18 STEPS to Health and Wellbeing

Joint Local Health and Wellbeing Strategy 2024 - 2029

Foreword

Councillor Piers Allen

It is with great pleasure that I provide the foreword for this refreshed Joint Local Health and Wellbeing Strategy (JLHWS) for Richmond upon Thames. This 5-year (2024–2029) strategy embodies our shared vision for the future and reflects our commitment to improving the health and wellbeing of the local community, and to reducing inequalities across all ages. The priorities included in this strategy were identified in the Joint Strategic Needs Assessment which was undertaken by the Health and Wellbeing Board (HWB) to identify the current and future health and care needs of the local community.

The strategy recognises the need for a coordinated, joined-up, collaborative approach to health and wellbeing and is in alignment with the NHS South West London Joint Forward Plan[1] and its commitment to local organisations working together over the next 5 years to meet the needs of local people. This involves working together with residents, the statutory and voluntary sectors and the local community and recognising the impact of the wider determinants of health. By implementing this strategy and working with our partners, the Health and Wellbeing Board believes we can make meaningful and long-lasting improvements to people's health and wellbeing, reduce inequalities across the borough, and make Richmond upon Thames a better place for all.

It also affirms how the HWB is adapting to the changes introduced by the Health and Care Act 2022[2] and using our influence as leaders of the Richmond upon Thames Place within the wider South West London Integrated Care System[3].

We would like to thank all those who have contributed to the development of the refreshed JLHWS and who remain committed to the successful implementation of the 5-year strategy, including our residents who have been instrumental in providing their feedback to ensure that the actions are the right ones to meet the needs of our community.

Cllr Piers Allen
Chair, Health and Wellbeing Board
London Borough of Richmond upon Thames

1 Our five-year plan for the NHS in South West London A joint forward plan 2023–2028. NHS South West London Integrated Care Board: Wimbledon. June 2023. https://www.southwestlondon.icb.nhs.uk/wp-content/uploads/2023/07/SWLICBJFP_June2023Final.pdf. Last accessed: 25 July 2023.
2 Health and Social Care Act 2022. https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted. Last accessed: 25 July 2023.
3 Health and Wellbeing Boards: guidance. Department of Health and Social Care. Nov 2022. https://www.gov.uk/government/publications/health-and-wellbeing-boards-guidance. Last accessed: 25 July 2023.

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Executive Summary

The Joint Local Health and Wellbeing Strategy (JLHWS) is a strategic plan that sets out the priorities for collective action to be taken by the local authority, NHS, and other partners including the voluntary and community sector, over the next 5 years. The JLHWS aims to improve the health and wellbeing of Richmond residents, tackle inequalities, empower our communities, and focus on prevention. The health, care and wellbeing needs of Richmond residents were assessed in the latest revision of the Joint Strategic Needs Assessment (JSNA), published in 2022.

To help determine which priorities identified in the JSNA would be the focus of the refreshed JLHWS, we held a series of prioritisation seminars, one focusing on children titled 'Start Well,' and a second focusing on adults and older people titled 'Live Well and Age Well.' This life-course approach addresses the diverse needs and challenges of Richmond residents at different stages of life and acknowledges the wide range of factors influencing our health and wellbeing over time. The theme of the strategy, '18 Steps to Health and Wellbeing,' follows this life course approach.

The 'Start Well' seminar identified the main priorities as self-harm and social, emotional, and mental health needs; childhood obesity; and childhood immunisations.

The priorities from the 'Live Well' seminar were immunisations, cervical cancer screening, long-term conditions, lifestyle and health behaviours, suicide prevention, air quality, and climate change. This seminar also identified falls and frailty, dementia, and social isolation as the priority areas for the 'Age Well' section of the life course.

The strategy is a collaborative effort, produced by a multi-agency task and finish group on behalf of the Health and Wellbeing Board (HWB). Membership of the task and finish group is presented in Appendix 1. The priorities set out in the strategy will inform the forward plan of the HWB over the next 5 years.

A statutory public consultation was conducted in July and residents were invited to help ensure that the actions proposed by the strategy to address local priorities were bold enough to make a real difference.. The results of the consultation and response from the HWB are published as an accompanying document alongside an Equality Impact Needs Assessment (EINA) which is a process to ensure that the strategy serves all members of the community fairly.

To monitor progress in delivering the actions in the strategy, a dashboard will be published alongside the refreshed strategy.

About the Health and Wellbeing Board

The Richmond Health and Wellbeing Board (HWB), established as part of the Government's 2012 health service reorganisation, is a collaborative partnership between Richmond Council, local GPs, the NHS which includes NHS South West London Integrated Care Board (responsible for commissioning and overseeing health services), and the voluntary and community sectors. Closer collaboration between Richmond Council and local health professionals presents an opportunity to enhance the wellbeing of our residents and advocate for a healthier borough.

The focus of the board is to:

1. Improve population health and reduce health inequalities
2. Help reform the way the health and care system works
3. Protect the health of residents

It does this by:

- Leading the development of the Council's role in integrating the commissioning of health, social care and other services.
- Leading the development of local partnerships for health and social care which share a common view about local need, priorities and service development.
- Ensuring the engagement and involvement of local people in the development of the health and social care system locally.
- Working with regional and pan-London bodies to ensure that the health and social care needs of local people are understood and considered when commissioning services at regional and pan-London level.

The Joint Local Health and Wellbeing Strategy

The Richmond HWB have a duty to produce the JLHWS. The JLHWS sets out the priorities for collective action to be taken by the local authority, NHS, and other partners including the voluntary and community sector, to improve the health and wellbeing of Richmond residents and reduce inequalities across all ages. The health, care and wellbeing needs of the local community were assessed in the latest revision of the Joint Strategic Needs Assessment (JSNA) for Richmond, published in 2022. The JSNA is structured across the life course (Start Well, Live Well, Age Well) and highlights our commitment towards improving the health and wellbeing of Richmond residents across all life stages. The refreshed strategy also considers the wider determinants of health which are important determinants of people's health and wellbeing, including housing, employment, education, crime, and transport.

Strategy Development

The refreshed strategy presents several priorities that the HWB will focus on to improve the health and wellbeing of the Richmond residents. As it was not possible to address all the issues identified in the JSNA in the refreshed strategy, Public Health supported a prioritisation exercise involving key stakeholders and an evidence-based prioritisation tool was used to identify the key priorities that the HWB could focus on over the next 5 years to improve health outcomes for our residents. The 'Start Well' prioritisation seminar identified the key priorities for children and young people based on the 'Start Well' chapter of the JSNA, while the 'Live Well' and 'Age Well' seminar identified key priorities for adults and older people as highlighted in the latest JSNA for these age groups.

Our principles

The Health and Wellbeing Board agreed that any actions proposed should be guided by a set of five principles that are at the core of the strategy and embedded across all priority areas. The agreed principles are as follows:

1 Tackling inequality

We are committed to providing the most support to those who need it the most, and to work towards creating a fairer and more equal community. There are several groups within our community who have poorer health outcomes due to health inequalities which are avoidable and unfair, and we will ensure they are prioritised within our strategy actions.

2 Focus on prevention

We want to promote positive health and wellbeing by delivering an evidence-based approach to prevention by embedding our Prevention Framework within the Health and Wellbeing Strategy. This will include facilitating making the healthy choice, the easy choice, supporting a tailored approach to prevention, connecting with polices and initiatives to enable prevention work to be sustainable, and creating supportive communities and health promoting environments.

3 Empowering our communities

Communities are at the heart of everything we do, and we need to work with and empower our communities to produce positive, sustainable benefits for our residents. This strategy wants to add social value to our communities and ensure that the actions we take enable them to continue to improve their local communities after our initiatives are complete.

4 Holistic approach to individuals and families

By considering individuals holistically and supporting families through their life course, we will ensure that no group gets left behind. We will make sure that we have considered the needs of each group at different stages of life and identify areas where we can improve health at each part of the life course, particularly transition periods which can present the most challenging times. We will ensure individuals are considered within their wider social context to ensure we are offering effective support that looks beyond a diagnosis and is personalised to the individual. This includes identifying carers and ensuring they have access to adequate support.

4 Place integration

The new JLHWS provides a footprint which is owned and driven by all organisations working across the borough's health and care system, with a view to coordinate activity and bring about system wide change in response to the needs of our residents. We recognise that there are existing partnerships and strategies in place which will contribute to the success of the JLHWS. We will not seek to duplicate the work being done by existing strategies, but aim to recognise, coordinate, streamline and support a well-connected system working together to improve the health and wellbeing of our communities.

Prevention Framework

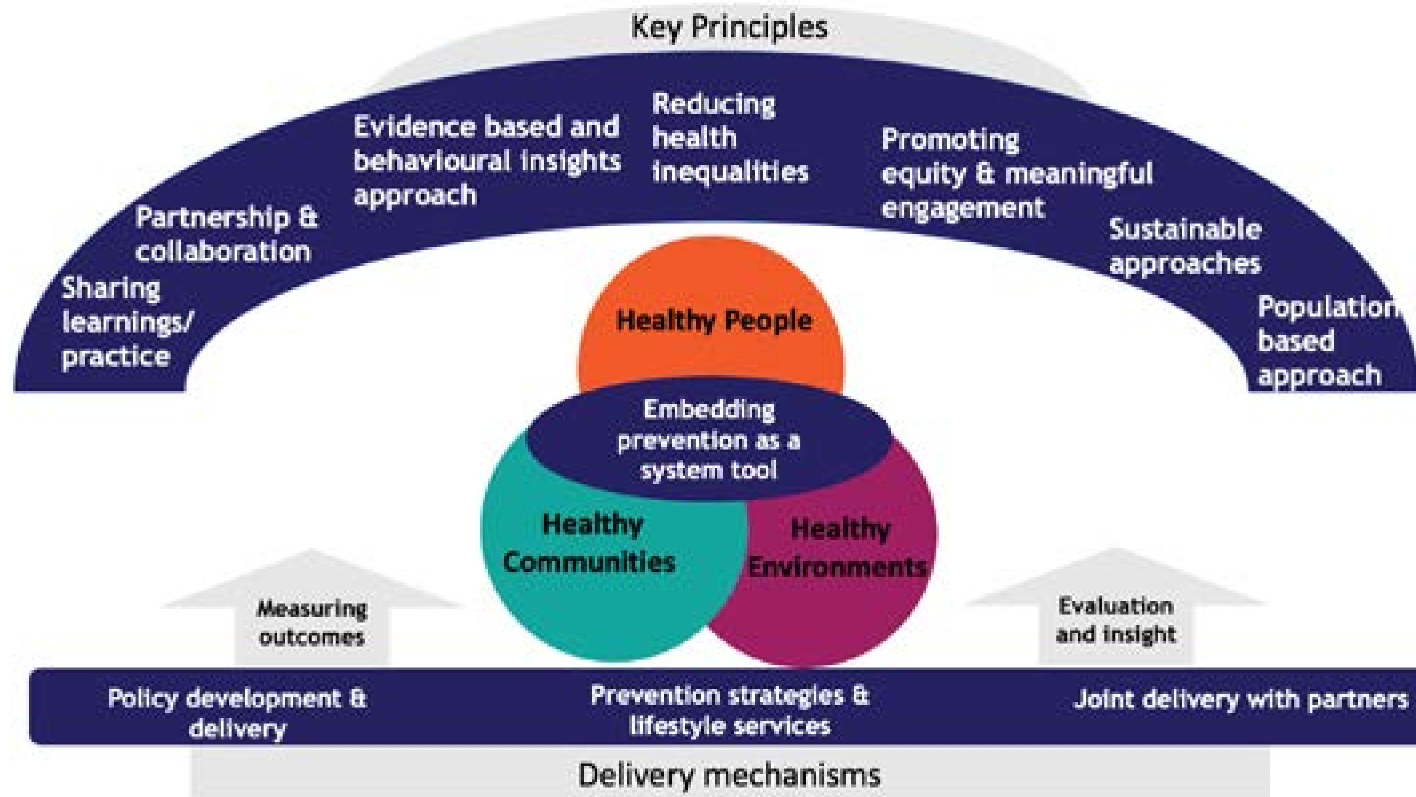
The Prevention Framework (PF) represents a whole-systems approach to preventing ill health, promoting positive health and wellbeing, and addressing health inequalities. The PF is illustrated in Figure 1.0 and represents the Council's commitment to embedding prevention in all policies and strategies at three interconnecting levels – people, community, and environment. The framework recognises the importance of the wider determinants such as housing, crime, employment, education and income, on people's health and wellbeing. It will also stem the demand for health and social care services through promoting independence and self-care, using strengths and assets in the community thus delaying, preventing, or reducing the need for health and social care services.

A focus on prevention is one of the five principles that informed the development of the refreshed JLHWS, and the refreshed strategy is one of the delivery mechanisms of the Council's PF 2021-2025.

The key objectives of the Framework are to:

1. Deliver an evidence-based approach to prevention to support the wider Council to strengthen delivery of prevention through its work,
2. Facilitate making the healthy choice, the easy choice,
3. Support a tailored approach to prevention,
4. Connect with policies and initiatives to enable prevention work to be sustainable, and
5. Create supportive communities and health-promoting environments.

Figure 1.0 Richmond Council's Prevention Framework

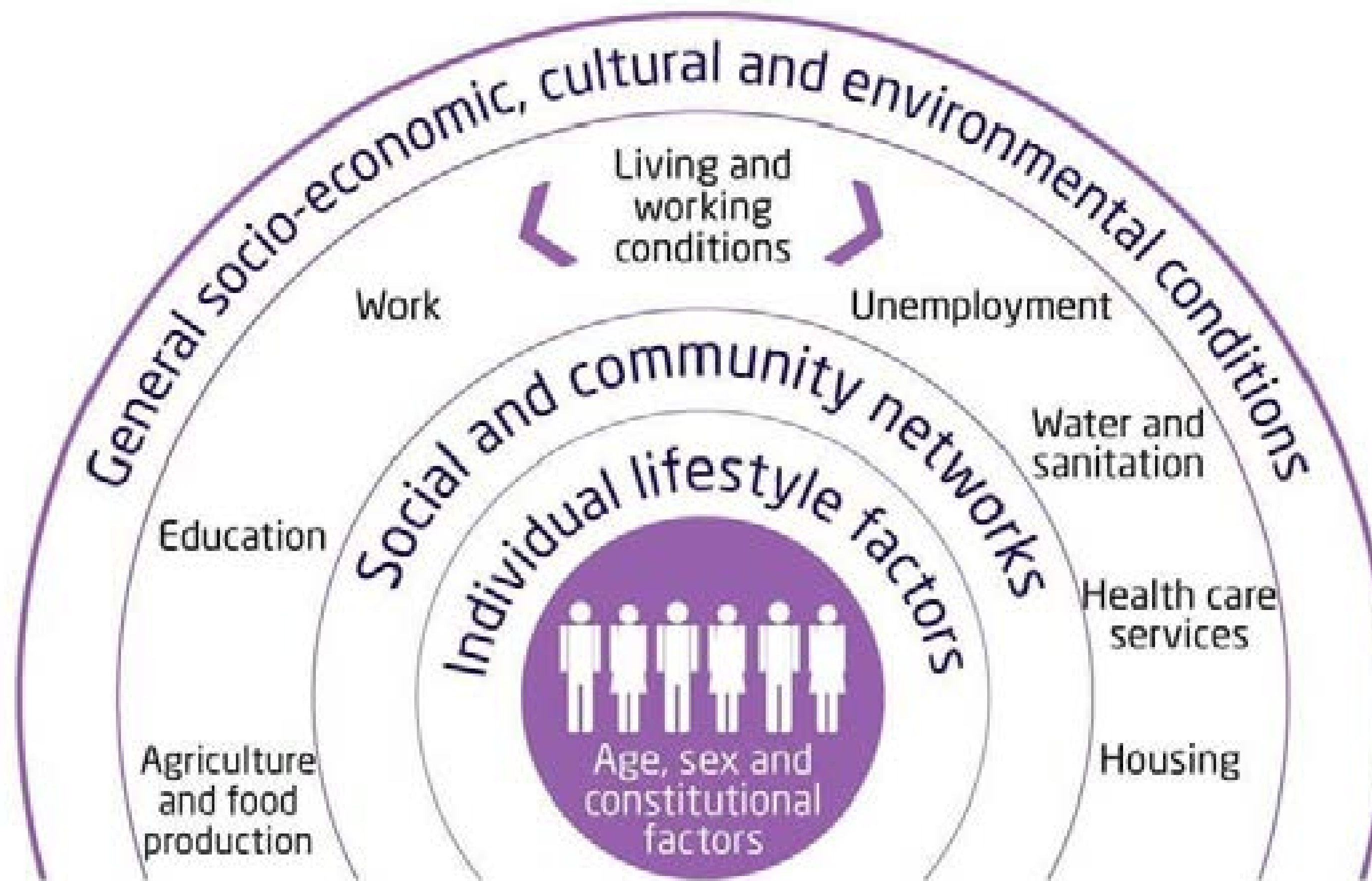


Wider Determinants of Health

The wider determinants of health encompass the broad range of social, economic, cultural, and environmental factors that influence an individual's health and wellbeing. These determinants, which include education, employment, housing, transport, and the built and natural environment, play a crucial role in shaping health outcomes and health inequalities within communities. Figure 2.0 presents the widely cited Dahlgren and Whitehead model of the main determinants of health.

These wider determinants were carefully considered in the development of the JLHWS and are integrated in the actions of the refreshed strategy. By addressing these underlying factors that impact health, the strategy aims to create the supportive conditions required for Richmond residents to lead healthier lives and experience improved health and wellbeing.

Figure 2.0 Wider determinants of health



Source: Dahlgren, G. and Whitehead, M. (1993) Tackling inequalities in health: what can we learn from what has been tried? https://www.kingsfund.org.uk/projects/time-think-differently/trends-broader-determinants-health

Start well

18 STEPS
to Health and Wellbeing

Start Well

STEP 1: Self-harm and social, emotional,and mental health needs

The average emotional wellbeing score for children and young people in Richmond is the fourth lowest in London. Local data shows that the number of children and young people unable to attend school due to their emotional health has increased. Notably, there is a worry about an increase in self-harming behaviours in young people. Richmond has the second highest rate of hospital admissions for deliberate self-harm among 10- to 24-year-olds in London. Further information can be found in the JSNA section on children with significant social, emotional and mental health needs.

Action

- Promote Kooth as the local online mental health support service for young people.
- Ensure all schools have access to advice and support from wellbeing specialists in the Mental Health Support Teams.
- Introduce the Sutton self-harm prevention model as part of the implementation of the Thrive mental health framework.
- Deliver an emergency care service to support young people attending hospital due to deliberate self-harm.

Tracking progress

- Personal wellbeing estimates by local authority
- Mental Health Services Dashboard (NHS England)
- Other mental health dashboards
- Hospital admissions as a result of self-harm (10-24 years)

What does success look like?

- Increase in the number of children and young people seeking early support from Kooth.
- Increase in the average emotional wellbeing score for children and young people.
- Reduction in the number of children and young people being referred to Child and Adolescent Mental Health Services.
- Reduction in the number of young people presenting at hospital due to deliberate self-harm.

STEP 2: Childhood obesity

In the year that they start school (age 5), 4.7% of children in Richmond are clinically described as obese. This is the lowest childhood obesity rate in England; however, by the time they reach Year 6 (age 11), the rate of childhood obesity doubles to 11% and is higher in the more deprived areas of the borough. Further information can be found in the JSNA section on healthy weight in children.

Action

- Deliver the Healthy Early Years London programme within early years' settings.
- Implement the Healthy Schools programme to promote healthy eating and physical activity.
- Expand parent-and-child cooking and healthy eating activities as part of the development of Family Hubs.
- Deliver the targeted Holiday Food and Activities initiative for children aged 5 to 16.
- Deliver targeted follow-up advice and support to parents following the National Childhood Measurement Programme.
- Expand the range of active play, sports, and adventurous activities available to children.

Tracking progress

- Percentage of physically active children and young people
- Reception: Prevalence of obesity (including severe obesity)
- Reception: Prevalence of severe obesity
- Year 6: Prevalence of obesity (including severe obesity)
- Year 6: Prevalence of severe obesity

What does success look like?

- Increase in the uptake of the healthy eating and physical activity programme by children in the target groups.
- Increase in the number of schools achieving the Healthy Schools Award.
- Increase in the number of children participating in 60 minutes of physical activity per day.
- Reduction in the number of children described as clinically obese in Reception Year.
- Reduction in the number of children described as clinically obese in Year 6.

STEP 3: Childhood immunisations

Childhood immunisation rates across most indicators have been declining over recent years. As highlighted in the latest JSNA, Richmond performed lower than the national average across all immunisation programmes, and vaccination coverage was lower than the 95% benchmark goal for most indicators. The borough faces challenges in uptake due to high population mobility, increasing population size, and vaccine hesitancy. There is a need to work collaboratively to increase uptake and coverage, while reducing inequalities. Further information can be found in the JSNA section on childhood vaccinations.

Action

- Improve community engagement to address inequalities.
  - Develop outreach programmes based on joint working with public health, Healthwatch, and voluntary sector and community groups, to support hard-to-reach groups to get vaccinated and tackle health inequalities.
  - Using a population health management approach to understand groups with lower uptake.
- Improve access to immunisation services
- Innovate and flex the system to improve uptake.
  - e.g., centralised call centre for all immunisations
- Improve access to better quality data to help identify gaps.

Tracking progress

- Population vaccination coverage: MMR for one dose (5 years old)
- Population vaccination coverage: MMR for two doses (5 years old)
- Population vaccination coverage: MMR for one dose (2 years old)
- Population vaccination coverage: Flu (primary school aged children)
- Population vaccination coverage: HPV vaccination coverage for one dose (12–13-year-old females)
- Population vaccination coverage: Dtap IPV Hib (1 year old)
- Population vaccination coverage: Dtap IPV Hib (2 years old)
- Population vaccination coverage: Hepatitis B (1 year old)
- Children in care immunisations

What does success look like?

- Improved vaccine coverage (especially in underserved groups)
- Improved access to data
- Improved access to immunisation services
- Improved engagement with underserved groups

Live well

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Live Well

STEP 4: Adult immunisations

Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. There are three vaccinations routinely offered to people aged 65 years and over: seasonal flu vaccine, pneumococcal polysaccharide vaccine (PPV), and shingles vaccine.

As highlighted in the latest JSNA, vaccination coverage for seasonal flu and PPV were lower than the benchmark goals and national average. The borough faces challenges in uptake due to high population mobility, increasing population size, and vaccine hesitancy. There is a need to work collaboratively to increase the uptake, and while reducing inequalities. Further information can be found in the JSNA section on vaccinations.

Action

- Improve community engagement to address inequalities.
  - Develop outreach programmes based on joint working with public health, Healthwatch, and voluntary sector and community groups, to support underserved groups to get vaccinated (tackling health inequalities)
  - Using a population health management approach to understand groups with lower uptake.
- Improve access to immunisation services.
- Innovate and flex the system to improve uptake (e.g., centralised call centre for all immunisations).
- Improve access to better quality data to help identify gaps.

Tracking progress

- Population vaccination coverage: Flu (aged 65 and over)
- Population vaccination coverage: Flu (at risk individuals)

What does success look like?

- Improved vaccine coverage (especially in underserved groups)
- Improved access to data
- Improved access to immunisation services
- Improved engagement with underserved groups

STEP 5: Cervical cancer screening

In 2022, cervical screening uptake for the 25-49 years age group in Richmond showed a level of coverage (66.7%) that is better than the London average but lower than the England average. For the 50-64 years age group, the coverage (72.3%) was higher than the London average but lower than the England average. Evidence suggests that women from deprived areas, from certain ethnic minority groups, and those with any disability (including learning disabilities) are less likely to attend cervical screening. Therefore, it is crucial to work collaboratively on these areas to improve coverage and uptake and to help reduce inequalities. Further information can be found in the JSNA section on cancer screening.

Action

- To work in partnership to access and analyse more granular quantitative and qualitative data to help understand where the inequalities exist, the barriers to access, and how to target them effectively.
- To address health inequalities by targeting underserved populations and those less likely to take up services (example: utilising the Homeless Health Offer).
- To promote health education to highlight the importance of screening amongst the eligible cohort, including in schools.
- To carry out community engagement and communications, including engaging with women through primary care services and with faith groups to promote cancer screening.
- To provide communication in a variety of languages and formats to increase accessibility.
- To opportunistically offer cervical screening through sexual health clinics, in line with the current NHSE/CLCH program in development, with the potential to offer this via other sites.

Tracking progress

- Cancer screening coverage: cervical cancer (aged 50 to 64 years old)
- Local authority screening- coverage map

What does success look like?

- Increased screening uptake and coverage, especially in underserved groups.
- Better understanding of barriers to participation, especially amongst the more vulnerable groups/groups less likely to take up services and the development of action plans to address this. Connecting Health Communities is a project already underway to engage the community, identify barriers to access, and develop actions to address this.
- Improved working relationships with PCNs to help improve uptake and reduce health inequalities.

STEP 6: Diabetes

It is estimated that 12,553 people in Richmond have diabetes. This includes people that have already been diagnosed by their GP and those who have diabetes but do not know it (undiagnosed). Notably, it is estimated that 5,649 (45%) of people are living with undiagnosed diabetes and are not receiving treatment and missing out on vital health checks. We know that only about half of the known diabetic people in Richmond are receiving optimal treatment and achieving the desired treatment targets. Further information can be found in the JSNA section on diabetes.

Action

- Work with people in groups most at risk to target NHS health checks
- Develop community led health clinics to find people at risk of type 2 diabetes
- Social prescribing to promote weight management services
- Promote awareness of structured education programmes and how to access

Tracking progress

- Data available at PCN level [PCN code for Richmond U90453]
- Estimates of diabetes

What does success look like?

- People in Richmond living with type 2 diabetes will all receive the 8 care processes.
- People in Richmond with type 2 diabetes will achieve the 3 Treatment Targets.
- By addressing lifestyle factors that contribute to disease, we will lower the incidence of type 2 diabetes.
- Increase percentage of people with type 2 diabetes who attended the diabetes structured education programme with 12 months.
- Increased referrals to the national diabetes prevention programme and local prevention programmes.

STEP 7: Cardiovascular disease

Cardiovascular disease (CVD) is a general term for conditions that affect the heart or blood vessels, and includes coronary heart disease, heart attack, angina, and stroke. CVD is the 5th most common cause of all age mortality before the age of 75. Hypertension significantly increases the risk of developing CVD and therefore identification and management of hypertension is essential to improving outcomes. In Richmond, 20,397 patients have been diagnosed with hypertension, with a further 17,000 people estimated to be undiagnosed. We also know that not all diagnosed people are on optimal treatment. Further information can be found in the JSNA section on cardiovascular disease.

Action

- Work with people in groups most at risk to target NHS Health Checks.
- Develop community led health clinics to identify people with undiagnosed hypertension.
- Social prescribing to promote services that support lifestyle changes.
- Optimise the medical management of people with CVD in primary care.

Tracking progress

- Cumulative percentage of the eligible population aged 40 to 74 who received an NHS Health check
- Statistics on NHS Stop Smoking services
- Physical activity tool
- Persons referred to, enrolled on, and completed tier 2 adult weight management service
- Hypertension QOF measure
- CVD QOF measure

What does success look like?

- Increased percentage of people aged over 40 completing an NHS Health Check.
- A systematic outreach programme within targeted communities to support in the identification of people with undiagnosed hypertension.
- Increased number of people with access to activities and programmes that support lifestyle change and prevent and/or address CVDs. Activities to include smoking cessation services, physical activity services, weight management services, and healthy eating.
- Patients with diagnosed hypertension or CVD will have their condition optimised through medication and support to maintain a healthy lifestyle.

STEP 8: Respiratory health

Respiratory conditions are among the leading causes of mortality and emergency admissions in the UK. These conditions include asthma, chronic obstructive pulmonary disease (COPD), lung cancer, pulmonary fibrosis, and pneumonia.

Asthma is the most common lung disease in the UK, affecting up to 8 million people at some time in their life. Although asthma is treatable, in 2018, there were 1,400 deaths from asthma (across all ages) in the UK. Asthma accounts for up to 60,000 hospital admissions and 200,000 bed days per year in the UK. Still more people attend A&E with exacerbations each year, but do not require admission. In Richmond, 21,026 people have a diagnosis of asthma and the relative risk of having an emergency admission for asthma is 0.8029 compared to the average risk in England, Scotland, and Wales. Asthma incidence is 36% higher in the UK's most deprived communities compared to the least deprived, and prevalence is 11% higher. Possible contributing factors are damp housing leading to exposure to fungal spores, increased exposure to pollution, and the inhalation of second-hand smoke.

COPD affected 1.2 million people in the UK in 2021, representing 2% of the population and 4.5% of over 40's. Even more concerning is that an estimated two-thirds of people suffering from COPD are undiagnosed and therefore untreated. COPD affects people living in the most deprived areas more than those living in the least deprived areas. In Richmond, 2183 people have a COPD diagnosis and the relative risk for someone living in Richmond of having an emergency hospital admission due to COPD in 2012 was 0.7218 compared to the average risk for Scotland, England, and Wales. Further information can be found in the JSNA section on respiratory disease.

Action

- Improve access to smoking cessation and reducing the use of Vapes.
- Develop population health tools allowing us to identify groups more likely to smoke.
- Establish community spirometry hublets.
- Ensure clear pathways into post covid services including psychological therapies.

Tracking progress

- COPD QOF prevalence
- Asthma QOF prevalence
- Smoking prevalence in adults
- Air pollution: fine particulate matter (new method - concentrations of total PM2.5)
- Emergency hospital admission for COPD

What does success look like?

- Increased identification of people with COPD.
- Increased rates of early identification and improved diagnosis of people with asthma.
- Optimal treatment of people with COPD and asthma.
- Reduction of the number of people in the borough who smoke.
- Established diagnostic Spirometry Hublets in primary care.
- Reduction of air pollutants and the effect on people's respiratory health.
- Reduction in the number of emergency admissions for asthma and COPD.

STEP 9: Post COVID-19 syndrome

Long COVID, also known as Post-COVID Syndrome, is defined by NICE as 'signs and symptoms that develop during or following an infection consistent with COVID-19 which continue for more than 12 weeks and are not explained by an alternative diagnosis.'

The latest data from the Office of National Statistics show that 1.9 million people (2.9% of the population) had self-reported symptoms of long COVID as of 30 March 2023. Of these, 79% reported that their long COVID symptoms affected their activities of daily living, of whom 20% were 'limited a lot.' The majority (69%) of people self-reporting long COVID symptoms had an acute COVID infection at least 12 months prior, while 41% had an acute COVID infection at least 24 months prior. The most common symptoms of long COVID are fatigue (72%), difficulty concentrating (51%), muscle aches (49%), and shortness of breath (48%).

The prevalence of long COVID symptoms is greatest amongst 35–69-year-olds, females, those living in more deprived areas, those working in Social Care, people 16 years and above not working and not actively looking for work, and those with an activity-limiting health condition or disability.

Long COVID has a non-linear recovery pattern and differing levels of support and rehabilitation through a multi-disciplinary approach provides the best chance of recovery. It is also important that ongoing support is available over a longer period. As the condition affects people of working age in higher numbers, a focus on promoting a return to work and/or independence is imperative to reduce the risks of long-term disability due to the condition. Further information can be found in the JSNA section on post COVID syndrome.

Action

- Develop a long COVID service which is fully integrated with psychological services and Adult Social Care through a care co-ordination approach.

Tracking progress

- Ongoing symptomatic COVID-19 (4-12 weeks after infection)
- Post-COVID-19 syndrome (12 weeks plus)
- Signposting to Your COVID Recovery
- Referral to post-COVID assessment clinic
- Post-COVID-19 syndrome resolved.

What does success look like?

- Integrated pathways for long COVID to provide co-ordinated care in place.
- More people with long COVID supported back to work or independent living.

STEP 10: Climate change

Climate change has been identified as one of the most significant health risks globally. There are also co-links between climate change and air pollution emissions.

Climate change threatens human health through direct and multiple or complex pathways including extreme weather events, food scarcity, rises in certain types of vector-borne diseases, as well as impact on mental health. Immediate dangers for residents of Richmond upon Thames are increases in the frequency, magnitude and duration of extreme climate and weather events such as heatwaves, heavy rainfall, and flash flooding. For example, excess heat can put pressure on the heart, brain, and lungs, increasing the death rate from cardiovascular, cerebrovascular, and respiratory diseases, particularly for those with pre-existing health conditions. Elderly people and babies are particularly vulnerable to heat-related illnesses including dehydration.

Summer temperatures have steadily increased over recent years; 2022 saw the highest recorded temperature in England at 40.3°C, which prompted the first ever Level 4 Heat-Health Alert and Red National Severe Weather Warning Service Extreme Heat warnings to be issued by the government. The UK Health Security Agency estimated 2,985 all-cause excess deaths were associated with the 5 heat episodes which occurred during the year for England, the highest number in any given year. For London, all-cause excess mortality was estimated to be 387. More excess deaths in those aged 65 and over occurred than any year since the government's heatwave plan began, since 2003 (Office for National Statistics, 2022). Premature deaths due to hotter summers are projected to triple by 2050 in London if not action is taken.

More needs to be done in Richmond to tackle climate change and reduce its health impacts. Further information can be found in the JSNA section on climate change, the NHS Long Term Plan (Health Inequalities and Air Pollution: NHS Long Term Plan v1.2 August 2019), and NHS England Delivering a 'Net Zero' National Health Service (2022).

Action plans

- Work collaboratively as a health and social care system in achieving Net Zero targets and in reducing emissions.
- Implement the Council's Climate Change Strategy to help tackle climate change.
- Borough adoption and implementation of the new Local Spatial Plan, to ensure new developments in the borough help to limit carbon emissions.
- Work collaboratively with the partners including NHS bodies, local pharmacies, and voluntary sector organisations to help raise awareness of health and climate change co-benefits and to highlight the impact of climate change on vulnerable groups.
- All partners to develop adverse/extreme weather and health plans (heat/cold/drought/flood) as an adaptation measure to help minimise the risks to peoples' health.

Tracking progress

- Greenhouse Gas Emissions (GHG) borough data from the Department for Energy Security and Net Zero: UK greenhouse gas emissions: local authority and regional - data.gov.uk
- National Atmospheric Emissions Inventory

What does success look like?

- Decreased levels of carbon emissions via action plans and monitoring reports on emissions
- Increased identification and engagement of communities including vulnerable groups in climate change risk locations (e.g., heat island locations via climate change risk map) within the borough to raise awareness of climate change and health.
- Borough adoption and implementation of the new Local Spatial Plan
- Assurances from all borough partners and organisations regarding their adverse weather and health plans and their implementation to help protect individuals and communities from the health effects of adverse weather and to build resilience. E.g., via Table-top exercises

STEP 11: Air quality

It has been estimated that the annual mortality of human-made air pollution in the UK is roughly equivalent to between 28,000 and 36,000 deaths (OHID, 2022). The Greater London Authority estimated that in 2019 the equivalent of between 3,600 to 4,100 deaths were attributable to air pollution in the city (GLA, 2021).

Air pollution in parts of Richmond upon Thames, especially around our main roads and town centres, exceed legal UK objective limits. The health impact of air pollution is significant as an environmental hazard which is often not visible but can cause significant damage to people's health. This includes exacerbation of asthma, impaired lung development in children, and increased risk of chronic conditions such as cardiovascular and respiratory diseases including lung cancer leading to reduced life expectancy. There is also significant overlap between air pollution and climate change in terms of emissions and greenhouse gases. The estimated fraction of mortality or deaths attributable to particulate air pollution place Richmond 23rd out of the 33 boroughs in London at 6.2%; this is higher than the England and London averages of 5.5% and 6.5%, respectively (OHID, Fingertips, 2021 data). More needs to be done to raise health awareness and help tackle air pollution in the hotspot areas of the borough. Further information can be found in the JSNA section on air quality.

Action plans

- For local organisations and partners to progress to achieving NetZero and reduce emissions.
- Implementation and progress of the Borough Air Quality Action Plan
- Work with local NHS bodies, local pharmacies, and voluntary sector partners to raise awareness of health, air pollution and vulnerable groups.

Tracking progress

- National Atmospheric Emissions Inventory

What does success look like?

- Decreased levels of air pollution in the borough (Annual Air Quality Status Report).
- Decreased levels of carbon emissions via actions, monitoring and reporting of local organisations and partners.
- Greater engagement of vulnerable groups in terms of health and air pollution awareness.
- Decreasing fraction of mortality attributable to particulate air pollution (OHID, Fingertips).

STEP 12: Physical activity and healthy eating

Physical activity

Physical inactivity is the 4th leading risk factor for global mortality and is a contributing risk factor to 1 in 6 deaths in the UK, therefore placing a large burden on both healthcare and adult social care. The majority (77.2%, 113,300) of adults in Richmond upon Thames are physically active, defined as more than 150 minutes of physical activity a week, which is higher than the national, London and statistical neighbours' average of 62.4%. However, 18.5% of adults are participating in less than 30 minutes of physical activity per week. Physical inactivity is more common among older adults; Black, Asian, and Minority Ethnic groups (representing approximately 16% of the Richmond population); people in lower socio-economic groups; women; adults with physical disability, long-term health conditions, and those with multiple co-morbidities; adults who have problems with weight management, with men's participation in weight loss programmes being particularly low; and carers, of whom approximately 46% are physically inactive.

The Richmond Health Watch survey found that Richmond residents have a strong desire to be physically active to improve their general health and appearance. The research found that professional advice such as health checks and convenience were significant factors that would influence people to change. Most participants perceived physical activity as a costly, structured or led behaviour requiring payment for gym membership or classes. There is a strong community desire for affordable and well-run council leisure, sports and physical activity opportunities that are easy to access and book.

Healthy eating

Low fruit and vegetable intake and obesity contribute to one third of all deaths from cancer and cardiovascular disease. Poor diet is also a driver for other long-term conditions such as type 2 diabetes and musculoskeletal conditions. Those groups most at risk of developing diet-related disease are older adults; Black, Asian, and Minority Ethnic groups (Black African and Caribbean groups are three times more likely to develop type 2 diabetes); carers; adults with learning disabilities (approximately 40% of adults with a learning disability are obese); people living on low incomes; and adults who are overweight and obese. Most adults (64.4%, 98,114) in Richmond are currently meeting the recommended '5-a-day' on a 'usual day'. Although this is higher than national average of 55.4%, a significant proportion (35.6%, 54,237) of adults are therefore not meeting this recommendation. Further information can be found in the JSNA sections on physical activity and healthy eating.

Action

Ensure these proposed actions are included in the forthcoming Leisure, Sport, and Physical Activity Strategy

- Target and support inactive adults to become more active.
- Identify barriers to participation and reduce them where possible, including reviewing concessions.
- Create pathways for inactive adults to take small steps or 'doses' of physical activity.
- Promote the benefits of physical activity to Richmond adults, specifically targeting those groups who are the least physically active and improve signposting to opportunities to be physically active.
- Create an on-line physical activity offer for those who are unable to leave home.
- Work with organisations who are supporting food insecurity to promote the benefits of healthy eating and consider providing a community recipe resource.
- Promote the benefits of healthy eating when adults take their first step to join the physical activity ladder.

Tracking progress

- Percentage of physically inactive adults
- Percentage of adults aged 16 and over meeting the '5-a-day' fruit and vegetable consumption recommendations (new method)
- Percentage of adults walking for travel at least three days per week

What does success look like?

- Richmond to become one of the most active boroughs in London.
- By 2031, to reverse the decline in physical activity caused in part by the COVID-19 pandemic and to help those who are inactive become active and move more.
- To achieve the short, intermediate, and long-term targets as set out in the Richmond Public Health Physical Activity Plan
  - Short to medium-term target is for 3,550 or more inactive adults to become active (a 15% decrease in inactive adults from the May 2020/2021 baseline of 20% to 17% by May 2025/2026 or earlier
  - Longer-term target is to reduce the inactive population to 12% of the population or better (11,700 people from baseline), specifically amongst the groups most at risk (this is a 40% decrease in inactive adults from an estimated 2021 baseline of 15%).

STEP 13: Alcohol

Alcohol consumption is high locally. Richmond upon Thames had the seventh highest rate of litres of alcohol sold per adult through the off-trade in London, with wine sales being the most popular. In 2017/2018 there were 12.7 licenced premises selling alcohol per square km in Richmond – the 8th lowest in London, but 901% higher than the England average. One in 3 adults in the borough drink over 14 units of alcohol a week which is higher than London and England and there were an estimated 1400 dependent drinkers in the borough. Alcohol continues to be a key contributor to hospital visits with 3,016 hospital visits in 2021/22 attributed to alcohol related conditions and 1,205 due to alcohol specific conditions. In 2021/22, the rate of alcohol-related admissions in under 40s was 122.7 per 100,00 (n=104). Locally, 59 people died from alcohol related conditions in 2018. Alarmingly, the rate of alcohol-related road traffic accidents in 2014-16 was 19.8 per 100,000 (n=27), which is the 4th highest rate in London and 82.4% higher compared to 2010-12. Finally, in a survey of year 6 pupils in Richmond upon Thames, 2% of boys and 1% of girls reported having alcohol in the previous seven days. Among year 8 and year 10 pupils, 56% reported that they had tried alcohol while 3% reported consuming alcohol once or twice a week. Further information can be found in the JSNA section on substance misuse.

Action

- Ensure that Licencing policy and applications consider the health and wellbeing of local communities by monitoring the number of new alcohol licences, licence renewals and change applications in Richmond upon Thames by creating a pathway for reviewing applications received. This pathway will review on and off licence requests and make recommendations based on local data linked to crime, hospital admissions, surrounding premises, road traffic incidents, and complaints.
- Ensure implementation of the Combatting Drugs Partnership's delivery action plan to improve continuity of care in prison; facilitate the delivery of screening and brief advice for alcohol inpatient settings; improve pathways for children and young people with alcohol-related admissions; and deliver evidence-based school-based prevention and early intervention for substance use, including alcohol.
- Continue promoting the Drink checker tool to identify harmful drinking and provide information, advice, and education as to the risks of alcohol and the benefits of reducing intake.
- Ensure information is in easy-to-read formats and translated to be accessible to the widest population.
- Improve availability of alcohol alternatives and alcohol-free social activities by partnering with businesses.
- Leverage social motivations by campaigns aimed at encouraging social contacts to support others to reduce their consumption.

Tracking progress

- Admission episodes for alcohol-related conditions (Narrow) (Persons)
- Admission episodes for alcohol related conditions
- Admission episodes for alcohol related conditions
- Casualties in road traffic accidents where a failed breath test (or refusal to provide a sample) occurred
- Number of premises licensed to sell alcohol per square kilometre

What does success look like?

- Reduction in hospital admissions for alcohol related conditions among 40–64-year-olds.
- Reduction in hospital admissions for alcohol related conditions in under 40's.
- Reduction in alcohol-related road traffic accidents.
- Reduction in volume of pure alcohol sold in the borough.
- Reduction in alcohol related anti-social behaviour.

STEP 14: Smoking

Smoking remains one of the biggest causes of death and illness in the UK. Every year, around 76,000 people in the UK die from smoking, with many more living with debilitating smoking-related illnesses (NHS UK). There is a need to reduce smoking rates and improve overall health outcomes in Richmond upon Thames, with a particular focus on reducing health inequalities related to smoking. Further information can be found in the JSNA section on smoking, the Action on Smoking and Health and the NHS website.

Action

- Provide targeted interventions for high-risk groups such as young people, pregnant women, and people with mental health conditions, while maintaining a universal offer.
- Ensure access to evidence-based smoking cessation services, including nicotine replacement therapy, behavioural support, and digital interventions, to support people to quit smoking.
- Monitor progress towards reducing smoking rates and improving health outcomes by clear and measurable indicators, such as smoking prevalence, quit rates, hospital admissions for smoking-related illnesses, and health inequalities related to smoking.
- Develop new and strengthen existing smoking cessation pathways across different health organisations and partnerships across NHS Trusts, the local authority and voluntary sector, particularly those aimed at targeted groups and reducing inequalities.
- Advocate across the Integrated Care System the importance of stopping smoking on health outcomes and increase awareness of and visibility of smoking cessation services, pathways, and access points with a focus on targeted groups and reducing inequalities, utilising the London Tobacco Alliance as a resource to effect change.

Tracking progress

- Smoking prevalence in adults (18+)
- Smoking prevalence in adults in routine and manual occupations (18-64 yrs.)
- Smoking status at time of delivery
- Smoking attributable mortality
- Smoking attributable hospital admission
- No. of people setting a quit date
- Smoking prevalence in adults (18+) with serious mental illness (SMI)
- Smokers that have successfully quit at 4 weeks
- Smoking attributable hospital admissions (new method)

What does success look like?

- Maintain and further reduce smoking prevalence in the local population, particularly among high-risk groups such as young people, pregnant women, and people with mental health conditions.
- An increase in the number of people accessing evidence-based smoking cessation services and successfully quitting smoking from 2022-23 baseline.
- A decrease in the number of hospital admissions for smoking-related illnesses, such as lung cancer, heart disease, and stroke.
- A reduction in health inequalities related to smoking, particularly among disadvantaged communities.

STEP 15: Suicide prevention

Suicidal thoughts and behaviours are associated with high levels of distress for those affected. Death by suicide is preventable. Each life lost is a tragedy. One suicide will always be one too many. In Richmond upon Thames, self-harm is one of the top five leading causes of death and the borough had the second highest rate of emergency hospital admissions for intentional self-harm in 2020/21 for London, with a rate of 151.9 per 100,000. The rate for 2021/22 as per Fingertips was 147.9 per 100,000. In 2019/2021, there were 37 deaths due to suicide compared to 47 in 2017/2019, of which 27 were male. Vulnerable groups including autistic adults and people identifying as LGBTQ+ are at higher risk from self-harm. Further information can be found in the Richmond Mental Health Needs Assessment, JSNA section on mental health, and the Richmond Suicide Prevention Strategy 2022-25.

Action

In addition to the action plan already set in the recent Richmond Self-Harm and Suicide Prevention Strategy 2022-25:

- Include health inequalities as an element for reduction when more data is available on demography of deaths by suicide and self-harm.
- Community led support network for higher risk groups.
- Tailored approaches to improve mental health in high-risk groups.
- Holistic and integrated approach that considers financial and other key determinants.
- To ensure there is resource to continue monitoring of Realtime Suicide Prevention data.

Tracking progress

- Suicide rate
- Hospital admission due to intentional self-harm (10-24 years)

What does success look like?

- The environment we live in promotes conditions which protect against suicide risk – this includes our psychological, social, cultural, economic, and physical environment.
- Our communities have a clear understanding of suicide, risk factors and its prevention so that people and organisations are more able to respond in helpful and informed ways when they, or others, need support.
- Everyone affected by suicide can access high quality, appropriate and timely support which promotes wellbeing and recovery.
- Embed a coordinated integrated collaborative approach to suicide prevention that takes national trend and best practice into account.

Age well

18 STEPS
to Health and Wellbeing

Age Well

STEP 16: Falls and frailty

A fall is defined as an event which causes a person to unintentionally rest on the ground or lower level and is not a result of a major intrinsic event or overwhelming hazard. The Public Health Outcomes Framework reported that in 2021-22 there were around 820 emergency hospital admissions related to falls among patients aged 65 years and over in Richmond upon Thames, with 510 of these emergency admissions for people patients aged over 80 years. However, about half of this number is due to patients being transferred between hospital sites. This has meant that Richmond has the 13th lowest rate of falls for people 65 and over in England. The number of falls has also reduced over the last year and is currently achieving the Better Care Fund ambition within the 2023-25 Better Care Fund Plan.

The likelihood and severity of injury resulting from a fall is related to bone health. People with low bone mineral density are more likely to experience a fracture following a fall. One of the main reasons why people have low bone mineral density is osteoporosis. In the UK, over 3 million people have osteoporosis, and they are at much greater risk of fragility fractures. Further information can be found in the JSNA section on Falls, Frailty and Mobility.

Action

- To work together with Richmond care homes and improve their access to the Urgent Community Response (UCR) falls pickup service, embed falls acoustic monitoring into care homes through the South West London Integrated Care Board Enhanced health in care homes programme, and provide additional support to care homes that have increased falls rates or no-pickup policies in place.
- To understand the numbers of people who are admitted as an emergency for less than 1 day or via the Same Day Emergency Care as a proportion of those people being admitted for a fall and working with Hounslow and Richmond Community Healthcare to consider alternative pathways away from hospital.
- To utilise population health management data from hospitals and community providers to ensure that falls recovery services are accessible for the Richmond upon Thames population.
- To implement the Fracture liaison pathway at Kingston Hospital to identify bone density issues, refer into community falls services and to prevent subsequent falls and fractures.

Tracking progress

- Emergency hospital admissions due to falls in people aged 65 and over
- Emergency hospital admissions due to falls in people aged 80 plus

What does success look like?

- Reduction in the rate and number of emergency admissions related to falls for people agreed 65 and over (Better Care Fund), with emphasis on those people aged 80 years and over.
- Jointly held understanding of initial and subsequent falls seen for the residents of Richmond.
- Increased level of referrals into community falls services from acute hospitals as part of fracture liaison service and from care homes via the UCR service, including increased bone density (DEXA) scanning available as part of the pathway. No deterioration in the waits for UCR and for falls recovery services.
- Jointly managed communications and training from HRCH and Local Authority Quality Assurance teams to Richmond Care Homes regarding access to Richmond falls pickup services, and regular Care Home falls LAS conveyance reporting to provider risk panels.

STEP 17: Dementia

Dementia is a progressive disease often associated with complex health and social care needs. These needs are expected to increase in Richmond upon Thames because of expected increases in numbers of older adults living in the borough. There are several gaps and opportunities that should be addressed to improve the dementia offer across Richmond. Therefore, enacting a comprehensive dementia prevention and care support offer for residents affected by and living with dementia remains a priority for Richmond Council alongside partners across the health and social care arena.

Dementia is not a single disease but is a term used to describe the symptoms that occur when there is a decline in brain function. Several different diseases can cause dementia. Many of these diseases, such as Alzheimer's, are associated with an abnormal build-up of proteins in the brain. This build-up causes nerve cells to function less well and ultimately die. As the nerve cells die, different areas of the brain shrink. In vascular dementia, if the oxygen supply to the brain is reduced because of narrowing or blockage of blood vessels, some brain cells become damaged or die; in dementia with Lewy bodies, tiny abnormal structures (Lewy bodies) form inside brain cells, disrupting the chemistry of the brain and leading to the death of brain cells.

As of March 2023, there were 1,376 people aged 65 and over diagnosed with dementia on Richmond GP Practice systems, with a further 50 people aged below 65 diagnosed with dementia. The expected prevalence of dementia in people registered with a Richmond GP Practice in March 2023 is 2,032.2, based on the table below:

Age Group	Females	Males
65-69	1.8%	1.2%
70-74	2.5%	3.0%
75-79	6.2%	5.2%
80-84	9.5%	10.6%
85-89	18.1%	12.8%
90+	35.0%	17.1%

The proportion of people with a dementia diagnosis is 67.71%, which is higher than the national standard of 66.7%. However, dementia diagnosis rates vary by primary care networks (PCNs), ranging from 59.97% in Sheen and Barnes to 77.45% in Hampton. This may well be linked with the rates of people in Care Quality Commission registered care homes which each practice has within it's PCN, which would not affect the prevalence above, but would increase the numbers of people with dementia identified. Further information can be found in the JSNA section on Dementia Prevention and Care.

Action

- Work together with primary care and the Hounslow and Richmond care home support team to ensure that every person diagnosed with dementia has a Universal Care Plan in place to support them and identify barriers to dementia care.
- Increase the number and rate of people diagnosed with dementia in care homes in line with the 70% expectation within the Enhanced Health in Care Homes Framework, adopting a model where clinicians visit care homes to case find.
- Introduce a community-based loan service that loans 'sensory based, interactive digital technology' for people with dementia or cognitive impairment in care homes or within community settings, which provides both an in reach and outreach service.
- Provide access to psychosocial support for families and carers of people with dementia including bereavement and therapy services.
- Consider appropriate respite and activities for people with young onset dementia separately to older people's dementia services.
- Ensure timely diagnosis pathway including primary care, diagnostic testing and the memory assessment services at South West London and St Georges Mental Health NHS Trust, including appropriate pre-diagnostic support.

Tracking progress

- Estimated dementia diagnosis rate (aged 65 and over)

What does success look like?

- Increased proportion of the population receiving a dementia diagnosis, building on the 66.7% national standard
- Reduced ununderstood variation in dementia diagnosis rates for registered populations by PCN and increased dementia diagnosis rates of people in older people's care homes.
- Increased proportion of people with dementia being discussed and support identified through Proactive Anticipatory Care multidisciplinary teams.
- Other goals identified through the ten-year Richmond Health and Care Dementia Strategy.

STEP 18: Social isolation

One in six adults in Richmond upon Thames report feelings of loneliness or social isolation most or all the time. Reducing the barriers to accessing community services that offer opportunities to make connections with others results in improvements in both physical and mental health for older people, particularly those in vulnerable groups who are more at risk, including unpaid carers, people living with long term conditions, people living with mental health conditions, and older people living alone. Further information can be found in the JSNA section on Social Isolation.

Action

- Build 'social capital' and use local networks and community assets (e.g., volunteering) to increase resilience.
- Support the use of digital technology to aid access to health and wellbeing advice and reduce loneliness and isolation.
- Review and improve transport provision to enable increased access to social opportunities in the community.
- Ensure opportunities for breaks and social connections are available particularly for vulnerable groups (unpaid carers, older people with long term health conditions, mental health).
- Establish a system for community service providers to highlight gaps and issues that increase risk of social isolation in older people.

Tracking progress

- Social Isolation: percentage of adult carers who have as much social contact as they would like (18+ yrs.)
- Social Isolation: percentage of adult carers who have as much social contact as they would like (18+ yrs.)
- Social isolation: percentage of adult social care users who have as much social contact as they would like (18+ yrs.)
- Loneliness: Percentage of adults who feel lonely often or always or some of the time

What does success look like?

- Increased opportunities, in person and online, for people to feel less isolated and be involved in social engagement that improves their health and wellbeing.
- Increased percentage of adult carers who report that they have as much social contact as they would like.
- Increased percentage of adult social care users who report they have as much social contact as they would like.
- Decreased percentage of older adults who feel lonely often or always or some of the time.
- Decreased number of adults who cite lack of transport as a barrier to engaging in their community.
- Increased number of healthcare professionals who have an awareness of community assets that can reduce loneliness and isolation and how to connect people to them (e.g., through Social Prescribing link workers).
- A developed system for all partners to identify and address any gaps in data or actions needed.

Glossary of terms

A&E	Accident & Emergency
CLCH	Central London Community Healthcare
COPD	Chronic Obstructive Pulmonary Disease
CVD	Cardiovascular Disease
DEXA	Dual Energy X-ray Absorptiometry
EINA	Equality Impact Needs Assessment
HRCH	Hounslow and Richmond Community HealthCare NHS Trust
HWB	Health & Wellbeing Board
JLHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
LGBTQ	lesbian, gay, bisexual, transgender, queer
NHS	National Health Service
NHSE	NHS England
PCN	Primary care Network
PHOF	Public Health Outcomes Framework
PF	Prevention Framework
PPV	Pneumococcal Polysaccharide Vaccine
QOF	Quality Outcomes Framework
UCR	Urgent community response

APPENDIX 1:
Membership of the Task and Finish Group

Richmond and Wandsworth Councils	
Ian Dodds	Director of Children's services, Achieving for Children
Shannon Katiyo	Director of Public Health
Nike Arowobusoye	Consultant in Public Health
Natalie Daley	Consultant in Public Health
Usman Khan	Consultant in Public Health
Sakeella Meiyanathan	GP SPIN FELLOW
Patricia Mighiu	GP SPIN FELLOW
Alexandra Brooke	GP SPIN FELLOW
Riya Verma	GP SPIN FELLOW
Lynn Wild	Associate Director - Health and Care Integration
Paul Martland	Head of Child Health Wellbeing and Early Help
Kay Willman	Assistant Director (Housing Strategy, Compliance and Enabling)
Lesli Good	Interim Assistant Director of Environment and Community Services (Leisure)
Michael Liu	Housing Policy and Performance Officer
James Armitage	Head of the Regulatory Services Partnership
Andrew Hagger	Head of Climate Change and Sustainability
Trudy Jones	Partnerships and Programmes Manager
Wendy Phillips	Public Relations Manager
Effie Lochrane	Head of Communications
Katherine Foreman	Communications Manager
Katrina Waite	Head of Resident Engagement
Catherine Pierce	Consultation Manager

Richmond Partners	
Kathryn Williamson	Director, Richmond CVS
Jennifer Allan	Chief Operating Officer South West London and St George's Mental Health NHS Trust
Rachel Tucker	Consultant Clinical Psychologist Disorders - South West London & St George's Mental Health NHS Trust
Mike Derry	Chief Officer, Healthwatch Richmond
Alison Danks	Associate Director of Health Services, Achieving for Children
Denise Madden	Director of Strategic Partnersips and Integration - Kingston Hospital and Hounslow and Richmond Community Healthcare, Kingston Hospital
Anne Stratton	COO and Director of Clinical Services, Hounslow and Richmond Community Healthcare NHS Trust
Anubha Prasad	Integration and Partnerships manager, SWL and St George's Mental Health NHS Trust
Melissa Wilks	Chief Executive, Richmond Carers Centre
Attracta Asika	Primary Care Commissioning, NHS SWL Integrated Care Board
Nicolas Grundy	Primary Care Lead, NHS SWL Integrated Care Board
Heather Bryan	Primary Care Lead, NHS SWL Integrated Care Board
Sue Lear	Deputy Director of Transformation (Kingston and Richmond) , NHS SWL Integrated Care Board
Tara Ferguson-Jones	Director of Communications and Engagement, Kingston Hospital and Hounslow and Richmond Community Healthcare NHS Trust

Wandsworth Partners	
Priya Samuel	Integrated Partnerships Manager, SWL and St George's Mental Health NHS Trust
Jason Edgington	CEO, Wandsworth Care Alliance
Jummy Dawodu	Director of Operations, South West Division at Central London Community HealthCare NHS Trust
Stephen Hickey	Chair, Healthwatch Wandsworth
Mary Idowu	Deputy Director – Wandsworth Place Partnership, NHS SWL ICB
Philip Murray	Director of Finance and Performance, SWL and St George's Mental Health NHS Trust
Mark Creelman	Executive Locality Lead - Wandsworth and Merton, NHS SWL Integrated Care Board
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