



London Borough of Richmond upon Thames

# The Annual Report of the Director of Public Health 2013/14



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**of the Director of Public Health**  
**2013/14**

## Authors

**Anna Bryden**

Consultant in Public Health

**Sean Gillen**

Economic Development Manager

**Ayisha Jessa**

Public Health Lead

**Dr Amanda Killoran**

Public Health Principal

**Dr Caoimhe O'Sullivan**

Public Health Principal

**Anna Raleigh**

Consultant in Public Health

**Katherine Thompson**

Public Health Principal

**Peter Yuen**

Public Health Specialist/Statistician

**Dr Dagmar Zeuner**

Director of Public Health

## Acknowledgements

### **David Allister**

Head of Parks, Documents and Delivery, London Borough of Richmond upon Thames

### **Daniela Acosta-Pagliari**

Head of Integrated Working, London Borough of Richmond upon Thames

### **Steve Bow**

Information Assistant, Public Health England

### **John Coates**

Special Projects Manager, London Borough of Richmond upon Thames

### **Ben Fryer**

Principal Transport Planner, London Borough of Richmond upon Thames

### **Isabella Galka**

Public Health Project Support Officer, London Borough of Richmond upon Thames

### **Gillian Gouch**

Head of Children's Workforce Development, London Borough of Richmond upon Thames

### **Dr Fiona Hamilton**

Specialty Registrar in Public Health, London Borough of Richmond upon Thames

### **Mac Heath**

Strategic Head of Family Support Services, London Borough of Richmond upon Thames

### **Aileen Jackson**

Commissioning Manager, Joint Commissioning Collaborative

### **Pauline Kirby**

Head of Consumer Protection, London Borough of Richmond upon Thames

### **Carol Lee**

Technical Officer, London Borough of Richmond upon Thames

### **Judy Mace**

Head of Commissioning (Children), Joint Commissioning Collaborative

### **Oliver McKinley**

Public Health Analyst, London Borough of Richmond upon Thames

### **Dr Emer O'Connell**

Specialty Registrar in Public Health, Public Health England

### **Dr Sukhmeet Panesar**

Specialty Registrar in Public Health, London Borough of Richmond upon Thames

### **Dr Cleo Rooney**

Consultant in Communicable Disease Control, Public Health England

### **Charlotte Taylor**

Surveillance Officer, Public Health England

### **Dr Barry Walsh**

Director/Consultant in Communicable Disease Control, Public Health England

### **Phillip Wealthy**

Head of Policy and Design, London Borough of Richmond upon Thames

### **Risa Wilkinson**

Sustainability Team Leader, London Borough of Richmond upon Thames

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# Foreword

Welcome to the 2013/14 annual public health report for Richmond upon Thames. As the Director of Public Health this is my first report since our move from the NHS into the Local Authority, and I would like to thank officers and councillors in Richmond for the support and warm reception that we have received.

The new public health duties of Local Authorities are summarised below, in addition to the production of this independent annual public health report they include:

- Advising officers and elected members on all matters health.
- Commissioning a range of specified public health services such as sexual health, drugs and alcohol, healthy lifestyle and school nursing.
- Providing commissioning support back to the NHS, mainly to Richmond Clinical Commissioning Group (CCG).
- Assuring effective health protection arrangements are in place for Richmond residents, including immunisations, screening, emergency planning and infection control.
- Being a statutory member of the Health and Wellbeing Board.

In the past, the annual public health report used to be the main reference document giving an overview of the health of a local population. This role was superseded by the Joint Strategic Needs Assessment (JSNA). Since 2008, it has been a statutory requirement for the NHS and Local Authority to work together to better understand the health and wellbeing needs of the local population which informs joined-up service planning. The recent Health and Social Care Act has further strengthened the role of the JSNA as a statutory duty of the new Health and Wellbeing Boards.

This annual public health report therefore builds on evidence and data from the JSNA without duplicating it. It allows me to highlight opportunities for tackling current and preventing future public health challenges, ensuring that Richmond remains a healthy place to live and work.

The four main chapters are structured around key messages of relevance not just to the Local Authority and Clinical Commissioning Group but also the voluntary sector, Healthwatch, as well as patients and the public in Richmond. I hope they will serve as a useful summary for the busy reader and encourage and stimulate further debate on

how we might best direct our collective efforts in meeting the health challenges faced by Richmond people.

The report begins with a chapter on early years. The importance of this period for the health and wellbeing, not only of our children, but future generations, is gaining increasing attention. Children in Richmond generally have a good start in life but some risks and harms are more hidden. New opportunities are arising for collaborative working with the Local Authority's Education and Children's Services Directorate as public health will now commission school nursing and health visitors from 2015. This is of particular importance to securing ongoing investment in preventative services, often hit first in times of austerity. The chapter provides insight into a few chosen areas of interest.

The second chapter is on dementia. Dementia is an important challenge for health and social care in Richmond, both currently and into the future, with an increasingly ageing population. The needs analysis presented here can help guide a pattern of investment that is cost-effective and affordable.

The third chapter considers multimorbidity. Traditionally in the health system the delivery of care has been built around the management of single diseases. However, the analysis in this chapter demonstrates that the occurrence of several chronic conditions in the same patient is becoming the norm. Understanding the pattern of multimorbidity allows better planning of integrated health and social care services that focus on the holistic needs of patients and carers.

The last chapter focuses on environmental factors that can impact on health and wellbeing. The importance of the physical environment on health is well known, including its influence on healthy lifestyle choices. Richmond is a well-maintained attractive borough with lots of parks and open spaces and the environment is highly valued by its people. Closer working with colleagues from the Environment Directorate is one of the exciting new opportunities that the move of public health from the NHS into the Local Authority has brought. While the potential scope of this topic is extensive, this chapter reflects the mere beginning of our relationship with environmental colleagues by covering a few selected topics. I am particularly indebted to their support in putting the content together (see acknowledgements).



At the back of the report (see appendices), we have included for easy reference the summary JSNA, a list of main health indicators, a link to further information about the health of Richmond people and our contact details. If you have any comments or questions about the report we would like to hear them.

I am very grateful to colleagues in the Council's Children's Services, Adult and Community Services and Environment directorate, as well as from Richmond Clinical Commissioning Group

(CCG) and Public Health England for their support in the development of this year's report. I would like to pay particular thanks to the efforts of contributors shown in the acknowledgements.

**Dr Dagmar Zeuner**

*Director of Public Health  
London Borough of  
Richmond upon Thames*



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**A**s the Cabinet Member for Health and Children's Services I am pleased to welcome the Public Health department to the Local Authority. This transition brings with it new duties, and is one of the most significant extensions of our functions in a generation.

A lot of what Local Authorities are responsible for already has a direct or indirect effect on health, for example social care, planning, education, environmental health, housing – to name but a few areas. The new public health function presents further opportunities to complement and strengthen our existing duties.

This is why I commend this independent annual report of our Director of Public Health for Richmond which brings to our attention some of the key issues and opportunities for working across

council departments and with Richmond Clinical Commissioning Group for better health services and better health of Richmond people. We are proud that Richmond already has some of the best health outcomes in the country but we are not complacent and I am confident that in combining our efforts we will be in an even better position to support Richmond residents and communities to stay healthy.

**Councillor Christine Percival**

*Strategic Cabinet Member for  
Health and Children's Services  
London Borough of  
Richmond upon Thames*



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**R**ichmond's newly formed Clinical Commissioning Group is responsible for commissioning health services on behalf of residents. As its Chairman I am aware that the health care needs of many of the individuals we see on a day-to-day basis are becoming increasingly complex.

As people get older we are faced with the challenge of providing high quality care to increasing numbers of individuals with multiple morbidities and mental health problems such as dementia. Good health and social care for these individuals is essential, but equally we need to get better at helping residents to stay healthy in the first place. This means protecting and developing a physical environment that enables individuals to make healthy choices, and giving every child a good start in life.

In tackling these challenges, in the context of the current financial pressures, it is important that we explore the opportunities for collaborative solutions. This involves close working with the Local Authority, facilitated by our co-location. I commend the publication of this first independent annual public health report and look forward to continuing to draw on public health intelligence and evidence to inform our joint work.

**Dr Andrew Smith**

*Chairman, Richmond upon Thames  
Clinical Commissioning Group*



# 1 Early years



## Key messages

1

Children in Richmond generally have a good start in life. However, there are pockets of health inequalities, and some risks and harms are more hidden such as parental substance misuse or mental health problems. Furthermore, the health and wellbeing agenda in Richmond can be dominated by the needs of older people – with a lesser voice for children, their parents and carers. This is why advocacy and leadership for children and their families need to be ongoing priorities.

2

The early years period is critical in a child's development, and experiences during this period have wide-ranging effects well into adult life. Prevention measures and early interventions have long-lasting positive impacts on a range of health, wellbeing, education and economic outcomes. Maintaining investment in prevention during times of austerity is a major challenge but makes compelling economic sense.

3

Young children and families come into contact with a range of professionals and organisations. Working in partnership is crucial to ensure a shared understanding of roles and effective delivery of services around the needs of the child. This is particularly important at key transition stages throughout the life course, starting with pre-conception and pregnancy through early years, school age and adolescence into adult life.

4

Services for young children and their parents are often not connected around the family as a whole. A family-focused approach is particularly important in effectively tackling lifestyle issues such as obesity, and in addressing risks that might be hidden such as parental drug misuse or mental health problems.

5

The NHS reforms have divided commissioning responsibilities for children's services between Local Authorities, NHS Clinical Commissioning Groups and NHS England. The new system offers opportunities for greater integration between NHS and Local Authority children's services but also brings challenges of potential fragmentation and lack of clarity of roles and responsibilities.

6

Shared staff training is needed to avoid conflicting advice and to deliver a more integrated service across professionals involved in early years services. This is of particular importance in Richmond where parents are generally well-educated, vocal and rightly demand excellent services for their children. Staff need to be equipped to respond to the challenges that this brings, including spotting and acting on hidden risks and harms.

## Introduction

A child's early years - a term used to describe the life stage for children under the age of five years - are critical and can have a long-lasting impact on a wide range of health, wellbeing, education and economic outcomes. Although children in Richmond upon Thames generally have a good start there are inequalities, and some risks and harms are more hidden. This chapter draws on a recent early years Joint Strategic Needs Assessment (JNSA) to highlight some key topics crucial to ensuring that Richmond's children are given the best possible start in life.

## Advocacy and leadership for children

Most children in Richmond start life well. For example, Richmond has a relatively low percentage of children with low birthweight (< 2500g) – 5.8% of births compared to over 7% in London and England. This generally good start can partly be explained by relatively low deprivation levels in the borough. Figure 1 shows that, in Richmond, only 8.4% of households with dependent children have no adults in employment (1,989 households). This is relatively low compared to London (18.3%) and England (14.4%).

Figure 1: Percentage of households with dependent children that have no adults in employment, 2011

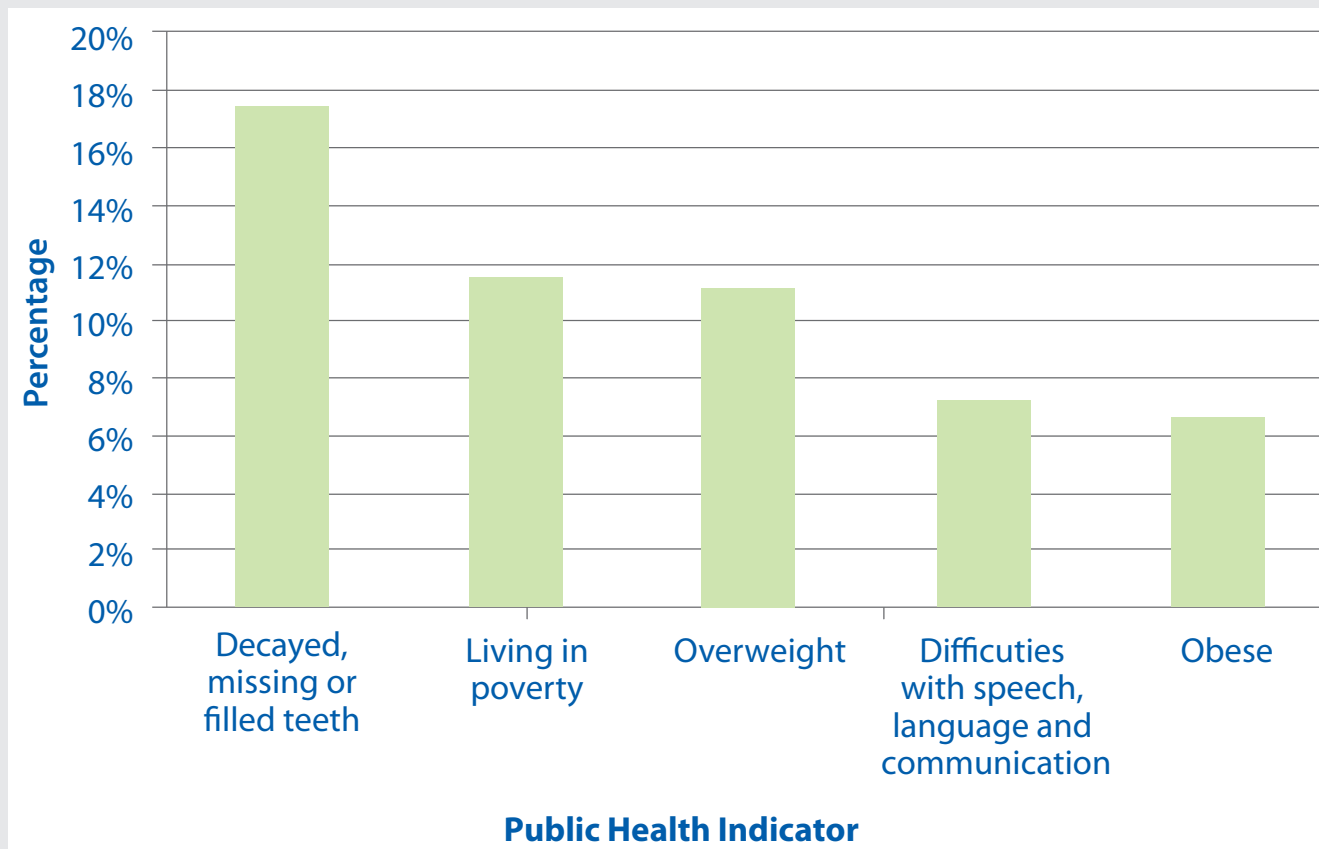


Source: Office for National Statistics, 2012

## Early years: Advocacy and leadership for children

Despite favourable comparisons with other areas, there are still substantial numbers of young children experiencing poorer health outcomes. By the time that children start school it is estimated that: around 430 will have decayed, missing or filled teeth; 282 will be living in poverty; 240 will be overweight; 175 will have difficulties with speech, language and communication; and 140 will be obese, see figure 2.

Figure 2: Public health indicators for Richmond's five-year-olds

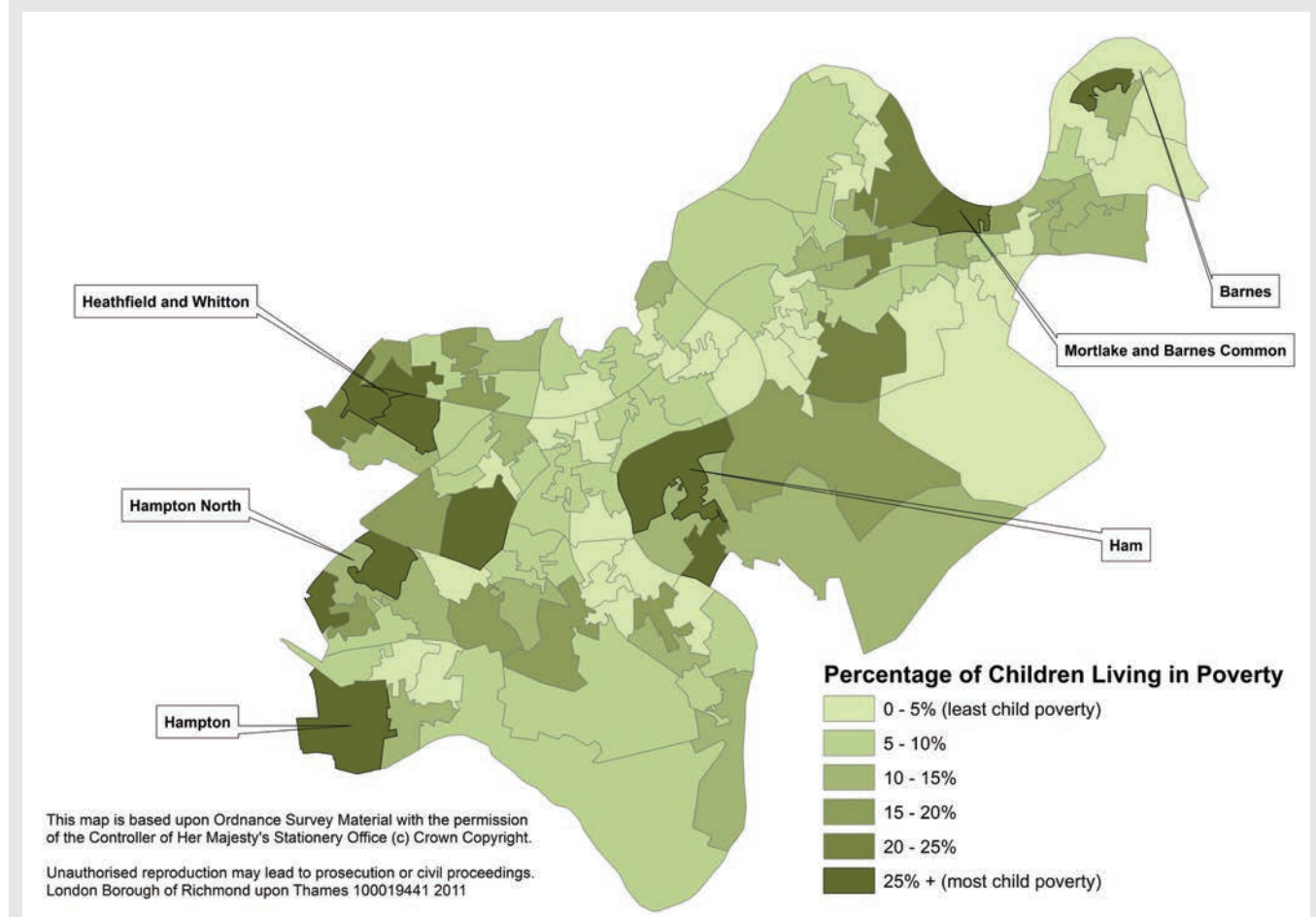


Source: Office for National Statistics, 2012; Public Health England, 2012; HM Revenue and Customs, 2008; Health and Social Care Information Centre, 2012; Commissioning Support Programme, 2011

## Early years: Advocacy and leadership for children

Borough-wide data can mask inequalities. For example, there is wide geographical variation in the percentage of children living in poverty. Although these data are for children of all ages, they clearly illustrate existing inequalities which affect the early years population. Estimates for the percentage of children living in poverty range from 1.1% to 43.7% between small areas (Lower Super Output Areas) in Richmond. There are 15 small areas within the borough that have above the national average level of child poverty (20.9%) and six areas that have above the London level (30.8%), see figure 3. These are co-terminus with areas of high social housing.

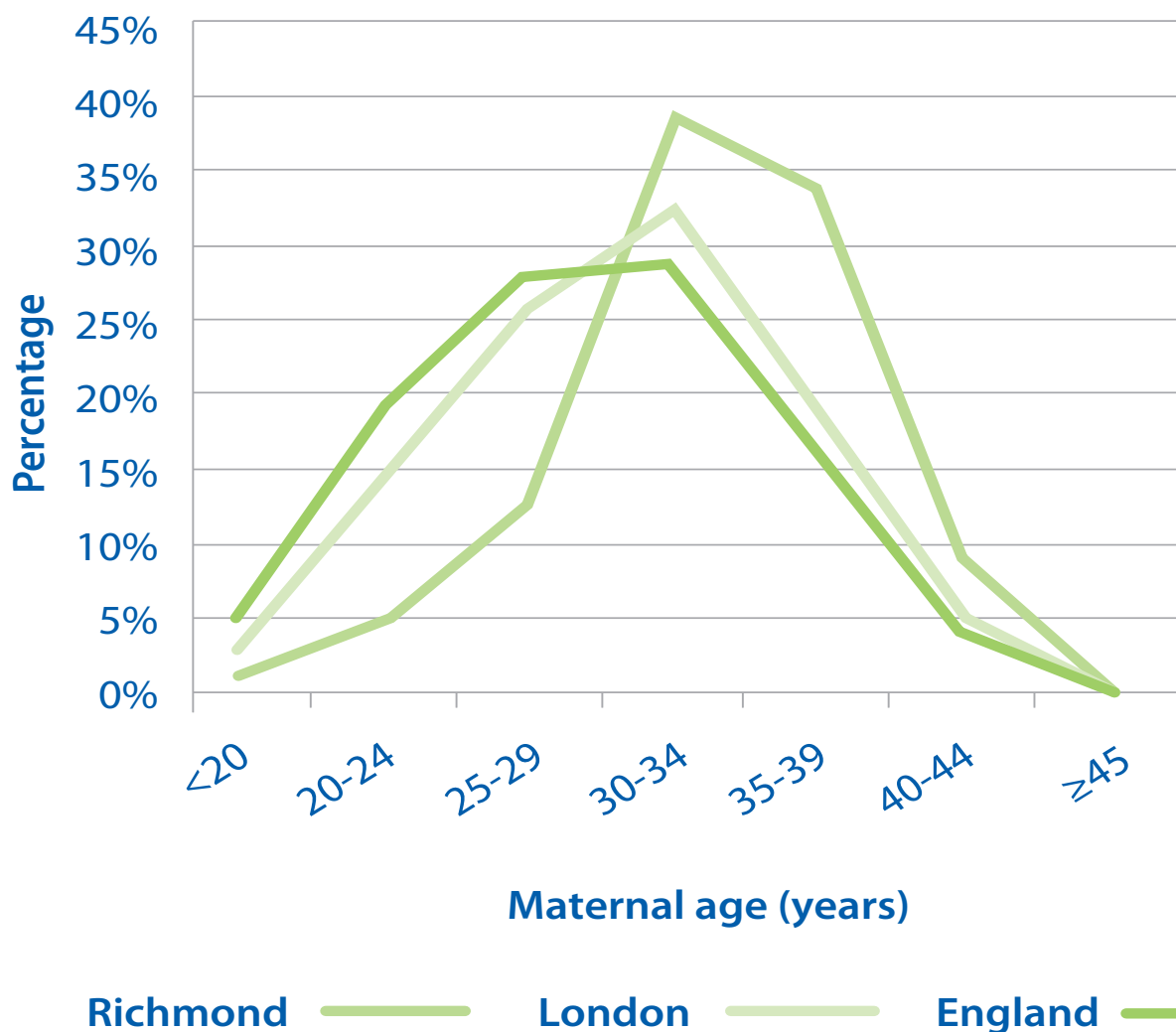
Figure 3: Proportion of children living in poverty, 2008



Source: HM Revenue and Customs, 2008

Young children in the borough can be affected by 'hidden' risks and harms. Firstly, there are local demographic factors which can be associated with increased risks. Around 19% of five year-olds (500 children) have English as an additional language, which can be a risk factor for increased speech and language needs. A higher maternal age can be associated with an increased risk of pregnancy-related complications such as high blood pressure and congenital abnormalities, e.g. Down's Syndrome. Richmond has a relatively high proportion of women who give birth over the age of 35 years (34% compared to 20% in London), see figure 4.

Figure 4: Age profile of mothers in Richmond compared to London and England, 2011



Source: Office for National Statistics, 2012

Secondly, children can be affected by ‘hidden’ risks and harms that relate to parental health and wellbeing, such as parental mental health problems and substance misuse. Applying national estimates to the local population, there are approximately 350 women per year with postnatal depression and there may be around 4,000 children under the age of five who are living with at least one binge-drinking parent. Between April 2011 and October 2012, a total of 87 children under the age of five were identified as living within families who had experienced domestic abuse. Almost 40% of active child protection plans (27 plans) are for children in this age group.

Despite these important health and wellbeing needs of young children, the health and wellbeing agenda in Richmond can be dominated by the needs of older people - with a lesser voice for children, parents and carers. Advocacy and leadership for children and their families should therefore be an ongoing priority.

## Prevention

The early years period is critical in a child's development. As stated in 'The Marmot Review':

*"The foundations for virtually every aspect of human development - physical, intellectual and emotional - are laid in early childhood".<sup>1</sup>*

A wealth of research has clearly shown that experiences early on in a child's life are likely to have impacts well into adult life.<sup>1,2,3</sup> These experiences can affect outcomes for the individual as well as for society as a whole. For example, around one-third of children who are obese at pre-school age will go on to be obese adults, and children who witness domestic violence are more likely to have relationship difficulties and emotional problems during adulthood.<sup>4,5</sup>

Primary prevention measures designed to promote and protect health, for example immunisations, and secondary prevention measures, such as interventions to reduce a child's weight, can be very effective in supporting children to reach their full potential during the early years period and can have long-lasting positive impacts. Early identification of potential problems and early intervention, for example speech and language therapy, can be crucial in preventing the further development of health and wellbeing problems. Although interventions at a later stage in life can also be important, they are likely to be less effective if good foundations are not already in place.<sup>1</sup> Due to the potential impacts on a wide range of health, wellbeing, education and economic outcomes, investment at an early stage in life is, therefore, highly cost-effective.<sup>3,6</sup> Examples of important prevention opportunities are outlined in the following sections.

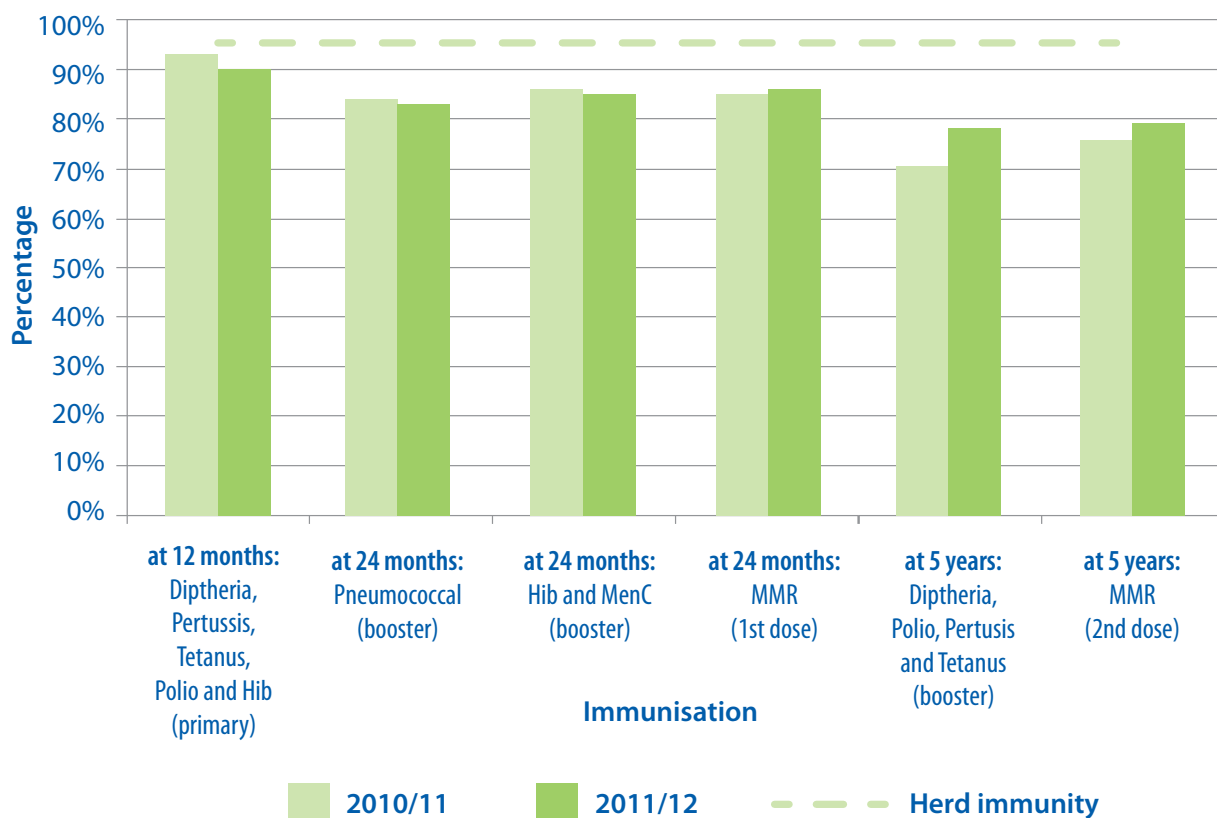
### Immunisations

The childhood immunisation programme plays a vital role in protecting children and their communities against common and potentially serious infections. Although NHS England is responsible for commissioning immunisation programmes, Public Health teams in Local Authorities are responsible for providing assurance on the immunisation programmes offered to their local population.

Childhood immunisation uptake in the borough is currently below the level needed to protect all local children and young people from a range of infectious diseases - known as 'herd immunity'. Local uptake of immunisations varies both between vaccines and years. While improvements can be seen for some vaccines over the past two years the uptake of other vaccines has reduced, see figure 5. Overall immunisation uptake remains below the level needed for herd immunity (95%) and more needs to be done to increase the proportion of children benefiting from the protection of these vaccinations.



Figure 5: Immunisation uptake at 1, 2 and 5 years in Richmond for 2010/11 and 2011/12



Source: Health Protection Agency COVER surveillance data, 2012 and 2013

One component of the childhood immunisations programme is the Measles, Mumps and Rubella (MMR) vaccine which should be given at age 13 months and again at pre-school age. Measles in particular is highly infectious and can spread easily amongst communities with low vaccination rates. There was a substantial decline in the uptake of the MMR vaccine across the UK in the late 1990s and early 2000s as a result of widespread concern around the now discredited link between MMR vaccination and autism.<sup>7</sup> Due to this decline in the uptake of MMR, there has recently been a substantial rise in the number of measles cases, with a record high of almost 2,000 cases in England during 2012. This is believed to be related to the high number of children now aged 10-16 years who did not receive an MMR vaccine during their early years.

In Richmond, there are estimated to be 2,400 children aged 10-16 years who have not received an MMR vaccine and who are therefore unprotected against these diseases.<sup>8</sup> Although there has only been one case of measles confirmed in the last year in Richmond Borough, the large number of unvaccinated children is a significant cause for concern. To ensure that this group of children are protected, NHS England commenced an MMR catch-up programme that was implemented locally over the summer of 2013. Unvaccinated and partially vaccinated 10-16 year olds were invited to receive the MMR vaccination through their GP practice.

## Breastfeeding

There is clear evidence that breastfeeding has positive health benefits for both mother and baby. For example, mothers who breastfeed have been shown to have a reduced risk of ovarian and breast cancer later in life. For the infant, breastfeeding is associated with a reduced risk of gastric and respiratory infections, obesity in later childhood and diabetes. Breastfeeding prevalence in Richmond is one of the highest in England, with over 90% of mothers initiating breastfeeding. However, this drops to around 71% at 6-8 weeks.

## Obesity

The prevalence of obesity has more than doubled in the UK in the last 25 years.<sup>9</sup> People who are obese as children are more likely to be obese in adulthood. Of those who are obese at pre-school age, research suggests that between 26% and 41% will go on to be obese in adulthood and will be at an increased risk of cardiovascular disease, some cancers and osteoarthritis.

Addressing obesity during early years is therefore an important prevention opportunity. The prevalence of obesity in children aged 4-5 years is significantly lower in Richmond than in London and England. However, there are still 140 children at this age in the borough who are obese and 240 who are overweight - and importantly the percentage of children who are obese doubles during their time at primary school. There are also inequalities in obesity and overweight prevalence within the borough. See the Environment chapter (four) for more information on it's link to obesity.

Figure 6: Overweight and obesity prevalence in Richmond children (age 4-5) compared to London and England, 2011-12



Source: Health and Social Care Information Centre, 2012

### Oral health

Oral health is an important part of a child's overall health, wellbeing and quality of life, enabling children to communicate effectively and to eat a varied diet. The majority of oral diseases are entirely preventable. Around one in six children entering school in Richmond has decayed, missing or filled teeth - approximately 430 five-year olds.<sup>10</sup> This measure compares positively with England where around one in four children has decayed, missing or filled teeth. Richmond has the lowest prevalence of dental decay in London. For the first time this year, the national Child Dental Health Survey will be carried out in special support schools. Previous surveys have suggested that there may be significant inequalities in oral health and this survey will help us to understand more about the oral health status of children with special needs in Richmond borough.

### Prioritising prevention

Despite clear evidence for the long-term and wide-ranging positive impacts of investing in prevention during early years, there are challenges with prioritising prevention. When there are limited resources, short-term gains may seem more attractive than long-term gains. This challenge of prioritising long-term gains from preventive interventions has increased recently because of austerity measures and planned reductions in public sector funding.

There may also be difficult choices to make between investing in universal prevention measures that are for the whole population (e.g. immunisations) and measures that are targeted at certain population groups (e.g. healthy eating schemes for deprived communities). Although evidence generally provides support for universal interventions to improve the health of all young children and to reduce inequalities, in populations like Richmond where outcomes are generally good and there are relatively low levels of deprivation, targeting some preventive measures rather than offering them to all may be a proportionate response in some cases.<sup>1</sup> This is known as 'proportionate universalism'.<sup>1</sup> The challenge is to achieve an appropriate and cost-effective balance of universal and targeted interventions.

Early years prevention must be central to the joint health and wellbeing agenda. Given the challenges outlined above, a collaborative approach to planning early years services is necessary to ensure that prevention measures are prioritised. With the establishment of 'Achieving for Children'<sup>1</sup> in Richmond and Kingston, good learning can be shared between the boroughs about different prevention initiatives. Responsibility for commissioning the Health Visiting service is also likely to move from NHS England to public health in 2015-16, which will provide a key opportunity to systematically embed sustainable, evidence-based preventive interventions which are relevant and effective for our local population.

<sup>1</sup> 'Achieving for Children' is a new integrated children's service being established between Kingston and Richmond Councils. It will be a local authority company jointly owned by the two boroughs and operating under the leadership of a joint Director of Children's Services. Achieving for Children will be in place by 1st April 2014.

## The way forward

Most interventions to improve health and wellbeing in the early years involve collaboration between a range of professionals and organisations. Partnership working and multi-disciplinary training for early years professionals are therefore important aspects of improving services.

### Multi-agency working

Multi-agency working is an important aspect of effective delivery for early years services. The 'Healthy Child Programme' provides a national framework for services from pregnancy upto age five. Although it is led by the health visiting service, it is delivered by a range of professionals including Doctors, Practice Nurses, Midwives, Community Nursery Nurses and Family Support Workers. A shared understanding of the roles, responsibilities and contributions of different professionals is needed, both by parents and by all professionals involved in the early years.<sup>11</sup>

Multi-agency working is particularly important in the early identification of potential development problems and provides the opportunity for practitioners to share their expertise and discuss their insight of a child's needs. Working together in partnership is particularly important at key transition stages through the life course, starting with pre-conception and pregnancy through early years, school age and adolescence into adult life.

There are significant national reforms planned for special educational needs support. One of the major changes proposed is to introduce a new single assessment process and an 'Education, Health and Care Plan', to bring together professionals from education, health and social care. This should help to improve multi-agency working for children, especially those with complex needs. It should also help to support the transition to adulthood, as it will be introduced from birth to age 25.

### Family focus

The family environment has a crucial impact on a child's development during the early years. There is good evidence for the effectiveness of family-focused interventions<sup>12</sup> and there has recently been a clear national policy shift from the individual to a more holistic, family-focused approach. Having a family focus is particularly important in identifying 'hidden' issues within a family that may put a child's development and wellbeing at risk, such as parental mental health problems or alcohol misuse. It can also be particularly important for addressing lifestyle issues, such as childhood obesity.

An example of a national programme to re-focus support around the family is the Troubled Families Programme. The aim of this programme is to work with families with complex issues and needs, for example non-attendance at schools and anti-social behaviour, and to work with the family as a whole. The Council has identified 156 families to work with over a three-year period. To date, positive outcomes have been achieved with 69 families. This is the best performance for the Troubled Families Programme in London and the fifth best in England. However, there are a larger number of families with complex needs outside of this programme who could potentially benefit from this 'team around the family' approach. Learning from this programme will be useful in informing longer term plans for a more comprehensive service for families with complex needs.

### Collaborative commissioning

Due to the recent NHS reforms, commissioning responsibilities for children's services have been divided between Local Authorities, Clinical Commissioning Groups (CCG) and NHS England, with input from Public Health England. This offers a new challenge for commissioners regarding clarity of roles and responsibilities and potential fragmentation of commissioning plans. However, the Public Health team, Richmond CCG and the Education and Children's Services Directorate are co-located and are working closely to ensure that commissioning plans are developed in a collaborative way. Local partners are also working closely with NHS England to ensure that the childhood immunisations programme and the health visiting service are being developed in appropriate ways for Richmond's population.

### Professional training

In addition to partnership working, robust training for early years professionals is paramount. Frontline professionals need relevant skills and knowledge so that they can provide advice and support to parents on healthy child development and identify additional needs or whether a child may be at risk. At a national level, many clinical staff do not have adequate training in child health.<sup>13</sup> Non-health professionals, for example, those working in education contribute significantly to the health and wellbeing of children during their early years, but often have minimal training in child health and development. Improving training for early years professionals is therefore crucial to improving health and wellbeing outcomes.

In general, Richmond's parents are relatively well-educated and rightly demand excellent services for their children. Early years professionals need to be equipped to respond to the particular challenges that this brings, including identifying and acting on hidden risks and harms.

Due to the wide-ranging and overlapping nature of services involved in early years, shared multi-disciplinary training is particularly important for this age group. This can help to share learning and perspectives, avoid conflicting advice and deliver a more integrated service to children and families.<sup>11</sup> It can also help to increase confidence in working with other professional groups.<sup>14</sup> An example of this is child safeguarding training, where multi-agency training has been shown to be effective in creating a shared understanding of good practice relating to assessments and decision making and in helping professionals to have a clear understanding of their respective roles.<sup>14</sup> During 2012-13, over 1,700 professionals in the borough attended multi-agency child safeguarding training. Attendance has increased following a recent safeguarding training review that resulted in a restructure of how professionals access training.

Richmond continues to support the development and implementation of early intervention training for early years professionals. In the past year, 54 front-line early years staff, including those from the health visiting service and Children's Centres, have been trained to identify domestic abuse and substance misuse. The workforce development team within the Local Authority continues to work across departments to find opportunities to deliver inter-agency training to all early years staff.

Another example of local efforts to improve training for early years professionals is breastfeeding training for Health Visitors. This was identified as an area for development by a local breastfeeding partnership group and a UNICEF Baby Friendly Initiative trainer from West Middlesex University Hospital was commissioned to deliver this. As of April 2013, 22 health visiting team members have been trained and are currently delivering weekly breastfeeding advice sessions at Children's Centres in the borough.

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# 2 Dementia





## Key messages

1

The ageing profile of the Richmond population, and in particular the increasing proportion that are over 80 years-of-age, means that the number of people with dementia living in the borough will increase.

2

People with dementia often have other health issues such as depression, diabetes and heart disease. Maintaining both the physical and mental health of people with dementia is vital to their quality of life and wellbeing.

3

In Richmond, as nationally, only about 50% of people with dementia currently receive a formal diagnosis. Early diagnosis of dementia adds value to people's lives when it allows them to plan and receive treatment and care earlier, and can prevent future crises. However, the pursuit of strategies that result in premature diagnosis of individuals with mild memory loss may lead to overtreatment and diversion of resources. To minimise such harm and maximise benefits the focus needs to be on a 'timely' diagnosis of dementia.

4

Families and friends rather than health and social care, bear the greater burden of caring for people with dementia. Support for carers is crucial to maintaining the quality of life of the person with dementia as well as the carer, and is a cost effective investment.

5

The overall financial costs of dementia care are significant and are projected to increase. Current investment in dementia care is often not deployed to best effect - being concentrated at the later stages of the disease. Local analysis suggests that further investment in preventative and community-based options that reduce unnecessary hospital admissions, and periods in hospital, could potentially achieve significant savings.

6

Health and social care are essential, but clearly not sufficient, in ensuring people are able to live well with dementia. The creation of 'dementia friendly communities', a nationally-led initiative, can be an important local focus for engaging all sectors of the community including businesses, public services and community groups to better understand dementia and support people in the early stages of the disease maintain their independence. This initiative challenges attitudes and can help overcome the stigma and isolation associated with dementia.

## Introduction

Dementia is an important challenge for health and social care in Richmond upon Thames, both currently and into the future. This chapter sets out the challenges that the disease presents to people with dementia, their carers, friends and families, the NHS and social care in the borough. It also highlights key messages to guide the development of services for people with dementia, their families and carers.

## Current level of dementia in the borough

In Richmond borough around 1860 people - which includes those not presenting to services or formally diagnosed - are estimated to be living with dementia. This estimate is based on the use of a dementia calculator.<sup>1</sup> This tool estimates the prevalence of dementia - the number of cases - by applying national dementia prevalence rates to the local population. It takes into account the number of elderly people living in residential homes and care homes.

Table 1 shows the estimated number of people with dementia living in the borough according to age and illness severity. A third of this group (around 600 people) are estimated to have a moderate level of dementia and 13% (around 230 people) severe dementia. The table demonstrates the pattern of increasing severity of dementia among people 80 years and over.

**Table 1:** Estimated cases of dementia in Richmond borough according to age and severity

Severity of dementia	Age in years								Total of cases	Percentage of cases
	<65	65-69	70-74	75-79	80-84	85-89	90-95	95+		
Mild	25	59	93	148	247	259	145	40	1016	54.7
Moderate	25	31	45	82	139	155	98	33	608	32.7
Severe	-	6	11	30	49	62	54	22	234	12.6
<b>Total</b>	<b>50</b>	<b>96</b>	<b>149</b>	<b>260</b>	<b>435</b>	<b>476</b>	<b>297</b>	<b>95</b>	<b>1858</b>	<b>100</b>

Source: NHS England and NHS South of England, 2012

Around one third of people with dementia are estimated to live in residential care settings and almost two thirds in private households in the community. Of those living in private households, one third are living alone.<sup>2</sup> Consequently in Richmond around 1430 people with dementia are estimated to live in the community (including around 480 living alone), and 430 in care homes.

## Living well with dementia

People with dementia often have other health issues, for example, depression, diabetes, heart disease, and respiratory conditions that impact on their quality of life, complexity of needs and service requirements.<sup>3</sup>

It is important that people with dementia have routine check-ups of their physical and mental health and can see healthcare professionals when they have concerns.

Local analysis shows around 71% of Richmond patients with dementia have three or more other chronic conditions, including depression, diabetes, heart disease and respiratory conditions, see table 2. Further information on this is highlighted in the multimorbidity chapter.

**Table 2:** Distribution of co-morbid dementia and other conditions among Richmond residents (GP population April 2013)<sup>i</sup>

Number of conditions <sup>ii</sup>	aged 65+		all ages	
	number	percentage	number	percentage
Dementia only	52	5	68	6
Dementia +1	81	7	103	9
Dementia +2	162	15	180	15
Dementia +3	810	73	840	71
<b>Total</b>	<b>1105</b>	<b>100</b>	<b>1191</b>	<b>100</b>

*Source: Based on Richmond Public Health analysis using SUS data and GP data extraction, 2013*

A recent national survey highlighted the impact of loneliness and social isolation on people living with dementia, particularly for those living alone.<sup>4</sup> Nearly two-thirds of people with dementia surveyed said they felt anxious or depressed. Of those living alone, nearly two-thirds reported feeling lonely. Difficulties in maintaining social relationships and other features of dementia contributed to this sense of isolation.

Health and social care are essential but clearly not sufficient in enabling people to live well with dementia. The national programme ‘dementia friendly communities’ is designed to help communities meet the needs of people with dementia. Richmond Council has recently provided funding to the Alzheimer’s Society to pilot a programme of dementia friendly activities that help people to live well with dementia and improve their quality of life. An initial pilot phase will inform the setting up of four community hubs that will develop dementia friendly activities throughout the borough, working in conjunction with a variety of services such as leisure centres and libraries.

<sup>i</sup> The analysis is based on revised coding criteria for dementia, and use of hospital data in addition to GP practice data. Therefore the figure of 1191 total patients with dementia is higher than the number on GP dementia Quality and Outcomes Framework (QOF) registers.

<sup>ii</sup> Including: congestive heart failure, hypertension, ischaemic heart disease, disorders of lipid metabolism, diabetes, hypothyroidism, asthma, COPD, chronic renal failure, bipolar disorder, schizophrenia, depression, Parkinson’s disease, seizure, age-related macular degeneration, osteoporosis, rheumatoid arthritis, low back pain, immune-suppression transplant, glaucoma.

## Avoiding unnecessary hospital usage

People with dementia are high users of hospital services.

Richmond has a higher level of hospital admissions rates for dementia compared to that for England. 91 per 100,000 Richmond population 65 years and over were admitted to hospital for dementia compared to 80 per 100,000 for the population 65 years and over for England as a whole. This is based on three year pooled data 2009/10 to 2011/12.<sup>5</sup>

The high level of chronic illness among people with dementia increases the risk of hospital admission. Reports nationally have repeatedly shown marked variation in quality and effectiveness of hospital provision for people with dementia.<sup>6,7</sup>

- The main reasons for admission to hospital for people with dementia are falls or fracture, urinary infection, chest infection and transient ischaemic attacks.
- People with dementia stay far longer in hospital than other people who are admitted for the same procedure.
- The longer people stay in hospital, the worse the effect on the symptoms of dementia and the individual's physical health, discharge to a care home becomes more likely and antipsychotic drugs are more likely to be used.

Most recently the Care Quality Commission reported that, in more than half of Primary Care Trust areas in the country, people with dementia living in a care home are more likely to go into hospital with avoidable conditions, such as urinary infections, dehydration and pressure sores, than similar people without dementia.<sup>8</sup> This national picture is reflected locally. Investigation of the Richmond care home population showed that hospital admissions were related to the same set of conditions.

## Costs of caring

Nationally, dementia care in the UK is estimated to currently cost the NHS, Local Authorities and families £23 billion a year (2012).<sup>4</sup> This is projected to grow to £27 billion by 2018 driven by the ageing profile of the UK population.

Table 3 shows the distribution of costs of care for people with different stages of dementia according to the provider of care.<sup>2</sup>

**Table 3:** Distribution of the percentage of annual costs of dementia care by provider <sup>2</sup>

Provider	Percentage of annual costs of care, per person, in the community			Percentage of annual costs, per person, in residential care
	Mild dementia	Medium dementia	Severe dementia	
NHS	15.0	9.4	7.0	4.3
Social services	29.6	24.0	20.7	1.2
Informal care	55.4	66.6	72.3	3.0
Accommodation	0.0	0.0	0.0	91.5
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>

Source: Alzheimer's Society, 2013

## Dementia: Costs of caring

Carers clearly bear the majority of the costs of caring. Furthermore informal carers rather than health and social care, bear the greater cost as patients move from relatively mild to more severe dementia.

However the level and distribution of cost alters substantially when people move from the community into a care home setting. It is estimated that 80% of people with dementia living in care homes have severe levels of the illness.

Locally, the costs relating to different social care services are not recorded by health diagnosis information. There is limited information on spending on dementia care by health services. National evidence indicates investment on dementia is often not deployed to best effect - being concentrated at the later stages of the disease.<sup>9</sup>

Local data on unplanned admissions to acute hospital of people with dementia over a 12-month period, up to February 2013, indicate that the top reasons for unplanned admission were urinary tract infection, pneumonia, and hip fracture. The total cost of these unplanned admissions of people with dementia was over £2.2 million. A proportion of these admissions is likely to be avoidable and could result in substantial cost savings.

## The importance of early diagnosis of dementia

Diagnosis of dementia, particularly in the early stage of the illness, enables individuals and their carers to benefit from early treatment and support services.

However there is considerable debate about what the focus on early dementia actually means, particularly given that GPs are being encouraged to undertake 'active case finding' among patients over 75 years (and high risk groups). It is important that policy and practice is evidence based.

In order to ensure that benefits of dementia diagnosis for individuals and their families are realised it is worth making a distinction between 'early' diagnosis and 'timely' diagnosis.<sup>10</sup> It is argued that 'timely' diagnosis is a better way of describing current policy and practice intention.

*'Timely' diagnosis 'suggests a person centred approach, does not tie the diagnosis to any particular disease stage and encompasses the fact that the person (and/or their families and carers) will gain benefit from the process.'*<sup>10</sup>

The term 'timely' diagnosis also recognises that there may be adverse consequences of a premature diagnostic process, for example anxiety experienced among individuals with mild memory problems.

Support to carers is critical to enabling the individual to live well with dementia and is cost effective. Carer support and counselling at diagnosis can reduce subsequent care home placement by 28%.<sup>11</sup> Access to anti-dementia medications can improve cognitive functioning and help reduce behaviours that carers can find challenging.

Such early interventions can improve independent living and avoid crisis and unnecessary admissions to hospital as well as delay entry to long term nursing home care.<sup>12,13</sup>

## Dementia: The importance of early diagnosis of dementia

It is important to be clear that early diagnosis is not about implementation of population 'screening' for dementia. The introduction of screening programmes in the UK has always required an evaluative framework showing that benefits outweigh costs including the potential harm relating to over-diagnosis and over treatment. As yet such evidence for dementia screening is lacking.

In Richmond, approximately 46% of those estimated to have dementia have received a formal diagnosis. Table 4 shows the actual numbers of people who have been formally diagnosed with dementia in Richmond and are on GP dementia registers compared with the estimated prevalence. Currently 870 people with dementia are on GP Quality & Outcomes Framework dementia registers compared to the estimate of 1,858 people.

**Table 4:** Calculating the dementia diagnosis rate in Richmond

Estimated prevalence of dementia	Number (percentage)
Living in the community	1433
Living in Residential Care	425
<b>Total</b>	<b>1858</b>
<b>Diagnosed</b>	<b>870 (46)</b>
<b>Diagnosis gap - undiagnosed</b>	<b>988 (54)</b>

*Source: Dementia calculator NHS Commissioning Board/NHS South of England, 2012*

This Richmond dementia diagnosis rate is similar to England. There is significant variation in dementia diagnosis rates across the London boroughs, the highest being Islington with a diagnosis rate of 69%. Such variation shows that there is considerable potential for improving the rate of dementia diagnosis.

There is significant variation in diagnosis rate across general practices in Richmond. This variation may in part be due to some differences in actual numbers of people with dementia and influenced by the presence of nursing homes. The variation may also be due to coding of dementia and recording processes. This disparity in coding and recording processes is evident nationally. A recent analysis based on revised coding - undertaken by Richmond Risk Stratification Project - identified additional numbers of patients with dementia, see table 2. This work will provide more accurate and improved dementia diagnosis rates.

General practice also has an important role in identifying and assessing the health needs of carers of people with dementia. Carers of people who have dementia are particularly vulnerable to experiencing psychological distress and depression as well as having chronic physical illness.

Locally, the Richmond Wellbeing Service - a primary mental health service - is now promoting their services to carers through GPs and carers support organisations. Carers who are experiencing depression and anxiety are able to refer themselves directly to this service.

## The way forward: focusing on quality

The National Dementia Strategy and Prime Minister's challenge, in conjunction with the local context, are key drivers for action in Richmond. Richmond's Health and Wellbeing Strategy and Out of Hospital Strategy provide the local framework for moving forward.

Our strategy commitments recognise that there is considerable scope to improve the quality of services for people with dementia and their carers. Delivery is dependent on an integrated approach to commissioning to health and social care and across the care pathway.

The National Institute for Health and Care Excellence (NICE) standards describe high-priority areas for quality improvement in supporting and caring for people with dementia, and along with guidance inform a pattern of investment in dementia care that is cost effective and affordable.<sup>14,15</sup> Use of these quality standards by commissioners, providers and patients will be important in assessing whether high quality services for people with dementia are being delivered in Richmond, see table 5.

**Table 5: NICE Quality Standards for people with dementia (2010, 2013)**

People with suspected dementia are referred to a memory assessment service specialising in the diagnosis and initial management of dementia.
People with dementia are enabled, with the involvement of their carers, to take part in leisure activities during their day based on individual interest and choice.
People with dementia are enabled, with the involvement of their carers, to access services that help maintain their physical and mental health and wellbeing.
Carers of people with dementia are offered an assessment of emotional, psychological and social needs and, if accepted, receive tailored interventions identified by a care plan to address those needs.
People with dementia who develop non-cognitive symptoms that cause them significant distress, or who develop behaviour that challenges, are offered an assessment at an early opportunity to establish generating and aggravating factors. Interventions to improve such behaviour or distress should be recorded in their care plan.
People with suspected or known dementia using acute and general hospital inpatient services or emergency departments have access to a liaison service that specialises in the diagnosis and management of dementia and older people's mental health.
Carers of people with dementia have access to a comprehensive range of respite/short-break services that meet the needs of both the carer and the person with dementia.

Source: National Institute for Health and Clinical Excellence, 2011

## Dementia: The way forward

Richmond's joint commissioning plans include important developments in services for people with dementia and their carers that will help achieve the NICE dementia quality standards and outcomes.

In response to the Prime Minister's challenge on dementia 2012 Richmond has set a dementia diagnosis rate target of 65% for 2015, see table 6.

**Table 6:** Planned increase in dementia diagnosis rate in Richmond

	Year				
	2011/12	2012/13	2013/14	2014/15	2015/16
Diagnosis rates	46.8%	51.4%	55.9%	60.5%	65.0%
Number of patients diagnosed with dementia	870	977	1087	1200	1316

*Source: NHS England and NHS South of England, 2012*

The implementation of the strategy offers a package of investment which is designed to release some resources, particularly from the acute sector, to fund services in other health and social care settings. There is potential for achieving cost savings from reducing unplanned hospital admissions and length of stay in hospital.



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# 3 Multimorbidity



## Key messages

1

The ageing population in Richmond as elsewhere means that having multiple rather than a single long-term condition will become the norm. Long-term conditions can often interact with each other resulting in an increase in the complexity of care.

2

It is especially important to recognise the common co-existence of physical and mental health conditions as outcomes for each are worsened when they occur together.

3

There is a need for policy makers, commissioners and providers of services to move away from traditional single disease pathways, typical in current care models. Instead there needs to be a shift towards recognising multimorbidity as a condition in its own right.

4

Tackling multimorbidity will require a holistic approach where patients, carers and professionals work together with the aim of optimising wellbeing and quality of life rather than treating single diseases. Locally the work on integrating health and social care services is putting this approach into practice.

## Introduction

Multimorbidity is usually described as the co-existence of two or more long-term conditions in an individual.<sup>1</sup> This chapter highlights the patterns of multimorbidity in patients registered with Richmond GP practices, and the challenges faced by the health and social care system in moving from the current single disease management approach, for example, a diabetes pathway of care, to a more integrated model of care.

## Profile of multimorbidity

### Population projections

Approximately 198,500 people were registered with a Richmond Clinical Commissioning Group (CCG) general practice as at April 2013 and the majority, around 90%, also live in the borough.

The number of people living in the London Borough of Richmond upon Thames is expected to grow by approximately 3,000 each year between 2013 and 2018. The expected overall increase for this period in those aged 65 years and above is 2,800 (10%). Residents are also living longer with an overall life expectancy at birth of 82 years for men and 86 years for women.

The combination of an ageing population and increasing life expectancy means that the number 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<sup>i</sup> - will increase.

### Multimorbidity and age

A local analysis<sup>ii</sup>, using GP and hospital data, of the Richmond CCG registered population shows that nearly one in three had one or more long-term condition and nearly one in ten had three or more, see table 7. Strikingly, the number of people with three or more long-term conditions increases from 4% in people under the age of 65 to 44% in those over the age of 65.

**Table 7:** Number and percentage of people with multimorbidity, 2013

Number of people with one or more long-term conditions	Number	Percentage of the corresponding population
Aged < 65 years	41,000	24
Aged > 65 years	22,000	81
<b>Total</b>	<b>63,000</b>	<b>32</b>
Number of people with three or more long-term conditions	Number	Percentage of the corresponding population
Aged < 65 years	6,600	4
Aged > 65 years	12,000	44
<b>Total</b>	<b>18,600</b>	<b>9</b>

*Source: Based on Richmond Public Health analysis using SUS data and GP data extraction, 2013*

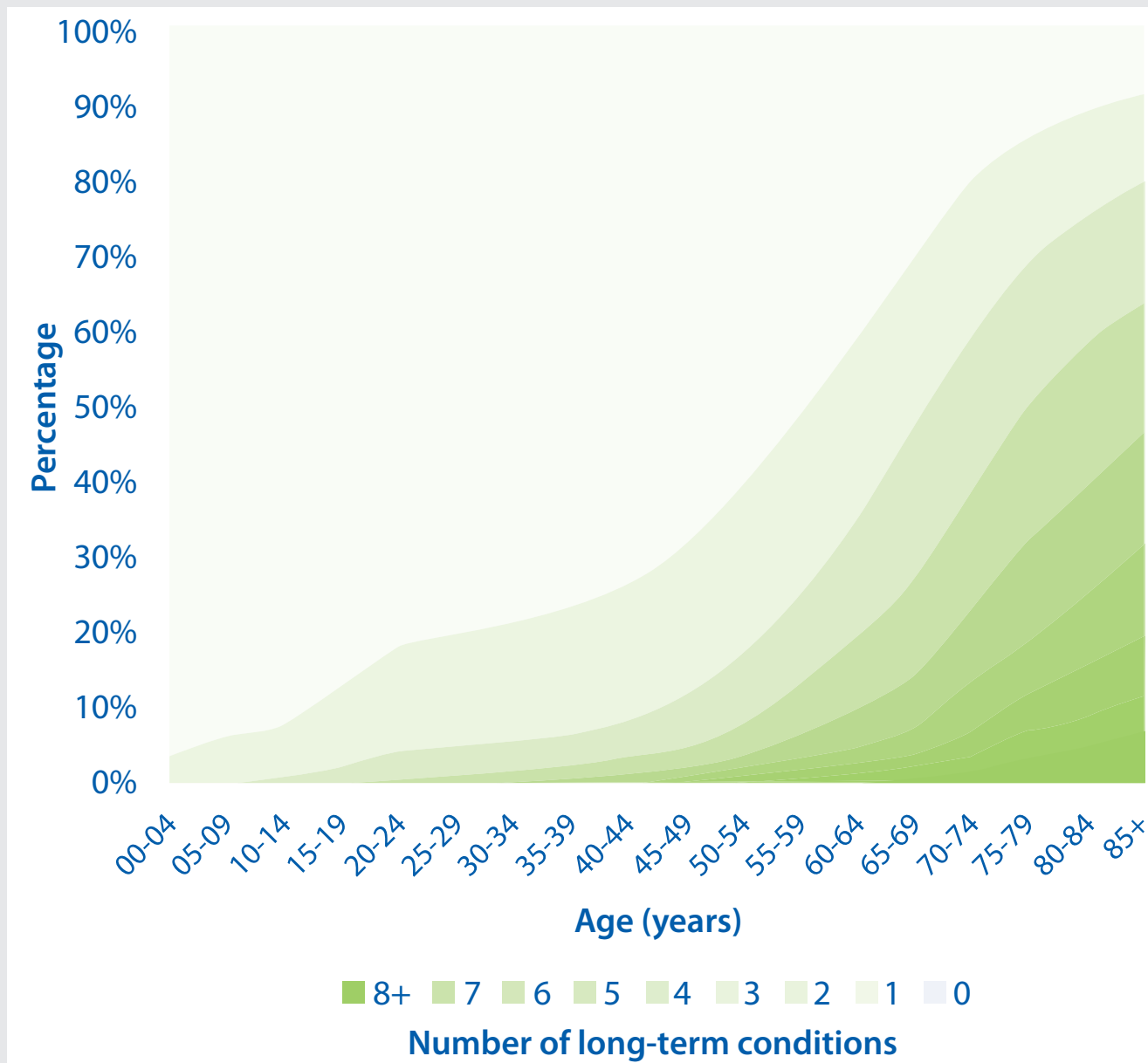
<sup>i</sup>Long term physical and mental health conditions included in this report: congestive heart failure, hypertension, ischaemic heart disease, disorders of lipid metabolism, atrial fibrillation, stroke, cancer, diabetes, hypothyroidism, obesity, asthma, chronic obstructive pulmonary disease (COPD), chronic renal failure, bipolar disorder, schizophrenia, anxiety, depression, Parkinson's disease, seizure, multiple sclerosis, age-related macular degeneration, osteoporosis, rheumatoid arthritis, low back pain, gout, glaucoma, diabetic retinopathy.

<sup>ii</sup>Analysis conducted on data up until March 2013.

## Multimorbidity: Profile of multimorbidity

This well recognised association of multimorbidity with age is illustrated by figure 7. However, a large number (6,600) of those with three or more long-term conditions, one in three people, are younger than 65 years. This suggests that health and social care interventions should not be restricted to older age groups.

Figure 7: Number of long-term conditions by age, 2013

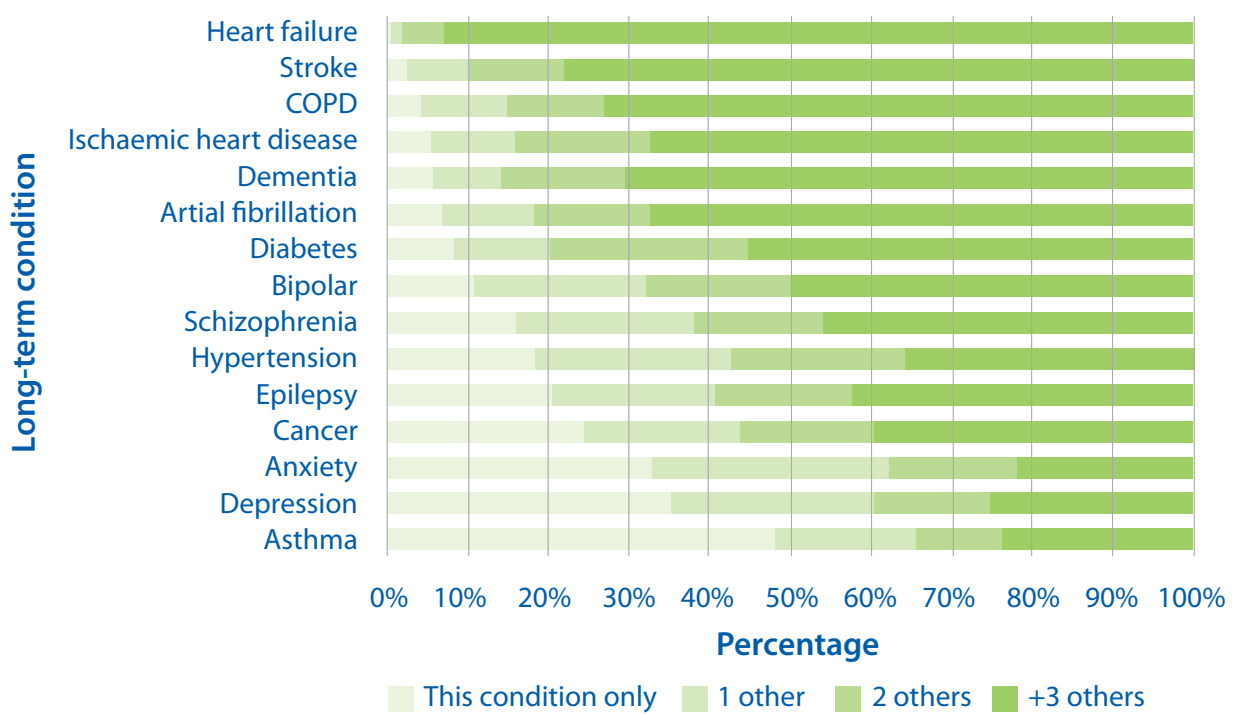


Source: Based on Richmond Public Health analysis using SUS data and GP data extraction, 2013 (n=198,500)

### Multimorbidity is the norm

The percentage of people with at least one other long-term condition varies depending on the long-term condition, see figure 8. The highest is heart failure - 93% of those with heart failure have three or more long-term conditions, compared with 23% of those with asthma. For most people living with any one of the long-term conditions listed, multimorbidity is the norm.<sup>2</sup>

Figure 8: Percentage of patients who have other long-term conditions, 2013



Source: Based on Richmond Public Health analysis using SUS data and GP data extraction, 2013 (n=198,500)

## Multimorbidity: Profile of multimorbidity

Nearly 32,000 of the Richmond CCG registered population have a heart condition (including congestive heart failure, hypertension, ischaemic heart disease, disorders of lipid metabolism and atrial fibrillation). Around 12,000 suffer from chronic respiratory disease, for example, asthma or chronic obstructive pulmonary disease (COPD). Joint pain caused by musculoskeletal problems such as, rheumatoid arthritis, low back pain, and gout, affects some 13,000 patients, see table 8.

**Table 8:** Number and rate per 10,000 population of some of the major long-term physical and mental health disease areas

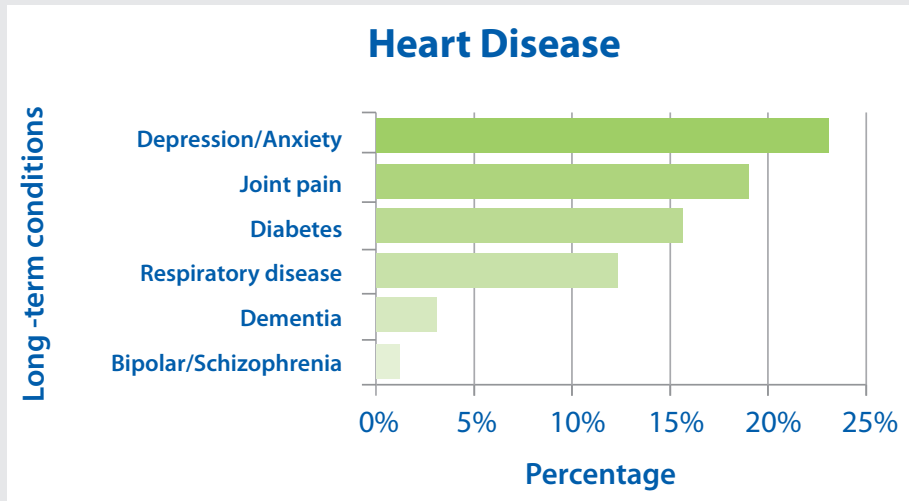
Long-term condition	No. of patients	Rate per 10,000
Heart disease	31,706	1,597
Respiratory disease	11,758	592
Diabetes	5,840	294
Joint pain	12,880	649
Dementia	1,191	60
Depression/Anxiety	20,023	1,009
Bipolar/Schizophrenia	861	43

*Source: Based on Richmond Public Health analysis using SUS data and GP data extraction, 2013 (n=198,500)*

### Physical health and mental health

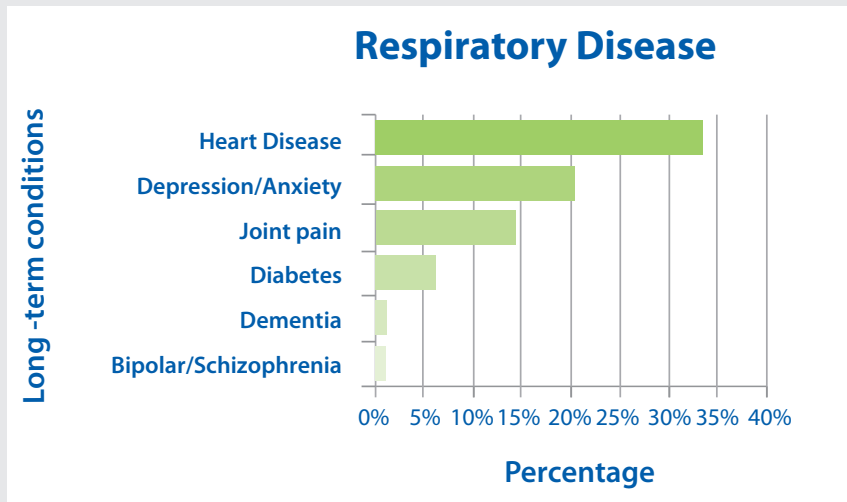
One in 10 of the population in Richmond suffers from minor mental health problems such as depression and anxiety. Some 25% of heart disease patients experience depression and/or anxiety - figure 9a - while similar levels of mental health problems are seen in patients suffering from respiratory illness - figure 9b - diabetes - figure 9c - or joint pain - figure 9d. Forty percent of dementia patients also have depression/anxiety problems - figure 9e.

Figure 9a: Proportion of patients with heart disease affected by other chronic diseases



Source: Based on Richmond Public Health analysis using SUS data and GP data extraction, 2013 (n=198,500)

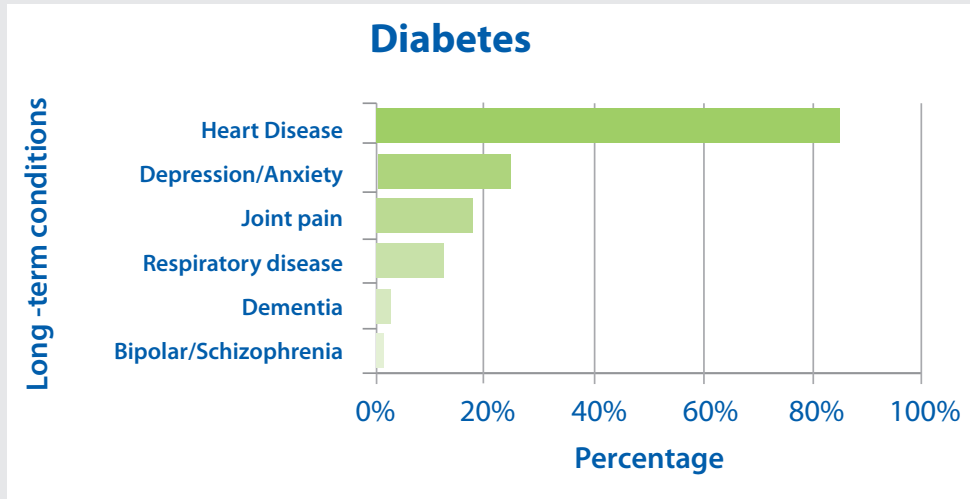
Figure 9b: Proportion of patients with respiratory disease affected by other chronic diseases



Source: Based on Richmond Public Health analysis using SUS data and GP data extraction, 2013 (n=198,500)

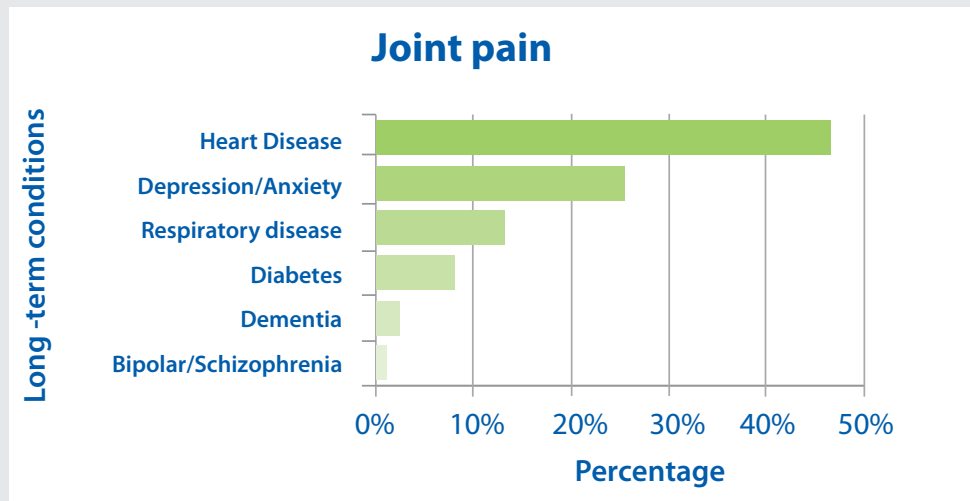


Figure 9c: Proportion of patients with diabetes affected by other chronic diseases



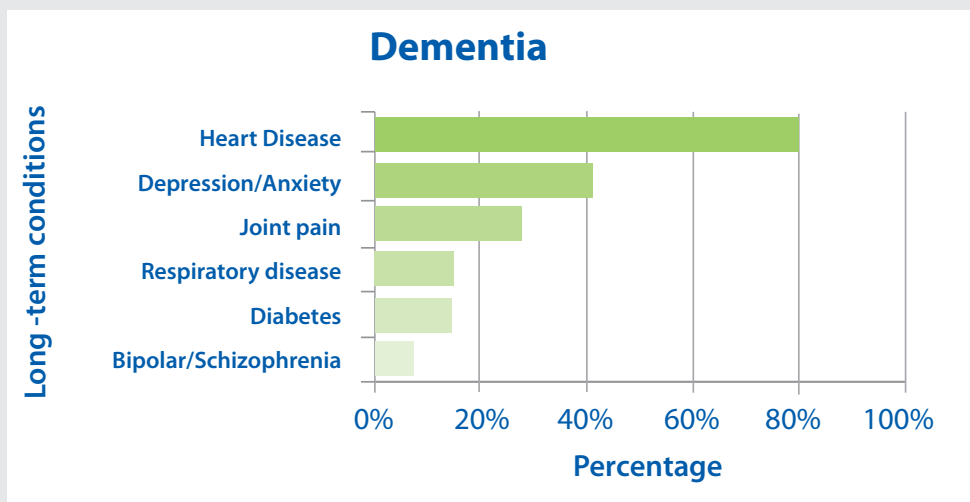
Source: Based on Richmond Public Health analysis using SUS data and GP data extraction, 2013 (n=198,500)

Figure 9d: Proportion of patients with joint pain affected by other chronic diseases



Source: Based on Richmond Public Health analysis using SUS data and GP data extraction, 2013 (n=198,500)

Figure 9e: Proportion of patients with dementia affected by other chronic diseases

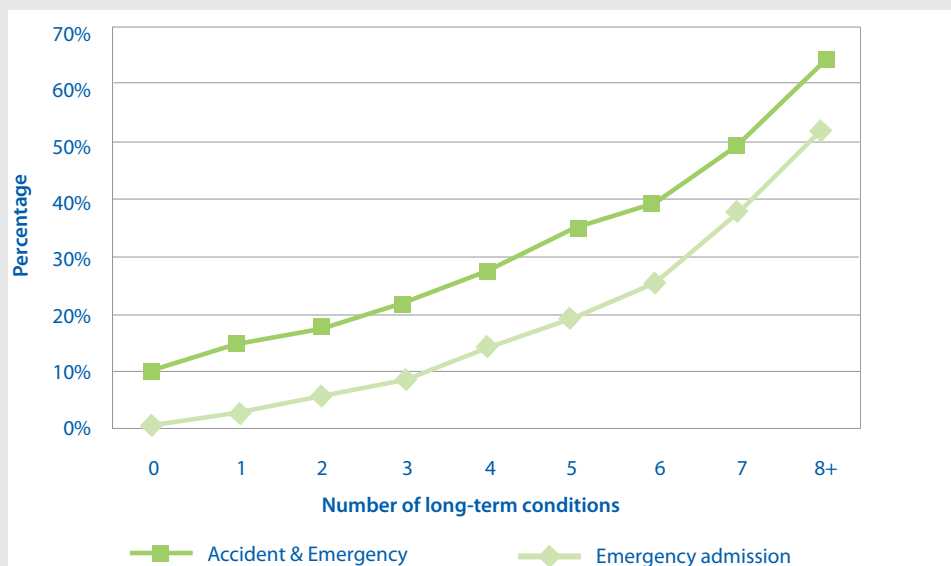


Source: Based on Richmond Public Health analysis using SUS data and GP data extraction, 2013 (n=198,500)

## Accident and Emergency attendances and emergency hospital admissions

The percentage of people attending Accident and Emergency (A&E) or an emergency hospital admission at least once in one year rises steeply with increasing numbers of long-term conditions, see figure 10.

Figure 10: Percentage of patients who attend A&E or had an emergency hospital admission (EM), 2013



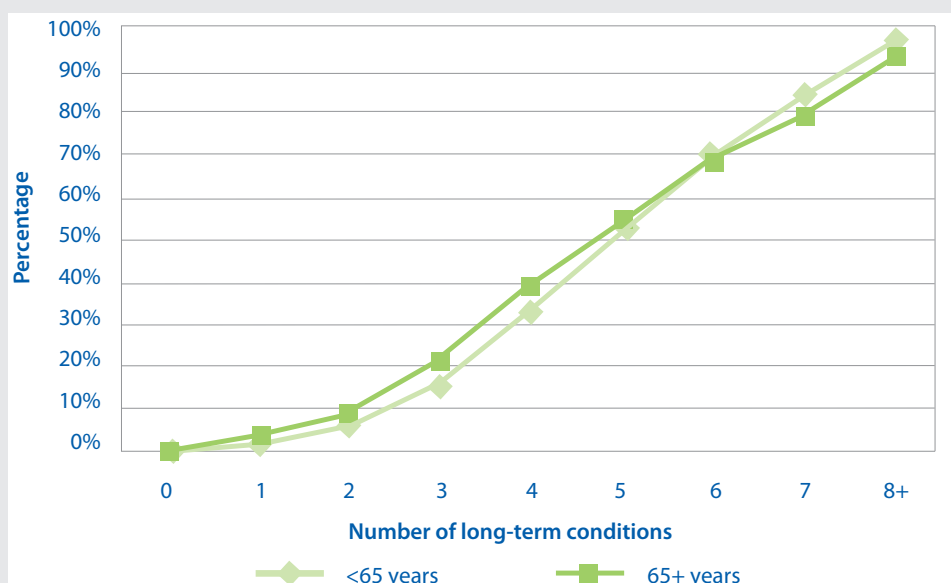
Source: Based on Richmond Public Health Analysis using SUS data and GP data extraction, 2013 (n=198,500)

In 2012/13, 27,000 registered patients had at least one A&E attendance and 7,100 had at least one emergency hospital admission. However, it is the small proportion of individuals with 3 or more long-term conditions (9%) that account for over a quarter (26%) of A&E attendances and more than half (54%) of all emergency admissions.

## Use of medicines

The percentage of patients with more than 10 unique prescriptions per year rises sharply with increasing multimorbidity, see figure 11.

Figure 11: Percentage of patients over 65 years and under 65 years who had more than 10 unique prescriptions per year, 2013



Source: Based on Richmond Public Health Analysis using SUS data and GP data extraction, 2013 (n=198,500)

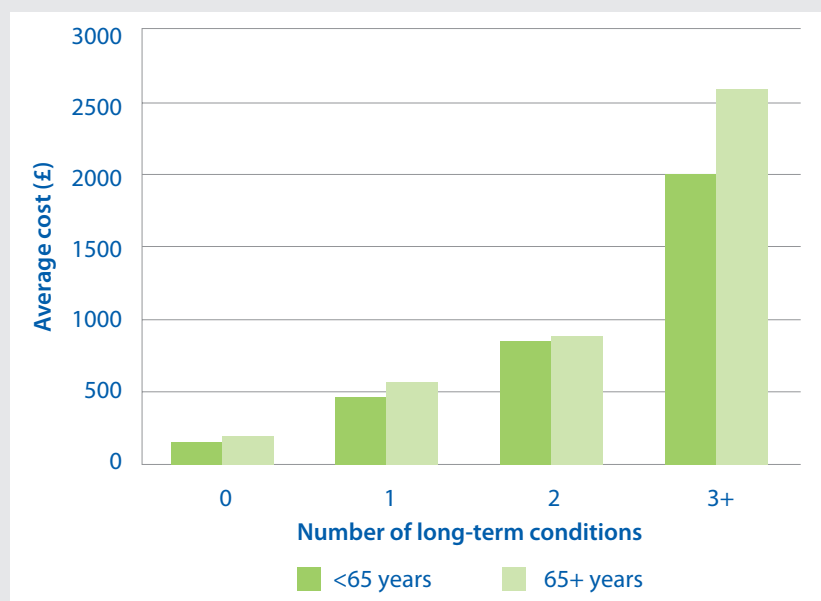
## Multimorbidity: Profile of multimorbidity

Appropriate use of medicines is particularly important for those with multimorbidity since these patients will often be on multiple medications - polypharmacy. Polypharmacy can be appropriate for patient care, but it is associated with riskier prescribing and is often particularly problematic in people who are physically frail or have cognitive impairment. Polypharmacy is an extremely strong predictor of A&E attendance and hospital admission, partly due to adverse drug reactions.

### Spend on community prescribing and acute hospital care

The average community prescribing and acute hospital spend on a patient in one year increases with multimorbidity, see figure 12. For example, the average payment by results tariff expenditure in one year for a patient age 65 or over with two long-term conditions is £900 compared with £2,600 for a patient with three or more long-term conditions.

Figure 12: Average acute hospital cost using Payment by Results tariff and community prescribing cost, 2013



Source: Based on Richmond Public Health Analysis using SUS data and GP data extraction, 2013 (n=198,500)

### Interaction of physical and mental health

Mental health problems are one of the most common forms of co-morbidity. This is well illustrated in the profile of multimorbidity in Richmond as set out in the previous sections. Research also suggests that this is particularly the case in populations from the poorest socioeconomic groups who are more likely to develop multimorbidity at a younger age and to have greater mental health problems compounding difficulties in their management.<sup>3</sup>

The coexistence of both physical long-term conditions and mental health problems such as anxiety and depression is particularly important since the prognosis for the physical condition and quality of life can deteriorate markedly.<sup>3</sup> In addition, the costs of providing care to this group of people are increased as a result of less effective self-care and other complicating factors related to poor mental health.<sup>3</sup>

Improving the way we support an individual with both physical and mental health problems would have a high impact in terms of patient experience and clinical outcomes, since both of these outcomes are substantially poorer relative to those for people with a single condition.<sup>4</sup> Integrated models of disease management have been found to deliver savings four times greater than the investment required,<sup>5</sup> and there are now models of liaison psychiatry in acute hospitals.<sup>4</sup>

## The way forward

### Moving away from single disease models of care

Currently, health services and health policy are largely organised around single diseases and do not often take multimorbidity into account, despite the evidence that many people have more than one long-term condition.<sup>6</sup> Increasing sub-specialisation and the decline of generalism in hospital settings can create a lack of co-ordination and oversight of patients' multiple needs.<sup>7</sup> These impact greatly on the wellbeing of patients and their carers.

Multimorbidity needs to be treated as an entity in itself. There is a clear need for integrated care of multiple conditions within the health care system. Recent work to understand pathways for diabetes, neurological conditions, and dementia has highlighted potential for integration and multidisciplinary approaches to health care. Furthermore, the needs of younger patients with multimorbidity are likely to be different and include problems related to employment and absenteeism.<sup>8</sup>

Prevention and self care services, such as LiveWell Richmond, which support healthy lifestyle, are crucial in the prevention and lifestyle management of long-term conditions, helping individuals to reduce the risk of developing complications. Interventions such as ensuring regular reviews of medication use, particularly for those with multimorbidity, are hugely important in helping to prevent complications and reduce need for urgent care services.

The number of carers and the burden on carers is likely to increase as multimorbidity increases and new pathways will need to address this.

### An integrated model of health and social care

A better understanding of the epidemiology of multimorbidity is necessary in order to develop interventions to prevent it, reduce its burden, and align health and social care services more closely with the needs of patients and their carers.<sup>2</sup>

Predictive risk tools combined with clinical expertise have been shown to be an effective way of identifying people who are at high risk. In Richmond in 2012/13, we successfully used such a tool.<sup>9</sup> Through the Richmond (virtual) Community Ward the tool was used to identify people at high risk of unplanned hospital admission, and provide a multidisciplinary health and social care community ward service for these patients. Being able to identify those people most at risk of beginning high-cost care so that they might be offered intensive 'upstream' preventive care and support will promote independent living and be more cost-effective.

The London Borough of Richmond upon Thames and Richmond CCG are jointly using risk stratified data in innovative ways to help inform development of our local dementia, diabetes, neurological, COPD and other care pathways. These care pathways explicitly address patterns of multimorbidity and acknowledge the need for carers, health professionals and social care workers to work together to optimise wellbeing rather than just cure disease alone. For instance, care for large numbers of people with both long-term conditions and mental health problems can be improved by better integrating mental health support with primary care and chronic disease management programmes. Closer working between mental health specialists and other professionals are crucial to enabling this.<sup>3</sup>

Both integration of mental health and physical health, and integration of health and social care are key priorities of Richmond's Health and Wellbeing Strategy for 2013-16.

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# 4 Environment



# Key messages

1

The environment in which we live and work has a fundamental impact on our health and wellbeing. In Richmond, residents benefit from a range of rich environmental assets such as high quality parks, sport and leisure facilities and access to the River Thames and wetlands. It is these assets that enable and encourage the high level of sport and physical activity participation reported in the borough. Preserving these and other health enhancing environmental characteristics is crucial if we are to continue to support residents to stay healthy.

2

There is considerable synergy between wider efforts to reduce impacts on the environment and healthy lifestyles. This gives more strength to both arguments. For example, infrastructure schemes that assist in the greater take-up of travel options such as cycling and walking reduce energy consumption, improve air quality and at the same time make healthy lifestyle choices easier.

3

Forging new relationships between Public Health, the Environment Directorate and partners such as Transport for London, is one of the exciting opportunities that the move of Public Health from the NHS into Local Authority has brought. By working in collaboration we can systematically 'spot opportunities for health' and ensure that we do everything possible to maximise the impact of the physical environment.

4

In progressing opportunities to maintain and enhance our environmental assets we will need to understand, explore and manage the practicality of change, striking a balance between competing priorities. For example, while the presence of fast food outlets ensures that high streets offer a diverse range of eating options, a proliferation of them near to schools can attract young people and encourage unhealthy food choices. It is being explicit about potential trade-offs that allows informed decision-making.

## Introduction

The importance of the physical environment on health is well known, including its influence on healthy lifestyle choices. The London Borough of Richmond upon Thames is well-maintained, attractive and has lots of parks and open spaces, offering an environment which is highly valued by its residents.

As the scope of the environment's impact on health is extensive, this chapter focuses only on a few topics, opportunistically selected because of the potential for developing new partnerships and projects. Long-standing joint work, for example with licensing, trading standards and housing remain important but are not covered in this chapter.

## Protecting and developing the borough's environmental assets

### Natural spaces

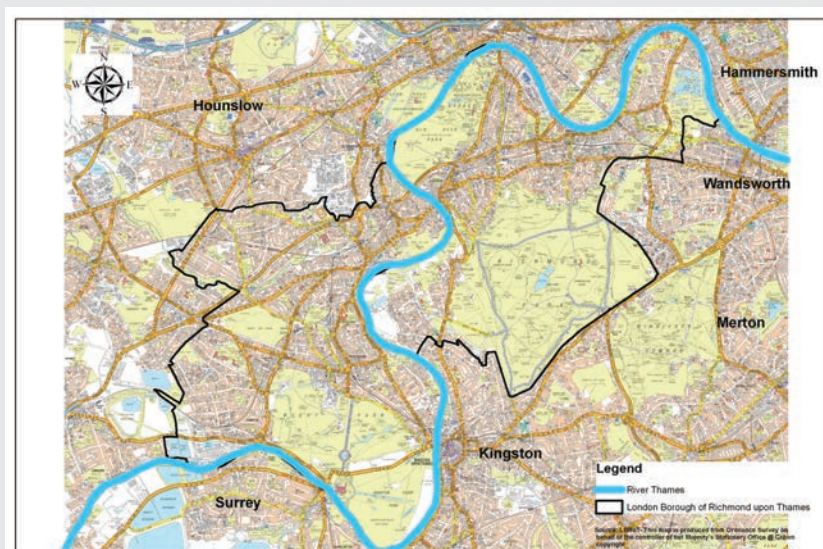
Natural space enhances health and wellbeing by providing: areas of relative tranquillity, which can help with relaxation and stress relief; trees and vegetation, which reduce ambient noise and provide a calming environment; and by providing spaces that facilitate play, recreation and leisure, and physical activity opportunities.<sup>1</sup>

### Green space

Over one third of the area of the borough is open space. With a population of 187,000 this amounts to 11.6 hectares of green space per 1,000 population. Some of Richmond's open spaces are world renowned, for example Richmond Park National Nature Reserve, Kew Gardens and the historic landscapes along the River Thames.

There is also an extensive network of smaller open spaces and green routes in the borough. There are 21 parks and green spaces that hold the accolade of green flag status, achieving exceptional quality standards. Richmond's outdoor spaces are regularly used for a wide range of activities. They have a key role to play in facilitating some of the highest levels of sport and physical activity participation in England: 68% of adults in Richmond achieve the Chief Medical Officer's recommendation of participating in 150 minutes of physical activity a week. Local green space is deeply cherished by residents,<sup>2,3</sup> making it a key asset that benefits the health and wellbeing of local people.

Figure 13: A map of parks and green spaces in Richmond upon Thames



Source: London Borough of Richmond upon Thames, 2013



## Environment: Protecting and developing the Borough's environmental assets

First discovered in the borough in 2006, the Oak Processionary Moth (OPM) is classified as a tree pest and is known to inhabit local oak trees, see figure 14. As well as damaging the health of oak trees, at certain stages of its life cycle the moth's fine hairs, which can be wind carried, can cause itching skin lesions, sore throats and eye problems.<sup>4</sup>

Since their discovery, there has been an extensive national and local programme of action to control the spread of the moths on public land. As a result, the risk of exposure to the hairs is considered to be low. National research is currently underway and continues to evaluate the potential harm of the OPM to the public.

Figure 14: The Oak Processionary Moth



Source: Environment Agency, 2013

## Blue space

In addition to green spaces, residents also benefit from a rich wetland landscape and access to the River Thames, towpaths and the surrounding natural environment. These environments offer a range of leisure and recreational opportunities such as bird watching, fishing, kayaking, mass participation swimming events, as well as access to sports of historical significance to the area such as rowing and sailing. All of these activities and the many other leisure and recreation past-times that take place in our blue space offer benefits to both health and wellbeing.

In order to maximise the considerable potential of the River Thames for enhancing the health and wellbeing of residents it is essential that all River users practice good personal hygiene, and that where swimming does take place i.e. through mass participation events, swimmers should use non-tidal parts of the river.

This is because research shows that the 1.5% of the local population regularly using both tidal and non-tidal parts of the river to participate in rowing and canoeing are exposed to an increased risk of gastrointestinal tract illness (GI).<sup>5</sup> In addition, in October 2012, at least 30% of participants in a large swimming event - hosted from Hampton Court in the non-tidal part of the Thames - experienced GI after the event.<sup>5</sup> By addressing issues of personal hygiene as part of the 2013 event no swimmers experienced GI.

In the longer-term, improvements to water quality in the tidal part of the Thames will be secured through the proposed Thames Tideway initiative, a significant project that will improve the capacity of London's sewerage system thereby reducing the incidence of sewer overflows discharging into the River Thames.

## Noise

Noise permeates everyday life. A loss of hearing is the most common consequence of being regularly exposed to a noisy work place or social environments. However, there is growing evidence that exposure to noise can also lead to: annoyance, anger, stress and sleep disturbance, as well as an increase in the occurrence of hypertension and cardiovascular disease and impaired educational performance in school children.<sup>6</sup>

This impact on health has further repercussions. A recent study of exposure to aircraft noise in London boroughs near to Heathrow airport reported that high levels of aircraft noise is also associated with an increased risk of both hospital admissions and mortality from stroke, coronary heart disease, and cardiovascular disease.<sup>7</sup>

Estimates indicate that in Richmond about 12.5% of the population are exposed to road, rail and air transport noise of 65dB or more during the daytime. At night, about 18.6% of the population are exposed to road, rail and air transport noise of 55dB.<sup>8</sup> For these indicators the borough is the 16th and 15th highest respectively among the 33 London boroughs.

Estimates also suggest that 7.8 complaints per 1000 population are received each year about noise, it is likely that these complaints are predominantly linked to domestic noise. This rate of complaints is similar to the average for England and is the 8th lowest in London.

### Health effect of noise at night

#### **30 - 40 dB $L_{Aeq}$**

A number of effects on sleep are observed from this range: body movements, awakening, self reported sleep disturbance, arousal. The intensity of the effect depends on the nature of the source and number of events. Vulnerable groups, for example, children, people who are chronically ill and the elderly, are more susceptible.<sup>6</sup>

#### **40 - 55dB $L_{Aeq}$**

Adverse health effects are observed among the exposed population. Many people adapt their lives to cope with noise at night. Vulnerable groups are more severely affected.<sup>6</sup>

#### **Above 55 dB $L_{Aeq}$**

The situation is considered increasingly dangerous for public health. Adverse health effects occur frequently, the affected population become increasingly annoyed and sleep-disturbed. There is evidence that the risk of cardiovascular disease increases.<sup>6</sup>

## Air quality

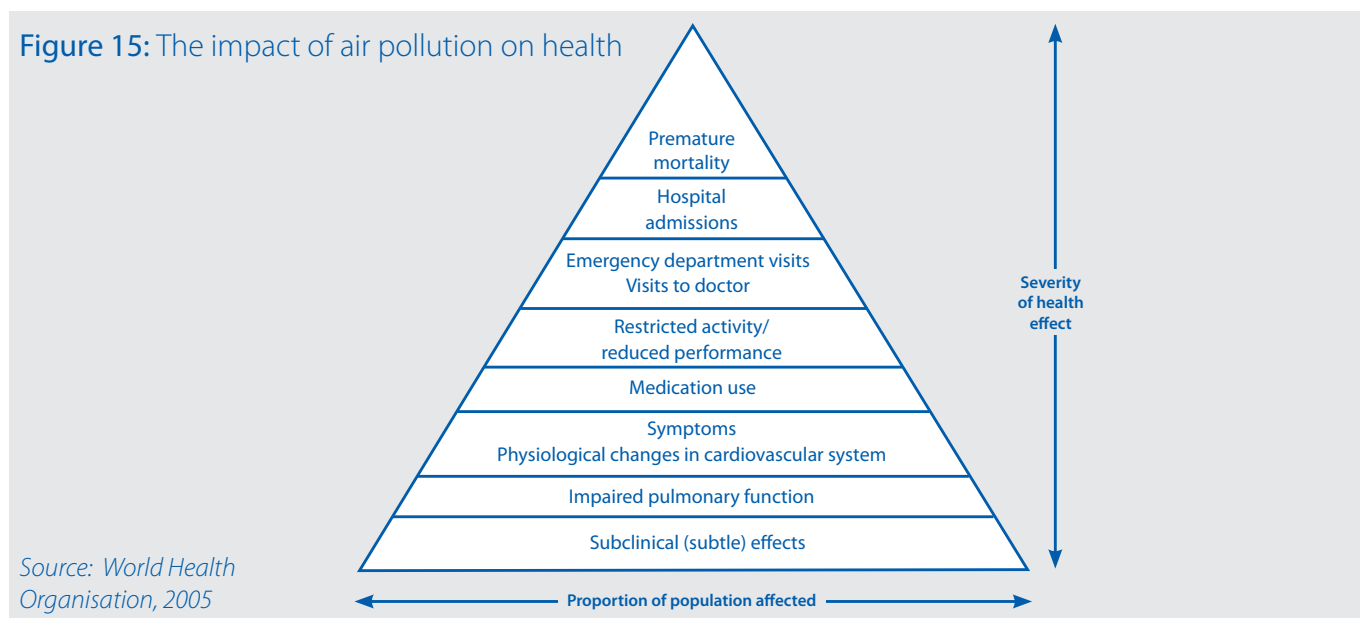
It is now widely recognised that day-to-day variations in the concentration of air pollution - the release of particles and noxious gases such as carbon monoxide, sulphur dioxide, nitrogen dioxide, ozone and particulate matter (PM) - are associated with variations in health.

In the short-term, people with an underlying health condition such as asthma and chronic obstructive pulmonary disease - of which there are more than 11,000 in Richmond - can experience a worsening and increased frequency of symptoms as a result of high concentrations of PM.<sup>10</sup> In turn, this can lead to an increase in medicine use and hospital admissions, see figure 15.<sup>11,12</sup>

Over the long-term, research shows that exposure to PM is associated with an increased risk of premature mortality. Estimates for Richmond suggest that 6.8% of premature deaths can be attributed to exposure to PM<sub>2.5</sub>.<sup>13,14,15,16</sup> Although levels of PM<sub>10</sub> in Richmond have remained below the air pollution levels set by the Government evidence shows that there are no safe levels of exposure below which there would be no adverse health effect.<sup>11</sup>

Levels of PM in Richmond are determined by local production through human activity such as traffic, construction and fires; as well as levels of background air pollution which originates outside of the borough from human sources, for example, road transport, airports such as Heathrow, power stations and industrial processes as well as natural sources. Day-to-day concentrations of PM are also dependent on other factors such as the weather, traffic volume, traffic congestion and the extent to which the physical layout of a street enables the dispersion of air pollution.

Although this means that tackling the underlying issues can be complex, action can be taken to reduce pollution from traffic by increasing sustainable travel, reducing traffic speed and reducing traffic congestion. In addition, vulnerable individuals can take action to avoid activities that might increase their exposure by signing up to the AirTEXT system which provides users with alerts on local pollution levels - [www.airtext.info](http://www.airtext.info).



### Health Effects of Air Pollution

PM<sub>10</sub> and PM<sub>2.5</sub> - Lung inflammation linked to coronary heart disease and lung cancer.

Nitrogen dioxide - An irritant that can cause inflammation of the airways.

Carbon monoxide - Reduces oxygen supply to the heart.

Ozone - Irritation and inflammation of the lungs.

Sulphur dioxide - Coughing, tightening of chest, irritation of the lungs.

## Transport

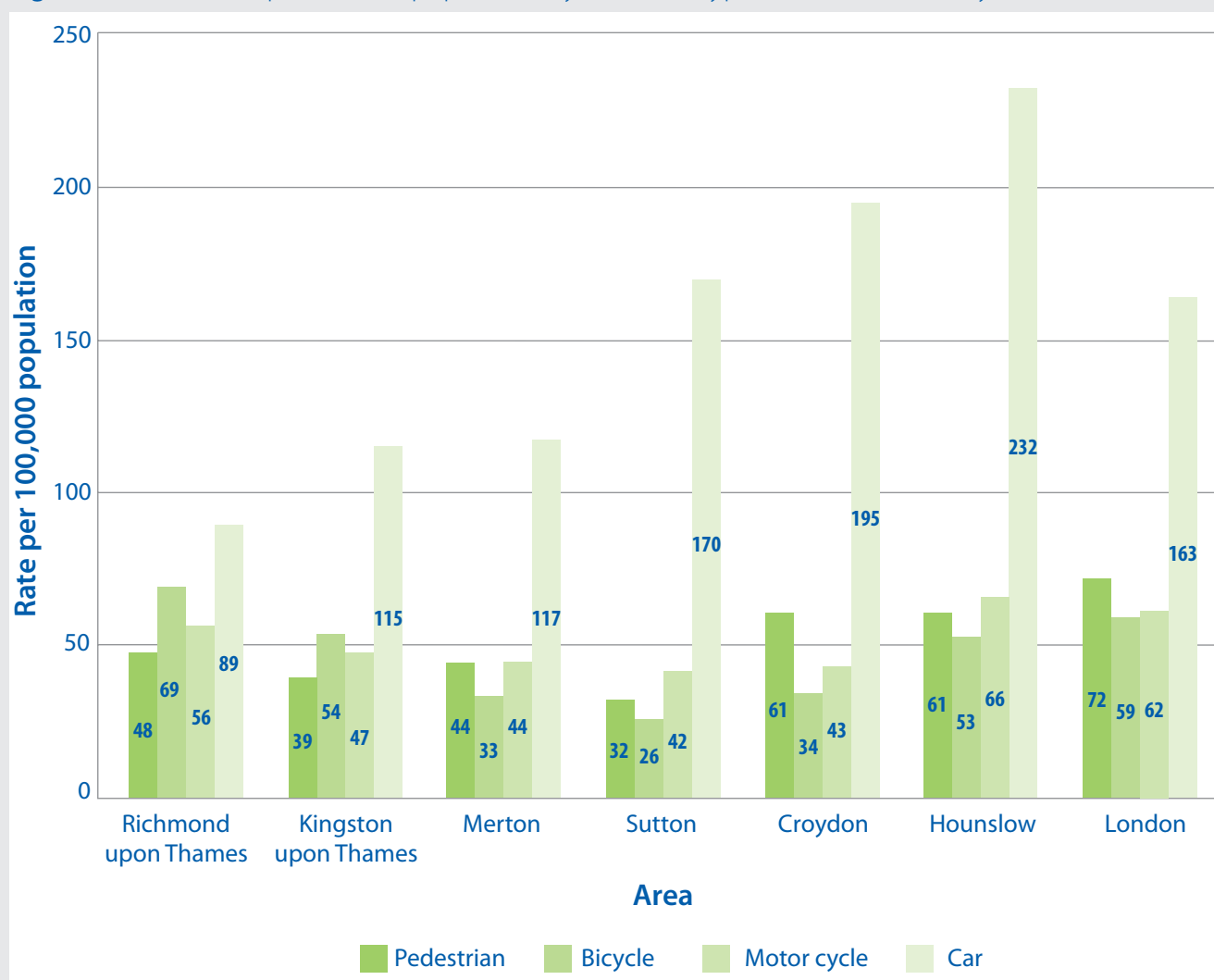
The way the road network is designed, the presence of pedestrian crossings and cycle lanes, speed limits and everyone's understanding of road safety have an important role to play in the occurrence of road traffic accidents that can result in injury and death.<sup>17</sup>

In 2012, 1 individual was killed, 51 seriously injured and 421 slightly injured on the borough's roads. This compares to an annual average of 486 casualties - which includes individuals killed, seriously injured and slightly injured - between 2005 and 2009.<sup>18</sup>

Comparing Richmond's rate of casualties per 100,000 population to those of neighbouring boroughs shows that in 2011 the rate of pedestrian casualties was lower than that for Croydon and Hounslow although not as low as the other south west boroughs, see figure 16.

In 2011, bicycling casualty rates for Richmond were higher than all the other south west boroughs, see figure 16. However, the proportion of journeys taken in Richmond on foot and by bicycle, 5% and 35% respectively, are considerably higher than the average for outer London boroughs of 2% and 28%.<sup>19</sup> When the number of bicycling casualties are considered per 1000 bicycling journeys the casualty rate is lower than other south west London boroughs where the proportion of journeys taken by bike are lower, see table 9.

Figure 16: Casualties per 100,000 population by road user type and Local Authority, 2011



Source: Department for Transport Statistics, 2011

**Table 9:** Average percentage of journeys taken by bicycle between 2008/09 and 2010/11 and rate of bicycling casualties per 1000 bicycling journeys for south west London boroughs in 2011/12

	Percentage of journeys taken by bicycle	Rate of cycling accidents per 1000 bicycling journeys
Richmond	5	6
Kingston	4	6
Merton	2	8
Sutton	1	12
Croydon	1	16
Hounslow	4	6

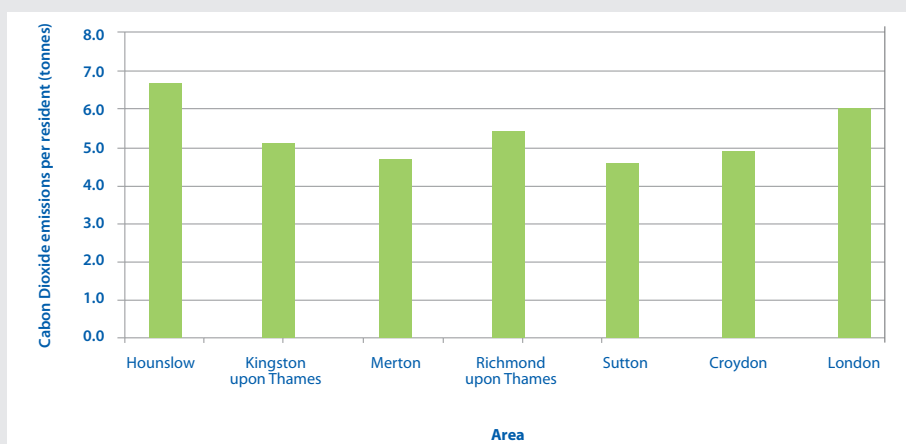
Source: Department for Transport, 2013, and Transport for London, 2013

### Sustainability

Increases in extreme weather conditions including extremes of temperatures, flooding and strong winds have important implications for communities and, in particular, the health and wellbeing of the most vulnerable individuals. This is because increases in extremes of temperature result in: heat or cold related mortality; increases in air pollution which may lead to an increase in mortality; and flooding which can result in displacement, a reduced food supply and increases in vector, food and water-borne diseases e.g. Malaria and Salmonella poisoning.<sup>20</sup>

Current estimates suggest that annually 5.4 tonnes of carbon dioxide are produced in Richmond per resident, figure 17. 'Reducing Richmond's carbon footprint by 'going green' can be achieved through a range of activities such as increasing walking and cycling; growing and cooking more locally sourced food and reducing the consumption of animal products; improving the energy efficiency of homes; and reducing the burning of fossil fuel. This synergy between sustainability and health presents a strong argument for taking action.<sup>21</sup>

**Figure 17:** Carbon Dioxide emissions in Richmond compared to other outer London boroughs and the London average, 2008



Source: Department of Energy and Climate Change, 2008

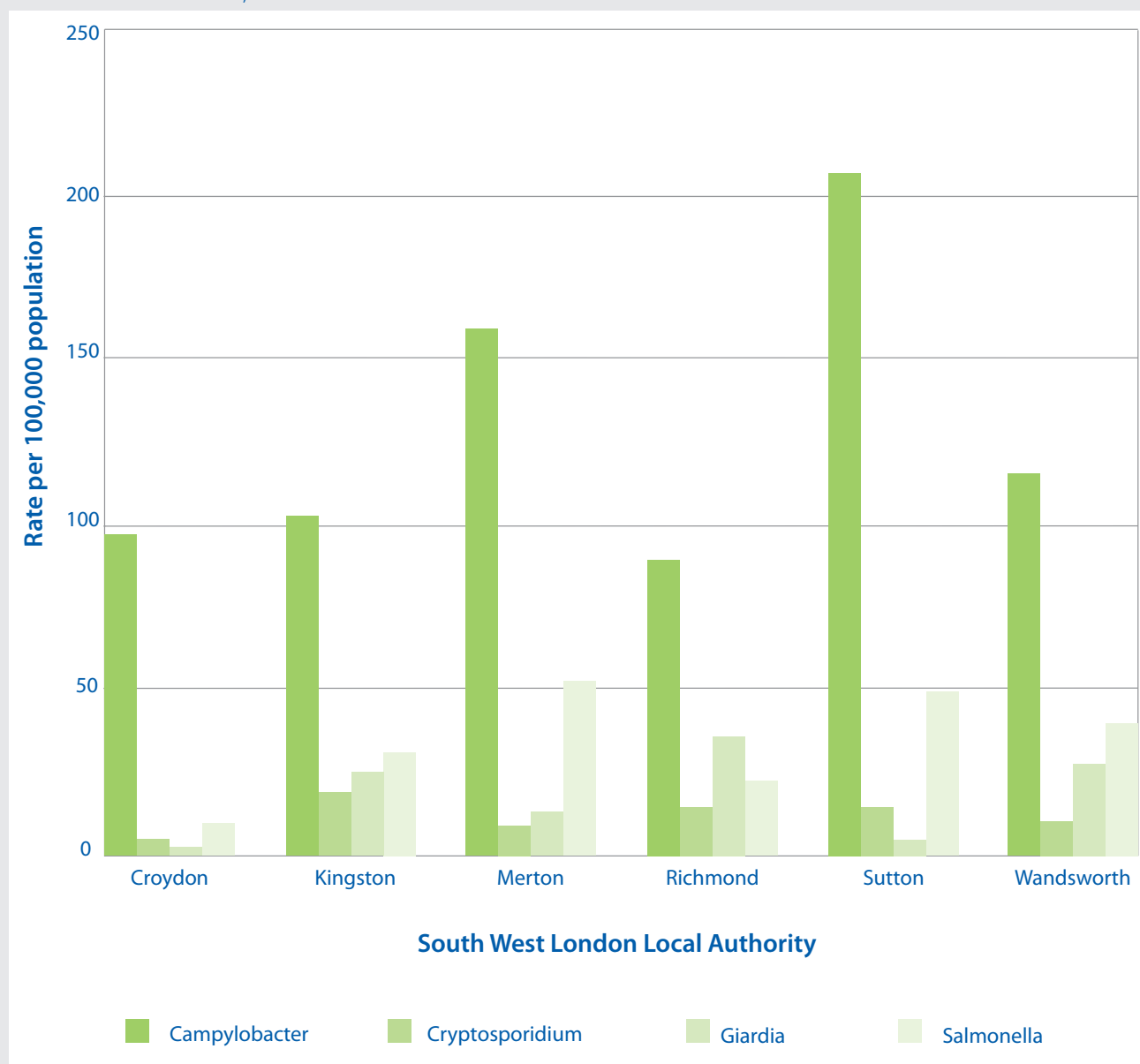
## Environmental Health

Workplace health and safety, and food safety standards achieved by local businesses can have a crucial impact both on an individual's health and the productivity of local businesses.

In Richmond, 9.5% of businesses are classified as hotels or restaurants, this is a much higher proportion than London or England averages of 7.3% and 6.7% respectively. Even with this higher presence of food businesses in the borough, in 2011, 87.8% were broadly compliant with the national food standards compared to the national average of 84.1%.

Although no suspected or confirmed food poisoning incidents were reported in food businesses, in 2011, the rate of gastrointestinal disease in Richmond was still high with 615.7 cases per 100,000 population, considerably higher than the England average of 360 per 100,000 population. In line with the national trend the most common food-borne infection was campylobacter, see figure 18.

Figure 18: Rates of food-borne infections per 100,000 population in South West London local authorities, 2012



Source: Health Protection Unit, 2013

## Environment: Protecting and developing the Borough's environmental assets

With most cases of food-borne infections individuals experience symptoms for about three days. This suggests that in 2011 the rate of incidents could have led to 2,023 working days lost. With 726 home businesses and 23% of people working in the borough classed as self-employed, compared to 15% in London, it is likely that this could have a considerable impact on the capacity of small local businesses.<sup>22</sup>

Although economic development in Richmond has stalled with the national recession, hair and beauty salons have been an expanding small business,<sup>23</sup> with approximately 150 currently operating locally. While access to these services can, for some people, be a key means of stress relief - helping to improve mental health - they may also pose a low risk to health. Poor sterilisation and disinfection practices can present the potential for the transmission of bacterial and blood-borne viruses to users, for example, through fish pedicures, piercings, tattoos and nail treatments.<sup>24,25</sup>

To ensure that higher risk activities such as tattooing are compliant with health and safety requirements a condition of the locally issued operating licence is that providers of these services are inspected for compliance. In Richmond there have been no recent cases of individuals contracting the blood-borne virus Hepatitis B infection through piercings or tattoos, although three cases were reported elsewhere in London in 2011.<sup>26</sup>

### Planning policy

The way the environment influences our behaviours is complex but evidence shows that there are a wide range of factors that have a bearing on our everyday lifestyle choices which, in turn, impact on health issues. For example, living in a community that restricts or makes it hard for individuals to be physically active or eat healthily can make it all too easy to make lifestyle choices that lead to weight gain and obesity.<sup>27</sup>

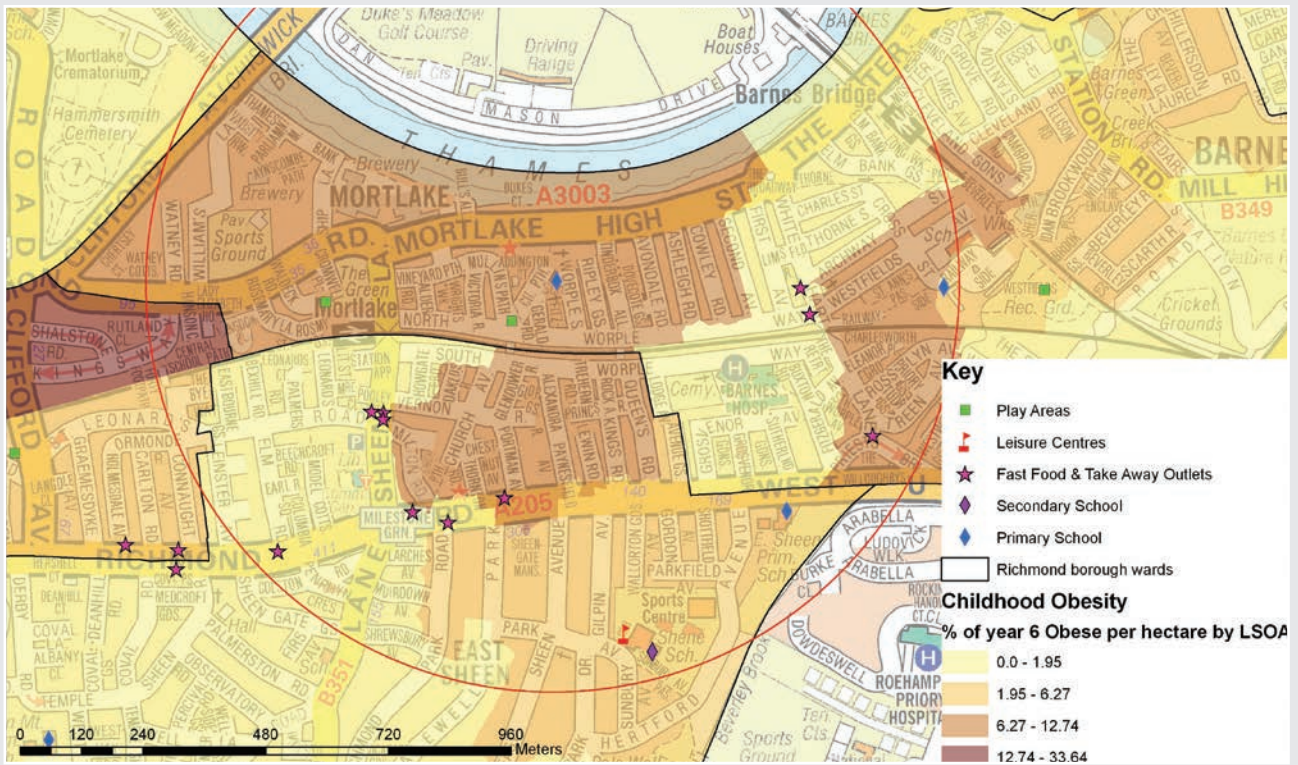
In particular, the availability of affordable fresh fruit and vegetables, walkability and bikeability of an area, availability of indoor and outdoor exercise and physical activity facilities, and the density of fast food outlets have been shown to influence levels of obesity.<sup>28</sup>

In Richmond, levels of child obesity are lower than those of other London boroughs but despite this the number of obese children doubles from reception to year 6.<sup>29</sup> A steady rise in the number of overweight and obese children has also been seen over the last six years. The data shows that the number of obese and overweight 4 to 5 year-olds has increased from 305 in 2006/7 to 379 in 2011/12. In 10 to 11 year-olds numbers have increased from 357 in 2006/7 to 413 in 2011/12. For more information on obesity in children see the early years chapter.

Furthermore, there are areas in the borough where there is the potential for environmental factors to drive up obesity levels. For example figure 19 shows a map of Mortlake where obesity in year 6 children is already higher than other parts of Richmond. It also shows that within an 800m radius of three primary schools and a secondary school there are two play areas and a leisure centre but 10 fast food outlets<sup>i</sup> concentrated within the town centre.

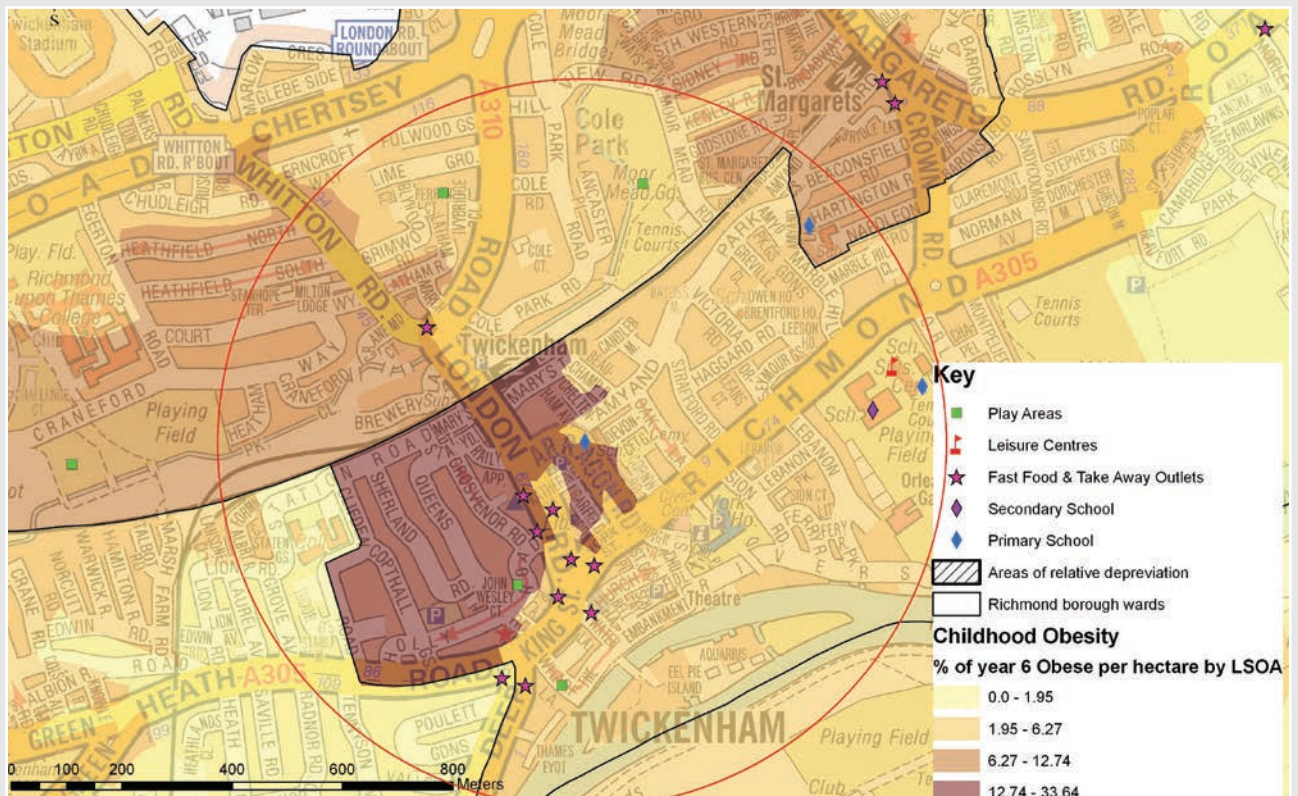
<sup>i</sup> The approach to licensing fast food outlets changed in 2005, therefore the figures may not provide a complete picture of all outlets.

Figure 19: A map of Mortlake, showing 2011/12 levels of obesity in Year 6 children by Lower Super Output Area (LSOA) and environmental characteristics associated with obesity



Source: London Borough of Richmond upon Thames, 2013

Figure 20: A map of Twickenham, showing 2011/12 levels of obesity in Year 6 children by Lower Super Output Area (LSOA) and environmental characteristics associated with obesity



Source: London Borough of Richmond upon Thames, 2013



## Environment: Protecting and developing the Borough's environmental assets

A similar pattern in environmental characteristics can be seen in Twickenham, see figure 20. These two figures show areas which are close to town centres where there is inevitably a wide range of shops and services. Nevertheless it is important to ensure that, through planning powers, the licensing of fast food outlets considers the potential impact of these establishments on health.

Evidence shows that the density of fast food outlets has a key role to play in the healthy food choices of children and young people. In particular, this is because children will: walk 800m or more to access fast food; purchase food along their journey to school; purchase fast food several times a week; and fast food tends to be high in calories, fat and saturated fat.

By working closely with the planning team we can seek to maximise the health benefits secured from planning policies by retaining and, if possible, creating new open spaces, play areas and sports fields, sports and leisure facilities and pedestrian and cycle routes to encourage physical activity. The transportation team are already taking action to encourage more walking and cycling through Twickenham by connecting existing walking and cycling ways into a corridor from Moorhead to the Stoop. Richmond's Mini Holland bid also sets out key aspirations for improving bikeability in the borough.

## The way forward

### Opportunities and Relationships

Richmond is rich in many environmental assets making it a place where people can live healthier lives. Protecting and enhancing these assets is a hugely significant factor in not only improving health and reducing health inequalities, but in fulfilling local commitments on air pollution, food safety, health and safety at work, road safety, active transport and sustainability.

Many services and interventions delivered by the Public Health and Environment teams are already making cross-cutting contributions to achieving health and environmental priorities. These can be further strengthened by exploiting the synergy between the two agendas and working in collaboration to tackle issues together.

By forging new working relationships between Public Health and teams in the Environment Directorate, we can 'spot opportunities for health' as well as add value to and increase the success of services. For example, by working with the Air Pollution Team, Public Health can ensure that services such as AirTEXT - which provides daily alerts to subscribers when pollution is high so that they can take action to avoid high levels of exposure – is an integral part of relevant clinical care pathways.

Public Health can also support the work of the Transport Team in encouraging people to adopt active and sustainable modes of transport through a joint approach to the delivery of campaigns such as 'walk to work week' and 'walk once a week'. There are also opportunities to connect existing services such as cycle safety training and the LiveWell Richmond programme, and to collaborate on the forthcoming cycling strategy.

Joint work is already underway between Public Health and Environmental Health in the delivery of the Healthy Catering Commitment - where fast food outlets make healthy changes to the way food is prepared, cooked and sold. There are also other prospects for forming coalitions. For example, promoting healthy and safe workplaces presents an ideal opportunity to extend this relationship and also engage the sustainability and Economic Development team.

Lastly, there is the potential for Public Health to make a considerable contribution to the work of planning colleagues by inputting public health advice, intelligence and expertise to inform and shape decisions. Some key areas of input include reviews of policies e.g. the Site Allocation Plan, development of planning priorities and Community Investment Levy priorities. We can also work with planning colleagues to monitor applications for fast food outlets and seek to avoid the creation of new outlets and proliferations of fast food takeaways, for example, near to schools where they will attract young people.

### Balancing Priorities

Many of the opportunities for maximising the positive impact of the environment on enabling people to live healthier lives make a strong contribution to both health and the environment priorities. However, there may be occasions when outcomes that support health are incongruous with other local commitments.

Existing planning policies in Richmond provide a strong foundation for maximising positive health gains but at times action to improve health may be compromised because of its impact on other local priorities such as economic growth. For example, while providing free parking may give a welcome boost to the local economy the consequence may be to discourage walking and cycling and contribute to localised air pollution.

Fostering a better understanding of the synergies between health and the environment will help to ensure that the impact of policies and services are fully appraised. By working together we will be in a stronger position to provide explicit advice about potential trade-offs and so support a process of informed decision-making that balances priorities and outcomes across the Council.

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### Appendix A: Joint Strategic Needs Assessment - The Richmond Story, JSNA link and contact details

## Joint Strategic Needs Assessment - The Richmond Story

### Introduction

The Joint Strategic Needs Assessment (JSNA) is a statutory duty, led by the London Borough of Richmond upon Thames, and owned by its Health and Wellbeing Board. The JSNA is the ongoing process that the London Borough of Richmond upon Thames undertakes, in partnership with the NHS and local stakeholders, to describe the current and future health and wellbeing needs of the local population to inform services. The Richmond Story is a snapshot of the local needs identified through the JSNA process.

The JSNA, alongside the Joint Health and Wellbeing Strategy, provides a framework for improving local health and wellbeing and addressing inequalities. The Health and Wellbeing Board is the owner of, and contributor to, the JSNA and has used the JSNA to inform the content of the strategy.

The Richmond Story is updated annually.

### The Richmond Story 2013/14

#### Overall, Richmond is healthy, safe and rich in assets

- Life expectancy is increasing, premature mortality is low. Levels of crime and accidents remain low compared to the rest of London. We have many green spaces, high educational attainment and high levels of volunteering.

#### BUT areas where we can improve include:

#### Reducing health inequalities

- Life expectancy is about 6 years lower for men and 4 years lower for women in the most deprived than in the least deprived areas within Richmond (mainly due to coronary heart disease, chronic obstructive pulmonary disease and cancers).
- Eleven small areas with nearly 18,000 (9%) residents have above average levels of deprivation compared with the England average. An estimated 3,900 children in Richmond are living in poverty.
- Population projections from the 2001 census suggested growth in older people would primarily be in wards with higher levels of deprivation (awaiting projections from 2011 census).
- There is wide variation between schools in the numbers of children eligible for free school meals (FSM) (i.e. percent eligible in primary schools ranges from 2% to 35%), and a gap in educational attainment (i.e. percent achieving level 4 or above in Key Stage 2 is 75% (FSM eligible) compared with 95% for pupils not eligible).
- Richmond has a small community of approximately 100 travellers. National research shows that, even when compared with other minority groups, travelling communities tend to have poorer health outcomes.

### Maximising prevention opportunities

- Despite favourable comparison with London and England, estimated numbers of people in Richmond with unhealthy lifestyles are substantial:
  - ◆ 29,000 adults smoke (approx 20%), 200 deaths per year (1 in 6) are attributable to smoking.
  - ◆ Approximately 1,500 primary school aged children are obese, with prevalence doubling between Reception and Year 6 (from 6.5% to 13%). In this age group in 1984, obesity was about 0.9% nationally.
  - ◆ 55% of Richmond residents report not being active for 30 minutes per week compared with 64% for England.
- Young people's risky behaviour often indicates various overlapping of family needs (i.e. sexual health, mental health and substance misuse). National prevalence models suggest that there are large numbers of people with undiagnosed long-term conditions in Richmond (e.g. 2,700 people with undiagnosed coronary heart disease, and 4,400 people with undiagnosed diabetes).

### Minimising hidden harms and threats to health

- Approximately 15,700 provide some level of unpaid care and 2,400 (1.3%) of those provide more than 50 hours unpaid care per week. 3,400 (14%) of those aged 65 years and over, and 900 (2%) people aged under 25 are carers.
- A high proportion (37%) aged 65 and over live alone, compared with 31% London-wide; most of those living alone are female. Social isolation and lack of social support are important risk factors for both mental and physical illness, particularly among older people.
- A higher than average percentage of people die in winter months (excess winter deaths) in Richmond (21%) compared with the England average (19%). This equates to 75 additional deaths per year.
- National prevalence models estimate that substantial numbers of Richmond residents are drinking at levels potentially harmful to their health (around 45,000 adults). Alcohol-related hospital admissions are increasing (especially in older age groups).
- Screening coverage of eligible women for breast (72.6%) and cervical (73.9%) cancers is significantly lower than the national averages (76.9% and 75.3% respectively).
- Childhood MMR vaccination coverage is below the level needed to protect all local children and young people from measles, mumps and rubella.
- Estimating prevalence of domestic violence is difficult due to under reporting and the way data is captured. In Richmond there was a 10% increase in the rate of domestic violence cases reported between 2010/11 and 2011/12. The 2011/12 rate was the highest reported rate in South West London at 30 per 10,000 females (total 268).
- Neighbouring Hounslow has one of the highest tuberculosis incidence rates in London at 73 per 100,000 population (Richmond 10 per 100,000).
- Prevalence of diagnosed HIV is one of the lowest in London, but still higher than the England average. The Richmond diagnosed HIV rate is 223 per 100,000 population aged 15-59 years (total number diagnosed [all ages] and accessing HIV services in one year: 285). 39% of cases are diagnosed late.

## Appendix A

- Although Richmond has some of the best quality air in London, we compared poorly with some national indicators as London overall has lower quality air than England. Further work is taking place to understand harms and threats to health.

### Planning for increasing numbers of people with multiple long-term conditions

- In 2013 the number (percentage) of people with more than one long term condition is estimated to be 19,600 (10%) and is expected to increase to 24,500 (12%) by 2018.
- Overall, the emergency hospital admission rate is among the lowest in the country. However, around 1,870 (15%) emergency admissions (costing £4.2 million per year) are for potentially preventable conditions. Emergency readmission rates for females (12.8%) are significantly higher than the national average (11.4%).
- Deaths in hospital have reduced year-on-year since the implementation of the End of Life Care Strategy in 2008. A high proportion of terminal admissions (49%) are for those aged 85 years and above compared with England average (38%).
- 7% (£1.7 million per year) of spend on emergency admissions is attributable to care homes. 30% of emergency hospital admissions from care homes are short stay (0 or 1 day) suggesting there is potential to reduce these.

## What is new for 2013/14?

### Population

- The population is expected to grow by almost 15,000 (8%) between 2013 and 2018 with an increase of approximately 3,000 each year. The increase in those aged 0-4 is expected to be 480 (3%) and the increase in those aged over 65 is expected to be 2,800 (10%). The greatest increase in numbers is expected for those aged 70-74 years (2,200 [38%]), 5-14 years (3,600 [16%]), and 50-59 years (3,600 [15%]).
- The number of live births was approximately 2,900 to 3,000 per year between 2007 and 2011 – a year on year increase of approximately 20 births. The Census based projections for 2013 to 2019 expect that births will remain static at approximately 3,000 per year, however, the Greater London Authority projections predict births will decrease by about 50 each year.
- More detail about Richmond from the 2011 Census data is available at [http://www.richmond.gov.uk/borough\\_profile](http://www.richmond.gov.uk/borough_profile)

### Children and young people

- 43% of women who gave birth in Richmond are over the age of 35 years, compared with 25% in London and 20% in England (2011).
- The Richmond Young People's Survey (RYPS) has identified concerns about alcohol and drug use among 12 and 15 year olds (total number of pupils = 1,750). 20% of pupils (340) said they had had an alcoholic drink in the last week. 30% (500) of pupils report having been offered illegal drugs. 7% (130) of pupils report taking an illegal drug in the last month.
- Children and young people exposed to parental alcohol and drug misuse are more likely to experience behavioural problems, poor educational attainment and to engage in substance misuse themselves. Initial estimates suggest that potentially up to 4,800 are at risk or may be affected by substance misuse locally.



## Appendix A

- Most children and young people of school age assess their emotional wellbeing as high (RYPS). However, the emotional wellbeing of a proportion of children is at risk, for example through exposure to bullying. 20% of 10-12 year old pupils (240) (years 6 and 7, total =2,470) and 21% of 12-15 year olds pupils (360) (years 8 and 10, total =1,750) experience bullying type behaviour 'often' or 'every day'. 13% of 10-12 year olds (310) said that their school deals with bullying 'badly' or 'not very well', while 23% of pupils aged 12-15 year olds (390) said that their school deals with bullying 'badly' or 'not very well'.

### Government welfare reforms

- The Government's welfare reforms may have implications for the health and wellbeing of adults and children, carers and families, in particular those with physical and learning disabilities, and mental health issues. Impact will be monitored.

### Detailed profile of people with more than one long term condition

- Approximately 5,300 (90%) patients with diabetes have other conditions such as cardiovascular disease, hypertension, depression, asthma, chronic kidney disease and disorders of lipid metabolism.
- In 2011/12 there were 870 people with dementia on GP dementia registers. Based on revised coding criteria, and using hospital data in addition to GP practice data, we estimate locally that there are approximately 1,200 as at April 2013.

### Examples of translating JSNA findings into better services

Young people's risky behaviour: service developed to prevent risk taking behaviour and increase protective factors such as self esteem and resilience.

Care homes: GP led NHS and local authority nursing and residential care homes group has progressed initiatives to reduce hospital admissions and improve quality and safety in partnership with Hounslow and Richmond Community Healthcare NHS Trust.

End of life care: an electronic shared care record 'Co-ordinate My Care' has been implemented locally. This included a financial incentive for quality outcomes was in the contract with the community provider (Hounslow and Richmond Community Healthcare) to identify people at end of life and develop care plans that help people to achieve their preferred place of care and death.

Avoidable hospital admissions: a comprehensive chronic obstructive pulmonary disease pathway from prevention (smoking) to end-of-life care was developed. This included setting up a community 2 hour rapid response and early discharge service in partnership with the local authority.

Excess winter deaths: joint council, NHS and voluntary sector Winter Warmth campaigns.

### JSNA Deep Dives

Completed 2012/13: Mental Health, Learning Disabilities, Early years, Cancers.

Underway/Planned 2013/14: Alcohol, Health & Wellbeing of Children, Dementia, Carers, Care homes, and more to follow.

## JSNA link and contact details

The Richmond story is only a snapshot of the wealth of more detailed information available. See [www.richmond.gov.uk/jsna](http://www.richmond.gov.uk/jsna)

The JSNA incorporates a wide variety of quantitative and qualitative data about demography and the pattern of determinants of health, risk factors and diseases, service utilisation, effectiveness, patient and public voice and cost. To make sense of local information, data is compared over time (trends), with other comparable boroughs (benchmarking), where available with standards (expected pattern) and with what local people and health and social care professionals tell us (voice). A better understanding of local issues is gained by bringing together information from different sources.

Throughout the year short topic based reports (Bitesize JSNAs) are published on the council website, enabling key messages to be shared in a timely manner with local partners; national data releases are summarised and circulated swiftly following publication (JSNA Newsflashes). These complement the four or five in-depth needs assessments (JSNA Deep Dives) on issues, populations or services that are undertaken each year. Themed JSNA Newsletters are produced each quarter to highlight key findings in an accessible format to a wide range of stakeholders. The JSNA core dataset is updated regularly and is now available on DataRich [www.datarichinfo](http://www.datarichinfo). You can also view a huge range of data and information relating to the borough and its residents including Richmond's 2011 Census data on DataRich.

For more information or to feedback please contact: [jsna@richmond.gov.uk](mailto:jsna@richmond.gov.uk)

## Appendix B: Public Health Outcome Framework health indicator spine charts

## Public Health Outcome Framework Indicators for the London borough of Richmond upon Thames

## Spine charts as of December 2013

Overarching indicators	Period	Local value	Eng. value	Eng. lowest	Range	Eng. highest
0.1i Healthy life expectancy at birth - Male	2009 - 11	70.3	63.2	55.0		70.3
0.1i Healthy life expectancy at birth - Female	2009 - 11	72.1	64.2	54.1		72.1
0.1ii Life Expectancy at birth - Male	2009 - 11	81.5	78.9	73.8		81.9
0.1ii Life Expectancy at birth - Female	2009 - 11	86.0	82.9	79.3		86.1
0.2i Slope index of inequality in life expectancy at birth based on national deprivation deciles within England (provisional) - Male	2009 - 11	-	9.65	-		-
0.2i Slope index of inequality in life expectancy at birth based on national deprivation deciles within England (provisional) - Female	2009 - 11	-	7.18	-		-
0.2iii Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (provisional) - Male	2009 - 11	7.0	-	-		-
0.2iii Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (provisional) - Female	2009 - 11	4.3	-	-		-
0.2iv Gap in life expectancy at birth between each local authority and England as a whole - Male	2009 - 11	2.59	0.00	-5.11		2.99
0.2iv Gap in life expectancy at birth between each local authority and England as a whole - Female	2009 - 11	3.11	0.00	-3.59		3.21

## How to interpret the spine charts

England lowest      England value      England highest

25th percentile      75th percentile

● Significantly lower      ● Significantly higher      ● Not significant

○ Significance Not Tested

## Appendix B

Wider determinants of health	Period	Local value	Eng. value	Eng. lowest	Range	Eng. highest
1.01ii Children in poverty (under 16s)	2011	10.0	20.6	6.9		43.6
1.03 Pupil absence	2011/12	4.57	5.11	4.30		6.66
1.04i First time entrants to the youth justice system	2012	302	537	151		1,427
1.05 16-18 year olds not in education employment or training	2012	3.9	5.8	2.0		10.5
1.06i Adults with a learning disability who live in stable and appropriate accommodation	2011/12	67.1	70.0	30.9		93.8
1.06ii Adults in contact with secondary mental health services who live in stable and appropriate accommodation	2010/11	89.0	66.8	1.3		92.8
1.08i Gap in the employment rate between those with a long-term health condition and the overall employment rate	2012	13.2	7.1	-5.3		21.7
1.08ii Gap in the employment rate between those with a learning disability and the overall employment rate	2011/12	58.4	63.2	40.2		73.1
1.09i Sickness absence - The percentage of employees who had at least one day off in the previous week	2009 - 11	1.6	2.2	0.6		3.5
1.09ii Sickness absence - The percent of working days lost due to sickness absence	2009 - 11	1.1	1.5	0.3		2.7
1.10 Killed and seriously injured casualties on England's roads	2010 - 12	34.3	40.5	16.9		81.8
1.12i Violent crime (including sexual violence) - hospital admissions for violence	2009/10 - 11/12	29.0	67.7	9.9		213.5
1.12ii Violent crime (including sexual violence) - violence offences	2012/13	8.8	10.6	4.1		27.1
1.13i Re-offending levels - percentage of offenders who re-offend	2010	20.6	26.8	17.3		36.3
1.13ii Re-offending levels - average number of re-offences per offender	2010	0.60	0.77	0.41		1.25
1.14i The percentage of the population affected by noise - Number of complaints about noise	2011/12	7.8	7.5	2.5		58.4
1.14ii The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime	2006/07	12.5	5.4	0.3		29.8
1.14iii The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time	2006/07	18.6	12.8	0.8		57.5
1.15i Statutory homelessness - homelessness acceptances	2011/12	3.1	2.3	0.2		9.7
1.15ii Statutory homelessness - households in temporary accommodation	2011/12	3.1	2.3	0.0		32.4
1.16 Utilisation of outdoor space for exercise/health reasons	Mar 2012 - Feb 2013	10.0	15.3	0.5		41.2
1.17 Fuel Poverty	2011	11.1	10.9	3.8		18.0
1.18i Social Isolation: % of adult social care users who have as much social contact as they would like	2011/12	40.9	42.3	32.2		54.2

§: there is a note associated with this value - see end of document for details

### How to interpret the spine charts

England lowest      England value      England highest  
 25th percentile      75th percentile

● Significantly lower      ○ Significantly higher      ● Not significant  
 ○ Significance Not Tested

## Appendix B

Health improvement	Period	Local value	Eng. value	Eng. lowest	Range	Eng. highest
2.01 Low birth weight of term babies	2011	2.58	2.85	1.60		5.30
2.02i Breastfeeding - Breastfeeding initiation	2011/12	89.6	74.0	41.8		94.3
2.02ii Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth	2011/12	-	47.2	19.7		82.8
2.03 Smoking status at time of delivery	2011/12	3.2	13.2	2.9		29.7
2.04 Under 18 conceptions	2011	19.8	30.7	9.4		58.1
2.06i Excess weight in 4-5 and 10-11 year olds - 4-5 year olds	2011/12	17.6	22.6	16.1		30.0
2.06ii Excess weight in 4-5 and 10-11 year olds - 10-11 year olds	2011/12	26.6	33.9	26.6		42.8
2.07i Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2011/12	97.8	118.2	68.7		211.4
2.07ii Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24)	2011/12	117.1	144.7	71.6		278.7
2.08 Emotional well-being of looked after children	2011/12	13.1	13.8	9.5		20.1
2.13i Percentage of physically active and inactive adults - active adults	2012	67.6	56.0	43.8		68.5
2.13ii Percentage of active and inactive adults - inactive adults	2012	20.0	28.5	18.2		40.2
2.14 Smoking prevalence - adults (over 18s)	2011/12	19.7	20.0	13.2		29.3
2.15i Successful completion of drug treatment - opiate users	2012	11.3	8.2	3.8		17.6
2.15ii Successful completion of drug treatment - non-opiate users	2012	39.4	40.2	17.4		68.4
2.17 Recorded diabetes	2011/12	3.60	5.76	3.60		8.02
2.20i Cancer screening coverage - breast cancer	2013	70.3	76.3	58.2		84.5
2.20ii Cancer screening coverage - cervical cancer	2013	71.9	73.9	58.6		79.9
2.21vii Access to non-cancer screening programmes - diabetic retinopathy	2011/12	86.9	80.9	66.7		95.0
2.22i Take up of NHS Health Check Programme by those eligible - health check offered	2012/13	28.7	16.5	0.7		42.5
2.22ii Take up of NHS Health Check programme by those eligible - health check take up	2012/13	34.0	49.1	7.7		100.0
2.23i Self-reported well-being - people with a low satisfaction score	2011/12	26.9	24.3	14.6		30.5
2.23ii Self-reported well-being - people with a low worthwhile score	2011/12	21.6	20.1	12.8		25.4
2.23iii Self-reported well-being - people with a low happiness score	2011/12	30.2	29.0	19.2		36.6
2.23iv Self-reported well-being - people with a high anxiety score	2011/12	43.5	40.1	34.4		48.3
2.24i Injuries due to falls in people aged 65 and over (Persons)	2011/12	1655	1665	1,070		2,985
2.24i Injuries due to falls in people aged 65 and over (males/females) - Male	2011/12	1216	1302	704		2,535
2.24i Injuries due to falls in people aged 65 and over (males/females) - Female	2011/12	2094	2028	1,298		3,713
2.24ii Injuries due to falls in people aged 65 and over - aged 65-79	2011/12	890	941	545		1,726
2.24iii Injuries due to falls in people aged 65 and over - aged 80+	2011/12	5098	4924	2,892		8,965

### How to interpret the spine charts

England lowest      England value      England highest  
 25th percentile      75th percentile

● Significantly lower      ○ Significantly higher      ● Not significant  
 ○ Significance Not Tested

## Appendix B

Health protection	Period	Local value	Eng. value	Eng. lowest	Range	Eng. highest
3.01 Fraction of mortality attributable to particulate air pollution	2011	6.76	5.36	2.99		8.32
3.02i Chlamydia diagnoses (15-24 year olds) - Old NCSP data	2011	1502	2125	783		5,995
3.02ii Chlamydia diagnoses (15-24 year olds) - CTAD	2012	1308	1979	703		6,132
3.02ii Chlamydia diagnoses (15-24 year olds) - CTAD - Male	2012	852	1368	383		4,364
3.02ii Chlamydia diagnoses (15-24 year olds) - CTAD - Female	2012	1746	2568	987		7,314
3.03i Population vaccination coverage - Hepatitis B (1 year old)	2011/12	80.0	-	-		-
3.03i Population vaccination coverage - Hepatitis B (2 years old)	2011/12	20.0	-	-		-
3.03iii Population vaccination coverage - Dtap / IPV / Hib (1 year old)	2011/12	90.6	94.7	84.9		98.8
3.03iii Population vaccination coverage - Dtap / IPV / Hib (2 years old)	2011/12	94.6	96.1	85.7		98.8
3.03iv Population vaccination coverage - MenC	2011/12	89.7	93.9	81.4		98.6
3.03v Population vaccination coverage - PCV	2011/12	90.5	94.2	83.8		98.6
3.03vi Population vaccination coverage - Hib / MenC booster (2 years old)	2011/12	85.3	92.3	75.7		97.3
3.03vi Population vaccination coverage - Hib / Men C booster (5 years)	2011/12	78.2	88.6	0.0		97.6
3.03vii Population vaccination coverage - PCV booster	2011/12	83.6	91.5	74.7		97.0
3.03viii Population vaccination coverage - MMR for one dose (2 years old)	2011/12	86.5	91.2	78.7		97.2
3.03ix Population vaccination coverage - MMR for one dose (5 years old)	2011/12	89.2	92.9	79.8		98.0
3.03x Population vaccination coverage - MMR for two doses (5 years old)	2011/12	79.4	86.0	69.7		95.3
3.03xii Population vaccination coverage - HPV	2011/12	79.8	86.8	62.3		97.2
3.03xiii Population vaccination coverage - PPV	2011/12	71.3	68.3	52.8		76.6
3.03xiv Population vaccination coverage - Flu (aged 65+)	2011/12	76.9	74.0	64.8		81.5
3.03xv Population vaccination coverage - Flu (at risk individuals)	2011/12	53.3	51.6	43.4		66.3
3.04 People presenting with HIV at a late stage of infection	2009 - 11	42.3	50.0	0.0		75.0
3.05i Treatment completion for TB	2012	- x	82.8	22.6		100.0
3.05ii Incidence of TB	2010 - 12	8.0	15.1	0.0		112.3
3.06 Public sector organisations with a board approved sustainable development management plan	2011/12	75.0	84.1	20		100

x, \$: there is a note associated with this value - see end of document for details

### How to interpret the spine charts

England lowest      England value      England highest  

 25th percentile      75th percentile

● Significantly lower      ○ Significantly higher      ● Not significant  
 ○ Significance Not Tested

## Appendix B

Healthcare and premature mortality	Period	Local value	Eng. value	Eng. lowest	Range	Eng. highest
4.01 Infant mortality	2009 - 11	3.30	4.29	2.28		8.02
4.02 Tooth decay in children aged 5	2011/12	0.40	0.94	0.35		2.10
4.03 Mortality rate from causes considered preventable (provisional)	2009 - 11	107.7	146.1	100.7		264.2
4.04i Under 75 mortality rate from all cardiovascular diseases (revised provisional)	2009 - 11	42.4	60.9	39.5		113.3
4.04ii Under 75 mortality rate from cardiovascular diseases considered preventable (provisional)	2009 - 11	24.5	40.6	23.0		75.1
4.05i Under 75 mortality rate from cancer (revised provisional)	2009 - 11	90.6	108.1	84.0		153.2
4.05ii Under 75 mortality rate from cancer considered preventable (provisional)	2009 - 11	51.7	61.9	45.2		98.1
4.06i Under 75 mortality rate from liver disease (provisional)	2009 - 11	12.4	14.4	8.7		39.3
4.06ii Under 75 mortality rate from liver disease considered preventable (provisional)	2009 - 11	11.5	12.7	7.5		37.0
4.07i Under 75 mortality rate from respiratory disease (provisional)	2009 - 11	17.0	23.4	13.7		62.0
4.07ii Under 75 mortality rate from respiratory disease considered preventable (provisional)	2009 - 11	7.0	11.6	5.3		28.6
4.08 Mortality from communicable diseases (provisional)	2009 - 11	27.2	29.9	22.0		54.9
4.10 Suicide rate (provisional)	2009 - 11	7.4	7.9	4.3		13.9
4.11 Emergency readmissions within 30 days of discharge from hospital	2010/11	12.6	11.8	8.1		13.8
4.11 Emergency readmissions within 30 days of discharge from hospital - Male	2010/11	12.1	12.1	8.6		14.8
4.11 Emergency readmissions within 30 days of discharge from hospital - Female	2010/11	12.8	11.4	7.2		13.2
4.12i Preventable sight loss - age related macular degeneration (AMD)	2011/12	74.5	110.5	12.8		225.2
4.12ii Preventable sight loss - glaucoma	2011/12	13.6	12.8	3.0		34.5
4.12iii Preventable sight loss - diabetic eye disease	2011/12	-	3.8	0.9		15.8
4.12iv Preventable sight loss - sight loss certifications	2011/12	28.8	44.5	5.1		82.5
4.14i Hip fractures in people aged 65 and over	2011/12	474.5	457.2	337.9		599.5
4.14ii Hip fractures in people aged 65 and over - aged 65-79	2011/12	200.6	222.2	135.7		346.7
4.14iii Hip fractures in people aged 65 and over - aged 80+	2011/12	1707	1515	993		2,021
4.15i Excess Winter Deaths Index (Single year, all ages)	Aug 2010 - Jul 2011	12.1	17.0	2.0		34.0
4.15ii Excess Winter Deaths Index (single year, ages 85+)	Aug 2010 - Jul 2011	24.6	21.2	-0.7		47.1

### How to interpret the spine charts

England lowest      England value      England highest  
 25th percentile      75th percentile

● Significantly lower      ● Significantly higher      ● Not significant  
 ○ Significance Not Tested