LONDON BOROUGH OF RICHMOND UPON THAMES

NHS Richmond Clinical Commissioning Group

Better Care Closer to Home

Richmond Out of Hospital Care Strategy 2014-2017

Contents

1 Foreword

We are very pleased to present Richmond's first Better Care Closer to Home (Out of Hospital Care) Strategy (2014-17), which is a joint strategy of the Richmond Clinical Commissioning Group and the London Borough of Richmond upon Thames. It sets out our plans for meeting the future needs of Richmond residents and people registered with a Richmond General Practitioner.

In Richmond we are working towards providing truly integrated, person-centred care. There are so many benefits in doing this well. By having joint plans and services we can ensure that people's needs are met in a holistic way and that people no longer have to repeat their story several times to different health and social care practitioners. We are already piloting exciting new services that meet this ambition of working together and providing integrated care.

Whilst our strategy will impact everyone, the most to benefit will be vulnerable older people since they access health and social care most often.

We value our residents and are always keen to listen to their views on ways of improving the care and support people receive. We want to continue to develop person-centred, high quality services in partnership with the people who use them. The contribution of all those who took time to tell us what 'care closer to home' means to them and to comment on our draft strategy was invaluable. We will continue to work with service users and patients as we develop the plans set out in this strategy to ensure they meet the needs of those using these services.

Councillor Percival
Cabinet Member for Health and Children's Services
Chair of Health and Wellbeing Board

Andrew Smith
Chair
Richmond Clinical Commissioning Group

2 Executive Summary

This three year strategy has been developed jointly by Richmond Council and Richmond Clinical Commissioning Group. It sets out high level plans to transform health and social care in Richmond so that residents and the registered patient population are treated holistically, accessing services that are personalised, integrated and closer to home. We want to create a borough in which services are fully integrated, of high quality and deliver our vision to:

Provide person centred, integrated, high quality care and support that promotes independence and wellbeing so that people are prevented from becoming unwell and are supported to maintain their social and community links. Early intervention and prevention will ensure that people only attend hospital when, and for as long as is clinically necessary and the need for long-term residential or nursing care is delayed or avoided.

The impetus for developing the strategy comes from the national direction towards integration, with the requirement to integrate health and social care by 2018.

The move towards integration is being driven by changes in projected population needs developing in a challenging financial environment. By commissioning integrated services, health and wellbeing outcomes will be improved, as well as the efficiency of services. This is a view that has been reflected in our stakeholder engagement: people do not feel the need to distinguish between health and social care services providing they are high quality and meet their health and/or social care needs at the right time and in the right place.

The strategy sets out the initiatives we aim to introduce in the areas of: prevention and early intervention, short-term targeted care and support and longer term care and support. These will be introduced in a phased manner, with existing services being scaled-up and consolidated in 2014-2015 as we prepare to introduce larger-scale transformational changes from 2015-2016 onwards. These will include responding to the actions outlined in the Care Bill and building on the work already started on:

- 7 day services
- Single point of access
- Single assessment and care planning
- Holistic directory of services
- Integrated information and data sharing

All initiatives will be performance monitored in keeping with key service outcomes frameworks, and through a process of continuous stakeholder engagement. This is to ensure the services deliver the best possible outcomes for our patients, service users and carers.

In order to be certain that the outcomes measured are holistic and include everyone, the strategy should not be seen as an isolated document, but one that links with other local key strategies, including the Richmond Health and Wellbeing Strategy 2013-2016, Children and Young People's Plan 2014-2017 and the Carers Strategy 2013-2015 as well as others listed in the appendix to this document.

These will all contribute to the delivery of our vision and rely on a number of key enablers, including engagement, workforce development, governance and partnership working.

Our planning process will continue as we await more information on the Care Bill and strategic decisions are made about the use of the Better Care Fund. This process of review and improvement will support the strategy in providing services that are not only integrated, person-centred and closer to home, but personalised and of high quality. This will ensure that Richmond continues to have the highest life expectancy in England and that the quality of life outcomes for people are consistently high for everyone.

3 Introduction

This three-year strategy has been developed jointly by the Richmond Clinical Commissioning Group (RCCG) and the London Borough of Richmond upon Thames (LBRuT).

The strategy sets out high level plans to transform the way Richmond residents will be supported in their homes to maintain their independence, health and wellbeing for as long as possible, and avoid hospital admission unless clinically necessary. Services in all settings will be personalised, integrated, and responsive to people`s social care and health needs. People will be treated holistically, minimising the risk of people being treated as a list of individual needs relating to seemingly disconnected conditions.

This should mean that no-one has to repeat their story or be passed unnecessarily between different services, as health and social care services will be integrated and seamless.

Whilst the aims of this strategy include everyone, the focus is primarily on services for vulnerable older people since they typically use these services the most. Around 75% of community health services and 68% of social care services are used by people aged 65 and over.

This strategy links closely with a number of more specific Richmond strategy documents including:

- Health and Wellbeing Strategy 2013-2016;
- Children and Young People's Plan 2014-2017
- Annual Public Health Report/Statement
- The separate operating plan, summarising the work being undertaken to deliver our vision for out of hospital care over the next three years

3.1 Vision

This strategy sets out how we will commission services in line with our vision to:

Provide person centred, integrated, high quality care and support that promotes independence and wellbeing so that people are prevented from becoming unwell and are supported to maintain their social and community links. Early intervention and prevention will ensure that people only attend hospital when, and for as long as is clinically necessary and the need for long-term residential or nursing care is delayed or avoided.

What this means is that people will receive timely care that is organised to meet their needs. The health and social care services they require will be coordinated as a coherent package with a focus on helping them to stay healthy, get better, prevent relapses and get on with their normal lives.

This translates into 5 strategic goals which will determine how we will change in Richmond.

		***Strategic goals*:**	***This means:***
1	Prevention and early intervention	Greater emphasis on **early intervention and prevention**, keeping people healthy, connected to their communities, preventing ill health and reducing health inequalities to reduce the demand on services focusing particularly on the frail elderly	All professionals will find opportunities to talk to people about their lifestyles including diet, physical activity, smoking and drinking habits and wider issues determining wellbeing such as housing and social isolation
2	Targeted care and support	**Easy access** to **high quality, responsive primary care** to make local community care the first point of call for people	GPs and primary care teams will be at the heart of ensuring everyone who provides care does so to consistently high standards and integrates its work with all other partners
3	Targeted care and support	**Prevent unplanned hospital admission or A&E attendance and facilitate early supported discharge** so that fewer people need to access hospital care	For an urgent need a clinical response will be provided within 2 hours. Care providers will manage discharge from hospital into planned supportive out of hospital care
4	Longer term care and support	Clearly understood **planned care pathways** that ensure out of hospital care is *not* delivered in a hospital setting	Wherever possible people will have access to care closer to home with reconfiguration of local community provision to facilitate this
5	Longer term care and support	**Social and healthcare providers working together**, with the person at the centre, to proactively manage the elderly, long term conditions and end of life care in community settings	People will have a named coordinator who will make sure they have all the services they need.

3.2 Aims and Objectives:

We aim to:

- Ensure people have strong community links and networks, supporting them to remain living independently in their own homes for as long as possible.
- Encourage and educate people to only use emergency care such as Accident & Emergency, Walk in Centres and Urgent Care Centres at the right time and for the appropriate types of needs.
- Ensure people are able to leave hospital as soon as they are ready, not staying any longer than they need to.
- Provide patients with greater choice with more day cases/outpatient treatments and consultations being delivered in community based settings closer to people's homes where it is clinically safe to do so.
- Reduce reliance on adult social care services.
- Enable people to remain in their own homes for as long as possible, delaying or avoiding admissions to long-term residential and nursing care unless absolutely necessary.

To achieve these aims we will:

- Prevent health deterioration and loss of independence, promote self-management and support people to take responsibility for their health and wellbeing as much as possible.
- Provide equitable access to good quality information and advice so that people are able to understand and navigate the health and social care system when they need to.
- Develop primary, community, social and voluntary care services in the community. These services must be accessible, effective, and joined up so that everyone receives the care and support they need at the right time, in the right place delivered by the right people with the right skills.
- Ensure all services are person-centred and focus on caring and supporting the person as well as a focusing on treating the condition.
- Integrate health and social care services where it will improve service user and carer experience and outcomes and offer better value for money.

3.3 Principles

To achieve our aims, services will be underpinned by our agreed principles to:

- **Promote:** the health, wellbeing and independence of people and communities, improving the health of the poorest, fastest
- **Provide:** high quality information and support for people to manage their own care so that they will be able to find their own solutions from within the community whilst being supported to be safe
- **Protect:** the population from serious health threats and help people live longer healthier lives
- **Safeguard:** the safety and wellbeing of people accessing services and develop systems and processes to protect people at risk from abuse, harm or exploitation
- **Champion:** preventative and early intervention measures and avoid unnecessary hospital admissions with people receiving the right care, at the right time, in the right place
- **Innovate:** wide ranging support so that everyone will be empowered to have more control and choice irrespective of how their support is funded
- **Enhance:** the experience and quality of care that people receive, focusing on better outcomes
- **Improve:** efficiency of our collective resources; making sure that our money is spent effectively
- **Deliver:** High quality services

4 Why do we need a Better Care Closer to Home (Out of Hospital Care) Strategy?

4.1 National Case for Change

The current model of care focuses on the social model of health which is focused on **preventing, delaying and managing** lifelong illness and disease, as opposed to the medical model of illness which focuses on acute care and preventing premature death.

A list of influential policies and reports relating to this strategy can be found in the references section at the end of this document. The key documents that have influenced the development of this strategy are:

1) **The Health and Social Care Act (2012):**
   - The abolished Primary Care Trusts were replaced with NHS England and local Clinical Commissioning Groups thereby placing clinicians in charge of commissioning; established Health and Wellbeing Boards and transferred all Public Health responsibilities to Local Authorities.

2) **Integrated care and support: our shared commitment (May 2013):**
   - This outlines the aim for all localities to have adopted models of joined-up (integrated) commissioning within the next two years and for integrated services to be the norm within five years.

3) **The Care Bill (May 2013)**
   - This is currently progressing through Parliament. Once passed, it will place additional responsibilities on Local Authorities to develop services by 2015 that are wide-ranging and personalised ensuring that people can get better care that works for them. It emphasises a new approach to social care that promotes wellbeing, strengthens carers' rights and introduces a new adult safeguarding framework.

These national drivers and the strategic direction from NHS England have made it clear that a 'do nothing' option is unsustainable if we are to address the challenges being faced both nationally and locally in Richmond.

Overall these national policy and financial drivers recognise that:

- There is widespread agreement that we must commission more community-based services and shift spending out of acute services into the community.
- Integration is no longer just an option. The Government has committed to fully joining up health and social care across the country by 2018. There are a number of measures in place to ensure that this happens.
- Richmond CCG and LBRuT will continue to face financial challenges in the forseeable future. Therefore, efficient and value-for-money services are essential. Primary care, social care, community and voluntary care services must be effective in ensuring that people maintain their health and wellbeing and remain independent for as long as possible in their own homes, avoiding unnecessary hospital activity or early admission to a care home.

We have engaged with the local population, service providers and other stakeholders to produce this strategy and an engagement report and an Equality Impacts Needs Assessment are published as appendices. The following figures outline what we discussed during this engagement:

Figure 2: Questions we considered in our engagement process:

Figure 3: Responses received through the engagement process:

4.2 Local Case for Change – the Richmond story

Richmond is the greenest borough in London, located 15 miles southwest of central London with the River Thames running through it. Overall, Richmond is healthy, safe, rich in assets and currently has the highest healthy life expectancy in the UK. In addition, the rates of emergency admissions to hospitals in neighbouring boroughs are amongst the lowest in the country.

However:

- Local analysis suggests that 15% of emergency hospital admissions (costing ~£4.2m/year) are for potentially preventable conditions and the overall positive picture masks areas of inequality in the borough.
- There is a life expectancy gap of 5 years between those living in the most affluent areas compared to the most deprived areas of Richmond, and almost 9% of people in the borough experience above average levels of deprivation.
- Emergency hospital readmission rates for females (12.8%) are significantly higher than the national average (11.4%).
- 7% (£1.7 million per year) of spend on emergency admissions is attributable to local care homes.
- 30% of emergency hospital admissions from care homes are short stay (0 or 1 day) suggesting there is potential to reduce these.

Additionally, in line with national projections, the make-up of the local population is expected to change considerably over the course of the next ten years.

- The overall population is expected to increase by 9% by 2020
- This increase includes an additional 14% in the number of people over 65
- The number of people aged 65-74 living alone in Richmond is already high and is projected to increase by 23% by 2020 with an18% increase in the number of people aged 75+ living alone.

These demographic changes will inevitably increase pressure on health and social care services, since people aged 65 + are typically those who use these services most. Around 75% of community health services and 68% of social care services are currently used by people aged 65+, many of whom have more than one long term condition.

With increasing numbers of elderly people living alone and potentially isolated there will be additional pressure on health and social care services since
Isolation can significantly affect a person's mental and physical health, confidence and wellbeing.

A review of the Joint Strategic Needs Assessment and engagement with the public has highlighted that the needs of the population are also increasing, including:

- Projected increases of 20% and 19% of older people with depression and severe depression respectively by 2020.
- A forecast increase of 18% in the numbers of older people with dementia by 2020. Nationally, an estimated 70% of hospital beds are occupied by older people, of whom around half have cognitive impairment including dementia and delirium. Hospital stays for 60-74 year olds increased by more than 50% during the 10-year

period between 1999 and 2009 and those with dementia tend to spend longer in hospital than those without.

- Increased pressure on carers. An estimated 25% increase in the number of people who are carers aged 65 and over and thereby the number of carers with a long-term health condition. Currently we know that 20% of carers registered with the Richmond Carers Hub Service have a long-term condition; this is also expected to increase.
- Rising mental health needs. Currently, an estimated 20,000 people in Richmond have a common mental health disorder, with around 50% needing treatment, and of these there are 1500 people with some form of severe mental illness. Rising levels of stress relating to, for example, economic factors is having an impact on these levels.
- Increasing numbers of hospital admissions related to 'hidden harms,' resulting from alcohol use and smoking.

Therefore, although a variety of factors influence the health and wellbeing of the people in the borough, these increases in population demographics and potential support needs will pose a real challenge for us in future.

We know that services in Richmond are generally good. Richmond CCG and Council services are rated well in terms of their overall performance when measured against a range of national indicators within which they operate. This is a view that is also supported by service user feedback, such as that provided by the adult social care survey. However, feedback from some service users and carers, (eg the national GP survey), tells us that their experiences are not always as positive as the performance data indicates.

We know that too many people go to Accident &Emergency unnecessarily rather than accessing walk-in centres or Urgent Care Centres and often, in the case of A&E attendance, people are admitted to hospital when this could have been avoided. We also know that when people are in hospital, they often stay longer than is clinically necessary because the care and support they need in the community is not there at the right time.

The Council has made good progress in recent years in reducing the numbers of people who go into long-term residential care. as a result of a very successful Reablement programme and the availability of extra care housing. The number of people placed into care homes via the council has reduced from 170 in 2009/10 to 146 in 2012/13. However, it may be possible to reduce the number of admissions to long term residential care further by developing further extra care accommodation in the borough.

Feedback also tells us that some people find the system complex and confusing and it is key to delivering the aims of this strategy that people are better informed about local provision and encouraged to only use emergency care at the right time and for the appropriate types of needs. People state that they have no preference in accessing either a health or social care service; they only want to access the ***best care*** that meets their needs..

Ultimately, our aim is to make integrated and coordinated health and social care **the norm**, so that organisations work together as seamlessly as possible, sharing data and

communicating better between themselves and with service users, their carers and families. This will mean finding ways to work in a system in which NHS care is free whilst social care is chargeable.

Our vision is being able to provide the right support and care, at the right time, in the right way, in the right place, from the right people with access to the right resources.

4.3 Financial Context and Drivers

Financial Challenges

Richmond CCG and Richmond Council are facing increasing financial pressures. People are living longer but often with one or more long term conditions. The cost of drugs is increasing and whilst technology can provide some solutions it is often slow to implement.

One of these pressures is Continuing Healthcare funding. The numbers of people with eligible needs accessing this funding is increasing which is putting considerable strain on CCG spend in this area. With a greater emphasis placed on prevention and early intervention measures people will be supported to be independent for longer without the more intensive nursing associated with Continuing Healthcare.

These financial pressures place an imperative on commissioners to focus on the challenge of ensuring we have a financially sustainable health and social care system that meets everyone's needs both now and in the future.

For the first time the Government is using the threat of financial penalties to drive forward the integration agenda and reduce spend in the acute sector. In May 2013 the NHS announced the introduction of the Better Care Fund (previously the Integration Transformation Fund). This is not new money but transfers a significant proportion of CCG commissioning budget to the Council to be used on joint integration projects aimed at reducing spend in acute hospitals.

The Better Care Fund is a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local Council. It is worth £3.8 billion nationally and in Richmond will provide circa £5m in 2014/15 and £11m in 2015/16. Access to the fund will be dependent on meeting a range of criteria which include delivery of more integrated services, better data sharing and seven day services,

Two year plans for 2014/2015 and 2015/2016 will be jointly agreed between the CCG and Council and endorsed by the Richmond Health and Wellbeing Board by February 2014.

Further to this both the CCG and the Council are required to make designated year on year savings to maintain financial balance. More detail on our financial position and plans can be found in appendix B.

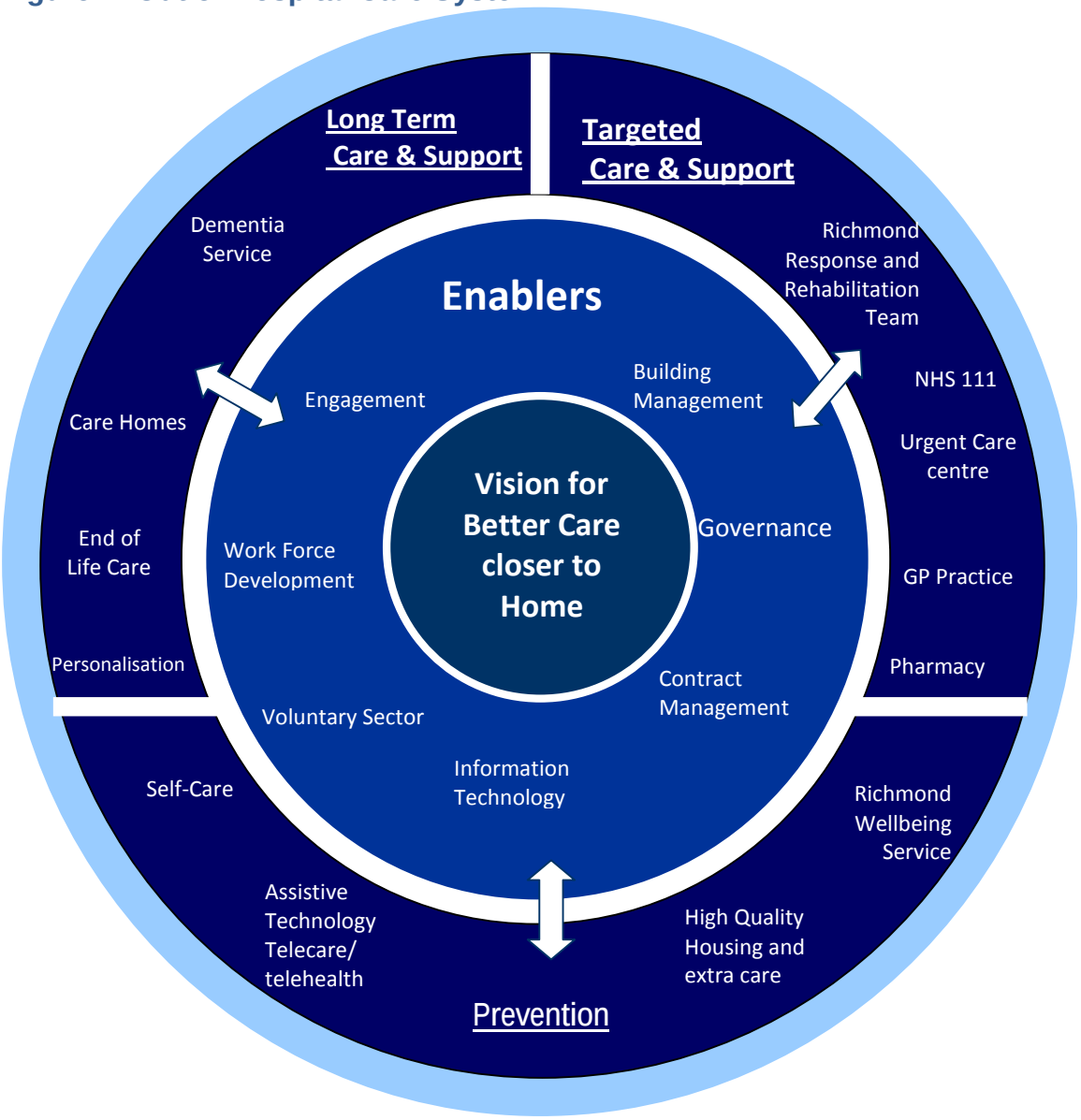
4.4 Integrated health and social care model and person centred support

The integration of health and social care services presents many opportunities as well as challenges, particularly as the system is complex and can be confusing for many people.

The Council already has excellent experience of designing services in a personalised way. It is ranked number one in the country for Personal Budgets (funding given to individuals to spend, in a way that they choose, on their social care). Person centred support cannot be achieved without services being delivered around the needs of people and not organisations. This means developing an effective integrated local system, with the support and engagement of all stakeholders. Providers and commissioners will work together with people, their families and carers to achieve the same shared outcomes that will deliver the aims of this strategy.

Figure 4 below diagrammatically represents how all aspects of the system come together to produce this vision.

Figure 4: Out of Hospital Care System



4.5 Who is the strategy for?

This strategy takes a holistic view of the local population, ensuring everyone's diverse range of health and social care needs are met. As such, the strategy has a wide scope including:

- All Richmond borough residents, including those in residential or nursing care or supported accommodation.
- Patients registered with a Richmond GP practice (including those not resident in Richmond).
- Patients not registered with a Richmond GP practice, but resident in or temporary visitors to Richmond.
- People with long term conditions, mental health, learning disability, and physical disability health and care needs, and their carers

Whilst the local strategic changes will impact on everyone, the most to benefit will be **vulnerable older people** since they access health and social care services most often.

What services are locally commissioned?

- Planned and unplanned care in all settings of care (primary, community and acute hospital)
- All services provided by NHS, local authority and voluntary care organisations

What services are nationally commissioned?

Due to the structural changes that were introduced into the NHS and Public Health in April 2013, there are a number of areas that are commissioned nationally. These include:

- Dentistry, which is managed by NHS England
- Optometry, which is managed by NHS England
- General contracts for general practices and pharmacies which are managed by NHS England. This includes mental health interventions provided under the GP contract.
- Secure psychiatric services which are managed by NHS England
- Locally commissioned services for pharmacies as the responsibility for these has not been delegated to local health teams by NHS England as it has been for general practice enhanced services

We will work with NHS England to support their improvement of primary care services and invest in locally commissioned primary care services that support the delivery of this strategy.

We will also work closely with partners in the South West and North West London sectors since the Out of Hospital strategies for these areas are key to effecting changes in provision at Kingston and West Middlesex Hospitals. There is joint commitment from neighbouring commissioners to ensure that there is an agreed strategic framework for Care Closer to Home so that the impact on our hospitals is clearly understood and jointly planned.

Available local resources and technology

There are no acute hospitals within Richmond. The closest acute hospitals are in neighbouring boroughs.

- Kingston Hospital in the Royal Borough of Kingston Upon Thames
- West Middlesex Hospital in the London Borough of Hounslow
- Charing Cross Hospital in the London Borough of Hammersmith

In the borough the existing health and social care resources include, but are not limited to, the following:

- 30 GP practices
- 46 Pharmacies
- 4 integrated health and social care teams located at three health and social care centres at Whitton, Teddington and Mortlake
- Specialist mental health services located in Richmond Royal and Twickenham
- Specialist learning disability health and social care services
- Community hospital and walk-in centre at Teddington Memorial Hospital
- Integrated health and social care provided by South West London St. George's adult community mental health team
- Inpatient provision in specialist Mental Health hospitals Tolworth, Queen Mary's and Springfield.
- 800 community and voluntary sector organisations
- 3 council run intensive day care centres and several voluntary sector centres
- 20 care homes for older people
- 28 care homes for adults with a learning disability
- Specialist services such as falls clinic, neuro-rehabiliation service
- Council property portfolio with a value of £568m

This strategy aims to create more options in the community by targeted investment in key areas. These include, for example,

- enabling general practice to provide extended services;
- developing local pharmacies to provide more responsive urgent care services;
- reviewing and redesigning the services hosted at Teddington Memorial Hospital in order to provide community based diagnostic and treatment services especially for frail and elderly patients.

In addition to considering the local market and available resources we will ensure there is a wealth of information available about managing health conditions and available community resources to support people in self-managing their conditions.

We will use information technology to create integrated systems which prevent people from having to repeat themselves when accessing different services and promote holistic understanding of people's needs with improved communication between services.

We will also explore ways to maximise efficiency and reduce time spent accessing services for people by managing chronic conditions through telehealth solutions.

Over the lifetime of the current strategy a number of housing schemes will be developed to offer good quality affordable homes and homes that meet specific support needs including the review of local extra care housing provision.

5 How we will deliver better care, closer to home

This section outlines the key areas that we will work on to enable us to deliver our strategic aims. They are arranged into three themes as set out below.

- **Prevention and early intervention**
- **Targeted care and support**
- **Longer term care and support**

Within each theme a number of key priorities that the Council and Richmond CCG will be taking forward are described including services or care pathways already developed or commissioned which we are now monitoring and/or seeking to improve over the next three years together with areas where we have not yet fully formulated our future plans. An operational plan is attached in Appendix C.

The priorities detailed within each of the three themes in this section have been identified through stakeholder engagement, analysis of local needs and through a process of local and national benchmarking. These themes mirror a pathway of care which may be experienced in part or in full by service users.

Whilst the Council and Richmond CCG's priorities are unlikely to change significantly during this three year period, the individual work streams in the Operational Plan will be reviewed annually and refreshed to ensure they continue to meet local and national priorities.

5.1 Prevention and early intervention

Below is an outline of the key priorities over the next three years to help people in Richmond to live more independent lives and reduce the need for and reliance on health and social care services.

Early intervention aims to identify people at risk and halt or slow down any deterioration and actively seek to improve their situation. Interventions include screening and case finding to identify individuals at risk of specific health conditions or events (such as stroke or falls) or those who have existing low level social care needs.

Support from unpaid carers is essential to help people remain living independently in their own homes and therefore support for carers is included in this section:

Priorities for prevention and early intervention:

- Good ***information and advice*** is key to enabling people to make decisions about their health and social care needs. We want to improve provision of information and advice across the healthcare economy and educate the public on where to go for specialist information and advice. By having an up-to-date **directory of services** on the web we plan to help people to select appropriate services. We also acknowledge the need to provide information and advice through a variety of non-electronic methods such as in person and over the phone for those who do not have access to the internet, or would prefer to speak to someone in person.

- By identifying risk factors to poor health early on we aim to provide general low level support and care that will help people stay healthy and avoid problems associated with unhealthy lifestyles. We have commissioned the ***Livewell Richmond*** service which is an evidence based healthy lifestyles intervention service with a single point of access that supports a tiered approach to health improvement. The service addresses both primary prevention (in terms of promoting healthy choices) and secondary prevention (in terms of enabling self care for those with existing long term conditions). The service includes the provision of health coaching (based on motivational interviewing) alongside the coordination of care. The service also provides a range of expert patient programmes for various illnesses and for carers. We aim to improve access to Livewell Richmond services by increasing awareness amongst healthcare professionals in order to facilitate signposting and referrals.
- We will encourage the proactive management of people with long-term conditions in order to avoid unnecessary hospital admissions and put people in control of their health and wellbeing. Our aim is that people with long-term conditions will have a ***self care plan*** that takes account of deterioration and emergency care. Care plans will include signposting to both local NHS, voluntary or community organisations for support. Better referrals of people with long-term conditions to existing services that help them manage and maintain their health will empower individuals to take care of themselves. We will provide more accessible information about self care and will be launching a programme of social marketing to encourage, support and educate people to maintain their wellbeing.
- We are committed to expanding the use of **assistive technology** with a focus on **telehealth** systems that assist people with long term health conditions and who are at risk of frequent hospital admissions as a result. The following key groups of people would benefit from the use of assistive technology and will be targeted in Richmond:
  - People who are at risk of frequent hospital admission due to heart or lung conditions
  - People managing diabetes
  - People with dementia
  - People who need support with medicines management
  - People who are at risk from falls, isolation or increasing frailty in old age linking with the falls and bone health service
  - People with additional needs, including those who have a learning disability, who may be able to move from care homes to live more independently with assistive technology and other support
- **Voluntary sector services** are key to enabling people to live independently, be active in their community, create a local support network and navigate the health and social care system should they need to. In Richmond we have over 800 voluntary sector organisations and a wide network of volunteers who give their time to help local people, including older and vulnerable adults. We have been reshaping the way that the Council funds some voluntary sector services. A new **Community Independent Living Service** (CILS) has been commissioned from local third sector organisations to enable older people (and other vulnerable groups) to continue living as independently as possible in their local community, and to achieve and maintain their abilities in relation to physical, intellectual, emotional and social well-being. The service will promote independence and reduce social isolation by:
  a) providing information on and support to access services available to maintain older people living in their own home, e.g., information/care navigators;

b) delivering a range of age–appropriate physical and social activities that promote both physical and mental health and wellbeing of people over 65 years of age;
c) provision of befriending service to older people living alone where this does not already exist; and
d) being sensitive to diverse needs arising from a person's racial/ethnic background; gender; and /or faith/belief; and be able to meet these needs appropriately

- The CILs will operate in four locations across the borough to provide a responsive voluntary sector network of services for adults with a wide range of needs, In addition, a number of other voluntary sector services have recently been commissioned, including ***home maintenance*** and ***advocacy*** services, both of which are aimed at supporting vulnerable adults.
- We recognise that unpaid carers play a significant role in enabling people with health and social care needs to remain independent and at home. It is important that carers look after their own health and wellbeing and access support to enable them to continue with their caring role. In commissioning the local ***Carers Hub*** Service carers can access information, advice and support around their caring role. Our aim is to improve the way we identify carers (including young carers), and ensure they are offered carers support and services. We will be working to improve access to mental health services for carers as well as prioritising them for NHS health checks in order to improve both their physical and mental wellbeing. We will also continue to encourage carers to take a break from caring and broaden the range of ways that carers can take up respite. This work will involve planning for the impact of the Care Bill (2013) when it comes into effect from 2015 with strengthened rights for carers.

5.2 Targeted care and support

Short-term targeted care and support is support required in the short term to assist people to recover their health and wellbeing. This theme includes support received from GPs as well as the support needed when in a crisis (ie unplanned care).

- In close association with the Access Team the **Richmond Response and Rehabilitation Team** (RRRT) aims to ensure prompt service delivery that is person-centred and holistic. The RRRTeam is a newly reconfigured service which aims to deliver seamless care, support recovery and enable people to stay independent in their own homes as well as staying out of hospital, residential or nursing care, no matter what their particular care need is. The new service also has an early intervention and prevention function by being a first point of contact for many people. This service brings together nurses and therapists from Hounslow and Richmond Community Healthcare (HRCH) with therapists and social workers from Richmond Council, into one service enabling a more person-centred approach which is key to delivering our out of hospital strategy.
- The RRRT also works closely with local GPs, 111 service, and hospitals and supports people to be discharged home as quickly as possible and continue to remain independent and well. A clear care pathway following discharge from hospital ensures people get the right care, at the time and for the duration they need it, from appropriate highly skilled workers. We aim to reduce ***delays in discharging*** people from hospital by working with local acute hospitals to identify the main reasons for delays occurring. In addition, Richmond CCG will continue to work in partnership with both the Hounslow and Kingston Urgent Care working groups to reduce the number of delayed transfers of care, through improved patient pathways and improved communication between partners.

- ***The Richmond Community Ward*** service draws on a range of community health and social care professionals to look at people`s full support needs. It is based on the John Hopkins risk stratification model which is a predictive tool to identify people who will become high users of acute services in the next 2 years. The ward aims to undertake a holistic assessment of needs and engage the person in managing their condition effectively in the future. The number of avoided hospital admissions required to fund this service is 420 (a 3.5% reduction in emergency admissions – based on average costs).
- **Teddington Memorial Hospital** (TMH) is a vital local resource which was redesigned in December 2011 and includes a walk-in centre, diagnostics department, 2 wards with beds for inpatient rehabilitation and a number of outpatient clinics. We aim to undertake a review of the provision on this site with a view to providing a frail and elderly multidisciplinary integrated Assessment Unit which could provide a one-stop shop for GPs to refer patients as an alternative to sending them to A&E. There is also an opportunity to consider establishing a day case facility (eg for IV clinics) which would provide local options instead of patients attending hospital outpatients as well as facilitating earlier hospital discharge for some ambulatory patients requiring IV. NHS England will also be reviewing the pharmacy service at TMH in 2014, supported by local stakeholder input.
- The new ***Richmond Wellbeing Service*** delivers rapid access to integrated primary mental health care for people who can be cared for in the community. The service consists of psychological treatment for people with common mental health problems and access to specialist mental health expertise within the Primary Care Liaison team and has demonstrated speedy access to care and clinical effectiveness with recovery rates approaching 50%. The service has recently rolled out access to anonymous online support providing 24/7 access to a moderated peer support site and plans to implement a telemedicine delivery of care which will enable people to speak directly to clinicians or receive support in their own home.
- In order to deliver more care out of hospital settings, a community service provided by ***GPs with special interests*** is available as an alternative to attending a hospital outpatient appointment. These GPs receive extended training in a specific area, (such as dermatology or neurology) beyond the normal scope of general practice, which allows them to provide this service in a GP practice or other community setting. This service is effective in reducing waiting times for outpatient appointments as well as moving health care closer to the homes of Richmond borough residents. A review of the current provision is currently underway in order to extend this provision locally.
- We will ensure that general practice and local pharmacies respond to key strategic requirements though the use of appropriately targeted **Local Enhanced Services** (**Locally Commissioned Services**) A review and redesign process of these services is currently underway.
- The **out of hours primary care provision** is also being reviewed to determine the best way that this can be provided. Extended GP hours and the link to out of hours provision (24/7 services) need to work together to avoid unnecessary hospital activity.
- ***Richmond Clinical Assessment Service (RCAS)*** is the peer review and demand management system for GP to secondary care referrals. RCAS peer reviews selected NHS referrals initiated by GPs, GPs with Special Interest and primary care providers and consultants to ensure quality and appropriateness. This service has contributed to reducing hospital admissions by reducing inappropriate referrals to hospitals as well as ensuring people go to the most appropriate service, in the most

appropriate location for their need (which can often be in the community, closer to a patient's home). The service also reduces waiting times for appointments and encourages consultants from the acute sector to provide value for money services in a community setting. Our aim is to increase the usage of this service amongst local GP practises.

- In order to avoid unnecessary A&E attendances and provide emergency support nearer to home we aim to promote alternative emergency services, such as the new **NHS 111 service.** Richmond and Kingston CCGs launched NHS 111 jointly in early 2013 and are committed to expanding it to make it a responsive advice and assessment service which patients call before accessing other urgent healthcare services. It will not replace 999 or direct contact with patients' own GPs, but will facilitate rapid access to appropriate services across the rest of the healthcare system. By increasing uptake of this service we will reduce the amount of inappropriate A&E activity by only referring people to A&E when this is clinically necessary.
- We aim to develop local ***community pharmacy*** services to provide more responsive urgent care services which can be accessed via NHS 111. These services will include reviews of medicine use in the home for people who are housebound as well as running minor ailments schemes to take pressure off GP services. We will be promoting this service more widely to increase the number of people accessing it. We will also be looking at ways of increasing the flexibility that people are prescribed medication, by having more pharmacists able to supply specific medications.
- We aim to improve access to support people at times of a ***mental health crisis***. The Crisis Resolution and Home Treatment service, with the support of the Community Mental Health Teams, Crisisline and Hospital Liaison Psychiatry services, sets out to prevent a large number of inappropriate admissions to hospital or residential care as well as reducing the flow of frequent attendees at A&E departments. We aim to provide timely, responsive and proactive services for people in a crisis to avoid mental health conditions escalating. In order to improve support to people in a crisis we will be looking at extending the service user network to anyone with a severe or enduring mental illness. This service provides peer support to those who have a relapse in their mental health and is currently available to those with personality disorders.
- By improving the effectiveness of ***specialist treatment services for substance misuse*** with the focus on recovery goals of education, housing, employment and family and social networks we intend to improve the health and wellbeing of people with addictions.
- We are working alongside Hounslow CCG to promote and manage the ***Urgent Care Centre*** (UCC) service which opened at West Middlesex University Hospital in March 2012. As part of the service specification, Richmond CCG will work towards a reduction in the transfer rate of patients from the UCC to the A&E department (from 18% to 12%), since this is currently above average. This will ensure patients are being treated in the right setting, first time.
- In July 2013 Hounslow and Richmond Community Healthcare Trust introduced an **early supported discharge team for stroke survivors** resident in the borough of Richmond. It aims to provide comprehensive support for Richmond stroke survivors and their carers, by maximising rehabilitation and recovery, promoting independence, reducing reliance on long-term institutional or social care packages and reducing the risk of secondary stroke and acute admission for patients.

Wider determinants of health and wellbeing

- We aim to focus on improving the way we work across all agencies: health, social care, housing, education, employment and community safety to ensure that we work in an integrated way to benefit residents. We want to improve communication and signposting so that people receive the most appropriate support that will contribute to their health and wellbeing. For example, anti-social behaviour picked up by housing officers or the police may be symptomatic of a mental health illness and would be best treated by the community mental health teams so joint working is essential to provide personalised support. We plan to look at ways to support ***homeless*** people to access health services since many are not registered with a GP and often end up at A&E to access services.
- By ensuring housing is fit for purpose we can enable people to continue to live independently at home and better support families including children with disabilities and also delay moves into residential care homes. We will continue to provide ***disabled facility grants*** to help people who cannot afford to adapt their homes. The home improvement agency also assists people who can afford to adapt their homes but need a reliable agency to organise and carry out adaptation work.

5.3 Longer-term care and support

Longer term care and support describes the ongoing support people need in order to manage specific conditions as well as the support people need when nearing the end of their life.

Priorities for longer term care and support:

The focus on this part of the strategy is on supporting the 5% of patients who consume the largest proportion of the health and social care resources– in both time and money (with roughly the top 1% accounting for 20% of the spend). The aim is to promote self-management and provide appropriate specialist care at the point of need. The approach which we will adopt focuses on 4 localities where the community health and social care teams wrap around GP practices to ensure seamless and integrated services.

- All general practices in the borough are contracted to provide general medical services by NHS England with the contract reviewed annually. The contract for 2014-15 stipulates a number of changes that will improve the way out of hospital care is provided, including all patients aged 75+ having **a named GP,** giving them a more personalised experience of local healthcare, improving services for people with complex health and social care needs and improving the quality of out of hours services.
- We know that people living in ***care homes*** have high levels of health and social care needs and that 7% (approximately £1.7 million per year) of spend on emergency hospital admissions is from patients living in care homes. Our aim is to reduce the number of these emergency admissions by improving the coordination and quality of care received in the 20 borough care homes for older people. This will be achieved by improving training to care home staff, particularly around symptom recognition, practical skills, condition planning and including a rapid response element to avoid unnecessary hospital admissions.
- The Council has a contract until 2026 with three local care homes providing a total of 175 beds. The mix of accommodation has been reviewed recently with a view to adjustment to reflect service demands. Currently 39 beds are being reconfigured to

provide additional residential and nursing dementia provision. Further reviews are planned to ensure the provision reflects local demand and future requirements.

- We aim to improve the experience and support that people nearing the end of their life receive; in particular we will ensure they receive an advanced care plan detailing their end of life care wishes. Richmond has an established **Coordinate My Care** (CMC) programme which provides a contemporaneous record of an individual's end of life care needs and preferences. It also contributes to ensuring people die in their preferred place, which is one of our key aims for good **end of life care**. We also acknowledge the difficulty of caring for someone who is dying and will be piloting a new service to provide emotional support and benefits advice to carers of those nearing the end of their life to work closely with our bereavement service. Our **care home pilot** is designed to reduce unplanned hospital admissions for people in the last year of life, with care homes being supported in care planning and 'difficult conversations' with care home residents, carers and relatives and supporting people to enable them to remain at home.
- We realise that there is a link between people diagnosed with a life-changing long-term health conditions (e.g. diabetes) and mental health problems such as clinical depression. We want to improve the diagnosis of mental health conditions amongst those with long-term conditions to ensure people are accessing psychological therapies to improve their mental health and wellbeing.
- The Council and Richmond CCG are committed to improving the lives of people with dementia and creating a ***dementia-friendly*** borough that has a greater awareness of the symptoms of dementia and are willing to support people with dementia to live more fulfilling lives. We aim to increase the number of people formally diagnosed so that they can access specialist dementia support services. In March 2014 we are launching a **Dementia Action Alliance** with local businesses and organisations to raise awareness and advise people working in public-facing jobs how they can best support people with dementia.
- **Care pathways** – In addition to dementia we are also reviewing care pathways relating to a number of other conditions (eg, diabetes, cardiology, neurology, and chronic obstructive pulmonary disease) in order to help people manage their conditions more effectively and prevent unnecessary hospital admissions. A key priority is to improve the way that referrals to health and social care services take place to ensure that the most appropriate service is accessed in the most appropriate setting. We will review local information on referral patterns to identify other conditions where care pathways can be integrated and improved. We will focus on a '**year of care'** whereby the pathways for a specific conditions is focused on by all providers of care to drive up the quality of the care received by this patient group.
- In line with the final report on Winterbourne, all people with a learning disability living in a hospital setting have been reviewed and health and social care commissioners are working in partnership with people and their carers to ensure that people can receive their treatment and care needs closer to home. A local Commissioning Strategy is being developed in 2014 to ensure high quality care and support for all adults with a learning disability.
- People with a learning disability continue to face significant barriers to accessing some healthcare services. We will develop hospital pathways and treatment options that ensure reasonable adjustments are made for the person with a learning disability at the point of referral. We will ensure that everyone with a learning disability has a current health action plan and patient passport that support access to appropriate treatment options and ensure planned admissions with accessible

treatment plans and coordinated discharge planning with after care delivered in their home.

6 Enablers of change

In order to make Richmond a borough with excellent integrated health and social care services in the community, we must rely on a number of enablers:

To be successful we need to:	Requirements:
Engage with patients and carers 	• Inform people, listen to them and act on their input • Engage GPs, community and hospital providers and other stakeholders to ensure buy-in and commitment to shared positive solutions
Develop our people and our organisations 	• Developing our leadership, improve the skills of our workforce to deliver the aims of this strategy • Communicating using face to face, email, SMS and other methods
Partnership Working 	• Sharing of knowledge and understanding • Accessible advice available to everyone. • Empowering providers to allow the individual to be at the centre of their care.
Put in place the right information and tools 	• Unified IT systems providing shared records, leading to better patient care and transparency on performance • Clear shared protocol regarding information sharing
Develop the right contracts and incentives 	• Align contracts and incentives for all providers to drive up quality and ensure delivery of care to appropriate clinical standards
Managing our Buildings 	• We will ensure that our buildings are utilized fully and offer local and accessible fit for purpose community based services and are developed further to enhance the provision of these services.
Agree on how we will be governed 	• Commit to common set on clinical standards and process of monitoring and variance management • Assign roles, responsibilities and accountability • Create development plan to ensure consistency and clarity on our accountabilities

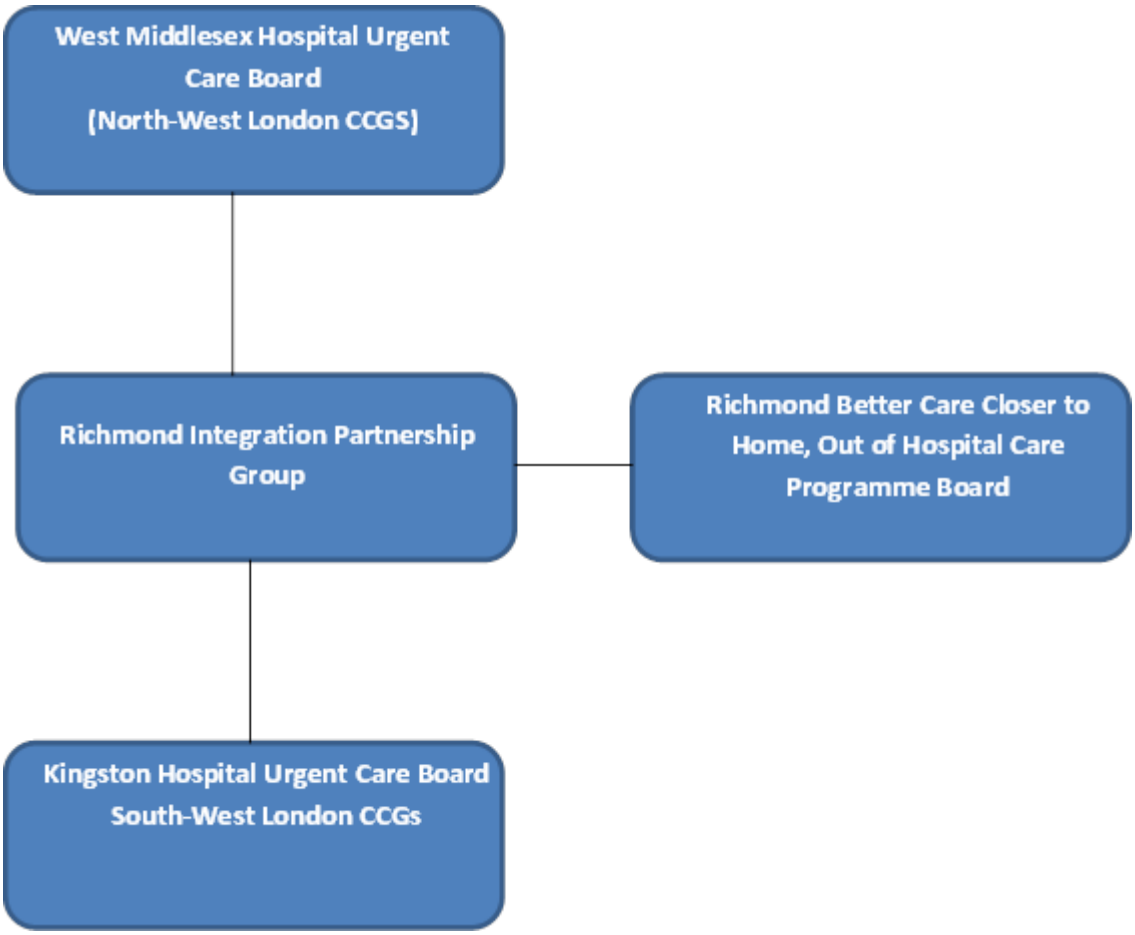
For the local workforce

We will ensure that the wider health economy including the acute health sector, primary and community care have the appropriate skills to deliver care closer to home. This may involve both culture change as well as the development of new skills for some of the workforce. Consideration needs to be given to the impact of reducing reliance on hospital care and the new skills that are required for staff moving into integrated community teams. This work will involve sector-wide partners in NW and SW London to ensure the workforce changes are coordinated at a strategic level in order to avoid duplicated work.

7 Making this vision a reality: next steps

This strategy sets out the vision for Care Closer to Home (out of hospital) health and social care in Richmond including the key priorities for the Council and CCG over the next three years. Whilst there is work already underway which supports out of hospital care and many existing services that support the objective of providing care closer to home; further detailed planning will be undertaken over the next few months in order to ensure that Commissioning plans align with the strategic vision.

To ensure that better care close to home becomes a reality, we have established local robust governance arrangements which link to the Urgent Care Boards at West Middlesex and Kingston hospitals as well as the NW and SW strategic planning groups to ensure that the impact of all regional changes are understood sector wide as shown below.



Overall, we will ensure quality is at the heart of everything we do so that we listen to, share and act on feedback from people, their carers and providers, to compliment the performance data obtained from monitoring service contracts.

By ensuring such a commitment to increased performance and safeguarding standards, the vision of this strategy will become a reality. In addition we will ensure that policies are in place, in conjunction with existing safeguarding adults policies and national guidance, so that people accessing the services developed through the strategy are appropriately safeguarded by ensuring that:

- there are clear arrangements in place with health and social care providers which promote safeguarding arrangements to maintain the safety and wellbeing of people accessing the services;
- systems and processes are developed to protect adults at risk from abuse, harm or exploitation.

The next steps involve using this strategy to inform our health and social care plans for the next five years, in keeping with the requirement to produce a 2-year operational plan and a 3-5 year strategic plan highlighting the importance of the integration agenda. The strategy will inform the 'Vision and Schemes' part of the Richmond Better Care Fund plan and will, as a result, become the delivery mechanism for implementing larger transformational changes in community provision.

In 2014/15 we will scale up and consolidate those services that currently support the aims of this strategy, We will also develop more detailed plans for further transformational changes to be implemented from 2014/15 into 2015/16.

From January 2014, we will map the existing and planned services against expected outcomes in order to identify possible duplication or gaps, especially in relation to supporting frail elderly residents.

Embedding the changes in our culture of care will take time and will be reliant on investment in appropriate technologies and targeted workforce development to ensure that we have staff with the right skills working in the right place at the right time.

We are confident that the investment and time taken to implement these changes is worthwhile since they will lead to more a more positive experience for people using services in the short-term and improved outcomes in the long-term.

Alongside our planning we will be working on implementing the actions from the 2013 Care Bill. This is widely considered to be the biggest reform to the adult social care system in 65 years. The changes it stipulates and the new responsibilities for local authorities are large-scale and wide-ranging with a focus on improving the quality and safety of services. The timeline for these changes is illustrated in the table below:

Action	Date
Out of Hospital Care Strategy finalised and published	February 2014
Better Care Fund Plans Agreed	March 2014
CCG 2 year operational plan agreed	April 2014
CCG 5 year strategic plan agreed	June 2014
Care Bill action implementation phase 1	From April 2015
Care Bill action implementation phase 2	From April 2016

Whilst the scale and pace of change in shifting activity into community settings may seem daunting, we are excited by the prospect of delivering the resulting reshaped

health and social care services in Richmond. Local services will not only be integrated, person-centred and closer to home, but personalised and of high quality ensuring that Richmond continues to have the highest life expectancy in England and that the quality of life outcomes for people within this lifetime are consistently high for everyone.

8 References

Community Care Statistics, Social Services Activity: England (2012-13)

Department of Health, *Adult Social Care Outcomes Framework*, 2013-14

Department of Health, *Equity and Excellence: Liberating the NHS,* (2010)

Department of Health, *NHS Outcomes Framework,* 2013-14

Department of Health*, Our Health, Our Care, Our Say: A new direction for community services,* (2006)

Department of Health, *Public Health Outcomes Framework for England*, 2013-16

Department of Health, *The Health and Social Care Act*, 2012

Department of Health, *Transforming care: A national response to Winterbourne View Hospital, 2012*

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London Borough of Richmond upon Thames, *Adults Strategic Plan*, 2010-2013

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London Borough of Richmond upon Thames, *Richmond upon Thames Community Plan*, 2013-18

London Borough of Richmond upon Thames, *Richmond upon Thames dementia commitment*, 2013

London Borough of Richmond upon Thames, *Uplift Strategy*

London Borough of Richmond upon Thames and Richmond Clinical Commissioning Group, *Carers Strategy*, 2013-16

London Borough of Richmond upon Thames and Richmond Clinical Commissioning Group, *Children and Young People's Plan,* 2014-17

London Borough of Richmond upon Thames and Richmond Clinical Commissioning Group, *Health and Wellbeing Strategy* (2013-16)

London Borough of Richmond upon Thames and Richmond Clinical Commissioning Group, *Mental Health Joint Commissioning Strategy for Adults of Working Age*, 2010 – 2015

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London Borough of Richmond upon Thames and Richmond Clinical Commissioning Group, *Richmond Joint Health and Social Care Strategy for people with autism,* 2013-2016

London Borough of Richmond upon Thames and Richmond Clinical Commissioning Group, *Richmond Joint Strategic Needs Assessment*

National Collaboration for Integrated Care and Support, *Integrated Care and Support: Our shared commitment,* (May 2013)

NHS*, Improving Health, Improving Lives: NHS Choices* (2011)

NHS England, T*he NHS belongs to the people: A Call to Action* (2013)

Richmond Clinical Commissioning Group, *End of Life Care Strategy*, 2010-13

Key influential documents and policies in developing the strategy (chronological order)

Our Health, Our Care, Our Say: A new direction for community services **(2006)**

- This initiated the move towards providing joined-up health and social care services citing:
  - Convenience of access
  - Cost effectiveness
  - Quality of services
  - Cost savings

Equity and Excellence: Liberating the NHS **(2010)**

- This outlines the framework for service development, placing the focus of progress in health development not changes to structures/processes

The *No Health Without Mental Health* government strategy (in full Feb 2011)

- This sets out the ambitions of the coalition government to mainstream mental health in England, through greater integration and recognition, to result in improved outcomes for all those with mental health problems.

The *Health and Social Care Act* (2012)

- This called for a health system based on systematic user involvement in the design of health and social care services

The *Welfare Reform Act* (2012)

- This introduced the biggest changes to the welfare system for over 60 years. It simplified the system, removing the need for people to claim different benefits from different agencies. The changes will result in approximately 3.1million claimants being better off and 2.8 million claimants being worse off

The Department of Health Review: *Transforming Care: A national response to the Winterbourne View Hospital* (in full Dec 2012)

- This sets out a series of mandated actions for health and local authority commissioners, designed to transform care and support for people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging. It sets out the strategic direction for greater integration leading to the right care being provided in the right place for people with learning disabilities or autism, and also the measures that will be used to measure progress on this direction.

The Francis report of the *Mid Staffordshire NHS Foundation Trust Public Inquiry* (in full Feb 2013)

- This sets out a number of recommendations that focus on developing a common patient-centred culture within the NHS that is based on transparency, high-quality care and timely response to evidence-based performance monitoring.

Integrated Care and Support: Our Shared Commitment **(May 2013)**

- This outlines the aim for all localities to have adopted models of joined-up (integrated) commissioning within the next two years and for integrated services to be the norm within five years

***The Care Bill* (May 2013)**

- This is currently progressing through Parliament, If passed, it will require Local Authorities to develop services that are wide-ranging and personalised ensuring that people can get better care that works for them

***The NHS belongs to the people: A Call to Action* (2013)**

- This states that if current flat funding is combined with stagnation in service delivery, the funding gap will grow by £30bn between 2013/14 and 2020/21