Surrey County Council
Commissioning Strategy for Older People 2021-2030

Cabinet Approved: November 2021

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1. Foreword

Surrey County Council (SCC) recognises that getting older and living longer is a privilege for many however it is not something we should take for granted. We understand that to live healthy and well, with dignity and independence and to remain in your own home can prove more challenging for some than others but we want this to be the aspiration for all residents living in Surrey.

> ***"Ageing presents a wide variety of issues and from the whole cohort of 'Older People'. Navigating the route to a fully supported set of needs is truly challenging." – Older Person lived experience volunteer***

This strategy for Older People and unpaid carers (those 65 and above) living in Surrey provides an overview of work that the Council, and its partners commit to in order to make Surrey a place where people can maximise their own life opportunities, whether eligible for social care services, or not. It has been informed through collaboration and consultation with older people living in Surrey and their networks of support. Responses and experiences of people using social care and support services have driven the content of this strategy. Individuals' preferences and priorities have been captured including what we will do to respond to these and have become '*our priorities*'.

> **"You can rest assured that engagement was well designed and delivered" - *Unpaid older carer living in Surrey***

Surrey is a unique place to live and work. We will respond differently to the needs of Surrey's vibrant and diverse population, which is to be celebrated, but also to recognise that Surrey has significant health inequalities with some people still feeling excluded or disadvantaged which we must address. We will therefore continue our work consistently across Surrey and work closely with health colleagues to ensure we align our efforts. This is to ensure no-one is left behind and to ensure there is fair and equal access to services and support regardless of who you are, where you live and whether you can fund your care package or not. Additionally, we have a duty under the Care Act to ensure that people who lack capacity to make decisions themselves are supported to access and use these services.

This document is how we plan to champion greater choice, quality, and control for older people as it sets out changes in our approach to commissioning care and support and our work with stakeholders. By outlining improvements for existing services and sharing our ambition and commitment to innovation and collaborative working with partners we will enable Surrey residents to thrive in later life.

Our key areas of focus:

- Supporting residents, unpaid carers, and their families to **have access to the right services and information, advice, and guidance** to make informed decisions about the care and support they need.
- Work with partners such as the NHS in Surrey, the eleven district and borough councils and local community and volunteer run organisations to **provide services that work together seamlessly and help provide a sense of community**
- Continue **to work closely with providers of social care services and develop good working relationships** with them to learn from best practice and their expertise within the sector to innovate, improve quality and increase choice available to residents.
- Continue to **listen, engage, and collaborate** with Surrey residents, unpaid carers, partners, and stakeholders to ensure they are **visible and valued** to enable SCC to continually improve and learn.

When drafting this strategy, it was made clear that we cannot simply define old age by a number. Many residents and unpaid carers we engaged with are living independently, working, and volunteering well into their 70s, 80s and beyond. This strategy aims to ensure that residents and unpaid carers like these and others, can continue to champion the active lives they want.

The strategy been produced in the most uncertain of times for the public, NHS and social care sectors and responding to the pandemic has taught us some valuable lessons and enabled some positive change to take place in the way we work together with all partners. Local communities and support services have demonstrated resilience and an ability to adapt and innovate to respond to the needs of new challenges to communities which we want to build upon for the future.

The most significant positive has undoubtedly been relationships. In the face of adversity and uncertainty providers of social care, social work teams and NHS colleagues have relied heavily upon each other and we will continue to improve this joint working. We must also acknowledge the devastating impact on social care, affecting unpaid carers, the provider market, and their workforce during the COVID pandemic. Over the coming months and years, we will ensure that COVID recovery is upmost in our minds as we deliver the outcomes detailed within this strategy.

At the time of finalising this strategy we have also seen the Governments initial proposals for the health and social care sectors contained within their Build Back Better plans. The key messages contained within that document align with the ambitions set out within this strategy. Surrey is committed to greater integration and collaboration between NHS and social care to improve outcomes for residents by accessing services and support in the most appropriate place to meet their needs. We will ensure our services and plans account for future proposed changes to personal budgets and caps on care by continuing to work closely with providers and residents. We understand that it can be an often complex, confusing, and uncertain time when individuals require health and social care services whether funding them directly or not. As the Government take forward its intention to reform social care in order to meet the increasing complex needs of the ageing population, Surrey will continue to adapt and review its plans and priorities set out in this strategy to ensure we deliver these reforms in a way that works for Surrey residents.

We will ensure that our aims and objectives link clearly with key strategies for Dementia, All Age Autism and Surrey Health and Well Being (to name a few) as well as our Surrey County Council Community Vision 2030. The detail for achieving these outcomes will then be clearly defined in a series of Market Position Statements (MPS) – the main aim of these documents is to encourage commissioners, people who use services, unpaid carers, and provider organisations to work together to detail what care services and support is needed in the area and why.

This strategy is **your** strategy. If you are one of Surrey's older people, an unpaid carer, family member or provider this strategy outlines and responds to the feedback and views you have shared through our comprehensive coproduction approach conducted over the last 12-24 months. This includes your responses given at engagement sessions and survey findings relating to specific services and support provided by SCC.

Thank you for taking the time to help shape this strategy. Please take the time to read this strategy, and we look forward to continuing to work with you to deliver the strategy and creating a brighter and better future for all of us living and working in Surrey.

Jonathan Lillistone, Assistant Director Commissioning

Health, Wellbeing and Adult Social Care - Surrey County Council

2. Introduction to Adult Social Care (ASC) in Surrey

The provision of services and support for older people is significant part the Adult Social Care (ASC) Directorate of SCC, accounting for over 32% of its annual budget of £506m (21/22). Through this budget SCC not only provides funded support to over 5,600 older people, their unpaid carers and voluntary organisations that support too, but also gives guidance and advice to older people, their relatives, and unpaid carers to understand their future care options and help them make informed care-related decisions.

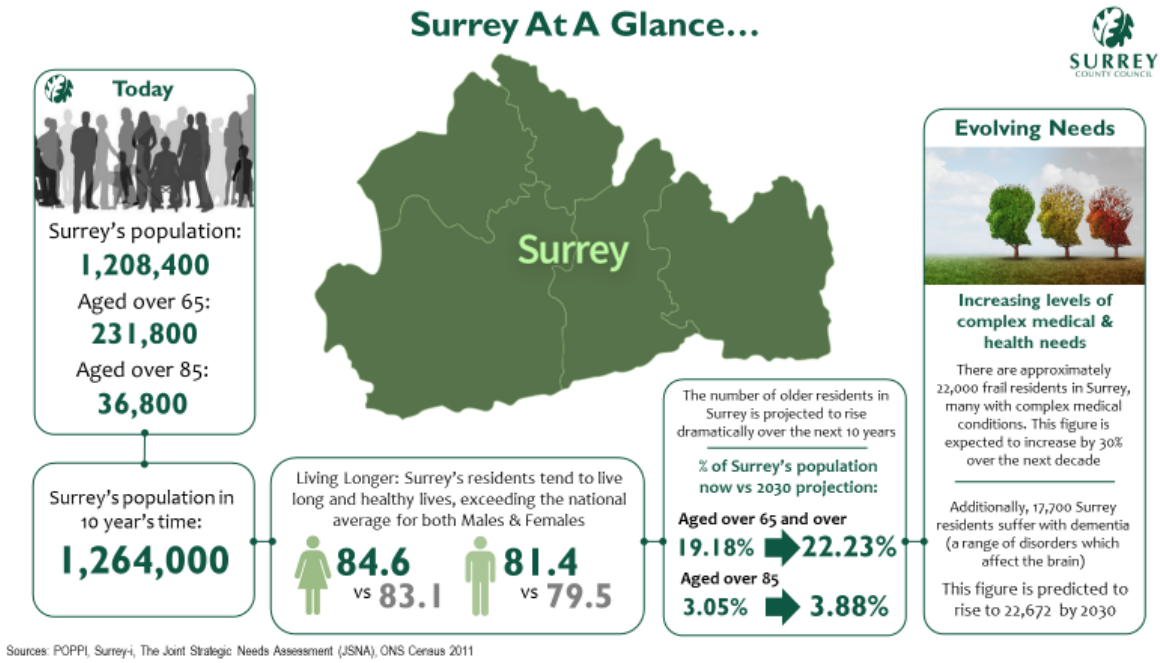
The purpose of this strategy is to set out how the ASC Directorate will, from 2021 to 2030, support people to age well and live as independently as possible in Surrey. Acknowledging the growth in demand and recognising that this strategy is about supporting SCC to manage within its resources, this document will show through **"We will"** statements what commissioning will do to deliver the strategy and with whom:

- ✓ Ensure older people and their unpaid carers get the care and support they need at the **right time and place**, with an emphasis on promoting choice, dignity, and independence
- ✓ Work with our strategic partners to move to an **early intervention** approach in supporting people, focused on older people's strengths and reablement to avoid a crisis happening, where possible
- ✓ Engage fully with voluntary and private sector providers to shape and **diversify the market** of care and support
- ✓ Understand and act on the direct experience of people receiving care, alongside people expecting to receive care in the future, when deciding **how to commission** services and support
- ✓ Focus on the achievement of individual and community outcomes through **good quality**, value for money services

In 2018, SCC engaged with residents, communities, and partners across the county to understand what Surrey should look like by 2030. After being informed by these conversations SCC created a **Community Vision for Surrey in 2030**, which included the following commitment for health and social care:

Surrey 2030 Vision

"By 2030 we want Surrey to be a uniquely special place where everyone has a great start to life, people live healthy and fulfilling lives, are enabled to achieve their full potential and contribute to their community, and no one is left behind"



The Joint Strategic Needs Analysis (JSNA), which looks at the health needs of Surrey's population, confirms that the county has an increasingly ageing population with a life expectancy above the national average. Rising life expectancy is a cause for celebration, though with more people living longer potentially more Surrey residents will need some form of care and support at some point in their life. **Our aim with this strategy is to increase the years of healthy life for our residents and measure this over time as a key indicator of success.** There are also changes in the structure of our society which mean that increasingly older people are living alone with less family support. ***By 2030, the number of people aged 75+ predicted to be living alone will have increased by 27%.***

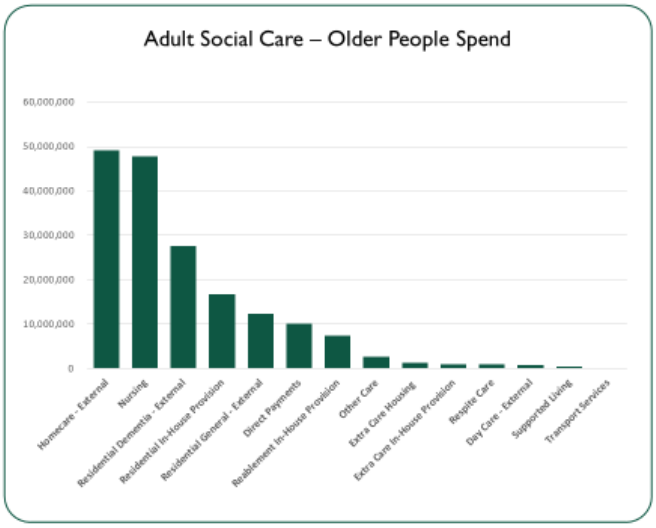
Information taken from the 2011 Census and Office for National Statistics (ONS) population projections, predicted the number of unpaid carers 65 and over would increase by 17% from 2016 to 2025, and for unpaid carers aged 85 and over this was 31%. Additionally, recognising the number of unpaid carers that care for someone with Dementia which influences the health and well-being of those older (and younger) carers, and the impact that then has on their own health and future ability to be financially self-supporting. This is not to demonstrate the reliance on unpaid carers but to acknowledge the importance of the huge part they pay in supporting people, whilst many being an older person themselves. More information on unpaid carers is available in Surrey-Carers-Strategy-Consultation-Document-NApp.pdf (actionforcarers.org.uk)

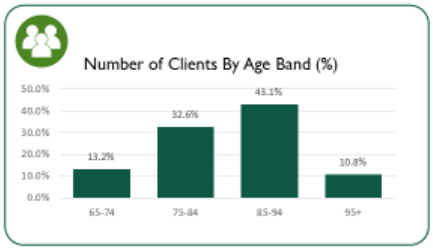
Multimorbidity (defined as the co-occurrence of two or more chronic conditions) and frailty (which commonly coexist) contribute to more complex care needs for residents. In addition, there is an increasing number of children and younger adults with high complex needs surviving into older age. One of the health conditions closely linked to the provision of care and support is dementia, associated with an ongoing decline of brain function. Dementia is most common amongst older people and in Surrey and ***it is estimated that between 2020 and 2030 the overall number of people with dementia is forecast to increase by 28%, from 17,700 to 22,672.***

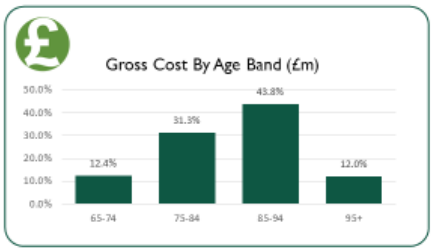
In 2019, a significant amount of the social care budget for older people (as the primary need) was spent on residential and nursing care. However, to support people to maintain their independence and wellbeing for as long as possible, we need to review how we use our resources

so that we can focus more on preventative services and not wait until an emergency develops before action is taken to support people.

SCC spend on older people's Social Care







ASC Commissioners are working jointly with a wide range of stakeholders: Our NHS partners, community, public health, operational and hospital teams across Surrey, as well as the voluntary and community sector. Our focus is to improve the way we work and how people access our services. We are committed to integrating services where it is sensible to do so to achieve improved outcomes.

> ***"More often than not an individual's social care journey starts with a health conversation. We need to ensure people receive the right information and are given time to make decisions about their own long-term health and social care needs." – NHS colleague***

What does this mean when considering Older People's expectations and gaps in provision?

Adult social care and NHS services can be quite complex and bewildering to navigate. This is even more challenging when people are accessing services for the first time, usually during or following a personal crisis. Between January and March 2021, Adult Social Care received over 8,000 enquiries into the contact centre. These were from residents, unpaid carers and families requesting information and advice about future care and support needs, as well as looking for immediate help. Surrey also has a strong self-funder market which means individuals and families will often arrange and pay for their own care, and many Surrey resident typically do not consider contacting Adult Social Care. For example, as of January 2020, SCC commissioned a total of 2,133 residential and nursing placements in the county out of the 10,762 beds available in local services with the remainder being used by people who fund their own care. The placements SCC funds equates to around 20% of the Surrey care home market but SCC will work to ensure the sustainability of the whole market to ensure that the council has sufficient partners from which it can purchase care at value for money, that meets the needs of the growing ageing population with complex needs.

A focus for us is to ensure people are making informed decisions about their own care and support, this is to prevent common issues such as individuals entering care arrangements that aren't right for them. And with many individuals living longer with some care arrangements that cannot be sustained financially in the longer term.

> ***"Key themes recorded around the public's attitudes towards social care expose a lack of awareness about social care, confusion about how services are funded and a widespread lack of preparation or planning for future care needs." – SCC employee***

It is therefore essential that we strengthen our relationships with not only our partners in the NHS, community and faith sector but also develop closer relationships with providers of health and social care services. This will be through raising awareness of information, advice and guidance for providers and residents but also through more formal contract, relationship, and market management arrangements.

Due to the scale of self-funding within the Surrey market, there are challenges for statutory health and social care services when agreeing prices for care services with the market for care provision. Whilst health and social care are significant purchasers of care from providers, purchasing the right care at rates that are fair and affordable for Health and Social Care budgets remains an ongoing challenge. Despite people's needs changing, **there remains a lack of available capacity for people with complex needs, who are at high risk of falls and that have physical and behaviours that challenge care givers as examples**. Within this strategy and associated Market Position Statements, we will set out clearly how we intend to address these market issues.

A further challenge for health and social care is to **invest in services that provide greater opportunities for residents to be assessed and supported before entering longer term care arrangements**. These services are often referred to as intermediate care services and ensure that a crisis or often a health emergency doesn't lead to an inappropriate care placement. Often residents, when afforded the right time and support, can return home independently, or receive a service within their home as opposed to moving into residential or nursing care arrangements. This strategy will talk about these types of services, in particular **Discharge to Recover and Assess (D2A) and Collaborative Reablement Service (CRS)** referenced in more detail on page 15 which will further this ambition.

3. The Vision – Commissioning Intentions

Our plan and approach to commissioning Older People's services sits alongside a broader **Adult Social Care Commissioning Intentions** document. These have been produced as one-page documents and are available on the SCC website. These documents are reviewed annually and set out our plans publicly. This year we have highlighted 8 key areas of focus for 2021-22 and beyond. Key elements of the current document are as follows:

Transforming commissioning

In January 2020, SCC re-introduced strategic county wide commissioning teams to ensure that through a more strategic commissioning approach it could deliver better outcomes for Surrey residents. With a strong focus on commissioning services across the county to meet the assessed care needs for Surrey residents we are working increasingly closely and in partnership with the NHS and other partners. For example, collaborating with our Integrated Care Systems (ICS) and

placed based partnerships to shape services from a county wide perspective through to working with district and borough councils, and Primary Care Networks (PCN) when providing services to a smaller group of residents and in defined geographic areas. The Council needs to ensure equitable good quality services for all residents, ensure fair access for all, oversee, and manage large provider markets while working at pace and scale

Consistency is essential in providing support to health and social care teams as well as providers, and this includes key commissioning functions such as contract management, relationship management, good service design and delivery. Building on the good and learning from the not so good, starts with effective commissioning and understanding the needs of both residents and our teams. Commissioning must enable good practice, strong financial management and better outcomes for all.

Market Management

We want to change the nature of the council's relationships with providers. We want to demonstrate true partnership, trust and respect that will lead to greater transparency, shared endeavour, and innovation. We are also committed to building better management IT systems to become more business-like in our operation which will benefit our colleagues and stakeholders as much as it will our providers and residents. Market management will also extend to better communication with the social care sector and tackling common issues together such as workforce and changes to Government policies and legislation. With a market of around 200 Home Based Care Providers and 238 Residential and Nursing providers the scale of this task in huge. Essential to this is working closely with the Surrey Care Association who represent a proportion of the market and provide good oversight and support to Surrey's care sector.

Partnership working with NHS Integration and District and Borough

We are committed to identifying and developing opportunities to collaborate with NHS colleagues and District and Borough's. We will ensure we play a central part in local and countywide conversations to share learning and information to enhance our collective work. For example, we will commit to attending the Health and Wellbeing Board, Dementia Board, Home Adaptation Steering groups, community meetings and local planning forums. Through this approach we will use our resources together more effectively to codesign services for the benefit of residents that recognises all aspect of health and social care services that are important to Older People, for example Dementia, Carers, Learning Disability and Mental Health services. We will work with our partners at Surrey and Borders Partnership NHS Foundation Trust (SABP) to draw on their expertise to ensure therapeutic advances in the support for people with dementia become an embedded part of Surrey's approach. This may involve, for example, early identification and assessment of mild cognitive impairment, timely access to sophisticated scanning for amyloid disease and access to lumber puncture.

Delivering value for money and improved outcomes for Surrey residents

The delivery of the Commissioning Strategy for Older People is likely to take place during a continued period of constrained public finances. A key principle running across the whole of the commissioning strategy is therefore ensuring services are commissioned as cost effectively as possible and within the resources available while still delivering improved outcomes for Surrey's residents.

"The council cannot deliver the Vision for Surrey alone; we will need the support and involvement of partners and residents" – SCC employee

4. Introduction to our strategy

Coproduction of this strategy

> ***'Co-production is an approach where people, family members, carers, organisations and commissioners work together in an equal way, sharing influence, skills and experience to design, deliver and monitor services and projects. Co-production acknowledges that people who use social care and health services (and their families) have knowledge and experience that can be used to help make services better, not only for themselves but for other people who need them, which could be any one of us at some time in our lives. Real co-production means that people are truly involved in planning and designing services from the very beginning'. Co-Production Network, Think Local Act Personal***

We are committed to engaging with and collaborating with older people who can share their own lived experience of living and ageing within Surrey to the table. Whether they have received support through social care services, their families, unpaid carers or the agencies and organisations who offer a range of health and social care support service in Surrey getting feedback from a wide a range of people as possible has been an integral part of developing this strategy. Through a number of working groups, we have sought incorporate the feedback and comments provided and commit to ongoing coproduction as we deliver our commitments. The list of those involved can be found in appendix 7.2 and 7.3.

What did we do?

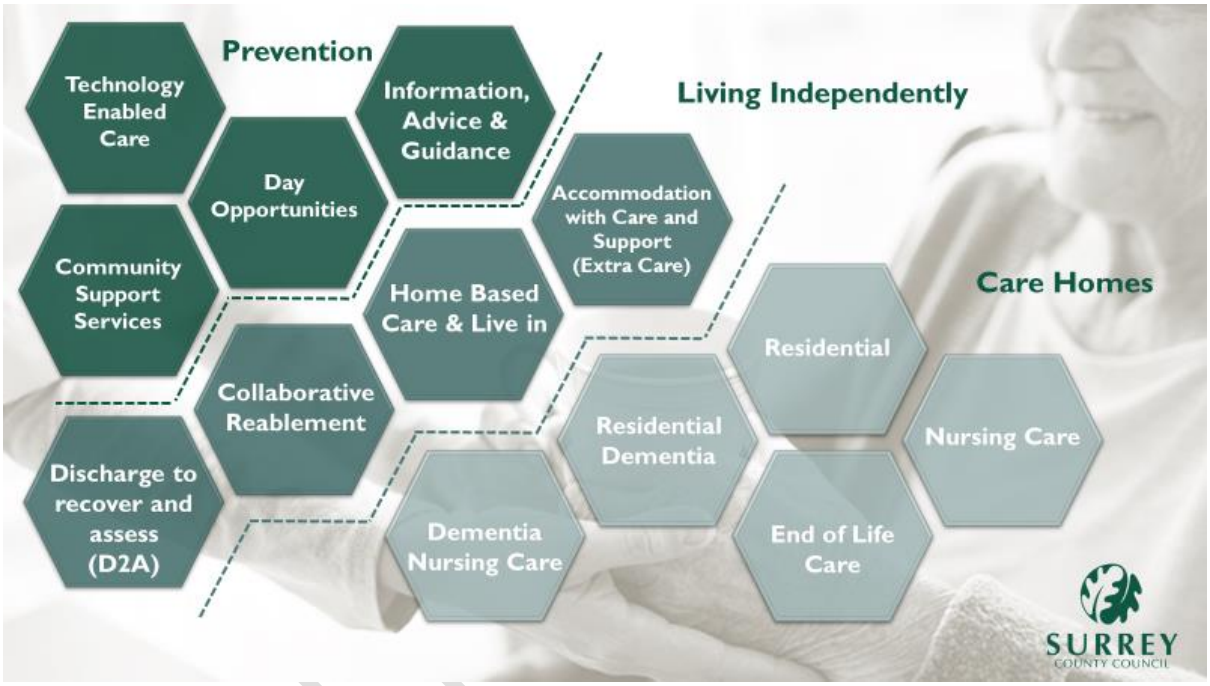
Due to the national Covid restrictions, we were only able to hold virtual meetings and asked the core project group to engage with their contacts virtually as well. Even with these restrictions in place we managed to obtain 750 separate responses during the coproduction process and some prior months before Covid.

During coproduction we worked mainly online with different groups of Surrey residents of all ages, unpaid carers, providers, partners, and colleagues over a period of 7 months. This online approach enabled people to connect and input across Surrey flexibly. We conducted surveys and workshops focused on what works well, what doesn't work well, what could be improved and what is important to our residents. We also connected and had conversations with residents via the phone and sought feedback regarding providers and their services from their service users and families.

> ***"Thank you for all the work you are doing to pull the strategy together and have a full and meaningful engagement with older people." Chief Executive – Age UK Surrey***

5. Our priorities

Our priorities are your priorities and these focus on key services delivered by social care and jointly delivered services and support with colleagues from NHS, the community and voluntary sector. The following diagram illustrates the key aspects of Older Peoples services and support. You will they cover low level services and interventions that focus on enabling individuals to be independent and prevent the need for statutory services, through to more dependent forms of care such as residential and nursing care.



We will be focusing firmly on supporting people to remain at home or return home where possible. There are two key aspects to this, firstly maximising people's ability to remain at home following a crisis or hospital admission including providing services within the home. Secondly, we want to provide alternative homes for residents in the form of Extra Care Housing that will provide the opportunity to have options to choose from that allow residents to continue to live more independently for longer – a positive life choice.

Through focussing on enabling people to live well and as independently as possible for a long as possible we will ensure our approach recognises every individual's situation is different. The process of ageing and the support a person may need at any point in time in their journey is not linear and therefore our aim is to enable their independence at every opportunity.

Prevention: Supporting people to stay healthy, happy, and independent for as long as possible

You said:

Organised community groups, specific support groups such as memory lane and carers support, and **day services with activities** such as walking, gardening & accessing nature were highly valued.

> *"I rely on the assistance of several services within my community, they have always been excellent and reliable" – Surrey resident*

Emphasis on the importance of mental health through community services that support people to remain independent within their local community. These services are mainly provided by local district and borough Councils and community providers.

It was important for residents and unpaid carers to feel connected within their own local community, to be offered a range of services to choose from and for those services to be affordable to everyone that has a need.

Services need to be accessible in all areas of the County and importantly need to offer support for people, families and unpaid carers living with dementia. This was highlighted as essential and was a common thread through the whole engagement process.

Services need to be improved when residents and unpaid carers are discharged from hospital and there needs to be better communication and information available. Residents want to return home and need support to do so.

An improvement to the overall **information and advice** services within Surrey was also a key theme. These services need to provide better pathways for people accessing information on services both locally and countywide to prevent the need for formalised care. They need to map pathways for residents moving from local community services to statutory services at the right times.

There is a need to recognise that people accessing **day services** have much higher and complex needs now, therefore the day centres and the staff need to be better equipped and trained to support this.

The push for online services isn't welcomed by all, some preferring face to face and others feeling unable or lacking confidence with **technology**.

> *"as you get older it's harder to learn new technology and skills may wane, which will see more older people become excluded." – Surrey unpaid Carer*

More funding and financial sustainability is required to support the increase in demand across NHS, social care, and voluntary and community sector partners as a whole system for preventative services.

We will....

Information, advice, and guidance

- ✓ Within the Information and Engagement Team, work closely with our Communities and Prevention team and local system partners such as Primary Care Networks, Integrated Care Pathways, District & Borough Councils', and Public Health, as well as the community, voluntary and faith sector, to promote better community support services and opportunities to remain healthy, well and active for longer.
- ✓ Ensure residents know about the different options available to them locally in the community and how to get support to live independently. A 'whole family approach' will consider how the needs of the person being assessed impacts on other family members, or anyone in their support network such as unpaid carers.
- ✓ Focus on [our] information, advice and guidance offer to ensure everyone accessing care and support for themselves or for someone else, can have the right information at the right time to make informed decisions and choices about the care and support required.
- ✓ Help people to remain independent, safe, and well, or to maintain their current health and wellbeing for longer, by making informed choices and preventing or delaying the need for social care support.
- ✓ Promote better information to residents when considering care, enabling informed decisions to be made about the appropriate time to consider care and how to find the most suitable choice for an individual when considering funding their own care.
- ✓ Have a key focus on local social prescribing services which allow GPs, nurses, and other healthcare workers to signpost patients to support outside of health services, through community organisations, local support groups and dedicated support hubs.
- ✓ Launch a Considering Care Campaign focused on individuals being able to make good and timely choices for care and the funding implications of these decisions.
- ✓ Work to remove age discrimination and support initiatives to make ageing a positive not negative process

'Being part of your community' – Day Services and Community Support

- ✓ Move towards a model of 'Being part of your community' across Adult Social Care. Through coproduction with Surrey residents develop services with older people, unpaid carers, families, and the community to maintain their health, wellbeing, and independence.
- ✓ Stimulate a vibrant market for self-funders and generate viable opportunities for the use of direct payments. See an increase in Surrey residents accessing day services and activities to engage with their communities and stay independent for longer.
- ✓ Develop and coproduce a Market Position statement for this work with District and Borough and NHS colleagues to ensure community and voluntary sector partners can focus their activity and resources on services and support that residents want and need.
- ✓ Work with existing services that are valued by local communities to understand what's available and how to help sustain these services learning from their experiences in order to provide similar services across the County where right to do so to stop a 'post code lottery' of services
- ✓ Continue to improve and enhance other commissioned services such as Advocacy and Stroke recovery support to ensure people continue to be enabled to participate in, and make choices about, their own care and support needs.
- ✓ Ensure transport services and support provided from public, private and community services are accessible for everyone. For example, considering the accessibility of services when

making placements and when developing new accommodation with care and support within local communities.

Digital and Technology

- ✓ Maximise opportunities for innovation and more efficient models of care as people become more dependent on technology. With recent internet use in the 65 to 74 years age group increasing from 52% in 2011 to 83% in 2019, we need to ensure residents feel comfortable with this change and have the right skills
- ✓ Use technology to complement the face-to-face care people receive, provide greater opportunities to monitor risks, deterioration in needs and access to care and support and we will ensure technology is considered as part of an individual's care needs both at home and when receiving social care funded services
- ✓ Ensure our online and digital offer of information, advice, support, and services are inclusive and accessible
- ✓ Actively promote the use of readily available technology and how this can enable residents to live independently for longer
- ✓ Promote and embed better use of technology to support residents, social work teams and providers as people transition from home or hospital to social care placement
- ✓ Recognise that technology isn't a key preference for all residents and will ensure that other options need to be available to support too to ensure no one is digitally excluded

Living Independently: Facilitating and enabling people to continue living at home for as long as possible through timely care and support that works around their priorities and outcomes

You said:

People in Surrey want to live independently in their own home for as long as possible, that was a strong view voiced by many. **Home Based Care** and **Live In Care** are valued services.

People living in **extra care and supported living accommodation** told us that these settings helped them to maintain social interactions, keep in touch with local communities and reduce loneliness. They feel they have support all around them and that the care is accessible as and when it's needed. Surrey needs more of these.

> *"I have my own freedom but help if I need it, support around me living in a small community with coffee mornings, bingo nights and people to talk to" – Surrey resident*

It was strongly agreed that the care delivered by providers through our **Collaborative Reablement** service was kind, considerate and provided by compassionate people. The individuals assessed in the service said they were involved in planning for the support they received, and they agreed the goals to help them become independent. This was important to people.

Reablement and **Discharge to Recover and Assess (D2A)** out of hospital support giving people more time to 'get well/recover before being assessed or longer-term decisions being made [*intermediate care services*] were seen as essential in giving people confidence to return home or access the right care.

Areas that were reported to not work as well for some people were not being able to make informed choices, some areas in the county people are unable to access extra care and when there was capacity choice wasn't always given as an option.

Transport options to ensure people could access services across the county as well as within their local community need to be improved.

There was feedback given that the process of accessing the NHS and ASC system is confusing and that people had experienced paperwork, communication and equipment issues when being discharged from hospital back into the community. Communication [*health and social care*] could be greatly improved to support people at often difficult and confusing times of their lives.

Improvement suggestions were made for our **Home-Based Care** services. Surrey needs to ensure consistency of schedules [*planning of visits*], that better trained staff are available especially for specific needs such as people with dementia and continuity of staff delivering care and support. Some individuals with lived experience felt that often an increase in availability of hours needs to be reviewed in order to keep some safe at home for longer.

Definitions of the services highlighted in **bold are below*

We will….

Collaborative Reablement: SCC working collaboratively with local home-based care providers to deliver short term interventions to increase and promoting independence in the community.

- ✓ Ensure our in house reablement teams will grow to support more individuals who could benefit from reablement. This will not simply be limited to Older People but will focus on people with mental health and learning disabilities. This service will work with more community referrals as well as those being discharged from hospital and NHS services.
- ✓ Commission a Collaborative Reablement services with providers of Home Care to increase our capacity and ability to ensure more people can return home with little or no care where possible or with reduced needs for ongoing and higher care and support services
- ✓ Ensure the availability, quality and the standard of the care and support provided is the best it can be; person centred, responsive, inclusive and maximises strength and skills gain for residents

Discharge to Recover and Assess (D2A): Funding and support given to people to leave hospital, when it's safe and appropriate to do so, of being ready for discharge or as soon as possible in the same day. This will enable individuals to receive care and support out of hospital before being assessed for long-term needs ensuring they are assessed over a period of time, at the right time and in the right place.

- ✓ Ensure that more people leave hospital with a package of care in their own home rather than entering more formalised care arrangements such as residential and nursing care.
- ✓ Work alongside Collaborative Reablement, Rapid Response services, District and Borough Home from Hospital services and Intermediate Care and Community services to ensure residents that are discharged from hospital can develop skills, regain independence, and reduce the need for ongoing and higher care and support services.
- ✓ Ensure high needs packages of care, for example temporary Live in Care, and/or placements into residential and nursing care homes where necessary, are commissioned with specific service providers to deliver D2A and communicate clearly to providers and residents what to expect from these services.

- ✓ Ensure services will be available to all residents and allow for recovery, reablement and enablement during which time they will be assessed for their ongoing care requirements and an individual financial assessment will be undertaken.
- ✓ Through a discharge pathway, ensure individuals will receive therapeutic and community services where appropriate to provide the comprehensive support required to achieve better outcomes.
- ✓ Integrate the approach between NHS and ASC to ensure a seamless service for residents and unpaid carers with clear communication for the benefit of providers and residents.
- ✓ Ensure residents, unpaid carers and families are well informed of the discharge process, given access to all personal assessment paperwork and information required, and have a carers assessment completed in a timely manner before leaving the hospital
- ✓ Work with NHS colleagues to provide a robust offer of intermediate health care services and Home first services

Home Based Care and Live in Care: In 2021, SCC recommissioned Home-Based Care services with NHS Surrey Heartlands Clinical Commissioning Group (CCG) who hosts Continuing Healthcare (CHC) on behalf of the two Surrey CCGs. The services fall into the following categories:

- Home Based Care – domiciliary care
- Live In Care – where someone lives in an individual's home
- Sleep in and Waking night support

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- ✓ Develop the home-based care offer with providers that deliver care in specialisms (Dementia care, learning disabilities and mental health support as examples) to share their experience and training with us in order to support residents with the most suitable provider to meet their needs
- ✓ Maximise the use of End of Life and unpaid Carer break contracts to ensure we can support residents better
- ✓ Respond to the requirement for consistent carers, ensuring planned visits take place and monitoring care delivery we have requested that all providers use, and provide access to information from, Electronic Care Management (ECM) systems which will ensure commissioners can manage these contracts more closely
- ✓ Ensure that residents have valued interactions with carers during all visits by removing 15-minute visits in assessment planning
- ✓ Ensure that all residents who receive homecare commissioned by SCC and the NHS CHC team have a regular review of care needs and SCC will work with providers to ensure that individual strengths and abilities are fully recognised in the care review process
- ✓ Have a clear focus on the quality of providers, Surrey's Quality Assurance team and commissioners will support providers to deliver good quality services so that residents and their family can be confident in the care commissioned
- ✓ Enable providers to join the joint SCC and NHS dynamic purchasing system contract for homecare services at any time, and commissioners will manage the provider market to help good providers consolidate and grow their business to support social workers with the availability of care required to meet future demand

Accommodation with Care and Support: Extra Care Housing (age criteria is 55+) enables people to remain independent in their own flat which is specifically designed with their future in mind that is accessible and includes technological infrastructure and provides a level of on-site support and care by staff which can scale to changing needs.

- ✓ Actively work to enable people to access the right health and social care, at the right time and in the right place through the delivery of the most suitable accommodation with care and

support for residents. Through our **Accommodation with Care and Support Strategy** we want to develop and grow our Extra Care Housing provision with 725 affordable units within Surrey.

- ✓ Provide new accommodation that will not resemble institutional environments, it will clearly be housing with care and support that offers a level of on-site support and care by staff which can scale to meet changing needs
- ✓ Be ambitious in providing an equitable coverage of Extra Care Housing for residents across Surrey
- ✓ Develop accommodation that will be modern and built in the heart of communities near shops, transport, and GP's and provide on-site communal facilities to make them part of the wider community
- ✓ Deliver care and support to Extra Care residents from CQC registered home based care provider – both for emergency response and to meet anticipated care needs
- ✓ Work collaboratively and involve the communities within which homes will be built and the individuals and residents who will live there to design and deliver this ambition
- ✓ Enable people to remain in place, promote independent living and help people to self–care. It will also provide a base for daytime activities and community-based therapy

Residential and Nursing Care Homes: Maintaining a strong emphasis on strength-based, personalised care for older people who require intensive support in a specialist care environment

You said:

There was positive feedback about staff within care homes. Some individuals stated that staff have a good understanding of dementia and that it was a good place for people to recover when they needed help.

However, this area also received feedback that was contradictory. Through our engagement sessions and online surveys, unpaid carers and families that had received services within a care home felt the staff were not person-centred enough. It felt like many care homes treated all residents 'the same', regardless of their background or interests.

When looking at how the council made placements, some people felt they were not being offered choice and others said they were being placed away from their family which resulted in them feeling lonely. Some felt that the placement sourcing approach demonstrated a "postcode lottery" and that they would like to better understand how decisions were made about placements.

> *"The level of care is always getting better, but some care homes aren't great, and you would not wish to send your family members to those" – Surrey resident*

Ensuring the right home is selected in the first place, one that offers the right training for staff and support for residents, was regularly raised along with other suggested improvements for the sector. These included the need for more specialist care homes, dedicated to those with higher needs or advanced dementia.

Feedback focused on the need for a person-centred approach for everyone, with better communication and more activities to offer a better continuity of care for residents. When accessing services, residents felt they lacked a clear understanding of the whole process.

Residents felt that both care home providers and social care teams needed to help individuals and families with decisions not only about the right care, but also about how to manage the cost of care to prevent people running out of money too soon.

> *"Enable people to have a better understanding of the process of assessment for care and financial implications, especially for self-funders" – Surrey resident*

People want to have a choice of care home and highlighted the importance of key factors such as affordability, closeness to family and friends, a good activity offer and a high quality of care.

There was still a "nervousness from Covid", as well as concerns over repeat admissions from care homes into hospitals that could be avoided if the system was better equipped to support care homes. The links between care homes, community and mental health partners and social care needed to be strengthened

Overall, the feedback was that people want to remain in their own home for as long as possible.

We will….

- ✓ Ensure there is the right provision available for the changing needs of Surrey's population through the private market
- ✓ Work jointly with Surrey Heartlands CCG Continuing Healthcare to commission and procure services to ensure there is enough capacity across the county to meet the increasing demands to support complex, high needs packages.
- ✓ Work more closely with the market to achieve better relationships and improve partnerships so that we can identify strategic partners who can help us innovate and shape the social care market.
- ✓ Work with Surrey District and Borough Councils, and SCC Land and Property team to encourage the development of the right services and support for Surrey residents.
- ✓ Work alongside the **Accommodation with Care and Support Strategy** to work with providers, residents, and their families to gain a comprehensive and up to date picture of what older people, and people approaching older age, want their residential and nursing care provision be in the future.
- ✓ Complete a comprehensive review of the current care home offer within Surrey. This will include considering the outcome of the in-house consultation when looking at the contract arrangements we have in place with providers to deliver social care capacity.
- ✓ We will make sure we identify and understand how services can be improved or repurposed to meet the increasing needs of residents, ensuring that services are fit for the future as we seek to address current known service gaps and anticipated future needs.
- ✓ This comprehensive care home portfolio review will be completed with colleagues across health and social care and include systematic engagement with stakeholders and residents to ensure we are looking at future needs from all perspectives.

- ✓ Work in partnership with NHS colleagues to achieve the Enhanced Health in Care Homes (EHCH) model. This moves away from traditional reactive models of care delivery and towards proactive care that is centred on the needs of individual residents, their families and care home staff. This can only be achieved through a whole-system, collaborative approach.
- ✓ Work with NHS colleagues to improve our offer of support, training, and information exchange with providers to improve quality and outcomes for residents receiving care whether health and social care funded or privately funded.
- ✓ Continue to work with homes to ensure Care Market Authority and Care Act Duties and Guidance are being adhered to especially around an individual's financial circumstances and choices.

6. Way forward

There is no doubt that our ageing population will have an impact on the way our providers, partners, stakeholders, and colleagues will deliver services for older people for the foreseeable future. We may not know what these services will look like in 10 or 20 years, but we must start planning for this now. SCC cannot address these issues alone; this strategy and the delivery of this work will need us to work closely with partners who will often be better placed to deliver some aspects of our vision. Partnerships and relationships are therefore essential.

We have outlined straightforward, practical responses to the challenges described within this strategy and with the full involvement of our residents, we will regularly monitor and evaluate our "We will" statements. This will allow us to continue to develop our understanding of what works, and does not work, learning from our failures and building on our successes collaboratively.

The challenge we face is bigger than just the provision of quality services. It is a challenge that we face both as providers and individuals. Our society is ageing, and we need to take positive steps now to review the way we think about ageing, looking at how best we can provide the services and opportunities not only that residents, unpaid carers and families want now but that the ageing population will want in later life too.

This is reflected in changes in expectations we hold for later life. The next generation of Older People will arguably be more informed, more empowered to access information and advice and utilise technology to support their own independence and stay connected to loved ones and friends. Equally many older people will remain in employment until later life and will be living longer with more complex needs such as learning disabilities, dementia, physical disabilities, and mental health needs. This provides often unique challenges that we as a wider health and social care system must be prepared for.

It is here that the real challenges to success lie, we need to act, but to succeed we must work differently. Our three key principles are:

1. **Joint approach:** across health and social care we are often working towards the same objectives but do not work together as often as we should to achieve them; if we work together to align our goals and outcomes we can work more efficiently and deliver more effective services.
2. **Innovation:** we must not be afraid to innovate, to take risks, and be prepared to invest in innovation as a source of learning as well as a source of better outcomes.
3. **Prevention:** to truly change how we provide older people's services and to make a lasting impact we need to increase investment in preventative services. This is a huge challenge in

the current economic climate, but the long-term impact and value of these services is indisputable.

> *''Older People in Surrey will have a voice, choice and control over the care and support they receive whether eligible for social care or not'' – SCC employee*

This strategy will remain a live working document over the next 9 years till 2030. The outcomes and objectives listed below will be reviewed by the core project group that helped to coproduce the strategy and with other stakeholders. This is to ensure that we are delivering on our strategic commitments and measuring the delivery of the stated outcomes at a strategic, service and individual level across all Older Peoples services.

Prevention: Supporting people to stay healthy, happy, and independent for as long as possible	✓ By **June 2021**, undertake a day opportunities survey to understand what people value and use this information to shape a community and voluntary sector Market Position statement in 2022 ✓ By **November 2021**, develop and share a provider communication and engagement plan that ensures better support for residents through bridging the gap between social care services and Surrey ✓ By **December 2021** act on the findings from the Information and Advice strategy surveys and workshops to review existing service offer for Older People and plan an improved information and advice offer for Older People and their families and unpaid carers ✓ By **December 2021**, review and implement changes to Surrey County Council webpages to ensure residents, providers and stakeholders can maximise the use of information provided ✓ By **January 2022** – launch considering care campaign, highlighting choice and informed decision-making support, online and over the phone through better marketing
Living Independently: Facilitating people to continue living at home for as long as possible through timely care and support that works around their priorities and outcomes	✓ By **October 2021** launch recommissioned Home-Based Care and Live In Care arrangements, in partnership with NHS colleagues, to deliver better options for care provided within the home. ✓ By **October 2021** launch recommissioned 'Collaborative Reablement' service, a vital service supporting people to return home and reduce their dependency on social care through promoting independence and strengths ✓ In **2021/2022** successfully tender for and award our first three (3) Extra Care Housing developments for Surrey ✓ By **October 2021** begin piloting and developing our Discharge to Recover and Assess services with greater clarity over central Government funding ✓ In **2021/2022** contribute to the audit of the Better Care Fund (a joint fund between health and social care) in order to maximise the impact of this funding for better services and support to residents
Residential and Nursing Care Homes: Maintaining a strong emphasis on strength-	✓ By **October 2022** we will have a Brokerage Team in place to provide consistency in placements being made and money being spent. The brokerage team will ensure contracts are in place and providers are supported with making decisions about who they can and cannot support. ✓ By **January 2022** have a regular calendar of events and communication strategy to work more closely with the social care sector managed jointly between social care and NHS colleagues

based, personalised care for older people who require intensive support in a specialist care environment	✓ By **April 2022** implement a new approach to purchasing Residential and Nursing Care, in partnership with NHS colleagues, to promote choice and fairness and better provider management and oversight of quality ✓ By **April 2022** have a strategy in place to address any gaps in the provision of care available from the private market, including a full review of existing contracts and arrangements across Surrey
Supporting work	✓ By **December 2021** have in place robust systems for managing our provider market – this will include systems to manage spend, placements and the quality of the provider market

8. Appendices

7.1 Linked Strategies

- Surrey County Council Community Vision 2030
- Surrey Health and Wellbeing Strategy (healthysurrey.org.uk)
- Dementia Strategy Dec 2017.pdf (cshsurrey.co.uk)
- Surrey-Carers-Strategy-Consultation-Document-NApp.pdf (actionforcarers.org.uk)
- Palliative & End of Life Care Strategy 2020-2025 (surreycc.gov.uk)
- Information and Advice Strategy 2016-20 (surreycc.gov.uk) (New strategy to be publish for 21-26)
- Accomodation-with-Care-and-Support-Strategy-.pdf (surreycc.gov.uk)
- Surrey All Age Autism Strategy Framework 2021-2026 (surreycc.gov.uk)
- NW Surrey, Adult Frailty Strategy/Framework – In draft
- Physical Sensory Impairment – Still working though engagement
- Carers Strategy – Signed off but not published yet

7.2 Coproduction Core Project Group members

- Surrey County Council (SCC) – Lead
- Surrey Heartlands Clinical Commissioning Group (CCG)
- Elmbridge Borough Council (EBC)
- Surrey and Borders Partnership (SABP) NHS Foundation Trust
- Action for Carers
- Healthwatch
- Age UK Surrey
- Surrey Minority Ethnic Forum (SMEF)
- Alzheimer's Society
- Surrey Coalition of Disabled People
- Lived experience volunteer
- Unpaid carer and older person living in

7.3 Surrey Organisations and groups included in developing the strategy

- Surrey Care Association
- Home based care providers
- Care home providers
- District and borough community partnership leads
- NHS colleagues

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