Better Care Fund 2022 - 2023

Narrative Plan

London Borough of Richmond upon Thames

Introduction

The borough of Richmond upon Thames has a long history of working collaboratively with health, social care and wider determinant partners. The Better Care Fund (BCF) plan for the financial year 2022-23 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 2022-23 including the work to refresh the Richmond Health and Care Plan 2022-24, development of the Proactive Anticipatory Care Model of Working. These partnership arrangements have been further strengthened by the transition to the new Integrated Care System (ICS) and Place-based working in Richmond.

During this time, much of the local engagement work with partners has been 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 and Public Health
- Richmond Place-based Partnership Committee
- NHS South-West London Integrated Care Board (Richmond Local delivery team)
- Hounslow and Richmond Community Healthcare (Community Health provider)
- Richmond Council for Voluntary Services (Voluntary Sector)
- Kingston Hospital NHS Foundation Trust
- Chelsea and Westminster Hospital NHS Foundation Trust (West Middlesex site)
- Primary Care Networks and the Richmond GP Alliance GP federation
- Healthwatch Richmond

Sign-off of the 2021-22 BCF plan had been reviewed by the partners above, and regular reporting on the progress of the BCF locally in Richmond has been reported through to the Richmond Health and Wellbeing Board and the Richmond Place based Partnership Committee.

When the draft BCF guidance had been released for 2022-23, a review group was convened comprised of Kingston, Richmond and Wandsworth Councils, NHS South-West London ICB and Kingston Hospital.

Specific workstreams for finance, metrics and demand and capacity were set up, comprised of the members above and including community health providers.

The draft BCF plan for 2022-23 will be reviewed by the Richmond Place-based Partnership Committee in August, with the committee being appraised of progress before signoff by the Richmond Health and Wellbeing Board.

Executive summary

The key priorities for the wider system and therefore the focus of the BCF for 2022-23 is to deliver the following:

- Develop a shared local ***frailty pathway*** which delivers timely interventions to the resident when required, to ensure the patient leads as independent and fulfilled life, at home, for as long as possible. This ensures that a proactive approach to care is taken, to intervene before a patient deteriorates and requires more acute, unplanned care. New falls and frailty pathways have been worked on by partners across the system to enable more responsive support to fallers.
- Implement a model of care for ***long term conditions***, encompassing prevention and tackling risk factors through to managing advanced disease; to identify areas of inequality in access and health outcomes and to support identified populations to self-manage and influence their behavioural choices. This incorporates an obesity management and healthier lifestyles workstream to support areas of deprivation and to create healthier environments.
- Expand the Richmond and Kingston ***proactive anticipatory care*** (PAC) model from the proof-of-concept stage to deliver anticipatory care to the 11 PCNs across both boroughs, applying learning from the pilots across both boroughs. This development of an anticipatory model of care for people with escalating risks is deemed a priority area by system partners and ensures that people can be better supported at home, harnessing the strengths within the communities and proactively managing people with rising health and social care risks and complexity before exacerbation or emergency hospitalisation.
- Support the system to manage increased and continuing ***demand*** seen in all urgent and unscheduled care services after the intensive demand seen during COVID-19 by ensuring people only stay in hospital when and for as long as they medically need to, and that discharge planning is commenced as early as possible. This builds on the work in 2021-22, where there were programmes of work focusing specifically to develop and refine the discharge to assess pathways and embed the Home First principles.
- Proactively support people with complex ***mental health*** needs to reduce the adverse physical effects of chronic mental health issues.
- Ensure the needs of ***carers*** are considered in all service development, policies and delivery
- To continue to support the local home care and care home market to improve the quality of care and support for local residents.
- To develop and improve mechanisms for ***sharing information*** across health and social care.
- Support the Social Care Reform priorities

During 2021-22, a key priority was 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 (RRRT) is adequately staffed and funded to meet demand 7 days a week. In addition to the RRRT service, Hounslow and Richmond Community Healthcare (HRCH) successfully implemented the urgent community response (UCR) service, which is providing support across the borough and is performing above the 90% response expectation.

The support to care homes and people in residential settings was another key focus during 2021- 22, and in addition to the care home oversight group and other forums supporting the care market, the adoption of tools such as the RESTORE2/ NEWS2 and remote monitoring solutions is being expanded. A Red Bag coordinator has been employed at Kingston Hospital to work with care homes so that residents can arrive with information to support their care, and to enable expedited discharge where possible. In addition to this, the Urgent Care Plan for London has gone live on 27th July 2022 and will support advance care planning and the sharing of information with acute hospitals.

Governance

The Better Care Fund plan for Richmond has been jointly developed and agreed between NHS South West London ICB and the Local Authority, using existing and emerging governance structures within Richmond Place to involve all partners in the formation and implementation of the plan in 2022-23, as well as progress throughout the year.

The governance for the plan is incorporated within existing joint structures including the Kingston Hospital A&E Delivery Board, the Richmond Place Based Partnership Committee, the Richmond Integrated Health and Care Services Joint Management Group and the Richmond Health and Wellbeing Board, which enables the system to have ongoing oversight of delivery of the BCF plan throughout the year. This 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 ultimate ownership of the BCF and is responsible for scrutinising and the signing off the BCF Plan in public.

The Richmond Place Based Partnership Committee 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 leadership and oversight for planning locally, including the Health and Care Plan refresh. System partners have been involved in the BCF end of year submission for 2021-22 and the planning for 2022-23, including the intermediate care demand and capacity plan.

The Richmond Integrated Health and Care Services Joint Management Group manages and reports on the performance of integrated services:

- Richmond Response and Rehabilitation Team (RRRT) delivered by HRCH
- A hospital social work service delivered by the Council
- Commissioning and managing a Joint Equipment service which supports community health and social care provision

This committee reports on progress and issues jointly to the senior management teams of Adult Social Care, ICB and HRCH on a regular basis with a focus on areas of concern and to highlight service developments and risks.

The Local Kingston Hospital A&E Delivery Board is chaired by Jo Farrar (chief executive of Kingston Hospital and Executive Lead of the Richmond Place Based Partnership Committee). Executive partners across the local health and social care system (Kingston, Richmond and Surrey), undertake the regular planning of and oversight of urgent care service delivery. The deliverables of the A&E Delivery Board include demand and capacity planning to ensure sustained performance of the urgent care system, 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.

Overall BCF plan and approach to integration

All partners across the health and care system are committed to developing an integrated approach across health and social care. This can be demonstrated in several ways at system and place level.

Richmond Health and Care Plan 2022-2024

A key development has been the refreshed Health and Care Plan for 2022-2024 which has been developed and consulted on in partnership. The draft plan has been approved by the local Health and Wellbeing Board. The two-year plan for 2022-2024 is a refresh of some of the existing priorities with a new focus on tackling health inequalities across the life course, tackling obesity, improving mental health and improving the lives of carers. The priority areas across the Richmond Health and Care plan are:

Start Well

- Maximise emotional wellbeing, mental health and resilience
- Promote a healthy weight approach
- Provide opportunities for those with special educational needs and disabilities (SEND) to flourish and be independent

Live Well

- Support people to stay healthy and manage their long-term health conditions
- Promote mental wellbeing and support people who experience poor mental health to avoid mental health crisis
- Reduce health inequalities for people with learning disabilities

Age Well

- Encourage active, resilient, and inclusive communities that promote healthy ageing and reduce loneliness and isolation
- Support people to live at home independently and 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

The Richmond Health and Care Plan 2022-24 includes a system population health approach working to reduce health inequalities (including for those people with learning disabilities), support to people to stay well, build community resilience and enable people to make informed choices and focus on what matters to them, widening choice available, methodology to identify gaps in commissioned services, and to promote mental wellbeing and support those who experience poor mental health to avoid mental health crisis. The plan will guide and ensure that health inequalities drive the commissioning and improvement developments.

A delivery plan is being developed mapping the actions and will provide a framework to support implementation and evaluation. Many of the actions align to existing programmes of work, such as social prescribing and the borough's dementia strategy, whereas others may require a new programme for work to be established. Delivery will be reported into the Health and Wellbeing Board and the partner organisations. Health and Care Plan system indicators and metrics are reported into the Richmond Place Based Partnership Committee, alongside the BCF metrics.

Richmond Response and Rehabilitation Team (RRRT)

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 can provide 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 playing 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.

In addition to the RRRT service, Hounslow and Richmond Community Healthcare (HRCH) successfully implemented the urgent community response (UCR) service, which is providing support across the borough and is performing above the 90% response expectation. The vast majority of UCR contacts have been in a person's home, allowing them to be stabilised and to remain independent for longer.

Proactive Anticipatory Care (PAC) Model

The Kingston and Richmond Proactive Anticipatory Care (PAC) Model was developed in conjunction with partners across the local system in response to increased demand in primary, community, secondary and social care. The model improves the identification and support of people with rising health and social care risks and complexities. PAC aims to improve the lives of patients by utilising a patient-centred approach and better enabling professionals to work collaboratively towards a shared goal. Taking this proactive approach means that the people this model focuses on are not always on the radar of traditional health care services.

A pivotal part of the person-centred PAC model is a 30-minute weekly MDT meeting for each GP practice. This MDT includes representation from Primary Care, Secondary Care, Social Care, Mental health, Community Services and new 'PAC Coordinator' roles. This dedicated core team of professionals surround each PCN, and as well as attending the weekly MDTs, they also form smaller 'huddle' meetings, and one clinician will be assigned as the patient's PAC Care Lead. The MDT focuses on reducing escalating risks.

Patients are referred from local professionals, wider community care partners and through the use of a bespoke risk stratification tool, provided by the South West London ICB Health Insights function, accessible to health and social care partners across the system. The model improves the lives of patients by enabling professionals to work collaboratively to a shared goal.

The overarching aim is to better support people to stay at home longer and build their resilience. Outcomes have demonstrated that those people under the PAC model have accessed emergency and unscheduled care services much less that before they were referred into the PAC model. Work is continuing to incorporate ASC data into the local risk stratification system to enable the move to a health and care population model and away from a population health-only model.

Frailty and Falls Pathways

A programme has commenced across the local system to share a frailty pathway at Place, which delivers timely interventions to the patient, when required, to ensure the patient leads as independent and fulfilled

life, at home, for as long as possible. This workstream into ensure that a proactive approach to care is taken, to intervene before a patient deteriorates and requires more acute, unplanned care.

This incorporates a review of falls services across Kingston and Richmond, as well as a jointly owned understanding of the outcomes seen in each borough, enabling joint working across Kingston and Richmond. A joint fracture liaison and falls business case has been drafted and will be presented to the Richmond Place Based Partnership Committee and the Kingston Place Based Partnership Committee within 2022-23.

Long Term Condition Management

The system is working towards having a consistent approach across Richmond for the delivery of care for people with, or at risk of developing long term conditions, encompassing prevention and risk factors through to managing advanced disease. This will be achieved through the identification of areas of inequality in access and or health outcomes. There will be a focus on supportive self-management and influencing behavioral choices.

Proof of concept projects are being developed and embedded within Kingston and Richmond Primary Care Networks (PCNs), linking into the Core20 Plus 5 agenda to target geographical areas of social deprivation. This work focusses on prevention, early identification and self-management of long-term conditions. A steering group across Kingston and Richmond has been set up to oversee this work, incorporating partners from health, the council, public health and primary care.

A pilot project targeting specific areas of social deprivation in Hampton Primary Care Network has begun. A social prescribing wellbeing co-ordinator is in post within the PCN, and a process is being agreed for identifying and contacting registered patients. A wellbeing co-ordinator has begun outreach work with a focus on engaging with potential volunteers and community groups. Barnes PCN has recruited care co-ordinator to engage with long term conditions and high impact outreach work to identify those cohorts with long term conditions and health inequalities in that area. In addition, a new Type 2 Diabetes prevention programme (the Prevention Decathlon) will be piloted with three Richmond PCNs within 2022-23.

A community-led health and wellbeing project has commenced, working with local communities to recruit, train and support volunteers to provide local health and wellbeing support. This work underpins the pilot projects above.

A population health management approach to target specific patients based on level of need. This will look wider than geographic boundaries, targeting populations such as people living with specific diseases, not necessarily facing health inequalities.

Establishing a whole system approach to addressing obesity which engages stakeholders across Kingston and Richmond to develop a shared vision and actions that tackle the root causes. This will include environmental, retail, travel and recreation across the borough. A Healthy Weight and Physical Activity (HWPA) Task Force has been established to oversee this work.

Four priority areas have been identified and the outputs from the stakeholder workshop (March 2022) will determine initial projects/initiatives under each.

1. Healthy workplaces and communities
2. Healthy environments
3. Children, young people and families
4. Health disparities and underserved communities

The Locality and Network development programme focuses on defining a vision of integrated working between H&CC partners across Kingston & Richmond boroughs. The model will build on the success of Primary Care Networks, and previous network development programmes, with a view of creating stronger partnerships across networks to shape healthier and fairer communities. The model will be developed and structured through multiple phases. Future phases are yet to be determined.

It will support health and social care services to improve the health outcomes and wellbeing of local people. And will help local people to have a good experience when receiving treatment, care and support.

It seeks to improve the health and wellbeing of the local population to help prevent people getting ill or unwell; and to reduce health inequalities between diverse groups and areas in the community. Lastly, as resources are tight, the draft Locality model will seek to achieve these goals in the most efficient ways it can.

Enhanced Health in Care Homes

The Enhanced Health in Care Homes (EHCH) model moves away from traditional reactive models of care delivery towards proactive care that is centred on the needs of individual residents, their families and care home staff. Such care can only be achieved through a whole-system, collaborative approach.

The Richmond Strategic Care Home Oversight Group (SCHOG) was set up during May 2020 with a key focus on providing support to care homes during the Covid - 19 pandemic. This group is made up of council, public health, ICB and GP clinical leads across Richmond and Wandsworth to support the care home market across the two boroughs. This group continues to support the care home market and to ensure that the EHCH framework is delivered.

The strategic direction is agreed across health and social care partners, and a review of current provision has been mapped against the EHCH elements. Additional aging well monies have been invested in community service care home support teams ensure parity of access to disability/ mental health homes, which has been an area of historical disparity.

Care homes have been supported to report on capacity tracker and to adopt new tools such as RESTORE2/ NEWS score, as well as the roll out of the remote monitoring pilot. Through the SWL Enhanced Care in Care homes group and the South London Partnership a SWL Social care workforce strategy and plan is to be commissioned across all 6 boroughs highlighting the collective commitment to ensuring system resilience. The 2 hour urgent community response service is available to care homes, and work is continuing to inform and educate care homes that have not used this and other services that this support is available.

Information sharing and digital opportunities

To develop improve mechanisms for sharing information across health and social care. The Urgent Care Plan for London went live on 27th July 2022 and will support advance care planning and the sharing of information between primary care, community health and acute hospitals. A recent decision to extend read/ write access to Social Care staff is to be implemented over the coming months

Mental Health

Improve and develop mental health support. Many people with mental health disorders have experienced a further deterioration in their mental health and well-being as a result of the pandemic. Treatment and support services are reporting unprecedented levels of demand, as well as increased complexity and lengthening waiting times. Over the next 12 months the focus will be on improving range of prevention and early intervention approaches Suicide prevention training is being delivered to staff in the voluntary and

community sector and residents with caring responsibilities. Mental Health First Aid will be delivered to the same groups and Youth Mental Health First Aid will be delivered in schools.

Carers

Ensure the needs of **carers** are considered in all service development and delivery with a focus on providing support to carers to continue in their caring roles. Over the past 2 years a number of initiatives have been introduced to support people in their caring roles and this will be further enhanced. There is a well-established jointly Commissioned service for Carers in Wandsworth which is jointly funded via the BCF by the council and the ICB which delivers on the government's commitments on empowering unpaid carers, as set out in the adult social care reform white paper, 'People at the Heart of Care.'

Social care reform

Support the Adult **Social Care Reform** priorities such as the 'Market Sustainability and Fair Cost of Care' programme and the preparation for the social care charging reform. The intention is for all parties to "arrive at a shared understanding of what it costs to run quality and sustainable care provision in the local area that is reflective of local circumstances" for residential and nursing care for older people age 65+, and domiciliary care age 18+. This work will also include delivering the digital and data ambitions set out in the Adult Social Care Reform and Integration White Papers and developing a joint approach to tackling workforce pressures across South West London.

Implementing the BCF Policy Objectives

Richmond borough residents' access multiple local acute hospital Trusts, and people accessing Trusts outside of South West London such as West Middlesex Hospital as well as Kingston 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 system has reviewed the discharge model and approach for the areas highlighted in the high impact change model and is flexing services and working through actions to improve areas of flow.

The review of the high impact change model has resulted in the transfer of care (TOC) hub being created to co-locate community, hospital and social care colleagues from Kingston Hospital, Hounslow and Richmond Community Healthcare, Your Healthcare and the two local authorities to support complex case discussions, and to improve communication routes and sharing of workload between the different organisations to support patient flow. The TOC hub supports the need for multi-disciplinary working and trusted assessment and incorporates housing and other wider services that are essential for safe and early discharges and continuing a home first model.

A system wide demand and capacity workstream has been set up though Hounslow and Richmond Community Healthcare incorporating system partners across Kingston and Richmond, reporting back to the Kingston Hospital A&E Delivery Board. Feedback and learning from Multiagency Discharge Events (MADE) and other enhanced support is also shared across the system through the Kingston Hospital A&E Delivery Board. A discharge coordinator has been placed within the Kingston and Richmond Continuing Healthcare team to improve the communication with care homes at the point of discharge, and a Red Bag coordinator is funded to support early and discharge of care home residents back to their care home. Information from

Capacity Tracker and other sources to ensure that there is a consistent view of the available care home bed capacity available to place people, either as additional step-down capacity or for ongoing care home placements.

The system continues to review discharge arrangements, and an urgent discharge workshop is being held in October 2022 to review arrangements to improve flow.

The Richmond Response and Reablement Team (RRRT) is an integrated team of hospital social workers, therapists, and nurses, who work together 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 demand pressure on acute hospital beds has continued 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 of delays.
- 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.

Partners across the ICB, acute trust, the Council and Community health providers have created the local multi agency transfer of care (TOC) hub along with partners in the system, this became operational from 22 November 2021. Members of the Councils team are regularly based at the hospital collaborating with partner agencies such as hospital therapies and the community provider focusing on timely and safe discharge for Kingston residents. The system facilitates Richmond residents enabling people to return to their home as the first option or alternatives if they have nursing needs. Our transformation plans are to develop our trusted assessor programme with our reablement and home first providers, and re-energise our maximising independence pathways, learning from the additional winter plan resources as well as bring the hospital team and our front door access team together to create our maximising independence team.

Across Richmond and Kingston, a system-wide approach to Long Term Conditions (LTC) supporting the development of health behaviours and lifestyles is being developed that enables our population to make choices within a healthy community environment facilitated by the wider determinants of health. Alongside the ongoing work undertaken by public health including programmes aimed at obesity management and healthier lifestyles there are a number of BCF programmes aimed at personalised care and support aimed at maximising the independence and wellbeing of the population. A key aspect of this includes the work undertaken via our Disabilities Facilities Grant programme of work to assist residents with necessary housing adaptations. In addition, we have a jointly funded equipment provision which provides equipment to enable people to remain as independent as possible in their own homes. Demand on for equipment has increased significantly. Developing a proactive Anticipatory Model of Care for people with escalating risks was deemed a priority area by all system partners to ensure these people can be supported 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 two PCNs across Richmond and Kingston 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 partners within the community and voluntary sectors. We will continue to develop our Social Prescribing service to address people's needs in a holistic way by facilitating access to the right support, in the right place, at the right time. The current service which enables clinicians to refer people to a range of local, non-clinical services to improve their health and wellbeing via link workers within each Primary Care Network. This works closely with our Enhanced Care Navigators who support people to access the right care in the right place to reduce health inequities and promote independence and well-being

Richmond upon Thames Adult Social Care has enhanced provision 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, which will effectively manage demand and meet more people's needs at the initial point of contact. This work is supported by the council's care technology offer to residents as a preventative service or as part of an ongoing package of care to allow people to live a full and independent life. Social care staff can purchase a range of technology, including smart watches, tablets, and smart speakers. To reduce digital exclusion, the Council has commissioned a comprehensive voluntary sector offer to provide support to residents around the three core components of digital inclusion: Accessibility, Connectivity and Digital Skills. Digital inclusion services are designed to help older and vulnerable residents access mainstream digital technology to live independently whilst learning lifelong digital skills. Building on the learning from the Video Carephone deployment during the pandemic, Richmond and Wandsworth have commissioned Alcove and Rethink Partners to deliver a Digital Care Demonstrator. The Digital Care Demonstrator expands the product range to over 50 devices including sensors, falls wearables and smart devices. Technology company Alcove are providing an end-to-end service, from referral to installation to follow up and will provide care technology packages that can be customised to people's needs and that becomes embedded in their daily lives. The work is supported by change consultants, Rethink Partners, who will be shaping and organising support and training for social care practitioners and providers to help achieve the culture change needed to accelerate the transition to digital. The aim of the project is to embed technology as a core part of the adult social care offer and build the evidence base for longer term commissioning.

Care homes within the borough have been trained in RESTORE2/ NEWS2, and a remote monitoring solution is in place across South West London, piloted in 120 care homes. A bid has ensured that remote monitoring can be rolled out to the majority of CQC registered care homes and is supported by an overall digital clinical lead and borough based clinical digital educators, employed through HRCH.

The Urgent Care Plan (UCP) for London will support people to live at home for longer, taking account of their wishes. The UCP has gone live on the 27th July 2022, and is accessible to NHS 111, the London Ambulance Service, acute hospital emergency departments, social workers, community services and GP

Practices. Care Homes who had access to Coordinate my Care have access, and there is a workplan to onboard those care homes who are at DSPT standards met, as well as to support care homes who are not at standards met to do so. Work is also underway to pilot access to wider health and care information for Care Homes using the Connecting my Care platform (the Shared Care Record in South West London). Projects to enhance the Shared Care Record are being led by the ICB and are at early stages. The initial focus is on sharing with Social Care providers to prevent hospital admissions and to support more effective hospital discharge services.

The ambition is to develop a Locality Model across Richmond and Kingston which brings together partners from across health, social care, community (VCSE) and within 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.

Many people with mental health disorders have experienced a further deterioration in their mental health and well-being as a result of the pandemic. Treatment and support services are reporting unprecedented levels of demand, as well as increased complexity and lengthening waiting times. A mental health needs assessment has been undertaken in Richmond, across the life course, to better understand the level of mental health need in the population and the impact of the pandemic. This will be used to inform commissioning decisions over the next five years. The borough's self-harm and suicide prevention strategy has been refreshed and is accompanied by an action plan to support implementation. A suicide and self-harm prevention pathway and toolkit have been developed to support children and young people, their parents/guardians and frontline staff including teachers and healthcare professionals. This will support children and young people to access the most appropriate care for their level of need. Suicide prevention training is being delivered to staff in the voluntary and community sector and residents with caring responsibilities. Mental Health First Aid will be delivered to the same groups and Youth Mental Health First Aid will be delivered in schools. Youth Mental Health First Aid will be offered to teachers to enable them to identify signs of mental health issues, offer first aid and guide children and young people to the support they need. Mental Health Support Teams are currently provided in 25 of 44 primary schools and 8 of 11 secondary schools. They provide training and guidance to teachers and other professionals, and support children and young people with anxiety, low mood and challenging behaviour. They can also support access to other CAMHS services. The PATHS Programme, designed to facilitate the development of self-control, emotional awareness and interpersonal problem-solving skills, is delivered in some Richmond primary schools. There are plans to increase the number of participating schools from September.

A key priority for social care is to support the Adult Social Care Reform priorities such as the 'Market Sustainability and Fair Cost of Care' programme and the preparation for the social care charging reform. This includes understanding the rates paid for nursing care across both health and social care and having a joint understanding of the sustainability of the local market. This work will also include developing a joint approach to tackling workforce pressures across South West London and the development of a Workforce Strategy for SWL working with the South London Partnership.

Supporting unpaid carers

The Richmond Carers Hub is funded through the BCF and delivers support services to anyone providing unpaid care within the boundaries of the London Borough of Richmond upon Thames.

The main aim of these services is to support carers to deliver quality care for their loved ones whilst maintaining their own health and well-being. As unpaid carers deliver services that are worth six times the budget for social care, supporting their capacity to keep on caring is fundamental to reducing the demand for social care packages.

The Richmond Carers Centre is the lead provider for the Richmond Carers Hub. The Centre sub-contracts with other providers to deliver the following services for carers:

- Information and advice for those seeking help in their caring role. This includes specialist advice for people caring for people living with specific conditions such as dementia, mental health disorders, neurological conditions and addictions.
- One-to-one and group emotional support for carers and former carers including specialist support for carers outlined above as well as young carers.
- Training for carers.
- Professional awareness sessions.
- Short breaks and leisure activities for young carers.
- Respite through Caring Cafe for carers of people living with dementia and other appropriate means as is possible/appropriate.

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.

In the light of the hardship experienced by unpaid carers during the pandemic, the Council has enhanced the support commissioned through the Carers' Hub to include additional flexible support for respite and breaks for carers.

The Richmond Carers strategy 2022-25 has actions to support carers over its four priority areas:

1. Improving the recognition of carers and our understanding of their needs
2. Mitigating the economic and academic impact of caring
3. Creating carer friendly services and communities
4. Improving carers health and wellbeing

Adult social care has awarded three digital inclusion contracts and spec included expectation that services will support unpaid carers in each of the cohorts – older adults, adults with disabilities and mental health, and social workers can now micro-commission digital/Assistive technology to clients including unpaid carers. Richmond has London School of Economics research on digital needs for unpaid carers of people with dementia and is working to increase the number of carers receiving statutory carer's assessments, as well as improving recognition of unpaid carers in GP settings. Work is continuing through the South West London ICB Kingston and Richmond End of Life Care Group to support carers who are caring for people at the end of their life, including how the Urgent Care Plan for London can support carers.

The Chief Executive of the Richmond Carers Centre has recently been appointed to the Richmond Place-Based Partnership Committee, mirroring the Carer representative who is appointed to the Richmond Health & Wellbeing Board.

Disabled Facilities Grant (DFG) and wider services

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 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.

During the current year, 153 requests were received by the home improvement agency, mainly from OTs and similar staff groups. The most frequently requested adaptations are level access showers and stair lifts with an average cost to the DFG of £10,000 per adaptation. 38 adaptations did not proceed following a referral into the home improvement agency mainly because the people were unwilling to engage with the means testing financial assessment or are unwilling to pay the client contribution to the adaptation costs. Some of the funds associated with the BCF are used to waiver contributions clients where people do not have family or an advocate or are struggling to provide information requested. The decision making on discretionary DFG's is shared between housing and social services with a focus on maintaining independence and supporting safe hospital discharge. The housing improvement agency perform well on undertaking adaptations.

Assistive technology, including telecare and telehealth is used both to support people in communities and as part of the effective hospital discharge. In addition to telecare options which are offered to people to support their independent and reduce reliance on services, the Council have commissioned Alcove and Rethink Partners to deliver a Digital Care Demonstrator. The Digital Care Demonstrator expands the product range to over 50 devices including sensors, falls wearables and smart devices. Alcove (our Technology partner) provide an end-to-end service, including referral, installation and follow up on the digital products, The care technology packages can be customised to people's needs and thus promote independence. The work is supported by change consultants, Rethink Partners, who will be shaping and organising support and training for social care practitioners and providers to help achieve the culture change needed to accelerate use of technology.

The BCF has created new opportunities for the Local Authority to develop and fund joint commissioning plans with Integrated Care Boards 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 unscheduled hospital admissions and Accident & Emergency attendance.
- Facilitate earlier hospital discharges, reducing the length of stay and 'bed blocking' in hospitals.
- Reduce long term care costs by avoiding or delaying admissions to residential care and the need for paid care workers.
- Play a key role in the delivery of early intervention and prevention strategies and in avoiding crisis admissions to high-cost services.
- Promoting independence, safety, social inclusion, quality of life and improved end of life care

Adaptations provided via Mandatory and Discretionary 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 from the equipment budgets.. The outcomes achieved by the Mandatory and Discretionary DFGs are reported to the Council's Finance, Policy and Resources Committee.

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).
- Waiving of client contributions in cases where a person does not have family or an advocate, and who are struggling to provide the necessary information and their health is deteriorating,

The Home Improvement agency have recently appointed a specialist Housing Occupational Therapist into the team. The OT agrees changes and amendments to adaptations thus speeding up the process and reducing delays in the completion of the work. There are plans to extend grants to dementia clients when they are first diagnosed, which will allow them to purchase basic equipment such as white boards and telephones which will improve the quality of their lives. The planning for this has been collaborative across a wide range of stakeholders and the aspiration if for this to be implemented by the December 2023

Richmond joint equipment provision is jointly commissioned with the health care provider, Hounslow Richmond Community Healthcare (HRCH) NHS Trust, and is part of the London Community Equipment Consortium Framework, led by the 'Bi-Borough' (Royal Borough of Kensington and Chelsea (RBKC) and Westminster City Council (WCC). Over the past year, equipment has been ordered at faster speeds to facilitate hospital discharges. In particular high-cost items include profiling beds, pressure relieving mattresses, hoists, specialist seating, due to people's more complex needs being supported in the community. There are some supply chain issues which have affected stock levels; therefore, alternatives are being purchased to meet demand. The demand for and cost of equipment has increased considerably over the past 2 years by circa 18% which places pressure on budgets.

The Richmond Integrated Community Equipment Contract is piloting the Next day as standard speed for delivery, collection, and repairs which started 1st July 2022. This replaced the former 5 days as standard speed. The aim is to provide a better service to the service users through them receiving items that support their needs swiftly and efficiently the next day. It is a cost neutral project where costs of speeds that were

being spent previously will not increase but a quicker service is being provided to service users the next day.

Response times are being reviewed weekly ensure that prescribers are selecting the next day speed. It is expected that the next day speed will increase as the most used speed over the next 3 months. Quality Assurance team are sending regular communications to prescribers in Richmond to embed this improved service standard.

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 Joint Management Group to ensure that the work supporting people who of hospital and RRRT performance can be aligned.

Equality and health inequalities

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

This has meant that there is a commonly held view of the population, and that health inequalities are identified, and addressed by the system. The population health workstream has enabled the system across Richmond to identify and support different localities though several workstreams promoting Long-Term Condition management (including obesity) involving specific PCNs and local community groups.

During the COVID-19 pandemic, the need to share management and population data was identified and is being addressed by ensuring that all system partners have the same view of ICB-held information to plan and support the population of Richmond. This work identified areas of variability for COVID vaccine penetration linked to deprivation, where council and ICB staff members joined with community groups to undertake health fairs and other forms of outreach.

Work is continuing using the South-West London ICB Health Insights team to identify linked areas with worse health outcomes within the borough and carry out pieces of joint work between NHS and the Council to understand and to work together to reduce inequalities in these areas, linked to NHS annual health checks and other interventions.

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. There is an enhanced offer for unpaid carers to ensure we provide equity of support for this group of people.

The PAC model supporting anticipatory care within Richmond has targeted two PCN groups that are being worked with to support people with emerging risks, which is planned to be rolled out as per the anticipatory care operating framework. It is expected that one outcome of anticipatory care within South-West London is to understand the Core20PLUS5 cohorts within areas in Richmond and to increase the number of patients within the anticipatory care cohort from most deprived areas (identified by the Index of Multiple Deprivation),

and to reduce the variation of emergency admissions for ambulatory care sensitive conditions between the least and the most deprived areas.

The Core20PLUS5 program is also recruiting and training local Community Connector volunteers to support the development of focused community led activities to increase NHS health checks in those areas and to diagnose and support people with hypertension and chronic respiratory disease where there is marked variations in the rates of NHS health checks in parts of Richmond. The latest cancer strategy has actions to promote screening and early diagnosis, and this program will also support that work throughout the borough.

Mental health disorders are common, and the population has experienced a further deterioration in their mental health and wellbeing over recent years. Research has highlighted the groups (women, children, young adults, people with existing mental health disorders, ethnic minorities, and key workers) that have been particularly susceptible to deteriorating mental health. Treatment and support services are reporting unprecedented levels of demand, as well as increased complexity and lengthening waiting times. There are several important programmes that are underway across health and social care help to reduce the burden of mental disorder locally. These include a comprehensive mental health needs assessment, refreshed transformation plans across child, adolescent and adult mental health services and a new South West London strategy to maximise the impact of the new Integrated Care Systems, including support to increase the numbers and proportion of SMI annual health checks carried out, as well as reducing variation in signposting referrals to other support services prompted by the SMI annual health check.

Equality assessments are carried out on programmes within the BCF and are incorporated within each partner organisation's Public Sector Equality Duty, which are being brought together through the Health and Care Plan to ensure that any gaps can be addressed by the Richmond Place Based Partnership Committee. A notable example of this is the equality impact and needs analysis of the Richmond Carers hub, which has reported extensive findings and improved outcomes for protected groups within Richmond.