Better Care Fund 2021 – 2022

Narrative Plan

London Borough of Richmond upon Thames

Contents

1. Foreword

As Chairman of the Richmond Health and Wellbeing Board (HWB) and on behalf of the HWB, I would like to express our deep disappointment with the short time frame given to boroughs to complete the 2021-22 Better Care Fund (BCF) Planning Template and Narrative. The HWB supports Officers delivering programmes that meet the BCF outcomes and would appreciate if planning processes are provided in advance of the financial year applications are being made. This provides a plan of activities and programme spend which the HWB can discuss in advance of the submission as opposed to retrospectively during the year of programme delivery.

I would welcome hearing from NHSE/I confirming the process for 2022-23 as soon as possible, noting the Richmond HWB will be meeting in March 2022.

Cllr Piers Allen, Richmond Health and Wellbeing Board Chairman

2. Bodies involved in preparing the plan

How have you gone about involving these stakeholders?

The borough of Richmond upon Thames has a long history of working collaboratively with health, social care and wider determinant partners. This Better Care Fund (BCF) 2021-22 Plan reflects the ongoing work that has been designed and agreed as a whole system working in partnership.

The borough has established networks and forums that are used to engage and involve all partners, there have been several whole system events during 2021-22, including working together on the Richmond Health and Care Plan 2022-24 refresh (involving Acute Hospitals, social care, Primary Care, CCG, voluntary and community sector, community provider, Healthwatch Richmond, Public Health meeting regularly to review design and content) and development of the Pro-active Anticipatory Care Model of Working.

During the pandemic, the majority of the engagement work was achieved through virtual mechanisms which has been shown to impact positively on people's ability to engage. Using virtual meeting platforms wider and consistent engagement has been achieved.

Stakeholders involved in producing the Richmond BCF Plan include:

- London Borough of Richmond upon Thames Adult Social Care, Housing, Public Health
- South-West London Clinical Commissioning Group (Richmond Local delivery team)
- Hounslow and Richmond Community Healthcare (Community Health provider)
- Richmond Council for Voluntary Services (Voluntary Sector)
- Kingston Acute Hospital
- West Middlesex Acute Hospital
- Primary Care Networks including GP Provider Networks
- Healthwatch Richmond.

3. Executive Summary

The key priorities for the system and therefore the focus of the BCF for 2021-22 has been recovery from COVID-19 to sustain discharge and flow through the system. One programme of work is focusing specifically to develop and refine the discharge to assess pathways and embed the Home First principles. this was developed by using a multi partner approach involving the Local Authority, CCG, HRCH and Acute Hospital. A need identified as part of this programme, was for a Discharge Coordinator at Kingston Hospital; this system post has been recruited to and works with the joint assessment and discharge team developing a transfer of care hub during Q3 and Q4. This will strengthen the discharge and flow processes providing visibility of discharges and expediting transfers of care between settings and improving the patient journey. Weekly multi-partner meetings (for example 'joint surge') take place to address discharge issues in an agreed, collaborative way.

A key priority is to build on the significant progress made during the pandemic to formalise Discharge to Assess arrangements across the system ensuring the Richmond Response and Reablement team is adequately staffed and funded to meet demand 7 days a week.

Support to care homes and people in residential settings is another key focus and during 2021-22 partners have worked together to provide resilience to this market. A multi-agency Care Home Oversight Group was set up with representatives from Adult Social Care, CCG, Public Health and GPs to maintain close oversight of care homes target support where appropriate. Care homes have been supported to report on capacity tracker and to adopt new tools such as the NEWS score.

Throughout the pandemic, a substantial amount of partnership work has been delivered with care homes including mental health and learning disability homes to ensure positive take-up of the COVID-19 vaccination by both residents and care home staff. COVID-19 vaccination workshops and information were shared with care home staff, providing facts about the vaccinations. Work is currently ongoing to support care homes with business continuity to off-set any issue arising from staff shortages due to the mandatory vaccine regulation.

We have also developed a system wide model for pro-active anticipatory care which is focused on pro-actively identifying and manage people with escalating risks. The intention is to reduce dependency and hospital admission by adopting a strength-based approach and for the health, care and voluntary sectors to work together as a multi-disciplinary team wrapping services around individuals. This is being tested within a Primary Care Network footprint with the intention of rolling out across the borough.

An Urgent and Emergency Care Sustaining Flow Programme has been established in Kingston and Richmond with the programme managed through a multi-agency Steering Group with representatives from Kingston and Richmond councils, Kingston Hospital, and community health providers. The programme aims to:

- Work as a system to ensure patients only attend an acute setting where relevant and appropriate.
- Commence discharge planning as early as possible.
- Consider and develop consistent model of discharge to assess (D2A) provision and standardise approach.
- Provide enhanced wrap around support in the community to support emergency flow.

All of these initiatives build on the existing work streams within the current BCF plan and reflect the shift to 'Place based' arrangements. These work programmes featured within COVID-19 pandemic partners response reports which were discussed at Health & Wellbeing Board Business meetings. These reports provided updates as to systems partner joint responses to health challenges that were created due to the pandemic.

4. Governance

The BCF is a jointly developed and agreed approach and plan between the CCG and the Local Authority and the governance for the plan reflects this. As such, governance for the plan is incorporated within existing joint structures. This allows oversight of delivery of the BCF plan in terms of ongoing delivery but also allows the consideration of the BCF's role in supporting and enabling the broader integration agenda for Richmond.

The Richmond Health and Wellbeing Board has ownership of the BCF and is responsible for signing off BCF Plan.

The Richmond Place Leaders Forum is a group of senior leaders across CCG, NHS Providers, the Local Authority and Voluntary Sector setting the strategic direction for health and social care integration in Richmond, including providing the leadership for the Health and Care Plan.

The Local A&E Delivery Board is where executive partners across the health and social care system across Kingston, Richmond and Surrey undertake the regular planning of urgent care service delivery, planning for the capacity required to ensure delivery; overseeing the co-ordination and integration of services to support the delivery of effective, efficient, high quality accessible urgent and emergency services to the population and measuring performance and initiating and completing corrective action as necessary

5. Overall approach to integration

Brief outline of approach to embedding integrated, person-centred health, social care and housing services, including:

- *Joint priorities for 2021-22.*
- *Approaches to joint/collaborative commissioning*
- *Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.*
- *How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21.*

Richmond has a long history of working in collaboration to deliver improved health and care to our residents. The CCG and the Local Authority work in partnership across health and social care, with our local population, to prevent ill health, reduce inequalities and support people to start well, live well and age well, both physically and mentally.

The Council is committed to developing an integrated approach across health and social care. This is demonstrated in a number of ways at system and place level. A key development has been the refreshed Health and Care Plan for 2022 - 2024 which has been developed in partnership, consulted on and the draft plan approved by the local Health and Wellbeing Board in October 2021 with final sign off due January 2022.

Richmond is part of a complex system, with the Local Authority and CCG working across different geographies. Richmond Council has been part of a Shared Staffing Arrangement (SSA) with Wandsworth Council since 2016 and Richmond CCG have a shared Local Delivery Unit with Kingston CCG. NHS Community Services are provided by Hounslow and Richmond Community Health Trust, who also provide community services in Hounslow. Richmond is unusual in that it doesn't have an acute hospital in the borough and is served by Kingston hospital in Kingston borough and West Middlesex hospital in Hounslow with also a significant flow of residents into Acute Trusts outside of the borough.

Working across the CCG and Local Authority footprint offers benefits as to how we engage with Acute Trusts in and outside of the borough, for example, working across Richmond and Kingston on aligned discharge pathways from Kingston Hospital. There will be further opportunities through SWL CCG to work and engage at a South-West London level.

The BCF Plan and Health and Care Plan are set in the context of the wider strategic landscape for health and care integration for adults in the borough. This is supported by other joint plans, including:

- Joint Health and Wellbeing Strategy 2016-2021
- SWL Primary Care Strategy for 2019 and beyond
- Kingston Hospital Strategy 2020-2025
- Richmond Carers Strategy 2020 – 2025

The services outlined below are as a direct result of the integrated commissioning approach adopted by the CCG and Local Authority with local health and care partners/providers. We are proud of the response from our providers in meeting the challenge over the past 12 months and working across the system as equal partners, providing flexibility and providing mutual aid across the system to ensure resilience in the face of the unprecedented position the pandemic has created.

5.1. Richmond Response and Rehabilitation Team

The Richmond Response and Rehabilitation Team is our established integrated health and social care service working in partnership with Hounslow and Richmond Community Health (HRCH) Trust and the London Borough of Richmond Upon Thames Council. The team provide integrated health and social care packages of support to help people regain their independence and wellbeing. The team is multi-disciplinary and includes nurses, occupational therapists, physiotherapists, hospital social workers and therapy assistants.

The team provides a range of short-term interventions including intensive therapy and practical support following a period of illness, disability or following hospital discharge. For people who have been admitted to hospital, the team will support a safe and timely discharge home or to a community setting. This team has played a key role in facilitating Discharge to Assess since the start of the pandemic. The team also provides a rapid response service to manage crisis and support people to stay at home, preventing unnecessary admission to an acute hospital or a residential/ nursing home.

5.2. Demand Management and Workforce Planning

Under the Urgent and Emergency Care Programme, the Council and HRCH are working with a specialist NHS provider to carry out demand modelling to ensure we have a clear understanding of what the demand is and to ensure our commissioned services can meet not only the demand but also the complexity of needs for Discharge to Assess whilst effectively providing rehabilitation and reablement support to those who need it to promote independence and improve wellbeing. This system-wide modelling supports us to be agile and flexible within our commissioning decisions.

5.3. Locality Model and Proactive Anticipatory Care Model

The NHS Long Term Plan set out an ambition to dissolve the historic divide between Primary Care, community, and social care services. The development of Primary Care Networks (PCNs) and the need to anticipate, prevent and be proactive are central to that goal. Our data analysis and mapping of the “As Is” model clearly highlights that our services were reacting to escalations. People with complex needs and escalating risk pose an increased demand not just within Primary Care but also within community health and social care.

Across Richmond and Kingston, we are striving to develop a system-wide approach to Long-Term Conditions (LTC) supporting the development of health behaviours and lifestyles that enable our population to make choices within a healthy community environment facilitated by the wider determinants of health. Developing a proactive Anticipatory Model of Care for people with escalating risks was deemed a priority area by all system partners to ensure we can continue to support these people at home, harnessing the strengths within the communities and act in a timely way.

As such, a Proof of Concept (POC) has been developed working with a PCN in Richmond, to proactively identify people and create a network based dedicated core team that will support people with escalating health and social care risks, working hand in hand with our partners within the community and voluntary sector. Early findings from the pilot has demonstrated that individuals who have been managed by the multi-disciplinary team are enabled to remain in their own home and deterioration in their physical condition delayed.

At the same time, Richmond upon Thames Adult Social Care has developed its Front Door Pilot project, which aims to develop an effective service at the first point of contact to social care. The model is based on the principles of early intervention and prevention and strength-based approaches, that will effectively manage demand and meet more people's needs at the initial point of contact.

Looking forward, our ambition is to develop a Locality Model across Richmond and Kingston based on a PCN geography which brings together partners from across health, social care, community (VCSE) working with the local population to create a new way of working. The Locality model signifies a fundamental shift in focus from the treatment of individuals to improving wellbeing of the whole population and rebalancing and realigning the system to ensure the right activity takes place in the right place.

5.4. Carers

Richmond Carers Centre is funded through the BCF, to provide support to unpaid adult carers. The core services include:

- Advice, information, and informal advocacy
- Peer support
- Respite and unplanned replacement care
- Back care and therapies
- Health and social care liaison and training.

Richmond Carers Centre is well established across the health and social care system and the wider community. Service users who access the service report high levels of satisfaction.

The support to unpaid carers is a priority area within our Local Health and Care Plan across each of the life courses, recognising the valuable contribution that they provide in supporting the care system.

5.5. Care Homes

In addition to the Strategic Care Home Oversight Group referenced in the Executive summary, Hounslow and Richmond Community Healthcare (HRCH) provide support to the older people's care homes in Richmond, including RESTORE2/ NEWS and infection prevention and control training, and support for other areas such as supporting the move to Proxy Ordering.

The Richmond Joint Intelligence Group (JIG)/ provider risk panel is in place in Richmond, and is made up of representatives from the Council, the CCG, HRCH, and CQC, and has a rounded view of the risks to care homes and their residents.

The Council together with health partners, and care homes arranged a workshop on 13 September 2021 to discuss and identify priorities for care homes for the year ahead. Key priorities were identified with a view for more scoping work to happen to support the market in the future:

- **Workforce resilience** - market resilience scoping to understand gaps in workforce (followed by targeted recruitment campaigns and tools for care home managers to retain staff)

- **Training** to improve quality of information exchanged with health and social care colleagues should focus on core elements like end of life, dementia, and increasing IT skills. Mental Health and wellbeing support for care home staff
- **Shared processes and communication** - Single point/interface for communication with care homes is required with access and availability to shared health and care records/care home records scheme. Increase communication with Discharge to Assess hub about placements into care homes.
- **Equity of services to care homes across all client groups** – Consistent and tailored support for all care homes (all client groups), parity of access to services for Mental Health and Learning Disability homes – NHS and ASC commissioners to scope going forward.

5.6. Voluntary Sector

Richmond has an active and established community and voluntary sector offering a diverse range of services. Support for the voluntary sector is delivered through Richmond CVS. Richmond CVS is a champion of the local voluntary and community sector and they support the sector to raise their profile and provide opportunities for the voice of the sector to be heard. There is a strong history and theme of partnership working in Richmond with the voluntary sector. Richmond recognises the potential within the voluntary sector to play an active part in addressing the health and wellbeing challenges that we face, and Richmond CVS represents the voluntary sector on the Health and Wellbeing Board and Richmond Place Leaders Forum.

6. Supporting Discharge

What is the approach in your area to improving outcomes for people being discharged from hospital? How is BCF funded activity supporting safe, timely and effective discharge?

6.1. Local Approach

Richmond borough residents' access multiple local acute hospital Trusts. The majority of people accessing either Kingston Hospital Foundation Trust or West Middlesex Hospital. The community health and social care staff from the Richmond Response and Reablement team interface directly with these two hospital trusts. Discharge plans are agreed with both Acute Hospital Trusts for joint working to plan and arrange discharges, across 7 days and with clear escalation contacts and processes in place.

The Richmond Response and Reablement Team RRRT) is an integrated team of hospital social workers, therapists, and nurses, who work together under the auspices of the community health provider to ensure communication and a seamless approach to the management of discharges. RRRT provides the following support post discharge:

- Improving the transition from acute hospital admissions to community services through facilitating safe and timely discharge from hospital
- A range of short-term interventions, which help people recover their skills and confidence after an admission to hospital
- Providing short-term intensive reablement support to people to regain independence and wellbeing
- A person-centred package of support to people in their own homes, in hospital or in a care home setting which is jointly delivered by health and social care professionals
- Ensuring an effective referral process to district nursing and/or other specialist teams as appropriate
- Maintaining effective communication with GPs and other referrers to the service.

A Joint Assessment and Discharge team has been in place for several years working in partnership with Kingston Hospital and Kingston Council; Whereby, the community Rapid Response Team, Local Authority Social Workers and the Hospital Discharge Team work together using the principles of discharge to assess to adopt a Home First model. Building on the joint assessment and discharge team, RRRT are working with Kingston Hospital Trust to build a Transfer of Care Hub and to co-locate in partnership with the Trust, Community Health Providers and Richmond and Kingston Councils.

The Richmond (and Kingston) 'Transfer of Care Hub' is now launched. It is the next stage in an ongoing programme of work, bringing together expertise from the community and acute teams, co locating community, social care and, Kingston Hospital professionals , to facilitate safe and effective transfers of care into and out of hospital. By bringing together these partners 'under one roof', communication routes and sharing of workload between the different partners will support patient flow and enable colleagues to learn from each other enriching their professional development. Coming together in this way, will assist us, through a multi-partner approach and place us in a stronger position to provide solutions to growing and more complex challenges.

6.2. Looking Forward

Richmond borough was in a good position to meet Discharge to Assess requirements at the start of the pandemic with a well-established RRRT and joint assessment and discharge team at Kingston Hospital. The pandemic has placed significant challenges on all system partners. Main areas of challenge have been the capacity within the Care Provider market, Community Health and Social Care workforce. To mitigate these challenges and build on current arrangements to further implement the Discharge Policy, we have collectively identified the following priorities:

- **Supporting the Home Care market** to ensure stability of the local market, including Infection Prevention Control (IPC) and effective capacity monitoring to support timely discharges
- **Supporting the Care Homes market** through the creation of the multi-agency Strategic Care Home Oversight Group whose role was to ensure stability of the local market including raising vaccine awareness, Infection Prevention Control (IPC) and supporting provider completion of the capacity tracker.
- **Strengthening our reablement offer** to deliver through four external providers with clear contingency plans in place to ensure sustainability of services during the ongoing pandemic.
- **Formalising arrangements for 7 day working** and extended working hours in social work.
- **Streamlining discharge pathways** including improving data collection and introducing smarter use of IT systems.

The demand pressure on acute hospital beds has increased during 2021-22 and since easing of pandemic restrictions has created huge demand pressures across the system. In response to this pressure several initiatives have been put in place:

- Twice daily operational discharge calls in place with partners to support hospital flow, discharges and attending to blockages.
- Twice weekly strategic system partners call to address emerging themes.
- A transformation programme to review and improve discharge and flow across the system led by the community health provider but all partners involved.
- Recruitment of a system role for discharge co-ordination.
- Development of a Transfer of Care Hub at Kingston Hospital.
- Improving admission avoidance with RRRT working in partnership with community health and Kingston Hospital.

6.3. BCF Funding to Support Discharge

The key areas of BCF funding for safe timely and effective discharge are the Joint Assessment and Discharge team, Discharge to Assess Packages of Care, including reablement and equipment, and community multi-disciplinary teams including the Richmond Response and Reablement Team.

The BCF also funds the Richmond Age UK Nightingale Service, which provides a free, short-term service that provides a range of practical support to prepare the home for hospital discharge. Services include:

- Fitting key safes.

- Decluttering to remove trips and falls hazards.
- Removing furniture and clearing space so hospital equipment can be installed.
- Cleaning.
- Ensuring the resident has food in the house before discharge.

All of these initiatives are commissioned to ensure people are discharged from hospital in a timely manner and are supported safely live within their own homes.

7. Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

Under the provisions of the Housing Grants, Construction and Regeneration Act 1996, the Council provides mandatory means tested Disabled Facilities Grants (DFG) to assist residents with the cost of providing adaptations to dwellings or common parts of buildings containing flats where the adaptation is considered 'necessary and appropriate' and 'reasonable and practical'.

The Regulatory Reform Order (RRO) 2002 provides Local Authorities a broader freedom and opportunity to address living conditions in their area including to provide, directly or indirectly, assistance to adapt or improve living accommodation and repair living accommodation. The RRO allows Local Authorities to create assistance schemes using the DFG funding, helping people to meet their needs without going through the full DFG process. Additional funding under the BCF has expanded the scope of help available to include discretionary DFG schemes. This widening of funding enables more people to remain independent and prevents the need for care and support for longer.

The BCF has created new opportunities for the Local Authority to develop and fund joint commissioning plans with Clinical Commissioning Groups to meet the needs of residents across care groups.

The Discretionary DFGs and Housing Assistance Policy supports the development of these plans by providing the policy context for how commissioning partners will use the funding available to develop a range of DFG funded services. The broad priorities of the policy are to improve outcomes for disabled and older people, reduce admissions or re-admissions through prevention, help people remain independent for as long as possible, reduce care costs where possible and help facilitate more efficient discharge from hospital. More specifically, the funding for discretionary DFGs sits within the BCF and funding for services is prioritised and targeted at initiatives which:

- Reduce or are eliminating hospital admissions.
- Allow speedier discharge from hospital.
- Consider the long-term needs of individuals and reductions in associated treatment and social care costs.
- Provide for works, adaptions, or provision of equipment, not provided by any other service.

The Local Authority implemented a Discretionary DFG and Housing Assistance Policy in early 2019. The policy sets out how the discretionary funding can be used, and it includes the local agreed approach for funding in the following areas:

- Speeding up the delivery of adaptations: additional staff and/or training.
- Funding adaptations over the maximum mandatory DFG limit.
- Relocation funding.
- Hospital Discharge Grants.
- Fast track non-means tested assistance.
- Preventative outreach and independence assistance.

- Telecare and Telehealth services.
- Adaptation of temporary accommodation.
- Provision of interim placements (for people awaiting adaptations).

Adaptations provided via Mandatory DFGs are managed by the Council's Home Improvement Agency while equipment and services provided via the Discretionary DFG Policy are delivered across a wider range of services including Social Services and Hospital Discharge teams. The outcomes achieved by the Mandatory DFGs and the Discretionary DFGs initiatives are monitored by the CCG, Social Care and the Housing and Regeneration Department as the Local Housing Authority Spend and activity is reported to the BCF Board.

7.1. BCF Funding for DFGs

The funding for discretionary DFGs sits within the BCF. Richmond Council's Discretionary DFG and Housing Assistance Policy sets out how commissioning partners plan to use increased funding to develop a range of DFG funded services with the aim of improving outcomes for disabled and older people. The table below outlines the schemes that have been jointly agreed against the DFG as set out in the Better Care Fund Plan:

Disabled Facilities Grant	**Budget 2020-21**	**Budget 2021-22**
Major Adaptations – Housing	£1,725,738	£1,725,738
Adult Social Care – Equipment, Minor Adaptations and OT staff recharges	£200,000	£200,000
Total DFG allocation	**£1,925,738**	**£1,925,738**

The Occupational Therapy Service works in partnership with Home Improvement Agency (HIA) to aid prevention, admission avoidance and to support clients to continue to live as independent as possible. Examples of use of DFG funding are set out below:

- Occupational Therapist identified that a client was at risk of falling while negotiating the stairs which would lead to a possible hospital admission. This resulted in a recommendation for stair lift with a referral to the HIA to provide a stair lift.
- Client identified with difficulties accessing the bath, putting him at risk of injuries resulted in a recommendation for a level access shower to be completed with the adaptation provided by the HIA.
- Wheelchair user was unable to access the community due to step or stairs – recommendation made for the provision of a permanent ramp or a step to be provided by the HIA to enable client to live independently.

The total number of home adaptation/ housing assistance policy interventions of all types provided in 2020/21 and paid for out of the DFG allocation was 94. In the first two quarters of 2021/22 57 DFGs have been completed.

8. Equality and Health Inequalities

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- *Changes from previous BCF plan.*
- *How these inequalities are being addressed through the BCF plan and services funded through this.*
- *Inequality of outcomes related to the BCF national metrics*

- Addressing health inequalities and promoting equality for all residents in Richmond is at the heart of all our plans. Through the development of PCN's we are adopting a population health management approach to understanding at a local level where our inequalities lie and tailoring our services to address these inequalities.

- All partners have ensured there is a shared understanding of the population of Richmond, and that health inequalities are identified and being addressed. For example, the population management workstream has enabled Richmond system partners to identify and support different localities though several workstreams promoting Long-Term Condition management, involving specific PCNs and communities. We have identified community champions in areas where there are inequalities in access to or poor health outcomes to engage with local people and signpost to appropriate support. We are providing training through the health equality partnership. This is a joint venture between the CCG and Public Health team at the council.

- Equality assessments are carried out on programmes within the BCF and are incorporated within each partner organisation's Public Sector Equality Duty.

- The COVID-19 pandemic has highlighted areas of health inequality. By taking a population health approach, we have a much greater understanding of where we have pockets of inequality and We have developed strategies to engage with these communities, to understand what is important to them and what the barriers and challenges are to align our commissioned services appropriately. Specific areas of inequality have been highlighted within the vaccination programme rollout, and partners are working together using shared resources and intelligence to target support to where it is most needed in ways that reach the specific groups identified.

- One area that has been highlighted has been the increase in mental health concerns within communities. The BCF scheme to improve mental health support in the community is focused on prevent escalating need. We also have an enhanced offer for unpaid carers to ensure we provide equity of support for this group of people.

- Delivering equitable services to clients in mental health and learning disability care homes has been identified as another priority for this year and next, as this was highlighted as a gap during the pandemic. This will be achieved by funding additional therapy and nursing services for these care homes, building on the current service delivery model provided to care homes for older people.