London Borough of Richmond upon Thames

Joint Health and Wellbeing Strategy 2016-21

Consultation Draft, December 2015.

LONDON BOROUGH OF RICHMOND UPON THAMES

healthwatch Richmond upon Thames

NHS Richmond Clinical Commissioning Group

Forewords

Councillor Christine Percival, Chair of the Health and Wellbeing Board

Note: To add following consultation period

Dr Graham Lewis, Vice Chair of the Health and Wellbeing Board, and Chair of Richmond CCG.

Note: To add following consultation period

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Introduction

The Health and Wellbeing Board

LONDON BOROUGH OF RICHMOND UPON THAMES

Richmond's Health and Wellbeing Board (HWB) is a systems leader that brings together elected members and local leaders from the health and social care system for adults and children to improve the health and wellbeing of their local population and reduce health inequalities. This includes councillors, the Chief Executive of Richmond Council, senior officers from Adult and Community Services and Public Health, GPs and senior officers from the Richmond Clinical Commissioning Group, the Chief Executive of Achieving for Children, as well as representatives from the voluntary sector, NHS England and Healthwatch (local health voices).

The HWB's partner organisations are:

- ***London Borough of Richmond upon Thames***
- ***Richmond Clinical Commissioning Group (CCG)***
- ***Healthwatch***

As a systems leader, the role of the HWB is to work together to understand the community's needs and assets, agree strategic priorities and enable commissioners to work in a more joined up way to promote the health and wellbeing of residents.

How the Health and Wellbeing Board Operates

CHAMPIONING ASPIRATIONS

The HWB has committed to championing the key aspirations as outlined in this strategy, and in the HWB's Guiding Principles. Through championing, HWB members have a collective and individual responsibility to ensure that these are reflected in the business of their own and partner organisations, are heard in other groups and committees, and become embedded in strategies and commissioning across the health and social care system.

This is a two way process and board members also have a role to play in feeding back insights and learning from their own and partner organisations to further inform the work and priorities of the board.

As a result, local people should experience better health and higher quality, more joined up, health and social care services which are focused on the outcomes as articulated by local residents.

GUIDING PRINCIPLES

As part of its development, the members of the HWB worked together to develop a set of 'Guiding Principles' that underpin everything the HWB does, including how it will deliver the aspirations of this strategy.

1. **Commitment for all** – to work towards the best possible outcomes for all the people of Richmond – the Health and Wellbeing Board (HWB) will challenge on behalf of any groups overlooked.

2. **Public and patient involvement**– the public will have an active role to play in shaping public services. The HWB expect that people will be helped to have their say, their preferences will be taken into account and they will be given an account of the way their views were used.

3. **Carers, and support for carers**– is a key component of our local model of care. The HWB will seek response to local needs that acknowledge the vital role of carers and their support.

4. **Integrated responses to need**– the HWB seek to amplify integrated responses to people's needs and will examine the intended and unintended consequences of any commissioning strategies on other local partners.

5. **Evidence based approach –** the HWB are committed to a transparent and open approach, and rigour of declaring sources of evidence, including costs and value for money. The HWB will ensure the flow of evidence into decision making.

6. **Prevention and promotion of independence**– strategies will evidence a systematic approach to prevention and promoting independence. The HWB will look for root causes of problems, not just quick fixes of symptoms.

7. **Better care, closer to home**– the HWB will support strategies that aim to streamline pathways; improve access, and provide care closer to home

8. **Sustainability for Richmond** – the HWB are committed to developing a care system that is not only financially sustainable, but also minimises adverse impacts on society and on the natural environment, which could jeopardise the ability of future generations to meet their health and social care needs.

About the Strategy

Richmond's Health and Wellbeing Vision

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

Strategic Theme

"Prevention and joined up services across the life course to enable all residents to start well, live well and age well"

The HWB's first Joint Health and Wellbeing Strategy (JHWBS), 2013-16, focused on the integration of services, identifying priority areas where improvements could be made through addressing the interfaces between organisations across health and social care.

This refreshed strategy highlights the continuing commitment to integration through the theme of **'supporting joined up services'** and aims to widen its reach to include **'maximising prevention support'**; championing approaches to help prevent, reduce, or delay residents' need for care.

To do this, the strategy highlights the need for joint working to drive forward preventative approaches at all levels: through targeted services for those who are ill or most at risk; through community approaches which promote social connectivity and an underpinning community resilience, and; place-level approaches which enable an environment in which the preferred and easy choice is also the healthy choice.

For a summary of achievements of the JHWBS 2013-16, see ***Appendix 1.***

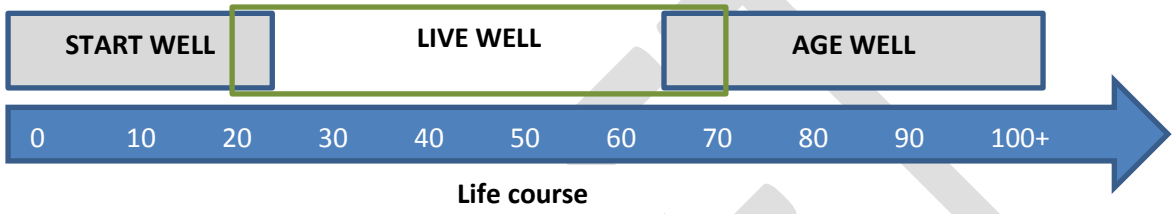
PURPOSE

This strategy aims to be concise and purposeful, rather than a comprehensive review of all work across the health and social care system. **This high level overview is a tool that will enable the HWB as a systems leader to champion key principles and initiatives, and provide a framework for other strategies and commissioning plans** across health and social care in Richmond.

STRUCTURE

The themes of 'joined up services' and 'maximising prevention support' underpin the three main chapters of the strategy (Start Well, Live Well, Age Well) which outlines health and wellbeing across the life course (from conception to end of life), acknowledging that the stages overlap.

Each chapter highlights why it is important, specific issues in Richmond, how the HWB will take action, and how it will drive change through a purposefully identified selection of 'transformational initiatives'. These initiatives are selected specifically as areas that the board feels can drive forward the transformation it wants, and areas where the HWB can have most impact.



Context and Enablers

To ensure the success of the Joint Health and Wellbeing Strategy and commitment to its key priorities, it is important to acknowledge and understand the **context** in which the HWB must operate, and how these external factors can form both constraints and opportunities. Within this context, integration and prevention are identified as **enablers**- the main capabilities through which the HWB will advance its strategic goals. Outcomes Based Commissioning can also be seen as an enabler in achieving integration and, by enabling partners to work together to manage demand and risk, developing services with a more preventative ethos.

Context

AUSTERITY

The Council and CCG are operating within the context of significant budget pressures due to central government reductions or restrictions, combined with increased demand for local services. Central government funding restrictions are expected to continue for the foreseeable future, as part of the Government's strategy to reduce the national deficit.

The HWB aims to support the Council, CCG and its partners in managing demand pressures to help ensure the long term sustainability of our services and wider environment. The board has identified prevention and joined up services as the focus of the refreshed strategy as these areas contribute to the long term sustainability of the health and social care system and it is aware that these areas are often vulnerable to budget cuts during times of austerity because of their longer term outcomes.

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

WANDSWORTH AND RICHMOND SHARED STAFFING STRUCTURE

Wandsworth and Richmond Councils are in the process of establishing a Shared Staffing Arrangement (SSA) for the officer functions of the two Councils by 2017. The initial focus is on joining management structures and reducing duplication. In the longer term, opportunities for further savings to reduce overheads, for example getting better deals from suppliers when commissioning services, will be pursued.

The shared approach is estimated to save up to £10 million for each borough per year. The Councils will adopt a Political Sovereignty Guarantee that clearly describes how local autonomy and identity will be safeguarded, and each Council will continue to develop its own role for community leadership. For the HWB, this will mean continuing to focus on the needs of the Richmond population and the local service responses to those needs.

OUTCOMES BASED COMMISSIONING

Richmond HWB is committed to championing an Outcomes Based Commissioning (OBC) approach to commissioning health and social care services. 'Outcomes' refer to the impacts or end results of services on a person's life. As such, outcome-focused services aim to achieve the aspirations, goals and priorities of service users.

Richmond CCG and Council intend to commission a long term (7-10 years) outcomes based contract for the delivery of out of hospital health and social care services for the adult population of the borough of Richmond. Further work is also taking place to develop an OBC approach for mental health community services and it is intended that this will be in place by April 2017. OBC will enable commissioners to create the circumstances in which provider organisations can innovate to deliver integrated models of care and better outcomes for services users, and realise efficiencies across the system.

Enablers

INTEGRATION

Integration and the joining up of services has been, and, continues to be, a key aspiration of the HWB, and the board has used its position as a systems leader to champion and drive this forward. For example, it formed the focus of the first HWB Strategy, which addressed aligning the interfaces between services which were not joined up from a patient perspective.

As a result, integration has become one of the defining features of how the HWB, local authority and Richmond CCG conduct their business now and in the future. This refreshed strategy builds on integration and aims to widen its reach by highlighting ways in which joint working (through health, social care and other departments such as environment) can strengthen and support prevention.

PREVENTION

Prevention is recognised as a priority of the Council and CCG, as demonstrated in strategies such as the Prevention Framework and Better Care, Closer to Home. The JHWBS outlines the role that the HWB can take in further driving this forward and supporting a shift towards more cost-effective place and community level approaches to prevention, enabling an environment in which the preferred and easy choice is also the healthy choice.

To do this, action must be taken to join up work across the organisations and help partners (such as environment and planning) to understand their role and contribution towards the prevention agenda. Working with communities (such as localities, village areas and vulnerable groups), will enable the HWB to build on community assets, promoting a community resilience that works alongside integrated, targeted health and social care interventions for those who fall ill or are most at risk.

Strategy Development

To develop this strategy the board engaged in a **'learning by doing' process**, participating in facilitated seminars to draw out themes and priorities. Development of the strategy included:

- Review of the JSNA including 'The Richmond Story 2015-16'.
- A review of previous engagement reports.
- Engagement in HWB 'Listening Events'.
- A series of strategy working groups with HWB members and key council and CCG officers.

Engagement

Richmond HWB recognises the value of involving our community and local stakeholders in shaping decisions about health and social care and the services they receive.

As part of its wider consultation and engagement process, a range of existing public and patient engagement data was reviewed to inform the content of the strategy, specifically, this included the in-depth OBC engagement process.

The HWB also held two public 'Listening Events'. These events gave the opportunity for HWB members to hear directly from residents and the organisations that work with them about their experiences of health and wellbeing. These were on the themes of 'Healthy Lifestyles' and 'Health and Wellbeing for Children and Young People'. Feedback from the listening events has further informed the theme and content of this strategy. A summary of key themes are highlighted below.

HEALTHY LIFESTYLES- MARCH 2015

Enhance the assets available in the local community to promote healthier choices and to motivate people to choose the healthy option

Opportunities for the commissioners to connect with the community, voluntary organisations and employers to improve access to services and healthy environments

Improve local communities to help older people stay healthy. For example, adapt the environment to increase accessibility and provide opportunities for people to develop new skills

Need to consider everyone has different needs. We need to engage and support vulnerable groups to live healthily too, e.g. carers, older people, people with learning difficulties

CHILDREN AND YOUNG PEOPLE- SEPTEMBER 2015

A whole family approach to prevention and intervention is important in helping parents feel supported, and children feel cared for and make progress towards their developmental milestones

Universal services should provide a nurturing environment in which preventive services and advice can be delivered e.g. schools, wider community

Need to raise awareness of mental ill health within the wider community in order to de-stigmatise mental health

It is important that young people have confidence in the services they come into contact with e.g. school nurse. Professionals need to be approachable, trustworthy and able to signpost them to the correct support

OUTCOMES BASED COMMISSIONING ENGAGEMENT REVIEW

Integrated care across health and social care in terms of seamless care and effective communication and information sharing between all involved in providing care

Services need to develop a holistic outcomes approach - people want better integration between services addressing patients' and carers' mental, physical and social needs

Invest in long term prevention (including de-stigmatising mental health) and recovery services which include the local voluntary sector, and start at the beginning with schools

Patients and carers want to see the same health and social care professionals every time, in order to build a relationship and develop trust

The full OBC engagement report is available at: ***www.richmondccg.nhs.uk***

Joint Strategic Needs Assessment

Through the Health and Wellbeing Board, Richmond council and Richmond CCG have a statutory duty to prepare and publish a Joint Strategic Needs Assessment (JSNA) for Richmond. The JSNA is the ongoing process to describe the current and future health and wellbeing needs of the local population to inform services.

The JSNA provides a framework for improving local health and wellbeing and addressing inequalities. For all JSNA products, visit: ***www.datarich.info/jsna***

THE RICHMOND STORY 2015-16

The Richmond Story is a snapshot of the local needs identified through the JSNA process. It is developed to inform commissioning intentions and the JHWBS.

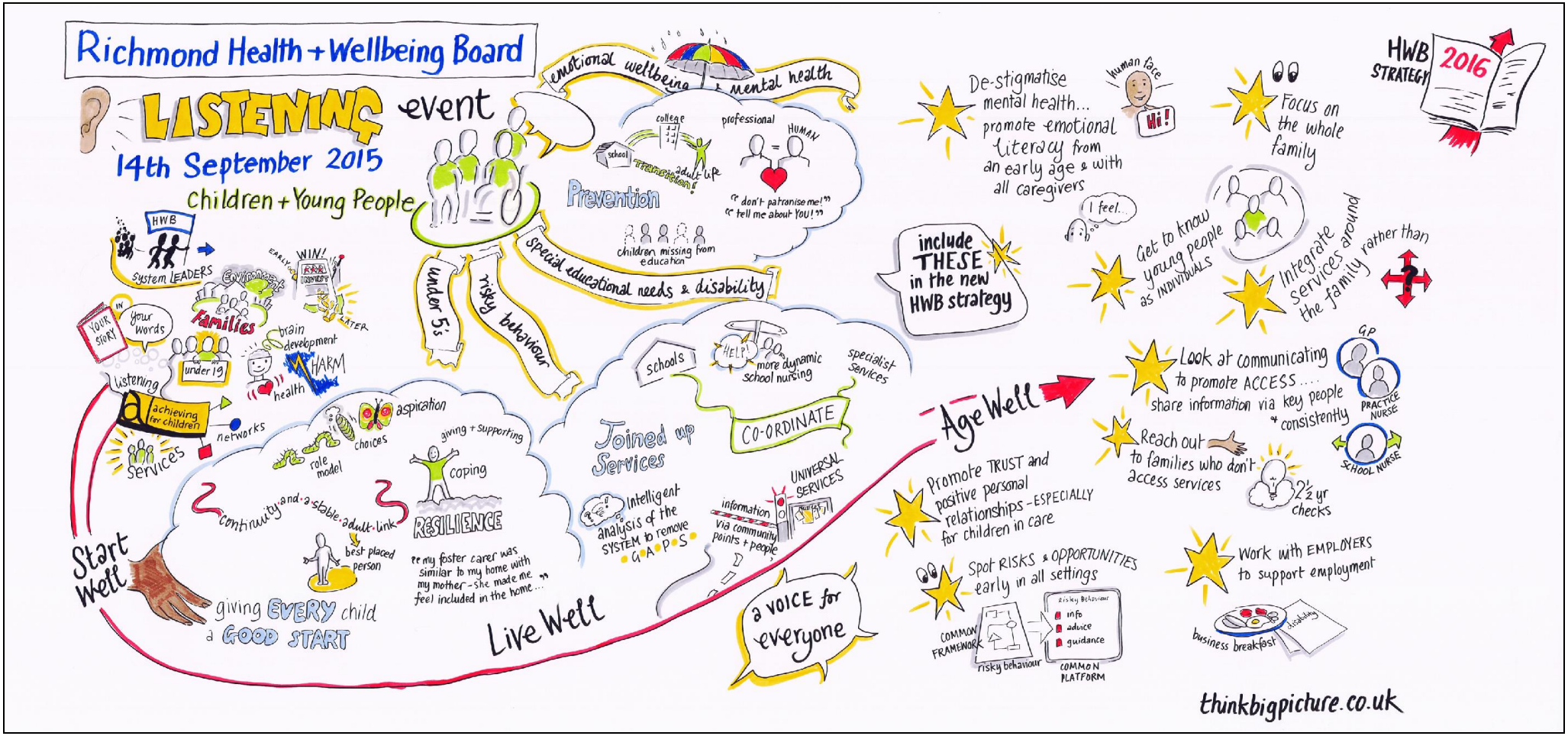
The Richmond Story 2015-16 highlighted the following priority areas.

- **Maximising prevention opportunities**
- **Reducing health inequalities**
- **Minimising harms and threats to health**
- **Planning for increasing numbers of people with long-term conditions and promoting independence**

For a summary of the Richmond Story, see ***Appendix 2,*** or for the full version visit ***www.datarich.info/jsna***

The Joint Health and Wellbeing Strategy

Think Big Picture- graphic recording of listening event for Children and Young People



1. Start Well

ABOUT THIS THEME –WHY IS IT IMPORTANT?

- What happens early in life (starting from conception) affects health and wellbeing in later life – from obesity, heart disease and mental health, to educational achievement and employment opportunities.
- Pregnancy and early childhood (0-3 years) are particularly important periods –a loving, nurturing family environment provides the foundation for healthy development and ensuring a child is ready for school.
- There is a strong economic case for investing in prevention programmes. Intervening early can avoid the potential high costs of dealing with developmental problems, drug and alcohol misuse, antisocial behaviour, domestic abuse and crime.

SPECIFIC ISSUES IN RICHMOND

Most children and young people in Richmond are healthy and have a good start in life. However not all children and young people enjoy similar positive health outcomes and therefore opportunities to achieve. Prevention is critical to ensuring that all children and young people can fulfil their potential, particularly those living in poorer social circumstances.

- Most children achieve a 'good level' of developmental progress by 5 years old, but children living in less well-off families are less likely to achieve this marker of readiness for school.
- Around 3,000 (21%) primary school aged children are obese or overweight.
- The School Health Survey shows that many children and young people experience anxiety and emotional difficulties due to a range of concerns including exams, bullying and relationships.
- Young people say they want early access to specialist mental health support to avoid later crisis. Evidence indicates that Richmond has higher rates of young people attending hospital who are self-harming compared to other London boroughs.
- Service improvements for vulnerable young people with special education needs and disabilities, and those leaving care, are needed, especially improved access to training, employment and housing.

How will the Health and Wellbeing board, as a systems leader, take action to enable people to start well?

- **Enable children, young people and families to be resilient, connected and able to look after themselves and each other.**

- **Promote positive conditions and places for children, young people and families to grow, learn, work and play and be safe.**

- **Ensure all children and young people feel included and not stigmatised; and empowered to meet their aspirations- regardless of social and cultural background, or disability and mental health difficulties.**

- **Ensure services and professionals work sensitively and in partnership with children, young people and families, and ensure better understanding and transparency about issues of sharing of information/ confidentiality and safety.**

- **Integrate and coordinate services around the family.**

- **Make prevention and early help central to universal /mainstream services.**

TRANSFORMATIONAL INITIATIVES THAT THE BOARD WILL CHAMPION

The strategy for Start Well encompasses a number of significant developments that seek to increase focus and resources towards prevention and early intervention, and demands strong partnership working to make best use of resources.

Ensure the Best Start in Life for all Children

The Early Years Development Plan (currently being developed) has the aim of ensuring all children have the best start in life through a joined up approach to family health and wellbeing. The Early Years Pathway provides the framework for enabling integrated delivery of high quality prevention and early intervention services across health visiting, children centres, early education, primary care, maternity and safeguarding.

The focus is on joint working in areas of high impact:

- Transition to parenthood
- Maternal mental health
- Breast feeding and managing healthy weight
- Parent-led integrated 2 ½ year review (health and early education)
- Managing minor illness

For example health visiting and children centres are working to achieve the internationally recognised standards (UNICEF) that means services are 'BabyFriendly' –an approach that respects a mother's choice, whilst providing sensitive advice and support for breastfeeding.

Many women can suffer mental health problems during and after pregnancy –from mild to more severe level. We aim to have a clear pathway in place covering early detection and diagnosis, and additional support (for example 'listening visits' by the health visitor) and /or access to specialist mental health services.

Promote Resilience and Emotional wellbeing through a Whole Systems Approach

A new Transformation Plan is the start of a five year Emotional Wellbeing and Mental Health Strategy for children and young people. This is based on extensive engagement with children, young people and

families. This plan is focused on improving outcomes through a whole-system approach; families, communities, schools and services.

The strategy centres on promoting resilience and early help, particularly through schools and community settings, and improving access to specialist mental health support. Schools will be a fundamental partner. It also addresses the needs of children and young people with special education needs and disabilities including attention deficit hyperactivity disorder (ADHD) and autism.

Champion the Strengthening Families Programme

This is a nationally-led strategy for supporting families with a range of complex needs- including unemployment, low income, domestic abuse, health problems (such as mental health difficulties and misuse of drugs and alcohol), and young children who are not thriving or older children engaging in anti-social behaviour or truancy. It is based on a multi-agency model – a team approach that is focused on the family.

Achieving for Children is taking forward Phase 2 – a five year programme starting 2015/16. This involves a multi-agency approach to ensure families are identified as early as possible and that there is a comprehensive response to their needs. A method of risk stratification will support the process.

Champion the Development of an Outcomes Framework

We propose to take forward the development of an outcomes framework for children and young people. This framework will enable strategic partners to work together and commission services that are focused on achieving the outcomes that matter to children and young people. Importantly it will involve a significant engagement process with children, young people and families to define a set of 'outcomes'- measures of improvement in health and wellbeing as the basis for the design and commissioning of programmes and services.

Case Study

WHOLE-SCHOOL APPROACHES TO PROMOTING EMOTIONAL WELLBEING AND MENTAL HEALTH

'Whole-school' approaches to promoting the social and emotional wellbeing of children and young people encompass all aspects of the school life, as well as learning and teaching. The school nursing service will develop its role in promoting emotional wellbeing and mental health. This will include effective personal, social, health and economic (PSHE) classes on healthy relationships and sexual health, addressing issues such as body image, stress management, positive relationships, and on-line safety. It will also include providing advice and support through confidential drop-in sessions, group sessions and telephone and on-line communications. Outreach school and community based clinics will be piloted by the Emotional Health service to provide timely access to psychological therapies.

2. Live Well

ABOUT THIS THEME – WHY IS IT IMPORTANT?

- The main unhealthy behaviours of smoking, alcohol misuse, poor diet and lack of physical activity, as well as poor emotional and mental wellbeing are responsible for a large proportion of ill health and long-term conditions, including cancers, cardiovascular disease and dementia.
- These health behaviours are known to be primarily influenced through exposure to cues in the environment, social circumstances or psychological stresses, establishing 'automatic' processes which result in unhealthy behaviors, e.g., eating too many sugary foods or being inactive.
- There is interdependency between emotional wellbeing, mental health and the prevention and management of long term conditions. Living with a long-term condition (and being unable to work as a result, for example) can decrease emotional wellbeing, and unhealthy behaviours are often taken up as a coping mechanism (e.g. smoking), resulting in further ill health and decreased wellbeing.
- Cost effective and universal interventions have an opportunity to reach all populations regardless of socioeconomic group.
- Universal interventions require a systems approach which includes interventions at a place, community and individual level.

SPECIFIC ISSUES IN RICHMOND

Most people in Richmond are healthy, but the incidence of people living with long term conditions in older adulthood is increasing at an alarming rate. Important opportunities for prevention include:

- Engagement in the four risk behaviours in Richmond is significant, 17,000 (11%) adults smoke, 24,000 (16%) adults are physically inactive, 68,000 (45%) adults do not eat 5 fruit & veg per day and 38,000 (25%) adults drink alcohol at increasing or higher risk levels. Population estimates indicate that over 65,000 (45%) people living in Richmond are carrying excess weight.
- Emotional wellbeing underpins health behaviours, 22,000 (16%) adults in Richmond are living with a common mental disorder, such as anxiety or depression.
- Many people would benefit from diagnosis and treatment of previously undiagnosed disease, or behavior change support if at high risk of disease.
- Local residents say making full use of local assets such as green spaces to increase opportunities for physical activity, and increasing the availability of healthy food, for example, can help support healthy behaviours and reduce poor health outcomes.

How will the Health and Wellbeing board, as a systems leader, take action to enable people to live well?

- **Embed prevention through cross council and CCG commissioning.**
- **Further utilise Workplaces and Village Planning for connectivity and inclusion.**
- **Coordinate access to Health Checks, Health Improvement Services, and Psychological Wellbeing Services. Promote access to community assets such as parks, open space, accessible streets and cultural activities.**

- **Increase the focus on access to services and healthy environments in and around the Workplace in partnership with communities, local businesses, community organisations and the voluntary sector.**

TRANSFORMATIONAL INITIATIVES THAT THE BOARD WILL CHAMPION

A Systems approach to Prevention

The Prevention Framework and the Annual Public Health Report, outline the need for a whole systems approach to Live Well. To have the required population impact efforts must be targeted to enable the healthy and preferred choice, to be the easy choice. This can be achieved through coordinated efforts at a place and community level which provides cues and supports automatic processes for living well. These universal approaches offer more cost-effective alternatives to one to one service level interventions. This could include, for example, a coordinated and partnership approach to the promotion and ability to engage in active travel. The Mental Health Strategy for Richmond highlights the importance of supporting resilience in working age men, this could include community driven approaches such as workplace programmes and individual solutions such as the Improving Access to Psychological Therapies (IAPT) programme. Access to individual level support services are also required for vulnerable and at risk groups to support people to overcome physical, cognitive and social challenges to living well.

Champion Active Travel in the London Borough of Richmond upon Thames

Being active everyday makes us feel good, gives us the space to notice what's around us and has protective benefits, improving resilience and physical health. To achieve sustainable improvements in physical activity levels we also know that activity needs to be embedded into the day to day routine and become an automatic process. *'If Londoners swapped motorised trips that could reasonably be walked and cycled, 60% of them would meet the recommended 150 minutes of physical activity per week through active travel alone. The population of London would gain over 60,000 years of healthy life every year which would deliver an economic health benefit of over £2 billion annually through reduced sickness and increased productivity.'* Mayor of London's Office

The Prevention Framework for Richmond outlines the required partnership of the CCG and Council to develop the infrastructure and community norms to enable active travel. Active travel is a central element to the integrated transport plan and cycling strategy. The council is also developing a short training package to enable council staff to promote active travel.

The HWB has a critical role to play to lead and co-ordinate partners to embed active travel. This could be achieved through training frontline health and social care staff to promote the benefits of active travel, work with transport to improve road infrastructure, work with schools to promote active travel and Physical Education in school time, and local businesses to enhance their travel plans to encourage (help to buy cycle schemes) and enable (provide storage and shower facilities) active travel.

Champion improved accessibility to balanced food options

Accessibility to varied and balanced food options is the biggest predictor of our consumption. To enable people to make the preferred and healthy choice, a whole systems approach is needed. This will include the availability of a variety of foods in the places where people spend their time, for example workplaces and around schools. Where choice has been limited, high fat and high sugar foods often become the default for many people. An increased awareness of a variety of foods and the associated positive

experience can be introduced with workplace programmes and parent and child cooking initiatives. To achieve this, a collaborative partnership approach is required with local businesses, communities and voluntary sector services. A recent workshop held between Richmond and the Town and County Planning Association (TCPA) included partners across the council and highlighted the benefits of planning for health for a population level impact. This included a restriction in the density of take away outlets close to schools. Championing a comprehensive and cross-partner approach to support health and wellbeing will be essential for living well.

Champion Midlife Live Well checks in the Workplace

Health checks provide awareness of risk which is relevant and tailored to the individual based biochemical markers. Furthermore, risk information is communicated by the GP which is known to be an effective conduit for galvanising change and access to support services. The new healthy living service for Richmond will be focusing even more attention on taking Health Checks out to communities that healthcare has so far been less able to reach. Given that the population of Richmond is, in the most part, of working age and in employment, the HWB Board could have a role in championing an approach to target workplaces.

The new healthy living service has been tasked with demonstrating better linkages between services and community assets for living well. There is an opportunity to promote the importance of Midlife Live Well Checks, with a specific focus on men.

Case Study

LIVE WELL CHECKS In 2013/14 Richmond's Health Check programme reached 6,040 residents. Over 15% of those identified as 'at risk' were referred to the Live Well service. The Live Well, Health trainer programme has already been working with users to set goals for emotional wellbeing. This has included links with psychological therapies and the expert patient programme and has benefitted 78% of their service users.

Mike Richmond is 47 years old, inactive and works in a busy firm in Richmond. When his Director told the team that they were being given the opportunity for a 'Live Well Check' his initial response was to have a laugh with his colleagues and say "not for me". However, following his assessment which identified pre-diabetes, things quickly changed for Mike.

He met with a health trainer who identified that his days were often spent sitting at work or on the train. They talked about what was important to him and put him in touch with volunteers for the local rugby club where he used to be a member. He was also encouraged and reluctantly attended a Health Walk with a colleague, where he was positively surprised by how good it felt to get out of the office and connect with colleagues. One year on, Mike is making the most of all of his time, he cycles to work, dropping off the kids with their scooters on the way after a catch-up. Mike also volunteers, guest coaching for the Rugby club once a month which he says makes him feel 10 years younger as he is so focused on the team, he completely forgets about work. As a result, his blood sugar has returned to normal levels and Mike feels healthier and more energetic.

3. Age Well

ABOUT THIS THEME – WHY IS IT IMPORTANT?

- As they age, most people see themselves living an independent and fulfilling life connected to their family, friends and community in the place they call home. But for far too many, this desire does not translate into reality.
- Although people are living longer, this has not been matched by a similar increase in the length of time people live in good health. As a result people tend to live for longer in poor health, and with a diminished quality of life.
- Older people are particularly vulnerable to social isolation or loneliness owing to loss of friends and extended families, mobility or income.
- Many people assume caring roles in midlife and older age, and the stress associated with providing care, including for someone with dementia, cancer or stroke, can result in high levels of psychological distress and depression.
- Being a carer can also restrict the ability to participate in social activities (as well as paid employment), with consequences for physical and mental health, for depression and obesity.
- Furthermore, issues like loneliness and isolation exacerbate poor health and are a causal factor in many long term conditions, e.g., loneliness and isolation is associated with, and predictive of depression and dementia.
- Whilst we should very much welcome the fact that people are living longer, our challenge is to make sure that our residents live longer in good health and with a good quality of life.

SPECIFIC ISSUES IN RICHMOND

- There are around 24,000 people (12.6%) who are aged 65 years and over, which is higher than the proportion across London (11.5%) but lower than the England average of 16.3%.
- From age 65 onwards, women and men have 6.2 years and 4.7 years, respectively, of healthy life expectancy, this is approximately 7 years longer than the equivalent for both London and England. This means that approximately, adults in Richmond live for 13 years in ill health.
- Richmond has the highest proportion of people aged over 75 and living alone in London (51% in Richmond vs. 35% for London). A survey found that just under half of adult social care users feel they have as much social contact as they would like.
- Of the 85 years and over population only 34% received a council funded service at home and 7% in a care home, meaning that approximately 2,400 (59%) older people aged 85 and over are either not receiving care or are arranging care themselves.
- An estimated 14% (3,442) of older people in Richmond borough are carers, providing help and support to a partner, child, friend, relative or neighbor due to age, physical or mental illness, addiction or disability.
- It is estimated that 2,072 Richmond residents have dementia. Around 64% of the estimated number has received a formal diagnosis, which is higher than the national average but lower than the London average, and below the target of 66%. Of those with dementia, 70% (840 people) have one or more other long term conditions, and it is estimated that two-thirds of those with dementia live in the community (outside of a residential care or clinic setting).
- Nearly one in three people registered with a GP in Richmond has one or more long-term condition and nearly one in ten has three or more. The proportion of people with three or more long-term conditions is significantly higher in those aged 65 and older (44%).

How will the Health and Wellbeing board, as a systems leader, take action to enable people to age well?

- **Galvanise partners across the health and social care system to deliver integrated health and social care services.**

- **Work to reduce the number of people experiencing loneliness and social isolation by supporting people to age well, feel connected and stay at home for as long as it is safe for them to do so.**

- **Work with individuals, communities and services to recognise the contribution of carers.**

TRANSFORMATIONAL INITIATIVES THAT THE BOARD WILL CHAMPION

Champion Richmond's Outcomes Based Commissioning Approach

We know we need to make transformational changes to the health and social care systems to address increasing pressures arising from an aging population, increased multi-morbidity and financial constraints.

We need a future system that focuses on prevention, early intervention, shared decision making and self-care to prevent, reduce and delay the need for care. When problems occur that need the intervention of health and social care services, our service response must be co-ordinated and targeted.

The HWB has a role as systems leaders, to drive forward the integration of health and social care via championing an outcome based commissioning (OBC) approach to commissioning as a way of transforming the health and social care system. The Better Care Closer to Home Strategy and the Prevention Framework outline the CCG and Council's approach to developing services with a preventative ethos and joined up approach. The board will work to ensure these strategies are embedded in our new OBC approach.

Dementia Friendly Villages

People with dementia and their carers talk about the everyday challenges they face in living well with dementia. This can include difficulty using technology, getting appropriate service in shops, banks and post offices and in using transport, going on holiday, maintaining social contact and hobbies. Although help from health and care services is vitally important, making it possible for people affected by dementia to live well will require help from people and organisations across society.

Working with the Village Planning process (developing a vision for locally identified areas) are rolling out dementia friendly Villages to encourage organisations, businesses, cafes and restaurants, and retailors to be "dementia aware" and commit to supporting connected and vibrant communities that people can age well in.

Champion the identification of carers and referral for carer's assessment

The number of carers in Richmond reported in the 2011 Census (15,802; 8.5%) is much higher than the number of carers that have been identified by services and who utilise key carer specific and open-access services for residents. This is demonstrated, for instance, in general practice (less than 1,000 carers, 0.45%

of the registered population), in the voluntary sector (around 2,300 adult carers identified by the Carers Hub Service, and around 370 by Richmond Borough Mind "Carers in Mind") and in social care (853 adults had a carer's assessment in 2011-12). This suggests that health and social care professionals may not be aware of the carer's responsibilities and associated support needs of patients.

Engagement with carers, carers' organisations and others identified that: many carers do not consider themselves to be a carer but as just part of a family; accessibility of information and advice is important; respite care and breaks for carers are important; steps must be taken to protect the health and the carer and support them to stay well; and there is a need to recognise carers as an expert partner in care.

Increasing the identification of carers in general practice, community health services and mental health services is a key priority in the Carers Strategy. General practice and the carers assessment will play a key role in the identification of carers and signposting them to available services.

Case Study

DEMENTIA FRIENDLY VILLAGES

Richmond DAA already has over 52 services, churches, organisations and businesses, including local council and health services, who have signed up to show their support. The Richmond Dementia Action Alliance aims to raise awareness of dementia by directly approaching businesses and organisations to pledge their contribution to a more dementia friendly borough. The Alliance asks the businesses or services to make sure that all staff are "dementia aware", via training using an online video or staff training session and pledge to undertake up to 3 actions to improve their premises or environment for people with dementia.

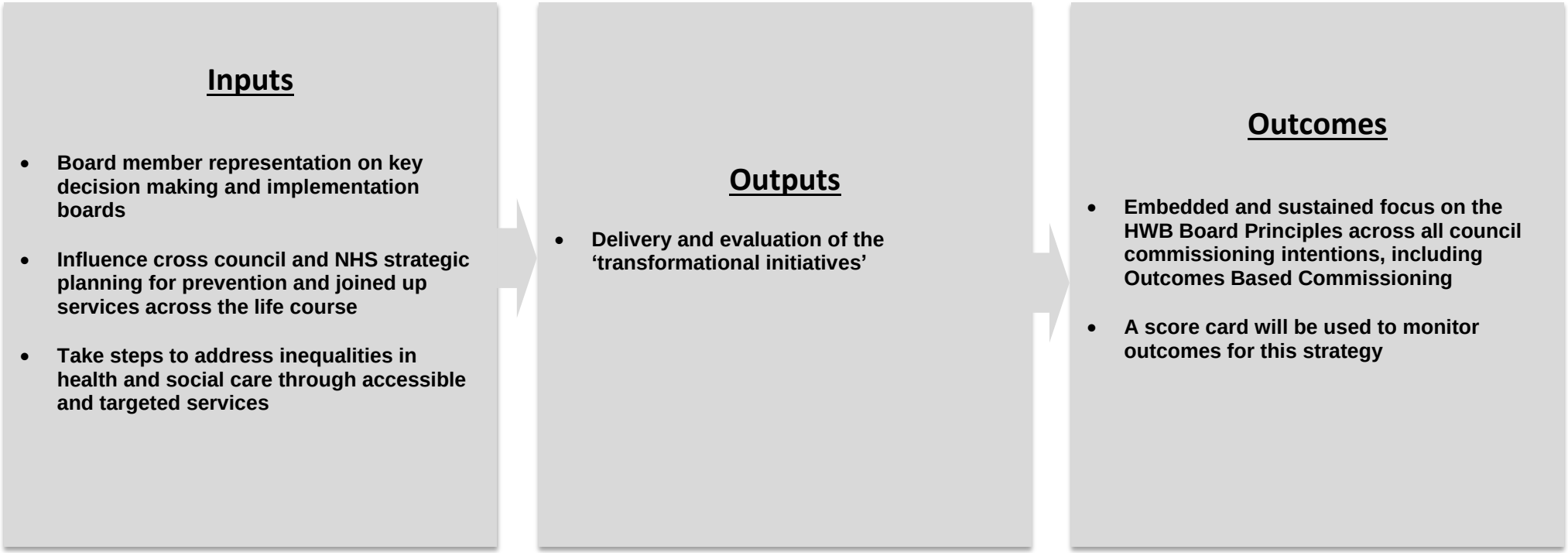
A local newsagent in Richmond upon Thames had recently encouraged its customer-facing staff to take part in a dementia friends training session, as part of the Dementia Friendly Villages initiative that was taking part in the local village area. As result, the shop keeper noticed that the staff had more confidence in interacting with a range of customers and that the shop felt friendlier and more welcoming.

One morning Martha Barnes, aged 82, popped in for her morning paper, as she did most days. However, this time, Martha became very confused and agitated. The cashier recognised that Martha may have dementia and remained patient. Eventually she was able to gently persuade Martha to give her the phone number of a family member who was able to take her home.

How will the HWB measure its impact across the system?

The impact of the leadership of the Health and Wellbeing Board, and the Joint Health and Wellbeing Strategy, will be assessed across the system, through inputs, outputs and outcomes. On the whole, it propose to use the national indicators or other existing local indicators to measure outcomes of the strategy, including the outcomes defined by local residents as part of the OBC process.

The HWB will continue to work with partners to understand how it will monitor success over the course of the next five years.



Appendix 1

Summary of achievements of the Joint Health and Wellbeing Strategy 2013-16

The HWB focused their first strategy on integration of services that from a patient perspective are not joined up. The table below outlines the four priority areas which were identified for where improvement could only be made in partnership.

Priority area for integration of services	Progress made
Child to adult services transition- for young people with long-term health and social care needs.	• A transitions protocol has been signed up to across all children's services. There is now clear tracking of children from the age of 14 in order to identify those with future support needs and to identify who would be the right people to lead the assessment. • Adult services staff are undertaking adults' assessments to enable a more seamless transfer of care, and NHS specialist health workers are assessing continuing health care needs, both in advance of the young person's 18th birthday. • A new adult Attention Deficit Hyperactivity Disorder (ADHD) service has been commissioned to fill this gap for adults. • Two new supported living services (located in Ham and Whitton) for young adults with autism and complex needs have been commissioned to provide local options for residential services for young adults with complex needs. • The recent Care Act and Children and Families Act means that there are now more options for young adults with mild and moderate conditions who would not previously have been eligible for services. • Furthermore, a number of work-related college programs have been introduced and Remploy are offering programs to support young adults into work.
Physical and mental health services- Many people have both long term physical health conditions and mental health problems	• A comprehensive engagement process was carried out with residents, patients and carers, to develop an adults' framework of mental health and social care outcomes that matter to local people. This will underpin a new mental health outcomes based commissioning approach. • Referral pathways between physical health services and the mental wellbeing services continue to be identified and developed to ensure patient's mental health needs are addressed alongside their physical

	needs. • 'No Health without Mental Health' training has been rolled-out to ensure all staff are aware of the interfaces between mental and physical health. • A pilot service is being developed to support people with diabetes to better manage their condition. The pilot will support people to identify and manage low level mental health conditions which can adversely people's health and self-management of their condition.
Health and social care services- fragmentations in social care and community health care services	• Joint commissioning arrangements across health and social care have been established in a co-located team. • The Better Care Closer to Home Strategy has been developed and implemented, in response to local people's requests for services in the community that help them to remain independent for as long as possible. • The Better Care Fund plan has been implemented to better integrate health and social services in order to create greater health and social care systems resilience. • A comprehensive engagement process was carried out with residents, patients and carers, to develop an adults' framework of health and social care outcomes that matter to local people. This will underpin a new mental health outcomes based commissioning approach. • A GP Led Care Model of Integrated Care (which looks to strengthen links across GPs, community nurses, therapists, and social workers) has been implemented to identify people at risk of hospital admission and support them to stay safe and well in their own homes and communities. • The Community Independent Living Service was commissioned jointly by the Council and CCG to act as a flexible hub, increasing access to low level support and information navigation for vulnerable adults, local to where people live. • The Carers' Hub service offers carers: Information advice and support; financial and debt advice; short breaks and leisure programmes; training and workshops for carers; a young Carers Service; opportunities for carer engagement; Carers awareness training for professionals; and strategic leadership. • The council and CCG have jointly commissioned Richmond Response and Rehabilitation Team (RRRT). This aims to facilitate a safe and timely discharge from hospital, and provide a time-limited service to support people to retain or regain their independence at times of crisis or transition. It provides a range of flexible professional services and interventions.

Hospital to community services – develop out of hospital services from a range of diverse providers	• The integrated Falls Service (IFS) is a coordinated service which offers a multidisciplinary specialist assessment with the provision of treatment and recommendations in falls prevention and bone health management. This service delivers to those aged 50 years and over, and has established strong links with clinical leadership from Primary care, Secondary care (Kingston Hospital, West Middlesex Hospital, Imperial College NHS Trust), Teddington Memorial Hospital, Queen Mary's Hospital, Local Authority including Public Health and social services, London Ambulance Service, and the voluntary sector. • Early Supported Discharge (ESD) for Stroke Survivors has been locally designed to ensure that stroke survivors meeting specific eligibility criteria are able to leave hospital earlier with the support of a stroke specialist community rehabilitation service. This provides a home-based rehabilitation service at the same level of intensity as a hospital-based stroke rehabilitation team. • The Better Care Fund has been used to commission community geriatricians to work closely with GPs by providing specialist information and advice to GPs as well as in A&E. • Liaison Psychiatric Service has been established to integrate specialist mental health expertise and resource into acute hospitals to effectively manage care for people with mental health problems. • Richmond CCG is engaged in developing two assistive technology services (sleep apnoea and cardiac home monitoring), providing patients with practical technology based solutions. This forms part of a holistic, integrated approach to meeting health care needs, including diagnosis, treatment, and monitoring of specific long term conditions, which in turn will deliver significant enhancement to patients' quality of life. • Work across care homes, community services, and primary care has taken place to ensure difficult conversations are held early enough in the patient journey to ensure adequate planning for a good death in the patients preferred place. This results in a reduction in hospital deaths and a corresponding increase in community deaths, suggesting that more people are dying in their place of choice.

Appendix 2

The Richmond Story 2015-16: Summary

The Richmond Story is a snapshot of the local needs identified through the Joint Strategic Needs Assessment (JSNA) process and informs commissioning intentions. The full Richmond Story and the accompanying scorecard of indicators can be viewed or downloaded at ***www.datarich.info/jsna***

A few highlights from the Richmond Story are included below.

WHAT DOES THIS MEAN FOR RICHMOND?

Overall, Richmond is healthy, safe and rich in assets, but areas where we can improve include:

MAXIMISING PREVENTION OPPORTUNITIES

- Despite favorable comparison with London and England, estimated numbers of people in Richmond with unhealthy lifestyles are substantial:
    - An estimated 17,000 (11%) adults in Richmond smoke.
    - Approximately 3,300 primary school age children and almost half of adults (approximately 65,000) are estimated to be obese or overweight.25,000 adults are estimated to do less than 30 minutes of physical activity a week and fewer than half (43%) of residents achieve the standard of 5 portions of fruit and vegetables per day.
    - Richmond has higher than average estimated proportions of increasing-risk (21.3%) and higher-risk (7.8%) drinkers compared to England. In addition, alcohol-specific mortality is higher than the London average and the rate of hospital admissions due to substance abuse in those aged 15-24 years is 5th highest in London.
- 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 4,850 people with undiagnosed diabetes).

REDUCING HEALTH INEQUALITIES

- Life expectancy is about 5 years lower for men and 4 years lower for women in the most deprived than in the least deprived area.
- An estimated 3,140 (8.8%) children in Richmond are living in poverty.
- Of those aged 16-18 years, 4.5% are not in education, employment or training.
- Only 8.2% of working age adults receiving mental health services in Richmond are in paid employment.
- 451 adults with learning disabilities are known to general practice.

MINIMISING HARMS AND THREATS TO HEALTH

- Approximately 15,800 provide some level of unpaid care and 15% of those provide more than 50 hours unpaid care per week.

- In 2013/14, there were 107 hospital admissions as a result of self-harm in those aged 10-24 years, the highest rate in London, and on average around 12 Richmond residents commit suicide per year.
- Richmond has the highest proportion of people aged over 75 and living alone in London (51% in Richmond vs. 35% for London).
- In Richmond, over 40% of acute sexually transmitted infection(STI) diagnoses are among those aged 15-24. STI rates have remained relatively stable over recent years in Richmond, but there have been increases in herpes and gonorrhoea.

PLANNING FOR INCREASING NUMBERS OF PEOPLE WITH MULTIPLE LONG TERM CONDITIONS AND PROMOTING INDEPENDENCE

- Nearly one in three people registered with a GP in Richmond has one or more long-term condition and nearly one in ten has three or more.
- Almost 32,000 of the GP registered population have a heart condition and there are 5,840 patients with diabetes.
- Around 1,700 people are estimated to have some form of severe mental illness and there are about 2,000 people recorded to be in contact with specialist mental health services. An estimated 22,000 people in Richmond have a less severe, common mental disorder (such as depression and anxiety) and there 6,164 adults identified with depression by GPs.
- Delayed transfers of care (DTOC) from hospital are an important measure of the quality of the interface between health and social care services. The rates of DTOC (8.1 per 100,000) and, in particular, those which are attributable to social care (2.3 per 100,000) are high compared to similar boroughs.
- There are 1,780 people recorded as having multiple sclerosis, Parkinson's disease or epilepsy and it is estimated that 2,072 Richmond residents have dementia.