibility of an earlier JSNA version.

The format of the 2023 Kingston JSNA follows the national JSNA guidance, taking a high level approach to assess the 'Top 5' needs in Kingston for mortality, morbidity and other factors. Within these, equalities data has been reviewed. National and local data has been reviewed together with commissioner and targeted resident surveys. By taking a high level approach to the local data, the JSNA does not go into detail into the conditions reviewed. However, the data can be used to consider which areas might merit further in depth review in the future.

## Demography

The Royal Borough of Kingston upon Thames (RBK) is located in south-west London and shares borders with the London Boroughs of Wandsworth, Richmond, Sutton and Merton, and the county of Surrey. It has the third smallest population of any borough in London<sup>4</sup> (after the City of London and Kensington and Chelsea) and is the smallest outer London borough in terms of geographical area.

### Age breakdown

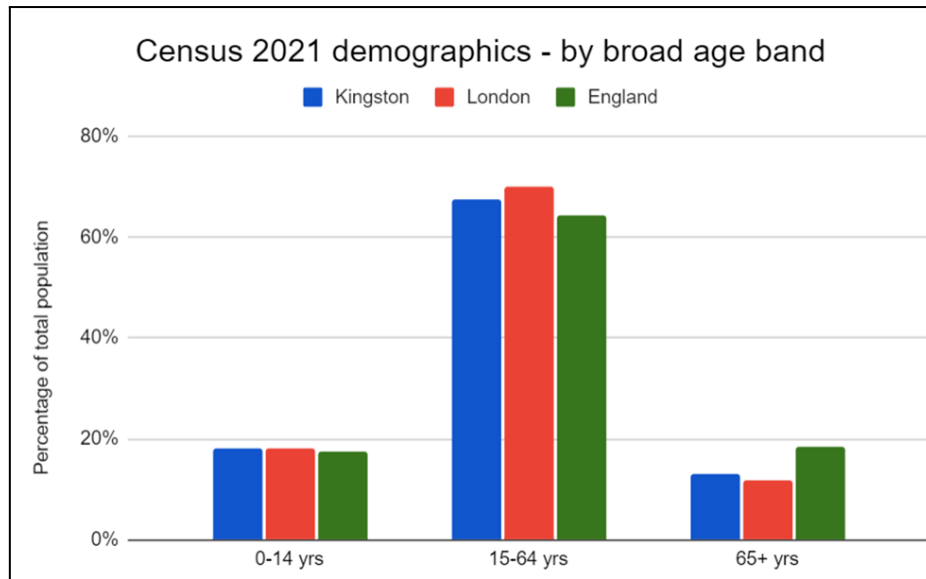
The 2021 Census recorded Kingston's population as 168,085, an increase of 8,000 people (5%) from the previous Census in 2011, which is a slower rate of increase than London overall (6.6%). 18.2% of the Kingston population is estimated to be aged between 0 and 14 years old, similar to 18.1% for London overall, and 17.4% for England. People between 15 and 64 years comprise 67.3% of the Kingston population, compared to 70% for London and 64.2% for England.

Kingston has an older demographic when compared with London (11.8%), with 13.1% of its population aged 65 and over. However this is much lower than the 18.4% of people aged 65 and over nationally.

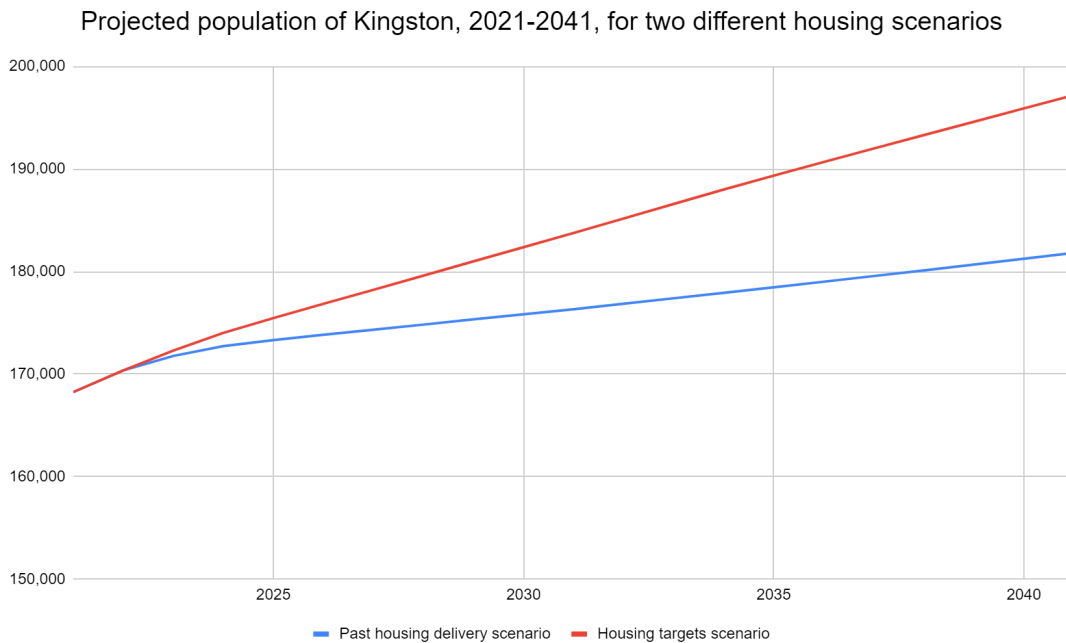
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<sup>4</sup> ONS:

<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/populationandhouseholdestimateswales/census2021> (accessed January 2023)



GLA projections<sup>5</sup> estimate Kingston’s population will grow by between 8% and 17% in the next 20 years, depending on the level of housing development. This would be an extra 13,000 - 19,000 people.



If we assume that future housing delivery in Kingston will be similar to past levels, the adult population (18 years and over) will likely increase by around 8,000 people in the decade to 2033. However, the vast majority of this increase will be due to growth in the 65 years and over population, estimated to grow by almost 7,000 people in a decade, a rise of around 25%.

<sup>5</sup> GLA. Housing-led population projections, 2020 base. <https://maps.london.gov.uk/population-projections/>

## Healthy Life Expectancy and Disability Free Life Expectancy:

Healthy life expectancy (HLE) has been identified as a key outcome measure in assessing the extent to which health is improving and disparities are narrowing. A recent [report](#) into Understanding the Drivers of Healthy Life Expectancy (HLE)<sup>6,7</sup> aimed to assess the relative impact of mortality rates and self-reported health on HLE. It showed that changes in self-reported good health prevalence have a considerably larger impact on HLE than changes in mortality rates.

In Kingston (for babies born in 2018-20), HLE for boys and girls was almost identical, at around 69½ years<sup>8</sup>, with both sexes being in the top three London boroughs. Residents aged 65 in 2018-20 have, on average, almost 12 years HLE (men) or just under 14 years (women), again amongst the highest levels in the capital.

Disability-free life expectancy (DFLE) is a related measure – Kingston’s 65 year old men (in 2018-20) have a DFLE of around 12 years, very similar to their HLE, however for Kingston’s women, their DFLE is only 10½ years. This is considerably lower than their HLE, is in the middle of the London rankings, and reflects the higher proportion of older female residents in Kingston living with a disability.

## Ethnicity

Census 2021 recorded Kingston’s ethnicity as 68.3% White, which is higher than the London figure (53.8%), but lower than the national equivalent (81%). The next largest broad ethnic group in Kingston is Asian (17.9%) (London 20.8%, England 9.7%). The main difference between Kingston and London is that the Black community is significantly smaller in Kingston (2.7%) than in London (13.5%), and also smaller in Kingston than England (4.2%).

Over the past decade, Kingston has become more ethnically diverse, with the proportion of White residents 6.2% lower than in 2011 (68.3% compared to 74.5%). This is a greater rate of diversification than England (4.4% reduction in the White population) and London (6%).

Since the 2021 Census, there have been further changes to Kingston’s population related to global events. The borough has welcomed over 400 people from Ukraine under the Homes for Ukraine scheme and likely at least a further 100 under the Ukraine Family Scheme since 2022. The borough has also welcomed an estimated 1,000 people from Hong Kong through the UK British National Overseas ‘BN(O)’ scheme since it was expanded in 2021. New arrivals from Afghanistan will also be welcomed through the national Afghan Relocations and Assistance Policy (ARAP) and Afghan Citizens Resettlement Scheme (ACRS) from 2022 onwards .

**Languages in Kingston:** When looking at the share of the population who speak a specific language, the 2021 Census showed the three most widely-spoken languages in the borough were unchanged from 2011. Polish and Arabic swapped places at 4th and 5th while Urdu dropped from 7th to 9th position. Bulgarian saw the largest increase in the rankings, from 17th in 2011 to 10th in 2021, with Portuguese and Italian also showing notable increases. German and Farsi dropped out of the top 10 over the past decade.

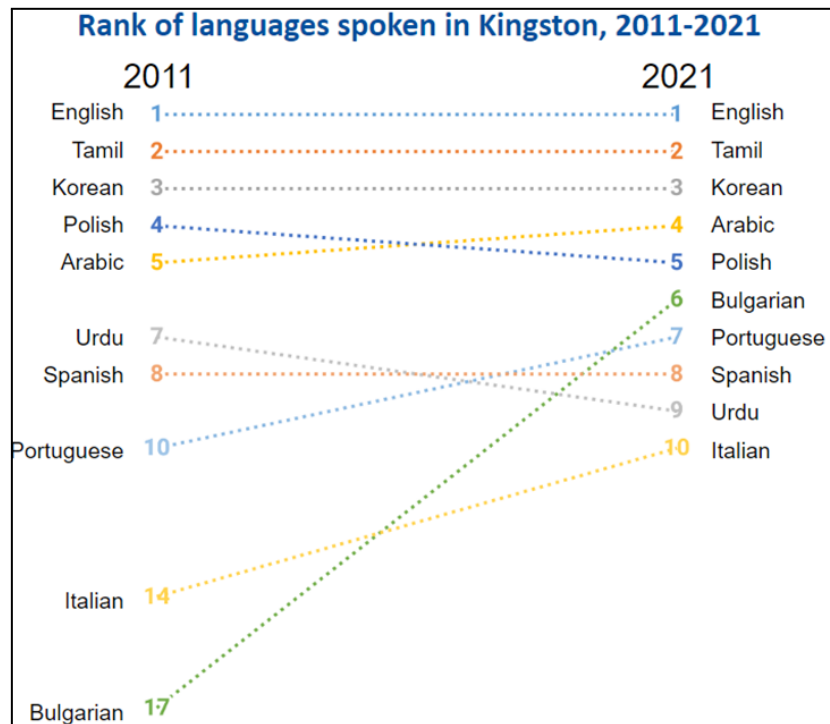
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<sup>6</sup> Gov.uk, <https://www.gov.uk/government/publications/understanding-the-drivers-of-healthy-life-expectancy/understanding-the-drivers-of-healthy-life-expectancy-report#key-points>

<sup>7</sup> Healthy life expectancy can be defined as ‘a measure of the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health’

<sup>8</sup> OHID fingertips, <https://fingertips.phe.org.uk/search/healthy%20life%20expectancy#page/1/gid/1938133280/pat/6/par/E12000007/ati/402/are/E09000021/iid/93523/age/94/sex/2/cat/-1/ctp/-1/yr/3/cid/4/tbm/1/page-options/car-do-0>

Figure 1: Languages in Kingston Census data from 2011, 2021



### Deprivation - Index of Multiple Deprivation (IMD 2019)

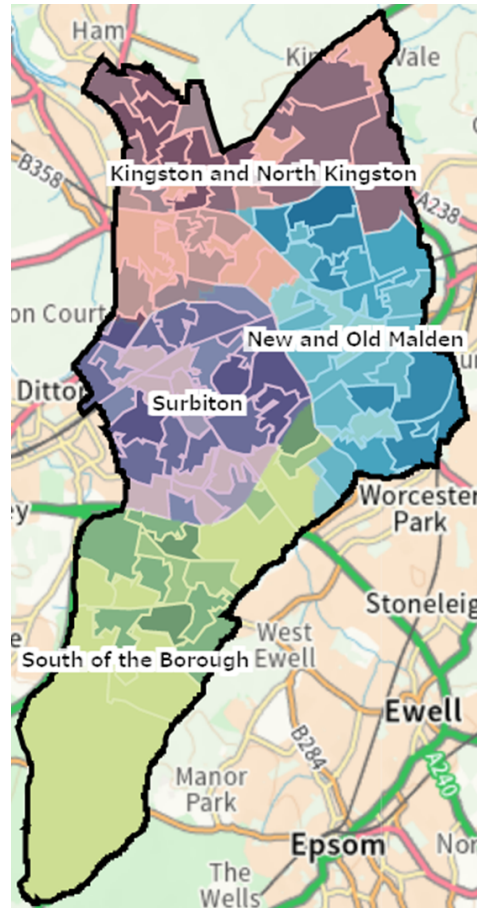
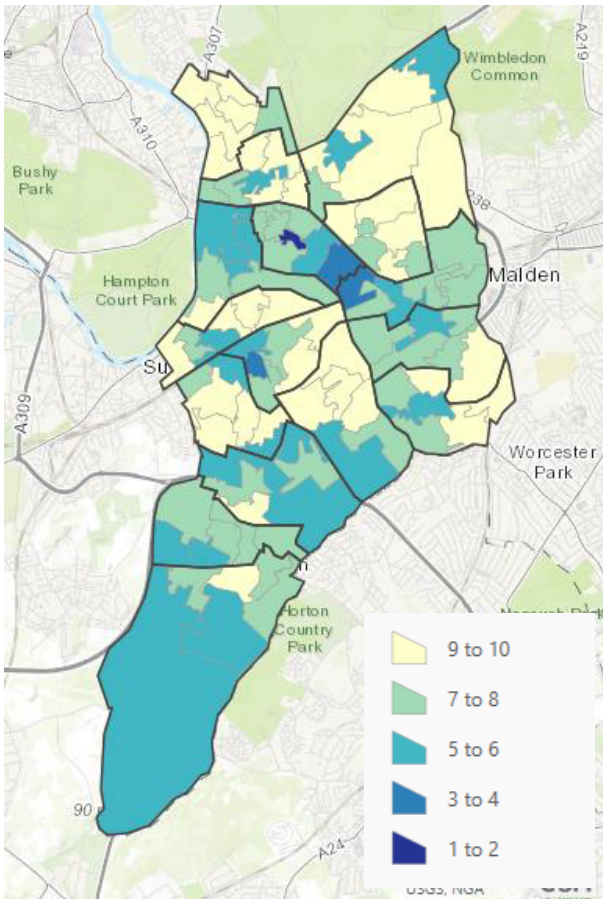
Kingston has relatively low levels of deprivation compared to London and England overall, nevertheless one small area (LSOA) of the borough is in the most deprived 20% nationally, with another three LSOAs in the most deprived 40%.

The most deprived small area in the borough is situated in the Kingston and North Kingston neighbourhood, with the next most deprived LSOAs being in New and Old Malden, and Surbiton. The South of the Borough, however, is the most deprived neighbourhood overall.

Figure 2: Small area (LSOA) map (left) showing IMD deciles (2019) and neighbourhood map (right)

(lower decile = more deprived area)





## Neighbourhoods:

Kingston's four neighbourhoods were originally created in 1994 as combinations of adjacent electoral wards, in order to enable more democratic decision-making to be made at a local level. Some neighbourhood names were amended, and boundaries realigned, as part of the broader boundary changes in 2022. Key summary information on the neighbourhoods' populations are as follows (all details from the 2021 census):

Neighbourhood name	Number of wards within	Population	Population Density (persons/sq km)	Median age (years)	% Ethnic Minority
Kingston and North Kingston	6	54,918	5,470	36.9	34.1
New and Old Malden	5	40,772	5,135	41.5	41
Surbiton	5	46,156	6,220	37.8	26.9
South of the Borough	3	26,210	2,212	39.9	23.8

## Student Population and Children Looked After

In 2023, Kingston had approximately 14,000 students aged 11 or younger (Year 6 or below) in state funded primary education, with a further 12,500 in Year 7 or above. The borough contains 36 schools for pupils in Year 6 and below, with 11 secondary schools, three special

schools and one pupil referral unit (PRU). There are also 12 independent schools in the borough.

In terms of early years provision, Kingston has (in 2023):

- 7 Private, Voluntary and Independent nurseries (PVI)
- 24 Schools with nurseries
- 1 Maintained nursery
- 5 of our Independent Schools take 2/3 year olds
- 153 childminders

Home schooled students: In Kingston, there were just under 300 children registered as being 'electively home educated' (EHE) in early 2023.

According to ONS figures<sup>9</sup> taken from the 2021 Census, Kingston's residents include 8,800 full time students aged 18-30 inclusive. Over 31% of Kingston's 18-30 population are full time students, which is the fourth highest proportion in London, and the highest in outer London. Kingston University has a total full time roll of over 16,000 students<sup>10</sup>, so around half are assumed to live within the borough.

A child who gets accommodation from the local authority for a continuous period of more than 24 hours, is subject to a care order (to put the child into the care of the local authority), or is subject to a placement order (to put the child up for adoption) is said to be a 'Child Looked After'. At 31st March 2022, 133 children were classified as being a Child Looked After in Kingston<sup>11</sup>.

## Carers and Care Homes in Kingston

Over 11,500 people in Kingston reported being an unpaid carer in the 2021 Census, i.e. that they "look after, or give any help or support to, anyone because they have long-term physical or mental health conditions or illnesses, or problems related to old age".

Of these 11,500 people, 340 were aged between 5 and 17 years inclusive (under 5's were not asked the question) and included 45 children caring for 50 or more hours per week. Carers are the latest care workforce in Kingston. Kingston's new All Age Carers' Strategy<sup>12</sup> contains further information on caring in the borough.

With 766, Kingston has the second highest number of care home beds per 100,000 population (second to Croydon, which has 779) in London in May 2023. Kingston has 1,286 care home beds across 39 care homes. In May 2023, there were 45 registered domiciliary care providers operating in Kingston providing care in people's homes.

## Disability: data from Census 2021

In 2021, 13% (21,990) of Kingston residents reported having a disability as defined by the Equality Act (2010), which requires that a person has a physical or mental impairment, and

<sup>9</sup> ONS. Usual resident population in full-time education by age 18 to 30 years, England and Wales: Census 2021. Published January 2023. Online at: <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/usualresidentpopulationinfulltimeeducationbyage18to30yearsenglandandwalescensus2021>

<sup>10</sup> Kingston University, Student Profiles. Online at: <https://www.kingston.ac.uk/aboutkingstonuniversity/factsandfigures/studentprofiles/>

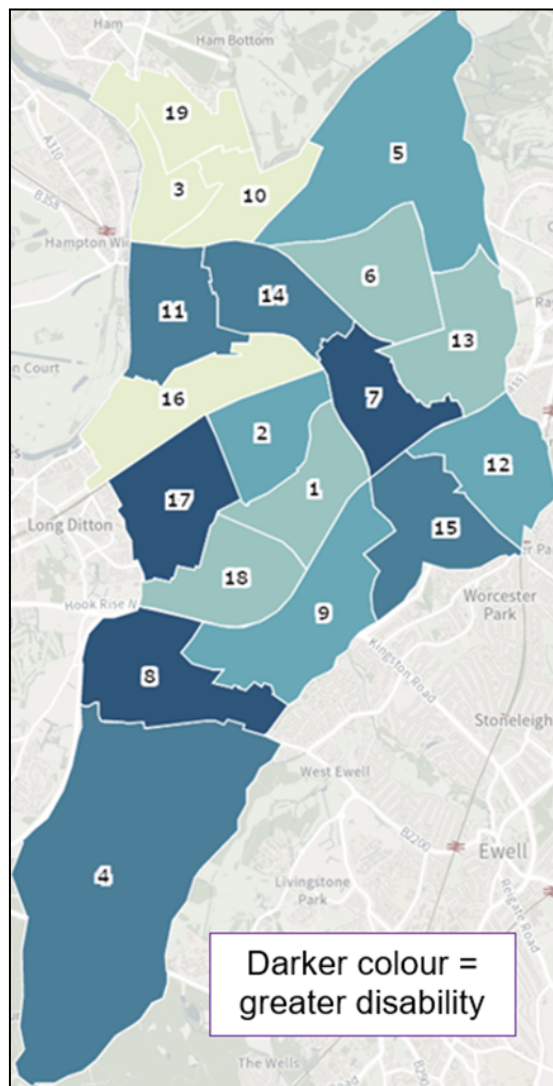
<sup>11</sup> Gov.uk, Looked After Children statistics from England, including adoption, 2021 to 2022. Online at: <https://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption-2021-to-2022>

<sup>12</sup> Royal Borough of Kingston, "All Age Carers' Strategy 2022 - 2027". Online at: link. <https://modern.gov.kingston.gov.uk/mgConvert2PDF.aspx?ID=98190>

that the impairment has a substantial and long-term adverse effect on their ability to carry out day-to-day activities. Levels of disability in the borough have remained stable since the previous census in 2011.

Areas with higher deprivation tend to correlate with greater disability. In Kingston the most disability (at ward level) can be seen in Green Lane & St. James (ward 7 on the map, which partially includes the 'Kingston Road corridor' area of relatively high deprivation) and Surbiton Hill (ward 17, which includes Alpha Road, another highly deprived part of the borough).

Figure 3: Levels of disability affecting daily living, all ages, by ward (post-2022 boundaries), Census 2021



See the latest Census 2021 Kingston data:

For the full Census 2021 data on population, please visit [the Kingston data website](https://data.kingston.gov.uk/population/#/view-report/63aeddf1d7fc44b8b4dffcd868e84eac/E09000021/G3)<sup>13</sup>.

<sup>13</sup> <https://data.kingston.gov.uk/population/#/view-report/63aeddf1d7fc44b8b4dffcd868e84eac/E09000021/G3>

## Top 5s (Health, risks, hospitalisation)

The primary data focus for the JSNA was to consider the 'Top five' health needs of Kingston residents in various age categories, in terms of ill-health morbidity, causes of hospitalisation, mortality, and key risk factors. Following this, any potential gaps in service provision relating to these needs would be identified, and ideas sought on how such gaps could be filled.

Data regarding 'wider determinants' of risk, any sex differences in the prevalence of the top five conditions, and relevant health inequality information would also be factored in.

The four age categories to be analysed were:

- Young Children (age 0-4 years inclusive)
- Older Children (5-19 years)
- Adults (20-69 years)
- Older Adults (70+ years)

### Data sources

The main data sources used for this analysis were the Global Burden of Disease Study<sup>14</sup> (GBD) for ill-health, mortality and risk factors for both, the NHS Hospital Episode Statistics<sup>15</sup> (HES) database for hospitalisations, and the NHS south-west London Integrated Care System's 'Health Insights' analysis suite<sup>16</sup> for PCN breakdowns. .

#### Global Burden of Disease study (GBD)

The 2019 GBD Study provides a tool to quantify health loss from hundreds of diseases, injuries, and risk factors. GBD data capture and rank causes of premature death and disability from more than 350 diseases and injuries in 195 countries. The 2019 dataset is the most recent version available, and was captured prior to the Covid-19 pandemic, so considerations as to how this has affected the health of our residents will need to be factored in.

Not all episodes of ill-health and death can be linked to specific risk factors, and conversely some illnesses will have multiple risk factors of varying strengths attached. Where multiple contributing causes or factors were identified, each has been allotted a fraction of 1.

The top five causes of mortality in Kingston in 2019 (as ranked by the number of deaths), morbidity (as ranked by Disability-Adjusted Life Years [DALYs] - one DALY is equal to one year of healthy life lost) and risk factors for both were analysed from GBD data.

#### HES (Hospital Episode Statistics)

HES is a database containing details of all admissions, A and E attendances and outpatient appointments at NHS hospitals in England, initially collected during a patient's time at hospital. HES data covers all NHS facilities in England, with each HES record containing a wide range of information about an individual patient admitted to an NHS hospital, including:

- clinical information about diagnoses and operations
- patient information, such as age group, gender and ethnicity
- administrative information, such as dates and methods of admission and discharge
- geographical information such as where patients are treated and where they live

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<sup>14</sup> <https://www.healthdata.org/gbd/2019> (accessed January 2023)

<sup>15</sup> <https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/hospital-episode-statistics> (accessed January 2023)

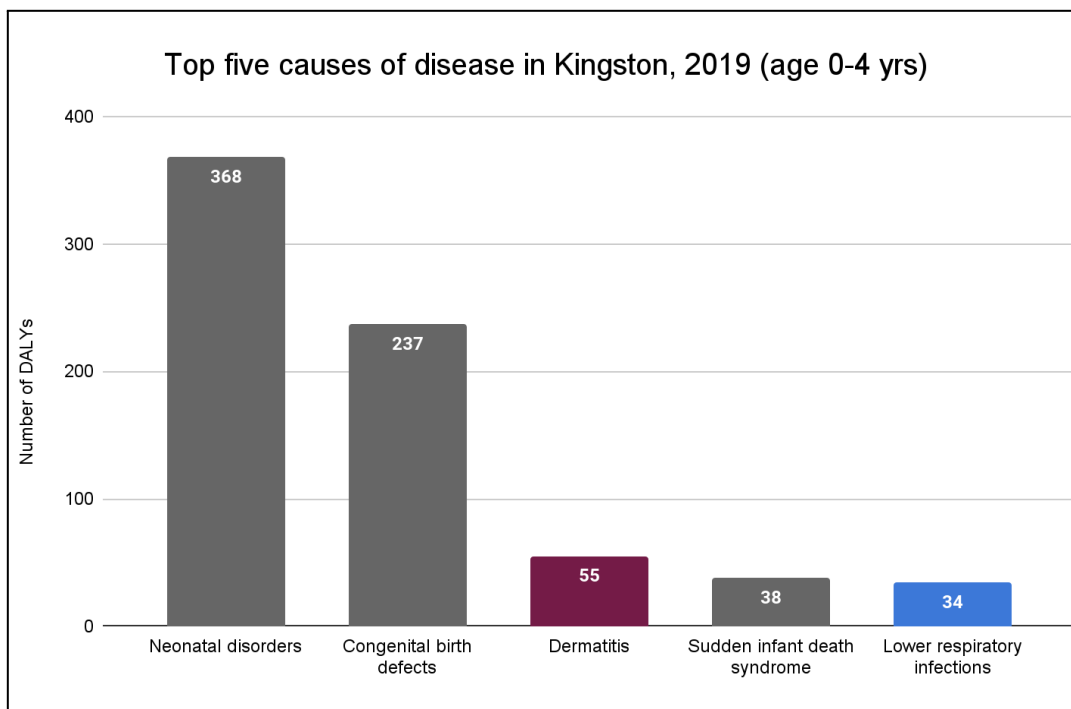
<sup>16</sup> <https://susi.sharepoint.com/sites/SWL> (unpublished, accessed January 2023)

For this analysis, the top five causes (as denoted by International Classification of Disease [ICD] 4-character code) of in-patient admissions for Kingston residents for the past four full years (2017-18 to 2021-22) were analysed from HES data for the four age ranges. Each hospitalisation can be linked to multiple reason ICD codes, in this analysis only the primary reason was used, with a broader time frame considered so as to include both pre- and peri-pandemic years. No risk factor data are available for hospitalisations.

**N.B.** Each live birth is recorded as an in-patient hospitalisation for both mother and child(ren); standard birth-related reasons were the top reason for admission for the 0-4 yrs and 20-69 yrs age groups, and have been excluded to focus on 'ill health' causes.

## Top five reasons for ill-health, hospitalisation and mortality: Young Children

Figure 4: Ill-health 0-4 years<sup>17</sup>

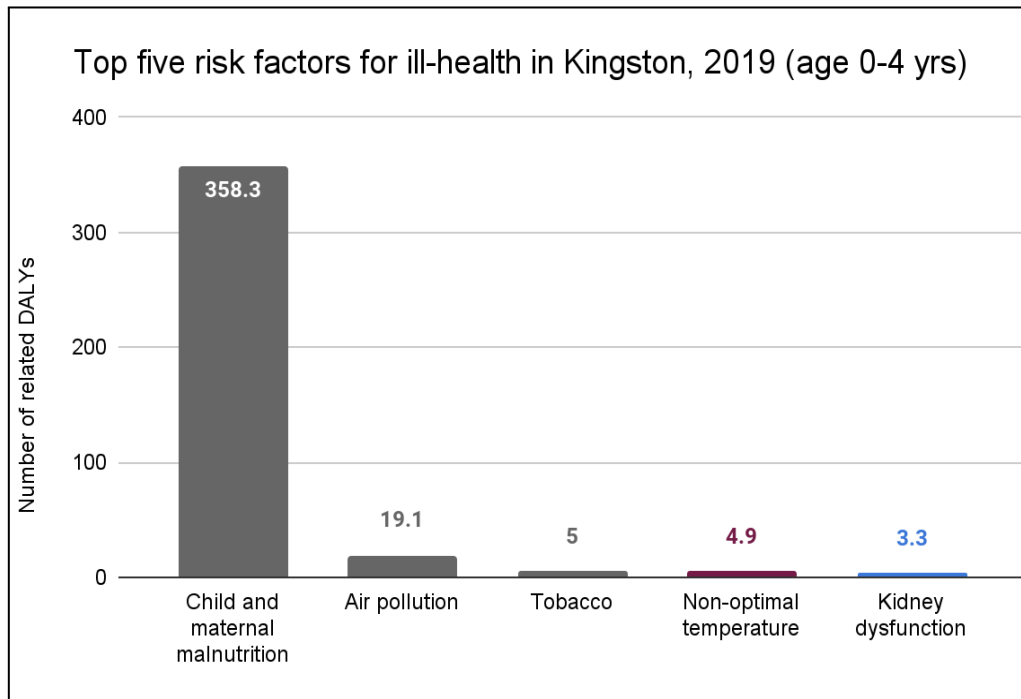


A total of over 2,000 DALYs were noted in the GBD in Kingston's 0-4 year olds, with the two main causes of note being neonatal disorders and congenital birth defects, fairly evenly spread across baby boys and girls.

<sup>17</sup> Colour coding for charts:

- Purple columns are more common in females
- Blue are more common in males
- Grey - minimal sex difference

Figure 5: Risks for ill-health 0-4 years



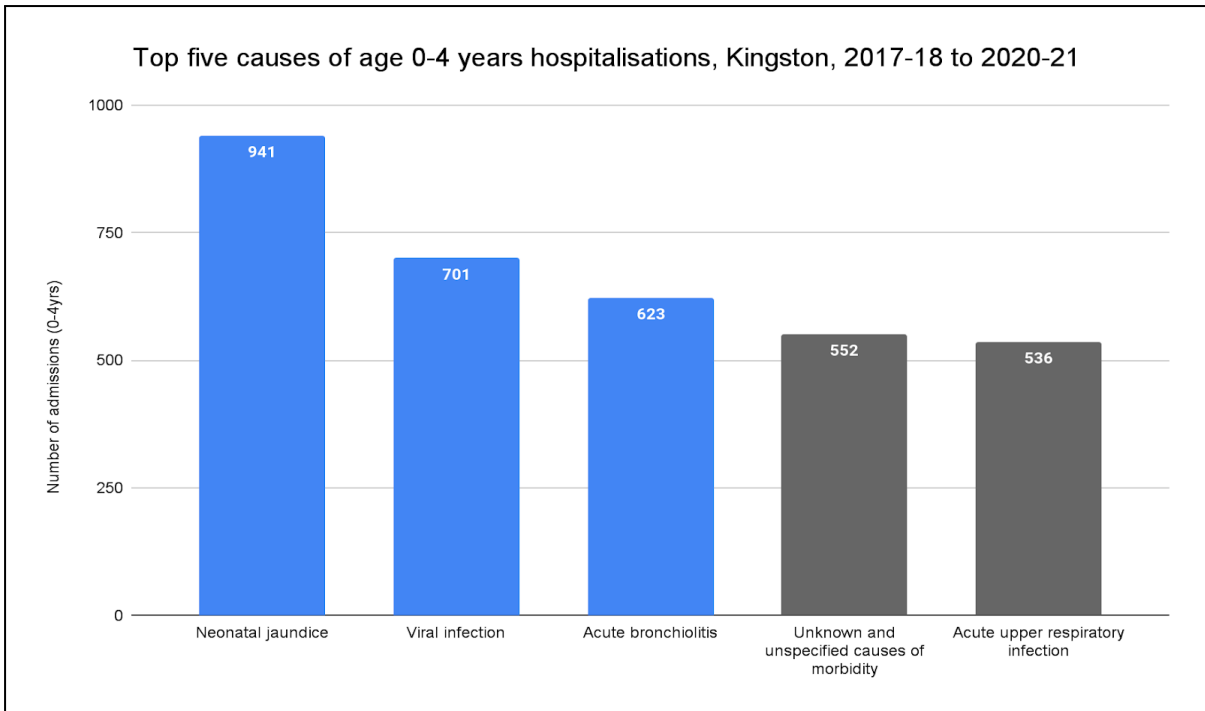
Risks for all types of ill health in the 0-4 age group in Kingston were reviewed in the Global Burden of Disease (GBD) data (2019). The main risk to ill health for this age group by far is the category of ‘Child and Maternal Malnutrition<sup>18</sup>’ (which accounts for 358 ‘Disability Adjusted Life Years’ or DALYs). The next greatest risk is Air Pollution, which accounts for 19.1 DALYs). Other risks account for less than 10 DALYs.

Figure 6: Hospitalisation 0-4 years<sup>19</sup>

<sup>18</sup> Malnutrition in this context can include disorders of both under- and overnutrition, in very young children under-nutrition is more common. <https://www.healthdata.org/diet>

<sup>19</sup> Hospitalisations are ranked on an ‘overall need’ basis, i.e. by the number of admissions in total per condition, rather than the number of people admitted





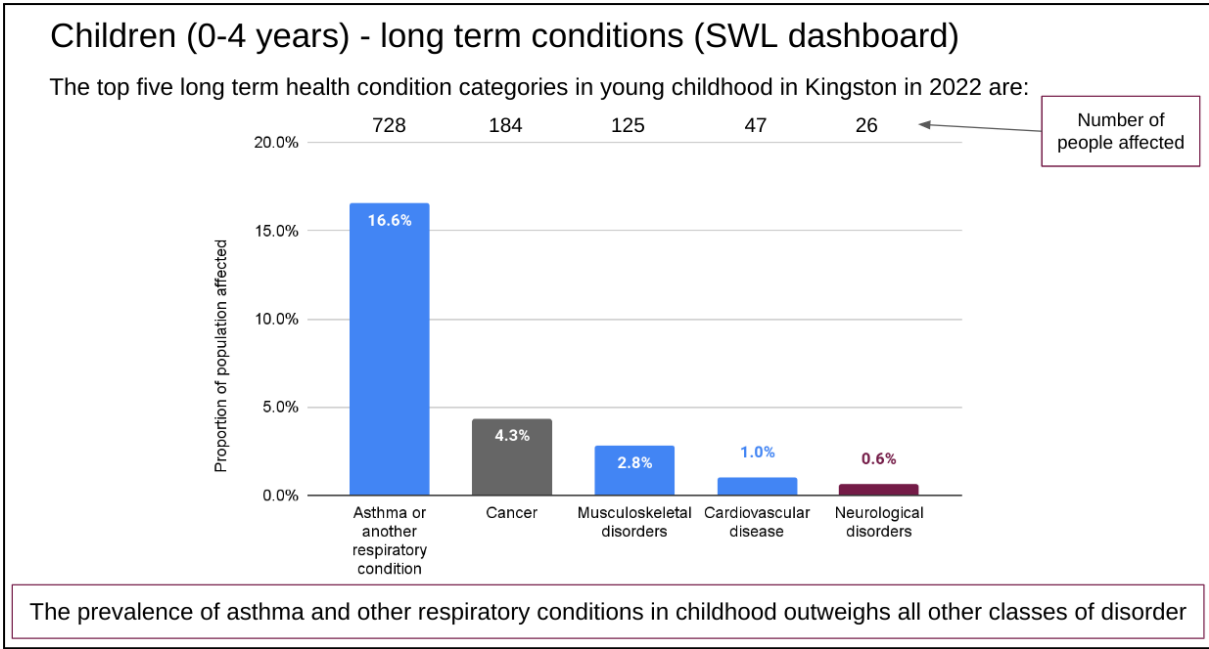
From a total of 14,500 admissions in young children across the four years (excluding unproblematic births), about 25% involved the 'top 5' as the primary reason for admission.

Around one in six newborns was admitted for jaundice, and the top three reasons were all more predominant in boys. Infections and inflammatory conditions (and unknown reasons) round out the top five.

#### Top 5 Long Term Conditions (LTC), Children aged 0-4 years, Kingston, 2022

The Top 5 Long Term Conditions (LTC) for children aged 0-4 years shows that asthma is the main LTC for this age group, with 728 children in this age group (16.6% of this age group) with this condition in 2022.

*Figure 7: Top 5 Long Term Conditions (LTC), Children aged 0-4 years, Kingston, 2022*

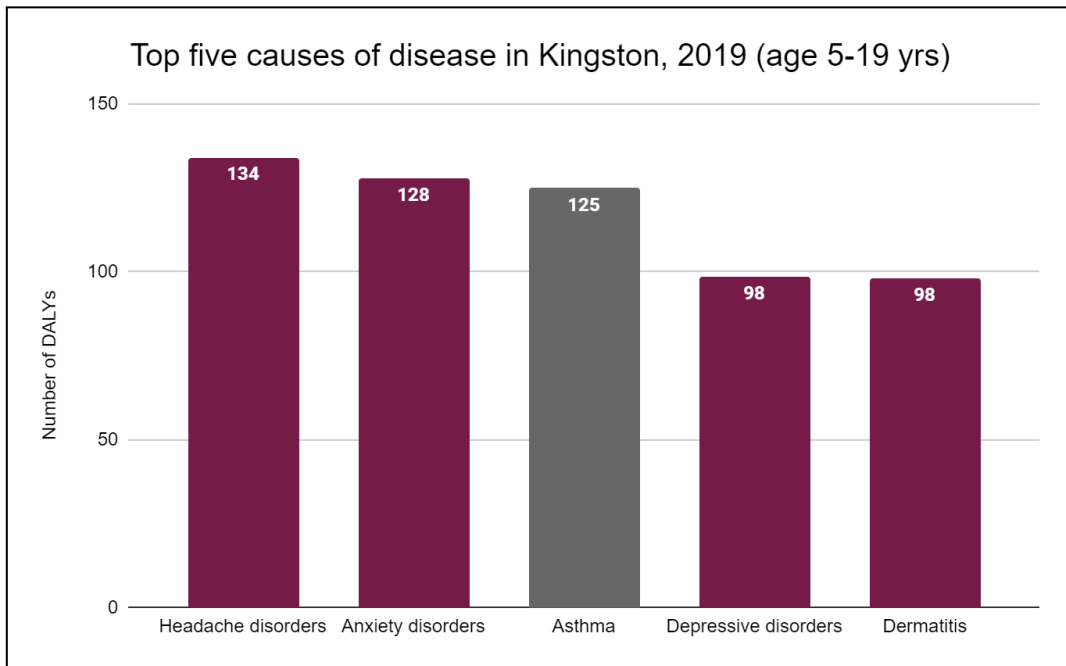


### Mortality 0-4 years

The number of child deaths in Kingston for 2019 were less than five in each Top 5 category. For this reason, the causes are not provided here.

## Top five reasons for ill-health, hospitalisation and mortality: Older Children

Figure 8: Ill-health (5-19 years)



A total of over 4,000 DALYs were noted in the GBD, with several causes having a similar level of prevalence. All but one of the top five causes were more common in girls.



## Risks for ill health 5-19 years

The overall 'Risk Factors' in the Global Burden of Disease data were reviewed for ill health of children and young people aged 5-19 years (2019 data). The majority of ill-health in older children (88%) was not linked to specific risk factors. However, amongst the risk factors identified, the main risk factor was 'Child and Maternal Malnutrition' (accounting for 81.4 'Disability Adjusted Life Years' or DALYs). Drug use, childhood sexual abuse and bullying, alcohol use and high fasting plasma glucose were the following risk factors.

Figure 9: Top 5 Risk Factors for ill health in Kingston, 5-19 years (2019)

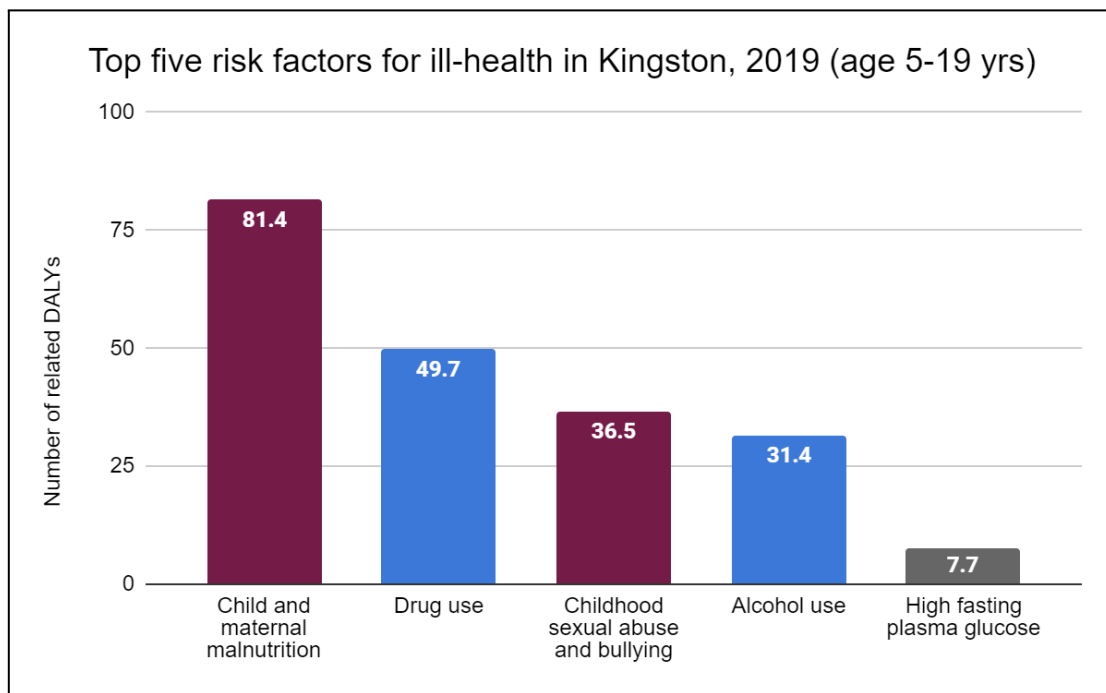
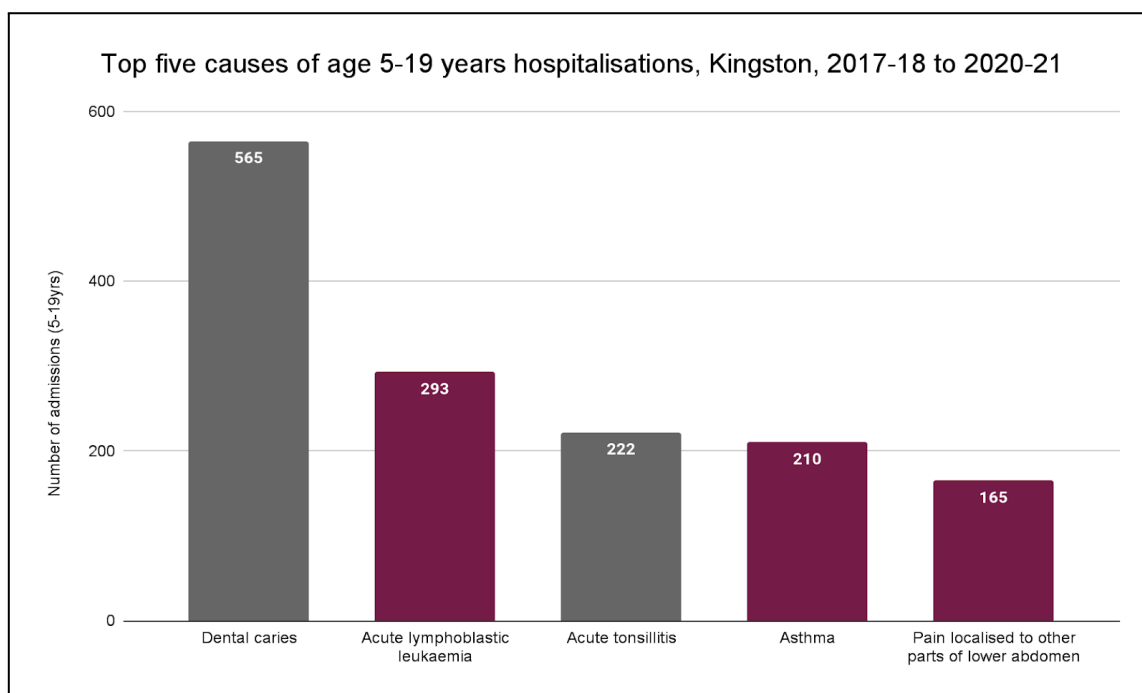


Figure 10: Hospitalisation (5-19 years)



Older childhood has the fewest hospitalisations of any age group, with 12,000 across the

four-year span. Dental decay is by far the most common primary reason for admission (almost 5% of all admissions). Three of the top five are more common in girls.

Chest and abdominal conditions are the most prevalent in the top five, and continue to feature just outside this list.

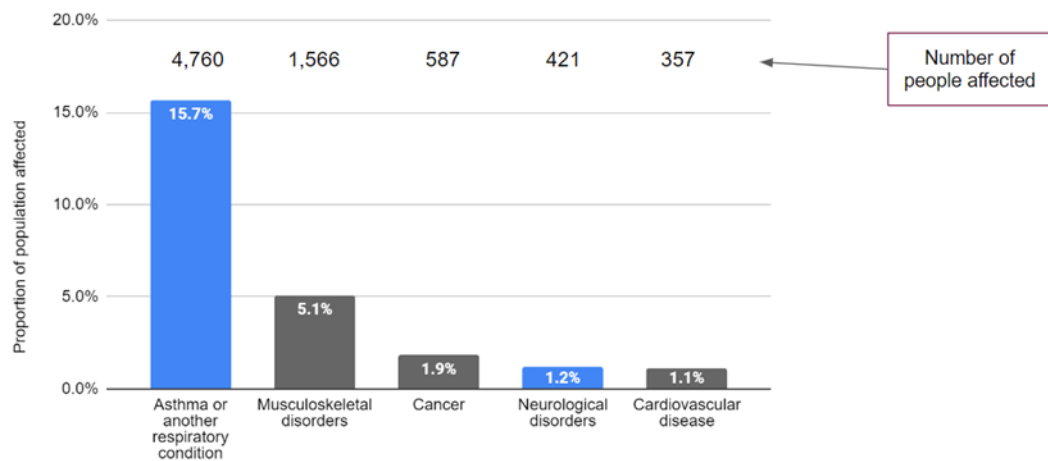
### Top 5 Long Term Conditions (LTC), Older Children aged 5-19 years, Kingston, 2022

The Top 5 Long Term Conditions (LTC) for older children aged 5-19 years shows that asthma is the main LTC for this age group, with over 4,700 children (15.7% of this age group) with this condition in 2022.

Figure 11: Top 5 Long Term Conditions (LTC), older children aged 5-19 years, Kingston, 2022

### Children (5-19 years) - long term conditions (SWL dashboard)

The top five long term health condition categories in older childhood in Kingston in 2022 are:



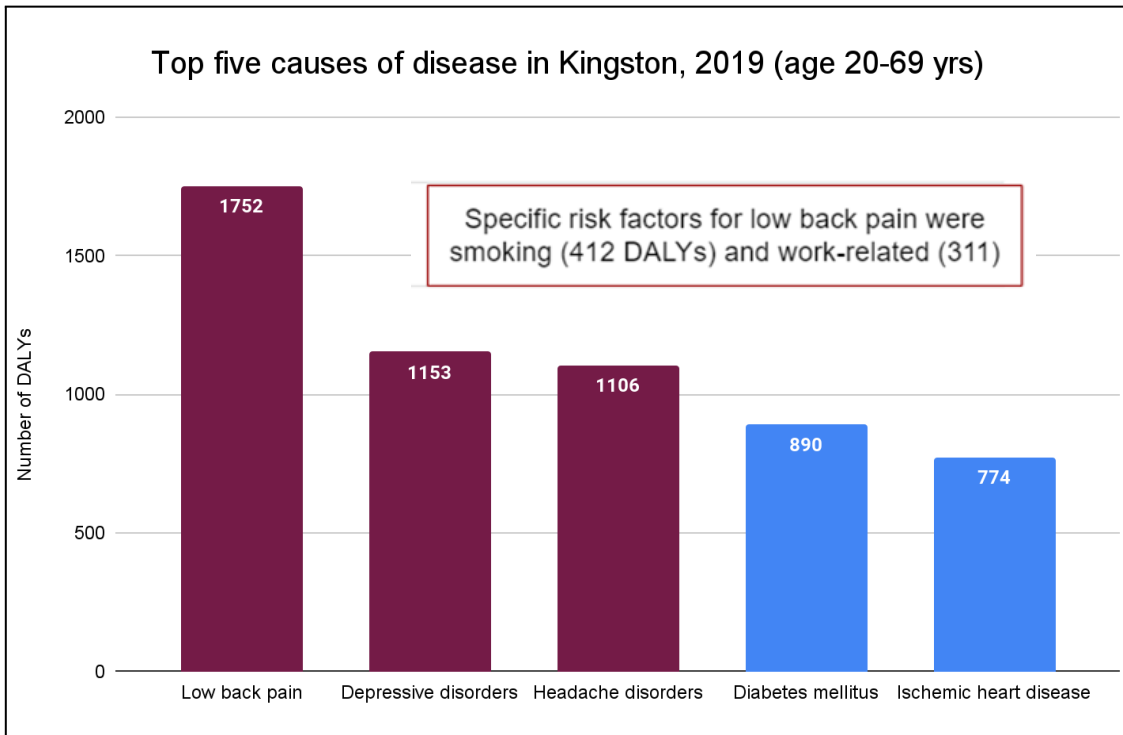
The prevalence of asthma and other respiratory conditions continues to be the highest

### Mortality (5-19 years)

The number of deaths in children aged 5-19 years were less than five in each 'Top 5' cause. The reasons are therefore not included here.

## Top five reasons for ill-health, hospitalisation and mortality: Adults (20-69 years)

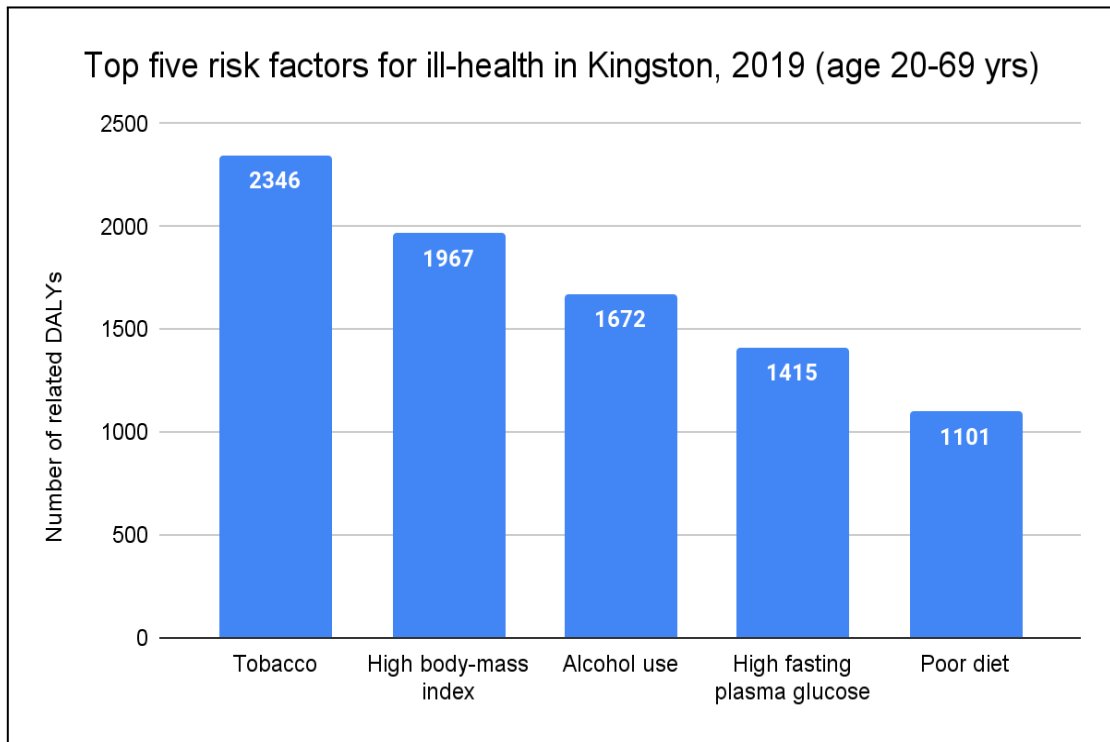
Figure 12: Ill-health 20-69 years



Almost 23,000 DALYs were noted in the GBD for this age group, with the top five causes comprising musculoskeletal, mental health and systemic disorders, and the top three all more common in women.

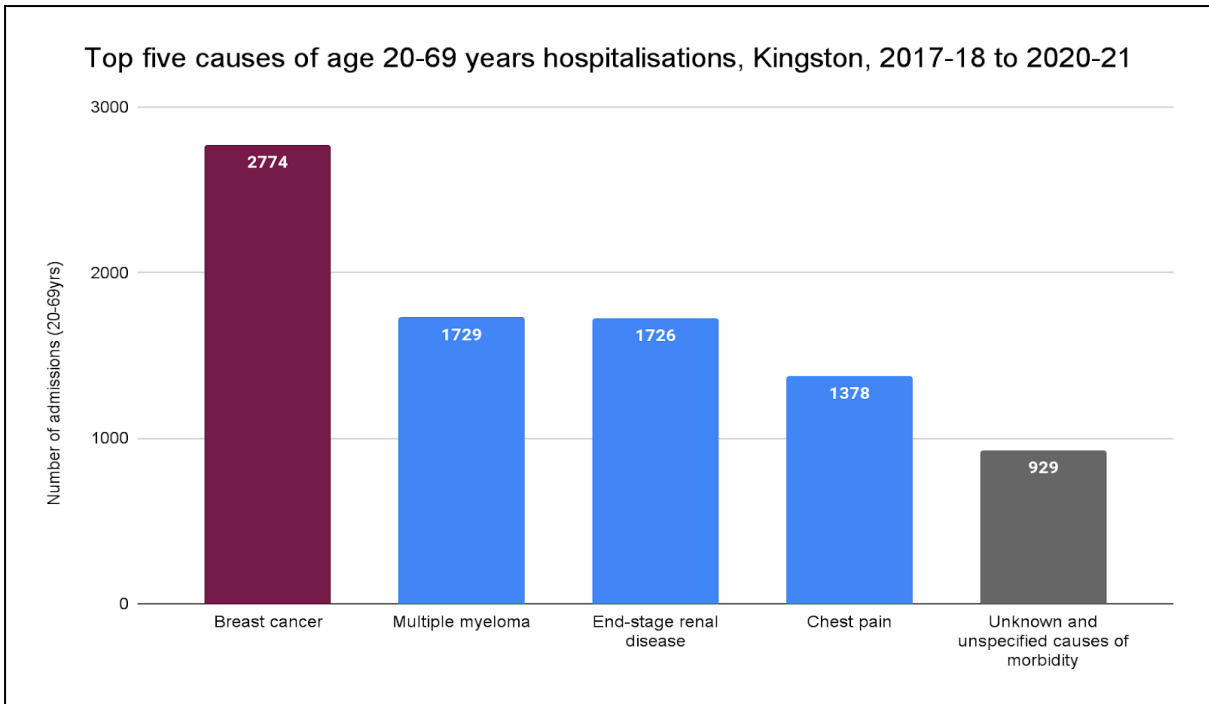
Risks for ill-health 20-69 years

Figure 13: Risks for ill-health, Kingston, 20-69 years, 2019



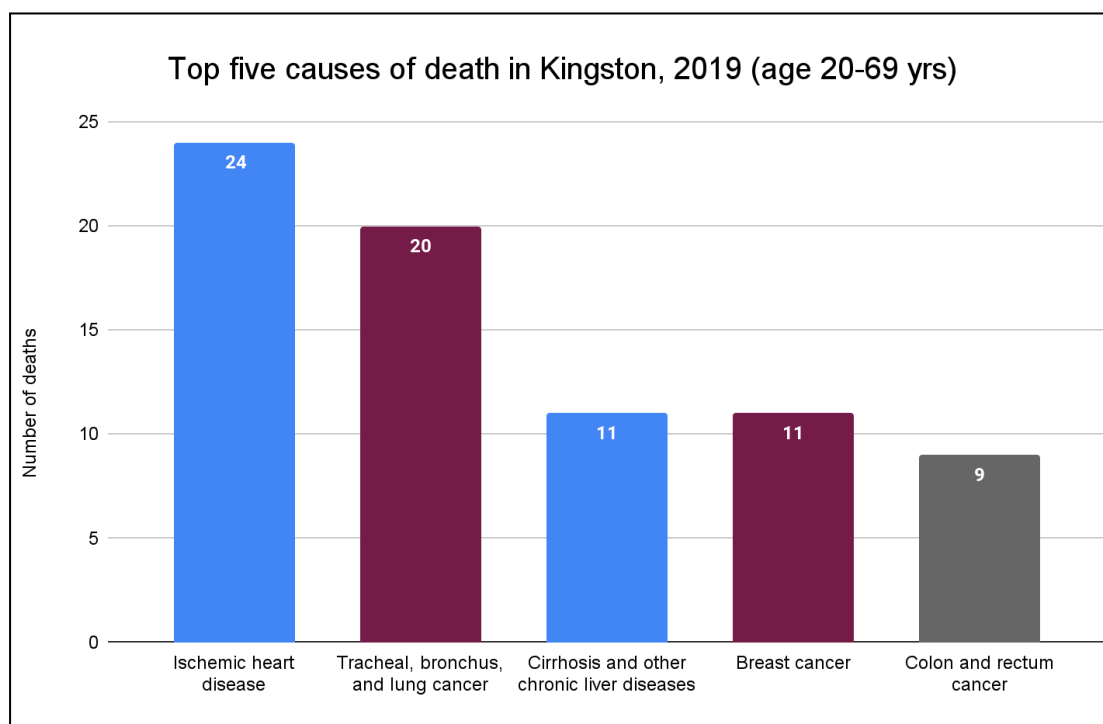
Tobacco is the biggest risk to health of adults aged 20-69 years in Kingston, according to the 2019 Global Burden of Disease (GBD) data. This accounts for 2,346 Disability Adjusted Life Years. Overweight and obesity (High Body Mass Index measure) is the second biggest risk to health of adults in the borough (accounting for 1,967 DALYs). Alcohol is the third largest factor, also accounting for 1,672 DALYs. Two diet related factors, 'High Fasting Plasma Glucose' and 'Poor Diet' are the fourth and fifth top risk factors.

Figure 14: Hospitalisation 20-69 years



Over 120,000 admissions were recorded in the 20-69 age group from 2017-18 to 2020-21. Breast cancer and multiple myeloma were the first and second top reasons for admissions. Kidney (end stage renal disease) and chest pain were the third and fourth main causes. The fifth most frequent reason was 'unknown and unspecified' causes. Breast cancer admissions are of course seen overwhelmingly in women. Expanding the Top Five list to the 'top six', then the next most common cause of hospital admission for 20-69 year olds was 'chronic renal failure'.

Figure 15: Mortality 20-69 years<sup>20</sup>



Deaths before 70 years are classified as ‘premature deaths’. 209 such deaths were recorded in the GBD, with almost 120 contributory causes. Cancers were the overall biggest factor, but at a deeper level of detail, heart disease was the most common cause. Including a sixth most common cause (to account for breast cancer) would mean adding COPD (8 deaths).

In Kingston, many more ‘premature deaths’ occur in residents in our most deprived areas of the borough. From 2017-19, almost half of residents in the most deprived areas of Kingston who died were aged under 75, compared to just over a quarter of residents in the least deprived parts<sup>21</sup>.

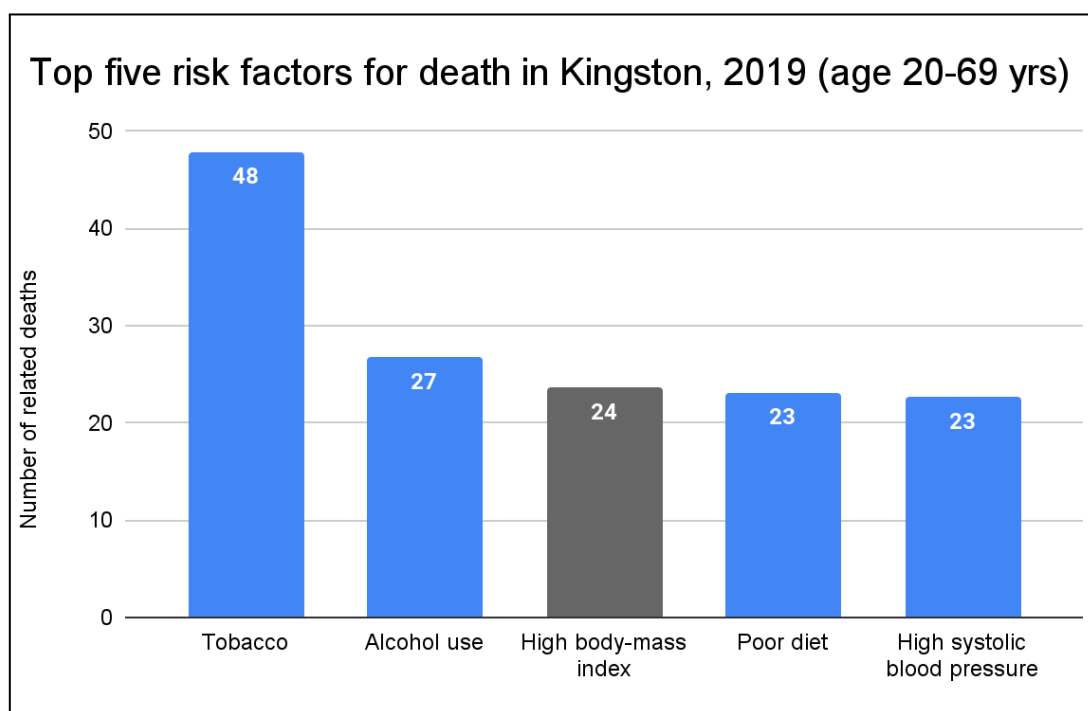
#### Risk factors for premature mortality 20-69 years

The risk factors for death in the 20-69 years (premature mortality) were reviewed on the 2019 Global Burden of Mortality data for the Kingston population. Tobacco is the number one risk factor for early death in Kingston and accounts for nearly twice the level of any of the other risks alone. This is followed by alcohol use. Overweight and obesity (High Body Mass Index) is the third main reason for early death in the borough. ‘Poor diet’ and ‘High Systolic Blood Pressure’ are the fourth and fifth main risks for early death in Kingston. Combining unhealthy weight related risks (eg High Body Mass Index, Poor Diet) would place diet related risks as the number two highest risk in the borough for premature death.

<sup>20</sup> Data rounded to the nearest whole number

<sup>21</sup> NHS England, Primary Care Mortality Database (PCMD), unpublished

Figure 16: Top 5 Risk Factors for Death (20-69 years) (Premature Mortality), Kingston, 2019



#### Primary Care Network (PCN) Mortality:

The Kingston mortality data was reviewed by Primary Care Networks (PCNs) to look at the main causes recorded within each network. Primary Care Networks, which are groups of GP Practices, do not necessarily cover a geographical area. The data below is for a slightly different period to the Global Burden of Disease data and also a slightly different age group (15-64 years). The PCN data for people aged 15-64 years is shown for two periods, with the second period including the first two years of the COVID-19 pandemic (2020-2022).

Within the PCN data, for 2019-20 to 2021-22, the Top 5 causes of premature mortality for men (defined here as 15-64 year olds) were:

Rank	Cause of death	Mortality rate / year / 100,000 residents
1	Cancer of digestive organs	14.9
2	Ischaemic heart diseases	13.7
3	Covid-19 related	12.1
4	Diseases of liver	8.1
5	Intentional self-harm	6

Within the PCN data, for 2019-20 to 2021-22, the Top 5 causes of premature mortality for women (defined here as 15-64 year olds) were:

Rank	Cause of death	Mortality rate / year / 100,000 residents
1	Cancers of breast	10.8
2	Cancers of digestive organs	10.3

3	Cancers of female genital organs	6.4
4	Cancers of respiratory organs	5.9
5	Diseases of liver	5.4

There was considerable variation in the types of mortality by PCN network which may merit further analysis. **Mortality in men** due to cancer of digestive organs was much higher in the Canbury PCN than all other PCNs. Likewise, ischemic heart disease was much higher in Canbury than all other PCNs for males aged 15-64 years. Male mortality due to liver disease was much higher in Surbiton PCN than all other PCNs for this age group. **For women**, Canbury PCN also had a much higher level of premature death due to cancers of digestive organs. Women in Canbury also had much higher levels of early death due to diseases of the liver (more than all other PCNs combined). It should be remembered that numbers of deaths in this age group from specific causes are low.

### Top five reasons for ill-health, hospitalisation and mortality: Older Adults (70 years and older)

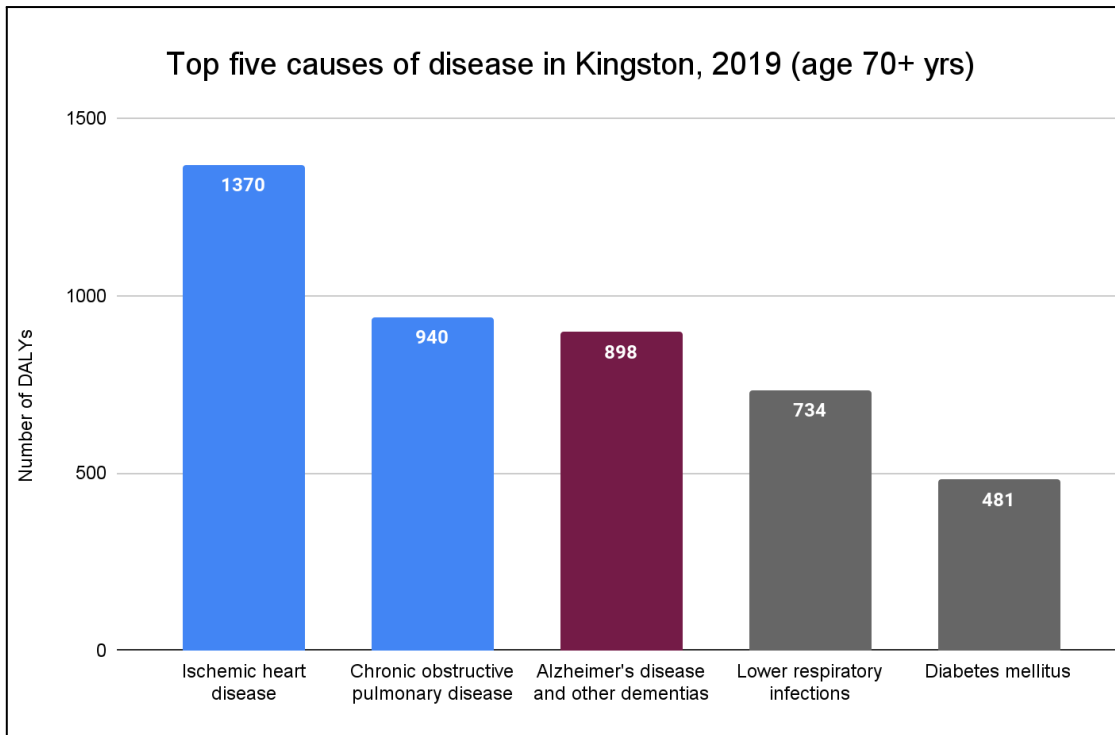
In this section, an overview of the 'Top Five' reasons for ill health, hospitalisation, Long Term Conditions for residents aged 70 years and over is given. Data on the Top 5s for ill health and causes of death come from the 2019 Global Burden of Disease (GBD). Thus, the GBD data does not reflect the COVID-19 pandemic from 2020 onwards, which, (as shown in the COVID-19 section), has greatly impacted older residents in Kingston from 2020 onwards.

#### Ill-health 70 years and older

Ischaemic heart disease was the main cause of ill health in 2019 in Kingston for people aged 70 and over. This was followed by Chronic Obstructive Pulmonary Disease (COPD) as the second greatest cause of ill health. Alzheimer's Disease and other dementias were the third highest cause of ill health. Lower respiratory infections and then diabetes were the fourth and fifth highest causes of ill health in 2019.

*Figure 17: Top 5 causes of ill health, Kingston, people aged 70 years and over, 2019*

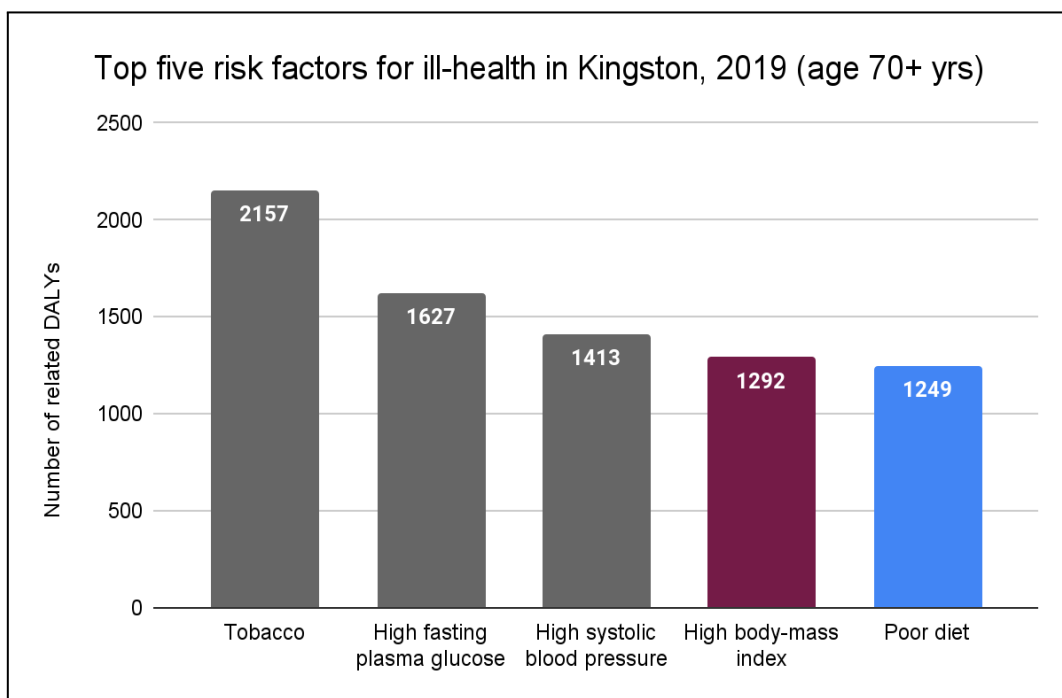




### Risk factors for ill health in people aged 70 and above

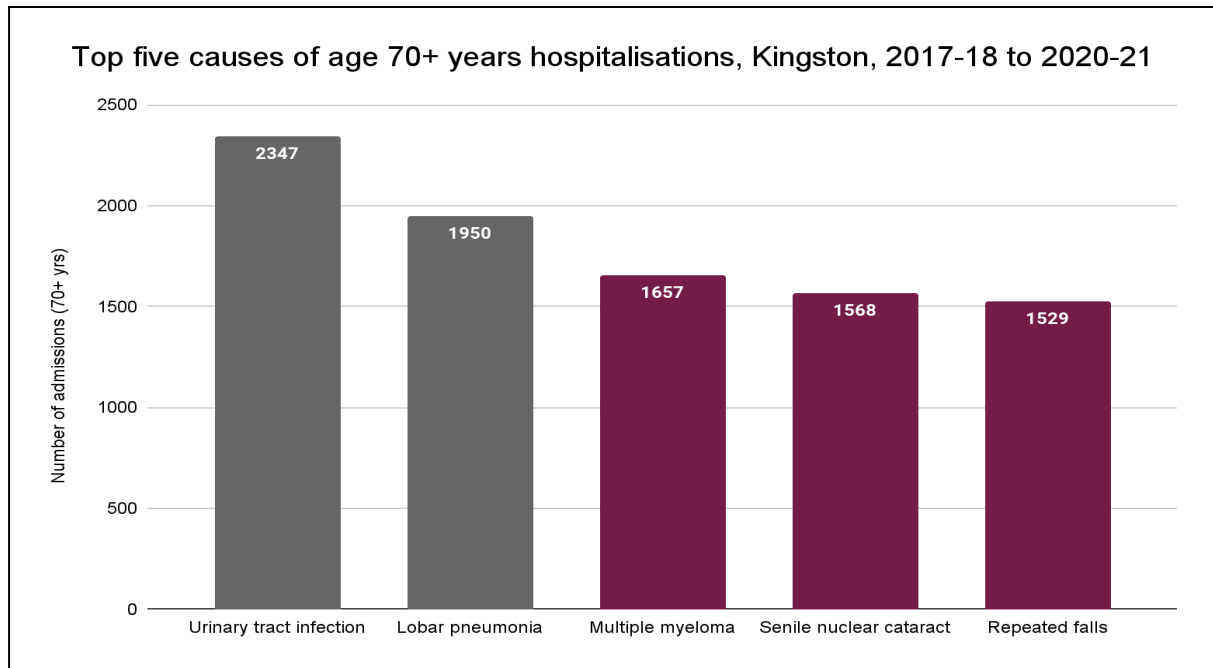
Tobacco was the number one risk for ill health in people aged 70 over in Kingston, according to the 2019 GBD data. High fasting plasma glucose (a condition mainly related to diabetes) was the second highest risk factor for ill health in the older age group. High systolic blood pressure, overweight and obesity (high body mass index) and poor diet were the next highest risk factors in 2019.

Figure 18: Top Five Risk Factors for Ill Health, people aged 70 years, Kingston (2019)



## Hospitalisation 70 years and older

There were 74,000 hospital admissions of Kingston residents aged 70 years and over between 2017-18 and 2020-21. 9,000 (12%) of these admissions were due to the 'top 5' causes of admission, listed below (i.e. most admissions were due to a range of other reasons, with levels less than those listed here as the Top 5 main causes). Urinary Tract Infections (UTIs) were the main reason for hospital admissions of residents aged 70 and above<sup>22</sup>. A broad mix of reasons can be seen, with UTIs and pneumonia at the top. Lobar pneumonia was the second highest reason, followed by multiple myeloma and senile nuclear cataract(s). Repeated falls was the fifth highest reason, with 1,529 hospital admissions recorded for repeated falls over this period.



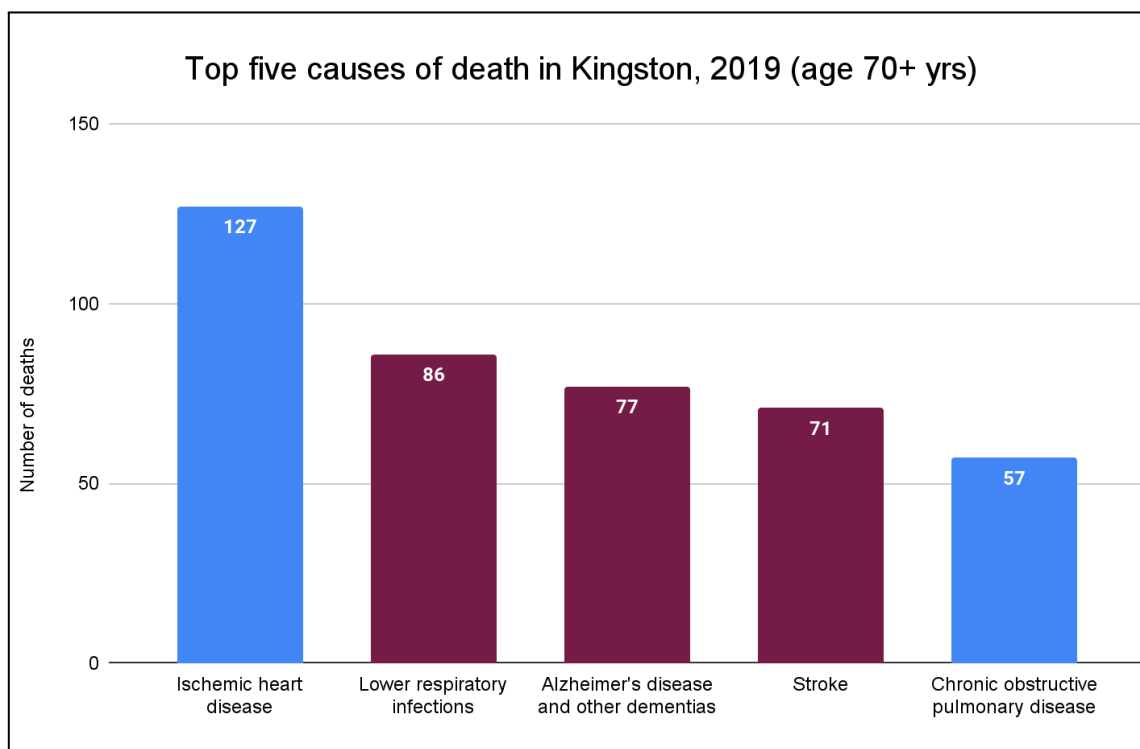
## Mortality 70 years and older<sup>23</sup>

<sup>22</sup> In addition to UTI admissions being the main reason for hospital admissions for this age group, 'RightCare' data from 2019 shows that SW London as a whole, UTI hospital costs and admissions are higher than for most other areas. The RightCare pack identified areas where focus could be made to reduce UTI admissions and also make savings. Length of stay for UTI admissions was also longer for people in SW London than the national average. Readmissions for UTI are also higher in SWL than in most other areas for the 2019 data. See:

[file:///media/fuse/drivefs-508e315620ffa4bbf77a8e97add95cc8/root/NHS-SW-London-CCG-UTI-201920-\\_2021-01-04\\_-\\_V4.html](file:///media/fuse/drivefs-508e315620ffa4bbf77a8e97add95cc8/root/NHS-SW-London-CCG-UTI-201920-_2021-01-04_-_V4.html)

<sup>23</sup> Data rounded to the nearest whole number

Figure 19: Top 5 causes of death in Kingston, age 70 years and older



80% of all deaths occur in the 70+ years group, with 865 in total recorded here in the 2019 GBD data. In 2019, ischaemic heart disease was the main cause of death (more common in men). This was followed by Lower Respiratory Infection (more common in women). Alzheimer's Disease and other dementias, followed by stroke and COPD were the next most commonly recorded causes of death in 2019 for those aged 70 and above.

## Mortality Summary (cause, and rate per 100,000 residents), Kingston, 2019

Figure 20: Mortality Summary (cause, and rate per 100,000 residents), Kingston, 2019

Age band (years)	1st cause	2nd	3rd	4th	5th
<b>All ages</b>	Ischaemic heart disease 88.7	Lower respiratory infections 53.6	Alzheimer's disease and other dementias 46.3	Stroke 45.7	Chronic obstructive pulmonary disease 37.9
<b>20-69</b>	Ischaemic heart disease 29.5	Tracheal, bronchus, and lung cancer 24.8	Cirrhosis and other chronic liver diseases 11.6	Breast cancer 11.5	Colon and rectum cancer 11
<b>70+</b>	Ischaemic heart disease 722	Lower respiratory infections 485	Alzheimer's disease and other dementias 438	Stroke 403	Chronic obstructive pulmonary disease 322

<b>Preventable (&lt;75)</b>	Ischaemic heart disease 39.3	Tracheal, bronchus, and lung cancer 30.8	Chronic obstructive pulmonary disease 15.8	Colon and rectum cancer 14	Breast cancer 13.6
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External
Other
Circulatory
Respiratory
Cancer

## Health patterns by Primary Care Network (PCN)

Primary Care Networks (known as ‘PCNs’) are groups of GP practices that work together to provide primary care to residents registered with the GPs in the PCN group. PCNs can commission some services and also provide some services jointly. PCNs do not necessarily cover a geographical area. (In fact, some people who are registered with a Kingston GP may not live in Kingston but may choose to be registered with a Kingston GP). Because PCNs do not cover a geographical area, it is harder to understand some of the ‘wider determinants of health’ (covered in a following section) such as air pollution, access to green space etc because the people registered with the PCN do not all live in a similar area.

In 2023, Kingston has five PCNs which are:

- CANBURY CHURCHILL ORCHARD BERRYLANDS PCN (name shortened to ‘Canbury’)
- CHESSINGTON AND SURBITON PCN (Chessington)
- KINGSTON PCN (Kingston)
- NEW MALDEN & WORCESTER PARK PCN (New Malden)
- SURBITON HEALTH CENTRE PCN (Surbiton)

As PCNs are the main way that Primary Care services are arranged in Kingston, and because they can also commission and plan services for large groups of people in the borough, the ‘Top 5s’ data was also looked at for the Kingston PCNs. The data shows what the major causes of ill health.

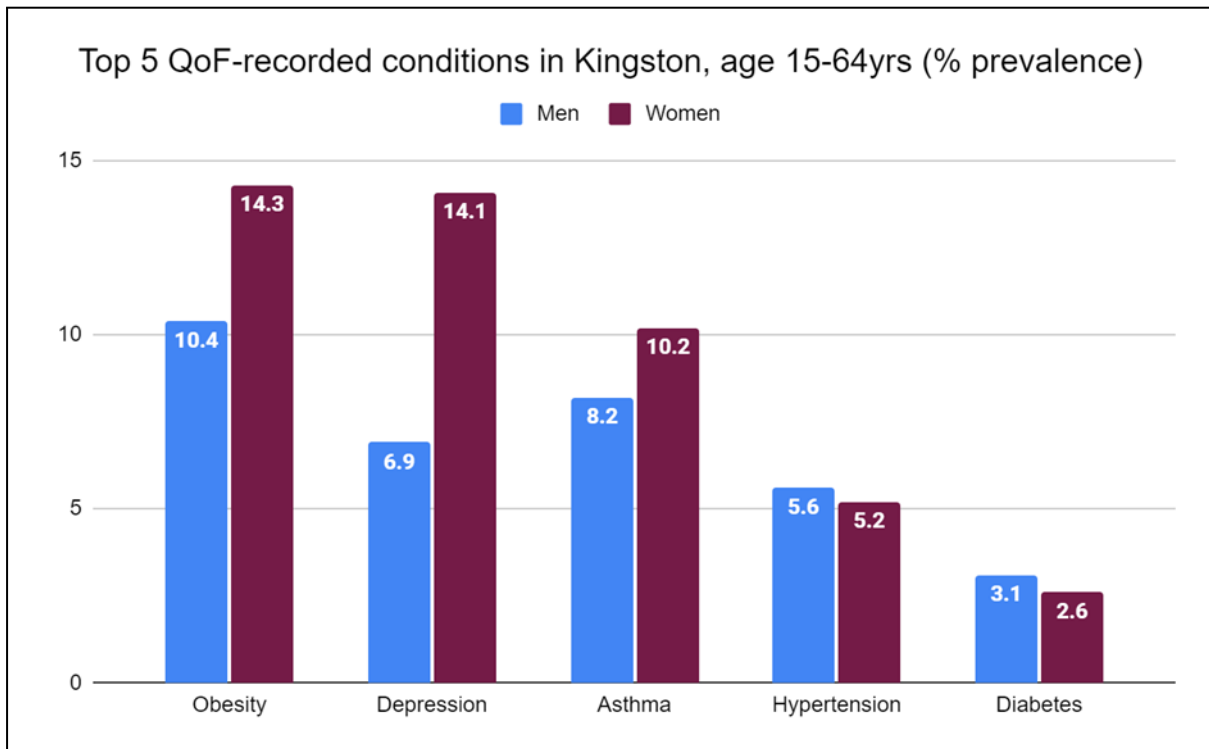
*Figure 21: Overview of Kingston Primary Care Networks (PCNs):*

PCN name (shortened)	Number of GP practices	Number of patients	Proportion of ethnic minority patients (15+yrs)	Proportion of patients 65 years or over (%)
Canbury	Four	19,285	<b>26.0%</b>	13.6%
Chessington	Five	34,601	17.5%	12.0%
Kingston	Three	47,146	15.4%	<b>8.8%</b>
New Malden	Five	<b>62,670</b>	24.6%	15.2%
Surbiton	Three	30,033	10.4%	<b>16.4%</b>

The Quality Outcomes Framework (QoF) data (which is data that is recorded by the GP practice) was analysed to understand the ‘Top 5’ conditions recorded by the Kingston PCNs

in Kingston for 2022. The top 5 conditions were also analysed by male and female prevalence.

Figure 22: PCN data - The Top 5 QoF recorded conditions in Kingston age 15-64 yrs, 2022 (% prevalence)



The 2022 PCN data shows a higher level of obesity, depression and asthma recorded for women in three of the 5 Top 5 conditions recorded. Further analysis of the PCN data is covered in the following sections on 'Inequalities'.

## Inequalities in the Top 5s

In this JSNA, the 'Top 5s' were considered for mortality, morbidity and other factors. For the conditions and risks identified, data relating to 'equalities' within the borough was reviewed. Data was looked at on the issue related to deprivation, ethnicity, sex and geography where available. In this section, the equalities data is presented. Where people live, the deprivation of that area, and their ethnicity can all play a part in disparities in their health and wellbeing, and their access to, and uptake of, health-related services.

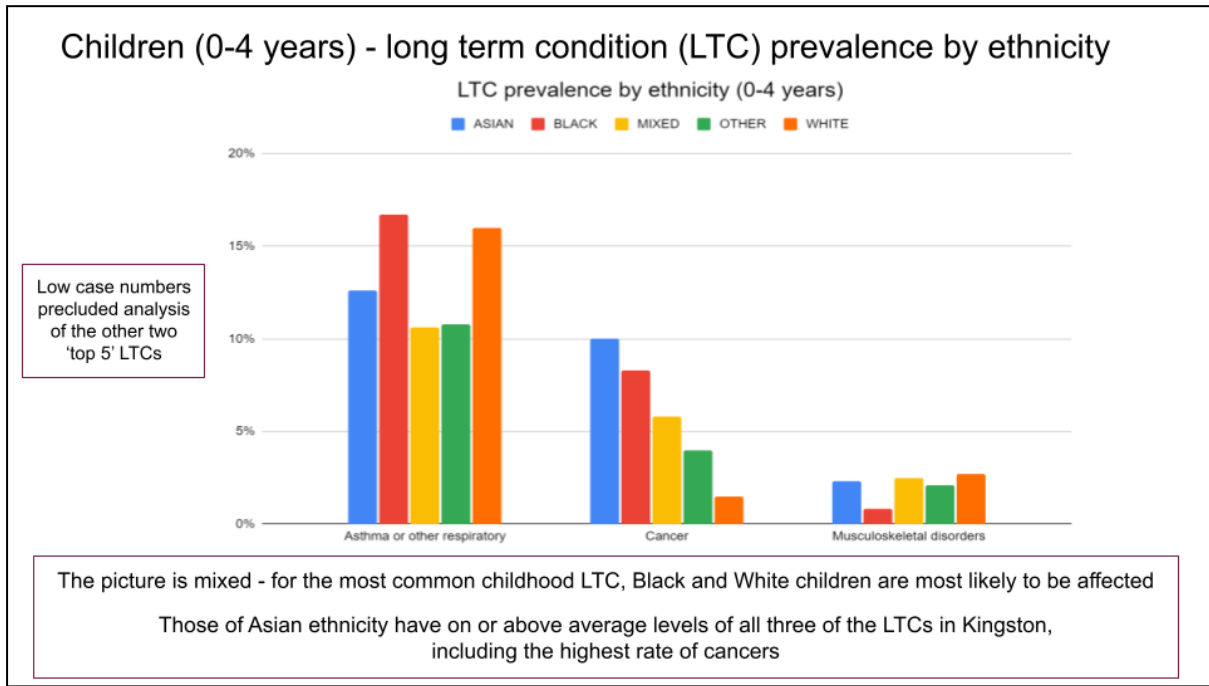
The 2019 Global Burden of Disease (GBD) Study, which we have used to rank the top five causes and risk factors for ill-health and death, does not allow for within-borough analysis. However, other sources enable a picture of the key disparities in the borough, in terms of: Prevalence of long term conditions (LTCs), Quality and outcomes framework (QoF - the main primary care benchmarking dataset for disease prevalence) - in adults only, in-patient hospital admission reasons (from HES, the NHS Hospital Episode Statistics database). In addition, some disease prevalence and mortality rate maps by ward available from the OHID Local Health tool closely match some of the Top 5s from the GBD study.

## Inequalities: Young Children (0-4 years)

For young children aged 0-4 years, levels of ill-health and hospitalisation are low in this age

group. Thus, only a limited analysis was possible. Caution should be taken when interpreting results. In this section, data is shared on Long Term Condition prevalence and hospital admissions.

Figure 23: Long Term Condition Prevalence, Ethnicity, Children in Kingston aged 0-4 years, 2022<sup>24</sup>

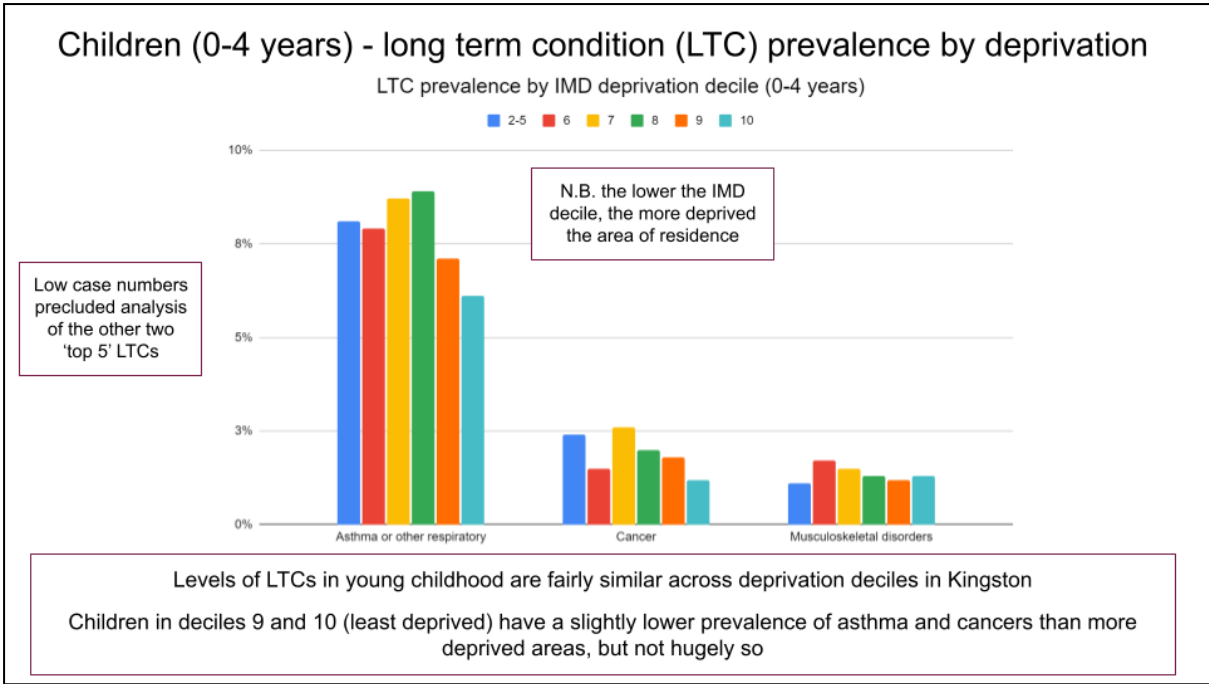


The picture for Long Term Conditions (LTC) in very young children varies. For the most common childhood LTC, asthma, Black and White children are most likely to be affected. Those of Asian ethnicity have on or above average levels of all three of the LTCs in Kingston, including the highest rate of cancers.

Figure 24: Long Term Condition (LTC) Prevalence in Children in Kingston aged 0-4 years, by deprivation, 2022<sup>25</sup>

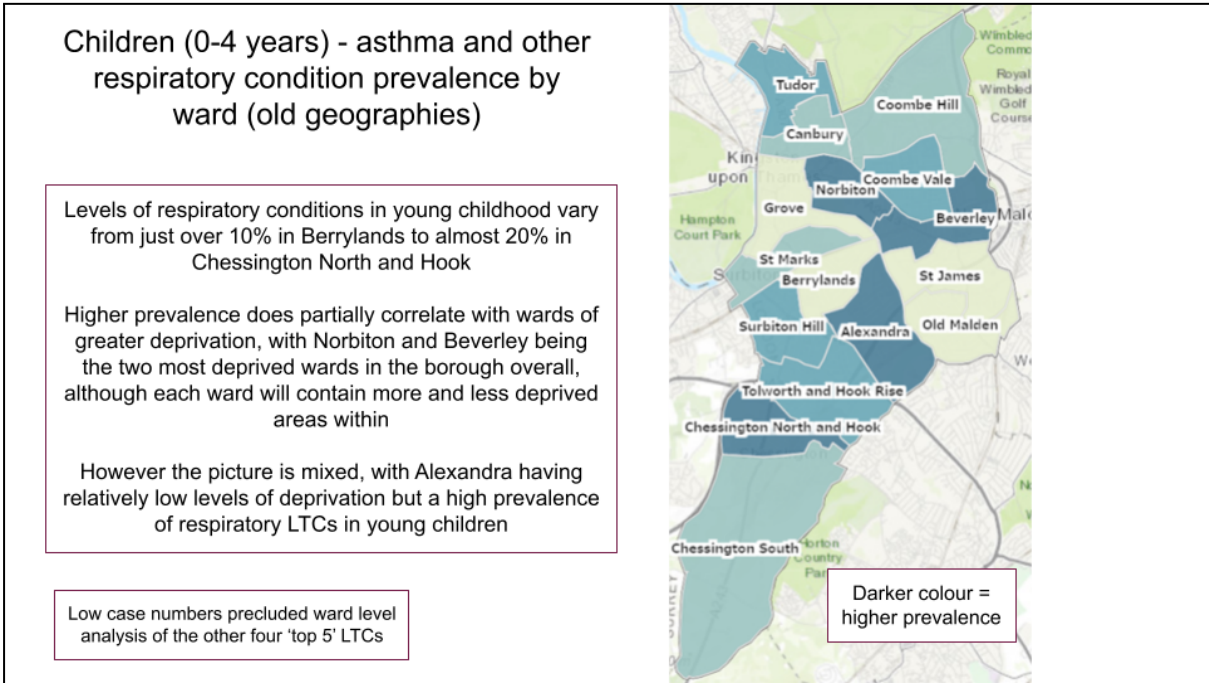
<sup>24</sup> NHS England, south west London ICS Health Analytics dashboard, unpublished

<sup>25</sup> NHS England, south west London ICS Health Analytics dashboard, unpublished



Levels of LTCs in young childhood (0-4 years) are fairly similar across deprivation deciles in Kingston. Children in deciles 9 and 10 (least deprived) have a slightly lower prevalence of asthma and cancers than more deprived areas.

Figure 25: Asthma and other respiratory condition prevalence, by ward, Children in Kingston 0-4 years, 2022<sup>26</sup>



Levels of asthma and other respiratory conditions in young childhood vary from just over 10% in Berrylands to almost 20% in Chessington North and Hook. Higher prevalence does partially correlate with wards of greater deprivation, with Norbiton and Beverley being the two most deprived wards in the borough overall, although each ward will contain more and

<sup>26</sup> NHS England, south west London ICS Health Analytics dashboard, unpublished

less deprived areas within. However the picture is mixed, with Alexandra having relatively low levels of deprivation but a high prevalence of respiratory LTCs in young children.

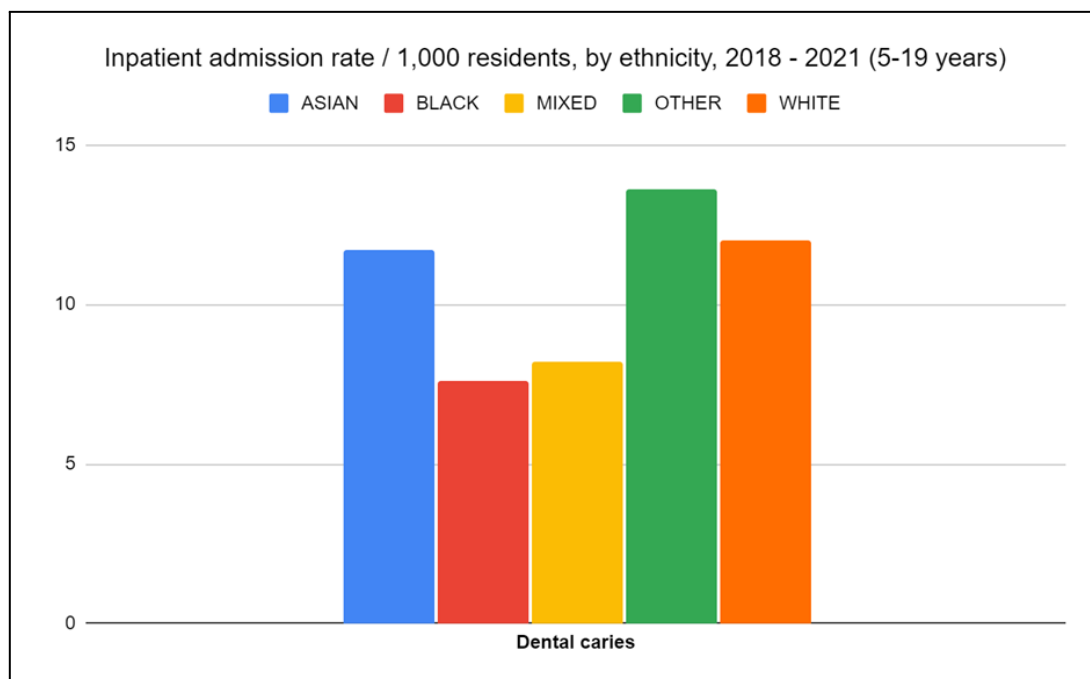
#### In-patient hospitalisation reasons, Children aged 0-4 years, 2018-2021

The inpatient hospitalisation reasons for children 0-4 years were reviewed for 2018-2021 by ethnicity and deprivation. Geography of admissions was also reviewed. The differences in numbers of hospitalisations between groups were too low to draw any conclusions and this data is not presented here.

### **Inequalities: Children and young people aged 5-19 years**

For young children aged 5-19 years, levels of ill-health and hospitalisation are low, thus only a limited analysis was possible. Caution should be taken when interpreting results. In this section, data was reviewed on Long Term Condition prevalence and hospital admissions.

Figure 26: Children aged 5-19 years, Inpatient Hospitalisations, Ethnicity, 2018-2021

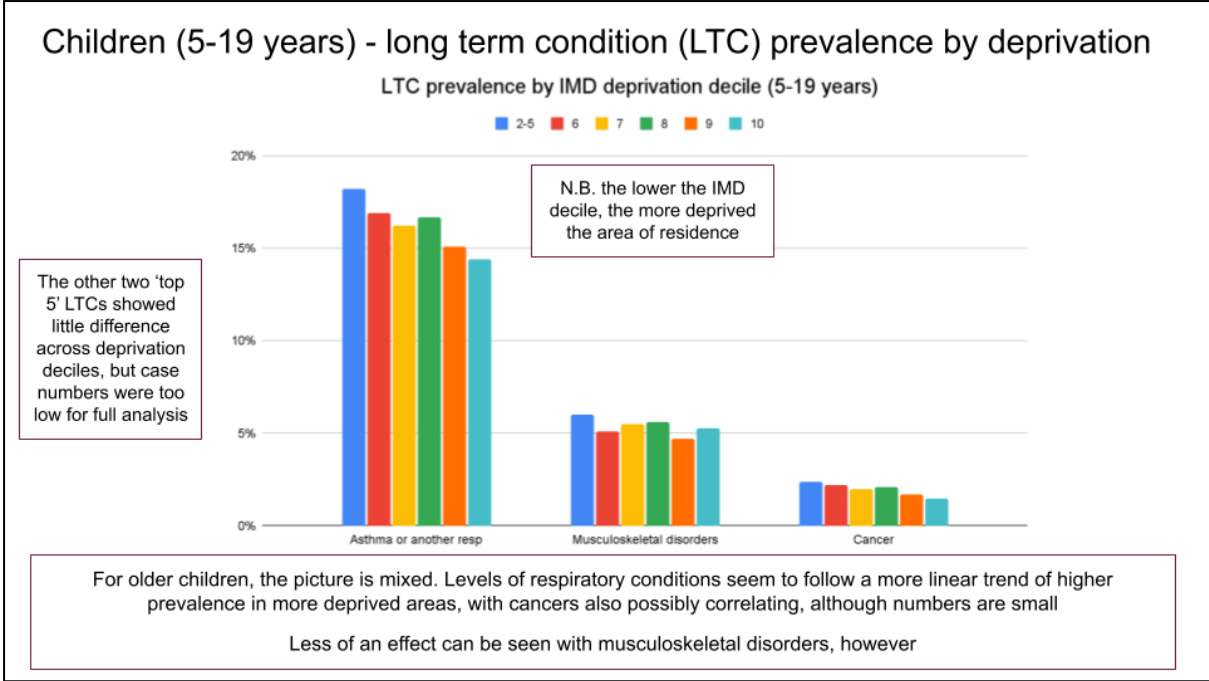


For the hospital admissions data for children aged 5-19 years, numbers were too low in four of the five conditions to look at any ethnicity patterns. For dental caries, Asian, Other and White children showed higher rates of admission than Black children or the 'Mixed' category.

Figure 27: Long Term Conditions, Deprivation, Children 5-19 years in Kingston, 2022<sup>27</sup>

<sup>27</sup> NHS England, South West London ICS Health Analytics dashboard, unpublished





Long Term Conditions in children in Kingston aged 5-19 years for 2022 were reviewed by 'deprivation deciles'. For asthma, higher levels are found in the most deprived populations of Kingston (deciles 2-5), with generally decreasing levels to least deprived decile (decile 10). Case numbers are too small for any conclusions to be drawn about the two other top 5 Long Term Conditions in this age group.

Figure 28: Children aged 5-19 years, asthma and other respiratory conditions by ward, 2022<sup>28</sup> (using pre-2022 ward geographies )

<sup>28</sup> NHS England, south west London ICS Health Analytics dashboard, unpublished

## Children (5-19 years) - asthma and other respiratory condition prevalence by ward (old geographies), 2022

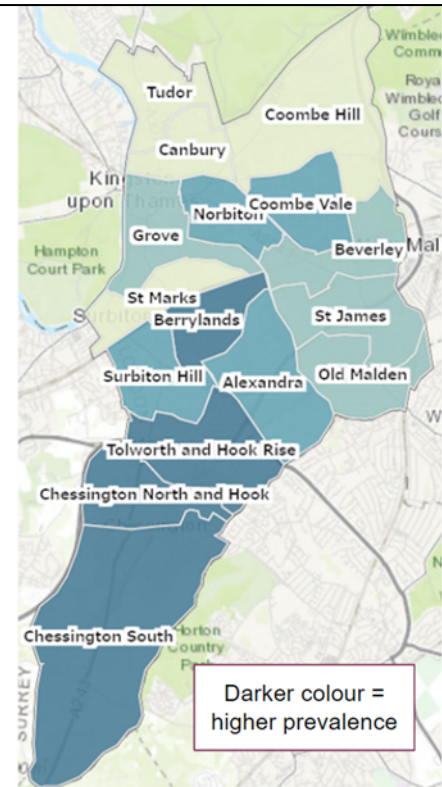
In older childhood, respiratory conditions levels are closer than in young children, with a 7% difference between the highest and lowest wards compared to 10% in 0-4yrs.

The geographical pattern is also very different to younger children, with all four wards with the lowest prevalence being different, as well as three of the four highest wards

With older children, a geographical pattern begins to emerge, with wards in the north of the borough having lower levels of lung conditions than those in the south

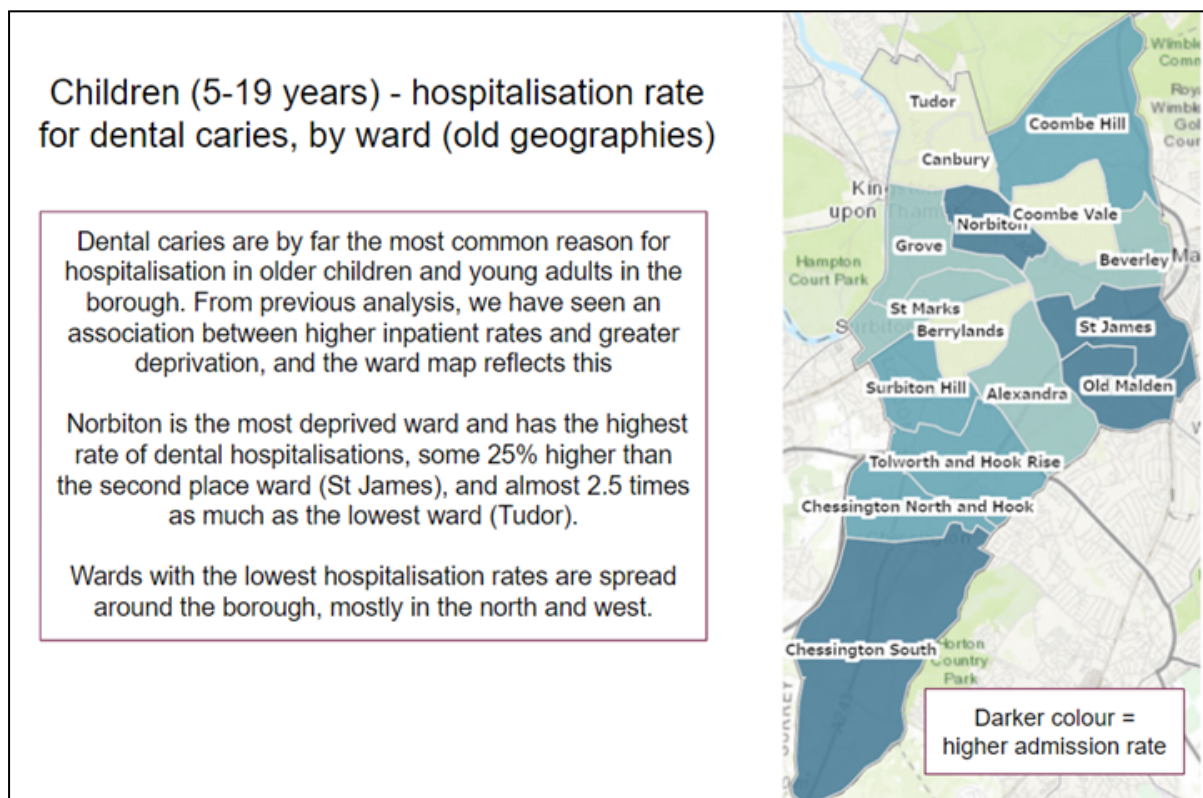
Major roads running through the south of the borough may play a part in increased levels of respiratory disorders

A similar pattern could be seen for the number two LTC (musculoskeletal conditions) with low case numbers precluding ward analysis of the others



Asthma and other respiratory conditions for children aged 5-19 years were reviewed by geographical distribution, There is a higher level of asthma found across the south of the borough. High levels are also found in Berrylands.

Figure 29: Children 5-19 years, Hospitalisation Rate for Dental Caries, by ward, 2022<sup>29</sup> (using pre-2022 ward geographies)



The geographical distribution of hospital data for dental caries for children aged 5-19 years for 2022 (i.e. the ward where the child was living) was reviewed. The map shows the highest rates of children requiring hospitalisation for dental caries were Chessington South, Old Malden, St James and Norbiton. Of these, Norbiton had the highest rates in the borough.

### Inequalities: Adults (20-69 years)

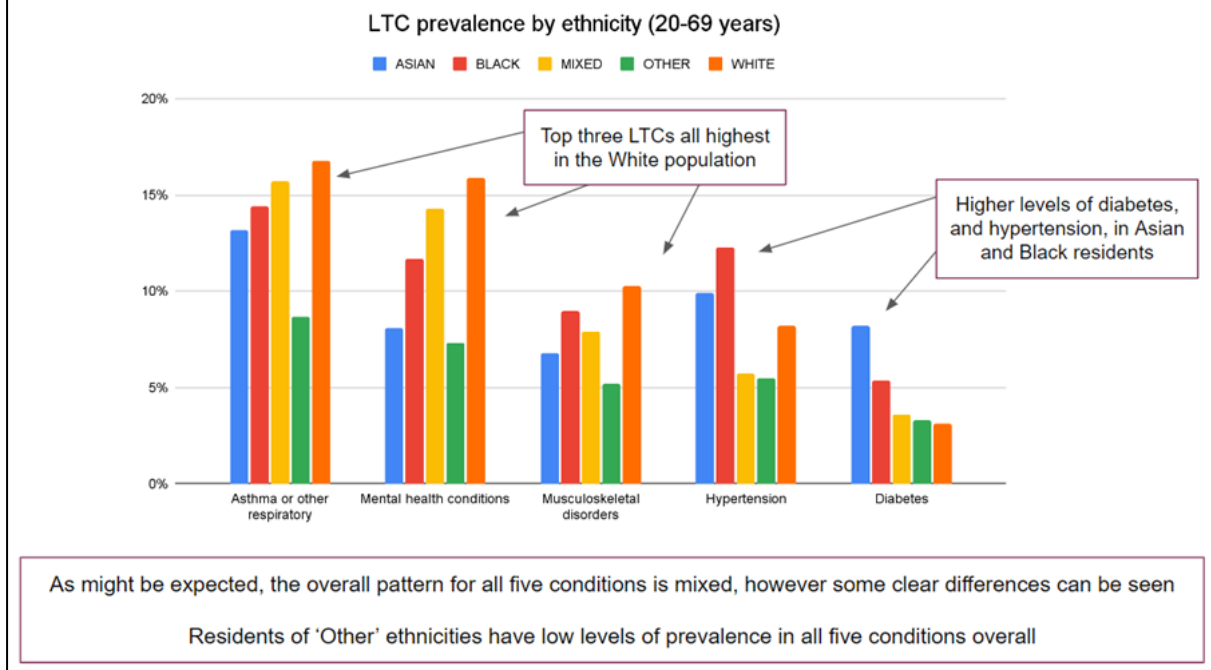
The data for adults was reviewed to look for any differences within the borough in terms of deprivation, ethnicity and geography. For the Primary Care Network (PCN) data, the closest available age range has been used (15-64 years).

Figure 30: Long Term Conditions (LTC) prevalence in Kingston, 2022<sup>30</sup>, by ethnicity

<sup>29</sup> NHS England, south west London ICS Health Analytics dashboard, unpublished

<sup>30</sup> NHS England, south west London ICS Health Analytics dashboard, unpublished

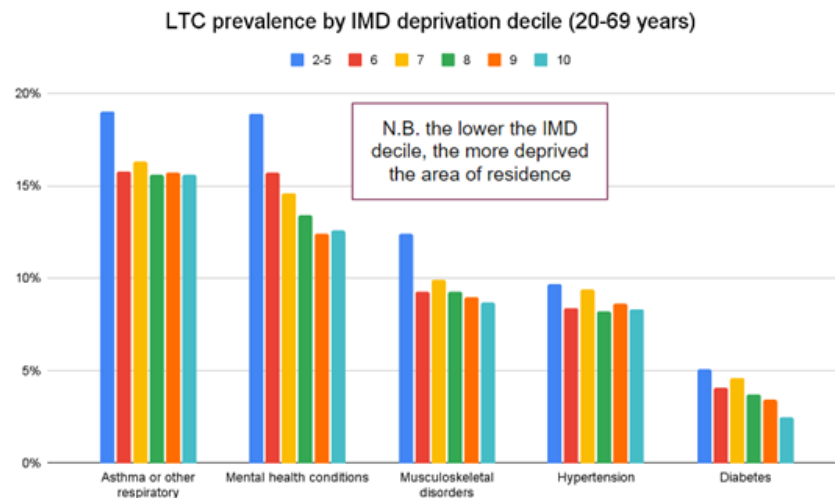
## Adults (20-69 years) - long term condition (LTC) prevalence by ethnicity



High rates of asthma were found in White residents in Kingston (about 1 in 6 White residents in this age category). Highest rates of mental health conditions were found in the White population. For musculoskeletal disorders, the White population had the highest recorded levels in the borough. Black residents had the highest levels of hypertension (over 10% of Black residents), followed by Asian residents (about 1 in 10). In terms of diabetes, significantly higher levels are recorded in Asian residents (about one in 12 people in the 20-69 age category). Black residents have the second highest level of diabetes (around one in 18 people).

Figure 31: Long Term Conditions (LTC) prevalence in Kingston, 2022<sup>31</sup>, by deprivation

### Adults (20-69 years) - long term condition (LTC) prevalence by deprivation



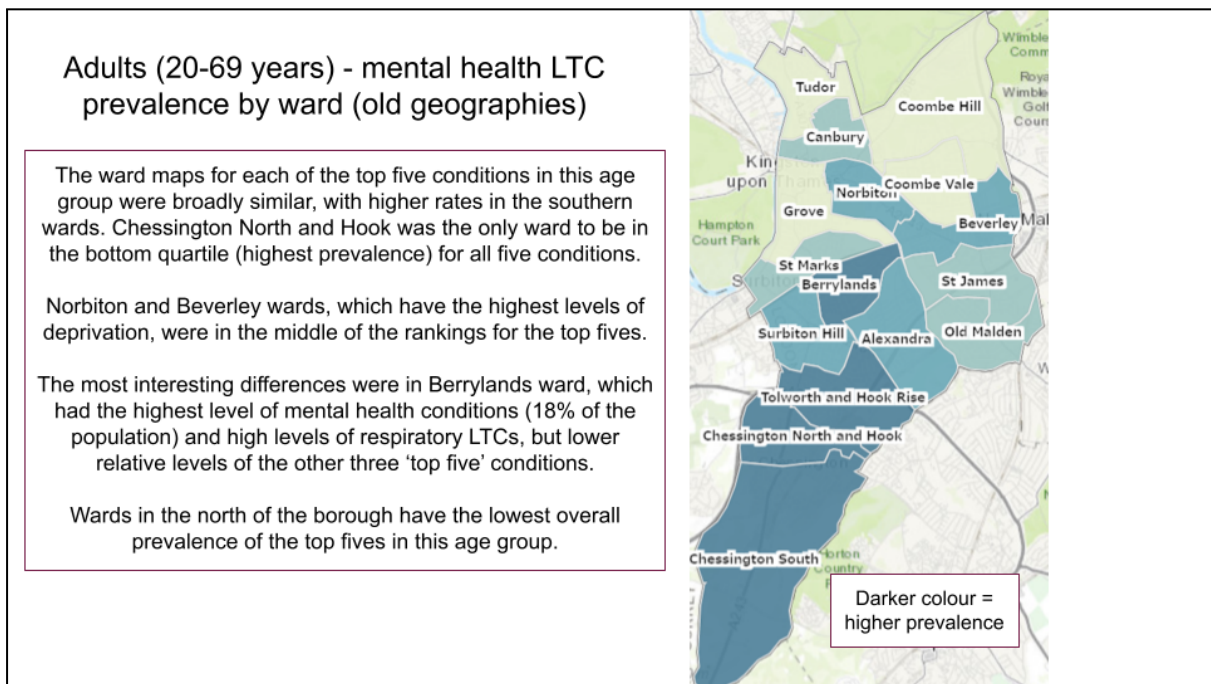
In adults, LTC rates by deprivation show a distinction between those residents in the lowest deciles (2-5: most deprived areas) and all other Kingstonsians  
 Rates are highest in deciles 2-5 for all the top five conditions, however for the top three the difference is particularly stark

The Top 5 Long Term Conditions (LTCs) were reviewed to see if there was any pattern in terms of deprivation and prevalence of condition for the 20-69 year olds. For this age group, there is a clear link between deprivation and prevalence of the Top 5 Long Term Conditions in 2022<sup>32</sup>. Higher levels of people being diagnosed with a Long Term Condition are found in the more deprived areas. For asthma, approaching 20% of adults in the most deprived areas (deciles 2-5) in Kingston aged 20-69 years, have been diagnosed with asthma. Asthma levels are around 15% for the rest of the borough (deciles 6-10). Mental Health conditions are highest in the highest deprivation deciles in Kingston (deciles 2-5), with a generally decreasing pattern as deprivation decreases. For musculoskeletal conditions, hypertension and diabetes, these are all highest in the most deprived areas of Kingston (deciles 2-5). However, for deciles 6-10, there is a more mixed picture as deprivation decreases.

<sup>31</sup> NHS England, south west London ICS Health Analytics dashboard, unpublished

<sup>32</sup> NHS England, south west London ICS Health Analytics dashboard, unpublished

Figure 32: Mental Health Long Term Conditions, Prevalence by ward, Adults 20-69 years, Kingston, 2022



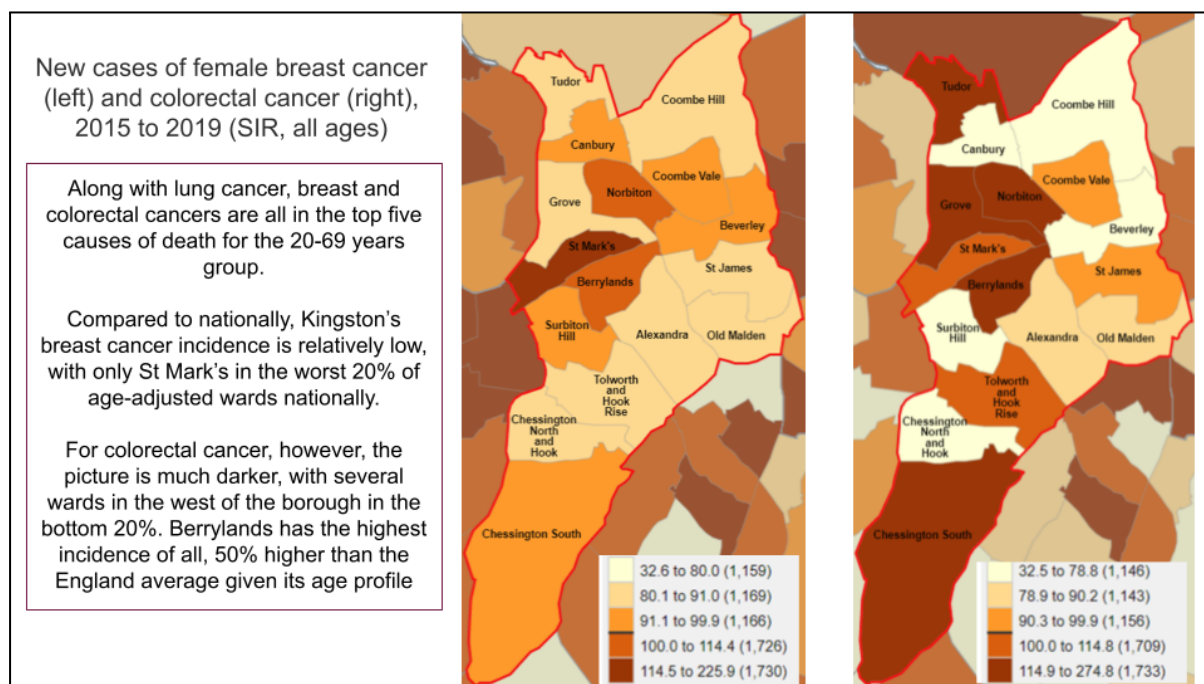
The ward maps for each of the top five conditions in this age group were broadly similar, with higher rates of adults diagnosed with Mental Health Conditions as a Long Term Condition in the southern wards. Berrylands also has a higher level of adults diagnosed with Mental Health Long Term Conditions.

Cancer (breast cancer, colorectal cancer), 2015-2019, all ages, by ward: Along with lung cancer, breast and colorectal cancers are all in the top five causes of death for the 20-69 years group. For breast cancer, St Mark's is the only one of Kingston's wards in the worst 20% of age-adjusted wards nationally.

For colorectal cancer, several wards in the west of the borough are in the bottom (worst) 20% of wards nationally. Berrylands has the highest incidence of all wards in Kingston, and is in the bottom 3% of wards in England, with new cases of colorectal cancer 50% higher than the national average given its age profile.



Figure 33: Cancer (breast cancer, colorectal cancer), 2015-2019, all ages, by ward



**Coronary Heart Disease (CHD) (all ages), geographical differences in emergency hospital admissions and deaths:** Coronary heart disease (ischaemic heart disease) is the top cause of premature death in Kingston (20-69 years) and the leading cause of ill health and death for people aged 70 years and over. Emergency hospital admissions data for CHD for all ages in Kingston was reviewed by ward area for 2016-2021. The data shows that Norbiton and Berrylands wards again have the highest values in Kingston, and are the only two with an SAR greater than 100 (meaning that the ward has a higher than expected rate). Norbiton is in the top (worst) 20% of wards nationally, with a rate 35% higher than would be expected, given its age profile.

In terms of deaths from coronary heart disease, Kingston as a whole is close to the national average for this metric. However, several wards in the central belt of the borough have above average mortality rates for CHD. St James has the highest rate overall, with Norbiton in second place, both more than 20% greater than would be expected for their demographic profile.

Figure 34: Emergency hospital admissions for Coronary Heart Disease (CHD), all ages, 2016 - 2017 to 2020 - 2021 (SAR)

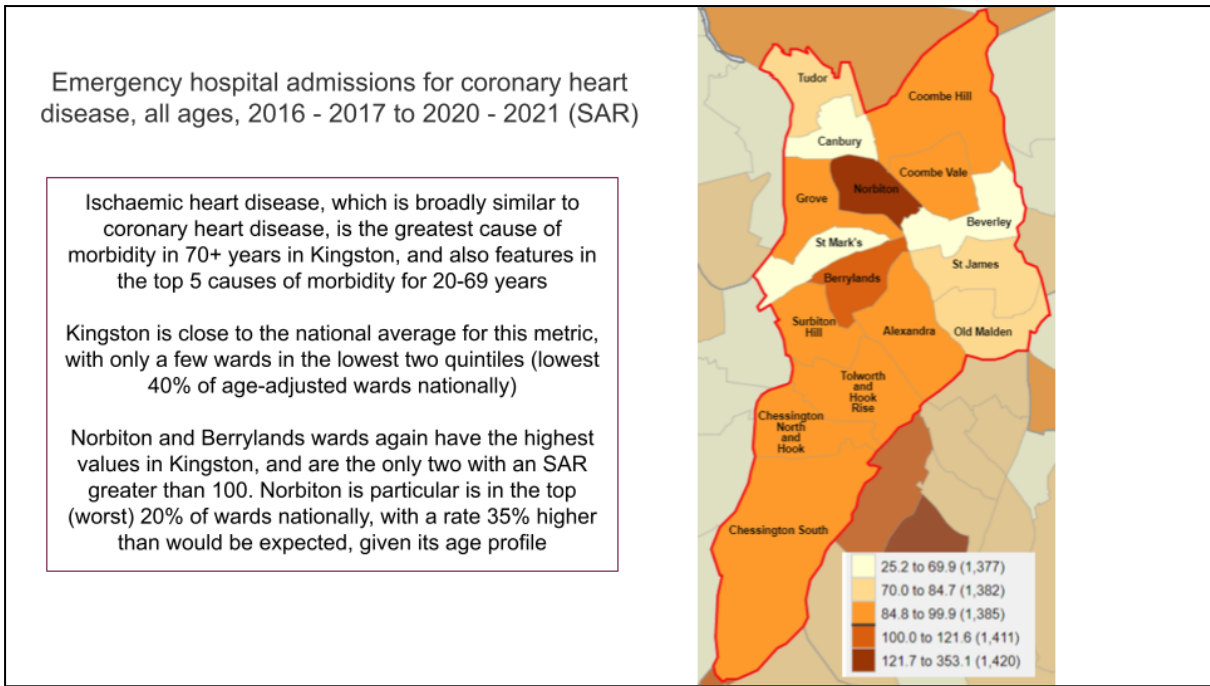
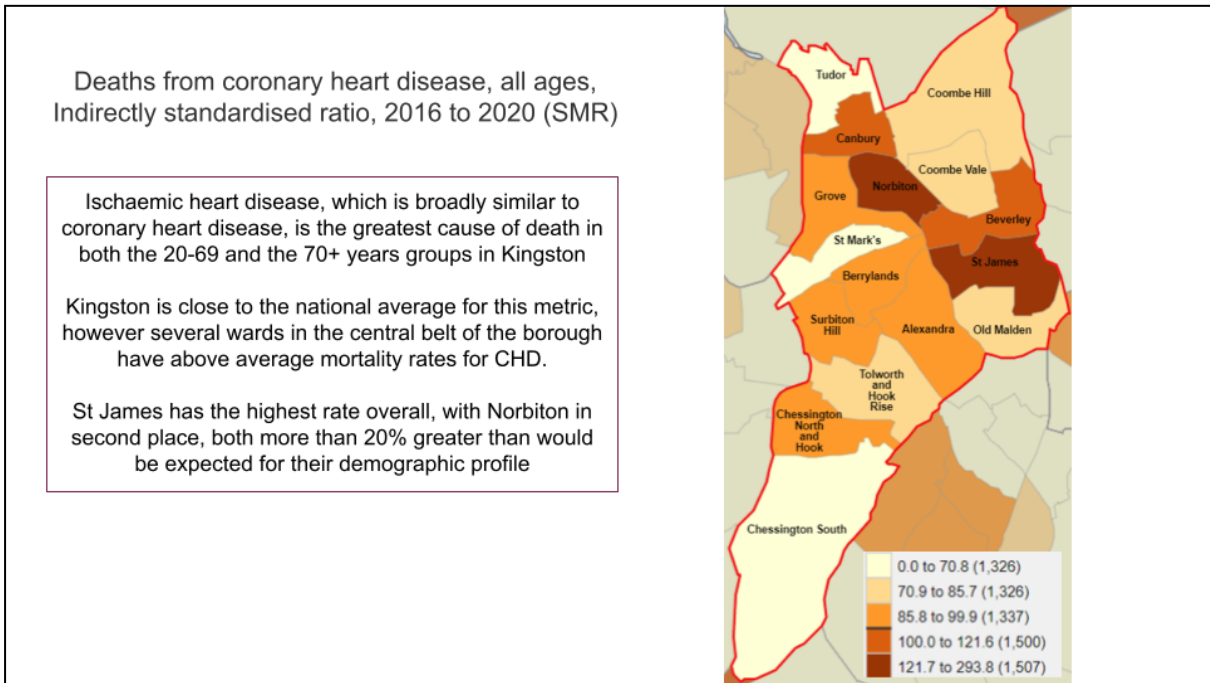


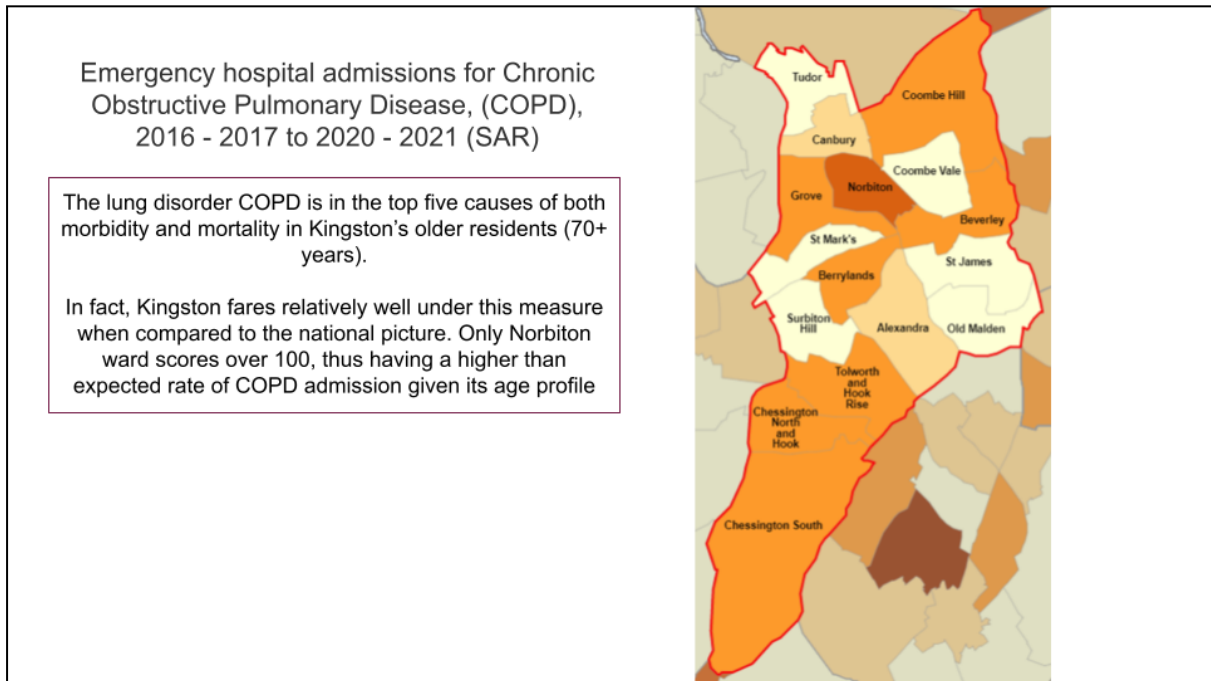
Figure 35: Deaths from Coronary Heart Disease (CHD), all ages, Indirectly standardised ratio, 2016 to 2020 (SMR)



**COPD (Chronic Obstructive Pulmonary Disorder) emergency hospital admissions, 2016-2021, all ages, Kingston by ward:** COPD is the second leading cause of ill health for people aged 70 and over in Kingston. Looking at the data by ward for COPD emergency hospital admissions, there is a clear area with the highest rate - Norbiton - which is the only area in Kingston with a higher level of emergency hospital admissions for this condition.



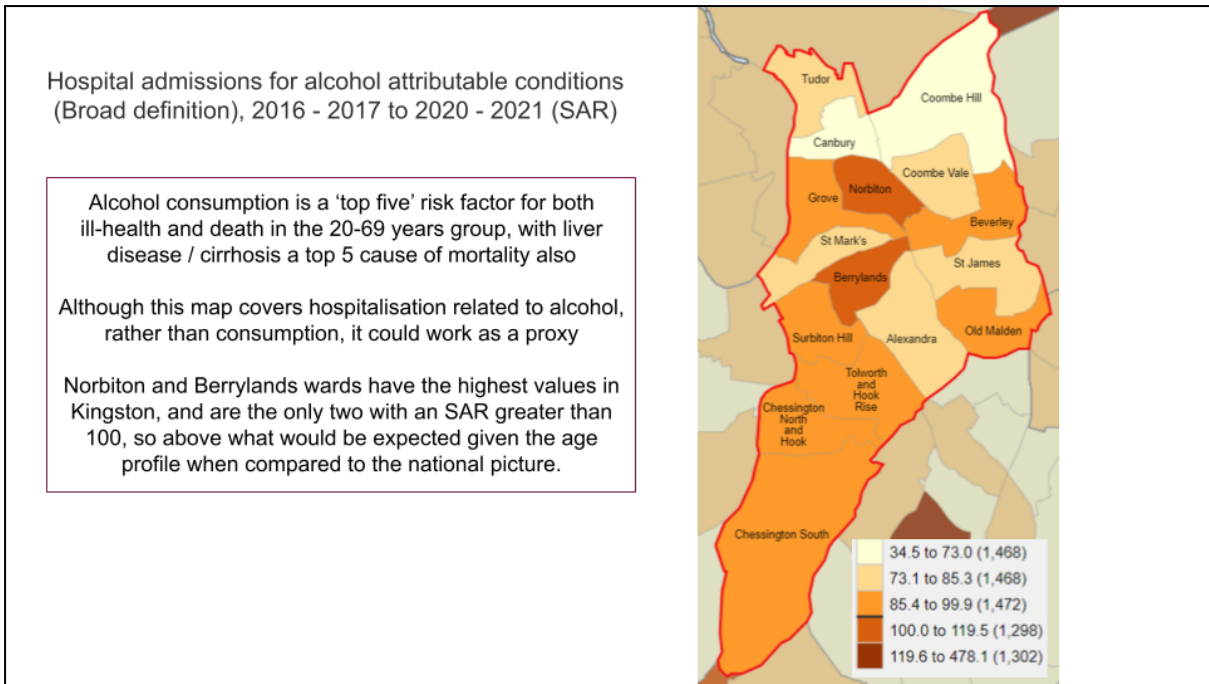
Figure 36: COPD and emergency hospital admissions, 2016-2021, all ages, Kingston by ward



#### Inequalities in Risk Factors for Ill Health 20-69 years

**Alcohol and Hospital admissions for alcohol attributable conditions (broad definition):** Alcohol consumption is a 'top five' risk factor for both ill-health and death in the 20-69 years group, with liver disease / cirrhosis a top 5 cause of mortality also. Data is not available by ward on alcohol consumption. Thus, data on alcohol related hospital admissions for 2016-2021 was reviewed in terms of geography of areas of particular risk. Norbiton and Berrylands wards have the highest values in Kingston. They have levels above what would be expected given the age profile when compared to the national picture.

Figure 37: Hospital admissions for alcohol attributable conditions (Broad definition), 2016-2021



## Primary Care Network (PCN) Health Inequalities

The Primary Care Network (PCN) data was reviewed to see if there were any differences in their 'Top 5' health conditions. The Quality Outcomes Framework (QoF) data was used for this. A summary table of the findings is below:

Figure 38: PCN Health Inequalities, 2022, QoF data, top 5 causes of morbidity and % prevalence, age 15-64 years:

Rank	Canbury	Chessington	Kingston	New Malden	Surbiton
1	Obesity (12.7%)	Obesity (13.8%)	Obesity (10.2%)	Obesity (12%)	Depression (14.4%)
2	Depression (11%)	Depression (10.4%)	Depression (7.7%)	Depression (9.4%)	Obesity (13.1%)
3	Asthma (8.9%)	Asthma (9.4%)	Asthma (7.3%)	Asthma (9.4%)	Asthma (11.5%)
4	Hypertension (5.8%)	Hypertension (5.9%)	Hypertension (3.7%)	Hypertension (6%)	Hypertension (6.2%)
5	Diabetes (2.9%)	Diabetes (3.6%)	Diabetes (1.8%)	Diabetes (3.4%)	Diabetes (2.8%)

Surbiton PCN patients have a higher prevalence of depression than obesity, for all other PCNs obesity is the number one QoF-reported condition in this age group.

Figure 39: PCN Health Inequalities, 2022, QoF data, top 5 causes of morbidity and % prevalence, age 65+ years:

Rank	Canbury	Chessington	Kingston	New Malden	Surbiton
1	Hypertension (46%)	Hypertension (43.8%)	Hypertension (42.8%)	Hypertension (43.2%)	Hypertension (42.9%)
2	Obesity (21.1%)	Obesity (22%)	Obesity (17.4%)	Obesity (19.1%)	Obesity (20.5%)

3	Diabetes (15.3%)	Diabetes (18.1%)	Diabetes (14.3%)	Diabetes (17%)	Depression (17.8%)
4	Depression (13.3%)	Depression (13.9%)	Depression (11.5%)	Depression (12%)	Diabetes (16.4%)
5	Asthma (9.6%)	Asthma (11.2%)	Asthma (9.4%)	Asthma (11.1%)	Asthma (11.8%)

For the older age group, Surbiton PCN remains an outlier with depression in third place as opposed to fourth in all other PCNs. Chessington and Surbiton PCNs have the highest levels of the top 5 conditions combined in older adult patients.

When looking at sex differences in the top 5 condition prevalence by PCN, the data showed levels of depression in women aged 15-64 years were more than double that of men, across all PCNs. Obesity and asthma were also significantly higher in women.

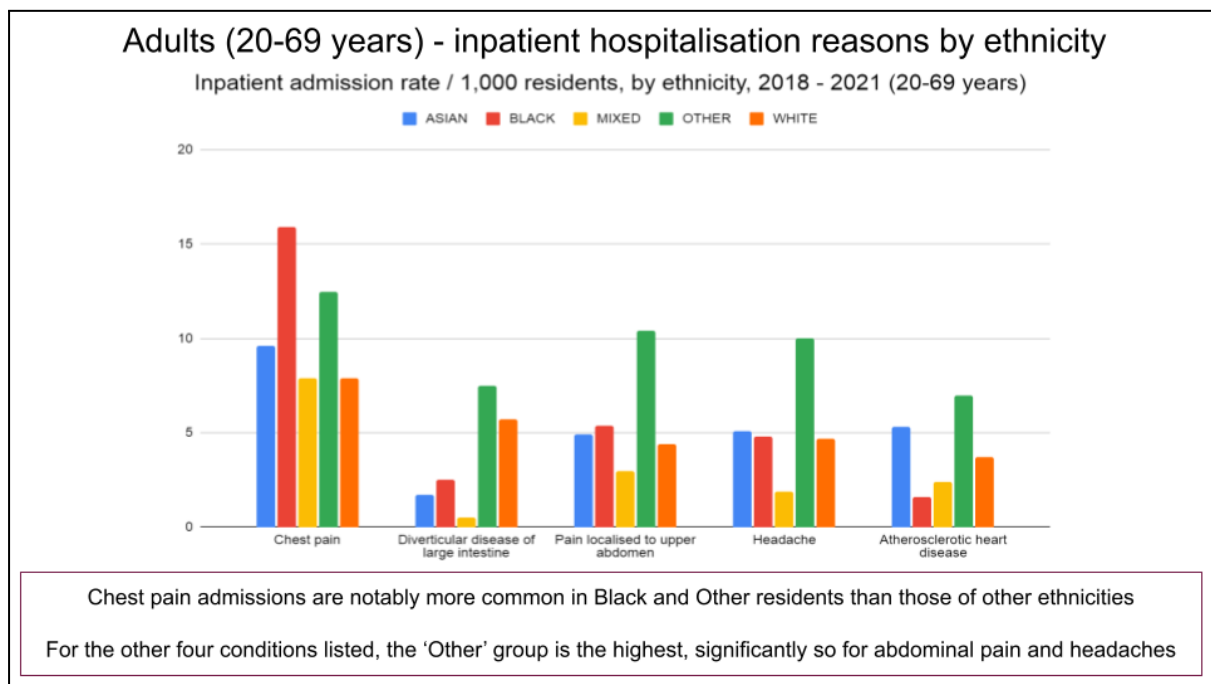
For the older age group (65 years and over) fewer sex differences could be seen, with higher diabetes in men, and higher depression in women the main differences of note. This data indicates the differences in health by gender and the importance of understanding the specific needs in relation to women's health.

## Inequalities and In-patient hospitalisation reasons

Inpatient hospitalisations for 20-69 year olds in Kingston were reviewed for the years 2018-2021, looking at any differences by ethnicity, deprivation and geography.

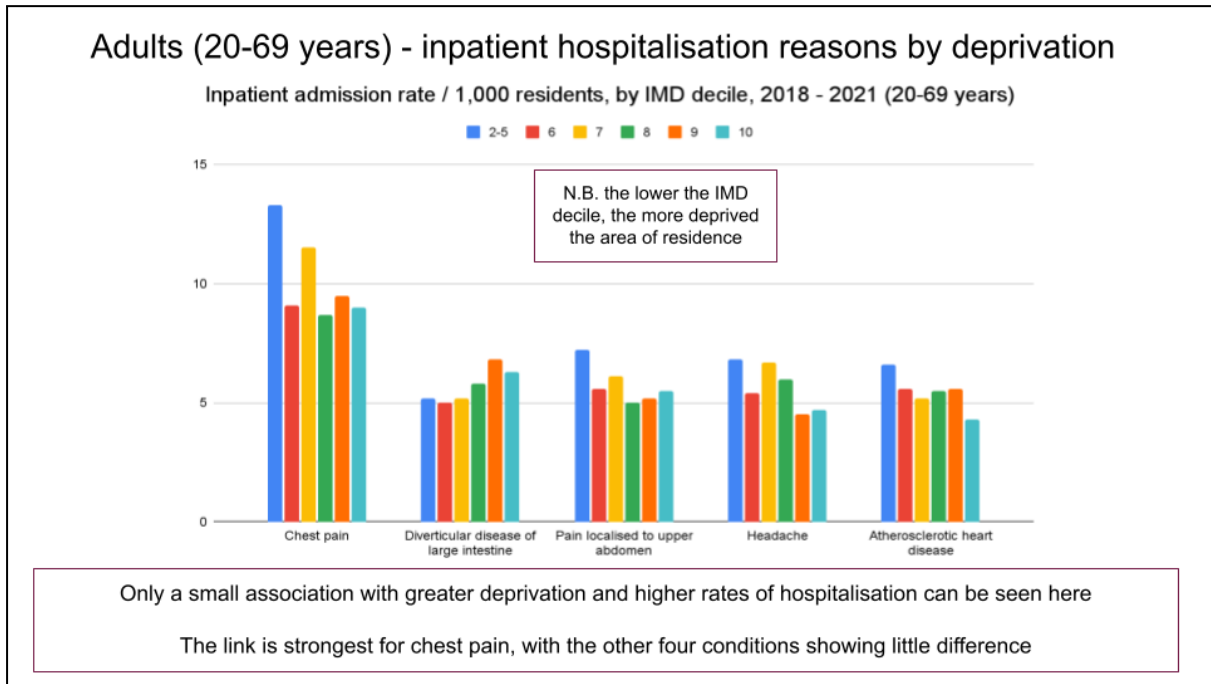
**Ethnicity and hospitalisations:** Chest pain admissions were much more common for Black and 'Other' adults than other groups for 2018-2021. Following 'Other', inpatient hospitalisation is much higher for White residents for diverticular disease of the large intestine than other groups.

Figure 40: Adults 20-69 years, inpatient hospitalisations, ethnicity, 2018-2021



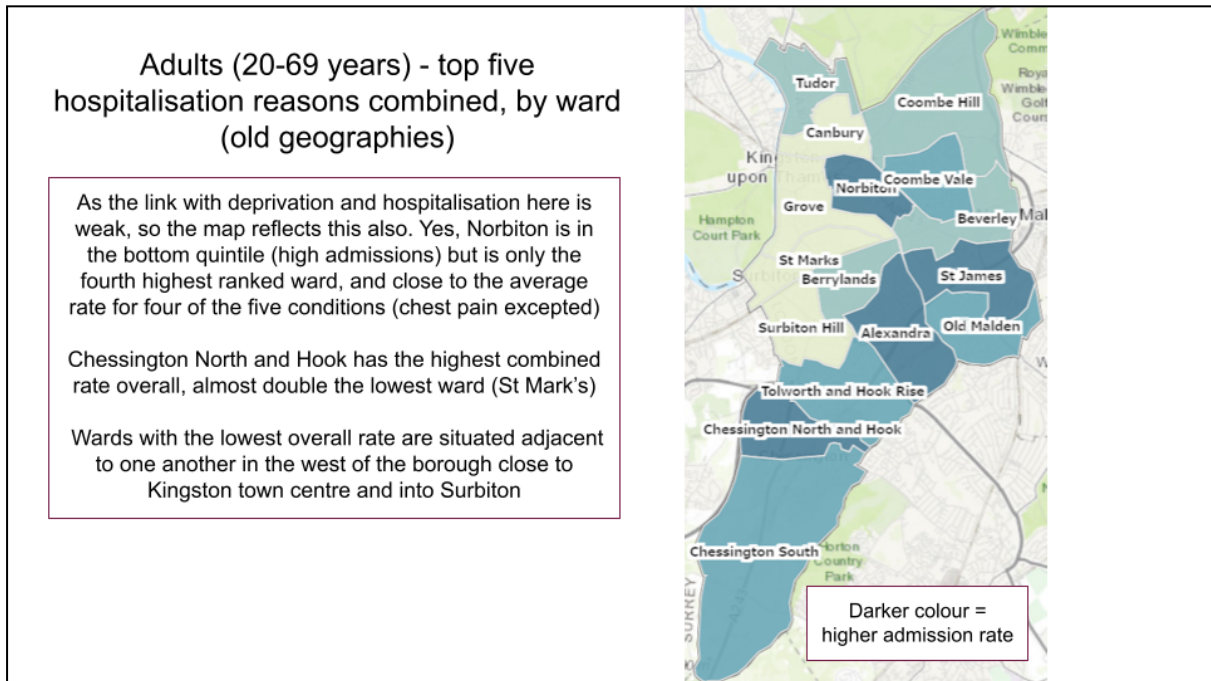
**Deprivation and hospitalisations:** People from the most deprived areas (deciles 2-5) aged 20-69 years had a much higher rate of inpatient hospital admission for chest pain than the less deprived areas over 2018-2021. There is a mixed picture for chest pain admissions across deciles 6-10. For diverticular disease of the intestine, there is a reversal of the situation, with the least deprived areas having higher rates of hospitalisation than the most deprived areas. For the other main conditions (pain localised to upper abdomen, headache and atherosclerotic disease), higher levels of hospitalisation are found in the most deprived areas (deciles 2-5), with a mixed picture across deciles 6-10.

Figure 41: Inpatient hospitalisations, 20-69 years, Kingston, Deprivation



**Geography and hospitalisations:** Chessington North and Hook have the highest combined rate overall of geographical areas (almost double the ward with the lowest rates, St Mark's).

Figure 42: Hospitalisation, Top Five Hospitalisation Reasons combined, Ward (Old Geographies), 2018-2021



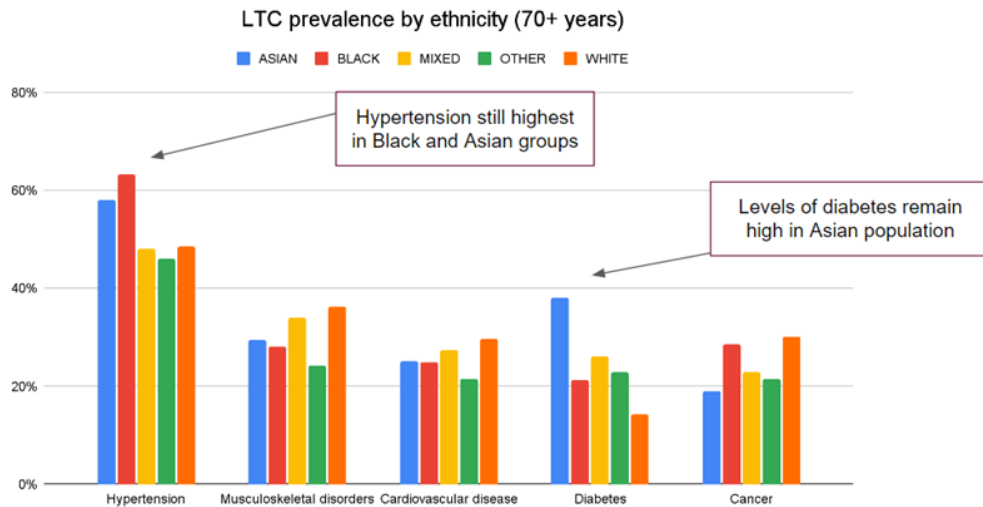
## Inequalities and Older Adults (70+ years)

The Top 5s data was looked at in terms of any inequalities within the borough for the residents aged 70 and over (and for some categories, a slight variation in age groups reviewed e.g. 65 years and above, for some data). Data on ethnicity, deprivation and geographies were reviewed, where available.

**Long term conditions and ethnicity, 70 years and above:** For people aged 70 years and above, the Quality Outcomes Framework (QoF) data for 2022 showed some variation in prevalence and ethnicity for the Long Term Conditions (LTCs) reviewed. For hypertension, Black people had the highest rates recorded (with over 60% of this group having hypertension recorded). The Asian group closely follows this group with levels approaching 60%. Other ethnic groups have hypertension rates under 50%. White residents have the highest recorded levels of musculoskeletal disorders, cardiovascular disease and cancer. Diabetes is notably higher in Asian residents over 70 years than in other ethnic groups.

Figure 43: Long Term Condition prevalence, Ethnicity, Kingston, 70 years and above, 2022

Older adults (70+ years) - long term condition (LTC) prevalence by ethnicity

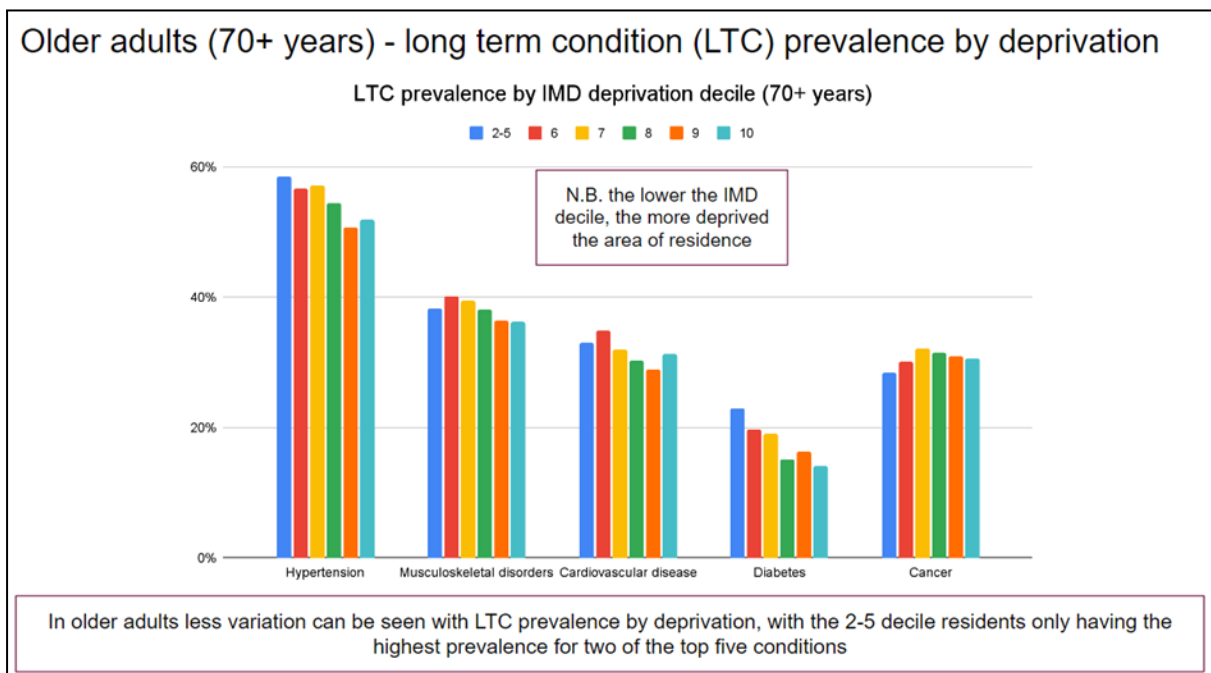


Variation between ethnic groups in this age range is similar to younger adults, for the three 'top 5' LTCs common to both age groups (hypertension, musculoskeletal disorders and diabetes)  
 A smaller amount of difference can be seen in cardiovascular diseases and cancers

**Long Term Conditions (LTC) in older residents and deprivation:** There is a strong correlation between increased deprivation and levels of some Long Term Conditions (LTCs) for older residents for 2022. Data from the SWL ICB 'Health Insights' dashboard, shows that for the residents in the most deprived areas (deciles 2-5), hypertension and diabetes are highest in these groups, with a generally decreasing trend as deprivation decreases across deciles 6-10. Cancer, as a LTC, is slightly lower but similar in the most deprived deciles, but there is not a clear picture for this condition. Musculoskeletal conditions show a decreasing trend from decile 6 to 10.

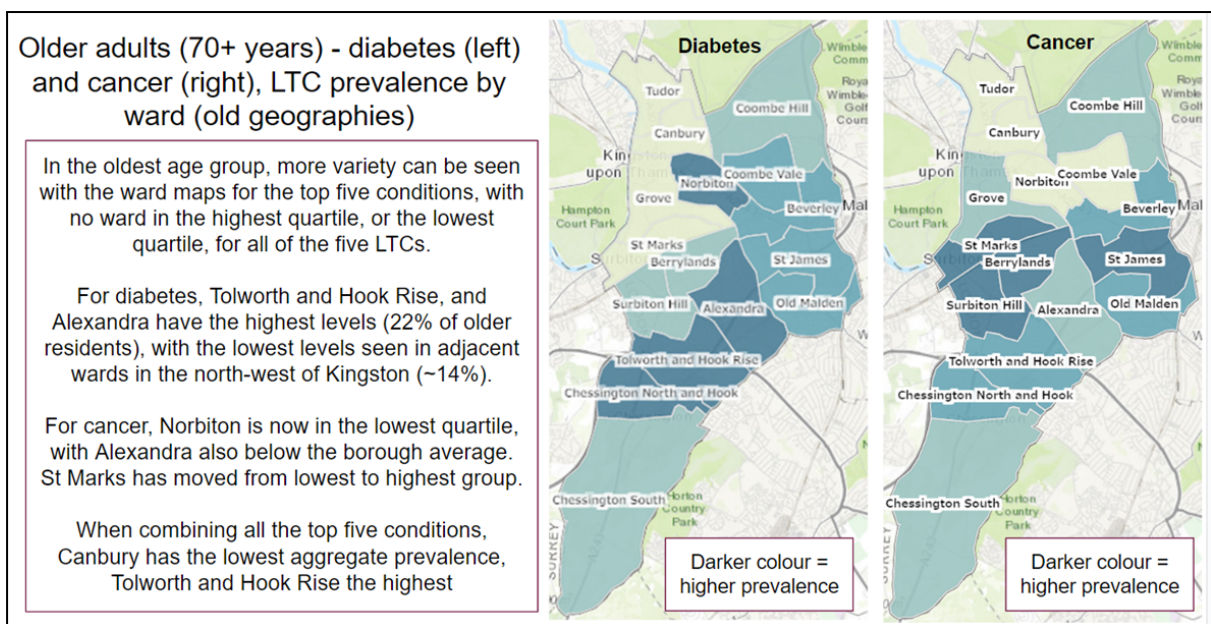


Figure 44: Long term conditions, people aged 70 years and over, deprivation, Kingston, 2022



**Diabetes and Cancer, people aged 70 and over, Kingston, wards, 2022:** Long Term Conditions (LTC) diabetes and cancer in people in Kingston aged 70 and over for 2022 were reviewed by ward geography. For diabetes, Tolworth and Hook Rise, and Alexandra have the highest levels (22% of older residents), with the lowest levels seen in adjacent wards in the north-west of Kingston (around 14%). For cancer, Norbiton is now in the lowest quartile, with Alexandra also below the borough average. St Marks has the highest level.

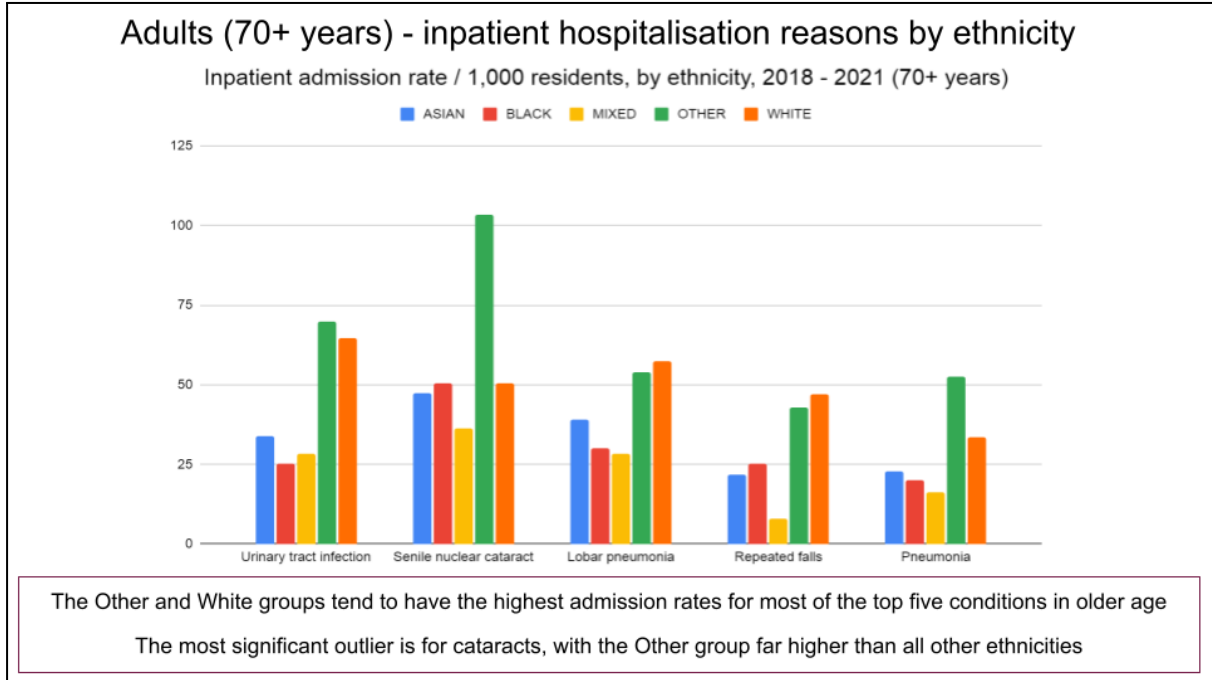
Figure 45: Diabetes and Cancer, people aged 70 and over, Kingston, wards, 2022



**In patient hospitalisation, people aged 70 years and over, ethnicity:** White and 'Other' residents had the highest in patient hospitalisation rates per ethnic group for all 5 conditions

reviewed for 2018-2021 (UTIs, senile nuclear cataract, lobar pneumonia, repeated falls, pneumonia).

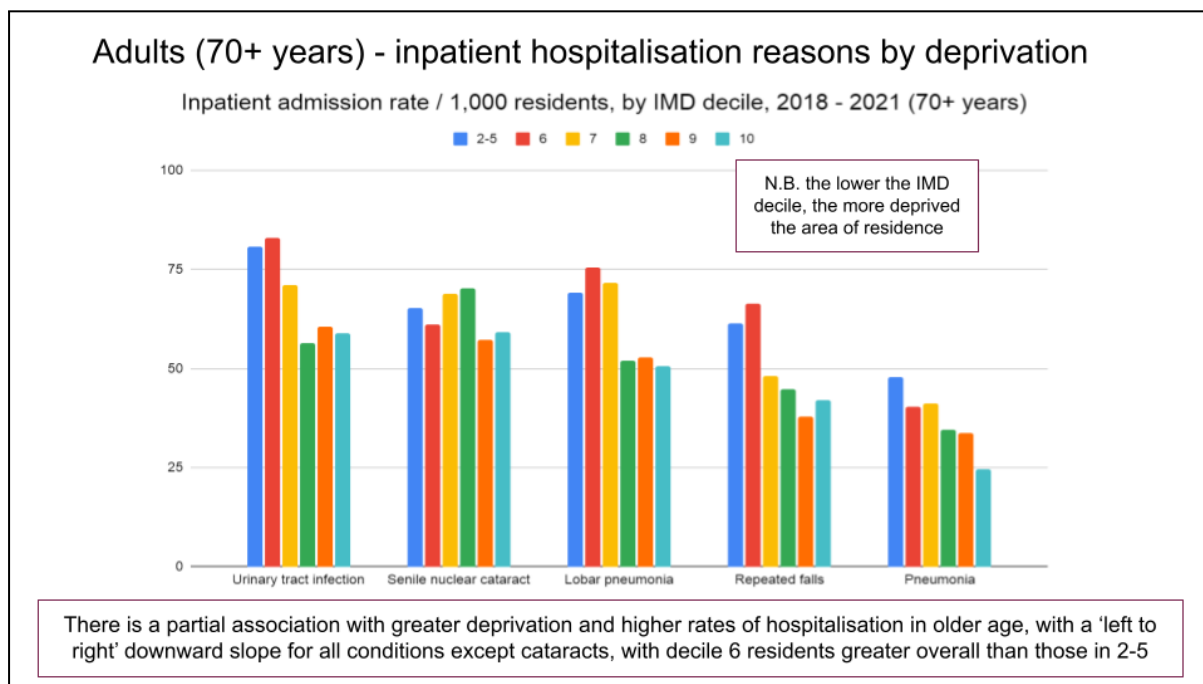
Figure 46: In patient hospitalisation, people aged 70 years and over, ethnicity, Kingston, 2018-2021



**In patient hospitalisation, people aged 70 years and over, deprivation, Kingston 2018-2021:** There is a partial association with greater deprivation and higher rates of hospitalisation in older age, with higher levels found in the most deprived areas for all conditions except cataracts, with decile 6 residents greater overall than those in deciles 2-5.



Figure 47: In patient hospitalisation, people aged 70 years and over, deprivation, Kingston 2018-2021



***In patient hospitalisation, falls, people aged 70 years and above, Kingston, 2018-21<sup>33</sup>***

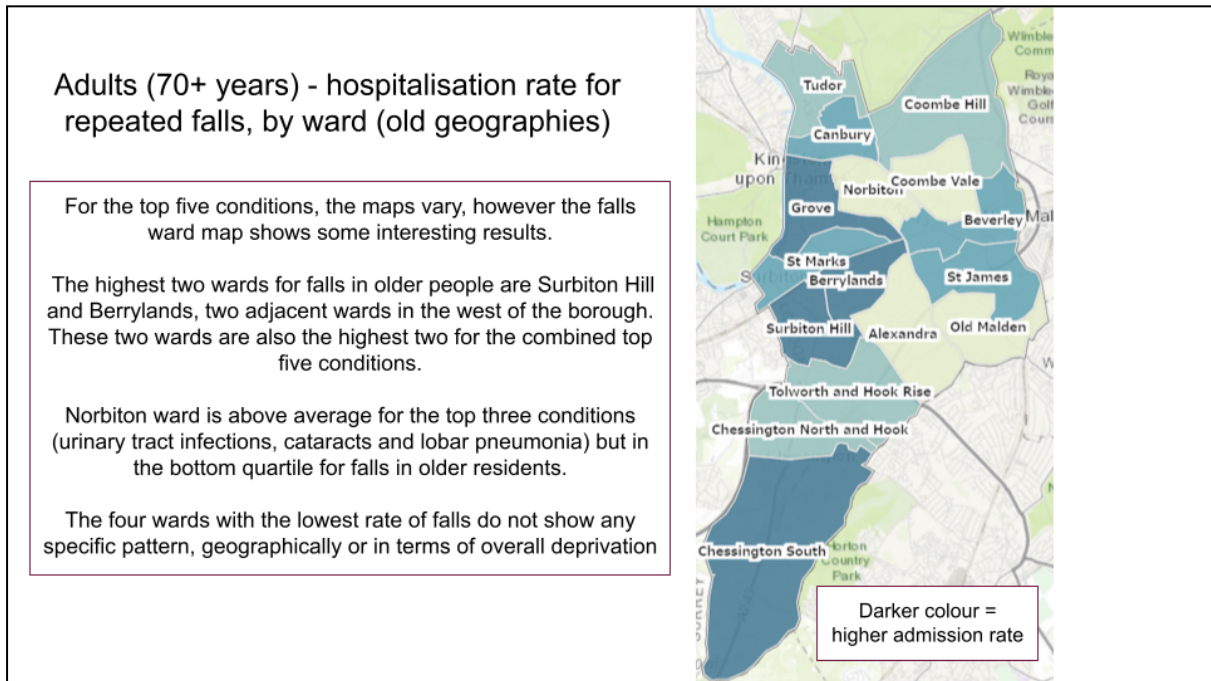
The falls data shows some variation across the borough for older people. The highest two wards for rate of falls in older people aged 70 years and above are Surbiton Hill and Berrylands, each having around 6% of residents hospitalised for falls across the four year period (1 in 17 residents, 140 people in total in the two wards).

These two wards are also the highest two for the combined top five conditions. The four wards with the lowest rate of falls do not show any specific pattern, geographically or in terms of overall deprivation. As noted in the Social Determinants section, Kingston has a higher rate of **emergency hospital admissions due to falls in people aged 65 years and over than England as a whole (21/22)<sup>34</sup>**.

<sup>33</sup> NHS England, Hospital Episode Statistics (HES), <https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/hospital-episode-statistics>

<sup>34</sup> PHE Fingertips: [Fingertips: Public Health Profiles](#) [Accessed July 2023]

Figure 48: In patient hospitalisation rate, falls, people aged 70 years and above, ward (old geographies), Kingston, 2018-2021<sup>35</sup>



## Overall reasons for the gap in life expectancy between most and least deprived in Kingston

For 2020-21, there was a 5.2 year gap in life expectancy between the least and most deprived men in Kingston. For women, there was a 3.5 year gap. In this section, the data looking at the percentage contribution of percentage contribution of various causes to the difference in life expectancy between the highest and lowest quintiles in Kingston (2020-21) was reviewed. This data comes from the OHID's segment tool<sup>36</sup>. In the previous sections, some of the differences in the Top 5s were considered in terms of inequalities. In this section, the overall contribution of the various reasons for differences are analysed - and give some further insight into where efforts to reduce health inequalities might be considered, in terms of disease type. In this data, which includes more recent data than the Global Burden of Disease data, which we have reviewed for the main 'Top 5s', COVID-19 is also included.

For 2020-21, more deaths in the most deprived areas from 'circulatory disease' (which covers a range of conditions such as coronary heart disease, stroke and others<sup>37</sup>), was the main reason for the gap in life expectancy between most and least deprived men in Kingston. For women, more deaths from cancer in the most deprived areas were the main reason for less life expectancy for women. More deaths from respiratory conditions and circulatory disease in women in the most deprived areas were the next main reasons for the

<sup>35</sup> NHS England, Hospital Episode Statistics (HES), <https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/hospital-episode-statistics>

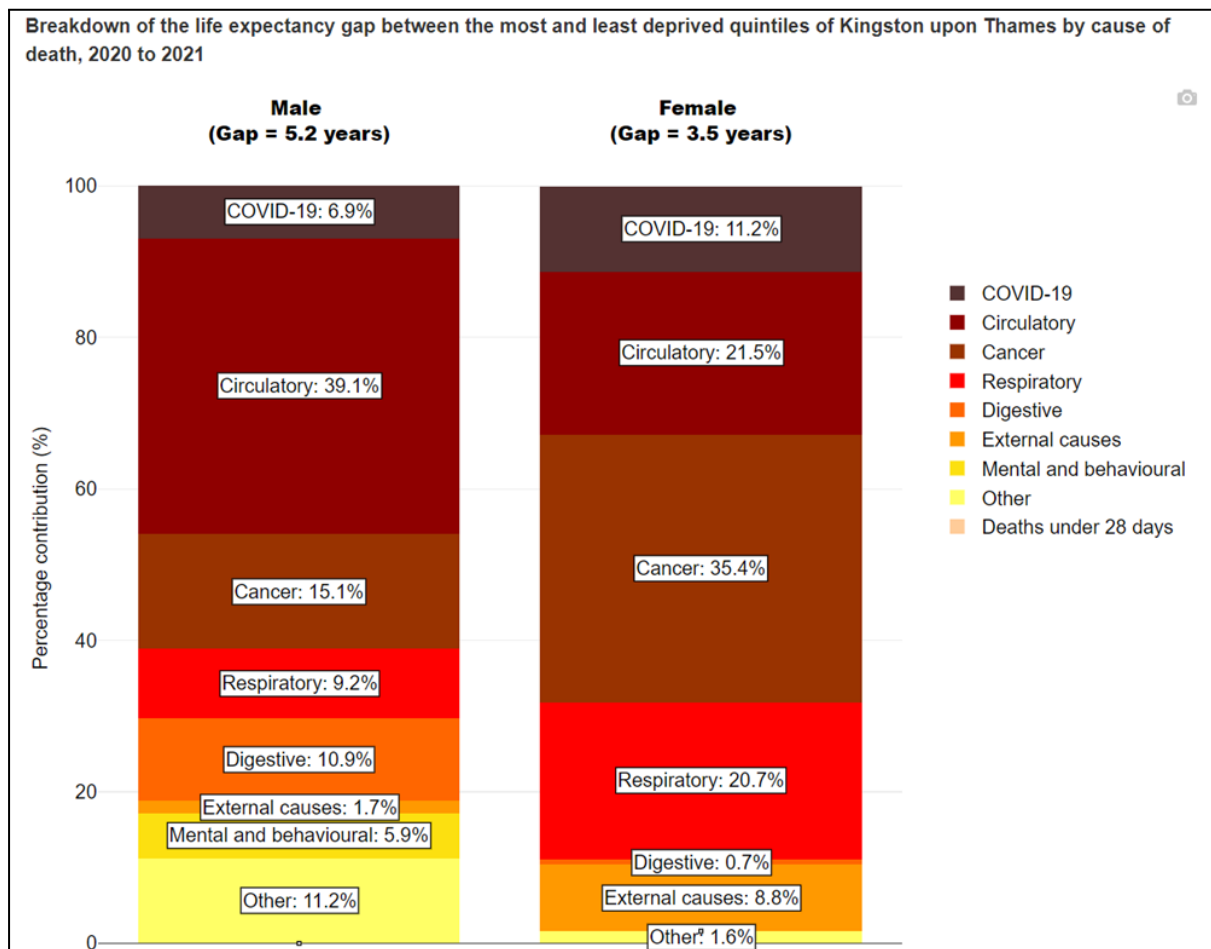
<sup>36</sup> <https://analytics.phe.gov.uk/apps/segment-tool/>

<sup>37</sup> Conditions included in 'Circulatory Disease' can be found here: <https://www.icd10data.com/ICD10CM/Codes/I00-I99>

gap in life expectancy. COVID-19 was also a reason for more deaths in the more deprived areas than in the least deprived in 2020-21 in Kingston (accounting for about 7-11% of the reasons for the gap for men and women, respectively).

Looking over 2014-2021, circulatory disease is increasing its contribution to the male gap in life expectancy from just over 25% to almost 40% in the past few years. For women, cancer is increasing its contribution over the years to the gap in life expectancy between the least and most deprived.

Figure 49: Breakdown of the life expectancy gap between the most and least deprived quintiles of the Kingston by cause of death, 2020-2021



## How residents report their own health

In the 'Top 5s' analysis, we reviewed what the healthcare data tells us about the health of people in Kingston. Census 2021 also asked people about how they perceived their own health in terms of their own rating of their general health. Census 2021 showed that in Kingston, 87% of residents (145,000 people) rated their health as 'good' or 'very good', which is higher than London overall, and the national average, and similar to Kingston's health in the previous census, in 2011. However, 5,700 Kingston residents (around 1 in 30 people) rated their health as 'bad' or 'very bad' in 2021, with poorer health tending to be associated with increasing deprivation of the area in the borough where people live.

## Wider Determinants

Studies suggest that healthcare may account for between 15% and around 40% of people's overall health. Other factors, such as their environment and their behaviour account for the majority of influences on their health<sup>38</sup>. Environmental and social influences are known as 'Wider Determinants of Health' or 'Social Determinants of Health'. 'Wider Social Determinants' refer to the many and diverse social, economic and environmental factors which have an impact (which can be positive or negative) on people's health. The impact of these factors is in turn influenced by how much access people have to power and resources and the way in which local, national and international power and resources are distributed and shape daily life. Each person is influenced slightly differently - however, one can look at the borough level to assess if there are any major issues that may be affecting many or specific groups or in a particular area or age group.

The 'Wider Social determinants' data that is available at the borough level is included here to: support understanding of health patterns in Kingston, to inform communications and because action to address some of the determinants themselves are within the influence of Health and Wellbeing Board member organisations, for example, in terms of planning, licensing and resource allocation (i.e. some of the Wider Determinants themselves can be changed by local decision making and commissioning).

The Office of Health Improvement and Disparities (OHID) produces the data sets on the 'Wider Determinants' for Kingston. This enables an overview of the data for Kingston and also for Kingston to be compared with other areas. Data is shown below for Kingston compared with England as a whole. Where Kingston is an outlier (worse outlier) this is highlighted. The data is divided into six groupings: Natural and Built Environment, Education, Work and the Labour Market, Housing, Income, and Crime.

To see the latest Wider Determinants Data for Kingston as it is published, please use this link: [Wider Determinants of Health - Data - OHID](#)

### Natural and Built Environment<sup>39</sup>

The Natural and Built Environment data covers a wide range of issues ranging from Transport to some aspects of Housing. The data, which is from the latest available year (which differs by indicator) shows that Kingston fares less well in five of the main 'natural and built environment' indicators compared to England as a whole. The five outlier factors where Kingston performs worse than England as a whole are: **A. high prevalence of premises licensed to sell alcohol per square kilometre** (data 2017/18), **B 'Access to Healthy Assets and Hazards Index (AHAH)'**. The AHAH index is comprised of four domains: access to retail services (fast food outlets, gambling outlets, pubs/bars/nightclubs, off licences, tobacconists), access to health services (GP surgeries, A&E hospitals, pharmacies, dentists and leisure centres), the physical environment (access to green spaces, and three air pollutants: NO<sub>2</sub> level, PM<sub>10</sub> level, SO<sub>2</sub> level) and air pollution (NO<sub>2</sub> level, PM<sub>10</sub> level, SO<sub>2</sub> level). The AHAH index provides a summary of an area's relative performance on these indicators (the second and third domains conceptualised as health promoting and the first (access to retail) as health demoting). The third outlier area is C: **Air Quality** (data 2021, 2020) (See Air Quality Section). The fourth outlier area is: the '**Winter Mortality Index** (data from Aug 2020-July 2021). The purpose of the winter mortality measure is to compare the number of deaths that occurred in the winter period (December to March) with the average of

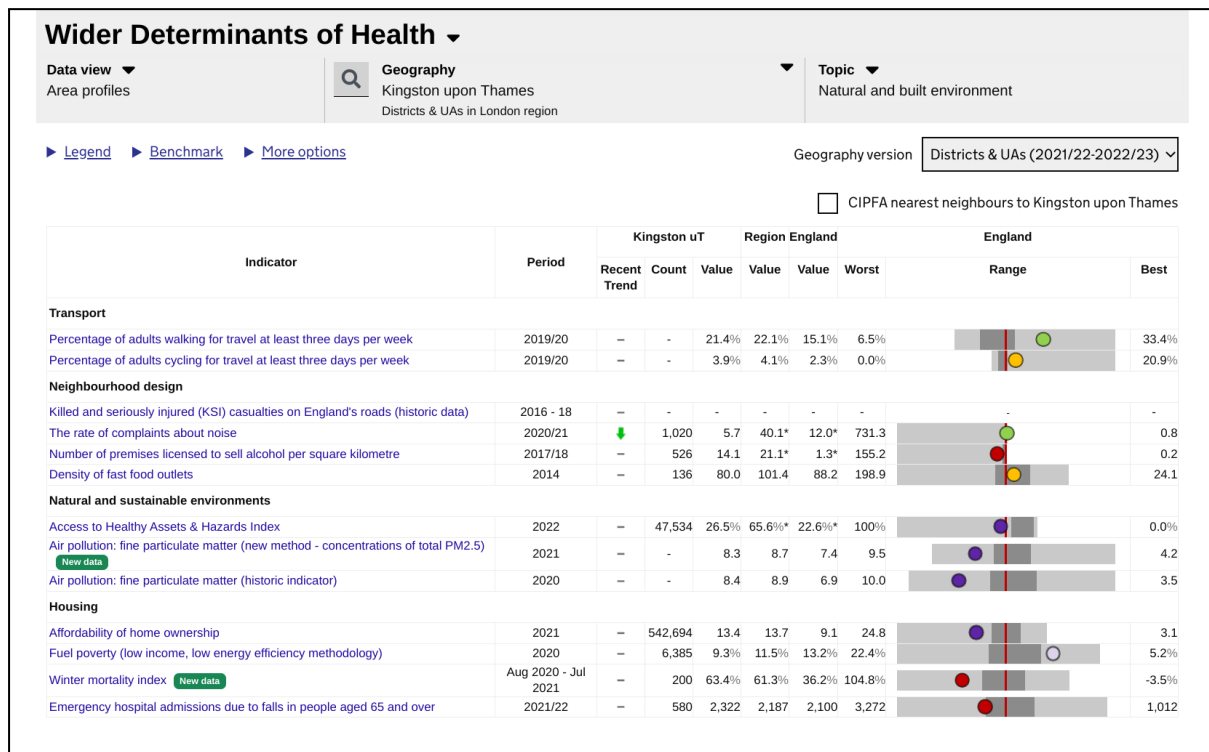
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<sup>38</sup> The Kings Fund, 'Broader determinants of health: Future trends'; [link](#) [Accessed April 2023]

<sup>39</sup> PHE Fingertips Wider Social Determinants data: [Natural and built environment: Wider Determinants of Health - Data - OHID](#) [Accessed May 2023]

the non-winter periods (August to November and April to July). Winter mortality is not solely a reflection of temperature, but of other factors as well. These include respiratory diseases and pressure on services, which have been more intense than usual during and following the height of the pandemic. It is an important measure as it allows users to assess whether policies are having an impact on mortality risks during the winter period (2). The fifth outlier is **emergency hospital admissions due to falls in people aged 65 years and over**. For 2021/22, Kingston was an outlier (significantly worse than England as a whole) for emergency hospital admissions due to falls in people aged 65 and over.

Figure 50: Natural and Built Environment Wider Social determinants



## Education

Education is a key determinant for health outcomes. One of the important indicators to consider is how well children who are entitled to 'Free School Meals' (as a proxy measure for living in a household with a low income) perform on educational outcome measures. Higher levels of education are associated with a range of health benefits, including improved educational attainment, greater social mobility, fewer co-morbidities and longer life expectancy<sup>40</sup>. For this measure, Kingston is compared against the other London boroughs.

Children receiving Free School Meals (FSM) in Kingston do less well compared to children FSM in nearly all other London boroughs on a number of measures. On the latest available data (2021/22), 'School Readiness: % of children with free school meal (FSM) status achieving a good level of development at the end of Reception', Kingston is third from bottom in comparison to all London boroughs for this indicator<sup>41</sup>. Only 49% of children receiving FSM do well at the end of Reception in Kingston (compared with 64% across London as a whole). At the end of Year 1 (the year following Reception), children receiving

<sup>40</sup> Education, schooling and health Summary, Sept 2021, gov.uk; [link](#) (accessed March 2023)

<sup>41</sup><https://fingertips.phe.org.uk/search/free%20school%20meals#page/3/gid/1/pat/6/par/E12000007/ati/402/are/E09000021/iid/90632/age/34/sex/4/cat/-1/ctp/-1/yr/1/cid/1/tbm/1/page-options/car-do-0>

FSM in Kingston continue to do worse than all boroughs in London except one on the 'phonics' measure<sup>42</sup> (School readiness: percentage of children with free school meal status achieving the expected level in the phonics screening check in Year 1).

For 'Attainment 8' (Pupils are aged 15-16 and attending state-funded schools in England), for children receiving Free School Meals, Kingston ranks in the middle of all London boroughs<sup>43 44 45</sup>.

Figure 51: Education Wider determinants of health, school outcome measures

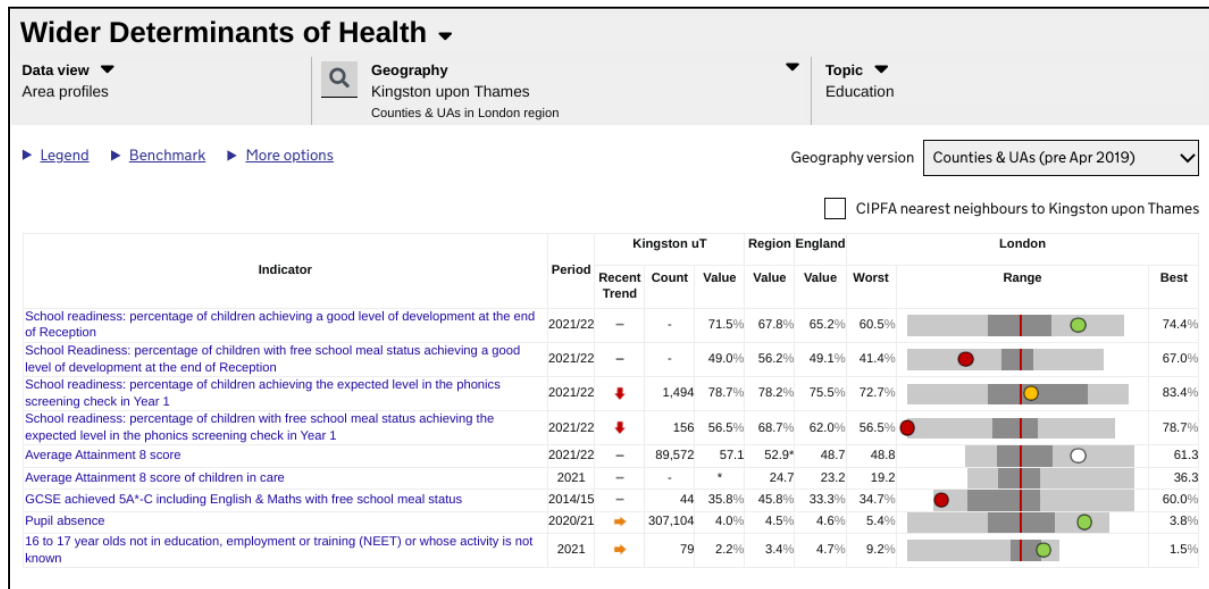


Figure 52: School Readiness: percentage of children with free school meal status achieving a good level of development at the end of Reception, 2021/22<sup>46</sup>

42

<https://fingertips.phe.org.uk/search/free%20school%20meals#page/3/gid/1/pat/6/par/E1200007/ati/402/are/E09000021/iid/90634/age/35/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1>

43

<https://fingertips.phe.org.uk/search/free%20school%20meals#page/3/gid/1/pat/6/par/E1200007/ati/402/are/E09000021/iid/93865/age/175/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0>

44

45 It should be noted that summer exams were cancelled in 2020 and 2021 because of the COVID-19 pandemic. In 2021 students were awarded assessment grades based on what their teacher believed they would have achieved had exams gone ahead. This is different from the 2020 awards so cannot be compared with any previous data.

46 'Attainment 8' is a way of measuring how well pupils do in key stage 4, which they usually finish when they are 16 years old. The data measures the results of pupils at state-funded mainstream schools in England in 8 GCSE-level qualifications in 8 subjects including maths and English. Each grade a pupil gets is assigned a point score from 9 (the highest) to 1 (the lowest). Each pupil's Attainment 8 score is calculated by adding up the points for their 8 subjects, with English and maths counted twice and is out of 90.

<https://fingertips.phe.org.uk/profile/wider-determinants/data#page/3/gid/1938133071/pat/6/par/E1200007/ati/102/are/E09000021/iid/90632/age/34/sex/4>



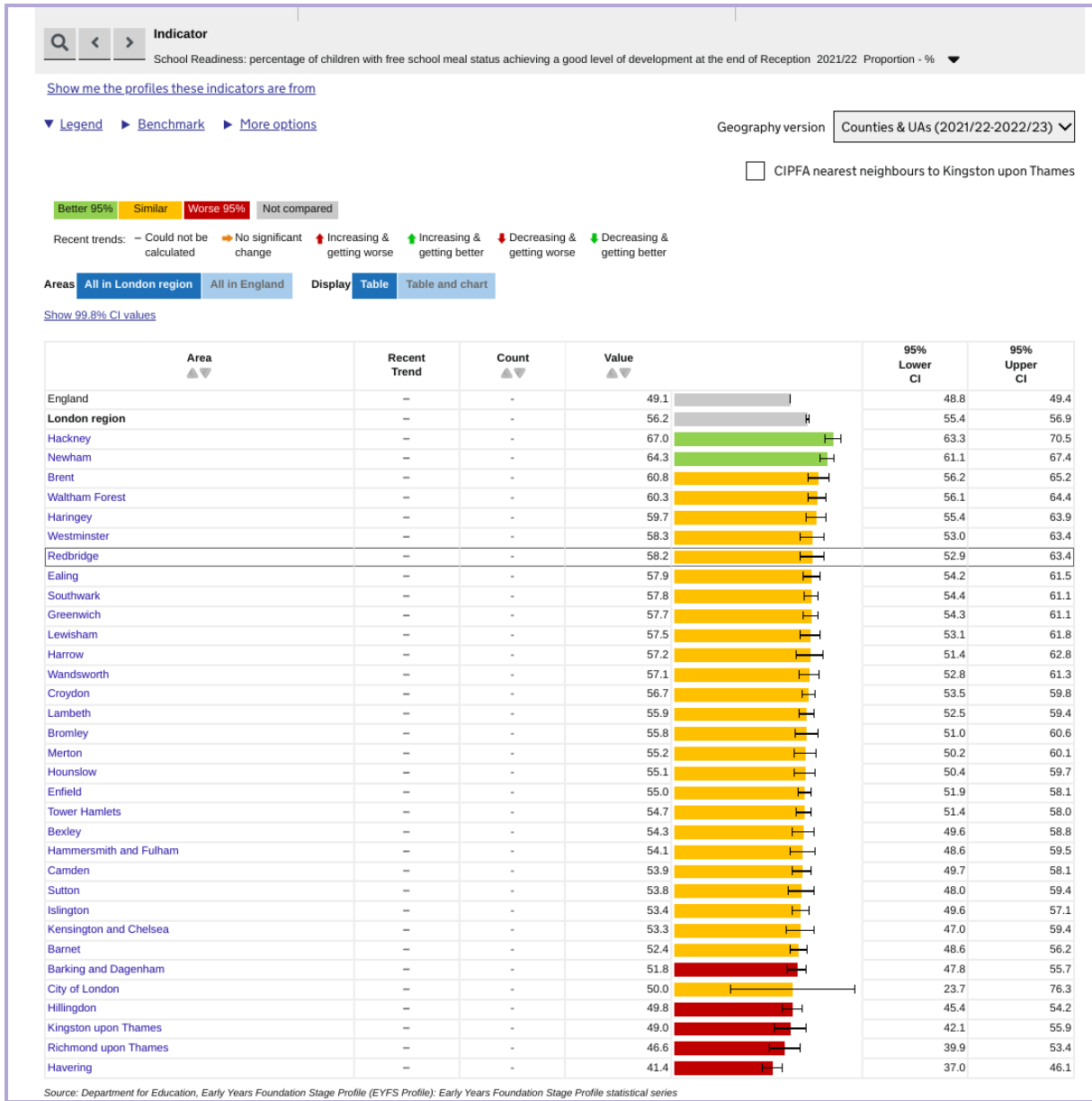
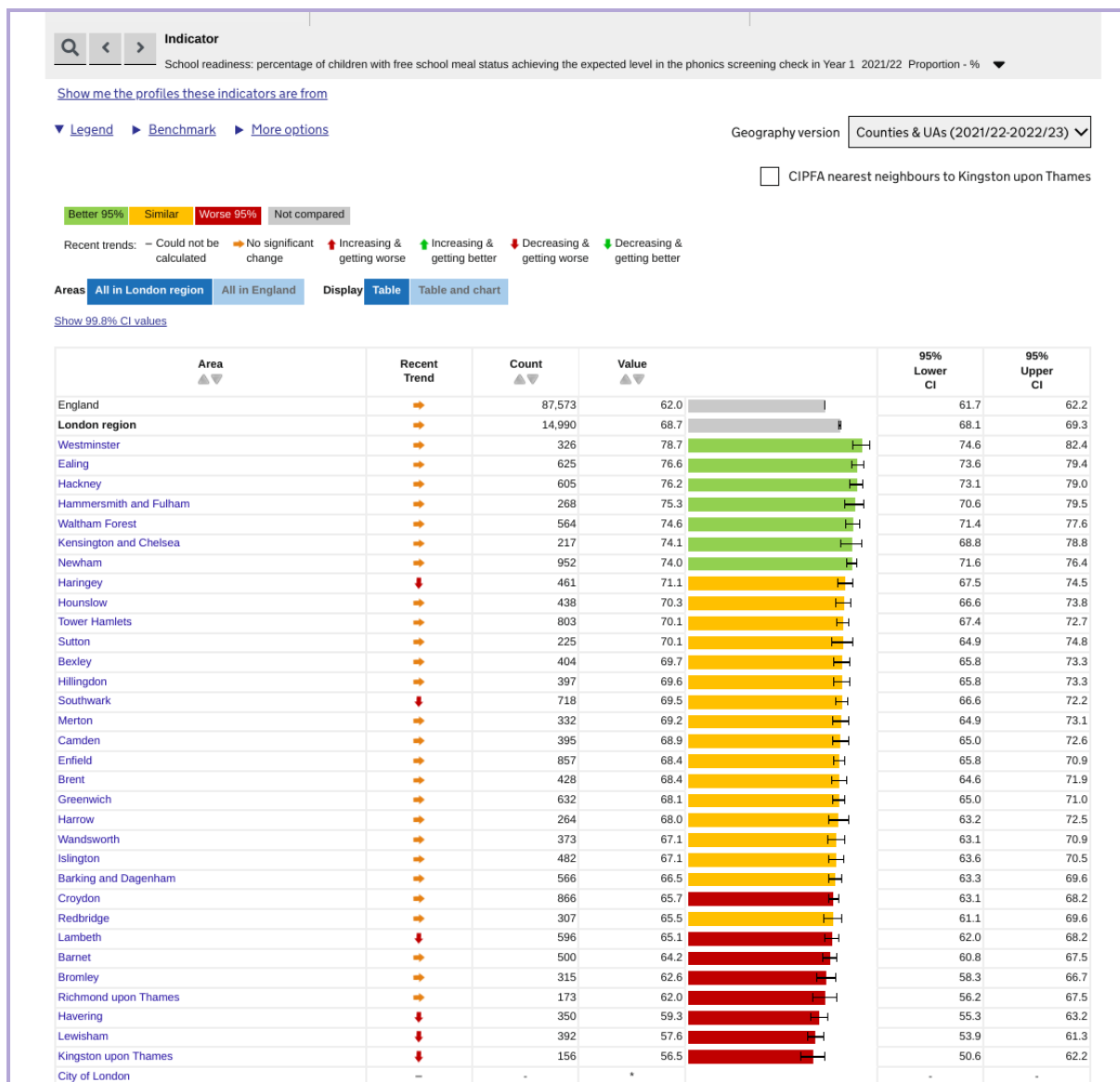


Figure 53: School readiness: percentage of children with free school meals achieving the expected level in the phonics screening check in Year 1 2021/22



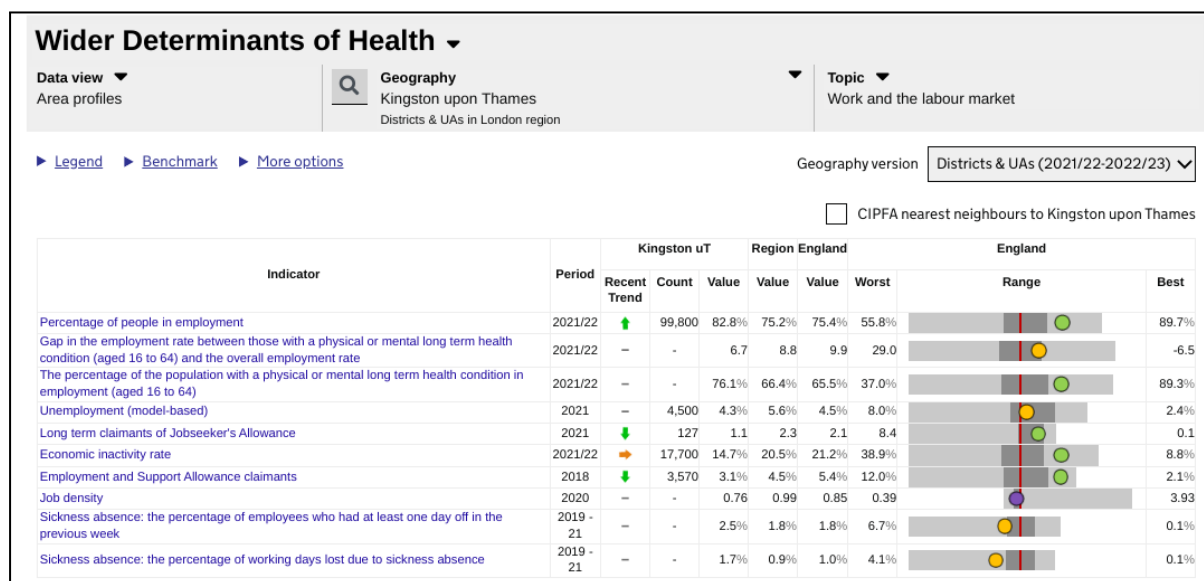
## Work and the Labour Market

Work is a key determinant of health. OHID data<sup>47</sup> compares Kingston with England as a whole. In this data set there are no 'worse' outlier indicators for Kingston. At the borough level, Kingston performs at the same level or better for the indicators considered.

<sup>47</sup> [Work and the Labour Market: Wider Determinants of Health - Data - OHID](#)



Figure 54: Work and the Labour Market, Kingston and England as a whole



New data for Kingston from Census 2021 shows that although Kingston has a very similar total percentage of economically inactive people\* as London (at 34% and 33.8% respectively), that this masks a significant difference when comparing geographical areas within the borough. Cambridge Road Estate (CRE) area, in Norbiton ward, has 12.4% more economically inactive people than RBK, with 46.4%. CRE also has more than double the percentage of unemployed people than the RBK average (8.5% in Cambridge Road Estate compared to the borough average of 3.9%). CRE has approximately 2.7 times the percentage of long-term sick or disabled than RBK<sup>48</sup>.

## Housing

Housing is an important determinant of health. Kingston, like all London boroughs, is currently facing extreme housing pressures. The data shown here looks at 'vulnerabilities' around housing<sup>49</sup>. The data shows that Kingston is performing better on nearly all indicators, with no indicators worse than London as a whole. However, like all London boroughs, the pressures on housing continue to increase.

Figure 55: Housing and Vulnerability, Kingston and other London boroughs

<sup>48</sup> ONS Census 2021 (via Nomis) <https://www.nomisweb.co.uk/datasets/c2021ts066>

<sup>49</sup>

<https://fingertips.phe.org.uk/profile/wider-determinants/data#page/1/gid/1938133044/pat/6/par/E1200007/ati/401/are/E09000021/iid/93736/age/-1/sex/-1/cat/-1/ctpl/-1/yr/1/cid/1/tbm/1>

**Wider Determinants of Health**

Data view: Area profiles | Geography: Kingston upon Thames (Districts & UAs in London region) | Topic: Vulnerability

Legend | Benchmark | More options | Geography version: Districts & UAs (2021/22-2022/23) |  CIPFA nearest neighbours to Kingston upon Thames

Indicator	Period	Kingston uT		Region England				London		Best
		Recent Trend	Count	Value	Value	Value	Worst	Range		
Homelessness: households owed a duty under the Homelessness Reduction Act	2021/22	-	344	4.9	14.4	11.7	23.0		4.6	
Homelessness - households with dependent children owed a duty under the Homelessness Reduction Act	2021/22	-	148	6.8	17.4	14.4	33.8		6.0	
Homelessness - households owed a duty under the Homelessness Reduction Act (main applicant 16-24 yrs)	2021/22	-	48	0.7	2.5	2.4	4.6		0.7	
Homelessness - households owed a duty under the Homelessness Reduction Act (main applicant 55+ yrs)	2021/22	-	51	1.9	5.2	2.8	12.5		1.6	
Homelessness: households in temporary accommodation	2021/22	-	-	*	16.3	4.0	-	insufficient number of values for a spine chart		
Adults in contact with secondary mental health services who live in stable and appropriate accommodation <span style="color: green;">New data</span>	2021/22	-	-	24.0%	21.0%	26.0%	7.0%		54.0%	
Mortgage home repossessions: rate per 1,000 dwellings	2017/18 Q2	↗	10	0.15	0.23*	0.20	0.42		0.10	
Landlord home repossessions: rate per 1,000 dwellings	2017/18 Q2	-	81	1.22	-	1.42*	-	-	-	
Food Insecurity (INDIRECT measure) – percentage of local authority population living in areas at highest risk of food insecurity	2021	-	1,892	1.1%	-	-	-	-	-	

**Accessing housing for those on a low income:** With 11.0%, Kingston has the second to lowest total percentage of social-rented households in London (32 out of 33 London boroughs). The London average percentage of social-rented households is 23.1%<sup>50</sup>. The lack of social and affordable housing available in Kingston is a significant issue, as highlighted in Kingston’s Interim Housing Strategy 2020-25<sup>51</sup>. Kingston’s Homelessness and Rough Sleeping Strategy 2022-27 cites the lack of affordable accommodation in Kingston as leading to a high use of temporary accommodation in the borough and some out of borough placements. Customers are placed in temporary accommodation through the council’s Housing Register and Rehousing team, until a permanent sustainable home is sourced. In March 2020, there were 862 households in temporary accommodation across Kingston and in out of borough placements which rose to over 904 families by March 2022. At present the main exit route for customers in temporary accommodation is into social housing. This is a restricted and limited option, due to the small number of properties which are available for homeless households in Kingston. Kingston was only able to provide 85 households with family sized social housing in 2021/22 (47 from RBK housing stock and 38 from Registered Provider partners).

**Overcrowding and quality of housing:** The Health Foundation has highlighted the fact that housing is much more than a physical structure and influences our health in many ways. Housing should be warm and dry, have enough space for everyone, feel safe, be affordable, stable and be connected to services and networks. The standard of housing is hugely important, for example, “a warm and dry house can improve general health outcomes and specifically reduce respiratory conditions”. Insecure, poor quality and overcrowded housing causes stress, anxiety, and depression, and exacerbates existing mental health conditions<sup>52</sup>. Overcrowding affects the quality of relationships between those living together as families, creates stress, and is a risk for mental health outcomes and poor health behaviours<sup>53</sup>. Amongst children, overcrowded living conditions are a risk for poorer socio-economic development and educational outcomes, both of which can contribute to

<sup>50</sup> ONS Census 2021 (via Nomis)  
<sup>51</sup> Interim Housing Strategy 2020-2025; [link](#).  
<sup>52</sup> de Sa, J. (2017). *How does housing influence our health?* | The Health Foundation. [online] The Health Foundation. Available at: [link](#).  
<sup>53</sup> Bell, R., and Marmot, M. (2018). *Social Inequalities and Mental Health* [Book chapter]. Available from: D. Bhugra, K. Bhui, S.Y.S. Wong and S.E. Gilman (Eds.), *Oxford Textbook of Public Mental Health*. Oxford University Press. [Accessed 04 January 2020]

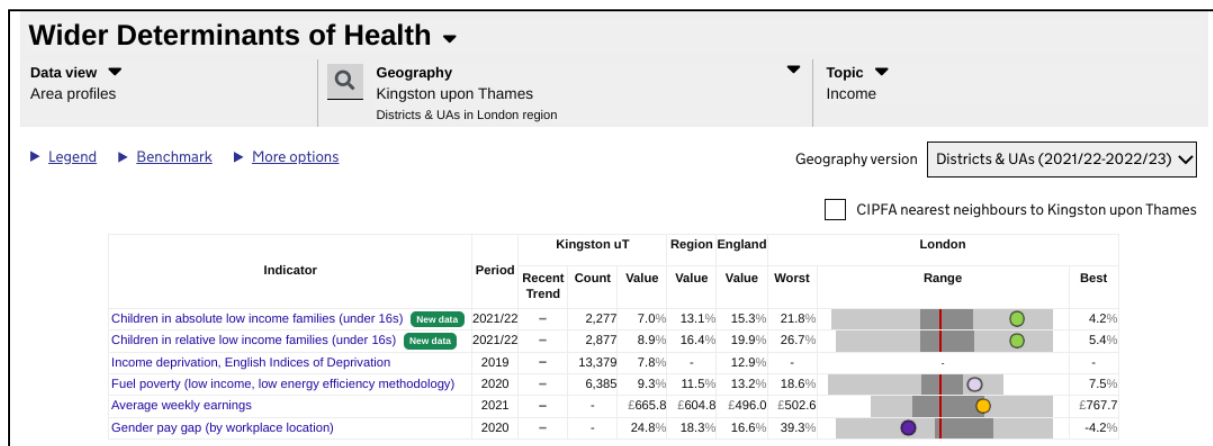
poor mental and physical health outcomes during young adulthood and later life. According to the 2021 Census, 6% of households in Kingston were overcrowded (with fewer bedrooms than required). This varies across the borough, with the highest concentrations of over-occupied bedrooms found in Norbiton (11.3%), Green Lane & St James (8.4%) and Tolworth (7.0%) wards<sup>54</sup>.

## Income

Income is an important factor relating to health outcomes<sup>55</sup>. The data here compares Kingston as a whole to the other London boroughs<sup>56</sup>. The 'Indices of Multiple Deprivation' (IMD) is also available at lower level geographies, which provides a more detailed view of in borough differences (see the Kingston Data website: <https://data.kingston.gov.uk/>)<sup>57</sup>. Kingston either performs better or at the same level as other London boroughs on all but one indicator, gender pay gap (by workplace location). Despite this, there were 2,277 children under 16 years in absolute low income families in Kingston in 2020. 6,385 people were estimated to be in fuel poverty in 2020 in Kingston, a number that has likely increased with the 'cost of living' pressures and steep rises in fuel costs over 2022 and 2023.

**Gender pay gap (by workplace location):** Kingston is an outlier, showing that it has a significantly higher (worse) gender pay gap than the average London borough (by workplace location). The measure reflects less the different financial resources of residents, and more the role of local businesses in generating those differences. It had the fifth highest pay gap of all London boroughs in 2020, with an increasing gap since 2017 (a trend not seen across England).

Figure 56: Income, Kingston, compared to other London boroughs



**Which areas of Kingston are particularly impacted by low income?** In Kingston there are two small areas ('LSOAs') in the 20% most deprived nationally in terms of income (deciles 1 and 2), which are the Cambridge Road Estate and the Alpha Road area. 24 (of

<sup>54</sup> ONS Census 2021 (via Nomis)

<sup>55</sup> Money and Resources, *What drives health inequalities?* <http://health.org.uk/evidence-hub/money-and-resources> (accessed December 2022)

<sup>56</sup>

<https://fingertips.phe.org.uk/profile/wider-determinants/data#page/1/gid/1938133045/pat/6/par/E12000007/ati/401/are/E09000021/iid/93701/age/169/sex/4/cat/-1/ctp/-1/yr/1/cid/1/tbm/1>

<sup>57</sup> Kingston Data Website, 'Deprivation' section, provides Indices of Multiple Deprivation Data by various geographies, including borough, and data by each ward. [Link](#); accessed April 2023.

Kingston's 98) smaller areas (LSOAs) fall within the 50% most deprived. 28 of the 98 LSOAs in Kingston are in the 20% least deprived nationally in terms of income (deciles 9 and 10).<sup>58</sup>

**Children in low income households:** There are two supplementary indices that look at income deprivation affecting specific cohorts of the population. The Income Deprivation Affecting Children Index (2019) ranked Kingston 135 out of 151 upper-tier local authorities in England (where 1 = most deprived), which is roughly in line with the Income Domain as a whole (131 out of 151).<sup>59</sup> Children living in poorer areas or in households with a low income are much more likely to have poor health outcomes. 7.2% (2,622) of children under the age of 16 in Kingston lived in absolute low income families and 8.8% (3,182) in relative low income at 2020/21.<sup>60</sup>

**Older people and low income:** The Income Deprivation Affecting Older People Index ranked Kingston slightly lower at 103 out of 151 upper-tier local authorities in 2019.<sup>61</sup> By this measure, Kingston has 3,564 older people living in poverty; which means that 11.7% of Kingston's population aged over 60 are living in poverty. This compares to an average of 14.2% across England.

## Crime

Crime affects physical and mental health in many ways. Violence against people is the most direct link, while the psychological effects of experiencing crime, whether violent or not, can also have far reaching consequences. Through less direct channels, the fear of crime can not only have psychological effects but directly reduce health-promoting behaviours such as physical activity and social contact. Furthermore, the economic cost of crime to both individuals and public services may reduce resources available for health improvement. Perpetrators of crime are also more likely to have worse health across a range of conditions than the general population<sup>62</sup>. A public health approach recognises that crime and violence are not inevitable and can be prevented.

Data shared here compares Kingston as a borough with other London boroughs on some key measures for crime and health. Kingston has the same or lower (better) crime levels compared to other London boroughs on the measures shown here. However, violent and sexual offences show a concerning upward trend.

*Figure 57: Crime as a wider determinant of health, Kingston and other London boroughs*

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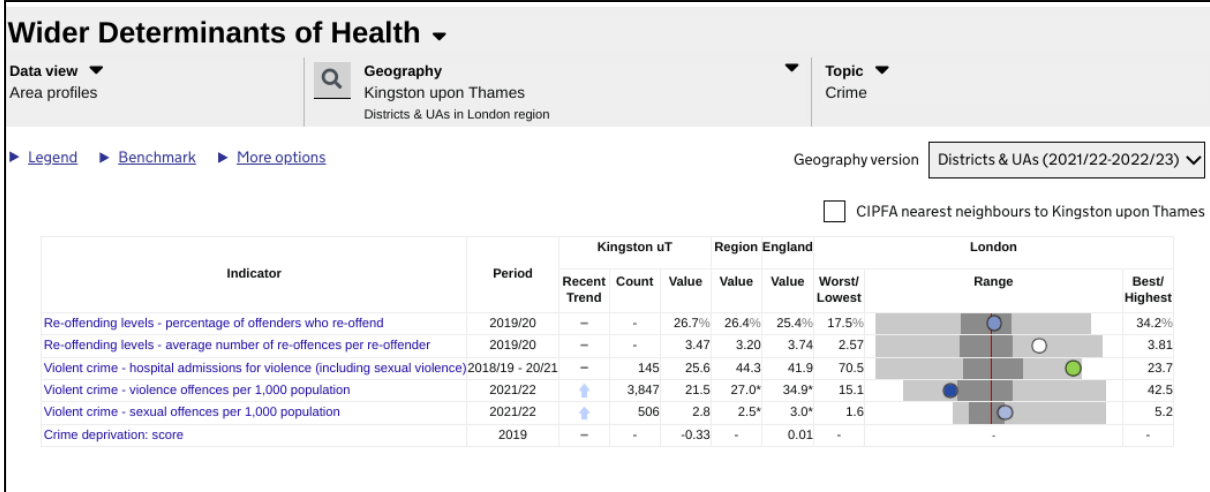
<sup>58</sup> Ministry of Housing, Communities and Local Government, 2019. *English indices of deprivation 2019 - File 2: domains of deprivation* [Online]. Available from: <https://www.gov.uk/> [Accessed 19 December 2019]

<sup>59</sup> Ministry of Housing, Communities and Local Government, 2019. *English indices of deprivation 2019 - File 11: upper-tier local authority summaries* [Online]. Available from: <https://www.gov.uk/> [Accessed 10 December 2019]. Note: Based on the weighted average of the ranks at LSOA level.

<sup>60</sup> DWP, 2020-21. Accessed from the Kingston Data website (under Deprivation): [link](#); accessed April 2023.

<sup>61</sup> Ministry of Housing, Communities and Local Government, 2019. *English indices of deprivation 2019 - File 11: upper-tier local authority summaries* [Online]. Available from: <https://www.gov.uk/> [Accessed 10 December 2019]. Note: Based on the weighted average of the ranks at LSOA level.

<sup>62</sup> <https://www.gov.uk/government/publications/health-profile-for-england-2018/chapter-6-wider-determinants-of-health#fn:35>

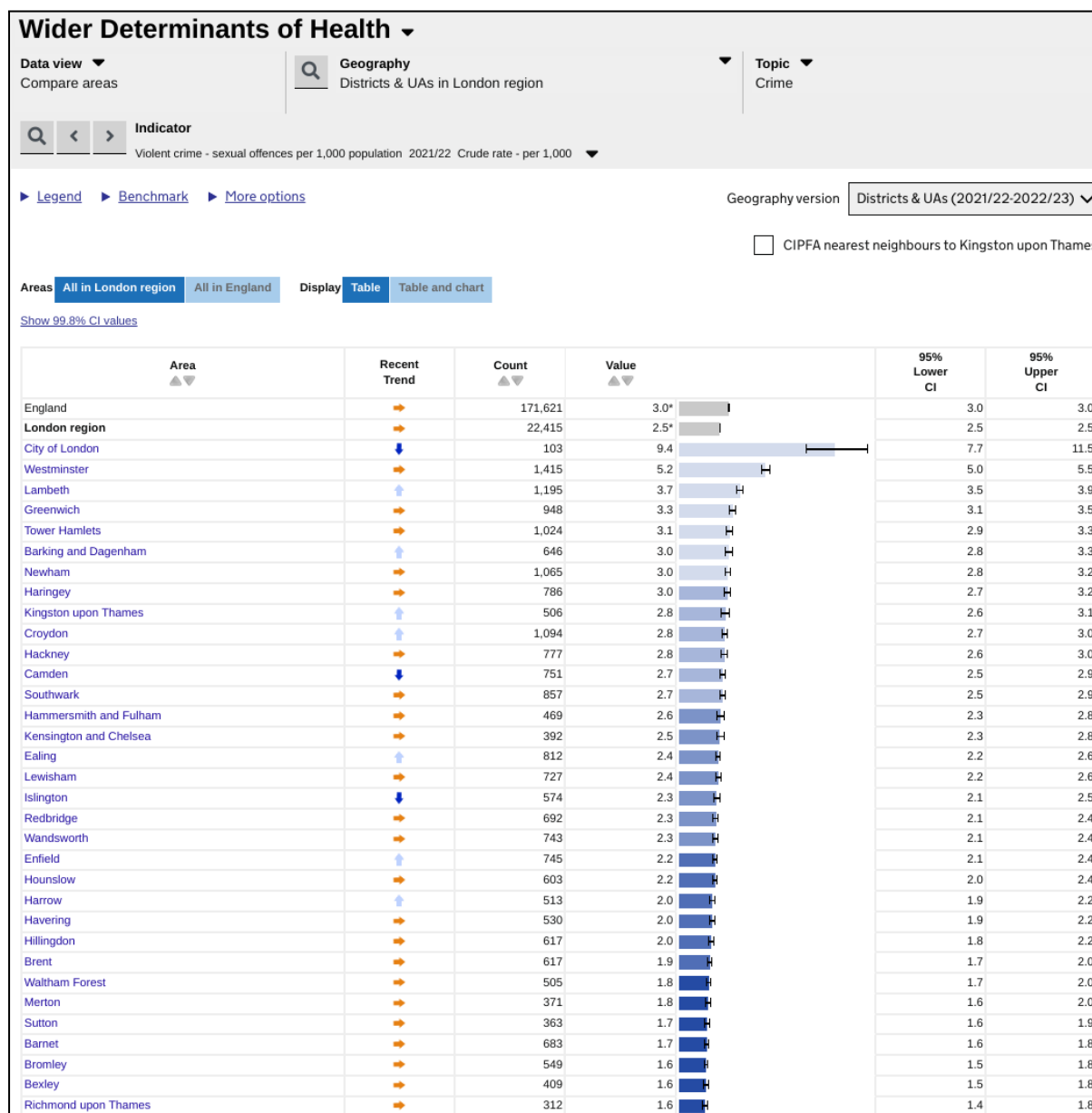


**Violent Crime - sexual offences:**

Kingston has the ninth highest level of violent crime in the form of a sexual offence of all London boroughs for the latest data of 2021/22. Of the nine highest boroughs, Kingston was one of three showing an upward trend in such sexual offences<sup>63</sup>.

<sup>63</sup> The ONS encourages caution when interpreting both violence and sexual offences data as they may reflect a number of factors including improvements made by police forces in identifying and recording offences and the impact of high-profile cases and campaigns on victims' willingness to report incidents ONS, Crime in England and Wales: year ending June 2022, [bulletin link](#)

Figure 58: Violent crime - sexual offences per 1,000 population, 2021/22



The Index of Crime Deprivation measures the rate of recorded crime for four major crime types – violence, burglary, theft and criminal damage – representing the risk of personal and material victimisation at a small area level. There are 32,844 areas (lower super output areas) in England. They are ranked with 1 as the most deprived. Kingston’s is in the mid range<sup>64</sup>.

While there is no borough level data available on perceptions of crime, findings from the recent ONS ‘Opinions and Lifestyle Survey’ (OPN) (2022) show the following, all of which have links to health (e.g. factors influencing likelihood to consider exercising in a park or outdoors in the evening / winter afternoons or impacts on general health and wellbeing)<sup>65</sup>:

<sup>64</sup> Ministry of Housing, Communities & Local Government, Indices of Deprivation 2019, Crime Deprivation domain. [Link](#).

<sup>65</sup> Perceptions of personal safety and experiences of harassment, Great Britain: 16 February to 13 March 2022; based on the Opinions and Lifestyle Survey (OPN). ONS Bulletin: [link](#). [Accessed: March 2023]

- people felt less safe walking alone in all settings after dark than during the day; with women feeling less safe than men in all settings after dark
- disabled people felt less safe in all settings than non-disabled people
- more women (27%) than men (16%) reported they had experienced at least one form of harassment in the previous 12 months
- more people felt unsafe “in a park or open space”; this increased from 7% to 11% during the day and from 60% to 63% after dark.

## Climate

The world has warmed by 1.2°C degrees Celsius since the industrial revolution and we are seeing serious impacts around the world and locally. The heatwaves of 2022 broke records in the UK, with temperatures of over 40°C on 19th July and the first ever Level-4 heat-health warning, meaning that illness may occur in fit and healthy populations, not just vulnerable groups.

Within five ‘heat-periods’ identified in 2022, 3,271 excess deaths were recorded (excluding COVID-19 deaths). 2,703 of these excess deaths were recorded in those over 65<sup>66</sup>. The full impacts of the 2022 were many and varied with fires across London, cancelled trains due to infrastructure damage and power outages causing failure of IT systems, particularly in hospitals<sup>67</sup>.

At time of writing, the world is not reducing carbon emissions at a rate that is on track to keep temperatures within the ‘safe limit’ of 1.5°C as per the Paris Agreement. This means that Kingston’s health and social care sector needs to prepare for an increase in the severity of climate change impacts on its populations and factor in predicted impacts of climate change into all policies and services.

Kingston Council declared a Climate Emergency in June 2019, and adopted a Climate Action Plan in March 2022. At the time of writing (July 2023), the council is also further developing its adaptation strategy which will include health impacts of climate change.

The Climate Action Plan identifies improvements in health and wellbeing as one of the main co-benefits of climate action. Any action to reduce carbon emissions on the local level will not only contribute to Kingston doing its fair share of reducing worldwide emissions as per the Paris Agreement, but also bring health benefits related to warmer and better insulated homes, green spaces full of biodiversity, healthier and more active people, a reduction in poverty in inequality and better air quality<sup>68</sup>.

One of the main five recommendations of the most recent Marmot Review is to *create and develop healthy and sustainable places and communities*<sup>69</sup>. The report highlights that mitigating climate change will also help mitigate health inequalities. It is recommended that this is done by improving active travel, green spaces, the food environment, transport and the energy efficiency of housing.

The report pays special attention to emissions from home and active travel. Action to make homes energy efficient is not only crucial to meeting climate targets, but also will reduce fuel

<sup>66</sup><https://www.lse.ac.uk/granthaminstitute/wp-content/uploads/2023/06/The-2022-heatwaves-Englands-response-and-future-preparedness-for-heat-risk-June-2023.pdf>

<sup>67</sup> <https://www.worldweatherattribution.org/wp-content/uploads/UK-heat-scientific-report.pdf>

<sup>68</sup> <https://www.kingston.gov.uk/downloads/file/1694/kingston-s-climate-action-plan> p.8

<sup>69</sup> <https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on>



poverty and health inequalities . Active travel is important because, in a similar fashion, it tackles emissions and delivers important public health outcomes, while reducing inequalities<sup>70</sup> .

Statutory regular assessment of UK climate risks mentions a wide range of health related risks, the majority of them are assessed as 'requiring more action'. For example, risks to health from high temperatures, flooding, changes in air quality, vector-borne diseases, risks to food and water security and water quality, risks to health & social care delivery, and risks to public health from climate change overseas<sup>71</sup>.

The impacts of the climate crisis will not be felt equally across the borough. How badly a person or group will be affected will depend not just on their exposure to the event, but on their social vulnerability - that is, how well they are able to cope with and respond to events like floods and heatwaves.

The following list of priority groups for reasons of climate vulnerability has been compiled based on Climate Just research<sup>72</sup> and criteria used for GLA Bloomberg Maps<sup>73</sup> vulnerability mapping, and includes those that are present in Kingston:

- Very young children
- Older people (On average, Kingston has a slightly older population compared with other London boroughs)
- People in poor health and with underlying health conditions
- Poor mobility, disabled mentally or physically
- Deprived and low income
- Socially isolated
- Tenants and people on short stay
- BME and non-English speaking
- Occupants of housing vulnerable to climate change - high rise, basement flats, poorly insulated (all present in Kingston)
- People lacking access to green infrastructure (Kingston ranks among 20 local authorities with least natural space per person in England<sup>74 75</sup>)

Areas of our housing estates (Cambridge Road, Alpha Road) as well as south Tolworth and parts of New Malden and North Kingston scored highest in terms of overall climate risk of its inhabitants (sensitivity and exposure combined).<sup>76</sup> (GLA Bloomberg Maps)

Public Health and the care sector have a key role in climate adaptation - helping to protect the most vulnerable residents from the increasing impacts of climate change, and helping to prepare the borough for the health impacts of climate change.

The health impacts of climate change affecting Kingston are likely to be varied and increasingly severe, even though less so than in other parts of the world.<sup>77</sup>  
Both nationally and in Kingston, we are likely to experience some of the following:

- Injury & death related to extreme weather events

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<sup>70</sup> <https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on>

<sup>71</sup> <https://www.ukclimaterisk.org/>

<sup>72</sup> <https://www.climatejust.org.uk/socially-vulnerable-groups-sensitive-climate-impacts>

<sup>73</sup> <https://data.london.gov.uk/dataset/climate-risk-mapping>

<sup>74</sup> <http://files.localgov.co.uk/nature.pdf>

<sup>75</sup> <https://friendsoftheearth.uk/nature/access-green-space-england-are-you-missing-out>

<sup>76</sup> <https://data.london.gov.uk/dataset/climate-risk-mapping>

<sup>77</sup> <https://www.cdc.gov/climateandhealth/pubs/animatedslideENGLISH.pptx>



- Increase in heat-related illness (see areas with high heat hazard score<sup>78</sup> and GLA climate risk maps<sup>79</sup> combining exposure and social sensitivity to risk)
- Changes in disease patterns - worsening existing diseases and new diseases emerging
- Mental health impacts (e.g. Climate anxiety<sup>80</sup> in children)
- Food and water scarcity due to droughts
- Respiratory and heart diseases related to wildfires and ground level ozone<sup>81</sup>
- Increase in allergies due to changes in pollen season<sup>82</sup>

Integrated health and social care systems will play an important role in both carbon reduction and climate adaptation. According to the UK government guidance Climate and Health<sup>83</sup>. Everyone working in health and care needs to prepare for and be equipped to respond to the health impacts of the climate crisis. To make a real difference, a real commitment from leaders and partners will be required.

## Reducing carbon emissions and mitigation for health and care:

Health and care systems should especially focus on the following priorities for carbon emissions reduction and mitigation, that also offer significant public health benefits.<sup>8485</sup>

### 1. Active Travel

The transport sector is the largest contributor to greenhouse gas emissions in the UK. Reduction in road transport and increase in active travel will provide multiple health benefits including decrease in obesity-related morbidity and mortality. Increasing physical activity by cycling and walking, and minimising the time spent sitting down helps not just to maintain healthy weight but also reduces the risk of cardiovascular disease, type 2 diabetes, cancer and depression.<sup>86</sup> Reducing road travel will also bring improvements in air quality (see below)

### 2. Air Quality

Air pollution and climate change are closely related. As well as driving climate change, the main cause of CO<sub>2</sub> emissions - the extraction and burning of fossil fuels - is also a major source of air pollutants. Air pollution is linked to a risk of a range of diseases and conditions including cardiovascular (e.g. coronary heart disease, stroke) and respiratory diseases (asthma, lung cancer)<sup>87 88</sup>. Kingston has high rates of asthma and lower respiratory infections in all age groups. The prevalence of asthma and other respiratory conditions in childhood outweighs all other classes of disorder, and COPD is in the top five causes of both morbidity and mortality in Kingston's older residents. Air pollution, often linked to the above-mentioned diseases, is also more likely to affect people who are already more vulnerable to climate change impacts, such as those living in deprivation and BME groups.<sup>89</sup>

### 3. Housing

<sup>78</sup> <https://www.bbc.co.uk/news/uk-62243280>

<sup>79</sup> <https://data.london.gov.uk/dataset/climate-risk-mapping>

<sup>80</sup> <https://researchportal.bath.ac.uk/en/publications/climate-anxiety-in-children-and-young-people-and-their-beliefs-ab>

<sup>81</sup> <https://sitn.hms.harvard.edu/flash/2022/a-deadly-mix-wildfires-and-urban-air-pollution-create-toxic-ozone/>

<sup>82</sup> <https://www.hsph.harvard.edu/c-change/subtopics/climate-change-and-allergies/#:~:text=The%20carbon%20pollution%20and%20warmer,can%20make%20allergy%20symptoms%20worse.>

<sup>83</sup> <https://www.gov.uk/government/publications/climate-change-applying-all-our-health/climate-and-health-applying-all-our-health>

<sup>84</sup> <https://www.gov.uk/government/publications/climate-change-applying-all-our-health/climate-and-health-applying-all-our-health>

<sup>85</sup> <https://www.health.org.uk/publications/long-reads/health-and-climate-change-complex-problems-with-co-benefits>

<sup>86</sup> <https://www.health.org.uk/evidence-hub/transport/active-travel/health-benefits-of-active-travel-preventable-early-deaths#:~:text=Increasing%20physical%20activity%20and%20minimising,2%20diabetes%2C%20cancer%20and%20depression.>

<sup>87</sup> <https://www.gov.uk/government/publications/health-matters-air-pollution/health-matters-air-pollution>

<sup>88</sup> <https://www.taskforceforlunghealth.org.uk/taskforce/plan/prevention>

<sup>89</sup> <https://www.london.gov.uk/press-releases/mayoral/bame-and-poorer-londoners-face-air-quality-risk>

Poorly insulated (often also damp and mouldy) homes can get too cold or too hot which negatively affects health.<sup>90</sup> In 2020, 9.3% of Kingston residents lived in fuel poverty<sup>91</sup>. Ensuring homes are well insulated and energy efficient, with appropriate ventilation to prevent build-up of moisture, will reduce carbon emissions, save money as well as bring significant health benefits.

#### 4. Food

The foods most damaging to our health are often those with the highest emissions, pollution, land and water use.<sup>92</sup> Policies to reduce meat consumption – especially red meat – and increase in the consumption of vegetables and legumes would reduce both greenhouse gas emissions and the incidence of some of the leading causes of death in the UK. Food growing, apart from benefits for climate mitigation (reducing emissions from transport), adaptation (reducing dependency on imports and resilience to potential disruption to the global food production) also brings mental and physical health benefits, and should be part of social prescribing by GPs, healthcare commissioners and healthcare providers as outlined in the Mayor of London's Food Strategy.<sup>93</sup>

#### 5. Green spaces

Protecting and enhancing nature (e.g. by rewilding) is another 'win-win' for health and climate. Health benefits of exposure to green spaces are well documented. However, green space access is closely linked to health and social inequalities. The most affluent wards in England have five times the amount of parks and green space compared to the most deprived 10% (Public Health England, 2020).

In 2017 the Natural Capital Accounts for public greenspace in London, calculated that Kingston was the 26th greenest of the 33 London Boroughs in terms of proportion of area under publicly accessible green space<sup>94</sup>. A 2020 study by Friends of the Earth identified that Kingston was one of the 50 UK council areas which need to be prioritised for green space investment because they have the greatest number of green space-deprived neighbourhoods<sup>95</sup>. These statistics for areas of open space deprivation are likely to only worsen if projected local population increases are realised.

Overcoming barriers to the community accessing public spaces to improve their physical and mental health, requires a clear alignment of the Council's Climate Action agenda and Greenspaces Strategy, with the work of the Public Health team and as part of the Health and Wellbeing Strategy for Kingston. This includes protecting and promoting green spaces and nature-based interventions for health such as 'green walking' for mental health or 'green social prescribing', food growing, improving the health of people and the planet, while reducing health inequalities.<sup>96</sup>

## Health Protection

'Health Protection' as a subject covers issues from communicable disease to adverse weather and biological and other incidents. In this section, as with the general high level morbidity and mortality data review, a 'Top 5s' approach has been taken here to focus on five

<sup>90</sup> <https://www.bmj.com/content/376/bmj.o606>

<sup>91</sup> <https://www.gov.uk/government/statistics/fuel-poverty-detailed-tables-2023-2022-data>

<sup>92</sup> <https://eatforum.org/eat-lancet-commission/eat-lancet-commission-summary-report/>

<sup>93</sup> [https://www.london.gov.uk/sites/default/files/final\\_london\\_food\\_strategy.pdf](https://www.london.gov.uk/sites/default/files/final_london_food_strategy.pdf)

<sup>94</sup> Natural Capital Account for London, 2017. London.gov.uk. [Link](#).

<sup>95</sup> England's green space gap, Friend's of the Earth. Published: September 2020; [link](#).

<sup>96</sup> <https://www.gov.uk/government/publications/climate-change-applying-all-our-health/climate-and-health-applying-all-our-health>

Health Protection issues in Kingston selected for particular focus in 2023. The Health Protection 5s have been selected based on: global and local urgency, numbers of people affected and impact of the issue. The five Kingston issues selected are: 1. Childhood immunisation - focus on measles and polio 2. Adult immunisation - focus on maternal whooping cough, flu and COVID-19 3. Adverse weather and associated health risks 4. Screening 5. Sexual Health

For data about other Health Protection issues for Kingston and the latest data, please use this data link:

<https://fingertips.phe.org.uk/profile/health-protection/data#page/1/gid/1000002/pat/6/ati/402/are/E09000021/iid/93863/age/1/sex/4/cat/-1/ctp/-1/yr/1/cid/4/tbm/1>

## 1. Childhood vaccination uptake - focus on Measles and Poliovirus

Childhood vaccination in Kingston, like many other London boroughs, has not met national targets for at least 10 years and was not meeting these targets prior to the onset of the COVID-19 pandemic in 2020. Although Kingston has often had higher vaccination rates than many other London boroughs, by not meeting national targets, the vaccination levels are not high enough to prevent community spread of vaccine preventable illnesses. This is putting children in Kingston and beyond at risk of serious illnesses. Unfortunately, vaccination levels in London have been so low for a sustained period that two major issues have arisen in 2022 and continue into 2023: 1. Poliovirus has been found in London wastewater at levels suggesting community transmission (although no polio cases have been identified) and 2. There has been transmission of measles in the UK - After briefly achieving measles elimination in 2016 and 2017, since 2018 the UK has re-established transmission of measles virus<sup>97</sup>. Thus, we have the unfortunate combination in 2023 of the spread of two vaccine preventable illnesses not seen in recent times combined with several thousand children in Kingston and many thousand children across London not protected against these diseases.

### Polio:

Polio vaccination rates in London are lower than the rest of the country with 87% of children receiving all their polio vaccinations by the time they turn 1 year compared to 91% in England as a whole. In Kingston in the period October to December 2022, the rate was 89%. Whilst this coverage is slightly better than the London average, it falls short of the WHO target of 95% needed for polio elimination. Uptake for the preschool booster that includes polio vaccine for children aged 5 years for the same period was 87% in London and 89% in Kingston compared to 91% in England.

In May 2022, it was reported that poliovirus had been detected in a number of routine samples of sewage London<sup>98</sup>. In August 2022, the UK Health Security Agency (UKHSA) declared a national enhanced polio incident response. The Joint Committee on Vaccination and Immunisation (JCVI) advised that, as well as the ongoing catch-up polio vaccination offer, a supplementary polio booster campaign should be implemented for children aged 1 to 9 years in London that included those with a complete course of polio vaccination. This 'Phase 1' of the polio response offered supplementary boosters and catch up vaccinations and ran from August to December 2022. Wastewater sampling has also continued and detected poliovirus in samples until November 2022. Although this is encouraging, the risk from poliovirus remains. It should be noted that no paralytic polio cases have been reported.

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<sup>97</sup>

<https://www.gov.uk/government/publications/measles-and-rubella-elimination-uk/uk-measles-and-rubella-elimination#:~:text=The%20WHO%20confirmed%20that%20the%20established%20transmission%20of%20measles%20virus.>

<sup>98</sup>

<https://www.gov.uk/government/publications/inactivated-polio-vaccine-ipv-booster-information-for-healthcare-practitioners/polio-immunisation-response-in-london-2022-to-2023-information-for-healthcare-practitioners>

The World Health Organization (WHO) requires evidence of 12 months of zero detections before the UK is no longer considered to be a polio 'infected' country. The 'Phase 2' of the special London response (May/June 2023) focuses on those children aged 1-11 years who need to catch up with their polio immunisations as they are unvaccinated or have missed doses. The NHS-led programme will be delivered through GP practices and community and primary school based clinics, with the support of partners such as the council and others.

### **Measles:**

The WHO defines measles elimination as the absence of circulating measles, in the presence of high vaccine coverage, along with good systems to identify cases of the disease<sup>99</sup>.

The UK achieved WHO measles elimination status in 2017, based on data from 2014-2016. However, in 2018, there was a marked increase in the number of confirmed measles cases, with 991 confirmed cases in England and Wales, compared with 284 cases in 2017. The WHO determined that measles could no longer be considered 'eliminated' in the UK and that transmission of measles had been re-established. In 2019 there were 880 lab confirmed measles cases in the UK and 82 cases were confirmed in early 2020 prior to the first COVID-19 lockdown in March. There were only two cases of measles in the UK in 2021 and 54 in 2022. From the 1st January to the 20th April 2023 there were 49 laboratory confirmed measles cases in England, 33 (67%) of these in London<sup>100</sup>. Twenty (61%) of the London cases were in children under 10 years of age. Measles is an infection that spreads very easily and can cause serious problems in some people. Having two doses of the MMR (measles, mumps and rubella) vaccine is the best way to prevent it.

The childhood vaccination uptake rates have shown a decline in recent years in England, London, South West London and Kingston. As a result the UK Health Security Agency (UKHSA) has urged parents and guardians to ensure their children are up to date with all their routine childhood immunisations, warning that children face serious health risks from not having them. The Kingston Cover of Vaccination Evaluated Rapidly (COVER) programme data shows that the WHO target for 95% of children having received the recommended combined vaccine for diphtheria, whooping cough (pertussis), tetanus, polio and Hib (Haemophilus influenzae type b) by the age of five is not being met. These target levels, recommended by the WHO for all childhood immunisation programmes, help prevent the spread of preventable serious diseases by supporting 'herd immunity' (reducing opportunities for viruses to spread).

Due to the COVID-19 pandemic, vaccine uptake rates for routine childhood programmes have fallen globally, worsening immunity gaps and leaving more children vulnerable to this potentially fatal disease. The Kingston immunisation data ('COVER data') for MMR 2 at 5 years of age, shows there was a fall from 86% for January to March 2022 to 77% in April to June 2022. The rate for the last quarter for which there is data from October to December 2022 was 80%. Kingston's rates for MMR1 at 2 yrs and 5 yrs MMR2 at 5 yrs are not meeting the World Health Organisation (WHO) target of 95% which is necessary to achieve and maintain elimination. It should be noted that during the last reported quarter (October to December 2022), the NHS had written to parents and carers of children who had not received MMR vaccination or who had not completed the two dose course. This may have

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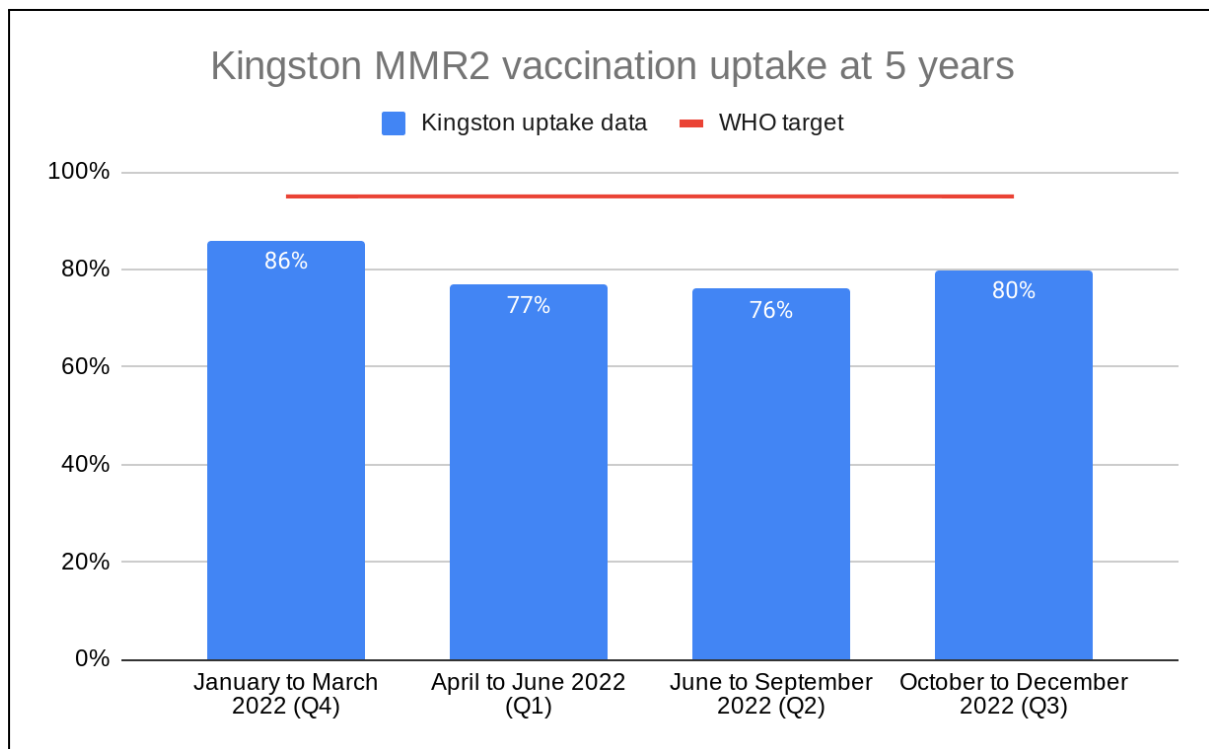
<https://s3.amazonaws.com/wp-agility2/measles/wp-content/uploads/2021/02/Measles-Rubella-Strategic-Framework-Updated.pdf>

<sup>100</sup>

<https://www.gov.uk/government/publications/health-protection-report-volume-17-2023/hpr-volume-17-issue-5-news-4-may-2023#update-on-uk-measles-epidemiology-and-actions-to-prevent-a-measles-resurgence>

resulted in the uptick in numbers. Whilst these rates are above the London and SW London rates, they are below the national rate.

Figure 59: MMR vaccination uptake, Kingston at 5 years, 2022



The Kingston Health and Care Plan notes the following groups face barriers to accessing vaccinations<sup>101</sup>: People living in areas of higher socio-economic deprivation, Children who are ‘Looked After’, Children who are hospitalised, Children in larger families and minority ethnic groups and ‘Health Inclusion’ groups<sup>102</sup>. Increasing vaccine take-up by tackling vaccine hesitancy or reluctance, promoting vaccine confidence and safety has been outlined as an action in the [Kingston Health and Care Plan 2022 to 2024 - South West London ICS](#). Hounslow and Richmond Community Healthcare (HRCH) is the School Aged Immunisation Service (SAIS) NHS England commissioned provider delivering the [National routine childhood immunisation programme](#) in schools. At the time of writing (May 2023), National and London Immunisation Strategies are awaited and work is underway to collate a SWL Immunisation Strategy with key stakeholders in all six boroughs who will then update their local borough plans to reflect each strategy’s recommendations.

## 2. Adult vaccinations, decline in whooping cough vaccination coverage in pregnant women, flu vaccination and COVID-19

**Whooping cough (pertussis):** The latest published UK Health Security Agency (UKHSA) data on the maternal pertussis (whooping cough) vaccine programme shows that uptake has dropped to its lowest level in seven years. Maternal vaccination was first introduced in 2012

<sup>101</sup> [Kingston Health and Care Plan 2022 to 2024 - South West London ICS](#)

<sup>102</sup> Inclusion health is an umbrella term used to describe people who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma. This includes people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery. <https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/what-are-healthcare-inequalities/inclusion-health-groups/>



due to very high rates of whooping cough<sup>103</sup>. A study published in 2022 found the vaccine provided 89% protection against hospitalisation and 97% protection against death from whooping cough in babies born to vaccinated mothers<sup>104</sup>.

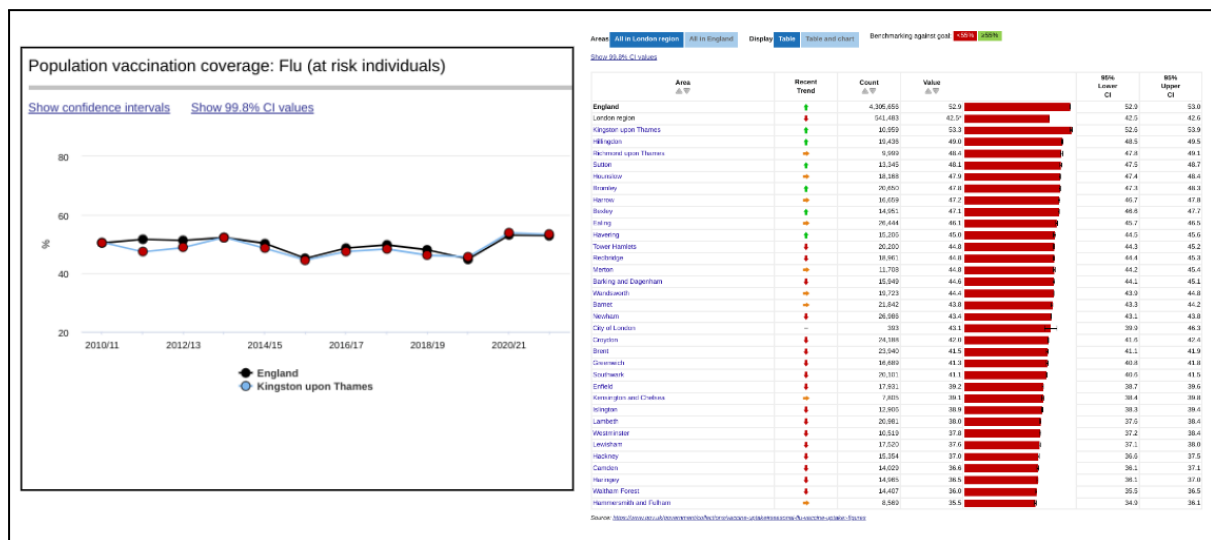
Data for 2022 shows an average uptake across England of 61.5%, a decrease of 3.9% since 2021 and 7.6% from 2020. Coverage in London is particularly low at 41.4%.

Pertussis vaccination coverage in pregnant women in SWL was 50% in December 2022, down from 56% in November 2022 and 52.4% in December 2021. (Data is not provided at borough level).

The maternal vaccine provides newborn babies with protection against whooping cough which lasts until they are old enough to be routinely vaccinated, with the immunity from the mother passed through the placenta during pregnancy. It is important that babies continue to be protected against this serious disease, though rates have fallen since 2012. Whooping cough is associated with difficulty breathing, and can lead to pneumonia, permanent brain damage and even death, particularly in infants under 6 months.

**Flu vaccination in adults:** While Kingston is one of the top performing London boroughs for flu vaccination uptake overall, it is not meeting targets for those in 'at risk' groups<sup>105</sup>. While Kingston was the top of the London boroughs in reaching these 'at risk' groups in 2021/22, uptake did not reach the national vaccination uptake ambitions for all at risk groups<sup>106</sup>. The targets as set out in the annual flu letter for 2021/22 season from the Chief Medical Officer, NHSE and PHE, were at least 85% in those aged 65 and over, at least 75% in those aged 50 to 64 years, at least 75% in those aged under 65 years and in a clinical risk group including pregnant women and 70% in children aged 2 to 16 years old<sup>107</sup>.

Figure 60: Flu Vaccination in 'at risk' individuals 2021/22



103

<https://www.gov.uk/government/news/7-year-low-in-maternal-whooping-cough-vaccine-uptake-puts-newborns-at-serious-risk-of-hospitalisation#:~:text=A%20study%20published%20last%20year,babies%20born%20to%20vaccinated%20mothers.>

104 <https://academic.oup.com/cid/article/76/3/e1129/6663311>

105 <https://fingertips.phe.org.uk/search/flu>

106

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1128172/GP-patients-flu-annual-report-2021-to-2022-corrected\\_final.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1128172/GP-patients-flu-annual-report-2021-to-2022-corrected_final.pdf)

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<https://webarchive.nationalarchives.gov.uk/ukgwa/20220412180617/https://www.gov.uk/government/publications/national-flu-immunisation-programme-plan/national-flu-immunisation-programme-2021-to-2022-letter>

**COVID-19 Vaccination:** The COVID-19 vaccination programme commenced in December 2020 with the residents and staff in care homes for older adults being offered vaccination followed by other eligible cohorts in order of priority with children 5 years and over being offered vaccination from April 2022. In April 2023, the JCVI advised that those who are in a clinical risk group aged 6 months to 4 years, should be offered primary vaccination<sup>108</sup>. A total of 357,300 vaccinations have been in Kingston since 2020<sup>109</sup>. Uptake has been very high in the oldest age groups, dropping off in the younger age groups. Uptake also varies by ethnicity.

### 3. Adverse Weather and associated health risks

Heat-periods and health risks:

In 2022, a heat-period was defined as day(s) on which a Level 3 Heat Health Alert is issued and/or day(s) when the mean Central England temperature is greater than 30°C; between June and August 2022, there were five heat-periods that met this criterion. In May 2023, the alert system was changed to four alert levels; green, yellow, amber and red for extreme heat or cold<sup>110</sup>.

Data compiled by the Office for National Statistics (ONS) using deaths occurrence from death registrations, showed during the five heat-periods between June and August 2022, 56,303 deaths occurred in England and Wales and were registered by 7 September; this is 3,271 deaths (6.2%) above the five-year average<sup>111</sup>. A Heat-Health Watch Level 4 was issued for London valid on Monday 18th and Tuesday 19th July 2022. The temperature exceeded 40 degrees for the first time ever in the UK in this period. The 2022 heat-period with the largest number of excess deaths was the second heat-period (10 to 25 July), with 2,227 excess deaths nationally (10.4% above average). The average number of deaths per day was higher for heat-period days than non-heat-period days.

The potential impacts from exceptionally high temperatures include a danger to life and health impacts on the most vulnerable including adults older than 65 years and very young children, those with pre-existing medical conditions, such as cardiovascular and respiratory diseases, but it can also lead to heatstroke and heat exhaustion even on those who are normally fit and healthy. With such high temperatures, there is also the possibility of impacts on infrastructure, such as on heat-sensitive equipment, utility outages and delays to transport, and a significant increase in water safety incidents. Welfare issues can also be a concern for those caught in transport delays and there is also an increased mortality risk from outdoor activities, increased violence, and mental health problems<sup>112</sup> <sup>113</sup>. Continued work with partners in Kingston on dealing with, and protecting residents, from extreme hot temperatures will be needed as we go forward. Updated national guidance sets out actions and advice for stakeholders and the public in response to heat health alerts (yellow, amber and red) and should be shared widely in the event of a heat-health alert. Advice based on the alert level ranges from advice for those who are particularly vulnerable, likely to struggle

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108

<https://www.gov.uk/government/publications/covid-19-vaccination-of-children-aged-6-months-to-4-years-jcvi-advice-9-december-2022/covid-19-vaccination-of-children-aged-6-months-to-4-years-jcvi-advice-9-december-2022>

109 <https://coronavirus.data.gov.uk/details/vaccinations?areaType=Itla&areaName=Kingston%20upon%20Thames>

110

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1155634/User-guide-impact-based-weather-and-health-alerting-system-v2.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1155634/User-guide-impact-based-weather-and-health-alerting-system-v2.pdf)

111

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/excessmortalityduringheatperiods/englandandwales1juneto31august2022#main-points>

112 <https://www.gov.uk/government/publications/mortality-insights-from-gad-april-2023/mortality-insights-from-gad-april-2023>

113 <https://www.gov.uk/government/publications/hot-weather-and-health-supporting-vulnerable-people>

to cope and where action is required within the health and social care sector specifically to where there is significant risk to life for even the healthy population<sup>114 115</sup>.

### Cold and health risks

Severe cold weather can increase the health risks to vulnerable people and disrupt the delivery of services. The risk of death in the UK during periods of cold temperature is greater than during warmer periods. As a result, there have been more deaths in the winter than in non-winter periods historically. This occurrence is known as ‘excess winter mortality’<sup>116</sup>. On average, there are approximately 30,000 ‘Excess Winter Deaths’ (EWDs) each year in England and Wales. In Kingston between August 2019 and July 2020, 80 excess winter deaths were reported with 30 of those being in those over 85 years of age<sup>117</sup>. There are several complex factors that contribute to EWDs. Although excess winter deaths are associated with low temperatures, conditions directly relating to cold, such as hypothermia, are not the main cause of excess winter deaths. Most cold-attributable deaths are due to cardiovascular and respiratory conditions and infections such as COVID-19 and influenza with other significant causes being dementia and Alzheimer’s.

Deaths arising from hypothermia as the primary cause are relatively rare events. Whilst the greatest impact is seen in older age groups, EWDs do occur across all age groups or in those who are otherwise vulnerable such as those with pre-existing medical conditions, living in poor housing circumstances, homelessness and rough sleeping. The current ‘Cost of Living Crisis’ in 2022/23 with high fuel costs may be adding additional risks. Both extreme cold and warm temperatures have the greatest effect on older people. A. Gasparrini et al reported that for people aged over 85 years, the relative risk of mortality is highest at both extreme hot and cold temperatures<sup>118</sup>. For people aged below 85 years of age the relative risk is higher at extreme cold temperatures than extreme hot. EWDs present a significant health inequality, with those experiencing greater deprivation more likely to be affected.

An episode of cold weather presents a concurrent risk with respiratory infections, such as COVID-19 and flu, due to the following: there are individual vulnerabilities (i.e. age, pre-existing medical conditions); social isolation (a recognised risk factor for cold-related morbidity and mortality) and demands on capacity across health and social care services for vulnerable people. The Adverse Weather and Health Plan<sup>119</sup> sets out details of actions that organisations and agencies should take to support the most vulnerable in their area in response to cold weather alerts. Tips for keeping warm in winter<sup>120</sup> provides advice on how to stay warm and healthy especially during cold weather, and what benefits and services people may be entitled to. The seasonal COVID-19 and influenza vaccination programme delivered by the NHS, offers protection to those most at risk of complications associated with COVID-19 and influenza infection.

## 4. Below Target National Cancer Screening Programme Uptake

In England there are currently three cancer screening programmes: cervical, breast and bowel. The aim of a cancer screening programme is either to reduce mortality and morbidity

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<sup>114</sup> <https://www.gov.uk/government/publications/adverse-weather-and-health-plan>

<sup>115</sup> <https://www.gov.uk/government/collections/hot-weather-and-health-guidance-and-advice>

<sup>116</sup> <https://www.gov.uk/government/publications/mortality-insights-from-gad-april-2023/mortality-insights-from-gad-april-2023>

<sup>117</sup>

<https://fingertips.phe.org.uk/search/excess%20winter%20deaths#page/3/gid/1938133216/pat/15/par/E92000001/ati/401/are/E09000021/iid/90360/age/1/sex/4/cat/-1/ctp/-1/yr/1/nn/nn-12-E09000021/cid/4/tbm/1/page-options/car-do-0> accessed 21/04/2023

<sup>118</sup> [https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196\(22\)00138-3/fulltext#seccesstitle130](https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196(22)00138-3/fulltext#seccesstitle130)

<sup>119</sup> <https://www.gov.uk/government/publications/adverse-weather-and-health-plan>

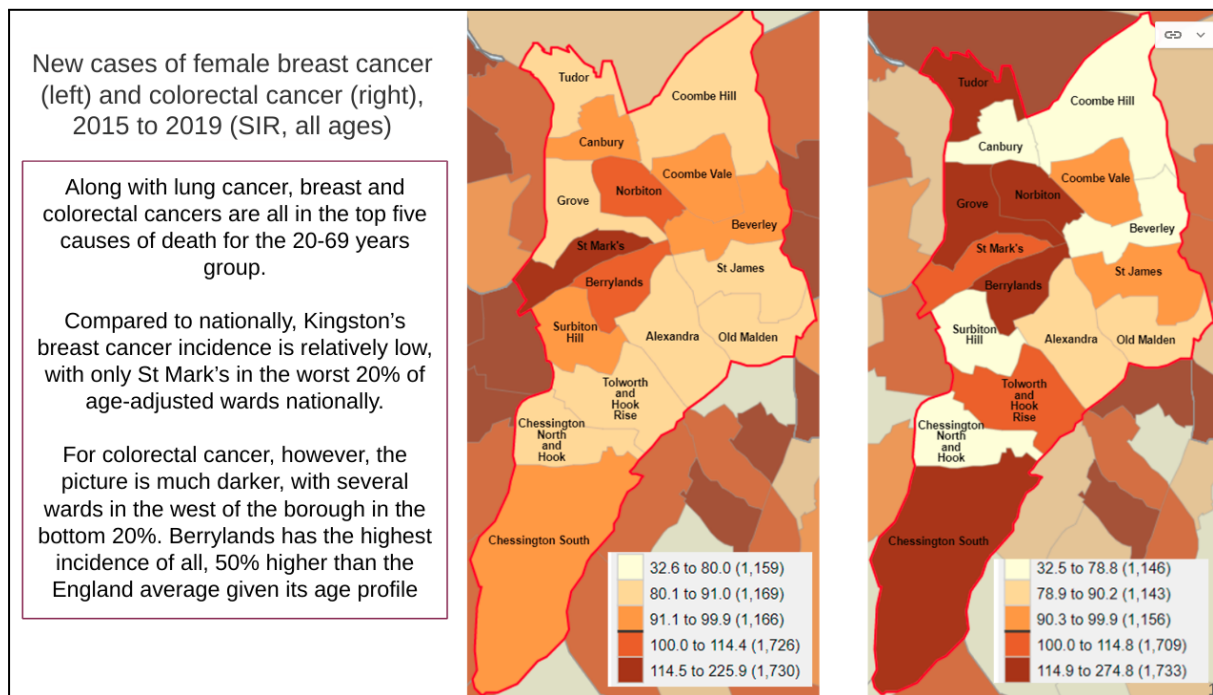
<sup>120</sup> <https://www.gov.uk/government/publications/keep-warm-keep-well-leaflet-gives-advice-on-staying-healthy-in-cold-weather>



in a population by early detection and early treatment of a cancer (for example, breast screening), or to reduce the incidence of a cancer by identifying and treating its precursors (such as cervical and colorectal screening)<sup>121</sup>. Cancer screening programmes have been very impacted by the COVID-19 pandemic - through reduced offers and also a likely reluctance of people to come forward for screening. However, even before the pandemic, cancer screening programmes were not meeting national targets for uptake and this continues in 2023.

The NHS reports that bowel cancer is the fourth most common type of cancer seen and local data shows that colorectal cancer is in the top five causes of death in 20-69 year olds in Kingston in 2019. Breast cancer is also shown in the top 5 causes of death in Kingston in 2019. Whilst some risk factors for cancer cannot be changed - such as getting older and inherited genes, there are lifestyle risk factors that can be modified to help reduce risk. National and local campaigns and initiatives are in place to support residents to stop smoking and get to a healthy weight, and treatment for those experiencing alcohol problems. Along with lifestyle modifications, early cancer detection and treatment of cancer before the onset of symptoms, and the identification of precursors for cervical and bowel cancer through screening, can improve morbidity and reduce mortality.

Figure 61: Breast cancer and colorectal cancer in Kingston, 2015-2019



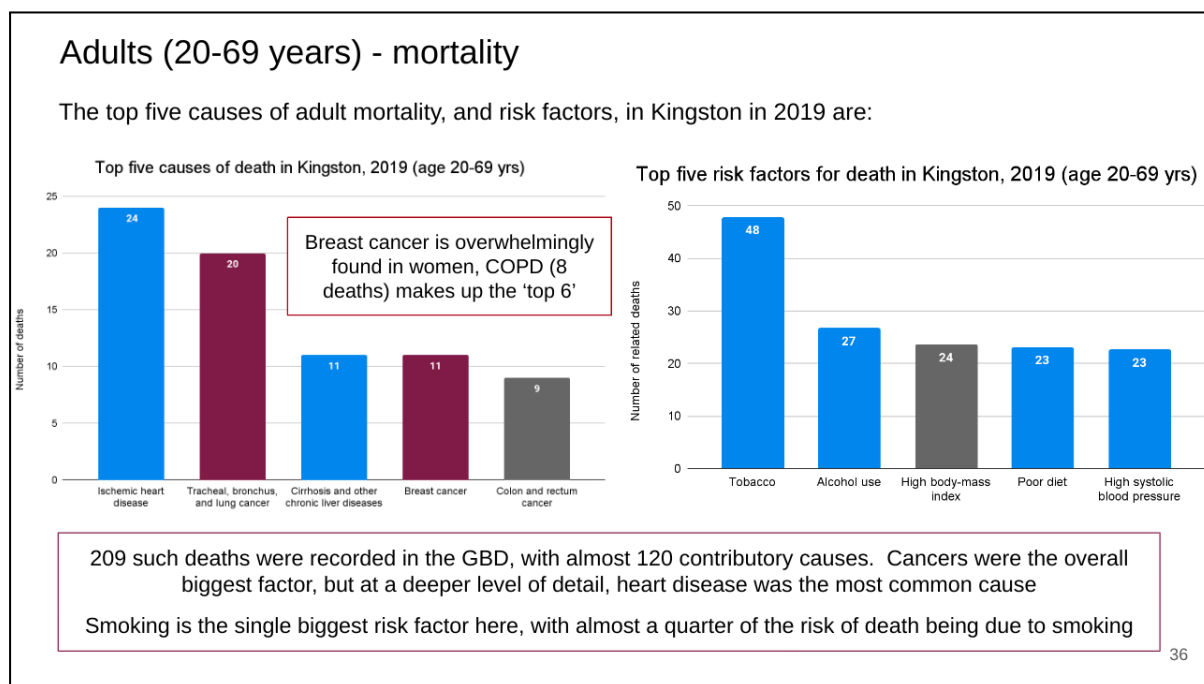
The data shows tobacco, alcohol, high Body Mass Index and poor diet are in the top 5 risk factors for death in Kingston in 20-69 year olds. These are also all risk factors for bowel cancer. Drinking alcohol increases the risk of breast cancer in women with the risk increasing with each extra unit of alcohol per day. Breast cancer risk can also be increased by being overweight.

The National Bowel Cancer Audit in 2019 found that one in ten patients were diagnosed with bowel cancer through the National Screening Programme<sup>122</sup>.

<sup>121</sup> <https://apps.who.int/iris/bitstream/handle/10665/351396/9789289057561-eng.pdf>

<sup>122</sup> <https://www.nboca.org.uk/content/uploads/2020/01/NBOCA-2019-FINAL-Draft.pdf>

Figure 62: Adults 20-69 Years - mortality



### Cervical Screening

Cervical Screening is offered to women aged 25-49 every three years, and to women aged 50-64 every five years. Patients registered as female receive a letter from NHSE asking them to contact their GP Practice to book a screening appointment<sup>123</sup>. Cervical screening can take place in either primary care or sexual and reproductive health services in Kingston.

Data from OHID Fingertips for 2022 showed cervical cancer screening coverage for female 25-49 year olds in 2022, was 62% in Kingston compared to 59% for London and 68% for England for the same period<sup>124</sup>. For women 50 to 64 years in 2022, the data showed coverage was 72% in Kingston compared to 71% for London and 75% for England for the same period<sup>125</sup>. The national screening target for both cohorts is 80%.

### Breast Cancer Screening

Breast Cancer Screening is offered to women aged 50-70 years of age every three years. An invitation to attend for screening is sent to the individual's home address but women over 71 years of age can call up their local screening unit to request an appointment<sup>126</sup>. Data from OHID Fingertips for 2022, showed breast cancer screening coverage in 2022, was 62% in Kingston compared to 56% for London and 65% for England for the same period<sup>127</sup>. The national screening target is 70%.

### Bowel Cancer Screening

<sup>123</sup> <https://www.nhs.uk/conditions/cervical-screening/>

<sup>124</sup> <https://fingertips.phe.org.uk/search/cervical%20screening%20coverage#page/3/gid/1/pat/6/par/E12000007/ati/401/are/E09000021/iid/93560/age/299/sex/2/cat/-1/ctp/-1/yr/1/cid/4/tbm/1> accessed 02/05/2023

<sup>125</sup> <https://fingertips.phe.org.uk/search/cervical%20screening%20coverage#page/3/gid/1938133280/pat/6/par/E12000007/ati/401/are/E09000021/iid/93561/age/273/sex/2/cat/-1/ctp/-1/yr/1/cid/4/tbm/1/page-options/car-do-0> accessed 02/05/2023

<sup>126</sup> <https://www.nhs.uk/conditions/breast-screening-mammogram/>

<sup>127</sup> <https://fingertips.phe.org.uk/search/breast%20screening#page/3/gid/1/pat/6/ati/501/are/E09000021/iid/22001/age/225/sex/2/cat/-1/ctp/-1/yr/1/cid/4/tbm/1/page-options/car-do-0> accessed 02/05/2023

Bowel Cancer Screening is offered to men & women aged 56 to 74 years every two years but by 2025, it is planned that all people over the age of 50 will receive an invitation for bowel screening. In addition, people over 75 years of age can ask for a kit every two years by phoning the free bowel cancer screening helpline. A testing kit is sent by the NHS to the home address of this cohort<sup>128</sup>. Data from OHID Fingertips for 2022, showed bowel cancer screening coverage in 2022, was 68% in Kingston compared to 62% for London and 70% for England for the same period. The national screening target is 60%.

**COVID-19 and screening:** The COVID-19 pandemic impacted on the National Breast Screening Programme when there was a three month pause to allow staff to be deployed to support acute areas in the health system. Routine screening for the total eligible population recommenced in June/July 2020, resulting in backlogs of women waiting to be invited for screening. COVID-19 restrictions (social distancing & additional infection prevention and control measures) impacted on lengthened appointment times and increased time between screening invitations. Workforce sickness/self-isolation and redeployment was also an issue. Fewer women presented for breast screening which may also have been due to COVID-19 infection and/or self-isolation and shielding<sup>129</sup>. Data gathered on cancer screening uptake from Public Health England (PHE) showed substantial reductions in performance across the two cancer screening programmes that require in-person attendance (breast and cervical) and contact with a clinician, whereas no meaningful reduction was noted in the bowel screening programme that involves the use of a home testing kit in the initial stage<sup>130</sup>.

## 5. Sexual Health

Sexual health is a whole population and life course issue. In early childhood, children begin developing their sense of identity and relationships with those around them, while adolescent young people begin to develop their independence and form sexual relationships. Those who are sexually active should have access to good contraceptive services, information and treatment services, in order to maintain good sexual health.

The COVID-19 lockdown restrictions resulted in many new challenges and therefore changes to patient access to healthcare, including Sexual and Reproductive Health (SRH) services. Local councils were engaged in one of the biggest modernisation exercises in the history of Public Health, such as a rapid channel shift to online consultations, app, home testing and home sampling<sup>131</sup>.

Social distancing restrictions and staff redeployment, meant many services across London were significantly reduced during 2020/21. Face-to-face appointments for patients with the highest level of need were prioritised and others were encouraged to use alternative services such as online STI testing. In Kingston, services adapted promptly and developed telephone triage processes to ensure patients in the greatest need were seen as a priority.

### The Kingston Picture

Kingston's Sexual Health Needs Assessment 2021<sup>132</sup> highlighted that 7.6% of women and 9.9% of men presented with a new sexually transmitted infection (STI) at a sexual health service between 2015 and 2019, were re-infected with a new STI within 12 months<sup>133</sup>. This is

<sup>128</sup> <https://www.nhs.uk/conditions/bowel-cancer-screening/>

<sup>129</sup>

<https://digital.nhs.uk/data-and-information/publications/statistical/breast-screening-programme/england---2020-21/covid-impact--programme-summary-2020-21>

<sup>130</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8318685/>

<sup>131</sup> "Breaking point: Securing the future of sexual health services." 15 Nov. 2022,

<https://www.local.gov.uk/publications/breaking-point-securing-future-sexual-health-services>. Accessed 12 May. 2023.

<sup>132</sup> [https://data.kingston.gov.uk/wp-content/uploads/2022/07/JSNA\\_Sexual\\_Health\\_Needs\\_Assessment\\_2021.pdf](https://data.kingston.gov.uk/wp-content/uploads/2022/07/JSNA_Sexual_Health_Needs_Assessment_2021.pdf)

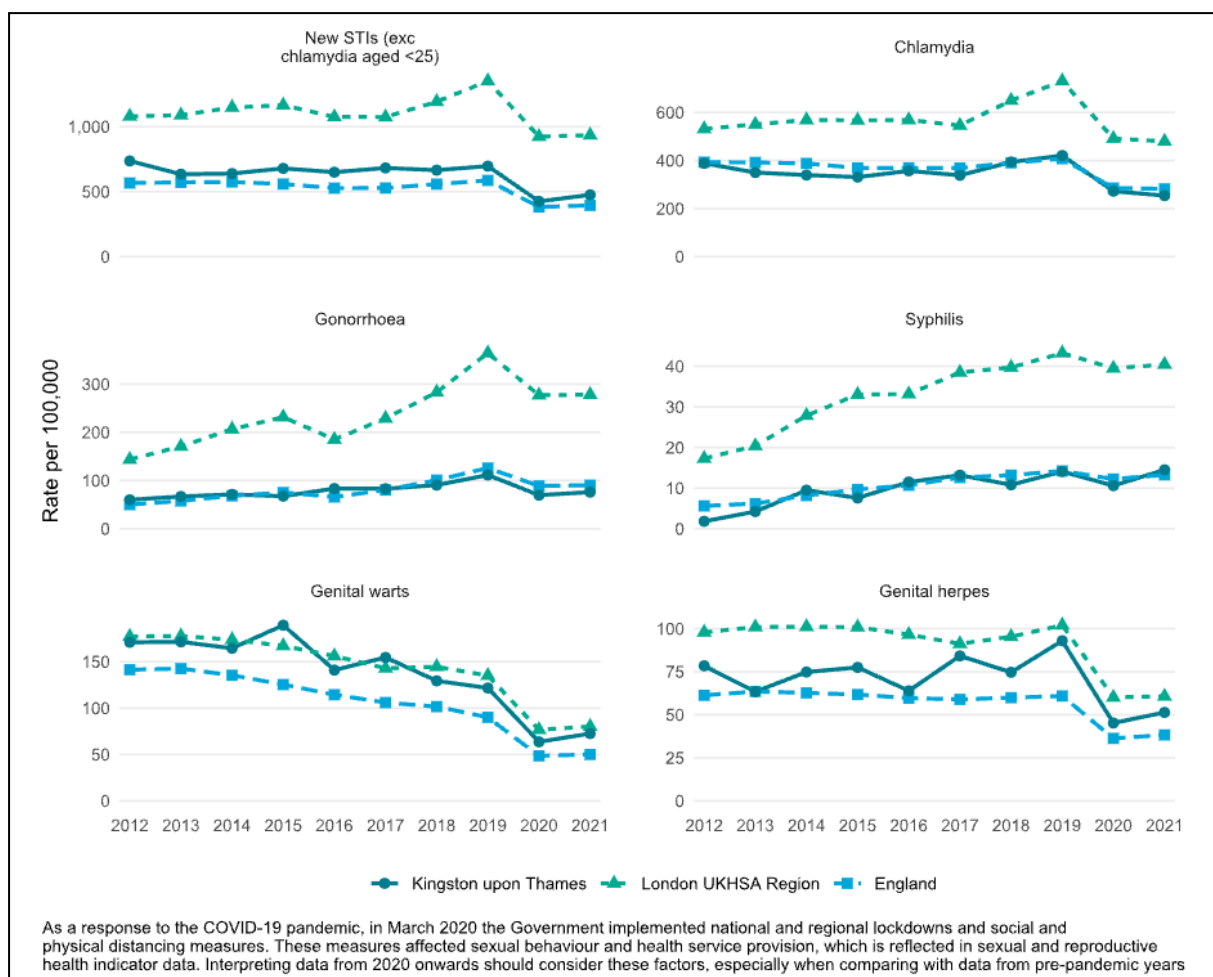
<sup>133</sup> SPLASH Supplement Report. Public Health England. 17 Aug 2021,

file:///media/fuse/drivefs-03d6eed35d184d0158fd9db160d11340/root/E09000021.html Accessed 22 Sep 2021

similar to the England average during the same time period (7.1% of women and 9.9% of men became re-infection with a new STI within 12 months in England)<sup>134</sup>. However, reinfection rates amongst young people in Kingston were higher than the national average. From 2015 to 2019, 13.7% of women aged 15-19 years in Kingston (England average = 11.4%) and 14.5% of men aged 15-19 years in Kingston (England average = 10.4%) in Kingston presenting with a new STI as a sexual health service, became reinfected within 12 months<sup>135</sup>.

Reinfection rates for STIs can be used as a proxy to measure continued risky sexual behaviours including failure to complete treatment, a partner not getting treated, and not practising safer sex. Repeated infections with STIs including gonorrhoea and chlamydia, can also lead to infertility.

Figure 63: Rates per 100,000 population by STI diagnosis by year in Kingston upon Thames compared to rates in London UKHSA Region and England, 2012-2021.



<sup>134</sup> SPLASH Supplement Report. Public Health England. 17 Aug 2021, file:///media/fuse/drivefs-03d6eed35d184d0158fd9db160d11340/root/E09000021.html Accessed 22 Sep 2021.

<sup>135</sup> SPLASH Supplement Report. Public Health England. 17 Aug 2021, file:///media/fuse/drivefs-03d6eed35d184d0158fd9db160d11340/root/E09000021.html Accessed 22 Sep 2021

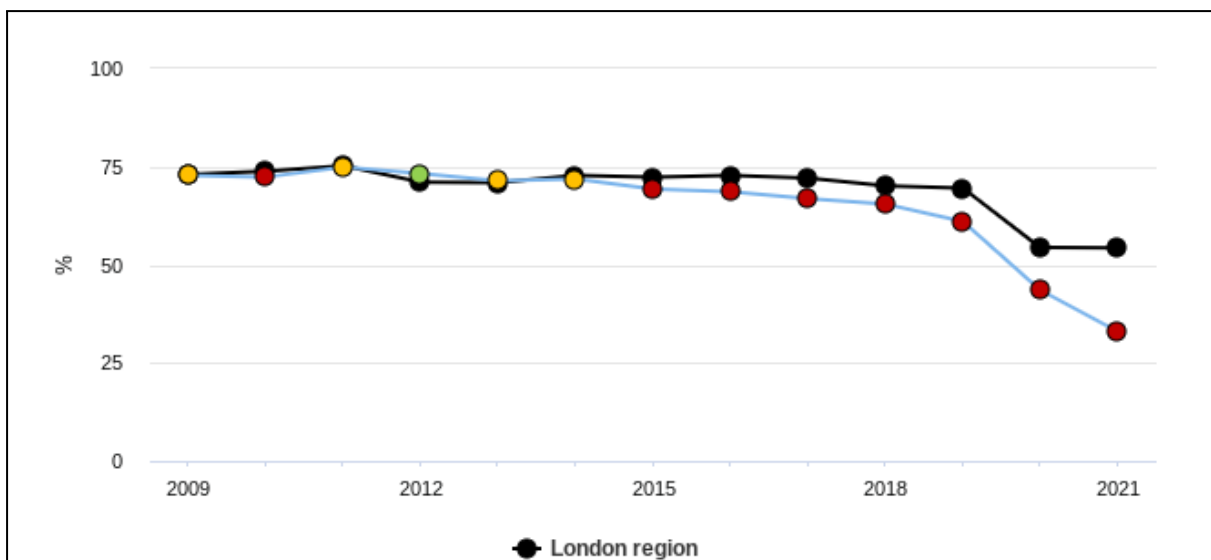
In March 2023, UKHSA published data for England that showed that gonorrhoea diagnoses from January to September 2022 were 21% higher than those reported during the same period in 2019<sup>136</sup>.

The introduction of routine commissioning of Pre-Exposure-Prophylaxis (PrEP) in England in April 2021 meant that PrEP was routinely available to those eligible. It is a possibility that this increased availability of PrEP may have led to an increase in risky sexual behaviours as it provides less of an incentive to practise safe sexual practices (e.g. wearing a condom with new partners)<sup>137 138</sup>. This increase could also be as a result of increased STI screening at regular PrEP visits, especially as some individuals may be asymptomatic<sup>139</sup>.

## HIV

Kingston Public Health is aware that HIV testing (shown via fingertips in the figure below) has been declining since 2015. The number of HIV tests shown below in 2021 was 1,167.

Figure 64: Kingston (blue line) HIV testing coverage, proportion of eligible attendees accepting a test <sup>140</sup>



However, it is important to highlight that this indicator only includes tests performed in Sexual and Reproductive Health (SRH) services and does not include all the other services where residents can access HIV testing. HIV testing can be accessed via primary care, emergency departments, local outreach services and online. In terms of online testing, Kingston has seen one of the largest channel shifts of in-clinic testing to online services since the COVID-19 pandemic. The HIV and other Sexually Transmitted Infection testing data will be further reviewed to understand accessibility and uptake across the population.

<sup>136</sup>

<https://www.gov.uk/government/news/ukhsa-urges-those-with-new-or-multiple-sexual-partners-to-get-tested-after-gonorrhoea-cases-resurge>

<sup>137</sup> "Risk Compensation in PrEP: An Old Debate Emerges Yet Again - PMC." 1 Nov. 2014, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4308722/>. Accessed 31 Mar. 2023.

<sup>138</sup> "Incidence of sexually transmitted infections before and after ... - NCBI."

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5865505/>. Accessed 31 Mar. 2023.

<sup>139</sup>

<sup>140</sup> "Fingertips - Public health profiles - OHID."

<https://fingertips.phe.org.uk/search/HIV%20testing%20coverage>. Accessed 2 Mar. 2023.

## COVID-19

This is the first Kingston JSNA to cover COVID-19, the new virus that emerged at the end of 2019 in China and becoming a global pandemic in 2020. In 2023, Kingston, like the rest of the UK, is in the current phase called [Living with COVID-19](#)<sup>141</sup>. At the end of March 2023 (when the national ONS COVID-19 infection survey<sup>142</sup> was completed before the cessation of this survey), case rates in the population remained very high. Across London, in May 2023 over 700 people are in London hospitals with COVID-19<sup>143</sup>. From 2020 to 2022, the borough fought strongly against the virus by isolation, testing and tracing, face coverings, vaccinations, communications and more. The healthcare system cared for many thousands of infected people and continues to do so. Sadly, 393 residents lost their lives to the virus between 2020 and February 2022 (with the number rising), with many more impacted in other ways. In this section, an overview of the pandemic in Kingston is shown in some summary data (all taken from the gov.uk coronavirus dashboard)<sup>144</sup>. For further details on the borough response, see [Kingston's Annual Public Health Report 2020-2022](#) and other information sites of Kingston organisations.

Data from the COVID-19 pandemic continues to be analysed across the world. However, data to date shows that some groups were at particular risk of more severe outcomes from COVID-19. For example, people with obesity and diabetes are at increased risk of severe illness and hospitalisation<sup>145</sup>. Some of the risk factors are found at higher rates in areas of higher deprivation (for example, obesity and diabetes - see the Health Inequalities section). National level data from 2020-2022 shows that higher deprivation groups had higher age-standardised mortality rates from COVID-19 in the first two years of the COVID-19 pandemic in the UK, and that some ethnic groups were at higher risk of COVID-19 infection and higher levels of mortality<sup>146 147 148</sup>. There are many factors that may help understand this which will likely be fully understood as more is learned about the virus. Issues that are possible explanatory factors range from they are more likely to live in urban areas<sup>149</sup>, higher levels of public-facing work outside the home<sup>150</sup>, overcrowding in the home<sup>151</sup>, lower COVID-19 vaccination rates<sup>152</sup>, higher rates of certain risk factors such as obesity, diabetes and asthma<sup>153</sup>.

## Kingston COVID-19 data 2020-2022

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<sup>141</sup> [COVID-19 Response: Living with COVID-19 - GOV.UK](#)

<sup>142</sup> [Coronavirus \(COVID-19\) Infection Survey: England - Office for National Statistics](#)

<sup>143</sup> <https://coronavirus.data.gov.uk> (accessed February 2023)

<sup>144</sup> <https://coronavirus.data.gov.uk> (accessed February 2023)

<sup>145</sup> [COVID-19: Impact of obesity and diabetes on disease severity - PMC.](#)

<sup>146</sup> <https://www.kingsfund.org.uk/publications/deaths-covid-19>

<sup>147</sup> [Updating ethnic and religious contrasts in deaths involving the coronavirus \(COVID-19\), England - Office for National Statistics](#)

<sup>148</sup> [COVID-19 confirmed deaths in England \(to 31 December 2022\): report - GOV.UK](#)

<sup>149</sup> <https://www.kingsfund.org.uk/publications/deaths-covid-19>

<sup>150</sup> [Coronavirus \(COVID-19\) related deaths by occupation, England and Wales - Office for National Statistics](#)

<sup>151</sup> [Disparities in the risk and outcomes of COVID-19](#)

<sup>152</sup> [Deaths from Covid-19 \(coronavirus\): | The King's Fund](#)

<sup>153</sup> [Dataset Pre-existing conditions of people who died due to coronavirus \(COVID-19\), England and Wales](#)



Figure 65: COVID-19 testing, Kingston, 2020-2022

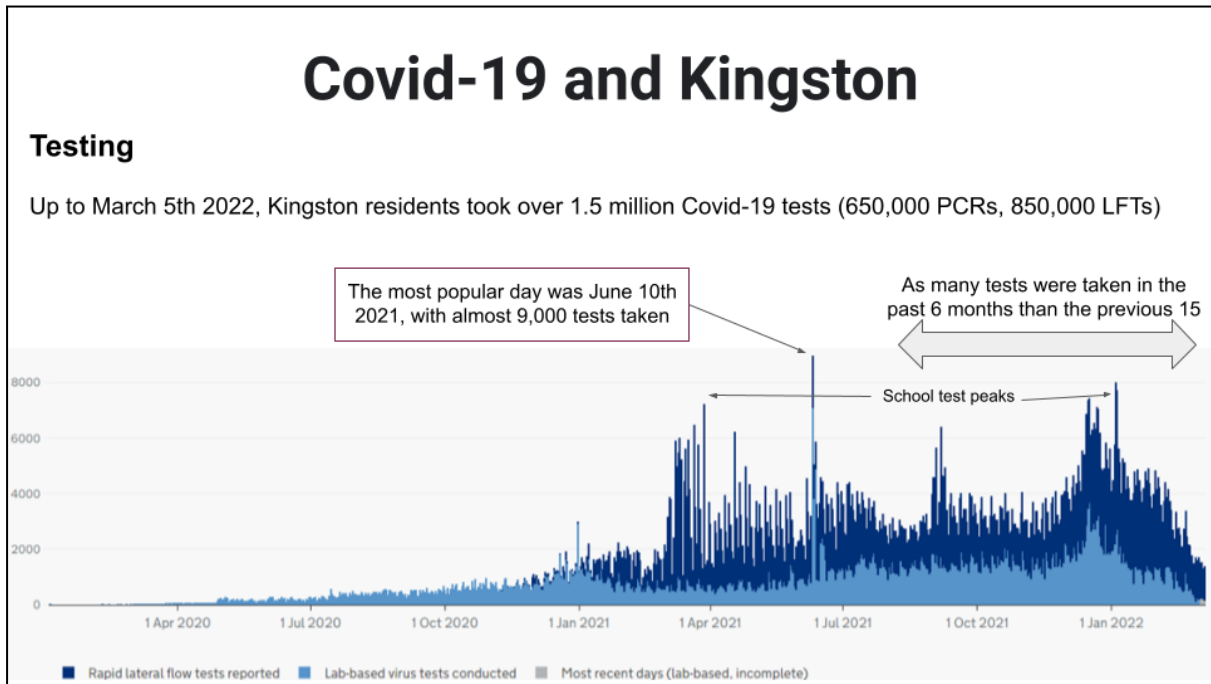


Figure 66: COVID-19 cases recorded in Kingston, 2020-2022

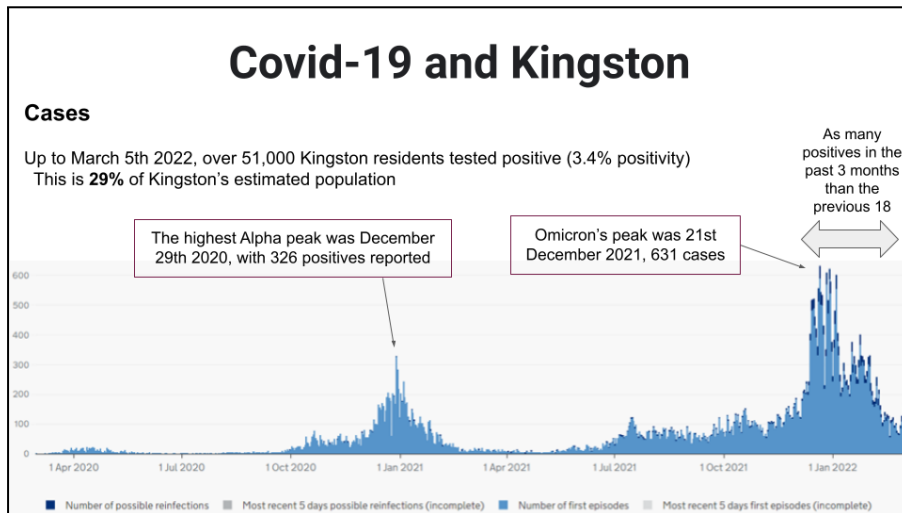


Figure 67: Proportion of Kingston's population testing positive for COVID-19 2020-2022

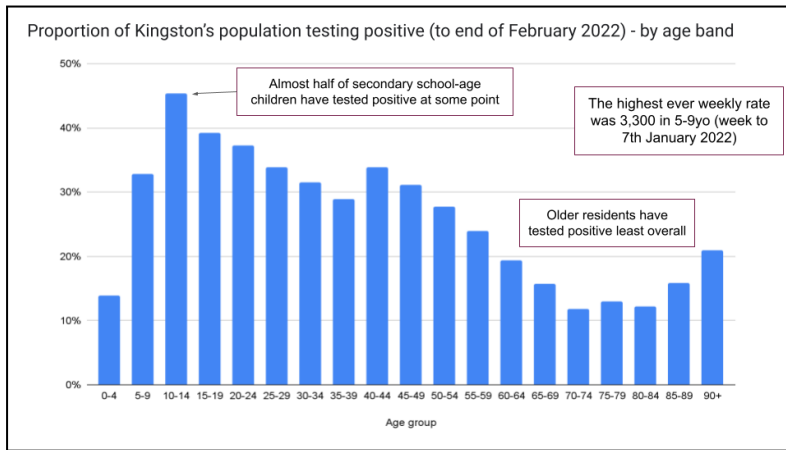


Figure 68: Rank of London boroughs by proportion ever testing positive for COVID-19, to 2022

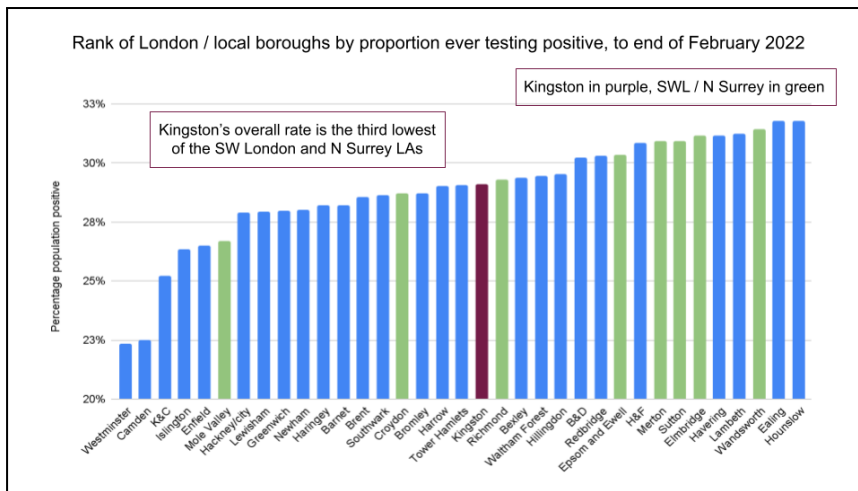


Figure 69: COVID-19 weekly rate per 100,000 population, July 2020-Aug 2022

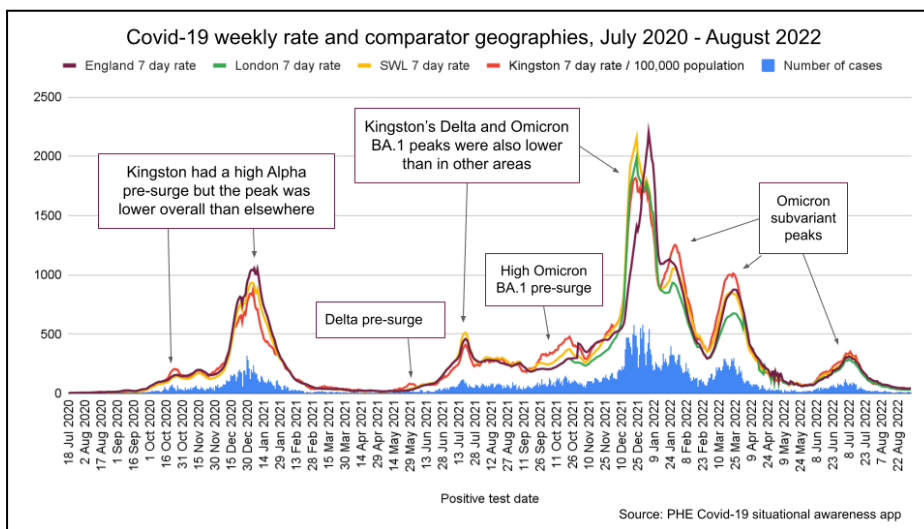




Figure 70: COVID-19 Hospitalisations in Kingston, 2020-2022

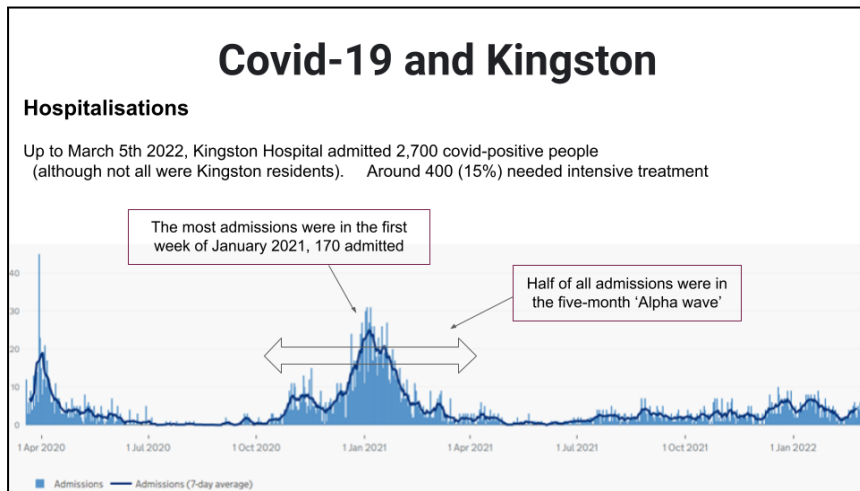


Figure 71: COVID-19 deaths recorded in Kingston 2020-February 2022

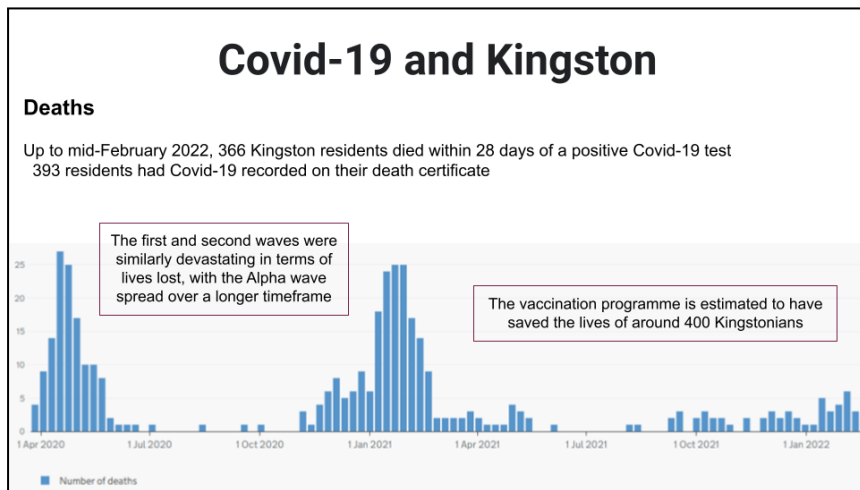
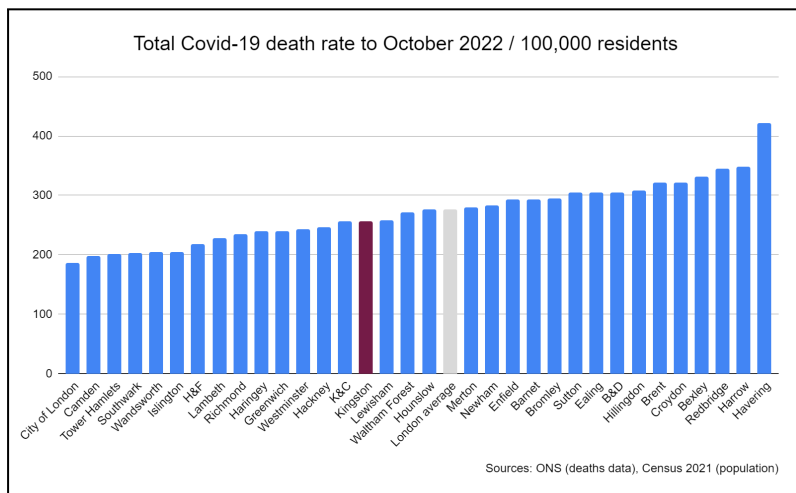


Figure 72: Total COVID-19 death rate, London boroughs, to Oct 2022



## The impact of COVID-19 on healthcare utilisation

One systematic review<sup>154</sup> of global healthcare usage during the initial phase of the COVID-19 pandemic in 2020-21 reported a reduction in usage of one third overall, and a greater reduction in people with less severe illness. The latest DHSC analysis on the impact of COVID-19 and healthcare in England<sup>155</sup> confirms that “lower overall activity across the pandemic has led to ‘missing’ appointments and referrals”. Some effects given as a result of the pandemic are:

### Primary Care

- A higher proportion of GP consultations taking place remotely
- Levels of referrals falling significantly in 2020, only returning to normal levels in summer 2021
- Reductions in diagnoses of long-term conditions, including some that have still not returned to normal, namely coronary heart disease (CHD), asthma and chronic obstructive pulmonary disease (COPD)

For example, the pandemic period has seen an estimated 140,000 fewer diagnosed heart conditions than would be expected, 26,000 fewer strokes and Transient Ischaemic Incidents (TIAs), and 190,000 fewer asthma and COPD diagnoses. If Kingston's population were typical of the national picture, that would mean almost 500 'missing' heart condition diagnoses, 80 'missing' incidences of strokes and 600 'missing' respiratory cases in the borough.

### Secondary Care

- NHS staff absences due to COVID-19 continue to place an increased burden on service delivery
- Bed occupancy by patients with COVID-19 is decreasing, but still significant
- Elective procedure levels remain below pre-pandemic times, with longer waiting lists. Only 62% of patients in Jan-May 2022 waited less than 18 weeks for treatment, compared to almost 90% in the same period in 2019

### Mental Health Impact

- Self-reported mental health and wellbeing has worsened throughout the coronavirus pandemic, particularly for children and young people
- The prevalence of depression among adults during the start of the pandemic rose significantly, doubling from 10% in 2019 to 21% in early 2021
- The number of people in contact with mental health services in South West London grew by more than 7,000 between the start of 2020 and the summer of 2022, including an estimated extra 850 Kingston residents.

These and many other aspects of health and social care have been affected by the pandemic, from the persisting adult social care pressures which have worsened since the advent of COVID-19, to increased waiting times for ambulance patients to be transferred to hospital, greater levels of alcohol consumption, and the prevalence of ‘long covid’ symptoms, mean the effects of the pandemic will play a role in healthcare delivery for many years to come.

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<sup>154</sup> <https://bmjopen.bmj.com/content/11/3/e045343>

<sup>155</sup>

<https://www.gov.uk/government/publications/direct-and-indirect-health-impacts-of-covid-19-in-england-emerging-omicron-impacts>

## Cost of Living

The 'cost of living crisis' refers to the fall in 'real' disposable incomes (that is, adjusted for inflation and after taxes and benefits) that the UK has experienced since late 2021<sup>156</sup>. In 2022, the Russian invasion of Ukraine led to steeply rising fuel prices and added to the cost of food prices. National government has responded to the crisis with a range of support including the 'Energy Price Guarantee'<sup>157</sup>, extension of the 'Household Support Fund' and other measures. However, incomes are not keeping up with inflation. Food prices are showing particular rises in 2023<sup>158</sup>. As a result, many households are feeling financial pressure. Of particular concern are households that were already in financial distress before costs started the large increases over 2022.

In this section, Kingston data has been presented to provide a local picture of the cost of living crisis, in terms of which households and where in the borough appears to be most affected<sup>159</sup>. The 'Cost of Living Crisis' is directly linked to health (for example in terms of ability to buy food, heat homes, travel for services etc) - and of likely highest risk to the health of people already in lower income households. Over the winter of 2022/23, fuel prices were very high and although there was some government support, many households reduced their fuel use for house heating etc<sup>160</sup>. It is likely that the additional financial pressures are also contributing to mental health stresses<sup>161</sup>.

### **Kingston data on benefit claimants, deprivation data**

When considering levels of deprivation within the borough, as of March 2023 Kingston had 10,906 people on Universal Credit<sup>162</sup>. Universal Credit is a relatively new working age benefit for support with living costs. It is replacing six legacy benefits in a phased approach. For this reason, trends over time can be difficult to interpret as claimants are continually migrating onto the benefit.

The figure below shows that Universal Credit claimants in Kingston more than doubled in the first few months of the pandemic (March to May 2020). This was likely due to job losses rather than the managed rollout of the benefit, which was paused at the time. The 105% rise in Kingston during this period was greater when compared to both London (90%) and England (76%).

*Figure 73: Universal Credit claimants in Kingston, Jan 2016 to Mar 2023*

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<sup>156</sup> <https://www.instituteforgovernment.org.uk/explainer/cost-living-crisis>

<sup>157</sup> <https://www.instituteforgovernment.org.uk/explainer/energy-price-cap>

<sup>158</sup> Data shows that within the rising food prices, some items have shown particularly high rises. These include meat, yoghurt and vegetables have almost doubled in price from May 2022 to May 2023.

<https://www.which.co.uk/news/article/which-urges-rishi-sunak-to-act-as-some-food-prices-double-a1kTs3p0JFKI>

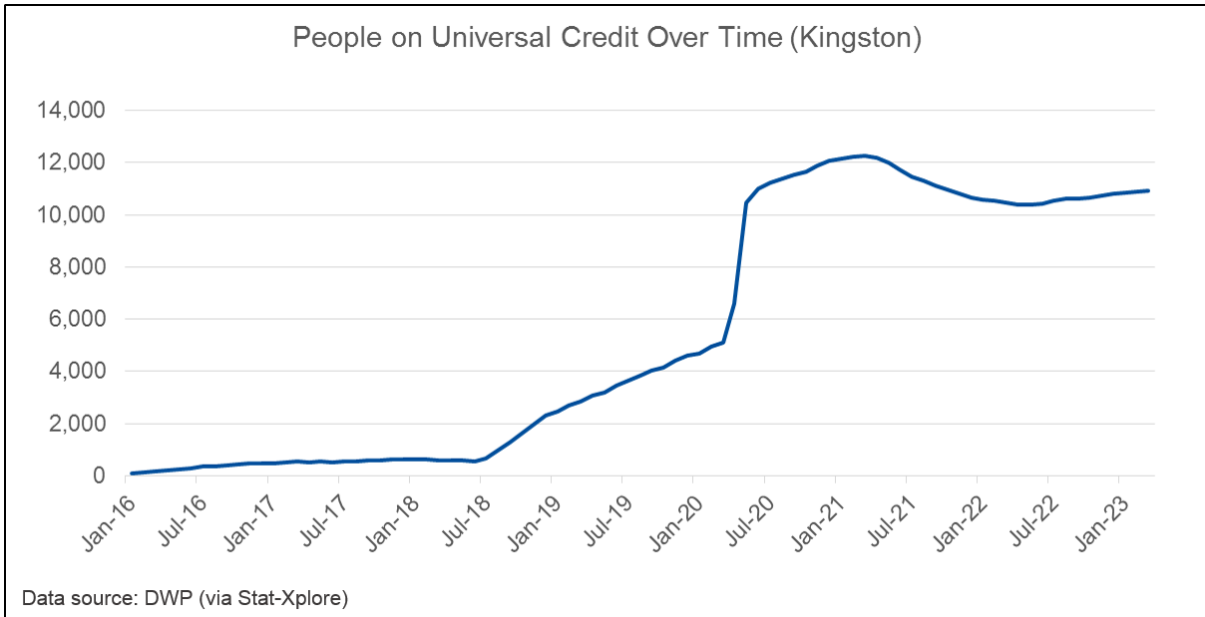
<sup>159</sup> Data source: ONS Census (via Nomis)

<sup>160</sup>

<https://www.ons.gov.uk/peoplepopulationandcommunity/housing/articles/census2021howhomesareheatedinyourarea/2023-01-05>

<sup>161</sup> <https://www.nhsconfed.org/long-reads/can-mental-health-services-afford-cost-living-crisis>

<sup>162</sup> Data source: DWP (via DWP Stat-Xplore)



Universal Credit data cannot be used as a direct measure of the impact of the cost of living, which relates more to changes in household budget pressures than benefit eligibility. However, what it does show is that the caseload in Kingston (and nationally) remained relatively high after the pandemic - with the caveat that ongoing migration may have partly contributed towards this. Therefore many people were already in financial difficulty before the 2021 'Cost of Living' situation started.

**Kingston data on 'Cost of Living Risk Factors':**

The first map below shows the number of households claiming benefits for support with housing costs. It should be noted that this dataset is skewed towards rental properties (and areas with higher populations<sup>163</sup>). The map on the right shows the percentage of households deprived in one or more dimensions by small areas<sup>164</sup>. The deprivation dimensions are education, employment, health and housing. The use of percentages accounts for varying population sizes.

*Figures 74: Households claiming Housing Benefit and Universal Housing Credit Entitlement, Deprivation<sup>165</sup>:*

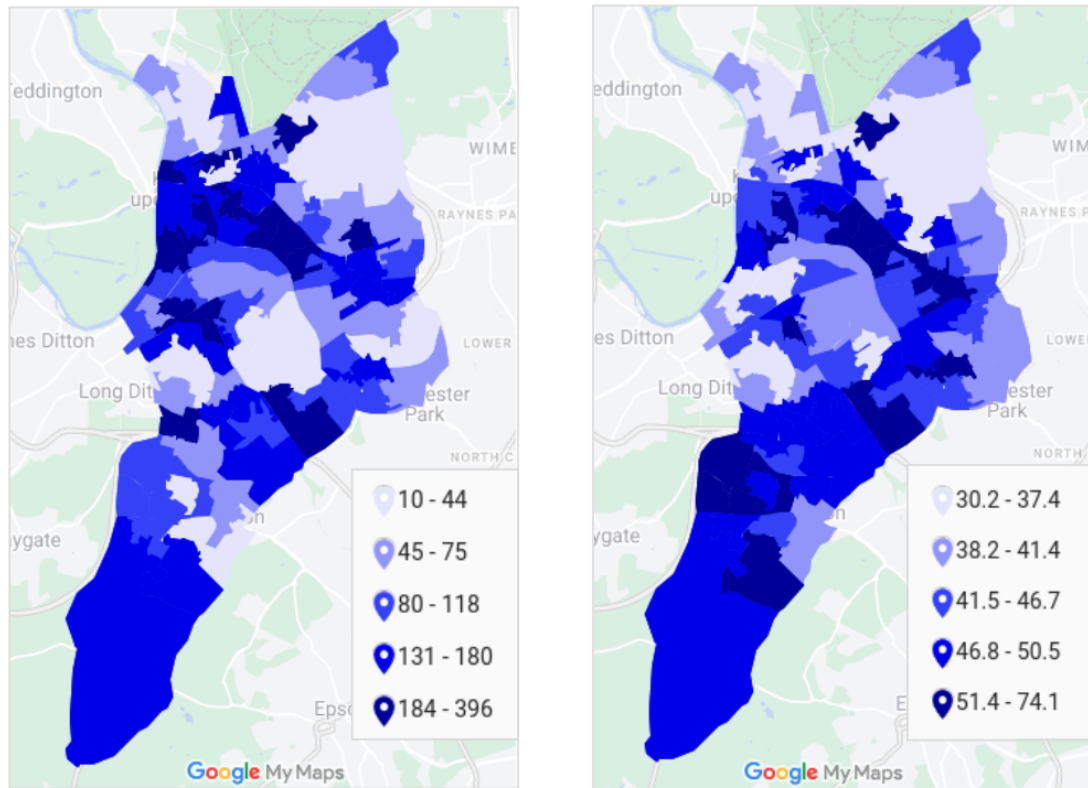
<sup>163</sup> Data source: DWP (via DWP Stat-Xplore - provisional data)

<sup>164</sup> Data source: ONS Census (via Nomis)

<sup>165</sup> It should be noted that this Housing Benefit and Universal Credit dataset is skewed towards rental properties (and areas with higher populations)

Count of Housing Benefit and Universal Credit Housing Entitlement claimants (Kingston LSOAs, May 2022)

Percentage of households deprived in one or more dimensions (Kingston LSOAs, 2021)



Map source: Google My Maps with boundaries adapted from the ONS and Ordnance Survey (via Nomis)

These maps identify some broad areas which indicate higher levels of overall risk in relation to the cost of living crisis. This includes the area along Kingston Road stretching from the eastern edge of Kingston Town Centre to New Malden (the 'Kingston Road Corridor'), which includes the Cambridge Road Estate area, Alpha Road (Surbiton) and surrounding area, and south east to south of the borough, including the Hook area of Chessington. By looking at this data, we are able to identify new and emerging areas/households which may be vulnerable to the pressures of the cost of living crisis.

The geographical areas identified here are generally impacted by multiple factors, with high representation of households with:

- Children aged 0-4 in low income families (Count of children aged 0 to 4 in relative low income families, 2020-21<sup>166</sup>), this measure has been used because of the high cost of childcare.
- Adults claiming disability benefits (Count of DLA and PIP cases with entitlement, February 2022<sup>167</sup>),
- Lone Parent families (identified through claiming Universal Credit, May 2022<sup>168</sup>),
- Residents in work deprivation (Count of people on Universal Credit in employment, August 2022<sup>169</sup>)

<sup>166</sup> Data source: DWP (via DWP Stat-Xplore - provisional data)

<sup>167</sup> Data source: DWP (via DWP Stat-Xplore)

<sup>168</sup> Data source: DWP (via DWP Stat-Xplore - provisional data)

<sup>169</sup> Data source: DWP (via DWP Stat-Xplore)

In Kingston there is a mixed picture geographically in terms of privately owned (with a mortgage) and privately rented properties. There are a higher percentage of households privately owned with a mortgage from the south east to the south of the borough, whereas there are a higher proportion of households privately renting in the Surbiton, Kingston and New Malden town centre areas<sup>170</sup>. There are additional at-risk factors to consider when looking at this data, including the impact of increased interest rates and the high cost of the rental market.

Furthermore, there is specific demographic data to consider when looking across the borough at possible cost of living vulnerabilities, for example:

- Hook, Alexandra / Berrylands, Old Malden, Coombe Hill areas in the borough have both a high proportion of older residents<sup>171</sup>, and a higher proportion of lower energy efficiency of housing<sup>172</sup>
- The Alpha Road Estate area has 21% of households aged 66 and over living alone<sup>173</sup>, and
- The Cambridge Road and Kingsnympton estate areas have the highest proportion of single parent households in the borough (with 27% and 23% respectively)<sup>174</sup>.

#### Partnership approach to the cost of living

In Kingston there has been a strong partnership approach to the Cost of Living crisis over 2022 and onwards. Kingston's active Voluntary and Community Sector (VCS) has been providing 'Warm Spaces' (communal heated spaces, often with a range of activities and refreshments) and other support to residents. A 'Worrying about Money' leaflet was produced with VCS partners and an RBK leaflet was sent to all residents in 2022 with information and advice on where to get support with health and wellbeing, as well as financial advice and information.

The Household Support Fund ('HSF', a national scheme, administered through the council) has directly supported households in crisis through a voucher scheme; and all children with Free School Meals have received food vouchers over school holidays. The VCS have also been able to access the HSF scheme to support their work with communities struggling in the crisis. A new Community Resilience Fund was launched in Kingston 2023 to support Cost of Living actions. For further information on information being provided to residents about the Cost of Living see: <https://www.kingston.gov.uk/benefits-5/support-rising-living-costs>.

## Communications

Communicating about health and care - such as staying healthy advice, information about a particular condition, details about available services or emergency information - has always been important. Over the last three COVID-19 pandemic years, this has been particularly critical with large amounts of highly important, new and urgent information to be imparted - and there has been much learning about ways to reach people, types of information that are helpful and measuring uptake of information. The importance of clarity of message, ease of finding information and analysing whether information being shared is effective has been shown. In this section, national data is shared on media use by adults and children, including

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<sup>170</sup> Data source: ONS Census 2021 (via Nomis)

<sup>171</sup> Data source: ONS Census 2021 (via Nomis)

<sup>172</sup> ONS, 2021-22

<sup>173</sup> Data source: ONS Census 2021 (via Nomis)

<sup>174</sup> Data source: ONS Census 2021 (via Nomis)

the types of media used (e.g. social media, television) and the different ways in which each media type is used or accessed. On the basis of these insights, this section provides recommendations for how health and care messages could be communicated.

In the absence of media usage data on Kingston residents specifically, this section is based on national data from three interrelated reports produced by, or for, Ofcom: Jigsaw Research (2022). *News Consumption in the UK: 2022*<sup>175</sup>; Ofcom (2022). *Adults' Media Use and Attitudes report*. Ofcom (2022)<sup>176</sup>; and *Children and parents: media use and attitudes report 2022*<sup>177</sup>.

## Media Use:

Ofcom's 2022 report on adults' media use shows very high levels of home internet use among 16-34s (99%), 35-54s (97%), and 55-64s (96%), although there is a notable drop off in the 65+ age group (73%)<sup>178</sup>. In 2021, almost all internet users were using at least one of the following: messaging sites/apps, video-sharing platforms, social media, and live-streaming platforms. Across these four uses, YouTube was the site/app used by the most internet users (80%), followed by Facebook (74%) and WhatsApp (72%). Instagram was the only other site or app to be used by more than half of internet users (54%), but there were many other popular sites being used.

Nearly all children (99%) went online in 2021, with the majority using a mobile phone (72%) or tablet (69%)<sup>179</sup>. The most popular online activity for children (3-17) was using video-sharing platforms (95%), which include YouTube and TikTok. YouTube is the most widely used online platform among children (89%), while around half use TikTok. A considerable number of children watch live television (47%), but they are much more likely to watch paid-for on-demand streaming services; 78% watched services like Netflix and Amazon Prime.

## News Consumption:

Jigsaw Research's 2022 report<sup>180</sup> finds that, nationally, television<sup>181</sup> (75%) and the internet<sup>182</sup> (66%) are the most-used news sources among adults (16+). The figures for radio<sup>183</sup> and newspapers<sup>184</sup> are 41% and 38%, respectively<sup>185</sup>. Word of mouth is also a notable source of news (30%).

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<sup>175</sup> Jigsaw Research (2022):

[https://www.ofcom.org.uk/\\_data/assets/pdf\\_file/0027/241947/News-Consumption-in-the-UK-2022-report.pdf](https://www.ofcom.org.uk/_data/assets/pdf_file/0027/241947/News-Consumption-in-the-UK-2022-report.pdf) (accessed March 2023).

<sup>176</sup> Ofcom (2022). *Adults' Media Use and Attitudes*:

[https://www.ofcom.org.uk/\\_data/assets/pdf\\_file/0020/234362/adults-media-use-and-attitudes-report-2022.pdf](https://www.ofcom.org.uk/_data/assets/pdf_file/0020/234362/adults-media-use-and-attitudes-report-2022.pdf) (accessed March 2023)

<sup>177</sup> Ofcom (2022). *Children and parents: media use and attitudes report 2022*:

[https://www.ofcom.org.uk/\\_data/assets/pdf\\_file/0024/234609/childrens-media-use-and-attitudes-report-2022.pdf](https://www.ofcom.org.uk/_data/assets/pdf_file/0024/234609/childrens-media-use-and-attitudes-report-2022.pdf) (accessed March 2023).

<sup>178</sup> Ofcom (2022). *Adults' Media Use and Attitudes*:

[https://www.ofcom.org.uk/\\_data/assets/pdf\\_file/0020/234362/adults-media-use-and-attitudes-report-2022.pdf](https://www.ofcom.org.uk/_data/assets/pdf_file/0020/234362/adults-media-use-and-attitudes-report-2022.pdf) (accessed March 2023).

<sup>179</sup> Ofcom (2022). *Children and parents: media use and attitudes report 2022*:

[https://www.ofcom.org.uk/\\_data/assets/pdf\\_file/0024/234609/childrens-media-use-and-attitudes-report-2022.pdf](https://www.ofcom.org.uk/_data/assets/pdf_file/0024/234609/childrens-media-use-and-attitudes-report-2022.pdf)

<sup>180</sup> Jigsaw Research (2022):

[https://www.ofcom.org.uk/\\_data/assets/pdf\\_file/0027/241947/News-Consumption-in-the-UK-2022-report.pdf](https://www.ofcom.org.uk/_data/assets/pdf_file/0027/241947/News-Consumption-in-the-UK-2022-report.pdf)

<sup>181</sup> Television includes TV news accessed online

<sup>182</sup> Internet comprises social media, podcasts and all other websites/apps accessed on any device.

<sup>183</sup> Radio includes radio news accessed online.

<sup>184</sup> Newspapers comprise both print versions and website/app versions. If we only count print, the figure drops to 24%.

<sup>185</sup> TV and internet figures have remained fairly stable over the last few years, but the figures are declining for radio and newspapers. In the case of newspapers, the decline is fairly sharp. If we include newspapers accessed online/via apps, the figures are 51% in 2018, 47% in 2020, and 38% in 2022. The print-only figures are 40%, 35% and 24%.



What is hidden in the above figures are the marked differences between age groups. Younger age groups are much more likely to access news online and via social media than older age groups, which tend to prefer traditional media channels. For example, among the 16-24 age group, use of the main platforms for news are as follows: social media (79%); radio (25%); print newspapers (10%); television (53%). For the 75+ group, the same figures are: social media (12%); radio (44%); print newspapers (51%); television (95%). Among children (12-15), the most common ways to find out about news are talking with family (65%), watching television (59%), social media (57%) and talking with friends (53%).

When it comes to specific platforms, a notable finding is that TikTok's reach has risen from 1% in 2020 to 7% in 2022 - the largest usage increase of any individual news source. More than half of its users for news are aged 16-24 and, notably, those who use TikTok for news get more of their news on TikTok from 'other people they follow' than from news organisations.

### Digital exclusion:

In 2021, 6% of households nationally had no internet access in 2021<sup>186</sup>, while a further 2% had access but did not use it. Half of those who had no access reported having proxy use via other people; mostly this was to buy something (63%), but 18% wanted to access public services provided by the Government or council on their behalf, 15% wanted to access health services online, and 9% wanted to apply for or claim some type of benefit.

The groups most likely to not have internet access at home are those aged 75+ (26%), those in the DE social grade (14%)<sup>187</sup>, and those who are most financially vulnerable (10%).

Another important finding is that 21% of internet users were accessing the internet exclusively via smartphone, with the highest figures among the 24-34 age range (32%); the C2 (28%) and DE (31%) social grades and the most financially vulnerable (31%). Accessing the internet exclusively via smartphone was also higher among women than men (24% vs 18%).

### Discussion:

**Use of sources of information:** As the two most popular sources of news by far, it is important to consider the use of both television and the internet as channels for communicating public health, care and service messages to residents of Kingston. In practice, the use of television may be out of reach (e.g. due to cost), in which case it may be necessary to consider other non-digital channels (e.g. local radio, local newspapers) in combination with internet-based communication. The most popular internet-based platforms are YouTube, Facebook, WhatsApp, Twitter and Instagram, thus these platforms should always be considered for communicating important messages to residents of Kingston. The Council's main website (and other Health and Wellbeing Board member organisation's websites) and Connected Kingston are also important channels in the local context. These should be optimised for use on smartphones as well as web browsers, due to the prevalence of smartphone-only internet access in the general population.

**Accessibility:** All communications should use plain language and accessible formats to ensure messages are easy to understand and accessible for everyone. The JSNA has

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186

<sup>187</sup> The 'DE' designation relates to the NRS social grade system. NRS comprises 6 categories based on occupation: A (upper middle class, inc. higher managerial roles), B (middle middle class, inc. intermediate managerial roles), C1 (lower middle class, inc. supervisory or clerical and junior managerial roles), C2 (skilled working class, inc. skilled manual workers), D (working class, inc. semi-skilled and unskilled manual workers) and E (non-working, inc. state pensioners, casual and lowest grade workers, and the unemployed with state benefits). 'DE' combines working class and non-working.



reviewed languages used in Kingston and groups particularly impacted by specific health conditions. It is important to always consider whether there is a need to translate messages into different languages to reach non-English speakers. People are more likely to trust information that comes from sources they know and trust, so consider how the health and care professionals can work with community leaders and other trusted sources to communicate health information. An additional consideration here is the fact that nearly a third of people use word of mouth as a source of news.

Barriers in regards to refugee and migrant communities accessing and using our NHS and social care services have been reported by stakeholders locally. This includes issues in relation to language barriers in registering for or accessing health appointments, as well as a lack of knowledge and understanding on how to access services.

**Tailoring messages:** To maximise the effectiveness of the communication, it is important to consider the target group or demographic. The JSNA 2023 data for the health data considered has shown variations by age group, geography and other factors. The national media use data shows that different age groups and socio-economic groups have varying preferences for communication platforms, and reaching them requires a tailored approach. Tailoring our approaches by taking account of the above factors will increase the chances of key messages being received, understood, and acted upon.

Tailoring communications for our residents:

**Younger children (0-4 years):** Communication should target parents, which in most cases means using platforms popular among adults aged between 25 and 45, e.g. YouTube, Facebook, WhatsApp, Twitter and Instagram.

**Older children (5-19 years):** For children between 5 and 12, it is recommended that communications target parents, which in most cases means using platforms popular among adults aged between 30 and 50, such as YouTube, Facebook, WhatsApp, Twitter and Instagram. **For children between 13 and 19**, these same platforms remain popular, but it is important to note that Facebook is relatively less influential within this demographic than in the general population. On the other hand, TikTok and Snapchat are relatively *more* influential among the 13-19 age range. A high proportion (nearly 90%) of this demographic uses all four types of online communication messaging sites/apps, video-sharing platforms, social media, and live-streaming platforms<sup>188</sup>.

**Adults (20-69 years):** National data on media use shows that there is significant variation across this age range. The lower end of the range (**20-30 years**) is more similar to young people in terms of there being a high proportion using all four types of online communication (89-84%) as well as in terms of preferred news sources, hence Facebook is relatively less influential than in the general population, and TikTok and Snapchat are relatively more influential. It is important to note also that adults between the ages of 24 and 34 have a higher rate of smartphone-only access to the internet than the general population. The middle of the range (**30-60 years**) has very high levels of home internet use (between 99% and 96%), but there are declining levels in the use of all four types of online communication (ranging between 81% and 36%); the most popular platforms are YouTube, Facebook, WhatsApp, Twitter and Instagram. The upper end of the range (**60-70 years**) is closer to older adults (70+), meaning social media becomes relatively less important as a news source. (The use of social media as a news source has a negative correlation with age). Communications targeting adults in the upper end of the range should place a greater emphasis on traditional news media. This does not mean avoiding internet-based

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<sup>188</sup> Ofcom (2022). Adults' Media Use and Attitudes:  
[https://www.ofcom.org.uk/\\_data/assets/pdf\\_file/0020/234362/adults-media-use-and-attitudes-report-2022.pdf](https://www.ofcom.org.uk/_data/assets/pdf_file/0020/234362/adults-media-use-and-attitudes-report-2022.pdf)

communications, but rather using channels (both analogue and digital) that are recognised as traditional sources of news and information, e.g. BBC, ITV, local radio, newspapers.

**Older adults (70+ years):** Digital exclusion increases dramatically in the 75+ group, so for this group the use of non-internet-based platforms is important. This includes TV, radio and local newspapers, but also other means of communication such as billboards, community boards, telephone calls, and direct mail.

**Socioeconomic status:** Digital exclusion is also higher among the DE social grade and among those who are most financially vulnerable than it is among the general population. In addition, there is also a higher rate of smartphone-only access to the internet among lower-income households than in the general population.

**Gender/sex:** Smartphone-only internet access is also higher among women than men.

## Commissioner and Resident Survey

Following the summarisation of the 'Top 5s' data at the borough level, the views of Commissioners and Stakeholders were sought for the identified 'Top 5 Health Conditions' for each life stage group. A questionnaire was devised for each regarding aspects of the 'Top 5s'. The questionnaire was sent out in early 2023 via contacts in all parts of the local system including via the Kingston Partnership Board, Healthwatch Kingston, Kingston Voluntary Action and other local Voluntary sector groups and others.

The responses have been gathered and useful themes are highlighted below. The response rate was low. We were not successful in getting a full understanding of the commissioned services for the Top 5 conditions and any issues related to their provision (such as any waiting times). Thus, it is important to point out that while the responses received are useful pointers, the numbers of responses overall for both groups are not sufficient on their own, without further investigation, to formulate concrete recommendations.

The engagement exercise was not intended to be an exhaustive community and provider consultation. A full public consultation of partners, commissioners, stakeholders, and wider community takes place after the first drafting of the JSNA. This exercise asked questions in a number of areas of interest to drafting the JSNA and understanding the data. These areas included:

*For stakeholders:* how they accessed information about services specific to their age group and condition and how information and communication could be improved. How and where services are provided, whether the services met their needs and if not what else was needed or could be different.

*For commissioners:* How they promoted and communicated information about their services, whether their services met the current level of need and what the next three years might look like. Whether they have concerns regarding levels of access and who accesses their services and whether they are meeting the needs as they present themselves.

We asked both groups about what in general might help people stay healthy for longer or prevent ill health to generate some feedback around the wider social determinants of health and their role in ill health prevention.

### Themes and issues of concern

The responses of each group to all the questions were analysed and emerging themes and areas of interest drawn out. These themes and areas provide an interesting insight into areas that worry those who responded, and these are highlighted below:

Looking across the responses from stakeholders and commissioners there is concern about the capacity and flexibility of services to meet the needs of:

**A future population** with more people living in poverty, more older people, more carers. The triple impact of population change, people living longer with disabling conditions, and the cost-of-living crisis and how it impacts on people's needs and ability to pay and the variety and scope of services offered.

**People with co-existing conditions** for whom the service offer does not reflect the impact of one condition on another. This might be for those with depression and diabetes, drug/alcohol dependency and depression, neurodiversity and depression, dementia and diabetes and such other combinations. This reflects on the ability of services to be flexible to fit varying needs. Thus, it is suggested that there needs to be consideration of these co-existing conditions in the commissioning of services - for example, those with a traditionally single purpose without the necessary expertise to be adaptable for those with co-existing conditions.

**People who struggle to access services** that may well be suitable and useful and desired. Access is limited because they rely on virtual delivery or promotion, or delivery is centralised in location or delivered in places that are 'off putting' or expensive to reach. There is a strain on communities as a result of the cost-of-living crisis that may either directly affect people's ability to pay for services or may indirectly place pressure on their finances so that they cannot choose to pay for accessing the offer.

**People who are unable, or it is inappropriate for them, to self-manage their condition.** This might be older people, those with co-existing conditions and those whose mental wellbeing presents a barrier and includes those for whom 'navigation' of the offer itself is challenging.

**There is a desire amongst stakeholders for more and better community-based services, for services delivered in the home and for support outside service commissions, within communities.** Feedback indicates that some services are failing to meet stakeholder expectations – particularly around reliability in responding to requests, waiting time for services and length of visit and quality of inputs. Overall, this is reflected in some calls for more community-based staff e.g. District Nurses and local mental wellbeing expertise. Thus, there was some call to improve and scale up existing community-based support. There is an implication that the community and voluntary sector is under-supported and under-resourced for filling gaps and providing creative, and local, support (that enables people to connect socially, get respite and build connections locally to increase mental wellbeing).

**Support for carers:** There is a real concern that the system in place for supporting carers and enabling carers to look after themselves is insufficient for the actual and potential demand. Carers are essential for providing a flexible response to need that extends beyond clinical intervention and a resource which lowers demand and costs to services.

**Prevention:** In relation to the questions which sought a view around prevention, early intervention, and the wider determinants of health there was an emphasis in the following areas.

- The need for a wide variety of opportunities to improve physical health that were appropriate (including for those with requirements that reflect their disability), affordable and local.
- That the community and locality where people lived offered the potential to bolster and support mental wellbeing significantly. This included social groups, local drop in venues, clubs, day centres etc which were all seen as part of an essential tapestry of support for those with health conditions and their carers. There were concerns about the robustness and availability of these offers and environments.
- Finally, there was some feedback that early intervention and preventative work was suffering due to scarcity of resources and that there was an 'expertise' gap in some professional areas such as early mental health support, care staff with expertise in co-existing conditions and neurodiversity. This sat alongside some general concern about sufficiency of current staffing resources, especially community-based staff, and care staff but also specialist clinics and services for depression and anxiety.

## Discussion and themes

In the data analysis for this JSNA 2023, the JSNA Steering Group considered over 160 summary sets of data for Kingston. These covered the 'Top 5s' of morbidity, mortality, risk factors for ill health and mortality, hospital admissions, PCN Top 5s, wider determinants, Health Protection Top 5s, COVID-19, Cost of Living data and communications use. The data was then considered as a whole for any emerging themes, urgent issues, trends of note, geographies of note, COVID-19 implications, any questions arising from the data and any gaps. These themes were then looked at further.

The following key themes were identified:

- Obesity and Physical Activity,
- Alcohol,
- Smoking and Respiratory Health,
- Geographies,
- Mental Health,
- COVID-19 implications,
- 'Immunisation and Education: basics for good health'
- Communications and Navigation.

The themed reports are provided as separate 'JSNA theme' documents. The recommendations in this report include the recommendations coming from those themed documents.

## Recommendations:

### Climate:

1. Communicate clearly the benefits of climate action for **reducing health inequalities**.
2. Continue to promote health and lifestyle advice to residents to encourage increased use of greenspace, active travel and in the continued development of the social prescribing offer in Kingston, ensure 'green' social prescribing offers are promoted and embedded in our offers for residents.
3. Review existing and upcoming **health & care strategies and plans** to reflect the importance of climate change as a health & wellbeing issue

4. Ensure the climate change agenda and the most recent knowledge on health & care related impacts are represented by at least **one designated member of the Health & Wellbeing Board** with a specialist knowledge.
5. Review existing climate change mitigation plans across healthcare providers (e.g. NHS Green Plan) and consider models for whole system coordination.
6. Review current adaptation plans, and enhance as required, to tackle each predicted health impact of climate change locally (e.g. [Under the Weather](#))
7. Review processes and design frameworks for joint working of Public Health, Social Care, Health colleagues and VCS with emergency response & emergency planning to ensure the most vulnerable will be protected during extreme weather events.

### **Obesity Recommendations:**

1. Continue to develop local breastfeeding support and building on good progress with the Baby Friendly Initiative in Kingston
2. Further promotion of the 'Healthy Start' scheme as part of future communication and engagement and more targeted work to increase the uptake. Review best practice in other areas that have higher take up.
3. Carry out targeted work promoting physical activity and healthy diet to reduce increasing levels of overweight in schools (and surrounding areas) with high levels of increasing overweight between Reception and Year 6
4. Schools – all schools to support to implement 30 minute daily physical activity for all children as per the National Plan of Action on Child Obesity<sup>189</sup> and further encourage uptake of the Daily Mile where not already adopted
5. Continue to expand the 'Play Streets' initiative to increase physical activity opportunities while supporting social cohesion
6. Expand oral health promotion offer in Kingston Schools and Early Years settings to reduce levels of dental caries hospital admissions
7. Expand borough level physical activity offer for early years and school age children with a focus on areas on higher deprivation
8. Ensure all new developments have adequate and easily accessible green play space for both young children and teenagers
9. Review levels of mental wellbeing support in schools in relation to need regarding healthy weight and body dysmorphia and possible eating disorders
10. Work with Transport planners to ensure that safe ways to actively travel are available in areas of high overweight
11. Review eating and drink offers for staff and residents/ patients in all local government and NHS facilities in Kingston to lead by example with 'healthy eating' promotion
12. Work in partnership across the borough to support people identified at high risk of diabetes in accessing and taking up healthy lifestyle measures and activities (including reviewing acceptability and access to these offers to ensure that they match local need)
13. Increase promotion and uptake of the 'Diabetes 9 checks' to improve health of people with diabetes in Kingston
14. Work with RBK Waste Services and other teams in partnership to reduce food waste and food associated carbon emissions while promoting healthy eating
15. Promote physical activity related activities and volunteering opportunities to maximise wellbeing and community, and support local green areas (and link these opportunities to physical activity promotion) - with a focus in areas of higher overweight and areas of premature mortality
16. Work in partnership with Parks and Green Spaces Teams and Kingston partners to try and get a daily offer physical activity offer in all Kingston green spaces - consider piloting in highest weight/ deprivation areas to start

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<sup>189</sup> <https://www.gov.uk/government/publications/childhood-obesity-a-plan-for-action/childhood-obesity-a-plan-for-action>

17. Back pain: undertake a review of the Kingston offer of back pain services and local support to ensure that the offer meets the local need and are linked to the available preventive offers where appropriate (Back Pain having been identified as the highest cause of ill health in adults in Kingston)
18. Consider implementing evidence based 'brief interventions;' in General practice to provide healthy weight advice. See example from Oxford <sup>190</sup>.
19. Continue improving safety on roads and implement segregated cycle ways, where possible, for active travel.
20. Review data on who does/ doesn't use Kingston's existing lifestyle and healthy weight services e.g. by geographical area/ age/ sex/ condition (where possible, eg severe mental illness) etc and consider reorienting offer to meet local needs (ie check offers are available in high overweight areas)
21. Review existing lifestyle and healthy weight services on the outcomes of service users and against best practice outlined in the NICE guideline on Obesity: identification, assessment and management<sup>191</sup>.
22. Include in all new strategies, such as Leisure, Transport and others, ways to make it easier for people to be more physically active in Kingston.
23. Build on signposting by all council, NHS, pharmacies and other services to local exercise opportunities and advice on healthy eating. As part of this, consider building on GP Physical Activity Champion training
24. Consider linking campaign messaging on alcohol with messaging on healthy weight (ie calorie content of alcoholic drinks)
25. Healthy Active Ageing for Older people: ensure that appropriate offers for older people are available in all parts of Kingston, with a focus in areas in places with poorer health in older people, to stay active. Consider timing and location of offers and other considerations to make it attractive and also possibly linking to volunteering. Consider suggestions related to the 'Age Friendly Communities' guidance<sup>192</sup>.
26. Improve assets using available development investment and other resources to allow free or low-cost exercise in the borough: parks, heritage sites (include specific exercise promotion components eg guided walks/ runs/ distance markings etc), targeting investment to the areas of highest need and consider both small and large green spaces within close reach of target residential housing
27. Ensure all new developments have adequate and easily accessible green outdoor space for adults of all ages and health status. Service areas (Council and partners) should ensure that their offers meet the standards as set out in guidance from the National Institute for Health and Clinical Excellence (NICE) in relation to obesity and physical activity. The NICE recommendations include some of the following areas: identification and management of obesity,<sup>193</sup> physical activity and the environment,<sup>194</sup> physical activity, walking and cycling,<sup>195</sup> physical activity in the workplace,<sup>196</sup> and physical activity for children and young people<sup>197</sup>.

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<sup>190</sup> <https://pubmed.ncbi.nlm.nih.gov/27789061/>

<sup>191</sup> <https://www.nice.org.uk/guidance/cg189/chapter/Recommendations>

<sup>192</sup> <https://ageing-better.org.uk/age-friendly-communities/eight-domains>

<sup>193</sup> National Institute for Health and Clinical Excellence (NICE) Guidance, "Obesity: identification, assessment and management". Published, November 2014; last updated: July 2023. Online: [link](#).

Guidance <https://www.nice.org.uk/guidance/cg189/chapter/Recommendations#generic-principles-of-care>

<sup>194</sup> NICE Guidance, "Physical Activity and the Environment". Published: March 2018. Online: [link](#).

<https://www.nice.org.uk/guidance/ng90> NICE guideline [NG90] Published: 22 March 2018.

<sup>195</sup> NICE Guidelines, "Physical activity, walking and cycling". Published: November 2012. Online:

[link "https://www.nice.org.uk/guidance/ph41/chapter/recommendations#:~:text=This%20guidance%20considers%20walking%20and%20exploring%20parks%20or%20the%20countryside.](https://www.nice.org.uk/guidance/ph41/chapter/recommendations#:~:text=This%20guidance%20considers%20walking%20and%20exploring%20parks%20or%20the%20countryside.)

<sup>196</sup> NICE Guidelines, "Physical activity in the workplace". Published: May 2008. Online: [link](#).

Public health guideline [PH13] Published: 28 May 2008 <https://www.nice.org.uk/guidance/ph13>

<sup>197</sup> NICE Guideline, "Physical activity for children and young people". Published: January 2009. Online: [link](#). Public health guideline [PH17] Published: 28 January 2009



## Smoking Recommendations:

1. RBK Public Health to commission the Smoking Cessation service to target the groups identified in the Health Inequalities section where the smoking prevalence is high compared to the rest of the smoking population in Kingston. These include those who work in routine and manual occupations, who are pregnant, who have mental health conditions, who live in social housing and who are dealing with substance misuse.
2. RBK Public Health to follow any updated guidance with regard to the safety of e-cigarettes in regard to commissioning of local support for smoking cessation for those trying to quit smoking.
3. RBK Public Health to continue to have a Smoking Cessation Service in Kingston because stop smoking support is a highly cost effective measure to improve health
4. RBK Public Health to commission the Smoking Cessation service to review the primary care offer and look at ways to increase patient uptake.
5. RBK Public Health and the Smoking Cessation service to work with Kingston Hospital on the smoking part of the NHS Long Term Plan.
6. The Kingston Smoking Cessation service to work with Health Visiting, Maternity, Housing, Mental Health Services and Adult Social Care.

## Alcohol

1. There is a strong evidence base for local population-wide prevention interventions for alcohol. Kingston's Public Health team facilitate the following interventions, which we recommend continue to be prioritised and disseminated out:
  - a. exercising full licensing powers to manage the availability and accessibility of alcohol, and
  - b. rolling out Alcohol Identification and Brief Advice (Alcohol IBA) training to key partners (such as Adult Social Care, GPs, Housing and Voluntary Sector agencies) to help individuals reduce their alcohol consumption and reduce the risks of ill health and deaths.
2. There is a need to use existing and new channels of communication and engagement to maximise the benefit of existing alcohol harm prevention and treatment services (particularly the e-drink check tool and Kingston Wellbeing Service), to residents in Kingston. This will include developing messages for different target populations to channel people to existing services. Also to collaborate with the signposted services to assess changes in access or contacts resulting from any campaigns.
3. Hospital based Alcohol Care Teams (ACT) also have a strong evidence base. They identify inpatients and A&E attendees with alcohol problems and provide specialist care. These services save money by reducing length of stay, re-admissions, A&E attendances, and ambulance callouts. Kingston is one of the few London boroughs that does not have an ACT in its hospital as the threshold for need is not felt high enough. A new review and business case to develop this service is scheduled for 2023 and it is recommended that this business case is considered.
4. Protect funding that invests in substance misuse harm reduction and treatment. [Part Two of Dame Carol Black's independent review](#) of England's drug & alcohol systems highlights the strong Return on Investment (ROI) for continued substance misuse funding (without disinvestment) by the Local Authority. Evidence suggests that for: *Every £1 currently spent*

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<https://www.nice.org.uk/guidance/ph17/chapter/1-Recommendations#recommendation-6-responding-to-children-and-young-people>

*on harm reduction and treatment gives a combined health and justice return on investment of £4.* Failure to invest will inevitably lead to increased future pressures on the criminal justice system, health services, employment services and the welfare system.

5. The requirement for areas to establish a 'Combating Drugs Partnership' has been set out in the current [Drug Strategy](#) published in 2021. In Kingston this is known as the Strategic Partnership for Alcohol and Drugs (SPAD). It is recommended that the SPAD ensures that there is collective leadership across all relevant partners to establish, promote and embed a clear vision to reduce drug and alcohol related harm in Kingston and ensure there is a clear strategy and delivery model owned by all key agencies.
6. There is a need for further exploration of the potential link between obesity and alcohol use in Kingston.
7. Implement the recommendations relating to alcohol in the Substance Misuse Needs Assessment including: Strengthening partnership with schools and Addressing Co-occurring/ Dual diagnosis

## **Geographies**

1. Prioritise an urgent focus on the key poor health 'hotspot' of the Cambridge Road Estate: Work with Cambridge Road Estate (CRE) residents and other local partners to address residents' top priorities for improving their health and wellbeing - reducing crime and anti-social behaviour, improving mental health, having more support with long-term health conditions (including cardiac health), having improved estate facilities, and having help with increasing their levels of physical activity and exercise. Consider similar work for Alpha Road estate.
2. High levels of obesity in Chessington PCN and depressive disorders in Surbiton PCN are the two stand-out disparities in the PCN 'top 5' analysis. Further analysis on the reasons behind these figures should be undertaken, and a review of current related services and uptake, with a view to enhance service provision.
3. Encourage local services in Surbiton to become Be Well hubs<sup>198</sup> and to become places for people to turn to when they feel their mental health is low or simply to feel more connected with their local community
4. A more general look into the South of the Borough could be beneficial, can any factors be established that might link in with residents' poorer health overall? Are there sufficient local services and facilities? Is distance or limited / lack of transport a barrier?
5. Norbiton and Berrylands wards have the highest levels of several morbidities, risk factors, and causes of death in the borough. Furthermore the health-related local improvements identified in the CRE Health Needs Assessment resident survey were 'to improve and support residents to manage their long-term conditions' and 'support with mental health', 'reducing crime and anti-social behaviour', having improved Estate facilities, and having help with increasing their levels of physical activity and exercise. This data suggests there may be a need for targeted local services in these areas to reduce wider inequalities (e.g. targeted comms, pop up services etc), which should be considered.
6. The difference in incidence of colorectal cancers is very broad at ward level, with some areas seeing 2.5 times as many cases as others, given resident age profiles. Kingston's screening uptake at borough level is increasing and one of the highest (better) in London. Where possible, it would be useful to review data to ensure that uptake is consistently high across the borough and, if any low uptake areas or groups, consider further work to encourage uptake.
7. Are the higher incidence wards simply a result of more local screening, or could this be an area for promotion of preventative services around bowel health, healthy

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<sup>198</sup> The [South London Listens action plan](#) includes establishing 120 'Be Well' hubs for people to turn to when they feel their mental health is low or simply to feel more connected with their local community.



eating and / or screening? National data shows bowel cancer screening is lower in areas of higher deprivation.

8. Target health promotion work with older people in those areas with the highest proportion of older residents in poor health or with a life-limiting disability including developing the offer of physical activity opportunities
9. Review the existing falls prevention pathway and improve engagement of all relevant services in promotion of falls prevention services and advice.
10. Undertake targeted health and wellbeing promotion with older people related to/ linked to Pension Credit, the Warm Homes Better Health scheme and other financial support, as well as promoting the new package of support to help over 50s jobseekers back into work<sup>199</sup> and the Age Friendly Employers' Pledge<sup>200</sup>.
11. *Undertake a further cross topic and deep dive analysis (drawing together expertise across all sectors and partners) to bring health, poverty and deprivation data together to identify and target multi agency action and initiate new or enhanced support, where health outcomes are poor. The aim being to reduce the rising health inequality gap locally.*
12. *Consider a further analysis of populations at particular exposure to climate related risks eg floods, heats*

Suggested areas for more in-depth consideration:

- a. Further analysis on the reasons behind higher levels of obesity in the Chessington PCN and depressive disorders in the Surbiton PCN should be undertaken, and a review of current related services and uptake, with a view to enhance service provision.
- b. Further consideration of the South of the Borough area, in terms of factors that might relate to residents' poorer health overall. Are there sufficient local services and facilities? Is distance or limited / lack of transport a barrier?
- c. Norbiton and Berrylands wards have the highest levels of several morbidities, risk factors, and causes of death in the borough. As referenced in the CRE 2021 review, residents have asked for local services that improve their health and wellbeing and improve how they manage long-term conditions. With the CRE development team, Housing partners and other colleagues, look at how local services in these areas can support residents and reduce wider inequalities (e.g. targeted comms, pop up services etc).
- d. The difference in incidence of colorectal cancers is very broad at ward level. More information could be gathered on local screening, and where there are these significant geographical differences, targeted promotion of prevention activity and advice and the importance of screening should be prioritised.

### **Mental Health and Co-existing Conditions**

1. Cross reference the analysis of the data sets undertaken as part of the preparatory work for this JSNA to update and implement the recommendations of the mental health and wellbeing JSNA.

Some key recommendations drawn from this JSNA and the Mental Health JSNA (see the MH JSNA for the full list of these recommendations):

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<sup>199</sup> <https://www.gov.uk/government/news/new-package-of-support-to-help-over-50s-jobseekers-back-into-work>

<sup>200</sup> <https://ageing-better.org.uk/age-friendly-employer-pledge>

2. Review access to supported employment by people with low level mental health issues, homelessness and drug and alcohol issues and people with autism who don't meet the RBK Adult Social Care (ASC) criteria and how these could be better promoted and coordinated and potentially increased in a future supported employment contract.
3. Improve the identification of the mental health needs of victims of domestic violence to ensure they receive the support they need and, as part of the forthcoming Kingston 'Violence against Women and Girls' Strategy, ensure that women and girls' mental health is assessed and that all agencies in this area are trained in MHFA.
4. Encourage local organisations in Kingston to become 'be well hubs' , and members of these communities to become mental health champions particularly those in areas with higher levels of mental health problems e.g. Surbiton and those working with groups at higher risk of mental health problems.
5. Improve access to support for children and young people with neurodiverse conditions and their families, in particular access to support with their mental health.
6. Improve joint working between substance (drug or alcohol) misuse and mental health services to strengthen delivery, treatment pathways, inter-agency working and workforce skills / development. Particularly target work with young and working aged men and in Norbiton and Berrylands.
7. Increase the ways of identifying people who are lonely and supporting them to access local services and local volunteering opportunities - consider any opportunities to link people to the local offers (including any relevant offers through Kingston Adult Education and volunteering structures) through the Social Prescribing arrangements in GP surgeries and other locations.
8. Work with older people, particularly those who are not accessing existing services, to develop ways for them to build social connections.
9. Widely promote the new Perinatal Trauma and Loss Service and monitor the uptake of this service by Kingston mothers.

## COVID-19

1. Residents are advised to follow the relevant guidance and stakeholders should keep up to date with setting specific guidelines to minimise the risk of spread of respiratory infections including COVID-19.
2. There are simple actions that can be taken to help reduce the spread of COVID-19 and other respiratory infections and protect those at highest risk. These include:
3. Get vaccinated
4. Let fresh air in if meeting others indoors
5. Practise good hygiene:
  - i. wash your hands
  - ii. cover your coughs and sneezes
  - iii. clean your surroundings frequently
6. Wear a face covering or a face mask
7. Those who have symptoms of a respiratory infection, including COVID-19, and with a high temperature or not feeling well enough to go to work or carry out normal activities, are advised to try to stay at home and avoid contact with other people especially those who are at high risk of becoming seriously unwell if they are infected with COVID-19<sup>201</sup>.

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<sup>201</sup> <https://www.gov.uk/guidance/people-with-symptoms-of-a-respiratory-infection-including-covid-19>

8. Those [who have been informed by the NHS that they are at highest risk](#) of becoming seriously unwell might be eligible for testing and COVID-19 treatments<sup>202</sup>
9. Ensure adults and families with children who are overweight have access to weight management support to minimise the risks of ill-health related to overweight and obesity. Borough-wide initiatives should promote and facilitate a healthy lifestyle, active travel and physical activity with not only a focus on reducing overweight, but also prevention of overweight.
10. Those with diabetes need to take steps to avoid complications to live well. They should have regular reviews with health professionals and personal care plans with targets for HbA1c (glucose control), blood pressure and serum cholesterol and regular checks set out in the '8 care processes' (plus diabetic eye screening, the '9th process'). In addition, they should have access to structured health education shortly after diagnosis and diabetes technology, emotional and psychological support and guidance on weight management.
11. All stakeholders should ensure emergency preparedness and that plans are in place to maintain resilience against significant resurgences or future variants that risk putting unsustainable pressure on the NHS and local services.
12. Consider reviewing and implementing the recommendations from the Healthwatch Kingston report on 'Living with Long Covid in the Royal Borough of Kingston upon Thames' (2022). Create a comprehensive screening process with seamless referral pathways to care and support: Ensure a multi-disciplinary team approach to care and support based on needs, supported by education and training. Develop self-help support groups (peer-led) inclusive of those that have missed an opportunity for a diagnosis. Improve integrated and coordinated care and support in the community, particularly post discharge from hospital.
13. Key stakeholders should continue to work together to reach our vulnerable and high risk residents and ensure they are made aware of all vaccination offers and have easy access to vaccination
14. Continue data collection and analysis to better understand the longer-term impact of COVID-19 on the Kingston population.
15. Continue to promote services to support people suffering with the long-term effects of COVID-19, with specific health needs, as well as more holistic support offers.
16. Continue to work with Regulatory Services to promote businesses and organisations to ensure good ventilation in enclosed spaces.

## Sexual Health

1. Continue to monitor and utilise local data to undertake targeted social media online testing promotion to those groups most at risk of STI's and/or areas of lower uptake.
2. Continue to support the London Sexual Health Programme in recommissioning of the Sexual Health London (SHL) online STI and remove contraception service.
3. Consider recent Public Health analysis of the challenges and needs of young people, particularly vulnerable groups, in accessing local services since the COVID-19 pandemic and make changes necessary to improve access. This could include providing walk-in clinics for young people and/or alternative clinic locations across the borough.
4. Consider a borough wide Sexual Health Board to help coordinate and take forward work to improve sexual health in Kingston

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<https://www.gov.uk/government/publications/covid-19-guidance-for-people-whose-immune-system-means-they-are-at-higher-risk>

## **The basics of health: immunisation and education**

1. Consider the JSNA data on the school readiness and achievement gap of children eligible for FSM. Work in partnership with related stakeholders (AfC, RBK, RBK Schools, and voluntary sector) to provide further targeted support for children.
2. Review recommendations from the new Women's Health Strategy 2023, as well as the toolkit and resources available to support the set up and growth of Women's Health Hubs.
3. Consider the role of businesses in reducing the gender pay gap and ensuring this is considered as part of the development of the Economic Development Strategy (to be published in early 2024).

### ***Immunisation***

1. Immunisation should be part of health conversations across the life course using a 'Making every contact count' approach across settings and organisations in Kingston.
2. Ensuring that all staff are trained and encouraged to have these supportive conversations needs to be developed further, including discussion around vaccine hesitancy and reluctance where feasible.
3. Translated and easy read immunisation resources should be readily available to support all immunisation conversations, as well as access to translators.
4. Colleagues across RBK (including housing and Adult Social Care), Achieving for Children (Kingston's Children's Services), the voluntary sector (including those working with new arrivals), and trusted community and group leaders should be aware of where to signpost parents and carers to immunisation information for all ages and how to register with a GP if not already registered.
5. At specific educational stages, health visitors, school nursing teams, GPs and educational staff should check vaccination history for gaps, and the importance of receiving the outstanding vaccinations should be discussed with the child or young person and/or their parents or carers. They can also be signposted to the relevant organisation.
6. The School Health team can help to raise awareness of immunisation during Early Help Assessments.
7. Where possible, those working with parents and carers of children who are Electively Home Educated and Children Looked After should promote the offer of childhood immunisations and how to register with a GP if not already registered so these children do not miss out.
8. Offering vaccinations in a more diverse range of locations including the use of Children's Centres, should continue and reminder services to be improved by using innovative methods such as social media pop-ups.
9. The benefits of the schools based immunisation programmes should be promoted and parents and carers be encouraged to take up the offer of vaccination in the school setting. Schools should be encouraged to continue to support school based vaccination sessions.
10. Details of any additional community catch up clinics where vaccinations that have been missed, including flu (seasonal), HPV, pre-school and teenage boosters, MenACWY and MMR, can be received, should be shared widely. Access to these offers should also be available to looked after children and those who are home

educated.

11. Encourage education on the value and importance of vaccination and immunisation in schools in the science and PSHE curriculum through existing lesson plans and resources.
12. All partners and those who have contact with families should check and encourage families and carers to ensure they are registered with a GP and share details of how to register if not.
13. Through data analysis from Childhood Health Information Services (CHIS), identify wards and groups with low GP registrations and work with partners to promote GP registration.

#### **Education:**

1. Carry out a short review of interventions that the highest performing boroughs are using to support education for children eligible for FSM and consider possible use in Kingston
2. Undertake a review to understand why performance of Black boys is lower than other children at Attainment 8 - and consider any interventions used in higher performing areas for local use
3. Based on the national findings of poor educational outcomes nationally, review educational outcomes for Children Looked After and children from the Gypsy, Roma and Traveller (GRT) community against borough average and assess whether further any interventions are required to support this group
4. Review Kingston data for 'Children Looked After' and compare with data for other groups in Kingston. If outcomes are low, consider reviewing approaches from areas with higher levels of outcomes for this group of children.

#### **Communication and Navigation**

1. Optimise the council's main website and Connected Kingston, as access channels for health messaging, for use on smartphones as well as web browsers, due to the prevalence of smartphone-only internet access in the general population.
2. Use the health data contained in this JSNA document to target appropriate health related messaging to target groups in the community.
3. Ensure all communications developed internally, and with partners, uses plain language and is available in accessible formats to ensure messages are easy to understand and accessible for everyone. Always consider whether there is a need to translate messages into different languages to reach non-English speakers.
4. Work with local health professionals, community leaders and other trusted sources to communicate health information in the appropriate format for the target population.
5. Share best practice internally and with partners, in terms of learning from targeted communication methods, to ensure future communications are effective and appropriate.

## Glossary

AfC	Achieving for Children (Kingston's Children's Services)
CHD	Coronary Heart Disease
COPD	Chronic Obstructive Pulmonary Disorder
DHSC	Department of Health and Social Care
ICB	Integrated Care Board (replaced clinical commissioning groups (CCGs) in the NHS in England from 1 July 2022)
OHID	Office for Health Improvement and Disparities
ONS	Office of National Statistics
RBK	Royal Borough of Kingston upon Thames
SAIS	School Aged Immunisation Service
SWL	South West London
UKHSA	United Kingdom Health Security Agency
WHO	World Health Organisation