Kingston Joint Strategic Needs Assessment (JSNA) 2023

(Summary Document)

Prepared by the Kingston JSNA Steering Group

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Introduction:

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

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

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

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

Climate change is already impacting health worldwide in a myriad of ways. These include death and illness resulting from increasingly frequent extreme weather events, such as

[1] World Health Organisation Website: link.

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

heatwaves, droughts, storms and floods, the disruption of food systems, increases in zoonoses and food-borne, water-borne and vector-borne diseases, and mental health issues. Furthermore, climate change is undermining many of the social determinants for good health, such as livelihoods, clean air, safe drinking water, sufficient food and equality and access to health care and social support structures (WHO).

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

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

The Kingston data shows that good health is not found equally in all. Some of the 'Top 5' conditions show a link with deprivation - with higher levels found as deprivation increases. These conditions contribute to the actual shorter length of life of residents in the most deprived areas of the borough - with male residents in these areas living around 5 years less than those in the least deprived, and women around 3 years less. There are some geographical 'hotspots' for poor health, most notably the Cambridge Road Estate (CRE) but some other locations also. Some health conditions are found at higher rates in some ethnic groups, compared with others. Education, a key 'wider determinant' of health, shows that children in Kingston in the lowest income groups (eligible for Free School Meals) do less well than not only other more well off children in Kingston, but also children also eligible for Free School Meals in other parts of London.

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

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

In this summary version of the JSNA, key highlights from the main document are given. Further details for each section are available in the main full JSNA 2023 report. The recommendations from the main report are attached to this summary report at the end.

How the JSNA 2023 was developed:

The format of the 2023 Kingston JSNA follows the national JSNA guidance[3], taking a high level approach to assess the 'Top 5' needs in Kingston for mortality, morbidity and other health factors for children and young people, adults aged 20-69 and people aged 70 years and over. Within these, equalities data has been reviewed. Specific population groups were not reviewed separately, although equalities data was considered in terms of the 'Top 5's where data was available. National and local data has been reviewed together with a

[3] https://www.gov.uk/government/publications/jsnas-and-jhws-statutory-guidance

commissioner and targeted resident survey. By taking a high level approach to the local data, the JSNA does not go into detail within the conditions reviewed. However, the data can be used to consider which areas might merit further in depth review in the future. A Kingston JSNA Steering Group completed the preparation of the Kingston JSNA on behalf of the Kingston Health and Wellbeing Board and work was carried out from September 2022-July 2023.

Some main data sources precede the COVID-19 pandemic and thus the impact of COVID-19 is not reflected in those sources. There was limited service data accessed as part of the JSNA exercise so the data focuses mainly on health conditions and risks to health rather than detailed analysis of gaps in service provision for these conditions.

In this summary, some highlighted key data findings are shared.

Our Kingston population

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

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

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

The population of Kingston is estimated to grow by 8,000 in the next decade, 7,000 of which will be over 65s - a rise of about 25% in this age group. This forecast change in the population means that service requirements will change, with an increase in need for services for older people - together with the opportunity for further preventative work to keep people in good health for longer.

Steady population growth, over the next 10 years, together with other current national factors impacting on housing, alerts us to the increasing pressure on housing[5] and resulting impacts on health.

The Census 2021 recorded Kingston's ethnicity as 68.3% White, which is higher than the London figure (53.8%), but lower than the national equivalent (81%). The next largest broad ethnic group in Kingston is Asian (17.9%) (London 20.8%, England 9.7%). The main difference between Kingston and London is that the Black community is significantly smaller in Kingston (2.7%) than in London (13.5%), and also smaller in Kingston than England (4.2%). The borough has also recently welcomed new arrivals from Ukraine, Hong Kong, Afghanistan and Syria, amongst others. For more demography information including the latest from the Census 2021, see here: https://data.kingston.gov.uk/

[4] ONS: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/populationandhouseholdestimateswales/census2021 (accessed January 2023)

[5] GLA. Housing-led population projections, 2020 base. https://maps.london.gov.uk/population-projections

Index of Multiple Deprivation:

Kingston has relatively low levels of deprivation compared to London and England overall, nevertheless one small area (Lower Super Output Area or 'LSOA'[6]) of the borough is in the most deprived 20% nationally, with another three LSOAs in the most deprived 40%.

The most deprived small area in the borough is situated in the Kingston and North Kingston neighbourhood, with the next most deprived LSOAs being in New and Old Malden, and Surbiton. The South of the Borough, however, is the most deprived neighbourhood overall. For more information on deprivation, see here:https://data.kingston.gov.uk/

Key findings:

The 'Top 5s' for ill health, mortality, long term conditions and hospitalisations were looked at by four main age categories over the population as a whole. The key data shows the following (please see the main document for further details). It is important to note that for some of the key data that was used (Global Burden of Disease data), the data is from 2019 and thus does not include the impact of COVID-19. COVID-19 is addressed in a separate section in the main document:

Starting Well - Health Challenges For Children Aged 0-4:

The Top 3 causes of ill health and top 5 overall ill health risk factors for 0-4 yrs (2019)[7]:

Top 3 causes of ill health and top 5 overall ill health risk factors for 0-4 yrs in Kingston (2019)	
Ill health causes	**Ill health risks**
Neonatal Disorders (412 DALYs)[8]	Child and maternal malnutrition (358 related DALYs)
Congenital Birth Defects (287)	Air Pollution (19)
Dermatitis (153)	Tobacco (5)
	Non optimal temperature (4.9)
	Kidney disfunction (3.3)

The mortality data for the 0-4 year olds for Kingston is not shown here as the numbers are below 10 in each category.

The Top 5 reasons for hospital admissions for 0-4s in Kingston (2017-18 to 2020-21) were[9]:

Top 5 reasons for hospital admissions for 0-4 yrs in Kingston (2017-18 to 2020-21)
Neonatal Jaundice (941 admissions across the four year period, 677 individuals)

[6] Lower layer Super Output Areas (LSOAs) are made up of groups of OAs, usually four or five. They comprise between 400 and 1,200 households and have a usually resident population between 1,000 and 3,000 persons.

[7] Data from Global Burden of Disease for Kingston 2019

[8] The disability-adjusted life year (DALY) is a measure of overall disease burden, expressed as the number of years lost due to ill-health, disability or early death

[9] Data source: Hospital Episode Statistics

Viral Infections (701, 475)
Acute bronchiolitis (623, 457)
Unknown and unexpected causes of morbidity (552, 459)
Acute upper respiratory infection (536, 431)

The Top 5 Long Term Conditions for 0-4 yrs in Kingston (2022) are[10]:

Condition	**Number of people (nearest 10)**
Asthma or another respiratory condition	730
Cancer	180
Musculoskeletal disorders	130
Cardiovascular disease	50
Neurological disorders	30

Children And Young People aged 5-19 years

For children and young people aged 5-19 years[11], the top 5 ill health causes and overall ill health risks in 2019 were:

Ill health causes	**Ill health risks**
Headache disorders (134 DALYs)	Child and maternal malnutrition (81 related DALYs)
Anxiety disorders (128)	Drug Use (50)
Asthma (125)	Childhood sexual abuse and bullying (37)
Depressive Disorders (98)	Alcohol use (31)
Dermatitis (98)	High fasting plasma glucose (8)

The top 5 reasons for inpatient hospital admissions for the 5-19 year olds in Kingston for 2017-18 to 2020-21 were[12]:

Top 5 reasons for inpatient hospital admissions for 5-19 year olds in Kingston
Dental Caries (565 admissions across the four year period, 468 individuals)
Acute lymphoblastic leukaemia (293, 10)
Acute tonsillitis (222, 168)
Asthma (210, 136)

[10] Data Source: SWL ICB Dashboard
[11] Data Source: Global Burden of Disease, Kingston data 2019
[12] Data Source: Hospital Episode Statistics 2017-2021

Pain localised to other parts of lower abdomen (165, 144)

The Top 5 Long Term Conditions for 5-19 year olds in Kingston are[13]:

Condition	Number of people (nearest 10)
Asthma or another respiratory condition	4,760
Musculoskeletal disorders	1,570
Cancer	590
Cardiovascular disease	420
Neurological disorders	360

The mortality data for the 5-19 year olds for Kingston is not shown here as the numbers are below 10 in each category.

Living Well - Adults 20-69 years

For people aged 20-69 years, the Top 5 causes and risks of ill health and premature mortality (2019), were[14]:

Top 5 causes of ill health and premature mortality and risks for people aged 20-69 years in Kingston (2019)			
Causes of ill health	**Risks for ill health**	**Causes of premature mortality**	**Risks for premature mortality**
Low back pain (1752 DALYs)	Tobacco (2346 related DALYs)	Ischaemic heart disease (24 related deaths)[15]	Tobacco (48 related deaths)[16]
Depressive disorders (1153)	High body mass index (1967)	Tracheal, bronchus and lung cancer (20)	Alcohol use (27)
Headache disorders (1106)	Alcohol use (1672)	Cirrhosis and other chronic liver diseases (11)	High body mass index (24)
Diabetes mellitus (890)	High fasting plasma glucose (1415)	Breast cancer(11)	Poor diet (23)
Ischemic heart disease (774)	Poor diet (1101)	Colon and rectum cancer (9)	High systolic blood pressure (23)

[13] Data Source: SWL ICB Dashboard

[14] Data source: Global Burden of Disease, Kingston data 2019

[15] Rounded to the nearest whole number. N.B. this doesn't mean that 24 people died from ischaemic heart disease (IHD), it means for all the people who died in Kingston in 2019 in this age group, the entire contribution of IHD was 24 e.g. if IHD played a 50% part in 48 deaths, then the total mortality figure would be 24 (48 * 0.5)

[16] Rounded to the nearest whole number. Similarly to the causes of premature mortality, this doesn't mean that 48 people died partially due to smoking, it means for all the people who died, the entire burden of smoking risk adds up to 48

Low back pain is the number one cause of ill health for adults up to 69 years of age in Kingston. Heart disease is the main cause of premature mortality, followed by cancer of the respiratory system. Tobacco is the number one risk factor for both ill health and premature mortality.

The Top 5 reasons for hospital admissions for people in Kingston aged 20-69[17] for 2017-18 to 2020-21 were:

Breast cancer (2774 admissions across the four year period, 235 individuals)
Multiple myeloma (1729, 39)
End stage renal disease (1726, 106)
Chest pain (1378, 1116)
Unknown and unspecified causes of morbidity (929, 582)

The Top 5 Long Term Conditions for people aged 20-69 years in Kingston in 2022 were:

Condition	Number of people (nearest 10)
Mental health conditions	15,340
Asthma or another respiratory condition	11,660
Musculoskeletal disorders	10,240
Hypertension	9,370
Diabetes	5,160

Ageing Well - Older People aged 70 and above

Heart disease is the main cause of ill health and mortality in the oldest residents of Kingston, followed by Chronic Pulmonary Obstructive Disease (COPD). Tobacco is the highest risk factor for both. High fasting plasma glucose (a condition linked to diabetes) and high blood pressure are the next two highest risk factors. A poor diet and being overweight are the fourth and fifth highest risk factors.

The top 5 types of ill health and mortality and overall risks for both in 2019 were[18]:

Causes of ill health	Risks for ill health	Causes of mortality	Risks for mortality
Ischaemic heart disease (1370 DALYs)	Tobacco (2157 related DALYs)	Ischemic heart disease (127 related deaths)[19]	Tobacco (144 related deaths)[20]
Chronic Obstructive Pulmonary disease (COPD) (940)	High fasting plasma glucose (1627)	Lower respiratory infections (86)	High systolic blood pressure (121)

[17] Data source: Hospital Episode statistics 2017-2021
[18] Data source: Global Burden of Disease, Kingston data 2019
[19] See footnote above for what the '127' figure means, it does not mean 127 deaths were due IHD
[20] Similarly, see footnote above for what the '144' figure means

Alzheimer's disease and other dementias (898)	High systolic blood pressure (1413)	Alzheimer's disease and other dementias (77)	High fasting plasma glucose (107)
Lower respiratory infections (734)	High body mass index (1292)	Stroke (71)	Poor diet (99)
Diabetes Mellitus (481)	Poor diet (1249)	Chronic Obstructive Pulmonary disease (COPD) (57)	High body mass index (75)

The Top 5 reasons for hospital admissions for people aged 70 and over in Kingston over 2017-18 to 2020-21 were:

Causes of hospitalisations, people aged 70 and over, Kingston (2017-18 to 2020-21)
Urinary tract infection (2347 admissions across the four year period, 1174 individuals)
Lobar pneumonia (1950, 1066)
Multiple myeloma (1657, 42)
Senile nuclear cataract (1568, 1113)
Repeated falls (1529, 839)

The Top 5 Long Term Conditions for people aged over 70 years in Kingston in 2022 are[21]:

Condition	**Numbers affected (nearest 10)**
Hypertension	9,360
Musculoskeletal disorders	6,480
Cardiovascular disease	5,640
Cancer	5,250
Diabetes	3,500

Does everyone have the same level of health in Kingston?

No. Residents in the most deprived areas have shorter lives, on average, than those in the least deprived. In Kingston there was a 5.2 year gap in life expectancy at birth between the least and most deprived men in Kingston in 2020/21. For women, there was a 3.5 year gap, [22] and the gap is growing. Length of life in good health also varies amongst our residents. The data shows that there are geographical differences in health in the borough, there are differences by ethnicity and also income level and sex. Differences vary by type of condition. Some key findings are highlighted below. More detail is available in the full JSNA 2023 document.

[21] Unpublished, SWL NHS Data
[22] https://analytics.phe.gov.uk/apps/segment-tool/

Census 2021 asked people how they rated their own health. This showed that in Kingston, 87% of residents (145,000 people) rated their health as 'good' or 'very good', which is higher than London and national averages, and similar to Kingston's health in the previous census in 2011. However, 5,700 Kingston residents (around 1 in 30 people) rated their health as 'bad' or 'very bad' in 2021, with poorer health tending to be associated with increasing deprivation of their local area within the borough. The Census data also shows that levels of disability vary considerably from from 10.6% in Kingston North to 16.1% in Chessington South. There is now scope to analyse the Census 2021 data further.

Health Inequalities in Kingston: key findings by age group

We looked at all the data that might tell us something about inequality of experience or access and where there may be greater prevalence in some groups than others. For our age ranges, and for the top 5 ill health causes and risks, we were able to draw some interesting conclusions about the different communities in Kingston.[23]

For children aged between 0 and 4 years

- Asthma levels show a pattern of higher levels in more deprived areas compared to least deprived areas (0-4 years, 2022). Levels of 'asthma and other respiratory conditions' in young childhood vary from just over 10% in Berrylands to almost 20% in Chessington North and Hook (2022)
- The top 5 reasons for hospital admissions do not show a clear pattern in relation to deprivation or ethnic group

For children 5-19 years

- Dental caries is the main reason for hospitalisation for children aged 5-19 years (2017-18 to 2020-21). Highest admission rates are from the Other and White groups, followed by Asian residents[24]. Admissions are highest from the most deprived deciles (2-6), although the next highest level of admissions is from the least deprived decile (10). Norbiton is the most deprived ward in Kingston and has the highest rate of dental hospitalisations, some 25% higher than the second place ward (St James), and almost 2.5 times as much as the lowest ward (Tudor).
- Asthma and other respiratory conditions show a pattern of higher levels in the more deprived areas compared to least deprived areas (5-19 years, 2022). Wards in the north of the borough have lower levels compared to those in the south of the borough (2022)

For adults 20-69 years

- Women have higher reported levels of obesity, depression and asthma than men (15-64 year olds, 2022)
- Black residents have the highest levels of obesity of all ethnic groups, the White ethnic group has the highest numbers of people with obesity (2022)
- Depression levels are highest in White residents (15-64 years, 2022)
- Hypertension (high blood pressure) is highest in Black residents, followed by Asian residents. The greatest numbers of people with high blood pressure are in the White ethnic group (15-64 years, 2022)
- Highest levels of diabetes are recorded in Asian residents, followed by Black residents. More cases are recorded in men than women across the borough. (15-64 years, 2022)

[23] NHS England, south west London ICS Health Analytics dashboard, unpublished

[24] Excluding the 'other' category

- Higher levels of premature mortality due to heart disease in men, and cancer of digestive organs for both men and women, are found in the CCOB PCN registered population. Higher levels of premature death due to diseases of the liver are found in the male Surbiton PCN registered population and in the female CCOB PCN population. (15-64 years, 2019-20 to 2021-22)
- For all of the top 5 Long Term Conditions in Kingston for 20-69 year olds, the highest levels are found in people living in the most deprived areas (deciles 2-5) (2022)
- Asthma, mental health conditions and musculoskeletal conditions are highest in the White population aged 20-69 years (2022). High blood pressure is highest in the Black population and diabetes is highest in the Asian population (2022).
- Hospital admissions for chest pain are significantly higher in residents of the most deprived deciles (2-5) than other parts of Kingston (2017-18 to 2020-21, 20-69 years)

For older people (70 years and over)

- Higher levels of depression are found in women than men in the older age groups (65 years and above, 2022)
- Highest levels of hypertension are found in the Black and Asian residents for the ages 65 years and above (2022). White residents aged 65 years and above had the highest numbers of hypertension followed by Asian residents.
- Numbers of people with obesity are highest in the NMWP PCN service users for people aged 65 and above. Highest numbers of older people with obesity are White, followed by Asian and Black residents[25] (2022).
- Numbers of people with diabetes aged 65 years plus (2022) are highest in New Malden PCN service users (while the highest population rate level is in Chessington PCN service users). Asian people aged 65 years plus are the group with highest diabetes levels, particularly those using GP practices in the Surbiton PCN.
- Surbiton and Chessington PCN service users aged 65 plus have the highest rates of asthma compared to other PCNs. However, the PCN with the greatest number of older people with asthma is NMWP
- Higher levels of deprivation are only slightly associated with increased levels of Long Term Conditions in older people, with diabetes showing the clearest correlation (70 years and above, 2022)
- Hospital admissions for people aged 70 and over are higher in White residents than all other ethnicities (excluding the 'Other' category, 2017-18 to 2020-21)
- There is a partial association with greater deprivation and higher rates of hospitalisation in older age. Higher rates are usually found in more deprived deciles (2-5 & 6) for all conditions except cataracts, with decile 6 residents greatest overall
- Urinary tract Infections (UTIs) are the main reason for hospitalisations of people aged 70 years and above. 2019 Data, from other NHS research, indicates that across SW London UTI hospital costs and admissions, length of stay and readmissions are higher than for most other areas.

Geography and health inequalities:

With regards to the impact of where you live (geography), who you are (ethnicity) and your economic status (deprivation levels) our data also shows:

- Older adults (over 70) from a White or 'Other' background had the highest in patient hospitalisation rates per ethnic group for all 5 conditions reviewed for 2017-18 to 2020-21 (UTIs, senile nuclear cataract, lobar pneumonia, repeated falls, pneumonia)[26].

[25] Excluding 'other' category

[26] NHS Digital, Hospital Episode Statistics (HES), link.

- For the same period there was an association with greater deprivation and higher rates of hospitalisation for older adults, with higher levels found in the most deprived areas for all conditions except for cataracts[27].
- Kingston has been ranked nationally as an area with a significantly high number of emergency hospital admissions due to falls of people aged over 65[28]
    - The two wards with the highest rates of falls are Surbiton Hill and Berrylands
    - Norbiton appears as above average for hospitalisation of 70+ year olds for the top three conditions (UTIs, cataracts and lobar pneumonia)[29].

Health Protection

A different approach was taken to select the 'Top 5's for Health Protection. Whereas the overall top 5s for health conditions were ranked by the largest number of years or people affected, for the Health Protection section the top 5s were chosen as those issues with the biggest potential impact or risk. For example, polio immunisation was included because of the global concern that vaccine-derived poliovirus had been detected in London wastewater on several occasions in 2022[30]. No confirmed cases of polio virus have been detected in the UK but there is a risk that there could be disease spread, particularly in communities where vaccine uptake is lower. This poses a threat to health and the progress of the global polio eradication programme. COVID-19, the Health Protection issue that has had the recent largest overall impact and continues to do so and is considered in a standalone section. The top 5 Health Protection issues (in addition to COVID-19) identified are:

- Childhood immunisation - focus on measles and polio
- Adult immunisation - focus on maternal whooping cough, flu, and COVID-19
- Adverse weather and associated health risks
- Cancer screening
- Sexual health

In the main JSNA document, each issue is discussed in more detail. Highlight key findings for the 5 health protection issues are:

Childhood immunisation - focus on measles and polio

- In 2018, the WHO determined that measles could no longer be considered 'eliminated' in the UK and that transmission of measles had been re-established
- From 1st January to 20th April 2023 there were 49 laboratory confirmed measles cases in England, 33 (67%) of these in London[31]. Twenty (61%) of the London cases were in children under 10 years of age
- Receiving two doses of MMR gives the best protection against measles infection. Kingston's rate for children at five years having received two doses of MMR are not meeting the World Health Organisation (WHO) target of 95% which is necessary to achieve and maintain elimination
- In May 2022, poliovirus was detected in a number of routine samples of London wastewater[32]. Polio vaccination coverage in Kingston and across London falls short of the WHO target of 95%. An initial polio booster campaign ran across London from

[27] NHS Digital, Hospital Episode Statistics (HES), link

[28] PHE Fingertips Wider Social Determinants data: Natural and built environment: Wider Determinants of Health - Data - OHID [Accessed May 2023]

[29] Source: OHID Local Health tool. *Causes of morbidity and mortality - ward maps, 2018-21.* Link.

[30] https://www.gov.uk/government/news/poliovirus-detected-in-sewage-from-north-and-east-london

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

[32] https://www.gov.uk/government/news/poliovirus-detected-in-sewage-from-north-and-east-london

August to December 2022, with a polio catch up aimed at under-vaccinated children in London aged 1 to 11 years commencing in May 2023[33].

Adult immunisation - focus on maternal whooping cough, flu, and COVID-19

- Data reported in 2022 on the maternal pertussis (whooping cough) vaccine programme shows that uptake has dropped to its lowest level in seven years[34]
- The maternal vaccine provides newborn babies with protection against whooping cough which lasts until they are old enough to be routinely vaccinated
- Whilst Kingston is one of the top performing London boroughs for flu vaccination uptake overall, it is not meeting national targets for those in 'at risk' groups

Adverse weather and associated health risks

- The potential impacts from exceptionally high temperatures include a danger to life and health impacts on the most vulnerable including older adults, very young children and those with pre-existing medical conditions
- Severe cold weather can increase the health risks to vulnerable people and disrupt the delivery of services. The risk of death in the UK during periods of cold temperature is greater than during warmer periods
- The current 'Cost of Living Crisis' in 2022/23 with high fuel costs may be adding additional risks

Cancer Screening

- Cancer screening programmes have been significantly impacted by the COVID-19 pandemic
- Data from 2022 shows that the national targets for cervical and breast screening were not being met in Kingston[35] [36]

Sexual Health

- Data from 2021 for Kingston showed 7.6% of women and 9.9% of men who presented with a new sexually transmitted infection (STI) at a sexual health service between 2015 and 2019 were re-infected with a new STI within 12 months[37]. STI reinfection rates amongst young people in Kingston were higher than the national average
- Reinfection rates for STIs can be used as a proxy to measure continued risky sexual behaviours including failure to complete treatment, a partner not getting treated, and not practising safer sex. Repeated infections with STIs including gonorrhoea and chlamydia can also lead to infertility

COVID-19

This is the first Kingston JSNA to cover COVID-19, the new virus that emerged at the end of 2019 in China and was classified as a global pandemic in 2020. In 2023, Kingston, like the

33 https://www.gov.uk/government/news/polio-vaccine-catch-up-campaign-for-london-as-sewage-surveillance-findings-suggest-reduced-transmission

34 https://www.gov.uk/government/news/7-year-low-in-maternal-whooping-cough-vaccine-uptake-puts-newborns-at-serious-risk-of-hospitalisation

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

36 https://fingertips.phe.org.uk/search/breast%20screening#page/3/gid/1/pat/6/ati/501/are/E09000021/iid/22001/age/225/sex/2/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0 - accessed 02/05/2022

37 https://data.kingston.gov.uk/wp-content/uploads/2022/07/JSNA_Sexual_Health_Needs_Assessment_2021.pdf

rest of the UK, is in the current phase called Living with COVID-19'[38]. At the end of March 2023 (when the national ONS COVID-19 infection survey[39] was completed before the cessation of this survey), case rates in the population remained very high. Across London, in May 2023 over 700 people are in hospital with COVID-19[40]. From 2020 to 2022, the borough fought strongly against the virus by staying at home when requested, supporting people to 'self isolate', testing and tracing, wearing face coverings, vaccinations, communications and more. Many thousands of school days were missed through total school closures and 'self isolation' of cases and contacts. Businesses were impacted and families and friends were kept apart. The healthcare system cared for many thousands of infected people and continues to do so. At the same time, many people did not access healthcare for other conditions and it is estimated that many cases of the 'Top 5' health conditions have been undiagnosed in the last few years. Sadly, 393 residents lost their lives to COVID-19 between 2020 and February 2022 (with the number rising), with many more impacted in other ways. Around 2% of the population are reported to have 'long COVID-19' symptoms[41]. Please see the JSNA COVID-19 section in the main JSNA 2023 document for more details. For further details on the borough response, see Kingston's Annual Public Health Report 2020-2022 and other information sites of Kingston organisations.

Since the onset of the pandemic in the UK in 2020, COVID-19 has been a major cause of ill health and death. In the two most severe 'waves' of the pandemic (March – May 2020 and November 2020 – February 2021) around 30% of all deaths in Kingston listed COVID-19 as the main, underlying cause[42]. COVID-19 was by far the most commonly-recorded underlying cause of death in the borough in 2020 and 2021, around twice as common as the second-highest group of causes (ischaemic heart diseases). Even in 2022, with the pandemic having seemingly receded, COVID-19 was just outside the top five most common underlying causes of death.

Data from the COVID-19 pandemic continues to be analysed across the world. However, data to date shows that some groups were at particular risk of more severe outcomes from COVID-19. For example, people with obesity and diabetes are at increased risk of severe illness and hospitalisation[43]. Some of the risk factor conditions are found more often in areas of higher deprivation (for example, obesity and diabetes). National level data from 2020-2022 shows that higher deprivation groups had higher age-standardised mortality rates from COVID-19 in the first two years of the COVID-19 pandemic in the UK, and that some ethnic groups were at higher risk of COVID-19 infection and higher levels of mortality[44] [45] [46]. There are many factors that may help understand these differences in outcomes, which will likely be fully understood as more is learned about the virus. Possible explanatory factors include people living in urban areas[47], having higher levels of front facing work outside the home[48], overcrowding in the home[49], lower COVID-19 vaccination rates[50], higher rates of certain risk factors such as obesity, diabetes and asthma[51].

The JSNA has shown that in Kingston in 20-69 year olds, some of the conditions that are additional risk factors for poorer COVID-19 outcomes such as asthma and other respiratory conditions and diabetes are in the top 5 long term health conditions in the borough. Risk

[38] COVID-19 Response: Living with COVID-19 - GOV.UK
[39] Coronavirus (COVID-19) Infection Survey: England - Office for National Statistics
[40] https://coronavirus.data.gov.uk (accessed February 2023)
[41] https://www.england.nhs.uk/publication/the-nhs-plan-for-improving-long-covid-services/
[42] NHS England, Primary Care Mortality Database (PCMD), unpublished
[43] COVID-19: Impact of obesity and diabetes on disease severity - PMC.
[44] https://www.kingsfund.org.uk/publications/deaths-covid-19
[45] Updating ethnic and religious contrasts in deaths involving the coronavirus (COVID-19), England - Office for National Statistics
[46] COVID-19 confirmed deaths in England (to 31 December 2022): report - GOV.UK
[47] https://www.kingsfund.org.uk/publications/deaths-covid-19
[48] Coronavirus (COVID-19) related deaths by occupation, England and Wales - Office for National Statistics
[49] Disparities in the risk and outcomes of COVID-19
[50] Deaths from Covid-19 (coronavirus): | The King's Fund
[51] Dataset Pre-existing conditions of people who died due to coronavirus (COVID-19), England and Wales

factors that predispose to additional COVID-19 risk are also in the Kingston 'Top 5' risk factors for adults including overweight. Thus, in the period defined by national government as 'Living with COVID-19[52]', consideration needs to be given to preventing and managing health conditions that have additional risk for poor outcomes related to COVID-19.

Views from residents and commissioners:

As part of the JSNA exercise, commissioners and some resident groups were asked for their perspectives on the Top 5 conditions, access to services and any gaps, and views on preventing ill health. The response rate was not high enough to draw conclusions about service gaps. However, some themes came through about aspects of health provision in relation to the Top 5s.Issues for further consideration included the following (see the main JSNA document for further detail):

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

People with co-existing conditions for whom the service offer does not reflect the impact of one condition on another. This might be for those with depression and diabetes, drug/alcohol dependency and depression, neurodiversity and depression, dementia and diabetes and such other combinations. Thus, it is suggested that there needs to be consideration of these co-existing conditions in the commissioning of services - with an ability for services to be flexible to fit varying needs

People who struggle to access services that are suitable, useful and desired. Access is sometimes limited because they rely on virtual delivery or promotion, or delivery is centralised in location or delivered in places that are 'off putting' or expensive to reach.

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

There is a desire amongst stakeholders for more and better community-based services, for services delivered in the home and for support outside service commissions, within communities. Feedback indicates that some services are failing to meet stakeholder expectations – particularly around reliability in responding to requests, waiting time for services, length of visit and quality of inputs. This is reflected in some calls for more community-based staff e.g. District Nurses and local mental wellbeing expertise. Overall, there is interest to improve and scale up existing community-based support.

Support for carers: Feedback indicated some concern that the system in place for supporting carers and enabling carers to look after themselves is insufficient for the actual and potential demand. Carers are essential for providing a flexible response to need that extends beyond clinical intervention and a resource which lowers demand and costs to services[53].

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52 https://www.gov.uk/government/publications/covid-19-response-living-with-covid-19/covid-19-response-living-with-covid-19#living-with-covid-19

53 The 2022 Kingston Carer Strategy has identified priorities and gaps, and a partnership action plan is being developed to address concerns that the system in place for supporting carers and enabling carers to look after themselves is at times insufficient.

Prevention: Access/ ability to take early intervention and preventative action, for example access, affordability, and appropriateness of opportunities for physical activity which was the area most identified by responders for its potential to improve the health of residents. There was some feedback that early intervention and preventative work was suffering due to scarcity of resources and that there was an 'expertise' gap in some professional areas such as early mental health support and care staff with expertise in co-existing conditions and neurodiversity. This sat alongside some general concerns about sufficiency of current staffing resources, especially community-based staff and care staff, but also specialist clinics and services for depression and anxiety.

What influences health in Kingston? The conditions in which people are born, grow, live, work and age

Some estimates suggest that health care may only account for between 15% and around 40% of people's overall health[54]. Other factors, known as the 'wider determinants of health', are thought to influence the majority of people's health[55] .

Following and using the Office of Health Improvement and Disparities (OHID) data, key highlights of some of the wider determinants of health in Kingston issues are summarised below. Further detail is in the main JSNA document, which also covers a range of other wider social determinants not covered in this summary:

Education

Education is a key health determinant – children who have 'better education' and do better at school tend to have better health outcomes and vice versa. We consider children eligible for receiving Free School Meals (FSM)[56] as a proxy for looking at how children from poorer households do at school compared to those living in less income restricted households. Children eligible for receiving Free School Meals (FSM) in Kingston do less well compared to children entitled to FSM in nearly all other London boroughs on a number of measures at younger ages. There are variations in achievement levels by ethnic groups in Kingston, with Black boys having the lowest achievement at Key Stage 4 ('Attainment 8'). Nationally, Gypsy Roma and Traveller children have the lowest Attainment 8 outcomes[57]. Local data on this is not published. Data is not published at the borough level for children receiving Free School Meals (FSM) and ethnicity. However, national data[58] for 2020/21 shows that white children eligible for Free School Meals have the worst educational outcomes of all ethnic groups

[54] The Kings Fund, 'Broader determinants of health: Future trends'; link [Accessed April 2023]

[55] World Health Organization, Commission on Social Determinants of Health. Geneva: WHO; 2008. Closing the gap in a generation: health equity through action on the social determinants of health. CSDH final report. [PubMed] [Google Scholar]

[56] https://fingertips.phe.org.uk/search/free%20school%20meals#page/3/gid/1/pat/6/par/E12000007/ati/402/are/E09000021/iid/93865/age/175/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0

[57] https://www.ethnicity-facts-figures.service.gov.uk/education-skills-and-training/11-to-16-years-old/gcse-results-attainment-8-for-children-aged-14-to-16-key-stage-4/latest

[58] https://www.ethnicity-facts-figures.service.gov.uk/education-skills-and-training/11-to-16-years-old/gcse-results-attainment-8-for-children-aged-14-to-16-key-stage-4/latest#:~:text=Eligibility%20for%20free%20school%20meals%20(FSM)%20in%20England%20is%20used,scores%20than%20non%2Deligible%20pupils

eligible for FSM at this age. National data and London data shows that 'Children Looked After', perhaps the most in need, have the worst educational outcomes of all children[59].

Crime

It would not be uncommon for people thinking about health, treatment for illness and health improvement not to consider crime as a factor with immediate impact. However, crime affects physical and mental health in many ways. Violence against people is the most direct link, while the psychological effects of experiencing crime, whether violent or not, can also have far-reaching consequences. Through less direct channels, the fear of crime can not only have psychological effects but directly reduce health promoting behaviours such as physical activity and social contact. There are also strong links between fear of crime, physical environments that enable people to feel safe and social and physical activity for some groups, whether young children are allowed to 'play out' or whether older people, people with disabilities and women feel secure at night on the streets.[60]

We include data around crime in our consideration of the wider social determinants, however the data often doesn't help us identify direct causal relationships. The data we have at our disposal looks at Kingston's crime levels in relation to other London Boroughs. This shows that while Kingston has the same or lower levels of crime than other boroughs, there is a worryingly upward trend in crimes of violence and sexual offences. In fact, Kingston has the 9th highest level of violent crime in the form of a sexual offence of all London boroughs for the latest data of 2021/22.

Housing

Accessing housing for those on a low income:

Kingston has the second to lowest total percentage of social-rented households in London at 11% (32 out of 33 London boroughs). The London average percentage of social-rented households is 23.1%[61]. The lack of social and affordable housing available in Kingston is a significant issue, as highlighted in Kingston's Interim Housing Strategy 2020-25[62]. Kingston's Homelessness and Rough Sleeping Strategy 2022-27 cites the lack of affordable accommodation in Kingston as leading to a high use of temporary accommodation in the borough and some out of borough placements. People are placed in temporary accommodation through the council's Private Leasing Scheme until a permanent sustainable home is sourced. In March 2020, there were 862 households in temporary accommodation across Kingston and in out of borough placements which rose to over 904 families by March 2022. At present the main exit route for people in temporary accommodation is into social housing. This is a restricted and limited option due to the small number of properties which are available for homeless households in Kingston. Kingston was only able to provide 85 households with family sized social housing in 2021/22 (47 from RBK housing stock and 38 from Registered Provider partners).

Overcrowding and quality of housing:

The Health Foundation has highlighted the fact that housing is much more than a physical structure and influences our health in many ways. Housing should be warm and dry, have enough space for everyone, feel safe, be affordable, stable and be connected to services and networks. The standard of housing is hugely important, for example, "a warm and dry house can improve general health outcomes and specifically reduce respiratory conditions".

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59 https://explore-education-statistics.service.gov.uk/find-statistics/outcomes-for-children-in-need-including-children-looked-after-by-local-authorities-in-england

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

61 ONS Census 2021 (via Nomis)

62 Interim Housing Strategy 2020-2025; link.

Insecure, poor quality and overcrowded housing causes stress, anxiety, and depression, and exacerbates existing mental health conditions[63]. Overcrowding affects the quality of relationships between those living together as families, creates stress, and is a risk for mental health outcomes and poor health behaviours[64]. Amongst children, overcrowded living conditions are a risk for poorer socio-economic development and educational outcomes, both of which can contribute to poor mental and physical health outcomes during young adulthood and later life. According to the 2021 Census, 6% of households in Kingston were overcrowded (with fewer bedrooms than required). This varies across the borough, with the highest concentrations of over-occupied bedrooms found in Norbiton (11.3%), Green Lane & St James (8.4%) and Tolworth (7.0%) wards.[65]

Work and the labour market

For work and the labour market, Kingston's performance is similar to, or better than, the rest of England. However, Census 2021[66] data shows significant 'within borough' variation that aligns with the most deprived areas where unemployment, numbers of residents who classify themselves as long term sick or disabled, and the economically inactive is double the rates for some other areas within the Borough.

Income

Income is an important factor relating to health outcomes[67]. The data here compares Kingston as a whole to the other London boroughs[68]. The 'Indices of Multiple Deprivation' (IMD) is also available at lower level geographies, which provides a more detailed view of in borough differences (see https://data.kingston.gov.uk/ for more information)[69]. Kingston either performs better or at the same level as other London boroughs on all but one indicator, gender pay gap (by workplace location). Despite this, there were 2,277 children under 16 years in absolute low income families in Kingston in 2020. 6,385 people were estimated to be in fuel poverty in 2020 in Kingston, a number that has likely increased with the 'cost of living' pressures and steep rises in fuel costs over 2022 and 2023.

Two geographical areas emerge as particularly impacted by low-income levels. The Cambridge Road Estate and Alpha Road area are both within the 20% most deprived 'LSOAs' nationally with regard to income deprivation.

Gender pay gap (by workplace location):

Kingston is an outlier, showing that it has a significantly higher (worse) gender pay gap than the average London borough (by workplace location). It had the fifth highest pay gap of all London boroughs in 2020, with an increasing gap since 2017 (a trend not seen across England).

Natural and Built Environment:

The Natural and Built Environment data covers a wide range of issues ranging from transport to some aspects of housing. The data, which is from the latest available year (which differs by indicator), shows that Kingston fares less well in five of the main 'natural and built

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[63] de Sa, J. (2017). *How does housing influence our health?* | The Health Foundation. [online] The Health Foundation. Available at: link.

[64] Bell, R., and Marmot, M. (2018). *Social Inequalities and Mental Health* [Book chapter]. Available from: D. Bhugra, K. Bhui, S.Y.S. Wong and S.E. Gilman (Eds.), *Oxford Textbook of Public Mental Health.* Oxford University Press. [Accessed 04 January 2020]

[65] ONS Census 2021 (via Nomis)

[66] ONS Census 2021 (via Nomis)

[67] Money and Resources, *What drives health inequalities?* http://health.org.uk/evidence-hub/money-and-resources (accessed December 2022)

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

[69] Kingston Data Website, 'Deprivation' section, provides Indices of Multiple Deprivation Data by various geographies, including borough, and data by each ward. Link; accessed April 2023.

environment' indicators compared to England as a whole. The five outlier factors where Kingston performs worse than England as a whole are: **A**. ***high prevalence of premises licensed to sell alcohol per square kilometre*** (data 2017/18). Kingston is similar to other London boroughs for this indicator, **B *'Access to Healthy Assets and Hazards Index (AHAH)***'. The AHAH index comprises four domains: access to 'unhealthy' retail services, access to health services , the physical environment and air pollution The third outlier area is **C: *Air Quality*** (data 2021, 2020) (See Air Quality Section in the fill 2023 JSNA). The fourth outlier area is: **D** '***Winter Mortality Index*** (data from Aug 2020-July 2021) which compares the number of deaths that occurred in the winter period (December to March) with the average of the non winter periods (August to November and April to July). Winter mortality is not solely a reflection of temperature, but of other factors as well, including respiratory diseases and pressure on services, both of which have been more intense than usual during and following the height of the pandemic. The fifth outlier is ***emergency hospital admissions due to falls in people aged 65 years and over***. For 2021/22, Kingston was an outlier (significantly worse than London as a whole) for emergency hospital admissions due to falls in people aged 65 and over.

A further look at smoking, obesity and physical activity, alcohol and mental health

As part of the Top 5s review of the Kingston illness and mortality data, the key risks were also considered within the Global Burden of Disease data from 2019. For all age groups, poor diet (and related overweight / malnutrition) features as one of the Top 5 risk factors for ill health and mortality. Tobacco is the number one cause of ill health and mortality for adults. Alcohol features as a key risk factor for age groups starting from children and young people to the oldest age categories. Air pollution features as a risk factor for Kingston's youngest residents.

In this section we briefly consider the way some headline risks impact on health and what data exists to help us understand the greatest risk areas for the Kingston population. Shown here are brief summaries of wider reports that can be found on the JSNA 2023 webpages.

Smoking and respiratory health

Tobacco was the number one risk to health and premature mortality and mortality for adults in Kingston for the 2019 data. Smoking is uniquely harmful, causing damage not only to smokers themselves but also to the people around them. Smoking is one of the main causes of health inequalities in England, with the harm concentrated in disadvantaged communities and groups. A wide range of diseases and conditions are caused by smoking, including cancers, respiratory diseases, coronary heart and other circulatory diseases, stomach and duodenal ulcers, erectile dysfunction, infertility, osteoporosis, cataracts, age-related macular degeneration and periodontitis[70].

There is a major implication for Adult Social Care related to smoking. Smokers in England need care when they are 63, ten years sooner than non-smokers. The analysis, by Landman Economics for ASH, finds that 1.5 million people need help with everyday tasks, such as dressing, walking across a room and using the toilet, due to smoking[71].

A quarter of the risk of death for Kingston adults is due to smoking. In 2021 adult smoking prevalence within Kingston was about 1 in 10 adults (10.5% compared to 13% nationally). In

[70] National Institute for Health and Care Excellence (NICE), 'Smoking cessation: What are the harms caused by smoking?', last updated March 2023. Link. Accessed: May 2023.
[71] https://ash.org.uk/media-centre/news/press-releases/over-1-5-million-people-need-social-care-because-of-smoking

Kingston people in routine and manual occupations have much higher smoking rates than others in Kingston - nearly 1 in 5 people in Kingston in these types of occupations smoke (18.5% in Kingston, compared to 24.5% nationally). Amongst people with long term mental health conditions in Kingston, nearly 1 in 3 of these smoke (28.7%)[72].

Asthma, air pollution, tobacco and housing quality: Smoking also links to another key long term condition prevalent in Kingston - asthma. Air pollution is another risk factor for young people linked to asthma, identified in the Global Burden of Disease data. In the UK, around 5.4 million people are currently receiving treatment for asthma; the equivalent of 1 in every 12 adults and 1 in every 11 children. In Kingston, the prevalence of asthma and other respiratory conditions (14.9%) in childhood (0 to 19 years) outweighs all other classes of disorder. In Kingston adults, asthma or other respiratory conditions are in the top five long term health condition categories in adulthood in Kingston in 2022 with 11,664 (9.5%) of residents.

There are links between development and severity of asthma and smoking tobacco, which can be reversed with smoking cessation. There are also evidence-based interventions to address tobacco use. Please see the full JSNA for further details of the programmes in Kingston and further details on the health and care system impact.

Alcohol

In adulthood, excess alcohol consumption, alongside smoking and excess weight, is a key risk factor for ill health and death. Alcohol is cited as third in the top 5 risk factors for ill health in Kingston for those aged 20-69[73]. Like other London boroughs, Kingston has a high density of alcohol selling premises. While the level is similar to other London boroughs, compared to England as a whole, Kingston is in the top 10% of local authorities with the highest (worst) density of alcohol selling premises nationally[74].

Geographical hotspots Hospital admissions for alcohol attributable conditions (broad definition) from 2016/17-2020/21 suggests higher rates coming from those living in Norbiton and Berrylands wards. Norbiton ward includes the Cambridge Road Estate area with the highest deprivation in the borough; Berrylands ward includes the Alpha Road Estate area (social housing) These figures are higher than expected, given the age profile, when compared to the national picture.

Additional data Kingston's Substance Misuse Needs Assessment carried out in 2022 suggested residents are less likely to abstain from[75] alcohol (13.8%) than the rest of England (16.2%), although fewer (17.5%) are drinking over 14 units per week compared with the rest of England (22.8%) (2015-2018, via LAPE, PHE). The assessment also highlighted Kingston had the third highest rate of hospital admissions for alcohol related conditions in the under 40's age group and the highest rate in London for admissions by intentional self poisoning by alcohol (2021/22 data). For further information, please see the full report in the main JSNA.

[72] PHE Fingertips 2021 available from https://fingertips.phe.org.uk/profile/tobacco-control/data#page/4/gid/1938132900/pat/6/par/E12000007/ati/401/are/E09000021/iid/93454/age/168/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0 [accessed May 2023]

[73] Global Burden of Disease Survey; 2019. Source: https://www.healthdata.org/gbd.

[74] Source:Public Health England: Risk Factors Intelligence (RFI) team (from published Home Office data) (2017/18). Accessed via OHID Fingertips: Local Authority Health Profiles - OHID

[75] PHE Alcohol Commissioning Support Pack 2023-23

Weight and Physical Activity

Overweight in children in Kingston almost doubles between the first year and last years of primary school[76]. In adults, over half of all residents are overweight[77] and about one in 16 adults, obese[78]. Despite being a borough doing well overall on many health indicators at the borough level compared with other areas, about 15% of adults are physically inactive[79], a factor closely related to weight. The JSNA Top 5 analysis shows that obesity is one of the top five risks for both ill health and premature mortality for adults. Diet-related conditions also feature for our youngest residents, with 'Child and maternal malnutrition' being one of the top risk factors for ill health in the under 5s, as well as dental caries, strongly associated with diet, the number one reason for admissions to hospital for those aged 5-19 years.

The Kingston data shows that overweight and overweight-related risks are concentrated in certain areas and in some groups. Nationally, overweight in children is much more common in those living in the more deprived areas compared to the least deprived. Thus, overweight and obesity, and related health conditions, are likely to play a role in the gap in both life expectancy and healthy life expectancy in the borough between the most and least deprived residents.

Obesity-related ill health not only causes difficulties for the individuals and families affected, but also, in the short, medium and long term adds to costs for council services and NHS services. Such services include mental health services for children and social care costs for adults. In terms of diabetes alone, one estimate suggests that the total amount spent on caring for people with diabetes in social care settings represents 12.7% of the total amount spent on caring for people in residential care, nursing care and home care settings across England[80]. If trends in such obesity related conditions rise, the council care and other services will face potentially overwhelming rises in costs if budgets do not rise at the same rate.

Hospital admissions: There has been a large increase in hospital admissions where obesity is a factor for Kingston. A decade ago, there were 251 hospital admissions per 100,000 population in 2013/14. This had increased to 1,027 per 100,000 in 2019/20[81]. For hospital admissions directly attributable to obesity, the Kingston rate doubled between 2017/18 to 2019/20 from 13/100,000 per year to 28/100,000 per year.

Childhood and weight: In childhood, being overweight or obese is associated with asthma, early onset type-2 diabetes and cardiovascular risk factors. Some mental health conditions such as depression, low self esteem and behavioural problems[82] are also linked to childhood

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https://fingertips.phe.org.uk/search/weight#page/4/gid/1/pat/6/par/E12000007/ati/302/are/E09000021/iid/20602/age/201/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0

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80 https://www.diabetesfrail.org/wp-content/uploads/2015/07/Idop-behind-closed-doors.pdf

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https://app.powerbi.com/view?r=eyJrIjoiYzVlMTAxM2ItMzQ1Ni00ZmUxLTg0MzAtYTRjMmM5MjVjZjNhIiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9

82 http://healthsurvey.hscic.gov.uk/media/78619/HSE17-Adult-Child-BMI-rep.pdf

obesity. Poor diet is also associated with poor oral health. As the data has shown, dental caries are the number one reason for child hospital admissions in Kingston for those aged between 5 and 19 years.

Older Children (5-19 years): Childhood obesity and excess weight are significant health issues for children and their families[83]. Obesity is linked with a range of adverse physical, mental health and societal outcomes, and children living with obesity are at a greater risk of being overweight and having life-limiting comorbidities in adulthood[84]. Nationally, obesity prevalence is highest among children living in the most deprived areas, with children more than twice as likely to be living with obesity than those living in the least deprived areas[85] [86]. The 2021/22 'NCMP' (schools height and weight measurement) data shows that in Kingston around 1 in 6 children (16.8%) in the Reception Year (aged 4-5 years) were overweight or living with obesity. Levels of excess weight nearly double while children are in primary school. In Year 6, almost 1 in 3 children (29.8%) in Year 6 (aged 10-11 years) were overweight or living with obesity. While Kingston's children show better (lower) levels of being overweight than most other London boroughs, children being overweight is a significant issue for the borough.

Adult weight: According to 2021/22 data, 57.2% of adults in Kingston are overweight, compared to the national average in England (63.8%)[87] [88]. In Kingston, the latest data from GP records shows that 10,240 adults in the borough were recorded as being obese in 2021/22. The data also indicates that obesity levels are highest among the more deprived areas of the borough.

Poor diet and physical inactivity are leading risk factors for overweight and obesity. 15% of adults in Kingston were physically inactive in 2021/22[89], which is lower than the national average of (22.3%)[90]. Poor diet and physical inactivity also significantly increase the risk of developing other conditions (some which also feature in the Kingston Top 5 causes of ill health and mortality) including type 2 diabetes, some cancers, cardiovascular and liver disease, dementia and mental health conditions[91]. Cancer Research UK has highlighted the role of obesity in cancer, second only to tobacco as a cause, and a growing risk factor[92]. Obesity can also impact day-to-day living as a result of breathing difficulties, tiredness and joint pain.

Diabetes: There is an estimated threefold increase in the development of diabetes associated with being overweight and a 7-fold increase in those with obesity[93]. Numbers of people in Kingston with diabetes is showing an upward trend, with 9,378 Kingston residents recorded with diabetes in 21/22, an increase of over 2,000 people in a decade from 7,142 in 2012/13[94].

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[83] "Childhood obesity: applying All Our Health - GOV.UK." 7 Apr. 2022, link. Accessed 11 May. 2023.
[84] "Interventions to prevent obesity in school-aged children 6-18 years." 19 Oct. 2022, link. Accessed 11 May. 2023.
[85] "Obesity statistics - The House of Commons Library - UK Parliament." 12 Jan. 2023, link. Accessed 15 May. 2023.
[86] "Latest obesity figures for England" - NHS Digital, link. Accessed 15 May 2023.
[87] Baker, Carol, House of Commons Library, Obesity Statistics. Published January 2023, link. Accessed 10 May 2023
[88] Public Health Profiles by Local Authority (Fingertips), link.
[89] https://fingertips.phe.org.uk/search/inactivity#page/4/gid/1/pat/6/par/E12000007/ati/302/are/E09000021/iid/93015/age/298/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0
[90] Public Health Profiles, Physical Activity profile, link. Accessed May 2023.
[91] NHS England, Obesity - Causes, link. Accessed May 2023.
[92] https://www.cancerresearchuk.org/about-cancer/causes-of-cancer/obesity-weight-and-cancer
[93] Managing obesity in people with type 2 diabetes | RCP Journals
[94] https://fingertips.phe.org.uk/search/diabetes#page/4/gid/1/pat/6/par/E12000007/ati/402/are/E09000021/iid/241/age/187/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0

Back pain: Back pain is the top cause of ill health for adults (20-69 years) in Kingston (1,752 adult residents)[95]. While back pain can have many causes, data shows obesity can also be a risk factor. Research has shown that the prevalence of back pain found in people with higher BMI compared with those at normal or underweight BMI showed a gradual increase with each BMI increment[96].

Mental health and co-existing conditions

The data in this JSNA has shown the link between mental health problems and deprivation. In adults (20-69 years), mental health is the second highest long term condition, with rates by deprivation showing much higher rates for residents living in areas in the lowest deciles (2-5: most deprived areas) than all other residents[97]. This is supported by Kingston's Better Mental Health JSNA 2021 (MH JSNA 2021)[98], which describes the association between deprivation (a lack of money, resources and access to life opportunities) or being in a position of relative disadvantage (having significantly fewer resources than others) and poorer mental health outcomes[99].

Interaction between physical and mental health: There is a strong bi-directional relationship between obesity and mental health issues, particularly depression[100]. Preventing and tackling obesity through exercise, are protective factors against poor mental health. Some minority ethnic groups, as well as disabled people, have lower rates of participation in physical activity. Furthermore, men are more active than women and activity declines with age[101].

People with long term physical illnesses ('Long Term Conditions' or 'LTC') e.g. diabetes and COPD, suffer more complications if they also develop mental health problems. Yet much of the time this goes unaddressed[102]. There are a number of areas with high proportions of people claiming benefits for support with a limiting long-term physical or mental health condition or disability, including Chessington/south of the borough. The Kingston Mental Health JSNA 2021 notes the importance of increasing access to psychological therapies for those with LTC.

It is of note that Berrylands ward had the highest levels of mental health disorders as well as of respiratory long term conditions. Two thirds of people with serious mental health problems die prematurely due to treatable cardiovascular, pulmonary and infectious diseases[103] and smoking is the single largest contributor to their 10-20 year reduced life expectancy[104]. Smoking prevalence in adults with a long term mental health condition in 2020/21 was higher in Kingston than the London and England averages[105].

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[95] The Global Burden of Disease (GBD) study, 2019. Link.

[96] Su, C.A., Kusin, D.J., Li, S.Q., Ahn, U.M. and Ahn, N.U. (2018). The Association Between Body Mass Index and the Prevalence, Severity, and Frequency of Low Back Pain: Data From the Osteoarthritis Initiative. *Spine*, [online] 43(12), pp.848–852. Link.

[97] ONS Census 2021, 'Health, Disability and Unpaid Care', link.

[98] A summary of the' Better Mental Health JSNA 2021' is available on Kingston's 'lets talk' website:link. An accessible version of the report will be published on the Kingston data website shortly.

[99] Poverty and Social Exclusion, 2016. Deprivation and Poverty [Online]. Available from: https://www.poverty.ac.uk [Accessed 10 December 2019].

[100] Mannan, M., Mamun, A., Doi, S., & Clavarino, A. (2016).' Is there a bi-directional relationship between depression and obesity among adult men and women?': Systematic review and bias-adjusted meta analysis. Asian journal of psychiatry, 21, 51-66. Link.

[101] Public Health England, Health Matters, Getting every adult active every day. Published: 19 July 2016. Link.

[102] NHS England (A report from the independent Mental Health Taskforce to the NHS in England), The Five Year Forward View for Mental Health. Published February 2016, link.

[103] Public Health England, Better Mental Health Toolkit: Working Aged Adults: Integrating Physical and Mental Health. Published, October 2019. Link.

[104] Brown S, Kim M, Mitchell C et al (2010) Twenty-five year mortality of a community cohort with schizophrenia. British Journal of Psychiatry, 196, 116-121.

[105] Public Health Data (Fingertips): Mental Health and Wellbeing JSNA. Link.

For further details on mental health, please see the main JSNA 2023 and also the 2022 Kingston Mental Health Needs Assessment (See: https://data.kingston.gov.uk/).

Where you live, and why this matters

Having reviewed the Kingston data, some clear geographical patterns emerge about where need is particularly high. The full JSNA contains a lengthy description of how geographies are described and what the various areas are. Unfortunately, our boundaries and the boundaries of other organisations whose data we access and use are not always coterminous but we can still see particular geographies where there are greater levels of poor health and these broadly map against areas of deprivation. Kingston's key poor health hotspots are the Cambridge Road Estate and, somewhat, the Alpha Road area. The Cambridge Road Estate is an area of Kingston where poor health outcomes are much higher than other parts of the borough for a range of key issues. Please see the full JSNA for further details and also the recent Cambridge Road Estate Health Needs Assessment[106]. In addition to this poor health 'hotspot' there are also some geographical variations in health outcomes, some of which are age-related and thus are linked to areas where there are more older people. Some health conditions particularly related to the environment (both housing conditions and also air pollution), such as asthma, vary in different geographical ways and these are outlined in the fuller document.

Climate

The world has warmed by about 1.2 degrees Celsius since the industrial revolution and we are seeing serious impacts around the world and locally. At time of writing, the world is not on track (by reducing carbon emissions) to keep temperatures within the 'safe limit' of 1.5 degrees Celsius as per the Paris Agreement, and this means that Kingston's health and social care sector needs to prepare for an increase in the severity of climate change impacts on its populations and factor in predicted impacts of climate change into all policies and services.

Kingston Council declared a Climate Emergency in June 2019, and adopted a Climate Action Plan in March 2022. The Climate Action Plan mentions improvements in health and wellbeing as one of the main co-benefits of climate action. Any action to reduce carbon emissions at the local level will not only contribute to Kingston doing its fair share of reducing worldwide emissions as per the Paris Agreement, but also bring health benefits related to warmer and better-insulated homes, green spaces full of biodiversity, healthier and more active people, a reduction in poverty in inequality and better air quality (CAP p.8).

One of the main five recommendations of the most recent Marmot Review is to *create and develop healthy and sustainable places and communities* (Health Equity in England, The Marmot Review, 10 years on). The report highlights that mitigating climate change will also help mitigate health inequalities. It is recommended that this is done by improving active travel, green spaces, the food environment, transport and the energy efficiency of housing.

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

The impacts of the climate crisis will not be felt equally across the borough. How badly a person or group will be affected will depend not just on their exposure to the event, but on

[106] https://www.cambridgeroadestate.com/assets/pdf/CRE_HNA_final_(Nov_2021).pdf

their social vulnerability - that is, how well they are able to cope with and respond to events like floods and heatwaves.

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

- Very young children
- Older people (On average, Kingston has a slightly older population compared with other boroughs, see Census, 2021)
- People in poor health and with underlying health conditions
- Poor mobility, disabled mentally or physically
- Deprived and low income (see areas of deprivation in Kingston, and areas at risk from cost of living crisis JSNA from slide 97 onwards)
- Socially isolated
- Tenants and people on short stay
- Ethnic minority and non-English speaking
- People in particular type of housing vulnerable to climate change - high rise, basement flats, poorly insulated (all present in Kingston)
- People lacking access to green infrastructure (Kingston ranks among 20 local authorities with least natural space per person in England, see Mapping Access to Nature report p. 27, and a FoE interactive map)

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

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

Both nationally and in Kingston, we are likely to experience some of the following: injury & death related to extreme weather events, increases in heat related illness (see areas with high heat hazard score and GLA climate risk maps combining exposure and social sensitivity to risk), changes in disease patterns - worsening existing diseases and new diseases emerging, Mental health impacts (e.g. Climate anxiety in children), Food and water scarcity due to droughts, Respiratory and heart diseases related to wildfires and ground level ozone (see for example Harvard), Increase in allergies due to changes in pollen season (see Harvard)

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

Reducing carbon emissions and mitigation for health and care:

Health and care systems should especially focus on the following priorities for carbon emissions reduction and **mitigation,** that also offer significant public health benefits (adapted from Climate and Health and Health and Climate Change).

Active Travel and climate

The transport sector is the largest contributor to greenhouse gas emissions in the UK. A reduction in road transport and increase in active travel will provide multiple health benefits including decreasing obesity-related morbidity and mortality. According to sources, increasing

physical activity by cycling and walking, and minimising the time spent sitting down, helps not just to maintain healthy weight but also reduces the risk of cardiovascular disease, type 2 diabetes, cancer and depression. Reducing road travel will also bring improvements in air quality (see below)

Air Quality and climate

Air pollution and climate change are closely related (WHO). As well as driving climate change, the main cause of CO_2 emissions - the extraction and burning of fossil fuels - is also a major source of air pollutants. Air pollution is linked to a risk of a range of diseases and conditions including cardiovascular (e.g. coronary heart disease, stroke) and respiratory diseases (asthma, lung cancer) (see Health Matters and BLF). Kingston has high rates of asthma and lower respiratory infections in all age groups. The prevalence of asthma and other respiratory conditions in childhood outweighs all other classes of disorder, and COPD is in the top five causes of both morbidity and mortality in Kingston's older residents (JSNA) Air pollution, often linked to the above-mentioned diseases, is also more likely to affect people who are already more vulnerable to climate change impacts, such as those living in deprivation and BME groups. (see Mayor of London)

Housing and climate

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

Food and climate

The foods most damaging to our health are often those with the highest emissions, pollution, land and water use. Policies to reduce meat consumption – especially red meat – and increase the consumption of vegetables and legumes would reduce both greenhouse gas emissions and the incidence of some of the leading causes of death in the UK. Food growing, apart from benefits for climate mitigation (reducing emissions from transport), adaptation (reducing dependency on imports and resilience to potential disruption to the global food production) also brings mental and physical health benefits, and should be part of social prescribing by GPs, healthcare commissioners and healthcare providers (Mayor's Food Strategy p.43).

Green spaces and climate

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

In 2017 the Natural Capital Accounts for public greenspace in London, calculated that Kingston was the 26th greenest of the 33 London Boroughs in terms of proportion of area under publicly accessible green space[107]. A 2020 study by Friends of the Earth identified that Kingston was one of the 50 UK council areas which need to be prioritised for green space investment because they have the greatest number of green space-deprived neighbourhoods[108]. These statistics for areas of open space deprivation are likely to only worsen if projected local population increases are realised.

Overcoming barriers to the community accessing public spaces to improve their physical and mental health, requires a clear alignment of the Council's Climate Action agenda and

[107] Natural Capital Account for London, 2017. London.gov.uk. Link.
[108] England's green space gap, Friend's of the Earth. Published: September 2020; link.

Greenspaces Strategy, with the work of the Public Health team and as part of the Health and Wellbeing Strategy for Kingston. This includes protecting and promoting green spaces and nature-based interventions for health such as 'green walking' for mental health or 'green social prescribing', food growing, improving the health of people and the planet, while reducing health inequalities. (see Health and Climate)

Communication and access to information and services

Communicating about health and care - such as staying healthy advice, information about a particular condition, details about available services or emergency information - has always been important. Over the last three COVID-19 pandemic years, this has been particularly critical with large amounts of highly important, new and urgent information to be imparted - and there has been much learning about ways to reach people, types of information that are helpful and measuring uptake of information. The importance of clarity of message, ease of finding information and analysing whether information being shared is effective has been shown. In the absence of available comprehensive local media use, national data was reviewed on media use by adults and children, including the types of media used (e.g. social media, television) and the different ways in which each media type is used or accessed. Please see the full JSNA 2023 for details on types of media use and recommendations for how health and care messages could be communicated.

Recommendations:

Climate:

1. Communicate clearly the benefits of climate action for **reducing health inequalities.**
2. Continue to promote health and lifestyle advice to residents to encourage increased use of greenspace, active travel and in the continued development of the social prescribing offer in Kingston, ensure 'green' social prescribing offers are promoted and embedded in our offers for residents.
3. Review existing and upcoming **health & care strategies and plans** to reflect the importance of climate change as a health & wellbeing issue
4. Ensure the climate change agenda and the most recent knowledge on health & care related impacts are represented by at least **one designated member of the Health & Wellbeing Board** with a specialist knowledge.
5. Review existing climate change mitigation plans across healthcare providers (e.g. NHS Green Plan) and consider models for whole system coordination.
6. Review current adaptation plans, and enhance as required, to tackle each predicted health impact of climate change locally (e.g. Under the Weather)
7. Review processes and design frameworks for joint working of Public Health, Social Care, Health colleagues and VCS with emergency response & emergency planning to ensure the most vulnerable will be protected during extreme weather events.

Obesity Recommendations:

1. Continue to develop local breastfeeding support and building on good progress with the Baby Friendly Initiative in Kingston

2. Further promotion of the ‘Healthy Start’ scheme as part of future communication and engagement and more targeted work to increase the uptake. Review best practice in other areas that have higher take up.
3. Carry out targeted work promoting physical activity and healthy diet to reduce increasing levels of overweight in schools (and surrounding areas) with high levels of increasing overweight between Reception and Year 6
4. Schools – all schools to support to implement 30 minute daily physical activity for all children as per the National Plan of Action on Child Obesity[109] and further encourage uptake of the Daily Mile where not already adopted
5. Continue to expand the ‘Play Streets’ initiative to increase physical activity opportunities while supporting social cohesion
6. Expand oral health promotion offer in Kingston Schools and Early Years settings to reduce levels of dental caries hospital admissions
7. Expand borough level physical activity offer for early years and school age children with a focus on areas on higher deprivation
8. Ensure all new developments have adequate and easily accessible green play space for both young children and teenagers
9. Review levels of mental wellbeing support in schools in relation to need regarding healthy weight and body dysmorphia and possible eating disorders
10. Work with Transport planners to ensure that safe ways to actively travel are available in areas of high overweight
11. Review eating and drink offers for staff and residents/ patients in all local government and NHS facilities in Kingston to lead by example with ‘healthy eating’ promotion
12. Work in partnership across the borough to support people identified at high risk of diabetes in accessing and taking up healthy lifestyle measures and activities (including reviewing acceptability and access to these offers to ensure that they match local need)
13. Increase promotion and uptake of the ‘Diabetes 9 checks’ to improve health of people with diabetes in Kingston
14. Work with RBK Waste Services and other teams in partnership to reduce food waste and food associated carbon emissions while promoting healthy eating
15. Promote physical activity related activities and volunteering opportunities to maximise wellbeing and community, and support local green areas (and link these opportunities to physical activity promotion) - with a focus in areas of higher overweight and aras of premature mortality
16. Work in partnership with Parks and Green Spaces Teams and Kingston partners to try and get a daily offer physical activity offer in all Kingston green spaces - consider pilotinging in highest weight/ deprivation areas to start
17. Back pain: undertake a review of the Kingston offer of back pain services and local support to ensure that the offer meets the local need and are linked to the available preventive offers where appropriate (Back Pain having been identified as the highest cause of ill health in adults in Kingston)
18. Consider implementing evidence based ‘brief interventions;’ in General practice to provide healthy weight advice. See example from Oxford [110].
19. Continue improving safety on roads and implement segregated cycle ways, where possible, for active travel.
20. Review data on who does/ doesn't use Kingston’s existing lifestyle and healthy weight services e.g. by geographical area/ age/ sex/ condition (where possible, eg severe mental illness) etc and consider reorienting offer to meet local needs (ie check offers are available in high overweight areas)
21. Review existing lifestyle and healthy weight services on the outcomes of service users and against best practice outlined in the NICE guideline on Obesity: identification, assessment and management[111].

[109] https://www.gov.uk/government/publications/childhood-obesity-a-plan-for-action/childhood-obesity-a-plan-for-action
[110] https://pubmed.ncbi.nlm.nih.gov/27789061/
[111] https://www.nice.org.uk/guidance/cg189/chapter/Recommendations

22. Include in all new strategies, such as Leisure, Transport and others, ways to make it easier for people to be more physically active in Kingston.
23. Build on signposting by all council, NHS, pharmacies and other services to local exercise opportunities and advice on healthy eating. As part of this, consider building on GP Physical Activity Champion training
24. Consider linking campaign messaging on alcohol with messaging on healthy weight (ie calorie content of alcoholic drinks)
25. Healthy Active Ageing for Older people: ensure that appropriate offers for older people are available in all parts of Kingston, with a focus in areas in places with poorer health in older people, to stay active. Consider timing and location of offers and other considerations to make it attractive and also possibly linking to volunteering. Consider suggestions related to the 'Age Friendly Communities' guidance[112].
26. Improve assets using available development investment and other resources to allow free or low-cost exercise in the borough: parks, heritage sites (include specific exercise promotion components eg guided walks/ runs/ distance markings etc), targeting investment to the areas of highest need and consider both small and large green spaces within close reach of target residential housing
27. Ensure all new developments have adequate and easily accessible green outdoor space for adults of all ages and health status. Service areas (Council and partners) should ensure that their offers meet the standards as set out in guidance from the National Institute for Health and Clinical Excellence (NICE) in relation to obesity and physical activity. The NICE recommendations include some of the following areas: identification and management of obesity,[113]physical activity and the environment, [114]physical activity, walking and cycling,[115]physical activity in the workplace,[116]and physical activity for children and young people[117].

Smoking Recommendations:

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

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[112] https://ageing-better.org.uk/age-friendly-communities/eight-domains

[113] National Institute for Health and Clinical Excellence (NICE) Guidance, "Obesity: identification, assessment and management". Published, November 2014; last updated: July 2023. Online: link. Guidancehttps://www.nice.org.uk/guidance/cg189/chapter/Recommendations#generic-principles-of-care

[114] NICE Guidance, "Physical Activity and the Environment". Published: March 2018. Online: link. https://www.nice.org.uk/guidance/ng90 NICE guideline [NG90] Published: 22 March 2018.

[115] NICE Guidelines, "Physical activity, walking and cycling". Published: November 2012. Online: link"https://www.nice.org.uk/guidance/ph41/chapter/recommendations#:~:text=This%20guidance%20considers%20walking%20and,exploring%20parks%20or%20the%20countryside.

[116] NICE Guidelines, "Physical activity in the workplace". Published: May 2008. Online: link. Public health guideline [PH13]Published: 28 May 2008 https://www.nice.org.uk/guidance/ph13

[117] NICE Guideline, "Physical activity for children and young people". Published: January 2009. Online: link. Public health guideline [PH17]Published: 28 January 2009 https://www.nice.org.uk/guidance/ph17/chapter/1-Recommendations#recommendation-6-responding-to-children-and-young-people

5. RBK Public Health and the Smoking Cessation service to work with Kingston Hospital on the smoking part of the NHS Long Term Plan.
6. The Kingston Smoking Cessation service to work with Health Visiting, Maternity, Housing, Mental Health Services and Adult Social Care.

Alcohol

1. There is a strong evidence base for local population-wide prevention interventions for alcohol. Kingston's Public Health team facilitate the following interventions, which we recommend continue to be prioritised and disseminated out:
    a. exercising full licensing powers to manage the availability and accessibility of alcohol, and
    b. rolling out Alcohol Identification and Brief Advice (Alcohol IBA) training to key partners (such as Adult Social Care, GPs, Housing and Voluntary Sector agencies) to help individuals reduce their alcohol consumption and reduce the risks of ill health and deaths.
2. There is a need to use existing and new channels of communication and engagement to maximise the benefit of existing alcohol harm prevention and treatment services (particularly the e-drink check tool and Kingston Wellbeing Service), to residents in Kingston. This will include developing messages for different target populations to channel people to existing services. Also to collaborate with the signposted services to assess changes in access or contacts resulting from any campaigns.
3. Hospital based Alcohol Care Teams (ACT) also have a strong evidence base. They identify inpatients and A&E attendees with alcohol problems and provide specialist care. These services save money by reducing length of stay, re-admissions, A&E attendances, and ambulance callouts. Kingston is one of the few London boroughs that does not have an ACT in its hospital as the threshold for need is not felt high enough. A new review and business case to develop this service is scheduled for 2023 and it is recommended that this business case is considered.
4. Protect funding that invests in substance misuse harm reduction and treatment. Part Two of Dame Carol Black's independent review of England's drug & alcohol systems highlights the strong Return on Investment (ROI) for continued substance misuse funding (without disinvestment) by the Local Authority. Evidence suggests that for: *Every £1 currently spent on harm reduction and treatment gives a combined health and justice return on investment of £4.* Failure to invest will inevitably lead to increased future pressures on the criminal justice system, health services, employment services and the welfare system.
5. The requirement for areas to establish a 'Combating Drugs Partnership' has been set out in the current Drug Strategy published in 2021. In Kingston this is known as the Strategic Partnership for Alcohol and Drugs (SPAD). It is recommended that the SPAD ensures that there is collective leadership across all relevant partners to establish, promote and embed a clear vision to reduce drug and alcohol related harm in Kingston and ensure there is a clear strategy and delivery model owned by all key agencies.
6. There is a need for further exploration of the potential link between obesity and alcohol use in Kingston.
7. Implement the recommendations relating to alcohol in the Substance Misuse Needs Assessment including: Strengthening partnership with schools and Addressing Co-occurring/ Dual diagnosis

Geographies

1. Prioritise an urgent focus on the key poor health 'hotspot' of the Cambridge Road Estate: Work with Cambridge Road Estate (CRE) residents and other local partners to address residents' top priorities for improving their health and wellbeing - reducing

crime and anti-social behaviour, improving mental health, having more support with long-term health conditions (including cardiac health), having improved estate facilities, and having help with increasing their levels of physical activity and exercise. Consider similar work for Alpha Road estate.

2. High levels of obesity in Chessington PCN and depressive disorders in Surbiton PCN are the two stand-out disparities in the PCN 'top 5' analysis. Further analysis on the reasons behind these figures should be undertaken, and a review of current related services and uptake, with a view to enhance service provision.
3. Encourage local services in Surbiton to become Be Well hubs[118] and to become places for people to turn to when they feel their mental health is low or simply to feel more connected with their local community
4. A more general look into the South of the Borough could be beneficial, can any factors be established that might link in with residents' poorer health overall? Are there sufficient local services and facilities? Is distance or limited / lack of transport a barrier?
5. Norbiton and Berrylands wards have the highest levels of several morbidities, risk factors, and causes of death in the borough. Furthermore the health-related local improvements identified in the CRE Health Needs Assessment resident survey were 'to improve and support residents to manage their long-term conditions' and 'support with mental health', 'reducing crime and anti-social behaviour', having improved Estate facilities, and having help with increasing their levels of physical activity and exercise. This data suggests there may be a need for targeted local services in these areas to reduce wider inequalities (e.g. targeted comms, pop up services etc), which should be considered.
6. The difference in incidence of colorectal cancers is very broad at ward level, with some areas seeing 2.5 times as many cases as others, given resident age profiles. Kingston's screening uptake at borough level is increasing and one of the highest (better) in London. Where possible, it would be useful to review data to ensure that uptake is consistently high across the borough and, if any low uptake areas or groups, consider further work to encourage uptake.
7. Are the higher incidence wards simply a result of more local screening, or could this be an area for promotion of preventative services around bowel health, healthy eating and / or screening? National data shows bowel cancer screening is lower in areas of higher deprivation.
8. Target health promotion work with older people in those areas with the highest proportion of older residents in poor health or with a life-limiting disability including developing the offer of physical activity opportunities
9. Review the existing falls prevention pathway and improve engagement of all relevant services in promotion of falls prevention services and advice.
10. Undertake targeted health and wellbeing promotion with older people related to/ linked to Pension Credit, the Warm Homes Better Health scheme and other financial support, as well as promoting the new package of support to help over 50s jobseekers back into work[119] and the Age Friendly Employers' Pledge[120].
11. *Undertake a further cross topic and deep dive analysis (drawing together expertise across all sectors and partners) to bring health, poverty and deprivation data together to identify and target multi agency action and initiate new or enhanced support, where health outcomes are poor. The aim being to reduce the rising health inequality gap locally.*
12. *Consider a further analysis of populations at particular exposure to climate related risks eg floods, heats*

Suggested areas for more in-depth consideration:

[118] *The South London Listens action plan includes establishing 120 'Be Well' hubs for people to turn to when they feel their mental health is low or simply to feel more connected with their local community.*

[119] https://www.gov.uk/government/news/new-package-of-support-to-help-over-50s-jobseekers-back-into-work

[120] https://ageing-better.org.uk/age-friendly-employer-pledge

a. Further analysis on the reasons behind higher levels of obesity in the Chessington PCN and depressive disorders in the Surbiton PCN should be undertaken, and a review of current related services and uptake, with a view to enhance service provision.

b. Further consideration of the South of the Borough area, in terms of factors that might relate to residents' poorer health overall. Are there sufficient local services and facilities? Is distance or limited / lack of transport a barrier?

c. Norbiton and Berrylands wards have the highest levels of several morbidities, risk factors, and causes of death in the borough. As referenced in the CRE 2021 review, residents have asked for local services that improve their health and wellbeing and improve how they manage long-term conditions. With the CRE development team, Housing partners and other colleagues, look at how local services in these areas can support residents and reduce wider inequalities (e.g. targeted comms, pop up services etc).

d. The difference in incidence of colorectal cancers is very broad at ward level. More information could be gathered on local screening, and where there are these significant geographical differences, targeted promotion of prevention activity and advice and the importance of screening should be prioritised.

Mental Health and Co-existing Conditions

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

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

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

Education and volunteering structures) through the Social Prescribing arrangements in GP surgeries and other locations.
8. Work with older people, particularly those who are not accessing existing services, to develop ways for them to build social connections.
9. Widely promote the new Perinatal Trauma and Loss Service and monitor the uptake of this service by Kingston mothers.

COVID-19

1. Residents are advised to follow the relevant guidance and stakeholders should keep up to date with setting specific guidelines to minimise the risk of spread of respiratory infections including COVID-19.
2. There are simple actions that can be taken to help reduce the spread of COVID-19 and other respiratory infections and protect those at highest risk. These include:
3. Get vaccinated
4. Let fresh air in if meeting others indoors
5. Practise good hygiene:
    i. wash your hands
    ii. cover your coughs and sneezes
    iii. clean your surroundings frequently
6. Wear a face covering or a face mask
7. Those who have symptoms of a respiratory infection, including COVID-19, and with a high temperature or not feeling well enough to go to work or carry out normal activities, are advised to try to stay at home and avoid contact with other people especially those who are at high risk of becoming seriously unwell if they are infected with COVID-19[121].
8. Those who have been informed by the NHS that they are at highest risk of becoming seriously unwell might be eligible for testing and COVID-19 treatments[122]
9. Ensure adults and families with children who are overweight have access to weight management support to minimise the risks of ill-health related to overweight and obesity. Borough-wide initiatives should promote and facilitate a healthy lifestyle, active travel and physical activity with not only a focus on reducing overweight, but also prevention of overweight.
10. Those with diabetes need to take steps to avoid complications to live well. They should have regular reviews with health professionals and personal care plans with targets for HbA1c (glucose control), blood pressure and serum cholesterol and regular checks set out in the '8 care processes' (plus diabetic eye screening, the '9th process'). In addition, they should have access to structured health education shortly after diagnosis and diabetes technology, emotional and psychological support and guidance on weight management.
11. All stakeholders should ensure emergency preparedness and that plans are in place to maintain resilience against significant resurgences or future variants that risk putting unsustainable pressure on the NHS and local services.
12. Consider reviewing and implementing the recommendations from the Healthwatch Kingston report on 'Living with Long Covid in the Royal Borough of Kingston upon Thames' (2022). Create a comprehensive screening process with seamless referral pathways to care and support: Ensure a multi-disciplinary team approach to care and support based on needs, supported by education and training. Develop self-help support groups (peer-led) inclusive of those that have missed an opportunity for a diagnosis. Improve integrated and coordinated care and support in the community, particularly post discharge from hospital.

[121] https://www.gov.uk/guidance/people-with-symptoms-of-a-respiratory-infection-including-covid-19

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

13. Key stakeholders should continue to work together to reach our vulnerable and high risk residents and ensure they are made aware of all vaccination offers and have easy access to vaccination
14. Continue data collection and analysis to better understand the longer-term impact of COVID-19 on the Kingston population.
15. Continue to promote services to support people suffering with the long-term effects of COVID-19, with specific health needs, as well as more holistic support offers.
16. Continue to work with Regulatory Services to promote businesses and organisations to ensure good ventilation in enclosed spaces.

Sexual Health

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

The basics of health: immunisation and education

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

Immunisation

1. Immunisation should be part of health conversations across the life course using a 'Making every contact count' approach across settings and organisations in Kingston.
2. Ensuring that all staff are trained and encouraged to have these supportive conversations needs to be developed further, including discussion around vaccine hesitancy and reluctance where feasible.
3. Translated and easy read immunisation resources should be readily available to support all immunisation conversations, as well as access to translators.
4. Colleagues across RBK (including housing and Adult Social Care), Achieving for Children (Kingston's Children's Services), the voluntary sector (including those working with new arrivals), and trusted community and group leaders should be aware of where to signpost parents and carers to immunisation information for all ages and how to register with a GP if not already registered.
5. At specific educational stages, health visitors, school nursing teams, GPs and educational staff should check vaccination history for gaps, and the importance of receiving the outstanding vaccinations should be discussed with the child or young

person and/or their parents or carers. They can also be signposted to the relevant organisation.

6. The School Health team can help to raise awareness of immunisation during Early Help Assessments.
7. Where possible, those working with parents and carers of children who are Electively Home Educated and Children Looked After should promote the offer of childhood immunisations and how to register with a GP if not already registered so these children do not miss out.
8. Offering vaccinations in a more diverse range of locations including the use of Children's Centres, should continue and reminder services to be improved by using innovative methods such as social media pop-ups.
9. The benefits of the schools based immunisation programmes should be promoted and parents and carers be encouraged to take up the offer of vaccination in the school setting. Schools should be encouraged to continue to support school based vaccination sessions.
10. Details of any additional community catch up clinics where vaccinations that have been missed, including flu (seasonal), HPV, pre-school and teenage boosters, MenACWY and MMR, can be received, should be shared widely. Access to these offers should also be available to looked after children and those who are home educated.
11. Encourage education on the value and importance of vaccination and immunisation in schools in the science and PSHE curriculum through existing lesson plans and resources.
12. All partners and those who have contact with families should check and encourage families and carers to ensure they are registered with a GP and share details of how to register if not.
13. Through data analysis from Childhood Health Information Services (CHIS), identify wards and groups with low GP registrations and work with partners to promote GP registration.

Education:

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

Communication and Navigation

1. Optimise the council's main website and Connected Kingston, as access channels for health messaging, for use on smartphones as well as web browsers, due to the prevalence of smartphone-only internet access in the general population.

2. Use the health data contained in this JSNA document to target appropriate health related messaging to target groups in the community.

3. Ensure all communications developed internally, and with partners, uses plain language and is available in accessible formats to ensure messages are easy to understand and accessible for everyone. Always consider whether there is a need to translate messages into different languages to reach non-English speakers.

4. Work with local health professionals, community leaders and other trusted sources to communicate health information in the appropriate format for the target population.

5. Share best practice internally and with partners, in terms of learning from targeted communication methods, to ensure future communications are effective and appropriate.