South West London
Health & Care Partnership
Start well, live well, age well

The London Borough of Richmond upon Thames

Health and Care Plan

2019-2021

RICHMOND
Health & Wellbeing
BOARD

South West London Health & Care Partnership

Richmond's Health and Care Plan

– an introduction from Cllr Piers Allen, Health and Wellbeing Board Chairman

The Richmond Health and Care Plan describes our vision, priorities and actions to meet the health and care needs of local people and deliver improvements in their health and wellbeing. It has been developed in partnership with residents, voluntary and community groups, health and care partners and health and care service providers, all of whom proactively shared and developed their views through consultation and engagement events.

These local voices have given us their local health and care priorities which are included in the themes 'Start Well, Live Well' and 'Age Well'; with 'prevention', the need for early intervention and support for unpaid carers featuring across these themes. Our plan identifies the actions we will take to create environments that enable communities and residents to lead healthy lives and be confident in their ability to care for themselves and others.

This two-year (2019–2021) plan focuses on the actions which no single organisation could achieve alone. By working together, health, social care and the voluntary sector can deliver quality health and care services that support local people. Our Health and Care Plan should be read alongside other local health and care strategies produced jointly by the Council, Richmond Clinical Commissioning Group and the South West London Health & Care Partnership.

The Richmond Health and Wellbeing Board will oversee the delivery of the Health and Care Plan and intends to use this plan as a 'conversation starter' across the Council, health and care partners, providers, voluntary and community sectors and with residents. We will continue to work together with local people to implement the actions that will provide the high-quality health and care services our residents deserve.

Cllr. Piers Allen
Richmond Health and Wellbeing Board Chairman,
July 2019

South West London Health & Care Partnership

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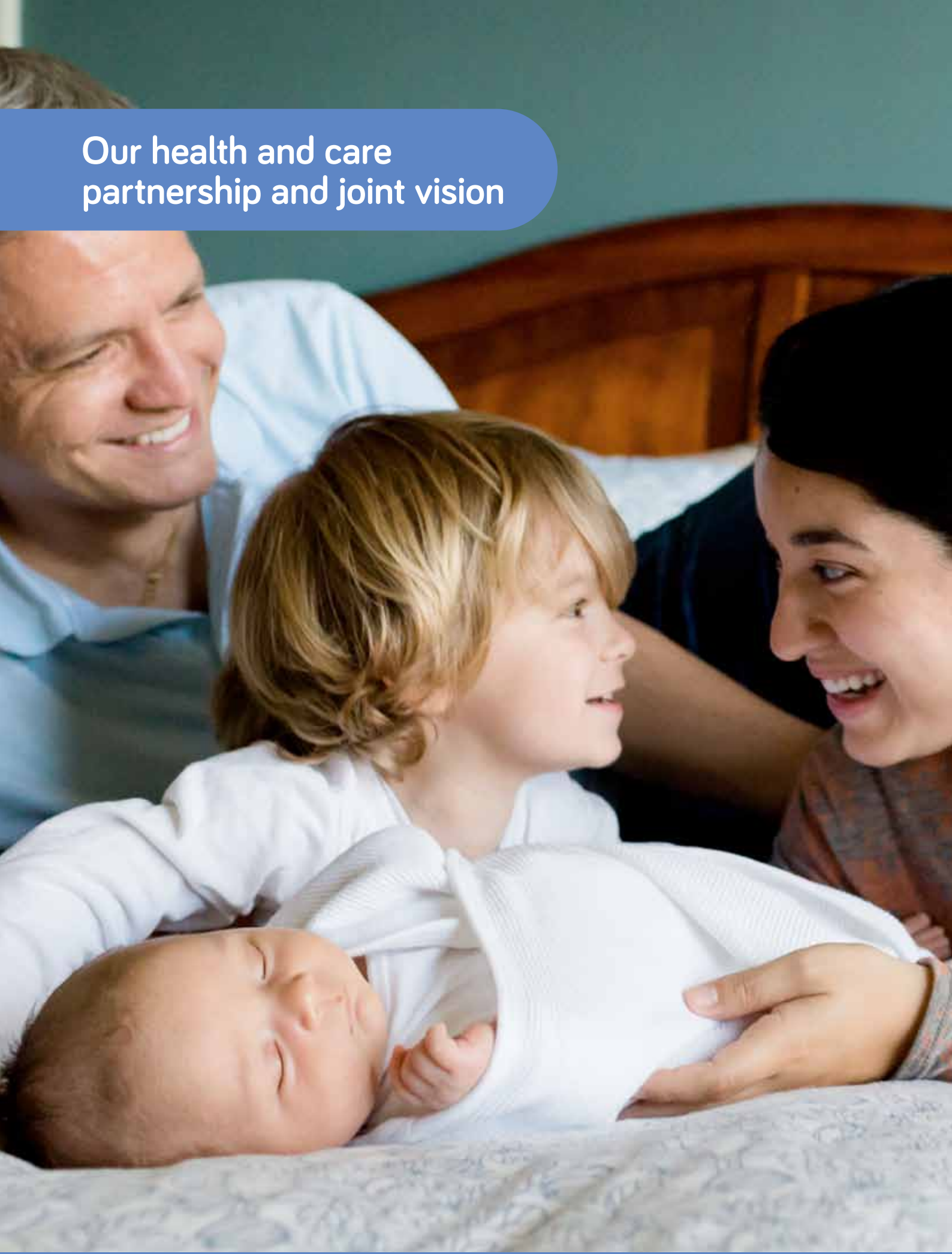

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Our health and care partnership and joint vision

The plan has been developed in partnership with local people, voluntary community groups and health and care partners in the borough of Richmond.

Here's a list of the partners involved:

- Local people
- Achieving for Children
- Chelsea & Westminster NHS Foundation Trust (West Middlesex)
- London Borough of Richmond upon Thames
- Your Healthcare Community Interest Company
- Community pharmacists
- Kingston Hospital NHS Foundation Trust
- NHS Richmond Clinical Commissioning Group
- South West London and St George's Mental Health NHS Trust
- Richmond Council for Voluntary Service
- East London Foundation Trust
- Central London Community Healthcare NHS Trust
- Richmond GP Alliance / Richmond GPs
- Healthwatch Richmond

Our vision

We have a long history of working together in the borough of Richmond to deliver improved health and care to our local people. We have established partnership arrangements to support partnership working, including the:

Richmond Health & Wellbeing Board – brings together elected members and local leaders from the health and social care system for adults and children, to improve the health and wellbeing of its local population and work to reduce inequalities.

Our vision for improving the health and wellbeing of local people is that:

"All people in the borough of Richmond are able to achieve their full potential, live their lives with confidence and resilience, and access quality services that promote independence and deliver value for money."

This vision is underpinned by five aims:

1. We want people to live **longer, healthier lives.** Our vision is that local people should be supported to look after themselves and those they care for and have access to high quality, joined up physical and mental health and care services when they need them.

2. We will focus on **prevention and early intervention,** making sure people are treated in the right place to meet their needs. Proactive, preventative care will mean fewer people need to access emergency or specialist services.

3. We will deliver **asset based, co-ordinated health and social care services** to residents that will improve service user experience and deliver better outcomes.

4. We want to give people the best possible chance to remain as independent as possible for as long as possible, supported by a health and social care system that is easier to access, is timely in the support it provides and brings together expertise to provide a cohesive and intuitive approach to health and wellbeing.

5. We believe this supports people in the borough of Richmond to be **partners in their own care and support** and, where possible, lead their own care.

The Richmond story

The Richmond story

The London Borough of Richmond upon Thames is a prosperous, safe and healthy borough. Life expectancy is high and rates of premature mortality are lower than other areas. Richmond has low levels of crime and accidents, good schools and high levels of volunteering.

See Richmond's Strategic Needs Assessment for more information about local health and social care needs https://www.richmond.gov.uk/jsna

Prevalence of main health conditions

- c22,000 people are diagnosed with a common mental disorder and there are 6,517 adults identified with depression by GPs
- Nearly one in three people has one or more long-term condition and nearly one in ten has three or more
- National prevalence modeling suggests c 7,500 people with undiagnosed long-term conditions e.g. coronary heart disease and diabetes
- Multimorbidity is common; over 15% of people with a heart condition have at least three other long-term conditions and 20% have either depression or anxiety
- 2,072 Richmond residents have dementia.

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Start well

What happens in early life, starting from conception, affects health and wellbeing in later life. Prevention is critical to ensuring that all children and young people can fulfil their potential.

The health and wellbeing of children in the borough of Richmond is generally better than the England average. Good educational attainment is linked to better physical and mental health, as well as income, employment and quality of life. Intervening effectively when children and adolescents are starting to develop mental health problems could prevent between a quarter and a half of adult mental illness. Nationally, up to half of all lifetime mental health problems start before the age of 14.

Children and young people with learning disabilities are among the most vulnerable in a community with a wide range of support and access needs. Many will have additional health problems, including physical disabilities and sensory impairments.

Speech, language and communication needs are the second most common primary care need. Children with disabilities or special needs are more likely to experience or live in poverty.

Obesity in children can cause social and emotional problems and illnesses such as childhood diabetes. Obesity persisting into adulthood can lead to type 2 diabetes, cardiovascular disease, joint problems and poor general health.

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How are we doing in the borough of Richmond?

- A significantly lower percentage of children (78%) have received 2 doses of MMR immunisation at or before the age of five compared with the England (88%)
- 12% of the children have special educational needs or disabilities
- The rate of A&E attendances (0-4 years) at 732 per 1,000 is significantly higher than both the England average (588 per 1,000) and the London average (707 per 1,000)
- 90 hospital admissions are a result of self-harm in those aged 10-24 year-olds, which equates to the third highest rate in London
- The average mental wellbeing score for 15 year olds in the borough of Richmond is the fourth worst in London
- The rate of hospital admissions as a result of self harm in those aged 10-24 is the highest rate in London. The breakdown by age shows that this problem worsens with age: the rate for those aged 10-14 is better than the London rate, but for those aged 15-19 almost double the London rate, while for those aged 20-24 it is over three times the London rate
- In reception year, 5.1% of children are obese, the lowest in England. Nevertheless, by Year 6, prevalence more than doubles to 11%, and is even higher in the more deprived areas of the borough
- The rate of hospital admissions due to substance misuse (excluding alcohol) in those aged 15-24 years is showing an increasing trend
- 39 young people were in specialist treatment for cannabis (82%), alcohol (69%), ecstasy (28%) and cocaine (21%) misuse
- The cumulative risk from multiple unhealthy behaviours is significant in our 15 year olds where:
  - Prevalence of smoking is 14.3%, twice the London average (6.1%),
  - 19% report having tried cannabis, the highest proportion in London, and third highest in the country (London and England averages 11%)
  - drink more regularly than in any other London borough – 9% are regular drinkers and 25% reported being drunk in the previous 4 weeks.

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Richmond Clinical Commissioning Group Start well

People aged 0-17 who are Registered with a Richmond Practice December 2018
47,930
(1.1% increase compared to December 2017)

People aged 0-4 who are Registered with a Richmond Practice December 2018
12,765
(2.6% decrease compared to December 2017)

People aged 5-9 who are Registered with a Richmond Practice December 2018
14,760
(0.8% decrease compared to December 2017)

People aged 10-17 who are Registered with a Richmond Practice December 2018
20,405
(4.96% increase compared to December 2017)

Females aged 0-17 who are Registered with a Richmond Practice December 2018
23,586
(Females are 49.2% of all 0-17 year olds)

Number of Ambulance Conveyances to an A&E dept. for 0-17 year olds 2018
3,668
(An increase of 39.3% compared to 2017

Number of Accident and Emergency Attendances for 0-17 year olds 2018
23,710
(1 in 6 were brought in to A&E via Ambulance)

Number of Emergency Admissions for 0-17 year olds 2018
2,645
(11.2% of all A&E attendances were admitted to a hospital)

Number of 0-17 year olds referred for outpatient care 2018
24,159
(An reduction of 0.84% on 2017)

Number of elective/daycase operations for 0-17 year olds 2018
1,067
(4.42% of all referrals had an elective prodedure)

Estimated Prevalence of MH Disorders in CYP aged 05-16 2017-18
7.0%
(London Prevalence is 9.3%. England Prevalence is 9.2%)

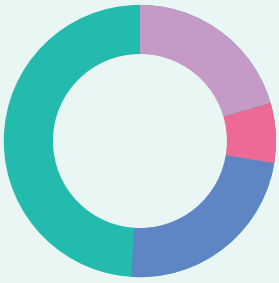
Prevalence of Obese Children (Reception) 2017/18
5.3%
(London Prevalence is 10.1% England Prevalence is 9.6%)

Prevalence of Obese Children (Year 6) 2017/18
11.4%
(London Prevalence is 23.1% England Prevalence is 20.1%)

Children with Learning Disabilities known to schools per 1,000 Pupils 2018
11.3
(London Rate is 23.0 England Rate is 33.9)

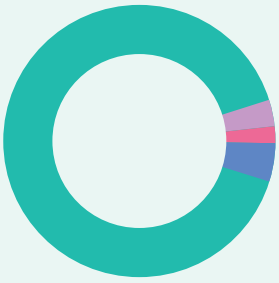
Looked After Children per 10,000 <18 Population 2015-16
25.9
(London Rate is 50.5 England Rate is 60.3)

Elective Admissions 2018



- Diseases of Childhood and Neonates 48.7%
- Ear, Nose, Mouth, Throat, Neck and Dental 20.6%
- Skin, Breast and Burns 7.0%
- Other Areas 23.6%

Emergency Admissions 2018



- Diseases of Childhood and Neonates 90.3%
- Musculoskeletal System 3.1%
- Digestive System 2.0%
- Other Areas 4.5%

0-17 year olds in contact with CYP mental health services March 2018
545
(51.3% increase on numbers seen March 2017)

Number GP Practice appointments for 0-17 year olds 2018
127,177
(Each 0-17 year old sees their GP Practice 2.6 times per year)

Source: NHS

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Live well

Healthy choices are influenced by our environment, communities and wellbeing. Preventative approaches are needed at all levels; engaging communities, utilising local assets (e.g. parks) and targeting those most at risk.

The health and wellbeing of our working age population often impacts not just the individuals themselves, but also families, children, workplaces, business and communities. Although people of working age are relatively less likely to suffer ill health than younger and older people, as they are the largest population group they are an important source of activity for public services. Promoting good health in adulthood can also prevent the development of long-term conditions and disability in older age. Healthy choices are influenced by our environment, communities and wellbeing.

As a health and care system we are moving beyond a focus on individual behaviour towards a wide range of social and environmental interventions to improve the health of the population and reduce preventable diseases. We are also taking a more proactive approach in certain health conditions to intervene earlier, prevent serious consequences of those conditions and deliver more efficient care.

Some working age adults are 'at risk' and or will be diagnosed with a long-term condition (a condition that cannot, at present, be cured but is controlled by medicines and/or other therapies.) These can be limiting long-term conditions, a health problem, or disability which limits someone's daily activities or the work they can do.

Having one or more long-term conditions generally reduces quality of life and increases the chances of requiring support from health or social care services. It is recognised that if people with long-term conditions are managed effectively in the community, they should remain relatively stable and enjoy a quality of life free from frequent crises or hospital visits. Local health and care partners are working together to work in more integrated ways to support people with long-term conditions to manage their own conditions and improve the care they receive when they come into contact with our services.

Our live well plan will drive forward a preventative approach at all levels; engaging communities, utilising local assets (e.g. parks) and targeting interventions to reach those most at risk.

How are we doing in the borough of Richmond?

- Rate of people receiving an **NHS Health Check** per year fell significantly from 11.2% (2013/14) to 7.5% (2017/18) and is significantly lower than England's rate of 8.3%
- 12.9% of the adult population (21,995) are estimated to have **anxiety and/or depression**
- One in ten has **3 or more long-term conditions**
- 85% of patients with a **severe mental illness** (SMI) recorded consuming alcohol in the past 12 months
- The borough's prevalence of **learning disabilities** is 0.2% (524 people) and the rate of adults aged 18-64 with learning disabilities in stable
- The proportion of eligible adults with **learning disabilities having a GP health check** is 57%
- Although **smoking rates** are low compared to London, it is estimated that 12.7% of adults smoke (around 15,000) and the number of people quitting is falling
- **Sports club membership** down from 39% to 32% in last decade
- Proportion of females aged 50-70 invite for and taking up **screening for breast cancer** is down significantly and lower than London average
- Proportion of females aged 25-64 attending **cervical screening** within target period has fallen significantly from 72.6% to 69.9% over the past 2 years.

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Richmond Clinical Commissioning Group Live well

People aged 18-64 who are Registered with a Richmond Practice December 2018
140,356
(1.1% increase compared to December 2017)

Number GP Practice appointments for 18-64 year olds 2018
503,051
(Each 18-64 year old sees their GP Practice 3.6 times per year)

People 18-64 with 3 or more Long-term Conditions March 2018
11,085
(7.9% of people aged over 65 have 3 or more LTCs)

Number of People with a Serious Mental Illness March 2018 (QOF)
1,791
(1.04% of the adult population)

The number of people estimated to have Depression and/or Anxiety 2018-19 (IAPT)
21,995
(12.8% of the adult population)

Number of Ambulance Conveyances to A&E for 18-64 year olds 2018
7,318
(An increase of 20.8% compared to 2017)

Number of Accident and Emergency Attendances for 18-64 year olds 2018
48,634
(1 in 7 were brought in to A&E via Ambulance)

Number of Emergency Admissions for 18-64 year olds 2018
6,495
(13.3% of all A&E attendances were admitted to a hospital)

Number of 18-64 year olds referred for outpatient care 2018
84,109
(A reduction of 1.02% on 2017)

Number of elective/ daycase operations for 18-64 year olds 2018
10,550
(12.54% of all referrals had an elective prodedure)

People with Learning Disabilities as a proportion of Total Population 2017-18
0.25%
(Compared against the England Rate of 0.49%)

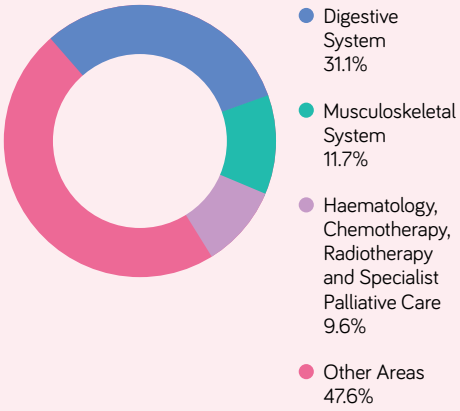
Proportion of people with a learning disability receiving an annual health check 2016-17
57.1%
(Compared against the England Rate of 48.8%)

Mental health admissions to hospital: rate per 100,000 population 2017-18 Q4
225.3
(London Rate is 325.7 England Rate is 274.3)

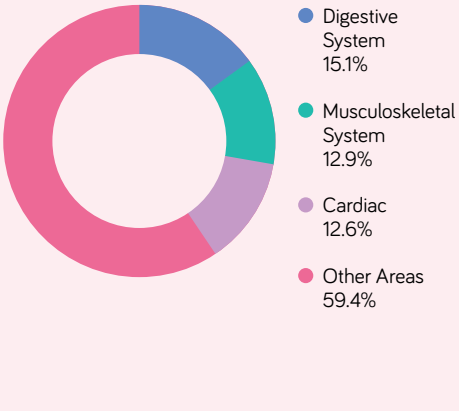
Cancers diagnosed at an early stage (Stages 1 or 2) Calendar Year 2016
55.6%
(Compared against the England Rate of 52.6%)

Social care-related quality of life score for 18-64 year olds 2017-18
20.0/24.0
(England Average is 19.5 out of 24.0)

Elective Admissions 2018



Emergency Admissions 2018



Number of People on their practice register with COPD or Asthma March 2017
11,662
(6.8% of the adult population)

Number of People on their practice register with Diabetes March 2018
6,363
(3.7% of the adult population)

Source: NHS

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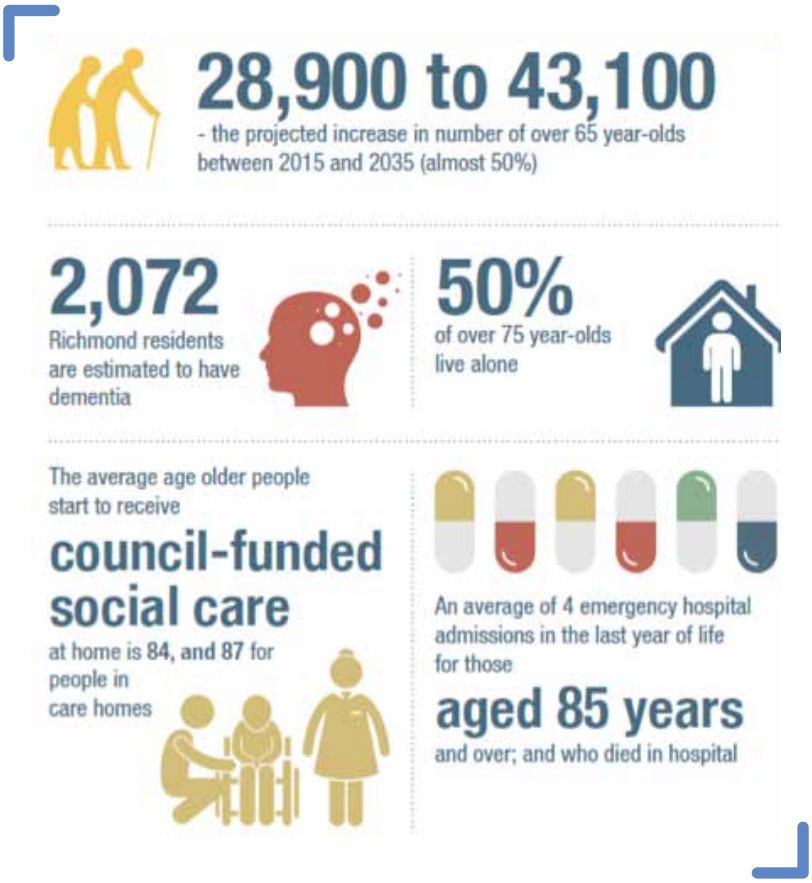
Age well

Whilst people are living longer lives, many older people are also living with a reduced quality of life due to ill health or disability, or experience loneliness and isolation.



Maintaining health into older age will increase people's chances of remaining independent and in control of their lives. Healthy lifestyles continue to be important, as well as staying socially connected and being able to manage long-term conditions. Many older people also find themselves in a caring role. Health and social care provision needs to adapt as the population over the age of 65 continues to increase.

Meeting the needs of an ageing population has considerable consequences for planning health and social care services. One of the highest risk factors for loneliness is older age. Widowed homeowners living alone with long-term conditions are at particular risk.

Housing is a key determinant of health, and the need for suitable accessible accommodation and adapted properties increases with age. People generally prefer to stay in their own home rather than move into residential or nursing care. Being unable to afford to sufficiently heat a home can lead to heart disease and respiratory diseases, and to excess deaths in winter that should be preventable.

Long-term conditions are more common in older people. People with long-term conditions are three times more likely to have mental health problems than the general population.

Delaying and reducing the need for care and support with earlier diagnosis, intervention and reablement delivered in the most appropriate setting is more cost-effective and means that older people and their carers are less dependent on intensive services and regain their independence.

Good end of life care enables residents to have a dignified, controlled and peaceful end to their life. Richmond aims for people to live in the way they want to when they are approaching the end of their life so they can die with dignity.

How are we doing in the borough of Richmond?

- 30,600 over 65s make up the population
- The proportion of those aged 65+ living alone is 5.12% (9,434 people) which is significantly higher than in London (3.86%)
- 19,000 A&E attendances resulting in 8,000 emergency admissions
- Those aged 65 years and over who died in hospital were admitted to hospital an average of 4 times in the last year of life
- The social care quality of life score for over 65s is 19/24 compared to England 18.9/24
- In the past 5 years, the number of people with dementia has increased by 58%
- The proportion of adult social care users who have as much social contact as they would like is 48.2%
- The number of carers aged over 65 years is increasing more rapidly than the general carer population
- The proportion of adult carers who have as much social contact as they would like is 32.1%.

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Richmond Clinical Commissioning Group Age well

People aged 65+ who are Registered with a Richmond Practice December 2018
31,360
(2.2% increase compared to December 2017)

Number of people aged 65+ with Dementia December 2018
1,360
(4.3% of people aged 65+ are on dementia registers)

People 65+ with 3 or more Long-term Conditions December 2018
14,168
(45.2% of people aged over 65 have 3 or more LTCs)

Number of People eligible for Continuing Healthcare December 2018
535
(Rate of 155.78 per 50,000 18+ population)

People aged 65+ supported by District Nursing Teams 2018
7,755
(24.7% of people aged 65+ in Richmond)

Number of Ambulance Conveyances to A&E for 65+ year olds 2018
5,902
(A reduction of 9.1% compared to 2017

Number of Accident and Emergency Attendances for 65+ year olds 2018
20,267
(1 in 3 were brought in to A&E via Ambulance)

Number of Emergency Admissions for 65+ year olds 2018
8,040
(39.7% of all A&E attendances were admitted to a hospital)

Number of 65+ year olds referred for outpatient care 2018
48,527
(An increase of 4.94% on 2017)

Number of elective/ daycase operations for 65+ year olds 2018
9,438
(19.4% of all referrals had an elective prodedure)

Admission to residential and nursing care homes 65+, per 100,000 population 2017-18
328.1
(Compared against the England Rate of 585.6)

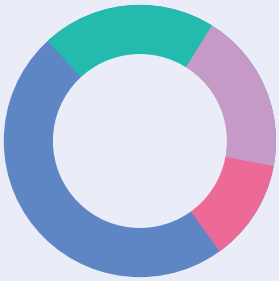
Emergency Admissions from Care/Nursing Homes 2018
540
(6.7% Emergency Admissions from Care/ Nursing Homes)

People Returning To Usual Place of Residence after an Emergency Admission 2018
84.6%
(Increased from 81.6% in 2017)

People Feeling Supported to manage their condition (Primary Care Survey 2016-17)
70.7%
(Compared against the England Rate of 64.0%)

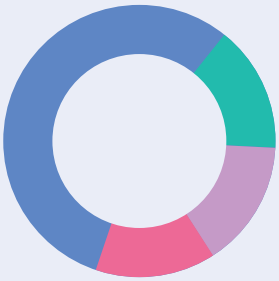
Social care-related quality of life score for 65+ year olds 2017-18
18.7/24.0
(England Average is 18.9 out of 24.0)

Elective Admissions 2018



- Digestive System 20.6%
- Haematology, Chemotherapy, Radiotherapy and Specialist Palliative Care 19.1%
- Urinary Tract and Male Reproductive System 11.8%
- Other Areas 48.5%

Emergency Admissions 2018



- Respiratory System 15.2%
- Cardiac 15.0%
- Musculoskeletal System 14.2%
- Other Areas 55.7%

Proportion of People who were still in their own home having received reablement 2017-18
92.0%
(6.4% incease compared to the rate in 2016-17)

Number GP Practice appointments for 65+ year olds 2018
266,282
(Each 18-64 year old sees their GP Practice 8.5 times per year)

Source: NHS

The wider determinants of health in Richmond

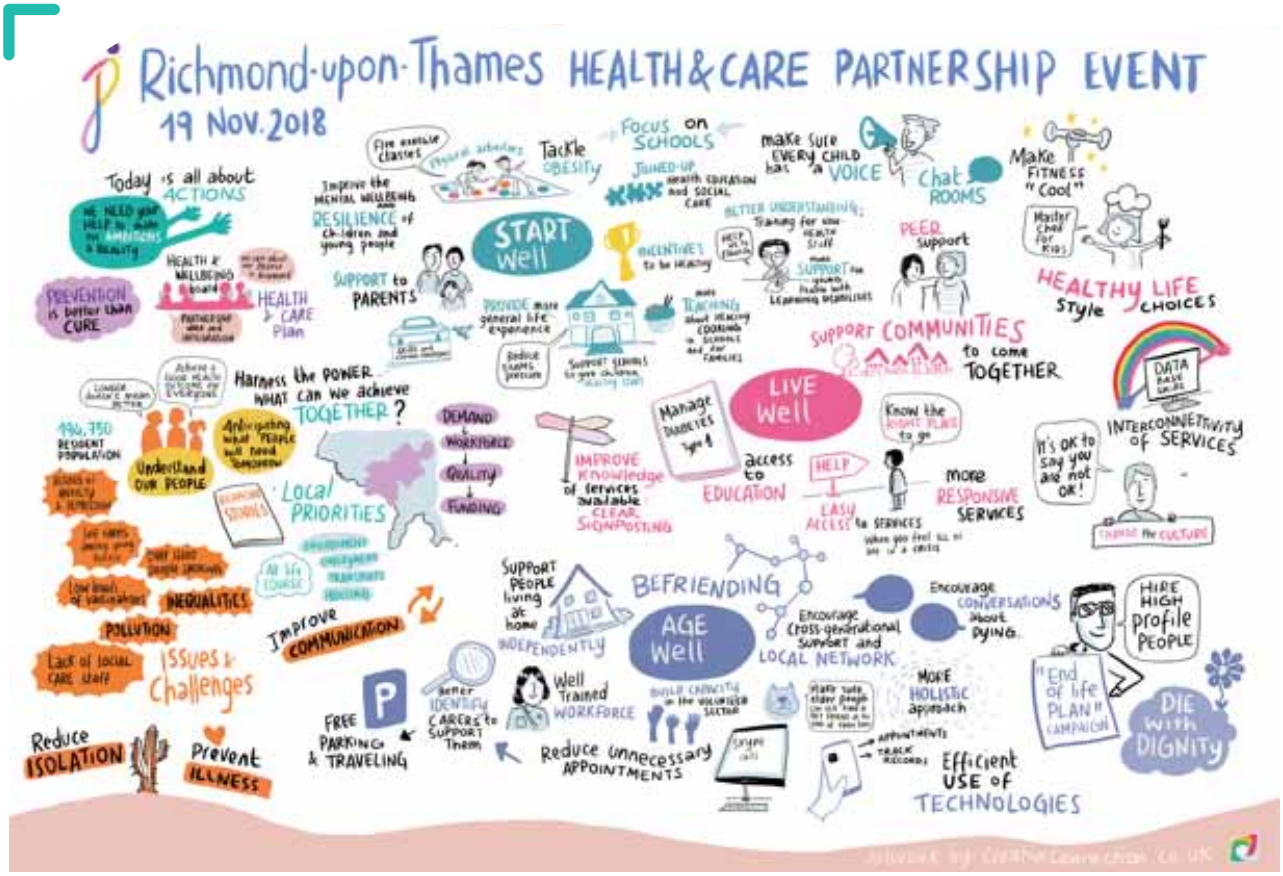
The wider determinants of health in the borough of Richmond

The wider determinants of health are a diverse range of social, economic and environmental factors which impact on people's health. In Richmond:

- **Air quality:** The the borough of Richmond has been declared an Air Quality Management Area because it has exceeded permissible levels of pollution; 3 primary schools are within areas that exceed legal pollution limits.
- **Green spaces:** Publicly accessible parks (regional, metropolitan, district, local, small and pocket parks) make up 40% of the total area of the borough of Richmond.
- **Physical activity:** There is inequality in engagement rates in physical sports activity: women, older adults, and people with disabilities and mental health difficulties demonstrate lower levels of participation. Only 28% of residents use outdoor space for exercise or health reasons, although this is the second highest percentage in London.
- **Housing:** Home ownership is associated with increased life satisfaction. The median house price to median earnings ratio in the borough has increased from 9.2 to 14.5 in the past year.
- There is an **educational attainment gap** between children eligible for free school meals and those not.
- **Poverty** – Richmond foodbank provides c 1,800 three-day emergency food supplies for people in crisis. Benefit delays and low income are the most common reasons why people are currently being referred.

What local people have told us

What local people have told us



It is essential that the views and experiences of local people are at the heart of our plans, driving forward the changes needed to improve local services. We believe in on-going conversations and making sure that the needs of local people are central to what we do. Nobody knows more about how we can make things better than the people who use our services. We have used the views and experiences that local people in the borough of Richmond and across south west London have shared with us over the last two years to shape our thinking as we developed our local health and care priorities.

In November 2018, we held an event which brought together over 150 local people, health and care frontline staff, and representatives from different community organisations to talk about the kinds of things which no single organisation can achieve alone – like combating childhood obesity and supporting people with diabetes. We wanted to check whether we were focusing on the right areas for the borough of Richmond, and how to ensure the action we take has maximum impact for local people. There was great energy and fresh ideas in the room. It was clear that people were passionate about health and care in our borough and wanted to support us. You can read more about our engagement event here:

http://www.richmondccg.nhs.uk/have-your-say/health-care-plan-event

In March 2019, a mix of health and care professionals from NHS, Council, voluntary sector and Healthwatch Richmond came together for a working session to build on the information we have about the borough of Richmond and what we heard from local people to agree the key actions and outcome measures to support our health and care priorities.

These conversations informed Richmond's Health and Care Plan discussion document. This was published at the beginning of May 2019, and during this month targeted engagement took place to sense check and test the proposals with groups in start well, live well and age well. This work has been led by the borough's communications and engagement group with representation from key health and care partners, Richmond CVS and Healthwatch Richmond.

Information about the discussion document and how to provide feedback was shared with health and care partner networks and to a range of local voluntary and community organisations and groups. This included completing a short online survey hosted on Richmond Council's website.

Where it was possible we also used relevant forums and groups meeting during May to discuss the document and seek feedback.

An engagement report providing an overview of the insight and engagement activities has been produced and you can find it, along with a 'You Said, We Did' document which summarises the actions we have taken in response to what we heard from local people, and health and care partners here:

http://www.xxxxxxxxxx/xxxxxxxxxx/xxxxxxxxxx/xxxxxxxxxx/xxxxxxxxxx

Following publication of the Health and Care Plan we will continue to work with those most involved in and affected by the plan as we deliver the actions.

Financial context

Financial context

Good, sustainable and adaptive health and care services need to be underpinned by sustainable financial balance, however health and social care sectors both face significant financial challenges.

The health sector is in deficit and has been set challenging financial targets for the 2019/20 financial year. Richmond Clinical Commissioning Group incurred an in-year deficits in 2018/19 financial year and has a £3.9m underlying deficits. Funding for services is expected to increase by £44.9m in 2023/24 however in the same period our costs are expected to rise by £53.4m.

Richmond Council is proactively responding to the current financial challenges of reducing Government funding and increasing demographic pressure. The Council reported a net underspend of £2.4m (1.6% of 18/19 Council Tax Requirement). This excludes ring-fenced money for schools which recorded a net overspend of just under £3m which although outside the Council's control if not recovered within school funding in future years could form a call on other Council reserves.

The Council has seen a reduction in its core funding in recent years with general government grant reducing by £40m (70%) since 2010 and is one of the few borough's potentially affected by the Government's proposal to introduce negative revenue support grant (removed for 2019/20 but uncertainty remains for future years). Within adult social care the Council was one of the few to receive none of the 'enhanced Better Care Fund.' In addition, the Council expects to see increasing demand for services from an increasing demographic, particularly from increased demand in Children's social care services and children with special educational needs and disabilities (SEND) and adult social care. For example, the number of older people over 65 in the borough of Richmond is expected to increase by 6.5% and number of people over age 85 increasing by 7.1% by 2021 and the number of adults with a learning disability expected to increase by 5% per annum, equating to an estimated additional 188 service users by 2021.

Against this backdrop the Council has achieved efficiencies of around £62m since 2010. £28m of these have been achieved by internal restructuring and the sharing of services with other organisations, £21m from procurement and contract savings and £13m from income generation, inflation restrictions and other savings. The funding issues faced by the Council will require additional savings to be identified and implemented, an additional £3m of extra savings/ income has already been identified for 2019/20. The gap between costs and funding, assuming that £7.9m of efficiency savings are successfully delivered, could rise to £24.8m by 2023/24 which would need to be met from further cost reductions, increased income (including council tax) or the use of reserves.

In common with the rest of local government the Council faces uncertainty about the future of local government funding and the long-term funding of adult social care where the Government continues to promise a Green Paper on changes to put adult social care on a sustainable footing for the long-term but yet final proposals have not been published.

The new NHS Long Term Plan shows a clear intention to move towards making all NHS organisations and systems financially sustainable within 5 years. This is supported by a clear national intention that local systems move to a more transparent and collaborative approach to planning and delivery, to reduce costs but also to maintain and improve services.

In the borough of Richmond, there is now a clear shift towards collaborative working, both within the health sector and with Local Authority and other partners in terms of planning and providing services in an integrated way that is focused around the person.

Effective reduction of costs whilst providing quality services is possible, and as such system leaders in the borough of Richmond are determined to restore and maintain financial balance to support and enable this ambitious Health and Care Plan.

As part of implementation planning, work will be undertaken to model the financial implications of the proposed actions in this plan. However, a significant focus of the plan is on service transformation within existing resources.

Our priorities and the actions we will take to deliver them

South West London Health & Care Partnership

Our priorities and the actions we will take to deliver them

Based on the conversations we have had with local people, the borough of Richmond story and the case for change we have agreed some priority areas for actions.

Within this report priorities and actions are grouped in the following areas:

Prevention and early intervention

Start well

Live well

Age well

Unpaid Carers

South West London Health & Care Partnership

Prevention and early intervention

In developing our plan we identified prevention and early intervention, as a theme which is relevant across all of the life stages. Further down this document you will see that we have embedded actions into each of the life stages to ensure that prevention and early intervention is key.

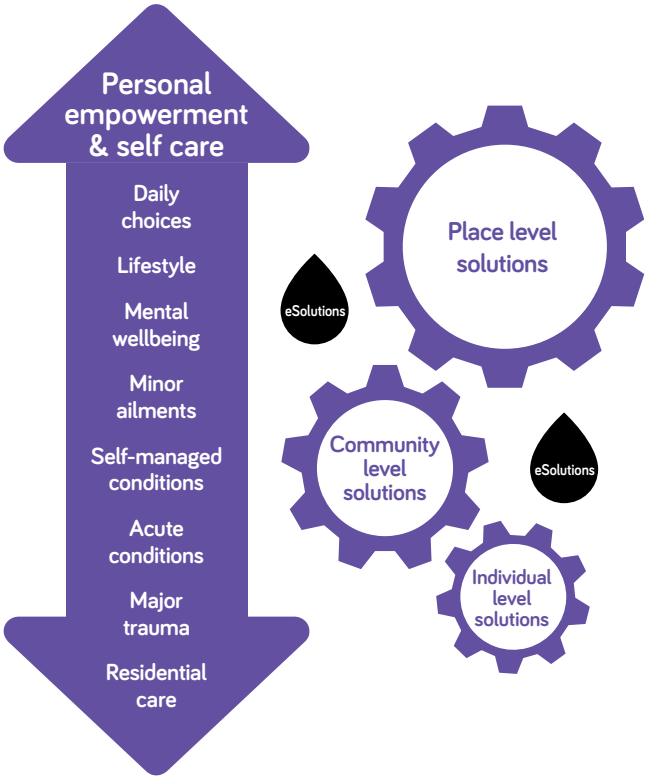
This section describes our partnership approach and how prevention is a priority for all.

The NHS Long Term Plan

The NHS Long Term Plan states that we need to shift focus to prevention and public health or we will be faced with a sharply rising burden of avoidable illness. It is therefore essential that prevention is embedded into every aspect of health and care provision. Health and care partners in the borough of Richmond have agreed that prevention is a cross cutting priority and we should create environments and enable communities and individuals to lead healthy lives and be confident in their ability to care for themselves and others.

A whole system approach to self care

The diagrams below illustrate that we need to take a whole systems approach and embed prevention with a focus on maintaining independence and self-care.



Approach

Promoting healthy daily choices
E.g. planning, active travel, community safety and licensing

Community-led and owned support

Social marketing

E-solutions
For self-care and self-management

Individual-focused interventions
E.g. smoking cessation, weight management, alcohol reduction and falls prevention

Enablers

Needs assessment

Align strategies
Across all sectors in the borough, including health and social care

Collaborative partnerships between health and care systems and local communities
Social prescribing, Patent Participation Groups

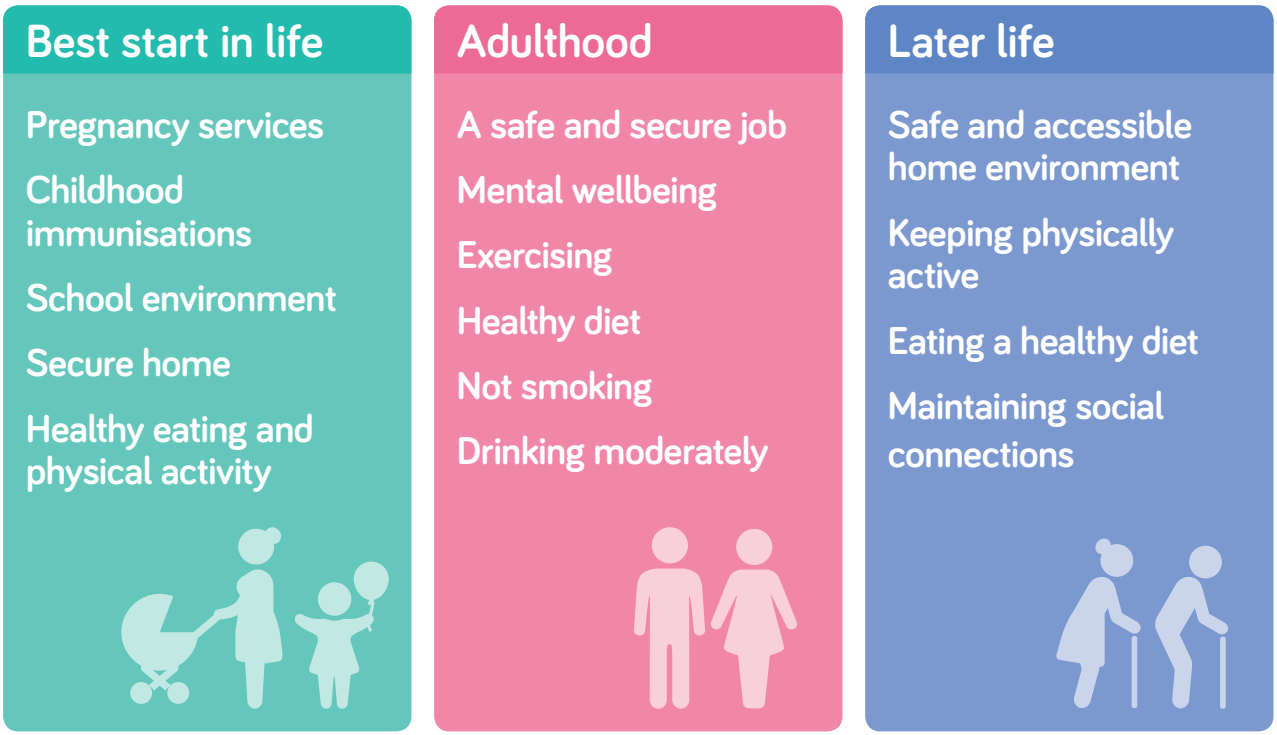
Systematic workforce development
Making Every Contact Count, London Healthy Workplace charter

Embedding prevention throughout systems and services
Prevention integrated within all clinical and care pathways e.g. NDPP

Messages on benefits of self-care and raising awareness and access to technologies that promote self-care

South West London Health & Care Partnership

Young and old: prevention matters



Source: Public Health England

Here is a summary of the work which is ongoing in the borough of Richmond in the area of prevention.

The first 1,000 days

The first 1,000 days of life, from conception to age 2, is a critical phase during which the foundations of a child's development are laid. If a child's body and brain develop well then their life chances are improved. Exposure to stresses or adversity during this period can result in a child's development falling behind their peers. Left unaddressed, experiences can stay with children throughout their lives, can cause harm to them and to others, and might be passed on to the next generation.

Intervening more actively in the first 1,000 days of a child's life can improve children's health, development and life chances and make society fairer and more prosperous. Improving support for children, parents and families during this vulnerable period requires a long-term and coordinated response with high-quality local services for children, parents and families founded on the following six principles:

services are available to all but targeted in proportion to the level of need

- prevention and early intervention
- community partnerships
- a focus on meeting the needs of disadvantaged groups
- greater integration and better multi-agency working
- evidence-based provision.

We will work to develop a plan to improve support for children, parents and families in the first 1,000 days of life, which reflects these principles.

Making every contact count

- Many long-term diseases in our population are closely linked to known behavioural risk factors. Around 40% of the UK's disability adjusted life years lost are attributable to tobacco, hypertension, alcohol, being overweight or being physically inactive.
- Making changes such as stopping smoking, improving diet, increasing physical activity, losing weight and reducing alcohol consumption can help people to reduce their risk of poor health significantly. Making every contact count (MECC) is an approach to behaviour change that utilises the millions of day to day interactions that organisations and people have with other people to encourage changes in behaviour that have a positive effect on the health and wellbeing of individuals, communities and populations.
- Using every appropriate opportunity to have a health conversation, to help and encourage people to make healthier choices, so they can achieve positive long-term behaviour change to improve their health and wellbeing.

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Social prescribing

Social prescribing enables GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services. Recognising that people's health is determined by a range of social, economic and environmental factors, social prescribing seeks to address people's needs in a holistic way and support them to take greater control of their own health.

Social prescribing schemes involve a variety of activities which are typically provided by voluntary and community sector organisations. Examples include volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating advice and a range of sports. There are many different models for social prescribing, but most involve a link worker or navigator who works with people to access local sources of support.

Social prescribing is designed to support people with a wide range of social, emotional or practical needs, and many schemes are focused on improving mental health and physical wellbeing. Those who could benefit from social prescribing schemes include people with mild or long-term mental health problems, people who are socially isolated, and those who frequently attend either primary or secondary health care.

Prevention into care pathway design

NHS health checks and prevention programmes are embedded in all care pathways.

London Healthy Workplace Award

The London Healthy Workplace Award provides a framework for employers which can be used to help them focus on the health and wellbeing of the workforce. The business benefits of having a healthy, fit and committed workforce are clearly recognised e.g. lower absence rates, fewer accidents, improved productivity, staff who are engaged and committed to the organisation and fitter employees as they grow older. The Award supports employers to build good practice in health and work in their organisation. It covers a range of health and wellbeing themes including mental health and wellbeing, smoking, physical activity, healthy eating and problematic use of alcohol and other substances.

South West London Health & Care Partnership

Start well

What happens in early life, starting from conception, affects health and wellbeing in later life. Prevention is critical to ensuring that all children and young people can fulfil their potential.

Within **Start well** we have identified three priority areas for actions:

1 **Improve the mental wellbeing and resilience of children and young people**

2 **Support children and young people with special educational needs, disabilities and complex health and care needs to flourish and be independent in their local communities**

3 **Reduce obesity to improve the health of our children and young people**

Within each of these priority areas we now describe the specific actions we will take and the expected outcomes.

1 Priority: improve the mental wellbeing and resilience of children and young people

The actions we will take:

By April 2020 we will complete an assessment of the **mental health needs of the under 5** population of the borough of Richmond, to inform development of services.

Ensure that there is an **emotional wellbeing programme in all our schools,** by April 2021. This will include wellbeing support, training and information to students, parents and staff.

Work with young people to design and develop peer led services to reduce involvement in risk taking behaviours by 2020.

Establish a **digital youth project** steering group by January 2020 to review and expand the range of resources and tools to support emotional wellbeing and strengthen resilience.

By April 2020 we will complete a review of the current **neurodevelopment assessment offer and services** ensuring that by 2021 the recommendations of the review are fully implemented.

The impact of these actions will be:

Children and families will receive **early targeted** support to prevent the development of serious difficulties.

Children and young people **will have timely access to support with local counselling,** 7 days a week, through the digital offer.

Improvements in mental wellbeing and incidences of self-harm will reduce due to children and young people receiving better support.

Reduced waiting times for access to child and adolescent mental health services (CAMHS).

Neurodevelopment assessment referrals will always be completed within 12 weeks.

The number of young people who smoke, drink alcohol and use cannabis regularly will reduce.

2 Priority: support children and young people with special educational needs, disabilities and complex health and care needs to flourish and be independent in their local communities

The actions we will take:

Work with children and young people, parents and carers to ensure they can have their say and are involved in **decisions about their own education and health and care support.**

Promote the **local SEND website** so that more people are aware of its value as a one-stop shop for information on local health and care services.

Co-design with young people, parents/carers and professionals, an **improved local therapies** offer. This will be in place by March 2020.

Build on the existing **transition protocol and preparing for adulthood strategy** improve the transition between children and adult health and care services.

Develop a local **post-16 learning offer** for specific groups most likely to use residential provision maximising the use of the adult education curriculum and community assets.

The impact of these actions will be:

Feedback will increase from children and young people, their parents and carers and measure their confidence that plans reflect their needs.

Assessment and intervention waiting times for therapy services will improve. Better satisfaction rates from parents and carers and schools will also be reported.

The number of specialist resource provision places will increase to reflect the needs identified in the ten-year SEND provision plan.

Young people will experience a **planned and smooth transition from children's to adult health and care services.**

A local post-16 learning offer will be put in place and the number of young people, with post-16 educational health and care plans on vocational pathways, will increase.

3 Priority: reduce obesity to improve the health of our children and young people

The actions we will take:

Roll-out the **Family Start programme** to support children who are identified through the national child measurement programme by March 2020.

Promote and support an increased roll out of the **Daily Mile** (getting all children to run for 15 minutes a day in school), in the borough's primary schools by April 2021.

Carry out a **needs assessment on breastfeeding** by April 2020 to identify if there are areas of the population where uptake is below the London average of 49%.

Develop a **Healthy Catering Commitment Plan** to ensure that healthy food is served or sold in all of the borough's schools by 2021.

Enhance parent programmes that **promote healthy eating and active play for 0 to 5 year olds** in children's centres by March 2021.

The impact of these actions will be:

The number of children and young people who are overweight will reduce year-on-year, including those who are obese.

An increase in primary schools in the borough undertaking the **Daily Mile initiative** by April 2021.

The uptake in breast feeding will increase to ensure that all parts of the borough meet the London average by April 2021.

All schools are signed up to the healthy catering commitment by 2021.

Children's centres offer a range of programmes that promote healthy eating and active play.

South West London Health & Care Partnership

Live well

Healthy choices are influenced by our environment, communities and wellbeing. Preventative approaches are needed at all levels; engaging communities, utilising local assets (e.g. parks) and targeting those most at risk.

Within **Live well** we have identified three priority areas for action:

1 **Support people to stay healthy and manage their long-term health conditions**

2 **Promote mental wellbeing and support those who experience poor mental health to avoid mental health crisis**

3 **Reduce health inequalities for people with learning disabilities**

Within each of these priority areas we now describe the specific actions we will take and the expected outcomes.

South West London Health & Care Partnership

1 Priority: support people to stay healthy and manage their long-term conditions

The actions we will take:

Promote **prevention and early identification of long-term conditions** – by increasing the uptake of health checks and providing information on healthy lifestyles.

Develop and roll out the **social prescribing offer across the borough** by March 2020.

Proactively support **people with complex health and care needs** by bringing health and care professionals together around the individual – through primary care networks, across the borough by March 2020.

Transform the way people access **outpatient hospital appointments** so that more care is received closer to home.

Expand **IAPT (psychological therapies)** to include people with long-term conditions to meet the 22% access target by March 2020.

Support a culture of health and wellbeing by providing **healthy working environments** which support those working with long-term conditions, so that by 2021 all health and care organisations have signed up to the Healthy Workplace Award.

The impact of these actions will be:

People "at risk" or diagnosed with a long-term condition will have the **knowledge to self-manage their condition,** and will recognise the triggers and take early action to prevent a deterioration in their condition.

Social prescribing will be available for local people in the borough.

People with complex health and care needs will receive **joined up care and support** to help them manage their conditions. This will achieve a 15% reduction in avoidable hospital admissions.

Over the next 5 years outpatient hospital appointments will reduce by 30% in line with the NHS Long Term Plan.

People with long-term health conditions will report good mental wellbeing.

People with health needs will experience a better environment at health and care workplaces across the borough.

South West London Health & Care Partnership

2 Priority: promote mental wellbeing and support those who experience poor mental health to avoid mental health crisis

The actions we will take:

Ensure people with **serious mental illness get support for their physical health** as well as their mental illness - 60% of people on the GP serious mental illness register by March 2020.

Build on the work of the multi-agency interface group and emerging primary care networks to proactively support people with **complex mental health needs.**

Increase access to the **IAPT (psychological therapies)** services for all, with a specific emphasis on vulnerable groups to meet the 50% recovery target and the 22% access target by March 2020.

Implement the borough of Richmond's **suicide prevention strategy** to improve identification of risk and access to support, so that we see a reduction in suicides year on year.

Review and redesign the **mental health crisis model and pathway** to provide responsive access and effective mental health support by March 2020.

The impact of these actions will be:

60% of people who are registered on the mental illness register at their GP practice will have **annual physical health checks** and follow-up interventions.

People with a serious mental illness will receive **joined up holistic care**.

The number of people who experience **positive mental wellbeing** through the local IAPT service (psychological therapies) will increase.

The number of people who **take their own lives will reduce** year-on-year.

Workplace sickness absence due to **poor mental wellbeing** will reduce.

The number of people who attend A&E in a **mental health crisis will reduce by 50%.**

South West London Health & Care Partnership

3 Priority: reduce health inequalities for people with learning disabilities

The actions we will take:

Increase the uptake of GP annual health checks for those with learning disabilities to at least 75% by March 2020 to ensure they receive support and care for their health needs.

Support Mencap to deliver the **Treat Me Well Campaign** across the borough of Richmond health providers.

Continue to support people to access **Choice Support** – a dedicated, support employment service for people with learning disabilities.

The impact of these actions will be:

60% of people with a learning disability, who are on their local GP practice register, will receive an **annual physical health check** and effective support.

The number of **people with a learning disability who die prematurely** will reduce.

Staff in services who support or deliver care to **people with a learning disability will recognise individual needs** and adjust their approach as outlined in the Treat Me Well Campaign.

South West London Health & Care Partnership

Age well

Whilst people are living longer lives, many older people are also living with a reduced quality of life due to ill health or disability, or experience loneliness and isolation.

Within Age well we have identified three priority areas for actions:

1 Encourage active, resilient and inclusive communities that promote healthy ageing and reduce loneliness and isolation

2 Support people to live at home independently, for as long as possible including people with dementia

3 Support people to plan for their final years so they have a dignified death in a place of their choice

Within each of these priority areas we now describe the specific actions we will take and the expected outcomes.

South West London Health & Care Partnership

1 Priority: encourage active, resilient and inclusive communities that promote healthy ageing and reduce loneliness and isolation

The actions we will take:

Explore and build **opportunities for social connections / community hubs** that bring people together in their community.

Promote **wellbeing and healthy lifestyles** for all older people, including Making Every Contact Count.

Improve access to **health and care information and advice** for people and their unpaid carers.

Improve access for older people and their carers to **outreach and community-based services,** including through the delivery of **Community Independent Living Services (CILS) and social prescribing** by March 2020.

Roll out of **Care Home Support** programme to improve the quality of health care to people living in care homes.

The impact of these actions will be:

Increase in opportunities for people to **remain connected** to others and **improve their health and wellbeing.**

Reduction in people who feel **lonely and isolated.**

Reduction in **non-medical related GP appointments** and A&E presentations.

Social prescribing will be available for local people in the borough.

Reduction in the number of **hospital admissions from care homes.**

South West London Health & Care Partnership

2 Priority: support people to live at home independently, for as long as possible including people with dementia

The actions we will take:

Identify and proactively support older people wi**th complex health and care needs** by bringing health and care professionals together around the individual – through primary care networks, across the borough by March 2020.

Increase the number of **shared care plans developed** with older people who have complex needs and their unpaid carers.

Redesign the pathways for **integrated community based urgent care services** and **'home first'** discharge from hospital services by March 2020.

Review, refresh and implement our joint **dementia strategy** by March 2020.

The impact of these actions will be:

People will be supported to **live independently** for as long as they are able.

By March 2020 unnecessary **attendances in A&E will reduce** by 15% with a focus on people admitted for up to 72 hours.

There will be an increase in older people who receive **reablement support and recover at home.**

People with **dementia** and their families will have a **better experience and receive more support.**

South West London Health & Care Partnership

3 Priority: support people to plan for their final years so they have a dignified death in a place of their choice

The actions we will take:

Support people to **plan for their old age and have sensitive conversations** to include about death and dying.

Improve end of life care by progressing delivery of our **End of Life Care Strategy** to ensure that end of life issues are addressed.

Support people to take up **health and social care personal budgets** to enable them to receive personalised care to meet their needs, including for their end of life care by 2021.

Improve **care coordination and information** sharing across health and social care at the end of life, including rolling out access to the integrated **Coordinate My Care system.**

The impact of these actions will be:

People will have **more personalised health and social care services** at the end of their life. This will result in improved outcomes and people's experience of health and social care.

More people will have **an advanced care plan and coordinate my care** will be delivered across all care settings. This will result in a year-on-year increase in both areas.

More than 50% of people will have their **end of life wishes followed** and die in a place of their choice.

South West London Health & Care Partnership

Unpaid carers

1 Priority: Improve our practice in identifying and recognising carers of all ages so they are linked into support options, enabling carers to reduce the emotional, social, financial and health impacts they face.

The actions we will take:

Implement the recommendations from the consultation on the **Richmond Carers' Strategy** by March 2020 and work with Richmond Carers Network to review how carers' needs are assessed and responded to in their own right to ensure they are 'not forgotten.'

Improve the approach and practice in relation to **carer assessments and support planning.**

Improve the **recognition of young carers** and develop a range of support options including within the school environment.

Support carers to **stay well and look after themselves.**

Recognise the impact **after caring.**

The impact of these actions:

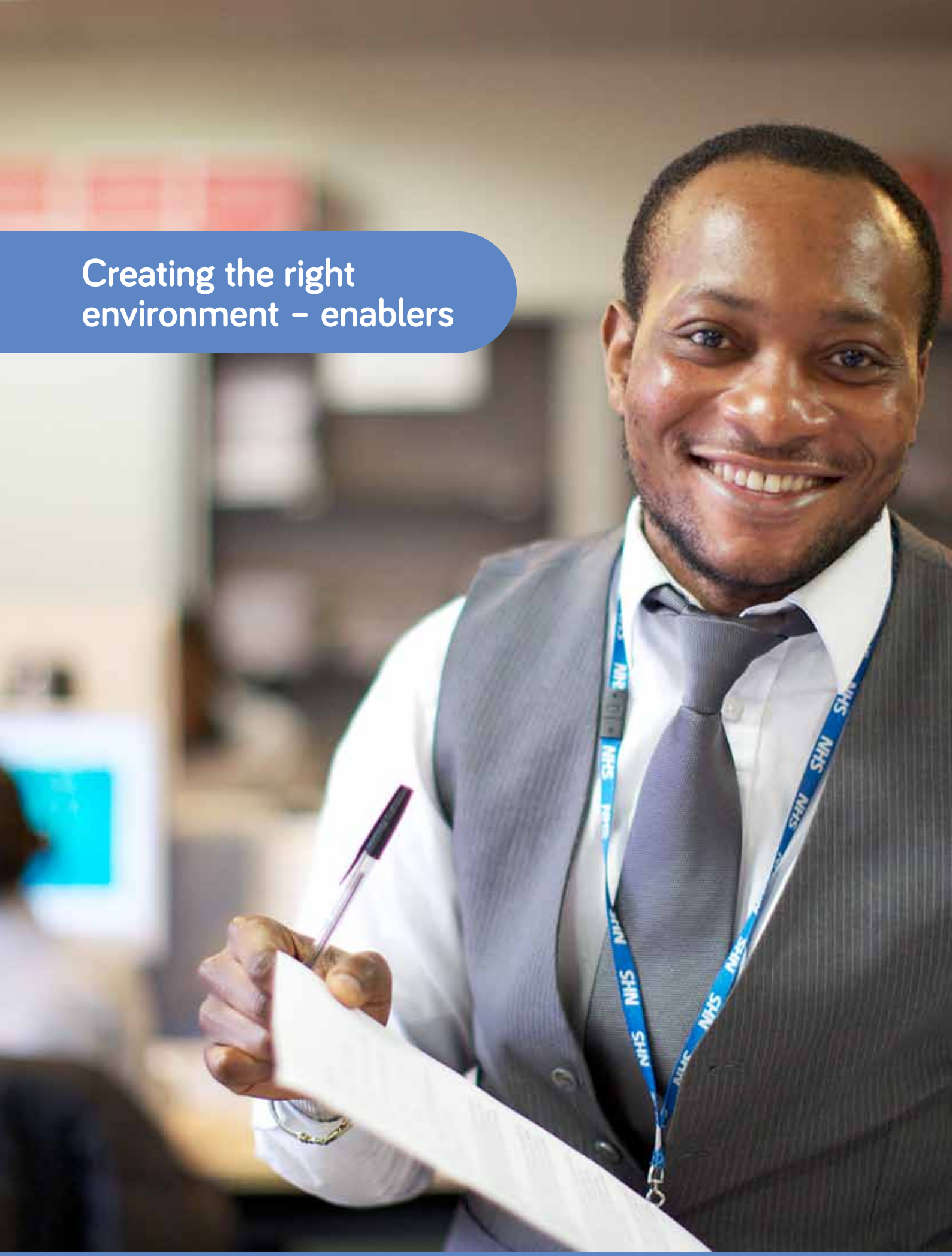
Carers needs are taken into consideration as well as the person being cared for.

Carers are **better supported** in their caring role and have **access to a range of support options.**

Young carers are better supported educationally, emotionally and physically.

Carers experience **improvements in their physical and mental health wellbeing.**

Creating the right environment – enablers



Creating the right environment – enablers

In delivering our plan there is a number of enablers – which are summarised below.

Workforce

The borough of Richmond faces several workforce challenges that are affecting the health service nationally: the numbers of **nurses** (particularly in community and mental health) and **GPs** have fallen and **social care** faces difficulty in recruiting to specialist roles for more complex work.

The increase in demand means our valued health and care professionals are overstretched.

In addition, there are difficulties in attracting staff to Richmond due to the high cost of living in the borough. Richmond can only offer outer London wage supplements which means it is hard to attract staff from neighbouring London boroughs

We will work together to:

- Offer flexible working patterns and improve working environments to retain our staff
- Develop our staff to embrace new ways of working and models of care
- Take innovative approaches to the recruitment of staff
- Provide job opportunities through apprenticeships
- Provide job opportunities for vulnerable groups in our community

Digital

Technology is developing fast. We will embrace technologies to support the delivery of care and management of care exploiting interoperability technology. We will work together to provide and support

- Online access to information and advice
- Online interventions e.g. talking therapies and counselling
- Online access to GP practice appointments and prescriptions
- Virtual consultations across all core settings
- Patient self-management of their long-term conditions
- Using assistive technologies to enable people to remain living in their own homes
- Share information and care records between practitioners and across care settings
- Technological advances in treatment

Estates

The council and health providers have a wide range of estate across the borough from which they provide and deliver services.

We will work together to:

- maximise the use of our estate
- co-locate services where appropriate
- explore access to estate by community groups to support community connections

Delivery of the Richmond Health and Care plan

South West London Health & Care Partnership

Delivery of the Richmond Health and Care Plan

A delivery plan is being developed mapping the actions and will provide a framework to support implementation and evaluation. Many of the actions align to existing programmes of work, such as social prescribing and the borough's dementia strategy. Whereas others may require a new programme for work to be established. Delivery will be reported into the Health and Wellbeing Board and the partner organisations.

We want to continue to work with local people and health and care professionals across our organisations to deliver the plan. In particular, we want to involve people with lived experience to help us shape and deliver the actions and ensure health and care outcomes for local people are met. We will provide more information about opportunities to get involved in the months ahead. If you would like us to contact you about involvement opportunities in a particular programme of work please email us at richmondccg.involve@swlondon.nhs.uk

Other work we are doing in Richmond

South West London Health & Care Partnership

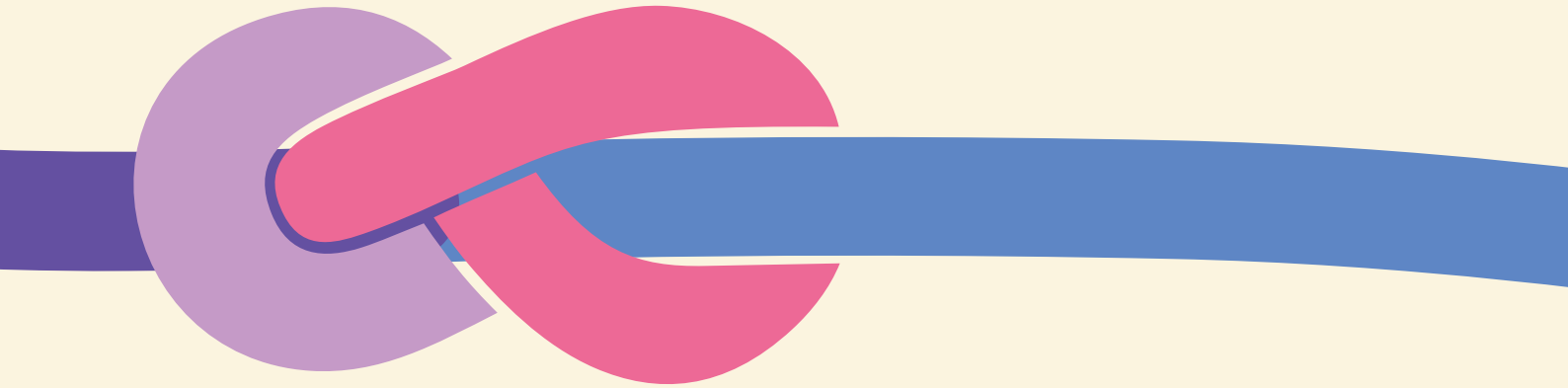
Other work we are doing in the borough of Richmond

Here's a list of existing plans which health and care colleagues in the borough of Richmond have a been working together with local people to design, develop and implement to improve the health and wellbeing of the local population. Some of the actions within the Richmond Health and Care Plan will be delivered and monitored within these strategic plans.

- CAMHS transformation plan
- SEND Partnership Plan
- Carers Strategy
- Dementia strategy
- Health and Wellbeing Board Strategy
- Richmond Mental Health OBC
- Suicide Prevention Strategy
- End of Life care
- Air quality plan
- NHS Long Term Plan

South West London Health & Care Partnership

Appendix:
Plans on a page – a summary of the actions within this health and care plan – and the outcomes we expect



Start well in Richmond 2019/2021

What happens in early life, starting from conception, affects health and wellbeing in later life. Prevention is critical to ensuring that children and young people can fulfil their potential.

Improve the mental wellbeing and resilience of children and young people	Support children and young people with special educational needs, disabilities and complex health and care needs to flourish and be independent in their local communities	Reduce obesity to improve the health of our children and young people
Action	**Action**	**Action**
• By April 2020 we will complete an assessment of the **mental health needs of the under 5** population of Richmond, to inform development of services • Ensure that there is an **emotional wellbeing programme in all our schools**, by April 2021. This will include wellbeing support, training and information to students, parents and staff • Work with young people to design and develop **peer led services to reduce involvement in risk taking behaviours** by 2020 • Establish a **digital youth project** steering group by January 2020 to review and expand the range of resources and tools to support emotional wellbeing and strengthen resilience • By April 2020 we will complete a review of the current **neurodevelopment assessment offer and services** ensuring that by 2021 the recommendations of the review are fully implemented	• Work with children and young people, parents and carers to ensure they can have their say and are involved in **decisions about their own education and health and care support** • Promote the **local SEND website** so that more people are aware of its value as a one-stop shop for information on local health and care services • Co-design with young people, parents/carers and professionals, an **improved local therapies** offer. This will be in place by March 2020 • Build on the existing **transition protocol and preparing for adulthood strategy** improve the transition between children and adult health and care services • Develop a local **post-16 learning offer** for specific groups most likely to use residential provision maximising the use of the adult education curriculum and community assets	• Roll-out the **Family Start programme** to support children who are identified through the national child measurement programme by March 2020 • Promote and support an increased roll out of the **Daily Mile** (getting all children to run for 15 minutes a day in school), in the borough's primary schools by April 2021 • Carry out a **needs assessment on breastfeeding** by April 2020 to identify if there are areas of the population where uptake is below the London average of 49%. • Develop a **Healthy Catering Commitment Plan** to ensure that healthy food is served or sold in all of the borough's schools by 2021. • Enhance parent programmes that **promote healthy eating and active play for 0 to 5 year olds** in children's centres by March 2021.
We will take action **to improve our practice in identifying and recognising carers of all ages** so they are linked to appropriate support options, enabling carers to reduce the social, financial and health impacts they face.		
Impact	**Impact**	**Impact**
• Children and families will receive **early targeted support** to prevent the development of serious difficulties • Children and young people **will have timely access to support with local counselling,** 7 days a week, through the digital offer • **Improvements in mental well-being and incidences of self-harm will reduce** due to children and young people receiving better support • **Reduced waiting times** for access to CAMHS • Neurodevelopment assessment referrals will always be completed **within 12 weeks** • The **number of young people who smoke, drink alcohol and use cannabis regularly will reduce**	• **Feedback will increase** from children and young people, their parents and carers and measure their confidence that plans reflect their needs • **Assessment and intervention waiting times for therapy services will improve**. Better satisfaction rates from parents and carers and schools will also be reported • **The number of specialist resource provision places will increase** to reflect the needs identified in the ten-year SEND provision plan • Young people will experience a **planned and smooth transition from children's to adult health and care services** • **A local post-16 learning offer will be put in place** and the number of young people, with post-16 educational health and care plans on vocational pathways, will increase	• **The number of children and young people who are overweight will reduce year-on-year,** including those who are obese • An increase in primary schools in the borough undertaking the **Daily Mile initiative** by April 2021 • **The uptake in breast feeding will increase** to ensure that all parts of the borough meet the London average by April 2021 • All schools are signed up to the **healthy catering commitment** by 2021 • Children's centres offer a range of **programmes that promote healthy eating and active play**

Live well in Richmond 2019/2021

Healthy choices are influenced by our environment, communities and wellbeing. We will drive forward preventative approaches at all levels – engaging communities, utilising local assets (e.g. parks) and targeting approaches to reach those most at risk.

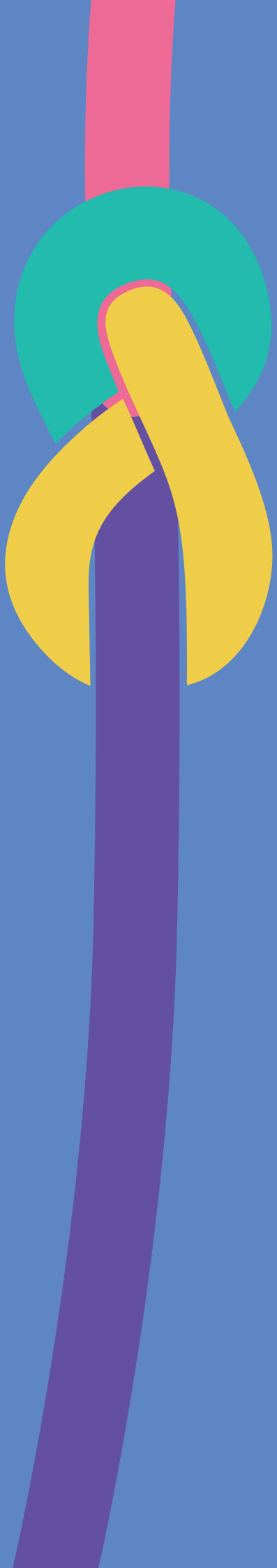
Support people to stay healthy and manage their long-term health conditions	Promote mental wellbeing and support those who experience poor mental health to avoid mental health crisis	Reduce health inequalities for people with learning disabilities
Action	**Action**	**Action**
• Promote **prevention and early identification of long-term conditions** – by increasing the uptake of health checks and providing information on healthy lifestyles • Develop and roll out the **social prescribing offer across the borough** by March 2020 • Proactively support **people with complex health and care needs** by bringing health and care professionals together around the individual – through primary care networks, across the borough by March 2020 • Transform the way people access **outpatient hospital appointments** so that more care is received closer to home • Expand **IAPT (psychological therapies)** to include people with long-term conditions to meet the 22% access target by March 2020 • Support a culture of health and wellbeing by providing **healthy working environments** which support those working with long-term conditions, so that by 2021 all health and care organisations have signed up to the Healthy Workplace Charter	• Ensure people with **serious mental illness get support for their physical health** as well as their mental illness - 60% of people on the GP serious mental illness register by March 2020 • Build on the work of the multi-agency interface group and emerging primary care networks to proactively support people with **complex mental health needs** • Increase access to the **IAPT (psychological therapies)** services for all, with a specific emphasis on vulnerable groups to meet the 50% recovery target and the 22% access target by March 2020 • Implement Richmond's **Suicide Prevention Strategy** to improve identification of risk and access to support, so that we see a reduction in suicides year on year • Review and redesign the **mental health crisis model and pathway** to provide responsive access and effective mental health support by March 2020	• **Increase the uptake of GP annual health checks** for those with learning disabilities to at least 75% by March 2020 to ensure they receive support and care for their health needs • Support Mencap to deliver the **Treat Me Well campaign** across Richmond health providers • Continue to support people to access **Choice Support** - a dedicated, support employment service for people with learning disabilities
We will take action to **improve our practice in identifying and recognising carers of all ages** so they are linked to appropriate support options, enabling carers to reduce the social, financial and health impacts they face.		
Impact	**Impact**	**Impact**
• People "at risk" or diagnosed with a long-term condition will have the **knowledge to self-manage their condition**, and will recognise the triggers and take early action to prevent a deterioration in their condition • **Social prescribing** will be available for local people in the borough • People with complex health and care needs will receive **joined up care and support** to help them manage their conditions. This will achieve a 15% reduction in avoidable hospital admissions • Over the next 5 years **outpatient hospital appointments will reduce by 30%** in line with the NHS Long Term Plan • People with long-term health conditions will report **good mental wellbeing** • **People with health needs will experience a better environment** at health and care workplaces across the borough	• 60% of people who are registered on the mental illness register at their GP practice will have **annual physical health checks** and follow-up interventions • People with a serious mental illness will receive **joined up holistic care** • The number of people who experience **positive mental wellbeing** through the local IAPT service (psychological therapies) will increase • The number of people who **take their own lives will reduce** year-on-year • Workplace sickness absence due to **poor mental wellbeing** will reduce • The number of people who attend A&E in a **mental health crisis will reduce by 50%**	• 60% of people with a learning disability, who are on their local GP practice register, will receive an **annual physical health check** and effective support • The number of **people with a learning disability who die prematurely** will reduce • Staff at services who support or deliver care to **people with a learning disability will recognise individual needs** and adjust their approach as outlined in the Treat Me Well Campaign

Age well in Richmond 2019/2021

Whilst people are living longer, many older people are also living with a reduced quality of life due to ill health or disability, or experience loneliness and isolation.

Encourage active, resilient and inclusive communities that promote healthy ageing and reduce loneliness and isolation	Support people to live at home independently, for as long as possible including people with dementia	Support people to plan for their final years so they have a dignified death in a place of their choice
Action	**Action**	**Action**
• Explore and build **opportunities for social connections / community hubs** that bring people together in their community • Promote **wellbeing and healthy lifestyles** for all older people, including Making Every Contact Count. • Improve access to **health and care information and advice** for people and their unpaid carers • Improve access for older people and their carers to **outreach and community-based services,** including through the delivery of **Community Independent Living Services (CILS) and social prescribing** by March 2020 • Roll out of **Care Home Support** programme to improve the quality of health care to people living in care homes	• Identify and proactively support older people **with complex health and care needs** by bringing health and care professionals together around the individual – through primary care networks, across the borough by March 2020 • Increase the number of **shared Care Plans** developed with older people who have complex needs and their unpaid carers • Redesign the pathways for **integrated community based urgent care services and "home first"** discharge from hospital services by March 2020 • Review, refresh and implement our **joint dementia strategy** by March 2020	• Support people to **plan for their old age and have sensitive conversations** to include about death and dying • Improve end of life care by progressing delivery our **End of Life Care Strategy** to ensure that end of life issues are addressed • Support people to take up **health and social care personal budgets** to enable them to receive **personalised care** to meet their needs, including for their end of life care by 2021 • Improve **care coordination and information** sharing across health and social care at the end of life, including rolling out access to the integrated **Coordinate My Care system**
We will take action to **improve our practice in identifying and recognising carers of all ages** so they are linked to appropriate support options, enabling carers to reduce the social, financial and health impacts they face.		
Impact	**Impact**	**Impact**
• Increase in opportunities for people to **remain connected** to others and **improve their health and wellbeing.** • Reduction in people who **feel lonely and isolated** • Reduction in **non-medical related GP appointments** and A&E presentations • **Social prescribing** will be available for local people in the borough • Reduction in the number of **hospital admissions from care homes**	• People will be supported to **live independently** for as long as they are able • By March 2020 unnecessary **attendances in A&E will** reduce by 15% with a focus on people admitted for up to 72 hours • Increase in older people who receive **'reablement' support and recover at home** • People with **dementia** and their families will have a **better experience and receive more support**	• People will have more **personalised health and social care services** at the end of their life. This will result in improved outcomes and people's experience of health and social care. • More people will have **an advanced care plan and coordinate my care** will be delivered across all care settings. This will result in a year-on-year increase in both areas • More than 50% of people will have their **end of life wishes followed** and die in a place of their choice

South West London
Health & Care
Partnership



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