Living Well in Later Life Commissioning Strategy for Older People 2021 – 2030

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SURREY
COUNTY COUNCIL

Contents

Foreword

Surrey County Council (SCC) knows that getting older and living longer is something we should all look forward to. However, living a healthy life and living well for yourself, including staying in your own home, can be more difficult for some people. This is our plan to help support older people in Surrey to make this happen.

This strategy is for older people and unpaid carers (those 65yrs and above) living in Surrey. It tells you what the council and its partners will do to help make Surrey a place where people can make the most of their old age.

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

This is our plan for how we will help residents to have more choice and control over the care and support they need, when and where they need it. We will change how we design and buy services and work with partners to make these changes.

What we want to do:

Support residents, unpaid carers, and their families to have access to the right services and information, advice, and guidance to make good decisions about the care and support they need.

Work with partners such as the National Health Service (NHS) in Surrey, the eleven district and borough councils and local community and volunteer-run organisations to provide services that work together and help provide a real 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 care to do things differently, improve quality and increase the choice available to residents.

Continue to listen, engage, and work with Surrey residents, unpaid carers, partners, and stakeholders to ensure they are seen, heard, and valued to enable Surrey County Council to continually improve and learn.

The Government has now shared their initial plans for the health and social care sectors in a document called Build Back Better. We are pleased that many of the messages in the Government's plan are the same as ours and we will make sure that we can support residents with changes as these are implemented.

We will ensure that our work for older people also links closely with other key strategies for Dementia, All Age Autism and Surrey Health and Wellbeing (to name a few) as well as our Surrey County Council Community Vision 2030.

This strategy is your strategy. If you are one of Surrey's older people, an unpaid carer, family member or provider, this strategy is here to support you.

Jonathan Lillistone, Assistant Director Commissioning

Health, Wellbeing and Adult Social Care - Surrey County Council

Introduction to Adult Social Care (ASC) in Surrey

In 2021/2022 Adult Social Care in Surrey spent £506 million to support older people. This money helped over 5,600 older people and their unpaid carers. Money was also spent with voluntary organisations that support people in their community too. Adult Social Care also ensures services for information, advice and guidance are available to help people understand their care options and to make good care-related decisions.

This strategy covers our plans for 2021 to 2030 and how we will support people to age well in Surrey. This document uses “We will” statements to be clear on our tasks and activities that will:

- Ensure older people and their unpaid carers get the care and support they need at the right time and in the right place
- Work with our partners to move to an earlier support approach, focusing on older people’s strengths to avoid a crisis happening and reducing its impact when it does
- Work with voluntary and private providers to improve the market of care and support
- Understand and act on the experiences of people receiving care, alongside people expecting to receive care in the future, when deciding how to provide services and support.

In 2018, Surrey County Council engaged with residents and partners across the county to understand what Surrey should look like by 2030. The result was a Community Vision for Surrey in 2030, which includes the following commitment for health and social care:

“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 county of Surrey has a population which is getting older with people living longer than in other parts of the country. These changes mean that many more people are likely to be living alone, without support from their family. By 2030, the number of people aged 75+ predicted to be living alone will have increased by 27%. Our aim with this strategy is to increase the time that people live well into old age.

National reporting states that the number of unpaid carers 65 years old and over will increase by 17% from 2016 to 2025, and for unpaid carers aged 85 and over this will be 31%. We need to look after unpaid carers as they play a large part in supporting so many residents even when they reach old age themselves.

Many individuals will enter old age with more than one health condition which makes living well more challenging. One health condition we are most concerned about is dementia. Dementia is most common amongst older people and in Surrey it is estimated that between 2020 and 2030 the overall number of people with dementia could increase by 28%, from 17,700 to 22,672.

Introduction to our strategy

Co-production 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..' **Co-Production Network, Think Local, Act Personal**

What did we do?

Due to the Covid pandemic face to face meetings were not possible, however we were able to hold meetings via the internet and on the phone. We spoke to over 750 people living in Surrey. We worked with many diverse groups of Surrey residents of all ages including unpaid carers, care providers, partners, and colleagues. This took seven months and included workshops and surveys. We wanted to know what works well, what does not work well, what could be improved and what is important to our residents.

"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

We will continue to listen to and learn from older people who can share their own experience of living and ageing within Surrey. These will be people who have, and have not, received support from social care services. This will include families, unpaid carers and the organisations who provide health and social care services in Surrey. Using this feedback has been important in writing this strategy.

Our priorities

Within older people's services and support in Surrey there are low level prevention and intervention services, as well as services that focus on enabling individuals to be independent and prevent the need for statutory services. This includes more specialist forms of care such as residential and nursing care within a care home setting.

We want to support people to remain at home or return home wherever possible. We need to provide services that give the best chance for people to remain at home following a crisis or hospital stay. This includes care and support in the home. We also want to provide alternative homes for residents in the form of Extra Care Housing that will be more like having a home of their own.

We know that every individual is different and that their needs and wishes will also be different. The process of getting older does not mean that everyone should experience the same services or indeed will require the same services.

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, and accessing nature were highly valued.
- 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.
- 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 is not welcomed by all, some preferring face to face and others feeling unable or lacking confidence with technology.

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

***"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**

We will:

Information, advice, and guidance services

- Work to provide, with partners, better community support services and opportunities to remain healthy, well and active for longer.
- Help residents to know about the different options available to them locally in the community and how to get support to live independently.

- 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.
- Enable residents to make good decisions about when to consider care and how to find the best choice for them.
- Work to remove age discrimination and support initiatives to make ageing a good experience for all.

Day services and community support services

- Work with residents and partners to help people be part of their community to improve their health and wellbeing. We will ensure Direct Payments are a real option for meeting someone's needs. (Direct payments are local Health and Social Care (HSC) Trust payments for people who have been assessed as needing help from social services. And who would like to arrange and pay for their own care and support services instead of receiving them directly from the local trust.)
- Support an increase in Surrey residents accessing day services and activities within their local communities to stay independent for longer.
- Help sustain services valued by residents, learning from their experiences 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 services such as Advocacy and Stroke recovery support to ensure people continue to be enabled.
- Work to ensure transport services and support provided from public, private and community services are accessible for everyone.

Digital and technology services

- Use new and existing technology to improve people's care choices and independence.
- Support individuals to be more confident in the use of technology.
- Use technology to complement the face-to-face care people receive. Monitoring risks and deterioration in needs as examples.
- Ensure our online and digital offer of information, advice, support, and services are inclusive and accessible.
- 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.
- Understand that technology is not a preference for all residents and ensure that other options are available to support too. 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, stay connected with local communities and reduce loneliness. They feel they have support all around them and that the care is accessible as and when it is needed. Surrey needs more of these.
- It was strongly agreed that the care delivered by providers through our Collaborative Reablement service (CRS) was kind, considerate and provided by compassionate people. People 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, being unable to access extra care in some areas of the county and when there was capacity, choice was not 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 social care 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 improved to support people at often difficult and confusing times of their lives.
- Improvement suggestions were made for our Home-Based Care services. The council 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 to keep some people safe at home for longer.

***"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**

We will:

Collaborative Reablement: Surrey County Council is working with local home-based care providers to deliver short term support to residents to increase and promote independence in the community and keep people at home.

- Ensure Surrey County Council's reablement teams grow to support more individuals who could benefit from reablement.
- Continue to purchase Collaborative Reablement services with providers of Home Care to increase our ability to support more people to 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.
- Ensure technology enabled care is considered when supporting someone's independence during this time.

Discharge to Recover and Assess (D2A):

This is funding and support given to people to leave hospital when it is safe and appropriate to do so. 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 care plan to be delivered in their own home, rather than entering more formalised care arrangements such as residential and nursing care homes.
- Ensure more complex packages of care, for example temporary Live in Care, and/or placements into residential and nursing care homes where necessary, are made with specific providers trained to support people to improve.
- 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.
- 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

Home-Based Care and Live-in Care:

In 2021, Surrey County Council, working with NHS Surrey Heartlands Clinical Commissioning Group (CCG) who hosts Continuing Healthcare (CHC) on behalf of the two Surrey CCGs, began new arrangements with Home-Based Care services for: Home-Based Care – domiciliary care, Live-in Care – where someone lives in an individual's home and sleep in and waking night support.

- Develop the home-based care offer with providers that deliver care in specialisms (Dementia care, learning disabilities and mental health support as examples).
- 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.
- Ensure that residents have valued interactions with carers during all visits by removing 15-minute visits.
- Ensure that all residents who receive homecare commissioned by the county council and the NHS CHC team have a regular review of care needs.
- Ensure availability of care providers delivering good quality care and support

Accommodation with Care and Support: Extra Care Housing (age criteria is 55+) enables people to remain independent in their own 'home' which is specifically designed with their future in mind. These homes are accessible and include technological infrastructure to support independent and safe living arrangements. Extra Care Housing provides a level of on-site support and care by staff which can scale to changing needs.

- Provide up to 725 Extra Care Housing units for Surrey residents.
- 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.
- Provide new accommodation that will not resemble old fashioned and institutional environments.
- Be ambitious in providing good geographical 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 GPs and provide on-site communal facilities to make them part of the wider community.
- Work with communities within which homes will be built and the individuals and residents who will live there to design and deliver this ambition.

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.
- 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 complete 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.
- 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.

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

We will….

- Ensure there is the right provision available for the changing needs of Surrey's population through the private market.
- Ensure there is enough capacity across the county to meet the increasing needs of individuals. To achieve this, we will work more closely with the market to achieve better relationships and improve partnerships.
- Work with care home providers, residents, and their families to gain a good understanding and up to date picture of what older people, and people approaching older age, want from their residential and nursing care provision now and in the future.

Way forward

There is no doubt that our ageing population will impact the way our providers, partners, stakeholders, and colleagues will deliver services for older people now and in the future. We may not know what these services will look like in 10 or 20 years, but we must start planning for this now as best we can.

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, enabling us to learn from our failures and build on our successes.

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

Prevention: to 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.

Joint approach: across health and social care we are often working towards the same objectives but do not work together as well 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.

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.

Appendices

Linked Strategies

- Surrey County Council Community Vision 2030
- Surrey Health and Wellbeing Strategy
- Joint Health and Social Care Dementia Strategy for Surrey 2022 – 2027
- Surrey Carers Strategy
- Palliative & End of Life Care Strategy 2020-2025
- Information and Advice Strategy: care and support 2021-2026
- Accommodation-with-Care-and-Support-Strategy
- Surrey All Age Autism Strategy Framework 2021-2026

Co-production 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 (Surrey)
- Healthwatch Surrey
- 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 council community partnership leads
- NHS organisations.