Richmond health and care plan – *You said, we did*

Cross cutting/general themes

You said	We did
General	
There was a request to consider including Central London Community Healthcare NHS Trust and Your Healthcare as local health and care partners.	These have now been included as health and care partners.
Many people told us they would like to understand how this plan links with other programmes of work with a focus on long term conditions and mental health.	The final plan will reference links to other programmes of work as appropriate. As part of implementation HCP leads will link with these programmes of work and identify opportunities to work across programmes.
Young people told us that the plan's vision was too formal and that it should be more like Kingston's vision.	Noted, however the Richmond vision has been developed with local partners and stakeholders.
Some people wanted to know if actions within each life stage will be accessible to individuals in another life stage e.g. mental health actions applied to older people in age well.	Yes, the plan has been set out by life stage but services will be delivered per individual need.
Implementation	
Most people support the aims of the plan but are keen to have more detail about how it will be implemented and monitored with a timeline. People asked us to clarify: • How local people and stakeholders will be involved in the implementation • Will people receive regular updates and how this will be provided • how the actions will be monitored and who is responsible/accountable for this work • finances and resources that will be available to deliver the plan	Richmond's Health and Wellbeing Board will have oversight and monitor this plan and will receive six monthly reports. HWB members have been identified as sponsors for each life stage. Each HCP programme of work will have its own implementation plan which will include monitoring and evaluation. We want to involve people with lived experience in the implementation plans and will share opportunities on how to get involved as these arise.
The Plan needs to include a commitment that it is patient-centred rather than focusing on the needs of the system.	We believe the plan is patient-centred as reflected by the actions. We will also involve people with lived experience in delivering the initiatives to ensure we remain patient centred and can deliver the right outcomes for local people.

Some people asked for a commitment to involve experts by experience and to empower local communities to co-produce initiatives to ensure outcomes for local people are delivered.	Yes, we are committed to involving people with lived experience in delivering the initiatives set out in the plan.
Two years seems a very short timeframe to achieve the plan.	Noted.
Enablers	
People asked to see stronger aspirations about how the plan will address the areas of workforce, training and development of staff, quality of care/services and interoperability.	We have included more information on enablers to the plan which includes these areas.
Some people had concerns around the capacity within organisations to deliver the plan.	Noted.
The plan needs to have stronger aspirations and actions around partnership working across organisations to address fragmentation experienced by service users.	The impetus for this plan is partnership working across health, social care and the voluntary sector where it can make a difference for our local population.
There was a request to review funding and contractual arrangements to support collaboration e.g. longer term contracts and the use of grants which are more compatible with co-productive partnership working.	Noted for consideration in the longer term as we move towards a local, integrated care system.
Role of the voluntary sector	
This plan is an opportunity to enable funding to follow the patient. The voluntary and community sector (VCS) can deliver elements of the plan and make limited resources go further. With some funding, VCS can increase effectiveness and outcomes.	Noted. The VCS is a key partner in both the development of this plan and will be for elements of delivery.
Local VCS organisations should be an active partner in the development and delivery of the plan. All partners including VCS need to complement and work together.	As above.
Wider determinants	
Some people asked for the plan to demonstrate a stronger link to the impact of wider determinants on health e.g. air pollution, congestion, crime, and education.	Noted. The plan now references the importance of wider determinants of health and will link with programmes of work outside of this plan e.g. air quality strategy.
There is a need for affordable/social housing to support wellbeing including sheltered housing to enable older people to remain independent within their community.	Noted.
Some people highlighted the negative impacts of welfare reforms on wellbeing.	Noted.

Prevention

You said	We did
People told us that the plan needs a stronger overarching narrative around people taking responsibility for their own health and empowering people to self-care.	Noted. The prevention section has been strengthened and many of the actions throughout the plan support and empower people to self-care.
To introduce a culture of self-care requires resources to empower and increase capacity of individuals to negotiate services and situations e.g. low level self-advocacy training and information and advice to become familiar about local health and care. This support needs to be embedded as part of service delivery in future. This can lead to less pressure on navigation services and over time increase capacity for self-reliance and be self-sustaining.	Noted as above.
Some people told us there is not enough detail in the plan about prevention and links to the wider determinants of health e.g. community life, crime, and environment – Richmond has an issue with air quality and noise (Heathrow) which other boroughs may not have.	Noted. The plan now references the importance of wider determinants of health and will link with programmes of work outside of this plan e.g. air quality strategy.
Suggestion of combating car use and resulting air pollution and impact on obesity by support for integrating active travel into every-day life – cost effective and encourages good habits.	Noted.
Some people want to see a greater focus on personalisation and personal health budgets to support people to take responsibility for managing their health.	Noted. There is an emerging programme of work around personalisation. As this develops we will consider initiatives for inclusion in future.
The plan has too much of a medical focus and not enough about wellbeing and outcomes for social functioning and care distinct from health.	Noted.
Some people wanted to see initiatives such as the expert patient programme in supporting prevention. This initiative is currently funded in Kingston but not in Richmond.	Noted. This is one of a range of self-care models which will be considered in line with the development of social prescribing in the borough.
People asked that the plan consider initiatives to address health inequalities alongside prevention e.g. to address the difficulties of accessing healthcare and looking after your health if you are homeless.	Noted as a concern. This will require a more focused piece of work and will be taken back to partners and the health and wellbeing board for consideration.

Unpaid carers

You said	We did
We will take action to improve our practice in identifying and recognising carers of all ages so they are linked to appropriate support options, enabling carers to reduce the social, financial and health impacts they face.	
People supported the priority to improve identification and recognition of carers but wanted to see specific actions and resources to achieve this.	Agreed. The plan now includes more actions to support this priority including connecting with the carers strategy.
Some people asked that unpaid carers should be included when developing prevention initiatives to support people to stay well and look after themselves.	Noted.
Some people told us about the specific support needed for unpaid carers who are caring for someone at the end of life.	Noted. We would expect unpaid carers to be considered and supported by services looking after individuals at the end of life. Initiatives such as advanced care planning and coordinate my care could support this. They should be also able to access generic support for unpaid carers.
Carers told us that there is a need to put support in place to address the increased burden on unpaid carers when supporting people with complex needs in the community.	Noted. The plan now includes more actions to support unpaid carers.
Some people highlighted the role of the VCS in supporting unpaid carers.	Noted and we acknowledge the work of the voluntary sector with unpaid carers.
Some people asked us to consider individuals who are no longer carers “ex-carers” and how to identify and support those who don’t identify as carers e.g. parents, siblings etc.	Noted and an action about recognising the impact after caring has been included.

Start Well

You said	We did
Improve the mental wellbeing and resilience of our children and young people	
Most people welcomed the focus on mental wellbeing and resilience of children and young people	Noted.
Most people support the role of schools in supporting children and young people's (CYP) mental health e.g. awareness programme for parents and schools to identify signs of poor mental health; strategy to support pupils and engage parents; activities to counter bullying.	Noted.
People told us that there was a need for specific support and education for parents around CYP's mental health and wider health and wellbeing and that this should start at antenatal stage.	Noted. The emotional wellbeing programme in schools will include support for parents as will initiatives around the first 1000 days
People asked us to consider dividing up Start Well into age ranges as the needs and support are different dependent on age.	Noted. Consideration to the needs of different age groups will be considered during implementation of the actions.
The plan doesn't make it clear what support is available for 18-25 years and specifically with the transition between CYP and adult mental health services.	Noted. This is addressed by the actions around transition protocol and preparing for adulthood strategy and post-16 learning offer for specific groups.
Some people highlighted the tension between the plan's focus on mental wellbeing and the funding cuts for groups working with young people.	Noted.
Some people told us that the actions for mental health resilience could be stronger. That there is a need to include robust measures of access to support with an emphasis on better access in schools at tier 2 and an emphasis on capacity and waiting times at tier 3.	Noted. This will be considered as part of implementation and will be also be addressed as part of the borough's Child and adolescent mental health service (CAMHS) transformation plan.
Youth Out Loud has its own digital project that could support the action to establish a digital youth steering group.	We would welcome the involvement of the YOL's digital project with this initiative.
Youth Out Loud (a group of young people aged 13-17) asked why the plan contained actions relating to children aged 0-5 when they could see that the people most in need were aged 15. They were also unclear how you could tell the difference between regular small child behaviour and mental health conditions. They worried that under 5 was too young to have a mental health intervention, that would stigmatise the child.	Noted. The actions around needs assessment for under 5s relates to early intervention to prevent poor mental health and to build mental wellbeing and resilience for the future.
Children and young people (CYP) told us that they would value some education around how to look	Noted. The plan includes actions to address this including working

after their own mental health and how to support their friends if they are having difficulties.	with young people to design and develop peer led services to reduce involvement in risk taking behaviours and the emotional wellbeing programme in schools.
People asked for a stronger focus on preventing risky behaviours given the statistic around mental health wellbeing of 15 year olds.	Noted. The plan now includes a specific action around working with young people to design and develop peer led services to reduce involvement in risk taking behaviours.
Reduce obesity to improve the health of our children and young people	
Health inequalities should be given greater consideration e.g. impact of being in a low-income family and different cultures and communities' attitudes and approaches to food.	Noted and health inequalities will be picked up as part of implementation of the actions for this priority.
People supported the Daily Mile initiative. However, some people told us that our targets for the Daily Mile and Heathy Catering Commitment were not ambitious enough and should have an earlier implementation date.	Noted. The target dates consider lead in times for schools to introduce new initiatives or change existing arrangements to accommodate these initiatives.
Some people told us that there should be a greater focus on health and care from conception to age 2 – the first 1000 days – as critical period for laying down foundations of good physical and mental health.	Agreed. The plan now references, under prevention the first 1000 days with a commitment to develop a plan to support children, parents and families at this stage of life.
Consider working with other providers/services outside of the school environment to improve access to physical activity for children and young people.	Noted. This can be picked up as part of implementation around how the plan links with the work of other areas e.g. leisure services.
Some people told us that providing information and support for breastfeeding needs to be delivered sensitively to avoid mothers feeling a failure as it may not be an option for all. That investment should be on promotion and support rather than needs assessments.	Noted.
Support CYP with special educational needs, disabilities and complex health and care needs to flourish and be independent in their local communities.	
Request for focus on getting the right professional help for young people who do not have "visible problems" or there is a difficulty with diagnosis.	Noted. This would be addressed by other programmes of work including the local child and adolescent mental health services (CAMHS) transformation plan and SEND futures plan. Feedback will be also shared with council's education services particularly relating to pre-school activities.

There was concern that assessments and diagnoses for children could take a long time. These delays mean that children do not get the help they need until later which can lead to gaps in their learning.	Noted. The plan will also link with the work of the Special Educational Needs and Disability (SEND) partnership board and the SEND futures plan.
Questioned whether transition arrangements start at year 9 rather than year 11.	Noted. The action around transition has been updated to build on transition protocols and preparing for adulthood strategy rather than a specific age.
Some people asked that the plan should aim for full vaccination coverage.	This is not within the remit of this plan. Vaccination take up is the responsibility of Public Health England.

Live Well

You said	We said
Support people to stay healthy and manage their long-term health conditions	
People support the roll out of social prescribing with a request to involve and make best use of the significant experience of local voluntary and community organisations in developing the model and delivering the service.	Noted. The VCS is a key partner in this plan and in the development of social prescribing in the borough alongside health, social care and developing primary care networks.
Some people wanted to understand how social prescribing would work and how it could involve the wide range of community schemes and initiatives such as therapeutic gardening; healthy walks, arts and culture, intergenerational work and volunteering.	Noted. The plan now provides more information on the role of social prescribing in supporting people to live healthy lives and manage their own health. It also describes the range of activities it could include.
Some people told us that there is a need for this life stage to have a greater focus on prevention, self-management and empowerment in line with Age Well. To have a greater emphasis on people taking responsibility for their own health.	Noted. The overarching prevention section has been strengthened and many of the actions throughout the plan support and empower people to self-care. The actions within each life stage are not age exclusive.
The actions for long terms conditions (LTCs) are not as well developed as those for children and young people and mental health. Concerns that the most pertinent or currently assessed conditions will dominate so how do you ensure parity across all LTCs including neuro conditions.	Noted. The actions for LTCs focus on (a) prevention and supporting people to stay well and (b) supporting people to manage complex conditions. This latter is about identifying individuals at risk or most in need of targeted intervention to support them regardless of their condition.
There was a request for the new primary care networks to analyse and understand the LTCs within	Noted. The PCNs will support and further develop the work

their local population to support people with LTCs to manage their conditions and live well.	referenced above and the existing multi-disciplinary case management for complex cases.
Promote mental wellbeing and support those who experience poor mental health to avoid mental health crisis.	
It is not always clear how the actions lead to the impacts listed e.g. will result in reduction of A&E attendance for mental health crisis by 50%.	Noted and an explicit action has now been included to redesign the mental health crisis model and pathway which will impact on number of people attending A&E with a mental health crisis.
Some people told us that there is a gap in support and prevention for people with a serious mental health condition (SMI). Very few people with an SMI hold a personal health budget and this should be addressed to support them to manage their condition and avoid crisis	Noted. There is an emerging programme of work around personalisation and personal health budgets. As this develops we will consider initiatives for inclusion in the future. People with an SMI are included when the plan refers to people with a LTC.
People are keen to have more access to evening and weekend activities to support staying well and avoiding a mental health crisis. There is a need for a local crisis café in the borough as it is not feasible for people who are unwell to travel to crisis cafes in Wandsworth and Merton.	Noted. This will be considered as part of the redesign of the mental health crisis model and pathway.
Some people told us there is a need to expand the remit of psychological therapies (IAPT) to respond to the support gap between IAPT and community mental health teams as people can fall between these services.	Noted. This is not within the remit of this plan but will be considered as part of the mental health transformation programme.
People highlighted the lack of choice in mental health care.	Noted.
People suggested the following initiatives to support people avoid crisis: peer support networks; access to therapeutic communities; drug free programmes; professional support to reduce medication, improve links with national networks e.g. Hearing Voices Network and Zero Suicide Alliance.	Noted. This will be considered as part of the redesign of the mental health crisis model and pathway
There is a need to take account of the diverse attitudes to mental health within communities and work with these communities to develop responses to break down barriers to support. Consider BME communities when developing mental health campaigns as mental illness in Asian and Afro-Caribbean communities is highly stigmatised.	Noted. This will be shared with the HWB to consider for future health and care campaigns and health promotion.
The role of complementary medicine to support anxiety, depression and pain management e.g. acupuncture to reduce burden on services.	Noted. Due to lack of evidence base the NHS does not commission complimentary medicine.

People asked that there is mental health training for all health and care staff.	Noted.
Reduce inequalities for people with a learning disability	
Mencap's Working Together Group support the plan including the Treat Me Well campaign and involvement of Kingston Hospital.	Noted.
People support the inclusion of Choice Support and stressed the importance of services providing employment support.	Noted.
Some people asked that the remit of Choice Support is widened to include other groups who need support to access employment e.g. mental health conditions and other LTCs.	Noted.
The delivery plan needs to focus on what is needed to support people e.g. tailored support; information and education about local health and care services; how to look after yourself and encouragement to try physical activity.	Noted. This feedback will be shared also with the Learning Disability (LD) Partnership Board to inform work outside of the health and care remit.
Health checks are viewed as important to support people with a learning disability to be healthy. However, individuals may need additional time and support to engage effectively with a health professional about their health. It was suggested that health checks take place in alternative venues to make them more accessible.	Noted and will be considered as part of implementation.
People with a learning disability should be able to access support locally to local after your health e.g. RISE, social prescribing.	Noted.
People asked that all health and care staff should receive learning disability awareness training.	Agree and actions such as the Treat Me Well campaign support this.
The overarching outcomes should be to provide a better quality of life for people with a learning disability.	Agree.

Age Well

You Said	We did
Encourage active, resilient and inclusive communities that support people to live at home independently, where possible	
Some people told us that this section is limited in its priorities and actions and lacks ambition when compared to start and live well.	Noted and this section has been revised to include an additional priority and actions.
People wanted to see a stronger emphasis on positive ageing and the role of social prescribing to enable people to stay connected in their communities.	Noted and this has been reflected in the revised actions.
Some people told us that care home residents are often overlooked by society and can also experience	Agree the actions set out in this section are available for all older people including care home

loneliness and isolation. Therefore, the initiatives should be available to care home residents.	residents as it is classed as their home.
Consider the use of IT and assistive technology to support people to continue to live independently.	Noted. Digital and assistive technology is a key enabler and this will be considered as part of implementation across the priorities in Age Well.
People highlighted the role VCS in enabling older people to live well with LTCs, reducing loneliness and isolation.	Noted. The VCS is a key partner in this plan.
Support people to plan for their final years so they can have a dignified death in a place of their choice.	
Some people suggested that end of life care should be a cross-cutting theme rather than being a priority under age well.	Noted. For this first plan, we are focusing on end of life care for older people. The borough's end of life care strategy is for all ages.
Some people asked for the plan to have a greater focus on support and educating people on their approach to dying; planning and having difficult conversations rather than focusing on where people die.	Noted and the plan now includes actions related to planning for their old age and having sensitive conversations about death and dying and support people to take up health and social care personal budgets to receive personalised care.
There should be a greater focus on the last six months of life rather than just the final days. People should be able to spend their last months in a place of their choice and not just at the point of death.	Noted and this has been reflected in the plan with the additional action around planning for old age and having sensitive conversations about death and dying.
Consider initiatives such as soul midwives and end of life doulas (trained lay companions) to provide support for the dying and their carers and help having a good death at home.	Noted. We will link this feedback with the work taking place with Princess Alice Hospice to develop compassionate communities involving a range of roles to support people during end of life.
Some people told us that there is a need to improve the discharge process across health and care to improve experience for patients and carers and reduce impact on families/carers health.	Noted and this is included in the plan with the action to redesign the pathways for integrated community based urgent care services and "home first" discharge from hospital.
People asked for the plan to have a greater emphasis on coordinating care both between services and between providers as many older people have more than one LTC.	Noted and this is now reflected in the plan with the action to improve care coordination and information sharing across health and social care.
Clarification about capacity and skills of local workforce to support community based urgent care for older people.	Noted. This will be considered as part of implementation for specific actions under workforce planning.

Some people suggested that dementia should be identified as a LTC rather than sitting under a priority for end of life care. Others saw dementia sitting under Live Well and were keen to understand how people who fit in both life stages would be supported.	Agreed and this is now reflected as a separate priority within the plan.
People asked for dementia training for all health and care staff including GPs and practice staff.	Noted.
Some people told us that there was a need for dementia awareness programme for BAME communities. We should include dementia and depression in older people when developing mental health campaigns.	Noted. This will be shared with the Health and Wellbeing Board (HWB) to consider for future health and care campaigns and as part of the borough's dementia strategy and dementia friendly communities.
The plan should link with the borough's dementia strategy and dementia friendly communities' initiative.	Noted and this is referenced in the plan.
People living with Alzheimer's told us about the positive impact of taking part in activities and social interaction can have on managing their dementia and the need to encourage and support others to do the same.	Noted.
People wanted to understand how information will be made available/shared with older people. There is a need to provide support and education for people to access information online, mobile phones etc. Some people wanted to understand the role GPs and CILS in providing information to older people.	Noted. The new Community Independent Living Service (CILS) will offer an element of information, signposting and navigation in a range of formats. This will complement the social prescribing offer to be developed. All services have a role in providing relevant information for the individuals using the service.
People living with Alzheimer's asked for an accessible central directory/portal of information on support services, including early onset dementia.	Noted and will share this feedback with the dementia strategy work programme.
Some people asked that initiatives should be co-designed with this age group rather than imposed on them from a service.	Noted. We want to work with people with lived experience to develop further and implement the actions within the plan.