LONDON BOROUGH OF
RICHMOND UPON THAMES

The Annual Report of the Director of Public Health 2014/15

Contents

Forewords

Dr. Dagmar Zeuner

Director of Public Health

Welcome to the 2014-15 Annual Public Health Report for Richmond upon Thames.

There is a statutory duty for the Director of Public Health to produce an independent Annual Public Health Report. This report complements the Joint Strategic Needs Assessment (JSNA) – we aim to produce a report that does not duplicate the JSNA and gives maximum added value.

The focus of this year's report is on understanding health and wellbeing outcomes that are included in the four National Outcomes Frameworks – Adult social care, NHS, Public Health and Children & young people. Together the frameworks provide an overview of the health and wellbeing of local populations and support partnership working, as single services or sectors cannot achieve the outcomes on their own.

In producing this report, we seek to make these datasets accessible to a wider audience. By exploring what the indicators actually measure and how the data is collected, we can better interpret Richmond borough's performance on the indicators and judge how useful and robust the indicators are in monitoring the health and wellbeing of the local population. For example, some green ratings might not necessarily be good (e.g. green for smoking prevalence but still over 20,000 smokers), some red ratings might flag up areas for improvement but relate to very small numbers (e.g. number of suicides) and some indicators might not actually measure what you think they do at first glance!

The five chapters are structured around 'domains' of outcomes indicators – improving the wider determinants of health, prevention & early intervention, children & young people, integrated health & social care and reducing premature mortality.

As the report is intended to be a reference source on the indicators from the Outcomes Frameworks, we haven't included information on local strategies or on current or planned programmes of work to improve performance and haven't made any recommendations.

I hope that you will find this report useful in making sense of the indicators and in understanding what they mean for Richmond borough, as well as stimulating further debate on how we measure and use outcomes indicators.

Already, the process of developing the report has fostered more collaboration – with the advice and input from many colleagues helping to achieve a common understanding of what the outcomes indicators mean for Richmond borough.

Many thanks to colleagues in the Adult and Community Services and Environment directorates, Achieving for Children and Richmond Clinical Commissioning Group for their positive support and contribution. These efforts are much appreciated – on top of everyone's busy day-to-day work.

We are keen to make our Annual Public Health Reports useful for partners so would welcome any comments. Please email PublicHealth@richmond.gov.uk with your feedback.

Councillor Blakemore and Councillor Marlow

Councillor Blakemore (Cabinet Member for Housing and Public Health) and Councillor Marlow (Strategic Cabinet Member for Adult Services and Health)

As the Cabinet Members responsible for Public Health, we commend this annual report of our Director of Public Health. This report helps local partners to understand the health and wellbeing of Richmond borough residents. Importantly, it also helps us to understand how we measure outcomes so that the Health and Wellbeing Board can monitor the progress of local programmes of work and identify priorities. The topics covered in this report are wide ranging and cut across the responsibilities of many different sectors – public, private, voluntary and community. This means that no single department or organisation can achieve better outcomes on their own – the only way is by working together in partnership for Richmond borough people.

Dr. Graham Lewis

Chair of Richmond Clinical Commissioning Group

As the Chair of the Richmond Clinical Commissioning Group, the issue of how we measure the health and wellbeing of local patients is crucial in ensuring that we are commissioning high quality services and are making a positive difference. There has historically been more of a focus on measuring processes and activity and we are working on moving the focus to measuring outcomes that matter to patients. As part of this, we are currently undertaking a large programme of work to move towards 'outcomes-based commissioning' for community health services that provide out-of-hospital care to our population. This annual report will help us to further understand how we measure outcomes as we go forward with this work.

I commend this annual report which complements this work and helps us to link outcomes identified by patients with measurable indicators that are already collected for monitoring.

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Introduction

Introduction

The 2014-15 Annual Public Health Report is a resource to support local partners to better understand Richmond borough's position in the National Outcomes Frameworks.

Increased focus on outcomes

The importance of outcomes in health and local government has been widely recognised for many years. This includes outcomes ranging from people dying prematurely to the quality of life of service users.

Over recent years, both at national and local levels, different models and tools have become available that allow a more systematic approach to defining and measuring outcomes. This has allowed us to focus more on results from services and investments – rather than activity (e.g. numbers of people attending services).

This report demonstrates the use of one set of tools – National Outcomes Frameworks – that helps us to focus on measuring and assessing the health and wellbeing outcomes of the people of Richmond borough.

National Outcomes Frameworks

Four National Outcomes Frameworks have been developed in recent years – Adult social care[1], National Health Service (NHS)[2], Public Health[3] and Children & young people[4]. The Outcomes Frameworks are sets of validated indicators provided at local authority level, which can be benchmarked against other areas.

Many of the indicators are already reported and monitored through other local and national reporting systems for topic areas, although they might not be recognised as being part of the National Outcomes Frameworks. The Frameworks are freely available on the internet and are regularly updated.

It is important to be aware that the Frameworks include a mixture of indicators – some are high-level population measures whereas others focus on individual experiences (measured at a local authority level); some indicators can be affected by short term changes whereas others can only be changed over long periods of time; some are relatively straight forward to improve whereas others are complex and multifactorial; some can be affected by local-level initiatives whereas others may be more influenced by national level changes.

The four Frameworks are complementary and together provide an overview of the health and wellbeing of local populations. The combined Frameworks provide a structure for measuring and monitoring improvements across public health, healthcare, children's and adult social care systems and to support partnership working and integration, as single services or sectors cannot achieve the outcomes on their own.

Purpose of the report

This year's report is based on an analysis of Richmond borough's position across the full range of indicators in the National Outcomes Frameworks. In bringing together the Outcomes Frameworks, we aim to support joint working on outcomes shared between local partners.

The report will provide a concise reference source to make sense of the indicators from the Outcomes Frameworks and to understand what they mean for Richmond borough. This report seeks to make these datasets accessible to a wider

audience by exploring what the indicators actually measure and how the data is collected, interpreting Richmond borough's performance on the indicators (both in absolute numbers and benchmarked against other areas) and judging how useful and robust the indicators are in monitoring the health and wellbeing of the local population.

It is outside the scope of this report to describe, evaluate or make recommendations on local strategies, interventions or current or planned programmes of work to improve Richmond borough's performance on the indicators, although some indicators do relate specifically to local programmes or services. However, the report does signpost readers to further sources of local information, such as local strategies or Needs Assessments (although this is not meant to be a comprehensive list) – this is to be found in Appendix A.

Methodology

Engagement

In developing this report, the Public Health team has engaged with colleagues across the local authority, Achieving for Children and the Richmond Clinical Commissioning Group (CCG) who understand the details of how the indicators have been constructed and how to interpret Richmond borough's performance. These have often been the leads responsible for collecting and submitting data on the indicators and/or the strategic leads for a topic area. This has been a very positive process and has been helpful in coming to a common understanding.

Indicators

The indicators used in this report are drawn from the NHS Outcomes Framework (NHSOF), the Public Health Outcomes Framework (PHOF), the Adult Social Care Outcomes Framework (ASCOF) and the Child Health Profiles (CHP). All outcome indicators are included in this report to ensure a comprehensive and transparent picture.

There are a total of 173 indicators in the Outcomes Frameworks for which Richmond data is available – 119 from PHOF, 28 from NHSOF, 23 from ASCOF and 28 from CHP. There is overlap between the Fameworks, with some indicators belonging to more than one Framework. Data are correct as of 31st October 2014. The index in Appendix B provides the Framework references for each indicator.

The outcome indicators are presented according to five categories or 'domains' – each domain is the focus of a chapter in the report. The five domains are: improving the wider determinants of health, prevention & early intervention, children & young people, integrated health & social care and reducing premature mortality. We are aware that there are other ways to group up the indicators, but this was deemed to be the most useful for the purpose of this report. A chapter has been specifically dedicated to children & young people because there is a separate Outcomes Framework for this age group and there are dedicated services to meet many of their needs. The other chapters are based on themes that cross all age groups but are mainly focused on adults. It was not feasible to have a separate chapter on older people, although it is acknowledged that this is an important group, and they are well covered in the chapter on integrating health and social care.

Some NHSOF, PHOF and CHP indicators report data for Richmond CCG, rather than Richmond borough. The Richmond CCG population includes all patients registered to a GP in the area of Richmond CCG (which is coterminous with Richmond borough). People do not have to register with a GP in their own borough, so this population is not the same as the resident population. Nevertheless, there is a great deal of overlap between the populations, so, in the absence of resident-specific data, we use "Richmond borough" to refer to both populations.

Outline of each chapter

Each chapter in the report comprises a summary, a profile of relevant indicators and an interpretation of Richmond borough's position. Links to relevant local documents (e.g. local strategies or Needs Assessments) have been included in Appendix A, so that readers can find more detailed information.

Comparator areas

For most indicators, the peer comparison is London boroughs or CCGs▼. The exception is those indicators which are derived from the ASCOF, in which case the comparison is against boroughs selected using the Chartered Institute of Public Finance and Accountancy (CIPFA) Nearest Neighbour Model, which identifies similarities between authorities based upon a range of socio-economic and demographic indicators◆.

The national comparisons are drawn between London Borough of Richmond upon Thames (or Richmond CCG, where necessary) and the rest of the local authorities (or CCGs) in England.

The majority of data sources break data down by upper-tier authority – 156 authorities in England and 33 in London. However, a small number of data sources break data down by lower-tier authority – 326 authorities in England and 33 in London. As for CCGs, there are 211 in England and 32 in London●.

There are many instances in which data are not available for all comparators in a group. Where this occurs, the Richmond borough data is simply compared against those comparators for which data are available.

Ranking of areas

Richmond borough's performance is coded according to the quartile in which it falls, when compared to other areas. This is calculated by ranking the full set of areas (e.g. local authorities within England) according to their performance on a given indicator, and splitting the list into four groups of equal number. The first group contains the top (best performing) 25% of areas, or first quartile.

There are a number of caveats with using this methodology:

- This methodology differs from that employed by PHOF and CHP, which looks at statistical similarity or difference to local or national comparators.
- Quartiles give an indication of performance relative to the other comparator areas, irrespective of how the data is distributed.
- This method takes no account of absolute standards, such as national targets for certain outcome indicators (e.g. childhood immunisations). Relative performance may be shown to be good/green, even when a target has been missed.
- In London, the small resident population of the City of London makes it a statistical outlier. This may slightly skew the overall London figure and the calculation of the quartiles.

▼ Some data sources precede the Health and Social Care Act 2012, so present data according to the CCG's predecessors, Primary Care Trusts (PCTs).

◆ Further information about the Nearest Neighbour Model can be found on the CIPFA website: http://www.cipfastats.net/resources/nearestneighbours. CIPFA comparator councils for Richmond borough are: Barnet, Bexley, Bromley, Croydon, Ealing, Enfield, Harrow, Havering, Hillingdon, Hounslow, Kingston upon Thames, Merton, Redbridge, Sutton and Wandsworth.

● Previously, there were 152 PCTs in England and 31 in London.

Rankings are not necessarily the primary basis for performance management, but are a helpful way of comparing Richmond borough's performance with other areas – offering simplicity of analysis, ease of interpretation and consistency across the four Frameworks. Using the rankings may help to identify areas where improvement may be required.

Colour coding

Dark green (and a number 1) indicates Richmond borough performance in the top (best performing) quartile, light green (2) and amber (3) indicate performance in the second and third quartiles respectively, and red (4) indicates performance in the bottom quartile.

For some indicators, higher values are preferable (e.g. vaccination coverage) and, for others, lower values are preferable (e.g. mortality rates); the colour codes reflect this, so that green always indicates the desirable direction of performance. In some cases, the polarity of an indicator is ambiguous, in which case performance has been ranked smallest to largest, with low values marked green and higher values red. This is detailed visually in Table 1. For black and white printing, the quartile number (1-4) has been included.

Table 1. Colour-coding of performance by quartile

Example	Polarity	1st Quartile	2nd Quartile	3rd Quartile	4th Quartile
Population vaccine coverage	Aim to maximise	High			Low
Premature mortality rate for liver disease	Aim to minimise	Low			High
Fraction of mortality attributable to air pollution	None	Low			High

Recent trends

The recent trend based on the last few year's data (up to 5 years, where available) for each indicator is shown symbolically:

+ Increasing
= No clear trend/stable
- Decreasing

The direction of each trend was a subjective judgement, based on the data available. It was not based on a statistical analysis or modelling. Trends were judged by two reviewers to ensure agreement.

Where there are fewer than three years' data available, a trend has not been inferred, due to the uncertainty around the degree of year-on-year variation.

Relationship to other projects / frameworks

The 'Richmond Story' is produced annually and provides a summary of local needs identified through the JSNA process. This year's Annual Public Health Report is complementary to the Richmond Story and provides a more detailed narrative on, and interpretation of, indicators from the National Outcomes Frameworks.

Linked to the Richmond Story, an accompanying scorecard has recently been developed for the Health and Wellbeing Board. The indicators in the scorecard were also selected from the National Outcomes Framework to serve as a high-level surveillance tool for the Board to be able to spot changes in Richmond borough's population health and to monitor progress against the high-level priorities in the Joint Health and Wellbeing Strategy. The scorecard continues to be refined and the Annual Public Health Report will help inform the final set of indicators selected for the scorecard. It will also help with more in-depth understanding of the indicators in the scorecard.

Richmond CCG and the local authority are currently undertaking a large programme of work to move towards 'outcomes-based commissioning' (OBC) for community healthcare services that provide out-of-hospital care. This links to wider work around integrating health and social care, particularly for people who are frail and elderly and in receipt of numerous local services. As part of this programme, a local OBC outcomes framework is being developed which focuses on outcomes that are important to service users. Outcomes in this OBC framework have been defined by local stakeholders (e.g. "I want my care to be timely"). Some population-level indicators from the National Outcomes Frameworks (e.g. delayed transfers of care), as well as other indicator sets and surveys, are used to measure performance against these locally defined outcomes. The Annual Public Health Report is therefore complementary to the development of the OBC outcomes framework. It aims to help local understanding of how the National Outcomes Framework indicators are measured and how to interpret Richmond borough's performance against the indicators, and helps to link outcomes identified by patients with measurable indicators that are already collected for monitoring progress.

Improving the wider determinants of health

What does this mean for Richmond borough?

- People's ability to lead healthy lives is heavily influenced by the impact of the places in which they live, work and play, and the communities they are part of. Partners can work together with residents to create an environment that makes the healthiest choice the easiest choice for local people.
- Richmond borough performs relatively well on employment measures, although the percentage of young people who are not in education, employment or training is lower than in London (a red rating). There were data quality issues with this indicator, but improvements have subsequently been made in tracking young people.
- There are a number of indicators that look at potential inequalities in employment for people with learning disabilities, mental health problems and long-term conditions. Although there are two red ratings in this theme, these specific indicators may be misleading. The indicators measure the difference in the percentage of people in these groups that are in employment and the percentage of all adults in employment – a higher total employment rate in Richmond borough than in other areas means that interpretation of these indicators is difficult. It is more meaningful to use the indicators that measure the absolute percentage of people with learning disabilities and mental health problems that are in paid employment – in which Richmond borough performs relatively well. In addition, only looking at paid employment may not be the most appropriate measure for people with learning disabilities and mental health problems, as 'meaningful occupation' may include voluntary work or everyday activities for some people.
- Rates of homelessness are generally higher in London than in England, which helps to explain the red ratings for national comparison. During 2012-13, there were 357 households accepted for housing support. There has been an increase in the number of homeless households locally in recent years, as there has been across London.
- The indicators on stable and appropriate accommodation for people with learning disability or mental health problems are an important topic area but the way they are measured may result in difficulties in interpretation. The indicators do not define residential care homes as stable and appropriate accommodation, but it is likely that some service users will always require a residential care environment to meet their high and complex needs.
- Richmond borough's performance on indicators relating to excess winter deaths and fuel poverty is relatively good. However, there are estimated to be 45 excess winter deaths per year and 5,780 households that are in fuel poverty – these are preventable. These are particularly important indicators for Richmond borough as there is a high proportion of older people living alone and a large number of big, older properties which can be difficult to heat, particularly on a low income.
- The closeness of Heathrow Airport means that aircraft noise is a particular problem in the borough, both during the day and at night. The percentage of residents estimated to be exposed to unacceptable levels of transport noise (road, rail and air) appears higher than in England.
- Richmond borough has some of the best air quality in London but pollution is sufficiently high for it to be designated as an Air Quality Management Area. There is a red rating for the percentage of deaths that can be attributed to long-term exposure to air pollution, which is based on modelled data.
- There has been a steady improvement in the number of people seriously injured on roads over recent years, and there were no fatalities in 2013. The vast majority of road traffic incidents are preventable.
- The indicator on sustainable development relates to an important topic area for the health of future generations and indicates positive progress in local NHS organisations, but does not give any information on the local authority's actions.
- The Public Health Outcomes Framework includes an indicator on the use of outdoor space for exercise/health reasons. Richmond borough's seemingly poor performance on this indicator is surprising given the abundance of green space in the borough. This indicator is misleading in a number of ways – the sample size is very small, the amount of time spent outdoors is not measured, there is no way of saying how beneficial the time spent outdoors was on an individual's health and, importantly, time spent outdoors is likely to have health and wellbeing benefits

even if that is not the purpose of the visit. In addition, this data contrasts with local survey data on the use of parks for exercise (which shows a more positive picture) and also with indicators on physical activity where Richmond borough is one of the highest performers in the country.

- Richmond borough is one of the safest boroughs in London and is the safest borough for violent crime. Except for the indicator on violent crime, the local Community Safety Partnership does not tend to use the indicators in the Outcomes Framework to measure overall performance on safety and crime – it uses the total crime rate as an overall indicator. Other priorities not measured in the Outcomes Framework include non-residential burglaries, domestic violence and anti-social behaviour.

Introduction

People's health is heavily influenced by the impact of the places in which they live, work and play, and the communities they are part of – but individuals also help to create their own health though the lifestyle choices they make, for example through eating healthily, exercising and stopping smoking. Partners can work together to create a health-promoting environment that makes the healthiest choice the easiest choice for local people.

Examples may include using legislation to protect against known harms (such as alcohol licensing or restricting where fast food takeaways are over-concentrated), incentives to encourage participation (such as subsidised leisure centres), support initiatives (such as support to get people into employment), ensuring that the transport infrastructure encourages walking and cycling, and making green spaces safe and accessible.

Although growth in local populations brings benefits (e.g. expanded employment opportunities), it needs to be managed to reduce any potential negative impacts on wellbeing (e.g. increased traffic and stretched services).

Employment

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
Not in education, employment or training - 16-18 yrs (per cent)	4	1	4.5%	2013	=
Employees who had at least one day off in the previous week (per cent)	1	1	1.6%	2009-11	N/A
Working days lost due to sickness absence (per cent)	2	1	1.1%	2009-11	N/A
Adults with learning disabilities in paid employment (per cent)	2*	1	14%	2013/14 Provisional	=
Secondary mental health service users in paid employment (per cent)	2*	2	8.4%	2013/14 Provisional	-
Gap between employment rate for those with a learning disability and the general population (per cent)	3	2	58%	2011/12	N/A
Gap between employment rate for those in contact with secondary mental health services and the general population (per cent)	4	4	65%	2012/13	N/A
Gap between employment rate for those with a long-term health condition and the general population (per cent)	4	4	13%	2012	N/A

*ASCOF measure, peer comparison is against local authorities in CIPFA group.

Employment is a key aspect of the Government's Public Health strategy 'Healthy Lives, Healthy People'. People who are not in employment have a higher risk of poor physical and mental health outcomes[5]. Being out of work (either through unemployment or sickness) also has a substantial negative impact on the economy through lost productivity and benefits.

In Richmond borough, 4.5% of 16-18 year-olds are not in education, employment or training (NEET) – 170 young people. This is lower than in England (5.3%) but higher than in London (3.8% - a red rating). There are four boroughs within London that have achieved less than 3% NEET – Harrow, Barnet, Lambeth and Southwark. The Richmond borough figure has fluctuated slightly over recent years and most young people in this age group who are in education are educated out of borough. The Public Health Outcomes Framework highlights data quality issues with this indicator in Richmond borough, due to the number of young people whose activity was not known; the red comparison with London may not therefore be valid. However, it is helpful to note that the data used for this indicator was from a three-month period, during which work was carried out to track young people – the data quality was therefore improved by the end of the period.

An estimated 1.6% of employees had at least one day off in the previous week due to sickness absence and 1.1% of working days are lost due to sickness absence. These indicators are based on data from the Labour Force Survey which is the largest household survey in the UK. Richmond borough performs reasonably well for these indicators – overall they are similar to, or better than, London and England.

The Outcomes Frameworks include a number of indicators that look at the employment rate for people with learning disabilities, mental health problems and long-term conditions▼. These indicators use data from the Labour Force Survey as well as data from social care and mental health services. Richmond borough's overall performance is relatively good. The indicators show that 14% of people with learning disabilities are in paid employment compared to 9.2% in London and 6.8% in England, and that 8.4% of people using secondary mental health services are in paid employment compared to 5.5% in London and 7.1% in England. The proportion of mental health service users in employment has almost halved in Richmond borough, from 15% three years previously – we are not clear on the reason for this change.

However, there is a substantial difference in the percentage of people with learning disabilities and mental health problems that are in employment and the percentage of all adults in employment – the 'gap' in employment rate. This gap is particularly large for people using secondary mental health services.

It is difficult to meaningfully compare Richmond borough's performance to London and England for the three indicators on the 'gap' in employment rate (two of which have red ratings). These indicators take into account the percentage of all adults in employment (the total employment rate) which is higher in Richmond borough than in London and England – this is positive but means that interpretation of the employment gap indicator is difficult. It is more meaningful to use the indicators that measure the absolute percentage of people with learning disabilities and mental health problems that are in paid employment – in which Richmond borough performs relatively well.

These measures only look at adults known to services and who are in paid employment. This may not be the most appropriate measure for people with learning disabilities and mental health problems, as the focus (especially for people with higher needs) may be on 'meaningful occupation'. This is an activity which can give a sense of purpose and control and help someone to feel part of their local community. This may be paid employment for some people, but may include voluntary work or everyday activities for other people. Even for those in paid employment, low-hour jobs may be most appropriate. It is therefore not clear to what extent it would be appropriate to aim for an increase in Richmond borough's performance against these indicators.

▼ An additional indicator (NHS Outcomes Framework 2.5) compares the employment rate of those with a self-reported mental illness with the general population. This indicator is produced quarterly, not annually, and the Richmond Value fluctuates substantially from quarter to quarter. It is therefore not included in this report. This indicator records a smaller gap in employment rate, averaging around 30 percentage points.

Housing

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
Homelessness acceptances (per 1,000)	3	4	4.1	2012/13	+
Family homelessness (per 1,000)	2	4	2.9	2012/13	+
Households in temporary accommodation (per 1,000)	1	4	3.0	2012/13	=
Secondary mental health services users in stable and appropriate accommodation (per cent)	1*	1	87%	2013/14 Provisional	=
Adults with a learning disability in stable and appropriate accommodation (per cent)	3*	4	66%	2013/14 Provisional	+
Excess Winter Deaths Index - Single year, all ages (per cent)	1	1	12%	Aug 2011 - July 2012	-
Excess Winter Deaths Index - 3 years, all ages (per cent)	1	1	13%	Aug 2009 - Jul 2012	-
Excess Winter Deaths Index - Single year, over-85s (per cent)	1	2	19%	Aug 2011 - July 2012	-
Excess Winter Deaths Index - 3 years, over-85s (per cent)	2	2	22%	Aug 2009 - Jul 2012	-
Households in fuel poverty (per cent)	2	1	7.6%	2012	N/A

*ASCOF measure, peer comparison is against local authorities in CIPFA group.

Housing plays a key role in supporting good health. Whilst the majority of Richmond borough's residents are adequately housed, for those in inadequate or insecure housing there can be negative impacts on health and wellbeing. This includes physical and mental health conditions and injuries that are preventable. For example, poor housing conditions may leave a house suffering from damp, which is associated with childhood asthma[6], and a home that benefits from energy efficiency improvements has the potential to lead to improvements in a resident's circulatory health[7].

Housing is especially important for the health and wellbeing of children. Poor housing can increase the risk of poor physical health, including slow growth and accidents, as well as mental health problems, behaviour problems, lower educational attainment and unemployment in the long term[8].

The relationship between housing and health is complex and other factors are often relevant, such as income, unemployment and social isolation. Older people may require adaptations to remain within their home and vulnerable residents with mental health problems or a learning disability can gain the skills to live independently within a supported housing environment. At the most extreme end, people who are sleeping rough are at a particularly high risk, with an average age of death of 47 years[9]. For some rough sleepers, substance misuse and mental health problems create complex and inter-related needs.

The indicators included within this housing theme are therefore mixed and housing may only be one relevant aspect.

The Outcomes Frameworks include three indicators relating to homelessness, all of which relate to statutory homelessness where the local authority has a duty to house people who are unintentionally homeless and eligible for support. During 2012-13, there were 357 households accepted for housing support, of which 249 (70%) included children or pregnant women (referred to as 'family homelessness' in the indicator).

Homelessness rates are generally higher in London than in England, which helps to explain the red ratings for national comparison. This is largely due to the pressurised housing market in the capital, with high house prices and expensive private rents creating issues of affordability for low- to middle-income households. Welfare reforms, such as changes to the Local Housing Allowance (LHA) also impacted London disproportionately during 2012-13. London accounts for around 30% of all homelessness applications in England.

There has been an increase in the number of homeless households locally in recent years, as there has been across London. This seems to have been contributed to by increasing private rental costs that are unaffordable for low-income households reliant on welfare benefits.

Although Richmond borough has received a red rating for households in temporary accommodation compared to England, the rate (3.0 per 1000) is substantially lower than in London (11.9 per 1000) and only slightly higher than in England (2.4 per 1000).

Stable and appropriate accommodation can help to improve outcomes for people with a learning disability or mental health problems by improving safety and reducing the risk of social exclusion, and can help prevent hospital attendances or more expensive residential care. Richmond borough's performance for secondary mental health service users is good, with a higher percentage (87%) than in London (79%) and substantially higher than in England (61%). However, there are around 85 mental health service users who are not in stable and appropriate accommodation according to this indicator. Richmond borough's performance for people with learning disabilities is lower at 66%. This is lower than in London (69%) and England (75% - rated red). This equates to around 130 people with learning disabilities who are not in stable and appropriate accommodation according to this indicator. Performance on both of these indicators reaches over 90% in some local authorities (e.g. Brent).

It is important to note that the definition used for these indicators may potentially be misleading. 'Stable and appropriate accommodation' includes people living in their own home, with family or in supported housing but not people living in residential care homes. These are good ambitions to have for many service users, but it is likely that some service users will always require a residential care environment to meet their high and complex needs.

Excess winter deaths▼ and fuel poverty◆ are complex issues, with a number of interacting causes. As well as housing (e.g. poor energy efficiency, availability of heating, size/age of house), the rate of excess winter deaths is influenced by winter temperatures, behaviour in cold weather (e.g. use of heating and warm clothing) and levels of disease in the population (e.g. flu). Fuel poverty is also caused by low income, energy prices and energy consumption. Older people are most susceptible to higher death rates in winter and around one in ten excess winter deaths is thought to be caused by fuel poverty.

There are four indicators for excess winter deaths – figures are given for single years but are also pooled to even out any annual variations in small numbers; figures are also given for all ages and specifically for over-85s, as most excess winter deaths affect older people and the figure will be partly dependent on the proportion of older people in the population.

These are particularly important indicators for Richmond borough as there is a high proportion of older people living alone (see the section on loneliness and isolation) and a large number of big, older properties which can be difficult to heat, particularly on a low income - half of the older people who live on their own in the borough have two additional bedrooms more than they require.

Richmond borough's performance is relatively good for all of these indicators and data indicates that there may have been an improvement in performance over recent years. However, there are estimated to be 45 excess winter deaths per year and 5,780 households that are in fuel poverty – these are preventable.

▼ Excess Winter Deaths is measured as a ratio of the number of extra deaths that occur in the winter months compared to the number of deaths that would be expected at other times of the year.

◆ Households are considered to be fuel poor where they have required fuel costs that are above average and, were they to spend that amount, they would be left with a residual income below the official fuel poverty line.

Built environment

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
Population exposed to road, rail and air transport noise of 65dB(A) or more - daytime (per cent)	3	4	12%	2011	N/A
Population exposed to road, rail and air transport noise of 55dB(A) or more - night-time (per cent)	3	4	17%	2011	N/A
Complaints about noise (per 1,000)	2	3	7.8	2011/12	N/A
Air-pollution attributable mortality (per cent)	1	4	6.1%	2012	-
Killed and seriously injured road casualties (per 100,000)	3	2	34	2010-12	N/A
Killed or seriously injured in road traffic accidents - 0-15 yrs (per 100,000)	3	2	18	2010-12	N/A
NHS organisations with a board approved sustainable development management plan (per cent)	1	1	75%	2012/13	=

The borough's environment is generally positive in terms of factors that influence health and wellbeing (such as the large amount of green space and river frontage). However, some aspects of the environment can have a negative impact on health and wellbeing. Poor health outcomes related to these factors are largely preventable. There are multiple interacting factors affecting the relationship between the built environment and health and a combination of national, regional and local initiatives are required to make improvements.

Noise pollution can reduce quality of life, increase stress levels and may increase the risk of heart problems. The closeness of Heathrow Airport means that aircraft noise is a particular problem, both day and night. National survey data indicates that residents find noise from aircraft to be more annoying than from other transport sources. Based on national data modelling, the percentage of residents exposed to unacceptable levels▼ of transport noise (road, rail and air) during the daytime (estimated over 20,000 people) and night time (estimated over 30,000 people) appear higher than in England. The local authority received 1,465 complaints about non-aviation noise pollution in 2011-12, with 7.8 complaints per 1,000 population – similar to England (7.5) but much lower than in London (16.4). Noise complaints about aircraft are handled directly by the airport, and Heathrow received 4,421 complaints from Richmond borough residents in 2013 (not in the Outcomes Frameworks).

Air pollution has negative impacts on health, particularly relating to heart and breathing problems. Although Richmond borough has some of the best air quality in London, pollution is sufficiently high for it to be designated as an Air Quality Management Area. In general, background air pollution is highest in those areas of the borough that are closest to the centre of London and for properties closest to busy roads. For someone with breathing problems, the way in which pollution affects people is more sensitive to the distance of their house from a road than the actual volume of road traffic. National modelling estimates that 6.1% of deaths can be attributed to long-term exposure to air pollution – only slightly higher than in England at 5.1% (a red indicator).

▼ Noise level of 65dB(A) or more during daytime and 55dB(A) or more during night time.

Road traffic incidents are a major cause of preventable deaths and injuries, especially in children. Although the rates are similar to London and England, 48 people were seriously injured on roads in 2013, including three children, although there were no fatalities in that year. There has been a steady decrease in recent years, down from a high of 72 people in 2010. The vast majority of road traffic incidents are preventable. Various prevention initiatives may be used, including awareness raising, road safety education, changes to road infrastructure to improve safety (including speed restrictions) and vehicle safety initiatives. Not all of these are within the control of the local authority, for example the A205 and A316 are managed by Transport for London.

Public sector organisations have a key role to play in cutting carbon emissions and making their operations environmentally sustainable – helping to protect the health of future generations. The Sustainable Development Unit provides support and monitors activity across the NHS, public health and social care. Six out of eight NHS organisations that provide services to the borough have a Board-approved sustainable development management plan, which indicates positive progress.

This indicator does not give any information on the local authority's role in sustainable development and how well it is doing in this area. The recently updated Climate Change Strategy for the local authority contains a borough-wide target for a 34% reduction in carbon emissions between 1990 and 2020. The local authority also monitors the amount of energy consumed by its estate every year. Government policy is that all social housing meets the Decent Homes Standard, which includes an indicator on the energy efficiency of properties. The vast majority of housing association property in Richmond borough meets this standard.

Green space

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
People utilising outdoor space for exercise/health reasons (per cent)	3	4	10%	Mar 2012 - Feb 2013	N/A

There is good evidence that green space has a positive impact on both physical and mental wellbeing[10,11]. The availability of green space can help increase levels of physical activity and reduce levels of obesity, blood pressure and stress. Green space is also important for wider health benefits, such as planting trees to cool the temperature in towns.

Green space is a key asset in Richmond borough, with over 20 miles of river frontage and more than a third of the borough being open space. Many of these spaces have pedestrian and cycle links through or along them, which can be used for exercise or active travel. Green spaces can offer quieter, safer and less polluted routes for trips on foot or by bike, compared to alternative routes along main roads.

According to a national survey on how people use the natural environment, only 10% of people surveyed in Richmond borough said that they spend time outdoors (excluding shopping trips or time spent in own garden) for health or exercise reasons – similar to London but lower than England (15% - a red indicator). The highest value is 41% nationally and 20% in London.

This indicator needs careful interpretation for a number of reasons.

Firstly, this indicator is based on a relatively small survey and there were only 82 respondents from Richmond borough. Secondly, the amount of time spent outdoors is not measured. Thirdly, there is no way of saying how beneficial the time spent outdoors was for an individual's health (i.e. was the activity intensity high enough to be beneficial). Fourthly, time spent outdoors is likely to have health and wellbeing benefits even if the purpose of the visit is not for health or exercise (e.g. dog walking), so this indicator is likely to give an underestimate of the positive health impact of using green space in the borough.

It is interesting to compare this indicator with a larger local survey on parks carried out in 2013, which found that 31% of respondents who visited parks did so for the purpose of exercise. The local authority is also currently undertaking a survey on sport, open space and recreation which includes a question on the reason for undertaking an activity.

There are other indicators on physical activity in the Outcomes Frameworks where Richmond borough is one of the highest performers in the country (see the chapter on Prevention and early intervention).

Safety and crime

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
Violent offences (per 100,000)	1	2	8.8	2012/13	=
Sexual offences (per 1,000)	1	1	0.57	2012/13	=
Hospital admissions for violence (per 100,000)	1	1	23	2010/11 - 12/13	N/A
Offenders who re-offend (per cent)	1	2	25%	2011	N/A
Re-offences per offender	2	2	0.68	2011	N/A
First time entrants to the Youth Justice System (per 100,000)	1	1	310	2013	-

The levels of crime in a local area can have a substantial negative impact on the wellbeing of residents. Offending behaviours are also often closely linked to the physical and mental health of individuals, especially substance misuse problems. Offenders often have high levels of unmet health needs and there are substantial health inequalities which can persist across generations.

Causal factors are complex and this is reflected in the wide range of partners involved in the local Community Safety Partnership (CSP) – including the police, fire brigade, community groups, probation, housing, youth services, safeguarding, substance misuse and public health.

The Outcomes Frameworks include indicators for three aspects of safety and crime – violent crime, re-offending and youth offending.

Richmond borough is one of the safest boroughs in London and is the safest borough for violent crime. However, there are over 1,500 violent crimes per year with around 45 people being admitted to hospital due to violent incidents and around one-quarter of offenders will re-offend. These figures have stayed relatively stable over recent years.

The indicator on youth offending (first time entrants to the Youth Justice System) is a statutory indicator. Although there is no specific target, it is expected that local areas will work to drive down the numbers over time. In 2013 there were 48 young people who received their first conviction or caution and this number has reduced steadily over recent years, from 104 young people in 2010. It is thought that this is mainly as a result of local interventions put in place to help prevent youth offending.

Except for the indicator on violent offences, the local Community Safety Partnership does not tend to use the indicators in the Outcomes Framework to measure overall performance on safety and crime. Two indicators are used to measure overall performance on safety and crime – the rate of total crimes (not included in the Outcomes Framework) and the indicator on the rate of violent crimes. Although Richmond borough is the safest borough in London for violent crime, this remains a priority for the CSP and a high level of resources are required to keep the borough in this position. Other priorities for the CSP (not in the Outcomes Frameworks) are non-residential burglaries (e.g. thefts from sheds and garages), where Richmond borough is 29th out of 31 London boroughs; domestic violence and anti-social behaviour.

Prevention and early intervention

What does this mean for Richmond borough?

- Under the Care Act, local authorities must provide or arrange for services, facilities or resources which would prevent, delay or reduce individuals' needs for care and support, or the needs for support of carers. A local prevention strategy for adults is being developed that will focus on promoting wellbeing and independence, preventing people from developing poor health and reducing deterioration of wellbeing.
- There is increasing national interest in how to measure wellbeing and a large national survey has recently been introduced. Some of the data from this survey is currently only collected at an Outer London level. The indicators measured at a borough level show contrasting pictures – with good levels of happiness but poor levels of anxiety.
- There is a red rating for suicides compared to London, but the numbers per year are small (around 15 per year) which makes it difficult to meaningfully compare Richmond borough to other areas.
- Richmond borough has relatively good performance for obesity and physical activity, and has the lowest percentage of people in the country who are inactive. However, substantial numbers of local people are affected by obesity and physical inactivity, with almost half of all adults (approximately 72,000 people) being overweight or obese. Despite the green ratings, this is an area of significant concern.
- Richmond borough has the lowest rate of diagnosed diabetes in the country (3.7% – around 5,700 adults). A low prevalence would be expected due to the ethnic make-up and low deprivation level in the borough. However, national modelling suggests there are up to 4,200 more people with diabetes who have not been diagnosed.
- Richmond borough has a relatively low prevalence of smoking (green ratings) but this remains an area of significant concern. Over 20,000 people are smokers and there are over 200 deaths every year related to smoking. It should be noted that the data on the number of people who smoke is based on a survey and the estimate for Richmond borough has fluctuated over the last few years.
- Measures relating to drug misuse indicate that the local treatment services are performing relatively well. There are currently around 480 Richmond borough clients in drug treatment (280 opiate users and 200 non-opiate users). Many also have drinking problems. Overall, Richmond borough has a treatment population of less complex cases compared to many other areas, and therefore service performance would be expected to be comparatively good in relation to London and England.
- Richmond borough has comparatively low rates of hospital admissions that are related to alcohol. Nevertheless, this equates to 733 admissions in 2012-13. Over the last five years Richmond borough rates have been generally stable. There are other important indicators that are not in the Outcomes Frameworks that help to understand substance misuse issues in the local population. For example, significant numbers of Richmond borough residents are estimated to be drinking alcohol at levels potentially harmful to their health, and Richmond borough ranks poorly compared to other local authorities. Around 15,000 adults are estimated to be drinking at higher risk levels.
- There were 620 injuries due to falls and 160 hip fractures in 2012-13 in people aged 65 and over. There are a large number of different indicators for falls and hip fractures as they are reported for different age groups, because the risk of falls and initiatives to prevent falls differ by age group. Richmond borough's performance is similar to or better than London and England, except for the rate of hip fractures in people aged 65-79 which has increased slightly and is now higher than in London (a red rating).
- Richmond borough's performance for the number of people receiving a late diagnosis of HIV (being diagnosed after the point at which someone should have started treatment) is rated green but, due to low numbers (around 8 people per year), it is difficult to make meaningful comparisons with other areas. Despite the low numbers and the green rating, this is an important area for improvement in Richmond borough because of the substantial potential to improve health outcomes in the individuals diagnosed, to reduce the risk of onward transmission and to reduce long-term health and social care costs.
- Richmond borough's performance on screening for diabetic retinopathy is one of the best in London, but performance data for breast and cervical screening is mixed. We do not have information on women attending screening at private clinics, so these indicators may give an underestimate of uptake. International debate in recent years about the balance between the benefits and potential harms of breast screening may have resulted in decreased uptake.

- Indicators for the NHS Health Checks programme in Richmond borough suggest generally good performance. The indicators for this programme are complicated and difficult to interpret. A single indicator on its own does not give a full picture and should therefore be interpreted with caution in assessing performance. In addition, there is no measure of subsequent changes in lifestyles and improvement in people's long-term health.
- Uptake of immunisations programmes for adults is relatively good in Richmond borough, although only half of at-risk individuals took up the offer of a flu vaccine in 2012-13.
- Only small numbers of people are diagnosed with tuberculosis (TB) in Richmond borough, but nearby boroughs (such as Hounslow) have high rates.

Introduction

Under the Care Act, local authorities must provide or arrange for services, facilities or resources which would prevent, delay or reduce individuals' needs for care and support, or the needs for support of carers. A local prevention strategy for adults is being developed with health, public health, adult social care, other council departments and community representatives. This will focus on promoting wellbeing and independence, preventing people from developing poor health, reducing deterioration of wellbeing as a result of ageing, illness or disability, and delaying the need for more costly, intensive and long-term care and support services.

Wellbeing

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
People with low happiness score (per cent)	1	1	7.7%	2012/13	N/A
People with high anxiety score (per cent)	4	4	25%	2012/13	N/A
People with low satisfaction score (per cent)*	-	-	6.0%	2012/13	N/A
People with low worthwhile score (per cent)*	-	-	4.1%	2012/13	N/A
Suicide rate (per 100,000)	4	2	8.3	2010-12	=

There is increasing national interest in how to measure wellbeing, and in using it as an indicator of the nation's overall progress along with existing economic, environmental and social measures. The Office for National Statistics is leading on a long-term programme of work that explores how to measure national wellbeing[12].

Local initiatives may help to support long-term improvements in wellbeing, but the causal relationships are highly complex. In a national debate about what wellbeing is, the most common responses related to health, relationships with family and friends, employment (job satisfaction and security) and the environment. People with higher wellbeing generally have better physical and mental health and recover more quickly from illness. There are also links with higher life expectancy and lower unemployment[13].

There are four aspects of wellbeing which are currently monitored through a large national survey – happiness, anxiety, satisfaction and a sense of being worthwhile. During 2013-14, 683 Richmond borough residents were surveyed. These are relatively new indicators and data is only available for two years.

* Data available for outer London only

In Richmond borough, a smaller proportion of people have a low happiness score (7.7%) than in London and England (10% in both). There is a different picture for anxiety, with a relatively large percentage of people having a high anxiety score (a red rating) – 25% compared to 22% in London and 21% in England. Although it is difficult to meaningfully compare Richmond borough to other areas due to relatively low numbers, this does indicate that a substantial proportion of the population experiences high anxiety.

The data for satisfaction and a sense of being worthwhile are only available for Outer London as a whole, due to small numbers at borough level – so there is limited interpretation possible for Richmond borough. However, the data indicates that relatively small percentages of people have low satisfaction (6.0%) or low worthwhile scores (4.1%) – comparable to London and England figures.

In this section we have also included the national outcome measure on suicides. There are around 15 suicides per year in Richmond borough, and the rate is 8.3 per 100,000 – similar to England but slightly higher than London (a red rating). The numbers per year are small and so this indicator gives pooled data over a three-year period to try to smooth out annual random fluctuations. However, even with pooled data, it is difficult to meaningfully compare Richmond borough to other areas. Both London and England rates have been generally decreasing over recent years, but it is not possible to see if this is also happening in Richmond borough due to small numbers.

Obesity, physical activity and diabetes

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
Overweight or obese - adults (per cent)	1	1	48%	2012	N/A
Physically active adults (per cent)	1	1	66%	2013	N/A
Physically inactive adults (per cent)	1	1	16%	2013	N/A
Diabetes prevalence (per cent)	1	1	3.7%	2012/13	+

Obesity increases the risk of a range of long-term health problems, such as Type 2 diabetes, heart disease, cancer and joint problems[14]. Prevalence of obesity has more than doubled in the UK in the last 25 years and tackling obesity is a national goal.

There are multiple, interacting factors that cause obesity, but lifestyle and the environment play major roles. Prevention of obesity from an early age is crucial as this can have a positive impact on health and wellbeing throughout an individual's life. This is discussed further in the chapter on children and young people.

Based on data from a large national survey (with 450-650 local respondents), Richmond borough performs relatively well for indicators on excess weight and physical activity, and is 'best' in the country for the indicator on inactivity (i.e. lowest percentage of people who are inactive). However, although Richmond borough's figures look good compared to other areas, there are substantial numbers of local people affected by obesity and physical inactivity. Almost half of all adults are estimated to be overweight or obese (approximately 72,000 people) and an estimated one in six adults do less than 30 minutes of physical activity per week (approximately 25,000 people). In addition, there is usually some over-reporting in surveys when people are asked about physical activity, with people saying that they do more than they actually do – so the number of inactive adults is likely to be even higher. Despite the green ratings, this is an area of significant concern.

Diabetes is a major cause of premature death and 90% of people with diabetes will also have at least one other condition. In Richmond borough, it is estimated that 3.7% of adults have been diagnosed with diabetes – around 5,700 people. This is the lowest in the country, with London and England at around 6%. We would expect Richmond borough to have a relatively low prevalence of diabetes due to the ethnic make-up of the population (low numbers of people from South Asian and black ethnic groups) and the low level of deprivation. National modelling suggests that there are up to 4,200 people with diabetes in Richmond borough who have not been diagnosed. Adding together the estimated number of people with diabetes who have been diagnosed and those who have not been diagnosed (a total of 6.5%), Richmond borough still has one of the lowest estimated percentages of people with diabetes in the country.

Smoking

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
Smoking prevalence - adults (per cent)	1	1	14%	2012	=
Smoking prevalence - adults with routine/manual occupation (per cent)	1	1	18%	2012	=

Smoking is the single most preventable cause of ill health and early deaths. Smoking is linked to cancers (lung, throat, mouth and bladder), breathing problems and heart disease. Half of all smokers will die prematurely from a smoking-related disease.

The costs of smoking are partly for the NHS, but also for wider society through the costs of social care support, cleaning up cigarette butts, tackling fires caused by smoking and lost productivity for employers.

Richmond borough has a relatively low prevalence at 14% of adults compared to 18% in London and 19.5% in England. The prevalence data is based on a survey and the estimate for Richmond borough has fluctuated over the last few years. Despite the green rating, this is an area of significant concern as substantial numbers of people are affected – over 20,000 people are smokers and it is estimated that there are over 200 deaths and 1,000 hospital admissions every year related to smoking.

Although local partners are committed to ongoing initiatives to reduce the prevalence of smoking, such as supporting people to quit smoking and supporting young people not to start smoking, national-level tobacco control policies such as raising taxes have been found to have the biggest impact on reducing the number of smoking-related deaths and disabilities[15].

Substance misuse

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
Opiate treatment completion (per cent)	2	1	11%	2012	+
Non-opiate treatment completion (per cent)	2	3	39%	2012	-
Alcohol-related admissions (per 100,000)	1	1	431	2012/13	=

Substance misuse has a substantial negative impact on health and is also related to crime and community safety, road traffic incidents, housing, employment support and welfare benefits. Alcohol and drug use can also be associated with domestic violence and adverse effects on children and young people.

Becoming free from dependency on drugs has a significant impact on health and wellbeing, for example a reduced transmission of blood-borne viruses, improved physical and mental health and increased life expectancy. Cessation of drug use also significantly reduces reoffending rates (see the section on crime and safety).

There are two indicators that measure the impact of Richmond borough drug treatment services on enabling people to become free from dependency on drugs. These measure the proportion of service users who successfully completed treatment and did not return to the service within the next six months.

There are currently around 480 Richmond borough clients in drug treatment (280 opiate users and 200 non-opiate users). Many also have drinking problems.

Richmond borough ranks in the top 25% of local authorities in England for successful treatment completions for people using opiates (e.g. heroin). In 2012, 11% of Richmond borough opiate users successfully completed treatment, compared to 9.6% in London and 8.2% in England. This also compares well with neighbouring Kingston (8%).

In 2012, 39% of Richmond borough non-opiate users successfully completed treatment, compared to 35% in London and 40% in England. This also compares relatively well with neighbouring Kingston (28%).

Although the proportion of successful completions appears to be increasing for opiate users and decreasing for non-opiate users, trend data for both of these indicators should be treated with caution as numbers are relatively small each year.

It is important to recognise that the level of successful completions will be influenced by the complexity of client cases. Overall Richmond borough has a treatment population of less complex cases compared to other local authorities. Therefore, Richmond borough's performance would be expected to be comparatively good in relation to London and England.

Although indicators on successful completions of treatment are important, it is also important to ensure that people who are at risk of, or are engaging in, substance misuse actually access prevention, early intervention and treatment services as necessary. Some local prevalence estimates are provided by the National Treatment Agency (now Public Health England) for opiate users. It is estimated that 630 people aged 15-64 in Richmond borough are dependent on opiate and/or crack cocaine use.

Rates of alcohol related admissions to hospital are a measure of the avoidable harm caused by alcohol, as well as the cost to the NHS. Over the last five years Richmond borough rates have been generally stable. Richmond borough has lower

rates of admissions compared to London and England. Nevertheless, there were 733 alcohol-related hospital admissions in 2012-13. Such admissions are potentially avoidable through prevention measures.

There are other important indicators that are not in the Outcomes Frameworks that help to understand substance misuse issues in the local population. For example, significant numbers of Richmond borough residents are estimated to be drinking alcohol at levels potentially harmful to their health, and Richmond borough ranks poorly compared to other local authorities. Around 15,000 adults are estimated to be drinking at higher risk levels.

Two indicators on young people's drug and alcohol misuse are included in the chapter on children and young people.

Falls prevention

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
Injuries due to falls - over-65s (per 100,000)	1	2	2,033	2012/13	+
Injuries due to falls - 65-79 yrs (per 100,000)	2	3	1,039	2012/13	+
Injuries due to falls - over-80s (per 100,000)	1	2	4,913	2012/13	=
Hip fractures in people - over-65s (per 100,000)	2	1	519	2012/13	=
Hip fractures in people - 65-79 yrs (per 100,000)	4	3	260	2012/13	=
Hip fractures in people - over-80s (per 100,000)	2	1	1,270	2012/13	=

Falls are the leading cause of older people being admitted to hospital as an emergency. Having a fall can have a significant negative impact on long-term outcomes, and can often lead to an older person having to move out of their own home into nursing or residential care. More than 95% of hip fractures are caused by falling. Identifying people at risk of falling and providing appropriate support (e.g. balance training or an assessment of home hazards) can help to prevent falls.

Richmond borough has a relatively large elderly population living on their own (see the section on loneliness and isolation). People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year. Some studies report a higher prevalence of falls amongst people who are lonely and isolated. Tackling loneliness and isolation should be part of a wider strategy to prevent falls in the elderly.

There are a large number of different indicators for falls and hip fractures as they are reported for different age groups. This is because the risk of falls increases by age (see paragraph above), and also because falls prevention initiatives tend to be different for younger, active people than for older, frailer people.

Richmond borough's performance is similar to or better than London and England for these indicators, except for the rate of hip fractures in people aged 65-79 which is now higher than in London (a red rating). Substantial numbers of local people are affected by falls – with 620 injuries and 160 hip fractures in 2012-13 in people aged 65 and over.

HIV late diagnosis

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
HIV late diagnosis (per cent)	1	1	41%	2010-12	N/A

Diagnosing HIV at an early stage means that someone can access effective treatment, experience substantially improved health outcomes and is significantly less likely to pass on the infection to other people. Being diagnosed after the point at which someone should have started treatment (late diagnosis) is the most important predictor of morbidity and mortality among those with HIV infection.

It is estimated that there are around 100 people in Richmond borough living with HIV who are unaware of their HIV status. The prevalence of HIV in Richmond borough is 2.4 per 1,000 people (aged 15-59 years), which makes the borough a 'high prevalence' area (defined as having a prevalence above 2 per 1,000 people).

During 2010-12, 41% of new cases in Richmond borough had a late diagnosis which equates to around eight people per year. Due to very low numbers it is difficult to meaningfully compare this figure with other areas.

Despite the low numbers and the green rating, this is an important area for improvement in Richmond borough due to the substantial potential to improve health outcomes in the individuals diagnosed, to reduce the risk of onward transmission and to reduce long-term health and social care costs.

Screening and health checks

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
Diabetic retinopathy screening take-up (per cent)	1	1	87%	2011/12	N/A
Breast cancer screening coverage (per cent)	2	4	70%	2013	=
Cervical cancer screening coverage (per cent)	2	3	72%	2013	=
NHS health checks offered (per cent)	2	1	25%	2013/14	N/A
NHS health checks take-up (per cent)	3	3	44%	2013/14	N/A
NHS health checks received (per cent)	2	2	11%	2013/14	N/A

Screening is an evidence-based method of identifying apparently healthy people who may be at an early stage of a disease or health condition. Information, further tests and treatment (if necessary) can then be provided to reduce the risk of poor health outcomes.

Diabetic retinopathy

All people with diabetes are at risk of getting diabetic retinopathy, which is one of the most common causes of sight loss and blindness in the UK. It may not cause symptoms until it is quite advanced so people with diabetes are offered regular eye screening tests as part of a national programme. This allows prompt identification and effective treatment, if necessary.

While some people with diabetes may choose to decline an offer of screening, the level of uptake is an important indicator of the management of diabetes. With 87% uptake, Richmond borough has the third highest percentage of people screened in London.

Breast and cervical screening

The breast and cervical screening programmes play an important role in reducing late diagnosis of cancer. Improvements in screening coverage would mean that more cancers are detected at earlier, more treatable stages.

In Richmond borough, 70% of eligible women received breast screening. This is higher than in London (69%) but lower than the England value (76% - a red rating). In Richmond borough, 72% of eligible women received cervical screening, compared to 69% in London and 74% in England. However, we do not have information on women attending screening at private clinics, which may give an underestimate of true uptake.

There has been international debate in recent years about the balance between the benefits of breast screening and the potential harms (e.g. anxiety and people undergoing treatment that they may not have needed). With a generally well-educated population in the borough of Richmond borough, this debate is likely to decrease uptake.

NHS Health Checks

All healthy adults aged 40-74 are offered an NHS Health Check every five years. This assesses an individual's risk of diabetes, heart disease, kidney disease, stroke and dementia and provides an opportunity to be given support and advice to help prevent long-term problems. This may include a referral to lifestyle support programmes, such as weight management or healthy walks.

National prevalence models suggest that there are large numbers of people with undiagnosed long-term conditions in Richmond borough – for example, up to 2,700 people with undiagnosed coronary heart disease and 4,200 people with undiagnosed diabetes (see the section on obesity and diabetes). Coronary heart disease and stroke contribute to a lower life expectancy in the most deprived areas in Richmond borough.

There are three indicators in the Outcomes Framework for the health checks programme. The first one looks at the percentage of the eligible population who have been invited to have a check ('NHS health checks offered') – this is measured on a five-year cycle so the aim is that around 20% of those eligible should be offered a check each year. The second indicator looks at the percentage of people who received a check out of those offered one ('NHS health checks take-up'). The national aim is for at least 50% uptake in 2013-14, rising to 66% in 2014-15 and 75% in 2015-16. The third indicator measures the percentage of the eligible population who received a check and is therefore an overall measure of programme performance ('NHS health checks received').

The indicators have recently started to be reported as cumulative measures over a five-year cycle, rather than for individual years. This may make it more difficult to interpret performance for a particular year.

Richmond borough performs relatively well on these indicators.

2013-14 is the first year of a five-year cycle. During 2013-14, 11% of everyone eligible has so far received a check, which is similar to London (10%) and England (9%). Achievement of around 10% is what would be expected, as this indicates that everyone eligible in that year was offered a check and half of them took up the offer. Kingston has a particularly high figure (18%) as more people were invited than would be expected in the year.

These indicators only measure the performance of the Health Checks programme, and do not measure the subsequent activity, such as onward referrals to lifestyle programmes, changes in lifestyles and improvement in people's long-term health. Referral figures are collected locally for monitoring purposes.

Infectious diseases

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
PPV immunisation - over-65s (per cent)	1	3	68%	2012/13	-
Flu vaccination - over-65s (per cent)	1	2	75%	2012/13	=
Flu vaccination - at risk groups (per cent)	2	2	53%	2012/13	=
Tuberculosis incidence (per 100,000)	1	3	8.0	2010-12	N/A

There are two national immunisation programmes for adults – for pneumococcal disease and influenza.

Pneumococcal disease is a significant cause of morbidity and mortality among vulnerable groups, including the elderly. It can cause septicaemia, pneumonia and meningitis. The Pneumococcal Polysaccharide Vaccine (PPV) is offered to people aged 65 and over, and to people with long-term health conditions. PPV coverage is 68% in Richmond borough, compared to 64% in London and 69% in England.

Influenza (or flu) is highly infectious. It is a serious disease that can lead to hospitalization and sometimes death. Increasing the uptake of flu vaccine also helps to ease winter pressures on health and care services. Flu vaccination is offered each year to people aged 65 and over as well as people in clinical risk groups (including children from age 6 months). These groups are at greater risk of developing serious complications, such as bronchitis and pneumonia. In Richmond borough, 75% of eligible adults aged 65 and over received the flu vaccine in 2012-13, which is higher than in London (71%) and England (73%). Just over half (53%) of at risk individuals (excluding pregnant women) were vaccinated in Richmond borough, compared to 51% in London and England. Uptake among pregnant women is reported separately (not in the Outcomes Frameworks) – this group is at risk from flu but otherwise 'healthy' and it is difficult to accurately identify the denominator.

Tuberculosis (TB) is a serious condition but can be cured. It usually affects the lungs but can affect other parts of the body. If left undiagnosed, an individual with infectious TB can infect 10 to 15 other people over a year. Richmond borough has a low level of TB cases, with a rate of 8.0 new cases per 100,000 per year compared to 41.4 in London and 15.1 in England. However, other boroughs in London have high rates, including Hounslow (74.4 per 100,000 population). Efforts to prevent TB include early diagnosis and treatment of individuals as well as offering the BCG vaccine. BCG vaccine is offered for babies born in areas of high incidence (such as at West Middlesex Hospital in Hounslow) but not for babies born in areas of lower incidence (such as at Kingston Hospital). Therefore, some Richmond borough children will have received the BCG vaccine at birth and others not.

Children and young people

What does this mean for Richmond borough?

- Most children and young people living in Richmond borough are healthy and have a good start in life. Many of the outcomes for Richmond borough are better than in London and England. However not all children and young people enjoy similar positive outcomes and consequently have the same chances of good health when they are adults. This includes those with additional educational needs and those with disabilities.
- These inequalities in outcomes can be reduced through prevention and early intervention – the role of both universal and targeted health, children's and education services. Early help is critical in helping buffer the impact of adverse family circumstances such as low income or parental mental health problems.
- 'School readiness' is a key measure of a child's developmental progress at five years of age. Richmond borough had a low ranking in London and England in 2012-13. It is likely that this ranking reflects inconsistencies in applying the new assessment processes (recently introduced) in different areas. In 2014 there was significant improvement, with 64% of children securing a good level of development which was above the national figure (60%). Nevertheless there is clear variation in this outcome measure among children in Richmond borough, with children from poorer social backgrounds doing less well.
- Although levels of childhood poverty and rates of children in care are lower in Richmond borough compared to other local authorities, these children are at higher risk of experiencing poor outcomes throughout their lives unless services effectively intervene. There are an estimated 3,500 children under age 16 who are living in poverty in the borough.
- Richmond borough has lower levels of coverage for all childhood vaccinations compared to figures for England. Although local coverage has been improving year on year, it is currently below the 95% level needed to protect all local children and young people from serious infectious diseases.
- Levels of overweight and obesity among primary school aged children in Richmond borough are significantly lower than nationally. Nevertheless, approximately 3,000 primary school aged children are overweight or obese. In addition, between reception and year six levels of obesity double in Richmond borough (which reflects national trends).
- Richmond borough has the best performance in London on dental health of children. However, around one in six children aged five have at least one tooth that is decayed, missing or filled - these are wholly preventable.
- Richmond borough has a comparatively low teenage conception rate, but still around 50 teenagers conceive per year and one-third of these will become teenage mothers. The indicator for Chlamydia detection needs careful interpretation, as it is used as a success measure of a screening programme which aims to identify asymptomatic cases that may not otherwise be diagnosed and treated, i.e. the higher the rate, the better. Richmond borough has a relatively low detection rate (a red rating).
- Alcohol and drug misuse are markers of risky behaviours and vulnerability among young people. The rate of hospital admissions for substance misuse among young people is lower than rates for London and England. However, the Richmond borough rate of hospital admission due to alcohol-specific conditions (39 per 100,000 of under 18 year olds) was sixth highest among London boroughs. While actual numbers of alcohol and drug related admissions are small, such admissions are avoidable.
- In 2012-13 the Richmond borough rate of hospital admissions for self-harm in young people was the fourth highest among London boroughs. There were 222 admissions for self-harm over a three-year period.
- There are almost 7,000 A&E attendances in children under age 5 per year. Despite a comparatively positive ranking and improvement from the previous year, these attendances are often avoidable and many could have been treated in primary care.
- Injuries are a leading cause of hospitalisation and premature mortality among children and young people. In 2012-13 the Richmond borough rates for hospital admissions due to injuries for age groups under 25 years were lower than in England but above rates in London. This represented 520 admissions among children and young people that may have been avoided through preventative measures.

Introduction

There is now strong evidence demonstrating that what happens early in life affects health and wellbeing in later life[16]. Furthermore there is a strong economic case for improving the health and wellbeing outcomes of children and young people - the long term societal costs of adverse outcomes such as premature births, childhood obesity and mental health are significant.

The new Children and Families Act 2014 reflects this life course perspective – with reforms particularly relating to Special Educational Needs and Disabilities (SEND) as an opportunity to improve the life chances of those with additional needs.

Improving health and wellbeing is a key aim of Richmond borough's Children and Young People's Plan 2013-17. The outcomes indicators in this chapter help measure progress towards this aim.

Healthy start

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
Smoking in pregnancy (per cent)	1	1	2.5%	2012/13	-
Breastfeeding initiation (per cent)	1	1	91%	2012/13	=
Low birthweight - live births (per cent)	1	2	2.6%	2011	=
Low birthweight - live and still-births (per cent)	1	2	6.4%	2012	=
Admission of full-term babies to neonatal care (per cent)	1	1	3.1%	2011	N/A
Neonatal mortality and stillbirths (per 1,000)	1	1	3.1	2012	=
Infant mortality - under 1s (per 1,000)	1	1	2.7	2010-12	=
Child mortality - 1-17 yrs (per 100,000)	2	2	11	2010-12	-

Key outcome indicators show that most children in Richmond borough have a good start in life.

Few mothers in Richmond borough smoke during pregnancy – 2.5% (65) compared to 5.7% in London and 12.7% in England (2012-13). This is a reduction in Richmond borough from 4.2% in 2010-11. 91% of mothers (2,384) initiated breastfeeding compared to 87% in London and 74% in England. These positive outcomes are important predictors of a child's healthy development.

In Richmond borough 2.6% of all live births were of low birthweight (under 2500g) in 2011, compared to 3.2% in London and 2.8% in England. This equated to 69 low birthweight babies. Richmond borough ranked tenth lowest in London for this outcome. However this is a slight increase in low weight births in Richmond borough compared to the previous five years. A similar pattern of performance is evident for the number of low weight births as a proportion of all live and still births.

Richmond borough rates of admission of full term babies to neonatal care are comparatively low - 3.1% of births (83 babies), compared to 6.9% in England in 2011.

Infant mortality is a sensitive measure of the overall health of the population. Fewer infants die under one year of age in Richmond borough – 2.7 per 1000 live births, compared to 4.1 in London and England in 2010-12. This equated to 24 deaths, and there was a reduction from a rate of 3.3 in 2009-2011. This comparatively low level of infant mortality is a reflection of the positive living conditions that influence the overall positive health status of the Richmond borough population.

The Richmond borough child mortality rate (deaths at age 1-17 years) was 11 per 100,000 in 2010-12, compared to 14 in London and 13 in England. After the age of one, the commonest cause of death in young people is injuries. Although in Richmond borough the number of child deaths is small (13 deaths in 2010-12), some may be avoidable.

Readiness for school and education attainment

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
Children with good development within Early Years Foundation Stage Profile (per cent)	4	4	43%	2012/13	N/A
Children with free school meal status achieving a good level of development within Early Years Foundation Stage Profile (per cent)	4	4	21%	2012/13	N/A
Year 1 pupils achieving expected level in phonics screening check (per cent)	1	1	79%	2012/13	N/A
Year 1 pupils with free school meal status achieving expected level in phonics screening check (per cent)	3	1	60%	2012/13	N/A
GCSE achieved - 5A*-C including English and maths (per cent)	1	1	68%	2012/13	+
Pupil absence (per cent)	1	1	4.5%	2012/13	N/A

Early child development and educational attainment are important determinants of future health and wellbeing. Performance is influenced by quality of provision but most significantly by family social background.

'School readiness' is a key measure of a child's developmental progress at five years of age at the end of the Early Years Foundation Stage – EYFS (end of reception). It is a key marker of early years' experiences, including the quality of parenting and early learning environment.

Children are defined as having reached a good level of development (GLD) if they achieve at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development; physical development; and communication and language and the early learning goals in the specific areas of mathematics and literacy.

In 2012-13, 43% of children in Richmond borough achieved a good level of development. This was lower than the London figure of 53%, and England of 51%. However it is important to note that this is a new indicator that reflects significant recent changes in the way children are assessed at the end of the early years foundation stage. The comparatively low ranking of Richmond borough is likely a reflection of inconsistencies in applying this new assessment process in different areas.

In 2014 there was significant improvement, with 64% of Richmond borough children securing a good level of development, which was above the national figure (60%).

Nevertheless there is clear variation in this outcome measure among children in Richmond borough, with children from poorer social backgrounds doing less well. 21% of children with free school meal status achieved a good level of development.

School readiness is further assessed at Key Stage 1 using the measure of the phonics screening check at year 1. This is a measure of a child's achievement against the expected level for a range of development areas (reading, writing, speaking and listening). At this stage Richmond borough achieved a higher ranking – 79% of Richmond borough pupils achieved the

expected level, compared to 72% in London and 69% in England. This is the best in London and second best in England. However, the marked inequality seen in the readiness for school indicator also persists in this indicator, with 60% of pupils with free school meal status achieving the expected level in the phonics check.

In 2012-13, 68% of pupils achieved 5 or more GCSEs at grade A*-C including English and Maths in state maintained schools. This was the eighth highest in London. It is above the performance in London and England (65% and 61% respectively).

Richmond borough has one of the lowest levels of pupil absence in London and in England (as measured by percentage of half days missed due to overall absence – authorised and unauthorised). In 2012-13 the Richmond borough absence rate was 4.5%, compared to 4.8% in London and 5.3% in England. This is an improvement in Richmond borough from 5.4% in 2010-11.

Vulnerable children and young people

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
Children in poverty - under-16s (per cent)	1	1	10%	2011	-
Children in poverty - dependent children under 20 (per cent)	1	1	10%	2011	-
Children in care (per 10,000)	1	1	20	2013	=
Emotional wellbeing of children in care (average difficulties score)	2	1	13.1	2012/13	=
Children in care up-to-date with immunisations (per cent)	1	1	100%	2013	=

Evidence clearly demonstrates that childhood poverty can lead to premature mortality and poor health outcomes in adulthood.

Ten per cent of children under 16 years live in poverty in Richmond borough, compared to 27% in London and 21% in England. These are children living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% of median income. Richmond borough has the lowest level of child poverty of all London boroughs and the fifth lowest in England. This is a downward trend from 12% four years previously.

Although this is comparitively positive, around 3,500 children under 16 are living in poverty in the borough.

Children in care are a particularly vulnerable group and generally do worse than their peers in terms of their physical and mental health, and also their education. Richmond borough has low rates of the child population in care - 20 per 10,000 under 18 years, compared to 55 in London and 60 in England in 2013. This equates to 85 children and young people.

The emotional wellbeing of looked after children is measured as the average score reported on the 'strengths and difficulties' questionnaire (a validated tool for measurement of wellbeing). A higher score indicates greater difficulties (a score of under 14 is considered normal, 14-16 is borderline cause for concern and 17 or over is a cause for concern). This assessment tool is designed to ensure that risks relating to mental health, the breakdown of placement and poor educational outcomes are monitored and addressed. Children in care in Richmond borough have an average wellbeing (difficulties) score of 13.1, compared to 13.4 for London and 14.0 for England.

Richmond borough children in care are well supported by health services. Immunisation coverage for children in care (100%) is the best in London and among the best in England.

Immunisation

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
MMR immunisation - by age 2 (per cent)	2	4	88%	2012/13	=
MMR immunisation - one dose - by age 5 (per cent)	2	4	91%	2012/13	=
MMR immunisation - two doses - by age 5 (per cent)	3	4	80%	2012/13	=
Dtap/IPV/Hib immunisation - by age 1 (per cent)	2	4	94%	2012/13	=
Dtap/IPV/Hib immunisation - by age 2 (per cent)	2	4	95%	2012/13	=
MenC immunisation - by age 1 (per cent)	2	4	92%	2012/13	=
Hib/MenC immunisation - by age 2 (per cent)	3	4	87%	2012/13	=
Hib/MenC immunisation - by age 5 (per cent)	3	4	87%	2012/13	N/A
Hepatitis B immunisation - by age 2 (per cent)	4	4	40%	2012/13	=
PCV immunisation - by age 1 (per cent)	2	4	93%	2012/13	=
PCV booster immunisation - by age 2 (per cent)	3	4	88%	2012/13	=
HPV immunisation - 12-13 yr old girls (per cent)	3	4	79%	2012/13	=

Vaccination coverage is the best indicator of the level of protection (immunity) that a population has against vaccine preventable communicable diseases.

Currently the European Region of the World Health Organisation recommends that on a national basis at least 95% of children are immunised against diseases preventable by immunisation – specifically diphtheria, tetanus, pertussis, polio, Haemophilus influenza type b (Hib) and measles, mumps and rubella (the MMR vaccine covers all three).

The indicators in the Outcomes Framework measure the level of vaccination coverage achieved for each of these different diseases. Richmond borough coverage is currently below the 95% level needed to protect all local children and young people from certain serious diseases.

Richmond borough has lower levels of coverage for all childhood vaccinations compared to the figures for England. Richmond borough's performance ranks within the bottom 25% of boroughs in England. Richmond borough's performance, compared to other London boroughs, is better. However, childhood immunisation coverage in London is widely incomplete against the target of 95%.

Childhood MMR vaccination coverage is particularly low. In 2012-13 in Richmond borough, 80% of children received 2 doses before the age of 5, compared to 89% in London and 88% in England. In Kingston 84% was achieved.

In the UK, all 12-13 year old girls (school year 8) are offered vaccination against Human Papilloma Virus (HPV) through the national HPV immunisation programme. The HPV vaccine protects against the two types of HPV that cause over 70% of cervical cancers. 79% of 12-13 year old girls in Richmond borough received the HPV immunisation in 2012-13 compared to 79% in London and 86% in England.

NHS England is responsible for commissioning immunisation programmes, and Public Health teams in local authorities are responsible for liaising with NHS England to ensure that effective immunisation programmes are offered to their local population.

Healthy weight

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
Overweight or obese - age 4-5 yrs (per cent)	1	1	16%	2012/13	=
Overweight or obese - age 10-11 yrs (per cent)	1	1	26%	2012/13	=
Obese children - age 4-5 years (per cent)	1	1	5.7%	2012/13	=
Obese children - age 10-11 years (per cent)	1	1	12%	2012/13	=

Children who are overweight or obese can experience poorer physical and mental health during childhood and are at greater risk of cardiovascular disease and diabetes in later life.

The outcomes indicators look at the levels of overweight children, including those children who are obese, among primary school aged children based on the findings of the National Child Measurement Programme (NCMP). This measures the weight and height of children in reception class (age 4-5) and year 6 (age 10-11)▼.

Levels of overweight and obesity among primary school aged children in Richmond borough are lower than in London and England (2012-13).

In reception year 16% of children are overweight or obese, making Richmond borough the second lowest in London and eighth lowest in England. In Kingston 16% of children are overweight or obese. Six per cent of Richmond borough reception children are obese.

In Year 6 the level of overweight and obesity is 26%. Richmond borough has the lowest level of overweight and obesity at Year 6 in London. In Kingston 30% of children are overweight or obese. 12% of Richmond borough Year 6 children are obese.

Despite Richmond borough's positive ranking, approximately 3,000 primary school aged children are overweight or obese.

In addition, between reception and Year 6 levels of obesity double in Richmond borough (which reflects national trends). There has been a slight increase since 2006-7 in the percentage of children who are overweight and obese at Year 6, although a slight reduction at reception age.

▼ Children's heights and weights are measured and used to calculate a Body Mass Index (BMI) centile.
- Overweight is defined as a BMI greater than or equal to the 85th centile but less than the 95th centile (i.e. overweight but not obese).
- Obese is defined as a BMI greater than or equal to the 95th centile.

Dental health

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
Children with decayed/missing/filled teeth (per cent)	1	1	17%	2011/12	N/A
Tooth decay in children aged 5 - number of decayed/missing/filled teeth	1	1	0.4	2011/12	N/A

Two childhood dental health indicators are included in the Outcomes Frameworks. These are based on the regular national surveys conducted in state maintained primary schools, as part of the National Dental Epidemiology Programme (NDEP) for England. The indicators are good direct measures of dental health but also act as indirect, proxy measures of child health and diet.

In 2011-12, 17% of Richmond borough children aged 5 had one or more decayed, missing or filled teeth, compared to 33% for London and 28% for England. Richmond borough had the best (lowest) figure among London boroughs for this indicator.

'Tooth decay in children in children aged 5' measures the average number of teeth per child that are decayed or have been filled or extracted. Richmond borough has the best figure (0.40 teeth) among London boroughs. London's figure was 1.23 and England's was 0.94.

Sexual health

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
Teenage conceptions - 13-15 yrs (per 1,000)	1	1	2.8	2012	=
Teenage conceptions - under-18s (per 1,000)	1	1	20	2012	=
Teenage mothers - under-18s (per cent)	1	1	0.5%	2012/13	+
Chlamydia detection - 15-24 yrs, CTAD data (per 100,000)	3	4	1,308	2012	N/A
Acute sexually transmitted infections - including Chlamydia (per 1,000)	1	2	31	2012	N/A

Teenage pregnancy is generally associated with poorer health, education and economic outcomes for young parents and their children. The teenage conception rate in Richmond borough is relatively low. Around 50 teenagers conceive per year in Richmond borough and one-third of these will go on to become teenage mothers.

Chlamydia is the most prevalent sexually transmitted infection (STI) in England, particularly among young adults. Most people with Chlamydia do not have any symptoms. If left untreated, Chlamydia infections can persist for months or years and can lead to long-term fertility problems. The National Chlamydia Screening Programme (NCSP) seeks to address this issue by regularly testing sexually active under-25s who do not have any symptoms.

The detection rate is used as a success measure of the NCSP which aims to identify asymptomatic cases that may not otherwise be diagnosed and treated. To help with interpretation, the name of the indicator in the Public Health Outcomes Framework has recently been changed from 'Chlamydia diagnoses' to 'Chlamydia detection rate' – the higher the detection rate, the better. The NCSP recommends that local areas achieve a rate of 2,300 per 100,000 young people. In Richmond borough, the detection rate was 1,308 per 100,000 in 2012 (a red rating) compared to 1,979 per 100,000 in England (London-wide data not available).

There are two elements to the NCSP – percentage of eligible age group screened each year (coverage) and percentage of those screened who receive a positive result (positivity). Both elements are slightly lower in Richmond borough than other areas. Using 2012 data, Richmond borough achieved 24% coverage compared to 26% in England, and 5.5% positivity compared to 7.7% nationally.

Richmond borough rates of acute STIs among young people (aged 15-24) are comparatively low at 31 per 1000, compared to 42 in London and 34 in England.

Use of drugs and alcohol

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
Substance misuse hospital admissions - 15-24 yrs (per 100,000)	3	2	77	2010/11-2012/13	N/A
Alcohol-specific hospital admissions - under-18s (per 100,000)	4	2	39	2010/11-2012/13	=

Alcohol consumption and drug and alcohol misuse are markers of risky behaviours and vulnerabilities among young people.

Evidence suggests that use of recreational drugs increases the risk of damage to mental health including suicide, depression and disruptive behaviour disorders. Regular use of cannabis or other drugs may also lead to dependence. Other adverse outcomes of drug use include truancy, exclusion from school, homelessness, time in care and serious or frequent offending.

In Richmond borough, 77 per 100,000 15-24 year olds were admitted to hospital for drug related disorders, compared to London (58) and England (75) (2011-13). Although the numbers were comparatively small (41 young people), the amber rating indicates that some admissions are avoidable through prevention measures.

Alcohol misuse in young people is a major contributor to criminal and antisocial behaviour. Although evidence suggests that the number of teenagers who drink has decreased nationally in recent years, the amount of alcohol drunk by those who do drink has increased.

The Richmond borough rate of hospital admissions due to alcohol specific conditions (39 per 100,000 of under 18 year olds) was higher than London (29) but lower than England (43). Although again actual numbers for Richmond borough were small (16 young people), this is a red rating for the comparison with London. Such admissions and related negative outcomes are potentially avoidable through prevention and early intervention measures.

Mental health

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
Mental health hospital admissions - under-18s (per 100,000)	2	2	67	2012/13	=
Self-harm hospital admissions - 10-24 yrs (per 100,000)	4	2	275	2012/13	N/A

Currently the national Outcomes Frameworks include two indicators that directly measure levels of mental health problems among children and young people. Nationally, one in ten children aged 5-16 years has a clinically diagnosable mental health problem and, of adults with long-term mental health problems, half will have experienced their first symptoms before the age of 14.

Also self-harming is known to be much more common in children and young people with mental health disorders – with 10% of 15-16 year olds having self-harmed.

In 2012-13, the Richmond borough rate of hospital admission for mental health conditions under 18 years was 67 per 100,000 population – below the London and England rates (both 87). This compares with the rate of 48 per 100,000 population in Kingston. The Richmond borough rate equates to 28 young people under 18 years and there was a fall in the rate over the last three years.

In 2012-13, the Richmond borough rate of hospital admissions as a result of self-harm in those aged 10-24 years was lower than in England (275 per 100,000, compared to 346 for England). However, Richmond borough ranked the sixth highest among London boroughs (a red rating). In a three-year period (2010-11 to 2012-13), there were 222 hospital admissions as a result of self-harm in those aged 10-24 years.

Hospital care

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
A&E attendances - 0-4 yrs (per 1,000)	1	2	484	2011/12	N/A
Injury hospital admissions - 0-4 yrs (per 10,000)	3	2	111	2012/13	+
Injury hospital admissions - 0-14 yrs (per 10,000)	3	2	93	2012/13	=
Injury hospital admissions - 15-24 yrs (per 10,000)	3	1	104	2012/13	=
Asthma hospital admissions - under-18s (per 10,000)	1	1	94	2012/13	N/A

In 2011-12 there were 6,816 A&E attendances for Richmond borough children aged under 5 years. Richmond borough attained a positive ranking – with a rate of 484 per 1,000 population aged 0-4 years, compared to 693 in London and 511 in England. This was the lowest rate in London and is also an improvement from the previous year. Despite this comparatively positive ranking these attendances are often avoidable and many could have been treated in primary care.

Injuries (unintentional and deliberate) are a leading cause of hospitalisation and represent a major cause of premature mortality for children and young people. In 2012-13 there were 338 hospital admissions of Richmond borough children aged 0-14 years due to injury – 93 per 10,000 compared to 85 in London and 104 in England. There were 182 hospital admissions of Richmond borough 15-24 year olds due to injury (104 per 10,000 compared to 101 in London and 131 in England). Richmond borough's rating in London is amber, while nationally it is green. This may be a reflection of the better performance of London boroughs overall (lower rates of hospital admissions).

Asthma is the commonest long-term medical condition in childhood. Emergency admissions to hospital should be avoided whenever possible. Richmond borough has significantly lower rates of emergency admissions for asthma than in London and England. In 2012-13 the Richmond borough rate was 94 per 100,000 compared to 212 in London and 221 in England. This was the lowest of all London boroughs and equated to 41 admissions, with a reduction seen from the previous year.

Integrated health and social care

What does this mean for Richmond borough?

- Richmond borough achieves comparatively positive rankings for many of the health and social care outcome indicators. Nevertheless there is potential for improving outcomes in a number of areas. The Richmond borough Out of Hospital Care Strategy and implementation of the Care Act reforms provide the framework for securing improvements.
- Richmond borough performs well in avoiding unnecessary emergency admissions to hospital. Richmond borough rates of avoidable hospital admissions for chronic and acute conditions are the fifth lowest in London. However there are still around 2,000 hospital admissions (all ages) annually of Richmond borough residents that are deemed 'avoidable'. These are conditions that could be treated through alternative preventative and community based services.
- Securing effective discharge of patients from hospital is dependent on many factors and is a complex aspect of care. Over the last three years there has been a continued increase in the rate of delayed discharge of Richmond borough patients from hospital due to issues relating to social services. Improving this outcome is a key focus in the Richmond borough Out of Hospital Care Strategy.
- Outcomes measuring support to recovery of patients following discharge from hospital show improvements over the past three years. In 2013-14 Richmond borough ranked in the top 25% of boroughs in London and in England on the indicator measuring the proportion of older people who are being offered reablement following hospital discharge; and most of those receiving support were able to remain at home (and not readmitted within 91 days of discharge).
- Richmond borough is performing well in providing more personalised services. Self-directed support, such as use of personal budgets, gives people more choice over how their community-based care and support works. In Richmond borough 98% of people using community-based services received self-directed support (2013-14). Richmond borough ranked the third highest borough in England for this outcome.
- The indicator 'social care related quality of life' is an overall measure of users' satisfaction with different aspects of care and support (such as dignity, personal care, food and nutrition and safety). Richmond borough ranks in the top 25% of similar local authorities and in England. The results are based on a representative sample of Richmond borough users of social services participating in the annual Adult Social Care Survey. It is important to note that the results do not at present identify directly the contribution of a local authority's adult social care services towards this quality of life outcome.
- 60% of Richmond borough users reported that they were extremely satisfied or very satisfied with the care and support they received. This was similar to the user satisfaction rating in comparator local authorities, but was markedly lower than England (65%).
- For carer reported quality of life scores, Richmond borough ranks in the top 25% of similar local authorities, and in the middle range for England as a whole (national Carers Survey). However, reported overall satisfaction of carers with social services is less positive.
- Richmond borough patients' reported experiences of NHS health care was mixed, based on the results of the Richmond borough patient sample in the national GP survey.
- Health-related quality of life scores of patients with long term conditions rank in the top 25% of boroughs in London and in England. Similarly the proportion of patients who feel supported in managing their condition ranks in the top 25% of boroughs in London and in England.
- 52% of Richmond borough patients described their experience of out-of-hours GP services as Very Good or Fairly Good. This was lower than in England (66%) and London (58%).
- Feeling isolated and lonely has a profound negative effect on physical and mental health and wellbeing. This is especially important in Richmond borough, where we have the highest proportion of people aged over 75 living alone in London (51% compared to 35% in London). Compared to other areas, performance is relatively good. However, over half of social service users and carers do not have as much social contact as they would like.

Introduction

In recent years, out-of-hospital care has become a priority in national and local strategies with the aims of helping people maintain their health and independence as long as possible and support recovery from periods of ill health.

The duty to promote integrated services across health and social care around the 'needs and wellbeing' of the individual is central to the Care Act.

Richmond borough's Out of Hospital Care Strategy 2013-2017 (Richmond CCG and the London Borough of Richmond upon Thames), supported by the Better Care Fund, seeks to ensure that health and social care is provided in a more integrated way and closer to home. Many of the outcomes in this chapter provide the measures for assessing progress towards achieving the aims of the strategy.

Avoidable admissions and readmissions

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (per 100,000)	1	1	567	2012/13	=
Unplanned hospitalisation for asthma, diabetes and epilepsy - under 19s (per 100,000)	1	1	151	2012/13	-
Emergency admissions for acute conditions that should not usually require hospital admission (per 100,000)	1	1	841	2012/13	=
Emergency hospital admissions of children with lower respiratory tract infections (per 100,000)	2	1	228	2012/13	-
Emergency readmissions within 30 days of discharge from hospital (per cent)	2	3	12%	2011/12	=

Four indicators (above) measure the emergency admissions that could be avoided by primary prevention or community-based interventions. Richmond borough consistently performs well on these outcomes - with comparatively low rates of 'avoidable emergency admissions'.

Richmond borough has the fifth lowest rate of acute and chronic avoidable admissions (all ages) in London (2012-13). Nevertheless there are around 12,000 emergency admissions per year (all ages), and around 2,000 of these are deemed avoidable. It is the relatively small group of older people and people with three or more long-term conditions (frail and elderly) that accounts for the majority of avoidable admissions.

Emergency re-admissions following the first admission to hospital can also represent an indicator of adverse outcomes that could be avoided if suitable alternative community provision is in place (although other factors can affect the probability of readmission).

Richmond borough's rate of emergency readmissions ranked 'amber' among CCG/local authorities nationally (2011-12). 12% of emergency admissions by Richmond borough residents (all persons) were readmitted within 30 days of being discharged from hospital for the last previous admission.

Effective hospital discharge and rehabilitation

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
Delayed transfers of care from hospital (per 100,000)	3*	2	8.1	2013/14 - Provisional	+
Delayed transfers of care from hospital attributable to adult social care (per 100,000)	4*	2	2.3	2013/14 - Provisional	+
Older people who were offered reablement services following discharge from hospital (per cent)	1*	1	6.8%	2013/14 - Provisional	+
Older people who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (per cent)	2*	2	89%	2013/14 - Provisional	-

*ASCOF measure, peer comparison is against local authorities in CIPFA group.

'Delayed transfers of care' measures the impact of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults. A lower figure is better. It is an important measure of the quality of the interface between health and social care services. A delayed transfer of care occurs when a patient is assessed as ready for transfer from a hospital bed, but is still occupying such a bed.

The measure has two parts, and reflects 1) the overall number of delayed transfers of care, and 2) the number of these delays which are attributable to social care services. This measure specifically identifies delays due either to social care services, or both the hospital and social services.

Richmond borough ranked 75 out of all boroughs in England for the overall rate of delayed transfer of care (2013-14). Richmond borough's rate of delayed transfers (8.1 per 100,000 all persons) was lower than in England (9.7) but higher than the rate for similar local authorities (6.3).

Richmond borough's performance for delayed discharges due to social care services also ranked 75 out of all boroughs nationally (2013-14). However, for this outcome indicator, Richmond borough ranks in the bottom 25% of similar local authorities ('nearest neighbours'). In 2013-14 the rate was 2.3 per 100,000 compared to the rate of 1.8 for similar local authorities (and 1.4 for Kingston). Timely transfer of care is dependent on many factors and is a complex area. Over the last three years there has been a continued increase in the rate of delayed discharge due to social services. This shows that difficulties remain and consequently improvements are a key focus in the Out of Hospital Care Strategy.

Outcomes measuring support to recovery of people following an episode in hospital show improvements. In 2013-14, 6.8% of older people (65 years and above) who were discharged from hospital were offered reablement services. This is a marked increase in the proportion of older residents being offered reablement services in 2011-12. The proportion is markedly higher than in London (5.1%) and England (3.3%).

The majority of these older people in Richmond borough who received reablement services appeared to benefit, i.e. remained either at home or in other community based residence. 89% of older Richmond borough residents were still at home 91 days after being discharged from hospital to reablement services (2013-14) (and representing improvements from previous years). Richmond borough's performance is similar to London (88%) and higher than England (82%).

Community provision

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
Adults, older people and carers supported to receive self-directed support (per cent)	1*	1	98%	2013/14 - Provisional	+
Adults, older people and carers supported to receive self-directed support via a direct payment (per cent)	1*	1	41%	2013/14 - Provisional	+
Permanent admissions to residential and nursing care homes - 18-64 yrs (per 100,000)	1*	1	5.0	2013/14 - Provisional	=
Permanent admissions to residential & nursing care homes - over-65s (per 100,000)	2*	1	436	2013/14 - Provisional	=

*ASCOF measure, peer comparison is against local authorities in CIPFA group.

Self-directed support gives people more choice over how their social care and support works through the allocation and use of personal budgets. This is one measure of personalisation of services. A higher level of self-directed support implies greater personalisation of services. In Richmond borough 98% of people using community-based services received self-directed support, such as a personal budget (2013-14). Richmond borough was the third highest out of 150 boroughs for this outcome.

41% of people using community-based services receive self-directed support as a direct payment. Receiving payments directly lets recipients of care and their carers spend money on care and support in ways and at times that make sense to them. Richmond borough was the fifth highest out of 150 boroughs for this outcome.

Richmond borough has a significantly lower rate of admissions to residential care homes of adults aged 18-64 years – 5 per 100,000, compared to 14.4 for London and 8.9 for similar local authorities in 2012-13. This measure does not include people who are funding their own stay in a care home. Richmond borough's positive ranking for this outcome (sixth lowest in England) suggests community based support is helping people to remain at home, however the lower rate of admissions could in part reflect the high numbers of people in Richmond borough who self fund their stay in care.

Richmond borough has slightly higher rates of admissions of people over 65 years to residential care homes than similar local authorities (436 per 100,000, compared to 417 for similar local authorities and 668 in England). Richmond borough's positive ranking for this outcome (thirteenth lowest in England) suggests community based support is helping people stay independent at home, however the lower rate of admissions could in part reflect the high numbers of people in Richmond borough who self fund their stay in care.

Quality of life and users' experience of social care

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
Social care related quality of life (score)	1*	1	19.2	2013/14 - Provisional	=
Service users feeling safe (per cent)	1*	1	71%	2013/14 - Provisional	=
Service users feeling safe and secure (per cent)	3*	2	82%	2013/14 - Provisional	=
Service users who have control over their daily life (per cent)	1*	3	75%	2013/14 - Provisional	=
Service users satisfied with the care and support they receive (per cent)	2*	4	60%	2013/14 - Provisional	=
Ease of finding information about services - service users (per cent)	1*	1	81%	2013/14 - Provisional	N/A

*ASCOF measure, peer comparison is against local authorities in CIPFA group.

The Personal Social Services Adult Social Care Survey is an annual survey for England. This provides an important source of service users views on a range of outcome areas▼. The results for Richmond borough are based on a representative sample, and therefore can be applied to all users of social care services in Richmond borough.

Richmond borough achieves positive rankings across a range of indicators measuring service users' experiences of services and quality of life.

The indicator 'social care related quality of life' is a composite measure of users' responses to questions which asked how satisfied or dissatisfied the users were with aspects of quality of life (control, dignity, personal care, food and nutrition, safety, occupation, social participation and accommodation). A higher score is better, however it is important to note that this indicator does not, at present, identify the contribution of a local authority's adult social care services towards these outcomes.

The average quality of life score for users was 19 (out of a possible total of 24), which is the same as in England and in similar local authorities (2013-14). Richmond borough's performance ranks in the top 25% in the grouping of similar local authorities ('nearest neighbourhoods') and in England as a whole.

Richmond borough achieved top ranking for the proportion of users who said they 'feel safe'. A further question asked whether they felt their care and support had contributed to making them feel safe and secure – i.e. measured the impact of services on this outcome. Richmond borough achieved an amber rating amongst similar local authorities for this outcome.

▼ The survey method is based on a stratified random sample design. Councils are asked to send questionnaires to users of social care services that are fully or partly funded by the council (the 'eligible population') to meet a defined sample size. In Richmond borough the eligible population for the 13-14 survey was 1655 people, and 344 questionnaires were completed. This number met the sample size required to produce results that could be applied to all the eligible population.

In the survey, users were asked directly how satisfied or dissatisfied they were with the care and support services they received. 61% of Richmond borough users said that they were extremely satisfied or very satisfied with the care and support they received, and this is similar to the level of satisfaction in similar local authorities. However, this is lower than user satisfaction in England (65%) – a red rating.

Carers' experience and quality of life

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
Carer-reported quality of life (score)	1*	3	8.0	2012/13	N/A
Carers' health-related quality of life (score - "1" is maximum)	1	1	0.83	2013/14	=
Carers satisfied with social services (per cent)	2*	4	36%	2012/13	N/A
Carers feeling included and consulted in discussions about patient (per cent)	2*	3	69%	2012/13	N/A

*ASCOF measure, peer comparison is against local authorities in CIPFA group.

Carer-reported quality of life score gives an overarching view of the quality of life of carers and is based on questions asked in the national Carers Survey. It is a composite measure which combines individual responses to six questions measuring different outcomes related to overall quality of life - covering occupation, control, personal care, safety, social participation and encouragement and support▼. This measure does not at present identify the contribution of a local authority's adult social care services towards these outcomes.

Richmond borough ranks in the top 25% of similar local authorities ('nearest neighbourhoods') and in England for this outcome.

Richmond borough performs less well for a direct question about the level of satisfaction they and the person they care for have received from Social Services (a red rating for national comparison). Evidence suggests that reported satisfaction with services is a good predictor of the overall experience of services and quality.

▼ In Richmond borough, 447 carers participated in the survey in 2012/13 out of an eligible sample of 866 (52% response rate). This meets the sample size required.

Patients' experience of health care and health-related quality of life

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
People with long-term conditions' health-related quality of life (score - "1" is maximum)	1	1	0.80	2013/14	=
People feeling supported to manage their condition (per cent)	1	1	69%	2013/14	=
Patient experience of GP services - "fairly good" or "very good" (per cent)	1	1	88%	2013/14	=
Patient experience of GP out-of-hours service - "fairly good" or "very good" (per cent)	4	4	52%	2013/14	=
Patient experience of NHS dental services - "fairly good" or "very good" (per cent)	3	4	79%	2013/14	=
Patient reported outcomes measures for hip replacement (score)	4	4	0.39	2011/12	-
Patient reported outcomes measures for knee replacement (score)	1	3	0.30	2011/12	=
Patient reported outcomes measures for groin/hernia (score)	3	4	0.07	2011/12	=

The results of the national GP Patient Survey measures patients' experiences of NHS care and health related quality of life. The results provide the basis of the outcomes included in the NHS Outcomes Framework.▼

In the national GP Patient Survey, participants who reported to have a long-standing health condition were asked if they had enough support from local services or organisations to help manage their long-term condition in the last six months. In 2013-14, of respondents in Richmond borough, 68.9% reported that they received enough support to manage their condition. This is higher than for patients in London (59.7%) and England (65.1%).

Richmond borough GP patients reported better experience of their GP surgery (2013-14) compared with London and England. 88% of patients described their experience of their GP surgery as Very Good or Fairly Good, compared to 81% for London and 86% for England.

Patients reported less positive experiences of out-of-hours GP services (red ratings). 52% of Richmond borough patients described their experience of out-of-hours GP services as Very Good or Fairly Good (2012-13). This was lower than in England (66%) and London (58%), and is lower than the result in the previous year (58% in 2012-13).

Patients' reported experience of NHS dental services is also variable. In 2013-14, 79% of Richmond borough patients described their experience as very good or fairly good. This is similar to London (80.5%) and lower than England (84% - a red rating).

▼ Out of 10,860 questionnaires that were sent out to patients registered with a GP practice in Richmond borough, 3,723 (34%) were completed (2013/14). It may be that people who choose to take part in the survey differ from the people who do not take part. However, the response rate in Richmond borough is similar to the average for England (35%).

The Patient Reported Outcomes Measures (PROMs) programme measures patients' reported improvement following elective procedures (planned), including hernia, hip replacement and knee replacement. The results need careful interpretation as some level of variation between CCGs can be expected.◆

The actual levels of self-reported improvements by Richmond borough patients for these conditions are not significantly different from England, although Richmond borough's rankings against other CCGs show a mixed picture.

Preventable sight loss

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
Sight loss					
Preventable sight loss - sight loss certifications (per 100,000)	3	1	30	2012/13	+
Preventable sight loss - age-related macular degeneration (per 100,000)	4	2	94	2012/13	+
Preventable sight loss - glaucoma (per 100,000)	3	3	12	2012/13	N/A

There are three indicators covering sight loss and eye diseases that result in blindness or partial sight if not diagnosed and treated in time. Prevention of sight loss helps people maintain independence as long as possible and can avoid the need for social care support. Research suggests that 50% of cases of sight loss are preventable if these diseases are diagnosed and treated early. The risk of sight loss is strongly influenced by ethnicity, deprivation and age.

The rate of sight loss certification of Richmond borough residents increased from 24.4 per 100,000 in 2010-11 to 30.1 in 2012-13. This equated to 149 cases of sight loss in total over the three years. This increase may in part reflect the aging profile of Richmond borough residents. Although numbers are comparatively small, a proportion was likely to be preventable. The Richmond borough rate of sight loss certification was significantly lower than England (42.3 per 100,000). This lower rate may in part reflect the comparative affluence of the Richmond borough population.

The Richmond borough rate of sight loss due to age related macular degeneration (AMD) among people aged 65+ increased from 56.4 per 100,000 in 2010-11 to 94 in 2012-13. This equated to 58 Richmond borough cases over the three years. Although lower, this rate was not significantly different to the rate for England (104.1 in 2012-13) – but achieved a red rating for peer comparison.

The Richmond borough rate of sight loss due to glaucoma among people aged 40+ per 100,000 was not significantly different to that of England (12.2 and 12.5 respectively in 2012-13). The number of Richmond borough residents with sight loss due to glaucoma is small (25 cases in the two years 2011-13).

◆ Because of random variation between patients and differences in the number of patients that underwent the procedure (in Richmond borough: 113 for hip replacement, 83 for knee replacement and 41 for groin hernia), some variation between CCGs is expected.

Loneliness and isolation

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
Adult social care users with enough social contact (per cent)	1*	2	46%	2012/13	N/A
Carers with enough social contact (per cent)	2*	3	39%	2012/13	N/A

*ASCOF measure, peer comparison is against local authorities in CIPFA group.

Social and community networks can have a strong, positive impact on physical and mental health and wellbeing. Feeling isolated and lonely has a profound negative effect on health, and tackling loneliness and isolation is a key issue both at national and local level. It is especially important in Richmond borough, where we have the highest proportion of people aged over 75 and living alone in London (51% in Richmond borough compared to 35% in London).

Carers also often experience inequalities and require support. Taking on a caring role can mean facing isolation, poor health and depression. This also applies to young carers, as their free time and opportunities for social contact can be limited. There are almost 16,000 adult carers in Richmond borough, but over 13,000 are unknown to health and social care services.

In a large national survey which included 390 service users and 435 adult carers from Richmond borough, 46% of social care users and 39% of carers stated that they have as much social contact as they want with people that they like. A further 36% of service users stated that they have adequate social contact with people (this option was not available in the survey for carers). This is a nationwide problem – the 'best' figures in England are 54% for service users and 59% for carers.

Using these figures, it is estimated that there are 5,320 people aged over 65 feeling mildly lonely, between 2,128 and 2,660 feeling intensely lonely and 3,192 feeling trapped in their homes. National survey data indicates that people with dementia are at a particularly high risk of loneliness and isolation, related in part to living alone and/or having difficulties in maintaining social relationships.

Reducing premature mortality

What does this mean for Richmond borough?

- The indicators cover a range of long term outcomes that measure how long people in Richmond borough live, how long they live in good health, if there are areas where people live longer than in other areas, how many people die when they are relatively young and how many deaths could have been postponed until an older age by effective healthcare or prevention. They measure the cumulative impact of all experiences, behaviours and circumstances of Richmond borough residents in the past decades.
- Life expectancy at birth measures how long babies that are born today can expect to live. Life expectancy in Richmond borough is among the highest in England and London and continues to increase. However, it is important to measure what proportion of these additional years of life are spent in good health and if there are any groups with a shorter life expectancy.
- Healthy life expectancy indicators estimate the number of years of life spent in 'Very good' or 'Good' health based on how individuals perceive their health. Healthy life expectancy of men in Richmond borough is the highest in the country and for women it is the second highest in the country. Life expectancy and healthy life expectancy are both increasing, but national data suggests that healthy life expectancy is increasing more quickly. Therefore, people are spending a larger proportion of life in good health.
- Within Richmond borough, life expectancy in the most deprived areas is about seven years lower for men and four years lower for women than in the least deprived areas. Even within Richmond borough's generally affluent population there are differences in life expectancy. This is because differences are not only seen between the very best-off and the very worst-off: the higher someone's social position, the better their health.
- The differences in life expectancy by deprivation are caused by inequalities in people's circumstances and the cumulative effects of disadvantages through life. Early childhood is particularly important.
- While people are living longer and healthier, 30% of deaths in Richmond borough occur before the age of 75 ('premature mortality'). Most deaths under the age of 75 are considered avoidable and could be postponed until an older age by timely and effective healthcare, by public health interventions or changes in behaviour.
- The premature mortality rate for cardiovascular disease, respiratory disease, cancer and liver disease is average or better than average in Richmond borough. However premature mortality rates could be brought down even further, considering Richmond borough's generally affluent population.
- In Richmond borough, the mortality rate for adults with serious mental illness is three times higher than the mortality rate for the general population (the causes of death are the same as in the general population). This is mid-range compared to other local authorities in London and England.
- The number of life years that are lost because of deaths that could have been avoided by timely and effective healthcare (such as certain deaths due to infection, cancer, diabetes or cardiovascular disease) is relatively low in Richmond borough.
- Certain other deaths can be prevented through individual behaviour or public health interventions. For example, lung cancer can be prevented by the avoidance of smoking, and certain infectious diseases can be prevented by vaccination. The overall mortality rate from causes considered preventable in Richmond borough is relatively low.

Introduction

The indicators in this chapter cover a range of long term outcomes that measure how long people in Richmond borough live, how long they live in good health, if there are areas where people live longer, how many people die when they are relatively young and how many deaths could potentially have been postponed until an older age by effective healthcare or prevention. They measure the cumulative impact of all experiences, behaviours and circumstances of Richmond borough residents in the past decades.

Indicators on life expectancy measure how long children born in Richmond borough can expect to live. They measure the overall health status of the population.

In addition to life expectancy, it is important to measure what proportion of people's lives is spent in good health, and if there are any groups with a shorter life expectancy. This is measured by indicators on healthy life expectancy and inequality in life expectancy.

While people are living longer and healthier, a child born in England today still has a one in three chance of dying before the age of 75. How this differs across the country and for different causes of death is measured by indicators of the under 75 mortality rate. Certain deaths can potentially be avoided by timely and effective healthcare, by public health interventions or changes in behaviour. This is measured by indicators of the potential years of life lost from causes amenable to healthcare, and indicators of premature mortality that is preventable.

Richmond borough performs very well on these indicators of premature mortality. Healthy life expectancy for men in Richmond borough is the highest in the country and for women the second highest in the country. Other areas in London show a different picture. For example, a boy born in Richmond borough can expect to live 4.6 years longer than a boy born in Tower Hamlets and can expect to live 17.5 years longer in good health.

Life expectancy

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
Life expectancy at birth - male (years)	1	1	82	2010-12	+
Life expectancy at birth - female (years)	1	1	86	2010-12	+
Life expectancy at age 65 - male (years)	1	1	20	2010-12	+
Life expectancy at age 65 - female (years)	1	1	23	2010-12	+
Gap between life expectancy at birth in Richmond and England - male (years)	1	1	2.5	2010-12	=
Gap between life expectancy at birth in Richmond and England - female (years)	1	1	2.9	2010-12	=
Healthy life expectancy at birth - male (years)	1	1	70	2010-12	N/A
Healthy life expectancy at birth - female (years)	1	1	71	2010-12	N/A
Slope index of inequality in life expectancy at birth - male (years)	2	2	6.8	2010-12	+
Slope index of inequality in life expectancy at birth - female (years)	2	1	3.9	2010-12	=

Life expectancy

Life expectancy at birth measures how long a child born in Richmond borough can expect to live. It is used as a measure of the overall health status of the population.

People in Richmond borough and across England are living longer. On average, a baby born now in Richmond borough would be expected to live 1.5 years longer than someone born four years ago.

Life expectancy at birth in Richmond borough is among the best in England and London - 82 years for men (20th highest in England; 3rd highest in London) and 86 years for women (3rd highest in England; highest in London). Men aged 65 in

Richmond borough can expect to live for a further 20 years (until age 85) and women aged 65 for a further 23 years (until age 88).

Women live longer than men. However, with life expectancy increasing across the population, the difference in life expectancy between men and women is becoming smaller[17].

How long we live depends greatly on where we live. Separate indicators measure the difference in life expectancy at birth in Richmond borough and in England as a whole. Men live on average 2.5 years longer than in England, and women live 2.9 years longer. This good performance on overall life expectancy is not unexpected. Differences between areas in life expectancy are largely explained by differences in deprivation that have an impact throughout people's lives. The Richmond borough population is affluent on the whole, and therefore lives longer. However, it is important to measure what proportion of these additional years of life are healthy and without disability, and if there are any groups with a shorter life expectancy.

Healthy life expectancy

Healthy life expectancy indicators estimate the number of years of life spent in 'Very good' or 'Good' health based on how individuals perceive their health (derived from the Annual Population Survey ▼). It is a measure of the average number of years a person could expect to live in good health.

Healthy life expectancy for men in Richmond borough is the best in the country (70 years), and for women in Richmond borough it is the second best in the country (71 years). This is approximately 7 years higher than the national figure (63 years for men and 64 years for women).

As the total life expectancy is 82 for men and 86 for women, men in Richmond borough live on average 12 years in "Not good" general health, and women 15 years. This is less than the figures for London and England, particularly for men (men: London 17 years, England 16 years; women: London 20 years, England 19 years).

Life expectancy and healthy life expectancy are both increasing, but national data suggests that healthy life expectancy is increasing more quickly. Therefore, people are spending a larger proportion of life in good health[18]. Data for Richmond borough (although not included in the Outcomes Framework) on the proportion of years spent without disability shows a similar pattern[19].

Inequality in life expectancy

Deprivation is associated with lower life expectancy[20,21]. The differences by deprivation are the product of people's circumstances and the cumulative effects of disadvantages through life. Early childhood is particularly important. What happens during these early years lays the foundation for physical, intellectual and emotional development and has lifelong effects on many aspects of health and wellbeing, from obesity, heart disease and mental health, to educational achievement and economic status. This begins even before birth. Disadvantaged mothers are more likely to have babies of low birth weight, and low birth weight is associated with poorer long-term health and educational outcomes[21].

Richmond borough is less deprived than other areas. However, even within Richmond borough's generally affluent population there are differences in life expectancy. This is because differences are not only seen between the very best-off and the very worst-off: the higher someone's social position, the better their health.

▼ The Annual Population Survey by the Office for National Statistics interviews only a proportion of the population. In Richmond borough, 683 people participated in the survey in 2013/14. Measures have taken place to ensure that the sample reflects the composition of the general population. People are asked the following question: "How is your health in general: would you say it was: very good, good, fair, bad or very bad?". The responses "very good" and "good" are categorised as "Good" general health, and "fair", "bad" or "very bad" as "Not good" general health. The information about general health is combined with data on mortality and population estimates to calculate estimates of healthy life expectancy at birth.

Within Richmond borough, life expectancy in the most deprived areas is about seven years lower for men and four years lower for women than in the least deprived areas. There is greater inequality in life expectancy among men than among women, reflecting the national pattern (9.2 years for men and 6.8 years for women).
The indicators on inequality are measured by the 'slope index of inequality in life expectancy', which is based on a statistical model of the relationship between deprivation and life expectancy. It takes account of inequality across the whole population distribution rather than focusing only on the extremes, and gives greater weight to larger populations and less weight to smaller populations.

On the whole, the extent of inequality in life expectancy in Richmond borough is mid-range compared to England and London. Measures of inequality should be interpreted together with measures of life expectancy. For example, between areas within Islington there is relatively little inequality but, compared to other boroughs, Islington has a lower overall life expectancy. The opposite picture is seen in Kensington and Chelsea - this borough has the highest life expectancy in London, but the largest level of inequality. In Richmond borough, overall life expectancy is high, and inequality is average.

Inequality in life expectancy is mainly due to cancer (contributes to 28% of the gap in men and 12% in women), respiratory disease (14% in men and 31% in women), coronary heart disease and stroke (13% in men and 20% in women), liver disease and other digestive disease (18% in men and 9% in women) and external causes (18% in men and 5% in women)[22].

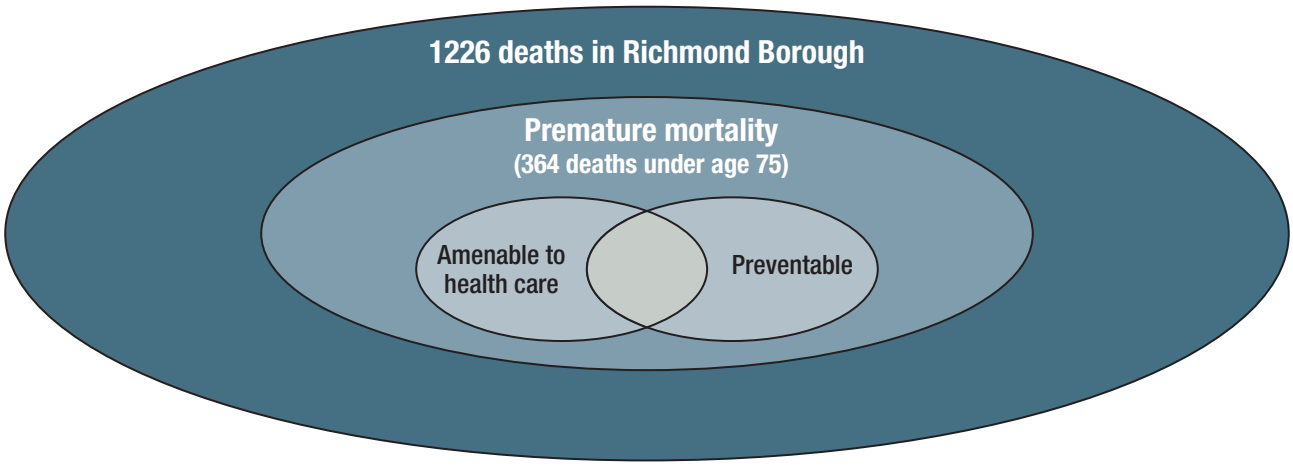
Mortality

Indicator	Peer comparison	National comparison	Richmond Value	Period	Trend (symbol)
Premature (under 75 yrs) mortality rate from cardiovascular disease (per 100,000)	1	1	57	2010-12	-
Premature (under 75 yrs) mortality rate from respiratory disease (per 100,000)	1	1	26	2010-12	=
Premature (under 75 yrs) mortality rate from liver disease (per 100,000)	1	2	15	2010-12	=
Premature (under 75 yrs) mortality rate from cancer (per 100,000)	2	1	129	2010-12	=
Mortality from communicable diseases (per 100,000)	1	1	59	2010-12	-
Excess under 75 mortality in adults with serious mental illness (per cent)	3	2	312%	2011/12	=
Potential years of life lost from causes considered amenable to healthcare (per 100,000)	1	1	1,743	2012	-
Potential years of life lost from causes considered amenable to healthcare - adult (per 100,000)	1	1	2,096	2012	-
Preventable all-cause mortality (per 100,000)	1	1	147	2010-12	=
Premature (under 75 yrs) mortality from preventable cardiovascular diseases (per 100,000)	1	1	34	2010-12	-
Premature (under 75 yrs) mortality from preventable respiratory disease (per 100,000)	2	1	13	2010-12	+
Premature (under 75 yrs) mortality from preventable liver disease (per 100,000)	1	2	13	2010-12	=
Premature (under 75 yrs) mortality from preventable cancer (per 100,000)	2	1	76	2010-12	=

Premature mortality

An overview of measures of premature mortality is shown in Figure 1.

Figure 1 Measures of premature mortality (2013)



In Richmond borough, 1,226 people died in 2013. Of these, 364 (30%) people were aged younger than 75 years, as shown in Figure 1. Most deaths under the age of 75 are considered avoidable and could be postponed until an older age by prevention and treatment.

Some deaths can be postponed to an older age by timely and effective healthcare ('amenable to health care'), for example by early diagnosis and effective treatment. Certain other deaths can be prevented through individual behaviour or public health interventions by limiting individual exposure to harmful substances or conditions. For example, lung cancer can be prevented by the avoidance of smoking, and certain infectious diseases can be prevented by vaccination. Some deaths are both preventable and amenable; for example mortality from heart disease can be prevented by the promotion of a healthy lifestyle and can in some cases be amenable to effective treatment. This is indicated by the overlapping area in Figure 1. Other deaths are preventable only (e.g. malignant lung cancer) or amenable only (e.g. leukaemia).

These indicators of premature mortality demonstrate the importance of prevention as well as treatment. In addition to providing appropriate diagnosis, care planning and treatment, the NHS and local authorities and national bodies have a role in encouraging healthy behaviours and uptake of screening and vaccination options.

The indicators of avoidable mortality that are included in the Outcomes Frameworks are described in the following sections.

Under 75 mortality rate

To capture premature mortality from the major causes of death, the Outcomes Frameworks include indicators on deaths in people younger than 75 years for cardiovascular disease, cancer, respiratory disease, and liver disease. These indicators include all premature deaths, not only those that are preventable or that are amenable to health care.

The under 75 mortality rate from cancer (129 per 100,000) is mid-range compared to London and in the best quartile in England. It has remained stable over the last four years. Premature mortality from cardiovascular disease (57 per 100,000) has declined over the last four years and is among the best in the country (London 83 per 100,000; England 81 per 100,000). The under 75 mortality rate for respiratory disease (26 per 100,000) is also among the best in England and London. Premature mortality from liver disease (15 per 100,000) is in the best quartile for London and mid-range for England (London 19 per 100,000, England 18 per 100,000).

Although performance in Richmond borough is average or better than average, premature mortality rates could be brought down even further, considering Richmond borough's affluent population – see the last section in this chapter for more details.

Mortality from infectious diseases

Infectious diseases (or communicable diseases) are spread from one person to another, and include for example influenza, pneumonia, and sexually transmitted infections (STIs). Rapid identification, treatment and prevention of spread can reduce mortality, for example by good vaccination coverage and the local authority role in dealing with health protection incidents, outbreaks and emergencies[23,24]. Mortality from communicable diseases in Richmond borough is relatively low.

Excess under 75 mortality in adults with serious mental illness

From national research it is known that people with a serious mental illness die between 15 and 25 years earlier than the general population. These premature deaths are generally from the same causes of death as in the general population (such as cancer and cardiovascular disease). In Richmond borough, the mortality rate for adults with serious mental illness is 3.1 times higher than the mortality rate for the general population. This difference in mortality rates is mid-range compared to London and England.

Potential years of life lost from causes considered amenable to health care

This indicator relates to deaths for conditions that are considered amenable to health care. These include certain deaths from infections, neoplasms, diabetes, neurological disorders, cardiovascular disease, respiratory diseases, digestive disorders, genitourinary disorders, maternal and infant deaths and unintentional injuries, mostly in people younger than 75 years. The number of potential years of life lost due to these conditions is calculated using the average age-specific life expectancy▼. Therefore deaths at younger ages are weighted more heavily than those at older ages.

In Richmond borough, 1,743 years were lost per 100,000 population. This is considerably lower than in England (2,303 per 100,000). Over the last four years a downward (improving) trend was seen for women in Richmond borough, while the potential years of life lost fluctuated in men. For adults in Richmond borough aged 20 years and over, 2,096 years were lost per 100,000 compared to a London figure of 2,831 and England figure of 2,801. The indicator for children and young people is currently not available by local authority.

Mortality from causes considered preventable

This indicator measures the mortality from causes that could have been prevented by public health interventions. It is complementary to the indicator measuring potential years of life lost from causes considered amenable to healthcare.

The overall mortality rate from causes considered preventable in Richmond borough is relatively low. In addition to overall preventable mortality, separate indicators measure preventable mortality from the major causes of death: cardiovascular disease, cancer, respiratory disease and liver disease. Richmond borough is in the best quartile for the indicators for cardiovascular disease and liver disease in London. Richmond borough's performance for respiratory disease and cancer is in the second quartile of London boroughs (best quartile for England).

Public health interventions that may prevent deaths in those under age 75 include NHS Health Checks, tobacco control initiatives and smoking cessation services, vaccinations, initiatives to reduce excess death as a result of seasonal mortality, alcohol and drug misuse services and interventions that help support a healthy lifestyle[24]. Many of these interventions are referred to in other chapters of this report.

▼ For example, consider a 54 year old man who dies as a result of hypertensive disease, which could have been avoided by timely treatment. The average life expectancy of a man at age 54 is 82 years. Therefore, 82-54 = 28 potential years of life lost.

Appendix A - Further sources of local information

- 2013 Parks Customer Satisfaction Survey, London Borough of Richmond upon Thames
- Air Quality Action Plan, London Borough of Richmond upon Thames
- Better Care Closer to Home: Richmond Out of Hospital Care Strategy 2014-17, Richmond Clinical Commissioning Group & London Borough of Richmond upon Thames
- Climate Change Strategy, London Borough of Richmond upon Thames
  To be published on www.richmond.gov.uk in Spring 2015
- Economic Indicators and Health (2014), London Borough of Richmond upon Thames
- Homelessness in Richmond upon Thames Health Needs Assessment (2014), Richmond JSNA
- Homelessness Strategy Richmond upon Thames 2012-16, London Borough of Richmond upon Thames
- Local Implementation Plan for Transport, London Borough of Richmond upon Thames
- London Borough of Richmond upon Thames Housing Strategy 2013-17, London Borough of Richmond upon Thames
- Loneliness and Isolation Health Needs Assessment, Richmond JSNA
  To be published on www.richmond.gov.uk/jsna in January 2015
- Obesity in Adults Health Needs Assessment (2014) – Richmond JSNA
  To be published on www.richmond.gov.uk/jsna in January 2015
- Obesity in Children Health Needs Assessment (2014) – Richmond JSNA
- Richmond Joint Strategy for the Prevention of Substance Misuse 2013-16, London Borough of Richmond upon Thames & Richmond Clinical Commissioning Group
- Richmond upon Thames Carers Strategy 2013-15, London Borough of Richmond upon Thames & Richmond Clinical Commissioning Group
- Richmond upon Thames Children and Young People's Plan 2013-17, London Borough of Richmond upon Thames
- Sexual Health Joint Commissioning Strategy 2014-18, London Borough of Richmond upon Thames & Richmond Clinical Commissioning Group
  To be published on www.richmond.gov.uk in February 2015
- Sexual Health Needs Assessment (2014) – Richmond JSNA
- Strategic Assessment 2013, London Borough of Richmond upon Thames & Community Safety Partnership
- Strategic Principles for Sport & Fitness 2014-18, London Borough of Richmond upon Thames
  To be published on www.richmond.gov.uk in January 2015
- The Joint Richmond Children and Young People's Health Strategy and Commissioning Plan 2014-17, London Borough of Richmond upon Thames & Richmond Clinical Commissioning Group

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