Prevention:
Redressing the Balance in a Time of Austerity
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In a time of austerity, the role of prevention and public health interventions in reducing societal costs associated with unhealthy behaviours and subsequent ill-health has never been more important. This Annual Report of the Director of Public Health brings together the key facts and ways to reduce the costs.

### THE CHALLENGE

1. In the London Borough of Richmond upon Thames, like elsewhere, cost pressures in the health and care system are due to the inexorable rise in numbers of people with multiple long-term conditions and, on current trends, this will become unaffordable.

2. Cardiovascular disease and cancers remain the main killers, but an increasing burden of disease and suffering is also due to mental ill health.

3. The main unhealthy behaviours of smoking, alcohol misuse, poor diet and lack of physical activity, as well as poor emotional and mental well-being are responsible for at least a third of ill health and are amenable to cost-effective preventative interventions.

4. In Richmond, despite favourable comparison with elsewhere, the absolute numbers of people who adopt unhealthy behaviours and lack emotional and mental well-being are large (tens of thousands).

5. Health behaviours are driven by choice, but also by the places and conditions we live and work in and the pressures of our day-to-day life. Emotional and mental well-being underpins all we do.

### THE SOLUTION

1. Public health interventions have an important part to play to stem the tide of long-term conditions and increasing costs. Preventative strategies that combine interventions at individual, community and population level work best.

2. There is growing evidence that, compared with population level interventions, those limited to the individual level cost around five times more and are less effective in reducing health inequalities.

3. Focusing on prevention earlier in the life-course will accumulate greater benefits, but even in middle and older age, preventative approaches are cost-effective.

4. Public health prevention strategies (both at individual and population level) are much more cost-effective than clinical interventions.

5. Health-promoting environments, i.e. those where the healthier choice is both the easier and the preferred choice, are also more economically and environmentally sustainable.

6. Local people are engaging in the debate and are willing to trade-off some of their individual choice in exchange for health-promoting environments to improve their health, the health of their families and the health of future generations.
As the Chair of the Richmond Clinical Commissioning Group (CCG), I am aware that the health care needs of many patients seen by clinical colleagues are becoming increasingly complex.

As the population in Richmond get older the CCG has the challenge of commissioning high quality health care for an increasing numbers of individuals with multiple physical and mental health problems. Good health and social care for these individuals is essential, but equally we need to get better at helping residents to stay healthy for as long as possible. This means protecting and developing an environment that enables individuals to start well, live well and age well.

There are many synergies with the NHS 5-year forward view, a plan which highlights the importance of prevention and the workplace in supporting healthy choices.

When tackling these challenges, in the context of the current financial pressures, it is important that the CCG explores opportunities for collaborative solutions. This involves close working with the local authority. I commend the publication of this annual public health report and its focus on the role of communities and the wider physical environment.

Dr Graham Lewis,
Chair of Richmond CCG

As the Cabinet Members responsible for Public Health, we commend this annual report of our Director of Public Health.

Undoubtedly one of our biggest challenges is how to stem the rise in multiple long-term conditions that causes misery to individuals and communities and will bankrupt the health and care system if action is not taken now.

Cllr Lisa Blakemore,
Cabinet Member for Housing and Public Health

Cllr David Marlow,
Strategic Cabinet Member for Adult Services and Health

I am delighted to present my fourth and final independent annual report on the health of the population of Richmond upon Thames, in fulfilment of my statutory duty as Director of Public Health. This report complements the joint Strategic Needs Assessment (JSNA) and adds to our understanding of health and well-being in Richmond.

The report considers the four main unhealthy behaviours in Richmond (smoking, unhealthy diet, being physically inactive and, drinking too much alcohol, underpinned by emotional and mental well-being), and demonstrates how these are primary causes of long-term conditions, resulting in personal and societal costs. At current trends, these costs are unaffordable.

This year we have outlined potential solutions to the challenge to make the case for preventative approaches across place, community and individual levels. Place and community level approaches are highlighted for their potential for a scaled, universal and population impact, and the report illustrates the importance of targeted individual level approaches for vulnerable groups. These solutions work together to support healthy behaviours and establish an environment in which the healthy choice is the easy and preferred choice.

I am grateful to my team and colleagues in the Adult and Community Services, Environment directorate, Achieving for Children and Richmond Clinical Commissioning Group for their positive support and contribution. These efforts are much appreciated – on top of everyone’s busy day-to-day work - and result in a more informed and collaborative output. We are keen to make our Annual Public Health Reports as useful for partners as possible. Please email PublicHealth@richmond.gov.uk with any feed-back you might have.

Dr Dagmar Zeuner,
Director of Public Health

This report makes a strong case for the importance of healthy behaviours, underpinned by emotional and mental well-being, for preventing chronic diseases, including dementia.

We very much welcome the focus of the report on affordable and publicly acceptable solutions that make best use of our local assets, such as Richmond’s active community, vibrant voluntary sector and fantastic green environment.

The report provides an overview of a whole-council approach which is in line with the council’s wider public health duties and clearly sets out the role that connected and resilient communities and our wider environments play in “making the healthy choice the easy and preferred choice”. The solutions proposed in this report are wide ranging and involve many different sectors – public, private, voluntary and community. No single organisation or department can master the challenge in isolation - the only way is by working together in partnership for and with Richmond people.
In a time of austerity

This Annual Report of the Director of Public Health is produced in a time of austerity, and a time when the costs of unhealthy behaviours are spiralling out of control.

This report aims to be purposeful and not prescriptive, using data from a range of sources and providing examples of practice to inform the debate around solutions for health improvement and sustainability. An appendix of references by chapter is available separately to the report.

People of Richmond

On the whole, Richmond’s population is healthy. However, the population is ageing and with this comes the challenge of caring for increasing numbers of people living with multiple long-term conditions. The number of people in Richmond engaging in unhealthy behaviours is substantial and the costs of dependency on health and social care are unaffordable at current trends. However, a significant proportion of long-term conditions are avoidable with the adoption of healthy behaviours.

Four key unhealthy behaviours

National evidence highlights that unhealthy diet, closely followed by tobacco, was the leading cause of poor quality and reduced length of life in 2015. Physical inactivity and alcohol are also major risk factors for disease. This report will focus on these four key unhealthy behaviours which contribute to poor outcomes.

• Smoking; all smoking is harmful, this includes exposure to second hand smoke.

• Unhealthy diet; including excess fat, sugar and salt, as well as insufficient fruit and vegetable intake.

• Being physically inactive; engaging in less than 150 minutes a week of physical activity (that is, less than 30 minutes a day for adults and 60 minutes a day for children).

• Drinking too much alcohol; drinking more than the nationally recommended limit. Too much can refer to the frequency a person has a drink and how much they have on each occasion.

Influence of place and community

The reasons for regular engagement in unhealthy behaviours are complex. They are often formed through exposure to cues in the environment, social circumstances or psychological stresses, establishing ‘automatic’ and not-chosen processes.

Emotional and mental well-being

There is a two-way relationship between emotional and mental well-being and unhealthy behaviours. Reduced emotional well-being often leads to engagement in coping behaviours, such as the consumption of high sugar foods, smoking, alcohol use and reduced activity. For example, sleep deprivation, which is often caused by stress, is one of the leading causes of obesity due to the effects of low energy, including increased craving for high energy dense foods and reduced energy to engage in physical activity. Engagement in these behaviours is then related to poor mental health, either directly, for example due to the depressant effects of alcohol, or indirectly, through the effects of weight gain following increased intake of sugary foods. This means that emotional and mental well-being must be considered for effective solutions for prevention.

Sustainable solutions

This report aims to redress the balance, by considering the potential solutions to reduce the burden of long-term conditions and costs. This will be achieved by outlining the growing evidence-base for effective, wide reaching and sustainable interventions which optimise the positive influence of places, community assets, and targeted individual level intervention. These solutions enable the uptake of healthy behaviours and psychological resilience.

Examples of effective solutions are described at three levels:

• Place and policy level solutions: including environment and planning, legislation and regulation.

• Community level solutions: including, mass media campaigns, volunteering, community cohesion, and connectivity.

• Individual level solutions: comprising services for target groups that are delivered one to one or in groups.

Where possible, the cost-effectiveness of solutions is outlined throughout.

Public willing to make the trade-offs

The public, in Richmond and nationally, are engaged in the debate and are open to exploring the trade-offs for a healthy, sustainable and prosperous environment for generations to come.
Unhealthy behaviours lead to long-term conditions

The causal chain to long-term conditions

The causal chain leading to long-term conditions is complex. The impact of a person's social and environmental surroundings, including employment and housing, and factors such as loneliness and isolation, influence the uptake of unhealthy behaviours. These behaviours go on to account for a high proportion of disease. The subsequent impact of poor health and mental well-being results in huge costs to the individual, the economy, and the health and social care system.

Health behaviours

Our social and physical environment has an impact on what we do both directly, through our opportunities and the availability of resources, and indirectly, through associated stresses and pressures. The COM-B model, displayed below, outlines how our Capability, Opportunity and Motivation influence our Behaviour.

We all make reflective and automatic decisions every day. Day-to-day activities, such as walking to work, quickly become automatic processes. The behaviour (walking) is triggered by opportunities in the physical and social environment (such as suitable walk-ways or colleagues who also walk), and psychological cues and routines (such as the effect of a long or stressful day).

The dominance of automatic processes

Automatic processes require minimum effort and dominate the majority of our activities. These routines may begin at a young age and can be sustained across the life-course.

Reflective decision-making processes are needed to make changes. These require effort and planning, which can be difficult to maintain when daily routines are dominated by cues from the places we live in and people we interact with. Therefore the focus on information-giving and motivation, which have historically been adopted to support changes in behaviour, may not be the most effective method of intervention. Instead, the place and community have a significant role to play.

The role of emotional and mental well-being

Our capability to make choices and changes is affected by our emotional and mental well-being; resources are depleted following a sustained period of psychological or physical stress. We all know, for example, how challenging it can be to do anything different if we are stressed or sleep-deprived, anxious or depressed.

Resilience is a person's ability to adapt to and recover from stresses, and respond to adverse events with positive beliefs and behaviours. This is often mistaken to be an in-built and static state, but in reality it is a process. We all experience negative emotion in response to negative events, but we are best able to be resilient to this when our social and environmental influences provide the resources for us to do so. A person's resilience, therefore, is dependent on the resources and assets available. This has a major impact on our well-being and health behaviours.
The costs of unhealthy behaviours

Initially, the costs of unhealthy behaviours can be exposed as stress, reduced productivity and short term illness and absenteeism. There can also be, however, wider societal costs. Binge drinking, for example, can result in violence (in public or at home) and accidents which can impact on the need for emergency services and treatments. Smoking is the leading cause of catastrophic house fire and, along with junk food, increases litter on our high streets.

Increasing the risk

Over time, these unhealthy behaviours can become the direct cause of conditions such as obesity, hypertension and pre-diabetes, which we are now seeing at epidemic levels. These conditions dramatically increase the risk of developing more serious, often life changing, long-term conditions.

Not only do these conditions have an impact on businesses and the economy through sickness and absenteeism, but they have direct cost implications for the local authority, NHS and primary care. Musculoskeletal problems, for example, are a side effect of obesity and one of the leading causes for sickness absence. To help identify these conditions, NHS Health Checks have been commissioned. When conditions are identified, access to Healthy Living Services and, in some cases, medication is required, at further cost to the local authority and the NHS.

‘No health without mental well-being’

The conditions also have a wider impact on an individual’s personal and social life and there is a two-way relationship between these and emotional mental well-being. Given that a large proportion of the population will experience mental illness at some point in their life, the truth that there is ‘no health without mental health’ cannot be overestimated. For example, poor mental well-being can lead to alcohol misuse in the home, which can have a devastating impact on the family. The misuse of alcohol is reported in over half child neglect cases which, in turn, can have an unacceptable impact on the outcomes of a child and also lead to additional avoidable and sustained costs to the local authority.

Long-term conditions

Long-term conditions can be debilitating, often leading to the need for carers and state benefits and the restriction, if not elimination, of opportunities for employment. Diabetes, for example, each week causes over 100 people in England to undergo an avoidable diabetes related amputation. In one year diabetes directly cost the NHS £9.8 billion but the wider personal, social and economic costs of this are unquantifiable.

Reduced well-being and ill health

People living with long-term conditions are unsurprisingly more likely to experience mental health difficulties, and often adopt coping mechanisms in the form of unhealthy behaviours such as smoking and overeating. These coping mechanisms quickly manifest as health problems (such as obesity), which further affect well-being, exacerbating problems such as an inability to work, lack of mobility and feelings of loneliness.

There is a need to target support to those with long-term conditions which is tailored to address both the psychological and physical challenges.

Will’s story 1: How places and community can effect what we do...

Will is 45 years old and lives in Richmond with his partner and two children. Will commutes to London each day for his job. He has always been health conscious, and was a keen member of the rugby club before he had such pressing work and family commitments.

Will gets up at 6.30am, has a cappuccino and helps his partner get breakfast together while he goes through the times tables with his son. The route to the train station is a challenge and time is tight, so Will’s partner drops him at the station during the school-run.

Will’s job is high-pressured and there is strong competition between colleagues. Most days are spent in meetings where he grabs snacks and coffee throughout the day.

Recently, he has started joining his colleague for a cigarette break as an excuse to get a break from his desk.

He leaves work at 18.30 to try to get home for the kids’ bath time. On the way home he grabs a takeaway and a bottle of wine to unwind for the night with his partner.

Will goes through the same routine every day, and doesn’t feel good. He is not sleeping well and is putting on weight.
**START WELL**

Every additional month of breastfeeding is associated with a 4% decrease in obesity.

Children with long-term illnesses are 35% more likely to be obese.

Black African children in reception are TWICE AS LIKELY to be obese compared to white British children.

**LIVE WELL**

OVER 80% of adults with learning disabilities are inactive.

Carers providing informal home care are more likely to be obese 50%.

Men smoke more, drink more, and eat less fruit and vegetables.

People with the lowest earnings spend more on processed meat than those earning the most 25%.

UNDER 10% of adults with learning disabilities in supported accommodation eat a balanced diet.

Bangladeshi, Black Caribbean, Pakistani, and Irish women are more likely to have a raised waist-to-hip ratio.

42% of cigarettes are smoked by people with a mental disorder.

People in the most deprived areas are 2x as likely to smoke as those in the least.

**AGE WELL**

80% of type 2 diabetes and 75% of cardiovascular disease is preventable.

30% of dementia cases could be prevented by changing lifestyle.

Rate of inactivity in over 65s is 3x higher compared to 16–18 year olds.

**Prevention: redressing the balance in a time of austerity**
Unhealthy behaviours
in London Borough of Richmond upon Thames

The reality behind the comparisons
Against national comparisons of health behaviours Richmond performs well, with the exception of alcohol use which remains relatively high. A higher than average proportion of residents adopt healthy behaviours, including being physically active and eating enough fruit and vegetables, and a lower than average proportion smokes.

However, comparisons can mask the reality that the absolute numbers of people in Richmond at risk due to smoking, unhealthy diet, physical inactivity; excess alcohol and accompanying emotional and mental ill health are substantial.

Even in Richmond, the numbers of people adopting the four key behaviours that increase our risk of disease – smoking, being inactive, eating a poor diet, drinking too much alcohol – are large.

Trends show a mixed picture
Whilst there have been some positive recent trends, such as decreasing use of tobacco, this is not true for all health-related behaviours. For example, the average number of walking trips per person in London has fallen in recent years: 75% of Richmond households own a car (the fifth highest in London) and over a third of journeys could be walked in less than 25 minutes. Furthermore, longer term trends give stark contrast to recent improvements. For example, nationally, the number of units of alcohol consumed per person has more than doubled since the 1950s, with current consumption comparable to pre-twentieth century levels.

Behaviours across the life-course
Patterns of behaviours are often established early in life, both through education and what is observed at home in the family. Therefore, children and young people, (who make up nearly quarter of the population) and families with dependent children (who make up a third of the households) are an important focus for preventative solutions.

Beyond childhood, younger adults can be more prone to unhealthy behaviour, with tobacco use and binge drinking generally being associated with this group. Although obesity rates generally increase with age, 90% of cases of obesity in the borough are in working age adults (16-65 years old) – a ticking time bomb of future health burden.

In older age come the accumulated impacts of unhealthy behaviours engaged in earlier in life. On top of this, excess alcohol intake is more prevalent in older people, and overall prevalence is likely to rise as the population ages.

Equally, and across the age-range, there is a substantial and often overlooked burden of mental health illness, which is associated both with increased risk of unhealthy behaviour and poorer outcomes.

Demographics drive behaviour differences
Although Richmond is relatively affluent, there are around 18,000 residents living in areas with deprivation above the England average and these pockets are likely to see higher prevalence rates of unhealthy behaviours. We know that people in routine or manual occupations in Richmond, for example, are almost twice as likely to smoke compared to the general population and a local map of low participation in sport bears a striking resemblance to the map of deprivation.

However, not all unhealthy behaviours are linked to deprivation; estimates suggest that binge-drinking is more prevalent in more affluent areas and lowest in the more deprived wards of Whitton, Heathfield and Hampton North. Furthermore, the difference in health-behaviours and outcomes between males and females is often as large as between the most and least deprived.
1.9% women smoke at time of delivery

92% breastfeed in first 48 hours

44,500 children, 4,000 more travelling in for school

36% of 15 year-olds have tried smoking – highest in England

34 parents in treatment for alcohol misuse

17,000 adults smoke

38,000 adults drink alcohol at increasing or higher risk levels

Levels of higher risk drinking are 10th highest in country

24,000 adults are physically inactive

Mental health

- 22,000 have a common mental disorder
- 1,700 with severe mental illness
- 2,000 in contact with specialist mental health services

28,900 to 45,700: the projected increase in number of over-65s between 2015 and 2035

51% of over-75s live alone – highest in London

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Ordnance Survey 100019441
Produced from London Borough of Richmond upon Thames Corporate Geographic Information System

Source: ONS - Lower super output area boundaries and Department for Communities and Local Government

Index of multiple deprivation 2015
National decile (1 = most deprived; no Richmond residents live in the most deprived decile)
Consequences and costs of unhealthy behaviours in London Borough of Richmond upon Thames

Suffering the consequences

The consequences of smoking, physical inactivity, unhealthy diet, excess drinking and the associated emotional and mental ill health are already colossal and this report outlines just some of the costs to society and public services. However, the problem is not going away. In fact, indications are that the impact of these unhealthy behaviours is only just beginning to be felt. Rates of obesity continue to rise. Nationally, the prevalence of obesity in children has tripled since the 1970s and severe obesity has more than doubled in women and tripled in men in the past two decades. It is now estimated that almost half of Richmond adults are obese or overweight.

Older and sicker

At the same time, the population is ageing. In this borough, the number of people aged 65 or over is projected to increase by almost 25% by 2025, twice the growth of the overall population. Combined with the increase in the prevalence of excess weight, this means the numbers of people with long-term ill health will continue to grow. Diabetes is a prime example: the diabetic population in the borough is predicted to increase from around 10,000 in 2015 to 15,000 in 2030.

Already in Richmond, a quarter of people aged under 65 and four out of five people aged 65 and over have at least one long-term condition. In fact, the scale of the problem is even greater than the recorded data shown, for we know that not all people with disease will have received a formal diagnosis, so will not be counted on disease registers.

Many people have a combination of physical and mental long-term conditions, which increases both the impact on their day-to-day lives and the costs the illness is likely to incur on themselves and society. For example, in Richmond, 15% of people with a heart condition have at least three other long-term conditions, including a fifth who have either depression or anxiety. Similarly, 70% of people with dementia have one or more other long-term conditions.

Financially and socially unsustainable

Taking into account the rising costs of medical technologies, this growing burden of disease will have massive financial implications on the health and social care system. Projecting based on current trends, the UK will be spending over 30% of GDP on health care by 2080. Likewise, based on current trends, the proportion of GDP spent on social care is projected to double by around 2025. This is just the tip of the iceberg, as the wider costs of smoking, unhealthy diet, physical inactivity and excess alcohol and their associated physical, emotional and mental ill health spread across the whole face of society.

Unhealthy behaviours combined with an ageing population, the number of people with one or more long-term conditions, and the associated economic, social and health costs, are spiralling at an unaffordable rate.”

<table>
<thead>
<tr>
<th>Condition</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overweight and obese</td>
<td>3,300 primary school age children 65,000 adults (45%)</td>
</tr>
<tr>
<td>High blood pressure (hypertension)</td>
<td>39,667 but only 20,896 diagnosed</td>
</tr>
<tr>
<td>Non-diabetic hyperglycaemia (pre-diabetes)</td>
<td>15,033</td>
</tr>
<tr>
<td>Diabetes</td>
<td>10,614</td>
</tr>
<tr>
<td>Heart conditions</td>
<td>32,000</td>
</tr>
<tr>
<td>Dementia</td>
<td>2,072</td>
</tr>
<tr>
<td>Stroke</td>
<td>3,172 but only 2,261 diagnosed</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease (COPD)</td>
<td>5,093 but only 1,970 diagnosed</td>
</tr>
</tbody>
</table>
### Condition Cases

<table>
<thead>
<tr>
<th>Condition</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic kidney disease</td>
<td>10,887 but only 4,101 diagnosed</td>
</tr>
<tr>
<td>Lung cancer</td>
<td>80 new cases per year</td>
</tr>
<tr>
<td>Oral cancer</td>
<td>60 new cases per year</td>
</tr>
<tr>
<td>Hip osteoarthritis</td>
<td>7,061 (1,695 severe)</td>
</tr>
<tr>
<td>Knee osteoarthritis</td>
<td>10,720 (2,887 severe)</td>
</tr>
</tbody>
</table>

### Societal Costs and Consequences

#### Consequences

- **Over 1,000 alcohol-related ambulance callouts per year**
- **250 people in alcohol treatment per year**
- **2,500 violent crimes per year**
- **9 accidental fires due to smoking (causing 1 death every 3 years)**
- **20 domestic abuse incidents per 1,000 people annually**
- **3 tonnes of cigarette waste as street litter per year**
- **15,802 provide unpaid care; 15% of those provide more than 50 hours per week**
- **21,447 with a disability**
- **2,802 economically inactive due to permanent ill health**
- **£90 claiming benefits due to alcohol misuse per year**

#### Costs

**Smoking costs...**
- £10.3m due to premature deaths
- £14.2m due to smoking breaks
- £2m due to sick days
- £1.2m local authority funded care
- £880k self-funded care

**Nationally, obesity costs...**
- Wider economy £27bn
- Social care £352m
- 16m sick days

...per year
HEALTHCARE COSTS AND CONSEQUENCES

Smoking costs...
£4.2m
(12% for passive smokers)
Over 1,000 hospital admissions

Excess weight costs healthcare £47m per year
(over 50% due to obesity)

Physical inactivity costs healthcare over £1,323,260 due to CVD and cancers per year

230 emergency admissions for COPD per year, costing £500k

600 hospital admissions for falls in 65+ per year

Alcohol costs healthcare...
£8.9m
530 hospital admissions including around 20 under-18s
40 hospital admissions for alcoholic liver disease

Loss of Life

Smoking causes over 200 deaths per year
(1/3 are from lung-cancer)

Alcohol causes 20 deaths per year (5th highest rate in London)

1–15 preventable early deaths due to alcoholic liver disease per year

Diabetes causes 8 deaths per year

45 preventable premature cardiovascular deaths per year
To redress the balance of spiralling costs, we need to provide solutions which can meet the scale of the challenge with the limited resource we have available. To achieve this, we need to apply what we know about health behaviours; and recognise that the people and places we interact with, the associated pressures and our physical and psychological health underpin all that we do.

Opportunities in the environment
Our surrounding environment can enable or hinder the opportunities to make healthy choices. This has a direct influence through the resources we have available, like access to a green space or supportive relationships, and indirectly, for example, through stress caused by poor housing, which limits our ability to take the steps towards healthier living.

Making the healthy choice the easy and preferred choice
Providing information about health behaviours is one of the least intrusive and expensive options. However, although information provision is important, it is only likely to lead to action in a small proportion of the population. It does not work where people do not have the time or energy to reflect on the information provided, do not have the capability and opportunity to change or do not possess the motivation to persevere with changed or newly established routines. When did you last change your daily routine after receiving a leaflet?

Individual level solutions, such as stop smoking services, help people to address all of these challenges. However, limited service capacity means only a fraction of people who need to make a change can be helped in this way. For the rest of us, sustainable change will require new environmental cues which enable the adoption of a healthy life.

To make the healthy choice the easy choice, nationally recognised, evidence-driven solutions can be applied. These solutions work by enhancing the environment and establishing the skills to initiate and maintain changes. Key components of effective solutions include environment planning, building communities, communications and marketing and legislative changes. On top of this, vulnerable groups, who face multiple challenges to effecting change, require support through the provision of services.

Addressing health inequalities
The major advantage of place and community level solutions is that they provide population-wide exposure to positive environmental and social cues, with no inequalities in access. They benefit all people, from children through to older adults.

Ways to well-being
Place and community are conducive to delivering five key elements for well-being which are important for resilience.

1. **Give**, doing things for others
2. **Connect**, spending time with people you trust
3. **Learn**, developing yourself by learning something new
4. **Keep Active**, releases feel good chemicals and sense of achievement
5. **Be Aware**, being present and mindful

Consideration of these elements in the design of solutions will be critical to preventing the adoption of unhealthy coping behaviours.

Creating an environment where the healthier choice is the easier choice – to walk, to cycle, to eat well – will contribute to achieving a green and sustainable borough.

The economic case
As highlighted by the World Health Organisation, there is a strong economic case for preventative solutions. The trends outlined throughout this report verify the picture that the costs of not taking action are unsustainable and unacceptable.

Focusing on prevention earlier in the life-course will accumulate greater benefits but even in working and older age, preventative approaches are cost-effective.”
A population which adopts healthy behaviours not only sees benefits in terms of improvements to the individual’s health, the health of those around them and their families, but also in terms of environmental and economic sustainability. In a time of austerity, intelligent investment is required. Place and community solutions are per capita, low cost solutions whose benefits will be realised immediately and far into the future. For example, studies in the UK have demonstrated that for every £1 invested in the early years there are social returns (e.g. through education, mental health, foster care and family relationships) of between £1.37 and £9.20.

The World Health Organisation has conducted extensive analysis and identified the top interventions for benefits realisation now.

### Will’s story 2: What do place and community solutions mean for Will?

*For Will, whose scenario was outlined earlier, small changes to the place and enhanced community interaction have made a big difference. A new cycle lane has been built nearby, (meaning Will now has a safe path past school to work), the density of takeaway outlets has decreased, and school and workplace programmes have been introduced. He is now reaping the benefits. Initially, Will thought that the changes to the roads were a pain, but the benefits, including the time he saves each morning and the quality time he gets to spend with his children, were brought to light through the Healthy Schools and Healthy Workplace programme.*

Will now wakes up with time to have breakfast. His journey to work is now by bicycle with his kids. He drops them and their scooters off to school after a catch-up on their plans for the day. His workplace now offers healthy snacks in meetings meaning that Will gets his 5-a-day without even thinking about it. Will’s colleague quit smoking at part of the Stoptober campaign so together they now go for a walk on the riverbank or to the local supermarket for their breaks, which is encouraged through the workplace health programme. The workplace is promoting flexible hours and so he now leaves work at 18.00 two evenings a week. Will’s journey time is more predictable now and he doesn’t pass any takeaway outlets on the way home and doesn’t fancy a drink. He cooks an evening meal with his partner and kids.

Will is sleeping well and reports feeling fitter, calmer and more in control. After receiving an email from work about the benefits of volunteering, he is thinking positively about doing some voluntary work at his rugby club, where he once enjoyed being a member.
The mechanisms of each level of solution are described and illustrated in three interlinked gears throughout this section. The three gears represent place, community and individual level solutions, and are presented to illustrate how they must work together in a coordinated way to enable changes and the adoption and maintenance of healthy behaviours. The size of each of gear represents the population scale of each solution level.

E-solutions have the potential to ‘oil the gears’ of community and individual level solutions and scale-up the population reach of individual level solutions to increase cost-effectiveness.

Digital E-solutions can utilise the benefits of both community solutions with the use of social media networking links and of the evidence base components applied in individual level solutions.

**PLACE level solutions**

Provide people with the opportunity to make the healthy choice. They enable people to develop positive automatic and routine responses that are supported by the physical environment.

**COMMUNITY level solutions**

Have an impact on our capability, opportunity and motivation in two ways. Firstly, by enabling us to review what others are doing and compare ourselves, and, secondly, by offering social interaction, connectivity and belonging. Some community level solutions cover both. For example; the Breast Feeding Friendly programmes provide a peer group, support and connectivity for making the healthy choice.

**INDIVIDUAL level solutions**

Are delivered in a group or on a one to one basis. Services for smoking, diet, physical inactivity and excess alcohol offer support and techniques for making personal changes. These techniques include, planning and goal setting to overcome challenges, and promoting self-monitoring of both behaviours and outcomes. Support is also given for reflection for planning further actions. In addition to behavioural services, low intensity psychological well-being services are also available.
## PLACE

- Smoke-free places
- Minimum alcohol unit pricing
- Cycle lanes
- Speed restrictions
- Traffic calming
- Filter permeability
- Segregated cycling routes
- Widened pavements
- Healthier catering commitment
- Sugar tax
- Salt regulation
- Open green spaces
- Alcohol free zones
- Plain packaging on cigarettes and display units
- Age restricted alcohol and tobacco use
- Tobacco control
- Vending machine availability
- Widened stairways, narrow escalators
- Standing desks
- Cycle parking
- Safe attractive environments
- Stopping local shops from selling alcohol to minors
- Limiting the number of hours when we can purchase alcohol
- Limiting the number of places that sell alcohol
- Tackling take-away saturation zones
- Sugar free check outs
COMMUNITY

Volunteering
Learning, further education
Employment
National Campaigns: No smoking day, Dry January, Change 4 Life, Mental Health Week. ‘This Girl Can’ – getting women into sports
Healthy Workplace Charter – including; mental well-being, sports, physical activity
Social marketing
Breast feeding friendly
Health Walks
Friends of the Parks
Dementia Friendly communities and parks
Green Gym
Good Gym
Families programmes
Making every contact count
Active travel
5 a day campaign
Sugar Swaps Campaign
Bullying prevention in schools
Healthy schools programmes including healthy school meals and emotional well-being
Healthy catering commitment
Health Champions

INDIVIDUAL

Stop smoking service
Walking away from diabetes programme
Health checks
Identification and brief advice for alcohol harm reduction
Community alcohol services
Weight management programmes
Exercise on referral
Richmond Inclusive Sports and Exercise (RISE)
Improving Access to Psychological Therapies
Mindfulness training
Alcohol liaison programmes
Perinatal mental health programmes
Debt advice
Redressing the balance
place level solutions

Place has an observable impact on our routines (e.g. travel to work) and our spontaneous actions (e.g. what we do when we leave work). Small changes in the environment can result in dramatic changes to behaviour. A historical illustration of the importance of place is the reduction in rates of suicide by intoxication that was observed in the 1960s and 70s; almost wholly due to the reduction of levels of carbon monoxide in domestic gas supplies.

Place level initiatives, such as healthy weight environments, tobacco control and alcohol harm reduction can have a huge impact. This section will consider several examples to illustrate the potential for this approach. Relatively short-term, low cost input is required to initiate these solutions in return for long-term and sustainable gains, often with minimal ongoing maintenance. Interventions at a place level have the potential to have positive effects across the life-course. Place level solutions include changes to infrastructure and access to an environment conducive to healthy choices.

There are wide ranging place level examples, from minimum unit alcohol pricing to the access to safe places to play. Two examples have been further highlighted here.

Examples of place level solutions

Protecting people from tobacco smoke

On the 1st October 2015 a ban on smoking in cars carrying passengers under the age of 18 was introduced. By reducing the exposure to deadly smoke fumes, significant health benefits will be observed in those under 18 years old.

This legislation will also have much wider reaching benefits by removing an environmental cue to smoking for the driver, and break the automatic behaviours of adults who habitually smoke in cars.

Addressing inequalities

The largest drop in smoking prevalence in the UK (27% in 2007 to 21% in 2011), was seen immediately after the ban on smoking in public places. The significant positive impact of smoke free public places led to a reduction in exposure to smoke in more affluent children, but not for those from the poorest families where toxicology highlights that one in three children passively consume smoke, often in domestic settings. The ban of smoking in cars addresses this inequality, reducing the socioeconomic gaps in benefits of smoke-free public places.

Partners

The local authority has an active part to play in enforcing and communicating the changes in legislation.

Addressing unhealthy diet by reducing children’s access to energy-dense foods

Sugary soft-drinks have no nutritional value. Although children, if given the choice, will opt for energy-dense drinks and food, sugar free options pass the taste test and most children do not have a preference for high sugar drinks on taste alone. Studies have shown that the introduction of a sugar tax reduces purchases and that the subsequent reduction in consumption reduces people’s weight. Brighton and Hove are the first Council to take local action, introducing a voluntary 10p surcharge on sugary drinks. The beneficiary of all proceeds will be the Children’s Health Fund.

We know that the placement of sugary foods near checkouts increase purchasing by 50% and that for every £1 the food industry spends on healthy food promotion it spends £500 on the promotion of energy-dense consumables. Planning for health with restrictions to reduce the density of fast food outlets also has an indisputable impact.

Partners

Collaborative steps need to be taken to reduce children’s intake. Economic development, planning and enforcement partners need to provide the environment for CEOs of food and drink outlets to implement an initiative together. Recently, Tesco were the first supermarket chain to launch sweet free checkouts, illustrating an appetite for collaborative working.
The mechanisms of place level solutions

A worked example: Increasing Physical Activity

To enable active travel (by foot or bicycle), street layout, safety and open green spaces are imperative. Safe road infrastructure, including cycle lanes and traffic calming measures provide the opportunity for the behaviour to become a routine which will become the automatic action rather than the outcome of a daily decision making process.

Centrally, the government aims to improve road infrastructure, the environment, and green spaces to increase physical activity. In London, there is an ambition to halve the road trips which are less than 5 miles.

Planning guidance for housing and business developments also have an important part to play, for example, by making stairs more attractive and accessible. Stair use is one of the best cardiovascular workouts we can do on a day-to-day basis and evidence published in Sweden illustrated that by making stairs more engaging (by painting them to look like a piano), use increased by a striking 66%.

The benefits for physical activity can be seen across the life-course. When children see their parents being active by cycling or taking the stairs, this increases the young person’s likelihood of adopting the behaviours. This will have short, medium and long-term benefits. Children exposed to routine, easy and healthy choices, through cycle and scooting to school schemes, are more likely to adopt these in the longer term, and subsequently will not require intensive interventions.

Equally, active older people are significantly less likely to have falls and the associated complications.

If Londoners swapped motorised trips that could reasonably be walked and cycled, 60% of them would meet the recommended 150 minutes of physical activity per week through active travel alone. The population of London would gain over 60,000 years of healthy life every year which would deliver an economic health benefit of over £2 billion annually.”

Mayor of London’s Office

1 Sustainability

The World Health Organisation and the European Environment Agency have made the link between healthy behaviours and reducing our carbon footprint and have identified road safety and green spaces as a high impact approach.

Reduced car use will result in improved air quality and reduced congestion, injuries and noise pollution.

2 Scale and reach

Place level solutions reach everyone, addressing inequalities in health and improving social cohesion.

3 Start, live and age well

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4 Cost-effectiveness

Promoting physical activity through place level solutions, may enable local authorities to reduce sickness absenteeism and associated loss of productivity by £6.5bn a year. Cycle demonstration towns which have made changes to the infrastructure and availability of bicycles to enable the uptake of cycling, have observed a 27% increase in physical activity. The reduction in associated deaths alone equates to a £2.50 benefit on every £1.00 invested. Similarly, there are savings in health benefits, NHS costs, productivity gains and reductions in air pollution and congestion, of up to £768 and £539 respectively, for each child who takes up walking or cycling to school.
Solutions that work on a community level are powerful in helping people to make changes. Wide-scale national campaigns work by communicating both the risks of unhealthy behaviours (to the self and to others) and actions to address these risks. Local community-driven solutions can augment social connectivity and directly influence social norms (e.g. to promote an alcohol-free office). The range of effective solutions is wide reaching and includes well-established interventions such as breast feeding initiatives and volunteering in sports.

Examples of community level solutions

Social change through the workplace and schools

The workplace and school are where the majority of people in Richmond spend their time. Healthy workplaces and schools programmes provide the mechanisms for a culture of psychological well-being. This is achieved through effective management and personal development, alongside embedding routine practices of non-smoking, active and healthy behaviours.

Altering the social acceptability of behaviours in the workplace and schools provides an opportunity and motivation for sustainable change. For example, for each £1 invested smoking prevention and anti-bullying programmes in schools a return worth £15 could be expected, partly through direct benefits (e.g. reduced healthcare use) but mainly through indirect benefits (e.g. reduced absenteeism and greater lifetime productivity). This peer influence also impacts adults; a person is 34% more likely to quit smoking when a co-worker quits and 67% more likely when a partner quits.

As such a large proportion of people living in Richmond have young families, the spill-over of this approach will also reach to children, through the influence on their well-being practices and routines, e.g. cycling to school and supportive parenting approaches. Additionally, the influence of our actions on our friends, family and co-workers has wider implications. Service providers and carers who are supported to adopt health behaviours themselves, for example, exercise programmes in the workplace, are more likely to successfully offer referrals and advice for health and well-being.

Workplace programmes are dependent on the workforce championing and leading change from within. The sense of belonging and achievement from going through this process has further considerable benefits for well-being in its own right.

Campaigns which galvanise action, ‘Dry January’

Alcohol use can become habitual or automatic in response to emotional (e.g. a bad day at work) or environmental (e.g. multi-buy offers) cues.

The ‘Dry January’ campaign raises awareness of the obstacles to abstinence by encouraging people to give up all alcohol for a month. This awareness, alongside alcohol free action, goes some way towards reducing habitual or automatic alcohol use.

Lipid test studies undertaken before and after Dry January demonstrate the physiological impact of habitual drinking. Following just 28 days of abstaining from alcohol, observed benefits included an average drop in cholesterol of 5% and a drop in blood sugar levels of 23%, alongside significant reduced liver fats, improved concentration and reports of a better night’s sleep. This mass campaign with a call to action could have significant and scaled impacts on the population’s drinking behaviours.

The mechanisms of community level solutions

Community level solutions have a positive impact throughout the life-course, with direct and indirect influences. Achieving for Children’s Strengthening Families Programme is an excellent example of this and has objectives to create and strengthen family links with the community, ensuring that multi-agency support is available.
Volunteering in the Community
Approaches such as Health Walks and Green Gyms (where volunteers who were previously not physically active, are given the opportunity to undertake physical activity through conservation and gardening activities) have the added benefit of enhancing well-being through social connectivity, which reduces the experience of loneliness and isolation.

1 Sustainability and impact
Community programmes are driven and delivered by the community, often requiring only small amount of start-up funding for initiatives and approaches which may be sustained for generations.

2 Addressing health inequalities
These solutions work within the communities themselves and so are able to reach and support specific groups. Furthermore, as the delivery and momentum of interventions are from within the community, insights are gathered ensuring the approach is responsive to the needs of the community. This tailoring of approaches using existing assets in the community, has been demonstrated as one of the most effective mechanisms for sustainable change as it is delivered by, and enables comparisons to, ‘people like me’, (and example of which is the ‘This Girl Can’ Sports England programme).

3 Partners
Community solutions and alignment can be achieved through all council departments through volunteering, communications and engagement. The Village Planning process in the council offers a unique opportunity to facilitate and embed community driven solutions.

Emotional and mental well-being
Volunteering offers two of the five known factors for positive well-being; doing things for others and connectivity. Linking in with our community promotes a sense of belonging and identity. Health champions, appropriately utilised in communities and in the workplace report enhanced well-being, which in turn has preventative benefits.

The World Health Organisation has identified community based family support initiatives and supporting mental health in the workplace as two of the top ‘quick wins’.

Community solutions have the potential to tackle social inequalities and encourage social inclusion, reducing loneliness and isolation.

Cost-effectiveness
The cost-effectiveness of social and community driven solutions for the adoption of health behaviours is significant.

Cost-effectiveness information for Dry January is not yet available. However other widespread campaigns such as ‘Stoptober’, which applies the same techniques as Dry January but for smoking, has been estimated to have generated an additional 350,000 quit attempts, with a huge number of life-years saved.

NICE have supported economic modelling on the impact of the healthy workplace programmes on labour turnover, absence rates and productivity. For a medium-sized business, implementation costs of £40,000 per year would produce cost-savings of £340,000 within one year.

Nearly 22 million adults volunteer in sport and physical activity opportunities in England. These unpaid volunteers are invaluable community assets and would cost £2.7 billion to replace with a paid workforce.

Further return on investment studies of volunteering for conservation demonstrated over the first 5 year period £7.35 was saved for every £1 invested. Befriending also has significant gains, with £3.75 saved through reduced mental health service use and improved health for every £1 invested.
The mechanisms of individual level solutions

Raising awareness of the need for change

There is a discrepancy between recognising risk in others and recognising our own unhealthy behaviours. One of the highest impact solutions is GP-delivered brief tailored advice on risk which raises the awareness of a need to change. Another nationally leading example of this approach is the NHS Health Checks programme which provides real time biochemical feedback on health risks and supports access to services for change.

Addressing challenges to change

Individual level programmes are underpinned by evidence-based components: goal-setting and support to overcome challenges to change. These challenges include physical dependence and social and environmental cues. Target groups for services are those who are pregnant, with the aim to reduce the impact on early years, and vulnerable and at-risk groups, including those accessing secondary care and mental health services. Services which include these components are available for smoking, physical inactivity, unhealthy diet and excess alcohol intake. Further support to overcome specific challenges is available in Richmond. This includes ‘RISE’ which offers support for people with special education needs to get involved in sports. Clustering of any combination of unhealthy behaviours is related to double the risk of depression. This highlights that integrated and joined up service delivery is critical to address psychological well-being and health behaviours together. The Improving Access to Psychological Therapies (IAPT) services provide low-intensity tools and support for coping with symptoms of anxiety and depression. Tailored intensive support packages are available as part of postnatal care and long-term condition management.

Scale and reach

The need for face-to-face interaction through a GP appointment limits the reach of these approaches to those who access services. Unfortunately, access to effective services is known to be one of the biggest inequalities in health. The reach of these interventions can be improved with new technologies such as online apps which incorporate the effective intervention components.

Cost-effectiveness

The cost of individual or service level interventions for all of those who adopt unhealthy behaviour is unaffordable and not viable. Individual solutions are most cost-effective when targeted. Economic analysis of targeted alcohol liaison appointments in a general hospital identified savings of ten times its own cost in reducing repeat admissions alone.

Partners

Public Health, NHS and Social Care Partners alongside the Voluntary and Community sector have an important role to play in delivery. Individual level solutions are costly and required to support vulnerable groups who have challenges to change. This means that careful tailoring and targeting are required for the success of this approach. We need to scale up the elements that we know work, using other methods including new technologies.

Emotional and mental well-being

Low level mental well-being and health behaviour support programmes develop the skills to respond positively to future challenges.
Technology offers a low cost solution for scaling individual level interventions up to the community level by removing the need for face-to-face delivery.

One of the biggest challenges to alcohol identification and brief advice (IBA) is the perceived stigma of revealing a problem to a third person. Electronic solutions may go some way to overcome this and may be a better way of delivering IBA. These E-solutions can adopt the evidence of what works for individual level solutions, including setting goals, and combine it with the mechanisms of community level solutions, such as the support from a social network. This can save £5 for every £1 invested. Similar solutions may also be offered for smoking cessation.

Furthermore, harnessing social media and networking has huge potential to influence change on a large scale. E-solutions also offer the opportunity to follow the positive examples of people ‘like me’ via social networking, and mobile phone and tablet applications can support people to self-monitor achievement of goals and prompt reminders on action and progress.

The success of online campaigns for initiating smoking quit attempts through ‘Stoptober’ and apps which include incentivised goal setting and review of what peers are doing have had demonstrable success in helping people achieve weight loss.

Furthermore apps to support skills for mindfulness, an important tool for developing resilience and well-being, are also showing promising outcomes.
Public support for health solutions
People are both aware of, and are engaging with the problem of unhealthy behaviours. A significant proportion of the population name issues such as overeating, alcohol and smoking as the main threats to the population’s health.

The message about the risks of unhealthy behaviours is out there and understood. However, how well we recognise our own risk is an interesting question. National studies have highlighted that stress is identified and recognised as an important issue to us as individuals; however unhealthy behaviours are recognised as more of an issue for other people.

NHS Health Checks go some way to personalise the relevance of information about risk for those who are eligible. However, for population level change, population level solutions are required.

Local support for making the healthy choice the easy and preferred choice
Our day-to-day experiences shape our activities, and local people want opportunities that make the healthier choice the easier choice.

Residents’ discussions at our recent Health and Wellbeing Board ‘listening event’ on healthy living highlighted an understanding of how the environment shapes the ability to make healthy decisions. Residents raised key issues including the over-accessibility of unhealthy food outlets as opportunities for the council to intervene to enable healthy living.

The ladder of interventions
Nationally, the Nuffield Council on Bioethics has proposed a ‘ladder of interventions’, as a useful tool when considering the public acceptability of health interventions. Nuffield states that more intrusive interventions (those further up the ladder) require proportionately more justification and stronger evidence in support of them.

Public acceptability is not a static process and support for interventions increases as the benefits are realised. Therefore, effective communications about what is happening, why, and the benefits of changes, are central for the acceptability of change. Information must be seen as credible, be available, and be proactively communicated.

Interventions
what do people say?

Which of the following, if any, are the 3–4 biggest threats to the health of the British population/your health? (Prompted) Top 10 mentioned shown

<table>
<thead>
<tr>
<th>Health Threat</th>
<th>GB Adults 16–75 %</th>
<th>Source: Ipsos MORI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity/overeating</td>
<td>54%</td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>43%</td>
<td></td>
</tr>
<tr>
<td>Poor diet</td>
<td>22%</td>
<td></td>
</tr>
<tr>
<td>Smoking</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Lack of exercise</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Heart disease</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Drugs abuse</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Stress</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>12%</td>
<td></td>
</tr>
</tbody>
</table>

Local people are engaging in the debate and are willing to make trade-offs between individual and societal impacts to improve their health, the health of their families and the health of future generations.”

The Nuffield Council on Bioethics, Ladder of Interventions

Greater levels of intervention:

- Eliminate choice: regulate to eliminate choice entirely
- Restrict choice: regulate to restrict the options available to people
- Guide choice through incentives: use financial and other incentives to guide people to pursue certain activities
- Guide choice through disincentives: use financial or other disincentives to influence people to not pursue certain activities
- Enable choice: enable people to change their behaviours
- Provide information: inform and educate people
- Do nothing or simply monitor the current situation
**Understanding acceptability**

The sociological and psychosocial factors that determine the public acceptability of health interventions, or more actively lead to the public demand for them, are complex and understanding in this area is evolving.

Interventions that protect and promote the health and wellbeing of children and young people are most acceptable and often even demanded by the public, despite the potential reduction in personal freedom (for example, the recent ban of smoking in a car with a person under the age of 18).

**Local support for council-led place level change**

In the recent ‘listening event’ residents were definitive that the council has a critical role to play in enabling healthy living. Community level solutions, which utilise the borough’s existing assets, such as the parks, local street-scene and volunteers, dominated discussions. This was alongside place level solutions that targeted businesses (i.e. limiting licensing for take-away shops), which were frequently cited as the solution to unhealthy weight in the borough.

The ‘listening event’, and extensive engagement in other initiatives, such as Village Planning, recognises the council as a natural systems leader in shaping the local environment and presents a real opportunity to embed place and community-level solutions throughout the council’s core business and decision making processes.

Taking action at place and community-level will not only promote the green and healthy borough that people want, but form part of the interventions that are proven to be most effective in preventing long-term conditions and curbing spiralling costs.