Richmond
South West
London
Integrated
Care System

The London Borough of
Richmond upon Thames

Refreshed Health and Care Plan 2022-2024

Richmond's Health and Care Plan

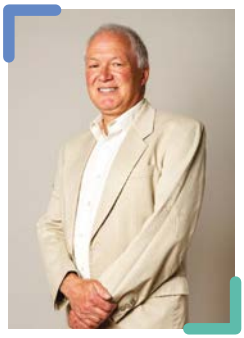
– an introduction from Cllr Piers Allen, Health and Wellbeing Board Chair

This is a refreshed version of the Richmond Health and Care Plan, building on the first plan published in 2019—2021. This refreshed 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'. The refresh also includes overarching themes of identifying, recognising and supporting unpaid carers of all ages; enabling people to live physically active and healthy lifestyles, at a healthy weight; to prevent ill-health and improve wellbeing; promoting the mental health and resilience of residents of all ages; and tackling inequalities in health to reduce disparities for those most disadvantaged (especially in light of the Covid-19 pandemic). Our refreshed 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 (2022—2024) 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. Some of the previous plan's actions continue to be a priority and therefore continue to feature in this refreshed version, taking into account updated population health needs and trends. Our Health and Care Plan should be read alongside other local health and care strategies produced jointly by the Council and South West London Integrated Care System (SWL ICS).

The Council's Health and Wellbeing Board (and the Richmond Place-Based Partnership Committee, a borough-based part of the SWL ICS) will oversee the delivery of the Health and Care Plan (and the evaluation of its impact) and will continue to work together with local people and communities to implement the actions that will provide the high-quality, joined-up health and care services our residents deserve.



Cllr. Piers Allen, July 2022

Chair, Health and Wellbeing Board, London Borough of Richmond upon Thames;
Convenor, Richmond Place-Based Partnership Committee, SW London Integrated Care System

Contents

1. Our health and care partnership and joint vision

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

The partners involved include:

- Local people
- Achieving for Children
- Chelsea & Westminster NHS Foundation Trust (West Middlesex University Hospital)
- London Borough of Richmond upon Thames
- Hounslow and Richmond Community Healthcare NHS Trust
- Your Healthcare Community Interest Company
- Community pharmacists
- Kingston Hospital NHS Foundation Trust
- NHS South West London Integrated Care System
- South West London and St George's Mental Health NHS Trust
- Richmond CVS
- 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 Richmond to deliver improved health and care to our local people. We have established partnership arrangements to support collaborative working, including the:

Richmond Health & Wellbeing Board – A partnership board that brings together elected members and local leaders from the health and social care system, 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:

"We want people of all ages to remain as healthy as they can for as long as they can."

This refreshed Health and Care Plan describes this vision, priorities, objectives and outcomes to help us to meet the health and care needs of local people and deliver improvements on their health and wellbeing.

It has been developed with the aim of ensuring residents Start Well as children, Live Well as adults and Age Well for longer as older adults. It includes some of the health and care services delivered across the borough that no single organisation can achieve alone. Our local NHS organisations, the council and voluntary and community services will continue to work together towards these goals in partnership with our communities.

Start Well

What happens in early life affects your health and wellbeing as you get older. We want to make sure that all children in Richmond have a good start to life and the right support to thrive and fulfil their potential.

Live Well

The health and wellbeing of our working age population impacts not just individuals, but also families, workplaces and communities. We will promote good health in adulthood, with the ambition of preventing the development of long-term conditions and disabilities, enabling people to live in good health for longer.

Age Well

We want to encourage active, resilient communities that promote healthy ageing and reduce loneliness and isolation for older residents. We will also support people to live at home independently and for as long as possible, including people with dementia.

2. What we have achieved so far

This refresh is made two years into the global Covid-19 pandemic which has greatly affected the borough. Sadly, we have lost one in every 600 residents and almost 20,000 have had a confirmed Covid-19 infection. Many people have missed routine medical care and treatment and there is increased pressure on the health system to catch up, while Covid-19 remains with us.

Despite the enormous challenges and impact on everyone in the borough, the people and organisations of Richmond have risen to the challenge to protect residents' health and find new ways of doing things. Excellent partnership work has enabled us to reach some vulnerable residents and meet many of the aims of the original 2019-2021 Health and Care Plan, despite the disruptions of the pandemic.

Progress was reported to our Health and Wellbeing Board in September 2021 and can be found here:

Start Well progress report

Live Well progress report

Age Well progress report

3. Our priorities and the actions we will take to deliver them

Based on the conversations we have had with local people, the Richmond story and the case for change we have agreed some priority areas for actions. Within this Health and Care Plan these priorities and actions are grouped under the following life course themes:

Start Well

Mental health

With a national increase of mental disorders being diagnosed in 5 to 15 year olds and an increase in the number of referrals to Child and Adolescent Mental Health Services (CAMHS), the Covid-19 pandemic has further increased the number of referrals to CAMHS with an increasing number of children presenting with more complex needs. We want to maximise the mental wellbeing and resilience of our children and young people.

Healthy weight

We will take action to promote active lifestyles and healthy weight in all ages, expanding parent-led programmes that promote healthy eating and active play for children in their early years, and creating more opportunities for children and young people to take part in active play, sport and adventurous activities.

Children with special educational needs and disabilities (SEND)

Children and young people with SEND are among the most vulnerable in our community and can have a wide range of support and access needs. Many will have additional health conditions, including physical disabilities and sensory impairments. We want to give children and young people with SEND opportunities to flourish and be independent.

Live Well

Managing Long Term Conditions

Having one or more long-term condition generally reduces quality of life and increases the chances of requiring support from health or social care services. Local health and care partners will continue working together 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 health and care services.

Mental Wellbeing

We will support people with serious mental illness to get support for their physical health as well as their mental illness. We will continue to build on the work with our partners that proactively supports people with complex mental health needs to reduce the adverse physical effects of chronic mental health issues.

Reducing Health Inequalities for those with Disabilities

We will increase the uptake of GP annual health checks for those with learning disabilities to make sure that they receive support and care for their health needs. We will continue to provide dedicated supported employment for people with a Learning Disability and increase the number of residents with a Learning Disability who are able to live independently in settled accommodation.

Age Well

Live Independently, including people with dementia

We want to maximise people's independence and resilience to enable them to live well at home where that is their choice. We will ensure that joined up health and care teams in the community provide a range of services that help people get and stay well and improve their experiences of health and care.

Tackling loneliness and isolation

The Covid-19 pandemic has had a particular impact on the health of our older residents over the last two years. Many have faced a challenging time through isolation over the various lockdown periods and experienced difficulties in accessing healthcare. On a positive note, many people have also embraced digital technology in new ways, including accessing health and wellbeing advice and social connections and we will support this further to reduce loneliness and isolation for everyone.

Planning for final years

We will continue to strive for residents to have the best possible health throughout their life. We aim for good end of life care, enabling a dignified, controlled and peaceful end to their life. We aim to support people approaching the end of their life to have control over how their last days are lived, and for them to be able to die with dignity.

Overarching Themes

Four overarching themes that feature across all three life courses have been identified by the borough's Health and Wellbeing Board and Richmond's local system leaders to focus on over the next two years:

Unpaid Carers – Identifying, recognising and supporting unpaid carers of all ages, including young carers, to ensure unpaid carers are linked to appropriate support options; enabling them to reduce the social, financial, mental and physical impacts they face.

Healthy weight – Enabling people to live physically active and healthy lifestyles, at a heathy weight, to prevent ill health and improve wellbeing.

Mental health – Promoting the mental health and resilience of residents of all ages.

Health inequalities – Tackling inequalities in health to reduce disparities for those most disadvantaged (especially in light of the Covid-19 pandemic).

How we will know if we have made a difference

We will monitor a number of metrics for improvements that will show us whether what we are doing is making a difference. See appendix 1 for detailed metrics.

4. Creating the right environment - enablers

The following enable delivery of our Health and Care Plan:

Workforce

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.

However, through one of the most testing times within healthcare, we have seen how acute, community and social care partners can come together to deliver health and care needs. The NHS long term plan describes the need for collaboration and co-ordinating care by breaking down barriers between organisations.

To address these workforce constraints across Place, we will need to create a solution that will enable the workforce across all providers to come together and deliver services in a more effective way. It will require development within 5 key areas that include, role redesign, resourcing, pay and conditions, mobility and deployment and Organisational Development.

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

Digital health and social care will be key to transforming services across Richmond. Joint planning, partnership working and stakeholder engagement at local level will ensure health and social care services consider digital technology as a key resource to facilitate enhanced engagement, improve service delivery and connect services and records which can be accessed by the patients. 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
- Sharing 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
- Work to ensure providers' buildings are used for the benefit of our partners and to support the key determinants of health

5. 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.

Resident Population
200,705

Employment
79%
working-age adults are in employment
the highest rate in London

49%
volunteer
highest rate in London (25%)

Life Expectancy at Birth:
82.2 years
For men
(1.9 years greater than London

86.4 years
For women
2.1 years greater than London

Heritage sites:
Hampton Court Palace, Richmond Park, Kew Gardens, Bushy Park – approximately
4.5 million visitors
from across the world every year

Education
A borough with some of the highest performing primary and secondary schools in the country

International Sporting Events:
Autumn International Rugby Fixtures, Twickenham Six Nations, Twickenham largest dedicated rugby union venue in the World, with a capacity of
82,000

12 libraries with a variety of services, events and support sessions

Community Safety
4th out of 32
for crime overall
Safest borough for violent crime

Open spaces **40%** of the area of the Borough

100+ parks

21 miles of river frontage

23,000 bike journeys per day in the borough 2nd out of 33 in London

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

Prevalence of main health conditions

- 20, 430 people are diagnosed with a common mental disorder and there are 16, 195 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.
- 1,413 Richmond residents have dementia.

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 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.

Lower levels of children receiving MMR1 immunisation by the age of two compared to England (87% vs. 90%)

10,310 A&E attendances for under 5 year-olds - significantly higher than both the England and London averages

22.4% **point gap** in achieving a 'good' level of development in reception between children eligible for free school meals and those not

Prevalence of obesity more than **doubles** between reception and year 6

61% of 15 year-olds in Richmond are sedentary for over 7 hours per day

Highest in London for 15-year-olds **drunk** in the previous month (25%), tried **smoking tobacco** (36%) and **cannabis** (19%) and **multiple risky behaviours** (22%)

4th The average **mental wellbeing score** for 15 year-olds in Richmond is the **fourth worst** in London

Second highest rate of hospital admissions for **self-harm** in 10-24 year-olds in London

Children and young people with special educational needs and disabilities (SEND) 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.

Children with special education needs and disabilities are more likely to experience or live in poverty.

It is important to maintain a healthy weight in childhood. If a healthy weight is not maintained, it can cause social and emotional problems and illnesses such as childhood diabetes. Should difficulty maintaining a healthy weight persist into adulthood, it can lead to type 2 diabetes, cardiovascular disease, joint problems and poor general health.

How are we doing in Richmond?

- Children make up 23% of the population.
- A significantly lower percentage of children at 75% have received 2 doses of **MMR immunisation at or before the age of five** compared with 86% for England.
- 12% of children and young people are registered with a **special educational need or disability**.
- The rate of **A&E attendances (0-4 years)** at 831 per 1,000 (up from 732) is significantly higher than both the England average (660 per 1,000–up from 588) and the London average (707 per 1,000).
- The average **mental wellbeing** score for 15-year-olds in Richmond is the fourth worst in London.
- 110 hospital admissions are a result of **self-harm** in 10-24-year-olds (up from 90), which equates to the second highest rate in London.
- The rate of hospital admissions as a result of self harm in those aged 10-24 is the second highest rate in London, although the borough was previously the highest. The breakdown by age shows that this problem worsens with age: the rate for those aged 10-14 is 5th highest in London, but for those aged 20-24 it is still more than double the London rate.
- In reception year, 4.7% of children are clinically described as obese, still 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. This is however the lowest in London.
- The rate of hospital admissions due to substance misuse (excluding alcohol) in those aged 15-24 years was showing an increasing trend, but has decreased since the last report.
- 58 young people were in specialist treatment for **cannabis, alcohol, ecstasy** and **cocaine** misuse in the last year.
- 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
  - 19% report having tried **cannabis**, the highest proportion in London, and third highest in the country
  - **drink more regularly** than in any other London borough – 9% are regular drinkers and 25% reported being drunk in the previous 4 weeks.

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.

16,400
adults are estimated to smoke

35%
of adults drink more than the recommended 14 units of alcohol a week

20,430
people have a common mental disorder, such as depression and anxiety

1,333
incidents of domestic abuse in 2021

Nearly one in ten has
three or more
long term conditions

An estimated
18,000
people provide some level of unpaid care

In 2021 the number of
rough sleepers
increased to 128 – Lower than London but similar to the England rate

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 condition 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 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 Richmond?

- The proportion of the eligible population receiving **health checks** between 2017 and 2021 has improved slightly but is still below the London aggregate, with Richmond at 27.5% compared to London at 29.4%, and slightly above the England average of 26.3%.
- 13.2% of the adult population (20,430) are estimated to have **anxiety and/or depression**.
- One in ten has **3 or more long term conditions**.
- 36% 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 is stable.
- The proportion of eligible adults with **learning disabilities having a GP health check** is 57%.
- **Smoking rates** are low compared to London, it is estimated that 10.5% of adults smoke (around 16,500) and although the number of people quitting was reported as falling in 2019, this is lower than 12.7% of adults recorded to smoke then.
- Proportion of females aged 50-70 invited for and taking up **screening for breast cancer** is down significantly and lower than the London average.
- Proportion of females aged 25-64 attending **cervical screening** within target period has fallen significantly from 72.6% to 68% over the past 5 years.
- The number of people on Richmond GP practice registers with Diabetes is 6,865.
- The number of people on Richmond GP practice registers with COPD or Asthma is 11,620.

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.

32,403 to 45,784
- the projected increase in number of over 65 year-olds in the next 20 years

1,413
Richmond residents over 65 estimated to have dementia

50%
of over 75 year-olds live alone

The average age older people start to receive
council-funded social care
at home is 84, and 87 for people in care homes

An average of 4 emergency hospital admissions in the last year of life for those
aged 65 years and over

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.

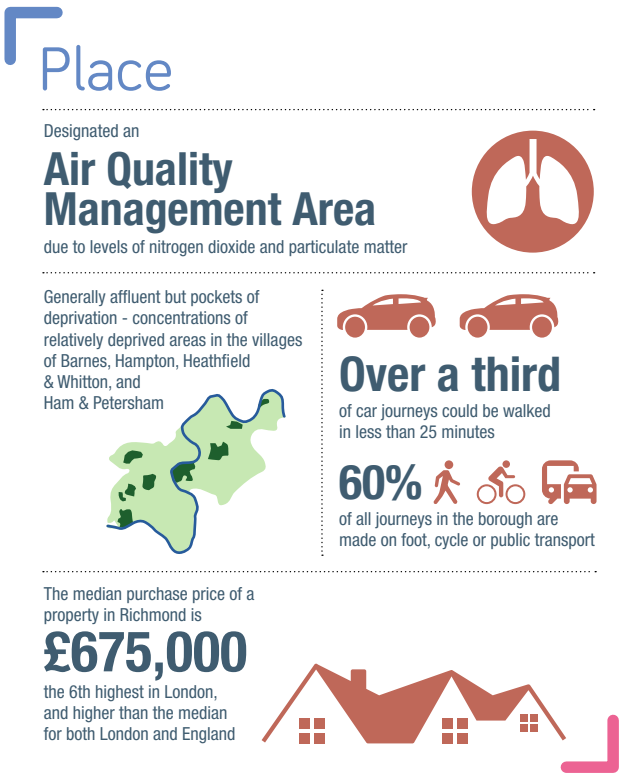
How are we doing in Richmond?

- 33,820 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 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 7.6%.
- The proportion of adult social care users who have as much **social contact** as they would like is 46.8% for 2019-20 compared to the proportion for London of 40.1% and proportion for England of 43.4%.
- 22% of **carers** in Richmond are aged over 65.
- The proportion of adult carers who have as much social contact as they would like is 21.9% for 2018-19 which is a significant decrease from the last figure of 32.1% and lower than the proportion for both London of 34.3% and England of 34.5%.

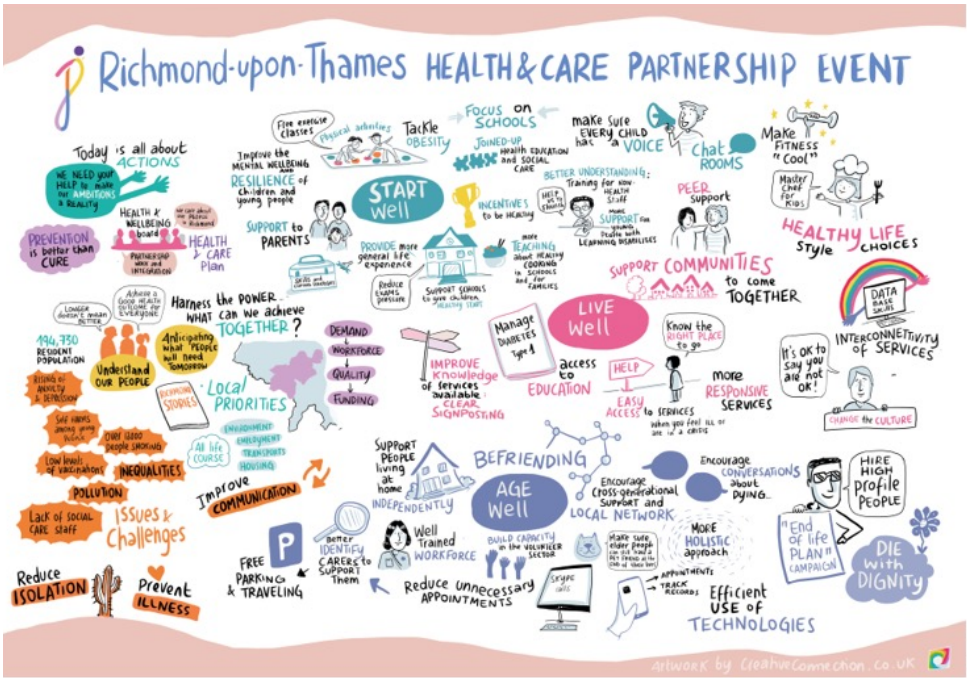
6. The wider determinants of health in Richmond

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 borough 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 Richmond.
- **Physical activity:** There is inequality in engagement rates in physical sports activity: women, older adults, and people with special educational needs and 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 increased from 13.5 in 2020 to 16.61 in 2021.
- There is an **educational attainment gap** between children eligible for free school meals and those not.
- **Poverty** - Richmond foodbank provided c 5,300 three-day emergency food supplies for people in crisis in the last year.



7. 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 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.

Building on the comprehensive community engagement undertaken in 2018 to inform the original plan, we undertook further engagement to ensure the refreshed plan reflects the needs of our local population. Surveys and reviews carried out during the pandemic response period together with the results of community engagement have been used to inform the Refreshed Health and Care Plan 2022-24. Between 15 November and 10 December 2021 an online survey was hosted on Richmond Council's website. Information about the Refreshed Health and Care Plan and how to provide feedback was also shared within local networks and to a range of local voluntary sector and community organisations and groups.

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.

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: www.southwestlondonics.org.uk/publications/richmond-health-and-care-plan-2022-to-2024.

8. Summary Plans for Each Life Course Theme

Start Well in Richmond 2022-2024

Richmond South West London Integrated Care System

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.

Maximise emotional wellbeing, mental health and resilience	Promote a healthy weight approach	Provide opportunities for those with special educational needs and disabilities (SEND) to flourish and be independent
Objective	**Objective**	**Objective**
• Ensure there is an emotional wellbeing programme in all schools, including training and information for students, parents and staff • Promote access to online resources and digital mental health care • Develop a multi-agency community hub-based approach to provide integrated support for emotional health needs, including help with bereavement, grief and loss • With young people, co-produce and promote peer-led services that reduce involvement in self-harm and risk-taking behaviours • Provide advice and support to all parents and carers to develop their confidence in caring for their child • Implement preventative programmes to reduce serious youth violence and exploitation	• Promote breastfeeding and safe infant feeding practices to improve nutrition of babies and infants in their first 1,001 days • Work with all schools implementing initiatives that actively promote healthy weight through healthy eating, regular physical activity; Maximising opportunities for children to safely walk or cycle to school • Expand parent-led programmes that promote healthy eating and active play for children in their early years. Implement a healthy lifestyle programme for parents and children aged 5 to 11 years • Promote healthy lifestyle activities via online platforms and through social media campaigns • Create more opportunities for children and young people to participate in active play, sport and adventurous activities, including targeted programmes for those who need support to reach and maintain a healthy weight	• Improve the early identification of SEND through improved multi-agency working and information-sharing • Work with children, young people, parents and carers to input into and be involved in decisions about their own education, health and care support • Support schools to deliver Quality First Teaching so that they can support more children and young people in mainstream settings and achieve good outcomes • Improve the quality and timeliness of education, health and care assessments, plans and reviews and ensure they promote independence, and provide good value for money • Implement a balanced model for the delivery of an improved therapy offer • Develop the neuro-developmental service to improve timeliness of assessments and pre- and post-diagnostic support
Outcome	**Outcome**	**Outcome**
• Open access to digital emotional wellbeing support increases • Reduction in incidences of self-harm and suicide (CCG) • More children and young people have their emotional wellbeing and mental health needs identified earlier and receive more timely support including for bereavement, grief and loss (CCG) • Reduction in the number of young children who smoke, drink alcohol, use cannabis and misuse other substances (AFC) • Reduction in youth violence and exploitation (AFC)	• Increase in the number of new mothers who breastfeed their baby for the first six to eight weeks (Public Health) • More schools achieve the Healthy Schools London Award and participate in the Daily Mile (Public Health) • Increase in the number of children and young people who take part in physical activity for at least 60 minutes every day (Public Health)	• Participation in local services for children and young people with SEND increases due to greater awareness of local health and care services (AFC & CCG) • More pupils with SEND are in mainstream schools and education settings with support from health and care services (AFC) • Children and young people who use local therapy services have shorter waiting times for assessment and therapy programmes (CCG) • The identification of neurodevelopmental support takes place earlier and assessments are completed within 12 weeks of referral (CCG)

Overarching Themes

We will improve our practice in identifying and recognising young carers so they are linked to appropriate support, enabling them to reduce the social, financial and health impacts they face. To strengthen the early identification and assessment of young carers to ensure their mental health and wellbeing needs are met and supported

Outcome: More young carers have an assessment of their needs and appropriate support for their mental health and wellbeing is identified

We will tackle inequalities in health and reduce disparities for those most disadvantaged between 0 to 25 by tackling wider determinants of health and targeting resources where there is appropriate need to improve life chances

Outcome: Young people with SEND have a better planned and smoother transition to post-16 education and support from Adult Social Care Services where this is needed

We will promote healthy weight, enabling young people to live physically active with healthy lifestyles to prevent ill-health and improve wellbeing be developing a system-wide healthy weight strategy with a particular emphasis on whole-family approaches to reducing obesity and maintaining healthy weight

Outcome: The number of children and young people who have healthy weight increases

We will promote the mental health and resilience of residents of all ages by implementing a new model of mental health care for children and young people aged 0 to 25 years to provide swift and flexible support based on their holistic needs with an emphasis on prevention and early intervention

Outcome: Young people with identified mental health needs have a better planned and smoother transition between child and adult mental health services

Live Well in Richmond 2022-2024

Richmond South West London Integrated Care System

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

Objective

- Promote prevention and identification of long-term conditions and risk factors such as obesity through:
  - Targeting the NHS Health checks programme to identified at risk sub populations – e.g. people who smoke, harmful drinking, have high BMI, high Cardio-vascular disease risk etc
  - Working with communities at higher risk of Type 2 diabetes to improve awareness of risk factors and increase uptake of diabetes prevention services
  - Working with communities to increase awareness of risk factors and increase uptake of weight management services
  - Identifying risky behaviours such as high alcohol consumption
  - Identifying people with high blood pressure early and effectively manage this
- Implement a model of care for long term conditions to include prevention, detection, management, and optimisation. Promoting a standardised approach to care; Identifying and addressing areas of inequality of access and health outcomes across the borough
- Build a social prescribing model to support personalisation for more patient choice and control over their care
- Develop a culture of health and wellbeing by providing healthy working environments, supporting those working with long-term conditions, working with health and care organisations to sign up to the Healthy Workplace Award and extending this to voluntary and business sectors in the borough

Outcome

- Steady decrease in the proportion of people classified as overweight
- Increase in the number of community pharmacies offering health checks
- The proportion of people referred from NHS health checks who take up a service
- Increase in the number of people identified with high blood pressure and on optimal treatment
- Increase annual monitoring in Primary Care for identification of non-diabetic hyperglycaemia and early diagnosis of Type 2 diabetes
- Deliver awareness campaigns that are targeted at diverse communities
- Increase in the uptake of people attending weight management services
- Reduction in Accident & Emergency attendances and admissions due to alcohol related conditions
- System-wide approach to identify and manage people with long-term conditions
- Improved intelligence on areas of inequality, access and health outcomes across the borough with action plans to address these
- An outcomes-based tool to measure the impact of the model
- Increase in the number of organisations that sign up to the Healthy Workplace Award

Promote mental wellbeing and support people who experience poor mental health to avoid mental health crisis

Objective

- 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 in line with NHSE national targets by:
  - Providing additional support to GP practices to engage patients with serious mental illness
  - Working with low-performing GP practices to improve the outcome of serious mental illness checks for their patients
- Build on the work of the multi-agency interface group and emerging Primary Care Networks to proactively support people with complex mental health needs by:
  - Implementing the Mental Health Worker Model across the Primary Care Networks
  - Establishing multi-professional, and voluntary sector interface meetings to discuss and resolve complex mental health needs for patients that fall between service provision
- Increase access to the Improving Access to Psychological Therapies services for all, with a specific emphasis on vulnerable groups to meet the national access target. With a specific focus on increasing local access to:
  - People with a long-term condition - People with Post Covid Syndrome (Long COVID-19) - Men aged 35-44 - Older adults and carers
- Lead the implementation of a Suicide and Self-harm Prevention Strategy to improve identification of risk and access to support, to:
  - Establish a real-time suicide surveillance system to inform a needs-based approach to prevention
  - Develop suicide and self-harm factsheets to enable appropriate crisis support in Primary Care Settings
  - Provide access to Mental Health First Aid and suicide prevention training for the Voluntary and Community Sector
  - Encourage employers to sign-up to "Employers for Carers"

Outcome

- 60% of people on the GP serious mental illness register will have physical health checks in line with NHSE national targets
- Increase in the number of mental health workers employed within PCN's
- National target for access to IAPT services will be achieved
- More people in the targeted groups will be seen in IAPT services
- System wide suicide and self-harm strategy

Reduce health inequalities for people with learning disabilities

Objective

- Increase the uptake of GP annual health checks for those with learning disabilities in line with national targets to ensure they receive support and care for their health needs through:
  - Easy-to-read information to share with family, carers and household members to support the uptake of yearly physical health checks
  - Pre-Annual Health Check questionnaire to be sent to the person and family in preparation for a yearly health check to improve engagement
  - Allocation of dedicated Healthcare Worker time to support learning disability health checks and the post check process
- Support Mencap to deliver the Treat Me Well campaign across Richmond health providers
- Continue to provide dedicated supported employment for people with a learning disability
- Increase the number of people with a learning disability able to live independently in settled accommodation by focusing on increasing the availability of Supported Living Schemes

Outcome

- More people with a learning disability will receive an annual health check
- More people with a learning disability will have the opportunity to take up and sustain paid employment
- More people with a learning disability will live independently in settled accommodation

Overarching Themes

We will identify, recognise and support unpaid carers of all ages, to ensure that in all the objectives, unpaid carers are linked to appropriate support options enabling them to reduce the social, financial and mental and physical health impacts they face

We will promote healthy weight in all ages, encouraging people to live physically active and healthy lifestyles to prevent ill-health and improve wellbeing

Age Well in Richmond 2022-2024

Richmond South West London Integrated Care System

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 and 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
Objective	**Objective**	**Objective**
• Continue to build on the strengths of local communities to increase the opportunities for residents to get involved and live happy, active, and fulfilling lives • Continue to promote wellbeing and healthy lifestyles to give people the best chance to stay well, independent and resilient for as long as possible • Embrace innovation and the use of digital technology to empower and support residents to live the best life they can and remain independent, resilient, and well for as long as possible • Ensure the Care Home Support programme continues to improve the quality of health and care of people living in care homes • Develop and expand our social prescribing offer	• Join up health and care teams in the community to provide a range of services that help people get and stay well and improve their experiences of health and care • Identify and proactively support older people with complex health and care needs by wrapping professionals together around the individual • Review and redesign local Discharge to Assess pathways in line with 'Home First' principles and make the most of available resources • Provide joined-up and timely support in the community to help people regain or maintain their independence and avoid hospital admission • Review the falls pathway across the borough to maximise the opportunities to prevent people falling and ensure they have access to the correct support to reduce the risk of repeat falling and associated injury	• Support residents to plan for their old age and have sensitive conversations about end of life and death • Improve end of life care by progressing delivery of our End-of-Life Care Strategy • Improve care coordination and information sharing across health and social care at the point of 'end of life', including rolling out access to urgent care to care homes • Review bereavement services to identify any potential gaps and ensure the needs of the whole population including those harder to reach are served and enhance supportive networks within the community based on learning
Outcome	**Outcome**	**Outcome**
• Increase in opportunities for people to remain connected to others and improve their health and wellbeing • Reduction in people who feel lonely and socially isolated • Reduction in non-medical related GP appointments and Accident & Emergency presentations • Increase in the number of people benefitting from social prescribing • Increase in the number of carers referred/accessing social prescribing and CILS Navigation Service	• Increase in residents supported to live independently & well for as long as they are able • Increase in older residents who receive 'reablement' support at home • Increase in number of residents who return to normal place of residence after hospital discharge • Residents with dementia and their families will have a better health and care experience and receive more support • Reduction in the number of falls in people aged 65 and over • Residents are seen by the right clinician/therapist, at the right time and in their usual place of residence • Extended availability of discharge services in the community with more support available through voluntary sector • Greater use of digital technology to support people to remain independent in their own home	• Residents have personalised Health and Social Care services at the end of their life, resulting in improved outcomes and of resident's experience of health and social care systems • More residents have an Advanced Care Plan • Urgent care delivered across all care homes • Care homes are more digitally integrated across health and social care • Increase in the number of people with palliative and end of care needs identified and included on the palliative care register

Overarching Themes

We will identify, recognise and support unpaid carers of all ages, to ensure that in all the objectives, unpaid carers are linked to appropriate support options enabling them to reduce the social, financial and mental and physical health impacts they face

We will encourage people to live physically active and healthy lifestyles to prevent ill-health and improve wellbeing

We will promote the mental health and resilience of residents of all ages

9. 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 richmond.involve@swlondon.nhs.uk.

10. Other work we are doing in Richmond

Here's a list of existing plans which health and care colleagues in Richmond have 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.

- Community mental health transformation for adults and older adults
- SEND Futures Plan (Easy Read Version)
- Richmond Carers Strategy
- Dementia strategy
- Health and Wellbeing Board Strategy
- Transforming mental health services for children, young people and their families
- Suicide Prevention Strategy
- End of life care priorities
- Air quality plan
- NHS Long Term Plan

Appendix 1 – Richmond Health and Care Plan Metrics

Start Well

Mental Health

- Percentage of pupils who said they were 'not happy' with their emotional health
- Rate of hospital admissions due to substance misuse (15-24 years)
- The percentage of 'children looked after' in the borough whose emotional wellbeing is a cause for concern
- Hospital admissions as a result of self-harm (10-24 years) per 100,000 population

Population Health

- Percentage of new births visits completed within 14 days
- Percentage of children who received a 2 to 2.5 year review of health & development
- Rate of Childhood Immunisation

Healthy Weight

- Reception Prevalence of Obesity
- Year 6 Prevalence of Obesity
- Percentage of 5 year olds with visually obvious dental decay
- Difference in excess weight levels between most and least deprived ward
- Percentage of children aged 5-16 completing physical activity for an average of at least 60 minutes per day across the week

SEND

- Proportion (%) of young people aged 16 to 25 with EHC plans who are in education, training or employment
- Proportion (%) of young people aged 16 to 25 at SEN support level who are in education, training or employment
- Proportion (%)of young people aged 14 to 17 with learning disabilities who receive an annual health check

Live Well

Managing Long Term Conditions

- Percentage of adults (aged 18+) classified as overweight or obese
- Percentage of physically active adults
- Inequality in life expectancy at 65 years
- Rate of emergency admissions for alcohol specific conditions
- Proportion of eligible people receiving an NHS Health Check
- Percentage of people with diabetes who attended the diabetes structured education programme within 12 months of diagnosis

Mental Wellbeing

- Hospital admissions as a result of self-harm (20-24 yrs) per 100,000 population
- Smoking prevalence in adults with a long term mental health condition (18+)
- Proportion of people with severe mental illness (SMI) who have received a complete physical health check
- Excess mortality rate for people with SMI (under 75 years)
- Proportion of people with anxiety and depression accessing psychological therapies (IAPT)

Reducing Health Inequalities for those with Disabilities

- Proportion of people with a learning disability who have received an annual health check (all ages)

Age Well

Live Independently, including people with dementia

- Emergency Hospital Admissions due to falls in people aged 65 and over
- Fuel poverty - Percentage of people aged 65+ receiving winter fuel allowance
- Percentage of hospital discharges to usual place of residence *
- Percentage of people staying in hospital for 14 days or more *
- Percentage of people aged 65 and over offered reablement services following discharge from hospital
- Percentage of people aged 65 and over who were still at home 91 days after discharge from hospital into reablement services *
- Rate of permanent admissions to residential care per 100,000 population (65+) *
- Unplanned hospitalisation for chronic ambulatory care sensitive conditions *

Tackling loneliness and isolation

- Social Isolation: percentage of adult carers who have as much social contact as they would like (65+)
- Social Isolation: percentage of adult social care users who have as much social contact as they would like (65+)

Planning for final years

- Excess winter deaths index (Ratio %)
- Percentage of deaths that occur in hospital

Richmond
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