Age Well in Richmond 2022-2024

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

Encourage active, resilient and inclusive communities that promote healthy ageing and reduce loneliness and isolation

Objective

- Continue to **build on the strengths of local communities** to increase the opportunities for residents to get involved and live happy, active, and fulfilling lives
- Continue to promote **wellbeing and healthy lifestyles** to give people the best chance to stay well, independent and resilient for as long as possible
- Embrace **innovation and the use of digital technology** to empower and support residents to live the best life they can and remain independent, resilient, and well for as long as possible
- Ensure the **Care Home Support** programme continues to improve the quality of health and care of people living in care homes
- Develop and expand our **social prescribing** offer
- Identify and support people **at risk of diabetes** and increase diagnosis and care

Support people to live at home independently and for as long as possible, including people with dementia

Objective

- **Join up health and care teams** in the community to provide a range of services that help people get and stay well and improve their experiences of health and care
- Identify and proactively support older people **with complex health and care needs** by wrapping professionals together around the individual
- Review and redesign local **Discharge to Assess pathways** in line with 'Home First' principles and make the most of available resources
- Provide joined-up and timely support in the community to help people **regain or maintain their independence** and avoid hospital admission.
- Review the **falls pathway** across the borough to maximise the opportunities to prevent people falling and ensure they have access to the correct support to reduce the risk of repeat falling and associated injury.

Support people to plan for their final years so they have a dignified death in a place of their choice

Objective

- Support residents to **plan for their old age and have sensitive conversations** to include 'death' and 'dying'
- Improve end of life care by progressing delivery of our **End-of-Life Care Strategy to** ensure end of life issues are addressed
- Improve **care coordination and information** sharing across health and social care at the point of 'end of life', including rolling out access to the integrated **Coordinate My Care** (Name to be changed)
- Review **bereavement services** to identify any potential gaps and ensure the needs of the whole population including those harder to reach are served and enhance supportive networks within the community based on learning

Outcome	Outcome	Outcome
• Increase in opportunities for people to **remain connected** to others and **improve their health and wellbeing** • Reduction in people who **feel lonely and socially isolated** • Reduction in **non-medical related GP appointments** and A&E presentations • Increase in the number of people benefitting from **social prescribing** • **Earlier diagnosis** of people aged 65+ with Type 2 diabetes • Increase in the number of carers referred/ accessing the Social Prescribing Navigation Service (CILS)	• Increase in residents supported to **live independently & well** for as long as they are able • Increase in older residents who receive **'reablement' support at home** • Increase in number of residents who return home after **hospital discharge** • Residents with **dementia** and their families will have a **better health and care experience and receive more support** • Reduce the **number of falls** in people aged 65 and over • Greater **skill-mix across clinical roles,** particularly therapists (HRCH) • **8am to 8pm discharge services** established during the week, including weekend cover (HRCH) • Increased discharge support services **commissioned through voluntary sector** (HRCH) • Increased **rapid discharges** over winter (HRCH)	• People have **personalised Health and Social Care services** at the end of their life, resulting in improved outcomes and resident's experience of health and social care systems • More residents have **an Advanced Care Plan and 'Coordinate My Care'** (name to be changed) will be delivered across all care settings, resulting in a year-on-year increase • Care homes are more **digitally integrated** across health and social care

Overarching Themes

We will **identify, recognise and support unpaid carers of all ages, to ensure that in all the objectives, unpaid carers are linked to appropriate support options** enabling them to reduce the social, financial and mental and physical health impacts they face.

We will **address obesity in all ages, encouraging people to live physically active and healthy lifestyles** to prevent ill-health and improve wellbeing – by identifying risky behaviours such as **high alcohol consumption**

We will promote the **mental health and resilience** of residents of all ages

We will **tackle inequalities in health** to **reduce disparities for those most disadvantaged**

South West London Health & Care Partnership