Live Well in Richmond 2022-2024

Healthy choices are influenced by our environment, communities and wellbeing. We will drive forward preventative approaches at all levels – engaging communities, utilising local assets (e.g. parks) and targeting approaches to reach those most at risk.

Support people to stay healthy and manage their long-term health conditions

Objective

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

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

Objective

- Ensure people with **serious mental illness get support for their physical health** as well as their mental illness.60% of people on the GP serious mental illness register in line with NHSE national targets by:
  - Providing additional support to GP practices to support engagement of patients with SMI.
  - Working with low-performing GP practices to improve the outcome of SMI checks for their patients
- Build on the work of the multi-agency interface group and emerging primary care networks to proactively support people with **complex mental health needs** by:
  - Implementation of the Mental Health worker model across the primary care networks.
  - Establishing multi-professionals, and voluntary sector interface meetings to discuss and resolve complex mental health needs for patients that fall between service provision.
- Increase access to the **IAPT (psychological therapies)** services for all, with a specific emphasis on vulnerable groups to meet the national access target. With a specific focus on increasing local access to:
  - People with a long-term condition
  - Older adults and carers
  - Men aged 35-44
  - People with Long COVID
- Lead the implementation of a **Suicide and Self-harm Prevention Strategy** to improve identification of risk and access to support, key actions to include:
  - Establishment of a real-time suicide surveillance system to inform a needs-based approach to prevention
  - Development of suicide and self-harm factsheets to enable appropriate crisis support in primary care settings
  - Providing access to Mental Health First Aid and suicide prevention training for the Voluntary and Community Sector
  - Encouraging employers to sign-up to "Employers for Carers"

Reduce health inequalities for people with learning disabilities

Objective

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

Outcome	Outcome	Outcome
• Steady decrease in the proportion of people classified as overweight • Increase in the number of community pharmacies offering health checks • The proportion of people referred from NHS health checks who take up a service • Increase in the number of people identified with high blood pressure and on optimal treatment • Increase annual monitoring in primary care for identification of non-diabetic hyperglycaemia and early diagnosis of Type 2 diabetes • Deliver awareness campaigns that are targeted at diverse communities • Increase uptake of people attending weight management services • Reduce A&E attendances and admissions due to alcohol related conditions • There will be a system-wide approach to identify and manage people with long-term conditions • There will be improved intelligence on areas of inequality, access and health outcomes across the borough with action plans to address these • Develop an outcomes-based tool to measure the impact of the model. • An increase in the number of organisations that sign up to the Healthy Workplace Award	• 60% of people on the GP serious mental illness register will have physical health checks in line with NHSE national targets • Increase in the number of mental health workers employed within PCN's • The national target for access to IAPT services will be achieved • More people in the targeted groups will be seen in IAPT services • A system wide suicide and self-harm strategy	• More people with a Learning Disability will receive an annual health check • More people with a Learning Disability will have the opportunity to take up and sustain paid employment • More people with a Learning Disability will live independently in settled accommodation

Overarching Themes

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

We will address obesity in all ages, encouraging people to live physically active and healthy lifestyles to prevent ill-health and improve wellbeing – by identifying risky behaviours such as **high alcohol consumption**

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

We will tackle inequalities in health to **reduce disparities for those most disadvantaged**

South West London
Health & Care Partnership