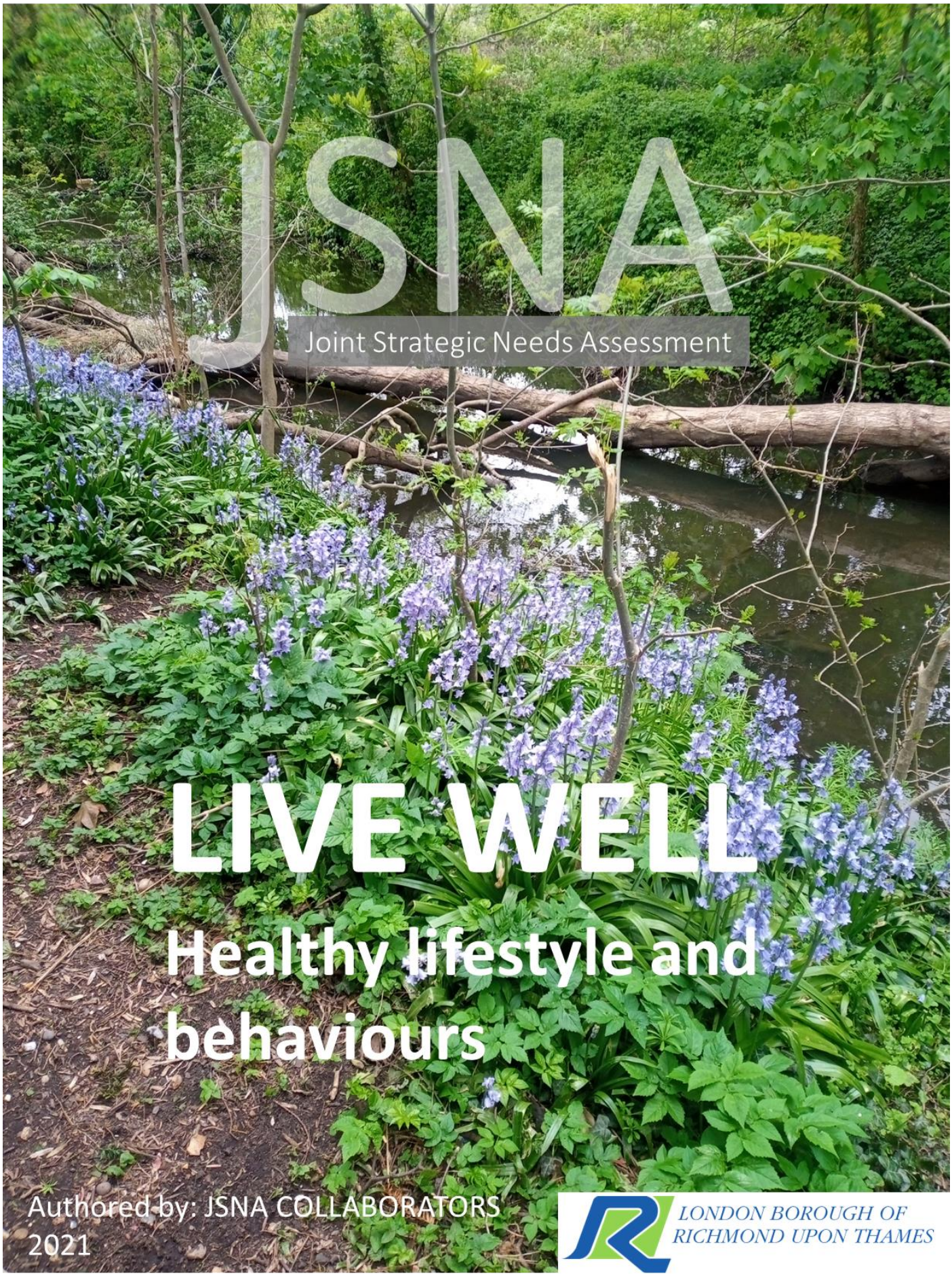

Authored by: JSNA COLLABORATORS

2021

LONDON BOROUGH OF RICHMOND UPON THAMES

Table of Contents

Live Well: Healthy Lifestyle and Behaviours

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-19 on key statistics. The Protect Well chapter has more detailed COVID-19 health outcomes and impact. It is expected that the first post-COVID information will be available in the next 12 months as we continue to monitor the available information.

1. Health Behaviours and Lifestyle

This JSNA Chapter presents data around healthy eating, good nutrition, physical activity and those groups in the Borough which need targeted support. Please note further information and more detail around these topics can be found elsewhere in the relevant sections of the JSNA.

1.1 Introduction to Health Behaviour

Human behaviour and lifestyle factors can affect every aspect of health and wellbeing both favourably or unfavourably and to a different degree throughout an individuals' life. Lifestyles and health behaviours are complex and influenced by multiple factors including genetics, wider determinants of health, previous experiences throughout life, the environment, societal factors, cultural factors as well as individual and interpersonal factors. Therefore, the misconception that individual's behaviour is due to 'choice' alone, over-simplifies our understanding.

The health of people of Richmond is generally faring better than the rest of England. Life expectancy at birth for men and women of Richmond is 82.6 and 86.3 respectively, higher than national figures[1]. Healthy life expectancy at birth for residents is also higher than the national figures for both men, at 71.4 years, and women, at 68.1 years[2]. However, there are areas for improvement.

When considering health behaviours and lifestyle, it is helpful to think of health and wellbeing on a dynamic continuum over the life course. While the degree of influence and need for intervention will vary based on individual circumstances and need, the fundamental components of a healthy lifestyle are relevant to all individuals, irrespective of health and wellbeing status and can favourably influence health and wellbeing at all life stages. Therefore, the potential benefit of healthy lifestyle behaviour change should not be under-estimated.

The behaviours endangering health are modifiable and reducing them will improve multiple areas of health and wellbeing for the residents of Richmond such as preventing long term conditions, improving mental health and wellbeing of residents and encouraging social connectedness of residents in the borough. Whilst there is good work happening across the borough and evidence of good practice, numerous residents are engaging in behaviours that are detrimental to health in both the short and long term or exposed to environmental and metabolic risks for poor health. This chapter considers the contribution of lifestyle and health behaviour on the health and wellbeing of the residents of Richmond based on current evidence and local data.

Currently, the impact of the COVID-19 pandemic on the lifestyles, health behaviours and health and wellbeing of local residents remains unclear. However, the need for supporting residents in improving physical and mental health, in part with promoting and facilitating healthy behaviours is a priority in light of the COVID-19 pandemic. The opportunity for new ways of working with the formation of the Integrated Care Systems and the creation of the Office of Health Promotion provide opportunities to build upon the collaborative partnerships formulated in response to the COVID-19 pandemic across the borough to reduce the risk from behavioural, metabolic and environmental risks to health and ultimately improve the health and wellbeing of Richmond residents can in part be achieved with improving health behaviours of local residents.

Health Behaviour across the Life Course

Making healthy lifestyle changes has the potential to reduce risk of developing long-term conditions, improve health and wellbeing and also improve health and ability to function independently in later life. Evidence suggests that

[1] Public Health England (2021) Fingertips Data: Life Expectancy at Birth (2017-19)

[2] Public Health England (2021) Fingertips Data: Healthy Life Expectancy at Birth (2016-18).

behaviour change is both easier to achieve, more cost-effective, gives a greater return on investment and is more likely to be long-standing if established early in life[3].

Throughout the life course, from preconception to end of life care, all individuals are vulnerable to the risks posed by health-harming behaviours and environments. Children and elderly people are at increased risk from poor health behaviours and therefore are more vulnerable to risk factors that contribute to poor health and wellbeing and ultimately chronic conditions.

Within the first two years of life, a child's absorbs new information and learns from and adapts to its surroundings. This process is influenced by diet, relationships, stress, socio-economic status and physical activity – all of which form the foundations for a child's cognitive development and affects not only their health and wellbeing, but all areas of learning including social and intellectual development. Parents, families and caregivers are, of course, crucial for shaping childhood behaviour and healthy, or unhealthy, behaviour. Behaviour in childhood lays the foundation for behaviour in adulthood, for example, those who are physically active in childhood are much more likely to be physically active as adults.

In Richmond the latest available data comes from the What About YOUth (WAY) Survey that took place in 2014/15[4] stated the percentage of physically active young people aged 15 was 13.9%, slightly higher in comparison to the London average of 11.8% and similar to the national average of 13.9%[5]. In the same survey, the percentage of residents with a mean daily sedentary time of 7 hours per day was 61.0% compared to 69.8% in London and 70.1% in England. Based on evidence that physical activity declines with age and sedentary or inactive behaviours are more difficult to change, this is a risk factor for physical inactivity and harmful levels of sedentary time in adulthood. This can lead to intergenerational patterns of behaviour in relation to physical inactivity passing through families. Therefore when considering behaviour change in any age group, it is important where possible to take a whole family approach where able and with interventions in teens, peer level interventions may be more successful than a family approach depending on the age and individual.

In Richmond 19.3% (49,341) of the total population were under 18 in 2019[6] and it is projected to largely stay the same, with a small decrease of 0.1% by 2029 (from 49,341 in 2019 to 49,290 in 2029). Given health behaviours are shaped early in life, when considering local services that work to achieve behaviour change, taking a life course, family- and community- focussed approach to behaviour change and utilising behavioural insights across the life course enables local decision makers to provide effective, intergenerational, high quality and compassionate services for the residents of Richmond to support the local population in creating healthy behaviour changes.

Those aged 10-24 years' experience a range of changes in lifestyle with associated behavioural, emotional and social changes, it is at this age in which life-long health behaviours tend to become set in place, which provides a unique opportunity to intervene and promote healthy behaviour within this age range with the view to impact positively on health outcomes later on. Typically behaviour change at this stage is influenced by peers rather than the family unit, therefore whole-school approaches or services allowing these age groups to interact with peers are likely to be more effective. Intervention in this age group is key in preventing chronic disease later in life as most health harming behaviours become habituated in adolescents and early adulthood.

[3] García, Jorge Luis, James J. Heckman, Duncan Ermini Leaf, and María José Prados. (2020) Quantifying the Life-Cycle Benefits of an Influential Early-Childhood Program. Journal of Political economy Volume 128, Number 7

[4] What About YOUth? Survey (2015) Health and Social Care Information Centre [online] Available at: https://files.digital.nhs.uk/publicationimport/pub19xxx/pub19244/what-about-youth-eng-2014-rep.pdf

[6] DataWand. 2021.

It is currently unclear how many adults locally are exposed to multiple risk factors, however these risk factors typically cluster and risk accumulates with additional risk factors. Taking a life course approach to health behaviour, the WAY survey from 2015 showed that Richmond ranked highest of all London Boroughs for 15-year-olds reporting three or more risky behaviours including smoking, alcohol use, drug use, physical inactivity with 21.5% reporting engaging with three or more behaviours. This was significantly higher than both the London average of 10.1% and England average of 15.9%[7]. Given those aged 15 at the time of the survey would be in early adulthood at the time of writing and given that there is evidence to suggest that behaviour in adolescence forms the basis of health behaviour in adult life, it is likely that some of these risky behaviours have continued into young adulthood.

Older adults and children are at an increased risk of the detrimental health impacts of poor health behaviour and these behaviours are likely to accumulate over the life course. Therefore, taking a life course, place-based, community approach to design services for older adults living in the borough to promote positive health behaviours in these areas, could reduce the risk of future health conditions, improve management of current long-term conditions, improve mental wellbeing and promote independence later in life and potentially increase social connection in this age group.

In 2015, along with Age UK, The Office for National Statistics has produced estimates of subjective loneliness for people aged 65+. Richmond ranks lowest in London out 33 in London and 205 out of 326 in England (1 being the highest in terms of risk of loneliness in both cases) [8] [9]. With a predicted rise in the population of older adults in the borough, services that promote social connection within this age group will need supporting in the coming years to maintain the boroughs low ranking in this area. While loneliness and social connection are not directly linked, social connection is an important driver to reduce social isolation which is a risk factor for loneliness, along with age. Social connection and the link with health is elaborated on later in the chapter.

1.2 Lifestyle risk factors for long-term conditions

Unhealthy behaviours tend to cluster together creating multiple risk factors for poor health both in individuals and communities. Chronic diseases are the leading causes of death and disability worldwide and the WHO acknowledges that rates of these conditions are accelerating and account for around 71% of deaths globally. The WHO states the 5 main risks for developing non-communicable disease, as follows, all of which involve modifiable human behaviours:

- Unhealthy diet: high in salt, sugar or unhealthy fats
- Tobacco use
- Air pollution
- Harmful use of alcohol
- Physical inactivity

Cardiovascular disease, cancer, respiratory diseases and diabetes account for most of deaths globally, with the local information on each of these long-term conditions has been explored in separate sections of the JSNA. These long-term conditions are of course also the result of a combination of genetic, physiological, social and environmental factors alongside the modifiable individual behaviours. However, each of the conditions listed can, to some degree, be prevented, outcomes improved and in some cases disease processes reversed with changes in lifestyle behaviour. These lifestyle behaviours can be introduced at an individual, community and societal level. Richmond health data may fare relatively well when compared to national data for certain lifestyle behaviours, however, this can be falsely reassuring when considering the multiple detrimental impacts of physical inactivity, poor diet or substance misuse can have on all aspects of health and wellbeing both the short and longer term.

[7] Public Health Outcomes Framework (2021) Percentage with 3 or more risky behaviours at age 15 What about Youth? Survey (2015)
[8] Probability of loneliness for those aged 65 and over. Office for National Statistics (ONS) 2015
[9] *NOMIS Census 2011 via DataWand*

The relationship between risk factors and burden of disease is complex given the nature of the risks and interaction between behavioural, environmental, metabolic factors risk factor exposure. Depending on the disease considered, the degree of attributable risk varies, however, on the whole, the main risk factors accounting for the total burden of disease in England, according to PHE,[10] [11]can be categorised into the following groups:

Behavioural Risks

Behavioural risks according to the Global Burden of Disease Study (2013) [12] [13]

- Tobacco use
- Alcohol consumption
- Drugs usage
- Diet low in fruits, vegetables or whole grains
- Physical inactivity

Prevalence and need locally:

Tobacco

Smoking prevalence for adults in Richmond as of 2019/20 is significantly lower than London and England with the prevalence of smoking reducing substantially in the last 7 years.

Smoking prevalence for 2019/20 in individuals with a long term mental health conditions was 17.9% which also is significantly lower than London (26.6%) and England (25.8%) averages.

In Richmond, there is a higher prevalence of smoking within individuals who work in routine and manual occupations when comparted to the prevalence in the borough overall. In 2019, 29% of those working in routine or manual occupations aged between 18-64 in Richmond were current smokers. While this is not significantly different from London (20.7%) and England (23.2%) averages, the last time the prevalence for this group in Richmond was significantly lower than the national average was in 2013 with a prevalence of 17.5% in Richmond compared to 30.1% in England. Since this, national figures for this group have continued to decline year on year. Therefore this could be a group to target locally with smoking related interventions.

Residents smoking at the time of delivery (3.2%) is significantly lower than averages for London (4.8%) and England (10.4%) and has consistently remained lower since 2010, however, since 2015 there has been no significant decrease in the number of residents smoking at the time of delivery. While numbers are low, with an average of 57 per year over the last 5 years, smoking during pregnancy and at the time of delivery have a detrimental impact on health of both the mother and baby during pregnancy and throughout the life course, therefore, the borough should aim to be making consistent progress to reduce prevalence of smoking in this group.

[10] J. N. Newton, A. D. Briggs, C. J. L. Murray, D. Dicker, K. J. Foreman and H. Wang, "Changes in health in England, with analysis by English regions and areas of deprivation, 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013," *The Lancet,* no. http://dx.doi.org/10.1016/S0140-6736(15)00195-6, September 2015.

[11] Public Health England (2020) The Burden of Disease in England compared with 22 peer countries : A report for NHS England https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/856938/GBD_NHS_England_report.pdf (PDF)

[12] J. N. Newton, A. D. Briggs, C. J. L. Murray, D. Dicker, K. J. Foreman and H. Wang, "Changes in health in England, with analysis by English regions and areas of deprivation, 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013," *The Lancet,* no. http://dx.doi.org/10.1016/S0140-6736(15)00195-6, September 2015.

[13] Public Health England (2020) The Burden of Disease in England compared with 22 peer countries : A report for NHS England https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/856938/GBD_NHS_England_report.pdf (PDF)

Alcohol

In Richmond, whilst admission episodes for alcohol-related conditions in 2018/19 were significantly lower than in London and England, the trend in the last 5 years suggests admission episodes for alcohol related admissions are increasing. In 2018/19 there were 3,467 admission episodes locally where the primary diagnosis or any of the secondary diagnoses were an alcohol-attributable cause and 949 admissions where the primary diagnosis is an alcohol attributable code or a secondary diagnosis is an alcohol-attributable external cause code.

Admission episodes for alcohol-specific conditions in Richmond in 2019/20 have been increasing over the last 5 years. In 2019/20, this was the first year where the rate per 100, 000 in Richmond (612 per 100,000) has been recorded as 'not significantly different' from the London (598 per 100,000) or England (644 per 100,000) having historically been significantly lower than the London and England average on annual recordings since 2009/09. The number of admissions in 2019/20 was 1,110.

Drugs

South West London had the highest proportion (11.7%) of drug use amongst all London regions as of 2018/19[14]. More on drugs and substance misuse can be found in section 6 of this chapter.

Diet low in fruits, vegetables or whole grains

Based on the results from the Active Lives Survey 2019/20, the proportion of the local population aged 16 and over who, when surveyed, reported that they had eaten the recommended 5 portions of fruit and vegetables on a usual day was 64.4% a figure which has remained stable since 2015/16 and has consistently remained significantly higher than London (55.8%) and England (55.4%)[15]. In 2019/20, Richmond ranked the 2nd highest London borough for this measure, second only to the City of London.

However, within the national data significant inequalities exist. Whilst we do not have local data, the following was shown at a national level:

- More females reported eating the recommended 5 portions of fruit and vegetables on a usual day than males.
- The 55-84 year old age group reported significantly higher intake in fruit and vegetables than the national average, while all other age groups below 16-55 were lower than the national average. The 85+ age group were around the same as the national average.
- Black, Asian and Chinese ethnicity groups reported lower consumption of fruit and vegetables than the England average, whereas White other, mixed and other ethnicity groups were similar to the national average. The only ethnicity group that reported above the national average eating 5 portions of fruit and vegetables on a usual day were those of White ethnicity.
- Those answering the survey from the four most deprived quintiles in the borough reported below England average consumption for fruit and vegetables and just 45.7% of those answering the survey from the most deprived decile in the borough reported consuming the recommended fruit and vegetable intake on an average day compared to 60.2% in the least deprived decile.

Physical inactivity

17.1% of adults were reported to be physically inactive, completing less than 30 minutes of physical activity per week in 2019/20. While this is a lower proportion of the local population who are physically inactive than the London (23.8%) and England (22.9%), the percentage of adults who are physically inactive locally has increased from 12.9% in 2018/19 which brings multiple health and wellbeing risks[16]. Given physical inactivity is a more difficult behaviour to change than

[14] Home Office National Statistics (2019). Drug Misuse: Findings from 2018/19 Crime Survey for England and Wales. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/832533/drug-misuse-2019-hosb2119.pdf (PDF)

[15] Public Health England (2021) Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults) 2019/20

[16] **Public Health England Fingertips Data (2021) Percentage of physically inactive adults (2019/20)**

keeping residents active, this change in percentage of individuals that are inactive needs to be considered when tackling inactivity within the borough in taking a proactive approach to reducing inactivity.

Metabolic Risk Factors

Metabolic risks according to the Global Burden of Disease Study (2013) [17] [18]

- High body mass index
- High systolic blood pressure
- High plasma fasting glucose

Level of need locally:

High BMI: As of 2019/20 around half of adults aged 18+ (51.9%) in Richmond are still classified as overweight or obese. Whilst locally, obesity rates are lower than in London (55.7%) and England (62.8%), this data can seem falsely reassuring given that still more than half of the adult population in Richmond are at significant risk of morbidity and mortality associated with overweight and obesity[19].

High systolic blood pressure: In Richmond QOF data from 2019/20 recorded that 23,174 patients on practice disease registers had a diagnosis of hypertension, 4.1% of registered population, which was a lower percentage of total patients on the practice list (9.7%) than in London (11%) and England (14%)[20].However, Richmond identifies only 40% of the patients with hypertension, which is one of the lowest proportions of diagnosed hypertension among London boroughs [21].

High plasma fasting glucose: According to NHS digital, 7,720 residents in Richmond were recorded as diabetic on practice disease registers in 2019/20, which is the 2nd lowest proportion in London[22]. However, the estimated diabetes diagnosis rate in 2019/20 was 58.6% which was lower compared to London (81.4% and England (78.0%)[23].

Trends in Risk Factor Exposure

Generally, over the last decade there are some notable trends in risk factor exposure in England[24]:

- Declines in air pollution, smoking, cholesterol and hypertension
- Increases in exposure to low physical activity, high BMI and drug use
- Little change in dietary exposures

In summary, in Richmond data suggests there has been:

- There has been an increase in physical inactivity in adults locally, based on pre-COVID-19 data.
- Minimal changes have occurred in the proportion adults aged 18+ classed as overweight or obese or adults aged 18+ who are currently smoking.

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[17] J. N. Newton, A. D. Briggs, C. J. L. Murray, D. Dicker, K. J. Foreman and H. Wang, "Changes in health in England, with analysis by English regions and areas of deprivation, 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013," *The Lancet,* no. http://dx.doi.org/10.1016/S0140-6736(15)00195-6, September 2015.

[18] Public Health England (2020) The Burden of Disease in England compared with 22 peer countries : A report for NHS England https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/856938/GBD_NHS_England_report.pdf (PDF)

[19] PHOF 2019/20 Percentage of adults (aged 18+) classified as overweight or obese *Public Health England (based on Active Lives survey, Sport England)*

[20] Hypertension: QOF prevalence (all ages) 2019/20 Quality Outcomes Framework, NHS Digital https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2019-20

[21] Expected hypertension prevalence: PHE National Cardiovascular Intelligence Network. Adult hypertension prevalence estimates, 2017. *Recorded prevalence: QOF 2017/18*

[22] *Diabetes QOF prevalence 17+ Source: Quality and Outcomes Framework (QOF), NHS Digital, 2019/20*

[23] Prevalence estimates of Diabetes, Public Health England, 2016

[24] Public Health England (2020) The Burden of Disease in England compared with 22 peer countries : A report for NHS England https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/856938/GBD_NHS_England_report.pdf (PDF)

- A large number of the residents are exposed to metabolic risks with around half of the adult population being classified as overweight or obese.

Addressing these risk factors and tackling health harming behaviours and their drivers in the borough will improve the health and wellbeing of residents, given we are aware of the cumulative nature of the above risks and the knowledge these risk factors tend to cluster.

1.3 Inequalities in Health Behaviours

Health conditions are poorer in most deprived quintile of areas in Richmond. Often, clustering of behaviours detrimental to health is associated with social factors such as socio-economic status including educational attainment thus creating multiple risk factors for poor health. Individuals living in more deprived circumstances are more likely to be exposed to multiple risk factors, further influencing health behaviour and lifestyles which act to further widen social inequalities in health.

Given health behaviours begin to form in childhood and both older people and children are vulnerable to the increased risk of behaviours detrimental to health and that poor health behaviours are associated and exacerbated by socioeconomic status, addressing the wider determinants of health in children and older adults in Richmond is important.

The King's Fund reported that individuals with no qualifications were more than five times as likely as those with higher education to engage in all four unhealthy behaviours including low physical inactivity, alcohol, smoking and poor diet.

1.4 Impact of the Local Environment on Health Behaviours

Increasing physical activity, improving nutrition, getting the recommended amount of good quality sleep, spending time in nature and connecting with others fostering positive relationships and reducing stressors or improving ability to cope with stressors promotes a healthier lifestyle for physical and mental health. Positive health behaviours can prevent and improve management of and improve recovery from illness as well improving general health and wellbeing. Therefore, there is potential for multiple gains from engaging in healthy behaviours and interventions to improve the health behaviour of local residents can seek to address multiple health benefits.

Understanding the basis of human behaviour can help to inform local decision making around lifestyle services and behaviour change interventions to provide effective, high quality, compassionate services.

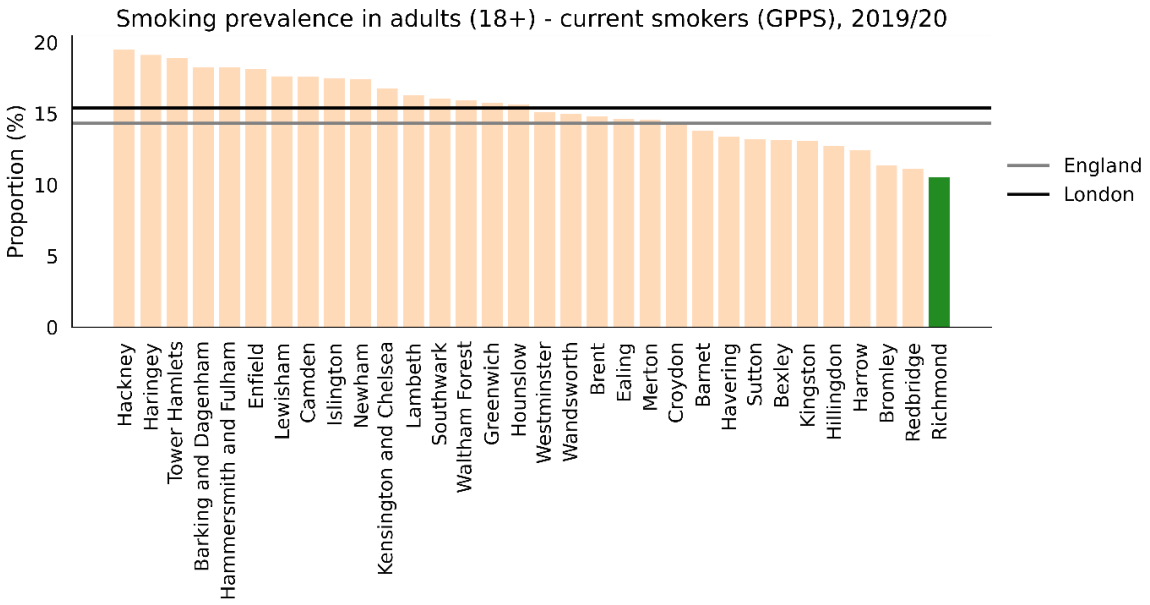
Humans' instinctive behaviours and responses can, in current modern-day living, be detrimental to our health and wellbeing whereas historically, these same behaviours would have been advantageous for survival. In a relatively short time the environment we live in has changed to lend itself to an increasingly sedentary, convenient lifestyle with regular access to unhealthy foods, artificial 'rewards' and constant exposure to stressors. However, over the same timeframe, the systems within our bodies remained largely unchanged and have not adapted to our new conditions.

2. Smoking

2.1 Smoking Prevalence

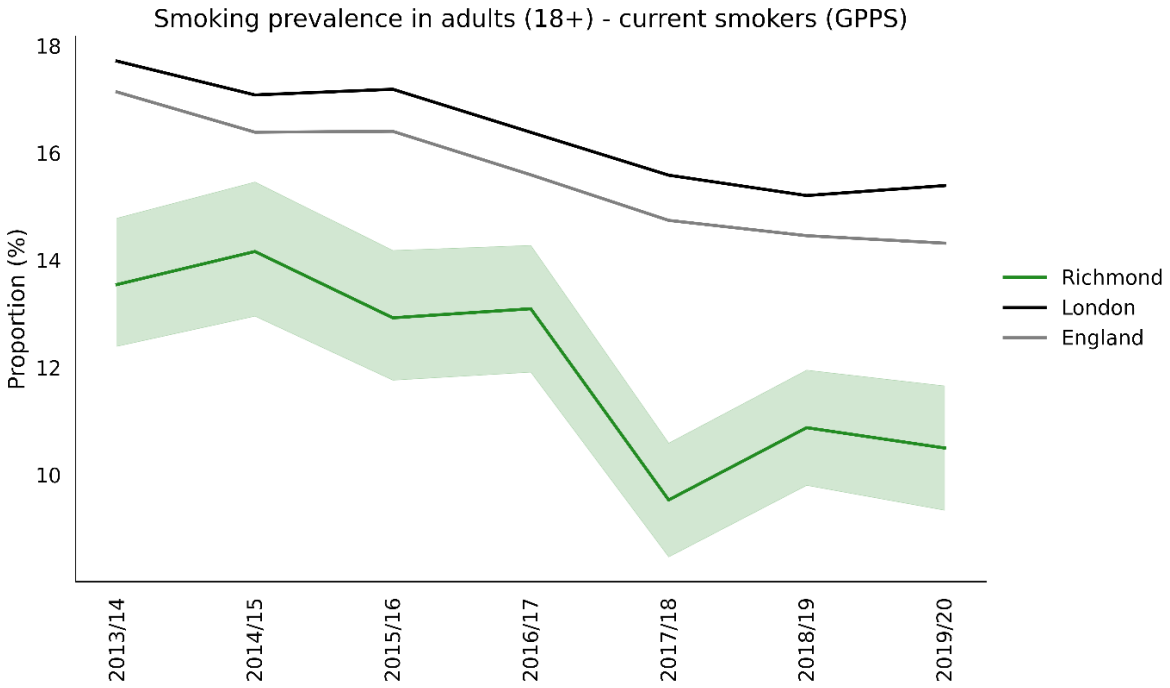
In 2019/20, Richmond's smoking prevalence in adults was 10.5%, which is the 1st lowest rate in London (**Figure 1**), 26.7% lower than the England average and 31.8% lower than the London average. The latest Borough figure was also 22.5% lower than in 2013/14, in comparison with 16.4% decrease in England's rate in the equivalent time period (**Figure 2**).

Figure 1: Smoking prevalence in adults by local authority, 2019



Source: PHE Public Health Profiles

Figure 2: Smoking prevalence in adults, 2012–2019



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

Between 2016-18, 461 residents died from a smoking related death and between 2018-19 there were over 1,182 smoking related hospital admissions, at a cost of approx. **£2.7m**. Between 2019-20, 56 women were smoking at time of delivery.[25]

Smokers take more sick-leave from work than non-smokers and smoking increases the risk of disability and premature death. **£22.4m** of potential wealth is lost from the local economy in Richmond each year due to smoking.[26]

There were 233 early deaths due to smoking resulting in 353 years of lost economic activity, costing businesses about **£11.6m**. A further 49 employees in Richmond are economically inactive and unable to work due to smoking-related sickness, resulting in an annual **£2.5m**. It is estimated that smoking breaks cost businesses in Richmond **£5.8m**.[27]

Many current/former smokers require care in later life as a result of smoking-related illnesses. Each year this costs society in Richmond an additional **£1.2m**. There is a significant number of older people suffering from smoking attributable illnesses whose needs remain unmet by formal care. If all such individuals were instead to receive formal social care, it would cost the system a potential further **£27.9m**.[28]

It is estimated that London Fire brigade will attend about 15 smoking-related house fires each year in Richmond. **£548,590** is lost annually in the borough as a result.[29]

Smoking materials constitute 35% of all street litter. The majority of cigarette filters are non-biodegradable and must be collected and disposed in landfill sites. Smokers in Richmond consume about 73,990 cigarettes every day. Of these roughly 62, 740 are filtered, resulting in among 11 kg of waste daily. This represents 4 tonnes of waste annually, of which 2 tonnes is discarded as street litter that must be collected by the Council.[30]

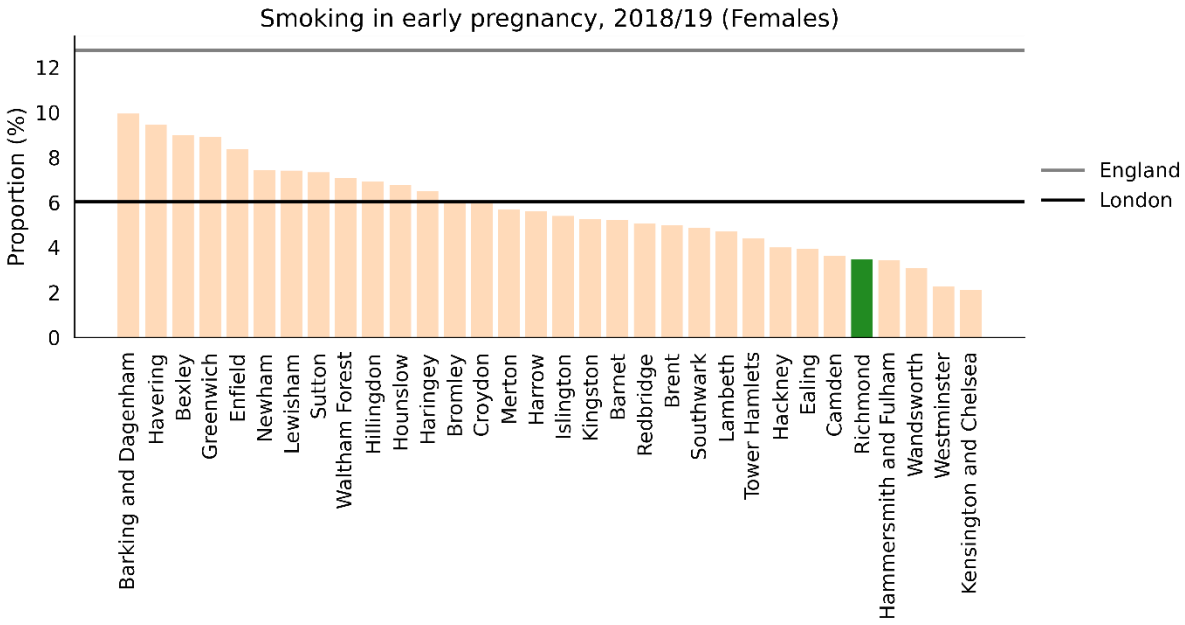
Pregnancy

Smoking in pregnancy increases the risk of premature birth, neonatal complications, as well as miscarriage and still birth. Prevalence of smoking in pregnancy is considerably higher in more disadvantaged groups and in women under the age of 20 than in more affluent and older groups. There is, therefore, a major health inequality associated with smoking in pregnancy as disadvantaged groups are at a much greater risk of complications during and after pregnancy. Children who grow up with a parent who smokes are also more likely to be smokers themselves [31].

In 2018/19, Richmond's smoking rate in early pregnancy was 3.5%, which is the 5th lowest rate in London, 72.8% lower than the England average and 42.5% lower than the London average (**Figure 3**).

[25] Public Health England Fingertips Data, Local Tobacco Control Profiles, accessed online, October 2020
[26] Action on Smoking and Health, Ready Reckoner Tool, accessed online, October 2019
[27] Action on Smoking and Health, Ready Reckoner Tool, accessed online, October 2019
[28] Action on Smoking and Health, Ready Reckoner Tool, accessed online, October 2019
[29] Action on Smoking and Health, Ready Reckoner Tool, accessed online, October 2019
[30] Action on Smoking and Health, Ready Reckoner Tool, accessed online, October 2019
[31] Towards a Smokefree Generation: a tobacco control plan for England, accessed online, 2020

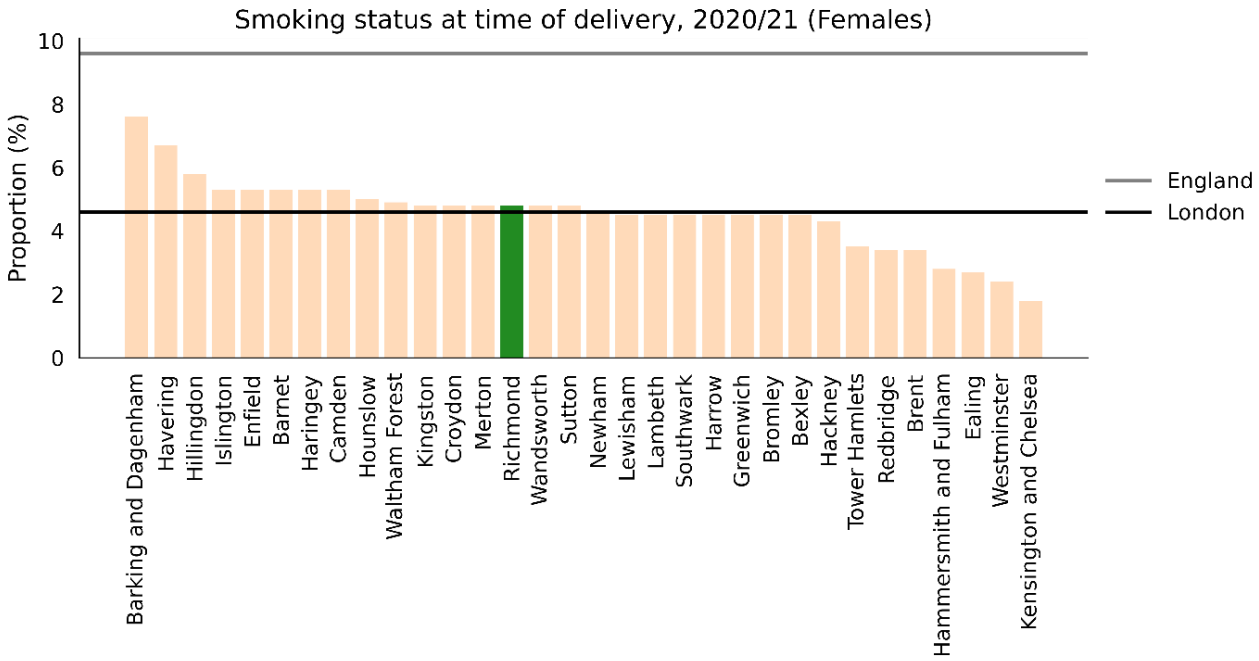
Figure 3: Smoking in early pregnancy by local authority, 2018/19



Source: PHE [Public Health Profiles]

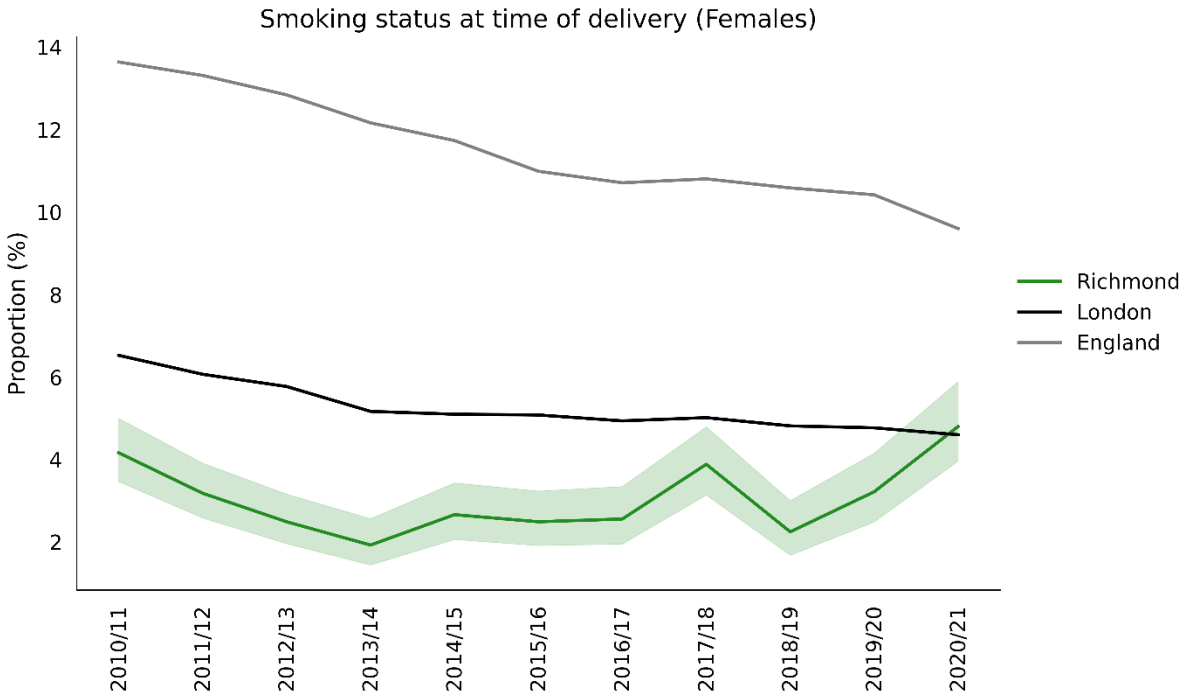
In 2020/21, Richmond's rate of smoking among mothers at time of delivery was 4.8% (n=92), which is the 13th highest rate in London (**Figure 4**), 50.0% lower than the England average and 4.3% higher than the London average. The latest Borough figure for 2020/21 was also 15.3% higher than in 2010/11, in comparison with 29.6% decrease in England's rate in the equivalent time period (**Figure 5**).

Figure 4: Smoking at time of delivery by local authority, 2020/21



Source: PHE [Public Health Profiles]

Figure 5: Smoking at time of delivery, 2010/11 – 2020/21



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

Young People

Discouraging young people from smoking is a national priority. There are a number of factors associated with regular smoking amongst young people, including: having smokers at home. Many young people become addicted to tobacco before they fully understand the health risks and smoking rates amongst young people impacts on future adult smoking rates [32].

Deprivation

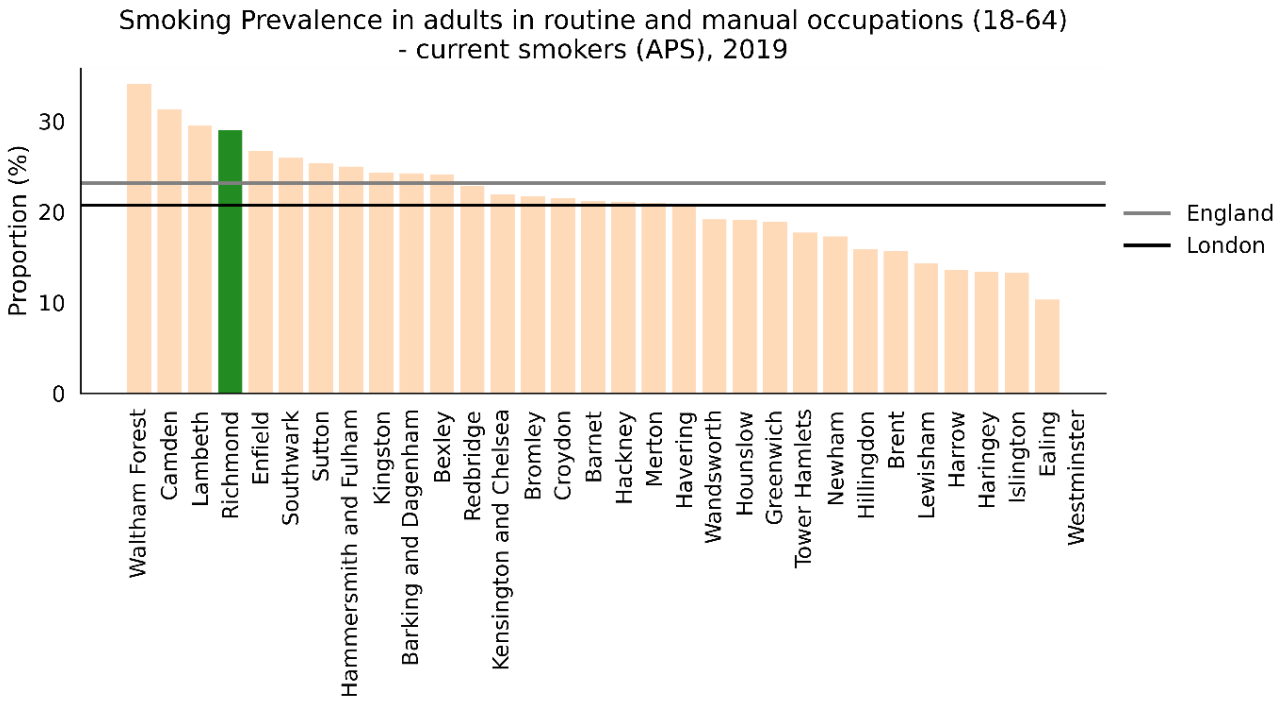
Smoking accounts for approximately half of the difference in life expectancy between the richest and the poorest in society [33]. The prevalence of smoking increases with deprivation, as such, residents living in the 20% most deprived areas of the country are more likely to smoke than those in less deprived areas [34]. A Government ambition is to reduce the inequality gap in smoking prevalence between those in routine and manual occupations and the general population. Smoking rates are almost three times higher amongst the lowest earners compared to the highest earners and smoking costs have the potential to push low-income households further below the poverty line.

Routine and Manual Workers

In 2019, Richmond's smoking prevalence in adults in routine and manual occupations was 29.0%, which is the 4th highest rate in London (**Figure 6**), 25.2% higher than the England average and 39.7% higher than the London average. The latest Borough figure for 2019 was also 21.6% lower than in 2011, in comparison with 27.8% decrease in England's rate in the equivalent time period (**Figure 7**).

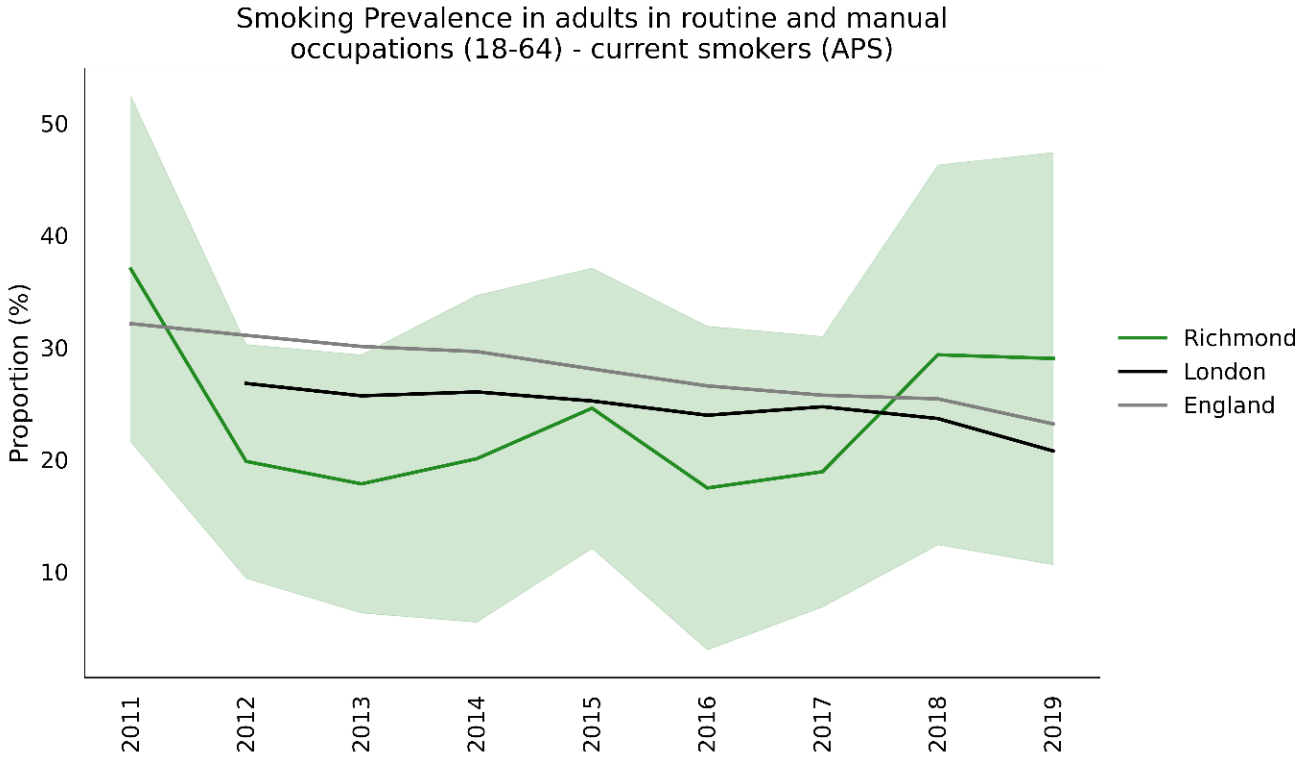
[32] Towards a Smokefree Generation: a tobacco control plan for England, accessed online, 2020
[33] Towards a Smokefree Generation: a tobacco control plan for England, accessed online, 2020
[34] Public Health England Fingertips Data, Local Tobacco Control Profiles, accessed online, 2020

Figure 6: Smoking prevalence in adults in routine and manual occupation by local authority, 2019



Source: PHE Public Health Profiles

Figure 7: Smoking prevalence in adults in routine and manual occupation, 2011–2019



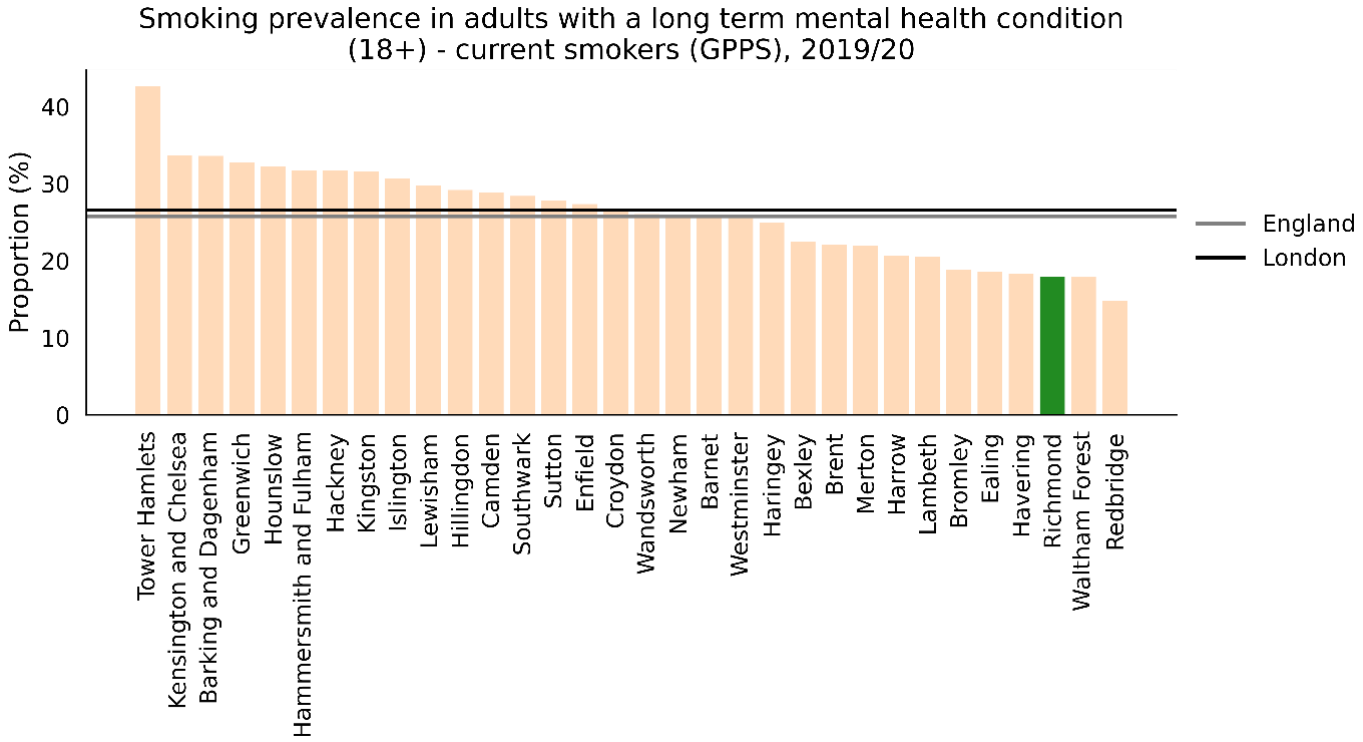
**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

Mental Health Conditions

Smoking prevalence is higher in people with mental health conditions. A report by the Royal College of Physicians and the Royal College of Psychiatrists states that, when compared to the general population, adults with a common mental health disorder (such as depression or anxiety) are twice as likely to smoke and adults with schizophrenia or bipolar disorder are three times more likely to smoke. High smoking rates among people with mental health problems are the single largest contributor to their 10 to 20-year reduced life expectancy compared to the rest of the population.

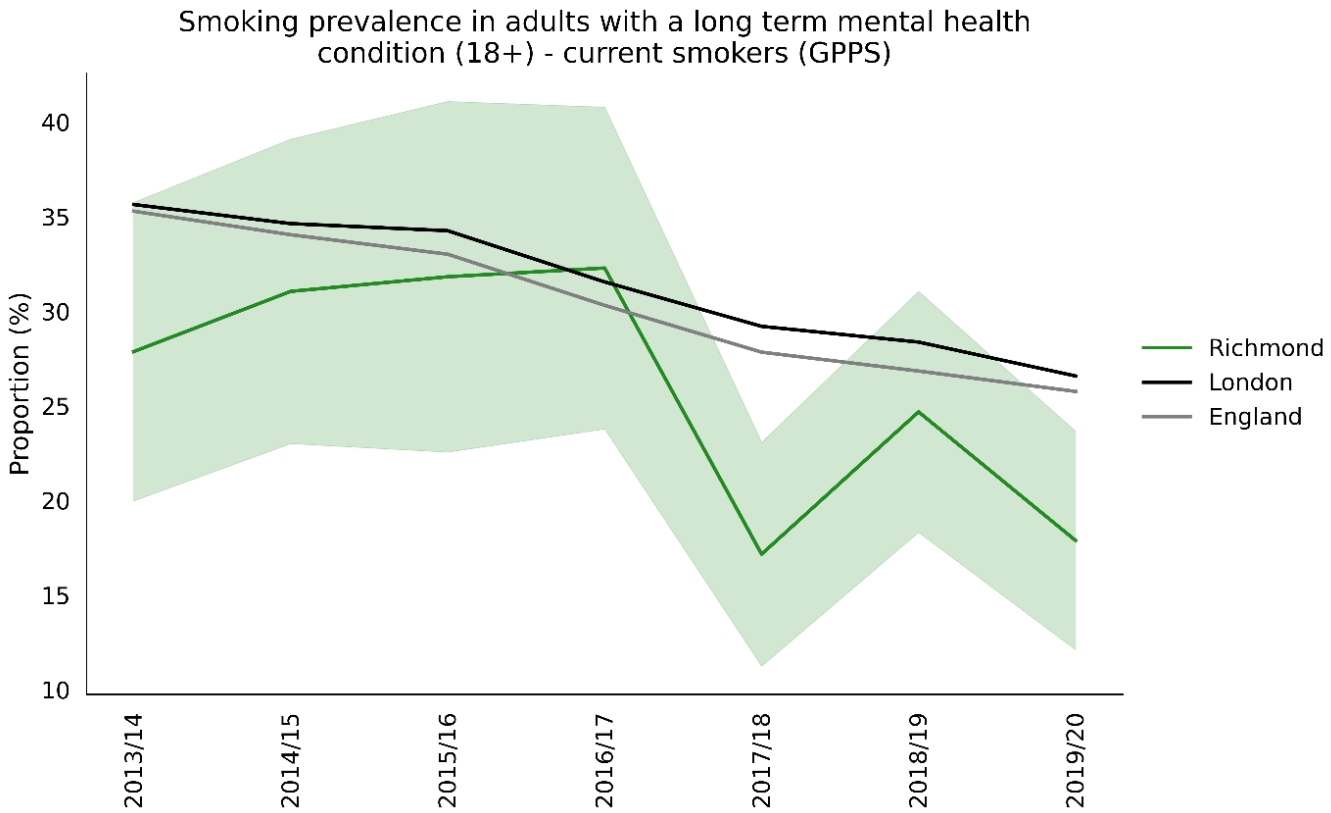
In 2019/20, Richmond's smoking prevalence in adults with a long term mental health condition was 17.9%, which is the 3rd lowest proportion in London (**Figure 8**), 30.6% lower than the England average and 32.7% lower than the London average. The latest Borough figure was also 35.8% lower than in 2013/14, in comparison with 27.0% decrease in England's rate in the equivalent time period (**Figure 9**).

Figure 8: Smoking prevalence in adults with a long term mental health condition by local authority, 2019/20



Source: PHE Public Health Profiles

Figure 9: Smoking prevalence in adults with a long term mental health condition, 2013/14 – 2019/20



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

Long-Term Conditions

Tobacco addiction causes and exacerbates Long Term Conditions (LTC). For example: People who smoke are much more likely to suffer from a LTC. Among those who are heavily addicted to tobacco, 44% self-report a long-term illness or disability compared with 32% of never smokers [35]. People on low incomes are associated with higher rates of LTCs.

COPD caused 25,791 deaths in England in 2018 [36]. Smoking accounts for 86% of COPD related deaths [37]. People with Asthma who smoke experience higher rates of hospitalisation, worse symptoms, and more rapid decline in lung function than those with asthma who do not smoke [38].

Smoking significantly increases the risk of heart disease and stroke. People who smoke are 6 times more likely to have a stroke[39]. People with diabetes who smoke have increased risks of complications and premature death [40].

Rates of smoking are also high among low-income groups thereby exacerbating LTCs and deepening health inequalities. Smoking is responsible for half the difference in life expectancy between the richest and poorest in society and, later in life, people who smoke are almost twice as likely to need some form of social care than never smokers [41].

[35] Office for National Statistics, Adult smoking habits in the UK 2015, access online, 2020
[36] Nomis, accessed online, 2020
[37] NHS Digital, accessed online, 2020
[38] Action on Smoking for Health, accessed online, 2020
[39] Stroke Association, accessed online, 2020
[40] Health Effects of Smoking, available online, 2020
[41] ASH Health Inequalities and Smoking, available online, 2020

2.2 Recent Developments to the Smoking Landscape

Nationally and locally the demand and uptake of smoking services has been affected by falling prevalence and the advent of e-cigarettes. Notably, within the last few years, new developments have been taking place at regional, sub-regional and locality levels that will influence the future direction of travel of stop smoking services. This has created a level of uncertainty regarding the emerging commissioning landscape and its impact on the provider markets.

There is a range of influences on future smoking prevalence, including the effect of e-cigarette use on smoking cessation, with new research suggesting that e-cigarettes have contributed to tens of thousands of additional quitters in England, thus accelerating the drop-in smoking rates across the country [42].

Public Health England (PHE) advise that vaping carries a small fraction of the risk of smoking. Using a nicotine-containing e-cigarette makes it much more likely that someone will quit successfully than relying on willpower alone – vaping is twice as effective for quitting smoking than NRT alone. But it is important to use UK-regulated e-liquids and never risk vaping home-made or illicit e-liquids.

Equally, it is important to address other forms of tobacco use, which are more common in certain communities. Shisha, which is one such use, creates smoke containing harmful chemicals, is becoming increasingly an area of concern. The populations where shisha is most commonly used, including BAME groups, are the same communities that are at higher risk of diseases such as heart attacks and stroke.

The health effects of Shisha smoking have received less research attention than cigarette smoking. However, the available evidence indicates that shisha smoking is associated with cancer, heart disease and lung disease. There have also been reports of increased risk of infectious disease, and the large amount of carbon monoxide created by the constant heating of tobacco by burning charcoal introduces the risk of carbon monoxide poisoning. The existing evidence base supports the need to monitor shisha smoking and minimise use, particularly regular use.

In recent decades, shisha has become more popular in western countries, particularly in young people. Despite a low prevalence of shisha use at the national level, additional data collected in specific communities highlight that shisha use is an issue of growing concern in certain areas. Local tobacco control programmes need to be sensitive to local cultural context [43].

2.3 Stop Smoking Services

NICE recommends that services should aim to treat at least 5% of the estimated local population of people who smoke or use tobacco in any form each year. Of this figure, 35% are expected to be validated as 4-week quitters. Applying this figure to Richmond means that the annual target (2020-21) is 155 validated quits.[44]

Smoking Cessation interventions are important in helping to improve people's health, quality of life and life expectancy, as well as cut costs to healthcare and public services. In July 2017 the Government published the Tobacco Control Plan – Delivery Plan 2017-22 [45]. The plan identifies specific areas of focus including:

- Reduce the prevalence of 15-year olds who regularly smoke from 8% to 3% or less by the end of 2022
- Reduce smoking prevalence amongst adults in England from 15.5% to 12% or less by the end of 2022

[42] E-cigarettes and heated tobacco products: evidence review, accessed online, 2020
[43] Waterpipe Smoking (Shisha) in England: the public health challenge, Associated of Directors of Public Health, accessed online, 2020
[44] NICE, monitoring stop smoking services, accessed online, October 2020
[45] Tobacco Control Plan, accessed online, 2020

- Reduce the inequality gap in smoking prevalence between those in routine and manual occupations and the general population by the end of 2022
- Reduce the prevalence of smoking in pregnancy from 10.7% to 6% or less by the end of 2022

Data relating to the local stop smoking service is provided through the data management system – Quit Manager. This data is used to determine quit figures for the borough, which are reported to the Department of Health (DoH) for inclusion within the national datasets. The Council is reliant on publicly available information, much of which has gaps in data and/or limitations in what is reported, particularly at a local level. Improved reporting of data and increased granularity in reported data would support work to increase targeting to most at risk populations and groups more likely to smoke.

Two-thirds of smokers say that they want to quit, however most try to do so unaided, which is the least effective method. Smokers who get the right support are up to four times more likely to quit successfully.[46]

Richmond council operates a smoking cessation service. This service is delivered in collaboration with primary care (GP surgeries and pharmacies), NHS Trusts, voluntary organisations and outreach with local community venues. The council also has a team of smoking cessation sessional workers who support delivery in stop smoking interventions across all settings. Service users are supported with access to free Nicotine Replacement Therapy (NRT) for up to 6 weeks. The Council funds NRT provided through GP surgeries and Community Pharmacies.
Richmond councils Stop Smoking Service offers free help, advice and access to stop smoking medications to all Adult smokers who live, work or are receiving long-term treatment in the Richmond area.
Service provision includes:

- Tips on managing withdrawal symptoms and coping with smoking triggers
- Regular carbon monoxide checks
- Accurate information on what to expect when trying to quit and how to deal with difficult situations
- Access to stop smoking medications and guidance on using these
- Nicotine replacement therapy (NRT)
- advise on professional help offered by GPs and pharmacists in the borough

There are well established Drop-in Services at St Georges and Queen Mary's Hospital". These Drop-in services work closely with the Hospital stop smoking leads to support in-patients, out-patients and maternity patients who require support to quit smoking. The Service also supports people going into surgery that need to stop before their procedure.

Richmond council is also part of the London Smoking Cessation Transformation Programme (LSCTP).[47] The LSCTP vision is to change smoking behaviours and encourage more quit attempts among the general population to support London to become the first smoke free city in England by 2029. Stop Smoking London is the public facing identity of the LSCTP[48]. Stop Smoking London offers telephone consultations for people who do not need face-to-face interventions or who are time-poor.

During 2019/20, Richmond Council supported 237 people to successfully stop smoking, in comparison with 307 people in 2018/19.

[46] Health Matters: stopping smoking – what works, PHE, accessed online, October 2019
[47] London Smoking Cessation Transformation Programme, Association of Directors of Public Health, accessed online, October 2020
[48] Stop Smoking London, accessed online, October 2020

Young People

The Council works with Catch 22[49] to provide smoking cessation advice and treatment at schools and colleges. Catch 22 is a social business specialising in early intervention, and targeted support services including substance misuse to young people. Catch 22 also conducts outreach and provides workshops to educate young people about the risks associated with smoking and offers stop smoking support to smokers who want to quit.

In 2018/19 182 young people (12-18) assessed support to quit smoking. Of these, 115 were aged between 12-15, and 93 went on to quit smoking successfully.

Adults

Richmond Councils Stop Smoking Service[50] offers free help, advise and access to stop smoking medications to all adult smokers who live, Work or are receiving long-term treatment in the Richmond area.

Service provision includes:

- Tips on managing withdrawal symptoms and coping with smoking triggers
- Regular carbon monoxide checks
- Accurate information on what to expect when trying to quit and how to deal with difficult situations
- Access to stop smoking medications and guidance on using these
- Nicotine Replacement Therapy (NRT)
- Advice on professional help offered by GPs and pharmacists in the Borough

There are well established drop-in services at St Georges and Queen Mary's Hospital". These drop-in services work closely with the Hospital stop smoking leads to support in-patients, out-patients and maternity patients who require support to quit smoking. The service also supports people going into surgery that need to stop before their procedure:

- Patients who are being discharged and may need further smoking cessation support can also access these drop-in services
- Stop Smoking support is also being accessed through mental health settings through Stop Smoking Wards and Grounds Project with the mental health trust. Staff have been trained and specialist advisors have been provided to support the effective delivery of smoking cessation support at all levels.

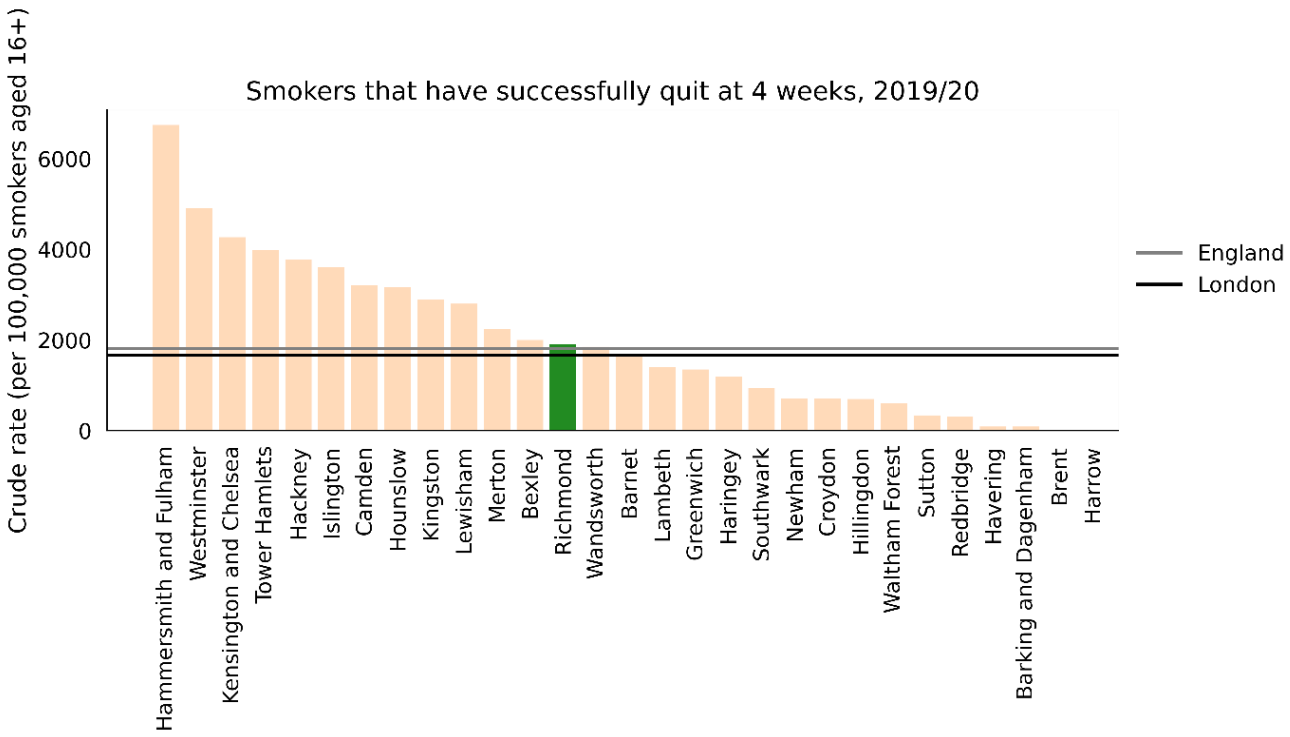
Smoking Quitters

The effectiveness of the local smoking cessation services is measured using the proportion of smoking quitters at 4 weeks out of the estimated local smokers' population. Successful quitters are those smokers who successfully quit at the four-week follow-up. A client is counted as a 'self-reported 4-week quitter' when assessed four weeks after the designated quit date, if they declare that they have not smoked, even a single puff on a cigarette, in the past two weeks.

In 2019/20, Richmond's rate of smokers that have successfully quit after 4 weeks from setting a quit was 1894.3 per 100,000 smokers aged 16+ (n=237), which is the 16th lowest rate in London (**Figure 10**), 4.7% higher than the England average and 13.8% higher than the London average. The latest Borough figure for 2019/20 was also 47.9% lower than in 2013/14, in comparison with 51.7% decrease in England's rate in the equivalent time period (**Figure 11**).

[49] Catch22, accessed online, 2020
[50] Richmond Stop Smoking Service, available online, 2020

Figure 10: Smoking quitters at 4 weeks by local authority, 2019/20



Source:

PHE Public Health Profiles

Figure 11: Smoking quitters at 4 weeks, 2013/14 – 2019/20

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

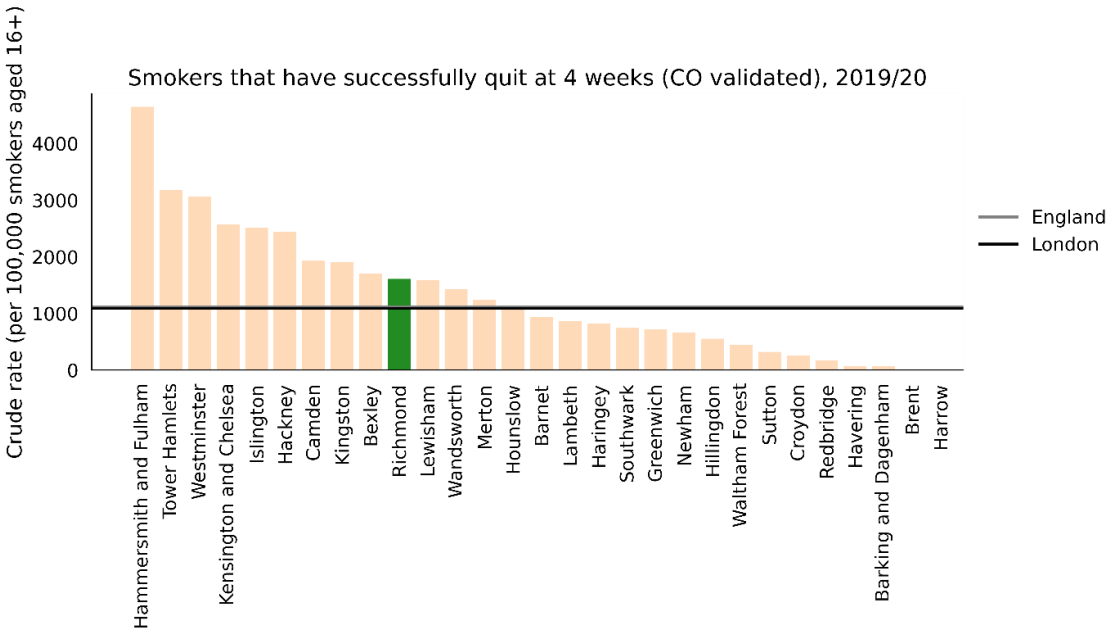
Source: PHE Public Health Profiles

CO Validated Smoking Quitters

CO validated smoking quits provide an objective measure in addition to self-reported quits, and CO validation may also help incentivising clients to quit.

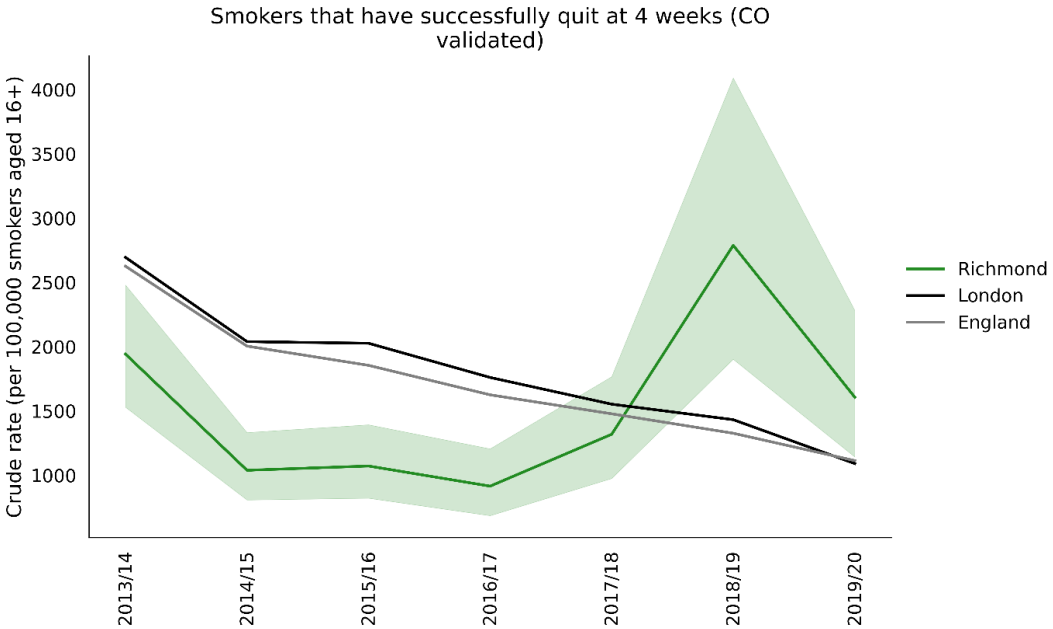
In 2019/20, Richmond's rate of smokers that have successfully quit at 4 weeks with a validated CO reading was 1606.5 per 100,000 smokers aged 16+ (n=201), which is the 14th highest rate in London (**Figure 12**), 44.3% higher than the England average and 47.4% higher than the London average. The latest Borough figure for 2019/20 was also 17.3% lower than in 2013/14, in comparison with 57.6% decrease in England's rate in the equivalent time period (**Figure 13**).

Figure 12: CO validated smoking quitters at 4 weeks by local authority, 2019/20



Source: PHE Public Health Profiles

Figure 13: CO validated smoking quitters at 4 weeks, 2013/14 – 2019/20

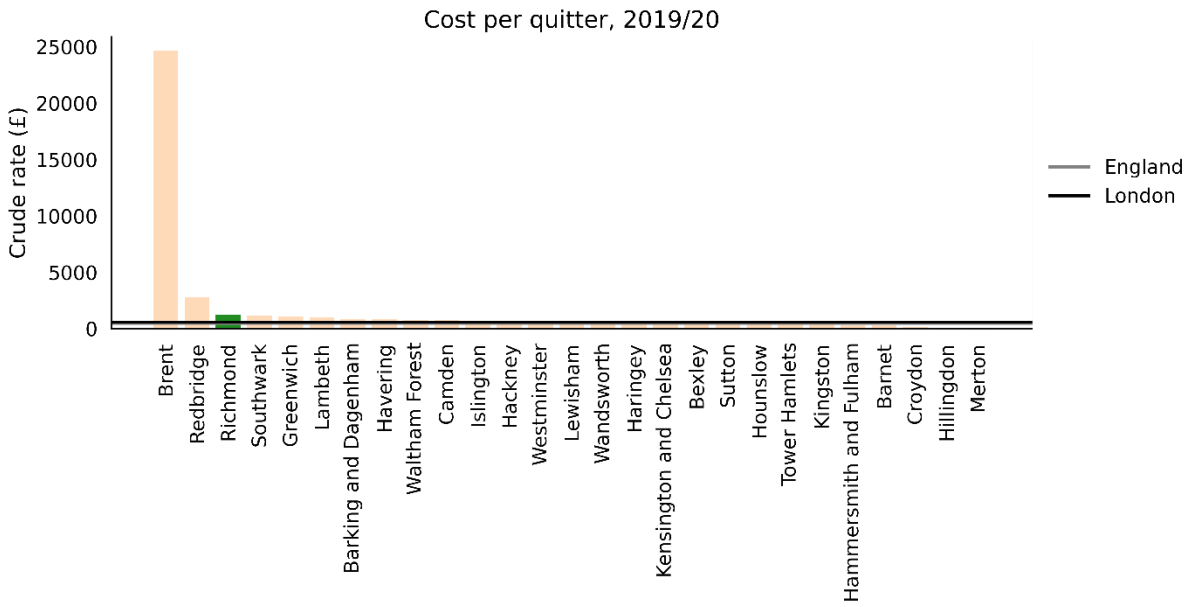


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

Cost per Quitter

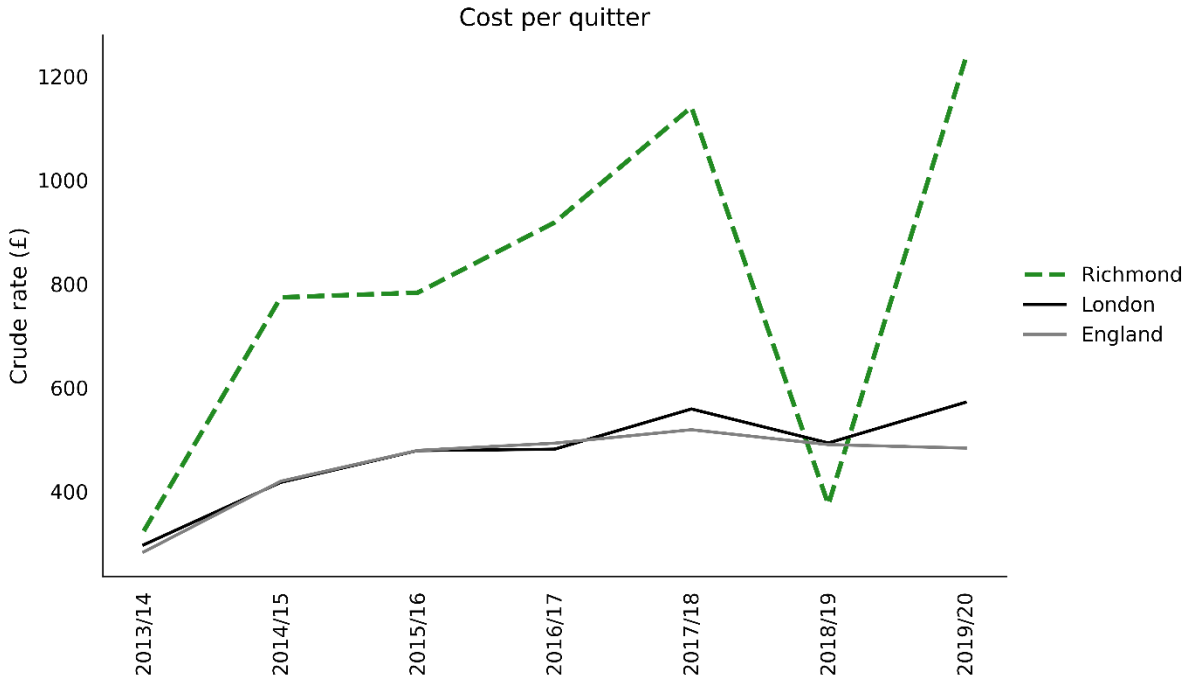
In 2019/20, Richmond's smoking cessation service cost per quitter was £1,232, which is the 3rd highest rate in London (**Figure 14**), 154.8% higher than the England average and 115.6% higher than the London average. The latest Borough figure for 2019/20 was also 280.6% higher than in 2013/14, in comparison with 70.6% increase in England's rate in the equivalent time period (**Figure 15**).

Figure 14: Cost per quitter by local authority, 2019/20



Source: PHE Public Health Profiles

Figure 15: Cost per quitter, 2013/14 – 2019/20

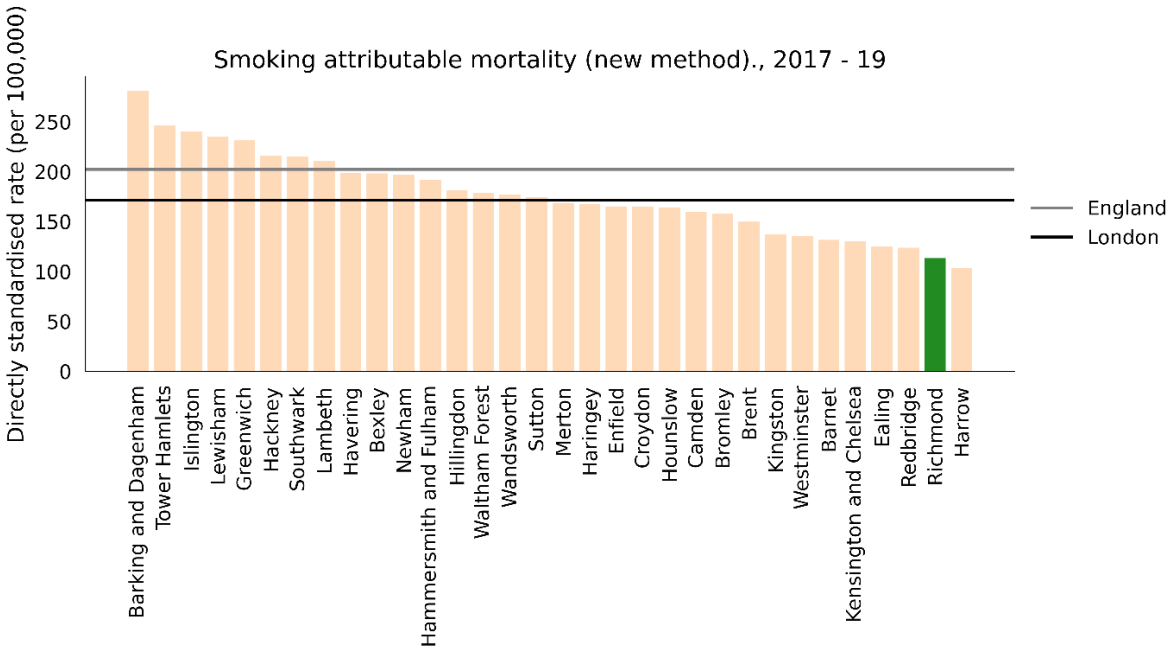


Source: PHE Public Health Profiles

2.4 Smoking Related Mortality

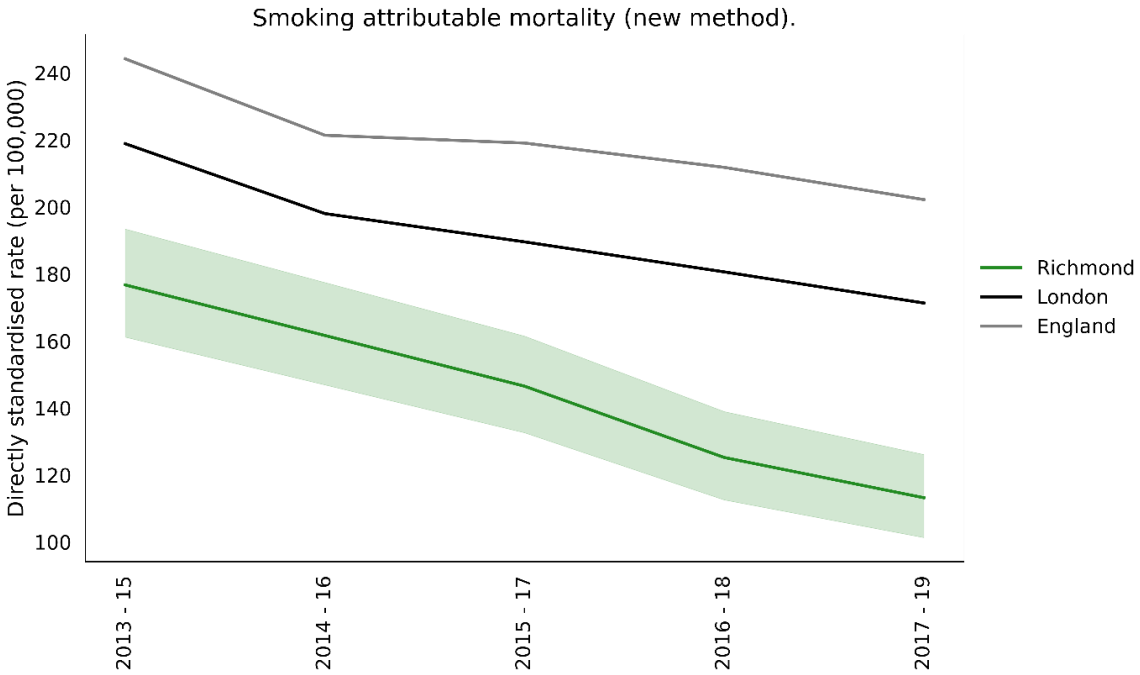
In 2017 - 19, Richmond's smoking attributable mortality rate was 113.2 per 100,000 (n=333), which is the 2nd lowest rate in London (**Figure 16**), 44.0% lower than the England average and 33.9% lower than the London average. The latest Borough figure was also 36.0% lower than in 2013 - 15, in comparison with 17.2% decrease in England's rate in the equivalent time period (**Figure 17**).

Figure 16: Smoking attributable mortality by local authority, 2017–19



Source: PHE Public Health Profiles

Figure 17: Smoking attributable mortality, 2013/15 – 2017/19

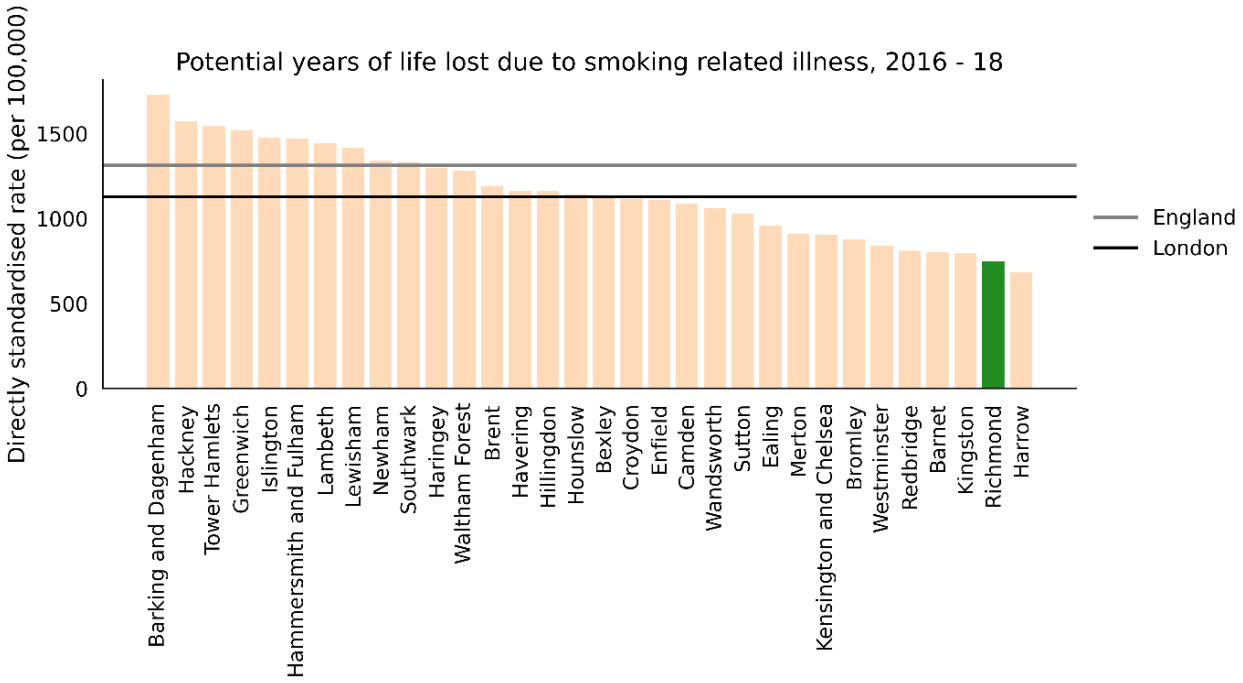


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

Potential Years of Life Lost due to Smoking Related Illness

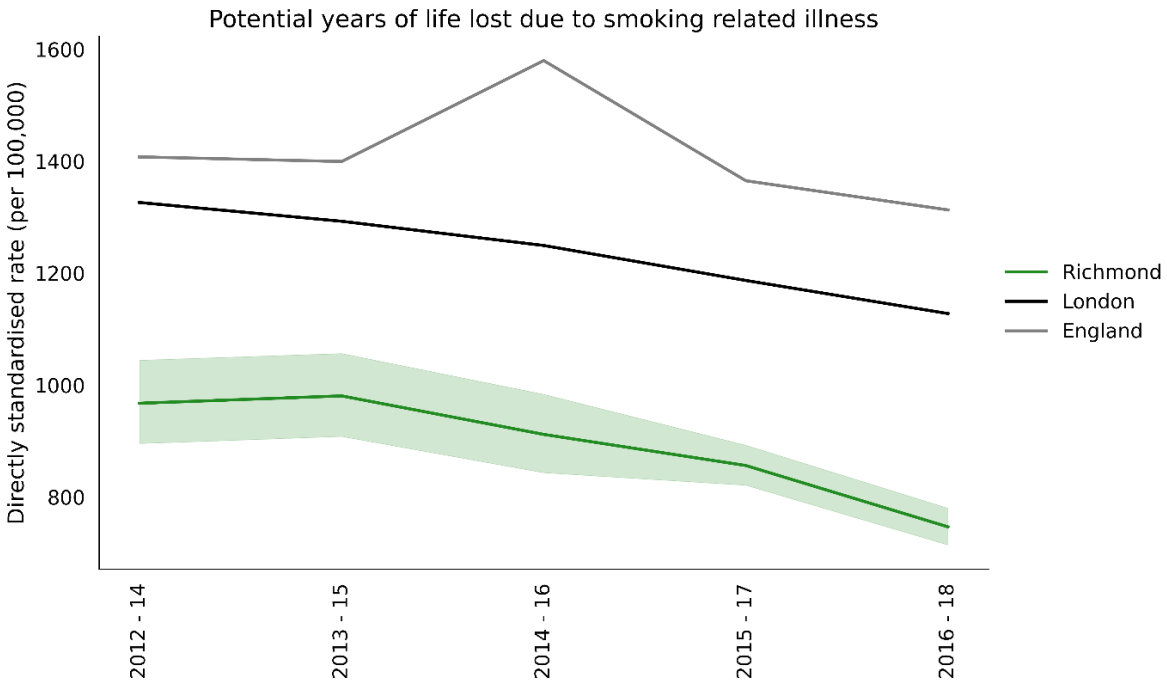
In 2016 - 18, Richmond's rate of years of life lost due to smoking related illness was 746.3 per 100,000 (n=2040), which is the 2nd lowest rate in London (**Figure 18**), 43.1% lower than the England average and 33.8% lower than the London average. The latest Borough figure was also 22.8% lower than in 2012 - 14, in comparison with 6.7% decrease in England's rate in the equivalent time period (**Figure 19**).

Figure 18: Potential years of life lost due to smoking related illness by local authority, 2016–18



Source: PHE Public Health Profiles

Figure 19: Potential years of life lost due to smoking related illness, 2012/14 – 2016/18



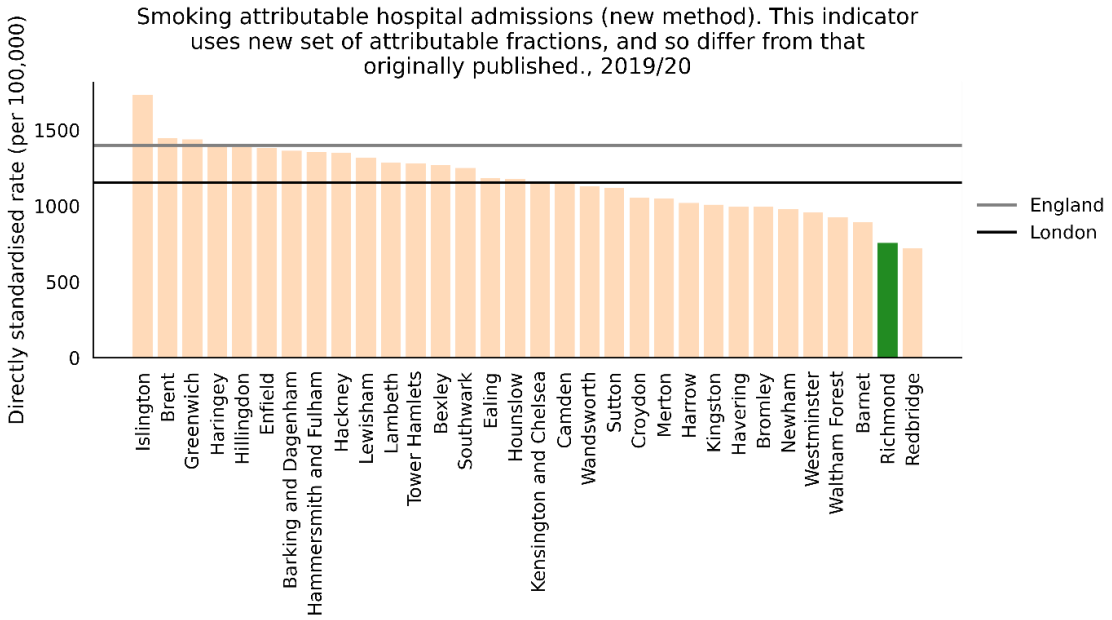
**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

2.4 Smoking Related Ill Health

Smoking Attributable Hospital Admissions

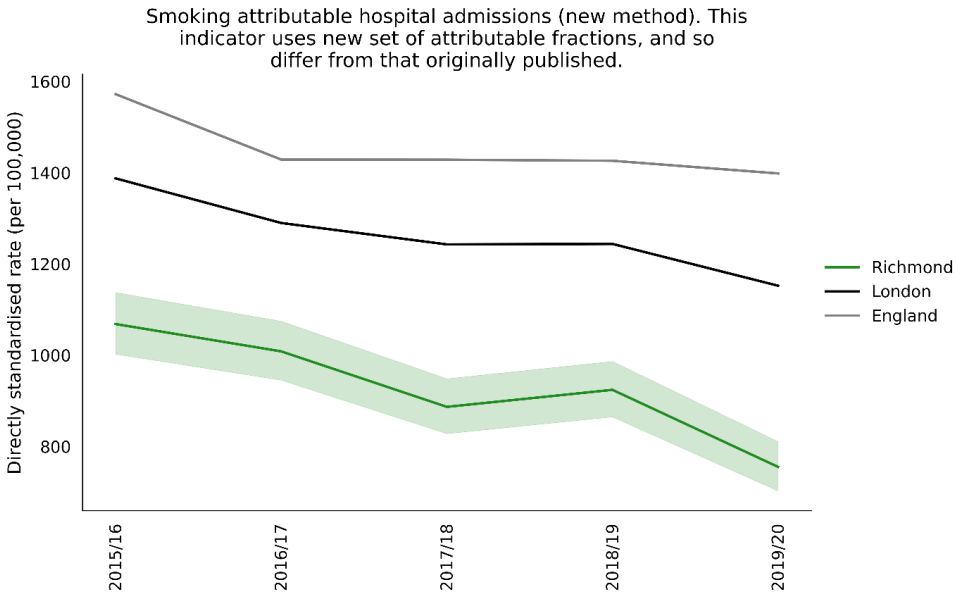
In 2019/20, Richmond's rate of smoking attributable admissions was 754.6 per 100,000 (n=776), which is the 2nd lowest rate in London (**Figure 20**), 46.0% lower than the England average and 34.5% lower than the London average. The latest Borough figure was also 29.3% lower than in 2015/16, in comparison with 11.1% decrease in England's rate in the equivalent time period (**Figure 21**).

Figure 20: Smoking attributable admissions by local authority, 2019/20



Source: PHE Public Health Profiles

Figure 21: Smoking attributable admissions, 2015/16 – 2019/20

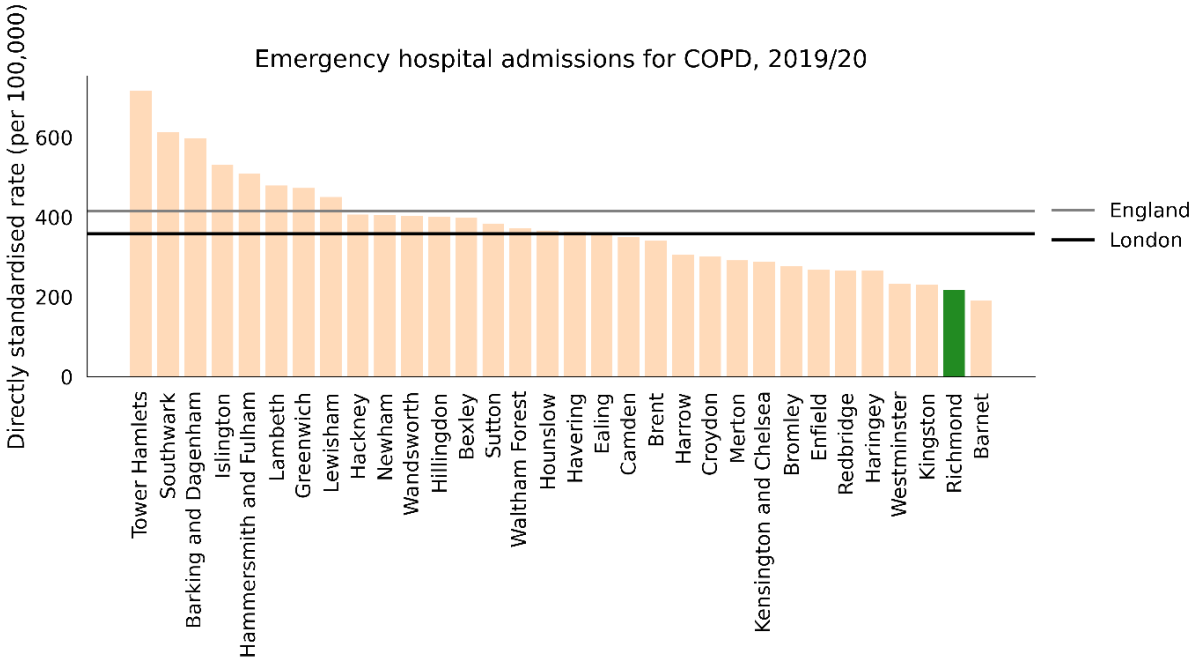


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

Emergency COPD Admissions

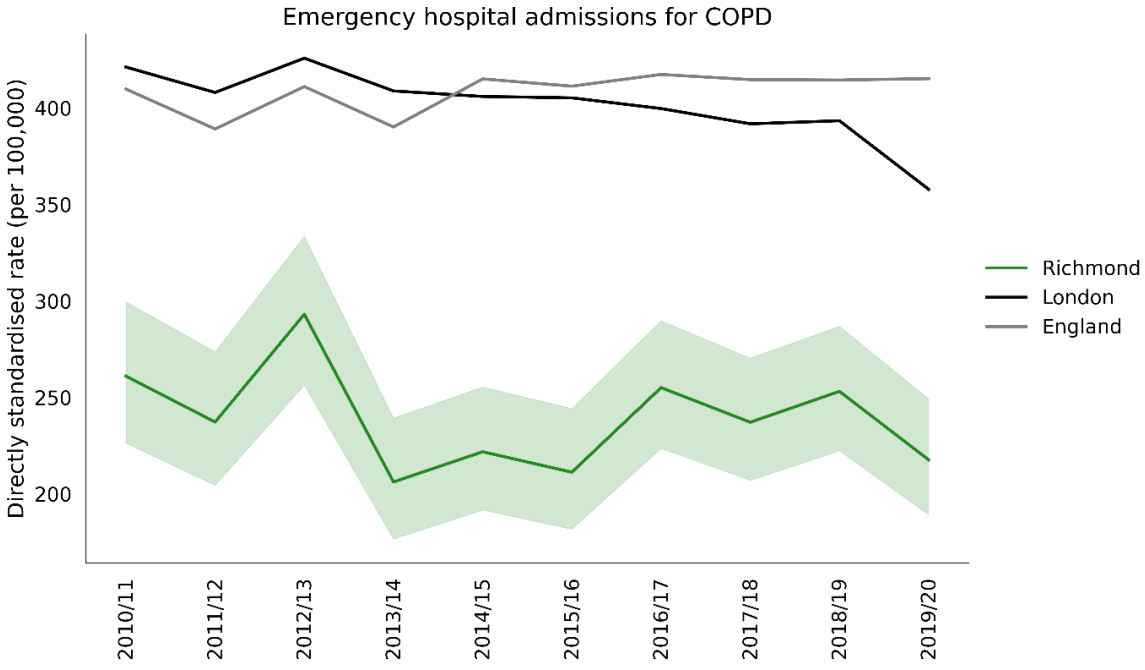
Most of the incidences of chronic obstructive pulmonary disease are linked to smoking. In 2019/20, Richmond's rate of emergency admissions for chronic obstructive pulmonary disease (COPD) was 217.6 per 100,000 (n=215), which is the 2nd lowest rate in London (**Figure 22**), 47.6% lower than the England average and 39.2% lower than the London average. The latest Borough figure was also 16.6% lower than in 2010/11, in comparison with 1.3% increase in England's rate in the equivalent time period (**Figure 23**).

Figure 22: Emergency COPD hospital admissions by local authority, 2019/20



Source: PHE Public Health Profiles

Figure 23: Emergency COPD hospital admissions, 2010/11 – 2019/20



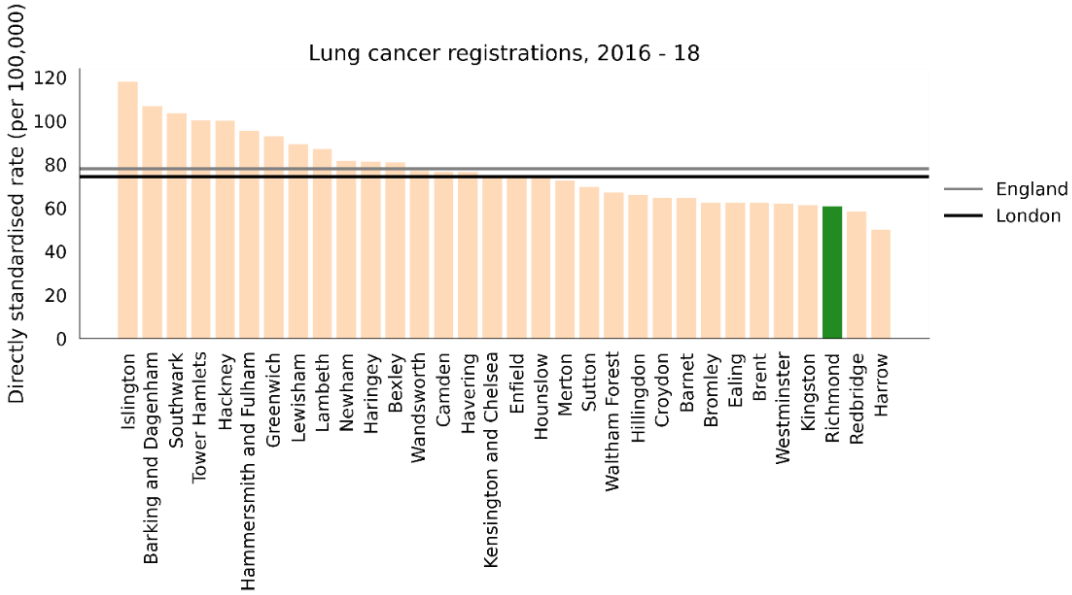
**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

Lung Cancer Registrations

Lung cancer registration is a direct measure of smoking-related harm. Given the high proportion of these registrations that are due to smoking, a reduction in the prevalence of smoking would reduce the incidence of lung cancer[51].

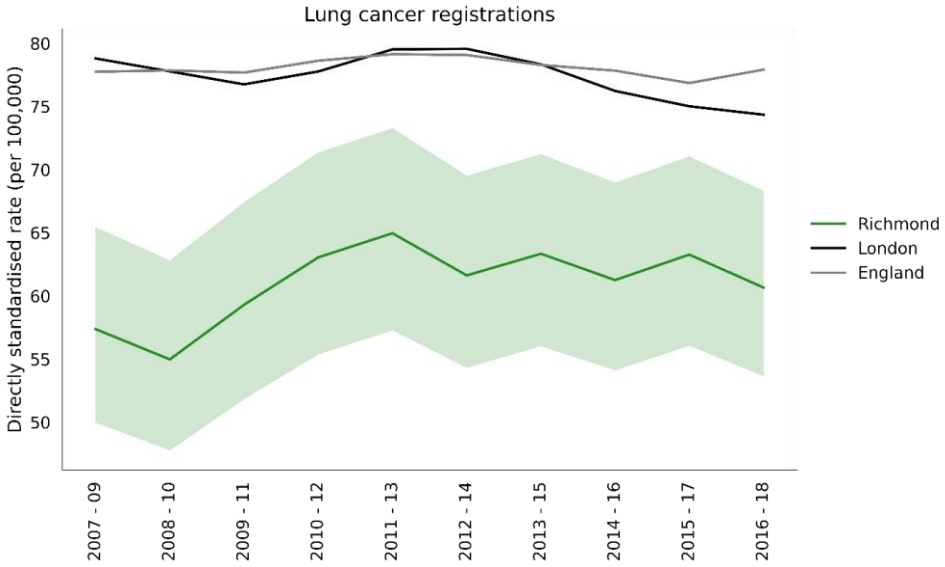
In 2016 - 18, Richmond's rate of lung cancer registrations was 60.6 per 100,000 (n=284), which is the 3rd lowest rate in London (**Figure 24**), 22.1% lower than the England average and 18.4% lower than the London average. The latest Borough figure was also 5.7% higher than in 2007 - 09, in comparison with 0.2% increase in England's rate in the equivalent time period (**Figure 25**).

Figure 24: Lung cancer registrations by local authority, 2016–18



Source: PHE Public Health Profiles

Figure 25: Lung cancer registrations, 2007/09 – 2016/18



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

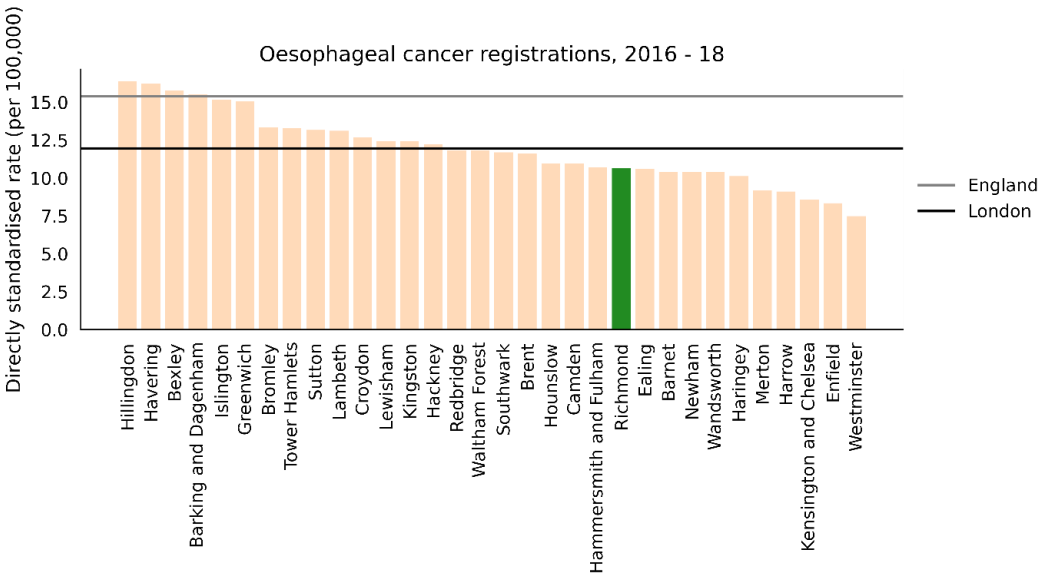
[51] PHE Public Health Profiles. 2021

Oesophageal Cancer Registrations

The relative risks of cancers that could be caused by smoking list oesophageal cancer as the third after lung cancer and head & neck cancers [52].

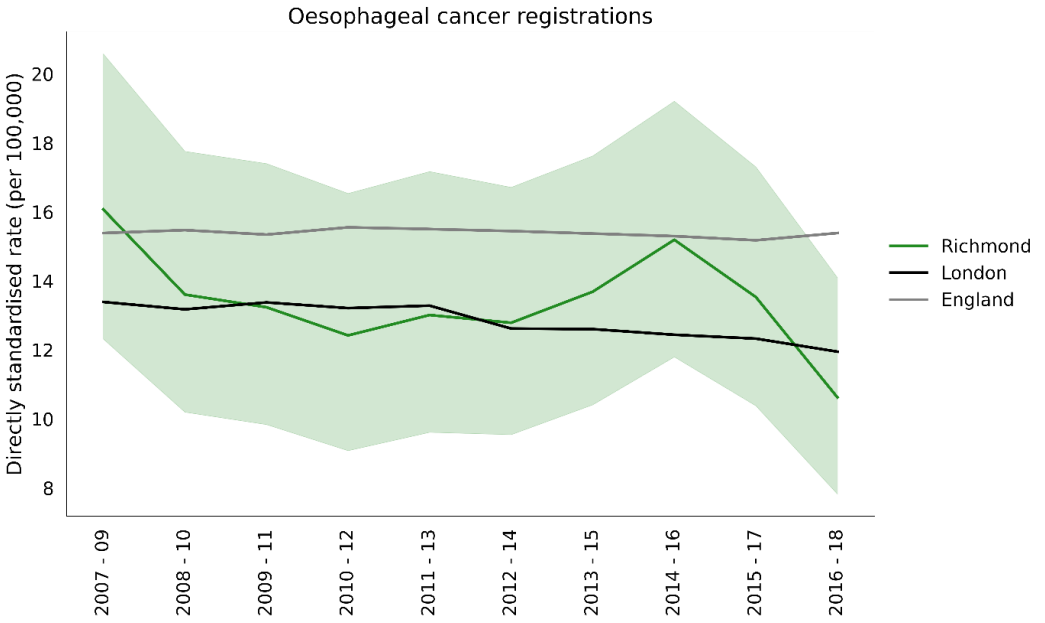
In 2016 - 18, Richmond's rate of oesophageal cancer registrations was 10.6 per 100,000 (n=49), which is the 11th lowest rate in London (**Figure 26**), 31.0% lower than the England average and 11.1% lower than the London average. The latest Borough figure was also 33.9% lower than in 2007 - 09, in comparison with 0.0% increase in England's rate in the equivalent time period (**Figure 27**).

Figure 26: Oesophageal cancer registrations by local authority, 2016–18



Source: PHE Public Health Profiles

Figure 27: Oesophageal cancer registrations, 2007/09 – 2016/18



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

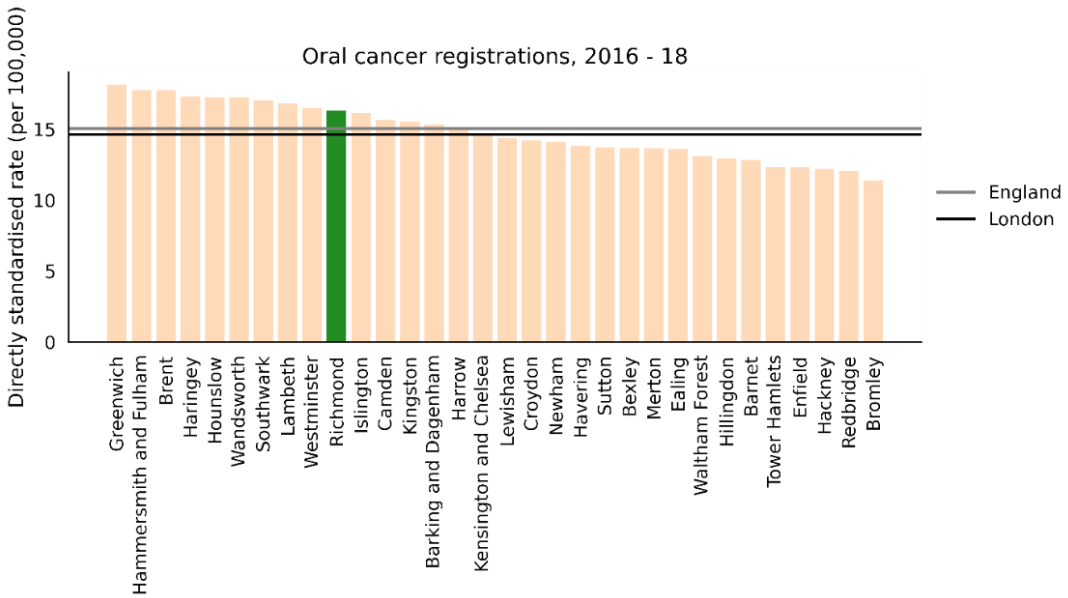
[52] PHE Public Health Profiles. 2021

Oral Cancer Registrations

Oral cancer registration is a direct measure of smoking-related harm. Given that around 65% of these registrations are due to smoking, a reduction in the prevalence of smoking would reduce the incidence of oral cancer[53].

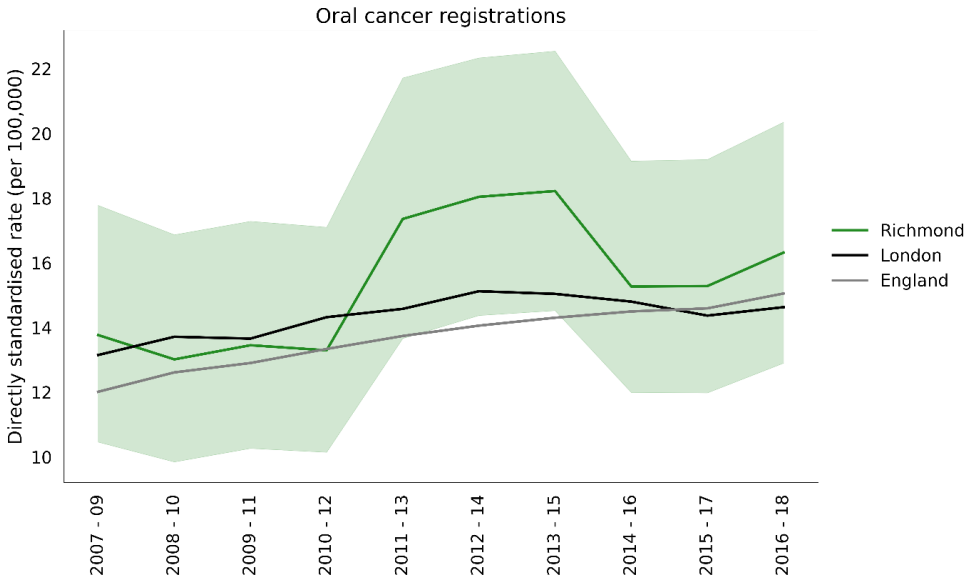
In 2016 - 18, Richmond's rate of oral cancer registration was 16.3 per 100,000 (n=81), which is the 10th highest rate in London (**Figure 28**), 8.4% higher than the England average and 11.5% higher than the London average. The latest Borough figure for 2016 - 18 was also 18.5% higher than in 2007 - 09, in comparison with 25.3% increase in England's rate in the equivalent time period (**Figure 29**).

Figure 28: Oral cancer registrations by local authority, 2016–18



Source: PHE Public Health Profiles

Figure 29: Oral cancer registrations, 2007/09 – 2016/18



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

[53] PHE Public Health Profiles. 2021

2.5 Evidence Based Interventions/Approaches

According to NICE, commissioners and providers of stop smoking services should implement the following approaches locally:

- Use sustainability and transformation plans, health and wellbeing strategies, and any other relevant local strategies and plans to ensure evidence-based stop smoking interventions and services are available for everyone who smokes
- Use Public Health England's public health profiles to estimate smoking prevalence among the local population
- Prioritise specific groups who are at high risk of tobacco-related harm. These may include:
  - People with mental health problems, including mental health disorders (for example, see NICE's guidelines on depression in adults and smoking: acute, maternity and mental health services)
  - People who misuse substances (for example, see NICE's guideline on coexisting severe mental illness and substance misuse: community health and social care services)
  - People with health conditions caused or made worse by smoking (for example, see NICE's guidelines on cardiovascular disease: identifying and supporting people most at risk of dying early, type 1 diabetes in adults, asthma And chronic obstructive pulmonary disease)
  - People with a smoking-related illness (see NICE's guideline on lung cancer)
  - Populations with a high prevalence of smoking-related morbidity or a particularly high susceptibility to harm
  - Communities or groups with particularly high smoking prevalence (such as manual workers, travellers, and lesbian, gay, bisexual and trans people)
  - People in custodial settings
  - People living in disadvantaged circumstances
  - Pregnant women who smoke (see NICE's guideline on smoking: stopping in pregnancy and after childbirth). [2018]

In addition, NICE have produced a series of evidence-based recommendations for commissioners and providers of Smoking Cessation Services, which include the following:

- Ensure the following evidence-based interventions are available for adults who smoke:
  - Behavioural support (individual and group)
  - Bupropion
  - Nicotine Replacement Therapy (NRT) – short and long acting
  - Varenicline
  - Very brief advice
- Consider text messaging as an adjunct to behavioural support
- Offer Varenicline as an option for adults who want to stop smoking, normally only as part of a programme of behavioural support, in line with NICE's technology appraisal guidance on varenicline
- For adults, prescribe or provide varenicline, bupropion or NRT before they stop smoking
- Agree a quit date set within the first 2 weeks of bupropion treatment and within the first 1 to 2 weeks of Varenicline treatment. Reassess the person shortly before the prescription ends
- Agree a quit date if NRT is prescribed. Ensure that the person has NRT ready to start the day before the quit date
- Consider NRT for young people over 12 who are smoking and dependent on nicotine. If this is prescribed, offer it with behavioural support
- Ensure behavioural support is provided by trained stop smoking staff (see the National Centre for Smoking Cessation and Training [NCSCT] training standard

- Ensure very brief advice is delivered according to the NCSCT training module on very brief advice

3. Healthy Eating

3.1 Healthy Eating Definition

A healthy, balanced diet is vital to enable optimal health and wellbeing. In eating a wide variety of foods in the right proportions, we ensure enough intake of the nutrients essential for health. Forming part of healthy eating, good nutrition is not simply defined as following a diet which is low in fat, salt and sugar, rather it is eating a wide range of nourishing foods to enable the body to function well and help to protect against disease. This includes eating essential vitamins and minerals, as well as an appropriate energy (calorie) and macronutrients (fat, protein and carbohydrate) intake.

Consuming a healthy diet throughout the life course helps to prevent health problems caused by poor diet, as well as a range of non-communicable diseases and conditions. Current nutrition guidance from Public Health England (PHE) and the NHS, recommends that balance is the key to a healthy diet. Eating a variety of foods in the right proportions and consuming a suitable amount of food and drink during the differing life stages, will achieve and maintain a healthy body weight and help prevent diet-related health conditions.

Expert evidence-based scientific research forming these guidelines, promotes a diet based on starchy carbohydrate foods such as potatoes, wholegrain bread, rice and pasta; plenty of fruit and vegetables (recommendation is at least five portions a day); protein-rich foods such as meat, fish, tofu and lentils; milk and dairy foods; and limited fat, salt and sugar. By following these recommendations, intake of dietary fibre and ‘free’ sugars along national regulations will be easier to achieve; currently these two food groups are under and over consumed respectively across the general population.

The PHE 'Eatwell Guide' [54] presented in **Figure 30** highlights the different types of food that make up our diet and illustrates the proportions that should be eaten to achieve the recommendations.

[54] https://www.nhs.uk/live-well/eat-well/the-eatwell-guide/

Figure 30: The Eatwell Plate

Source: PHE

3.2 Healthy Eating and Nutrition

Poor diet is a public health issue as it increases the risk of some cancers and cardiovascular disease (CVD), both of which are major causes of premature death. Dietary risks, such as low fruit and vegetable intake and obesity contributes to approximately one third of all deaths from cancer and CVD [55]. These diseases, along with type 2 diabetes (T2D), which increases CVD risk, are associated with obesity, which has a very high prevalence in adults in London and England [56]. Alongside obesity, it is important not to forget the impact of malnutrition; under-eating, not having enough protein, vitamin rich foods and dehydration can also cause health problems, particularly amongst the young [57] and elderly [58].

According to the National Institute for Health and Clinical Excellence (NICE), healthier diets could prevent around 1 in 20 cancers [59]. Regularly eating foods high in fibre can reduce the risk of some cancers and over consumption of processed and red meat, and alcohol can increase the risk of some cancers. Furthermore, controlling intake of salt, saturated fats and transfats can reduce the risk of CVD [60]. CVD is often caused by high blood pressure and high cholesterol, which can potentially be reduced without the need for medication by following a healthy diet and exercise plan.

[55] https://www.who.int/news-room/fact-sheets/detail/cancer
[56] https://fingertips.phe.org.uk/search/obesity/
[57] Maternal and child nutrition Public health guideline [PH11] March 2008 https://www.nice.org.uk/guidance/ph11/chapter/2-Public-health-need-and-practice
[58] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2563720/
[59] https://www.cancerresearchuk.org/about-cancer/causes-of-cancer/diet-and-cancer
[60] https://www.nice.org.uk/guidance/ph25/evidence

The impact of good nutrition on brain health can also not be dismissed. Malnutrition affects both mental and physical wellbeing. Eating a nutrient-rich diet, particularly one that has lots of fruits and vegetables, omega 3 fats, and low amounts of sodium and saturated fats, helps to maintain good brain health, which is important for the prevention of dementia[61], coronary heart disease, high blood pressure and high cholesterol; all these conditions can also be alleviated, to some extent, by following a healthy diet. Promoting optimal nutrition for all Richmond residents is important to prevent the onset of these long-term conditions.

The way we shop, cook and eat food has changed significantly over the last decade, particularly with the availability and affordability, of fast food and eating out. The increased production of processed food, rapid urbanisation and changing lifestyles has led to a shift in dietary patterns. People are now consuming more 'ultra-processed' foods, which are high in energy, saturated fats, free sugars and salt/sodium. Consequently, a significant proportion of the population are not consuming adequate intakes of fruit, vegetables and dietary fibre [62]. The number of takeaways in London alone has increased from 4,100 in 2010 to 5,335 in 2018 [63]. The introduction of smart phone apps has made it even easier to have fast food delivered to home or work and this market has increased by 72% in the last decade [64].

The food market has shown some positive steps towards healthy eating. For example, there are several companies offering households to subscribe to fruit and vegetable boxes or for deliveries of fresh ingredients to enable them to cook from scratch with pre-prepared ingredients delivered to homes and this represents a positive step towards healthy eating at home. However, this approach tends to serve those who have the financial resources and there remains population groups who face attitudinal, financial or knowledge barriers to benefit from healthy eating.

The issue of being overweight or obese is usually given most attention when healthy or unhealthy eating is being discussed. However, it is important to consider the other less visible effects of unhealthy eating and poor nutrition; the risk this poses to health and the groups who may be most affected. For example, a diet with high salt intake or low vitamin consumption may not cause weight gain but can still put an individual's health at risk.

Sustainability and waste are also an issue associated with food. It is estimated that food and drink accounts for 10% of London's total consumption-based greenhouse gas emissions. For every two tonnes of food eaten in the UK, another tonne is wasted [65]. Climate change impacts on fuel and food prices, which further impact on population groups that are already disadvantaged or vulnerable.

Healthy Diet and Nutrition Behaviours

Current UK diet and nutrition recommendations include [66]:

- At least 5 portions of fruit and vegetables per day for those aged 11 years and over
- For adults (ages 19 and over), average intakes of red and processed meat should not exceed 70 grams per day
- At least 1 portion of oily fish (140 grams) per week for all ages (equivalent to 20 grams per day)

[61] https://www.alzheimers.org.uk/about-dementia/risk-factors-and-prevention/mediterranean-diet-and-dementia
[62] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/699241/NDNS_results_years_7_and_8.pdf
[63] Mayor for London Food Strategy https://www.london.gov.uk/what-we-do/business-and-economy/food/london-food-strategy-0
[64] Retail consortium data
[65] London Environment Strategy
[66] https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-obesity-physical-activity-and-diet/statistics-on-obesity-physical-activity-and-diet-england-2019/part-6-diet

- Limit free sugars to no more than 5% of daily calorie intake
- Limit saturated fat intake to no more than 11% of daily calorie intake

National trends in diets indicate that the general population may not be consuming the right foods to support a healthy lifestyle [28]:

- Ready meals and convenience meat products continue a clear upward purchasing trend
- Purchases of fish and fish products are falling steadily
- Fresh green vegetables have shown slight downward trend, however, there has been a 5% increase in purchase of other fresh vegetables
- Potato purchases continue a downward trend
- Purchases of both white and wholemeal bread have fallen
- Milk purchases have generally declined over the last 10 years
- Between 2013 and 2016/17, purchases of takeaway food brought home have increased by 10%. Expenditure on takeaway foods was £2.17 per person per week in 2016/17, 23% higher than in 2013

3.3 Risk Factors of developing or experiencing diet-related ill health.

There are several risk factors which help us to understand the key groups which would benefit from targeted work as they are at greatest risk of developing or experiencing diet-related disease. These risk factors are as follows:

- Age (being over the age of 60)
- Ethnicity (South Asian or Black African or Black Afro Caribbean)
- Carers
- Learning disability
- Low income
- Being overweight or obese

There are some population groups who may be more at risk of developing a diet related diseases for different reasons. The most prominent risk factors are outlined below.

Ethnicity

Adults from Black African and Black Caribbean population groups are three times more likely to have T2D than the White population, with South Asian population groups are six times more likely to develop T2D [67]. This is partly due to genetics but also can be due to cultural norms, influences and diets within these communities (please also see related JSNA Live Well Long Term Conditions diabetes chapter for further data).

In addition, the prevalence of circulatory diseases is far greater among some BAME groups. Rates of heart attacks are higher among South Asian groups at an earlier age and death rates from cardiovascular disease are approximately 50% higher [68]. Adults of South Asian origin are more likely to develop coronary heart disease than White Europeans. Similarly, adults of African or African Caribbean origin are at higher risk of developing high blood pressure and having a stroke than other ethnic groups.

[67] https://www.gov.uk/government/publications/health-matters-preventing-type-2-diabetes/health-matters-preventing-type-2-diabetes

[68] https://www.bhf.org.uk/informationsupport/risk-factors/ethnicity

Age

In Richmond, 16% of residents are in the over 65 years age range and 19% over 50 years; it is projected that there will be an increase in people living longer in Richmond in comparison to all Outer London and London.

Older people are also at risk of poor nutrition, particularly those living alone. Older people may face mobility issues and limited access to healthy, nutritious food if they find it difficult to leave the house independently or do not live close to a large supermarket. Older people living alone may also be less likely to consume a varied diet or eat as regularly as they should. Older people are therefore more at risk of the health effects associated with malnutrition and dehydration. It is important to also note that healthy eating is a key factor in preventing Dementia and poor diet may contribute to someone's risk of developing dementia.

Being a Carer

Nutrition is an important but often a hidden issue for carers and their families. Carers can neglect their own diet as a result of their caring responsibility [69]. For example, carers are time poor which can result in a poor diet or no pattern to their eating, sometimes eating their own meals very late at night. Poor nutrition and eating habits can put carers at risk of developing diet related illness.

Malnutrition can also affect those who are receiving care. According to Carers UK, 60% of Carers worry about the diet of the person they care for. Many carers are responsible for preparing meals, yet less than half received nutritional advice for the person for whom they provide care. For those that receive care, poor nutrition can add to their health problems and it is likely to increase their care needs.

Learning Disabilities

Adults with learning disabilities may not have the support, equipment and skills to prepare healthy nutritious meals. They may not have the financial resources to buy healthy food. Adults with learning disabilities are therefore more likely to be overweight or obese. It is estimated that around 40% of adults with a Learning Disability are obese [70] and therefore, at greater risk of developing diet related illness such as type 2 diabetes. Type 2 diabetes is more common in people with a learning disability than the general population. On average 10% of adults with learning disabilities have type 2 diabetes compared with approximately 3% of the general population.

Low Income

Looking further through the lens of inequality, deprivation is an underlying and recurring theme in relation to diet and nutrition. Key research shows that households and individuals who are in poverty or socially disadvantaged have worse dietary-related health outcomes. People living on low incomes or those who are unemployed and households with dependent children are more likely to have less healthy diets and experience food poverty. Amongst adults, this may be characterised by parents on low incomes going without food so that their children can eat; working people whose low wages leave them struggling to buy healthy food; or older people unable to prepare meals without support. The percentage of spend on food continues to be highest for households with the lowest 20% of income, at 14.3% in 2016/17. Food is the largest item of household expenditure for low-income households, after housing, fuel and power costs [71].

[69] Carers UK Nutrition and Care Research briefing

[70] https://www.gov.uk/government/publications/obesity-weight-management-and-people-with-learning-disabilities/obesity-and-weight-management-for-people-with-learning-disabilities-guidance

[71] https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-obesity-physical-activity-and-diet/statistics-on-obesity-physical-activity-and-diet-england-2019/part-6-diet

Other Determinants

There is a range of other factors which may be responsible for poor diet. These can affect any group and include:

- *Availability of unhealthy food* - Fast food consumption is associated with increased BMI, obesity and body fat ratios [72]. Consumption of takeaway food at home is more likely for children in deprived households [73], food purchased out of the home may also come in larger portions. There is limited information available on local patterns of healthy eating, however, fast food outlets in 2017 were reportedly at a ratio of 64 per 100,000 of the population, a relatively small amount compared to Boroughs countrywide [74] and in late 2020 the Governments 'Eat out to Help Out' led to fewer meals eaten at home; consumers spent £155 million less in the supermarkets due to this, compared with July 2020 [75]
- *Being time poor* - many processed foods can be high in salt and sugar and whilst these may appear to be cleverly marketed as 'low in fat', they may contain high levels of salt and sugar. There may be groups who are more likely to purchase convenience foods for example the working age population buy ready-made food at lunchtime such as takeaway sandwiches. Adults who are working (and living alone) may be more likely to buy ready-made meals for convenience than opting to cook from scratch. Similarly, parents may also opt for meals and snacks which save preparation time and are quick to serve for themselves and their families and these may be higher in salt, fat and sugar
- *Income* - food prices have increased; all food and non-alcoholic beverage groups have risen in price since 2007, with rises ranging from 22% to 56% [76]; since 2008, the price of food has risen 10% more than other goods [77]
- *Lack of knowledge and skills* – Limited knowledge about nutrition and the absence of practical cooking skills can contribute to a poor diet
- *Environment* – We are living in an obesogenic environment where less healthier choices are the default, which encourage excess weight gain and obesity. Evidence suggests that the increasing consumption of out-of-home meals, often cheap and readily available, has been identified as an important factor contributing to rising levels of obesity [78]
- *Living alone* – A recent review of evidence suggests that living alone could negatively affect some aspects of food intake and contribute to the relationship between living alone and poor health outcomes [79]

3.4 Dietary Behaviours in Richmond

In Richmond, the proportion of adults meeting the recommended '5 a day' on a usual day is above average for London (66% vs 54%). In Richmond, just over a third of adults (35%) drink more than the recommended units of alcohol a week, which is the third highest in London and well above the London average (26%)[80].

[72] Fraser, L.K., Clarke, G.P., Cade, J.E., & Edwards, K.L. (2012) Fast food and obesity: a spatial analysis in a large United Kingdom population of children aged 13–15. American journal of preventive medicine, 42 (5): e77-e85.
[73] Adams, J., Goffe, L., Brown, T., Lake, A.A., Summerbell, C., White, M. & Adamson, A.J. (2015) Frequency and socio-demographic correlates of eating meals out and take-away meals at home: cross-sectional analysis of the UK national diet and nutrition survey, waves 1-4 (2008-12). International Journal of Behavioral Nutrition and Physical Activity, 12 (1): 51
[74] https://www.gov.uk/government/publications/fast-food-outlets-density-by-local-authority-in-england
[75] kantar.com/uki/inspiration/fmcg/2020-supermarket-sales-slow-as-uk-shoppers-eat-out
[76] https://www.gov.uk/government/publications/food-statistics-pocketbook/food-statistics-in-your-pocket-summary
[77] http://researchbriefings.files.parliament.uk/documents/POST-PN-0522/POST-PN-0522.pdf
[78] https://www.gov.uk/government/publications/health-matters-obesity-and-the-food-environment/health-matters-obesity-and-the-food-environment--2#factors-behind-the-rise-in-obesity-levels
[79] https://academic.oup.com/nutritionreviews/article/73/9/594/1832837
[80] https://fingertips.phe.org.uk/search/alcohol#page/3/gid/1/pat/6/par/E12000007/ati/102/are/E09000002/iid/92778/age/168/sex/4

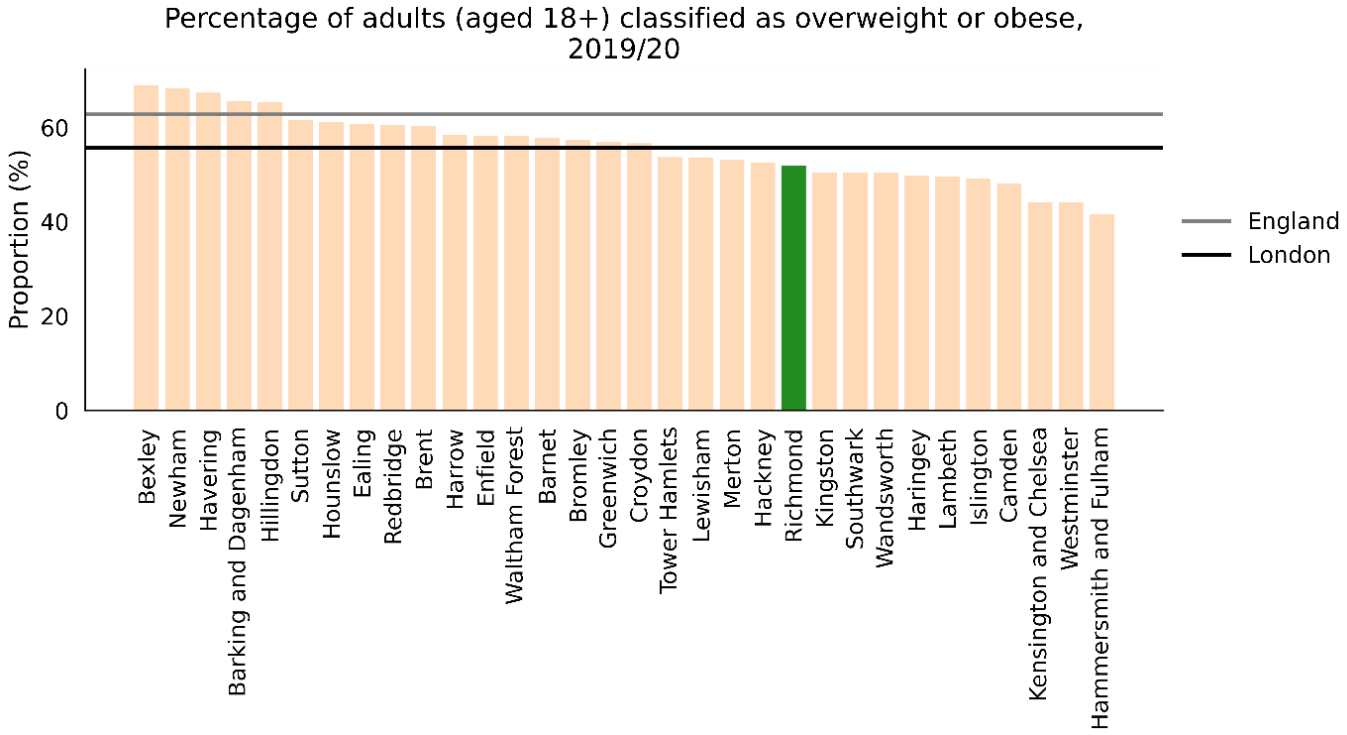
Whilst there is no local data available about the diets of Richmond residents, the National Diet and Nutrition Survey (NDNS) provides an indicator that adults may not be consuming the right foods to support a healthy lifestyle[81]:

- The average daily intake of 'free' sugars (those added to food or drinks, or found naturally in honey, syrups and unsweetened fruit juices) is 11%, which is double the recommended daily intake of no more than 5%. Main sources of free sugars in all age groups are biscuits, buns, cakes and pastries; sugar, preserves and confectionery; cereal and cereal products; sugar sweetened beverages (SSBs) (including fruit juice), and for adult men, beer, lager and cider are also contributors [82]
- Only 9% of 19-64-year-olds and 7% of those aged 65 and above are meeting the recommended daily intake of fibre of 30g per day [83]. Main sources of fibre include wholegrains (for example, brown pasta, breads and oats), vegetables and fruit (including their skins and peel)
- Average weekly consumption of oily fish is 77g which is around half the recommended amount (140g). Oily fish includes anchovies, carp, trout, mackerel, herring, pilchards, salmon (including canned), sardines, sprats, swordfish, tuna (fresh only)

Diet-related health conditions in Richmond

In 2019/20, Richmond's proportion of adults classified as overweight or obese was 51.9%, which is the 11th lowest rate in London (**Figure 31**), 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 2.5% increase in England's rate in the equivalent time period (**Figure 32**).

Figure 31: Proportion of adults who are overweight or obese by local authority, 2019/20



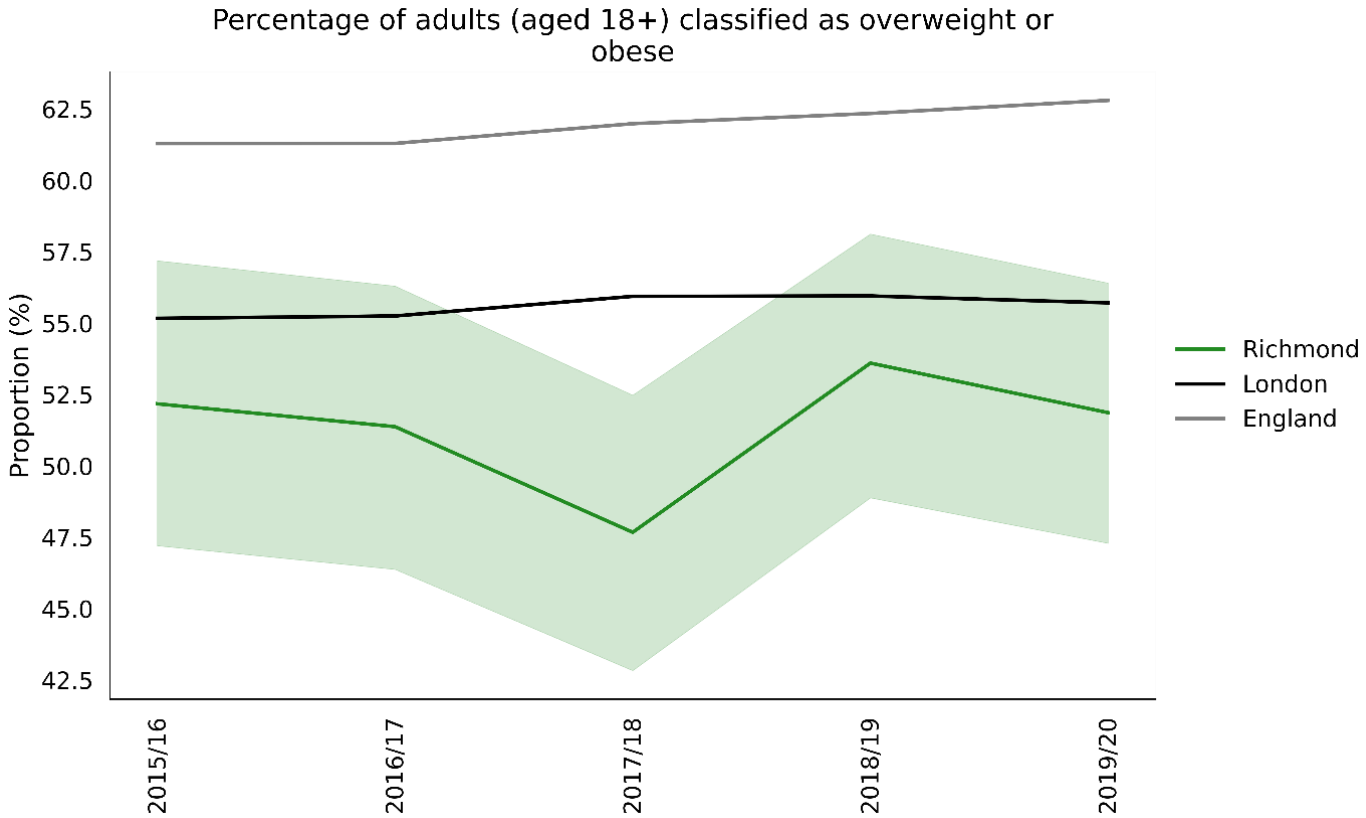
Source: PHE Public Health Profiles

[81] https://www.gov.uk/government/statistics/ndns-results-from-years-7-and-8-combined

[82] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/445503/SACN_Carbohydrates_and_Health.pdf

[83] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/699241/NDNS_results_years_7_and_8.pdf

Figure 32: Proportion of adults who are overweight or obese, 2015/16–2019/20



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

Obesity increases the risk of a range of chronic diseases, particularly T2D, stroke and coronary heart disease. In the UK obesity related disease cost the NHS more than £6bn per year and are calculated to impact wider society to the amount of £27bn per year [84]. Unless significant action is taken, it is estimated that by 2050 overweight and obesity will cost the NHS £9.7bn per year, with societal costs of £49.9bn [85].

Some health conditions are preventable by following a healthy diet and maintaining a healthy weight. The most notable diet-related health conditions are cardiovascular disease such as T2D, heart disease, circulatory conditions such as high blood pressure and some cancers. The data for Richmond shows that:

- Early mortality (under 75 years) from CHD is significantly lower than the England rate
- Mortality from cancer is lower than the average for London and England
- Diabetes prevalence is one of the lowest in London (4.1%) [86]. However, it is estimated that approximately 7% of people are living with diabetes (type 1 or type 2), both diagnosed and undiagnosed.

Exposure to fast food through advertising is known to influence the purchase and consumption of food and forms part of the issue that need addressing around the obesogenic environment. important issue to address. Locally, Public

[84] https://www.gov.uk/government/publications/health-matters-obesity-and-the-food-environment/health-matters-obesity-and-the-food-environment--2
[85] https://www.gov.uk/government/publications/health-matters-obesity-and-the-food-environment/health-matters-obesity-and-the-food-environment--2
[86] https://fingertips.phe.org.uk/profile-group/cardiovascular-disease-diabetes-kidney-disease/profile/diabetes-ft/data#page/3/gid/1938133138/pat/46/par/E39000018/ati/154/are/E38000193/iid/241/age/187/sex/4/cid/4/page-options/ovw-do-0_car-do-0

Health carried out a snapshot of fast-food adverts in Richmond and found that of the adverts advertising food products, the vast majority were for foods high in fat, salt and sugar.

A report published in 2018 by Cancer Research UK found young people who recalled seeing junk food adverts were more than twice as likely to be obese. The same study identified 87% of young people found adverts for high fat, salt and sugar products appealing, with three quarters tempted to eat a product after seeing such an advert. The purpose of the ban is to reduce this exposure to foods and drinks high in fat, salt and sugar and therefore reduce the likelihood of those foods being purchased and consumed.

In Richmond, the density of fast-food outlets is the lowest in London (measured at 68.5 per 100,000 people in the borough) but close to the average for the rest of England. Whilst not all fast food is unhealthy, it can be high in calories, saturated fat and salt, plus low in fibre, fruit and vegetables. A Town Centre survey is periodically carried out by the Council Planning Team. Analysis of the number and type of food outlets in Richmond shows that these have remained similar over time. The majority of food outlets are sandwich shops (classified as A1) and on average around three quarters are classified as this type. Around one in five are cafes/restaurants (classified as A3) and only 5% of food outlets are hot food takeaways (classified as A5).

Ethnicity

Considering the risk factors mentioned earlier, adults from South Asian and Black African, Black Caribbean groups are at greater risk of being affected by diet related disease and it is important that are equipped to take steps to prevent this through healthier diets. In 2019, there were 2,556 BAME people aged 65 years or older in Richmond. By 2029, this number is predicted to increase to 4,240, an increase of 66%. 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 14% for the Borough). Detailed geographic breakdown at Ward level and lower can be found on DataRich. The BAME population is more likely to be in the 0-19 and 20-44 age groups, with a much smaller proportion aged 65 and over compared to the white population.

The Heathfield ward has a much higher proportion of adults of Asian and Black African or Black Caribbean origin than any other ward in the borough. These residents may need more information and support relating to maintaining a healthy diet, particularly around the prevention of Type 2 diabetes.

Age

In Richmond, the majority of those living in one-person households in Richmond are over 50 years old (making up 71% of these households). In 2019, the largest age group living in these households' types are those aged 70-74 (1,541 households). Older people and older people living alone are also noted to be at risk of malnutrition.

Richmond's population median age falls within the mid-range of the country with an age of around 40.7 years (London=35.1) with the highest proportions of population aged 40+ years in London. The largest increase in numbers, will be among those aged 55+ years, but the largest percentage increase will be in the population aged 80-84 years which will grow by 59%.

The proportion of older people aged 65 years and over living alone in Richmond is also higher than the London average (37% vs 34%)[87] and older people living in deprivation (34% vs 22%)[88]. Older people living alone are at greater risk of malnutrition and health effects associated with malnutrition. Solitude has an impact on the physical and mental health and eating patterns of this elderly population and weight loss is associated with frailty in older people. The graph below shows that older people living in Heathfield ward have twice as many older people living in

[87] https://fingertips.phe.org.uk/search/living%20alone#page/3/gid/1/pat/6/par/E12000007/ati/102/are/E09000027/iid/93103/age/27/sex/4
[88] https://fingertips.phe.org.uk/search/living%20alone#page/3/gid/1/pat/6/par/E12000007/ati/102/are/E09000027/iid/93279/age/214/sex/4

deprivation than older people in East Sheen. This could put them at risk of experiencing food poverty and health issues from poor nutrition.

Local service data also illustrates the need for support with healthy eating in Richmond. In 2018/19, sixty elderly Richmond residents were in receipt of food delivered to their homes, a 33% rise in demand since 2017/18. Furthermore, approximately 18,000 hot lunches per year are served to elderly service users and service users with dementia across the two-day centres in Richmond.

There are currently 60 elderly residents, most referred by social services, who receive delivered meals in Richmond. At least 14 people receive no other support from social services other than a hot meal every day and at least 10 of these residents are in their late 80s to mid-90s. This figure represents a 33% rise in demand since 2017/18.

People with a Caring Responsibility

There are an estimated 18,000 unpaid carers in Richmond, who are responsible for providing care for a friend or family member. One in ten carers in a Richmond survey that they have experienced loss of appetite as a result of their caring role and 16% felt they were neglecting themselves in relation to eating well or getting enough sleep.

Disability

Data from the Clinical Commissioning Group shows there are almost 500 adults with a learning disability living in the borough of Richmond. These individuals may need support with buying and preparing healthy food.

Living Alone

In Richmond 1 in 3 residents live alone. Research has shown that people living on their own can lead to a less healthy diet and more regularly opting for takeaway, fast food or pre-packaged dinners. A recent review of evidence suggests that living alone could negatively affect some aspects of food intake and contribute to the relationship between living alone and poor health outcomes[89].

3.5 The Obesogenic Environment

In recent years Britain has become a nation where being overweight is prevalent; by 2050, around 50% of adults and 25% of all children under 16 could be obese [90].

Today's 'obesogenic' environment, with its abundance of convenience and energy dense foods and increased sedentary lifestyles, reducing the prevalence of obesity is challenging. Exposure to fast food through advertising is known to influence the purchase and consumption of food and forms part of the issue that need addressing around the obesogenic environment. Locally, Public Health carried out a snapshot of fast-food adverts in Richmond and found that of the adverts advertising food products, the vast majority were for foods high in fat, salt and sugar.

A report published in 2018 by Cancer Research UK found young people who recalled seeing junk food adverts were more than twice as likely to be obese. The same study identified 87% of young people found adverts for high fat, salt and sugar products appealing, with three quarters tempted to eat a product after seeing such an advert. The purpose of the ban is to reduce this exposure to foods and drinks high in fat, salt and sugar and therefore reduce the likelihood of those foods being purchased and consumed.

[89] https://academic.oup.com/nutritionreviews/article/73/9/594/1832837

[90] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/287943/07-1469x-tackling-obesities-future-choices-summary.pdf

3.6 Limitations to the Data/Information

Additional data would assist with building a more comprehensive picture locally about diet and nutrition. For example, the following health related behaviour measures relating to food and drink would be useful at a Borough level:

- Local data on fast food consumption and takeaway usage
- Local data based on diet and nutrition survey measures
- Local barriers to following a healthy diet
- Level of skills and education levels amongst adults around preparing nutritious meals
- Data on fizzy drink consumption
- Data on felt need/perceived need in relation to healthy eating
- Data from adults with learning disability about healthy eating

3.7 Current Services

The council offers both public facing services and policy approaches to support healthy eating for adults in particular groups. These are as follows:

- The men's Adult Weight Management service in Richmond is Move it to Lose It. It is based on the Fit Fans model using circuit training exercises coupled with nutritional and lifestyle advice. The programme is targeted at men (40-60 years of age) with a BMI equal to or greater than 25. The programme includes an element of nutrition and behavioural change techniques such as goal-setting or self-monitoring, and the use of technology, e.g. 'WhatsApp' group to encourage participation.
- The Richmond Meals on Wheels service provides a hot meal to elderly and vulnerable adults in the borough. This includes the delivery of hot meals, frozen meals and afternoon tea packs. The same service also delivers meals to two-day centres in the borough.
- Including healthy catering criteria in commissioned service contracts, for example age well centres and leisure centres. Plans are being developed to influence the food environment by reducing exposure to unhealthy food through retail planning, healthy catering for restaurants and takeaways. The council is also considering the feasibility of limiting exposure to High Fat Salt Sugar foods through advertising and marketing restrictions.
- There are twenty-four allotment sites across the Borough which provides several environmental benefits including the support and regulation of ecosystem services. Allotment gardening also results in more sustainably produced food, promotes healthy eating and acts as an educational resource.

Further to services directly delivered by the Council, it is also a key partner/stakeholder in the delivery of the Social Prescribing service, commissioned by Richmond Clinical Commissioning Group (CCG). The Social Prescribing service is delivered jointly by Age UK Richmond, Richmond Aid and Richmond Users Independent Living Scheme (RUILS). It helps residents to identify local support and information based on social needs and interests, which often includes lifestyle support. It also offers more intensive support to adults who may need more assistance with improving their wellbeing.

The Voluntary Sector also provides a number of services and projects for Richmond residents to help them and their families to eat healthily, particularly those who are low income or in need of emergency support.

The following are services which are available to residents to support healthy eating and nutrition.

- **Richmond Food bank -** Alongside its foodbank services, the Richmond Foodbank offers a free six-session course teaching people cookery and nutrition skills to help make tight budgets stretch further. This includes cookery, budgeting, hygiene and nutrition.
- **Richmond Borough Mind** offers *Food and Mood* courses for volunteers to support their roles.
- **Richmond Nutrition Service** offers a *Healthy cooking on a budget* course to anyone who is using food banks or has limited funds.

- **Richmond Adult Community College** offers a range of course for adults to support healthy eating, including *Family Meals Made Easy* and *Quick and Healthy Family meals.* These may be accessed at a 50% discounted rate for an adult who is on low income, in receipt of benefits, a carer, over 65 and living alone, learning disabilities or has mental health difficulties. The college also offers a cookery courses for adults with learning disabilities (although this is delivered in Merton on behalf of the College).

3.8 Evidence Based Interventions/Approaches

Evidence Based Marketing and Campaigns

PHE and the NHS deliver two key marketing campaigns to support healthy eating amongst adults *One You* and *One You: Nutrition on the Go* to support eating out. https://www.nhs.uk/oneyou/

There is also the Sugar Smart campaign which is delivered by Sustain and supported by PHE https://www.sugarsmartuk.org/. This campaign has been adopted by other Boroughs across London and England.

NICE Guidance and Quality Standards

There is a wide range of NICE guidance on healthy eating and nutrition, which recommends evidence-based interventions. Also cited here are NICE Guidance and Quality Standards for the prevention obesity and excess weight gain and type 2 diabetes:

- Preventing excess weight gain (NG7) 13 March 2015
- Obesity prevention (CG43) 1 March 2015
- Weight management: lifestyle services for overweight or obese adults (PH53) 28 May 2014
- Weight management before, during and after pregnancy (PH27)
- Cardiovascular disease prevention (PH25)
- Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups (QS167)
- Obesity in adults: prevention and lifestyle weight management programmes (QS111) 19 January 2016
- Obesity in adults: prevention and lifestyle weight management programmes (QS111) 19 January 2016
- Obesity: working with local communities (PH42) June 2017
- Type 2 diabetes prevention: population and community-level interventions (PH35) May 2011
- Dementia, disability and frailty in later life - mid-life approaches to delay or prevent (NG16) (October 2015)

4. Physical Activity

Physical Activity (PA) is universally acknowledged to be an important part of healthy functioning and well-being. An active lifestyle is essential for health and the health benefits of routine PA and exercise[91] participation is irrefutable. PA reduces the risk of many preventable diseases, from cancer to diabetes, and conditions like obesity and depression[92]. PA increases your chances of staying independent in later life, thereby reducing demand for NHS an Adult Social Care services. National Picture of Physical Activity

The national picture shows that over the last 50 years, the UK has experienced a 20% decline in PA levels (UK Active, 2014). It also shows that around 34% of men and 42% of women are not active enough for good health[93].

Over the last 50 years, the UK has experienced a 20% decline in PA levels (UK Active, 2014). If current trends continue unchallenged then it is estimated that 35% of people would become less active by 2030. Sport England's latest Active Lives Survey found that a quarter of adults (11.3 million) do less than thirty minutes of activity per week in the UK.

4.1 Physical Activity Guidelines

Both Public Health England and the UK Chief Medical Officer (CMO) have produced PA Guidelines, that cover older people, pregnancy and disability. These are summarised below.

Public Health England (PHE)

Tackling physical inactivity is critical to delivering many national priorities e.g., reducing Dementia and Obesity rates and giving every child the best start in life.

Being physically active is define as doing at least 15 moderate intensity equivalent (MIE) minutes of PA per week[94] or more in the previous 28 days. Alternatively, this can be achieved by 75 minute of vigorous intensity activity a week or more. Physically inactivity is defined as doing less than 30 MIE minutes of PA per week. For adults not reaching 150mins the guidance also says doing 'more' will always be beneficial. But the most benefits are achieved at 150 MIE.

Being physically active is define as doing at least 15 moderate intensity equivalent (MIE) minutes of PA per week or more in the previous 28 days. Alternatively, this can be achieved by 75 minute of vigorous intensity activity a week or more. Physically inactivity is defined as doing less than 30 MIE minutes of PA per week.

PHE guidance also states that as well as being physically active, all adults are advised to minimise the time spent being sedentary for extended period. Even among individuals who are active at the recommended levels, spending large amounts of time being sedentary increases the risk of adverse health outcomes, see Health matters: getting every adult active every day.

[91] Bradley, J. The BMJ. [Online]. Available from: https://www.bmj.com/content/bmj/368/bmj.m4.full.pdf [Accessed 23 October 2020].

[92] Department of Health, Start Active, Stay Active: A Report on Physical Activity from the Four Home Countries' Chief Medical Officers (2011). Page 10. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216370/dh_128210.pdf [Accessed July 2020].

[93] PHE Guidance "Physical activity, applying All Our Health – updated 16 October 2019 – see https://www.gov.uk/government/publications/physical-activity-applying-all-our-health/physical-activity-applying-all-our-health

[94]Chief medical officer. UK Chief Medical Officers' Physical Activity Guidelines. [Online]. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/832868/uk-chief-medical-officers-physical-activity-guidelines.pdf [Accessed August 2020].

UK Chief Medical Officer

Adults and older people should:

- Do at least 150 minutes (moderate intensity) or 75 minutes (vigorous activity) or a combination of moderate and vigorous PA per week, nonetheless some exercise is good, more is better
- Include strength and balance activities two days per week
- Older adults at risk of falls should also incorporate balance and coordination PA at least two days per week
- Minimise sedentary behaviours

World Health Organisation

The term PA should not be confused with exercise which is a subcategory of PA which is planned, structured, repetitive and aims to improve or maintain one or more components of physical fitness. Beyond exercise, any other PA that is done during leisure time, for transport to get to and from place, or as part of a person's work, has health benefits.

The most recent updated guidelines also include advice on safe levels of activity for pregnant and postpartum women as well as older people.

4.2 Impact and Benefits of Physical Activity

Prevention has become increasingly important in recent years, as the cornerstone of the drive to improve peoples' health and well-being as well as their quality of life. PA helps reduce peoples' need for high-cost health treatments and care services. Therefore, prevention is now seen as everyone's business and PA remains one of the core elements of a healthier lifestyle. PA also helps us get out our homes and connect with others, avoiding social isolation. It also helps mitigate against substantial economic burden[95], as well as increasing social capital and community spirit.

The importance of being physically active and not having sedentary lifestyles is championed by CMOs. They advocate that the strength of the relationship between PA and health outcomes persists throughout people's lives, highlighting the potential health gains that could be achieved if more people become more active throughout the life-course[96].

This ties into the Council's public health prevention focus on Start Well, Live Well and Age Well in this JSNA. Regarding the latter the evidence according to CMO is that:

- Regular PA contributes to the key determinants of healthy ageing: good physical and mental function; opportunities for social interaction; a sense of control over, responsibility for one's own health and well-being; and managing or coping with disease symptoms and functional limitations.
- Increasing PA contributes to improving social functioning and reducing loneliness and social isolation, especially as you age
- PA contributes to increased physical function, reduced impairment, independent living, and improved quality of life in both healthy and frail older adults
- PA in later life can help treat and offset the symptoms of a range of chronic conditions (e.g., Depression, CVD, Parkinson's Disease)
- New evidence, [specifically for older people] has strengthened and reinforced the main elements of those

[95] Ding D, Lawson KD, Kolbe-Alexander TL, et al., Lancet Physical Activity Series 2 Executive Committee. "The economic burden of physical inactivity: a global analysis of major non-communicable diseases". Lancet 2016; 388: 1311-24. doi:10.1016/S0140-6736(16)30383-X pmid:27475266. Available from: https://www.bmj.com/content/366/bmj.l4570 [Accessed September 2020]

[96] Department of Health, Start Active, Stay Active: A Report on Physical Activity from the Four Home Countries' Chief Medical Officers (2011). Page 10. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216370/dh_128210.pdf [Last accessed July 2020]. This paper has been withdrawn and the new version (September 2019) is available at https://www.gov.uk/government/publications/physical-activity-guidelines-uk-chief-medical-officers-report

The benefits of PA are not only vast for the individual, but it is also the same at a societal level. On an international scale, PA has been recognised as a contributing factor towards 13 of the 17 United Nations Sustainable Development Goals[97]. At a societal level, the higher the percentage of people engaged in PA can assist in tackling many of the important health and social care challenges faced by Richmond Borough and it can also have a positive economic impact.

In relation to a positive economic impact, it is estimated that a 1% reduction in inactivity levels results in savings equivalent to £44 per household, and it also helps improve the health and well-being of the local community[98]. The benefits of being physically active are summarised in **Table 1** below.

Table 1: Benefits of physical activity/ active lifestyle

Benefits of Physically Active Lifestyle	
All-cause mortality[3]	If a person participates in moderate or vigorous intensity PA at least 24 min/day or 150 minutes across a week they have the maximal risk reduction of about 60%[99]. This is about twice the previously thought 30% risk reduction.
Cardiovascular Disease	It can lead to a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke[100] in comparison with those who have a sedentary lifestyle. persuading inactive people to become more active could prevent one in ten cases of stroke[101] and heart disease[102]. The WHO says that PA can help reduce the level of ischaemic heart disease burden as physical inactivity is the principal cause of circa 30% of cases ("WHO | Physical Activity Factsheet," 2016) Helps to prevent or slow the development of osteoporosis, which is a health condition that weakens bones, making them fragile and more likely to break. It develops slowly over several years.
Type 2 Diabetes	It reduces the risk of type 2 diabetes[103] and type 2 diabetic complications (boosting levels of good cholesterol[104]) and thus the need for medications by 30%-40%. The WHO says that PA can help reduce diabetes burden as physical inactivity is the principal cause of circa 27% of cases ("WHO | Physical Activity Factsheet," 2016)
Disability	The combination of improved physical inactivity, a good but not high Body Mass Index (BMI) and eating a healthy diet are the biggest overall contributors to positive Disability Adjusted Life Years (DALY's)[105]

[97] WHO, "Global action plan on physical activity 2018–2030: more active people for a healthier world", June 2018 available at https://www.who.int/publications/i/item/9789241514187 [Last accessed 10/11/2021]

[98] Turning the Tide of Inactivity, UK Active, 2014, http://researchinstitute.ukactive.com/downloads/managed/Turning_the_tide_of_inactivity.pdf

[99] See https://www.bmj.com/content/366/bmj.l4570 (last accessed 06.10.2020)

[100] Public Health England reports that, "Persuading inactive people to become more active could prevent one in ten cases of stroke and heart disease in the UK." Everybody active, every day: An evidence-based approach to physical activity, PHE, 2014; Page 7

[101] Lee I-M, et al. (2012) Effect of physical inactivity on major non-communicable diseases worldwide: an analysis of burden of disease and life expectancy. The Lancet 380: 219–29

[102] Lee I, Shiroma EJ, Lobelo F, Puska P, Blair SN, Katzmarzyk PT (2012) Effect of physical inactivity on major noncommunicable diseases worldwide: An analysis of burden of disease and life expectancy. The Lancet 380:219- 229.

[103] PHE Everybody active, every day: An evidence-based approach to physical activity, PHE, 2014; Page 7

[104] Durstine J.L. & W.L. Haskell. 1994. "Effects of exercise training on plasma lipids and lipoproteins". Exercise and Sports Science Reviews. 22:477-522. Also, Skoumas J, et al, 2003, "Physical activity, high density lipoprotein cholesterol and other lipids levels, in men and women from the ATTICA study". PMC US National Library of Medicine, National Institutes of Health.

[105] Newton, J. N., Briggs, A. D., Murray, C. J., Dicker, D., Foreman, K. J., Wang, H., Naghavi, M., et al. (2015). Changes in health in England with analysis by English region and areas of deprivation: findings of the Global Burden of Disease Study 2013. Lancet, 386 2257-2274. https://doi.org/10.1016/S0140-6736(15)00195-6

Muscle mass	Lower the risk of sarcopenia, or loss of muscle mass, as people age and become less mobile[106].
Musculoskeletal health	Moderate evidence that it helps with a 36% - 68% reduction in hip fracture, and 1% - 2% increase in bone density. Improved quality of life and strong evidence of reduced pain in people with osteoarthritis (OA), rheumatoid arthritis (RA) and fibromyalgia
Blood pressure	Helps to lower blood pressure and it helps improve better circulation.
Weight management	Reduces the risk of becoming overweight or obese or helps people reduce their weight to a healthy level, considering their biology as well as addressing a person's psychology, food consumption and social economic status which all play an important role too. PA also helps to maintain a healthy weight and improves health, regardless of weight[107]
Functional Capacities, mobility and falls	It helps with a 30% reduction in functional limitations and 30% reduction in risk of falls
Cancer prevention	It is associated with a reduced risk of colon cancer by 30% and breast cancer by 20%[108]
Mental Health	It is associated with improved mental health; helping to relieve stress, anxiety, depression (inactive individuals have three times higher prevalence of moderate to severe depression than physically active people) and anger[109]. Strong evidence of supporting a 20% - 30% reduction in depression and dementia.
Dementia	It helps reduce the risk of vascular dementia[110]. In terms of the main sub-types of dementia approximately 30%[111] of cases can be prevented by regular PA (physical inactivity levels are the biggest modifiable risk factor for preventing dementia[112]).
Productivity	It can help individuals boost their workplace productivity whilst also reducing absences due to sickness.
Community	PA has the ability to strengthen social networks and community cohesion. Having an active population can help to reduce levels of crime and antisocial behaviour. Through PA and sport individuals can develop a sense of belonging and can build quality peer relationships with other members of their community.

In terms of health, it increases peoples' risk and likelihood of developing disabilities and diseases. Inactivity and sedentary lifestyles and resulting overweight and obesity are both associated with higher risks of developing chronic diseases such as coronary heart disease (CHD), hypertension, stroke, type 2 diabetes, and certain forms of cancer such as breast and colon. It can also lead to increasing / multiple co-morbidities and can reduce life expectancy[113]. As you get older, these risks become greater according to CMOs.

[106] See https://www.gov.uk/government/publications/health-matters-getting-every-adult-active-every-day/health-matters-getting-every-adult-active-every-day
[107] A vision for population health: Towards a healthier future, Kings' Fund, November 2018.
[108] PHE Ibid, page 7.
[109] https://www.heart.org/en/healthy-living/fitness/fitness-basics/why-is-physical-activity-so-important-for-health-and-wellbeing
[110] PHE Ibid, page 7
[111] https://www.datawand.info/dementia/
[112] https://www.datawand.info/dementia/
[113] https://www.bmj.com/content/366/bmj.l4570.

Inactivity is the fourth largest cause of disease and disability in the UK[114]. At worse, inactivity and a sedentary lifestyle are one of the top leading risk factors of death[115]. For example, physical inactivity is responsible for one in six UK deaths, equal to smoking, and globally is the 4th leading risk factor for mortality accounting for 6% of deaths globally[116]. Also, higher sedentary time is associated with a higher risk of death and that this risk increases at levels greater than 9.5 hours a day.

At a societal level, inactivity and sedentary lifestyles puts pressure on both local government and NHS resources and funding, making services unsustainable. Across the UK physical inactivity is costing the UK an estimated £7.4bn a year[117]. For example, long-term conditions such as diabetes, cardiovascular and respiratory disease not only increase hospital admissions and GP visits. It can also lead to greater dependency on home, residential and ultimately nursing care, which puts a drain on resources as well as the personal strain it puts on families, individuals, and carers[118]. If current trends continue, and become more reflected in Richmond, the increasing costs of health and social care could destabilise public services and is likely to take a toll on the quality of life for individuals, carers and communities[119].

Importance of Targeting Inactivity

According to the CMO, targeting and supporting inactive people to become more active, even if falling short of the recommended levels of activity, is where the biggest public health gains lie[120]. Therefore, getting inactive people to become active has greater health benefits than getting active people to do more activity. This is something that will take time to accomplish. The best approach to reducing sedentary time and subsequently increasing total PA is to take small steps as this is likely to be achievable for the majority of people[121]. This is supported by Sports England, Sporting Future Strategy where they maintain that we must have a stronger focus on tackling inactivity,

"Sporting Future makes it clear that in the past much of the action and funding supported people who would probably have been active anyway. It is important to ensure they continue to be catered for, however the biggest gains and the best value for public investment are found in supporting the people who are least active. **Figure 33**[122] shows the value of getting people active from different starting points. It illustrates that although increasing the activity of an already active person (say from 200 minutes to 300 minutes a week) will benefit that individual's health, it is nowhere near the benefit experienced by a sedentary person who takes up even a small amount of activity" [123].

[114] Everybody active, every-day framework - An evidence-based approach to physical activity

[115] Physical activity: applying All Our Health).

[116] Physical activity: applying All Our Health

[117] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/374914/Framework_13.pdf

[118] Everybody active, every day: An evidence-based approach to physical activity, PHE, 2014; Page 7.

[119] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/374914/Framework_13.pdf

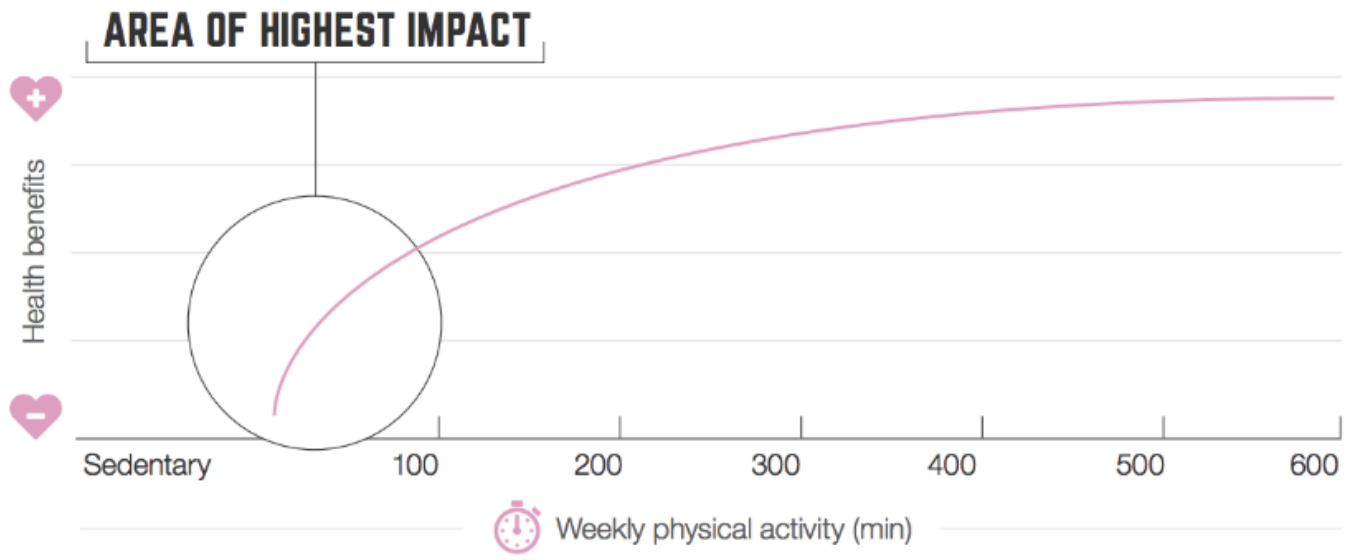
[120] Department of Health, Start Active, Stay Active: A Report on Physical Activity from the Four Home Countries' Chief Medical Officers (2011), https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216370/dh_128210.pdf

[121] "Physical activity and mortality: what is the dose response and how big is the effect?", http://dx.doi.org/10.1136/bjsports-2019-101765

[122] Dose-response curve for physical activity, Nigam, 2011

[123] https://www.activehw.co.uk/uploads/sport-england-towards-an-active-nation.pdf page 21

Figure 33: Dose-response curve for physical activity



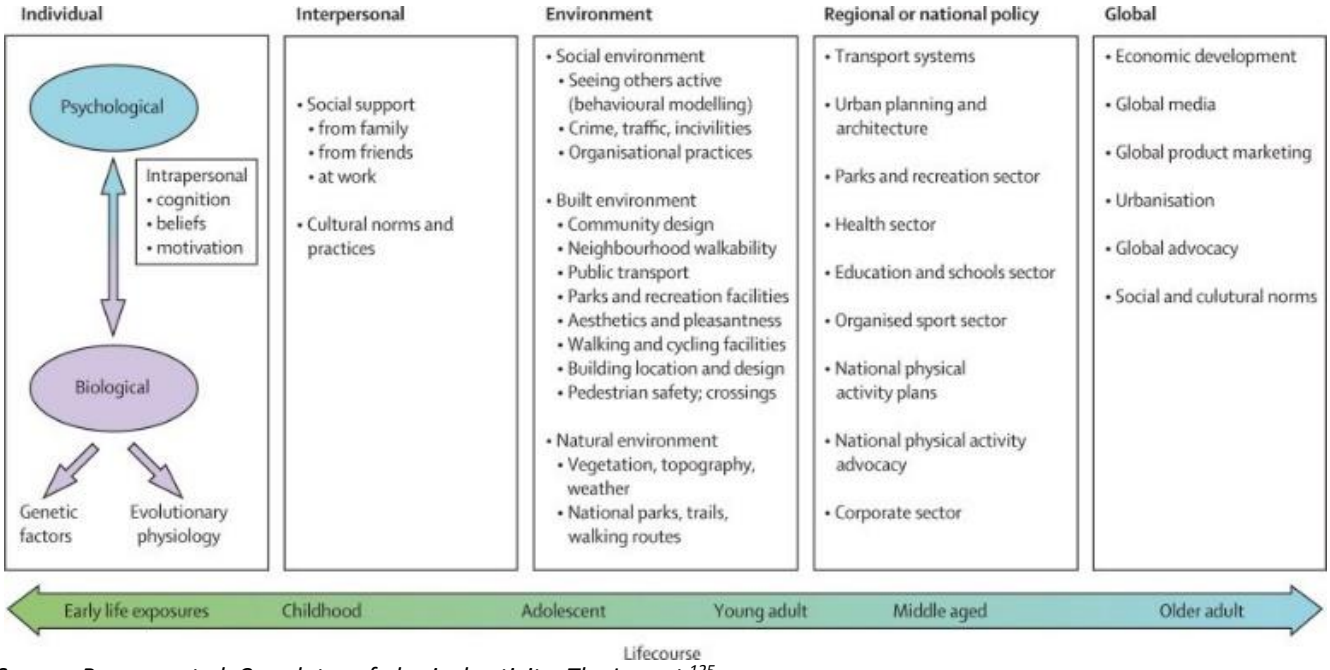
Source: Sport England Strategy 2016-21, Nigam 2011[124]

As we noted earlier, tackling inactivity and sedentary behaviour requires an understanding of the causes and determinants of physical inactivity. This is essential for the development and improvement of public health interventions. There are two perspectives to understanding what makes people physically active or inactive. One looks at the correlating factors associated with activity or inactivity and the other looks at the determinants.

The predominant focus in the past has been on individual-level factors. There is now a movement to focus more on determinants which are at the other end of the ecological model spectrum. They take a broader view of health behaviour causation, with the social and physical environment included as contributors to physical inactivity, particularly those outside the health sector, such as urban planning, transportation systems, and parks and trails. In addition, more recent research on determinants is now identifying genetic factors that contribute to the propensity of people to be physically active. An understanding of correlates and determinants, as advocated by the ecological model (**Figure 34**), would help to reduce the scale of future epidemics of inactivity and contribute to effective prevention of non-communicable diseases.

[124] Sport-england-towards-an-active-nation.pdf (activehw.co.uk); For the data behind this curve see https://www.bmj.com/content/366/bmj.l4570. Accessed 06.10.2020

Figure 34: Adapted ecological model of the determinants of physical activity



Source: Bauman et al, Correlates of physical activity. The Lancet [125]

4.3 Prevalence and Picture of Physical Activity

The Richmond Culture Partnership Strategy 2015-2019 was put in place in to ensure the role of sport, physical activity (including dance), the friendly parks initiative and wider culture offer is championed as it seeks to raise ambitions across this spectrum in Richmond. The strategy has also been complemented by the Council guidance pamphlet on physical activity, "Act Now: Be Healthy" in 2015 [126]. The Culture Partnership strategy is being updated in 2020/21 and will consider this JSNA's findings. The London Borough of Richmond upon Thames' 'Health and Care Plan 2019-2021' also emphasises the importance of physical activity for health and wellbeing.

The Richmond Health and Care Plan identifies that,

"There is inequality in engagement rates in physical sports activity: women, older adults, and people with disabilities and mental health difficulties demonstrate lower levels of participation.

Only 28% of residents use outdoor space (despite green spaces making up 40% of the total area of the borough) for exercise or health reasons.

Making changes such as stopping smoking, improving diet, increasing physical activity, losing weight and reducing alcohol consumption can help people to reduce their risk of poor health significantly."[127]

Richmond needs to draw more explicitly on a number of local, regional and national policies on physical activity and sport to develop its' new Culture Partnership strategy and any associated refresh to its' PA and Sports guidance. This will ensure physical activity through sport, culture (such as dance), better use of green spaces and active recreation, and active travel is taken up by even more residents going forward. Shifting more people from being inactive and sedentary to regularly and meaningfully taking part and volunteering in sport and physical activity will help to deliver

[125] "Correlates of physical activity: why are some people physically active and others not?" Prof Adrian E Bauman (PhD), et al, The Lancet, series| physical activity| volume 380, 9838, P258-271, July 21, 2012, Source: https://doi.org/10.1016/S0140-6736(12)60735-1

[126] See 'Physical Activity – Act now: be healthy', 2015 - https://www.richmond.gov.uk/media/3683/physical_activity_-_act_now_be_healthy_012015.pdf

[127] The London Borough of Richmond upon Thames Health and Care Plan 2019-2021 - http://www.richmondccg.nhs.uk/wp-content/uploads/2019/09/Richmond-health-and-care-plan.pdf

significant public health benefits to our residents, enabling them to improve their health and wellbeing, to connect with their community and live well and age well.

Physical Activity Levels in Richmond

In November 2018/19, 9.7% of Richmond adult residents have been categorised as fairly active (Sport England's annual Active Lives Survey[128]). At that time, circa 73% of Richmond's adult population, up from 69.3% in 2015[129], achieve 150 minutes of PA per week – see **Table 2** below. This far exceeds London's and the national figures of 64.4% and 63.2% respectively, representing a significant increase of 9.3% since measurement began in 2015.

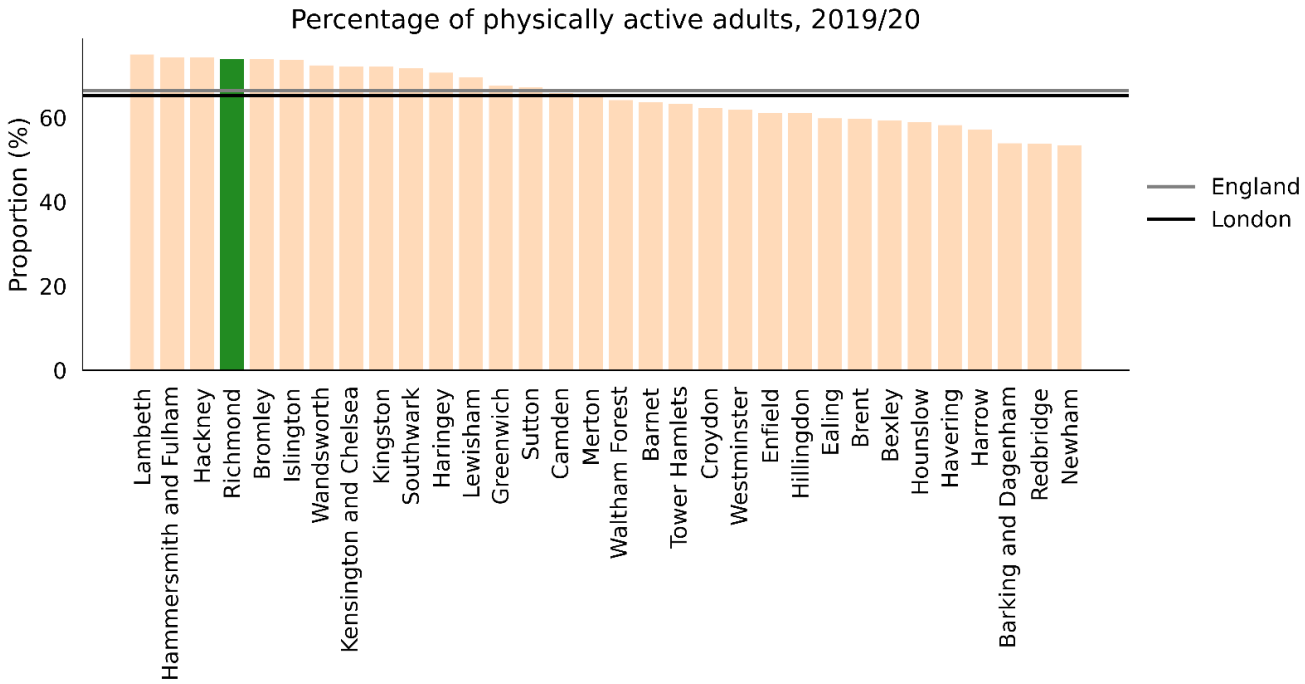
Table 2: Physical activity levels

Physical Activity Levels			
Activity Level (November 2018/19)[130]	**Richmond**	**London**	**England**
Physically Active (150+ minutes per week)	73.4%	64.5%	63.3%
Fairly Active (30-149 minutes per week)	9.7%	11.7%	12.2%
Inactive (<30 minutes per week)	16.9%	23.0%	24.3%

Source: Sport England Active Lives Survey

In 2019/20, Richmond's proportion of physically active adults was 73.9%, which is the 4th highest rate in London (**Figure 35**), 11.3% higher than the England average and 13.4% higher than the London average. The latest Borough figure for 2019/20 was also 3.1% higher than in 2015/16, in comparison with 0.4% increase in England's rate in the equivalent time period (**Figure 36**).

Figure 35: Percentage of physically active adults by local authority, 2019/20



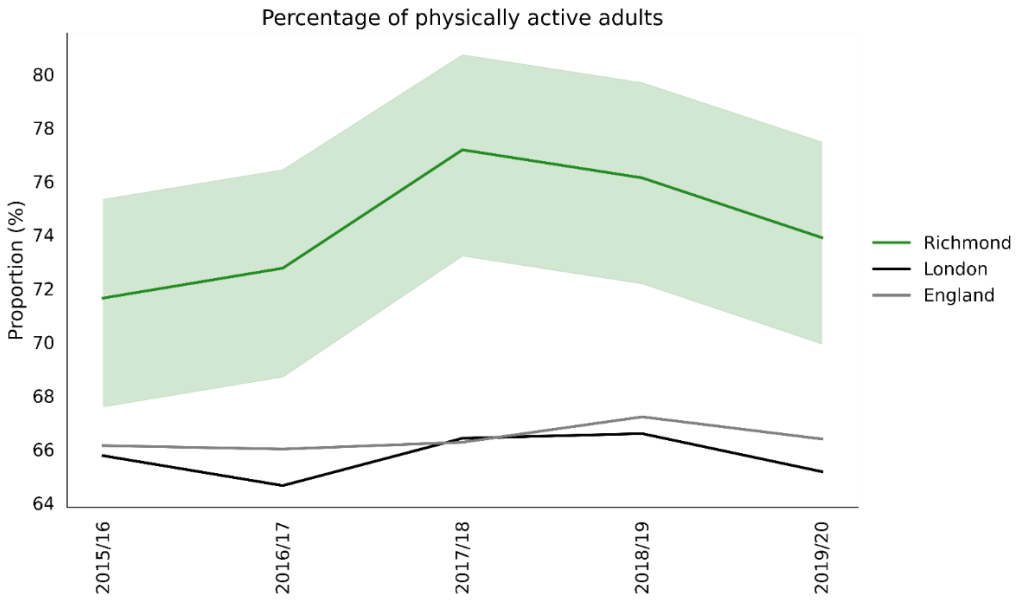
Source: PHE Public Health Profiles

[128] https://www.sportengland.org/know-your-audience/data/active-lives

[129] https://fingertips.phe.org.uk/documents/Additional%20physical%20activity%20data.xlsx

[130] Source: Public Health England (based on Active Lives, Sport England), November 2018-19 data set. See https://sportengland-production-files.s3.eu-west-2.amazonaws.com/s3fs-public/2020-04/Active%20Lives%20April%202020%20Tables%201-3%20Levels%20of%20Activity.xlsx?MGSfRKx5WR5Mr8kvLSx1b8QBqBhfjbDh

Figure 36: Percentage of physically active adults, 2015/16 – 2019/20

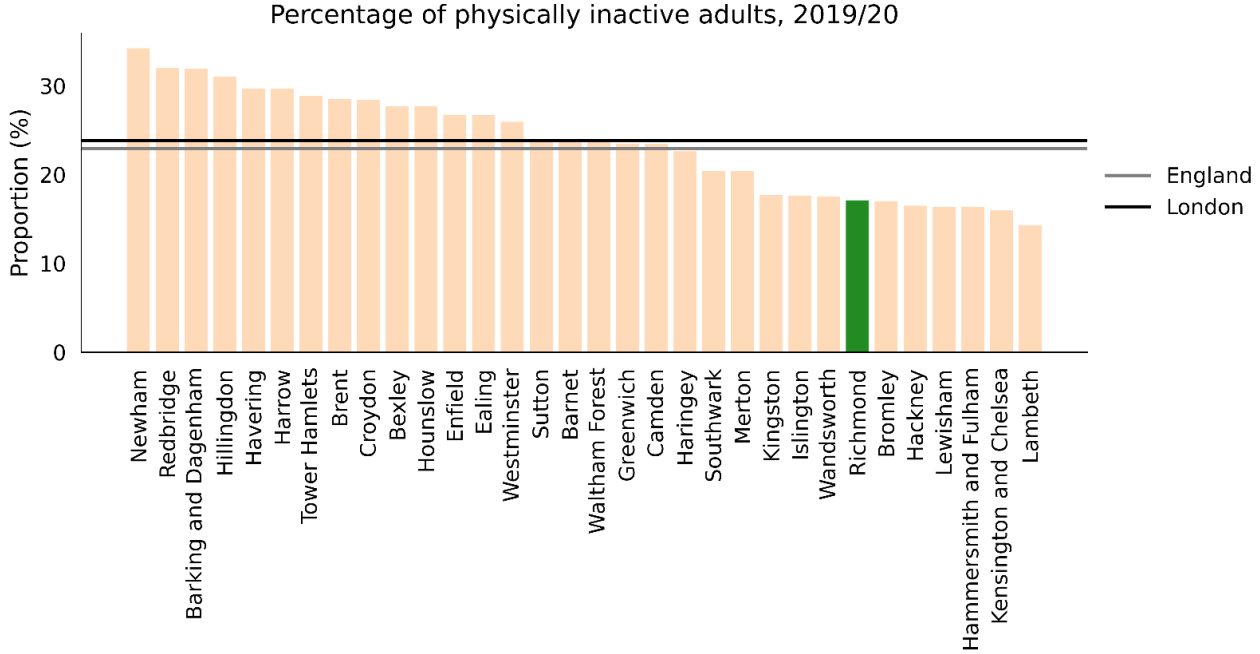


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

Physical Inactivity

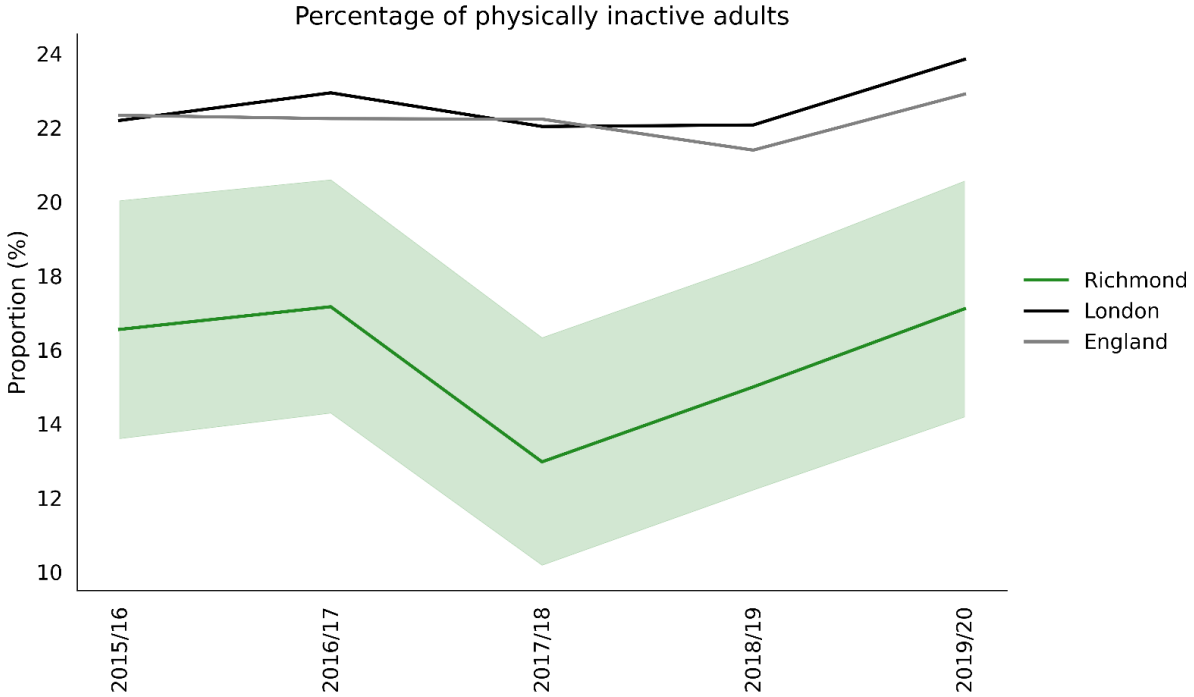
In 2019/20, Richmond's proportion of physically inactive adults was 17.1%, which is the 7th lowest rate in London (**Figure 37**), 25.3% lower than the England average and 28.3% lower than the London average. The latest Borough figure was also 3.4% higher than in 2015/16, in comparison with 2.6% increase in England's rate in the equivalent time period (**Figure 38**).

Figure 37: Proportion of physically inactive adults by local authority, 2019/20



Source: PHE Public Health Profiles

Figure 38: Proportion of physically inactive adults, 2015/16 – 2019/20



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

Physical Inactivity Attributable Factors for Poor Health

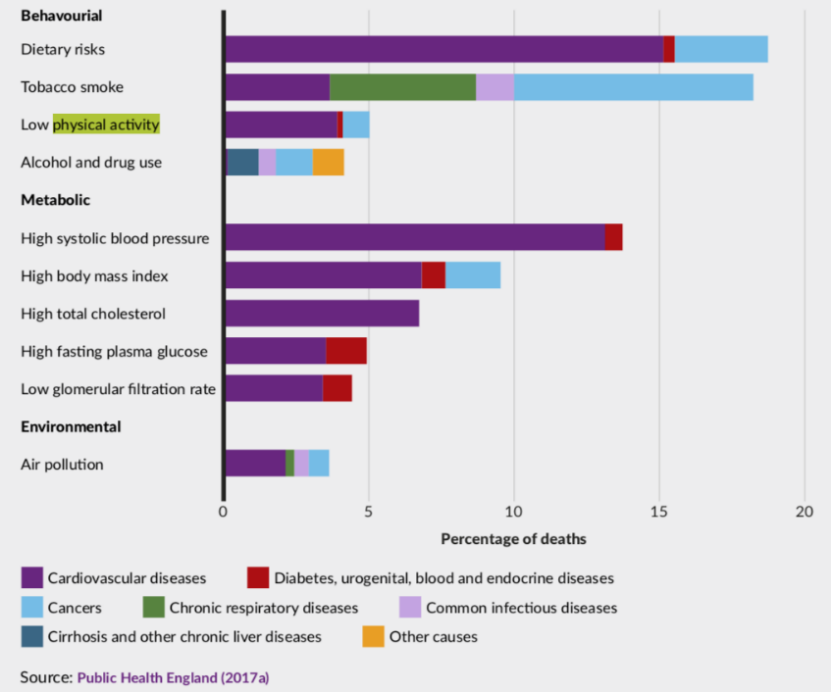
The people who are inactive that engage in sedentary behaviours and lifestyles have greater risk of poor physical and mental health. It is known that a mixture of physical inactivity, unhealthy diet and high BMI is the largest overall contributor to disability-adjusted life years (DALYs).

Government research shows that over a quarter of adults in the UK are classed as inactive, costing the UK economy £20bn per year. The evidence suggests that general physical inactivity increases risk to health and, as Lancet reports, is an important contributor to non-communicable diseases in countries of high income, and increasingly so in those of low and middle income[131]. This can be made worse for people who engage in sedentary behaviour such as long hours of sitting time whether due to work or because they watch a lot of TV or both. Sedentary behaviour is associated with increased risks of several chronic conditions and mortality. It is argued that high levels of moderate intensity PA (i.e., about 60–75 minutes per day) seem to eliminate the increased risk of death associated with high sitting time. However, this high activity level attenuates, but does not eliminate the increased risk associated sedentary behaviour[132].

The causes of disease and disability are complex, interrelated and interconnected. Physical inactivity (and sedentary behaviour) is in the top 10 factors attributable for the burden of disease, disability and poor mental health. PHE reports that physical inactivity is the 4th leading risk factor for global mortality accounting for 6% of deaths globally (**Figure 39**). In the UK, physical inactivity is responsible for one in six (circa 17%) UK deaths with estimated costs to the UK of £7.4 billion annually (including £0.9 billion to the NHS alone) [133]. It has been estimated that 37,000 deaths a year could be prevented in England if everyone met the CMO's PA guidelines for adults (UK Active, 2014)[134]. The rise of sedentary office jobs and the gig economy has not helped, contributing to people becoming less active.

[131] "Correlates of physical activity: why are some people physically active and others not?" Prof Adrian E Bauman (PhD), et al,The Lancet, series| physical activity| volume 380, issue 9838, P258-271, JULY 21, 2012, https://doi.org/10.1016/S0140-6736(12)60735-1
[132] "Does physical activity attenuate, or even eliminate, the detrimental association of sitting time with mortality? A harmonised meta-analysis of data from more than 1 million men and women". Professor Ulf Ekelund (PhD), et al, The Lancet, 388, 10051, P1302-1310, SEPTEMBER 24, 2016, source: https://doi.org/10.1016/S0140-6736(16)30370-1
[133] Physical activity: applying All Our Health, Update October 2019, PHE - https://www.gov.uk/government/publications/physical-activity-applying-all-our-health/physical-activity-applying-all-our-health
[134] https://www.ukactive.com/news/radical-overhaul-of-office-life-needed-to-save-nhs-claims-baroness-tanni-grey-thompson/

Figure 39: Attribution of deaths to risk factors, by broad cause of death, England 2013



Physical Inactivity is estimated as the principal cause for approximately[135]:

- 21–25% of breast and colon cancer burden
- 27% of diabetes burden
- 30% of ischaemic heart disease burden

Risk Factors

It is also known that PA varies with age, tending to deteriorate as people get older[136]. By the age of 75 years, only one in ten men and one in twenty women meet the recommended requirements for good health with respect to PA (Varney et al., 2014).

People with disabilities or long-term conditions are, according to PHE, twice as likely not to be active enough. Research carried out by Britain Thinks on behalf of the Richmond Group of Charities (funded by Sport England) in 2016, found that many currently inactive people with long-term conditions knew that they should do more PA but faced barriers in doing so. For example, in the main people gave the following reasons for not being active: pain, fatigue and low mood. These are all internal issues that are challenging to overcome[137].

Participation in exercising and other kinds of leisure is less common in socio-economically deprived communities. This may not hold true for all cases as there is a minority of individuals, it has been argued, from low socioeconomic groups who are actually more active[138]. The wider determinants of health can also affect levels of inactivity and the propensity to be physically active.

[135] Physical activity Factsheet," 2016

[136] file:///Users/tonymay/Downloads/bhf_physical-activity-statistics-2015feb.pdf

[137] "People with long-term conditions and attitudes towards physical activity: Research conducted on behalf of the Richmond Group", March 2016, Britain Thinks, https://richmondgroupofcharities.org.uk/sites/default/files/richmond_group_debrief_final.pdf

[138] [source: Stalsberg R, Pedersen AV. Are differences in physical activity across socioeconomic groups associated with choice of physical activity variables to report? Int. J. Environ Res Public Health 2018;15:1-23. 10.3390/ijerph15050922 29734745]. Source Letters: Bradley, J. Thebmj. [Online]. https://www.bmj.com/content/bmj/368/bmj.m4.full.pdf

Regular PA helps to improve physical and mental functions as well as prevent or reverse the risks and some effects of chronic disease. In older people it also helps them keep more mobile and independent. That is why maintaining PA throughout the day, to avoid long periods of sitting or lying down is also important, particularly amongst older people who may engage less in being active or undertaking moderate or vigorous exercise.

Health Conditions Associated with Physical Activity

Prevalence information or rates for disease and disability associated with physical inactivity are summarised in **Table 3** which includes National, London and Richmond Borough data.

Table 3: Richmond prevalence rates for diseases and disability associated with physical inactivity compared to England and London average

Indicator	Period	England	London	Richmond
Excess weight: adults classified as overweight or obese	2017/18	62.0%	55.9%	47.7%
Type-2 recorded diabetes	2018	78.0%	71.4%	4.1%
Colorectal cancer (per 100k)		70.43		71.15
Colorectal cancer standard incidence ratio[139]	2012-16	100	90.8	101.5
Breast cancer (per 100k)	2014	173.38		216.6
Breast cancer screening[140]	2019	74.5%	67.3%	73.9%
Breast cancer standard incidence ratio[141]	2012-16	100	94.7	106.0
Bowel cancer (screening coverage)[142]	2019	60.1%	51.5%	59.4%
Hypertension: QOF prevalence (all ages)[143]	2018/19	14.0	11.0	9.8
CHD: QOF prevalence (all ages)[144]	2018/19	3.1	2	1.9
Stroke: QOF prevalence (all ages)	2018/19	1.8	1.1	1.1
Depression recorded presence (18+)[145], (GP Patient Survey)	2018/19	10.7	7.6	7.3
Depression & anxiety prevalence (18+)[146]	2016/17	13.7	-	12.9
Life expectancy at birth (Male)[147]	2016/18	79.6	80.7	82.5

[139] https://fingertips.phe.org.uk/search/colorectal#page/0/gid/1/pat/6/par/E12000007/ati/102/are/E09000032/cid/4/page-options/ovw-tdo-0

[140] https://fingertips.phe.org.uk/search/breast#page/3/gid/1/pat/6/par/E12000007/ati/102/are/E09000027/iid/22001/age/225/sex/2/cid/4/page-options/car-do-0

[141] https://fingertips.phe.org.uk/search/breast#page/3/gid/1/pat/6/par/E12000007/ati/102/are/E09000032/iid/93235/age/1/sex/2/cid/4/page-options/car-do-0

[142] https://fingertips.phe.org.uk/search/Bowel%20Cancer#page/0/gid/1/pat/6/par/E12000007/ati/102/are/E09000027/cid/4/page-options/ovw-tdo-0

[143] https://fingertips.phe.org.uk/search/hypertension#page/0/gid/1/pat/6/par/E12000007/ati/102/are/E09000032/cid/4/page-options/ovw-tdo-0

[144] Coronary heart disease and heart failure prevalence, 2018/19 (per cent)

[145] https://fingertips.phe.org.uk/search/depression#page/0/gid/1/pat/6/par/E12000007/ati/102/are/E09000032/cid/4/page-options/ovw-tdo-0

[146] https://fingertips.phe.org.uk/search/anxiety#page/3/gid/1/pat/6/par/E12000007/ati/102/are/E09000032/iid/90647/age/168/sex/4/cid/4/page-options/ovw-tdo-0_car-do-0

[147] https://fingertips.phe.org.uk/search/life%20expectancy#page/0/gid/1/pat/6/par/E12000007/ati/102/are/E09000032/cid/4/page-options/ovw-tdo-0

Life expectancy at birth (Female)	2016/18	83.2	84.5	86.4
Healthy life expectancy at birth (Male)	2016/18	63.4	64.2	71.9
Healthy life expectancy at birth (Female)	2016/18	63.9	64.4	69.7

Source: PHE

Notes:

Coronary Heart Disease CHD – In 2018/19 the admission rate for CHD in NHS Richmond CCG was 460.5 for every 100,000 (765 admissions). This is slightly lower than England average (488.2 per 100,000). Data shows that since 2004 there has been a gradual decrease from just over 600 to circa 460 in Richmond.

The average Richmond number of annual Coronary Heart Disease (CHD) deaths 2015/17 was for men (77) and Women (53), according (British Heart Foundation Statistics). For Cardiovascular deaths in 2015/17, the average for men (155) and Women (149) .

Type 2 Diabetes: Richmond is among the London boroughs with the lowest prevalence rates with Type 2 diabetes .

Life expectancy: the 2016-18 data for life expectancy at birth for males in Richmond is 82.5 years old which is slight increase from 82.3% in 2015/2017. The 2016/2018 data for life expectancy at birth for females in Richmond is 86.4 years old which is a slight increase from 2015/2017 of 85.7 years.

Gender

Richmond gender split is 51% female and 49% male.

In terms of physical activity by gender there are some imbalances. The Active Lives data (May 2018/2019) indicates that in Richmond there is a 13.4% difference between males and females reporting they are physically active: with males reporting at circa 79.9% and females at circa 66.7%. Health data also shows better than national average health across the borough, including lower obesity rates than London/ UK average, and a fairly low level of inactivity. In terms of inactivity, the Active Lives survey provides no data for men in Richmond, however, in terms of female inactivity it is c.19.5%.

In the most deprived areas of Richmond compared to the least deprived areas, physical inactivity and sedentary behaviour are one of a complex set of contributing factors behind lower life expectancy. In 2015-17, a male living in the most deprived quintile of the borough was expected to live 78.8 years, while his counterpart living in the least deprived quintile would expect to live 7.2 years longer (86.0 years). Among females the gap was slightly smaller 83.7 years in most deprived versus 87.5 years in the least deprived.

Ethnicity

The largest ethnic group in Richmond are those identifying as White British. Findings from Active Lives May 2018/2019 report[148] show that in England, 'Mixed' and 'White Other' adults continue to have the highest activity levels, while 'Asian' (excluding Chinese), 'Black' and those with other ethnic origins are the least likely to be active. The Richmond ethnicity population is shown in **Table 4**. Richmond does not have the data to determine who in our ethnicity categories are physically active or inactive. If we assume England average applies to Richmond, then we would expect to see less physical activity and more inactivity amongst any Asian and Black groups and perhaps also Other BAME groups in Richmond borough.

[148] See https://sportengland-production-files.s3.eu-west-2.amazonaws.com/s3fs-public/2020-01/active-lives-adult-may-18-19-report_1.pdf?ehS5l7YBm3YeLHgNwXLmUSbTZPENafJY

Table 4: Ethnicity Breakdown for Richmond Borough, 2019

Ethnicity	2019 n (%)
White	174,908 (71.8%)
BAME	32,608 (16.2%)
Black Caribbean	1,112 (0.6%)
Black African	1,964 (1.0%)
Pakistani	1,819 (0.9%)
Indian	6,158 (3.1%)

Source: DataRich

4.6 Barriers to Participation

A wide range of barriers can affect people's participation in any type of physical activity. These need to be continually identified and addressed to enable more people to get physically active. Richmond Council has not yet carried out its' own specific survey of its' residents on the subject of barriers to physical activity. Council's sports team anecdotally hear that cost and time are the key barriers often quoted to them when they ask people as to why they do not increase their physical activity level. These are but two of a wide range and at times interconnected barriers Richmond residents may face. In addition, to the barriers highlighted in the aforementioned Richmond survey by Let's Go Outside and Learn[149], many other researchers have identified numerous other barriers as outlined on the below list.

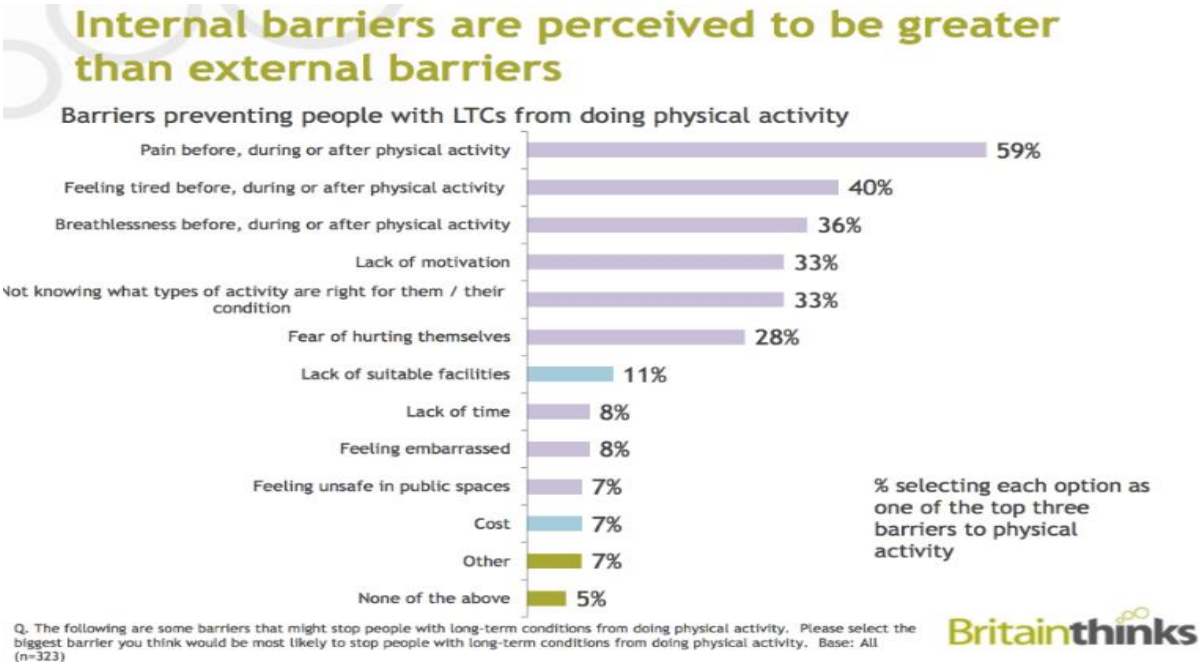
Current generic research in England looking at barriers to PA have found the following factors listed below (these barriers can have a disproportionate effect on people's ability to become more physically active as per the CMOs recommended guidelines):

- Personal barriers such as a person's own perception of their health or age (too old) or disability
- Fear of feeling embarrassed or having negative body consciousness
- Lack of motivation support for people with long-term conditions, mental health or learning disabilities
- Lack of energy – perceived or actual
- Discouragement as the idea of getting physically active to the recommend level feels too daunting especially coming from a place of inactivity. This barrier was identified in recent evidence review of PA for disabled adults and the latest guidance now recognised that for older adults "some is good, more is better" as "any activity is better than none, and more is better still" [150]
- Lack of time – Too time poor as working long hours at work or due to shift patterns not coinciding with PA opportunities, and/or looking after their family
- Lack of motivation or interest, especially to start exercise from scratch
- Lack of peer support to encourage someone to get physically active
- A person may feel the benefit of PA does not outweigh the cost such as the pain and tiredness they feel or perceive
- Key barriers to walking according to Transport for London (TfL) were time constraints (most frequently cited reason for not walking more), followed by traffic levels being too high and cars travelling too fast. Other reasons were, personal security concerns, streets not being pedestrian friendly, a lack of fitness and having another preferred mode of travel are also common reasons given for not walking

[149] Further research into specific groups of people in Richmond barriers to physical active may be beneficial to aid targeted work.
[150] UK Chief Medical Officers' Physical Activity Guidelines, 2019, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/832868/uk-chief-medical-officers-physical-activity-guidelines.pdf

- Key barriers to cycling according to TfL are fear of collisions, a perceived lack of fitness and a lack of confidence
- Isolation and loneliness can prevent people accessing options, especially without support or a companion
- Lack of support to enable a person to become physically active such as primary child carer or if they are a carer for someone to look after the person, they are taking care of so they can be free to exercise or become physically active
- Lack of awareness of what is on offer in their community
- Fear of injury or exacerbating a health issue, especially for those who are not regularly active, are disabled, have a health condition, are pregnant, or are older or frail
- Open spaces either lacking or that are not developed or utilised appropriately and other barriers to participation such as not feeling safe (personal safety) or not easy to access or too far away or lack of toilet/ changing facilities
- Lack of transport or facilities nearby
- Limited active travel options
- Location, cost/ expense, and/or timing of physical activities such as sports or classes
- Internal barriers are perceived to be greater than external barriers to doing PA especially for people with long term conditions (LTCs) – see **Figure 40**[151].
- Perceptions of what sports or classes might be like such as will they make me too sweaty or too aggressive/ energetic or too loud (such as music), etc.
- Lack of certain activities of particular interest to men or women of certain faith groups (Muslim women's preference for women only aerobics or swimming classes)
- Religious beliefs and associated cultural practices
- Bad weather

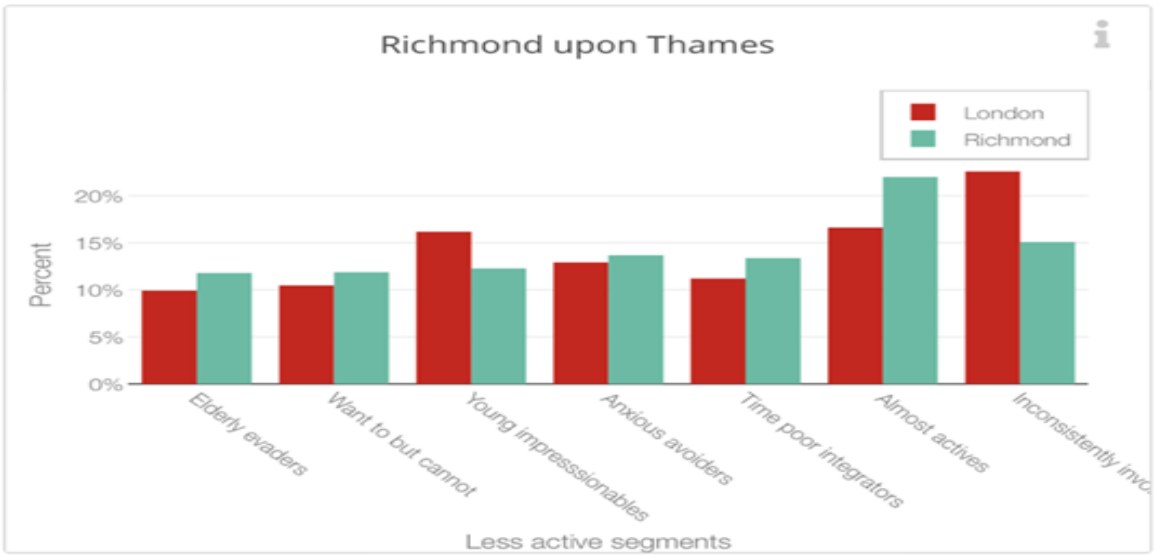
Figure 40: Internal barriers vs external barriers preventing people with LTC from doing physical activity



[151] Britain Thinks', "People with long-term conditions and attitudes towards physical activity: Research conducted on behalf of the Richmond Group", March 2016 – Base: All 323 respondents.

London Sport has identified seven different 'less active' segments. These are what people say prevent them becoming more physically active. These are outlined for Richmond in **Figure 41**[152].

Figure 41: London Sport, Less Active population Segments in Richmond[153]



Source: London Sport

Social Prescribing and other initiatives offer support to get physically active and remove the barriers that prevent residents from becoming more physically active.

Outdoor Spaces in Richmond

The London Borough of Richmond upon Thames is one of the greenest boroughs in London. It is also the only borough where residents live on both sides of the river. Green space promotes active living and provides important physical, psychological and social health benefits for individuals and the community. There are over 500 hectares of formal parks, sports grounds, playgrounds and nature conservation sites for residents to enjoy. Publicly accessible parks (regional, metropolitan, district, local, small and pocket parks) make up 57% of the total area of Richmond (2018).[154]

Some of Richmond parks and open spaces host fitness equipment such as outdoor gym equipment or fitness facilities such as installed in Old Deer Park[155], Richmond.

Heathfield Recreation Ground[156] has been upgraded to encourage physical activity so that its' equipment is now suitable for both users who suffer from mobility problems and those that are able bodied. A Friendly Parks for All consultation[157] took place in 2017 and a report[158] was published along with a number of recommendations[159] which

[152] London Sport https://data.londonsport.org/#31

[153] Source: London Sport (https://data.londonsport.org/#31)

[154] https://www.richmond.gov.uk/media/17991/nature_conservation_policy_statement.pdf

[155] See https://www.richmond.gov.uk/services/parks_and_open_spaces/find_a_park/old_deer_park

[156] See https://www.richmond.gov.uk/services/parks_and_open_spaces/find_a_park/heathfield_recreation_ground

[157] See https://haveyoursay.citizenspace.com/richmondecs/dementia-friendly-parks/consult_view/

[158] See: https://haveyoursay.citizenspace.com/richmondecs/dementia-friendly-parks/results/friendly-parks-for-all-consultation-report.pdf

[159] See https://haveyoursay.citizenspace.com/richmondecs/dementia-friendly-parks/results/friendly-parks-for-all-recommendations.pdf

the Council has been working on. The Friendly Parks For All leaflet[160] and bulletins[161] informs residents about the types of facilities and activities now available in Richmond parks and open spaces. Parks and outdoor spaces enable residents to get physically active in many ways such as:

- To ride their bike through the park
- Go for walk or run either alone or with a group
- Organise a group game of football or cricket
- Hire a rowing boat on the Thames for a fun day out
- Organise a nature trail or go orienteering
- Stroll or run along the Thames towpath
- Go horse riding
- Play boules or skittles

A recent Nature and Wellbeing survey (2020)[162] by a local Richmond CIC found that well maintained accessible nature-rich green space, near to people's homes have taken on a new importance in urban areas during the pandemic, and that people are now recognising more the link between wellbeing and spending time outside and many report that spending time in nature was important for their wellbeing.

Despite the availability of green spaces and outdoor equipment in Richmond borough, according to Public Health Profiles (2016), there was only 9.8% utilisation of this outdoor space for exercise or health reasons.[163] This is considerably lower than the London and England average of 18.0% and 17.9% respectively. A consultation carried out by the Council identified that due to the lack of seating areas, resting points and parking areas were all main barriers to utilisation of green spaces. The aforementioned, Nature and Wellbeing survey, however, identified that, "while many people were able to benefit from access to parks, and were able to use green spaces to support their health and wellbeing, the study highlighted the barriers and inequalities that limit access for some people." For example:

- Some people are not able to spend time outside because of poor physical or mental health, limited mobility, lack of toilet facilities or worry about spreading or contracting coronavirus while visiting parks.
- For some others they had no access to outdoor spaces and public gardens, or parks were too distant for them to get to.

To increase better use of outdoor spaces, and in addition to the outdoor gym equipment mentioned above, Richmond has as part of the Friendly Parks for All project implemented recently:

- Designed 'Health and Wellbeing walks', and the new Weekly Stroll and Chat in Richmond, as well as actively promoting the usage of outdoor spaces, gardens and parks. The Council is working alongside Mind, a mental health charity, and Ruils, a local charity that supports independent living to deliver this initiative.
- The funding of the Green Gym initiative (https://www.tcv.org.uk/london/green-gym-london/richmond-green-gym), and
- Dose of Nature (https://www.doseofnature.org.uk/)

[160] See https://www.richmond.gov.uk/media/14125/friendly_parks_for_all_leaflet.pdf

[161] See https://www.richmond.gov.uk/media/18302/friendly_parks_for_all_update.pdf

[162] For more information about the Nature and Wellbeing Survey 2020 run by Let's Go Outside and Learn (LGOAL) CIC and it's reports please visit the website https://www.lgoal.org/nature-and-wellbeing/nature-and-wellbeing-survey-20/

[163] https://fingertips.phe.org.uk/search/outdoor#page/0/gid/1/pat/6/par/E12000007/ati/102/are/E09000032/cid/4/page-options/ovw-tdo-0

4.7 Limitations to the Data/Information

Richmond has reported a good level of physical activity (73.4%) based on the Active Lives Survey. However, the limitation to this data is that they are all estimates based on a very small sample size. For example, the England total sample size in 2015/2016 was 198,911 and for Richmond 508; whereas in November 2018/2019 is was 181,535 for England and Richmond it was 506 respondents. Despite no clear trends of over or underreporting via surveys in comparison to direct measures of PA[164], some argue that PA surveys could be influenced by over-reporting or conversely underestimating true physical activity levels. This could be, it is argued, due to ambiguity in terminology used, participant reporting of PA or variations in activity or misunderstanding of what each category of intensity actually means in practice.

In the absence of ward level specific data in terms of physical activity or inactivity and other related data we have had to take Active Lives averages and estimates combined with findings from a literature review and any sets of national and local guidance as identified above, to be incorporated into a future physical activity strategy that applies these assumptions/ best practice to Richmond.

4.8 Current Services

The Council's Culture commission a portfolio of contracted and licenced culture services across sports, leisure, arts and parks of which many can help people to become more active and improve their health and wellbeing such as in the latter Green Gym or Friendly Parks for All services. Richmond Cultural Partnership Strategy 2015-19 outlines what is available and how culture offer will develop. In 2021/22 the Council intends to renew this strategy for the next 5-years with a greater focus on improving opportunities for physical activity especially amongst those who are inactive and adversely impacted by health inequalities.

Public Health Commissioned Services

In August 2015, MyTime Active was awarded the contract to deliver all lifestyle services in Richmond (this included weight management, exercise on referral, walking away from diabetes, management of NHS health checks and health walks). This Lifestyle Prevention service was found not to be reaching those most in need and demand was low for their services. Therefore, after analysis the Council took the decision to decommissioned them in 2017 as part of a savings drive. The remaining resources was to be reallocated to a more sustainable and community-based model approach.

The decommissioning of this Lifestyle Prevention service contract left a distinct gap in lifestyle service provision for residents in Richmond. Upon the termination of the contract, the Council sought to develop a Culture Hub. This was revised in 2019 to an Integrated Culture Navigation and Social Prescribing service. The aim is to support eligible clients access community and voluntary sector activities or Council Culture (Sports, Arts, Leisure and Parks) commission or licenced services to increase adult physical activity levels and provide adult weight management. The purpose is to help people improve their health and wellbeing, and remain independent for as long as possible, preventing the development and progression of non-communicable diseases and long-term conditions. This service also helps support the local system innovate and build capacity to meet identified demand and opportunities via the Civic Pride Culture Grant fund.

Move It to Lose It

CMO say that 'physical activity expends energy, and therefore makes a valuable contribution to weight management by reducing adiposity.' Their evidence reviews suggested that greater than 150 minutes of physical activity, together with dietary restriction, may be required for weight loss. Move It to Lose It programme, managed by Brentford FCT

[164] Prince, S.A, Et al. A comparison of direct versus self-report measures for assessing physical activity in adults: a systematic review. Int J Behav Nutr Phys Act. [Online] 2008;5(56). Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2588639/ [Accessed 23 October 2020].

and funded by Richmond Council, supports people to get physically active and eat more healthily in order to help them reduce their weight and live a better, healthier life with greater wellbeing.

Move to lose it is an evidence-based 12-week programme for men (40-60 years of age) with a BMI 25+ in Richmond, enabling them to become more physically active both during the programme and afterwards, and combined with nutritional advice and social opportunities, lose weight/ reduce their BMI. The cost to participants has been subsidised by Richmond Council to keep the cost of participation low. Move It to Lose It is based on the Fit Fans model (see www.efltrust.com/projects/fitfans/).

Evidence suggests that the following components are associated with successful weight loss programmes for men:

- A combination of a weight reducing diet (not crash diets) with physical activity.
- Evidence shows that 5-10% weight loss can produce significant health benefits and even moderates increases in physical activity provide health and social benefits
- A group environment (some men may prefer men-only groups) with some individually tailored advice
- Use of behavioural change techniques such as goal-setting or self-monitoring, and perhaps the use of technology or props such as pedometers.
- Interventions in community settings, like sports clubs or workplaces, are more attractive to men than healthcare settings. Studies have found that programmes run in sports venues to which men felt a strong connection demonstrated low drop-out rates and high participant satisfaction. Men in these programmes also valued the sense of camaraderie and 'team spirit' which came from working in a supportive group environment with other similar men.

The programme has capacity for two groups of 15-20 men each. Participants are recruited through the NHS Health Checks, Social Prescribing and Brentford Football club's own football fan database and marketing channels, along with wider social media advertising using Councils channels, social media and other promotional channels that encourage self-referral.

The programme includes an element of nutrition and behavioural change techniques such as goal-setting or self-monitoring, and the use of technology, e.g. 'WhatsApp' group to encourage participation.

The programme is developed to encourage a sense of commitment and comradery where individuals or small teams win points for physical activities as well as for losing weight.

Following the end of the programme the participants are given an exit plan into local sport and leisure services to support continued physical activity and behaviour change.

Richmond Friendly Parks For All

The Friendly Parks for All project is managed through the London Borough of Richmond Parks Department as part of Richmond Council's continued commitment to improve Parks and Open Spaces. The project has been promoting nature-based health activities since 2017 and runs the project in parallel with other park-based initiatives such as provision of accessible parks through Friendly Parks for All project that is funded by the council to provide the following activities: Health and Wellbeing Walks (see below), Accessible Walk, Carers Walk, Parkrun, Green Gym (see below), and the provision of outdoor gym equipment in many parks in the borough.

The Friendly Parks for All project seeks to:

- Encourage more use of parks and open space in the borough
- Increase the number and diversity of people inspired by and enjoying them
- Work with partners to help improve the quality of everyone's experience of parks
- Better understand the issues, barriers and priorities of residents to help improve engagement in parks.

The Friendly Parks for All seeks to realise the benefits of nature-based activities and green care interventions that are backed by research that shows significant benefits to spending time in local parks. These benefits include:

- Physical health, mental wellbeing and life satisfaction are all enhanced through access to and use of parks and green spaces. Research shows that visiting parks can help address policy priorities such as reducing obesity, diabetes and heart disease and visits to green spaces support mental wellbeing and stress relief.
- Parks create important opportunities for social integration and a feeling of belonging. Richmond has over 400 hectares of open space across the borough which are free to access. Green infrastructure is a vital part of the way residents experience life in an urban environment.
- Parks provide opportunities for community engagement Many are part of the local community infrastructure and have Friends of groups which provide further opportunities to get involved such as community gardening or events.
- Parks and green spaces enable people to connect with nature, which in turn brings benefits in terms of wellbeing. Nature connectedness includes experiencing the natural world through the physical senses, learning about it, and engaging mindfully with nature by noticing and paying attention.
- Connectedness with nature is associated with feelings of belonging in a place. Feeling connected to the natural world helps people recover from stress and mental illness. Connections with nature also help to build a sense of place and community and foster a sense of gratitude and self-worth.

Accessible Wellbeing Walk

This is an accessible Wellbeing Walk organised by Ruils charity that was set up in 2019 in association with Walking for Health, Outdoor Learning, and Richmond Upon Thames Council.

The Wellbeing walk is open to all people, but specifically designed for those using wheelchairs or with limited mobility. Friends and Carers are encouraged to participate as well.

The idea is to provide a friendly, interesting and most important nature filled walk that wheelchair users and those using walking aids or with mobility problems can enjoy. The entire walk is on paths and has been fully risk assessed. Initial feedback has been very positive and Ruils looks forward in 2020/21 to growing the group.

Dose of Nature

In 2020 via the Civic Pride Grant fund the Council supported Dose of Nature (https://www.doseofnature.org.uk/). They are a local charity that provides a ten-week programme that introduces individuals, who have been referred by their GP or other mental health professional, to the mental health benefits of spending time in nature. It aims to inspire lifestyle changes that will have a significant and lasting impact on mental wellbeing. This is achieved through a combination of education, first-hand experience and practical and motivational support, led by a trained volunteer, Dose of Nature guide.

Participants will spend time in natural environments over the ten-week period, committing to a minimum of three visits a week for at least one hour on each occasion. Throughout the programme, the Guide and client meet in a natural setting on a weekly basis. During these visits, the Guide is there to explain the evidence supporting the mental health benefits of being in nature. They also demonstrate a variety of exercises and activities, encouraging the client to engage all their senses in order to gain maximum health benefits from their time in nature.

Green Gym

The Green Gym is funded by the Council by run by The Conservation Volunteers (TCV) charity. The Green Gym was originally designed as a way for Dr William Bird to refer patients to get outside and be active. Green Gyms are fun and free outdoor sessions where participants are guided in practical activities such as planting trees, sowing meadows and establishing wildlife ponds. Richmond Green Gym has been running for over four years and is one of four Green Gyms active in South West London. Two of those are community-led and are now managed independently. Volunteers carry out their tasks in two main sites: Mereway Nature Park and Meadway Orchard, with additional activities at Crane Park, Kneller Gardens, Craneford Way Playing Fields and Duke of Northumberland's riverside, all of them in the Twickenham area.

Unlike other conservation projects, with Green Gyms, the emphasis is very much on health and fitness. It seeks to enhance physical and mental wellbeing through increased contact with nature, the social benefits of group activity, and by helping people contribute something positive to their community. The Richmond Green Gym is held weekly, free and is open to anyone. Volunteers/ participants warm up and cool down, in preparation for a range of light to vigorous activities to suit all abilities. It was found that following weekly 3-hr participation in the Green Gym over 8-weeks, participants reported higher levels of well-being and lower levels of stress, anxiety and depression. Statistically significant differences and medium to large effects were observed. Participants collected saliva samples to measure the stress hormone cortisol.

5. Sexual Health and Contraception

5.1 Sexually transmitted Infections (STIs)

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"[165]. 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 services[166]. Sexual health services currently focus on treatment for sexual health transmitted infections, HIV and unplanned pregnancies as well as prevention.

Improving the sexual health of Richmond residents is a priority because it not only contributes to reducing inequalities in health across the life course but can deliver savings to the wider health and social care economy. Preventing STIs, HIV and unwanted pregnancies is cost effective and evidence of return on investment is strong. For every pound spent on sexual health services, for example, £86 could be saved on future public spending[167,168] and every pound spent on contraception saves £11 in reduced healthcare costs[169].

Nationally deprivation and socio-economic status are associated with poorer sexual health.

5.2 Sexual Health Indicators

National and local evidence clearly demonstrates that sexual health need varies according to factors such as age, gender, sexuality and ethnicity with inequalities in sexual health disproportionately affecting Black & Asian, Minority Ethnic (BAME) communities, those identifying as LGBTQ+, men who have sex with Men (MSM)

People identifying as LGBTQ+ can experience a greater degree of health inequalities, including sexual health[170]. 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.

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

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[165] WHO (2006) Defining sexual health: Report of a technical consultation on sexual health, 28-31 January 2002, Geneva:

[166] Department of Health (2001) The national strategy for sexual health and HIV.

[167] Lucas, S. (2013) Unprotected nation: the financial and economic impacts of restricted contraceptive and sexual health services. Family Planning Association.

[168] Lucas, S (2015) Unprotected Nation: An Update on the Financial and Economic Impacts of Restricted Contraceptive and Sexual Health Services. Family Planning Association.

[169] Kings Fund (2014) Health Select Committee Inquiry into public expenditure on health and social care: evidence submission

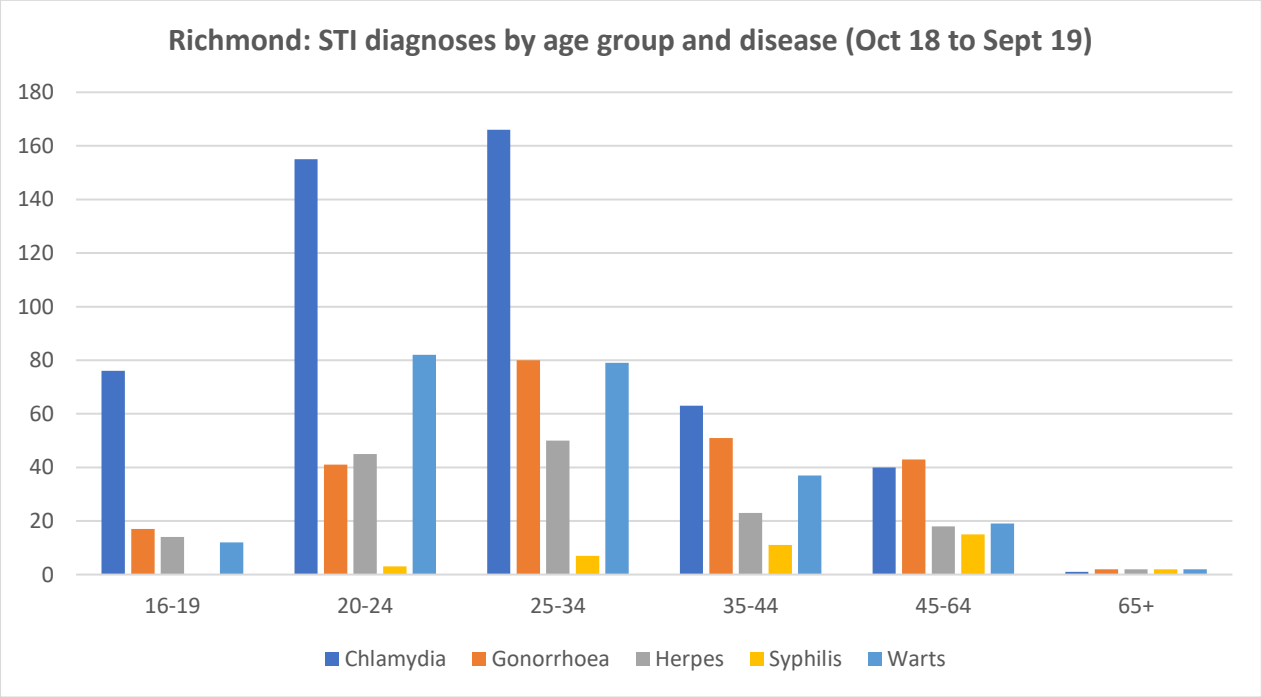
[170] Government Equalities Office (2018) LGBT Action plan 2018 – improving the lives of lesbian, gay, bisexual and transgender people

Deprivation can further exacerbate poor sexual and reproductive health with those living in deprived areas most at risk of unintended pregnancy[171]. Furthermore, unintended pregnancy can cause additional financial, housing and relationship pressures as well as having an impact on existing children[6,172].

In Richmond 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 largest number of abortions occurred in the over 35-year-old age group (144) in Richmond, which is almost six times the number in under 18 age group (24) and three times the 18-19 age group (47) (ONS, 2018). The percentage of conceptions leading to abortion has reduced by 50% since 2009. 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. This rate is at similar levels seen in 2012.

Long Acting reversable Contraception (LARC) is known to be the most common form of effective contraception. LARC usage (excluding injections) in Richmond has seen an increase in recent years which is encouraging (1793) and now stands at a rate of 44.1/1000 slightly lower than that seen in England (49.5) (2018). LARC prescribed through General Practice in Richmond (30.8/1000), however, has improved minimally since 2013, and is now at similar levels seen across England (29.2/1000). LARC prescribed through Specialist Sexual Health and Reproductive Services in the borough sees a steady increasing trend which is now at 16.3/1000 which remains lower than both London (24.5) and England averages (20.3). There remains scope for improving access to LARC through General Practice across the borough and this is reflected within the Richmond Sexual Health Story regarding primary care.

Figure 42: Sexually transmitted infections in Richmond by disease and age group, October 2018 – September 2019

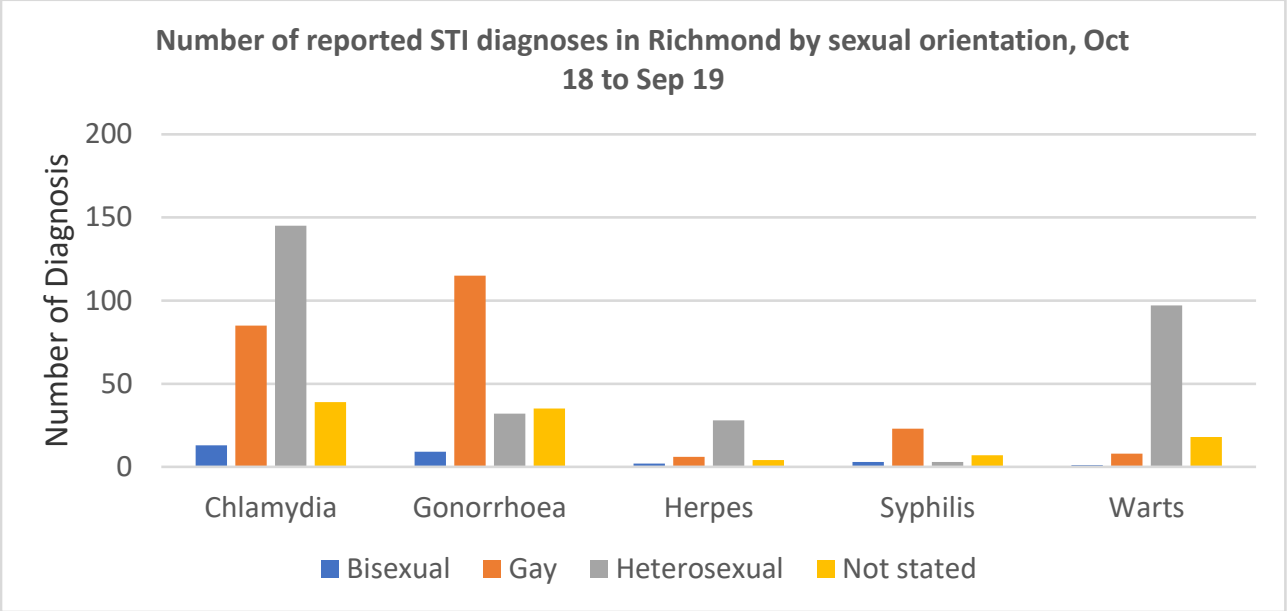


Source: GUMCAD Extracted Feb 2020

[171] Public Health England (2018) Health Matters: reproductive health and pregnancy planning.

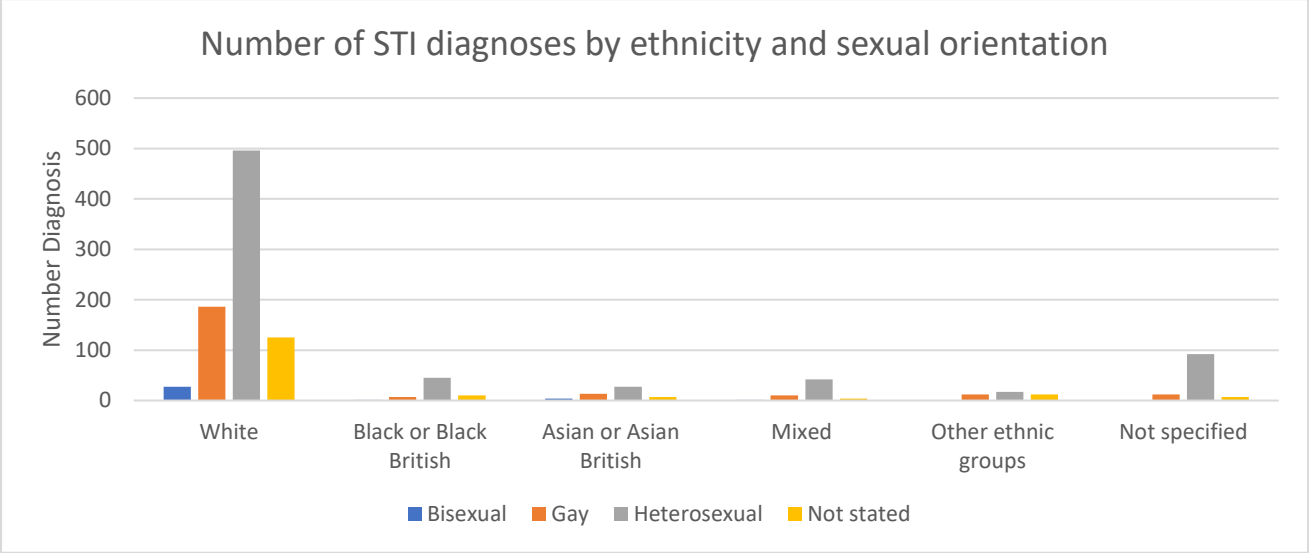
[172] Department of Health (2013) A framework for sexual health improvement in England:

Figure 43: Reported STI diagnoses in Richmond by sexual orientation, Oct 18 to Sep 19



Source: GUMCAD Extracted Feb 2020

Figure 44: Reported STI diagnoses in Richmond by ethnicity and sexual orientation, Oct 18 to Sep 19

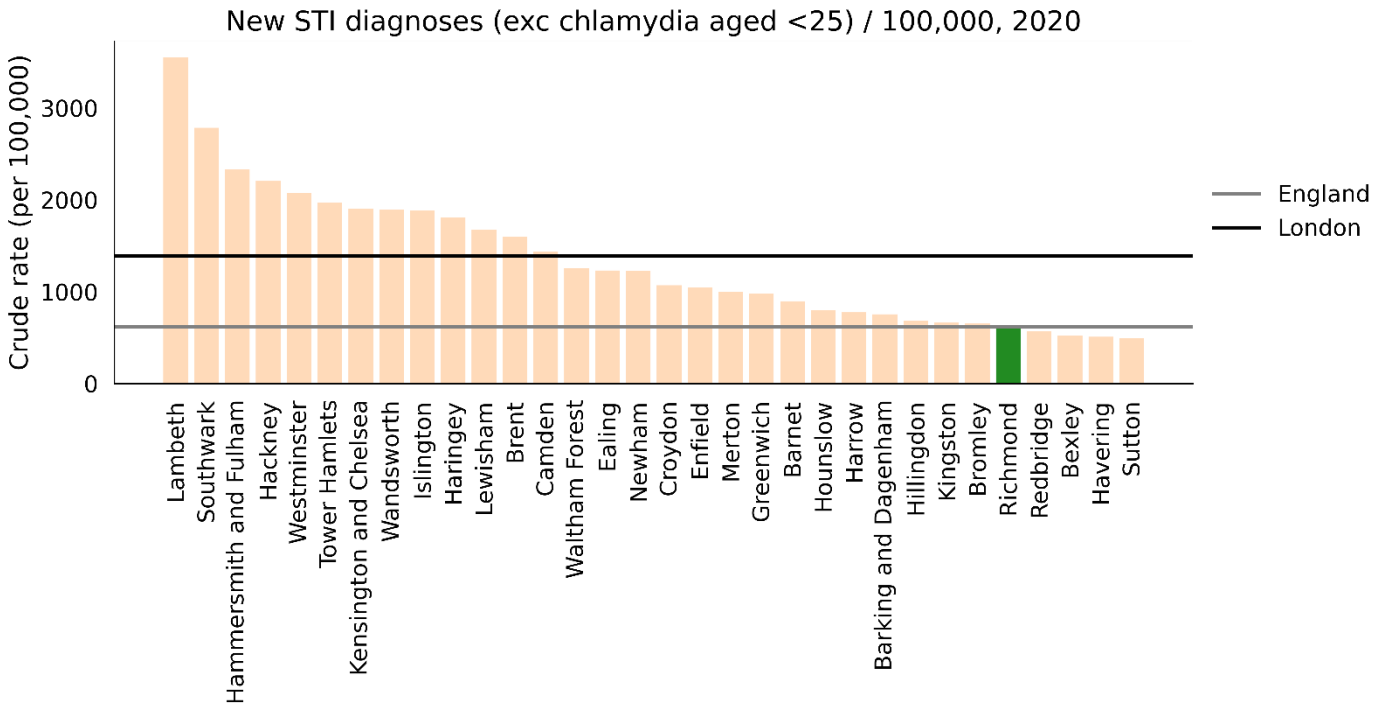


Source: GUMCAD Extracted Feb 2020

Level of Need

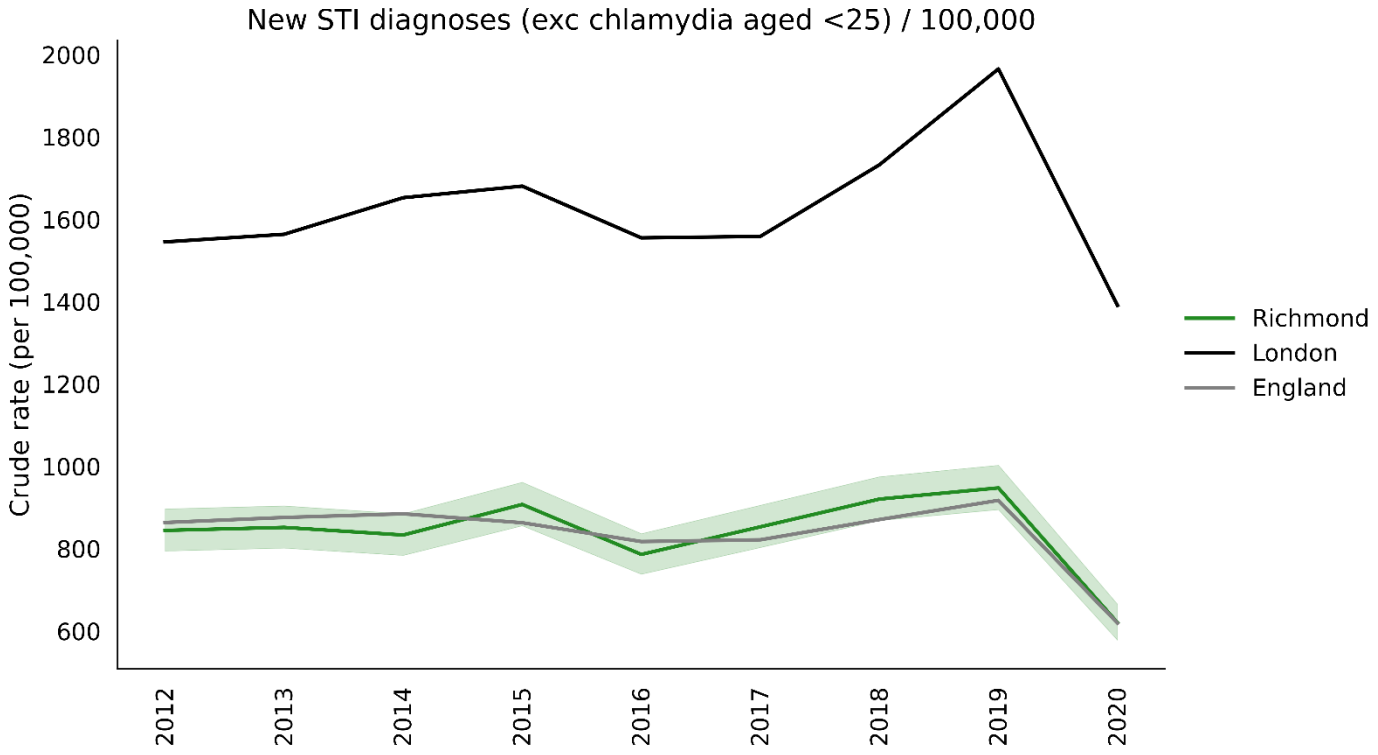
In 2020, Richmond's rate of newly diagnosed STIs (excluding chlamydia aged <25) was 620.0 per 100,000 (n=788), which is the 5th lowest rate in London (**Figure 45**), 0.2% higher than the England average and 55.4% lower than the London average. The latest Borough figure was also 26.5% lower than in 2012, in comparison with 28.3% decrease in England's rate in the equivalent time period (**Figure 46**).

Figure 45: New STI diagnoses (excluding chlamydia in under 25s) by local authority, 2020



Source: PHE Public Health Profiles

Figure 46: New STI diagnoses (excluding chlamydia in under 25s),2012–2020



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

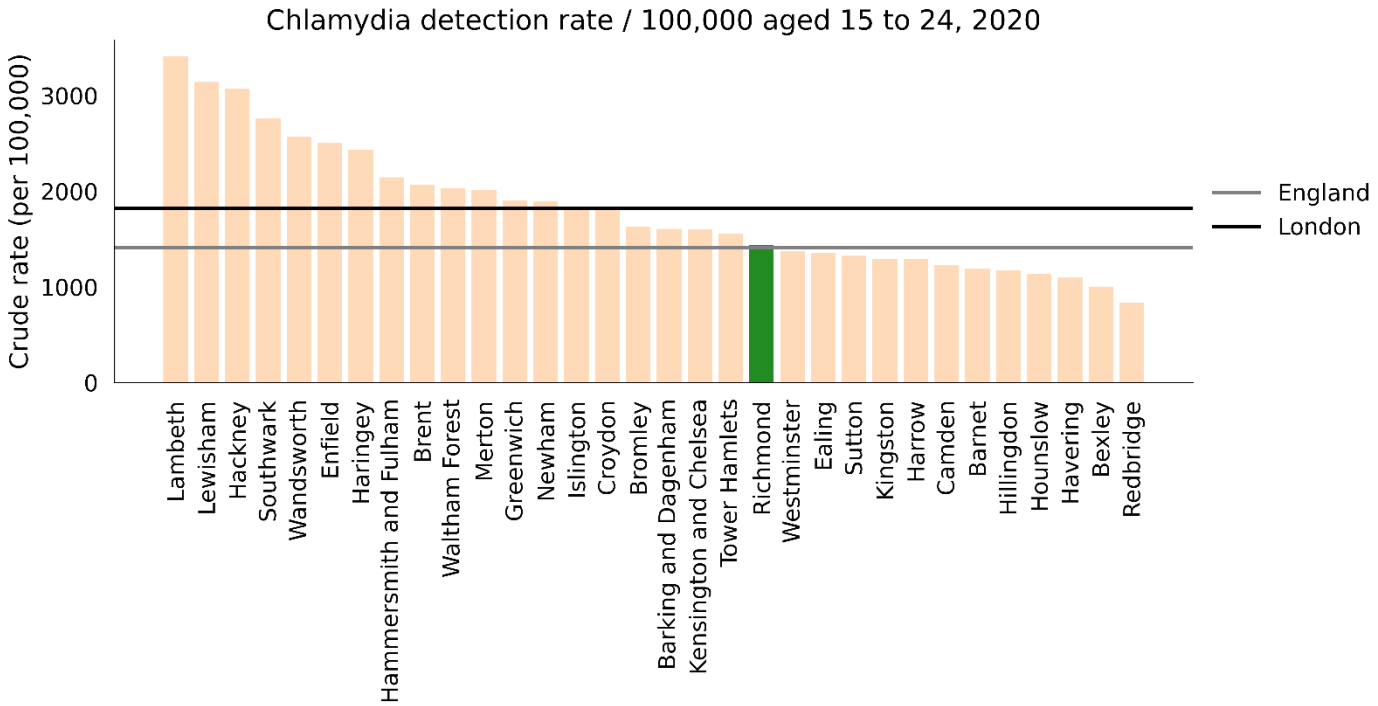
Genital Chlamydia Trachomatis is the most commonly reported bacterial STI in England. Infection is asymptomatic in at least 70% of women and 50% of men and as a result most infections remain undiagnosed[173]. Untreated chlamydia infection has significant health consequences. It is associated with considerable 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 Profiles (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.

Chlamydia Detection Rate

PHE recommends that Local Authorities work towards achieving a Chlamydia detection rate of above 2,300 per 100,000 population aged 15 to 24; the recommended level recommendation was set at a high level to encourage an increase in volume of screening and diagnoses. The PHE expectation is that increased level of screening is likely to result in a continued Chlamydia prevalence reduction.

In 2020, Richmond's chlamydia detection rate was 1435.7 per 100,000 (n=261), which is the 13th lowest rate in London (**Figure 47**), 1.9% higher than the England average and 21.1% lower than the London average. The latest Borough figure was also 5.9% higher than in 2012, in comparison with 32.8% decrease in England's rate in the equivalent time period (**Figure 48**).

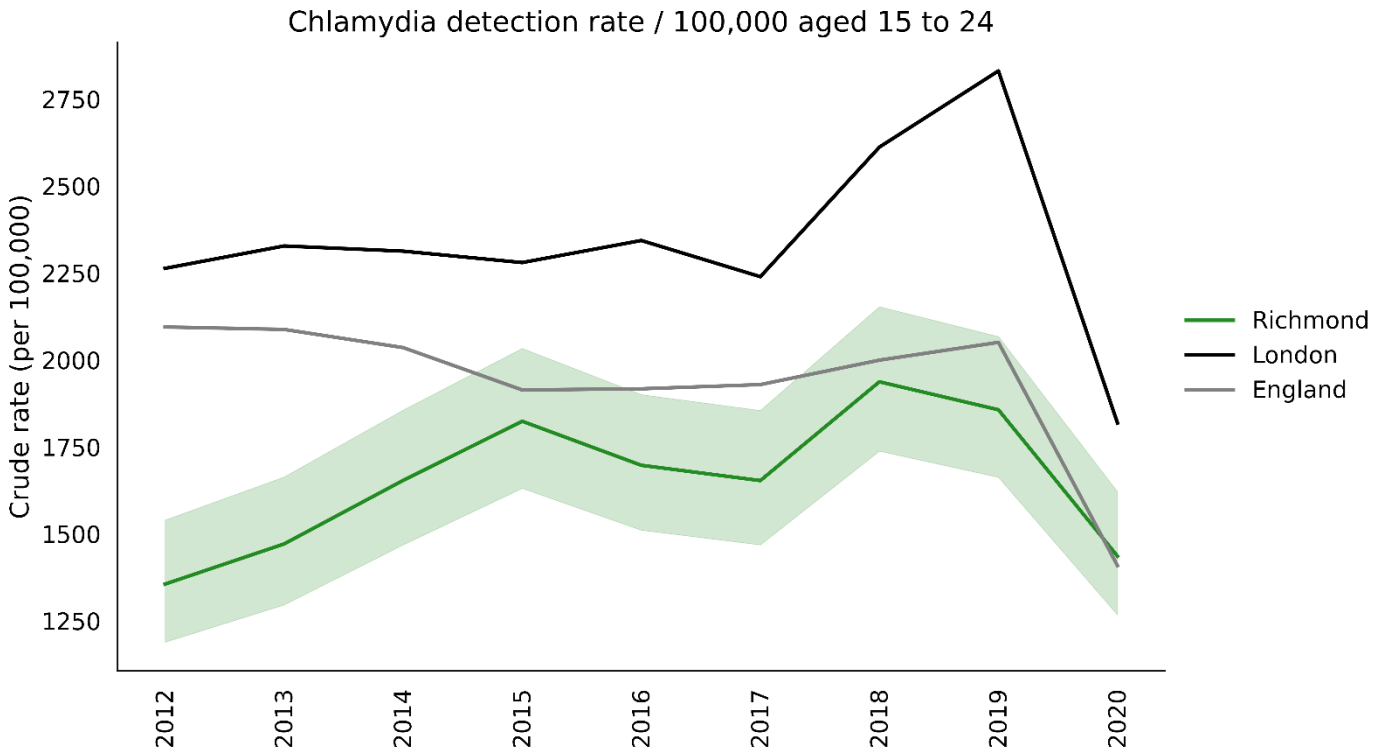
Figure 47: Chlamydia Detection Rate / 100,000 aged 15 to 24 by Local Authority, 2019



Source: PHE Public Health Profiles

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

Figure 48: Chlamydia Detection Rate / 100,000 Aged 15 to 24, 2012 - 2019



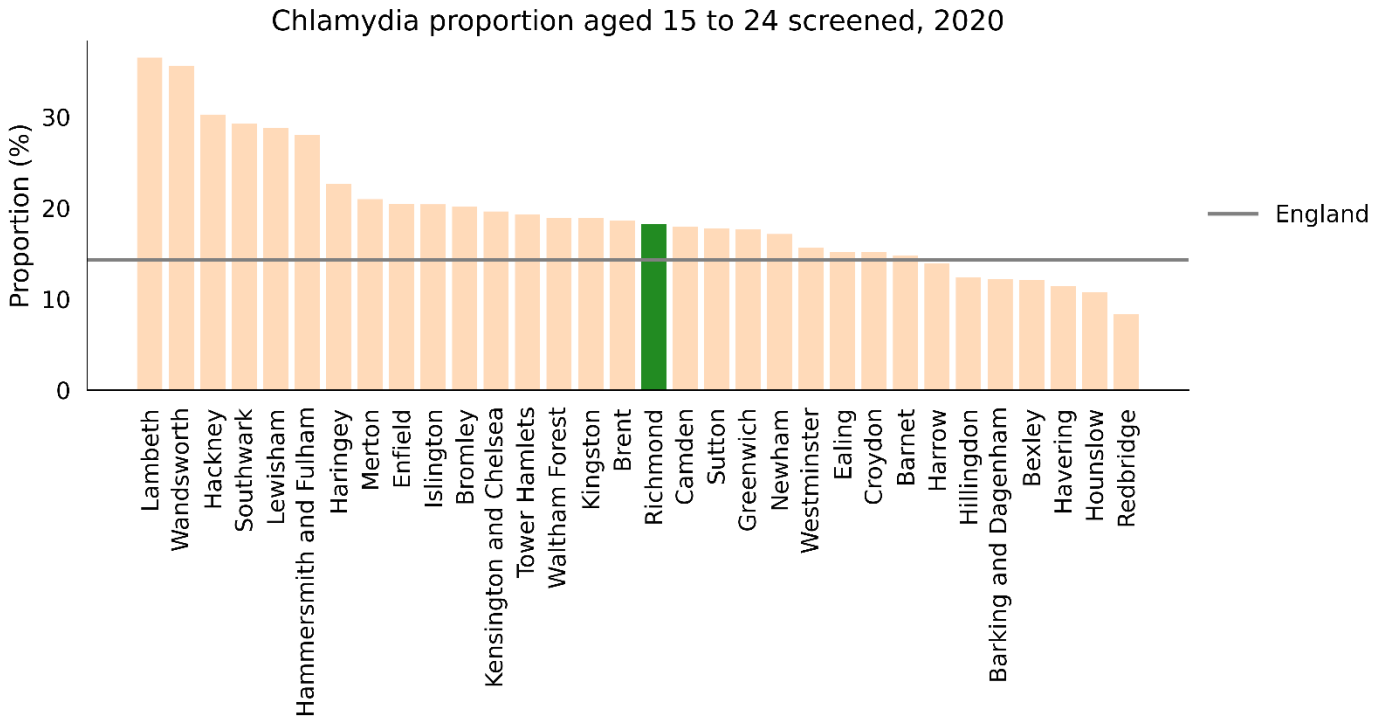
**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

Proportion of Young People Aged 15-24 Screened for Chlamydia

In 2020, Richmond's proportion of residents aged 15 to 24 screened for chlamydia was 18.2% (n=3311), which is the 16th lowest rate in London (**Figure 18**), 27.5% higher than the England average. The latest Borough figure for 2020 was also 25.9% lower than in 2012, in comparison with 47.0% decrease in England's rate in the equivalent time period (**Figure 19**).

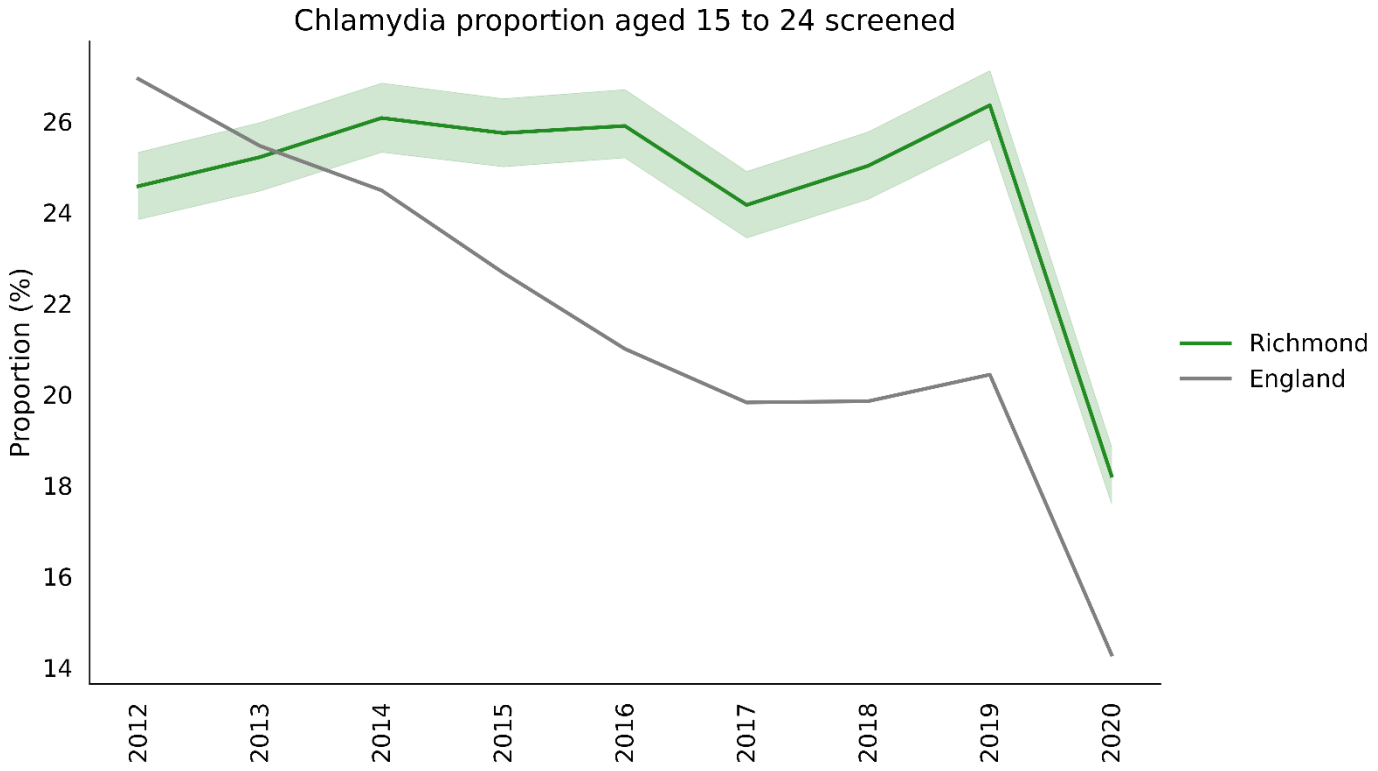
Data for London is available on PHOF website but not included in the fingertips data download section and therefore not presented on the charts.

Figure 18: Proportion of Population aged 15-24 Screened for Chlamydia by Local Authority, 2019



Source: PHE Public Health Profiles

Figure 19: Proportion of Population Aged 15-24 Screened for Chlamydia, 2012 - 2019

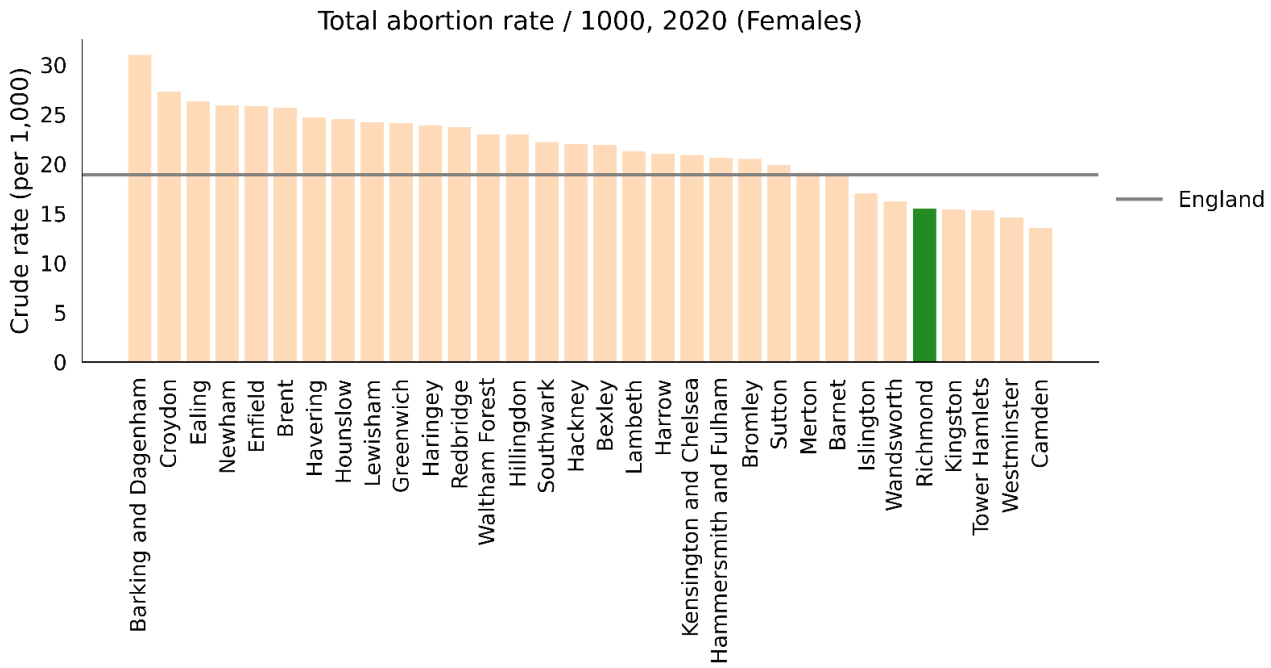


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

5.4 Abortion

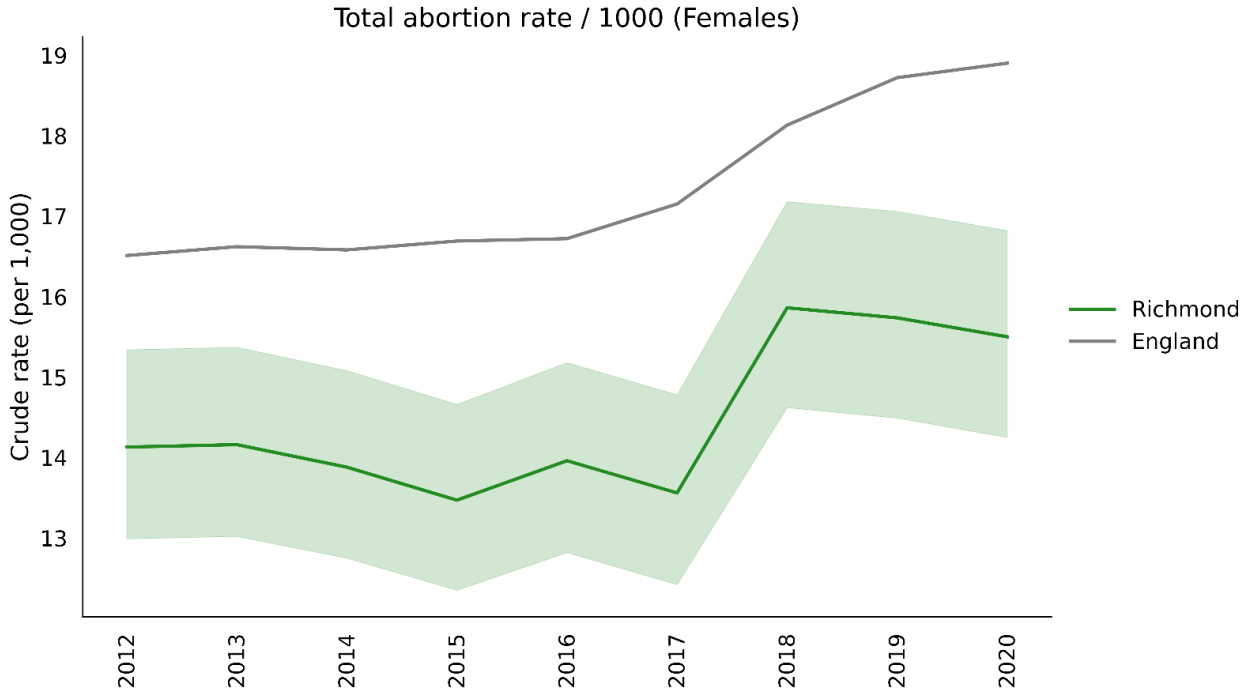
In 2020, Richmond's total abortion rate was 15.5 per 1,000 females (n=569), which is the 5th lowest rate in London (**Figure 49**), 18.0% lower than the England average. The latest Borough figure for 2020 was also 9.7% higher than in 2012, in comparison with 14.5% increase in England's rate in the equivalent time period (**Figure 50**).

Figure 49: Abortion rate by local authority, 2020



Source: PHE Public Health Profiles

Figure 50: Abortion rate, 2012–2020

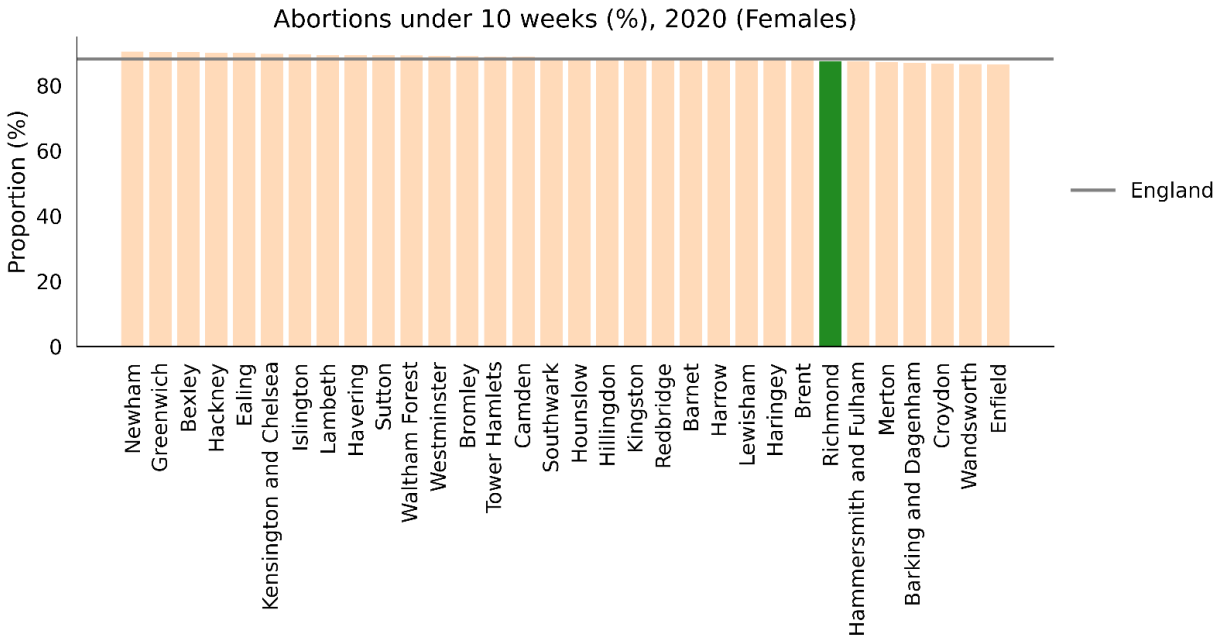


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

Abortions Under 10 Weeks

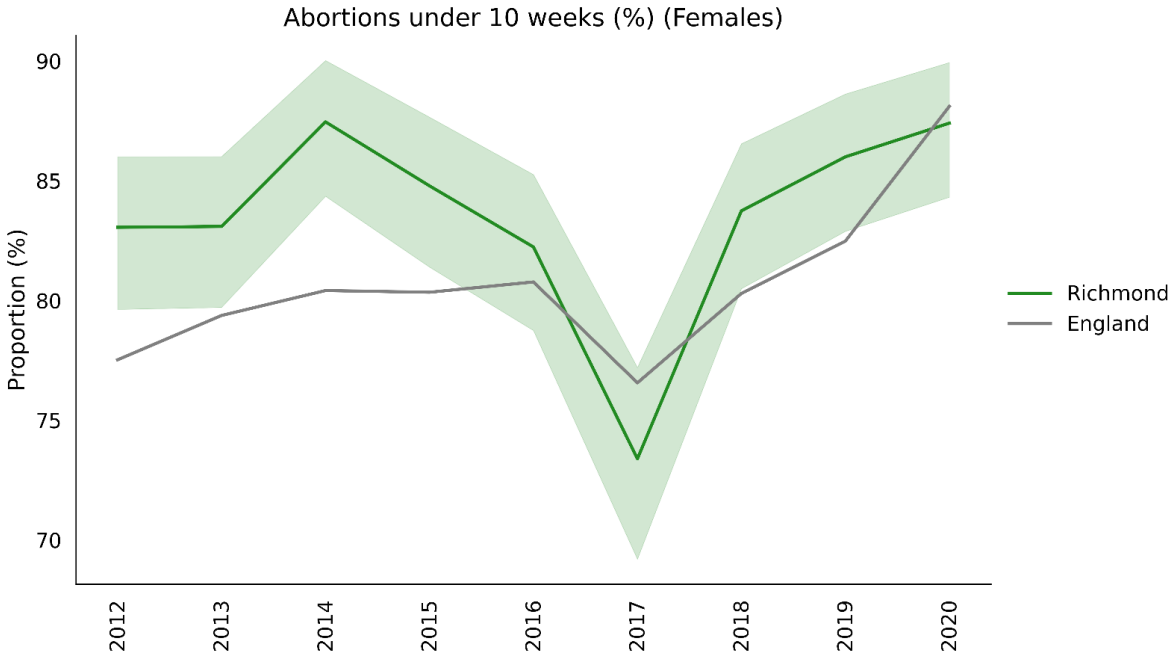
In 2020, Richmond's proportion of abortions under 10 weeks was 87.4% (n=471), which is the 7th lowest rate in London (**Figure 51**), 0.8% lower than the England average. The latest Borough figure for 2020 was also 5.2% higher than in 2012, in comparison with 13.6% increase in England's rate in the equivalent time period (**Figure 52**).

Figure 51: Proportion of abortions of foetuses that are under 10 weeks old by local authority, 2020



Source: PHE Public Health Profiles

Figure 52: Proportion of abortions of foetuses that are under 10 weeks old, 2012–2020

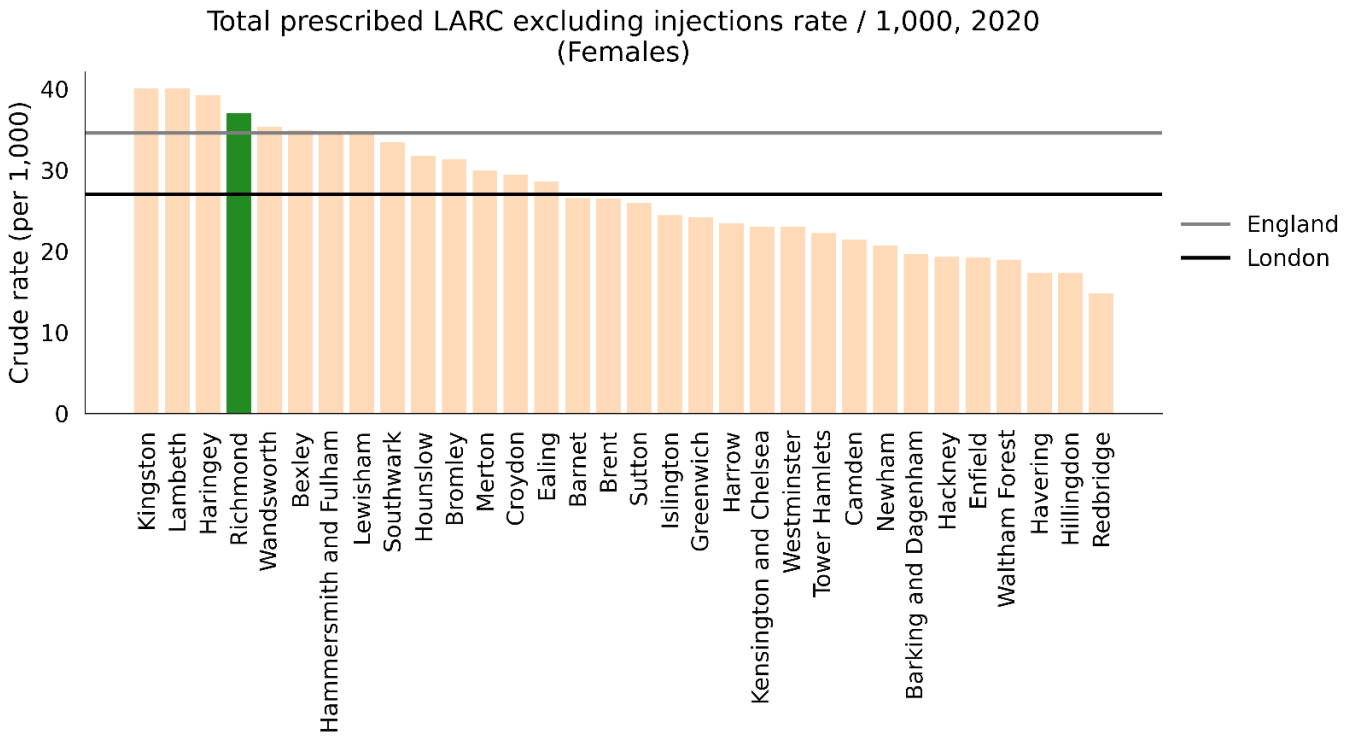


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

5.6 Contraception

Long Acting Reversable Contraception (LARC) is known to be the most common form of effective contraception[174]. LARC usage (excluding injections) in Richmond had seen an increase in recent years and in 2019 the rate exceeded 50 per 1,000 females. However COVID-19 pandemic resulted in a significant drop in LARC prescriptions. In 2020, Richmond's total prescribed LARC excluding injections rate was 37.0 per 1,000 (n=1360), which is the 4th highest rate in London (**Figure 53**), 7.2% higher than the England average and 37.1% higher than the London average. The latest Borough figure for 2020 was also 8.9% lower than in 2014, in comparison with 31.1% decrease in England's rate in the equivalent time period (**Figure 54**).

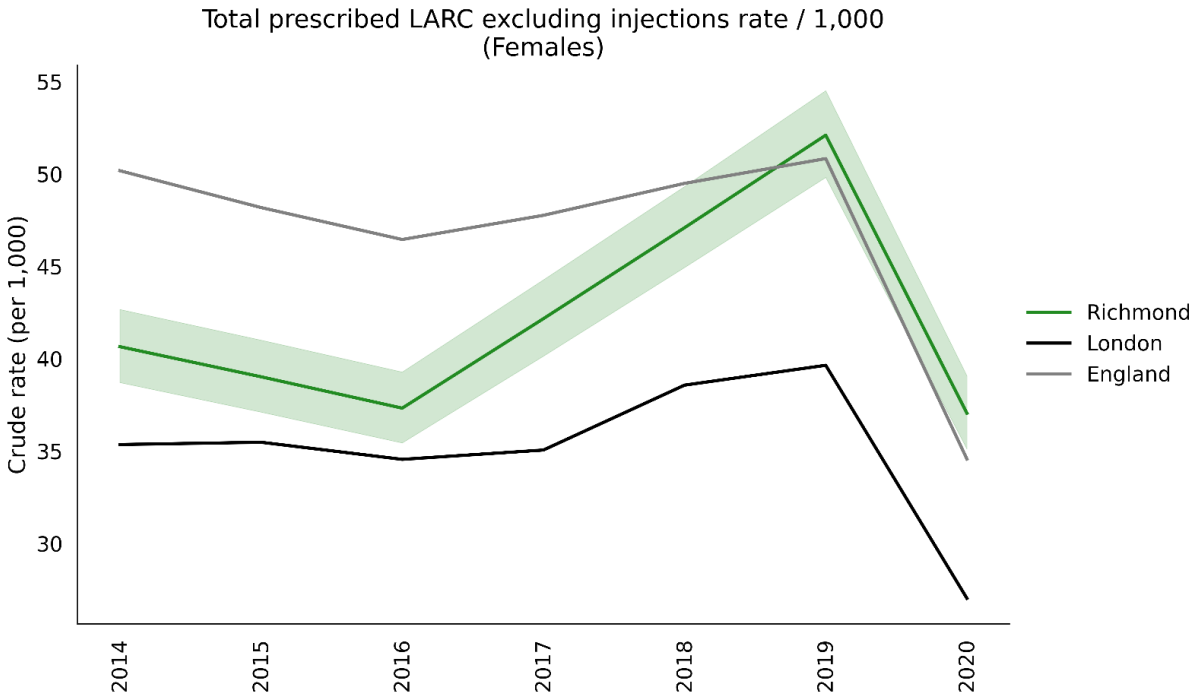
Figure 53: Total prescribed LARC excluding injections by local authority, 2020



Source: PHE [Public Health Profiles](#)

[174] National Institute for Health and Care Excellence (2005) Long acting reversible contraception. NICE guidelines CG30. October 2005.

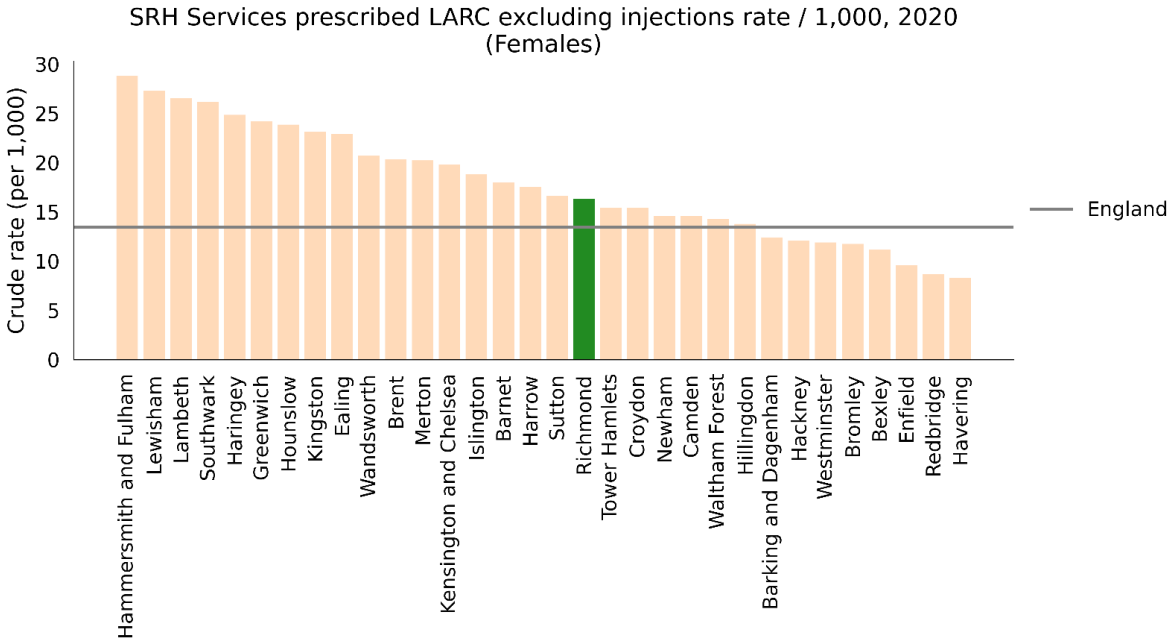
Figure 54: Total prescribed LARC excluding injections, 2014–2020



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

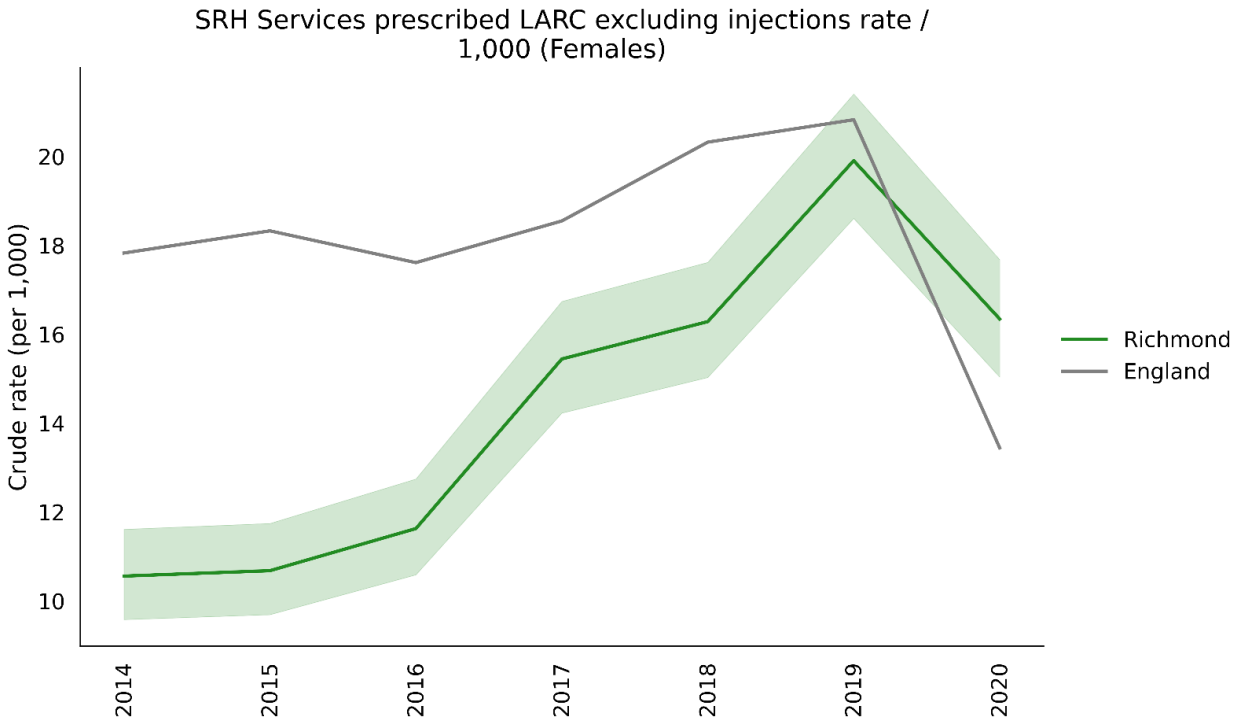
A high proportion of LARC in Richmond are prescribed by Sexual and Reproductive Health (SRH) services. In 2020, Richmond's rate of SRH prescribed LARC was 16.3 per 1,000 (n=600), which is the 15th lowest rate in London (**Figure 55**), 21.6% higher than the England average. The latest Borough figure for 2020 was also 54.8% higher than in 2014, in comparison with 24.6% decrease in England's rate in the equivalent time period (**Figure 56**).

Figure 55: SRH prescribed LARC excluding injections by local authority, 2020



Source: PHE Public Health Profiles

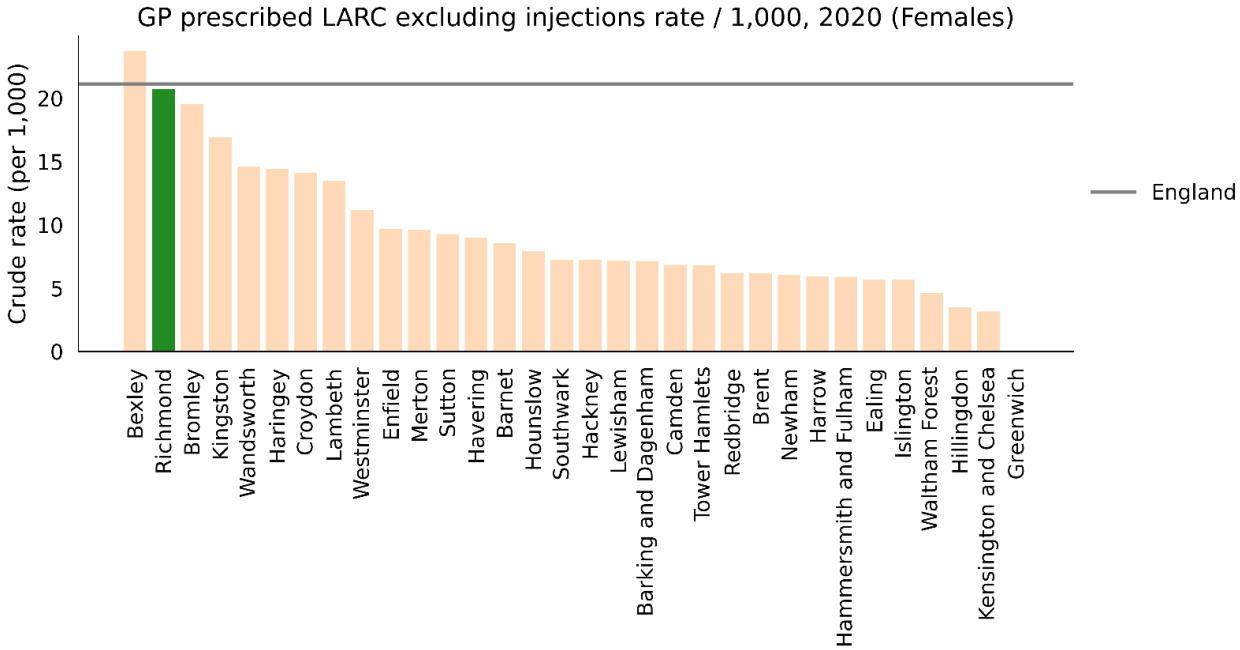
Figure 56: SRH prescribed LARC excluding injections, 2014–2020



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

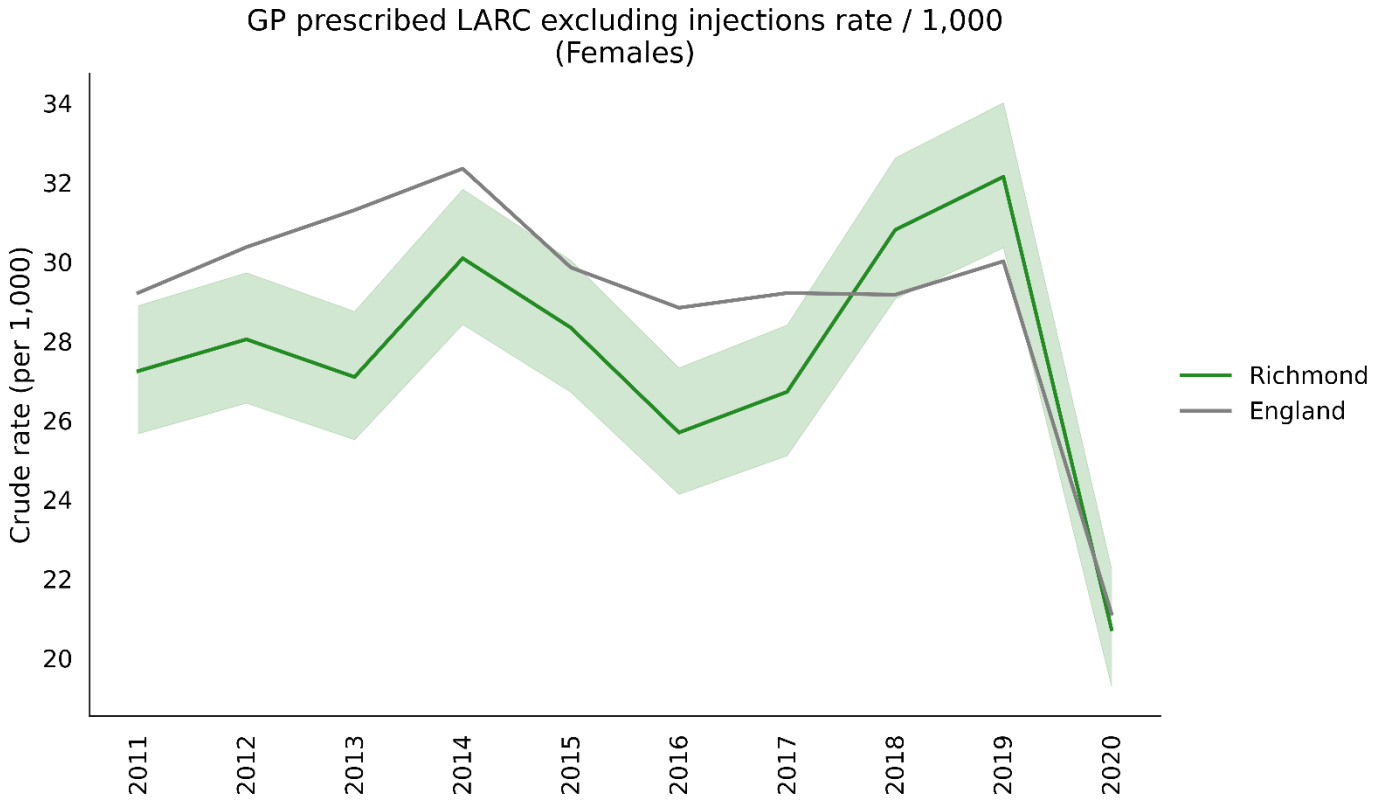
The highest proportion of LARC in Richmond are prescribed by GP practices. In 2020, Richmond's rate of GP prescribed LARC was 20.7 per 1,000 (n=761), which is the 2nd highest rate in London (**Figure 57**), 1.9% lower than the England average. The latest Borough figure for 2020 was also 23.9% lower than in 2011, in comparison with 27.7% decrease in England's rate in the equivalent time period (**Figure 58**).

Figure 57: GP prescribed LARC excluding injections by local authority, 2020



Source: PHE Public Health Profiles

Figure 58: GP prescribed LARC excluding injections, 2014–2020



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

5.7 Current Services

Key messages from Public Health England (2019) on the detection, management and treatment of STIs suggest that approaches to promoting positive sexual health and reducing STI and HIV prevalence should include:

- The provision of open-access sexual health services providing rapid treatment and partner notification can reduce the risk of STI complications and the spread of infection.
- Focussing prevention, diagnosis, treatment and care of STIs on the general population as well as targeted groups.
- Continue to address the continued increase in syphilis diagnosis.
- Consistent and correct use of condoms to reduce STIs through condom distribution schemes.
- Annual testing for HIV and STIs for those having sex without condoms or those with new or casual partners.
- Immunisation against hepatitis A and hepatitis B in MSM.

Richmond takes a joined-up approach to promoting positive sexual health and commissioning of sexual health services. Further detail is set out in the Richmond 2019 -2024 Sexual Health Strategy and corresponding Action Plan which set out the priorities and approaches for improving sexual health in the borough.

Sexual Health services are commissioned under the legal framework of the Health & Social Care Act 2012 and the subsequent transfer of public health responsibilities to local authorities in 2013. Local authorities therefore have a statutory duty to commission open access[175], demand-led sexual health services, including contraception and testing and treatment of STIs. Open access services are therefore often, high demand and high volume in nature. In the first

[175] Open access means that the local authority must pay for its residents wherever in the country they choose to access services.

three quarters of 2019/20 the service recorded a footfall of 27680 patients attending clinics. From October 2018 to end Sept 2019 a total of 715 patients with a recorded Richmond address attended the service, this compares to over 13,000 Wandsworth residents, suggesting that the hub service may not be as accessible for Richmond residents.

Integrated sexual health and contraception services are delivered by Sexual Health South West London (CLCH) across Wandsworth, Richmond and Merton. Services, commissioned in line with national guidance[176],[177] , offer a hub and spoke service model including both walk in and booked appointments. Dedicated clinics are also offered for young people, women, and men who are gay, bisexual and have sex with men. Clients contact the service via a single point of access phone number and are triaged accordingly.

Table 5 below summarises the services on offer through both the integrated sexual health provision and other voluntary and community sector services:

Table 5: Local sexual health services

Clinic/service	Services provided	Clients
Hub clinic (160 Falcon Road, Clapham Junction)	Testing for those with symptoms, STI treatment, complex contraception, psychosexual counselling, specialist gay men's clinic sessions, walk in sessions for young people.	Symptomatic patients All gay men
Spoke clinic The Medical Centre, Holly Road, Off The Record, Twickenham.	Testing for asymptomatic patients, treatment for chlamydia and gonorrhoea, contraception, advice, walk in session for YP.	Asymptomatic patients
Sexual health outreach	Sexual health prevention, engagement and signposting in the community (including HIV testing)	Groups at high risk of poor sexual health outcomes
HIV prevention and treatment	Care and support services for HIV London HIV Prevention Programme, including the 'Do It London' campaign and outreach programmes	people living with or at risk of HIV
Crossways Pregnancy Crisis Centre www.crosswaypregnancy.org.uk	Independent pregnancy centre offering free and confidential service to support women and their partners with: • an unintended pregnancy, post abortion, pregnancy loss through termination, miscarriage, ectopic pregnancy, preterm loss or stillbirth • by offering counselling and psychotherapy	Women and their partners

In Richmond there are 20 GP surgeries and 5 pharmacies contracted by the local authority to deliver sexual health services for residents. The services GP surgeries are contracted to deliver are Chlamydia screening and LARC. Due to

[176] Department of Health (2013) Commissioning Sexual Health services and interventions - Best practice guidance for local authorities: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/144184/Sexual_Health_best_practice_guidance_for_local_authorities_with_IRB.pdf

[177] Public Health England (2015) Making it work: A guide to whole system commissioning for sexual health, reproductive health and HIV: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408357/Making_it_work_revised_March_2015.pdf

historical contractual arrangements LARC is not offered universally across all GP surgeries. In 2015, a decision was made to decommission delivery of the NCSP in GP surgeries due to sustained low activity levels and outcomes. A single GP surgery (York Medical Practice) retained a contract to deliver Chlamydia screening due to its affiliation with St. Mary's University and access to a high number of eligible young people. Pharmacies are contracted to deliver Chlamydia screening, treatment and emergency contraception. Services are demand led. This means that service activity will not be consistent throughout the year and varies based on the needs of service users at any one time.

Public Health England recognises that community pharmacies are a health, social and a community asset having strong links to the diverse and vibrant communities they serve. Pharmacies play an important role in supporting people with sexual health, reproductive health and HIV. They are accessible to all especially deprived communities who may not access other conventional NHS services, helping to reduce health inequalities and the burden on existing providers.178. Likewise, given the ongoing challenges, there remains a need for GPs to be able to manage patients swiftly, pragmatically and appropriately[179.]

The Richmond Sexual Health Story shows that commissioning of sexual health services in GP surgeries and pharmacies is inconsistent and limited in geographical reach leaving gaps in provision in some areas of the borough. Among commissioned providers, activity varies with a small number inactive. Chlamydia screening is being delivered effectively and the Oral-EC conversation rate (the percentage of service users receiving an Oral-EC consultation who screen for Chlamydia) is good, indicating that pharmacies are implementing the MECC approach. LARC activity increased in relation to the previous year and not all GP surgeries delivered the recommended minimum number of insertions required within a given period. More women than men are accessing sexual health services in primary care and Black, Asian and Minority Ethnic (BAME) users of the Oral-EC service are slightly over-represented in comparison with the borough profile for age range.

The *Richmond Sexual Health Story* recommends that sexual health services should continue to be provided in GP surgeries and pharmacies. However, commissioning from 2020 should look to strengthen the accessibility of services and equity of access, so that they are commissioned more consistently with greater geographical reach, are situated in areas where they are most needed, where demand is highest and provided by those who have demonstrated that they are best able and motivated to deliver services to residents consistently.

Consideration should be given to the demographic characteristics of service users and the positive and negative drivers of the overrepresentation of particular groups. This includes differences in the demand and utilisation of services between male and female, specific age groups and BAME and White service users. Actions should be taken by commissioners to improve the data capture of LARC and Chlamydia treatment to support improvements in the monitoring of service user demographics.

Qualitative work should be undertaken to compliment and contextualise the quantitative findings. Methods such as feedback from providers, consultation with service user groups, and mystery shopping exercises would add further value to the story by incorporating the patient and practitioner voice.

Commissioners should regularly assess the continually changing landscape seeking opportunities that may arise for service development and contractual delivery following the maturation of Primary Care Networks (PCNs), the transformation of Clinical Commissioning Groups (CCGs) and implementation of the NHS Long-Term Plan. Financial resources and expertise should be optimised through cross-divisional spending agreements between public health and commissioning departments within the Directorate of Adult Social Services and Public Health (DASSPH) in the council and collaborative commissioning opportunities with other local authorities across South West London should be scoped.

[178] The Pharmacy Offer for Sexual Health, Reproductive Health and HIV A resource for commissioners and providers, Public Health England (2019), accessed online, available at The Pharmacy Offer for Sexual Health, Reproductive Health and HIV A resource for commissioners and providers

[179] Sexually Transmitted Infections in Primary Care 2013 (RCGP/BASHH) by Lazaro N. Available at www.rcgp.org and www.bashh.org/guidelines

In addition to the Integrated Sexual Heath Service Richmond also provides sexual health prevention and treatment through pharmacists in line with Public Health England Pharmacy offer[180], including emergency Hormonal Contraception (EHC), Chlamydia Screening and treatment.

Latest available data in respect of the above services demonstrates that by the end of quarter two (2019/20) Richmond had conducted over 1100 chlamydia screens an increase of 28% on the previous quarter but achieved a low positivity rate of 1.5%. Pharmacy screens rose from 27 screens and 7.4% positivity in quarter one to 46 screens and 11% positivity by the end of quarter two. Test access via freetestme also increased 15% from 143 (Q1) to 168 (Q2), however, this increase did not have a correlative impact on positivity and diagnosis was reduced from 7.7% to 5.4% in the same time period. Conversely, sexual health hub screening nearly doubled from 53 (Q1) to 90 (Q2) achieving a positivity rate of 5.6%.

E-service use also increased by 56 screens with 306 tests and 6.5% positivity for Q2 against 250 screens and 5.2% positivity during quarter two. Screening provided at sexual health clinics also rose from 688 in quarter one to 759 in quarter two with positivity rising at this site from 6.7% to 7.2%. E-service use from clinics rose from 1,308 screens and 4.5% positivity during quarter two to 1,362 tests and 5.2% positivity for quarter two. This provides good evidence to suggest that the channel shift form clinic to e-services is starting to take hold. This will in-turn reduce pressure on clinic times to allow more complex sexual health cases to be addressed within clinic. GP services did not undertake any screening activity in the second quarter which is consistent with historic activity. Further work is being done to increase chlamydia screening at the sexual health spoke clinic.

In addition to accessing services at the local ISH service, borough residents can also choose to access sexual health service anywhere in the country. Latest available service data shows that there has been good and improving access to the variety of sexual health services offered across the borough. 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[181].

[180] Public Health England (2019) The pharmacy offer for sexual health, reproductive health and HIV: a resource for commissioners and providers

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

6. Substance Misuse

The British Medical Association's Scientific Board describes substance misuse as the use of a substance for a purpose that is not consistent with legal or medical guidelines. The substance in this definition includes synthetic or natural psychoactive substances. Substance use disorders are not only a risk to the physical and mental health of the individual; they also place strain on the community and its residents because substance misuse is often the root cause behind crime and social issues.

Psychoactive or psychotropic substances when ingested, smoked or injected affect the mental health, mood, cognition, sensation and behaviour. There are legal (licit) substances such as alcohol, tobacco and prescription drugs, and illegal (illicit) substances such as cocaine, and heroin. Typically, substance misuse involves the consumption of alcohol and illegal drugs, however other risky behaviours include addiction to prescription drugs, painkillers, illegal highs and 'chemsex'. Except for alcohol, psychoactive substances are controlled by the Substance Misuse Act 1971.
Harm also extends into the family and wider communities through domestic abuse, crime and burden on services. Substance misuse is a priority for the government and the Richmond Council to prevent health and social issues and improve community safety.

Substance misuse data for young people is included in the Start Well JSNA chapter.

Alcohol Use Disorders

The NHS defines alcohol misuse as drinking "in a way that's harmful" or dependence on alcohol. And advises all adults not to regularly drink more than 14 units a week.

The country still responds to the 2012 National Alcohol Strategy which set out the following ambitions:

- A change in behaviour so that people think it is not acceptable to drink in ways that could cause harm to themselves or others
- A reduction in the amount of alcohol-fuelled violent crime
- A reduction in the number of adults drinking above the NHS guidelines
- A reduction in the number of people binge drinking
- A reduction in the number of alcohol related deaths

Drug Use Disorders

The World Health Organisation defines Substance Misuse as 'the harmful or hazardous use of psychoactive substances, which can lead to dependence syndrome'. In the UK, the most common illicit drug is cannabis, followed by cocaine and ecstasy. Other drugs include painkillers, prescription drugs, illegal highs and drugs used for chemsex.

Drug possession, supply and production comes under criminal law in the UK. Drugs are classified into A, B, C and Temporary Class Drugs; the maximum penalties for drug possession, supply and production are dependent on the class of drug.

There is a National Drug Strategy from 2017 which focuses on reducing demand by universal and targeted preventative action, restricting supply by tackling criminal activity and building recovery by improving treatment quality.

A new Richmond and Wandsworth Substance Misuse Strategy is currently under development and is likely to take a three-pillar approach to tackling drugs and alcohol with 'prevention and behaviour change, treatment and

enforcement and regulation'. Each pillar is based on the age group with Start Well, Live Well, Age Well. The substance misuse strategy development links into other local authority strategies, including Children and Young People Need's Assessment, Sexual Health Strategies, Homelessness, Community Safety, Corporate Plan.

6.1 Risk Factors Associated with Substance Misuse

Individual Risks

Substance use can increase the risk of short-term consequences to the individual with or without a substance use disorder. These include accidents and injury, violent and anti-social behaviour, unsafe sex, loss of personal possessions and alcohol poisoning which may result in unplanned time off work or education.

A substance use disorder can also have serious long-term health risks including increasing blood pressure, stroke, pancreatitis, liver disease, cancer, depression, dementia, sexual problems, mental / emotional health needs and infertility. Alcohol misuse is the biggest risk factor for death, poor health and disability among 15 – 49-year olds in the UK. There are also increased risks of social issues including family/relationship breakdown, unemployment, homelessness and legal or financial problems.

Risks to the Community

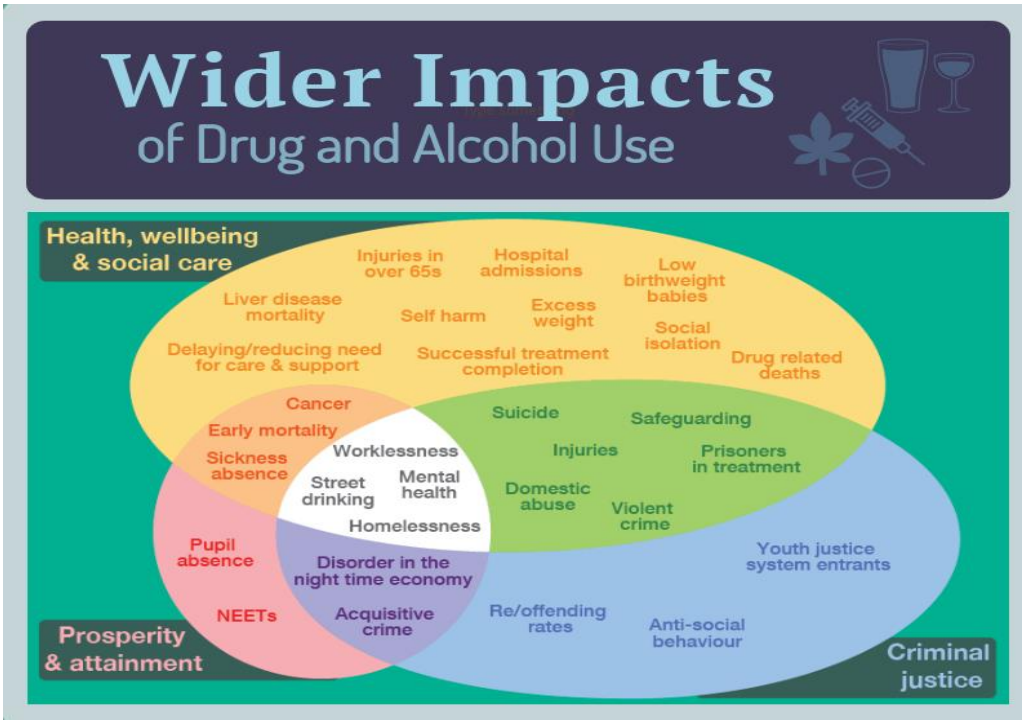
The prevalence of substance misuse disorders in an area can impact on community cohesion and safety. Around 1,000 assaults[182] were linked to alcohol in 2017/18. Generally, there is a strong correlation between those parts of the borough with a high density of alcohol licenses and areas with high rates of crime, assault and late-night violence. Over the last five years, the two LSOAs with the highest level of crime, assault, late night violence and violence with serious injury have been the same LSOAs which currently have the highest and second highest number of licensed premises – one in Richmond town centre, the other in Twickenham town centre.

Alcohol use is a major factor in domestic violence with two thirds of domestic abuse incidents known to the police involving one or more person "under the influence"[183]. People who try illicit drugs are more likely than others to commit other forms of law-breaking. It is estimated that a minority of this group, approximately 100,000 people in the UK, finance their drug use through crime. The majority of those who steal to buy drugs were involved in crime before their drug use became a problem for them.

There are other wider impacts of substance use as shown in **Figure 59**. These can be categorised under three domains: health, wellbeing and social care, prosperity and attainment and criminal justice. As the figure shows, while some impacts are individual to the domain, many impacts span over two or three domains. This highlights the intricate and extensive impact substance misuse has on communities.

[182] A crude application of 2013/14 Crime Survey for England and Wales (CSEW). The primary finding of the survey was that 53% of violence involving adults had links to alcohol and was most likely to involve male victims.
[183] Gilchrist et al. (2014) Roles of Alcohol in Intimate Partner Abuse. Alcohol Research UK. Available at https://alcoholchange.org.uk/publication/roles-of-alcohol-in-intimate-partner-abuse.

Figure 59: Wider impacts of drug and alcohol use



Source: PHE 2019

Barriers to Healthy Living

People with substance use disorders may have financial issues caused by their substance use that affect their ability to live in a healthy manner. For example, there are times when alcohol or drugs may be prioritised over food, clothing, health issues and housing. This can mean travel costs to attend health support or treatment services can be challenging.

Some people may live chaotic lifestyles, this may include lack of a long-term address or a distrust of professionals and persons in a position of authority (particularly when illegal drug use is involved) and timekeeping may be a problem. When someone is without a long-term address there may also be difficulties in getting a message to them, for example when arranging for an appointment.

People with substance use disorders may also face psychological barriers in accessing treatment and other services. This can be because of the stigma around substance use or from negative prior experience or low confidence/self-worth that can result in unwillingness to engage

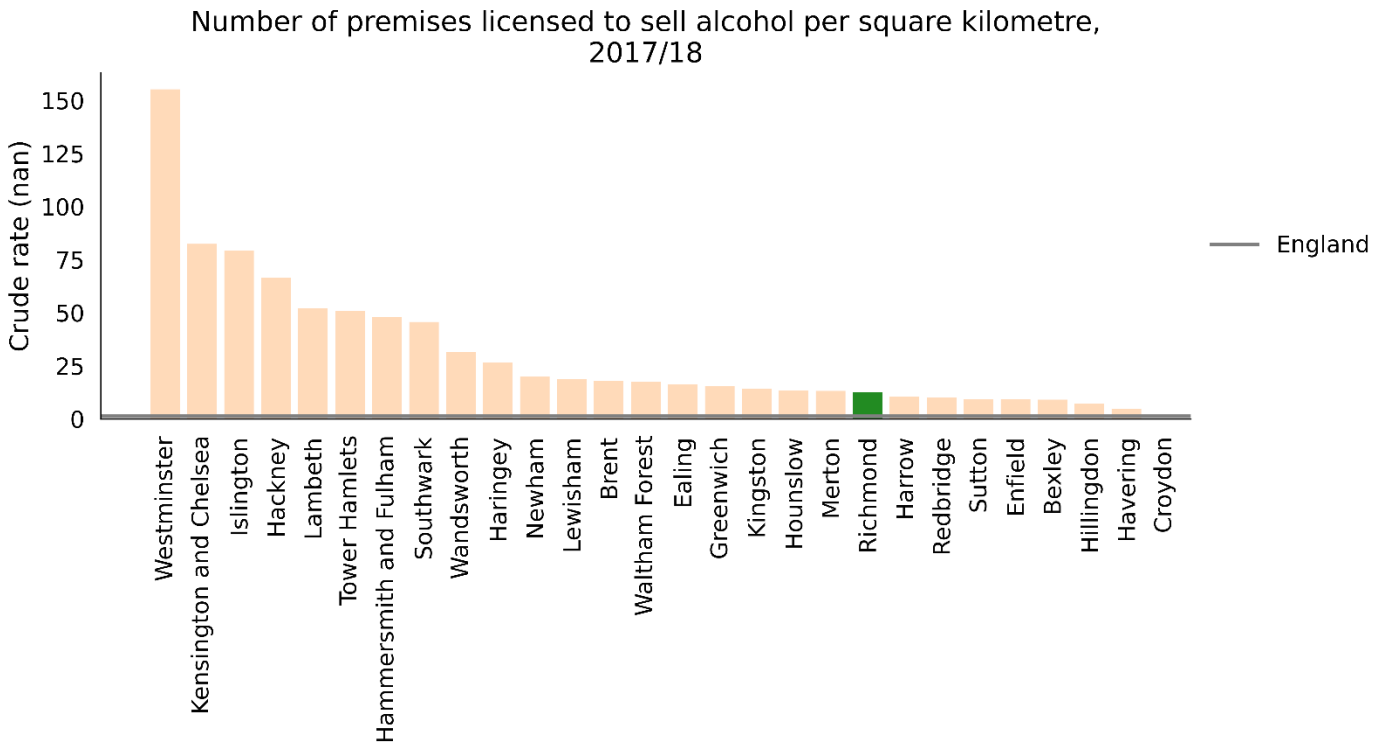
6.2 Population Prevalence and Need

Alcohol Use in Richmond

Premises Licensed to Sell Alcohol

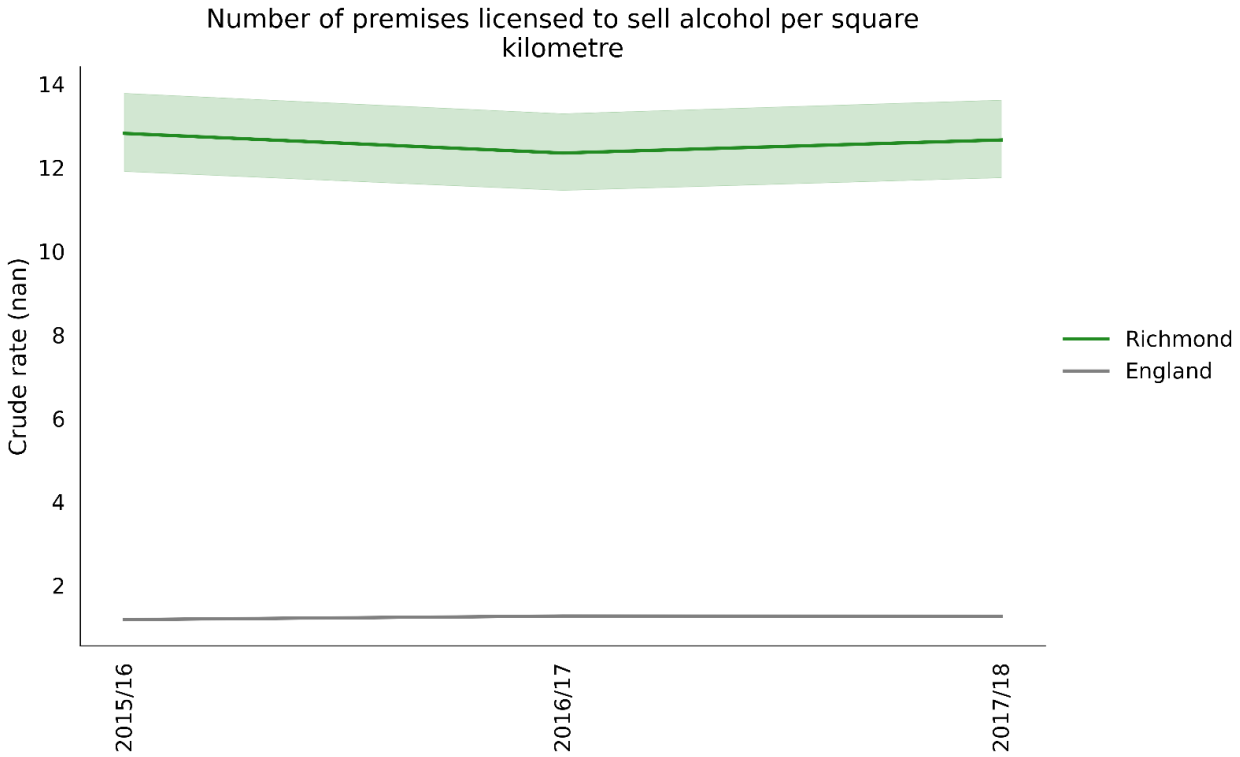
In 2017/18, Richmond's number of premises licensed to sell alcohol was 12.7 per square kilometre (n=727), which is the 8th lowest rate in London (**Figure 60**), 901.0% higher than the England average. The latest Borough figure for 2017/18 was also 1.2% lower than in 2015/16, in comparison with 6.7% increase in England's rate in the equivalent time period (**Figure 61**).

Figure 60: Number of premises licensed to sell alcohol per square kilometre by local authority, 2017/18



Source: PHE Public Health Profiles

Figure 61: Number of premises licensed to sell alcohol per square kilometre, 2015/16 – 2017/18

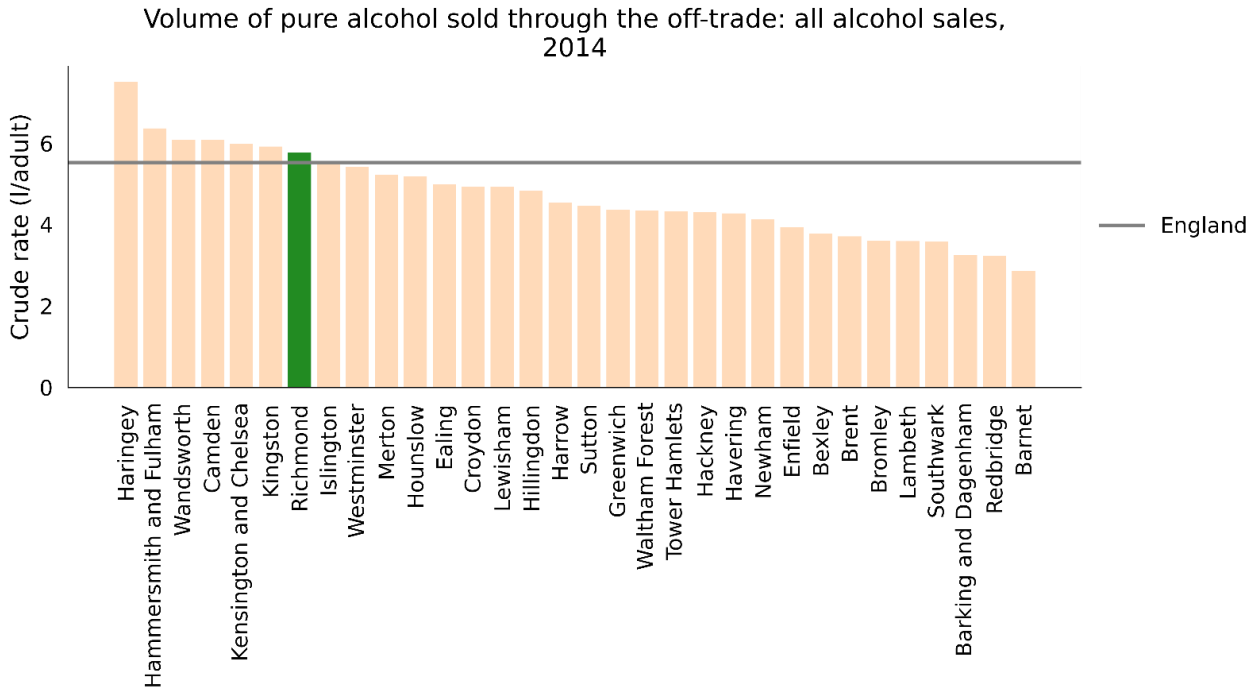


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

Volume of Alcohol Sales

In 2014, Richmond's volume of pure alcohol sold through the off-trade was 5.8 l/adult (864,329 litres), which is the 7th highest rate in London (**Figure 62**), 4.4% higher than the England average.

Figure 62: Volume of pure alcohol sales by local authority, 2014

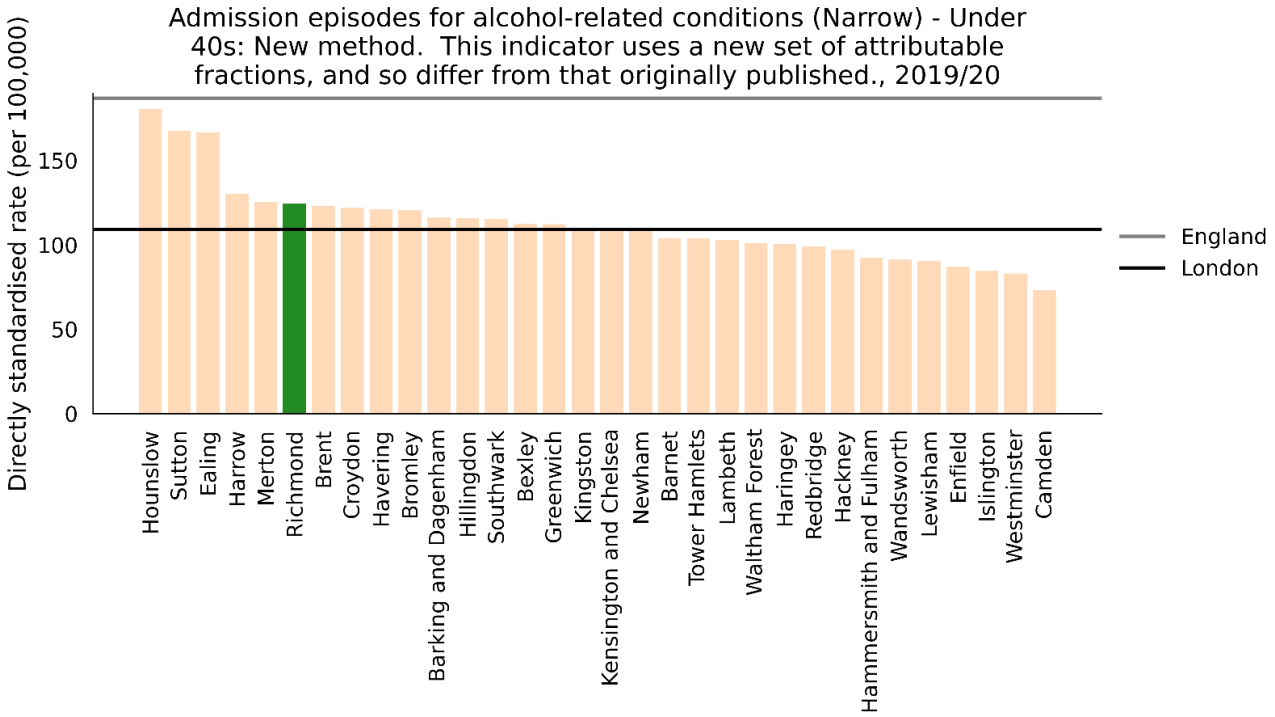


Source: PHE Public Health Profiles

Alcohol-Related Admissions

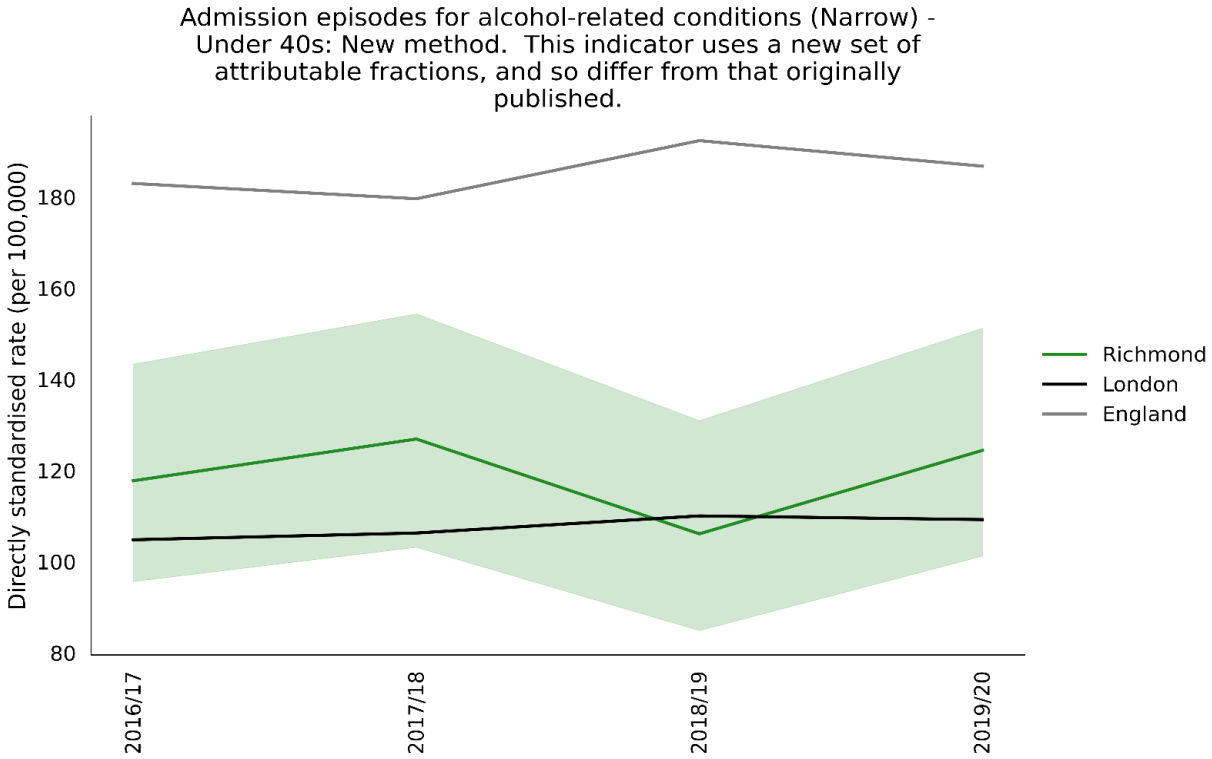
In 2019/20, Richmond's rate of admissions for alcohol-related conditions in residents aged under 40 was 124.4 per 100,000 (n=104), which is the 6th highest rate in London (**Figure 63**), 33.4% lower than the England average and 13.9% higher than the London average. The latest Borough figure for 2019/20 was also 5.7% higher than in 2016/17, in comparison with 2.1% increase in England's rate in the equivalent time period (**Figure 64**).

Figure 63: Hospital admissions for alcohol-related conditions in residents aged under 40 by local authority, 2019/20



Source: PHE Public Health Profiles

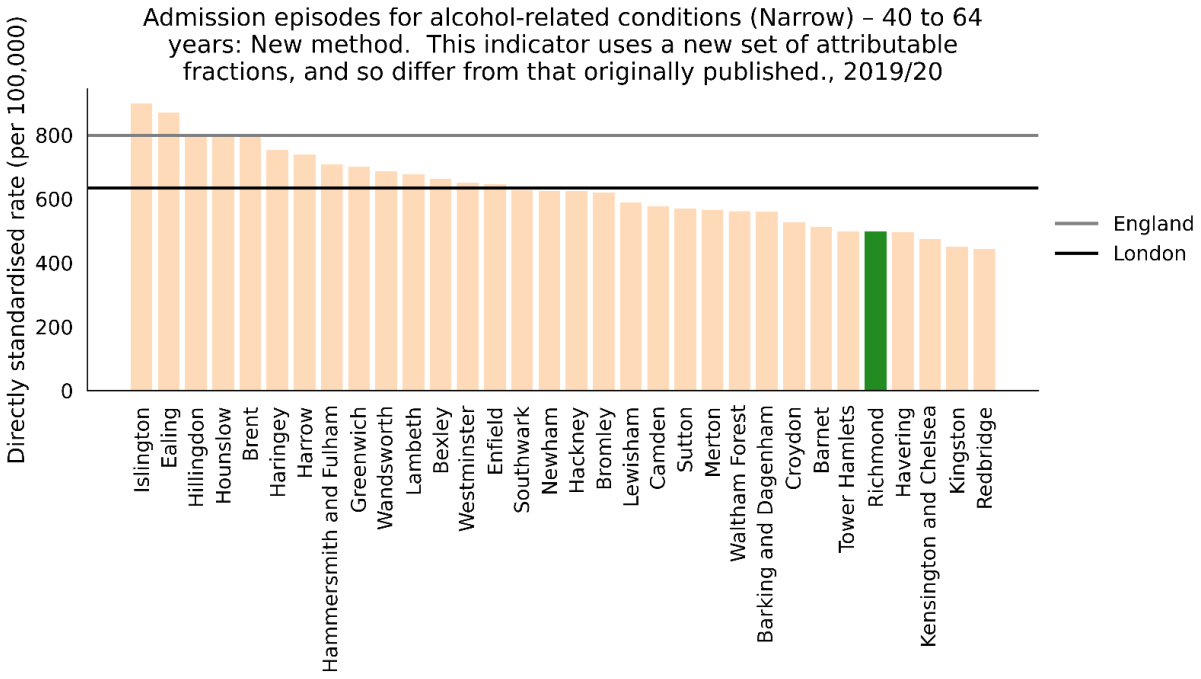
Figure 64: Hospital admissions for alcohol-related conditions in residents aged under 40, 2016/17 – 2019/20



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

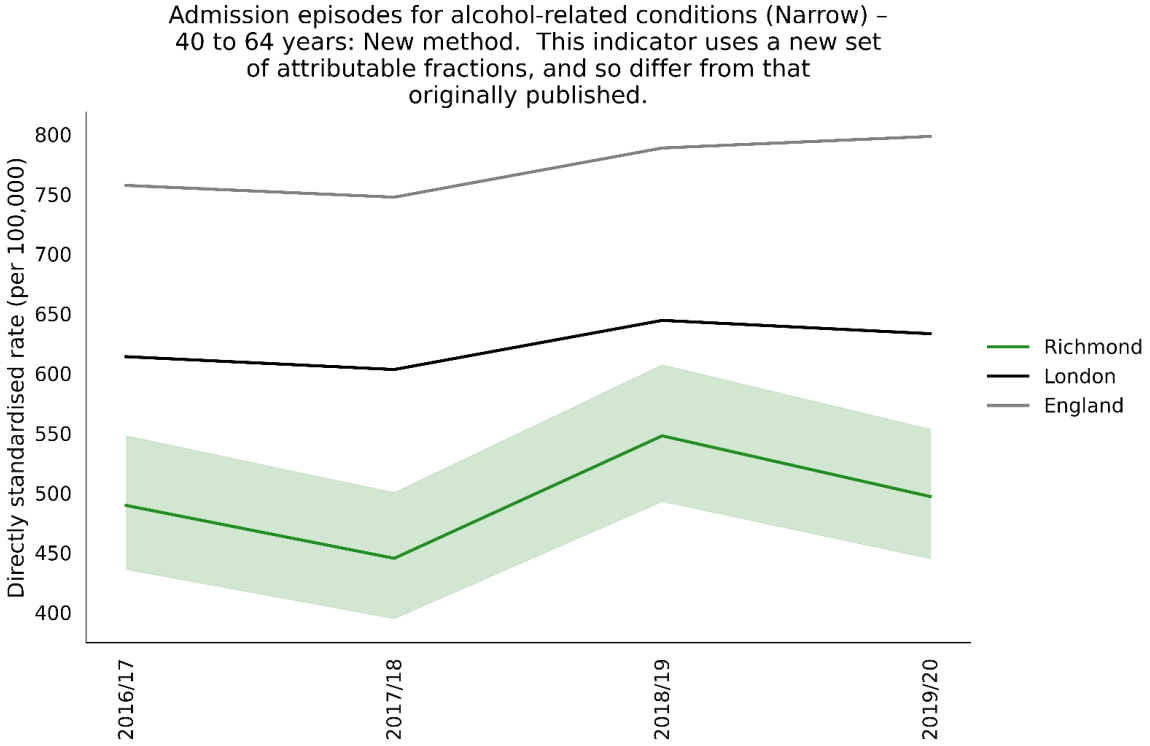
In 2019/20, Richmond's rate of admissions for alcohol-related conditions for residents aged 40 to 64 was 496.8 per 100,000 (n=339), which is the 5th lowest rate in London (**Figure 65**), 37.8% lower than the England average and 21.5% lower than the London average. The latest Borough figure was also 1.5% higher than in 2016/17, in comparison with 5.4% increase in England's rate in the equivalent time period (**Figure 66**).

Figure 65: Hospital admissions for alcohol-related conditions of residents aged 40–64 by local authority, 2019/20



Source: PHE Public Health Profiles

Figure 66: Hospital admissions for alcohol-related conditions of residents aged 40–64, 2016/17 – 2019/20

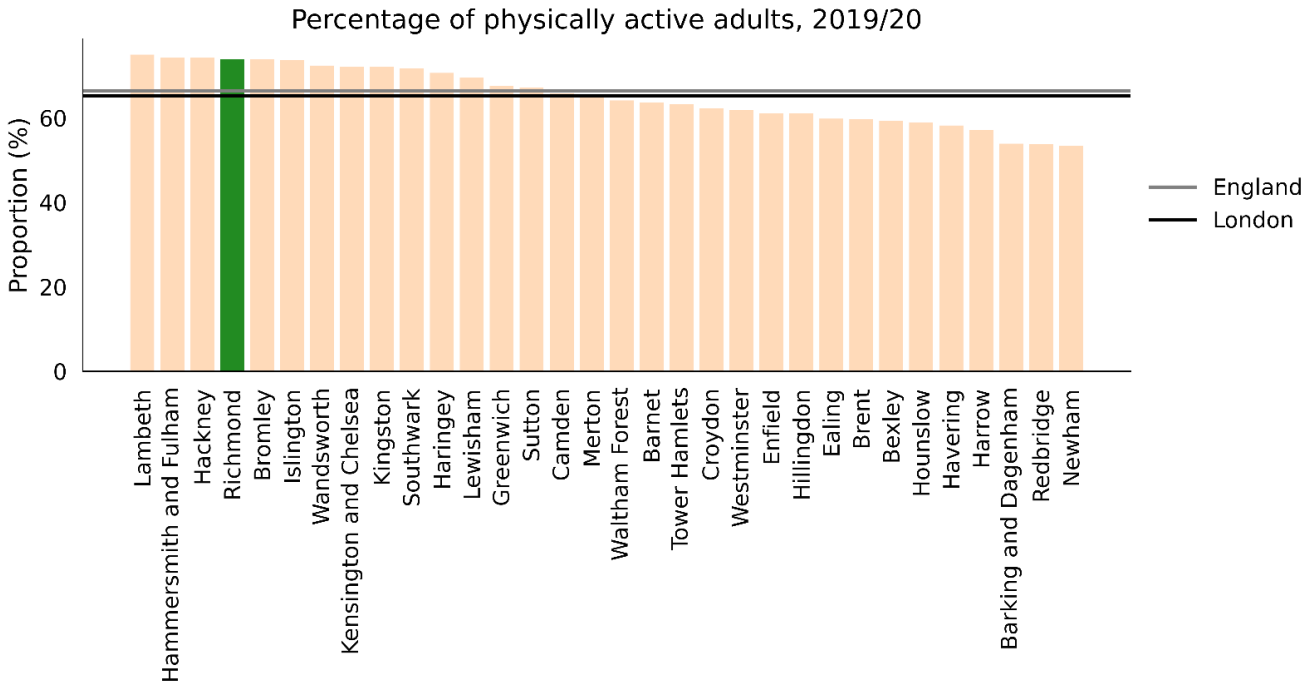


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

Alcohol-Related Road Traffic Accidents

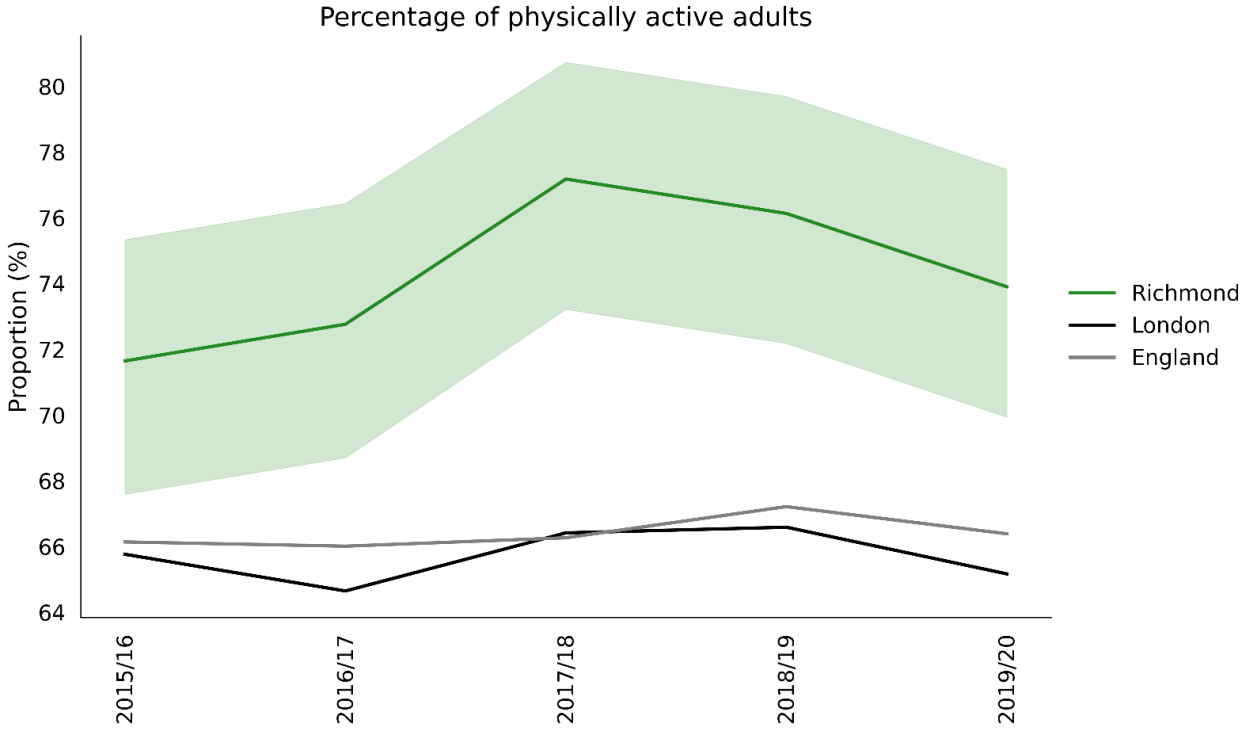
In 2014 - 16, Richmond's rate of alcohol-related road traffic accidents was 19.8 per 1,000 population (n=27), which is the 4th highest rate in London (**Figure 67**), 25.3% lower than the England average. The latest Borough figure for 2014 - 16 was also 82.4% higher than in 2010 - 12, in comparison with 4.6% decrease in England's rate in the equivalent time period (**Figure 68**).

Figure 67: Alcohol-related road traffic accidents by local authority, 2014–16



Source: PHE Public Health Profiles

Figure 68: Alcohol-related road traffic accidents by local authority, 2010–12 – 2014–16

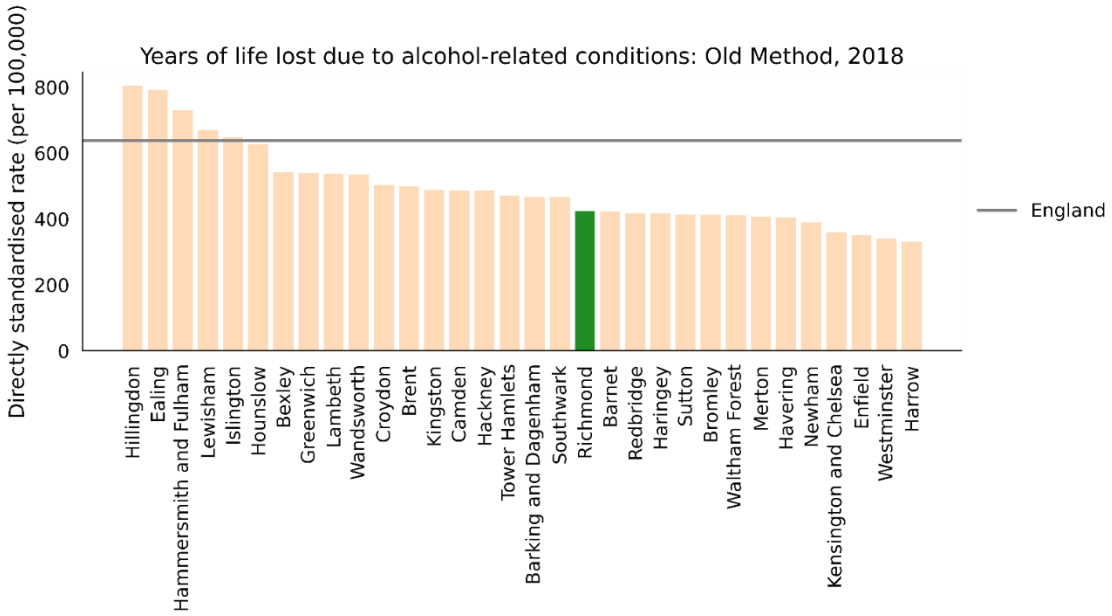


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Profiles

Years of Life Lost due to Alcohol-Related Conditions

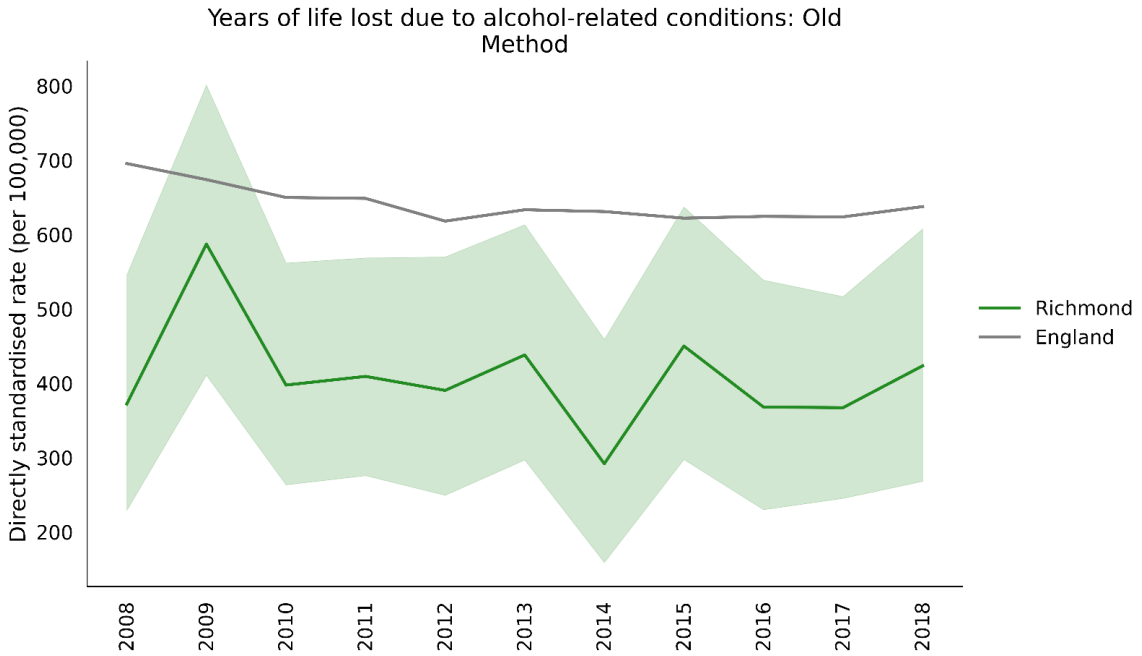
In 2018, Richmond's rate of years of life lost (YLL) due to alcohol-related conditions was 423.1 per 100,000 (n=742), which is the 14th lowest rate in London (**Figure 69**), 33.6% lower than the England average. The latest Borough figure for 2018 was also 13.8% higher than in 2008, in comparison with 8.3% decrease in England's rate in the equivalent time period (**Figure 70**). Unfortunately, no data beyond 2018 is available at the moment, this YLL indicator has been calculated using historic alcohol-attributable fractions for health conditions whilst the YLL data based on the current attributable fractions has not been published yet.

Figure 69: Years of life lost due to alcohol-related conditions by local authority, 2018



Source: PHE Public Health Profiles

Figure 70: Years of life lost due to alcohol-related conditions, 2008–2018



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

Drug and Alcohol Related Deaths

Nationally, the number of people in treatment has fallen, however the number of deaths related to the use of drugs and alcohol has risen consistently since 2012. Although London experiences significantly fewer than the rest of the country.

The ONS made the following observations on drug deaths in England and Wales from drug use in 2017:

- There were 3,756 deaths relating to drug poisoning in England and Wales in 2017, a rate of 66.1 deaths per 1 million population, and similar to levels seen in 2016
- Two-thirds of drug-related deaths were related to drug misuse, accounting for 43.7 deaths per 1 million in 2017
- Deaths involving cocaine and fentanyl continued to rise while deaths related to new psychoactive substances halved in 2017

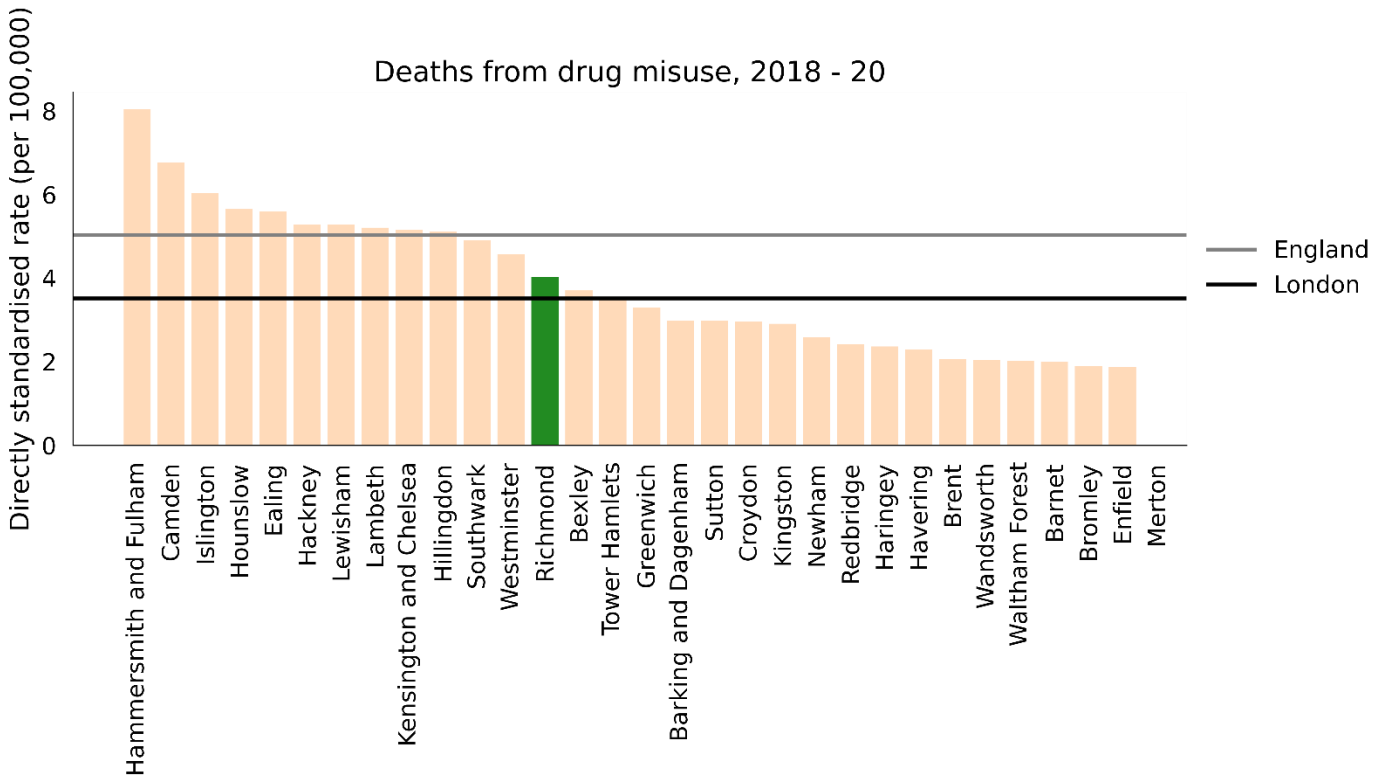
For alcohol, deaths are split between alcohol specific and alcohol related deaths. ONS commented on alcohol specific deaths for 2017 as follows:

- In 2017, there were 7,697 alcohol-specific deaths in the UK, an age-standardised rate of 12.2 deaths per 100,000 population, over double that of drug related deaths
- For the UK, alcohol-specific death rates have increased in recent years to similar rates observed in 2008 where they were at the highest recorded
- Since the beginning of the time series in 2001, rates of alcohol-specific deaths among males have been more than double those observed among females (16.8 and 8.0 deaths per 100,000 in 2017 respectively)
- In 2017, alcohol-specific death rates were highest among 55- to 59-year-old females and 60- to 64-year-old males

Deaths from Drug Misuse

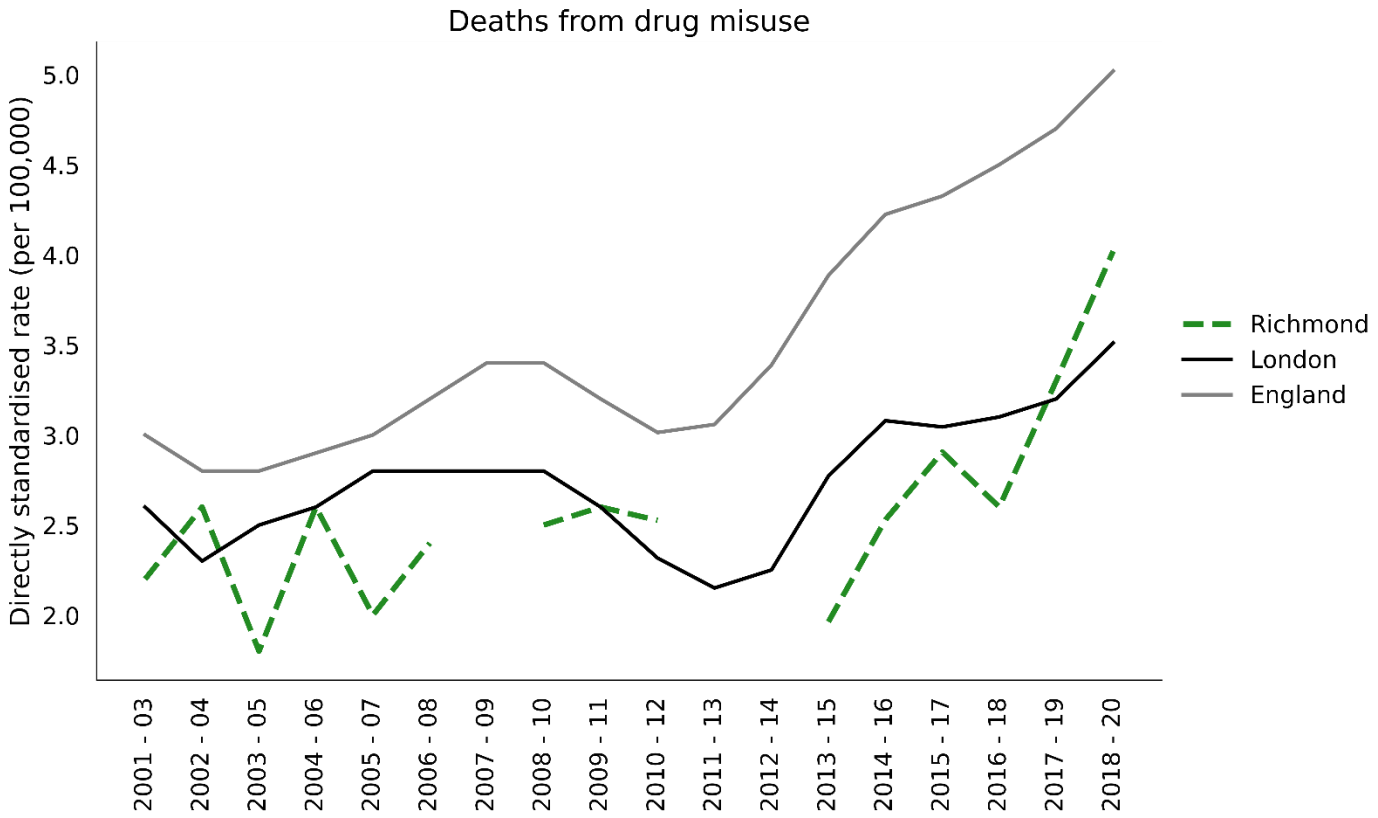
In 2018 - 20, Richmond's rate was 4.0 per 100,000 (n=22), which is the 15th highest rate in London (), 19.9% lower than the England average and 14.5% higher than the London average. The latest Borough figure for 2018 - 20 was also 82.7% higher than in 2001 - 03, in comparison with 67.3% increase in England's rate in the equivalent time period (). For some years the number of deaths was small and had to be suppressed with no Richmond data on rates of death from drug misuse being published.

Figure 71: Deaths from drug misuse by local authority, 2018–20



Source: PHE [Public Health Profiles]

Figure 72: Deaths from drug misuse, 2001–2020

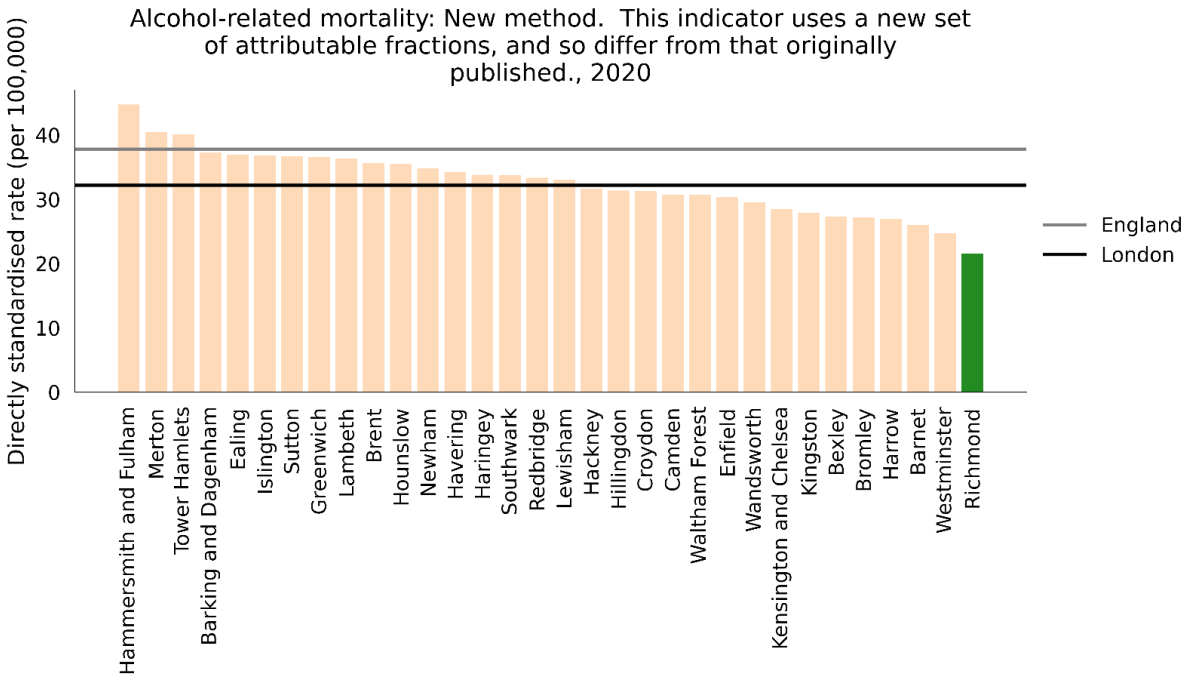


Source: PHE [Public Health Profiles]

Alcohol-related Mortality

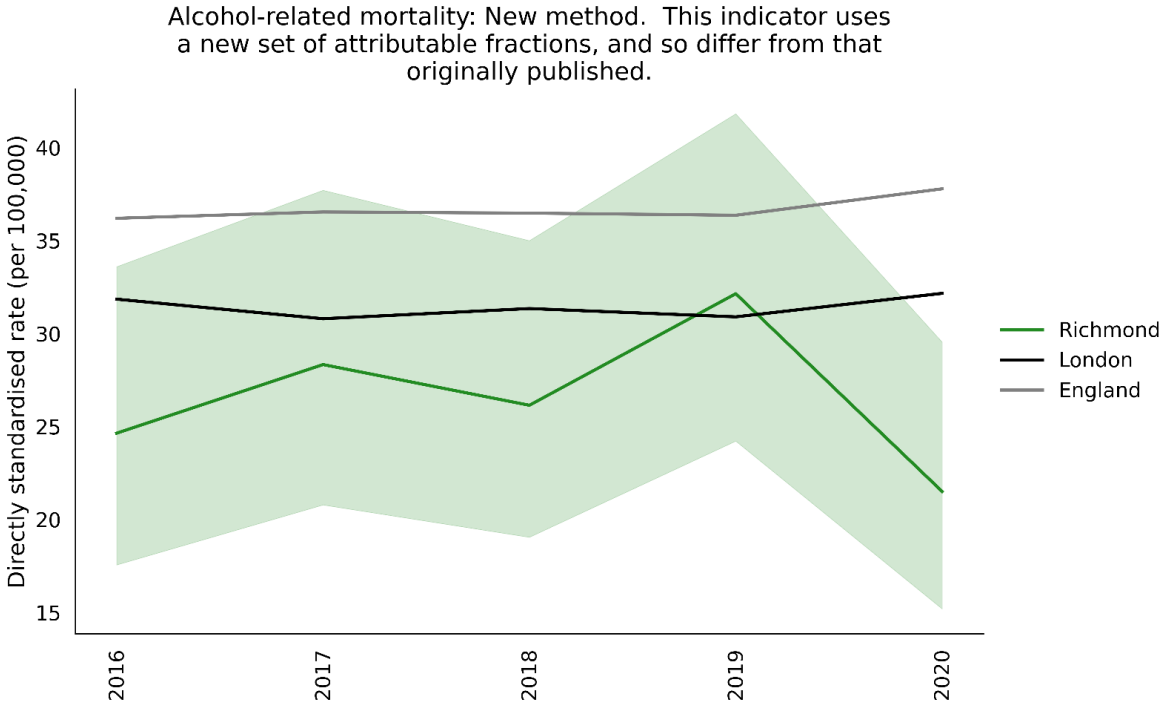
In 2020, Richmond's rate of alcohol-related mortality was 21.5 per 100,000 (n=39), which is the 1st lowest rate in London (**Figure 73**), 43.1% lower than the England average and 33.1% lower than the London average. The latest Borough figure was also 12.7% lower than in 2016, in comparison with 4.4% increase in England's rate in the equivalent time period (**Figure 74**).

Figure 73: Alcohol-related mortality by local authority, 2020



Source: PHE Public Health Profiles

Figure 74: Alcohol-related mortality, 2016–2020



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

Acronyms

Acronym	Meaning
BAME	Black, Asian and minority ethnic
CCG	Clinical Commissioning Group
CHD	Coronary Heart Disease
CMO	Chief Medical Officer
COPD	Chronic Obstructive Pulmonary Disease
CVD	Cardiovascular disease
DOH	Department of Health
EOR	Exercise on Referral
IMD	Index of Multiple Deprivation
JSNA	Joint Strategic Needs Assessment
LSCTP	London Smoking Cessation Transformation Programme
LSOA	Lower Super Output Area
LTC	Long Term Conditions
LTC	Long Term Conditions
MIE	Moderate Intensity Exercise
NCSCT	National Centre for Smoking Cessation and Training [NCSCT] training standard
NDNS	National Diet and Nutrition Survey
NICE	National Institute for Health and Clinical Excellence
NICE	National Institute for Clinical Excellence
NRT	Nicotine Replacement Therapy
PA	Physical Activity
PCN	Primary Care Network
PHE	Public Health England
PHE	Public Health England
T2D	Type 2 Diabetes
TFL	Transport for London
WHO	World Health Organisation

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Authors	Dr Amy Bannerman Public Health Registrar Dr Nike Arowobusoye Consultant in Public Health
Contributors	Benjamin Humphrey Senior Public Health Lead Cornelius Bella Primary Care Contracts Officer Martin Donald Primary Care Contracts Officer Chloe Bannerman Public Health Programmes Support Officer Louise Duffy Public Health Lead Lea Siba Senior Commissioning Manager - Prevention & Wellbeing Rabia Khattak Public Health Lead Tony May Public Health Lead JSNA Operational Group
Governance	JSNA Strategic Group
Reviewer	Dr Nike Arowobusoye Consultant in Public Health Shannon Katiyo Director of Public Health Richard Sekula
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