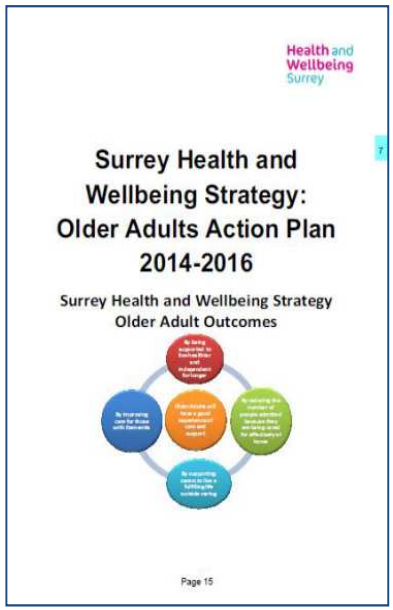
Improving Older Adults Health and Wellbeing



Priority Update December 2014

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Health and Wellbeing Surrey

Performance scorecard

no.	Improving Older Adults Health and Wellbeing Outcomes	RAG Rating
1	Older Adults will stay healthier and independent for longer	Green
2	Older adults with dementia will have access to care and support	Green
3	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	Green
4	Older Carers will be supported to live a fulfilling life outside caring	Green

Key:

Red	Outstanding issues
Amber	Action plan to be implemented to bring on track
Green	On track

Health and Wellbeing Surrey

1. Older Adults will stay Healthier & Independent for Longer

Status: Green

Action	Key achievements	Next steps	By when
Increase the number of cardiovascular health checks completed.	• Over 6,500 NHS health checks delivered so far this year which is a significant increase on last year.	Delivery of action plan for each CCG area. Progress to be reported at the end of the March 2015.	March 2015
Increase the number of people living with an undiagnosed long-term condition receiving a diagnosis & access to treatment.	• North West Surrey CCG has focused on diabetes and COPD. • East Surrey CCG has focused on atrial fibrillation & diabetes. • Surrey Heath CCG has focused on diabetes. • North East Hampshire & Farnham CCG has focused on respiratory health & diabetes • Surrey Downs: COPD and Heart Failure	Delivery of action plan for each CCG area. Progress to be reported at the end of the March 2015.	March 2015
Target prevention initiatives (including diet, exercise, smoking & alcohol) at higher risk communities & individuals.	• Prevention plans developed with each CCG incorporating key initiatives in partnership with district and borough councils. • Continued alignment of Public Health initiatives and support for living and aging well programme	• Pilot Alcohol 'Identification and Brief Advice' to improve identification and support for higher risk drinkers • Develop and renew Public Health Agreements (smoking, health checks etc) • Develop public health offer to friends families and community support. • Review and monitor prevention plans	Jan – Jun 2015 Mar 2015 Apr 2015 Apr 2015

Health and Wellbeing Surrey

1. Older Adults will stay Healthier & Independent for Longer

Status:	Green

Action	Key achievements	Next steps	By when
Increase the number of people with a self management care plan.	All GPs across Surrey have been incentivised to develop self care management plans for their top 2% at high risk of admission patients.	Direct Enhanced Services required this to occur by September 30th. Widen care plans to other cohorts.	Completed 2015/16
Increase the use of assistive technology, such as Telecare & Telehealth by collaborating with borough & district councils.	The use of Telehealth in supporting people with long term conditions continues to grow in Surrey. All of the CCGs are now involved in the programme and there are around 340 people now using Telehealth equipment and being remotely monitored by Medvivo (provider of Telehealth) Specialist Nurses.	Local Joint Commissioning Groups are meeting to review progress to date and agree next steps in terms of roll out of Telehealth. A joint Telecare Commissioning Guidance Strategy has been developed and is currently being reviewed by the Local Joint Commissioning Groups. This will help inform their future delivery and commissioning plans.	March 2015

Key risks

Local Joint Commissioning Groups may decide to not continue investing in telehealth.

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1. Older Adults will stay Healthier & Independent for Longer

Status:	Green

Clinical Commissioning Groups Highlights

North West Surrey

10% more undiagnosed patients with diabetes have been identified though proactive interventions; such as targeting high risk groups such as taxi drivers and attending Mosques.

East Surrey

Developing a virtual directory of current prevention services across the locality

North East Hampshire and Farnham

Developed hydration campaign for residential and nursing homes.
Self-sustaining delivery model in place with 'train the trainer' model in care homes.

Surrey Downs

Bid submitted to Innovation fund to implement screening, diagnosis and post diagnosis patient education a and lifestyle intervention packages for pre-diabetic patients.

Guildford and Waverley

Increasing the number of carers known and registered by GPs and ensuring >30% have their own care plans

Surrey Heath

CCG funding longer consultations for over 75's, health checks for over 75s, support within 24 hours of discharge from hospital, care co-ordinators posts in practices,

Health and Wellbeing Surrey

2. Older adults with dementia will have access to care and support

Status: Green

Action	Key achievements	Next steps	By when
Increase 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.	• All CCGs working to a diagnosis rate of 67% (increased from 54%). • North West Surrey CCG: An Admiral Nurse working with 10 practices to train staff, support diagnosis & work with hard to reach patients. 2 GPs work closely with practices to help the 'dementia clean up exercise', funded via dementia fellowship training. These practices have shown an increase of patients on the dementia register. • Adult social care: actively encouraging people worried about their memory to visit their GP, as part of 'Dementia Friendly Surrey' campaign. Working with Surrey Heath CCG to increase support in the community for people with a diagnosis via a new befriending project. Funding peer support groups through Dementia Friendly Surrey. • East Surrey CG: All GP practices signed up to an enhanced service specification to increase number diagnosed with dementia. Each practice has been set a trajectory. • North East Hampshire and Farnham CCG: Partnership approach in place with a range of agencies to deliver training including the Wessex Medical Council. • Guildford and Waverley CCG and Surrey Downs CCG: working with Surrey and Borders to identify patients in care homes with dementia and to put in place management plans. • Surrey Heath CCG: Additional investment agreed to enhance community mental health practitioners as part of Integrated Care Team & Older Person's consultant psychiatry capacity.	Increase diagnosis rates to 67% Review 'community opportunities' available in each CCG area for older people and people with dementia. Roll out of the training scheme during 2015/16 in primary care including other practice staff.	April 2015 April 2016 April 2016

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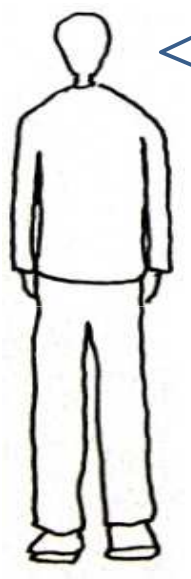
2. Older adults with dementia will have access to care and support

Status: Green

Action	Key achievements	Next steps	By when
Increasing support for people in crisis to prevent admission of those people they care for with dementia.	Health and Social Care Integrated Pathways are in development across all CCGs to support the frail and elderly (including those with dementia) and are reflected through Better Care Fund Programmes.	Implementation of Better Care Fund plans	2014-2016
Increasing specialist support for those caring for and with dementia to support earlier discharge from hospital.	Health and Social Care Integrated Pathways are in development across all CCGs to support the frail and elderly (including carers) and are reflected through Better Care Fund Programmes	Implementation of Better Care Fund plans	2014-2016
Increasing the number of Dementia Navigators and Local Champions – working with Adult Social Care.	The original target was to recruit 120 dementia champions across Surrey. There are 175 individuals and organisations signed up since May 2013. In April 2013 the Dementia Navigators had a total of 840 people in Surrey on their caseload. In April 2014 this figure rose to 1,385 people (65% increase). The figure at September 2014 was 1,219 people being supported (increase of 45% since April 2013).	Identify mechanism for engagement with champions and ensure their enthusiasm for making a difference is channelled constructively.	March 2015
Promoting and developing Dementia Friendly Communities.	**Training:** Over 750 people have attended dementia awareness training including private sector, high street shops as well as public organisations e.g. Police, fire and rescue & health. **Innovation fund:** Funded 15 projects (2 e.g's in case study slide). Dementia Friendly Surrey campaign ran in September. More than 20 public awareness events were attended across the county to raise awareness. Dementia Diaries were sent to all primary and secondary schools in the county and every library.	Develop local approach with borough/district councils & local champions by creating Dementia Action Alliances and Dementia Friendly towns. Re-run Dementia Friendly Communities campaign.	April 2015 January 2015

2. Older adults with dementia will have access to care and support

Status:	Green



Dementia Awareness Training

"the Dementia Awareness Training that I went on last week was really excellent. The combination of listening, watching videos, taking part in quizzes made all the information sink in. I also thought the trainer made everyone feel at ease and had the perfect level of humour/light heartedness to balance with the serious subject matter - everyone seemed to feel comfortable discussing a subject that sadly still has some stigma attached to it.

I'd encourage others to go on this training, I can see how it would help handle situations sensitively with residents/customers I come into contact with."

Key risks

- Dementia Champions not actively engaged
- Sustainability of projects funded through Dementia Friendly Surrey
- Drawing Dementia Navigators away from peer support groups to focus on one to one support and sustaining peer support groups
- CCGs may have difficulty reaching the new 67% target (moved from 54%) due to capacity to deliver within primary care

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2. Older adults with dementia will have access to care and support

Status:	Green

Case studies: Dementia Innovation Fund

Age Concern Epsom and Ewell

In collaboration with The Alzheimer's Society Age Concern have trained and recruited 6 'moment makers' to undertake befriending for people with dementia. Another three are in training at present. It is evident that some of the 90 'regular' befrienders are now visiting clients that have developed early stages of memory problems. Moment Maker Training will be offered to those who now fit in this category so that they are more aware of what it's like to live with dementia.

Mrs G is 56 and has early onset dementia. Moment Maker Lesley visits once a week and they listen to music as Mrs G used to love visiting the opera. Mrs G's husband says that the service has proved invaluable as he still has to work. He has carers visiting daily but like the fact that Lesley is more of a 'friend'. The daughter if Mrs B said: "My mother had her first visit from her "moment maker" today & she is delighted! "

Reading together.....reading aloud

Tandridge Voluntary Service Council received a grant through the Innovation Fund to set up a reading group for people diagnosed with early onset dementia or for those who may be experiencing problems with memory or concentration. The aim was to create a more positive attitude within the local community to people suffering from dementia and to encourage activities that are inclusive and sustainable in the future

"This activity has really brought me out of myself and helped my confidence. I enjoy it so much and often turn down other things to make sure I can be there."

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3. 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

Status: Green

Action	Achievements	Next steps	By when
Increasing the use of risk stratification tool to identify those most at need and proactively directing services to them.	All CCGs have a risk stratification tool in place which directs GPs to review their high risk population and develop care plans for the top 2%. Risk stratification also directs the patients to the caseloads supports by integrated frailty services.	To continue risk stratifying	Complete
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.	Through the Surrey Skills Academy, we are investing in training for the independent sector and supporting care home forums being established in Surrey.	Roll out a programme of good employment practice, including values based recruitment, to domiciliary care agencies which focuses on bringing the right people into the sector.	March 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.	GP Practices are participating in the Avoiding Unplanned Admissions Directed Enhanced Service which requires the development of a management plan with patients aged 75 or over and complex patients Health and Social Care Integrated Pathways are in development across all CCGs to support the frail and elderly and are reflected through Better Care Fund Programmes	Annual programme Implementation of BCF plans	March 2015 2014-2016

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3. 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

Status: Green

Action	Achievements	Next steps	By when
Reframing the threshold and use of community beds, including nursing and rest home.	Health and Social Care Integrated Pathways are in development across all CCGs to support the frail and elderly and are reflected through Better Care Fund Programmes.	Implementation of BCF plans.	2014-2016
Increasing the scope and number of older people receiving personal health budgets and direct payments (DPs).	• People receiving an on-going DP has increased by 23%, of these aprox. 59% are older people • Commissioning support services to help people to use DPs e.g. More info. & advices/reconciliation service/support groups to 'pool' DPs • Personal Health budgets (PHBs) have been available since April 2014, uptake is slow	Further development of the DP market e.g. Range and number of training and workshop sessions for people receiving DPs and potential Pas Systems and processes in place within Continuing Healthcare Team to manage requests from this cohort. Explore (with social care) additional groups where PHB/DPs would be beneficial	April 2015 April 2015 April 2015
Proactively planning for the end of life, for people to die in their chosen place as much as possible.	Health and Social Care Integrated Pathways are in development across all CCGs to support the frail and elderly and are reflected through Better Care Fund Programmes	See case studies	2014-2017

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3. 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

Status: Green

Action	Achievements	Next steps	By when
Proactively planning for the end of life, for people to die in their chosen place as much as possible.	Health and Social Care Integrated Pathways are in development across all CCGs to support the frail and elderly and are reflected through Better Care Fund Programmes. Some CCG area examples include: **East Surrey:** Increasing the numbers of carers accessing Crossroads during End of life care situation. **Guildford and Waverley and Surrey Downs CCG:** Increasing the number of people with advanced directives and that they are included in any electronic record **Surrey Heath:** Raised profile of EOL care with member practices. EOL being the focus of Protected learning time during November meeting. **North West Surrey:** NHS NWS CCG has commissioned a new community end of life care service to provide 24/7 care for people who want to be cared for and die at home. This is a partnership approach co-ordinated by Woking and Sam Beare Hospice as the lead provider and co-ordinator with Princess Alice Hospice, Virgin Care and Marie Curie as partners. **North East Hampshire and Farnham:** Launched the 'Find the 1% Campaign' within the CCG to identify the predicted 1% of the population to die within the next 12 months and implemented Nepali End of Life project.	These are 5 year strategic year plans – with different outcomes expected after one year for each CCG. All, will have something to report after March 2015.	2014-2017

Key risks

Personal Health Budgets uptake is increasing slowly in number due to patient reluctance to move to a new system and upskilling of staff in supporting patients to have more confidence in the new offer. All CCGs are working on reducing admissions and improving services to the frail and elderly in an integrated manner - the risk is that it does not deliver at the rate expected.

Health and Wellbeing Surrey

4. Older Carers will be supported to live a fulfilling life outside caring

Status: Green

Action	Key achievements	Next steps	By when
Increasing the number of carers identified and involving them in care planning for their relative.	Health and Social Care Integrated Pathways are in development across all CCGs to support the frail and elderly (including carers) and are reflected through Better Care Fund Programmes. Key activities includes: • Guildford and Waverley CCG: Proactively working with GP Practices to build their carer registers. • Action for Carers commissioned to undertake a 'GP carer recognition project' that supports & trains primary care to increase awareness of carers' needs & health concerns. As a result more GPs are recognising and supporting carers (in 2013 13,539 carers were registered as part of this project, rising to 16,714 in 2014).	Implementation of BCF plans	2014-2016
Increasing involvement of the third sector and voluntary groups in providing respite, support and recreational activity.	Health and Social Care Integrated Pathways are in development across all CCG areas to support the frail and elderly and the involvement and engagement of voluntary groups are reflected through Better Care Fund Programmes. Key activities includes: • East Surrey CCG: Working with Surrey Action for Carers to support practices to identify carers and provide support. • Surrey Heath CCG working with Surrey County Council to increase understanding of what support is provided to carers locally once on carers register & jointly review if improvement potential exists.	Implementation of BCF plans	2014-2016
Promoting carers to continue caring through the use of personal health budgets and direct payments.	Health and Social Care Integrated Pathways are in development across all CCGs to support the frail and elderly and are reflected through Better Care Fund Programmes.	Implementation of BCF plans	2014-2016

4. Older Carers will be supported to live a fulfilling life outside caring

Status: Green

Action	Key achievements	Next steps	By when
Proactively supporting carers to be physically and mentally healthy.	Health and Social Care Integrated Pathways are in development across all CCGs to support the frail and elderly (including carers) and are reflected through Better Care Fund Programmes. Key activity includes: • North East Hants and Farnham: Developing training and increasing uptake of services offered by local carers groups. • Surrey Downs CCG: Developing care plans for carers and the individuals they are caring for. Supporting carers own health needs to ensure that they remain healthy both mentally and physically.	Implementation of BCF plans	2014-2016
Providing respite breaks for carers.	All GPs in Surrey are able to offer respite break to their patients who are carers. North West Surrey CCG: Commissioned a respite service to care for dementia patients at home in an emergency when their carer is unwell or admitted to hospital. Crossroads Care Surrey provides respite breaks to support carers and is jointly funded by health and social care.	On-going	March 2014

Key risks
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