Health and Wellbeing Surrey

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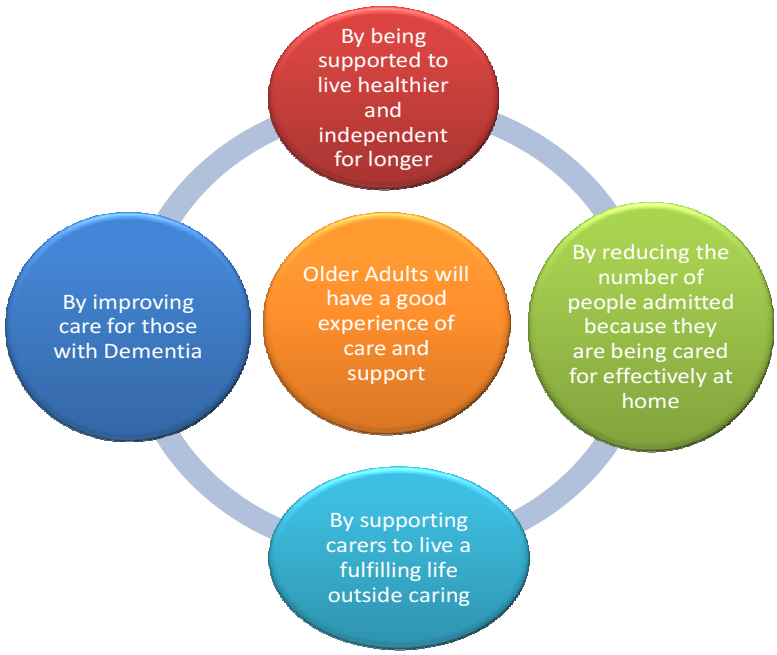
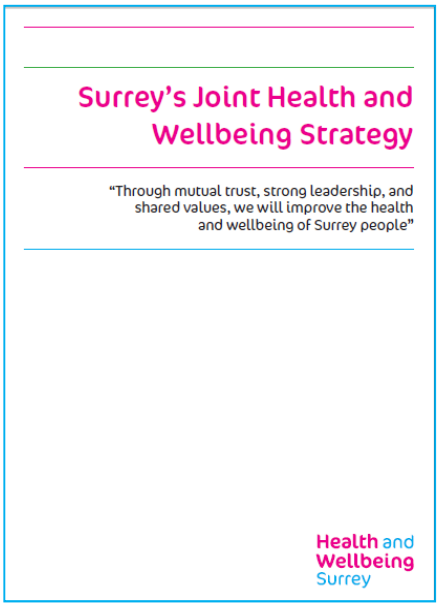
Surrey Health and Wellbeing Strategy: Older Adults Action Plan 2014-2016

Surrey Health and Wellbeing Strategy Older Adult Outcomes



Introduction



Surrey's Joint Health and Wellbeing Strategy, approved in April 2013, sets out five priority areas for Surrey's Health and Wellbeing Board to focus upon - these are:

- Improving children's health and wellbeing
- Developing preventive approach
- Promoting emotional wellbeing and mental health
- Improving older adults' health and wellbeing
- Safeguarding population

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In developing its work programme, and to ensure sufficient focus and time is spent on each priority, the Board decided to tackle each of the five priorities in turn with the aim of translating the high level strategic intentions described in the Strategy into clear sets of actions for the Board and its member organisations to take forward together.

The Board has also agreed a set of cross cutting principles which underpin the Board's work on each of the priority areas:

- Early intervention
- Improved outcomes
- Centred on the person, their families and carers
- Evidenced based
- Opportunities for integration
- Reducing health inequalities

This report provides an update on the work that has been undertaken to develop the Health and Wellbeing Board's action plan for the 'Improving older adults' health and wellbeing' priority – it sets out the rationale for the priority (the evidence base), describes what the work is trying to achieve and also how it will be achieved.

This report should be read in conjunction with Surrey's Better Care Fund report (also being presented to the Health and Wellbeing Board on 3 April 2014) which includes a key focus on integrating services for older adults in Surrey.

The proposed actions and approach described in this report are aligned to the policy and strategic intent already set out in Surrey's six Clinical Commissioning Group Commissioning Strategies and the County Council's Adult Social Care Directorate Strategy.

Background

This joint action plan describes how health and social care commissioners, in partnership with older adults, will support local organisations to improve the lives of older residents in Surrey. Health and social care commissioners[1], both independently and collectively, have an enormous opportunity to radically reshape the way in which care and support is provided to older adults.

This plan has been written at a time when central government is asking health and social care to gather momentum towards 2015/16, when the Better Care Fund[2] will support a fuller integration of health and social care. It will do this by identifying new ways of working and transforming services, to deliver outcomes for the benefit of residents in Surrey. The outcome based approach to commissioning services for older adults' sets out future ways of delivering care in Surrey. This shift means we (the Surrey Health and Wellbeing Board) as commissioners will move away from commissioning purely for a service itself, but a move towards measuring outcomes as defined by the older adult and their carer. As the Better Care Fund encourages us to work closer together, it is therefore an important way of delivering this joint plan.

Why is this action plan needed?

The population aged over 65 and over 85 years old is projected to grow at around the same as the national average. Improvements in health and wellbeing and residents living longer are a cause for celebration. The ageing population also means that Surrey will have a growing proportion of residents with increasing health and social care costs and have conditions that require additional care needs including:

- Dementia and depression
- Visual and hearing impairment
- Long term health conditions as a result of a stroke
- Frailty and being prone to falls and consequent fractures (particularly hip fractures)
- An inability to manage domestic tasks, self-care or move around on their own.
- Social isolation

[1] Health commissioners are known as Clinical Commissioning Groups (CCGs) that replace former Primary Care Trusts and are responsible for delivering NHS services in local areas. There are six CCGs in Surrey. Social care commissioners are Surrey County Council.

[2] The Better Care Fund nationally combines some existing budgets into one health and social care pot. The fund is not additional money; instead it brings together NHS and local government funding that are already committed to services. It will provide an opportunity to improve services and value for money, through a requirement to work closer together than ever before.

Additionally, older adults are more likely to have multiple chronic diseases requiring multiple medications and to be in the later stages of the disease when complications have manifested. Therefore improving end of life care for our population is a priority; ensuring people and their families are able to access the care they need, as well as die with dignity in their preferred setting of care will be a focus of this action plan.

The current consequence of the demographic changes is causing significant financial and service pressures. To respond, health and social care commissioners must redesign services that promote prevention and wellbeing, as well as services that are sustainable and affordable. To meet this challenge, any service redesign needs to be a radical redesign of the delivery and supply of health and social care and support services in our locality.

We also recognise the important role that family, carers, friends and the wider community have in maintaining good health and wellbeing. These can often support older people to maintain an active role in the community, give advice and information and remain independent. Voluntary and faith sector organisations play a key role in supporting older adults in Surrey and we are committed to maximising their contribution.

The evidence - our Joint Strategic Needs Assessment tells us that:

- The number of older people aged 65 and over in Surrey is projected to rise from 181,500 in 2013 to 233,200 in 2020
- It is estimated that the number of people aged 85 and over in Surrey will increase from 32,000 people in 2013 to 46,000 by 2020
- Dementia is a significant issue in Surrey. Around 14,500 people over 65 have a diagnosis of dementia, but this is likely to be an under-estimate
- Although the 65+ population accounted for 17.6% of the county's total population in 2011, people aged 65 or over accounted for almost 41% of all hospital spells in Surrey from 2011 to 2012, and accounted for over 67% of total bed usage
- Around 75,000 people over 65 have a long term health condition, which is projected to rise to 90,000 in 2020
- An estimated 7,770 carers aged 65 and over are providing more than 20 hours of care every week
- People from all ethnic groups are affected by dementia. Across the country the number of people with dementia in minority ethnic groups is around 15,000 but this is set to rise sharply. People from some communities access support services less than people from other communities. This is because of many different reasons, for example language challenges (in many Asian languages there is no word for dementia) or social stigma.

Annex one provides links to a range of evidence sources which have informed the work on this action plan.

Surrey has a rapidly ageing population that requires more joined up out-of-hospital care to enable older adults to stay independent, healthy and well. It is therefore important that we develop an integrated model of health and social care, linked into services such as; mental health, nursing and residential homes and care at home, as well as services provided by borough and district councils, such as Telecare, handyman, care and leisure services.

What are we trying to achieve?

The joint action plan (annex two) summarises what health and social care commissioners have agreed to deliver together. The actions are listed alongside four of the desired outcomes defined in Surrey's Joint Health and Wellbeing Strategy:

- Older adults will stay healthier and independent for longer
- More older adults with dementia will have access to care and support
- Older adults will experience hospital admission only when needed and will be supported to return home as soon as possible
- Older carers will be supported to live a fulfilling life outside caring.

All of the actions will contribute to the achievement of the fifth desired outcome defined in the Strategy – 'Older adults will have a good experience of care and support' and the proposed approach is also aligned to the 'Ageing Well Commitment'[3] (see annex three)

The joint action plan will be delivered from 2014 - 2016 – each action has an identified measure of success and it is proposed that progress against each outcome will be reported on 6 monthly basis to the Surrey Health and Wellbeing Board. In addition each of the action plans will be shared via local Older People forums, Patient and Carer Forums and the Ageing Well group. The individual action plans have already been developed within each CCG locality and are being progressed and driven through Locality Better Care commissioning boards.

The first progress report will be made in December 2014.

What will help us make the plan happen?

- Working in partnership:

Health and social care commissioners will work in partnership to support and influence decisions with local planners and housing partnerships to address inequalities. The plan also recognises the essential role that a well planned community infrastructure has in supporting health and wellbeing and sustaining care and support at home through housing adaptations and Disabled Facilities Grants.

In order to achieve the outcomes of this action plan we will have in place some key enabling systems that will help deliver better outcomes for older

[3] The **Surrey Ageing Well Commitment**3 is a public statement of intentions that offers local organisations a set of shared guiding principles and values to help plan and deliver services in conjunction with local people.

people. These will include joint commissioning, better data-sharing, **seven day working** across health and social care services and an **accountable lead professional** for packages of integrated care for older people.

The **personal care plan** is a plan developed with health or social care support that contains information about health, lifestyle, preventative options, social and community support, and options for treatment or care. It addresses a person's personal situation as a whole, recognising that the persons has a range of needs and outcomes, not just medical that will support total health and well-being.

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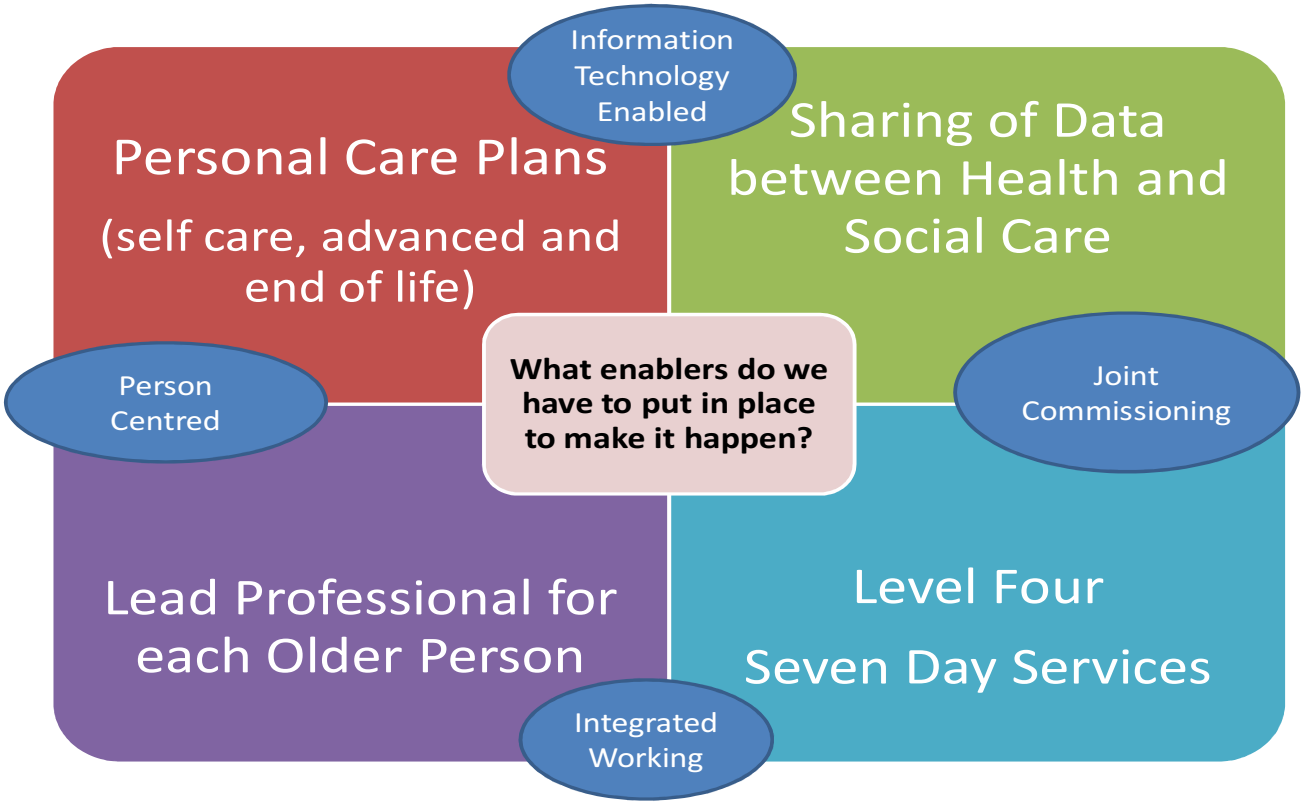
The safe, secure technology to support **sharing of data** in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information, fostering a culture of secure, lawful and appropriate communication to support better care.



As the detailed work on the action plan develops, the lead organisations involved may feel that developing integrated service models will deliver the best outcomes for service users / patients - those organisations will then define the most appropriate model of integration and seek approval from their organisation as appropriate (e.g. through the Clinical Commissioning Group governing bodies, County Council's Cabinet and other partners governance mechanisms).

Annex one: the evidence base

Ageing Well in Surrey
http://www.surreycc.gov.uk/__data/assets/pdf_file/0020/452126/CS2444-Ageing-Well-Commitment_WEB.pdf

Health Checks Implementation and Review
https://www.gov.uk/government/publications/nhs-health-check-implementation-review-and-action-plan

Occupational therapy and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care
http://www.nice.org.uk/nicemedia/pdf/ph16guidance.pdf

Falls Prevention Assessment and Prevention http://guidance.nice.org.uk/CG161

Outpatient Services and Primary Care: A scoping review of research into strategies for improving outpatient effectiveness and efficiency
www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1518-082_V01.pdf

Avoiding Hospital Admissions: Lessons learnt from evidence and experience
http://www.kingsfund.org.uk/publications/articles/avoiding-hospital-admissions-lessons-evidence

Dementia Pathway http://pathways.nice.org.uk/pathways/dementia

Dementia Quality Standards www.guidance.nice.org.uk/QS1

Dementia: Supporting people with dementia and their carers in health and social care
www.nice.org.uk/nicemedia/pdf/cg042niceguideline.pdf

Quality standard for Supporting People to Live with Dementia
http://publications.nice.org.uk/quality-standard-for-supporting-people-to-live-well-with-dementia-qs30

End of Life Care NICE guidelines www.guidance.nice.org.uk/QS13

Transforming Urgent care and emergency services
www.nhs.uk/NHSEngland/keogh-review/.../UECR.Ph1Report.FV.pdf

Equality For All: Delivering Safe Care 7 Days Week
www.improvement.nhs.uk/documents/SevenDayWorking.pdf

Improving General Practice. A Call for Action
www.england.nhs.uk/wp-content/uploads/2013/09/igp-cta-evid.pdf

Support for Carers of Older People
www.audit-commission.gov.uk/.../OlderPeople_5_Report.pdf

Integrated Care Models that work on frail older people
http://www.kingsfund.org.uk/topics/integrated-care

Example – Warwick http://www.hsj.co.uk/resource-centre/best-practice/local-integration-resources/the-principles-behind-integrated-care-for-older-people/5051571.article

Annex two: Improving older adults' health and wellbeing action plan 2014 - 16

Outcome One	**Older Adults will stay healthier and independent for longer**
Why is this a priority?	We plan to reduce incidence of disease which can shorten life or increase disability in later life and support the delivery of primary and secondary prevention measures for those at risk of diabetes, cancer, cardiac and stroke.

Action	North West CCG	Guildford & Waverley CCG	Surrey Heath CCG	Surrey Downs CCG	North East Hampshire & Farnham CCG	East Surrey CCG	Public Health	Adult Social Care	Measure of success	Reporting officer	By when
Increasing the no. of cardiovascular Health Checks completed.	√	√	√	√	√	√	√	√	Increase in uptake of CVD Health Checks	Joanne Alner	June 2015
Increasing the no. of people living with an undiagnosed LTC, receiving a diagnosis and access to treatment.	√	√	√	√	√	√	√	√	Reduce the gap between the expected prevalence and actual no. of those diagnosed with Diabetes, CHD and COPD	Joanne Alner	June 2015
Targeting prevention initiatives (including diet, exercise, smoking and alcohol) at higher risk communities and individuals.	√	√	√	√	√	√	√	√	Reduce premature mortality for at risk groups	Helen Atkinson	June 2015
Increasing the number of people with a self management care plan	√	√	√	√	√	√	√	√	Increase in the no. people who have a self care management plan	Joanne Alner	June 2015
Increase in the use of assistive technology, such as Telecare and Telehealth.	√	√	√	√	√	√	√	√	Increasing no. of people supported to live independently with technology Increase in the no. of people using technology to support self care management	Joanne Alner/ Jean Boddy	March 2015

Outcome Two	**Older adults with dementia will have access to care and support**										
Why is this a priority?	We are aware that with an ageing population, there are more people in Surrey living with dementia, many of whom are currently undiagnosed and therefore unsupported. We are aiming to diagnose dementia earlier and look after people better so they can live with the condition at home for as long as possible.										
Action	**North West Surrey CCG**	**Guildford & Waverley CCG**	**Surrey Heath CCG**	**Surrey Downs CCG**	**North East Hampshire & Farnham CCG**	**East Surrey CCG**	**Public Health**	**Adult Social Care**	**Measure of success**	**Reporting officer**	**By when**
Increasing the number of people who receive an earlier diagnosis of dementia and access to effective treatment and support in conjunction with Adult Social Care and Public Health	√	√	√	√	√	√	√	√	Reduce the gap between the expected prevalence and actual number of those diagnosed with Dementia	Joanne Alner/ Donal Hegarty	June 2015
Increasing support for people in crisis to prevent admission of those people they care for with dementia	√	√	√	√	√	√	√	√	Decrease in emergency admissions to nursing/care homes or hospital due to breakdown of support	Joanne Alner	June 2015
Increasing specialist support for those caring for and with dementia to support earlier discharge from hospital	√	√	√	√	√	√	√	√	Reduction in length of stay and excess bed days	Joanne Alner/ Donal Hegarty	June 2015
Increasing the number of Dementia Navigators and Local Champions – working with Adult Social Care	√	√	√	√	√	√	√	√	Number of people who have accessed a dementia navigator Number of dementia champions	Joanne Alner/ Donal Hegarty	June 2015
Promoting and developing Dementia Friendly Communities	√	√	√	√	√	√	√	√	Project ongoing	Donal Hegarty	June 2015

Outcome Three	**Older adults will experience hospital admission only when they need to access urgent care services and will be supported to return home as soon as possible.**
Why is this a priority?	Accessing urgent care can be confusing and time consuming for all patients, particularly the elderly and frail, as there are many services available and it is not often clear when and where to go. This is resulting in unnecessary admissions to our acute hospitals for conditions that could be managed within the local community.

Action	North West Surrey CCG	Guildford & Waverley CCG	Surrey Heath CCG	Surrey Downs CCG	North East Hampshire & Farnham CCG	East Surrey CCG	Public Health	Adult Social Care	Measure of success	Reporting Officer	By when
Increasing the use of risk stratification tool to identify those most at need and proactively directing services to them	√	√	√	√	√	√	√	√	Increase in the % of people in medium to high risk category receiving care	Joanne Alner	March 2015
Investment in the health and social care workforce, bringing the right values and skills specialised in and dedicated to assessing, treating and supporting the frail elderly	√	√	√	√	√	√	√	√	Reduction in emergency admissions and A&E attendances Reducing excess bed days and LOS.	Ken Akers/ Jean Boddy/ Joanne Alner	June 2015
Health and Social care working together to develop and redesign services to enable older adults to be cared for at home or helping them to return home from hospital soon as possible	√	√	√	√	√	√	√	√	Reduction in emergency admissions and attendances at A&E. Reduction in excess bed days and LOS. Decreasing the number of people requiring a nursing or care home.	Joanne Alner / Jean Boddy	June 2015

Reframing the threshold and use of community beds, including nursing and rest home.	√	√	√	√	√	√	√	√	Reduction in emergency admissions Reduction in excess bed days and LOS	Joanne Alner/ Jean Boddy	June 2015
Increasing the scope and number of older people receiving personal health budgets and direct payments	√	√	√	√	√	√	√	√	Decreasing the number of people requiring a nursing or care home Increasing the number of carers receiving financial support	Joanne Alner/ Jean Boddy	June 2015
Proactively planning for the end of life, for people to die in their chosen place as much as possible.	√	√	√	√	√	√	√	√	Increase in the no. on an electronic register (Palliative Care Co-ordination System). Increase in the no. of people who have an electronic advanced and end of life care plan. Increasing the no. of people who die in their preferred place. Reduction in the number of unscheduled admissions for patients in their last year of life. Increase in no. of nursing homes with GSFCH accreditation.	Joanne Alner /Jean Boddy	June 2015

Outcome Four	**Older Carers will be supported to live a fulfilling life outside caring**
Why is this a priority?	We want to promote caring and support those who do it. We support the Surrey Joint Strategy for Carers, in particular the focus on the older person as a carer. It is important that carers have their own care plans as well as the individuals they are caring for; to support their own physical and mental health needs.

Action	North West Surrey CCG	Guildford & Waverley CCG	Surrey Heath CCG	Surrey Downs CCG	North East Hampshire & Farnham CCG	East Surrey CCG	Public Health	Adult Social Care	Measure of success	Reporting Officer	By when
Increasing the number of carers identified and involving them in care planning for their relative	√	√	√	√	√	√	√	√	Increase the number of carers know to primary and social care Increase the number of carers with a personal care plan	Joanne Alner/ Jean Boddy & John Bangs	March 2015
Increasing involvement of the third sector and voluntary groups in providing respite, support and recreational activity	√	√	√	√	√	√	√	√	Decreases in the number of caring relationships breaking down Increases in the number of carers accessing employment or recreational activity	Joanne Alner/ Jean Boddy	June 2015
Promoting carers to continue caring through the use of personal health budgets and direct payments	√	√	√	√	√	√	√	√	Increasing the numbers of people accessing personal health budgets and direct payments Reduction in the number of nursing and care home placements	Joanne Alner/ Jean Boddy & John Bangs	June 2015
Proactively supporting carers to be physically and mentally healthy	√	√	√	√	√	√	√	√	Increase the number of carers with a personal care plan	Joanne Alner/ Jean Boddy	June 2015
Providing respite breaks for carers	√	√	√	√	√	√	√	√	Increasing the scope of carers who have accessed planned respite and carer breaks	Joanne Alner/ Jean Boddy	June 2015

Annex three - Ageing Well Commitment

The **Surrey Ageing Well Commitment**[4] is a public statement of intentions that offers local organisations a set of shared guiding principles and values to help plan and deliver services in conjunction with local people. It can be used by the wider public in Surrey to raise awareness and be a 'call to action' when individuals face age inequality in the county. The Commitment ensures that across Surrey collectively and individually organisations are working towards the same aims of changing perceptions of getting older and making Surrey a place where people want to live and age well, as well as tackling geographical isolation and barriers that arise due to belonging to an ethnic minority or faith group. This Older Adults Action plan will endorse and promote the same overall outcomes as the Ageing Well Commitment.

1. I/we will ensure that people feel included as full and equal members of the community and are not socially isolated or excluded. That they have opportunities to be involved socially and economically and are able to play an active role in the community if they wish regardless of age, disability, race, religion or belief, sex, sexual orientation or caring responsibilities;
2. I/ we will enable people to get out and about on transport easily;
3. I/we will ensure people know where to access clear advice and information that will help people remain independent and in control of their lives as they age;
4. I/we will ensure people will have access to supportive technology that enables people to live independently in their own homes;
5. I/ we will encourage people to be active, eat well and be informed about how to stay healthier both physically and mentally;
6. I/ we will ensure people will have access to practical help and support available from competent, trustworthy and affordable agencies for activities such as housework, home maintenance, gardening and shopping;
7. I/ we will ensure that people with additional or particular needs are supported flexibly at critical times, for example those older people living with dementia and older people who need assistance after a period of illness and/ or bereavement; Visit Surrey Information Point for more information about **Dementia Friendly Surrey**, how you can be a champion and apply to the Innovation Fund.
8. I/ we will ensure that support is available to people that allows them to feel safe and secure at home and when out in the community;
9. I/we will ensure that people are as aware of relevant allowances such as the attendance allowance or grants to seek to ensure financial stability with as much control as possible over money;
10. I/ we will ensure that carers will have access to timely and accessible support.

[4] http://www.surreycc.gov.uk/__data/assets/pdf_file/0020/452126/CS2444-Ageing-Well-Commitment_WEB.pdf

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