London Borough of Richmond upon Thames
Promoting wellbeing and independence – a Framework for Prevention
2015-2018
Foreword

We are pleased to present Richmond’s first framework for prevention (2015-18), a joint framework of the Richmond Clinical Commissioning Group and the London Borough of Richmond upon Thames. It sets out our plans for meeting the future health prevention needs of Richmond residents and people registered with a Richmond General Practitioner. The framework will be accompanied by a high-level implementation plan for 2015/16 in order to meet the needs and aspirations of people living in the Borough. Whilst our framework will impact everyone, it will focus on adults and children going through transition.

The need to invest in preventative services to delay people’s need for social care and health services and to promote the wellbeing of our community is widely recognised. A shared preventative approach across organisations in the public, voluntary, community and private sector to deliver services to a changing and ageing population is required if health and social care services are to be sustainable.

This prevention framework recognises the impact of the places where we live, work and play on health and well-being and attempts to bring together actions across CCG and council wider strategies that contribute towards the prevention agenda. A major focus is to identify, at the earliest possible stage, the most vulnerable people in our communities - who are at risk of poor health and likely to require social care as well - to be supported by programmes that promote their capacity to maintain an independent lifestyle.

We value our residents and are committed to listening to their views on ways of improving the care and support they receive. The process for developing this framework has included engagement and consultation with services users, patients and carers to better understand their needs, current services and any gaps. We will continue to work with residents as we develop the prevention plans set out in this strategy to ensure they meet the needs of those using these services. Further engagement has also taken place across a wide range of services in the council, CCG and with partners to develop a shared understanding of the wide range of services that promote health and well-being, e.g., transport, parks, and planning. The contribution of all those who took time to tell us what health and wellbeing means to them and to comment on our draft strategy has been invaluable.

The success of this strategic framework will depend on the strength of partnership, working across health, social care, housing and other partners, to come together in a joined up approach to address the needs and aspirations of people living in the London Borough of Richmond upon Thames to live healthy lives for longer.

Councillor David Marlow 
Strategic Cabinet Member for Adult Services & Health
London Borough of Richmond upon Thames

Dr Graham Lewis
Chair
Richmond Clinical Commissioning Group
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Executive Summary

The London Borough of Richmond upon Thames Local Authority (LA) and Clinical Commissioning Group (CCG) are committed to working in partnership to deliver our first integrated three year Prevention Strategic Framework - to improve the health and well-being of our population and to support people to remain independent.

The Care Act (2014) emphasises the importance of a shift in service provision towards preventative services, with the aim of preventing, reducing and delaying the need for care. The promotion of wellbeing and the maintenance of independence lie at the heart of the Act.

To inform the development of this strategic framework, an assessment was conducted of the needs of the population and service provision was mapped alongside a consultation to inform what would be needed for a comprehensive approach to prevention.

All areas of the public sector, particularly health and social cares, face significant budget pressures, alongside pressures on existing services from an increasing, aging population. This document aims to provide a framework for all preventative services to help ensure the long term sustainability of health and social care services.

The framework recognises that health and wellbeing are influenced, not only by people’s choices or the health and social care services that we provide, but are under the impact of much wider forces that ultimately encompass the environment and communities in which people live their lives.

An overview of Richmond’s approach to influence socio-economic, cultural and environmental factors, social and community factors and individual lifestyle factors is outlined within this framework. Key current and future interventions are identified.

The four priorities for this strategic framework are identified as:

**Priority 1:** Making health and wellbeing everyone’s business

**Priority 2:** Creating healthy communities – harnessing local community assets to support people and their carers

**Priority 3:** Re-shaping healthy lifestyles services and embedding self-care

**Priority 4:** Reducing and delaying demand for care – promoting a recovery focussed model across health and social care pathways

The actions from this strategic framework have formed an integrated implementation plan.
1. Introduction – setting the scene

1.1 Context
The Care Act 2014 brings a significant reform in care and support, putting those with care needs and their carers in control and at the heart of their care and support to improve independence and wellbeing. Similarly, the NHS Five Year Forward View (2014) sets out a vision for the future of the NHS and calls on system leaders, NHS staff, patients and the public, to play their part in disease prevention alongside the development of new, flexible and integrated models of service delivery tailored to local populations.

All areas of the public sector face significant budget pressures. The NHS and local authorities are by no means exempt. Improving the public’s health will help secure the future of health and social care services and deliver longer, healthier lives for all of us. Working together, we can achieve the cultural shift that is needed to sustain health and wellbeing improvements for people who live in Richmond and create a focus on the promotion of health rather than the treatment of illness.

1.2 Vision
The vision is that:

*People in Richmond are empowered to take responsibility for their own health and wellbeing in a safe and supportive environment, achieve their full potential and live their lives with confidence and resilience.*

1.3 Key aims
Our five key aims are to:

- Focus action to embed prevention of ill health.
- Recognise the contribution that our communities and places have on our health and wellbeing.
- Recognise that our Borough is rich in assets and harness these assets to aid our change in direction.
- Enable people to have access to high-quality information and lifestyles interventions that prevent their health and care needs becoming serious.
- Inform decision-making at the right time and place to reduce and delay the need for care, recognising the need for people living with a health condition and their carers to have appropriate recovery services and the right information.
1.4 Objectives

Our key objectives are outlined in figure 1.

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<tr>
<th>Prevent</th>
<th>Reduce</th>
<th>Delay</th>
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<tbody>
<tr>
<td>● Prevent people from being overweight and obese</td>
<td>● Reduce numbers of hospital admissions</td>
<td>● Delay the need for residential or nursing care placement</td>
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<tr>
<td>● Promote physical activity and increase the use of our local assets, e.g. parks and green spaces</td>
<td>● Reduce readmission into hospital</td>
<td>● Delay the need for people to access social care support</td>
</tr>
<tr>
<td>● Prevent smoking and harms caused by tobacco abuse</td>
<td>● Reduce delayed transfer of care</td>
<td>● Increase the number of people at home 91 days after discharge</td>
</tr>
<tr>
<td>● Prevent alcohol-related harms</td>
<td>● Reduce numbers of falls</td>
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<tr>
<td>● Prevent people from developing long term conditions, e.g. diabetes, heart disease, dementia</td>
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*Figure 1. Key Objectives*

1.5 Purpose

This strategic framework sets out high level plans to transform the way Richmond residents will be supported to maintain their independence, health and wellbeing for as long as possible. This will be in line with the Care Act (2014) and LA and CCG priorities, to provide a shift in service provision, with an increasing focus upon preventative services with the aim of preventing, reducing and delaying the need for care. This should allow us to reach our goal of providing people with adequate information and advice, thus enabling them to access high-quality services at an early stage to aid their independence for as long as possible in their community and own homes.

1.6 Scope of the strategic framework

The framework is for all adults in the London Borough of Richmond upon Thames, including those young people in transition, i.e. moving from Children’s to Adult’s Services – this is in line with the requirement of the Care Act (2014). We recognise that the greatest contributor to our health and wellbeing is a good start in life and children and young people’s health and
wellbeing are addressed in other local strategies and planning documents including the Children’s and Young Peoples Plan.

This strategic framework includes actions to prevent, reduce and delay the need for care which are fully integrated into other strategies and services relating to well-being, health and social care.

The Council has developed a Making information & advice count strategy for Adult Social Care and this will act as a key partner to our Prevention Strategic Framework, which addresses our information and advice offer in more detail. A resource directory will be developed for our population and health and social care practitioners, which will contain information about the services we have in Richmond, including commissioned and non-commissioned services and services provided by the voluntary sector to enable healthier choices and pathways to be made.

We also recognise that significant work has taken place locally to develop an integrated health and social care whole system response for those at risk or already using health and social care services. This revised system is outlined in Better Care Closer to Home (2014) and Richmond’s Better Care Fund Plan (2014).

1.7 Financial Implications

The annual proportion of spend on prevention is 15% for Adult Social Care and 5% for the CCG.

The Council and CCG are operating within the context of significant budget pressure 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.

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

The Prevention Framework will be a key enabler by preventing or delaying the need for health and care services, which will assist the Council and CCG in managing demand pressures and help ensure the long term sustainability of our services.

‘…five minutes of advice in a general practice setting to enable access to lifestyle services can save £30 per person for a cost of £11 per person’ [extracted from: The Kings Fund. Transforming our health services. Top Ten Tips for commissioners. 2010]
2. Methodology

2.1 Overview of the framework

Health and wellbeing are influenced not only by people’s lifestyle choices or the health and social care services that we provide, but are under the influence of much wider forces that encompass the places and communities in which people live their lives. Legislation, housing, employment, transport infrastructure, recreational areas and community safety can all have an impact.

This three year framework has been developed jointly by the CCG and the LA. This partnership brings together partners and agencies in statutory, private, voluntary and community sectors. Its purpose is to understand local needs and evidence based practice; map existing services and identify gaps; and engage with local residents, service users and carers to inform priorities.

2.2 Assessing the needs of the population in Richmond

To inform a tailored approach to the strategic framework, we analysed the needs of the population. This included projections for the characteristics of a growing population, including age and the prevalence of long term conditions. Given the known detrimental impact of loneliness and isolation, the number of older adults living alone was also assessed.

2.3 Evidence base for prevention interventions

To inform the strategic framework we conducted a review of interventions to ‘prevent’, ‘reduce’ and ‘delay’ the need for care.

2.4 Mapping prevention services

To inform how we would need to shape prevention services in the future, we conducted a mapping exercise of existing services (e.g. weight management programmes), resources (e.g. sports equipment) and facilities (e.g. swimming pools and arts and culture programme) available for the population and specifically for the nine key client groups (see figure 3). We did this by firstly designing a mapping template, we then identified council service areas including; Adult and Community Services, Arts and Culture, Environment and Arts and Culture including Libraries and Achieving for Children (the new social enterprise for children’s services), to complete the templates with their knowledge of provision. This was followed by a review of the initial data collection which informed a wider engagement incorporating a
series of workshops, to identify; the offering of each service, eligibility criteria, the volume of use and the outcomes of the services. This provided recommendations based on gaps and opportunities in the current prevention offer.

2.5 Review of strategies which address prevention

To develop a full systems approach to prevention, we reviewed strategies across each of the departments in the LA and NHS partner(s). Effective prevention requires changes to the environment which nudge people to make healthy choices. This could include for example; road planning which includes cycle lanes providing the opportunity for physical activity.

2.6 Consultation and engagement

This framework was widely consulted across all directorates of the LA and NHS partners. Implementation will be enabled by on-going consultation; Richmond Health and Wellbeing Board (HWB) will facilitate partners to promote a whole Richmond approach to health and well-being. The HWB are currently undertaking a number of listening events to hear local residents’ views and experiences of health and well-being. The first of these took place in March this year and focussed on healthy lifestyle. This work is intended to inform the next Health and Wellbeing Board Strategy in 2016.

2.7 Equality Impact Needs Assessment

To ensure that health inequalities were addressed, we carried out an equality impact needs assessment. Whilst the general population in Richmond is relatively healthy there are pockets of deprivation and life expectancy is 7 years lower for men and 4 years lower for women in the most deprived compared to the least deprived parts of the borough. Within the whole population some sub groups have specific health needs and these groups have been identified. The equality impact needs assessment provides a tool for us to consider:

- The population structure is important when considering need, the older population is expected to grow and in line with this the demand for services will increase.
- The current and changing pattern of health inequalities among groups with protected characteristics, and the related needs and service requirements.
3. Local context – where are we now?

3.1 The needs for the people in Richmond

The number of people living in the London borough of Richmond is expected to grow by approximately 2,500 each year between 2014 and 2019 rising from 194,000 to 206,500. The expected overall increase for this period in those aged 65 years and above is 3,100 and in those 85 and over is around 500 (figure 2).

The prevalence of people with three or more long-term conditions increases from 4% in people under the age of 65 to 44% in those over the age of 65 (figure 3).

In Richmond this means that the number of people with more than one long term condition is expected to increase from 19,000 (10%) in 2013 to 24,500 (12%) in 2019.

The number of those aged 75 years and over living alone is projected to increase from 6,015 in 2012, to 7,157 in 2020 (an 18% increase). These growing numbers of older people will be at increased risk of depression and dementia. The estimated number of people currently living with dementia is 2,080. Those with limiting long-term illness will be particularly vulnerable to depression.

The combination of an ageing population and increasing life expectancy means that the number of people living with long-term conditions – conditions that cannot be cured but can
be managed through medication and/or therapy over a period of years or decades – will increase.
3.2 The evidence base

Socio-Economic, Cultural and Environmental Influences: Economic factors and Housing quality have a direct impact on health. Debt has a severe impact on mental health. Cultural influences and environmental influences such as the workplace also have an indirect impact on health via factors which are known to promote psychological wellbeing such as learning and connecting with others.

Social and Community Networks: Strong communities, families, and social networks protect and promote health and wellbeing and help to address inequalities. Communities can also be powerful agents of change by helping to spread positive norms, e.g. attitudes toward drink-driving and smoking. Communities with high trust and neighbourliness have lower crime. Communities have assets which, when mobilised, are highly beneficial to health, wellbeing and resilience. Initiatives such as volunteering, adult learning, and collective efforts to improve the local environment, all can build a sense of belonging.

Healthy Lifestyle: Much ill-health and disability is preventable. Up to 60% of cardiovascular disease and 40% of cancers are avoidable – recent evidence is emerging that most forms of dementia are also avoidable. Much of the collective impact of these diseases is caused by four key risk factors – smoking, physical inactivity, unhealthy diet and drinking alcohol at levels considered risky or harmful to health.

The relationship between physical health and wellbeing: There is vast evidence which highlights the relationship between psychological wellbeing and physical health, as outlined in the cross-government strategy, ‘No Health, without Mental Health’ (2011). Mental health problems are related to a quarter of all ill health and will affect half of the adult population at some point in their lifetime. The onset of ill health and living with a long term condition has a well-known detrimental impact on psychological wellbeing.

Each of these areas of influence on health and well-being are illustrated in sections as outlined below in the Dahlgren and Whitehead's (1992) model of the wider determinants of health (figure 4).
3.3 Local preventative services

To inform the development of local preventative services, we reviewed national strategies and facilitated a number of consultation events, which identified key principles to inform the remit of these services. This was followed by a mapping exercise of existing provision.

Key principles for prevention services

To achieve our aims and meet the needs of our population, all services will be underpinned by our agreed principles to:

- **Promote**: the health, wellbeing and independence of people and communities, improving the health of the poorest, fastest
- **Provide**: high quality information and support for people about the range of services available, enabling them to manage their own care
- **Protect**: the population from serious health threats and help people live longer healthier lives
- **Champion**: preventative and early intervention measures
- **Innovate**: utilise new technologies and approaches to enable people to have more control and choice in their care
- **Integrate**: encourage a joined-up approach to embedding prevention in care pathways
- **Assets**: utilise community, environmental and individuals assets to promote and maintain good health
- **Partnerships**: to facilitate local partners to work towards the best possible outcomes for all the people of Richmond

The mapping exercise identified a wealth of provision (*Developing the Prevention Strategy: Interim Mapping Report. March 2015*). A number of key themes emerged from the exercise which informed plans for future provision. These can be summarised as the need for:

- better communication of what resources are available and how to access them
- equitable distribution of services across the Borough.
- Connectivity and continuity between services. It was perceived that access to one service should enable easy flow between services for prevention.
- Alignment of incentives for older people and key priority groups across all services.

A number of opportunities arose throughout the mapping exercise. It was noted that:

- raising awareness of provision would be beneficial across all directorates of the council and externally for local residents.
- Cross-directorate strategic alignment would be required to identify preventative opportunities, we have applied this approach and the evidence base as illustrated in figure 2 to the development of a strategic framework, this is presented in the next section, 3.4.

Voluntary and community sector services are key to enabling people to live independently, be active in their community, create a local support network and help navigate the health and social care system should they need to.

We will continue to work with our Council Voluntary Sector Partnership Team and Commissioning Team to ensure a coordinated and joined up approach to developing and supporting the local voluntary and community sector. Future commissioning intentions will look to engage with the local third sector to support people to live as independently as possible in their local community and maintain their good health and wellbeing.
3.4 Strategic Framework for Prevention across Richmond

How do we know our strategies are responsive to the needs of the people in Richmond?

In Richmond there is a process for all strategies to be assessed alongside an Equality Impact Needs Assessment and address 9 protected population characteristics: Age, Disability, Gender, Marriage & Civil Partnership, Pregnancy & Maternity, Gender Reassignment, Sexual Orientation, Religion & Beliefs, Race.

An assessment of the needs of some key population groups has shaped this strategy. These population groups are: all adults; older people; adults with physical, sensory and other disabilities; adults with learning disabilities; adults with mental health problems; carers; vulnerable/socially excluded groups; people in transition (young people moving from children’s services into adult’s services); adults with autism.

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**Relevant Overarching Strategies**
- Community Plan, Corporate Plan, Medium Term Financial Strategy

**Relevant Strategies**
- AFC Business Plan 2014/17
- Looked After Children Strategy 2014/15
- Parks & Open Spaces
- Local Development Framework
- Local Implementation Plan for Transport
- Licensing Policy
- Village planning

**Relevant Strategies**
- Cultural Strategy
- Digital Inclusion Strategy

**Relevant Strategies - joint**
- Better Care Fund Plan
- Better Care Closer to Home Strategy
- Joint Health and Wellbeing Strategy

**Relevant Strategies**
- Annual Public Health Report
- Autism Strategy
- Carers Strategy
- Community Safety
- Partnership Plan
- Housing Strategy
- Homelessness Strategy
- Village Planning

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**Figure 5. Strategic Framework illustrating the strategies for addressing the Wider Determinants of Health for Richmond**
4. Priorities

Where do we want to go?

Review of the local and national context led to the identification of 4 key priority areas for action; these are listed in table 1 alongside the objective they are designed to address.

Table 1: Key Priorities

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<thead>
<tr>
<th>PRIORITY AREA</th>
<th>PREVENT</th>
<th>REDUCE</th>
<th>DELAY</th>
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<tbody>
<tr>
<td>Priority 1 Making health and wellbeing everyone’s business</td>
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The remainder of this strategic framework will outline each priority and the strategies to address each, these are presented with reference to what type of intervention will be required (for example, environmental, community or individual consistent with the wider determinants of health model illustrated in section 3.4).

Each section addresses our objectives; prevent, reduce and delay in turn; we have included a case study illustrating possible public experiences of these components of the proposed strategy. We have also listed at the end of each section the actions which will be delivered in partnership. These actions are collated into a supporting implementation plan for the mobilisation, management and to enable us to report on progress in implementing this framework.

The review of strategies and their influences on the prevention agenda (outlined in 3.4) enabled the leads for each element of the implementation plan to be easily identified and prevent duplication of efforts.
4.1.1 Leading the Prevention Agenda

A whole Richmond approach

To make health and wellbeing everyone’s business we must work together to achieve the cultural shift we need to improve the health and wellbeing of all our residents and create a focus on the promotion of health and wellbeing rather than the treatment of illness.

Through the development of this framework we have worked with all council directorates and NHS partners to improve their understanding of prevention in its widest sense, recognise the potential and seize upon opportunities each directorate has to promote health and well-being, map the services and identify priorities. Richmond LA and CCG currently invest significant sums of money on services which focus on preventing problems arising in people’s lives and communities, or stopping current issues deteriorating further. These are delivered by many organisations across the borough and are very rarely joined up in a cohesive way.

As commissioners of public services, the LA and CCG are in a position to ensure that service providers promote health and well-being. Contracts and incentives to encourage providers to improve health and wellbeing and reduce health inequalities are utilised. The new Outcomes Based Commissioning (OBC) approach being adopted by the LA and CCG provides new opportunities for the health and social care system to put prevention at the heart of delivery.
Skilling up the workforce

Every contact with the public should be seen as an opportunity to signpost and provide information on a wide range of services that can improve people’s health. ‘Making Every Contact Count’ (MECC) is an approach to improving health and reducing health inequalities developed by locality-based NHS and local government partners. As well as encouraging healthier lifestyle choices, this approach can consist of psychological wellbeing (including stress and mental health), leisure and recreation, welfare benefits advice, housing, social care, routes to employment, education and training, home safety, domestic abuse and so on. There is good evidence behind this approach. MECC, including behaviour change interventions, can lead to improvements in people’s health and wellbeing, reduce avoidable premature mortality linked to poor lifestyle choices, and help people to better manage and self-care long term conditions. This approach can be implemented across all frontline providers and support, including the voluntary sector which is a major partner in delivery of these resources.

The Healthy Living Pharmacy Programme, recognises the significant role of community pharmacy for the proactive promotion of health and wellbeing.

Training for the, ‘No Health without Mental Health’ initiative, which includes awareness and information on how to access support is available for staff across the LA.

What will be the experience of this approach for Richmond residents?

A case example:

‘S visited the library to collect a book for her grandson. When S checked her books out she was provided information on affordable winter warmth. S had been unable to afford to heat her home to a comfortable temperature and called the helpline. S was awarded an affordable warmth grant and was able to heat her home. Unlike previous years, this year S does not need to be admitted to hospital with a respiratory infection.’

We will ensure that people get access to prevention services, information and advice by:

3. Implementing “Making Every Contact Count” across the council and encourage our partners to adopt this initiative.

4. Implement a “Healthy Living” community pharmacy initiative or approach across the borough.

5. Supporting the rollout of the “No Health without Mental Health” training initiative.

What we will do to lead the prevention agenda:

1. Ensure that prevention is embedded in the outcomes based commissioning approach that is being implemented across health and social care services.

2. Richmond Health and Well-being Board will provide systems leadership and facilitate partners to promote health and well-being starting by undertaking a series of “Listening Events” to understand local resident’s views and experiences.
Creating Healthy Workplaces

Workplaces are a key setting for improving people’s mental and physical health, as well as their overall wellbeing. Supporting employees to improve their health and wellbeing can help improve productivity and reduce staff absence rates.

The London Borough of Richmond upon Thames has signed up to London Healthy Workplace Charter process and has been awarded the first of three accreditation levels for being a healthy workplace in March 2015. The Charter involves a rigorous assessment against standards in eight themes, these are: Corporate support for wellbeing; Attendance management; Health and safety; Mental health and wellbeing; Tobacco; Healthy eating; Physical activity; and Problematic use of alcohol and substances.

There is good evidence that a system based approach to health and wellbeing in the workplace can support employees to improve their health and wellbeing. The outcome of this has observable benefits for the local economy, by:

- Improvements to productivity and increased economic productivity
- Reduced staff absence rates and subsequent generation of savings on employment costs

We will act as exemplar of good practice for organisations and businesses in Richmond and as a borough in London. We are proposing that: all our partners consider signing up to becoming a healthy workplace; we will explore how we can build capacity to support health and wellbeing in the local economy through healthy workplaces.

What will be the experience of this approach for Richmond residents?

A case example:

‘J lives in Twickenham and works for a small business in Richmond. The company he works for has signed up to becoming a healthy workplace which has led to a review of absenteeism. J has had many days off sick over the year and was asked to attend a meeting with occupational health for a review. The review identified that J shares the care for his elderly mother and he is struggling with the demands on him. After periods of care giving J experiences minor ailments for which he visits the GP. Together the company and J were able to negotiate flexible working arrangements. J reports feeling supported, has not needed unscheduled absence and has not experienced any further illness.’

We will further support the health of the Richmond workforce by:

6. Richmond Council plan to achieve London Healthy Workplace Charter and continue to develop this programme of work.
7. Identifying and supporting businesses across the local economy that could maximise the benefits of working towards adopting a healthy workplace approach.
4.1.2 Addressing the cultural and environmental influences on health

Housing

Housing plays a key role in supporting good health, conversely poor housing conditions can impact on both physical and mental health and wellbeing. Assisting older and disabled people to maintain their ability to live independently in their own home can be achieved by a number of council based initiatives including: facilitating Disabled Facility Grants and developing Extra Care housing to meet need. The borough aims to reduce care home admissions, promote independent living where appropriate and to reduce acute hospital admissions. This may be achieved by increasing the provision of supported housing for the most vulnerable, in particular those with learning disabilities, Autistic Spectrum Condition (ASC) and mental health issues, where there is an identified need. There will also be an offering of a range of housing choices to older borough residents, including extra care housing.

Cold housing has a known detrimental impact on health, for example circulatory diseases, respiratory problems and mental health are all affected by cold housing. During the winter months offers of a home visit to vulnerable residents and to families with disabled children who may be vulnerable to the cold to offer practical advice and support on staying healthy and well has significant evidence for reducing hospital admissions and ill health. During such home visits, trained advisors may make referrals to local grant schemes for insulation and central heating installations and repairs and arrange for the handy person scheme to install up to five low cost energy saving measures alongside more health specific measures, such as completing a checklist of health interventions (i.e. flu jabs, falls prevention etc.)

Over crowing also has a direct and indirect impact on health, with a clear link to exacerbation of respiratory conditions for example, alongside a detrimental impact on education outcomes. Initiatives to address over-crowding offer a significant contribution to reducing health inequalities in the short and long term.

There is also a wealth of evidence that a home fire safety visit as part of London Fire Brigade’s free, home fire safety visit can reduce likelihood of a range of risks of hazards in the home. They assess people’s homes and offer advice on how to make it safer; and where appropriate fit a smoke alarm. The home fire safety visit is usually for people regarded as having a higher risk of fire in the home, such as: older people living alone, people with
mobility, vision or hearing impairments, people accessing mental health service users and those liable to intoxication through alcohol and/or drug use.

Rough sleeping has a marked detrimental effect on both physical and mental health and nationally the average age of death of someone sleeping rough is 47 years for men and 43 for women. Many rough sleepers have “complex needs” facing mental health, physical health and drug and alcohol misuse issues. They also may not have the skills to manage a tenancy or live independently. Those who are homeless also face significant barriers to access health services, unable to register with regular services due to being unable to provide details of a residential address. Homeless people may be assisted to access the right support by accessing SPEAR our local single homeless provider.

SPEAR are developing a ‘trauma informed’ care approach for people using the services, which recognises the life events leading to or perpetuating street homelessness. SPEAR also provide an accommodation ‘pathway’ model out of homelessness, supporting residents move from hostel based accommodation to permanent settled housing. They have also attracted funding to better improve rough sleepers access to primary and secondary (mental health) care services.

These interventions are included throughout strategic plans for housing across the Borough. Furthermore, the incorporation of sustainable transport facilities into existing / new housing developments has an important part to play in encouraging active travel. For example, improving pedestrian connection, provision of secure cycle parking facilities etc.
We will further support prevention through housing by:

8. Continuing to provide ‘Coldbuster’ grants as part of our winter warmth scheme. The Local Assistance Scheme to eligible residents who need help with fuel bills over the winter period. The scheme is open to all residents on low incomes, including pensioners, those on benefits and those with low earnings and will be reviewed on a yearly basis.

9. Increase the independence of older people with long term conditions through Disabled Facility Grants with our Home Improvement Agency.

10. Tackling overcrowding through an “Extensions Programme” with our housing association partners and support those residents who are seeking to voluntarily downsize from a home which they are under-occupying.

11. Promoting a Housing Health & Safety Rating System to landlords to improve housing conditions and using enforcement actions where necessary. We also plan to commission the Building Research Establishment to provide a Health Impact Assessment of Richmond residents living in properties with housing hazards.

12. Improving the health of rough sleepers in the borough in partnership with SPEAR (Single Persons Emergency Accommodation in Richmond).

13. Providing a range of supported in borough housing options for people with learning disabilities, Autistic Spectrum Condition (ASC) and mental health problems.

14. Working with registered housing providers to ensure they consider potential for specialist dementia provision.

15. Seeking opportunities to work with Registered Providers to improve the housing offer to older people which could include remodelling of existing provision and/ or further Extra Care schemes in the borough.

Parks and open spaces

Green space in people’s living environment has a positive association with the perceived general health of residents. Exposure to nature quickly decreases stress and reduces pain, slowing respiration and lowering blood pressure.

Richmond upon Thames is unique in London for the extent, richness and variety of its parks and open spaces. The borough also benefits from having an extensive section of the River Thames, towpaths and riverside walks with a third of the land area of the borough being green space. The Borough has a strong ‘parks culture’, with parks and open spaces highly valued as the hub for local communities for activities, events, sports and relaxation. Volunteer Initiatives such as Nature’s Gym for example, which is a conservation scheme utilise and support Richmond’s parks and green spaces aim to improve physical, mental and
social well-being by taking part in fun conservation activities such as clearing rivers, weeding making paths etc.

The Council has developed a series of strategic principles by which the Parks will be managed, which include creating a sustainable legacy for future generations, enriching the life, health and wellbeing of residents and visitors and increasing community participation.

To improve access to parks and green spaces for all, we will:
16. Continue to implement measures to make our parks as safe and welcoming as possible.
17. Expand access to resources such as green gyms: We have installed exercise equipment in six parks across the borough to encourage particular groups such as older people, who are less likely to belong to gyms, to make exercise part of their daily routine. It is our intention in the long term to increase this number.
18. Work with priority groups including the local dementia groups to better our understanding of how we can make our parks and open spaces better designed and more accessible for people living with dementia, including at the design and build stage.

Employment
There is a strong evidence base showing that work is generally good for physical and mental health and well-being – it can be central to an individual’s identity, their roles and status in society. People of working age who are unemployed generally suffer from poorer mental health, long-standing illness and have higher hospital admissions and medicine consumption than the employed.

Richmond has the lowest percentage of 16-64 year olds claiming Job Seekers Allowance (JSA) in Greater London, and has high rates of self-employment. However, as is the case nationally, there is a relationship between social housing tenure and worklessness, where residents in social housing may face greater barriers to access employment. We are supporting our registered housing providers, as well as our community and voluntary sector to address worklessness and will continue to work towards ensuring all communities have access to employment opportunities.
Further education and lifelong learning

Lifelong learning can yield significant health and wellbeing benefits for individuals, and has the potential to improve health, both long term and immediate. Education has both direct and indirect effects on health, and people with more full time education tend to enjoy better health and have a higher standard of living, suffering fewer health inequalities related to poverty. Lifetime learning through adult education can continue to provide individuals with many health benefits, and keeping mentally active has protective health effects; for instance, it can reduce and delay the risk of dementia in older adults.

Adult community learning through activities such as learning a language, participating in arts, movement and music lessons also promote general well-being and mental health. Attending classes also promotes social interaction, giving participants the opportunity to make new friends, and reducing loneliness and isolation. Art and music is also used to help patients recover more quickly and leave hospital earlier, as well as reduce stress and anxiety, improve well-being and enhance the way we fight infection.

What we will do to further support learning:

23. Support our partner Richmond Adult Community College in their provision of adult learning to stimulate personal development, self-fulfillment, and provide work and vocational training and skills.
24. Support the College in developing work and life skills training for adults with learning disabilities.
25. Continue to provide arts and reading workshops for people with dementia, people wanting to improve their mental wellbeing and those wishing to participate in social activities.
Transport

Health conscious transport planning can have a profound influence upon lifestyle, the quality of life and reduce health care costs and the cost to society, as well as focusing on improving access and accessibility. It is also significant in terms of influencing the quality of the urban environment in respect of air quality, noise, and risk of collision. Enabling people to incorporate walking and cycling into their daily routine can also help to reduce traffic levels and improve local air quality. Evidence further suggests that increased ‘walkability’ within a built environment can improve perceptions of risk and personal safety, further encouraging walking and social networks within particularly vulnerable groups, including older people and the infirm.

We are working to progress a range of schemes and initiatives to encourage active travel and improve road safety, as cycling and walking can deliver benefits to personal wellbeing, public health, the economy and the environment. For instance, much work and investment has gone into improving the quality of the pedestrian environment in our town centres such as Richmond, Twickenham and Whitton, including minimising street clutter which has helped people with mobility and visual impairments. Improvements for cyclists have also been delivered and a new network of cycle routes is being planned. The Council is currently working with Transport for London to improve accessibility for wheelchair users at bus stops. A comprehensive road safety education programme is also in place, which includes delivering pedestrian training to school children and cycle training to anyone living, working or studying in the borough.

Our Accessible Transport Unit (ATU) manages transport services for residents in the borough with mobility difficulties and provides information and advice for older or disabled transport users in the Borough, promoting the London Taxicard service and Super Shopper Bus. Door to door accessible transport can be provided to residents aged over 60, with physical frailty, who might otherwise be isolated in the community, including those who suffer from physical disability, sensory loss or dementia.
What we will do to improve the opportunities for active travel and to improve access to affordable travel:

26. Continue to implement schemes and initiatives that encourage active modes of travel, thereby reducing congestion and improving air quality (we have successfully increased the number of journeys made by cycles so far).

27. Implement measures to improve pedestrian and cyclist safety and accessibility. Regular consultation through our Village Planning process will help to inform this programme.

28. Support the voluntary and community sector to provide high-quality low-cost accessible transport services to people and groups across the borough.

29. Ensure our Accessible Transport Unit continues to provide a quality and flexible service to older and disabled users across the borough.

Regulation and Enforcement

The high street environment experienced by the Richmond residents has a profound impact on their opportunity for healthy choices, safety and wellbeing. A healthy high street is characterised by a number of factors including; encouraging healthy choices, promoting social interaction, allowing greater access to health care and promoting mental wellbeing (Royal Society of Public Health. 2015). Councils can enable healthy lifestyles by nudging local business to promote health by, for example; encouraging healthier cooking methods, promoting healthier lifestyle choices, limiting the availability of high alcohol by volume drinks and using enforcement powers to deter harmful activities and create safer environments e.g. preventing the sale of age restricted products like tobacco, alcohol, knives, solvents etc., to young people; and introducing plastic or toughened glass containers in pubs, bars and nightclubs to prevent facial injuries.

Community Safety

Crime affects health both indirectly and directly. A person’s health can be affected directly if they are the victim of crime, anti-social behaviour, suffer violence or injury. Indirectly, the fear of crime can also affect the health of people in the community and change their behaviour, for example, if they are afraid to walk the streets or let their children play outdoors.

Older people can experience social isolation if they are afraid to leave their house, and there are psychological consequences of crimes, such as burglary, anti-social behaviour, motor vehicle incidents, vandalism, fraud and bogus callers. Drug and alcohol misuse can increase
acquisitive crime (i.e. theft or robbery) in an area, and also have an impact on health care
services including accident and emergency. People with health issues can both become a
victim of crime or anti-social behaviour and can also perpetrate anti-social behaviour or
crime. Individuals may come to the attention of professionals in this way and it highlights
unmet health needs that require additional support.

Preventing and reducing reoffending, anti-social behaviour, domestic abuse and violent crime
and ensuring that more people successfully complete structured drug treatment will help
reduce crime, the fear of crime and antisocial behaviour, so that people will feel safe in their
homes and neighbourhoods.

**What we will do to support community safety:**

30. Safeguard vulnerable members of the community in partnership with members of the
Safeguarding Adults Partnership Board.

31. Assist young and adult offenders through our Integrated Offender Management scheme to
access employment, accommodation and receive help with substance abuse where
appropriate.

32. Support police initiatives such as the “Nominated Neighbour” scheme through the local Safer
Neighbourhood Teams across the borough.

33. Work in partnership with the police and other agencies to use a range of different methods to
reduce crime and anti-social behaviour, these include drug testing people on arrest, new anti-
social legislation which controls public drinking and the dispersal of people and targeted
licencing work on venues that have any problems to ensure that residents and visitors to our
town centres remain safe and are not disturbed by alcohol related anti-social behaviour.

34. Support residents who experience domestic abuse and we will improve the existing service to
help reduce the risk of physical violence and increase the safety of those experiencing
domestic abuse.

35. Refer neighbour disputes to mediation schemes to secure a resolution. To support the
Tenant’s Champion and to continue to develop the community trigger process where residents
can ask for a review of actions taken on anti-social behaviour cases.
In Richmond we are fortunate to have a wealth of “assets” that promote health and wellbeing. An asset is any factor or resource which enhances the ability of people and communities to maintain and sustain health and well-being. These can be individual, family or community and act as protective and promoting factors to buffer against life’s stresses.

4.2.1 Culture and sports
Participation in cultural or sporting activity can also promote social interaction and build social networks, build self-esteem, confidence and emotional resilience, increase personal choice and control, a sense of belonging, as well as provide volunteering, work experience and employment opportunities. The *Cultural Partnership Strategy (2015-19)* has three goals increasing participation, raising ambition and a sense of place. These goals which have been developed by the Cultural Partnership (all arts, sports and culture organisations in Richmond) with the aim to widen participation and create more opportunities for all people to participate in cultural and sporting activities over the next four years. This will include targeting provision and support for low participant groups and neighbourhoods, developing more opportunities for people to learn, achieve, volunteer and develop skills through cultural activities, and increasing opportunities for cultural activities to improve the health and emotional wellbeing of participants, spectators and audiences. The strategy provides an opportunity for the legacies of the Olympic Games and Rugby World Cup to be realised, encouraging greater participation in sport and culture from priority groups., and acknowledges the important role that culture can play in supporting people with dementia, mental health issues and disabilities.
Volunteering opportunities

Research has shown a clear link between volunteering and good health both for volunteers and health service users. Volunteering can increase volunteers’ longevity, improve their mental health, keep them fitter, and enable them to cope better with illness when it occurs. Volunteering also has a positive impact on a range of factors affecting the health of service users including their self-esteem, disease management, adoption of healthy behaviours, compliance with medical treatment and relationships with health care professionals.

Richmond upon Thames has a thriving and vibrant voluntary sector with 800 local voluntary organisations providing services and activities to the community, and high levels of volunteering. There are currently more registered volunteers than volunteering opportunities in Richmond. We also have Civic Pride funding available for smaller volunteer-led projects which individuals and informal groups in the community want to progress and is especially geared towards helping communities launch new ideas locally.

One of the priorities identified for the future is to look at providing support for volunteer organisations to be able to develop volunteering opportunities that match the aspirations of new volunteers and provide appropriate levels of supervision and support to assist volunteers in their new roles.

What we will do to support the development of volunteering opportunities:

38. We will review our priorities around volunteering in the borough and re-commission the volunteering service in 2016.

39. Continue to offer seed-funding of volunteer led community projects through the Civic Pride Fund.
4.2.4 Addressing loneliness and isolation

Social isolation and loneliness impact upon individuals’ quality of life, adversely affecting their health and wellbeing, and increasing their use of health and social care services. Research suggests that its influence on the risk of death is comparable with well-established risk factors such as smoking, alcohol consumption, physical inactivity and obesity. Interventions to reduce loneliness and isolation will be considered as priority, and a number of studies on applied arts and cultural interventions have shown a positive impact on those with long term conditions.

Loneliness and isolation is an identified priority for the Health and Well-being Board. The numbers of those who are feeling lonely and isolated are hard to directly measure. However, it is possible to use risk factors to predict numbers feeling lonely, e.g. in Richmond there are a significant number of over 75s living alone (6,400). Richmond has the highest proportion of people over 75 and living alone in London (51% in Richmond vs 35% in London). An asset based needs assessment has been undertaken to help understand this problem in Richmond, this included a stakeholder workshop training local residents as researchers and holding workshops with local groups.

**What will be the experience of this approach for Richmond residents?**

A case example: ‘B’s wife passed away several years ago, his daughter was B’s only source of interaction, and she has now emigrated for work. B subsequently had no interaction on a weekly basis and was nervous about leaving the house on his own. He had subsequently become sedentary, and drinking scotch in the evenings as he believed it would help him sleep in the evenings as he did not feel tired. He had gained weight. Following the implementation of the loneliness and isolation plans B participates in a group walk three times a week, helping him to sleep and reduce his alcohol use. He also reports enjoying visiting the shops in his village as he is participating in improving the village and he feels they are supporting him and he is adding value’.

**What we will do to support communities to address loneliness and isolation:**

40. Implement the loneliness and Isolation project action plan, reducing social isolation through e.g. arts projects for people with dementia, mental health, and talking & drawing workshops.
41. Continue to build on peer-researcher models to understand health and well-being needs of our residents.
42. Embed initiatives to prevent loneliness and isolation in local strategies and plans, e.g. Culture Strategy, Sports, Housing and Parks. Also Richmond Dementia Action Alliance is working to increase availability of dementia friendly activities in the community.
4.2.5 Village Planning; empowering communities

By involving local people in local initiatives and services, the provision can be better developed to suit local and individual needs. Empowering communities also gives people an opportunity to improve their physical and mental health. When communities can get involved in decision making and delivery of services the strength of networks and relationships between people is improved – which, in turn, improves their sense of wellbeing. The Council is committed to involving residents to shaping their village areas and uses the village planning process as a key engagement tool to encourage residents to get involved by raising their issues, concerns and opportunities about environmental and planning issues affecting their village area. 14 Village plans have been created which describe a vision for the village area and identifies what the Council will do and what local people can do to achieve the vision together. Since their launch, the plans are continually being updated and developed through consultation with local residents, community and voluntary groups in each village.

The Villages as identified by the communities are illustrated below.

![Figure 6. Village boundaries informed by consultation with residents](image)

**What we will do to support prevention:**

43. The Council will work with residents to develop a Village Work Plan for each village area over the next two years to look at how money is invested by both the Council and its partners on local priorities including health prevention initiatives.

44. Continue to fund Community Links Officers in each village, working with local people to identify and promote opportunities to get involved in; and helping local people and groups find the support they need to take an active part in their village.

45. Use the online Village Plans to publicise and promote local health initiatives across the borough, with the aim of increasing uptake in NHS Checks, smoking cessation programmes and other health improvement services.

46. Each village to work towards becoming a “Dementia Friendly” village.
Information and advice are essential for the promotion of healthy lifestyles and management of health, approaches to improve access to this are outlined in our *Making Information and Advice Count Strategy*. The Council and CCG will continue to support the delivery of Public Health England (PHE) campaigns locally, such as Change 4 Life which promote strategies for healthy living. There are opportunities to develop a more planned and joined-up approach to local campaigns, which need to be explored.

4.3.1 Re-shaping healthy lifestyle services
Richmond Council has undertaken a comprehensive review of lifestyle services and has developed a new streamlined and focused model in response to population needs and consideration of future funding constraints. More effective targeting is the most effective way of utilising the limited resources available to us. The aim of this new model is to identify those at risk of long-term conditions, offer brief behavioural change intervention and services to address need. The services will focus on main causes of long term conditions that are amenable to local action: Weight management; Dietary advice; Increase physical activity; Health education (diabetes prevention); Smoking (brief advice, signposting); Alcohol (brief advice, signposting); Mental wellbeing (brief advice, signposting).

4.3.2 Embedding self-care and self-management
There is evidence to suggest that self-care and self-management may improve health outcomes and improve patient experiences, as well as reduce the number of attendances to
primary and secondary health care services for people living with certain long-term conditions\(^1\). Considering the number of people living in the Borough with long-term conditions affecting either their physical or mental health or both, and the potentially preventable nature of some of these conditions, there is a real need to consider how best to provide opportunities for residents to have access to self-care and self-management tools at the earliest possible stage in order to be able to manage their own health and wellbeing, encompassing both physical and mental health, with support from health and social care professionals when necessary.

Richmond Response and Rehabilitation Team (RRRT) provide services for hospital discharge, rapid response and community rehabilitation. This seamless transfer from hospital to home and appropriate community rehabilitation enables patients have the resource for their self-care at home, alongside management. Hounslow and Richmond Community Healthcare NHS Trust host the services in partnership with the Council to provide integrated health and social care support. A self-management project for people who are at risk of deterioration is currently being planned by a RRRT Nurse and is due to be further developed later this year.

Other self-care and self-management opportunities available to access in the Borough include:

- **BERTIE and DESMOND** – education programmes to encourage self-management for individuals with type 1 and type 2 diabetes, respectively.

- **Walking Away from Diabetes** – a programme for those who are at risk of developing diabetes, available to access through the LiveWell Richmond service.

- **Expert Patient Programme** – this is a self-management programme for people living with long-term conditions, delivered by expert tutors living with long-term conditions, which can help individuals learn skills to improve their quality of life and wellbeing, available to access through the Richmond Prevention service.

In order to successfully develop an appropriate and acceptable strategy, we will engage with local residents and health and social care professionals. We will also utilise technology to support the delivery of the strategy.

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\(^1\) Transforming our healthcare system. The King’s Fund. April 2013.
What will be the experience of this approach for Richmond residents?
A case example:
‘M has been living with Type 1 Diabetes for many years, he has had a career working abroad for many years and has not paid much attention to the management of his condition. M recently attended a routine eye health check and has been identified as at risk of deterioration in his sight and invasive medical procedures if he does not manage his blood sugars and blood pressure. M was referred to the DESMOND diabetes management programme where he learnt simple ways to manage his medications and eating, considering the variations in time zones which he experiences for work. This has prevented deterioration in his sight and any further medical procedures.’

What we will do reshape lifestyle prevention services and embed self-care:
47. Develop a joined up approach to communication of national campaigns locally across partner organisations.
48. Deliver the actions set out in the “Making information & advice count” strategy including access to self-care resources and facilities.
49. Re-commission (agreeing a new contract based on the efficiency and effectiveness of interventions and the populations needs) a new targeted health lifestyles service.
50. We will build on existing opportunities in the Borough by developing a self-care and self-management strategy.
51. We will adapt the self-management model developed by RRRT for other services to provide a consistent self-management approach for use across the Borough.
52. We will promote available self-care and self-management opportunities to local residents and health and social care professionals in line with the programme of work set out by the Making information and advice count strategy.
53. We will build on existing opportunities in the Borough by developing a self-care and self-management strategy.
54. We will adapt the self-management model developed by RRRT for other services to provide a consistent self-management approach for use across the Borough.
55. We will promote available self-care and self-management opportunities to local residents and health and social care professionals in line with the programme of work set out by the Making information and advice count strategy.
56. We will promote opportunities for self-care through new technologies.
We can reduce and delay the future demand for care through shaping better tailored pathways that promote recovery and independence for individuals and support carers. Richmond Council and CCG have already drawn up a number of key plans that have a focus on prevention and reducing dependency on health and social care. Our Better Care Closer to Home (BCCH) and Better Care Fund (BCF) programmes have a number of initiatives which are already up and running or we have committed funds to for 2015-16.

Voluntary Care Groups play a major role in the delivery of services to enable independence, including transport, home visiting services and befriending. Two flagship preventative services include the following:

**4.4.1 Richmond Response and Rehabilitation Team (RRRT)**
The community rehabilitation service 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.

**4.4.2 Community Independent Living Service (CILS)**
This service uses a Community Independent Living ‘Hub & spoke’ model, which is a network of connected support services in each of the four localities across the borough, to all vulnerable adults and older people. The range of services delivered are designed to maximise people’s independence, through either aiding recovery or delaying deterioration.
and dependency, through supporting people to participate and make a positive contribution to their local community.

The CILS is delivered via a ‘Hub’, which is a single access point that can be accessed by telephone and in person for all vulnerable adults living in that area, to obtain support and information as required to maintain health and well-being. This service offers a combination of building based and outreach support activities, to ensure that everyone in the locality has ease of access to person-centred support and information without the need to travel long distances.

Groups covered by these services include:
- Older People, particularly those who live alone or are physically frail
- People living with Dementia
- Adults, with a Learning Disability
- Adults, with Physical or Sensory Impairment, including neurological conditions
- Adults, with or in recovery from common Mental Health issues

4.4.3 Respite Care

We recognise that unpaid carers play a significant role in enabling people with health and social care needs to remain independent and at home. The health and wellbeing of carers is recognised as critical to sustain care at home. The Joint Commissioning Collaborative (JCC) will monitor respite/carers breaks within the Carers Hub Service contract. Carers will be offered their own assessment to have their own needs taken into account when the person being cared for is being assessed by Richmond Council. Carers with eligible needs will have a support plan developed which will set out how these needs will be met and that will include the provision of services to the cared for to give the carer respite.

Building on the success of the Shared Lives Scheme for adults with learning disabilities, a new Shared Lives Scheme 3 (pilot) for people living with dementia has been established. The evaluation of this Shared Lives pilot will inform the future delivery of this scheme including its possible expansion to other care categories.

We will continue to commission carers’ support services through the Carer’s hub. Ensuring that Carers and family members are given the right support is essential to preventing the breakdown of existing support networks and key to preventing unnecessary use of
Emergency Departments as well as nursing and residential placements. Any changes to carers services will be designed with Carers and commissioners will work closely with carers groups.

4.4.4 Harnessing new technologies to support people to remain independent longer

Using new technology can enable more people to take responsibility for their health and manage their conditions, enabling them to stay well and maintain their independence. Assistive technology services can also be used to deliver technology-based options to patients, as part of the wider provision of health care, in the diagnosis, treatment and monitoring of long term conditions.

This can be achieved in a number of different ways, including the following:
- The use of apps and online programmes to aid self-care and self-management
- Connecting people to local support groups
- Keeping people connected to their social networks
- Ordering services, for example, online shopping
- Learning new skills, for example, cooking and ICT skills

If we are to develop services based around new technologies we need to ensure that our workforce and local residents have access to adequate training resources to ensure that they are equipped with the necessary skills to use these services.

In October 2014 an ‘Older people and new technology workshop’ was hosted by Councillor Marcel, Champion for Older People in the London Borough of Richmond upon Thames, which identified existing services in the Borough that support older people in the use of new technology. The workshop acted as a springboard for the development of a steering group to drive forward a unified campaign to promote technology services for older people across the Borough.

Technological-based health and social care services currently in use in the Borough include a range of tele monitoring devices that enable people to live independently at home e.g. devices that detect movement and falls and emergency alarms linking to fire and smoke response teams. We are also developing *Telehealth* services linking to a diagnosis and monitoring of a range of long-term conditions. We recognise that new technologies could enhance other existing health and social care services and in order to explore these
opportunities thoroughly, a workshop in partnership with the technology industry is planned, with the aim of identifying issues with current services and outlining potential technological solutions. Our Housing strategy 2014-17 aims to improve the health outcomes for residents, be they in private or housing association property, one key objective is to: promote the use of assistive technology, for example through tele-monitoring to support users and their carers, friends and family to live independently for longer.

What we will do to harness new technologies:
57. A multi-agency technology and older people steering group has been set up to deliver a work programme particularly with regard to ICT training opportunities for older people in the Borough.
58. Skilling up our workforce to promote and share technological solutions with local residents
59. Working with technology industry to consider technological based solutions for delivering appropriate services.
60. Working alongside clinicians to identify and develop telehealth solutions, including the diagnosis and monitoring of long-term conditions.
61. Developing and rolling out two separate telehealth solutions for those with long-term heart conditions and sleep apnoea.
62. Increasing uptake of telemonitoring devices through free introductory offer available to all Richmond residents who meet required eligibility criteria.
63. Develop a local library of apps, IT resources and hardware for local residents.

4.4.5 Integration and communication for recovery closer to home
A number of key initiatives which promote recovery and independence in place in Richmond support early detection of risk, engagement for ownership of care and independence, multi-disciplinary pathway planning to meet people’s needs for access to the right care in the community. These initiatives include:

- Carers Support Services – to improve the recognition of carers, their access to information, support and advice and to recognise carers as expert partners in care.
- Prevention of Falls Service – to target and ensure that the needs of older people are met around falls and bone health with an early intervention and preventative approach.
- Early Supported Discharge – to enable stroke survivors to maintain independence, prevent health deterioration and prevent avoidable hospital admissions and extended stays.
- Multi-disciplinary care management led by primary care for the 3% of people at highest risk of emergency hospital admission, including support from wider services such as community beds and Community Geriatrician
- Community Respiratory Care Service – to provide high quality effective community respiratory care services.
- Psychiatric Liaison Service – to integrate specialist mental health expertise and resource into acute hospital to effectively manage care for people with mental health issues.

Promoting and supporting delivery of BCCH and BCF is essential, by driving through the service reforms outlined in these plans we will achieve more recovery-focused models of care.

A new Outcomes Based Commissioning (OBC) approach is being developed across the whole health and social care system and this provides opportunities for incentives across the system to focus on prevention.

**What will be the experience of this approach for Richmond residents?**

A case example:
‘W is living with dementia and occasionally wakes in the night, disorientated and walks around looking for help. Her medical team have concerns about her previous falls which resulted in a broken hip. W has been advised to continue inpatient medical care. Following the implementation of the new technologies plan, W has a sensor mat by her bed, which activates and alarm to carer support. This enabled W to reduce the number of inpatient stays in hospital.’

**What we will do to reduce and delay the demand for care:**

64. Our BCF and QIPP schemes are being monitored via the CCG’s new Project Management Office in order to ensure that they deliver the desired outcomes, provide value for money and improve the outcomes for patients and service users in Richmond.

65. Promote and support the delivery of the “Better Care Closer to Home” and “Better Care Fund” strategies.

66. Ensure that prevention and recovery based models of care are core to proposed Outcomes Based Commissioning (OBC) approaches.

67. An assessment of need for the development of respite provision for carers of adults with severe mental health conditions will be given priority. This will include identifying outcomes, strategies and actions to meet these needs.

68. Re-shape service provision in response to the mapping exercise.
5. Implementation and Governance

A prevention programme team of health and social care representatives, including Public Health was formed to undertake the mapping and development for this strategic framework across the LA, CCG and borough. The programme team report to the multi-agency steering group and the Care Act Transformation Board, which in turn reports to the Strategic Partnership Group – the CCG and Social Care partnership that leads on the Joint Commissioning Collaborative. See Appendix 5 Terms of Reference.

An integrated implementation plan which will take forward the priority actions of the direction of care, is currently under development in response to this framework. The plan will outlined specific actions and priorities for year 1, 2, and 3. Monitoring and review of the implementation will incorporate the actions identified in the Equality Impact Needs Assessment. This plan will be signed off by the Care Transformation Board and the Strategic Partnership Board. An operational prevention programme team will meet on a monthly basis to oversee the implementation and liaise across the whole council, CCG and borough to facilitate support when necessary.

A communications strategy will be developed to align with the implementation plan.

Conclusion

Our first integrated Prevention Framework will aid us in developing a local approach to prevention in order to meet the recommendation outlined by the Care Act (2014) that ‘a local authority 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’¹. While recognising and responding to those who continue to require care.

Through joint working with our multi-agency steering group we have been able to create a cohesive picture of the existing preventative landscape across the Council, as well as developing novel and innovative actions to take forward. Monitoring and delivering these actions will be essential in ensuring that we are able to achieve our vision.

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Appendices
Appendix 1 Equality Impact Needs Assessment

Equality Impact and Needs Analysis (EINA) template and summary guidance

October 2014
SUMMARY OF THE KEY FINDINGS

The Care Act 2014 emphasises the importance of a shift in service provision towards preventative services. This is with the aim of preventing, reducing and delaying the need for care. The Prevention Strategic Framework has been designed to support the new architecture presented by the Care Act. The Care Act and Prevention Framework offer an opportunity for collaboration between all council directorates.

In Richmond upon Thames there are pockets of deprivation and differences in life expectancy (mainly due to coronary heart disease, chronic obstructive pulmonary disease and cancers). Although morbidity and mortality rates vary between geographical wards, this variation is not fully accounted for by deprivation alone, indicating that there is a need for intervention to improve health, which is not confined only to deprived areas.

To examine the potential impact of the Preventative Framework, we carried out an Equality Impact Needs Assessment which considered Richmond’s priority groups. The main findings of the EINA indicate that the greatest benefits will be derived by targeting older people requiring care; disabled adults; and carers.

Implications of the Prevention Strategic Framework for all priority groups are summarised below:

- Age: There is an increasing ageing population, with a noteworthy increase in BME groups. This will have implications for supporting with the management of long term conditions. Initiatives, interventions and resources will be targeted to engage older populations, including BME groups.
- Disability: 11% 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. Therefore, the strategy recommends a targeted and tailored approach for this group.
- Gender: Men are more likely to engage in multiple risk behaviours (for example, smoking and drinking) which have a multiplicative detrimental impact on health. Men are also less likely to engage with primary health services. Targeted approaches will be implemented to support men to adopt a healthy lifestyle and self-care.
- Race/Ethnicity: BME groups represent 14% of the population of Richmond. BME groups (including Gypsy/Traveller communities) are more likely to have poorer health than the White British population. Community based health interventions are known to be more effective in these groups than information giving. Community based approaches are utilised throughout the strategic framework.

- LGBT: In Richmond, 5-10% of the population consider themselves LGB. LGBT communities are more likely than the general population to engage in substance misuse, self-harm and attempt suicide. Older LGBT communities are more likely to be single and living alone compared to their heterosexual counterparts. Targeted interventions will be required for this population group.

- Carers: 8.5% of all residents are carers and with the ageing population this is likely to increase. The carer population is also ageing. Carers are more likely to report health problems compared to those not providing care. Interventions will be adopted to offer a flexible approach to accessing prevention services.

There are key links between the protected characteristics and health and wellbeing. People with disabilities or long term conditions, carers, and people who are alone and feel isolated are found in all social groups and in all areas. The likelihood of being in one or more of these groups increases with age.

The framework will identify where we need to focus to reduce the inequalities in the borough and work to build healthy communities. An overview of local health needs assessments and population health statistics informs the prevention strategic framework. These identified needs can best be addressed by having a systematic, targeted strategic approach to prevention and self-care.

The strategy is anticipated to have largely positive impacts on most of the groups. Potential negative impacts on protected groups may be observed due to the targeted nature of commissioned services. This may result in some groups not engaging with services, or the offer not being suitable for the group's needs. This risk may be mitigated by i.e. Increased monitoring and evaluation, increase on-going consultation with key groups for example, Carers.

We will bring in a modernised approach to services with creativity and innovation. These will include the most up to date evidence based approaches. We will take full advantage of new technologies to facilitate and empower people to take control of their lives. The strategic framework will be supported by an implementation plan with high level commissioning intentions which will inform the continuation, redesign, decommissioning or shifting of resources as appropriate.
1. Briefly describe the service/ function/ policy:

The London Borough of Richmond upon Thames (the Borough) Local Authority and the Clinical Commissioning Group (CCG) are working in partnership to deliver an integrated three year Prevention Strategy.

The purpose of the strategy is to develop a local approach to prevention in order to meet the recommendation outlined by the Care Act (2014) that ‘a local authority 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. The strategy is for all adults. An information and advice strategy has also been developed to support recommendations from the Care Act (in press).

Prevention means many things to many people. In its broadest sense, prevention includes a wide range of services and activities that are designed to:

Promote wellbeing and independence
- Preventing people from developing poor health and care and support needs in the first instance (Prevent)
- Prevent or delay the deterioration of people’s wellbeing as a result of ageing, illness or disability (Reduce)
- Delay the need for more costly, intensive and long-term care and support services (Delay)

We recognise that health and wellbeing is influenced not only by people’s choices or the services that we provide but the much wider forces that ultimately encompass the environment and communities in which people live their lives.

Rather than replacing existing policies and strategies, this document aims to build on and complement them. Some of the key local strategies already in place or being developed are fundamental to the delivery of our vision for prevention.

This framework builds on local strategic priorities which have been identified in:

- Health and wellbeing strategy,
- Better Care Closer to Home,
- Annual Public Health Report
- Joint Strategic Needs Assessment
- Housing strategy

The Joint Strategic Needs Assessment (JSNA) suite of products, Data Rich as well as comprehensive provider and stakeholder engagement provide evidence for the development of the EINA and strategy.

**Strategy approach**
The prevention framework will focus on promoting wellbeing and independence,
preventing people from developing poor health and reducing deterioration of wellbeing.

The strategy will use the timing of the Act as a catalyst to develop new approaches to improving health and wellbeing backed by the leadership from the Health and Well-being board.

We have identified four priority areas:

1. Making health and wellbeing everyone’s business
2. Creating healthy communities – harnessing local community assets to support people and their carers
3. Re-shaping healthy lifestyles services and embedding self-care
4. Reducing and delaying the need for care through integrating recovery focussed models across health and social care pathways

Maximising prevention opportunities

Healthcare services contribute to an estimated third of the improvement in the population’s life expectancy. The remaining two-thirds has been attributed to public health activities aimed at changing people’s lifestyle behaviours and tackling health inequalities.

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 through 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.

(Appendix 1 for contributing factors). Everyone can take action, although there is a role that policies and services can take to make this easier for individuals.

The number of people living in Richmond is expected to grow by 3,000 each year, between 2014 and 2018 there is an expected overall increase in those aged over 65, with an increased life expectancy. This combination means that the number of those living with one or more long term condition will increase. Evidence also suggests that there is an increase in the number of people under 65 who have three or more long term conditions.

National research on loneliness and isolation estimates that about 20% of the older population is mildly lonely and another 8–10% is intensely lonely. Twelve per cent of older people feel trapped in their own home, with 6% of older people reporting leaving their house once a week or less. Social isolation and loneliness impact upon individuals’ quality of life, adversely affecting their health and wellbeing. We know from research that there are many risk factors to loneliness and isolation, including: being aged 75 years and over; living alone; becoming a carer or giving up caring; poor health or disability; and living in an area of deprivation. Minority ethnic groups and lesbian, gay, bisexual and transgender older people are also at risk. Richmond has the highest proportion of people aged over 75
and living alone in London (51% in Richmond vs. 35% for London).

The number of people living with dementia worldwide currently stands at 35.6 million, and is expected to double by 2030, and triple by 2050. In Richmond Borough around 1860 people - which include those not presenting to services or formally diagnosed - are estimated to be living with dementia.

Life expectancy is about 7 years lower for men and 4 years lower for women in the most deprived than in the least deprived areas within Richmond. This is mainly due to coronary heart disease and stroke, cancer, respiratory disease, liver disease and other digestive disease and external causes.

Eleven small areas with nearly 18,000 (9%) residents have above average levels of deprivation compared with the England average. An estimated 4,065 (10%) children in Richmond are living in poverty.

Approximately 15,800 people provide some level of unpaid care and 15% of those provide more than 50 hours unpaid care per week. Carers are more likely to report health problems compared to those who do not provide care and this risk of poor health increases with the number of hours of unpaid care that are provided.

Despite favourable comparison with London and England, estimated numbers of people in Richmond with unhealthy lifestyles are substantial:

- An estimated 20,400 (14%) adults in Richmond smoke. In Richmond, per year over 200 deaths are attributable to smoking, and over 1,000 hospital admissions are due to smoking related conditions. (1)
- Approximately 3,000 primary school aged children are overweight or obese. In reception year 16.3% of children are overweight or obese making Richmond the eighth lowest local authority in England. In Year 6 this has risen to 26.1% making Richmond twenty lowest local authority. (2; 3)
- An estimated 29,900 (20%) Richmond residents report not being active for 30 minutes per week, compared with 28.5% for England (4).
- Survey results have shown that only 10% of residents use outdoor space for exercise or health reasons. (5). While this is similar to the average for London (10.5%), the use of the many green spaces in Richmond could be improved.
- Estimates indicate that Richmond has higher than average proportions of increasing-risk (21.3%) and higher-risk (7.8%) drinkers, compared to England. After year-on-year increases in alcohol-related mortality and hospital admissions in Richmond, the latest data (2012) show some decreases. (6; 7)
- Hospital admissions due to substance abuse in those aged 15-24 years is mid-range compared to London (8).

Recent evidence is emerging that healthy lifestyles such as avoidance of tobacco, alcohol,
poor diet and physical inactivity can reduce the risk of dementia \[9\].

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 \[10;11\], and 4,200 people with undiagnosed diabetes \[12;11\]).

The overall mortality rate from causes considered preventable in Richmond is relatively low \[13\]. The under 75 mortality rate from respiratory disease (12.8/100,000) and cancer (75.6/100,000) considered preventable is midrange \[14\].

There are large numbers of people with undiagnosed long-term conditions, e.g. diabetes

The Prevention strategy will focus on nine client groups which have been identified that are likely to be significantly and positively impacted upon by a shift towards the provision of preventative services as outlined in the Care Act (2014); are as follows:

1. All adults
2. Older people
3. Adults with mental health problems
4. Adults with physical and sensory disabilities
5. Vulnerable and socially excluded groups
6. Adults with learning disabilities
7. Carers
8. Adults with autism
9. Transitions

A separate needs assessment has been carried out on these areas.

2. **Why the equality is impact and needs analysis being undertaken?**

This is a new strategy document which brings together a range of options, services and environments to enable people to stay healthy and well. The EINA aims to determine whether groups with certain ‘protected categories’ will have equality of access to, and benefit from, prevention services according to their needs. In addition the EINA identifies possible impacts of the prevention framework.

Key issues are:

- Whilst the general population in Richmond is relatively healthy there are pockets of deprivation and life expectancy is 7 years lower for men and 4 years lower for women in the most deprived compared to the least deprived. Within the whole population some sub groups have specific health needs and these groups have been identified
- The population structure is important when considering need, the older population is expected to grow and in line with this so will the demand for services increase

There is a requirement to address the needs of these populations and in doing so to consider the protected characteristics that will span throughout all of these groups; the
nine protected characteristics are as follows:

The Equality Act 2010 identifies 9 protected characteristics:

- Age
- Disability
- Gender
- Race
- Religion/Belief
- Sexual Orientation
- Marriage / CP
- Maternity
- Gender Reassignment

There is acceptance that the whole adult population will benefit from improved wellbeing, better prevention, greater clarity, consistency and equality of access to support.

There are generic actions in the prevention strategy which are expected to benefit people with all protected characteristics; other proposals may particularly benefit people from groups with a protected characteristic.

3. Has the Service/Function/Policy undertaken a screening for relevance

An overarching Care Act screening for relevance has been completed which informs this EINA. The proposed strategy potentially affects most borough residents as it relates to a wider range of issues as well, as more specific issues.

4. What sources of information have been used in the preparation of this equality impact and needs analysis?

<table>
<thead>
<tr>
<th>Information source</th>
<th>Description and outline of the information source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint strategic needs analysis (JSNA) The Richmond Story 2014/15</td>
<td>The Richmond Story is a snapshot of the local needs identified through the JSNA process. It is developed to inform commissioning intentions.</td>
</tr>
<tr>
<td>Data Rich</td>
<td>Population forecast</td>
</tr>
<tr>
<td>DOH Care ACT EINA</td>
<td>This includes the general responsibilities of local authorities (including provision of information), assessment and eligibility provisions, direct payments, and safeguarding (Appendix 2)</td>
</tr>
<tr>
<td><strong>Information source</strong></td>
<td><strong>Description and outline of the information source</strong></td>
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</tr>
<tr>
<td>Public Health Annual Report 2013/14</td>
<td>Gives a summary of the population’s health with a focus on particular groups and health conditions.</td>
</tr>
<tr>
<td>NHS Five Year forward view</td>
<td>Sets out how health needs are changing and a more engaged model is proposed with a focus on empowerment and prevention.</td>
</tr>
<tr>
<td>BME Communities and Dementia – Race Equality Foundation November 2013</td>
<td>Provides and overview of issues of dementia in Black Minority Ethnic (BME) communities</td>
</tr>
<tr>
<td>JSNA equality bitesize editions 2014</td>
<td>A series of JSNA looking at data and priority issues for the 9 protected characteristic groups covered under the Equality Act.</td>
</tr>
<tr>
<td>A Survey of the Health Needs of Black and Minority Ethnic Groups in Norfolk 2010</td>
<td>Race for Health, an NHS-based programme that wishes to understand more fully the health inequalities experienced by Black and Minority Ethnic (BME) groups and to develop services that are responsive and appropriate to their needs.</td>
</tr>
<tr>
<td>Improving health and social care support for BME carers Race Equality Foundation September 2010</td>
<td>This briefing paper draws attention to the experience of black and minority ethnic carers in the context of mainstream service provision and recent policy developments such as the National Carers Strategies.</td>
</tr>
<tr>
<td>Prevention strategy Phase one engagement report 2015</td>
<td>The report describes the methodology and results from the initial engagement for the prevention strategy.</td>
</tr>
<tr>
<td>Opening the dialogue… Faith and Public Health faith action 2013</td>
<td>The document describes how faith settings can be used to promote health.</td>
</tr>
<tr>
<td>JSNA news flash Public health outcomes 2013</td>
<td>Describes the Framework contains a range of indicators for health.</td>
</tr>
<tr>
<td>Information source</td>
<td>Description and outline of the information source</td>
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<tr>
<td>The state of Men’s Health in Europe. Alan White Centre for Men’s Health Leeds Metropolitan University 2011</td>
<td>The extended report gives an overview of men’s lifestyles and preventable risk factors gives a detailed overview of men’s health behaviours, which in the most part contribute to much of men’s premature mortality.</td>
</tr>
<tr>
<td>Clustering of unhealthy behaviours over time Implications for policy and practice David Buck Francesca Frosini August 2012</td>
<td>Using data from the Health Survey for England, this is an examination how four lifestyle risk factors – smoking, excessive alcohol use, poor diet, and low levels of physical activity – co-occur in the population and how this distribution has changed over time.</td>
</tr>
<tr>
<td>Department of Health Older lesbian, gay and bisexual (LGB) people.</td>
<td>This paper describes how older lesbian, gay and bisexual (LGB) people have often been invisible in service provision for older people.</td>
</tr>
<tr>
<td>Issues facing Older Lesbians, Gay Men and Bisexuals Age Concern.</td>
<td>This paper describes the issues faced by older Lesbians, Gay Men and Bisexuals and provides recommendations for service providers.</td>
</tr>
<tr>
<td>Mental Health Joint Commissioning Strategy for older people</td>
<td>The document sets out the joint mental health commissioning strategy for older people in Richmond upon Thames</td>
</tr>
<tr>
<td>The Big Plan JSNA</td>
<td>The document considers the challenges that people with LD face. This encompasses a number of themes including; health employment and accommodation.</td>
</tr>
<tr>
<td>Richmond upon Thames Learning Disability JSNA 2014/15</td>
<td>The Learning Disabilities JSNA is a needs assessment for Richmond. We have completed the engagement and stakeholder elements. The JSNA will be finalised by the end of 2015.</td>
</tr>
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</table>
ANALYSING IMPACT, NEEDS AND EFFECTS

It is important that the analysis addresses each part of the duty assessed as relevant to the area being examined.

The strategy is aimed at the general adult population with a focus on specialist groups previously identified.

<table>
<thead>
<tr>
<th>Protected Group</th>
<th>Findings</th>
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<tbody>
<tr>
<td>Age</td>
<td>As the Act seeks to improve both levels of access, and improve how services are provided, this is the group that will benefit mostly as a result of the Care Act policy measures. The Act also includes a specific duty on local authorities to prevent or delay the development of care and support needs, which is likely to especially benefit older people as they are most likely to develop such needs and so will be a natural focus of many local authorities. Richmond Borough has highest proportion of people over 75 and living alone in London. However, it is not only older people who will benefit as a result of the Act. In addition disabled adults aged 18-65 will benefit from improved services. It is important to recognise what the health and social care needs of people in different life-course groups vary widely. The risk of the majority of diseases, and associated disability and needs, increases substantially with life-course progression beyond infancy and childhood. However, it is also increasingly recognised that there are life-long benefits of a healthy choices made in the early years of life, including before birth. However, it is important that all relevant services are accessible to and appropriate for all age groups; and that age specific services (e.g. elderly care) are of equivalent quality in the widest sense, including considerations such as humanity and dignity. The proportion of Richmond’s resident population from BME groups has increased from 9.0% to 14.0% since the 2001 Census, and growth is expected to continue. This</td>
</tr>
</tbody>
</table>
remains an important issue.

The estimated impact on this protected characteristic is high.

**Disability**

The Act is designed to help overturn traditional approaches to disability, and implement a social model approach. This is underpinned by approaches which seek to place greater power in the hands of all service users, including disabled people.

The introduction with innovative services with this reliance on traditional models will reduce restriction and promote choice.

Information on people with disabilities in Richmond is available from a variety of sources, which focus on particular disabilities and measure different aspects of disability. Together they help to form the overall picture of disability in Richmond. People with disabilities are more likely to suffer a range of barriers.

Also, research suggests that people with disabilities are also at higher risk of other health problems, for example, almost a third of people with long-term physical conditions have a concurrent mental health problem such as depression and anxiety. Furthermore, surveys of people with disabilities report that they enjoy lower levels of life satisfaction and mental wellbeing (e.g. anxiety).

21,447 (11.5%) of people in Richmond report that they have some form of disability or health problem that affects their day-to-day activities a lot or a little. 2802 (2%) of people in Richmond aged 16-74 years consider themselves to be economically inactive due to a permanent sickness or disability.

Population estimates based on Census data and research suggest that among Richmond residents aged 18-64 years 9,180 people have a moderate physical disability and 2,673 a severe physical disability.

Research suggests that BME populations who have a disability are more likely to be unemployed and live in Poverty.

People with a learning disability (LD) generally have higher and more complex health needs, a higher level of unmet health need and a different pattern of health need.
### Deaf Blind people

Specific health problems experienced by people with a LD may be a result of the physiological issues inherent in the underlying causes of LD (e.g. genetic factors), but health problems will also be exacerbated by other, more controllable factors such as access to services.

In Richmond borough, it is estimated that 3,621 adults have a LD. Of these, 770 adults are estimated to have a moderate or severe LD, and therefore likely to be in receipt of services.

Access to services is made more difficult because of communication difficulties and barriers to access.

Disabled people are one of the groups most affected by fuel poverty in Richmond.

The Act includes a specific duty on local authorities to maintain registers of deafblind people in their local area. The registers that local authorities already maintain for the sight impaired are significantly more accurate than the registers maintained currently for disabled people and it is important not to lose this good practice.

Moreover, there are benefits linked to being registered that does not apply to people who may be registered with other disabilities. For example, someone may be able to get help with NHS costs and leisure discounts and free public transport.

However, the concession entitlement will depend on whether the person is registered as severely sight impaired or sight impaired.

In addition to the sight registers, local authorities may also continue to establish and maintain a register of people living in their area that have a disability. Giving local authorities the power to maintain registers for specific groups and categories of people with disabilities should lead to better and more accurate recording according to local priorities compared to the generic registers that currently apply.

The estimated impact on this protected characteristic is high.

### Gender (Sex)

The most relevant aspect to gender equality is around the provision in the Act for carers. As the last UK census outlines, there are approximately 6 million carers in the...
UK, and the vast majority of these are women. The Act for the first time sets out a number of rights for carers for the first time, placing a series of duties on local authorities to meet a carer’s needs for support. This should have a significant benefit for a large number of women.

In Richmond, the numbers and proportions of men (91,149: 49%) and women (95,849: 51%) are roughly equal overall, and across life-course age-bands until later life. As women experience longer life expectancy than men, by the time people are aged 85 years and over there are more than twice as many women as men.

This pattern has a number of implications for the needs of women. For instance, the older age profile of women means that they suffer higher rates of chronic disease and require access to appropriate models of chronic disease and elderly care services, and it needs to be recognized that they are more likely to be living alone without a partner/ carer.

Gender inequality exists in many aspects of society and refers to lasting and embedded patterns of advantage and disadvantage.

In relation to health and health & social care, men and women can be subject to differences in both risks relating to the wider determinants of health and wellbeing (e.g. employment and educational opportunities,) and biological risks of particular diseases (e.g. men – prostate cancer; women – cervical cancer and reproductive health).

There is much evidence on access and use of health services – GP consultation rates are higher in women than men. Men are less likely than women to use general practice or to visit a pharmacy. A King’s Fund study that looked at four behaviours – smoking, drinking, diet and exercise – found that men were more likely to participate in a combination of three or four risky behaviours.

| Gender reassignment | Estimates of the prevalence and incidence of gender dysphoria and Transsexualism are difficult to quantify due to the lack of robust national data. Commissioning of health services for gender dysphoria has historically been based on the results of a Scottish primary care study published in 1999 which estimated a prevalence of 8.18 |

56
per 100,000 population aged over 15 years.

It is accepted that gender dysphoria, if not treated, can severely affect a person’s quality of life and health status. High levels of depression are reported within Trans communities. The majority of individuals have considered suicide, with an estimated 35% reporting an attempted suicide at least once in their lifetime. Roughly half of Trans individuals have self-harmed at some point.

Workplace harassment and abuse from fellow employees can have a damaging effect on an individual's health and wellbeing, Housing is a key concern for the Trans community as roughly 30% of Trans individuals report being thrown out of their home as a result of their status. Physical transition of gender may also have an impact on health.

<table>
<thead>
<tr>
<th><em>Marriage and civil partnership</em> (<em>only in relation to first part of the duty: eliminate discrimination and harassment</em>)</th>
<th>There is limited, systematically considered evidence available on the particular health and social care needs of people in terms of marriage and civil partnership. However, it is important that health and social care services are aware of and respectful of the legal equivalence of marriage and civil partnership when dealing with individuals, their partners and families. The estimated impact on this protected characteristic is low.</th>
</tr>
</thead>
</table>

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<tr>
<th>Pregnancy and maternity</th>
<th>No inequitable impacts upon pregnancy and maternity have been identified. The health of a mother can affect the health of her baby, before birth, in childhood and later in their life. Enabling a mother to stay healthy and well both during and after pregnancy helps the baby to develop, grow and get the care that they need in order to get the best start in life. The age profile of mothers giving birth in the London borough of Richmond upon Thames, London and England in 2011 is older than the London and England averages – 33.6% of mothers in the borough were aged 35 or over, compared to 19.8% in London and 16.1% in England. In 2012, of the live births to Richmond residents 37%</th>
</tr>
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</table>
were to mothers born outside of the UK. This is lower than in London (57.4%) but higher than in England (26.7%). The top five non-UK countries of birth of mothers were, starting with the largest, Poland, Australia, South Africa, Ireland and the United States of America.

Country of birth data is useful, but need to consider that it will not capture those whose ethnic origin is from a BME group, where their country of birth is the UK, which will now apply to second and third generations BME groups.

Smoking is not only harmful to the mother but affects the growth and development of the baby. Richmond borough has low levels of smoking during pregnancy – in 2012/13, 2.4% of pregnant women reported smoking at the time of delivery. This is lower than London (5.7%) and significantly lower than England (12.7%).

In Richmond borough in 2012/13, 90.6% of mothers breastfed their new-born babies. This is the sixth highest rate of breastfeeding initiation in England, and the second highest in south west London.

In Richmond borough in 2012, 74% of children were born to mothers who were married or in a civil partnership.

Maternal mental disorders can significantly impact a child’s mental and emotional wellbeing and can lead to negative outcomes in adolescence and adulthood.

More needs to be done to ensure that more pregnant women access maternity services by week 12.

Considering cultural and language requirements should be a key part of commissioning and providing maternal and child services.

| Race/ethnicity | According to responses to the 2011 Census, 160,725 (86.0%) of Richmond’s residents categorise themselves as belonging to a White ethnic group, and 26,265 (14.0%) to a Black and minority ethnic (BME) group. |
Also, 75.7% of Richmond’s population were born in the UK. Consequently almost a quarter of Richmond’s residents were born outside the UK, with 14.3% of the population born outside Europe.

One aspect of the Act which we have aligned with language barriers is that of Information and Advice. The Act places a duty upon Local Authorities to provide Information and Advice to service users in the ‘appropriate’ format, to ensure accessibility. Guidance will set out that this may also include needing to ensure this information is provided in different languages/available in different formats.

It is recognised that access to appropriate information which is able to meet diverse needs is key if we are to reduce inequalities.

While the health issues facing particular ethnic groups vary, overall, people from BME and some non-British white ethnic groups (e.g. Irish, Gypsy/Travellers) are more likely to have poorer health than the White British population. This represents an important health inequality.

A well-documented body of evidence demonstrate that the reasons for this are multiple, and likely to be influenced to varying degrees by the following determinants of health:

**Genetically** inherited susceptibility to particular health risks and diseases.

The UK has a higher prevalence of vascular dementia than other communities. However, there are increasing indications that the prevalence of dementia in Black African-Caribbean and South Asian UK populations is greater than the white UK population.

There are 25,000 people with dementia from BME groups in the UK This figure will double by 2026

The Gypsy/Irish Traveller group have the highest percentage (29.8%) of people who consider their health to be fair, bad or very bad; compared to 20.0% of the
White British group.

Research shows that Gypsy/Traveller communities are twice as likely to report anxiety and respiratory problems (e.g. asthma & bronchitis) as health problems, and five times more likely to report chest pain. Rates of detention under the Mental Health Act are higher than average for Black Caribbean, Mixed, Other White, and Pakistani groups.

Mental Health – has emerged as a significant problem among BME communities. There is substantial complexity around this issue as it straddles both the conventional view of mental illness and the social conditions that contribute positively and detrimentally.

Women in BME groups aged over 65 years suffer high incidence of dementia and depression. Sickle cell and thalassaemia are inherited blood cell disorders which cause anaemia are more common in a range of BME groups.

Support from faith groups, cultural associations and/or community groups can constitute a significant means of coping with health-related issues and loneliness and isolation.

- Difficulties with access (e.g. language, awareness, isolation, inadequate cultural sensitivity, discrimination) to and lower utilisation of disease prevention and health care services. Some medical terms do not exist in other languages there is no single equivalent word for dementia in the South Asian languages.
- Difficult concept of dementia is difficult to translate into many languages. There are different cultural views on ageing
- Public health messages take longer to have an impact with migrant communities.
- Community based health interventions can be more effective with BME communities and traveller groups

Little health outcome data is available on Richmond’s residents from different ethnic groups. However, insight into the health and needs of ethnic groups in Richmond can be provided by national data and research from elsewhere. National data suggests substantial local variation in patterns of ethnicity among areas and
educational institutions within the Borough which need to be taken into account in the commissioning and delivery of public health programmes.

The particular recognised needs and experiences of different ethnic groups in relation to health and use of health and social care services needs to be taken in to account.

Socio-economic disadvantage (e.g. income employment, housing).

Overcrowding is an important risk factor for a wide range of physical health conditions including diseases and it is more prevalent in social housing than in other housing sectors, research shows that overcrowding disproportionately affects (BME) communities.

BME populations are one of the groups most affected by fuel poverty in Richmond.

| Religion and belief including non-belief | The wellbeing principle set out at Section 1 of the Care Act includes the duty to have regard to a person’s beliefs, which includes both religious and non-religious beliefs, when exercising a care and support function. This should ensure that people of all forms of belief are not discriminated against by having those beliefs ignored or marginalised compared to other views, wishes or feelings. Little evidence is available on the particular health needs of people of different religions and belief. Most specific health issues that might be associated with people of different religions are actually associated with their race or ethnicity. However, it is important that health and social care services are aware of the need to respect and be sensitive to the preferences of people of particular religions and beliefs relevant to the services they delivery. The proportion of the population reporting themselves as Christian is declining and those reporting no religion increasing. Compared to London as a whole, Richmond continues to have a higher proportion of Christian (55% vs 48%), a higher proportion reporting no religion (28% vs 21%), and lower proportions of other religions. People from BME groups more likely than the white majority to be practising their religious faith. |
South Asian women use prayer as a major coping strategy for depression. Research has shown that religious involvement is associated with positive mental health outcomes. Higher proportion of African Caribbean people affirmed a religious belief than that of the white population/other BME groups.

Faith groups and organisations are well positioned in many communities around England that are termed 'marginalised. This provides opportunities.

A growing number of studies are showing that spirituality, religious faith and practice have a definite positive impact on people's wellbeing.

Places of worship can provide a support and improve networking to reduce loneliness and isolation.

Thus, religion/belief are significant contributing factors in the health and wellbeing of many older people and especially those from minority ethnic groups.

| Sexual orientation | The 2011 census did not have a specific question regarding sexual orientation, but found that 665 people (0.35% of the Borough population) reported being in a same sex Civil Partnership.

The terms lesbian, gay, bisexual (LGB) abbreviation have been adopted in this section

Beyond Richmond, surveys found that 1.5% of the national population and 2.5% in London consider themselves LGB and a government report estimated that between 5% and 7% of the population in England and Wales is LGB. A conservative estimate (5%) equates to 9,500 people in Richmond. However, some local organisations suggest an estimate of 10%, equating to 19,000 people, is more realistic.

LGB people, of course, have the same health and social care needs as their heterosexual counterparts, though also often have particular additional or different needs (e.g. sexual, reproductive, & mental health), including access to services which are accepting and sensitive to their sexuality, preferences, and needs. |
An optimal balance needs to be struck between addressing the general and particular health needs among LGB people. It is important to note that the particular needs of gay and bisexual men and lesbian and bisexual women vary substantially.

Lack of awareness of LGB needs, alongside stereotypical assumptions of LGB social and sexual practices causes many screening and treatment needs to be negated or ignored. Stigmas prevail that marginalize and exclude people and diminish social confidence, causing higher likelihood of mental and physical ill health,

LGB people are statistically as likely as the general population to use alcohol and other drugs and to misuse substances when young, but are more likely to maintain that level of use in later life.

Higher tendency (when compared to the general population) amongst the LGB population to self-harm, attempted suicide and achieved suicide.

Older lesbians, gay men and bisexuals face many issues in respect of ageing in common with older heterosexuals; for example, reduced income following retirement, health concerns, the loss of friends and family members and ageism. Experience of disability may exacerbate problems such as poverty and isolation.

Some face multiple-discrimination; with older lesbians, gay men and bisexuals from ethnic minorities facing racism/

The older generation of the LGB community are: 3 times more likely than their heterosexual counterparts to be single and live alone, less likely to have children and far more likely to be estranged from their families. They are significantly more likely to experience damaging mental health problems. Many LGB people (aged 60–91) have been subjected to verbal abuse. Discrimination; access; social isolation; are key areas to be considered in the reduction of health inequalities. LGB people may feel anxious about accessing some services.

There are over 100,000 older lesbian, gay, bisexual and transgender (LGBT) people living in London today, many
The Opening Doors London project, led by Age UK Camden, provides a range of services and activities for Lesbian, Gay, Bisexual and Transgender (LGBT) people over 50 in London.

<table>
<thead>
<tr>
<th>Carers</th>
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The Care Act for the first time enshrines rights for carers in legislation. This includes a duty upon local authorities to provide support and services for carers.

Key characteristics of carers in Richmond upon Thames include:

- 15,802 (8.5% of all residents) identified themselves as carers. This is similar to London, and lower than the average in England.
- There are more female than male carers (59% of carers are female).
- The peak age for caring is 50-64 years. 34% of carers are aged between 25 and 49 years, 38% between 50 and 64 years, and 22% are aged over 65 years.
- Carers are more likely to report health problems: 20% of carers report their health is not good, compared to 11% of those who do not provide care.
- While 60% of carers are economically active, providing care is often a reason for not working or for working part-time.

There are a number of carers specific services in Richmond.

- In terms of ethnicity British (11.1%), Irish (11.0%), and Gypsy/Irish Travellers (10.7%) were most likely to be providing unpaid care; and Mixed White and Black African (4.9%), Chinese (5.3%), and Mixed White and Asian (5.3%) were least likely (ONS, 2013b). Gypsy/Irish Travellers were more likely than any other ethnic group to provide more than 50 hours of care per week.
- Wide regional variations are seen in terms of levels of caring across the UK associated with population age, disability, and deprivation (ONS, 2013c).

The assumption that BME carers are a homogeneous group overlooks the diversity between and within communities and the ways in which ethnicity and disability intersect with other aspects of carer and service user identity.
have you identified any data gaps in relation to the relevant protected characteristics and relevant parts of the duty?

<table>
<thead>
<tr>
<th>Gaps in data</th>
<th>Action to deal with this</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve collection of robust equality data for some protected groups.</td>
<td>Development of Equality KPIs for new contracts.</td>
</tr>
<tr>
<td>Improve performance monitoring in all contracts.</td>
<td></td>
</tr>
<tr>
<td>Improve data collection, sharing and integration across commissioned services and partner organisations.</td>
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</tbody>
</table>

6.

CONSULTATION IN THE EINA PROCESS

The EINA was well received and approved at ESSG ON 4/3/15.

We have carried out consultation using various approaches with people who live in Richmond to get their views on how they keep healthy and well and what they would like in the future to keep healthy and well. This information will be used to inform the priorities in the implementation plan.

A cross-council group with multi agency partners has been formed to steer the development of the Prevention Framework.

Stakeholders and residents were asked to submit feedback directly via a web questionnaire on Richmond Council public website. The survey respondents closely matched the borough residents profile slightly more women than men made.
consultation returns.

We undertook a mapping exercise to gather evidence on commissioned and universal services with all departments in Richmond and used this was a way of engaging with providers both statutory and voluntary and officers to understand the gaps in services and use of the term prevention in service provision. We used this as an opportunity to meet with directorate leads to promote their role in prevention. We have engaged with stakeholders at a Health Watch workshop to ascertain their understanding and interest in promoting prevention interventions.

We will begin consulting on the Prevention Framework in March. A full consultation report will be available see phase 1 report (Appendix 3)

### ACTION PLANNING

<table>
<thead>
<tr>
<th>Issue identified</th>
<th>Planned action</th>
<th>Lead officer</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioning and procurement to be targeted.</td>
<td>Ensure services commissioned and work with providers and local communities are focussed to deliver bespoke services where high impact is noted. Increase ongoing consultation with key groups.</td>
<td>PH/H&amp;SC/JCC</td>
<td>August 2016</td>
</tr>
<tr>
<td>Reduction in inequalities</td>
<td>A more targeted approach to support groups with the greatest need i.e. BME, Older People and those with a Disability.</td>
<td>PH/H&amp;SC/JCC</td>
<td>August 2015</td>
</tr>
<tr>
<td>Improve data collection in contracts</td>
<td>Increase monitoring and evaluation processes. Develop consistent equality monitoring reporting processes.</td>
<td>PH/H&amp;SC/JCC</td>
<td>August 2015</td>
</tr>
</tbody>
</table>
MONITORING AND REVIEW

7. How will the actions in the action plan be monitored and reviewed? For example, any equality actions identified should be added to business, service or team plans and performance managed.

- The action plan will be agreed and monitored
- Equality Monitoring data, complaints, user feedback will be recorded

PUBLISHING THE FULL COMPLETED ANALYSIS

<table>
<thead>
<tr>
<th>Approved by</th>
<th>Directorate Equality Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of approval</td>
<td>April 2015</td>
</tr>
<tr>
<td>Date of publication</td>
<td>May 2015</td>
</tr>
</tbody>
</table>

DECISION-MAKING PROCESS

A summary of the key findings will be contained within the cabinet report April 2015 and the EINA as an appendix to the report.

References

2. Obesity JSNA.
6. LAPA profile 2012.
11. Quality & Outcomes Framework 2013 prevalence, gpcontract.co.uk.

Appendix 1
Diagram of contributory factors

Health inequalities and population health

Appendix 2
Department of health EINA

Care Bill EINA relevance for screening

Appendix 3
Phase 1 consultation

Phase One Prevention Strategy Engagement
Appendix 2 – Needs Assessment

Developing the Prevention Strategy

A Summary of Needs for Key Client Groups

April 2015
Contents

1. Introduction
   1.1 Source and purpose
   1.2 Definition of prevention
   1.3 Scope of the strategy
   1.4 Purpose of this document

2. Summary of needs for key client groups
   1.1 All adults
   1.2 Older people
   1.3 Adults with physical, sensory and other disabilities
   1.4 Adults with learning disabilities
   1.5 Adults with mental health problems
   1.6 Carers
   1.7 Vulnerable / socially excluded groups
   1.8 Transitions
   1.9 Adults with autism
1. Introduction

1.1 Source and purpose
The London Borough of Richmond upon Thames Local Authority (LA) and the Clinical Commissioning Group (CCG) are working in partnership to develop and support the delivery of an integrated three year Prevention Strategic Framework.

The purpose of the Prevention Strategic Framework is to embed a local approach to prevention in order to meet the recommendation outlined by the Care Act (2014) that:

‘A Local Authority 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.’

To achieve this aim, all adults within the local population, not just those with existing care and support needs should be considered. To inform a population level approach which is tailored to need, we reviewed and summarised existing needs assessments. This provided insights into:

1. The needs of the local population
2. The current prevention offer
3. Gaps in the current preventive offer i.e. unmet need

1.2 Definition of prevention
Prevention services, facilities and resources are defined by the Care Act (2014) as supporting the population at three different levels of need:

- **Primary prevention** – promoting wellbeing/prevent
  These are services, facilities or resources that are universally accessible and are aimed at individuals with no current health or care support needs.

- **Secondary prevention** – early intervention/reduce
  These are services, facilities or resources that are targeted towards individuals who are at risk of developing further health or care support needs.

- **Tertiary prevention** – delay
  These are services, facilities or resources that are for individuals with existing health and care support needs; the emphasis is placed on minimising further deterioration.

1.3 Scope of the strategic framework
The population of interest includes all adults resident in the Borough, including young people in transition from Children’s to Adult’s Services. Additionally, identification of those at high risk of

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needing health and care support will be important. Taking this into account, a review of existing needs assessments was undertaken for each of the following client groups:

1. All adults
2. Older people
3. Adults with physical, sensory and other disabilities
4. Adults with learning disabilities
5. Adults with mental health problems
6. Carers
7. Vulnerable / socially excluded groups
8. Transitions
9. Adults with autism

1.4 Purpose of this document
The purpose of this document is to provide a summary of existing needs assessments for each of the following client groups identified above, with the following areas being addressed for each:

- Definition of client group
- Local priorities
- Local demographic profile
- Local services
- Key documents
2. Summary of understanding of needs for key client groups

2.1 All adults

### Definition of client group

All those who are aged over 18 years old and are resident in the Borough. Those local residents approaching the age of 18 who will enter Adult Services from Children’s Services will form a separate client group, entitled ‘Transitions’.

### Local priorities

The recently published Annual Report of the Director of Public Health (2015) [1] outlines the Borough’s position across indicators used in the National Outcomes Frameworks. Indicators are being increasingly used as a measure of assessing health and wellbeing outcomes at both a national and local level and may be helpful in establishing local priorities for prevention locally. The indicators analysed in the report are outlined below:

1. **Improving the wider determinants of health**: employment, housing, built environment, green space, safety and crime.
3. **Integrated health and social care**: avoidable admissions and readmissions, effective hospital discharge and rehabilitation, community provision, quality of life and users’ experience of social care, carers’ experience and quality of life, patients’ experience of health care and health-related quality of life, preventable sight loss, loneliness and isolation
4. **Reducing premature mortality**: life expectancy, mortality

There is an increasing ageing population, with a noteworthy increase in BME groups. This will have implications for supporting with the management of long term conditions. Initiatives, interventions and resources will be targeted to engage older populations, including BME groups.

### Local demographic profile

The Annual Report 2014/15 [1] highlights some of the key features of the local demographic profile as based on indicators in the areas outlined above; some of the key features that the report are extracted and illustrated below:
Improving the wider determinants of health

Employment:
- 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.

Housing:
- During 2012-13, there were 357 households accepted for housing support.
- There are estimated to be 45 excess winter deaths per year and 5,780 households are in fuel poverty

Built environment:
- 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.

Green space:
- Green space is a key asset in the Borough, with over 20 miles of river frontage and more than a third of the borough being open space.

Safety and crime:
- Richmond 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.

Prevention and early intervention

Obesity:
- 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.

Physical activity:
- An estimated one in six adults do less than 30 minutes of physical activity per week (approximately 25,000 people).

Diabetes:
- 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%. National modelling suggests that there are up to 4,200 people with diabetes in Richmond borough who have not been diagnosed.

Smoking:
- Richmond borough has a relatively low prevalence at 14% of adults compared to 18% in London and 19.5% in England. 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.

Substance misuse:

- There are currently around 480 Richmond borough clients in drug treatment (280 opiate users and 200 non-opiate users).
- In 2012, 11% of Richmond borough opiate users successfully completed treatment, compared to 9.6% in London and 8.2% in England. In 2012, 39% of Richmond borough non-opiate users successfully completed treatment, compared to 35% in London and 40% in England.
- Richmond borough has comparatively low rates of hospital admissions that are related to alcohol. Nevertheless, this equates to 733 admissions in 2012-13. Around 15,000 adults are estimated to be drinking at higher risk levels.

HIV diagnosis:

- 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).
- It is estimated that there are around 100 people in Richmond borough living with HIV who are unaware of their HIV status.

Screening and health checks:

- Diabetic retinopathy – with 87% uptake, Richmond borough has the third highest percentage of people screened in London.
- Breast screening – in Richmond borough, 70% of eligible women received breast screening. This is higher than in London (69%) but lower than the England value (76%).
- Cervical screening – in Richmond borough, 72% of eligible women received cervical screening, compared to 69% in London and 74% in England.
- NHS Health checks – 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.

Infectious diseases:

- Influenza vaccination – 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.
- 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.

- 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.

Reducing premature mortality

- Life expectancy – 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).
- Healthy life expectancy – 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).
- Inequality in life expectancy – 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).
- Premature mortality – in Richmond borough, 1,226 people died in 2013. Of these, 364 (30%) people were aged younger than 75 years. Most deaths under the age of 75 are considered avoidable and could be postponed until an older age by prevention and treat
- 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).

In addition to detail about the local demographic profile outlined by the Annual Report 2014/15, the Joint Strategic Needs Assessment (JSNA) The Richmond Story 2014/15 [2] provides some additional information, relevant extracts are illustrated below:

Long-term conditions

- 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 number of people with three or more
long-term conditions increases from 4% in people under the age of 65 to 44% in those over the age of 65.

- In Richmond, almost 32,000 of the GP registered population have a heart condition (including congestive heart failure, hypertension, ischemic heart disease and atrial fibrillation). Multi-morbidity is common; over 15% of people with a heart condition in Richmond have at least three other long-term conditions. In addition, 20% of patients have either depression or anxiety.

- There are 1,780 people with multiple sclerosis, Parkinson’s disease or epilepsy resident in the Borough of Richmond.

- It is estimated that 2,075 Richmond residents have dementia. Around 50% of the estimated number of people with dementia has received a formal diagnosis, which is similar to the national average. Locally a goal has been set of achieving a diagnosis rate of 66% by 2015 in line with the national goal. Of those with dementia, 70% have one or more other long term conditions, and it is estimated that two-thirds of those with dementia live in the community.

### Local services

Local healthy lifestyle services in the London Borough of Richmond upon Thames, include:

- Livewell Richmond
- NHS Health Checks
- English for Health Club
- Richmond Community Wellbeing Service
- Winter Warm
- Kick It smoking cessation service
- Falls Prevention Service
- DESMOND Programme
- Walking Away from Diabetes
- Expert Patient Programme
- Sexual Health Services
- Drug and Alcohol Support Services

### Key documents

2.2 Older people

**Definition of client group**

All those aged 65 years and over who are resident in the Borough. This group of people can be further categorised according to specified age ranges, for example, those aged over 75.

**Local priorities**

Local priorities for older people living in the Borough include:

- Addressing lifestyle issues such as alcohol consumption and obesity.
- Prevention and early identification of long-term conditions.
- Tackling loneliness and isolation particularly for those who live alone.
- Ensuring provision of appropriate housing.
- Interventions and resources will be targeted to engage older populations, including BME groups.

**Local demographic profile**


**Number of people who are aged 65 years and over**

- In the London Borough of Richmond upon Thames, 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 of 16.3% [1].

**Healthy life expectancy for those aged 65 years and over**

- In Richmond, from age 65 onwards, women and men have 16 years and 13.9 years, respectively, of healthy life expectancy, this is approximately one and a half years longer than the equivalent for both London and England [1].

**Lifestyle**

- LBRuT hospital admissions for alcohol-related conditions continue to rise and men over 65 are more than twice as likely to be admitted for an alcohol-related condition compared to women (7,274 and 3,155 spells per 100,000 respectively) [1].
- Obesity prevalence increases with age and is highest in the 65 to 74 year age group [1].

**Long-term conditions**

- The number of people with three or more long-term conditions increases from 4% in
people under the age of 65 to 44% in those over the age of 65 [2].

- It is estimated that 2,075 Richmond residents have dementia. Around 50% of the estimated number of people with dementia has received a formal diagnosis, which is similar to the national average. Locally a goal has been set of achieving a diagnosis rate of 66% by 2015 in line with the national goal. Of those with dementia, 70% have one or more other long term conditions, and it is estimated that two-thirds of those with dementia live in the community [2].

**Falls risk**

- 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 [3].

**Variations in where older people live in the Borough**

- The following wards have higher proportions of particular age groups: older people (60-74 years) in Hampton and Hampton North; elderly (75+ years) in Ham, Petersham and Richmond Riverside and Whitton [4].

**Independent living**

- Richmond has the highest proportion of people aged over 75 and living alone in London (51% in Richmond vs. 35% for London) [2].
- An estimated 12% of older people in Richmond borough are carers, providing help and support to a partner, child, friend, relative or neighbour due to age, physical or mental illness, addiction or disability [1].
- Of the 85+ population only 34% received a council funded service at home and 7% in a care home meaning that approximately 2,400 older people aged 85 and over are either not receiving care or are arranging care themselves [1].

**Housing**

- An estimated 73% of head of households of pensionable age live in owner occupied accommodation in Richmond borough and this will impact on their future housing needs and aspirations [1].
- A large percentage (47.5%) of one and two older person households occupy three and four bedroom houses which may be difficult to heat and repair, the majority of which are owner occupied [1].
- 13% of older people live in households with no central heating with a high proportion in the private rented sector [1].

**Excess winter deaths**

- There has been a downward trend in the percentage of people who die in winter months (excess winter deaths) in Richmond. Older people are most susceptible to higher death rates in winter. In those aged 85 years and over, there were 30 (19.2%) additional deaths in winter in Richmond, compared to 45 (11.8%) in all age groups. This is similar to London and England [2].
Hospital admissions from care homes
- 10% (£1.7 million per year) of spend on emergency admissions is attributable to care homes. 34% of emergency hospital admissions from care homes are short stay (0 or 1 day) suggesting there is potential to reduce these [2].

Mental health conditions
- Estimates suggest the following numbers of Richmond residents aged over 65 years (2011) with mental health problems:
  - 2,254 people with depression
  - 716 with severe depression
  - 26 with probable psychotic disorder
  - 506 with 2 or more conditions [5]

Local services
Local services available for older people in the Borough include:
- Winter Warm
- Falls Prevention Services
- A range of support services commissioned by the borough provided by voluntary organisations i.e. support services
- Neighbourhood groups

Key documents


### 2.3 Adults with physical, sensory and other disabilities

#### Definition of client group

**Disability**

Disability is a protected characteristic under the Equality Act 2010. A person with a disability can be defined as someone with a physical or mental impairment which has a substantial and long-term adverse effect on that person’s ability to carry out normal day-to-day activities.

Disabilities take many forms but are often classified into the following main groups[1]:

- Physical disability
- Learning disability
- Mental health problems
- Sensory disability
- Special educational needs

#### Local priorities

- Review of service specifications for the commissioned services included in all council provided programmes, to ensure an adequate and consistent approach to equality issues relating to the protected characteristic groups.
- Review of access to data essential to undertake adequate equality monitoring of key public health services, particularly immunisation and screening. To extend this to include council provided services i.e. leisure, parks culture, libraries.
- To ensure that the health and social care services are able to provide effective specialist services to meet the needs of disabled people, and ensure that other universal services (e.g. primary care, health improvement and disease prevention initiatives) are accessible to people with disabilities and sensitive to their needs.
- Those with disabilities are more likely to have long term conditions and more complex health needs. Therefore, the strategy recommends a targeted and tailored approach for this group.

#### Local demographic profile

Protected characteristic groups in Richmond: Disability (2014) [1] outlines some of the local demographic profile of people living with physical, sensory and other disabilities in Richmond and relevant data from this document is extracted and illustrated below:

**Number of people living with a physical disability in the Borough**

- Population estimates based on Census data and research suggest that among Richmond residents aged 18-64 years 9,180 people have a moderate physical disability and 2,673 a severe physical disability [1].

**Number of people living with a sensory disability in the Borough**
• Registration data for Richmond show that in 2011 370 people were blind, 260 were partially sighted, and in 2010 550 were deaf or hard of hearing [1].

Local services

Richmond’s NHS Health Checks programme targets people with learning disabilities and severe mental health problems, and carers as priority groups. In addition, further efforts to target people with disabilities are underway, including increases in incentives for GPs and other providers to undertake health checks for people with disabilities, a pilot outreach service, and promotional events with Carers Hub, and local disability charities and service providers.

Key documents


2.4 Adults with learning disabilities

Definition of client group

Disability

Disability is a protected characteristic under the Equality Act 2010. A person with a disability can be defined as someone with a physical or mental impairment which has a substantial and long-term adverse effect on that person’s ability to carry out normal day-to-day activities. Disabilities take many forms but are often classified into the following main groups[1]:

• Physical disability
• Learning disability
• Mental health problems
• Sensory disability
• Special educational needs

Local priorities

Ensuring people with a learning disability get the support, care and services they need is crucial to improve outcomes and may require allowances to be made, including scheduling longer appointment times, providing appropriate and timely information and support.

• People to direct their own support and lives and for support to be equitable
• People to live locally – local services for local people
• People supported to live as independently as possible
- People to have paid employment where possible
- People to have supported carers
- Targeted interventions will be required for this population group.

### Local demographic profile


**Number of adults living with learning disabilities in the Borough**
- Estimates suggest that in 2011 Richmond 3,621 people aged 15-64 years have a learning disability, and that of these 770 have a moderate or severe learning disability [1].
- According to GP data 439 (2.76/1000) adults with a learning disability are known to GPs in Richmond, compared to population rates of 3.44/1000 in London and 4.65/1000 in England [1].

**Independent living**
- According to other data 412 adults with a learning disability receive council services, of whom 169 live in a care home and 243 receive community services [1].

**Employment**
- 14% of people with learning disabilities are in paid employment compared to 9.2% in London and 6.8% in England [3].
- The borough has an ‘in-house’ supported employment service (Power Employment) for people with LD.

**Housing**
- There are around 130 people with learning disabilities who are not in stable and appropriate accommodation [3].
- Three new supported living homes have been recently established in the borough, as a result of collaboration between adult social care, housing, registered social landlords and families.

**Health**
- People with learning disabilities are reported to have markedly worse health than the population as a whole. The 2006 Disability Rights Commission report estimated that people with a learning disability are 2½ times more likely to have health problems

### Local services

The Richmond Specialist Health Care Team (RSHCT) for adults with LD is provided by Your Healthcare
CIC. The service is multi-disciplinary and co-located with the borough’s care management team for adults with a learning disability.

The London Borough of Richmond upon Thames provides social care services for adults with a learning disability who are eligible for support. The London Borough of Richmond upon Thames manages a steering group and health improvement group.

**Key documents**


2.5 Adults with mental health problems

<table>
<thead>
<tr>
<th>Definition of client group</th>
</tr>
</thead>
<tbody>
<tr>
<td>All those who are aged over 18 years old and are living with a mental health problem in the Borough. Further classification by condition or severity can be helpful.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Local priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local priorities for adults living with mental health problems in the Borough are outlined in the Profiles of mental health and wellbeing (2010), these are extracted and displayed below [1]:</td>
</tr>
</tbody>
</table>

- Improving the detection and diagnosis of mental health problems in primary care.
- Integration of detection and management of physical and mental health conditions.
- Promotion of mental health in the workplace.
- Ensuring care pathways are in place for the effective assessment and management of those with serious mental health problems, and delivery through collaboration between primary health care and specialist mental health services.
- Strengthening early intervention in psychosis, and crisis intervention and home treatment to prevent inappropriate hospital admission.
- Improving the early detection and diagnosis of dementia within primary care in conjunction with the new memory assessment service.
- Strengthening community based services and approaches that promote independence and social engagement and help prevent depression and other mental disorders among vulnerable groups, particularly older people.
- Strengthening integrated approaches to prevention and management of co-morbid mental health and physical health conditions.
- Targeted interventions will be required for this population group. |

<table>
<thead>
<tr>
<th>Local demographic profile</th>
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</table>

**Number of adults living with mental health problems in the Borough**

- Estimates suggest the following numbers of people in Richmond aged 18-64 years (2011) have mental health problems [2]:
  - In total, 20,510 people with a common mental health problem
9,155 have two or more psychiatric disorders
1,526 have a serious mental illness (i.e. 574 borderline personality disorder, 442 anti-social personality disorder, 510 psychotic disorder)

- Estimates suggest the following numbers of Richmond residents aged over 65 years (2011) with mental health problems [2]:
  - 2,254 people with depression
  - 716 with severe depression
  - 26 with probable psychotic disorder
  - 506 with 2 or more conditions

Suicide rate
- There are around 15 suicides per year in Richmond borough, and the rate is 8.3 per 100,000 [3].

Dementia
- The number of older people with dementia in Richmond is projected to increase from around 2,000 individuals in 2012 to 2,300 in 2020 – an increase of 18%. Two thirds are likely to live in the community, and cared for by family and mainstream primary and social services. The remaining third are likely to be living in care homes (probably with more advanced illness) [1].

Co-morbidities
- Estimates provided through the Richmond Risk Stratification Project show high levels of co-morbid mental illness (depression and dementia) and chronic physical conditions (including heart disease and diabetes). Co-morbidity increases significantly with age. For example 36% of men and 50% of women aged 65+ years who have depression also have three or more other physical conditions [1].

Substance misuse
- Dual diagnosis of substance misuse and psychiatric illness is frequent [1].
- There are currently around 480 Richmond borough clients in drug treatment (280 opiate users and 200 non-opiate users) [3].
- In 2012, 11% of Richmond borough opiate users successfully completed treatment, compared to 9.6% in London and 8.2% in England. In 2012, 39% of Richmond borough non-opiate users successfully completed treatment, compared to 35% in London and 40% in England [3].

Detection of common mental health disorders
- A significant number of people with a common mental health disorder do not access primary care and are not diagnosed. Around 10,500 (6.7%) Richmond residents are diagnosed as having depression (QOF 2011/12). This is a lower proportion compared to London and England as a whole. The lower figure may be due to actual lower levels of common mental health problems in Richmond, but in part may be due
to lower detection rates [1].

**Employment**
- 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 from 15% three years previously [3].

**Housing**
- There are around 85 mental health service users who are not in stable and appropriate accommodation [3].

**Social isolation**
- Social isolation and a lack of social support are important risk factors for both mental and physical illness, particularly among older people. The number of 65-74 year olds living alone in Richmond is projected to increase from 3,500 in 2012 to 4,300 in 2020 (an increase of 23%). The number of those 75 years and over living alone is projected to increase from 6,000 in 2012 to 7,100 in 2020 (an 18% increase) [1].

**Local services**
Local services available for older people in the Borough include:
- Richmond Wellbeing Service
- Richmond Integrated Recovery Service

**Key documents**


### 2.6 Carers

#### Definition of client group

A carer is someone of any age who, without payment, provides help and support to a partner, child, relative, friend or neighbour, who could not manage without their help. This could be due to age, physical or mental illness, or disability [1].

#### Local priorities

The Carers Health Needs Assessment (2014) [1] and the Richmond upon Thames Carers Strategy (2013-2015) [2] outline some of the key priorities for carers in the Borough, have been extracted from these documents and displayed below:

- **Increasing the identification of carers.** The number of carers reported in the 2011 Census is much higher than the number of carers that are identified in general practice, the voluntary section and in social care. Engagement showed that many carers do not consider themselves a carer.

- **Recording and monitoring the service utilization.** This is important so that their accessibility and quality can be maintained and improved.

- **Providing advice, information and support.** A range of services is available for carers, but the access of these services by carers should be improved.

- **Improving carers health and wellbeing.** Carers are more likely to report health problems. Existing wellbeing services available for all residents will be promoted among carers, as well as better support for carers to remain in employment.

- **Carers as expert partners in care.** Carers should be valued and respected as expert partners in the care of the person they look after, and should continue to be involved in engagement activities to inform local strategy. The Richmond Carers Strategy Reference Group will be regularly involved in future joint strategic needs assessments.

- **Flexible access.** Interventions will need to be adopted to offer a flexible approach to accessing prevention services.

#### Local demographic profile

The Carers Health Needs Assessment (2014) [1] outlines some of the key characteristics of carers in the Borough, which are repeated from this document here:

- 15,802 (8.5% of all residents) identified themselves as carers. This is similar to London, and lower than the average in England.

- Three quarters of carers provides care for 1-19 hours a week, 10% 20-49 hours and 15% more than 50 hours.

- There are more female than male carers (59% of carers are female).

- The peak age for caring is 50-64 years. 34% of carers are aged between 25 and 49.
years, 38% between 50 and 64 years, and 22% are aged over 65 years. Five percent of carers are younger than 25 years (n=864).

- Carers are more likely to report health problems: 20% of carers report their health is not good, compared to 11% of those who do not provide care.
- While 60% of carers are economically active, providing care is often a reason for not working or for working part-time.

### Local services

The Carers Health Needs Assessment (2014) [1] outlines the key services for carers in the Borough, which are extracted and displayed here:

- **The Carers Hub, providing**: universal information and advice service, emotional support, financial and debt advice, short breaks, leisure programmes, a dedicated young carers service, training for carers, opportunities for carer engagement, carer awareness training for professionals and strategic leadership. Services are provided by a group of nine charities working together: Richmond Carers Centre (lead), Addiction Support and Care Agency, Alzheimer’s Society, Crossroads Care, Ethnic Minorities Advocacy Group, Grace Debt Advice, Homelink, Integrated Neurological Services, and Richmond Homes and Lifestyle Trust.

- **Richmond Borough Mind Carers in Mind**: a support service for families and friends of people with a mental illness or disorder.

- **Carers assessments**: these give carers the opportunity to discuss the physical, emotional and practical impact of caring on their life and enables social care practitioners to direct them to services which can support them.

- **Carers break payments**: one payment per financial year (while funding available from Richmond Council and Richmond Clinical Commissioning Group) which may be used to enhance the carer’s health and wellbeing.

- **Carers Emergency Card**: available to carers who have had a carer’s assessment and enables access to emergency respite if the carer is suddenly unable to provide care due to accident or other exceptional circumstances.

- **Shared Lives dementia scheme**: the scheme helps carers of people with dementia, by providing a Shared Lives Carer to look after the person they care for.

- **Telecare/Careline and emergency alarms**: 24 hour emergency monitoring systems that can help older and vulnerable people to remain living independently and safely in their own homes, giving peace of mind to carers who do not live with the person they look after.

- **Children’s services**: single point of access (SPA: the SPA acts as a single gateway for all incoming contacts into the Richmond upon Thames Children’s Services, providing telephone and web-based support to professionals, children, young people.
and parents. Children’s Services refer adults for a self-directed support assessment where young people are identified as providing a caring role to an adult with disabilities. Young carers identified by Adult Services are referred to Children’s Services for appropriate assessment and support.

- **Seasonal flu vaccination**: Carers are eligible for free seasonal flu vaccination. Also a range of universal services are available to improve the health and wellbeing of Richmond upon Thames residents, including carers. These include:
  - **Richmond LiveWell**, a health-improvement service.
  - **The Richmond Wellbeing Service**, a service for local people who experience common mental health problems, such as depression or anxiety.
  - **Free NHS Health Checks** for people aged between 40 and 74 years.

### Key documents


2.7 Vulnerable / socially excluded groups

**Definition of client group**

The definition of a Gypsy or Traveller is far from clear-cut.

This population group with a traditionally itinerant (travelling) lifestyle, (some locally are settled) also variously known as "travellers", or gypsies, who maintain a set of traditions whatever their race or origin.

**Local demographic profile**

Whilst significant progress has been made in delivering improvements in health outcomes across the population, meeting the needs of the small population of people with the most complex health needs remains a considerable challenge.

People from socially excluded groups experience poor health outcomes across a range of indicators including self-reported health, life expectancy and morbidity.

In Richmond borough, in 2013 there were 95 Gypsies and Travellers, accounting for 0.06% of the population. Nearly 60% of the local community are women, (compared to 51% in Richmond overall), one in three (33%) are under the age of 18, (compared to 22% in Richmond overall), more than half (56%) are between 18 and 59 years of age (59% in Richmond overall) and about one in ten (11%) are over the age of 59 (19% in Richmond overall)

**Housing**

- The total population is estimated to be about 0.6% of the total UK population, of which only a proportion are living in, or seeking, caravan site accommodation
- In Richmond, there is one authorised socially-rented site in Hampton North. The site is managed by Richmond Housing Partnership (RHP) and has 12 pitches for chalets/temporary homes. This site houses 51 of the 95 Gypsies and Travellers living in Richmond borough. The community living on the site is a relatively stable and settled one with many of the families having held licenses for the pitches for over 10 years.
- Of the remaining 33 Gypsy and Travellers living in Richmond borough 18% own their house, 60% live in socially rented accommodation, and 22% live in private rented accommodation

**Health**

- The All Ireland Traveller study [1] reported life expectancy of Gypsy and Traveller males as 62 years - this had remained unchanged since 1987 – and life expectancy for females as 70 years - an increase of 5 years since 1987. This is noticeably lower than life expectancy for the general population in England and Wales: 78 years for males and 82 years for females.
- Evidence suggests that where Gypsies and Travellers have access to secure permanent sites
and adequate medical care life expectancy may be closer to that of the surrounding sedentary population.

- Disadvantaged minority groups such as Gypsies and Travellers are recognised as having a greater burden of injuries than the general population.
- Despite depression and anxiety being common among the Traveller population, it has been found that there is stigma associated with being “mentally ill” - seen as something to be ashamed of and to be kept hidden.
- The All Ireland Traveller Study found levels of lifestyle health risk factors among the Gypsy and Traveller population such as drinking alcohol, smoking, and consumption of excessive salt and saturated fat were high. It also found a lack of physical activity common among the Gypsy and Traveller population.

**Education**

- A common feature of the Gypsy and Traveller community are the low levels of literacy and education. Evidence suggests that educational underperformance may be due to a combination of factors including a nomadic lifestyle, financial deprivation, low levels of parental literacy and aspiration for their children’s academic achievement, poor attendance, and bullying.

**Employment**

- Evidence from Gypsy Traveller Accommodation Assessments indicates that both age and locality of residence have an impact on employment rates: Gypsies and Travellers in Surrey for example, are more likely to be working in a range of non-traditional work and with a relatively high rate of employment.
- In Richmond borough [2], 37% of Gypsies and Travellers have never worked, this compares to 37% in London and 31% nationally1. The majority of Gypsies and Travellers, who do work, undertake routine, semi routine or low supervisory occupations.

**Local services**

Gypsies and Travellers in the borough are able to access primary care by either registering as a permanent patient with a local practice or a temporary patient if they are visiting the area. The majority of primary care provision is provided by Hampton Medical centre. Health Visitors undertake home visits to new mothers on the site; in addition, they deliver educational sessions.

There are two Richmond Housing Partnership (RHP) family outreach workers who provide support with benefits, appointments, correspondence, and help Gypsies and Travellers link to other services including healthcare.
There are also a series of specialist services offered, by the family outreach worker, urban academy, a community police officer and a specialist teacher visits the site.

The Richmond Wellbeing Service is part of the national Improving Access to Psychological Therapies (IAPT) scheme. This scheme aims to provide therapies to people with common mental health problems. The Richmond Wellbeing Service work from GP surgeries and community venues.

**Local priorities**

Although Gypsies and Travellers in the Richmond borough make up a small proportion of the population, the community experiences significant health inequality and do not access generic council services.

- Community providers such as NHS stop smoking, LiveWell Richmond, Richmond Wellbeing and NHS Health Checks should ensure that their services are known about and accessible to Gypsies and Travellers on the Hampton North site.
- Trying different approaches to promoting screening and prevention services possibly through a community champion approach.
- Use the local GP practice to promote NHS smoking cessation services and alcohol support services.
- Encouraging healthcare professionals to use any Gypsy or Traveller engagement with a service as an opportunity to promote /complete appropriate screening services and health checks for that individual.
- Supporting ways to improve continuity of care to enable professionals to develop long-standing relationships with Gypsies and Travellers.
- Targeted approaches will be implemented to support men to adopt a healthy lifestyle and self-care.

**Key documents**

[1] All Ireland Traveller Health Study Team (2010): All Ireland Traveller Health Study

### 2.8 Transitions

**Definition of client group**

Transitions are those young people approaching the age of 18 years old who will enter Adult Services from Children’s Services and who are resident in the Borough.
The documents Carers Health Needs Assessment (2014) [1] and the Richmond Joint Health and Social Care Strategy for People with Autism (2013-16) [2] outline some of the local demographic profile of young people in transition from Children’s to Adult Services in Richmond and relevant data from these are extracted and illustrated below:

**Parent carers**

- The Health and Social Care Information Centre (2010) data suggest that Richmond’s population is estimated that there are a total of 2,100 parent carers in the borough, making up around 13% of the carer population. Also, it is estimated that around 1,300 are caring for children with disabilities and a further 800 are caring for adult children [1].

**Autistic-spectrum conditions (ASC)**

- There are also 41 young people aged between 13 and 18 years of age with ASC who will require transition planning and will transfer to adult services over the next 5 years [2].
- There are currently around 130 adults with ASC as a presenting need known to the local authority (January 2013). The majority of individuals receive a service from the Richmond specialist adult social care team [2].

**Local services**

Local services available for young people in transition in the Borough include:

- Transition and Family Support Service

**Local priorities**

- Appropriate transition planning for individuals with ASC to be in place, including appropriate information sharing.
- Adults with ASC receive the appropriate support to access employment.
- Community access, social and leisure opportunities exist for individuals with ASC.
- Information about transition and services is easily accessible and available.
- Targeted interventions will be required for this population group.

**Key documents**


2.9 Adults with autism

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<th>Definition of client group</th>
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The Richmond Joint Autism Strategy uses the term Autism Spectrum Conditions. This includes autism, Asperger’s syndrome and atypical autism.

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<th>Local demographic profile</th>
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The most recent estimates on the prevalence of Autism Spectrum Conditions (ASCs) in adults in England indicate that around 1.1% of people have ASC. The rate is higher in men (2.0%) compared to women (0.3%). These national prevalence figures have been extrapolated to the Richmond population to estimate the number of people with ASC in the borough. Estimated numbers of people in Richmond over 18 with ASC: Male 1,413, Female 2,228. There are currently around 130 adults with ASC as a presenting need known to the local authority (January 2013). The majority of individuals receive a service from the Richmond specialist adult social care team.

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<tr>
<th>Local services</th>
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Richmond has begun to develop good transition arrangements for young people with disabilities. A new transition framework has been established to ensure improved shared working arrangements, oversight and scrutiny, and to deliver a robust professional service to young people moving to adulthood.

For adults who present with social care needs who have a learning disability and ASC and/or with a mental health problem and ASC, initial referrals can currently be made to the Council’s Adult and Community Services Access Team or to the learning disability or mental health teams directly. The health needs of adults with a learning disability who also have ASC/ suspect ASC can be referred to the Specialist Health Care Team and/or the Psychology and Challenging Behaviour Team for a health assessment and treatment. This is currently provided through a contract with Your Healthcare. The overall aim of the service is the provision of specialist health care support to meet the specific needs of adults with learning disabilities.

The local National Autistic Society (NAS) works with, but is separate to The Bridge, a parent led charity serving Richmond and South West London. The Bridge works with people and families with social communication difficulties including ASC, attention deficit hyperactivity disorder and dyspraxia. The Bridge currently provides drama, sports and teenage youth clubs; advice, signposting and information services, including awareness raising and training in schools etc.

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<th>Local priorities</th>
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National guidance combined with the knowledge gathered about existing pathways and services, as
well as the issues and concerns experienced by people with ASC and their carers / family members / friends, has led to a number of actions required over the next three years.

- Raising Awareness and Staff Training
- Care pathways for ASC (including identification, diagnosis and assessment)
- Adults
- Children and young people
- Accessing Services
- Leadership and Governance
- Targeted interventions will be required for this population group.

<table>
<thead>
<tr>
<th>Key documents</th>
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Appendix 3 - Further Reading


Appendix 4 – Developing the Prevention Strategy: Mapping Report

Developing the Prevention Strategy
Interim Mapping Report

March 2015
1. BACKGROUND

The London Borough of Richmond upon Thames Local Authority and Clinical Commissioning Group (CCG) are committed to working in partnership to deliver an integrated three year Prevention Strategy to improve the health and well-being of the local population and to support people to remain independent. The purpose of the strategy is to develop a local approach to prevention in order to meet the recommendation outlined by the Care Act (2014) that ‘a local authority 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.’

The Care Act (2014) further expands upon the use of the terms ‘prevent, delay or reduce’ and provides the following definitions as a matter of guidance:

- **Prevent** – primary prevention; promoting wellbeing; services, facilities or resources which are universally accessible and aimed at individuals with no current health or care support needs.
- **Reduce** – secondary prevention; early intervention; services, facilities or resources for individuals who are at risk of developing further health or care support needs.
- **Delay** – tertiary prevention; services, facilities or resources for individuals with existing health and care support needs; the emphasis is placed on minimising further deterioration.

This guidance has helped to shape the vision of the Prevention Strategy as such:

**People in Richmond are empowered to take responsibility for their own health and wellbeing in a safe and supportive environment, achieve their full potential and live their lives with confidence and resilience.**

In order, to achieve this vision, four key priority areas have been identified, which are as follows:

- **Priority 1** Making health and wellbeing everyone’s business
- **Priority 2** Creating healthy communities – harnessing local community assets to support people and their carers
- **Priority 3** Reshaping healthy lifestyles services and embedding self-care
- **Priority 4** Reducing and delaying need for care through integrating recovery focused models across health and social care pathways

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1.1 Scope of the strategy
The strategy is for all adults in the Borough, including those young people in transition i.e. moving from Children’s to Adult’s Services. The recognition of nine key client groups across the local population will allow the strategy to be shaped in an equitable fashion. These client groups are as follows:

- All adults
- Older people
- Adults with physical, sensory and other disabilities
- Adults with learning disabilities
- Adults with Mental Health problems
- Carers
- Vulnerable/socially excluded groups
- Transitions (young people in transition from Children’s to Adult’s services)
- Adults with autism

Additionally, a partner strategy, the Making Information and Advice Count Strategy, has been developed alongside the Prevention Strategy, which will provide greater detail about current information and advice available for local residents.

1.2 Purpose of the mapping exercise
A good understanding of the current preventive offer is required to develop the four priority areas that have been identified above, particularly with regard to the reshaping of current services. Therefore, a mapping exercise has been undertaken to collate information about the provision of preventive services, facilities and resources across the Borough, with a particular emphasis on the distribution across the nine key client groups outlined above.

1.3 Purpose of the report
The purpose of this report is threefold:
1. To outline the approach taken for the mapping exercise
2. To summarise the preventive services, facilities and resources identified as part of the mapping exercise
3. To provide recommendations based on gaps and opportunities in the current preventive offer identified as a result of the mapping exercise

2. METHODOLOGY
2.1. Preparation and initial data collection – from October to November 2014
Firstly, a mapping template (see Appendix 1 for a link to the mapping template) was designed and developed by the prevention strategy programme team for the collection of data about preventive services, facilities and resources. Secondly, the team identified teams within the local authority to include in the mapping exercise, these are outlined below:

- **Achieving for Children**
- **Adult and Community Services** – Commissioning Care Services; Community Service Operation: Housing and Transport; Joint Commissioning Collaborative; Public Health
- **Arts and Culture**
- **Environment** – Development and Street Scene; Property, Parks and Sustainability including Leisure; Traffic and Transport
- **Libraries**

Thirdly, mapping templates were sent out to leads in the above teams for further circulation within their teams to individuals with specialist knowledge about identified preventive services, facilities or resources. Templates were then completed and returned to the prevention strategy programme team with incoming templates tracked and the data transferred to a separate spreadsheet (see Appendix 2 for a link to the folder of completed mapping templates).

**2.2. Review of initial data collection – from December 2014 to January 2015**

A mapping workshop was held (see Appendix 3 for a link to the outcomes from the mapping workshop) in order for the prevention strategy programme team and team leads to discuss the mapping exercise so far and to identify areas for further elaboration. The deadline for completion of the mapping exercise was extended to January 2015.

**2.3. Engagement – from January 2015 to February 2015**

A key outcome of the mapping workshop was the identification that prevention, in its broadest sense, is embedded into the work of some teams through their strategies and implementation plans even though there may not provide explicit preventive services, facilities and resources. Further collaboration between the Prevention Strategy Programme Team and council teams allowed for the identification of preventive opportunities, which is reflected upon in the Results section of this report.

**3. RESULTS**

The results section is divided into three sections, firstly, the outcomes from the mapping workshop are summarised; secondly, consideration is given to the preventive services, facilities and resources that have been mapped as part of this mapping exercise and finally, consideration is given to preventive opportunities across the Council that have not been mapped as part of this exercise.
3.1 Mapping workshop outcomes
A mapping workshop was held in December 2014 where the Prevention Strategy Programme Team met with representatives from Achieving for Children, Arts and Culture, Environment, Joint Commissioning Collaborative (JCC), Housing, Leisure and Libraries to discuss the current preventive offer for each team and identify any gaps or opportunities for further preventive work. Table 1 summarises the outcomes from the mapping workshop for each directorate and a link to the full outcomes from the mapping workshop can be found in Appendix 3.

Table 1: A table summarising outcomes for each Council directorate consulted with at the mapping workshop.

<table>
<thead>
<tr>
<th>Team</th>
<th>Outcomes from mapping workshop</th>
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<tbody>
<tr>
<td>Achieving for Children</td>
<td>Transition and Family Support Service</td>
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<td></td>
<td>Robust sexual health services for those not eligible for a family support worker</td>
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<td></td>
<td>Services for those young people with high-functioning autism</td>
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<td></td>
<td>Provision of housing services at the right time</td>
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<td></td>
<td>Support for carers</td>
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<td></td>
<td>Difficulty in monitoring need for services for those who are not eligible for a family support worker</td>
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<td></td>
<td>Linking between Children’s and Adult’s Services to identify services that have been utilised by a young person prior to transition into Adult’s Services</td>
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<tr>
<td>Arts and Culture</td>
<td>Exhibitions/buildings/collections: Orlean’s House Gallery and the Riverside Gallery</td>
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<td></td>
<td>Events: Richmond Literature Festival; Holi and Carnival</td>
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<td></td>
<td>Education: Art &amp; Soul; Imagine; Talk &amp; Draw</td>
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<tr>
<td></td>
<td>Gaps in geographical distribution of Arts projects across the Borough</td>
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<tr>
<td></td>
<td>Linking with Community Independent Living Services (CILS) to share information about arts services.</td>
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<tr>
<td>Team</td>
<td>Outcomes from mapping workshop</td>
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<tr>
<td>Joint Commissioning Collaborative (JCC)</td>
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| Libraries | Events held in libraries help to add to the aim of libraries forming a community hub  
Books on prescription  
Home Delivery Service  
Talking books  
Range of available activities for people to access in libraries e.g. reading groups and ICT training courses  
Provision of information and advice for local people | Team and the Sports and Fitness Strategy Programme Team  
Building relationships with voluntary sector partners | Opportunity to hold events in libraries that could help to promote health and wellbeing and reduce loneliness and isolation |
| Team | **Outcomes from mapping workshop** |  |
|  | **Current preventive offer** | **Gaps in current preventive offer** | **Opportunities identified** |
3.2 Identified preventive services, facilities and resources mapped across the Council

As a result of the mapping exercise, mapping templates were completed for the following preventative services, facilities and resources across the Council as summarised in Table 2 below; a link to completed mapping templates can be found in Appendix 2.

**Table 2: A table to summarise preventive services, facilities and resources by directorate mapped across the Council.**

<table>
<thead>
<tr>
<th>Team</th>
<th>Preventive services, facilities and resources identified and mapped</th>
<th>Commissioning Group (CCG) and JCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieving for Children</td>
<td>Transition and Family Support Service</td>
<td>Centre</td>
</tr>
<tr>
<td>Arts Services</td>
<td>Art and Soul</td>
<td>Community Independent Living Services Equipment</td>
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<td></td>
<td>Chat and Draw</td>
<td>High-functioning Autism/Asperger Drop-in and Social Skills Development Groups</td>
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<td></td>
<td>Imagine Workshops</td>
<td>Meals</td>
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<td></td>
<td>Talk and Draw</td>
<td>Richmond Aid Welfare Benefits Service</td>
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Summary tables of mapped preventive services, facilities and resources
These mapped preventative services, facilities and resources have been summarised in two tables below:

- **Table 3** demonstrates the spread of mapped preventive services, facilities and resources across the nine key client groups, identified as being priority groups for the Prevention Strategy, which are:
  - All adults
  - Older people
  - Adults with physical, sensory and other disabilities
  - Adults with learning disabilities
  - Adults with Mental Health problems
  - Carers
  - Vulnerable/socially excluded groups
  - Transitions (young people in transition from Children’s to Adult’s services)
  - Adults with autism

- **Table 4** demonstrates the spread of mapped preventive services, facilities and resources across the three different levels of prevention, as recognised by the Care Act (2014), which are:
  - Prevent – primary prevention; promoting wellbeing; services, facilities or resources which are universally accessible and aimed at individuals with no current health or care support needs.
  - Reduce – secondary prevention; early intervention; services, facilities or resources for individuals who are at risk of developing further health or care support needs.
  - Delay – tertiary prevention; services, facilities or resources for individuals with existing health and care support needs; the emphasis is placed on minimising further deterioration.
### Table 3: A table summarising mapped preventive services, facilities and resources available for key client groups across Council directorates

<table>
<thead>
<tr>
<th>Team</th>
<th>Key client groups</th>
<th>Preventive services, facilities and resources</th>
<th>All adults</th>
<th>Older people</th>
<th>Adults with physical, sensory and other disabilities</th>
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<th>Adults with Mental Health problems</th>
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Key client groups
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<th>Team</th>
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<th>Primary/Prevent</th>
<th>Secondary/Reduce</th>
<th>Tertiary/Delay</th>
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<td>Primary/Prevent</td>
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</table>

Primary, secondary and tertiary prevention
3.3 Identified preventative opportunities across the Council that have not been mapped

Consideration is now given to preventative opportunities across the Council that have not been mapped as part of this exercise, which are categorised into the following three areas:

a) Work streams that contribute to the preventative offer of the Council but are not strictly services, facilities or resources
b) Preventative services, facilities and resources addressed by other work streams
c) Identified preventative services, facilities and resources for which a mapping template was not completed

a) Work streams that contribute to the preventative offer of the Council but are not strictly services, facilities or resources

As the mapping exercise unfolded, it became apparent that using a mapping template was not an appropriate method for capturing information about all work streams taking place across the Council that contribute to the preventative offer. This particularly rang true for the Environment directorate and subsequently the Prevention Strategy Programme Team presented at departmental meetings i.e. Development & Street Scene; Property, Parks & Sustainability and Traffic & Transport to identify synergies with the prevention strategy agenda. As a result, the key areas highlighted in Figure 1 were identified as contributing to the current preventative offer across the Council.

Figure 1: A summary of some of the key areas in the Environment directorate identified as contributing to the current preventative offer.
b) Preventative services, facilities and resources addressed by other work streams
Additionally, it was noted during the mapping exercise that several preventative services, facilities and resources were being addressed by other existing work streams, for example, recent plans for the Better Care Fund\(^5\) outlined by the JCC and the CCG highlight several preventative initiatives, which include those listed below. As part of the mapping exercise, mapping templates were completed for the first four listed initiatives; however for the remainder of these initiatives, mapping templates were not completed.

- Assistive Technology Services
- Carers Support Services
- Community Independent Living Service (CILS)
- Richmond Response and Rehabilitation Team (RRRT)
- Early Supported Discharge for Stroke Survivors
- GP led model of integrated care
- Prevention of Falls Service
- Psychiatric Liaison Service
- Respiratory Care Service

c) Identified preventative services, facilities and resources for which a mapping template was not completed
The following preventative services, facilities and resources were identified as part of the mapping exercise, however, mapping templates have not yet been received for these, these areas are listed below, categorised by directorate:

- **Commissioning Care Services:** Advice Services – Citizens Advice Bureau; Employment
- **Housing:** Paragon; Places for People Homes Ltd; Thames Valley Housing Association
- **Public Health:** Livewell; Kick-it smoking cessation services; Sexual health services

\(^5\) [http://www.richmond.gov.uk/better_care_funding_plan_1.pdf](http://www.richmond.gov.uk/better_care_funding_plan_1.pdf)
4. ANALYSIS

In order to inform the development of the Prevention Strategy, analysis of information gained as a result of the mapping exercise, including: mapping workshop outcomes; engagement with directorates; and feedback on individual service areas from completed mapping templates, has been drawn together to provide a summary of opportunities and gaps for each priority area of the strategy. Key themes that are applicable to the overarching development of the strategy have been drawn out; additional key findings and limitations are also subsequently summarised in the sections below.

4.1 Key themes

Several recurring issues arose consistently throughout the mapping exercise, which are summarised in Figure 2 below. These issues address broader concepts than are necessarily within the reach of the Prevention Strategy; however, they have been included as they have arisen as a result of the mapping exercise and aid in contextualising the wider profile within which the Prevention Strategy sits.

Firstly, communication was identified as a key issue and was noted to be particularly problematic between teams providing similar services in different geographical areas, for example, for Community Mental Health Teams covering different areas, particularly if patients move between these areas. Secondly, the geographical distribution of preventative services, facilities and resources was noted to be inequitable across the Borough, for example, the availability of some Arts and Leisure services are limited to certain areas of the Borough, which may prove more difficult to reach for some local residents and thus discourage access. Thirdly, limited resources, including funding and workforce teamed with a high demand for services were noted to be contributing factors to the final issue raised – that of a lack of continuity between services.

Figure 2: Issues that arose throughout the mapping exercise

| Communication | Distribution of services, facilities and resources | Resources | Continuity between services |
Additionally, a key opportunity arose through to help tackle some of these issues; it was noted that raising awareness of available preventative services, facilities and resources could be beneficial within the Council across different directorates and also externally for local residents; in order to achieve this, it was recognised that cross-directorate strategic alignment would be required, particularly for the identification of preventative opportunities.

4.2 Priority 1 Making health and wellbeing everyone’s business
Making health and wellbeing everyone’s business is the first key priority for the Prevention Strategy, this encompasses embedding prevention across directorates within the Council; skilling up the local workforce to promote health and wellbeing to residents and creating healthy workplaces.

Through the mapping exercise, it was recognised that partnership working across different directorates at a strategic level could be an important factor in embedding prevention across the Council, specific opportunities noted included joint working on the upcoming Sports and Fitness and Cultural strategies, alongside continued joint working on the Cycling Strategy.

Additionally, some gaps were noted in the provision of preventative services, facilities and resources across the Borough, which included geographical distribution across the Borough, as previously mentioned. In addition, specific gaps in particular service areas were noted, for example, through the mapping workshop it was noted that the availability of housing service provision for older people living with a learning disability and for people living with dementia is particularly limited in the Borough.

4.3 Priority 2 Creating healthy communities – harnessing local community assets to support people and their carers
The second key priority area focuses on creating healthy communities, through harnessing existing assets within the Borough with a particular focus on, volunteering, preventing loneliness and isolation and developing existing village plans.

Through the mapping exercise, it was highlighted that development of the existing Community Independent Living Services could result in local residents having a greater understanding of the activities available to them and the channels through which to access these activities. Additionally, using existing community hubs, such as libraries, was recognised as a potential avenue through which health and wellbeing opportunities could be promoted to local residents.

4.4 Priority 3 Re-shaping healthy lifestyles services and embedding self-care
The third area highlighted as a priority for the Prevention Strategy is the re-shaping of healthy lifestyles services and embedding of self-care through the re-commissioning of a new targeted healthy lifestyles service and the development of a self-care and self-management strategy, alongside the actions outlined by the Making Information and Advice Count Strategy.
Through the mapping exercise, several opportunities were identified, which could potentially contribute to the development of the self-care and self-management strategy. Firstly, the Richmond Response and Rehabilitation Team, which provides services for hospital discharge, rapid response and community rehabilitation, are in the process of developing a self-management project for people identified as being at risk of deterioration. Secondly, as a result of the Better Care Fund, several preventative initiatives have been highlighted, including the commissioning of a new Cardiac Home Monitoring Service, which may include a self-management aspect. Finally, the Books on Prescription service offered by Libraries, which is a self-help reading scheme used to promote wellbeing could be further promoted as part of the self-care and self-management strategy.

4.5 Priority 4 Reducing and delaying demand for care – recovery focused model integrated across health and social care pathways

The fourth priority area for the Prevention Strategy is reducing and delaying the demand for care through the use of a recovery focused model integrated across health and social care pathways, which emphasises the importance of a number of initiatives already outlined in partnership by the Council and the CCG, through the Better Care Closer to Home Strategy and plans for the Better Care Fund.

Through the mapping exercise, several opportunities were noted for this priority area; firstly, it was highlighted that the Richmond Response and Rehabilitation Team may be reviewed with regard to the role of the team in placing people from hospital, including those discharged from hospital with mental health needs. It was also noted that the uptake of the meals service is relatively low across the Borough, which could potentially provide an opportunity for consideration of innovative solutions for the delivery of a robust meals service.

4.6 Additional findings

Additional findings that arose as a result of the mapping exercise are summarised here as they do not directly fit under any of the key priority areas of the Prevention Strategy as outlined above, but are of relevance to the nine key client groups outlined previously.

Firstly, it was highlighted through the mapping workshop that there are a lack of robust sexual health services for those young people in transition from Children’s to Adult’s Services, who are not eligible for a Family Support Worker. Additionally, it was highlighted that there could be further support for carers of young people going through transition from Children’s to Adult’s Services.

Secondly, it was noted that there is a lack of funding for the High-functioning Autism and Asperger Drop-in and Social Skills Development Groups and that these services may not be commissioned in the future, thus reducing the current preventative offer for those adults with autism.
Finally, it was suggested through the mapping exercise that consideration be given to the development of the current Refuge service through the introduction of Children's Workers to enable the delivery of an enhanced service to those affected by domestic violence.

4.7 Limitations of the mapping exercise

Limitations of the mapping exercise became apparent throughout the process; firstly, as previously alluded to it was noted that using a mapping template was not necessarily the best method for capturing the entirety of the current preventative offer across the Council and thus the method of mapping was adjusted to facilitate those areas that did not align to the mapping template.

Secondly, the mapping template did not always lend itself well to identifying specificities, for example, across the nine key client groups, it was quite easy to categorise certain services as being applicable to all key client groups, when actually the service in question may have had something more specific to offer for a certain key client group, notwithstanding that it is readily available to everyone else as well.

Finally, not all mapping templates were completed for identified preventative services, facilities and resources and in addition to this, it is unlikely that the entirety of truly preventative services, facilities and resources available across the Council were picked up as a part of this mapping exercise.
5. CONCLUSIONS & RECOMMENDATIONS

The mapping exercise provided an opportunity for collaborative working across Council directorates and as a result, a great deal was learnt about the current preventative offer, which has acted to inform the development of the priority areas for the Prevention Strategy as outlined previously. It is important to note that this mapping exercise is by no means exhaustive; however it is useful in providing a springboard for further work to better understand the full preventative offer in the Borough.

As such, the following recommendations can be made as a result of this report:

First recommendation – mapping of preventative services, facilities and resources to continue across the Council

As outlined above, in order to achieve the aim of having a better understanding of the current preventative offer across the Council, further mapping of preventative services, facilities and resources is required. Alignment with the Making Information and Advice Count Strategy will be needed to ensure that this information remains accurate; additionally consideration should be given to how this information is made available to local residents.

Second recommendation – mapping of preventative services, facilities and resources across the voluntary sector

In order to fully appreciate the entirety of the preventative offer in the Borough, it is essential to recognise the contribution of preventative services, facilities and resources available through the voluntary sector and some work has already begun to map these preventative opportunities, which will continue to be developed further, alongside the implementation of the Making Information and Advice Count and Prevention Strategies.

Third recommendation – better understanding of discounts available across the Council

As a result of the mapping exercise, it became apparent that there is a need for alignment across the Council with regard to the availability of discounts for certain groups and further work in this area is needed, firstly, to better understand which discounts are available across the Borough and secondly, to make this information easily accessible through a single portal for residents.
7. APPENDICES

Appendix 1 – Mapping template
S:\Social Services\Adults S&R\Care Act 2014\Project 2 - Prevention & Info & advice\Mapping\Templates\Up to date versions of templates\Mapping Template 1.1.docx

Appendix 2 – Folder of completed mapping templates
S:\Social Services\Adults S&R\Care Act 2014\Project 2 - Prevention & Info & advice\Mapping\Completed mapping templates

Appendix 3 – Outcomes from mapping workshop
S:\Social Services\Adults S&R\Care Act 2014\Project 2 - Prevention & Info & advice\Mapping\Mapping workshop\Outcomes\Outcomes Mapping Workshop v0.6.docx