London Borough of
Richmond upon Thames

Joint Health and Wellbeing Strategy 2016-21

NHS
Richmond
Clinical Commissioning Group

healthwatch
Richmond upon
Thames

LONDON BOROUGH OF
RICHMOND UPON THAMES

Foreword

As representatives of the three statutory partners of the Health and Wellbeing Board, we are delighted to present the refreshed Joint Health and Wellbeing Board Strategy (JHWBS) for the London Borough of Richmond upon Thames.

The Health and Wellbeing Board brings together elected members and leaders from the local health and social care system. We have understood that the strength of the board lies in its position as a systems leader, and our ability to champion key aspirations in the actions of our own and partner organisations. The strategy does not outline specific projects or action plans, therefore, but establishes the direction we want our health and social care services to take, which it is the duty of the council, Clinical Commissioning Group (CCG) and other partners to implement in their own commissioning and action plans. The strategy is not exhaustive of all health and care issues but covers those which demonstrate this sense of direction.

This strategy marks a chapter in the ongoing development of the Health and Wellbeing Board and reflects our learning from public meetings, seminars, working groups and Listening Events, which have given us the invaluable opportunity to hear directly from residents. It is through this process that we identified key themes for the strategy and explored ways that the board can have most impact.

The theme of this strategy is **"prevention and joined-up services throughout people's lives, to enable all residents to start well, live well and age well"** and builds on the focus of the previous strategy which was integration of services.

Integration has become one of the defining features of how the Health and Wellbeing Board, council and CCG operate and we will continue to drive this forward. In the strategy we have acknowledged Outcomes Based Commissioning as one of the vehicles for achieving integration and for delivering the outcomes that residents, patients and carers tell us they want. As a Board, we emphasise that, in the context of the current financial pressures, it is important that we continue to explore opportunities for collaborative solutions and efficiencies.

Whilst ensuring that people with long-term conditions and mental health problems receive high quality and joined up services, equally, we need to get better at helping residents to stay healthy for as long as possible. The theme of prevention marks an important shift in resources towards community-based initiatives, working with villages, communities and our partners to protect and develop an environment that enables individuals to start well, live well and age well. The approach throughout people's lives emphasises the importance of nurturing health and wellbeing from the start of life and acknowledges children's services, communities and schools as key players in this.

In implementing the strategy, we would like to express our ongoing commitment to engaging with our residents, service-users and carers. They have a vital role to play in shaping services and highlighting unmet need, and ensuring that services deliver the outcomes that people want.

If you have any comments about the strategy or questions about the Health and Wellbeing Board, please contact **public.health@richmond.gov.uk**.

Councillor Christine Percival
London Borough of Richmond upon Thames

Dr Graham Lewis
Chair of Richmond Clinical Commissioning Group

Julie Risley
Healthwatch Richmond

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NHS Richmond Clinical Commissioning Group

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Executive Summary

HEALTH AND WELLBEING BOARD

Richmond's Health and Wellbeing Board (HWB) brings together elected members and local leaders from the health and social care system for adults and children, in order to improve the health and wellbeing of its local population and work to reduce inequalities.

ABOUT THE STRATEGY

The Joint Health and Wellbeing Strategy 2016-2019 (JHWBS) aims to build on the achievements and aspirations of the HWB to date. This refreshed strategy highlights the Board's continuing commitment to integration through the theme of **"prevention and joined-up services throughout people's lives, to enable all residents to start well, live well and age well"**.

It is the purpose of this strategy to provide a framework that the Council, Richmond Clincal Commissioning Group (CGG) and other partners will implement through subsequent commissioning and action plans. Therefore, the strategy aims to be concise and purposeful rather than a comprehensive review of work across the health and social care system; each chapter incorporates carefully selected actions and 'Transformational Initiatives' that the Board feels and can have significant impact. The HWB will review the progress of the strategy on an annual basis and it is intended that a 'score card' of performance measures will be developed.

CONTEXT AND ENABLERS

The JHWBS is set in the context of significant budget pressures due to central government reductions or restrictions, combined with increased demand for local services. Wandsworth and Richmond Councils are in the process of establishing a Shared Staffing Structure to help deliver some of these savings.

Within this context, integration and prevention are identified as enablers - the main capabilities through which the HWB will advance its strategic goals. Outcomes Based Commissioning can also be seen as an enabler in achieving integration and, by enabling partners to work together to manage demand and risk, developing services with a more preventative ethos.

STRATEGY DEVELOPMENT

Richmond HWB recognises the value of involving our community and local stakeholders in shaping decisions about health and social care and the services they receive. To develop this strategy the Board engaged in a 'learning by doing' process, participating in facilitated seminars to draw out themes and priorities, hosting Listening Events and a public consultation on the draft strategy.

The Joint Health and Wellbeing Strategy

START WELL

The Start Well chapter recognises that what happens in early life, starting from conception, affects health and wellbeing in later life – from obesity and mental health, to educational achievement and employment opportunities. While most children and young people in Richmond are healthy and have a good start in life, not all enjoy the same opportunities to fulfil their potential and achieve.

The strategy encompasses a number of significant developments that seek to increase focus and resources towards prevention and early intervention, and demands strong partnership working to make the best of resources. The HWB intend to target their work as a systems leader, to ensure the best start in life for all children through a joined-up approach to family health and wellbeing, to ensure all children and young people are able to reach their full potential. Promoting resilience and emotional wellbeing through a whole systems approach is an important aspect of this work; connecting families, communities, schools and services to provide holistic support to the borough's children and young people.

LIVE WELL

The Live Well chapter tackles the four main unhealthy behaviours of smoking, drinking too much alcohol, poor diet and lack of physical activity as well as poor emotional and mental wellbeing, which are responsible for a large proportion of ill health and long term conditions in the borough. These health behaviours are known to be primarily influenced through exposure to cues in the environment, social circumstances or psychological stresses. The HWB understand the importance of working with communities and the Council to adapt the local environment to minimise these behaviours.

The HWB will take action to embed prevention through cross council and CCG commissioning, further utilising workplaces and Village Planning to ensure connectivity and inclusion. The Board intends to promote access to community assets such as parks, open space, accessible streets and cultural activities, improving access to services and healthy environments.

AGE WELL

The Age Well chapter recognises the disparity between the number of people in the borough living longer and the number of people in the borough living longer with a diminished quality of life. Loneliness and isolation is a principle concern, as are the physical and psychological implications of assuming caring roles.

In order to make a meaningful change, the Board will need to galvanise partners across the health and social care system to deliver integrated health and social care services. Through working with individuals, communities and services, the HWB intends to reduce the number of people experiencing loneliness and social isolation, ensure the contribution of carers of all ages is recognised and support and enable older residents to stay as independent as possible.

Introduction

The Health and Wellbeing Board

LONDON BOROUGH OF RICHMOND UPON THAMES

Richmond's Health and Wellbeing Board (HWB) brings together elected members and local leaders from the health and social care system for adults and children, in order to improve the health and wellbeing of its local population and work to reduce inequalities. Membership includes councillors, the Chief Executive of Richmond Council, senior officers from Adult and Community Services and Public Health, GPs and senior officers from the Richmond Clinical Commissioning Group and Achieving for Children, as well as representatives from the voluntary sector, NHS England and Healthwatch Richmond. In addition to membership, the HWB also has joint working arrangements with other partners, such as the Local Safeguarding Children's Board.

The HWB's statutory partner organisaions are:

- **London Borough of Richmond Upon Thames**
- **Richmond Clinical Commissioning Group (CCG)**
- **Healthwatch Richmond**

Acting as a systems leader for health and wellbeing, it is the responsibility of the HWB to work together to understand the community's needs and assets, agree strategic priorities and enable commissioners to work in a more joined up way in order to promote the health and wellbeing of residents. For more about the responsibility and accountability of the board, see **www.richmond.gov.uk/health_and_wellbeing_partnership**

How the Health and Wellbeing Board Operates

CHAMPIONING ASPIRATIONS

The HWB has committed to championing the key aspirations as outlined in this strategy, and in the HWB's Guiding Principles. Through championing, HWB members have a collective and individual responsibility to ensure that these are reflected in the business of their own and partner organisations, are heard in other groups and committees, and become embedded in strategies and commissioning across the health and social care system.

This is a two way process and board members also have a role to play in feeding back insights and learning from their own and partner organisations to further inform the work and priorities of the board. As a result, local people should experience better health, reduced health inequalities, and higher quality, more joined up, health and social care services which are focused on the outcomes as articulated by local residents.

Guiding Principles

As part of its development, the members of the HWB worked together to develop a set of 'Guiding Principles' that underpin everything the HWB does, including how it will deliver the strategy.

1. **Commitment for all:** to work towards the best possible outcomes for all the people of Richmond – the HWB will challenge on behalf of any groups overlooked.
2. **Public and patient involvement:** the public will have an active role to play in shaping public services. The HWB expect that people will be helped to have their say, their preferences will be taken into account and they will be given an account of the way their views were used.
3. **Carer of all ages, and support for carers:** is a key component of our local model of care. The HWB will seek response to local needs that acknowledge the vital role of carers, including young carers, and their support.
4. **Integrated responses to need:** the HWB will strengthen integrated responses to people's needs and will examine the intended and unintended consequences of any commissioning strategies on other local partners.
5. **Evidence based approch:** the HWB are committed to a transparent and open approach, and rigour of declaring sources of evidence, including costs and value for money. The HWB will ensure the flow of evidence into decision making.
6. **Prevention and promotion of independence:** strategies will evidence a systematic approach to prevention and promoting independence. The HWB will look for root causes of problems, not just quick fixes of symptoms.
7. **Better care, closer to home:** the HWB will support strategies that aim to streamline pathways; improve access, and provide care closer to home.
8. **Sustainability for Richmond:** the HWB is committed to developing a care system that is not only financially sustainable, but also minimises adverse impacts on society and on the natural environment, which could jeopardise the ability of future generations to meet their health and social care needs.

CO-PRODUCTION AND ENGAGEMENT

The HWB understands the vital contribution that residents, service-users and carers have in shaping the design and delivery of local services. The board have role to play in ensuring their voice is included co-productively at all levels within the operations of its own and partner organisations.

For more information on the HWB's engagement framework see: **www.richmond.gov.uk/health_and_wellbeing_partnership**

About the Strategy

> **All people in Richmond are able to achieve their full potential, live their lives with confidence and resilience, and access quality services that promote independence and deliver value for money"**
>
> Richmond's Health and Wellbeing Vision

Strategic Theme

> **Prevention and joined up services throughout people's lives to enable all residents to start well, live well, and age well"**
>
> Theme of the Joint Health and Wellbeing Strategy 2016-21

The HWB's first Joint Health and Wellbeing Strategy (JHWBS), 2013-16, focused on the integration of services, identifying priority areas where improvements could be made through addressing the interfaces between organisations across health and social care.

This refreshed strategy highlights the continuing commitment to integration through the theme of **'supporting joined up services'** and aims to widen its reach to include **'maximising prevention support'**; championing approaches to help prevent, reduce, or delay residents' need for care.

To do this, the strategy highlights the need for joint working to drive forward preventative approaches at all levels: through targeted services for those who are ill or groups that are most at risk; through community approaches which promote social connectivity and an underpinning community resilience, and; through approaches that influence the place and environment we live in, enabling the preferred and easy choice to also be the healthy choice.

For a summary of achievements of the JHWBS 2013-16, see **Appendix 1.**

How the Strategy Works

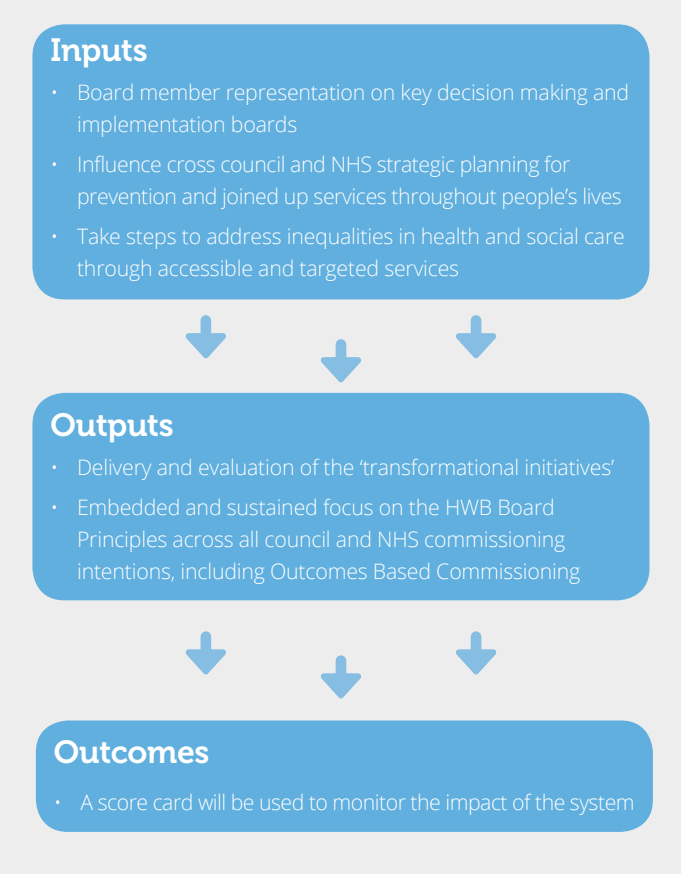
This strategy is a tool that will enable the HWB as leaders in the health and social care system, to champion key principles and set out a direction of travel for health and wellbeing in the London Borough of Richmond upon Thames.

It is the purpose of this strategy to provide a framework that the whole council, CCG and other partners will implement through subsequent strategies, commissioning and action plans. Therefore, the strategy aims to be concise and purposeful rather than a comprehensive review of work across the system; each chapter incorporates carefully selected actions and 'Transformational Initiatives' that the board feels demonstrate this sense of direction and can have significant impact. A number of relevant strategies are illustrated on the following page to demonstrate the JHWBS's reach across the CCG, Local Authority and partners.

MONITORING IMPACT ACROSS THE SYSTEM

The impact of the leadership of the HWB, and the JHWBS, will be assessed across the system, through inputs, outputs and outcomes.

The HWB will conduct an annual review of progress made on the strategy, which will be published as part its programme of public meetings. It is intended that a 'Score Card' of performance measures using national indicators and other local indicators will be developed to assess the impact of the system.



STRATEGY STRUCTURE

The themes of 'joined-up services' and 'maximising prevention support' underpin the three main chapters of the strategy (Start Well, Live Well, Age Well) which outlines health and wellbeing throughout people's lives (from conception to end of life).

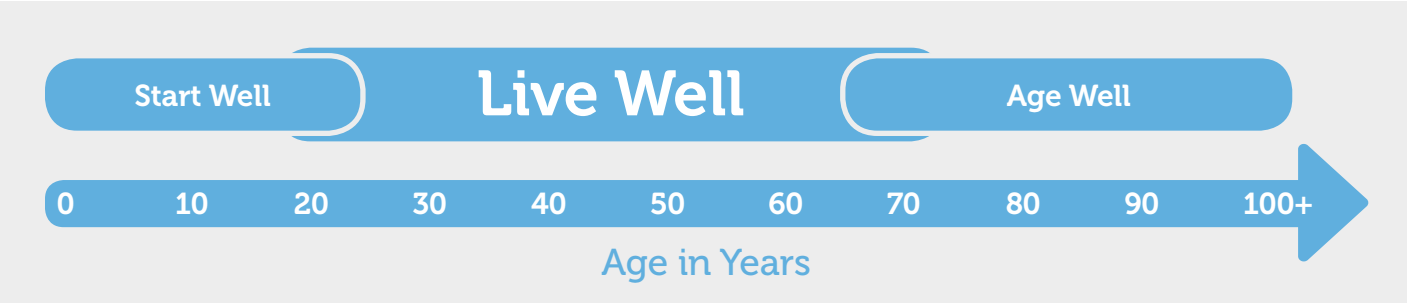
Each chapter highlights why it is important, specific issues in Richmond, how the HWB will take action, and how it will drive change through a purposefully identified selection of 'transformational initiatives'. These are listed in the most relevant chapter, however the HWB understands that stages in the life are not clearly defined and many aspects of health as wellbeing, such as active travel and caring, are relevant throughout people's lives.

Each chapter contains an illustrative case study to show how actions could impact the experience of residents in practice.

AUDIENCE AND PARTNERS

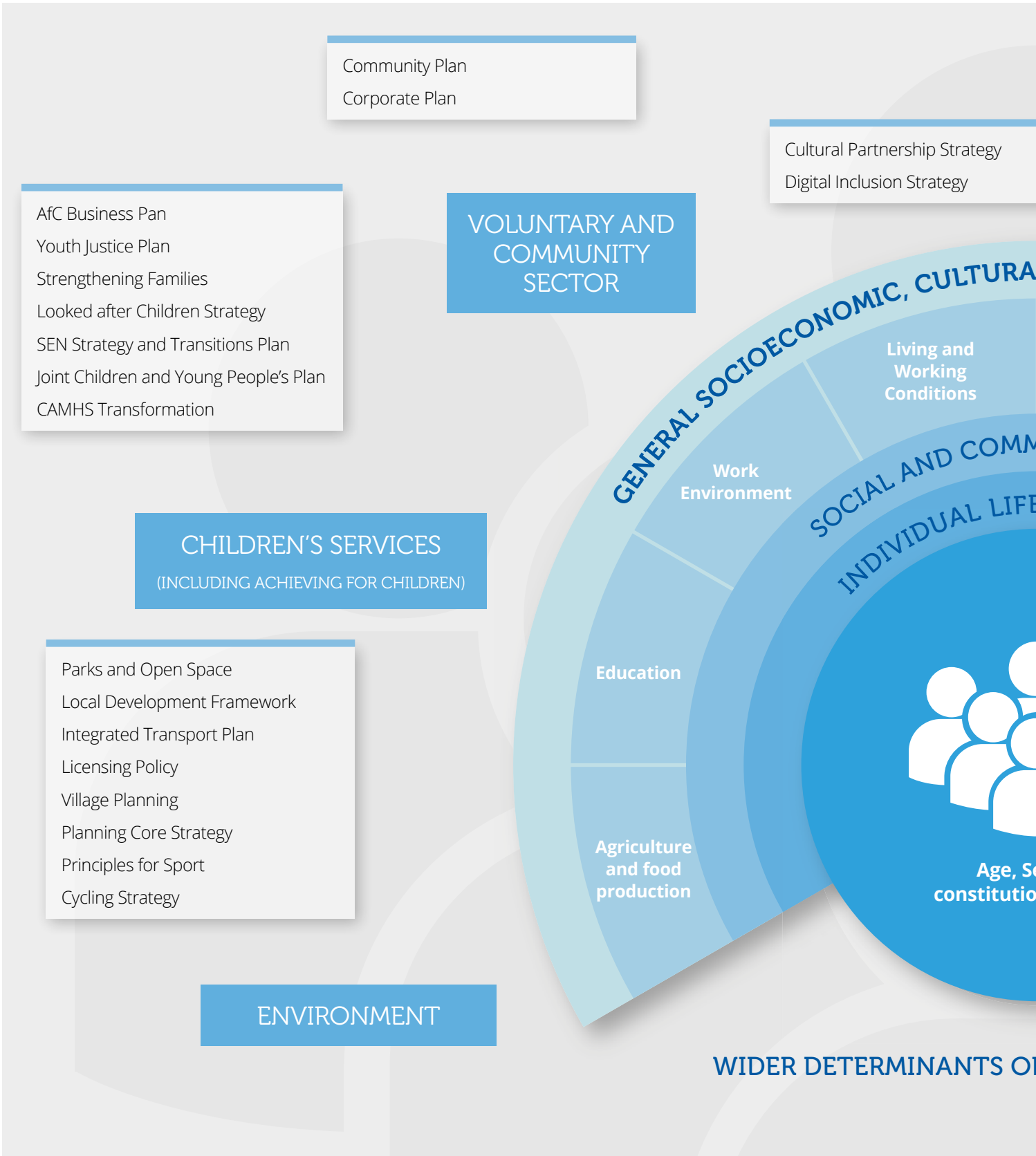
The primary audience for the JHWBS is the HWB, local leaders, officers and commissioners who are responsible for its delivery. However, care has been taken to make the strategy as accessible as possible and we trust it will also be useful for residents and partners, such as the voluntary sector and schools, in understanding priorities and how all partners can contribute to health and wellbeing.

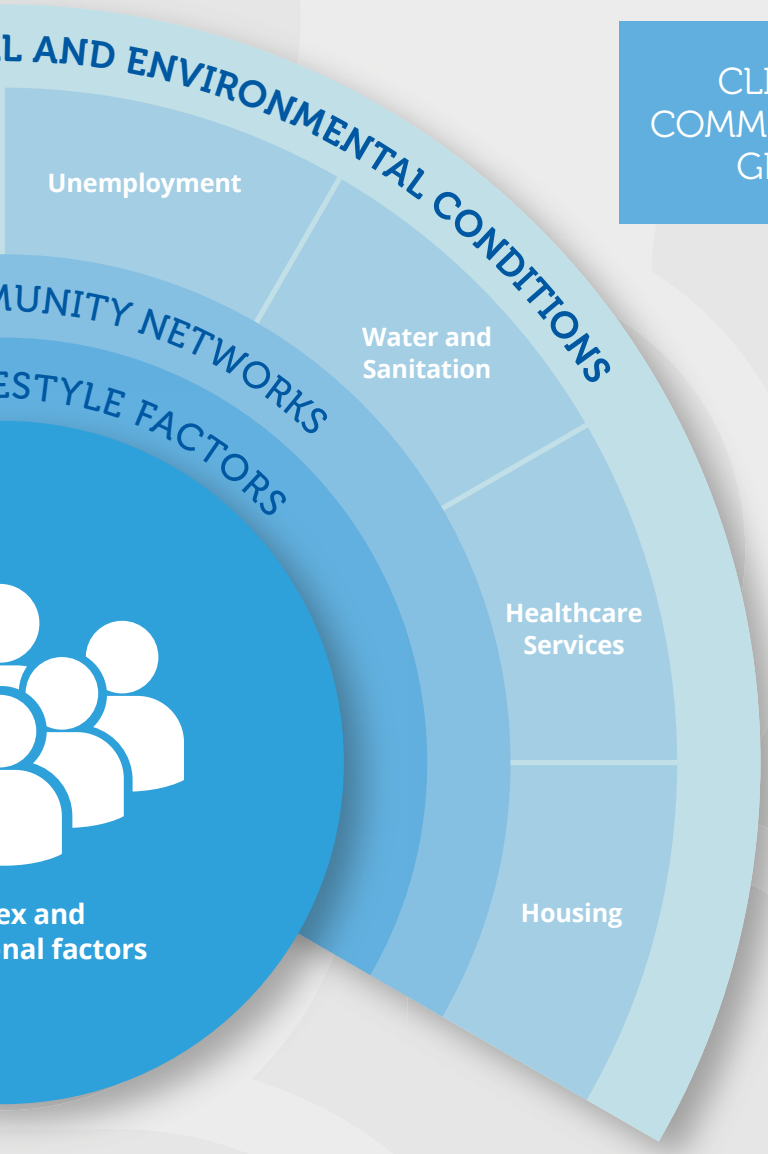
A summary version of the strategy will be developed that is more accessible to a wider audience. A glossary of key terminology is attached as **Appendix 3.**



Health and Wellbeing: strategic links

This JHWBS is not intended to supersede or replace existing strategies for specific areas or client groups, but provides an overview that will link with plans across the council and CCG, some of which are outlined below.





F HEALTH AND WELLBEING

FINANCE AND CORPORATE SERVICES

- CCG System Transformation Plan (STP)
- Operating Plan
- Systems Resilience Plan
- Commissioning Plans
- Richmond Cancer Strategy

CLINICAL COMMISSIONING GROUP

Joint CCG and Council:

- Better Care Fund plan
- Better Care Closer to Home Strategy
- Prevention Framework
- Dementia Strategy
- Carers Strategy
- Outcome Based Commissioning

ADULT AND COMMUNITY SERVICES

- Annual Public Health Report
- Autism Strategy
- Community Safety Partnership Plan
- Housing Strategy
- Homelessness Strategy
- Village Planning
- Substance Misuse Strategy
- Sexual Health Strategy

Context and Enablers

To ensure the success of the Joint Health and Wellbeing Strategy and commitment to its priorities, it is important to acknowledge and understand the context in which the HWB must operate, and how these external factors can form both constraints and opportunities. Within this context, integration and prevention are identified as enablers - the main capabilities through which the HWB will advance its strategic goals. Outcomes Based Commissioning can also be seen as an enabler in achieving integration and, by enabling partners to work together to manage demand and risk, developing services with a more preventative ethos.

Context

AUSTERITY

The Council and CCG are operating within the context of significant budget pressures due to central government reductions or restrictions, combined with increased demand for local services. Central government funding restrictions are expected to continue for the foreseeable future, as part of the Government's strategy to reduce the national deficit.

The HWB aims to support the Council, CCG and its partners in managing demand pressures and highlights synergies to help ensure the long term sustainability of our services and wider environment. The board has identified prevention and joined-up services as the focus of the refreshed strategy as these areas contribute to the long term sustainability of the health and social care system. The HWB are aware that these areas are often vulnerable to budget cuts during times of austerity because of their longer term outcomes.

No additional financial resources have been identified to implement this strategy. We will be seeking to implement the strategy within, and through the redistribution of, existing resources.

WANDSWORTH AND RICHMOND SHARED STAFFING ARRANGEMENT

Wandsworth and Richmond Councils are in the process of establishing a Shared Staffing Arrangement (SSA) for the officer functions of the two Councils by 2017. The initial focus is on joining management structures and reducing duplication. In the longer term, opportunities for further savings to reduce overheads, for example getting better deals from suppliers when commissioning services, will be pursued.

The shared approach is estimated to save up to £10 million for each borough per year. The Councils will adopt a Political Sovereignty Guarantee that clearly describes how local autonomy and identity will be safeguarded, and each Council will continue to develop its own role for community leadership. For the HWB, this will mean continuing to focus on the needs of the Richmond population and the local service responses to those needs.

The scope of the SSA does not currently include Richmond's children's services which are delivered through the community interest company Achieving for Children, in partnership with the Royal Borough of Kingston upon Thames.

OUTCOMES BASED COMMISSIONING

Richmond HWB is committed to championing an Outcomes Based Commissioning (OBC) approach to commissioning health and social care services. 'Outcomes' refer to the impacts or end results of services on a person's life. As such, outcome-focused services aim to achieve the aspirations, goals and priorities of service users.

Richmond CCG and Council intend to commission a long term (7-10 years) outcomes based contract for the delivery of out of hospital health and social care services for the adult population of the borough of Richmond. Further work is also taking place to develop an OBC approach for mental health community services and it is intended that this will be in place by April 2017. OBC will enable commissioners to create the circumstances in which provider organisations can innovate to deliver integrated models of care and better outcomes for services users, and realise efficiencies across the system.

Enablers

INTEGRATION

Integration and the joining up of services has been, and continues to be, a key aspiration of the HWB, and the Board has used its position as a systems leader to champion and drive this forward. For example, it formed the focus of the first HWB Strategy, which addressed aligning the interfaces between services which were not joined-up from a patient perspective. As a result, integration has become one of the defining features of how the HWB, local authority and Richmond CCG conduct their business now and in the future. This refreshed strategy builds on integration and aims to widen its reach by highlighting ways in which joint working (through health, social care and other departments such as environment) can strengthen and support prevention.

PREVENTION

Prevention is recognised as a priority of the Council and CCG, as demonstrated in strategies such as the Prevention Framework and Better Care, Closer to Home. The JHWBS outlines the role that the HWB can take in further driving this forward and supporting a shift towards more cost-effective place and community level approaches to prevention, enabling an environment in which the preferred and easy choice is also the healthy choice.

To do this, action must be taken to join up work across the organisations and help partners (such as environment and planning) to understand their role and contribution towards the prevention agenda. Working with communities (such as localities, village areas and vulnerable groups), will enable the HWB to build on community assets, promoting a community resilience that works alongside integrated, targeted health and social care interventions for those who fall ill or are most at risk.

Strategy Development

Learning by Doing

To develop this strategy the board engaged in a 'learning by doing' process, participating in facilitated seminars to draw out themes and priorities. Development of the strategy included:

- Review of Joint Strategic Needs Assessment (JSNA) including 'The Richmond Story 2015-16'
- An Equalities Impact Needs Assessment (EINA) on the potential impact of the strategy
- A wide review of previous engagement reports
- Engagement in HWB Listening Events
- A series of strategy working groups with HWB members and key council and CCG officers
- An 8-week public consultation on the draft strategy

Engagement

Richmond HWB recognises the value of involving our community and local stakeholders in shaping decisions about health and social care and the services they receive.

As part of its wider consultation and engagement process, a range of existing public and patient engagement data was reviewed to inform the content of the strategy, specifically, this included the in-depth OBC engagement process.

The HWB also held two public 'Listening Events'. These events gave the opportunity for HWB members to hear directly from residents and the organisations that work with them about their experiences of health and wellbeing. These were on the themes of 'Healthy Lifestyles' and 'Health and Wellbeing for Children and Young People'. Feedback from the Listening Events has further informed the theme and content of this strategy. A summary of key themes are highlighted below.

Healthy Lifestyles – March 2015

Children and Young People – September 2015

A whole family approach to prevention and intervention is important in helping parents feel supported, and children feel cared for and make progress towards their developmental milestones

Universal services should provide a nurturing environment in which preventive services and advice can be delivered e.g. schools, wider community

Need to raise awareness of mental ill health within the wider community in order to de-stigmatise mental health

It is important that young people have confidence in the services they come into contact with e.g. school nurse. Professionals need to be approachable, trustworthy and able to signpost them to the correct support

Outcomes Based Commissioning Engagement Review

Integrated care across health and social care in terms of seamless care and effective communication and information sharing between all involved in providing care

Services need to develop a holistic outcomes approach - people want better integration between services addressing patients' and carers' mental, physical and social needs

Invest in long term prevention (including de-stigmatising mental health) and recovery services which include the local voluntary sector, and start at the beginning with schools

Patients and carers want to see the same health and social care professionals every time, in order to build a relationship and develop trust

The full OBC engagement report is available at: **www.richmondccg.nhs.uk**

Equalities Impact Needs Assessment

To examine the potential impacts of the JHWBS an EINA was carried out, examining the nine protected characteristics. These are: age, disability, gender, race, religion/belief, sexual orientation, marriage/civic partnership, maternity, and gender reassignment.

Importantly, the process showed that there are strong links between protected characteristics and health and wellbeing, and that several groups may be at a greater risk of poorer outcomes. Whilst the strategy (particularly in relation to the theme of prevention) will consider a shift towards more universal, place-level interventions, it is important that, in addition, targeted services are in place to protect the most vulnerable. All characteristics were considered, and the greatest impact highlighted for:

- **Age;** There is an aging population in Richmond presenting associated issues such as managing long-term conditions, loneliness and isolation, and dementia. A significant proportion of the population is under the age of 19 presenting the opportunity for significant impact by establishing preventative approaches early in development.
- **Disability;** 12% of people in Richmond are living with a disability. Those with disabilities are more likely to have long-term conditions and more complex health needs, and therefore targeted, tailored services are required.
- **Gender;** Research shows that men smoke more, eat more, and eat less fruit and vegetables than women, and therefore are more at risk of ill health and poor wellbeing. Women experience a longer life expectancy than men and are more likely to take on the caring role in later years.
- **Pregnancy and Maternity;** Pregnancy and early years has a significant impact both on the health of the child and the mother, presenting a significant opportunity to promote health and wellbeing throughout people's lives.
- **Race and Ethnicity;** Black and Minority Ethnic (BME) groups represent 14% of the population of Richmond. Some BME groups can be at risk of poorer health outcomes. Research shows that community and place-level approaches to prevention, as well as reaching the whole population, are effective in these groups.
- **Sexual orientation;** Lesbian, Gay, Bisexual and Transgender people generally have higher needs in some areas, particularly mental health which can impact on health behaviors such as alcohol use, smoking poor diet, and physical activity.

The full EINA is available at
www.richmond.gov.uk/acs_eina_reports

Joint Strategic Needs Assessment

Through the HWB, the council and CCG have a statutory duty to prepare and publish a Joint Strategic Needs Assessment (JSNA) for Richmond. The JSNA is the ongoing process to describe the current and future health and wellbeing needs of the local population to inform services.

The JSNA provides a framework for improving local health and wellbeing and addressing inequalities. For all JSNA products, visit: **www.datarich.info/jsna**

THE RICHMOND STORY 2015-16

The Richmond Story is a snapshot of the local needs identified through the JSNA process. It is developed to inform commissioning intentions and the JHWBS. The Richmond Story 2015-16 highlighted the following priority areas:

- **Maximising prevention opportunities**
- **Reducing health inequalities**
- **Minimising harms and threats to health**
- **Planning for increasing numbers of people with long-term conditions and promoting independence**

For a summary of the Richmond Story, see **Appendix 2**, or for the full version visit **www.datarich.info/jsna**

The Joint Health and Wellbeing Strategy

Think Big Picture – graphic recording of listening event for Children and Young People


HWB STRATEGY 2016
De-stigmatise mental health... promote emotional literacy from an early age & with all caregivers
human face
Hi!
Focus on the whole family
include THESE in the new HWB strategy
I feel...
Get to know young people as INDIVIDUALS
Integrate services around the family rather than
Age Well
Look at communicating to promote ACCESS.... share information via key people & consistently
GP
PRACTICE NURSE
SCHOOL NURSE
Reach out to families who don't access services
2½ yr checks
Promote TRUST and positive personal relationships - ESPECIALLY for children in care
Spot RISKS & OPPORTUNITIES early in all settings
COMMON FRAMEWORK
risky behaviour
Risky Behaviour
info
advice
guidance
COMMON PLATFORM
Work with EMPLOYERS to support employment
business breakfast
disability
specialist services
thinkbigpicture.co.uk

1. Start Well

ABOUT THIS THEME –WHY IS IT IMPORTANT?

- What happens early in life (starting from conception) affects health and wellbeing in later life – from obesity, heart disease and mental health, to educational achievement and employment opportunities.
- Pregnancy and early childhood (0-3 years) are particularly important periods –a loving, nurturing family environment provides the foundation for healthy development and ensuring a child is ready for school.
- There is a strong economic case for investing in prevention programmes. Intervening early can avoid the potential high costs of dealing with developmental problems, drug and alcohol misuse, antisocial behaviour, domestic abuse and crime.

SPECIFIC ISSUES IN RICHMOND

Most children and young people in Richmond are healthy and have a good start in life. However not all children and young people enjoy similar positive health outcomes and therefore opportunities to achieve. Prevention is critical to ensuring that all children and young people can fulfil their potential, particularly those living in poorer social circumstances.

- Most children achieve a 'good level' of developmental progress by 5 years old, but children living in less well-off families are less likely to achieve this marker of readiness for school.
- Around 3,000 (21%) primary school aged children are obese or overweight.
- The What about YOUth survey showed that 15 year olds in Richmond engage in significantly more risky behaviours (smoking, alcohol and drug use) compared to peers nationally.
- The School Health Survey shows that many children and young people experience anxiety and emotional difficulties due to a range of concerns including exams, bullying and relationships.
- Young people say they want early access to specialist mental health support to avoid later crisis.
- Evidence indicates that Richmond has higher rates of young people attending hospital who are self-harming compared to other London boroughs.
- Service improvements for vulnerable young people with special education needs and disabilities, and those leaving care, are needed, especially improved access to training, employment and housing.

How will the Health and Wellbeing board, as a systems leader, take action to enable people to start well?

- Enable children, young people and families to be resilient, connected and able to look after themselves and each other.
- Promote positive conditions and places for children, young people and families to grow, learn, work and play and be safe.
- Ensure all children and young people feel included and not stigmatised; and empowered to meet their aspirations- regardless of social and cultural background, caring responsibilities, or disability and mental health difficulties.
- Ensure services and professionals work sensitively and in partnership with children, young people and families, and ensure better understanding and transparency about issues of sharing of information/ confidentiality and safety.
- Integrate and coordinate services around the family.
- Make prevention and early help central to universal / mainstream services.

TRANSFORMATIONAL INITIATIVES THAT THE BOARD WILL CHAMPION

The strategy for Start Well encompasses a number of significant developments that seek to increase focus and resources towards prevention and early intervention, and demands strong partnership working to make best use of resources.

Ensure the Best Start in Life for all Children

The Early Years Development Plan (currently being developed) has the aim of ensuring all children have the best start in life through a joined up approach to family health and wellbeing. The Early Years Pathway provides the framework for enabling integrated delivery of high quality prevention and early intervention services across health visiting, children centres, early education, primary care, maternity and safeguarding.

The focus is on joint working in areas of high impact:

- Transition to parenthood
- Maternal mental health
- Breast feeding and managing healthy weight
- Parent-led integrated 2 ½ year review (health and early education)
- Managing minor illness

For example health visiting and children centres are working to achieve the internationally recognised standards (UNICEF) that means services are 'BabyFriendly' –an approach that respects a mother's choice, whilst providing sensitive advice and support for breastfeeding.

Many women can suffer mental health problems during and after pregnancy –from mild to more severe level. We aim to have a clear pathway in place covering early detection and diagnosis, and additional support (for example 'listening visits' by the health visitor) and /or access to specialist mental health services.

Champion the Strengthening Families Programme

This is a nationally-led strategy for supporting families with a range of complex needs- including unemployment, low income, domestic abuse, health problems (such as mental health difficulties and misuse of drugs and alcohol), and young children who are not thriving or older children engaging in anti-social behaviour or truancy. It is based on a multi-agency model – a team approach that is focused on the family.

Achieving for Children is taking forward Phase 2 – a five year programme starting in 2015/16. This involves a multi-agency approach to ensure families are identified as early as possible and that there is a comprehensive response to their needs. A method of risk stratification will support the process.

Promote Resilience and Emotional wellbeing through a Whole Systems Approach

A new Transformation Plan (encompassing the Children and Adolescent Mental Health Services (CAMHS) transformation) is the start of a five year Emotional Wellbeing and Mental Health Strategy for children and young people. This is based on extensive engagement with children, young people and families. This plan is focused on improving outcomes through a whole-system approach; families, communities, schools and services.

The strategy centres on promoting resilience and early help, particularly through schools and community settings, and improving access to specialist mental health support. Schools will be a fundamental partner. It also addresses the needs of children and young people with special education needs and disabilities including attention deficit hyperactivity disorder (ADHD) and autism.

Champion the Development of an Outcomes Framework

We propose to take forward the development of an outcomes framework for children and young people. This framework will enable strategic partners to work together and commission services that are focused on achieving the outcomes that matter to children and young people. Importantly it will involve a significant engagement process with children, young people and families to define a set of 'outcomes'- measures of improvement in health and wellbeing as the basis for the design and commissioning of programmes and services.

Case Study: Whole-school approaches to promoting emotional wellbeing and mental health

'Whole-school' approaches to promoting the social and emotional wellbeing of children and young people encompass all aspects of the school life, as well as learning and teaching. The school nursing service will develop its role in promoting emotional wellbeing and mental health. This will include effective personal, social, health and economic (PSHE) classes on healthy relationships and sexual health, addressing issues such as body image, stress management, positive relationships, and on-line safety. It will also include providing advice and support through confidential drop-in sessions, group sessions and telephone and on-line communications. Outreach school and community based clinics will be piloted by the Emotional Health service to provide timely access to psychological therapies.

Sarah started cutting herself at 15 years old. She found self-harming gave a sense of control in dealing with her emotions of distress, confusion and loneliness. Unkind text messages made her feel worse. A collaborative initiative by the school nursing service and the emotional wellbeing service was established in response to a number of schools concerns about young people self-harming. Sarah was able, in a small group setting, to understand the feelings and reasons for her self-harming. She gained the confidence to understand everyone reacts to situations in different ways and was able to find other coping mechanisms that are healthier, giving her hope for the future.

2. Live Well

ABOUT THIS THEME – WHY IS IT IMPORTANT?

- The main unhealthy behaviours of smoking, alcohol misuse, poor diet and lack of physical activity, as well as poor emotional and mental wellbeing, are responsible for a large proportion of ill health and long-term conditions, including cancers, cardiovascular disease, diabetes and dementia.
- These health behaviours are known to be primarily influenced through exposure to cues in the environment, social circumstances or psychological stresses, establishing 'automatic' processes which result in unhealthy behaviors such as eating too many sugary foods or being inactive.
- There is interdependency between emotional wellbeing, mental health and the prevention and management of long term conditions. Living with a long-term condition (and being unable to work as a result, for example) can decrease emotional wellbeing: unhealthy behaviours are often taken up as a coping mechanism (e.g. smoking), resulting in further ill health and decreased wellbeing.
- Cost effective and universal interventions have an opportunity to reach all populations regardless of socioeconomic group.
- Universal interventions require a systems approach which includes interventions at a place, community and individual level. In a time of austerity, place and community level interventions are required for a population reach. Individual level interventions will be required for a targeted approach for vulnerable groups.

More information about this theme can be found in the Annual Report of the Director of Public Health 2016.
www.richmond.gov.uk/annual_public_health_report

SPECIFIC ISSUES IN RICHMOND

Most people in Richmond are healthy, but the incidence of people living with long term conditions in older adulthood is increasing at an alarming rate. Important opportunities for prevention include:

- Engagement in the four risk behaviours in Richmond is significant, 17,000 (11%) adults smoke, 24,000 (16%) adults are physically inactive, 68,000 (45%) adults do not eat 5 fruit & veg per day and 38,000 (25%) adults drink alcohol at increasing or higher risk levels. Population estimates indicate that over 65,000 (45%) people living in Richmond are carrying excess weight.
- Emotional wellbeing underpins health behaviours, 22,000 (16%) adults in Richmond are living with a common mental disorder, such as anxiety or depression.
- Many people would benefit from diagnosis and treatment of previously undiagnosed disease, or behavior change support if at high risk of disease.
- Local residents say making full use of local assets such can help support healthy behaviours and reduce poor health outcomes. For example, green spaces to increase opportunities for physical activity, and increasing the availability of healthy food.

How will the Health and Wellbeing board, as a systems leader, take action to enable people to live well?

- Embed prevention through cross council and CCG commissioning and place level planning.
- Further utilise Workplaces and Village Planning, including Community Links, for connectivity and inclusion.
- Coordinate access to Health Checks, Health Improvement Services, and Psychological Wellbeing Services. Promote access to community assets such as parks, open space, accessible streets and cultural activities.
- Increase the focus on access to services and healthy environments in and around the Workplace in partnership with communities, local businesses, community organisations and the voluntary sector.

TRANSFORMATIONAL INITIATIVES THAT THE BOARD WILL CHAMPION

Champion a Systems Approach to Prevention

The Prevention Framework and the Annual Report of the Director of Public Health, outline the need for a whole systems approach to Live Well. To have the required population impact efforts must be targeted to enable the healthy choice to be the easy and preferred choice. This can be achieved through coordinated efforts at a place and community level which provides cues and supports automatic processes for living well. These universal approaches offer more cost-effective alternatives to one-to-one service level interventions. This could include, for example, a coordinated and partnership approach to the promotion and ability to engage in active travel. The Mental Health Strategy for Richmond highlights the importance of supporting resilience in working age men, this could include community driven approaches such as workplace programmes and individual solutions such as the Improving Access to Psychological Therapies (IAPT) programme. Access to individual level support services are also required for vulnerable and at risk groups to support people to overcome physical, cognitive and social challenges to living well

Champion Improved Accessibility to Balanced Food Options

Accessibility to varied and balanced food options is the biggest predictor of our consumption. To enable people to make the preferred and healthy choice, a whole systems approach is needed. This will include the availability of a variety of foods in the places where people spend their time, for example workplaces and around schools. Where choice has been limited, high fat and high sugar foods often become the default for many people. An increased awareness of a variety of foods and the associated positive experience can be introduced with workplace programmes and parent and child cooking initiatives. To achieve this, a collaborative partnership approach is required with local businesses, communities and voluntary sector services. A recent workshop held between Richmond and the Town and County Planning Association (TCPA) included partners across the council and highlighted the benefits of planning for health for a population level impact. This included a restriction in the density of take-away outlets close to schools. Championing a comprehensive and cross-partner approach to support health and wellbeing will be essential for living well.

Champion Active Travel in the London Borough of Richmond upon Thames

Being active everyday makes us feel good, gives us the space to notice what's around us and has protective benefits, improving resilience and physical health. To achieve sustainable improvements in physical activity levels we also know that activity needs to be embedded into the day to day routine and become an automatic process.

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

The Prevention Framework for Richmond outlines the required partnership of the CCG and council to develop the place level infrastructure and community norms to enable active travel. Active travel is a central element to the Integrated Transport Plan and Cycling Strategy. The council is also developing a short training package to enable council staff to promote active travel.

The HWB has a critical role to play to lead and co-ordinate partners to embed active travel. This could be achieved through training frontline health and social care staff to promote the benefits of active travel, working with transport to improve road infrastructure, working with schools to promote active travel and Physical Education in school time, and engaging local businesses to enhance their travel plans to encourage (help to buy cycle schemes) and enable (provide storage and shower facilities) active travel.

Champion Midlife Live Well Checks & Workplace Health

Prevention

Health checks provide awareness of risk which is relevant and tailored to the individual based biochemical markers, such as raised blood sugar. Furthermore, risk information is communicated by the GP which is known to be an effective conduit for galvanising change and access to support services. The new healthy living service for Richmond will be focusing even more attention on taking Health Checks out to communities that healthcare has so far been less able to reach. Given that the population of Richmond is, in the most part, of working age and in employment, the HWB will have a role in championing an approach to target workplaces.

Recovery

The new healthy living service has been tasked with demonstrating better linkages between services and community assets for living well. There is an opportunity to promote the importance of Midlife Live Well Checks, with a specific focus on men. Being in employment has vast positive benefits to health and wellbeing. These positive effects of psychological wellbeing needed for the management of long term conditions, including cancers, are an important asset for supporting the best health outcomes. Living with a long term condition does also require additional aspects of self-care which need to be accounted for and with appropriate flexibility and support from employers and colleagues. The healthy workplace charter includes guidance for organisations to provide appropriate one-to-one support for people to manage their conditions, alongside their work commitments in addition to organisational leadership which instills a supportive environment for recovery.

Case Study:

LIVE WELL CHECKS

In 2013/14 Richmond's Health Check programme reached 6,040 residents. Over 15% of those identified as 'at risk' were referred to the Live Well service. The Live Well, Health trainer programme has already been working with users to set goals for emotional wellbeing. This has included links with psychological therapies and the expert patient programme and has benefitted 78% of their service users.

Mike Richmond is 47 years old, inactive and works in a busy firm in Richmond. When his Director told the team that they were being given the opportunity for a 'Live Well Check' his initial response was to have a laugh with his colleagues and say "not for me". However, following his assessment which identified pre-diabetes, things quickly changed for Mike.

He met with a health trainer who identified that his days were often spent sitting at work or on the train. They talked about what was important to him and put him in touch with volunteers for the local rugby club where he used to be a member. He was also encouraged and reluctantly attended a Health Walk with a colleague, where he was positively surprised by how good it felt to get out of the office and connect with colleagues. One year on, Mike is making the most of all of his time, he cycles to work, dropping off the kids with their scooters on the way after a catch-up. Mike also volunteers, guest coaching for the rugby club once a month which he says makes him feel 10 years younger as he is so focused on the team, he completely forgets about work. As a result, his blood sugar has returned to normal levels and Mike feels healthier and more energetic.

RECOVERY IN THE WORKPLACE

Peter Sheen is 55 years old, and was diagnosed with Prostate Cancer last year. Peter works for a busy firm and was concerned that he would need to leave his job. Peter's manager supported him in discussions with Occupational Health and Human Resources where they worked through a flexible working plan during his time of treatment. For a period of time, it was clear that he would be unable to meet the requirements of his substantive role, an interim was brought in to support with the daily demands and Peter retained other duties of his post for a protected duration of time. He had regular meetings to review the flexible working agreement which enabled Peter to remain part of the organisation with influence over his work streams without the pressure of day-to-day delivery. Following treatment Peter wasn't able to get much sleep and so maintained home working whilst maintaining regular contact with the Workplace Champions Group, of which he is a keen member. Getting active after treatment was important to him, the journey to and from work was of concern too, but was made possible by the access to the community toilet scheme and benches. The workplace health programme also offered gentle yoga sessions which Peter reports have been invaluable socially, physically and psychologically. Peter is now back at work full time and reports that the supportive infrastructure as invaluable to his recovery.

3. Age Well

ABOUT THIS THEME – WHY IS IT IMPORTANT?

- As they age, most people see themselves living an independent and fulfilling life connected to their family, friends and community in the place they call home. But for far too many, this desire does not translate into reality.
- Although people are living longer, this has not been matched by a similar increase in the length of time people live in good health. As a result people tend to live for longer in poor health, and with a diminished quality of life.
- Older people are particularly vulnerable to social isolation or loneliness owing to loss of friends and extended families, mobility or income.
- Many people assume caring roles in midlife and older age, and the stress associated with providing care, including for someone with dementia, cancer or stroke, can result in high levels of psychological distress and depression.
- Being a carer can also restrict the ability to participate in social activities (as well as paid employment), with consequences for physical and mental health, for depression and obesity.
- Furthermore, issues like loneliness and isolation exacerbate poor health and are a causal factor in many long term conditions, for example loneliness and isolation is associated with, and predictive of depression and dementia.
- Whilst we should very much welcome the fact that people are living longer, our challenge is to make sure that our residents live longer in good health and with a good quality of life

SPECIFIC ISSUES IN RICHMOND

- There are around 24,000 people (12.6%) who are aged 65 years and over, which is higher than the proportion across London (11.5%) but lower than the England average (16.3%).
- From age 65 onwards, women and men have 6.2 years and 4.7 years, respectively, of healthy life expectancy, this is approximately 7 years longer than the equivalent for both London and England. This means that approximately, adults in Richmond live for 13 years in ill health.
- The percentage of the population aged over 75 in Richmond is projected to increase; it is estimated that currently 6% of older adults are from a Black, Asian or minority ethnicity, but this is expected to double to 12% by 2041.
- Richmond has the highest proportion of people aged over 75 and living alone in London (51% in Richmond vs. 35% for London). A survey found that just under half of adult social care users feel they have as much social contact as they would like.
- Of the 85 years and over population, only 34% received a council funded service at home and 7% in a care home, meaning that approximately 2,400 (59%) people aged 85 and over are either not receiving care or are arranging care themselves.
- An estimated 14% (3,442) of older people in Richmond borough are carers, providing help and support to a partner, child, friend, relative or neighbor due to age, physical or mental illness, addiction or disability.
- It is estimated that 2,072 Richmond residents have dementia. Around 64% of the estimated number has received a formal diagnosis, which is higher than the national average but lower than the London average, and below the target of 66%. Of those with dementia, 70% (840 people) have one or more other long term conditions, and it is estimated that two-thirds of those with dementia live in the community (outside of a residential care or clinic setting).
- Nearly one in three people registered with a GP in Richmond has one or more long-term condition and nearly one in ten has three or more. The proportion of people with three or more long-term conditions is significantly higher in those aged 65 and older (44%).

How will the Health and Wellbeing board, as a systems leader, take action to enable people to age well?

- Galvanise partners across health and social care system to deliver integrated health and social care services.
- Work to reduce the number of people experiencing lonelines and social isolation by supporting people to age well, feel connected and stay at home for as long as it is safe for them to do so.
- Work with individuals, communities and services to recognise the contribution of all carers.

TRANSFORMATIONAL INITIATIVES THAT THE BOARD WILL CHAMPION

Champion Richmond's Outcomes Based Commissioning Approach

We know we need to make transformational changes to the health and social care systems to address increasing pressures arising from an aging population, increased multi-morbidity and financial constraints.

We need a future system that focuses on prevention, early intervention, shared decision making and self-care to prevent, reduce and delay the need for care. When problems occur that need the intervention of health and social care services, our service response must be co-ordinated and targeted.

The HWB has a role as systems leaders, to drive forward the integration of health and social care via championing an Outcomes Based Commissioning (OBC) approach to commissioning as a way of transforming the health and social care system. The Better Care Closer to Home Strategy and the Prevention Framework outline the CCG and Council's approach to developing services with a preventative ethos and joined up approach. The Board will work to ensure these strategies are embedded in the new OBC approach.

Champion Dementia Friendly Villages

People with dementia and their carers talk about the everyday challenges they face in living well with dementia. This can include difficulty using technology, getting appropriate service in shops, banks and post offices and in using transport, going on holiday, maintaining social contact and hobbies. Although help from health and care services is vitally important, making it possible for people affected by dementia to live well will require help from people and organisations across society. A joint health and social care Dementia Strategy is being developed to plan for the expected increases in the numbers of people living with dementia in the next 5-10 years.

Working with the Village Planning process, we are rolling out Dementia Friendly Villages to encourage organisations, businesses, cafes and restaurants, and retailers to be "dementia aware" and commit to supporting connected and vibrant communities that people can age well in. This will include wider environmental issues, for examples, community toilet schemes, pavements, benches, crossings and signage.

Champion the Identification of Carers and Referral for Carer's Assessment

Caring can affect residents of any age. The number of carers in Richmond reported in the 2011 Census (15,802; 8.5%) is much higher than the number of carers that have been identified by services and who utilise key carer specific and open-access services for residents. This is demonstrated, for instance, in general practice (less than 1,000 carers, 0.45% of the registered population), in the voluntary sector (around 2,300 adult carers identified by the Carers Hub Service, and around 370 by Richmond Borough Mind "Carers in Mind") and in social care (853 adults had a carer's assessment in 2011-12). This suggests that health and social care professionals may not be aware of the carer's responsibilities and associated support needs of patients.

Engagement with all carers, carers' organisations and others identified that: many carers do not consider themselves to be a carer but as just part of a family; accessibility of information and advice is important; respite care and breaks for carers are important; steps must be taken to protect the health and the carer and support them to stay well; and there is a need to recognise carers as an expert partner in care.

Increasing the identification of all carers in general practice, community health services and mental health services is a key priority in the Carers Strategy. General practice and the carers assessment will play a key role in the identification of carers and signposting them to available services.
A refreshed Carers Strategy is currently under production and will be launched in summer 2016.

Living with Cancer and Beyond

In Richmond, there are approximately 3,410 people living with a diagnosis of cancer and the number of people diagnosed with cancer is rising, reflecting the impact of our ageing population as well as improvements in diagnosis. Additionally, more people will live for longer with their cancer diagnosis, and survive, as treatments improve. Hence, the move towards treating cancer as a long term condition.

Much of the emphasis in the London Cancer Strategy and locally is on preventing cancer and early detection. Whilst this is important for improving outcomes it is also important to recognise the needs of those who have cancer and the needs of their families and friends. Across the whole population good care for those with serious illness can have a major impact on the wellbeing of many.

Richmond CCG, with its partners, has made it clear that it is committed to improving patient outcomes in cancer and all aspects of care, improving the patient and carer experience across all pathways of care and throughout all stages of cancer care.

Case Study: Dementia friendly villages

Richmond Dementia Action Alliance already has over 60 services, churches, organisations and businesses, including local council and health services, who have signed up to show their support. The Richmond Dementia Action Alliance aims to raise awareness of dementia by directly approaching businesses and organisations to pledge their contribution to a more dementia friendly borough. The Alliance asks the businesses or services to make sure that all staff are "dementia aware", via training using an online video or staff training session and pledge to undertake up to 3 actions to improve their premises or environment for people with dementia.

A local newsagent in Richmond upon Thames had recently encouraged its customer-facing staff to take part in a dementia friends training session, as part of the Dementia Friendly Villages initiative that was taking part in the local village area. As result, the shop keeper noticed that the staff had more confidence in interacting with a range of customers and that the shop felt friendlier and more welcoming. One morning Martha Barnes, aged 82, popped in for her morning paper, as she did most days. However, this time, Martha became very confused and agitated. The cashier recognised that Martha may have dementia and remained patient. Eventually she was able to gently persuade Martha to give her the phone number of a family member who was able to take her home.

Appendix 1

Summary of achievements of the Joint Health and Wellbeing Strategy 2013-16

The HWB focused their first strategy on integration of services that from a patient perspective are not joined up. The table below outlines the four priority areas which were identified for where improvement could only be made in partnership.

Priority area for integration of services	Progress made
Child to adult services transition - for young people with long-term health and social care needs	• A transitions protocol has been signed up to across all children's services and adults' services. There is now clear tracking of children/ young people from the age of 14 in order to identify those who are likely to need support as adults and to identify which team should lead the assessment. • Social workers in adult services staff are undertaking adults' assessments to enable a more seamless transfer of care, and NHS specialist health workers are assessing continuing health care needs, both in advance of the young person's 18th birthday. • A new adult Attention Deficit Hyperactivity Disorder (ADHD) service has been commissioned to fill this gap for adults. • Four new supported living services for young adults with a learning disability have been commissioned, two for those with autism and complex needs to ensure that there are local accommodation options and to prevent out of borough placements. • The recent Care Act and Children and Families Act means that there are now more options for young adults with mild and moderate conditions who would not previously have been eligible for services. • Furthermore, a number of work-related college programs have been introduced and Remploy are offering programs to support young adults into work.
Physical and mental health services – many people have both long-term physical health conditions and mental health problems	• A comprehensive engagement process was carried out with residents, patients and carers, to develop an adults' framework of mental health and social care outcomes that matter to local people. This will underpin a new mental health outcomes based commissioning approach. • Referral pathways between physical health services and the mental wellbeing services continue to be identified and developed to ensure patient's mental health needs are addressed alongside their physical needs. • 'No Health without Mental Health' training was piloted across four South West London boroughs (Richmond, Merton, Kingston and Croydon) to ensure all staff are aware of the interfaces between mental and physical health. This training is currently being evaluated, and the next steps are to be decided in due course. • A pilot service is being developed to support people with diabetes to better manage their condition. The pilot will support people to identify and manage low level mental health conditions which can adversely people's health and self-management of their condition.

Priority area for integration of services	Progress made
Health and social care services – fragmentations in social care and community health care services	• Joint commissioning arrangements across health and social care have been established in a co-located team. • The Better Care Closer to Home Strategy has been developed and implemented, in response to local people's requests for services in the community that help them to remain independent for as long as possible. • The Better Care Fund plan has been implemented to better integrate health and social services in order to create greater health and social care systems resilience. • A comprehensive engagement process was carried out with residents, patients and carers, to develop an adults' framework of health and social care outcomes that matter to local people. This will underpin the Outcomes Based Commissioning approach. • A GP Led Care Model of Integrated Care (which looks to strengthen links across GPs, community nurses, therapists, and social workers) has been implemented to identify people at risk of hospital admission and support them to stay safe and well in their own homes and communities. • The Community Independent Living Service was commissioned jointly by the Council and CCG to act as a flexible hub, increasing access to low level support and information navigation for vulnerable adults, local to where people live. • The Carers' Hub service offers carers: Information advice and support; financial and debt advice; short breaks and leisure programmes; training and workshops for carers; a young Carers Service; opportunities for carer engagement; Carers awareness training for professionals; and strategic leadership. • The council and CCG have jointly commissioned Richmond Response and Rehabilitation Team (RRRT). This aims to facilitate a safe and timely discharge from hospital, and provide a time-limited service to support people to retain or regain their independence at times of crisis or transition. It provides a range of flexible professional services and interventions.
Hospital to community services – develop out of hospital services from a range of diverse providers	• The integrated Falls Service (IFS) is a coordinated service which offers a multidisciplinary specialist assessment with the provision of treatment and recommendations in falls prevention and bone health management. This service delivers to those aged 50 years and over, and has established strong links with clinical leadership from Primary care, Secondary care Kingston Hospital, West Middlesex Hospital, Imperial College NHS Trust, Teddington Memorial Hospital, Queen Mary's Hospital, Local Authority including Public Health and social services, London Ambulance Service, and the voluntary sector. • Early Supported Discharge (ESD) for Stroke Survivors has been locally designed to ensure that stroke survivors meeting specific eligibility criteria are able to leave hospital earlier with the support of a stroke specialist community rehabilitation service. This provides a home-based rehabilitation service at the same level of intensity as a hospital-based stroke rehabilitation team. • The Better Care Fund has been used to commission community geriatricians to work closely with GPs by providing specialist information and advice to GPs as well as in A&E. • Liaison Psychiatric Service has been established to integrate specialist mental health expertise and resource into acute hospitals to effectively manage care for people with mental health problems. • Richmond CCG is engaged in developing two assistive technology services (sleep apnoea and cardiac home monitoring), providing patients with practical technology based solutions. This forms part of a holistic, integrated approach to meeting health care needs, including diagnosis, treatment, and monitoring of specific long term conditions, which in turn will deliver significant enhancement to patients' quality of life. • Work across care homes, community services, and primary care has taken place to ensure difficult conversations are held early enough in the patient journey to ensure adequate planning for a good death in the patient's preferred place. This results in a reduction in hospital deaths and a corresponding increase in community deaths, suggesting that more people are dying in their place of choice.

Appendix 2

The Richmond Story 2015-16: Summary

The Richmond Story is a snapshot of the local needs identified through the Joint Strategic Needs Assessment (JSNA) process and informs commissioning intentions. The full Richmond Story and the accompanying scorecard of indicators can be viewed or downloaded at **www.datarich.info/jsna**

A few highlights from the Richmond Story are included below.

WHAT DOES THIS MEAN FOR RICHMOND?

Overall, Richmond is healthy, safe and rich in assets, but areas where we can improve include:

MAXIMISING PREVENTION OPPORTUNITIES

- Despite favorable comparison with London and England, estimated numbers of people in Richmond with unhealthy lifestyles are substantial:
  - An estimated 17,000 (11%) adults in Richmond smoke.
  - Approximately 3,300 primary school age children and almost half of adults (approximately 65,000) are estimated to be obese or overweight. 25,000 adults are estimated to do less than 30 minutes of physical activity a week and fewer than half (43%) of residents achieve the standard of 5 portions of fruit and vegetables per day.
  - Richmond has higher than average estimated proportions of increasing-risk (21.3%) and higher-risk (7.8%) drinkers compared to England. In addition, alcohol-specific mortality is higher than the London average and the rate of hospital admissions due to substance abuse in those aged 15-24 years is 5th highest in London.
- National prevalence models suggest that there are large numbers of people with undiagnosed long term conditions in Richmond (e.g. 2,700 people with undiagnosed coronary heart disease, and 4,850 people with undiagnosed diabetes).

REDUCING HEALTH INEQUALITIES

- Life expectancy is about 5 years lower for men and 4 years lower for women in the most deprived than in the least deprived area.
- An estimated 3,140 (8.8%) children in Richmond are living in poverty.
- Of those aged 16-18 years, 4.5% are not in education, employment or training.
- Only 8.2% of working age adults receiving mental health services in Richmond are in paid employment.
- 451 adults with learning disabilities are known to general practice.

MINIMISING HARMS AND THREATS TO HEALTH

- Approximately 15,800 provide some level of unpaid care and 15% of those provide more than 50 hours unpaid care per week.
- In 2013/14, there were 107 hospital admissions as a result of self-harm in those aged 10-24 years, the highest rate in London, and on average around 12 Richmond residents commit suicide per year.
- Richmond has the highest proportion of people aged over 75 and living alone in London (51% in Richmond vs. 35% for London).
- In Richmond, over 40% of acute sexually transmitted infection(STI) diagnoses are among those aged 15-24. STI rates have remained relatively stable over recent years in Richmond, but there have been increases in herpes and gonorrhoea.

PLANNING FOR INCREASING NUMBERS OF PEOPLE WITH MULTIPLE LONG TERM CONDITIONS AND PROMOTING INDEPENDENCE

- Nearly one in three people registered with a GP in Richmond has one or more long-term condition and nearly one in ten has three or more.
- Almost 32,000 of the GP registered population have a heart condition and there are 5,840 patients with diabetes.
- Around 1,700 people are estimated to have some form of severe mental illness and there are about 2,000 people recorded to be in contact with specialist mental health services. An estimated 22,000 people in Richmond have a less severe, common mental disorder (such as depression and anxiety) and there 6,164 adults identified with depression by GPs.
- Delayed transfers of care (DTOC) from hospital are an important measure of the quality of the interface between health and social care services. The rates of DTOC (8.1 per 100,000) and, in particular, those which are attributable to social care (2.3 per 100,000) are high compared to similar boroughs.
- There are 1,780 people recorded as having multiple sclerosis, Parkinson's disease or epilepsy and it is estimated that 2,072 Richmond residents have dementia.

Appendix 3

Glossary

Word/Phrase	Definition
Acronyms commonly used in this strategy	CCG – Clinical Commissioning Group CAMHS – Child and Adolescent Mental Health Services HWB – Health and Wellbeing Board JHWBS – Joint Health and Wellbeing Strategy
Accountability and responsibility of the HWB	The Health and Wellbeing Board are responsible for working with a range of organisations, to improve local health and wellbeing outcomes in the short, medium and long term and to address health inequalities. The Board are held accountable by full Council, and through this, the public. Healthwatch Richmond plays a key role in representing the views of patients, service users and the wider local population. More information about the board is can be found here: **www.richmond.gov.uk/health_and_wellbeing_partnership**
Active Travel	Cycling, walking or other active means of commuting, as opposed to commuting via car, taxi or public transportation.
Better Care Fund	The Better Care Fund is a pot of money which must be used to support health and social care services to work more closely in the borough. In Richmond the focus of our BCF is to support frail and elderly patients/service users who tend to be higher users of health and social care services than other population groups. Further information can be found here: **www.richmondccg.nhs.uk**
Better Care Closer to Home Strategy	The strategy outlines how Richmond CCG and Richmond Council intend to improve care provided out of hospital. More information and the full strategy is available here: **www.richmondccg.nhs.uk**
Built environment	The built environment includes all of the physical parts of where we live and work (e.g. homes, buildings, streets, open spaces, and infrastructure). The built environment influences a person's level of physical activity. For example, inaccessible or non-existent pavements and cycle paths contribute to sedentary habits. These habits lead to poor health outcomes such as obesity, cardiovascular disease, diabetes, and some types of cancer.
CAMHS	Child and Adolescent Mental Health Services - CAMHS is used as a term for services that work with children and young people who have difficulties with their emotional or behavioural wellbeing.
CAMHS Transformation Plan	The transformation plan for Richmond aims to make the system work better together through joined up assessment and provision; and co-operation and collaboration between referrers, schools, providers and service users, to improve children and young people's mental health. The full plan can be viewed here: **www.richmondccg.nhs.uk**
Community	Refers to the area where a person lives and the assets available to that person, including the people, spaces and services in that area. This includes residents, local businesses, services and the environment e.g. parks and open spaces. Also known as localities and village areas.

Word/Phrase	Definition
Community-level approaches (prevention)	Have an impact on our capability, opportunity and motivation in two ways. Firstly, by enabling us to review what others are doing and compare ourselves, and, secondly, by offering social interaction, connectivity and belonging. Some community level solutions cover both. For example; the Breast Feeding Friendly programmes provide a peer group, support and connectivity for making the healthy choice. Further information can be found in Richmond's Annual Public Health Report: **www.richmond.gov.uk/annual_public_health_report**
Community Links	The Community Links Team work with residents and businesses in the 14 villages to help promote community involvement by: • keeping local communities informed about what the Council is doing; • building a better understanding of what community activity is already happening; • identifying and promoting opportunities for local people to get involved; and • helping local people and groups find the support they need to take part. **www.richmond.gov.uk/community_links**
Engagement	Engagement is the process of involving partners, providers, service users, patients, carers and local residents in our work. The Health and Wellbeing Board believes that the public has an active role to play in shaping public services. The board expect that people will be helped to have their say, their preferences taken into account and they will be given an account of the way the public's views were used. More information on engagement can be found here: **www.richmond.gov.uk/health_and_wellbeing_partnership**
Individual-level approaches (prevention)	Preventative services that are delivered in a group or on a one to one basis. Services for smoking, diet, physical inactivity and excess alcohol offer support and techniques for making personal changes. These techniques include, planning and goal setting to overcome challenges, and promoting self-monitoring of both behaviours and outcomes. Support is also given for reflection for planning further actions. In addition to behavioural services, low intensity psychological wellbeing services are also available. Further information can be found in Richmond's Annual Public Health Report: **www.richmond.gov.uk/annual_public_health_report**
Integration	This involves breaking down the barriers between services and organisations, to encourage them to work together and create joined up services.
Long Term Conditions	Refer to health conditions that last a year or longer, impact on a person's life, and may require ongoing care and support. Examples include: diabetes, high blood pressure (hypertension), cancer, COPD (chronic obstructive pulmonary disease), dementia, and poor mental health.
Multi-agency	Where two or more organisations work together to design or deliver a service, project or policy.
Multi-morbidity	When a person is suffering 2 or more chronic medical conditions at the same time e.g. obesity can cause a person to have both diabetes and high blood pressure.
Norms	Something that is usual, typical or standard. Much of our behaviour is determined by societal norms.
Outcomes Based Commissioning (OBC)	A relatively new approach to commissioning health and social care services in the UK. It rewards both value for money and delivery of better outcomes that are important to patients and other service users. 'Outcomes' refer to the impacts or end results of services on a person's life. As such, outcome-focused services aim to achieve the aspirations, goals and priorities of service users.

Word/Phrase	Definition
Place-level approaces (prevention)	Place or environmental level approaches provide people with the opportunity to make the healthy choice. They enable people to develop positive automatic and routine responses that are supported by the physical environment. Further information can be found in Richmond's Annual Public Health Report: **www.richmond.gov.uk/annual_public_health_report**
Prevention	Aims to prevent, reduce and delay the need for care and enable individuals to remain independent for as long as it is safe to do so. There are three tiers of prevention: • Prevent - universally accessible services aimed at individuals with no current health or care support needs, e.g. park runs. • Reduce - resources for individuals who are at risk of developing further health or care support needs, e.g. suitably modified work so injured or ill workers can return safely to their jobs. • Delay – services for individuals with existing health and care support needs; the emphasis is placed on minimising further deterioration e.g. support for elderly people to live at home.
Resilience	A person's ability to adapt to and recover from stresses, and respond to adverse events with positive beliefs and behaviours. This is often mistaken to be an in-built and static state, but in reality it is a process. We all experience negative emotion in response to negative events, but we are best able to be resilient to this when our social and environmental influences provide the resources for us to do so. A person's resilience, therefore, is dependent on the resources and assets available. This has a major impact on our well-being and health behaviours.
Shared Staffing Arrangemets (SSA)	The joining of staff working for the London Boroughs of Richmond upon Thames and Wandsworth into a single staffing structure across the two boroughs. The new staffing structure is expected to deliver estimated savings of up to £10 million per year for local tax payers in each authority. More information on the arrangement can be found here: **www.richmond.gov.uk/wandsworth**
Systems Approach	See 'Whole Systems Approach'
Systems Leader	One of the main functions of the HWB is to provide leadership of the local health & social care system, by promoting greater integration and partnership, including joint commissioning, integrated provision, and pooled budgets. This includes Richmond Council, Richmond CCG, Healthwatch, and local voluntary sector and charitable organisations providing care and support services in the borough. This strategy expands the board's leadership role to encompass services across the entire system of services that contribute towards health and wellbeing, to include the Planning and Environment departments within the Council, local schools and local businesses.
Transformational Initiatives	Examples of ways the aspirations of the board can be put into practice and make a positive difference in Richmond.
Unhealthy Behaviours	Unhealthy behaviours are the things we do every day which contribute towards poor health outcomes. These behaviours are major risk factors for developing long term health problems. There are four main unhealthy behaviours which contribute to poor health and wellbeing, these are smoking, unhealthy diet, being physically inactive, and drinking too much alcohol. There is a two-way relationship between emotional and mental well-being and unhealthy behaviours. Reduced emotional well-being often leads to engagement in coping behaviours, such as the consumption of high sugar foods, smoking, alcohol use and reduced activity. Further information on unhealthy behaviours can be found in the Annual Public Health Report: **www.richmond.gov.uk/annual_public_health_report**

Word/Phrase	Definition
Village Planning	By listening to residents and businesses across Richmond, the Village Planning process outlines each of the 14 local areas identified, and their vision for how the area will develop in the future. Key issues, priorities and opportunities were identified for each village as well as ways the local community can begin to make these changes happen. Further information is available here: **www.richmond.gov.uk/village_plans**
Vulnerable Groups	A group which has a specific characteristic that puts it at higher risk of poor health and wellbeing. Examples include the elderly, people who identify as LGBT (Lesbian, Gay, Bisexual and Transgender), people of Black or minority ethnicities.
Whole Systems Approach	An approach which encompasses all of organisations within the system to work together to achieve a certain outcome. This includes departments across Richmond Council (from Public Health to Environment and Planning), Richmond CCG, Healthwatch, NHS England, the voluntary sector, local and national charities, local schools, and local businesses to name a few.

NHS
Richmond
Clinical Commissioning Group

healthwatch
Richmond upon
Thames

LONDON BOROUGH OF
RICHMOND UPON THAMES