Adult Social Care Select Committee
23 October 2014

Surrey Health and Wellbeing: Older Adults Priority

Purpose of the report: Scrutiny of Services and Budgets/ Policy Development

This report provides an update on the work undertaken to develop the Health and Wellbeing Board's action plan in relation to its priority to "Improving older adults' health and wellbeing". It also outlines the relationship between the action plan and the Better Care Fund.

Introduction:

1. 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 on - these are: improving children's health and wellbeing, developing a preventive approach, promoting emotional wellbeing and mental health, improving older adults' health and wellbeing and safeguarding population.

2. 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.

3. 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, Evidence based, Opportunities for integration and Reducing health inequalities.

4. 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.

5. 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.

7

6. 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.

7. 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 and 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. A summary of the Better Care Fund planning in Surrey to date can be found in Annex 1, which contains slides presented to the Health and Wellbeing Board on 2 October 2014.

Why is this action plan needed?

8. 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 as well as 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.

9. Additionally, older adults are more likely to have multiple chronic diseases requiring numerous medications and to be in the later stages of the disease when complications manifest themselves. 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 and to die with dignity in their preferred setting of care will be a focus of this action plan.

10. 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.

11. We also recognise the important role that family, carers, friends and the wider community have in maintaining good health and wellbeing. These groups 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.

12. 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.

13. 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.

7

What are we trying to achieve?

14. The joint action plan 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.

15. 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].

16. 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 forums for older people, patient and carer forums and the Ageing Well group.

17. The individual action plans have already been developed within each CCG locality and are being progressed and driven through Locality Better Care commissioning boards.

18. The first progress report will be made in December 2014.

[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.

What will help us make the plan happen?

19. Working in partnership:

a) 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.

b) 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 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.

c) 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 they have a range of needs and outcomes not just medical that will support total health and well-being.

d) 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.

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