**London Borough of Richmond upon Thames**

**Promoting wellbeing and independence – an Integrated Prevention Strategy**

**2015-2018**





**Foreword**

We are pleased to present Richmond’s first Prevention Strategy (2015-18), a joint strategy 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.

This strategy 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 strategy 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. This strategy sets out a shared approach across organisations in the public, voluntary, community and private sector to deliver services to a changing and ageing population. A major focus will be 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. We want to continue to develop person-centred, high quality services in partnership with the people who use them. 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 was invaluable. We will continue to work with service users and patients as we develop the prevention plans set out in this strategy to ensure they meet the needs of those using these services.

The success of this strategy 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 Dr Graham Lewis

Strategic Cabinet Member for Adult Services & Health Chair

London Borough of Richmond upon Thames 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 Strategy 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 preventive 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.

This acts as a timely reminder 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.

We need to enhance the effect that we can have on shaping the environment, which can be achieved through recognising the importance that legislation, housing, employment, transport infrastructure, recreational areas, community safety, access to high-quality information and interventions have on ensuring that people are empowered to make healthy choices where possible.

**Our vision**

This has shaped our vision 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.*

**Key Aims**

Our aims are to:

* Focus action to mainstream 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.
* Recognise the need for appropriate recovery services for people and carers with adequate information to inform decision making at the right time and place to reduce and delay the need for care.

**Scope of the strategy**

The strategy 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. We do 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.

This strategy is not intended to stand alone - but provide a framework to ensure that actions to prevent, reduce and delay the need for care 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* S*trategy* (add link) as a partner to our overall Prevention Strategy, which addresses our information and advice offer above in more detail.

**Priorities**

**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 need for care through integrating recovery focused models across health and social care pathways

**Priority 5** Harnessing new technologies to support people to remain independent longer

**Implementation and Governance**

The governance of the “Promoting wellbeing & independence: an integrated Prevention Strategy” will be agreed through the Health & Wellbeing Board for Richmond upon Thames. A comprehensive plan with indicators of success will be developed in response to this strategy, and the Health & Wellbeing Board will provide whole systems leadership to support its delivery and implementation.

1. **Introduction – setting the scene**

**1.1 Context**

The *Care Act 2014* brings a significant reform over care and support in more than 60 years, putting people and their cares 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 parts of the public sector face significant budget pressures and 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 wherever they live and create a focus on the promotion of health rather than the treatment of illness

**1.2 Purpose**

The strategy 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 council priorities, to provide a shift in service provision, with an increasing focus upon preventive 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. Whilst the aims of this strategy include everyone, the focus is primarily on adults and those children in transition

**1.3 Methodology**

This three year strategy has been developed jointly by the Richmond Clinical Commissioning Group (RCCG) and the London Borough of Richmond upon Thames (LBRuT). A partnership has been developed together with partners and agencies in statutory, private, voluntary and community sectors 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 set out in the strategy.

1. **Outcomes – what do we want to achieve?**

**2.1 Our vision**

This has shaped our vision 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.*

**2.2 Key aims**

Our aims are to:

* Focus action to mainstream 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.
* Recognise the need for appropriate recovery services for people and carers with adequate information to inform decision making at the right time and place to reduce and delay the need for care.

**2.3 Principles**

To achieve our aims, 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

**2.4 Outcomes****Prevent** * Numbers of people who are overweight and obese
* Numbers of people who are physically inactivity and use of our local assets, e.g., parks and green spaces
* Numbers of people smoking
* Numbers of people drinking at harmful levels
* Numbers of people with long term conditions, e.g., diabetes, heart disease, dementia

**Reduce*** Reduce numbers of hospital admissions
* Reduce re admission into hospital
* Reduce delayed transfer of care
* Reduce numbers of falls

**Delay*** Delay the need for residential or nursing care placement
* Numbers of people accessing social care support
* Increase the number of people at home 91 days after discharge
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# Scope of the strategy

# The strategy 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. We do 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.

This strategy is not intended to stand alone – but provide a framework to ensure that actions to prevent, reduce and delay the need for care 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* (add link) as a partner to our overall Prevention Strategy, which addresses our information and advice offer above 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)*.

# The recognition of nine key client groups across our 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 e.g., Homeless, drug users
* Transitions (young people moving into adulthood)
* Adults with autism

**3. Local context – where are we now?**

**3.1 Local Needs**

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.

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.

The incidence 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 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%).

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. Those with limiting long-term illness will be particularly vulnerable.

In addition, the number of carers aged 65 years and over in Richmond and receiving services is estimated to increase from 400 to around 500, an increase of 25%. This group is particularly vulnerable to mental health problems.

**3.2 Sustainability of local services**

The borough and local NHS services are facing increasing demands for services at a time when financial resources are reducing. The borough, along with its partners, is required to make significant savings over the next 4 years. The borough needs to save £30 million over the next four years. £8m has already been identified and plans to merge officer functions with the London Borough of Wandsworth are estimated to save a further £10m.

1. **Priorities – where do we want to go?**

|  |  |  |  |
| --- | --- | --- | --- |
| **PRIORITY AREA** | **PREVENT** | **REDUCE** | **DELAY** |
| **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 need for care through integrating recovery focused models across health and social care pathways  |  |  |  |
| **Priority 5** Harnessing new technologies to support people to remain independent longer |  |  |  |

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

**4.1.1 Whole Richmond approach**

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 impact 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. 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.

Richmond Health and Wellbeing Board (HWB) will galvanise 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 residences views and experiences of health and well-being. The first of these will focus on healthy lifestyle. This work is intended to inform the next Health and Wellbeing Board Strategy in 2016.

Through the development of this strategy we have worked with all council directorates and the CCG to improve their understanding of prevention in its widest sense, recognise the potential and opportunities each directorate has to promote health and well-being, map services and identify priorities. Richmond Council and CCG currently invest significant sums of money on services which focus on preventing problems arising in people’s and community’s lives, 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 Council 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 should be utilised. The new Outcomes Based Commissioning approaches being adopted by the Council and CCG provide new opportunities for the health and social care system to put prevention at the heart of delivery.

**What we will do:**

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 galvanise partners to promote health and well-being starting by undertaking a series of “Listening Events” to understand local resident’s views & experiences.

**4.1.2 Skilling up the workforce**

Every contact with a customer 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 the NHS and local government. As well as encouraging healthier lifestyle choices, this approach can include leisure and recreation, welfare benefits advice, housing, social care, routes to employment, education and training, home safety and so on.

There is good evidence behind this initiative. MECC, including behaviour change interventions, can lead to improvements in people’s health and well-being, reduce avoidable premature mortality linked to poor lifestyle choices, reduce health wellbeing and help people better manage long term conditions. A number of councils and NHS partners have started to implement this initiative.

**What we will do:**

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

4. Support the rollout of the “No Health without Mental Health” training initiative.

**4.1.3 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 with the aim of achieving Healthy Workplace Achievement (intermediate) status 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 requirements; Mental health and wellbeing; Tobacco; Healthy eating; Physical activity; and Problematic use of alcohol and substances.

There is good evidence that the London Healthy Workplace Charter can:

• Support employees to improve their health and wellbeing

• Improve productivity

• Reduce staff absence rates

• Generate savings on employment costs

• Promote health and wellbeing in Richmond borough and increase economic productivity

• 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 London Healthy Workplace Charter process; and the Council has plans in place to roll this process out to businesses across the local economy.

**What we will do:**

5. Richmond Council plan to achieve London Healthy Workplace Charter Healthy Workplace Achievement (intermediate) status in March 2015 and continue to develop this programme of work.

6. Identify and support employers that could maximise the benefits of working towards the Workplace Wellbeing Charter

**4.1.4 Housing**

Housing plays a key role in supporting good health, conversely poor house conditions can impact on both physical and mental health and wellbeing. Our Housing strategy 2014-17 aims to improve the health outcomes for residents, be they in private or housing association property, and key objectives are:

* Assisting older and disabled people maintain their ability to live independently in their own home by facilitating Disabled Facility Grants.
* Promoting the use of assistive technology, for example through telecare –to support users and their carers live independently for longer.
* 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
* Offer a range of housing choices to older borough residents including sheltered housing which is no longer fit for purpose
* Develop Extra Care housing to meet Borough aims to reduce care home admissions and promote independent living where appropriate; to reduce acute hospital admissions;
* Supporting SPEAR, our local single homeless provider, who have developed a ‘trauma informed’ care pathway approach for their Customers, which recognises the life events leading to street homelessness. They have also attracted funding to better improve rough sleepers access to primary health care services.

**What we will do:**

7. Tackle the impact of cold and fuel poverty through Cold Buster Grants, Winter Warmth home

 visitor service & energy efficiency work

1. Increase the independence of older people with long term conditions through Disabled Facility Grants with our Home Improvement Agency
2. Tackle overcrowding through an “Extensions Programme” with our housing partners and support those residents who are seeking to voluntarily downsize from a home which they are under-occupying.
3. Promote 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
4. Improve the health of rough sleepers in the borough in partnership with SPEAR (Single Persons Emergency Accommodation in Richmond)
5. Work towards ensuring households are not in temporary accommodation for more than 6 weeks
6. Providing a range of supported in borough housing options for people with learning disabilities, Autistic Spectrum Condition and mental health problems
7. Work with registered housing providers to ensure they consider potential for specialist dementia provision
8. Seek opportunities to develop Extra Care schemes in the borough

**4.1.5 Leisure, Culture and Sports**

Culture and sport can alleviate both physical and mental health problems and make major contributions to ill-health prevention. Getting and keeping people fit and healthy through sports has huge ‘upstream' benefits, particularly for an increasingly older community. The benefits of regular physical activity throughout life are clear, it reduces the risk of more than 20 chronic conditions, including coronary heart disease, stroke, type 2 diabetes, cancer, obesity and mental health problems. It also promotes healthy development of children and young people, and improves productivity in the workplace.

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 Council’s *Cultural Strategy (2009-13)* is currently being reviewed and we will continue to work towards priorities around widening participation and creating more opportunities for all people to participate in cultural and sporting activities. This will include targeting provision and support at 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.

**What we will do:**

1. Review and publish a new Cultural Strategy in 2015, building on previous strategies and renewing our vision for a borough where cultural and sports activity encourages participation, brings enjoyment, sparks creativity, contributes to health and wellbeing, transforms public spaces, attracts visitors, stimulates the local economy and brings communities together.

**4.1.6 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 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.

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.

**What we will do:**

1. Parks and open spaces will become dementia friendly and we are working with local dementia groups to better our understanding on how we can make our parks and open spaces better designed and more accessible for dementia sufferers, including at the design and build stage. 18.
2. 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.

19. We will continue to implement measures to make our parks as safe and welcoming as possible,

 for instance by installing benches every 100 meters across our parks.

**4.1.7 Employment**

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

Locally we have the lowest percentage of 16-64 year olds claiming Job Seekers Allowance (JSA) in Greater London, and have 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 providers such as Richmond Housing Partnership (RHP) and Richmond Churches Housing Trust, 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.

**What we will do:**

1. Support Registered Providers and the voluntary sector develop their strategies aimed at getting residents into work or job related training over the next 5 years.
2. The Council works in partnership with JobCentre Plus (JCP) to ensure that relevant training (pertinent to new businesses locating in the borough) is available for unemployed residents. They also work jointly with the Council on assisting residents affected by welfare reform back into work or training.

**4.1.8 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. Reducing traffic is key, to reduce pollution and increase pedestrian and cyclist safety, 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 our initiatives to encourage active travel, as cycling and walking can deliver benefits to personal wellbeing, public health, the economy and the environment. 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, those who suffer from physical disability, sensory loss or dementia.

**What we will do:**

1. Continue to reduce the number of vehicles on the roads by encouraging other modes of transport, especially cycling, (we have successfully increased the number of journeys made by cycles so far).
2. Implement measures increasing pedestrian and cyclist safety. This will be done via regular consultation through our Village Planning process.
3. Support the voluntary and community sector to provide high-quality low-cost accessible transport services to people and groups across the borough.
4. Continue to fund the Freedom Pass which covers the cost of providing free off peak bus travel for disabled and elderly residents.
5. Ensure our ATU continues to provide a quality and flexible service to older and disabled users across the borough.

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

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.

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 Volunteering**

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 health 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. 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 to assist them in their new roles.

**What we will do:**

1. We will review our priorities around volunteering in the borough and re-commission the volunteering service in 2016.
2. Continue to offer seed-funding of volunteer led community projects through the Civic Pride Fund.

**4.2.2 Loneliness and Isolation**

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).

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.

**What we will do:**

1. 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.
2. Continue to build on peer-researcher models to understand health and well-being needs of our residents.
3. Embed initiatives to prevent loneliness and isolation in local strategies and plans, e.g., Culture Strategy, Sports, Housing and Parks

**4.2.3 Village Plans**

By involving local people in local initiatives and services these 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 in their areas, and we asked residents about their priorities in each local area, .creating 14 Village Plans 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.

**What we will do:**

1. 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.
2. 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.
3. Use the online Village Plans to publicise and promote local health initiatives across the borough, with the aim of increasing participation in NHS Checks, smoking cessation programmes and other health improvement services.
4. Each village to work towards becoming a “Dementia Friendly” village.

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

Much ill-health and disability is preventable. Up to 60% of cardiovascular disease and 40% of cancers are avoidable – recent evidence is also emerging that some forms dementia are avoidable. Much of the collective impact of these diseases is caused by four key risk factors – smoking, physical inactivity, unhealthy diet and alcohol.

Information and advice are essential for the promotion of healthy lifestyles, approaches to improve access to this are outlined in our *Making Information and Advice Count Strategy* (add link). The Council and CCG will continue to support the delivery of Public Health England (PHE) campaigns locally, such as Change 4 Life. There are opportunities to developing 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 have undertaken a comprehensive review of lifestyle services and have 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**

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]](#footnote-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 an early 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. 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 LiveWell Richmond 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.

**What we will do:**

1. Develop a joined up approach to communication of national campaigns locally across partner organisations.
2. Deliver the actions set out in the “Making information & advice count” strategy
3. Re-commissioning a new targeted health lifestyles service
4. We intend to build on existing opportunities in the Borough by developing a self-care and self-management strategy
5. 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
6. 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

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

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) have a number of initiatives which are already up and running or we have committed funds to for 2015-16. Two flagship preventive 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 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 ‘Hub’ 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 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 problems

**4.4.3 Other key initiatives**

Other key 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 ensure that the needs of older people are met around falls and bone health with an early intervention and preventive 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 in 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 problems.
* Assistive Technology Services – 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

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 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 we will do:**

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.

1. Promote and support the delivery of the “Better Care Closer to Home” and “Better Care Fund” strategies
2. Ensure that prevention and recovery based models of care are core to proposed Outcomes based commissioning approaches.

**4.5 Priority 5: 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. 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, meals online
* 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 *Telehealth* and *Telecare*, with assistive technology services under development at present. 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 industryis planned, with the aim of identifying issues with current services and outlining potential technological solutions.

**What we will do:**

1. 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
2. Skilling up our workforce to promote and share technological solutions with local residents
3. Working with technology industry to consider technological based solutions for delivering appropriate services.

**5. Implementation and Governance**

A prevention strategy programme team of health and social care representatives, including Public Health was formed to undertake the mapping and development for this strategy across the Council, 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 NHS and Social Care partnership that leads on the Joint Commissioning Collaborative. See link to Terms of Reference.

A comprehensive implementation plan with indicators of success will be developed in response to this strategy. The Prevention strategy programme team will continue to meet on a monthly basis to oversee the implementation and liaise across the whole council, CCG and borough to galvanise support when necessary. The Health and Well-being Board will provide the whole systems leadership to support the delivery and implementation of this strategy.

**Conclusion**

Our first integrated Prevention Strategy 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.’* [[2]](#footnote-2)

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

In summary, the Prevention Strategy takes a further essential step towards putting prevention at the heart of the Council and CCG’s agenda.

**Appendix 1 Needs Assessment**

**Older people**

* In 2014, an estimated 14.5% of the population in Richmond are older people (aged 65 and over). The proportion of older people in Richmond is growing at a rate above the London average and is expected to rise to 19% by 2034.
* As a result, the number of people living with long-term conditions (i.e. conditions that cannot be cured but can be managed through medication and/or therapy over a period of years or decades), will increase.
* There is a higher proportion of people aged 85 and over in Richmond compared to the rest of London. In 2012, there were an estimated 4,200 in this age group. This figure is estimated to increase by 14% in the period until 2020.

**People living with 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.
* 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. 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.

**People living with disabilities**

* Some21,500 (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. This compares to 17.6% in England as a whole.
* 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;
* In 2011, 370 people in Richmond were registered blind, 260 were partially sighted, and 550 were deaf or hard of hearing.

**People living with mental illness**

* Around 1,500 people are estimated to have some form of severe mental illness. Co-morbidity among psychiatric conditions is high. In addition, an estimated 20,000 people in Richmond have a less severe, common mental disorder (such as depression and anxiety) (44).

**Emergency admissions to hospital**

* Overall, the emergency hospital admission rate is among the lowest in the country (45). However, around 2,073 (15%) emergency admissions (costing £4.2 million per year) are for potentially preventable conditions (46). Emergency readmission rates (11.6%) are similar to London 11.8% (47).

**Loneliness and Isolation**

Social isolation has been addressed by the Health and Wellbeing Board as a key local issue. A comprehensive needs assessment and action plan is in place to prevent and alleviate loneliness and isolation.

* Richmond has the highest proportion of people aged over 75 and living alone in London (51% in Richmond vs. 35% for London).

**Carers**

Information published by Carers UK in 2011 informs us that Social Services and the NHS rely on the willingness and ability of carers to provide care. The care provided by carers is worth an estimated £119 billion per year – considerably more than total spending on the NHS (£98.8 billion in 2009/10).

* Approximately 15,800 provide some level of unpaid care and 15% of those provide more than 50 hours unpaid care per week;
* In addition, the number of carers aged 65 years and over in Richmond and receiving services is estimated to increase from 400 to around 500, an increase of 25%. This group is particularly vulnerable to mental health problems.

**Healthy Lifestyles**

Much ill health and disability is preventable, and unhealthy lifestyles are driving an epidemic of chronic diseases. Despite performing well on healthy lifestyle indicators compared to London and England, we have significant number of people who are smokers, physically inactive, overweight and obese and drinking at higher than recommended levels.

* 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.
* An estimated 29,900 (20%) Richmond residents report not being active for 30 minutes per week, compared with 28.5% for England
* Over 65,000 (45%) are overweight or obese
* 87,000 do not eat 5 portions of fruit and vegetables per day
* Almost 28,000 (18%) adults report they binge drink. Estimates indicate that Richmond has higher than average proportions of increasing-risk (21.3%) and higher-risk (7.8%) drinkers, compared to England.

**Council funded social care**

As one of the most affluent boroughs in London, Richmond has a high number of self-funders who arrange and manage their own care and support;

* The average age older people start to receive council funded social care in Richmond is 84 for people receiving care at home and 87 for people in care homes;
* In 2013, the total number of self-funders known to the Council was 660 people. With only 13.5% of people aged 80 and over in receipt of council funded care and support, it is anticipated that there are many more self-funders in the borough.

**Appendix 2 – Summary of actions**

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| **Priority 1: Making health and wellbeing everyone’s business**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 galvanise partners to promote health and well-being starting by addressing unhealthy lifestyles as a key contributor to chronic disease.
3. Implement “Making Every Contact Count” across the council and encourage our partners to adopt this initiative.
4. Support the rollout of the “No Health without Mental Health” training initiative.
5. Richmond Council plan to achieve London Healthy Workplace Charter Healthy Workplace Achievement (intermediate) status in March 2015 and continue to develop this programme of work
6. Identify and support employers that could maximise the benefits of working towards the Workplace Wellbeing Charter
7. Tackle the impact of cold and fuel poverty through Cold Buster Grants, Winter Warmth home visitor service & energy efficiency work
8. Increase the independence of older people with long term conditions through Disabled Facility Grants with our Home Improvement Agency
9. Tackle overcrowding through an “Extensions Programme” with our housing partners and support those residents who are seeking to voluntarily downsize from a home which they are under-occupying.
10. Promote 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.
11. Improve the health of rough sleepers in the borough in partnership with SPEAR (Single Persons Emergency Accommodation in Richmond)
12. Work towards ensuring households are not in temporary accommodation for more than 6 weeks
13. Providing a range of supported in borough housing options for people with learning disabilities, Autistic Spectrum Condition and mental health problems
14. Work with registered housing providers to ensure they consider potential for specialist dementia provision
15. Seek opportunities to develop Extra Care schemes in the borough
16. Review and publish a new Cultural Strategy in 2015, building on previous strategies and renewing our vision for a borough where cultural and sports activity encourages participation, brings enjoyment, sparks creativity, contributes to health and wellbeing, transforms public spaces, attracts visitors, stimulates the local economy and brings communities together.
17. Parks and open spaces will become dementia friendly and we are working with local dementia groups to better our understanding on how we can make our parks and open spaces better designed and more accessible for dementia sufferers, including at the design and build stage.
18. 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.
19. We will continue to implement measures to make our parks as safe and welcoming as possible, for instance, by installing benches every 100 meters across our parks.
20. Support our Registered Providers and voluntary sector develop their strategies to get residents into work and job related training over the next 5 years.
21. The Council works in partnership with JobCentre Plus (JCP) to ensure that relevant training (pertinent to new businesses locating in the borough) is available for unemployed residents. They also work jointly with the Council on assisting residents affected by welfare reform back into work or training.
22. Continue to reduce the number of vehicles on the roads by encouraging other modes of transport, especially cycling, (we have successfully increased the number of journeys made by cycles so far).
23. Implement measures increasing pedestrian and cyclist safety. This will be done via regular consultation through our Village Planning process.
24. Support the voluntary and community sector providing high-quality low-cost accessible transport services to people and groups across the borough.
25. Continue to fund the Freedom Pass which covers the cost of providing free off peak bus travel for disabled and elderly residents.
26. Ensure our ATU continues to provide a quality and flexible service to older and disabled users across the borough.
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| **Priority 2: Creating healthy communities – harnessing local community assets to support people and their carers**1. We will review our priorities around volunteering in the borough and re-commission the volunteering service in 2016.
2. Continue to offer seed-funding of volunteer led community projects through the Civic Pride Fund.
3. 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.
4. Continue to build on peer-researcher models to understand health and well-being needs of our residents
5. Embed initiatives to prevent loneliness and isolation in local strategies and plans, e.g., Culture Strategy, Sports, Housing and Parks
6. 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.
7. 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.
8. Use the online Village Plans to publicise and promote local health initiatives across the borough, with the aim of increasing participation in NHS Checks, smoking cessation programmes and other health improvement services.
9. Each village to work towards becoming a “Dementia Friendly” village.
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| **Priority 3: Re-shaping healthy lifestyles services and embedding self-care**1. Develop a joined up approach to communication of national campaigns locally across partner organisations.
2. Deliver the actions set out in the “Making information & advice count” strategy
3. Re-commissioning a new targeted health lifestyles service
4. We intend to build on existing opportunities in the Borough by developing a self-care and self-management strategy
5. 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
6. 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
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| **Priority 4: Reducing and delaying demand for care – recovery focused model integrated across health and social care pathways**1. Promote and support the delivery of the “Better Care Closer to Home” and “Better Care Fund” strategies
2. Ensure that prevention and recovery based models of care are core to proposed Outcomes based commissioning approaches.
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| **Priority 5: Harnessing new technologies to support people to remain independent longer**1. 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
2. Skilling up our workforce to promote and share technological solutions with local residents
3. Working with technology industry to consider technological based solutions for delivering appropriate services.
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**Appendix 3 - Further reading**

* [Autism Strategy 2013-16(pdf, 491KB)](http://www.richmond.gov.uk/richmond_autism_strategy_april_13.pdf) - a joint strategy between Adult Social Care, Children’s Services and Health Services.

* [Better Care Fund Plan 2014 (part 1)(pdf, 1710KB)](http://www.richmond.gov.uk/better_care_funding_plan_1.pdf) - details of our Better Care Fund submission.

* + [Better Care Fund Plan 2014 (part 2)(pdf, 608KB)](http://www.richmond.gov.uk/better_care_funding_plan_2.pdf) - includes metrics and finance.

* [Carers Strategy 2013 - 2015(pdf, 611KB)](http://www.richmond.gov.uk/carers_strategy_13_15.pdf) - a strategy to meet the needs and ensure continued improvements in the quality of life, health and well being of carers living and caring in the London Borough of Richmond upon Thames.

* [Carers Strategy Action Plan 2013 - 2015(pdf, 372KB)](http://www.richmond.gov.uk/carers_strategy_action_plan_2013_15.pdf)

* [Community Plan 2007 - 2017](http://www.richmond.gov.uk/home/council/how_we_work/policies_and_plans/community_plan.htm) - outlines the vision for Richmond Upon Thames from 2007 to 2017.
* [Health and Wellbeing Strategy 2013 - 2016(pdf, 705KB)](http://www.richmond.gov.uk/health_and_wellbeing_strategy_april_13.pdf) - a framework for improving health and wellbeing by developing better responses to local needs.

* [Learning Disability Commissioning Strategy 2009 - 2013(pdf, 224KB)](http://www.richmond.gov.uk/ld_strategy_-_final_version_-_jan10__3_.pdf) - a strategy to meet the needs and aspirations of people with a learning disability within Richmond upon Thames.

* [Lifelong Opportunities - Ageing Well Strategy 2009 - 2013(pdf, 1985KB)](http://www.richmond.gov.uk/lifelong_opportunities_strategy_l_-2.pdf) - a strategy to meet the needs and aspirations of people aged 50 and over.

* [Market Position Statement(pdf, 1573KB)](http://www.richmond.gov.uk/lbrut_market_position_statement_2014.pdf) - The MPS provides information on current supply and demand, planned changes and emerging trends for services, that will guide and give context to existing providers in the borough and those considering starting a new business or extending their operations into Richmond.

* [Mental Health Joint Commissioning Strategy for Working Age Adults 2010 - 2015(pdf, 732KB)](http://www.richmond.gov.uk/mental_health_jsna_for_adults_of_working_age.pdf) - this strategy sets out the joint mental health commissioning strategy for adults of working age in Richmond upon Thames.

* [Mental Health Joint Commissioning Strategy for Older People 2010 - 2015(pdf, 375KB)](http://www.richmond.gov.uk/combined_report_for_respite_provision_final.pdf.pdf) - this strategy sets out the joint health commissioning strategy for older people in Richmond upon Thames.

* [Richmond Clinical Commissioning Group - commissioning intentions briefing 2013/14(pdf, 150KB)](http://www.richmond.gov.uk/ccg_commissioning_intentions.pdf) - intended to help local partners understand the purpose of developing commissioning intentions

1. Transforming our healthcare system. The King’s Fund. April 2013. [↑](#footnote-ref-1)
2. Care and Support Statutory Guidance. June 2014. *Department of Health*. Last accessed on 23/12/14 at: [www.gov.uk/government/uploads/system/uploads/attachment\_data/file/315993/Care-Act-Guidance.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf). [↑](#footnote-ref-2)