
JSNA
Joint Strategic Needs Assessment
LIVE WELL
Long term conditions
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LONDON BOROUGH OF
RICHMOND UPON THAMES

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Live Well: Long Term Conditions

COVID-19 Impact on the JSNA Report

The COVID-19 pandemic in 2020 has had multiple and wide ranging impacts on the population. It has increased and expanded the role of both statutory and voluntary sector organisations, and other community led services. The Pandemic has created a whole new set of challenges for carers, hospitals, GPs and care homes, leaving in its wake health and social care service backlogs, establishment and management of a new and significant vaccination programme. The impacts span the life course and wide-ranging issues from political, economic, social, technology, lifestyle and health.

The pandemic has highlighted more starkly, issues such as health and social inequalities and deprivation, anxiety and mental ill-health, and many others. The JSNA health outcomes and wider determinants data presented in this JSNA generally predate the pandemic and could be expected to deteriorate in areas such as life expectancy, mortality and morbidity rates. Mortality from COVID-19 has had an unequal impact on different population sub-groups and exacerbated health inequalities; however, this will not be fully reflected in this JSNA as the data is not yet available at a local level.

It remains important to monitor pre-Covid time trends to understand the baseline from which to measure the local effects of Covid on key statistics. The Protect Well chapter has more detailed COVID health outcomes and impact. It is expected that the first post-COVID information will be available in the next 12 months.

1. Introduction to Long Term Conditions in Richmond

The sheer scale of the Long-Term Conditions (LTCs) challenge for modern healthcare systems means that a shift is needed – away from the 'medical model' of illness (which worked efficiently in the 19th and 20th Centuries to bring down mortality and morbidity) towards a model of care which takes into account the expertise and resources of the people with LTCs and their communities. This will help to provide a holistic approach to their care and lives and help them achieve the best outcomes possible.

The Five Year Forward View (FYFV) https://www.england.nhs.uk/ourwork/futurenhs/ published by NHS England and its partners (2014) sets out the vision for the future of the NHS. It notes that 'long term conditions are now a central task of the NHS; caring for these needs requires a partnership with patients over the longer term rather than providing single, unconnected "episodes" of care. 'This is particularly important in supporting the increasing numbers of people with more than one long term condition, more commonly known as multimorbidity – helping people with long term conditions to live well, age well and die well.

NHS systems are expected to work with partner organisations to access rigorous and validated population health management capabilities that improve prevention, enhance patient activation and supported self-management for long term conditions, manage avoidable demand, and reduce unwarranted variation in line with the Right Care programme.

The 15 million people in England with long term conditions have the greatest healthcare needs of the population (50% of all GP appointments and 70% of all bed days) and their treatment and care absorbs 70% of acute and primary care budgets in England. The barriers to great care for people with long term conditions have been identified by a wide range of reports and reviews, and can best be summed up as failure to provide integrated care around the person:

- Single condition services: services dealing with single conditions only and adopting single condition guidelines (with attendant dangers of polypharmacy and excluding a holistic approach to service users).
- Lack of care coordination: people being unaware of whom to approach when they have a problem, and nobody having a generalist's 'bird's eye' view of the total care and support needs of an individual.
- Emotional and psychological support: in particular, a lack of attention to the mental health and wellbeing of people with 'physical' health problems (as well as failure to deal with the physical health of people with mental disorder as their primary long term condition).
- Fragmented care: the healthcare system remaining within its own economy, and not being considered in a whole system approach with social care or other services important to people with long term conditions (e.g. transport, employment, benefits, housing). Failure to support people with 'more than medicine' offers as provided by, for example, third and voluntary sectors.
- Lack of informational continuity: care records which can't be accessed between settings, or to which patients themselves don't have access.
- Reactive services, not predictive services: failure to identify vulnerable people who might then be given extra help to avoid hospital admission or deterioration/complications of their condition(s).
- Lack of care planning consultation: services which treat people as passive recipients of care rather than encouraging self-care and recognising the person as the expert on how his/her condition affects their life.

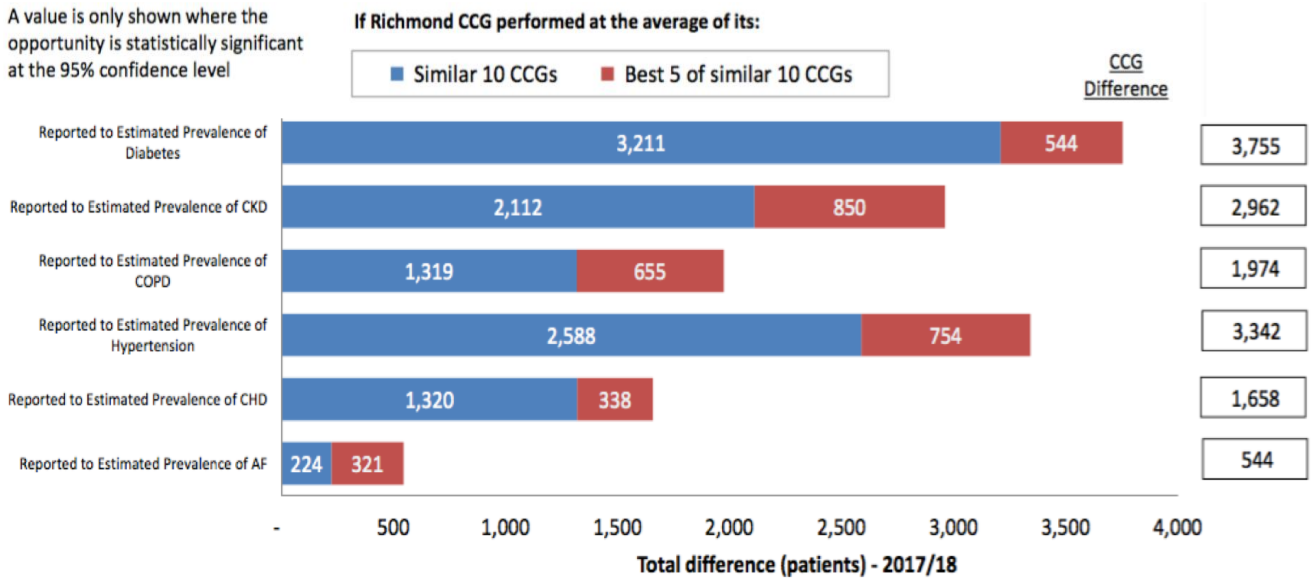
In 2019 the NHS Long Term Plan http://www.longtermplan.nhs.uk/ was published. This plan aims to support people to live longer, healthier lives through helping them to make healthier lifestyle choices and treating avoidable illness early on. The plan sets out a need for the NHS to work in collaboration with local authorities to deliver joined up care and to focus prevention programmes on reducing smoking, obesity and alcohol

intake. This approach will reduce the risk of early ill health and diseases such as cancer, cardiovascular disease, stroke, respiratory disease and mental ill-health.

1.1 Prevalence and Need

A significant number of people who are classified as fit with between 1 and 4 long term conditions are being admitted to acute care as an emergency presentation, with an observed growth in the under 65's.
There is a significant number of unidentified prevalence for hypertension (>5000 people). Other areas where identification needs to be improved include diabetes, coronary heart disease, atrial fibrillation and chronic obstructive pulmonary disease. **Figure 1** compares Richmond to the 10 most similar CCGs in England, demonstrating the detection opportunity if Richmond were performing to the level of its peers.

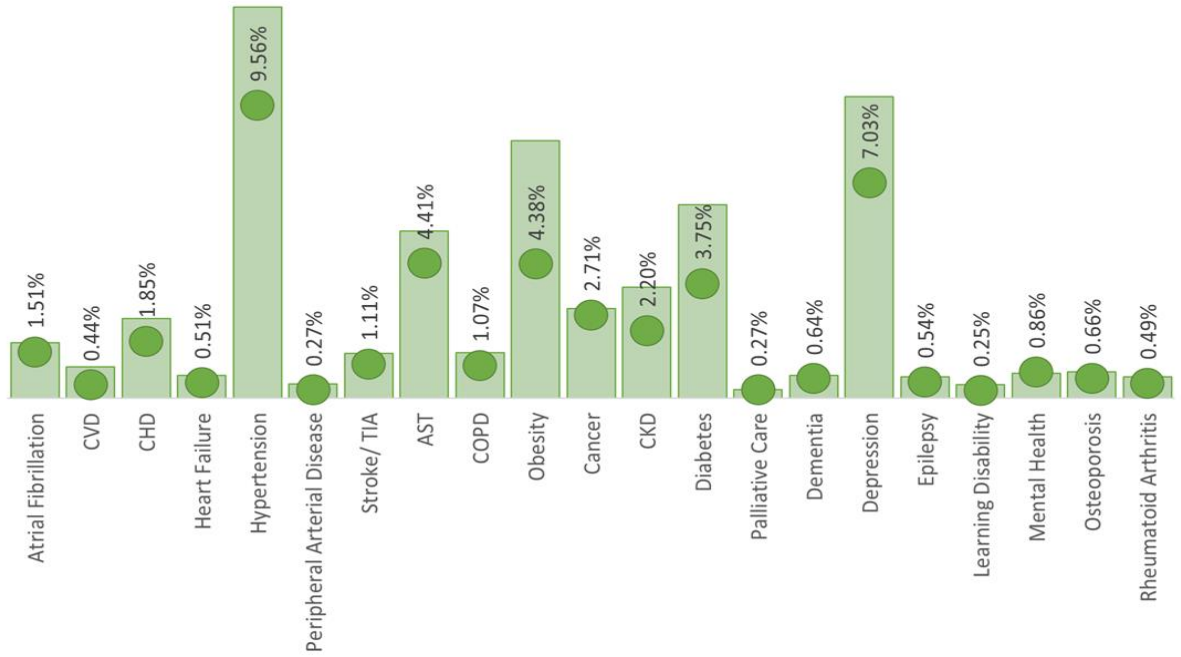
Figure 1: Identified long-term conditions compared to peer group, 2017/18



Source: Right Care data 2017/18

This data is then triangulated with GP practice registers and **Figure 2** below shows that there are marked variations in GP registers for hypertension, obesity, diabetes and depression compared to the 10 most similar CCGs.

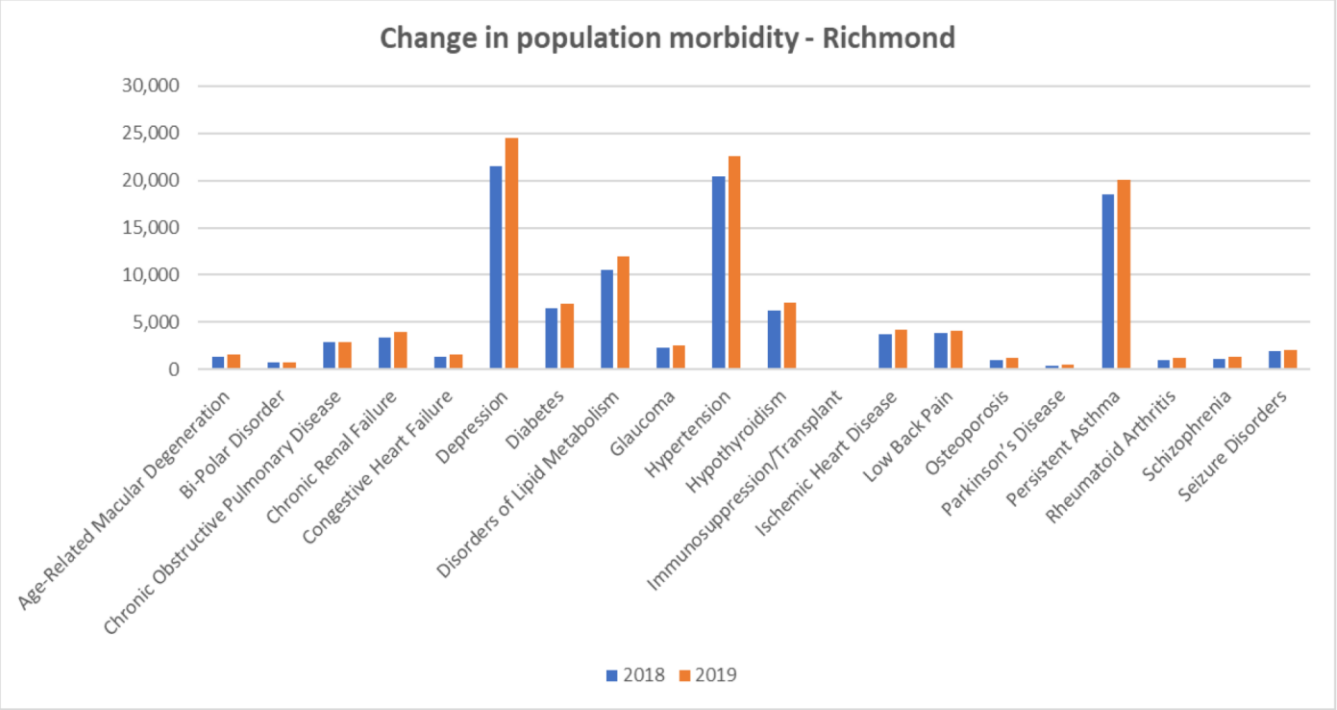
Figure 2: GP Practice registers, recorded incidence of disease, 2019–20



Source: 2019/20 QOF, NHS Digital

The issue of undetected disease is increasing within Richmond with a demonstrable growth in morbidity between 2018 and 2019 in these conditions (**Figure 3**).

Figure 3: Change in population morbidity, 2018–2019



Source: Sollis Clarity 2018/19

People often present with multiple morbidity factors and as the population ages the incidence of multi-morbidity increases. **Table 1** below shows the likelihood of a particular long-term condition as multi-morbidity increases, expressed as percentage.

For people with three or more long-term conditions, circa 45% of people are coded with Hypertension, whereas for people with 9+ LTCs, this rises to circa 92% of that cohort.

Table 1: Multi-morbidity in Richmond

Long Term Conditions	Hypertension	Hyperlipidemia	Depression	Asthma	Diabetes	Hyperthyroidism	Chronic Renal Failure	Ischemic Heart Disease	Congestive Heart Failure	Osteoporosis	Seizure Disorder	COPD	Glaucoma	Low Back Pain	Age Related MD	Arthritis	Schizophrenia	Bipolar Disorder	Parkinsons Disease	Immunosuppression Transplant
3	44.7%	34.3%	43.3%	27.3%	10.8%	11.0%	4.9%	4.5%	2.7%	5.4%	5.7%	3.8%	4.2%	3.2%	2.1%	2.3%	2.0%	1.3%	0.9%	0.5%
4	58.8%	47.0%	45.0%	27.8%	15.9%	14.1%	9.5%	8.3%	6.0%	8.5%	7.7%	6.1%	6.8%	4.6%	3.6%	3.0%	2.7%	1.9%	1.5%	0.6%
5	68.0%	57.0%	47.8%	30.9%	21.8%	16.6%	13.4%	13.4%	10.4%	10.8%	10.2%	10.2%	8.4%	6.2%	5.0%	3.7%	3.7%	2.8%	2.3%	0.6%
6	75.7%	63.5%	48.8%	31.3%	25.5%	17.9%	17.8%	18.5%	16.7%	12.9%	12.6%	12.4%	10.5%	7.7%	6.7%	4.9%	4.8%	3.2%	2.2%	1.1%
7	81.2%	65.4%	47.9%	34.2%	28.8%	18.7%	23.5%	24.8%	21.3%	15.5%	12.6%	15.8%	10.6%	8.9%	8.7%	4.7%	5.0%	3.6%	3.5%	1.9%
8	83.9%	73.3%	50.6%	35.6%	33.0%	19.5%	28.9%	31.7%	26.3%	20.9%	16.6%	19.9%	9.6%	9.4%	6.8%	4.5%	3.4%	1.9%	2.6%	1.9%
9+	91.6%	76.0%	52.3%	38.4%	37.1%	22.4%	40.6%	43.5%	45.8%	27.8%	20.2%	26.0%	15.1%	18.9%	12.5%	7.0%	5.5%	3.3%	4.5%	2.0%

Source: Sollis Clarity Partners

The presence of multi-morbidity of long-term conditions manifests in multiple ways including a rise in A&E attendances, Non-elective or emergency admissions to hospital, repeated attendance to the GP, a rise in sickness absence and an impact on overall mental wellbeing (Table 2**).**

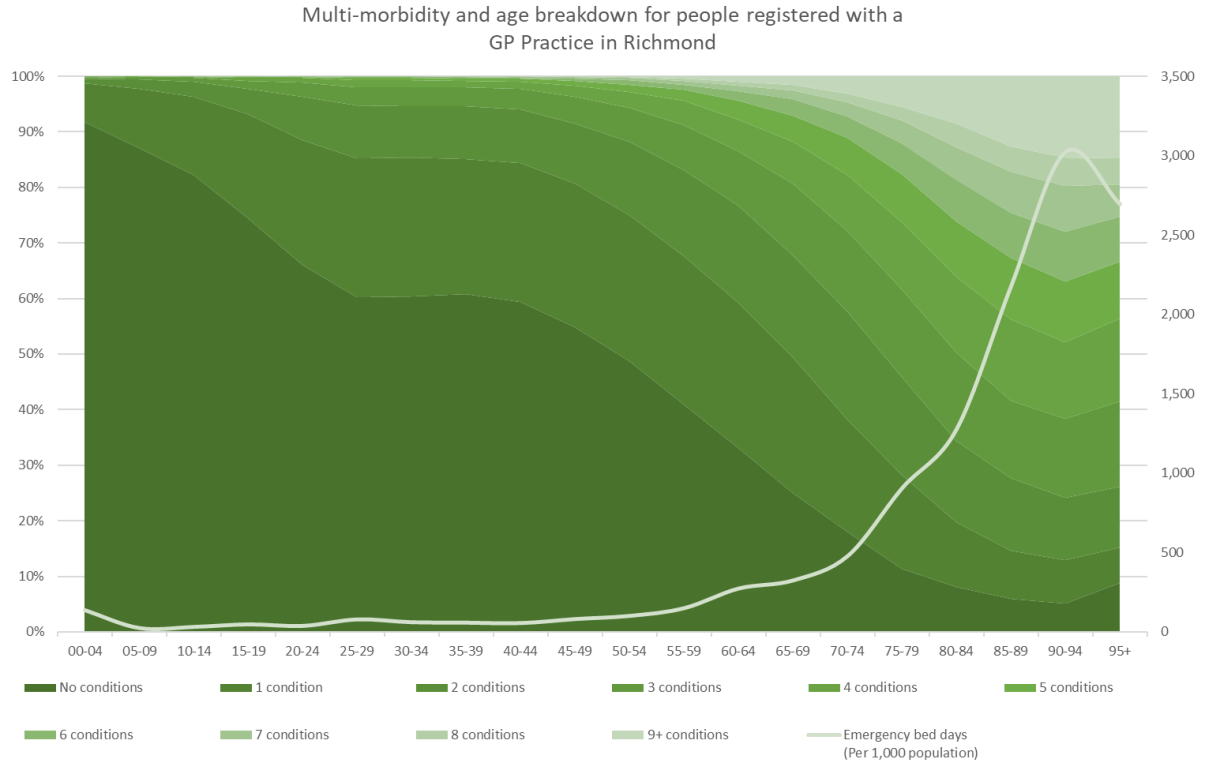
Table 2: Correlation between unidentified long-term conditions and hospital attendances

Average Activity Per Person Regstered with a Richmond Practice	All Ages			00 - 19 years			20 - 64 years			65 + years		
	A&E Attendances	Emergency Admissions	Emergency Bed Days	A&E Attendances	Emergency Admissions	Emergency Bed Days	A&E Attendances	Emergency Admissions	Emergency Bed Days	A&E Attendances	Emergency Admissions	Emergency Bed Days
No Conditions	0.25	0.10	0.71	0.39	0.11	0.71	0.18	0.09	0.70	0.15	0.09	0.87
Single Condition	0.32	0.14	1.03	0.56	0.18	1.04	0.29	0.13	1.05	0.24	0.17	0.90
Condition +1	0.42	0.19	1.25	0.80	0.27	1.19	0.41	0.18	1.15	0.34	0.19	1.63
Condition +2	0.51	0.28	1.69	1.02	0.49	1.77	0.55	0.24	1.52	0.41	0.33	1.92
Condition +3	0.67	0.35	2.17	1.96	0.47	2.21	0.80	0.30	2.07	0.51	0.40	2.28
Condition +4	0.83	0.43	2.60	1.42	0.61	1.36	0.98	0.42	2.66	0.72	0.44	2.62
Condition +5	1.06	0.47	3.04	2.46	0.70	3.38	1.46	0.45	2.90	0.87	0.48	3.12
Condition +6	1.19	0.57	3.23	0.30	5.33	2.94	1.60	0.51	2.58	1.06	0.59	3.53
Condition +7	1.48	0.64	4.15	3.25	0.54	1.00	1.78	0.56	2.75	1.38	0.67	4.63
Condition +8 +	2.41	0.78	4.88	1.00	1.00	0.83	3.34	0.73	4.40	2.27	0.79	4.99
Grand Total	0.36	0.23	2.42	0.43	0.14	0.98	0.29	0.18	1.79	0.52	0.46	3.64

Source: Sollis Clarity Partners

The information in **Table 2** above and **Table 3** below shows that it is the presence of multi-morbidity and therefore complexity of a person's condition that drives higher usage of hospital attendances and the number of bed days once a person is admitted, and not necessarily increased age alone. In all age categories those with a higher number of conditions will attend hospital more frequently and stay longer once admitted.

Table 3: Multi-morbidity by age in Richmond



Source: Sollis Clarity Partners

Within Richmond the identification of long-term conditions is managed by primary care through a suite of locally commissioned services aimed at the detection of specific conditions, there are schemes in place to:

- Increase identified prevalence of COPD
- Encourage the optimum identification and management of patients with diabetes in primary care
- Identification of people with atrial fibrillation

The community provider works to support primary care through the community respiratory and diabetes clinics, and the specialist heart failure nurses to optimise the management of people with long-term conditions and to support education and training for people to manage their own long-term conditions.

1.2 Services and Plans in Richmond

Richmond has a predominantly white population, and it is this cohort that has the highest detected prevalence of long-term conditions and specifically within the 15–64 age groups, this information correlates with the age profile of attendance to hospital.

Current services are not as joined up as they need to be which can lead to fragmentation of pathways of care, people not being actively managed or followed up in a timely manner resulting in exacerbation and disease progression.

Addressing long-term conditions in Richmond

Richmond's model of care supports the development of healthy behaviours and lifestyles that enable the population to make choices within a healthy community environment facilitated by the wider determinants of health. It aims to empower people to self-manage any long-term health conditions, maintain independence and an enjoyable lifestyle within the parameters of disease and to prevent the progression of disease into complexity and frailty.

We will underpin our model with the use of technology and work with our partners in health, social care and the voluntary sector to maximise resources and opportunities.
The approach is through a framework of ***Prevent; Detect; Manage; Optimise***

Prevent

To target weight management and support people to make healthy lifestyle choices by maximising the public health offer to the at-risk groups starting early in life to build good habits.
Supporting mental health and wellbeing recognising the connectivity between a person's mental and physical health specifically in relation to stress and anxiety

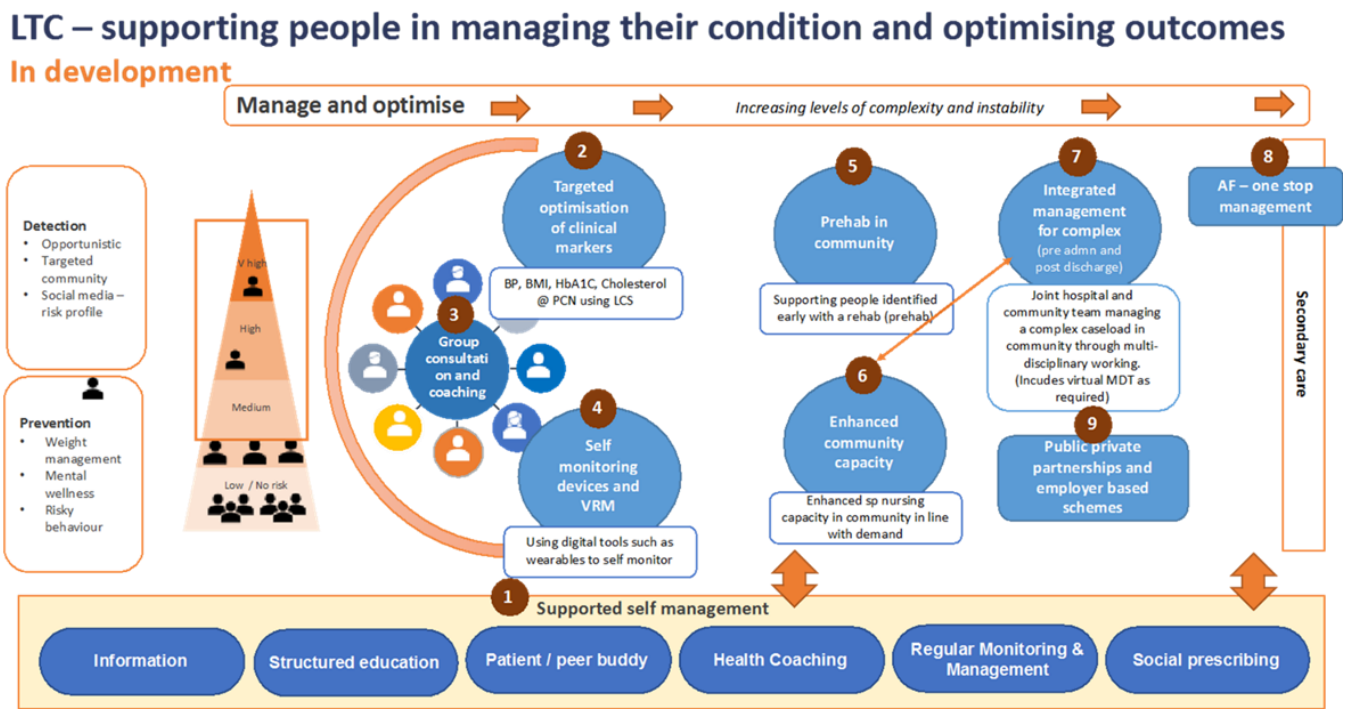
Detect

Develop a service for active opportunistic identification of people at risk of developing a long-term condition or those who are undiagnosed working with community pharmacies/ optometrists etc.
Optimise the impact and opportunity for finding people with an undiagnosed long-term condition through existing annual health checks
Opportunistic screening of identified cohorts of people who may be hard to reach or vulnerable to developing a long-term condition and may not be picked up through traditional methods of detection.

Manage

Develop a model of supported self-management whereby a person with a newly diagnosed long-term condition will be assessed as to their motivation levels, has a care plan developed and then has access to a range of interventions to enable them to self-manage their condition, i.e. information, structured education, buddying, health coaching regular monitoring and social prescribing (**Figure 4**).

Figure 4: Proposed model of care for LTCs



Source: SWLCCG

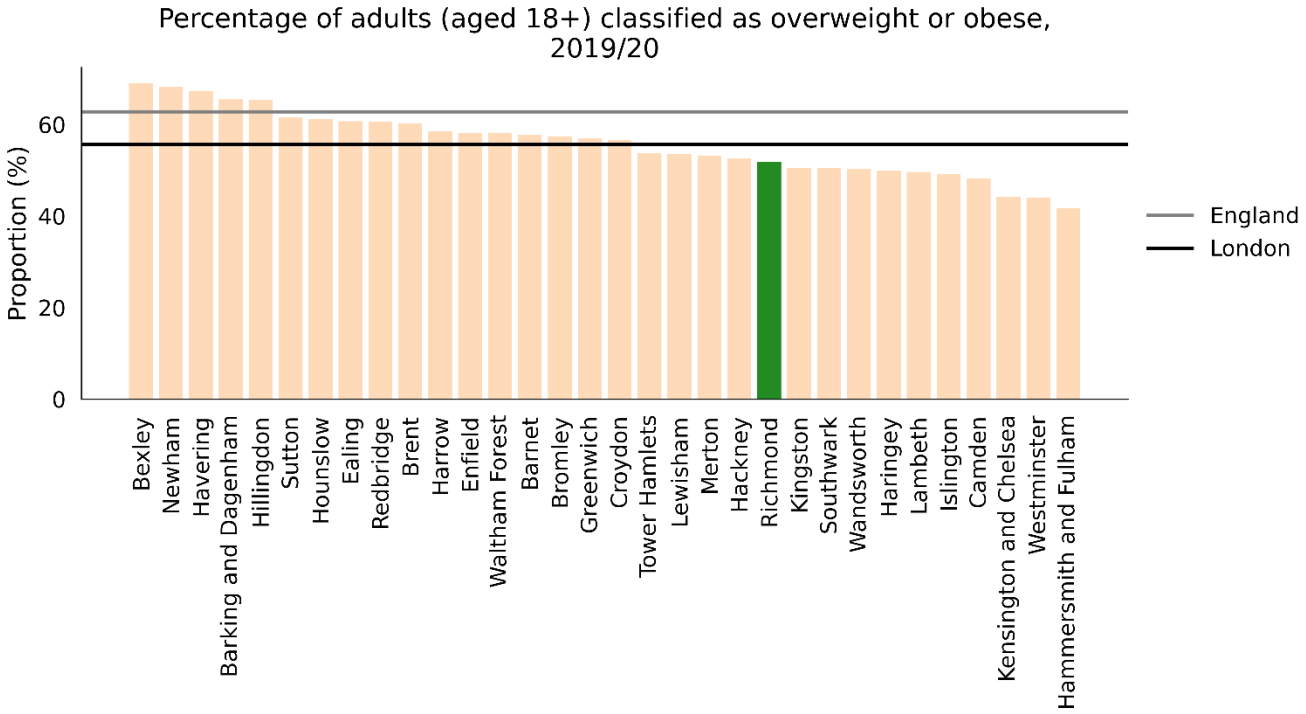
2. Obesity

Obesity is a modifiable risk factor for several long term conditions. Obesity is one of the key behavioural risk factors that the NHS health checks assesses.

2.1 Prevalence

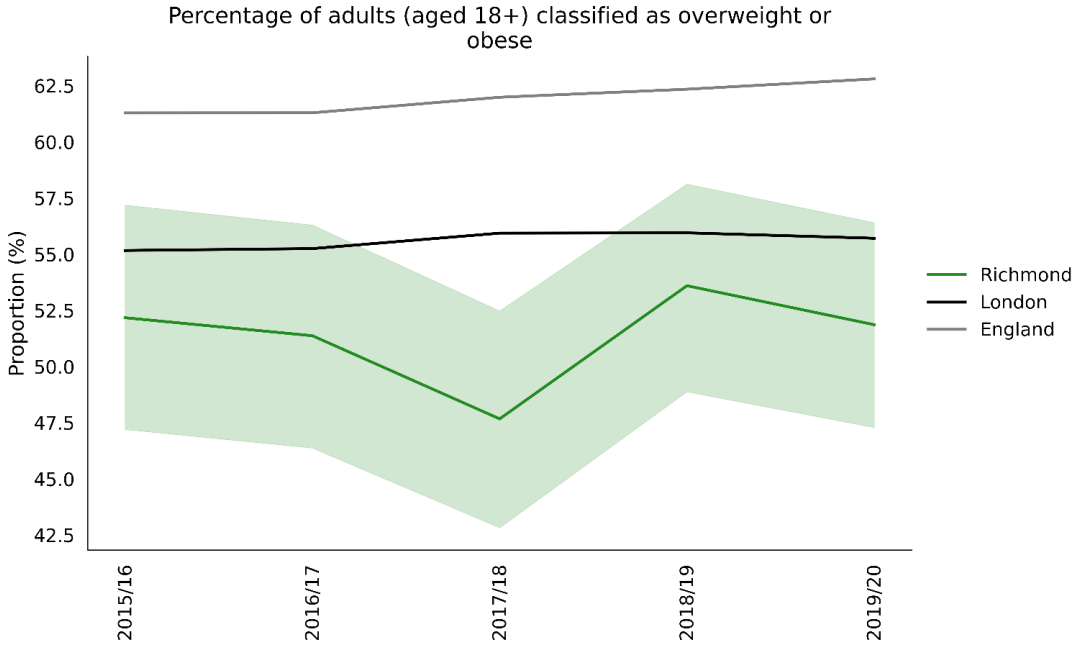
In 2019/20, Richmond's percentage of adults (aged 18+) classified as overweight or obese was 51.9%, which is the 11th lowest rate in London (**Figure 5**) , 17.4% lower than the England average and 6.9% lower than the London average. The latest Borough figure was also 0.6% lower than in 2015/16, in comparison with a 2.5% increase in England's rate in the equivalent time period (**Figure 6**).

Figure 5: Proportion of obese or overweight adults by local authority, 2019/20



Source: PHE Public Health Profiles

Figure 6: Proportion of obese or overweight adults, 2016–2020



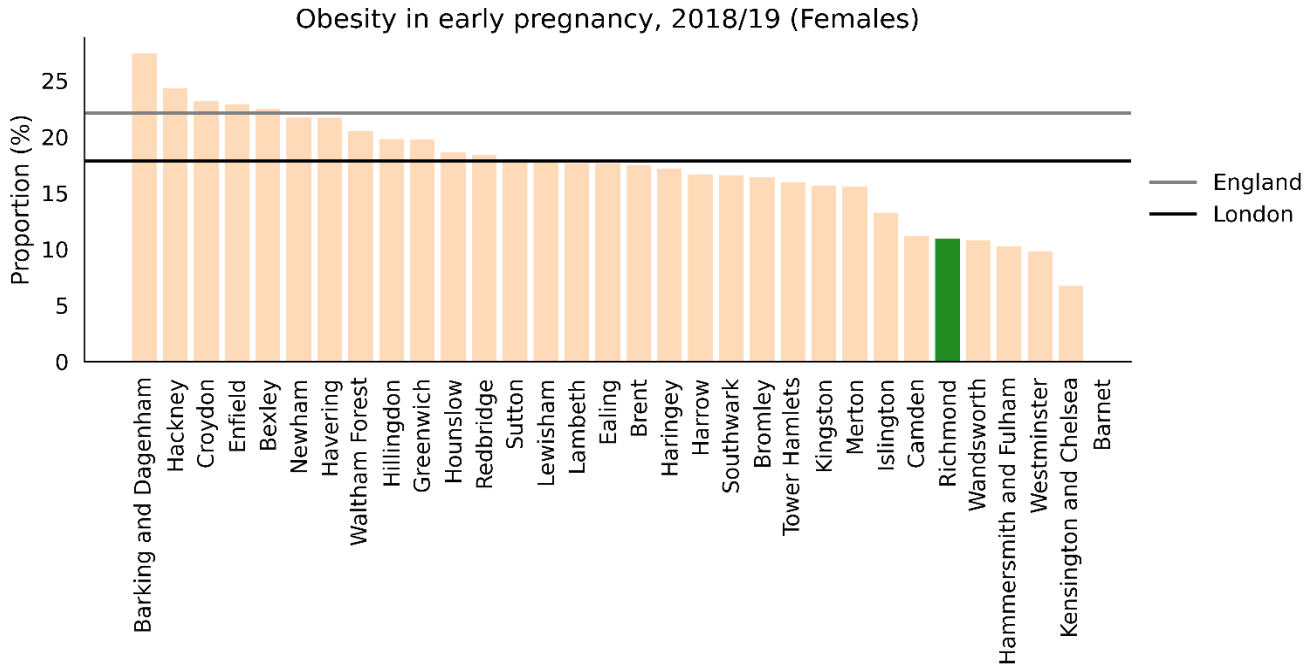
**- green ribbon shows 95% confidence interval around Wandsworth's indicator values*

Source: PHE Public Health Profiles

2.2 Obesity in early pregnancy

In 2018/19, Richmond's obesity prevalence in early pregnancy was 10.9%, which is the 5th lowest rate in London (**Figure 7**), 50.5% lower than the England average and 38.6% lower than the London average. No time trend information is available for this indicator.

Figure 7: Prevalence of obesity in early pregnancy by local authority, 2019/20



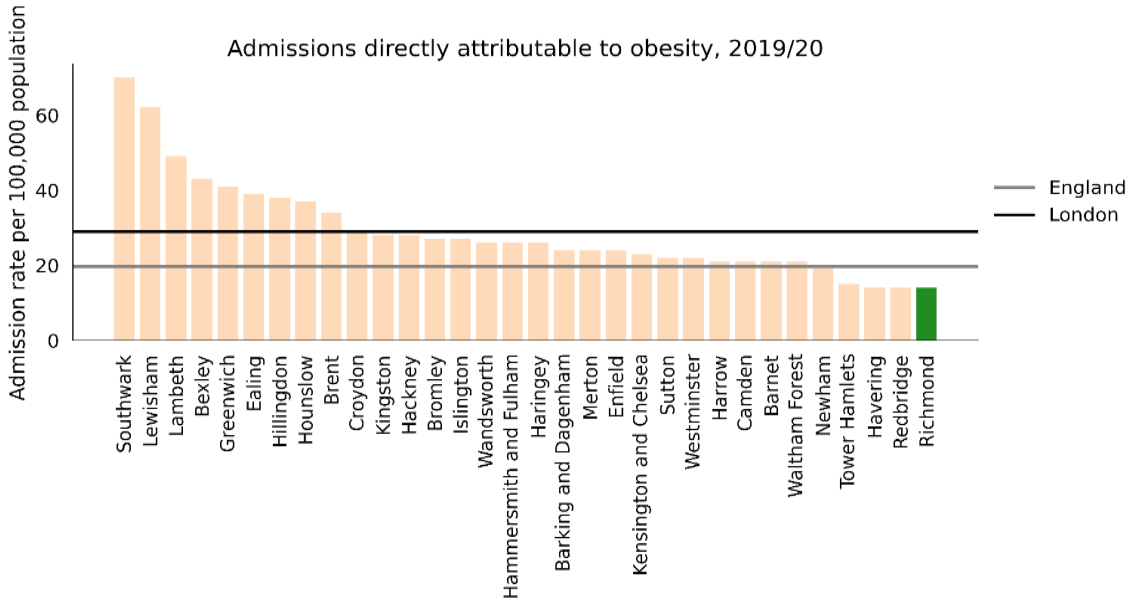
Source: PHE Public Health Profiles

2.3 Hospital Admissions for Obesity

Admissions directly attributable to obesity

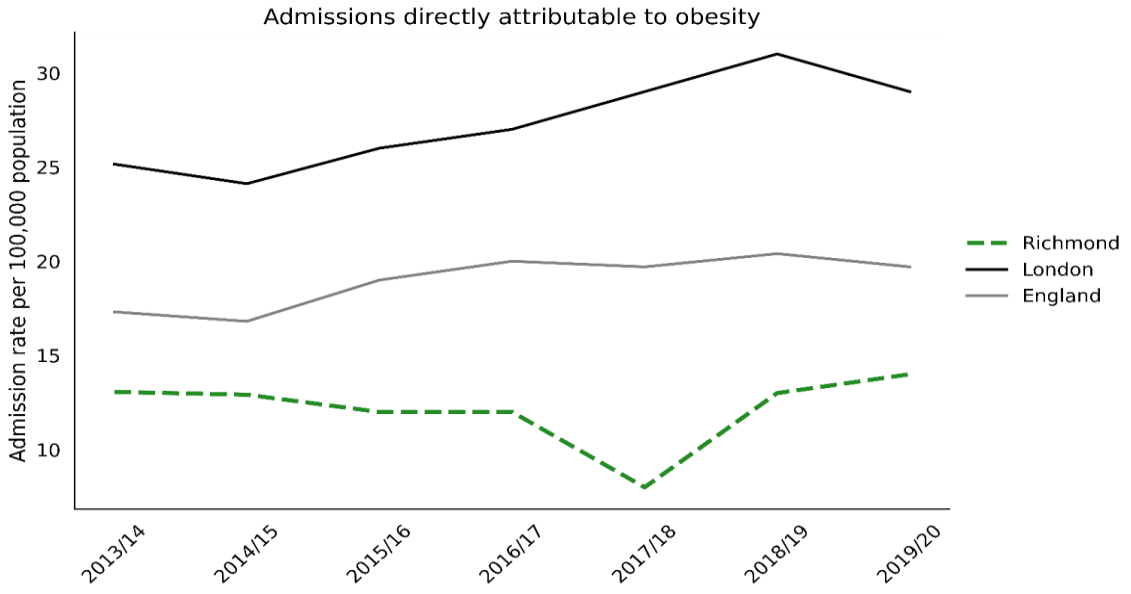
In 2019/20, Richmond's rate hospital admissions directly attributable to obesity was 14.0 per 100,000 population, which is the lowest rate in London (**Figure 8**) , 28.9% lower than the England average and 51.7% lower than the London average. The latest Borough figure was also 7.2% higher than in 2013/14, in comparison with a 13.8% increase in England's rate in the equivalent time period (**Figure 9**).

Figure 8: Admissions with obesity in primary diagnostic field by local authority, 2019/20



Source: NHS Digital Statistics on Obesity, Physical Activity and Diet

Figure 9: Admissions with obesity in primary diagnostic field, 2014–2019

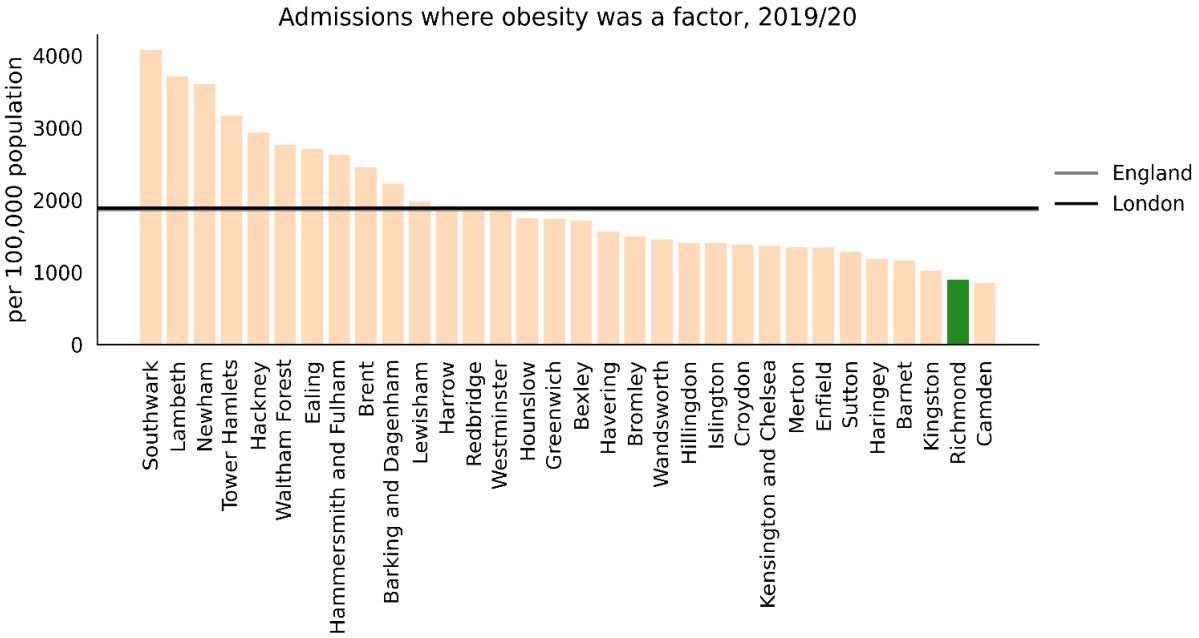


Source: NHS Digital Statistics on Obesity, Physical Activity and Diet

Admissions where obesity was a factor

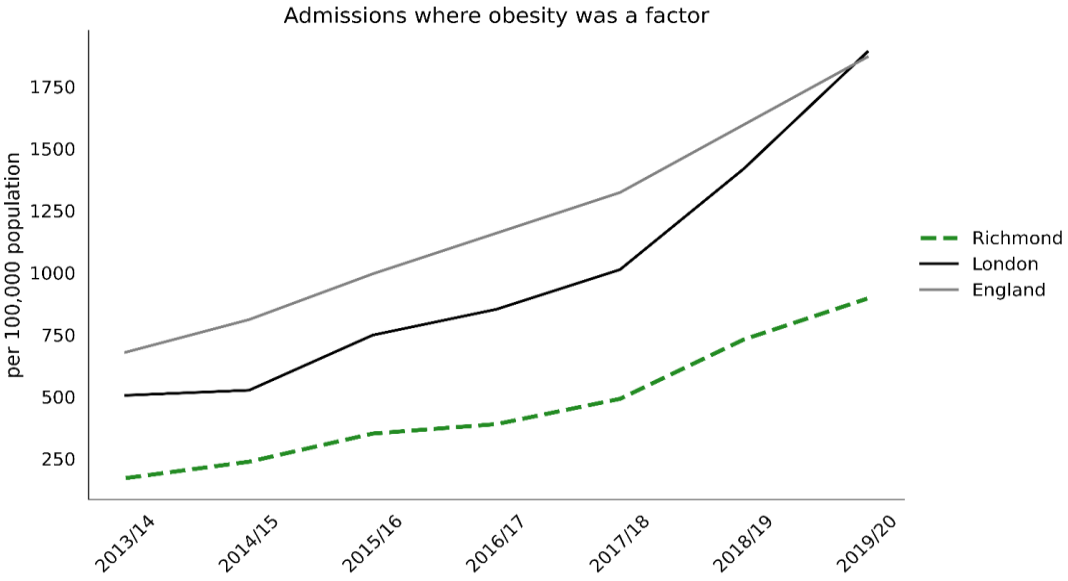
In 2019/20, Richmond's rate of admissions where obesity was recorded anywhere in the diagnostic fields was 895.0 per 100,000 population, which is the 2nd lowest rate in London (**Figure 10**) , 52.1% lower than the England average and 52.6% lower than the London average. The latest Borough figure was also 422.2% higher than in 2013/14, in comparison with a 175.4% increase in England's rate in the equivalent time period **Figure 11**).

Figure 10: Admissions with obesity mentioned in either primary or secondary diagnostic fields by local authority, 2019/20



Source: NHS Digital Statistics on Obesity, Physical Activity and Diet

Figure 11: Admissions with obesity mentioned in either primary or secondary diagnostic fields, 2014–2020

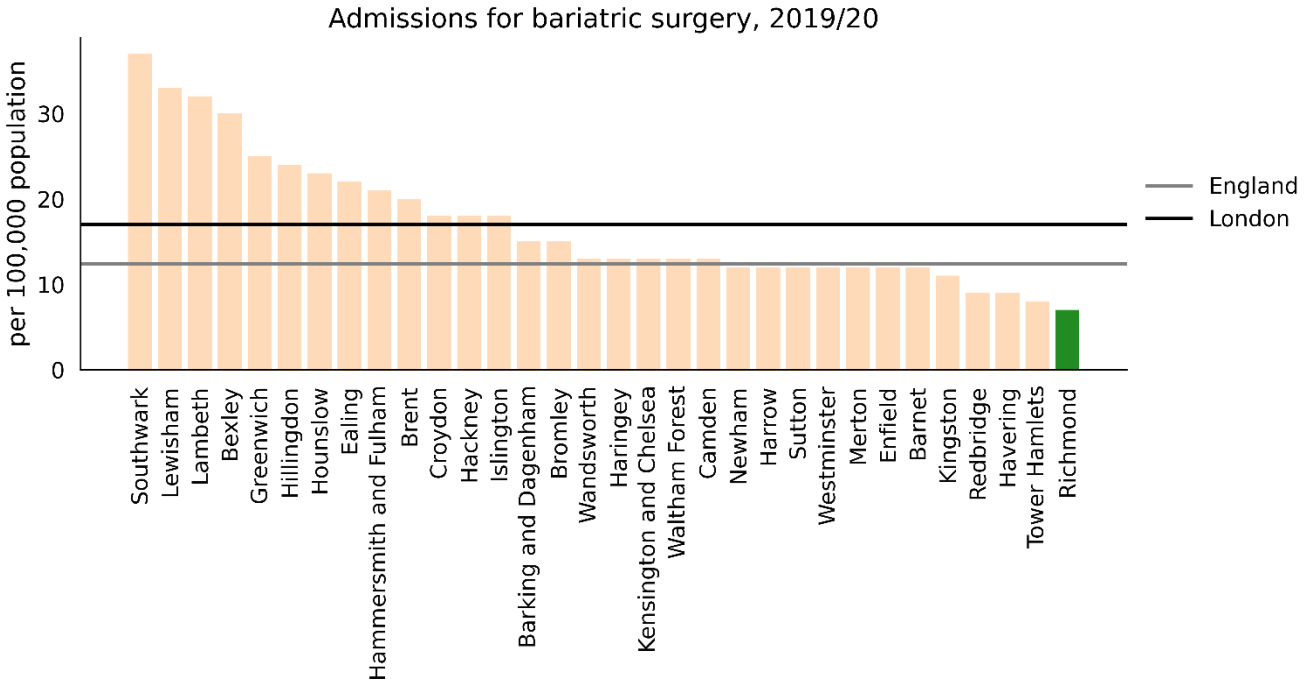


Source: NHS Digital Statistics on Obesity, Physical Activity and Diet

Bariatric surgery admissions

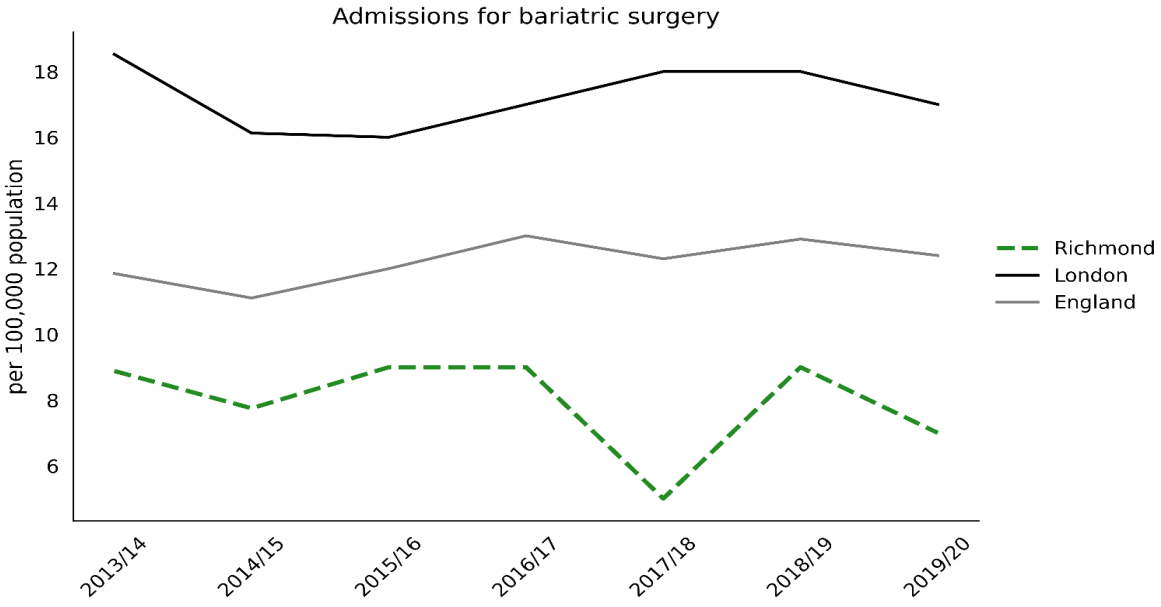
In 2019/20, Richmond's rate of admissions for bariatric was 7.0 per 100,000 population, which is the lowest rate in London (**Figure 12**) , 43.5% lower than the England average and 58.8% lower than the London average. The latest Borough figure was also 21.2% lower than in 2013/14, in comparison with a 4.6% increase in England's rate in the equivalent time period **(Figure 13**).

Figure 12: Admissions for bariatric surgery by local authority, 2019/20



Source: NHS Digital Statistics on Obesity, Physical Activity and Diet

Figure 13: Admissions for bariatric surgery, 2014–2020



Source: NHS Digital Statistics on Obesity, Physical Activity and Diet

3. Cardiovascular Disease

In this section the latest available Richmond-level information on prevention, prevalence, primary care management, hospitalisations and mortality linked to cardiovascular conditions will be explored. This national programme for adults in England aged 40 to 74 is designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia. An NHS Health Check helps find ways to lower this risk. The NHS Health Check programme has a clear role in delivering preventative and personalised solutions to ill-health, and empowering individuals to live healthier and more active lives.

Cardiovascular Disease, CVD, includes a group of diseases of the heart or blood vessels. The list of specific diseases within the CVD classification include coronary heart disease (CHD), myocardial infarction (heart attack), angina, coronary artery diseases and stroke. Primary prevention of CVD requires that patients at risk are identified before disease has become established. People with hypertension are at high risk of developing CVD; controlling blood pressure is therefore a significant factor that protects the patient from developing serious circulatory conditions.

3.1 NHS Health Checks

The NHS Health Checks Programme is a mandated service under the Health and Social Care Act (2012). Local Authorities have a legal duty to invite 100% of its eligible population over a 5-year period and to deliver NHS Health Checks to 50%. The annual local targets translate to 20% invites and 10% NHS Health Checks. The programme is a systematic vascular risk assessment and management programme that aims to prevent heart disease, stroke, diabetes and kidney disease, and raise awareness of dementia both across the population and within high risk and vulnerable groups. It helps people to take action to avoid, reduce or manage their risk of developing these conditions as well as opportunities to make progress in tackling health inequalities, including socio-economic, ethnic and gender inequalities.

Public Health England estimate that the NHS Health Check Programme could, on average, prevent 1,600 Heart Attacks and Strokes and save at least 650 lives each year as well as prevent over 4,000 people a year from developing diabetes and detect at least 20,000 cases of diabetes or kidney disease earlier, allowing individuals to be better managed and improve their quality of life. It achieves this by assessing the top seven risk factors driving the burden of non- communicable disease in England and by providing individuals with behavioural support and, where appropriate, pharmacological treatment.

Aims and Delivery Model

The NHS Health Checks programme aims to prevent heart disease, stroke, diabetes, and kidney disease and raise awareness of dementia both across the local population and within high risk and vulnerable groups[1].
It also helps people to take action to avoid, reduce or manage their risk of developing these conditions as well as opportunities to make progress in tackling health inequalities, including socio-economic, ethnic and gender inequalities.

The service is available to individuals between 40 and 74 years of age without existing cardiovascular disease (CVD). Invitations can be prioritised for residents who are estimated to have a high CVD risk score (Q-risk)[2].
The aims of the NHS Health Check programme are to offer an NHS Health Check to 20% of the eligible population every year as part of a 5-year rolling programme with an uptake level of 50%:

- To reduce the prevalence of CVD
- To narrow health inequalities in premature death from these vascular related conditions.

In Richmond 25 GP Surgeries and 2 pharmacies are contracted to deliver NHS Health Checks. Activity data is automatically extracted from GP surgeries clinical data system Vision Plus and from pharmacies via Pharmoutcomes.

Demographics of service users accessing the service via GP surgeries during 2019/20:

- 46.20% were aged between 40–50
- 27.9% were aged between 51–60
- 17.5% were aged between 61–74
- 57% were female
- 40.6% were male
- 53.7% were BAME
- 1.3% were Mental Health Patient
- 0.2% were learning disability patients
- 0.7% were carers[3]

Demographics of service users accessing the service via pharmacies during 2019/20:

- 49% were aged between 40–50
- 28% were aged between 51–60
- 23% were aged between 61–74
- 62% were Female
- 11 were BAME
- 45% were Male[4]

The data shows that during 2019/20, females were more likely to access an NHS Health Check than males. The majority of service users (46% GP surgeries, 49% pharmacies) were aged 40–50. The BAME population is slightly overrepresented in comparison with the borough profile for age range. However, there is a data quality issue with ethnicity not being recorded in nearly one third of all consultations.

[1] NHS Health Checks, accessed online, 2020
[2] QRisk is a prediction algorithm for cardiovascular disease that uses traditional risk factors together with body mass index, ethnicity, measures of deprivation, family history and clinical values
[3] Vision Plus, data accessed securely online, 2020
[4] Pharmoutcomes, data accessed securely online, 2020

During 2019/20 the Richmond NHS Health Check programme outcomes included:

- 23 service users were diagnosed diabetic
- 52 service users were identified with a high QRISK score (>20%)
- 69 service users were diagnosed hypertensive
- 4 service users were diagnosed with chronic kidney disease (CKD)[5]

Referrals from an NHS Health Check to lifestyle support services during 2019/20 included:

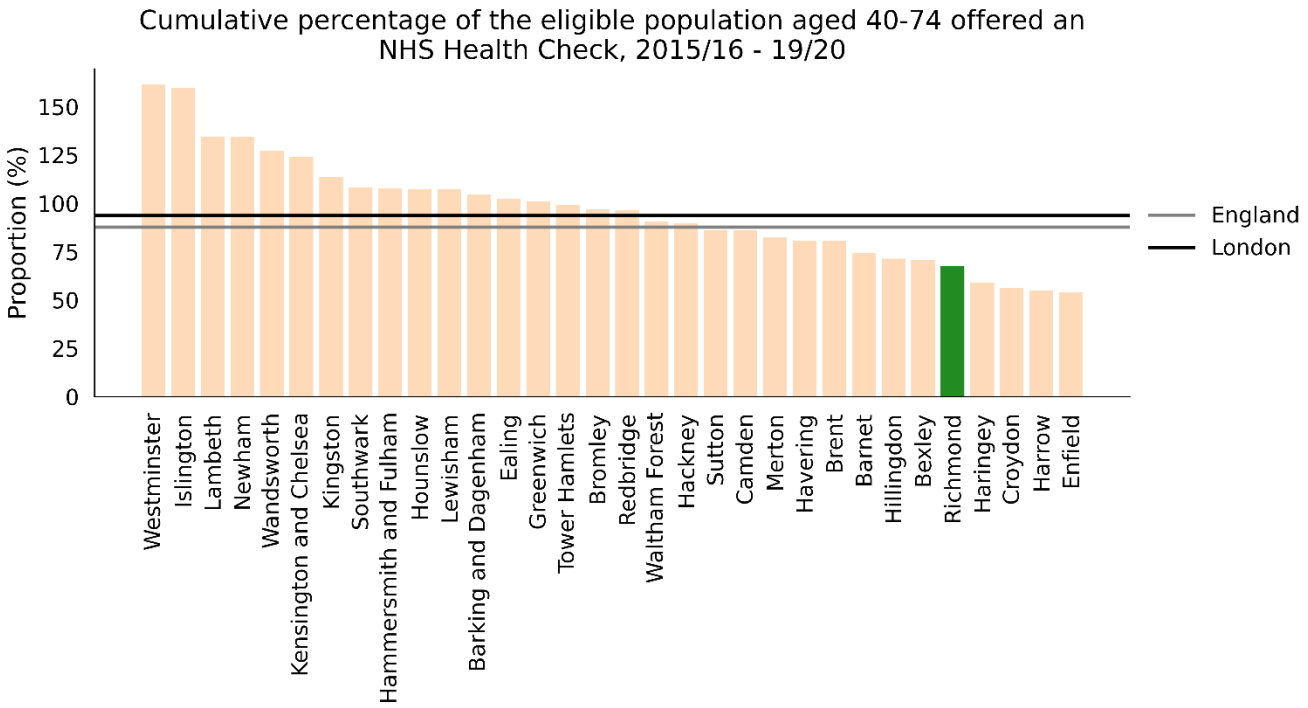
- 59 service users were referred to the National Diabetic Prevention Programme (NDPP)[6]
- 17 service users were referred to exercise on referral programme
- 32 service users were referred to the Health Walks programme
- 19 service users referred to weight management programme
- 207 service users were referred to smoking cessation services[7]

In July 2020, The Department of Health and Social Care (DHSC) asked Public Health England (PHE) to carry out an evidence-based review of the NHS Health Check programme. The review will advise Ministers on how NHS Health Checks can evolve in the next decade to maximise the future benefits of the programme in preventing illness and reducing health inequalities. This may include recommendations on the content of NHS Health Checks, how the programme is delivered and how it links to the wider health and social care system.[8]

In 2015/16–19/20, Richmond's cumulative percentage of the eligible population aged 40–74 offered an NHS Health Check was 67.6% (n=41174), which is the 5th lowest rate in London (**Figure 14**) , 22.9% lower than the England average and 27.7% lower than the London average. The latest Borough figure was also 11.8% lower from 2013/14–17/18, in comparison with a 3.5% decrease in England's rate in the equivalent time period (**Figure 15**).

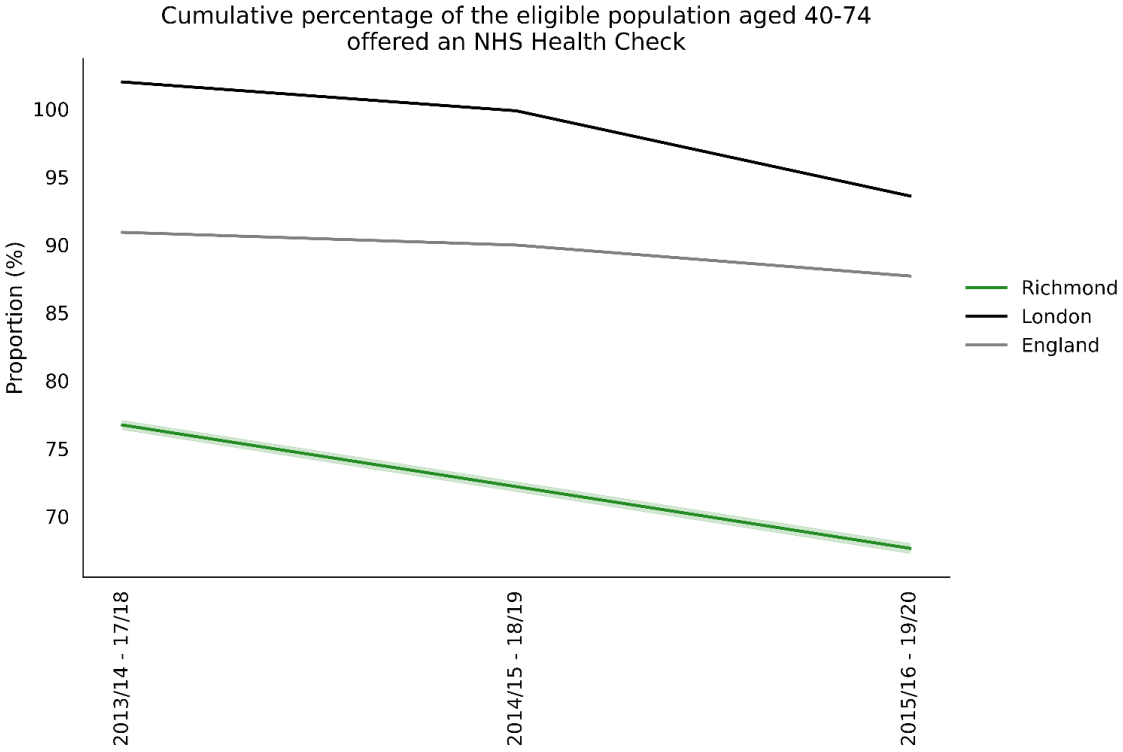
[5] Vision Plus, Search and Report, accessed securely online, 2020
[6] Q-Diabetes is a risk prediction algorithm which calculates an individual's risk of type 2 diabetes taking account of their individual risk factors such as age, sex, ethnicity, and clinical values
[7] Vision Plus, Search and Report, accessed securely online, 2020
[8] NHS Health Check Programme Review, accessed online, 2020

Figure 14: Cumulative percentage of the eligible population aged 40–74 offered an NHS Health Check, 2015/16–2019/20



Source: PHE Public Health Profiles

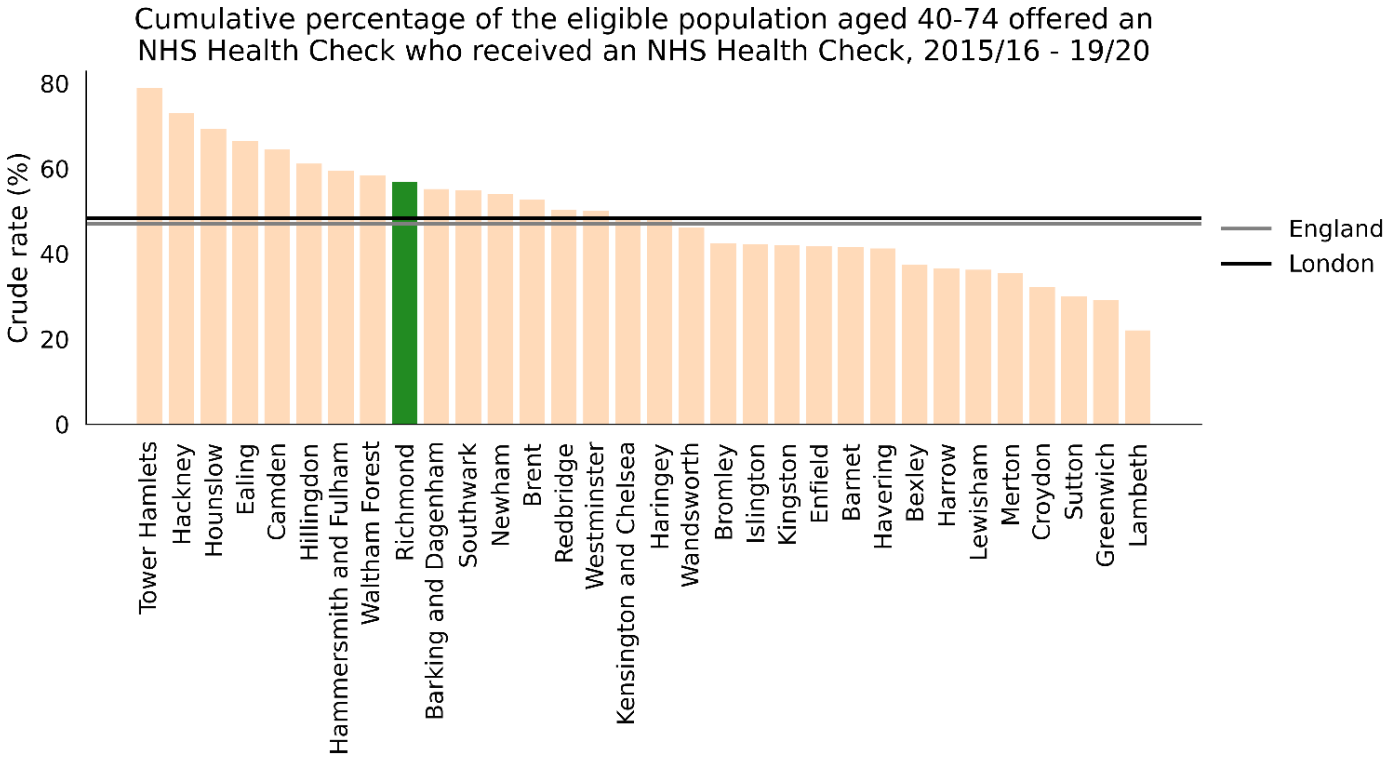
Figure 15: Cumulative percentage of the eligible population aged 40–74 offered an NHS Health Check, 2018–2020



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

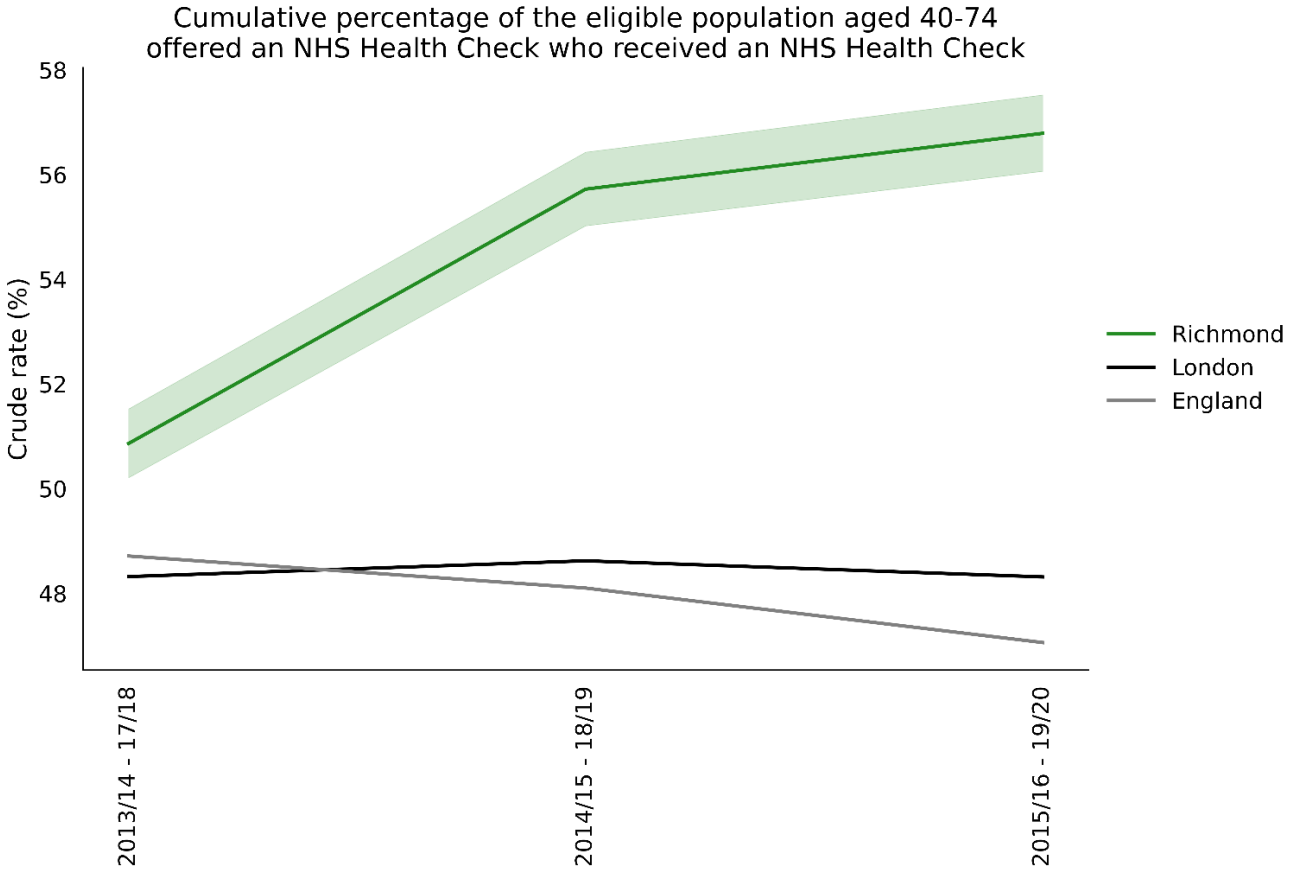
In 2015/16–19/20, Richmond's cumulative percentage of the eligible population aged 40–74 offered an NHS Health Check who received an NHS Health Check was 56.8% (n=23380), which is the 9th highest rate in London (**Figure 16**), 20.7% higher than the England average and 17.5% higher than the London average. The latest Borough figure for 2015/16–19/20 was also 11.6% higher from 2013/14–17/18, in comparison with a 3.4% decrease in England's rate in the equivalent time period (**Figure 17**).

Figure 16: Cumulative percentage of the eligible population aged 40–74 offered an NHS Health Check who received and NHS Health Check by local authority, 2016–2020



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

Figure 17: Cumulative percentage of the eligible population aged 40–74 offered an NHS Health Check, 2018–2020



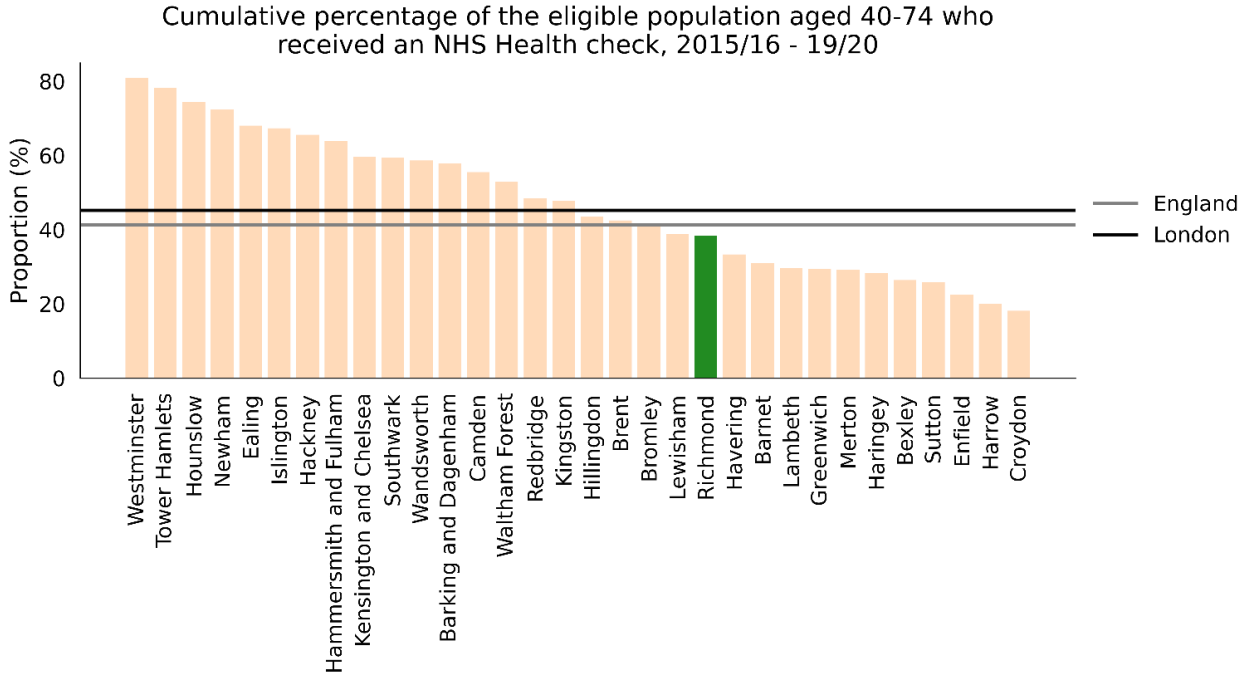
**- Definition: The rolling 5-year cumulative percentage of the eligible population aged 40–74 who received an NHS Health check*

**- green ribbon shows 95% confidence interval around Richmond's indicator values*

Source: PHE Public Health Profiles

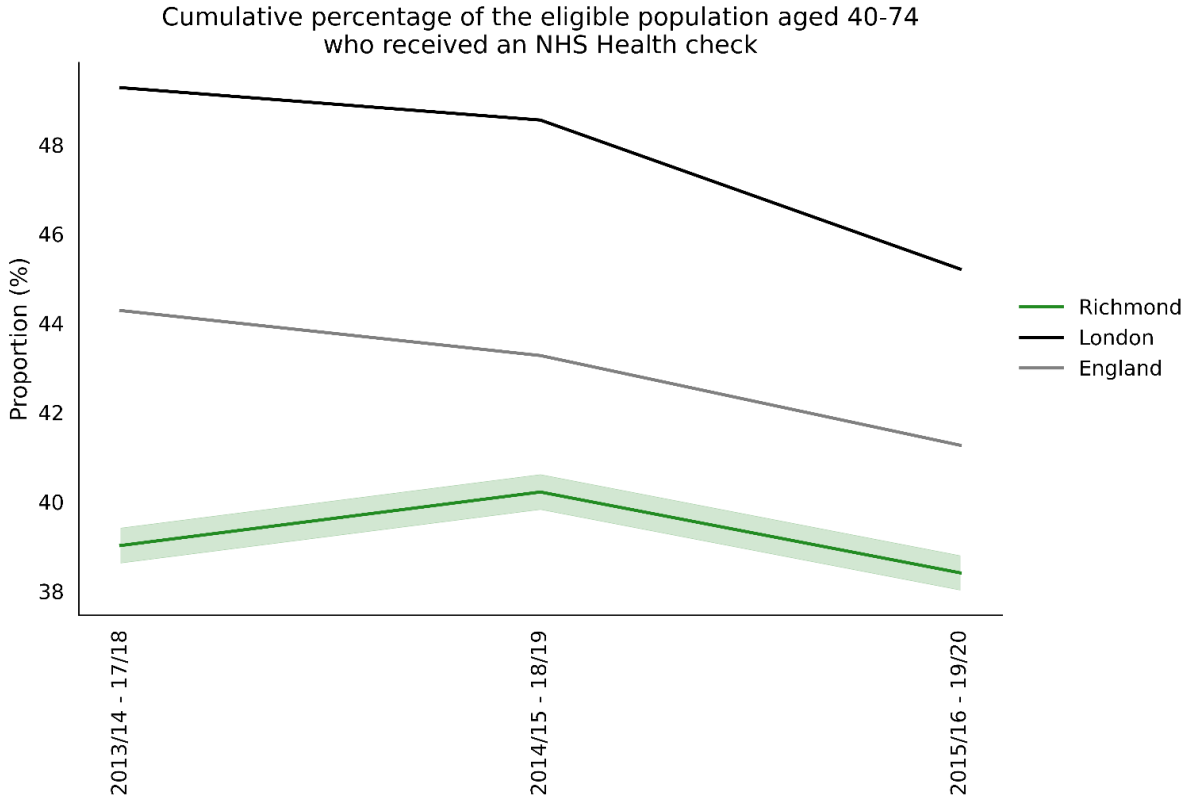
In 2015/16–19/20, Richmond's cumulative percentage of the eligible population aged 40–74 who received an NHS Health Check. was 38.4% (n=23380), which is the 12th lowest rate in London (**Figure 18**) , 6.9% lower than the England average and 15.1% lower than the London average. The latest Borough figure was also 1.6% lower from 2013/14–17/18, in comparison with a 6.8% decrease in England's rate in the equivalent time period (**Figure 19**).

Figure 18: Cumulative percentage of the eligible population aged 40–74 who received an NHS Health Check by local authority, 2015/16 – 2019/20



Source: PHE Public Health Profiles

Figure 19: Cumulative percentage of the eligible population aged 40–74 who received NHS Health Check, 2018–2020



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

NHS Health Checks Programme -diabetes risk assessment

The NHS Health Checks programme provides cardiovascular risk assessments for people between the ages of 40 and 74 years and are an important part of type 2 diabetes prevention and diagnosis. The NHS Health Checks programme includes a diabetes risk assessment or filter, which should lead onto blood testing for those identified at risk. Those people identified with NDH following their blood test should be offered a referral to the NDPP and other lifestyle support services. People identified as having diabetes are managed through the diabetes care pathway through primary care.

In 2019/20, Richmond completed 5187 NHS Health Checks; 23 of these people were diagnosed with diabetes and 59 people were referred to the NDPP. Nationally, it is estimated that Health Checks could prevent 4,000 people a year from developing diabetes[9] and for every 80 – 200 NHS Health Checks, 1 person is diagnosed with type 2 diabetes (1.25%–0.5% of checks).[10] Richmond was lower than this range with 0.44% of checks resulting with a diabetes diagnosis.

3.2 Diabetes

Causes of Diabetes

Diabetes is a condition where the amount of glucose (a type of sugar) in the blood is too high. When people do not have Diabetes, their blood sugar levels are controlled by insulin produced in their pancreas. There are many types of Diabetes including Type 1, Type 2, Gestational, and other rarer types of Diabetes. Type 1 diabetes accounts for around 8% of cases, other rarer types of Diabetes accounts for 2%, and type 2 diabetes accounts for 90%.

Type 1 Diabetes develops when the body is unable to produce any insulin. Type 2 diabetes develops when the body stops producing enough insulin or the body's cells stop reacting to the insulin produced. This means that sugar builds up in the blood and can't get into the cells of the body where it's used for fuel.

This section focuses on type 2 diabetes as it is associated with lifestyle factors and can be delayed or prevented through support to change behaviour around lifestyle choices. Other types of Diabetes, such as type 1 diabetes, are not related to lifestyle issues and cannot be prevented.

The number of people developing type 2 diabetes has been increasing globally. Around four million people in the UK have type 2 diabetes and by 2030 it is estimated that there will be more than 5.5 million people with it.[11] This is largely due to the rise in obesity, which is estimated to account for 80–85% of all type 2 diabetes cases in the UK.[12] Being overweight or obese is the major modifiable risk factor for type 2 diabetes.

Impacts of Diabetes

There are many significant impacts on the health and wellbeing of people living with type 2 diabetes in Richmond. Additionally, there are large financial impacts on the NHS and wider social and economic costs due to the rise in type 2 diabetes.

[9] Public Health England, NHS Health Check Best practice guidance, March 2016.
[10] Public Health England, Emerging evidence on the NHS Health Check: findings and recommendations, 2017.
[11] Diabetes UK, Us, Diabetes and a lot of facts and stats, January 2019
[12] Diabetes UK, Us, Diabetes and a lot of facts and stats, January 2019

Premature Mortality

Type 2 Diabetes is a major cause of premature mortality, with around 22,000 people with diabetes dying early each year in England. people with diabetes are more likely to die than their peers of the same age and sex in the general population. In Richmond, the additional risk of death in people with diabetes is 50.9%; for England, the additional risk was 21.8%.[13] In England and Wales, people aged 35 to 64 living with type 2 diabetes are up to two times more likely to die prematurely.[14]

Complications /multi-morbidity

Those who develop type 2 diabetes are subsequently at greater risk of developing complications from the disease:

- CVD including heart attack and stroke – type 2 diabetes leads to an increased risk of CVD. In Richmond, people with diabetes are 164.8% more likely than people without diabetes to have a heart attack, and 62.6% more likely to have a stroke.[15]
- Blindness- leading cause of preventable slight loss among people of working age
- Nerve damage - most often in legs or feet
- kidney disease and failure - diabetes is the leading cause of kidney disease

People with diabetes rarely die as a direct result of diabetes. Most die from complications such as heart disease, stroke and kidney failure.

Diabetic Foot Disease

Diabetic foot disease is a potential consequence of the complication of nerve damage and the complication of peripheral vascular disease. Foot problems are the most frequent reasons for hospitalisation amongst people who have diabetes. Latest figures[16] for Richmond show that between 2015/2016 and 2017/2018, there were 325 hospital spells for diabetic foot disease. The median length of stay in hospital was 7 days and the total number of days spent in hospital for diabetic foot disease was 3,359.

Diabetes is one of the leading causes of amputation of the lower limbs. From 2015/2016- 2017/2018 there were 35 minor amputation procedures (removal of toes or feet) performed in Richmond, giving a directly age and ethnicity standardised rate of 18.7 minor amputations per 10,000 population-year. This was not significantly different to the England average. There were only 6 major amputation procedures (above or below the knee amputation) performed, which was not large enough to calculate a robust standardised rate for comparison to England.

Hospital admissions

People with diabetes are more likely to be admitted to hospital and have longer stays than similar people without the condition. One in six of all people in hospital in England have Diabetes. While Diabetes is often not the reason for admission, they often need a longer stay in hospital, are more likely to be re-admitted, and their risk of dying is higher.

Mental Health

A type 2 diabetes diagnosis can also negatively impact quality of life and social contact, which can have an adverse effect on mental health. people with diabetes are more likely to be diagnosed with Depression.

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[13] Public Health England. Public Health Profiles, Additional risk of death in people with diabetes, 03 Feb 2018.
[14] NHS Digital, National Diabetes Audit 2018-10, Report 2a: Complications and Mortality
[15] Public Health England, CVD Profiles – Diabetes, NHS Richmond CCG, May 2020.
[16] Public Health England, National Cardiovascular Intelligence Network (NCVIN), Diabetes Foot Care Profiles- NHS Richmond CCG, April 2019.

Depression is more prevalent among people living with type 2 diabetes, compared with those who are not. This, as well as many other complications of type 2 diabetes, increases their risk of premature death.

A survey[17] conducted by Diabetes UK also found that:

- 3 in 5 people (64%) living with diabetes experience emotional or mental health problems as a result of their condition
- just 3 in 10 people living with diabetes said they definitely felt in control of their condition
- nearly a third of people living with diabetes had at some point relied on self-help materials
- one in 5 people living with diabetes had used support or counselling from a trained professional to help them manage their Diabetes.

Dementia

There is a close association between type 2 diabetes and dementia, in particular Alzheimer's Disease and Vascular Dementia:[18]

- Type 2 Diabetes is associated with a 60% increase in risk for all-cause Dementia
- Individuals with a longer duration and earlier age of onset of Diabetes have the highest risk
- Women with type 2 diabetes have a greater chance of developing vascular Dementia than men
- There is a 56% increased risk of developing Alzheimer's Disease in individuals with type 2 diabetes but also people with Alzheimer's Disease have an increased risk of developing type 2 diabetes and impaired glucose tolerance

Social Consequences

In addition to mental health and quality of life, the important social consequences of type 2 diabetes include impacts on individuals' family life, education and employment. These are wider consequences that are just as important as health outcomes, as they have far-reaching impacts.

Inequalities

Certain Black, Asian and minority ethnic (BAME) groups have a greater chance of developing type 2 diabetes than people from White ethnic groups. The South Asian population living in the UK are up to six times more likely to develop type 2 diabetes than that of the white population.[19] People of African and African-Caribbean descent are three times more likely to have type 2 diabetes than the white population.[20] In Richmond, nearly 22% of people with type 2 diabetes are of ethnic minority origin.[21]

Costs

Diabetes treatment currently accounts for around 10 per cent of the annual NHS budget. This is just under £10 billion a year, with 80% spent on managing preventable complications associated with the condition, and 20% on treatment (e.g. primary care and prescribing).

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[17] Diabetes UK, Engaging People with diabetes in the Future of Diabetes project: Methodology and summary of findings, November 2017.
[18] TREND-UK, For Healthcare professionals: Diabetes and Dementia: Guidance on Practical Management, 2018.
[19] Public Health England, Health Matters: preventing type 2 diabetes, 24 May 2018
[20] Public Health England, Health Matters: preventing type 2 diabetes, 24 May 2018
[21] Public Health England. Public Health Profiles, Percentage of people with type 2 diabetes who are of minority ethnic origin, 08 January 2019.

In 2018/19, costs for diabetes drugs for Richmond CCG amounted to £1,778,198.6.[22] Diabetes prescriptions made up 12.5% of the total cost of prescribing in England during 2018/19. There are also major indirect costs, such as loss of productivity due to increased death and illness and the need for social care.

COVID-19 impact on Diabetes

People with underlying health conditions, such as Diabetes are at a higher risk of poor outcomes from COVID-19 than people without these conditions. Recent national data reviews[23] show that Diabetes was mentioned on 21% of death certificates where COVID-19 was also mentioned. People with type 2 diabetes are twice as likely to die than people who don't have Diabetes when in hospital with COVID-19.

BAME groups are also at an increased risk of death from COVID-19. The proportion where Diabetes was mentioned on death certificates was higher in all BAME groups when compared to White ethnic groups and was 43% in the Asian group and 45% in the Black group.

Due to lockdown periods, many people will have been less physically active, have unhealthier diets, and not accessing healthcare and lifestyle services as usual. Some people with non-diabetic hyperglycemia (high risk of Type 2) may now have Diabetes. There may be a greater number of people living with undiagnosed Diabetes following COVID-19.

As people with diabetes can be more vulnerable to becoming seriously ill from COVID-19, it is important to continue to identify people at risk of or living with undiagnosed Diabetes. Prevention work to improve the health and fitness of people, through activities such as exercise, eating well, losing weight and stopping smoking, will help to minimise the health impact of COVID-19. People at high risk of Diabetes should be offered effective support (e.g. Diabetes Prevention Programme) and they should be monitored for progression to Diabetes, which will support early diagnosis.

Type 2 Diabetes

Risk of type 2 diabetes

The risk of type 2 diabetes is about the chance or likelihood of developing type 2 diabetes over a period of time. A person's level of risk depends on a combination of factors including genetics, which cannot be changed, and preventable lifestyle factors, with risk levels varying over the life course. Risk can be reduced in the universal population through population and community interventions on healthy eating and physical activity throughout pregnancy, infancy, childhood, adulthood. Many people will have low risk for type 2 diabetes by maintaining a healthy lifestyle.

Risk increases with a change in lifestyle factors, such as obesity, as well as with age. People at increased risk are likely to not be aware as they may not have symptoms. Without changes to lifestyle, the risk of type 2 diabetes can progress, leading people to become high risk for developing type 2 diabetes. People are at high risk of developing type 2 diabetes if their blood sugars are raised, but not high enough to be diagnosed with type 2 diabetes. They are also at increased risk of other cardiovascular conditions.[24]

[22] NHS Digital, Prescribing for Diabetes in England 2008/09–2018/19, Nov 2019.
[23] NHS England, Type 1 and type 2 diabetes and COVID-19 related mortality in England, 20 May 2020.
[24] NHS Diabetes Prevention Programme (NHS DPP) Non-diabetic hyperglycaemia, Produced by: National Cardiovascular Intelligence Network (NCVIN), Date: August 2015

The risk factors for being at high risk of type 2 diabetes and developing type 2 diabetes are the same. These factors include:

- Overweight or obesity - there is a seven times greater risk in people who are obese and three times if overweight
- High Blood Pressure - people are more at risk if they have ever had high blood pressure
- Certain ethnicities - People of South Asian origin are six times more likely to develop Diabetes and Black-Caribbean and Black African are three times more likely
- Age - Risk increases with age. People are more at risk if they are older than 40 or older than 25 if they are Black Caribbean, Black African, or South Asian
- Family History - People are two to six times more likely to get type 2 diabetes if they have a parent, brother, sister or child with diabetes
- Smoking - Smoking has been proven to be an independent risk factor for Diabetes, and amongst diabetics it increases the risk of complications. The highest risk is among heavy smokers and risk remains elevated for about 10 years after smoking cessation, reducing more quickly for lighter smokers.[25]
- Deprivation is strongly associated with higher levels of obesity, physical inactivity, unhealthy diet, smoking and poor blood pressure control, all of which are linked to the risk of developing type 2 diabetes. Prevalence of type 2 diabetes is 60% more common among individuals in the most deprived quintile compared with those in the least deprived quintile in England[26]
- Gestational Diabetes - Gestational Diabetes affects around 5% of all pregnancies.[27] Women who have had Gestational Diabetes are at a sevenfold increased risk of developing type 2 diabetes later in life, especially if they gain weight. Children born to mothers with diabetes during pregnancy tend to have a greater BMI, raised fasting glucose levels and an increased risk of developing type 2 diabetes later in life

People at high risk of type 2 diabetes have a greater chance of developing type 2 diabetes in the future. One out of four people with high risk will develop type 2 diabetes in the next 10 years.[28]

There are various terms used for high risk of Diabetes including: pre-Diabetes, borderline Diabetes, Impaired Fasting Glucose (IFG), Impaired Glucose Tolerance (IGT), Impaired Glucose Regulation (IGR), or Non-diabetic hyperglycaemia (NDH), which all mean that someone is at high risk of a diagnosis of for developing type 2 diabetes. NDH will be used throughout this Section to mean high risk of type 2 diabetes.

Once people know they are at risk, they can often prevent or delay type 2 diabetes from starting by making healthy changes to their diet and lifestyle. Without lifestyle changes, people with NDH are very likely to progress to type 2 diabetes. Eating healthy foods, incorporating physical activity in daily routines, and maintaining a healthy weight can help bring blood sugar levels back to normal.

[25] World Health Organization, Global Report on Diabetes, 2016.
[26] Public Health England, Health Matters: preventing type 2 diabetes, 24 May 2018
[27] NICE, Diabetes in pregnancy: management from preconception to the postnatal period, last updated August 2015.
[28] Diabetes UK, https://www.Diabetes.org.uk/preventing-type-2-Diabetes/what-does-it-mean-if-im-at-risk

Diagnosis

A blood test which detects the level of glucose in your blood is needed to make the diagnosis of NDH and type 2 diabetes. An HbA1c blood test is often used and gives an average of how high your blood glucose levels have been over the preceding few months.

NDH is defined as an HBA1c value between 6.0% (42mmol/mol) and 6.4% (47mmol/mol) excluding those who had already been diagnosed with diabetes with an HBA1c value in this range. An HbA1c value of 6.5% (48 mmol/mol) or above is recommended as the blood level for diagnosing Diabetes. A value of less than 48mmol/mol (6.5%) does not exclude Diabetes diagnosed using glucose tests.

Diabetes: Level of Need in Richmond

Around 16% of the Richmond population are from BAME groups.[29] Asian/Asian British is the largest BAME group in Richmond (7.3%). In terms of location, St Margaret's and North Twickenham had the greatest proportion of the White/White British ethnic group at 88%, while Heathfield had the highest proportion of the BAME ethnic group at 30% (compared to 16% for the Borough). BAME groups are expected to increase to 17.2% by 2030.

Richmond maintains a rank within the 10% least deprived Local Authorities (LAs) in England between 2015 and 2019 and remains the least deprived London borough. In terms of older people, 34% (c. 68,240 residents) of the Richmond population are aged 50 years and over. The number of older people over 65 in the borough of Richmond is expected to increase by 6.5% and number of people over age 85 increasing by 7.1% by 2021. Hampton/Teddington, Heathfield/Whitton, and Kew Gardens are areas with a higher proportion of older people. The most deprived areas in terms of income deprivation affecting older people are Hampton North, Heathfield, Barnes, and North Richmond.

In addition to Hampton and Heathfield, Whitton, Hampton North and Hampton Hill tend to have higher prevalence of heart disease, respiratory disease and other conditions. These areas are also relatively more deprived. Nearly one in three people registered with a GP in Richmond has one or more long-term condition and nearly one in ten has three or more.[30]

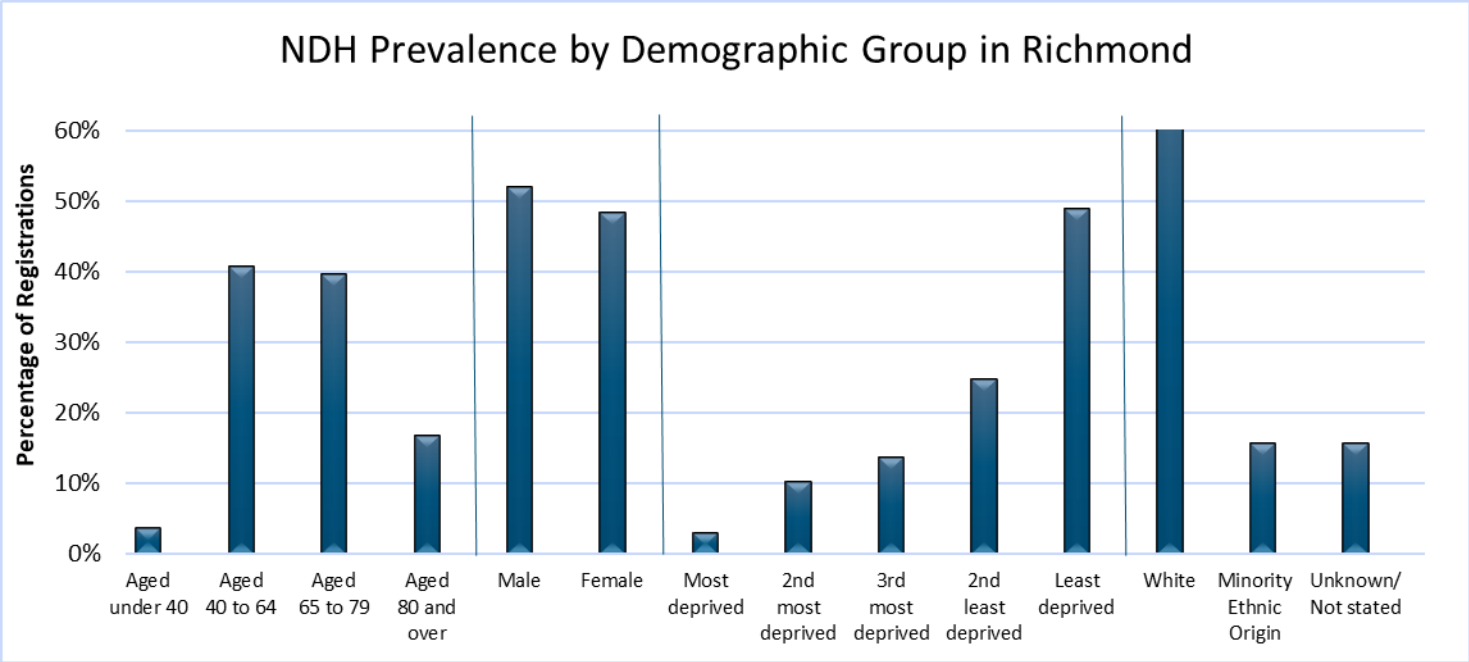
There are an estimated 15,000 residents 16 years and over (9.6% of population) that have NDH in Richmond. In 2018/19, GP Practices identified around 4,000 of these people (1.3%). This means there could be around 11,000 people who are unaware they are high risk for developing type 2 diabetes.

Figure 20 provides the demographic breakdown of people in Richmond registered with NDH by their GP Practice. At individual GP practice level, the percent of people identified with NDH varies, ranging from around 0.2% to 6%.

[29] Richmond Story 2017–18, https://www.datarich.info/wp-content/uploads/2018/04/Richmond-Story-2017-18.pdf

[30] The London Borough of Richmond upon Thames Health and Care Plan, 2019–2021

Figure 20: NDH prevalence by demographic group, Richmond, 2018/19



Source: NHS Digital. National Diabetes Audit. 2018/19

Prevalence Trends

- Males and females have a similar percent of people registered with NDH
- The 40–64 years and 65–79 years age groups have a similar proportion of people registered with NDH, together comprising 80% of NDH prevalence. As risk increases with age, it may be more likely that a higher proportion of the 80+ age group have already been diagnosed with diabetes.
- Nearly 50% of people with NDH are from the least deprived quintile, and 13% from the two most deprived quintiles.
- Around 69% of people registered with NDH are White and 15% are of Minority Ethnic Origin (BAME). BAME groups make up around 16% of the population in Richmond.
- As NDH doesn't tend to have symptoms associated with it, identification is based on a blood test alone. It is estimated that many more people have NDH but are unaware of it.

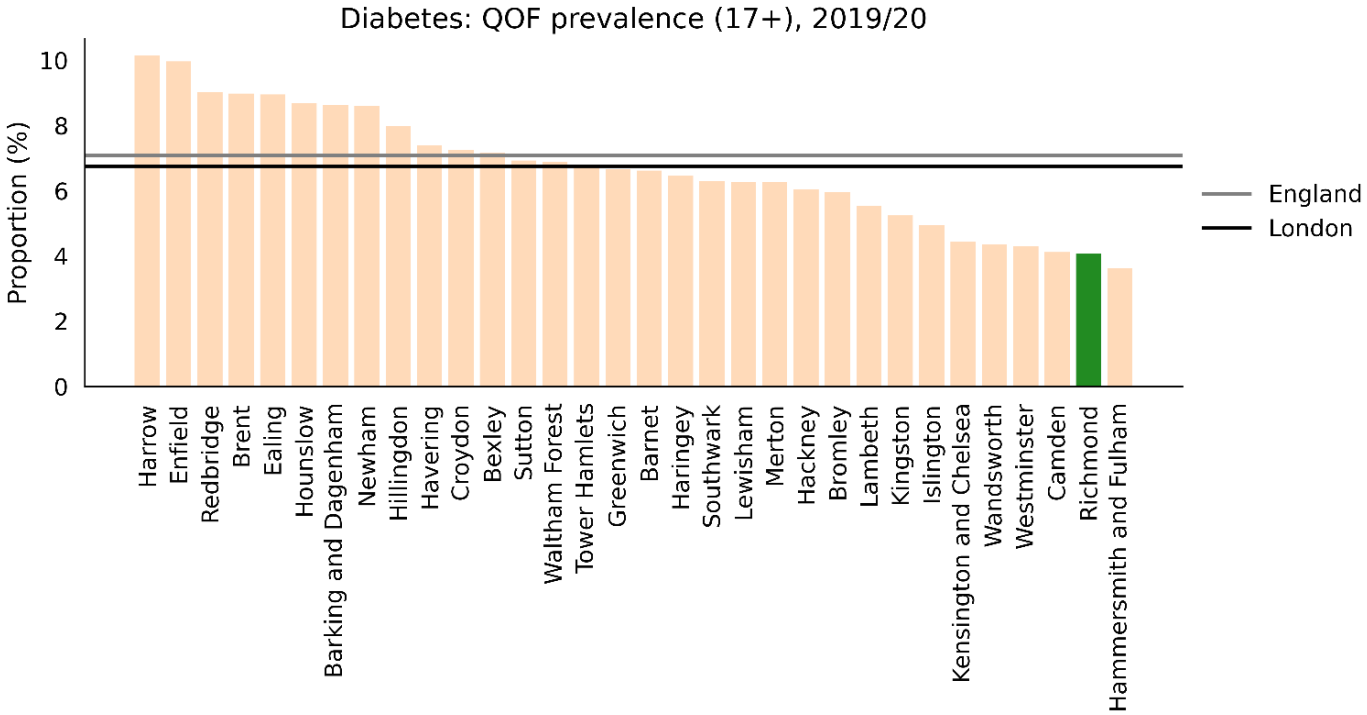
GP Practice Data on Diabetes

At individual GP practice level, the prevalence of diagnosed Diabetes ranges from around 1% to 6%.[31] In 2018/19, there were 5,770 people diagnosed with type 2 diabetes.

In 2019/20, Richmond's prevalence of Diabetes was 4.1% (n=7720), which is the 2nd lowest rate in London (**Figure 21**) , 42.6% lower than the England average and 39.8% lower than the London average. The latest Borough figure was also 20.7% higher from 2009/10, in comparison with a 31.2% increase in England's rate in the equivalent time period (**Figure 22**).

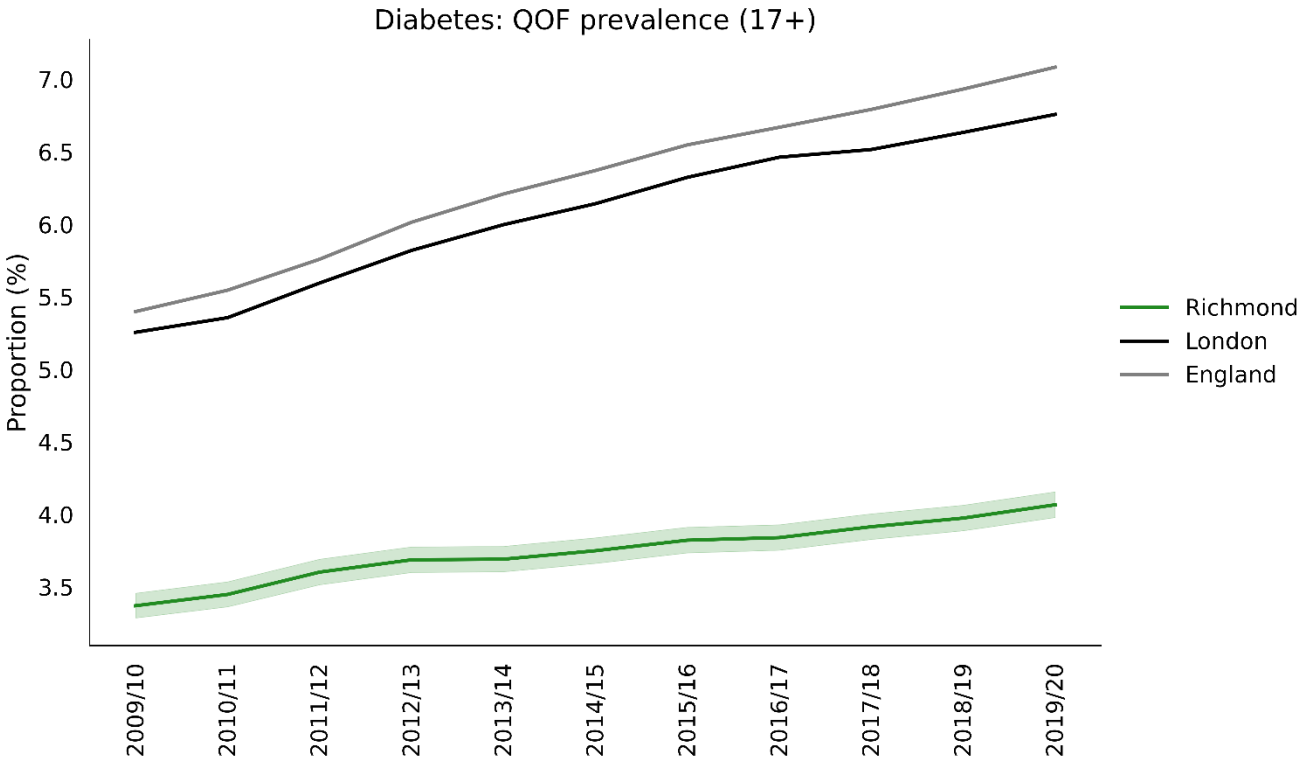
[31] NHS Digital, National Diabetes Audit (NDA) 2018/19 Interactive report for England, Clinical Commissioning Groups and GP practices, 13 December 2019

Figure 21: Diabetes prevalence by local authority, 2019/20



Source: PHE Public Health Profiles

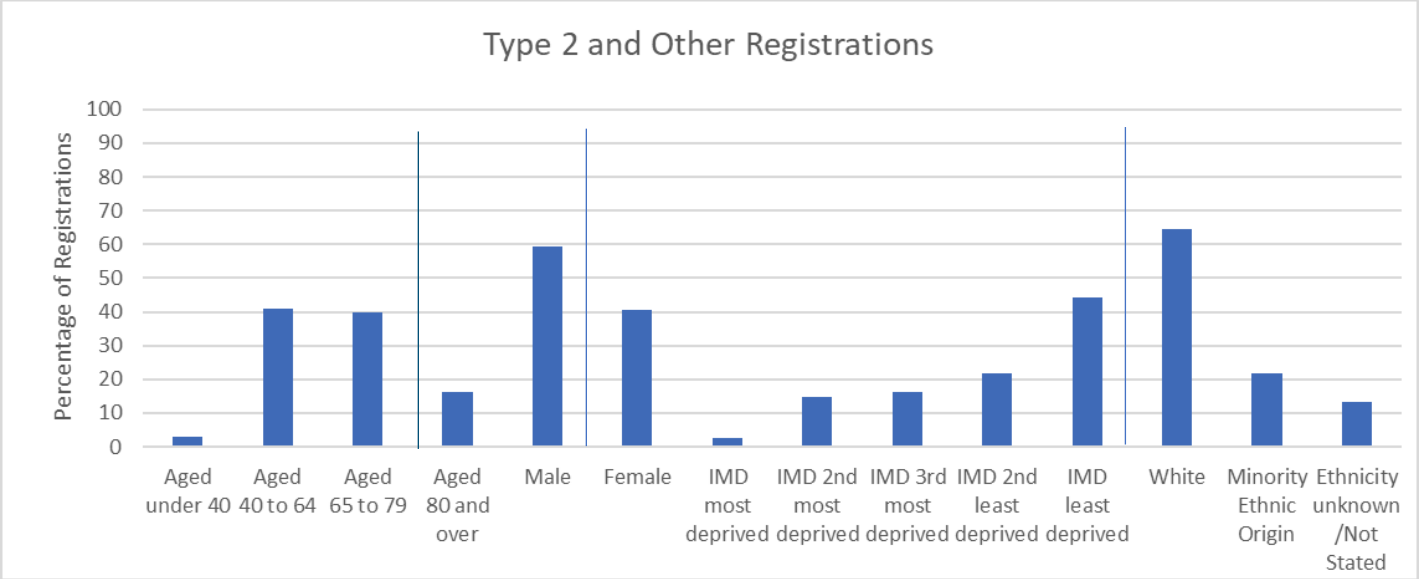
Figure 22: Diabetes prevalence, 2010–2020



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

Figure 23 provides the demographic breakdown of people diagnosed with type 2 diabetes.

Figure 23: Demographic breakdown of people diagnosed with type 2 diabetes, 2018/19



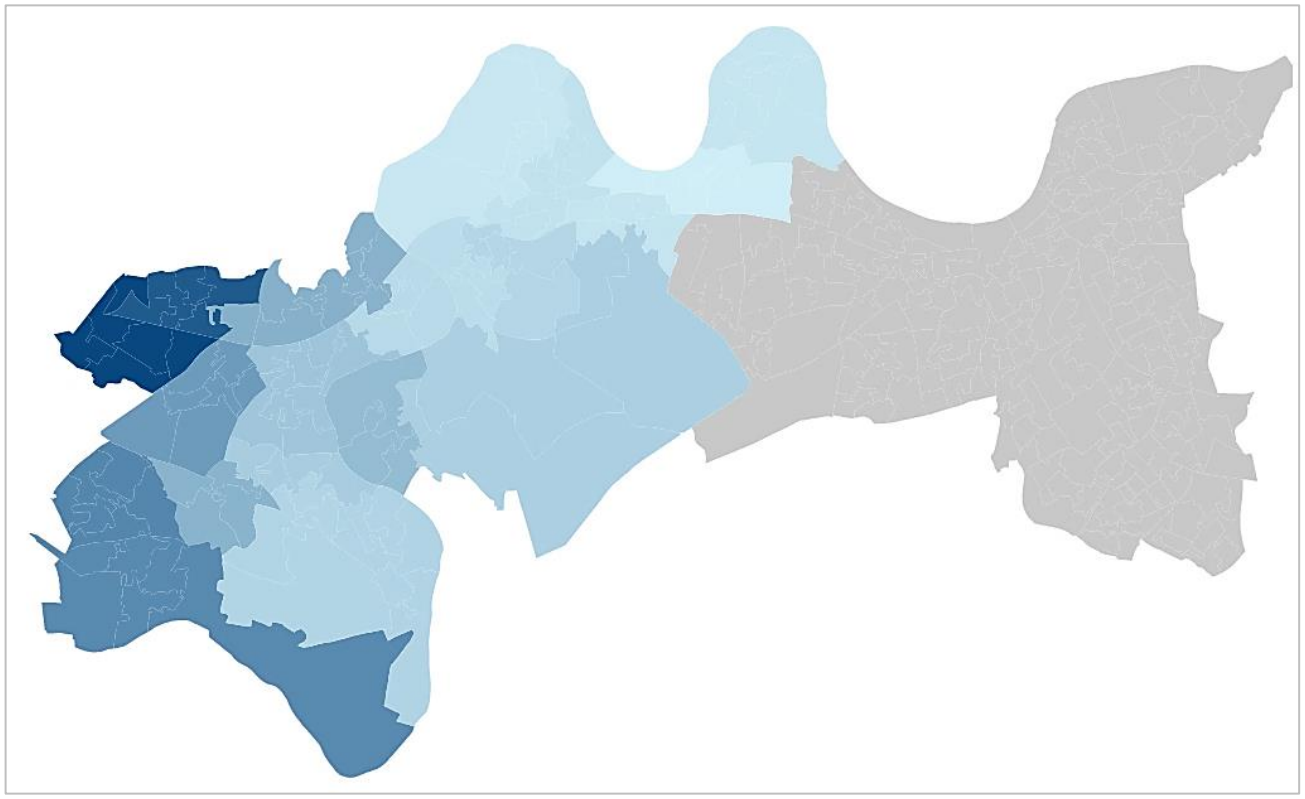
Source: NHS Digital. National Diabetes Audit. 2018/19

- Type 2 diabetes is more common in males than females; 60% are male. While there is little difference in the prevalence of NDH by sex, males have a higher prevalence of diabetes compared to females.
- The 40–64 years and 65–79 years age groups have a similar percentage of people diagnosed with type 2 diabetes. Around 56% of people with type 2 diabetes in Richmond are aged over 65. Richmond has one of the lowest percentage of people aged 40–64 with type 2 diabetes in London, and the second highest percentage of people with type 2 diabetes aged 80 and over.
- Around 43% of people diagnosed with type 2 diabetes are from the least deprived quintile and 18% from the two most deprived quintiles.
- Around 65% of people diagnosed with type 2 diabetes are White, 22% Minority Ethnic Origin, with a further 13% unknown or not stated. As BAME groups comprise 16% of the population, this reflects the health inequality of diabetes among minority ethnic groups.

Geographic Prevalence

There is variation in diabetes prevalence across the borough. Diabetes is most prevalent in Heathfield and Whitton, followed by Hampton. This corresponds with having a higher proportion of BAME groups, older people aged 65+, and deprived areas of the borough, which are risk factors for type 2 diabetes (**Figure 24**).

Figure 24: Diabetes prevalence in Richmond by LSOA, 2017/18



Source: DataRich https://www.datarich.info/covid-19/#wmdata

Undiagnosed Diabetes

It is estimated that 12,553 people in Richmond have diabetes (all types of diabetes). This includes people that have already been diagnosed by their GP and those who have diabetes but do not know it (undiagnosed). Around 55% of people living with diabetes are diagnosed.[32] This is lower than the diagnosis rates for England and London, 78% and 71.4% respectively and is the third lowest in London.

Considering the diagnosed prevalence for Type 1 and Type 2 and other diabetes, it is estimated that there are 5,649 people living with undiagnosed diabetes (45%) that are not receiving treatment and are missing out on vital health checks.

As Richmond has a lower prevalence of some of the risk factors for diabetes (e.g. obesity, hypertension), higher prevalence of healthy lifestyle behaviours (e.g. healthy eating, physical activity), and lower prevalence of people with complications related to diabetes (e.g. stroke, CHD), it is a possibility that the observed number of people with undiagnosed diabetes in Richmond is actually lower than the estimated number. There is the caveat with all modelled data, that there are data limitations and a degree of uncertainty associated with these estimates. Nonetheless, the estimates can still be considered indicative, showing that there is still room for improvement in diabetes diagnosis in Richmond.

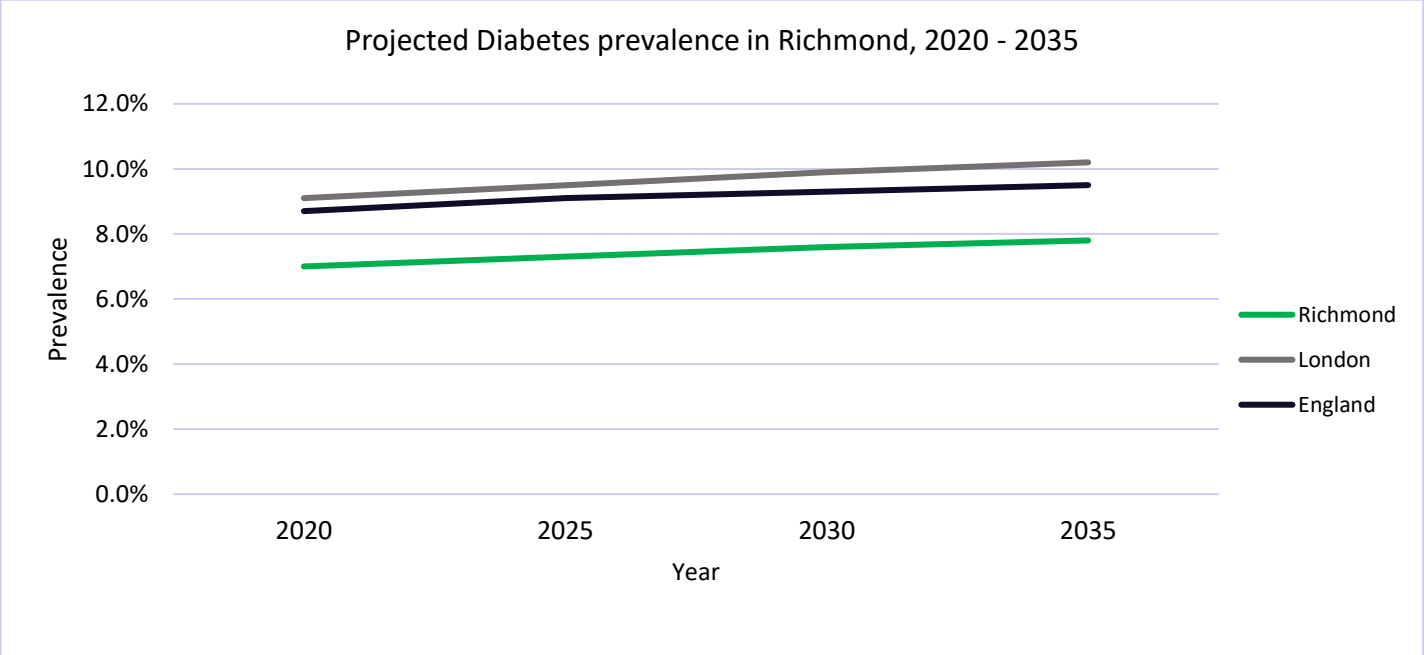
Some of the undiagnosed cases could be within the more elderly groups. Richmond is one of only six boroughs in London that has more than 30% of its population aged over age 50 years. It also has the highest prevalence of type 2 diabetes (39.9%) in people aged 65 to 79 years old compared with all the other London boroughs. Some of the hidden/undiagnosed diabetes cases could be within the elderly population.

[32] Public Health England, Public Health Profiles, Estimated diabetes diagnosis rate, 05 February 2019.

Projected Diabetes Prevalence

Projections for Diabetes prevalence up to 2035 show an increase in the number of people living with diabetes in Richmond, as well as in London and England at a similar rate. By 2035, it is estimated that 7.8% of people in Richmond will be living with diabetes. This is less than a 1% increase but amounts to a further 3,609 people living with diabetes in Richmond over the next 15 years (**Figure 25**).

Figure 25: Projected diabetes prevalence in Richmond. 2020–2035



Source: Prevalence estimates of Diabetes, Public Health England, 2016

Treatment Targets

NICE recommends treatment targets for Hba1c (glucose control), blood pressure and serum cholesterol: Target Hba1c reduces the risk of all diabetic complications, target blood pressure reduced the risk of vascular complications and reduced the progression of eye disease and kidney failure and target cholesterol reduced the risk of vascular complications. 'Meeting all three treatment targets' is achieved where a patient has HbA1c ≤58mmol/mol, cholesterol <5mmol/L and blood pressure ≤140/80 (**Table 4**).

In 2018/19, 46.4% of people with type 2 diabetes achieved all three treatment targets; this is higher than similar CCGs, STP, and England. Achievement of each treatment target was also higher in comparison. However, there was variation in the achievement between GP Practices, ranging from around 30%-60%.

Table 4: Percentage of people achieving their treatment targets for type 2 diabetes, 2018/2019

	Richmond	Similar CCGs	STP	England
HbA1c ≤ 58 mmol/mol (7.5%)	69.9	67.8	66.7	66.5
Blood Pressure ≤ 140/80	75.1	74.7	74.7	74.5
Cholesterol < 5 mmol/L	82.2	79.6	78.8	78.4
All Three Treatment Targets	46.4	43.5	42.6	41.7

Source: National Diabetes Audit (NDA) 2018/19

Vulnerable Groups

People with Learning Disabilities

The prevalence of diabetes in people with a learning disability is unknown, but general population data indicate it is around 10% (including Type 1, but in most cases this is type 2 diabetes). [33] Applying this figure to the number of people with learning disabilities in Richmond (695 people with learning disabilities[34]) provides a rough estimate of 70 people with learning diabetes that have diabetes. The onset of diabetes is seen at an earlier age for people with a learning disability.[35]

People with Severe Mental Illness

People with severe mental illnesses are at substantially higher risk of diabetes compared with the general patient population. People with schizophrenia, psychosis, bipolar depression and anxiety are at double the risk of developing type 2 diabetes.[36] In Richmond, 1,896 people were registered with their GP with schizophrenia, bipolar affective disorder and other psychoses, with 64% of patients over age 40 having a record of blood glucose or HbA1c in the preceding 12 months.[37]

Care Homes

Current estimates place the number of older people with diabetes resident in care homes at one in four.[38] Research has shown that in addition to those with a known diagnosis of diabetes, there are people with undiagnosed diabetes in care homes whose needs for care are not being met.

Data limitations

The estimated NDH prevalence is based on modelled data but does not include confidence intervals. PHOF states a caveat that "with all modelled data, there is a degree of uncertainty associated with these estimates therefore should be considered indicative only." Additionally, ward level or LSOA breakdown of the data is not available for either data set, making it difficult to interpret this data beyond borough level.

Like the estimated NDH prevalence data, estimated Diabetes prevalence is based on modelled data and does not include confidence intervals.

Current Services on Offer

A range of services are available for people at high risk of developing type 2 diabetes and for people diagnosed with type 2 diabetes. The services offer support to people to help prevent type 2 diabetes, as well as help identify people with diabetes early, and ensure quality of care and effective management of their Diabetes.

Primary Care

Much of the management and monitoring of patients at risk of and with type 2 diabetes is undertaken by GPs and members of the Primary Care Team, for example through:

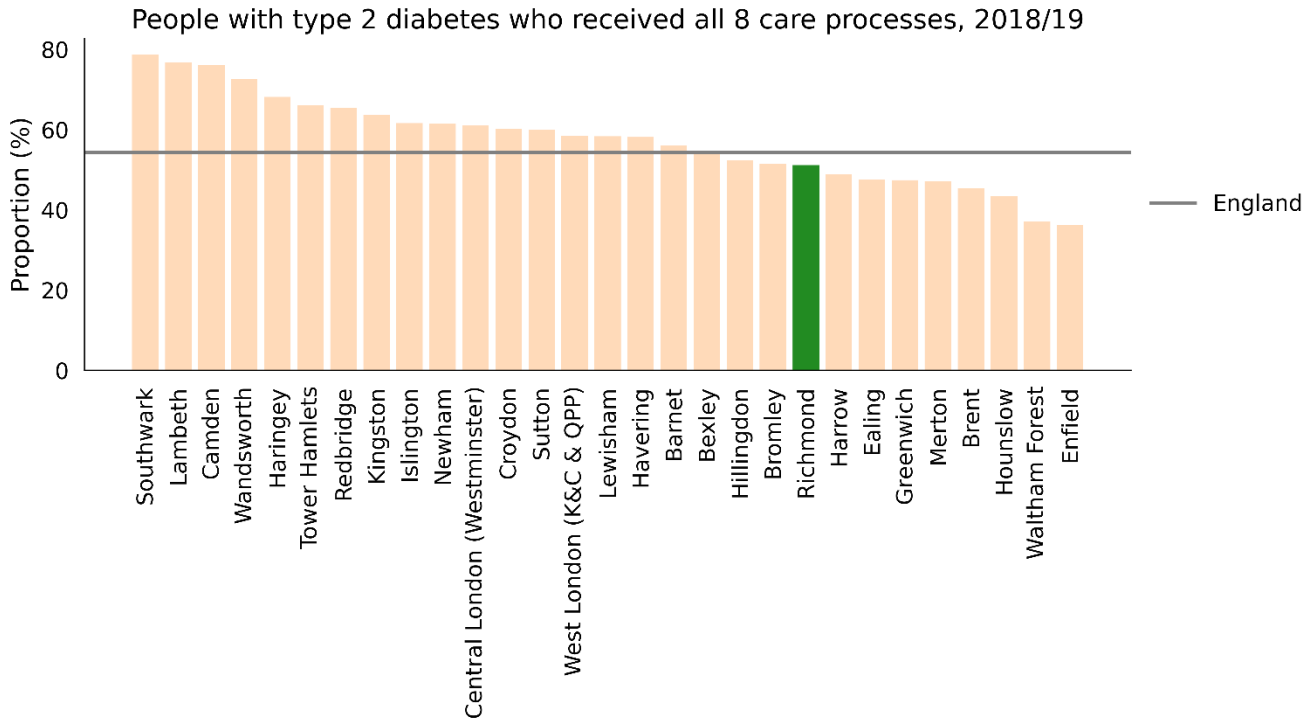
- Identification through blood test
- Maintain register of patients with type 2 diabetes and high risk- and annual recall
- Advice and signposting- GPs and Practice Nurses

[33] Diabetes UK, Improving care for People with diabetes and a learning disability- Fact Sheet 1, January 2018.
[34] Public Health England, Learning Disability Profiles, November 2019.
[35] NHS England, NHS Right Care Pathway: Diabetes, July 2017.
[36] NHS England, NHS Long Term Plan, January 2019.
[37] NHS Digital, QOF Mental Health Indicator, 2019.
[38] Diabetes UK, Diabetes in care homes: Awareness, screening, training, September 2017.

- Medication- e.g. metformin, insulin
- Blood sugar checks (HbA1c)- every 3 months when newly diagnosed and every 6 months once stable
- Annual Diabetic Review (8 care processes recommended by NICE) - These are five risk factors (body mass index, blood pressure, smoking, glucose levels (Hba1c) and cholesterol) and four tests to identify early complications (urine albumin creatinine ratio, serum creatinine, foot nerve and circulation examination). These important markers ensure diabetes is well controlled and are designed to prevent long-term complications.

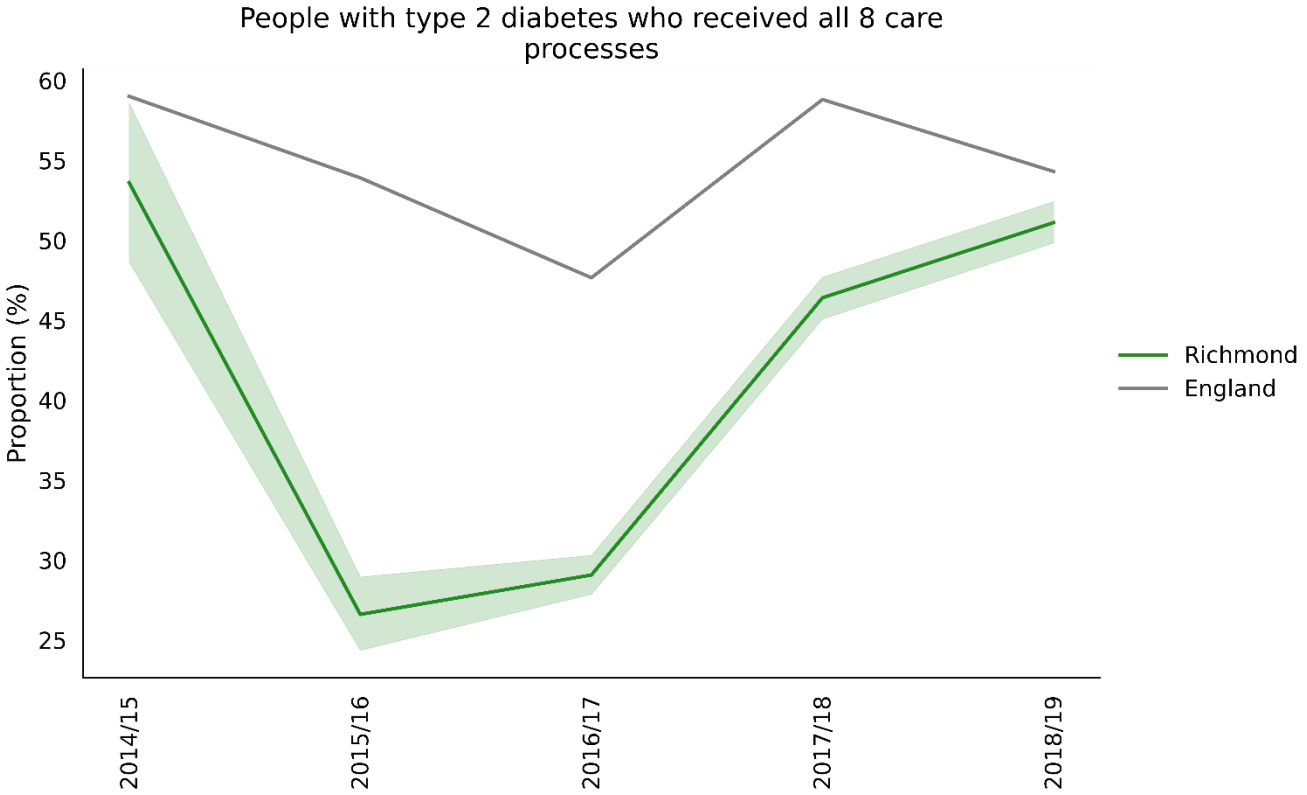
In 2018/19, Richmond's proportion of people with type 2 diabetes who received all 8 care processes was 51.1% (n=2950, 9th lowest rate in London, **Figure 26**), which was 5.9% lower than the England average. The latest Richmond's figure for 2018/19 was also 4.7% lower from 2014/15, in comparison with an 8.0% decrease in England's rate in the equivalent time period (**Figure 27**). Richmond's proportion has almost doubled in the last two years.

Figure 26: Percentage of people on GP diabetes registers who received all 8 care processes by CCG, 2018/19



Source: PHE Public Health Profiles

Figure 27: Percentage of people on GP diabetes registers who received all 8 care processes, 2015–2019



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

To support the Enhanced Primary Care Diabetes Service of GP Practices, the CCG has partnered with the local GP Federations to focus on quality, support and education for primary care (April 2019-March 2021). This will ensure that all GP Practices have access to the expertise and support to achieve improvements in the delivery of high- quality care for patients with, or at risk of, Diabetes.

Healthier You: NHS Diabetes Prevention Programme (NDPP)

The NDPP is an intensive lifestyle support programme for people identified as high risk for developing type 2 diabetes. Individuals are eligible if they are identified by their GP with NDH, defined as having an HbA1c 42 – 47 mmol/mol (6.0 – 6.4%) or a fasting plasma glucose (FPG) of 5.5 – 6.9 mmol/l. The service offers tailored, personalised support to reduce the risk of type 2 diabetes including education on healthy eating and lifestyle, help to lose weight and physical exercise programmes. Local group sessions are delivered in community settings, and a digital option is offered to those declining face-face group sessions. Early outcomes of the Service across England demonstrate that those completing the Programme had a mean weight loss of 3.3 kg and an HbA1c reduction of 2.04 mmol/mol.[39]

From June 2018-November 2020, 1,305 of people in Richmond were referred to the service. **Table 5** shows the outcomes of the service.

[39] Valabhji J , Barron E, Bradley D et al. Early Outcomes from the English National Health Service Diabetes Prevention Programme. Diabetes Care Jan 2020, 43 (1) 152-160; DOI: 10.2337/dc19-1425

Table 5: NDDP outcomes, Richmond, 2018–2020

Total referred	**1305**
Percent Uptake	57%
Mean weight change at 6 months	-3kg

Source: Richmond NDPP data

Of the people who attended the NDPP Service in Richmond:

- 59% were male, 41% Female
- 59% were aged less than 70
- 30% were of Asian, Black, mixed or other ethnicity (15% of people with NDH in Richmond are of minority ethnic origin)
- 21% were from the three most deprived quintiles (although 26% of people with NDH are from the three most deprived quintiles)
- 23% were of normal weight (BMI 18–24.9), 39% overweight (BMI 25–29.9), and 36% obese (BMI >30)

Structured Education

Structured education programmes can help adults with type 2 diabetes to improve their knowledge and skills and help to motivate them to take control of their condition and self-manage it effectively. A range of diabetes education programmes exist in London, such as DESMOND and X-PERT. Remote courses such as Oviva are also available for those who prefer digital support.

Table 6 provides an overview of referrals to Structured Education in 2017.[40]

Table 6: Referrals to Diabetes Structured Education, Richmond, 2017

Newly diagnosed Type 2 Diabetes	Offered within 12 months of diagnosis	Offered within 12 months of diagnosis (%)	Attended within 12 months of diagnosis	Attended within 12 months of diagnosis (%)
430	300	69.8%	40	9.3

Table 7 provides an overview of referrals to Diabetes Book & Learn from October 2018-January 2020 for people with type 2 diabetes in Richmond. However, these are rough figures as there have been issues with recording of attendance by providers on the Diabetes Book & Learn platform.

Table 7: Referrals to Diabetes Book & Learn, October 2018-January 2020, Richmond

Total referrals to the Diabetes Book & Learn Oct 2018-Jan 2020	**175**
Percent of patients accessing courses outside Richmond	19%
Percent of patients accessing digital/remote provider	15%

[40] NHS Digital, National Diabetes Audit (NDA) 2018/19 Interactive report for England, Clinical Commissioning Groups and GP practices, 13 December 2019.

Specialist Diabetes Service

Wherever possible patients with diabetes are treated by their own GP with support from a Diabetes Specialist Nurse allocated to the practice. However, HRCH's specialist diabetes team can provide specialist care for cases that are too complex to be dealt with by a patient's GP practice, but not complex enough to warrant hospital admission.

The teams work with the patient to agree outcomes and then produce a care-management plan, which the patient's GP practice can implement between visits to the specialist clinic. This approach means that patients with diabetes are receiving specialised care for their condition at the most appropriate level and do not have to make unnecessary trips to acute hospitals.

The HRCH diabetes service in Richmond provides:

- A consultant led service
- Specialist nurse advice
- Specialist diabetes dieticians
- Telephone advice line and email service
- Podiatry
- Retinal screening service, based at Teddington Memorial Hospital and provided by St. Georges Hospital retinal screening service
- Structured education sessions – Nationally accredited programme DESMOND programmes for Newly Diagnosed and Foundation course FOR THOSE WITH Established Diabetes.
- BERTIE - Diabetes Education Programme for people with type 1 diabetes.
- Carbohydrate Counting and Insulin Dose adjustment
- Continuous glucose monitoring
- Referrals to other local healthy lifestyle intervention programmes.
- Established insulin pump users
- Domiciliary visits for housebound clients
- Hypoglycaemic Pathway for the prompt treatment and support of patients calling 999 for hypoglycaemia. This service is provided alongside London Ambulance Service.
- Psychological support and onward referral to Richmond Well-Being Service where needed. Retinal screening also available at Queen Mary's Hospital (in addition to Teddington Memorial Hospital)

Dietetics Service

Having a healthy diet is an important part of living with type 2 diabetes and managing it well. Dietetics can provide individuals with advice and guidance about their diet. Dietetic services are available through Kingston Hospital as well as through St. Georges Hospital based Queen Mary's Hospital. Additionally, Specialist Diabetes Dietitians are available in the HRCH Diabetes Team and the Beta Cell Diabetes Team at Queen Mary's Hospital.

Foot Care

Podiatry care is offered to patients with diabetes in Richmond to reduce the risk of lower limb ulceration and early amputation. HRCH Podiatry and Foot Health team are a registered "Any Qualified Provider" (AQP) of routine podiatry care, as well as the only NHS provider for specialist podiatry care to people registered with a Richmond GP. Referrals can be made by a Richmond GP or other health care professional.

Secondary Care

Diabetes and Endocrinology departments are mainly accessed by Richmond residents at Kingston Hospital and Queen Mary's Hospital. The clinical needs of patients referred to this service have a greater complexity or complications. Input may also be required from other specialities, as clinically appropriate.

The specialist nurse led services, provide care for people with diabetes requiring additional support and help with their diabetes management. Consultant led clinics are also provided in their outpatient departments and outreach centres.

Foot Care

Podiatric foot care is offered to patients in Richmond to reduce the risk of lower limb ulceration and early amputation. Healthshare Richmond is the provider of NHS Community Podiatry Services in Richmond. Referrals can be made by a Richmond GP or other Health Care Professionals.

Diabetic Eye Screening

Type 2 diabetes increases the risk of having an eye problem called retinopathy. It is important to have regular eye screening checks for retinopathy. These are different from normal sight tests and specifically look for early signs of damage caused by Diabetes. Eye screening should happen at or around the time of diagnosis and if there are no concerns, then at least once a year after that. If there are signs that damage may be developing, individuals may be offered another check or may be referred to an eye specialist at a hospital.

In 2019, 68.4% of people with diabetes on GP registers had a record of retinal screening in the preceding 12 months.[41] This is lower than London and England (73.7% and 77.3% respectively).

Vulnerable Groups

From 2016/17, the National Diabetes Audit has looked at the care of people with Serious Mental Illness, SMI and Diabetes and compared this to the care received by the whole population of people with diabetes. People with SMI and type 2 diabetes are, on average, younger than those with type 2 diabetes who do not have SMI.

Evidence-based Diabetes Treatment/Interventions

NICE Guidance

NICE provides evidence-based guidance and advice on the prevention, diagnosis and management of Diabetes:

- NICE Guideline PH35- type 2 diabetes prevention: population and community level interventions (May 2011)
- NICE Guideline type 2 diabetes: prevention in people at high risk
- NICE Guideline NG28 – Diabetes in adults: management, example recommendations
- NICE Guideline CG189- Obesity: Identification, Assessment and Management

NHS RightCare Pathway: Diabetes

- The Diabetes Pathway shows the core components of an optimal Diabetes Service, evidence of the opportunity to reduce variation and improve outcomes and the key evidence-based interventions which the system should focus on for greatest improvement, supported by practice examples from across the NHS

[41] QOF 2019

Lifecourse Approach

- Taking a lifecourse perspective is essential for preventing type 2 diabetes, as it is for many health conditions. A lifecourse approach recognises critical windows for intervention to lessen the risk of obesity and type 2 diabetes in later life
- There are opportunities to prevent and control type 2 diabetes at key stages of life from preconception, through pregnancy, infancy, childhood and adolescence, through to adulthood
- One review provides an overview of summarised evidence on effective strategies to prevent Diabetes in the following four cohorts: (1) pregnant women and young families, (2) children and adolescents (<15 years), (3) working-age population (15–64 years), (4) the elderly (>64 years), alongside evidence-based communication strategies (health campaigns, food labelling, etc.) [42]

Intensive Lifestyle Intervention[43]

- Behavioural interventions conducted in 'real world' settings are effective in reducing weight and reducing the incidence of Diabetes. Overall, the incidence of Diabetes was reduced by 26% over a period of 12–18 months post-intervention
- The NDPP is underpinned by this strong evidence base. The learning from this evidence review, alongside an Expert Reference Group and existing NICE guidelines, was used to inform the structure and content of the NDPP intervention.

Diet and Lifestyle Changes[44]

- Type 2 Diabetes is preventable by changing lifestyle and the risk reduction is sustained for many years after the active intervention
- Healthy dietary changes based on the current recommendations and the Mediterranean dietary pattern can be recommended for the long-term prevention of Diabetes

Metformin Compared to Diet or Exercise[45]

- Metformin compared with placebo or diet and exercise reduced or delayed the risk of type 2 diabetes in people at increased risk for the development of type 2 diabetes
- Metformin compared to intensive diet and exercise did not reduce or delay the risk of type 2 diabetes
- The combination of Metformin and intensive diet and exercise compared to intensive diet and exercise only neither showed an advantage or disadvantage regarding the development of type 2 diabetes

Low Calorie Diets

- Findings from the Diabetes Remission Clinical Trial (DiRECT) has shown that some people with type 2 diabetes can achieve remission through adoption of low-calorie diets. This allowed nearly half of patients

[42] Timpel, P., Harst, L., Reifegerste, D. et al. What should governments be doing to prevent Diabetes throughout the life course?. Diabetologia 62, 1842–1853 (2019). https://doi.org/10.1007/s00125-019-4941-y

[43] Public Health England, A systematic review and metaanalysis assessing the effectiveness of pragmatic lifestyle interventions for the prevention of type 2 diabetes mellitus in routine practice, August 2015.

[44] https://www.ncbi.nlm.nih.gov/pubmed/31683759

[45] Madsen KS, Chi Y, Metzendorf M, Richter B, Hemmingsen B. Metformin for prevention or delay of type 2 diabetes mellitus and its associated complications in persons at increased risk for the development of type 2 diabetes mellitus. Cochrane Database of Systematic Reviews 2019, Issue 12. Art. No.: CD008558. DOI: https://doi.org/10.1002/14651858.CD008558.pub2

to stop taking anti-diabetic drugs and still achieve non-diabetic range glucose levels, with over a third remaining in remission after two years[46]

- NHS England is piloting the Low-Calorie Diet Programme, based on results from the DiRECT trial, across 10 areas in England, including North East London and North Central London. Eligible participants will be offered low calorie, total diet replacement products including soups and shakes consisting of up to 900 calories a day for up to 12 weeks. Alongside this, participants will receive support for 12 months including help to re-introduce food after the initial 12-week period

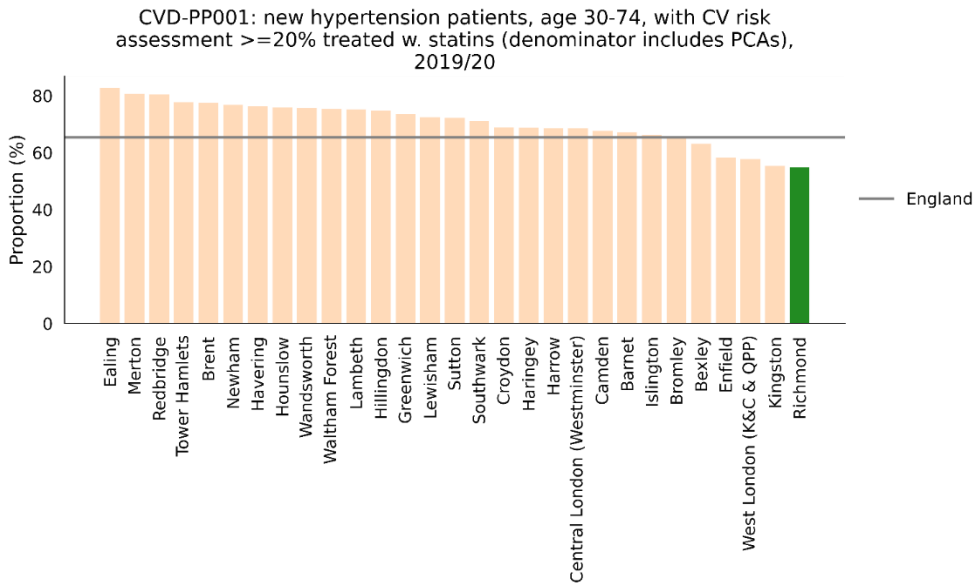
Culturally Appropriate Health Education[47]

- Culturally appropriate health education has short- to medium-term effects on glycaemic control and on knowledge of Diabetes and healthy lifestyles
- While pharmacotherapy may appear to achieve greater improvements in biochemical measures, culturally appropriate Diabetes Education (both for ethnic minority groups and indeed for all people with type 2 diabetes is vital to compliance with pharmacotherapy

3.3 Hypertension

In 2019/20, Richmond's percentage of high CVD risk patients with a new diagnosis of hypertension recorded in the last year that are treated with statins was 54.8 (n=23 , the lowest rate in London, **Figure 28**), which was 16.3% lower than the England average. The latest Richmond's figure for 2019/20 was also 5.3% lower from 2013/14, in comparison with a 2.2% increase in England's rate in the equivalent time period (**Figure 29**).

Figure 28: High CVD risk patients with hypertension diagnosis that are treated with statins by the CCG, 2019/20

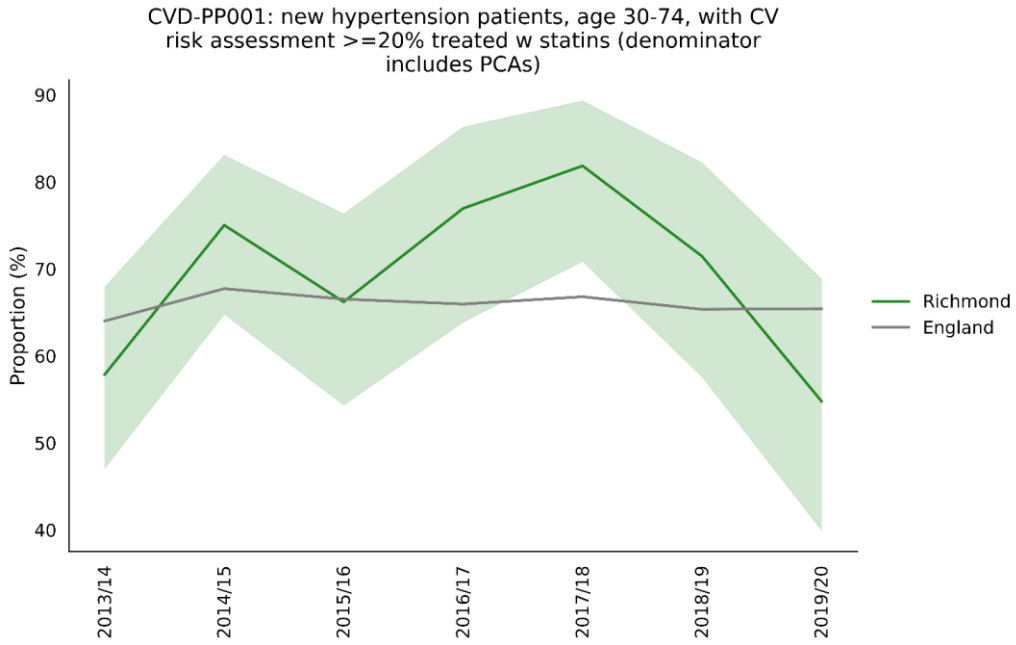


Source: PHE Public Health Profiles

[46] Lean, M. E.J. et al. (2019) Durability of a primary care-led weight-management intervention for remission of type 2 diabetes: 2-year results of the DiRECT open-label, cluster-randomised trial. Lancet Diabetes and Endocrinology, 7(5), pp. 344-355. (doi:10.1016/S2213-8587(19)30068-3)

[47] Attridge M, Creamer J, Ramsden M, et al. Culturally appropriate health education for people in ethnic minority groups with type 2 diabetes mellitus. Cochrane Database of Systematic Reviews 2014, Issue 9. Art. No.: CD006424. DOI: 10.1002/14651858.CD006424.pub3.

Figure 29: High CVD risk patients with hypertension diagnosis that are treated with statins, 2014–2020



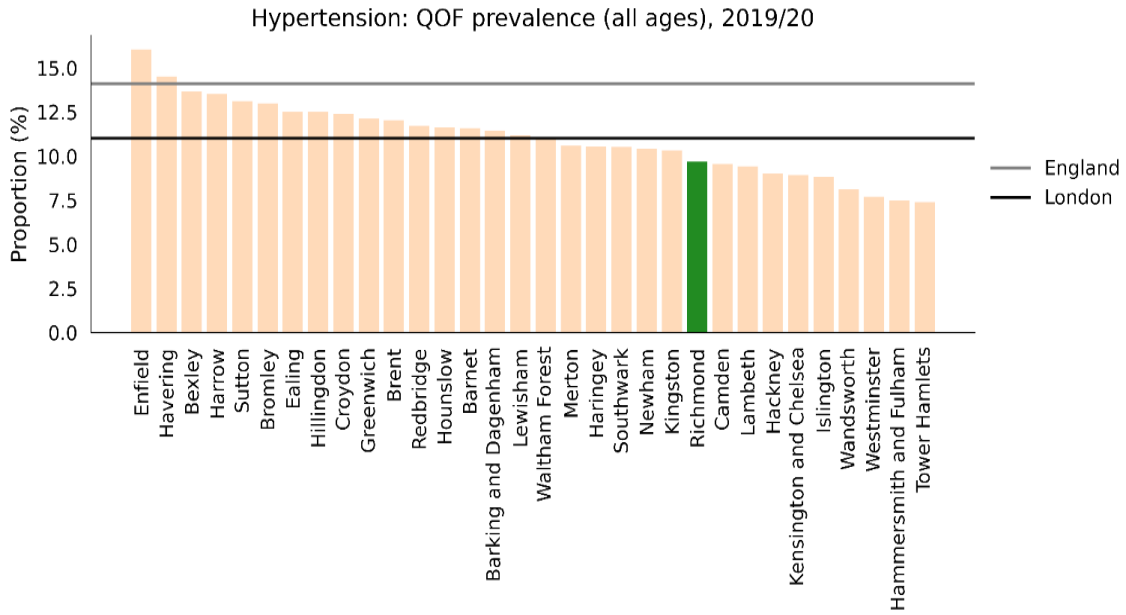
**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

GP Recorded Hypertension Prevalence

Early diagnosis and treating hypertension significantly reduces the risk of CVD.

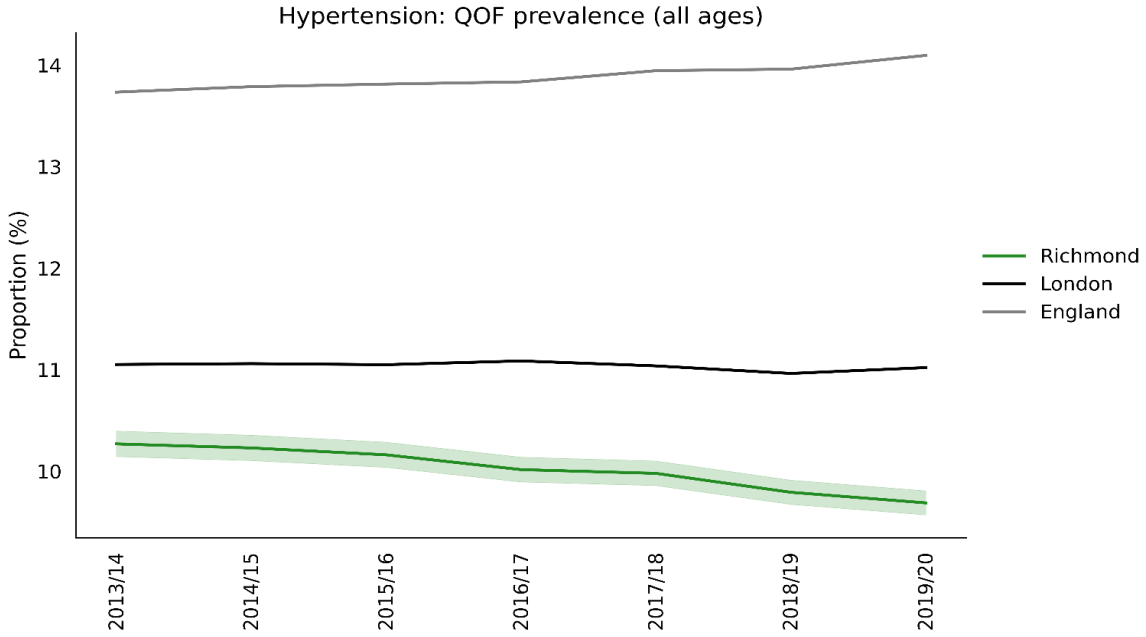
In 2019/20, Richmond's GP recorded prevalence of hypertension was 9.7% (n=23174), which is the 10th lowest rate in London (**Figure 30**) , 31.3% lower than the England average and 12.1% lower than the London average. The latest Borough figure was also 5.7% lower from 2013/14, in comparison with a 2.6% increase in England's rate in the equivalent time period (**Figure 31**). The trend in prevalence is decreasing for Richmond, whilst London and England's prevalence figures continue to increase.

Figure 30: Recorded prevalence of hypertension by CCG, 2019/20



Source: PHE Public Health Profiles

Figure 31: Recorded prevalence of hypertension, 2010–2020

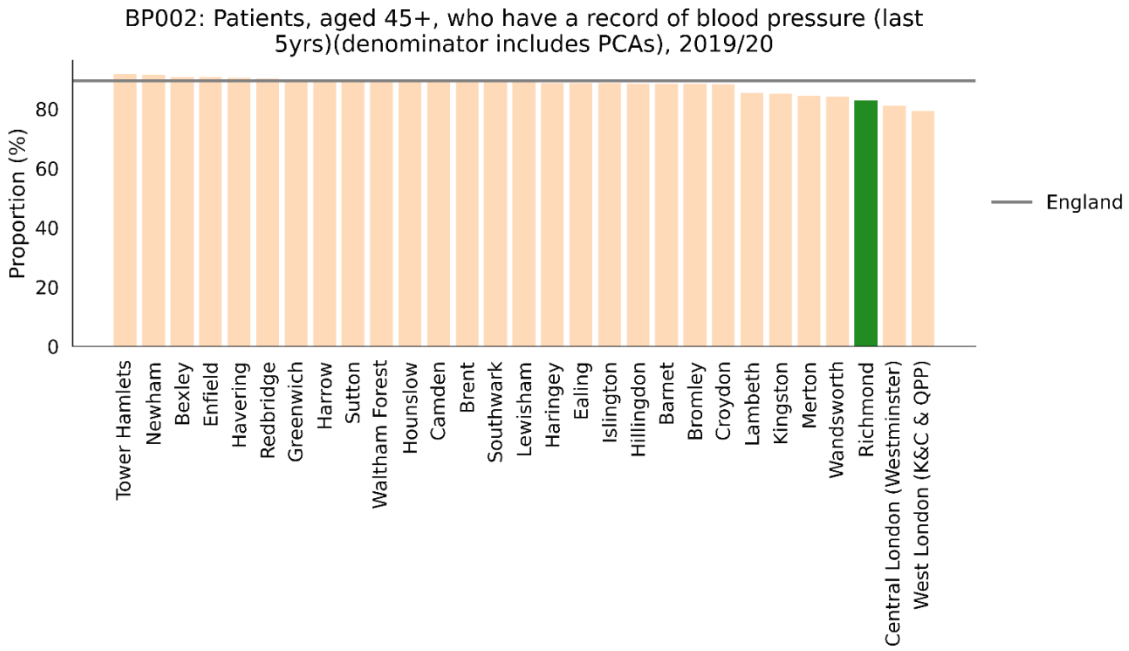


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

Blood Pressure Measurement

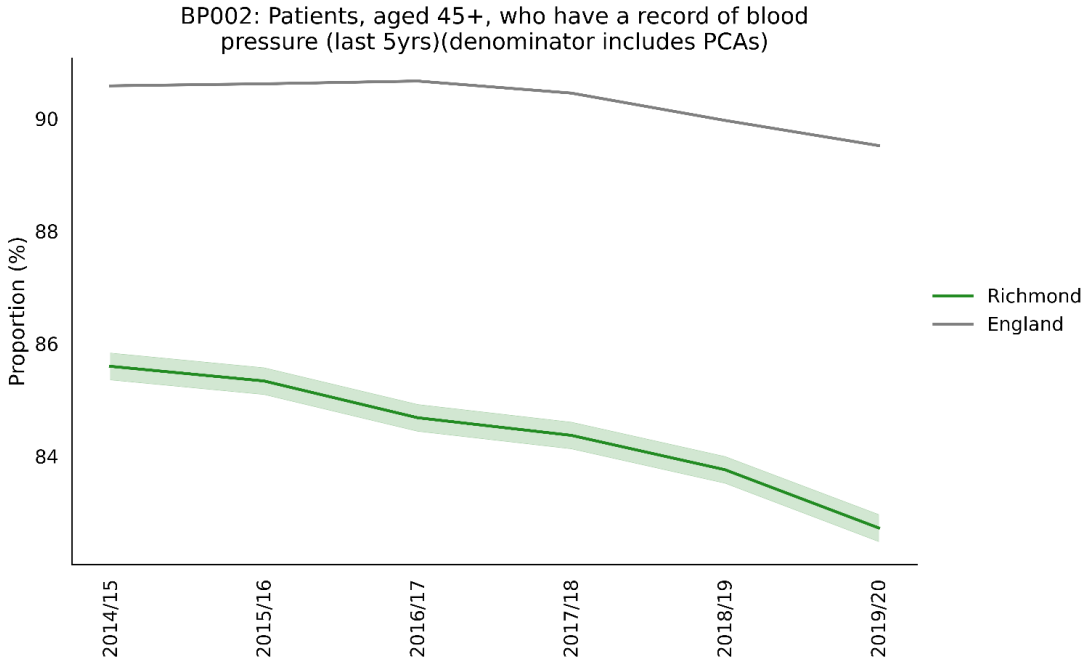
In 2019/20, percentage of Richmond's patients who have a record of blood pressure in the last 5 years was 82.7% (n=78000), which is the 3rd lowest rate in London (**Figure 32**) , 7.6% lower than the England average. The latest Borough figure for 2019/20 was also 3.4% lower from year 2014/15, in comparison with a 1.2% decrease in England's rate in the equivalent time period (**Figure 33**).

Figure 32: Patients aged 45 and over who had their blood pressure recorded in the last 5 days by CCG, 2019/20



Source: PHE Public Health Profiles

Figure 33: Patients aged 45 and over who had their blood pressure recorded in the last 5 days, 2015–2020



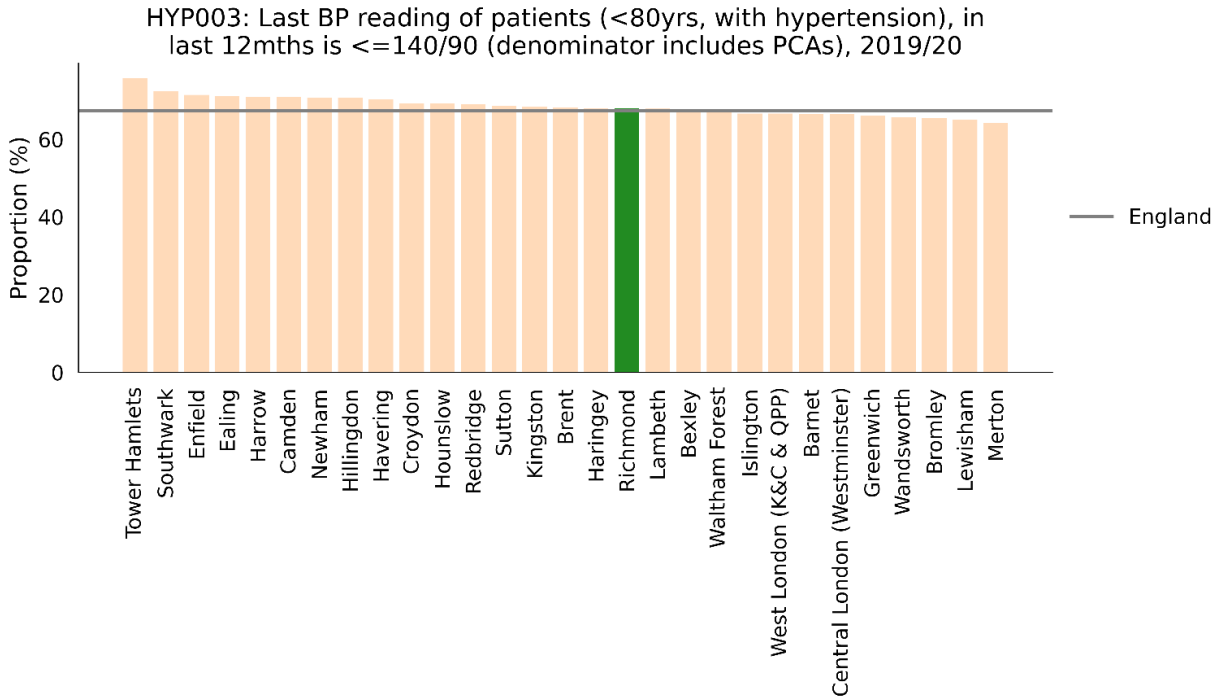
**- green ribbon shows 95% confidence interval around Richmond's indicator values*

Source: PHE Public Health Profiles

Hypertension Treatment

In 2019/20 the proportion of hypertensive patients aged under 80 that had their blood pressure measurements within the agreed limits of less than 140/90 was 67.8% (n=11016), the 13th lowest rate in London (**Figure 34**), and higher than the England average. No time trend data is available for this indicator.

Figure 34: Patients with hypertension with controlled blood pressure by CCG, 2019/20



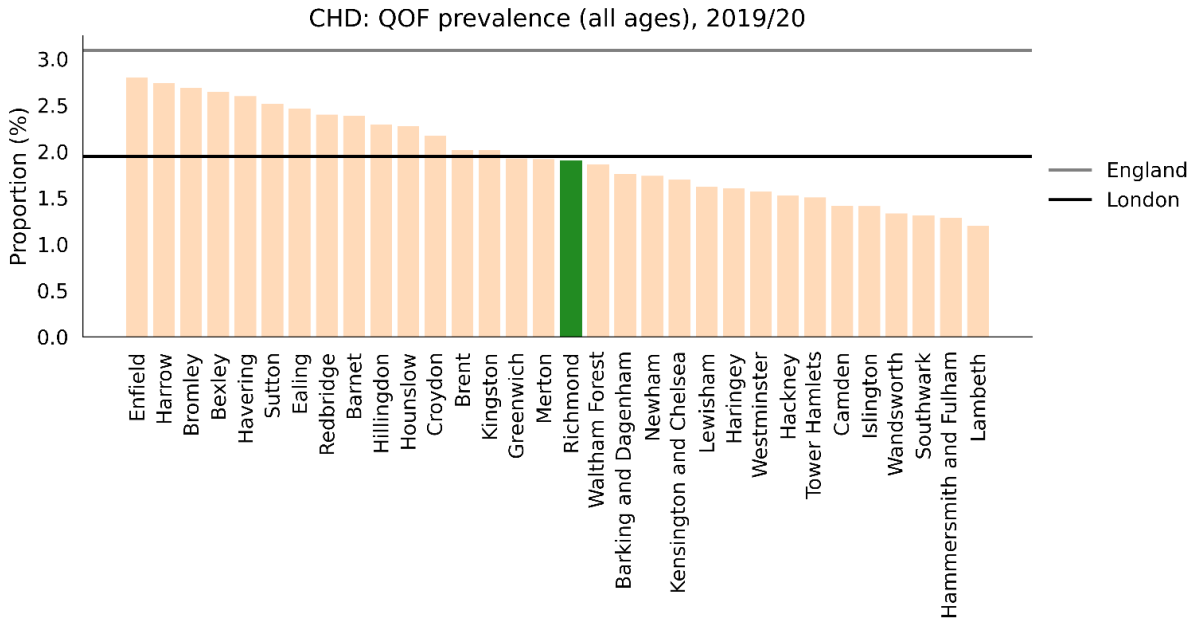
Source: PHE Public Health Profiles

3.4 Coronary Heart Disease (CHD)

GP Recorded CHD Prevalence

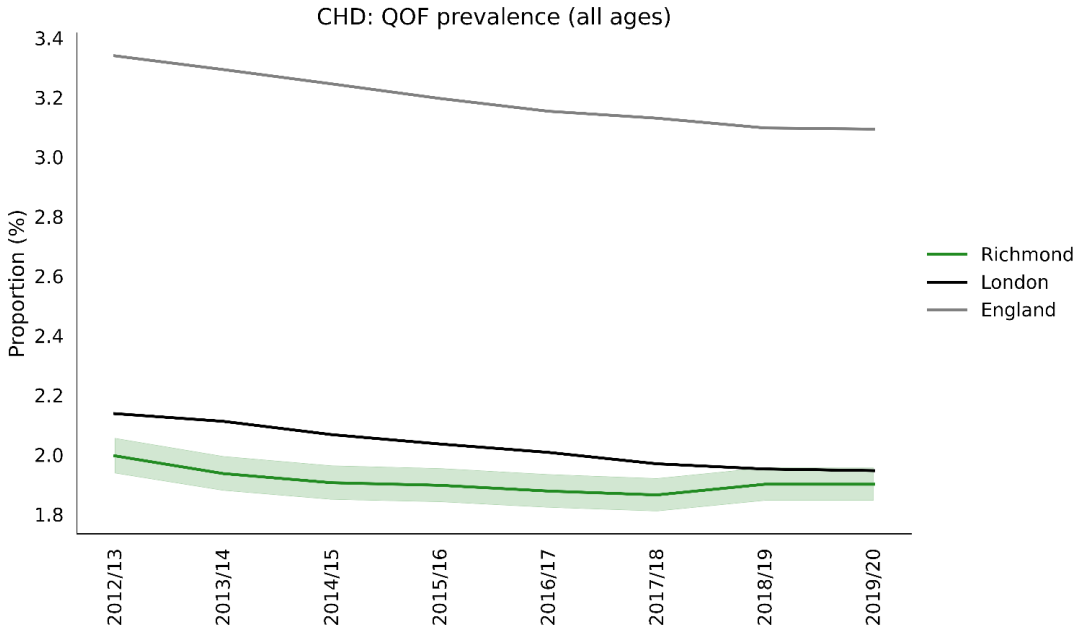
In 2019/20, Richmond's recorded prevalence of CHD in GP population was 1.9% (n=4547), which is the 16th lowest rate in London (**Figure 35**) , 38.6% lower than the England average and 2.4% lower than the London average. The latest Borough figure was also 4.8% lower from 2012/13, in comparison with a 7.4% decrease in England's rate in the equivalent time period (**Figure 36**).

Figure 35: GP recorded CHD prevalence by CCG, 2019/20



Source: PHE Public Health Profiles

Figure 36: GP recorded CHD prevalence, 2011 – 2020

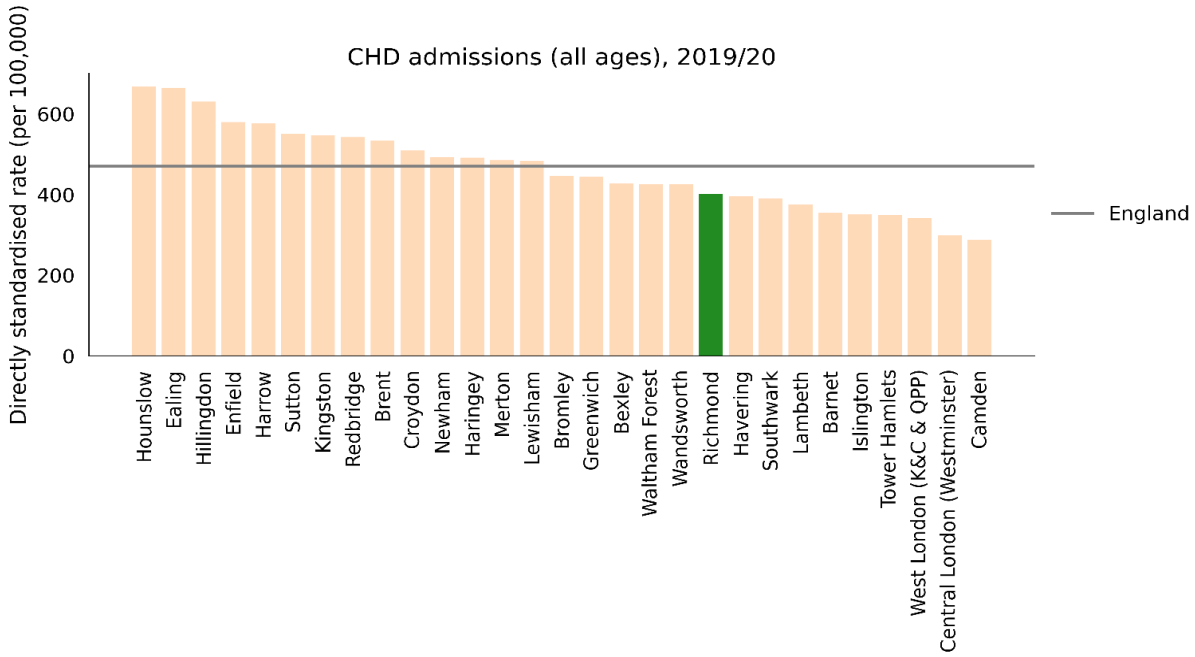


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

CHD Admissions

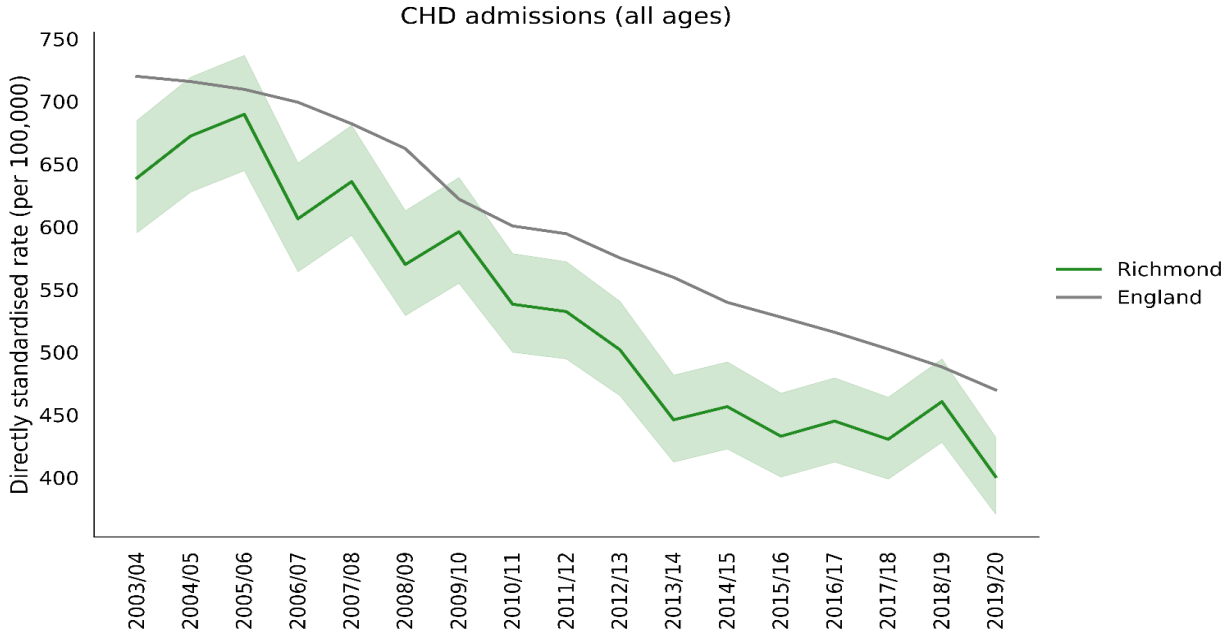
In 2019/20, Richmond's CHD admissions rate was 400.7 per 100,000 population (n=680 , 10th lowest rate in London, **Figure 37**), which was 14.7% lower than the England average. The latest Richmond's figure for 2019/20 was also 37.3% lower from 2003/04, in comparison with a 34.7% decrease in England's rate in the equivalent time period (**Figure 38**).

Figure 37: CHD admissions by CCG, 2019/20



Source: PHE Public Health Profiles

Figure 38: CHD admissions, 2004–2020

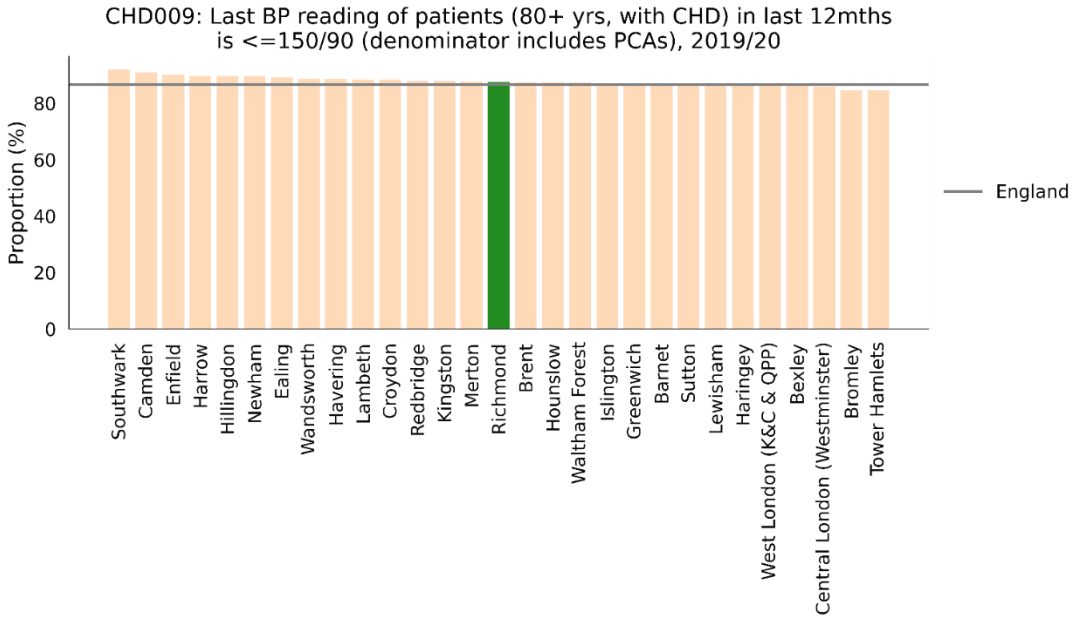


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

CHD Management

In 2019/20, Richmond's proportion of CHD patients aged 80+ with last blood pressure measurement within the agreed standard was 87.4% (n=1173 , 15th highest rate in London, **Figure 39**), which was 1.0% higher than the England average. No time trend data is available for this indicator.

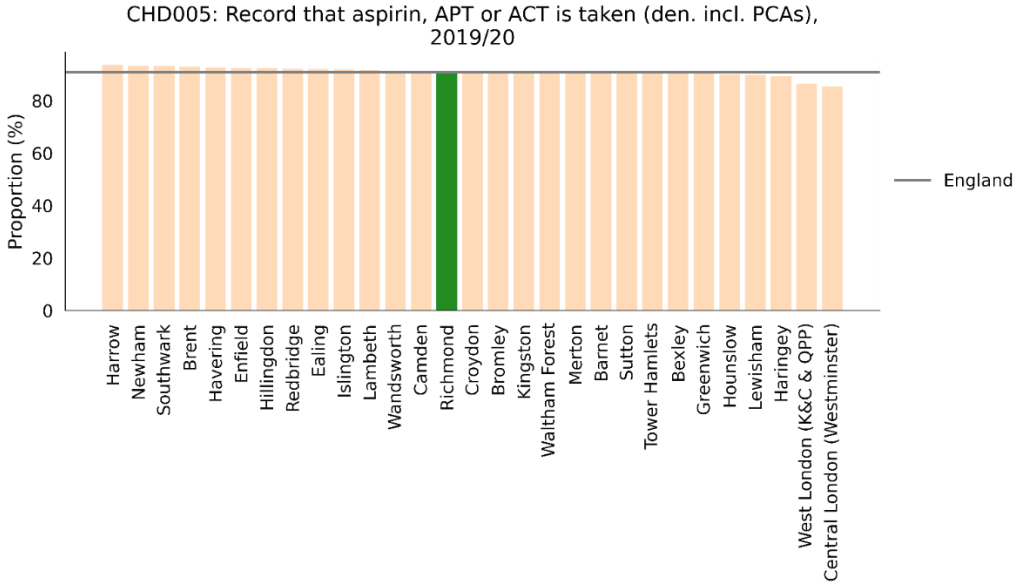
Figure 39: CHD patients aged 80+ with blood pressure measurement within the agreed standards by CCG, 2019/20



Source: PHE Public Health Profiles

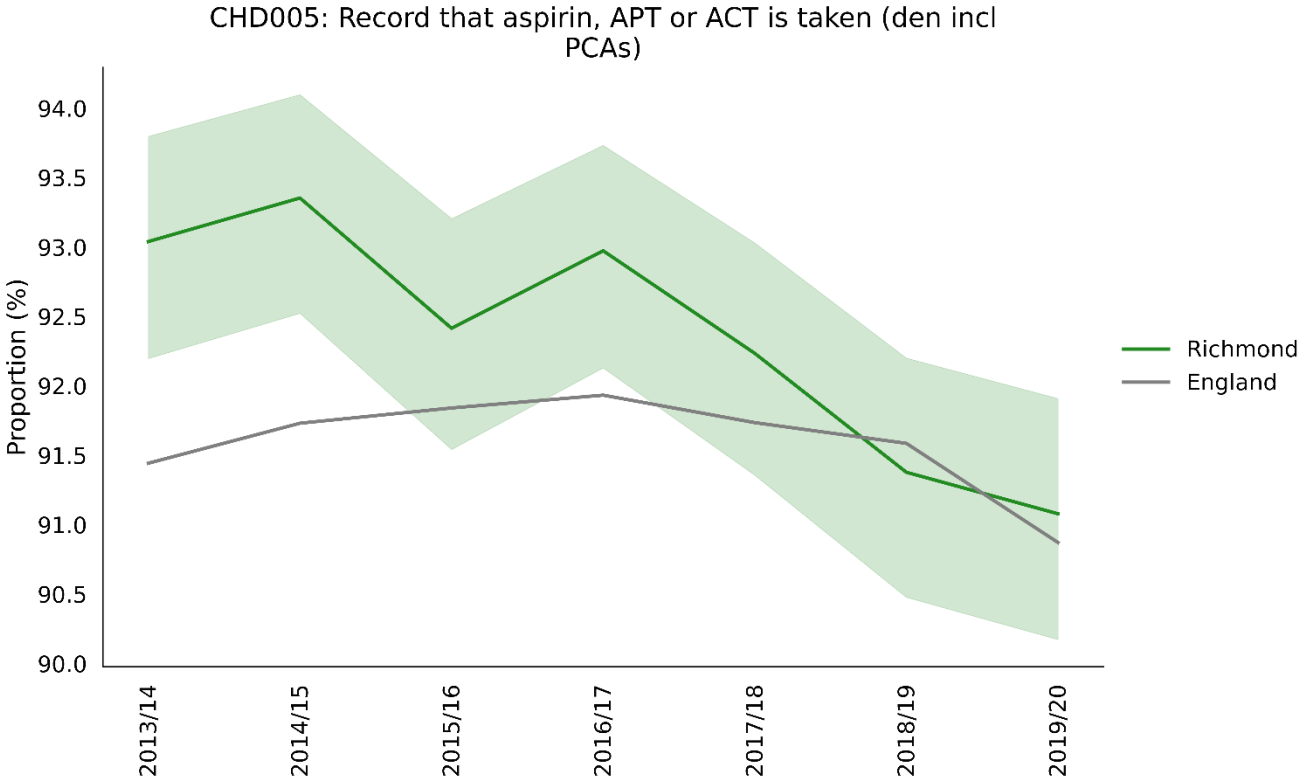
In 2019/20, the proportion of CHD patients in Richmond that were recorded as regularly taking recommended aspirin, or equivalent was 91.1% (n=3777 , 14th highest rate in London, **Figure 40**), which was 0.2% higher than the England average. The latest Richmond's figure for 2019/20 was also 2.1% lower from 2013/14, in comparison with a 0.6% decrease in England's rate in the equivalent time period (**Figure 41**).

Figure 40: CHD Patients regularly taking recommended dose of aspirin or its equivalent by CCG, 2018/19



Source: PHE Public Health Profiles

Figure 41: CHD patients regularly taking recommended dose of aspirin or its equivalent, 2014–2020



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

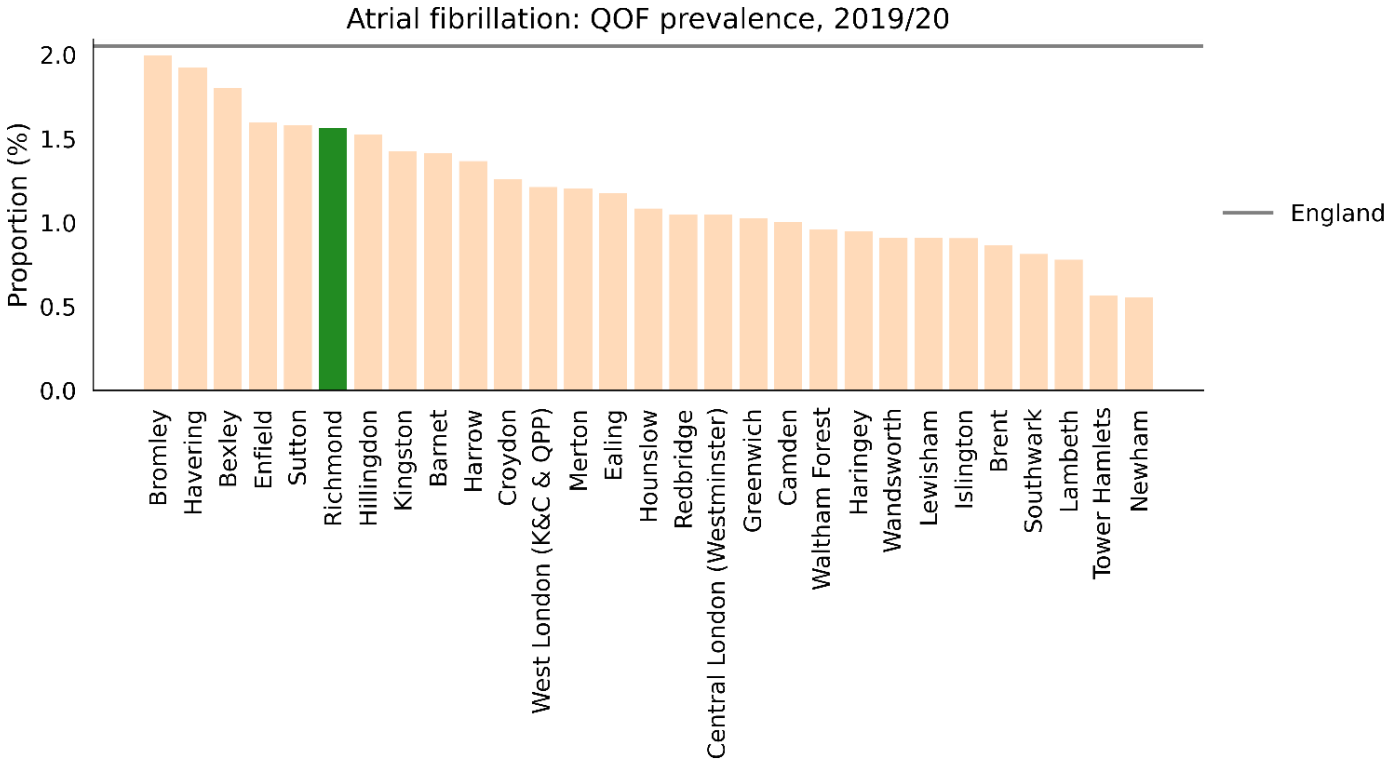
3.5 Atrial Fibrillation

Atrial Fibrillation (AF) is an important cause of morbidity and mortality. The prevalence of AF in England is rising, possibly due to improved survival rates of people with CHD, the main underlying cause of AF. 5% of over 65s, and 9% of over 75-year-olds are affected by AF. Atrial fibrillation is associated with a 500% increase in risk of stroke.

GP Recorded AF Prevalence

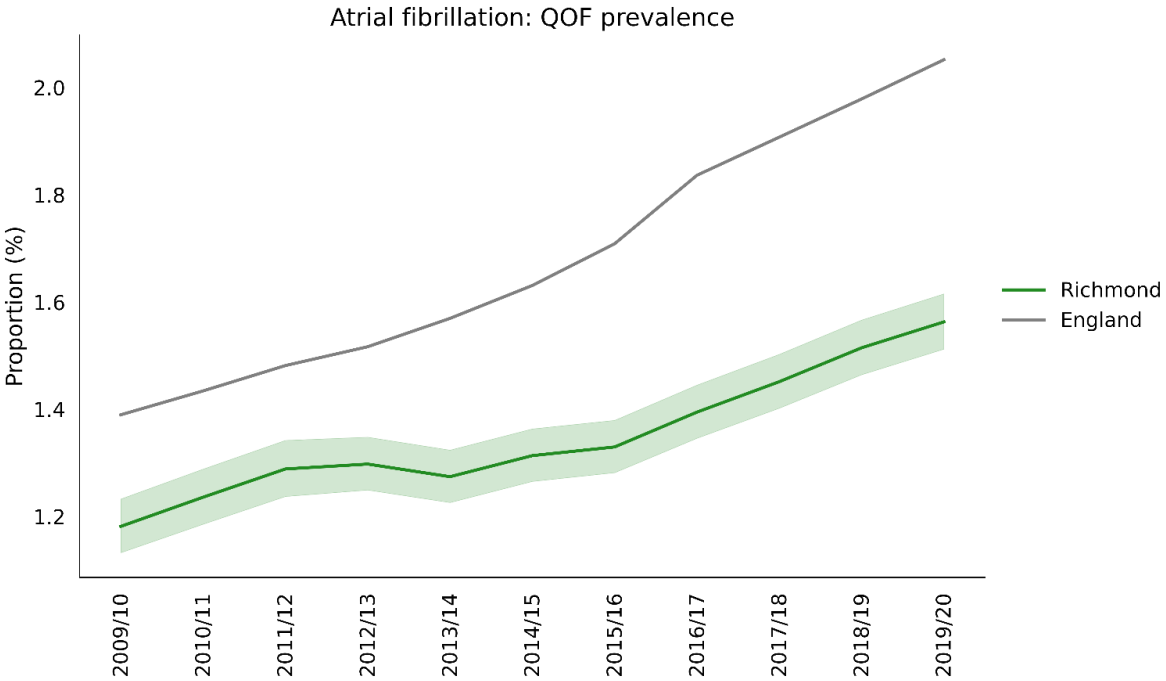
In 2019/20 Richmond's recorded prevalence of CHD was 1.6/100 (n=3476) this is the 6th highest in London (**Figure 42**), which was 23.8% lower than the England average. The latest Richmond's figure for 2019/20 was also 32.3% higher from 2009/10, in comparison with a 47.7% increase in England's rate in the equivalent time period (**Figure 43**).

Figure 42: GP recorded AF prevalence by CCG, 2019/20



Source: PHE Public Health Profiles

Figure 43: GP recorded AF prevalence, 2011 – 2020

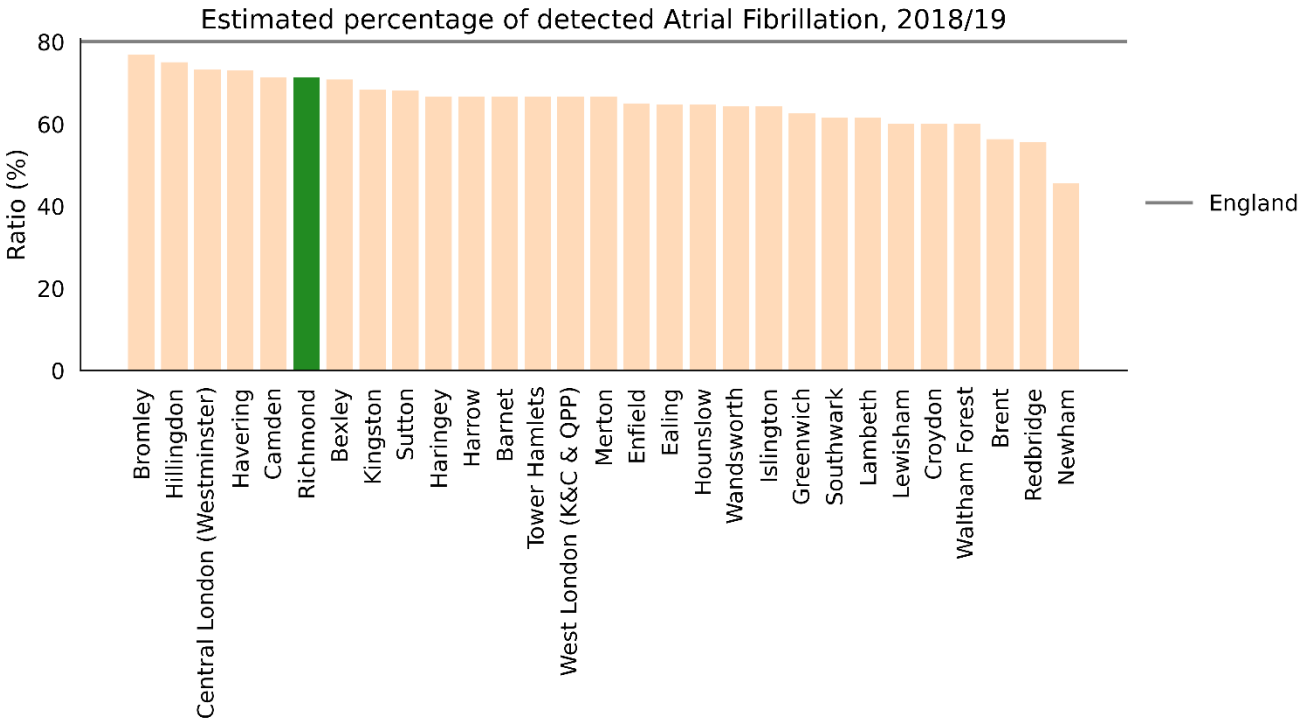


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

AF Detection Rate

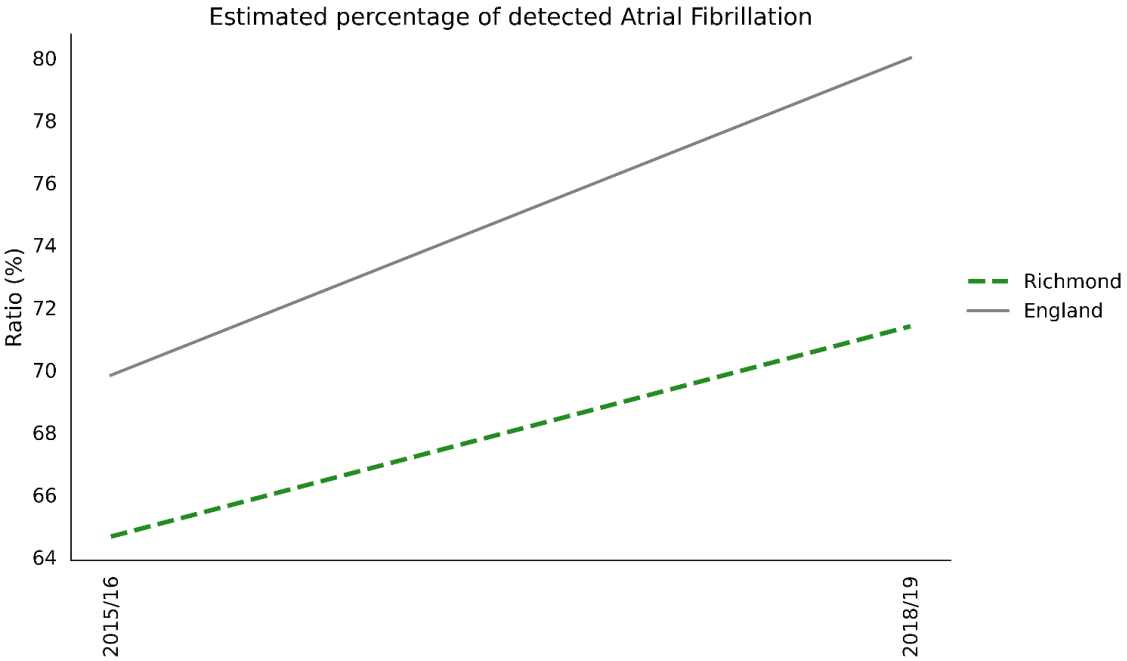
In 2018/19, Richmond's estimated detection rate for AF was 71.4%, which is the 5th highest rate in London (**Figure 44**), 10.7% lower than the England average. The latest Borough figure for 2018/19 was also 10.4% higher from 2015/16, in comparison with a 14.6% increase in England's rate in the equivalent time period (**Figure 45**).

Figure 44: Estimated AF detection rate by CCG, 2018/19



Source: PHE Public Health Profiles

Figure 45: Estimated AF detection rate, 2016 – 2019



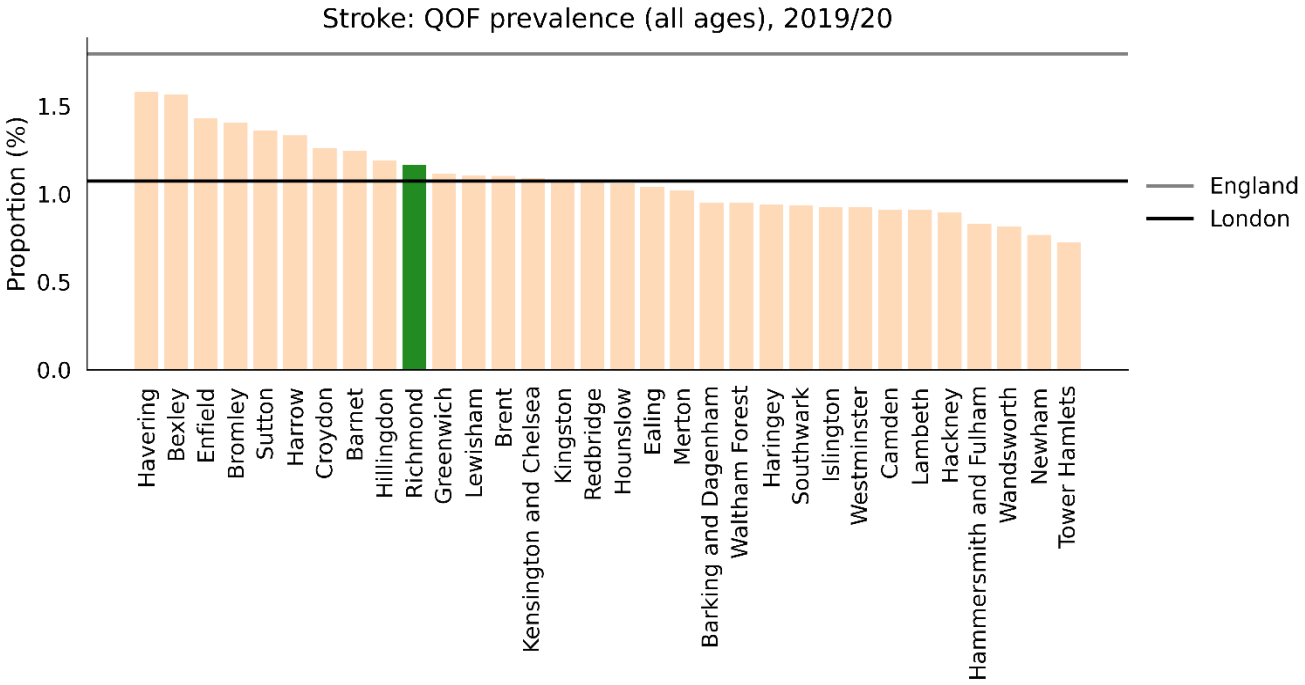
**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

3.6 Stroke

GP Recorded Prevalence of Stroke

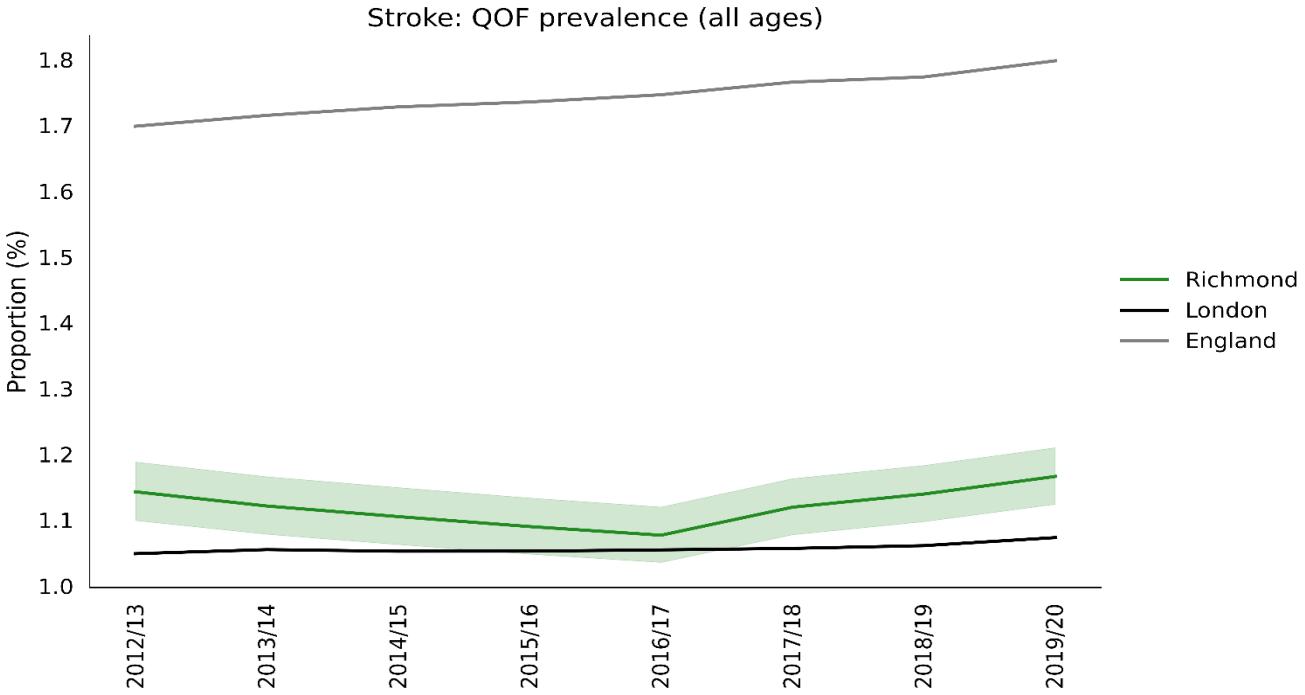
In 2019/20, Richmond's recorded prevalence of Stroke was 1.2% (n=2790), which is the 10th highest rate in London (**Figure 46**), lower than the England average and higher than the London average. The latest Borough figure for 2019/20 was also 2.0% higher from 2012/13, and is showing a rising trend since 2016/17(**Figure 47**).

Figure 46: GP Recorded stroke prevalence by local authority, 2019/20



Source: PHE Public Health Profiles

Figure 47: GP Recorded stroke prevalence, 2011 – 2020



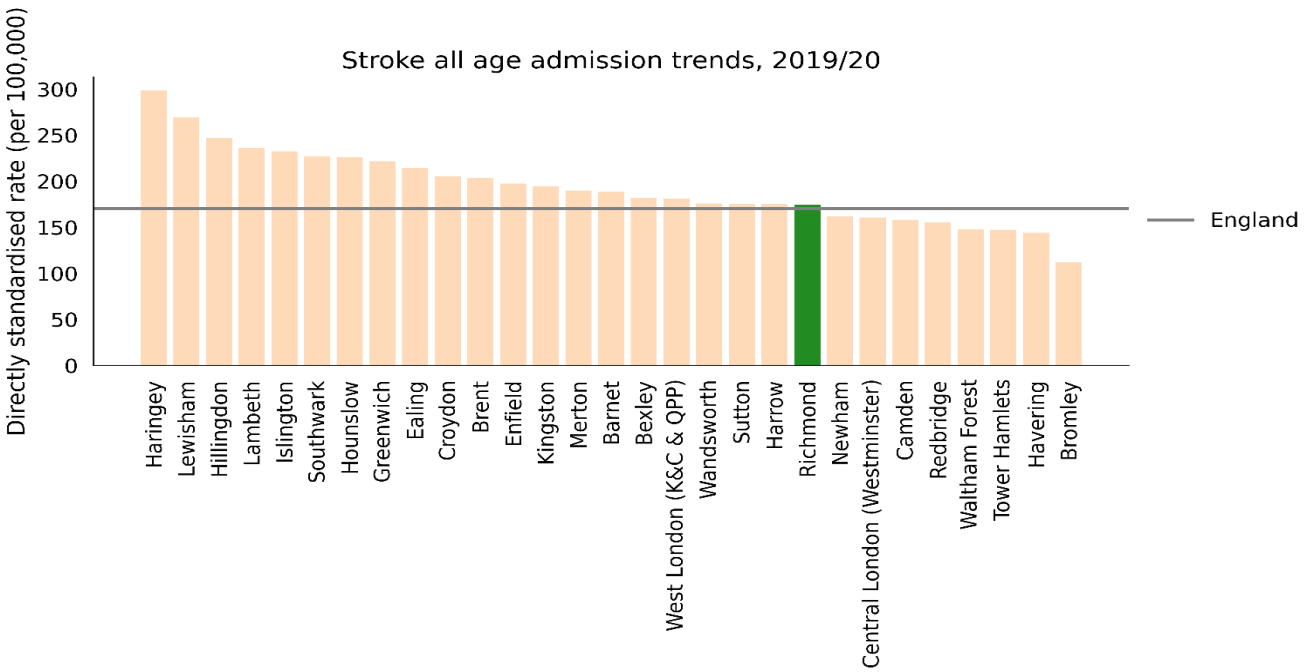
**- green ribbon shows 95% confidence interval around Richmond's indicator values*

Source: PHE Public Health Profiles

Stroke Admissions

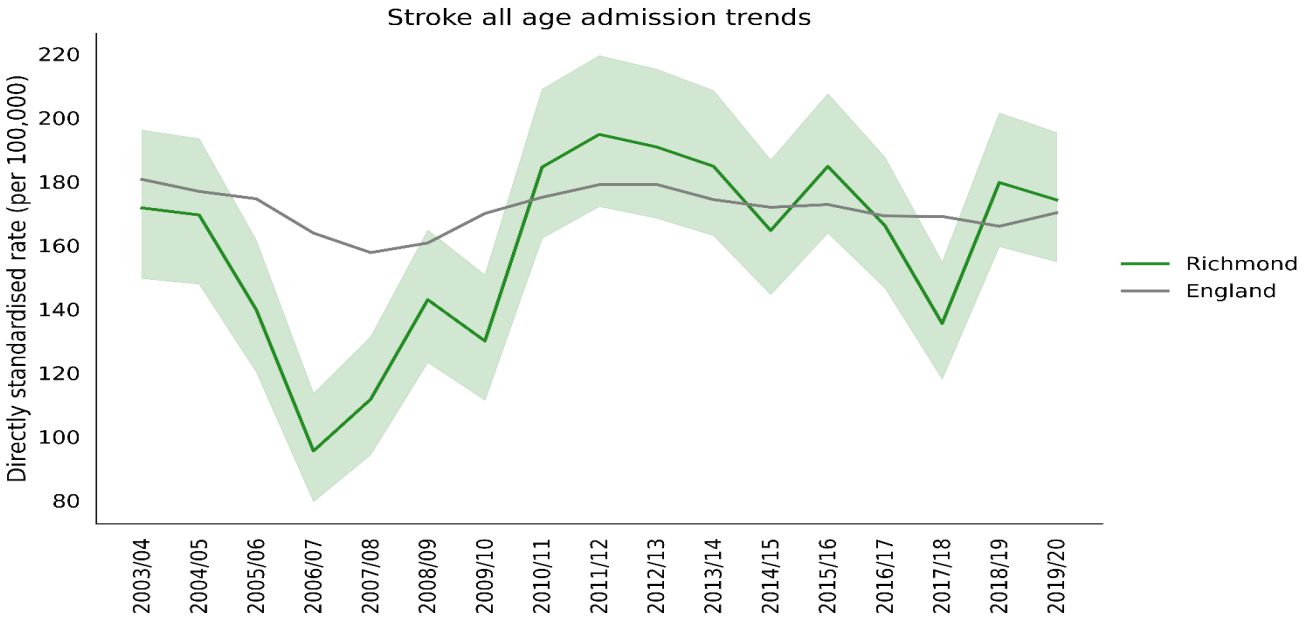
In 2019/20, Richmond's rate was 174.3 per 100,000 population (n=295), which is the 9th lowest rate in London (**Figure 48**) , 2.4% higher than the England average. The latest Borough figure for 2019/20 was also 1.5% higher from 2003/04, in comparison with a 5.8% decrease in England's rate in the equivalent time period (**Figure 49**).

Figure 48: Stroke admissions by CCG, 2019/20



Source: PHE Public Health Profiles

Figure 49: Stroke admissions, 2004–2020

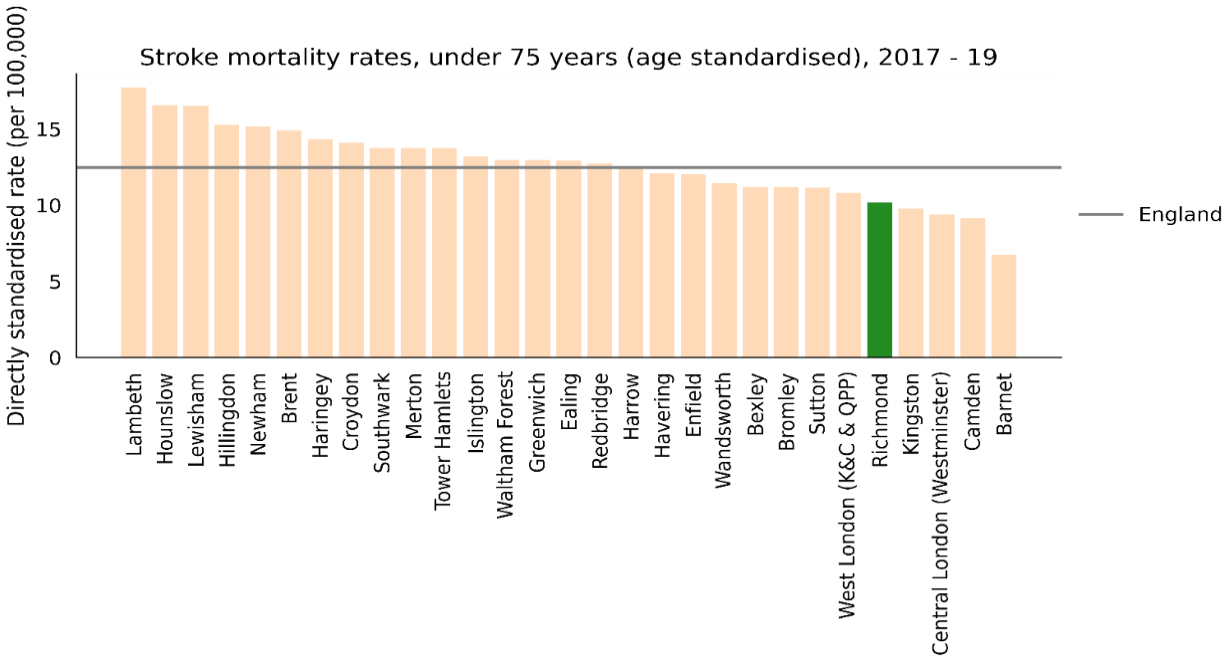


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

Stroke Mortality

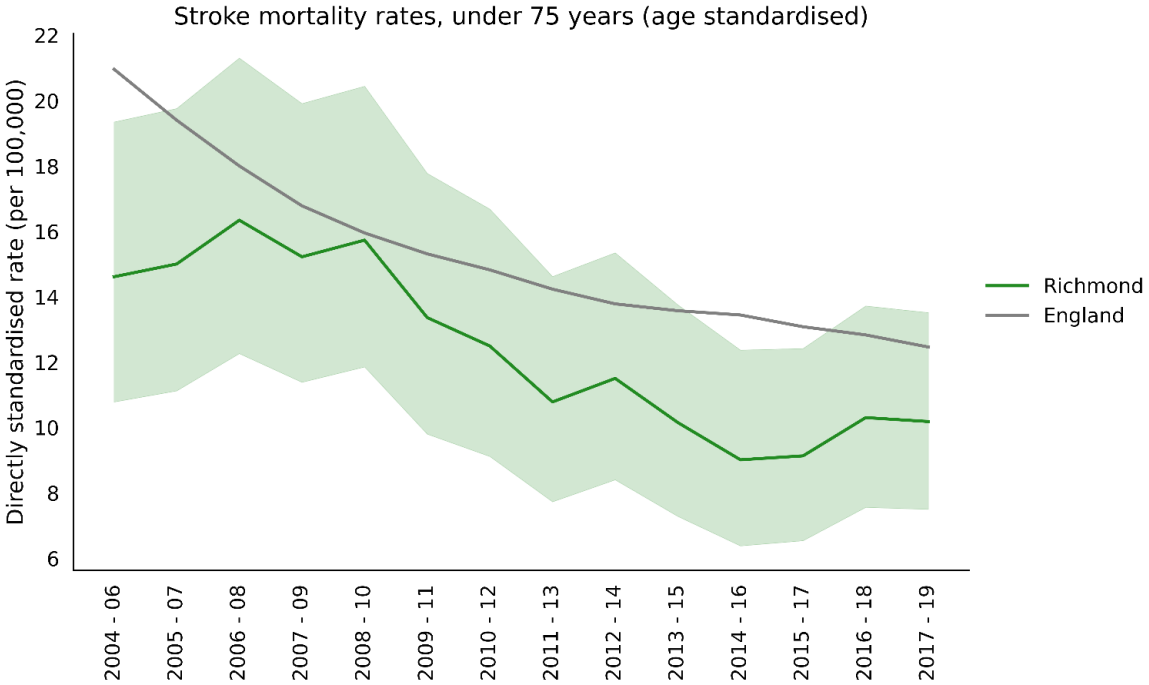
In 2017–19, Richmond's under 75 Stroke mortality rate was 10.2 per 100,000 population (n=48), which is the 5th lowest rate in London (**Figure 50**), 18.3% lower than the England average. The latest Borough figure for 2017–19 was also 30.3% lower from 2004–06, in comparison with a 40.6% decrease in England's rate in the equivalent time period (**Figure 51**).

Figure 50: Stroke mortality in people aged under 75 by CCG, 2019/20



Source: PHE Public Health Profiles

Figure 51: Stroke mortality in people aged under 75, 2004–2020

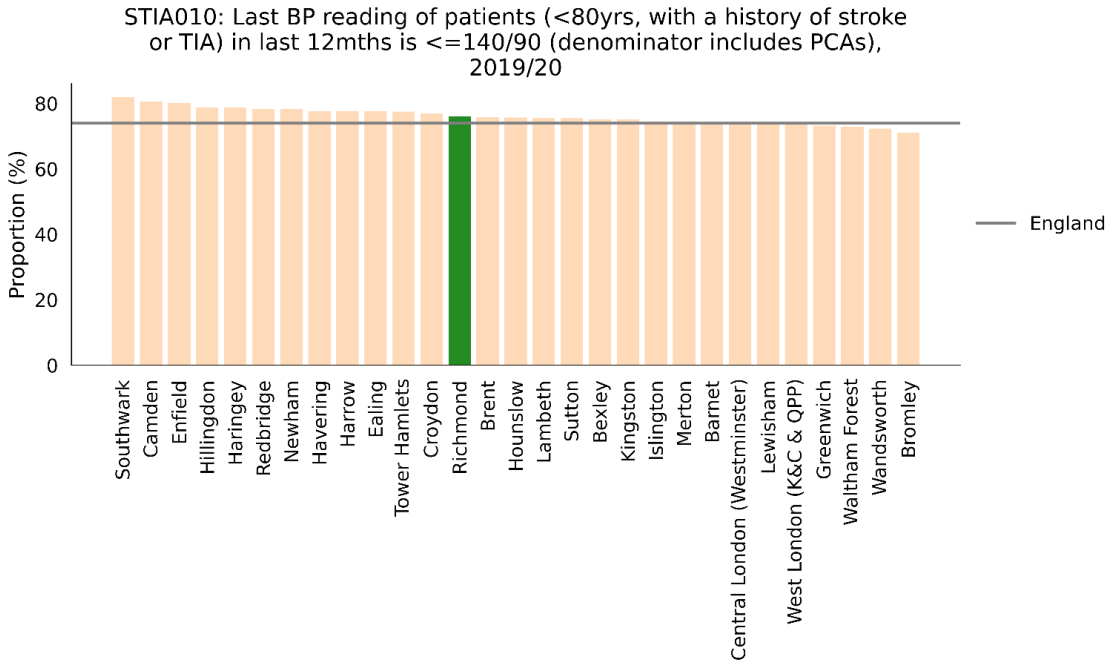


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

Stroke Management

In 2019/20 Richmond's proportion of Stroke patients aged under 80 with last blood pressure measurement within the agreed standards was 76.0% (n=1193), which is the 13th highest rate in London (**Figure 52**), which was 2.8% higher than the England average. No time trend data is available for this indicator.

Figure 52: Stroke patients aged 80+ with blood pressure measurement within the agreed standards by CCG, 2019/20



Source: PHE Public Health Profiles

4. Respiratory Diseases

Respiratory diseases may be caused by infection, smoking tobacco, by breathing in second-hand tobacco smoke, radon, asbestos, or other forms of air pollution. Respiratory diseases include asthma, chronic obstructive pulmonary disease (COPD), pulmonary fibrosis and pneumonia. In this section the latest available Richmond-level information on prevalence, hospitalisations and mortality linked to respiratory conditions will be explored. Most of the data presented are published for registered CCG population[48] (patients registered with Richmond's GP). In the last two years 5 South West London (SWL) CCGs have merged into a single South West London CCG which, starting from year 2019/20, makes it difficult to distinguish information specific to Richmond; for most CCG indicators the data presented in the chapter is 2 years old, as the latest 2019/20 and 2020/21 data is only available at SWL CCG level.

4.1 COPD

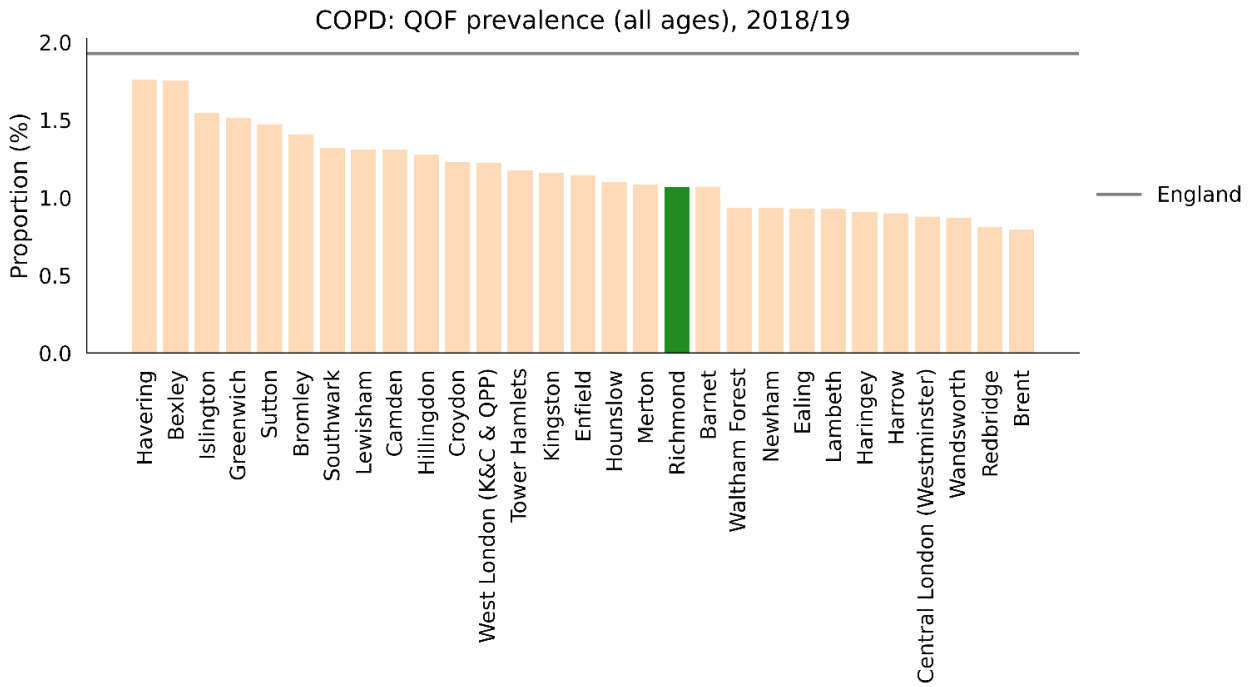
COPD (Chronic Obstructive Pulmonary Disease) is a diagnostic term that captures a variety of serious lung conditions including chronic bronchitis and emphysema. COPD is usually prevalent in adults over the age of 35. COPD is a serious lung disease for which smoking is the biggest preventable risk factor.

[48] PHE. Public Health Profiles. 2021

GP Recorded Prevalence of COPD

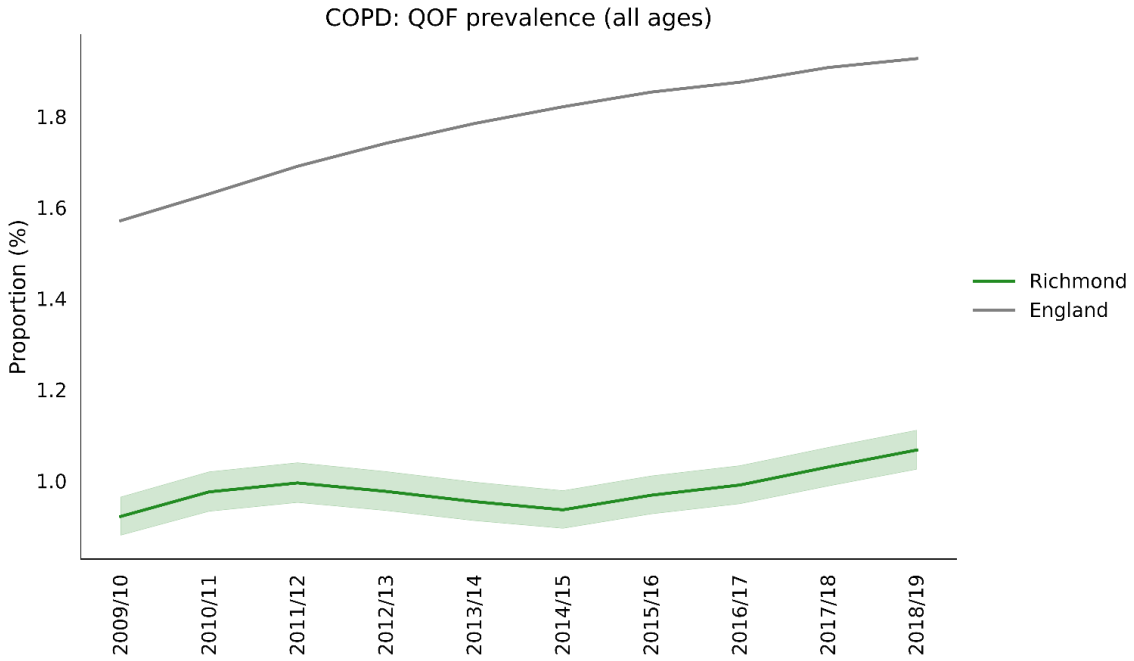
In 2018/19, Richmond's percentage of patients with COPD recorded on GP practice disease registers was 1.1% (n=2353), which is the 12th lowest rate in London (**Figure 53**) , 44.6% lower than the England average. The latest Borough figure for 2018/19 was also 15.8% higher from 2009/10, in comparison with a 22.7% increase in England's rate in the equivalent time period (**Figure 54**).

Figure 53: GP recorded prevalence of COPD by CCG, 2018/19



Source: PHE Public Health Profiles

Figure 54: GP recorded prevalence of COPD, 2010–2019

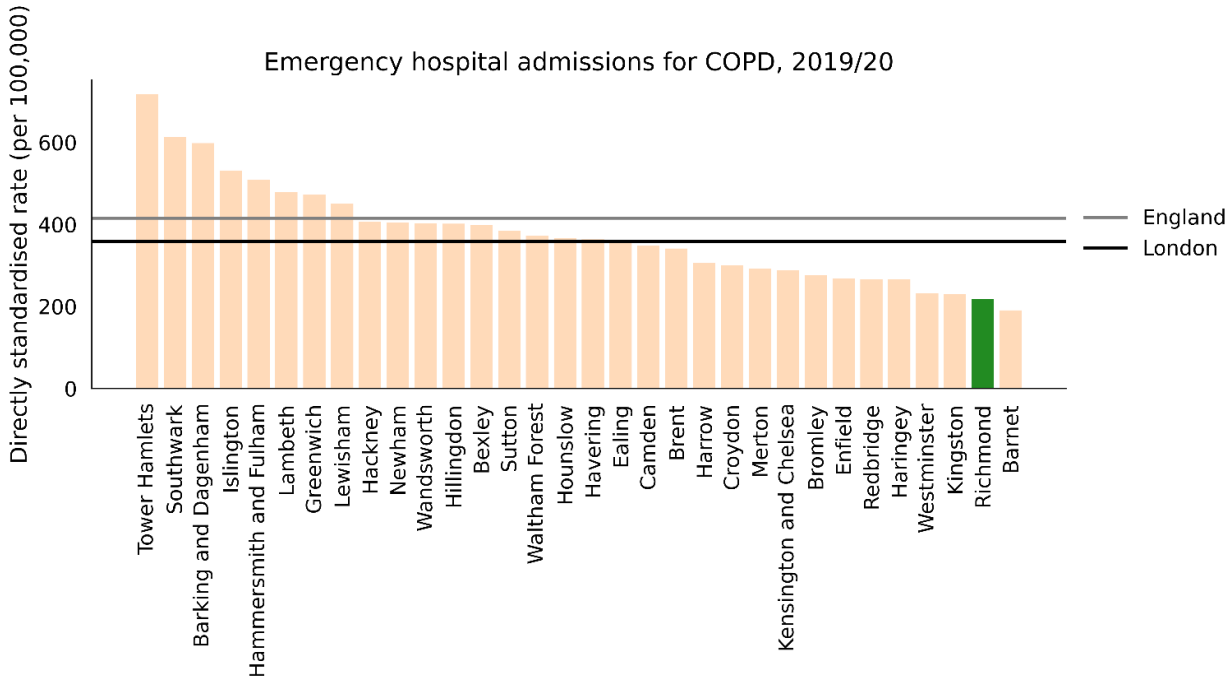


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

Emergency Hospital Admissions for COPD

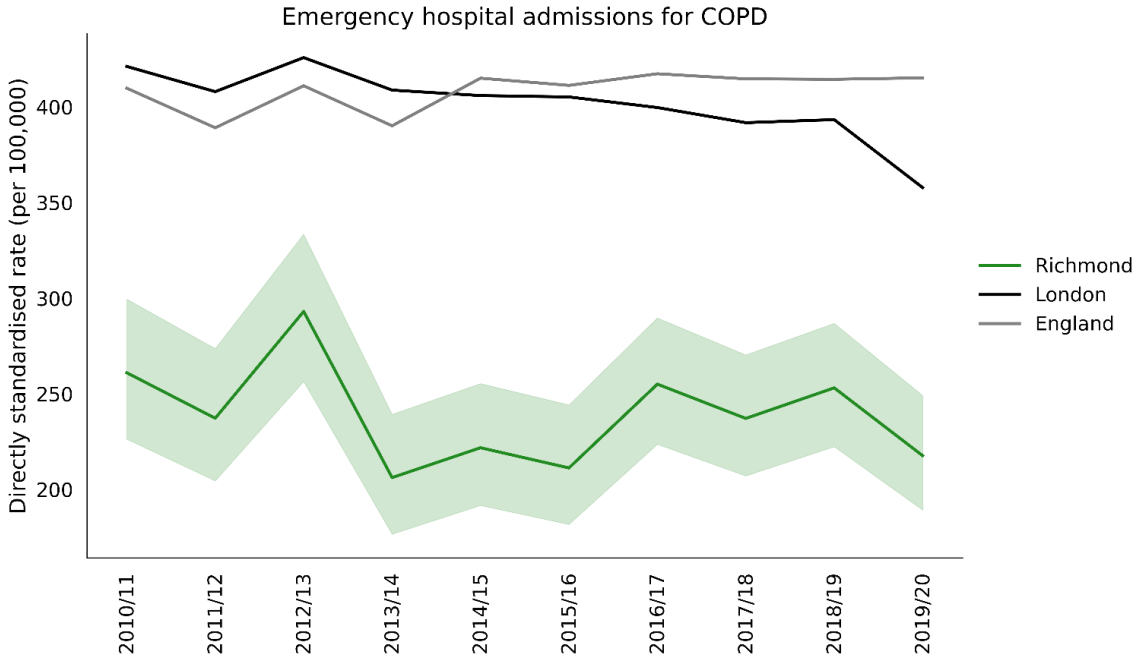
In 2019/20, Richmond's rate of emergency hospitalisations for COPD was 217.6 per 100,000 population (n=215), which is the 2nd lowest rate in London (**Figure 55**) , 47.6% lower than the England average and 39.2% lower than the London average. The latest Borough figure was also 16.6% lower from 2010/11, in comparison with a 1.3% increase in England's rate in the equivalent time period (**Figure 56**).

Figure 55: emergency hospitalisations for COPD by local authority, 2019/20



Source: PHE Public Health Profiles

Figure 56: Emergency hospitalisations for COPD, 2011 – 2020



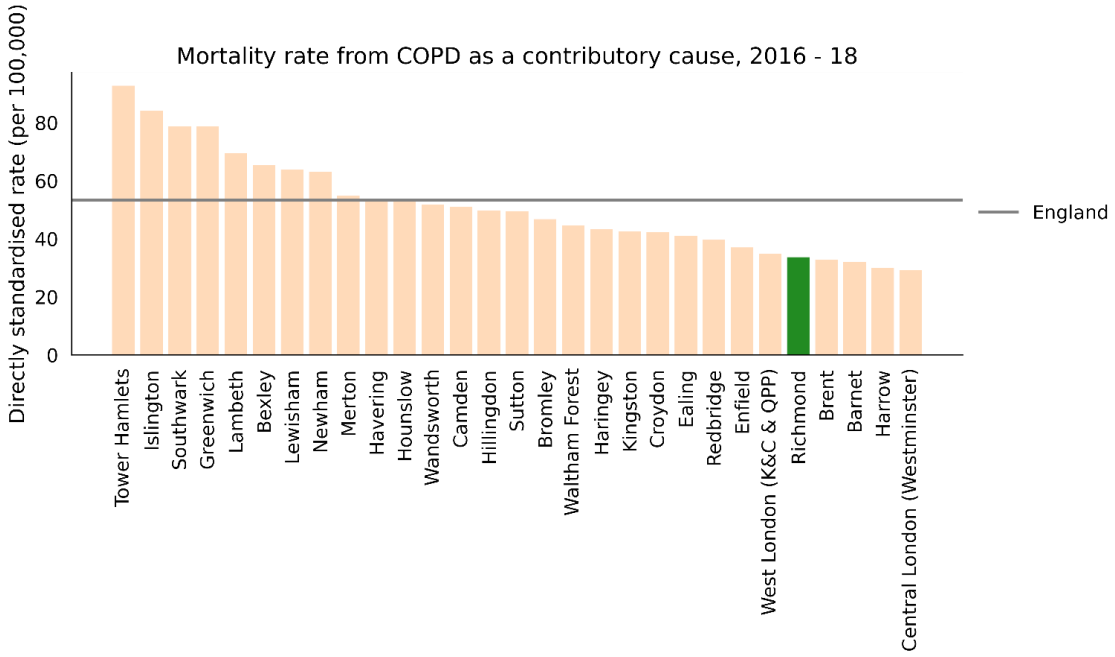
**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

Mortality from COPD as a Contributory Cause

This indicator presents mortality from COPD in all contributory causes of deaths fields (not including the underlying cause of death). Focusing on those that die with but not directly from COPD allows to understand better the role of COPD in mortality from other conditions.

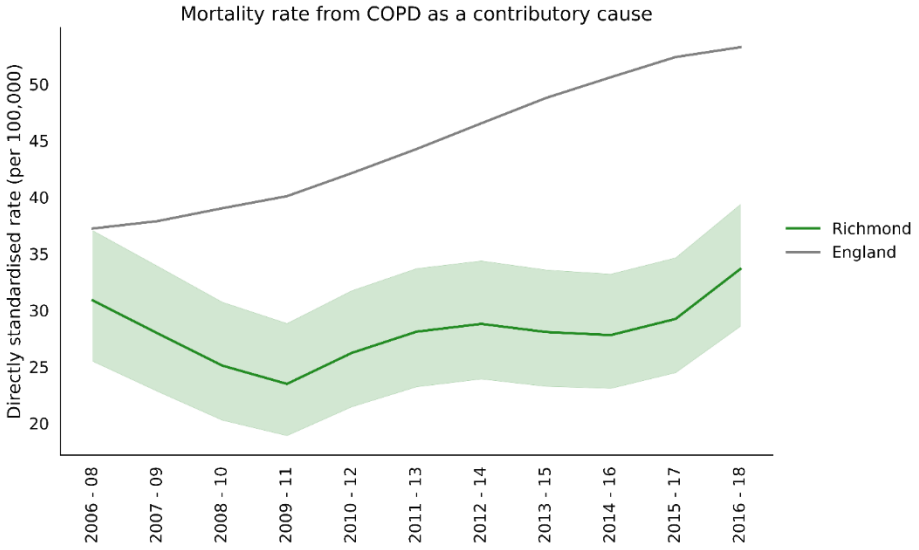
In 2016–18, Richmond's mortality rate for COPD as a contributory factor was 33.6 per 100,000 population (n=158), which is the 5th lowest rate in London (**Figure 57**) , 36.8% lower than the England average. The latest Borough figure for 2016–18 was also 9.0% higher from 2006–08, in comparison with a 43.1% increase in England's rate in the equivalent time period (**Figure 58**).

Figure 57: Mortality from COPD as a contributory cause by CCG, 2016–18



Source: PHE Public Health Profiles

Figure 58: Mortality from COPD as a contributory cause, 2008–2018



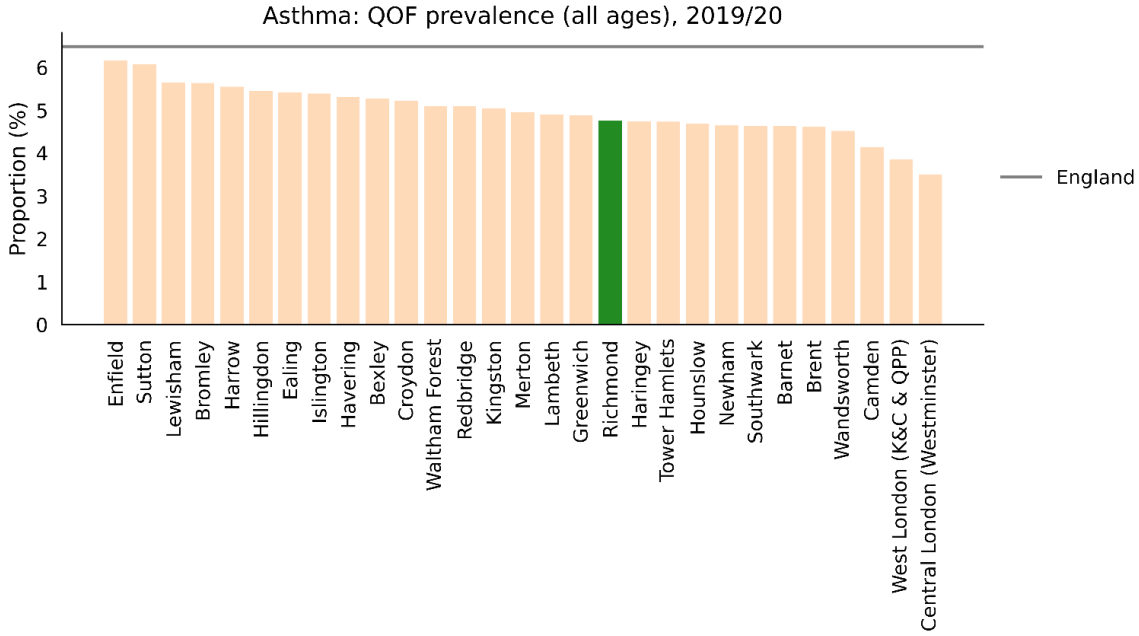
**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

4.2 Asthma

Asthma Recorded Prevalence

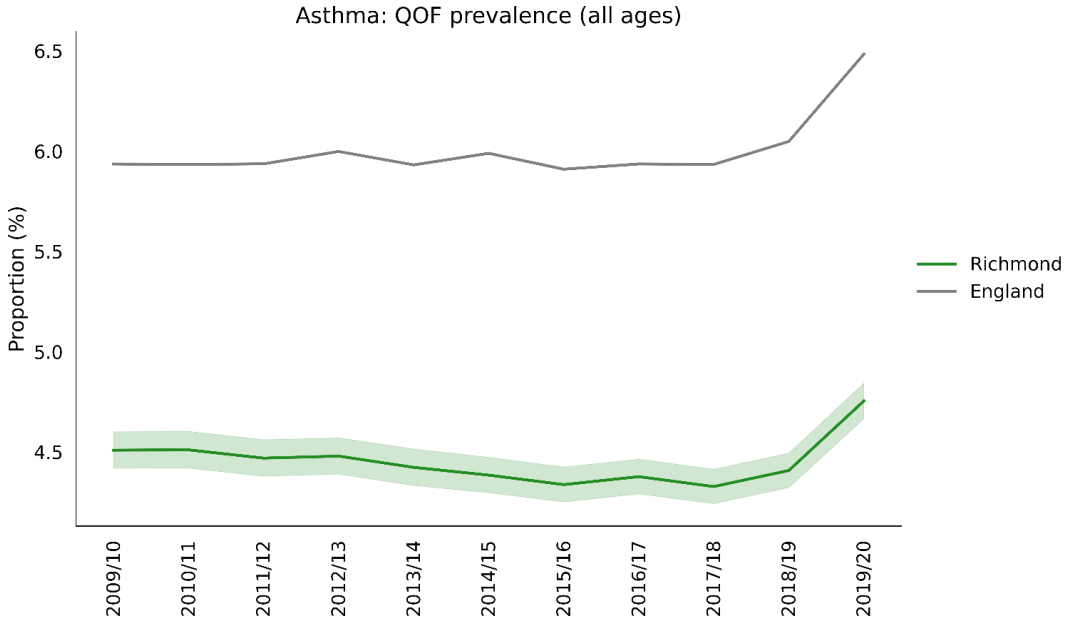
In 2019/20, Richmond's GP recorded Asthma prevalence was 4.8% (n=10575), which is the 12th lowest rate in London (**Figure 59**) , 26.7% lower than the England average. The latest Borough figure for 2019/20 was also 5.4% higher from 2009/10, in comparison with a 9.2% increase in England's rate in the equivalent time period (**Figure 60**). There has been a substantial increase in Asthma diagnoses in the last year in Richmond and elsewhere.

Figure 59: GP recorded prevalence of asthma by CCG, 2019/20



Source: PHE Public Health Profiles

Figure 60: GP recorded prevalence of asthma, 2010 – 2020

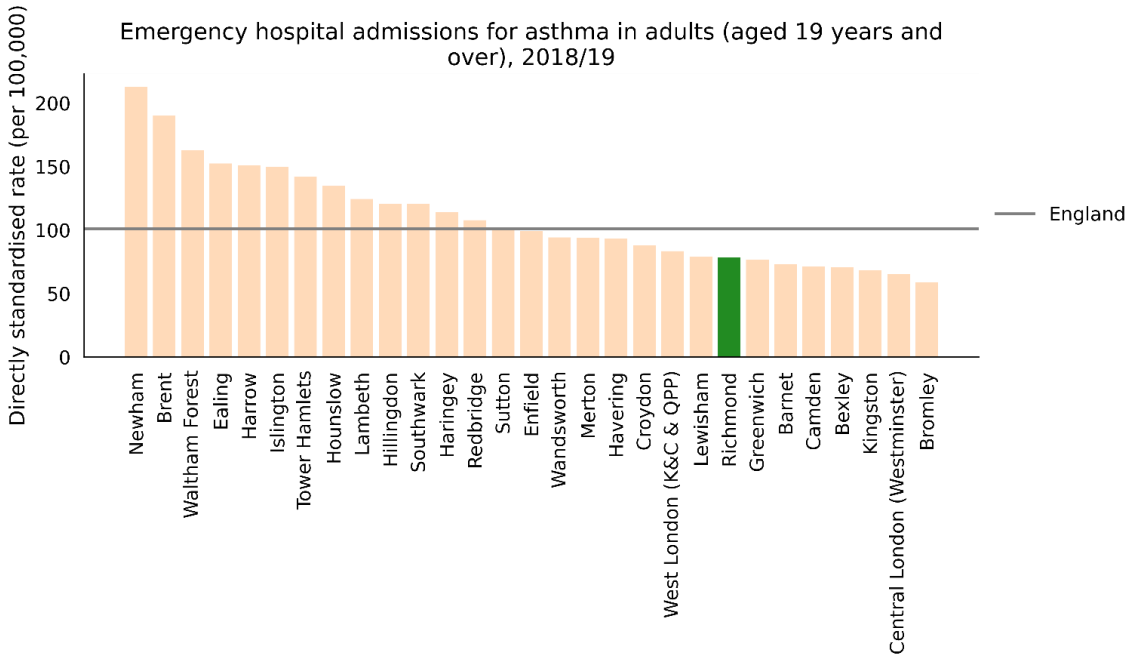


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

Emergency Hospital Admissions for Asthma in Adults

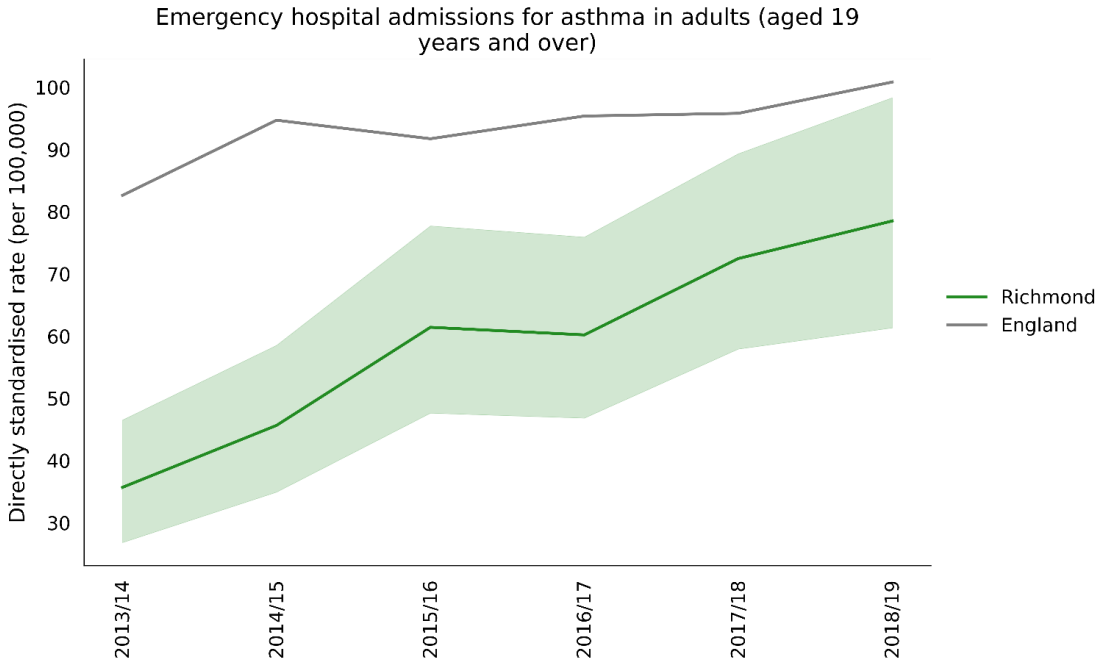
In 2018/19, Richmond's rate of emergency hospitalisations for asthma in adults aged 19 and over was 78.5 per 100,000 population (n=110), which is the 8th lowest rate in London (**Figure 61**) , 22.1% lower than the England average. The latest Borough figure for 2018/19 was also 120.0% higher from 2013/14, in comparison with a 22.0% increase in England's rate in the equivalent time period (**Figure 62**).

Figure 61: Emergency hospitalisation for asthma in adults by CCG, 2018/19



Source: PHE Public Health Profiles

Figure 62: Emergency hospitalisations for asthma in adults, 2014–2019



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

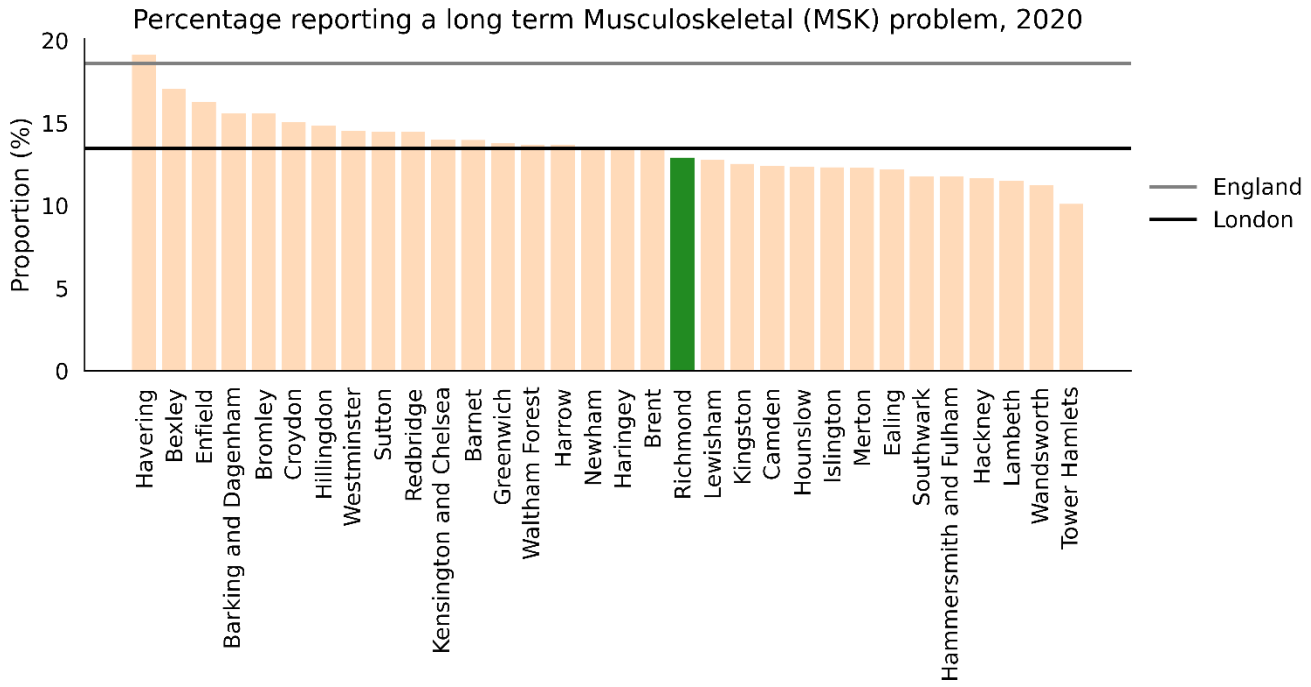
5. Musculoskeletal (MSK) Conditions

MSK conditions are injuries and disorders that affect the human body's movement or musculoskeletal system (i.e. muscles, tendons, ligaments, nerves, discs, blood vessels, etc.). Musculoskeletal conditions are the largest cause of years lived with disability (YLDs), accounting for 17% of all YLDs worldwide[49].

5.1 Prevalence of Long-term MSK Problems

In 2020, Richmond's proportion of population reporting a long term Musculoskeletal (MSK) problem was 12.9%, which is the 14th lowest rate in London (**Figure 63**) , 30.7% lower than the England average and 4.2% lower than the London average. The latest Borough figure was also 14.5% lower than in 2018, in comparison with a 1.2% decrease in England's rate in the equivalent time period (**Figure 64**).

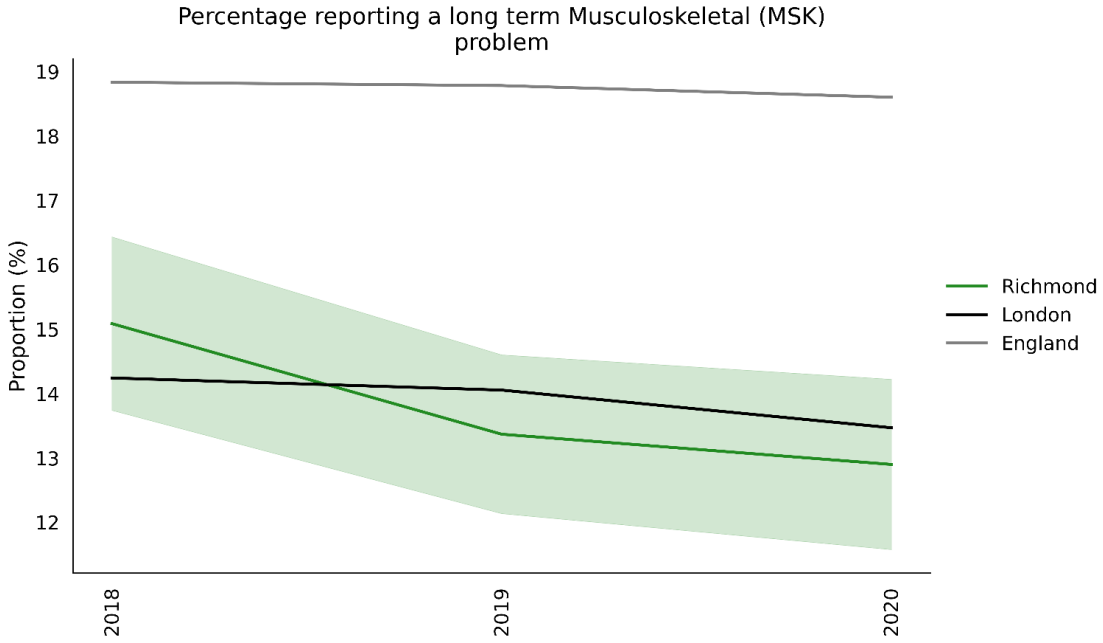
Figure 63: Proportion of population reporting a long term MSK problem by local authority, 2020.



Source: PHE Public Health Profiles

[49] WHO. Musculoskeletal conditions. 2021

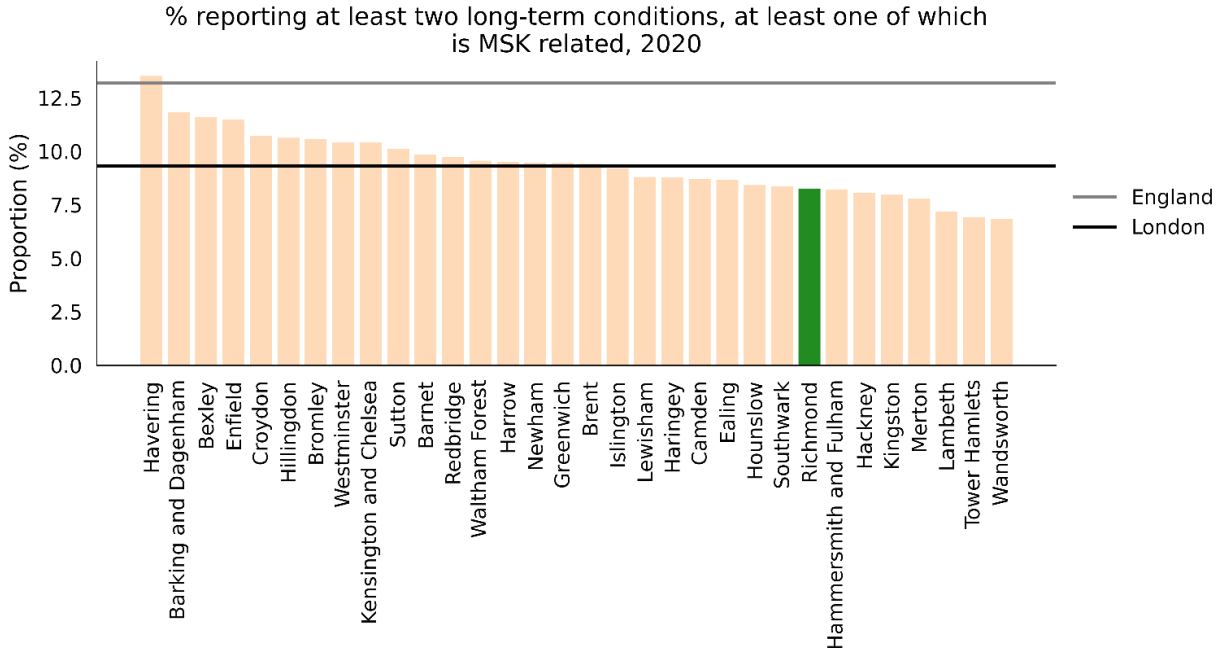
Figure 64: Proportion of population reporting a long term MSK problem, 2018–2020



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

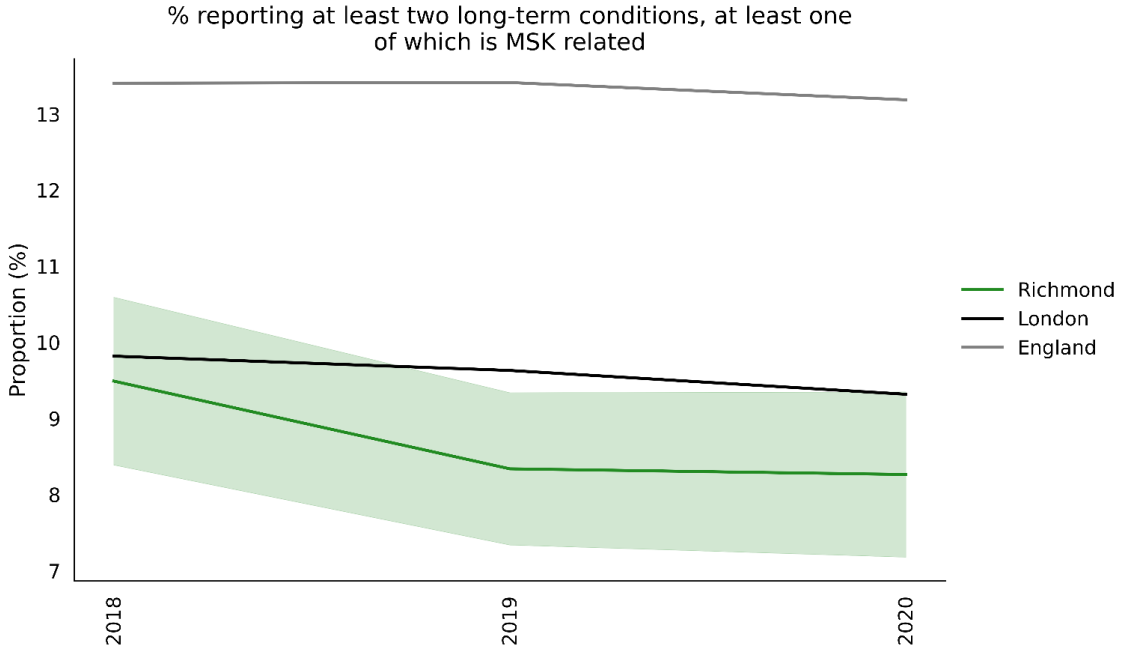
In 2020, Richmond's proportion of population reporting at least two long-term conditions, at least one of which is MSK related was 8.3%, which is the 8th lowest rate in London (**Figure 65**) , 37.4% lower than the England average and 11.3% lower than the London average. The latest Borough figure was also 12.9% lower than in 2018, in comparison with a 1.6% decrease in England's rate in the equivalent time period (**Figure 66**).

Figure 65: Proportion of population reporting at least two LTCs with one of them being MSK by local authority, 2020



Source: PHE Public Health Profiles

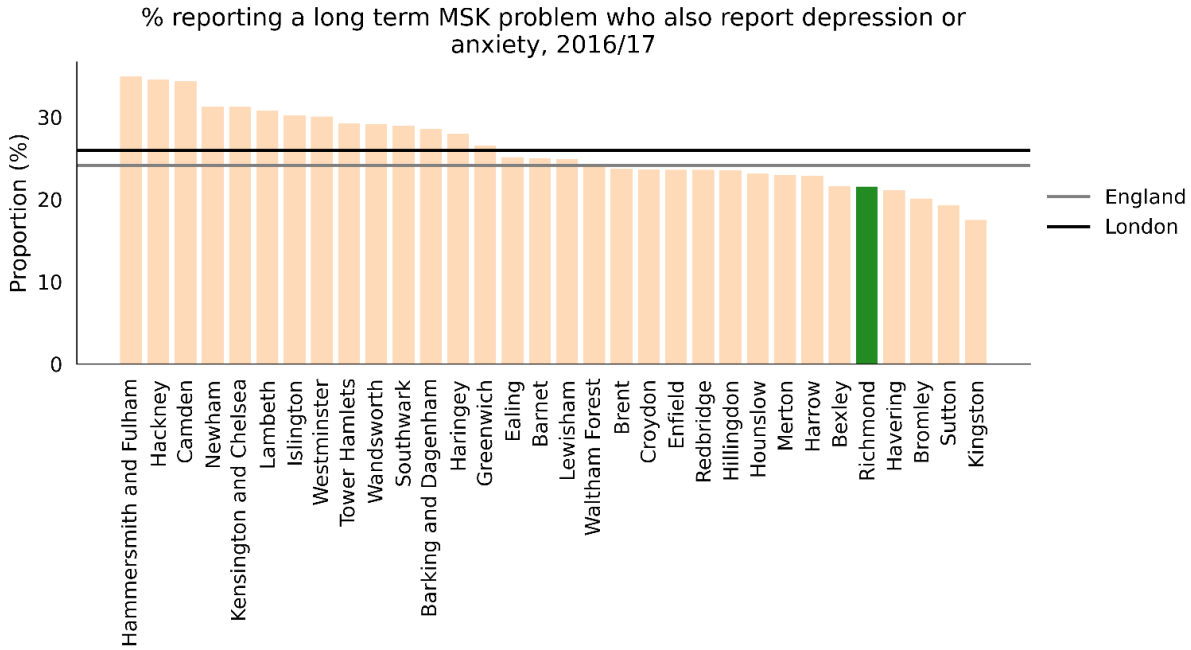
Figure 66: Proportion of population reporting at least two LTCs with one of them being MSK, 2018–2020



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles: GP Patient Survey (GPPS)

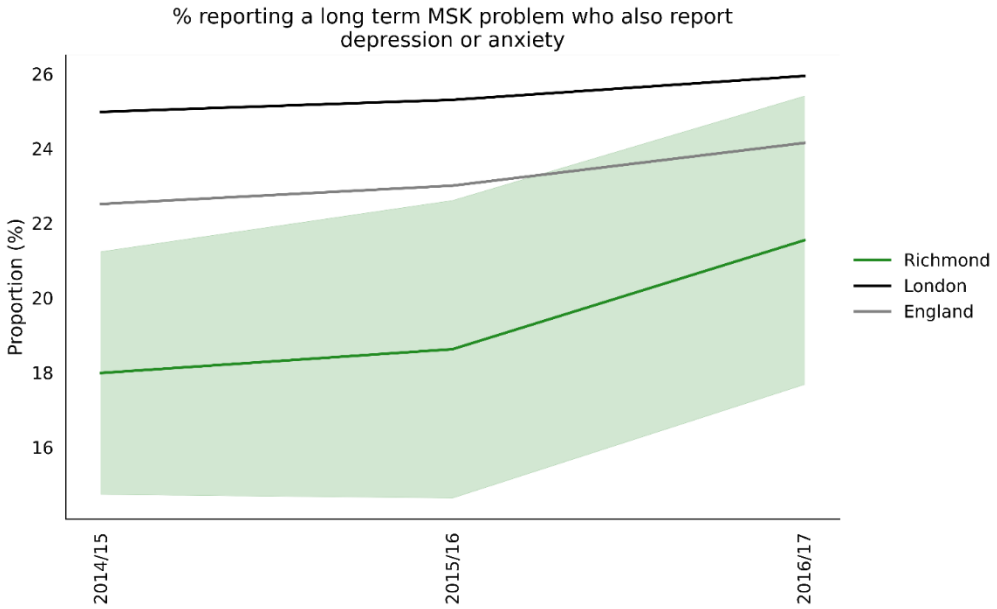
In 2016/17, Richmond's proportion of population reporting a long term MSK problem who also report depression or anxiety was 21.5%, which is the 5th lowest rate in London (**Figure 76**) , 10.8% lower than the England average and 17.0% lower than the London average. The latest Borough figure was also 19.8% higher than in 2014/15, in comparison with a 7.3% increase in England's rate in the equivalent time period (**Figure 77**).

Figure 67: Proportion of population reporting a long term MSK problem who also report depression or anxiety by local authority, 2016/17



Source: PHE Public Health Profiles

Figure 68: : Proportion of population reporting a long term MSK problem who also report depression or anxiety, 2015–2017

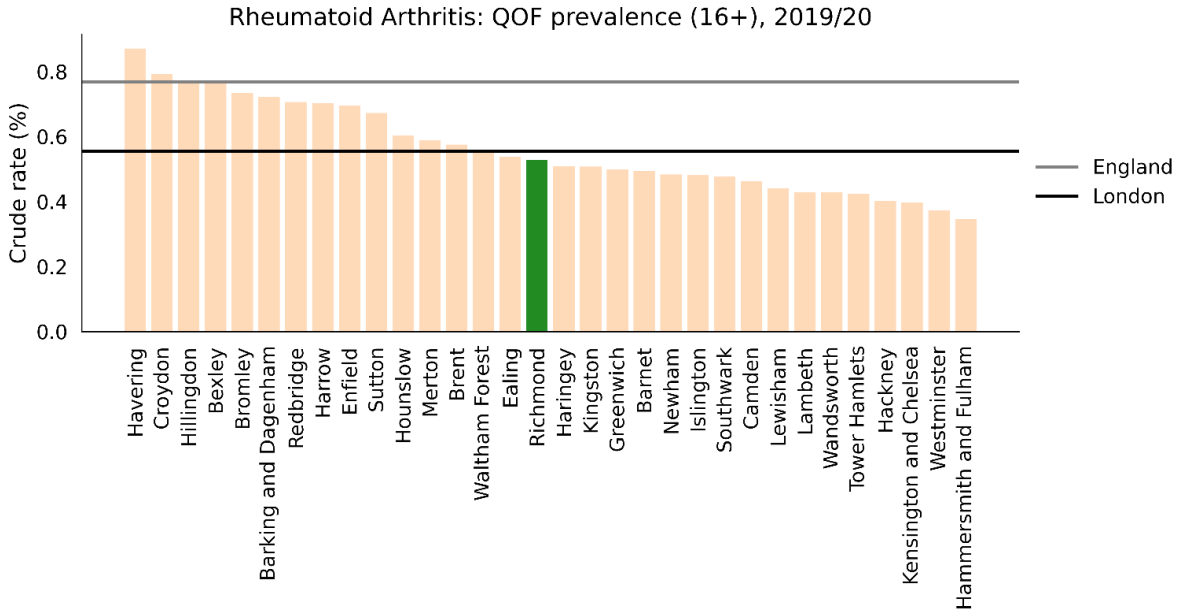


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

5.2 Rheumatoid Arthritis

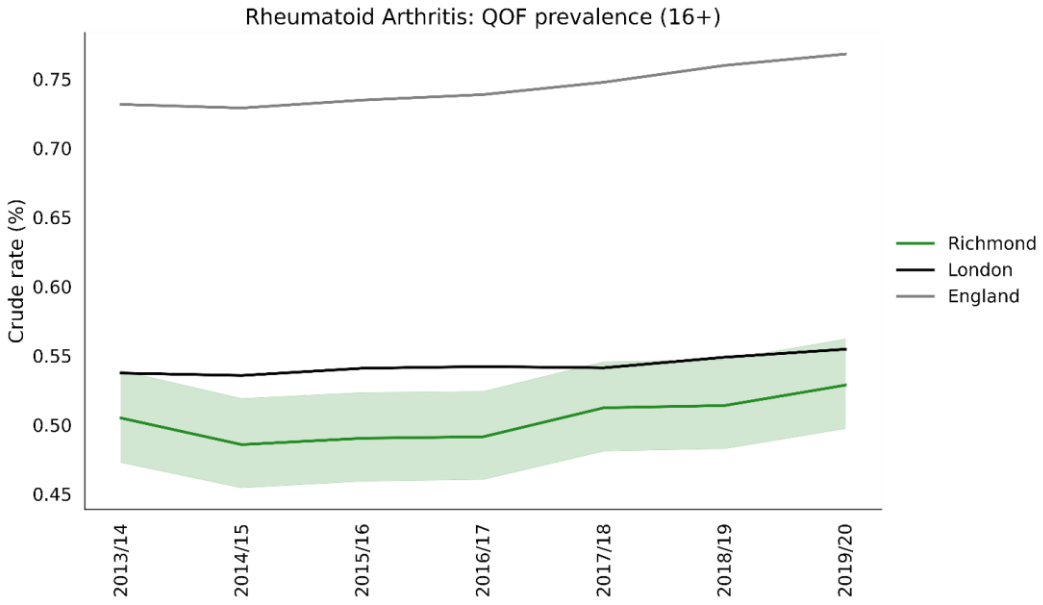
In 2019/20, Richmond's GP recorded prevalence of rheumatoid arthritis was 0.5% (n=1018), which is the 16th highest rate in London (**Figure 69**), 31.2% lower than the England average and 4.7% lower than the London average. The latest Borough figure was also 4.7% higher than in 2013/14, in comparison with a 5.0% increase in England's rate in the equivalent time period (**Figure 70**).

Figure 69: GP recorded prevalence of rheumatoid arthritis by local authority, 2019/20



Source: PHE Public Health Profiles

Figure 70: GP recorded prevalence of Rheumatoid Arthritis, 2014–2020

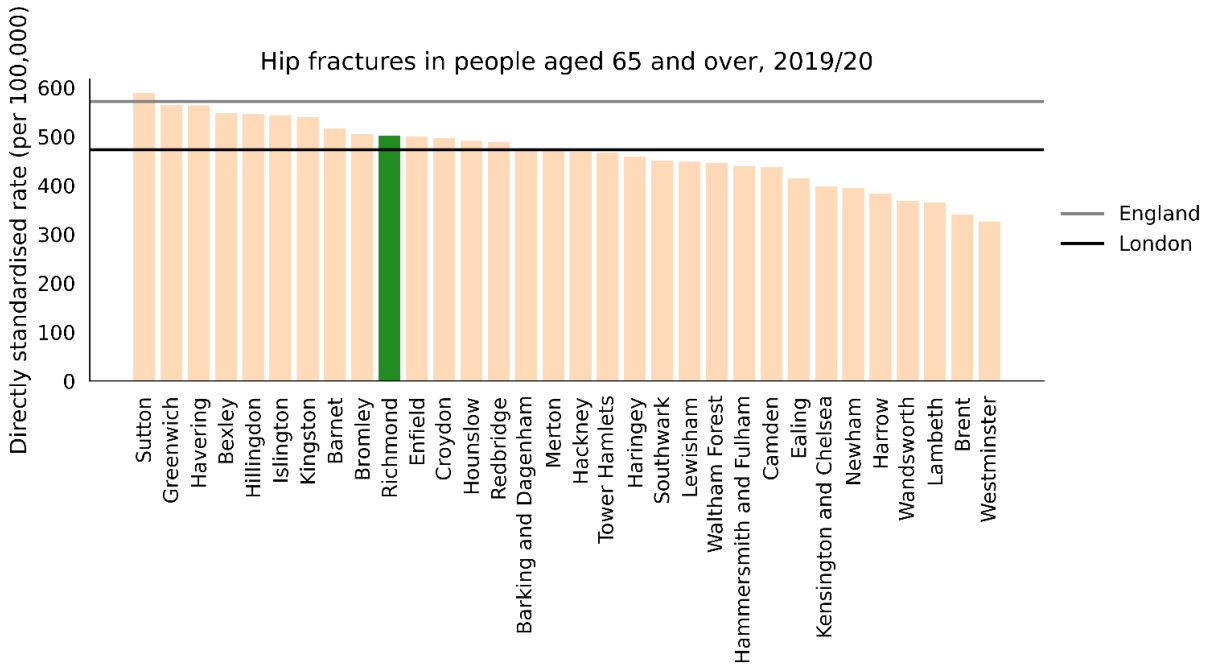


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

5.3 Hip Fractures

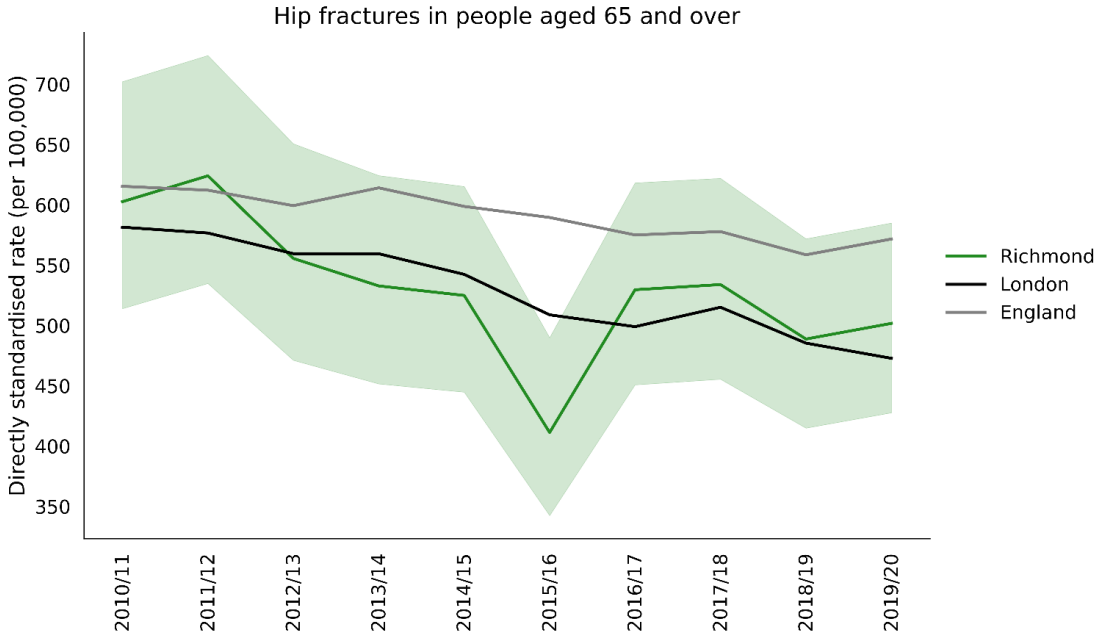
In 2019/20, Richmond's rate of hip fractures in people aged 65 and over was 501.6 per 100,000 (n=165), which is the 10th highest rate in London (**Figure 71**), 12.2% lower than the England average and 6.1% higher than the London average. The latest Borough figure for 2019/20 was also 16.7% lower than in 2010/11, in comparison with a 7.1% decrease in England's rate in the equivalent time period (**Figure 72**).

Figure 71: Hip fractures rate by local authority, 2019/20



Source: PHE Public Health Profiles

Figure 72: Hip fractures rate, 2011–2020



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

6. Mental Health

People living with mental health problem are more like to endanger their health and well-being through their lifestyle choices; they are twice as likely to smoke[50]. Mental health problems often lead to alcohol and substance misuse[51]; increasing the risk of obesity, asthma, diabetes, chronic obstructive pulmonary disease (COPD) and cardiovascular disease[52]. This section provides an overview of nationally available data on mental health in adults living in Richmond, including GP recorded prevalence of mental illnesses, referral rates to specialist services, admissions to hospital, employment rates, accommodation status and premature mortality rates in adults with mental health problems.

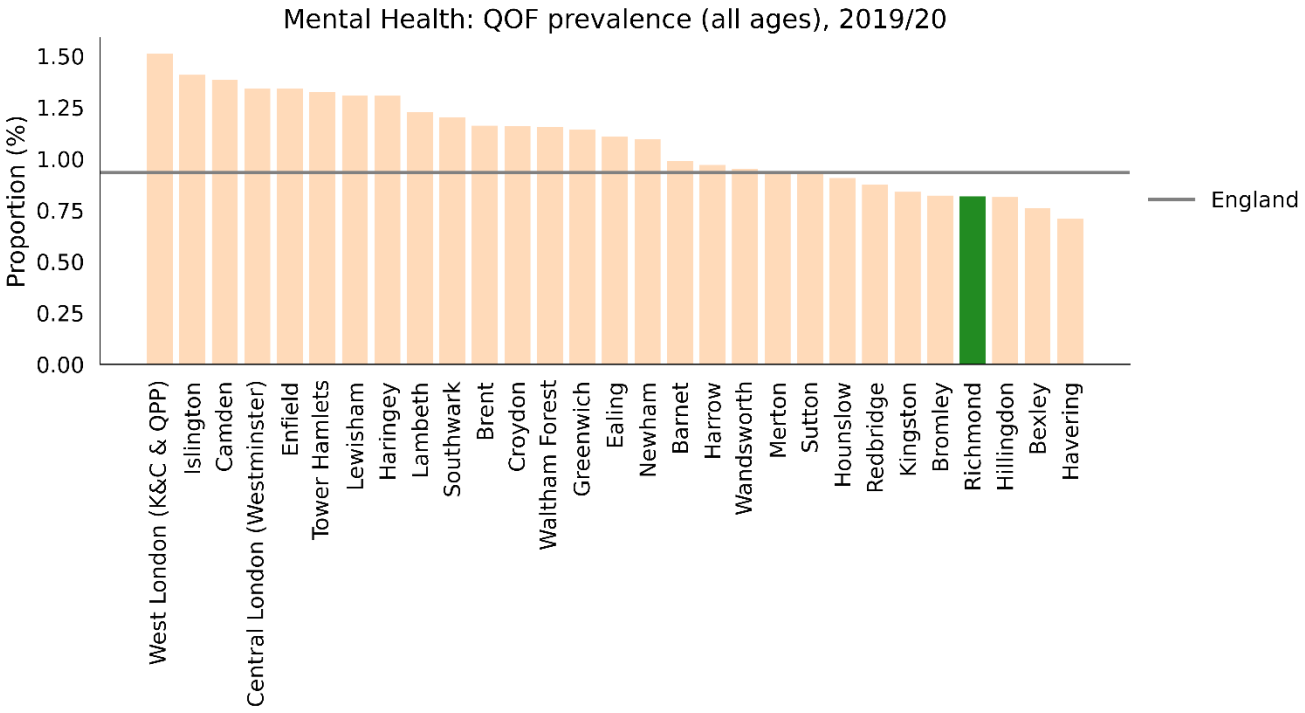
6.1 Key Demographics and Need

GP Recorded Prevalence of Mental Illness

GP Mental Health Registers include patients with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses. In 2019/20, Richmond's proportion of registered patients with recorded mental illness was 0.8% (n=1815), which is the 4th lowest rate in London (**Figure 73**) , 12.4% lower than the England average. The latest Borough figure for 2019/20 was also 0.6% lower from 2012/13, in comparison with a 11.0% increase in England's rate in the equivalent time period (**Figure 74).**

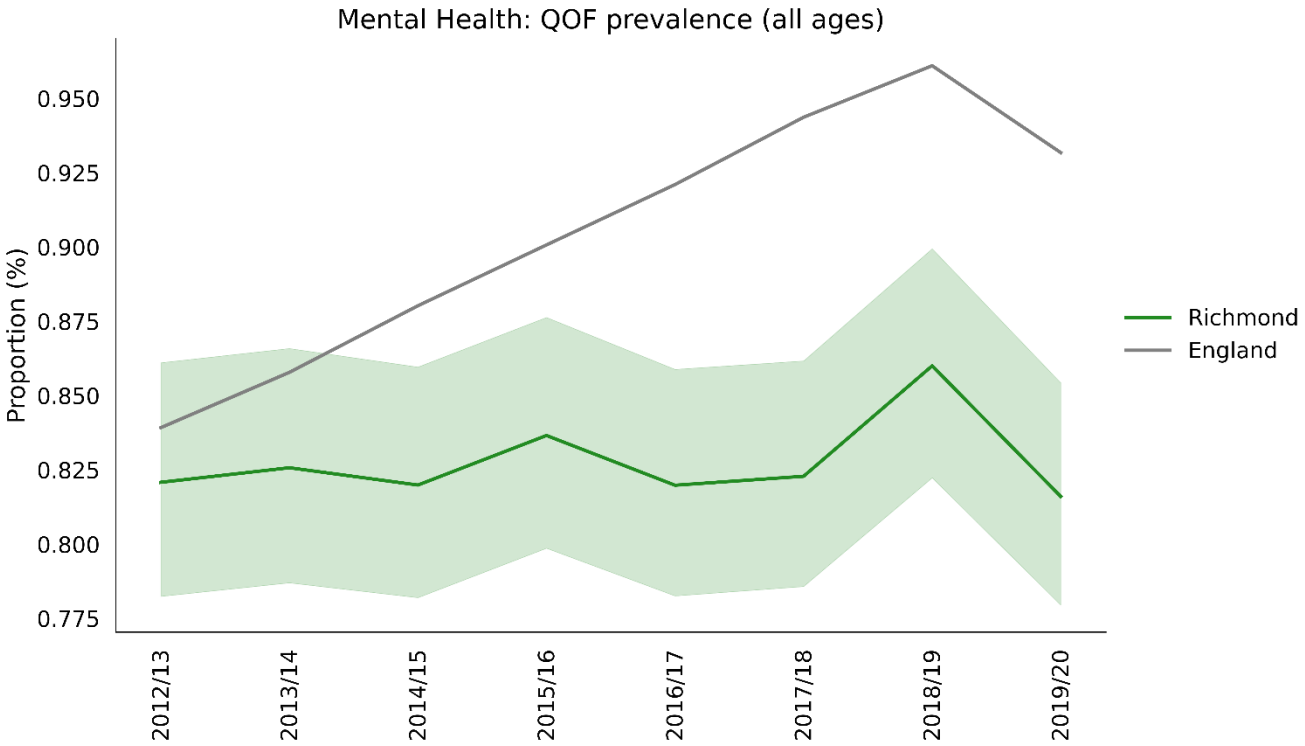
[50] https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities
[51] Langås, AM., Malt, U.F. & Opjordsmoen, S. Comorbid mental disorders in substance users from a single catchment area - a clinical study. *BMC Psychiatry* 11, 25 (2011). https://doi.org/10.1186/1471-244X-11-25
[52] https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities

Figure 73: GP recorded prevalence of mental illness by CCG, 2019/20



Source: PHE Public Health Profiles

Figure 74: GP Recorded prevalence of mental illness, 2010–2019

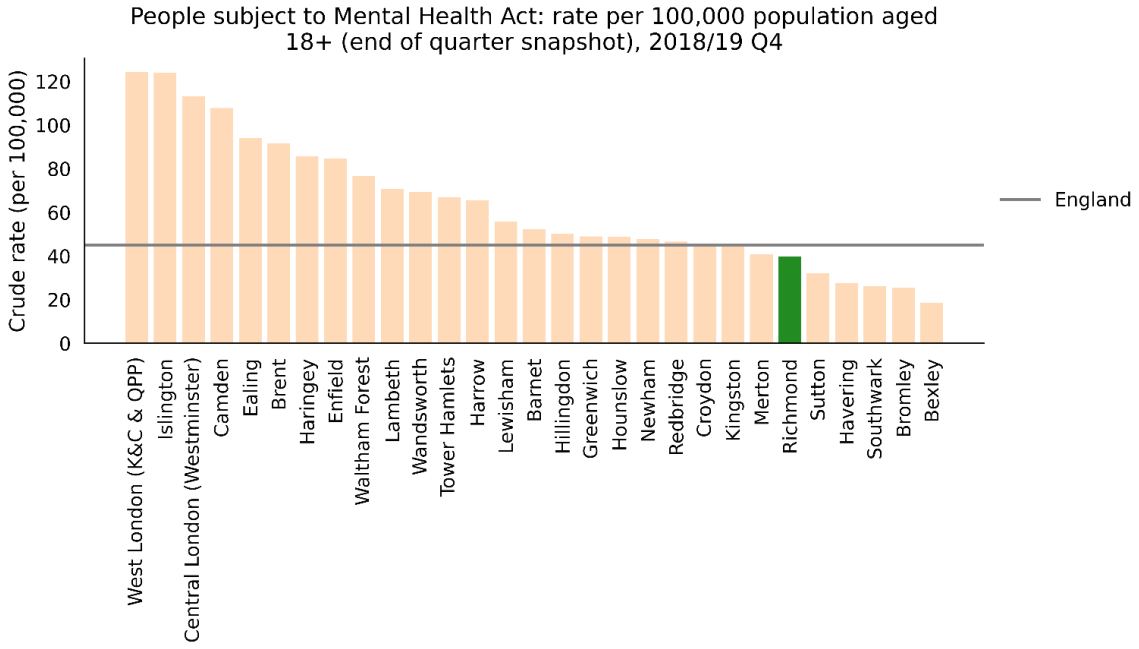


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

People Subject to Mental Health Act

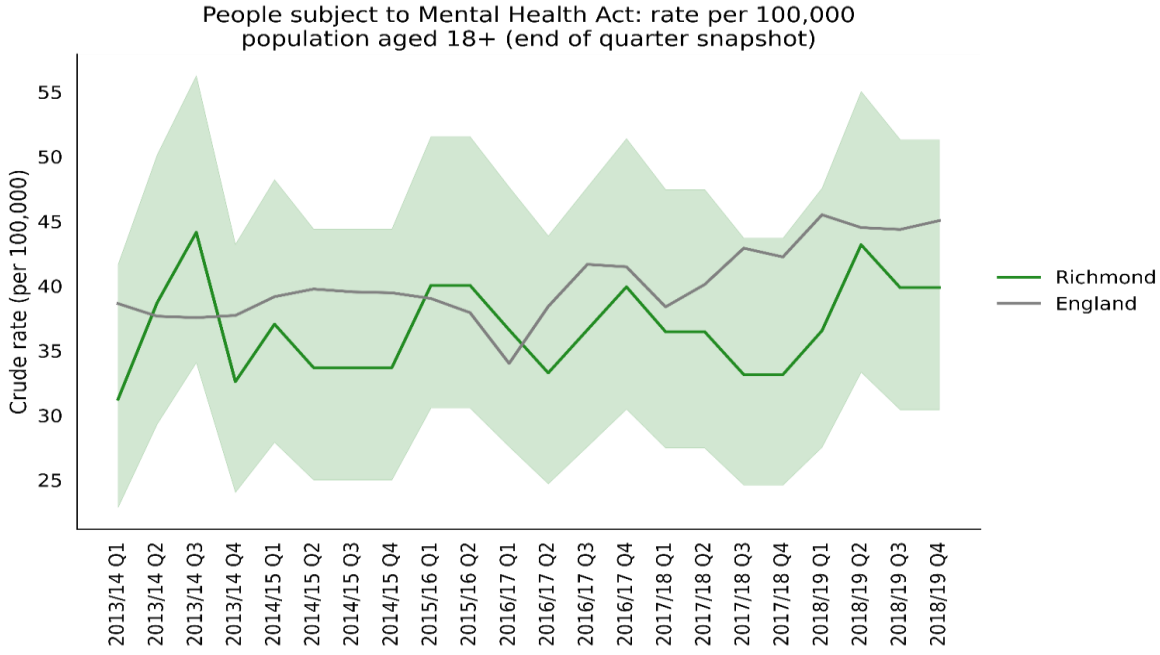
The Mental Health Act is used to formally detain a patient for their own safety, or that of other people.
In 2018/19 Q4, Richmond's rate of people aged 18+ detained under the Mental Health Act was 39.9 per 100,000 population (n=60), which is the 6th lowest rate in London (**Figure 75**) , 11.5% lower than the England average. The latest Borough figure for 2018/19 Q4 was also 27.6% higher from 2013/14 Q1, in comparison with a 16.6% increase in England's rate in the equivalent time period (**Figure 76**).

Figure 75: People detained under Mental Health Act by CCG, 2019/20



Source: PHE Public Health Profiles

Figure 76: People detained under Mental Health Act, 2014–2019



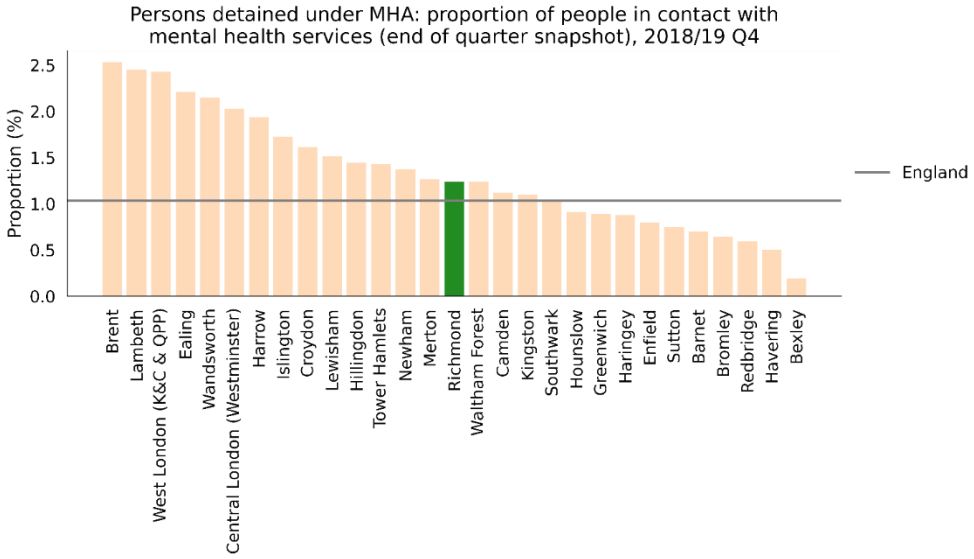
**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

Proportion of People in Contact with Mental Health Services that are Detained under the Mental Health Act

This indicator explores the people who are accessing Mental Health Services who end up being detained. A high detention rate can indicate that the Service is not sufficiently resourced once a person is at risk to themselves and others; it may also indicate missed opportunities for early intervention or that people are reaching crisis before their treatment commences.

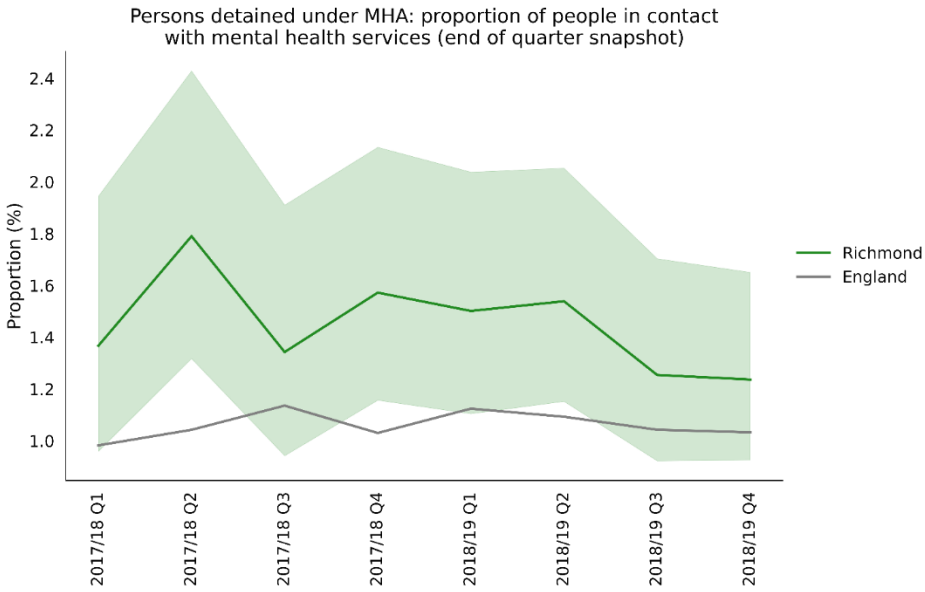
In 2018/19 Q4, Richmond's proportion of detained Mental Health Service Users was 1.2% (n=45), which is the 15th highest rate in London (**Figure 77**), 19.8% higher than the England average. The latest Borough figure for 2018/19 Q4 was also 9.5% lower from 2017/18 Q1, in comparison with a 5.1% increase in England's rate in the equivalent time period (**Figure 78**).

Figure 77: People detained under Mental Health Act by CCG, 2018/19 Q4



Source: PHE Public Health Profiles

Figure 78: People detained under Mental Health Act, 2014–2019

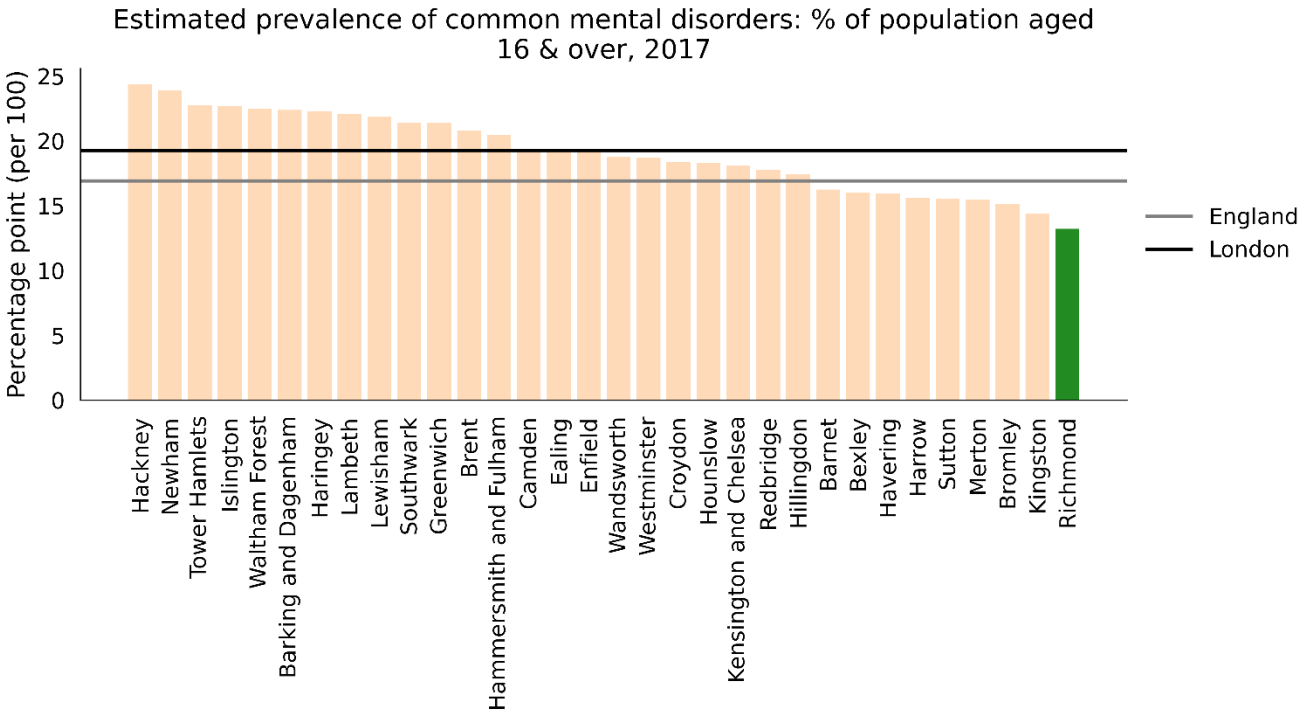


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

Estimated prevalence of common mental disorders

In 2017, Richmond's estimated prevalence of common mental disorders was 13.2% (n=20430), which is the lowest rate in London (**Figure 79**) , 21.9% lower than the England average and 31.4% lower than the London average.

Figure 79: Estimated prevalence of common mental disorders by Local Authority, 2017



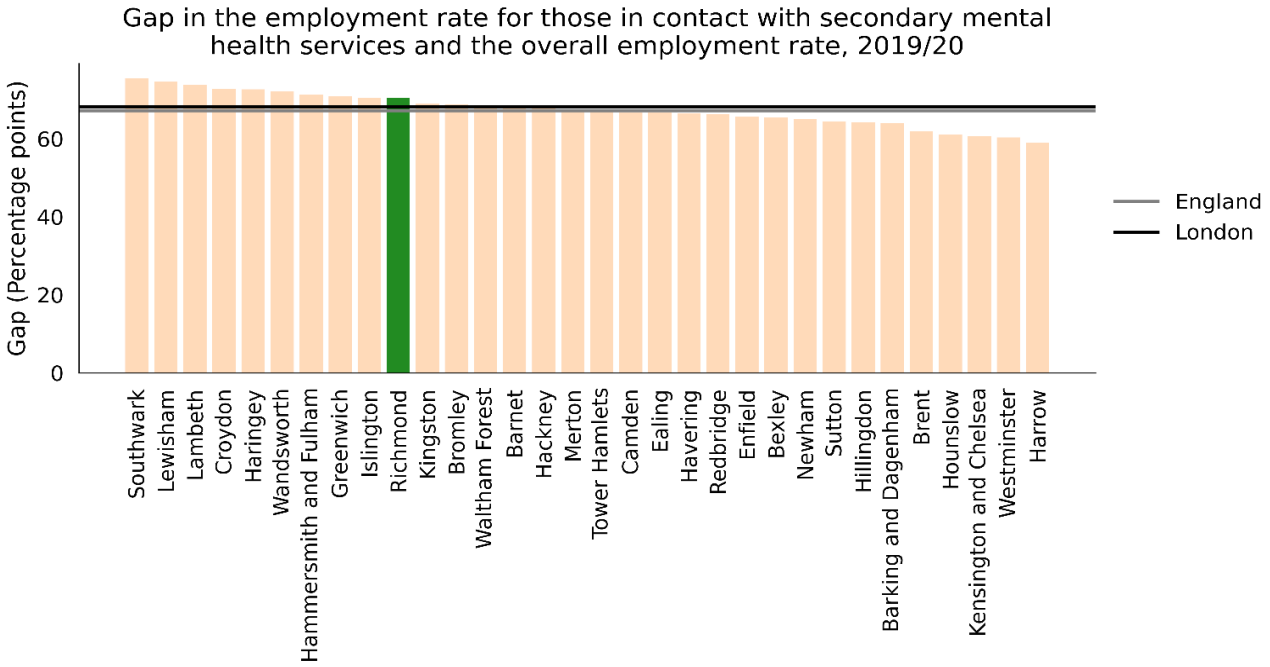
Source: PHE [Public Health Profiles]

6.2 Social Factors

Employment of Mental Health Service Users

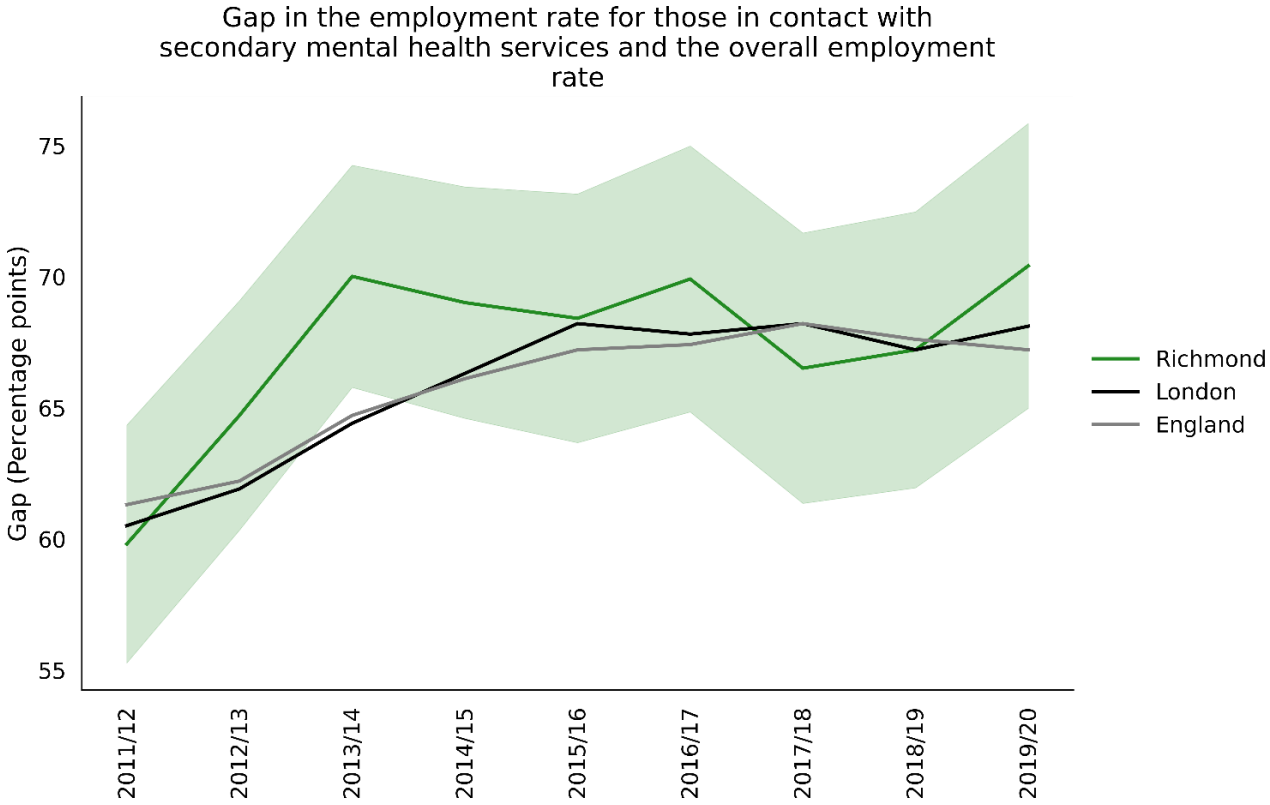
In 2019/20, Richmond's gap in the employment rate for those in contact with Secondary Mental Health Services and the overall population was 70.4%, which is the 9th highest rate in London (**Figure 80**), 4.8% higher than the England average and 3.4% higher than the London average. The latest Borough figure for 2019/20 was also 17.7% higher from 2011/12, in comparison with a 9.6% increase in England's rate in the equivalent time period (**Figure 81**).

Figure 80: Gap in employment for secondary mental health service users and the general public by local authority, 2019/20



Source: PHE Public Health Profiles

Figure 81: Gap in employment for secondary mental health service users and the general public, 2012–2020

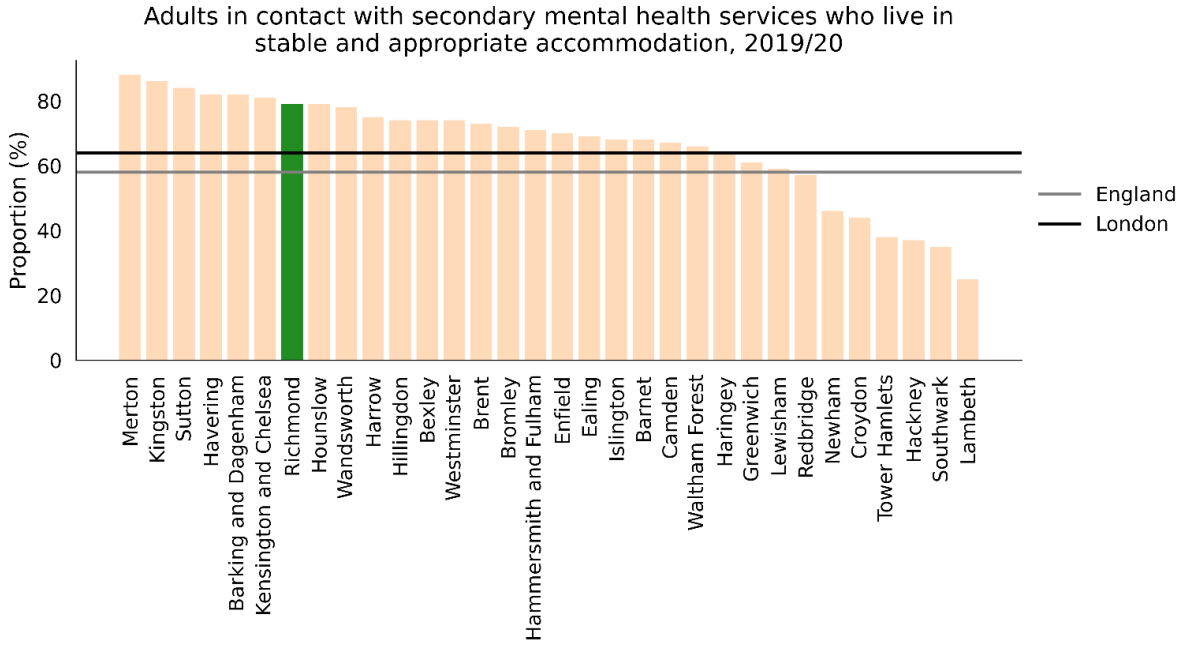


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

Mental Health Service Users Living in Stable Accomodation

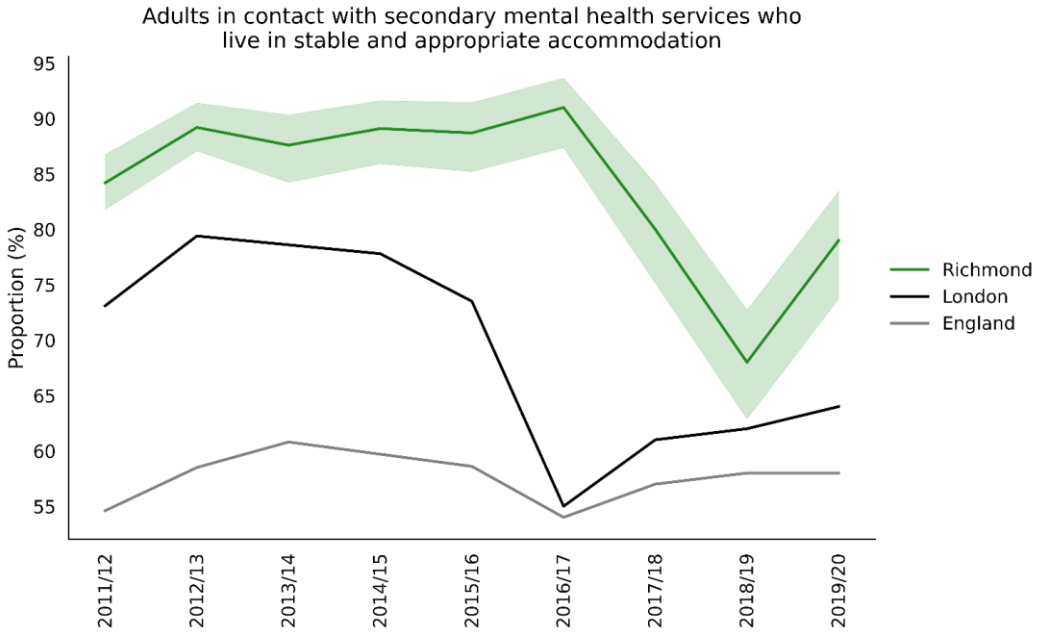
In 2019/20, Richmond's proportion of adults in contact with Secondary Mental Health Services who live in stable and appropriate accommodation was 79.0%, which is the 7th highest rate in London (**Figure 82**), 36.2% higher than the England average and 23.4% higher than the London average. The latest Borough figure for 2019/20 was also 6.2% lower from 2011/12, in comparison with a 6.2% increase in England's rate in the equivalent time period (**Figure 83**).

Figure 82: Proportion of secondary mental health service users living in stable accommodation by local authority, 2019/20



Source: PHE Public Health Profiles

Figure 83: Proportion of secondary mental health service users living in stable accommodation, 2012–2020



**- green ribbon shows 95% confidence interval around Richmond's indicator values*

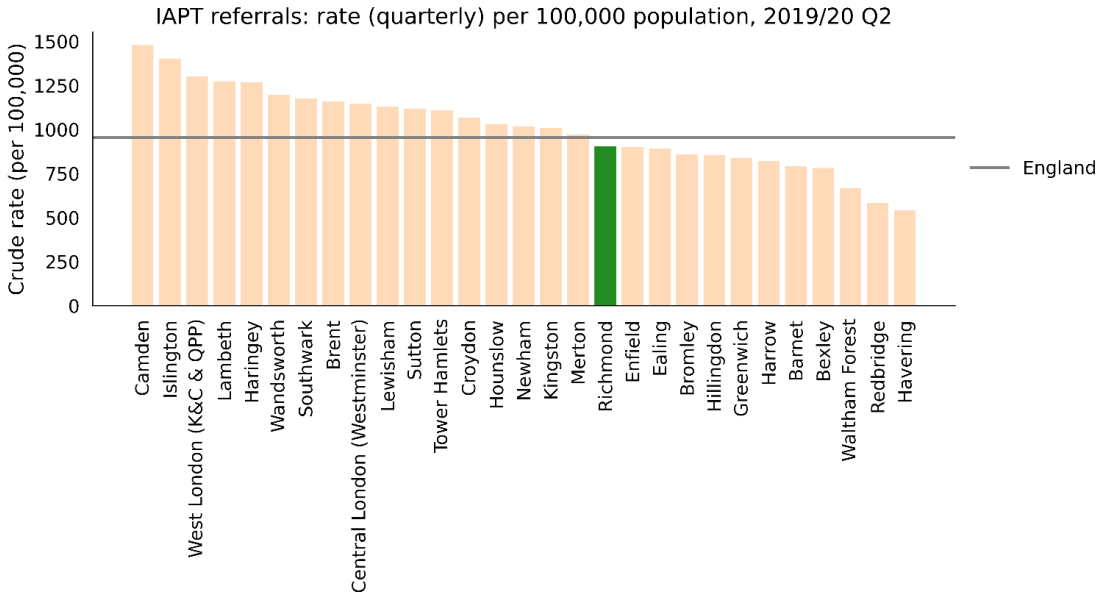
Source: PHE Public Health Profiles

6.3 Improving Access to Psychological Therapies (IAPT)

IAPT referral rates

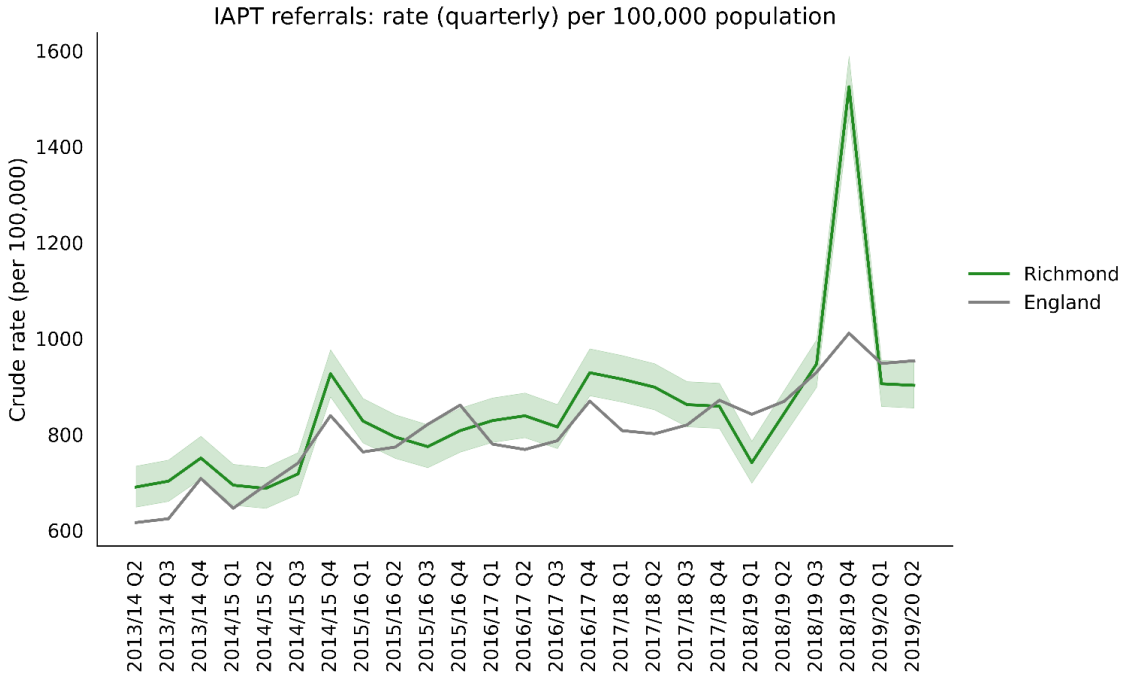
In 2019/20 Q2, Richmond's IAPT referral rate for adults aged 18+ was 901.7 per 100,000 population (n=1365), which is the 12th lowest rate in London (**Figure 84**) , 5.4% lower than the England average. The latest Borough figure for 2019/20 Q2 was also 30.7% higher from 2013/14 Q2, in comparison with a 54.8% increase in England's rate in the equivalent time period (**Figure 85**).

Figure 84: IAPT referral rate for adults aged 18 and over by CCG, 2019/20 Q2



Source: PHE Public Health Profiles

Figure 85: IAPT referral rate for adults aged 18 and over, 2014–2020



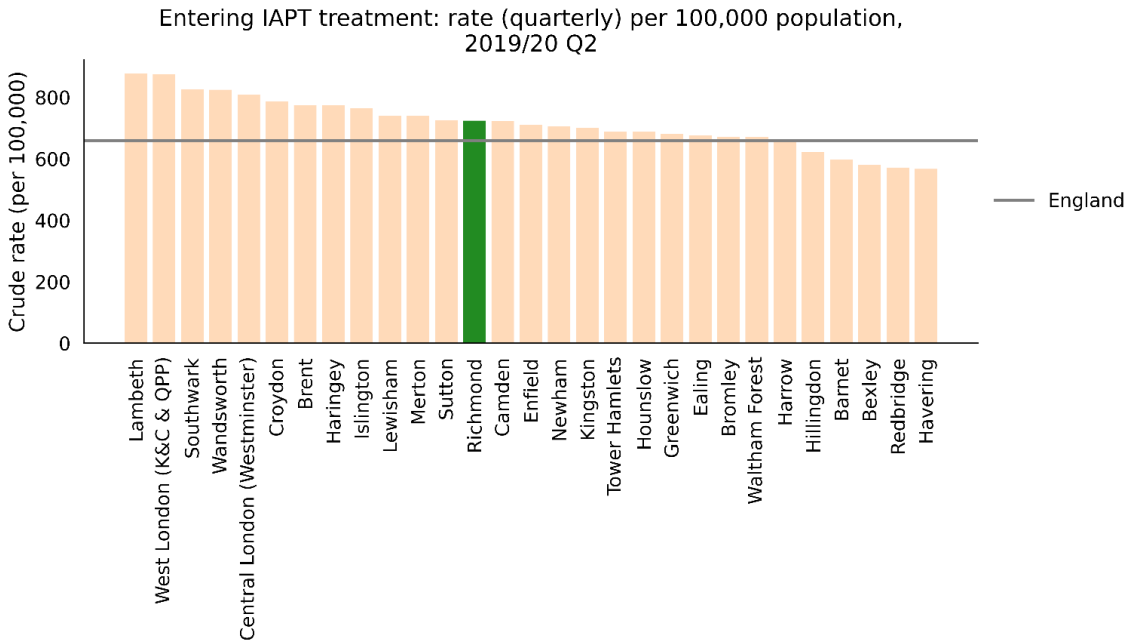
**- green ribbon shows 95% confidence interval around Richmond's indicator values*

Source: PHE Public Health Profiles

Rate of Adults Entering IAPT Treatment

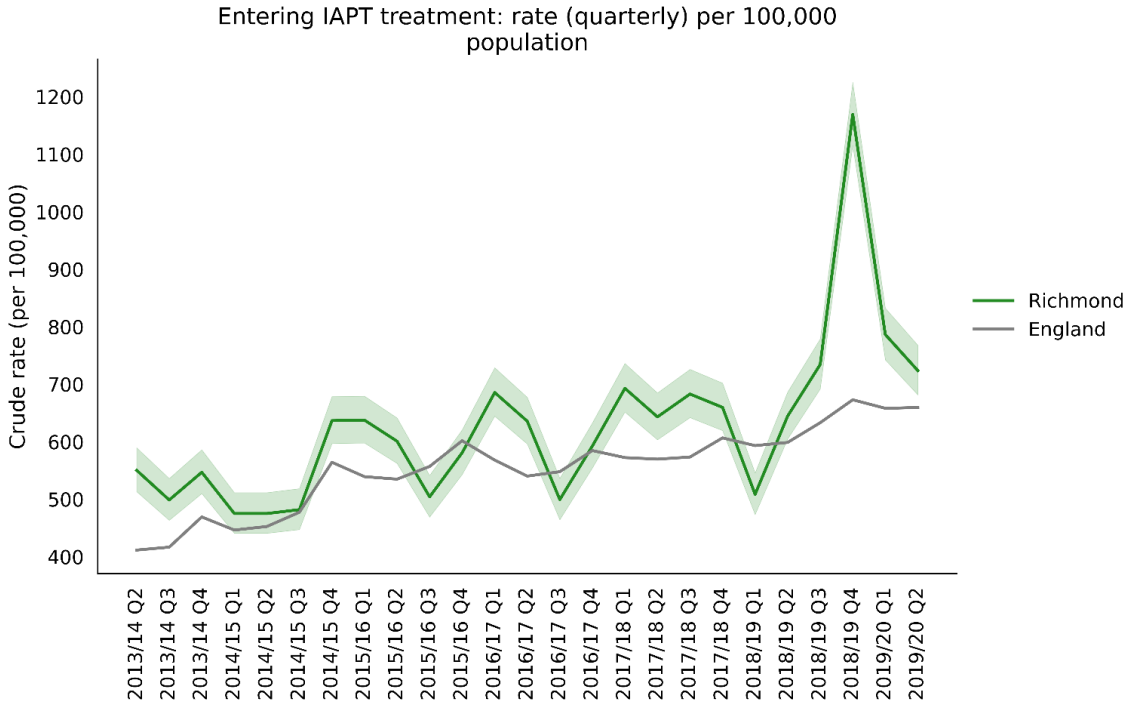
In 2019/20 Q2, Richmond's rate of adults aged 18+ entering IAPT treatment was 723.4 per 100,000 population (n=1095), which is the 13th highest rate in London (**Figure 86**), 9.7% higher than the England average. The latest Borough figure for 2019/20 Q2 was also 31.5% higher from 2013/14 Q2, in comparison with a 60.3% increase in England's rate in the equivalent time period (**Figure 87**).

Figure 86: IAPT treatment starts for adults aged 18 and over by CCG, 2019/20 Q2



Source: PHE Public Health Profiles

Figure 87: IAPT treatment starts for adults aged 18 and over, 2014–2020



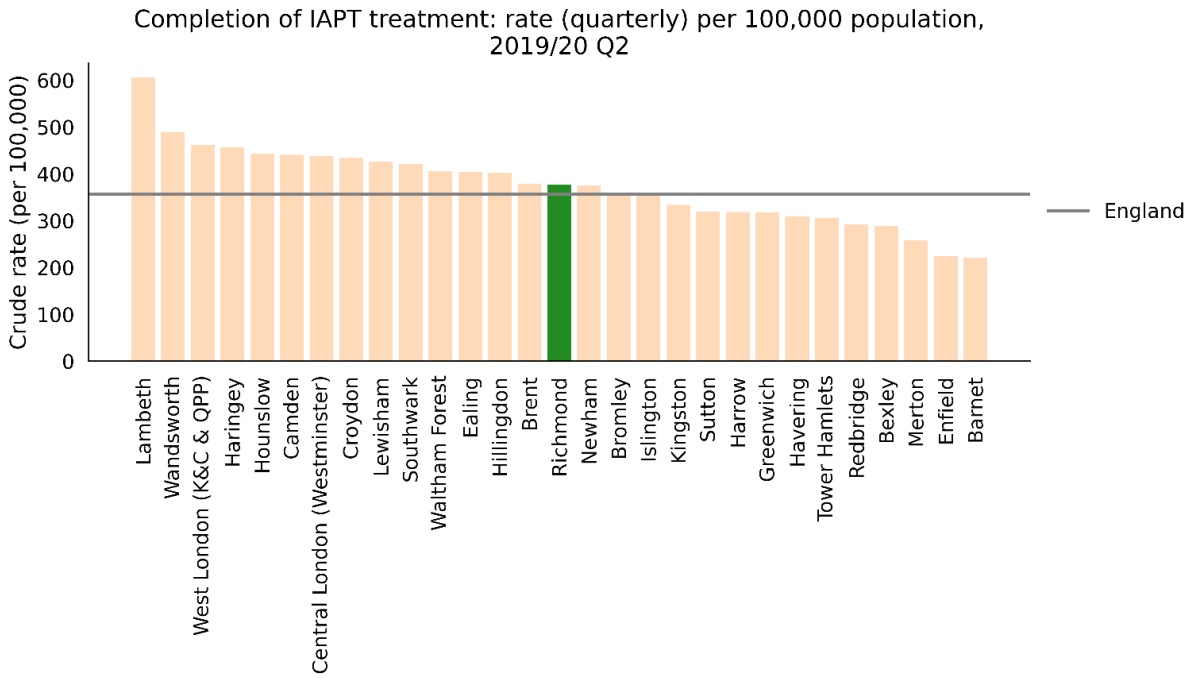
**- green ribbon shows 95% confidence interval around Richmond's indicator values*

Source: PHE Public Health Profiles

IAPT Completion Rates

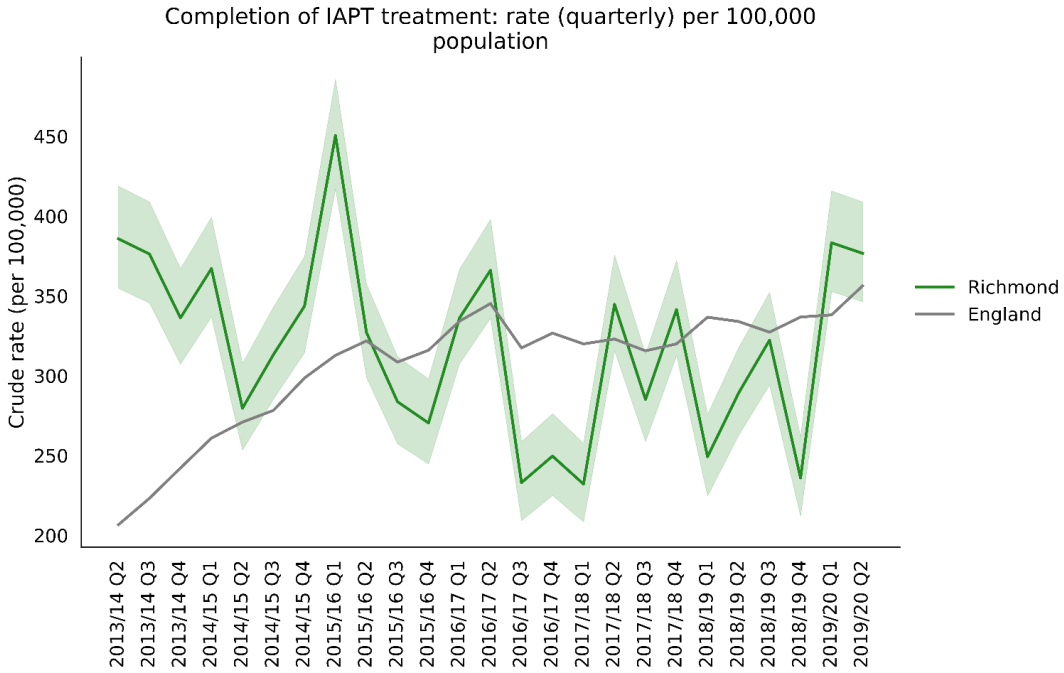
In 2019/20 Q2, Richmond's completion rate for IAPT was 376.5 per 100,000 population (n=570), which is the 15th highest rate in London (**Figure 88**), 5.7% higher than the England average. The latest Borough figure for 2019/20 Q2 was also 2.4% lower from 2013/14 Q2, in comparison with a 72.5% increase in England's rate in the equivalent time period (**Figure 89**).

Figure 88: IAPT completion rates for adults aged 18 and over by CCG, 2019/20 Q2



Source: PHE Public Health Profiles

Figure 89: IAPT completion rates for adults aged 18 and over, 2014–2020



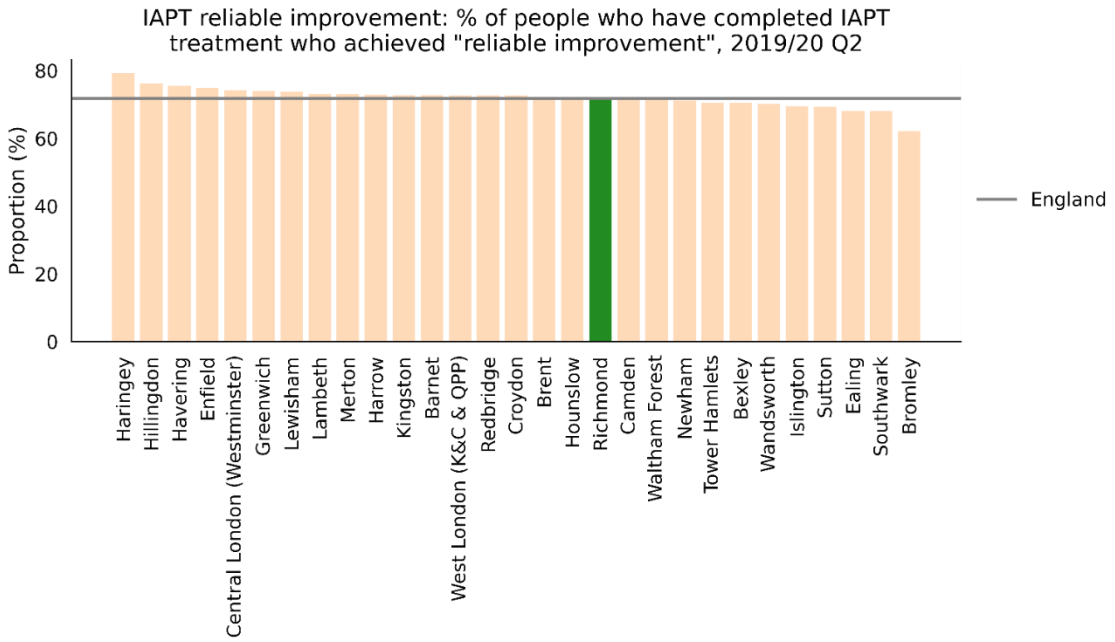
**- green ribbon shows 95% confidence interval around Richmond's indicator values*

Source: PHE Public Health Profiles

IAPT service users that achieved reliable improvement

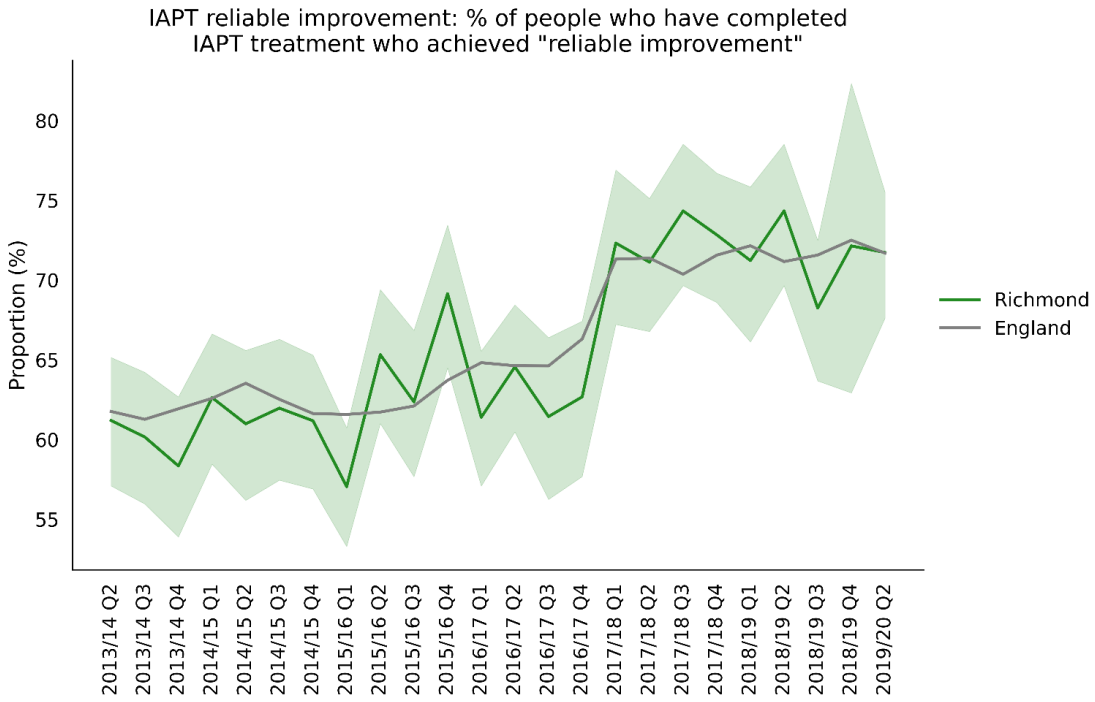
In 2019/20 Q2, Richmond's percentage of people who have completed IAPT treatment and achieved "reliable improvement" is was 71.7% (n=355), which is the 12th lowest rate in London (**Figure 90**), 0.1% higher than the England average. The latest Borough figure for 2019/20 Q2 was also 17.2% higher from the baseline (2013/14 Q2, in comparison with a 16.1% increase in England's rate in the equivalent time period (**Figure 91**).

Figure 90: IAPT completion rates for adults aged 18 and over by CCG, 2019/20 Q2



Source: PHE Public Health Profiles

Figure 91: IAPT completion rates for adults aged 18 and over, 2014–2020



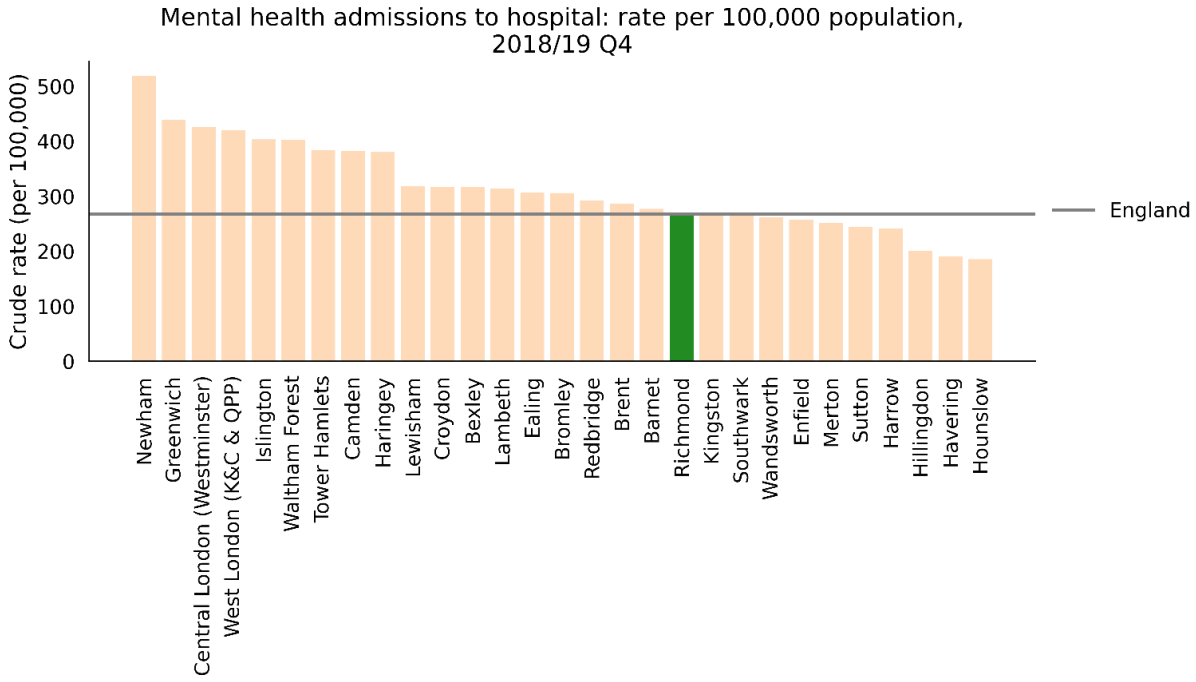
**- green ribbon shows 95% confidence interval around Richmond's indicator values*

Source: PHE Public Health Profiles

6.4 Admissions to Specialist Mental Health Hospitals

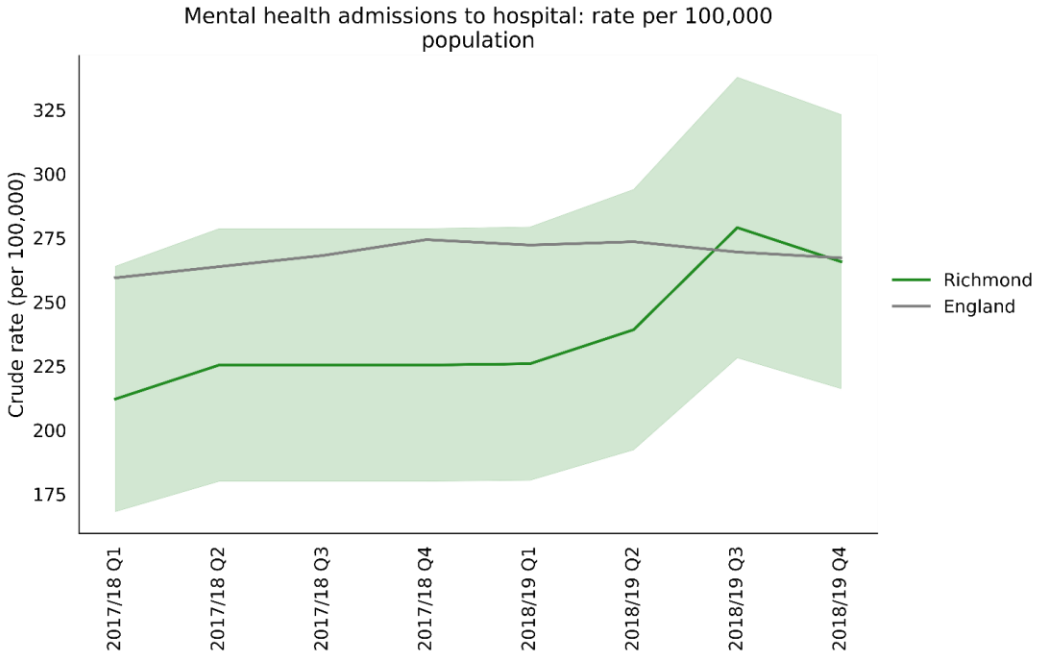
In 2018/19 Q4, Richmond's rate of admissions to mental health specialist trusts was 265.7 per 100,000 population (n=100), which is the 11th lowest rate in London (**Figure 92**) , 0.6% lower than the England average. The latest Borough figure for 2018/19 Q4 was also 25.3% higher from 2017/18 Q1, in comparison with a 3.0% increase in England's rate in the equivalent time period (**Figure 93**).

Figure 92: Admissions to specialist mental health hospitals by CCG, 2018/1 Q4



Source: PHE Public Health Profiles

Figure 93: Admissions to specialist mental health hospitals, 2018–2019



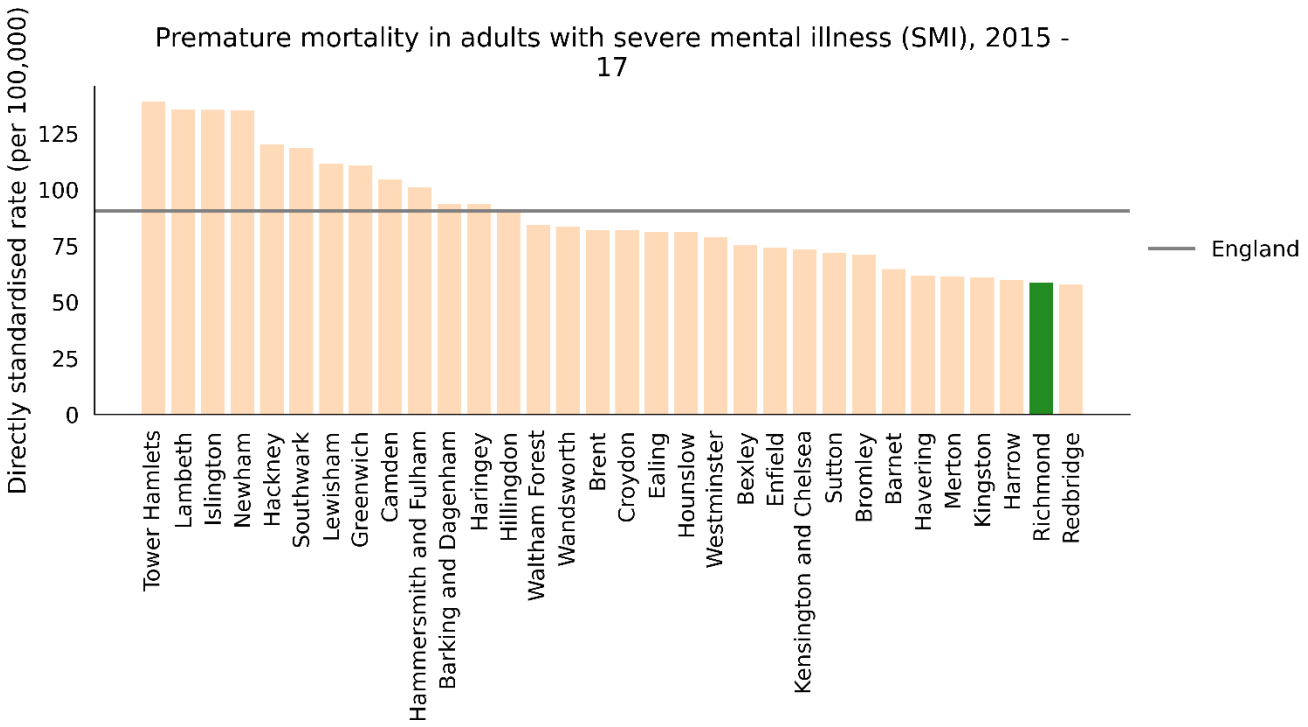
**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

6.5 Premature Mortality in Adults with Severe Mental Illness

In 2015–17, Richmond's premature mortality rate in adults with SMI was 58.6 per 100,000 population (n=210), which is the 2nd lowest rate in London (**Figure 94**) , 35.2% lower than the England average. No time trend data is available for this indicator.

People with serious mental health illnesses, such as bipolar and schizophrenia, are at an increased risk of premature mortality. In Richmond, the extent to which adults with a serious mental illness die prematurely compared to adults in the general population is 446% higher (2nd highest risk of excess deaths in London) – in comparison with the national average of 355% higher; more on this can be found in People chapter of the JSNA.

Figure 94: Premature mortality in adults with SMI by local authority, 2015–17



Source: PHE Public Health Profiles

7. Sexual Health

7.1 Sexually Transmitted Infections

Sexual health is an important public health issue with health, social and economic impacts that can affect the population across the life course and is a fundamental aspect of human identity and life experience. Richmond adopts the World Health Organisation's current working definition of sexual health which is described as: "a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence."[53] Poor sexual health can lead to sexually transmitted infections (STIs), HIV and unintended pregnancies which can lead to further long-lasting and costly impacts for both individuals and wider society. However, they can be reduced through safer sex practices such as the use of condoms, regular testing and access to sexual health and reproductive services54. Sexual health services currently focus on treatment for sexual health transmitted infections, HIV and unplanned pregnancies as well as prevention.

Prevalence

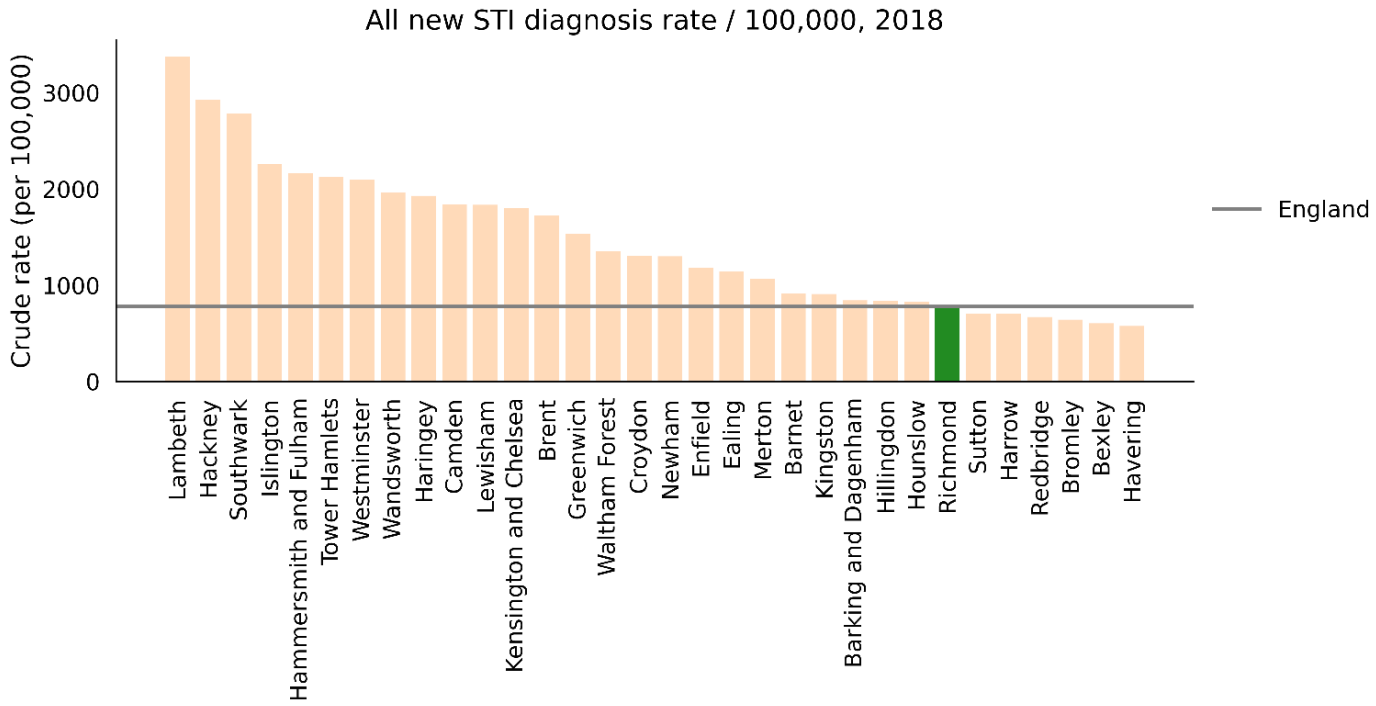
In 2018, there were 447,694 diagnoses of Sexually Transmitted Infections (STIs), an increase of 5% since 2017. National increases have been seen across the spectrum of different STIs, with the largest being seen in gonorrhoea. There were over 56,000 diagnoses of gonorrhoea reported in 2018 representing a 26% increase since 2017. This is most concerning as cases of drug resistant strains of gonorrhoea have also been identified. The UK has also seen an increase of syphilis (5%) since 2017.

In 2018, Richmond's rate of new STI diagnoses was 785.2 per 100,000 population (n=1546), which is the 7th lowest rate in London (**Figure 95**) , 0.8% higher than the England average. The latest Borough figure for 2018 was also 13.2% higher from 2012, in comparison with a 4.4% decrease in England's rate in the equivalent time period (**Figure 96**).

Further detail regarding Sexual Health profiles in Richmond can be found in the Sexual Health Needs Assessment and corresponding Strategy and Action Plan published in 2019.

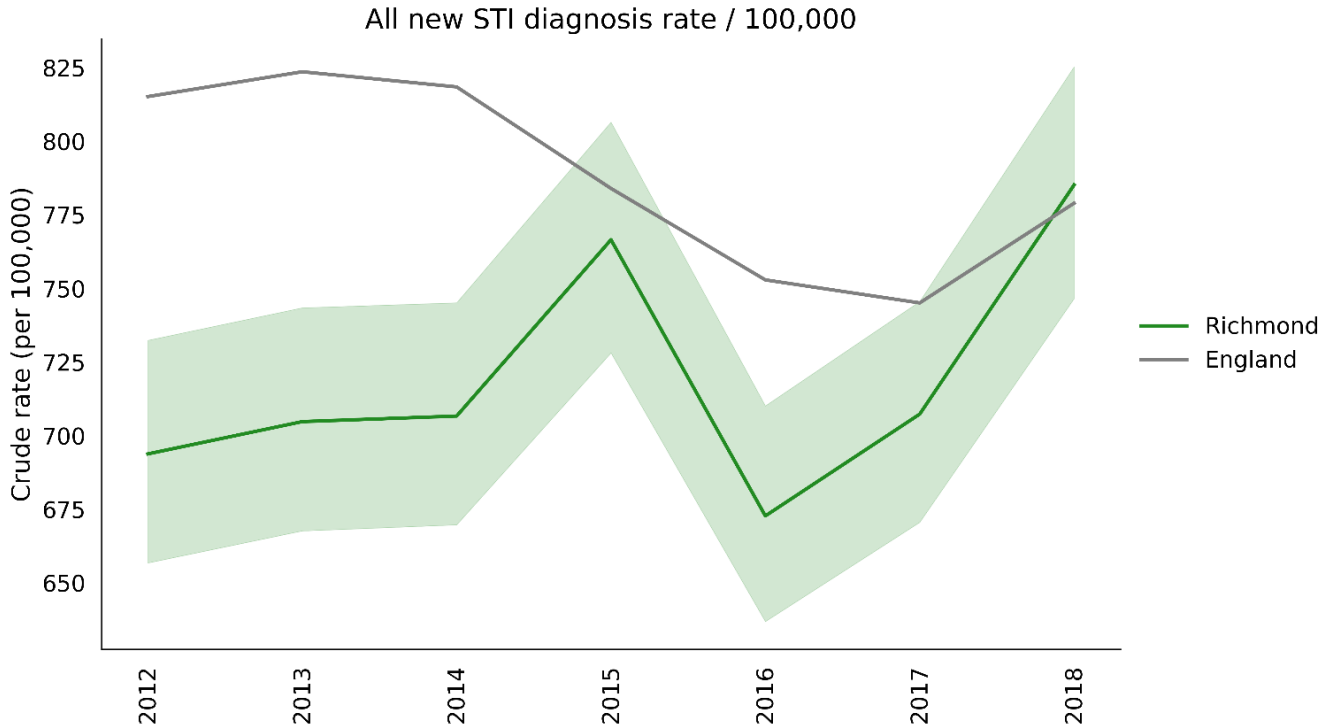
[53] WHO (2006) Defining sexual health: Report of a technical consultation on sexual health, 28-31 January 2002, Geneva
[54] Department of Health (2001) The national strategy for sexual health and HIV.

Figure 95: New STI diagnosis rate by local authority, 2018



Source: PHE Public Health Profiles

Figure 96: New STI diagnosis rate, 2012–2018



**- green ribbon shows 95% confidence interval around Richmond's indicator values*

Source: PHE Public Health Profiles

STIs key findings for Richmond:

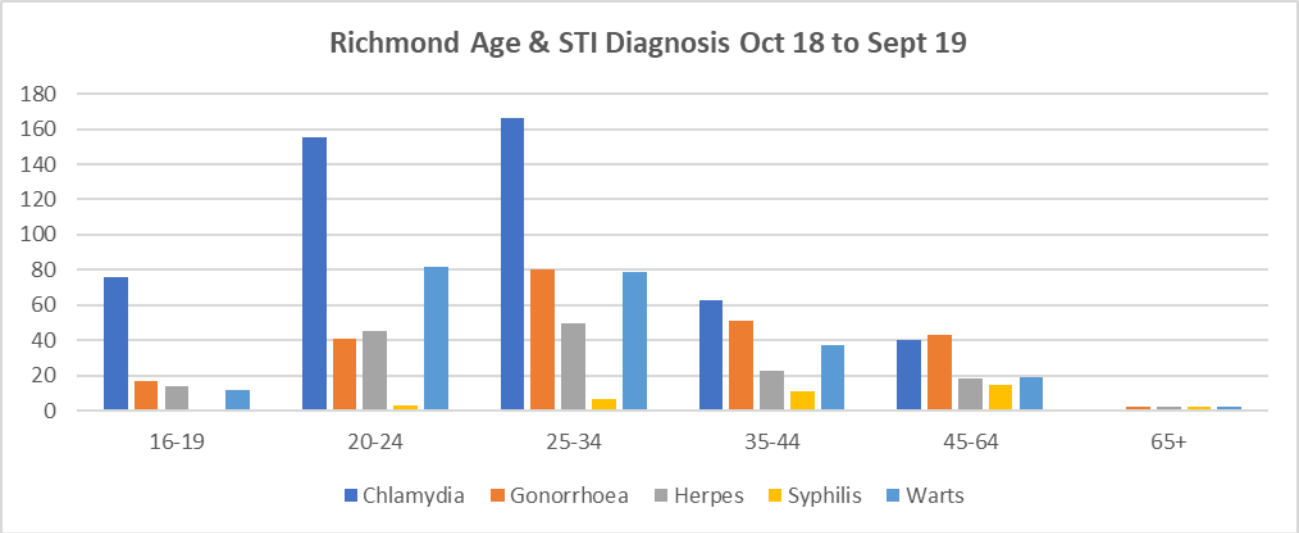
- The all new STI diagnosis rate for England is shown as 784/100,000 population and for Richmond as similar at 788/100,000 population for 2018.
- Newly diagnosed STIs (excluding chlamydia aged <25) currently stands at 936/100,000 population in Richmond (2018) which sees a slight increase on the last two years, but there is no overall increase in trend since 2012.
- In Richmond the diagnostic rate of Gonorrhoea per 100,000 population is 212/100,000 population, but recent trends are remaining static and is lower than the London average of 279.4, but significantly higher than all England (98.5/100,000 population).
- Recently, London has witnessed a sharp increase in the rate of Syphilis. Whilst the latest diagnostic rate (17.9/100,000 population) in Richmond remains lower than the rest of London, the borough has nevertheless seen an overall increase in the rate of syphilis since 2012.
- In line with the national picture, the number of diagnosis of gonorrhoea and syphilis are higher in gay men compared to heterosexual men.
- The rate of new HIV diagnosis per 100,000 population among people aged 15 years or above in the borough was 8.9 compared to 20.9 in the rest of London and 8.7 in England. Since 2015, Richmond has seen a 7.3% decrease in new HIV diagnoses.
- There has been a good shift to on-line services, however, there remains an inequality of access to sexual health provision for Richmond residents with little evidence that the pan-London sexual health transformation is pushing trends in the right direction fast enough.
- In 2018 the total abortion rate stood at 15.9/1000 15 to 44-year olds. This is lower than that of both England and London, indicating women in Richmond have consistently had good access to reproductive care over the last 6 years.
- The percentage of abortions performed under 10 weeks in Richmond was 83.7% which is higher than both England (80.3%) and London Percentage (82.3%), indicating Richmond residents are getting swift and improved access to abortion at an early stage of pregnancy.

MSM are among the largest groups diagnosed with a new STI diagnosis and STI diagnosis is increasing among MSM. BAME communities in Richmond also experience a significantly higher proportion of STI diagnosis compared with the proportion of the population from ethnic groups. The age and gender distribution of new STI diagnoses (Chlamydia, gonorrhoea, herpes, syphilis, warts) in Richmond in 2018 highlights that the largest number of newly diagnosed STI's are in the 25 to 34-year-old age cohort.

The age and gender distribution of new STI diagnoses (Chlamydia, gonorrhoea, herpes, syphilis, warts) in Richmond residents in 2018 highlights that the largest number of newly diagnosed STI's are in the 25 to 34-year-old age cohort (**Figure 97**). [55]

[55] NICE guideline [NG60] (2016) HIV testing: increasing uptake among people who may have undiagnosed HIV

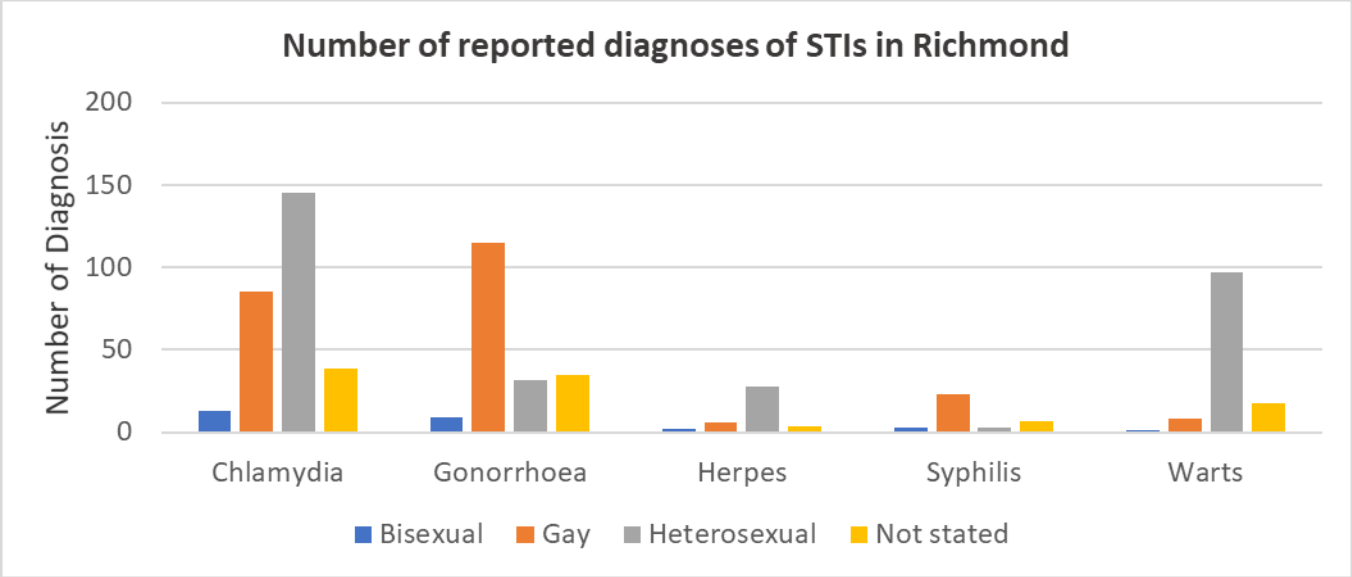
Figure 97: STI diagnoses by age group in Richmond, 2018/19



Source: GUMCAD Extracted Feb 2020

People identifying as LGBTQ+ can experience a greater degree of health inequalities, including sexual health[56]. National data shows that where gender and sexual orientation are known, MSM account for 29% of London residents diagnosed with a new STI in a specialist health clinic; 90% of those diagnosed with syphilis and 63% of those diagnosed with gonorrhoea. In line with the national picture, the number of diagnosis of gonorrhoea and syphilis are higher in gay men compared to heterosexual men (**Figure 98**).

Figure 98: Count of STI diagnoses in Richmond by sexual orientation

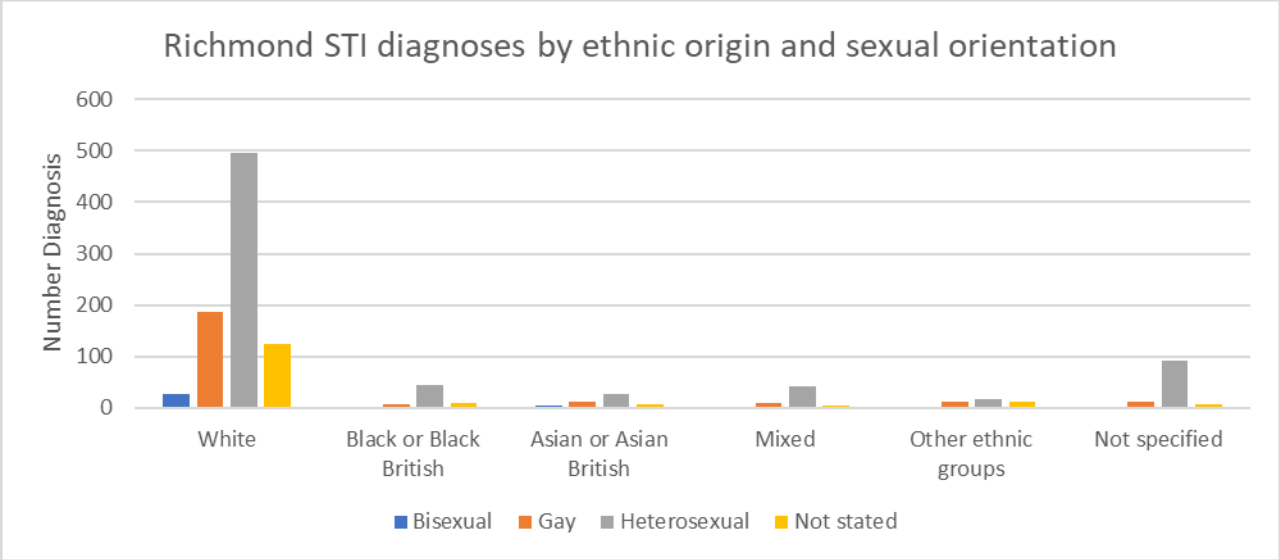


Source: GUMCAD Sep '18–Oct '19

[56] Government Equalities Office (2018) LGBT Action plan 2018 – improving the lives of lesbian, gay, bisexual and transgender people

When comparing new diagnosis of STIs by ethnic origin and sexual orientation a larger proportion of white gay/lesbian are newly diagnosed (**Figure 99**).

Figure 99: STI diagnoses in Richmond by ethnicity and sexual orientation

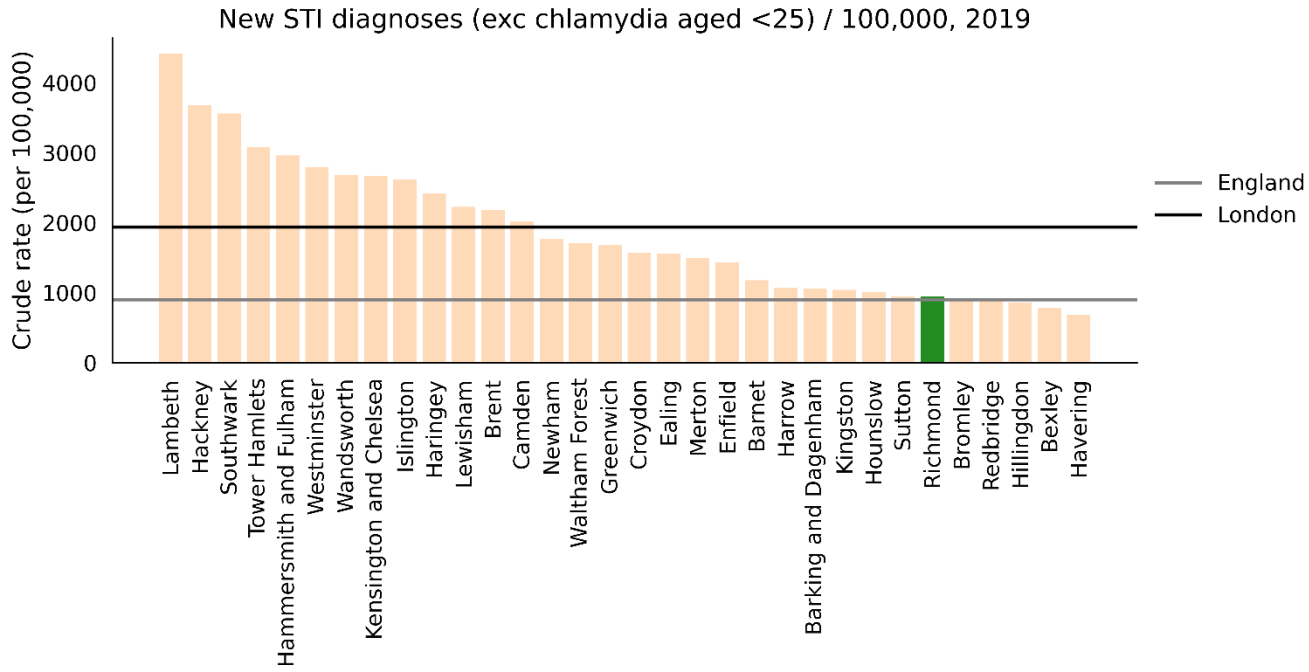


Source: GUMCAD extracted Feb 2020

New STI diagnoses (excluding chlamydia)

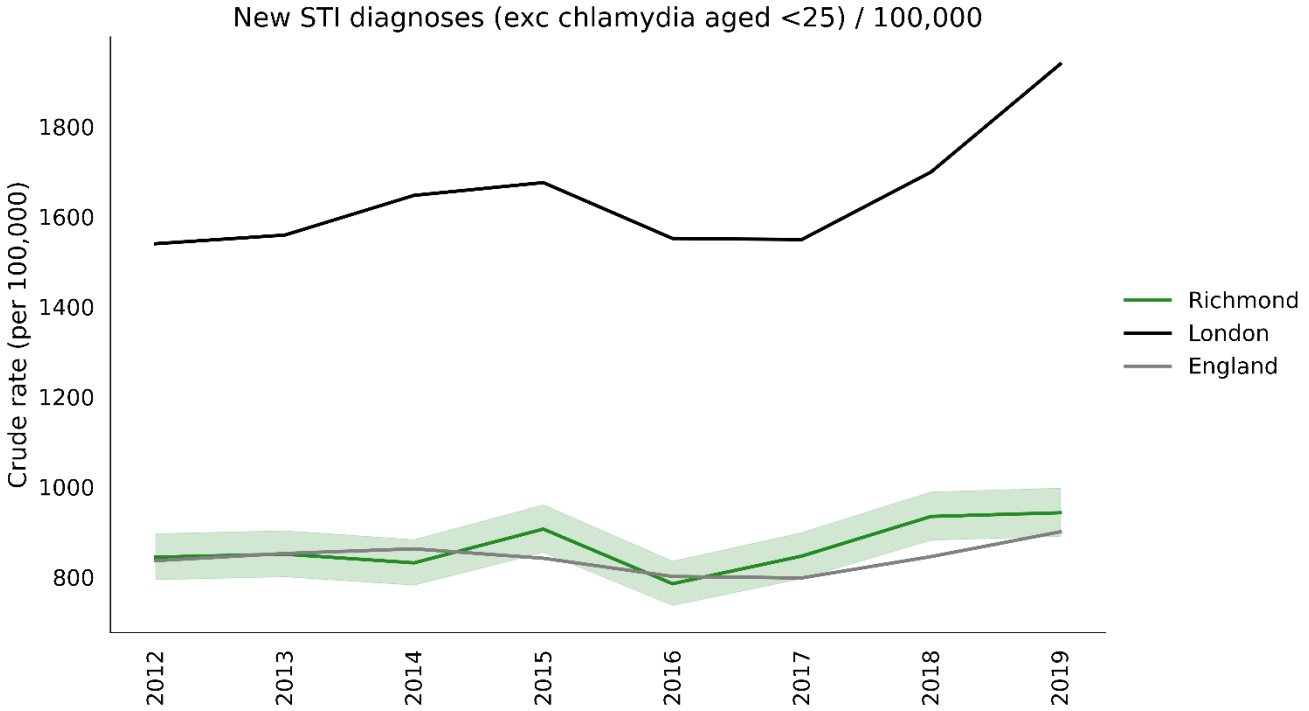
In 2019, Richmond's rate of new STI diagnoses (excluding chlamydia) in people aged under 25 was 942.6 per 100,000 population (n=1199), which is the 6th lowest rate in London (**Figure 100**) , 4.7% higher than the England average and 51.4% lower than the London average. The latest Borough figure was also 11.7% higher from 2012, in comparison with a 7.7% increase in England's rate in the equivalent time period (**Figure 101**).

Figure 100: New STI diagnoses, excluding chlamydia, in people aged under 25 by local authority, 2019



Source: PHE Public Health Profiles

Figure 101: New STI diagnoses, excluding chlamydia, in people aged under 25, 2012–2019



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

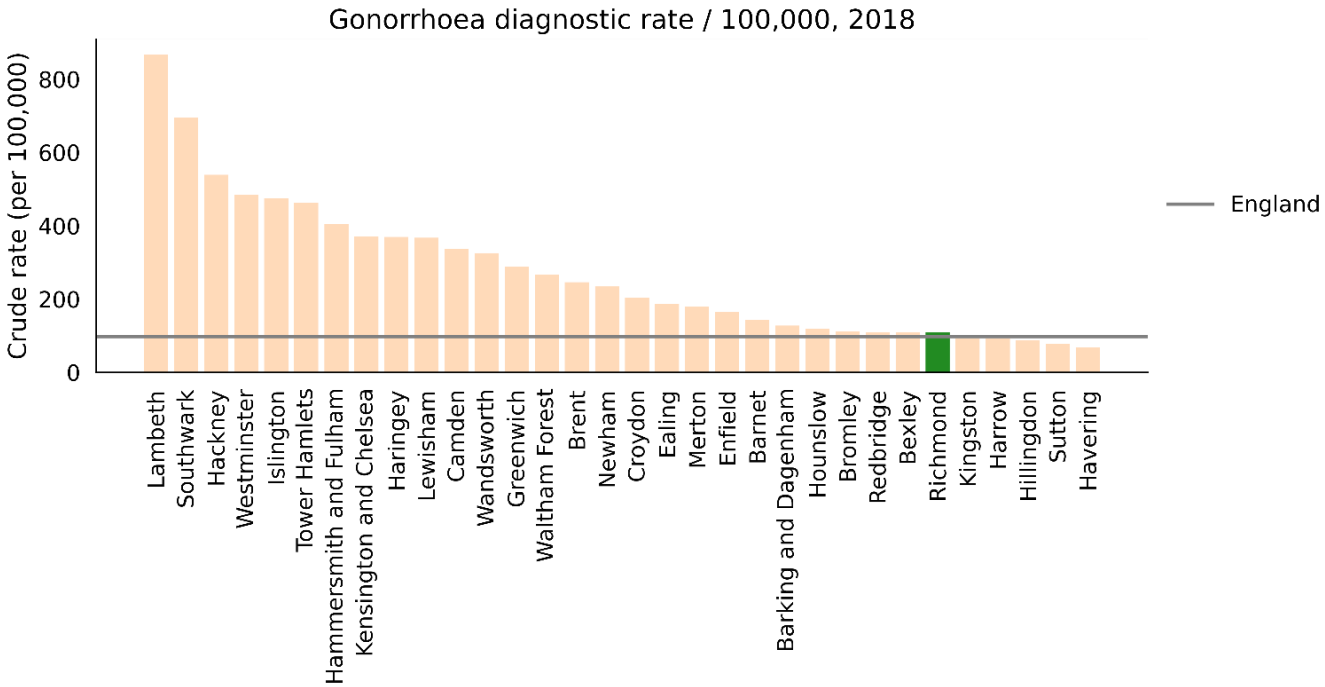
Genital Chlamydia Trachomatis is the most commonly reported bacterial STI in England. Infection is asymptomatic in at least 70% of women and 50% of men and as a result most infections remain undiagnosed[57]. Untreated chlamydia infection has significant health consequences. It is associated with considerable reproductive morbidity in women including pelvic inflammatory disease, ectopic pregnancy and infertility. In men, complications can include urethritis, epididymitis and Reiter's syndrome. The chlamydia detection rate is one of the Health Protection indicators within the Public Health Outcomes Framework (PHOF). In 2013 the department of Health set a recommended chlamydia detection rate of ≥2300 per 100.000 population as this indicates high volumes of screening and diagnosis.

Gonorrhoea Diagnoses

In 2018, Richmond's rate of gonorrhoea diagnoses was 108.7 per 100,000 population (n=214), which is the 6th lowest rate in London (**Figure 102**) , 11.1% higher than the England average. The latest Borough figure for 2018 was also 116.2% higher from 2012, in comparison with a 101.3% increase in England's rate in the equivalent time period (**Figure 103**).

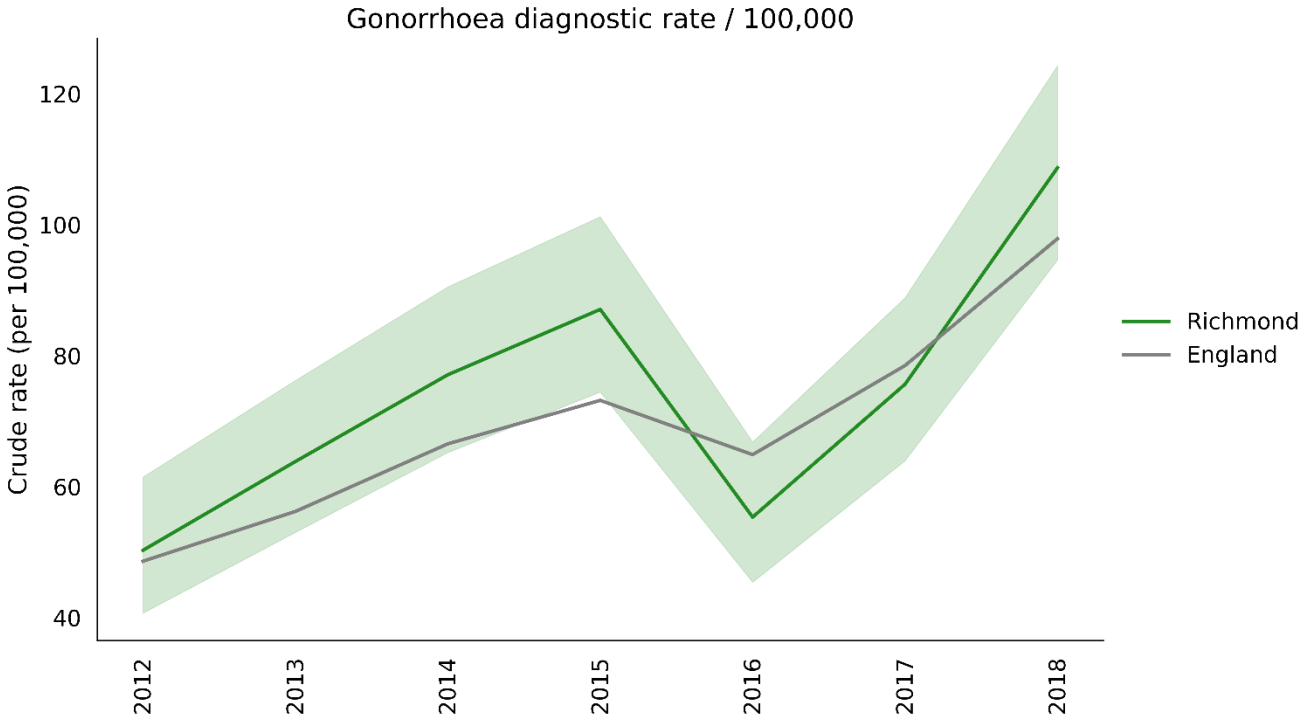
[57] Stamm W.E. Chlamydia trachomatis: progress and problems. Journal of Infectious Diseases. 1999; 179:S380-3.

Figure 102: Gonorrhoea diagnostic rate by local authority, 2019



Source: PHE Public Health Profiles

Figure 103: Gonorrhoea diagnostic rate, 2012–2019



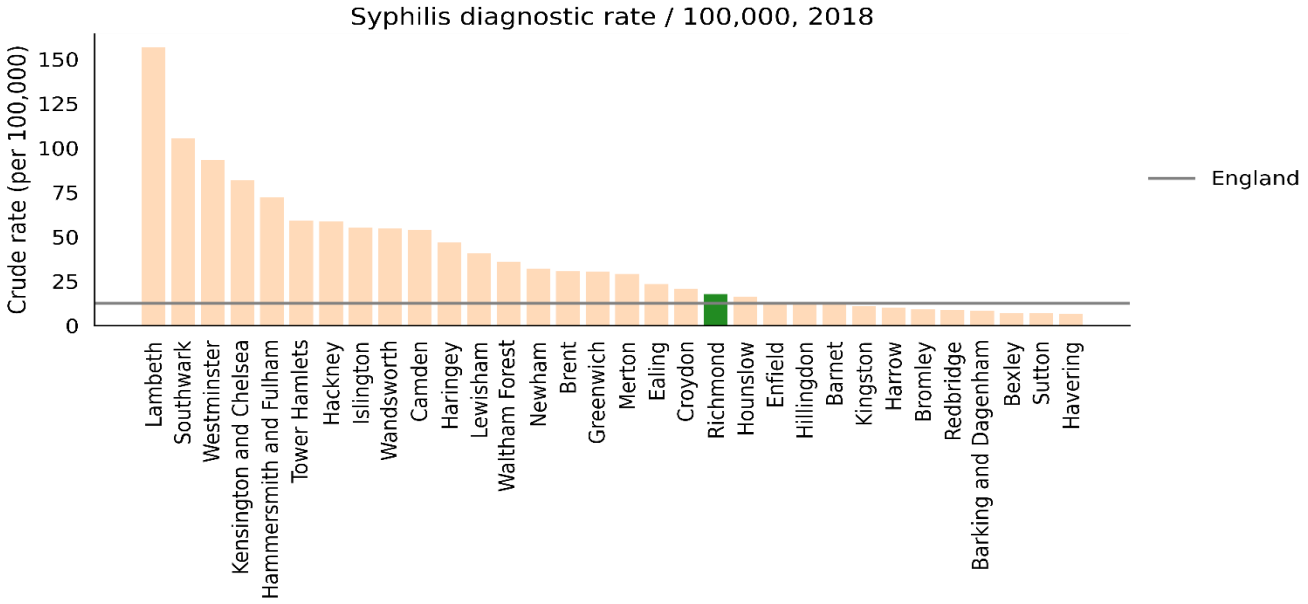
**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

Syphilis

In 2018, Richmond's syphilis diagnostic rate was 17.8 per 100,000 population (n=35), which is the 13th lowest rate in London (**Figure 104**) , 42.0% higher than the England average. The latest Borough figure for 2018 was also 179.9% higher from 2012, in comparison with a 128.9% increase in England's rate in the equivalent time period (**Figure 105**).

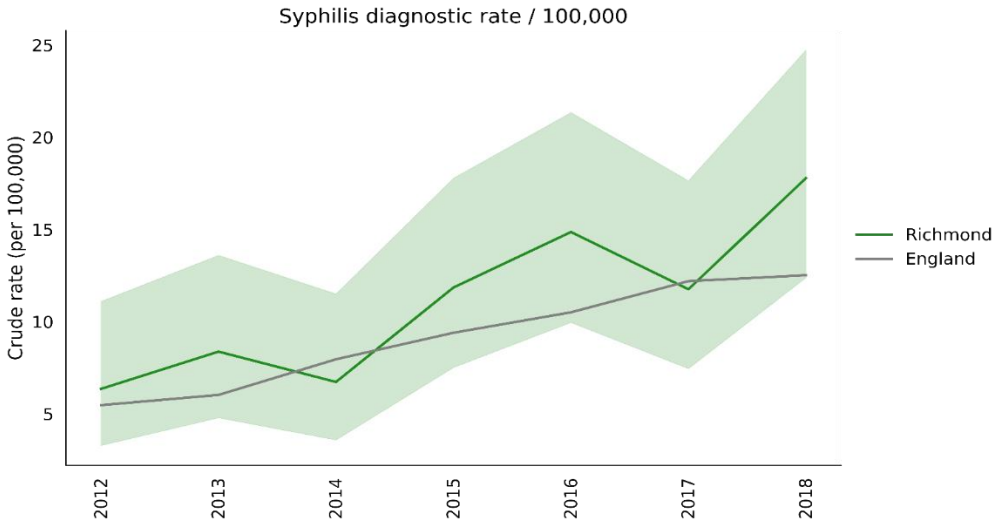
London is currently witnessing an increase in the rate of Syphilis. In response to the rise, Public Health England has formed a "Syphilis Action Group" to develop and initiate a London wide syphilis action plan. Richmond has been actively involved in the group since its creation in 2019.

Figure 104: Syphilis diagnoses by local authority, 2018



Source: PHE Public Health Profiles

Figure 105: Syphilis diagnostic rate, 2012–2018

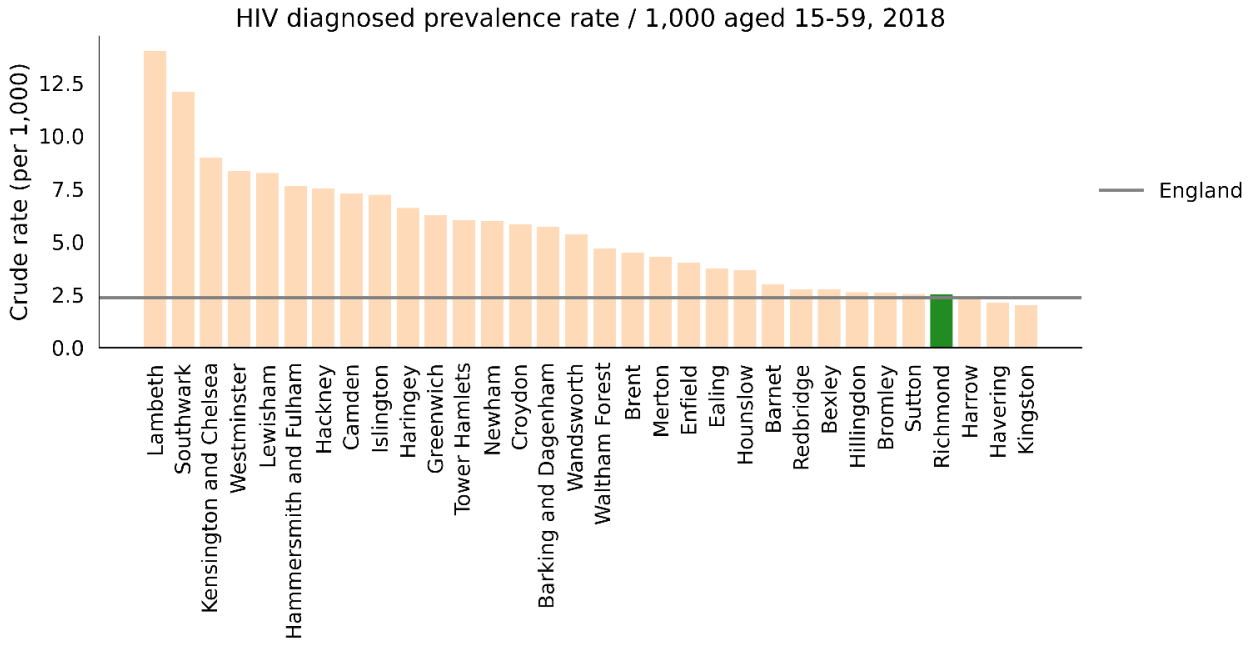


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

HIV prevalence

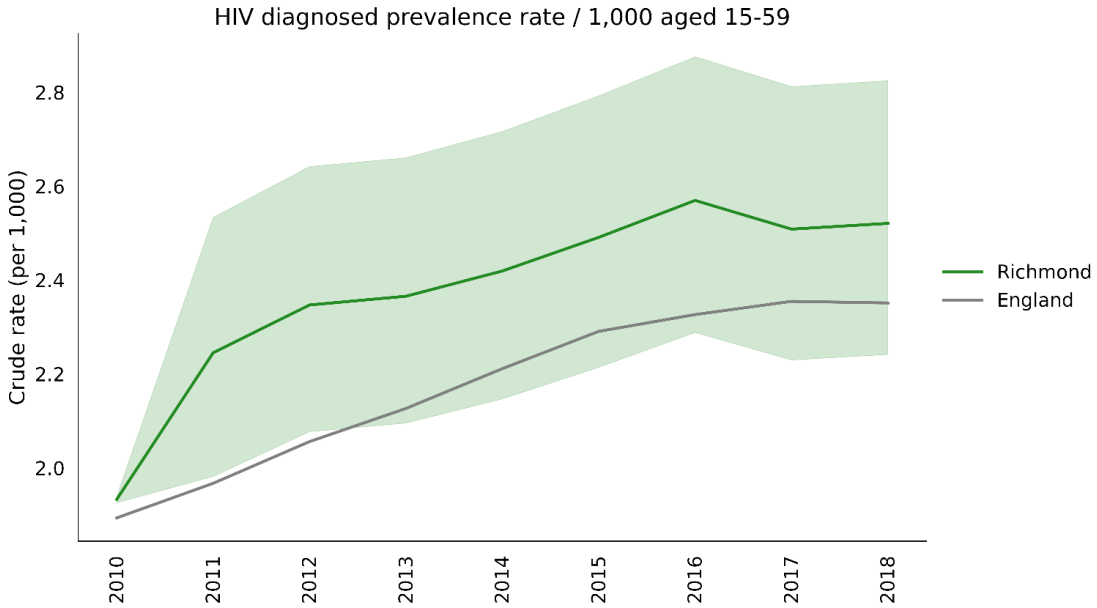
In 2018, Richmond's diagnosed prevalence of HIV was 2.5 per 1,000 (n=295), which is the 4th lowest rate in London (**Figure 106**) , 7.2% higher than the England average. The latest Borough figure for 2018 was also 30.4% higher from 2010, in comparison with a 24.2% increase in England's rate in the equivalent time period (**Figure 107**).

Figure 106: HIV diagnosed prevalence by local authority, 2018



Source: PHE Public Health Profiles

Figure 107: HIV diagnosed prevalence, 2011–2018



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

This year 14 adult residents of Richmond were newly diagnosed with HIV. The rate of new HIV diagnosis per 100,000 population among people aged 15 years or above in the borough was 8.9 compared to 20.9 in the rest of London and 8.7 in England. Since 2015, Richmond has seen a 7.3% decrease in new HIV diagnoses. The decrease highlights the success of combination HIV prevention which includes condom provision, pre-exposure prophylaxis (PrEP), expanded HIV testing and prompt initiation of treatment after diagnosis.

In Richmond the E-Service during this period had HIV detection rates for over 24 year olds of non-reactive 7,018 (99.7%) and reactive 21 (0.3%) while the numbers of postal test kits sent out by the newly commissioned SH:24 service totalled 26 with 11 being processed. Most of these kits were requested by people in the 25–34 age group (48.39%) and by males (64.34%). 2 reactive results were produced from those kits processed.

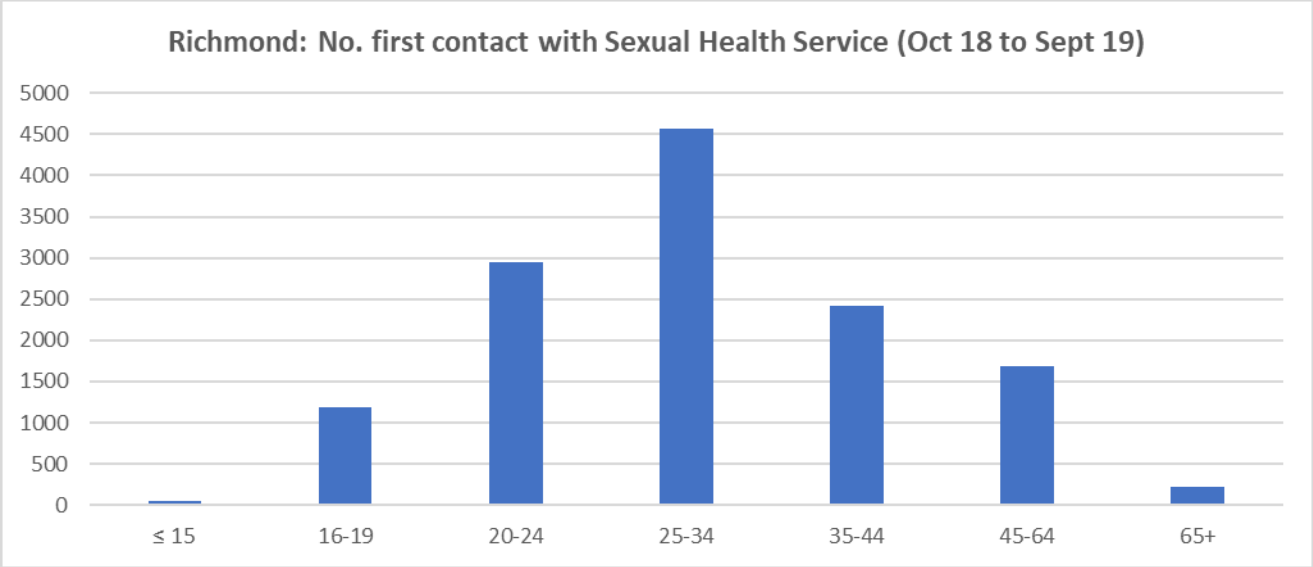
In Richmond the E-Service during this period had HIV detection rates for over 24 year olds of non-reactive 810 (99.6%) and reactive 3 (0.4%) while the numbers of postal test kits sent out by the newly commissioned SH:24 service totalled 5 with 5 being processed. Most of these kits were requested by people in the 25–34 age group (40.48%) and by males (63.16%). No reactive results were produced from those kits processed.

The vast majority (78.0%) of newly diagnosed patients in the borough were put on Antiretroviral treatment (ART) within 91 days of their diagnosis. Successful ART decreases a person's viral load, significantly reduces the risk of future transmission and transforms HIV from a fatal infection to a chronic but manageable condition. However, between 2016 and 2018, 48.5% of HIV diagnoses were made at a late stage of infection (CD4 count =<350 cells/mm 3). Late diagnosis is the most important predictor of HIV-related morbidity and short-term mortality and is a key component of valuating the success of HIV testing efforts.

Current services

In Richmond from Oct 2018 to 19 over 13,000 people accessed a sexual health service for the first time. Access was greater amongst females who represented 58% of attendees (**Figure 108**) [58].

Figure 108: Count of contacts with Richmond's sexual health service by age group



Source: GUMCAD Extracted Feb 2020

[58] GUMCAD (accessed Feb 2020), Richmond Patients attending all GUM and non-GUM services (30/09/2018-30/09/2019)

8. Cancer including Cancer Screening

Cancer is a group of diseases involving abnormal cell growth with the potential to invade or spread to other parts of the body. These contrast with benign tumours, which do not spread. This section presents cancer prevalence (including new diagnoses), hospitalisations and cancer survival rates of Richmond's patients.

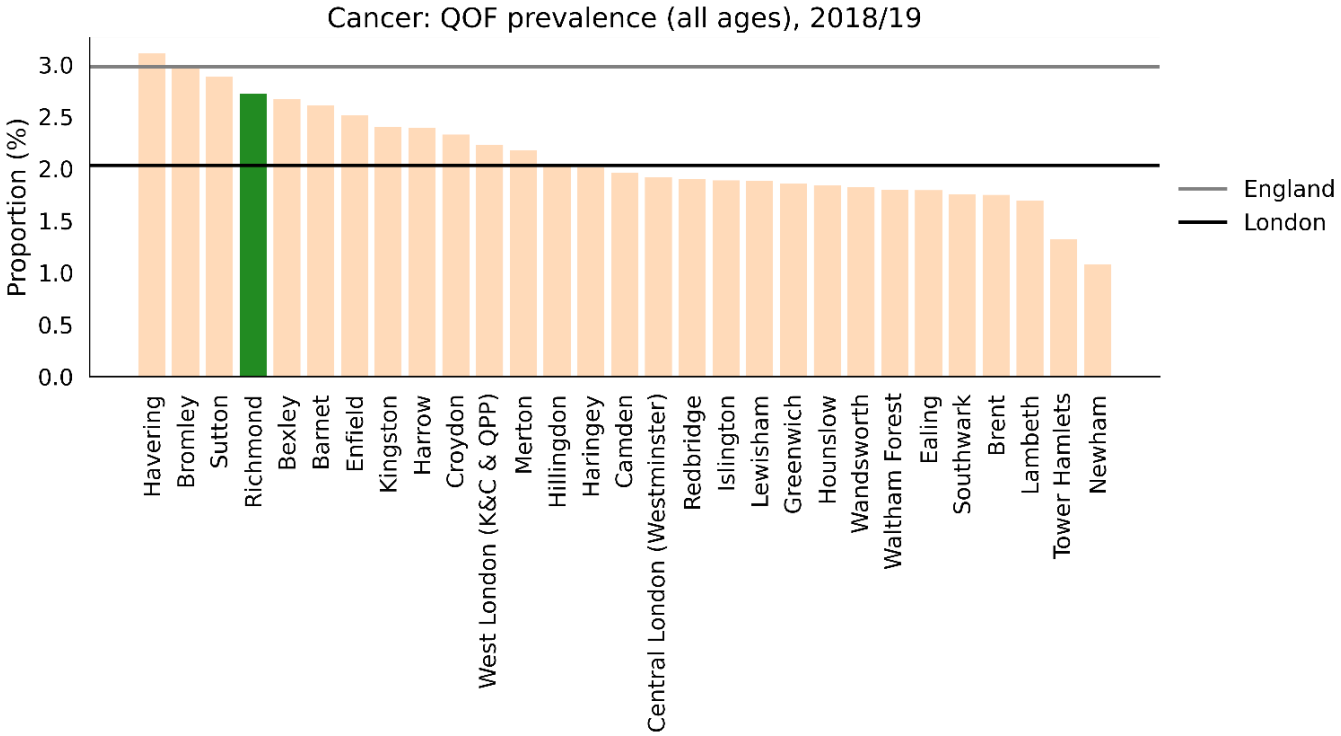
Most of the data presented are published for registered CCG population[59] (patients registered with Richmond's GP). In the last two years 5 South West London (SWL) CCGs have merged into a single South West London CCG which, starting from year 2019/20, makes it difficult to distinguish cancer information specific to Richmond; for most CCG indicators the data presented in the chapter is 2 years old, as the latest 2019/20 and 2020/21 data is only available at SWL CCG level.

8.1 Cancer Diagnosis and Prevalence

GP Recorded Cancer Prevalence

In 2018/19, Richmond's GP recorded cancer prevalence was 2.7% (n=5985), which is the 4th highest rate in London (**Figure 109**), 8.8% lower than the England average and 33.6% higher than the London average. The latest Borough figure for 2018/19 was also 61.1% higher from 2012/13, in comparison with a 54.2% increase in England's rate in the equivalent time period (**Figure 110**).

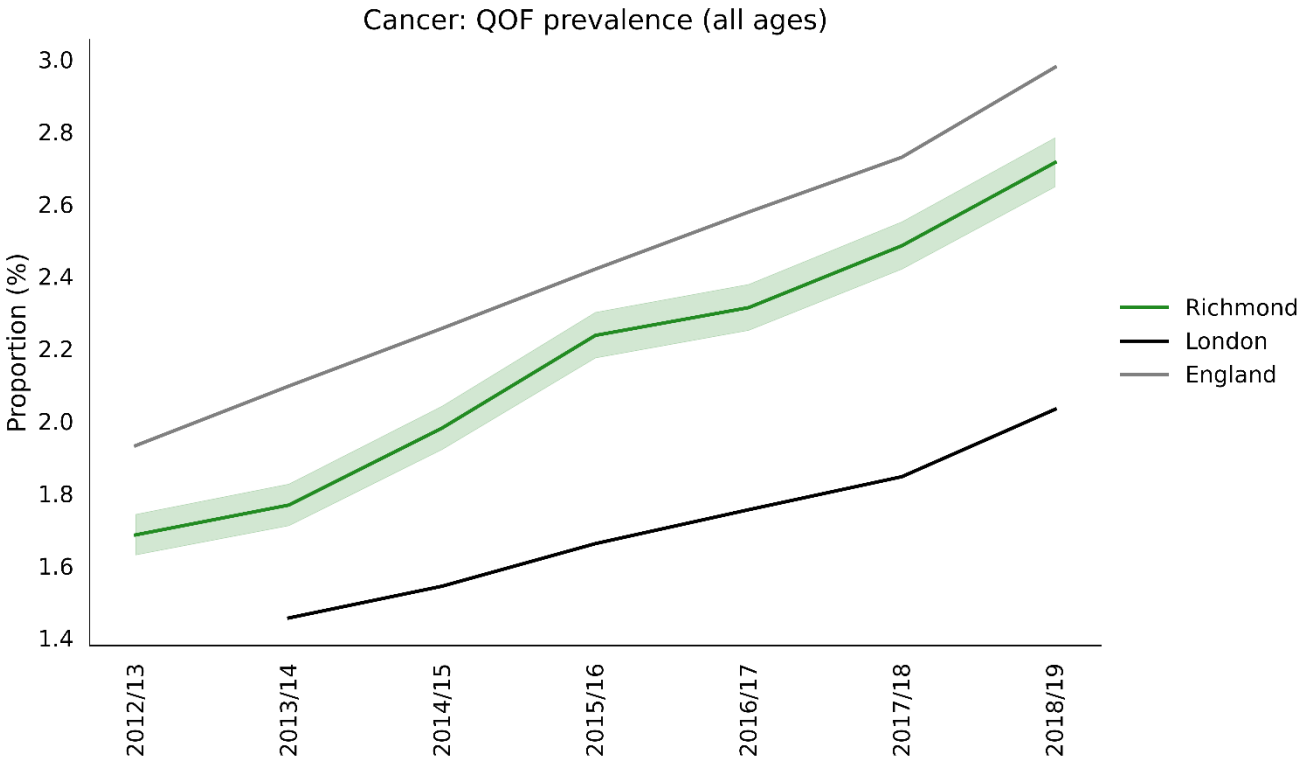
Figure 109: GP recorded cancer prevalence by CCG, 2018/19



Source: PHE Public Health Profiles

[59] PHE. Public Health Profiles. 2021

Figure 110: GP recorded cancer prevalence, 2013 – 2019

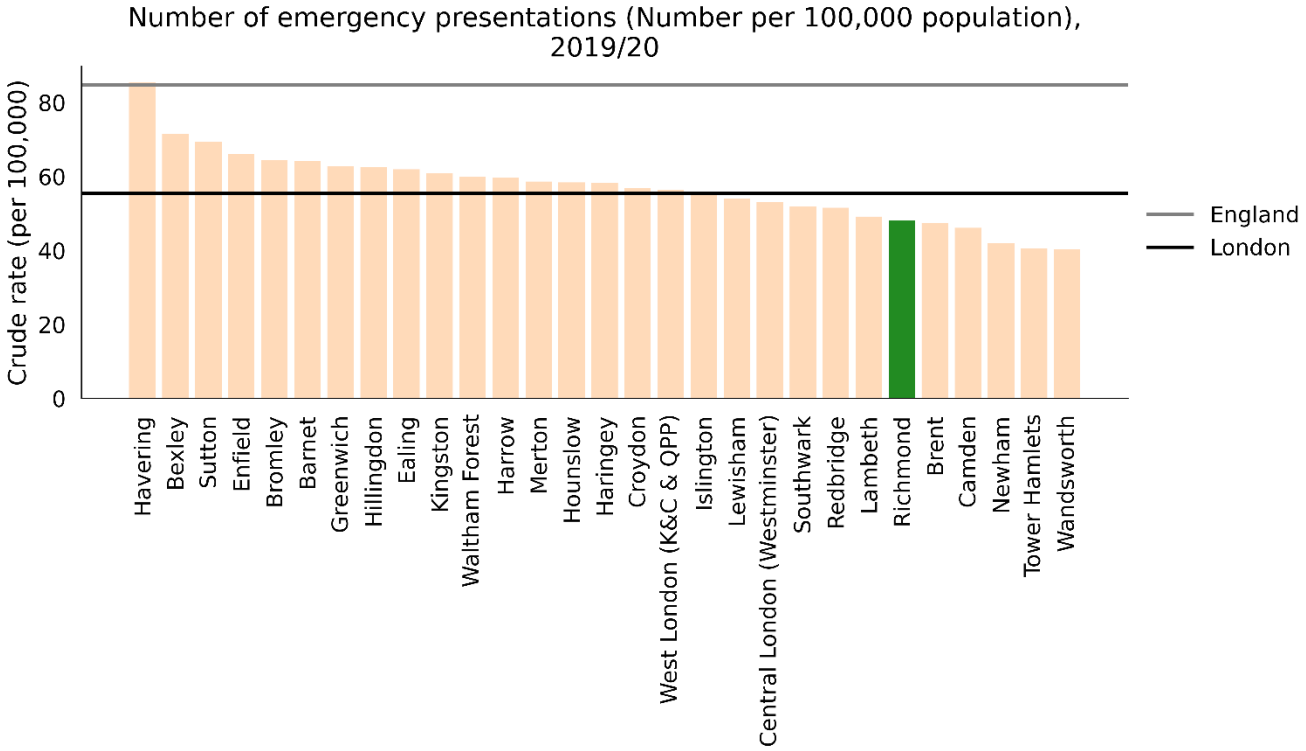


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

8.2 Cancer Emergency Presentations

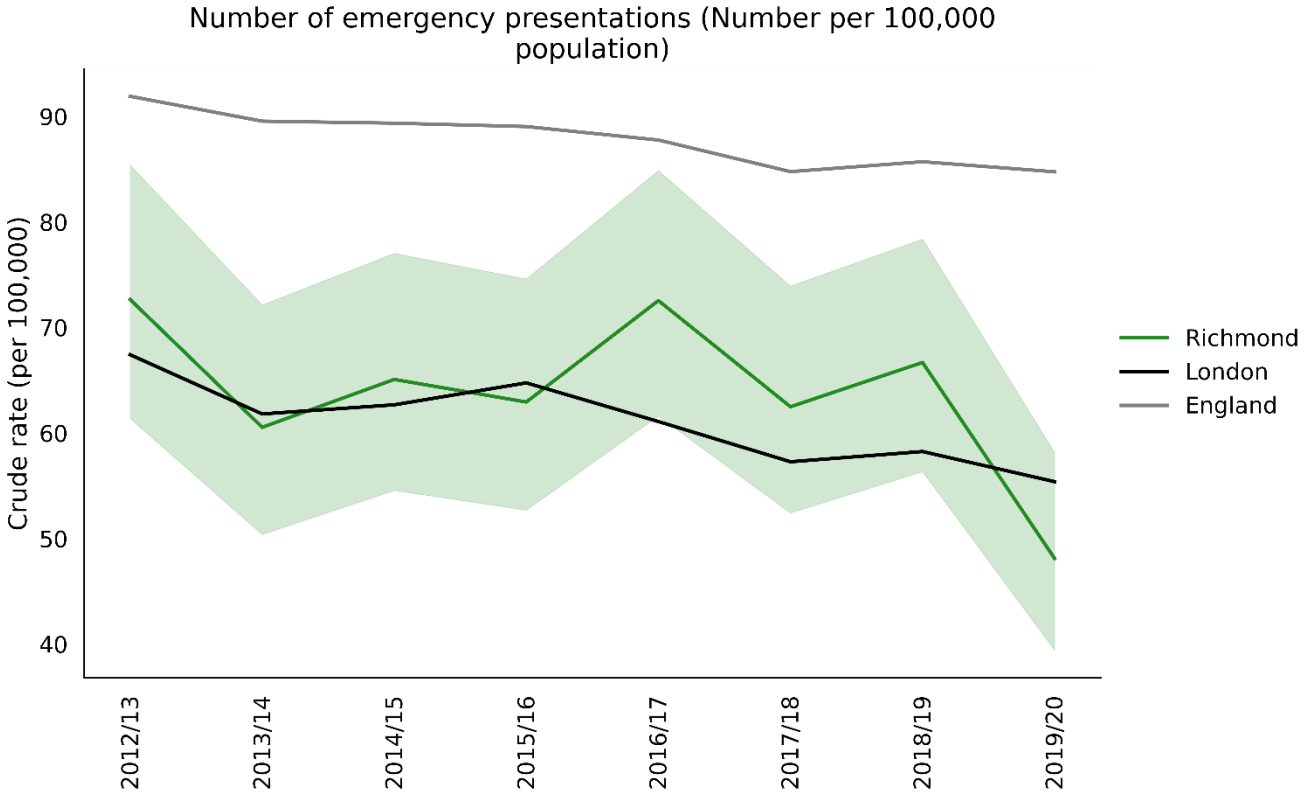
In 2019/20, Richmond's rate of emergency cancer presentations (cancers diagnosed in hospital following an emergency admission) was 48.1 per 100,000 population (n=107), which is the 6th lowest rate in London (**Figure 42**) , 43.2% lower than the England average and 13.1% lower than the London average. The latest Borough figure was also 33.8% lower from 2012/13, in comparison with a 7.8% decrease in England's rate in the equivalent time period (**Figure 43**). The 2019/20 rate of non-emergency cancer presentations for Richmond was 221/100,000 population, which means that 12.8% of cancer presentations were identified during an emergency hospital stay; the equivalent percentages for England and London were higher, at 17.8% and 18.4% respectively.

Figure 42: cancer emergency presentations by CCG, 2019/20



Source: PHE Public Health Profiles

Figure 43: Cancer emergency presentations, 2013–2020



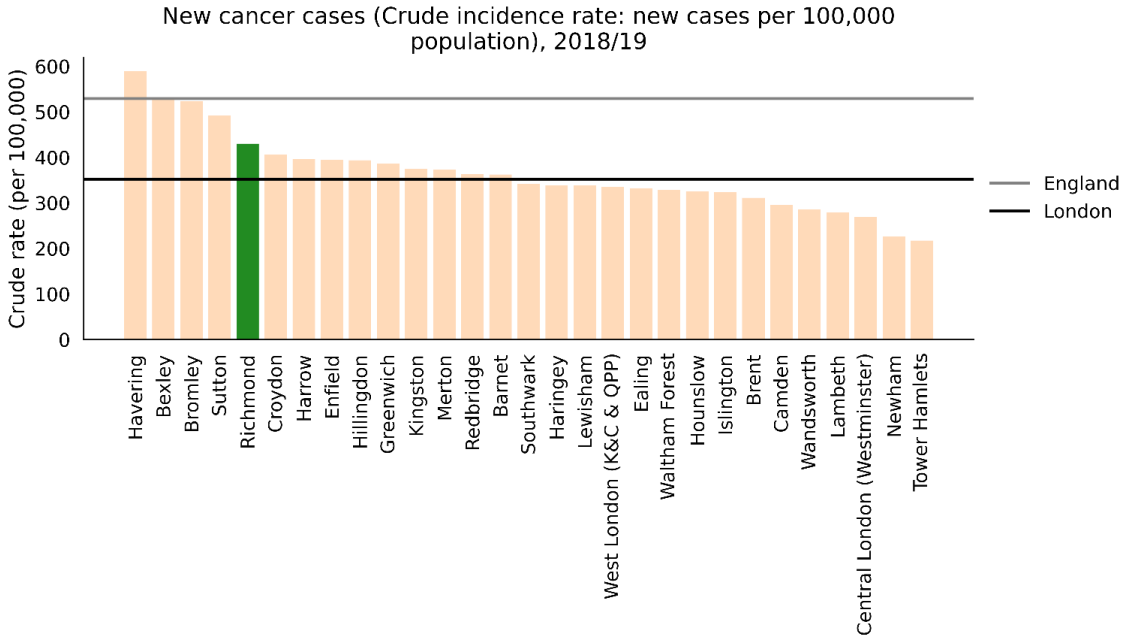
**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

8.3 Diagnosis

New Cancer Diagnoses

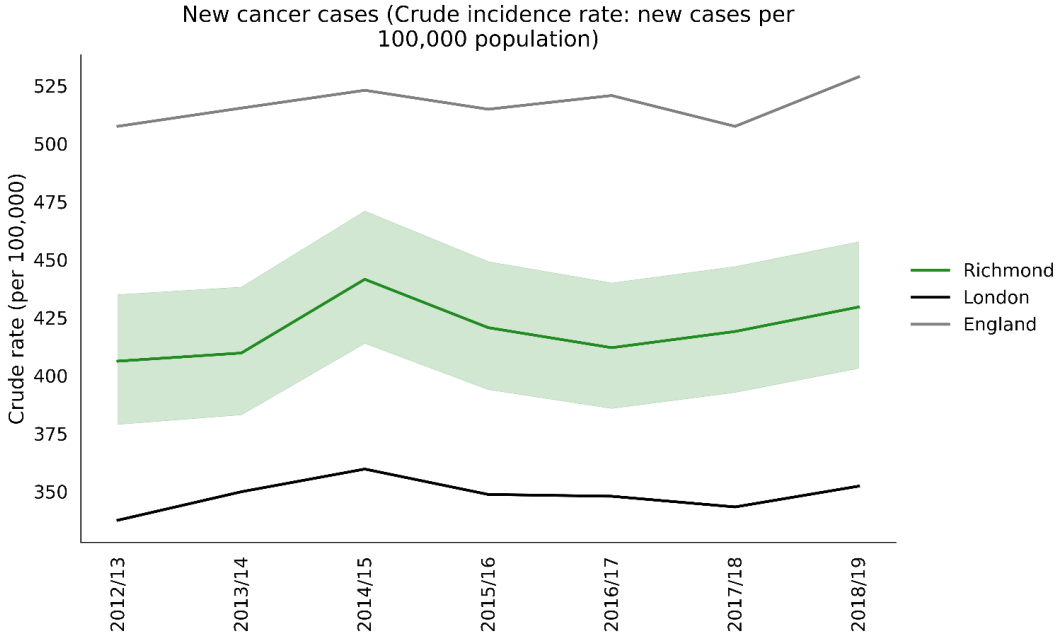
In 2018/19, Richmond's new cancer diagnosis rate was 429.5 per 100,000 population (n=947), which is the 5th highest rate in London (**Figure 111**), 18.8% lower than the England average and 21.9% higher than the London average. The latest Borough figure for 2018/19 was also 5.7% higher from 2012/13, in comparison with a 4.2% increase in England's rate in the equivalent time period (**Figure 112**).

Figure 111: New cancer diagnoses by CCG, 2019/20



Source: PHE Public Health Profiles

Figure 112: New cancer diagnoses, 2012–2019

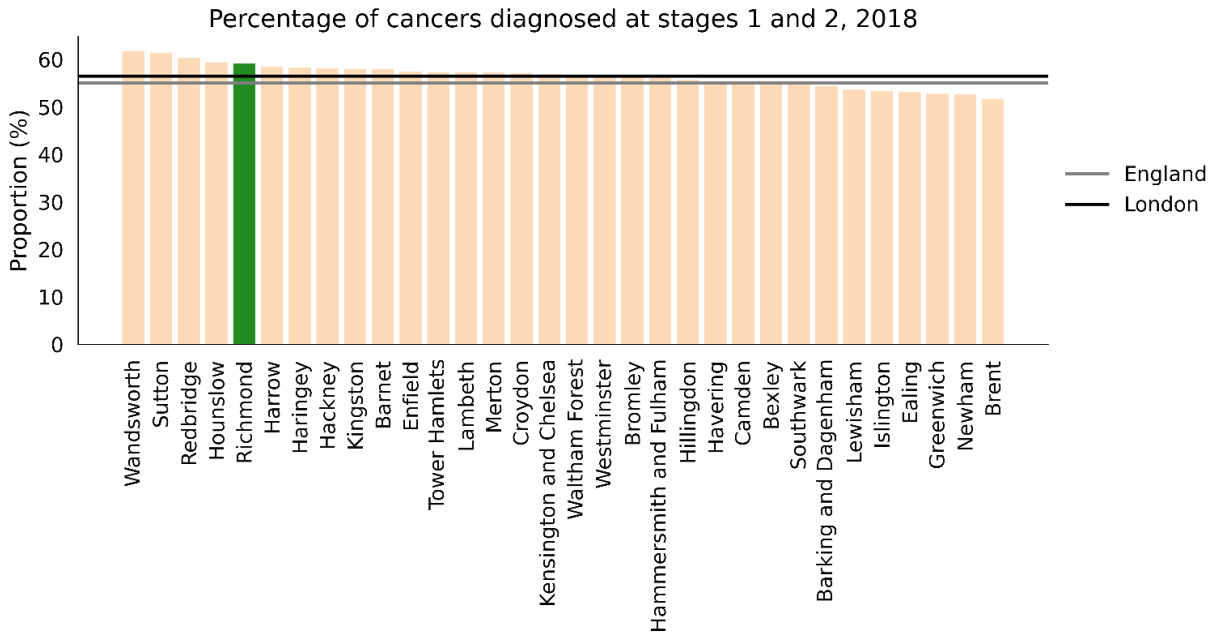


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

Cancer Diagnosed at Early Stages

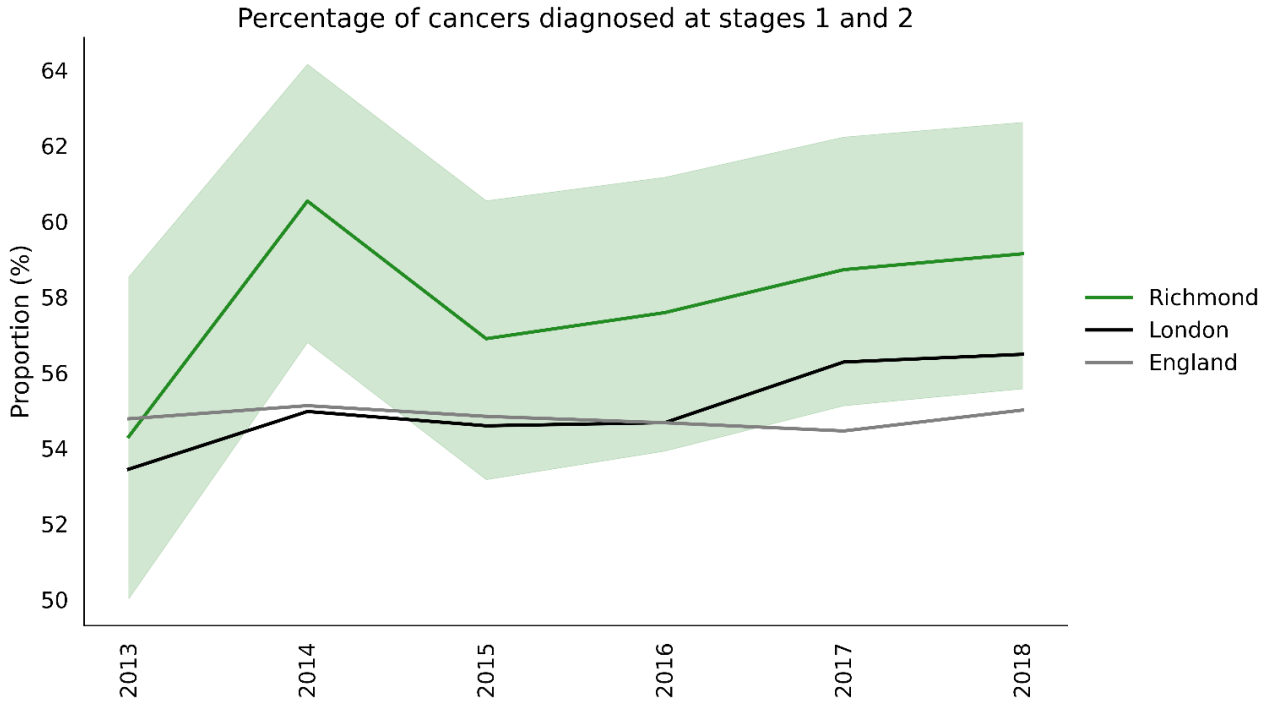
In 2018, Richmond's proportion of cancer diagnosed at early stages of disease was 59.1% (n=440), which is the 5th highest rate in London (**Figure 113**), 7.5% higher than the England average and 4.7% higher than the London average. The latest Borough figure for 2018 was also 8.9% higher from 2013, in comparison with a 0.4% increase in England's rate in the equivalent time period (**Figure 114**).

Figure 113: Percentage of cancer diagnoses made at early stages of the disease by local authority, 2018



Source: PHE Public Health Profiles

Figure 114: Percentage of cancer diagnoses made at early stages of the disease, 2013–2018



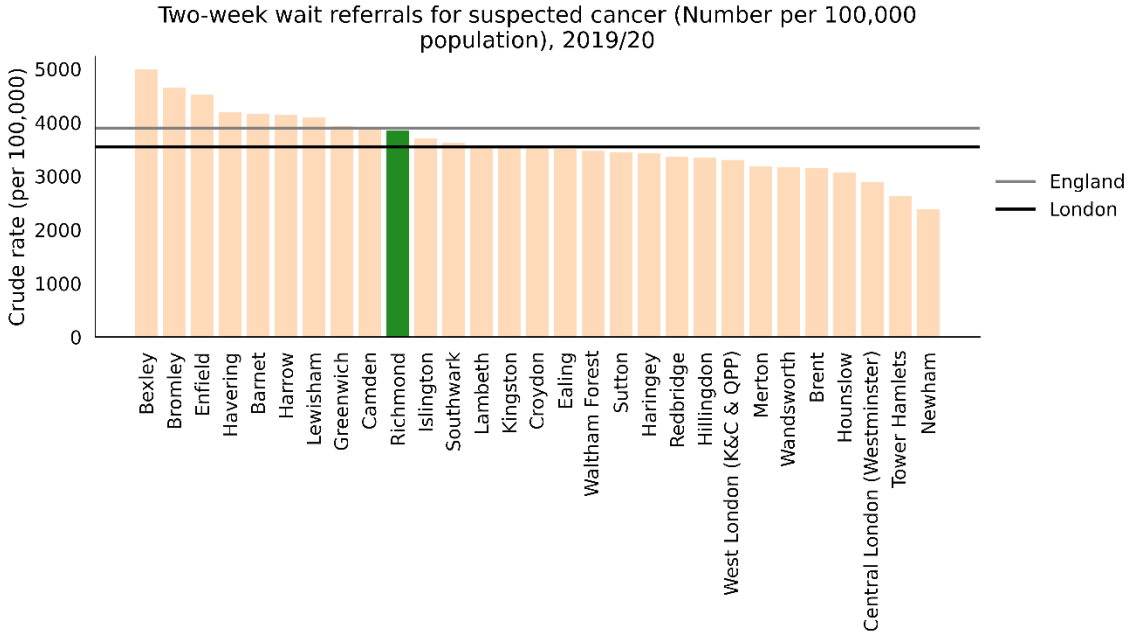
**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

8.4 Two Week Wait Referral Rate

Two Week Wait Referral Rate for Suspected Cancer

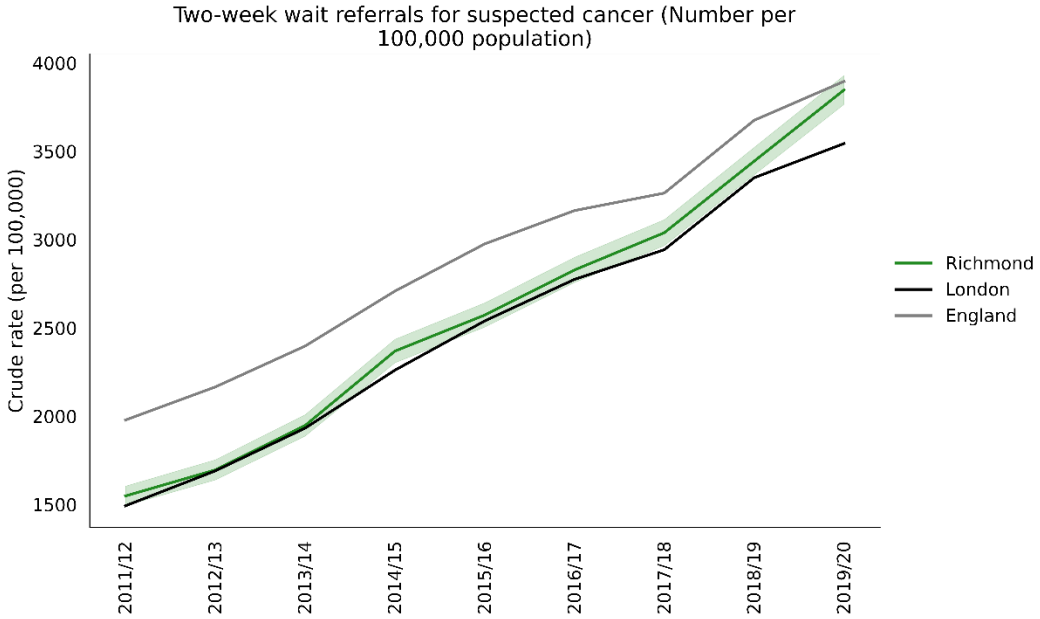
In 2019/20, Richmond's two week wait referral rate for suspected cancer was 3846.6 per 100,000 (n=8556), which is the 10th highest rate in London (**Figure 115**), 1.3% lower than the England average and 8.6% higher than the London average. The latest borough figure for 2019/20 was also 148.6% higher from year 2011/12, in comparison to 97.0% increase in England's rate in the equivalent time period (**Figure 116**).

Figure 115: Two week wait referral rate by CCG, 2019/20



Source: PHE Public Health Profiles

Figure 116: two week wait referral rate, 2010–2020



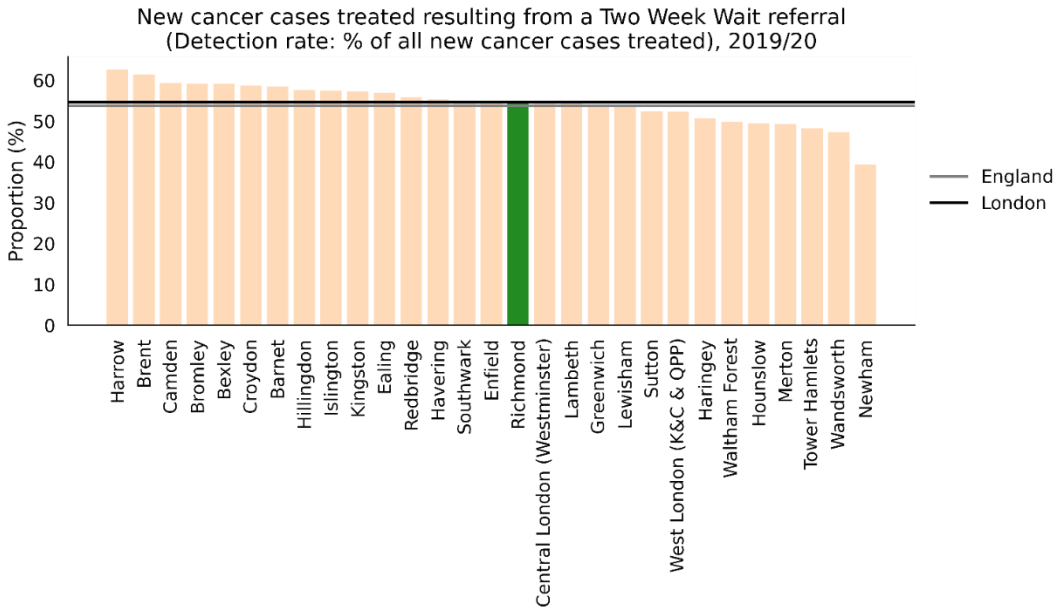
**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

New Cancer Cases Detected in Result of Two Week Wait Referral Made by GP

A high proportion of new cancer cases treated resulting from a Two Week Wait referral together with a high proportion of Two Week Wait referrals that resulted in cancer diagnosis reflects positively on GPs' abilities to screen for cancer symptoms among their patients and effectively act on their concerns.

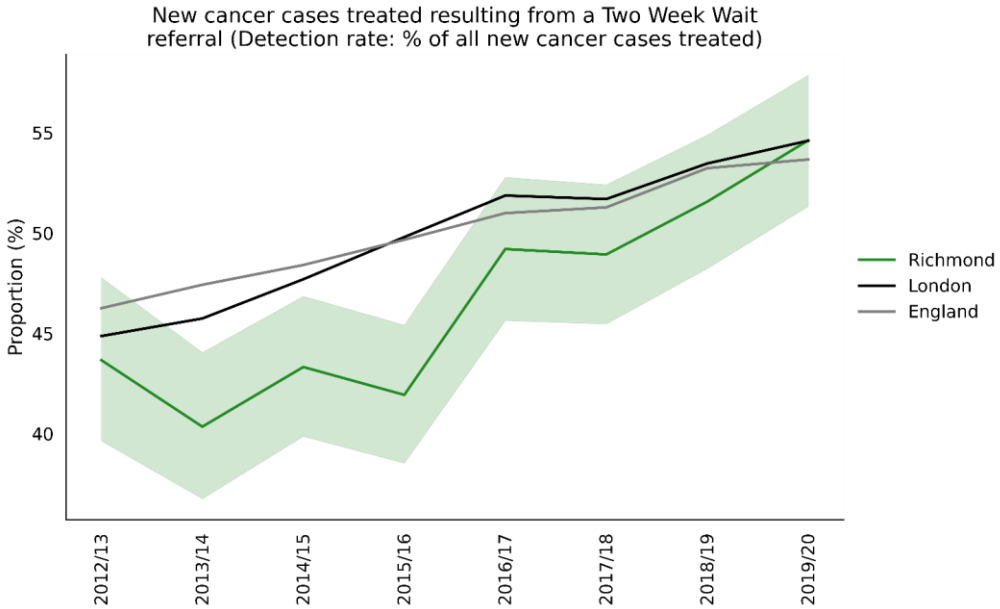
In 2019/20, Richmond's percentage of cancer detections that are attributable to Two Week Wait referrals was 54.6% (n=485), which is the 14th lowest rate in London (**Figure 117**) , 1.8% higher than the England average. The latest Borough figure for 2019/20 was also 25.1% higher from 2012/13, in comparison with a 16.0% increase in England's rate in the equivalent time period (**Figure 118**).

Figure 117: New cancer cases detected via two week wait route by CCG, 2019/20



Source: PHE Public Health Profiles

Figure 118: New cancer cases detected via two week wait route, 2010–2020

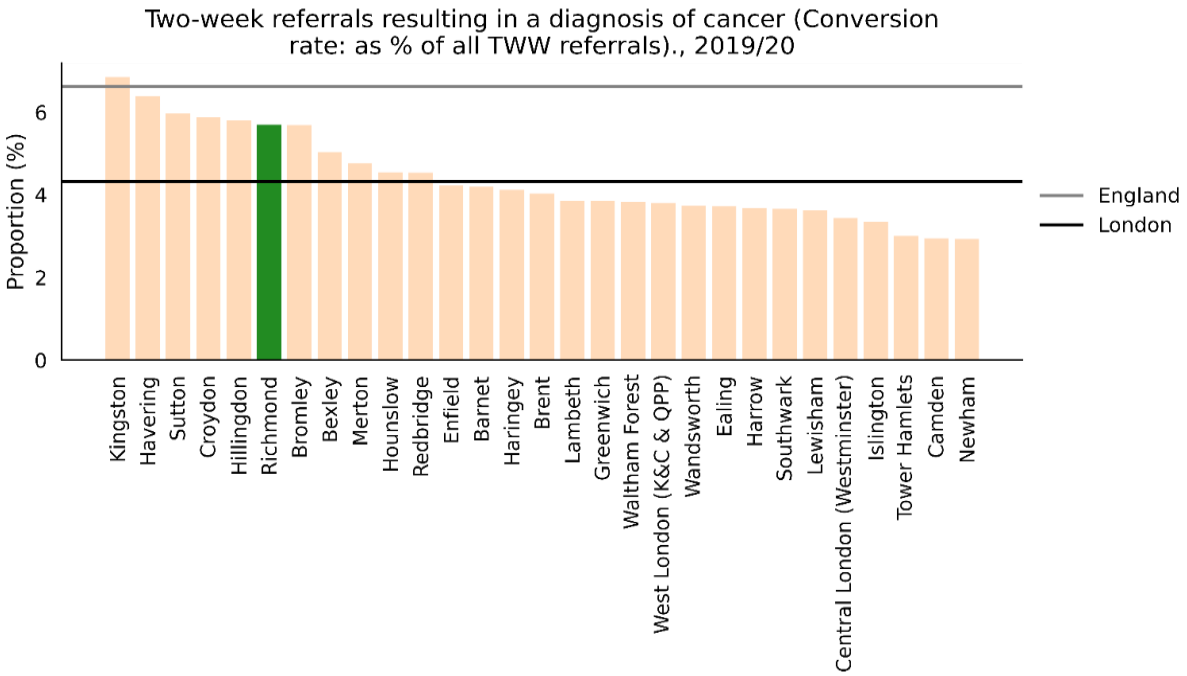


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

Two Week Wait Referrals Resulting in a Diagnosis of Cancer

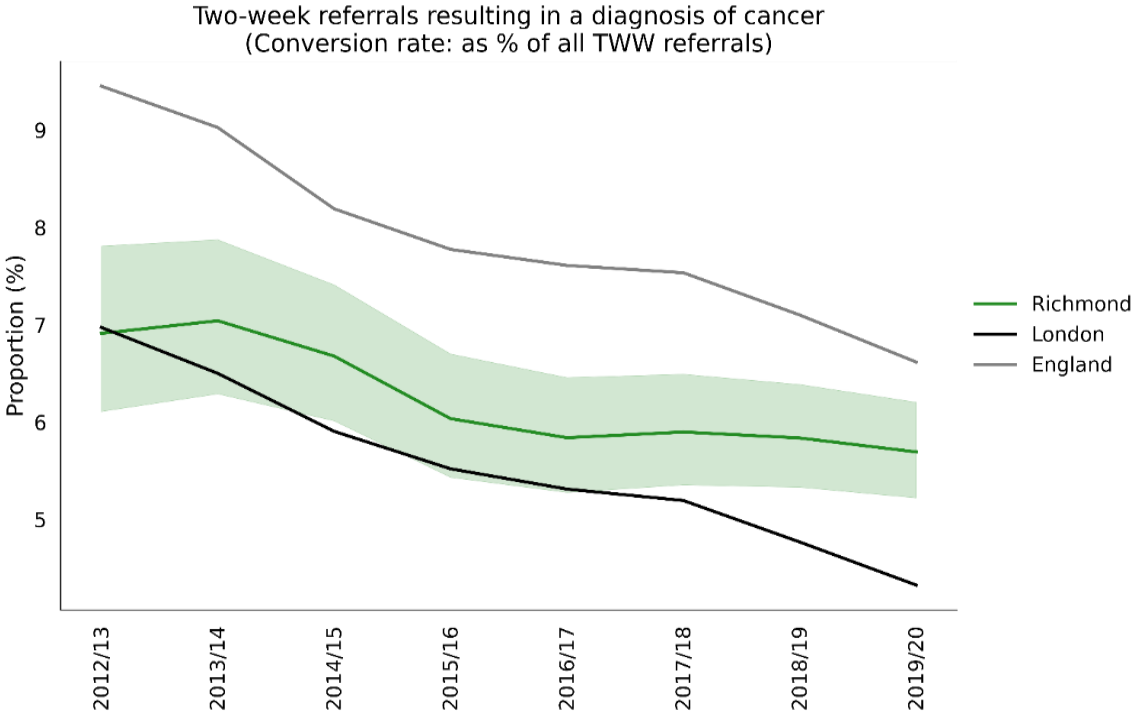
In 2019/20, the proportion of Richmond's Two Week Wait GP referrals that resulted in cancer diagnosis was 5.7% (n=487), which is the 6th highest rate in London (**Figure 119**), 14.0% lower than the England average and 31.6% higher than the London average. The latest Borough figure for 2019/20 was also 17.6% lower from 2012/13, in comparison with a 30.0% decrease in England's rate in the equivalent time period (**Figure 120**).

Figure 119: Proportion of two week wait referrals that resulted in cancer diagnosis by CCG, 2019/20



Source: PHE Public Health Profiles

Figure 120: Proportion of two week wait referrals that resulted in cancer diagnosis, 2010–2020

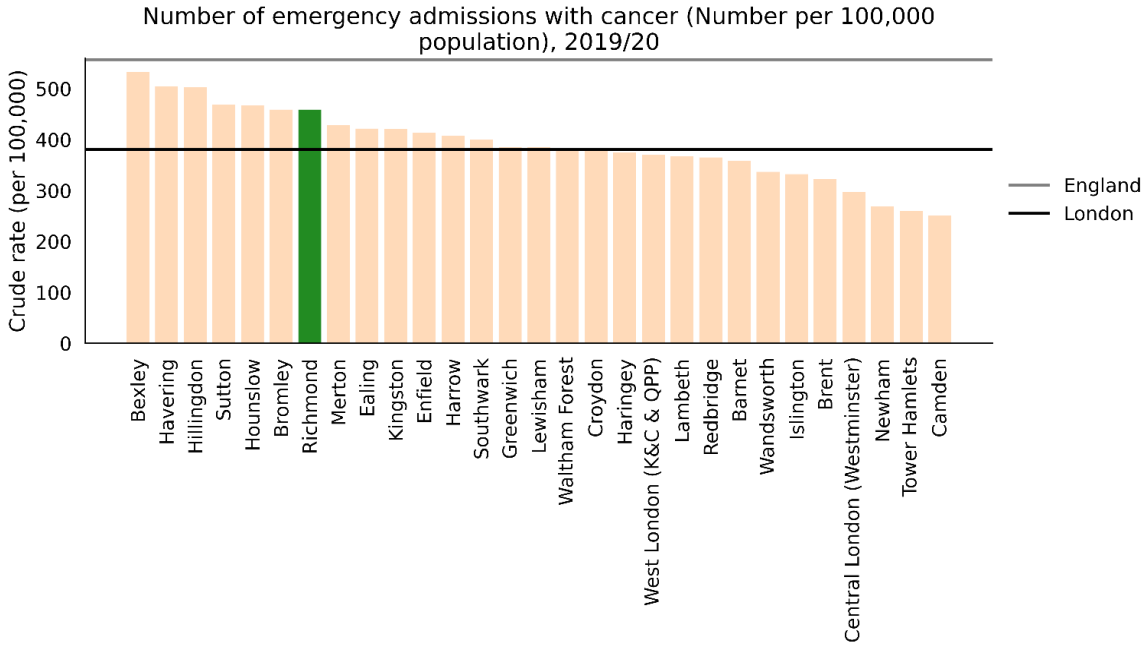


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

8.5 Cancer Emergency Admissions

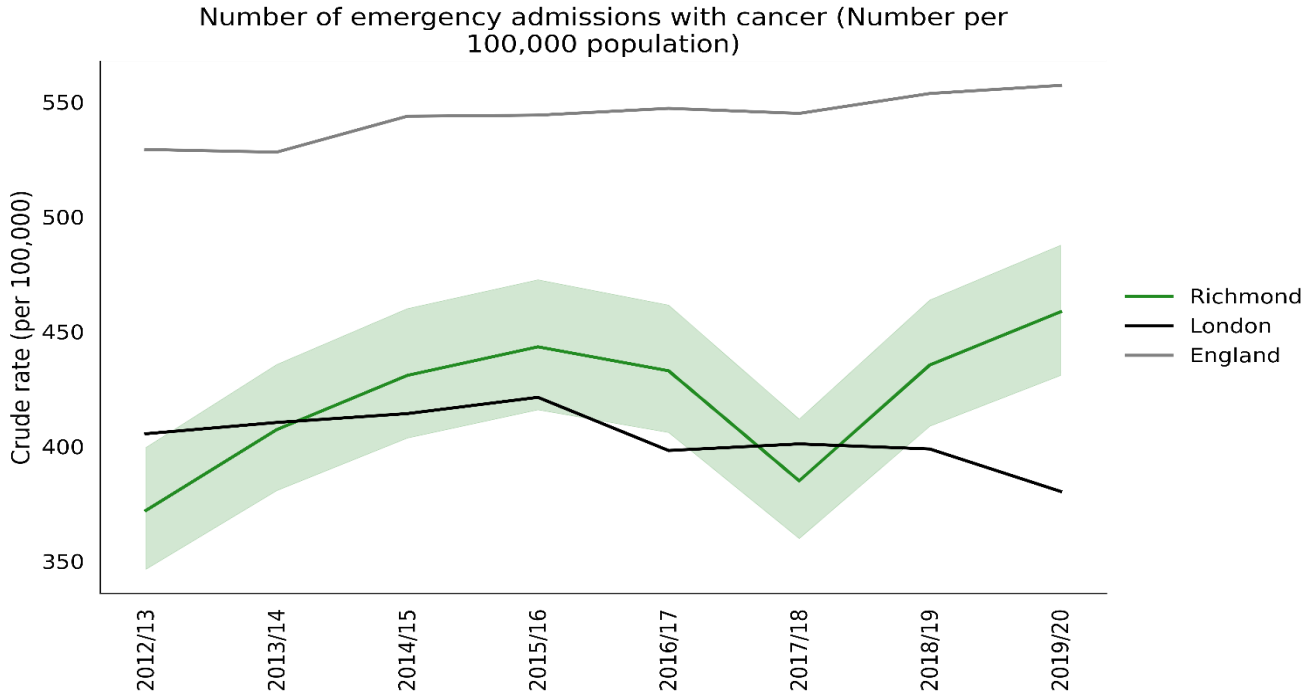
In 2019/20, Richmond's crude rate of cancer emergency admissions was 458.6 per 100,000 population (n=1020), which is the 7th highest rate in London (**Figure 121**), 17.7% lower than the England average and 20.6% higher than the London average. The latest Borough figure for 2019/20 was also 23.2% higher from 2012/13, in comparison with a 5.3% increase in England's rate in the equivalent time period (**Figure 122**).

Figure 121: Cancer emergency admissions by CCG, 2019/20



Source: PHE Public Health Profiles

Figure 122: Cancer emergency admissions, 2013 – 2020



**- green ribbon shows 95% confidence interval around Richmond's indicator values*

Source: PHE Public Health Profiles

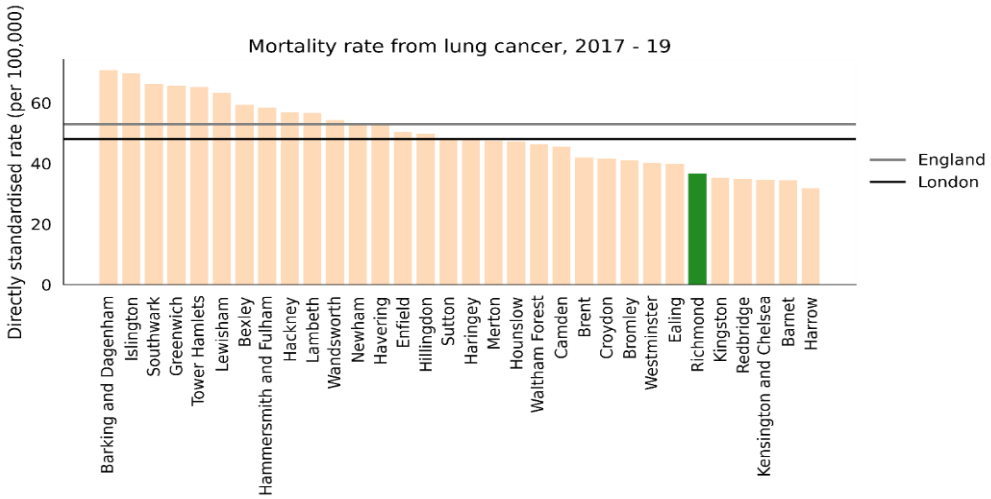
8.6 Cancer Mortality

Premature and preventable cancer mortality can be found in the People Chapter. This section presents mortality from main cancer types: Lung, Breast and Colorectal. There is no nationally available mortality for Prostate cancer that can be reported; however, the latest, 2012–16, Richmond's incidence ratio for prostate cancer was 109.2 per 100 (n=656), which is the 15th highest rate in London, 9.2% higher than the England average[60].

Lung Cancer Mortality

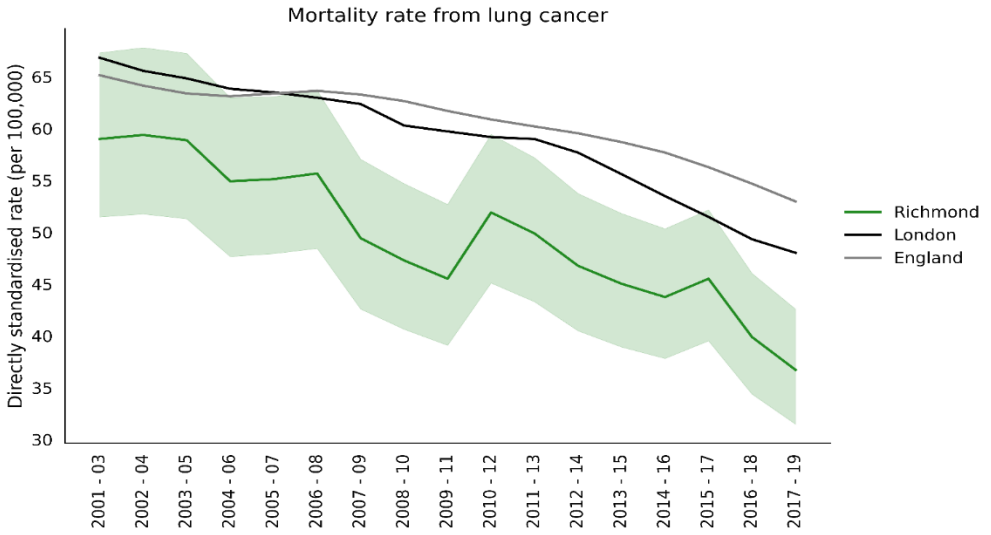
In 2017–19, Richmond's lung cancer mortality rate was 36.7 per 100,000 population (n=177), which is the 6th lowest rate in London (**Figure 123**) , 30.7% lower than the England average and 23.5% lower than the London average. The latest Borough figure was also 37.8% lower from 2001–03, in comparison with a 18.7% decrease in England's rate in the equivalent time period (**Figure 124**).

Figure 123: Lung cancer mortality by local authority, 2017–19



Source: PHE Public Health Profiles

Figure 124: Lung cancer mortality, 2003–2019



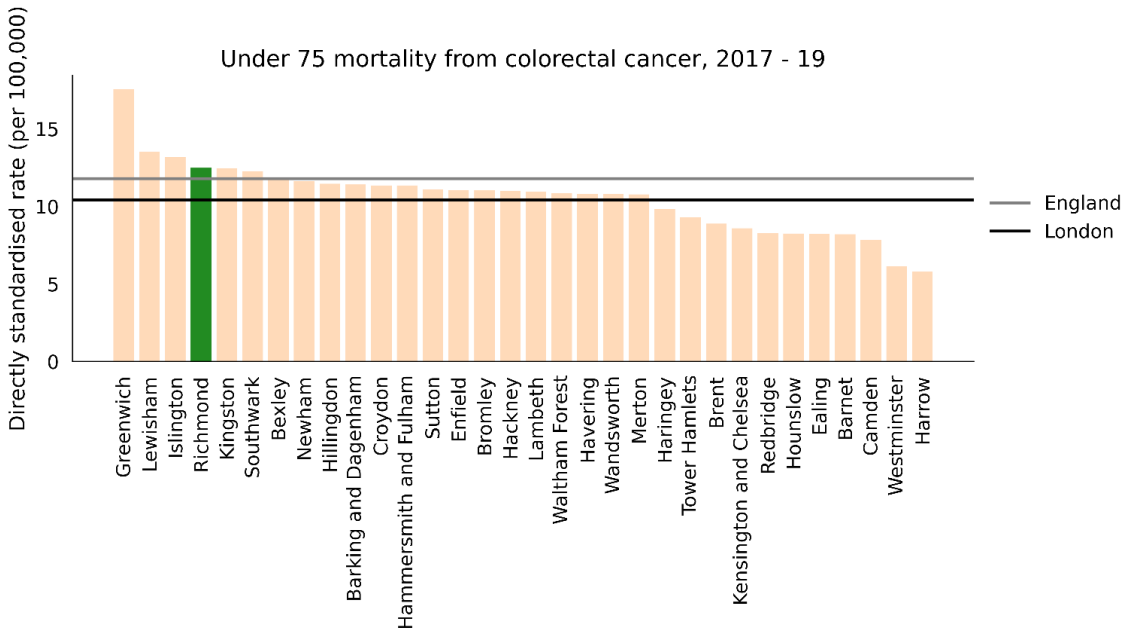
**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

[60] PHE. Public Health Profiles. 2021

Colorectal Cancer Mortality

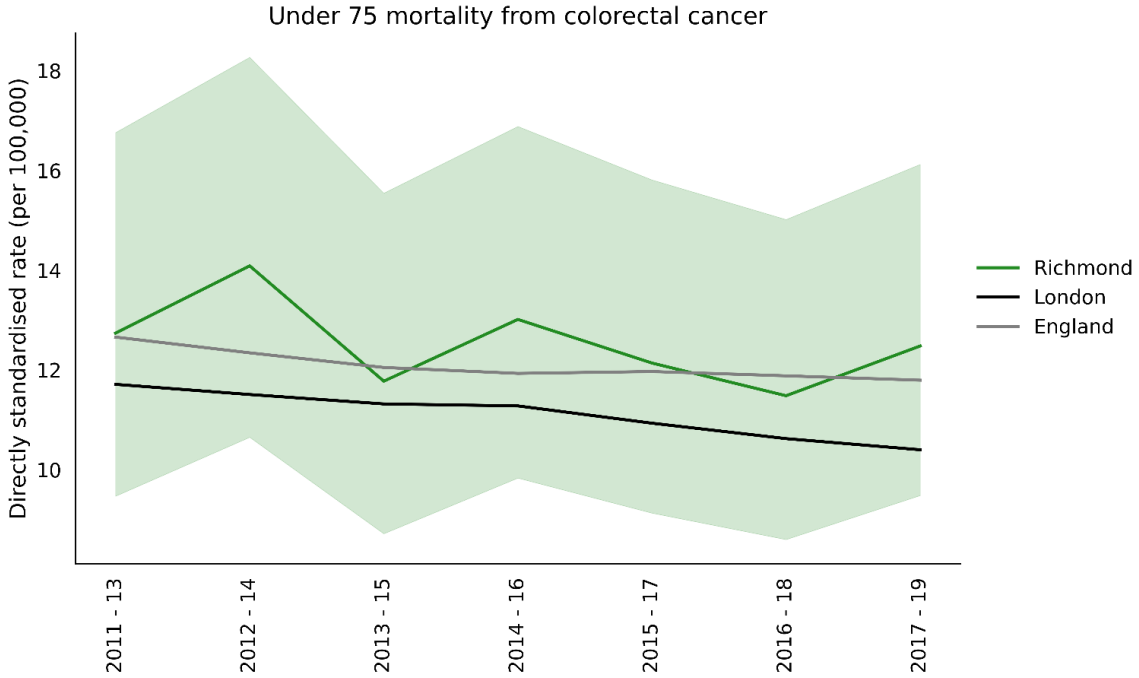
In 2017–19, Richmond's under 75 mortality from colorectal cancer was 12.5 per 100,000 population (n=59), which is the 4th highest rate in London (**Figure 125**), 5.8% higher than the England average and 20.0% higher than the London average. The latest Borough figure for 2017–19 was also 2.0% lower from 2011–13, in comparison with a 6.8% decrease in England's rate in the equivalent time period (**Figure 126**).

Figure 125: Colorectal cancer mortality in people aged under 75 by local authority, 2018/19



Source: PHE Public Health Profiles

Figure 126: Colorectal cancer mortality in people aged under 75

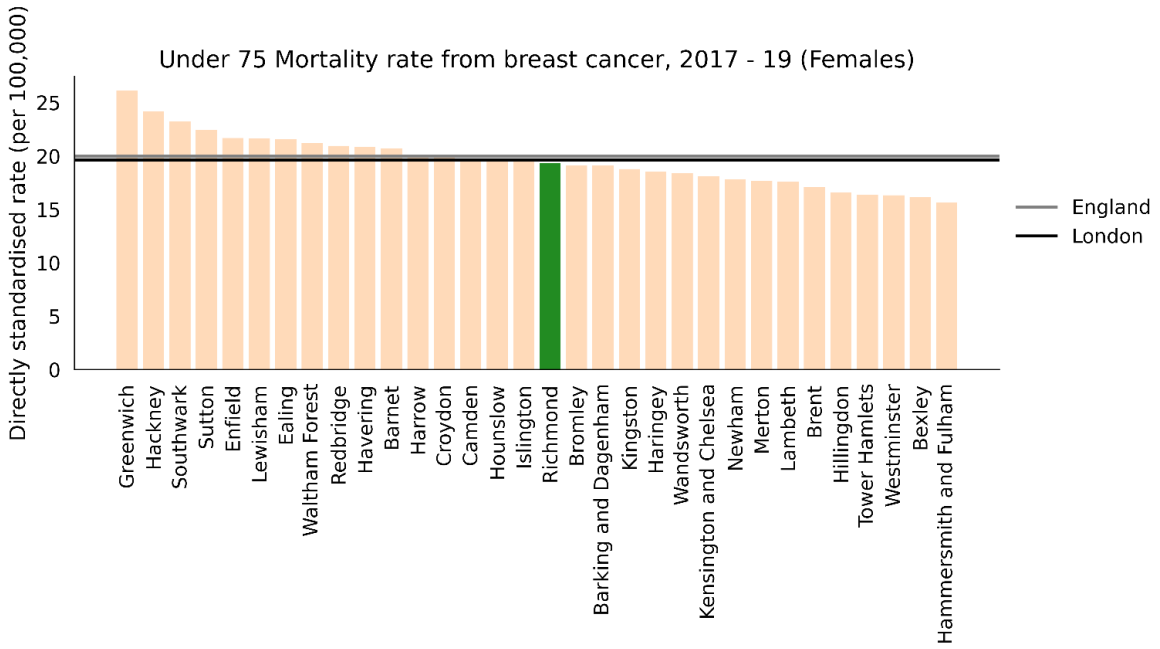


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

Breast Cancer Mortality

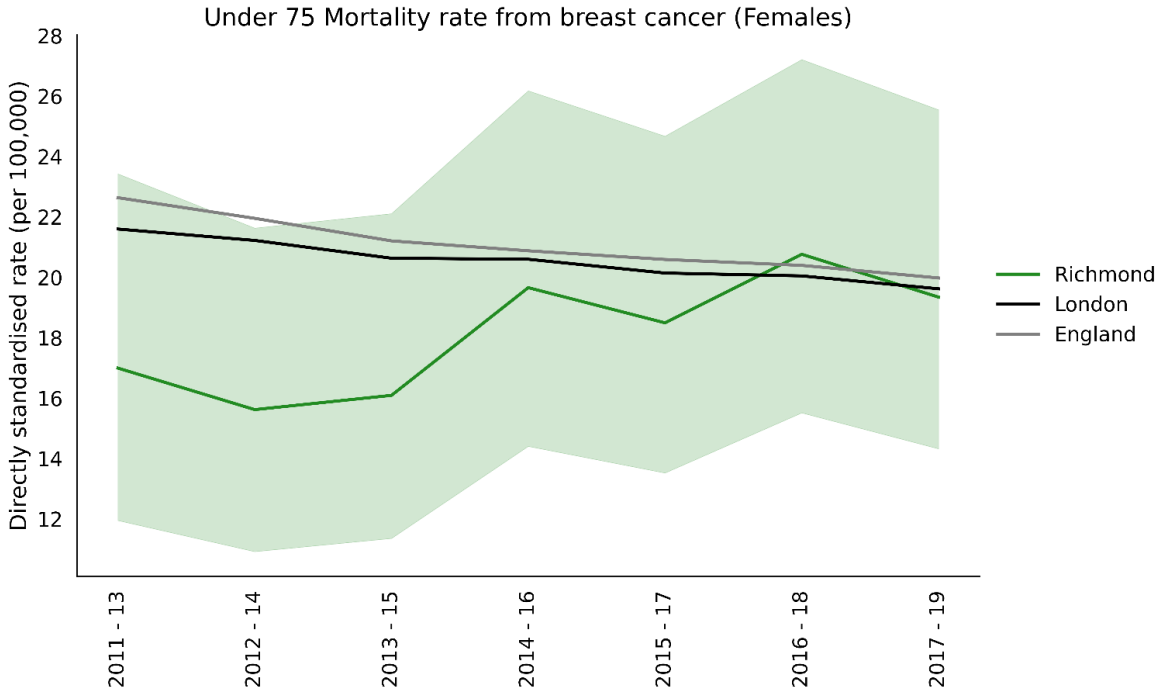
In 2017–19, Richmond's under 75 mortality from breast cancer was 19.3 per 100,000 population (n=50), which is the 16th lowest rate in London (**Figure 127**) , 3.2% lower than the England average and 1.4% lower than the London average. The latest Borough figure was also 13.8% higher from 2011–13, in comparison with a 11.7% decrease in England's rate in the equivalent time period (**Figure 128**).

Figure 127: Breast cancer mortality in females aged under 75 by local authority, 2018/19



Source: PHE Public Health Profiles

Figure 128: Breast cancer mortality in females aged under 75



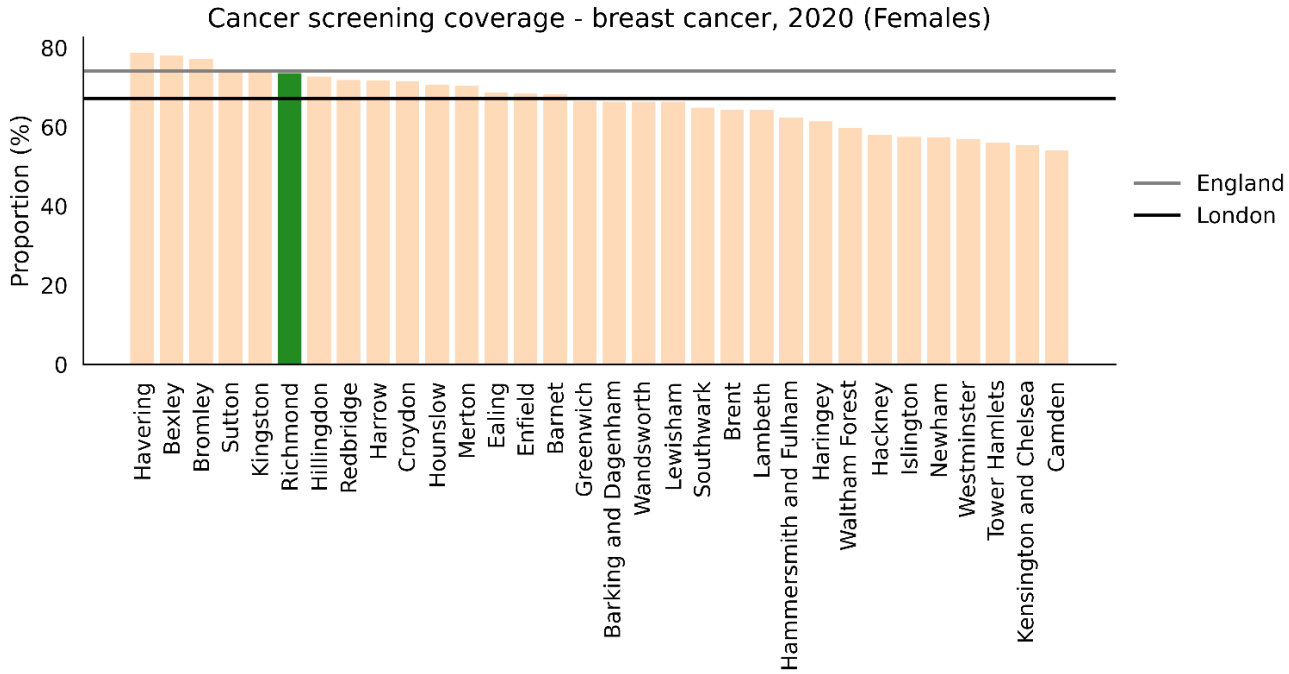
**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

8.7 Cancer Screening Programmes

Breast Cancer Screening

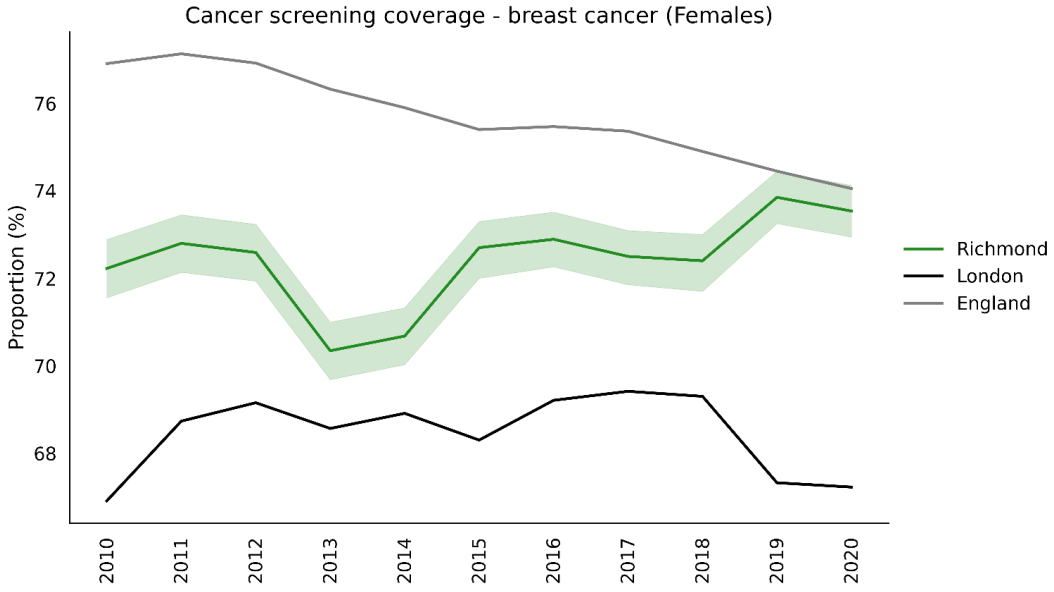
In 2020, Richmond's breast cancer screening coverage in females aged 50–70 was 73.5% (n=15790), which is the 6th highest rate in London (**Figure 129**), 0.7% lower than the England average and 9.4% higher than the London average. The latest Borough figure for 2020 was also 1.8% higher from 2010, in comparison with a 3.7% decrease in England's rate in the equivalent time period (**Figure 130**).

Figure 129: Breast cancer screening coverage by local authority, 2020



Source: PHE Public Health Profiles

Figure 130: Breast cancer screening coverage, 2010 – 2020

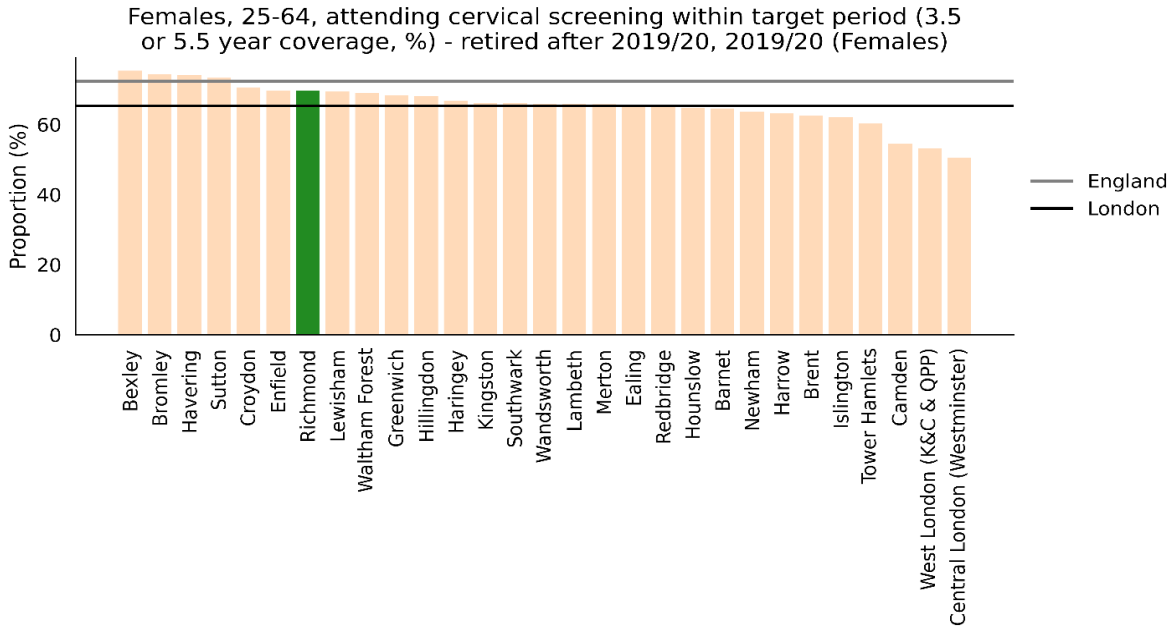


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

Cervical Cancer Screening

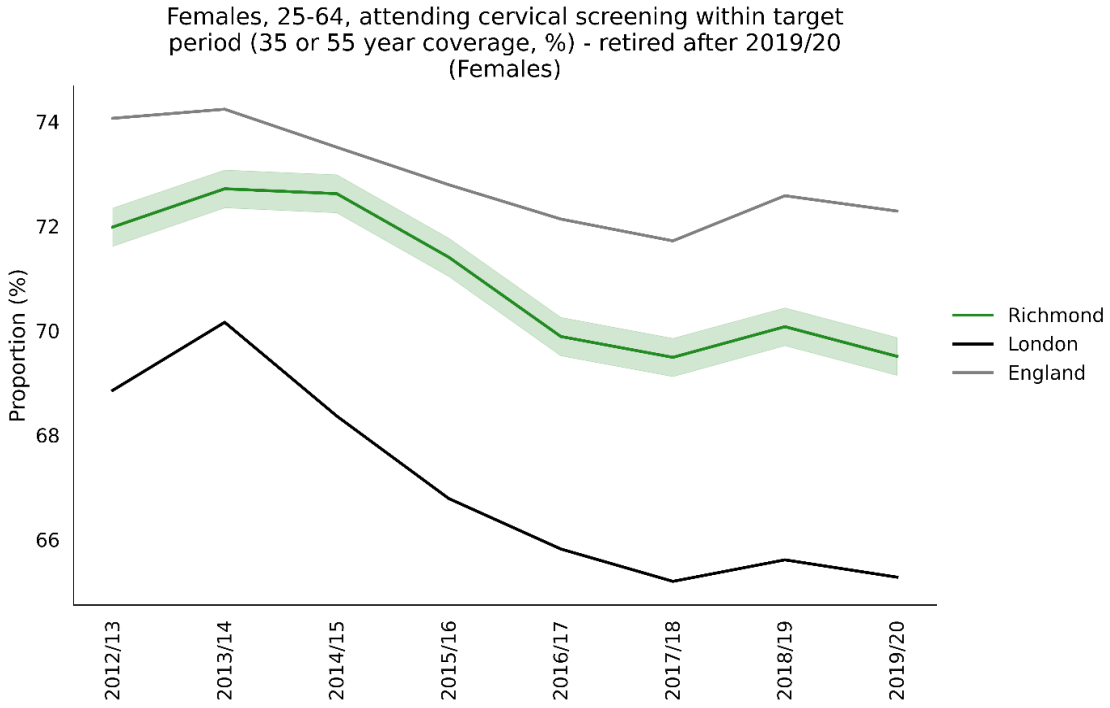
In 2019/20, Richmond's proportion of females aged 25–64 attending cervical screening was 69.5% (n=43070), which is the 7th highest rate in London (**Figure 131**), 3.8% lower than the England average and 6.5% higher than the London average. The latest Borough figure for 2019/20 was also 3.4% lower from the baseline year (2012/13), in comparison with a 2.4% decrease in England's rate in the equivalent time period (**Figure 132**).

Figure 131: Cervical cancer screening coverage by local authority, 2019/20



Source: PHE Public Health Profiles

Figure 132: Cervical cancer screening coverage, 2013 – 2020

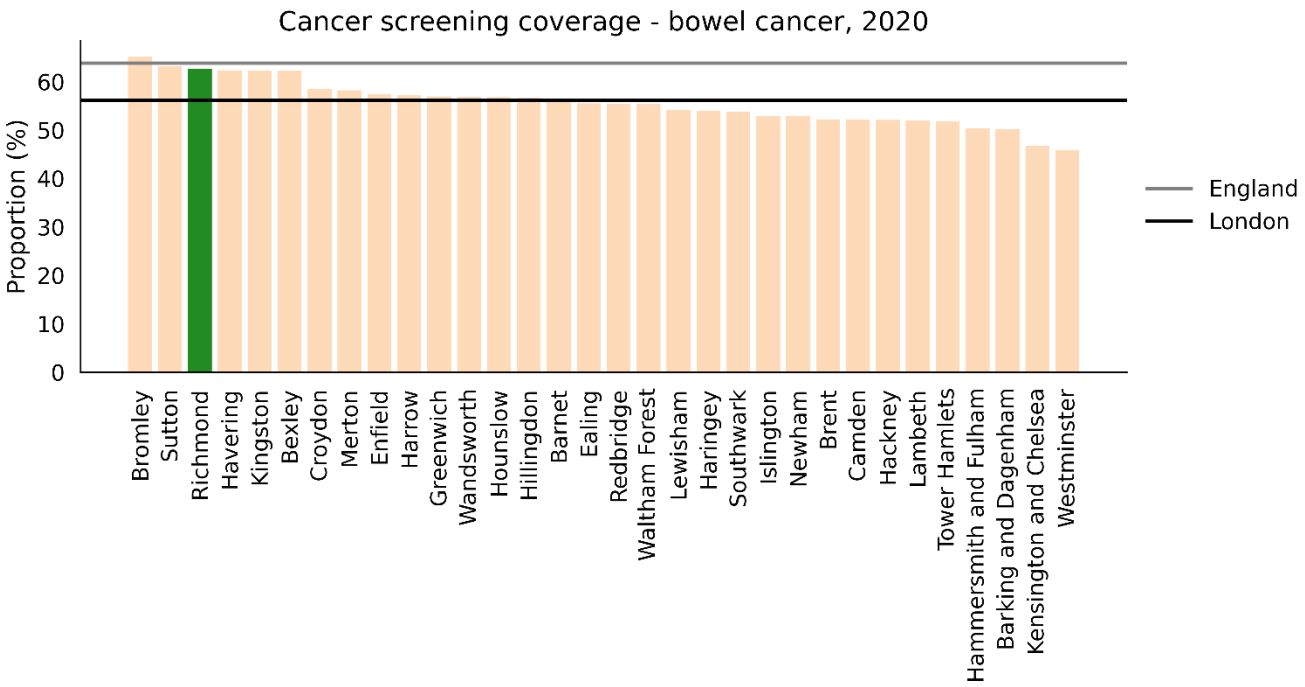


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

Bowel Cancer Screening

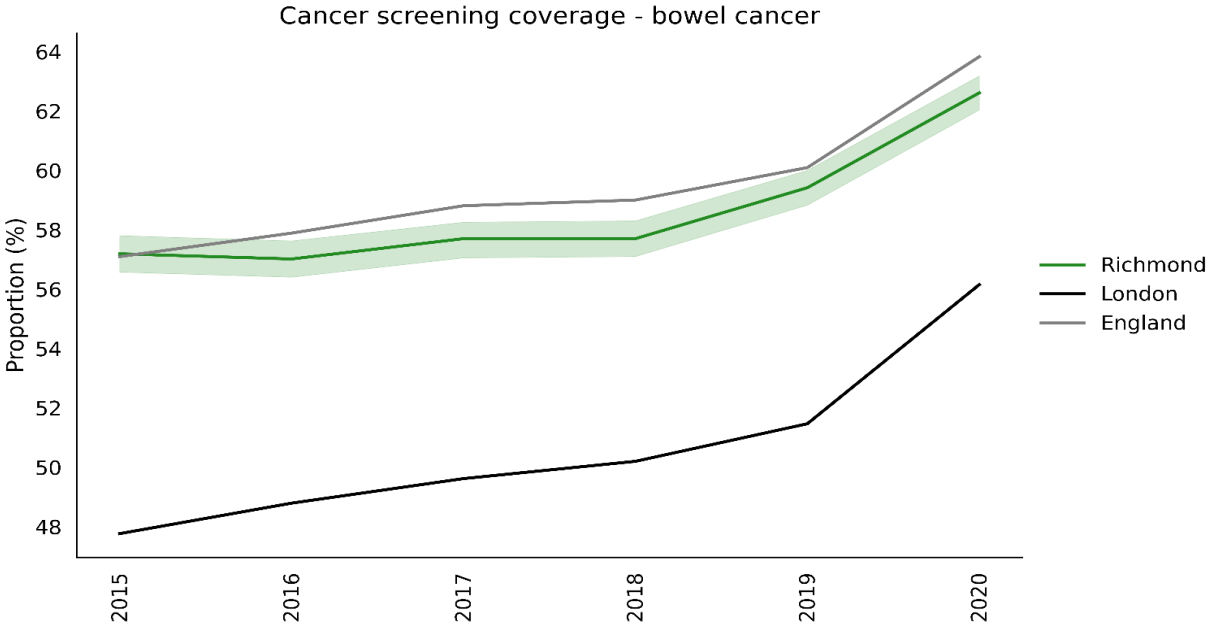
In 2020, Richmond's bowel cancer coverage in people aged 60–74 was 62.6% (n=17139), which is the 3rd highest rate in London (**Figure 133**), 1.9% lower than the England average and 11.5% higher than the London average. The latest Borough figure for 2020 was also 9.5% higher from 2015, in comparison with a 11.8% increase in England's rate in the equivalent time period (**Figure 134**).

Figure 133: Bowel cancer screening coverage by local authority, 2020



Source: PHE Public Health Profiles

Figure 134: Bowel cancer screening coverage, 2015 – 2020



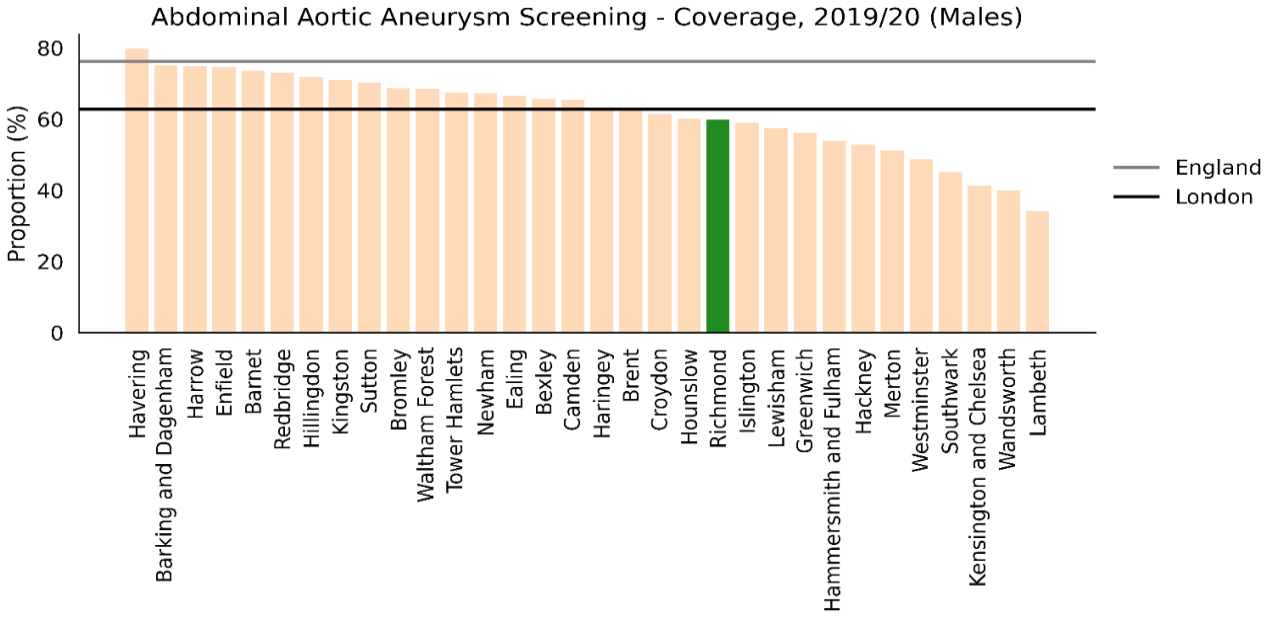
**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

9. Other Adult Screening

9.1 Abdominal Aortic Aneurysm Screening

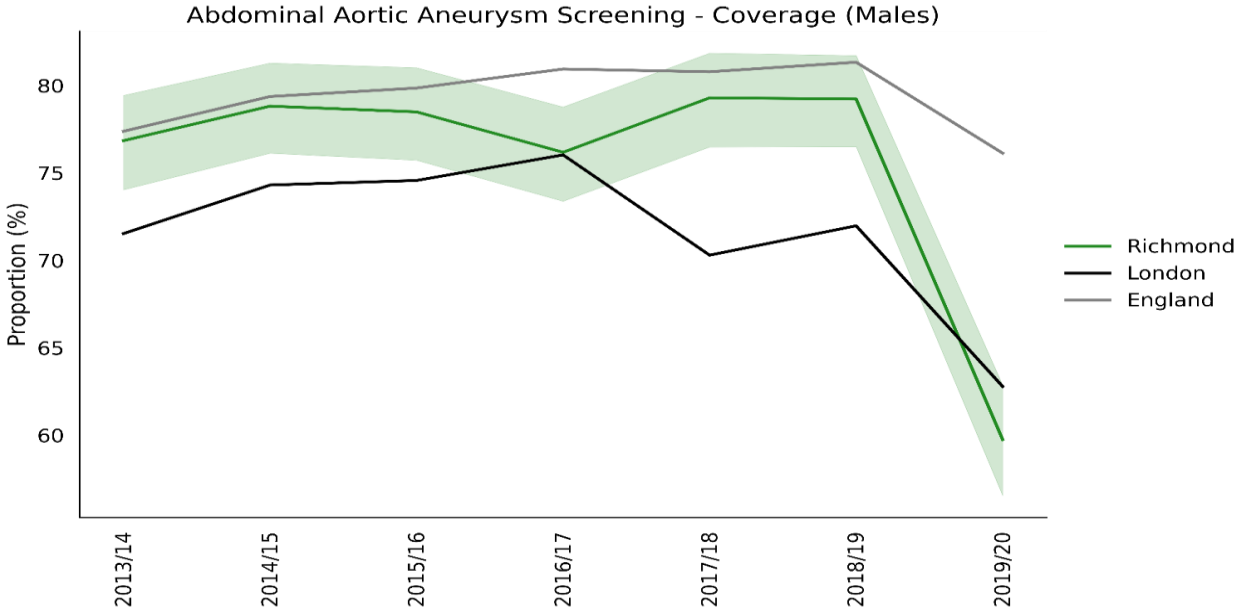
In 2019/20, Richmond's abdominal aortic aneurysm (AAA) coverage in males aged 60–74 was 59.7% (n=552), which is the 12th lowest rate in London (**Figure 135**) , 21.5% lower than the England average and 4.8% lower than the London average. The latest Borough figure was also 22.3% lower from 2013/14, in comparison with a 1.6% decrease in England's rate in the equivalent time period (**Figure 136**); there was a sharp fall in coverage rates in 2019/20 in Richmond and elsewhere.

Figure 135: Abdominal aortic aneurysm screening coverage by local authority, 2020



Source: PHE Public Health Profiles

Figure 136: Abdominal aortic aneurysm screening coverage, 2015 – 2020



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

9.2 Diabetic Retinal Screening

In 2019, 68.4% of people with diabetes on GP registers had a record of retinal screening in the preceding 12 months. This is lower than London and England (73.7% and 77.3% respectively).

Acronyms

AAA	Abdominal Aortic Aneurysm
AF	Atrial Fibrillation
BAME	Black, Asian and Minority Ethnic Groups
BMI	Body Mass Index
BP	Blood Pressure
CCG	Clinical Commissioning Group
CHD	Coronary Heart Disease
CKD	Chronic Kidney Disease
COPD	Chronic Obstructive Pulmonary Disorder
CVD	Cardiovascular Disease
IAPT	Improving Access to Psychological Therapies
JSNA	Joint Strategic Needs Assessment
LTC	Long Term Conditions
SMI	Serious Mental Illness
SWLCCG	South West London Clinical Commissioning Group
BAME	Black, Asian And Minority Ethnic Groups
NDH	Non Diabetic Hyperglycaemia
IFG	Impaired Fasting Glucose
IGT	Impaired Glucose Tolerance
IGR	Impaired Glucose Regulation
PHOF	Public Health Outcomes Framework
LSOA	Lower Super Output Area
NDPP	National Diabetes Prevention Programme
CLCH	Central London Community Healthcare
CBT	Cognitive Behaviour Therapy
NICE	National Institute For Clinical Excellence

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