Health and Wellbeing Board
6 December 2018

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

Purpose of the report: Policy development and review

Recommendations:

1. The Board are asked to:
   - Note and support the ongoing transformation work around Health and Social Care Integration, Adult Social Care Practice Improvement, and Accommodation with Care and Support.
   - Note the Better Care Fund returns for quarters one and two 2018/19.
   - Engage with and support the work to develop a Better Care Fund plan for 2019/20 once the Policy Framework and Planning Guidance for this is published by NHS England.
   - Note that the Surrey Strategic Health and Care Collaborative will act on behalf of the Health and Wellbeing Board to oversee preparation of Better Care Fund returns going forward.

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. A range of programmes are being undertaken across the partnership to improve the health and wellbeing of older adults. This Priority update will predominantly focus on integrated health and social care services (including the Better Care Fund), transformation work around Adult Social Care (ASC), and development of Accommodation with Care and Support in Surrey.

What we are trying to achieve

5. The Surrey Better Care Fund 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 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

Update on the actions we are taking together

Health and Social Care Integration

6. A range of work continues at Integrated Care System/Sustainable Transformational Partnership level, including prevention work around alcohol support services, Make Every Contact Count, social prescribing, and workplace wellbeing.

7. In addition, there are a range of health and social care integration projects being delivered at a community level:

North West Surrey

- Three multi-disciplinary Locality Hubs have now been established in the North West Surrey area: The Bedser Hub based at Woking Community Hospital, The Ashford Hub based on the Ashford Hospital site, and The Thames Medical Hub based at Walton Hospital. Multi-agency professionals triage individuals across health and social care and deliver interventions support the individual to remain healthy and independent in the community and prevent hospital admissions.
- ASC Reablement and Intermediate Care are working closely together in the Integrated Discharge Bureau, sharing cases and using joint paperwork to support discharges of medically fit individuals. At present, the service delivers same-day discharge for 90% of medically fit patients.

East Surrey

- ASC Reablement and First Community Health Intermediate Care Team are working jointly and embedding joint Standard Operating Procedures, with a view to potential colocation in the future. Individuals are supported to achieve their full potential and avoid/reduce their dependency on long term packages of care to remain healthy and independent in the community and on discharge from hospital.
- The Integrated Discharge Team at East Surrey Hospital continues to work to maintain low Delayed Transfers of Care.

- Wellbeing Prescription Plus services are live, building on existing health and wellbeing support services to residents. The Plus service supports high dependency residents, for example people who may already have been diagnosed with diabetes, dementia or arthritis. The Wellbeing Prescription Plus service will visit these patients in their homes to make sure they are accessing all available services to address their complex needs.
- All Together Practice champions work alongside GPs and wellbeing advisors to support individuals health and wellbeing in the community and reducing dependency on statutory services; reducing social isolation, promoting community and individual assets, talents and skills.
- The 21-bed Integrated Reablement Unit is operational in East Surrey Hospital. Progress has focused on reviewing the number of beds and ongoing development to reduce the length of stay to 5 days for those that need it.

Mid Surrey

- The Epsom Health and Care Alliance continues to work jointly, recently opening a post-acute unit ward with dedicated Reablement staff on Croft Ward at Epsom Hospital.
- Work is underway to develop comprehensive data sets for Primary Care Networks, with a view to risk stratification data and tools being used in multi-disciplinary teams by April 2018.

Guildford & Waverley

- Home First discharge to assess model including ASC Reablement, Intermediate Care and home based care agency support is established and embedded out of Royal Surrey County Hospital.
- Proactive Care Hubs are established in Central Guildford and Waverley and are continuing to develop shared pathways. Multi-agency staff within the hubs work collaboratively to provide services to residents with complex needs, acting on referrals from GP practices in the area.
- Intermediate Care Integration – A Memorandum of Understanding is being developed for integrated ASC Reablement and community provider intermediate care.

Surrey Heath

- Discharge to Assess service out of Frimley Park Hospital went live in July 2018. Evaluation is underway on the current model.
- Surrey Heath Integrated Care Team continues to operate an integrated front door service, where multiagency professionals triage individuals across health and social care. Interventions are delivered to support the individual to remain healthy and independent in the community and prevent hospital admissions.
- The anticipatory care for frailty project was extended to all GP practices in Surrey Heath in June 2018.

8. Some new models of care built on pre-existing partnerships between local services are developing into Integrated Care Partnerships in Surrey. A range of work is underway at this level. These ICPs will adopt evidence-based, population health management approaches to design and deliver place-based care models centred on individuals, integrating mental health, physical health and social care.

Accommodation with Care and Support

9. Surrey County Council is aiming to shape the accommodation with care and support market for older people and those with a learning disability. This will be achieved through the development of a commissioning strategy which includes a number of options to deliver the following priorities.

- Deliver an additional 724 affordable extra care places by 2028
- Ensure provision of 760 specialist residential and nursing care beds across the county to meet the population demand for 2028
- Enable 21% of those aged 18-64 year old with a learning disability and/or autism in residential care to transfer into supported living or other settled provision over a 3 year period.
- Reduced the proportion of those, who are 65+ with a learning disability and/or autism, who are in 'specialist' services.
- Developed more specialised placements and settings within Surrey to cater for more complex needs.

ASC Practice Improvement

10. Surrey County Council are initiating a transformation programme to manage the level of Adult Social Care demand down through a range of initiatives and interventions.

11. In broad terms the strategic approach is to strengthen and enhance preventative services, change the conversation to focus on family and community resilience, develop an enhanced offer for recovery and reablement (including an extended telecare offer) and for those who after an assessment require care and support, to tightly manage and consistently review their care and support needs.

12. The scope and approach of this work is in development at present.

Surrey Better Care Fund

13. Annexed to this report (Annex one and two) are the quarterly Better Care Fund returns made for quarters one and two for 2018/19. In addition to performance data against the BCF metrics, they include information about local BCF initiatives that support local systems.

14. The 2017-19 Surrey Better Care Fund Plan is in its second and final year of delivery. Once the Policy Framework and Planning Guidance for the next Better Care Fund Plan is published by NHS England, work will need to be done quickly to develop a plan for 2019/20.

15. The Health and Social Care Integration Board has merged with the CCG Collaborative to form the new Surrey Health and Care Commissioning Collaborative. The Collaborative will act on behalf of the Health and Wellbeing Board to oversee preparation of Better Care Fund returns going forward and Better Care Fund planning for 2019/20.

How we are tracking progress / impact

16. 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.

17. 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

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

18. According to the latest BCF return, Surrey County Council reablement service continues to support clients to remain at home 91 days after discharge from hospital. Over 80% of service users do not require long term support following the period of reablement. Despite this, current performance is just over target and similar to the same period in 2017/18.

19. In Surrey, we are on track to meet the target for admissions to residential care. We have reviewed the way this data is reported following the migration to a new database. Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population has reduced from 132.4 in quarter 1, to 112.0 in quarter 2. Current performance is also lower than the same period in 2017/18.

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

20. The proportion of Surrey adults (all ages) who have had an inpatient experience of health services and would recommend to their friends and family stood at 96% for September 2018.

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

21. Surrey achieved a diagnosis rate of 65.2% in 2018, which is an improvement from 64.1% in 2017.

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

22. In Surrey, Quarter 2 non-elective admissions were 2,539 per 100,000 population (for all ages), a variance of around 17% above planned activity. Ongoing challenges include ensuring that there is sufficient workforce profiled to match demand with capacity during the winter period, ensuring admission avoidance teams are well-staffed and flexibly deployed, SECAmb using all community conveyance options, and having social workers at the front door in times of surge.

23. The number of Delayed Transfers of Care (DTOC) delayed days decreased to 4782.1 in Q3[1]. Surrey is on track to meet its target with four out of the six Clinical Commissioning Groups performing well within or below their targets. The methodology for recording Delayed Transfers of Care changed for 2018/19 meaning direct comparison with figures in the previous Health and Wellbeing Board Older Adults update report cannot be made.

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

24. The most recent quality of life score given by carers in Surrey was an average of 7.9 on a scale of 1 – 12 in 2014/15. This was similar to the England average.

[1] This includes provisional data for September 2018

9

Next steps:

25. Next steps for this priority are to:
    - Continue and refine delivery of local Health and Social Care Integration projects.
    - Produce a Better Care Fund Plan for 2019/20 once the Policy Framework and Planning Guidance for this is published by NHS England.

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Sources/background papers:
BCF NHS England quarterly submission: quarter one 2018/19 (submitted on 20 July 2018)
BCF NHS England quarterly submission: quarter two 2018/19 (submitted on 19 October 2018)