Improving Older Adults Health and Wellbeing

Priority Update 2014/15 Review

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Health and Wellbeing Surrey

Index of Update Reports by Locality Joint Commissioning Group.

Page Numbers	Locality	Overall self assessment RAG rating
3-14	Guildford and Waverley Locality Joint Commissioning Group	Amber
15-25	North East Hampshire and Farnham Clinical Commissioning Group	Green
26-36	North West Surrey Clinical Commissioning Group	Amber /Green
47-47	Surrey Downs Clinical Commissioning Group	Amber
48-59	Surrey Heath Clinical Commissioning Group	Green
60-71	East Surrey Clinical Commissioning Group	Amber/Green

Slide 1 (Guildford & Waverley)

SURREY

Guildford and Waverley: Improving Older Adults Health and Wellbeing

Priority Update
2014/15 Review

Health and Wellbeing Surrey

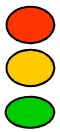
Slide 2 (Guildford & Waverley)

Priority 1: Older Adults will stay Healthier & Independent for Longer

Action	Achievements	Next steps
Increasing the no. of people living with an undiagnosed LTC, receiving a diagnosis and access to treatment.	• Integrated Respiratory Service reducing number of entry points for patient with long term respiratory conditions. • Increase the number of NHS Health Checks offered and delivered by Practices • Identify the prevalence gap for individual practices across common long term conditions and work with practices to reduce those gaps, as well as continuing to work with practices to improve the early diagnosis of cancer	• Developing direct access diagnostic services, ensuring that all patient seeing a consultant for the first time have the appropriate diagnostic tests and results available. • Support the promotion of campaigns that promote the early awareness and detection of long term conditions including Cancers, Hypertension and Diabetes, such as the national Be Clear on Cancer campaigns. • Increase the promotion of public health messages to support lifestyle change in the overall prevention of onset and continued development of disease. • Using available data, identify where management of long-term conditions appears to be suboptimal and work with practices to improve management.
Targeting prevention initiatives (including diet, exercise, smoking and alcohol) at higher risk communities and individuals.	Guildford and Waverley have commissioned an Acute Specialist Alcohol Liaison Nurse based in A&E RSCH and working to identify patients who have long term health needs. Have produced pilot small area predictive analytics to identify where older people likely to be suffering from social isolation, mobility issues, poorer housing, disabilities and riskier health behaviours to ensure that programmes and projects provided by Boroughs and voluntary sector to keep older people healthy and independent are focussed in areas of greatest need. Healthy Living project– working to improving physical activity (e.g. walking football, dementia sensory gardens) Health checks delivered by GPs and pharmacy up to Q4 14/15. Guildford and Waverley 2996 Total delivered in Surrey 14691, Six fold increase on 13/14	• Develop an integrated care pathway for people (including children and young people) who need support in tackling alcohol problems so that patients experience seamless care and healthcare professionals know where to refer patients depending on their need • Ensure early identification of alcohol misuse through programmes including NHS Health Checks and the use of the AUDIT-C screening tool. • Consider the commissioning of a physical activity care pathway or supporting the establishment of Green Prescription programme with links to pathways for mental health, cardiovascular disease, cancers and weight management. • Identify adults who are inactive using the GPAQ (early identification tool) and through initiatives such as NHS Health Checks. • Work with local practices to deliver brief advice for physical activity and encourage sign posting to local exercise referral programmes and wider physical activity opportunities particularly for older adults.
Increasing 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. The Frailty service is required to risk stratify the top 5% of their population and work to wrap integrated care around frail older individuals in the community.	My Care, My Choice has a full programme plan and is working toward piloting the locality based proactive care team in the Central Guildford Locality by July 2015. Totally health commissioned to provide telephone coaching for patients with COPD to maintain medication compliance and healthy lifestyles
Increase in the use of assistive technology, such as Telecare and Telehealth by collaborating with borough and district councils.	Through the Dementia Partnership board we have drafted a specification for a county wide dementia friendly towns project and will be inviting providers to quote on the basis of the outcomes identified through co-design. This includes discussions about how we can get mutual benefits for other vulnerable groups such as people with learning disabilities and mental health needs whilst recognising that this grant originated from the Prime Minister's Dementia Challenge.	To work with the Dementia Friendly Surrey provider to promote and identiify local communities to adopt the status.

Guildford and Waverley CCG Performance Scorecard

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



Key:

Red	No action has been taken
Amber	Achievement is not as planned
Green	Achievement as expected

Health and Wellbeing Surrey

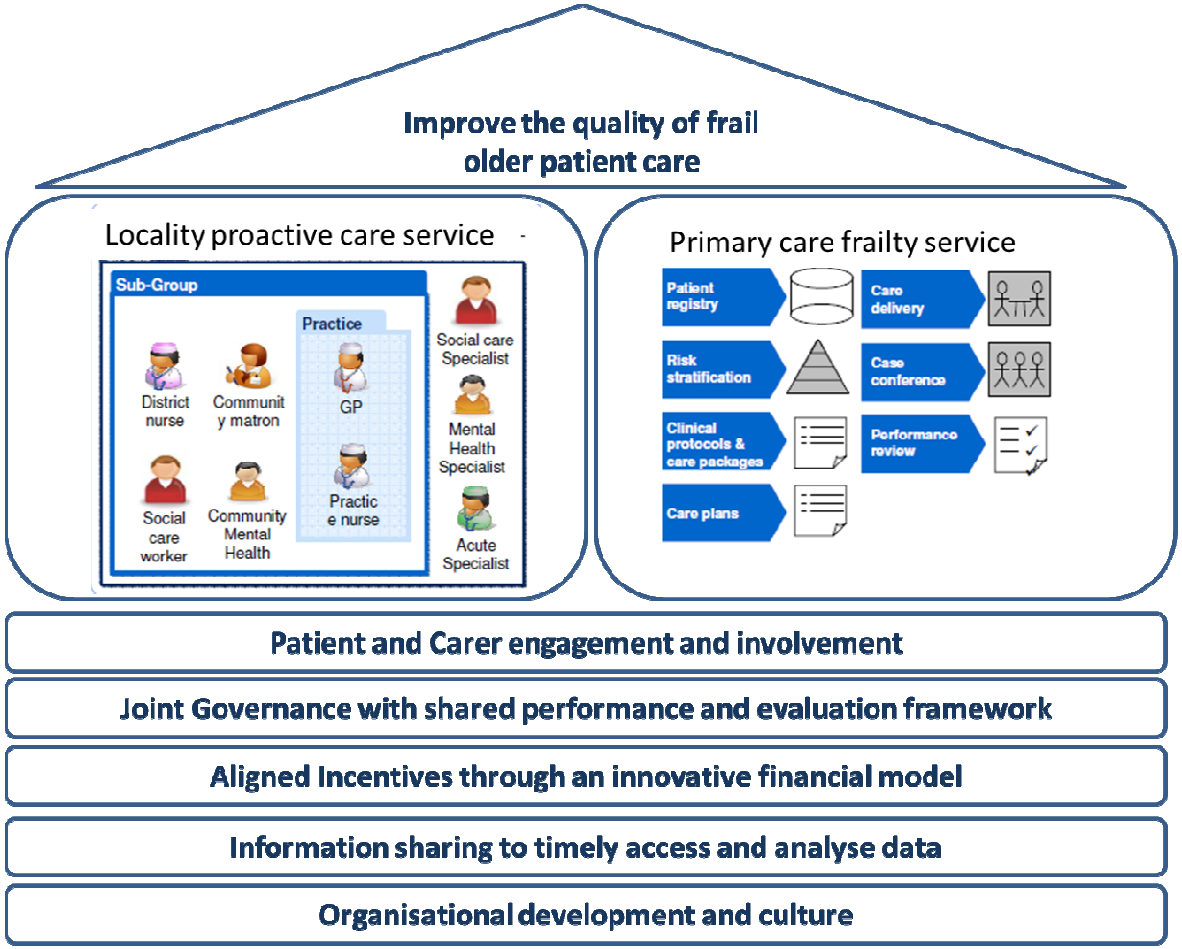
Priority 1: Older Adults will stay Healthier & Independent for Longer

Assessment of 2014/15 Performance: Green

- In general the population of Guildford and Waverley is healthy and affluent.
- GP practice profiles report male life expectancy at 81 years and 84.8 for females in Guildford and Waverley CCG compared with 78.3 and 82.3 for England respectively for the period 2006-2010
- Westborough (which is a Surrey priority place), Stoke and Godalming Central and Ockford and those areas where life expectancy is significantly lower than Surrey or where life expectancy has fallen over the last 10 years28, and the prevalence of risk factors e.g. smoking remain higher than the local and national average
- Between now and 2020 the over 65 population is projected to rise from 17.2% to 18.5% of the total population. The Guildford and Waverley CCG over 65 population is projected to grow less steeply than this, but the proportion of people over 65 will be 19.7% by 2020
- G&WCCG Prevention Plan will also help to support older people to stay well, active and independent, key outcomes for the local implementation plans for the Better Care Fund and the developing Integrated Care.
- G&WCCG are supporting providers to develop a new service operating model that will result in a multi-disciplinary team to meet the needs of frail older people, working to maxmise independence
- Age UK Integrated Care Programme status – Personal independence coordinators will work with frail older people to support them to regain independence

Slide 5 (Guildford & Waverley)

Guildford & Waverley Locality Model



Slide 6 (Guildford & Waverley)

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

Action	Achievements 2014/15	Next steps 2015/16
Increasing the number of people who receive an earlier diagnosis of dementia and access to effective treatment	During the year, the department of health tasked all CCGs to increase the proportion of people diagnosed with dementia set against the expected prevalence. CCG worked with the GP Practices with the lowest rates of diagnosis. This resulted in an increase from 44.5% in January 2015 to 50% in February 2015. The March data is not yet available but the rate is likely to have increased. However, this rate is not sufficient to achieve the 67% target so the CCG has to deploy more resources to ensure this will happen. Dementia care pathway map on SharePoint to guide patients, carers and GPs to what is available. Carers resource booklet available for carers of patients with dementia – Our plan	G&W CCG expects to achieve 67% by July2015 Improved awareness of dementia across GPs and primary care colleagues.
Increasing support for people in crisis to prevent admission of those people they care for with dementia	• IDT in A&E to divert admissions • In reach GP RSCH working to divert A&E attendances and identify frail older people on wards • Reablement seeking to support patients to remain in their normal place of residence • Age UK independence facilitators • Red Cross building community resilience	The recognition and appropriate dealing of mental health issues will be raised in GP forums and will be maintained.
Increasing specialist support for those caring for and with dementia to support earlier discharge from hospital	Carers working group established, action developed and implementation commenced	Continued implementation of actions
Increasing the number of Dementia Navigators and Local Champions – working with Adult Social Care	One Admiral Nurse is working with the G&W practices to train staff, support with diagnosis and work with hard to reach patients. Dementia Navigators are established in the locality.	Dementia Navigator to be mapped and additional capacity established
Promoting and developing Dementia Friendly Communities	Guildford and Waverley Borough Council implementing action plan to achieve : Through the Dementia Partnership board we have drafted a specification for a county wide dementia friendly towns project and will be inviting providers to quote on the basis of the outcomes identified through co-design. This includes discussions about how we can get mutual benefits for other vulnerable groups such as people with learning disabilities and mental health needs whilst recognising that this grant originated from the Prime Minister's Dementia Challenge.	RSCH have skilled MDT working closely with Surrey County Council and other organisation to create a dementia friendly Surrey.

(Priority 2) Older adults with dementia will have access to care and support

Assessment of 2014/15 Performance: Amber

G&W CCG is establishing a structure that will bring together the stakeholders to work collaboratively to identify people who have been undiagnosed with dementia as demonstrated by the improvements in our local dementia diagnosis rate. Data harmonisation and case finding is being continued supported by the GP registrar.

We have one Admiral Nurse and a GP clinical champion who support the development of services to become dementia friendly and better support patients and their carers.

At the Royal Surrey, we have a skilled multidisciplinary team who aim to improve the care and experience for both patients and carers. We are working alongside Surrey County Council and other statutory and voluntary organisations to create a dementia friendly surrey.

- The Royal Surrey County Hospital (RSCH) has committed to transforming the lives of people living with dementia and their carers by joining the Dementia Action Alliance.
- The RSCH has produced and action plan which identifies key areas where work will be undertaken to improve the care for patients and their carers staying in our hospital
- promote and adopt dementia friendly environments around the Trust, three ward areas have been adapted to improve patient experience for those being cared for dementia, delirium and confusion.
- Through the Dementia Partnership board we have drafted a specification for a county wide dementia friendly towns project and will be inviting providers to quote on the basis of the outcomes identified through co-design. This includes discussions about how we can get mutual benefits for other vulnerable groups such as people with learning disabilities and mental health needs whilst recognising that this grant originated from the Prime Minister's Dementia Challenge.

Slide 8 (Guildford & Waverley)

(Priority 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

Action	Achievements 2014/15	Next steps 2015/16
Increasing the use of risk stratification tool to identify those most at need and proactively directing services to them	GP Practices participated in the Avoiding Unplanned Admissions Directed Enhanced Service which required the development of a personal self management plan with patients aged 75 or over and complex patients GPs have been incentivised to upload an IBIS plan to SECamb. This plan communicates to ambulance crews a patients baseline measurement and allows appropriate clinical action to take place; avoiding unnecessary conveyances to hospital. Number of IBIS plans uploaded have increased from 300 to nearly 3000 in the last two months.	Risk stratification too now embedded in primary care 5000 IBIS care plans to be uploaded, during 2015/16
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 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	NW Surrey CCG has worked collaboratively with all providers(statutory and voluntary) to develop a new "fit for the future" health and social care service. This service aims to proactively support 10,000 vulnerable old and frail people, improving the physical and mental health of their carers. During 2014/15 the model of care has been developed, the required skill set defined and University of Surrey engaged to support workforce development plans and strategies. During 2014/15 we engaged all stakeholders and clinical and social care staff in the development of the model and they have been involved in the development of an integrated single health care record This model was shortlisted for Five Year View Plan MSP Vanguard status	Locality Hubs opened across three localities. Workforce requirements defined and new roles developed and recruited to. Increase in the number of people cared for at home or discharged in a timely manner Single Integrated heath care record available

Slide 9 (Guildford & Waverley)

(Priority 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

Action	Achievements 2014/15	Next steps 2015/16
Reframing the threshold and use of community beds, including nursing and rest home.	A comprehensive review of community capacity was commissioned and published. 20 nursing/social care short term placements were commissioned to be available on a spot purchase basis ;social care funding topped up by health funding. Supporting discharge to assesse approach.	Health and Social Care Integrated Pathways we will be implemented to support the frail and elderly and as reflected through Better Care Fund Programmes Integrated discharge team in place. Closure of 37 beds in Ashford hospital, supported by widening access to Walton community hospital and an increase in health/social care community packages.
Increasing the scope and number of older people receiving personal health budgets and direct payments	Personal Health budgets have been available since April 2014, uptake is slow A nurse-led training function will be created to support Personal Assistants, by following a comprehensive scheme of delegation, to undertake additional training allowing them to provide basic clinical support to the patient	Systems and processes in place within CHC team to manage requests from this cohort
Proactively planning for the end of life, for people to die in their chosen place as much as possible.	NHS NWS CCG commissioned a pilot 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 Bear Hospice as the lead provider with Princess Alice Hospice, Virgin Care and Marie Curie as partners. 249 people received this support during 2014/15 and the service has been commissioned substantively for a further three years.	End of Life Strategy published Commissioning intentions actioned

(Priority 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

Assessment of 2014/15 Performance: Amber

G&WCCG has assessed ourselves as amber as we saw a small rise in the number of people attending and being admitted to RSCH during the 2014/15 winter period. The conversion rate from A&E attendance to admission has also increased over the year making it the highest in Surrey. However, we are working with the RSCH to understand this growth in admissions and we are implementing a Rapid Assessment and Treatment pathway as part of our Emergency Pathway work.

In order to combat the growth in admissions in older adults, G&WCCG has been working with the RSCH to develop an Older Persons Days Assessment Service (OPDAS) to provide a rapid response service for the frail elderly cohort.

A key focus for G&WCCG is the continued work on the Frailty Initiative and it's evolution towards the Integrated Care Partnership (ICP) Localities. In 2014-15, the Frailty Initiative was successful in increasing the number of Care Plans uploaded to the Ambulance Trust's system, IBIS. As a result, conveyance rates to hospital reduced significantly.

Collaborative working across providers continues as G&WCCG develops the ICP model to help promote whole system health and social care provision that is built around the needs of the patient, their family and carers.

Slide 11 (Guildford & Waverley)

(Priority 4) Older Carers will be supported to live a fulfilling life outside caring

Action	G&W Surrey Achievements 2014/15	G&W Surrey Next steps 2015/16
Increasing the number of carers identified and involving them in care planning for their relative	G&WCCG increased the identification of carers in 2014-15 (3,560) when compared to the previous year (3,088). 870 carers were referred into carer support services. The CCG has a carer representative on it's Hospital Implementation Group (HIG), to raise the profile of carers and ensure that carers are involved in the care planning process.	The current work will continue in 15-16 and, in addition, G&WCCG has included a specific carers metrics in the CQUIN with the RSCH requiring the inclusion of carers early in the discharge process. *Adoption, implementation and promotion of both the GP and generic carers prescription mechanism* *Development of a carers risk stratification tool through the Surrey Carers and NHS providers' network*
Increasing involvement of the third sector and voluntary groups in providing respite, support and recreational activity	G&WCCG is has established the Integrated Care Partnership Programme Steering Group where providers and stakeholders work collaboratively to develop a new health and social care integrated service operating model. This service aims to proactively support older frail people and improve the physical and mental health of their carers. G&WCCG have been awarded Age UK Integrated Programme status and will represent the voluntary/third sector in the development of the model.	Localities established and running MDT meeting for patients who are at risk of admission The role of the voluntary and third sector will be clearly defined , commissioned and embedded in the service model Review of voluntary care grants provided by CCG, district and boroughs and SCC. Ensure optimal use of grant funding to deliver support to the old and frail which avoids
Proactively supporting carers to be physically and mentally healthy	The new operating model has been developed we are working with COBIC as a fast follower vanguard area.	To establish the pathway for assessing carers and development of support plans.
Providing respite breaks for carers	Crossroad delivered 14,119 hours of care for carers in G&WCCG and 2,280 hours of respite for carers of end of life patients.	Continue provision of respite care and record greater detail of patient ages i.e. 65+ and 85+.

(Priority 4) Older Carers will be supported to live a fulfilling life outside caring

Assessment of 2014/15 Performance: Amber

G&W CCG has self assessed our position as amber as we are currently at the beginning of the service transformation and have a significant way to go to demonstrate that carers are being supported to live a fulfilling life.

The new health and social care operating model we are developing will support older frail people in G&W CCG, seeking to improve the physical and mental health of their carers.

We will work with Age UK to establish how Personal Independence Coordinators will be able to support carers.

Slide 1 (North East Hants & Farnham)

SURREY

North East Hants & Farnham: Improving Older Adults Health and Wellbeing

Priority Update
2014/15 Review

Health and Wellbeing Surrey

NHS North Hants and Farnham CCG Performance Scorecard

	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

Slide 3 (North East Hants & Farnham)

(1) Older Adults will stay Healthier & Independent for Longer

Action	North East Hampshire & Farnham Achievements	Next steps
Increasing the number of cardiovascular Health Checks completed.	Health checks delivered by GPs and pharmacy up to Q4 14/15 North East Hampshire & Farnham 722 (Farnham only) Total delivered in Surrey 14691 Six fold increase on 13/14	
Increasing the no. of people living with an undiagnosed LTC, receiving a diagnosis and access to treatment.	North East Hants and Farnham CCG– focussed on increasing the prevalence of COPD with projects in GP practices and community pharmacy to identify people. Also NE Hants and Farnham have commissioned its IAPT service to develop a CQUIN project on long term conditions in 15/16	NEH F CCG will be looking at practice variation in these key areas and extending to atrial fibrillation and hypertension
Targeting prevention initiatives (including diet, exercise, smoking and alcohol) at higher risk communities and individuals.	During 14/15 NEH F CCG introduced a project in partnership with public health alcohol support services in both Hampshire and Surrey to identify people attending A&E with alcohol related needs and provide targeted support	Continue with this project and assess its impact. Prevention is a key work stream of the Vanguard initiative and will encompass Social Prescribing, Healthy Living Pharmacies and support for carers.
Increasing the number of people with a self management care plan	All GPs were incentivised in 14/15 to provide up to date self management plans for all patients on the COPD register. The majority of practices attended training for inhaler technique device to support improved inhaler use.	The Vanguard initiative will take this work forward
Increase in the use of assistive technology, such as Telecare and Telehealth by collaborating with borough and district councils.	The introduction of the use of telehealth was included in the new community respiratory service and will be assessed as part of the overall contract.	The use of assistive technology is being explored within the new models of care as part of the Vanguard workstreams

(1) Older Adults will stay Healthier & Independent for Longer

North Hants and Farnham self assessment: Green

In general the population of the CCG is healthy but there are significant differences in life expectancy across the area due to differences in deprivation. The CCG is committed to addressing these and is working closely with Public Health. The CCG has been chosen as one of the 29 NHS Vanguard sites and prevention is a major workstream within the new models of care going forward.

Specific projects undertaken in 2014/15 include the introduction of a Falls pathway across the wider health system. This has shown early signs if successfully reducing falls and improving recovery for people who have fallen. The hydration and nutrition projects have been very well received particularly in our care homes. We have also introduced a dementia case finding outreach nurse to support care homes and housebound

Slide 5 (North East Hants & Farnham)

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

Action	North East Hampshire & Farnham Achievements	Next steps
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	All CCGs have been tasked to increase the proportion of people diagnosed with dementia to approx. 67% of the expected prevalence by the department of health (increased from 54%) NEHF CCG have delivered a dementia awareness training programme to primary care which is being extended into 15/16. also in our primary care development programme we have developed an LSC to ensure follow up of patients discharged from hospital with a diagnosis of dementia. Have appointed Dementia outreach nurses to work with care homes and community nurses to identify and assess patients thought to have dementia in care homes and housebound Embedding data harmonisation work from 14/15 Dementia ES to ensure correct coding of patients	Continue to increase the proportion of people diagnosed with dementia and support them to access support services
Increasing support for people in crisis to prevent admission of those people they care for with dementia	Development in NEHF CCG through Vanguard of multi agency community hubs with single point of access. Safe haven café available to carers. Agreed to increase capacity of dementia advisor service recurrently. Supporting local Alzheimer's cafes	New models of care through Vanguard
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 older people including carers and are reflected through Better Care Fund Programmes NEHF CCG have invested in the Frimley System Psychiatric liaison service to embed 7 day 9-5 working for the older adults mental health team	New models of care through Vanguard
Increasing the number of Dementia Navigators and Local Champions – working with Adult Social Care	There are nineteen Dementia Navigators split across three regional teams.	Continue
Promoting and developing Dementia Friendly Communities	Through the Dementia Partnership board we have drafted a specification for a county wide dementia friendly towns project and will be inviting providers to quote on the basis of the outcomes identified through co-design. This includes discussions about how we can get mutual benefits for other vulnerable groups such as people with learning disabilities and mental health needs whilst recognising that this grant originated from the Prime Minister's Dementia Challenge.	To identify a community area to pilot Dementia Friendly Communities in Farnham

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

Assessment of North East Hants and Farnham 2014-15: Green

Partnership approach in place with a range of agencies to deliver training including the
Wessex Medical Council. Roll out of the training scheme outlined above during 15/16
in primary care including other practice staff rather than only GPs.

This was rolled out from December 2014. Dementia awareness training programme
extended into 15/16 piloting with support of AHSN a dementia friendly practice programme
The CCG have agreed with HCC to invest in dementia advisor service

The Vanguard programme will develop all the work underway to identify and support people with dementia

Slide 7 (North East Hants & Farnham)

(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

Action	Measure of success	Achievements	Next steps
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	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 services.	
Investment in the health and social care workforce, bringing the right values and skills specialised in and dedicated to assessing, treating and supporting older people		As one of the 29 Vanguard sites, the new models of care will be working with all our partners to deliver integrated services across our population. In Farnham we anticipate commencing the first Multi Disciplinary Integrated Hub by July 2015.	To embed the new models of care and introduce integration hubs across all 5 CCG localities
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.		

Slide 8 (North East Hants & Farnham)

(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

Action	Achievements	Next steps
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 older people and are reflected through Vanguard and Better Care Fund Programmes	Implementation of BCF plans and the Vanguard work programme
Increasing the scope and number of older people receiving personal health budgets and direct payments	Personal Health budgets have been available since April 2014, uptake is slow A nurse-led training function will be created to support Personal Assistants, by following a comprehensive scheme of delegation, to undertake additional training allowing them to provide basic clinical support to the patient resulting in a reduced requirement for external care agency support. This allows the patient to gain more control over their care and independence.	Systems and processes in place within CHC team to manage requests from this cohort Explore (with social care) additional groups where PHB/direct payments would be beneficial
Proactively planning for the end of life, for people to die in their chosen place as much as possible.	End of life strategy was published in early 2014a and there is system wide end of life steering group to support this work 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	Continue

(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

Assessment of North East Hants and Farnham 2014/15 performance: Amber

NEH F CCG saw a significant rise in attendances to Frimley Park A&E and a subsequent increase the number of admissions during the winter period mainly due to respiratory illnesses. Older people were particularly affected by this and there was a significant rise in acuity level on the population. There is a programme of work across our System Resilience Group to try to prevent this happening in the future and to be better prepared for increased pressure on our acute, community and primary care providers.

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

Action	NE Hampshire & Farnham Achievements 2014/15	Next steps 2015/16
Increasing the number of carers identified and involving them in care planning for their relative	Primary care has continued to identify the number of carers, in 2011, 263 carers had been identified, this has increased year on year and in 2015, 616 carers have been identified.	Continue to work with Action for Carers to support primary care on the identification of carers and enabling access to carers support services Work with Primary care and action for Carers to ensure carers are identified and carers prescription activated
Increasing involvement of the third sector and voluntary groups in providing respite, support and recreational activity	The CCG has worked collaboratively with all providers(statutory and voluntary) to develop a new "fit for the future" health and social care service. This service aims to proactively support 10,000 vulnerable older people. improving the physical and mental health of their carers.	Review of voluntary care grants provided by CCG, district and boroughs and SCC. Ensure optimal use of grant funding to deliver support to the older people
Proactively supporting carers to be physically and mentally healthy		Carer Champions have been recruited to support the co-design of the new integrated care services.
Providing respite breaks for carers	79 out of a possible 97 (81%uptake) respite breaks were provided to carers at a cost of £500 each.	Continue with offer, increase uptake to >95%.

(Priority 4) Older Carers will be supported to live a fulfilling life outside caring

Assessment of 2014/15 Performance: Amber

NE Hampshire & Farnham CCG has self assessed amber as we still have some way to go to demonstrate that carers are receiving the level of support we would wish to see as demonstrated by the uptake of carer respite breaks. We would also want to have had a higher uptake of our carer respite break allocation.

We would also want to look at increasing the number of carers prescriptions

North West Surrey: Improving Older Adults Health and Wellbeing

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NW Surrey CCG Performance Scorecard

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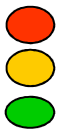

Key:

Red	No action has been taken
Amber	Achievement is not as planned
Green	Achievement as expected

Health and Wellbeing Surrey

Slide 3 (North West Surrey)

Priority 1: Older Adults will stay Healthier & Independent for Longer

Action	Achievements	Next steps
Increasing the number of cardiovascular Health Checks completed.	Health checks delivered by GPs and pharmacy up to Q4 14/15 by CCG: North West Surrey 4759 Surrey Downs 3069 Surrey Heath 1339 East Surrey 1806 Guildford and Waverley 2996 North East Hampshire & Farnham 722 Total delivered 14691 Six fold increase on 13/14	To continue with the momentum of delivery for GP and Pharmacy. Exploring relationships for workplace, borough and district and targeted communities organisations to compliment and build on existing delivery.
Increasing the no. of people living with an undiagnosed LTC, receiving a diagnosis and access to treatment.	NW Surrey priority during 2014/15 was to identify and briefly intervene with those at increased risk of harm due to their alcohol intake . We are waiting confirmation of achievement from the Area team.	We are aiming to identify people undiagnosed with COPD in the 21 GP practices with highest need. Aiming to review 1200 patients to identify 600 undiagnosed patients.
Targeting prevention initiatives (including diet, exercise, smoking and alcohol) at higher risk communities and individuals.	Local prevention plans have been developed with CCGs with key delivery actions around smoking, diet, physical activity and alcohol as well as other local priorities. The full document is embedded here.	Key milestones, metrics and risks will be developed and monitored as delivery is rolled out.
Increasing 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.	Completed 2014/15
Increase in the use of assistive technology, such as Telecare and Telehealth by collaborating with borough and district councils.	North West Surrey remain fully committed to technology supporting the integration agenda and enabling people to remain in their homes. We continue to see a growth in the use of technology.	Establish most effective combinations of technology to deliver best outcomes.

Priority 1: Older Adults will stay Healthier & Independent for Longer

Assessment of 2014/15 Performance: Green

In general the population of NW Surrey is healthy and affluent. Life expectancy is high at 86 and 7months for women and 84 and 4 months for men. However, the last 8-10 years of people's lives will be in ill health and due to the life expectancy increased frailty due to reaching advanced age is to be expected. A local health needs assessment identified that in NW Surrey there are currently an estimated 10,000 people who are considered to be frail, increasing to approximately 11,500 by 2018.

NW Surrey has implemented both prevention strategies to identify those undiagnosed and requiring treatment and support(Dementia, Diabetes and COPD) and developed a new model of service delivery to better support older people with a more proactive approach (Locality Hubs) towards those who are showing early signs or at increased risk of ill health

Slide 5 (North West Surrey)

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

Action	NW Surrey Achievements 2014/15	NW Surrey Next steps 2015/16
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	During the year, the department of health tasked all CCGs to increase the proportion of people diagnosed with dementia set against the expected prevalence. The original target in April 2014 was 54%, this was increased in November to 67%. NW Surrey achieved 63.7% in march 2015 and expects to reach 67% in April 2015	NW Surrey expects to achieve 67% by April 2015
Increasing support for people in crisis to prevent admission of those people they care for with dementia	NW Surrey has commissioned a respite service to care for dementia patients at home in an emergency when their carer is unwell or admitted to hospital. 115 people have been supported in the last 18 months	Evaluate performance against this contract and consider opportunities of widening scope of service.
Increasing specialist support for those caring for and with dementia to support earlier discharge from hospital	ASPHFT was incentivised to screen >90% of all patients who were admitted as an emergency fro delirium or dementia. This was achieved, often 100% of the time A specialist older persons mental health team is funded to support the acute trust staff to support patients	NW Surrey CCG is working collaboratively with providers to develop a health and social care service which aims to proactively support 10,000 vulnerable old and frail people; this includes people with dementia.
Increasing the number of Dementia Navigators and Local Champions – working with Adult Social Care	An Admiral Nurse is working with 10 NW Surrey practices to train staff, support with diagnosis and work with hard to reach patients. Two NWS GPs are working closely with all practices in NW Surrey, funded via the dementia fellowship training. There are nineteen Dementia Navigators split across three regional teams.	Continue
Promoting and developing Dementia Friendly Communities	Through the Dementia Partnership board we have drafted a specification for a county wide dementia friendly towns project and will be inviting providers to quote on the basis of the outcomes identified through co-design. This includes discussions about how we can get mutual benefits for other vulnerable groups such as people with learning disabilities and mental health needs whilst recognising that this grant originated from the Prime Minister's Dementia Challenge.	Identify a local community as an early adopter of DFC.

(Priority 2) Older adults with dementia will have access to care and support

Assessment of 2014/15 Performance: Green

NW Surrey CCG has worked tirelessly to identify those people who have been undiagnosed with dementia as demonstrated by the improvements in our local dementia diagnosis rate in 2014/15; we are proud of our results. We have an Admiral Nurse and two GP clinical champions who support the development of services to become dementia friendly and better support patients and their carers. Our acute hospital has also over achieved on what was expected of them in relation to identifying patients admitted.

Our Locality Hub model of care which will become live during 2015/16 will enhance the support currently offered to patients further.

Slide 7 (North West Surrey)

(Priority 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

Action	NW Surrey Achievements 2014/15	NW Surrey Next steps 2015/16
Increasing the use of risk stratification tool to identify those most at need and proactively directing services to them	GP Practices participated in the Avoiding Unplanned Admissions Directed Enhanced Service which required the development of a personal self management plan with patients aged 75 or over and complex patients GPs have been incentivised to upload an IBIS plan to SECamb. This plan communicates to ambulance crews a patients baseline measurement and allows appropriate clinical action to take place; avoiding unnecessary conveyances to hospital. Number of IBIS plans uploaded have increased from 300 to nearly 2000 in the last two months.	Risk stratification too now embedded in primary care 5000 IBIS care plans to be uploaded, during 2015/16
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 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	NW Surrey CCG has worked collaboratively with all providers(statutory and voluntary) to develop a new "fit for the future" health and social care service. This service aims to proactively support 10,000 vulnerable old and frail people, improving the physical and mental health of their carers. During 2014/15 the model of care has been developed, the required skill set defined and University of Surrey engaged to support workforce development plans and strategies. During 2014/15 we engaged all stakeholders and clinical and social care staff in the development of the model and they have been involved in the development of an integrated single health care record This model was shortlisted for Five Year View Plan MSP Vanguard status	Locality Hubs opened across three localities. Workforce requirements defined and new roles developed and recruited to. Increase in the number of people cared for at home or discharged in a timely manner Single Integrated heath care record available

Slide 8 (North West Surrey)

(Priority 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

Action	NW Surrey Achievements 2014/15	NW Surrey Next steps 2015/16
Reframing the threshold and use of community beds, including nursing and rest home.	A comprehensive review of community capacity was commissioned and published. 20 nursing/social care short term placements were commissioned to be available on a spot purchase basis ;social care funding topped up by health funding. Supporting discharge to assesse approach.	Health and Social Care Integrated Pathways we will be implemented to support the frail and elderly and as reflected through Better Care Fund Programmes Integrated discharge team in place. Closure of 37 beds in Ashford hospital, supported by widening access to Walton community hospital and an increase in health/social care community packages.
Increasing the scope and number of older people receiving personal health budgets and direct payments	Personal Health budgets have been available since April 2014, uptake is slow A nurse-led training function will be created to support Personal Assistants, by following a comprehensive scheme of delegation, to undertake additional training allowing them to provide basic clinical support to the patient	Systems and processes in place within CHC team to manage requests from this cohort
Proactively planning for the end of life, for people to die in their chosen place as much as possible.	NHS NWS CCG commissioned a pilot 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 Bear Hospice as the lead provider with Princess Alice Hospice, Virgin Care and Marie Curie as partners. 249 people received this support during 2014/15 and the service has been commissioned substantively for a further three years.	End of Life Strategy published Commissioning intentions actioned

(Priority 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

Assessment of 2014/15 Performance: Amber

NW Surrey has self assessed ourselves as amber as we saw a significant rise in the number of people attending and being admitted to ASPHFT during the 2014/15 winter period, 26% more people over the age of 75 years old were admitted during December 2014 when compared to 2013.

This created an unprecedented situation in the NW Surrey system and in terms of escalation was considered to be beyond black. Reasons for this increase in acuity level of our population are being explored: loss of effectiveness of the flu vaccine and potentially increases in winter excess death at a population level are being considered possible causes.

To ensure we are fit for the future, NW Surrey CCG has been working collaboratively with all providers(statutory and voluntary) to develop a new health and social care service for the older and frail person (Locality Hubs); but we are not where we would have hoped by the end of 2014/15, mainly due to estate issues.

Significant levels of engagement and work have been undertaken to ensure that the model can be delivered during 2015/16 and actions to improve communication between providers have been incentivised.

Slide 10 (North West Surrey)

(Priority 4) Older Carers will be supported to live a fulfilling life outside caring

Action	NW Surrey Achievements 2014/15	NW Surrey Next steps 2015/16
Increasing the number of carers identified and involving them in care planning for their relative	Developing GP and generic carers precription mechanism NW Surrey CCG has a carers population of 31,965 of which 19.4% are over the age of 65. Further analysis evidences that there are 596 carers over the age of 85 years. Approx 8% of these older carers are caring for over 50 hrs a week. NW Surrey CCG increased the number of carers registered with their GP to 6,902 compared to 5,190 in the previous year. 1,302 Older carers were supported by local Carers Support Services and estimated 212 received a GP Carers break.	Adoption, implementation and promotion of both the GP and generic carers prescription mechanism Development of a carers risk stratification tool through the Surrey Carers and NHS providers' network Current joint carers work will be continued with an emphasis on a whole systems approach to identifying and supporting carers. Adoption, implementation and promotion of both the GP and generic carers prescription mechanism Development of a carers risk stratification tool through the Surrey Carers and NHS providers' network
Increasing involvement of the third sector and voluntary groups in providing respite, support and recreational activity	NW Surrey CCG has worked collaboratively with all providers(statutory and voluntary) to develop a new "fit for the future" health and social care service. This service aims to proactively support 10,000 vulnerable old and frail people. improving the physical and mental health of their carers. During 2014/15 we engaged the voluntary/third sector in the development of the model . We worked collaboratively with Age Concern UK to define a distinct care coordinator role to support the patient access and receive support and treatment.	Locality Hubs opened across three localities, The role of the voluntary and third sector will be clearly defined , commissioned and embedded in the service model Review of voluntary care grants provided by CCG, district and boroughs and SCC. Ensure optimal use of grant funding to deliver support to the old and frail which avoids
Proactively supporting carers to be physically and mentally healthy	During 2014/15 the model of care has been developed, locations of delivery identified and an integrated health care record is in development. Shortlisted for Vanguard status This model was shortlisted for Five Year View Plan MSP Vanguard status	Carers care plans developed for all carers of patients on the Locality Hub caseload.
Providing respite breaks for carers	607 out of a possible 726 (84%uptake) respite breaks were provided to carers at a cost of £500 each.	Continue with offer, increase uptake to >95%.

(Priority 4) Older Carers will be supported to live a fulfilling life outside caring

Assessment of 2014/15 Performance: Amber

NW Surrey CCG has self assessed amber as we still have some way to go to demonstrate that carers are receiving the level of support we would wish to see as demonstrated by the number of carer care plans developed and the uptake of carer respite breaks. The new health and social care service (Locality Hub) we are developing will proactively support 10,000 vulnerable old and frail people in NW Surrey, aiming to equally improve the physical and mental health of their carers. This service is in the process of being developed and we have made significant strides towards full implementation. But we are not where we would have hoped by the end of 2014/15 mainly due to estate issues. We would also want to have had a higher uptake of our carer respite break allocation

Surrey Downs: Improving Older Adults Health and Wellbeing

Priority Update
2014/15 Review

Health and Wellbeing Surrey

Surrey Downs CCG Performance Scorecard

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

Key:

Red	No action has been taken
Amber	Achievement is not as planned
Green	Achievement as expected

Health and Wellbeing Surrey

Slide 3 (Surrey Downs)

Priority 1: Older Adults will stay Healthier & Independent for Longer

Action	Surrey Downs CCG Achievements	Next steps
Increasing the number of cardiovascular Health Checks completed.	Health checks delivered by GPs and pharmacy up to Q4 14/15 Surrey Downs 3069 Total delivered in Surrey 14691, Six fold increase on 13/14	
Increasing the no. of people living with an undiagnosed LTC, receiving a diagnosis and access to treatment.	Surrey Downs has been working with local providers to improve the diagnosis of and service to those who have COPD. There is currently a small respiratory nursing service and since beginning this work it is clear that there would be a patient benefit in redesigning the respiratory pathways. SDCCG has begun this work with the asthma pathway.	The redesign of the respiratory pathways has begun and will be completed by the end of the year.
Targeting prevention initiatives (including diet, exercise, smoking and alcohol) at higher risk communities and individuals.	Surrey Downs CCG has a multi agency Partnership Board co-chaired by the CCG and SCC, including membership from all the local Boroughs, Public Health and the Voluntary Sector. The aim of the group is to pull together and codesign all preventative initiatives. SDCCG recognises that it has a population at increased risk of social isolation and liver related illness. The PB are currently developing responses to this need.	Implement jointly agreed prevention plan.
Increasing 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.	Completed 2014/15
Increase in the use of assistive technology, such as Telecare and Telehealth by collaborating with borough and district councils.	On going promotion through Local Joint Commissioning Group of the Telecare agenda – date returns from borough councils are combined with another CCG area – details provided at end of the report	Review of effective models and telecare bundles : Continuing to explore best models for "Call for back up" initiatives

Priority 1: Older Adults will stay Healthier & Independent for Longer

Assessment of 2014/15 Performance: Green

The Surrey Downs CCG population profile is weighted towards the older adult population. Whilst overall the area covered by SDCCG is one of the least deprived in the country, there are pockets of deprivation in Court, Cobham Fairmile, Holmwood, Preston and Ruxley and in these areas there are some particular challenges around smoking and obesity. Life expectancy is higher than the national average but in the more deprived areas, life expectancy is falling. This is why the emphasis of the Surrey Downs Partnership Board has focussed on those aspects of intervention.

By 2020 the Surrey Downs over 65's population is projected to be 21% of the overall population. There is, therefore, an increased likelihood of dementia amongst the SDCCG population.SDCCG has implemented its early diagnosis of dementia project and is now currently ensuring that the GP's have access to the diagnosis information for their patients. The next phase will be to ensure that advice and support relating to dementia will be readily available in and delivered by the CMSP.

Slide 5 (Surrey Downs)

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

Action	Surrey Downs CCG Achievements 2014/15	Surrey Downs Next steps 2015/16
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	During the year, the department of health tasked all CCGs to increase the proportion of people diagnosed with dementia set against the expected prevalence. The original target in April 2014 was 54%, this was increased in November to 67%. Surrey Downs CCG achieved 56.95% in March 2015 and expects to reach 67% in June 2015. Surrey Downs has identified a number of blocks to practice identification e.g. confidence in diagnosis at practice level, non-standardisation of discharge letters with appropriate codes	Surrey Downs expects to achieve 67% by April 2015 through GP Lead support provided to those practices who failed to code, or identify patients
Increasing support for people in crisis to prevent admission of those people they care for with dementia	Surrey Downs is assessing national and local best practice to enable 'dementia friendly' practices to provide additional management and crisis care for dementia patients preventing the need for crisis admissions	Project scoping to be completed and pathways developed and implemented by January 2015
Increasing specialist support for those caring for and with dementia to support earlier discharge from hospital	Surrey Downs is working with its main provider to examine current discharge processes, the CCG is reviewing referral pathways, up-skilling GPs in diagnosis thereby reducing the necessity for acute diagnosis. The CCG is implementing the 'dementia friendly' practice approach across its 3 hubs.	Surrey Downs CCG is working collaboratively with providers to develop work on dementia, the Frail & Elderly and EoLC
Increasing the number of Dementia Navigators and Local Champions – working with Adult Social Care	There are dementia navigators working across Surrey Downs CCG, they are linked into the Health & Wellbeing Board via Surrey County Council	Dementia Navigators are to be included in the work around 'dementia friendly' practices and EoLC
Promoting and developing Dementia Friendly Communities	Through the Dementia Partnership board we have drafted a specification for a county wide dementia friendly towns project and will be inviting providers to quote on the basis of the outcomes identified through co-design. This includes discussions about how we can get mutual benefits for other vulnerable groups such as people with learning disabilities and mental health needs whilst recognising that this grant originated from the Prime Minister's Dementia Challenge.	Progress to identify communities in NW to adopt the Status of Dementia Friendly

(Priority 2) Older adults with dementia will have access to care and support

Assessment of 2014/15 Performance: Amber

Surrey Downs CCG has been working to identify those people who have been undiagnosed with dementia as demonstrated by the improvements in our local dementia diagnosis rate in 2014/15; however we have more to do. We have an excellent working relationship with our main provider and are ensuring integration across Frail & Elderly and End of Life Care Projects in order to better support patients and their carers.

Our CMSP model of care with trained 'dementia friendly' diagnosis and support, will become live from July 2015/16 further enhancing the support currently offered to patients.

Slide 7 (Surrey Downs)

(Priority 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

Action	Surrey Downs CCG Achievements 2014/15	Surrey Downs CCG Next steps 2015/16
Increasing the use of risk stratification tool to identify those most at need and proactively directing services to them	GP Practices participated in the Avoiding Unplanned Admissions Directed Enhanced Service which required the development of a personal self management plan with patients aged 75 or over and complex patients SDCCG have utilised the data from the risk stratification tool in order to scope the commissioning of the new CMT/CMSP which begins as of 1/7/15.	Risk stratification tool is now embedded in primary care
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 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	Surrey Downs CCG has co-produced the new integrated service model with its SCC partners, Community and Acute health providers and GP's. Service specifications role and job descriptions and a workforce plan has been developed with partners. An Integration Workshop was held in December 2014 for all partners. This model was shortlisted for Five Year View Plan MSP Vanguard status	To go live with the CMT as of 1/7/15 and to have an incremental go live from 1/7 for the CMSP's. There will be 3 locality teams. Single Integrated health and social care record feasibility will be reviewed during 2015 and early solutions facilitated.

Slide 8 (Surrey Downs)

(Priority 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

Action	Surrey Downs CCG Achievements 2014/15	Surrey Downs CCG Next steps 2015/16
Reframing the threshold and use of community beds, including nursing and rest home.	A comprehensive review of SDCCG commissioned Community Hospital services has been launched. Several public engagement meetings have been held and the review will incorporate defining capacity requirements, patient acuity, patient journey and experience, new 'step up' requirements. The review will end in July 2015 after which there will be recommendations proposed. Through the winter period a number of beds were spot purchased to enable people to be discharged from acute's and have a short stay period of recuperation in local nursing homes.	The outcome report from the review will be published. Recommendations made, actions agreed and implementation plan developed. Patients will be supported by both the CMT/CMSP's and a new model of community hospital, in order to prevent acute admissions and thereby improve patient experience and outcomes.
Increasing the scope and number of older people receiving personal health budgets and direct payments	Personal Health budgets have been available since April 2014, uptake is slow	Systems and processes in place within CHC team to manage requests from this cohort
Proactively planning for the end of life, for people to die in their chosen place as much as possible.	Surrey Downs CCG has developed a new End of Life Care Strategy which will be launched at the end of June. The action plan has number of multi-agency actions.	End of Life Strategy published Action Plan delivered and overseen by the Steering Group. Commissioning intentions actioned

(Priority 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

Assessment of 2014/15 Performance: Amber

Surrey Downs, along with most other CCG's experienced some significant challenges to acute admissions over the 2014 winter period. The CMT's and CMSP's are not scheduled to go live until July and will grow through the year. As such, the benefits realisation against non-elective admissions and supporting people to remain at home, will take time to embed. Due to these challenges, Surrey Downs CCG rates its progress as amber.

In addition there are a number of challenges pertaining to the suitability of estate options for the CMT/CMSP teams as well as the effectiveness, or otherwise, of the IT interoperability products on the market currently.

Slide 10 (Surrey Downs)

(Priority 4) Older Carers will be supported to live a fulfilling life outside caring

Action	Surrey Downs CCG Achievements 2014/15	Surrey Downs CCG Next steps 2015/16
Increasing the number of carers identified and involving them in care planning for their relative	SD CC has a carers population of 27,795 of which 14.5% are over the age of 65. Further analysis evidences there are 594 carers over the age of 85 years. Approximately 2% of these carers are caring for over 50 hours a week. SDCCG increased the number of carers registered with their GP to 4,319 compared to 3,984 in the previous year. 960 Older carers were supported by local Carers Support Services and an estimated 167 received a GP Carers Break. SD CCG GPs made 217 Carers Prescriptions representing 40.49% of the global Surrey referrals leading to 522 carers services provided. CSH Surrey piloted the Carers Prescription referring 76 Carers.	*Adoption, implementation and promotion of both the GP and generic carers prescription mechanism* *Development of a carers risk stratification tool through the Surrey Carers and NHS providers' network* Current joint carers work will be continued with an emphasis on a whole systems approach to identifying and supporting carers. Maintain lead position on Carers Prescription and roll out to other NHS providers. Development of a carers risk stratification tool through the Surrey Carers and NHS providers' network
Increasing involvement of the third sector and voluntary groups in providing respite, support and recreational activity	Surrey Downs CCG has reviewed its full range of voluntary sector services and has developed enhancements for several third sector options. These will be integrated into the CMSP model. The aim is to decrease the sense of social isolation amongst older carers in Surrey Downs.	Locality Hubs opened across three localities, The role of the voluntary and third sector will be clearly defined , commissioned and embedded in the service model Review of voluntary care grants provided by CCG, district and boroughs and SCC. Ensure optimal use of grant funding to deliver support to the old and frail.
Proactively supporting carers to be physically and mentally healthy		Carers needs will be assessed and planned for as part of the CMSP model.
Providing respite breaks for carers	There was excellent uptake in Surrey Downs for Carers Breaks this year.	Continue with offer, increase uptake.

(Priority 4) Older Carers will be supported to live a fulfilling life outside caring

Assessment of 2014/15 Performance: Amber

Surrey Downs CCG recognises that there are a number of our citizens who are both older and isolated in their caring role. It is anticipated that through both the delivery of the CMSP model, offering an increased level of integrated support and the SD Partnership Board projects, this situation will significantly improve.

It is still, however, very early days for both programmes of work and as such SDCCG cannot report its performance as green yet but hopes to be by the end of the year.

Slide 1 (Surrey Heath)

SURREY

NHS
Surrey Heath
Clinical Commissioning Group

Surrey Heath:
Improving Older Adults Health and Wellbeing

Priority Update from SH Local Joint Commissioning Group
2014/15 Review

Health and Wellbeing Surrey

Surrey Heath CCG Performance Scorecard

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

Key:

Red	No action has been taken
Amber	Achievement is not as planned
Green	Achievement as expected

Health and Wellbeing Surrey

Slide 3 (Surrey Heath)

Priority 1: Older Adults will stay Healthier & Independent for Longer

Action	SH Achievements	SH Next steps
Increasing the number of NHS Health Checks completed.	At the end of quarter 3, 2014-15, GPs and Pharmacists within Surrey Heath had delivered 731 NHS Health Checks to patients (under 75) within Surrey Heath. This is more than three times the number delivered in the previous year. New for 14/15: SH GPs providing Health Checks for 75+ patients as part of local CCG initiative. Used to inform action below.	Identify cohorts of patients where uptake is lower than average and undertake targeted approach. Workplace programme established
Increasing the no. of people living with an undiagnosed LTC, receiving a diagnosis and access to treatment.	New for 2014/15: Macmillan funded GP within the CCG works with practices and the community on raising awareness of the risk factors and symptoms of cancer, early diagnosis & embedding of living with cancer initiatives. High intensity assessments (20min GP appointments) introduced for complex patients (inc multiple LTC) The CCG has supported the implementation of a risk profiling tool (EMIS IQ) for practices which is in place and supporting the GP practice to identify patients at risk of developing LTCs	Development of a cancer survivorship programme event to support SH patients stay well To refine the risk profiling tool parameters to ensure optimum identification of patients at risk
Targeting prevention initiatives (including diet, exercise, smoking and alcohol) at higher risk communities and individuals.	New for 2014/15: The Surrey Heath Health and Wellbeing Board developed the Surrey Heath "prevention plan" which describes initiatives and services that help to prevent avoidable illness and premature death. These include smoking cessation, alcohol misuse and physical activity initiatives (including exercise referral). During this year agreement was reached and plans put in place for an alcohol intervention pilot at Frimley Park Hospital. The Surrey Heath Community Connector conducted a mapping exercise to identify all exercise programmes aimed at older people available within the Borough and communicated this to key partners. The CCG, along with other key partners, launched the Walking and Living with confidence programme (WALC). An innovative falls prevention and pathway programme based in the Frimley system footprint. The CCG and Borough council worked together to develop a "bin hanger" campaign around self-care and keeping well in winter, targeted at vulnerable people. Greater alignment between national & local campaigns	Further development and implementation of the priorities within the Prevention Plan (smoking, alcohol, physical activity, workplace health, older people). These will include the implementation of the alcohol pilot, implementation of the workplace health charter in Surrey Heath (including workplace health checks), expansion of the exercise on referral scheme and further roll out of Smoke Free initiatives plus a new smoking cessation service. Developing further early intervention health promotion to prevent first falls. Further campaigns have been developed jointly for "Preparing for hot weather" this summer.

Slide 4 (Surrey Heath)

Priority 1: Older Adults will stay Healthier & Independent for Longer (cont)

Action	SH Achievements	SH Next steps
Increasing the number of people with a self management care plan	The CCG is exploring the opportunities presented to develop a project to implement self management care plans alongside the existing advanced Care Plans (ACPs) The CCG currently supports the delivery of a self management six week course for patients with LTCs and a similar course for Carers.	Development of a report outlining the benefits of self management care plans. ICT roll out includes person centric approach to development of care plans including self management
Increase in the use of assistive technology, such as Telecare and Telehealth by collaborating with borough and district councils.	The Telehealth Project is ongoing with further development with the provider to work with the acute hospital discharge team to identify patients suitable for Telehealth. Ongoing discussions with the community teams for heart failure and respiratory disease to improve uptake. Working with SHBC community services to identify opportunities for joint working with Telecare	Development of further innovation in Telehealth with provider for Nursing homes application. Development of a collaborative approach for the promotion of Telehealth and Telecare with the borough council. Develop local technology strategy aligned to Surrey wide approach to move from just looking at tele-health to supportive technology in a broader sense.

Priority 1: Older Adults will stay Healthier & Independent for Longer

Assessment of 2014/15 Performance: Green

Surrey Heath locality has developed for the first time a joint Prevention Plan which pulls together the strategic approach and interventions across the CCG, SCC (inc Public Health) and SH Borough Council.

Significant investment has been made by the CCG and through the Better Care Fund to provide a service model (Integrated Care) to better support older people in their own communities with a more proactive approach towards those who are showing early signs or at increased risk of ill health.

An emphasis on health checks (including a local initiative for the over 75s) has given the opportunity to identify and support people with previously undiagnosed LTC.

Slide 6 (Surrey Heath)

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

Action	SH Achievements 2014/15	SH Next steps 2015/16
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	During the year, the department of health tasked all CCGs to increase the proportion of people diagnosed with dementia set against the expected prevalence. The original target in April 2014 was 54%, this was increased in November to 67%. At the end of March Surrey Heath had a reported achievement of 55% but this is expected to rise to 64% once some data issues with one of the practices is rectified. This was one of the best performances across Surrey, Sussex and Kent. The CCG funded a local schemes to increase early diagnosis. Our acute provider was incentivised to find, assess, investigate and refer people with dementia who presented as emergency admissions.	Surrey Heath expects to achieve 67% early in 2015/16 through greater engagement with voluntary and community sector and working with practices that are currently below the 67% target.
Increasing support for people in crisis to prevent admission of those people they care for with dementia	Surrey Heath continues to ensure the opportunity for carers breaks is high on the agenda at practice level. New for 2014/15: Opening of SH Wellbeing Centre including support to carers for people with dementia. Through the Integrated Care teams individual care plans have been develop to prevent crisis admissions. These include carer support plans.. Surrey Information Point has been reviewed to ensure signposts local support for carers. Our acute provider undertook and audit to identify additional support that might be required to support carers.	Full implementation of ICTs and associated support to people with dementia and their carers. Mapping of opportunities for increased support from voluntary and community sector.
Increasing specialist support for those caring for and with dementia to support earlier discharge from hospital	New for 2014/15: Significant increases in the investment in community mental health practitioners and consultants in older person's MH were identified and recruitment commenced as part of the establishment of the Integrated Care teams (ICTs).	Work with local acute provider will ensure greater awareness of community services available to support early discharge from hospital
Increasing the number of Dementia Navigators and Local Champions – working with Adult Social Care	New for 2014/15: Surrey Heath supported the attendance of one of its local GPs & practice nurse on a dementia training course s. We now have a "Dementia Fellow" (GP) who acts as a local champion within practices. Our local acute provider identified a Clinical Lead for dementia who has responsibility for ensuring staff are appropriately trained and supported to manage people with dementia and their carers.	The locality is currently reviewing a potential increase in dementia navigators to support the skills within the ICTs.
Promoting and developing Dementia Friendly Communities	New for 2014/15: Surrey Heath Health and Wellbeing Board committed to becoming a dementia friendly community and throughout 2014/15 run dementia friendly community events to increase the number of "dementia friends". Our local acute trust introduce the "Blue butterfly" initiative to ensure the needs for people with dementia are met without stigma or discrimination.	Continue to develop a whole community approach to supporting people with dementia and their carers

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

Assessment of 2014/15 Performance: Green

Surrey Heath CCG has worked hard throughout 2014/15 to identify those people who have been undiagnosed with dementia. This resulted in significant improvement in our dementia diagnosis rates in 2014/15.

The number of community champions has increased both within statutory organisations and within our community and dementia has had a much higher profile.

Significant additional investment was allocated during 2014/15 to ensure a more fully developed community service for people with dementia and their carers.

A locally established Dementia Steering group will drive this work forward in 2015/16.

Slide 8 (Surrey Heath)

Priority 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

Action	SH Achievements 2014/15	SH Next steps 2015/16
Increasing the use of risk stratification tool to identify those most at need and proactively directing services to them	GP Practices participated in the Avoiding Unplanned Admissions Directed Enhanced Service which required the development of a personal self management plan with patients aged 75 or over and complex patients CCG commissioned new risk stratification in 2014/15 with increased integration with existing GP systems to improve usage.	Embed risk stratification as part of ICTs. Increase sharing of data between partners so that care plans can be followed through by those not directly involved in care e.g. GP out of hours service, A&E, ambulance service. GPs have been incentivised in 2015/16 to increase use of special patient notes to support the above.
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 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	During 2014/15 a local integrated model of care has been co-designed with our population, patients and providers. Significant additional investment was committed by the CCG to enhance community service provision for the frail elderly. Phase one of the model went live from 1st April 2015. This model was shortlisted for Five Year View Plan Multi Community Provider (MCP) Vanguard status and has received "fast follower" status and support from the King's Fund. CCG funding for our over 75's population/frail elderly delivered through our practices included: • Longer consultations (20mins) • Health checks for the over 75s • Proactive contact with over 75's/frail elderly on discharge within 48 hours • Practice care co-ordinator to support over 75's/frail elderly	Embed full integrated care model including Surrey Heath access point for professional and population. Single commissioning plan for locality across health and social care

Slide 9 (Surrey Heath)

Priority 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

Action	SH Surrey Achievements 2014/15	SH Next steps 2015/16
Reframing the threshold and use of community beds, including nursing and rest home.	New for 2014/15: Interim nursing home beds were commissioned through Winter pressures monies. Good partnership working between health and social care has realised benefits. Increased matching between demand and capacity for community beds through regular system wide telephone calls.	Full review of local demand and capacity for bed based care to develop a whole system Surrey Heath strategy that supports/reflect new models of care. Increased integration of housing into system wide discussions/solutions. Local implications and way forward identified following the Surrey County Council in-house home consultation (Pinehurst)
Increasing the scope and number of older people receiving personal health budgets and direct payments	Personal Health budgets have been available since April 2014, uptake is slow A nurse-led training function will be created to support Personal Assistants, by following a comprehensive scheme of delegation, to undertake additional training allowing them to provide basic clinical support to the patient	Systems and processes in place within CHC team to manage requests from this cohort
Proactively planning for the end of life, for people to die in their chosen place as much as possible.	New for 2014/15 : Surrey Heath End of Life Strategy agreed. GP clinical lead recruited. Co-design Advanced Care Plans to support people thinking about end of life care developed and implemented. GPs introduced annual review of care to patients in nursing and residential homes – including end of life care conversation/review. Increased co-ordination of end of life care through increased alignment between Phyllis Tuckwell Hospice and the Beacon Service. CHC locality teams established with increased local responsibility for ensuring end of life care CHC arrangements are fast tracked to support people who wish to die outside hospital.	Review and implementation of End of Life care pathway in conjunction with G&W and NEHF CCG. Increased visibility of end of life care plans across system providers.

Priority 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

Assessment of 2014/15 Performance: Amber

Although good progress has been made to put the foundations in place to support people within their own homes and provide services to enable them to return home as soon as possible this has yet to see an affect on the number of people attending and being admitted to Frimley Hospital in 2014/15. Our self assessment is therefore amber.

The pressure being experienced at our local provider (A&E and ability to discharge) is greater than in previous years and the local Frimley System Resilience Group is working together to identify wider system wide solutions in addition to the Surrey Heath Integrated Care Teams.

Stimulating the provider market around home care placement provision & responsiveness (health and social care) and mapping the bed based care needs will be key local actions in 2015/16. These will be aligned with Surrey wide procurement projects.

Slide 11 (Surrey Heath)

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

Action	SH Achievements 2014/15	SH Next steps 2015/16
Increasing the number of carers identified and involving them in care planning for their relative	Surrey Heath has continued to promote the need to identify carers (including young carers) within the community and to signpost to support available. Have provided Advanced Care Planning booklets and information for Carers packs across the statutory and Voluntary sector.	Develop other media opportunities to further increase the number of carers identified e.g. Work place charter/health checks. Ensure carer identification & role in care planning becomes part of work within ICTs.
Increasing involvement of the third sector and voluntary groups in providing respite, support and recreational activity	SHCCG facilitated the collaborative working of the Carers Organisation Group with all providers (statutory and voluntary) which includes SHBC, SCC SC, CMHT and SH Carers Support and voluntary sector. The group aims to proactively support the SH population of vulnerable old and frail people by improving the physical and mental health of their carers. During 2014/15: • Promoted the SHBC Wellbeing Centre in Bagshot as a resource for carers. • Promoted a number of carers specific campaigns and developed website and tweets to support communications. • Supported Virgin Care to deliver the Emotion Gym sessions at St Mary's Church, Camberley to tackle low mood, anxiety and stress. • Worked with the Community Connector to map physical activity opportunities in SH for older people including carers. • Worked with the MH Lead to provide Carers access to Psychological Therapies via self referral. • Included voluntary services as part of ICT model	Working collaboratively with the Carers Organisations Group to agree TOR and a locally agreed pathway for carers support, joint working on Carers Awareness Week. Developing a forum for third sector and voluntary groups to provide further networking and development opportunities Review of voluntary care grants provided by CCG, district and boroughs and SCC. Ensure optimal use of grant funding to deliver support to the old and frail which avoids
Proactively supporting carers to be physically and mentally healthy		Further develop the Physical Activities offer with the Community Connector and SHBC Leisure Services. Deliver the commissioned Carers Self Management Course providing support for carers to be able to attend via a joint organisations offer. Further promote the Carers access to Psychological Therapies Further develop the role of the voluntary sector within the ICT model
Providing respite breaks for carers	188 out of a possible 194 (96% uptake) respite breaks were provided to carers at a cost of £500 each.	Continue with offer and working with GPs to identify carers in need of respite.

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

Assessment of 2014/15 Performance: Green

During 2014/15 there has been an increased local focus on developing relationships with carer organisations and ensuring the needs of carers are considered alongside patient care.

We have a Carers Organisations Group set up and TOR for the group and draft local pathway. Work will continue this year to further develop the group to deliver a joined up local service for Carers and a forum for statutory and voluntary groups to network and deliver improvements in the system.

Work is ongoing to improve the services for carers on the physical and mental wellbeing. Strong links have been made with the Surrey wide Carers network and through the Partnership Manager for Carers.

Expectations for improvement will be increased for 2015/16.

East Surrey: Improving Older Adults Health and Wellbeing

Priority Update 2014/15 Review

Health and Wellbeing Surrey

East Surrey CCG
Performance Scorecard

	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	Amber
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	Amber

Key:

Red	No action has been taken
Amber	Achievement is not as planned
Green	Achievement as expected

Health and Wellbeing Surrey

Slide 3 (East Surrey)

Priority 1: Older Adults will stay Healthier & Independent for Longer

Action	Achievements	Next steps
Increasing the number of cardiovascular Health Checks completed.	**Health checks delivered by GPs and pharmacy up to Q4 14/15 by CCG:** East Surrey **1806**	To continue with the momentum of delivery for GP and Pharmacy. Exploring relationships for workplace, borough and district and targeted communities organisations to compliment and build on existing delivery.
Targeting prevention initiatives at high risk communities and individuals	• Supported Public Health to review and develop a virtual/hard copy directory of current prevention initiatives/services provided across East Surrey • Supported increase physical activity, health eating programme • Supported Alcohol prevention "Stoptober" Programme and align with alcohol project • Supported Smoking Cessation programme New Year and Stop Smoking day in March 2015 • Supported Public Health to develop baseline/market segmentation of prevalence and design targeted health promotion programme for high prevalence areas	Implement targeted health promotion programme in high prevalence areas.
Increasing the number of people who receive an earlier diagnosis of AF and treatment to prevent stroke and TIA.	• Confirmed number expected to be living with undiagnosed AF as of April 1st 2014 • Implemented case finding programme with primary care. • By the end of 2014/15 reduce the number of people living with undiagnosed/untreated living with a stroke by 5%.	• Confirm number expected to be living with undiagnosed diabetes as of April 1st 2015 • Confirm number expected to be living with undiagnosed diabetes as of April 1st 2015 • By the end of 2015/16 reduce the number of people living with undiagnosed/untreated living with a stroke by 5%.
Increasing the number of people living with a personalised care plan	• Monthly monitoring of number of patients on community nursing caseloads as of April 1st 2014 • Implemented programme to support Proactive Care Team and named GP to provide personalised self care plans for those over 75 years old or with complex conditions in conjunction with primary care. • Achieved >50% of patients on all community nursing caseloads have an active personalised self care plan by the end of 14/15	• Confirm number of patients on community nursing caseloads as of April 1st 2015 • (Potentially Incentivised through CQUIN) • Confirm number of patients on GP practice lists as of April 1st 2015 • (Incentivised by DES) • 80% of patients on all community nursing caseloads have an active personalised self care plan by the end of 2015/16 • % of patients on GP practice list (who meet criteria) have an active personalised self care plan by the end of 2015/16

Priority 1: Older Adults will stay Healthier & Independent for Longer -

Assessment of 2014/15 Performance: Green

In general the population of East Surrey is healthy and affluent. Life expectancy is high at 86 and 7months for women and 84 and 4 months for men. However, the last 8-10 years of people's lives will be in ill health and due to the life expectancy increased frailty due to reaching advanced age is to be expected. A local health needs assessment identified that in East Surrey there are currently an estimated 10,000 people who are considered to be frail, increasing to approximately 11,500 by 2018.

East Surrey has implemented both prevention strategies to identify those undiagnosed and requiring treatment and support(Dementia, Diabetes and COPD) and developed a new model of service delivery to better support older people with a more proactive approach (Locality Hubs) towards those who are showing early signs or at increased risk of ill health.

Slide 5 (East Surrey)

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

Action	East Surrey Achievements 2014/15	East Surrey Next steps 2015/16
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	• Confirmed number of patients living with dementia as of April 1st 2014 with primary care practices. • Implemented case finding programme, supporting practices to identify patients. • Improved dementia diagnosis from 42.5% to 58.5% by the end of 2014/15 against a target of 66%.	• Confirm number expected to be living with diagnosed dementia as of April 1st 2015 • Continue case finding programme • Maintain the number of people diagnosed with dementia at 66% of predicted level
Increasing support for people in crisis to prevent admission of those people they care for with dementia	• Evaluated service delivered during 2013/14 • Support 100 people in last year (September 2013 – 2014) • Re-commission service in line with evaluation findings	TBC based on 2013/14 evaluation
Increasing specialist support for those caring for and with dementia to support earlier discharge from hospital	• Frailty Strategic Integrated Pathway Development and Consultation Enhanced support delivered though OPAL and redesigned community service funded through Better Care Fund that providing community MDT care. • Increased provision of rehabilitation in community in rehab beds or supported care at home	• Deliver service redesign following consultation • Enhanced support delivered though OPAL and redesigned community service funded through Best Care Fund
Increasing the number of Dementia Navigators and Local Champions – working with Adult Social Care	• Whole service redesign is underway to provide primary care based screening and diagnosis dementia service with specialists, and dementia navigators based in Primary Care • MDT meetings and case managers are being rolled out across GP practices. • Target is to have a total of 20 Dementia Champions – currently there are 11 (see attached Dementia Friendly Progress Report). Wide range of organisations signing up including Surrey Fire and Rescue, Surrey Library service, Trading Standards, care homes, domiciliary care providers, dental practices, opticians, pharmacies, legal practices, leisure providers, local authorities, voluntary organisations and GP practices	• Ongoing service redesign where dementia navigator and champion resource will have been determined • Dementia navigator resource or equivalent in place • Dementia champions in place

Slide 6 (East Surrey)

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

Action	East Surrey Achievements 2014/15	East Surrey Next steps 2015/16
Promoting and developing Dementia Friendly Communities	• Campaign to increase awareness and challenge the stigma surrounding dementia launched Sept 2013. Making use of a range of communication channels including local media, web and face-to-face contact. This campaign has included magazine advertorials, social media, local radio, bus and train panels, and local events. Champions and others encouraged to hold coffee mornings and other events to raise awareness. • Innovation fund support for Tandridge Voluntary Services Council to establish a weekly reading group for people living with dementia, led by volunteers at Oxted library started at end 2013. • Three colleges and one university have expressed interest in getting involved in dementia-friendly communities work. These include Brooklands College, East Surrey College, NESCOT and Royal Holloway University. • A menu of training options are available for those who may encounter people with dementia as part of their paid or voluntary position	• Carer and Peer Support: Increase in carers support in areas where there are gaps. • Increase in number of peer support groups in areas where there are gaps. • Increase in number of carers saying they feel better supported

(Priority 2) Older adults with dementia will have access to care and support

Assessment of 2014/15 Performance: Green

East Surrey CCG has worked tirelessly to identify those people who have been undiagnosed with dementia as demonstrated by the improvements in our local dementia diagnosis rate in 2014/15; we are proud of our results. We have an Admiral Nurse and two GP clinical champions who support the development of services to become dementia friendly and better support patients and their carers. Our acute hospital has also over achieved on what was expected of them in relation to identifying patients admitted.

Our Locality Hub model of care which will become live during 2015/16 will enhance the support currently offered to patients further.

Slide 8 (East Surrey)

(Priority 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

Action	East Surrey Achievements 2014/15	East Surrey Next steps 2015/16
Increasing the use of risk stratification tool to identify those most at need and proactively directing services to them	• GP Practices and the Proactive Care Team continue to use and evaluate the risk stratification tool available in order to prioritise service delivery • Patients predicted by the risk stratification tool as being at high risk of hospital admission now receive a programme of personalised and coordinated health & social care, coordinated through GP practices. • Personal care plans are uploaded to IBIS and 'Share My Care' to enable effective management of patients 24/7.	• Continued improvement in the MDT approach to delivering patient care. • A hub model of delivery is envisaged with primary and community care continuing to develop partnership working.
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	• Worked across the Surrey collaborative to scope stroke requirements and the design of an Integrated Stroke Care Pathway • Implemented Nursing Home Care Scheme • Integrated Discharge Team /CHC Assessment Process at SaSH • Long Term Conditions Telehealth Service for Heart failure & COPD patients • Urgent Care Pathway Development. • The Urgent Care Pathway development includes options for prevention of inappropriate A&E attendance and admission from A&E by looking at current health & social care domiciliary capacity and community services and A&E front door redesign.	• Continued development of community rehabilitation services in ESCCG area to provide Early Supported Discharge for stroke patients. • Targeted support to community nursing care homes to reduce avoidable A&E attendances & hospital admissions through proactive primary care management of patients. • To proactively manage the flow of patients out of a hospital bed as soon as they no longer require acute care. This will be achieved by hospital staff focusing on a coordinated and timely discharge for patients starting from their admission to hospital and by making one referral to a single MDT point of access on the hospital site resulting in a reduction of excess bed days. • Provision of a targeted remote monitoring system funded by the Better Care Fund (see first section). • Continued pathway development and transformation through a multi-provider shared care approach.

Slide 9 (East Surrey)

(Priority 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

Action	East Surrey Achievements 2014/15	East Surrey Next steps 2015/16
Increasing capacity and threshold of community beds.	• Implemented a model of community Step-down beds in the community for those patients that no longer require acute hospital care. • Embedded a sustainable operational resilience approach.	The Integrated Discharge Team and local CHC service will support the step-down bed model promoting discharge to assess where appropriate.
Increasing the scope and number of older people receiving personal health budgets and direct payments	• Aligned local approach to Surrey wide plan • Local plan in place • Monitor progress by plan	
Proactively planning for the end of life, for people to die in their chosen place as much as possible.	• Confirmed baseline as of April 1st 2014. • Agreed pathway in place in partnership with FCH&C and St Catherines Hospice. • 0.25% of palliative care patients to be on the EPaCCS	• Confirm baseline as of April 1st 2015 • 0.35% of palliative care patients to be on the End of Life Palliative Care Coordination System

(Priority 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

Assessment of 2014/15 Performance: Green

East Surrey has self assessed ourselves as green as we reduced non elective admissions by 4.4% when compared to 2013 and held A&E attendances to an increase of 1.6%

To ensure we are fit for the future, East Surrey CCG has been working collaboratively with all providers(statutory and voluntary) to develop a new health and social care service for the older and frail person (Locality Hubs); but we are not where we would have hoped by the end of 2014/15, mainly due to estate issues.

Significant levels of engagement and work have been undertaken to ensure that the model can be delivered during 2015/16 and actions to improve communication between providers have been incentivised.

Slide 11 (East Surrey)

(Priority 4) Older Carers will be supported to live a fulfilling life outside caring

Action	East Surrey Achievements 2014/15	East Surrey Next steps 2015/16
Increasing the number of carers identified and involving them in care planning for their relative	• Confirm number expected to be living as a carer as of April 1st 2014 • Implement case finding programme • By the end of 2014/15 increase the number of carers known and registered by GPs by (%) and that > 20% have their own care plan	• Confirm number expected to be living as a carer as of April 1st 2015 • Implement case finding programme • By the end of 2015/16 increase the number of carers known and registered by their GPs by (%). and that > 30% have their own care plan
Increasing involvement of the third sector and voluntary groups in providing respite, support and recreational activity	• Confirm value of funding provided to third sector as of April 1st 2014 • Jointly review current service provision and commission third sector with social care • Increase value of funding provided to third sector though the BCF	Jointly commission third sector with social care, increasing value of funding by % by the end of 2015/16
Proactively supporting carers to be physically and mentally healthy	• Continue to work with Surrey Action for Carers on Carers recognition project (within GP practices) • Assist practices to identify carers in need of respite breaks • Increased support for carers with breaks during End of Life Care situations • Ensure carers assessments are offered in continuing care cases • Introduce Carers Health Impact Indicators (piloted throughout Surrey 2013/14) to help GPs recognise carers with clinical need • ESCCG to approve better access to Crossroads services - for carers of people with a diagnosis of a life limiting condition with a 12 month prognosis. • Audit number of carers assessments offered as part of CHC process (work with Surrey Downs CCG)	• Continue to work with Surrey Action for Carers on Carers recognition project (within GP practices) • Assist practices to identify carers in need of respite breaks • Increased support for carers with breaks during End of Life Care situations • Ensure carers assessments are offered in continuing care cases • Monitor, review and evaluate
Providing respite breaks for carers	• Assess level of need following review programme of carers accessing breaks during 2013/14 • By the end of 2014/15, 700 (TBC) careers to have received breaks	• Assess level of need following review programme of carers accessing breaks during 2014/15 • By the end of 2015/16, 700 (TBC) careers to have received breaks

(Priority 4) Older Carers will be supported to live a fulfilling life outside caring

Assessment of 2014/15 Performance: Amber

East Surrey CCG has self assessed amber as we still have some way to go to demonstrate that carers are receiving the level of support we would wish to see as demonstrated by the number of carer care plans developed and the uptake of carer respite breaks. The new health and social care service (Locality Hub) we are developing will proactively support 10,000 vulnerable old and frail people in East Surrey, aiming to equally improve the physical and mental health of their carers. This service is in the process of being developed and we have made significant strides towards full implementation. But we are not where we would have hoped by the end of 2014/15 mainly due to estate issues. We would also want to have had a higher uptake of our carer respite break allocation