# Live Well in Richmond 2022-2024

South West London Health & Care Partnership

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

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

### Objective

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

### Outcome

- Steady decrease in the proportion of people classified as overweight
- Increase in the number of community pharmacies offering health checks
- The proportion of people referred from NHS health checks who take up a service
- Increase in the number of people identified with high blood pressure and on optimal treatment
- Increase annual monitoring in Primary Care for identification of non-diabetic hyperglycaemia and early diagnosis of Type 2 diabetes
- Deliver awareness campaigns that are targeted at diverse communities
- Increase in the uptake of people attending weight management services
- Reduction in Accident & Emergency attendances and admissions due to alcohol related conditions
- System-wide approach to identify and manage people with long-term conditions
- Improved intelligence on areas of inequality, access and health outcomes across the borough with action plans to address these
- An outcomes-based tool to measure the impact of the model
- Increase in the number of organisations that sign up to the Healthy Workplace Award

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

### Objective

- Ensure people with **serious mental illness get support for their physical health** as well as their mental illness. 60% of people on the GP serious mental illness register in line with NHSE national targets by:
  - Providing additional support to GP practices to engage patients with serious mental illness
  - Working with low-performing GP practices to improve the outcome of serious mental illness checks for their patients
- Build on the work of the **multi-agency interface group and emerging Primary Care Networks** to proactively support people with **complex mental health needs** by:
  - Implementing the Mental Health Worker Model across the Primary Care Networks
  - **Establishing multi-professional, and voluntary sector** interface meetings to discuss and **resolve complex** mental health needs for patients that fall between service provision
- Increase access to the **Improving Access to Psychological Therapies** services for all, with a specific emphasis on vulnerable groups to meet the national access target. With a specific focus on increasing local access to:
  - People with a long-term condition - People with Post Covid Syndrome (Long COVID-19) - Men aged 35-44 - Older adults and carers
- Lead the implementation of a **Suicide and Self-harm Prevention Strategy** to **improve identification of risk and access to support,** to:
  - Establish a real-time suicide surveillance system to inform a needs-based approach to prevention
  - Develop suicide and self-harm factsheets to enable appropriate crisis support in Primary Care Settings
  - Provide access to Mental Health First Aid and suicide prevention training for the Voluntary and Community Sector
  - Encourage employers to sign-up to "Employers for Carers"

### Outcome

- 60% of people on the GP serious mental illness register will have physical health checks in line with NHSE national targets
- Increase in the number of mental health workers employed within PCN's
- National target for access to IAPT services will be achieved
- More people in the targeted groups will be seen in IAPT services
- System wide suicide and self-harm strategy

## Reduce health inequalities for people with learning disabilities

### Objective

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

### Outcome

- More people with a learning disability will receive an annual health check
- More people with a learning disability will have the opportunity to take up and sustain paid employment
- More people with a learning disability will live independently in settled accommodation

## Overarching Themes

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

We will **promote healthy weight in all ages, encouraging people to live physically active and healthy lifestyles** to prevent ill-health and improve wellbeing