Age Well in Richmond 2022-2024

South West London Health & Care Partnership

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

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

Objective

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

Outcome

- Increase in opportunities for people to remain connected to others and improve their health and wellbeing
- Reduction in people who feel lonely and socially isolated
- Reduction in non-medical related GP appointments and Accident & Emergency presentations
- Increase in the number of people benefitting from social prescribing
- Increase in the number of carers referred/ accessing social prescribing and CILS Navigation Service

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

Objective

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

Outcome

- Increase in residents supported to live independently & well for as long as they are able
- Increase in older residents who receive 'reablement' support at home
- Increase in number of residents who return to normal place of residence after hospital discharge
- Residents with dementia and their families will have a better health and care experience and receive more support
- Reduction in the number of falls in people aged 65 and over
- Residents are seen by the right clinician/therapist, at the right time and in their usual place of residence
- Extended availability of discharge services in the community with more support available through voluntary sector
- Greater use of digital technology to support people to remain independent in their own home

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

Objective

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

Outcome

- Residents have personalised Health and Social Care services at the end of their life, resulting in improved outcomes and of resident's experience of health and social care systems
- More residents have an Advanced Care Plan
- Urgent care delivered across all care homes
- Care homes are more digitally integrated across health and social care
- Increase in the number of people with palliative and end of care needs identified and included on the palliative care register

Overarching Themes

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

We will encourage people to live physically active and healthy lifestyles to prevent ill-health and improve wellbeing

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