PUBLIC HEALTH
KINGSTON
Healthier living, happier lives

Eat well

Drink sensibly

Exercise more

2015

Annual Public Health Report

THE ROYAL BOROUGH OF
KINGSTON
UPON THAMES

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Introduction

My ninth report on the health of people in Kingston focuses on diet, exercise and alcohol. Each of these lifestyle issues has a major impact on health and wellbeing but in addition the three interact with each other so increasing their effect. This report aims to set out the different ways these issues affect us throughout our lives, how we can make healthier choices and how the Council and local partners can act to enable us to make these choices.

We have seen a huge rise in the proportion of people who are above a healthy weight with nearly two thirds of people in England now obese or overweight. This not only has a huge financial impact on the NHS (with direct NHS costs of diseases related to overweight and obesity totalling £15.4 billion nationally) and other services but also means many more people will die early from the illnesses associated with being above a healthy weight. The cause of being overweight or obese is consuming more energy in the form of calories in food than is used by the body. The amount of energy used can be increased by physical activity. So to achieve a healthy weight those of us who are overweight or obese need to exercise more and eat well.

What we eat is constantly in the news. In October 2015 the World Health Organisation stated that red meat probably raises the risk of developing some cancers and processed meat does raise the risk of colorectal cancer[1]. During the same month Public Health England released a report highlighting the negative impact of sugar on weight gain and tooth decay and recommending a range of measures including a tax on high sugar soft drinks[2]. A helpful visual guide to what a healthy diet consists of is the 'eatwell' plate (figure 1 on page 17).

The report looks at the impact of diet across the life course, commencing with pregnancy, the early years and children and young people. In the last of these the concerning rise in local children who are above a healthy weight between reception year (17.3%) and year 6 (28.5%) is highlighted. Dietary issues affecting adults and older people are discussed in chapters 1.4 and 1.5 and in the latter chapter the impact of malnutrition is noted, with 14% of all people aged over 65 being malnourished. Across the country malnutrition accounts for £18 billion in health and social care costs, which means that malnutrition in older people is a greater financial issue than obesity. Other chapters in this section examine food poverty, school food, food growing including allotments and healthy catering.

Taking sufficient physical activity – at least 150 minutes of moderate intensity activity a week for adults – reduces the risk of a wide range of illnesses including coronary heart disease, strokes, mental health problems and some cancers. The way we live our lives has changed radically, with a decrease in physical activity at work, much socialising taking place online and many leisure activities now being sedentary so it is not surprising that many people do not now meet recommended activity levels.

It is vital to take exercise throughout one's life. This includes during pregnancy where many common pregnancy symptoms can be improved by exercise (chapter 2.1). The importance of physical activity in helping to ensure the best start in life for young children is highlighted in chapter 2.2 as are the Department of Health guidelines for under fives which should be widely publicised. In older children, the extent to which girls take less exercise than boys is both a national and local issue that should be prioritised for action. The chapters on adults (2.4) and older people (2.5) highlight a range of ways in which people can be more active. These include the Get Active exercise referral programme for those with health conditions, Walking for Health (a national programme suitable for all the family) and Fit as a Fiddle which is focused on older people and has supported over 1,100 Kingston residents to increase their fitness.

Undertaking physical activity can be made easier by having access to green spaces and providing free opportunities for exercise such as outdoor gyms and fitness trails. There are seven such sites in Kingston (chapter 2.6). Formal sports provision locally has significant economic value (estimated at £68.6 million in direct economic value and nearly 2,000 jobs) and information on over 100 sports clubs can be accessed via the Council's website. Other chapters in this section discuss local leisure facilities, active travel – which is one of the easiest ways to build exercise into a regular routine – and the exciting mini-Holland programme which aims to transform the cycling environment in Kingston and so get many more people on their bikes like their Dutch counterparts.

The section of the report dealing with alcohol also starts with a life course approach. It includes a chapter (3.2) dealing with the impact of parental alcohol misuse on children which is estimated to affect 1.3 million children aged under 16 across England. Young people also can misuse alcohol directly and local information shows that year 10 students who drink alcohol are much more likely to have also smoked or taken illegal drugs (chapter 3.3). Although the majority of adults drink sensibly, 33% - which equates to 35,800 working age adults in Kingston – may be harming their health due to their level of alcohol consumption. Alcohol misuse in older people is a growing concern and it has been estimated that up to 60% of older people admitted to hospital with diagnoses such as confusion or recurrent chest infections may have unrecognised alcohol problems. Other chapters in this section deal with enforcement of the law with regard to alcohol sales, alcohol related issues in Kingston town centre, and alcohol and crime.

The interplay section looks at the interaction between all three lifestyle issues. The impact of deprivation is discussed in chapter 4.1 whilst chapter 4.2 focuses on Black, Asian, minority ethnic and refugee populations. A range of settings are then discussed – schools, Kingston College and Kingston University and workplaces. The last of these notes the correlation between all three lifestyle issues and productivity with physically active workers taking 27% fewer days off sick, employees with a healthy diet having 25% higher job performance and alcohol related illnesses causing 17 million working days to be lost each year. Chapter 4.6 discusses the relationship between sports clubs and the food and alcohol that is consumed there and notes the risk of inconsistent health messages being provided. The section concludes with how planning and licensing polices can assist in the promotion of eating well, exercising more and drinking sensibly.

This report also includes a chapter on the demography of Kingston whilst the statistical annex, together with the update on progress against recommendations in last year's report which focused on mental health and wellbeing can be accessed via: **www.kingston.gov.uk/health_and_wellbeing**

I would like to thank all the authors and contributors to the report and give a special mention to the editorial team: Jo Lockhart, Iona Lidington, Christopher Rimington and Dr James Moore.

As always I very much welcome both comments on the report and suggestions for future report topics which can be sent to me at jonathan.hildebrand@kingston.gov.uk

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1.0 Diet

From before birth and throughout our lives, our diet influences how we grow and our overall health. Poor diet is estimated to play a role in 70,000 preventable deaths in the UK every year which highlights the importance of promoting a healthy diet.

Maintaining a healthy weight is key to improving quality of life and reducing the risk of preventable diseases such as type 2 diabetes, cardiovascular disease and some types of cancer which are all associated with obesity. Being underweight (due to malnutrition or as a result of an eating disorder) can also have a major impact on people's health.

The following chapters explore how diet and nutrition influence health across the life course (from pre-conception to older age) as well as how our local food environment can also play a role in the promotion of the take up of a healthy diet.

1.1 Maternal diet (pre-conception, pregnancy and post natal)

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Introduction

Throughout pregnancy, it is important that a mother is well nourished for the health of both herself and her baby. Maternal nutritional status influences the growth and development of the baby and infant birth weight, as well as a child's weight and health status later in life[1, 2].
This includes the risk of non-communicable diseases such as cardiovascular disease and type 2 diabetes[3]. Women from disadvantaged groups are more likely to consume a poorer diet, including poor uptake of folic acid supplements. These women are more likely to either show low weight gain or be obese during pregnancy, and they are also less likely to breastfeed[2]. Information on the benefits of a healthy diet throughout pregnancy should be well communicated, and practical nutrition advice should be tailored to individual circumstances and to the stage of pregnancy.

Healthy diet

Before, during and after pregnancy, women are advised to follow a healthy balanced diet based around the eatwell plate. This plate[4] (figure 1) encompasses the government's recommendations on what a healthy balanced diet is, and provides a useful tool for individuals to determine how much they should be consuming from each food group[4]. Key advice for women who are planning a family includes eating five portions of fruit and vegetables each day and having an adequate intake of folate rich foods[5].

Women planning a pregnancy are also advised to supplement their diet with 400 micrograms (ug) of folic acid per day to reduce the risk of neural tube defects[2], although up to 50% of pregnancies in the UK are unplanned which may limit uptake[6]. For women who have had a baby with spina bifida, there is a 3 - 4% chance of having another baby with this condition[7], and for these women a higher dose 5 mg folic acid supplement is advised. Women who are obese and planning a pregnancy are also advised to take a 5 mg folic acid supplement daily to ensure adequate intake[8].

Figure 1 The eatwell plate.

Source: Department of Health (DH).

All family planning services should provide information on healthy eating, in particular folic acid and advice on being a healthy weight[2]. During pregnancy it is recommended that women continue to take a daily 400 ug folic acid supplement in the first trimester[2].

Pregnant women may also have an increased requirement for several other nutrients including vitamin D, iron and calcium[2]. All pregnant and breastfeeding women are at risk of vitamin D deficiency and a daily 10 ug vitamin D supplement is recommended[9, 10]. Babies born to mothers with low vitamin D status are at risk of developing rickets[11]. Calcium and iron requirements can be met with sufficient intakes from foods rich in these nutrients so routine supplementation is not required although may be recommended for certain individuals such as where the mother is anaemic or iron intakes are low[10, 12].

There are some foods to avoid during pregnancy, including soft blue or mould ripened cheeses, pâté, raw or undercooked eggs or meats, raw fish or shellfish, fish that are high in mercury, vitamin A (or other high dose vitamin supplements) and fish oils. Caffeine intake should be limited and alcohol should be avoided altogether[13].

Postnatally, women should continue to eat a healthy, well balanced diet and do not need to modify their diet to breastfeed[14]. Whilst there are increased requirements for a number of nutrients during lactation, these can be met through a varied and balanced diet, with the exception of vitamin D. Mothers should therefore continue to take 10 ug of vitamin D daily whilst breastfeeding.

Healthy weight

Weight for adults aged 18 to 65 years can be assessed using Body Mass Index (BMI) which is calculated as weight in kilograms divided by the square of the height in metres (kg/m^2). BMI correlates reasonably well with the level of body fat for most people, making it a useful clinical tool. Adults with a BMI between 18.5 - 24.9 kg/m^2 are considered to be of a healthy weight and a BMI above or below this range is considered to be overweight or underweight respectively. If an adult is above 30 kg/m^2 they are considered to be obese (table 1). For pregnant women, BMI measured pre-conception is used to define whether they are at a healthy weight and women are not routinely weighed during pregnancy unless there is a medical reason for doing so.

Table 1 Clinical diagnostic BMI criteria for adults.

Weight classification	BMI (kg/m^2)
Underweight	Less than 18.5
Healthy weight	18.5-24.9
Overweight	25-29.9
Obesity I	30-34.9
Obesity II	35-39.9
Obesity III (severely obese)	40 or more

Source: National Institute for Health and Care Excellence (NICE) and the World Health Organisation (WHO).

Women below or above a healthy weight should aim to achieve a healthy weight before conceiving to minimise the risks of being an unhealthy weight during pregnancy[15]. Approximately 20% of pregnant women are overweight or obese in England[16]. Maternal obesity puts both the health of the mother and infant at risk and increases pressure on service providers. Complications related to maternal obesity can include impaired glucose tolerance, gestational diabetes, pre-eclampsia, dysfunctional labour, caesarean section and miscarriages[15, 17].

Weight gain in line with recommended ranges is associated with improved maternal and infant outcomes[2, 18]. It is recommended that women who commence pregnancy at a healthy weight should gain no more than 11.5 kg to 16 kg[18]. This also applies to women who are overweight at the start of their pregnancy, whilst for women who are obese at booking, weight gain of 5 kg to 9 kg is recommended. For women who become pregnant below a healthy weight, recommended weight gain during pregnancy is 12.5 kg to 18 kg.

The period after pregnancy and childbirth has also been identified as a time when women are likely to gain weight[19]. Women who return to their pre-pregnancy weight by around six months have a lower risk of being overweight ten years later[20]. Postnatal women should be encouraged to lose excess weight, particularly before becoming pregnant again[15]. Moderate physical activity is a safe weight management strategy at this stage[15] but calorie restricted diets are not recommended whilst mothers are breastfeeding[15].

Breastfeeding confers numerous health benefits to the mother, including reducing the risk of some cancers[21] and may aid women in returning to their pre-pregnancy weight[2]. Managing postnatal weight can reduce the risk of entering future pregnancies above a healthy weight. Weight gain between pregnancies, even for those who are a healthy weight, may increase the risk of both gestational diabetes and gestational hypertension[15, 22].

National programmes

Healthy Start is a statutory national programme that provides food vouchers and vitamins for pregnant women and young children. Eligible pregnant women (which includes those who are on benefits or under the age of 18) can get Healthy Start vouchers worth £3.10 per week to be spent on milk, fresh or frozen fruit and vegetables and infant formula milk; and coupons for free vitamins that can be redeemed at participating shops.

Start4Life is a sister brand of the national social marketing campaign Change4Life. It is aimed primarily at pregnant women and new mothers and provides healthy lifestyle advice during pregnancy. This includes key nutritional messages such as ensuring adequate folic acid and vitamin D supplementation throughout pregnancy, healthy eating and advice on foods to include and avoid such as alcohol. The campaign also has a focus on maintaining a healthy weight throughout pregnancy with the "eat for you not for two" message, and a 28 day plan to boost fruit and vegetable intakes.

Breastfeeding is encouraged in national policy and is supported by the Start4Life campaign which highlights the postnatal benefits to new mothers who breastfeed including reductions in breast and ovarian cancer risk and the contribution that breastfeeding can play in postnatal weight loss. The benefits of breastfeeding to the newborn are discussed in chapter 1.2.

Women below or above a healthy weight should aim to achieve a healthy weight before conceiving to minimise the risks of being an unhealthy weight during pregnancy[15].

Local picture

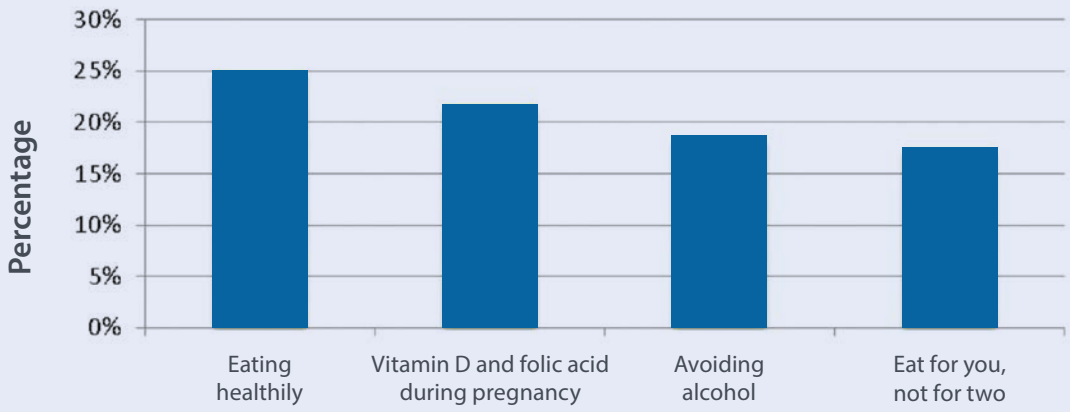
The number of live births to Kingston residents in 2014 was 2,247 whilst the number of deliveries at Kingston hospital for the same period was 5,596. The latter figure includes women who live outside the Borough but choose to have their antenatal care and give birth at Kingston Hospital.

Healthy diet

In 2014, a local nutrition survey found that all 64 pregnant women surveyed reported that nutrition and a healthy lifestyle was important for them and their children[23]. However, 61% of pregnant women had not heard of the national Start4Life scheme[23] described previously.

One key message of the Start4Life campaign during pregnancy is around nutrition and weight gain with the slogan "eat for you, not for two", but only 17% of local pregnant women surveyed were aware of this message[23]. The message that was most identified was 'eating healthily', but this was only recognised by 25% of the sample (figure 2). Low awareness of the scheme demonstrates a need to improve promotion of this scheme at both a national and local level before and during pregnancy.

Figure 2 Percentage awareness of the key Start4Life messages among respondents to a local survey of pregnant women.



Source: Nutrition in pregnancy and young children survey, 2014.

The same local survey found that awareness of recommended vitamin intakes during pregnancy varied. The majority of women (97%) were aware of the recommendation to take a folic acid vitamin supplement during the first 12 weeks of pregnancy. Knowledge on recommended vitamin D intakes during pregnancy and breastfeeding was lower, with only 75% being aware of this recommendation. Lower still at 38% was awareness of the national Healthy Start scheme (described above) despite local publicity being undertaken.

Local uptake figures remain low for women's vitamin tablets (4.1%)[24]. However, whilst this is lower than the London average (7.2%), it is higher than the England average (2.8%).

Table 2 Healthy Start women's vitamin tablet uptake by percentage of eligible women.

	Healthy Start women's vitamin tablet uptake
Kingston	4.1%
London	7.2%
England	2.8%

Source: Healthy Start Quarterly Report, March 2015.

Maintaining a healthy weight

Following NICE recommendations, weight and BMI are not routinely measured throughout pregnancy; however, women are routinely weighed at their initial booking appointment, from which the prevalence of maternal obesity can be ascertained. In Kingston Hospital there were approximately 5,749 women booked in 2014 and their BMI profile is presented in table 3.

It can be seen that a higher percentage of women booking at Kingston Hospital are at a healthy weight and a lower percentage are obese. However, it should be noted that the local figures will include many women who live outside Kingston Borough.

Table 3 Prevalence of maternal overweight and obesity at booking.

	Kingston*	UK**
Underweight	2.6%	4.9%
Healthy Weight 18.5 - 24.9 kg/m^2	57.2%	53.6%
BMI ≥ 25.0 - 29.9 kg/m^2	27.7%	25.9%
BMI ≥ 30.0 kg/m^2	12.5%	15.6%

* Based on booking weights at Kingston Hospital 2014 (data provided by Kingston Hospital Maternity Team).

**Data source: A nationally representative study of maternal obesity in England, UK: trends in incidence and demographic inequalities in 619,323 births, 1989 - 2007 and CMACE 2010 (Maternal obesity in the UK: findings from a national project).

In the Kingston survey[23], only 30% of pregnant women correctly reported that dietary intakes should only increase by 200 calories in the third trimester. Furthermore, 36% incorrectly reported that it is recommended that pregnant women need to consume more food. This highlights some confusion regarding key public health messages for pregnant women.

A survey carried out with midwives in the Borough (32 respondents) highlighted that 56% of midwives do not currently discuss weight gain during pregnancy with women during their visits. Limited knowledge about weight gain during pregnancy was cited amongst the reasons that this topic is not discussed, along with a lack of time and only discussing the topic if the woman had enquired. This highlights a lack of focus on weight management for pregnant women in the Borough.

Local action

Healthy eating and nutritional supplementation messages across the antenatal period are embedded within a number of services, activities, and health promotion materials in Kingston. Much of this is a shared responsibility between partners including Kingston Hospital staff, GP practice staff, and Your Healthcare CIC staff.

A Maternal Obesity Action Group (MOAG) was established in 2013 to encourage more collaborative working in this area, and has representation from each service and Public Health. The MOAG aims to promote the development of services for pregnant women who are above a healthy weight and oversees the implementation of actions from relevant local strategies.

Local support for national campaigns

National policies and standards are applied locally, for example, all antenatal services are responsible for promoting the national Start4Life scheme and healthy eating and weight management messages are shared with women of childbearing age who may be planning a pregnancy in both general clinics and specialist dietetic clinics.

Healthy Start

Healthy Start is embedded locally into midwifery service delivery and uptake is regularly discussed at strategic meetings. This includes the MOAG, the Infant Feeding Partnership, and the Maternity Services Liaison Committee. Pregnant women (and women with children aged less than four years) are provided with Healthy Start leaflets in all new birth packs, or they can be obtained through the midwifery service, their local health clinic or Children's Centre. Women who are eligible for Healthy Start can claim free vitamins by filling in an application form within these leaflets and requesting a health professional (usually the health visitor) to sign it. Women who are not eligible can now also purchase the vitamins from the Children's Centres and Hawks Road Clinic or their health visitor at £1.50 for children and £1 for women.

Pregnant women (and women with children aged less than four years) are provided with Healthy Start leaflets in all new birth packs, or they can be obtained through the midwifery service, their local health clinic or Children's Centre.

Vitamin D and folic acid

Vitamin D and folic acid promotion is integrated into local services. Partners that support this promotion include GP practices, Your Healthcare CIC and Kingston Hospital maternity and dietetic services. Kingston Hospital dietitians have developed vitamin D and folic acid promotional materials including posters which have been circulated across GP surgeries in the Borough. In addition, information on folic acid and vitamin D is routinely provided at booking appointments.

Vitamin D awareness is also incorporated into relevant community cooking and nutrition programmes such as Cook and Eat, which work with vulnerable groups who may be at risk of vitamin D deficiency. This may capture some women of childbearing age, although there are no specific community cooking programmes for pregnant women in Kingston.

Midwifery

Midwives should provide information on healthy eating, folic acid and vitamin D supplementation and normal weight gain. Vulnerable women at risk of a poor diet, such as teenage pregnant women and women who are above a healthy weight, are referred and signposted to specialist services. Midwives also act as a key contact to refer eligible women to the Healthy Start scheme.

Overweight and obese pregnant women are given an information booklet by their midwife at their booking appointment. Women are also invited to contact the dietetic department for a one-to-one appointment if they would like further support in managing their weight in pregnancy. To standardise the dissemination of information and care of these women, Public Health have been working with the midwifery team to develop the service. Goals include improving consistency in weight management information given to women at booking and throughout the antenatal period, and following on from the midwives' survey which highlighted a gap in raising the issue of weight to pregnant women, the MOAG has arranged for a clinical update on the topic to be given to midwives in late 2015.

Community weight management services

Pre-conception weight management

Free weight management services are available for women with a BMI ≥ 28kg/m^2 trying to conceive. This includes Slimming World, Weight Watchers (both for 12 weeks) and a locally developed service, Weigh 2 Go (lasting ten weeks). Women trying to conceive are encouraged to achieve a healthy weight prior to conception.

Antenatal weight management

Pregnant women who have a BMI ≥ 28kg/m^2 can attend Slimming World for 12 weeks free of charge. The programme focuses on long term lifestyle changes, providing support to women to eat healthily and prevent excess weight gain during pregnancy. Other public health messages are also embedded into the programme, including breastfeeding and physical activity. Eligible pregnant women on the programme are monitored by their midwife to support them in managing their weight during pregnancy.

Postnatal weight management

A 12 week community postnatal weight management service Beyond the Bump has been commissioned until March 2016 following a successful pilot of two programmes (with 19 participants) in early 2015. This provides evidence based postnatal weight management information for women in all BMI groups. This free programme is offered in local community settings such as Children's Centres, and whilst it is a universal programme, it aims to target women in low income areas. Healthy lifestyle messages for the whole family across the life course are embedded in the programme.

This consists of healthy eating information, including breastfeeding and weaning, Healthy Start and Start4Life messages, and physical activity. It also involves a training component for health professionals, including midwives, health visitors, GPs and early years providers around raising the issue of weight before, during and after pregnancy.

Postnatal women can also access the programmes highlighted under pre-conception weight management if they have had their six week postnatal check.

Kingston Hospital dietetic services

The Kingston Hospital dietetics team offer one-to-one dietary consultations for pregnant women who are underweight, obese or have another nutritional issue such as lactose intolerance. Women who are seen in this clinic are offered an additional follow-up appointment for postnatal weight management advice following their six to eight week check.

Referrals are accepted from midwives, however women are encouraged to self refer to maximise attendance. Uptake of these appointments is poor, and options to increase attendance are being discussed within the MOAG. All women attending dietetic clinics who may be thinking about starting a family are encouraged to follow national recommendations for folic acid intake and healthy weight prior to pregnancy.

There is currently no hospital multidisciplinary (MDT) weight management service available for women during the antenatal period following poor uptake of an MDT service trialled in 2013 - 14.
This issue is being discussed by the MOAG with a view to recommencing a service following a planned consultation with pregnant women around barriers to weight management in pregnancy.

Specialist services for gestational diabetes mellitus

Kingston Hospital offers a specialist antenatal clinic for women diagnosed with gestational diabetes mellitus (GDM) during their pregnancy. Any woman with GDM (or any pregnant woman with pre existing type 1 or type 2 diabetes mellitus) will attend this clinic every two weeks until delivery. The clinic is multidisciplinary and patients will see a specialist diabetes dietitian, diabetes specialist nurse, diabetes consultant and obstetrician.

In addition, a group education session for gestational diabetes is offered to anyone with existing or previous GDM. This is a one off teaching session including blood glucose monitoring and dietary advice and is run by the specialist diabetes dietitian.

Recommendations

1 **Continue to ensure local focus on diet in pregnancy through the MOAG.**

2 **Undertake a consultation with women of child-bearing age to assess knowledge and awareness of healthy eating and healthy weight before, during and after pregnancy.**

3 **Continue to raise awareness of healthy eating before, during and after pregnancy with a targeted focus on pre-pregnancy, to include information on vitamin D, folic acid and breastfeeding.**

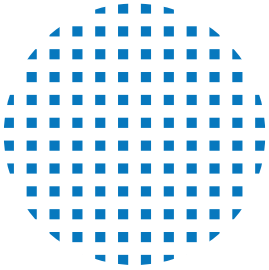
4 **Raise awareness of healthy weight gain for all pregnant women, and the importance of being a healthy weight pre-conception.**

5 **Continue to commission the Slimming World weight management service for pregnant women and the postnatal Beyond the Bump community weight management programme.**

6 **Review specialist weight management support at Kingston Hospital for pregnant women with a BMI ≥ 28kg/m^2 including the lack of a multi-disciplinary team for antenatal weight management.**

7 **Review barriers to uptake for Healthy Start and consider an additional awareness raising campaign for the Borough.**

8 **Consider an awareness raising campaign around vitamin D.**



1.2 Diet in the early years (0 - 5 years)

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Introduction

The first five years of life are critical in shaping health and wellbeing. Giving every child the best start in life is crucial to reducing health inequalities across the life course[25]. In England, by the time children reach reception class in primary school over 22% are above a healthy weight[26]. Early preventative action that develops healthy eating practices has a lifelong impact on health, including the achievement of a healthy weight[27, 28, 29]. Services should target vulnerable families, who are at risk of poor dietary intakes due to food insecurity, low education, unemployment, poor housing and poor access to food[25, 30].

Infant nutrition

Eating well is essential for infants from the first day of life. Milk through breastfeeding or infant formula is the first form of post birth nutrition.
The Department for Health (DH) recommends exclusive breastfeeding for the first six months of a baby's life to ensure that all the nutritional needs are met[31]. Breastfeeding encourages optimum development, resistance to infections and supports mother-child bonding[32, 33]. Children who are breastfed have a decreased risk of obesity, and other illnesses, such as type 2 diabetes in later life[32, 34, 35].

In the UK breastfeeding initiation rates are high but by six to eight weeks after birth the rate drops considerably, falling to just 55%[36]. Teenage mothers are 50% less likely to breastfeed than the general population[36], whilst only 73% of mothers living in deprived areas initiate breastfeeding, in comparison to 81% in the UK overall[36].

The most recent infant feeding survey showed that breastfeeding is most common among mothers who are aged 30 or over, are from minority ethnic groups, left education aged over 18, are in managerial and professional occupations and are living in the least deprived areas[36].

Children living in deprived communities are at higher risk of nutrition-related illness and disease, and therefore improving breastfeeding rates has particular value for this group[33]. Where women choose to use infant formula or breastfeeding is not an option, health professionals should provide accurate and unbiased information on the nutritional aspects and safety of infant formula milk.

Early years' nutrition

Healthy dietary intakes and eating behaviours during the early years are essential for ensuring optimum growth and development and set the foundations for future health and wellbeing.

The introduction of solid foods is recommended from approximately six months of age and children should be weaned onto a variety of foods[31]. By one year, children should be eating a varied and balanced diet. In the UK changes to children's diets in recent years means some children are eating foods that are low in iron, zinc and vitamins A and D, whilst being high in saturated fat, sugar and salt[37, 38]. This leaves children at risk of iron deficiency anaemia, poor growth or failure to thrive, problems with sight and other diet-related illness due to overweight and obesity. Implications of low levels of vitamin D in children can include rickets, delayed tooth eruption, increased risk of infection, decreased bone mass, seizures and delays in walking[39].

As many as 50% of children in the UK have a low vitamin A intake, and families in lower income groups are more likely to be consuming less vitamin C[40]. Children aged 1½ to 6 years (particularly those from lower income and one parent families) do not eat enough fruit and vegetables[32, 41]. Cases of rickets have increased in recent years due to low vitamin D intakes, especially in Asian populations[42]. It has been estimated that around 12% of young children have vitamin D deficiency, with as many as 40% having levels below the accepted optimal threshold[43]. Around 25% of children are estimated to be at risk of iron deficiency[37]. Vitamin and mineral deficiencies are likely to go unrecorded as often they are only diagnosed when a child has presented for other reasons such as faltering growth, fussy eating or are symptomatic. It is therefore essential that dietary health promotion information is in place in order to prevent vitamin deficiencies.

Oral health

Maintaining good oral health is strongly related to a healthy diet, with dental caries associated with a high sugar intake. Of particular dietary concern are the sugars that are added to foods and drinks[44]. Dental disease is defined as decayed, missing or filled teeth. Many children have poor oral health, especially those living in areas of deprivation[45, 46]. Children aged five years living in deprived areas are more likely to experience dental caries than children from less deprived areas (60% compared with 40% respectively)[47].

National initiatives

The Healthy Child Programme is the overarching NHS framework that is committed to supporting families in keeping their children healthy and safe during pregnancy and the first five years[48]. This programme is predominately delivered by health visitors, and actions include the reduction of childhood obesity through healthy eating (including breastfeeding) and physical activity.

The Early Years Foundation Stage (EYFS), as measured by Ofsted, is a framework that all early years' providers such as Children Centres and nurseries have a responsibility to meet. The welfare requirement within the EYFS includes a commitment to provide healthy, balanced and nutritious food and drink[49].

Sure Start is a national programme aiming to deliver the best possible start in life to children in deprived communities. Sure Start Children's Centres offer an opportunity for early interventions to prevent poor health in later life, and can be a source of advice on diet and nutrition in the early years through activities such as breastfeeding clinics, weaning sessions and postnatal support groups.

The national statutory Healthy Start scheme (see chapter 1.1) is a key programme in support of healthy dietary intake in children aged between six months and four years. The scheme provides food vouchers and vitamin coupons to spend on cow's milk, fruit and vegetables, infant formula milk and vitamins for low income pregnant women and young families. The children's vitamin drops contain vitamins A, C and D to ensure optimal growth and development.

Local picture

Low birth weight is a national public health indicator for premature mortality, avoidable ill health and inequalities in health. Adequate dietary intake for healthy growth is therefore particularly important for those babies born with a low birth weight. In Kingston in 2012, 163 (7.0%) babies had a low birth weight, which is in line with the England average (7.3%)[50].

Infant nutrition

In 2013 - 14, 90.2% of women in Kingston initiated breastfeeding[51], which was higher than the UK and England averages of 81.0% and 83.0% respectively[52]. By six to eight weeks, the prevalence of breastfeeding in Kingston was 76.5%[53], again, significantly higher than the UK percentage (55.0%)[36]. Despite strong breastfeeding continuation rates overall in Kingston, health inequalities remain. Areas of particular concern are those covered by Chessington and West Chessington Children's Centres where breastfeeding rates are low (table 1).

Table 1 Breastfeeding prevalence by Children's Centre 2013 – 14.

Children's Centre	Average totally or partially breastfed at 6 - 8 weeks 2013 - 14
Chessington	61%
Kingston Hill	77%
Kingston Town	75%
New Malden	83%
Norbiton	71%
North Kingston	73%
Old Malden	90%
Surbiton	83%
Tolworth	71%
West Chessington	57%

Early year's nutrition

There are approximately 1,100 pregnant women and young families eligible for the statutory Healthy Start scheme in Kingston. Of these, 66.0% are claiming food vouchers or vitamin tablets (table 2), which is below the England average (73.0%). However, the majority of those eligible are only using the food vouchers, and uptake is low for children's vitamin drops (3.5%) but this remains above the England average (1.9%).

Table 2 Uptake of Healthy Start Children's Drops.

	Healthy Start uptake	Children's drops
Kingston	66.0%	3.5%
England	73.0%	1.9%

Source: Data from National Healthy Start Yearly Report 2014 - 15, June 2015.

In 2014, a local survey[54] explored pregnant women and young parents' knowledge on national health promotion initiatives and priorities. A total of 93 parents and pregnant women were surveyed. Only 19% of parents were aware of the national Start4Life scheme. In contrast 61% of pregnant women were aware of the scheme, suggesting that this health message needs to be strongly reinforced throughout the early years. More positively, 86% of parents correctly reported that six months is the age at which the DH recommends introducing solid foods.

Oral health

The prevalence of tooth decay in children aged five years in Kingston is 19.3%, which is much lower than both the London and England average (see table 3). However, children living in deprivation are more likely to have poor dental health[45, 46, 47] and oral health promotion interventions should be targeted to these areas.

Table 3 Tooth decay in children aged five years.

	Prevalence of tooth decay in children aged 5*	Mean severity of tooth decay in children aged 5**
Kingston	19.3%	0.53
London	27.9%	1.23
England	32.9%	0.94

Data source: Public Health England, Public Health Outcomes Framework, 2011 - 12.

*Percentage having one or more teeth that were decayed to dentinal level, extracted or filled because of caries.

**Mean severity of tooth decay in children aged five years based on the mean number of teeth per child sampled which were either actively decayed or had been filled or extracted.

Local action

Kingston is committed to undertaking the nationally set early years' nutrition programmes highlighted above and this is highlighted in the Healthy Weight and Physical Activity (HWPA) Needs Assessment and Strategy 2013 - 16[55] and the work of the Community Sport and Physical Activity Network (CSPAN).

Infant nutrition

Public Health commission the Infant Feeding Team (IFT) at Your Healthcare CIC to support women who are experiencing breastfeeding difficulties in Kingston. The service has achieved Stage One of the World Health Organisation and United Nations Children's Fund (UNICEF) Baby Friendly accreditation. The IFT is now working in partnership with Kingston's Children's Centres to achieve Stage Two accreditation to ensure consistent local infant feeding nutrition messages[33]. The IFT also provide training for professionals, and has so far trained over 100 professionals working with breastfeeding mothers, as well as 17 mother-to-mother peer supporters.

In 2014, the IFT received 281 referrals for one-to-one breastfeeding support. In addition, there were nearly 1,300 visits to the six IFT drop-ins in Children's Centres. Importantly, attendance in some of the disadvantaged areas of Kingston (Norbiton and Chessington) almost doubled in 2014 when compared to 2013. The use of local peer supporters in these areas is believed to have helped to enhance attendance, however a formal evaluation of their impact is being carried out. The IFT also offer antenatal education, particularly focusing on young mothers aged less than 23 years, and is currently piloting 'early days' telephone support to mothers in deprived areas to reduce the number of women who stop breastfeeding in the first week.

Early years' nutrition

Healthy Start

In Kingston, the Healthy Start food vouchers to spend on cow's milk, fruit and vegetables and infant formula are redeemable at a variety of local shops and supermarkets. The Healthy Start vitamins are distributed through Children's Centres and health clinics (see table 4).

Table 4 Healthy Start vitamin distribution sites in Kingston.

Health Clinics	Children's Centres
Hawks Road	Chessington Children's Centre
Surbiton Health Centre (at Baby Clinic)	Norbiton Children's Centre
Hollyfield House	Old Malden Children's Centre
	Surbiton Children's Centre

Locally, Your Healthcare CIC is commissioned by Public Health to deliver the Healthy Start service in partnership with local Children's Centres. Public Health helps to promote this service and commenced a communication campaign in February 2015. The impact of this boost campaign should be known by March 2016.

From January 2015 Healthy Start vitamins can be sold for a very small profit to families not eligible for the scheme. This is currently being rolled out locally.

Eat Better Start Better

The Children's Food Trust Eat Better Start Better (EBSB) programme was piloted in Kingston in 2014. This supports early years' providers to meet children's nutritional needs and supports the EYFS welfare requirement for the provision of healthy, balanced and nutritious food and drink. In Kingston, eight settings were audited against the EBSB guidelines. All scored highly and demonstrated an interest in providing nutritious food in a healthy environment.

Cook and Eat

Cook and Eat is a local six week Public Health funded community programme which aims to improve parents' cooking skills and knowledge of healthy eating. Kingston Adult Education run the programme in Children's Centres and other early years' settings for families with children under five years. Programme outcomes include improved diet, such as reduced high fat, sugar and salt foods, increased nutritional knowledge and improved healthy eating behaviours. This programme also helps to build parent-child relationships resulting in an improvement in children's self esteem and so reduces their risk of adopting unhealthy lifestyles later in life[28].

Children's Centres

Children's Centres are community hubs that provide targeted support, in line with local need, with the overall aim of providing the best start in life. In addition to the Cook and Eat programme mentioned earlier, Children's Centres in Kingston provide a range of activities and services which support sustainable healthy eating and lifestyle messages. Programme examples include 'Let's explore food', 'Let's Cook', and 'Cooking around the world', delivered with local partners such as Kingston Adult Education. Guest speakers deliver sessions to parents on topics such as weaning and dental health. These programmes support sustainable healthy eating messages for families that need more than the six week Cook and Eat programme.

Public Health commission the Infant Feeding Team (IFT) at Your Healthcare CIC to support women who are experiencing breastfeeding difficulties in Kingston. The service has achieved Stage One of the World Health Organisation and United Nations Children's Fund (UNICEF) Baby Friendly accreditation.

Health visiting

Health visitors are registered nurses or midwives who have completed further training. They play a key role in the promotion of a healthy lifestyle during the early years. Health visitors deliver child and family health services from birth to five years, provide additional services for vulnerable children and families including referrals onto appropriate support services, contribute to the safeguarding and protection of children, and work with Sure Start Children's Centres to coordinate and deliver a range of health services and campaigns.

Community staff nurses and community nursery nurses (the latter are not qualified nurses but have qualifications in child development) provide support to the health visiting team by running groups or working directly with families if appropriate. This enables health visitors to support families with complex needs. The combined team implement the Healthy Child Programme.

The health visiting service offers five opportunities for appointments to all families as well as open access clinics and groups. These include:

- antenatal
- new birth
- postnatal (six to eight weeks)
- one year health review
- two year health review.

Health visiting teams provide practical advice and support on dietary issues and refer to generic or specialist services are required. A gap has been identified locally around support for, and mothers' understanding of, introducing solid foods. This presents a key opportunity for improving the support provided by both the health visiting service and the Children's Centres.

Oral health

An Oral Health Promoter from King's College Hospital NHS Foundation Trust delivers dental health talks at Children's Centres, and dietary information is available in support of good oral health. However, there is currently no comprehensive service provision across all of Kingston's early years' settings.

Dietetic services

A paediatric dietetic service at Kingston Hospital is available for specialist health issues such as food allergies and faltering growth. Children can also be seen when they have constipation, reflux, iron deficiency anaemia and 'fussy' eating which may affect a child's growth. Where possible, children requiring dietetic input should be referred to their GP practice dietitian, who can then refer to the hospital based service if this is required. Children with dental caries can also be referred to dietetic services by dentists.

Recommendations

1 **Continue to work through the CSPAN to improve healthy eating and access to healthy food for infants and young children.**

2 **Explore ways to extend the pilot EBSB programme across registered early years' settings in Kingston.**

3 **Consider developing dietary health promotion materials relating to dental health in Kingston to ensure consistent messages are disseminated across the early years' settings.**

4 **Continue to promote and expand the national Start4life campaign in Kingston.**

5 **Continue to promote Healthy Start in Children's Centres and health clinics, including improving uptake and embedding the payment option for vitamins for families that are not eligible for the scheme.**

6 **Establish evidence based training on introducing solid foods for health visiting and Children's Centre staff.**

7 **Explore potential barriers to breastfeeding and develop appropriate responses.**

Case study – Cook and Eat, Family Learning, Kingston Adult Education

A recent course at New Malden Children's Centre was particularly successful because for many of the parents attending the course it provided a starting point for them in their learning journey. The six week course ran in Autumn 2014 and parents were recruited through the Children's Centre and the local school (Burlington Infant and Nursery School). In total nine parents and nine children from a variety of ethnic backgrounds (including Korean, Sri Lankan, and White British) attended the programme.

Some did not have English as their first language and for many of the parents this was not only an opportunity to learn cooking skills and how to eat healthily, but also an opportunity to learn English in a sociable environment.

Learning how to prepare and cook healthy meals is the main focus of the Cook and Eat programme, with each week focusing on a key topic area. Sessions include reducing salt, sugar and fat, healthy portion sizes and how to read food labels. For some parents, their goals included: 'taste some English food and try some English ingredients'.

The programme also provides an opportunity for parents to reflect on their families eating behaviours, with one participant reporting a goal for: 'the whole family to have a meal together once a week'.

Additional feedback provided at the end of the programme included the following comments:

"I have made new healthy foods, which my family have enjoyed eating, I'm very happy."

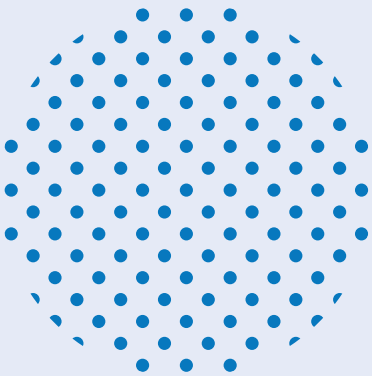
"I found a lot of new recipes and learned how to eat together as a family."

"I learned new recipes and it was very encouraging."

"I've enjoyed coming along to Cook and Eat. The other mums are lovely and it is nice to learn alongside them. It has made me think more about healthy cooking for my baby and whole household."

Tutor feedback was also positive including reports of a 'high level of attendance' and 'good group cohesion'. The Children's Centre Manager reported that Cook and Eat:

- "allowed parents lacking skills in English to develop their language in an informal way
- provided relatively isolated parents the opportunity to meet others and work closely as a team, and develop good friendships that have continued
- allowed children the first opportunity to be separated from the parents in a safe and supported way
- facilitated many discussions regarding healthy eating and diet for young children
- provided parents with recipes and the confidence to try some new dishes, and
- due to the successful course parents were more likely to engage with other courses and services run by the Centre."



Cook and Eat is often a 'starter' programme for many families new to Children's Centres as it provides an informal learning environment centred on food. Five parents continued with the 'Cooking around the World' programme. Four additional parents also attended this course providing a new social group to further their cooking skills and reinforce healthy eating messages introduced on the Cook and Eat programme. Some parents continued into programmes that supported them further with their English, whilst some of the original members of the group continued onto a 'Helping your child with maths' programme.

All learners were contacted by telephone three months after completing the Cook and Eat programme to establish whether the initial outcomes were sustainable. Of the 60% who responded:

- 100% still felt either 'very confident' or 'confident' about cooking healthy meals at home
- 100% said that they continued to either eat 'daily 'or 'sometimes' as a family together
- 80% said that they still read food labels on packaging
- 100% said they continued to cooked healthy meals at home
- 100% said they still ate three to five portions of fruit and vegetables daily.

1.3 Diet for children and young people (5 - 18 years)

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Introduction

Children and young people require sufficient energy and nutrition from food for health, growth and development[56]. Establishing well balanced dietary intakes in this age group is vital to maintaining lifelong health, including a healthy weight[57, 58]. Healthy dietary intakes in children and young people support improved school performance, concentration and self esteem[59, 60] and help to prevent non-communicable diseases later in life[61].

Children's and young people's nutrition

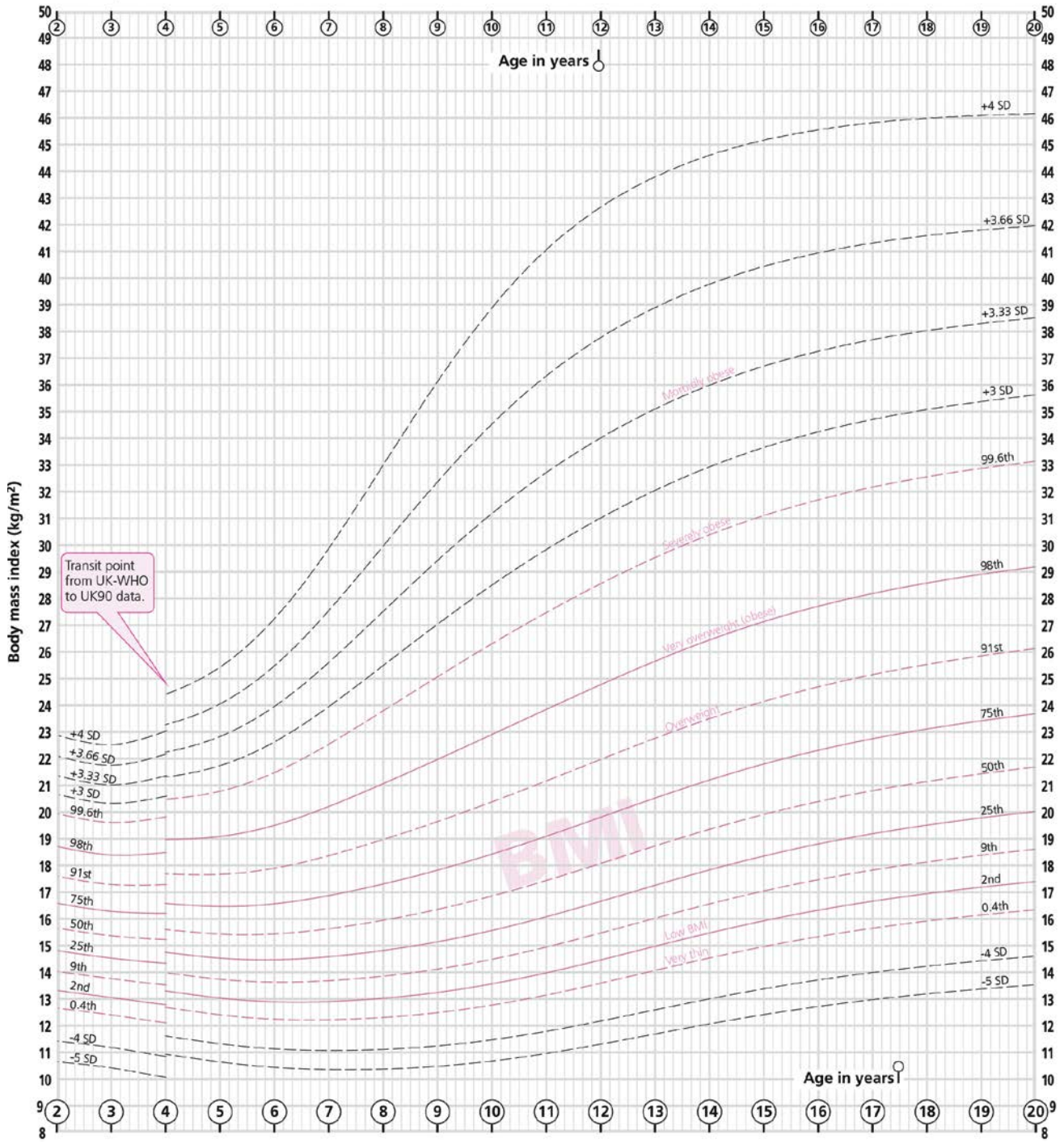
The nutritional needs of children are high in comparison to their size, especially during growth spurts and puberty when there is increased demand for energy, protein and several vitamins and minerals[62]. For example, children and young people require higher intakes of vitamin D and calcium for strong bone development.

National fruit and vegetable intakes in children indicate that girls on average consume 3.1 portions per day in comparison to 2.8 portions for boys[63], both of which are below the national recommendations of five portions per day.

Children and young people's weight

Healthy weight for children up to the age of 18 years can be assessed by monitoring their Body Mass Index (BMI). However as children and young people are growing, whether a child is of a healthy weight must be assessed using BMI centile charts which allow the tracking of BMI appropriate to a child's age and gender (see figure 1). Children and young people who fall below the 2nd centile or above the 91st centile for BMI are considered to probably be a low weight or overweight respectively. If a child or young person is above the 98th centile, they are considered to be obese.

Figure 1 Example BMI centile chart.



The nutritional needs of children are high in comparison to their size, especially during growth spurts and puberty when there is increased demand for energy, protein and several vitamins and minerals[62].

In England, 22.5% of reception children are above a healthy weight, increasing to 33.5% in year 6 children[64]. The percentage of obese children (9.5% for reception year and 19.1% for year 6) has increased since 2012 - 13[64]. Type 2 diabetes has also emerged in some overweight or obese children as young as 5 - 9 years of age[65]. This is an emerging change in the pattern of this disease and may be attributed to a combination of changes in diet and a reduction in exercise.

Obesity in children can result in numerous health conditions including orthopaedic disorders, pancreatitis and upper airways obstruction. Obese children are also more likely to be obese in adulthood, increasing their risk of suffering from a range of diseases (see chapter 1.4).

The prevalence of children and young people who are underweight in the UK is low (<2%)[64]. Undernutrition can result in stunted or delayed growth and has negative impacts on health, including a weakened immune system and possible limited future fertility[66]. Low weight or faltering growth may indicate an underlying health condition, such as type 1 diabetes or coeliac disease that often present in childhood, and therefore regular growth monitoring is important. Dieting, particularly crash diets amongst female adolescents can lead to low intakes of important nutrients including iron, calcium and B vitamins, and may increase the risk of eating disorders[67].

Nationally the government has made a commitment to tackling obesity[57]. 'Change4Life' is a national campaign which uses social marketing in order to change behaviours related to nutrition and physical activity.

Children and young people's wellbeing

Research suggests that pupils with better health and wellbeing are likely to achieve better academically[68]. Schools are advised to promote students self esteem and wellbeing through physical activity and healthy eating[69].
Being overweight as a child can have an adverse effect on a young person's self esteem and self image[59]. It can also result in poor social interactions and poorer academic achievement[62].

The most common age of admission to hospital for an eating disorder is 15 years for girls and 13 years for boys[70]. There is emerging evidence that eating disorders may be associated with more frequent social media use[71]. Eating disorders are associated with numerous adverse health outcomes, including having the highest mortality rate among psychiatric disorders[72].

National policy

Nationally the government has made a commitment to tackling obesity[57]. Change4Life is a national campaign which uses social marketing in order to change behaviours related to nutrition and physical activity. The campaign has a focus on families and children aged five to 11 years.

The National Child Measurement Programme (NCMP) is part of the government's Healthy Weight, Healthy Lives strategy and involves weighing and measuring children in reception year and year six to inform local planning and delivery of services for children. Food provided in schools in England must now meet the mandatory School Food Standards in support of optimum nutrient intakes[73] (see chapter 1.7).

Local picture

Children's and young people's diet

Children and young people aged four to 18 years consume 18 - 19g per day of sugar and chocolate confectionery nationally, which is higher than any other age group[63]. In Kingston a needs assessment in 2014 showed that 69% of young people are consuming chocolate and sweet confectionary once or twice a day[74]. One or more fizzy drinks were reported to be consumed by 40% of young people on a daily basis and energy drinks were consumed by 20% daily. This provides a useful indicator into young people's dietary choices in Kingston.

Children's weight

Kingston achieves excellent participation rates within the NCMP with 99.2% of reception year children and 99.0% of year 6 children participating in the 2013 – 14 measurements. These percentages equate to a ranking of 8th out of 151 boroughs for reception year and 5th out of 151 boroughs for year 6.

Locally, the majority (81.5%) of reception age children (aged four to five years) in 2013 - 14 were measured as having a healthy weight (table 1 overleaf). Similarly, the majority (69.1%) of year 6 pupils (aged ten to 11 years) were also measured as having a healthy weight, although this was significantly lower than in reception aged children.

The prevalence of underweight children in reception (1.2%) and year 6 (2.4%) in Kingston is low in absolute terms (see table 1); however it is above the national average for reception year (0.9%) and both the London and England averages for year 6 (1.7% and 1.5% respectively). Local resources should therefore be used to address being underweight, in addition to the focus on those who are overweight and obese.

In Kingston, 11.3% of reception aged children and 13.1% of year 6 children were measured as overweight which was below both the London and England averages (table 1). With regard to obese children in Kingston the percentages were 6.0% in reception year and 15.4% in year 6. Again these were less than the London and England averages[64].

The prevalence of obesity more than doubles between reception year and year 6 in Kingston, mirroring the London and England figures. In order to look at this more closely, Kingston has introduced a pilot programme weighing and measuring year 3 pupils. In 2014 – 15, 17 schools voluntarily took part but a commitment from all schools to take part in 2015 – 16 should ensure comparability with the NCMP data for this year.

Table 1 Prevalence of overweight and obesity in children in reception year and year 6.

RECEPTION				
	Underweight	Healthy weight	Overweight	Obese
Kingston	1.2%	81.5%	11.3%	6.0%
London	1.5%	75.4%	12.3%	10.8%
England	0.9%	76.5%	13.1%	9.5%

YEAR 6				
	Underweight	Healthy weight	Overweight	Obese
Kingston	2.4%	69.1%	13.1%	15.4%
London	1.7%	60.7%	15.2%	22.4%
England	1.4%	65.1%	14.4%	19.1%

Source: NCMP 2013 - 14.

Children's weight by ward

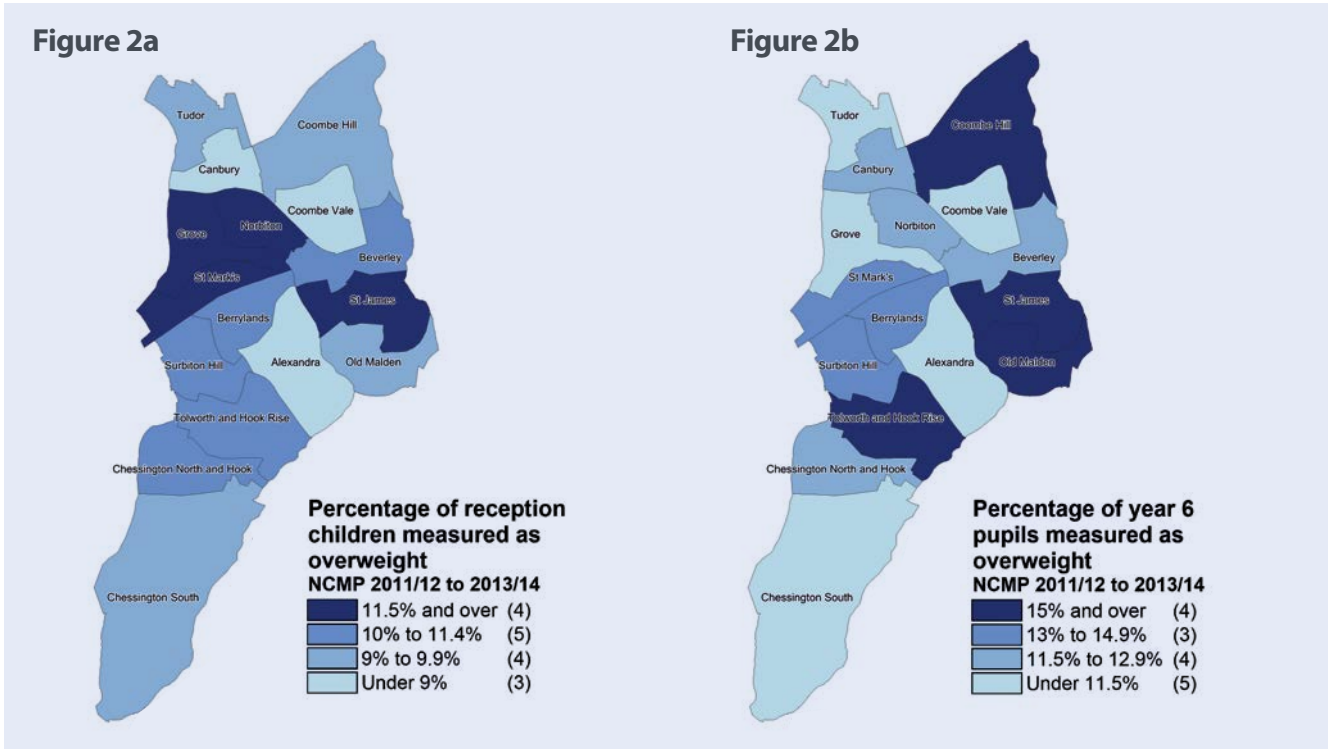
To study children's weight at ward level, three years of NCMP data are combined. Between 2011 - 12 and 2013 - 14, 10.4% of reception age children were measured as overweight. Figure 2a shows that Norbiton (14.0%), Grove (13.9%), St Mark's (12.1%) and St James (11.8%) wards had the highest percentages of overweight reception age children.

Over the same time period, 12.9% of year 6 pupils in Kingston were measured as overweight. Figure 2b shows that Coombe Hill (17.4%), Tolworth and Hook Rise (17.2%), St James (15.6%) and Old Malden (15.0%) wards had the highest level of overweight prevalence among year 6 pupils.

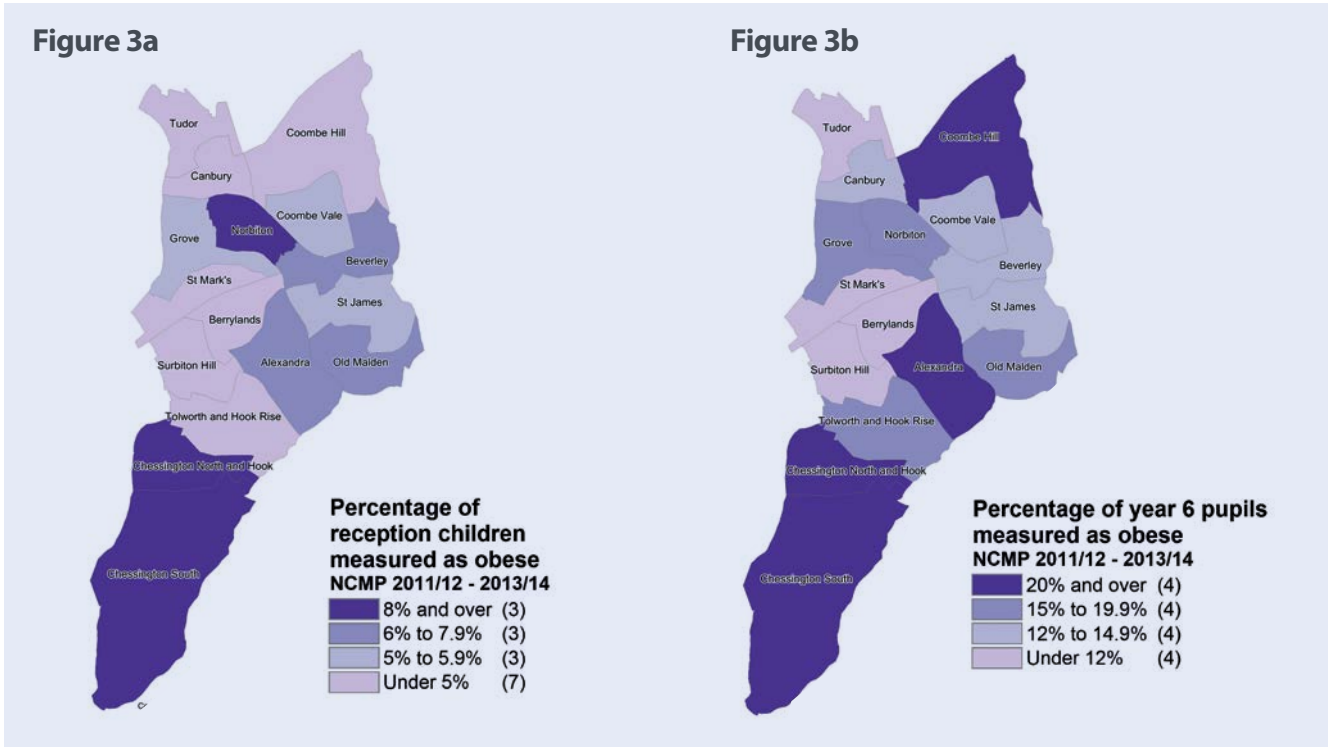
The prevalence of obesity in reception year children in Kingston was 6.0% for 2011 - 12 to 2013 - 14. Figure 3a shows that Norbiton (11.3%), Chessington North and Hook (9.8%) and Chessington South (8.1%) have the highest levels of obesity. In year 6 over the same time period, 16.1% of pupils were measured as obese and the ward data are shown in figure 3b; Chessington South (24.6%), Chessington North and Hook (23.8%), Coombe Hill (21.4%), Alexandra (20.6%) and Norbiton (19.6%) have the highest levels of obesity.

The prevalence of obesity in reception year children in Kingston was 6.0% for 2011 - 12 to 2013 - 14. In year 6 over the same period, 16.1% of pupils were measured as obese.

Figures 2a and 2b Percentage of reception and year 6 children measured as overweight 2011 - 12 to 2013 - 14.



Figures 3a and 3b Percentage of reception and year 6 children measured as obese 2011 - 12 to 2013 - 14.



The prevalence of underweight in reception year children in Kingston was 1.3% for 2011 - 12 to 2013 - 14. Figure 4a shows that Coombe Vale (2.3%), Chessington North and Hook (2.0%) and St James (1.8%) had the highest level of underweight prevalence among reception age children.

In year 6, over the same time period, 2.1% of pupils were measured as underweight. As shown in figure 4b, Old Malden (4.8%), Coombe Vale (3.5%) and St Mark's (3.1%) wards had the highest level of underweight prevalence among year 6 pupils.

Figures 4a and 4b Percentage of reception and year 6 children measured as underweight 2011 - 12 to 2013 - 14.

Figure 4a

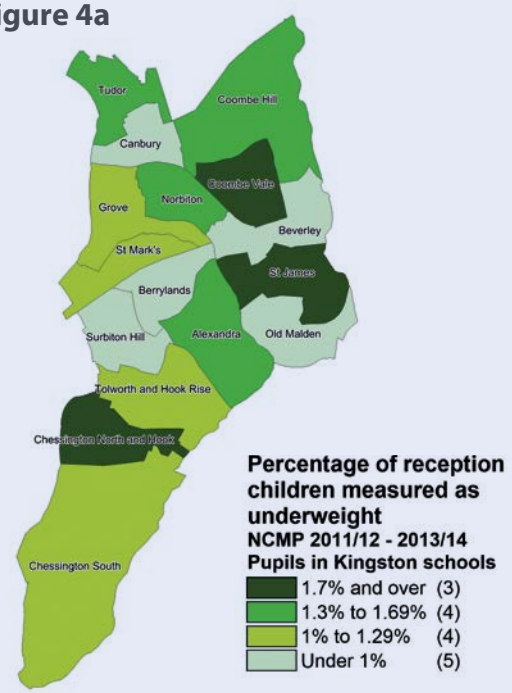
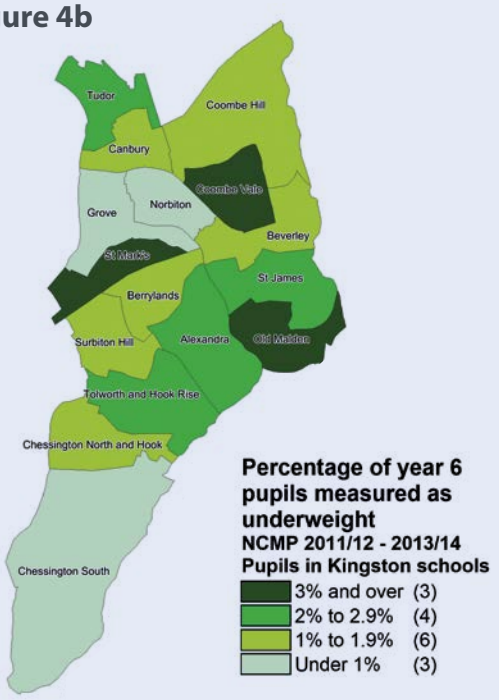


Figure 4b



Children's weight: ethnicity

Based on local 2013 - 14 NCMP data, Asian reception age children were more likely to be underweight (5.1%). A disproportionate number of Black (20.0%), Chinese (16.7%) and children in the 'any other ethnic group' category (15.7%) were overweight. Black (11.7%), Asian (9.1%) and Chinese (8.3%) children were more likely to be obese.

Amongst ethnic groups making up the year 6 pupils, White pupils (72.1%) and pupils from a mixed ethnic background (74.8%) were more likely to be at a healthy weight.

Higher percentages of Asian pupils (17.1%) and pupils in the 'any other ethnic group' category (21.1%) were overweight. With regard to obesity in year 6 pupils, rates were highest in Black and Chinese children (both with obesity rates of 22.2%) and Asian children (16.1%).

Young people's weight

In 2013, 3,982 students from years 7 to 10 were surveyed as part of the Schools and Students Health Education Unit (SHEU) Health Behaviour survey[75]. Of the pupils that responded, 46% said they were happy with their weight, 71% described themselves as being a healthy weight, 22% of pupils said they were overweight and 7% of pupils said that they would like to put on weight. The survey also addressed how weight affects wellbeing, with 32% of pupils reporting to worry 'quite often' or 'very often' about their weight. In addition, 27% of pupils said they worried about their diet, with year 9 girls being the most concerned.

There are no local data for the number of children and young people with eating disorders in Kingston, however in the period April 2014 to March 2015, there were only two new referrals made for children and adolescents from Kingston to the specialist South West London and St George's Mental Health Trust Eating Disorders service; seven children and adolescents were actively managed within this service over the same period. These figures should be interpreted with caution as they will not be reflective of the prevalence of eating disorders within the Borough.

Local action

Change4Life

The national Change4Life programme is promoted locally though health promotion events, local partners and commissioned services. Borough wide promotion has had positive results; during the most recent Change4Life sugar swap campaign 696 families in Kingston signed up[76].

Chef's Club

Chef's Club is a local nutrition and cooking programme that has been developed by Public Health. The programme is currently running in five schools: Burlington Junior School, Malden Manor Primary School, Robin Hood Primary School, St Luke's Church of England Primary School and St Philip's Special Educational Needs School.

Programmes run for six weeks and are delivered as an after school or lunchtime club. Children and young people acquire cooking skills within a small group environment that helps to increase confidence in cooking nutritious meals. Healthy eating messages are embedded into the programme.

The national Change4Life programme is promoted locally though health promotion events, local partners and commissioned services. Borough wide promotion has had positive results.

Cook and Eat

Cook and Eat is a local programme which is similar to the Chef's Club model however it is delivered in community settings rather than in schools. Cook and Eat is targeted at vulnerable young people and their families and aims to prevent unhealthy diets and obesity. Programmes for children and young people that ran in 2014 - 15 included one for Looked After Children (LAC) and one for young carers.

During the sessions participants learn about a healthy diet, experiment with new recipes and practice cookery skills. Participants were asked to self report their dietary habits and confidence in cooking healthily at the beginning and end of each 6 week programme. There was a 20% rise in the number of participants reporting good confidence in low fat cooking by the end of the programme in the LAC programme. A 22% rise was also noted in the number of LAC who ate vegetables on either most days or every day.

Young People's Health Link Workers

Young People's Health Link Workers (YPHLW) provide universal early intervention and prevention support to improve health outcomes for adolescents in Kingston. The team's work relating to diet and student health reached 678 students from September 2014 to July 2015. The YPHLW team assist schools by offering expertise, support and information to help equip schools and their students to grow their own food and deliver healthy eating messages as well as work towards their Healthy Schools awards (see chapter 4.3).

The YPHLW team are also trained to deliver child weight measurement sessions and if a young person is found to be in need of higher intensity work they will be referred on to an appropriate service.

To support the identification of young people at risk of eating disorders, the YPHLW team are trained Youth Mental Health First Aiders, equipped with the knowledge to identify early signs and symptoms of eating disorders and offer initial help to those in need.
Capacity building is achieved through Mental Health First Aid staff training ensuring school staff are aware of the importance of early intervention and know the warning signs of body image issues and eating disorders.
The YPHLW team are also trained to deliver a self esteem resource pack to help tackle body confidence concerns.

School Health team

The School Health team at Your Healthcare CIC is commissioned by Public Health to lead on the NCMP in Kingston. The results help to inform targeted healthy eating and weight management support for primary school aged children and can also be used as screening for childhood obesity, allowing early signposting on to appropriate services. Families are informed of their child's weight status through individualised feedback letters. Where children are above or below a healthy weight parents are encouraged to contact the School Health team for further information and support.

The School Health team also provides nutrition and weight management advice as required. This can include support for children who are demonstrating unhealthy eating behaviours, such as fussy eating or refusal of food, are vulnerable to food poverty, or are above or below a healthy weight. The team provide support either at school, via the phone or through home visits. Where further support is required, children and families are referred to specialist services.

Factor programmes

The 'Factor' programmes are commissioned healthy lifestyle and weight management programmes offered free to children and young people and their families. Between 2010 and 2015, these were delivered for those aged five to 16 years but this was expanded to include young people aged up to 19 years when the service was re-commissioned in March 2015.

Fun Factor is for children aged five to seven years and their families. Fwd Factor caters for children aged eight to 11 years and their families, and 4-U Factor is for young people aged 12 to 15 years. The new B-U Factor programme is for young people aged 16 to 19 years.

For the period April 2012 to March 2015, the 12 week programmes were delivered by Places for People Leisure and demonstrated a reduction in BMI. For Fwd Factor there was an average reduction in BMI of 0.8 whilst the 4-U Factor achieved an average reduction in BMI of 1.5.

The Fun Factor programmes did not have weight criteria (as this programme focused on promoting a healthy lifestyle) and therefore changes in BMI are not reported for this group.

The programmes are now delivered by Foodtalk CIC at a number of community venues and schools. They include a mixture of universal programmes for children of any weight, and targeted programmes for children who are overweight. Programmes are ten weeks long and combine dietary and physical activity information through a variety of age appropriate methods, including games, food tasting sessions, written information and physical activity and nutrition workshops. Parents and young people can self-refer to book their place on the programme or referrals can be made through health and care professionals.

Dietetic services

Children or young people with faltering growth or other nutritional problems that can affect growth and development (including Crohn's disease, iron deficiency anaemia, allergies, coeliac disease and swallowing difficulties) can be seen in Kingston Hospital outpatient department by specialist paediatric dietitians.

Specialist dietetic services: weight management

Children who are overweight or obese can be seen by a paediatric dietitian in 'The Health and Fitness Clinic' which is a specialist weight management outpatient clinic. These children may also be seen by paediatric dietitians in GP clinics throughout the Borough.

Specialist dietetic services: children and young people with eating disorders

Patients admitted to Kingston Hospital suffering with an eating disorder are managed routinely by the acute dietetics team during admission. There is currently no specialist dietetic eating disorder service in Kingston, however children and young people with eating disorders can be referred to the South West London and St George's Eating Disorder service. The service accepts referrals for anyone from the age of 11 years onwards and treatment is offered on an outpatient, daycare or inpatient basis dependent upon the individual needs of the patient.

Recommendations

1 **Continue to commission Chef's Club and Cook and Eat programmes for vulnerable children and young people.**

2 **Promote 'raising the issue of weight' training more widely across all schools and key partners working with children to improve confidence and knowledge.**

3 **Continue to promote the Factor children's weight management service to children, their families and young people and ensure successful embedding of the new B-U Factor programme for 16 to 19 year olds.**

4 **All nutrition, healthy eating and weight management programmes should be accessible to vulnerable groups, including children from ethnic minority backgrounds who are at a higher risk of underweight, overweight and obesity.**

5 **Continue to expand the year 3 weighing and measuring pilot in Kingston in order to better understand where services can have the most impact in reducing unhealthy weight (including the doubling in prevalence of overweight and obesity between reception year and year 6).**

1.4 Diet for adults (18 - 65 years)

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Introduction

Healthy diet

Poor diet is recognised as a contributory risk factor in an estimated 70,000 preventable deaths in people aged under 75 each year in the UK[77, 78, 79]. These deaths are mainly due to cardiovascular disease and cancers. Maintaining a healthy, well balanced diet throughout adulthood is therefore of great importance.

A balanced diet consists of a variety of foods that provide adequate macronutrients, minerals, micronutrients and fluid to maintain energy balance and hydration. In the UK, the eatwell plate[80] (see chapter 1.1, figure 1) encompasses the government's recommendations on what a healthy balanced diet is[80].

It is recommended that adults consume at least five portions of fruit and vegetables per day and limit intake of fat and free sugars[81, 82, 83]. Routinely supplementing the diet with vitamins and minerals is not necessary, although vitamin D supplementation may be recommended for people at risk of a deficiency of this vitamin given its role in bone health.

National survey data highlights that the UK population's diet does not resemble the eatwell plate and people are still consuming excess saturated fat, added sugars and salt and not enough fruit, vegetables, oily fish and fibre[84, 85].

Health effects of components of diet

Excessive consumption of particular food groups or nutrients (such as salt, fat and sugar) or being over or underweight is known to have detrimental effects on health. Due to their higher energy content, high fat and high sugar foods increase the overall energy density of the diet and promote weight gain. Reducing fat and sugar intakes are therefore important for energy restriction, weight management and overall health.

High intakes of high fat foods can also increase the risk of cardiovascular disease[81], in particular saturated and trans-fats which have adverse effects on cholesterol levels[81]. National recommendations are to limit both total fat and saturated fat intakes to no more than 35% and 10% of total energy intake respectively. Whilst the overall consumption of total fat in the UK is in line with recommendations, intake of saturated fat exceeds the recommendations for adults aged 19 to 64 years at 12.6% of total food energy[85].

Excess intake of free sugars that are added to food and drinks may displace more nutritionally adequate alternatives, resulting in an unhealthy diet[86]. Free sugars are associated with dental caries, which can have long term health implications such as affecting the ability to eat later in life[87]. Sugar intake should not exceed 5% of total energy intake, however sugar intake in the UK exceeds recommendations across all age groups, comprising 11.5% of total energy intake for adults aged 19 to 64 years[88].

For adults, sugar intake is generally higher in groups with the lowest incomes[85]. Dental decay affects 31% of adults in the UK[86, 89] with clear social variations. Adults from routine and manual occupation households are more likely to have decay than those from managerial and professional occupational households[89].

High dietary salt intake is associated with high blood pressure (hypertension) and this risk increases with both age and level of salt intake[90]. Hypertension increases the risk of stroke and premature death from cardiovascular diseases[90]. Salt consumption in the UK is also above dietary recommendations which are to consume no more than 6g per day. The mean estimated salt intake for adults aged 19 to 64 years is 8.1g per day (9.3g per day for men, and 6.8g per day for women)[91].

Nationally, one in five adults are estimated to have low vitamin D levels; 8% of 19 to 64 year olds had low vitamin D in summer, but this increased to 39% in winter and people with darker skin are at higher risk[92]. In winter 75% of Asian adults are estimated to have low levels of vitamin D[92].

Fruit and vegetable consumption

Nationally only 27% of adults (25% of men and 28% of women) consume the recommended five or more portions of fruit and vegetables per day[78]. Consumption of fruit and vegetables is associated with income, with 30% of men and 35% of women in the highest income quintile consuming five or more portions of fruit and vegetables per day compared with only 19% of men and 23% of women in the lowest quintile[84]. Amongst adults of working age, those aged 16 to 24 consume the lowest number of portions of fruit and vegetables per day[84].

Healthy weight

Weight for adults aged 18 to 65 years can be assessed using Body Mass Index (see chapter 1.1, page 18).

Black African, African–Caribbean and Asian (South Asian and Chinese) groups are considered to be at risk of diabetes and other health conditions at a lower Body Mass Index (BMI) than white Europeans[93]. Lower BMI thresholds (23 kg/m^2 to indicate increased risk of diabetes and 27.5 kg/m^2 to indicate high risk) have been recommended for these groups[93].

In England 62% of adults are now overweight or obese (67% of men and 57% of women). Although more men than women are above their ideal weight, the prevalence of severe (class III) obesity is consistently higher among women (3.9% in 2013) than amongst men (1.6% in 2013)[94].

In the UK there is a higher prevalence of obesity in women from deprived areas, with women from lower socio-economic groups more likely to be obese than those who are wealthier[95]. However the pattern is less straightforward for men, with only some measures of deprivation showing a relationship with obesity[96].

There is little national data on obesity prevalence in adults from BME groups, however women from Black African groups appear to have the highest prevalence of obesity, and men from Chinese and Bangladeshi groups the lowest[97]. Women have a higher prevalence than men in almost every minority ethnic group[98].

Carrying excess weight increases the risk of many health conditions including coronary heart disease, hypertension, stroke, liver disease and type 2 diabetes. Overweight and obesity has also been associated with an increased risk of some cancers, including breast, colon, kidney and endometrial cancers[93, 99, 100]. Being obese reduces life expectancy by an estimated average of two to four years for people with a BMI of 30 - 35 kg/m^2, and eight to ten years for people with a BMI of 40 - 50 kg/m^2 [93, 101]. People who are overweight or obese may also experience mental health problems, self esteem issues and suffer discrimination because of their weight[102]. The estimated annual cost in 2015 to the NHS of diseases related to overweight and obesity was £15.4 billion[103].

The fundamental cause of obesity and overweight is an energy imbalance between energy consumed and energy used[104]. Encouraging and supporting individuals to lose weight can be complex as there are numerous influences on dietary behaviours and weight including income, social deprivation, gender and ethnicity[95, 105, 106, 107].

The prevalence of people who are underweight in England is 1.2%. Being underweight or malnourished can cause measurable adverse health effects[108]. Malnutrition occurs in an estimated 26% of adults under the age of 70 in hospitals, care homes and mental health units[109]. Malnutrition can be a cause or consequence of ill health or underlying medical conditions[8] such as cancers, which increase the risk of weight loss, with 40% of patients with cancer suffering from malnutrition[110].

Malnutrition may also be related to eating disorders (including anorexia, bulimia nervosa and binge eating disorder) which can result in poor health and social outcomes, such as reduced fertility and a negative impact on relationships[111, 112]. The prevalence of eating disorders is difficult to determine due to their complex nature and inconsistencies in their diagnosis. However it has been estimated that between 608,000 and 725,000 people in the UK are suffering with an eating disorder, translating into total treatment costs to the NHS of between £3.9 billion and £4.6 billion[111].

Healthy diet and alcohol

Regularly consuming more alcohol than is recommended (no more than 3 - 4 units per day for men and 2 - 3 units per day for women) can increase overall energy intake, contributing to weight gain and increasing risk of obesity, as many people remain unaware of the calorie content of alcoholic drinks[113] .

National policy

Government initiatives encourage people to make healthier lifestyle choices through a combination of dietary and weight management advice. Examples include the 5-a-day and Change4Life campaigns which focus on increasing fruit and vegetable intakes, reducing fat and sugar intakes and increasing physical activity at an individual level. Government initiatives have focussed on reducing population intakes of salt by working alongside the food industry to reduce the salt content of manufactured foods and embedding information on salt into public awareness campaigns[114].

The fundamental cause of obesity and overweight is an energy imbalance between energy consumed and energy used[104]. Encouraging and supporting individuals to lose weight can be complex as there are numerous influences on dietary behaviours and weight including income, social deprivation, gender and ethnicity[95, 105, 106, 107].

Local picture

Fruit and vegetable consumption

A Kingston lifestyle survey undertaken in 2014[115] highlighted that fruit and vegetable intake in Kingston was much higher than the national average (table 2); 56% of Kingston residents reported eating five pieces of fruits and vegetables every day compared to 27% of adults in England[116]. A higher proportion of fruit and vegetable consumption was observed amongst women, reflective of the national picture. In Kingston, the age group with the highest percentage consuming five or more portions of fruit and vegetables was those aged 35 to 44 (at 64%). Of those aged 18 to 65, the lowest percentage consuming 5-a-day were the 25 to 34 age group (50%) although this percentage was much higher than the national average.

Table 2 Proportion of population who report eating recommended 5-a-day.

	Percentage of adults who report eating 5-a-day	Male	Female
Kingston*	56%	50%	62%
England**	27%	25%	28%

*Kingston breakdown for males and females is taken from the Healthy Lifestyle Survey, 2014.

**England data is taken from the HSE, 2013.

Weight

Extrapolating from national data, it can be estimated that the costs to the NHS in Kingston of diseases related to overweight and obesity is approximately £44 million[103].

In Kingston, the locally surveyed prevalence of both overweight and obesity were lower than both the London and England averages (table 3) with 31.1% of adults estimated to be overweight and 14.7% of adults estimated to be obese.

Table 3 Prevalence of underweight, overweight and obesity in adults in Kingston, London and England.

	Adults aged 18 and over		
	Underweight	Overweight	Obese/ severely obese
Kingston	3%	31.1%	14.7%
London	1 - 2%*	37.7%	19.6%
England	2%**	37.1%	24.7%

*based on WHO 2008 data[117] for underweight and Active People Survey, 2013 (adults aged 16 and over) for overweight / obese / severely obese.

**based on HSE 2013 data[94].

Source for local underweight/overweight/obese data: Lifestyle Survey, 2014 (adults aged 18 and over).

Source for London data: Active People Survey, 2013 (adults aged 16 and over).

In Kingston a lower percentage of men (47.1%) were at a healthy weight (table 4) compared with women (55.3%).

Table 4 Prevalence of underweight, overweight and obesity in adults in Kingston by gender.

	Underweight	Healthy weight	Overweight	Obese	Severely obese
Male	2.3%	47.1%	36.6%	11.7%	2.3%
Female	3.6%	55.3%	25.6%	13.4%	2.0%

Source: Kingston Lifestyle Survey, 2014.

These percentages equate to approximately 19,000 obese adults in Kingston, highlighting that action needs to be taken locally to reduce obesity rates and the associated health risks.

Whilst the national data show a correlation between weight and deprivation (more so for women than men), there is no local data to establish if this is mirrored in Kingston. Recognising the pockets of deprivation in Kingston, the national data need to be taken into consideration in service planning and provision, as does the fact that 28.8% of the population in Kingston is made up of BME groups[118].

There are approximately 2,860 adults in Kingston with either a BMI >35 kg/m^2 with co-morbidities or a BMI >40 kg/m^2 who could benefit from a specialised obesity bariatric service[115].

The prevalence of people who are underweight in Kingston is estimated to be higher at 3% than the England prevalence of 1.2%. There is no local prevalence data for the number of people with eating disorders in Kingston; however during the period April 2014 to March 2015, there were 47 referrals made for adults living in Kingston to the South West London and St George's Mental Health Trust Eating Disorders service which manages patients with severe eating disorders. On average over this time period, there were 30 adults being actively managed by this service each month. Although these numbers appear low, they do not include patients with mild to moderate eating disorders who will be managed by other services.

Local action

Healthy diet

Cook and Eat

Cook and Eat programmes for adults aim to promote a healthy diet and healthy weight by providing participants with the confidence and skills to cook and consume a healthier diet. They are provided at a variety of local community settings including the Joel Community Trust (aimed at homeless adults and those with substance misuse and/ or mental health problems), the Fircroft Trust and the Kingston United Reformed Church (both reaching adults with mental health problems) and via Learn English at Home (for adults whose first language is not English). In addition, the Moor Lane Centre provides Cook and Eat programmes for adults with learning disabilities.

Cook and Eat is designed to be sustainable in that it develops staff and volunteers from the participating organisations, providing the knowledge and skills to work with people in their local community and improve their health beyond the initial intervention.

The five Cook and Eat programmes in Kingston in 2014 - 15 have reached a total of 94 people. Participants on all of the programmes have reported improvements in a range of dietary behaviours including increased fruit and vegetable consumption and reduced intake of salt, fat, sugar and fizzy drinks.

Healthy weight: community services

A range of weight management programmes are offered to eligible adults who either live or work in Kingston or are registered with a Kingston GP. These services are offered to people who have a BMI greater than 28 kg/m^2, or more than 25 kg/m^2 if they have conditions that place them at greater risk of weight related illnesses.

Weigh 2 Go

Weigh 2 Go is a ten week programme offered free to adults aged 18 and over which aims to aid with weight management and promote healthy lifestyle changes including information on food label reading and portion size control. The programme is delivered by trained specialist advisors in selected GP surgeries and pharmacies in both one-to-one and group settings.

The majority of participants who attend Weigh 2 Go are female (77% in 2014 - 15) and most participants are aged between 18 - 65 years (78% in 2014 - 15). Weigh 2 Go has a very good retention and completion rate for a primary care led intervention when compared to other similar weight management programmes[119]. During the period 2014 - 15, 319 participants enrolled onto the programme with a retention rate of 57%. Of these, 75% of participants achieved some degree of weight loss in the short term with 18% of participants achieving a loss of 5% or more of their body weight[120].

Slimming World and Weight Watchers

Slimming World and Weight Watchers are national group weight management programmes that have been commissioned locally by Public Health in Kingston since October 2014. Twelve weeks are offered free of charge to eligible patients.

Slimming World focuses on long term lifestyle changes, providing support with healthy eating and weight management through a combination of nutritional information and a lifestyle activity programme. For the period October 2014 to June 2015, 84 participants were enrolled into the Slimming World programme in Kingston. Of these, 51 finished their 12 free weeks and 61% of those who 'completed' the programme (by attending 10 or more sessions), achieved a weight loss of

5% or more. Of those who did not complete the programme (attended fewer than ten sessions), 65% still achieved some degree of weight loss. Data on long term weight loss is not yet available. The overwhelming majority of participants attending Slimming World were female (96%).

Weight Watchers encourages weight loss through a diet plan and progression to the 'ProPoints' system which involves participants adhering to a points allowance per day. This is similar to calorie counting, however foods and drinks are allocated points taking into account their nutrient content. Weight Watchers is offered in a group setting at various locations throughout Kingston. For the period October 2014 to April 2015, 27 participants were enrolled into the Weight Watchers programme in Kingston. Of those who 'completed' the programme (attended ten sessions or more) 30% achieved a weight loss of 5% or more, however this is based on low numbers so the data should be interpreted with caution. The majority of participants attending Weight Watchers were female (90%).

Due to the relatively low numbers of residents taking up the new offer of free community weight management programmes, a 'Why Weight?' promotional campaign was commenced in April 2015 to raise awareness and encourage take up of these services. The impact of this campaign will be evaluated once complete. There is also a need to target high need groups and in particular men, as women continue to be the main users of all three community weight management programmes.

Physical activity services

In addition to the above weight management services, physical activity programmes are available for adults looking to manage their weight (see physical activity chapters 2.4 and 2.5).

Dietetic services

General dietetic services

Patients who are overweight or obese can be referred to the Kingston Hospital Dietetic Outpatient service for assessment by a dietitian. Healthy eating and healthy weight messages are also embedded into all other dietetic outpatient appointments, especially where there is a weight or diet related co-morbidity for example, diabetes, high cholesterol, hypertension or irritable bowel syndrome.

Specialist dietetic services

Patients in Kingston requiring more specialist weight management advice (due to being morbidly obese, potentially requiring bariatric surgery, or having an eating disorders such as binge-eating disorder) are currently managed by dietitians located in either the GP setting or hospital dietetic outpatient service due to the absence of a multidisciplinary weight management service in Kingston.

Eating disorders

The Kingston Hospital Dietetics team will review any patients with a diagnosed eating disorder who is admitted to the hospital in order to support them through their acute illness. There is currently no specialist eating disorder service at Kingston Hospital but patients can be referred for specialist support on discharge.

The Kingston Wellbeing Service (which provides psychological therapies) will see adults with mild to moderate eating disorders, who do not require a specialist service. In severe cases, or where more specialist input is required, patients are seen by the South West London and St George's Eating Disorder Service (see chapter 1.3 for further details on this service).

Recommendations

1 **Continue to promote healthy eating and healthy weight messages ensuring these are embedded into all public health services, weight management programmes and community events.**

2 **Continue to work with the voluntary sector and local communities to deliver healthy eating programmes such as Cook and Eat.**

3 **Continue to commission weight management services via both local and commercial programmes.**

4 **Consider ways in which to increase uptake of weight management services by the population as a whole and by men in particular.**

5 **Develop mechanisms to collect more measures of dietary behaviours for the local population including salt, fat, sugar and sugary drinks consumption.**

6 **Encourage NHS commissioners to consider commissioning a specialist adult weight management service with multidisciplinary input to reduce the need for bariatric surgery and help manage complex and severe obesity.**

7 **Develop closer links between Kingston Hospital and specialist eating disorders services to allow more holistic patient management and streamline the referral process.**

Joel Community Trust participants enjoy their meal.

Case study – Cook and Eat at Joel Community Trust

The Joel Community Trust (JCT) runs the first ever permanent night shelter for homeless adults in Kingston, located next to St Peter's Church. Four hundred people become homeless in the Borough every year.

The JCT in partnership with Kingston Churches Action on Homelessness has developed an exciting project where any homeless and vulnerable people in Kingston can find shelter, food and friendship. This project seeks to:

- play an active part in the life of the local community by relieving suffering and distress among homeless and vulnerable people irrespective of race or class
- protect the self esteem and dignity of homeless and vulnerable people and restore confidence, whilst providing security and stability
- provide opportunities for creativity and industry, inspiring homeless and vulnerable people to learn new skills and seek constructive employment
- promote social justice, partner with other organisations and support local initiatives that will bring about community action on behalf of homeless and vulnerable people.

The JCT recognises and addresses the importance of nutrition as a matter of urgency whilst working with their guests. It promotes the philosophy of "foods for moods".

Their philosophy states:

> "How can people expect their bodies, including their brains, to work effectively when they put in sub standard fuel? Everybody knows that the right diet can be the catalyst for huge change. The very least they can do for their guests is to ensure that they provide the healthiest range of food possible for the duration of their stay at the shelter."

To achieve this, at the beginning of the week, the staff team meet to plan the menu for the coming seven days and specific dietary needs are catered for at this time.

Public Health commissioned the JCT in September 2014 to run two Cook and Eat programmes. These programmes were successful and reached 12 adults residing at the night shelter. A success story of sustainability, the JCT now delivers Cook and Eat sessions independently. A rolling six week programme on addressing healthy eating within a budget is now delivered and all guests are invited to join this programme, and if they wish, may sit a Level 2 City and Guilds Food Safety and Hygiene exam funded by the JCT, to consolidate what they have learnt. The JCT are committed to providing and promoting a healthy lifestyle and in their first year were awarded five stars when inspected by the Kingston Environmental Health department.

The JCT does not provide or encourage the consumption of crisps, cakes, carbonated drinks, processed meats or any other food that may be harmful to health if consumed regularly and has recently removed refined sugar entirely from the shelter.

1.5 Diet in older age (65 years and over)

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Introduction

Healthy diet

Diet and nutrition play a vital role in maintaining the health and wellbeing of older adults. The eatwell plate as mentioned in previous chapters (see chapter 1.1, figure 1) is recommended for the general population. For older adults these recommendations should be amended to consider those at risk of under-nutrition which is common in adults aged over 65[121]. Adequate intakes of nutrient dense foods, protein, and fluid[122] need to occur in this age group, particularly during acute or chronic illness which can negatively impact on nutritional status.

With age, energy (calorie) requirements decrease but nutrient requirements remain the same or increase[123]. Inadequate nutrition is often disease related, however social factors (such as ethnicity and income) and mechanical factors (including reduced mobility, poor oral health or difficulty in swallowing) are also important[124, 125]. Low dietary intakes have been reported for several vitamins and minerals in older people, particularly those living in institutions[126]. Lower vitamin D status and higher levels of anaemia have been identified in people living in institutions when compared with those living in their own home[126].

Calcium and vitamin D are both required to maintain bone health and reduce the risk of osteoporosis. Fractures resulting from osteoporosis are a major cause of morbidity and mortality in older people and it is important to reduce this risk through dietary and lifestyle measures. Although calcium requirements in the elderly can be met via diet, requirements for vitamin D increase with age and given that dietary vitamin D is limited, routine supplementation is recommended for those over 65 years of age. Other vitamins and minerals that may be of concern in this age group include vitamin B12, iron, folate and vitamin C, however routine supplementation with these is not recommended.

In addition to nutrients, fluid intake is of particular importance for adults aged over 65 years. The risk of dehydration is much higher in older people due to numerous physiological changes including reduced kidney function and a reduced sensation of thirst. The consequences of dehydration can be severe, ranging from drowsiness and confusion to delirium, and can be fatal in the most severe cases. Approximately 10% of older people admitted to community hospitals are suffering from clinical dehydration and this is higher (25%) amongst immobile elderly patients[122].

Nationally adults aged 65 and over consume an average of 4.6 portions of fruit and vegetables per day and 41% of older adults met the 5-a-day recommendation[127].

Healthy weight

Non-communicable diseases affecting the elderly are often influenced by modifiable dietary lifestyle factors and have strong associations with diet. For example, the risk of diseases such as diabetes and some cancers increase with excess weight[128]. Issues regarding obesity are discussed in chapter 1.4, and it is important to note that the prevalence of overweight and obesity continues to increase through middle age and overweight is most prevalent amongst older adults aged 65 to 74[129, 130].

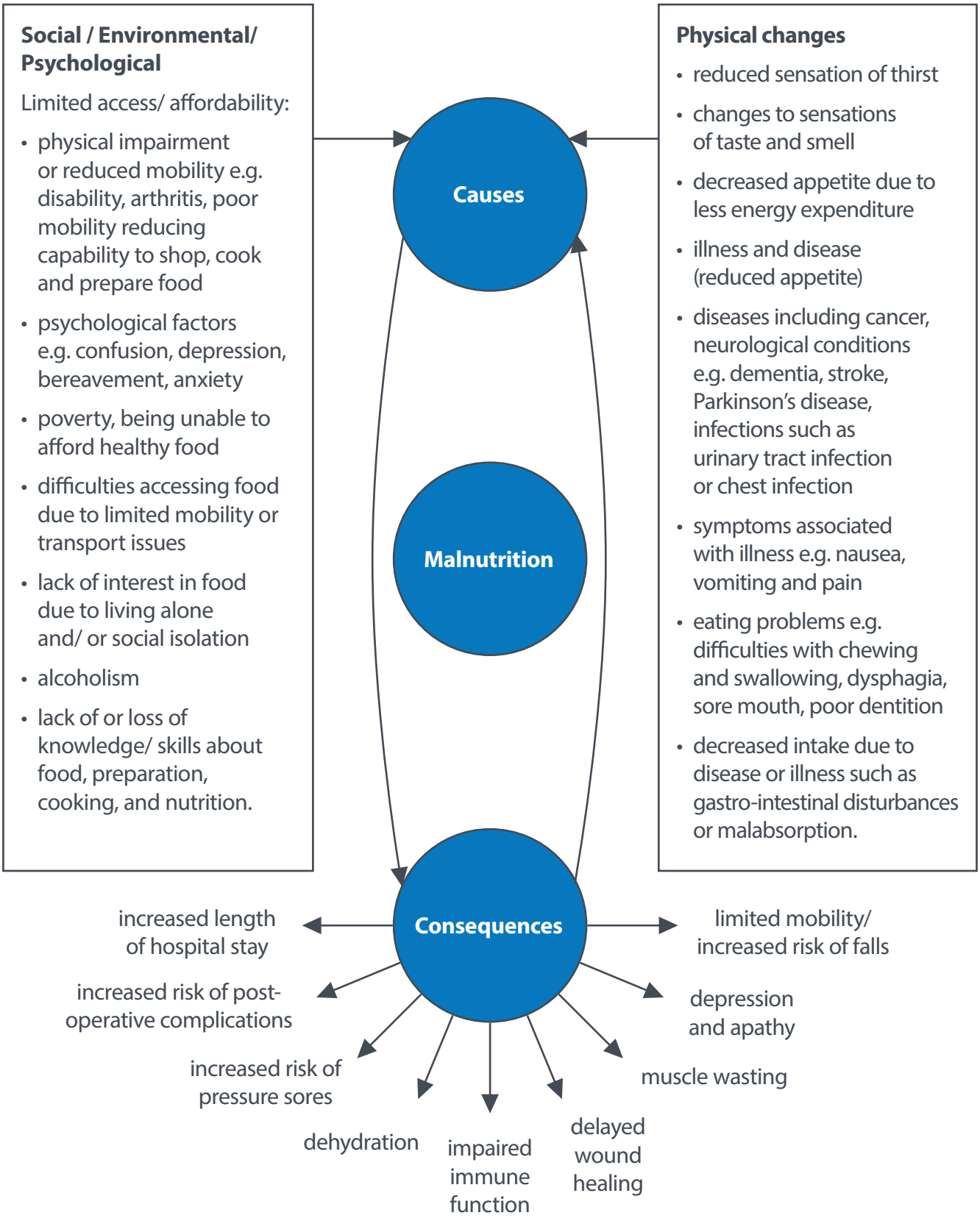
There is a reduction in the prevalence of obesity in the over 75 age group. According to data from 2013 the prevalence of obesity reduces in men from 31.1% in those aged 65 to 74 to 26.8% in those aged 75 and over. The corresponding figures for women are 32.7% to 23.5%[129]. This could be due to a number of factors, including reduced life expectancy in those who are overweight or obese[131] (there is a reduction in life expectancy of between eight to ten years amongst those who have morbid obesity[132]), loss of appetite with age resulting in unintentional weight loss or reduced muscle mass (due to inactivity or illness) affecting the overall BMI measurement.

There is particular concern in older people above a healthy weight that the excess weight 'hides' muscle loss, as visually the loss in muscle is masked by the excess fat that has been gained[133]. The reduction in lean body mass and increase in fat mass leads to changes affecting older people including a reduced ability to work, shop and cook and an increased risk of falling[132].

Malnutrition is a widespread problem affecting 1.3 million people over the age of 65, of which 93% are living in their own homes[121, 134]. The causes of malnutrition in the elderly are multifactorial and there are numerous clinical consequences for this age group (see figure 1 overleaf). In older adults, changes to digestive capacity, taste, basal metabolic rate, and feelings of hunger, satiety and thirst can all increase the risk of nutritional compromise. Age-related chronic neurodegenerative diseases such as dementia, Parkinson's disease and strokes can have a particularly significant impact on nutritional status.

People who are malnourished make 65% more GP visits, account for 82% more hospital admissions and stay in hospital 30% longer when compared with people who are well nourished[135,136]. As a result, malnutrition in older people is estimated in the UK to account for £5 billion in direct health care costs[138] with another £13 billion spent on associated health and social care needs[132, 138] making malnutrition a larger financial issue than obesity in older people[139]. As well as the health effects noted above, malnutrition negatively affects quality of life for both individuals and their carers and for all these reasons it is important to both prevent malnutrition and treat it in its early stages in older people living at home.

Figure 1 The causes and consequences[132] of malnutrition in elderly adults.



Local picture

Diet

Fruit and vegetable consumption is higher in Kingston than the England average for both women and men with nearly 60% of people aged 55 and over consuming the recommended five portions of fruit and vegetables each day[138]. In Kingston, adults aged 75 years and over were the least likely of all adult age groups to meet national guidelines, with only 47% reporting that they consumed five portions of fruit and vegetables per day. As with the national data, women consumed more fruit and vegetables than men.

Weight

Local survey data indicates that the prevalence of overweight and obesity reduces from 57.1% in those aged 65 to 74 to 44.0% in those aged 75 and over[140]. This equates to 6,600 people aged 65 to 74 and 4,500 people aged 75 and over.

Based on national data trends approximately 3,050 adults aged over 65 years in Kingston (table 1) will be malnourished. Nationally the prevalence of malnutrition is higher in care settings such as care homes, hospital inpatients and those receiving care at home[141]. This may well be influenced by the increased likelihood of patients in these settings being more accurately monitored and malnutrition recorded more often. Table 1 overleaf lists the estimated number of malnourished people in Kingston in a range of settings based on national data. It is also estimated that 30% of people aged over 65 admitted to hospital will be malnourished[142].

Fruit and vegetable consumption is higher in Kingston than the England average for both women and men with nearly 60% of people aged 55 and over consuming the recommended five portions of fruit and vegetables each day[138].

Table 1 Estimated number of malnourished older adults in Kingston amongst high risk groups.

Population Group	Kingston Population Data	Malnutrition* prevalence[132]	Estimated number malnourished based on national prevalence predicted by BAPEN
Population aged 65 years and over	21,808[a]	14%	3,053
RBK Sheltered housing	823[b]	10 - 14%	82 - 115
Home care users aged over 65	357[c]	25%	89
Total Population aged over 65 living in a care home with or without nursing care	776[d]	30 - 42%	233 - 326

a Source: Office of National Statistics Mid-year Population Estimates: Pivot Table Analysis Tool for the United Kingdom, 2013 - 14.

b Number of Sheltered Home places in Kingston is 832 for adults aged 55 and over people in Kingston as quoted by Royal Borough of Kingston Housing Contact Centre and of the 832 sheltered homes, nine Sheltered home places are vacant. Therefore 823 are occupied by adults aged 55 and over.

c Number of Kingston residents aged 65 and over provided home care by social services (excluding private/family care), 2015 quoted by strategic Business Team Social Services.

d POPPI system data for 2015 People aged 65 and over living in a care home with or without nursing by local authority projected to 2030. Accessed from www.poppi.org.uk on 9th January 2015.

*Note: Malnutrition prevalence is taken to be a BMI <18.5 kg/m^2 or <20.0 kg/m^2 depending on study.

The six monthly added cost of malnutrition to the NHS is £1,003 per patient. Put into a local context, this equates to malnutrition-related healthcare costs of approximately £6 million per year in Kingston given the estimated number of malnourished local people.

The number of people with dementia looked after by Kingston GPs is estimated to be over 1,800[144] and the risk of malnutrition is high amongst this group[145]. Studies have shown[146] that up to 45% of those living with dementia experience clinically significant weight loss over one year, and up to half of people with dementia in care homes have an inadequate food intake[147]. In Kingston Hospital 48% of inpatients above the age of 75 have a confirmed or suspected diagnosis of dementia and so preventing malnutrition in the hospital is a major task.

Local action

Community services

Better Bones service

The Better Bones Service is a 12 week exercise and education programme designed to improve people's bone health and reduce the risk of fragility fractures in the future. Key nutrition messages for older people accessing this service include following the eatwell plate in relation to improving bone health. It also focuses on the importance of calcium and vitamin D for good bone health. For more information see chapter 2.5.

Fit as a Fiddle

The Fit as a Fiddle programme is six weeks long and aims to tackle overweight and obesity amongst people aged over 50 from ethnic minority groups or from areas of social deprivation. Each session includes two components: one hour of activity (see chapter 2.5) followed by an hour of healthy lifestyles or weight loss workshops. Dietary eating habits and physical activity levels are recorded at the beginning and at the end of the programme.

There were 22 Fit as a Fiddle courses that took place from April 2014 to April 2015. They were attended by 279 older adults. Of these, 44% prioritised healthy eating as being their most important aim. By the end of the programme, 55% of participants rated their knowledge of healthy eating as between 9 - 10 (on a scale of 1 - 10 where 1 is very poor and 10 is very good), an improvement from only 25% rating their knowledge at this level at the start of the programme.

Of the 147 participants that completed both the entry and exit questionnaires, the number consuming five portions of fruit and vegetables a day more than doubled from 25 to 56. When followed up at three months, 99 participants responded and of these, 64% still reported eating a healthier diet.

Lunch clubs

There are a range of organisations in Kingston running lunch clubs for older people. These include the Charles Lesser lunch club in Chessington, Alfriston Day Centre in Surbiton and the Milaap Day Centre for older people from ethnic minority groups.

Kingston Stay Well at Home Befriending service

The Stay Well at Home service provided by Staywell includes volunteers supporting recently discharged patients from hospital in their home. Volunteers visit the client's home over a number of weeks making sure that the client is able to access the food they need. The service looks for different ways the client can get regular and varied food. This includes:

- clients using Wiltshire Farm Foods (a national frozen meals delivery service)
- eating at Raleigh House Day Centre and Bradbury Day Centre
- going to a local pub or cafe.

Community malnutrition screening

There is no universal malnutrition screening programme for care home residents across Kingston; however individual nursing and care homes can use screening tools such as the Malnutrition Universal Screening Tool (MUST) and should also regularly weigh their patients in accordance with Care Quality Commission (CQC) guidelines. Establishing the current picture of how established malnutrition screening is in nursing and care homes should be included as part of a local needs assessment for malnutrition.

Community dietetics

There is currently no community domiciliary dietetics service to cover oral nutritional support in Kingston. Where there is a concern, patients can be referred for nutritional support via their GPs to dietitians located in either the GP setting or hospital dietetic outpatient service. Although this service will meet the needs of some at risk patients, it may not be easily accessible to those most vulnerable to malnutrition, for example, those who are housebound or have limited mobility. A domiciliary service would improve access for these patients.

Adult Home Enteral Feeding (HEF) service

Patients who are receiving artificial nutrition such as percutaneous endoscopic gastrostomy (PEG) feeding are routinely reviewed by the specialist home enteral feeding (HEF) dietitians who provide a domiciliary service. Patients include those with limited oral intake secondary to long term conditions including stroke, dementia, motor-neurone disease and cancer, who are unable to meet their nutritional needs via oral intake alone. The HEF service is provided by one whole time equivalent dietitian, covering Kingston and Richmond Boroughs (approximately 120 patients in total).

Hospital services

Dietetics

All patients who are admitted to hospital are screened for malnutrition using the MUST. Screening should be completed within 24 hours of admission for all hospitalised patients and those identified as being at risk are referred to the dietitians who carry out individual assessments. A range of nutritional support is available to hospitalised patients. This includes a 'food-first' approach by offering high energy and high protein foods as a first line treatment. Depending on the severity of malnutrition, other measures including oral nutritional supplements such as high energy drinks or puddings or artificial nutrition and hydration, for example nasogastric feeding, may be indicated.

Dining Companions

The Dining Companions scheme started at Kingston Hospital in 2012, offering older patients with care needs support and companionship at mealtimes. Approximately 387 Dining Companion volunteers have been recruited since 2012 including public volunteers, non clinical staff and members of community groups. The scheme helps to relieve nursing staff time so that they are able to focus on patients with more complex feeding issues, for example, patients with severe dementia who require one-to-one support from trained staff. The scheme currently has 301 active volunteers and is able to provide two volunteers per mealtime for each ward, seven days a week.

Nutrition and hydration packs

On discharge, patients can be provided with a nutrition and hydration pack if they do not have food and drink readily available or accessible at home. The packs mainly consist of non-perishable food and drink but are not intended for long term storage or as a long term solution to managing a patient's diet so may contain some perishable food items such as fruit and juice.

Hospital staff training

Kingston Hospital dietitians host an annual Nutrition Study Day open to all health professionals including nursing and care home staff with a view to reaching the wider community. The study day involves education and training about malnutrition and practical ways of improving nutrition in the care setting, for example food fortification and the optimal use of prescribed nutritional supplements.

The H2H service is a new initiative that has been designed to provide support to vulnerable patients including older people and those with dementia who have been discharged to have a better experience of care between the hospital, home and the community.

Hospital 2 Home (H2H) project

For many patients being discharged from hospital and returning home can be a difficult and stressful time. The H2H service is a new initiative that has been designed to provide support to vulnerable patients, including older people and those with dementia who have been discharged, to have a better experience of care between the hospital, home and the community. H2H supports patients through the discharge process and helps them settle back into their everyday life. One component of the service is to ensure patients have sufficient food at the point of discharge.

Volunteers befriend patients on the ward, particularly those who have been in hospital for more than a week, and check they have fresh food for when they return home. This is to make sure that when patients are discharged home, they have enough ingredients to make a light meal.

Volunteers do not give any nutritional advice but once a patient is discharged home, they may contact the patient within a day or two. During this call, volunteers will check if the patients are eating and drinking enough food and liquid at home and sometimes refer people on to organisations like Wiltshire Farm Foods or to local community groups which provide assistance with shopping (such as a shopping bus service). Since being set up in February 2015 the service has provided one to one support to over 30 patients to help them in the transition from the hospital back to life at home.

Recommendations

1 Encourage the development of a multidisciplinary team approach to address malnutrition in older people in the community in Kingston.

2 Support the completion of a full malnutrition needs assessment, working with patients and stakeholders and using both quantitative and qualitative data to map current provision in more detail and develop recommendations in line with national policy.

3 Ensure the Healthy Weight and Physical Activity (HWPA) Needs Assessment and Strategy 2013 - 16 includes a stronger focus on malnutrition in future iterations.

4 Encourage NHS commissioners to consider commissioning a domiciliary community dietetics service to lead on oral nutritional support in the community and provide regular reviews of community patients including those in care homes, and training to nursing and care homes on nutrition issues.

5 Encourage all care and nursing homes to use the MUST tool at least monthly or when clinical suspicion arises and to follow the CQC standards for nutrition and hydration.

6 Identify nutrition training needs amongst front line staff working with older people across health, social and the voluntary sector in relation to malnutrition.

7 Continue to commission local community services to increase accessibility to a healthy diet.

8 Further develop prevention programmes such as Cook and Eat to include focussed education on avoiding malnutrition.

9 Continue to commission community weight management programmes to work towards reducing the prevalence of overweight and obesity in older adults.

Case study – Dining Companions scheme

The Dining Companions scheme started in 2012 offering older patients practical care, support and companionship at mealtimes. Since then, 387 dining companion volunteers have been recruited. The project frees up nursing staff time to focus on patients with more complex feeding requirements.

Benefits of the Dining Companions scheme

In a climate where many people are chronically lonely[147], dining companions provide social interaction that nursing staff simply cannot provide in a busy hospital environment.

> "Making someone feel at ease is very important and is quite a highlight of their day…because for a lot of elderly patients no one visits" (dining companion)[147].

A high quality volunteering force frees up staff to care for patients with more complex or urgent needs

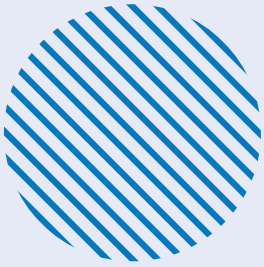
> "It's what we need and what the patients need as well…we can't be in six places at once…" (nurse)[147].

Volunteers supporting rather than treating patients can persuade patients to eat and drink more.

> "The nurse said "oh they don't want to eat..." but you have sat and talked with them and they have eaten, actually it's quite rewarding" (dining companion)[147].

Dining Companions also offers a rewarding volunteering experience.

> "When I started, I had no experience whatsoever in a clinical environment. I didn't know if I could make a difference… I am now more determined than ever to complete my studies in Dietetics and dedicate my life to working with patients in hospitals to improve their nutrition" (dining companion)[147].



1.6 Food poverty and insecurity

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Introduction

Food security is defined as when people have access to sufficient, safe, nutritious food to maintain a healthy and active life[148]. This includes the physical availability of and the economic access to food, as well as the nutritional knowledge to prepare and cook healthy food. Food poverty occurs when people are unable to access or afford healthy food, and so contributes to food insecurity[149].

This is especially the case for people on low incomes who have become increasingly vulnerable to food poverty. 'Food deserts' now exist where there is limited local availability of healthy food and instead cheap energy dense foods are easier to access. Those on low incomes consume more fat spreads and oils, non-diet soft drinks, pizza, processed meats and table sugar and eat fewer fruits and vegetables[150]. There are long term impacts on children from having a poor diet[151]. Food preparation can also be difficult if people lack the appropriate skills or confidence, have restricted access to cooking or food storage facilities, or where time is limited due to busy lives[152].

It is estimated that 17% (10.6 million) of all people in the UK are likely to be experiencing food poverty and therefore suffering from a poor diet[153]. This places them at risk from diet related ill health which is responsible for approximately 10% of deaths in the UK, and is estimated to cost the NHS £5 billion annually[154].

At the same time, 4.2 million tonnes of household food and drink worth £2.5 billion[155] is wasted each year. These include items such as fresh fruit and vegetables, bread and yoghurts.

Low income and social deprivation is also associated with obesity[156] as energy dense foods are often the affordable food choice. Obesity can often mask underlying food poverty and micronutrient deficiencies[157]. Community food projects are vital in supporting and encouraging healthy food choices[158]. Methods to address food poverty include foodbank sites, food kitchens, community food buying schemes, school breakfast clubs and lunch clubs for older people.

Local picture

Child food poverty

There are estimated to be 4,135 (12.1%) children and young people under 20 years old living in poverty in Kingston[159]. Whilst this number is lower than the England (18.6%) and London (23.5%) averages (table 1), these children are vulnerable to food poverty, which can limit their growth and development, school performance and later life achievements[156].

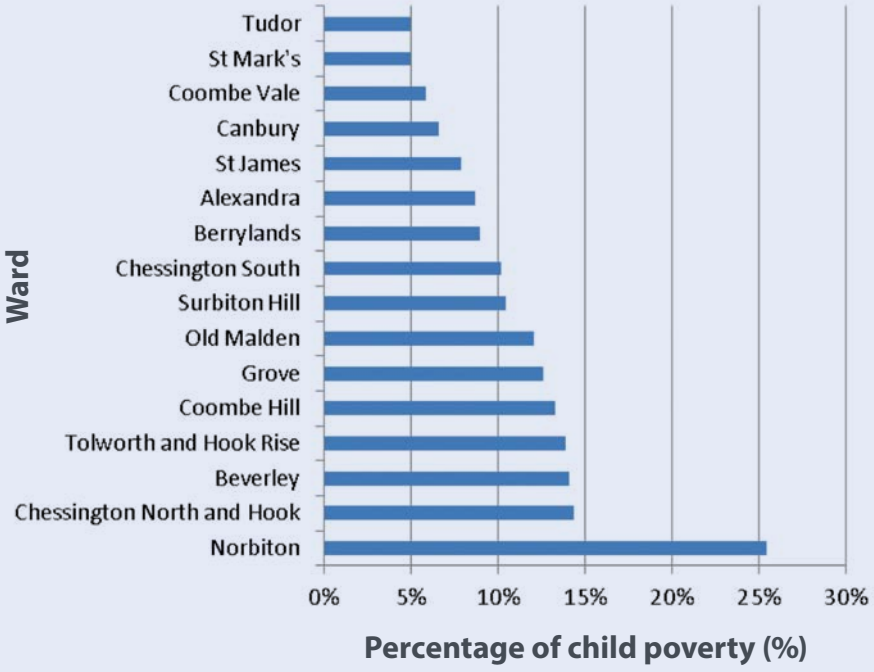
Table 1 Children living in poverty.

	% of children under 20 years old living in poverty
Kingston	12.1%
England	18.6%
London	23.5%

Source: PHO Indicators, 2012.

Ward level data (figure 1) demonstrates considerable variation in the percentage of children living in poverty. This varies from as much as 26% in Norbiton, which is higher than both the England and London averages, to less than 5% in Tudor and St Mark's wards[160].

Figure 1 Child poverty by ward in Kingston.



Source: London's Poverty Profile. End Child Poverty Commission, February 2013.

*Where 5% is reported on the graph, these wards have less than 5% child poverty and the exact figure has not been reported.

Adult food poverty

There is no accurate measure for food poverty in Kingston; however there are other indices that can be used as proxy measures. The numbers of people living in deprivation is one of these measures.

There are 1,880 adults (1.5%) living in Super Output Areas in Kingston that are in the most deprived 20% nationally[161], which is a much smaller percentage than the England and London averages (table 2).

Fuel poverty is also a useful indicator for food poverty, as individuals living in fuel poverty are also likely to be experiencing food poverty[161, 162]. A household is considered to suffer from fuel poverty if its energy costs are above the average for its household type and this expenditure pushes it below the poverty line[163]. In Kingston there are 5,405 (9.4%) households who experience fuel poverty, which is in line with the London average (9.8%) and slightly lower than the England average (10.4%)[165].

Table 2 Data indicators for food poverty in Kingston, London and England.

	% of people living in 20% most deprived areas in England*	% of households that experience fuel poverty, 2013**
Kingston	1.1%	9.4%
London	22.9%	9.8%
England	20.4%	10.4%

Source: *English Indices of Multiple Deprivation 2015, Department of Communities and Local Government, Small Area Statistics (Mid 2013 Estimates for LSOA), Office of National Statistics, 2015. **Department of Energy and Climate Change, 2013, accessible via Public Health Outcomes Framework, 2015.

A household is considered to suffer from fuel poverty if its energy costs are above the average for its household type and this expenditure pushes it below the poverty line[163]. In Kingston there are 5,405 (9.4%) households who experience fuel poverty, which is in line with the London average (9.8%) and slightly lower than the England average (10.4%)[164].

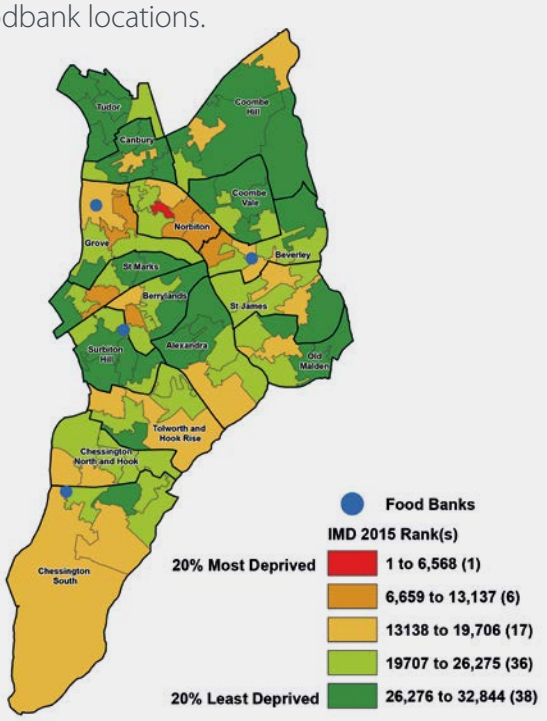
Adults aged over 60 years are especially vulnerable to fuel poverty[165]. Nationally, 22% of people aged 60 years and over have reported skipping meals in order to cut back on food costs and 42% admitted to struggling to afford essential items such as food, as well as gas and electricity[166]. Furthermore, 9% of people aged 60 and over reported that if they could not meet the cost of fuel during winter, they would cut back on essentials such as food[167].

Dietary intakes

Given national data[168, 169] it is highly likely that children and adults living in more deprived areas in Kingston will be consuming fewer fruit and vegetables than people living in the more affluent areas.

A survey of young people in Kingston aged 11 to 15 found that 12% had not had anything to eat or drink on the day of the survey[170], 9% had only had a drink for breakfast, and 7% ate their breakfast on their way to school. The numbers of girls skipping breakfast increased with increasing age. 16% also reported that they were eligible for Free School Meals (see chapter 1.7), and therefore at risk of food poverty. For some pupils, no or poor breakfast choices may be due to food poverty. For others in Kingston it is likely that body image concerns play a role; 32% reported that they worried about their weight 'quite often' or 'very often', and 27% reported that they worried about their diet.

Figure 2 IMD deprivation and Kingston Foodbank locations.



Contains Ordnance Survey data © Crown copyright and database right 2015. Source: Royal Borough of Kingston and English Indices of Deprivation, 2015.

Foodbanks

The numbers struggling to afford food in Kingston is evident by the increasing number of foodbank sites. Locally, there are now four: Surbiton New Life Baptist Church, Kingston United Reformed Church, The Kings Centre and New Malden Baptist Church all run by the Trussell Trust. Last year Kingston local foodbank sites were used by a total of 4,115 adults and children[171]. Sites are broadly located in line with local need (figure 2).

Food waste

Despite food poverty and food insecurity being a concern for some Kingston residents, a large proportion of food is wasted. Whilst 48% of residents are recycling food waste[172], 35% of the general residual waste generated in Kingston is food waste[173]. This is food that could have been eaten by those households, shared with households in need of food, or composted using the weekly food waste collection service.

Deprivation and weight

Deprivation, and therefore food poverty, is associated with obesity and under nutrition[156]. Obesity is particularly prevalent in women from deprived areas, although the pattern is less clear for men[174]. It is likely that this pattern is the case in deprived areas in Kingston.

The picture for local children living in poverty is clearer. The National Child Measurement Programme (NCMP) confidentially records children's postcodes and the National Obesity Observatory have published ward level obesity data which shows that for Kingston the wards with the highest levels of obesity tend to be those that are deprived (see chapter 1.3).

Local action

A range of initiatives are underway locally in line with the Kingston Healthy Weight and Physical Activity (HWPA) Needs Assessment and Strategy 2013 - 16. This strategy aims to change the food environment to encourage accessibility and affordability of healthy food, and also promotes a healthy food culture.

Kingston Foodbank

The main reasons for accessing Trussell Trust foodbank sites in Kingston in 2014 - 15 were due to benefit changes or delays, unemployment, low incomes or homelessness (see table 3)[171]. The most common reason was a low level of income[175].

Table 3 The five main reasons for people accessing foodbank sites in Kingston in 2014 - 15.

Crisis	No. of households	Adults	Children	Total – all ages
Benefit changes	261	366	237	603
Benefit delays	299	393	153	546
Homeless	639	702	22	724
Low income	870	1420	1146	2566
Unemployed	129	187	136	323

Source: Kingston foodbank data 2014 - 15.

People accessing foodbank sites in Kingston are predominately aged under 65 years; only 25 vouchers were redeemed in 2014 - 15 to people aged over 65 years. There are therefore concerns that vulnerable older people who are experiencing food poverty in Kingston may not be accessing this emergency food service.

Some individuals and families have longer-term needs for assistance than can be provided by the emergency foodbank service. In these circumstances the social and economic circumstances that are limiting access to food need to be addressed[176]. This requires multi-agency working and an emphasis on secure employment that pays a living wage[177], which emphasises the importance of addressing the underlying determinants of health.

Kingston Fuel Bank

All four Kingston foodbank sites started a pilot Fuel Bank in April 2015 in partnership with npower. People accessing the foodbank in an emergency who are responsible for the fuel costs of their accommodation and are on a pre-payment meter are eligible for a £49.00 voucher to spend on fuel with any energy provider. The pilot was due to run until June 2015, however it is still ongoing. The scheme will be evaluated before considering whether to roll it out more widely.

Fuel poverty

The Warm Homes Better Health programme is commissioned locally to reduce fuel poverty. People aged over 65 years who are living in a cold home or who are experiencing high fuel bills receive a free home visit to review energy efficiencies and savings. With reduced financial pressure residents are better able to afford to heat their home as well as releasing income to spend on food.

The Department of Health also provides funding to Staywell for the Warmer Homes Healthy People scheme to proactively stop vulnerable older people becoming unwell due to cold living conditions in the winter. The programme prioritises people who need support to keep warm and safe (funding up to 100 people), or responds to other practical support needs resulting from extreme weather. Support focuses on fuel poverty but can also include the provision of a hot meal or food shopping.

Food waste

The Council was recently awarded central government funding for an incentive scheme aimed at encouraging groups of residents living in flats to collectively commit to recycling more of their food waste. Funding was awarded as part of the government's Recycling Reward Scheme which aims to enable local authorities to drive behavioural change within their communities and reward residents for reducing and recycling their waste.

The local scheme consists of an online registration allowing groups living in flats to be in with a chance of winning a shared prize fund if they increase the amount of food waste they recycle. Efforts will also be made to encourage residents to reduce the amount of food they waste.

Cook and Eat

Cook and Eat is a programme that supports vulnerable communities to learn about nutrition and cooking healthy food on a budget (see chapter 1.4).

The Great Feast

The Great Feast is provided at St Peter's Church for people who are homeless and/ or vulnerably housed and supports people to have a hearty meal. From the 1st October 2015, this will become the Vintage Banquet, which is aimed at people over 60. This will be held on Thursdays from 11am to 3pm.

Refugee, Asylum Seeker and Migrant Needs Assessment

Work has been undertaken to identify and address food concerns in population groups at risk of food poverty and insecurity in Kingston. In 2015 a Refugee, Asylum Seeker and Migrant Needs Assessment identified food poverty as an issue, with some people reporting struggling to eat regular meals[178]. Participants also demonstrated poor nutritional knowledge on what constitutes healthy eating, and how to shop, cook and eat well using local British produce. The nutrition and food poverty related outcomes and actions from this strategy will be embedded into the new Community Sport and Physical Activity Network (CSPAN) Good Food subgroup (see below).

CSPAN Good Food subgroup

Kingston's Strategic CSPAN agreed to the development of a new subgroup to focus on food and the potential membership, function and purpose of this subgroup is currently being considered. Areas the subgroup will prioritise include how to improve the food environment in Kingston and improving accessibility and affordability to healthy sustainable food, which will contribute to reducing food insecurity. The subgroup will also seek to improve Kingston's position within the annually published Good Food for London report that measures all London boroughs' commitment to established food schemes.

Recommendations

1 **Embed sustainable food messages in all existing nutrition and weight management programmes, in support of reducing food poverty and obesity associated with deprivation.**

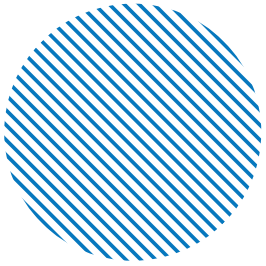
2 **Promote and create a healthy, sustainable food culture in Kingston, through work with early year's settings, schools, universities, hospitals, libraries, workplaces and food businesses.**

3 **Establish the CSPAN Good Food subgroup, and work to meet the agreed actions in support of a healthy, sustainable and accessible food environment in Kingston.**

4 **Explore closer working with local foodbank sites, including nutrition education, food budget information, and healthy cooking opportunities, to better support food security and sustainability.**

5 **Map local food provision to identify food deserts, and work with local businesses and charities to create fresh fruit and vegetable stands to make healthy food available at affordable prices.**

6 **Encourage fruit and vegetable market stalls to become Healthy Start businesses, accepting Healthy Start food coupons from eligible families to spend on fruit and vegetables at their stall.**



1.7 School food

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Introduction

Three national government departments lead on school food: the Department of Health, the Department for Education, and the Department for Environment, Food and Rural Affairs. All three emphasise the importance of good nutrition in order to perform well at school[179]. Creating a positive healthy school food environment contributes to a healthy weight in children and young people. It thereby reduces the emotional and psychological effects that are associated with being above or below a healthy weight including low self esteem[180], as well as improving social relationships[181].

The cross government department School Food Plan (SFP) was launched in July 2013[179]. As a result all children in state-funded infant schools have been eligible to receive free school meals since September 2014. From January 2015, all state-funded schools were required to adhere to the mandatory school food standards across the school day. This includes all food provided at lunch times, from tuck shops and snack bars, at breakfast clubs, after school clubs and food served at break times. Breakfast consumption in particular assists in addressing food poverty and ensuring optimum nutrition for concentration and performance at school[182, 183, 184].

Ofsted reports on children's health and wellbeing within school inspections and scrutinise the arrangements for a healthy food environment in support of children having a healthy weight[185]. Together with the SFP this emphasises the importance of the food environment in schools.

Local picture

There are 49 state-funded schools in Kingston; 35 primary schools, ten secondary schools, one pupil referral unit, and three Special Educational Needs schools[186]. According to the Spring School Census for 2015, there were 23,447 children aged 15 years and under on the school roll in Kingston[186].

Universal Infant Free School Meals

In September 2014, Universal Infant Free School Meals (UIFSM) were introduced for all children in reception year, year 1 and year 2 in all state funded schools in England. The January 2015 census identified 6,011 eligible children in Kingston. Of these, 5,597 took up their UIFSM, whilst 414 children did not.

Benefits-based free school meals

Children whose families are in receipt of benefits receive free school meals. In Kingston, 1,414 maintained nursery and state-funded primary school pupils have registered for Free School Meals (FSM), of which 1,228 are taking their FSM. In state-funded secondary schools only 882 pupils have registered for FSM, of which 695 are taking their FSM. There are a further 271 children attending Special Educational Needs schools in Kingston, of which 65 have registered for FSM, and 53 are taking their FSM. The total take-up rate is currently 1,976 (84%). This means there are 385 pupils (16%) who have registered for FSM and are then not choosing to take them up.

There are likely to be a number of other children who are not registered, with one possible reason being the stigma attached to being eligible for FSM. This is likely to be especially true for children and young people attending secondary schools as the figure drops from 1,414 primary aged children to 882 secondary school children.

School meal provision

There are 29 schools within the Central School Meals (CSM) contract with Cygnet Food Limited (CFL) which is managed by Achieving for Children (AfC) on behalf of those schools. This includes 26 primary schools, two special educational needs schools (SEN), and one secondary school. There are 20 schools not in the contract who manage their school food independently either through in house catering or through outsourced contracts to external providers.

For those 29 schools within the CSM contract, 22 now have cook on site facilities allowing them to cook all food fresh for pupils, compared to only five in July 2011. Other schools prepare much of their food but main meal entrees and desserts are prepared at the production hub in Tolworth, blast chilled and delivered in a refrigerated vehicle to the school kitchen for cooking the next day. As of March 2015, 61% of all pupils in schools within the CSM contract eat school meals.

Fruit and vegetable scheme

Fruits and vegetables are important components of a balanced diet. The current recommendation is that children should eat at least five portions of fruit and vegetables a day. The School Fruit and Vegetable Scheme is a government programme which was launched in 2000. It entitles children aged four to six years in fully state-funded schools to one piece of fruit or vegetable each school day. A choice of bananas, apples, pears, carrots, tomatoes and easy-peel citrus fruits, such as satsumas are delivered to schools three times a week. These are washed and handed out before the mid morning break. In Kingston 32 schools have taken up the scheme with a total of 7,631 children benefiting as of March 2015.

School milk subsidy scheme

The school milk subsidy scheme is a national government scheme that encourages children to drink milk to support bone health and school performance[187]. All children under five years attending day care are eligible for free milk under the nursery milk scheme, which also includes those children under five years in Reception classes. Children receive a third of a pint of milk for each day that they attend an approved care setting for two hours or more. In addition all children aged five to 11 years are eligible for subsidised milk under the scheme. Schools, local authorities, suppliers and management organisations can all claim the subsidy. In Kingston, there are 26 schools registered with Cool Milk, the main school milk supplier in the UK.

Breakfast clubs

A local survey completed in 2014 in Kingston found that 86% of the 24 primary schools who responded provide a universal breakfast club during term time[188]. The picture for the 11 primary schools that did not take part in the survey is not known. Further mapping is required to better understand breakfast club provision during the school holidays, school subsidies for children eligible for FSM, and ensuring that food provided at breakfast clubs meets the food based standards for schools.

Local action

School meal provision

Schools in the CSM contract benefit from management from AfC who are able to mass negotiate on food quality and price. The current provider, CFL were first awarded the contract in July 2011. The contract will end in July 2016 and consultation with schools started in July 2015 to ensure that the future provider complies with the national evidence base and local schools' needs. This consultation process will include support from Public Health.

A local survey completed in 2014 in Kingston found that 86% of the 24 schools who responded provide a universal breakfast club during term time[188].

All school catering providers, including the central schools meal contractor, should be adhering to the mandatory school food standards to ensure quality food. Occasionally there are requests to the Community Food Project Worker to advise on menus. Currently however, there is no independent monitoring in place to assess whether nutrition and food quality are in accordance with the food based standards for schools.

Food for Life Catering Mark

The Food for Life Catering Mark is run by the Soil Association and is an independent endorsement that encourages caterers to take steps to improve the food they serve, both using fresh ingredients which are free from trans fats, harmful additives and genetic modification and also having regard for animal welfare.

In Kingston, all schools in the CSM contract meet the Bronze Food for Life Catering Mark award. CFL is currently working towards achieving the Silver award, and this will be a mandatory requirement for the newly awarded contractor in 2016. The current focus is to ensure that all cook on site schools are accredited with the Silver award and that all other schools meet as many Silver requirements as possible, whilst maintaining a minimum bronze award. CFL is also working with cook on site schools to establish Gold award schools.

The number of schools meeting the Food for Life Catering Mark award outside of the CSM service is not known. However, efforts are made to make all schools aware of the scheme through the local Healthy Schools Network (see chapter 4.3).

Young People's Health Link Workers

The Young People Health Link Workers have facilitated awareness of food issues in secondary schools but further work is required to review current food policies and standards achieved.

Recommendations

1 **AfC and Public Health should continue to work together on the school food contract and commissioning process to ensure high standards are maintained.**

2 **Ensure that the CSM contract caterers maintain the Food for Life Catering Mark Bronze award across all schools, and Silver as a minimum in cook on site schools. Also promote the Catering Mark scheme to those schools not in the central contract.**

3 **Ensure that the CSM contract caterers meet higher animal welfare standards, and procure Fairtrade food and sustainable fish.**

4 **Explore the development and need for a formal monitoring process of school food quality (including breakfast clubs and after school clubs) in Kingston in line with the food based standards for schools.**

Case study – Green Lane Primary School

In 2012 - 13, uptake of school meals at Green Lane Primary School was only 35%. At the time the school meals were being delivered hot and served from a table in the school hall. The central school meals team at Kingston Council (now part of Achieving for Children) had a borough wide school meals project plan which ran from 2013 - 15 to re-develop food delivered hot in schools to cook on site schools.

For Green Lane Primary School, a new school kitchen and mini dining hall for Reception year children was designed and created over the school summer holidays in 2013 with the support of school representatives. In September 2013, a new cook on site school meal service was established and promotional events were held in partnership with the school, Kingston Council and the catering contractor.

The service was an instant success, with school meals uptake rising to 59% during the autumn term in 2013. A bespoke menu was designed for the school and by September 2014, when Universal Infant Free School Meals was introduced, the uptake had increased to 70%; double the initial uptake in one year. The school is now serving to a Food for Life silver standard with expected formal accreditation in October 2015.

1.8 Food growing

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Introduction

Nationally food poverty and obesity are major issues, due in part to an environment that can make it difficult to both use home grown food and have the time to prepare meals at home[189]. The direct cost to the NHS of poor diets is over £5 billion each year[190]. Food poverty is becoming more common, resulting in increased consumption of low cost energy dense foods that can result in weight gain. Changing the food environment to one which promotes healthy eating and food sustainability will help prevent health problems, and thereby reduce future costs. Food growing contributes to the multi-faceted approach that is required to challenge the current obesogenic environment[191, 192].

Locally grown food, whether through home gardens, green spaces, allotments, community gardens or schools encourages healthy eating through increased fruit and vegetable intake, and also increases awareness of where food comes from[193]. Local food production minimises carbon dioxide emissions produced from transporting food and so contributes to addressing climate change[194].

Schools that actively engage with food growing report increased fruit and vegetable consumption by pupils, increased environmental awareness and improved academic attainment, especially in core subjects such as science[194]. Growing food also teaches children about seasonality, which contributes to a sustainable diet[194].

Foods eaten in season are also likely to be of a higher nutritional quality than those grown out of season[195].

National and local government have a responsibility to ensure that people can access healthy food that is safe and sustainable[196] and local authorities also have a statutory responsibility to provide sufficient allotment sites to meet local demand[197].

Local picture

Kingston's draft Allotment Strategy 2015 – 21[198] details the management of allotments locally. Food growing is also included in other local strategies, including the Healthy Weight and Physical Activity (HWPA) Strategy and Needs Assessment 2013 - 16[199], the Tree Strategy[200] and the Local Development Framework. It is also embedded in the Kingston Plan[201].

Children and Young People

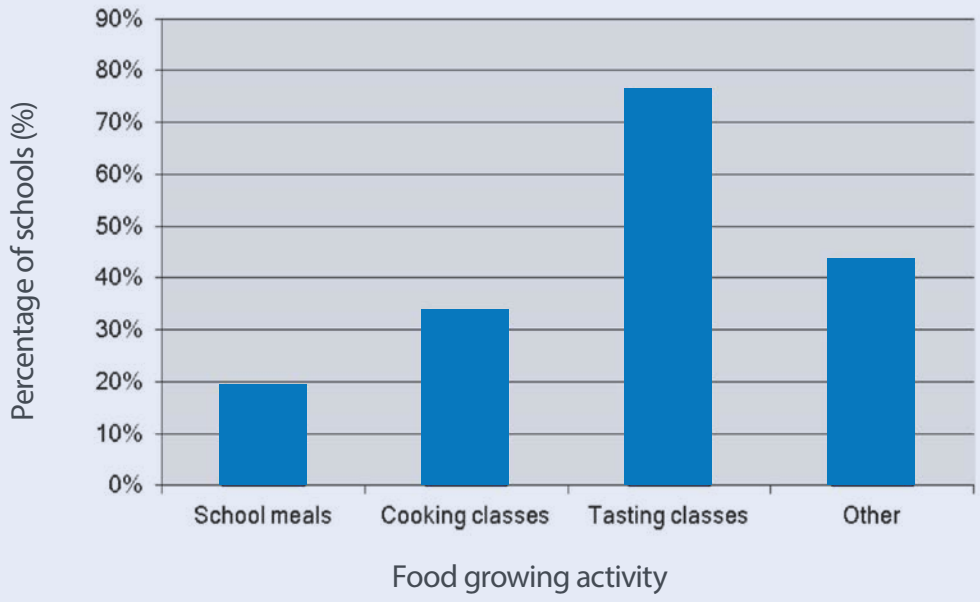
There are currently 21 schools in Kingston registered with Food Growing Schools London, a Greater London Authority partnership initiative that is led by Garden Organic, a charity that supports organic food growing for a healthy and sustainable environment.

The schools programme provides food growing expertise, information and support to enable London schools to be able to grow their own food. A recent local School Health survey with primary schools found that 23 out of the 24 primary schools surveyed have a food growing area.

The level of food growing activity and engagement was variable. Figure 1 below shows how schools were using the food they grow. Where 'Other' was chosen this predominately meant that food was grown for a curriculum activity, and frequently then not maintained.

For secondary schools, six out of ten have a food growing area, with one more school planning to build some raised beds in September 2015. The main barriers in secondary schools to creating a food growing space have been reported as being limited space and/ or capacity.

Figure 1 How Kingston primary schools use food growing.



Source: Kingston Primary School survey, 2014.

Adults and the community

An estimated 17.1% of green space is used for health activities in Kingston primarily for exercise[202] (see chapter 2.6). This is in line with the England average (17.1%) and above the London average (11.8%). However, utilisation of green space for food growing could increase.

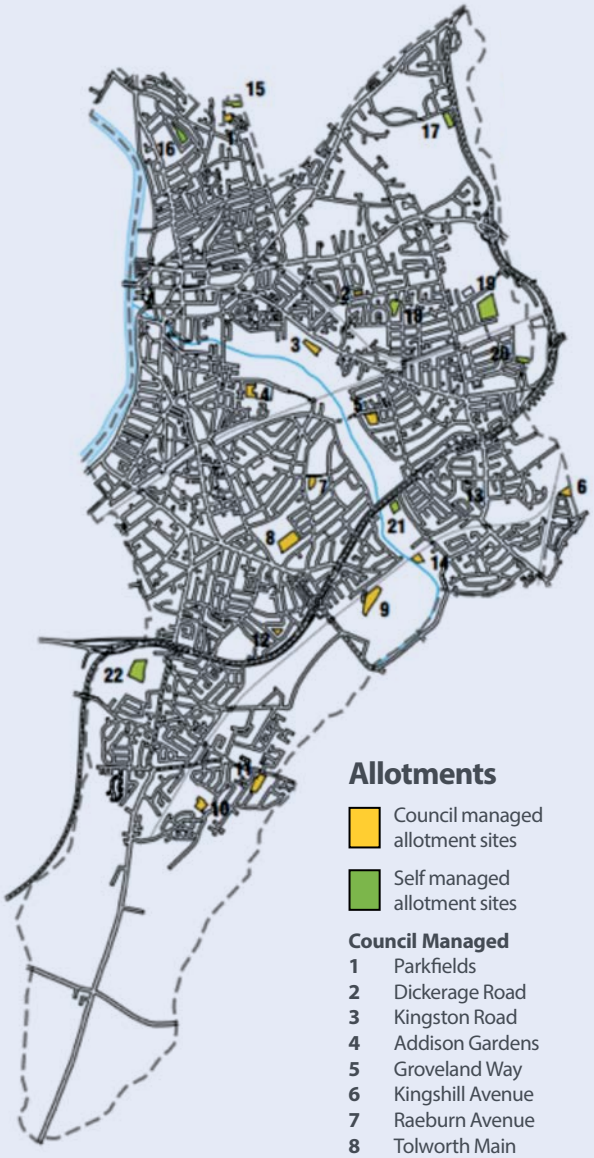
The built character of Kingston is changing from dwellings with large gardens to smaller properties with little or no outside space. Although there is awareness of this shift happening, the precise extent of this is not known.

As Kingston's population grows the need for efficient land use increases and one of the challenges is to ensure that wellbeing is not compromised, including the opportunity for food growing. Where new gardens are built in the Borough, they should be designed so as to allow future occupants the option to grow food[203]. This could include communal gardens for community food growing[204].

In Kingston there are 22 allotment sites (see figure 2), totalling 41.7 hectares which is 4.9% of the open space in the Borough. All sites are supported by the Kingston Federation of Allotment Gardeners (KFAG) who provide information and advice, encourage information sharing and promote allotments to the public. Ten sites are directly managed by a contractor covering 559 plots of which 520 plots are occupied as of September 2015. The other 12 sites are voluntarily managed by committees made up of allotment tenants and the proportion of occupied plots at these sites is not known.

There is currently a waiting list of 377 people, highlighting the opportunity to use this interest to promote community allotments that have wider community benefits while people are on the waiting list. This is addressed in the Kingston Allotment Strategy and is being explored within the Kingston CSPAN Environment, Place and Communities subgroup. Kingston has a number of community allotments and food growing gardens across the Borough already, but the level at which these are used varies.

Figure 2 Allotment sites in Kingston.



Source: Kingston Allotment Strategy 2015 - 21.

Local action

Children and young people

Food Growing Schools London is promoted locally, including through Young People's Health Link Workers and the Healthy Schools Kingston (HSK) Network (see chapter 4.3). Guest speakers from Food Growing Schools London attended the December 2014 HSK meeting to explain the scheme, which was well received by the attendees.

Holy Cross School is a local secondary school that has benefited from this regional expertise as well as local support. Public Health, Axis and Quadron all volunteered staff time to build raised beds and prepare the ground for food growing. Staff and students have recently planted fruits and vegetables, and there are plans to use the produce grown in school meals and cooking lessons (for students and parents). The beds will be used by tutor groups as a practical component to healthy eating workshops, and will offer students hands on experience and a greater understanding of where food comes from.

Richard Challoner School is in the early stages of redevelopment of their school garden with the help of both staff and students, having recently been awarded with the first prize in the 2015 Food Growing Schools London 'Grow Your Own School Garden' competition for their commitment and efforts to improving food growing.

Primary school examples includes St Luke's Church of England Primary School who run a popular weekly gardening club from their well established garden. Malden Manor Primary School also piloted a successful Chef's Club summer programme that included physical activity and food growing in 2014.

St Philip's SEN School is committed to it's school garden with every aspect of the outdoor surroundings promoting health and wellbeing (see case study on page 88).

Adults and the community

The importance of food growing for health and wellbeing is highlighted in the HWPA Strategy and Needs Assessment 2013 - 16[199] which includes a recommendation to develop mechanisms to assess accessibility of public and green spaces for family and community interaction and sustainable food growing opportunities[199]. Local food growing is also highlighted in both the Allotment Strategy 2015 - 21[198] and the Green Spaces Strategy 2015 - 21[205]. All of these strategies work towards the objectives in the Kingston Plan to create a sustainable and healthy borough, through creating and promoting local food growing opportunities in residential homes and in the community. This is largely done through the CSPAN Environment, Place and Communities subgroup. Actions include developing proposals for appropriate spaces for residents to grow their own food and the establishment of community gardens for food growing, as well as working with existing organisations and businesses to manage, promote and utilise their food growing sites.

Richard Challoner School receive their first prize from the Major of London, Boris Johnson.

Allotments

Kingston's Allotment Strategy 2015 - 21 is based on a number of policies that encourage plot holders to take an active role in the management of the sites. This helps to improve wellbeing, develop community involvement and reduce food waste through sharing of food. Voluntary management through a committee made up of plot holders is therefore encouraged. In addition there are Site Liaison Volunteers who liaise between the plot holder, committee, contractor and council, ensuring effective management and therefore optimum usage for food growth.

Some of the allotment plots are used for community purposes, rather than individual purposes, including one held by Public Health for Active Gardening in Tolworth. St Peter's Church is one community group that has used the allotment for people who are homeless or vulnerably housed who have little opportunity to grow and cook their own meals.

Refugee Action Kingston (RAK) has also run a food growing project as part of their Time Bank initiative giving people the opportunity to become active citizens by utilising their under used skills through giving their time and receiving credits. The project aims include increased knowledge of food growing techniques and improved access to food growing opportunities. The RAK project enabled 22 people to access the allotment and members were paid in credits to take part in the project and grow their own produce. Other community plot holders include the Girl Guides and the Fircroft Trust.

Community gardens

Organisations in Kingston have also built food growing areas at their sites. The Home Farm Trust has a well established Garden Project for adults with learning disabilities. Fruits and vegetables grown are used in the canteen.

Knollmead and Parkfield allotments have permaculture sites which grow fruits, vegetables and nuts. A new community garden at Millplace is being established by the Kingston Biodiversity Network, and Surbiton Fire Station is growing vegetables on its roof garden with the food used in the communal work kitchen. The Environment Centre also continues to build food growing areas for fruit and vegetables at their site, as well as supporting other sites in Kingston to secure a sustainable food environment such as at the Hogsmill Community Garden.

Parks and open spaces

Food production in Kingston extends beyond the remit of the allotments and community gardens, and includes parks and open spaces where fruit and nut trees are planted[209] to encourage sustainability and to contribute to reducing climate change. The Kingston Orchard Project, with the support of the Council, leads on this work.

Transition Town Kingston (TTK) also runs a number of projects that promote sustainable food growing. Projects include the Urbanfarmacy 'River of Herbs', which aims to plant medicinal and culinary herbs in public spaces in Kingston.

Recommendations

1 **Through the CPSAN Environment, Place and Communities subgroup and the new Good Food subgroup, work towards the food growing actions in the HWPA Strategy and Needs Assessment 2013 - 16, and the Green Spaces Strategy 2015 - 21.**

2 **Support schools in developing an active growing, cooking and eating environment in line with school food policies.**

3 **Explore ways to incorporate food growing into the existing Cook and Eat and Chef's Club programmes within schools and the wider community.**

4 **Consider mapping public and community food growing areas in Kingston and identify gaps in food growing opportunities for children and vulnerable adults.**

5 **Work more collaboratively with food growing partners, such as Transition Town Kingston and the Environment Centre to establish community food growing areas in Kingston.**

6 **Explore an intergenerational food growing project linking children and young people with older people through a volunteer reciprocal network, sharing skills and improving the sense of local community.**

7 **Explore how best to retain volunteer engagement and commitment to community food growing sites.**

8 **Review Kingston planning application procedures and incorporate food growing opportunities as a consideration for local Health Impact Assessment reviews of major planning development applications.**

Case study – St Philip's Special Educational Needs School Food Growing

St Philip's Special Educational Needs (SEN) School is committed to its school garden with every aspect of the outdoor surroundings promoting health and wellbeing. This includes an outdoor gym, adventure playground, wildlife path complete with ponds, beds of plants and fruits and vegetables.

The school grow fruit and vegetables all year round, and alter their harvest according to the season. All produce grown on the school site is used in the school canteen, the Sixth Form beach hut cafe, and within the food technology lessons. Students are also encouraged to tuck into the wild fruit during break and lunchtimes.

To enrich health and wellbeing further, the school has timetabled horticultural lessons for all key stage 3 students and an accredited course in horticulture for interested key stage 4 students. In total over 50 students visit the gardens on a weekly basis to complete manual tasks, tend to the grounds, harvest crops and to learn about plants, animals and wildlife.

The horticulture lessons are an ever growing success, providing a 'hands on' curriculum approach through gardening to enhance understanding on where food comes from and eating healthily.

St Philip's SEN School is now the training hub in South West London for Food Growing Schools London and Garden Organic and hosts training evenings throughout the year, where course attendees are able to visit the gardens and learn how to run similar projects in their schools.

1.9 Food establishments and healthy catering

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Introduction

In recent years more people are eating out instead of choosing home cooked food with one in six meals now consumed outside the home[206]. Food outside the home tends to be more energy dense and have a higher fat and salt content than food prepared at home. This type of diet combined with low physical activity is linked to many diseases such as obesity, heart disease, diabetes and some cancers[207].

Research suggests that obesity tends to be more prevalent in areas with a high concentration of fast food takeaways, and that outlets are often concentrated in areas of high deprivation[208]. Data analysed by the Greater London Authority (GLA) suggests that the London boroughs with the highest concentration of fast food takeaways tend to also rank amongst the most deprived boroughs in the capital[209].

London Metropolitan University in conjunction with the London Food Board, Chartered Institute of Environmental Health (CIEH) and the Association of London Environmental Health Managers (ALEHM) have produced a toolkit[209] which is designed to support those working to encourage healthier catering amongst fast food takeaways.

The toolkit notes that some food businesses have problems (both real and perceived) in offering their customers healthier food choices. These include[209]:

- healthier options can cost more (for example, cooking with rapeseed oil costs 25% more than less healthy vegetable hard oil)
- fear of a potential loss of profit as businesses think customers will not want healthier options
- some food businesses think there is less scope for making changes because of limited menu choices available
- lack of time and energy to make the changes required
- some of the recommended changes are difficult to implement in busy outlets.

Public Health Responsibility Deal

The national Public Health Responsibility Deal includes five core commitments and pledges on food, physical activity, alcohol and health at work. Workplaces and the food industry sign up voluntarily to these pledges, showing they are committed to improving public health and creating a healthier workforce.

In the long term, employers investing in their employees' health can help to save money[210] as, amongst other benefits, healthier staff have fewer days off from work due to sickness. Some of the food pledges for those workplaces and industries agreeing to commit to the Responsibility Deal include[210]:

- providing calorie information on all food and non-alcoholic drinks
- reducing salt in food and cooking
- removing trans fats in all food ingredients
- reducing calorie consumption
- industry, government and workplaces to work together to support consumers to lower their salt consumption to no more than 6g a day
- support consumers to reduce their intake of saturated fat.

Healthier Catering Commitment

London boroughs can play an important role in helping people to enjoy healthy food. The Healthier Catering Commitment is supported by the Mayor of London. This guides food businesses about how to make small simple changes which can make big differences in improving diets and also increase business profits. Simple and affordable steps include using more fruit and vegetables in a recipe and reducing the salt content[211].

The benefits to businesses from the healthy catering commitment scheme include:

- saving businesses money
- bringing in new customers
- meeting the changing needs of local consumers
- educating the local business community in how they can contribute to improving the health of their customers
- improving knowledge and skills of staff through training.

Businesses need to meet a minimum of eight criteria out of 22. There are four essential criteria which have to be met by all businesses:

1 If oil is used for cooking it should be a poly or monounsaturated fat rather than lard, palm oil or dripping.

2 There must be a reduction in the amount of salt used and available to customers.

3 Where soft drinks or energy drinks are offered, reduced sugar drinks should be available.

4 Smaller meal portions should be available for both adults and children.

Local picture

Local food economy in Kingston

In 2014 - 15 there were 1,486 food businesses* in Kingston, varying from cafes and coffee shops to fast food and restaurants. Of these restaurants, cafes and canteens totalled 334 (with takeaways accounting for 123) which provide Kingston residents and visitors with a large variety of food choices.

Table 1 highlights the food businesses in the Kingston Town neighbourhood (which is made up of Canbury, Grove, Norbiton and Tudor wards).

Table 1 Total number and breakdown of food businesses in Kingston Town.

Sector	Total in Kingston Town	Percentage of all businesses in the Borough
Cafes	37	31.9%
Restaurants	47	40.5%
Takeaways	17	14.7%

*Food also includes drink for these purposes and includes exporters/ importers, offices, pubs and clubs, retailers, food distributors, manufacturers, canteens, cafes, restaurants, retailers, schools, stalls, hotels and home carers.

Local action

Healthier Catering Commitment

The Food and Safety team in Environmental Health have worked closely with colleagues from Public Health to implement the Healthier Catering Commitment in Kingston. This is aimed at businesses which cater in the fast food sector and which meet the 'broadly compliant' standard for food hygiene (their food safety is rated as generally satisfactory or better). The scheme is attractive to a wide range of catering outlets wanting to provide more wholesome and healthier foods, including those offering curry, kebabs, pizza, burgers and stir fries.

If a business is interested in participating, a meeting is arranged between one of the food and safety team and the owner or manager of the business at the premises so that the requirements of the scheme can be discussed. At the meeting, menus are scrutinised, preparation and service of food are discussed, and the oils, spreads and sugar content of drinks in use are verified.

For businesses who meet the requirements a certificate and promotional sticker are provided for display on the premises. For those who do not meet all the criteria advice is given on how to improve with the option to reapply when ready to move forward.

In Kingston, four businesses have successfully achieved the Healthy Catering Commitment award:

- YMCA Hawker Centre (January 2014)
- YMCA Surbiton Centre (January 2014)
- Kingfisher Leisure Centre (November 2014)
- Kingston University Food Store (February 2015)

Additional food businesses that have shown interest in the scheme so far include:

- The Joel Community Trust
- Tolworth Leisure Centre
- Malden Leisure Centre
- Sitel UK (workplace staff canteen)

Public Health Responsibility Deal

Through the London Healthy Workplace Charter (see chapter 4.5) employees are encouraged to eat healthily during the working day by such means as posters promoting the eatwell plate, 5- a-day, Heart Healthy foods and support for the Change4Life campaigns.

Local Public Health events

In 2014 - 15, the following public health events took place:

- Kingston Food Festival held at Kingston Market Square in August 2015: activities included a Change4Life 10 minute shake up exercise programme and a drink swap where 150 bottles of carbonated flavoured water were given out.
- Public Health Healthy Eating, Alcohol and Physical Activity stand in the Kingston University canteen in February 2015: 30 - 50 people visited the stand and engaged in a healthy eating conversation.
- Your Healthcare CIC staff health and wellbeing event in November 2014: approximately 200 staff attended and engaged in healthy eating and food growing conversations.

Recommendations

1 **Consider mapping food businesses across Kingston to establish coverage in areas of deprivation and near schools to inform the licensing of new food businesses in these areas.**

2 **Implement the Healthy Catering Commitment more widely in Kingston by:**

- a **Exploring options for consultation with local businesses, Kingston First and the Chamber of Commerce to raise awareness of the scheme and increase participation.**
- b **Establishing the most appropriate approach to target areas of deprivation.**
- c **Considering developing options for healthy catering to be either generic or specialist to meet the needs of small fast food businesses, so making it easier for them to engage with the scheme.**
- d **Considering whether using a single tier approach or developing a tiered (Bronze, Silver and Gold) award scheme would suit Kingston businesses best.**
- e **Continuing to train staff from Environmental Health on nutrition issues and offer regular nutrition updates as required.**

YMCA London South West receiving the Healthy Catering Commitment Award with the then Leader of the Council, Councillor Liz Green.

Case study – Healthy Catering award YMCA London South West (LSW)

The YMCA in Surbiton was the first local organisation to take part in the Healthy Catering Commitment scheme.

Four of the five South West London YMCA sites now have the Healthy Catering award. Jules Hammond, Head of Healthy Catering Services, YMCA LSW reported:

"Four of our sites (including YMCA Surbiton and YMCA Hawker) have now achieved the Healthy Catering award and offer healthier food choices. We are complying with the Healthy Catering standards".

"We continue to use less fat and less salt in the food choices we offer".

The Chef at YMCA reported:

"Since the award, we no longer add any salt in our cooking".

"We use less cheese in lasagne and serve it with salad instead of chips".

"Twice a week, we serve healthy breakfast options for our residents".

"Our customers are satisfied and have not noticed any difference since we reduced the fat and removed the salt in cooking".

Outcomes achieved since the Healthier Catering award

The YMCA is very proactive at offering healthier food choices to their customers. Since the award:

- catering staff from the YMCA have run a six week healthy eating and cooking club to parents and children in seven primary schools in South West London and they are planning to deliver this to the new Kingston Community School
- every Saturday Surbiton YMCA offer an organic fruit and vegetable box to their customers to purchase
- plans have been developed to deliver a six week healthy cooking programme to YMCA residents that will show how to cook and eat healthily on a limited budget.

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2.0 Physical activity

Research suggests that being physically active can help reduce the risk of us developing over 20 chronic conditions such as type 2 diabetes, some cancers, and musculoskeletal conditions. It also impacts on wellbeing as noted in last year's report where 'be active' was highlighted as one of the five ways to wellbeing. Despite these clear benefits, on average the amount of physical activity we take has reduced over time.

This section of the report considers how physical activity can be undertaken throughout our lives through active recreation, active travel, physical activity and sport with a particular focus on the opportunities for leading a physically active lifestyle that are available in Kingston.

2.1 Maternal physical activity (pre-conception, pregnancy and postnatal)

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Introduction

The advice provided by the Family Planning Association is that both potential parents should start or maintain regular exercise when they are trying for a baby. For the mother, being more fit enables her to cope more comfortably as her body is better prepared for the physical demands of pregnancy[1].

Patterns of physical exercise indicate that most pregnant women fail to take as much exercise as guidelines recommend[2]. Studies show that in the vast majority of cases, exercise is safe for both mother and foetus during pregnancy and so should be supported[3]. Physical exercise has been shown to have positive effects on physical and psychological health in pregnancy and can improve many common pregnancy symptoms, such as fatigue, varicose veins, maternal weight gain, pre-eclampsia and lower back pain[4]. NICE guidance supports this evidence and recommends that pregnant women should aim to achieve at least 30 minutes of moderate intensity activity per day[5].

Women who exercised regularly before pregnancy should be encouraged to continue with suitable exercise for as long as they feel comfortable, although from the second trimester certain types of exercise and positions could cause adverse complications and should be avoided. These include lying on the back for more than a few minutes, stomach crunches and sit ups, as well as heavy weight training and high impact contact sports. Recreational exercise (any regular activity that a woman takes during her pregnancy, which involves aerobic exercise such as swimming or running and/ or strength conditioning exercise) can help women to adjust to the physical changes that occur during pregnancy. The aim of recreational exercise during pregnancy is for a woman to stay fit rather than to reach a peak fitness level.

The Royal College of Midwives (RCM) recommend that pregnant women who are new to exercise should build up slowly from short 15 minute sessions three times a week towards 30 minutes per day, subject to the guidance of their GP or midwife[6]. Although studies have not identified an upper level of safe exercise intensity, regular exercisers before pregnancy should be able to continue to engage in exercise such as jogging and aerobics, with no adverse effect to mother or foetus. Women who have not attained a high level of fitness through exercise prior to pregnancy should be cautious about starting higher levels of fitness activities during pregnancy and seek expert advice to ensure that the level of intensity proposed would not be harmful to the developing foetus or themselves. All women should expect a decline in overall activity and fitness levels as pregnancy progresses due to the physiological changes which may interfere with the ability to engage in some types of activity[7].

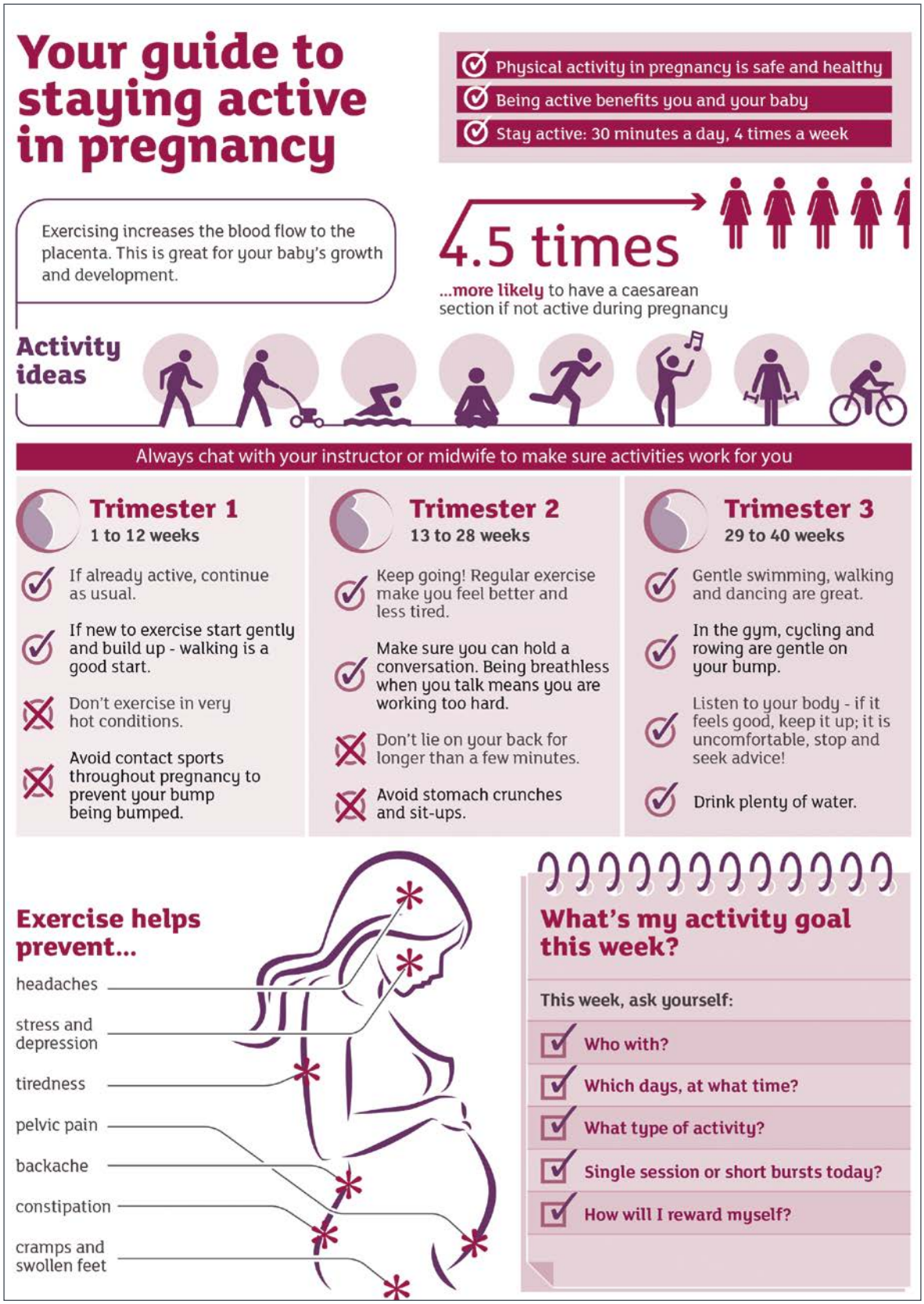
Exercise is helpful in improving glycaemic control in women with gestational diabetes mellitus (GDM) and plays a role in the primary prevention of this condition[8]. Expectant mothers who take moderate exercise can reduce their risk of developing GDM by as much as 30%[6]. Active women also experience less insomnia, stress, anxiety and depression in pregnancy[9]. Additionally, there is some evidence that weight-bearing exercise throughout pregnancy can reduce the length of labour and decrease delivery complications[3].

Women who incorporate exercise into their routine during pregnancy are more likely to continue after they give birth[7]. If women have not experienced any complications during pregnancy or delivery, then a mild exercise programme including walking, stretching and pelvic floor exercises can begin immediately[10].

It is thought that between 10% - 15% of women develop postnatal depression (PND), which equates to 80,000 to 120,000 women in the UK[11]. PND typically arises from a combination of hormonal changes, extreme tiredness and the often stressful adjustment to motherhood. One of the most commonly recommended treatments for women experiencing PND is exercise[11]. This is because exercise is known to maintain and improve feelings of wellbeing.

Physical exercise has been shown to have positive effects on physical and psychological health in pregnancy and can improve many common pregnancy symptoms, such as fatigue, varicose veins, maternal weight gain, pre-eclampsia and lower back pain[4].

Figure 1 Guide to staying active in pregnancy[12]



Local picture

Women discharged from hospital after delivery at Kingston Hospital are given a booklet entitled 'Going home after your baby' which contains information about healthy eating, exercise and promoting breast feeding. Information on local postnatal exercise classes is included, although these largely focus on pelvic floor exercises and not on aerobic activity.
The RCM advises midwives to strongly communicate the value of antenatal and postnatal exercise to pregnant women, however the extent to which individual midwives promote physical activity locally is not known.

Children's Centres in Kingston offer a rolling programme of free and low cost physical activity sessions. These are delivered by external providers and do not currently include opportunities for pregnant women or postnatal classes.
Antenatal and postnatal support groups are also hosted by the centres and information on how to maintain good health for mother and baby is provided by health visitors, which includes brief advice on the importance of physical activity. Based on local discussion, the picture in general practice is that communication on the value and benefits of physical activity in pregnancy is variable.

In 2011, a needs assessment was undertaken on obesity in pregnancy which included the subject of physical activity in pregnancy. One of the areas identified for service improvement was the development of antenatal and postnatal exercise classes focussing on aerobic activity, with adequate arrangements so that mothers could attend (such as flexible timing and the provision of childcare). This correlates well with the recommendation by NICE for local authorities to offer women more opportunities to exercise at an affordable price and with crèches for children[5].

Although there are some commercial organisations providing postnatal exercise classes in Kingston, it is evident from a recent consultation with local authority leisure providers that there is a considerable lack of recreational exercise provision for pregnant women during and after the maternal journey. This is recognised as an area for development.

Local action

There is a gap in low cost physical activity provision for women during pregnancy and in the postnatal period. However, there are a number of programmes available locally which can be used as a foundation to be built upon:

Children's Centres

During 2014, Children's Centres in Kingston facilitated nearly 200 sessions of physical activity for parents and children such as baby yoga, dance and general play which reached 320 families. There is potential to extend the physical activity offer to include classes for pregnant and postnatal women.

Kingston Hospital

The Maternity Wellbeing Project at Kingston Hospital offers a weekly programme of yoga for pregnant women at a cost of £10 per class. The providers are keen to develop stronger links with Public Health to expand the offer to include postnatal classes.

Beyond the Bump

Beyond the Bump is a free pilot weight management programme for postnatal women (see chapter 1.1) which incorporates physical activity. This programme targets women living in areas of disadvantage in Kingston. The first quarter's outcomes have been very positive. 100% of the participants felt extremely confident about being able to keep physically active in the future and walking increased from an average of 128 minutes per week pre programme to 296 minutes post programme. Sedentary behaviour (sitting time) decreased from an average of 1,932 minutes per week to 1,176 minutes per week post programme.

Bumps and Buggies

Development is underway to re-launch the free Bumps and Buggies walks for parents, which ceased due to a shortage of volunteers.

Get Active Exercise Referral

Work is in progress to expand the Get Active exercise referral programme to include exercise sessions for postnatal women.

Recommendations

1. **Communicate the value of physical activity to relevant health professionals by feeding into the Maternal Obesity Action Group (MOAG).**
2. **Forge stronger relationships with Kingston Hospital maternity teams to better understand the standard communication procedures in place for pregnant women on physical activity messages.**
3. **Further explore the communication methods within primary care on the provision of physical activity messages to pregnant and postnatal women.**
4. **Continue to map the provision of free and low cost physical activity programmes across Kingston and explore the development of potential opportunities with the CSPAN.**
5. **Ensure resources on the importance of exercise are available to new parents and at antenatal appointments.**
6. **Relaunch the Bumps and Buggies walks for pregnant women and new parents.**
7. **Capitalise on the early positive results from the Beyond the Bump programme by ensuring that suitable provision is in place for women to sustain their interest in physical activity.**
8. **Work with leisure providers to pilot postnatal exercise sessions with crèche facilities.**

2.2 Physical activity in the early years (0 - 5 years)

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Introduction

Physical activity is critical to optimal growth and development during the first five years of life as during this time babies and young children undergo rapid and wide-ranging physical and psychological developments, which lay the foundation for their future health and wellbeing. Future physical activity and sedentary behaviour patterns can also be developed during this time[13]. National guidelines highlight the importance of establishing a high level of activity at an early age, in order to encourage activity patterns and habits later in childhood that benefit long term good health.

In the first five years of life, children learn more physical skills than at any other time of their lives[13].

Research has shown that being physically active in the early years can help with[13]:

- motor skills such as balance and coordination
- maintaining a healthy weight
- strong bones, muscles and heart
- social skills.

The Department of Health (DH) has developed physical activity guidelines for children under five which include three key messages[14]:

1. Physical activity should be encouraged from birth, particularly through floor-based play and water-based activities in safe environments.
2. Pre-school aged children capable of walking unaided should be physically active daily for at least three hours, spread throughout the day.
3. All children under five should minimise the amount of time spent being sedentary for extended periods (except time spent sleeping).

In line with these, the British Heart Foundation has developed two Physical Activity guidelines for health professionals and early years practitioners to support families and parents of children under five years; one for children who are not yet walking and the other for walkers.

It is important for babies from when they are first born to have daily opportunities to move freely on their stomach or back in a variety of stimulating, safe spaces without being constrained for long periods by clothing, wraps or straps (which therefore includes car seats, baby chairs and bouncers)[13]. These opportunities allow them to practise important movements such as reaching for and grasping objects[13].

Children who are walking are most likely to be physically active through active play[13]. This enables them to develop their locomotor, stability and object control skills, experience a variety of play spaces and equipment and have fun and feel good about themselves and what they can do[15].

By the age of three, children should have opportunities to practise: locomotor skills such as running, jumping, hopping, galloping, skipping, dancing and water based activities; stability skills including balancing, riding a bike and climbing; and object control skills such as kicking, catching, throwing, striking and rolling a ball[15]. Adult encouragement, regular positive feedback and support are important to help young children develop these skills.

Everyday activities can contribute a large proportion of a young child's physical activity. These can include active travel through walking, tricycling or biking, scootering and physical tasks such as tidying up toys or gardening[15].

Early years settings play a key role in providing enabling environments which can contribute towards helping young children achieve the daily physical activity requirement for their health and wellbeing[13].

There has been a growing concern in recent years about a lack of physical activity and increased sedentary behaviour among young children. Parents report that only 43% of boys and 35% of girls aged two and 28% of children aged four in England exceed an hour per day of moderate to vigorous physical activity[15]. Children aged three and four years in the UK spend on average ten to 11 hours a day being sedentary[16].

The Health Survey for England 2012 showed that only 9% of boys and 10% of girls aged between two and four years were physically active for at least three hours per day in line with the national recommendations[17].

Local picture

There were estimated to be just under 7,200 children aged two to four years living in Kingston in 2014[18]. Given that there are no local data on physical activity in this age group, extrapolation from the national percentages given above indicates that approximately 330 boys and 350 girls met or exceeded the recommended level of at least three hours of physical activity per day, leaving 6,520 young children not meeting this benchmark.

Local action

The Early Years Service in Kingston focuses on ensuring all children are given opportunities to enable them to be ready to reach their full potential. Providing Children's Centres and offering a wide and varied range of opportunities for local families to access the services they need within their local community are priorities for the service.

There are currently eight Children's Centres in Kingston[19]. Health provision is integral to their activity and they offer a range of accessible sessions through the week which all families with children under five can access.

Kingston's Children's Centres hosted a total of 2,897 health related activities and events between April 2014 and March 2015 including a range of physical activities. These were attended by 7,493 families and 5,448 children aged five years and under. In the same year, the centres also hosted 189 sessions with a specific physical development focus through which they successfully engaged with 369 children. In addition Stay and Play sessions are provided at most Children's Centres[20].

The Kingston Family Information Service (FIS) webpage[21] has links to the Family Service Directory which contains information on a wide range of topics including physical activities. Information is also provided on the 'Local Offer' which is focused on information for families and children with special educational needs and disabilities (SEND). FIS also provides information through Facebook and Twitter.

Additional services in Kingston include the William Wates Memorial Trust grant funded 'Youth Sports Trust Top Tots' and 'Top Start' which provide a fun introduction to physical activity for pre-school children[22]. The Moor Lane Centre has an accessible playground, activity rooms and soft play for children with disabilities[23]. YMCA London South West (YMCA LSW) provide a variety of physical activity sessions for the under fives such as baby ballet, toddler's funtime and Moo Music (fun through singing, dancing and playing) at both YMCA Surbiton and the Hawker Centre. Places for People Leisure (PfPL) provide swimming lessons for children aged four and over at the Kingfisher Leisure Centre.

Further service mapping (such as establishing provision through nurseries) will improve the picture of provision for this age group in Kingston and should be included within the refresh of the Healthy Weight and Physical Activity (HWPA) Strategy and Needs Assessment in 2016.

Recommendations

1 **Continue to ensure the provision of physical activity in a safe environment and support parents and families to encourage uptake for those aged 0 - 5 to support their development.**

2 **Continue to support parents and families to reduce time spent being sedentary.**

3 **Ensure there is support for young children most at risk of not having enough physical activity, such as children from lower income families or those with disabilities.**

4 **Work to improve awareness of activities for young children through effective communications and marketing.**

5 **Continue to provide activities with a specific physical development focus within Children's Centres and other early years settings including outdoor play areas.**

6 **Explore the potential to offer advice and support to parents at their child's two to two and a half year check on physical activity, as suggested by the national healthy child programme (HCP)[24].**

7 **Work to better understand the local picture in Kingston in terms of participation in physical activity by young children aged under five years.**

8 **Include more detailed mapping of physical activity provision for young children aged under five years in the refresh of the HWPA Strategy and Needs Assessment in 2016.**

2.3 Physical activity for children and young people (5 - 18 years)

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Introduction

Regular physical activity in children and young people promotes health and fitness. Evidence shows that participation in regular physical activity by those aged five to 18 years is associated with[25]:

- improved cardiovascular health
- improved bone health
- stronger muscles
- maintenance of a healthy weight
- improved self confidence
- improved social skills
- reduced symptoms of anxiety and depression.

Undertaking insufficient physical activity increases the risk of obesity, which in turn can lead to diabetes, cardiovascular disease and mental health issues in future years.

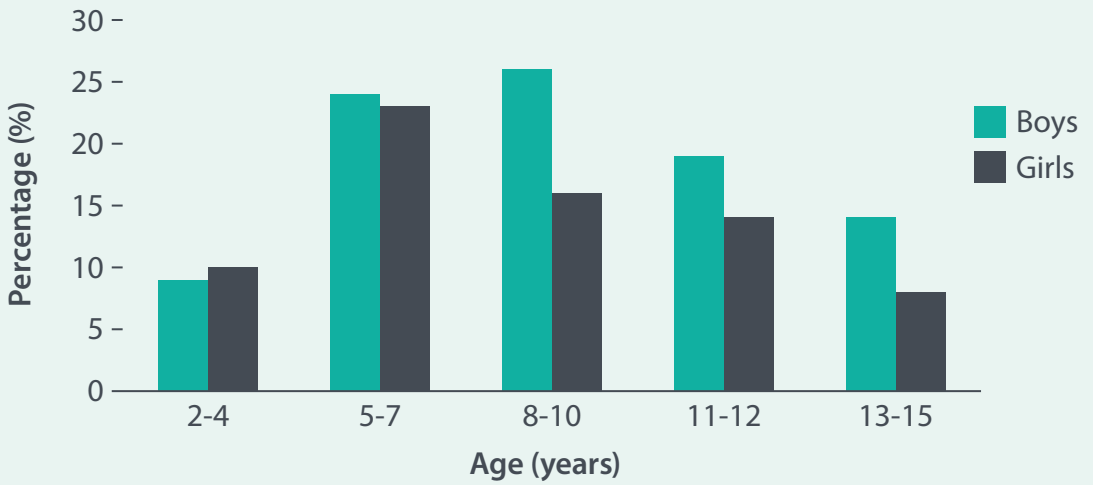
Results from a national study undertaken in 2010 found that 15% of young people aged 11 to 15 years reported having been diagnosed with a long term medical illness or disability[26]. The extent to which physical inactivity has impacted on the development of these conditions is uncertain, however there is growing evidence that regular physical activity can reduce the likelihood of risk factors and medical conditions developing and if a sufficient volume of exercise is maintained into adulthood, the risk of morbidity and mortality from chronic diseases later in life is reduced[25].

To assist in maintaining good health, the government recommends children and young people aged five to 18 years should undertake at least 60 minutes of physical activity every day, which should range between moderate intensity activity such as cycling and playground activities and vigorous intensity activity such as fast running and tennis. In addition to aerobic activities, muscle and bone strengthening activities should take place on at least three days a week[27].

Only 21% of boys and 16% of girls between the ages of five and 15 years were classified as meeting the government guidelines for physical activity, but amongst those aged 13 to 15 years, as few as 14% of boys and 8% of girls met recommended physical activity levels[28] (see figure 1).

To help understand why girls undertake less physical activity, research undertaken by the Women's Sport and Fitness Foundation in 2012 revealed that over half of secondary school girls say that they are put off sport and physical activity because of their experiences of school Physical Education (PE) or competitive sport, and over 75% agreed that they are self conscious about their bodies. Interestingly the research showed that 76% of 15 year old girls surveyed want to be active and enjoy the benefits of physical activity and staying healthy[28].

Figure 1 Children meeting physical activity recommendations, by age and gender, England 2012.



Source: Health Survey for England, 2012.

The latest government guidelines for physical activity incorporate recommendations in response to the increase in sedentary behaviour across the life course. Sedentary behaviour is not merely the absence of physical activity; rather it is a group of behaviours that involve low levels of energy expenditure. These include travelling by car, watching television and playing computer games and are very common amongst children and young people. Children in England between the ages of five and 15 years spend on average 3½ hours on weekdays and 8 hours over the weekend on sedentary pursuits[29]. The increase in the use of cars has had a major impact on the amount of exercise undertaken by children. In the past five decades the proportion of children regularly walking to primary school has fallen from 92% to 42%[30].

There is a clear dose-response between physical activity and health benefits in respect of both the total amount of activity and also its intensity[31]. From a public health perspective the greatest benefits will come from moving children and young people from very low levels of activity to regular, moderate intensity activity, and gradually developing the frequency and duration of exercise to 60 minutes or more a day. Increasing physical activity in children and young people can also help them in the acquisition of social skills through active play, better concentration in school and a reduction in anti-social and criminal behaviour[32].

Schools can be a major influence on children and young people where attitudes to physical activity and sport are formed and interests developed. PE is a compulsory part of the curriculum for all pupils from the age of five to 16 years. The current government recommendation is a minimum of two hours quality PE per week. The main platform for increasing physical activity levels in schools is through PE lessons but schools are increasingly providing physical activity beyond the curriculum through breakfast and after school clubs or active travel schemes. However, levels of pupil participation can remain a challenge for schools.

In 2014, the Youth Sports Trust (YST) undertook a national survey on PE. This showed a decline in the number of minutes per week that children and young people participated in PE compared with 2010. The most significant percentage declines were seen in five to eight year olds at 24% and nine to 15 year olds at 13%. On average, pupils across all Key Stages were offered less than two hours of PE per week. Only 38% of secondary schools offered extra-curricular activities for the least active and only 20% of schools consulted with young people to identify their needs[33]. The YST aims to conduct the survey on an annual basis to enable year on year comparisons.

The National Institute for Health and Care Excellence (NICE) guidelines provide a number of recommendations to increase the physical activity levels of those aged 18 years and under[34]. These include:

- Involve children and young people from the outset in identifying what would encourage them to participate in more physical activity and which activities they would like to participate in.
- Support the delivery of national campaigns, such as Change4Life at a local level. Integrate such campaigns into local initiatives.
- Educate children, parents and carers around the benefits of physical activity and the opportunities available locally, taking a whole family approach.
- Develop effective partnerships to deliver multi-component interventions (e.g. after school clubs) involving schools, families and communities.
- Have a coordinated approach to the development of school travel plans to encourage more physical activity.

From a public health perspective the greatest benefits will come from moving children and young people from very low levels of activity to regular, moderate intensity activity, and gradually developing the frequency and duration of exercise to 60 minutes or more a day.

Local picture

In Kingston, the need for local surveillance data to measure levels of physical activity and sport has been recognised and is one of the key recommendations in Kingston's HWPA Strategy and Needs Assessment 2013 - 16[35]. In response to this a number of consultations were undertaken with children and young people to identify their views on healthy lifestyles including physical activity.

Self reported outcomes from the Schools and Students Health Education Unit (SHEU) Health Behaviour Survey (2013) revealed that approximately 38% of secondary school pupils in years 7 to 10 took part in physical activity at least five times per week and 65% undertook some form of activity after school. Walking to school took precedence over cycling, with nearly 50% of pupils walking but only 3% cycling. In line with the national trend, girls' participation in physical activity declines with age. This reduction starts earlier in girls, at around ten to 11 years old and is more dramatic than in boys.

The national research finding (noted above[32]) that girls wish to be more active correlates with one of the key local findings that 54% of female respondents wanted to increase their activity levels. In response to this, local programmes are aiming to target girls but more needs to be done to create opportunities for girls and young women to participate in activities suited to their needs.

The Kingston Children and Young People's Plan 2013 - 17 sets out a range of commitments which includes supporting children and young people to lead healthy and active lifestyles and to provide opportunities to access play and sport. In line with this plan, Kingston Youth Service provides a diverse range of free and low cost physical activity and sports programmes, which have been developed through consultation with young people.

The Sainsbury's School Games Mark is a Government led awards scheme launched in 2012 to reward schools for their commitment to the development of competition across their school and into the community. It enables every child to participate in competitive sport across four levels of competition. Pupils who achieve level four are encouraged to develop their talent in sport through the local sports clubs talent pathway. A number of schools in Kingston are signed up to the scheme and have achieved the Games Mark award.

Local action

Leisure centres and swimming pools

There are four local authority owned leisure centres in the Borough providing a wide range of activities for children and young people. Leisure providers work with schools to provide extra-curricular opportunities for physical activity and sport, providing breakfast and after school clubs at both schools and leisure centres. Between 2014 and 2015 approximately 9,500 attendances were recorded for primary school children participating in physical activity programmes at local authority leisure facilities in Kingston.

There are only two public swimming pools in Kingston, with demand outweighing supply. Both pools offer swimming lessons as part of the Amateur Swimming Association (ASA) National Curriculum and Water Skills Award and approximately 320 school swimmers attended weekly classes during term time in 2014 - 15.

Leisure providers work with schools to provide extra-curricular opportunities for physical activity and sport, providing breakfast and after school clubs at both schools and leisure centres.

Youth service

Targeted programmes are delivered through the youth service for specific groups including young people who are socially excluded or have behavioural issues. The activities delivered are based on the needs of the individuals or those identified by a referring organisation. One such programme is hosted by Albany Park Sailing and Canoe Centre which provides water sport activities and outdoor education for schools and youth projects. Programmes are delivered daily throughout the week, offering opportunities to gain sporting qualifications in different disciplines such as canoeing, sailing, kayaking and mountain biking. A youth club is run at the Centre on a weekly basis that is open to all young people between the ages of 11 and 16 years, as well as a holiday programme. Over the last year the service has engaged with over 4,000 young people.

Duke of Edinburgh Award scheme

The Duke of Edinburgh Award scheme is delivered across the Borough and is open to young people aged 14 to 24 years old. This enables young people to engage in different categories of activity including learning a skill, taking part in a physical activity and volunteering. Between 2013 and 2014, 385 young people gained an award, which is an increase of 56% on the previous year. One out of every two participants who enrolled onto the programme went on to complete it.

PE and sport premium

The PE and sport premium helps primary schools improve the quality of the PE and sport activities they offer to their pupils. Schools receive a premium of £8,000 plus a bonus of £5.00 per pupil up until 2016. Kingston primary schools are using this money in a variety of ways and have been successful at increasing engagement and raising the profile of PE and sport in schools. Some schools have invested money in staff training to enhance skills, whilst others have increased opportunities to participate in after schools clubs or upgraded facilities to support greater engagement.

The London Youth Games

Kingston participates in the youth games in partnership with local sports clubs. The games are inclusive, free of charge and open to all young people aged between 7 and 18 years living in or going to school in London. Previous Kingston participants who have gone on to represent their country include Karina Bryant (Karate Bronze medallist at the London 2012 Olympics) and Abi Chamberlain (former England Ladies Rugby 7s Captain).

Kingston Satellite Clubs

Kingston has 13 satellite clubs in the Borough which exist to encourage youth engagement in community sport via a hub club. Secondary schools and other academic settings host the clubs and offer a range of popular sports such as cricket, football, gymnastics and athletics. Work is underway to increase the number of clubs in the Borough.

StreetGames

The StreetGames Doorstep Sports project is delivered in Norbiton and Chessington, two of Kingston's disadvantaged areas. Nationally, young people living in areas of deprivation are half as likely to be physically active than their peers living in more advantaged areas[29]. The project combines a variety of fun and challenging activities together with developing wider life skills, leadership and sport qualifications. The initial pilot successfully engaged 124 young people, 44% of whom were girls (see case study on page 129).

Sport and Physical Activity Directory for Disabled Young People (see chapter 2.7)

This directory was produced in response to a consultation with disabled people and features in excess of 70 physical activity and sport opportunities specifically designed for disabled children and young people. The website address is: **www.afclocaloffer.org.uk/pages/home/leisure-activities-and-short-breaks**

Junior Parkrun

Building on the success of the established adult Parkrun in Kingston, Junior Parkrun was launched in the summer of 2015. It offers a free opportunity for all the family to get involved on a regular basis to enjoy physical activity in the outdoors.

Work It

To address the decline in physical activity levels in women and girls, Work It was developed as a multi-component physical activity and healthy lifestyles programme for young girls aged 11 to 18 years. The programme offers a range of sport and physical activity options over an eight week period together with an interactive educational component. Between September 2014 and August 2015, 75 girls aged 11 - 14 years and 14 girls aged 15 - 18 completed the programme (attended for at least six sessions). Participants who complete the programme are offered free or heavily discounted access to their preferred activity for a further 12 weeks. As of September 2015, 15 girls have taken up leisure centre membership and the majority of participants reported improved diet, confidence and body image as a result of the programme.

Change4Life clubs

Primary sports clubs have been created to increase physical activity levels in less active seven to nine year olds, through multi-sport themes. The clubs will strive to create an exciting and inspirational environment for children to engage in school sport[36]. The allocation of Change4Life clubs in primary schools is based on NCMP data. In Kingston 19 clubs have been allocated and two are in place as at September 2015. The target is for 80% of these clubs to be set up by July 2016.

Recommendations

1 **Continue to involve young people in the design of service delivery through regular feedback sessions so that physical activity provision can continue to meet their needs.**

2 **Work with the Kingston CSPAN and wider partners to identify gaps in physical activity provision for children and young people.**

3 **Encourage schools in Kingston to participate in the annual YST survey to assist with local benchmarking and performance.**

4 **Continue to support the development of a specific programme of activities to engage young women and girls, such as women only sessions, including activities which are more likely to be attractive to those who are less 'sporty' or lacking in confidence.**

5 **Support the delivery of national campaigns, such as Change4Life at a local level.**

6 **Continue to respond to the recommendations and actions outlined in the HWPA Strategy and Needs Assessment 2013 - 16 with regard to children and young people.**

Case study – StreetGames

Searchlight Youth Club traditionally serves young people from the Norbiton area some of whom are known to be living in poverty and leading unhealthy lifestyles. Many young people who attend the club have limited access to physical activities and in the past have shown little interest in sporting activities.

This particularly applied to girls who have been reluctant to participate in any type of activity programme until StreetGames emerged. The programme instructors have been an inspiration to the young people, both boys and girls, but in particular have been able to motivate and engage girls between 13 - 16 years old to participate in a variety of activities each week.

The StreetGames workers have managed to slowly develop the girls' interest by initially introducing fun games like dodgeball and then progressing to more specialised activities such as trampolining.

An additional unexpected outcome has been that the girls have expressed an interest in wanting to learn more about other lifestyle issues such as diet to understand the importance of healthy eating and develop a better relationship with food.

Helen Terry, Youth Service Locality Lead for Kingston Town, Achieving for Children commented:

"This programme has achieved far more than I could have hoped for and has exceeded my expectations as a Senior Youth Worker. At the outset of the programme I was confident that they would have a degree of success in getting many of the boys involved, but I was amazed at the unexpected but positive impact it had on the girls.

This resulted in over 30 young people turning up for the finale in the Easter holidays to celebrate their end of term achievements, it was thrilling to see such a turn out. Having completed the pilot phase of this programme we are excited by the outcomes and are working on a sustainability plan. We hope to maintain momentum and take this through to the next stage of a healthy eating programme whilst still sustaining the enthusiasm for physical activity, which together I am sure we can achieve".

2.4 Physical activity for adults (18 - 65 years)

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Introduction

The health benefits of physical activity for adults are well documented. Research suggests physical activity can help reduce the risk of developing over 20 chronic conditions, including coronary heart disease, type two diabetes, stroke, some cancers, obesity, mental health problems and musculoskeletal conditions[37]. In addition, excess sedentary time is a standalone disease risk factor. Sedentary behaviour is defined as behaviours that involve low levels of energy expenditure. These behaviours are associated with an increased risk of obesity and cardiovascular disease independent of moderate to vigorous activity levels[38]. It is therefore possible for individuals who meet the recommended levels of physical activity to be susceptible to the adverse effects of prolonged bouts of sedentary behaviour[39]. Physical inactivity is the fourth leading risk factor for global mortality, accounting for 6% of all deaths[37].

Physical inactivity costs the NHS an estimated £1.06 billion a year. This figure is based upon five conditions specifically linked to inactivity: coronary heart disease, stroke, diabetes, colorectal cancer and breast cancer[40]. Inactivity also creates costs for the wider economy, through sickness absence, premature death of productive individuals and increased costs for individuals and their carers. In England, the costs of lost productivity have been estimated at £5.5 billion per year from sickness absence plus £1 billion per year from the premature death of people of working age[40].

In 2010 the Chief Medical Officer for England called for a doubling of walking and an eight-fold increase in cycling. A study by public health economists found that within 20 years this increase would lead to savings of roughly £17 billion (in 2010 prices) for the NHS in England and Wales[41].

Sport is one form of physical activity and can play a vital part in supporting economic recovery through both consumer spending on sport and the vast amounts of income that can be generated by hosting sporting events and the additional tourism these create. Consumer spending on sport in England was £17 billion in 2008[42] (see chapter 2.7). Participating in physical activity and sport can also increase productivity in the workplace whilst outside of work it can create many opportunities for volunteering[42].

There are more volunteers in sport than any other sector, with 22% of all volunteering in England taking place in the area of sports and exercise[43].

Physical activity can improve self esteem and wellbeing as well as reducing the symptoms of depression and anxiety[40]. 'Be Active' is one of the five ways to wellbeing identified by the New Economics Foundation[44].

Despite these clear benefits, over the past 60 years participation in physical activity amongst adults has decreased by 60% and without intervention, these trends are predicted to continue[45].

The reasons for this reduction in activity are complex and include:

- a decrease in physical activity at work and home
- increased use of inactive modes of transport
- increased reliance on technology
- changes in the way people socialise.

The Health Survey for England (HSE) reports four types of workplace physical activity: sitting down or standing up, walking around, climbing stairs or ladders, and lifting and moving or carrying heavy loads. In 2012, 59% of men and 54% of women reported spending five hours or more per work day sitting or standing. 43% of men and 46% of women spent no time at work walking around. More than half of men (57%) and around two thirds of women (65%) did not spend any time climbing stairs or ladders. 53% of men and 69% of women did not lift, carry or move heavy loads[46].

At home, according to the HSE, adults aged 25 and over spent more than half of their total sedentary time watching television[47]. Increased car use is also a major contributing factor to low levels of physical activity and this is reflected by the increase in car ownership in the UK. In 1961, 69% of households did not own a car or van, but by 2012 this had decreased to 25%. The number of households with two or more cars or vans has increased from 9% in 1972 to 31% in 2012[48].

According to the National Travel Survey, in 2013 just under 3% of all miles travelled per person per year were through walking[49]. Active travel reaps benefits beyond health, as when replacing journeys by car it can also help reduce congestion and emissions[47] (see chapter 2.9).

Research shows that the most common reasons people do not take part in sport are because they feel they are unhealthy, unfit or that sport is too competitive[45]. Despite this, sport continues to have a positive and valued impact on health across the life course (see chapter 2.7).

Physical activity guidelines

According to data from the Health Survey for England in 2008, only 6% of men and 9% of women in England could correctly define the UK Government physical activity guidelines[50].

Adults should aim to be active every day and minimise the amount of time spent being sedentary for extended periods. The recommended guidelines for physical activity for adults are at least 150 minutes of moderate intensity activity (such as brisk walking or cycling) a week. Alternatively, comparable benefits can be achieved through 75 minutes of vigorous intensity activity (such as running or playing sport) a week or through combinations of moderate and vigorous intensity activity. Adults should also undertake physical activity to improve muscle strength on at least two days a week[40].

If people are undertaking moderate intensity activity they will breathe faster, have an increase in their heart rate and feel warmer. Participants may even sweat on hot or humid days. An unfit or overweight person may only have to walk up a slope to feel these signs but a very fit athlete would have to run quite fast before they would feel this way.

Local picture

According to the Health Impact of Physical Inactivity online data tool, if everyone aged 40 - 79 years in Kingston were active, 75 deaths, 19 new cases of breast cancer and 11 new cases of colorectal cancer would be prevented each year[51]. The health cost of physical inactivity in Kingston is estimated to be over £2.4 million[51] per year.

Sport England's Active People Survey (APS) collects data on adult sport and active recreation at a local authority level. The APS key performance indicator NI8 identifies the percentage of adults achieving 30 minutes of sport three times a week and active recreation of moderate intensity over the previous 28 day period.

The activities reported on within NI8 are: sport, recreational cycling, recreational walking, walking for active travel purposes, cycling for active travel purposes, dance and gardening. The latest rolling 12 month interim result for Kingston from April 2014 to April 2015 is 22.4%. This is less than both the London (22.5%) and England (23.1%) averages[52].

Local action

There are numerous free and low cost physical activity and sports programmes in Kingston which provide opportunities for adults to be physically active.

Exercise Referral

Get Active

The Get Active exercise referral programme is a 12 week intervention for adults aged 16 and over who have existing health conditions or sedentary lifestyles. Participants receive a structured exercise programme from a qualified exercise referral specialist. Activities on offer include gym based exercise, aquacise, pilates, netball, active gardening and walking.

From April 2014 to March 2015, 632 patients were referred to the Get Active programme, which is an increase of approximately 12% on the previous year. Of these, 48% completed the programme (attended 80% or more). The majority (81%) of participants were aged 16 to 65. Programme outcomes were positive with 53% of participants achieving a reduction in their BMI at the end of the programme. Patient motivation to exercise increased by 30% after completing the programme demonstrating a change in attitudes towards physical activity, along with an increase of 52% reporting satisfaction with their activity levels six months post programme (37% reporting to be active for 30 minutes on at least five days a week).

From January to April 2015 the Get Active programme delivered a 12 week pilot walk for cancer patients. The walk was very successful and the feedback was very positive (please see the case study at the end of this chapter for more details). There were an average of eight to 12 walkers weekly and the walk is now ongoing with the group consisting of five walkers as of September 2015.

Healthy Lifestyle services

Kingston Walking for Health

Kingston's Walking for Health scheme provides free weekly walks which are led by volunteer walk leaders in parks and open spaces across the Borough. The walks range from 30 to 90 minutes and are aimed at people who would like to improve their health through gentle exercise. Between January 2013 and March 2014, there were 126 registered walkers on the programme with 742 attendances.

Good Energy Club

The Good Energy Club is run by Hestia in partnership with the Council for people with mental health needs in Kingston. The original pilot programme ran from December 2013 to November 2014 and has been extended until March 2016. The aim is to help people with stress, anxiety and other mental health conditions by improving mood through exercise and social activities. Between April 2014 and March 2015 there were 64 people on the programme, 60 of whom were aged 18 to 64.

Sports clubs and leisure centres

See chapters 2.7 and 2.8 for more information.

Back 2 Netball

Back 2 Netball is a gentle re-introduction to the sport for women aged 16 and over of all abilities. The sessions are coach led and cover the basics from chest passes to footwork. In Kingston there is a weekly session held at Kingston College. From January to April 2015 there were 36 new participants.

Parkrun

Parkrun is a free 5 km timed run, jog or walk open to all abilities and ages. Parkrun in Kingston is held every Saturday commencing at the Hawker Leisure Centre. From April 2014 to March 2015 there were 5,622 attendances, which equates to an average of 104 runners each week.

Recommendations

1 **Work with partners to expand the choice of activities on offer under the Get Active exercise referral programme to help improve choice and retention rates. This could include building on the successes of 'Back 2 Netball' by offering similar schemes with other sports.**

2 **Develop Kingston's Walking for Health programme by increasing the number of trained volunteer walk leaders, expanding the number of walks currently on offer, broadening the localities visited and introducing walks for specific target groups such as parents and children.**

3 **Work with partners to increase opportunities which attract groups with low levels of physical activity participation.**

4 **Promote the use of the Get Active London online sport and activity finder which lists all sports and recreation activities in the region to improve awareness of physical activity and sport opportunities in Kingston.**

5 **Introduce weekly cycle rides across the Borough to encourage participation in cycling for beginners.**

6 **Raise awareness of the recommended physical activity guidelines and promote the benefits of exercise, in order for adults in the Borough to make informed decisions about physical activity.**

Case study – Keith Day, Chessington resident and Get Active participant at the Malden Centre

Keith visited his GP for a routine blood pressure test, and was called back immediately for some blood tests. The results were bad; Keith had extremely high blood pressure and high cholesterol. Keith was also classified as obese, weighing in at 335 lbs (152 kg).

"The Doctor gave me a choice; change my ways or damage my organs forever!"

Keith was offered a gastric band, but after much discussion he decided not to take it and signed up for the Get Active programme instead.

Keith started the programme in January 2015. When he first met his instructor Magda, he took with him photographs of everything he had eaten that week. Magda gave Keith helpful advice to improve his eating habits as well as physical activity levels.

"It was clear I was not on a diet, I was on the beginning of a journey, a lifestyle change."

Magda introduced Keith to the gym and set him tasks to complete every week. Magda then checked Keith was doing the exercises correctly and introduced him to more cardio and core exercises, making them progressively harder every week.

"Magda has always been there for me either at the gym or at the end of the phone if needed. She has motivated and encouraged me throughout these few months."

Keith realises this is only just the start but the changes he has seen already have been amazing.

"I have considerably more energy during the day and find even small things like tying my shoe laces and putting on socks much easier. I am able to have a kick about with my children and chase them around the garden without ending up a wreck."

Since starting the Get Active programme Keith has lost 34 lbs (15.5 kg). On average this has been 2 to 3 lbs (1 - 1.5 kg) a week, which is really great progress.

"I still have a long way to go but I have had the best kick start thanks to Get Active and Magda."

Case study – Walks for people with cancer

In January 2015, Kingston Council in partnership with Macmillan at Kingston Hospital, piloted a weekly walk for cancer patients. The aim of the walk was to provide light, gentle exercise to improve patients' health, as well as offering support to those recovering from cancer.

The walk took place every Tuesday morning at Fairfield Recreation Ground in Kingston. Participants were encouraged to walk at their own pace to gradually build up their fitness levels. The walk was very sociable and the Kingfisher Leisure Centre provided a free hot drink to participants afterwards.

The 12 week pilot was a great success with 12 participants taking part, some attending every week, others when they could make it. The positive feedback received from participants has enabled the Council to continue the walk on an on-going basis and the group is now growing every week.

Participant comments included:

"A healthy, social morning – it's nice to be out in the air, rather than inside."

"First time with the group today- really enjoyed the walk, great to meet new people – a very friendly bunch."

"I appreciate the chance to take some exercise because that was the one thing I wasn't doing and that used to worry me. The Tuesday walks have really motivated me and I've met a lovely group of people."

"I look forward to every Tuesday to come and meet everyone – all the lovely girls (and boys!) – and to enjoy coffee and sometimes lunch afterwards."

"Enjoyable way to do gentle exercise and meet new friends."

"A good reason to get up on Tuesday mornings! Low key, friendly, walk at your own pace – always someone to chat to on the walk and over coffee afterwards."

"It's good to have the company and you always feel better for the exercise."

Archana Sood, the Macmillan Information and Support Manager at Kingston Hospital said:

"It's so fantastic that we can provide this service to our patients. I know that they have gained a lot of support and new friends from the walk."

2.5 Physical activity in older age (65 years and over)

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Introduction

It is important to promote physical activity in older people so that they can live a healthy lifestyle and avoid ill health. The needs of older people vary enormously and should not be defined by age. A more useful classification is to broadly split this population into three groups; active and independent older people, older people in transition and frail older people[53]. The focus of physical activity programmes targeting each group will vary given their differing needs.

The preventive effects arising from regular physical activity at recommended levels in later life are at least as strong as those found in middle age for all-cause mortality, cardiovascular disease and type 2 diabetes[54]. In addition, physical activity for older people can[54, 55]:

- lower the risk of dementia
- improve day to day cognitive functioning and the ability to carry out everyday tasks
- improve mood and self esteem
- help alleviate the symptoms of depression and anxiety
- reduce the risk of falls
- help to maintain a healthy weight and retain physical function and mobility
- increase bone strength and delay the onset of osteoporosis
- reduce joint pain for people with rheumatoid arthritis and knee osteoarthritis.

Being active can be an important way for older adults to maintain independence and social engagement. This in turn can contribute to higher levels of mental wellbeing. Activity in groups builds friendships and helps people feel that they belong.

Physical activity guidelines for people aged 65 and over

The suggested physical activity guidelines for older people are the same as for adults (150 minutes of moderate intensity physical activity a week), however the recommended activities differ. In later life, physical activity can be accessed in many ways such as active transport (for example walking to the shops), individual or group based activities (such as dance and movement classes, swimming and tai chi) and activities of daily living (such as climbing stairs, gardening and household activities)[55].

Falls are a major source of injury for older people and can result in hip fractures. Approximately 30% of people older than 65, and 50% of people older than 80, fall at least once a year[55]. It is predicted by 2036 over £6 billion a year could be spent in the UK on treating hip fractures[55]. It is recommended that older adults at risk of falls should incorporate physical activities such as tai chi or yoga in order to improve balance and coordination on at least two days a week[54].

NICE guidance suggests older people should be encouraged to attend a physical activity class once or twice a week[56].

Being active can be an important way for older adults to maintain independence and social engagement. This in turn can contribute to higher levels of mental wellbeing. Activity in groups builds friendships and helps people feel that they belong.

Local picture

The percentage of people aged 65 and over in Kingston participating in at least one 30 minute session of sport a week was 18.6% in 2014 - 15 which is slightly higher than the regional (17.5%) and national (17.5%) percentages[57].

In order to promote physical activity to over 65s in the area it is important to identify residents' physical activity preferences[51]. Sport England has developed 19 sporting segments to help us understand the nation's attitudes to sport, their motivations and barriers. According to Sport England's market segmentation tool (see chapter 2.7), the dominant segments of older residents in Kingston are retired couples enjoying active and comfortable lifestyles and retired single or widowed individuals[58]. Sport England's research indicates that these groups enjoy the following activities: keep fit/ gym, swimming, golf, tennis, cycling and bowls. The main motivations for participating in sport and physical activity amongst these segments are enjoyment, keeping fit and socialising[58]. This research, supported by independent local surveys, should be used to plan and develop effective physical activity initiatives.

Barriers to participation in physical activity

There are a number of factors that influence an older person's participation in physical activity. These include a complex range of individual, social and environmental factors such as cost, fear, limited mobility and overall health[55].

Older people living in areas of disadvantage have an above average propensity to have poor health, cardiovascular conditions and bone, muscle and joint problems. These can prevent them from accessing physical activity due to mobility issues and fear of either falling or damaging their health[56].

Ensuring physical activities meet the needs of residents living in disadvantaged communities is essential to address health inequalities. Examples include ensuring that transport costs are affordable and that activities are appropriate for the local ethnic profile[53].

For older people, particularly those living in areas of deprivation in Kingston, reducing social isolation is also very important. This can be achieved through developing group physical activity programmes, which aim to promote social interaction among isolated individuals or groups[60].

Bone health can have a major impact on an older person's ability to take part in physical activities. This includes both hip fractures and osteoarthritis of the hip or knee. The prevalence of these conditions in Kingston is as follows:

- The rate of hip fracture among those aged 65 and over in 2013 - 2014 was 573 per 100,000, very slightly lower than the England rate (580 per 100,000)[59].
- The percentage of hip osteoarthritis is 10.5% among those aged 65 - 74. This is lower than the England rate (11.4%)[61].
- The percentage of knee osteoarthritis is 16.7% among those aged 65 - 74, which is also lower than the England average of 19.2%[61].

According to the Department of Health, the common factors which increase the success rate of physical activity programmes are the consideration of older adults' needs and consideration of environmental support[54].
It is important therefore that health conditions and other factors are addressed to ensure that barriers to physical activity are removed.
In response to this, Kingston continues to provide a wide range of free and low cost targeted physical activity interventions across the Borough.

Local action

In response to local needs, Kingston Council and its partners have designed and implemented a range of activities for older people. These are summarised below.

Exercise Referral

Get Active

As described in chapter 2.4, this programme is a 12 week intervention for people with existing health conditions or sedentary lifestyles. From April 2014 to March 2015, 16% (98) of Get Active participants were aged between 66 and 95 years.

Healthy Lifestyle Services

Active Kingston Card and Leisure Centres

The Active Kingston Card provides Kingston residents who are over 60 with up to 70% discount on activities at seven leisure centres in the Borough. Activities include gym, racket sports, swimming, aerobic classes and athletics. A specific count of older people using the Active Kingston card is not available, however from April 2014 to March 2015 the total number of Active Kingston card users was 17,278.

Kingston Walking for Health

Kingston's Walking for Health scheme provides free weekly walks lead by volunteer walk leaders in parks and open spaces across the Borough. The walks are aimed at people who would like to improve their health through gentle exercise. Specific attendance by older people is not available at the time of writing due to a refurbishment of the database.

Fit as a Fiddle

Fit as a Fiddle, provided by the charity Staywell in partnership with Public Health, provides courses for people aged over 50 living in the Borough of Kingston (see case study). The aim is to help older adults get fit, lose weight, have fun and improve their general wellbeing.

The six week courses are free, each week including an hour's exercise (Nordic Walking, Aquacise, Cycling, Body Balance, or chair-based exercise) and a one hour weight loss and healthy lifestyle workshop.

In 2014 - 15, 22 courses were run and attended by 279 people ranging in age from 50 to 94. 88% were female, and 22% were from ethnic minority groups.

Ensuring physical activities meet the needs of residents living in disadvantaged communities is essential to address health inequalities.

Better Bones service

The Better Bones service is for people aged over 50 who have been diagnosed with or are at risk of osteoporosis. The 12 week programme is free and provides group based exercise in a sociable and friendly environment. The programme aims to give participants the skills, knowledge and confidence to improve their bone health through exercise and reduce the risk of fragility fractures in the future. The classes are fully supported by a qualified exercise specialist. Participants are eligible for the programme if any of the following apply:

- osteopenia or osteoporosis diagnosis
- previous 'low trauma' fracture
- early menopause (before 45 years)
- rheumatoid arthritis
- family history of osteoporosis or hip fracture
- regularly take oral steroids
- smoke cigarettes
- consume more than three units of alcohol per day.

Six courses were run in between October 2014 and March 2015 attended by 100 people.

Falls Prevention service

The Kingston Falls Prevention service provided by Your Healthcare works with people aged over 65 who have had a fall in the previous 12 months, have a fear of falling or are at risk of a fall. As part of the service they offer a 12 week strength and balance exercise class or a home exercise programme.

In 2014 - 15 there were 170 people who benefited from the home exercise programme and 108 people who benefited from a group strength and balance class.

Leisure Centres

YMCA London South West (LSW)

YMCA LSW has a Senior Programme Coordinator who organises activities for older people including zumba gold, bollywood fitness, line dancing, yoga, danceability and fitness gym sessions at both the Surbiton and Hawker Centres. Senior walks also take place. These are free of charge and include a stop for lunch. In 2014 - 15 the YMCA Senior Programme was used 2,962 times.

Places for People Leisure Centres (PfPL)

PfPL have a programme called Forever Active, which is specifically for over 50s and takes place at the four local leisure centres. Activities include a low impact studio class with an extended warm up to maintain and improve coordination, flexibility, strength and fitness and a zero impact aqua class in the pool using the natural resistance of the water for a gentle workout. On average the leisure centres have 200 people aged 50 or over attending each week.

In addition to the Active Kingston Card mentioned above, Kingston residents who are aged 80 and over are entitled to free swimming at the Kingfisher and Malden Leisure Centres. From March 2014 to April 2015 the total number of over 80 swims was 908, which was an average of 75 attendances per month.

Sports

Walking Football

Walking football is a new initiative aimed at over 50s. Normal football rules apply, but no running is allowed. The sessions are open to all abilities and focus on improving fitness, passing and technique. Weekly sessions take place at the Kingsmeadow Fitness and Athletics Centre. This programme started in April 2015 and so attendance figures are not yet available.

Parkrun

As described in chapter 2.4, Kingston Parkrun is a free weekly 5 km timed run, jog or walk open to people of all abilities and ages. Participation by the over 65s is currently low with only one or two runners from this age group taking part weekly.

Community venues

In addition to the above there are a number of community venues which deliver physical activity for their communities, these include:

- Milaap Cultural Centre – gentle exercise classes, yoga and bollywood dancing
- Shiraz Mirza Centre – keep fit
- Bradbury Centre – walking group, yoga, line dancing, chair exercise, zumba gold and tai chi
- Alfriston Day Centre – chair based exercise
- King Charles Centre – yoga and pilates

Recommendations

1 **Consider the development of new services that target older people who are unable to get out of their home to access physical activity programmes in the community by training existing care staff.**

2 **Work with partners to expand existing programmes such as introducing sports sessions (e.g. walking football) to the Get Active programme for older people and ensure strong inks between programmes to ensure participants can move from short term structured support to regular activity.**

3 **Develop communications to raise awareness of activities available for this age group in Kingston and in particular ensuring the provision of information to enable existing services to easily signpost residents to follow-on activities.**

Case study – Fit as a Fiddle

Over the last five years Fit as a Fiddle has helped over 1,100 older people to get fitter, lose weight and increase their wellbeing by running six week courses. From 2014 - 15 the results from the 22 courses run over this period showed:

- an average weight reduction of 1.4 kg (3 lbs)
- an average waist reduction of 1.82 cm
- a Body Mass Index reduction of 0.57 points
- 62% of participants lost weight and reduced their Body Mass Index
- the proportion of people in the ideal BMI range increased and those who were obese or morbidly obese decreased their BMI
- levels of inactivity decreased and those taking exercise on three - five days a week increased
- healthy eating habits improved (especially the consumption of fruit and vegetables, fish, and low fat foods)
- improvements in social capital such as 'feeling close to other people', 'feeling like I belong to a community' and 'feeling good about myself'
- at three month follow up 45% of participants said they now took more exercise; 27% continued to lose weight; and 64% ate a healthier diet.

Feedback was also very positive, with the following comments from participants:

"The Nordic walking course greatly improved my fitness and helped me lose weight. I would highly recommend the Fit as a Fiddle programme."

Max, Nordic walking participant

"The Aquacise course was very informative, encouraging and supportive. I enjoyed both sections of the course and it helped me start swimming again which I aim to continue in the future."

Susanne, Aquacise participant

"Excellent body balance course on all levels. I have lost weight, feel fitter, less aches and pains."

Eileen, Body Balance participant

The Fit as a Fiddle chair-based course made me aware of things I can do rather than things I now cannot."

Marianne, Chair-based exercise participant

2.6 Green spaces

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Introduction

Parks and open spaces contribute to all aspects of health and wellbeing including increasing levels of physical activity. They provide easily accessible and informal activity opportunities for people, which are usually free, such as walking, cycling or active play as well as more structured activity like taking part in sport.

Evidence suggests that people who take part in structured exercise programmes based in outdoor green environments are more likely to sustain their activity than if it was based in a gym or leisure centre[62].

Good access to urban green spaces is associated with greater use of the spaces, higher physical activity levels and a lower likelihood of being overweight or obese. Research shows that residents in environments rich in green spaces are three times more likely to be physically active and 40% less likely to be overweight or obese than those in areas with the lowest provision of these spaces[63], and the risk of developing type 2 diabetes is consistently less in the areas with the most green space[64].

Access to green space is unequally distributed across the country. The most affluent 20% of wards in England have five times the amount of green space compared with the most deprived 10% of wards[65]. This is likely to contribute to inequalities in health. To take one example, the National Children's Bureau found that children living in deprived areas are nine times less likely than those living in affluent areas to have access to green spaces to play[66].

As mentioned above, proximity to good quality and accessible green space is linked to more frequent use. National organisations have developed specific standards defining what constitutes an accessible green space. Natural England's Accessible Natural Greenspace Standard (ANGSt) provides guidance on the distance people should live from certain types and sizes of green space[67]. ANGSt recommends that everyone, wherever they live, should have accessible natural green space:

- of at least two hectares in size, no more than 300 metres (five minutes walk) from home;
- at least one accessible 20 hectare site within 2 km of home;
- one accessible 100 hectare site within 5 km of home; and
- one accessible 500 hectare site within 10 km of home; plus
- a minimum of one hectare of statutory Local Nature Reserves per thousand population.

Local picture

Kingston is considered to be a 'green and leafy' suburb and is well served by parks and open spaces as well as playing fields and other green facilities. These spaces provide recreation, active travel, physical activity and sport. There are 31 Council owned parks, as well as 24 Council owned playgrounds. Kingston commissions Quadron Services to manage and maintain these parks and open spaces. Sports clubs and community organisations are able to book and hire sports courts and pitches through Quadron Services. Kingston is also very fortunate to have the River Thames which is host to a variety of water sports clubs providing rowing, sailing, kayaking and canoeing. These clubs allow residents to use the river to take physical exercise.

In 2014, the Council undertook a public consultation to determine how and why people value and use green spaces. The results revealed that 40% of Kingston residents rated children's play areas as very important or important with approximately 20% being satisfied with the facilities. Nearly 50% ranked sport and leisure facilities as important whilst 23% were satisfied with the existing amenities. The overall findings of the consultation have informed the development of the Council's Green Spaces Strategy 2015 - 21[68] which features ten key themes, including:

- a focus on improving play facilities for children and young people
- increasing access to good quality green spaces to promote active and healthy lifestyles
- improving the quality of facilities to expand opportunities for sport.

Of the people surveyed in Kingston in 2013 to 2014, 17.1% said they spent time outdoors for health or exercise reasons. This is higher than London at 11.8% and level with the England average.

The provision of high quality, local and accessible green space helps to address a number of agendas. In order to maximize the impact of the Green Spaces Strategy, a collaborative partnership approach has been adopted. Within the Council this is particularly relevant to public health on shared goals within the Healthy Weight and Physical Activity (HWPA) Strategy and Needs Assessment 2013 - 16[69], the social care agenda, sports development through the Playing Pitch Strategy and the Mini Holland programme (see chapter 2.10). All of these plans feature actions aimed at improving the health and wellbeing of the Kingston population through developing opportunities to increase participation in physical activity and sport.

Local action

According to Sport England, cost and access to quality facilities are the two main barriers preventing inactive people or those in later life returning to physical activity. Kingston's parks and green spaces are freely accessible and provide an opportunity for people to engage in both structured and informal physical activity and sport. There are a number of fitness providers utilising the parks and open spaces to run paid activities, from one-to-one sessions to large boot camps. It is difficult to say how many of these freelance activities exist, but plans are underway to quantify these and improve how they are monitored and regulated.

The Council's offer of free and accessible physical activity and sport opportunities include:

Outdoor gyms and fitness trails

Five local parks and two residential green spaces are now equipped with outdoor gym facilities and/ or fitness trails. Two of the parks and both green spaces are located in areas of disadvantage. These facilities have created a great opportunity for local people on their doorstep where they can undertake free outdoor exercise at any time of day removing the barriers of cost and access which were the two key factors highlighted above. The seven areas with outdoor gym equipment are:

- Alexandra Recreation Ground
- Fairfield Recreation Ground*
- Churchfields Recreation Ground
- Manor Park
- King Georges Recreation Ground*
- Cambridge Gardens*
- Cambridge Road Estate*

*Located in an area of disadvantage.

Parkrun

Kingston Parkrun is a free, weekly, five kilometre event for runners of all standards and offers an opportunity for the local community to come together on a regular basis to enjoy taking part in a community physical activity event (see chapter 2.4).

Parkfit

The Kingston Parkfit programme was launched in Summer 2015 and is designed to improve access for local communities to increase participation in physical activity by providing a range of popular group exercise classes such as dance, pilates and circuit training. The programme is delivered in Churchfields Recreation Ground and King Edward's Recreation Ground which are both in Chessington. The programme is free for the first 20 weeks with an option to continue thereafter at a subsidised rate.

Kingston Walking for Health

Walking for Health encourages people to become physically active in their local communities. In Kingston there are six free health walks across the Borough (see chapter 2.4).

Recommendations

1 **Undertake local research to determine whether Kingston meets the Accessible Natural Greenspace Standard.**

2 **Continue to respond to the recommendations and actions outlined in the HWPA Strategy and Needs Assessment 2013 - 16 and the Green Spaces Strategy 2015 - 21 with regard to accessible and high quality green spaces:**

   a **Work with the Borough's parks and open spaces team to heighten awareness of opportunities for active recreation and sport.**

   b **Ensure the Borough's physical infrastructure becomes more conducive to supporting active living and active travel by bringing planning, housing, transport, environment, public health and community groups together.**

   c **Continue to work with partners to ensure all regeneration projects and planning considerations for open spaces supports the promotion of physical activity in the Borough.**

   d **Encourage the use of green spaces by local people to improve active and healthy lifestyles by improving the quality and accessibility of facilities.**

Good access to urban green spaces is associated with greater use of the spaces, higher physical activity levels and a lower likelihood of being overweight or obese.

2.7 Sport in Kingston

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Introduction

As described in earlier chapters, being physically active can improve and maintain health. Participating in sport is one way to be physically active. This can be undertaken individually (such as running or cycling), as part of a team (some examples being football or hockey) or as part of a supportive network (coaching, refereeing or volunteering).

Taking part in sport can have a range of benefits for people across the life course. Sport tends to involve vigorous levels of activity. Moderate intensity activity stimulates the body's cardio-respiratory, musculoskeletal and metabolic systems and causes them to adapt over time and become more efficient[70]. Exercise will therefore have a beneficial effect on maintaining functional ability, stimulating bone growth and reducing bone loss, lowering blood pressure and improving glucose metabolism[70]. It is also important to note the beneficial effects of sport on wellbeing such as improved mood, a sense of achievement, relaxation and release from daily stress[70].

In addition to health benefits sport can enhance self-esteem, and as part of wider development programmes such as Kickz (a national programme using football to engage 12 - 18 year olds in deprived areas whilst also delivering workshops on topics such as drug awareness) can have a positive impact on reducing crime and improving community safety by reducing reoffending[71]. Returns on investment in sports programmes for at-risk youth are estimated at £7.35 of social benefit for every £1 spent, through financial savings to police, the criminal justice system and the community[72].

There have been several studies suggesting a positive link between sport participation, academic achievement and lifelong learning particularly when sport is combined with out of school education programmes. The Culture and Sport Evidence programme led by the Department for Culture Media and Sport, has published evidence on the benefits of sport. For young people, participation in sport improves numeracy scores by 8% on average compared with non-participants. Underachieving young people who take part in sport see a 29% increase in numeracy skills and a 12% to 16% rise in other transferable skills[72]. Sports programmes also have the potential to strengthen local communities by improving social networks and strengthening community identity[71].

Nationally, the contribution of sport to the economy reached £20.3 billion in 2010, which placed sport in the top 15 industry sectors. The number of people employed in sport related jobs in 2010 was estimated at over 400,000 (2.3% of all employment in England). Furthermore, the estimated economic value of sport related volunteering is £2.7 billion and the health benefit from people participating in sport is estimated at £11.2 billion[71].

Sport England have developed a Sport Strategy for 2012 - 17 aimed at developing a sporting habit for life because evidence shows that there are specific times during an individual's life that are associated with a drop in participation. For example, it is vital to ensure a smooth transition from school sport to club sport, to maintain participation amongst young people in their late teens and early twenties[73].

The most common reasons people do not take part in sport is because they do not consider themselves to be healthy or fit enough and sport is seen as too competitive[74]. It is therefore key to raise awareness of sports available at all levels.

Local picture

The annual economic impact of sport in Kingston can be estimated using Sport England's Economic Value of Sport tool (see tables 1 and 2)[75].

Table 1 Economic value of sport in Kingston through participation and non-participation.

Participation	Gross Value Added	Jobs
Sports services	£29.5m	1,176
Sportswear and equipment	£5.4m	101
Sport education	£14.7m	193
Total participation	**£49.6m**	**1,470**
Non-participation	**Gross Value Added**	**Jobs**
Spectator sports	£6.3m	300*
Sportswear and equipment	£8.0m	150
Sports broadcasting and gambling	£4.7m	76
Total non-participation	**£19.0m**	**526**
	Gross Value Added	**Jobs**
Total direct economic value of sport	**£68.6m**	**1,996**

*Employment estimate directly from Business Register and Employment Survey and is rounded to the nearest 100.

Table 2 Wider impact and value of sport in Kingston.

Wider impacts	Wider value
Health	£67.4m
Volunteering	£9.9m
Wider spending	£9.0m

Source: Sport England, Economic Value of Sport tool, accessed 13th July 2015.

Using the 2014 Sport England Market Segmentation tool[76], Kingston's population can be broken down. Market segmentation is a powerful way of analysing the national and local population that allows those working in community sport to better understand who their different customer types are and where they are located. The segmentation process groups the adult population of England into 19 distinct sporting 'segments' and provides insight into the sporting behaviours and preferences of each of these segments, as well as their motivations and barriers to playing sport, satisfaction with the sporting experience, and the best ways to contact and market to people within each segment.

Figure 1 highlights that in Kingston, the two highest male segments are settling down males (14.9%) and competitive male urbanites (10.5%). For females the two highest are fitness class friends (10.1%) and stay at home mums (8.1%). Analysis of the sporting preferences of all the segments can provide insight as to how best to engage with people in Kingston to increase their participation in sport and access to sports clubs.

The Kingston Sports and Leisure service annual sports survey showed that when sports club membership was examined (Table 3) junior (under 16) membership was the highest with a total of 2,561, adults aged 16 to 49 was second highest with a total of 558 followed by seniors aged 50 years and over with a total of 397. The majority of members (60%) are male whilst 40% are female. It should be noted that just 17 clubs responded out of a total of 90 that were contacted.

Table 3 Membership of Kingston clubs by age.

Age	Number
Junior	2,561
Adults (16 years and over)	558
Senior (50 years and over)	397
Total	**3,516**

Kingston Sports and Leisure service annual sports survey 2014 (17 clubs participated out of 90).

The exact number of sports clubs in Kingston is unknown but there are approximately 100 sports clubs registered with Kingston Council's Sports and Leisure service and these represent a range of sports including traditional sports such as athletics, football, cricket and rugby and less traditional sports such as cheerleading and boccia. These clubs are supported by the Kingston Sports and Leisure service but mainly rely on volunteers to ensure their sustainability.

A key challenge for the majority of Kingston's local sports clubs is finding volunteers to take on roles and responsibilities in running a club. Clubs rely heavily on volunteers to carry out roles such as being a sports coach, kit washer, treasurer, facility maintenance or welfare officer, all of which are essential for a club to function. Many of Kingston's sports clubs struggle with limited staff capacity and are unable to take on any new members. In some cases this can lead to reduced accessibility for local residents.

From the most recent annual survey (2014) conducted by the Kingston Sports and Leisure service, of the 17 respondents:

- 76% (13) of clubs currently hire a facility and only one owns their facility
- 35% (six) of clubs have the financial capacity to bid to own their facility
- 71% (12) of clubs said they have seen an increase in membership in the past year.

The top five issues reported by clubs were:

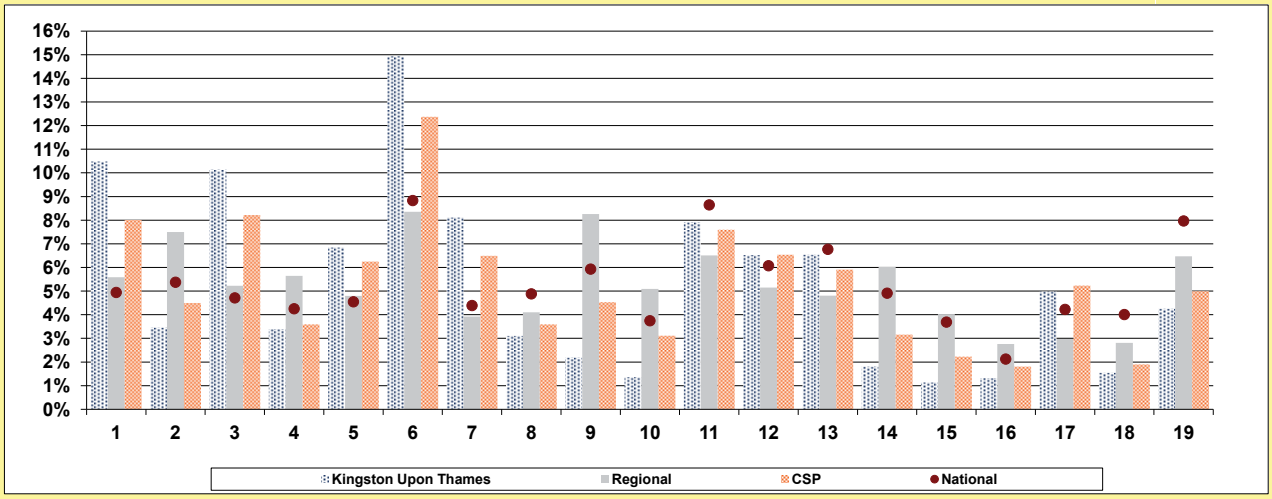
- recruiting new members
- obtaining Clubmark status
- accessing funds/ sponsorship
- generating sufficient income
- increasing facilities costs.

Figure 1 Market Segmentation for Kingston[76]

Sport England Market Segmentation

Market segmentation is a powerful way of analysing the population that allows those working in community sport to better understand who their different customer types are and where they are located. The segmentation process groups the adult population of England into 19 distinct sporting 'segments' and provides insight into the sporting behaviours and preferences of each of these segments, as well as their motivations and barriers to playing sport, satisfaction with the sporting experience, and the best ways to contact and market to people within each segment. The segments were developed by Sport England in 2010.

SPORT ENGLAND **Market Segmentation Local Authority Report for** Please select a Local Authority and then click 'Refresh Report' **Kingston upon Thames**



Segment	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
LA	10.5%	3.5%	10.1%	3.4%	6.8%	14.9%	8.1%	3.1%	2.2%	1.4%	7.9%	6.5%	6.5%	1.8%	1.1%	1.3%	5.0%	1.5%	4.3%
Regional	5.6%	7.5%	5.2%	5.6%	4.8%	8.4%	3.9%	4.1%	8.3%	5.1%	6.5%	5.1%	4.8%	6.0%	4.0%	2.8%	3.0%	2.8%	6.5%
CSP	8.0%	4.5%	8.2%	3.6%	6.2%	12.4%	6.5%	3.6%	4.5%	3.1%	7.6%	6.5%	5.9%	3.2%	2.2%	1.8%	5.2%	1.9%	5.0%
National	4.9%	5.4%	4.7%	4.3%	4.5%	8.8%	4.4%	4.9%	5.9%	3.7%	8.6%	6.1%	6.8%	4.9%	3.7%	2.1%	4.2%	4.0%	8.0%

Highest % :	Segment 6	14.9%	**Segment most above National % :**	Segment 6	6.1%
Lowest % :	Segment 15	1.1%	**Segment most below National % :**	Segment 9	-3.7%
Total Population :	126,262				

The chart above shows the proportion of each of the nineteen segments in the selected local authority, set against the regional, County Sport Partnership and national distribution.

Detailed information on the nineteen segments, (which are summarised in the table opposite), is contained in 'pen portraits' (see image below).

The pen portraits outline the key characteristics of each segment, including: family status; age; social group; media consumption; participation behaviours - what sports or activities people do, factors that would encourage participation, reasons for participating and not participating; engagement in other cultural activities; and volunteering.

For more information on the background to the segmentation model, how the segments were developed and to view the pen portraits and 'Frequently Asked Questions', visit www.sportengland.org/segments

Segment	Segment Name	Forename (s)
1	Competitive Male Urbanites	Ben
2	Sports Team Lads	Jamie
3	Fitness Class Friends	Chloe
4	Supportive Singles	Leanne
5	Career Focussed Females	Helena
6	Settling Down Males	Tim
7	Stay at Home Mums	Alison
8	Middle England Mums	Jackie
9	Pub League Team Mates	Kev
10	Stretched Single Mums	Paula
11	Comfortable Mid-Life Males	Philip
12	Empty Nest Career Ladies	Elaine
13	Early Retirement Couples	Roger & Joy
14	Older Working Women	Brenda
15	Local 'Old Boys'	Terry
16	Later Life Ladies	Norma
17	Comfortable Retired Couples	Ralph & Phyllis
18	Twilight Year Gents	Frank
19	Retirement Home Singles	Elsie & Arnold

Note: CSP refers to the London South County Sports Partnership. Regional refers to London.

In response to these findings, Kingston Sports and Leisure service worked closely with Sport England and their new initiative 'Club Matters' to provide free guidance, support and learning on all aspects of running a club. Seven free sports seminars were hosted in 2014 for local sports clubs to attend. These were well received with 22 sports clubs attending. The seminars were on specific themes:

- marketing strategy – reach out and attract with impact
- finance – build a firm foundation for your club
- PAYE and employment status of coaches
- business planning – securing a brighter future
- cash flow and budgeting – getting your finances into shape
- club structures – building for success
- policies and procedures – protect your club's future.

Kingston has 17 sports clubs that have achieved Clubmark accreditation. This is the universally acknowledged sport accreditation scheme for community sports clubs. It uses criteria which must be supported by specific evidence and is based on four key areas of club development:

- Activity/ playing programmes – this includes coaching qualifications required, insurance and coach-to-participant ratios.
- Duty of care and welfare – appropriate risk assessments, health and safety policies, training, compliance and child protection policies.
- Knowing the club and its community – this ensures that the club is committed to fairness and equity in respect of the way in seeks to attract and retain members from the local community.
- Club management – which covers club and committee structures and the general running of the organisation.

An additional six local clubs are currently working towards achieving Clubmark and a further 11 clubs do not have Clubmark, but would like to know more about how to start the process.

In addition to the Council led sports development service, the Borough has a dedicated independent sports Council called Sport Kingston. This is committed to the encouragement, development and promotion of all sports within Kingston. They support, advise and consult upon all sporting activities Borough wide and seek to promote sport at all levels. Sport Kingston lobby on behalf of local sports clubs and will liaise with authorities on their behalf to resolve issues that affect them.

Local action

Of the sports clubs in Kingston, over 100 are registered on the Council's sports club directory which is administered by the Kingston Sports and Leisure service. The directory's purpose is to provide the general public with an easy to use list of sports clubs that can be accessed on the Kingston Council website.

As well as the Sports Club directory, the Council has a dedicated Sports and Physical Activity Directory for Disabled Young People. Its purpose is to bring together and promote all of the sports and physical activity provision in the Borough for disabled young people. This is also hosted on the Kingston Council website.

Since 2012, Kingston Sports and Leisure service has successfully directly applied for, and supported local sports clubs to apply for national funding of over £1 million in total for a variety of projects. These have included a £50,000 award from the Sport England Inspired Facilities Fund to the Minima Yacht Club to install a disabled toilet and upgrade their clubhouse to make it accessible for disabled people. The Thames Sailing Club were awarded £50,000 to refurbish their very dated changing facilities. This has enabled existing members to have the opportunity to get changed at the club and made the club more appealing to new members. Malden Wanderers Cricket Club were awarded £50,000 to bring their disused tennis court back into use and in addition, to add netball lines on the court so making a multi-use games area.

Kingston Sports and Leisure service also works closely with a number of clubs to deliver community sports programmes and events. The Balfour Beatty London Youth Games event (the largest in Europe) relies on strong partnerships with local sports clubs. Clubs are commissioned to take on the team management of their chosen sport and ensure that there is a pathway for young people to go on and join the club once they have taken part in the London Youth Games. Thanks to this new way of working, Team Kingston entered 30 sports in 2015 including new entries such as Weightlifting, BMX Cycling, Girls Judo, Beach Volleyball and Rugby 7s. In addition, Team Kingston were able to enter a full team into the Para London Youth Games sports of Athletics, Boccia, Football and Swimming. Team Kingston finished 11th out of 33 London boroughs, its highest finish in over ten years, and collectively won 26 individual or team medals.

Since 2012, Kingston Sports and Leisure service has successfully directly applied for, and supported local sports clubs to apply for national funding of over £1 million in total for a variety of projects.

Abi Chamberlain, former England Ladies Rugby 7s Captain and ex London Youth Games Kingston competitor is very supportive of local sports clubs:

"There are unquestionable advantages to people having opportunities to remain active. Not only are the health incentives of an active lifestyle supported time and time again across the world, but also the social aspects; the transferable benefits to everyday life enabling people to meet day to day physical demands; and the skills it provides that directly translate into the working world. For many people, the opportunity to capitalise on such overwhelming benefits is only accessible throughout the hard work and in most cases resilience of local sports clubs. If it wasn't for the selfless efforts of volunteers in Kingston as I was growing up, I would have been incredibly limited in my opportunity to compete and enjoy the sports I did. I certainly wouldn't have had the platform on which I developed my career or the stepping stone to represent at higher levels".

Abi Chamberlain, former England Ladies Rugby 7s Captain and ex London Youth Games Kingston competitor.

The Virgin Giving Money London Mini Marathon is aimed at young people aged 11 to 17 years and in 2015, Kingston were able to field a full squad of 48 who represented the Borough in the six different age groups (each age group is made up of eight participants). A notable performance came from the Under 15 Boys category who finished third out of 33 London Boroughs, Kingston's highest ever placing. Team Kingston was managed by The Stragglers Running Club on behalf of the Council.

Many local schools use club coaches to run Physical Education (PE) classes as a means of talent spotting and recruiting into local sports clubs. This helps to raise awareness and inspire interest in participation after school hours, at weekends and after leaving school.

Kingston College have developed some key Borough Sports Club links which includes the Kingston Trampoline Academy which delivers the College's recreational Satellite Trampoline Club. The College are looking forward to further developing links with Kingston Wildcats Basketball team and Kingston Rugby Football Club in the next academic year. The College's Special Olympics project has also developed a strong link with Surbiton Racket and Fitness Club who have provided great coaching to their inclusive club that will also develop further into next year (see case study on pages 156 and 157).

Kingston University's Tolworth Court sports ground is well used by approximately 34 local community clubs as well as the student sports teams. There are also annual one-off bookings including:

- County of Surrey Archery Association "Surrey Archery Weekend", which this year had 600 participants, including a Great Britain v France International Challenge match.
- Racal Decca are hosting the "Smallest Rugby World Cup" to coincide with the Rugby World Cup 2015, with teams travelling from Trinidad & Tobago, Germany and Spain.

Kickz is a national programme which uses football to engage with young people living in disadvantaged areas. It delivers sports coaching and workshops on health issues. Kingston has two Kickz projects, one in Tolworth (School Lane) and one on the Cambridge Road Estate. This partnership programme is run by Fulham Football Club Foundation in conjunction with Kingston Police. In 2014 - 15, 42 young people were engaged with at the Cambridge Road Estate project, whilst 116 participated at School Lane, Tolworth.

Recommendations

1 **Continue to support local sports clubs to achieve Clubmark status.**

2 **Work with clubs to increase opportunities that attract groups who traditionally participate less in physical activity and sport, such as girls and women, people with disabilities and BME groups.**

3 **Utilise legacy opportunities from the London 2012 Olympic and Paralympic Games to inspire participation and support volunteering.**

4 **Create opportunities to enable more children and young people to take part in physical activity after school and in the community and also work to reduce the drop in activity on leaving school.**

5 **Work with Kingston College and Kingston University to reduce the drop in activity on leaving college and university.**

6 **Continue to work closely with Sport Kingston to ensure the voices of local sports clubs are heard by encouraging an increased response rate to the annual sports survey.**

7 **Ensure sports clubs are aware of local, regional and national funding streams, and support them to develop their skills in making applications for funding.**

8 **Continue to support local sports based programmes such as Kickz in areas of disadvantage.**

Case study – Disability Tennis

Surbiton Racket and Fitness Club (SRFC) is a community based sports and social club which was founded in 1881. The club is particularly motivated to encourage people of all abilities to participate in sport so that access can be offered to everyone, regardless of background. A recent key development to engage further with the local community has been the creation of partnerships with a number of organisations to provide an Inclusive Tennis programme for people with either physical or learning disabilities.

The aim of the programme is to allow people with little or no previous experience of the game to experience the sport in a welcoming environment. There are currently over 80 disabled children or adults accessing tennis with the SRFC through local schools and its year-round club programme.

In September 2012, SRFC became one of the country's first Disability Tennis Networks to be set up by the Tennis Foundation, the charitable arm of the Lawn Tennis Association. A senior internal coach was appointed to manage and develop the growth of the programme, linking in with Kingston CSPAN, local schools and the surrounding community to generate interest and publicise the opportunity to come and try the game of tennis. The initial drive was to reach out to children and adults with a learning disability. The first Inclusive Tennis session took place after school at the start of the summer term in 2013 and six children aged between 4 and 16 years took part. Thanks to funding from the Tennis Foundation, SRFC were able to fully subsidise the whole ten week term of sessions. A decision was quickly made to extend the sessions for the following term after the summer break, when the group increased in size to eight and then eventually to 12 children regularly accessing tennis on a weekly basis.

A smaller group of six children were talent spotted and invited to join this group and, thanks to SRFC's partnership with Special Olympics Great Britain (SOGB), they now train a minimum of 26 weeks a year to become eligible for one of the competitive pathways SOGB provides through its regional structure.

Future plans

In 2015, SRFC is will become an official partner of Special Olympics Surrey (SOS), which will enable those participants who become SOS members to access other sports within the Special Olympics family. It is hoped that some local friendly matches or competition can be arranged to provide the participants with the valuable experience that comes with simply taking part, and to help develop an understanding about how to take some individual decisions and responsibility during the game. SRFC is committed to providing a competitive pathway for those who want it, as well as maintaining a friendly, non-threatening and welcoming environment for those who do not.

Please see below a selection of comments from parents of those children who are accessing these sessions:

"They don't realise they are learning, they are just having fun! You can see the difference the tennis sessions have made – their co-ordination has improved, they are taking turns and willingly listening to instructions – that's a first! It's the first activity my son has enjoyed for as long as I can remember. It's great to see both my sons smile. They have loved the sessions."

Suzanne, mother of J and Z, aged ten

"What a wonderful environment for children who struggle in different ways to make excellent progress. They are supported, praised and have found new friends who understand them without judgment. R can't wait for tennis to start at school, because for once, he will be ahead of the game. His confidence has grown under the fantastic coaches and there is nothing like this available for him to access anywhere else."

Charlotte, mother of R, aged 11

"M has really improved his coordination and concentration since going to your classes. He loves playing tennis and is keen to practise in his spare time. He likes all the children in the class and it is so lovely to see how everyone just accepts him and does not focus on his disability. Your coaches are brilliant and very patient and successful in motivating everyone. Many thanks!"

Bini, mother of M, aged nine

2.8 Local leisure facilities

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Introduction

As described in previous chapters, physical activity has a wide range of benefits for people across the life course and one way of being active is through leisure and recreational activities. Leisure facilities provide opportunities for activity that would otherwise be inaccessible to the local population such as swimming pools and gyms.

Over the last 50 years physical activity levels have declined by 20% in the UK, with projections indicating a further 15% drop by 2030[77]. If trends continue, by 2030 the average British person will use only 25% more energy than they would have done had they just spent the day in bed[78].

To begin to reverse this trend, it is critical for there to be a clearly articulated national and local ambition. UK Active's document Turning the Tide of Inactivity[78], found that reducing physical inactivity by just 1% a year over a five year period would save the UK economy just under £1.2 billion[77] and save local taxpayers £44 per household[77]. In addition, this would improve the health and wellbeing of their local communities which would reap further economic benefits.

For local authorities to support this ambition it is vital to ensure that the local population can access a wide variety of options to encourage activity, recognising that different people will find different types of activity easier to access and sustain than others. Participation is influenced by a range of factors including cost, facilities, transport, and knowledge of what is available locally. The most inactive local authorities have on average a third fewer facilities than the least inactive areas[78] which highlights the importance of having good quality and accessible facilities locally to encourage activity amongst the local population.

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Local picture

Kingston has a number of leisure centres in the Borough. Four of these are owned by Kingston Council but run by Places for People Leisure (PfPL):

- Kingfisher Leisure Centre
- Malden Centre
- Tolworth Recreation Centre
- Kingsmeadow Fitness and Athletics Centre

There are also a number of independent centres run by other providers. These include:

- YMCA Surbiton
- YMCA Hawker Centre
- Chessington Sports Centre
- The King's Centre, Chessington

In addition, there are a number of private leisure facilities in Kingston run by companies such as Nuffield Health, David Lloyd and Virgin Active, as well as some smaller businesses, and some facilities which have been made available to local people such as those belonging to Kingston University.

The contract with PfPL is monitored by the Council to ensure that Health and Safety procedures and practices are in place and facilities are being properly maintained and kept clean. A partnership board works to ensure that comprehensive and inclusive programmes and activities are in place. These are regularly adjusted in response to customer demand and new trends (usually established through customer feedback cards, user groups and working with both sports governing bodies and Sport England). PfPL has invested in the facilities through capital injections, the most recent being over £100,000 to enhance a Sport England Grant to refurbish the wet side changing accommodation at the Kingfisher Leisure Centre.

Traditionally, the local YMCAs have delivered a number of fitness services including gyms and group exercise that meet the needs of regular exercisers or people that want to get fit for health reasons. Within the YMCA centres there are now a number of projects, programmes and services that work to reduce health inequalities and increase the ways for the local community to access healthy lifestyle opportunities.

Local action

PfPL centres

Activities provided across the PfPL centres include water based activities such as swimming, swim school, aqua, Swimtag and Swim4Heath™. Swimtag is a wristband worn in the pool that tracks distance covered, calories burned, distance per stroke, rest time, personal bests and many more metrics. Swim4Health™ (monitored by Swimtag) is an award winning programme that offers for £28 six weeks of unlimited swimming (at all welcome sessions which are open to the public and include some lane swimming and some open pool space for everyone, and aqua classes which are aerobics in the water suitable for all abilities) or six swimming lessons.

Kingston sites are showing a 14% increase in swimming attendances (the actual number of visits for swimming) year on year. This has been attributed to the continuing development of innovative programmes such as Swim4Health™ and Swimtag.

Other activities available at PfPL centres include gym, junior gym, football, squash, athletics, gymnastics, trampolining, group exercise and accessible exercise. The Get Active Exercise Referral scheme is also run at these sites (see chapter 2.4).

Between April 2014 and March 2015, the four PfPL centres had a combined footfall of 1,432,825 which was an increase of 55,585 (4%) on the previous year.

YMCA centres

The Hawker and Surbiton sites in Kingston offer a range of activities for the local population. Services for older people include Zumba Gold and Bollywood Fitness. There is also a pilot programme for participants that have completed the 12 week Kingston Bone Health programme (for people at risk of osteoporosis and with osteoarthritis) to continue their preventive care. Services for disabled people include Inclusive Fitness Line Dance, Inclusive Fitness Yoga, Inclusive Fitness Danceability, Inclusive Fitness Zumba, and Inclusive Fitness Gym sessions.

The YMCA also offers non centre based activities including Senior Walks, Kingston Youth Dance Company, and after school dance clubs at two primary schools. Club 1316 ensures the gyms are accessible to young people aged 13 to 16 years old. As part of their partnership work, YMCA also support the Good Energy Club and the Get Active scheme (see chapter 2.4).

Data for both YMCA sites (Surbiton and Hawker) show an overall attendance figure for 2014 - 15 of 133,663.

Recommendations

1 **Support local leisure providers' communications and marketing strategies to ensure services are well known amongst the local population and wider partners in Kingston.**

2 **Support leisure providers to promote activity as a means of improving emotional wellbeing and mental health.**

3 **Develop innovative interventions to support disadvantaged communities accessing leisure facilities.**

4 **Work to improve the accessibility of services through transport routes and improving affordability.**

5 **Encourage leisure settings to provide a wider healthy lifestyle offer such as providing healthy food options for people after exercise.**

Case study – Swim4Health™

Swim4Health™ monitored by Swimtag is an award winning programme run by Places for People Leisure (PfPL) which is delivered across all pools in the PfPL Group across the country. It is an aquatic route to fitness which aims to remove barriers to physical activity and encourage more people to be more active, more often.

The Swim4Health™ programme offers six weeks of unlimited swimming at all welcome sessions and aqua classes or six swimming lessons for a single payment of £28. Each participant is given aquatic advice and completes a personal needs analysis with health and wellbeing benchmarks. These benchmarks are reviewed at week six to monitor improvement.

Barriers include economic issues, low confidence, lack of time, not having someone to go with and travel. Swim4Health™ tackles these issues ensuring it is affordable at a rate of £28 for six weeks (£4.67 per week). Low confidence is addressed by offering the participant a personal needs analysis with an onsite aquatic advisor which gives them an open forum to ask questions that can help to address the issues around low confidence. Providing aqua sessions as group exercise can lead to meeting like minded people with shared goals. Tackling travel barriers is out of the scope of Swim4Health™ to address but the Kingston locations are well served by public transport and dedicated cycle routes.

Ability can be another barrier. As well as offering the swimming lessons, Swim4Health™ offers access to Swimtag at no extra cost. Swimtag is a wristband worn in the pool that tracks distance covered, calories burned, distance per stroke, rest time, personal bests and many more metrics. It complements the SwimFit experience (the ASA programme that helps improve stroke technique) as well.

Aquatic Advisors have access to the Swimtag Operator panel and can see exactly what swimmers have achieved, busiest times in the pool and many other features that can be reported back to commissioners. Between April 2014 and September 2015, 226 users have uploaded 3,848 swims, swimming a total distance of 5,350 km. These participants have spent over 104 days in the pool using swimtag. The average distance per swimmer is 1,390m currently (56 lengths) and the average duration of each swim is 32 minutes.

Graduates of Swim4Health™ are offered an exclusive membership joining offer to encourage sustainability, an offer 15% of participants have taken up.

Swim4Health™ has been successfully delivered at both the Kingfisher and Malden Centre since April 2014 with around 11 people each month on the journey. These numbers are small compared with the rest of the PfPL Group so plans are in place to increase its profile within the local community via an outreach programme, and engaging with local health professionals to encourage referrals.

2.9 Active travel

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Introduction

Active travel is one of the easiest ways to build exercise into a daily routine. Cycling and walking all or part of the way to work or school not only brings instant health and fitness benefits, it also benefits the wider environment[79] by reducing traffic congestion, local pollution and CO_2 emissions.

Research commissioned by Cycling England[79] found that for each new cyclist who cycles regularly for a year there was an economic benefit of between £540 - £640. This included costs associated with healthcare, congestion and pollution.

There is national and regional recognition of the value of active travel and, through bodies such as the Department for Transport and Transport for London (TfL), infrastructure and behaviour change programmes are being funded across the country.

It is important to consider how different population groups engage in active travel. The London Travel Demand Survey[80] shows that low income groups and BME communities are more likely to walk and use buses as their main form of transport, whilst white and more affluent groups are more likely to cycle.

Research commissioned by Cycling England[74] found that for each new cyclist who cycles regularly for a year there was an economic benefit of between £540 - £640. This included costs associated with healthcare, congestion and pollution.

Local picture

In Kingston, traffic congestion is consistently near the top of residents' concerns. In the 2014 'All in One' survey 82% of residents were not satisfied with the levels of traffic congestion in the Borough.

Kingston First's Retail Performance Report[81] calculated that the annual footfall in Kingston Town Centre in 2013 was in excess of 20 million, making Kingston one of the busiest retail centres in London outside the West End. Over the next few years the Borough will see considerable development and a subsequent rise in residential population, businesses and visitors. Facilitating active travel has never been more important both for people's health and to keep the Borough moving.

Kingston has the second highest rate of cycling in outer London, however only 5% (6,400) of local adults cycle to work[80] and 2% of children cycle to school[82]. The percentage of people who cycle at least once a week is 20%[80]. The most recent TfL Survey[80] indicates that around 31% of journeys are walked in Kingston, which is similar to the London average of 32%, although in inner London walking rates are higher at 37%. It is important that work is undertaken to increase the uptake of cycling and walking to deliver the health, economic and community benefits that active travel can bring.

In Kingston traffic congestion and overcrowding on public transport is evident during peak times. Kingston Town Centre and Surbiton are badly affected during rush hour, particularly in term time with school children, college students and university students all travelling at the same time.

TfL's London Travel Demand Survey[80] shows that car ownership in Outer London was higher in 2012 than in 2005. Kingston has some of the highest car ownership rates in Greater London with only 25% of households not owning a car in 2012.

School travel plans for 2015 show that around 46% of children walk to school and increasing numbers (8%) are using scooters[82], however car journeys made on the school run still significantly impact on local areas.

Local action

The Council works with other organisations across Kingston to promote sustainable travel through travel plans. This includes working with schools to ensure they actively promote cycling, walking and scootering in their plans.

Scootering is an increasingly popular way to get to school and scooter parking and scooter safety training are now required. Kingston offers a rolling programme of scootering proficiency training to primary schools. Between September 2014 to June 2015, 370 children received training and are now being supported to utilise their new scootering skills as a form of active travel to and from school.

The provision of road safety education and cyclist training in schools ensures children can safely walk or cycle to school. The Council's Sustainable Transport Team will cycle train up to 1,500 primary school children and 500 older children and adults this year – aiming for an increase of 20% on 2014.

The Sustainable Transport Team also works with partners to promote sustainable transport. This includes working with the Police to provide bike security marking. The Council has also embarked on a programme of installing secure cycle parking on social housing estates. Workplaces will also require more cycle parking over time as cycling rates increase.

Work is underway to improve the built environment to make it easier to walk and cycle around the Borough. To take two examples, new cycle lanes along Portsmouth Road will include landscaping between the road and riverside, and the Council is considering how to make the area outside Kingston Station a safer and more attractive place to walk and cycle. In March 2014, Kingston was named by the Mayor of London as one of just three London Boroughs to be awarded 'mini-Holland' programme status. This provides the Borough with access to more than £30 million of TfL funding to transform local cycling facilities (see chapter 2.10).

There is a local target to increase cycling rates to 10 - 15% by 2026 which would mean up to 19,000 residents cycling every day. To achieve these rates the investment in infrastructure noted above needs to be accompanied by promotional activities and cyclist training. The Council has successfully bid for funding for a three year active travel campaign which will be branded as 'Go'. This will engage with businesses and community groups to promote and actively support walking and cycling as transport options. There will be active travel road shows at community events and at local businesses. Practical help and activities such as bike loans, installation of cycle parking, health rides, walking clinics and personalised travel planning will support people to incorporate active travel into their daily routine.

The Council will be working to encourage people who are less likely to cycle to take to two wheels. Groups less likely to cycle include BME communities, women and older people. Programmes such as dedicated cycling courses for older people (for example including cycling as part of Fit as a Fiddle as a means of encouraging older people to become more active) and ethnic minority groups are planned, and links with the GP exercise referral programme are being explored with Public Health.

There will also be a strong focus on families cycling together to ensure that once trained to Bikeability level 2, primary school children can progress to the level 3 (the highest Bikeability level), with the aim of cycling to school when they make the transition to secondary school.

The Sustrans Active Travel project was launched in June 2014 in Malden Manor and Norbiton to encourage people to walk and cycle more. The project delivered a summer programme of activities including bike building, bike skills (including Learn to Ride and Bikeability training), bike polo, family rides, bike 'blinging', and stalls were held at the Cambridge Road and Sheephouse Way Fun Days (see case study).

Recommendations

1 **Increase the amount of Level 3 Bikeability Training in secondary schools to address the gap between younger children cycling and cycling in adulthood.**

2 **Continue to promote the uptake of cycling through public engagement, training and school participation programmes.**

3 **Increase the level of business engagement and use infrastructure improvements as a catalyst to increase the numbers of people regularly cycling to work.**

4 **Use specific interventions such as bike loans and personalised travel planning to motivate people to change their travel behaviour.**

5 **Develop promotional campaigns to initiate behavioural changes and highlight the benefits of active travel for the individual as well as the community.**

Case study – Sustrans Active Travel for Health

The Sustrans Active Travel for Health programme aims to improve the health and wellbeing of those living in disadvantaged areas by encouraging people to incorporate more walking and cycling into their everyday lives.

The programme works to enable people who are currently inactive to engage in the project and increase levels of physical activity through a range of fun walking and cycling initiatives. The project was launched in June 2014 as a one year pilot and focused on communities on the Cambridge Road Estate and in Malden Manor. These social housing estates were selected in light of the assessed needs in these areas.

Sustrans developed connections across the community, within the Council and with other community bodies. A high level of trust has been established with local schools, organisations like the Searchlight Youth Centre and Residents Associations. In addition, the project worked collaboratively with other community health programmes such as Learn English at Home (LEAH) and Fit as a Fiddle, so that participants in these programmes could access cycling and walk leader training.

As part of the project, Active Travel Champion volunteers have been recruited, trained and managed to ensure high quality service provision and programme sustainability. The Council's Sustainable Transport Team are working in partnership to deliver the programme and funding for a second year has been secured.

Activities have been well attended with an overall throughput of 927 attendees by April 2015 and key outcomes included:

- Increased walking and cycling: 875 registered or engaged individuals with at least 438 actively participating in walking or cycling
- Sustrans worked with twelve volunteers in Kingston and all were offered relevant training
- Successful partnership working with the Council's Sustainable Transport Team including the development of collaborative Bike Skills sessions, Family Rides, Walks and Dr Bike sessions, joint publicity and Sustrans Walk Leader training delivered to three Council cycling instructors
- Building strong relationships with and actively engaging in partnership initiatives through effective networking. Partners included Malden Manor Primary School, Richard Challoner School, Malden Manor Community Group, Malden Manor Resident's Association and the Kingston Residents Federation.

Feedback was collected at the end of the pilot phase. Participants were asked, "Has the project encouraged you to walk or cycle more?" Some responses are highlighted below:

"I now cycle every morning to get the newspaper and progressively make my journey longer 3-4 days a week. On Tuesday I cycled down by the river for 1 hour and 10 minutes. It's very pleasant this time of year. I didn't do this before Fit as a Fiddle. I'm using a loan bike until September but then taking it abroad where I'll keep it. I'll buy one then."

Geoff, Fit as a Fiddle participant

"I bought the bike a week after the ride. I'm riding from Chessington to Kingston. It's my regular commute. I'm enjoying it."

Lionel, Princes Trust trainee and Richmond Park ride participant

"The bench outside means I can sit outside and watch the children play. So it's a big plus for us. I've seen other people from other buildings sitting on it. I had never walked to the Six Acre Meadow before the bench unveiling and walk."

Kristina, Sheephouse Way Estate resident

"I already had a bike but the sessions helped me with my cycling skills. I had a bike for most of my life but now I'm more confident on the road. Big John (Council cycling instructor) was amazing. He taught me a lot. I really enjoyed it. It's definitely sunk in."

Jeanette, Fit as a Fiddle participant

2.10 Kingston mini-Holland programme

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Introduction

As part of the Mayor of London's Vision for Cycling[83] a budget of £913 million has been allocated over ten years to deliver a variety of major cycling initiatives in the Capital including three mini-Holland programmes, a network of Quietways, a Central London Grid and significant enhancements to the strategic Cycle Superhighway network.

Investment in cycling delivers impressive value for money; the Government's national (outside London) Cycling City Ambition Grant is expected to deliver £5 in benefits for every £1 spent, with 60% of benefits gained from increased physical fitness and 18% of benefits from network decongestion (with associated air quality benefits), with individual projects delivering cost benefits in the range 2:1 to 30:1[84].

A recently completed 10 year study of 10,000 commuters[85] found that there was a 'snowball effect' in which cyclists take up other forms of exercise, eat more healthily (48%), drink less alcohol (29%) and smoke less (20%). The study also found that though cycling felt challenging at first, it soon became an established part of life.

Investment in cycling will help to address inactivity in the population, leading to longer lives lived in good health, as well as reduced healthcare and social care costs that are due to the many health conditions linked to inactivity[86] that together cost the UK economy an estimated £8.2 billion per year[86].

Local picture

Kingston's mini-Holland programme represents an opportunity to transform the Borough and create a place where people choose to ride bikes more often as part of their daily routines.

All the indications show that investment in cycling will produce financial returns from savings which will be more than double the initial expenditure[87].

There is considerable scope to increase the level of cycling: Transport for London research[88] shows that only 8% of 'potentially cyclable' trips in Kingston are actually made by bike (see chapter 2.9 for more information on active travel in Kingston).

Local action

Kingston is one of three outer London Boroughs that form the Mayor's mini-Holland programme. The mini-Holland programme is designed to focus high spending on relatively small areas to transform the cycling environment. The idea is that, over time, these places will become every bit as cycle-friendly as their Dutch equivalent.

In Kingston the mini-Holland approach underpins the Borough's 'Go Cycle' programme, details of which can be found on the Council's website: **www.kingston.gov.uk**

The 'Go Cycle' programme will improve cycling facilities in four key areas of the Borough and create six new cycle routes.

Investment in cycling will help to address inactivity in the population, leading to longer lives lived in good health, as well as reduced healthcare and social care costs that are due to the many health conditions linked to inactivity[86].

The four key areas include:

- an off-road cycle track from New Malden to Raynes Park
- a new public plaza and cycle hub outside Kingston train station
- Wheatfield Way 'Greenway' in Kingston town centre
- a riverside 'boardway' for cyclists to bypass Kingston town centre

The six new safe, comfortable and convenient cycle routes include:

- Portsmouth Road
- Kingston Bridge / Kingston town centre connectivity
- Kingston Hill / Kingston Vale
- Kingston to Surbiton
- Cambridge Road / Kingston Road
- Ewell Road.

Analysis carried out for the Kingston mini-Holland business case[87] shows that there are 23,200 daily cycle trips within 3 km of Kingston town centre. By 2026 this is expected to reach 39,700 through population and employment growth, representing 7% of journeys. However, as a result of the mini-Holland programme, it is anticipated that there will be an additional 17,000 to 45,000 trips by bike per day by 2026.

A series of promotional and training activities will complement the main infrastructure programme. In addition to cycling benefits, the programme will improve public spaces which will encourage more walking.

Benefits realisation is a key component of the programme. The World Health Organisation's Health Economic Assessment Tool (HEAT) has been used to estimate the health benefits of the expected increase in cycling in financial terms. The HEAT calculation predicts that annual health benefits resulting from physical activity (based on reductions in 'all cause' mortality) to be worth between £4 million and £10 million per year by 2026[87]. The benefits of physical activity on people's health are discussed further in chapters 2.1 to 2.5.

The Council will work with Transport for London and undertake extensive surveys over the coming years to measure the actual changes in the amount of cycling that materialises as a direct result of the programme and how these affect local public health indicators.

Recommendations

1 **Continue to invest in designing and delivering a transformation in the environment for cycling in Kingston through the mini-Holland programme and other initiatives.**

2 **Ensure that 'benefits for all' are delivered as part and parcel of the mini-Holland programme to build support for a culture of cycling.**

Case study – Portsmouth Road

Today the Portsmouth Road corridor is a major arterial road connecting Kingston with Elmbridge. It is characterised by a simple carriageway with a centre line, busy motor-traffic, and relatively few cyclists or pedestrians. There is little about the road that would specifically encourage active travel on foot or bike, yet it features views across Kingston's most iconic asset – the River Thames.

As a result of feedback from residents and stakeholder groups that was overwhelmingly in support of a cycling project on this road, the project will deliver a cycle route that is direct, safe and comfortable, and complemented by public realm improvements. A two-way cycle track starting at Palace Road and running north to the town centre, eventually connecting to the potential riverside 'boardway', will enable people on bikes to enjoy the view of the river and feel much safer than they do today. South of Palace Road, cycle tracks separated by 'light segregation' elements will be provided on each side of the road.

Taken as a whole, the scheme will encourage more people to explore the riverside actively on foot and bike. New crossings will improve accessibility for all, and new ramps leading to the Queen's Promenade will open up the riverside public spaces, creating an attractive environment. The project will encourage people to cycle from the immediate hinterland and further afield, perhaps at first to try out the new infrastructure, and later to cycle more often and make routine use of it.

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3.0 Alcohol

Alcohol has been part of British culture for centuries and has a major influence on society. Drinking alcohol is associated with pleasure and enjoyable activities such as seeing friends or relaxation. Misusing alcohol can have a major impact on our health and wellbeing and is associated with other issues such as crime, anti-social behaviour and loss of productivity.

In the following chapters we look at how alcohol affects a person from before birth, how their childhood environment can affect their future development and how drinking habits can impact on people's health.

3.1 Alcohol in the pre-conception, pregnancy and postnatal periods

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Introduction

The Royal College of Obstetricians and Gynaecologists (RCOG) published updated patient information in February 2015 regarding alcohol in pregnancy[1]. They advise that, given the uncertainty regarding a safe level of alcohol during pregnancy, women should not drink at all during pregnancy if possible, particularly within the first trimester when there is an increased risk of miscarriage. Small amounts of alcohol (not more than one to two units once or twice a week) have not been shown to be harmful, but binge drinking during pregnancy may be harmful. This is consistent with the most recent NICE guidance on antenatal care, published in 2008[2].

Drinking alcohol whilst pregnant has been associated with miscarriage, stillbirth and premature labour[3]. Alcohol easily crosses the placenta and can seriously affect the baby's development, particularly that of the brain and spinal cord. It can also cause intrauterine growth retardation.

Excess alcohol consumption during pregnancy can lead to a range of health issues in the child known as foetal alcohol spectrum disorders, of which foetal alcohol syndrome is at the most severe end. Foetal alcohol syndrome is a complex, multi-factorial condition, where environmental and genetic factors are likely to play a part, as not all babies who have been exposed to heavy alcohol consumption in the womb will develop the condition.

At birth, babies with foetal alcohol syndrome may have ongoing poor growth and characteristic facial features including widely spaced small eyes and a thin upper lip. Long term features include cerebral palsy, mood, attention or behavioural problems and developmental delay. Learning disorders may manifest as problems with thought, speech or social skills. There may also be problems with the liver, kidneys and other organs, hearing and sight problems and epilepsy. These physical, cognitive and behavioural impairments can have huge long term implications for the individual and family[4]. Without early diagnosis and appropriate support, children with foetal alcohol syndrome may be susceptible to a number of issues in later life. They may misuse drugs and alcohol themselves, develop mental health problems and face difficulties within their school and work environments and in their relationships[3].

Alcohol misuse during pregnancy is a key public health issue due to the potential negative outcomes described above and the opportunity for primary prevention during the pre-conception and pregnancy periods, with foetal alcohol syndrome being completely preventable if alcohol is avoided during pregnancy.

There are no accurate figures for the incidence of foetal alcohol spectrum disorders in the UK. Accurate measurement of alcohol consumption is difficult and findings often unreliable. This may be attributed to the poor accuracy of self reporting of alcohol consumption due to the social stigma associated with heavy drinking during pregnancy, and the lack of a reliable data collection method. Most figures come from the U.S.A. where it is estimated that foetal alcohol syndrome occurs in 0.5 – 2 live births per 1,000 and foetal alcohol spectrum disorders occur at least three times as often as this[5].

Pregnant women drink less than their non-pregnant peers. Data collected in 2013 showed that pregnant women were three times more likely to be teetotal compared with other women (72% as opposed to 22%)[6]. Earlier statistics from the Infant Feeding Survey (IFS) collected in 2010[7] revealed that 40% of mothers in the UK drank alcohol during pregnancy in that year. This was a reduction from the 54% recorded in the previous survey conducted in 2005. Amongst mothers who drank alcohol prior to pregnancy, 49% gave up drinking completely during pregnancy, whilst 46% cut down the amount they drank. 86% of mothers who cut down or stopped drinking during pregnancy attributed this change in behaviour to concerns regarding the harmful effects of alcohol on the growing baby[7].

Seven in ten mothers who drank before pregnancy had received some form of information about drinking in pregnancy[8]. Variations in drinking were seen across different socio-economic, ethnic and age groups in the IFS. Mothers from managerial and professional occupations were the most likely to drink prior to pregnancy and during pregnancy. There were lower rates of drinking amongst mothers from routine and manual occupations, with the lowest rates in women who had never worked. Mothers from ethnic minority groups, particularly those from Asian backgrounds, were less likely to drink before and during pregnancy. There was an association between drinking during pregnancy and maternal age, with 28% of mothers under the age of 20 drinking during pregnancy compared with 52% of mothers aged 35 and over[8]. This may be an important consideration for Kingston given the high proportion of older mothers locally.

In the postnatal period, ongoing alcohol consumption is an important consideration as alcohol freely passes into breast milk and can cause altered taste of milk, altered infant sleep pattern and reduced infant feeding.

Local picture

The numbers of women identified by the Kingston Hospital Maternity Service as having significant, problematic alcohol use during pregnancy are small. This may not be fully reflective of the whole picture as the identification of women can be challenging.

The identification of women with problem alcohol use by maternity services can be made easier when information regarding previous alcohol history is provided on GP referrals as individuals can be unwilling to take the first step in discussing issues around alcohol. Information on alcohol use on the GP referral form assists the healthcare professionals in secondary care by providing an opening to directly discuss this issue. Women may also self refer directly to other local services including the Kingston Wellbeing Service (KWS) meaning that some women at high risk are not known to the maternity service. In some cases the quality of communication between the KWS and the maternity service could be improved. It is vital that concerns regarding alcohol intake are communicated so that there can be informed discussion and planning of antenatal and postnatal care for the woman, her child and the family allowing for reduction and minimisation of risk to all involved.

In 2014, out of all those who booked at Kingston Hospital (which would include the majority of Kingston residents accessing antenatal care), there were just ten women referred to the specialist Bridge Team (described overleaf) with a history of alcohol misuse. For five of the women this was previous alcohol misuse and for the other five it was current or very recent alcohol misuse. It is highly likely that the number of women misusing alcohol during pregnancy is higher, but as noted above the accuracy of figures relies heavily on women self reporting their alcohol intake and the sharing of information between local services.

Local experience has shown that in some cases, there is a misunderstanding regarding alcohol use in general. Women are not always aware of the unit measurements of alcohol and how this translates into their regular drinking patterns. During pregnancy this message can become more confusing and not all women feel that they have clarity regarding the current national guidance on the safety of alcohol during this time.

It is highly likely that the number of women misusing alcohol during pregnancy is higher, but the accuracy of figures relies heavily on women self reporting their alcohol intake and the sharing of information between local services.

Local action

Expectant mothers are asked about alcohol consumption, both at their initial GP consultation and again at their booking visit or first midwife appointment. If there is a history of alcohol misuse, women who have booked at Kingston Hospital are referred to the Bridge Team. This team consists of two full time midwives who cover safeguarding and perinatal mental health, a Support Midwife and a Maternity Support Worker[9].

Women with current alcohol misuse issues are automatically considered at high risk and offered an urgent appointment. Alcohol misuse within the last six to 24 months is considered medium risk unless there is an additional risk factor present such as domestic violence.

If an alcohol problem is suspected or identified at the booking visit, women should ideally be seen at 16 weeks gestation by the Safeguarding Midwife from the Bridge Team. During this consultation, appropriate individualised antenatal care is planned with the patient and their partner. This may range from no further appointments to a varying number of further consultations with the Bridge Team.
A woman with alcohol misuse would usually have consultant led antenatal care due to the higher risk of intrauterine growth retardation.

The Bridge Team also discusses liaison with other services and encourages referral where appropriate to the Kingston Wellbeing Service and/ or the Addiction Support and Care Agency (a local service that provides confidential, one-to-one counselling and advice in Kingston and Richmond)[10]. The Bridge Team will also make a referral to Children's Social Care in the majority of cases. It should be noted that the team are reliant on the information that women choose to share with them, unless women are already known to a service (and that service provides relevant information to the team) or if the GP shares information regarding previous or current alcohol use.

Recommendations

1. **Encourage all healthcare professionals working with women and their partners to enquire about alcohol intake in the antenatal period and ensure they are able to recognise cases where there may be high risk of alcohol misuse.**
2. **Should alcohol misuse be identified, ensure that treatment services are available and that professionals are aware of local referral pathways and services to which patients can be directed.**
3. **Work to engage with expectant fathers and involve them in all aspects of the care process.**
4. **Ensure planned support that continues into the postnatal period as this period can be very stressful for parents and there is a risk of relapse to former levels of alcohol misuse for those patients who may have achieved lower intake levels or abstinence.**
5. **Work to improve communication and sharing of information between healthcare professionals and services. This can help to ensure a common approach is taken to achieve common goals and that consistent advice is offered to women and their families.**
6. **Ensure an equitable approach is taken by healthcare professionals as pregnant women with problem alcohol use may be subject to social disapproval and judgemental attitudes. Discriminatory professional behaviour deters women from seeking help and so must be eliminated.**
7. **Work with professionals to ensure they encourage women at risk to engage with services.**

3.2 The impact of parental alcohol misuse on children

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Introduction

The Field Review highlighted that children's life chances are most heavily influenced by their development in the first five years of life[11]. Alcohol misuse can harm children's development directly, through exposure to alcohol in the womb and this is discussed in chapter 3.1. In young children cases of injury and death due to co-sleeping are often associated with parental alcohol misuse[12]. Alcohol can also impact on young children's health through its impact on parenting capacity[13].

Not all families affected by alcohol use will experience difficulties. However parental alcohol misuse can reduce the capacity for effective parenting by reducing their ability to provide a stable and supportive home and a safe, secure and nurturing family environment. This can adversely affect a child's wellbeing, development and safety. Parents may become inconsistent and unpredictable, emotionally unresponsive and less interactive, leading to disrupted households, a lack of routine, less frequent family activities and special events not being celebrated[14,15].

Research has indicated that the longer term consequences for children growing up in households where alcohol use is problematic is far reaching including (but not limited to) poor educational attainment, normalisation of alcohol misuse, emotional difficulties, neglect, abuse, taking on inappropriate caring responsibilities, family disharmony and violence[16].

In 2012, the Children's Commissioner for England published Silent Voices[17], a report specifically on the impact of parental or carer alcohol misuse on children, which recommended that far more attention is needed to this area.

Four key messages from this report are:

1 The misuse of alcohol by parents negatively affects the lives and harms the wellbeing of more children than does the misuse of illegal drugs.

2 Too often, parental alcohol misuse is not taken seriously enough, in spite of alcohol being addictive, easy to obtain, and legal.

3 The effects of parents' alcohol misuse on children may be hidden for years, whilst children try both to cope with the impact on them, and manage the consequences for their families.

4 Policies and strategies should take into account the impact on children who may be affected by a range of levels of parental alcohol consumption (not just by those who are dependent on alcohol).

It is estimated that 1.3 million children under 16 in England are affected by parents whose drinking is classified as either harmful or dependent[18] and just under 80,000 babies aged under one year live with a parent who is a problem drinker[19].

There is a strong stigma attached to alcohol misuse, which means that the issue can remain hidden, further exacerbating the problem. Parents and carers themselves require and deserve support and asking for help should be seen as a sign of responsibility rather than as a parenting failure.

It has to be noted that parental alcohol use is a common feature in Serious Case Reviews (SCRs) with 22% of SCRs undertaken across England from 2007 to 2009 mentioning parental alcohol misuse. Moreover SCRs frequently identify that drug and/ or alcohol misuse, mental health issues and domestic abuse are the three most common features and when these combine, the impact on children is deemed to be so damaging it has been called the "Toxic Trio"[20].

The impact of a parent or carer's problem drinking on children will vary from family to family, and children living with parental alcohol misuse will respond and cope differently. Experiencing alcohol misuse does not necessarily preclude loving and effective parenting[21]. There are protective factors that have been shown to encourage resilience. These include the presence of one stable (usually non-drinking) adult or a close bond with at least one adult carer (parent, sibling, grandparent) and a good support network beyond this.

Opportunities for intervention

Early intervention can be the most effective measure when helping parents deal with their alcohol misuse[22]. With the right support the harm to children can be significantly reduced. Pregnancy and infancy offer an important window of opportunity for intervention – help at this life stage is often well received by parents and can help to set the template for effective parenting and strong relationships[23].

Local picture

Table 1 below shows that half of Kingston adults receiving specialist alcohol treatment live with children, almost double the national average of 27%.

Table 1 Adults receiving alcohol treatment who are in contact with children, 2013 - 14.

Adults receiving alcohol treatment who are in contact with children 2013 - 14	Local % of all in treatment	National % of all in treatment
Living with children (own or other)	50%	27%
Parents not living with children	3%	27%
Not a parent/no child contact	45%	44%
Incomplete data	2%	2%

Source: National Drug Treatment Monitoring System[24].

Local action

There are a number of local services available to support families experiencing challenges around alcohol misuse:

Specialist Substance Misuse Worker and Breaking the Cycle

A Specialist Substance Misuse Worker has been employed within Achieving for Children (AfC), providing a combination of therapeutic, practical skills and interventions to enable individuals experiencing substance misuse issues to make positive choices for a better future for their children. This post is linked to the Breaking the Cycle (BtC) programme (developed by Addaction), which aims to reduce and ultimately stop intergenerational substance misuse[25]. Since the local BtC programme commenced in January 2012, over 200 families have been seen up to June 2015 and alcohol is the most common substance misused, accounting for 50% of all referrals.

The service is delivered in the family home using one-to-one sessions, joint working with local alcohol and drug services, peer support programmes, parenting support and domestic violence services in order to give maximum support. The Specialist Substance Misuse Worker is able to provide a continuity of care between the different services and help with a family's navigation between them.

Kingston Wellbeing Service

For children of alcohol misusing parents or carers, parental or carer engagement with treatment services is a protective factor. The Kingston Wellbeing Service (KWS) provides a range of evidenced based interventions to adults experiencing alcohol misuse issues.

Since the local BtC programme commenced in January 2012, over 200 families have been seen up to June 2015 and alcohol is the most common substance misused, accounting for 50% of all referrals.

Safeguarding children affected by parents, carers or other adults' substance misuse protocol

In response to the Munro Review[26] of child protection, the National Treatment Agency (now Public Health England) and the Department for Education published guidance on the development of local protocols between drug and alcohol treatment services and local safeguarding and family services. A local protocol regarding the safeguarding of children affected by parents, carers or other adults' substance misuse was developed in Kingston in 2011. Work is being undertaken to update this protocol which will link to the Local Safeguarding Children's Board (LSCB) 'See the Adult, See the Child Protocol', which has been developed by the Parental Mental Health group. This is because of research that strongly indicates that where children are being cared for by adults at risk, particularly those with domestic abuse, substance misuse or mental health problems, they are more likely to be at risk of being harmed within their families[27].

Recommendations

1. **Kingston's Public Health team and Kingston Wellbeing Service to work with Achieving for Children, Kingston Hospital's Safeguarding Midwife and Kingston's Local Safeguarding Children's Board (LSCB) to update the Safeguarding children affected by parents, carers or other adults' substance misuse protocol. The possibility of updating the protocol jointly with the Richmond Public Health Team and Richmond LSCB will also be explored.**

2. **Explore opportunities and resources to provide more Information and Brief Advice (IBA) to parents of young children in order to minimise the risk of alcohol related harm to children through Kingston's Alcohol Strategy Group.**

3.3 Alcohol and children and young people

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Introduction

Chapter 3.2 describes the impact of parental or carer alcohol issues on children and young people. The environment in which a child grows up has a major influence on a young person misusing alcohol, with those growing up with parents with alcohol dependence up to four times more likely to develop dependence themselves[28]. In 2005 it was found that nearly 2.5 million children live with one or more parents who misuse alcohol whilst 6% of adults report having grown up in such a family[29, 30].

Although harmful alcohol use is very uncommon before the age of ten, the prevalence of alcohol disorders increases steeply through adolescence. Children who drink alcohol before the age of 13 have a fourfold increase in risk of alcohol dependence in adulthood[31]. The drinking habits of young people are of great concern as excess alcohol consumption can affect brain development and also damage a range of other organs[32]. In addition to these effects, alcohol misuse in adolescents is associated with increased risky behaviours (including unprotected sex, antisocial behaviour and violence) and decreased family, social and educational functioning. Young people who drank on most days of the week were found to be more likely to smoke cigarettes and get involved in violence whilst their feelings towards school and education were more likely to be negative[33]. Drinking alcohol has been found to affect academic performance with children drinking daily achieving lower GCSE results (the methodology used took account of individual circumstances)[33].

British children are more likely to binge drink or get drunk compared to children in most other European countries[34]. A survey undertaken in 2012[35] found that in the UK 43% of all school students sampled (aged 11 - 15 years old) had drunk alcohol at least once in the previous year. 10% of all students had drunk alcohol within the past week with an average unit intake of 12.5 units (an increase from 10.4 in 2011)[35] .

Although harmful alcohol use is very uncommon before the age of ten, the prevalence of alcohol disorders increases steeply through adolescence.

Of those 11 - 15 year olds who drink alcohol, more girls than boys had drunk to harmful levels (76% and 59% respectively)[36]. Increasingly these young people are being seen in accident and emergency departments with a tenfold increase occurring nationally between 1990 – 2011[37].

Research undertaken in 2010 highlighted several trends around the national drinking habits of those in school years 9 to 12 (aged 14 to 17)[35]. Those of White ethnicity were most likely to have tried drinking alcohol, followed by those from Mixed and Black Caribbean ethnic backgrounds. Children were more likely to have tried alcohol at schools with a high percentage of White students irrespective of their own ethnic background. Girls from all-girl schools were more likely to have tried alcohol than their peers from mixed schools at age 16[35].

Research on why those underage start drinking has highlighted that drinking alcohol can perform several roles in social settings including assisting the processes of relaxing and bonding with peers and excusing inappropriate behaviour[38]. National data has shown that since 1999 between 11% and 20% of pupils in England have believed that it is "Ok to get drunk once a week". When asked why young people drank, responses included[36]:

- to be more sociable with friends
- to get a rush or a buzz
- to make them feel more confident.

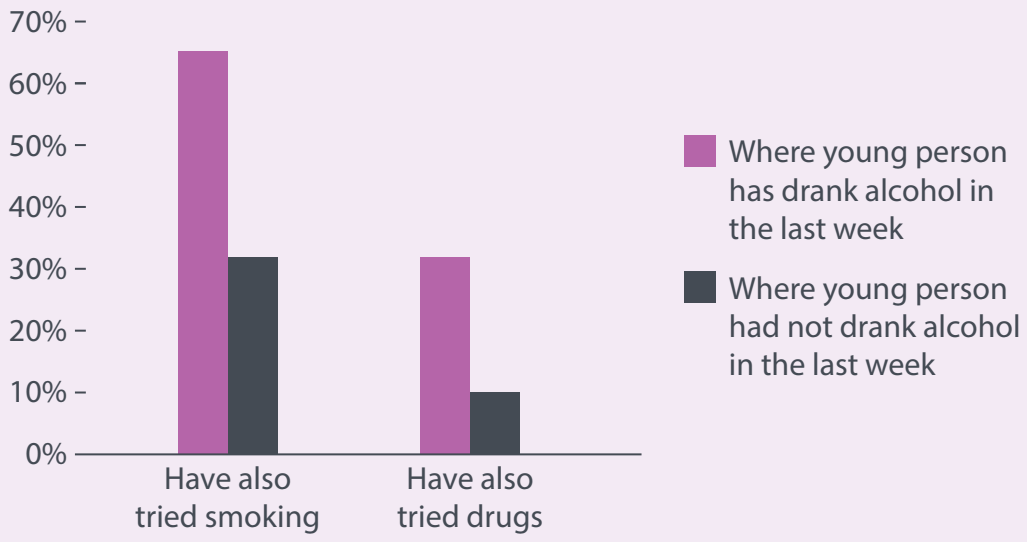
Local picture

Schools and Students Health Education Unit (SHEU) Young People's Health Behaviour survey 2013

The 2013 survey[39] was developed by the Schools and Students Health Education Unit (SHEU) in partnership with Public Health. A total of 3,982 pupils took part from eight secondary schools and the pupil referral unit. Of those students surveyed across Kingston 16% of pupils said that they had had an alcoholic drink during the previous week, which was higher than the national survey data from 2012 of 10%. This figure increases with age with 32% of year 10 pupils reporting that they had drunk alcohol compared with 10% of year 8 pupils.

The study also highlighted that those drinking alcohol were more likely to have undertaken risky behaviours (figure 1) with 65% of year 10 pupils who had drunk alcohol the previous week also having smoked compared with 32% of those who had not drunk alcohol in the past week. In addition 32% of year 10 pupils who drank alcohol the previous week said they had also used illegal drugs (as opposed to 10% of those who had not drunk alcohol).

Figure 1 Kingston Year 10 students substance use 2013.



Source: 2013 Kingston Young People's Health Behaviour Survey.

Ambulance call outs

Data from the London Ambulance Service for 2013 - 14 indicates that in the 15 to 19 age group there were a total of 161 alcohol related ambulance call outs, whilst there were seven calls for those aged ten to 14. Within the 15 to 19 age group twice as many girls had an alcohol related ambulance call out than boys, in contrast to all older age groups where there were more call outs for men than women[40].

Hospital admissions

The alcohol specific hospital admission rate for Kingston residents aged under 18 was 31.6 per 100,000 population for 2011 - 14. This was higher than the London average of 26.6 but lower than the England average of 40.1 although neither difference reaches statistical significance[41]. Kingston Hospital sends notifications of presentations where the primary problem is alcohol intoxication to the Young People's Substance Misuse Service for follow up.

Local action

Targeted Work

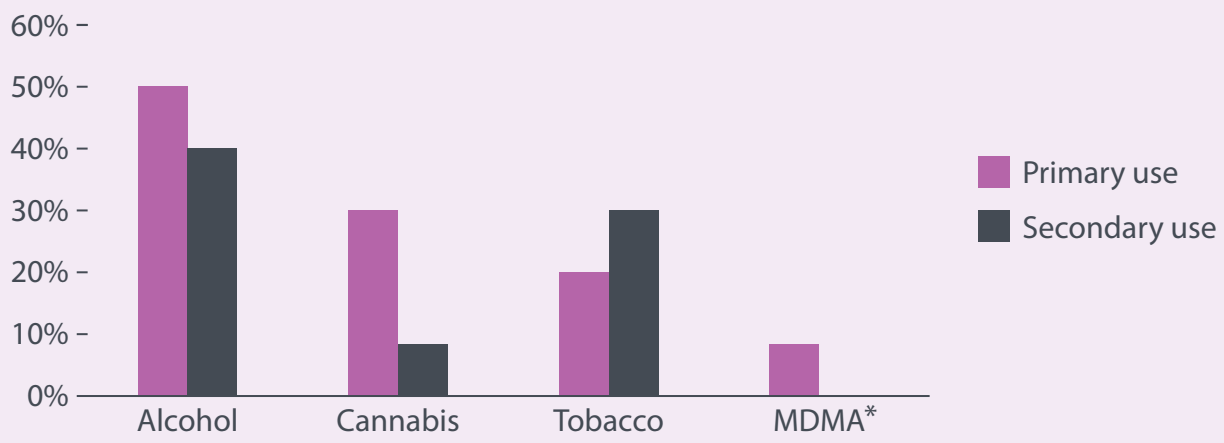
Young People's Health Link Workers (HLWs) work in secondary schools, the pupil referral unit and Kingston College. They provide early intervention and prevention support to improve health outcomes for adolescents in Kingston including targeted work around alcohol misuse. HLWs support the development and delivery of an effective Personal, Social, Health and Economic Education (PSHE) curriculum, which addresses the subject of alcohol misuse in the context of other risky behaviours.

To complement this offer a pilot was conducted by Achieving for Children (AfC) to provide additional support to young people in three schools around their substance use, which included alcohol and tobacco use. This included group work, one-to-one assessment and structured sessions and where required, referral into the tier 3 treatment service (see overleaf). One finding from the pilot was that 50% of the young people identified alcohol as their primary substance of choice (figure 2 overleaf).

"When you're younger it [drinking] can bring out a side of you. It can make you or break you. It's like some people – you can't talk to them without it – it's a connection. It's a drug."

Young person, male, 17.

Figure 2 Young people and their self reported substence use.



Source: Achieving for Children pilot, January - April 2015.

*MDMA has become widely known as Ecstacy although other names are also used.

Specialist services

In Kingston, there is a joint treatment service with the London Borough of Richmond which provides specialist interventions for young people under 18 who have alcohol (or drug) related issues, including a specialist clinical nurse post working with young people with complex mental health and substance misuse needs.

Between April 2011 and March 2013, 53 young people who used this service identified alcohol as the primary substance they used whilst another 54 used alcohol as part of their substance use but identified a different drug as being more problematic for them. Alongside one-to-one treatment the service provides general alcohol awareness sessions to large cohorts of pupils and students via PSHE (usually facilitated via the HLWs), as well as targeted education based workshops[40].

AfC are currently funding a pilot to provide additional targeted substance misuse support for young people who are Looked After Children (LAC) and those young people who are entitled to receive services as a care leaver. Work is also done in partnership with the Youth Offending Service to ensure that all young people who have substance related need or risks identified are assessed and an appropriate intervention is provided.

Parental substance misuse

In order to try and break the cycle of inter-generational substance misuse, AfC deliver the "Breaking the Cycle" (BtC) programme (see chapter 3.2).

Recommendations

1. **Increase awareness of young people's alcohol treatment services and relevant referral pathways.**

2. **Ensure training is provided to all staff in the Borough working with young people to improve early identification of alcohol misuse and increase referrals to both targeted and specialist services.**

3. **Work with schools, support and early help teams in AfC, and with voluntary and community sector (VCS) organisations working with young people to ensure safe and sensible drinking messages are embedded in PSHE curriculum at school, in youth settings and where children and young people access information and advice.**

4. **Ensure delivery of consistent and age appropriate messages highlighting the correlation between alcohol use and engagement in risky behaviour.**

5. **Deliver targeted alcohol prevention work with identified groups of vulnerable young people including those engaging in risky behaviours and those at risk of child sexual exploitation.**

6. **Ensure procedures are in place, reviewed and evaluated for smooth and effective transition for young people moving into local adult alcohol services (see chapter 3.4) where required.**

3.4 Alcohol and adults (18 - 65 years)

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Introduction

Drinking alcohol is widely socially accepted and associated with relaxation and pleasure, and most people drink alcohol without experiencing harmful effects. Although alcohol has been part of our culture for centuries and many people drink responsibly and sensibly, its misuse has become a serious public health problem in the UK[42].

Alcohol misuse (drinking more than the recommended limits of alcohol consumption) is a complex issue. It poses a threat to the health and wellbeing of the drinker, and is also associated with problems such as crime, anti-social behaviour and loss of productivity. It also impacts on the drinker's family and friends[43]. The estimated cost of harm to society from alcohol misuse is £21 billion per year[44].

More than 9 million people in England drink more alcohol than the recommended daily limits. Furthermore it is estimated that 1.6 million people may have some degree of alcohol dependence and around 250,000 are believed to be moderately or severely dependent and may benefit from intensive alcohol treatment[44].

Reducing the harm caused by alcohol is a key public health priority and the Government's Alcohol Strategy highlights the ambitions to reduce the number of adults drinking above the NHS guidelines, reduce binge drinking and reduce the number of people drinking at levels that damage their health[45].

NHS guidelines suggest that men should not regularly exceed 3 - 4 units per day and women should not regularly exceed 2 - 3 units per day[46] (figure 1 displays one unit in terms of alcoholic drinks).

Figure 1 Explanation of what one unit of alcohol looks like[47].

Trends in drinking behaviour

Data available from the Opinions and Lifestyle Survey[48] published by the Office for National Statistics (ONS) highlights that in Great Britain between 2005 and 2012:

- The proportion of men and women drinking alcohol in the week before being interviewed fell from 72% to 64% and 57% to 52% respectively.
- Over the seven years there was a fall from 22% to 14% in the proportion of men who were frequent drinkers (drank alcohol on at least five days in the week before interview), whilst for women the proportion fell from 13% to 9%.

In addition:

- Of those respondents who had drunk alcohol in the last week in 2012, 55% of men and 53% of women drank more than the recommended daily amounts and 31% of men and 24% of women drank more than twice the recommended amount.
- In 2012 adults aged 45 - 64 were more likely to report drinking on the last week than any other age group.
- Those aged 16 - 24 were most likely to have drunk very heavily at least once during the week in 2012, with similar proportions for men (26%) and women (28%)[48].

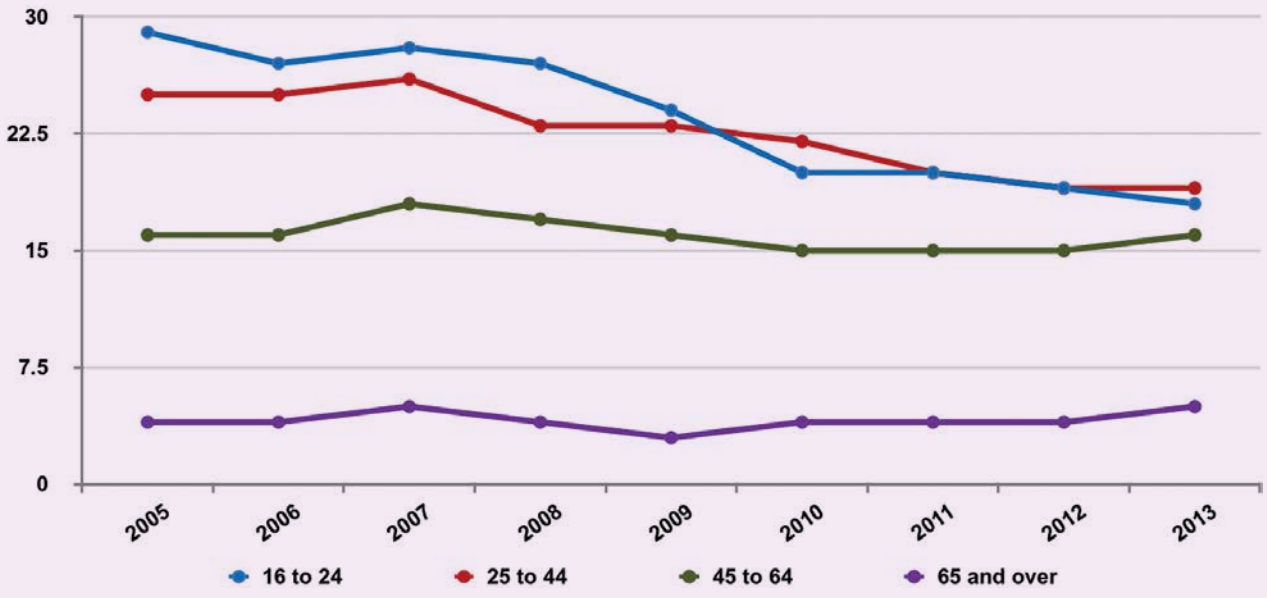
In 2013 more than one in five adults (21%) said they did not drink alcohol at all and this is a slight increase from 19% in 2005. Furthermore almost a third of adults in London (32%) said that they did not drink alcohol at all and this was considerably higher than any other region[49].

Binge drinking

The Government's Alcohol Strategy defines binge drinking as men who self report drinking more than eight units of alcohol on their heaviest drinking day in the week before interview and women who self report exceeding six units. Binge drinking can increase the risk of accidents or injuries through slower reaction times and loss of coordination. Longer term, binge drinking is associated with increased risk of strokes, some cancers, liver disease and high blood pressure. Binge drinking amongst adults has decreased from 18% in 2005 to 15% in 2013.

Young adults were mainly responsible for the decrease in binge drinking, with the proportion falling by more than a third since 2005, from 29% to 18%[50] (figure 2).

Figure 2 Binge drinking among adults, by age, Great Britain, 2005 - 13.



Source: Opinions and Lifestyle Survey, General Lifestyle Survey and General Household Survey; Office for National Statistics.

Harmful drinking and alcohol dependence

Harmful drinking is defined as a pattern of alcohol consumption causing health problems directly related to alcohol. This could include psychological problems such as depression, alcohol related accidents or physical illness such as acute pancreatitis. In the longer term, harmful drinking can cause high blood pressure, cirrhosis, heart disease and some types of cancer.

It is estimated that 24% (33% of men and 16% of women) of the population in England consume alcohol in a way that is potentially or actually harmful to their health or wellbeing[51].

Alcohol dependence is characterised by craving, tolerance, a preoccupation with alcohol and continued drinking in spite of harmful consequences (for example, liver disease or depression caused by drinking). Alcohol dependence can also be associated with increased criminal activity and domestic violence, and an increased rate of significant mental and physical health problems. It is estimated that around 6% (9% of men and 4% of women) of the population in England show signs of alcohol dependence. This means that drinking alcohol becomes an important, and sometimes the most important, factor in their life. Alcohol dependence occurs more often in White men and women than in people from minority ethnic groups[51]. 14% of people who were alcohol dependent were also receiving treatment for a mental or emotional problem[52].

Street drinking

Persistent street drinking is a dangerous and often self destructive lifestyle with individuals often experiencing multiple issues including homelessness, physical and mental health problems and drug use. Health issues can be exacerbated by poor diet and periods of rough sleeping. Alongside this, many street drinkers are dealing with personal trauma and loss, self harm and the risk of violence each day. Their lifestyle and multiple needs mean that services often struggle to know how best to support them.

Health conditions and alcohol

Alcohol is a causal factor in more than 60 medical conditions including mouth, throat, stomach, liver and breast cancers, high blood pressure, cirrhosis of the liver and depression[53]. It is also related to accidents, injuries and poisoning[54]. In 2012 - 13, there were estimated to be over one million hospital admissions related to alcohol consumption where an alcohol related disease, injury or condition was the primary reason for hospital admission or a secondary diagnosis[51]. The admissions cover all ages and of these admissions:

- 65% (651,010) were due to conditions which were categorised as partly attributable chronic conditions
- 6% (60,830) were for conditions categorized as partly attributable acute conditions
- 20% (198,600) were for mental and behavioural disorders due to alcohol
- men were more likely to be admitted to hospital with alcohol related diseases, injuries and conditions than women, with 65% of the overall admissions being male patients (however amongst those aged under 16, young women accounted for 55% of all admissions)
- over the year there were 1,890 alcohol related hospital admissions per 100,000 people in England
- the rate of alcohol related admissions varied regionally from an estimated 2,500 per 100,000 population in North East region to 1,500 admissions per 100,000 population in South East region[51]. The London rate was 1,970 per 100,000 people.

Alongside better known medical conditions, heavy alcohol use over a long period of time is associated with Wernicke-Korsakoff's syndrome which is caused by a lack of thiamine (vitamin B1). The syndrome is diagnosed in about one in eight people with alcoholism and it mostly affects men aged 45 - 65. There are two separate but related stages. Wernicke's encephalopathy is the first stage which if untreated often develops into Korsakoff's syndrome. People with Wernicke's encephalopathy can have evidence of undernutrition, involuntary eye movements, poor balance, confusion and mild memory loss. Korsakoff's syndrome sufferers have severe short term memory loss and may also develop personality changes.

Excessive drinking is also a risk factor for certain forms of dementia. Many people with long term alcohol misuse do not develop symptoms of Wernicke-Korsakoff's syndrome; instead they develop 'alcohol related dementia'. Researchers are increasingly grouping this diagnosis and Wernicke-Korsakoff's syndrome under the broader term 'alcohol related brain damage'[55] (see chapter 3.5).

Deaths related to alcohol consumption

Alcohol misuse can be directly related to deaths from certain types of disease, such as cirrhosis of the liver and may be associated with other causes of death, such as strokes. In 2012, there were 6,490 alcohol related deaths in England. This was a 19% increase from 2001 (5,476).

Alcoholic liver disease was responsible for the majority of alcohol related deaths and accounted for 63% (4,425) of the total in 2012. The most common decade for deaths from alcoholic liver disease was amongst those in their 50th to 59th year[56]. Liver disease is the only major cause of mortality and morbidity which is on the increase in England whilst it is decreasing in other European countries[57].

Local picture

Approximately 85% of the adult population in Kingston drink alcohol. Of this group it is estimated that about 67% consume alcohol within lower risk limits. The remaining 33% drink at levels that may result in alcohol related harm[58]. This equates to approximately 35,800 people aged 18 - 64. Of these, 27,000 consume levels of alcohol that place them in the increasing risk category for alcohol related harm by consuming between 15 - 35 units (women) and 22 - 50 units (men) of alcohol per week. A further 8,800 residents fall in to the higher risk category for alcohol related harm by regularly drinking more than 35 units (women) and more than 50 units (men) each week.

In 2011, compared to the London average, more women and men in Kingston drink alcohol with only 24.8% stating that they do not drink compared with 28.3% across London as a whole[59]. It is not certain why men and women in Kingston report drinking more, but it may be related to the social class makeup of the area. It has been consistently found that people in managerial and professional jobs drink more than their counterparts in routine or unskilled jobs[60] and in Kingston a high proportion of the population are employed in managerial or professional jobs.

Hospital admissions

Table 1 shows the age standardised all age hospital admission rate for Kingston residents from April 2013 to March 2014 with alcohol related conditions, compared with London and England rates. The Kingston rate is below both the regional and national rates, and the difference in both cases is statistically significant.

Compared to the London average, more women and men in Kingston drink alcohol with only 24.8% stating that they do not drink compared with 28.3% across London as a whole[59].

Table 1 Hospital admission rate (age standardised per 100,000 population - all ages) for residents with alcohol related conditions for 2013 - 14 in Kingston, London and England.

Kingston	London	England
447	541	645

Source: Public Health Outcomes Framework, 2015.

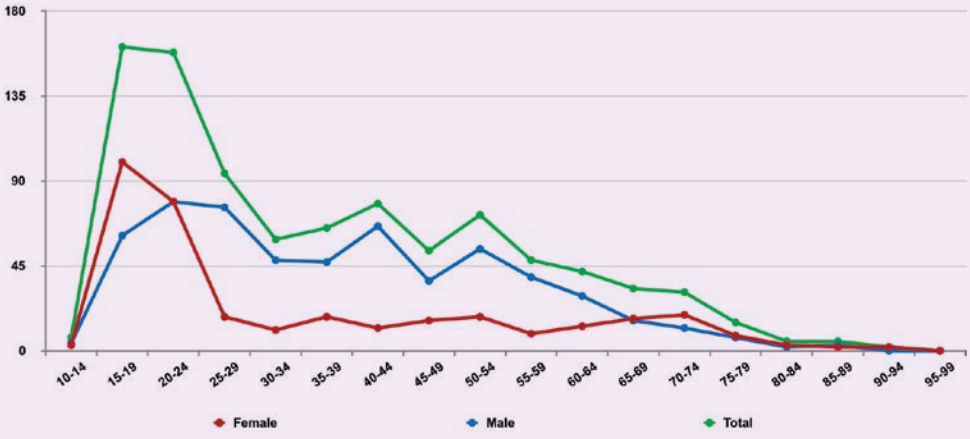
Note: See http://www.phoutcomes.info/search/alcohol%20related%20conditions#page/0/gid/1/pat/6/par/E12000007/ati/101/are/E09000021 for details on definitions used for alcohol related conditions.

London Ambulance Service (LAS)

Between April 2013 and March 2014, there were 984 alcohol related ambulance call outs to Kingston, an increase from the 835 recorded in 2012 - 13. Overall, nearly twice as many males (61%) were treated as females (36%), however in the 15 - 19 age group nearly twice as many girls had an alcohol related ambulance call out in comparison to boys of the same age (figure 3).

In terms of call outs by age, the highest numbers of call outs were for those aged 15 - 19 (161 call outs) and 20 - 24 (158 call outs), followed by 25 - 29 year olds (94 call outs)[61].

Figure 3 London Ambulance Service alcohol related ambulance call outs by age and gender, Kingston, 2013 - 14[61].



Note: There were 56 alcohol related call outs where either the age, gender or both is unknown which are not shown in this chart.

Alcohol treatment

Table 2 below illustrates the referral routes to Kingston's alcohol treatment service (for adults aged 18 years and over) in 2013 - 14 together with the national data.

Table 2 Referral source for referrals to the alcohol treatment service.

	Local		England	
Referral Source	**Number**	**%**	**Number**	**%**
Self referral	106	42%	34,289	42%
Criminal Justice	31	12%	8,035	10%
GP	58	23%	13,914	17%
Hospital/ A & E	7	3%	6,052	7%
Social Services	8	3%	1,511	2%
All other referral sources	42	17%	16,675	21%
Missing	0	0%	412	1%
Total	**252**	**100%**	**80,888**	**100%**

Source: JSNA Support Pack 2015 - 16[62].

Kingston has a higher proportion of GP referrals (23%) compared with the national profile (17%) whilst referrals from hospital/ A & E (3%) are below the national percentage (7%). This indicates that local GPs are proactively identifying and referring people with alcohol problems to specialist services. The Alcohol Advisory Group at Kingston Hospital is currently working with the Kingston Wellbeing Service (KWS) to explore opportunities for joint working and to formalise pathways for those individuals who want to access alcohol treatment services as well as using an Assertive Community Case Management approach for individuals who are not ready or require more support to engage with specialist alcohol services.

Waiting times to access alcohol treatment services

Alcohol users need prompt access to services that can help them to recover from their dependence. Keeping waiting times low plays a vital role in supporting recovery from alcohol dependence in the community. In Kingston 99% of people waited less than three weeks to access treatment in 2013 - 14, compared to 93% nationally[62].

Levels of complexity at start of treatment

In Kingston, during 2013 - 14, 76% of people accessing alcohol treatment services reported drinking over 200 units per month at the start of treatment compared to 71% nationally. In addition, 6% reported also using opiates and/ or crack cocaine compared to 4% nationally and 12% reported additional cannabis use compared to 10% nationally. In the same year, 8% were homeless compared to 4% nationally. All of these figures indicate a higher degree of complexity amongst Kingston residents accessing treatment compared with the national profile.

Age and gender

Table 3 below illustrates the age and gender of all adults in alcohol treatment in 2013 - 14. The Kingston age profile has a slightly higher percentage of 18 - 29 year olds compared with the national figures.

Parents in treatment

Accessing treatment services can be a protective factor for children living with parents who are experiencing problems with alcohol. In 2013 - 14 50% of the people accessing alcohol treatment in Kingston were living with children compared to 27% nationally. This indicates that the local treatment services are accessible to parents.

In Kingston, during 2013 - 14, 76% of people accessing alcohol treatment services reported drinking over 200 units per month at the start of treatment compared to 71% nationally.

Table 3 Age and gender of adults in alcohol treatment.

Age	Local		England	
	Male %	Female %	Male %	Female %
18 - 29	18	17	14	14
30 - 39	22	28	25	24
40 - 49	33	28	33	33
50 - 59	20	18	20	21
60 and over	8	9	8	9

Source: NDTMS Public Health England[63].

Length of treatment

NICE suggests that people drinking at harmful levels and those with mild alcohol dependence might benefit from a package of care lasting three months while those with moderate dependence might need a six month package and those with severe dependence or those with complex needs may need a package of care lasting up to a year[64]. Retaining clients for their full course of treatment is important in order to increase the levels of successful treatment completion and reduce rates of early treatment drop out.

Nationally the typical treatment period was around six months, although 10% remained in treatment for more than one year. Table 4 below compares local and national data. The pattern locally reflects what would be expected given the complexity data discussed above.

Inpatient and residential treatment

Structured alcohol treatment mostly takes place in the community, near to people's families and social networks, however a stay in residential rehabilitation services may be required for the most serious cases. In Kingston 4% of the treatment population accessed residential rehabilitation services in 2013 - 14 and this is the same as the national percentage.

A challenge for some people who need to access residential treatment is the need for stable and suitable accommodation when they leave treatment and this forms a key element of recovery planning. With the limited accommodation for vulnerable people in Kingston this presents the Borough with a challenge on how best to support those people who wish to change their lives and make a new start free of addiction.

Table 4 Treatment period data from 2013 - 14.

Length of time in treatment	Local		England	
	Number	% of all exits	Number	% of all exits
Under 3 months	75	43%	27,928	38%
3 - 6 months	45	26%	22,118	30%
6 - 12 months	47	27%	16,721	23%
Over 1 year	6	3%	7,272	10%
Average (median) days in treatment	116		121	

Source: NDTMS Public Health England[63].

Street drinking

Problems associated with street drinking are experienced in Kingston, as in other London boroughs. In order to understand how best to address the issue in Kingston it is important to understand why drinkers are gathering in specific areas. Lifeline Research were commissioned through a Norbiton Neighbourhood Grant to carry out a study exploring the needs and experiences of street drinkers in the Borough. The field work began by making the links with community members and key stakeholders and over 12 weeks the team carried out in situ interviews with street drinkers and those associated with them. The research identified a series of interconnected events that led to specific sites in the Borough becoming drinking hotspots:

- the closure of a low threshold harm reduction drug and alcohol service in Kingston town centre, that was reportedly tolerant of drinking, meant the group had to find alternative places to drink
- the introduction of a Designated Public Place Order (DPPO) in Kingston town centre in June 2014 in response to complaints about large groups of street drinkers gathering in the town centre, which led to a displacement of drinkers to locations outside of the town centre
- a local church initially welcoming the community of street drinkers and as a result the gardens becoming a place to congregate
- use of certain locations as a drop off/ pick up point for casual labour
- local shops selling single, high strength lager cans and cheap white cider.

Sociability and companionship were central themes that emerged from the research findings and for the vast majority of street drinkers these aspects were deemed as hugely positive in their lives. It was clear that there was connectivity between members that was rooted in commonality of experience and that shared attitudes and beliefs provided a sense of belonging and peer support. For many, being part of the street drinking community provided a sense of safety, both from reported verbal and physical abuse from the public and also from any tensions within the group.

The research also highlighted that the street drinking community was far from a homogenous group and that within the community there were a number of different groups requiring different service responses.

For many, being part of the street drinking community provided a sense of safety, both from reported verbal and physical abuse from the public and also from any tensions within the group.

Local action

To address the harm, costs and burden on public services from alcohol misuse, Kingston has assessed the local needs and community assets available, and aims to provide effective prevention, health improvement interventions for those at risk, treatment and recovery services for dependent drinkers and action to reduce binge drinking and its associated harm.

Population approaches

Population approaches include those that aim to control the availability of alcohol through pricing, licensing controls and preventing underage sales (see chapter 3.6). A variety of national and local public health campaigns promoting safe and sensible drinking have been supported across Kingston, publicised via bus stops, public venues, community events and statutory organisation homepages.

Individual approaches

NICE[65] and the former Health Development Agency (HDA)[66] have identified the following evidence based interventions as effective in reducing alcohol related harm:

- Screening - validated questionnaires such as the Alcohol Use Disorder Identification Test (AUDIT) are able to accurately identify people who may have an alcohol use disorder.
- Brief Interventions - a short one-to-one session (typically lasting no longer than 15 minutes) that focuses on drinking behaviour can be effective in reducing alcohol consumption in adults.
- Self help - web based alcohol programmes have been shown to be effective at reducing average alcohol consumption by up to 21.9 units for males (from 68.2 to 46.3 units) and 10.9 units for females (from 44.0 to 33.1 units) at the three month follow up stage[67].
- Bar staff training - comprehensive training for bar staff, coupled with appropriate management support can be effective in reducing alcohol consumption levels[68].

Identification and Brief Advice (IBA)

In Kingston, the identification of increasing and higher risk drinkers is conducted across a number of health settings such as GP practices, Kingston Hospital and a limited number of pharmacies. Two clinically validated screening tools are used, the Alcohol Use Disorder Identification Test (AUDIT) and the Paddington Alcohol Test (PAT). The AUDIT tool includes 10 questions and is an expanded version of the AUDIT- Consumption (AUDIT-C) which is a clinically validated short screen (three item questionnaire) that can be used to identify people who are 'higher risk' drinkers or have a current alcohol use disorder. The PAT test is a quick tool used in A & E departments to identify those with alcohol related problems.

Eight community pharmacies delivered an alcohol IBA service in Kingston during 2013 - 14. During this period the pharmacies completed over 2,000 screens using an AUDIT-C accredited tool and the age profile is presented in table 5 overleaf. The highest number of people screened were those aged 20 to 29.

Table 5 Audit-C alcohol questionnaires by age group, 2013 - 14.

Age (years)	Number of Audit-C alcohol assessment questionnaires completed 2013 - 14
Under 20	251
20 - 29	669
30 - 39	165
40 - 49	339
50 - 59	209
60 - 69	222
70 - 79	105
80 - 89	64
90 - 99	*

* = suppressed due to low numbers.

In 2013 - 14, 12,176 people over 16 registering with a GP in Kingston were screened for alcohol misuse. Out of this number a total of 1,167 individuals were identified as possible increasing/ higher risk drinkers. Nationally, it is estimated that for every 1,000 people on a GP practice list, 260 could be classified as 'increasing to higher risk drinkers'[69].

During 2012 - 13 an audit of 75 sets of hospital notes was conducted within Kingston Hospital, which showed that 93% of the adult patients in the audit had been screened for their alcohol consumption through the use of the AUDIT-C tool. The results of the screening, whether any onward referral was appropriate, whether referrals were made and if patients accessed services were not part of the audit. Given that alcohol is a contributory factor to a large proportion of hospital admissions (both elective and non-elective), and comprises up to 35% of all emergency department costs[70], consideration could be given to undertaking future audits including what actions were taken as a result of the alcohol screening.

Self help

Kingston's e-drink-check is the local website which helps residents to find out more about their own drinking. The website lets users assess their drinking and what impact it could be having on their health, as well as showing where they can get advice and professional help. It is anonymous, confidential and free. Between the launch of e-drink-check in November 2013 and September 2015, 578 people have used the website.

Bar staff training

Best Bar None (BBN) is a national award scheme supported by the Home Office and is aimed at promoting responsible management and operation of alcohol licensed premises. As at 2015 it has been running in Kingston for ten years and is open to all pubs, bars and nightclubs in Kingston town centre. Individual premises are responsible for training their staff appropriately and as part of the BBN scheme, an audit is carried out on staff training. Fourteen premises were accredited in 2015 and the best pub was The Druids Head and the best club was Pryzm.

Pre loading research

Public Health in partnership with Kingstonfirst, are funding a pre loading research project. For budgetary reasons some people pre load with alcohol at home or in public places prior to entering town centre licensed premises. This behaviour raises issues for policing, town centre management and residents' quality of life. The research project has been completed and initial findings were presented in October 2015 at Kingston's Alcohol Strategy Group.

Alcohol treatment services in Kingston

The KWS provides a range of alcohol treatment interventions within a stepped care model for people aged 18 years and over. The service comprises:

- a single point of contact, assessment and support to access a range of treatment and recovery interventions
- evidence based treatment interventions including one to one key working, group work programmes, medically assisted detoxification and prescribing to prevent relapse
- assessments for inpatient treatment and residential rehabilitation
- a range of wellbeing activities provided at the service hub to promote recovery including peer mentoring opportunities and practical and social activities to support individuals to sustain their recovery and make a positive contribution to their community.

The service hub is at Surbiton Health Centre and a range of targeted interventions are also provided in criminal justice, community and primary care settings.

Table 6 shows the number of people accessing specialist alcohol treatment services in Kingston by age group and gender during 2013 - 14.

Table 6 Number of people accessing treatment services by age group, 2013 - 14.

	Male	Female
Age Group	**Number accessing service**	**Number accessing service**
18 - 24	16	10
25 - 29	19	*
30 - 34	20	7
35 - 39	23	15
40 - 44	35	18
45 - 49	27	9
50 - 54	24	6
55 - 59	19	7
60 - 64	11	*
65 and over	*	*

* = value suppressed due to small numbers.

Source: Q4 2013 - 14 Purple Report NATMS website.

Shared care

Shared care is designed to cover the enhanced aspects of clinical care for patients that are beyond the remit of essential GP services. The enhanced aspect of clinical care for alcohol users included in this service is alcohol detoxification with clinical support. This provides a structured community based alcohol withdrawal regimen to patients who are mild to moderately dependent on alcohol.

Counselling services

The Addiction Support and Care Agency (ASCA) is an established charity which provides confidential one-to-one counselling and advice in Kingston for people experiencing issues with alcohol, as well as for affected carers and family members. Carers can also access a support group as well as counselling. ACSA also host Alcoholics Anonymous (AA) meetings in their Kingston service.

In 2014 - 15 ASCA provided counselling and assessment to 77 Kingston residents who had alcohol as a primary problem and also provided advice and telephone support to 58 people. During this time they also provided carers counselling or group support to 29 residents and telephone support to another 46.

Mutual aid

Mutual aid groups are a source of structure and continuing support for people seeking recovery from dependence, and for those directly or indirectly affected, such as partners, close friends, children and other family members.

In Kingston, there are a number of 12 step fellowship meetings (a set of guiding principles outlining a course of action for recovery from addiction, compulsion, or other behavioural problems), and these include AA as well as Self Management and Recovery Training (SMART) mutual aid groups for individuals experiencing issues with alcohol.

There are also interventions available to support family members, children and friends affected by alcohol misuse. These groups include Families Anonymous (FA) and the Kingston Carers Network (KCN). A Young Carers service is also available in Kingston and can support children and young people who are affected by a parent's alcohol misuse.

Peer support

Peer support has long been recognised as a valuable resource for people leaving treatment in order to prevent a relapse. This is a critical time for those wanting to remain abstinent or to achieve a level of stability. KWS provides a peer mentoring service and a range of peer led activities at Surbiton Health Centre.

Kingston Recovery Initiative Social Enterprise (RISE) offers regular social activities in the community and aims to create a positive social network within which community members can gain support and celebrate their recovery. RISE has developed strong links with specialist agencies in the community and encourages and supports community members to access these resources.

Street drinkers

The community research mentioned above highlighted that there should be no enforcement activity without the offer of support and that punitive enforcement approaches are not appropriate for the most vulnerable for example those with cognitive impairment. It was recommended that a multi agency team should be established to implement the recommendations and take the agenda forward with an emphasis on the positive options available alongside an acceptance that change will not happen overnight. Kingston Public Health has funded a pilot Assertive Community Case Management team, employed by KWS, to work with partner agencies and engage with the street drinking community to provide tailored packages of care. A multi agency strategy and action plan will be developed with key agencies to ensure activity is coordinated across the Borough.

Recommendations

1. **Work with stakeholders to develop an information and communication strategy which supports messages to promote safe and sensible drinking, knowledge about 'units', and signpost where to go for help.**
2. **Work with partners to further develop and deliver brief intervention training programmes so that screening and brief interventions can be offered in a wider range of settings.**
3. **Review the findings from the pre loading pilot and agree further action if required.**
4. **Develop a multi agency strategy and action plan to coordinate the activity to address street drinking across the Borough and ensure the recommendations from the community research are implemented.**
5. **Encourage the undertaking of audits of clinical care at Kingston Hospital which focus on whether people identified as having alcohol issues are appropriately counselled and referred.**

3.5 Alcohol in older age (65 years and over)

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Introduction

Research suggests that alcohol consumption generally declines with age and the proportion of non-drinkers increases as people get older[71]. However, there is evidence that today's population of older people may be relatively heavier drinkers than previous generations and also more likely to drink alone[71]. Due to longer life expectancy and demographic changes there has been an increase in the numbers of older people misusing alcohol in recent years and this is projected to continue in the future.

The sudden disruption in lifestyle caused by retirement and bereavement – which can both lead to decreased social activity – is thought to be a major contributory factor among older people who develop a drinking problem, as are isolation and loneliness. Some justify the regular consumption of particular beverages (such as brandy) on the grounds that they have medicinal properties, but this may instead help to foster a dependence on alcohol[71].

Researchers have identified three types of problematic drinkers in those aged 65 years and older[72]:

- early-onset drinkers (survivors) are those who have a continuing problem with alcohol which developed in earlier life (because of the health risk connected to heavy drinking and dependence on alcohol, the lifespan of an early onset drinker may be shortened by an average of ten to 15 years)
- late-onset drinkers (reactors) begin problematic drinking later in life, often in response to either traumatic life events such as the death of a loved one or retirement or chronic issues including loneliness, pain or insomnia
- intermittent (binge drinkers) use alcohol occasionally and sometimes drink to excess which may cause them problems.

Tolerance to alcohol is significantly lowered in older people. When compared with working age adults the same amount of alcohol can have a greater impact in older people and a given amount of alcohol will also depress the brain function to a greater extent, impairing coordination and memory, and raising the likelihood of incontinence, hypothermia, injury by accident and self neglect[72]. In light of this the Royal College of Psychiatrists have advised that over 65s should not drink more than 1.5 units of alcohol a day[73].

As highlighted in chapter 3.4, drinking more alcohol than the safe limit can lead to a range of physical health problems including high blood pressure, depression, stroke, liver disease, neurological, gastrointestinal and cardiovascular conditions, some cancers and can also affect bone health. It is also directly related to accidents and falls[74]. Alcohol misuse in older people is linked to or exacerbates mental health problems such as memory loss, dementia and depression[75]. Alcohol misuse can also lead to Wernicke-Korsakoff's syndrome, a disorder associated with memory loss (please see chapter 3.4).

Alcohol and medicines

Many older people take medicines on a daily basis which can put them at risk of complications due to mixing medications with alcohol. Given that many types of prescribed medication taken in conjunction with alcohol can cause adverse side effects, older people are usually advised against drinking alcohol when taking medication.

What do older people drink?

Office for National Statistics (ONS)[76] figures for Great Britain show that in 2009, older men were most likely to drink normal strength beers, lagers, ciders and wine. Older women were most likely to drink wine.

Older people and hospital admissions

An Alcohol Concern briefing[77] notes that there has been an 150% rise in hospital admissions for people aged 60 - 74 with alcohol related mental health problems between 2002 - 12, which is a higher rise than that experienced by the 15 - 59 age group (94%). The briefing also found a 140% increase during this decade in the number of over 60s being admitted to hospital with Wernicke's encephalopathy or Korsakoff's syndrome.

The Royal College of Physicians estimated that up to 60% of older people who are admitted to hospital because of confusion, repeated falls at home, recurrent chest infections and heart failure may have unrecognised alcohol problems[78].

What treatment options can be offered?

Brief interventions (see chapter 3.4), family interventions, motivational counselling, cognitive behaviour therapy (CBT) and group support have been successfully used to treat alcohol problems in older people[75]. Late onset and intermittent drinkers have a higher chance of managing their alcohol problem with appropriate treatment.

Preventive approaches can be used with older people so that they do not start problematic drinking. These may include bereavement counselling, enhancing coping skills in carers, opportunities to socialise and a wider education on what constitutes safe drinking in older age.

Local picture

The recent Kingston Lifestyle survey[79] provides age specific local information on alcohol consumption. This was completed by 267 people aged over 65. The survey found that 19.4% of people aged 65 - 74 drank alcohol every day and this increased to 23.3% amongst those aged over 75 (table 1). When asked how many units a day they drank on drinking days, 39.6% of those who responded aged 65 - 74 said that they drank three units or more, but this reduced to 25.6% amongst those aged 75 or over (table 2).

Table 1 Responses to: 'How often do you have an alcoholic drink?' by age.

How often do you drink alcohol	65 - 74	75 and over
Never	17.9%	23.3%
Less often than once a month	9.7%	9.0%
Once a month	8.2%	6.0%
2 - 3 times per month	3.7%	7.5%
Once a week	9.0%	11.3%
2 - 3 times per week	21.6%	11.3%
4 - 6 times per week	10.4%	8.3%
Every day	19.4%	23.3%

Source: Kingston Upon Thames annual Lifestyle survey (adults aged 18 and over), April 2015.

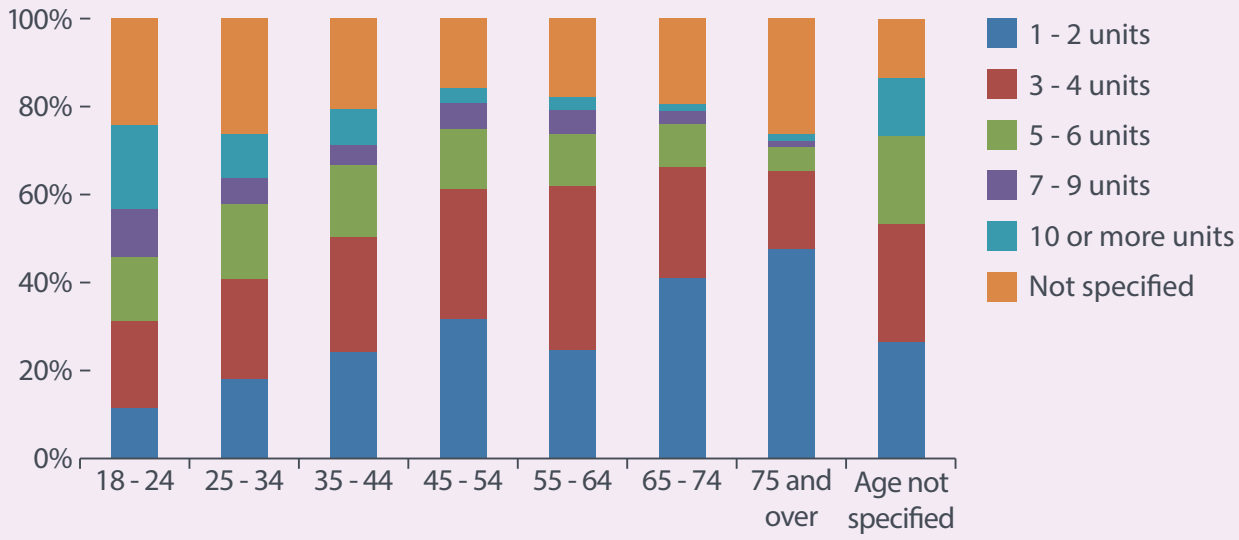
Table 2 Responses to: 'On the day when you are drinking, how many units of alcohol would you typically consume?' by age.

How many units do you drink	65 - 74	75 and over
1 - 2 units	41.0%	48.1%
3 - 4 units	25.4%	17.3%
5 - 6 units	9.7%	5.3%
7 - 9 units	3.0%	1.5%
10 or more	1.5%	1.5%
Not specified	19.4%	26.3%

Source: Kingston Upon Thames annual Lifestyle survey (adults aged 18 and over), April 2015.

When compared to the overall trend of alcohol drinking in Kingston, there is a significantly greater percentage of those aged over 65 drinking everyday compared to the percentage for all ages (8.8%). Although drinking on average on more days, older individuals are more likely to be drinking in low volumes when compared to individuals in younger age groups (figure 1). It is of interest that although (as noted above) nationally the percentage of non-drinkers increases with age, in Kingston this percentage is lower amongst 65 - 74 year olds (17.9%) than the total population (19.4%), although this is reversed amongst people aged 75 and over as 23.3% do not drink any alcohol.

Figure 1 On the day when you are drinking, how many units of alcohol would you typically consume by age.



Source: Kingston Upon Thames annual Lifestyle survey (adults aged 18 years and over), April 2015.

It is of interest that although as noted above nationally the percentage of non-drinkers increases with age, in Kingston this percentage is lower amongst 65 - 74 year olds (17.9%) than the total population (19.4%), although this is reversed amongst people aged 75 and over as 23.3% do not drink any alcohol.

Local action

Identification and Brief Advice (IBA)

In 2013 - 14 eight community pharmacies delivered an alcohol IBA service in Kingston (see chapter 3.4). During this period the pharmacies completed over 2,000 screens using the AUDIT-C accredited tool and nearly 400 of those screened were over 60 years of age.

In 2014, Public Health delivered alcohol IBA training to Kingston Staywell, Sheltered Housing and Kingston Hospital Physiotherapists in order to equip them with the knowledge and confidence to deliver alcohol IBA to older people.

e-drink-check

As discussed in chapter 3.4, e-drink-check.kingston.gov.uk is an anonymous, confidential and free website to help residents assess their drinking. Since the launch of the website in November 2013, 578 people have completed the full health screen and 3.8% were over the age of 65.

Treatment services

The Kingston Wellbeing Service offers a range of alcohol treatments. They work with individuals at any stage of their problem and provide a single point of access to assessment and treatment (see chapter 3.4). Despite being offered to all adult age groups there are very few older people accessing these services.

Addiction Support and Care Agency (ASCA) is an established local charity which provides confidential one-to-one counselling and advice in Kingston for people experiencing issues with alcohol, as well as for affected carers and family members (see chapter 3.4 and the case study for this chapter).

In 2015, Adfam (an Alcohol, Drugs and Families charity) started a monthly support group for older people living in London affected by someone else's drug, alcohol or medication use. Kingston residents are signposted to this service however current uptake is limited.

Recommendations

1. **Identify the alcohol related needs of older people in Kingston in order to explore opportunities in relation to reducing alcohol related harm and develop priorities for future action.**

2. **Explore opportunities to increase Identification and Brief Advice (IBA) provision for older people and to raise awareness of the issue of alcohol use in older people amongst professionals, in line with the alcohol strategy.**

3. **Raise awareness amongst professionals and the public of alcohol treatment services available for older people requiring specialist alcohol interventions.**

Case study – A retired client at ASCA 'Pauline'*

Pauline had always felt safe and secure in her marriage to Peter. They had been married 38 years and had lived overseas for much of that time given Peter's job in mine engineering. Their three children had grown and flown the nest and the couple had settled into an active retired life in South West London.

Approaching 70 Peter died of a sudden heart attack and although supported by her children Pauline found herself lonely and unhappy. Alcohol which had always been a part of her social life became increasingly important as both a tranquilliser and a crutch to lean on. She started to drink more and to go out less, she was becoming increasingly isolated.

Increasingly concerned, Stella*, one of Pauline's daughters started to look for help for her mother. She phoned ASCA and after a long talk with the Surbiton Manager decided that the service might suit her mother. Although reluctant at first Pauline contacted the service and attended an assessment. Her questions were answered clearly and sympathetically and she decided to opt for a course of open ended one-to-one therapy.

The therapy helped Pauline to both stop drinking and to understand the reasons she was doing what she was doing. She learnt about the root of her problem, her dependence on her husband and the gap it left when he died. Armed with this knowledge she was encouraged to explore her feelings, hopes and fears and, in time, to learn to cope with life on her own.

Pauline has learnt to live without her husband and without alcohol. She is now doing new things in her life. She has learnt to use public transport, plays bridge and even went on holiday to Florida with three friends last summer.

Therapy at ASCA has helped Pauline become the individual she is today, free of alcohol and living a busy independent life.

The therapy helped Pauline to both stop drinking and to understand the reasons she was doing what she was doing. She learnt about the root of her problem, her dependence on her husband and the gap it left when he died.

* Pseudonyms used to protect client's anonymity.

3.6 Alcohol enforcement

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Introduction

The Council's Trading Standards team enforce a number of areas of law concerning alcohol. These include the Licensing Act 2003[80] where Trading Standards (the "weights and measures authority") has a duty to enforce the provision in the Act concerning the sale of alcohol to anyone under the age of 18. This, at its simplest, is the legal basis for Trading Standards activities.

Both the licensee and the sales assistant may be liable to prosecution if an illegal sale is made. On all licensed premises it is an offence to do any of the following:

- sell alcohol to an individual aged under 18
- allow the sale of alcohol to an individual aged under 18
- for an individual aged under 18 to buy or attempt to buy alcohol
- for anyone to buy or attempt to buy alcohol for an individual aged under 18 – except where: the individual is at least 16 AND the alcohol is beer, porter or cider AND its purchase or supply is for consumption with a table meal on relevant premises AND the individual is accompanied at the meal by an individual aged 18 or over
- for any person who works in a licensed premises (paid or unpaid) to deliver alcohol to a person under 18 for consumption off the premises
- allow anyone to deliver alcohol to a person under 18 for consumption off the premises.

If alcohol is sold to anyone under 18, the maximum fine on conviction is £5,000 and the provider can lose their license.

The Trading Standards Institute have reported an increase in fake or illegally produced alcohol being sold in the UK. This is produced in unlicensed distilleries or in people's homes. It is illegal to distil and sell alcohol to the public in the UK without a licence from HM Revenue and Customs (HMRC)[81]. From 2005 to 2011 HMRC seized nearly 15 million litres of illegally produced alcohol .

Fake or illegal alcohol can contain dangerous chemicals[82]. Properly produced and certified alcoholic drinks are made with ethanol – an alcohol that is safe to drink in moderation. Fake alcoholic drinks can be produced using other cheaper types of alcohol which can have serious adverse health effects. Commonly used substitutes for ethanol include chemicals used in cleaning fluids, nail polish remover and automobile screen wash, as well as methanol and isopropanol which are used in antifreeze. These other types of alcohol can produce similar effects to ethanol but they are very dangerous to drink[82].

Local picture

The Council's corporate aims include making communities safer and to improve the overall health of the population. Regionally, minimising and monitoring under age sales are a London Trading Standards Association (LoTSA) priority. Trading Standards therefore undertake a range of enforcement activities around the sale of alcohol and other related issues.

Local action

Proof of age card

In 2014 - 15 the Council's Trading Standards and Public Health teams jointly launched a pilot initiative to promote a new, safe, and reliable proof of age card. The aim was to help businesses have a simple and secure way of verifying a young person's age when selling an age restricted product. It allows young people to have a document of no other intrinsic value than simply to prove their age, as an alternative to having to carry around a driving licence or passport, which if lost are expensive to replace and could be used by criminals to facilitate identity fraud.

The proof of age card chosen was one that had already been set up elsewhere and was Proof of Age Standards Scheme (PASS) accredited. The card was branded as a Proof of Age London (PAL) card, although it can be used throughout the UK as ID. It shows the person's name, age, and date of birth. The security features are the common PASS design and the PASS logo hologram.

The PAL card was offered free to all Year 13 pupils at all secondary schools in the Borough. Nine out of ten schools took up the offer and 569 PAL cards have been issued. The cards are released by the schools to pupils as they turn 18. As most shops operate a Challenge 25 policy (asking for proof of age to anyone that looks under 25 when selling an age restricted product), the cards should have a useful lifespan of at least seven years.

The card was launched at Kingston PubWatch in March 2015 and a mailshot was sent out to over 100 licensed premises in the Borough.
Many of the licensed premises within Kingston town centre are displaying the promotional posters and stocking leaflets for the scheme.
In addition pub and club door staff are wearing badges to promote the scheme.

Test purchasing

Test purchasing is divided into intelligence gathering and intelligence lead. For intelligence gathering, Challenge 25 test purchasing is undertaken using a purchaser aged 18 years old and therefore does not give rise to a criminal offence if alcohol is sold. The aim is to see if the shop is following good practice, which may also be a licence condition, by asking the 18 year old for ID. During 2014 - 15, 28% of retailers sold alcohol without asking for ID. The sample was quite small (32), so extrapolating conclusions from the data with a high degree of confidence is difficult although the percentage is lower than the two previous years (see table 1 below).

Table 1 Challenge 25 test purchasing.

Year	Number of test purchases	Number of sales	Number of sale refusals	Failure rate (%)
2012 - 13	17	11	6	**65%**
2013 - 14	46	41	5	**89%**
2014 - 15	32	9	23	**28%**

If the shop fails the Challenge 25 test purchase then they will be invited to attend a training session organised by Trading Standards. Currently, this would be followed by another Challenge 25 test purchase, which if failed would lead to an intelligence lead formal test purchase using a minor. However from 2015 - 16, a Challenge 25 failure will automatically lead to a formal test purchase, although training will still be offered.

During 2014 - 15 there were ten formal intelligence lead test purchases of alcohol carried out using a minor. Two business premises sold to them. Both sellers were issued with a Fixed Penalty Notice. One of the premises was issued with a Simple Caution and agreed, in lieu of a premises licence review, to vary its licence conditions to include Challenge 25. The other business was taken to a premises licence review hearing by the licensing committee where a seven day suspension was imposed along with the addition of several conditions to the licence. The failure rate over time is shown in table 2.

Table 2 Formal Intelligence Lead Test Purchasing in Kingston.

Alcohol	Number of test purchases	Number of sales	Number of sale refusals	Failure rate (%)
2012 - 13	22	1	21	**5%**
2013 - 14	25	1	24	**4%**
2014 - 15	10	2	8	**20%**

Licence applications

In its role as a "Responsible Authority", Trading Standards reviews premises licence applications and will where appropriate make representations (which are similar to making an objection to a licence application). On most occasions, businesses agree licence conditions recommended by Trading Standards, so averting the need to make representations. In 2014 - 15 a representation had to be made on one occasion.

Recommendations

1. **Involve partner agencies in considering how a problem solving approach could more effectively tackle the issue of enforcing the age restriction law on the sale of alcohol.**
2. **Prioritise the embedding of the new Proof of Age London (PAL) card.**
3. **Consider the routine collection and systematic sharing of underage sales data across Local Authorities to identify good practice and benchmark local data.**

3.7 Kingston town centre

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Introduction

Over the last 20 years town centres have been transformed by the expansion of the night time economy. Bars and pubs, restaurants, theatres, cinemas, and night clubs form an important part of the economy as well as providing key services for local residents, visitors and workers. However some aspects of night time entertainment and socialising, especially those associated with alcohol, can have negative impacts for the wider community, economy and environment. Some people may feel excluded from their town centre at night, particularly at the weekend and this can often lead to tensions between groups of people going out at night to enjoy themselves and the disturbance or nuisance problems they can cause for others.

The Office for National Statistics reported that in 2013 - 14, 20% of all violent incidents took place in or around a pub or club[83]. The problems associated with the night time economy can also put a strain on essential public services, including the ambulance services and Accident and Emergency (A & E) departments[84].

National schemes such as Best Bar None, Purple Flag, Pubwatch and Business Improvement Districts have shown that a thriving and growing night time economy can operate when excessive drinking is tackled consistently and robustly by local businesses, the police and the local authority working together. The Police Reform and Social Responsibility Act also provide helpful tools to address alcohol related harm, such as early morning alcohol restriction orders.

Local picture

Kingston is one of the safest London boroughs[85] and the local vision is that everyone who lives in, visits or works within the Borough should both be safe and feel safe.

Kingston town centre is a major source of night time entertainment and has one of the biggest night time economies in London[84].

The Safer Kingston Partnership (which brings together representatives from the Metropolitan Police, Kingston Clinical Commissioning Group, London Fire Brigade, London Probation Trust, Community Rehabilitation Company for London and Kingston Council and also includes the voluntary sector and business communities) has worked together with the local community to reduce alcohol misuse and associated crime and disorder in the town centre.

Kingston was one of the first places to be awarded a Purple Flag in 2010 which is an accredited scheme that recognises excellence in the management of town and city centres at night. To achieve Purple Flag status towns and cities must be welcoming to everyone, offer safe ways for visitors to travel home, provide a good mix of venues and be appealing after dark.

A Business Improvement District (BID) called Kingstonfirst has been set up in Kingston town centre, which ensures that local businesses including pubs and clubs pay a levy that is used to fund projects to enhance the appearance of the area, as well as promoting events to increase footfall.

The night time economy has expanded from a focus on late night clubs and drinking establishments to a much more diverse offer. This now includes the Rose Theatre, introduction of night markets and an increased choice of restaurants.

There are 95 venues in the Kingston BID area that are regularly open, at some point, between 8pm and 5am on Friday and/ or Saturday. This information is based on a combination of internet searching, information from Kingstonfirst and Kingston Council Licensing, and an 'on the ground' survey. Family restaurants comprise by far the largest single category of venue making up 40% of the total, illustrating Kingston's continued popularity as a destination for dining out.

The night time economy in Kingston has expanded from a focus on late night clubs and drinking establishments to a much more diverse offer.

Local action

Planning and licensing policies, enforcement activities, late night transport provision, street cleaning, policing, and the provision of emergency health services all contribute to achieving a balance between those going out at night and others who want a good night's sleep or to walk through a clean town centre first thing in the morning[84].

A responsive partnership approach is crucial to creating a better environment for people going out at night and to enhance everyone's enjoyment of the night time 'offer' in Kingston. Much of this work is carried out under the five core standards of the Purple Flag initiative:

1. **Wellbeing:** successful destinations should be safe and welcoming. All sectors have a part to play in delivering high standards of customer care and in Kingston initiatives include:
   - **Street Pastors:** this scheme is run by trained volunteers from local churches caring for town centre users on key nights between 10pm and 4am. They work locally with the Police and the Council to offer practical help and assistance to vulnerable people and can also assist in calming volatile situations. They also collect empty bottles ensuring they are on the street for as little time as possible.
   - **Best Bar None:** this is a national award scheme aimed at promoting responsible management and operation of alcohol licensed premises (see chapter 3.4).
   - **Pubwatch:** this is designed to make Kingston a safer place for everyone at night. There are over 30 Pubwatch members in Kingston town centre, including the Police, licensed premises, Kingstonfirst and the Street Pastors.
   - **Behave or Be Banned (BOBB) Red Card scheme:** Pubwatch lead on this scheme which excludes individuals who commit crime or anti-social behaviour from attending Pubwatch venues.
   - **Glassware management within premises:** glasses and bottles can be used as weapons and can result in accidental injuries so all late night venues use polycarbonate glasses and bottles.
   - **Alcohol Recovery Centre/ Safe and Sound:** please see case study on page 230.
2. **Movement:** getting home safely after an evening out is crucial as well as the ability to easily move around the centre on foot.
   - **Taxis:** these can act as a flashpoint for people who have consumed alcohol which can lead to violent incidents. Measures to address this include Taxi Marshalls who manage queues and assist customers as well as taxi ranks and associated booking kiosks (which assist in quick dispersal from the town centre). There are three kiosks, owned by the BID and which are located near the three largest night clubs. These manage over 20,000 journeys per year. The kiosks have a radio as part of the town centre radio link scheme to ensure effective communications to services such as the Police.

- **Queue management and barrier controls:** the Police and nightclub operators continue to work together to upgrade the existing barrier and clearance plan. This has included some licenses being changed to include extra conditions to reflect this.
- **Scan Net (ID Scan) system:** this scans ID from customers entering venues and is installed in seven night time venues.
- **Littoralis:** this is an internet based crime information scheme on which licensees can access information on individuals who have been excluded from night time venues.

3. **Appeal:** successful destinations should offer a vibrant choice of leisure and entertainment for a diversity of ages, lifestyles and cultures including families and older people. Kingston has the Rose Theatre, 11 new late night opening restaurants, live music and a new space called 'Kingston Riverside Edge' which offers space for two pop-up restaurants that change every six months.
4. **Place:** successful areas are alive during the day, as well as in the evening and this is very much the case locally given Kingston's large retail centre.
5. **Policy envelope:** after-hours policy crosses many professional and budgetary boundaries and the challenge is to bring clarity and focus to a complex area. A strategic approach is needed and in Kingston the following are in place:
   - **Safer Kingston Partnership (SKP) Plan 2014 - 17:** this plan ensures that the partnership is focused on the behaviours which cause most harm to local communities and provides a framework for the delivery of services to address those behaviours. Within the overall SKP plan is a Town Centre Action Plan.
   - **Kingston's Alcohol Strategy 2014 - 16:** this has been approved and an Alcohol Strategy Action Plan was produced in May 2015, detailing the activities that will be implemented to meet key objectives.
   - **RBK Statement of Licensing Policy 2014 - 19:** This sets out the arrangements the Licensing Authority will normally apply and consider in carrying out its licensing functions under the Licensing Act.
   - **Police Licensing Strategy 2015 - 16:** this strategy aims to provide a proportionate and robust response to all issues of licensing to ensure public safety and security.

Recommendations

1. **Implement the 'Good Night Out' campaign against harassment in key venues in the town centre.**
2. **Explore the use of the 'Cardiff Model' protocol where anonymised data regarding violence is shared by the local hospital with relevant partners.**
3. **Continue to work with partner agencies to maintain Purple Flag accreditation.**

Case study – Safe and Sound Initiative and the Alcohol Recovery Centre

These two initiatives aimed to:

- provide a safe haven in the town centre for vulnerable, distressed or overwhelmed people to wait and rest (Safe and Sound)
- reduce pressure on the local A & E department (Alcohol Recovery Centre).

The combined initiative ran on Fridays and Saturdays in December 2014 for a total of ten nights.

Based in the Everyday Church Kingston, Safe and Sound was an informal space run by volunteers drawn principally from Everyday Church who looked after vulnerable people as well as their friends and relatives. The London Ambulance Service (LAS) ran the adjacent Alcohol Recovery Centre (ARC) which provided a ward like environment where clinicians could observe apparently intoxicated patients.

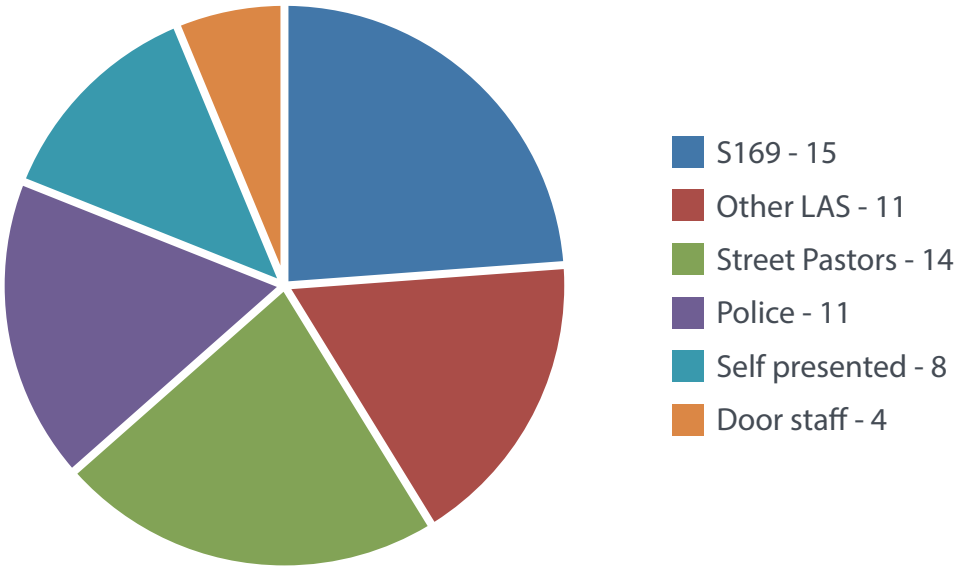
The schemes were well supported by a number of partner agencies:

- Valiant Security who provided a door security person for each of the ten nights at no cost
- The Samaritans who provided two volunteers for several of the nights
- Kingston Street Pastors who brought and referred people to the facility
- Public Health and Kingstonfirst who provided planning advice and press support and also provided a town centre radio set for use by the LAS
- Sainsbury's (Eden Walk) also set aside bread and cakes for users of the initiative, which was appreciated by many of the visitors and volunteers.

ARC staff were linked in with the town centre radio and also had a mobile phone number that was distributed to Police and Street Pastors to call them direct if they were with a patient fitting the Kingston ARC admission criteria.

Figure 1 details how patients arrived at the ARC. It should be noted that approximately 45 ambulance calls were probably prevented as a result of other agencies having direct access to the ARC. In addition most of the 63 people seen would otherwise have been taken to the A & E department. When nursing staff in A & E were contacted, they reported that the impact the ARC had made on their department was very positive.

Figure 1 How patients arrived at the ARC.



Note: S169 refers to the ambulance team that was dedicated to the ARC project.

3.8 Alcohol and crime

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Introduction

Alcohol is associated with a wide range of criminal and anti-social behaviours. It is estimated that across England in 2010 - 11 alcohol related crime costs £11 billion per year[86] and the Government's Alcohol Strategy primarily focuses on the importance of preventing and reducing the impact of alcohol related crime and disorder by tackling some of the root causes of the increase in alcohol consumption[86].

Alcohol related crime varies widely from low level activity such as drunkenness and public order offences, to more serious offences such as violent crime, domestic abuse or sexual violence. Analyses of key data sources have highlighted that:

- Victims perceived the offender(s) to be under the influence of alcohol in 53% of violent incidents measured by the 2013 - 14 British Crime Survey of England and Wales (CSEW). This equates to an estimated 704,000 incidents per year[87].
- 64% of violent incidents between strangers were perceived to be alcohol related[88].
- 20% of all violent incidents took place in or around a pub or club and this rose to 30% for 'stranger violence' incidents. 67% of violent offences occur in the evening or at night[87].
- 70% of violent incidents which took place in a public space were alcohol related compared with 40% of incidents in the home and 43% of incidents in and around the workplace[87].
- Injuries were typically more severe in incidents of alcohol related violence compared with other violent incidents. Victims were more likely to have received cuts (15%, compared with 9% of victims in non alcohol related incidents) or to have suffered concussion or loss of consciousness (5%, compared with 1% of victims in non alcohol related incidents)[87].
- Alcohol consumption is a contributing factor in sexual violence. It is estimated that 19,000 alcohol related sexual assaults occur each year in England and Wales[89]. Many people committing sexual assaults have consumed alcohol prior to an incident[90] (including 58% of men imprisoned for rape[91]) and in some cases are alcohol dependent[90]. Furthermore, many victims of sexual assault have been drinking prior to the event and research suggests that, in nightlife settings, perpetrators specifically target intoxicated young women due to their vulnerable state[92].

- Alcohol is estimated to be a factor in a third of all incidents of domestic violence, with many perpetrators having consumed alcohol prior to the assault[93]. Victims of domestic violence may also use alcohol as a coping mechanism[93].
- There were 9,939 casualties from drink driving accidents in the UK in 2012, including 230 deaths – accounting for 13% of all road fatalities in 2012[94].
- In 2008 - 09, 19% of prisoners surveyed reported having an alcohol problem when they entered prison[86, 93] and the percentage was higher in young adults (30%) and women (29%). The report highlighted that it was likely that the figures underestimated the scale of the problem, as many people with alcohol problems will fail to recognise or acknowledge them.
- Anti-social behaviour impacts on local communities and can affect people's quality of life. Nearly a quarter (24%) of adults in England and Wales reported people being drunk or rowdy in public places as 'a fairly big problem' in their area[95]. Reports of alcohol related anti-social behaviour often relate to domestic disputes, disturbances linked to the night time economy and street drinking.

Crime and anti-social behaviour associated with alcohol places a significant burden across a range of public services, businesses, local people and communities. There is no 'one size fits all' approach to reducing alcohol related crime and disorder. The underlying cause and nature of the problem will vary from area to area and collaborative working and a good understanding of the local issues are key to tackling local issues effectively. The most effective approaches seem to be multi-component, guided by evidence on the needs and demands in a local area, and include some form of community involvement[96].

Local picture

Kingston town centre is a major source of night time entertainment and has one of the biggest night time economies in London (see chapter 3.7). There are a large range of restaurants, pubs and clubs that play an important role in the town centre's night time economy, attracting thousands of visitors to the town every week. This brings with it a range of challenges that local partners need to address.

The link between alcohol and crime is complex, as although large proportions of offenders report drinking prior to offending, and victims often perceive offenders to be under the influence of alcohol, most people who consume alcohol do not go on to commit crime. However, some individuals will come into contact with the criminal justice system as a direct consequence of the alcohol related crime they commit. Some will serve community sentences and others will go to prison. In either case alcohol treatment for offenders should be widely available in the local community and in the prison estate. In Kingston this includes:

- **Identification and assessment of offenders:** specialist drug and alcohol workers are employed by the Kingston Wellbeing Service (KWS) and focus on identifying individuals with drug and alcohol problems who are in contact with criminal justice agencies and supporting them to access appropriate services. Specialist interventions are available in criminal justice settings and include brief interventions and harm reduction advice as well as referring people to treatment services where required. In 2014 - 15, 232 assessments were completed in criminal justice settings and an alcohol brief intervention was provided as part of each assessment.
- **Alcohol treatment:** 9.0% of all people receiving treatment for alcohol misuse were in contact with the criminal justice system in 2014 - 15 whilst the corresponding percentage for those who reported alcohol and non opiate (e.g. cannabis and powder cocaine) use was 17.4%. These were both slightly higher than the national figures of 6.3% and 15.0% respectively and suggest that local services are working effectively to identify, assess and refer offenders with an alcohol problem to local treatment services.
- **Alcohol Treatment Requirement (ATR):** an ATR is one of a range of community sentences available to the courts. It provides access to alcohol treatment for offenders where alcohol use is identified as a significant factor in their offending. Once the order is imposed by the courts the individual must agree to a treatment plan with their offender manager and the KWS. This plan sets out the level of treatment required throughout the order. ATR sentencing can range between six months and three years and the aim of the ATR is to promote the offenders' rehabilitation through:
  - accessing treatment
  - promoting personal and behavioural change
  - helping offenders produce a personal action plan to identify what they must do to reduce offending and address their alcohol use
  - making clear the links between alcohol use and offending and how alcohol affects health.

In Kingston, 13 individuals started a community sentence with an ATR in 2014 - 15 and all of them completed the treatment requirement part of their order.

Integrated Offender Management (IOM)

Services aimed at supporting the recovery of people with problematic alcohol use can be successful in reducing both dependency and reoffending. A reduction in reoffending has been identified as a priority by the Safer Kingston Partnership (SKP) and is one of the main aims of Kingston's Integrated Offender Management (IOM) scheme. IOM brings a cross-agency response to the crime and reoffending threats faced by local communities. The most persistent and problematic offenders are identified and managed jointly by partner agencies working together. IOM helps to improve the quality of life in communities by:

- reducing the negative impact of crime and reoffending
- reducing the number of people who become victims of crime
- helping to improve the public's confidence in the criminal justice system.

Approximately 90% of all individuals on Kingston's IOM scheme report drug and/ or alcohol misuse. Given the link between alcohol consumption and crime, supporting this group to address their alcohol misuse will have a significant impact on their offending behaviour. There are strong links between the IOM scheme and KWS and specialist drug and alcohol workers contribute by delivering alcohol specific interventions that are included in offender management plans.

Street drinking

Local Authorities often implement enforcement measures to address street drinking and in June 2014, Kingston put in place a Designated Public Place Order (DPPO) in the town centre giving police the discretionary power to stop an individual drinking alcohol in a public place within a designated area. As with other boroughs, this succeeded in disrupting large groups congregating in the town centre but displaced the problem to neighbouring areas indicating that the underlying issues still needed to be addressed. In order to gain a greater understanding of the nature of the street drinking community locally a research project was commissioned. This comprised interviews and focus groups with street drinkers alongside consultation with a wide range of professional stakeholders. The project produced a set of recommendations to:

- reduce crime and anti-social behaviour associated with street drinking
- improve health and social functioning of the street drinking population
- reduce street drinking in the Borough overall.

For more information on the community research please see chapter 3.4.

A reduction in reoffending has been identified as a priority by the Safer Kingston Partnership (SKP) and is one of the main aims of Kingston's Integrated Offender Management (IOM) scheme.

Local action

In Kingston much of the work to address alcohol related crime and anti-social behaviour is led by the SKP and the Strategic Partnership for Alcohol and Drugs (SPAD). A responsive partnership approach to managing the night time economy and reducing any associated adverse impacts is crucial to ensure that everyone who comes to Kingston can safely enjoy the night life on offer.

Schemes such as Best Bar None, Purple Flag and Pubwatch ensure that excessive drinking is tackled consistently and robustly by local businesses, the police, the local authority and partner agencies (see chapter 3.7 for more detail).

Alcohol related offending

In Kingston a range of interventions are provided to support offenders to address their alcohol misuse problems, these include:

- a requirement to attend an alcohol awareness session or alcohol treatment services can be included in the appeals process for the Behave or Be Banned (BOBB) Red Card scheme or as part of a Criminal Behaviour Order
- identification of offenders with alcohol problems and assessments completed in Kingston Custody Suite and the Courts
- partnership working with drug and alcohol treatment workers and offender managers to support offenders who are under offender management supervision to address their alcohol misuse
- alcohol treatment and support for offenders who receive a community sentence with an ATR
- a prison link service to provide a link for the offender pre release and encourage engagement with community alcohol treatment services following release
- use of an assertive community case management approach ensures that individuals who find it difficult to access treatment services receive additional support in the community to promote engagement with alcohol treatment services
- plans to commission a sports based mentoring project to work with street drinkers and individuals on the IOM scheme to increase access to positive activities.

Treatment of resistant drinkers in the context of domestic abuse

In order to improve practice and local responses to treatment for resistant drinkers, Kingston is participating in the Stella Project's initiative on domestic abuse and treatment for resistant drinkers supported by Alcohol Concern and Action on Violence and Abuse. The project will support a range of partner agencies to develop alternative approaches and pathways for individuals with alcohol misuse problems who are known to services but who do not want to reduce or stop their alcohol use and do not want to access alcohol treatment services. This programme will ensure that staff and volunteers in a range of agencies have the ability to work with these individuals with a focus on reducing risks and harm related to alcohol misuse and domestic abuse.

Alcohol related anti-social behaviour

There are five DPPOs in Kingston, with two being in the town centre. However, as noted above these interventions may displace the issue elsewhere in the Borough.

The Anti-social Behaviour, Crime and Policing Act 2014 introduced the option of a Criminal Behaviour Order (CBO) with positive requirements, for example attending appointments at an alcohol treatment service, and these may be a useful tool to support individuals to change their drinking behaviour and reduce reoffending.

Kingston Council took advantage of a "buy one get one free" offer from the Mayor's Office for Policing And Crime (MOPAC) and is part funding 12 constables with MOPAC, supervised by two local police funded sergeants. They work with the local Safer Neighbourhood teams and as a result there is seven day per week coverage with shifts meeting peak time demands. This includes policing coverage within the town centre until 5am on a Friday and Saturday night and during Sunday day time. As well as improving perceptions of safety in the town centre, the new team will increase officer resilience across the Borough – resulting in fewer abstractions from other wards to the town centre at busy times.

Local policing teams have taken a proactive approach to dealing with alcohol related crime and anti-social behaviour making use of Dispersal Orders and the DPPOs in areas experiencing alcohol related disorder or nuisance.

They also work in partnership with alcohol services to ensure that support services can be provided alongside any enforcement activity where possible. For example two CBOs are in the process of going through the Court system for persistent anti-social offenders which include requirements to attend appointments at an alcohol treatment service.

Operation Equinox

The Metropolitan Policed launched Operation Equinox across London in 2014. Working in partnership with the Council, Kingston Police actively targeted individuals who commit violence related offences in Kingston. Operation Equinox involved bespoke deployments of officers in key locations, the implementation of safe spaces, training for staff at venues with regard to dealing with vulnerable persons, and a number of other covert initiatives focused on drugs and illegal minicabs. No drinking zones in public spaces were enforced whilst rigorous spot checks were carried out in high profile venues in collaboration with Kingston Council licensing officers. The months following the launch saw a coordinated targeting of activity against a number of licensed venues, geographic areas and fast food outlets where violent offending disproportionately occurs. Operation Equinox followed on from the 2012 MOPAC challenge to reduce the number of violent incidents resulting in injury by 20% over three years. Kingston Police successfully achieved this target within two years.

Recommendations

1. **Develop a partnership response to address anti-social behaviour related to street drinking combined with targeted support.**

2. **Explore opportunities for funding to provide positive activities and peer mentoring services for offenders, including those with alcohol issues.**

3. **Partner agencies should implement the recommendations from their work to improve responses to treatment resistant drinkers in the context of domestic abuse.**

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4.0 Interplay

The interplay between diet, alcohol and physical activity has a huge impact on our health and wellbeing. These three lifestyle issues often come together in the environments in which we spend our daily lives. The unique connectedness of these factors provides both opportunities and challenges in how people can improve their health.

In the following chapters we discuss the interaction of these factors in a variety of settings in our daily life, how our cultural background can influence our behaviour and how our schools, universities and workplaces and leisure activities can impact on lifestyle choices.

4.1 Social deprivation and links with diet, physical activity and alcohol

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Introduction

Deprivation is the lack or denial of something considered to be a necessity. It does not just relate to poverty or a lack of material goods and resources, but also includes the concept of social deprivation - a reduction of everyday interaction between an individual and other members of society. Multiple deprivation relates to the occurrence of several forms of deprivation at the same time, such as a person living alone in a poor quality house, with limited income and little contact with other people around them.

There is a clear link between deprivation and poor health, including early death. Research published in 2015 found that male life expectancy at birth ranges from 75 to 83 years depending on where men live. The range in women is from 80 to 87 years[1].

Making connections

The reasons why people in different places have such variation in their chance of living long and healthy lives are not fully understood. Factors covered in this report (poor diet, a lack of physical activity and heavy alcohol use) can increase the risk of conditions such as diabetes, heart disease and strokes, which in turn increase the risk of dying early. These conditions are themselves associated with deprivation, and have therefore been made a priority both nationally and locally[2, 3, 4].

There is no single cause for the link between deprivation and unhealthy lifestyles as there are complex relationships between individuals and the social, economic and physical environments around them potentially leading to unhealthy behaviour. The same factors which can increase the risk of one unhealthy lifestyle factor, may also increase the risk of the others. When poor diet, a lack of physical exercise and high alcohol intake occur in the same individual these factors can combine together to further increase the risk to health.

Obesity is one potential consequence of poor diet and low levels of physical activity. Alcohol accounts for nearly 10% of the calorie intake amongst adults who drink, although it is still controversial whether moderate drinking is a risk factor for obesity[5, 6]. Recent research from the UK has found that excess body weight and alcohol consumption act together to increase the incidence of liver cirrhosis and liver related death and disability[7, 8]. The effect of these factors working jointly is multiplicative rather than additive, and so deprived communities where these factors are more common are at even greater risk of poor health outcomes. Healthy lifestyle and social development programmes must not just focus on one problem when many are present.

There is a clear link between deprivation and poor health, including early death. Research published in 2015 found that male life expectancy at birth ranges from 75 to 83 years depending on where men live. The range in women is from 80 to 87 years[1].

Local picture

Kingston is a relatively affluent Borough as a whole, but pockets of deprivation mean that there can be stark contrasts within small areas. Measuring deprivation is difficult, but one scale used is the Index of Multiple Deprivation (IMD). This shows relative levels of deprivation in small areas of England called Lower Super Output Areas (LSOAs). Seven domains are combined to give an overall deprivation score. Figure 1 shows deprivation scores in Kingston LSOAs in relation to the rest of England. There is one Kingston LSOA in the most deprived 20% of all areas in England and six in the in the most deprived 40%.

Within Kingston there is evidence that deprivation is linked with poor health. Figure 2 shows the deprivation score for each LSOA plotted against the percentage of people in the 2011 Census who reported their health as bad or very bad. In general there is a trend that the more deprivation in an area, the more people report their health as bad or very bad. This reflects national data[9].

Figure 1 English Indices of Multiple Deprivation 2015 for Kingston.

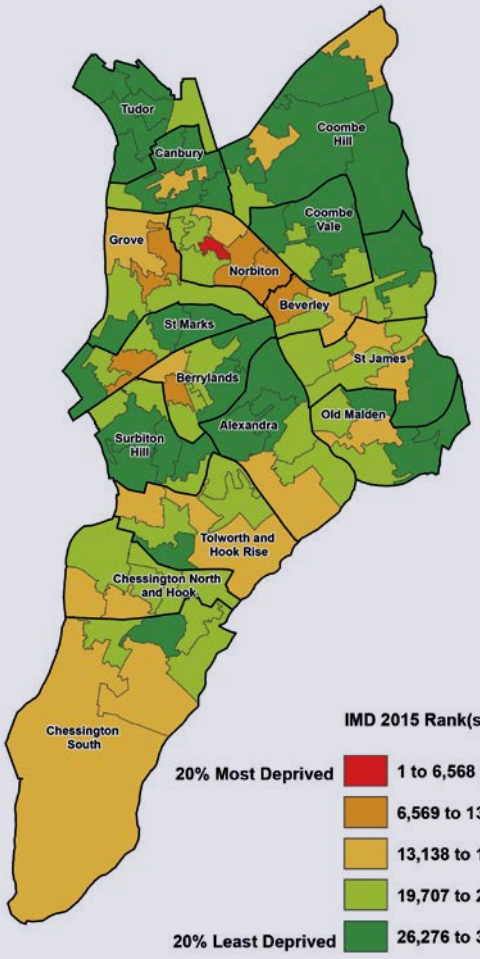
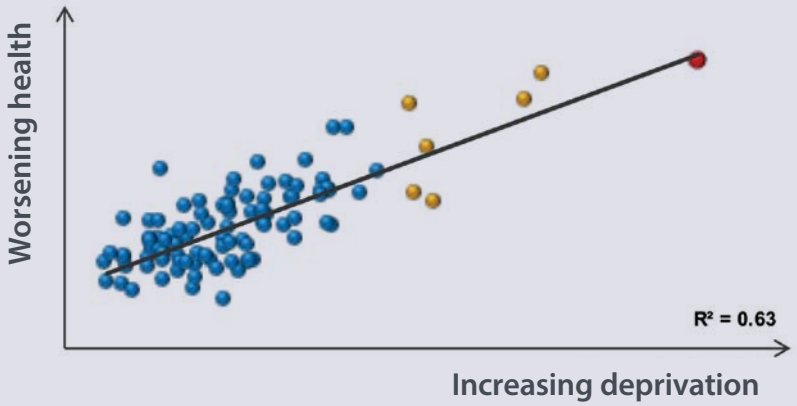


Figure 2 Kingston LSOA Index of Deprivation (2015) against self reported poor health (2011 Census).



- indicates Kingston LSOA in the most deprived quintile of LSOAs nationally
- indicates Kingston LSOAs within the second most deprived quintile of LSOAs nationally
- indicates Kingston LSOAs within the three least deprived quintile of LSOAs nationally

R^2 indicates the strength of relationship (value closer to 1 exhibits the strongest relationship).

Source: English Indices of Multiple Deprivation 2015, Department of Communities and Local Government 2011 Census, Office of National Statistics, 2015.

In Kingston there is a trend that the more deprivation in an area, the more people report their health as bad or very bad. This reflects national data[9].

Local action

Agencies in Kingston have a strong history of working in partnership to identify and address health inequalities experienced by deprived communities. Many of the projects led by Kingston Council to increase physical activity, improve diet and promote safer alcohol use are either focused on deprived communities or have specific programmes directed at more deprived communities. These are discussed in more detail in the individual lifestyle chapters (see previous sections of this report).

Within Kingston Council the Equalities and Community Engagement Team (ECET) are involved in a range of projects which aim to reduce health inequalities and address factors which can lead to differences in health. The team also work with socially marginalised and potentially deprived groups such as refugee and migrant populations to improve access to local health services. For more information see chapter 4.2.

Some local projects target several lifestyle factors at the same time and are targeted at more disadvantaged communities. These include the following:

Community Fun Days

Local health promotion programmes are operating to encourage a healthy diet, increase physical activity and promote safer alcohol use. These programmes are accessible to all, but there is a risk that if they are only used by better off people, differences in health could widen. Public Health staff attend local community fun days (such as the Alpha Road Fun Day and the Cambridge Road Estate Fun Day) to specifically promote healthy lifestyle programmes in more disadvantaged communities.

The Joel Community Trust

The Joel Community Trust runs a night shelter for homeless people. They also operate one of the local Cook and Eat programmes. This is a free programme of food workshops that include simple cooking tips and healthy eating advice. Residents can also be signposted into alcohol treatment programmes where this might benefit them. For more information see the case study in chapter 1.4.

Fairfield Football project

The Fairfield Football project started in November 2014 and aims to improve mental wellbeing through exercise. This project is aimed at people who are homeless, in a night shelter or vulnerably housed. Participants have a healthy meal and then join in some physical activity. Projects like this can not only help to improve physical and mental health, but can also provide a gateway into other services such as treatment for alcohol dependency.

Recommendations

1 **Continue work to prevent or reduce deprivation, for example by ensuring education, training and employment opportunities are available in disadvantaged areas and ensuring access to affordable housing.**

2 **Seek to limit the impact of deprivation on the population affected by providing public health services tailored to people's needs and working with partner agencies to ensure equitable access to health services.**

3 **Ensure that lifestyle interventions in deprived areas address a range of issues using a holistic approach.**

4.2 Diet, physical activity and alcohol consumption amongst Black, Asian, minority ethnic and refugee populations

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Introduction

There is a complex interplay of factors affecting the health of Black, Asian and minority ethnic and refugee (BAMER) communities in the UK. These factors, which include diet, consumption or abstinence from alcohol and variation in the amount of physical activity undertaken can have an impact on an individual's life chances, wellbeing, life expectancy and risk of long term illness[10].

It is well known that many BAMER communities have a lower life expectancy than the overall population. Evidence suggests that the majority of causal factors are due to poverty or lower socio-economic status[10] (see chapter 4.1). However, it should also be noted that BAMER communities vary hugely in cultural experiences, religion, education, experiences of migration, language barriers and access to and knowledge of positive lifestyle opportunities. All of these factors can have both positive and negative influences on life chances.

Diet

When considering diet, it is generally accepted that the diets of many ethnic minority communities are better than average[11]. However, there are anomalies such as some South Asian diets which can have a higher fat content including the cultural use of ghee (a type of clarified butter that originated in India and is commonly used in South Asian cuisine). Poorer diet amongst migrant populations has also been attributed to the loss of traditional dietary patterns as acculturation (the adoption over time by migrants of the habits of the host country) has been associated with poorer eating habits, especially in younger people[12].

Some minority ethnic groups are at risk of low iron status, and this is especially so for women. This is likely due to the dietary restrictions common to many groups. Vitamin D deficiency has also been found in South Asians and Black Africans and Black Caribbeans residing in the UK, particularly during the winter months.

This may be due to physiological or religious factors, such as having darker skin or wearing concealing clothing that blocks out the sun's rays. As vitamin D also aids calcium absorption in the body, this is likely to have an adverse effect on bone health in later life within these ethnic groups[12].

Breastfeeding rates amongst BAMER mothers are generally high. However, certain minority communities such as Gypsies and Travellers generally do not breastfeed, preferring to bottle feed. There are cultural reasons why breastfeeding rates are low amongst these communities[13].

Government guidelines suggest that babies should not be fed solid food until they are six months old (see chapter 1.2). Some BME communities have high rates of early weaning and a survey of 349 BME mothers in London identified inaccurate knowledge of the guidelines associated with weaning[14]. Mothers from BME communities were most influenced by weaning information from the previous generations of mothers in their families (which was associated with earlier weaning) and less so by professional infant feeding advice, which was associated with a later weaning age[14].

Religion and diet

Aspects of lifestyle, and in particular a person's diet, are an important part of religious observance for many different faiths including Christianity, Judaism, Islam, Hinduism and Buddhism. The role of food in cultural practices and religious beliefs is complex and varies amongst individuals and communities. Understanding the role of food in cultural and religious practice is an important part of showing respect and responding to the needs of people from a range of religious communities.

Being aware of certain religious festivals or holy periods, such as Lent and Ramadan, provides health professionals and others working with local communities an opportunity to promote healthy lifestyle behaviours as communities may be more receptive to health promotion campaigns during these periods. For example, during the month of Ramadan, Muslims abstain from eating and drinking from dawn to sunset. Whilst it is primarily a spiritual practice, it is also generally accepted that Ramadan can also be an opportunity to 'cleanse' and improve physical health. It can also be an opportunity to lose weight[15]. The period running up to and during Ramadan can be used to promote healthy lifestyle messages such as improving diet.

Black, Asian, minority ethnic and refugee (BAMER) communities vary hugely in cultural experiences, religion, education, experiences of migration, language barriers and access to and knowledge of positive lifestyle opportunities. All of these factors can have both positive and negative influences on life chances.

Physical activity

Physical activity is often embraced by BAMER communities. Examples include Yoga which originated in India, Tai Chi (from China), Judo (from Japan) and Taekwondo (from South Korea). There is considerable variation in physical activity between ethnic groups. Table 1 highlights participation rates in moderate or vigorous activity over a four week period by adults from a range of ethnic groups, although it should be noted that the original data is from 2004. There are many complex factors that underlie these figures including the cultural expectations of women, the cost and accessibility of exercise opportunities, lack of confidence and lack of awareness of the benefits of physical activity.

Table 1 Participation in moderate or vigorous activity in four weeks prior to interview, by ethnic group and gender.

	Men	Women
General population	41%	34%
Black Caribbean	46%	36%
Black African	43%	28%
Indian	32%	27%
Pakistani	31%	16%
Bangladeshi	26%	12%
Chinese	49%	34%
Irish	39%	38%

Source: Systematic review of the literature on Black and minority ethnic communities in sport and physical recreation[16].

Alcohol consumption

The Joseph Rowntree Foundation identified within literature reviews that many minority ethnic groups have higher rates of abstinence and lower levels of frequent and heavy drinking when compared with the British population as a whole and with people from White backgrounds. However, drinking patterns were also identified as varying between different BAMER communities. People from mixed ethnic backgrounds report relatively high rates of heavy drinking and are less likely to abstain than people from other minority ethnic groups[17].

Despite lower levels of drinking than the wider population, minority ethnic groups still have similar levels of alcohol dependence compared to the general population[17]. However, in 2009 minority ethnic groups were reportedly under represented in seeking treatment and advice for drinking problems which the Joseph Rowntree Foundation suggested was an indication services were not responsive enough to these population groups at that time[17].

The Joseph Rowntree Foundation also suggests that the process of acculturation (described above) helps to explain the changes in drinking rates observed in some ethnic groups. Stress associated with migration has also been linked with increases in levels of drinking among certain minority ethnic groups[17].

Deaths related to alcohol are higher for Irish men and women and Scottish men and women compared with the general population in England and Wales[17]. Eastern Europe is often cited in research as a region seriously affected by alcohol related harm[18]. There are high rates of alcohol consumption and dependency amongst male migrants who have come to the UK from Eastern Europe[18].

Alcohol related deaths are higher among Indian men compared with the general population, and research has shown Indian women in the UK have over time increased their consumption of alcohol. Indian women in higher income brackets are more likely to exceed recommended guidelines for alcohol consumption[17].

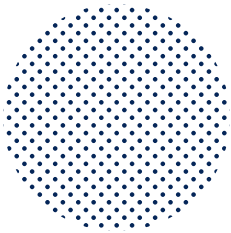
Sikh men show high rates of heavy drinking, and have high rates of liver cirrhosis. However, second generation male Sikhs are less likely to drink heavily than first generation men. Hindus are less likely to drink if they report that religion is important to them and people from Bangladesh are less likely to consume alcohol than other ethnic groups. Drinking rates are low among Pakistani men and women, but Pakistani men who do drink consume more units of alcohol compared with those from other minority ethnic groups[17].

Muslim men and women are both likely to abstain, but, amongst those who drink alcohol, rates tend to be high compared with other religious groups[17]. Chinese men and women tend to have low levels of reported drinking, although frequent and heavy drinking levels amongst Chinese men rose significantly between 1999 and 2004[17].

The Joseph Rowntree Foundation identified within literature reviews that many minority ethnic groups have higher rates of abstinence and lower levels of frequent and heavy drinking when compared with the British population as a whole and with people from White backgrounds.

Black Caribbean people have higher levels of drinking than people from South Asian and Chinese ethnicities, but lower levels compared to people from White backgrounds. Black African people have higher levels of drinking compared with most South Asian ethnicities, but lower rates of alcohol use than people from White backgrounds[17].

Qualitative research has identified sources of tension between generations in some minority ethnic groups. Young people from minority ethnic groups with strong religious ties that forbid drinking, or that are less tolerant of drinking amongst women, may hide their drinking for fear of repercussions and bringing shame on their families. This is evident among some young people in the Muslim, Sikh and Hindu religions[17].



Local picture

Local Demographics

BAME communities were estimated to make up 28.8% of the Kingston population in 2014, which equates to 46,567 people[19]. Within these communities, it is important to note anecdotal evidence that there are several religions represented across BAMER communities locally. For example, within the Tamil community there are Hindus, Catholics and Muslims. Within the Korean community a variety of different denominations of Christianity are represented. There are also less obvious correlations of religion and nationality such as some Afghans locally are Sikh, having come to the UK after seeking asylum fleeing from the Taliban. The Kingston Mosque serves a very diverse range of community members as do the Liberal and Orthodox Synagogues in Kingston[20].

Local evidence that informs the local picture

A number of research projects have been undertaken during 2014 - 15 which identified the needs of refugees, asylum seekers, non English speakers and people living in areas of disadvantage in Kingston[21, 22, 23]. All of these have highlighted food issues including lack of availability of culturally appropriate food, food poverty and food sharing, cooking together and the social aspects of food[22].

On the Sheephouse Way Estate in Malden Manor, where a high number of non English speaking families live, research participants spoke of their experiences of food poverty including having to take turns to lend bags of sugar to neighbours on a low income, not being able to cook hot food due to having to be conscious of fuel bills which added to a sense of isolation, and a reluctance to invite friends or family to stay because of not being able to afford the additional cooking, heating and lighting[21].

The Refugee, Asylum and Migrant Needs Assessment (RASMNA) carried out in 2014 highlighted how many people are living on a low income which is having a detrimental impact on their food choices. A Korean woman described how she was eating foods such as cheap crackers in order to 'fill herself up' and described how she felt that her nutritional levels were low[20].

Physical activity

Participants who took part in photo diaries as part of the local Refugee, Asylum and Migrant Needs Assessment research in Kingston, disclosed that they saw physical activity as a way to help keep a positive outlook. Participants reported walking, cycling and swimming to help alleviate symptoms of mental distress[20].

> "Before coming to the health club I don't have friends. I don't even have confidence, but now I gain my confidence back and I found good friends here, it also help me to make myself fit by doing exercise and the club gave me information about healthy foods also" (participant in Learn English at Home's Learn English and Be Healthy Club, 2014).

The Refugee, Asylum and Migrant Needs Assessment (RASMNA) carried out in 2014 highlighted how many people are living on a low income which is having a detrimental impact on their food choices.

Alcohol

Alcohol issues were disclosed during the research for the RASMNA[21].

> "I was working, I was living in a house, I was fine. Then the landlord evicted us. We went to the Police but there was nothing they could do so now I am homeless. When sleeping on the streets you do things like drinking and my mind got very bad" (Polish man in Kingston, 2014).

Local organisations such as RISE (Recovery Initiative Social Enterprise, an organisation set up for people in recovery from drugs, alcohol and mental illness) report they are supporting increasing numbers of migrants who are dependent on alcohol in Kingston. They are also supporting 'street drinkers' who are often Polish or from other Eastern European countries and are often either homeless or vulnerably housed[24] (see chapter 3.4).

A research study was conducted locally with street drinkers in Kingston. One distinct group was found to have been economic migrants from Central and Eastern Europe (mainly Poland). Many from this group reported they were keen to work and to reduce their alcohol intake[25].

Whilst ethnic monitoring of local treatment services has been carried out as well as data collated on the online e-drink-check website (see chapter 3.4), the numbers recorded are too low to draw any conclusions from. Therefore further research into the local BAMER population's consumption of alcohol or alcohol dependency should be undertaken.

Diet

The cost of food was reported locally in the RASMNA as a major problem for many individuals and families. Trying to adhere to culturally specific diets was expensive and difficult. The high cost of food was reported by many frontline workers working with refugees, asylum seekers and vulnerable migrants who also noted the high dependency on foodbank vouchers (see chapter 1.6) amongst their clients.

> "The vouchers, they help a lot. It means the difference between children going hungry and having something to eat" (front line worker, 2014).

> "I have to be at the supermarket after 7 o'clock everyday and buy leftover food. I have £35 (a week) and I should spend that for everything. I never had to do this before. I had a good job and it is humiliating" (Pakistani man in interview for the RASMNA in Kingston, 2014).

Participants reported having to fill up on cheap, carbohydrate heavy products. It was noted that fast food was a significant part of young people's diets. The use of fast food was not only because it was cheap but also due to a lack of knowledge about cooking and shopping.

Many refugees and migrants locally also lacked an understanding of key dietary issues such as accounting for salts, fats and sugars in food. Running healthy cooking classes such as Cook and Eat was considered an excellent way to support people with building these basic skills.

> "This course helps us to learn how to cook healthy food. I say thanks Zoe and her groups" (participant in Learn English at Home's Learn English and Be Healthy Club Cook and Eat programme, 2014).

Local action

In light of findings in the RASMNA, a chapter on food and nutrition is being developed for the new Refugee and Migrant Strategy 2016 - 21. In addition, this is planned to be incorporated within the Good Food subgroup of the Community Sport and Physical Activity Network (CSPAN).

Local examples of promoting healthy diets

- Refugee Action Kingston (RAK) ran a food growing project for three months during 2014. The aims of this project included increasing knowledge of food growing techniques and improving access to food growing opportunities. Members were paid in time credits through the Timebank and grew their own produce.
- Four Cook and Share sessions were held at RAK's Learning Centre. These sessions were also part of the Timebank and involved people sharing their skills and knowledge.
- Learn English at Home ran a Cook and Eat six week course which combined English lessons with learning about healthy food and healthy recipes.
- The Islamic Resource Centre also ran Cook and Eat classes. Participants learnt about the 'eatwell plate' which explains different food groups and how to achieve a balanced diet. At the end of the project attendees reported they were all confident about healthy food and healthy cooking.

Local examples of promoting physical activity

- The 'Learn English and Be Healthy' (LEBH) club provides a 24 week course combining physical activity, health education and English for speakers of other languages. It also includes a crèche. All participants who took part reported that they felt better and healthier as a result. Some members reported losing weight:

  "…my friend here, I've seen it front of my eyes. She has really lost weight. How much?" "I lost 30 pounds, three zero!" (two participants of the English for Health project in a focus group conducted by Dr Seetzen, Kingston University[22]).
- The Walkers and Talkers project was run in partnership by Learn English at Home (LEAH, a charity helping people to learn English) and Sustrans, a charity promoting sustainable travel and exercise. From December 2014 to March 2015, 32 participants registered to 'walk and talk', encouraging non English speaking residents to practice their English conversation whilst walking.
- RAK carried out numerous physical activity classes during 2014 and 2015 for their clients. These included Aerobic classes, Yoga and Zumba. Other popular physical activity classes included a walking club and line dancing. Older women reportedly preferred Yoga classes whilst Zumba classes proved popular with women who were from Afghanistan, Iraq and Syria.

Health improvement event organised by the Equalities and Community Engagement Team and carried out with Public Health team lifestyle specialists and community representatives in November 2014.

Alcohol – local health improvement event

A local event for marginalised communities in November 2014 included the examination of the issue of alcohol consumption with community representatives from different Black, Asian, minority ethnic and refugee communities.

One representative of the Polish community noted that there is a stereotype of Polish drinkers drinking vodka when it is now more common for people to drink beer. In terms of awareness raising, it was suggested that services should be promoted in Polish shops and consideration should be made to use Polish newspapers to advertise services.

Tamil community representatives noted that there were some men in the community who were consuming alcohol heavily and were either not aware, or were denying the extent of their alcohol use. One suggestion was to highlight the effects of alcohol on driving, parenting or being a good citizen to this group to try and motivate individuals to speak to their GP or the Kingston Wellbeing Service. It was suggested that a presentation on alcohol at community gatherings may be useful, and that education on this topic was particularly important.

The Chinese community representatives requested to have alcohol awareness raising presentations at community gatherings.

The health improvement event highlighted that further work is required to understand the needs of the large South Korean community living locally. Drinking alcohol is a normal part of South Korean culture and according to the World Health Organisation's Global Status report on alcohol and health published in 2014, South Korea has a high level of alcohol consumption[26]. It is not known if there are high rates of alcohol dependency amongst the local South Korean community.

Recommendations

1 **Develop a chapter in the 2016 - 21 Refugee and Migrant Strategy focused on food and nutrition and work to implement recommendations made within the RASMNA.**

2 **Implement recommendations from the evaluation report on Learn English at Home's Health Club.**

3 **Explore with young BAMER people how to reduce their use of fast food and support young people's increased awareness of food, cooking and shopping on a budget.**

4 **Encourage healthy diets with young BAMER people and promote the take up of the previous generation's healthy diets to prevent the loss of healthy traditional dietary patterns.**

5 **Continue to provide bespoke cooking, food and nutrition classes (such as Cook and Eat) targeted at refugees, asylum seekers and migrants across the life course, including those with low levels of English.**

6 **Use community newspapers to promote healthy lifestyles and accessible local support and interventions available with a particular focus on maximising opportunities during and running up to religious festivals.**

7 **Deliver community action initiatives that include targeted, peer health support groups.**

8 **Research the local BAMER population groups' consumption of alcohol, level of alcohol dependency and need for services.**

Case study – Learn English at Home's (LEAH) Learn English and Be Healthy (LEBH) Club for non English speakers

During April 2013 to March 2014, LEAH supported 125 people through the English for Health project and from April 2014 to March 2015 they supported 51 people through the Learn English and Be Healthy (LEBH) Club.

Healthy eating

LEAH's baseline assessments showed that prior to the course the majority of participants had little to no knowledge around the importance of healthy eating. This changed dramatically during the programme.

The majority of participants reported that they had changed their cooking in response to what they had learnt on the course. Participants also reported that they had enjoyed the healthy eating and cooking sections of the course. Practical demonstrations (such as dropping a coin into a carbonated soft drink and seeing how it reacts with the metal) helped participants understand the importance of healthy eating.

In addition to learning new recipes, participants wanted to learn how to prepare their meals more healthily. Moreover, participants expressed a desire to share their own recipes, as well as learn about other participants' dishes (groups are often attended by clients from a wide range of cultural backgrounds).

Physical activity

The LEBH Club also included physical activity classes. Most participants cited these as one of the aspects of the course that they most enjoyed.

In terms of their pre-course experience, participants were divided into three groups:

- those who had become less active following the birth of their children
- those who had participated in a limited amount of exercise and wanted to do more exercise, but were unsure about accessing local gyms
- those for whom this was the first time that they had participated in physical exercise.

The main barriers to accessing physical exercise facilities and courses for all groups were:

- a lack of spoken English
- difficulty in arranging childcare
- cultural expectations
- low confidence.

Many clients were unsure how to access community gyms and seemed worried at the prospect of negotiating access by themselves. The LEBH Club is therefore an important opportunity for them to access physical activity sessions.

During the course of the LEBH Club participants showed a growing motivation and determination to improve their physical fitness. The LEBH Club constituted a safe space where they could bring along their children, meet parents in a similar position and try out gym equipment as well as different exercises. Participating in physical exercise and learning about the effect of physical exercise on the body has had a positive impact on clients' sense of wellbeing, as well as their determination and confidence to continue to participate in physical activity.

Impact on health and wellbeing

All participants reported that they felt better and healthier as a result of attending the LEBH Club. Monitoring data for 2013 and 2014 indicated an increase in the level of fitness as well as a reduction in body mass index (BMI) amongst the majority of participants.

There is a clear focus on ensuring a longer term impact on attitudes and practices around health, and the LEBH Club leavers' group reported an increase in physical activity following the course (including attending community classes and gym sessions).

The majority of participants reported that they had changed their cooking in response to what they had learnt on the course. Participants also reported that they had enjoyed the healthy eating and cooking sections of the course.

Participants in the English for Health programme, run by Learn English at Home in 2014.

4.3 Healthy Schools Kingston

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Introduction

Better education is known to lead to better health, and recently evidence has been building to demonstrate that better health can lead to a better education[27].

A review undertaken by Public Health England in 2014[28] had four key findings:

1 pupils with better health and wellbeing are likely to achieve better academically

2 effective social and emotional competencies are associated with greater health and wellbeing, and better educational achievement

3 the culture, ethos and environment of a school influences the health and wellbeing of pupils and their readiness to learn

4 a positive association exists between academic attainment and the physical activity levels of pupils.

Schools maintained by local authorities have a statutory duty to promote children and young people's wellbeing[29] and a statutory responsibility to provide a curriculum that is broadly based, balanced and meets the needs of all pupils. Furthermore, such a curriculum must "promote the spiritual, moral, cultural, mental and physical development of pupils at the school and of society"[30,31].

Children's health and wellbeing is influenced by a range of factors and includes their subjective feelings as well as social, physical and psychological aspects of their lives[28]. Schools can be hugely influential in shaping general wellbeing given the amount of time children spend in them. The health and wellbeing of children and young people contributes to their ability to benefit from good quality teaching and to achieve their full academic potential[32] which in turn will impact on their life chances once they have left school. The Chief Medical Officer of England highlighted that "promoting physical and mental health in schools creates a virtuous circle reinforcing children's attainment and achievement that in turn improves their wellbeing, enabling children to thrive and achieve their full potential"[33]. Whilst academic success has a strong positive impact on children's subjective sense of how good they feel their lives are (life satisfaction) and is linked to higher levels of wellbeing in adulthood, children's overall level of wellbeing impacts on their behaviour and engagement in school and their ability to acquire academic competence in the first place[28].

Table 1 highlights the links between the Ofsted inspection framework and improving the health and wellbeing of pupils.

Table 1 Links between the Ofsted inspection framework and improving health and wellbeing of pupils.

Ofsted inspection framework: Key judgements	Links with pupils' health and wellbeing
1. Achievement of pupils	An 11% boost in results in standardised achievement tests has been linked to school programmes that directly improve students' social and emotional learning Higher attaining schools have greater levels of participation in physical activity and sports programmes than lower performing schools
2. Quality of teaching	Systematic structured teaching of social and emotional life-skills and values throughout school life has the potential to increase emotional wellbeing and academic achievement
3. Quality of leadership in, and management of, the school	Ofsted reported a close correlation between the grade that schools "were awarded for overall effectiveness in their last section 5 inspection and their grade for Personal Social Health and Economic education" The quality and nature of relationships - spanning pupil-to-pupil and pupil-to-teacher relationships - are key to engendering a sense of belonging and pupils liking school, which influences student wellbeing and readiness to learn
4. Behaviour and safety of pupils at the school	Pupils' sense of belonging to a school is a key determinant of their wellbeing and is higher in schools where children feel safe and have lower levels of bullying. These are also more likely to be high achieving schools

Source: The link between pupil health and wellbeing and attainment. A briefing for head teachers, governors, and staff in educational settings, Public Health England, November 2014[28].

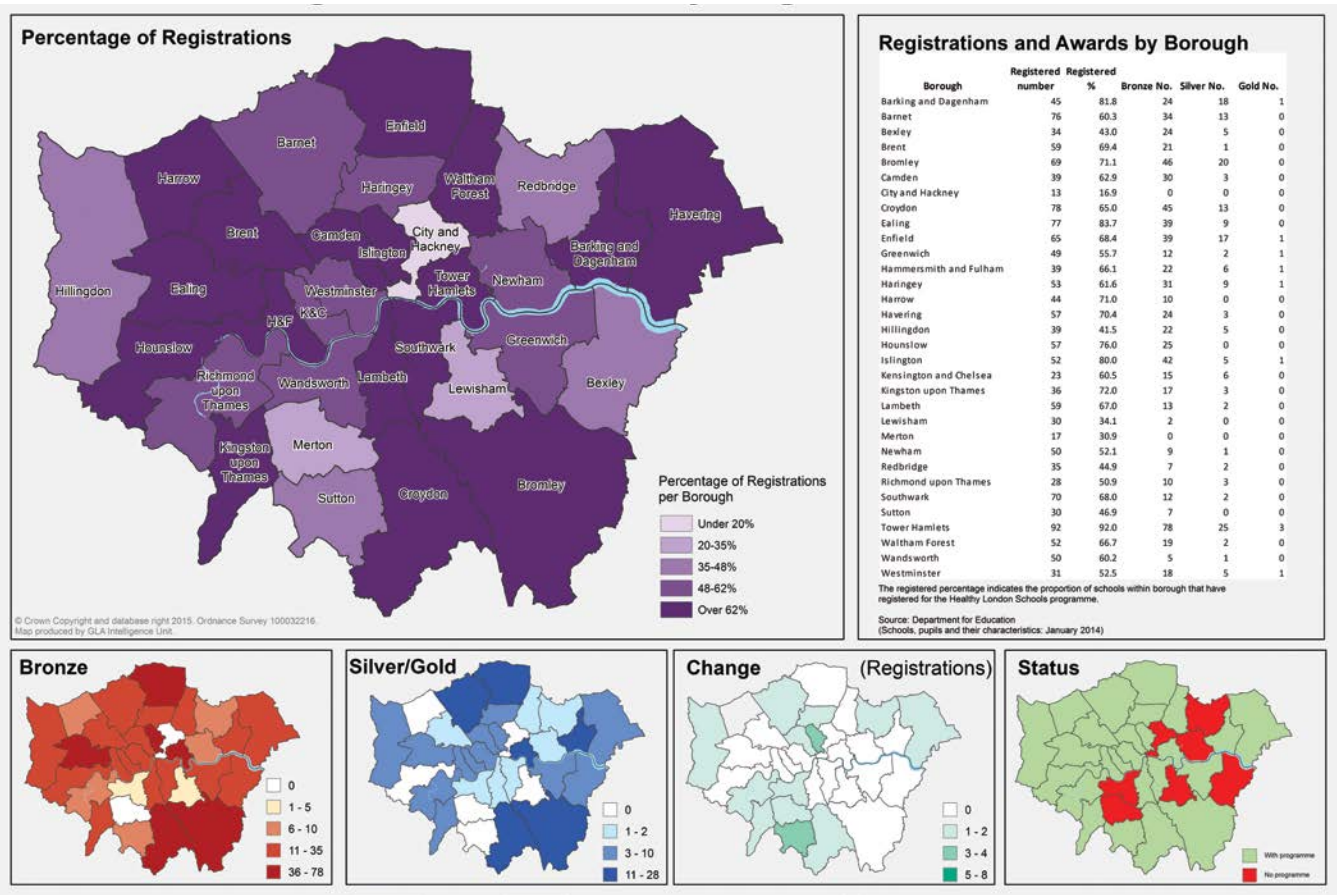
Whilst much of the health and wellbeing focus is on children and young people, schools are also workplaces and have a role in supporting staff to maintain their health and wellbeing. This in turn can act as role modelling for pupils such as eating healthily at lunchtime, drinking water throughout the school day, actively travelling to school, volunteering their time, participating in afterschool physical activity clubs or undertaking fundraising opportunities such as fun runs.

The national Healthy Schools programme ran from 1997 until 2011 when the funding was ceased. This programme was very well received with nine out of ten London schools achieving Healthy School status[34] and many boroughs nationally choosing to continue the scheme despite the loss of funding. This enthusiasm alongside the key priority to reduce the prevalence of childhood obesity resulted in the Greater London Authority developing a Healthy Schools London (HSL) programme which launched in April 2013. This has three levels of award: Bronze, Silver and Gold.

Bronze focuses on generic health promotion including healthy eating, access to good food, physical activity and providing appropriate information on drug, alcohol and tobacco use and healthy relationships. Silver requires the school to identify specific local needs and agree one universal (whole school) and one targeted (specific group of higher need students) intervention in an action plan. Gold requires the school to have implemented the action plan from their Silver award, evaluated the impact and considered their next steps. To date 49.6% (1,548) of London schools (3,119)[35] are registered with the HSL programme and of these 46% (713) schools have achieved Bronze award status, 11.8% (184) Silver and 0.65% (10) Gold.

The programme is open to all schools including special schools, local authority maintained schools, academies and private schools. The HSL website provides links to useful resources for schools to support their curriculum planning and policy development (**www.healthyschoolslondon.org.uk**). An evaluation of the programme is underway and findings will be available in 2016.

Figure 1 Map of Healthy Schools London registrations summary September 2015.



Local picture

In 2014, 24 (69%) Kingston primary schools took part in a local Healthy Schools survey to review their activity around healthy eating and physical activity. The survey revealed that 86% of responding schools provided a breakfast club, 90% had facilities to provide on site cooking classes and 95% had a food growing area.

All schools met the minimum curriculum requirements of two hours of physical activity per week and staff were most confident about teaching physical activity and managing bullying. Staff were least confident about tackling weight management, body image and mental health and this information has been used to help develop support packages for schools (such as providing a training on 'raising complex health issues with parents' at the March 2015 Healthy Schools Kingston network event).

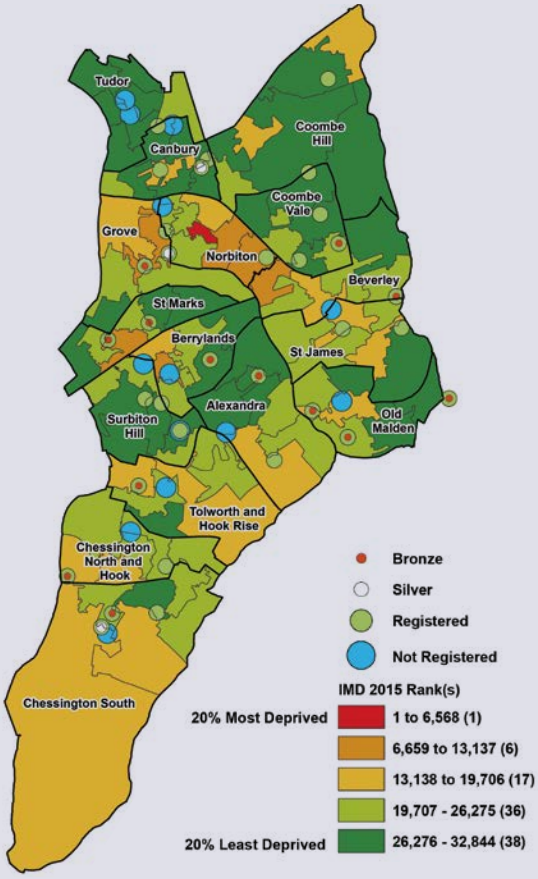
All schools met the minimum curriculum requirements of two hours of physical activity per week and staff were most confident about teaching physical activity and managing bullying.

In 2013, 3,982 pupils from years 7 to 10 from eight secondary schools and one pupil referral unit (PRU) completed the Schools and Students Health Education Unit (SHEU) Health Behaviour survey. Findings highlighted that on the day of the survey, 12% of pupils responding went to school without breakfast. Only 16% ate more than five portions of fruit and vegetables on the day before the survey. When asked about active travel, 48% reported walking but only 6% said they cycled to school. Only 38% participated in physical activity at least five times in the previous week. Furthermore, 32% said they worried 'quite often' or 'very often' about their weight, and 16% drank an alcoholic drink within the previous seven days. These figures were similar to the wider SHEU reference sample (consisting of data from 507 schools across seven regions in England) and the survey has been repeated in 2015. When available, this will be used to ensure services understand the key issues experienced by young people in Kingston.

Schools in Kingston work hard to support the health and wellbeing of their children and young people. The new HSL programme was launched in Kingston in November 2013. Burlington Junior School achieved the first Bronze award in Kingston which was presented at the well attended launch event by Councillor Victoria Borwick, the then Deputy Mayor of London. By September 2015, 72% (36) of local schools had registered with HSL (figure 1) which is above the London average. Of these, 47.2% (17) schools have achieved Bronze awards and 8.3% (three) have achieved Silver. It is hoped that the first Gold award will be achieved in early 2016. Figure 2 shows a map of Kingston schools registered with Healthy Schools London together with those that have achieved awards.

Schools in Kingston work hard to support the health and wellbeing of their children and young people.

Figure 2 Map of Kingston schools registered with Healthy Schools London by registration, Bronze and Silver awards, September 2015.



Note, the map will appear to show only 14 Bronze awards because the three schools that have Silver awards must have previously achieved their Bronze award in order to gain their Silver award (bringing the total to 17).

Students at Chessington Community College learn about alcohol.

Local action

The new HSL programme has recognised that schools are very busy environments and so developed new review tools that are significantly quicker to complete and also provide helpful examples. Kingston has developed its local programme within the HSL programme using their tools, updates and networks to develop support for local schools. This has been achieved within existing capacity and schools can request visits to talk them through the relevant review tool and are encouraged to send completed review tools to Public Health for advice and feedback prior to submitting their application. Schools are incentivised with a small payment to put towards further healthy schools interventions.

As part of the local support package offered to schools, network events are held once a term where schools can share their experiences and hear from outside speakers. These have included Food Growing Schools at the December 2014 event and Foodtalk CIC raising awareness of the new Factor Children's Weight Management programmes in Kingston at the July 2015 event. These events also provide the opportunity for schools to receive specific training and are generally well attended with between 15 and 20 schools represented.

Schools are encouraged to complete their award applications in advance of these events in order to celebrate new awards with their colleagues.

In 2013, Kingston invested in a new Young People's Health Link Worker team specifically to support local secondary schools. The team advise on policy and curriculum in relation to health and wellbeing and also support staff by developing their skills in delivering more challenging health topics. On occasion, they find young people access them on a one-to-one basis and they will then support the individual into the appropriate service for help and support as required.

Recommendations

1 **Develop an effective quality assurance process amongst suitably experienced and trained staff within Public Health to ensure all schools achieving awards locally are reaching the same high standards.**

2 **Explore opportunities to increase Public Health capacity to support Healthy Schools.**

3 **Continue to survey schools to identify evolving local need and consider cost effective ways to meet that need through training provision or signposting to high quality resources.**

4 **Continue to encourage and support schools to apply for their Healthy Schools awards and thereby gain recognition of their achievements in supporting the health and wellbeing of their children and young people.**

4.4 Diet, physical activity and alcohol at Kingston College and Kingston University

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Introduction

The increased freedom and choice associated with college and university makes Further Education (FE) and Higher Education (HE) students vulnerable to unhealthy lifestyle choices, as well as offering an opportunity for positive change[36].

Research into a range of lifestyle factors has indicated a tendency for these to aggregate in clusters, with individuals engaging in one high risk behaviour (such as hazardous alcohol consumption, unhealthy food choices, unprotected sex or low engagement in physical activity)[37] more likely to engage in others. Given this tendency for clustering there is increased acceptance of the need for 'holistic' approaches to health promotion which target a range of health behaviours.

One such holistic approach that has gained traction is the healthy settings movement[38]. This strategy advocates a whole system approach which integrates action across risk factors and has been adopted for a range of settings including cities, workplaces and prisons[39]. Whilst the Healthy Schools London programme has offered encouragement and incentives to London schools adopting such a holistic approach to health promotion (see chapter 4.3), less support is available for Healthy Colleges or Universities.

The recent Okanagan Charter for Health Promoting Universities and Colleges[40] indicates international support for a healthy settings approach and the UK Healthy Universities Network[41] and the Healthy FE programme[42] are both well established. Despite this, no national accreditation schemes exist. Although from September 2015 the new Ofsted Common Inspection Framework places greater emphasis on 'preparation for life and work' with specific reference to promoting welfare and positive outcomes, the framework is open to interpretation[43]. As a result health initiatives are largely down to individual settings, with initiatives often working in silos and targeting one particular aspect of health but not addressing others. The transient nature of student populations also presents unique challenges[44].

Kingston has both a college and a university, with a combined population of around 30,000 students making up a large and diverse part of Kingston's community.

Local picture

Kingston has both a college and a university, with a combined population of around 30,000 students making up a large and diverse part of Kingston's community. Large numbers of these students commute into the Borough. There are a wide range of businesses that students are free to frequent given the non campus settings of both the university and college. This represents a challenge for onsite services since they face competition for students' business and, to take one example, makes the adoption of healthy eating initiatives more challenging.

Kingston University

Kingston University is located across four sites and has a population of 17,613 full time and 3,055 part time students. 12,525 of these are between the ages of 18 and 21[45]. The university and Student Union (SU) work together to provide a set of services for students. There are three student union bars which in 2013 - 14 sold 78,070 pints of lager across the three venues. Figures from the SU reveal that the number of alcoholic drinks sold have been steadily declining over the last decade despite an increase in student numbers, which correlates with national trends of alcohol consumption in under 25s[46].

Data on health at the university is limited. An online alcohol checker completed by 256 Kingston University students (between October 2013 and May 2015) found 71% received scores indicating increasing or higher risk drinking (using the Audit C screening tool) with a mean average of 21 units consumed in the last week (n=226). The small sample size (1.2% of Kingston University students) means this cannot be extrapolated to the student body as a whole.

The only indication of eating habits at the university level is also provided by the online alcohol checker, with respondents reporting an average consumption of 2.8 pieces of fruit or vegetables per day (n=171).

No specific data is held around physical activity levels within the university, although there are a range of sporting facilities available including Tolworth Court sports ground and the University Fitness Centre. Indoor facilities are limited and are hired where necessary. A total of 1,470 students (7%) are registered with the SU Sport Federation, divided between 36 sports clubs.

Kingston College

Kingston College is located across three sites and has a student population of 8,250 students. A large percentage of these (38%) commute in from outside the Borough[47]. Little data on lifestyle issues are available for college students. A recent survey of 132 respondents (64 male, 52 female, 16 undisclosed) found that the average reported number of fruit and vegetable portions eaten on a typical day was 2.8, with only 11% achieving the recommended daily guidelines of five or more[48]. The same survey indicates that alcohol consumption is likely to be lower in comparison to university drinking levels, with only 4% of students reporting that they drink alcohol at least once a week and 86% reporting that they only drink on special occasions or not at all. No data is available for levels of physical activity although a range of sporting facilities are available for students through the Arena Sports Hall and gym, as well as local links with sports clubs.

Local action

Kingston University

Health promotion activity is largely coordinated by the Student Wellbeing Team, supported by six part time Health Connector roles (two healthy eating, two sexual health, and two homesickness and isolation). The majority of support is focused on the Penrhyn Road site, with limited health promotion work being undertaken across the satellite sites. In terms of holistic approaches to health, a number of outreach events are organised by the team including 'Health Week', which targets a range of healthy lifestyle factors including healthy eating, alcohol and substance misuse, and physical activity. The health week in 2015 saw heavy promotion of sport, with a number of taster sessions offered to students. Healthy eating components of the event promoted healthy food swaps, coordinated by the two Health Connectors and supported by students on the university's Nutrition course. Public Health also offers support through Healthy Lifestyle events. Health promotion around alcohol takes place at alcohol awareness events run in November and February.

Aside from events and initiatives delivered by the Student Wellbeing Team, pockets of good practice exist in the university but are small scale and largely function in isolation from one another. One such initiative is the 'Cook School', run by the on site caterer and offered once a month during term time. This programme sees a university chef teach students to prepare a cheap and healthy dish from scratch. Although successful, access is limited with 12 students per session and capacity is reached every month.

On site catering is run by Elior and there is engagement with their staff to promote healthy eating (a salad bar is now available, water is sold at a reduced cost, and healthy foods are made more accessible than unhealthy alternatives).

During the health week the canteen also offers a healthy hot meal at a subsidised price. The canteen however is a business and is driven by what will sell, so student demand largely dictates what is provided.

A variety of physical activity initiatives are coordinated by the university. The Sport England funded Active Lifestyles Programme aims to improve the breadth of sporting and active lifestyle opportunities available to the student body, with a focus on those who do not currently engage with the activities available. Based on consultation with 613 students, the five sports offered through the programme are swimming, badminton, table tennis, basketball and running/ jogging. The three year programme started in September 2014 and a six month return in April 2015 demonstrated that the programme has surpassed targets, with 760 students registered (356 male, 404 female, 56% BME, 14% with a disability) and a total of 4,460 individual activities undertaken (not including table tennis use which cannot be quantified).

A successful Sportivate bid has led to a sports development programme, with use of peer-led initiatives ('Sport Activator' volunteers) to increase sport participation. A key focus is on female participation with a steering group to look at the issue and the use of 'This Girl Can' branded material from the Sport England national campaign across the campus. An emphasis on community engagement has seen some of the Sport Activators volunteer in other locations, with some volunteers running Boccia sessions at a nearby school. Sports facilities are also shared with the wider community and the University's Tolworth Sports Ground is the base for 34 clubs. There are current plans to build indoor facilities, as large sums of money are spent hiring external facilities.

Kingston College

The majority of health promotion activity is delivered by the college's Student Support Services, which comprises two Enrichment Student Engagement Advisors overseen by the Head of Student Engagement, Guidance and Support. A member of the public health team (the Young People's Health Link Worker) works closely with this team and is based in the college for two days a week to support health related events alongside other projects.

The Student Engagement team run a range of holistic health events across the academic year, including the annual Freshers' Fair, a Safety and Wellbeing Day in November, and a Healthy Lifestyles event in January. All of these include stalls and health messages regarding healthy eating, substance misuse, physical activity and other health topics. These events are often attended and supported by various members of the public health team alongside other external agencies.

A five year Sport England project is currently underway in the College, with a College Sport Maker employed to encourage healthy behaviours with a particular emphasis on sport. Targeting 16 - 25 year olds with an emphasis on women and students with disabilities, this project offers a timetable of free sporting activities for both staff and students in the college including yoga, swimming and Special Olympics. Between September 2014 and February 2015, 187 women had registered, with a total of 881 attendances at the sessions. For the same period, over 30 students with disabilities had taken part in the Special Olympics sessions, with between ten and 15 students regularly attending. The vast majority attending these sessions were students (89% versus 11% staff) from a Black or other minority ethnic background (93%).

The Student Union representatives are also involved in health campaigns across the year. This team comprises six officers, voted in every October. This year's team conducted work around food availability on campus and ran consultations with both students and the catering team responsible for running the on site Deli. Work has been undertaken to map the healthy food available to students. Catering staff are keen to promote healthy eating, but as is the case with the University the canteen is a business and student demand will dictate what they serve. Resource availability has been cited as a limiting factor in the provision of fresh fruit and vegetables.

Recommendations

1 **Work to map the needs of the Kingston College and Kingston University populations in partnership with the National Union of Students to ensure health promotion interventions are appropriate and targeted.**

2 **Consider the provision of more frequent health events at the university, with support from public health.**

3 **Consider developing support for food labelling (calorie and nutritional content) alongside public health marketing materials for healthy eating to influence student tastes and preferences and therefore demand.**

4 **Improve communication and engagement between the Student Unions and Public Health teams.**

5 **Support Kingston College and Kingston University to engage in health promoting networks and incentives such as the Healthy Catering awards, the UK Healthy Universities Network and the Healthy FE Programme.**

4.5 Workplace health

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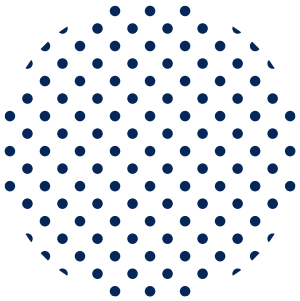
Introduction

A healthy workplace improves the quality of life for the people who work there and also increases productivity[49]. The London Healthy Workplace Charter (LHWC) is coordinated by the Greater London Authority and is an opportunity for employers to demonstrate their commitment to the health and wellbeing of their workforce. The Charter is an assessment framework that provides a series of standards for workplaces to meet under different key headings which include physical activity, healthy eating and alcohol.

Physical activity

An environment which supports and encourages employees to be physically active as part of the working day (and during their leisure time) offers a number of benefits for individuals and organisations. Physically active employees are less likely to suffer from major health problems and have an accident at work[50]. Physical activity programmes at work have been found to reduce sickness absence with physically active workers taking 27% fewer sick days[51,52]. There are further benefits for organisations and individuals highlighted in table 1.



Physically active employees are less likely to suffer from major health problems and have an accident at work . Physical activity programmes at work have been found to reduce sickness absence with physically active workers taking 27% fewer sick days[51,52].

Table 1 Employee and organisational benefits from physical activity[53, 54].

Employee Benefits*	Organisational Benefits
Up to 35% lower risk of Coronary Heart Disease	Reduction in sickness absence
Up to 50% lower risk of type 2 diabetes	Greater employee satisfaction
Up to 50% lower risk of colon cancer	Reduced staff turnover
Up to 20% lower risk of breast cancer	Increased productivity
30% lower risk of early death	Enhanced company reputation
Up to 83% lower risk of osteoporosis	Improved team working
Up to 30% lower risk of depression	
Up to 30% lower risk of dementia	

*Examples of selected benefits, not an exhaustive list.

Healthy eating

Diet related ill health is one of the top burdens on the UK economy and an issue every employer should be concerned about. If current trends continue, levels of working age adults who are overweight or obese will rise to approximately 90% in men and 80% in women by 2050[55]. Employees classified as 'obese' take more sickness absence (on average an extra four days a year) than workers who are a healthy weight[56, 57].

Employees consume around a third of their daily calorie intake while at work and therefore businesses have a unique opportunity to shape an environment which supports staff to make healthier food and drink choices. The greater the investment in good nutrition the greater the potential benefits for the health status of workers.

Research shows that employees who had a healthy diet had 25% higher job performance than those with a poor diet and those who ate five or more servings of fruit and vegetables at least four times a week were 20% more productive than those who ate less than this amount[58]. Good hydration contributes to workers' health and safety. Even mild levels of dehydration adversely affect both physical and mental performance[59].

Alcohol in the workplace

The International Labour Organisation recognises that up to 25% of staff in large workforces may be drinking alcohol in a way which puts their health at risk[60]. Studies have found that around 77% of employers are concerned about alcohol, given the threat it poses to employee wellbeing and its links to absenteeism[61]. Up to 17 million working days are lost each year in the UK due to alcohol related illness, costing employers an estimated £1.7 billion[62].

Alcohol is linked to problems in the workplace and subsequent unemployment which can result in additional pressure on families. Numerous studies have shown that excessive drinking outside of working hours can have the following long term effects on employee performance[63]:

- absenteeism
- inefficiency
- poor decision making
- damaged customer relations
- procrastination
- inconsistent performance
- neglect of detail
- poorer quality of work
- less quantity of work
- more frequent mistakes.

The Faculty of Public Health notes that

> "the workplace is a good place to identify alcohol and substance misuse problems at an early stage, through observing changes in work performance and behaviour. Early detection of substance misuse can prevent a serious problem developing and is more likely to lead to successful treatment and rehabilitation"[64].

Local picture

Kingston has a wide variety of employers with the majority of these being smaller businesses with less than 85 employees. Within Kingston there are 6,445 micro businesses (less than nine employees) and 515 small businesses (ten - 49 employees) compared with 115 businesses with greater than 85 employees[65]. This provides a challenge to local workplace health as although small enterprises may be interested in improving their employees' health, it is harder for them to engage with the health programmes being offered. Problems occur due to the inability to release staff for health related activities given that aspects of the business may have to be put on hold as a result. These businesses also do not have the buying power of larger organisations to provide corporate schemes such as bike purchasing or reduced gym membership.

The London Healthy Workplace Charter (LHWC) seeks to help all employers improve the health of their workplace. Kingston Council has reached "achievement level" and it encourages staff to incorporate an hour of exercise into their day. Some of the options are highlighted in table 2.

Table 2 Example of activities advertised to Kingston Council staff.

	Monday	Tuesday	Wednesday	Thursday	Friday
Before work		High Intensity Training		High Intensity Training	
Lunchtime			Mind and Body		Pilates
After work			Back 2 Netball Running Club	Badminton	

Local action

London Healthy Workplace Charter

The council's Public Health team have championed the LHWC since its inception and continue to promote this agenda through onward communications of LHWC related initiatives, campaigns and events to the business community.

Members of the Public Health team organised events at Your Healthcare CIC, Sitel, Kingston College, New England Seafood and Kingston University to raise awareness of the benefits of physical activity and healthy eating, and to provide advice around drugs, alcohol and mental health. Other organisations including the Kick It Stop Smoking Service and the Kingston Council Active Travel team were invited to promote their services at these staff events.

Through the LHWC employees are encouraged to be healthier during the working day by such means as posters promoting the eatwell plate, 5-a-day, heart healthy foods, Change4Life campaigns and the NHS Choices website which provides tips and tools centred around healthy eating, as well as information recommending that employees move away from their workstation at lunchtimes.

During the pilot stage of the LHWC, interviews with employers took place and it was felt that the Charter was a useful framework that supported the assessment of health and wellbeing strategies, in addition to recognising existing initiatives. It helps identify gaps and supports understanding of what more needs to take place in terms of supporting health at work.

Actions taken by local employers as a result of working towards the Charter standards include:

- investment in more formal management training
- development of health at work action plans
- establishment of health at work working groups
- policy reviews
- establishing senior management ownership on health at work
- introduction of healthy eating initiatives.

Staff from three local organisations (Balance, YMCA LSW and Kingston Voluntary Action) have participated in a video available on the LHWC website explaining how the Charter has helped improve wellbeing in their workplaces. The link is: **http://www.london.gov.uk/priorities/health/focus-issues/health-work-and-wellbeing**

These organisations have noticed that staff have benefited from initiatives such as bicycle hire schemes, lunchtime walks and staff sports days undertaken as a part of the work undertaken through the Charter. It has also enabled staff to socially interact more with one another so improving cohesion between teams and colleagues.

As at September 2015, 14 Kingston employers have gained the London Healthy Workplace Charter award so far and four more are working towards the next level of award in October 2015 (tables 3a and 3b).

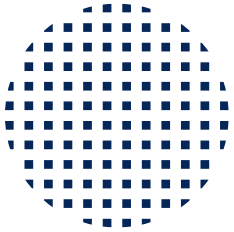


Table 3a Kingston workplaces involved in LHWC, organisations and award level.

Organisation	Award Level
Balance CIC	Commit
Coleman Solicitors	Excellence
Imagotech Media	Commit
Kingston Centre for Independent Living	Commit
Kingston Council	Achievement
Kingston Hospital	Excellence
New England Seafood	Excellence
Parabola Software	Commit
Sitel	Achievement
Wolters Kluwer Publishing	Achievement
Kingston Voluntary Action	Commit
Kingston YMCA	Commit
Kingston CCG	Commit
Your Healthcare CIC	Commit

Table 3b Organisations working towards October 2015 awards.

Organisation	Award Level
Databac	Commit
Mind in Kingston	Commit
Your Healthcare CIC	Achieve
Kingston Voluntary Action	Achieve

Workplace Challenge

The Workplace Challenge is a national programme organised by county sports partnership networks with core funding from Sport England and the National Lottery which aims to engage workplaces in sport and physical activity. Kingston workplaces are participating in this programme. The Challenge has a free website (**http://www.workplacechallenge.org.uk/**) where employees sign up to log activity, enter challenges and take part in local supporting activities such as the Richmond 10 km run.

Recommendations

1 **Continue to encourage local businesses to participate in the London Healthy Workplace Charter.**

2 **Encourage greater uptake and interaction with the Workplace Challenge.**

3 **Encourage workplaces to remove vending machines or replace products with healthier choices such as dried fruit, nuts and seeds.**

4 **Inform businesses about the importance of addressing alcohol misuse.**

4.6 Food and alcohol in a sports culture

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Introduction

Sport clubs: alcohol and food provision

Sports clubs contribute to making communities healthier by providing a range of physical activity opportunities. However, some businesses can have a negative impact on health by selling alcohol and unhealthy food and it is here that the contradiction can lie. As part of the sports culture, sports clubs usually serve food (often unhealthy) and alcohol for after-match meals and social occasions. This can be through community cafes, bars, and vending machines or other forms of food provision such as burger vans on site.

Sport clubs and venues therefore run the risk of providing inconsistent health messages and encouraging unhealthy habits. Even where food and alcohol is not provided, advertising at sports clubs is evident. The drinks company AB InBev reported that sales of Budweiser beer increased by nearly 19% during the 2010 FIFA World Cup, where it was an official sponsor, in comparison with the same period in the previous year[66]. At the most recent Olympic Games in London 2012, the biggest sponsors were McDonald's, Coca-Cola and Cadbury, all of which provide and promote unhealthy food[67].

The social relationship between sport, alcohol and food

Food promotion influences children's food preferences, as well as their own and their parents purchasing behaviour and consumption[68, 69]. The link at sports clubs of unhealthy food and physical activity can therefore prime children to think that by being active they can eat unhealthy foods[67].

Promotion at sports clubs usually extends to alcohol, with half of children associating their favourite football team and tournament with the beer brands that they are sponsored by; 47% of children associate Carlsberg beer with the English national football team[70]. Evidence shows that exposure to alcohol marketing encourages children to drink at an earlier age and in greater quantities than they otherwise would. The Science Committee of the European Alcohol and Health Forum concluded in 2009 that "alcohol marketing increases the likelihood that adolescents will consume more alcohol if they are already drinking alcohol"[71]. In addition it is the case that at both at the professional and non-professional level, sports players and fans report consuming alcohol at greater levels than people not involved in sports[71].

However, this relationship can be used in a positive way. People trust and believe that sport clubs are supportive of health and this platform has started to be used across the UK for health initiatives such as weight management programmes for male sport fans[72, 73] as a means of increasing uptake as men are routinely under represented in more traditional weight loss programmes. These sports clubs based programmes cover nutrition, alcohol and physical activity, with an average weight loss of 5% indicating that they are clinically effective.

Evidence shows that exposure to alcohol marketing encourages children to drink at an earlier age and in greater quantities than they otherwise would.

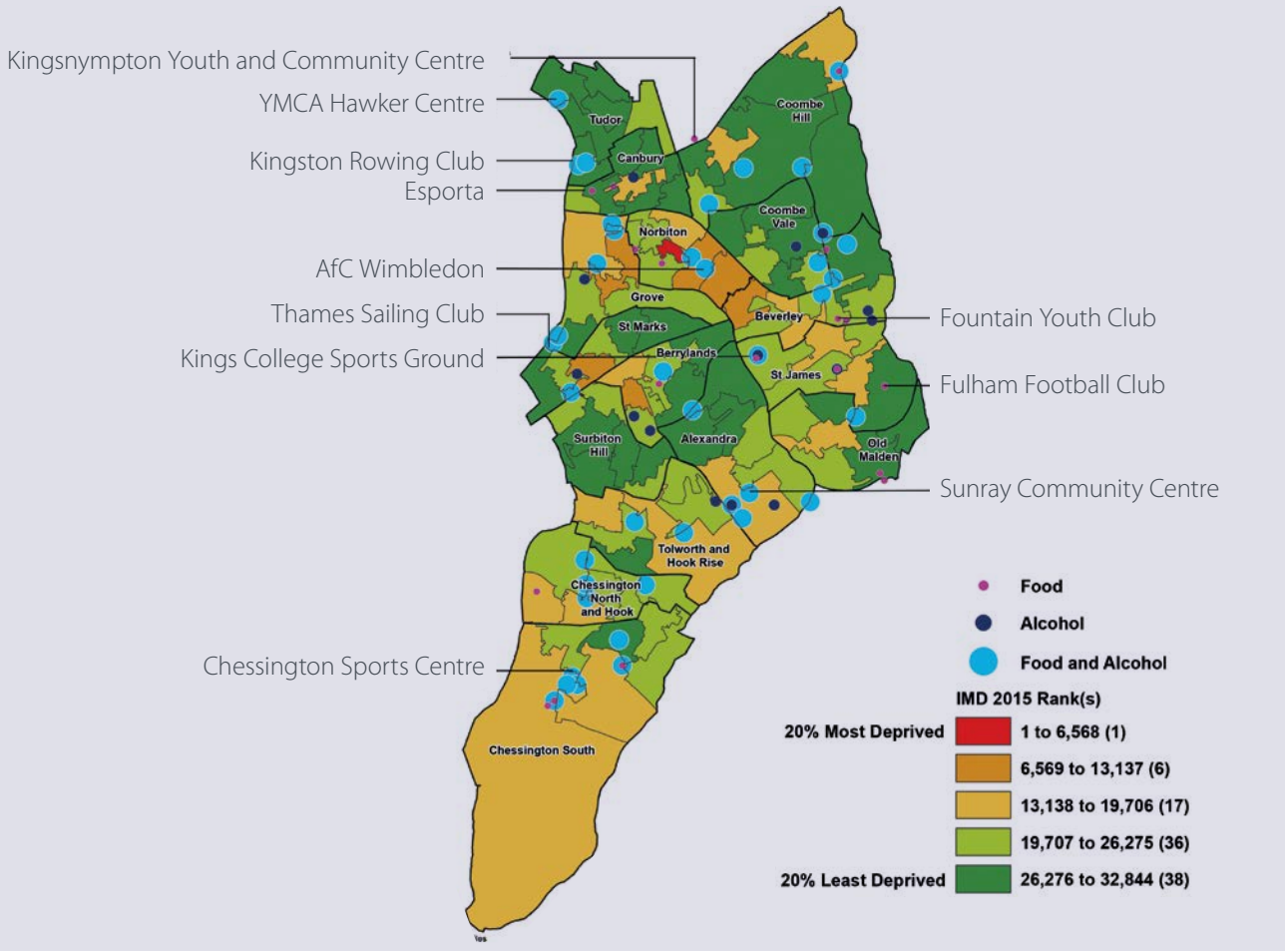
Local picture

At all the Council run leisure centres there are cafes operating on site serving fresh meals, and vending machines selling snack foods and drinks, with approximately four vending machines at each site.

Within Kingston 60 sports clubs (out of over 100) have a license to sell alcohol and 59 serve food and soft drinks. Figure 1 shows where sports clubs are serving food only, food and alcohol, or alcohol only. The type of food served at the clubs is not known, and the number of sports clubs that have vending machines is also not known.

It is reasonable to assume that many clubs will be offering unhealthy food choices, whether through cafes, restaurants, tuck shops or vending machines[67, 74], providing instant opportunities to eat and drink to club members. In addition while some local sport clubs do not serve food and/ or alcohol, there are plentiful opportunities to purchase food and alcohol at venues close to sport clubs.

Figure 1 Kingston sports clubs serving food, alcohol, or both food and alcohol.



Local action

Healthier Catering Commitment

The Healthier Catering Commitment (HCC) is discussed in chapter 1.9 and has been awarded to Kingfisher Leisure Centre (run by Places for People Leisure, PfPL), the two YMCA LSW sites (Surbiton and Hawker Centre) and Kingston University, all of whom run sports clubs. By ensuring the available catering meets the HCC standards, these centres are encouraging their sports participants to make healthier choices after exercise.

Leisure Centre vending provision

Consideration has been given to improving the vending provision in PfPL leisure centres by providing healthier options for people who exercise outside of cafe hours and therefore use the vending machines instead of the cafes that have achieved HCC status. However, further discussions around funding are required for this to progress any further due to the economic impact of a potential loss in sales due to the culture of choosing something 'comforting' rather than healthy after exercise.

Fulham Football Club Foundation

Fulham Football Club Foundation runs a Health Champions programme across a number of boroughs including Kingston that uses the context of football to educate on key health and wellbeing topics for vulnerable groups. The programme educates school children in years 5 and 6 about nutrition, health and wellbeing and the importance of exercise. Since Health Champions was established in 2012 the programme has engaged with 563 participants, of which 100% have reported increased knowledge on healthy eating and 93% reported an increase in physical activity. Programmes like this with strong messages about both healthy eating and physical activity can help to counter the messages that being active enables people to make unhealthy diet choices.

Recommendations

1 **Continue to work with the Community Sport and Physical Activity Network (CSPAN) partners on improving healthy food provision at sports clubs.**

2 **Continue to encourage commitment to the Public Health Responsibility Deal and celebrate local success where sports clubs are promoting consistent health messages on physical activity, alcohol and diet.**

3 **Explore mapping of all leisure centres' and sports clubs' alcohol and food provision, including snack bars, tuck shops and vending machines, to ensure a comprehensive map can be devised to improve their food provision and support people to make healthier choices.**

4 **Work towards getting all leisure centres accredited with the Healthier Catering Commitment award and expand to other sports club settings serving food.**

4.7 Planning and licensing

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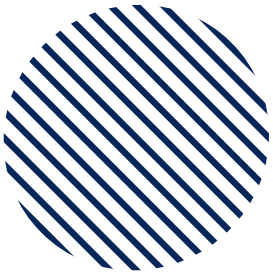
Introduction

Creating places that promote healthy lifestyles has long been identified as a precondition for improving health and wellbeing for individuals and the communities in which they live. The planning system has a key role to play in creating healthy places.

The National Planning Policy Framework (NPPF) sets out how planning contributes to promoting good design and sustainable places so improving the conditions in which people live, work, travel and take leisure[75]. Good design and good planning can help reduce healthcare costs over time by reducing health risks associated with issues such as worklessness, isolation, lengthy and time consuming travel to work, poor access to community facilities and poor quality housing[75].

Good design and good planning can help reduce healthcare costs over time by reducing health risks associated with issues such as worklessness, isolation, lengthy and time consuming travel to work, poor access to community facilities and poor quality housing[75].



Local picture

Locally the Council's planning policies aim to promote healthy, successful places for people to live, study, work and socialise by providing homes, jobs, and the services and facilities that people need.

The Kingston Core Strategy (as part of the Local Development Framework) was adopted in April 2012 and set out the development strategy over the next 15 years for the Borough. In order to create healthy and sustainable communities, the Marmot Review recommends a fully integrated planning system which includes housing, strategic policy, transport and neighbourhood plans[76]. The Core Strategy (together with the London Plan) is the overarching development plan that draws these strands together.

The Core Strategy and diet, physical activity and alcohol

The Core Strategy's area based spatial planning strategies and thematic policies seek to promote healthy sustainable living. They impact on diet, physical exercise and alcohol consumption in many ways, so reflecting the cross-cutting nature of planning policy.

A recommendation from the 2014 Public Health Annual Report was to undertake Health Impact Assessments (HIAs) for all major development proposals. A HIA helps evaluate the potential health effects of a project or policy before it is built or implemented. It can make recommendations to increase positive health outcomes and reduce or mitigate adverse health outcomes. HIAs bring potential public health impacts to the decision making process to add health outcome value to the consideration of land and amenity use.

The Core Strategy also outlines how proposals will be supported to promote healthy, safe and active living, particularly for those living in disadvantaged communities. The Core Strategy (Theme three: Safe, Healthy and Strong – Healthy and Safer Communities) recognises the contribution that can be made to influence the promotion of recreation and exercise and preventing ill-health, including through:

- The provision of more sporting and recreational facilities and access to open space to create more opportunities for physical exercise and active travel (Policies CS3, DM5 and CS6).
- Reducing the need to travel by protecting and enhancing the availability of employment and key facilities including shops, healthcare and leisure facilities conveniently distributed to serve local communities (Policy CS5).
- Improving community safety to reduce the negative effects of alcohol misuse and manage the night-time economy in accordance with the After Dark Strategy (Policy CS14).
- Resisting concentrations of uses such as pubs, clubs and hot food takeaways with the propensity to generate late night noise and disturbance (Policy DM22).
- Supporting the provision of new community facilities - including pubs and leisure centres - and resist their loss (Policies CS16 and DM24) recognising the important social role played by such facilities.

The Core Strategy and transport

Kingston's strategic road network, including the A3, carries large volumes of traffic that cause peak hour congestion on several key routes including the approaches to and from Kingston town centre.

There has been a reduction in traffic volumes on Kingston's roads since 2001 mainly as a result of the introduction of measures to both improve sustainable transport options and appropriately manage car parking.

To encourage a shift to sustainable modes of travel, the Core Strategy outlines how the Council will:

- protect and enhance the availability of employment and key facilities including shops, healthcare and leisure facilities within local communities
- locate major trip generating development in accessible locations well served by public transport including Surbiton, New Malden, Tolworth and Kingston town centres.

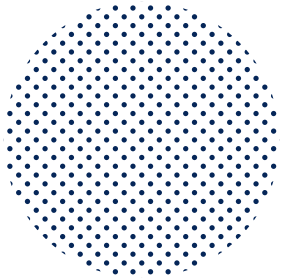
To support and encourage the use of public transport, cycling and walking the Core Strategy outlines how the Council will:

- promote and enhance the strategic cycling and walking networks
- enhance and promote Kingston's network of quiet residential roads, traffic free routes and open spaces as attractive, safe and convenient walking and cycle routes
- provide infrastructure, including cycle lanes and crossing facilities, to overcome barriers to the safety and convenience of cycling and walking trips
- tackle bike theft and provide adequate, secure and convenient cycle parking
- promote cycling and walking including through school and workplace travel plans and provide supporting measures such as cyclist training.

Licensing

With regard to the licensing of premises, legislation provides for applications involving alcohol to be tested against four licensing objectives:

- prevention of crime and disorder
- public nuisance
- public safety
- protecting children from harm.



There has been a reduction in traffic volumes on Kingston's roads since 2001 mainly as a result of the introduction of measures to both improve sustainable transport options and appropriately manage car parking.

Local action

Planning Policy

The Health Impacts policy in the Core Strategy (Policy DM21) seeks to resist the loss of healthcare facilities and seeks to support proposals for new healthcare facilities when certain conditions are met (such as in areas of identified need, with accessible sustainable transport links and no adverse impact on traffic or the environment, alongside other community facilities), resist the concentration of hot food takeaways close to schools; supports proposals that promote health, safety and active living for all age groups, particularly in areas of health inequality, and requires the submission of HIAs for all major planning applications.

Since the adoption of the Core Strategy in 2012 the Council has prepared three supplementary planning documents (SPDs) that provide guidance as to how the policies in the Core Strategy should be implemented.

The Sustainable Transport SPD explains how walking, cycling and public transport should be incorporated into all development proposals to maximise access to and from a site, providing better links to key facilities and services. This will help achieve the objective set out in the Core Strategy of reducing the need to travel by locating developments in sustainable locations.

The Residential Design SPD provides guidance to developers on key aspects of design for different types of housing (such as access to green spaces and cycle storage) seeking to ensure these are appropriately located and well designed for healthy living.

The Community Infrastructure Levy (CIL) Charging Schedule will, when adopted, allow the Council to collect and pool contributions from developers that will be used to fund essential new infrastructure. This could include the provision of local health centre facilities. Planning obligations secured under the Town and Country Planning Act 1990 (Section 106 agreements, S106) currently provide an opportunity to fund infrastructure in line with the priorities identified in the Core Strategy.

Planning Applications

The Development Management service review applications, seeking to maximise the benefits from all developments for residents, workers and visitors to Kingston and to protect and enhance the environment.

Recent planning permissions that provide facilities that support the health agenda include the refurbishment of the former Gala Bingo building on Richmond Road that will provide a new cinema, dance studio, and children's play centre supporting the recreation and leisure needs of residents and visitors alike.

An example of where a HIA has been requested and submitted in support of an application is the housing scheme that is enabling development for significant improvements at Tolworth Girls' School. The HIA identified that the existing provision of health centres in the area was sufficient to meet the additional needs that would be required as a result of the development thus ensuring any planning obligation benefits could be targeted at other needed infrastructure, in this case affordable housing.

Another example of where the HIA process has been undertaken is the proposed redevelopment of the Hotel Antoinette for the provision of housing. The Public Health team reviewed the HIA and supported the space and accessibility standards proposed for the housing, identified the type of health infrastructure that S106 contributions should be targeted towards and identified several ways that the development could do more to build healthy and sustainable communities. The proposal's lack of permeability to and through the site for other local residents was identified as an issue that needed to be addressed, as it would diminish community cohesion and discourage activities beneficial to improving public health and wellbeing such as walking, cycling and social interaction.

Development Management continue to negotiate financial contributions from all major developments towards sustainable transport, public realm, health and social care facilities and education. These contributions are utilised by the Council to deliver improved infrastructure benefits for the community and ensure that any negative impacts from development are adequately mitigated.

Licensing Policy

There is an ongoing review of the Statement of Licensing Policy that aims to promote a wider choice of licensed venue types that are less dominated by alcohol. The proposals in the policy are largely linked to perceptions around crime and disorder, but it can be argued that it also has associated health impacts by reducing the opportunity for binge drinking and the availability of cheap alcohol. The policy is currently at the mid-consultation point with decisions by members around its themes and policy statements likely to be made in 2016.

Recommendations

1 **Ensure the provision of technical Public Health support for the review of Health Impact Assessments (HIA) for major planning applications.**

2 **Make the case for the Community Infrastructure Levy (CIL) Infrastructure List to include general or specific items of health benefiting or health facility infrastructure.**

3 **Continue to lobby the Greater London Authority for key sub-regional infrastructure provision such as Crossrail 2.**

4 **Explore the benefits of introducing a Public Health focussed Supplementary Planning document to ensure healthy practices are adopted such as ensuring no fast food establishments can be approved within 400m of a school.**

5 **Work to ensure the review of the Statement of Licensing Policy maximises the opportunity to improve health by reducing the opportunity for binge drinking and the availability of cheap alcohol, and upholds the four licensing objectives and their wider public health impact.**

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5.0 Demography

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Introduction

Demographic changes have significant impact on the health of the population and its need for health and related services. The age structure of the population has a major impact on health service costs, with children and (especially) older people being the highest users of these services. Other demographic factors affecting use of health care services are the migration of people into and out of the area and the different ethnic backgrounds of the population. For example, the prevalence of diabetes is between two and a half and five times higher among South Asian groups than the White population and it tends to develop at a younger age[1].

This chapter provides a snapshot of the demographic factors affecting the health of the population of Kingston. Information is presented on demographic changes, risk factors, prevalence of different health conditions, social determinants of health, provision of health services and deaths. Some of the key facts are shown overleaf in box 1.

Key Facts

Box 1

2014 Mid-year population estimates	169,958	**2029 Population projection**	181,600 – 194,300
2014 BME population	28.8%	**2029 BME projection**	36.9%
2014 Births	2,247	**2013 Deaths**	1,122
2011 - 13 Male life expectancy	81.3 years	**2011 - 13 Female life expectancy**	84.5 years
2011 - 13 Male healthy life expectancy	64.9 years	**2011 - 13 Female healthy life expectancy**	66.9 years
2013 Most common cause of male mortality	Cancers	**2013 Most common cause of female mortality**	Circulatory system diseases

Kingston population

The population of Kingston was estimated to be 169,958 as at the mid-year of 2014; this represents an increase of 3,165 (1.9%) from 166,793 in mid 2013 (table 1 overleaf and figure 1 on page 298).

The median age of the population (the age at which half the population is younger and half the population is older) in mid 2014 was 36.1 years.

The number of older people (aged 65 and over) continued to rise from 21,808 (13.1% of the total population) in mid-2013 to 22,504 (13.2%) in mid-2014. The number of children (birth to 17 years of age) increased from 35,693 (21.4%) to 36,760 (21.6%) during the same period whilst the number of adults (aged 18 to 64 years) increased from 109,292 in mid-2013 to 110,694 in mid-2014, although the percentage of the total population they comprised decreased from 65.5% to 65.1% (table 2 on page 297). Table 2 also details the population in these age groups from 2005 to 2014, demonstrating the gradual decrease in the percentage of the total population made up by working age adults.

Table 1 The age and gender structure of the population of Kingston in 2014.

	2014 Mid-year estimates			
	Age group	**Female**	**Male**	**Person**
Five year age groups	0 - 4	5,795	5,946	11,741
	5 - 9	5,323	5,497	10,820
	10 - 14	4,465	4,374	8,839
	15 - 19	4,751	4,594	9,345
	20 - 24	7,085	6,491	13,576
	25 - 29	6,580	6,673	13,253
	30 - 34	7,266	7,101	14,367
	35 - 39	6,937	6,928	13,865
	40 - 44	6,544	6,643	13,187
	45 - 49	5,952	5,983	11,935
	50 - 54	5,262	5,128	10,390
	55 - 59	4,246	4,345	8,591
	60 - 64	3,839	3,706	7,545
	65 - 69	3,693	3,394	7,087
	70 - 74	2,550	2,364	4,914
	75 - 79	2,174	1,773	3,947
	80 - 84	1,810	1,298	3,108
	85 - 89	1,275	783	2,058
	90 and over	998	392	1,390
All Ages		**86,545**	**83,413**	**169,958**
Primary school*	5 - 11	7,186	7,279	14,465
Secondary school*	11 - 18	7,119	7,019	14,138
16 and under	0 - 16	17,396	17,556	34,952
18 and under	0 - 18	19,210	19,399	38,609
Reproductive age (female)	15 - 44	39,163	-	-
Adults	18 - 64	55,719	54,975	110,694
Older people	65 and over	12,500	10,004	22,504

*please note that 11 year olds are counted in both rows.
Source: 2014 Mid-year population estimates, Office of National Statistics, 2015.

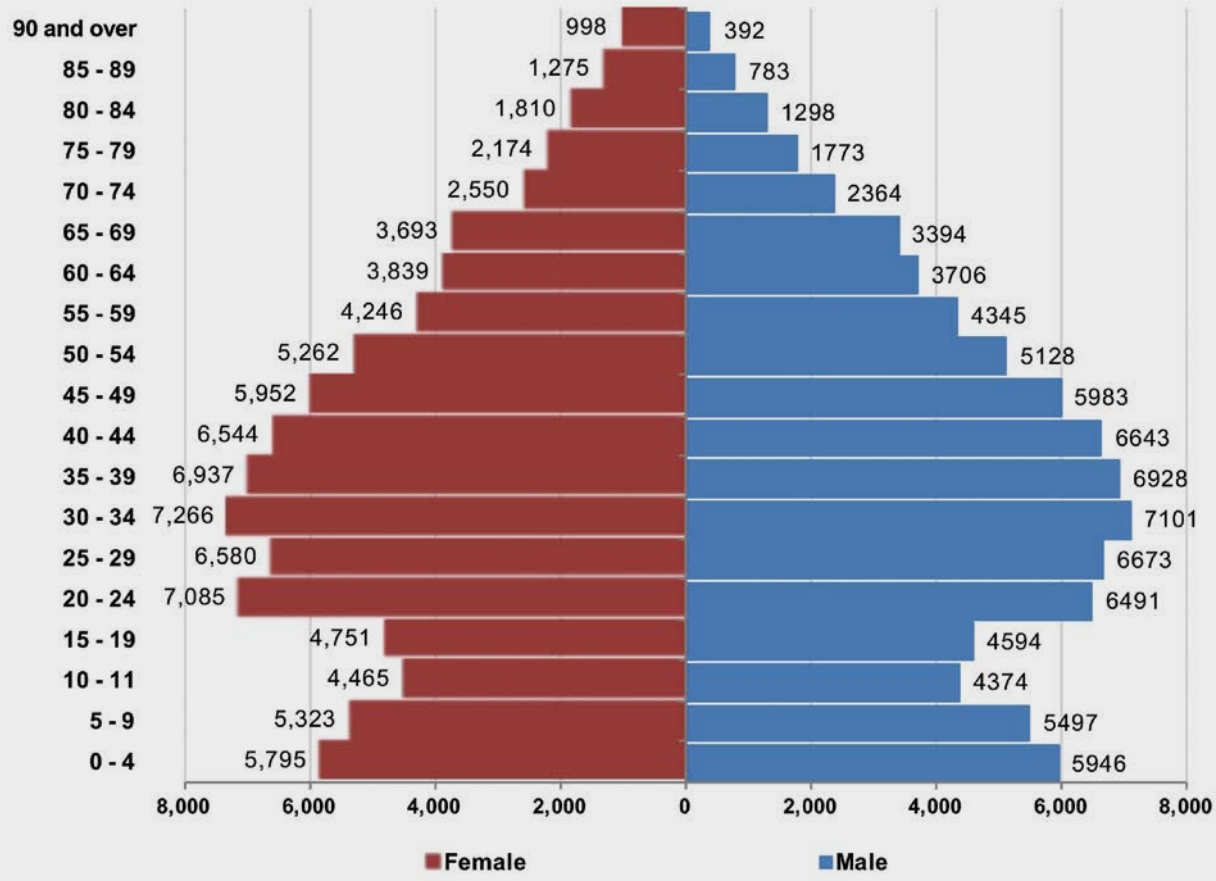
Table 2 Changes in the population of Kingston, 2005 - 14.

Mid-year estimates (number and percentage of total population)				
	Total	**0 to 17**	**18 to 64**	**65 and over**
2005	152,489	31,100 (20.39%)	102,122 (66.97%)	19,267 (12.64%)
2006	153,667	31,224 (20.32%)	103,343 (67.25%)	19,100 (12.43%)
2007	154,485	31,845 (20.61%)	103,509 (67.00%)	19,131 (12.38%)
2008	156,027	32,260 (20.68%)	104,332 (66.87%)	19,435 (12.46%)
2009	157,307	32,755 (20.82%)	104,857 (66.66%)	19,695 (12.52%)
2010	158,648	33,249 (20.96%)	105,318 (66.38%)	20,081 (12.66%)
2011	160,436	33,862 (21.11%)	106,069 (66.11%)	20,505 (12.78%)
2012	163,906	34,917 (21.30%)	107,730 (65.73%)	21,259 (12.97%)
2013	166,793	35,693 (21.40%)	109,292 (65.53%)	21,808 (13.07%)
2014	169,958	36,760 (21.63%)	110,694 (65.13%)	22,504 (13.24%)
Change in percentage of total population made up by age band over time				
Change between 2013 and 2014		0.23%	-0.40%	0.17%
Change between 2005 and 2014		1.23%	-1.84%	0.61%

Source: 2005 to 2014 Mid-year estimates, Office of National Statistics, 2015.

The population pyramid below (figure 1) shows the overall structure of Kingston's population in 2014 by age and gender.

Figure 1 2014 Mid-year population estimates for Kingston by age and gender.



Source: 2014 Mid-year population estimates, Office of National Statistics, 2015.

The change in the size of the population results from the interaction of births, deaths and migration. The increase in the population of Kingston from mid-2013 to mid-2014 was due to a natural increase of 1,178 people (2,169 births and 991 deaths), a net migration flow into Kingston of 1,948 people and a very small increase (39 people) due to other adjustments (table 3 overleaf).

Table 3 The components of population change in Kingston, 2014.

Components	Value
Estimated Population 2013	166,793
Births	2,169
Deaths	991
Internal Migration Inflow	*12,850*
Internal Migration Outflow	*13,038*
Internal Migration Net	-188
International Migration Inflow	*3,280*
International Migration Outflow	*1,144*
International Migration Net	2,136
Other Adjustments	39
Estimated Population 2014	169,958
Population Change	3,165

Source: 2014 Mid-year population estimates. Office of National Statistics, 2015.

Kingston Population Projections

The Greater London Authority (GLA) produces a range of annually updated population projections at Borough level. In general two groups of projection variants are produced; those based purely on trends in fertility, mortality and migration; and those that incorporate a forecast housing development trajectory. The projections discussed in this section are of the former type.

Two sets of population projections based on short term and longer term migration trends were released by the GLA to reflect the uncertainty about the number of people who will be migrating into and out of London Boroughs in the future. The short term variant assumes that recent migration patterns will persist for the duration of the projection period whilst the long term variant uses assumptions based on longer historical trends, where possible spanning multiple economic cycles. Using a long term trend has the advantage of yielding more stable projections. The bases for the trends used in short and long term scenarios are as follows:

- The short term migration scenario bases the volume of migration flows on estimates for the period mid-2008 to mid-2013. Age and sex characteristics for domestic flows are based on origin destination data from the 2011 Census.
- The long term migration scenario bases the volume of migration flows on estimates for the period mid-2001 to mid-2013. Age and sex characteristics for domestic flows are based on a combination of origin destination data from both the 2001 and 2011 Censuses.

For both projections the mortality and fertility methodologies are the same but the assumptions regarding the volume and characteristics of the migration flows vary. Kingston's total population is projected to rise from 168,900 in 2014 to 194,300 in 2029 (15.0%) in the short term migration variant and from 167,600 in 2014 to 181,600 in 2029 (8.4%) in the long term variant (tables 4 and 5 on pages 300 and 301 respectively).

Tables 4 and 5 show that the growth of the population of Kingston is not expected to be uniform across all age groups. The numbers of people aged 65 and over are projected to increase by 28.3% between 2014 and 2029 in the short term scenario and by 20.7% if the long term scenario is used. The population of children (from birth to 15 years) is predicted to grow in the short term scenario by 10.9% and in the long term scenario by 4.4% over the same period. The working age population (18 to 64 years) is also projected to increase during the same period by 13.1% in the short term migration scenario and 6.7% in the long term equivalent.

Table 4 The projected population of Kingston (short term migration scenario), 2014 – 29.

		Projections			
	Age group	**2014**	**2019**	**2024**	**2029**
Five year age groups	0 - 4	11,400	11,100	11,200	11,200
	5 - 9	10,300	11,300	11,000	11,200
	10 - 14	8,600	10,300	11,200	10,900
	15 - 19	9,600	9,500	11,000	11,800
	20 - 24	15,100	14,600	14,100	15,700
	25 - 29	13,400	14,600	14,200	13,700
	30 - 34	13,900	14,200	14,900	14,400
	35 - 39	13,700	14,500	14,700	15,200
	40 - 44	12,900	13,500	14,300	14,600
	45 - 49	11,900	12,700	13,100	13,900
	50 - 54	10,400	11,500	12,100	12,500
	55 - 59	8,400	9,700	10,700	11,200
	60 - 64	7,400	7,800	9,000	9,900
	65 - 69	7,000	6,600	6,900	8,000
	70 - 74	4,800	6,100	5,900	6,200
	75 - 79	3,900	4,200	5,500	5,300
	80 - 84	3,000	3,100	3,400	4,500
	85 - 89	2,100	2,100	2,300	2,600
	90 and over	1,100	1,100	1,300	1,600
All ages	**0 - 90 and over**	**168,900**	**178,500**	**186,800**	**194,300**
% Growth from (2014)	**0 - 90 and over**	**-**	**5.7%**	**10.6%**	**15.0%**
Primary school	5 - 11	13,900	15,700	15,500	15,600
Secondary school	11 - 18	13,900	15,200	17,600	17,800
16 and under	0 - 16	33,700	36,100	37,800	37,700
18 and under	0 - 18	37,500	39,800	42,000	42,400
Adults	18 - 64	111,500	117,300	121,700	126,100
Older people	65 and over	21,900	23,300	25,300	28,100

Source: 2014 Round of Demographic Projections - Trend-based population projections, short-term migration scenario, 2015.
 Note: Figures may not add due to rounding.

Table 5 The projected population of Kingston (long term migration scenario), 2014 – 29.

		Projections			
	Age group	**2014**	**2019**	**2024**	**2029**
Five year age groups	0 - 4	11,300	10,700	10,600	10,500
	5 - 9	10,200	10,900	10,400	10,400
	10 - 14	8,500	9,900	10,600	10,200
	15 - 19	9,500	9,200	10,500	11,200
	20 - 24	15,400	14,500	13,900	15,300
	25 - 29	13,200	14,100	13,500	12,900
	30 - 34	13,700	13,400	13,900	13,400
	35 - 39	13,600	13,700	13,600	14,100
	40 - 44	12,800	13,000	13,400	13,300
	45 - 49	11,800	12,200	12,400	12,800
	50 - 54	10,300	11,200	11,500	11,600
	55 - 59	8,300	9,400	10,200	10,400
	60 - 64	7,300	7,500	8,500	9,200
	65 - 69	6,900	6,400	6,500	7,400
	70 - 74	4,700	5,900	5,500	5,700
	75 - 79	3,900	4,100	5,200	4,900
	80 - 84	3,000	3,000	3,300	4,200
	85 - 89	2,100	2,100	2,200	2,500
	90 and over	1,100	1,100	1,300	1,600
All ages	**0 - 90 and over**	**167,600**	**172,300**	**177,000**	**181,600**
% Growth from (2014)	**0 - 90 and over**	**-**	**2.7%**	**5.5%**	**8.3%**
Primary school	5 - 11	13,700	15,200	14,600	14,500
Secondary School	11 - 18	13,800	14,700	16,700	16,600
16 and under	0 - 16	33,400	34,900	35,700	35,200
18 and under	0 - 18	37,200	38,400	39,800	39,600
Adults	18 - 64	110,700	113,100	115,200	118,100
Older people	65 and over	21,700	22,600	24,000	26,200

Source: 2014 Round of Demographic Projections - Trend-based population projections, long-term migration scenario, 2015.
 Note: Figures may not add due to rounding.

Ethnicity

Table 6 (below) and figure 2 (on page 304) show the projected ethnic composition for the population of Kingston in 2014.

Table 6 The ethnic compositions of the population of Kingston in 2014.

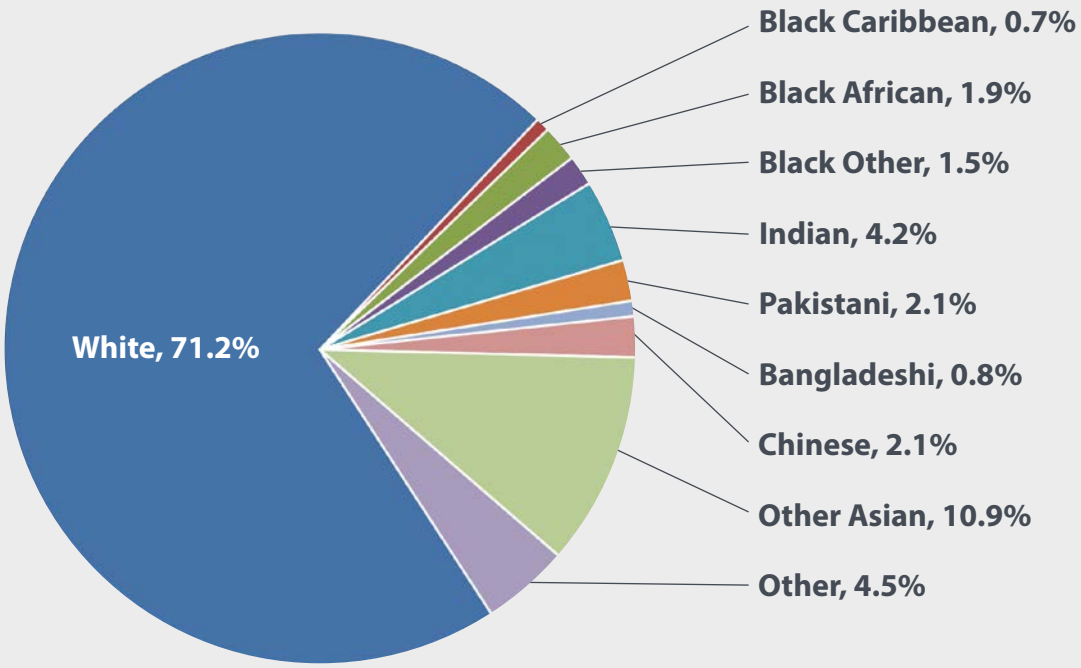
	All ethnicities	White	Black Caribbean	Black African	Black Other
0 - 4	11,283	6,945	57	274	430
5 - 9	10,234	6,356	52	220	397
10 - 14	8,491	5,367	42	190	259
15 - 19	9,546	6,482	53	199	204
20 - 24	15,364	10,109	184	451	350
25 - 29	13,201	8,484	111	371	237
30 - 34	13,662	9,287	100	297	171
35 - 39	13,577	9,475	74	297	115
40 - 44	12,831	9,104	97	257	117
45 - 49	11,823	8,726	112	207	100
50 - 54	10,270	7,798	111	162	77
55 - 59	8,325	6,488	63	84	42
60 - 64	7,332	6,000	31	50	28
65 - 69	6,896	5,829	24	48	25
70 - 74	4,742	3,946	38	19	17
75 - 79	3,861	3,317	22	15	12
80 - 84	3,012	2,714	5	*	8
85 - 89	2,075	1,919	12	*	*
90 and over	1,145	1,093	*	*	*
All Ages	**167,667**	**119,441**	**1,194**	**3,146**	**2,597**
%		**71.2%**	**0.7%**	**1.9%**	**1.5%**
5 - 11	13,748	8,506	72	294	506
11 - 18	13,847	9,110	69	313	357
16 and under	33,446	20,980	168	762	1,160
18 and under	37,192	23,519	189	845	1,243
15 - 44 Reproductive age (female)	39,406	26,819	364	935	635
18 - 64	110,703	78,412	909	2,254	1,328
65 and over	21,731	18,818	105	88	66

Note: Figures may not add up due to rounding. *Denotes suppressed numbers (less than 5).

Source: 2014 Round of Demographic Projections, Local authority population projections for 2014. Trend-based ethnic group projections, long term migration scenario, 2015. © GLA 2014 Round Demographic Projections, 2015.

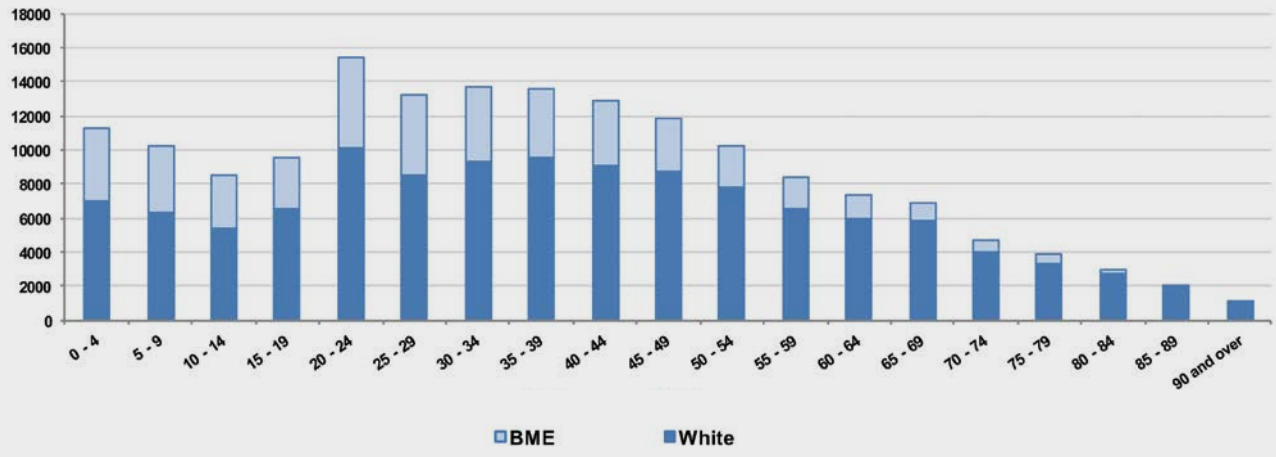
Indian	Pakistani	Bangladeshi	Chinese	Other Asian	Other	BME Total
406	325	109	156	1,738	842	4,339
350	328	105	106	1,669	649	3,877
310	268	70	96	1,409	482	3,124
344	275	83	188	1,226	492	3,063
706	374	233	575	1,550	833	5,255
706	312	167	532	1,438	838	4,716
759	340	175	389	1,488	657	4,375
671	269	126	274	1,701	572	4,102
568	254	87	209	1,615	523	3,728
470	199	45	193	1,381	389	3,096
391	165	30	198	1,002	334	2,472
357	113	36	171	706	266	1,838
295	77	23	157	495	174	1,332
243	77	14	96	362	176	1,068
212	58	11	59	241	142	796
156	52	10	34	148	95	544
90	19	*	27	98	42	299
40	6	*	13	55	28	156
10	*	*	5	20	8	52
7,085	**3,511**	**1,328**	**3,482**	**18,341**	**7,543**	**48,226**
4.2%	**2.1%**	**0.8%**	**2.1%**	**10.9%**	**4.5%**	**28.8%**
478	449	137	139	2,304	859	5,241
496	418	116	216	2,013	741	4,736
1,186	1,029	311	421	5,265	2,162	12,465
1,320	1,127	348	498	5,756	2,345	13,672
1,908	908	314	1,080	4,563	1,875	12,590
5,082	2,219	960	2,789	11,937	4,803	32,291
751	214	39	234	924	491	2,915

Figure 2 Key ethnic groups in Kingston, 2014.



Source: 2014 Round of Demographic Projections, Local authority population projections for 2014. Trend-based ethnic group projections, long term migration scenario, 2015. © GLA 2014 Round Demographic Projections, 2015.

Figure 3 The distribution of the ethnic minority population in Kingston by age group, 2014.



Source: 2014 Round of Demographic Projections, Local authority population projections for 2014. Trend-based ethnic group projections, long term migration scenario. © GLA 2014 Round Demographic Projections, 2015.

Figure 3 shows the ethnic composition of Kingston by age, showing that the proportion of the population made up by people of BME origin reduces with increasing age.

Projections of population of Kingston by ethnicity

Table 7 Projections of the population of Kingston by ethnicity, 2014 to 2029.

	2014	2019	2024	2029
White	119,441	116,332	114,883	114,653
Black Caribbean	1,194	1,369	1,497	1,599
Black African	3,146	3,751	4,222	4,580
Black Other	2,597	2,862	3,052	3,201
Indian	7,085	7,817	8,408	8,891
Pakistani	3,511	4,037	4,433	4,761
Bangladeshi	1,328	1,930	2,445	2,903
Chinese	3,482	4,040	4,461	4,791
Other Asian	18,341	21,294	23,643	25,518
Other	7,543	8,890	9,922	10,711
All ethnicities	**167,667**	**172,323**	**176,967**	**181,608**
BME	48,226	55,991	62,083	66,955
BME (%)	28.8%	32.5%	35.1%	36.9%

Note: Figures may not add up due to rounding.

Source: 2014 Round of Demographic Projections, Local authority population projections for 2014. Trend-based ethnic group projections, long term migration scenario. © GLA 2014 Round Demographic Projections, 2015.

Table 7 illustrates the projected change in the ethnic composition of the population of Kingston between 2014 and 2029. In 2029, the percentage of the total population made up of people of BME origin is projected to increase to 36.9% compared with 28.8% in 2014. The 'Other Asian' group is the largest BME community and is predicted to increase from 10.9% in 2014 to 14.1% in 2029.

Electoral Ward Population

The Royal Borough of Kingston is divided into 16 wards. The Greater London Authority (GLA) estimates of the electoral wards resident population showed that the wards with the highest number of residents in 2014 were Canbury and Grove. The average ward population size is projected to increase by approximately 11.9% between 2014 and 2029 but the population of all wards are not predicted to grow at the same rate.

The two wards that are estimated to experience the highest percentage growth rate are Grove and Tolworth and Hook Rise (table 8). In contrast, there will be very small increases in population in Tudor and Chessington North and Hook wards. These projections should be viewed with caution given that they are for small populations.

Table 8 Projections of electoral wards population, Kingston, 2014 - 29.

					% Change	% Change	% Change
	2014	2019	2024	2029	2014 - 2019	2014 - 2024	2014 - 2029
Alexandra	9,700	10,200	10,650	10,900	5.2%	9.8%	12.4%
Berrylands	10,100	10,400	10,700	10,900	3.0%	5.9%	7.9%
Beverley	10,650	11,300	11,800	12,000	6.1%	10.8%	12.7%
Canbury	13,300	14,550	15,000	15,300	9.4%	12.8%	15.0%
Chessington North and Hook	9,100	9,150	9,200	9,250	0.5%	1.1%	1.6%
Chessington South	10,700	11,000	11,500	11,900	2.8%	7.5%	11.2%
Coombe Hill	10,900	11,250	11,900	12,350	3.2%	9.2%	13.3%
Coombe Vale	10,100	10,350	10,450	10,550	2.5%	3.5%	4.5%
Grove	11,800	13,000	14,550	15,350	10.2%	23.3%	30.1%
Norbiton	10,800	11,250	11,700	12,700	4.2%	8.3%	17.6%
Old Malden	9,850	10,050	10,350	10,550	2.0%	5.1%	7.1%
St James	9,400	9,550	9,650	9,750	1.6%	2.7%	3.7%
St Mark's	11,250	11,650	11,950	12,300	3.6%	6.2%	9.3%
Surbiton Hill	11,000	11,400	11,800	11,950	3.6%	7.3%	8.6%
Tolworth and Hook Rise	10,400	11,650	12,750	13,250	12.0%	22.6%	27.4%
Tudor	9,950	10,200	10,150	10,100	2.5%	2.0%	1.5%
Kingston	**168,900**	**176,900**	**184,150**	**189,000**	-	-	-

Source: 2014 Round of Demographic Projections - Ward projections, SHLAA-based; short term migration assumption; Capped Household Size model. © Greater London Authority, 2015.

General Practice Population

A total of 199,666 people were registered with Kingston CCG general practices in April 2015 (table 9); an increase of 2,375 people over the previous year (March 2014). The total number of registered men (99,627) was slightly lower than the number of women (100,039).

Table 9 also compares the GP registered population with the resident population in Kingston. It shows that more people were registered with Kingston practices than those living in Kingston across all age groups and the numerical difference is at its highest in people aged 40 – 44 years.

Table 9 2014 Mid-year resident Kingston population estimates and Kingston CCG GP registered population, 31st March 2015.

Age Group	GP Registered	Resident	Difference
	(A)	(B)	(A - B)
0 – 4	12,673	11,741	932
5 – 9	12,418	10,820	1,598
10 – 14	10,506	8,839	1,667
15 – 19	11,092	9,345	1,747
20 - 24	16,050	13,576	2,474
25 - 29	15,312	13,253	2,059
30 - 34	16,601	14,367	2,234
35 - 39	16,848	13,865	2,983
40 – 44	16,365	13,187	3,178
45 – 49	14,773	11,935	2,838
50 – 54	12,822	10,390	2,432
55 – 59	10,231	8,591	1,640
60 – 64	8,567	7,545	1,022
65 – 69	8,153	7,087	1,066
70 – 74	5,679	4,914	765
75 – 79	4,472	3,947	525
80 – 84	3,399	3,108	291
85 – 89	2,249	2,058	191
90 and over	1,456	1,390	66
All ages	**199,666**	**169,958**	**29,708**

Source: Health and Social Care Information Centre, April 2015 for the GP Registered population.
2014 Mid-year Population Estimates for the resident population, Office of National Statistics, 2015.

Main Health Indicators

Birth

The number of births to Kingston residents in 2014 was 2,247. This was an increase of 135 (6.4%) from the 2013 figure of 2,112 but still below the number of births in 2012, which was 2,328.

The total period fertility rate (TPFR), which is the average number of live births that would occur per woman resident in an area, if that woman experienced her area's current age-specific fertility rates throughout her childbearing lifespan, was 1.6 for Kingston in 2014. This was below both the London rate of 1.7 and the England rate of 1.8.

The birth rates of Kingston women of different ages are shown in table 10 (please note that 2013 births are used as the breakdown by age for 2014 data was not available at the time of writing the report). The highest birth rate of 110.5 per 1,000 women occurred in women aged 30 to 34 years. Birth rates at older ages are associated with a higher level of risk for both mother and baby.

Key birth statistics for 2013 show that the percentage of Kingston mothers who were over 40 years of age increased from 6.7% in 2012 to 7.3% in 2013. The proportion of over 40 years old mothers also increased in London from 5.5% to 5.9% and in England from 4.1% to 4.2% during the same period.

The percentage of mothers under 20 years of age declined in Kingston from 1.6% in 2012 to 1.1% in 2013. Similarly, the London percentage decreased from 2.5% to 2.2% whilst the national prevalence increased slightly from 4.1% to 4.2% during the same period.

Low birth weight is the leading cause of infant mortality and is associated with chronic diseases later in life. A low birth weight infant weighs less than 2,500g. The percentage of live and still births weighing less than 2,500g was lower in Kingston in 2013 (7.2%) than the regional average (7.6%) but higher than the national average (7.1%).

Table 10 Live births (numbers and birth rates) by age of mother in Kingston, 2013.

Age groups	Number of births	Female population for the age group	Birth rate per 1,000 women
Under 18	9	2,743	3.3
Under 20	23	4,751	4.8
20 - 24	153	7,085	21.6
25 - 29	405	6,580	61.6
30 - 34	803	7,266	110.5
35 - 39	573	6,937	82.6
40 - 44	143	6,544	21.9
45 and over	12	5,952	2.0
All ages	2,112	39,163	53.9

Note: The rates for women of all ages, under 18, under 20 and 45 and over have been calculated using mid-2014 population estimates for the female population aged 15 - 44, 15 - 17, 15 - 19 and 45 - 49 respectively.

Source: The NHS Indicator Portal, 2015 and 2014 Mid-year population estimates, Office of National Statistics, 2015.

Infant Mortality

The infant mortality rate compares the number of deaths of infants under one year old in a given year per 1,000 live births. This rate is often used as an indicator of the level of health and wellbeing in an area.

There were eight infant deaths registered in Kingston in 2013, a decrease from 11 infant deaths in 2012. The infant mortality rate decreased in 2013 to 3.8 deaths per 1,000 live births, compared with 4.7 in 2012. The 2013 rate is below the England average (4.0 per 1,000) and the same as the London average.

There were nine stillbirths in Kingston in 2013, compared with five in 2012 and as a result the stillbirth rate increased from 2.1 per 1,000 live and stillbirths in 2012 to 4.2 in 2013. The latter rate is below both the London and England rates, which are 5.3 and 4.7 respectively.

Life Expectancy

Life expectancy is a common measure of the population's health and is often used as a summary measure when comparing groups of people living in different geographical areas. Life expectancy at birth indicates how long a person can expect to live on average given the prevailing mortality rates in that area.

Life expectancy at birth in England showed dramatic increases throughout the twentieth century as health and living conditions improved. Between 2000 and 2013 men's life expectancy increased in Kingston from 76.0 to 79.4 years and at the same time women's life expectancy has increased from 80.7 to 83.1 years. However, increases in life expectancy have not been uniform across all social groups.

Life expectancy has shown a noticeable increase for those in more affluent social groups whilst for those in the more deprived social groups there has been less progress. Reducing inequalities in life expectancy is one of the over-arching indicators in the current Public Health Outcomes Framework (PHOF).

Table 11 (overleaf) shows the life expectancy at birth and at 65 years between 2001 - 03 and 2011 - 13 in Kingston. In 2011 - 13, male and female life expectancy at birth in Kingston were 81.3 and 84.5 years respectively. These were above the London life expectancies of 80.0 years for men and 84.1 years for women and also above the England averages (male 79.4 years and female 83.1 years). The relative ranking of male life expectancy in Kingston has improved from being the 95th highest life expectancy in England in 2001 - 03 to occupying the 41st rank in 2011 - 13. During the same period, female life expectancy ranking rose from the 151st to the 67th rank.

Life expectancy at 65 years was 19.4 years for males living in Kingston and 21.7 years for females; above the England averages (male 18.7 years and female 21.1) but only above the London average for males (male 19.1 years and female 21.9). Kingston's life expectancy at age 65 rankings in 2011 - 13 was lower for both males and females in comparison with corresponding rankings for life expectancy at birth. Table 11 shows that the male ranking of life expectancy at age 65 rose from the 114th to the 91st rank over the last decade. The rank of female life expectancy in Kingston rose from 198th in 2001 - 03 to 114th in 2011 - 13.

Table 11 also shows that life expectancy at birth in 2011 - 13 declined by 0.1 year for males and 0.3 years for females from the 2010 - 12 figures. Life expectancy at age 65 in 2011 - 13 also declined from 2010 - 12 figures by 0.2 years for males and 0.4 years for females. Although these declines are not statistically significant these statistics merit careful observation in future years.

Table 11 Male and female life expectancy at birth and 65 (in years) for Kingston, 2001 - 03 to 2011 - 13.

	Life expectancy at birth			
Period	**Male**	**Female**	**Rank (Male)**	**Rank (Female)**
2001 - 03	77.7 (77.2 to 78.3)	81.3 (80.7 to 81.8)	95	151
2002 - 04	78.3 (77.7 to 78.8)	81.5 (81.0 to 82.1)	74	140
2003 - 05	78.4 (77.8 to 79.0)	82.2 (81.7 to 82.7)	88	91
2004 - 06	78.8 (78.3 to 79.4)	82.8 (82.3 to 83.3)	82	79
2005 - 07	79.1 (78.6 to 79.7)	83.1 (82.6 to 83.6)	87	75
2006 - 08	79.7 (79.2 to 80.3)	83.4 (82.8 to 83.9)	63	72
2007 - 09	80.3 (79.8 to 80.9)	83.7 (83.2 to 84.2)	42	61
2008 - 10	80.9 (80.3 to 81.4)	84.2 (83.7 to 84.7)	33	41
2009 - 11	81.1 (80.5 to 81.6)	84.5 (84.0 to 85.1)	38	49
2010 - 12	81.4 (80.8 to 81.9)	84.8 (84.3 to 85.3)	36	33
2011 - 13	81.3 (80.8 to 81.8)	84.5 (84.0 to 85.0)	41	67
London 2011 - 13	80.0 (80.0 to 80.1)	84.1 (84.0 to 84.2)	-	-
England 2011 - 13	79.4 (79.4 to 79.4)	83.1 (83.1 to 83.2)	-	-

Life expectancy at 65 years			
Male	**Female**	**Rank (Male)**	**Rank (Female)**
16.9 (16.5 to 17.3)	19.3 (18.9 to 19.6)	114	198
17.4 (17.0 to 17.8)	19.4 (19.1 to 19.8)	74	189
17.3 (16.9 to 17.7)	19.9 (19.6 to 20.3)	135	142
17.6 (17.2 to 18.1)	20.6 (20.3 to 21.0)	134	91
17.8 (17.4 to 18.3)	20.7 (20.4 to 21.1)	144	116
18.4 (18.0 to 18.8)	21.0 (20.6 to 21.3)	92	113
18.8 (18.4 to 19.3)	21.3 (20.9 to 21.7)	72	102
19.3 (18.9 to 19.7)	21.7 (21.4 to 22.1)	46	63
19.5 (19.0 to 19.9)	22.0 (21.6 to 22.4)	55	62
19.6 (19.2 to 20.0)	22.1 (21.7 to 22.4)	56	60
19.4 (19.0 to 19.8)	21.7 (21.4 to 22.1)	91	114
19.1 (19.0 to 19.1)	21.9 (21.8 to 22.0)	-	-
18.7 (18.7 to 18.7)	21.1 (21.1 to 21.1)	-	-

Note:
1. Values in brackets denote 95% confidence intervals.
2. Life expectancy figures presented to one decimal point. The rankings in this table reflect differences in unrounded numbers.
3. 1= Highest, 346= Lowest.
4. Three year rolling averages, based on deaths registered in calendar years and mid-year population estimates.

Source: Office of National Statistics, 2015.

Life expectancy at birth in England showed dramatic increases throughout the twentieth century as health and living conditions improved. Between 2000 and 2013 men's life expectancy increased in Kingston from 76.0 to 79.4 years and at the same time women's life expectancy has increased from 80.7 to 83.1 years.

Table 12 shows the life expectancy for people living in Kingston by ward. People living in Tudor have the highest life expectancy in Kingston (85.9 years) whilst those living in Norbiton have the lowest (78.8 years). Male life expectancy ranged from 77.1 years in Norbiton to 84.1 years in Tudor. Female life expectancy was also lowest in Norbiton (80.5 years) but highest in Old Malden (87.4 years).

Table 12 Life expectancy in years for males, females and persons in Kingston wards, 2009 - 13.

	2009 - 13		
	Male	**Female**	**Person**
Alexandra	83.4 (81.1 to 85.8)	86.9 (84.3 to 89.5)	85.2 (83.5 to 86.9)
Berrylands	79.0 (77.1 to 80.8)	83.3 (81.6 to 85.1)	81.2 (79.9 to 82.5)
Beverley	80.8 (79.1 to 82.6)	81.8 (80.3 to 83.3)	81.3 (80.2 to 82.4)
Canbury	81.0 (78.9 to 83.0)	85.8 (83.9 to 87.6)	83.4 (82.0 to 84.8)
Chessington North and Hook	80.4 (78.4 to 82.4)	86.8 (84.3 to 89.3)	83.7 (82.1 to 85.3)
Chessington South	83.3 (81.0 to 85.5)	83.9 (82.1 to 85.7)	83.5 (82.2 to 84.9)
Coombe Hill	83.2 (81.3 to 85.0)	84.8 (83.2 to 86.3)	84.0 (82.8 to 85.2)
Coombe Vale	82.9 (81.0 to 84.9)	86.1 (84.5 to 87.7)	84.6 (83.4 to 85.9)
Grove	79.2 (77.3 to 81.1)	87.2 (84.3 to 90.1)	83.1 (81.4 to 84.7)
Norbiton	77.1 (75.4 to 78.8)	80.5 (78.8 to 82.1)	78.8 (77.6 to 80.0)
Old Malden	83.6 (81.5 to 85.6)	87.4 (85.4 to 89.5)	85.5 (84.1 to 87.0)
St James	81.4 (79.9 to 83.0)	82.2 (80.2 to 84.1)	81.9 (80.6 to 83.1)
St Marks	81.7 (79.2 to 84.2)	84.3 (82.1 to 86.6)	83.0 (81.3 to 84.6)
Surbiton Hill	79.7 (78.0 to 81.5)	82.6 (81.3 to 84.0)	81.1 (80.0 to 82.2)
Tolworth and Hook Rise	80.3 (78.4to 82.2)	86.7 (84.3 to 89.1)	83.5 (82.0 to 85.0)
Tudor	84.1 (82.1 to 86.1)	87.2 (84.9 to 89.5)	85.9 (84.3 to 87.4)

Note:
1. Life expectancy figures are presented to one decimal place.
2. Values in brackets denote 95% confidence intervals.

Source: Office of National Statistics, 2015.

The healthy life expectancy[2] (HLE) for both males (64.9 years) and females (66.7 years) in the Borough were above the London (male 63.4 and female 63.8 years) and England (male 63.3 and female 63.9 years) averages (see table 13 overleaf).

Table 13 Healthy life expectancy (HLE) at birth for males and females in Kingston, London and England, 2010 - 12.

		Healthy life expectancy	Proportion of life spent in "Good" health (%)	HLE rank
		2010 - 12	2010 - 12	2010 - 12
Kingston	Male	64.9 (61.8 to 68.0)	79.8	43
	Female	66.7 (64.0 to 69.3)	78.9	26
London	Male	63.4 (62.9 to 63.9)	79.2	-
	Female	63.8 (63.3 to 64.3)	75.9	-
England	Male	63.3 (63.1 to 63.4)	79.7	-
	Female	63.9 (63.8 to 64.1)	76.9	-

Note:
1. The healthy life expectancy (HLE) at birth measure is only calculated for upper tier local authorities. There are 150 upper tier local authorities in England and therefore out of these, the healthy life expectancy rank at birth for Kingston was 43rd for males and 26th for females.
2. HLE estimates were calculated by combining the prevalence of "Good" general health across the upper tier local authorities and English regions with mortality data and mid-year population estimates (MYPE) in the period 2011 to 2013. The health prevalence data used in calculating HLE estimates for the various geographies in England were derived from the Annual Population Survey (APS).
3. Excludes residents of communal establishments except NHS housing and students in halls of residence where inclusion takes place at their parents' address.
4. Age 65 has been used as the state pension age for females where it will be by 2018.
5. Values in brackets denote 95% confidence intervals.

Source: Office of National Statistics, 2015.

The slope index of inequality in life expectancy

The slope index of inequality in life expectancy at birth is a measure of the socioeconomic inequalities in health between different areas that enables a focus on the deprivation that exists at small area level. The main factors explaining the life expectancy differences between areas were unemployment, deprivation among older people, gender and lifestyle[3]. Table 14 shows that in 2011 - 13, the gap in the life expectancy in Kingston between those living in the most and least deprived deciles was 4.8 years for men and 2.9 years for women. This shows that the gap had narrowed in Kingston since 2010 - 12 when it was 5.8 years for men and 3.7 years for women.

Table 14 Slope index of inequality in Kingston, 2010 - 12 to 2011 - 13.

		Slope index of inequality
2010 – 12	Male	5.8 (1.3 to 10.2)
	Female	3.7 (1.1 to 6.2)
2011 – 13	Male	4.8 (1.1 to 8.5)
	Female	2.9 (0.9 to 5.0)

Note: Values in brackets denote 95% confidence interval.

Source: Figures calculated by Public Health England using mortality data and mid-year population estimates from the Office for National Statistics and Index of Multiple Deprivation 2010 (IMD 2010) scores from the Department for Communities and Local Government.

Marmot indicators

Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups[4]. These differences are not inevitable but can be significantly reduced. A large and growing body of research suggests that socio economic inequalities are the fundamental cause of these health inequalities.

The importance of reducing the gap in health inequalities has been given increased impetus in recent years. Both the Marmot Review (2010)[5] and the 'Healthy Lives, Healthy People' White Paper[6] adopt a life course perspective for tackling the wider social determinants of health. This is reflected in the set of policy recommendations developed by the Marmot Review:

A. Give every child a best start in life.
B. Enable all children, young people and adults to maximise their capabilities and have control over their lives.
C. Create fair employment and good work for all.
D. Ensure a healthy standard of living for all.
E. Create and develop healthy and sustainable places and communities.
F. Strengthen the role and impact of ill health prevention.

Table 15 on pages 316 and 317 shows the key Marmot indicators – these include indicators of the social determinants of health, health outcomes and social inequality that broadly correspond to the policy recommendations proposed in the Marmot Review.

1. Health Indicators

The Marmot Review recommended monitoring life expectancy, healthy life expectancy and inequality in life expectancy at birth. All the information about these indicators is shown in the previous section of this chapter.

The Marmot Review also recommended monitoring the wellbeing of the population. Wellbeing is a key health issue as people with higher levels of wellbeing have lower rates of illness, recover more quickly and for longer and have better overall physical and mental health.

In 2013 - 14, the percentage of adults aged over 16 years of age reporting low levels of life satisfaction in Kingston was below the regional and national averages (table 15). Please note that the value for Kingston is not given due to the small number of people involved.

2. Giving every child the best start in life

The highest priority in the Marmot Review was the aim to give every child the best start in life as this is fundamental to reducing the health inequalities across the life course. As the foundation for future developments are laid in early childhood, the review proposed an indicator of readiness for school to capture the early year's development of the children.

Based on the new method of measurement for this indicator[7] a higher percentage of children in Kingston achieved a good level of development at end of reception year in 2013 - 14 than the London and England averages (table 15). However, the percentage of those with free school meal status achieving a good level of development at the end of reception during the same period was lower than both the London and England averages.

3. Enable all children, young people and adults to maximise their capabilities and have control over their lives

Increasing the participation of young people in learning and employment not only makes a lasting difference to individual lives, but also improves social mobility and stimulates economic growth[8]. The Marmot Review advocated the monitoring of GCSE attainments and the percentage of young people who are not in employment, education or training (NEET) to encourage services to work together to support young people, particularly the most vulnerable, to engage in education, training and work.

In 2013 - 14, 70.0% of children in Kingston achieved 5 or more GCSE at grade A* to C or equivalent including English and Mathematics. This was considerably higher than both the London (61.5%) and England (53.4%) averages (table 15). During the same period 41.9% of Kingston pupils known to be eligible for free school meals achieved these results. This was lower than the London average (46.5%) but higher than the average for England (33.7%).

Young people who are not in education, employment or training are at greater risk of a range of negative outcomes, including poor health, depression or early parenthood. Table 15 shows that in 2013, 4.2% of people in Kingston aged 19 - 24, were not in education, employment and training. This was higher than the London average (3.8%) but lower than the England average (5.3%).

4. Create fair employment and good work for all

Being out of work is associated with poorer health. In 2014, the percentage of those aged 16 and over who were unemployed in Kingston (5.3%) was lower than the London (7.0%) and England (6.2%) averages (table 15). The long term claimant rate in Kingston for 2013 was 3.7 per 1,000 population. This was significantly lower than London (10.6/1,000) and England (9.9/1,000) averages.

5. Ensure a healthy standard of living for all

The Marmot Review recommends that all people must have income that is high enough to ensure that they have enough money to buy those things required to live a healthy life.

In 2011 - 12, 23.0% of households in England did not receive enough income to reach an acceptable Minimum Income Standards. In London, where costs are higher, one in four households (29.3%) did not achieve this standard (table 15). This data is not available at local authority level.

Living in a cold home is associated with negative health outcomes and hence it is important to monitor fuel poverty. In 2013, the percentage of households who if they spent what they needed to on fuel would place themselves below the national poverty line was 9.4% in Kingston. This was lower than the regional (9.8%) and national (10.4%) percentages of households in fuel poverty (table 15).

6. Create and develop healthy sustainable places and communities

Access to safe, green spaces can improve a number of aspects of mental and physical health and wellbeing as well as various social and environmental indicators. It can also contribute to reducing the health inequalities in the area[9].

Table 15 shows that in Kingston, 17.1% of residents had accessed green space for health and exercise reasons between March 2013 and February 2014. This was the same as the England average and higher than the percentage for London (11.8%).

Table 15 Marmot indicators for Kingston, London and England, 2014.

Indicator
Health outcome indicators
People reporting a low life satisfaction score
Giving every child the best start in life
Percentage of children achieving a good level of development at age five
Percentage of children with free school meal status achieving a good level of development at age five
Enabling all children, young people and adults to maximise their capabilities and have control over their lives
Percentage achieving 5A* - C GCSEs inc. English and Maths
Percentage with free school meal status achieving 5A* - C GCSEs inc. English and Maths
Percentage of people aged 19 - 24 who are not in employment, education or training (NEET)
Create fair employment and good work for all
Unemployment (%) ONS model based estimates
Long term claimants of Jobseeker's Allowance (16 - 64 year olds claiming for more than 12 months, rate /1,000 population)
Work-related illness rate per 100,000
Ensure a healthy standard of living for all
Households not reaching the Minimum Income Standard
The percentage of households that experience fuel poverty
Create and develop healthy and sustainable places and communities
Utilisation of outdoor space for exercise/ health reasons

Note:
1. '-' denotes values not available and '*' denotes values suppressed for disclosure due to small count.
2. Life expectancy at birth, healthy life expectancy at birth and inequalities in life expectancy at birth are also part of the Marmot indicators (health indicator section). Please see pages 309 to 313 for life expectancy.

Source: Public Health England, 2015.

Period	Kingston	London	England
2013 - 14	*	5.5 (5.1 to 5.9)	5.6 (5.4 to 5.8)
2013 - 14	64.9 (62.9 to 67.0)	62.2 (61.9 to 62.5)	60.4 (60.2 to 60.5)
2013 - 14	43.9 (37.3 to 50.7)	52.3 (51.7 to 53.0)	44.8 (44.5 to 45.1)
2013 - 14	70.0	61.5	53.4
2013 - 14	41.9	46.5	33.7
2013	4.2 (3.6 to 4.1)	3.8 (3.7 to 3.9)	5.3 (5.3 to 5.3)
Jan to Dec 2014	5.3 (4.2 to 6.4)	7.0 (6.6 to 7.4)	6.2 (6.1 to 6.3)
2013	3.7 (3.4 to 4.1)	10.6 (10.6 to 10.7)	9.9 (9.8 to 9.9)
2011 - 12	-	2,920 (2,410 to 3,440)	3,640 (3,440 to 3,840)
2011 - 12	-	29.4 (27.7 to 31.3)	23.0 (22.4 to 23.7)
2013	9.4 (9.1 to 9.6)	9.8 (9.8 to 9.8)	10.4 (10.4 to 10.4)
Mar 2013 - Feb 2014	17.1 (10.5 to 23.7)	11.8 (10.8 to 12.7)	17.1 (16.7 to 17.6)

Morbidity

Morbidity is a measure of the incidence or prevalence of a disease or medical condition in a given population. General practice records are recognised as a potentially rich source of morbidity data that can be used for assessing local health needs. However, primary care consultations do not reflect all the health problems in the population since many of these may not be brought to the attention of health care services.

Data collected in primary care has strengths and limitations; the strengths of the data collected from general practice are that they are whole population based and not derived from an unrepresentative subset of the population. However, it is important to note the limitations with using this data source as the main indicator for the prevalence of many conditions in the community. Algorithms have been developed to clean and code the data in primary care, yet the quality of data entry can vary. The data relating to some conditions may not be comparable with other sources of prevalence data due to differences in the definitions used, year on year changes to the Quality and Outcomes Framework (QOF) registers may limit the ongoing use of this data source and the assiduousness with which registers are maintained will vary by practice.

Table 16 compares the local prevalence of conditions recorded in general practice with the estimated local prevalence obtained from calculated models, surveys and other studies.

Notes for table 16:

1. n/a = not applicable.
2. Number of people on disease register: The number of people identifies with a particular condition or a certain lifestyle.
3. % Practice Prevalence: The percentage of people identified with a particular condition or a certain lifestyle of all people registered with local practices.
4. National Prevalence: The estimated prevalence of a condition in the community.
5. Modelled Prevalence: The estimated prevalence of a condition in an certain community taking into account factors such as the ethnicity, deprivation, gender and age structure of that community.

*around 20% of the UK population aged 55 - 75 years have evidence of lower extremity peripheral arterial disease, one in 20 of whom have symptoms.

Source: Number on disease register and practice prevalence are taken from Practice Focus report, March 2015 and see box 2 on page 320 for modelled estimate and national population prevalence sources.

Table 16 Prevalence of main conditions in primary care in Kingston, March 2015.

	Number on disease register	Practice prevalence (%)	National population prevalence	Modelled prevalence of the condition in Kingston
Hypertension	20,572	10.2%	32.0%	20.0%
Obesity (16 years and over)	9,328	5.8%	27.0%	14.8%
Depression (18 years and over)	8,831	5.6%	5 - 20%	n/a
Asthma	9,362	4.6%	8.1%	n/a
Diabetes	7,887	3.9%	7.3%	6.9%
Coronary Heart Disease	4,323	2.1%	6.5%	3.8%
Chronic Kidney Disease	3,723	1.8%	8.8%	7.1%
Cancer	3,484	1.7%	2.0%	n/a
Chronic Obstructive Pulmonary Disease	2,287	1.1%	1.5%	3.5%
Atrial Fibrillation	2,286	1.1%	-	n/a
Atrial Fibrillation (64 years and over)	2,054	8.6%	4.7% of people aged 65 and over	n/a
Stroke or Transient Ischaemic Attacks	2,071	1.0%	2.3%	1.8%
Mental Health	1,626	0.8%	-	n/a
Dementia	1,000	0.5%	1.1%	n/a
Epilepsy	930	0.5%	2 - 5%	n/a
Heart Failure	897	0.4%	0.8%	n/a
Rheumatoid Arthritis	851	0.4%	-	n/a
Peripheral Arterial Disease	694	0.3%	-	n/a
Peripheral Arterial Disease (54 - 74 years)	681	2.3%	20% of 55 - 75 year olds*	n/a
Palliative Care	359	0.2%	n/a	n/a
Osteoporosis	75	0.04%	-	n/a
Osteoporosis (50 years and over)	75	0.2%	2% of people aged 50 years and over	n/a
Osteoporosis (79 years and over)	35	0.5%	25% at aged 80 years and over	n/a

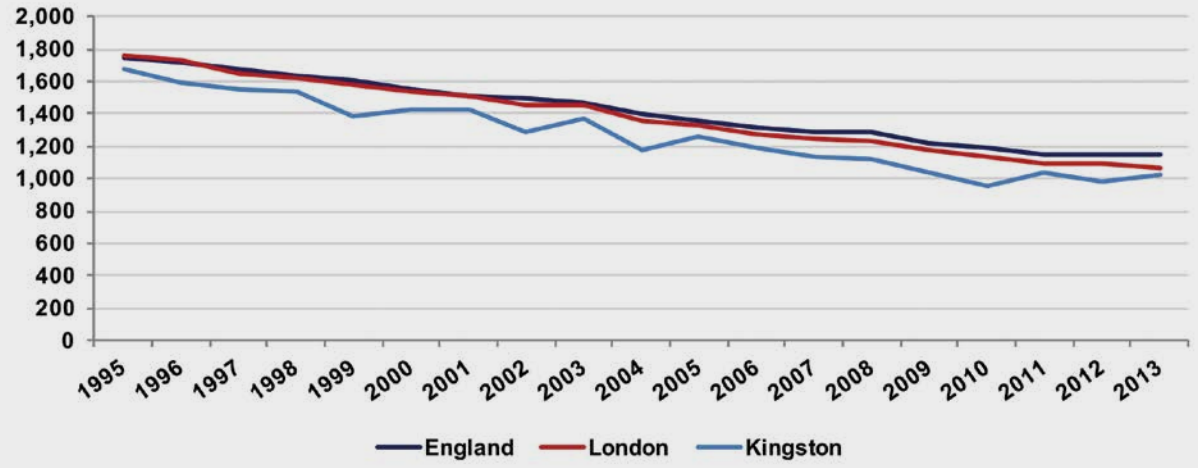
Box 2 Modelled estimates and national population prevalence sources.

Condition	Source
Hypertension	British Heart Foundation and Easing the pressure: tackling hypertension, Hypertension: the public health burden, Faculty of Public Health and National Heart Forum
Obesity	British Heart Foundation and Kingston Lifestyle Survey, 2014
Depression	Mental Health Foundation
Asthma	Health Survey for England, 2001
Diabetes	Association of Public Health Observatories (APHO) Prevalence Model, 2012
Hypothyroidism	Patient.co.uk
Coronary Heart Disease	British Heart Foundation
Chronic Kidney disease	APHO modelled prevalence
Cancer	Cancer prevalence in the UK; results from the EUROPREVAL study, Annals of Oncology.
Stroke or TIA	British Heart Foundation
Atrial Fibrillation (AF)	Bandolier
Chronic Obstructive Pulmonary Disease (COPD)	Trends in COPD fact sheet, Lung and Asthma Information Agency
Mental Health	The psychiatric morbidity survey of adults (aged 16 - 74) living in private households
Heart Failure	British Heart Foundation
Epilepsy	The incidence and prevalence of epilepsy, University College London (UCL) Institute of Neurology, Queen Square, London, Epilepsy Society
Dementia	Dementia UK
Osteoporosis	Osteoporosis in the UK at Breaking Point Report, 2010

Mortality

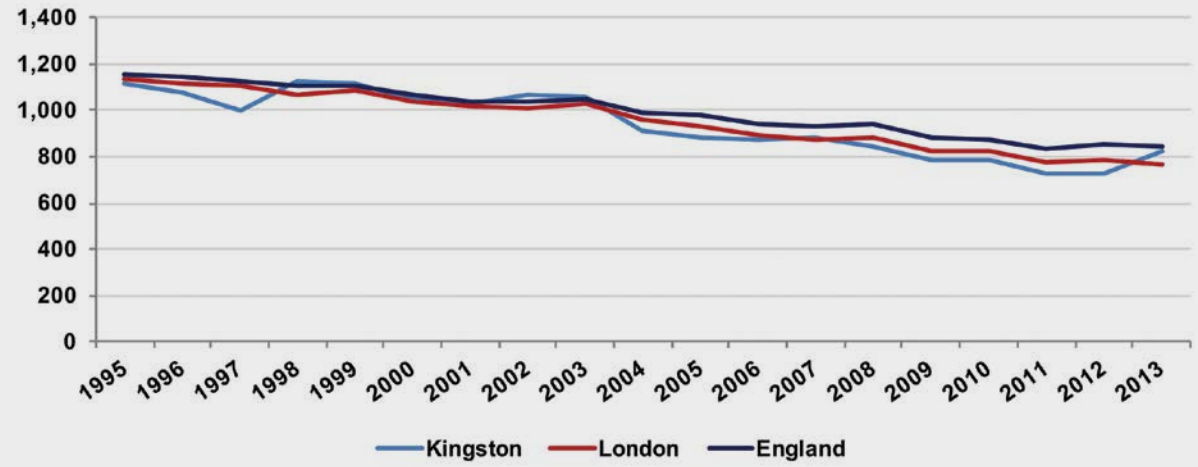
There were 1,122 deaths (497 males and 625 females) in Kingston during 2013, an increase of 102 deaths (10.0%) over the previous year. The local mortality rates for males have continued to decline since 1995 and they have remained lower than the regional and national rates (figure 4). The female mortality rates for Kingston have also declined during the same period but as can be seen from figure 5 have at times been higher than regional and national rates.

Figure 4 Directly standardised mortality rates from all causes, all ages for males in Kingston, London and England, 1995 to 2013.



Source: The NHS Indicator Portal, 2015.

Figure 5 Directly standardised mortality rates from all causes, all ages for females in Kingston, London and England, 1995 to 2013.



Source: The NHS Indicator Portal, 2015.

The main causes of deaths at all ages in Kingston comprising 68.2% of all deaths were (figure 6):

- diseases of the circulatory system comprising 27.5% of all deaths (309 individuals)
- malignant neoplasms making up 26.8% of total deaths (301 individuals)
- diseases of the respiratory system accounting for 13.9% of all deaths (156 individuals).

It is worth noting that in 2013 the number of deaths due to cancer in England for the first time exceeded the number of deaths due to circulatory disease whilst in Kingston circulatory disease remained the most common cause of death.

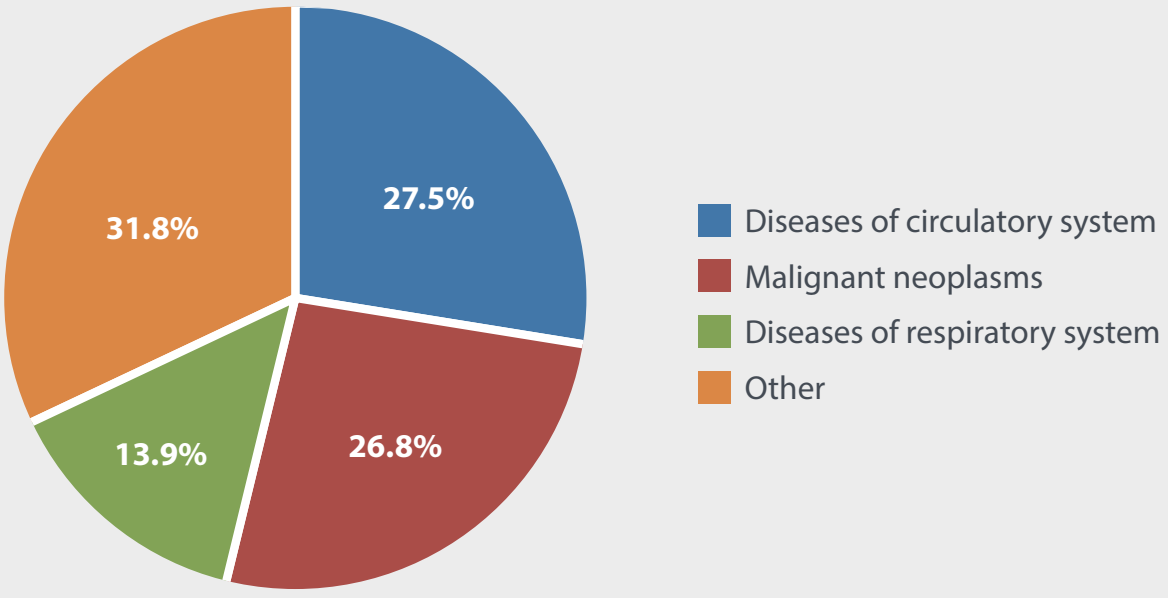
The commonest single cause of death in men at any age was ischaemic heart disease (16.1%, 80 men), followed by cancer of the digestive system (9.7%, 48 men) and cerebrovascular disease and lung cancer with both of the latter two conditions accounting for 6.0% of all deaths (30 individuals each).

The commonest single cause of death in women of any age was vascular and unspecified dementia (12.2%, 76 women) followed by ischaemic heart disease (10.6%, 66 women) and cerebrovascular diseases (7.4%, 46 women).

Of the 322 people who died under 75 years of age, the main causes of deaths were (figure 7 overleaf):

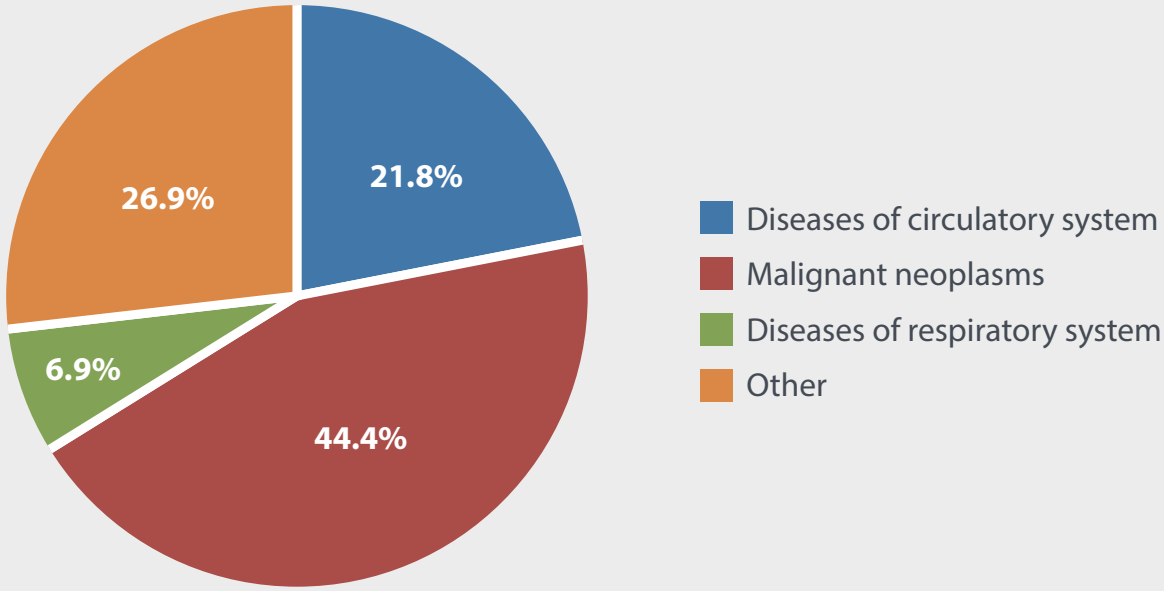
- malignant neoplasms (all cancers) making up 44.4% of the total number of deaths under 75 years of age (143 individuals)
- diseases of the circulatory system comprising 21.8% of the total number of deaths under 75 years of age (70 individuals)
- diseases of the respiratory system accounting for 6.9% of the total number of deaths under 75 years of age (22 individuals).

Figure 6 Causes of death in Kingston, all ages, 2013.



Source: Vital Statistics (VS3), 2013.

Figure 7 Causes of death in Kingston, under 75, 2013.



Source: Vital Statistics (VS3), 2013.

The largest single cause of death in men below 75 years of age was ischaemic heart disease (15.3%, 29 men), followed by cancer of the digestive system (12.7%, 24 men) and lung cancer (8.5%, 16 individuals).

The largest single cause of death in women under 75 years of age was breast cancer (12.0%, 16 women) followed by ischaemic heart diseases (8.3%, 11 women) and digestive system cancer (8.3%, 11 women).

Economic indicators

There is a strong evidence of an association between income and a range of health measures within developed countries. Health inequalities in these countries testify to the continued sensitivity of health to socioeconomic factors and in particular to the distribution of income in society[10,11].

The connection between unemployment and negative health outcomes is well established[12]. Unemployment has adverse mental and physical health consequences, including increased stress and depression.

Health damaging behaviours such as unhealthy eating, smoking and alcohol use may be used as coping mechanisms, further contributing to the risk of ill health.

Table 17 shows jobseekers allowance claimant count data released by the Office of National Statistics (ONS) on a monthly basis. It highlights that Norbiton has the highest rate of people claiming unemployment benefits, followed by Beverley and Chessington North and Hook. Table 18 overleaf enables comparison between Kingston, London and England showing the lower rates of out of work benefits that pertain in Kingston when compared with the other two geographical areas.

Table 17 Jobseekers allowance claimant count and rates by gender and geographical areas in Kingston, April 2015.

	Male		Female		Total	
	Number	Rate (%)	Number	Rate (%)	Number	Rate (%)
Alexandra	35	1.2	25	0.8	60	1.0
Berrylands	41	1.2	27	0.9	68	1.1
Beverley	57	1.7	34	1.0	91	1.3
Canbury	66	1.4	42	0.9	108	1.2
Chessington North and Hook	46	1.6	29	1.0	75	1.3
Chessington South	37	1.1	37	1.1	74	1.1
Coombe Hill	35	1.0	28	0.7	63	0.9
Coombe Vale	25	0.8	29	0.9	54	0.8
Grove	56	1.3	35	0.8	91	1.0
Norbiton	72	1.9	61	1.6	133	1.8
Old Malden	30	1.0	28	0.9	58	0.9
St James	28	1.0	24	0.9	52	0.9
St Mark's	59	1.3	38	0.8	97	1.1
Surbiton Hill	38	1.0	32	0.8	70	0.9
Tolworth and Hook Rise	42	1.2	24	0.7	66	1.0
Tudor	22	0.8	20	0.6	42	0.7
Kingston	689	1.2	513	0.9	1,202	1.1

Note: Rates are calculated for proportion of resident population (2013 mid-year estimates) aged 16 - 64 estimates.

Source: NomisWeb, 2015.

Table 18 Main out-of-work benefit* statistics for Kingston, London and England, February 2015.

	Kingston	Kingston	London	England
	(count)	(%)	(%)	(%)
Jobseekers	1,260	1.1	2.1	1.9
ESA and incapacity benefit	3,850	3.4	5.5	6.1
Lone parents	730	0.6	1.2	1.1
Carers	810	0.7	1.1	1.5
Others on income related benefits	140	0.1	0.3	0.3
Disabled	800	0.7	0.8	1.1
Bereaved	170	0.1	0.1	0.2
Main out-of-work benefits	5,990	5.3	9.1	9.4

Note:
1. Main out-of-work benefits include the groups: jobseekers, ESA and incapacity benefits, lone parents and other on income related benefits.
2. % is proportion of resident population of area aged 16-64.

Source: DWP benefit claimants – working age client group.

5.1 References

1 Khunti K, Kumar S, Brodie J (2009) Diabetes UK and South Asian Health Foundation recommendations on research priorities in British South Asians. London: Diabetes UK.

2 Healthy life expectancy (HLE) – also called disability adjusted life expectancy, represents the average number of years that a person can expect to live in full health. This measure of full health is based on contemporary mortality rates and the prevalence of self-reported good health. The prevalence of good health is derived from responses to a survey question on general health.

3 Buck D and Maguire D. Inequalities in life expectancy, Changes over time and implications for policy. Kings Fund, 2015.

4 World Health Organisation. 2015 Health Impact Assessment (HIA), Glossary of terms used [accessed October 2015]. Available from http://www.who.int/hia/about/glos/en/index1.html

5 Marmot M, Allen J, Goldblatt P, Boyce T, McNeish D, Grady M, et al. The Marmot review: Fair society, healthy lives. The Strategic Review of Health Inequalities in England Post-2010 2010.

6 HM Government. Healthy Lives, Healthy People: Our strategy for public health in England 2010 [accessed October 2015]. Available from https://www.gov.uk/government/publications/healthy-lives-healthy-people-our-strategy-for-public-health-in-england

7 The Department of Education modified the method of measuring the child's 'Good Level of Development' in 2012 and as a result these figures are not comparable with previous year's.

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Abbreviations

A & E Accident and Emergency

AfC Achieving for Children

ALEHM Association of London Environmental Health Managers

APS Active People Survey

ASA Amateur Swimming Association

ASCA Addiction Support and Care Agency

AUDIT Alcohol Use Disorders Identification Test

AUDIT C Alcohol Use Disorders Identification Test Consumption

BAMER Black, Asian, minority ethnic and refugee (communities)

BBN Best Bar None

BID Business Improvement District

BME Black and minority ethnic

BMI Body Mass Index

BMI SDS Body Mass Index Standard Deviation Score

BOBB Behave or Be Banned

BtC Breaking the Cycle

CAMHS Child and Adolescent Mental Health Service

CBO Criminal Behaviour Order

CBT Cognitive Behavioural Therapy

CCG Clinical Commissioning Group

CFL Cygnet Food Limited

CIC Community Interest Company

CIEH Chartered Institute of Environmental Health

CQC Care Quality Commission

CSEW British Crime Survey England and Wales

CSM Central School Meals (contract)

CSPAN Community Sport and Physical Activity Network

DH Department of Health

DPPO Designated Public Place Order

EBSB Eat Better Start Better

EFH English for Health

EYFS Early Years Foundation Stage

FA Families Anonymous

FGU From the Ground Up

FIFA Federation Internationale de Football Association

FIOW Family Information Outreach Worker

FIS Family Information Service

FRAX Fracture Risk Assessment Tool

FSM Free School Meals

GDM Gestational Diabetes Mellitus

GF Gluten Free

GLA Greater London Authority

GP General Practitioner

H2H Hospital 2 Home

HCC Healthier Catering Commitment

HCP Healthy Child Programme

HEAT Health Economic Assessment Tool

HEF Home Enteral Feeding

HIPI Health Impact of Physical Inactivity

HLW Health Link Workers

HMRC Her Majesty's Revenue and Customs

HSE Health Survey for England

HSL Healthy Schools London

HWPA Healthy Weight and Physical Activity (Strategy and Needs Assessment)

IAPT Improving Access to Psychological Therapies

IBA Identification and Brief Advice

ID Identification

IFS Infant Feeding Survey
IFT Infant Feeding Team
IOM Integrated Offender Management
JCT Joel Community Trust
KCN Kingston Carers Network
KVA Kingston Voluntary Action
KWS Kingston Wellbeing Service
LAC Looked After Children
LAS London Ambulance Service
LEAH Learn English at Home
LEBH Learn English and Be Healthy (club)
LHWC London Healthy Workplace Charter
LoTSA London Trading Standards Association
LSCB Local Safeguarding Children's Board
LSOA Lower layer Super Output Area
MDT Multidisciplinary team
MOAG Maternal Obesity Action Group
MOPAC Mayor's Office for Policing and Crime
MUST Malnutrition Universal Screening Tool
NATMS National Alcohol Treatment Monitoring System
NCMP National Child Measurement Programme
NEF New Economics Foundation
NHS National Health Service
NICE National Institute for Health and Care Excellence
ONS Office of National Statistics
PAL Proof of Age London
PASS Proof of Age Standards Scheme
PAT Paddington Alcohol Test
PEG Percutaneous Endoscopic Gastrostomy
PfPL Places for People Leisure
PHRD Public Health Responsibility Deal
PND Penalty Notice for Disturbance
POPPI Projecting Older People's Population Information
PRU Pupil Referral Unit
RAK Refugee Action Kingston
RASMNA Refugee, Asylum and Migrant Needs Assessment
RBK Royal Borough of Kingston
RCM Royal College of Midwives
RCOG Royal College of Obstetricians and Gynaecologists
RCPCH Royal College of Paediatrics and Child Health
RISE Recovery Initiative Social Enterprise
SCR Serious Case Review
SEN Special Educational Needs
SFP School Food Plan
SHEU Schools and Students Health Education Unit
SKP Safer Kingston Partnership
SMART Specific Measurable Achievable, Realistic, Timely (goals)
SOS Special Olympics Surrey
SPAD Strategic Partnership for Alcohol and Drugs
SRFC Surbiton Racket and Fitness Club
UGI Upper Gastrointestinal
UIFSM Universal Infant Free School Meals
UK United Kingdom
WHO World Health Organisation
YMCA LSW Young Men's Christian Association London South West
YPHLW Young People's Health Link Worker
YPSMS Young People's Substance Misuse Service

Glossary

Abstainers/ Teetotallers
Those individuals who said that they do not drink alcohol at all.

Addaction
A national drug and alcohol charity.

Alcohol dependence
A cluster of behavioural, cognitive and physiological factors that typically include a strong desire to drink alcohol and difficulties in controlling its use. Someone who is alcohol dependent may persist in drinking, despite harmful consequences. They will also give alcohol a higher priority than other activities and obligations. For further information, please refer to: 'Diagnostic and statistical manual of mental disorders' (DSM-IV) (American Psychiatric Association 2000) and 'International statistical classification of diseases and related health problems – 10th revision' (ICD-10) (World Health Organisation 2007).

Alcohol misuse
Consuming more than the recommended limits of alcohol.

Alcohol related harm
Physical or mental harm caused either entirely or partly by alcohol. If it is entirely as a result of alcohol, it is known as 'alcohol specific'. If it is only partly caused by alcohol it is described as 'alcohol attributable'.

Alcohol use disorders
Alcohol use disorders cover a wide range of mental health problems as recognised within the international disease classification systems (ICD-10, DSM-IV). These include hazardous and harmful drinking and alcohol dependence. See 'harmful' and 'hazardous' drinking and 'alcohol dependence'.

Allotment
A plot of land rented by an individual for growing vegetables or flowers.

Antenatal
The antenatal period refers to the period before birth; during or relating to pregnancy.

Addiction Support and Care Agency (ASCA)
ASCA is an established charity (c. 1990) offering confidential, one-to-one counselling and advice in Kingston.

Alcohol Use Disorders Identification Test (AUDIT)
An alcohol screening test designed to see if people are drinking harmful or hazardous amounts of alcohol. It can also be used to identify people who warrant further diagnostic tests for alcohol dependence.

Alcohol Use Disorders Identification Test Consumption (AUDIT C)
A clinically validated short screen used to identify people who are 'higher risk' drinkers or have a alcohol use disorder.

Bariatric surgery (types of surgery)
The three most widely used types of weight loss surgery are gastric banding, gastric bypass and sleeve gastrectomy.

Bariatric surgery (eligibility criteria)
NICE guidelines state that people are eligible for bariatric surgery if they have a body mass index of 40 kg/m^2 or above, or a BMI of 35 kg/m^2 or above with a serious health condition that can be improved with weight loss (e.g. diabetes or high blood pressure). Adults who have recently been diagnosed with type 2 diabetes may also be considered for an assessment for weight loss surgery if they have a BMI of 30 - 34.9 kg/m^2.

Basal Metabolic Rate
This is the amount of energy (calories) that the body requires to function whilst at rest.

Bikeability
Nationally accredited cyclist training. There are three levels: 1. Basic bike control 2. Making safe journeys on quiet roads 3. Making safe journeys on busy roads.

Binge drinking
Drinking more than double the lower risk guidelines for alcohol in one session.

Body Mass Index (BMI)
BMI is defined as the weight in kilograms divided by the square of the height in metres (kg/m^2). BMI is commonly used to measure whether adults are a healthy weight, underweight, overweight or obese; for most adults, BMI correlates reasonably well with their level of body fat. BMI also correlates to the risk of obesity and underweight associated morbidity. The risk of overweight associated health problems increases with increasing BMI. However, BMI is only a proxy for body fatness; other factors such as fitness, ethnic origin and puberty can alter the relation between BMI and body fatness and must be taken into consideration, and BMI should be used with caution for muscular people.

BMI SDS
A BMI standard deviation score (SDS) indicates how many units (of the standard deviation) a child's BMI is above or below the average BMI value for their age group and gender. For instance, a z score of 1.5 indicates that a child is 1.5 standard deviations above the average value, and a z score of –1.5 indicates a child is 1.5 standard deviations below the average value.

Bridge Team
This team consists of two full time midwives who cover safeguarding and perinatal mental health, a support midwife and a maternity support worker.

Brief intervention
This is a technique used to initiate change for an unhealthy or risky behaviour such as alcohol misuse. This can comprise either a short session of structured brief advice or a longer, more motivationally based session (see extended brief intervention overleaf). Both aim to help someone reduce their alcohol consumption (sometimes even to abstain) and can be carried out by non-alcohol specialists.

Challenge 25
This is a scheme where staff in a licensed premises can ask for proof of age to anyone that looks under 25 when selling an age restricted product.

Cognitive behavioural therapy (CBT)
Is a talking therapy that can help to manage problems by changing the way somebody thinks and behaves.

Glossary

Deprivation
The lack or denial of something considered to be a necessity.

Down Your Drink (DYD)
This was a website to help Kingston residents to find out more about their drinking and how to drink safely – but this has now been replaced by e-drink-check (please refer to e-drink-check below).

Eating disorders
Any of a range of psychological disorders characterised by abnormal or disturbed eating habits. The latest version of the DSM (Diagnostic Statistic Manual of Mental Disorders) cites the main eating disorders as anorexia, bulimia and binge eating disorder (BED).

e-drink-check
A website to help Kingston residents to find out more about their drinking and how to drink safely. It helps users to assess their drinking and what impact it could be having on their health, as well as showing where they can get advice and professional help.

Extended Brief Interventions
This is motivationally based and can take the form of motivational enhancement therapy or motivational interviewing. The aim is to motivate people to change their behaviour by exploring with them why they behave the way they do and identifying positive reasons for making change.

Fircroft Trust
A charity which supports adults living in the community with mental health problems and/ or learning disabilities.

Foetal Alcohol Spectrum Disorder (FASD)
An umbrella term which covers a range of disorders that are caused by being exposed to alcohol in the womb. The most commonly occurring diagnoses are Full Foetal Alcohol Syndrome (FAS) and Alcohol-Related Neurodevelopmental Disorder (ARND).

The Fracture Risk Assessment Tool (FRAX)
An online calculator that assesses a person's bone health.

Free sugars
Sugars (monosaccharides and disaccharides) added to foods by the manufacturer, cook or consumer, and sugars naturally present in honey, syrups, fruit juices and fruit concentrates. Free sugars do not include lactose when it is naturally present in milk and milk products.

Good Food for London report
An annually published report that ranks London boroughs on their support for good food.

Harmful drinking
A pattern of alcohol consumption that is causing mental or physical damage.

Hazardous drinking
A pattern of alcohol consumption that increases someone's risk of harm. Some would limit this definition to the physical or mental health consequences (as in harmful use). Others would include the social consequences. It is not a diagnostic term.

Health inequalities
Health inequalities are where different population groups experience different health status due to social (e.g. level of education or income), geographical (e.g. area of residence), biological (e.g. ethnicity) or other factors (e.g. lifestyle).

Hidden harm
The term hidden harm describes the experiences of many children affected by parental/ carer substance misuse as they often suffer in silence. Their circumstances are often not known to services and they often do not know where to turn to for help.

Higher risk drinking
Regularly consuming over 50 alcohol units per week (adult men) or over 35 units per week (adult women).

Improving Access to Psychological Therapies (IAPT)
A national NHS programme increasing the availability of services across England offering treatments for people with depression and anxiety disorders.

Identification and Brief Advice (IBA)
A short discussion aimed at motivating at-risk drinkers to reduce their alcohol use.

Index of Multiple Deprivation (IMD)
A national measure of deprivation that takes in to account income, employment, education skills and training, barriers to housing and services, crime and the living environment.

Increasing risk drinking
Regularly consuming between 22 and 50 units per week (adult men) or between 15 and 35 units per week (adult women).

Intelligence gathering
An activity that is used to obtain information to assess whether there is a problem that needs addressing.

Intelligence Lead activities
Evidence based activities that are founded on intelligence gathering.

Kingston Recovery Initiative Social Enterprise (RISE)
A peer support service in Kingston.

Korsakoff's syndrome
A brain disorder usually associated with heavy alcohol consumption over a long period.

Local offer
This is a term used by the Department for Education to describe the collection of information about support that Local Authorities must make available to help children and young people with special education needs and/ or disabilities and their families.

Glossary

Local Safeguarding Children's Board (LSCB)
Established by the Children Act 2004 which gives a statutory responsibility to each locality to have this mechanism in place. LSCBs are now the key system in every locality of the country for organisations to come together to agree on how they will cooperate with one another to safeguard and promote the welfare of children. The purpose of this partnership working is to hold each other to account and to ensure safeguarding children remains high on the agenda across their region.

Lower risk drinking
Regularly consuming 21 units per week or less (adult men) or 14 units per week or less (adult women). It is also known as 'sensible' or 'responsible' drinking.

Macronutrients
A type of food (e.g. fat, protein, carbohydrate) required in large amounts in the diet. Their role is to supply energy, structural material and to make compounds needed for normal metabolism.

Malnutrition
A serious condition that occurs when a person's diet doesn't contain the right amount of nutrients. Undernutrition occurs when not enough nutrients are consumed. Consuming more nutrients than needed can result in overnutrition.

Micronutrients
A chemical element or substance required in trace amounts for the normal growth and development of living organisms. Includes trace elements and vitamins.

mini-Holland programme
Part of the Mayor of London's Vision for Cycling. Kingston is one of three outer London Boroughs that form the mini-Holland programme which is designed to focus high spending on relatively small areas to transform the cycling environment.

Motivational counselling
Motivational counselling or interviewing is a form of collaborative conversation for strengthening a person's own motivation and commitment to change.

Mutual aid
Refers to members of a group who give each other social, emotional and informational support at every stage during their recovery from drug or alcohol dependence and can include people who are thinking about stopping their use of drug or alcohol or those who want to stay stopped.

Nasogastric tube (NGT) feeding
Nasogastric tube feeding involves feeding a patient artificially directly into the stomach through a tube which is passed through the patient's nostril that reaches directly into the stomach. This method of feeding is initiated if the patient is unable to swallow for various reasons such as being nil by mouth prior to or after surgery, disease (e.g. stroke), or unable to meet nutritional and energy requirements orally.

New Economics Foundation
A British think-tank that promotes social, economic and environmental justice.

Obesogenic
Pertaining to or tending to cause obesity.

Proof of Age London (PAL) card
This is a London specific proof of age identification card which is PASS accredited.

Proof of Age Standards Scheme (PASS)
This is a government backed scheme that gives young people a valid and accepted form of proof of age identification. The scheme is supported by the Home Office, the Trading Standards Institute (TSI) and the Association of Chief Police Officers (ACPO).

Paddington Alcohol Test
This tool is used to screen patients in A & E in order to identify alcohol related problems.

Percutaneous endoscopic gastrostomy (PEG)
A gastrostomy is a surgical opening made directly through the abdomen into the stomach. A feeding tube is then inserted through the opening, allowing for artificial nutrition and fluids as well as medicines, to be administered into the stomach. This artificial opening is introduced to help people who experience difficulty swallowing food and liquids.

Perinatal
The perinatal period commences at 22 completed weeks (154 days) of gestation and ends seven completed days after birth.

Permaculture
The development of agricultural ecosystems intended to be sustainable and self sufficient.

Premises licence review
This is where any interested party or a responsible authority asks to review a premises licence as there may be a matter arising in connection with one or more of the four licensing objectives.

Public Health Responsibility Deal (PHRD)
The Public Health Responsibility Deal aims to tap into the potential for businesses and other influential organisations to make a significant contribution to improving public health through their responsibilities as employers, as well as through their commercial actions and their community activities. Organisations can sign up to be either national partners or local partners.

Saturated fats
Saturated fat is a type of fat in food. Due to its chemical structure, it is usually solid at room temperature. Saturated fat is found in animal foods, such as the visible fat on meat, butter, cream and full fat dairy products. It is also found in plant foods such as palm and coconut oil.

Sedentary behaviour
Behaviours that involve low levels of energy expenditure. These behaviours are associated with an increased risk of obesity and cardiovascular disease independent of moderate to vigorous activity levels.

Glossary

Serious Case Review (SCR)
A serious case review (SCR) takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved, and there are concerns for how agencies worked together. Normally reviews are published. They look at lessons that can help prevent similar incidents from happening in the future. Serious Case Reviews are coordinated by the LSCB.

Stay and Play
A fully interactive play session involving children and parents/ carers working to support child development. These sessions have an educational focus on 'learning through play'.

Super Output Areas (SOA)
Used to identify areas of need, at the small geographical area level. These geographical areas were devised following the 2001 Census of Population, to be of a consistent size generated in a consistent way across the whole of England. These areas are nested, as far as possible, within electoral wards.

Test purchasing
This is where a young person enters a shop and will attempt to buy an age restricted product such as alcohol or tobacco.

Trans fats
Trans fatty acids can be formed when liquid oils go through a process called hydrogenation, which makes the oil more solid (known as hardening); for example in the manufacture of margarine, fat spreads and cooking fats. This type of fat, known as hydrogenated fat, can be used for frying or as an ingredient in processed foods. Artificial trans fats can be found in some processed foods such as biscuits and cakes, where they are sometimes used to help give products a longer shelf life. Trans fats can also be found naturally in some foods at low levels, such as those from animals, including meat and dairy products.

Transition Town Kingston
Part of a global Transition movement, an ongoing social experiment in which communities learn from each other and work towards a better future for the community, future generations and the planet.

Unit
In the UK, alcoholic drinks are measured in units. Each unit corresponds to approximately 8g or 10ml of ethanol. The same volume of similar types of alcohol (for example, 2 pints of lager) can comprise a different number of units depending on the drink's strength (that is, its percentage concentration of alcohol).

Wenicke-Korsakoff's syndrome
A spectrum of disease resulting from thiamine deficiency, usually related to alcohol abuse.

Wernicke's encephalopathy
An acute syndrome requiring urgent treatment resulting from thiamine deficiency, usually related to alcohol abuse.

Youth Sports Trust Top Tots and Top Start
A pre-school physical activity programme to introduce physical activity in a fun way for children whilst making positive contributions to parenting.

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Notes

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