South West London
Health & Care
Partnership

Age well in Richmond 2019/2021

Whilst people are living longer, many older people are also living with a reduced quality of life due to ill health or disability, or experience loneliness and isolation.

Encourage active, resilient and inclusive communities that promote healthy ageing and reduce loneliness and isolation	Support people to live at home independently, for as long as possible including people with dementia	Support people to plan for their final years so they have a dignified death in a place of their choice
Action	**Action**	**Action**
• Explore and build **opportunities for social connections / community hubs** that bring people together in their community • Promote **wellbeing and healthy lifestyles** for all older people, including Making Every Contact Count. • Improve access to **health and care information and advice** for people and their unpaid carers • Improve access for older people and their carers to **outreach and community-based services,** including through the delivery of **Community Independent Living Services (CILS) and social prescribing** by March 2020 • Roll out of **Care Home Support** programme to improve the quality of health care to people living in care homes	• Identify and proactively support older people **with complex health and care needs** by bringing health and care professionals together around the individual – through primary care networks, across the borough by March 2020 • Increase the number of **shared Care Plans** developed with older people who have complex needs and their unpaid carers • Redesign the pathways for **integrated community based urgent care services and "home first"** discharge from hospital services by March 2020 • Review, refresh and implement our **joint dementia strategy** by March 2020	• Support people to **plan for their old age and have sensitive conversations** to include about death and dying • Improve end of life care by progressing delivery our **End of Life Care Strategy** to ensure that end of life issues are addressed • Support people to take up **health and social care personal budgets** to enable them to receive **personalised care** to meet their needs, including for their end of life care by 2021 • Improve **care coordination and information** sharing across health and social care at the end of life, including rolling out access to the integrated **Coordinate My Care system**
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.		
Impact	**Impact**	**Impact**
• Increase in opportunities for people to **remain connected** to others and **improve their health and wellbeing.** • Reduction in people who **feel lonely and isolated** • Reduction in **non-medical related GP appointments** and A&E presentations • **Social prescribing** will be available for local people in the borough • Reduction in the number of **hospital admissions from care homes**	• People will be supported to **live independently** for as long as they are able • By March 2020 unnecessary **attendances in A&E will** reduce by 15% with a focus on people admitted for up to 72 hours • Increase in older people who receive **'reablement' support and recover at home** • People with **dementia** and their families will have a **better experience and receive more support**	• People will have more **personalised health and social care services** at the end of their life. This will result in improved outcomes and people's experience of health and social care. • More people will have **an advanced care plan and coordinate my care** will be delivered across all care settings. This will result in a year-on-year increase in both areas • More than 50% of people will have their **end of life wishes followed** and die in a place of their choice