Integration and Better Care Fund

Narrative Plan Template 2017/19

*Better Care Support Team*

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<thead>
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<th>Area</th>
<th>London</th>
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<tbody>
<tr>
<td>Constituent Health and Wellbeing Boards</td>
<td>Richmond</td>
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<tr>
<td>Constituent CCGs</td>
<td>Richmond</td>
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General

This template is a guide to help you to draft a BCF narrative plan for your area. You do not need to use this template or follow this structure but it has been provided to assist areas to cover all the requirements for the BCF in their narrative plan.

Your narrative plan should build on approved plans from 16/17, demonstrating that local partners have reviewed progress and used this information in developing plans for 17/19. The template will be complemented by the planning template available at (link) and should be completed with reference to the BCF Policy Framework and Planning Guidance. Local areas are also advised to use the key lines of enquiry (KLOEs) that will be used to assess the BCF narrative plans.

Please refer to the notes section below for each section for brief guidance on what to include in each section. Areas can use more than one page for each section and add diagrams and tables where helpful.

The BCF narrative plans must set out:

- The local vision and model for the integration of health and social care;
- A coordinated and integrated plan of action for delivering the vision, supported by evidence;
- A clear articulation of how the plan meets each national condition; and
- An agreed approach to performance and risk management, including financial risk management

Please note that referencing and use of hyperlinks to existing documents is advisable rather than copying content into your narrative submission. However, please try to signpost documents as comprehensively as possible e.g., include the citation reference (e.g. page number and relevant section).
1. Introduction / Foreword

High Level Summary

The Richmond Better Care Fund plan 2017/19 builds on the progress made in previous years. The plan has been developed in partnership between the Local Authority and CCG and benefits from existing well established joint working and a shared commitment to integration. As part of existing strategic and commissioning structures such as Richmond’s OBC programme, we have engaged with a wide range of stakeholders including providers, service users and carers.

Richmond has a complex health and care system due to its geography given that acute services accessed by our population are situated in neighbouring boroughs. As such Richmond needs to work across two STP footprints and several local authority boundaries in the strategic planning and delivery of our services. There are additional boundaries that add complexity to the development of integrated commissioning. In 2016, Wandsworth and Richmond Councils entered into a shared staffing agreement while Richmond and Kingston CCGs formed one of SWL two Local Delivery footprints.

As part of the South West London (SWL) vision for Right Care Best Setting, Richmond Council and Richmond CCG are jointly committed to implementing 7-day health and social care services across the local health economy at a joint leadership level. Both the CCG and the Council recognise that, in order for outcomes to be maximised, the people of Richmond need to be able to access the right care and the right time; paramount to this is the development of services that are available 7 days a week.

The next five years will be exceptionally challenging – an ageing population, increasing demands on services, our collective financial pressures and reducing core funding base necessitate a radical shift in the way services are delivered. This plan, demonstrates how we will work together to deliver better outcomes for the residents of Richmond whilst meeting those challenges.

Expected outcomes of the Plan

Outcome Based Commissioning (OBC)

Richmond CCG with our community provider HRCH and GP Federation (RCHiP) are delivering an outcome based contract to support increased levels of community care, avoid unnecessary admissions and reduce delayed transfers of care. The contract focus is on 5 pathways in Richmond where care could be better delivered in a community setting. This includes frail elderly, diabetes, cardiology, respiratory and end of life care. The CCG has worked with RCHiP and acute providers and the Local Authority as developmental partners to design and implement revised pathways for providing services within community settings.

In 2017/18 this will include:

- Roll out of Sutton vanguard to support reduced admissions within care homes.
- Community respiratory services to support moderate to severe cases who would otherwise be at risk of admission.
- Multi-disciplinary Teams which will focus on co-ordinated care to support the 3% of Richmond’s elderly population most at risk of admission.
- Increased capacity for Community Heart Failure clinic and cardio rehab service.
Reducing Delayed Transfers of Care (DToC). This remains one of the top priorities for Richmond BCF. Performance remained in D quartile at the end of 2016/17 but some improvements were seen in social care days delayed in the second half of the year. Strategically, improving DToC performance is being progressed as part of the Local Transformation Board priorities and as part of A&E Delivery Board. At an operational level, a DToC improvement plan is being implemented and reports to the BCF Delivery Group which oversees implementation of the BCF plan and agrees actions. Additionally, all of Richmond’s iBCF will be spent on improving performance. Key initiatives include.

- Increasing capacity in RRRT to ensure assessments are undertaken to agreed timescales.
- Working with Kingston hospital to implement the recommendations from the ECIP visit especially the correct application of the ‘Choice Protocol’.
- Rolling out the ‘Better at Home’ Discharge to Assess model at Kingston hospital.
- Implementation of the internal DToC escalation process.

Non Elective Admissions

Richmond has seen year on year growth in Non-Elective Admissions although the main driver for this relates to paediatric admissions, with almost all of this being related to stays of 0-1 days. However, Richmond’s Non-Elective Admissions rate is one of the lowest in London from the latest NHS England published data and therefore an additional target for non-elective admissions has not been set.

Through the plans that Richmond have in place, we will identify increasing number of patients who are vulnerable to emergency admissions and configure locality based services to ensure that by working in an integrated way across health, social care and voluntary sector, we will keep more people at home for longer, reducing non-elective admissions, ambulance conveyances and the required low level admissions to residential care.

Summary of Funding Contributions

Richmond Clinical Commissioning Group (RCCG) and Richmond Borough Council (LBRuT) have a strong history of collaborative working, high performance and achieving outcomes for the local population against a range of national benchmarks.

The table below summarises the contributions made to the Richmond BCF fund by LBRuT and RCCG for 2017/19:

<table>
<thead>
<tr>
<th></th>
<th>2017/2018</th>
<th>2018/2019</th>
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<tbody>
<tr>
<td>CCG</td>
<td>10,979,502</td>
<td>11,188,113</td>
</tr>
<tr>
<td>iBCF (Local Authority)</td>
<td>685,891</td>
<td>424,713</td>
</tr>
<tr>
<td>Disabled Facilities Grant (Local Authority)</td>
<td>1,440,159</td>
<td>1,572,854</td>
</tr>
<tr>
<td><strong>Total Pooled Budget</strong></td>
<td><strong>13,105,552</strong></td>
<td><strong>13,185,680</strong></td>
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Signatories to the Plan

The Richmond BCF Plan 2017/18 is owned by Richmond Borough Council and Richmond CCG and the authorised signatories for each organisation are:

- Health and Wellbeing Board;
- Tonia Michaelides, Managing Director Richmond and Kingston CCGs;
- Liz Bruce, Director of Adult Social Services, Richmond and Wandsworth Councils.

Other partners involved with the BCF plan are Richmond and Wandsworth Housing Department.
2. What is the local vision and approach for health and social care integration?

Shared Vision

Richmond Council and CCG are jointly reviewing and developing their shared vision for how health and social care will work together locally and across South West London (SWL) to provide integrated services for the local population. This is to reflect the strategic priorities across SWL but also in regard to shared working with Kingston CCG and Wandsworth Council. In doing so, Richmond CCG and the Local Authority are able to build on a well-established joint commitment and existing work towards delivering integrated services for local people.

Richmond CCG and the Local Authority are working across SWL as part of the SWL Alliance, to shape services to deliver care in the most appropriate place and closer to where people live.

Richmond CCG and the Local Authority want to work in partnership across health and social care, with our local population, to prevent ill health, reduce inequalities and support people to start well, live well and age well, both physically and mentally. The BCF will build on the existing plan and continue to support and facilitate the strategic direction in Richmond, to meet the requirements of the Five Year Forward View as set out in the vision of the SWL Sustainability and Transformation Plan (STP), to deliver integrated services to give people the care they have told us they want.

In line with the SWL STP ambition; Richmond’s approach to transforming care for people by 2020 is:

- We want people to live longer, healthier lives. Our vision is that local people should be supported to look after themselves and those they care for and have access to high quality, joined up physical and mental health and care services when they need them. We want to deliver better health outcomes within our budget.
- Our plan is being developed now because we know that if we do nothing, our services will not be sustainable in 5 years’ time. We know that many of the problems people face occur because our services are not set up in the best way to help them. We need all parts of the health and care system to work together. With the right approach, we can improve or maintain the current quality of care while making our services sustainable in the long term.
- We will invest in prevention and early intervention, making sure people are treated in the right place to meet their needs. Proactive, preventative care will mean fewer people need to access emergency or specialist services.
- Richmond CCG and Local Authority will deliver asset based, co-ordinated health and social care services to residents that will improve service user experience and deliver better outcomes. We want to give people the best possible chance to remain as independent as possible for as long as possible, supported by a health and social care system that is easier to access, is timely in the support it provides and brings together expertise to provide a cohesive and intuitive approach to health and wellbeing. We believe this supports people in Richmond to be partners in their own care and support and, where possible, lead their own care.

We will continue to build on the existing STP and BCF work to expand and improve the services provided outside hospital, increase skills in the workforce, specialisation in the community and provide high quality care out of hospital whenever appropriate. The BCF will continue to support progress against the 2016/17 national conditions to support joint
assessment and care planning utilising improved information sharing and system interoperability. In addition, we are continuing to ensure that services are available when local people tell us they need them and to support delivery of 7 day services as per the Primary Care Strategy requirements.

We will continue to do this by having 2 Primary Care Hubs open at Teddington Memorial Hospital and Essex House Practice which provide extended access hours. Future plans include the development of an Urgent Treatment Centre at Teddington Memorial Hospital which will include a combined service formed from the current Walk in Centre and a Primary Care Hub. This service will comply with the requirements of the Urgent Treatment Centre principle standards.

The Primary Care Hubs in Richmond have developed an interoperability interface with GP Practices being able to book appointments into the Primary Care Hubs to ensure local people benefit of an efficient service. The SWL Alliance has secured funding to invest in a “hub” which will facilitate improved interoperability. A project to define the appropriate solution has begun although no timeframe for delivery has yet been set.

Integrated services will also make better provision for mental health care to enhance overall wellbeing, independence and social capital. Our BCF plan aligns with the SWL STP to deliver the ambitions of the Five Year Forward View and will pave the way for integrated health and social care working by 2020.

**Links to other strategies**

Richmond’s strategic direction is also supported by our [Framework for Prevention 2015-2018](#), Five Year Dementia Strategy and Carers’ Strategy, Joint and Health and Wellbeing Strategy - Outcome Based Commissioning (see below).

Richmond’s BCF plan continues to be in line with our joint Better Care Closer to Home strategy which has as its strategic goals:

- Greater emphasis on early intervention and prevention.
- Prevent unplanned hospital admissions and facilitate early supported discharge.
- Health and social care providers working together, with the person at the centre to proactively manage the elderly, those with multiple long terms conditions and people nearing the end of life.

The strategy will be refreshed this year to reflect the joint work being carried out under the STP and sub regionally across both Kingston and Wandsworth.

Richmond has a well established Outcomes Based Commissioning (OBC) programme in place for physical health and is developing a similar approach for mental health. The OBC programme works closely with both our community and acute providers, in developing our approach to support our strategic intentions in line with the STP and Richmond’s BCF plan. The emerging mental health programme has all aspects of the mental health pathway included within its current scope from acute inpatient provision to voluntary sector services. The OBC programme facilitates the CCG and Local Authority to work together with providers to design and deliver the integrated services local people have told us they want.

The OBC contract for physical health focuses on collaborative working between health, social care and third sector providers, to support people in their own home and in the community for as long as is appropriate and possible, in order to reduce demand on:

- Emergency services
• Non-Elective Admissions
• Support effective transfers of care
• Reduce admissions to care homes

The Journey through Care

The model of care in the outcome based contract for physical health aligns with our BCF plan in that we want people to experience an uninterrupted journey through services, ensuring that families and carers receive education, support and improved connections to the voluntary sector. When people need specialist hospital care they should be returned home as soon as the acute episode is completed and our services need to be able to support this.

It is expected that service users will experience a seamless and integrated journey of care:

Developing our way of working

There are shared core principles with Richmond’s BCF plan that we will use to underpin the service models set out in our OBC programme and our Local Transformation service model:

• Understanding who is most at need and who is at risk of becoming dependent on services through the use of a risk stratification tool.
• Supporting the patient experience to be seamless through the co-ordination of care
• Harnessing our community assets making best use of our third sector partners.
• Development of our workforce to create opportunities for cross system working to support the recruitment and retention of staff.

To support this we are piloting our approach to Locality Teams in Hampton and Teddington. Locality Teams will work with defined populations of around 50,000 people and are based upon multi-disciplinary team working. The funding to support the development of the Locality Teams is included within our current BCF plan. The teams will align to GP practices and bring together staff across primary and social care, mental health, community services
and hospital specialists. They will place greater emphasis on prevention and early intervention, wrapping services around the health needs of the localities to support people to stay well and access care in the right place.

We are utilising risk stratification to identify people most at risk of hospital admission and enable services to be tailored to support individuals and their carers, to organise the care they need to enable them to be supported in the community and reduce the risk of admission to hospital. Under Richmond’s outcome based contract this includes community senior clinics, focusing on the frail elderly who represent the 3% most at risk in our population.

**Next Steps**

RCCG and LBRuT recognise that there is further work needed to fully integrate health and social care across Richmond and that this will be a phased redesign to meet the integrated vision of 2020. A project group will be formed to look at the learning so far and map what the new model of care looks like. This will include looking at the relationship with Kingston and Wandsworth boroughs. There will be a workshop held in the autumn to consider the options for further integration and develop a focused and well-grounded local implementation plan.

The BCF plan for 2017/2018 continues our commitment to the protection of adult social care, to carers, to the promotion of universal services and to services commissioned under the previous plan. The plan will continue to support the delivery of integrated services to meet the four national conditions. The CCG and Council continue to work together to recognise and incorporate learning into service delivery, including expanding or changing services where needed using BCF and other funding.
3. Background and context to the plan

The London Borough of Richmond upon Thames is a prosperous, safe and healthy Borough. It covers an area of 5,095 hectares (14,591 acres) in South West London and is the only London Borough spanning both sides of the Thames, with river frontage of 21½ miles. The main town centre is Richmond and there are four district centres at Twickenham, Teddington, East Sheen and Whitton. Richmond is becoming increasingly diverse and includes people who live, work, visit the Borough and use services.

The Joint Strategic Needs Assessment provides the ability to understand the specific needs of the Richmond population and the interventions required in order to address inequalities within the determinants of health and social care and to provide proactive and preventative services accordingly.

Local Demography

Resident population
The population of Richmond is 193,585 according to the ONS Mid-Year Estimates 2014 and has the fifth lowest population density of all London Boroughs. Approximately 51% of the population are female and 49% are male. 24% of the population are children and young people, 65% are working age and 14% are older people aged 65+. ONS Subnational Population Projections indicate that the population of Richmond will rise by 25% by 2037 to 239,400 residents. Regarding health inequalities, life expectancy is 5.8 years lower for men and 3.3 years lower for women in the most deprived areas of Richmond upon Thames than in the least deprived areas.

Race and Ethnicity
Looking at a high level breakdown of ethnic groups, 71.44% of the population of the Borough is White British, 14.52% are White Other and 14.05% are BME.

Older People
People aged 65+ make up 14% of the total population of Richmond. This is predicted to rise to 18% by 2035. People aged 85+ make up 2% of the total population of Richmond.

Learning Disabilities
According to the projections sourced from PANSI - a website providing adult needs and service information jointly managed by Oxford Brookes University and the Institute of Public Care, nearly 3,000 people in the Borough have a learning disability.

Physical Disabilities
PANSI estimate that there are over 9,000 people in Richmond with a moderate or severe physical disability.

Mental Health
PANSI predict nearly 20,000 people in the Borough have a common mental illness with 500 having a serious mental illness requiring higher support.

Carers
There are nearly 16,000 unpaid carers in the Borough according to the 2011 Census. Carers play a vital role in supporting family and friends with essential support in periods of crisis and throughout longer periods of decline in health and wellbeing.
The majority of carers in Richmond (75%) provide between 1 and 19 hours of unpaid care a week, 10% provide between 20 and 49 hours and 15% spend a very significant portion of time caring for others at over 50 hours per week.

Overall, nearly 14% of people aged 65+ are providing unpaid care. The number of carers aged 65 and over and receiving services is estimated to increase from 400 to 500, an increase of 25%; this group are at increased risk of mental health problems.

**Deprivation**

There are no areas in the Borough ranked in the most deprived decile of Local Authorities in England i.e. the 10% most deprived areas. This mirrors our understanding of Richmond as a fairly affluent area with high house prices, a skilled population and relatively high resident earnings.

**Future demographic challenges**

The number of people living in the London Borough of Richmond is expected to grow by approximately 2,500 each year 206,500 by 2019. The expected increase in people over the age of 65 years is 3,100 and 500 over the age of 85. Richmond has the highest proportion of people aged over 75 and living alone in London (51% compared to 35% in London).

The combination of an ageing population and increasing life expectancy means that the number of people living with long term conditions will increase. The incidence of people with three or more long term conditions increases from 4% in people under the age of 65 to 44% in those over the age of 65. In Richmond, this means that the number of people with more than one long term condition is expected to increase from 19,000 (10%) in 2013 to 24,500 (12%) in 2020. Growing numbers of older people living alone will be at increased risk of depression and those with limiting long term illnesses will be particularly vulnerable.

**Current state of Health and Social Care Market**

Richmond has a strong and well established health and social care sector with strong and effective relationships between the CCG, Local Authority and provider market.

Richmond has adopted an Outcome Based Commissioning (OBC) approach to support the delivery of its health and social care services. The Local Authority plays a key role as a strategic partner within the OBC programme. This decision was made after extensive consultation with local people in Richmond who told us that they wanted integrated person centred services that delivered outcomes that were important to them. The current programme is well established within physical health, with commissioners and providers working together to set the direction for the delivery of integrated services and care in the community which reduces unnecessary admissions and supports early and appropriate discharge.

Richmond is now developing its outcome based approach for mental health across the whole mental health pathway. Richmond has already been very committed in progressing parity of esteem for people with mental health needs, ensuring effective community and primary care support is available for most people, with specialist services available when required. This has also included expansion of Improving Access to Psychological Therapy (IAPT) services to support recovery and self-management for people with long term conditions. Over the life of the BCF plan Richmond will seek to align its physical and mental health OBC programmes to ensure integrated provision for physical and mental health.
The overall market picture across the homecare and care home market sectors in Richmond is one of stability. Over the last ten years there has been a realignment to maintain the care of people in their own homes as opposed to traditional care models. The homecare delivery model in Richmond, developed in 2016, is an outcomes commissioning model based on contracts with two well established providers in the Borough. This has helped create a stable market particularly since the providers can sub contract if they do not have sufficient capacity. Richmond is currently in phase 1 or year 2 of a 6 year delivery model. This “Help to live at home” contract also provides reablement home care provision in the person’s home facilitating discharge from hospital.

The market for residential care is also stable with residential care commissioned mainly via a long standing PFI agreement with Care UK. The capacity of Care UK commissioned by the Council is 175 beds. This contract still has a further 9 years to run. The demographics of the bed configuration within the contract portfolio have been reviewed part way through the contract term and will be reviewed again, so as to match bed based care to the needs of people requiring statutory funded care and the move away from the reliance on traditional residential care, utilising this for people with the most significant of needs which is match to our over strategic intentions of preventing people being admitted to hospital and ensuring their most timely support departure at the earliest possibility.

As with the national picture, ensuring a strong, stable and experienced workforce to deliver the care required remains challenging especially in an area where the cost of living and related housing costs for staff is so high. This does mean a high reliance of staff from outside the area.

This factors are important to ensure a strong and stable provider market responsive to the needs of the population, where demographics show the high numbers of people over the age of 65 and 75 and the avoid people accessing emergency care and developing reliance upon NHS services

**Key Challenges the Plan will aim to address**

Richmond as outlined above has many advantages in regard to the health and prosperity of its residents. However, the Borough does face health and social care challenges reflective of the demographics of our population.

**Ageing Population**

As detailed above and in previous submissions of the BCF, our specific demographic challenge concerns an ageing population (with a high percentage living alone), many of whom will also have multiple long term conditions. Our estimation of the elderly frail population (based on the John Hopkins University Adjusted Clinical Group case mix system) at the time of the previous submission was 2,600 of the 12,000 Richmond GP registered over 75 population. However, our risk stratification approach is predicated on a 3% percentage which produces a cohort of 4,800 patients.

The ageing population in Richmond, as elsewhere, means more people with more than one long term condition will become the norm. Long term conditions can often interact with each other resulting in an increase in the complexity of care.

This will require a holistic approach where patients, carers and professionals work together with the aim of optimising wellbeing and quality of life, rather than treating single diseases. Locally the work on integrating health and social care services is an attempt to put this approach into practice and the work around risk stratification will, by definition, include this group.
Richmond is utilising risk stratification as a tool to guide away from the organisation of health and social care services around the management of single diseases and reactive response; towards a more integrated and preventative model of care that is focused on the collective needs of individuals with multiple needs.

**Multi-Morbidities**

Multi-morbidity is an important current and future challenge for health and social care in Richmond. The key conclusions from needs assessment for this group are summarised below:

- The ageing population in Richmond means more people with more than one long term condition will become the norm. Long term conditions can often interact with each other resulting in an increase in the complexity of care.

- It is especially important to recognise the common co-existence of physical and mental health conditions for this group, as outcomes for each are worsened when they occur together.

- There is a need for commissioners and providers to move away from traditional single disease pathways, typical in current care models; instead there needs to be a shift towards recognising multi-morbidity as a condition in its own right.

- A holistic approach where patients, carers and professionals work together with the aim of optimising wellbeing and quality of life rather than treating single diseases. Locally the work on integrating health and social care services is an attempt to put this approach into practice and the work around risk stratification will support better treatment for this group.

Richmond’s BCF plan recognises this challenge and seeks to address and support improved outcomes for this group with the following schemes:

- 7 day Richmond Response & Rehabilitation Team
- Care Home Pilot.
- Community Independent Living (CILS).
- GP care co-ordination/case-management model.
- Self-management/assistive technology/tele-health.
- Personalised care, including direct payments & personal health budgets.
- Psychiatric Liaison Service

**Hidden Harms and Threats to Health**

A high proportion of residents (37%) aged 65 and over live alone (compared with 31% London wide), this rises to 51% living alone for those 75 and over; most of those living alone are female. Social isolation and lack of social support are important risk factors for both physical and mental illness, particularly amongst older people.

A higher than average percentage of people die in winter months (excess winter deaths) in Richmond (21%), compared with the England average (19%); this equates to 75 additional deaths per year.

National prevalence models estimate that substantial numbers of Richmond residents are drinking at levels potentially harmful to their health (around 45,000 adults). Alcohol related hospital admissions are increasing (especially in older age groups).

**Delayed Transfers of Care (DToC)**

DToC remain a significant challenge, particularly delays attributable to health. The primary reason for health delays continues to be awaiting further non acute NHS care and this is in
part due to the lack of neuro rehab beds which is a South West London regional issue. Despite improvements in social care delays, there are still challenges in relation to supporting people into specialist residential/nursing care homes in a timely way. Richmond along with Kingston are working closely with Kingston Hospital Foundation Trust to support an improvement in current DTOC performance. Strategically, improving DTOC performance is being progressed as part of the Local Transformation Board priorities and as part of the A&E Delivery Board. This is also being addressed via a number of operational measures, such as daily resilience calls to support and expedite blockages within the system. The BCF plan for 2017-19 continues its focus on improving DTOC performance. The Joint Operational plan with prioritised actions has assisted in improving performance and has been refreshed for 2017-18.

We recognise the DTOC targets are ambitious; however, these plans take account of the level of input required from both health and social care partners. An additional challenge is our complex commissioning landscape where we have to work across multiple STPs and in partnership with a wide range of health and social care organisations to deliver the DTOC targets. Nonetheless, there is a joint effort amongst health and social care partners and we will monitor achievements and adapting the plans to maximise delivery.

**Recruitment and retention of staff**
There has been an increasing reliance on agency staff to cover frontline posts in Adult Social Services with a vacancy rate of 48%, compared to average vacancy rates of 12% across London Boroughs. The Social Work Academy for newly qualified social workers will enable increased recruitment of permanent social work staff. Supporting 15 newly qualified social workers during their first year it will help promote Richmond as an employer of choice as part of the Shared Staffing Arrangement with Wandsworth Council.
4. Progress to date

Existing approach to integration and main points of current BCF plan

In 2017/18, the focus will be on managing Delayed Transfers of Care (DTOC) for older people, including those with mental health needs, particularly those needing specialist care home placements to support people with challenging behaviour.

By the end of 2017/2018, we would expect the BCF plan to have contributed to positive impacts on Non-Elective Admissions, Delayed Transfers of Care and to continue to protect social care services, support carers and keep admissions to nursing and care homes to a minimum. As part of the wider transformation plans of which BCF is a part, we expect to have integrated IT, improved care pathways, greater joint care planning and more effective multi-disciplinary working, expanded the 7 day offer and identified and supported the most vulnerable of our residents.

We have not significantly changed our approach and the BCF Plan 2017/2018 is a continuation of the 2016/2017 plan with schemes being extended into the new planning year.

We recognise that further evaluation will be necessary to shape these approaches going forward and to continue to implement learning and improvement as schemes develop.
Current performance on national metrics

In July 2017, NHS England published a national health and social care interface dashboard that brought together a range of metrics, indicating how closely health and social care work together in each Local Authority. The six key metrics (see below) assess local area performance against statistical nearest neighbours and nationally.

Overall Richmond has performed well against these metrics ranking 19th nationally. The local authority and CCG are aware that there is still work to do to improve DToC performance, and this is a priority for the 2017/18 BCF plan; funding is being prioritised to address performance in this area.

Richmond position against integration metrics as set out in the NHS-Social Care interface:

<table>
<thead>
<tr>
<th>Metric</th>
<th>Richmond upon Thames</th>
<th>London</th>
<th>Outer London</th>
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<tbody>
<tr>
<td>1) Emergency Admissions (65+) per 100,000 65+ population</td>
<td>23,713</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>2) 90th percentile of length of stay for emergency admissions (65+)</td>
<td>19</td>
<td>32</td>
<td></td>
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<tr>
<td>3) TOTAL Delayed Days per day per 100,000 18+ population</td>
<td>10.5</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>4) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services</td>
<td>86.4%</td>
<td>59</td>
<td></td>
</tr>
<tr>
<td>5) Proportion of older people (65 and over) who are discharged from hospital who receive reablement/rehabilitation services</td>
<td>4.6%</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>6) Proportion of discharges (following emergency admissions) which occur at the weekend</td>
<td>20.2%</td>
<td>43</td>
<td></td>
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National Rank (Dist from mean calculation) | 19
BCF Metrics

Non-Elective Admissions
There has been growth in total non-elective activity across all age bands during 2016/17 compared to 2015/16 and this has resulted in the target being missed. This increase has been largely driven by short stay emergency admissions for 0-18 year olds. The 65 plus cohort of patients make up 32% of all short stay (0 - 1 day length of stay) emergency admissions, and will constitute the main focus of admissions that could realistically be prevented through the implementation of alternative pathways. There is growing evidence that the increased focus of RRRT on admission avoidance is beginning to have a positive impact on non elective admissions.

Delayed Transfers of Care
Although overall performance performed below target, there has been a significant reduction of 41% in days delayed in quarter four compared with quarter one which demonstrates an overall positive and improving trend. Most notably there has been a reduction in delays for people waiting a social care assessment. This has been achieved through the implementation of the DToC joint delivery plan which includes;

- Implementation of an investment of additional social care staff in RRRT.
- Implementation of a robust DToC validation process.
- Fast track funding process —funding decisions to be made on day funding requested.
- Trusted assessment model for reablement.
- Validation of delays, disputing delays and discrepancies.

Delayed Transfers of Care remain a significant challenge, particularly delays attributable to health. The primary reason for health delays continues to be awaiting further non acute NHS care and this is in part due to the lack of neuro rehab beds which is a South West London regional issue. In social care, there are still challenges in relation to supporting people into specialist residential/nursing care homes in a timely way.

The CCG and Local Authority will continue to work with our acute and community providers to support a joint approach in reducing delayed transfers of care.

The DToC joint delivery plan continues to be developed for 2017/18 and initiatives include the Discharge to Assess initiative where Richmond and Kingston CCGs, both community providers (Hounslow and Richmond Community Healthcare (HRCH) and Your Healthcare (YHC) are working in partnership with Kingston Hospital Foundation Trust to embed new clinical pathways to increase the number of assessments undertaken outside an acute setting. Work is underway on developing pathways from hospital which will address people getting the right care and support in the best setting, and reducing the number of continuing health care assessments that are completed in an acute hospital.

Reablement
The RRRT service has continued to perform effectively throughout 2016-17. In terms of the proportion of older people supported to stay at home 91 days after discharge from hospital into reablement services, Richmond’s performance has remained fairly static with current performance at 85.6%. It supports an increasing number of elderly frail service users with complex needs which has impacted on performance.

The proportion of outcomes of RRRT have included more service users, year on year, who are leaving the service significantly less dependent than they came in. The service has demonstrated that 84% of service users have no ongoing care, or have reduced service needs, (including packages of care and residential and care home placements). Service user satisfaction levels have also shown a significant improvement on the previous year with 98%
of service users responding that they were satisfied or very satisfied compared with 92.4% in 2015/16.

**Admissions of 65 plus into residential and nursing care**
In 2016-17 there were 96 admissions (336.2 per 100,000 pop) against the annual target of 105 admissions. This is a notable improvement on the 110 admissions in 2016/17 and progresses Richmond to the top quartile of the London comparator group. Richmond has been successful in ensuring a low level of admissions into residential and nursing care, due to an increased focus on enablement through Rapid Response Rehabilitation Team (RRRT), extra care provision.

**Progress to date through BCF**
Richmond’s BCF schemes support delivery of both our local priorities and the national metrics as outlined above. Progress by the BCF schemes is outlined below:

**Outcome Based Commissioning**
There are a range of Outcome Based Commissioning BCF funded schemes including: Falls service, the Early Supported Discharge for Stroke Survivors, the COPD Respiratory Team and the Community Geriatrician at Acute Hospitals.

**Successes:**

- The number of contacts for the Falls Service decreased in 2016/17 compared to 2015/16 by 4.8% (15/16 contacts – 4,220; 16/17 contacts: 4,014). This is due to wide range of factors including lack of staffing and increased waiting time.
- In terms of the secondary care activity for falls, the number of admissions to acute services related to falls decreased in 16/17 compared to 15/16 by 2%.
- The number of admissions for people over 65 due to falls has remained stable for the past 2 years. The service contributes to maintaining these low levels of admissions.
- In 16/17 the waiting times for early supported discharge have slightly improved for routine appointments and patients are now seen within 1 to 2 weeks rather than 5-6 weeks. The overall activity for the Community Neuro rehabilitation service has slightly increased for 16/17.
- The number of referrals to the service (Stroke Early Supported Discharge Team) has increased in 16/17 compared to 15/16 by 17%.
- The number of admissions to acute services due to stroke has decreased in 16/17 compared to 15/16 by 40% (215/16: 187 admissions; 16/17 - 112 admissions). It is noted that the service is for people who have already had a stroke.
- The total activity for the respiratory services has slightly increased in 16/17 (from 2,980 to 3,123 by approximately 4.6%.
- Despite the service increasing its activity, low wait times and more people completing the Stop Smoking programme the number admissions due to COPD for patients over 65 has increased in 16/17 from 198 to 246.
- The waiting times for COPD Respiratory have improved for routine appointment and now patients are seen within a week rather than 3 to 5 weeks previously.
- In 16/17 the Stop Smoking service (Pulmonary Rehabilitation Starters) increased its number of patients from 119 to 128. In 16/17 the number of patients who completed the programme increased from 86.5% to 89%.

**RRRT**
The RRRT is a key BCF funded service which includes the following schemes: RRRT agency social workers, rehab assistants, weekend support and HRCH team. The service
Official consists of three core functions people who need short term, intensive support following a period of illness or disability or following discharge from hospital: rapid response, hospital discharge and early supported discharge and community rehabilitation and reablement.

**Successes:**

- Significant improvement in social care DToC through additional investment by Local Authority for additional social workers in RRRT.
- Reduced waiting times for assessment.
- Maintaining 7 day integrated service through RRRT, including rapid response for admission avoidance.
- 7 day service discharges into reablement which is part of RRRT service.
- No delays for clients awaiting reablement service.
- The number of RRRT referrals increased in 16/17 compared to 15/16 by 5.1% (from 4,815 to 5,079); however, the number of rapid response referrals decreased from 412 to 519 (20%).
- In 15/16, 100 patients were diverted from acute hospitals admissions; this number has improved in 16/17 to 206.
- The % of patients with self-care plan has improved from, 85% to 87%.
- Patients’ satisfaction: % of patients who are very satisfied or satisfied has improved from 92% to 98%; % of patients likely to recommend to friends and family has improved from 96% to 97%.
- % of patients leaving the service with no service or reduced service has improved from 74% to 84%.
- The number of complaints has slightly reduced in 16/17 from 5 to 4.
- Future plans include a service evaluation with a view to align the service functions with the national developments (e.g. discharge to assess)
- Introduction of GP cover in RRRT at Teddington Memorial Hospital focusing on admission avoidance and support timely discharge.

**GP & Multi-disciplinary Team**

This is made up of formerly separately designated schemes GP Led Model, Diabetes Locally Commissioned Service, Community Matrons, Social Workers for GP Led Model and the Increased Capacity of SW workforce to facilitate hospital discharge. The CCG will continue to invest in general practice to support and facilitate the development of multi-disciplinary teams to provide a more coordinated and coherent approach to the management of patients and their conditions.

**Successes:**

- In 15/16 the Community Matrons’ service had significant challenges with recruiting and retaining staffing and some of the activity was supported by District Nursing Service. These challenges have been overcome in 16/17 when the service has exceeded activity targets by 20%.

**Improved MH Out of Hospital Services**

This includes the formerly funded Psychiatric Liaison Service which, like the GP led service has benefited from learning of the previous years.

**Successes:**

- Improved discharge planning and community services such as the Street Triage and Crisis House service co-commissioned with Kingston have seen DToC reduced for adults with MH needs and a reduction in S.136 assessments.
5. Evidence base and local priorities to support plan for integration

Richmond’s BCF plan continues to be based on the ‘Case for Change’ developed in 2014 following extensive public engagement. The objective was to examine the provision of health and social care community services in Richmond. The subsequent report uncovered a number of key issues in the way in which services were delivered and commissioned:

- The public experienced a fragmented system and service that did not focus on improving outcomes for people in a holistic way. This was noted as a particular problem for elderly people with complex needs – a population group forecast to increase significantly over the next decade;
- Some staff did not feel that the way the services were commissioned and managed enabled them to do their best for patients - rather it forced them to work in ‘silos’ when they would rather be working in integrated teams;
- General Practitioners experienced an unexplained variability in access to, and engagement with, community services and felt this had the potential to impact negatively on patient care, service quality and efficiency;
- The report noted that the current contracts were poorly designed and not effectively managed;
- Key Performance Indicators (KPIs) focused on inputs and processes, rather than improvements to health. The current contract arrangements did not give commissioners the leverage they required to hold providers to account in order to deliver value for money and the outcomes that matter to people.

The Case for Change has shaped the design of the Outcome Based Commissioning approach which whilst concentrating on outcomes, gathers together services and providers across health and social care to concentrate, collectively and in partnership, on achieving positive outcomes for individuals.

Richmond will continue to further utilise risk identification and stratification. Richmond’s GP Led Project specification requires GPs to identify 3% of their total list size, of vulnerable patients and patients at risk of hospital admission/readmission or A&E attendances. GPs will have systems in place to proactively case manage these patients and to ensure equitable and effective care for them. In developing the Multi-Disciplinary Locality Teams, risk stratification will play a key part in identifying the right people in our population to benefit from integrated care planning and services. We believe that this approach will be effective in supporting the further reduction of NEAs and DTOC, supporting care in the community as far as possible.

The charts below outline the activity data which supports the direction and focus of Richmond’s BCF plan:

Non-Elective Admissions
Richmond has seen year on year growth in Non-Elective Admissions although the main driver of this over performance against plan relates to paediatric admissions, with almost all of this being related to stays of 0-1 days.

Despite this growth, Richmond’s Non-Elective Admissions rate is one of the lowest in London for the latest NHS England published data:
Due to the growth in admissions, particularly in paediatric patients and strong benchmarked position relative to other London CCG’s. Richmond did not seek to further reduce the level of Non-Elective Admissions for 2017/18 as part of the BCF; this is consistent with the 2017/18 operating plan agreed with NHS England.

**Non-Elective Admissions and Age**

- People over 65 accessing an accident and emergency department are 3.5 times more likely to be admitted into a hospital bed, compared with those aged 0-64.
- People over 65 are 6 times more likely to be admitted into a hospital bed as an emergency (216 per 1,000 for the over 65 population, compared to 36 per 1,000 for the 0-64 population).
- People over 65 admitted into a hospital bed as an emergency will stay an average of 7.6 days, compared to those aged 0-64, who have an average length of stay of 2.5 days.
- The rate of excess bed days per emergency admission for people over 65 is nearly 5 times higher than those people that are 0-64 years.
Non-Elective Admissions across General Practice
There is a marked variation in the rate of Non-Elective Admissions by different general practices, making the case for targeted support to general practices to reduce variation in Non-Elective Admissions.

For those who have had more than one emergency admission in 2016/17 are analysed, the reasons for admission are as follows:

![Graph showing Non-Elective Admission rates by different general practices.](chart1)

### Multiple Admissions by Top Ten HRG Chapters

- **J - Skin, Breast and Burns**: 8%
- **C - Mouth, Head, Neck, and Ears**: 5%
- **A - Nervous System**: 6%
- **N - Musculoskeletal System**: 5%
- **F - Digestive System**: 10%
- **E - Urinary Tract and Nephro-Urological System**: 11%
- **K - Cardiac Surgery and Primary Cardiac Conditions**: 12%
- **W - Infectious Diseases and Other Contacts with Health Services**: 12%
- **R - Respiratory System**: 18%
- **I - Diseases of Childhood and Neonates**: 15%
This analysis led to the enhancement and continued development of community health services, including the Richmond Response and Rehabilitation Team (RRRT) operating 7 days a week, providing a rapid response service designed to prevent avoidable hospital admissions.
Delayed Transfers of Care
With respect to Delayed Transfers of Care, the BCF metric focuses on the population of Richmond, wherever they are treated. Performance and benchmarked data for 2016/17 is shown in the charts below.
For people over 65, weekend discharges vary by specialty and are particularly low for Geriatric Medicine, Respiratory Medicine, Urology and Gastroenterology. These are all areas that have emerged from the analysis of the high-risk cohort and the rapid response service.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Total Discharges</th>
<th>Those Discharged over the Weekend</th>
<th>Proportion Discharged over the Weekend</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>3,597</td>
<td>559</td>
<td>15.5%</td>
</tr>
<tr>
<td>Accident &amp; Emergency</td>
<td>1,161</td>
<td>313</td>
<td>27.0%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>736</td>
<td>136</td>
<td>18.5%</td>
</tr>
<tr>
<td>ENT</td>
<td>530</td>
<td>117</td>
<td>22.1%</td>
</tr>
<tr>
<td>Urology</td>
<td>380</td>
<td>53</td>
<td>13.9%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>324</td>
<td>52</td>
<td>16.0%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>195</td>
<td>17</td>
<td>8.7%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>167</td>
<td>26</td>
<td>15.6%</td>
</tr>
<tr>
<td>Respiratory Medicine</td>
<td>132</td>
<td>16</td>
<td>12.1%</td>
</tr>
<tr>
<td>Colorectal Surgery</td>
<td>95</td>
<td>16</td>
<td>16.8%</td>
</tr>
<tr>
<td>Medical Oncology</td>
<td>89</td>
<td>11</td>
<td>12.4%</td>
</tr>
<tr>
<td>Ent</td>
<td>86</td>
<td>10</td>
<td>11.6%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>75</td>
<td>16</td>
<td>21.1%</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>61</td>
<td>12</td>
<td>19.7%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>55</td>
<td>9</td>
<td>16.4%</td>
</tr>
<tr>
<td>Other Specialties</td>
<td>47</td>
<td>9</td>
<td>13.6%</td>
</tr>
</tbody>
</table>
The GP Practice survey indicates that there is room for improvement in the proportion of people who know they have a care plan in place, and a low proportion of people with plans consider that it is regularly reviewed. This will be addressed and improved as part of the work in developing Locality Teams to support integrated care planning.
The BCF Plan 2017/2018 is a continuation of the 2016/2017 plan with the schemes within that plan being extended. The plan for 2017/19 has not significantly changed as many of the themes of our previous plans are now embedded within the SWL STP and strategic landscape for the sub region. The BCF for Richmond continues to support our key outcomes of delivering more care within the community, reducing unnecessary admissions and Delayed Transfers of Care. As with previous years we are committed to reviewing and
adjusting our plan and the schemes funded by them to incorporate learning as delivery continues and to adjust schemes where necessary to reflect the transformational approach taking place in Richmond. During 2017/18 we will carry out a review of the BCF schemes to measure the impact on achieving our outcomes, and to review in light of changes to care models such as Locality Teams.

The plan does reflect adjusted investment to support the work in developing Locality Teams to provide integrated proactive health and social care for groupings of 50,000 of our population in Richmond. Funding is being prioritised to address performance areas that require improvement, namely NEAs and DTOC. As outlined above we will review current schemes within the financial year to ensure schemes continue to be effective in supporting improvement in further reduction of NEAs and DTOC.
6. National Conditions

National condition 1: jointly agreed plan

The BCF plan has been developed in partnership by Richmond CCG and the London Borough of Richmond upon Thames and has been approved via the appropriate governance in both organisations. The BCF for Richmond will be jointly assured and monitored by the CCG and Local Authority and we will work in partnership to incorporate learning on an ongoing basis, review and adapt our plans to support delivery of the national conditions.

Richmond’s BCF has been produced in line with the broader strategic objectives set out in the SWL STP and Five Year Forward View. The BCF plan sets out our plans locally to support improved integrated care, improve care and outcomes in the community and reduce Delayed Transfers of Care.

The CCGs and the Local Authority through the ongoing work on Outcome Based Commissioning are engaging and working in partnership with health and social care providers. This includes those who are responsible for the delivery of the BCF plan. Commissioners are meeting providers regularly to deliver transformation including the BCF initiatives across physical and mental health. Any specific changes to providers funded via the BCF have been identified and agreed with providers on a one-to-one basis. In addition, Healthwatch is a member of the boards and groups supporting the delivery of the transformation.

The Health and Wellbeing Board is updated regularly on the progress of the BCF and the related transformation work including the OBC programmes. The wider transformation programme is also considered as part of a Members Scrutiny Panel for both physical and mental health.

Patient and Public Engagement for the BCF plan is being captured as part of the ongoing programme of engagement and representation for the OBC programme. This includes expert by experience involvement in clinical design sessions for transformed services, innovation sessions and public engagement events.

IBCF Fund
The Local Authority and CCG confirms that the IBCF totalling £685,891 is included within the plan for 2017-19. The planned investments will enable the Council with NHS partners to increase capacity in services to support people after a stay in hospital, including developing preventative services. This investment will ensure that Richmond maintains focus on continuing to improve its performance in reducing Delayed Transfers of Care from hospital, in the context of increased pressure on local NHS services and increasing demand for adult social care for people who have been in hospital.

Disabled Facilities Grant
The Housing Department is represented on the Better Care Fund Delivery Group and the Local Authority and the CCG confirm that the DFG has been included within the BCF plan for 2017-18. The value of the DFG is £1,440,159. Although the DFG is provided primarily for adaptations there is scope to allow for this money to also be spent on wider social capital projects as long as plans are jointly developed with and agreed by the local housing authority.
7. National Conditions (continued)

National condition 2: NHS contribution to adult social care is maintained in line with inflation

Protecting social care services in Richmond means ensuring that those in need of adult social care services, continue to receive the support they need in a time of growing demand and budgetary pressures, as well as continuing to invest in prevention and early intervention to delay the need for more intensive and expensive services.

We have compared the volumes of social care packages from 2015/2016 and the provisional outturn figures for 2016/2017. The outturn is showing a slight increase at 2%, so the measures we have taken to protect social care budgets are deemed to be sufficient.

The Council's budget 2016/17 has been set to ensure that known pressures are fully funded: demographic growth for older people, physical and learning disabilities, increased costs in commissioned services arising from the National Living Wage and increased costs of statutory services such as Deprivation of Liberty Safeguards. The Council applied a 2% precept to the Council tax to fund pressures in adult social care. The BCF Plan will mean that expenditure of £2m on preventative services can be maintained, social care services will be protected and there is provision for the additional requirements of the Care Act, including services for carers. The proportion of savings required for adult social care is lower than the proportion of the Council’s budget spent on adult social care. Savings are being targeted from shared services and procurement efficiencies with social care services being protected.

In Richmond we have a large number of self-funders. We expect the Better Care Fund to enable us to protect universal services that support those self-funding their care, with a particular focus on voluntary sector preventative services and our RRRT service which are available to all. This will improve outcomes and provide more choices for self-funders. Richmond’s definition of protecting adult social care services is summarised in our commitment to:

- Deliver essential services to those residents who need them.
- Continue to meet our statutory requirements in the provision of adult social care services and to support the requirements of the Social Care Act.
- Ensure that there is joint assessment on both Health and Adult Social care on the impact of plans and strategies to reduce spend in the acute sector and that joint plans reflect a sustainable shift in resources and spend across community health and social care services.
- Continue to provide long term care and support to residents who meet Richmond’s criteria for eligibility for services.
- Care and support is delivered in partnership between the NHS and social care with wider support from the voluntary and private sectors and housing.
- Safeguard those people who use them.
- Continue to invest in preventative and early intervention services to support people to stay healthy, maintain maximum independence, quality of life and reduce the need for higher level support and tackle loneliness and isolation in older people.
- Individuals not institutions take control of their care. Personal budgets and personal health budgets are provided to eligible people, with a high proportion of these being delivered as a direct payment.
- People’s needs are matched by diverse service provision with a broad market of high quality service providers.
Carers are valued and supported and are given the same respect as those they support.

Adult Social Care budgets are facing a number of challenges including the Council’s need to make significant savings to meet the costs of rising demand in light of reduced local government funding. Richmond prioritises adult social care services, spending 36% of its overall budget (excluding schools) on adult social care. It also spends a high proportion of its social care budget on preventative services which are universally available to residents (outside social care eligibility criteria). BCF funding will be used to support existing services or transformation programmes where such services or programmes are of benefit the wider health and care system, provide good outcomes for services and which would otherwise be reduced owing to budget pressures or to meet increased demand for services.

Richmond will maintain provision of social care services, and will continue to:

- Meet its statutory duties to meet assessed need;
- Offer carer’s assessments;
- Safeguard people who use social care services;
- Offer choice and control (by increasing the use of personal budgets to both service users and carers);
- Commission a wide range of services (including universal preventative services offered to those not meeting the national eligibility criteria such as the Community Independent Living Service, the Carers’ Hub and the Home Maintenance Service);
- Invest in the Richmond Rapid Response and Rehabilitation team to promote reablement;
- Move towards implementing the next phase of its ‘Help to Live at Home’ service which exemplifies a transformative approach;
- Concentrate on people suffering from dementia and their carers
- Commission the Carers’ Hub as well as refresh the strategy.
- Provide additional social care services and entitlements arising out the Care Act.

The CCG has also restated its commitment to commission a clinical model that will better support community services infrastructure to ensure that frail elderly patients are cared for in their home and community settings, set out in it’s 2016/2017 Operating Plan and the Council and the CCG have now published their prevention framework.

**Carers**

The Carers’ Hub service is a partnership of voluntary organisations, led by Richmond Carers’ Centre, designed to provide a co-ordinated offer of open access support services for carers, in line with the Council’s obligations under the Care Act. This service has been recommissioned for a one year period from 1st August 2018 (with an optional extension of up to two years) and now incorporates the Carers in Mind service previously commissioned separately from Richmond MIND. The information service will be reviewed alongside the CILS information navigation service in order to ensure that arrangements to support engagement with all voluntary sector support services are fully co-ordinated.
National condition 3: NHS commissioned out-of-hospital services

The table below outlines the committed sum allocated to NHS commissioned out of hospital services.

<table>
<thead>
<tr>
<th>Summary of NHS Commissioned Out of Hospital Services Spend from MINIMUM BCF Pool (**)</th>
<th>2017/18 Expenditure</th>
<th>2018/19 Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>£253,000</td>
<td>£253,000</td>
</tr>
<tr>
<td>Community Health</td>
<td>£3,573,000</td>
<td>£3,573,000</td>
</tr>
<tr>
<td>Continuing Care</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td>Primary Care</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td>Social Care</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td>Other</td>
<td>£1,448,940</td>
<td>£1,448,940</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£5,274,940</strong></td>
<td><strong>£5,274,940</strong></td>
</tr>
<tr>
<td>NHS Commissioned OOH Ringfence</td>
<td>£3,120,063</td>
<td>£3,179,344</td>
</tr>
</tbody>
</table>

Non Elective Admissions to Hospital
An additional target for non-elective admissions has not been set and there is no contingency fund.

Risk Sharing
The Council and CCG will consider appropriate risk sharing arrangements as integrated health and care services are developed locally.
8. National conditions (continued)

National Condition 4: Managing Transfers of Care

Richmond performs well overall in delivering the four national metrics and supports people to have care delivered in the most appropriate setting. However, the CCG and the Local Authority acknowledge there is still work to do in reducing Delayed Transfers of Care for Richmond patients.

Richmond’s BCF for 2017/18 continues to focus on supporting the reduction of DT0C and Non-Elective Admissions. The BCF and schemes proposed will facilitate delivering the High Impact Change model. The plan aligns with the work carried out by the Kingston, Richmond and Surrey Downs A&E Delivery Board and the proposals to implement the High Impact Model.

The overall vision is to ensure that patients return home as soon as possible and if home is not the best place they will be transferred promptly to the most appropriate care setting. Ensuring that people only stay in hospital as long as they need to can only be achieved via a whole system approach which incorporates managing patient flow, access to responsive integrated health and social care and supporting carers and families.

An initial self-assessment against the High Impact Model has been undertaken and a working group is tasked with taking this forward. The model identifies eight system changes which will have the greatest impact on reducing delayed discharge. The table below sets out the high impact model and how the BCF seeks to support delivery of the key elements of the model.

The CCG and the Council also work in partnership to reduce any existing and emerging DT0Cs for people with MH needs through the identified BCF and other non BCF funded schemes. There has been a significant reduction in MH DT0Cs over the last year.
<table>
<thead>
<tr>
<th>High Impact Change</th>
<th>BCF Schemes &amp; Initiatives in Place</th>
<th>Key Deliverables &amp; Future Plans</th>
</tr>
</thead>
</table>
| **Change 1: Early Discharge Planning.**  
*In elective care, planning should begin before admission. In emergency /unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow expected dates of discharge to be set within 48 hours.* | Early Discharge Planning is treated as part of the whole system with acute hospitals, community providers, local authority and RCCG working together to achieve a streamlined process to benefit the patients/Service Users. Some of the work already in place is mentioned below:  
- On admission patients are given Estimated Dates of Discharge at both acute hospitals (KHFT and Chelsea and Westminster)  
- Early discharge planning in the community is supported by the hospital systems (patient flow)  
- Daily discharged planning meeting at Chelsea and Westminster including a representative of Richmond Response and Rehabilitation Team.  
- The community provider (HRCH) facilitates early discharge and enable shorter period of hospital stay  
- Frailty team is a joint initiative across both Kingston and Richmond - community providers work in partnership with KHFT to provide a multidisciplinary in-reach team to A&E, AAU and all wards, support the early identification of the frail elderly and contribute to the development of the frailty work stream.  
- A small frailty service is currently in place at WMUH – this is a priority for the Trust to expand |  
- To build on the ECIP recommendations regarding identifying the optimal model for the Frailty Team, consider expansion of the Team to cover all areas and provide a 7 day a week service.  
- To start early discharge planning in the community through locality based joint health and social care teams for elective admissions, with GPs and DNs leading discussions.  
- To begin discharge planning in A&E for Non-Elective Admissions and to achieve an expected date of discharge to be set within 48 hours.  
- To set discharge dates which the whole hospital are committed to delivering.  
- To develop a suite of metrics to demonstrate and assess impact plus interdependencies.  
- To establish a patient tracking list to include internal delays within the hospital as per the ECIP recommendations.  
- Continue with existing MH DToC meetings with acute care provider and local authority to expedite any existing blockages for discharge and identify those approaching discharge to put a plan in place. |
| **Change 2: Systems to Monitor Patient Flow.**  
Robust patient flow models for health and | Patient Tracking List (PTL) is used to analyse each patient pathway and facilitate early discharge by indicating |  
- To establish robust patient flow models for health and social care. |


<table>
<thead>
<tr>
<th>High Impact Change</th>
<th>BCF Schemes &amp; Initiatives in Place</th>
<th>Key Deliverables &amp; Future Plans</th>
</tr>
</thead>
</table>
| social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services around the individual. | expected date of discharge. PTL is used across all inpatients wards at KHFT  
- Daily meetings with KHFT and community provider are in place to facilitate early discharge. Weekly long delays meetings are held at KHFT, led by the senior discharge coordinator  
- Daily discharge meeting with community providers and weekly escalation calls for WMUH  
- Monitoring calls with acutes, community providers and CCG are in place to highlight potential issues, identify and mitigate blockages in the system  
- Monthly joint DTOC meetings with CCGs, Local Authorities and community providers are in place to highlight possible issues and mitigate blockages within the system  
- Mutual aid - Agreement between community providers with regards to rehabilitation beds (Kingston patients have access to TMH beds if they meet the criteria for rehabilitation)  
- Daily and weekly monitoring of operational DTOC is undertaken by the CCGs  
- CCG has worked with MH provider to transform the Acute Care Pathway for Adult MH. This has included commissioning a Psychiatric Decision Unit and Crisis House as alternatives to admission and to improve patient flow | To analyse demand to calculate capacity needed for each care pathway focusing on demand variations such as admissions and causes of bottlenecks.  
- To agree, implement and monitor a robust local version of the SAFER patient flow bundle including a Red 2 Green approach to highlight and escalate internal and external delays.  
- To ensure a policy is agreed and a plan in place to match capacity to care pathway demand.  
- To complete analysis and practice changes are in place and evaluated. |

Work is underway (local authority, CCGs and community providers) to produce a DTOC action plan for 2017-18. This is being based on best practice set out in the high impact
Interventions self-assessment tool: High Impact Change Model for Managing Transfers of Care which has been promoted by the Better Care Fund for managing Delayed Transfers of Care.

<table>
<thead>
<tr>
<th>Change 3: Multi-disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector.</th>
<th>Social prescribing</th>
</tr>
</thead>
<tbody>
<tr>
<td>In terms of integrated discharge teams, there is already a level of integration between Health and ASC discharge teams (RRRT joint community and social care presence). Whilst a Joint NHS and ASC hospital based discharge team is not in place e.g. using the same assessment process etc. across Boroughs the aim is to work towards effective pathways and communication links. Plans are being developed to work closely with Kingston YourHealthcare to make processes more streamlined and coordinated and to introduce MDT’s on all wards (at Kingston?). This is promoting effective discharge and good outcomes for patients. Two-weekly meetings are taking place with Kingston and Partners. Focus is on moving people on within 24 hours.</td>
<td>• To establish integrated co-located discharge teams including hospital, community health providers and ASC staff which use single assessment and discharge process that support all hospital MDTs.</td>
</tr>
<tr>
<td>• To establish fully integrated discharge to assess arrangements for all complex cases.</td>
<td></td>
</tr>
<tr>
<td>• To provide in reach functions through the integrated discharge team to support the Frailty Team.</td>
<td></td>
</tr>
<tr>
<td>• To facilitate the provision of timely practical support to patients to facilitate discharge through volunteers.</td>
<td></td>
</tr>
<tr>
<td>• To review the care pathway for therapy provision across partner organisations to support assessment and discharge planning and develop common tools.</td>
<td></td>
</tr>
<tr>
<td>• To develop risk stratification in primary care MDTs which identifies the top 2% of patients at high risk including people that are frequently admitted to hospital or present at A&amp;E to ensure that a care plan and care coordination is established for these people.</td>
<td></td>
</tr>
<tr>
<td>• Continue to work with MH provider and Local Authority in joint DToC and discharge planning meetings for MH</td>
<td></td>
</tr>
</tbody>
</table>

Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients.
| Change 4: Home First/Discharge to Assess. Providing short-term care and reablement in people’s homes or using “step-down beds” to bridge the gap between hospital and home means that people no longer need to wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow. | • Roll out of Red Bag scheme for care homes, supporting care homes with co-ordinated care and support plans to prevent admissions and facilitate discharge.  

RCCG and community providers (Hounslow and Richmond Community Healthcare (HRCH) and YourHealthcare (YHC) are working in partnership with KHFT to embed new clinical pathways to increase and speed up the number of assessments undertaken outside an acute setting. The Discharge to Assess pathway commenced in part on 24th April 2017, with further plans to scale up. Work is in progress to support the initiative e.g., training/protocols to build patient confidence, enhance GP understanding.  

Robust processes are in place for ensuring people return home with reablement support from the RRRT integrated team who undertake risk assessments in A&E for those requiring reablement or simple packages before discharging to home. There is continued focus on ensuring people only enter a care/nursing home when their needs cannot be met through care at home. This has impacted positively on workflows length of stay.  

The work undertaken so far includes the following:  

• Agreement on philosophy that Home first is the best solution for the patient (or home as final destination) – currently, assessments are still happening in hospital. | • Inclusion of MH within MDT teams based in primary care to ensure good ongoing care planning and support in the community  

• To establish a partner agreement regarding a Discharge to Assess model (D2A) which reviews resource implications and considers a shared risk agreement as per ECIP recommendations  

• To agree an implementation plan for D2A and review the impact of the model and identify the system challenges.  

• Continue to develop use of Richmond and Kington’s MH Crisis House to support step down and facilitate appropriate discharge and assessment within a community setting and to ensure care packages are in place  

• Mobilisation of recommissioned MH Accommodation Pathway which provides a pathway of supported housing to facilitate discharge, step down and better support people in the community |
Official

- Well established community providers
- Simple discharge process is working well but work is in progress to scope and understand what is preventing the home first to manage more complex cases
- Pilot at WM with HRCH for Hounslow patients.

**Change 5: Seven-Day Service.**

Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people’s needs.

Health and reablement Social Care teams are working to new 7 day working patterns and rotas for health and social care staff are being drawn up and negotiated. Work for seven day operation is yet to be scoped regards Social Care Services who currently assess and start new care Monday to Friday and for Diagnostics, pharmacy and patient transport services.

- To review 7 day working requirements across hospital, community health providers and LA services to identify gaps and areas that need to be developed to establish the optimum model which includes therapy and social care services.
- To establish whole system commitment to enable care to restart within 24hrs 7 days a week.
- To arrange a health and social care team that works seven days a week.
- To arrange staffing rotas and contracts across all disciplines.
- To negotiate that all care providers assess and restart care at weekends.
- To establish a consistent medical review at weekends.
- To establish a resilient workforce that is not reliant on overtime working.
- To review patient transport requirements for 7 day cover.
- Core 24/7 psychiatric liaison service in place at Kingston Hospital by April 2018
- Street Triage service to support reduction of admissions has been increased to cover 7 days
| Trusted Assessors | An integrated assessment format has been agreed between community health and social care for reablement and care home providers too share responsibility for assessments. This has helped to reduce duplication and speeded up response times so that people can be discharged in a safe and timely manner. | • To develop a trusted assessor framework across all local discharge pathways.  
• To develop and implement a single holistic assessment tool.  
• To establish discharge and social care teams assessing on behalf of health and social care.  
• To establish trusted assessor competencies amongst staff across different disciplines and partner organisations.  
• To enable staff to be able to facilitate discharges across organisational boundaries and geographical areas. |
| Focus on Choice | New choice protocol has been implemented by Kingston Hospital and being followed by staff and further awareness training taking place. In addition, admission advice and information leaflets are in place and being used. | • To integrate choice protocols across Kingston Hospital and LA with clear triggers for escalation for all partners.  
• To ensure that all wards are aware of and are following the choice protocol. Choice protocols and escalation process embedded with ward staff / discharge facilitators/ LA staff. Joint training for key staff delivered on a 6 monthly basis to ensure process robustly followed and difficult decisions made. Training to ensure that staff across organisations educate patients and families and not raise expectations inappropriately regarding service response.  
• To review the range of voluntary and private sector organisations available to support patients and families to explore choices and assist with reaching |
Enhancing Health in Care Homes

<table>
<thead>
<tr>
<th>Work has already begun with Care Homes to improve/enhance the quality of care provided to residents. Some of the initiatives are mentioned below:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Richmond has implemented an element of Sutton Vanguard (Red Bag scheme already launched in Richmond – 31.05.2017).</td>
</tr>
<tr>
<td>• The Falls prevention policy for Care Homes was reviewed by the Local Authority in Richmond.</td>
</tr>
<tr>
<td>• Care Homes Forum held quarterly by the Local Authority both Kingston and Richmond</td>
</tr>
<tr>
<td>• Richmond’s Primary Care Liaison service supports GP’s and people with MH needs within community settings such as residential care and supported housing</td>
</tr>
</tbody>
</table>

<p>| • To facilitate a health and social care forum with Care Home Providers to identify areas of services which require strengthening to enhance the health of residents |
| • Plans in place to address high referring care homes. |
| • Establish community and primary care support to Care Homes to raise clinical practice standards and provide a timely response to people with behaviours that challenge. The service will raise clinical standards particularly in relation to falls prevention and end of life Coordinate My Care planning. |
| • Evaluate benefits and impact of elements of Sutton Vanguard and consider implementation plan (Red Bag scheme launched in Richmond 31.5.17). |
| • Monitor activity and quality of practice of care homes to target in-reach resources and raise practice standards, also provide clarity regarding the level of health support available locally. |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>To review / update the falls policy within care homes and disseminates through LA care home provider forums.</td>
</tr>
</tbody>
</table>
9. Better Care Fund plan and overview of funding contributions

BCF schemes, outcomes and spending

The 2017/18 builds on the previous year but through a process of evaluation we have rationalised the number of schemes, made amendments to pilots following review and learning and have re-designated some schemes to fit in with the wider transformational work going on across Richmond’s health and social care sector.

The funding contributions for 2017/2018 have been agreed by the relevant stakeholders and comprise:

<table>
<thead>
<tr>
<th></th>
<th>2017/2018</th>
<th>2018/2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG</td>
<td>10,979,502</td>
<td>11,188,113</td>
</tr>
<tr>
<td>Disabled Facilities Grant (Local Authority)</td>
<td>1,440,159</td>
<td>1,572,854</td>
</tr>
<tr>
<td>Improved Better Care Fund</td>
<td>685,891</td>
<td>424,713</td>
</tr>
<tr>
<td><strong>Total Pooled Budget</strong></td>
<td><strong>13,105,552</strong></td>
<td><strong>13,185,680</strong></td>
</tr>
</tbody>
</table>

Schemes for 2017/2018 are as follows:

<table>
<thead>
<tr>
<th>#</th>
<th>Scheme</th>
<th>Responsibility</th>
<th>Planned BCF funding 16/17 (£)</th>
<th>Planned BCF funding 17/18 (£)</th>
<th>Planned BCF funding 18/19 (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Outcome Based Commissioning - Falls Service</td>
<td>RCCG</td>
<td>275,000</td>
<td>275,000</td>
<td>280,225</td>
</tr>
<tr>
<td>2</td>
<td>Outcome Based Commissioning - Early Supported Discharge</td>
<td>RCCG</td>
<td>320,000</td>
<td>320,000</td>
<td>326,080</td>
</tr>
<tr>
<td>3</td>
<td>Outcome Based Commissioning - COPD Respiratory Team</td>
<td>RCCG</td>
<td>290,000</td>
<td>290,000</td>
<td>295,510</td>
</tr>
<tr>
<td>4</td>
<td>Outcome Based Commissioning - Community Geriatrician at Acute hospitals</td>
<td>RCCG</td>
<td>240,000</td>
<td>120,000</td>
<td>122,280</td>
</tr>
<tr>
<td>5</td>
<td>Community Services including Locality teams, Cardiac Rehab, Tissue Viability</td>
<td>RCCG</td>
<td>0</td>
<td>687,000</td>
<td>700,053</td>
</tr>
<tr>
<td>6</td>
<td>Outcomes Based Commissioning – Physical Health</td>
<td>RCCG</td>
<td>80,000</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>7</td>
<td>Carers Hub Service</td>
<td>LBRuT</td>
<td>446,000</td>
<td>397,320</td>
<td>404,869</td>
</tr>
<tr>
<td>8</td>
<td>Homecare reablement</td>
<td>LBRuT</td>
<td>1,284,000</td>
<td>679,000</td>
<td>691,901</td>
</tr>
<tr>
<td>9</td>
<td>HRCH</td>
<td>LBRuT</td>
<td>0</td>
<td>605,000</td>
<td>616,495</td>
</tr>
<tr>
<td>10</td>
<td>RRRT (Integrated Care Teams) - RRRT Agency Social Workers</td>
<td>LBRuT</td>
<td>50,000</td>
<td>50,000</td>
<td>50,950</td>
</tr>
<tr>
<td>11</td>
<td>RRRT (Integrated Care Teams) - RRRT Rehab Assistants</td>
<td>LBRuT</td>
<td>157,000</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Project Description</td>
<td>Provider</td>
<td>Costs 2015-16</td>
<td>Costs 2016-17</td>
<td>Costs 2017-18</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------------------</td>
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<td>----------------</td>
<td>----------------</td>
</tr>
<tr>
<td>4</td>
<td>RRRT (Weekend Working) - RRRT HRCH Team</td>
<td>RCCG</td>
<td>1,031,000</td>
<td>1,031,000</td>
<td>1,050,589</td>
</tr>
<tr>
<td>4</td>
<td>RRRT (Weekend Working) - RRRT Weekend Support</td>
<td>RCCG</td>
<td>250,000</td>
<td>250,000</td>
<td>254,750</td>
</tr>
<tr>
<td>5</td>
<td>GP &amp; Multi-disciplinary Team - GP led Model (enhanced DES, community nursing)</td>
<td>RCCG</td>
<td>936,000</td>
<td>936,000</td>
<td>953,784</td>
</tr>
<tr>
<td>5</td>
<td>GP &amp; Multi-disciplinary Team - Diabetes Locally Commissioned Service</td>
<td>RCCG</td>
<td>70,000</td>
<td>70,000</td>
<td>71,330</td>
</tr>
<tr>
<td>5</td>
<td>GP &amp; Multi-disciplinary Team - Community Matrons</td>
<td>RCCG</td>
<td>443,000</td>
<td>443,000</td>
<td>451,417</td>
</tr>
<tr>
<td>5</td>
<td>GP &amp; Multi-disciplinary Team - Social Workers to participate in GP led model</td>
<td>LBRuT</td>
<td>187,000</td>
<td>187,000</td>
<td>190,553</td>
</tr>
<tr>
<td>5</td>
<td>GP &amp; Multi-disciplinary Team - Increased capacity of SW workforce to facilitate hospital discharge</td>
<td>LBRuT</td>
<td>131,000</td>
<td>131,000</td>
<td>133,489</td>
</tr>
<tr>
<td>5</td>
<td>Improved Mental Health Out-of-Hospital Services - Contribution towards Psychiatric Liaison</td>
<td>RCCG</td>
<td>236,000</td>
<td>236,000</td>
<td>240,484</td>
</tr>
<tr>
<td>5</td>
<td>Improved Mental Health Out-of-Hospital Services - New funds for 16/17 only</td>
<td>RCCG</td>
<td>17,000</td>
<td>17,000</td>
<td>17,323</td>
</tr>
<tr>
<td>5</td>
<td>Equipment and assistive technologies - Joint Equipment Services (the £50k in the narrative last year for AT was not in the budget)</td>
<td>RCCG</td>
<td>600,000</td>
<td>600,000</td>
<td>611,400</td>
</tr>
<tr>
<td>5</td>
<td>Communication plan - Choose well Communications Plan</td>
<td>RCCG</td>
<td>30,000</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>Maintaining Adult Social Care</td>
<td>LBRuT</td>
<td>665,000</td>
<td>2,499,000</td>
<td>2,546,481</td>
</tr>
<tr>
<td>5</td>
<td>Additional responsibilities Care Act - Duties/Responsibilities</td>
<td>LBRuT</td>
<td>500,000</td>
<td>500,000</td>
<td>509,500</td>
</tr>
<tr>
<td>5</td>
<td>Winter warmth Scheme</td>
<td>LBRuT</td>
<td>58,000</td>
<td>38,795</td>
<td>39,532</td>
</tr>
<tr>
<td>5</td>
<td>Services commissioned from the voluntary sector</td>
<td>LBRuT</td>
<td>151,000</td>
<td>151,000</td>
<td>153,869</td>
</tr>
<tr>
<td>5</td>
<td>Personalised Services and Care at Home - CILS</td>
<td>LBRuT</td>
<td>305,000</td>
<td>266,387</td>
<td>271,448</td>
</tr>
<tr>
<td>5</td>
<td>DFG (Capital) - DFG &amp; others</td>
<td>LBRuT</td>
<td>1,307,000</td>
<td>1,440,159</td>
<td>1,572,854</td>
</tr>
<tr>
<td>5</td>
<td>IBCF - RRRT support Services</td>
<td>LBRuT</td>
<td>685,891.00</td>
<td>424,713.00</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Total</td>
<td></td>
<td>12,093,000</td>
<td>13,105,552</td>
<td>13,185,680</td>
</tr>
</tbody>
</table>
Overview of schemes:

**Outcome Based Commissioning**
This is the scheme within the previous BCF plan which was designated GP Led Model of Care and includes, going forward, schemes which are to be subsumed within the wider Outcomes Based Commissioning approach; these include the Falls Service, the Early Supported Discharge for Stroke Survivors, the COPD Respiratory Team and the Community Geriatrician at Acute Hospitals.

**Richmond Response and Rehabilitation Team (RRRT) – Integrated Care Teams and Weekend Working**
This service is a key service in the achievement of a number of the national conditions, particularly joint assessment and care planning, seven day working, NHS investment in out of hospital services, preventing unnecessary admissions and reducing Delayed Transfers of Care. Investment is being maintained in this service area.

**GP and Multi-disciplinary Team**
This scheme incorporates the previously designated GP Led Model of Care and the Diabetes Locally Commissioned Service. It is made up of formerly designated schemes GP Led Model, Diabetes Locally Commissioned Service, Community Matrons, Social Workers for GP Led Model and the Increased Capacity of SW workforce to facilitate hospital discharge. The successor to the GP Led Model specification has incorporated learning from the pilot and has enhanced expectations of GPs around multi-disciplinary working with hospitals, analysis and assistance to registered patients who have been the subject of a Non-Elective Admission.

**Improved Mental Health Out of Hospital Services**
This includes the formerly funded Psychiatric Liaison Service which, like the GP led service has benefited from learning. The new specification incorporates new funding (outside the BCF) to increase hours of operation from 9am to 9pm to 24/7.

**Equipment and Assistive Technologies**
This remains unchanged from 2016/2017 except for the increased focus on the possibilities of assistive technologies to keeping people at home. For example, the refreshed Carers’ Strategy will have an emphasis on the possibilities of new technologies to aid caring for and to help keep people at home.

**Personalised Services and Care at Home**
This strand incorporates the protection of adult social care and incorporates schemes previously designated Universal/Preventative services, Personal Budgets, Services Commissioned from the Voluntary Sector, CILS and Care Act Implementation

**Voluntary sector commissioning**
The bulk of voluntary sector preventative services in Richmond are commissioned through the Community Independent Living Service programme. This encompasses information navigation provision, designed to ensure that those in need of support are able to access the most appropriate provision and a range of health and wellbeing activities designed to prevent, reduce or delay the need for health and social care services. A review of CILS services is being undertaken during 2017/18, to inform procurement of the service against a new model from 1st October 2018.

A key feature of the service review is on the information navigation service. The revised service model will incorporate learning from the Nightingale Service commissioned from Richmond Age UK, which utilises voluntary resources to facilitate hospital discharge, and the social prescribing pilot initiated by Richmond CCG which is designed to support successful referrals from GPs into voluntary sector support services.
Carers’ Hub
The Carers’ Hub service is a partnership of voluntary organisations, led by Richmond Carers’ Centre, designed to provide a co-ordinated offer of open access support services for carers, in line with the Council’s obligations under the Care Act. This service has been recommissioned for a one year period from 1st August 2018 (with an optional extension of up to two years) and now incorporates the Carers in Mind service previously commissioned separately from Richmond MIND. The information service will be reviewed alongside the CILS information navigation service in order to ensure that arrangements to support engagement with all voluntary sector support services are fully co-ordinated.

Monitoring of BCF Schemes
The delivery and impact of BCF Schemes are monitored as part of the BCF governance structure set out in section 10 with regular reporting on performance and risk. This is supplemented by routing contract monitoring of services and review of activity.

DFG (Capital)
The Council is committed to assisting older people and the disabled to maintain their ability to live independently in their own home and works closely with the Home Improvement Agency (HIA) and facilitating Disabled Facility Grants to achieve this. The Housing Department is represented on the Better Care Fund Delivery Group and the Local Authority and the CCG confirm that the DFG has been included within the BCF plan for 2017-18.

iBCF spend
Investment from the IBCF is planned to support smooth transfers of care between NHS and social care, with a focus on transfers of care from hospital. The planned investments will enable the Council with NHS partners, to increase capacity in services to support people after a stay in hospital, including developing preventative services. This investment will ensure that Richmond maintains focus on continuing to improve its performance in reducing Delayed Transfers of Care from hospital, in the context of increased pressure on local NHS services and increasing demand for adult social care for people who have been in hospital. A key focus for managing performance in 2017/18 will be on managing Delayed Transfers of Care (DTOC) for older people with mental health needs in Tolworth Hospital, particularly those needing specialist care home placements to support people with challenging behaviour. The proposed expenditure to support transfers of care from hospital is set out below:

- Additional Capacity in the Richmond Response and Rehabilitation (RRR) Team: Richmond Adult Social Services made significant improvements in improving social care delay transfers of care from August 2016, particularly in relation to reducing waiting time for assessments. This has been managed through the investment of additional social care staff in Richmond Response and Rehabilitation Team, and the local authority taking back direct line management of the social work staff in the integrated team. Additional funding for 2017/18 was approved by Cabinet in March 2017, as well as formal line management arrangements for staff. The Adult Social Care Support Grant will fund 5 additional social work posts in the RRR Team to increase capacity to support improvements in transfers of care from hospital, as approved by Cabinet in March 2017, at a cost of £327,000. The IBCF will provide for funding of £337,000 in 2018/19 and £93,000 in 2019/20.

- Carers’ Support/Admissions Avoidance Services: Additional capacity in Community Teams in 2017/18 at a cost of £240,000 to provide additional support for carers and services to prevent hospital admissions. The additional capacity will ensure that the Council maintains its performance of timely assessments in the context of increasing demand for services (needs assessment and financial assessment).
Whole System Improvement with NHS Partners and Out of Hospital Care Services: A joint Delayed Transfers of Care (DTOC) Action Plan for 2017/18 is in development with Adult Social Services, Richmond CCG and Hounslow and Richmond Community Health (HRCH). This includes the development of “Discharge to Assess” models locally to reduce length of stay for (primarily) older people into hospital, and would need to include agreements with local providers (home care and care home) to be able to respond to earlier supported discharges. It is also anticipated that there will be greater demands on the Joint Equipment Service, particularly in relation to rapid delivery times to support discharge. Models for “Trusted Assessors” are also being explored. Using £455,000 from the IBCF grant, initiatives will be jointly developed with NHS partners to ensure the smooth transfer of care for people from hospital in 2017/18.
10. Programme Governance

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

The Governance Structure for the BCF is contained in the diagram below:

Richmond Health and Wellbeing Board have ownership of the Better Care Fund and is responsible for signing off BCF Plans.

Strategic Partnership Group has strategic oversight and is the key decision-making body. It is responsible for assurance of all joint CCG/Council partnership work and programmes. Its remit is all partnership projects which include commissioning as well as other partnership programmes across health and social care. It acts as joint commissioning board and reports to the Council/CCG Executive as required and to the Health and Wellbeing Board. The Group will oversee the delivery of the BCF and is authorised to make strategic decisions regarding resourcing.

Local Transformation Board – The LTB provides strategic leadership for Richmond and Kingston in the delivery of the STP and its priority programmes. The BCF for Richmond contributes to the delivery of the STP for SW London. Learning and progress from both groups will be shared and reported on as appropriate.

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

**BCF Delivery Group** will oversee the delivery and progress of the BCF schemes. The Board will identify any emerging risks or difficulties with delivery and identify corrective actions for implementation. The board will report to the Strategic Partnership Group, providing highlight reporting on delivery and escalation of key risks and issues. It consists of commissioners and providers who focus on commissioning BCF services as well as monitoring and managing the contracts with providers; they report into the Care Transformation Delivery Group.

**Richmond OBC Transformation Board** – provides strategic leadership for the delivery of Richmond’s OBC. The board is made up of representatives from the CCG, Local Authority, Acute and Community providers. Many of the schemes included within the BCF are being delivered through Richmond’s OBC programme. The group will feed into the BCF Delivery Group regarding progress on BCF schemes.

**Joint Improvement and Delivery Group** – provides oversight and monitoring for delivery of non OBC related schemes including Disabled Facilities Grant and community equipment. The group will feed into the BCF Delivery Group.

We also have well managed and attended engagement opportunities for patients and service users and a well-developed Equalities Impact Evaluation process which, collectively, help us to ensure that we are involving patients and services users and identifying groups with protected characteristics that may be disadvantaged. Richmond’s two OBC programmes are supported by well established patient engagement and involvement programmes and this will also be utilised to engage on the BCF plan and delivery.
11. Assessment of Risk and Risk Management

The table below provides an overview of the key risks identified to date. This risk log has been developed and agreed with relevant partners and will continue to be reviewed via the governance process outlines in section 10.

<table>
<thead>
<tr>
<th>There is a risk that:</th>
<th>How likely is the risk to materialise?</th>
<th>Potential impact</th>
<th>Overall risk factor (likelihood “potential impact”)</th>
<th>Mitigating Actions</th>
</tr>
</thead>
</table>
| Acute providers do not manage the financial risk of the reduction in emergency admissions | 2                                      | 4               | Low                                                 | • Significant and continuous provider engagement including the development of the OBC approach with providers. This has supported improved partnership working towards shared objectives.  
• Regular 1-1 discussions with both acute trusts to respond to any emerging concerns and issues |
| The financial risk to CCG and Council undermines ability to protect social care and NHS services | 2                                      | 4               | Low                                                 | • Detailed discussions between CCG CFO and Council ACS AD Finance throughout process to agree respective risks and mitigations  
• Significant proportion of BCF allocated to                                                                                                           |
<table>
<thead>
<tr>
<th>Category</th>
<th>Levels</th>
<th>Risk</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Council and CCG Commissioning Resource are insufficient in respect of capacity and capability to delivery all aspects of the BCF Plan</td>
<td>2</td>
<td>Low</td>
<td>- The majority of the implementation has been carried out and ongoing work is subsumed in wider transformational plans for which capacity has been identified.</td>
</tr>
<tr>
<td>Pressure on council budgets due to reduction in Central Government funding, combined with cost pressures in adult social care due to demographic growth.</td>
<td>3</td>
<td>Medium</td>
<td>- Council Medium Term Financial Strategy in place. - Risk sharing arrangements being developed as part of BCF pooled budget agreement.</td>
</tr>
<tr>
<td>Uncertainty and resistance around implementation of new care models destablises providers.</td>
<td>3</td>
<td>Low</td>
<td>- Commissioning is now well established with local providers as part of Richmond’s OBC programme for physical and mental health - Established engagement and involvement of community and acute partners in the process - Governance and project management structure in place to closely monitor and progress emerging problems and required interventions at an early stage</td>
</tr>
</tbody>
</table>

Potential negative impact on service delivery and outcomes for individuals
Richmond is on the cusp of 2 commissioning footprints for acute services and is not the lead commissioner. This may lead to a loss of influence.

<table>
<thead>
<tr>
<th>Risk share arrangements, Overspends and Underspends</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Established Commissioning frameworks and relationships in place with SWL and NWL Commissioning Teams</td>
</tr>
<tr>
<td>• Established local Integration Partnership Group in place with senior provider representation</td>
</tr>
</tbody>
</table>

Health and social care economy fails to secure the appropriate workforce to deliver change.

<table>
<thead>
<tr>
<th>Risk Share Arrangements, Overspends and Underspends</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Sector wide workforce development work-stream in place</td>
</tr>
<tr>
<td>• Work with local Providers to identify gaps and solutions</td>
</tr>
</tbody>
</table>

Plans are delivered but targets are not achieved

<table>
<thead>
<tr>
<th>Risk Share Arrangements, Overspends and Underspends</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Targets continue to be aligned to multiple streams of work and learning implemented to increase focus on low performing areas</td>
</tr>
<tr>
<td>• Review of current schemes to ensure impact and focus during 2017-19. First round of reviews will focus on the areas where targets are at risk of not being achieved.</td>
</tr>
</tbody>
</table>

Risk share arrangements, Overspends and Underspends
The BCF Section 75 Agreement, including provisions for risk sharing will be updated for 2017/18-2018/19 in line with this Plan. Within the pooled budget, the lead commissioner of each scheme (Council or CCG) will be responsible for either meeting any over spend that arises or taking remedial action to control expenditure within the approved budget or agreeing via the BCF Delivery Group to utilise underspends on other BCF schemes.

The Council and CCG will consider appropriate risk sharing arrangements as integrated health and care services are developed locally.
12. National Metrics

Non-Elective Admissions
There has been growth in total non-elective activity across all age bands during 2016/17 compared to 2015/16 but this has been largely driven by short stay emergency admissions for 0-18 year olds. The 65 plus cohort of patients make up 32% of all short stay (0 - 1 day length of stay) emergency admissions and will constitute the main focus of admissions that could realistically be prevented through the implementation of alternative pathways. There is growing evidence that the increased focus of RRRT on admission avoidance is beginning to have a positive impact on Non-Elective Admissions. The continued investment into RRRT in 2017-19 is expected to have a positive impact on performance.

Due to the growth in admissions, particularly in paediatric patients and strong benchmarked position relative to other London CCG’s. Richmond did not seek to further reduce the level of Non-Elective Admissions for 2017/18 as part of the BCF; this is consistent with the 2017/18 operating plan agreed with NHS England.

Reablement
In terms of the proportion of older people supported to stay at home 91 days after discharge from hospital into reablement services, Richmond’s performance has remained fairly static with current performance at 85.6%, which places Richmond in Quartile C within its London comparator group. The reablement service supports an increasing number of elderly frail service users with complex needs. The target set for 1017/18 is 86.1%.

The alignment of the service functions, continued investment to maintain capacity and introduction of GP cover in RRRT will have a positive impact on performance in 2017-19.

Delayed Transfers of Care
There were 7606 days delayed in 2016-17 against the annual target of <4499 days. Whilst the target has not been achieved there has been a significant reduction in overall delays in Quarter 4 of 41% compared with quarter 1 which demonstrates an overall improving trend. Overall, 57% of days delayed are attributable to Health; 40%, Social Care; and 3% have joint responsibility. Furthermore, there has been a significant improvement in the social care DToC since August 2016, most significantly is the reduction in delays for people waiting a social care assessment. This has been achieved through additional investment in social care staff in the integrated service and implementing a robust DTOC validation process.

Delayed Transfers of Care remain a significant challenge, particularly delays attributable to health. The primary reason for Health delays continues to be awaiting further non acute NHS care and this is in part due to the lack of neuro rehab beds which is a South West London regional issue. Despite improvements on social care delays, there are still challenges in relation to supporting people into specialist residential/nursing care homes in a timely way. The Joint Delivery plan with prioritised actions has assisted in improving performance and has been refreshed for 2017-18. Please see Planning Template for breakdown of performance target.

We recognise the DToC targets are ambitious; however, these plans take account of the level of input required from both health and social care partners. An additional challenge is our complex commissioning landscape where we have to work across multiple STPs and in partnership with a wide range of health and social care organisations to deliver the DToC targets. Nonetheless, there is a joint effort amongst health and social care partners and we will monitor achievements and adapting the plans to maximise delivery.

Admissions of 65 plus into residential and nursing care
In 2016-17 there were 96 admissions (336.2 per 100,000 pop) against the annual target of
105 admissions which is also the target for 2017/18). This is a notable improvement on the 110 admissions last year and progresses Richmond to the top quartile of the London comparator group. Richmond has been successful in ensuring low level admissions into residential and nursing care due to an increased focus on enablement through RRRT. Continued focus on enablement and investment in RRRT capacity will have a positive impact moving forward.
13. Delayed Transfers of Care (DTOC) plan

The Joint Delivery plan with prioritised actions has assisted in improving performance and has been refreshed for 2017-18. The main focus of the plan is supporting the developments against the High Impact Change Model to improve services to support people from hospital, including developing the Discharge to Assess model “Better at Home” and enhance equipment provision to support earlier discharges.

This includes additional social work posts in the RRR Team to increase capacity to support improvements in transfers of care from hospital, reduce waiting times for assessment and reduction in DTOC.

Areas identified for priority in 2017/18 include:

- Identification of gaps in provision which have been recognised as key contributors to delays, and development of appropriate commissioning strategies.
- The maintenance of additional funding to increase Social Work capacity in RRR Team.
- Continued work with Kingston hospital building on recommendations from ECIP visit especially the correct application of the choice protocol.
- ‘Better at Home’ initiative/ (Discharge to Assess) to be rolled out at KHFT. This scheme is led by the community provider in Kingston (YourHealthcare) and includes a joint effort with Richmond Community provider (HRCH), the acute hospital (KHFT) both CCGs and local authorities (Kingston and Richmond) –Implementation of Red Bag Scheme - the scheme has already been launched on 31.05.2017 and is monitored via the OBC programme.
- Exploring how Trusted Assessor Model can be extended beyond RRRT. – this will become embedded in the new clinical pathways provided by the Better at Home /Discharge to Assess initiative.
- Further development of process to validate delays and resolve discrepancies and disputes – further work needs to be undertaken with regards to the CHC and neuro rehabilitation delays.
- Implementation of the internal escalation process for DTOC - this will be undertaken by the DTOC Operational Group with oversight from the Strategic Partnership Board and BCF Delivery Group.
- Working with care homes to speed up length of time taken to assess clients on wards to avoid delays – specific work with regards to the discharge process during the weekend needs to be undertaken to minimise the length of stay in hospitals and reduce the DTOC targets.
- Continue with existing actions to support further reduction in Mental Health DTOCs which includes joint meetings to support and plan for discharge, improved crisis services to prevent admission and facilitate discharge and continued community and primary care support.

Other key initiatives include the Discharge to Assess/Better at Home initiative where RCCG, KCCG and both community providers (Hounslow and Richmond Community Healthcare (HRCH) and Your Healthcare (YHC) are working in partnership with Kingston Hospital Foundation Trust to embed new clinical pathways to increase the number of assessments undertaken outside an acute setting. Work is underway on developing pathways from hospital which will address people getting the right care and support in the best setting, and reducing the number of continuing health care assessments that are completed in an acute hospital.
The A&E DB is monitoring closely the DTIoC target via a bespoke Dashboard that includes a wide range of information with regards to the whole system status.
14. Approval and sign off

CCG Governing Body 29 August 2017
Strategic Partnership Group, LBRuT 6 September 2017
Health and Wellbeing Board 15 November 2017

Please refer to Delegated Decision Sheet for details of approval and sign off process.