South West London
Health & Care
Partnership

DRAFT
Richmond Health and Care Plan 2019-21

Discussion document

May 2019

Start well, live well, age well

The Richmond Health and Care Plan describes our vision, priorities and actions to meet the health and care needs of local people and deliver improvements in their health and wellbeing.

This two year plan focuses on actions which no single organisation can achieve alone: where health, social care and the voluntary sector working together has maximum impact. This plan should be read in the context of our other local health and care strategies.

This plan has been developed in partnership with local people, voluntary community groups, health and care partners.

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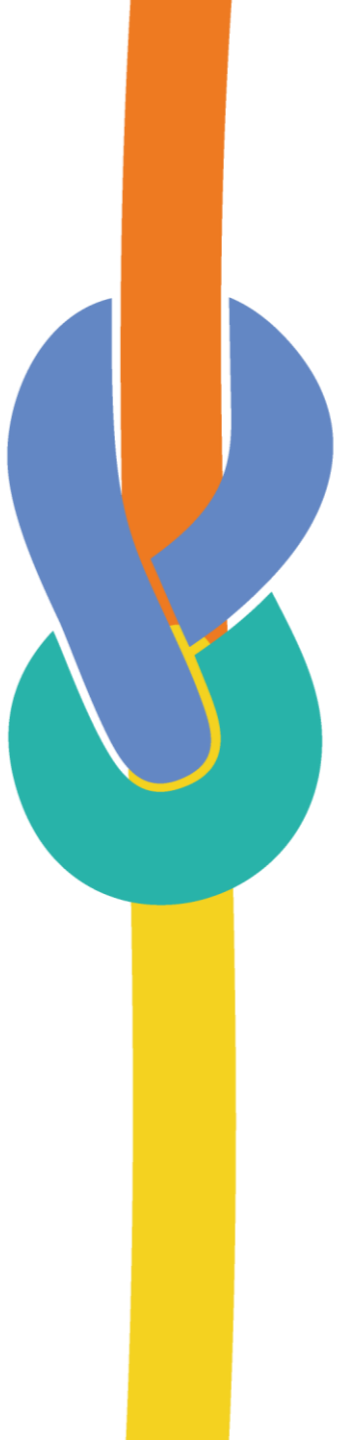


Local health and care partners

We want to improve services in the borough of Richmond through strong partnership working

- Local people
- Achieving for children
- Chelsea & Westminster NHS Foundation Trust (West Middlesex)
- London Borough of Richmond Upon Thames
- Hounslow and Richmond Community Healthcare NHS Trust
- Community pharmacies
- Kingston Hospital NHS Foundation Trust
- NHS Richmond CCG
- South West London and St George's Mental Health NHS Trust
- Richmond Council for Voluntary Service
- East London Foundation Trust
- Healthwatch Richmond
- Richmond GP Alliance / Richmond GPs

Our vision

"All people in Richmond are able to achieve their full potential, live their lives with confidence and resilience, and access quality services that promote independence and deliver value for money."

How we will deliver this

Focusing on prevention and early intervention: making sure people are treated in the right place to meet their needs. Proactive, preventative care will mean fewer people need to access emergency or specialist services.

How we will deliver this

Supporting patients to be involved in their own care: and where possible, lead their own care

Integrated and accessible person centred care: health, social care and voluntary sector teams in the community that will provide a range of joined up health and social care services to improve the experience of local people

How we will deliver this

Supporting independence for as long as possible: supported by a health and social care system that is easier to access, is timely in the support it provides and brings together expertise to provide a cohesive and intuitive approach to health and wellbeing

The Richmond story

Resident Population
194,730

Employment
80%
working-age adults are in employment
the highest rate in London

49%
volunteer
highest rate in London (26%)

Life expectancy at birth:

82 years
for men
(1.8 years greater than London)

85.4 years
for women
(1.3 years greater than London)

Heritage sites:
Hampton Court Palace, Richmond Park, Kew Gardens, Bushy Park - approximately
4.5 million visitors
from across the world every year.

Education
A borough with some of the highest performing primary and secondary schools in the country

International Sporting Events:
Autumn International Rugby Fixtures, Twickenham Six Nations, Twickenham largest dedicated rugby union venue in the World, with a capacity of
82,000

12 libraries with a variety of services, events and support sessions

Community Safety
4th out of 32
for crime overall
Safest borough for violent crime

Open spaces

40% of the area of the Borough

100+ parks

21 miles of river frontage

23,000
bike journeys per day in the borough
2nd out of 33 in London

See Richmond's Strategic Needs Assessment for more information about local health and social care needs
https://www.richmond.gov.uk/jsna

Our challenges in Richmond

- Ageing population / dementia
- Long term conditions
- High levels of A&E attendance
- Obesity in children
- Poor mental wellbeing
- Health inequalities
- Risky behaviours in children and adults

Finance summary

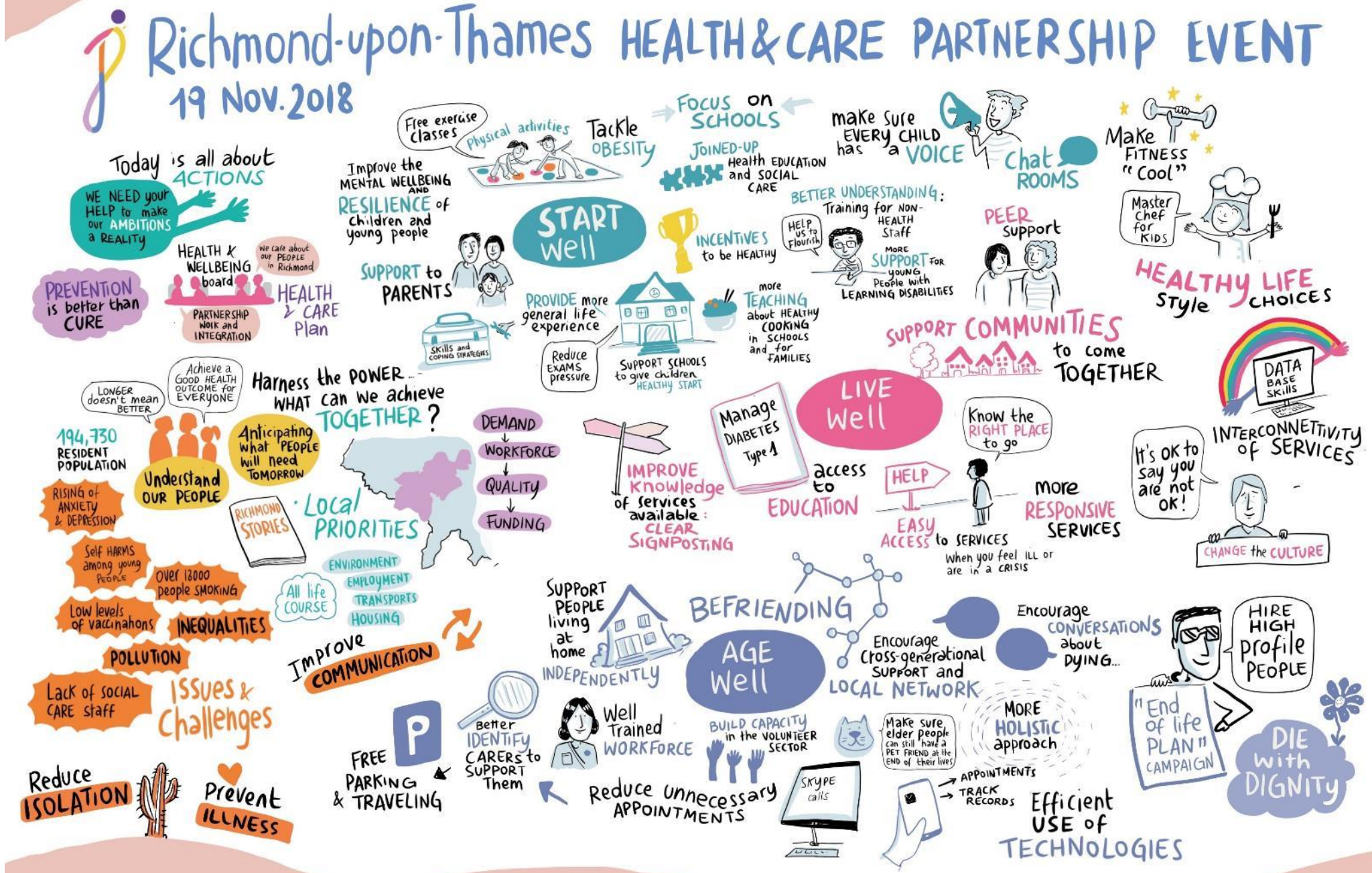
- The health and care system in Richmond faces significant financial challenge. With increasing demands from an ageing population and the need to improve quality and respond to rising patient expectations we must do more to improve the way we use the funding for health and care in the borough.
- It is therefore inevitable that the shape of services will have to change. To support our health and care plans we will shift the balance of our spend from reactive, high cost acute care to preventative, proactive out of hospital care.
- We know that by working together we can better manage our collective financial challenges, whilst delivering the health and care the people of Richmond deserve.
- Clinically led working groups are developing patient focused solutions along with the actions within this plan to deliver care within the resources available.

Local people

We have used the views of local people over the last two years to shape our thinking. This has included hearing from groups who do not always feel their voice is heard or may face specific barriers to involvement.

In November 2018, we held an engagement event for local people, health and care staff, and representatives from community organisations to talk about things which no single organisation can achieve alone. These conversations have informed the borough's Health and Care Plan.

For more information see: http://www.richmondccg.nhs.uk/have-your-say/health-care-plan-event


Richmond-upon-Thames HEALTH & CARE PARTNERSHIP EVENT
19 Nov. 2018
Today is all about ACTIONS
WE NEED your HELP to make our AMBITIONS a REALITY
PREVENTION is better than CURE
HEALTH & WELLBEING board
We care about our PEOPLE in Richmond
PARTNERSHIP WORK and INTEGRATION
HEALTH & CARE Plan
Free exercise classes
Physical activities
Tackle OBESITY
FOCUS on SCHOOLS
Improve the MENTAL WELLBEING AND RESILIENCE of children and young people
JOINED-UP Health EDUCATION and SOCIAL CARE
make sure EVERY CHILD has a VOICE
Chat ROOMS
Make FITNESS "Cool"
Master Chef for KIDS
START Well
INCENTIVES to be HEALTHY
BETTER UNDERSTANDING: Training for NON-HEALTH Staff
HELP us to Flourish
MORE SUPPORT FOR YOUNG People with LEARNING DISABILITIES
PEER support
HEALTHY LIFE Style CHOICES
SUPPORT to PARENTS
PROVIDE more general life experience
Reduce EXAMS pressure
Skills and COPING STRATEGIES
Support SCHOOLS to give children HEALTHY START
more TEACHING about HEALTHY COOKING in SCHOOLS and for FAMILIES
SUPPORT COMMUNITIES to come TOGETHER
DATA BASE Skills
INTERCONNETTIVITY of SERVICES
It's OK to say you are not OK!
CHANGE the CULTURE
LONGER doesn't mean BETTER
Achieve a GOOD HEALTH OUTCOME for EVERYONE
Harness the POWER ... WHAT can we achieve TOGETHER?
194,730 RESIDENT POPULATION
Understand OUR PEOPLE
Anticipating what PEOPLE will need TOMORROW
DEMAND
WORKFORCE
QUALITY
FUNDING
RISING of ANXIETY & DEPRESSION
RICHMOND STORIES
Local PRIORITIES
IMPROVE Knowledge of services available: CLEAR SIGNPOSTING
Manage DIABETES Type 1
LIVE Well
access to EDUCATION
Know the RIGHT PLACE to go
HELP
EASY ACCESS to SERVICES
When you feel ILL or are in a CRISIS
more RESPONSIVE SERVICES
Self HARMS among young PEOPLE
Over 18000 people SMOKING
Low levels of vaccinations
INEQUALITIES
POLLUTION
Lack of SOCIAL CARE staff
ISSUES & Challenges
All life COURSE
ENVIRONMENT
EMPLOYMENT
TRANSPORTS
HOUSING
Improve COMMUNICATION
SUPPORT PEOPLE living at home INDEPENDENTLY
BEFRIENDING
AGE Well
Encourage Cross-generational SUPPORT and LOCAL NETWORK
Encourage CONVERSATIONS about DYING...
HIRE HIGH profile PEOPLE
"End of life PLAN" CAMPAIGN
DIE with DIGNITY
Reduce ISOLATION
Prevent ILLNESS
FREE PARKING & TRAVELING
better IDENTIFY CARERS to SUPPORT Them
Well Trained WORKFORCE
BUILD CAPACITY in the VOLUNTEER SECTOR
Make sure elder people can still have a PET FRIEND at the END of their lives
MORE HOLISTIC approach
Reduce unnecessary APPOINTMENTS
SKYPE calls
APPOINTMENTS
TRACK RECORDS
Efficient USE of TECHNOLOGIES
Artwork by CreativeConnection.co.uk

Our plan – priorities for action

Start well

- Improve the mental wellbeing and resilience of our children and young people
- Support children and young people with special educational needs, disabilities and complex health and care needs to flourish and to be independent in their local communities
- Focus on reducing obesity to improve the health of our children and young people

Live well

- Support people to stay healthy and manage their long term health conditions
- Promote mental wellbeing and support those who experience poor mental health to avoid mental health crisis
- Reduce health inequalities for people with learning disabilities and serious mental illness.

Age well

- Encourage active, resilient and inclusive communities that support people to live at home independently, if possible
- Support people to plan for their final years so they have a dignified death in a place of their choice.

Based on the conversations we have had with local people over the past two years, the Richmond story and the case for change we have agreed these priorities for action.

Priorities across all life stages
Improve support to unpaid carers

Priority: Recognise and value carers, support them in their caring role and enable them to have a life outside of caring

Why is this important:

Approximately 15,800 people provide some level of **unpaid care** and 15% of those provide more than 50 hours unpaid care per week. This is much higher than the number of carers identified as such by GPs, the voluntary sector and social care

Action: We will improve our practice in identifying and recognising carers of all ages so they are linked to appropriate support options, enabling carers to reduce the social, financial and health impacts they face.

Priorities across all life stages Prevention

Priorities:

Create environments and enable communities and individuals to lead healthy lives and be confident in their ability to care for themselves and others

Act on the wider determinants of health to improve people's lives

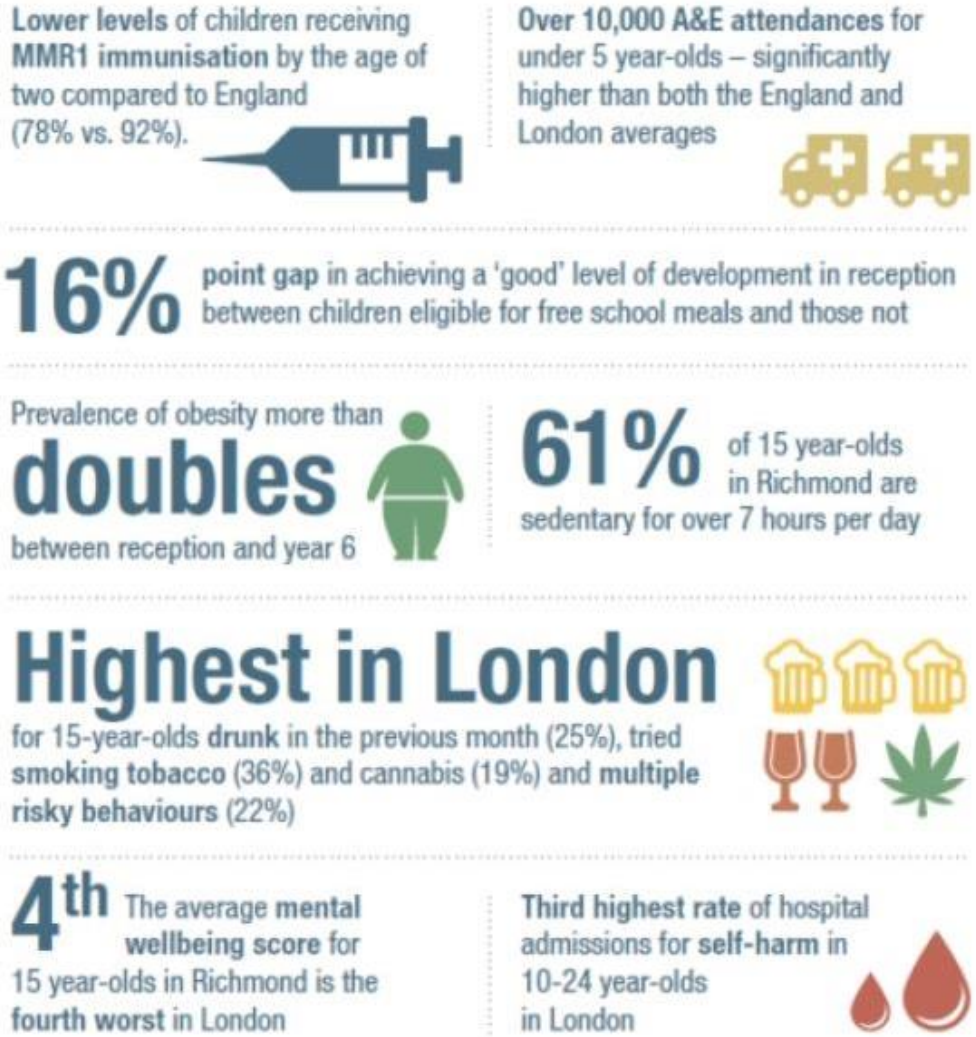
You will see prevention and early intervention throughout the actions outlined in this plan

Start well

What happens in early life, starting from conception, affects health and wellbeing in later life. Prevention is critical to ensuring that all children and young people can fulfil their potential.

What local people have told us about start well

For more information about what local people have told us see: https://bit.ly/2IdDN05



Start well
Together we will focus on:

1. Improving the **mental wellbeing** and resilience of our children and young people

2. Supporting children and young people with **special educational needs**, disabilities and complex health and care needs to flourish and be independent in their local communities

3. Focusing on **reducing obesity** to improve the health of our children and young people

1. Improve the mental wellbeing and resilience of children and young people

Why?

- The average **mental wellbeing** score for 15 year-olds in Richmond is the **fourth worst in London**
- 90 hospital admissions as a result of **self-harm** in those aged 10-24 year-olds, which equates to the **third highest rate in London**
- Hospital admissions due to substance misuse in those aged 15-24 years is increasing

1. Improve the mental wellbeing and resilience of our children and young people

What will we do?

- By April 2020 we will complete an assessment of the mental health needs of the under 5 population of Richmond, to inform development of services.
- Ensure that there is an emotional wellbeing programme in all of our schools, by April 2021 including wellbeing support, training and information to students, parents and staff
- Establish a digital youth project steering group, by January 2020 to review and expand the range of resources and tools to support emotional wellbeing and strengthen resilience
- By April 2020 we will complete a review of the current neurodevelopment and assessment offer for 0-5 year olds, ensuring that by 2021 the recommendations of the review are being implemented.

By doing this we will

- Ensure that children and families receive early targeted support to prevent development of serious difficulties
- Ensure that children and young people have timely access to support with local counselling 7 days per week through the digital offer
- Ensure that children and young people receive support so that the incidences of self-harm are reduced
- Ensure that neurodevelopment assessment referrals are always completed within 12 weeks

2. Support children and young people with **special educational needs**, disabilities and complex health and care needs to flourish and be independent in their local communities

Why?

- 12% of children have **special educational needs or disabilities**
- Children and young people with **learning disabilities** are among the most vulnerable in a community with a wide range of support and access needs.
- Children with disabilities or special needs are more likely to experience or live in poverty

2. Support children and young people with **special educational needs**, disabilities and complex health and care needs

What will we do?

- Work with children and young people, parents and carers to ensure they can have their say and are involved in **decisions about their own education, health and care support**
- Promote the **local SEND website** so that more people are aware of its value as a one-stop shop for information on local health and care services
- Co-design with young people, parents/carers and professionals an **improved local therapies** offer to be in place by March 2020
- Build on the existing **transitions protocol** between children and adult services, ensuring that this includes a review of all educational health and care plans at year 11

By doing this we will

- Increase the feedback from children and young people, their parents and carers on the educational health and care plan process
- Increase the numbers of young people with post-16 educational health and care plans on vocational pathways and develop a local post-16 learning offer
- Reduce waiting times for assessment and intervention; parents and carers report increased satisfaction with therapy services.
- Increase the number of specialist resource provision places to reflect the needs identified in the ten-year SEND provision plan
- Ensure that young people experience a planned and smooth transition between children's and adult mental health services

3. Reduce obesity to improve the health of our children and young people

Why?

- Children make up **25 % of the population**
- In reception year, 5.1% of children are obese, the lowest in England. Nevertheless, **by year 6 prevalence more than doubles to 11%,** and is even higher in the more deprived areas of the borough.

3. Reduce obesity to improve the health of children and young people

What will we do?

- Roll-out the **Family Start programme** to support children who are identified through the national child measurement programme by March 2020
- Promote and support roll out of the **Daily Mile** (getting all children to run for 15 minutes a day in school), in all of the borough's primary schools by April 2021
- Carry out a **needs assessment on breastfeeding** by April 2020 to identify if there are areas of the population where uptake is below the London average of 49%
- Develop a **Healthy Catering Commitment Plan** to ensure that healthy food is served or sold in all of the borough's schools by 2021
- Enhance parent programmes that **promote healthy eating and active play for 0 to 5 year olds** in children's centres by March 2021

By doing this we will

- See a year on year reduction in the number of children and young people who are overweight including those who are obese
- Increase the number of schools delivering the Daily Mile Programme – so that it is place in all primary schools by April 2021
- Improve the uptake in breast feeding ensuring that all part of the borough meet the London average by April 2021

Live well

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.

What local people have told us about live well

For more information about what local people have told us see: https://bit.ly/2IdDN05

Live well
Together we will:

1. Support people to stay healthy and manage their **long-term health conditions**
2. Promote mental wellbeing and support those who experience poor mental health to avoid **mental health crisis**
3. Reduce health inequalities for people with **learning disabilities**

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

Why?

- One in ten people in Richmond has three or more long-term health conditions
- 13% of adults in the borough smoke and the number of people quitting is falling
- The number of people getting an NHS Health Check has fallen and is below the average rate in England
- The proportion of women aged 50-70 taking up breast cancer screening has also dropped

1. Support people to stay healthy and manage their long term conditions. What will we do?

- Proactively support **people with complex health and care needs** by bringing health and care professionals together around the individual – through primary care networks, across the borough by March 2020
- Transform the way people access **outpatient hospital appointments** so that more care is received closer to home
- Promote **prevention and early identification of long-term conditions** – by increasing the uptake of health checks as part of the Quality Outcomes Framework
- Expand **IAPT (psychological therapies)** to include people with long-term conditions to meet the 22% access target by March 2019

- Support a culture of health and wellbeing by providing **healthy working environments** which support those working with long term conditions, so that by 2021 all health and care organisations have signed up to the Healthy Workplace Charter
- Roll out **social prescribing across the borough** by March 2020

By doing this we will

- Ensure people “at risk” or diagnosed with long term conditions have the knowledge to self-manage their condition and recognise the triggers to take early action to prevent a deterioration in their condition
- Ensure that people with complex health and care needs experience joined up care and support to manage their conditions and achieve a 15% reduction in avoidable hospital admissions
- Reduce the number of outpatient hospital appointments by 30% in line with the NHS Long Term Plan
- Receive reports of good mental wellbeing from people with long term conditions
- Encourage all health and care workplaces in the borough to provide environments that support people with health needs
- Provide social prescribing across the borough

2. Promote mental wellbeing and support for those who experience poor mental health

Why?

- 12.9% of the adult population are estimated to have anxiety or depression
- 85% of patients with a severe mental illness recorded consuming alcohol in the past 12 months
- Reduction in the percentage of people aged 18-69 on a Care Programme Approach in stable and appropriate accommodation

2. Promote mental wellbeing and those who experience poor mental health. What will we do?

- Increase access to the IAPT (psychological therapies) services for all, with a specific emphasis on vulnerable groups to meet the 50% recovery target and the 22% access target by March 2020.
- Implement Richmond's Suicide Prevention Strategy to improve identification of risk and access to support, so that we see a reduction in suicides year on year
- Build on the work of the multi-agency interface group which looks at the care of people with complex mental health needs
- 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 by March 2020.

By doing this we will

- Reduce the numbers of people attending A&E in a mental health crisis by 50%
- Reduce the number of people taking their own lives – year on year
- Ensure people with serious mental illness experience joined up holistic care
- Ensure 60% of those on a practice's serious mental illness register receive an annual physical health check and follow up interventions
- Reduce the number of staff who experience poor mental well-being in the work place - and this will be measured through a reduction of sickness absence for mental illness
- See an increase in the numbers of people reporting positive mental wellbeing through IAPT

3. Reduce health inequalities for people with learning disabilities

Why?

- The borough's prevalence of learning disabilities is 0.2% (524 people) and the rate of adults aged 18-64 with learning disabilities is stable.
- The proportion of eligible adults with learning disabilities having a GP health check is 57%

3. Reduce health inequalities for people with learning disabilities. What will we do?

- **Increase the** uptake of GP annual health checks for those with learning disabilities to at least 75% by March 2020
- Support Mencap to deliver the Treat Me Well campaign across Richmond health providers
- Continue to support people to access Choice Support - a dedicated, support employment service for people with learning disabilities

By doing this we will

- Reduce the number of people with a learning disability from dying prematurely in Richmond
- Ensure that 60% of those on a practice's people with a learning disability register receive an annual physical health check and effective support
- Ensure all services recognise the individual needs of people with a learning disability and adjust their approach when supporting or delivering care – through the Treat Me Well campaign

Age well

Whilst people are living longer, many older people are also living with a reduced quality of life due to ill health or disability, or experience loneliness and isolation.

What people have told us about age well

For more information about what local people have told us see: https://bit.ly/2IdDN05

Age well
Together we will:

1. Encourage **active, resilient and inclusive communities** that support people to live at home independently, where possible
2. Support people to plan for their **final years** so they have a dignified death in a place of their choice

1. Encourage active, resilient and inclusive communities that support people to live at home where possible

Why?

- 30,600 over 65s in the borough and 5.12% (9,434) living alone (London average: 3.86%)
- 19,000 A&E attendances and 8,000 emergency admissions
- Less than half of adult social care users feel they have as much social contact as they would like. For carers, this falls to just 32.1%

1. Encourage active, resilient and inclusive communities that support people to live at home where possible

What will we do?

- Improve **health and care information and advice** for people and their unpaid carers
- Increase access for older people and their carers for **outreach and community based services,** including respite care through the delivery of Community Independent Living Services
- Redesign the pathways for integrated **community based urgent care services and home first services** on discharge from hospital

By doing this we will

- Reduce the number of unnecessary attendances in the emergency departments by 15% by March 2021
- Reduce the number of unnecessary hospital admissions by 15% by March 2020 – in particular those admissions for 72 hours or less
- Increase in the percentage of older people receiving reablement on discharge from hospital, so that we see an increase in those able to recover at home or close to their own home.

2. Support people to plan for their final years so they can have a dignified death in a place of their choice

Why?

- Those aged 65 years and over who died in hospital were admitted to hospital an average of 4 times in the last year of life
- We would like to increase the numbers of people who die in a place of their choice

2. Support people to plan for their final years so they can have a dignified death in a place of their choice

What will we do?

- Improve end of life care by implementing our **end of life care strategy**
- Review the **joint dementia strategy**, ensuring specialist end of life care support is in place to support people with dementia and their carers

By doing this we will

- Increase the number of Advance Care Plans and coordinate my care across all care settings so we see an increase year on year for the duration of this plan
- Reduce the number of emergency admissions to hospital in the last year of life by 50%
- Increase the number of people who have their end of life wishes followed and die in a place of their choice by more than 50%
- Improve the support and experience for people with dementia and their families

Have your say

Having read this document we would like you to consider these questions:

- Do you understand what we will be focusing on for the next two years?
- Do you agree with the actions we are proposing to improve the health and care of local people over the next two years?
- Is there anything missing in our plans that you would expect to see there? If so, what?
- Have you any other comments about the Health and Care Plan discussion document?

You can do this by filling out our short online questionnaire which you can find here: https://bit.ly/2GPpm06

Emailing us at : richmondccg.involve@swlondon.nhs.uk

Calling us at: 020 3941 9917

Delivering the Health and Care plan

Where possible, we will use existing forums and groups to take forward the actions.

A delivery plan with clearly identified lead organisations will now be developed so that health and care partners can work together and make a difference for local people.

South West London
Health & Care
Partnership

Contact us:

richmondccg.involve@swlondon.nhs.uk