

# Health & Wellbeing Strategy 2013-16

## Foreword

We are delighted to present the first Joint Health and Wellbeing Strategy (JHWS) for the London Borough of Richmond upon Thames.

We have chosen to focus this strategy on integration of services where, from a patient perspective, the care system is not joined up; and where improvements can only be made in partnership rather than issues that are the remit of a single agency. The HWB has identified four priority areas for action:

- Children to adult services transition
- Physical and mental health services
- Health and social care services
- Hospital to community services

This strategy is not intended to supersede or replace existing health and social care strategies on discrete issues or client groups. This JHWS is intended as a framework for improving health and wellbeing by developing better responses to local needs. The strategy contains a number of tools to support effective commissioning and planning to meet health and social care needs, be effective and efficient in the use of limited resources, and build on local assets in a more integrated way.

Further work will take place over the next few months on our forward plan and our community involvement and engagement framework.

### **Lord True**

Leader, London Borough of Richmond upon Thames, Chair of Health & Wellbeing Board

### **Dr Andrew Smith,**

Chair, Richmond Clinical Commissioning Group

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## Executive Summary

<b>Our vision</b>	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		
<b>Strategic aims</b>	Giving children a good start	Increase independence of older people and those with long term conditions	Reduce hidden harms and threats to health
<b>Guiding principles</b>	<ol style="list-style-type: none"> <li>1. Commitment – 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 omitted.</li> <li>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.</li> <li>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.</li> <li>4. Integrated responses – 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.</li> <li>5. Evidence – 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.</li> <li>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.</li> <li>7. Better care, closer to home – the HWB will support strategies that aim to streamline pathways; improve access, and provide care closer to home.</li> <li>8. Sustainability – 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.</li> </ol>		
<b>JSNA</b>	<ul style="list-style-type: none"> <li>• Reduction in health inequalities</li> <li>• Maximisation of prevention opportunities</li> <li>• Identification of hidden harms and threats to health</li> <li>• Plan for increasing numbers of older people with long term conditions</li> </ul>		

<b>Priority areas</b>	Patient focused integration of services across organisational boundaries			
	Child to adult services transition	Physical and mental health services	Health and social care services	Hospital to community services
<b>Monitoring success</b>	<ul style="list-style-type: none"> <li>• Focus on root causes</li> <li>• Use of national validated indicators where appropriate (e.g. NHS, Public Health and Social Care Outcomes Frameworks)</li> <li>• Process indicators on each priority area</li> </ul>			
<b>Connecting strategies</b>	<p>Community Plan 2012-2017; Commissioning Strategy Plan 2012-16; Operating plan 2012-13; Adults Strategic Plan 2010-2013; Joint Out of Hospital Care Strategy 2013; Carers Strategy 2010-2013; Mental Health Joint Commissioning Strategy for Older People 2010-2015; Children and Young People's Plan for 2009-13; Children's Emotional Wellbeing and Mental Health Strategy; Child Poverty Strategy 2011-14; Mental Health Joint Commissioning Strategy for Adults of Working Age 2011-2015; Learning Disabilities Commissioning Strategy 2010-2013; End of Life Strategy; Community Safety Strategy.</p>			
<b>Tools</b>	<ul style="list-style-type: none"> <li>• Understanding the components of health and wellbeing</li> <li>• Commissioning cycle</li> <li>• Strategic questioning framework</li> <li>• Priority setting framework</li> <li>• Identifying related strategies and commissioning plans</li> </ul>			

## Chapter 1: Introduction

### What is a Health and Wellbeing Board?

Richmond's Health and Wellbeing Board (HWB) brings together local leaders from the health and social care system. The role of the HWB is to understand the community's needs, agree priorities and encourage commissioners to work in a more joined-up way. As a result, local people should experience more joined-up services from the NHS and the borough council in the future.

See [Appendix 1](#) for membership and duties and powers of the HWB.

### Scope and purpose of this strategy

The HWB have agreed their first Joint Health and Wellbeing Strategy (JHWS) will focus on the integration of services. The HWB has identified four priority areas for action from Richmond's Joint Strategic Needs Assessment (JSNA). These are priority areas where improvements can only be made in partnership rather than issues that are the remit of a single agency.

- Child to adults services transition
- Physical and mental health services
- Health and social care services
- Hospital to community services

This strategy is not intended to duplicate strategies that are already in existence or under development for key service groups and other health and wellbeing issues (e.g. learning disabilities, carers, air quality and cycling). The focus of this strategy is to enable the HWB to add value by focusing on the integration of services and how this can improve local people's experience of the care system. The HWB recognise how important the underlying determinants of health and wellbeing are (for example, education, housing, environment, etc) in ensuring a healthier Richmond. These are addressed through other key partnership strategic documents. See [Appendix 2](#) for an overview of components of health and wellbeing, and [Appendix 3](#) for links to strategies.

The audience for this strategy is primarily commissioners (the local authority and Clinical Commissioning Group (CCG) as members of the HWB) and providers of health and social care services. This JHWS is intended as a framework for improving health and wellbeing by developing better responses to local needs. The strategy contains a number of tools to support effective commissioning and planning to meet health and social care needs, be effective and efficient in the use of limited resources, and build on local assets in a more integrated way.

## How was this strategy developed?

The HWB have developed this strategy through an engagement process from April to November 2012 that included:

- Board discussions and workshops
- Working groups within the emerging CCG and Council
- Stakeholder events on April 23<sup>rd</sup> and September 20<sup>th</sup> 2012<sup>1</sup>
- Dialogue with stakeholder groups, for example, Joint Commissioning Group for Adults, Mental Health Strategy Group
- National guidance and shared learning from other areas, particularly the Kirklees Health and Wellbeing Partnership
- The draft JHWS was published on the Council's website for consultation between November 30<sup>th</sup> 2012 and January 12<sup>th</sup> 2013

The London Borough of Richmond of Richmond upon Thames and the CCG has a well established JSNA process for identifying health and wellbeing needs. The JHWS builds on knowledge and evidence identified in JSNA. Further information on the JSNA is available on [www.richmond.gov.uk/jsna](http://www.richmond.gov.uk/jsna).

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<sup>1</sup> The first stakeholder event on April 23<sup>rd</sup> explored the vision, guiding principles and priority areas. The second workshop on September 20<sup>th</sup> was part of a wider engagement event on the NHS Reforms. It included an update on work since April and focus groups on each of the four priority areas. Summaries of both workshops are available on [www.richmond.gov.uk/jsna](http://www.richmond.gov.uk/jsna).

## Chapter 2: Vision and Guiding Principles

### Health and wellbeing strategy vision

The JHWS sets out our vision for improving health and wellbeing of local people.

*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*

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This builds on three strategic aims that have been identified via Richmond's JSNA:

- Giving children a good start
- Increase independence of older people with long term conditions
- Reduce hidden harms and threats to health

The HWB have also identified four priority areas where from a patient perspective services are not joined up and require a co-ordinated multi-agency approach. By highlighting these areas, the HWB can use its powers and influence to overcome these barriers to achieving health and wellbeing:

- Child to adult services transition
- Physical and mental health services
- Health and social care services
- Hospital to community services

### Guiding principles

Richmond HWB has identified some guiding principles in the way it intends to operate in order to maximise its influence and to clarify its role and contribution in relation to other bodies working within the local health and social care system. There are many competing pressures on resources in a complex system and the HWB's role is to maintain a clear strategic direction of travel for the priority areas identified, in order to make a difference. These principles also set out an expectation of how services will be commissioned, designed, developed and delivered locally.

The HWB is seeking to shape and assure a commissioning system that is underpinned by the following principles:

1. Commitment – to work towards the best possible outcomes for all the people of Richmond – the HWB will challenge on behalf of any groups omitted.
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 – 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 – 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 Board 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 – 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.

### JHWS tools

The JHWS provides a set of tools to enable the HWB to assess member organisations key plans and strategies for their contribution to the JHWS. These tools are also intended to support people to work together to plan how they can contribute to achieving the JHWS vision and deliver on the four priority areas.

- Understanding the components of health and wellbeing (see [Appendix 2](#)).
- Consider what stage of the commissioning cycle you are starting from; developing a new service to an identified need, reviewing an existing service (see [Appendix 4](#)).
- Use the strategic questioning framework to identify how your proposal contributes to the JSNA and the JHWS vision (see [Appendix 5](#)).
- Use the prioritisation framework to help you decide in a transparent and open way what is to be tackled, and understand any opportunity costs (see [Appendix 6](#)).
- Identify how services relate to other strategies and commissioning plans (see [Appendix 3](#)).

The JSNA provides a wide range of intelligence from sources of information that should be used throughout the commissioning process. See [www.richmond.gov.uk/jsna](http://www.richmond.gov.uk/jsna) for further information.

## Chapter 3: Joint Strategic Needs Assessment (JSNA)

The JSNA, alongside the JHWS, provides a framework for improving local health and wellbeing and addressing inequalities. Richmond's shadow HWB is the owner of, and contributor to, the JSNA and has used the JSNA to inform the content of this strategy. An outline of the local JSNA process is available in [Appendix 7](#).

### The Richmond Story

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

- Increasing life expectancy, low premature mortality.
- Low levels of crime and accidents.
- Green spaces, good schools and high levels of volunteering.

#### *Reduction in health inequalities*

- There is a life expectancy gap of about 6 years and 4 years for men and women respectively between the best and worst deprivation decile scores (mainly due to coronary heart disease, chronic obstructive pulmonary disease and cancers).
- Eleven small areas (referred to as Lower Super Output Areas) with nearly 18,000 (9%) residents including some of the estimated 3,900 children living in poverty have levels of deprivation that are above average for England (Index of Multiple Deprivation, 2010).
- There is wide variation between schools in the numbers of children eligible for free school meals and a gap in educational attainment.

#### *Maximisation of prevention opportunities*

- Despite favourable comparison in London and nationally, numbers of people with unhealthy lifestyles are still big.
  - 29,000 adults smoke (approx 20%), and 200 deaths per year (1:6) are attributable to smoking.
  - Approximately 1,500 primary school aged children are obese, with prevalence increasing from 6.5% in reception to 13% in year 6. In this age group in 1984, obesity was about 0.9% nationally.
  - 45% of Richmond residents are active for 30mins a week whereas the figure is only 36% for England as a whole.
- Young people's risky behaviour often indicates various overlapping family needs (i.e. sexual health, mental health and substance misuse). Chlamydia screening uptake in high-risk groups is low.
- 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, 4,400 people with undiagnosed diabetes).

### *Identification of hidden harms and threats to health*

- About 16% of older people (age 75+ years) are carers; and 11% of carers are school-age children (age <18 years).
- A high proportion (16%) aged 65 and over live alone compared with 9% London-wide.
- A higher than average percentage of people die in winter months (excess winter deaths) in Richmond (21%) compared with the England average (19%). This equates to 75 additional deaths per year.
- Alcohol-related hospital admissions are increasing (especially in older age groups); mortality from liver disease (including cirrhosis) is variable due to low numbers.
- Childhood immunisation coverage is below herd immunity, but fortunately confirmed measles cases have been low in recent years (n=13 for 2010-12 pooled).
- Neighbouring Hounslow has one of the highest tuberculosis incidence rates in London at 73 per 100,000 population (Richmond 10/100,000).
- Prevalence of diagnosed HIV is one of the lowest in London, but the rate is still 2.23 per 1,000 population aged 15-59 and 39% of cases are diagnosed late.
- Although Richmond has some of the best air quality in London, we compared poorly with some national indicators as London overall has lower quality air than England. Further work is taking place to understand harms and threats to health.

### *Plan for increasing numbers of older people with multiple long term conditions*

- The number of people with physical long term conditions and with mental health conditions including dementia, is expected to increase in line with the population increase.
- Proportion of people with more than one long term condition (i.e. co-morbidities) is expected to increase by an estimated 50% over the next ten years, much of this increase corresponds to the increased prevalence of long term conditions in the increasingly older population.
- Whilst overall emergency admissions are relatively low around 16% (~ £5 million) of emergency admissions are for potentially preventable conditions.
- In 2008, 61% of deaths occurred in hospitals. Since the implementation of the End of Life Care Strategy there has been a decrease of 6% in hospital deaths.
- The number of care homes (20) is high relative to other boroughs. 7% (£1.7 million) of spend on emergency admissions is attributable to care homes. 30% of emergency hospital admissions from care homes are short stay (0 or 1 day) suggesting there is potential to reduce these. There are quality and safety issues identified in care homes.

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

## Chapter 4: Priority Areas

The HWB have focused their first strategy on integration of services that from a patient perspective are not joined up. These are four priority areas where improvement can only be made in partnership rather than issues that are the remit of a single agency.

### Child to adult services transition

#### *Why is this a priority?*

Transition has been identified as an area for improvement, and is a cross-cutting issue that requires strong partnership working and joint planning. For a young person with ongoing health and social care needs, the transition to adult services can be an anxious time. Without good transition protocols, vulnerable young people may not receive the most appropriate support. A positive transition can help to prevent health, social and economic problems in later life. Children's and adult services should be in discussions well before an individual's 18<sup>th</sup> birthday.

#### *Key issues in Richmond*

- The number of young people in transition is small, but their needs can be extremely complex.
- Richmond borough has begun to develop good arrangements for young people in transition.
- Five service areas have been identified where this is a particularly important issue:
  - Learning disabilities
  - Continuing care
  - Mental health
  - Substance misuse
  - Long term conditions

The following themes have been identified across services:

- Assessments are not always happening at an early enough age – assessments for adult health and social care services should begin at age 14-15.
- Local services should consider whether ongoing support is needed for young people with mild to moderate conditions, and the newly established Strategic Transition Board should identify any unmet needs.
- Limited support for young people with mild to moderate conditions.
- Lack of adult services for some conditions, for example, Attention Deficit Hyperactivity Disorder (ADHD).
- Few local options for adult residential services, especially for high-level needs.
- Potentially inappropriate environments for young adults.

### *How can the HWB address this?*

- The HWB should ensure that transition arrangements are included as a specific item when assessing strategies and commissioning plans.
- Commissioners should ensure that clear transition arrangements are included in relevant care pathways.
- Providers should ensure that they have clear transition arrangements between children's and adult health and social care services.

## **Physical and Mental Health Services**

### *Why is this a priority?*

Many people have both long term physical health conditions and mental health problems (co-morbidity). This can lead to significantly reduced quality of life and much poorer health outcomes. From a patient's perspective, there can be confusion and frustration if they feel that their health and wellbeing is not being dealt with in a holistic way. A more integrated response can significantly improve their experience of care and their health, as well as achieve more effective use of resources.

### *Key issues in Richmond*

- An estimated 30% of all people with a long term condition also have a mental health problem. Older people in particular tend to have multiple long term physical health problems which combine with mental health concerns.
- Co-morbidity is particularly high among older people in acute general hospitals. Also many residents in care homes are likely to have depression or dementia.
- Carers of people who have a physical or mental health condition are particularly vulnerable to experiencing psychological distress as well as having chronic physical illness.
- Commissioners and providers should seek to integrate mental and physical health more closely within strategies.

### *How can the HWB address this?*

- The HWB should support strengthening the integration of mental and physical health across all services when assessing relevant strategies and commissioning plans.
- Commissioners should ensure that strategies and service delivery provide an integrated response to individual needs.
- Providers should ensure that physical and mental health needs are addressed in an integrated way.

## Health and Social Care Services

### *Why is this a priority?*

The current social care and community health system exhibits shortcomings for residents and service users across the borough. The consequences of the fragmentation and inefficiency in service delivery include:

- Multiple and confusing points of access for individuals and their families.
- Demarcation lines between different professional groups and care organisations which lead to multiple care assessments and overlapping care plans.
- No single organisation responsible for care co-ordination, leading to fragmentation of care delivery, no single care plan and sometimes failure to deliver seamless care.
- Confusion about the relationship between social care and NHS funding arrangements and eligibility among individuals and their families.
- Increased costs for social care and/or health providers when individuals are unable to maintain their independence as they could have done with better co-ordinated care.

These shortcomings have at times had an adverse impact on the quality of the lives of a whole range of people, including frail older people and people with multiple chronic conditions and mental health illnesses.

### *Key issues in Richmond*

Richmond CCG and the LBRuT are committed to the integration of health and social care services. Currently community and Social Services are delivered by four Integrated Health and Social Care teams, two are managed by NHS and two teams are managed by Social Services. The teams operate on the basis of co-location rather than true integration. Care is currently built on relationships rather than a model or system of care resulting in inequality of access to services across the Borough.

Key priorities are to:

- Develop an Integrated Health and Social Care Commissioning Strategy which will clearly set out the challenge and vision for Richmond and how this will be delivered.
- Create a Joint Collaborative Commissioning Team for Health and Social Care.
- Consider further developments of integrated health, social care and social services for older people and adults with disabilities in the borough and how an Integrated Care Organisation (ICO) could deliver improvements to the local population, building upon the outcomes of the Feasibility Study published in February 2013.
- Reconfigure health and social care services into a local model of care that includes primary care and links to hospital services.

### *How can the HWB address this?*

- The HWB should promote the integration of health and social services when assuring any strategies or plans.
- Encourage commissioning organisations to have integration as an essential component of commission strategies.
- Encourage provider organisations to ensure integration is core to the service model and a key component of delivery.

## **Hospital to Community services**

### *Why is it a priority?*

The *Better Services Better Value* (BSBV) review has been set up to look at ways to drive up the quality of patient care and health services in South West London and to make sure the local NHS spends its money as effectively as possible. The BSVB Case for Change makes clear, health services in South West London are not sustainable in their current configuration. The review explored six clinical areas, each with its own clinical working group (CWG). The CCG is structuring its emerging out of hospital care strategy broadly in line with BSBV themes:

1. Planned Care
2. Urgent and Emergency Care
3. Maternity and Children's Services Newborn Care
4. Mental Health and Wellbeing
5. Long Term Conditions and End of Life Care

### *Key issues in Richmond*

GP commissioners are passionate about out of hospital care and are keen to further develop services from a range of diverse providers. The CCG have a desire to develop a model of care and support that is responsive to local need, but at the same time recognises there is a need for scale and collaboration with the local authority to work borough wide. There is recognition that services are currently designed to respond to acute health care problems, rather than manage care for people with long term conditions in a community setting. Funding needs to be released from the hospital sector to enable community services to be developed to support people and provide care closer to home. Local priorities include:

- Creating four local networks of primary care practices: each network will comprise a number of primary care practices mirroring the integrated Health and Social Care team.
- Integrating community health and social care services: services such as district nursing and adult social care will deliver care within the local networks of primary care practices, leading to a more joined up care service and better experience for patients.

- Integrating acute sector and specialist services provision: specialists, such as diabetologists, psychiatrists and ophthalmologists, will treat patients within local communities and build the capabilities of community-based practitioners by co-creating care pathways and sharing best practice across networks.
- Integrating healthy lifestyles: ensuring the promotion of self care and self management is routinely embedded into all care pathways to provide support and motivation to Richmond residents to make healthy lifestyle choices and ensure easy access to appropriate services in the community.
- End of life care: ensure difficult conversations are held early enough in the patient journey to ensure adequate planning for a good death in the patients preferred place.
- Carers and support for carers is a key component of our local model of care: identification and assessment of carers, advice and information to navigate the system and support services for carers.
- Commissioning voluntary sector services: recognising the role voluntary sector services can play in helping people to stay well and independent in the community.

*How can the HWB address this?*

By shaping and assuring a health and social care system that addresses the following points:

- Localising routine medical services means better access closer to home and improved patient experience.
- Centralising most specialist services means better clinical outcomes and safer services for patients.
- Where possible, care should be integrated between primary and secondary care, with involvement from social care, to ensure seamless patient care that is easy to navigate.

## Chapter 5: Monitoring Success

Richmond's HWB is committed to developing performance measures that focus on root causes not symptoms of problems. The HWB propose to use the national indicators or other existing local indicators to measure progress towards the vision. The Department of Health have published three outcomes frameworks: NHS, adult social care and public health. Some indicators are shared across the frameworks. From these, the HWB have identified the key outcomes to track progress on and prioritise (see [Appendix 8](#)). There is recognition that these outcomes will require the combined effort and resources of all partner agencies and will not be achieved overnight.

A Health and Wellbeing Board Forward Plan 2013-14 has been agreed and the HWB also propose to feedback annually on progress to address each of the four priority areas in line with the aspirations listed. These proxy indicators will be within the control of the HWB, unlike the long term outcome measures that are subject to a wide number of variable factors, and the success of the HWB will be measured on its ability to deliver on integration of services.

When the indicators have been agreed by the HWB a performance management system will be established to monitor progress. The system will link directly to existing and emerging organisational processes across the Council and local NHS wherever possible to avoid duplication.

The HWB will continue to work with partners to understand how it will monitor success over the course of the next year. As part of the consideration of this we will look at resources that are available between organisations to ensure that we are making best use of the resources that we hold jointly.

The strategy is ambitious, and there is recognition by the HWB that the key themes are long standing barriers to integration. Given the NHS Reforms and rapidly changing health and social care environment, the HWB will be consolidating its approach to implementation over the next 12 months.

## Chapter 6: Engagement

The CCG and the Council already have well developed frameworks for engagement.

Richmond HWB commissioned the Office of Public Management Ltd (OPM) to investigate community engagement on health and social care in the LBRuT. As a result we will be developing engagement tools for commissioners and identifying how the HWB will engage and involve local people (including services users and carers) and ensure that their experiences are reflected in decision making.

A community involvement and engagement framework and action plan has been developed to help shape engagement as a central element of the health and social care system.

## Appendix 1

### Health & Wellbeing Board Partners

- London Borough of Richmond upon Thames
- Richmond Clinical Commissioning Group
- HealthWatch

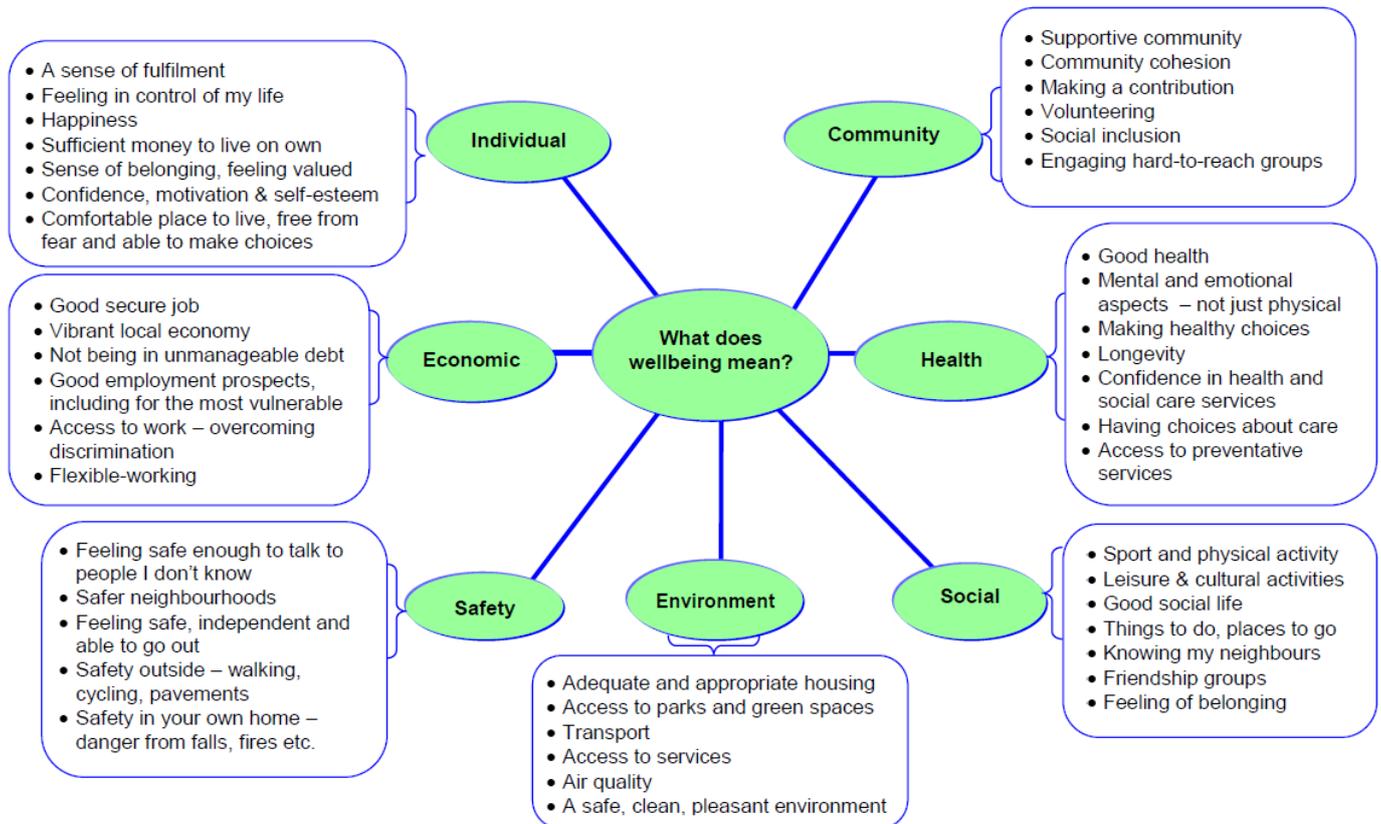
The membership of the joint HWB will be reviewed on an annual basis.

### Key powers and duties of the Health and Wellbeing Board

- Duty for CCG and Local Authority to undertake and publish a Joint Strategic Needs Assessment (JSNA) for the local authority area.
- Duty on CCGs and on local authorities to produce and publish a Joint Health and Wellbeing Strategy (JHWS) through the Health and Wellbeing Board (HWB).
- Duty to involve relevant third parties in preparation of the JSNA and JHWS (e.g. HealthWatch, the public, etc).
- Duty on all commissioners (the local authority, the CCG and the National Commissioning Board) to have regard to the JSNA and JHWS in their commissioning.
- Duty to consider making use of the Health Act flexibilities (integrated provision, pooled budgets, joint commissioning).
- Duty on HWB to promote integrated working, and to encourage integrated working across the wider determinants of health.
- Power for HWB to request information for assisting its functions, and a duty on CCGs, the local authority, HealthWatch and the NHS Commissioning Board to provide such information.
- The Health and Wellbeing Board has the power to write to the National Commissioning Board if it feels the CCGs' commissioning decisions are not following the strategy.

## Appendix 2

### Understanding the components of health & wellbeing



The Marmot Review in 2010 'Fair Society, Healthy Lives'<sup>2</sup> proposed evidence based strategies for reducing health inequalities including addressing social determinants of health. It concluded that a good start in life, a decent home, good nutrition, a quality education, sufficient income, healthy lifestyles, a safe neighbourhood, a sense of community and citizenship are the fundamentals for improving quality of life and reducing health inequalities. This strategy endorses the Marmot Principles and the notion of proportionate universalism.

#### Marmot Principles

1. Give every child the best start in life.
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives.
3. Create fair employment and good work for all.
4. Ensure a healthy standard of living for all.
5. Create and develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill health prevention.

<sup>2</sup> Fair Society, Healthy Lives: The Marmot Review. The Marmot Review, February 2010  
[www.ucl.ac.uk/marmotreview](http://www.ucl.ac.uk/marmotreview)

## Appendix 3

### Identifying related strategies and commissioning plans

- Community Plan 2012-2017
- Commissioning Strategy Plan 2012-16
- Operating Plan 2012-13
- Adults Strategic Plan 2010-2013
- Joint Out of Hospital Care Strategy
- Carers strategy 2010-2013 & change programme
- Mental Health Joint Commissioning Strategy for Older People 2010-2015
- Children and Young People's Plan for 2009-13
- Children's Emotional Wellbeing and Mental Health Strategy
- Child Poverty Strategy 2011-14
- Mental Health Joint Commissioning Strategy for Adults of Working Age 2011-2015
- Learning Disabilities Commissioning Strategy 2010-2013
- End of Life Strategy
- Community Safety Strategy

## Appendix 4

### Commissioning cycle



### Influencing Commissioning

By bringing together the commissioners for health and social care services, and jointly agreeing the needs and priorities for Richmond that will inform commissioning intentions, the HWB can exercise influence over the local care system to improve the lives of local people.

Commissioning is the total process for deciding how all resources available for children, young people, families, adults and communities are deployed to meet needs and improve outcomes in the most efficient, effective, equitable and sustainable way.

- Commissioning refers to the whole commissioning cycle
- Strategic planning refers to the strategic stages of the commissioning cycle
- Procurement refers to the stages of the commissioning cycle that include delivery decisions, contracting and review
- User and stakeholder engagement is an essential component of the cycle

## Appendix 5

### Strategic questioning framework\*

The purpose of the strategic questioning framework is to guide:

- the HWB in assessing strategies and plans that are presented to them for approval;
- commissioners and providers in developing strategies and services that are aligned with the priorities of the HWB and their direction of travel.

The questions are designed to address the components of health and wellbeing (including the wider determinants of health, e.g. housing, education, etc) and the guiding principles under which the HWB wish to shape the local health and social care system. Good strategies and plans will have addressed the questions contained in this tool and show evidence of consideration of the JSNA and eight guiding principles of the HWB.

Analyse	Plan
<p>Does the plan reference the JSNA?            What sources of evidence has been used in developing the strategy or plan?            What outcomes is the plan attempting to achieve?            Who else should be involved to achieve these outcomes?            What actions will be effective in achieving the outcomes?</p>	<p>Is there an integrated commissioning approach?            How are relationships with providers being developed?            Are there professional/organisational boundaries that may impede the plan? How will they be addressed?            What are the educational or organisational cultural changes and how are they being addressed for both staff and organisations?            How are interdependences addressed?</p>
Do	Review
<p>How are resources used to reflect the differing level of need between groups /communities?            Can resources be used more creatively across local partners to achieve the outcomes?            How are local people supported in having increased control and independence?            What is the evidence that this plan will/is making any differences?            How are safeguarding and diversity issues addressed?</p>	<p>How will the plan be monitored and evaluated?            Have risks been identified and mitigated?            What is the governance framework?            How effective are information flows?            Has sustainability been addressed as part of this plan or strategy?            How have patient and carer experiences informed service development and delivery?</p>

## Strategic Questions of specific issues and populations

These are questions that need to be considered when reviewing issues and populations

Wider factors	Positive behaviours	Biological conditions
<p><b><i>Does the plan:</i></b> Maximise its contribution to:</p> <ul style="list-style-type: none"> <li>• Increasing learning and skills</li> <li>• Enabling people to get and keep a job</li> <li>• Enabling people to live in affordable accommodation suitable for their needs</li> <li>• Supporting people to maximise their income and manage it effectively</li> <li>• Enabling people to feel safe</li> <li>• Increasing community capacity</li> <li>• Enabling people to deal with major life events</li> <li>• Improving the built environment to promote a sense of pride, belonging and safety</li> <li>• Conserving and enhancing the local environment i.e. air quality, transport, land use, waste disposal, procuring goods and services</li> </ul>	<p><b><i>Does the plan:</i></b></p> <ul style="list-style-type: none"> <li>• Maximise its contribution to tackling the key issues: tobacco use, food, alcohol, physical activity through:</li> <li>• Working with family / peer norms of behaviour, including intergenerational support</li> <li>• Promoting positive ways of coping to build resilience / self esteem</li> <li>• Understanding what moves and motivates the target audience e.g. drives the behaviour</li> <li>• Understanding key characteristics of target audience, (segment according to socio demographic etc</li> <li>• Addressing barriers to behaviour change</li> </ul>	<p><b><i>Does the plan:</i></b></p> <ul style="list-style-type: none"> <li>• Maximise its contribution to tackling the priorities: cancer, cardiovascular disease, diabetes, COPD, dementia, mental health problems through:</li> <li>• Increasing awareness of early signs</li> <li>• Supporting people to effectively manage their conditions, consequences and behaviours</li> <li>• Enabling early detection of significant conditions and infection</li> <li>• Maintaining and increase uptake of screening</li> <li>• Supporting positive behaviours in those with the conditions</li> </ul>

Vulnerable groups

<b><i>Does the plan enable vulnerable children and young people to:</i></b>	<b><i>Does the plan enable vulnerable adults of working age to:</i></b>	<b><i>Does the plan enable vulnerable older people to:</i></b>
<ul style="list-style-type: none"> <li>• Get the best start in life</li> <li>• Achieve to their full potential</li> <li>• Develop positive relationships and improved self esteem and so develop self-confidence and successfully deal with significant changes and challenges</li> <li>• Create an environment where language and communication is recognised as a crucial factor in child development</li> <li>• Support and strengthen positive family dynamics</li> <li>• Engage in education, employment or training on leaving school and so be ready for employment</li> <li>• Develop enterprising behaviour</li> <li>• Engage in decision making and support the community and the environment</li> <li>• Have access to transport and essential material goods</li> <li>• Access the jobs and opportunities they need</li> </ul>	<ul style="list-style-type: none"> <li>• Identify their own needs and outcomes and support them to achieve these</li> <li>• Maintain a healthy lifestyle</li> <li>• Build and maintain stronger social networks</li> <li>• Achieve positive mental health, especially in coping and resilience</li> <li>• Maximise their income and manage it effectively</li> <li>• Use self care to manage any health problems</li> <li>• Move from worklessness to work</li> <li>• Get around using appropriate transport including public where feasible</li> <li>• Live in accommodation suitable for their needs</li> </ul>	<ul style="list-style-type: none"> <li>• Maintain active healthy lives</li> <li>• Develop and maintain their social networks</li> <li>• Participate in learning and working (including volunteering)</li> <li>• Maintain or regain their independence</li> <li>• Manage their money effectively</li> <li>• Use 'self-care' to manage any health problems they may have and make their own decisions about any care and support they may need</li> <li>• Get around using appropriate transport</li> <li>• Live in accommodation suitable for their needs and keep safe and warm</li> </ul>

\*Amended from Draft Joint Health & Wellbeing Strategy for Kirklees

## Appendix 6

### Priority setting framework

#### *Purpose*

The aim of the framework is:

- To inform an explicit and coherent approach for strategic planning across partner organisations, commissioning/decommissioning decisions of individual services/pathways and decisions about individual patient requests.
- To streamline and simplify current processes and bring some logical hierarchy into the use of various criteria.
- To facilitate clear communications with partner organisations, patients and the public.

#### *Priority setting framework - four guiding principles to determine the value of a service*

<b>Need</b>	<b>Value for money</b>
= burden and distribution of disease / risk factors amenable to intervention Evidence: JSNA (including numbers and percentage of population affected, who affected and severity)	= effectiveness and efficiency, avoidance of waste, maximising health gain  Evidence: Service reviews (including cost-effectiveness, i.e. National Institute for Clinical Excellence (NICE), benchmarking, programme budgeting)
<b>Public preference</b>	<b>National targets, statutory/legal duties</b>
= demand, democratic accountability Evidence: surveys, Community Involvement Group, Patient Advice and Liaison Service/complaints, Health Watch	= outside local discretion  Evidence: priority and planning guidance, performance indicators, law

#### *Comments / caveats*

- Evidence is a relative term and varies by type, strength and availability.
- The suggested principles themselves are not unambiguous, i.e. ongoing debates about hierarchy of need, maximum health gain, who's voice, interpretation of statute / legal duties.
- There are numerous other criteria used in theory and practice of priority setting to determine value of services, i.e. 'high quality', 'closer to home'; 'patient-centred'; 'accessibility'; 'integrated, seamless'; 'preventative'; 'effect on the market place' etc. The four principles are suggested as high-level framework, the top of a hierarchy, under which second / third order criteria can be logically accommodated.

- The biggest challenge lies in trade-off between principles. For example value for money vs need: targeted interventions for the most needy often cost more for the same health gain. Public preference vs value for money: public might prefer interventions that are not evidence-based or cost-effective.
- Value needs to be balanced against deliverability (= reality check), i.e. affordability, capacity, capability, time, risk.

*Priority setting framework – four conditions to ensure legitimacy of process*

<b>Publicity</b>	<b>Appeal</b>
= decision and rationale publicly accessible (i.e. website)	= clear mechanism for challenge and dispute resolution
<b>Relevance</b>	<b>Enforcement</b>
= Rationale based on evidence, reasons and principles that fair-minded parties agree are relevant under resource constraints (i.e. above principles)	= voluntary or public regulation of the process

Based on ‘accountability for reasonableness’ approach used by NICE, original source by Daniel and Sabin (Philos Public Aff 1997; 26:303).

*How the framework can and cannot help*

**Can:** identify clear winners and losers; bring out conflict between principles; supports reasoned decision-making by providing justification for choosing priorities; facilitates communication of decisions with partners and public.

**Cannot:** provide a magic formula for trade-off between principles because there is no agreed upon dominant normative approach; value judgement in the light of evidence will always be required to reach context specific agreements.

## Appendix 7

### Local JSNA Process

In Richmond we have an established JSNA Steering Group between the Council and NHS that develops an annual programme of work, and a joint analyst operational group that works collectively to minimise duplication of effort and maximize analytical capacity between partners.

There is a core reference dataset that is updated annually, in addition to more in-depth needs assessments for specific conditions, client groups or localities.

The JSNA incorporates a wide variety of quantitative and qualitative data about demography and the pattern of determinants of health, risk factors and diseases, service utilisation, effectiveness, patient/public voice and cost.

To make sense of local information we compare Richmond data over time (trends), with other comparable boroughs (benchmarking) and where available with standards (expected pattern). To ensure validity we triangulate data from different sources.

Important analytical themes are: trying to understand Richmond populations (ie residents, registered with Richmond GP, working in Richmond, attending school in Richmond) because of variable future growth projections and population based funding streams; and root causes of ill health and overlapping need because combined action of partners with influence on different parts along a causal pathway is most cost-effective.

Throughout the year short topic based reports (Bitesized JSNAs) are published on the council website, enabling key messages to be shared in a timely manner with local partners; national data releases are summarised and circulated swiftly following publication (JSNA Newsflashes) to complement in-depth needs assessments (JSNA Deep dives).

In addition there is work under way to collate other information available about Richmond people and services from the wider council and partners under the umbrella of JSNA to make it easily accessible through one portal.

There is a JSNA involvement strategy that details how partner organisation, users and carers all contribute to the JSNA process. This involvement strategy has been supported by Links and is informed by the Clinical Involvement Group (CIG). This, and any further information requests, can be accessed from [JSNA@richmond.gov.uk](mailto:JSNA@richmond.gov.uk).

## Appendix 8

### Long term outcome indicators

- Reduction in gap in life expectancy at birth
- Reduction in premature mortality from cancer and cardiovascular disease
- Reduction in emergency hospital admissions for chronic long term conditions (inc. mental health)
- Increase in the percentage of people who have reduced their service or have no service after receiving adult social care to help them regain independence
- Reduction in delayed discharges from hospital
- Increase in the percentage of eligible service users with ongoing service with personal budget
- Reduction in smoking prevalence
- Reduction in alcohol-related admissions to hospital
- Reduction in the percentage of young people 16-19 not in education, employment or training.
- Increase uptake of immunisation
- Increase in the number of carers of adults offered an assessment
- Reduction in the proportion of hospital deaths
- Increase in the percentage of people using services who say that those services have made them feel safe and secure

Work is also underway nationally to develop an outcomes framework for children to update the existing Every Child Matters framework, and the NHS Commissioning Board will publish an NHS commissioning outcomes framework shortly. These will be reviewed and incorporated into the above if appropriate.