Public Health

LONDON BOROUGH OF RICHMOND UPON THAMES

healthwatch Richmond upon Thames

Public Perspectives on Healthy Living in Richmond

March 2023

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Executive Summary

An individual's ability to adopt healthy behaviours to prevent ill health is strongly shaped by the circumstances in which they live. This includes education, the resources they have and whether there are green spaces and safe streets to be physically active in.

Although population surveys describe factors contributing to healthy lifestyle behaviours and choices, no known local evidence from Richmond residents exists. This study was designed to investigate local perspectives and factors contributing to healthy lifestyle choices. The main aim of the study was to understand residents' needs, barriers, motivations and influences on healthy eating, being physically active, reducing alcohol intake and smoking cessation. Our purpose was to identify the extent to which these factors varied and could be addressed by locality with particular emphasis on demographic groups at higher risk.

Healthwatch Richmond, an independent not-for-profit organisation with a statutory role, was commissioned by Richmond Council's Public Health Division to complete this study. The findings will influence the healthy lifestyle offer and public health campaigns to support good health and reduce ill-health in the population of Richmond. Furthermore, the findings will inform the work of the Public Health division and other council teams, and other health and care partners in Richmond.

Data Collection

Data was collected using qualitative methods through a self-administered survey with open-ended questions and focus groups.

A hard copy survey was distributed to residents through outreach sessions, engagement in public areas, and postal distribution. Links to an online survey were shared via social media and GP test messaging services to residents' phones. 815 responses were received between May 2022 and July 2022.

The survey was distributed using purposeful sampling in areas of higher levels of deprivation and populations with at-risk conditions. The locations for the sampling were based on Lower Layer Super Output Areas (LSOAs) selected on the basis of multiple deprivation, disability and long-term illness, presence of carers and ethnic minorities. This narrowed the physical survey distribution to five groupings of LSOAs in the borough, namely 1) Ham, Petersham and Richmond Riverside; 2) Heathfield and Whitton; 3) Hampton North; 4) part of Barnes and 5) West Twickenham. People at risk for the purpose of this report were adults aged 40-74, who were eligible for NHS health checks or who had health conditions or disabilities, and carers.

The demographics of respondents aligned closely with the demographics of the borough. Respondents represented a higher proportion of carers and people with health conditions or disabilities than the borough average.

Twenty-two survey respondents participated in focus groups in August and September 2022. Healthwatch Richmond together with representatives from the Council's Public Health Division conducted the focus groups to gain a deeper understanding of the most common answers from the survey.

Analysis of the qualitative research was based on classifying the data into emergent themes. The themes were categorised based on the analytical framework of the Capability-Opportunity-Motivation Behaviour change model (COM-B). The survey results were analysed to identify potential policies and interventions based on these themes that could facilitate behaviour change at an individual level, in the community and in the physical environment, using the Council's Prevention Framework approach.

Findings

This report contains the experiences of over 800 residents and provides new perspectives on ways to improve healthy living and prevent ill health in Richmond and is the result of collaborative work with Public Health Richmond

Influences

Overall, the Healthy Living behaviours examined share similar influences on behaviour change in the Richmond adult population surveyed.

Results indicated that interpersonal relationships such as social networks and family can influence a person to adopt healthier lifestyle behaviours. Another common influence on peoples' behaviour was the advice of a healthcare professional.

Motivations

Residents reported their motivations such as preventing disease and healthy ageing, maintaining or improving their health, or improving their appearance as the main reasons why they would consider making changes. Social factors, such as avoiding modelling unhealthy behaviours or reducing future caring burdens on family were also mentioned.

Barriers

A common barrier to adopting a healthier behaviour was the limited access to and affordability of healthier food and gyms. Cost and access were also factors for alcohol consumption with limited availability of non-alcoholic alternatives at social events.

Time and cost required to prepare healthy food or to being physically active was also frequently cited as a barrier. Cost was most frequently cited as a barrier to being physically active and eating healthily by people who struggle to fund their basic necessities compared to people with a 'fair amount of disposable income'.

People spoke about lacking motivation due to habits and cravings, in particular with regard to food choice, alcohol use and smoking. Lastly, respondents reported a lack of opportunities to socialise without the social pressure to drink alcohol and/or smoke.

Solutions

Residents offered potential solutions that would help them adopt the healthy living behaviours asked about in the survey. The most common solutions were around social motivations. People would listen to family, friends or co-workers encouraging the behaviour, whether it was healthy eating, physical activity, modifying their alcohol consumption or not smoking. Another solution was shifting their self-belief or motivation to be able to adopt a certain behaviour.

The other common solution cited was receiving adequate and/or scientific information on the benefits of different foods and not drinking excessive alcohol. Solutions related to cost and affordability were proposed by respondents in relation to healthier eating and structured physical activity, particularly by those who were financially disadvantaged. Often cost and access were linked, for example better availability of lower priced alcohol free alternatives, easier booking of cheaper council exercise facilities, or easier access to affordable groceries.

At-risk groups

The findings reported by at-risk groups indicated that barriers to accessing, or the availability of, healthier food were more frequently cited by people who were financially disadvantaged. Financially disadvantaged people came from a range of demographics, employment, and occupational statuses. A quarter of people from minority ethnic groups, including a third of people describing themselves as Asian, disproportionately referenced cost as a barrier to adopting a healthier diet.

People with disabilities reported more often that they faced emotional and psychological difficulties in changing their diet to be healthier compared to people without a reported disability. They also more frequently cited disability and fatigue as a barrier to being physically active. Despite these barriers, they reported that they are motivated to change their physical activity to maintain or improve their health.

The graphics on the following pages present key findings by lifestyle factor. Further detail is provided in the chapter for each lifestyle behaviour.

Summary of findings for healthy eating

Healthy Eating

Reasons

3 in 10 people gave the reason to maintain and improve current health

To lose weight in order to improve health and appearance

Maintaining independence and healthy ageing

The cost savings if you prepare food yourself

Influences	Barriers	Solutions
Health professional support	Habitats and cravings - especially of sugary foods	Information and advice
Social motivation and support	Healthy foods being more expensive than unhealthy foods	Increased social motivations and support
Information and advice from a variety of sources	Time competing priorities	More affordable healthy food options
		Improvement of personal motivations
		Access and availability

Summary of findings for physical activity

Physical Activity

Reasons

To improve and maintain general health

Lose weight and improve overall appearance

To ensure healthy ageing

Increase their social network by meeting new people

Climate change and active travel

Influences	Barriers	Solutions
Professional support with personalised advice	Time competing priorities	Widen access and availability
Better access and availability to fit around their lifestyle	Gym membership and exercise classes are unaffordable	More affordable gyms and classes
Improving barriers such as improved bike lanes, closer facilities and childcare	Difficulties accessing facilities	Social motivation and support from family and friends
	Women reported safety concerns about exercising outdoors in the dark	Increased motivation

Summary of findings for alcohol

Alcohol

Reasons

1 IN 3 believed their alcohol intake was not excessive and did not wish to change their level of consumption

1 IN 5 reported that they do not consume alcohol at all

2 IN 5 reported that they want to or have decreased their alcohol consumption to prevent disease and ill health as they age.

Influences	Barriers	Solutions
No influences	Social barriers to reducing alcohol including social expectations	Continuing support from family and friends
Social motivations such as social gatherings pose an obstacle in reducing alcohol intake	Lack of alcohol free drink alternatives and social environments	Alcohol free social activities
Influenced through being more informed about harms of alcohol	Social habits such as drinking with food and friends	More motivation and compelling reasons to reduce alcohol intake
		Wider access to information, education and advice on benefits and consequences

Summary of findings for smoking

Smoking

Reasons

To maintain and improve health due to specific reason(s) such as diagnosis

To decrease household costs by not buying cigarettes

Social motivations such as wanting or having children

Influences	Barriers	Solutions
Generic health concerns encouraging people to maintain and improve current health	Habits, cravings and addiction	Changing habits, cravings and professional support
Social motivations and support from family and friends	Social motivations such as being surrounded by other smokers	Social motivations and further support options
Motivation and willpower	Lack of motivation	Maintain and improve current health conditions due to concerns about health consequences
		Increasing motivation

Conclusion

This report concludes that locality did not drive healthy living needs in Richmond. The impacts, barriers, and solutions individuals encountered were consistent across localities. Where differences existed they were primarily influenced by other demographic factors like financial status. Despite this, there was a strong desire for support and services to be delivered "locally".

From all the lifestyle factors examined, healthy eating had the highest proportion of participants who had changed their behaviour. It was primarily to maintain and improve current health, improve independence and healthy ageing, as well as lose weight and improve appearance. It was found that professional support and motivation from family and friends, along with improved information about healthy eating, led people to improve their diet.

Changing habits and reducing cravings were the most common barriers to a healthier diet. Respondents also reported that healthy food costs and takes a longer time to prepare. Participants wanted access to more affordable groceries with greater variety and better advice on maintaining a healthy diet. Furthermore, they reported that improved motivation and family and friend support could also improve their diets.

The majority of residents in Richmond expressed a desire to be physically active or to become more active as a way to improve general health, physical appearance and healthy ageing. Participants reported that they would be influenced to change their behaviour as a result of professional advice such as health checks. A second factor influencing physical activity was convenience and accessibility.

A majority of participants viewed physical activity as structured exercise, or led activity with costs associated. The desire for affordable, council-run facilities and activities was therefore strong, but access and booking were difficult. Respondents also wanted local services tailored to their physical ability levels and available during non-working hours.

Social factors were seen as key for increasing physical activity. These factors covered a range of factors from support from friends and family, adding a social element to exercising, or providing childcare.

Notably, few respondents reported wanting to make changes to their alcohol consumption despite data showing that a third of adults in Richmond consume more than 14 units of alcohol a week. A greater understanding of the health risks of alcohol and benefits of reducing consumption might support individuals to contemplate, prepare and take action to modify their alcohol intake.

Although many participants said that professional support, such as having a health check, would influence them to modify their intake, most would still face difficulties with making changes because of social settings and pressures and a lack of availability of alcohol free alternatives. Better availability of alcohol free alternatives would help individuals to change their behaviour.

A small proportion of the sample smoked and a small number of these respondents reported that they were contemplating or attempting to stop smoking. This reflects the relatively low levels of smoking in Richmond. Those current smokers who wanted to modify or stop smoking would largely do so for health reasons and influence from their family and social network.

Habits and cravings were the key challenges to changing smoking behaviour. Former smokers spoke about the effectiveness of medication or professional help to manage cravings. Few current smokers however identified these as solutions that they thought would help them to quit.

This report creates a solid foundation of insight that local individuals and organisations can use to help their communities to live more healthily. Whether as; a business providing alcohol-free options or promoting nicotine replacement; a professional talking about lifestyles; a friend or family member understanding and using social influence; or a public body involved in running public health interventions, there is a role for us all.

Introduction

Introduction

The environment in which an individual lives strongly influences a person's healthy behaviours. There are a number of factors that play a role in this, including the quality of education and support they receive in their early years, ability to purchase nutritious food, the availability of stores, and the availability of parks and safe streets. There are also a number of commercial factors to consider, such as the prices, availability, and promotion of alcohol, tobacco, and healthy foods. Different risk factors are directly and indirectly exposed to populations and individuals through these broader determinants of health, through complex causal pathways (The Health Foundation, 2022).

Our work, in partnership with Public Health Richmond, seeks to understand those circumstances for our most deprived populations and to identify how they can be addressed at a locality level, for individuals at risk of ill health and at borough level. Ultimately, the aim of this work is to gather insights to inform actions that reduce ill-health in the population of Richmond. Individuals at risk for the purpose of this report are people aged 40-74 who are eligible for NHS health checks or who have health conditions or disabilities.

Although Richmond is a relatively healthy borough, there are still many behaviour-related illnesses that could be improved through better health interventions and healthier environments. Based on analysis of publicly available data on the population's health needs, we focus on the behaviours of healthy eating, physical activity, alcohol consumption, and smoking. In Richmond, obesity is lower than the London average. However, more than half of adults in Richmond are overweight or obese. While green spaces in the borough cover 40% of its area, only 28% of residents use them for exercise or health reasons. Physically inactive adults are increasing, especially among women, older adults, people with disabilities, and those with mental health needs. Twenty percent of adults in Richmond reported being inactive (2020/21) compared to 14% in the year prior to the first COVID-19 lockdown (2019/20) (JSNA, 2021).

Almost a third of Richmond residents consume more than 14 units of alcohol per week, ranking 7th highest in London and above the England average. Despite the perception that smoking poses a relatively small problem in Richmond, smoking-related illnesses cost Richmond an additional £1.2m per year in late-life care costs. Residents have multiple channels through which they can access the stop smoking service. Despite this support, there are still residents who contemplate quitting that do not access these services (JSNA, 2021).

Chapter 1

Lifestyle and Wellbeing needs

Physical Activity	Physically active adults decreased from **76.1%** (2018/19) to **74%** (2020/21).	Only **28%** of residents use outdoor space for exercise of health reasons	Women, older adults, people with disabilities and mental health needs are less active.	Physical inactivity is responsible for one in six UK deaths and costs the UK **£7.4 billion** annually.
Obesity and Weight Loss	**51.9%** adults in Richmond are classed as obese compared to **62.8%** in England	Richmond is the **11th** lowest ranking in London of people with obesity	Richmond holds the lowest rate of hospital admissions in London directly attributable to obesity	Richmond is the **2nd** lowest ranking in London of rate of admissions where obesity was recorded
Alcohol	More than **1 in 3** residents drink more than **14** units a week	Rate of admissions for alcohol-related conditions in Richmond's under 40s is **124.4 per 100,000**	Richmond holds the **lowest** rate of alcohol-related mortality in London	Rate of alcohol-related road traffic accidents is **19.8 per 1,000** population
Smoking	In Richmond, many smoking-related illnesses cost an additional £1.2m per year	There is a socioeconomic inequality in the levels of smoking in Richmond	The number of adults who smoke with a long term mental health condition is **3rd lowest** in London	**10.5%** of adults in Richmond smoke, the lowest level in London

Content in infographic referenced in chapter

Background

Much is already known about ill-health in Richmond and indeed the factors causing it. A thorough review of this information was undertaken to ensure that the work was grounded on the existing evidence. The findings will be considered against the information gained from the qualitative research. The full version of this review is available to read as a separate companion document including further detail and references. At the time of writing, the 2021 Census had been undertaken but the data was not available. It is possible that more up to date metrics for Richmond may be available after publication of this report.

Physical Activity

The proportion of physically active adults decreased from 76.1% (2018/19) to 74% (2020/21)(GOV UK, 2021). Women, older adults, people with disabilities and mental health needs report lower levels of participation in physical activity. Only 28% of residents use outdoor space (despite green spaces making up 40% of the total area of the borough) for exercise or health reasons. National data suggests that people from minority ethnic groups and people living in more deprived areas of Richmond would be less physically active (JSNA, 2021).

Obesity and Weight Loss

Whilst Richmond has low levels of obesity, there are more than half of adults as overweight or obese.

Measure	England average	London ranking	Richmond average
Percentage of adults (aged 18+) classified as overweight or obese	62.8%	11th Lowest	51.9%
Rate of hospital admissions directly attributable to obesity	19.7	1st Lowest	14.0 per 100,000 population
Rate of admissions where obesity was recorded anywhere in the diagnostic fields	n/a	2nd Lowest	895.0 per 100,000 population

(JSNA, 2021)

Alcohol

Alcohol is a major risk factor in the health of Richmond's population. More than 1 in 3 residents drink more than 14 units a week, the 7th highest level of alcohol consumption in London and above the average for England.

Measure	England average	London ranking	Richmond average
Rate of admissions for alcohol-related conditions for residents aged 40 to 64	798.7 per 100,000	5th Lowest	496.8 per 100,000
Rate of alcohol-related mortality	37.8 per 100,000	1st Lowest	21.5 per 100,000
Volume of pure alcohol sold through the off-trade	5.5 l/adult	7th Highest	5.8 l/adult
Rate of admissions for alcohol-related conditions in residents aged under 40	186.8 per 100,000	6th Highest	124.4 per 100,000
Rate of alcohol-related road traffic accidents	26.5 per 1000	4th Highest	19.8 per 1,000 population

(JSNA, 2021)

Smoking

While smoking may be perceived as a relatively small issue in Richmond, many current/former smokers require care in later life as a result of smoking-related illnesses costing an additional £1.2m per year in Richmond.

Measure	England average	London ranking	Richmond average
Smoking prevalence in adults	14.1%	1st lowest	10.5%
Smoking attributable mortality rate	202.1 per 100,00	2nd lowest	113.2 per 100,000
Rate of smoking attributable admissions	1397.4 per 100,00	2nd lowest	754.6 per 100,000
Smoking prevalence in adults with a long term mental health condition	25.8%	3rd lowest	17.9%
Smoking rate in early pregnancy	12.6%	5th lowest	3.5%
Rate of smoking among mothers at time of delivery	9.6%	13th highest	4.8%
Smoking prevalence in adults in routine and manual occupations	23.1%	4th highest	29.0%

(JSNA, 2021)

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Chapter 2

Richmond Demographics

Age

Richmond is similar to the London average across most ages with slightly higher numbers of 5-14 year olds, lower numbers of 20-40 year olds, and higher numbers of 40-85+ year olds (JSNA, 2021).

The age profile of Richmond is shown against our sample in the *Who responded* section of this report.

Ethnicity

Richmond has a larger population of white people than the London average and lower numbers of people from Mixed, Asian and Black backgrounds. In mixed and Black groups, the actual number of individual residents is very small which presents challenges to reaching groups based on ethnicity within Richmond. There is also significant variation across Richmond; with people from minority backgrounds making up almost half (48%) of residents in some areas and only 6% in others (JSNA, 2021). Ethnicities for Richmond are shown against our sample in the *Who responded* section of this report.

Vulnerable Groups

People with Physical Disabilities and Long Term Health Conditions

People with disabilities and long term illnesses may face physical and social barriers to accessing services in the community, including health and wellbeing services (JSNA Vulnerable Groups 2021: 15). Disabled people, including those with physical, sensory, and learning disabilities, as well as those with long term mental health issues, are twice as likely to be inactive compared to non-disabled people (PHE 2018: 5).

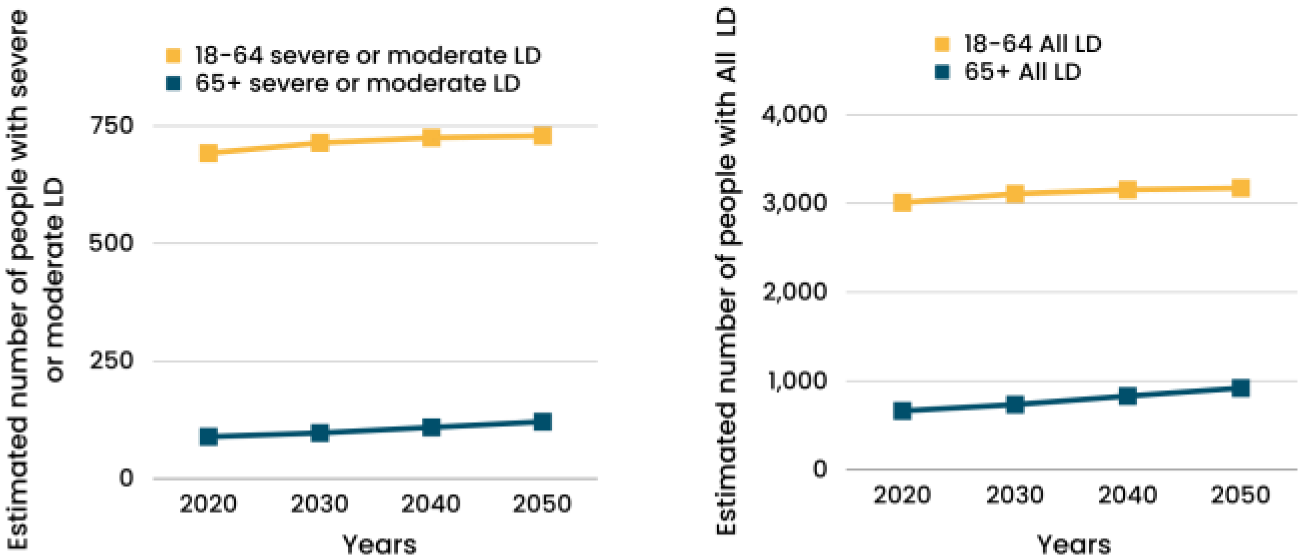
According to the 2011 Census, 11.5% of Richmond residents had a long term condition or illness. This is lower than both the England average (17.6%) and the London average (14.1%) (ONS Census 2011 QS303EW). These numbers are expected to increase by about 9% over the next 30 years (JSNA Vulnerable Groups 2021: 18). Despite low levels of physical disabilities and long term health conditions in the general population, within Richmond there are small areas (Lower Layer Super Output Areas - LSOAs) with rates higher than both England and London where 20% of the population is limited in its day-to-day activities (ONS Census, 2011). Based on diagnosed conditions, prevalence may underestimate the actual levels in certain populations (JSNA Vulnerable Groups 2021: 13).

People with Learning Disabilities

Certain health conditions have been found to be more prevalent amongst people with a learning disability. Adults with learning disabilities may not have the support, equipment and skills to prepare healthy nutritious meals or financial resources to buy healthy food. Adults with learning disabilities are more likely to be overweight or obese and have diet related illness such as type 2 diabetes than people without a learning disability.

The number of older adults living with learning disabilities is expected to increase significantly over the coming years. Despite people with learning disabilities facing significant lost years of life and challenges with addressing the lifestyle factors that lead to this, there is no particular offer for people with learning disabilities to enable them to address any of their lifestyle risks (JSNA, 2021).

Chart 1 Estimated numbers of Richmond Residents with a learning disability, 2008



People with Mental Health needs

In Richmond, the extent to which adults with a serious mental illness die prematurely is four times higher when compared to adults in the general population (JSNA People 2021: 46). According to estimates, in 2017 the prevalence of common mental disorders in the population aged 16 and over in Richmond was 13.2%; lower than the England average of 16.9% and the London average of 19.3% (JSNA Live Well 2021: 70; PHE Public Health Profiles, 2022). On the other hand, the JSNA highlights that in 2018/19 Richmond had high rates (higher than both England and London) of persons detained under the Mental Health Act (JSNA Live Well 2021: 69, PHE Public Health Profiles, 2022).

Carers

According to the 2011 Census there were 15,725 people providing unpaid care in Richmond, 8.5% of the resident population. Based on this percentage, the JSNA estimates the presence of 18,000 carers in Richmond in 2020 (JSNA Vulnerable Groups 2021: 37). In Richmond 20% of carers describe their health as poor, in comparison with 11% of those who do not provide care. There is also a high prevalence of long-term health conditions among carers: 53.3% of carers aged 18-64 and 67.4% of carers aged 65 and over report having at least one long-term condition.

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Chapter 3

What we did - Methodology

Section 1: Healthy Eating

Would you like to eat more healthily?

- I do not believe I should / do not intend to change my behaviour
- I believe I should change my behaviour but have not yet made plans to do so
- I intend to take action about this but have not started yet
- I am actively trying to modify my behaviour
- I have modified my behaviour some time ago
- Not applicable / prefer not to answer

What are your main reasons for wanting/not wanting to make this change?

Reasons may include but are not limited to: preventing disease and illness, your appearance and the way you look, feeling healthier - or already being happy with these, having time to prepare or buy fresh food, having the right information, ... liking or not liking

Section 4: Smoking Habits

Section 5: About You

Healthy Living in Richmond

What would help you?

Thank you for considering taking part in this survey.

Public health aims to prevent disease and promote healthy living for the population as a whole.

... is preventing them from doing so. Your answers will help to shape future interventions in Richmond.

By participating in this survey you consent to your data being stored by Healthwatch Richmond, and this may be shared with Public Health Richmond to help improve lifestyle and wellbeing services. We will not share any personally identifiable information.

If you have any questions about this survey or wish to give us more information about your situation, please contact us at info@healthwatchrichmond.co.uk or by phone: 020 8099 5335

Healthy Living in Richmond

Have you ever tried to improve your lifestyle?
What made it difficult?
What helped you?
Whether you are happy about your current lifestyle, or feel like it could be improved, we want to hear from you!

Scan to take the survey or call 020 8099 5335

Section 2: Physical Activity

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Healthwatch Richmond is a Registered Company (08382351) and Charity (1152333)

3.1 Identifying localities of need

We reviewed data available at Lower Layer Super Output Area (LSOA) level on demographics, health and financial need drawn from the Census, ONS and Joint Strategic Needs Assessments. From these, localities were identified based on validated measures of need and deprivation that were geographically coherent and aligned to the borough demography.

Table 2 - Locality selection (selected areas only, colours denote geographic grouping)

Lower Layer Super Output Area	Health deprivation and disability decile	Multiple deprivation decile	Disability & Long term illness decile	Carers decile	Ethnic Minority %
004D - North Richmond	8	5	4	4	30%
004E - North Richmond	8	5	1	3	15%
006D - South Richmond	7	5	2	6	15%
017B - Ham, Petersham & Richmond Riverside	5	3	1	2	15%
013B – Heathfield	5	4	2	3	34%
010C - Whitton	7	5	2	3	23%
013C – Heathfield	6	5	2	1	15%
013A – Heathfield	10	6	3	3	48%
013D – Heathfield	10	6	1	3	34%
020E - Hampton North	3	2	1	1	17%
020B - Hampton North	4	3	1	1	17%
023E – Hampton	5	4	1	3	10%
020F - Hampton North	8	6	1	3	14%
001G - Barnes	6	4	1	1	20%
015C - West Twickenham	6	5	1	2	17%

Table 2 shows the LSOAs that were selected for inclusion in this research. The deciles are ranked so that 1 = the 10% lowest ranked (e.g. most deprived) deciles, and 10 = the 10% highest ranked (e.g. least deprived) deciles. The Ethnic Minority % is the percentage of people giving their ethnicity as something other than White in the 2011 census.

3.2 Behaviour Change

Our research was grounded in behaviour change. Key insights from behavioural science theories were researched and reviewed (CommGAP). Our work is particularly influenced by The Behaviour Change Wheel (Daoud et al. 2018, Toomey et al. 2020, PHE 2019). This model of behaviour change influenced our data collection and analysis and is reflected in our findings.

3.3 Qualitative Research

We used a primarily qualitative research approach, which produces findings not derived from standard statistical procedures or other means of quantification. This can help to explain how or why a phenomenon exists in a specific setting. Qualitative research produces findings that are drawn from the meanings people give to their experiences rather than derived from statistical procedures or other means of quantification (Harris et al., 2009).

Sampling

The survey was open to anyone who encountered it and was willing to respond. It was purposefully promoted through substantial communication through a range of channels both within the localities and across the borough. As a result, a substantial proportion of the people in the target localities would have had access to the survey whether through paper copies delivered to their homes, a web-based link in a text message to their phones, or through in person, paper and electronic versions distributed through community venues and organisations.

Table 3: Sampling Methods

Method	Description	Reach	Responses
Outreach	40 sessions held in community locations	800	325
Text messages	Text messages sent to people with postcodes in localities by 30% of GPs	6,636	125
Targeted postal deliveries	Paper freepost return surveys (with QR codes) delivered to homes in localities	8,000	300
Communications and promotion	Extensive campaign including partner, direct, and paid advertising	32,000	65

Response numbers in the table above are approximate. People could respond in multiple ways from each engagement method. For example, paper surveys included QR codes linking to online surveys and receiving them may have prompted people to fill in surveys online.

Qualitative research relies on data saturation (the point at which no new emergent themes or concepts are generated from further data collection) to indicate when a sample is large enough. Data saturation was reached by 250 responses, which demonstrates that this sample greatly exceeded data saturation.

The co-production phase, where findings and possible solutions were explored in greater detail with a small number of people, was undertaken with *purposeful sampling* from the response group. Cohorts of people from specific localities and risk groups were drawn from the data to be representative of the socio-demographic makeup of the community from which they were drawn. This provides some confidence that the recommendations of this work are generalizable across locality, at risk groups, and demography. All members of the cohorts were invited to join discussion groups.

Table 4: Focus Group Attendance

Theme	Recipients	Contacts	Sessions held	People signed up	People attended
Healthy Eating	165	7	2	12	11
Physical Activity	139	4	2	15	8
Alcohol	43	5	1	3	1
Smoking	28	4	2	2	2

Contributions from focus groups are contained throughout this report, and may not always be specifically referenced, for example where they align with the wider survey findings. Where there are pertinent findings from the focus groups they are highlighted within blue text boxes.

Bias

Validated questions were used to build the survey questions, ensuring that bias was minimised in the design. To compile the questions, researchers conducted a desk-based literature review of 12 prominent and widely recognised behavioural surveys. Questions were evaluated against the aims of this research. Appropriate questions were selected and adapted for use in the data collection tool. The survey was approved by Public Health Richmond before distribution.

For the focus groups, purposeful sampling was used to ensure as demographically representative a group as possible. Prompts were taken directly from the most commonly occurring themes from the thematic analysis to reduce the risk of bias in the group discussion.

3.4 Data Analysis

To identify themes and patterns we created classification codes of emergent themes aligned to the COM-B Model. Emergent themes are codes that emerge from the key words or phrases that frequently appear in the responses. The COM-B model provided a framework to group these themes within. Each theme relates to one aspect of the COM-B framework, and each element of the COM-B framework may have one or many themes relating to it as follows.

Table 5: COM-B factors linked to emergent themes

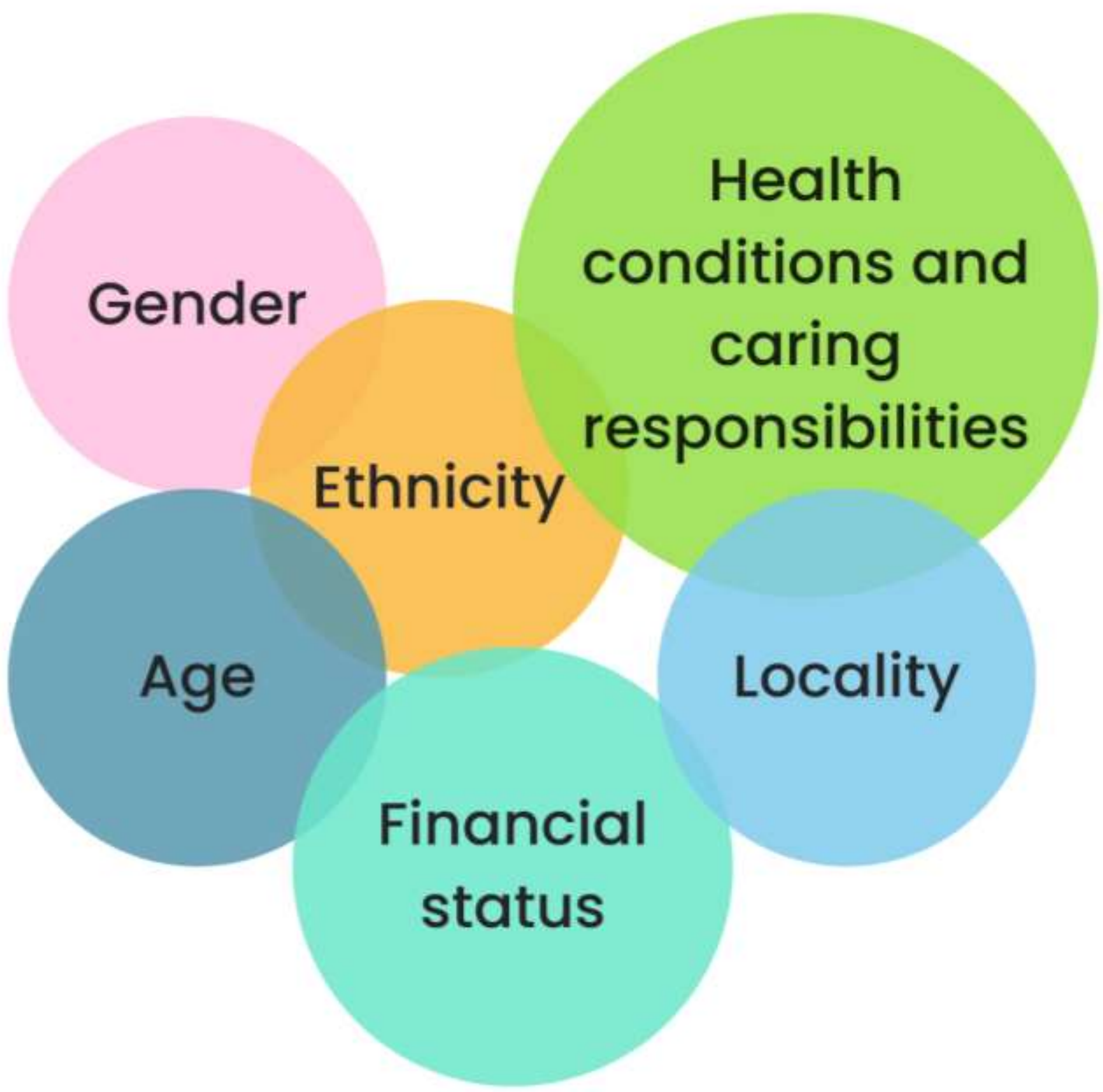
COM-B		Emergent theme
Capability	Psychological	Emotional/psychological difficulties Information and advice
Capability	Physical	Disability and Fatigue (physical health issues) Caring support
Opportunity	Physical	Time Cost Access and Availability
Opportunity	Social	Social motivations and support (Friends/family, etc.) Professional support
Motivation	Reflective	Weight loss/appearance Maintain Independence/ healthy ageing Maintain improve current health Motivation (willpower, self-confidence)
Motivation	Automatic	Habits/cravings

A description of the themes and interrelationships between them and demographics data was included where there were material differences between different demographic groups.

Each survey response was coded thematically by one staff member. A total of one third of the coding was reviewed by two separate members of staff to ensure consistency, validity and reliability of the coded themes.

Chapter 4

Who responded?



We received 815 responses within the data collection period – 12th May 2022 to 24th July 2022. The demographics of our respondents align closely with the demographics of the borough.

The sample had a slightly lower percentage of respondents aged 18-24 and 25-49 and had higher proportions of respondents aged over 50. More women and fewer men responded, however this pattern is common in research. The sample also contained higher proportions of respondents with disabilities, health conditions and caring roles than the wider population.

Chart 2 Respondents by gender

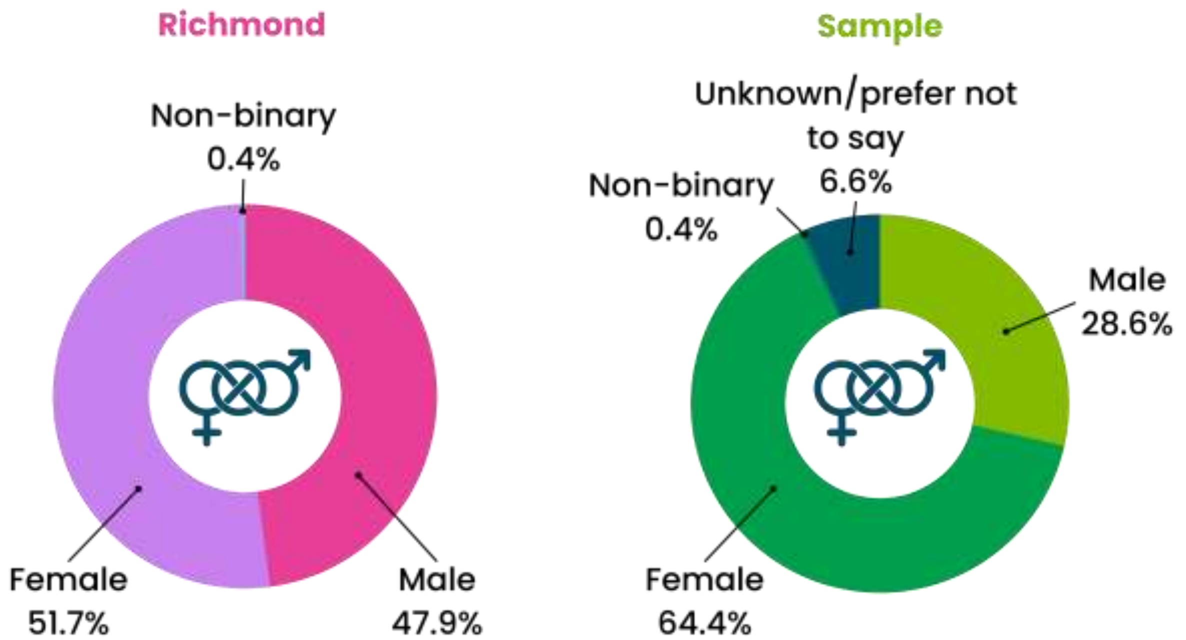
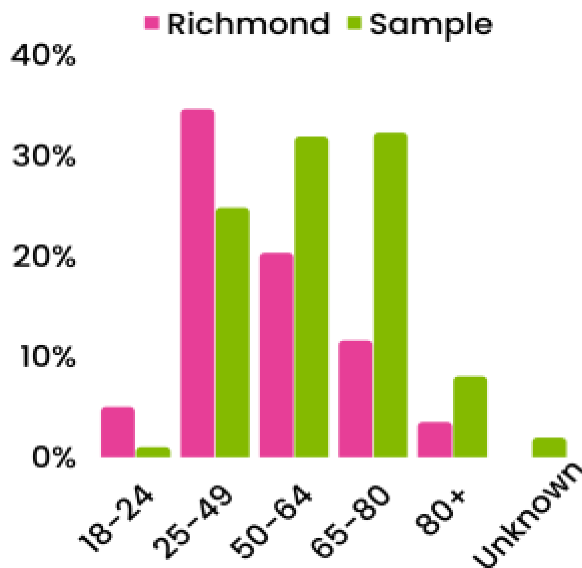
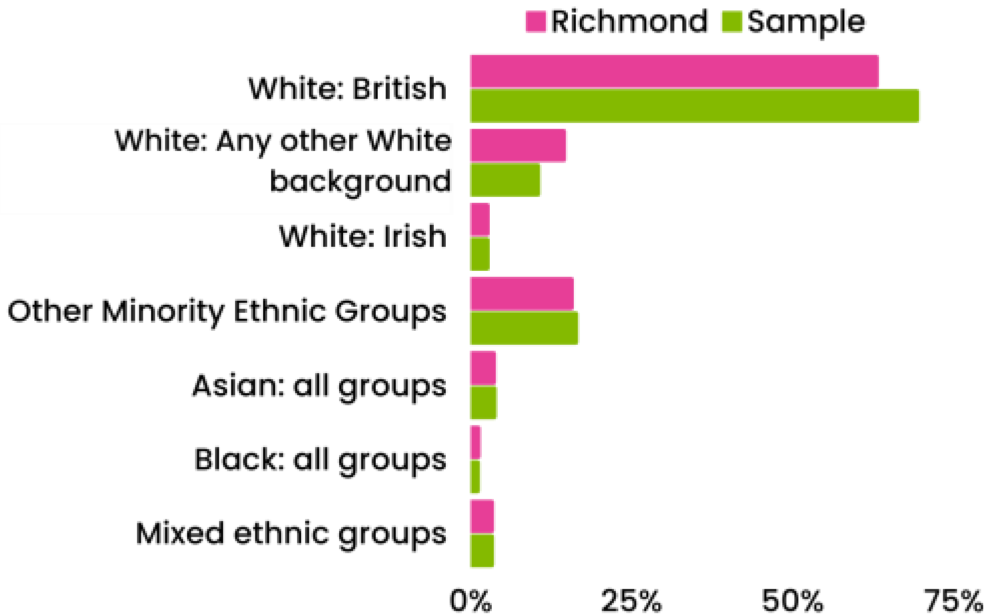


Chart 3 Respondents by age



The ethnicity of our respondents was a close match with the borough averages.

Chart 4 Respondents by ethnicity



The study sample was overrepresented in terms of carers and respondents with health conditions or disabilities (Charts 5 & 6). It is likely that this is a result of the deliberate approach to target individuals with health risks and carers and provides some confidence that their needs are well documented by this report.

Chart 5 Respondents by health conditions

To what extent do any of your conditions or illnesses reduce your ability to carry out day-to-day activities?

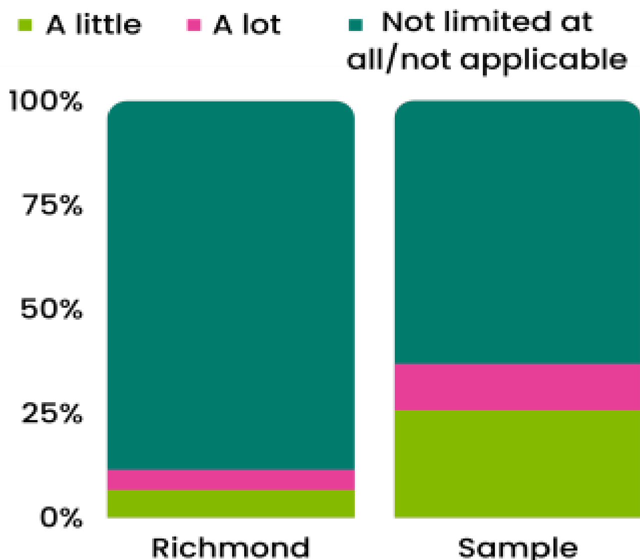
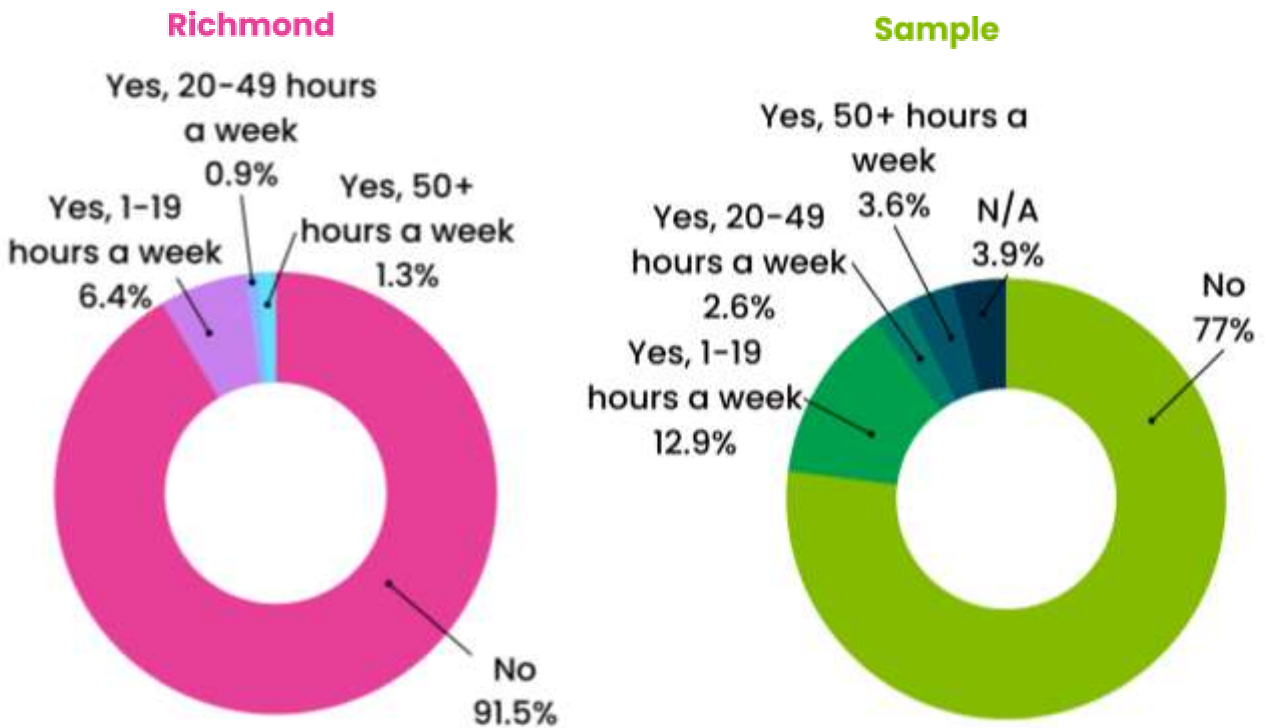


Chart 6 Respondents by caring responsibilities

Do you look after, or give any help or support to, anyone because they have any long-term physical or mental health conditions or illnesses, or problems related to old age?



We do not have direct comparators for financial status; however, 18.3% of our sample are in some financial hardship as measured by the survey question in Chart 7.

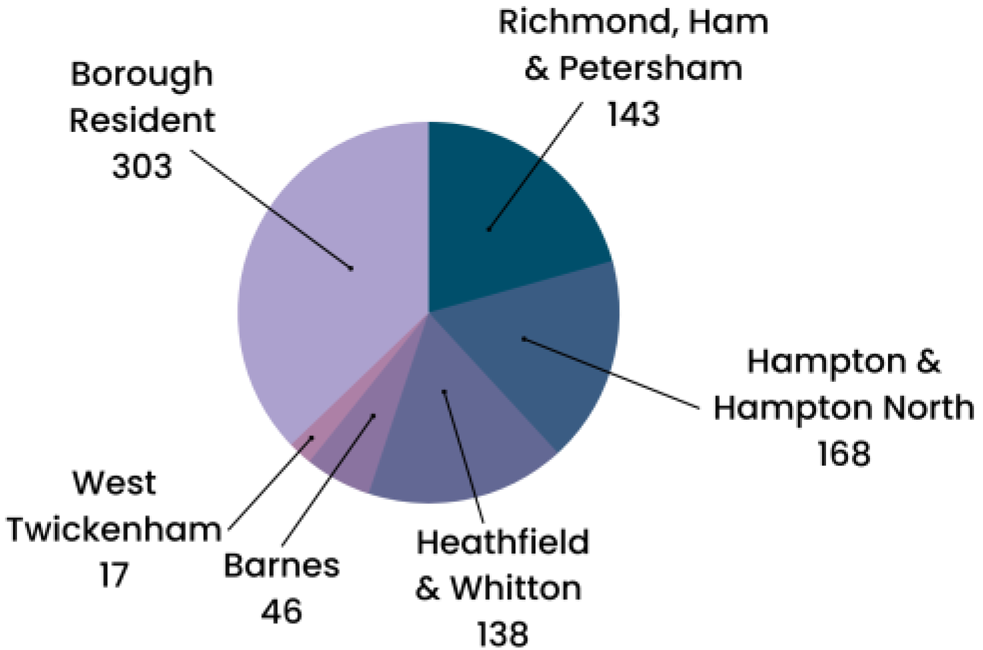
Chart 7 Respondents by financial status

5.2%	*"I don't have enough for basic necessities"*
13.1%	*"I only have enough for basic necessities"*
36.6%	*"I have a small amount of disposable income"*
39.9%	*"I have at least a fair amount of disposable income"*
5.3%	Left (blank)

The sample had generally more responses from people living in areas of deprivation. Response numbers are broadly proportionate to the geographic size of the Localities. Barnes and, in particular West Twickenham, are substantially smaller than the other areas of deprivation.

Data quality issues including insufficient, missing or illegible partial postcodes reduce the accuracy with which we can assess respondents as being residents of a particular Locality. All respondents who could not be ascribed to a locality were assigned to the Borough resident category, which means that this figure is likely overestimated. Similarly, partial postcodes mean that we cannot be certain that respondents live within areas of deprivation.

Chart 8 Respondents by locality



Public Health

LONDON BOROUGH OF RICHMOND UPON THAMES

healthwatch Richmond upon Thames

Chapter 5

Locality

Findings

With this research we aimed to understand the circumstances of the most deprived populations in Richmond *(see table 2 – locality selection, page 23)* for people at risk of ill-health and at borough level. Ultimately the aim of this work was to identify how they can be addressed to inform actions that reduce ill-health in the population of Richmond. However, our data did not demonstrate differences across localities. In fact, the thematic analysis identified considerable similarities between localities in relation to healthy living needs, influences, barriers, and solutions. The variation that occurred was associated more with other demographics, especially financial status, rather than locality. When the data were viewed at its most granular level (by partial postcode), the bases were insufficient for analysis.

A comprehensive analysis of postcodes may be required if locality is, in fact, correlated with need. However, the data does not support this conclusion. Analysis by individual postcodes was beyond the scope of this work. The mapping of localities to full postcodes is complex and the issues with data quality that we encountered may be exacerbated.

Despite no apparent pattern by locality, approximately 5% of responses referenced "local" as being an important consideration. Respondents who spoke about the necessity of locality were referring to a combination of solutions being conveniently located and connected to their local community.

“Lack of free time and nothing local. Cuts in budget for free exercise in Radnor gardens, Twickenham Green and Kneller Gardens”

“A local free group of similar age/ability to exercise with.”

“It would help to find local support to help with buying healthy food.”

“If something were very local and quick/easy to access”

Responses referencing "local" were more frequently associated with healthy eating and physical activity, as well as access to services and facilities. For respondents who mentioned local in relation to alcohol and smoking, they were concerned with accessing support services near to where they lived.

The desire for locally provided support seems to be consistent, despite the fact that locality itself does not appear to be a key factor.

Public Health

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Chapter 6

Healthy Eating

Reasons

3 in 10 people gave the reason to maintain and improve current health

To lose weight in order to improve health and appearance

Maintaining independence and healthy ageing

The cost savings if you prepare food yourself

Influences

Health professional support

Social motivation and support

Information and advice from a variety of sources

Barriers

Habitats and cravings - especially of sugary foods

Healthy foods being more expensive than unhealthy foods

Time competing priorities

Solutions

Information and advice

Increased social motivations and support

More affordable healthy food options

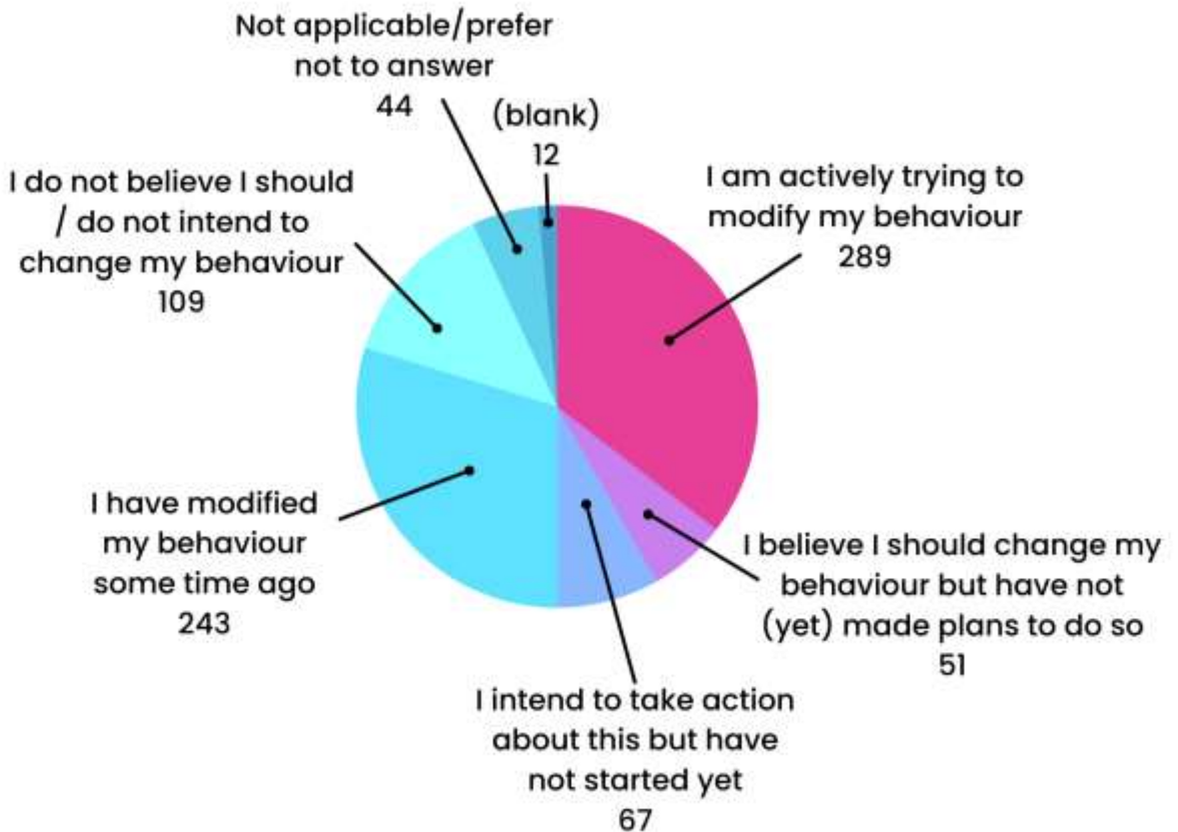
Improvement of personal motivations

Access and availability

Residents told us the reasons why they would eat more healthily. Although barriers exist to making this a reality, these insights may hold the answers to practical solutions based on lived experience and a desire for a healthy diet.

Healthy eating had the highest proportion of people who had changed (29.8%) or were at some stage of actively changing their behaviour (50.0%).

Chart 9 Would you like to eat more healthily?



6.1 Reasons

Respondents provided a variety of reasons as to why they ate healthily or wanted to eat more healthily. The majority of responses related to: maintaining and improving current health; weight loss and appearance; maintaining independence and healthy ageing; and cost.

Maintain and improve current health

Approximately 3 in 10 respondents cited reasons related to maintaining or improving current health. Many respondents specifically mentioned diet-related health issues (such as diabetes, pre-diabetes, cholesterol, or high blood pressure) in connection with being overweight as their reason for improving their healthy eating. Additionally, respondents stated that they

wanted to lose weight or eat more healthily in order to cope with other illnesses, such as osteoarthritis.

"I was diagnosed with High Blood Pressure and decided to eat better and exercise more to control it and hopefully come off the tablet but I have not succeeded."

"During Covid & Lockdown I gained weight which further issues with knees (osteoarthritis). The doctor informed me that if I didn't change my habits I would be in a wheelchair."

There was also a general desire to remain healthy and prevent disease within these responses, although the specific benefits were often less explicit.

"Feeling healthier and having more energy"

"Preventing illness and disease, feeling healthier"

Weight loss and appearance

Several respondents indicated that they needed to lose weight both as an objective in itself as well as in connection with improving their current health, appearance, or self-confidence. The purpose of weight loss was frequently to improve one's self-esteem, appearance, or general health.

"I am overweight and so I need to lose the excess weight to feel better about myself, to feel and be healthier and prevent disease"

"Lose weight, improve figure"

Maintain independence and healthy ageing

The desire to maintain good health into old age was cited frequently by respondents as a means of enjoying life and maintaining independence in old age.

"My body was aching and I knew I was overweight and wanted to get healthier as I enter my late 50s to be able to enjoy life"

"Main reasons are to stay healthy so to live longer for my grandchildren"

Cost

Several respondents stated the cost and affordability of healthy food was a contributing reason to them not changing their behaviour. In many cases this was linked to the availability of food, often in comparison to more readily available and affordable unhealthy alternatives.

"Difficulty is the expense of it - fresh fruit is more expensive that sugary chocolate bars, and buying organic is more expensive than not."

"I don't have enough money to change my behaviour. I have just enough to get some cheap fast food. That's all I can afford, it's all I can get. If I earned more or if healthier food was cheaper, I would consider it."

"There is a big variety of sweets, pastries, biscuits, crisps, that are ready to eat and around £1. One can't get a salad or sandwich for the same price."

The cost of healthy eating was also cited as a way for respondents to save money, but these references were more aspirational than experiential in nature, and were generally secondary to other factors. The responses did not indicate whether or not individuals had saved money by eating a healthier diet.

"To prevent disease/ill health and to save money"

"Preparing good balanced meals for my family. Cost savings on preparing food yourself from fresh produce."

6.2 Influences

Participants cited professional support, social motivations, and information and advice as being the most critical factors that would influence them to eat more healthily or to change their diet.

Professional support

The factor that most often influenced people to eat healthier was professional support. Approximately 1 in 4 people reported that they would change their eating habits if health professionals advised them to do so. Health professionals were described as a factor that enables individuals already planning to eat more healthily to do so. In this case, respondents indicated that the advice must be specific to the individual in question and consistent with their lifestyle choices.

"I would change my diet if a health professional advised me to."

"Dietician - not satisfied with their approach but it gave me a push to change my behaviour, health checks and the desire to improve my health condition also influenced me."

"I am clinically obese yet at my over 40s health check at my GP surgery nothing was said. Healthcare professionals encouraging me to lose excess weight would definitely help me."

"I need a pathway that suits my needs. I want to lose weight. Something that is tailored for me. For instance (1) most diets are based on foods I cannot eat. (2) There is conflicting advice. I am diabetic, should I use sweeteners instead of sugar/fructose?? Different advice from different people."

Respondents spoke of the importance of health checks, in influencing behaviour. Some referred to the need for more frequent checks or checks leading to more regular support and suggested that if this were improved, it would help them to adjust their diet.

"Health checks more frequent would help to exclusively discuss these issues. Current GP system does not deliver. Need a regular interaction even if it were online to manage, cajole and motivate."

"Had NHS health check recently, am heaviest ever and feel rubbish"

"Adverse results of health checks."

Social motivation and support

Approximately 1 in 6 respondents pointed to their family as a factor influencing their choice to eat more healthily; having family members (or friends) who are also attempting to eat healthier was a motivating factor. Several respondents noted that their families were a motivating influence, particularly if they were parents, grandparents, or caregivers, pushing them to be healthier in order to be able to support their children or dependents.

"Advice from doctors. Support from partner - it's easier to live a healthier lifestyle if your household is trying to do the same."

"My peer and social groups also have similar healthy lifestyles. [...] "

"For myself & to live long & be healthy so I can be there for my children."

Keeping healthy eating habits was also emphasised by social events and peers. Family relationships were often positive influences, but peer groups and social events could have a negative impact, including stigmatisation of healthy behaviours.

“Would change with fewer social events but I like social events, It’s a vicious cycle”

“Eating healthily not being seen as something to tease people about IE 'rabbit food‘

Information and advice

Information and advice was referred to as an influence in approximately 1 in 7 responses, both positively and negatively. People were both positively and negatively influenced by information they come from, including social media, advertisements, and the media. Additionally, respondents often mentioned the importance of having practical information and advice - specifically recipes that are quick and healthy.

“influence from press articles and radio news and programs on health issues”

“Good and useful information in advertising as well as recommendations from family and friends”

“Access to quick recipes with fresh ingredients which are easily available.”

6.3 Barriers

Respondents reported several obstacles to healthy eating, mainly related to habits and cravings followed by cost and time.

> Our focus groups aligned closely to the survey findings, citing the availability, cost, quality of food as well as the importance of time to prepare healthy meals. Links were made between time and social factors, cost, accessibility, time; with some people talking about needing to travel to access affordable food.

Habits and cravings

The most commonly cited barrier to healthy eating was habits and cravings. Many participants spoke of the difficulty they face when trying to change habits in order to become healthier. Respondents also reported that cravings were a barrier to changing habits, particularly with respect to sugar and chocolate cravings.

“Difficulty adjusting habits - I enjoy food & have a good appetite plus my willpower is not great”

“[...] cravings difficult to overcome”

"I like chocolate too much to find it easy to reduce. Biscuits on offer in places used to be tempting, though I fight this now by not taking when offered."

Whilst the importance of cravings was a clear barrier for our focus groups, the importance of managing the triggers of cravings was also clear. For some this was linked to shopping habits and the prominence of unhealthy food leading to having unhealthy food in the home. For others snacking for comfort, loneliness or because of sleep problems were triggers. The need for practical support around managing triggers was also seen as important.

Cost

The second most frequently cited barrier was the cost of food. Most respondents described difficulties due to having a limited budget. Approximately 1 in 6 of respondents indicated that healthy food, in particular fruit and vegetables, is more expensive than unhealthy food. Additionally, people with specific dietary requirements (such as gluten free, dairy free or Halal) expressed concern about how expensive these options are.

"Lots of unhealthy food easily available, but not so much healthy for an affordable price. Little time to cook for self and children, short lunch hour to eat healthily. High cost"

"High cost of gluten-free foods; switching to non-cows dairy is also more expensive. Lack of funds. Lack of access to gluten-free and cows-dairy-free healthy foods in cafes and restaurants. Mental health struggles. Lack of choice of healthy ready-food options that are gluten and cows dairy free."

A number of respondents specifically discussed the cost of living increases and how this made purchasing healthy foods more difficult. The cost of living crisis began during the collection period but has continued to develop. As a result, these findings may understate the importance of cost.

"With the cost of living going up and people's wages staying low it doesn't help when you want to purchase healthy food. It's cheaper to buy unhealthy option rather than fruit, veg etc."

"Price of healthy food is higher, there are no free weight loss support groups or places to go to meet peers on the same journey so you're all alone unless you pay for the slimming world type club which I can't afford. Swimming pools are very difficult to just turn up and swim-it has to all be booked and lanes rather than go when you have time like it used to be."

Time

Some respondents reported that they found it challenging to eat healthily due to a lack of time, primarily to plan and prepare healthy meals (usually due to work or family commitments).

"I don't have very much time to myself and find it hard to prioritise myself"

"lack of time to cook healthy meals, competing priorities"

6.4 What would help

Respondents shared what would support them to eat more healthily, or what they had already done to alter their diet. The majority of solutions in responses related to information and advice; social motivations and support; cost; motivation and lack thereof; and accessibility or availability.

Information and advice

One in seven respondents emphasised the importance of reliable and practical information regarding healthy eating. It was widely acknowledged that the media provides useful information about healthy eating. Several respondents provided examples of media outlets that have already provided information and advice regarding healthy eating, including television programs and newspapers. A number of respondents also discussed the importance of food education, both for adults and in schools, to teach healthy eating and cooking.

"Watching programmes such as Eat Well for Less"

"Maybe a website with thrifty nutritional recipes from all cultures as often many are more vegetarian - Guardian newspaper great but not focused on cost."

"Students at secondary schools should be taught how to cook nutritious foods, learn how to budget etc."

Focus group participants spoke about the need for practical, personal information including cultural, health conditions and medications, dietary needs and individual preferences. This is not out of step with the need for practical, consistent and personally relevant information described in the survey responses.

People would welcome receiving holistic information through face-to-face sessions, videos and resources that they can access or be signposted to by public facing staff like health professionals. Opportunities to ask trusted and credible professionals their questions and get answers, whether in person or remotely were also valued.

Social motivations and support

Social motivations accounted for approximately 1 in 8 responses pertaining to how to eat more healthily. Several respondents highlighted the positive influences of family and partner support when trying to eat more healthily or the drive to change behaviour to positively influence family members.

A strong motivating factor was the shared commitment to a healthier lifestyle among peers including co-workers and friends. Furthermore, respondents mentioned social isolation as a negative factor; beyond simply a lack of social support, social isolation was a demotivating factor in its own right.

"Support from family. Childcare so I can focus on my health."

"Co workers deciding to do the same"

"More time and healthier pursuits when with friends"

"Being a single person I can't always be bothered to cook a proper meal. I make do with pasta or toast."

> The feedback from the focus groups created a link between people's information needs and the social opportunities through which needs could be met. Low cost or free group training and support sessions, making use of community assets such as adult learning and community spaces may be an effective way of meeting this information need for some.

Cost

One in eight responses cited cost-based solutions regarding a variety of expenditures. Some respondents suggested that better affordability of groceries would be helpful, while others spoke in detail about the difficulty of affording healthy foods. Many respondents expressed the fact that their financial situations were very difficult and led them to prioritise other needs over healthy eating due to the high cost of living.

"It is often cheaper to buy less healthy food than to cook the same recipe from scratch - once you are tight on budget it is hard to keep choosing the more expensive option"

"Enough money to buy healthy food"

"having to choose between eating healthily or keeping warm"

Several respondents indicated that they would be more likely to lose weight if they had access to cheap or free weight loss courses. They referred to Slimming World and Weight Watchers as helpful, albeit financially unsustainable. Furthermore, some individuals suggested that gyms and exercise opportunities be made more affordable, emphasising the connection between healthy eating and physical activity.

"Free subscription to Slimming clubs, affordable gyms and cheaper healthy food"

Motivation or the lack thereof

A number of respondents indicated that improved personal motivation would help them eat more healthily. Some respondents also indicated that having a good social life may be associated with improved motivation. There were instances in which individuals reported that health issues would motivate them to eat healthier.

"Improved motivations, having purpose and direction, active social life."

"Own determination to lose weight because of Diabetes 2."

Access and availability

About 1 in 8 responses related to the availability of healthy foods. Access and availability were often associated with references to cost and affordability. A few respondents expressed a desire for more local produce. Some suggested reducing the availability of unhealthy foods as a means of promoting healthier eating by addressing the pervasiveness of unhealthy foods. There were also references to providing access to and availability of affordable options for individuals with dietary restrictions.

"Lowering availability or fast foods, or those high in sugar and increased access to healthy foods. Things are improving, but there is always more we can do."

" … Dietary restrictions "forced" me to eat healthily. At first the NHS helped me pay for special dietary needs - that's stopped now. … "

"Suggest for more products suitable for diabetes. Less sugar or sugar free for fruit drinks and cereals, and bread. They should be affordable. The food for these products tends to be more expensive than the ordinary sugar contents."

Our focus group linked accessibility with the cost of available healthy food. For people to eat more healthily, healthy food needs to be easier to find and more affordable food in shops.

6.5 Demographic variations

Age

As with gender differences, differences in ages were characterised by consistent responses. The differences in the proportion of responses were minor. Nevertheless, some general trends can be observed as a result of differences in ages, such as:

Physical Opportunity

The importance of time and costs as barriers decreases with age. These emerged strongly in responses from under 50s but became less important for the over 50s. The importance of solutions addressing cost and time as solutions also decreased with age but to a lesser extent.

Social Opportunity

Social motivations as an influence were referenced more frequently by those aged 25-49, less frequently by those aged over 50 and seemed immaterial to those aged 80+.

Ethnicity

Differences in frequency of responses by ethnicity were accompanied by consistency in the nature of the responses themselves. The area with most variation was in Physical Opportunities.

Physical Opportunity

Cost featured more frequently as a barrier for people from Asian, White other, and Other ethnic groups (around 1 in 4), but less frequently from White British people (around 1 in 6).

Time was referenced more frequently by those of Asian (1 in 3) and White other backgrounds (1 in 5), but less so for those of Other minority ethnicities and White British backgrounds (both around 1 in 8 responses).

Similarly access and availability of healthy food was a barrier mentioned more often by those of Asian backgrounds (1 in 5) than by those of other minority ethnicities and White British backgrounds (1 in 11).

Disabilities

Variations existed in the frequency of themes by health and disability statuses and the severity of impact of these on daily life. As with other demographic groups, the general pattern was of consistency in comments combined with often small bases.

Psychological Capability

Emotional and psychological difficulties feature strongly as barriers among those with mental health issues (1 in 6) compared to those without impairments (1 in 50).

Unpaid Carers

Physical Capability

Caring support was only mentioned by those caring for 20 or more hours a week, albeit infrequently even within this group.

Social Opportunity

A range of solutions were reported for both social motivations and support and professional support by around 1 in 5 of those caring for more than 20 hours a week.

People with no, or less than 20 hours a week of caring responsibility, mentioned social motivations about twice as frequently as those with more caring responsibility. People who cared for 20 or more hours a week spoke about professional support, around 4 times more frequently.

Financial Status

Financial status and cost were frequently mentioned as reasons, influences, barriers, or solutions to healthy eating. From our data, we estimate that cost was mentioned 10 times more frequently among the most financially challenged than among the least financially challenged people as a barrier to improving healthy eating. This suggests that the importance of cost as a barrier to healthy eating increases as financial difficulty increases.

Where cost was mentioned as a solution, this difference in importance was also present with around 1 in 3 of those in most financial hardship, compared to less than 1 in 20 for those in least financial hardship referencing cost as a solution with their responses.

The occupational status data shows that both those in employment and those out of work reference cost, and indeed financial hardship, with some consistency. Those who were employed in lower skilled occupations were more likely to mention cost in their responses than those who were employed in managerial and professional capacities.

Chapter 7
Physical Activity

Reasons

To improve and maintain general health

Lose weight and improve overall appearance

To ensure healthy ageing

Increase their social network by meeting new people

Climate change and active travel

Influences

Professional support with personalised advice

Better access and availability to fit around their lifestyle

Improving barriers such as improved bike lanes, closer facilities and childcare

Barriers

Time competing priorities

Gym membership and exercise classes are unaffordable

Difficulties accessing facilities

Women reported safety concerns about exercising outdoors in the dark

Solutions

Widen access and availability

More affordable gyms and classes

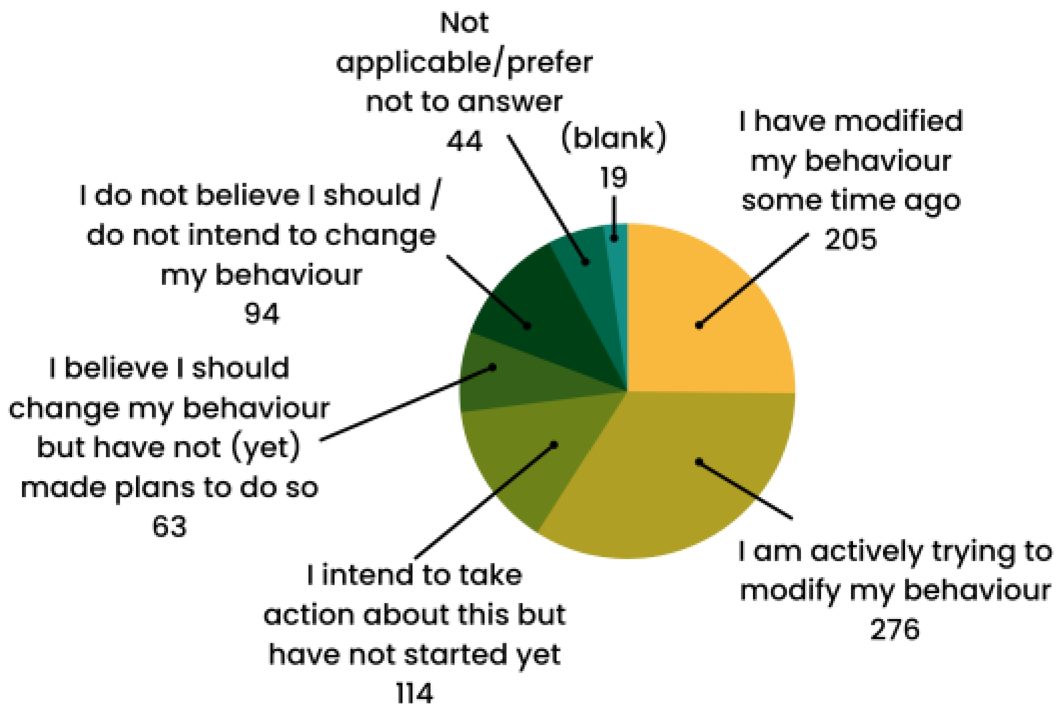
Social motivation and support from family and friends

Increased motivation

Residents told us their reasons why they would get physically active, although barriers exist to making this a reality. These insights offer practical solutions based on lived experience and provide some alternative motivations besides improved health.

Physical activity had a high proportion of people actively trying to modify their behaviour (33.9%) than the other lifestyle factors. Most of the remaining population had a positive attitude to physical activity, intending to make changes (14%) or having already done so (25.2%). Across this category, we also had a relatively low number of respondents not intending to change their behaviour (11.5%). This suggests a strong intent to be physically active among residents.

Chart 10 Would you like to increase your level of Physical Activity?



Within group discussions, participants were more likely to view physical activity in the broader sense including domestic or lifestyle activities and active travel. Whilst structured exercise was certainly a component of the discussion groups, most survey responses viewed physical activity primarily as structured exercise.

The transcripts of group discussions suggest that the dynamic may have led to more focus on physical activity as opposed to exercise, for example:

Q. [to person participating by phone whilst walking a dog] "is walking the dog physical activity?" A. "Yes definitely! [I would like to see] classes that you can bring your dog to"

Furthermore, in both group discussions, participants reported that many people view physical activity as structured exercise. Some participants gave insight into what might cause this differing view of physical activity.

"There is a lot of publicity… the message is that unless you do high intensity it's not worthwhile".

"People perceive exercise as costly, they just see physical activity as the gym… But it doesn't have to be restricted to the gym."

7.1 Reasons

Our respondents shared why they were physically active or why they wanted to become more active. There were four main reasons given for maintaining and improving current health: Maintain and improve current health; not applicable reasons; weight loss and appearance; or to maintain Independence and healthy ageing.

Maintain and improve current health

For approximately 1 in 3 respondents, their reason for engaging in more physical activity was to improve their health. This was often because they perceived themselves as having an unhealthy lifestyle or being unhealthy. Several of these statements referenced specific medical conditions, for example, lowering blood pressure, diabetes, or getting fitter for an upcoming medical procedure. The majority of these statements were general in nature.

"To improve overall health"

"To keep as healthy as possible"

"I developed high BP, cholesterol I was on the verge of becoming type 2 diabetic! Drastic action was to be taken immediately."

Maintaining health wasn't just about physical health, psychological wellbeing featured within our group discussions. There was a particular connection between outdoor activity and mental health:

"Psychological wellbeing and physical activity should be interlinked; stress plays a big part. Being in Nature is important. Environment is important."

Weight loss and appearance

Approximately 1 in 7 respondents stated that they would like to increase their physical activity in order to improve their health and lose weight. Weight loss was often discussed in conjunction with current and future health. Additionally, participants wanted to improve their physical appearance

to improve their self-esteem or fit into clothing by losing weight.

"I want to lose weight so I am a healthy weight, so that I am healthier in general and feel better about myself"

"To feel and look healthier and to avoid future illness"

"My appearance, wanting to fit into my clothes."

Maintain Independence and healthy ageing

Nearly 1 in 10 people indicated that they wanted to prevent illness or maintain good health as long as possible in old age. Most respondents reported that they wanted to prevent lifestyle-related ill health and conditions associated with ageing. Mobility and independence were described as important factors to maintaining and improving levels of physical activity. Furthermore, social motivations were mentioned in the context of being a good role model for children and the prevention of future pressures on the family or NHS as a result of lifestyle-related illnesses.

"Want to exercise more to prevent heart disease, dementia, osteoporosis, diabetes etc."

"To be healthier so in the long run I don't depend on others to care for me"

"Influencing children to keep active (…) good role models and setting healthy patterns for the future."

"To be able to look after cared for person and ensure that I can continue this well."
"Once you become much less active, with age, it's difficult. It's important to push that time back. Once something happens sometimes, that's it. "

7.2 Influences

People told us what would influence them to be more physically active, or what had influenced them if they had already made changes to their level of physical activity. The main influences related to professional support and to access and availability. Many people reported positive dispositions towards physical activity and did not feel that they did not needed to be influenced to increase their physical activity.

Professional support

Almost 1 in 6 respondents referenced the importance of professional advice

and support as an influence. Health checks and professional advice, or the lack thereof, were an influence on people's behaviour. Respondents referenced the need for advice personalised to their age, ability or needs. Professional support was less associated with structured exercise than other themes.

"There is no direction and I am just feeling around for things and ideas that some friends may suggest, rather than professionals health checks"

"tailored advice for me specifically (there will be lots of people like me - but advice on doing running, dance classes and cycling are no good for me). One size does not fit all!"

In a focus group, one participant noted that doctors and pharmacies were good, but felt that they were intended for individuals who were already ill. Medical professionals were not a key source of advice for our discussion group participants:

"Really is just stuff on the internet, I'll look stuff up."
"I haven't seen the GP myself in 7-8 years. Haven't been for a health check, no not at all, no."
"First point of contact would be schools - having that advice would be cool!"

People also cited a range of other sources of information that they rely on including community and Council newsletters.

Access and Availability

Just over 1 in 8 respondents would be influenced by better access to facilities to exercise that fit around their lifestyle. As an influence, accessibility often referred to removing or reducing barriers, for example; improved bike lanes, exercise opportunities at later hours, facilities close to where respondents lived, amenities such as childcare. This linking of influences to solution or reducing barriers aligns with the generally positive disposition toward physical activity. It is also notable that comments relating to access and availability predominantly, though not exclusively, viewed "physical activity" as being exercise that takes place outside of the home whether structured or otherwise. This view was common to all age groups and abilities groups. For those with disabilities and injuries responses often included a desire for group or gym based exercise.

"Local programmes that are easy to access e.g. park run. Childcare while I exercise"

"Very little seems to happen after 6 or 7 pm and Barnes is particularly poor in its offerings and variety of activities."

"Need more activities for older people that are easily accessible"

"Have not found a friendly affordable non-trendy youth obsessed gym since Bank of England Sports Centre closed"

Pools and community leisure facilities in the borough seem to be popular but respondents reported not using facilities due to poor upkeep, difficult booking arrangements or insufficient opening times.

"Pools closing is not the problem as much as the booking system"

Within group discussions, the appetite for structured exercise and community-based activities remained. Community and council run activities and the costs and challenges of accessing them formed significant parts of the discussion. In contrast to this however, the relative ease of access to less structured physical activity, the wealth of assets and opportunities in Richmond were discussed, as were ways to improve them:

"Lamp post thing, with challenges for people to move more. This app as well that measures your movement and incentivises it with free things or discounts. Better points app.

"There's more than Richmond and bushy parks or the river side. River crane, Hounslow heath, oak lane nature reserve, all of this is really good but people don't know about it."

7.3 Barriers

Participants reported that time, cost, and access and availability were as often barriers to being physically active.

Time

Having too little time was a barrier for a quarter of respondents. Whether this was due to long working hours and/or long commutes, or commitments to look after children and families, time was a key barrier preventing people from exercising. Furthermore, some respondents reported that they have difficulty increasing their level of physical activity due to the time it takes to reach their chosen place of physical activity.

"Lack of time, family pressures, feeling stressed and exhausted to be able to do any activity "

"Juggling competing priorities - particularly work and childcare."

"Lack of free time and nothing local" It is also a question of priorities and time that people have to allocate to activity. People can overestimate the demands it would be to be active"

Cost

According to approximately 1 in 7 respondents, gym membership and exercise classes are unaffordable. Others report that more affordable council facilities are far away or difficult to book due to limited space or challenges with booking systems.

"Joining a gym is anywhere between £45 - £95 a month - if you can't afford food, then how can you even afford this?"

"having to cancel my sports centre membership because I can no longer afford it"

"Limited free activity available locally at suitable times or low costs"

According to participants in one of our focus groups, Richmond can appear elitist regarding physical activity, with many classes being expensive or inaccessible for a large portion of the local population.

Access and Availability

For 1 in 7 participants accessing facilities or areas for physical activity presented a barrier. The majority of respondents reported that as well as limited access to exercise facilities in their area, they could not afford public transportation or petrol either to reach facilities afield. Moreover, some participants reported a lack of available classes for those with physical disabilities or older age groups. Respondents, particularly women, reported that it is difficult to exercise outdoors in the dark as they felt unsafe. Safety seems less related to viewing physical activity as structured activity.

"I can hardly afford petrol and will only use the car when I absolutely need to for example to go to a doctors appointment. Exercise would have to be in my area and within walking distance of I were to take part"

"Difficulties in getting to these places - it takes me almost 2 hours to get to my netball on public transport."

"Lack of classes for the keen but not 100% physically able, & or elder people"

"As a woman I would not feel safe running in the late evenings, which is when I have most opportunity to exercise"

7.4 What would help

In response to the survey, participants also shared ideas about how to increase their physical activity levels, as well as what has already helped them in changing their physical activity levels. Access and availability were the most common topics for respondents, followed by cost, social motivations and support, and motivation and lack thereof.

Access and Availability

Approximately 1 in 4 respondents wanted more affordable access to physical activity facilities, both outdoor and indoor. Many participants viewed council facilities, including gyms, classes and pools, as the only affordable option. Poor booking systems, an inefficient use of capacity, and difficulties with contacting the facilities or making a booking were barriers to accessing them. Therefore respondents asked for improved availability and more convenient booking processes.

"Make it easier to book swimming at pools on the park"

In our focus groups, participants highlighted the limitations of access to council facilities for people on low incomes. They were limited in their other options for physical activity when they did not have access to council facilities.

Our focus group discussion also highlighted that more could be done to promote the access and availability of green spaces and activities within the borough.

For many respondents there was a link between access and social motivations with activity providing an opportunity for socialisation. This was linked to a need for additional local classes for people of different abilities and backgrounds, as well as activities in the evening and childcare facilities to allow parents to be physically active while their children are in school. Some women expressed a desire for "women only" facilities, as they would feel more comfortable exercising in a space that is strictly reserved for women.

"I would like there to be a support group that I could go to free of charge and some exercise classes suitable for my age and level of fitness"

"Activities should encourage a social aspect as well as physical especially as one ages"

"Safe cheaper gyms, female only sessions"

"Active Whitton has good initiatives of sharing good walkways. Sharing things between people can be intriguing, almost treasure hunting. Curated maps like this which people can add on to, can be a good initiative."

"Everybody in Richmond still received a council tax bill. Can we put a little section in there?"

Cost

For 1 in 7 respondents, the majority of whom mentioned structured exercise, particularly access to gyms, solutions relating to cost were important. There was a strong desire for more free activities, particularly (as with access), those with a social component, both for families and individuals. Even for those who are active through community groups, gyms or commercial spaces, cost is a concern. Many participants expressed a need for more affordable local groups within their community spaces. Parents, particularly women, also expressed a desire for affordable childcare linked to exercise facilities.

"Feel that the borough should provide more, cheaper access to gyms/health facilities to all for equal access to all levels of income"

"More affordable gyms in the borough. Gyms local to me are charging a third of my monthly income for monthly membership"

"I've signed up to stretch and relax classes, yoga, zumba classes, however, I'm not sure how long I can afford these."

"Affordable Crèche facilities at gyms & swimming pools"

Social motivations and support

For 1 in 10 participants, support from family and friends would help them to increase their level of physical activity. As described in the sections above, physical activity was often viewed as a social opportunity.

"Support from friends and family to continue with healthy programme"

"More of a sense of exercise as a social event rather than having to go out for dinner etc."

During one of the focus groups, a new mother expressed that she wanted to meet others while being physically active.

Motivation and lack thereof
Approximately 1 in 10 respondents indicated that increased motivation would increase their level of physical activity. The details of how this motivation could be achieved were not provided.

"Improved motivation and self belief "

In a focus group discussion, a participant described their motivation to limit their contribution to climate change led them to take more physically active forms of transport such as riding their bike or walking rather than driving.

7.5 Demographic variations

Gender

Material differences were only observed between genders with regard to "what would help" to improve their level of physical activity.

Opportunity

Physical
Physical activity barriers were frequently cited by younger participants (around 1 in 3 under 50s), these references were less marked in older adults (1 in 6 over 65s), and were not mentioned by any respondents aged 80 and older.

Ageing

Opportunity
Physical
Physical activity barriers were more frequently cited by younger participants (1 in 3 under 50s), decreased as they grew older (1 in 6 over 65s), and were not cited by those aged 80 and older.

Disabilities

There were material differences between participants with disabilities when it came to the reasons given for being physically active or not, as well as influences and barriers to physical activity.

Capability
Physical
Individuals with disabilities referenced disability and fatigue (1 in 4) more frequently than those without disabilities or health conditions (1 in 17).

Motivation
Reflective
Maintaining and improving current health was the most frequent reason for being physically active for people reporting a disability or health condition (around 1 in 4), but was mentioned infrequently (about 1 in 17) by those without disabilities. The low bases in some types of disability or condition made it difficult to analyse by type or degree of disability.

Financial Status

The financial status of respondents was associated with the largest variation in responses. Differences in the financial status of respondents were most obvious in barriers and "what could help" to increase physical activity. Notably these differences were not linked to employment status.

Opportunity
Physical
Time was a barrier for those with the highest income levels (1 in 4) compared to those with the lowest incomes (1 in 7). Cost was the strongest theme among those who had difficulty affording basic necessities (1 in 3), but was cited infrequently by those with a reasonable level of disposable income (1 in 14).

Chapter 8
Alcohol

Reasons

1 IN 3 believed their alcohol intake was not excessive and did not wish to change their level of consumption

1 IN 5 reported that they do not consume alcohol at all

2 IN 5 reported that they want to or have decreased their alcohol consumption to prevent disease and ill health as they age

Influences

No influences

Social motivations such as social gatherings pose an obstacle in reducing alcohol intake

Influenced through being more informed about harms of alcohol

Barriers

Social barriers to reducing alcohol including social expectations

Lack of alcohol free drink alternatives and social environments

Social habits such as drinking with food and friends

Solutions

Continuing support from family and friends

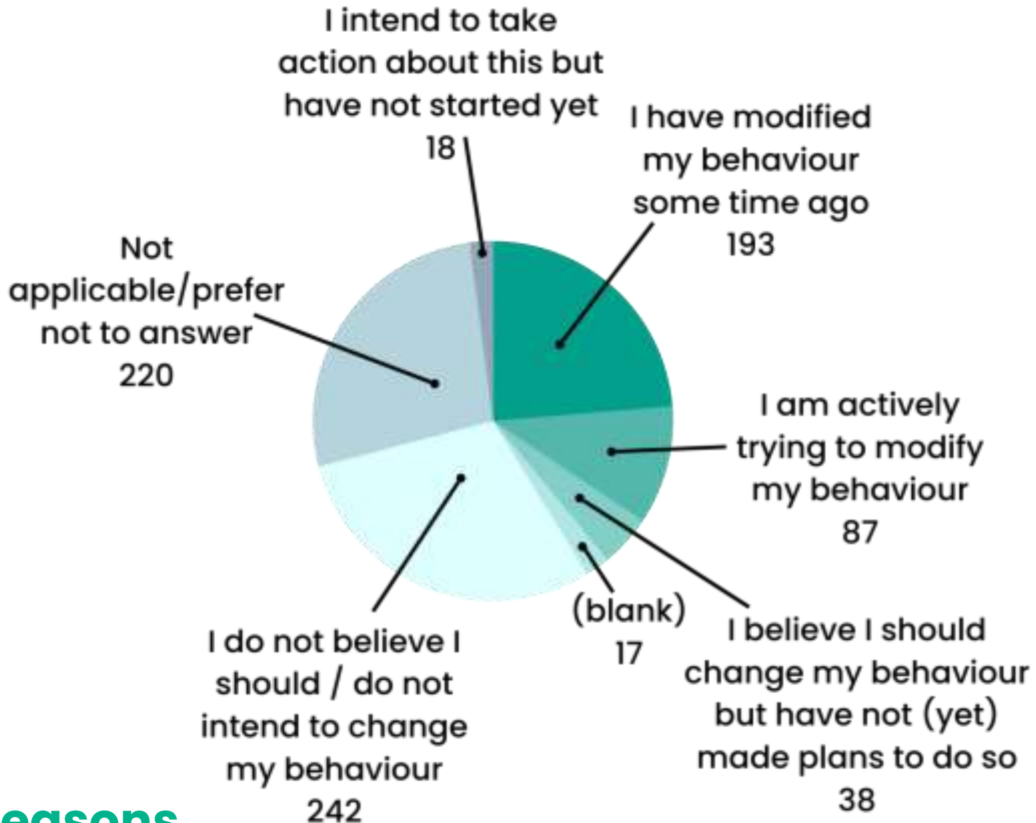
Alcohol free social activities

More motivation and compelling reasons to reduce alcohol intake

Wider access to information, education and advice on benefits and consequences

The number of respondents intending to change their alcohol consumption is 17.5%, which is considerably lower than the number who intend to change other healthy behaviours examined in this study. This is considerably lower than the proportion of people consuming 14 or more units a week (1 in 3) suggested by the JSNA.

Chart 11 Would you like to reduce the amount of alcohol that you drink?



8.1 Reasons

Participants provided reasons as to why they consumed alcohol or wanted to modify their consumption. These reasons included; being unwilling to modify behaviour; not considering it a problem; not consuming alcohol; and to maintain or improve current health.

Unwilling to change behaviour, don't consider it a problem

Almost 1 in 3 of respondents believed that their alcohol consumption was not excessive and did not wish to change their alcohol consumption levels as a result. It is unclear to what extent these views relate to people who do or do not consume alcohol.

“I believe my alcohol intake is not excessive, so do not plan any change at the moment.”

“I really enjoy wine which I only have at the weekend with food, I don't wish to change this habit”

Do not consume alcohol

Just over 1 in 5 respondents reported that they do not consume alcohol at all. This aligns with the number of people reporting their disposition to change as being not applicable and does not include those who did not provide a response.

"I do not drink alcohol therefore I have no reason to change my behaviour"

Maintain and improve current health

Almost 2 in 5 participants reported that they want to, or already have, decreased their alcohol consumption to prevent disease and ill-health as they age. This accounts for almost all of those who reported some level of past or present motivation to change their alcohol consumption. Frequently, these accounts referenced general ill-health and were not specific in nature. Some participants referenced subjective measures of general health and feeling better as either motivations or benefits of reducing alcohol consumption.

"Prevent disease, combat ageing, save money"

"I stopped drinking alcohol three years ago and feel much healthier"

Whilst as a proportion, responses referencing health concerns as a reason to modify behaviour were higher than the proportion of the community drinking to harmful levels. It is important to note that this includes people who have already stopped drinking or modified their alcohol intake for health reasons.

"Concerned that the consumption of alcohol would impede my health issues"

"I lost my ability to handle alcohol in volume when I injured my knee."

8.2 Influences

A number of respondents shared what they believed would influence them to reduce their alcohol consumption, or what had influenced them if they had already made changes. The majority of responses were "not applicable influences". This was followed by influences related to social motivation, maintaining and improving current health, and professional support.

Not applicable

1 in 4 respondents stated that nothing would influence them to modify their behaviour or they do not wish to change their behaviour. It is unclear to what extent these findings reflect the views of those who consume alcohol or do not consume alcohol.

Social motivations

The association between alcohol consumption and social gatherings was reported to be an obstacle to reducing alcohol consumption by more than one in six respondents. This social pressure was considerable amongst respondents and often referenced in relation to being viewed negatively by themself and others for not drinking alcohol in social situations. Alcohol consumption could be modified by changing cultural norms around alcohol and social pressures not to drink alcohol, according to the participants. For example, participants noted that social places without alcohol would assist in reducing alcohol consumption levels.

“Social pressure: sometimes I feel awkward telling others that I don't drink when offered alcohol, e.g. glass of wine”

“Being worried about being thought of as boring if you don't drink”

“Less social pressure to drink, making it the norm not to drink”

“More social places like ‘together as one’ without alcohol would be good generally”

Maintain and improve current health

1 in 8 respondents cited health as a factor affecting their alcohol consumption. Health awareness, education, courses, and advertising were reported as factors that could influence participants and their social networks in reducing their alcohol consumption. This was not just in the context of alcohol misuse but also in social situations. It is also possible that participants may be influenced to modify their drinking if they are informed about the harms of alcohol by a medical professional, such as a doctor.

“Health awareness campaigns about the problems of drinking”

“Being told by Doctor to stop drinking”

8.3 Barriers

In response to our survey, respondents described the main barriers they faced in modifying their alcohol consumption. The main barriers varied and were categorised as "not applicable barriers". These were followed by social motivations/support, access and availability, and habits/cravings.

Not applicable

As with other responses, a large proportion of responses, more than 1 in 4 reported that there were no barriers or difficulties to changing behaviour, either because they did not consume alcohol or because they did not wish to change their behaviour.

Social motivations

Over 1 in 5 responses cited the pervasive presence of alcohol in social settings as the most prevalent barrier to modifying alcohol consumption. According to respondents, pubs are the most obvious places to socialise and it is difficult to "opt out" of drinking once there. As seen with regard to influences, participants specifically pointed out that other people's expectations were obstacles to reducing alcohol consumption. In addition, the environments in which people socialise exert pressure. However, there have been recent improvements in social acceptance of not drinking alcohol, according to some responses.

"Social environments with alcohol, social pressure made it difficult to stop. Eventually people got used to it and I got the benefit of it."

"Peer pressure once had one drink want more. Feels strange to drink soft drinks when in a pub"

"Social People encourage one to drink with them. Has got better recently. There is better acceptance of not wanting to drink alcohol."

Access and availability (including alternatives)

Approximately 1 in 8 respondents reported a lack of alcohol-free options as a barrier. Alcohol-free options were often referred to as being more expensive or having fewer choices or low quality options than alcoholic drinks. Other respondents pointed out that it is difficult to modify one's alcohol consumption due to the lack of non-alcohol related social environments and activities available.

"It would be great if more brands could advertise lower alcohol content or zero alcohol content - there's not many adult alcohol-free options at pubs and restaurants"

"Non-alcoholic drinks often cost more in pubs and bars. Licensed premises need to be incentivized into making non-alcoholic drinks more affordable."

" [...] There are often few options to socialise after work except bars. Would be great if more cafes opened into the evening."

In the focus group discussion, participants discussed the barriers to changing habits due to easy access to alcohol.

"There are too many outlets for people to purchase alcohol at a reasonable price. If you go to a public house, the licensee is obliged not to serve by law, anyone that he deems to be drunk. If you were drunk, you can go into any shop here or even Waitrose and Sainsbury's and buy yourself six cans of lager at a reasonable price."

Habits

In comparison to other areas of healthy living, cravings were not a feature of responses on alcohol and therefore only habits is used in this section. The majority of respondents cited either habitual consumption of alcohol or enjoyment as the primary barrier to reducing alcohol consumption. Habitualised consumption of alcohol, such as drinking wine with a meal, was a barrier.

“My wish to enjoy a glass of wine”

“No barriers in achieving a cut down to the levels currently maintained. As wine with meals is an enjoyable part of the meal it will be difficult to change behaviour further.”

“difficult to change habits with friends”

8.4 What would help

We asked respondents what they would do to modify their alcohol consumption, or what they had already done in order to modify their alcohol consumption. Most responses were related to social motivations and support; motivation and lack therefore; maintaining and improving current health, and Information or advice.

Social motivations and support

More than 1 in 5 respondents cited social motivation and support as solutions. People indicated that support from friends, family, and partners would assist them in reducing their consumption of alcohol. Other respondents suggested the possibility of creating social activities and environments in place of pubs as a potential solution. There was a strong consensus among respondents that cultural and social expectations must be altered in this regard to reduce social pressures to drink. A need for respect and a lack of judgement over one’s choice was also mentioned.

“Support from family & friends.”

“Facilities/locations needed for people to socialise in other than a pub that is free to access”

“I feel I need to disguise when I don't want to drink when socialising with both close friends and in work settings.”

“Improved belief that I'm enough as I am and I don't need to drink to be cool/fun/accepted"

Maintain and improve current health

One in eight respondents cited health and a healthy lifestyle as a solution to help them consume less alcohol. A number of responses specifically mentioned awareness of health problems caused by drinking alcohol as a solution for encouraging people to reduce alcohol consumption.

"awareness of what alcohol does, liver damage (irreversible), reduced cognition. Impaired judgement, increased vulnerability, accident prone"

"[...] Keep my whole body organs going."

Furthermore, respondents indicated that exercising or living a healthier lifestyle in general helped them to modify their drinking habits - as they perceived drinking as hindering their ability to achieve their health goals. Lastly, people indicated that feeling better when not drinking was a factor that helped them to modify their behaviour. In some cases, personal experience was more important than future health risks.

"Going to the gym regularly helps, as it feels a shame to waste my progress on a drink"

"it was the effects felt in my own body that made me quit."

"I try to drink moderately as part of my effort to live healthily"

Information and advice

Approximately 1 in 9 responses stated that information, education, and advice would be effective in reducing alcohol consumption. Health was directly related to information and advice, both in terms of the benefits of reducing alcohol consumption, in addition to the negative consequences resulting from alcohol consumption.

"Information on the benefits of reduced alcohol intake."

"Education; realising how much sugar (calories) you can take in by drinking alcohol"

"Better info or education on consequences of alcohol, advice on benefits of reduced alcohol consumption and incentives from employers."

Participants in the focus group discussed the possibility that professional support could influence individuals' alcohol consumption behaviours.

I think it would be good to have somewhere where people could just drop in, and it's fairly anonymous, and they can have a chat with someone who's got some professional standing, and always has the ability to sort of pass them on to a professional

8.5 Demographic variations

Due to the relatively low number of respondents reporting a desire to change their behaviour, demographic variations were difficult to identify because the base sizes were often small.

Gender

As a barrier, women may be slightly more likely (1 in 10) than men (1 in 15) to mention the availability of alternatives.

There were some minor differences in responses that might indicate that social motivations are more material to women than men, and that health is a stronger influence for men. These differences were marginal and both health and social motivations were prominent themes across all gender groups.

Occupational Status

Respondents in managerial occupations were the least likely to report that they do not drink at all (1 in 10), compared with an overall cross-category average of 1 in 5. Routine non-manual occupations were the most likely to report that they do not drink at all (1 in 3), however the sample was small.

Public Health

LONDON BOROUGH OF RICHMOND UPON THAMES

healthwatch Richmond upon Thames

Chapter 9
Smoking

Reasons

To maintain and improve health due to specific reason(s) such as diagnosis

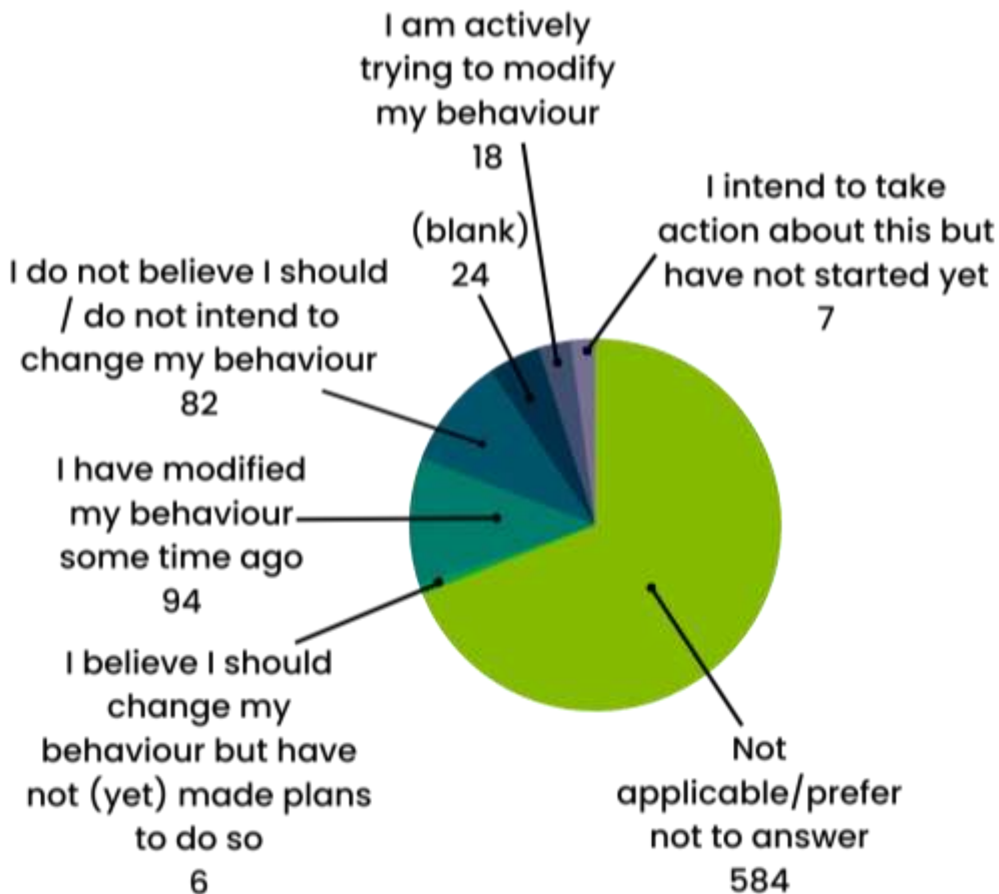
To decrease household costs by not buying cigarettes

Social motivations such as wanting or having children

Influences	Barriers	Solutions
Generic health concerns encouraging people to maintain and improve current health	Habits, cravings and addiction	Changing habits, cravings and professional support
Social motivations and support from family and friends	Social motivations such as being surrounded by other smokers	Social motivations and further support options
Motivation and willpower	Lack of motivation	Maintain and improve current health conditions due to concerns about health consequences
		Increasing motivation

The percentage of respondents who were open to changing their behaviour in this sample (3.8%) may appear to be a small proportion, however the population of Richmond that smoke, and therefore to whom modifying their behaviour may be applicable, is 10.5%.

Chart 12 Would you like to reduce the amount you smoke?



9.1 Reasons

Respondents told us about their reasons for smoking, wanting to modify their behaviour or stop their smoking habit. The main reasons given related to maintaining or improving health followed by cost and social motivations. Due to the low number of smokers and responses in the sample, we have not provided proportions.

Maintain and improve current health

Experiencing respiratory symptoms motivated people to stop smoking as did receiving a related diagnosis. A personal connection to significant respiratory or smoking-related health problems was also cited as a reason for quitting or never taking up smoking.

“I quit in January having been diagnosed with lung cancer”

“I caught COVID and was seriously ill. It was easy to stop after that.”

Cost

Several respondents cited costs as a reason for quitting or wanting to quit smoking, stating that they wanted to save money or that they considered smoking to be a waste of money.

"I gave up smoking many years ago because it seemed to be a waste of money. The serious health risks were not well known to the public at the time."

"Save money"

It was however suggested in an interview that addicted individuals often look for ways to avoid the rising costs of cigarettes as a way to maintain their habit.

"The price doesn't stop you, but it is debilitating. There is a black market though, nobody buys it in shops anymore. Or they buy roll ups. People find a way"

Social motivation

The reasons for quitting smoking varied by respondents. There were many social motives, such as quitting for one's children or for pregnancy. Social motivations seemed to be drivers of behaviour and were often associated with successful attempts to quit within this sample.

"[...] to be an example to my son"

"I gave up 10+ years ago when I wanted to get pregnant"

"Pregnancy, don't want to be a smoking parent"

9.2 Influences

Respondents provided us with information regarding the factors that would influence them or had influenced them to stop smoking. The key influences related to maintaining or improving health, followed by social motivations or support, and motivation.

Maintain and improve current health

It was noted by a number of respondents that generic health concerns were an important factor in their decision to stop smoking. Other respondents referred to a specific symptom or diagnosis as an important influence. There were some incorrect beliefs stated about the risks of giving up smoking.

"I worry the damage has already been done and that giving up will bring more problems like COPD"

"Asthma getting worse"

Social motivations and support

Respondents frequently mentioned family as a social influence to quit smoking. Others mentioned peer pressure - in both as a positive and negative influence.

"Family, my daughter helped me to stop."

"Partner habits."

Motivation

Several respondents referred to motivation and willpower as important factors influencing them to stop smoking. This is consistent with the responses linked to cravings and motivation.

"My own state of mind"

One interviewee indicated that cigarettes have diminished in quality and taste, which further influenced them to change their behaviour.

"They used to taste very nice. If they were still available today the odd packet would be very tempting. Now they're more expensive and less agreeable..."

9.3 Barriers

Most respondents reported that they had barriers to quitting smoking. The most common barriers were related to: habits and cravings, followed by social motivations and support and motivation.

Habits/cravings

1 in 3 people cited habits and cravings as a barrier to quitting smoking, twice as frequently as social and personal motivation (1 out of 6). Addiction was the greatest barrier to making behavioural changes.

"Addiction is hard. I don't take drugs but cigarettes have been hard to quit."

"Not wanting to give [up] what I enjoy", "Addiction to nicotine"

"Breaking habits is not easy. Remembering how I couldn't breathe and ongoing breathing difficulties helped."

"Addiction to nicotine"

During an interview, a former regular smoker revealed that they perceived smoking as a habit rather than an addiction.

"addiction in my mind would be something that heavy drug users or alcoholics experience, for which they would need treatment."

Social motivations and support

The second barrier was social motivations arising from links to other smokers, peer pressure to smoke, social environments where people smoke such as outside pubs and restaurants.

"Environments where people smoke, seeing smokers"

"being surrounded by others who smoke is hard to reduce or stop"

"Family and half my friends still smoke - temptation"

Motivation

A number of respondents cited lack of motivation as a barrier.

"self discipline", "Lack of willpower"

9.4 What would help

In response to the survey, respondents told us about the factors that would motivate them to stop smoking or what has helped them in the past. The majority of the answers were related to: social motivations or support, maintaining and improving their current health, and motivation.

Habits, cravings and professional support

Notably, whilst cravings were by far the most frequently cited barrier to quitting smoking, managing cravings was referenced specifically as a solution by only 2 people. Professional support was only referenced by 7 people. Of these people, all had either successfully quit smoking or were actively trying to.

"Pharmacist's support", "Support from professional", "Obtaining the right medication"

Social motivations or support

The most frequently mentioned solutions of factors that would help people stop smoking were social motivations. A lot of responses spoke of having children or having children around as being very effective in helping one to stop smoking.

"Wanting to set an example to my child"

Respondents suggested that it had been, or would be easier to stop if their friends or their partner also stopped. Support from friends, family and employers was also mentioned as a factor helping people to stop smoking. Some respondents suggested that the general perception of smoking as negative or anti-social is helpful.

"My partner also gave up at the same time which helped a lot"

"I didn't need much help but family support was helpful"

"Other people smoking was difficult. Change routines associated with smoking: much easier now that it is banned in most places"

"Improved motivation and self belief would help. But social support like a smoking cessation/ stop smoking support group"

Maintain/improve current health

A number of responses suggested that concerns about health consequences and experiencing symptoms helped respondents to stop smoking.

"Health concerns", "[...] my health + breathing"

"I stopped smoking to reduce the risk factor for cancer"

"Wanting to be more healthy"

An interview participant said that smoking was often used as a reaction to another health issue, and could be mitigated by addressing the underlying issue.
"Smoking becomes a self-medication... If you treat the root problem, smoking will mostly just become redundant"

Motivation

A number of respondents spoke of the importance of motivation in helping them to quit smoking.

"Faith", "Motivation, determination and self-belief"

"My mind set", "Changing my own attitude"

9.5 Demographic variations

Due to the low numbers of respondents who smoke and would consider changing their behaviour within the sample it is not possible to discuss material demographic variations for smoking from the data.

Conclusion

Aim

Our work, in partnership with Public Health Richmond, aimed to understand the broader determinants of health and healthy living needs of the population in the London Borough of Richmond.

To inform the survey, we focused on four lifestyle factors: Healthy eating, Physical activity, Alcohol consumption and Smoking cessation. Our aim was to identify how improvements in these lifestyle factors could be supported at a locality level, with particular emphasis on people at higher risk. Populations at risk for the purpose of this report were considered to be individuals aged 40-74, who are eligible for NHS health checks or who have conditions or disabilities.

Localities

According to our data, healthy living needs in Richmond were not driven by locality. We found substantial consistency between localities in terms of the influences, barriers, and solutions individuals experienced in different locations across the borough. Where differences did exist, they were linked to demographic factors, such as financial status.

Whilst it is possible that collecting full postcode level data may provide further detail on variations by locality, this is inherently complicated. It is unclear whether such an approach would be practicable given the large number of postcodes within Richmond. However, there remained a strong desire for local support and services among participants, even if Locality were not the major drivers of differences.

Healthy Eating

Our findings showed that healthy eating had the highest proportion of individuals who had changed their behaviour across all the lifestyle factors that we examined. Maintaining and improving current health, healthy ageing and independence as well as weight loss and appearance, were the primary reasons for wanting to change eating habits.

Important factors influencing individuals to improve their diet were; professional support and motivation through friends and family in addition improved information about healthy diets.

We asked residents to consider the barriers to a healthier diet. The most commonly cited barriers related to changing habits and reducing cravings. Respondents also reported that the cost of a healthy diet, and time to prepare healthy food, prevented them from eating more healthily. To improve their diet, participants wanted access to better advice on how to maintain a healthy diet in addition to access to more affordable groceries with greater variety. It was also often reported that improved personal motivation and support from family and friends could also help them to improve diets.

Physical Activity

Our survey demonstrated that residents in Richmond have a strong desire to be physically active. The main reason expressed for being physically active or wanting to become more active were to improve general health. Improving physical appearance was also a key reason for many participants. Around 1 in 10 reported that healthy ageing and maintaining independence was an important reason for them to be physically active.

Many participants also reported that they would be influenced to change their behaviour as a result of professional advice such as health checks. The convenience of physical activity was also an influence, often expressed by the removal of barriers to exercise, which supports the above view that there is a strong drive within the community to be physically active.

Most participants perceived physical activity as a costly, structured or led behaviour with the need to pay for gym memberships or classes. As such, there was a desire for affordable, council run facilities and activities, but challenges with accessing and particularly booking these. As well as wanting better access to services locally, respondents wanted services for different physical ability levels and scheduled at times outside working hours. This was largely due to respondents feeling that time limitations due to work and family commitments prevented them from being active.

Social factors were seen as important for increasing physical activity. These factors covered a range of factors from support from friends and family, adding a social element to exercising, or providing childcare. Whilst they did not come out strongly in this research, participants also made notable links between physical activity, particularly outdoors, the green agenda and improved mental health.

Alcohol

Whilst more than 1 in 3 residents drink more than 14 units a week, only 17.5% of our sample intended to change their behaviour. Participants who would consider reducing their alcohol consumption would largely do so for health reasons. A greater understanding of the health risks of alcohol and benefits of reducing consumption is likely to support individuals to contemplate, prepare and take action to modify their alcohol intake.

Although many participants said that professional support, such as through health checks, would influence them to modify their intake, most participants would still face difficulties with making changes because of social settings and pressures and a lack of availability of alcohol free alternatives. Better availability of these would help individuals to change their behaviour.

Smoking

The great majority of respondents in the sample reported that they do not smoke. However, among those who do, 3.8% of our respondents report that they are open to changing their smoking habits. The challenges in reducing or quitting smoking were largely related to breaking the habit and stopping cravings. Former smokers who had successfully quit spoke about the effectiveness of medication or professional help to manage cravings. Despite this, few current smokers spoke about managing cravings as solutions that they thought would help them to quit. This mismatch suggests that current smokers may not be aware of the effectiveness of these interventions.

Those current smokers who wanted to modify or stop smoking would largely do so for health reasons and influence from their family and social network. Although it seems as if some smokers have quit or would quit due to smoking being stigmatised, others said that their social network could support and motivate them to quit smoking.

Helping our residents to improve their healthy living and reduce lifestyle related ill health requires a partnership approach, including partners from outside of the NHS, Public Health and social care. This report contains the experiences of over 800 residents and presents a compelling body of insight. It is the result of collaborative work with Public Health Richmond and creates a solid foundation of insight that local individuals and organisations can use to help their communities to live more healthily.

Whether as; a business providing alcohol-free options, healthy activities or promoting nicotine replacement; a professional talking about lifestyles; a friend or family member understanding and using social influence; or a public body involved in running public health interventions, there is a role for us all.

We have chosen not to publish detailed recommendations for improving healthy living in Richmond within this report as there is considerable work going on to develop these at the time of publication. Instead, we ask Public Health as the sponsor of this work, and colleagues across the community, to use this report as a resource to inform the way they support our community to live more healthily.

Our recommendation is therefore that Public Health Richmond champion the consideration of this resource, the implementation of activities to improve healthy living, monitor the outputs and outcomes of this, and report on the results of this a year after the publication of this report.

Acknowledgements

With thanks to the Richmond Council Prevention Team for contributions to this report:

Dr Nike Arowobusoye, Public Health Consultant

JoAnn Taylor-Villanueva, Senior Public Health Lead

Tony May, Public Health Lead

Lee Pittock, Public Health Lead

Adam Fox, Public Health Placement

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Appendix 1: Research Questionnaire

Healthy Living in Richmond
What would help you?

Thank you for considering taking part in this survey.

Public health aims to prevent disease and promote healthy living for the population as a whole.

We all know that healthy behaviours like regular exercise, stopping smoking, cutting down on alcohol or having a healthy and nutritious diet can prolong life, promote wellbeing and prevent disease. However sometimes these can be hard to do.

To get an accurate picture of what people across the borough need to maintain a healthy lifestyle, we want to hear from a wide range of people. We need your support!

By taking part in this survey you will help us to understand what would enable individuals in the borough to maintain a healthy lifestyle and what is preventing them from doing so. Your answers will help to shape future interventions in Richmond.

By participating in this survey you consent to your data being stored by Healthwatch Richmond, and this may be shared with Public Health Richmond to help improve lifestyle and wellbeing services. We will not share any personally identifiable information.

If you have any questions about this survey or wish to give us more information about your situation, please contact us at **info@healthwatchrichmond.co.uk** or by phone: **020 8099 5335**

Once completed, please send us this survey by freepost (no stamp needed) to:
FREEPOST: RTXT-TYAK-HATJ, Healthwatch Richmond,
82 Hampton Road, Twickenham TW2 5QS

If you would rather complete this survey online instead, please go to www.healthwatchrichmond.co.uk or scan the QR code.

Section 1: Healthy Eating

Would you like to eat more healthily?

- ☐ I do not believe I should / do not intend to change my behaviour
- ☐ I believe I should change my behaviour but have not yet made plans to do so
- ☐ I intend to take action about this but have not started yet
- ☐ I am actively trying to modify my behaviour
- ☐ I have modified my behaviour some time ago
- ☐ Not applicable / prefer not to answer

What are your main reasons for wanting/not wanting to make this change?

Reasons may include but are not limited to: preventing disease and illness, your appearance and the way you look, feeling healthier - or already being happy with these, having time to prepare or buy fresh food, having the right information, having the skills to prepare healthier meals, cost or money, liking or not liking certain foods, how easy/difficult it is to access healthy food.

What is likely to influence you to change or not change this behaviour?

Influences may include but are not limited to: peer, social or professional groups and norms, managers, relatives and family, health professionals, health checks, information and advertising.

What barriers do you / did you face in changing your behaviour or habits?

Barriers may include but are not limited to: lack of time and competing priorities, social or family pressure, affordability of healthy food, lack of access to healthy food such as in supermarkets, difficulty adjusting habits and cravings, lack of social support.

What would help/ has helped you overcome these barriers or change your behaviour or habit?

Factors may include but are not limited to: support from family and friends, improved motivation and self-belief, concern about consequences of poor diet, time for food shopping and preparation, affordability of healthy foods, and access to healthier fresh food options, food education such as nutritional information and cooking classes, healthy social environments.

Section 2: Physical Activity

Would you like to increase your level of physical activity?

- ☐ I do not believe I should / do not intend to change my behaviour
- ☐ I believe I should change my behaviour but have not yet made plans to do so
- ☐ I intend to take action about this but have not started yet
- ☐ I am actively trying to modify my behaviour
- ☐ I have modified my behaviour some time ago
- ☐ Not applicable / prefer not to answer

What are your main reasons for wanting/not wanting to make this change?

Reasons may include but are not limited to: preventing disease and illness, your appearance and the way you look, feeling healthier - or already being happy with these, having time, having the right information, cost or money, liking or not liking exercise, access to spaces for exercise.

What is likely to influence you to change or not change this behaviour?

Influences may include but are not limited to: peer, social or professional groups and norms, managers, relatives and family, health professionals, health checks, information and advertising.

What barriers do you/ did you face in changing your behaviour or habits?

Barriers may include but are not limited to: lack of time, competing priorities, lack of spaces to exercise or transportation to these places, lack of knowledge of where or how to do physical activity, affordability, difficulty adjusting habits, lack of social or family support, anxiety or fear of getting injured.

What would help/ has helped you overcome these barriers or change your behaviour or habit?

Factors may include but are not limited to: support from family and friends, improved motivation and self-belief, concern about consequences of lack of physical activity, time to do exercise, affordability and access to spaces for exercise and classes, opportunity to combine social life and exercise, improved education on the importance of exercise and how to exercise properly, safe environments to exercise, incentives to exercise such as from your employer.

Section 3: Alcohol Consumption

Would you like to reduce the amount of alcohol that you drink?

- ☐ I do not believe I should / do not intend to change my behaviour
- ☐ I believe I should change my behaviour but have not yet made plans to do so
- ☐ I intend to take action about this but have not started yet
- ☐ I am actively trying to modify my behaviour
- ☐ I have modified my behaviour some time ago
- ☐ Not applicable / prefer not to answer

What are your main reasons for wanting/not wanting to make this change?

Reasons may include but are not limited to: preventing disease and illness, your appearance and the way you look, feeling healthier, saving money, having the right information, you're comfortable with your habits, difficulties because of social pressure, using alcohol as a stress reliever.

What is likely to influence you to change or not change this behaviour?

Influences could include, but are not limited to: peer, social or professional groups and norms, managers, relatives and family, health professionals, health checks, information and advertising.

What barriers do you / did you face in changing your behaviour or habits?

Barriers may include but are not limited to: Lack of social support, lack of social environments without alcohol, difficulty adjusting habits, lack of information or treatment services to meet my needs.

What would help/ has helped you overcome these barriers or change your behaviour or habit?

Factors may include but are not limited to: support from family and friends, improved motivation and self-belief, better information or education about the consequences of alcohol, reduced social pressures to drink, mental health support, advice and information on the benefits of reduced alcohol consumption, changes to incentives from your employer.

Section 4: Smoking Habits

Would you like to reduce the amount you smoke?

- ☐ I do not believe I should / do not intend to change my behaviour
- ☐ I believe I should change my behaviour but have not yet made plans to do so
- ☐ I intend to take action about this but have not started yet
- ☐ I am actively trying to modify my behaviour
- ☐ I have modified my behaviour some time ago
- ☐ Not applicable / prefer not to answer

What are your main reasons for wanting/not wanting to make this change?

Reasons may include but are not limited to: preventing disease and illness, your appearance and the way you look, feeling healthier – or already being happy with these, having time, having the right information, cost or money, using smoking to relax/relieve stress.

What is likely to influence you to change or not change this behaviour?

Influences may include but are not limited to: peer, social or professional groups and norms, managers, relatives and family, health professionals, health checks, information and advertising.

What barriers do you / did you face in changing your behaviour or habits?

Barriers may include but are not limited to: Lack of social support, lack of social environments without smoking, difficulty adjusting habits, lack of information or appropriate treatment services to meet my needs.

What would help/ has helped you overcome these barriers or change your behaviour or habit?

Factors may include but are not limited to: support from family and friends, improved motivation and self-belief, concern about consequences of smoking, reduced social pressure to smoke, mental health support, advice and education on the benefits of smoking cessation, incentives to stop smoking such as from your employer.

Section 5: About You

Please tell us a little bit about you so that we know if we're speaking to a wide section of the community or if we need to do more to reach some people.

What is your home address?

Please **ONLY** give the first four to five digits of your postcode.
For example: TW1 0 / TW11 0

What is your age?

- ☐ 18 to 24
- ☐ 25 to 49
- ☐ 50 to 64
- ☐ 65 to 80
- ☐ 80+ years
- ☐ Prefer not to say
- ☐ Not known

What is your gender?

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ Prefer to self-describe:
- ☐ Prefer not to say
- ☐ Not known

What is your ethnicity?

- ☐ Arab
- ☐ Asian / Asian British: Bangladeshi
- ☐ Asian / Asian British: Chinese
- ☐ Asian / Asian British: Indian
- ☐ Asian / Asian British: Pakistani
- ☐ Asian / Asian British: Any other
- ☐ Black / Black British: African
- ☐ Black / Black British: Caribbean
- ☐ Black / Black British: Any other
- ☐ Mixed / Multiple ethnic groups: Asian and White
- ☐ Mixed / Multiple ethnic groups: Black African and White
- ☐ Mixed / Multiple ethnic groups: Black Caribbean and White
- ☐ Mixed / Multiple ethnic groups: Any other
- ☐ White: British / English / Northern Irish / Scottish / Welsh
- ☐ White: Irish
- ☐ White: Gypsy, Traveller or Irish Traveller
- ☐ White: Roma
- ☐ White: Any other
- ☐ Any other ethnic group
- ☐ Prefer not to say
- ☐ Not known

Which of these descriptions best applies to your employment status?

- ☐ Student
- ☐ In paid employment or self-employment (or away temporarily)
- ☐ On a Government scheme for employment training
- ☐ Looking for paid work or for a Government training scheme
- ☐ Intending to look for work but prevented by temporary sickness or injury or caring
- ☐ Permanently unable to work due to long-term sickness or disability or caring
- ☐ Retired from paid work
- ☐ Looking after the home or family

Other, specify:

What is your occupational status?

- ☐ Not in employment
- ☐ Managerial (Managers have subordinates and do managerial/ administrative work)
- ☐ Professional (including other upper white collar employees, such as teachers and doctors but do professional work and typically do not have subordinates)
- ☐ Semi-professional (includes nurses, foremen and technicians, and other intermediate level white-collar employees)
- ☐ Routine non-manual worker (include non-professional clerical employees and other lower white-collar employees within the social and health services)
- ☐ Manual worker (include work in transport and other technical occupations as well as in cleaning and canteens)

Do you have a disability or long term health condition?

- ☐ Yes – physical of mobility impairment
- ☐ Yes – sensory impairment
- ☐ Yes – learning disability or difficulties
- ☐ Yes – mental health condition
- ☐ Yes – long term condition
- ☐ Yes – other
- ☐ No
- ☐ Prefer not to say
- ☐ Unsure

To what extent do any of your conditions or illnesses reduce your ability to carry out day-to-day activities?

☐ a lot ☐ a little ☐ not limited at all

Do you provide unpaid care to family members or friends who due to illness, disability, a mental health problem or an addiction, cannot cope without your support?

- ☐ No
- ☐ Yes, 1 – 19 hours a week
- ☐ Yes, 20 – 49 hours a week
- ☐ Yes, 50 or more hours a week

Which of the following best describes your current financial status?

- ☐ I have enough for basic necessities, and at least a fair amount of disposable income, that I can save or spend on leisure.
- ☐ I have enough for basic necessities, and a small amount of disposable income, that I can save or spend on leisure.
- ☐ I only have enough for basic necessities, I am living paycheck to paycheck or using savings.
- ☐ I don't have enough for basic necessities, I am struggling to make ends meet.

Would you be willing to take part in further research to improve lifestyle services and support?

- ☐ I consent to being contacted again for further research related to this specific project (eg. group discussions)
- ☐ I consent to receive news and updates about local health and social care services from Healthwatch Richmond.
- ☐ I do not want to be contacted.

What is your email address?

Please return this survey by post (no stamp needed) at the following address:

FREEPOST: RTXT-TYAK-HATJ,
Healthwatch Richmond,
82 Hampton Road,
Twickenham TW2 5QS

healthwatch
Richmond upon Thames

Healthwatch Richmond
82 Hampton Road
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www.healthwatchrichmond.co.uk
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@HW_Richmond

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