Health and Wellbeing Surrey

Health and Wellbeing Board
9 March 2017

Joint Health and Wellbeing Strategy Priority Update: Improving Older Adults' Health and Wellbeing

Purpose of the report: To update the Health and Wellbeing Board on progress against the Improving Older Adults' Health and Wellbeing priority within the Joint Health and Wellbeing Strategy. The report will also provide members with the Better Care Fund quarterly returns for quarters 1, 2 and 3 of 2016/17.

Recommendations:

1. The Health & Wellbeing Board is asked to:

   i. note the progress made towards the outcomes of the Improving Older Adults' Health and Wellbeing priority within the Joint Health and Wellbeing Strategy;
   ii. note the Surrey Better Care Fund returns for quarters one and two 2016/17;
   iii. endorse the next steps for the Improving Older Adults' Health and Wellbeing priority; and
   iv. note that an update on the Improving Older Adults' Health and Wellbeing priority will be brought to the Health & Wellbeing Board in six months' time.

Context

2. The Surrey Health and Wellbeing Strategy sets out the context for the 'Improving Older Adults' Health and Wellbeing' priority:

   "More people in Surrey are living longer, with the number of people over 85 years old predicted to increase significantly. This is great news, but this does pose some challenges as older people are more likely to experience disability and long-term conditions. Part of the challenge is to make sure that the right services are in the right place so that older people can remain independent for as long as possible. People over the age of 85 often need more support from health and social care services

and are at greatest risk of isolation and of poor inadequately heated housing, both of which can impact on health and wellbeing."

3. This 'priority update' sets out:

   - What we are trying to achieve
   - An update on the actions that we are taking jointly
   - How we are tracking progress / impact

4. At the heart of the work being done to improve older adults' health and wellbeing is the focus that has been taken across the partnership on the integration of health and social care (including the Better Care Fund) – updates on this will form the basis for the regular reports provided to the Health and Wellbeing Board. In addition, these priority updates will be supplemented by updates on key workstreams or programmes of work that support the achievement of the agreed outcomes such as work relating to dementia, nursing and care homes and domiciliary care and older carers.

What we are trying to achieve

5. The Health and Wellbeing Strategy sets out the outcomes that it is hoped will be delivered through the work being done to improve older adults' health and wellbeing. These outcomes are as follows:

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

6. In support of this the Surrey Better Care Fund (BCF) and the broader work to integrate health and social care services have agreed three strategic aims:

   - Enabling people to stay well - maximising independence and wellbeing through prevention and early intervention for people at risk of being unable to manage their physical health, mental health and social care needs.
   - Enabling people to stay at home - integrated care delivered seven days a week through enhanced primary and community services which are safe, effective and increase public confidence to remain out of hospital or residential/nursing care.
   - Enabling people to return home sooner from hospital - excellent hospital care and post-hospital support for people with acute, specialist or complex needs supported by a proactive discharge system which enables a prompt return home.

Update on the actions we are taking together

7. Partners across the Health and Wellbeing Board invest in a wide range of activities, services and programmes of work to improve the health and wellbeing of older adults. The updates presented under the Health and Wellbeing Strategy priority for this area focus on those things that we work together on – this update report will provide information relating to:

   - Health and social care integration (including the BCF)
   - Accommodation with Care and Support
   - Dementia
   - Carers

Health and social care integration including the Better Care Fund and Sustainability and Transformation Plans (Outcomes 1-5)

8. Partners have continued their focus on the integration of health and social care services to develop new models of care that improve outcomes for older adults across Surrey and are better able to cope with the rising demands placed on health and care services.

9. The health and wellbeing of older adults forms an important part of the three Sustainability and Transformation Plans (STPs) that cover Surrey. These are five year NHS plans setting out how health and social care in local areas will work together to improve the health and wellbeing of residents. The key themes relating to older adults in these plans include:
   - creating new models of care that enable older adults to access more integrated and co-ordinated care;
   - improved access to care outside of hospital for older adults;
   - improved quality of care, in particular fewer delays when transferring between care settings; and
   - preventing older adults from becoming unwell.

10. Good progress has been made in each area of Surrey over the last six months – the tables below set out a summary of the key integration workstreams in each area, the progress made, the difference it is making for older adults as well as the key next steps. The work being led in each area forms an important part of the STPs.

11. In addition to the progress being made in each area, headline achievements over the last six months include:

    - Over the winter months, health and social care partners in Surrey have managed the additional pressures and increased demand on services well. This is largely due to partners working together as one system, enabling many difficulties to be mitigated by ensuring the system kept flowing.
    - Surrey Local Joint Commissioning Groups are currently delivering the Surrey BCF plan for 2016 – 2017 which was endorsed by the Health and Wellbeing Board on 7 April 2016.
    - All Section 75 agreements have been signed
    - Surrey Local Joint Commissioning Groups have begun initial conversations locally to build what will be a two year Surrey BCF plan for 2017-18 & 2018-19. The Policy Framework and Planning Guidance, which is essential for completing the plan, has not yet

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been published by NHS England, but the national Better Care Support Team are in regular contact with leads in Surrey to provide what updates and information they are can until such a time as these can be agreed nationally and published.

- The Sustainability and Transformation Plans (STPs) and their respective Digital Roadmaps are hoping to implement integrated digital care records over the next two years. For example, the Surrey Digital Roadmap - the digital strategy for the Surrey Heartlands STP, plans to draw together records and case management information from health and care providers, to provide a single view of the resident across the system by 2019. This 'view' would be available to those care professionals that a resident has consented to sharing their data with. Older people will benefit from care professionals having access to all the information they need, when they need it to enable a more holistic approach to care management and this work will therefore be a key enabler in multidisciplinary settings, such as local integrated care hubs, ultimately aiming to facilitate a better care journey and experience.

12. Update summaries from each area within Surrey:

Area: East Surrey
Description of key BCF / integration workstreams: The East Surrey BCF plan sets out a number of investments and actions designed to further the broad objectives of the BCF and to meet the three overarching, Surrey-wide strategic aims: 1. Enabling people to stay well; 2. Enabling people to stay at home; 3. Enabling people to return home sooner from hospital; Key workstreams: • Development of the primary care strategy and wraparound model for out of hospital care in East Surrey; • Commissioning of a new service to provide enhanced medical care to people living in nursing and residential homes; • Development of the falls and fracture liaison pathway; • Further development of the Integrated Reablement Unit at East Surrey Hospital; • Development of a frailty unit at East Surrey Hospital; and • Development of Multi-speciality Community Provider in East Surrey to form the basis of the Out of Hospital provision;
Summary of progress – March – August 2016: • Progress has been made to develop a Multi-specialty Care Provider (MCP) in East Surrey. The MCP Executive Board includes partners from East Surrey CCG, SCC, East Surrey GP Federation and First Community Health and Care. The MCP will include complex case management and out of hospital services. • A business case for investment in the falls and fracture liaison pathway has been developed. • The Integrated Reablement Unit is operational – a lot of work has been progressed to improve performance. Progress has focused on reviewing the number of beds and ongoing development to reduce the length of stay to five days for those that need it. • A Frailty unit has been launched to prevent hospital admissions.

- Winter resilience budget from NHS England has helped facilitate discharges from hospital – in particular for home based care and care homes.

Difference this is making for older adults:
The BCF schemes are designed to enable older people to stay well, allow people to stay at home and enable people to return home sooner from hospital. The key impact of the schemes will be to reduce non-elective admissions to acute hospital for older people and to reduce and prevent crises in care and support that precipitate such admissions.

Key actions being taken March 2017 – Aug 2017:

- There will be further development of all the schemes outlined above.
- Further development and engagement from East Surrey CCG and SCC.
- Continued progressed to establish a MCP.

Area: Guildford and Waverley

Description of key BCF / integration workstreams:

- The Frailty Initiative - This service involves providing support for local GP Practices to proactively care for patients in the community who are vulnerable to an unplanned hospital admission.
- The Proactive Care Service for Haslemere and Guildford - This service consists of community based service hubs where integrated teams of professionals deliver coordinated care for patients who are vulnerable to an unplanned hospital admission.
- Discharge to Assess - This involves discharging patients to the community to have their care needs assessed once it has been determined by a clinician that the acute setting is no longer adding clinical value.
- Support for Frequent Fallers Pilot - This pilot consists of an integrated team of two district nurses and a paramedic conducting care for patients who have been frequently falling in their own home. This team will also provide training and other kinds of support for local care homes.
- Falls Prevention Classes Pilot - This pilot involves providing care via a multi-disciplinary team of care professionals for patients who are at high risk of a fall but have not yet suffered a fracture.
- Care Home Pilot - The pilot involves providing concentrated support for local care homes to assist them in providing the best care and reduce the number of avoidable hospital admissions.
- Voluntary Sector Forum - Guildford and Waverley CCG are holding a Voluntary Sector Forum later in the year to provide a setting in which local voluntary sector organisations can pitch care solutions.
- GP led community care hubs and an urgent care access point with a single team focused on the residents of Guildford & Waverley integrating rapid response Community Matrons Mental Health and Social Care.
- Reablement and Rapid Response integration to ensure targeted approach with therapy led intervention.
- Pooled Budgets 2017
- Development of an integrated community hub and urgent care access point based at Farnham Hospital with a single team dedicated to the residents of Farnham..

Summary of progress – March – August 2016:

- New service specification for Frailty Initiative has been agreed with local GP Practices. New service specification to be implemented in October 2016.

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- The new model of care, trialled through the Proactive Care Service, has shown good results in terms of preventing unplanned hospital admissions and has been rolled out in the Haslemere locality. Work is currently being undertaken to roll out the service to Guildford. This is an ongoing and evolving process – work is going on with the Service Delivery Board looking at patient flow and patient discharge. Guildford & Waverley CCG are looking to improve this with regards to available resource so that there is resource to check on more patients.
- Discharge to Assess is no longer a pilot and is now up and running. The CCG are looking to increase the resource so that it can have a greater impact for patients.
- Support for Frequent Fallers Pilot launched in September 2016 is ongoing.
- Falls Prevention Class Pilot launched in September 2016 and is ongoing.
- Care Homes Pilot has proven to be successful in reducing the numbers of people admitted to hospital from nursing and care homes.
- GP led community care hub is now up and running
- Reablement and Rapid Response integration continues and steps are being taken to increase the resource available for this.
- Pooled Budgets 2017 - Hoping to go into shadow year from April 2017.
- Integrated community hub and urgent care access point at Farnham Hospital is going at pace and accommodation is currently being refurbished. A number of staff have been identified.

Difference this is making for older adults:

- The BCF streams are focused on ensuring that older people stay well by enabling them to stay at home and receive the care they require whilst facilitating speedier discharge from hospital. BCF projects are being reviewed to ensure that they are delivering services as expected.
- The key impact of the schemes will be to reduce non-elective admissions to acute hospital for older people, to reduce and prevent crises in care and support that precipitate such admissions through the use and development of community hubs.
- Improved capability within GP practices to proactively manage patients who are at risk of an avoidable hospital admission. This is also linked to the hubs as well.
- Improved coordinated assessments of care needs undertaken by community-based care professionals as a result of using the new trusted assessment form as part of the Proactive Care Service. This has led to more effective care for patients in the community
- Improved capability to assess patients in the community thereby reducing the likelihood of a prolonged stay at hospital and the associated risks.
- Reduction in A&E attendances and emergency admissions for over 65s compared with the same point last financial year.
- Urgent care will be closer to home for Farnham residents - Care centred around local hubs with a proactive local multi-disciplinary model to support people to remain healthy and at home.

Key actions being taken Mar 2017 – Aug 2017:

- Evaluation of the Proactive Care Service in Guildford and Waverley.
- Evaluation of the Discharge to Assess Pilot.
- First meeting of the Voluntary Sector Forum.
- Complete the transfer of Farnham to Surrey Heath - ensure staff are in place and vacancies are recruited to – this will include the transfer of budgets and efficiency savings. It is hoped that this will be up and running by 1 April 2017.

- Continuing to scope pooled budgets for the shadow year to be in place from April 2017. Formalise the Section 75 agreements around pooled budgets.

Area: North West Surrey

Description of key BCF / integration workstreams:

Bedser Hub

- Delivers fully integrated assessment and support for frail older people. The Hub provides GP led assessment and planning, preventive, proactive and reactive care as well as rehabilitation for an identified cohort of people. Supported by a full multi-disciplinary team, including the voluntary sector. A single shared care record in EMIS, diagnostics, pharmacy and transport services.
- Wellbeing Co-ordinators linked to all GP practices.

Reablement and Community Health Rapid Response Service.

- Integrating both services increases capacity to provide timely interventions and ensures Therapist intervention is based on need not service provision.

Integrated Care Bureau

- A single point of referral managed and operated by acute/community and social care organisations in North West Surrey. Ensuring assessments take place out of an acute environment.

Discharge to Assess Model

- Provides joined up services including community hospital bed resource to facilitate assessments away from the acute setting. Care currency agreed to confirm what capacity across the system is available. This model is being embedded.

Summary of progress – Sept 2016 – Feb 2017:

- Change Manager in post working across the whole system in NW Surrey.
- Bedser Hub operational and is now business as usual. Looking to extend this offer to the wider community.
- Integrated Care Bureau went operational on 1 September 2016 and is delivering joined up seamless support to residents by linking to Discharge to Assess.
- Pathway 1 (discharge to home) went live in September 2016.
- North West Surrey CCG have been working to embed all of the above, pick up learning and adjust the learning as they go forward.

Difference this is making for older adults:

Bedser Hub

- Well-being co-ordinators provide proactive monitoring and support to ensure early intervention to promote independence and timely intervention to promote wellness.
- Older Adults only tell their story once, all professionals have the right information at the right time.
- Reduces the risk of older adult being admitted to hospital or Residential/Nursing Home.
- Reduces duplication.

Reablement and Community Health Rapid Response Service

- Older Adults maintain skills and remain as independent as possible.

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Integrated Care Bureau

- Promotes individual's wellbeing and safeguards the individual from deterioration.
- Timely response and time for the individual and their family to be in control, empowered in the decision-making.

Discharge to Assess Model

- Older Adults provided with time in the right setting.
- Robust assessment and interventions to achieve maximum independence before longer term decisions are made.

Key actions being taken Mar 2017 – Aug 2018:

- Continue to monitor and evaluate impact of Bedser Hub. Virtual hubs have gone live in the two remaining localities.
- Discharge to Assess will be operational and pathways embedded. Beginning to evaluate progress and impact.
- Pooling of budgets and evaluation of impact. Seeking to have a shadow arrangement in place for April 2017.

Area: Surrey Downs Aug16-Jan 17

Description of key BCF / integration workstreams:

Surrey Downs have developed three models of integration around the three GP localities. The new models have been designed with local residents, staff and clinicians to deliver improved outcomes and experience. The aims of the services include:

- improving the quality of health and social care for people who are frail, elderly with complex needs and are deemed to be at risk of admission;
- maximising independence and well-being through joined up prevention and early intervention;
- simplified pathways, reduced duplication;
- reducing non elective admissions, A&E attendances and length of stay; and
- Sharing information and people only having to tell their story once

Integrated Initiatives focusing on Prevention & Quality:-

- Surrey Downs have commissioned a Quality in Care Home Team to support quality assurance and admission prevention.

- In partnership with District & Boroughs, the Local Joint Commissioning Group has developed local prevention priorities and an action plan which is informed by the Joint Strategic Needs Asessment.

1. Epsom Health & Care Alliance (EHC)

Leaders from four partner provider organisations (SCC, GP Health Partners, Epsom Hospital and Central Surrey Health) formed a Provider Alliance under a Consortia Agreement and formally agreed a two year integrated business case in April 2016 with Surrey Downs. EHC was launched to provide new, integrated services to over 65s and the @home service currently provides integrated care through the delivery of:

- co-ordinated assessment and diagnostic unit (CADU) – A GP led multidisciplinary service offering same day diagnostics and care to prevent admissions;

- enhanced @home – intensive supported discharge service and rapid response aimed to prevent admission; and
- @home hub – longer term high level care (up to 12 weeks).

2/3. East Elmbridge and Dorking Integrated Community Hubs

The East Elmbridge Community Hub is an integrated primary and community care team that started operating in December 2015 as part of the CCG's strategy for frail elderly care. The Hub operates with a dedicated workforce across primary and community care providing a reactive service focusing on patients in crisis and at high risk of admission. It provides dedicated care co-ordination, nursing and GP input to frail elderly complex patients in the community five days a week with GP coverage extending across the weekends and bank holidays. The Community Medical Team also provide seven day support to Molsey Community Hospital.

Dorking Integrated Team is an integrated primary and community care team that started operating in 2016 as part of the CCG's strategy for frail elderly care. The additional resource of a Community Matron commenced in Autumn 2016. The team is now recruiting to support increased capacity.

Summary of progress August 16- Jan 17

Epsom Health & Care

The Provider Alliance has been established with a consortia agreement in place and has been delivering year 1 of the business case. Recruitment to new posts has been completed. The launch of the new model has been successful with the multi-disciplinary team working together as one team delivering improvements for service users and embedding new ways of working.

The Alliance has developed and submitted a business case to Surrey Downs CCG for the expansion of this service. The aim of this is to increase the scope of the service to support a wider cohort of the population and to shift the focus from reactive care to also include proactive and preventative support.

East Elmbridge Hub

The Hub is expanding in early 2017 to more than double the current team, including dedicated social care and reablement support, as well as extending nursing cover across the weekend. The Community Medical Team is well established and has had a positive impact on reducing length of stay in Molsey Hospital.

Dorking Integrated Team

Joint working is embedded, recruitment plans are in place and a business case is being developed.

Difference this is making for older adults:

Measures of success include:-

- Prevention of admission;
- Reduction in Non Elective Admissions (NEL);
- Length of stay;
- Patient feedback; and
- Meeting performance indicators which will help deliver financial sustainability plans.

A dashboard has been developed and this is monitored via the Local Joint Commissioning Group, Surrey Downs Integration Board and by providers

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delivering the services. Examples of the positive impact of the models to date include:-

- Epsom Health & Care – consistent positive feedback from users of the service; reduction in Length of Stay;
- East Elmbridge - Achieved a 6% drop in non-elective admissions into Kingston Hospital and a 4% drop in A&E admissions. Good relationships and a partnership approach across health and social care have been central to this success;
- Dorking – Non- elective admissions have decreased. Local partnerships and joint working is continuing to develop.

Key actions being taken Jan 17- March 18

Epsom Health & Care

- Development of and implementation of Business Plan (2017-19);
- Further develop care model for people over 65;
- Lay foundations for Full Population Model of Care;
- Prepare for integration through service transformation and redesign, develop role of Lay Partners and work closely with D&Bs and the Voluntary Sector;
- Oversee changes required to operating model to establish neighbourhood teams across Epsom;
- Agree arrangements required to establish PACS/ Alliance Care System; and
- Move to encompass more proactive care and develop prevention offer, including volunteering for EHC.

East Elmbridge

- Development of Integration Business Plan (2017/18);
- Complete review and implement recommendations - the start small approach has allowed the hub to understand what works and what needs changing – caseload now needs to be ramped up to achieve desired outcomes with a move to developing a proactive approach;
- Lay foundations for moving to MCP model of care; and
- Full evaluation completed.

Dorking

- Development of Integration Business Plan (2017/18);
- Embed joint working with social care and community health;
- Supporting a Primary Care Home approach to MCP; and
- Small start approach with community matron in place, recruiting to other posts to build capacity.

Area: Surrey Heath

Description of key BCF / integration workstreams:

- **Admission avoidance**
  To provide services and support to members of the community which prevent the need to access acute hospital services that result in an emergency admission.

- **Early return home from hospital**

Improve discharge planning and intermediate community services to support more timely discharge from hospital.

- **Rehabilitation / reablement**
  Reviewing and improving the services provided locally by social care which help people live independently in their own homes.

- **Nursing / residential homes**
  Activities and investments specifically focused on preventing emergency admissions from nursing and residential care homes and enabling earlier return home from hospital.

- **Dementia diagnosis and support**
  Develop a whole systems approach to early identification of dementia and a clear pathway to long-term support for people with dementia and their carers'.

Summary of progress – Oct – Feb 2017

Integration Progress SHCCG/SCC Locality:

- October: Development of Section 75 agreement to formalise shadow monitoring (1 year) on integrated health and care locality approach. Progress has included:
  - New governance arrangements for joint decision making and escalation;
  - Greater alignment strategies, aims and objectives and benefits monitoring;
  - Blending of senior team leadership (Governing Body and Executive Team);
  - Joint quality monitoring: care homes;
  - Joint staff meetings and public engagement; and
  - Shadow monitoring and decision-making around pooled funds and risk sharing arrangements.

Other key areas of progress:

- Integration of social care into Integrated Care Teams and single point of access/MDT meetings.
- Hospital integration enhanced (social care hospital team, CHC,ICT) and single point for discharge developed at Frimley Hospital.
- Integrated Care Staff away days were held in September focussing on how the integrated care model can be achieved through networking and teamwork. A mission statement and values were co-designed.
- A video has been developed to demonstrate the positive outcomes and aspects of working together as an integrated team in Surrey Heath.
- Psychological input into MDT meetings has proved successful and resulted in a greater understanding of individuals once their physical needs have been met.
- Significant progress around rapid response and reablement integration.
- Formation of local community equipment group:
  - developed and agreed joint pathways for assessment and issuing of equipment; and
  - agreed trusted assessor arrangements between health and social care staff.
- Local dementia strategy and action plan developed and agreed.

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• Nursing home forum established to improve model of care. • Continued development of joint (borough, county and CCG) prevention plan and actions. • Full integrated "winter pressures" plan with flexible bridging of care utilising private home care providers and health/social care resources. • Collaborative development of "living with frailty" approach with tools reflecting health and care needs, physical and psychological.
Difference this is making for older adults: **Integrated Care** • People are benefitting from a seamless service and are able to tell their story once. • Better experience and reduced delay in response to urgent needs and discharge from hospital. **Prevention** • Maximising independence and well-being through joined up prevention and early intervention. **Reablement and Rapid Response Integrated Intermediate Care Service** • Reduction in duplication resulting in improved patient experience and a more efficient service. • Improved ability to prevent admissions and deliver appropriate early supported discharges. **Clinical equipment** • Timely delivery of equipment for individuals resulting in fewer admissions. • Reduction in duplication of staff time. • Improved local budgetary control
Key actions being taken March 2017 – August 2018 **Integration structure (S75)** • Monitoring of schemes and benefits within BCF and Section 75 • Joint agreement to 2017-19 BCF (March 2017) **Integrated Care Developments** • Agreement and operationalisation of frailty approach across system; • Development of new integrated MDT nursing home care model; • Falls review and anticipated pathway changes; • Implementation of local dementia strategy; and • Intermediate care: alignment of pathways and capacity to better meet demand.

Accommodation with Care and Support (Outcomes 1 and 2)

13. The Accommodation with Care and Support programme is looking at all accommodation-based adult services that SCC commissions and provides for residents of Surrey who have care and support needs. The strategy aims to deliver the best options for accommodation with care and support to Surrey residents. In order to do this it is necessary to integrate approaches across health, care and the community.

14. For older people, the Programme has three strategic aims:

    - reduce the age at which people enter nursing provision;

- commission only dementia specialist residential care and in doing so reduce the ratio of beds commissioned by 10%; and
- provide 600 Extra Care apartments across the county by 2025.

Nursing/residential care - Over the next ten years it is anticipated that there will be a huge increase in the demand for residential and nursing provision as a direct result of the growing population. The fact that people are living longer with more complex needs means that nursing care and high end dementia specialist provision will be paramount. A strategy for residential and nursing provision is in progress, identifying how assets can be best used over the next ten years to meet the growing demand for accommodation with care and support. It is recognised that provision must be flexible, based on the local health & care system as well as the level of need. Work is underway with the market to understand how to overcome challenges that providers may face in delivering this. Any provision procured by Adult Social Care must be good quality, safe and sustainable enabling older people to have a good experience of care and support.

Extra Care - Extra Care housing is an option of accommodation for older people which can offer a choice of independent living in a community setting with care and support services delivered according to individual need. It offers a way for people to continue to live as independently as possible when their care and support needs increase without the need to move into more institutionalised forms of accommodation. The business case for the development of new Extra Care provision in Surrey was agreed by Cabinet in December 2016 including the identification of SCC assets to offer to the market in order to stimulate development. Based on the current profile of needs, at least a quarter of the residents supported in Residential Care, but possibly as many as a third, could have their needs met within an Extra Care setting and this work aims to offer this choice to older adults in Surrey.

Mental health and substance misuse – The objective of this project is to ensure that individuals have access to appropriate specialist accommodation that supports their recovery and promotes their independence and integration into the community where they live. The goal is to enable choice and control across the pathway. A needs assessment and commissioning statement is currently being developed to inform future provision that will meet the needs of individuals requiring accommodation to support their recovery.

People with learning disabilities - Surrey is undertaking a strategic shift towards providing more supported living for people with learning disabilities. People should be supported to live as independently as possible rather than living in institutionalised settings. Funding has been identified from NHS England to re-develop buildings into modernised supported living. These are sites that have previously provided care but are no longer deemed fit for the future. Work is underway to develop options for appropriate sites and engagement with market providers is taking place to develop new services based on demand.

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The whole programme aims to offer individuals choice as to how their care and support needs are met in order that they can stay healthier and independent for longer in an environment appropriate for their needs.

Dementia (Outcome 3)

15. In line with the accelerated integration of health and social care, partners in Surrey have developed a new dementia strategy for 2016 – 2021 which will incorporate six locally developed strategies; one for each CCG area that focuses in on the need of the local communities.

16. Good progress has been made across Surrey in programmes that enable more people with dementia to have access to care and support. Paragraphs 17 to 21 below outline this progress.

17. *Dementia Navigators*
The Dementia Navigator service was re-commissioned in 2016 and it has been agreed to extend this through to March 2018. This is jointly funded by health and social care across the county and supports over 1400 people with dementia and their carers each quarter. It provides continuity of specialist support and advice, actively facilitating access to services in the community in a personalised way in order to sustain and improve the quality of life of people with dementia, their carers and family, as and when they need it throughout their dementia journey. The navigators (currently under contract with the Alzheimer's Society) signpost people with dementia and their carers to access appropriate services and to provide them with information and advice in order to keep them as healthy and independent as possible in their own homes with choice and control over their lives, health and social care support.

The new contract has seen greater engagement with local SCC dementia commissioners, CCG Clinical Leads and commissioners to ensure that Dementia Navigators are embedded into local services to have a more visible presence to support people with dementia and their carers better e.g. Navigator presence at diagnostic clinics, GP clinics and multi-disciplinary hubs. Work will begin to re-tender the service for April 2018 and beyond.

18. *Dementia day opportunities*
In January 2017, the Alzheimer's Society announced that it would close the remaining four day centres they operated within Surrey. This followed the closure of two centres last year and the merger of another two. Commissioners have worked closely with the Society to ensure that a partnership approach was taken, with named social work practitioners allocated to each centre to assess individuals and their carers and work with the local Dementia Navigator and centre staff to look at alternative options based upon assessed needs.

The relatively new shift from block contracting with a small number of providers to opening up to the market to join the dementia community opportunities framework is ongoing. Commissioners have continued to engage with the provider market to encourage existing and new services

to join the dementia community opportunities framework to support people with dementia and their carers.

19. *Dementia Friendly Communities*
The Dementia Friendly Communities project has made significant progress in involving groups from across the county to become more dementia friendly. From 1 September 2016 to 1 January 2017, 106 Dementia Friends sessions have taken place in Surrey, resulting in over 1400 new Dementia Friends. Three service user groups have been established across the county with the aim of advising local businesses, leisure services and other organisations on how they could become dementia friendly by those affected with dementia directly.

Each borough and district area has several communities working to become more dementia friendly and sectors such as fire and rescue, libraries, police and leisure centres are engaged and developing action plans.

The project now reports into the Living and Ageing Well Board, consisting of partners from across the county, on a quarterly basis.

20. *Internet of things*
The "Internet of Things" Partnership project between Surrey and Borders Partnership Alzheimer's Society, University of Surrey and Royal Holloway running until March 2018, will put devices into homes of 700 people in Surrey with mild-moderate dementia for six months. 350 people will also act as a control group.

The start date for the trial has been delayed to February/ March 2017 due to the Health Research Approval process. People with dementia and their carers are still being recruited from across the county to take part.

21. *Get Active 50+ project*
Year one of the project saw 1,769 people taking part in activities which is more than half of the target across the two year period. A range of eight sports/ physical activities are on offer across the county with walking football, bowls, swimming, jogging, badminton, inclusive multisports, golf and exercise classes available for people to take part in. Providers have received dementia awareness training to ensure that people with dementia are well-supported. The project is funded from Sport England, borough and district councils, Active Surrey and SCC Public Health.

Older Carers (Outcome 5)

22. Partnership work across Surrey continues to improve outcomes for carers. The jointly developed Surrey Carers Commissioning and Development Strategy 2015 -16 to 2018-19 outlines the priorities and steps that will be taken across the health and care system to ensure carers are able to live a fulfilling life outside of caring. Each partner organisation has an action plan as to how the strategy will be delivered and support from the BCF budget has been dedicated to carers specific support across Surrey comprising £2.5 million per year for carer breaks

and £3.5 million per year for other carers support. The services funded include:

- carers' Support – independent information and advice;
- home based breaks including in end of life care situations;
- back care advice;
- carers' learning and work support;
- carers' support payments through carers organisations;
- GP carer breaks payments;
- benefits advice; and
- young carers' and young adult support services.

23. Significant progress has been made in referral pathways for carers into support, particularly through the carers' prescription.

24. These services provide support to over 20,000 carers a year with 11, 558 services provided to people aged over 65 years of age in 2015/16. 230 of these were over 85 years.

25. The Health and Wellbeing Board had an in-depth workshop on carers at the January 2017 business meeting. The Board agreed to support the Memorandum of Understanding that sets out principles for partners to collectively achieve the ongoing improvement of recognition and support for carers. This is a move towards a fully integrated approach and looks at the whole system as a process. A summary of the discussion can be found in the Public Update on www.healthysurrey.org.uk.

26. Future updates on carers on all ages will be reported as part of this 'improving older adults' health and wellbeing' priority update.

How we are tracking progress / impact

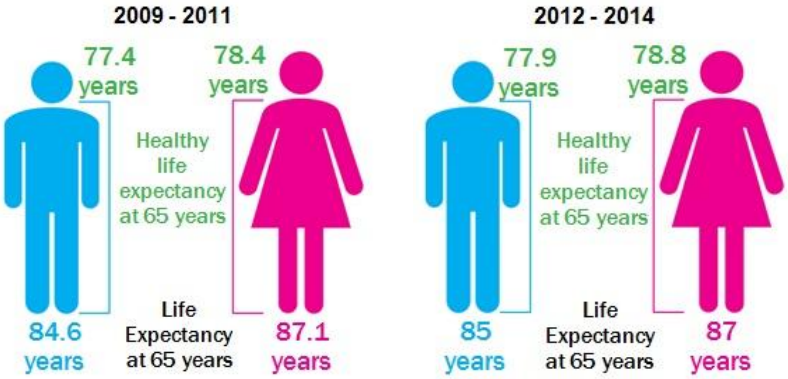
27. The Surrey Health and Wellbeing Board agreed a suite of measures to track progress across all five of the priorities set out in the Surrey Health and Wellbeing Strategy.

28. A dashboard has been developed and published on the internet to enable partners, key stakeholders and the public to keep track of Surrey's performance against these measures. The dashboard can be found at http://www.healthysurrey.org.uk/about-us/health-and-wellbeing-strategy

29. Measures included for the 'Improving older adults' health and wellbeing' priority are set out below under each of the outcomes with data from the BCF Quarter 2 data return from July to September 2016 (submitted to NHS England at the end of November 2016).

Outcome 1: Older adults will stay healthier and independent for longer

30. More people at age 65 in Surrey were expected to live longer and healthier lives in 2012 – 2014 than in 2009 – 2011.



31. According to the latest BCF return, SCC reablement service continues to support clients to remain at home 91 days after discharge from hospital. Countywide, 6% of clients had returned to hospital, 4% were in nursing or residential care homes and 10% had died. A further 5% were no longer in contact with SCC Adult Social Care. Given the complex needs and co-morbidities experienced by many service-users, these outcomes are mostly positive. The target is on track to be met.

32. In Surrey, meeting the target for admissions to residential care is on track. The way this data is reported following the migration to a new database has been reviewed. This has resulted in amendments to previous data and there is confidence in the updated figures provided for admissions to residential care homes. Previously reported: Q1 315; Q2 333 - 2016/17 admissions figures have been updated to Q1 - 142.2; Q2 - 129.6; Q3 - 83.8 per 100,000 population aged 65+

Outcome 2: Older adults will have a good experience of care and support

33. The proportion of Surrey adults (all ages) who have had an inpatient experience of health services and would recommend to their friends and family continues to improve. Surrey's performance for Q3 (95.2%) exceeds the target for 2016/17 (94.2%).

Outcome 3: More older adults with dementia will have access to care and support

34. Surrey achieved a diagnosis rate of 64.2% in Q3, which is an improvement from Q2, although still slightly below the target of 66.7%. CCGs in Surrey have developed strategies in their various localities to improve dementia diagnosis. Actions include the establishment of dementia work groups to ensure collaborative working, correct reporting of diagnosis by GP practices and setting up dementia friendly communities.

Outcome 4: Older adults will experience hospital admission only when needed and will be supported to return home as soon as possible

35. In Surrey, Q3 non-elective admissions increased by about 13% (28,740) more than the planned activity (25428). Increase in activity and variance to plan resulted from winter pressures, increased admission of patients with pneumonia and respiratory related conditions as well as short-term admissions of less than a day for observation. Work is on-going to understand the increases in non-elective admissions. On-going work programmes such as Primary Care in-reach programmes, Out of Hospital Primary Care access and demand and capacity modelling projects are underway in Surrey to help reduce non-elective admissions. (Data source MAR data General and Acute). Please note, this is for all ages and opportunities are being considered to break this down by age group.

36. The number of Delayed Transfers of Care (DTOC) increased to 1,006 in Q3. The rate of DTOC per 100,000 population (18+) in quarter Q2 was 771. This is a significant increase of about 57% in delayed discharges from planned activity (643). Two-thirds (66.5%) of the delays were attributable to NHS and 28% to Social Care. The top three reasons for NHS attributable delays were (1) Awaiting completion of assessment, (2) Nursing Home placement and (3) Patient or Family choice. For Social Care, these are (1) Awaiting Nursing home placement, (2) Awaiting care package in own home and (3) Awaiting completion of assessment. This information is being fed back to the various Local Joint Commissioning groups within Surrey to address issues relevant to their provider organisations.

Outcome 5: Older carers will be supported to live a fulfilling life outside caring

37. The quality of life score given by carers in Surrey is an average of 7.9 on a scale of 1 – 12 which is similar to England (2014/ 15). There is no trend data available for this indicator as the way it is collected has changed and therefore is not comparable.

Surrey Better Care Fund returns

38. The measures included within the Surrey Better Care plan are included in the measures set out above.

39. Annexed to this report (Annex one, two and three) are the quarterly Better Care Fund returns made for quarters one, two and three for 2016/17. In addition to the performance against the BCF metrics, they included information about the contributions to and expenditure from the Surrey BCF, progress against the national conditions and updates on a number of 'integration' metrics identified by NHS England.

Conclusions:

40. Much progress has been made in the last six months, most notably the focus of integrating health and social care, along with a focus on

improving the health and wellbeing of older adults in the STPs. There has also been significant progress at pace in each Local Joint Commissioning Group area.

41. The scale and pace of change required across the health and social care system is significant if it is to meet the rising demands placed upon services and become sustainable – the acceleration of integration plans is crucial to achieve this.

Next steps:

Next steps for this priority are to:

- Ensure improving the health and wellbeing of older adults is embedded in the three STPs covering Surrey.
- Produce a two year Better Care Fund Plan for 2017-18 and 2018-19 once the Policy Framework and Planning Guidance for this is published by NHS England.
- Have an in-depth workshop at a future Health and Wellbeing Board on nursing home and domiciliary care.

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Sources/background papers:
Annex 1 - BCF NHS England quarterly submission: quarter one 2016/17 (submitted on 9 September 2016) available online https://mycouncil.surreycc.gov.uk/ieListDocuments.aspx?CId=328&MId=5190&Ver=4

Annex 2 - BCF NHS England quarterly submission: quarter two 2016/17 (submitted on 25 November 2016) – available online https://mycouncil.surreycc.gov.uk/ieListDocuments.aspx?CId=328&MId=5190&Ver=4

Annex 3 - BCF NHS England quarterly submission: quarter three (submitted on 24 February 2017) available online https://mycouncil.surreycc.gov.uk/ieListDocuments.aspx?CId=328&MId=5190&Ver=4

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