Health and Wellbeing Board
5 April 2018

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

Purpose of the report: Performance Management/Policy Development and Review

Recommendations:

1. The Board are asked to:
   - Note the progress made in the last five years' of the improving older adults health and wellbeing priority of the Joint Health and Wellbeing Strategy
   - Note the Surrey Better Care Fund and Improved Better Care Fund returns for the 2017-18 Quarter two period (Annex 1).
   - Endorse the next steps for this priority in the context of the updated Strategy; and
   - Receive an update on this priority in 6 months' time.

Introduction

2. The Surrey Joint Health and Wellbeing Strategy, which was first published in 2012, set 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 strategy has recently been updated and identifies new areas for focus to improve the health and wellbeing of older adults in Surrey. This

9

priority update will look back at the journey we have taken in Surrey since 2012 and will look at where we are now, highlighting the achievements we have made along the way. This update will also look to the future to what we will focus on next and how we will track the progress of this to ensure we are making the differences we want to.

Background

4. In 2012, health and social care services for older adults looked very different to how they do today in Surrey. In 2012, services were variable across the county, older patients had to tell their story numerous times to a number of different health and social care professionals and had to attend a variety of different appointments. If older people were in hospital, they were waiting longer than needed to be discharged and were frequently ending up back in hospital soon after they had been discharged.

5. System-wide, there was no shared understanding of the issues for older adults and no shared understanding of a vision for how we could improve the health and wellbeing of older adults living in Surrey. There was a high proportion of people with dementia and people who were carers over the age of 65 years with limited working together to tackle these issues. The health outcomes for these groups were lower than for the general Surrey population.

6. Based on the needs of older adults identified in the Joint Strategic Needs Assessment, the Health and Wellbeing Strategy set out the outcomes that we hoped to see to improve older adults health and wellbeing:

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

7. The national Better Care Fund (BCF) programme aimed to bring health and social care partners together. In Surrey, the first BCF plan in 2014 set the strategic direction for the older adults priority, with the below three strategic aims, which the current two year plan (agreed by the Health and Wellbeing Board in September 2017), also prioritises.

   - 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 and 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

8. The Surrey Joint Health and Wellbeing Strategy and the Surrey BCF have been the main strategic delivery mechanisms for improving the health and wellbeing of older adults in Surrey over the last 5 years.

What actions have we taken together?

9. Partners across the Health and Wellbeing Board invested in a wide range of activities, services and programmes of work to improve the health and wellbeing of older adults from 2013.

10. The vision and strategic direction for this work was set at a series of Health and Wellbeing Board workshops starting in October 2013. These identified areas that required further focus across the health and social care system to make a difference to the health and wellbeing of older adults in Surrey; and the subsequent action plan for this priority was signed off by the Board in April 2014 - at the same time as the first BCF plan.

11. The action plan focused on the key outcomes of the strategy (paragraph 6) and the things that the system could do differently by working together.

12. The key achievements from 2012 to 2018 as a result of this action plan, the strategy and the BCF are outlined below under headings of the strategy outcomes.

13. Wider health and social care integration and BCF (supporting outcomes 1 – 5 of the Joint Health and Wellbeing Strategy)

- The BCF has acted as a catalyst for driving forward health and social care integration. As a system, we have learnt a great deal from our experience in developing plans, negotiating and agreeing governance arrangements, and through the implementation of our plans. Our governance and accountability arrangements in the Surrey system have matured, and provided the sound base upon which our STPs have been built, and the delivery of ever closer integration.

  The latest Surrey BCF plan for 2017-19 was formalised more quickly than in previous years, through seven joint Section 75 contracts. This BCF introduced further developments in our integrated working, agreeing as a system the approach for allocating the additional “Improved Better Care Fund” (iBCF), from the Department of Communities and Local Government (DCLG) . Also the introduction of the High Impact Change Model action plans for improving Delayed Transfers of Care from hospitals, with

separate joint plans being built for each Acute hospital system, being delivered in partnership with the local Acute Trusts.

- Wider integration and new models of care – current integrated models include (see previous updates for details on these):
  - East Surrey:
    - Integrated Reablement Unit
    - Integrated Discharge Team
    - Frailty Unit
    - CHC Discharge to Assess
    - East Surrey Intermediate Care Integration
  - Farnham:
    - Farnham Integrated Care Team (Vanguard project)
  - Guildford & Waverely:
    - Royal Surrey County Hospital (RSCH) Home First
    - Proactive Care Hubs in Guildford and in Waverley
  - North West Surrey:
    - Ashford Hub (SSASE Spelthorne GP area)
    - Thames Medical Hub (Runnymede and West Elmbridge GP area)
    - The Bedser Hub (Woking GP locality area)
    - Integrated Care Bureau (ICB)
  - Surrey Downs:
    - Epsom Health and Care (including the @Home Service) (20 GP practices in Epsom GP Health Partners Federation)
    - Dorking Integrated Community Hub (GP Federation Dorking Health Care)
    - East Elmbridge Integrated Community Hub (GP Federation - Surrey Medical Network)
  - Surrey Heath:
    - Surrey Heath Integrated Care Team
    - Surrey Heath Intermediate Care Integration

- The health and wellbeing of older adults forms an important part of the three Sustainability and Transformation Partnership plans (STPs) that cover Surrey. 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
  - Preventing older adults from becoming unwell.

14. Older adults will stay healthier and independent for longer

- We are helping more people to live independently with the proportion of older people (65 years and over) who were still at home 91 days after discharge from hospital has increased by 5% in Surrey from 2012/13 to 2016/17.
- More older people are able to choose how their care and support needs are met so that they can stay healthier and independent for longer in an environment appropriate for their needs. We have

done this through a county wide strategy aiming to deliver the best options of **accommodation with care and support** for older adults living in Surrey who need it. This includes nursing and residential care, extra care housing and specialist accommodation supporting people with mental health, substance misuse and learning disability needs. We are integrating our approach across health, care and community services in order to do this.

- One priority of the BCF, and monitored as one of its key metrics, is the rate of individuals aged 65 and over, who are permanently admitted to care homes. This metric is one way in which independence can be measured, as the desire is to maximise the number of people who can continue to be supported in their own homes, in a community setting. It has been possible to decrease the Surrey rate per 100,000 population from the 2014/15 year to date total to the 2016/17 full year total, by 12%.
- Simple equipment and technology enabled support, funded through our local BCF, has assisted older people to live more independently, supporting people with their activities of daily living, or by monitoring their safety. Simple equipment, or small changes to homes can make the difference between living independently and needing help or it can make caring for someone easier.
- Additionally, through the Disability Facilities Grant (DFG) pooled through the BCF, Surrey's Boroughs and Districts receive funding from DCLG for the provision of home adaptations which also supports older adults to remain independent and at home. And in 2017/18, a portion of that funding has also been provided by Boroughs and Districts to supplement health and care spend on community equipment.

15. Older adults will have a good experience of care and support

- The proportion of Surrey adults (all ages) who have had an inpatient experience of health services and would recommend to their friends and family was another key BCF metric and from April 2014 to March 2017, this improved from 92% to 97% across Surrey.

16. More older adults with dementia will have access to care and support

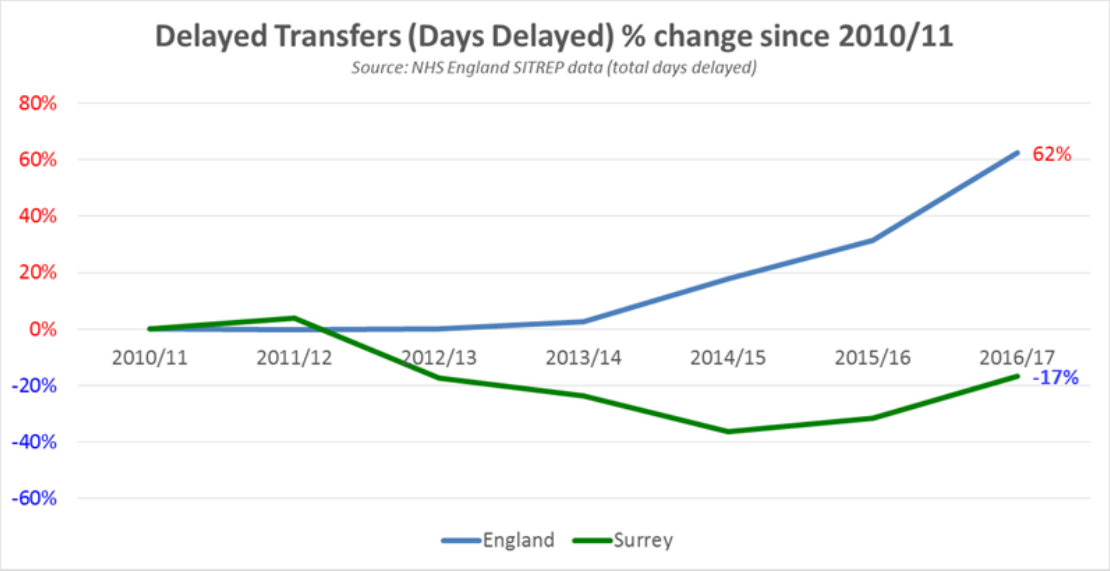
- Dementia diagnosis, as a percentage of local demographic estimates, was a locally identified BCF indicator and priority, and from April 2014 until March 2017, this improved by 14% across the county.
- We commissioned a dementia navigator service which supports over 1400 people with dementia and their carers each quarter; provides continuity of specialist support and advice; actively facilitates 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 carer's and family, as and when they need it throughout their dementia journey. The navigators (currently under contract with 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.

- Over 100 Dementia Friends sessions have taken place in Surrey, resulting in over 1500 new Dementia Friends.
- Piloted the "Internet of Things" partnership project between Surrey and Borders Partnership, Alzheimer's Society, University of Surrey and Royal Holloway. This involved putting devices into homes of 700 people in Surrey with mild-moderate dementia for six months. We are awaiting results of the research.
- Get Active 50+ provided sports and physical activities for over 2000 older people. Providers received dementia awareness training to ensure that people with dementia were well-supported.

17. Older adults will experience hospital admission only when needed and will be supported to return home as soon as possible

- A key BCF metric is the number of non-elective admissions to hospital, and it is a priority to keep this low for the system. Over the years of the BCF, while the rate has increased due to rising demand, Surrey has maintained a non-elective admission rate consistently below that of England overall.
- Delayed Transfers of Care (DTOC) from hospital, another BCF priority, has seen a decrease of 22% from April to November this financial year, across Surrey. And if we look at this measure over the last 7 years, DTOC days have increased by 62% in total across England though they have reduced by 17% in Surrey. Between 2010/11 - 2011/12 Surrey's performance was behind the England average. However, action taken since then, including embedding social care teams at hospital sites and implementing 8am to 8pm working 7 days a week, has enabled Surrey to significantly outperform the England average.



- Each local Acute system with support from ASC has built their own High Impact Change Model (HICM) action plans to improve Delayed Transfers of Care from hospitals. Some local examples of HICM activity include:

- East Surrey: Improved patient care in care homes - reduction in admissions and conveyances between care homes and the hospital, with continued growth in savings.
- G&W: Trusted Assessor model is in place in more than half of care homes. Out of area DTOCs (from Hampshire) have also decreased due to dedicated Adult Social Care resource in the local Acute hospital.
- North East Hampshire & Farnham & Surrey Heath: Phase one of the Frimley South Discharge to Assess plan has been initiated, focussing on intermediate care and complex individuals. Through a Discharge Collaboration Fund - protocol has recently been drafted for agreement.
- Surrey Downs: Continuing Healthcare trusted assessor process is now in place and being utilised.
- North West Surrey: The new Alamac database has been reviewed and updated to ensure full capture of system flow information; this has been completed in line with the Surrey Heartlands roll out of Alamac, which will provide both a local and STP view on activity.

18. Older carers will be supported to live a fulfilling life outside caring

- The quality of life score given by carers in Surrey, from the biennial Carers survey, 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.
- In 2018, services for carers in Surrey involve:
  - Independent Carers Support services
  - Breaks services agreed via GP practices
  - Identification of carers through the Carers Prescription system
  - High quality breaks services provided by Crossroads Care
  - Back care (moving and handling service for carers)
  - Support through Carers Assessments
  - Independent support for young carers and young adult carers
  - 25 Carer Practice Advisers supporting whole system working in statutory assessment teams and promoting integration at local level
  - Carers Digital Resource for carers
  - Promoting Carer Friendly Employment practice both within the health and social care workforce and wider community
- Below are some of the key achievements for older carers in Surrey in the last five years:
  - Receipt of a national Health Service Journal Award for Commissioning for Carers
  - Whole system working enhanced by adoption of “Together for Carers”
  - One of 4 exemplar areas working with NHS England on embedding carers issues within the work of STPs
  - 24,074 of carers registered with GP practices has risen by 8.66% in 2017-18

9

- 31,438 carers services delivered as a result of 20,953 carers prescriptions
- Carers Digital Resource was developed for Surrey but is now being rolled out nationally and is already used in 20 local authorities and several large employers as an employee benefit
-

What have we learnt?

19. As a health and care system, over the past 5 years, we have learnt a huge amount from our experience in developing plans, negotiating and agreeing governance arrangements, and through the implementation of our plans. Our governance and accountability arrangements in the Surrey system are now well matured, and have served well in the building of our STPs and will drive the delivery of integration across Surrey in the coming years.

20. The Health and Wellbeing Board built the work around whole systems partnership working and has proved invaluable at strengthening relationships and understanding between local government and NHS partners.

21. The re-alignment of Adult Social Care with CCG boundaries enabled and accelerated the development of local integrated health and social care services focused on the frail elderly. The BCF led to the development of new local joint commissioning arrangements between the council and CCGs, with pooling of budgets and co-location or integration of teams. By co-locating and integrating teams we have learnt that it enables information to flow easier meaning patients tell their story once instead of multiple times. By bringing different organisational cultures together we have seen improvements in communication, understanding and trust between partners.

22. The system has reaped the benefits of working through the challenges that the first year of the BCF provided. We learnt that true partnerships take time and commitment to develop and with open and honest dialogue, the development of shared objectives and ambitions it opens the system up to a greater appreciation of the opportunities integration can provide.

23. Having a partner lead on system wide health and social care metrics (Public Health team at Surrey County Council) enabled existing arrangements for intelligence sharing between partners to be expanded between CCGs, adult social care and public health. By using data visualisation such as Tableau, it has enabled us to communicate to a wider audience by presenting information clearly and succinctly and enabling us to have a shared understanding of the needs and performance across the county.

24. Building on the points above, the development of STPs in Surrey, has provided significant learning including:

- The importance of providers and commissioners leading and tackling challenges together
- The value of the wider determinants of health and the role the voluntary sector and districts and boroughs have to lead and deliver this
- Clinical and professional leadership across health and social care is crucial to enabling integration and system wide transformation
- Patient and public engagement is integral to the transformation of health and social care services
- The benefits of sharing skills across organisations, as demonstrated with local authority research expertise being used to develop the engagement model which has been recognised as best practice nationally.

What next?

25. The 2018 Health and Wellbeing Strategy continues to focus on older adults health and wellbeing and we will get it right so that:

    - Older adults stay healthier and independent for longer
    - Surrey is dementia friendly
    - Carers are identified and supported
    - People at the end of their life can choose where they die

26. A dashboard will be developed and published on the internet to enable partners, key stakeholders and the public to keep track of Surrey's performance against these updated strategy outcomes.

27. The BCF plan for 2017 – 19 has been agreed and outlines the areas of focus and next steps for integration of health and social care to be:

    - recognition that the pace of change and integration across Surrey needs to increase to meet rising demands, financial challenges and our ambitions for improving people's health outcomes;
    - the need to keep developing a more coherent and joined up approach to 'market management' as an important area of focus – this will help to ensure we have the right capacity to meet local needs and support the delivery of our sustainability goals;
    - the acceleration of our integration plans places greater importance on the engagement and involvement of patients and service users, and staff in shaping the changes that are being made; and.
    - focus on local delivery of HIC models in coordination with respective A&E Delivery Boards, to deliver improvements in helping individuals home from hospital
    - continue to coordinate Surrey-based integration plans and vision, across our complex system, and taking advantage of the opportunities in collaboration and shared system learning.

28. The BCF pooled budget arrangements across Surrey will be part of the future governance arrangements of STPs and integrated care

9

partnerships and wider joint commissioning arrangements. Integrating health and care services continues to be a key priority in the STPs going forward as described in the STP update at the 1 March 2018 meeting.

29. A few examples of local next steps include:

- A new model of integration involving Intermediate Care, Rapid Response and Reablement into one service in Guildford & Waverley
- The development of a hybrid health and care worker across both acute and community and community hospital discharges using current vacancies across all three services
- Continued development of the trusted assessor role across all disciplines
- A new Stroke Service launch in March in Epsom

30. The Health and Wellbeing Board had an in-depth workshop to understand and support some of the issues affecting older adults in February 2018. The Board heard about current work and challenges relating to falls prevention, frailty, social isolation and care market provision and discussed ways that they could work differently together to support older adults to live independently and healthily. Key actions to come out of this discussion included:

- The Health and Wellbeing Board to support partners to work better with communities to identify and help frail people.

- The Health and Wellbeing Board will work to embed the use of Health Impact Assessments across the health and social care system working with borough and district colleagues, Local Enterprise Partnerships and the care market. They will be used to champion the wider determinants of health; to help plan and prepare for health provisions and requirements relating to the care market; and to gather information relating to social prescribing to improve connectivity and combat social isolation.

- The Board will consider how the Making Connections programme – to help tackle social isolation – can be adopted widely in Surrey.

Conclusions:

31. We have achieved a great deal over the life-course of the previous strategy, however, there is always more that can be done. We will continue to work hard to deliver the new strategy to ensure that the health and wellbeing of older adults in Surrey is the best it can possibly be.

Next steps:

Next steps for this priority are to:

- Develop an action plan for this priority, feeding in the actions from the February Health and Wellbeing Board meeting.
- Provide a further update to the Health and Wellbeing Board in six months.

Report contact:
Victoria Heald, Health and Wellbeing Programme Manager, Adult Social Care and Public Health, Surrey County Council
Contact details: 020 8541 7492 / victoria.heald@surreycc.gov.uk

Annexes/ further reading:

Background papers circulated to the Board – Better Care Fund submissions to NHS England for quarter two.

This page is intentionally left blank