Adult Social Care Commissioning Strategy for older people in Surrey 2011 – 2020

'Working with all our partners to make a difference to the lives of people, through trusted, personalised and universal social care support, so people have choice and control, and can maximise their wellbeing and independence in their local community'

Surrey County Council

Adult Social Care Directorate Strategy

Contents

Executive Summary

1. This commissioning strategy for older people is focused on the needs of people requiring support from Surrey County Council and the resources available to meet those needs. On so doing, it recognises the initiatives that can delay or even prevent older people needing support. It is about how public value can be assured and outcomes improved, particularly for people with eligible needs for support.

2. The Ageing Well initiative in Surrey sets the context for this commissioning strategy for older people, and will explore and add more detail on the community and preventative opportunities for all older people in Surrey.

3. Figures 1 and 2 represent our strategic shift in supporting people:

Figure 1: Support for people today

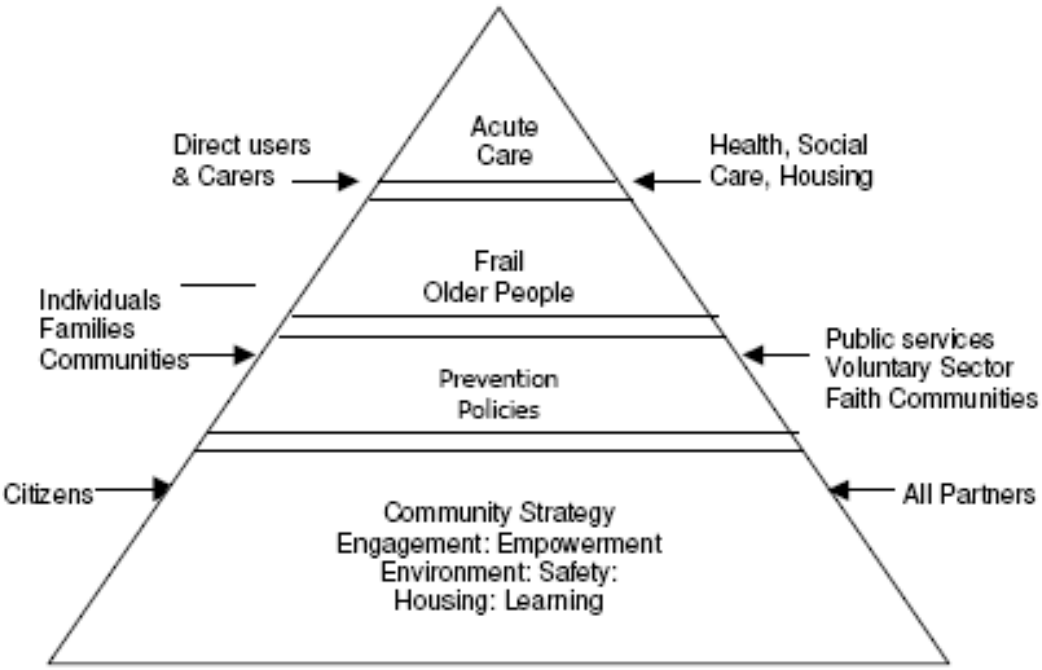
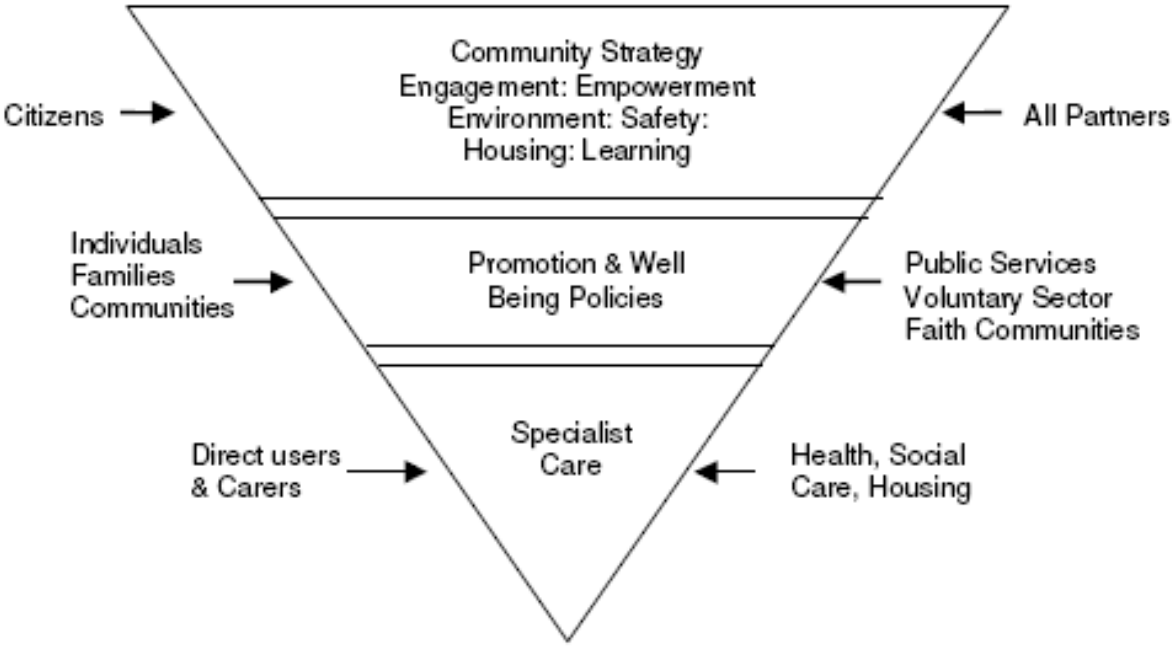


Figure 2: Support for people tomorrow



4. While this strategy is about adult social care services in Surrey, it recognises the imperative to work with a range of partners to deliver whole systems services that meet the needs of local communities.

5. This strategy needs to be seen in the overall context of how public services respond to an ageing population, in promoting choice and personalisation whilst creating the environment to support community well being. It therefore links to other strategic documents produced jointly by Surrey County Council and NHS Surrey, districts and boroughs. These strategies are:

   - Dementia and Older People's Mental Health Joint Commissioning Strategy
   - Health and Wellbeing strategy (in draft)
   - Joint Accommodation Strategy for people with care and support needs
   - Surrey Carers strategy
   - Joint End of Life Care Strategy (available shortly)

These strategies can be accessed via the Surrey County Council website (www.surreycc.gov.uk).

6. The aims of this strategy are to:

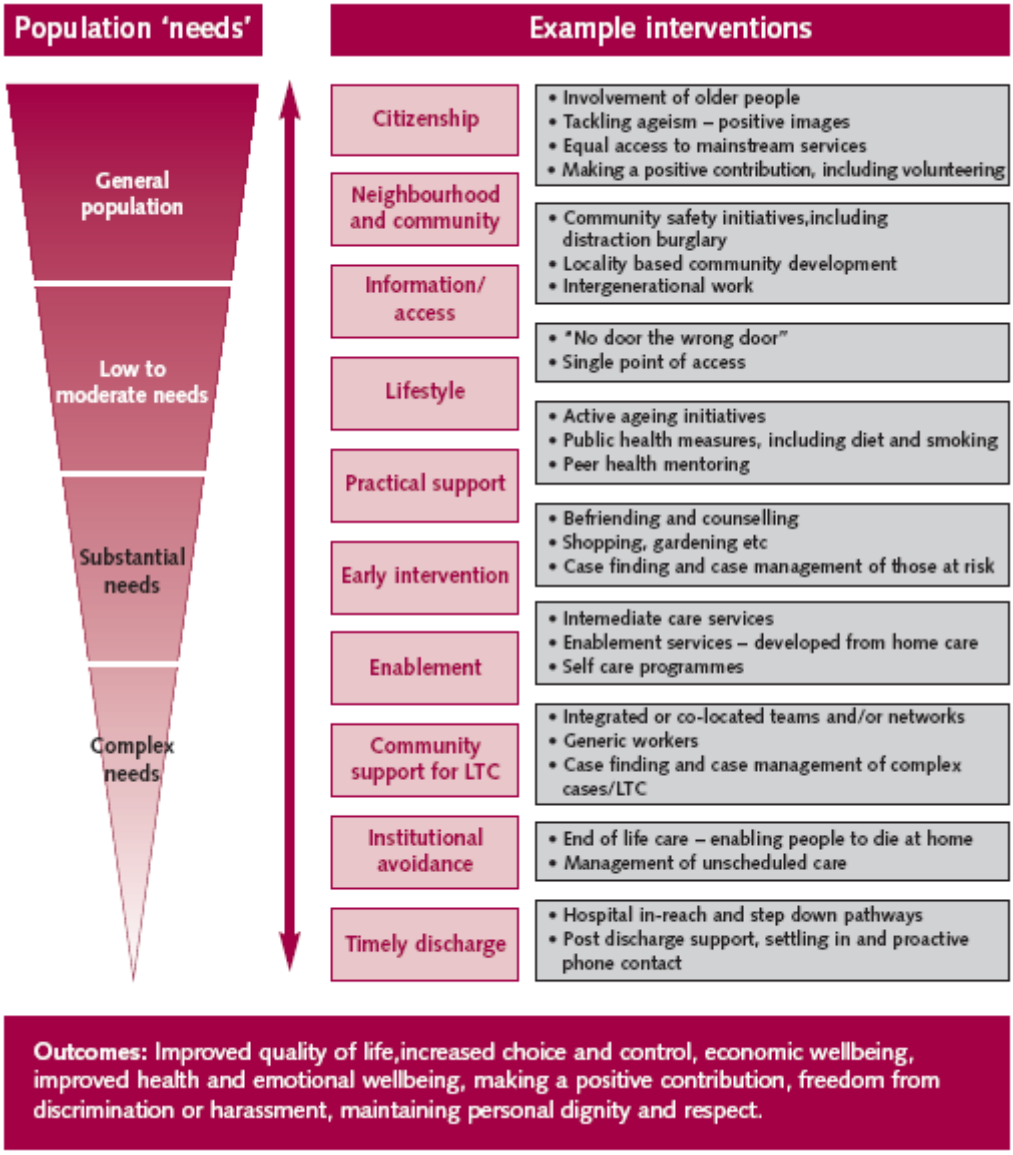
   - Stimulate the market to develop services which help older people make the most of personalisation and self directed support
   - Set up comprehensive commissioning arrangements for preventative services designed to improve the quality of life and maximize independence for older people and also control spend through managing increasing demand
   - Specifically improve services for dementia
   - Minimise the costs of services provided, to ensure that we can maximize our ability to help Older People in need of support. While we will do as much as is possible within the constraints of our budget, we will also taking into account the need for a sustainable market.

7. The coalition Government has set a challenging agenda with major restructuring within the NHS and significant financial constraints across the public sector.

8. The advent of Clinical Commissioning Consortia will set a new context for the delivery of effective joint commissioning and, coupled with the challenging economic climate for the foreseeable future, suggests that commissioning in partnership will be critical if we are to deliver quality and value for money services that people want across the whole system.

9. This strategy builds on the outcomes of the Older Peoples Public Value Review, which proposed a strategic shift of investment to personalised and preventative community services, reducing the need for 'tip of the triangle' interventions (see figure 3).

Figure 3: Delivering services across the spectrum of need



Source: Making a strategic shift towards prevention and early intervention (DH, October 2008)

10. The challenge is to meet peoples' changing aspirations through offering them, their family and their carers choice and control in meeting their eligible needs.

11. We want to focus on whole communities and not just acute need, preventing dependency on our services, producing better outcomes for individuals and their carers and value for money for the public purse. In

doing so, and in taking into account the effects that decisions may have on the diverse elements of the Surrey population, the strategy follows the Equalities Impact Assessment of the Older Peoples Public Value Review[1].

12. The strategic shift to investment in community preventative services may place significant pressure on social care systems as more people are supported in their local community.

13. The analysis of current and projected need leads to the conclusion that over the next 5 years there will be increasing demand for more flexible and diverse services, tailored to the needs of individuals. The numbers of places required in residential homes will rise but not in accordance with rates of population growth, whilst the volume of services delivered to people in their own homes in the community will also rise.

14. Personalisation is at the heart of our service delivery plans and we have set a clear objective that all people who use our services will have access to personal budgets by April 2013.

Population Demand

15. Surrey's population is predicted to rise over the coming decade with notable increases in the number of people aged 65 and over.

16. The 65+ population will increase by 10.8% and 19.6% by 2015 and 2020 respectively. The life expectancy in Surrey for men is 79.8 and 83.3 for women. Overall the 65+ population is expected to overtake that of the under 16s within 20 years.

[1] For the Older Peoples Public Value Review and associated documents see: http://www.surreycc.gov.uk/legcom/CouncilP.nsf/f5fb086c73d64f3000256954004aed25/0e844a0560c953b2802577f50043a93a?OpenDocument

17. Areas projected to have the highest percentage change in total population are Epsom and Reigate & Banstead. From 2011 to 2020, Surrey Heath and Tandridge will see their 85+ populations rise by 60% and 40% respectively.

18. There are four 'priority places' of deprivation identified by the joint strategic needs assessment (JSNA). They are:
    - Stanwell in Spelthorne
    - Maybury and Sheerwater in Woking
    - Westborough in Guildford
    - Merstham in Reigate and Banstead

19. There are 14,830 people with dementia over the age of 65 with a projected increase to 18,600 by 2020, reflecting the national picture of an ageing population.

20. As at 2011, 20,623 people in Surrey have a learning disability, with 3,969 aged 65 and over. The latter figure is expected to rise by over 20% to approximately 4,800 by 2020.

Planning for Tomorrow – national and local drivers

21. The national drivers for change are the:
    - The National Dementia Strategy (2009)
    - Our Health, Our Care, Our Say (2009)
    - The National Carers Strategy (2008)
    - Shaping the Future of Care Together (2009)
    - Health and Social Care Bill (2011)

22. These national policies emphasise the need to transform the way in which health, social care and housing support services are

commissioned, giving adults in later life and their carers more choice, control and personalised services.

23. We have established an engagement protocol committing us to co-designing all services we plan with the people who use our services.

24. Locally, Surrey has begun to restructure its services around the 11 districts and boroughs and aiming to deliver more community based, personalised services and greater choice to individuals.

25. Surrey has established 5 local transformation boards based around the 5 acute general hospitals in the county. Through them, local services are designed across whole systems between health, social care, the districts/boroughs and the voluntary sector.

26. A joint Mental Health and Dementia Strategy was established in 2010 which sets out a five year plan to establish a community based dementia service.

27. We use the Joint Strategic Needs Assessment (JNSA) as an indicator and description of the health and wellbeing needs of the population of Surrey and how this changes over time. This tool informs our decisions on the commissioning of all services.

Future commissioning intentions and service priorities

Prevention and early intervention services

28. There will be an injection of £10.6m in 2011/12 (and then £10.2m in 2012/13) of partnership monies across the health and social care system (as outlined in the One Plan schedule of spend – the joint allocation between NHS Surrey and Surrey County Council). This injection will pump prime preventative services for people who need support and

focus on promoting independence, avoiding admission to and speeding up discharges from acute or long term care.

29. A key strategy relates to reablement services and robust monitoring of outcomes and cost / benefits across the system. This will help signpost commissioning intentions beyond the 3-year funding limit of these monies and what needs to be sustained within resources available.

30. We will examine best practice models of reablement in home based care services and procure cost effective services by April 2012.

31. We will define the range of preventative services that we propose to commission such as day care, befriending, meals in wheels and invest in these services in the 11 districts/boroughs where gaps have been identified.

32. We will target £3.6m of the partnership allocation to the 11 districts and boroughs towards preventative and personalised services in April 2012. This will deliver a shift in emphasis on services we commission and will see the decommissioning of some traditional services.

33. We will support the current stroke specific service though our current investment of £439,140 and seek to expand these services across the county.

34. We aim to increase the use of telecare and telehealth and will be appointing a telecare/telehealth delivery manager in September 2011 to deliver this objective. This will be a joint appointment with NHS Surrey.

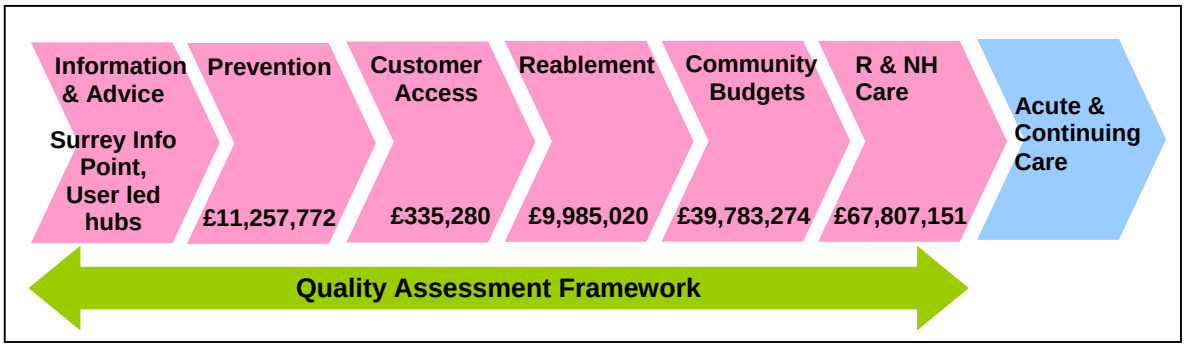
Managing the market investment in services

35. Surrey is a large county with a population of over 1.1million people. It has 1,109 providers of adult social care, which challenges the local

authority to ensure exemplary performance outcomes are maintained and to deliver value for money.

36. Our investment plan is to invest in services is illustrated in figure 4 below. It shows with an increasing investment year on year in prevention, reablement and community support budgets and in reducing investment in residential and nursing care.

Figure 4: Our investment in services for older people, financial year 2009/10



37. We have embarked on a re-tendering exercise for home-based care with personalisation and flexibility at the centre of new contractual arrangements.

38. We saw a 9.7% reduction in residential and nursing home care placement activity in 2010 /11 and this trend is expected to continue into the following year. Figure 5 shows the shift in resources away from residential care into community and reablement opportunities in this time. Regardless of our successes in doing this, we need to monitor the progress of this strategy against an outcomes framework which describes our areas of investment, to ensure that changes always focus on high quality care and support.

Figure 5: The shift in financial resources, 2010 - 2012

	Prevention	Customer Access	Reablement	Direct Payments, Self assessment and RAS	Home Based Services	Residential & Nursing care	Total

	£000s	£000s	£000s	£000s	£000s	£000s	£000s
2010/11 Actual Expenditure	12,121	226	9,586	9,285	27,148	76,896	135,263
2011/12 Budget	11,338	147	10,170	11,144	29,699	73,172	135,671

39. We are committed to two block contracts for residential care, one with Care UK and the other with Anchor Housing. The Care UK contract expires in 2027 and the Anchor contract expires in 2018. We continue to review the use of these commitments to assure public value.

40. Additionally we have 6 in-house residential homes which deliver residential care, day care and respite services. We have to consider the role of these services in the market place against our predicted demand.

41. The predicted demand for funded residential services for 2015 and 2020 is set out in figure 6.

Figure 6: Remodelled spot purchasing for residential care, 2015-2020

	Remodelled demand	In-house/ block capacity	93% occupancy adjustment	Gap for spot purchasing
2015	**1424**	**1242**	**1155**	**286**
Mid Surrey	380	308	286	94
North Surrey	331	251	233	98
South Surrey	428	352	327	101
East Surrey	285	331	308	0
2020	**1603**	**1186**	**1103**	**503**
Mid Surrey	426	308	286	140
North Surrey	365	241	224	141
South Surrey	490	323	300	190
East Surrey	324	314	292	32

The table shows that, if we utilised the in-house/block contracted services at almost maximum capacity, our level of spot purchasing in the independent sector would reduce from and estimated 30% currently to approximately 17% of all residential activity by 2020.

42. We are planning for occupancy rates of 93% to achieve this, given that it reflects the performance of high quality providers in the private sector.

43. We believe that it is wise for a county the size of Surrey to determine whether it wishes to be totally dependent on purchasing residential services from the independent sector, and we recognise the need to plan for any implications of the Dilnot Review. We know demand for funded care and support is most likely to come from older people with dementia, and so our commissioning intention is to offer excellent dementia care through contracted provision, alongside in-house provision. An analysis of current prices suggests that this is achievable with a unit cost of between £350 and £550 per week.

44. Our commissioning intentions would reduce the number of providers we work with. However, it would not compromise our commitment to informed choice and value for money, with the contracted and in-house provision being geographically spread throughout the county.

45. For people with dementia in particular this will mean pump priming the establishment of 24 hour, 7 day a week crisis services through an investment of £940k for two years. This will reduce the numbers of avoidable admissions to the 5 acute hospitals in Surrey.
The long term revenue to maintain these services will be picked up by the acute commissioners though efficiency savings.

46. We will fund hospital liaison services for the 5 acute hospitals with an investment of £745,000 over 2 years. These services will deliver timely discharges back to community services and reduce the length of stay in hospital beds. As with the crisis services, the acute commissions will pick up the revenue funding of these services through efficiencies.

47. We will reduce our current spend in residential care on dementia by 10% for 2011/2012 and thereafter by a similar amount.

48. We will increase the choice and availability of day care placements in the 11 boroughs and districts and examine models of services that are flexible and open 24 hours, 7 days a week.

49. We will realign our grant commitments to the 11 districts/boroughs based on dementia prevalence and population size.

50. We will develop peer support groups across the county based on our project experience with Friends of the Elderly in Woking and support groups to maximise the take up of personal budgets.

51. We will realign our investment in respite service to ensure choice and equality of access across the 11 districts and boroughs.

52. From April 2011 onwards, 18 Dementia Navigators (employed by the Alzheimer's Society) have been supporting people with dementia and their carers though their contact with statutory services.

53. We will work with block contract providers to ensure that investment in day care is fully optimised and that the volumes of day care are realigned to meet local needs.

Providing safe services

54. We have established a robust framework of quality assurance and position quality of care as one of the key ingredients of our procurement strategy.

55. We are developing an outcome monitoring tool for care home providers and have set up 4 local quality assurance groups across the county to monitor safeguarding trends and promote good practice.

Conclusion

56. This executive summary sets out our principles of care which amount to a commitment to personalisation and local community wellbeing. It outlines the challenge of supporting an ageing population and describes our priority commissioning intentions. The full description and data analysis of how we arrived at producing this strategy can be found in the main document.

1. Introduction

Background and context

1. The provision of services for older people is the most resource intensive activity within the Adult Social Care Directorate of Surrey County Council. These services account for £153 million[2] (41%) of the Directorate's budget of £373 million. Surrey County Council directly helps more than 13,000 people with social care and support needs and their carers[3].

2. Surrey County Council aims to deliver services which place it within the top 25% of local authorities for performance and in the lowest 25% for unit costs. To this end it has developed a programme of Public Value Reviews to identify how improved outcomes and value for money can be delivered for its residents. As part of this programme, the Council undertook a Public Value Review of services for Older People in 2010, leading to an analysis of spend across the care journey for older people (see Appendix 1 for its impact up to November 2010).

The purpose

3. The purpose of this Commissioning Strategy is to state how Surrey County Council's Adult Social Care Directorate will embrace the national principles and vision for adult social care, meet need and deliver excellent quality social care and support for an ageing population across the care pathway.

[2] Gross Older Peoples Budget 2011/12, including Section 256 (ie NHS funded) budgets.
[3] This figure is variable and is measured by counting the number of open cases at any one point in time. Open cases are defined as any case with an open referral status on SWIFT/AIS (our current social care recording system), and who have been assessed as meeting the eligibility criteria for services.

What is the strategy about?

4. The strategy will focus on establishing social care and support service priorities across Surrey for older people[4], identifying current provision and addressing gaps and inequalities in service delivery and access across localities. It will be mindful of access to investment opportunities to enable people to remain at home, such as Disabled Facilities Grant and the agencies available to support people to access these, such as Home Improvement Agencies.

5. This strategy will analyse local needs and outline the investment decisions made in response to these needs, and explain the positive impacts these decisions will have on the care and support journey.

6. Older people, carers and partners are at the heart of all that we do. They are involved at all stages and we make sure that people's views and experiences are heard, taken into account and strongly influence how we provide the best possible services.

[4] The legal age definition of "older people" (OP) is currently outlined in Section 45 of the National Assistance Act 1968 – as a result, Adult Social Care commissions Older People services for people over the age of 65. However, some of the preventative services available, such as sheltered housing for older people, may also support younger people if they would benefit from them.

2. National and local context

The national context

1. The Government's vision for adult social care[4] sets out how the Government wishes to see services delivered for people and marks a new direction for adult social care. It sets out the following key principles to modernise social care:

   Prevention – Empowered people and strong communities will work together to maintain independence.

   Personalisation – Individuals, not institutions, take control of their care.

   Plurality and Partnership – The variety of people's needs is matched by diverse service provision, with a broad market of high quality providers.

   Protection – There are sensible safeguards against the risk of abuse or neglect.

   Productivity – Greater local accountability will drive improvements and innovation to deliver higher productivity and high quality care and support services.

   People – We can draw on a workforce who can provide care and support with skill, imagination and who are given the freedom and support to do so.

2. "Living well with dementia - a National Dementia Strategy" was published in February 2009[5]. It set out a vision for transforming dementia services with the aim of achieving better awareness of

[4] "A Vision for Adult Social Care: Capable communities and active citizens": www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121508

[5] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_094058

dementia, early diagnosis and high quality treatment at whatever stage of the illness and in whatever setting.

3. The Health Bill and Social Care Bill, first introduced in Jan 2011, is a significant factor in our planning, as it aims to reform the NHS and pave the way for primary care trusts and strategic health authorities to be phased out by 2013[6]. Councils will take on the public health role of care trusts and local commissioning consortia will be responsible for planning and buying health services.

The local context

4. Surrey County Council set up a new Health and Wellbeing Board in May to promote greater local control over health services and join up social care and support, NHS services and health improvement. For older people in Surrey the emerging Ageing Well Strategy will benefit from these new arrangements.

5. The Surrey Adult Social Care and NHS Whole Systems Partnership Plan supports this restructure. This is an agreement made between NHS Surrey and Adult Social Care in June 2011 to set up a range of investments in health and wellbeing. The principle adopted in the plan is to set up permanent service arrangements on the basis that the measures are likely to prove advantageous from an 'invest to save' point of view, meaning that if specific funding becomes unavailable, it may still prove economically best to maintain the services. The aim of the plan is to develop a whole system, integrated reablement and recovery service centred on promoting, recovering and maintaining levels of independence and self care wherever possible. This integrated system will contain service and support elements which actively promote independence, prevent or delay hospital admission, provide opportunities

6 http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/HealthandSocialCareBill2011/index.htm

for reablement to support those in the community with long term health conditions to remain independent for as long as possible as well as supporting their carers.

6. The Dementia and Mental Health Services for Older People in Surrey Commissioning Strategy 2010-15[7] is a five-year plan to establish community based dementia services that are designed around the whole health and social care system and have clear care pathways that people with dementia and their carers can easily navigate and understand.

7. A Joint Strategic Needs Assessment (JSNA) is how Primary Care Trusts (PCTs) and Local Authorities identify and describe the health, care and well-being needs of the whole population. This assessment is then used to inform the prioritisation and planning of services to meet those needs. Locally, NHS Surrey and Surrey County Council jointly produced the first JSNA for Surrey in 2008, using information from a variety of sources. The JSNA is a continuous process and is updated as additional information becomes available, as gaps are identified and in response to feedback received[8].

8. From consultations done to produce the Ageing Well strategy and from feedback received through engagement events for the Public Value Review of Older People's services, we have found out that what matters to older people and their families and carers in Surrey is as follows:

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7 www.surreycc.gov.uk/sccwebsite/sccwspages.nsf/LookupWebPagesByTITLE_RTF/Dementia+and+Older+People's+Mental+Health+Joint+Commissioning+Strategy?opendocument

8 Accessible via www.surreyi.gov.uk/

Ageing Well in Surrey: Emerging Themes, Concerns and Priorities – A place where older adults enjoy a good quality of life

Theme	Priorities
Planning Ahead	- Planning for retirement: provide more information about ageing throughout life, but particularly in the run up to and in retirement.
Remaining as Well as Possible	- Remaining as well as possible (despite having some degree of illness: maximising prevention and early intervention - Managing episodes of ill health and reducing the need for hospital admission / readmission - Hospital admissions: facilitated discharge, support to recover closer to home, care navigators - Reablement/ rehabilitation - Dementia care - Good Nutrition
Choice and Control	- Having services and support available to enable person to remain at home - Attractive and sustainable environment, including transport, housing and green spaces - Existing services are valued, such as sheltered housing for older people
Promoting Independence	- Local Transport services need to meet the needs of OP - Coping alone after periods of hospitalisation - OP need to feel safe and secure within their communities and their homes - Support for managing mobility issues
Financial Matters	- Economic wellbeing, including employment and benefits information - Funding Care - Provision of advice and early identification of people with financial difficulties
Social Inclusion	- Depression, loneliness and isolation - Support for those with sensory impairments /loss of faculties
Get Digital	- Reducing digital exclusion and working to ensure that older people benefit from technological change - Role and availability of telecare/ telehealth
Championing Participation and Feeling Valued	- Opportunities to contributing to community they live in - Feeling devalued/useless - Opportunities for training, learning new skills - Age discrimination: raising awareness /implementation of new equalities legislation - involving older people and communities in discussions about priorities and opportunities for improving their wellbeing

	- Increased choice and positive contributions, including information to allow effective choices and volunteering opportunities
EOLC Issues	- Raising awareness of death and dying - Increased choice and control over EOLC
Carers	- Carers Support Network
Information	- Raining awareness and knowledge of services, support and opportunities available - Developing role of OP Champion - Information available online to be supplemented by telephone and face to face advice. There was a strong call for information to be kept local and relevant
Special Needs	- Increasing numbers of people 85+, differing needs

3. Future demand

Surrey population projections

1. Surrey's population is projected to rise over the coming decade with notable increase in the number of people aged 65 and over. Estimates (see Appendix 2) show that:

    - The 65+ population in Surrey will increase by 10.8% and 19.6% by 2015 and 2020 respectively. This is just below the average for England as a whole.

    - The proportion of the population aged 85 years and over, projected to increase until at least 2033, is slightly higher for Surrey than for England. This reflects the longer life expectancies in Surrey (79.8 years for men and 83.3 years for women) compared with England (77.6 and 81.8 respectively). It is also recognised that the fastest growing sector of the population is the 85+ age group, both nationally and in the county.

2. Overall the over 65 population of Surrey is due to overtake that of the under 16s within 20 years[9].

3. Changes in the population structure significantly affect the levels of need for support, in regard to both chronic illnesses and social care. People aged 85 years and over are more likely to have complex support needs than younger people. Part of the challenge for this age group is to provide access to sufficient preventative services to enable them to be independent and to self-care for as long as possible.

[9] http://www.statistics.gov.uk/cci/nugget.asp?id=949

Population trends in the boroughs and districts

4. Commissioning profiles for each of the eleven districts and boroughs within Surrey (based on data from JSNA and POPPI[10]) are being produced. These profiles give a high level illustration of adult social care needs in Surrey and begin to define how to shape commissioning intentions to meet those needs.

5. Areas projected to have the highest percentage change in total population are Epsom and Reigate & Banstead.

6. The percentage increase for the 75+ population is also below the national average - 7.8% and 21.4% for 2015 and 2020 respectively. Areas with the highest percentage change are Surrey Heath and Tandridge.

7. The percentage increase for the 85+ population is just above the national average. It is projected that it will increase by 12.3 % by 2015 and by 33% by 2020. This is even more significant for Surrey Heath, with a 60% increase by 2020 and 40% increase in Tandridge by 2020. This is of particular significance for Adult Social Care, as people aged 85 or over make up a large proportion of open cases, standing currently at 34%[11].

Geographical areas of special focus or need

8. "Priority Places" have been identified on the basis of national, regional and locally validated data sources, such as the Joint Strategic Needs Assessment (JSNA) and the 'Heatmaps' developed by Surrey County Council.

   The four initial areas of focus are:

   - Stanwell in Spelthorne Borough
   - Maybury and Sheerwater in Woking Borough

[10] Projecting Older People Population Information – www.poppi.org.uk
[11] As retrieved from InfoView as a snapshot as at 31 March 2011.

- Westborough in Guildford Borough
- Merstham in Reigate and Banstead Borough

As part of the Ageing Well Strategy we will be looking at the specific issues for older people in one of these Priority Places, and what lessons we can learnt related to a Total Place approach to ageing

The effects of ageing on a diverse population

9. The demand for care and support services arising from specific groups will place significant challenges for SCC in the coming years. In particular the challenges are around providing sufficient quantities of quality care with the skills, competence and knowledge to support people with dementia and the needs of an ageing population with a learning disability.

Learning disability

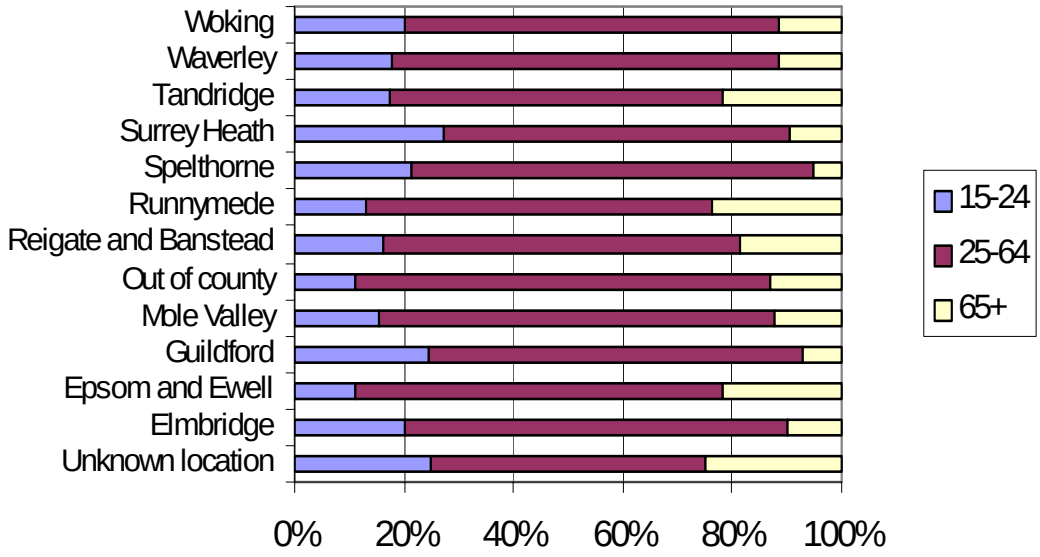
10. In Surrey in 2011, 20,623 adults are predicted to have a learning disability. Of this total, 16,654 people are aged 18-64[12] and 3,969 people are aged over 65[13].

11. The Public Value Review of Learning Disability Services (2011) has identified that Surrey County Council gives support to the following numbers of people with learning disabilities who are aged 50 and over:

Age	Male	Female	Total
50 - 64	519	345	864
65+	261	183	444
Total	**780**	**528**	**1,308**

[12] Source: Projecting Adult Needs and Service Information (PANSI), www.pansi.org.uk.
[13] Source: Projecting Older People Population Information (POPPI), www.poppi.org.uk

12. The graph below shows the age splits for people with learning disabilities receiving support, on a district and borough basis as at June 2011:



13. There are considerable variances in the proportions of people with learning disabilities between Boroughs and Districts, with Tandridge, Runnymede and Epsom & Ewell having the highest proportion of cases aged 65+

14. We recognise the needs of an ageing learning disability population and are aware of the insufficient breadth of provision at present to meet these needs. The future direction will be informed by the emerging outcomes of the Public Value Review Transition work stream.

Elderly Frail

15. Independence, choice and wellbeing come under threat when older people develop illnesses or become frail. If this is combined with a lack of access to the right type of support, then the overall sense of wellbeing amongst affected people will worsen, as they feel more isolated, become more dependent and are exposed to greater risk.

16. The term “frailty” does not have a single defined medical definition. It can relate to a chronic long term condition, such as heart disease, or a combination of conditions which together severely limit independence. As a result, "frailty" can be a condition that can be defined and measured by older people themselves.

17. Regardless of its description, the term “elderly frail” is used to define a pathway of care. The risk factors associated with early admission to long term residential or nursing care on the basis of frailty are not always disability related, and include:
    - Critical interval care needs (i.e. care needs relating to unpredictable conditions, such as incontinence).
    - Physical ill-health / impaired mobility
    - Depression
    - Dementia
    - Falls
    - Carer breakdown
    - Living alone, social exclusion and isolation
    - Fears for personal safety
    - Lower socio-economic status/ poverty
    - Previous admission into hospital over the last 12 months.

18. Aspirations for older people with frailty and associated high support needs cover a wide spectrum of interests, activities and relationships. Their aspirations are often around wanting the opportunity to "live a normal life", for example to be part of daily routines, to keep fit and healthy, and to contribute to family and community life.

    In responding to the aspirations of people who are frail and with associated needs, we will develop support and services that create the right conditions in which people can have choice and control. Alongside this, the Ageing Well Strategy

will address the promotion of wellbeing and promote more preventative care services.

Dementia

19. It is estimated that 14,830 people with dementia over the age of 65 are living in Surrey - 1 in every 13 people of that age group.

20. This figure is expected to increase to over 18,600 by 2020 – a 26% increase which reflects the increasing prevalence of dementia in an ageing population.

21. The increase in the number of people with dementia between 2011 and 2020 in Surrey is similar to the increase for England as a whole (c.26%). However, when the figures for the boroughs and districts are examined we can see diverse growth rates – increases amongst the 65+ population range from just under 20% in Epsom and Ewell to 39% in Surrey Heath.

22. One of the key challenges in relation to supporting people with dementia is diagnosis. Current best estimates suggest that only a third of people with dementia ever receive a diagnosis of their illness. This means that, according to the 2011 estimates, less than five thousand people in Surrey have a formal diagnosis of dementia. The remaining ten thousand people, if diagnosis rates do not improve, will find it difficult to plan their care and support appropriately and in enough time to live at home in the community for as long as they choose to.

23. 76% of dementia costs arise from emergency admissions to acute general hospitals, of which there are five in Surrey and one in Kingston, which the residents of East Elmbridge use.

24. Most people with dementia have more than one co-morbidity, which must be taken into account when care and treatment is provided.

Long term conditions

25. A long term condition is one that cannot be cured but can be managed through medication and/or therapy. There is no definitive list of long term conditions but it includes conditions such as, diabetes, asthma, coronary heart disease, chronic obstructive pulmonary disease (COPD), dementia and long term neurological conditions.

26. Around 15 million people in England, or almost one in three of the population, have a long term condition.

27. Figures from the DH show that:
    - Half of people aged over 60 in England have a long term condition.
    - While the number of people in England with a long term condition is likely to remain relatively steady, the number of people with comorbidities is expected to rise by a third in the next ten years.
    - People with long term conditions are the most frequent users of healthcare and social care services. Those with long term conditions account for 29% of the population, but use 50% of all GP appointments and 70% of all inpatient bed days.

28. Long term conditions fall more heavily on the poorest in society. Compared to social class I, there is a 60% greater prevalence of long term conditions and 60% higher severity of conditions amongst those in social class V.

29. SCC are working with the NHS and other partners to improve outcomes, services and support for those with Long Term Conditions. These improvements focus on:
    - Increasing awareness and reducing misconceptions
    - Improving choice and access to the care, support and treatment needed for people to manage their condition, reduce complications and remain as well and independent as possible

- Achieving a step-change from hospital and residential based care to health promotion, primary, community and intermediate care.
- Enhanced used of telecare, telehealth and telemedicine to enable people to live safely at home and to manage their own health.

Stroke

30. Stroke of cardiovascular accident is the third highest cause of death in Surrey.

31. In 2008/9, 17,229 people were on the GP stroke registers in the Surrey Primary Care Trust (PCT). The proportion that has had a stroke or transient ischaemic attack (TIA) is 1.5%. This compares with 1.7% in the P South East and 1.66% in England.

32. Prevalence of stroke varies across Surrey. Amongst the GP registered population, Mole Valley has the highest prevalence rate for stroke and TIA at 18.2 per 1,000 people, while Guildford has the lowest at 12.2 per 1000. The equivalent rate for Surrey was 14.9 per 1,000 people and for England it was 16.8 per 1,000.

33. It is projected that by 2015 the number of people aged 16 surviving a stroke in Surrey PCT will be just under 19,000, or 2.0% of the adult population. By 2020 this will rise to just over 20,500 or 2.1%. As the population gets older this is to be expected.

34. Surrey County Council is currently developing a Joint Long Term Conditions Neurological Conditions (LTNCs) Commissioning Strategy. The recent review of services and ongoing co-design has identified a number of areas for improvement, and the resulting set of recommendations are equally applicable to those with stroke.

Carers

35. The table below[14] shows that in 2012 there will be more than 106,000 carers in Surrey. Of this total, 51,000 people will provide over 20 hours of care per week, and over 23,000 will provide more than 50 hours of care per week.

Estimated Need
The projected number of carers in Surrey is as below

	As at 2012
Total carers	**106,740**
o Caring for 20 or more hours a week	**51,230**
o Caring for 50 or more hours a week	**23,480**
Estimated Carers working full or part time	**60,110**

36. From this it can be assumed that there are about 51,000 carers undertaking regular and substantial care and meet the criteria for having access to a carer's assessment.

Demand for Adult Social Care services

37. Our JSNA shows that older people are the age group most likely to receive a social care service.

38. In a 12-month period, Adult Social care receives approximately 34,800 contacts, 70% of these relate to people over the age of 65. 52% of these contacts are repeat referrals within a 12-month period.

39. 13,500 of the contacts progress to a referral to social care and 85% of these or 11,500 are for people aged 65+.

40. Some people are referred more than once in a year and overall 8, 035 new people aged 65+ were referred for social care in 2010-11. This equates to 90 per 10,000 people.

[14] From www.surreyi.org.uk

41. This is lower than comparative authorities; the latest published average rate in 2009-10 was 130 people per 10,000 populations.

42. Our JSNA indicates that using population projections we could expect to provide community services to an additional 3,200 people by 2015 compared to 2008/09

43. LGIU research indicates that 25% of self-funders ultimately fall back on public funding, mostly due to exhausting their own resources. In Surrey we have seen an increase in the numbers of people approaching the council for financial support. In 2010/11, 125 people who were self-funders approached the Council, having reached the threshold for public funding. This represents 8% of all new costs on an annual basis on a total residential and nursing budget of almost £77 million.

44. It is important that care and support providers work together with the Council to protect people who currently pay for their own residential care, as often people are paying for care at rates far above what the Council would normally expect to pay and therefore difficult decisions arise when the source of funding changes.

45. Evidence outlined in the ADASS report "People who pay for Care" (Jan 2011)[15] indicates the following trends with self-funders that will have a big impact on the publicly funded social care:
    - Increased longevity
    - Rising care home fees
    - Hidden volumes of top ups
    - Reducing property values
    - Housing market decline
    - Reduced value of assets (property and shares)

[15] People who pay for care: quantitative and qualitative analysis of self-funders in the social care market (SCIE/IPC, January 2011): www.thinklocalactpersonal.org.uk/Browse/Self-funders/?parent=8609&child=8647

- Changes in the demographics: the number of people aged 85 and over has increased significantly.
- Cost of care at home and increasing charges
- Higher price of residential and nursing home placements
- Increasing cost of domiciliary care for complex needs.

46. The Commission on Funding of Care and Support (also known as the Dilnot Commission) has presented its findings to the Government in its report "Fairer Care Funding", published on 4th July 2011[16].

    It recommends the following in terms of the future funding of care:

    - Individuals' lifetime contributions towards their social care costs – which are currently potentially unlimited – should be capped.
    - The means-tested threshold, above which people are liable for their full care costs, should be increased from £23,250 to £100,000
    - National eligibility criteria and portable assessments should be introduced to ensure greater consistency
    - All those who enter adulthood with a care and support need should be eligible for free state support immediately rather than being subjected to a means test

    These recommendations, if implemented, would increase demand for social care support and also have financial implications.
    This commissioning plan will need to be reviewed in 2012/13 to take into account the implication of any recommendations.

What we need to know more about

47. Surrey has few large urban areas, with approximately 70% of the county given over as 'green belt' land. Understanding the needs of those living in isolated areas is vital to ensure that isolation and inequality of access

[16] https://www.wp.dh.gov.uk/carecommission/files/2011/07/Fairer-Care-Funding-Report.pdf

due to location is not a factor for vulnerable older people accessing Surrey County Council Services.

48. Future work with LGID under the heading of Ageing Well will look at the specific issues related to rural isolation and access. This is due to commence in September.

49. There is currently no information showing the numbers of people within Surrey identifying themselves as being lesbian, gay, bisexual or transsexual (LGBT). If the Central Government estimation of 5-6% of the general population is used, then this would mean approximately 55,000-66,000 people identify themselves in this way within the county. However, it is likely this is a conservative estimate, with a more realistic estimate being 9-10% (ie 90,000-100,000 residents in Surrey). The number of older people within this figure is also unknown.

4. Our commissioning intentions

1. Adult social care provide a wide range of care and support services to older people by contracting with the independent and voluntary sectors and through in-house provision. The tables below summarise provision which is primarily focused on older people however many other care and support services are defined as generic or non-client specific and can therefore be accessed by older people in conjunction with any other client group. Taking into account the legislation directive we can identify that Adult Social Care commissions OP services for people over the age of 65 from 1,109 providers as follows:

Type of provider	**No. of providers**
Health	1
Independent / private	890
Voluntary	184
Public bodies	34
Total	**1,109**

Information and advice

Trustworthy, clear and accessible information helps make decisions about care less stressful and can give someone confidence that the service they have chosen will meet their requirements"
Age UK (2011)

2. At present we commission services to supplement the advice and information service provided by the Surrey County Council Contact Centre and the online information on Surrey Information Point (SIP)[17].

3. We commission Surrey wide services through Age UK Surrey: Taking over 4,500 calls a year from older people their families and carers with a significant number of calls dealing with entitlement to benefits. We also contribute to the funding to operate a Surrey Wide Advocacy Service specifically for Older People.

4. Through Surrey Information Point (link) we provide on line information services, and our citizen hubs in Epsom and Reigate have developed walk-in shops to support disabled people.

5. We commission Home Improvement Agencies to offer older people advice on "staying put", for example, through assisting with Disabled Facilities Grant applications and for overseeing trusted builders, or to offer advice and support in accessing alternative accommodation.

The gaps as identified by older people

6. One of the key themes emerging from our Ageing Well Strategy is the importance of timely information in an accessible format and we are told that choosing the right care services can be difficult. People tell us that

[17] www.surreyinformationpoint.org.uk

they can are sometimes forced to make choices and source care services at very short notice often following an illness or hospital visit.

7. We have heard that sourcing local services can be difficult.
8. We have identified that benefits take up, and in particular uptake of Attendance Allowance is variable across the county taking into account the percentages of older people in communities.

9. We have identified that people in care homes have limited access to the wider community including access to independent advice.

10. The Dementia Strategy has outlined a commitment to providing local information and advice on the range and availability of services

11. Through our older people network groups we have received feedback that GPs were a key, trusted source of information and advice for older people. We need to ensure that advice and information is easily available at the first key point of identifying need.

What we will do

- We will commission Wellbeing Centres in each of our borough council areas, having a wide range of accessible information and advice specifically aimed at older people, people with dementia and their family and carers. These wellbeing centres will be based in local focal points in the community. This will be an investment of £300,000 to our information and prevention agenda.
- By December 2011 a full map of information and advice will be completed and broad consultation and co-design to recommission advice and information services.
- We have undertaken an audit of information available in hospital settings and working with hospital Transformation Boards to commission the management of information systems and ensure we provide the right quantity and quality of information in the correct settings.

- We are commissioning brokerage services for older people, stroke support workers, dementia navigator services to help people, develop support plans, organize money, organize support, live life and monitor.
- Through our commission agreements we will ensure that promotion of benefits take up is central to any agreements with the specific aim to improve the geographical variance in Attendance Allowance uptake up in Surrey and improve economic wellbeing, choice and control of older people in need.
- We are consulting on an advocacy strategy and we will continue to commission services sensitive to the specific issues related to ageing and older people.
- We are in discussion with innovators through Future Gov to identify creative solutions to the problems older people face with access and interfaces with technology in particular for people who are in residential and nursing homes.
- Through our Ageing Well strategy we will continue to work with older people to agree the best local solutions, and the right place to access information for local people.

Prevention services

12. Surrey County Council allocates **approximately £3.6 million** funding in grants and contracts by borough and district, with a primary focus on prevention and promoting independence: services such as day care, befriending and meals on wheels. Recommendations through the Public Value Review are currently being implemented. We do not plan to disinvest any funding from the third sector, however it is important that what funding we do provide is delivering on the key strategic objectives, specific funding is targeted towards priority places with the greatest level of needs, and that funding begins to more accurately reflect proportionate to need and demography. In addition, approximately £3.66 million is allocated to older people services through the Supporting People programme, targeted towards sheltered housing services, Extra Care services and Home Improvement Agency services.

Community Meals: Nutrition and Hydration

13. The meals on wheels delivery service is the largest provider of community meals for older people. Adult Social Care commission these invaluable and reliable services through the borough and district councils. Meals on wheels services play a vital role in providing social contact, maintains social links has a positive influence on older people's mental and physical health. The support makes people feel a connection to their communities and enables them to remain living independently at home. It is important to provide meals that can deliver the nutritional standards required to meet the needs of people with complex needs as well as meeting cultural and religious needs.

14. The role of volunteers in the delivery of meals on wheels is absolutely invaluable.

15. There are 9 Boroughs/Districts who provide community meals (see the table below). The total cost to Surrey County Council is £275,087; the investment per meal delivered by the Council is therefore 76 pence.

Borough/ District	Predicted no. people aged 65+	No. of community meals 2010/11	Description
Epsom and Ewell	21,600	27,860	5 days hot, 2 days frozen + tea delivery
Elmbridge	12,400	58,084	7 days hot + tea delivery
Guildford	21,200	47,320	7 days hot, considering tea delivery
Mole Valley	17,600	None	None
Reigate and Banstead	22,500	None	None
Runnymede	14,000	40,700	5 days hot, 2 day frozen
Spelthorne	16,800	49,920	7 days hot
Surrey Heath	13,800	44,460	7 days hot
Tandridge	15,700	16,900	5 days hot, 2 days frozen
Waverley	23,400	40,300	5 days hot, 2 days frozen + tea delivery from Sept
Woking	14,100	37,700	7 days hot + tea delivery
TOTAL	193,000	363,244	

The gaps identified

16. When asked about future concerns in relation to the provision of their service, meals on wheels service providers referred to difficulties in relation to estimating and meeting demand for their services. Currently, older people are receiving meals on wheels, on the basis of where they live rather than on the basis of need. Innovative approaches are being developed as a result, in particular with the growth of personal budgets, to provide other choices.

17. Local care homes, public houses, and community lunch clubs /groups are developing to offer a range of choice and meet the growing demand of the ageing population in particular in rural areas.

18. In visiting acute hospitals we have also been told that one of the biggest threats to the wellbeing of older people is not drinking enough fluids. Hospital A&E departments have to deal with significant numbers of older people suffering dehydration, caused by lack of access to drinks or forgetting to drink. Families, carers and providers must be aware of this issue, and vulnerable people must have access to enough fluids during the day to help them remain well.

What we will do

- We will continue to invest with our partners in borough and district councils to continue these invaluable services commensurate with demand.
- We are working with our district and borough colleagues to expand existing Meals on Wheels delivery services and extend service to residents in Mole Valley and Reigate.
- We are working with other providers such as care homes, support workers and personal assistants, as well as volunteer groups in communities to continue to expand the range of service and develop community lunch clubs where gaps exist.
- We are exploring some really innovative ideas connecting volunteers and mobile phone text message technology to respond to older people who may need a meal at short notice eg a temporary illness
- Stimulate the market, promote diversification, and address needs relevant to small local areas.
- We are carrying out a review of older people services funded by Supporting People to see if services are being targeted in the most efficient way

- We are working with boroughs and districts to develop Extra Care housing where there is an identified need
- Our aim is to promote good hydration and nutrition in older people. Our plans for the following year include working with our partners and providers on the development of:
    - Hydration and Nutrition Action Plans
    - Training and development programs
    - Increase use of Personal Hydration / Nutrition Plans
    - Commissioning services with nutrition and hydration factors built into specifications.
    - Innovative ideas connecting volunteers and mobile phone text

Telecare and telehealth

19. In Partnership with our colleagues in the Boroughs and Districts we fund Telecare services and equipement. Telecare is a service which provides people who are usually elderly or vulnerable with the support to help them lead independent lifestyles. Telecare equipment makes it possible for them to call for help and assistance when needed.

20. Equipment can range from Community Alarms, Fall Sensors, Flood and Gas Sensors, and medication prompting to more sophisticated technology solutions to monitor and support people to remain safe.

21. Telecare services are relatively new and still developing applications of technology to support the provision of social care to people living independently in their homes.

22. Telecare is one of the fundamental planks of supporting older people with dementia to live safely in their own home.

23. The expectation is that most people in Surrey will pay for the cost of their own Telecare service, although those that are eligible for an Adult Social Care service will get financial help. However, it is envisaged that all who might benefit from Telecare will have an opportunity for a free Telecare service (up to 12 weeks) to see if the service meets their needs.

24. In addition, the Community Alarm Telecare (CAT) discharge services offers a free community alarm to all those who may benefit for up to 12 weeks on discharge from hospital.

25. **Telehealth** is about systems incorporated within existing care pathways that offers support to maximize health and wellbeing, support people with complex health needs in the community and reduce the need for unnecessary hospital admission through:

- Tele-monitoring of patients with adaptable clinical algorithms
- Remote consultations between patients at home and clinicians within their usual workplace
- Flexibility of connectivity - 3G mobile, broadband and analogue telephone systems

26. At present the amount of Telehealth equipment being used in Surrey is small. SCC are working with the NHS and other partners to improve outcomes, services and support for those with Long Term Conditions. These improvements focus on increasing awareness and reducing misconceptions, improving choice and access to care, support and treatment required to enable people to manage their condition, reduce complications and remain as well and independent as possible, achieving a step change from hospital and residential based care to health promotion, primary, community and intermediate care.

27. Through the Public Value Review we identified that the potential of telecare was under-utilised, partly because Adult Social Care staff have not yet fully embraced the concept, in terms of assistive technology being a positive option for people, and partly because of the general public not being aware of the benefits.

28. The Telecare Strategy is now addressing the gap in practitioner knowledge and competence. The Telecare Strategy and supporting Service Delivery Plan will confirm:
    - The type of Telecare equipment and sensors to be utilised initially
    - A projection of the volumes of equipment that is expected
    - How use of Telecare will be embedded in reablement services
    - How performance will be monitored
    - How costs will be captured and identified for Surrey County Council's medium term savings plan
    - The referral pathways
    - The funding streams for Telecare, be they pump-priming or ongoing subsidy

- Telecare installation and maintenance arrangements
- Appropriate links and developments to 24 hour response services
- A robust and comprehensive training programme for adult and social care practitioners to support wider community engagement.
- How we can further develop the agenda to embrace the opportunities offered by Telehealth

The gaps identified

29. The most important gap is recognising that whilst Telecare is technology based, it is very dependant upon local people being available to respond to a need. At present if people cannot identify a family member or carer then they are unable to benefit fully from the services.

30. Additionally we recognise people may need a service at any time of night or day, and that when people fall a standard first response may be an ambulance service. Older people are often worried that they may end up in hospital inappropriately.

What we will do

- We will develop equality of access to Telecare services across the county. This will provide comprehensive Telecare system which operates across organisational boundaries and ensures a seamless and efficient service which can be accessed locally
- People are supported to use Telecare to achieve “reablement” (preparing people to live independently at home again, after a period of hospitalisation or crisis). We will also install telecare equipment in our older people's reablement beds to support discharge planning.

- Through our Whole Systems Partnership Plan we will make significant investments in the telecare / telehealth infrastructure to demonstrably increase the effectiveness of support in the community for those living with chronic and long-term conditions. This will support the principles of the “virtual ward” model.
- To support the telecare / telehealth agenda we will commission a local service in each Borough and District to respond to individual older people who would otherwise have no family support or other community networks. This will ensure that when equipment alerts the call centre there is someone who will, if needed, be able get out speedily to the home and make sure the person is safe and well.
- We will commission a project manager to develop the Telecare/ Telehealth agenda, win the hearts and minds of people about the benefits to the whole community and health and social care system, ensure that we invest in the right technology, in the right place at the right time
- We will install Telecare and Telehealth information and demonstration points through our older people's Wellbeing Centres across Surrey to allow people to familiarise themselves with equipment and promote uptake.
- Through our commissioning specifications we will prompt use of telecare and telehealth in residential care and nursing homes for Older People to reduce inappropriate hospital admissions.

Stroke specific services

31. SCC is currently commissioning two stroke specific services to support those living with stroke and their carers through the specific DH accelerating progress on stroke grant.

32. The Stroke Association have been commissioned to provide 5 part time Stroke Support Workers - £408k over 3 years (June 2009-May 2012).

33. The support workers are locality based and form part of the multi-disciplinary stroke teams. They support people with stroke in several ways including:
    - Providing information, advice, navigation and signposting, acting as a key point of contact – supporting people to self care
    - Providing emotional support to those with stroke and their carers
    - Providing education around reducing risk factors
    - Raising public awareness and conducting "know your blood pressure" public awareness campaigns
    - Helping with self directed assessments – enabling choice, control and supporting development of personal support packages
    - Assisting with stroke recovery programmes, exercise classes and peer support groups

34. TALK Surrey – £31,140 on annual grant basis. TALK provides support for people of all ages with aphasia (following stroke) to regain lost skills. They work closely with speech and laungage therapists and with small groups of individuals helping them to improve communication skills, build confidence, provide social activity, support equipment, newsletters and peer support to promote social inclusion

35. SCC also commission a range of services from a variety of providers which while not stroke specific may provide care and support for those with stroke.

The gaps identified

36. Stroke is the single largest cause of adult disability. The National Stroke Strategy and quality markers provide a framework for improving outcomes for stroke by providing good services from prevention, having appropriate care pathways in place, raising public awareness., through to ongoing care and support. Specialist stroke services and community services, including social care, need to be well coordinated to promote independence and quality of life among stroke patients. The recent CQC audit of stroke services highlighted a number of local areas for improvement – in terms of the council this included – need for improved communication, ensuring appropriate support and follow-up and need for increased support for care homes.

What we will do

- The current funding to the Stroke association for the Stroke support Workers is due to end nearly next year. Evaluation (local and national) shows this service provides valuable support, is highly valued by those with stroke and contributes to delivering improved outcomes for those with stroke. We should therefore continue to commission this type of service in the future.
- TALK provides valuable specialist support for a small number of people with specific difficulties. This service is only available in some areas and we would need to consider plans for improving equity of access for older people including those in care home settings.

Respite care services

37. There are a number of ways that carers can take a break from a caring role. With personal budgets and direct payments people are beginning to be more creative about how they get respite from caring, for example gym membership, attending classes, or maybe going on a carers holiday break with a carers organisation. No matter what support the carer has they need reassurance that they have a quality service provided to the older person with needs.

38. **Residential respite care is one of the ways that can support carers.** . Residential care beds are an essential component in the suite of support to carers and the people who use our services.

39. **Domiciliary care/ Crossroads** - someone comes into the home and takes over care for a while (for a few hours or sometimes overnight) so the carer can go out or have some time to themselves.

40. **Day Care Services** - the person is involved in other activities, for example at a day care centre.

41. Adult Social Care commission:
    - Care UK - 30 respite beds
    - Anchor - 35 respite beds
    - In-house – 45 respite beds

42. When we look at the use of respite beds there are some anomalies that need to be understood. Respite beds are a valuable resource for many carers who benefit from regular support. There are problems with consistency of use and subsequent voids. Data analysis by Project Resolve has identified large variances and patterns of use of beds. In addition, the use of respite beds have not been used solely to support

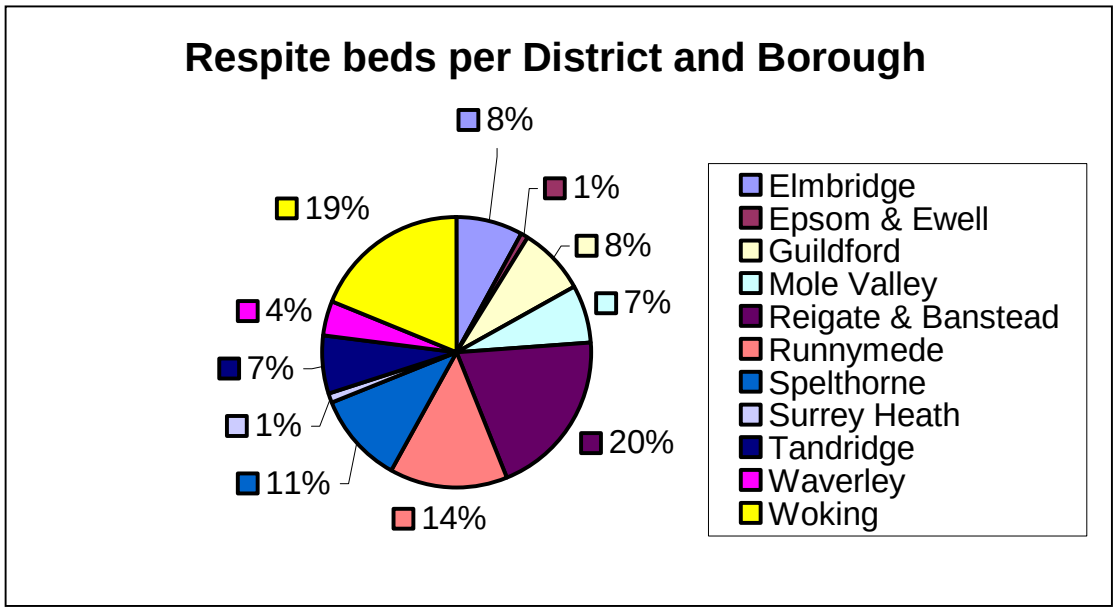
carers, with some significant periods of respite lasting over 30 days and up to a year.

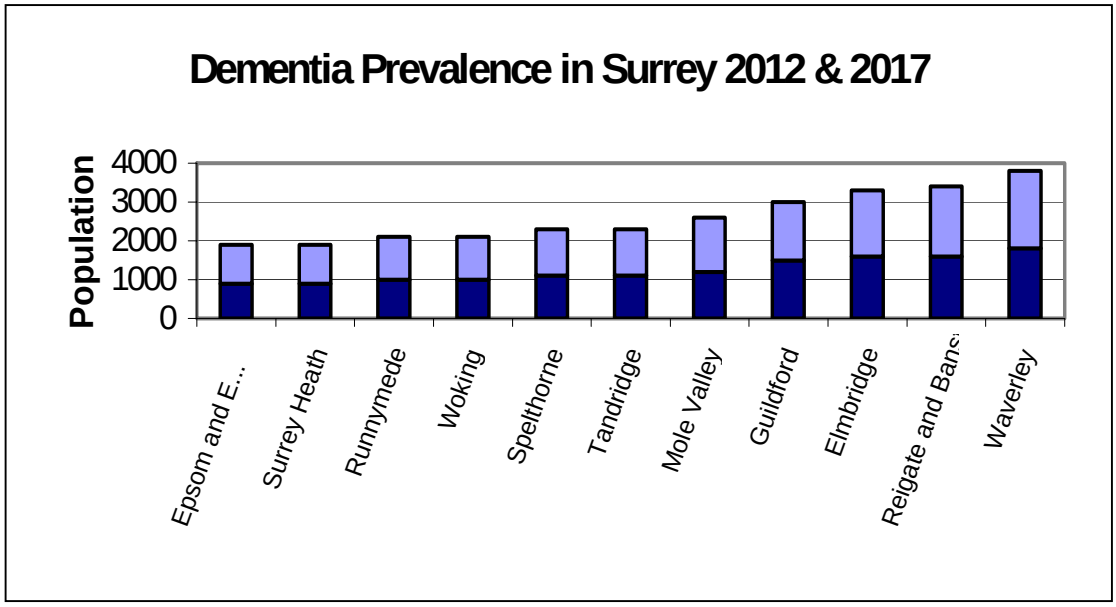
43. What is clear is that people who enter respite care do not get access to reablement services . This needs to change.

44. The districts / boroughs with the highest amount of respite beds are Woking, Reigate & Banstead and Spelthorne whist the other boroughs have between 1% and 8% of their bed capacities devoted to respite.

45. We need to establish a benchmark for local demand for dementia respite services and ensure we develop services that meet the needs of the borough / district populations. There is particular interest, and a need for, flexible night-sitting services for people with dementia and their carers living at home in the community.

46. The chart below shows the patterns of spend for individual older people in Surrey, together with a graph showing the 2012 and 2017 figures for people with dementia on a borough and district basis.





What we will do

- Improve the current level of efficiency in bed capacity and cost, we must reshape the way in which respite care beds are managed, including the option of seeking more cost effective options in the wider independent market.
- Establish an infrastructure of day care provision and respite service in each of the 11 boroughs for people with Dementia.
- Examine the respite services in the 11 district/boroughs to ensure equity of access in each borough/district in 2011/12 and reallocate spend to match need.
- Invest a proportion of the saving on residential care on increased day care and equitable respite services across the county based on population need.
- Once reablement beds are developed across the county we should cease the use of respite beds for people who do not have an identified carer.

Reablement services

47. Reablement is at the cornerstone of our prevention agenda. The investment in staff, training and resource supports the strategic aim to delay and reduce the need for more intensive forms of care.

48. The Council has refocused its home-based care services to offer a reablement service that helps people to settle back into being at home. Trained staff work with the individual to realise what is important for them to achieve, and where they might need help. Working with the person for a six week period, they will help with a range of activities from meal preparation to getting a person dressed, gradually doing less and less as the person's abilities and confidence return.

49. The current reablement teams are:

North West Reablement Team, Runnymede Centre

- Covering Runnymede, Spelthorne and Woking

South West Reablement Team, Farnham Hospital

- Covering Guildford, Surrey Heath and Waverley

Mid Surrey Reablement Team, The Squirrels, Banstead

- Covering Elmbridge, Epsom & Ewell and Mole Valley

East Surrey Reablement Team, East Surrey Hospital

- Covering Reigate & Banstead and Tandridge

50. At present we currently commission one bespoke domiciliary reablement service through an independent home care agency in Frimley. This contract is due to cease in April 2012.

51. Recommendations were made through the Public Value Review to ensure that these commissioned services reflect Adult Social Care key strategic priorities and that any future investments contribute to our strategic objectives of reducing delays, reduction in residential and nursing care placements and a safe and supported discharge home to

maximize independence. As this plan is being written services are being decommissioned and reviewed and new arrangements are set out below.

52. Adult Social has developed a 3-year Whole System Partnership Funding Plan of £21 million. The plan developed in conjunction with NHS Surrey will largely focus on telecare and telehealth as well as support the development of reablement services, improvements to the management of long-term conditions as well as supporting unexpected pressures on the systems such as severe winter weather, and responding to seasonal peaks in flu and other viruses. The outcome of the monies must demonstrate benefits to both health and and social care services, and encourage greater integration between health and social care at the local level. This investment will result in better outcomes for people needing support or treatment at a lower cost of provision overall.

53. This is an opportunity to develop innovation and joint working. The funding will cover at least **20** individual commissioning arrangements, which will be evaluated on a yearly basis. The specific investment in reablement services is over £1.5m.

The gaps identified

54. It must be considered that as the population increases and as the reablement strategy has a positive impact on people remaining in their own home, we can anticipate not only a demographic increase, but a potential 10% increase. This will be commensurate with reduced numbers in residential care, as well as an increase in the numbers of people who may go through reablement, potentially more than once.

55. Data from the NHS Unplanned Care Network highlights the continuing problem of inappropriate Length of Stay in acute settings for people with anxiety, confusion or dementia. In Surrey, a review has highlighted this as a problem across acute and community hospital settings and also the

gap in provision of reablement services for older people with mental health needs. A response to these unmet needs in Surrey includes:

- 24/7 admission avoidance services to include night services should be developed across the county to reduce admission to hospital;
- Further investment in reablement services, to help people regain their independence and reduce the need for ongoing care, for older people who have a mental health need.

56. Adult Social Care has provision for short-term bed based resources with the aim of reablement. The purpose of the beds are to support people being discharged home from hospital to long term care without getting opportunity to recover, regain skill and benefit from a detailed assessment in a community setting.

What we will do

- It is particularly important to achieve a rapid and efficient throughput from our reablement service and monitoring of activity and outcomes needs to be robust and continuous improvement made.
- We need to commission providers who can offer a short "stop gap" service, pending the completion of a support plan. This will require a change to the notice period for cessation of a service.
- We will require all care providers to demonstrate that they promote the values and philosophy of reablement.
- We should commission reablement capacity within the independent sector to cope with surges in demand and Winter Pressures.
- Our current reablement service will need to grow commensurate with demand arising from demography and changes underway in practice avoiding long term care
- In order to achieve sustainability of reablement services then unit cost reductions must be applied to the current delivery models. We need to aim for top quartile performance of hourly rate.(£25 per hour for domiciliary settings)

- We will commission up to 6 weeks multi-disciplinary therapeutic and health support to ensure people get early access to skills gain and can return home as speedily as possible where their physical and mental health needs have changed and dependency has increased.
- Cease the use of respite beds for people who do not have an identified carer.

Community equipment services

57. All equipment provided by three services detailed below aims to support older people's main functions in respect of their ability to live independently.

58. ICES: a service provided in partnership with NHS Surrey with current provider Millbrook Healthcare (appointed April 2009 following a competitive tendering process). Equipment provided covers some 130+ catalogue items as well as other non-standard equipment including bathing, toileting, moving and handling, access and mobility, beds and pressure care management.

59. Countywide specialist equipment service for users who are visually impaired provided by Surrey Association for Visually Impaired (SAVI). Individual receives specialist equipment assessment and equipment including: clocks/watches, kitchen aids, household items etc. The aim of the service is to allow individuals with visual impairment to live independently within their own home and community.

60. Countywide specialist equipment service for users who are deaf/hard of hearing: service provided by a countywide in house Deaf Services Equipment Team. Equipment provided includes: equipment for the home to offer access to the doorbell, smoke alarm, baby alarm and telephone.

What we will do

- We have identified the need to Quality Assure equipment within our older people block contracts and care homes and ensure that equipment is suitably maintained and replaced in line with NICE guidelines

- We are currently mapping the number of hoists used in the community with a view to commission equipment that can reduce the numbers of carers needed to operate the hoist. This will reduce costs for people who receive the services and the service as a whole
- Assessments are taking place of district and borough council offices in order to implement assessment software at a local level, this will support people locally to access online equipment services and reduce the wait for non-urgent equipment

Community budgets

61. Older people in Surrey are following the national trend at present with regard to Self Directed Support. The uptake of personal budgets and direct payments is lower than in other groups of people who are supported in Surrey.

62. Direct Payments however are increasing year on year. As at 31 March 2011 there were **819** people aged 65 and over who were in receipt of Direct Payments (including one off payments). The figure represents Direct Payments provided at any point in the year April 2010/March 2011.

63. Nine people aged 65+ were also holding a Supported Managed Account with SILC as at 31 March 2011.

64. We commission a service from Surrey independent Living to host and manager a number of services to support older people who have Direct Payments, and Personal Budgets.

The gaps identified

65. Through the Public Value Review in 2010 there was a strong message from the current generation of older people. They told us that they want to retain the traditional services and continue to have services arranged for them. We are also beginning to understand how people age 50 and over are spending their personal budgets. We need to anticipate how that might impact on the future commissioning plan of traditional services for older people.

66. We also need to identify whether these patterns can be sustained in the transition to older age. Further analysis is needed to plan for the financial impact this may have.

What we will do

- We recognise that older people and people with complex needs may need greater time and support to help them get the most from individual budget schemes,
- We will be working with providers to set unit costs where it is economically sensible.
- We are currently working with providers to develop direct book and pay systems to reduce bureaucracy.
- Brokerage services are developed and available to support people through self-directed support, should they choose it
- Individual service funds pilots are being developed this will allow providers to host and manage, and call off services against a set budget. They will do this on behalf of the older person.

Home based care

67. At present, Home Based Care services are provided through the primary provider model to individuals receiving support from Surrey County Council.

68. In 2008, and following a competitive tender process, this saw the County divided into 15 zones, and the supply base rationalised down from over 150 to under 50 with the objective of making both quality and price more consistent and manageable. Framework agreements were awarded to the successful providers on a 2 plus 2 basis.

69. In April 2010 SCC extended with those providers that met our quality and capacity criteria, and exited those that did not. We tendered to fill those vacancies in 2010.

70. The entire framework expires in April 2012. In March 2011 alone, SCC purchased 54,693 hours through the framework. Therefore, throughout the year April 2010 until March 2011 we estimate that SCC purchased **656,400** hours through the framework. No volume of work is guaranteed to providers under a framework agreement, and as such this offers SCC a greater degree of flexibility than a block contract arrangement.

71. The council has refocused its home based care services to offer a reablement service that helps people to settle back into being at home. Trained staff work with the individual to realise what is important for them to achieve, and where they might need help. Working with the person for a six week period they will help with a range of activities from meal preparation to getting a person dressed, gradually doing less and less as the person's abilities and confidence return.

72. The services traditionally may include elements of personal care (washing, toileting, getting up, dressed, medication, eating and drinking,

etc) and non-personal care (assistance with household cleaning, shopping, laundry, and accessing the community).

73. The current mapping of provision and provider organisations has provided valuable information on where to track changes in supply and demand. It is important to note that the increased levels of reablement and whole systems support will result in an increase year on year for community services and home based care. This will include a 10% increase arising from the number of people diverted from residential care as well as demographic pressures. This will result in an additional pressure of up to 10% on top of demographic pressures of demanding home based care at an average cost of £200 per week.

74. Great progress has been made on the development of electronic monitoring systems. The tender for home based care services will be issued ahead of the completion of the business case, which will assess whether the Council wishes to take forward electronic monitoring for external provision.

The gaps identified

75. One of the desired outcomes is to contract for personalised services, which enable people to stay in their own home, maintain and promote their independence, and, importantly, ensure they have choice and control over how they lead their lives to achieve a good quality of life. It is also important to note that the contract needs to achieve outcomes for carers of the individuals.

76. Increasingly, with the development of personalisation, it will be necessary to conduct further market shaping to encourage providers to offer a more flexible and diverse range of services in addition to the traditional personal care and support services to allow the service to become more outcomes focused.

77. Recent research shows that 98% of all paid domiciliary care staff work with people with dementia. The culture at present tends to work around blocks of timed care. Going forward, the service specification will require the provision of flexible care, which will allow for “pop backs” to cope with times when extra support is needed.

78. Our JSNA and mapping identifies that volumes of domiciliary care will increase by at least 10% plus over next 5 years on top of demography / population increases – for these providers the future is positive.

79. Through co-design we have established that some key priorities that a need greater attention, these include:
    - Principles of reablement and supporting the in-house reablement pathway and support planning
    - Dementia Care principles and flexible care are core business
    - Good Hydration and Nutrition is everyone’s responsibility
    - End of life care
    - Quality assurance and a move towards an outcome focus
    - Carer awareness
    - Reference to electronic monitoring implementation within the lifetime of the contract.

What we will do

- We will be seeking to build upon the good work already achieved in developing a robust and responsive provider base in the locality based zones across the county over the last three and half years. It is intended that the zones, in future, will be aligned as far as possible to the 11 Districts and Boroughs.
- A full heat map of current provision, capacity, and proposed zones can be found in Appendix 10.
- A home based care tender process is underway making overt reference to the need a move to outcome based personalised services over the next 3 years.
- Contracts for home based care will include overt references to the quality expectations outlined in the gaps analysis above.
- We will work with providers to implement individual service funds and promote the advantages of personalisation and self directed support for older people.

Day care

80. A full mapping of all day care provision has been undertaken as part of the Public Value Review of services for Older People which commenced in the second half of 2010. A full map of day care provision on a borough by borough basis is in Appendix 7.

81. District & Borough councils are increasingly aware of the need to support people with Dementia in the community and while their services in the past were entirely discretionary they are currently accommodating people with high needs. For example:
    - Elmbridge have 7 centres for retired people and 9 Dementia groups;
    - Surrey Heath have also moved to a model of supporting a greater number of people with high needs.
    - Notable gaps in borough council provision centre around Reigate & Banstead. It has three day care centres managed and run by volunteers, as the borough does not have the capacity to support people with personal care needs.

82. Day Care is also commissioned in block through our Care UK and Anchor Residential Day Care Centres. These services have very variable demand.

83. Anchor day care is not being utilised well. It only operates 3 days a week in two of the centres and average attendances can dip as low as 20%.

84. Care UK Day Care is variable in popularity. On average, based on analysis by Project Resolve, the average usage is 50% of capacity.

85. Day care is also purchased through spot purchase arrangements from alternative independent providers. This spot purchasing takes place despite having significant voids in existing contracts.

86. In addition, Adult Social Care Service Delivery directly provides 150 day care places per week with current staffing levels as per for an elderly frail cohort, providing basic day care, activities, meals and limited personal care.

87. There are three day care settings: Park Hall, Dormers and Pinehurst, which are based in residential homes in Reigate & Banstead, Tandridge and Surrey Heath respectively.

88. The overall spend of Adult Social Care on day care services in 2010/11 was £2.3 million.

89. Overall SCC spend £1,101,303 in total on dementia day services over a population of 182,412 people aged 65+. By calculating the cost according to prevalence of 65+ dementia (estimated to be 14,830 for 2011[18]), recommendations can be made as to whether the right amount is being invested in each area, assuming the total amount of investment is staying the same. The cost per head of dementia population is £76.54.

90. The most significant increases in investment would be in Epsom and Ewell, Reigate and Banstead and Spelthorne, Surrey Heath and Waverley, whilst the most significant decreases are in Guildford, Elmbridge, Mole Valley, Tandridge and Runnymede. This revised spend in each of the boroughs/districts will form part of out commissioning discussions for 2012/13.

91. The boroughs/districts are reviewing their usage of day centres. Some areas have very vibrant community day centres which are intergenerational and a direct response to the need to promote social inclusion These services do meet need for a local focus and centre supporting the whole local community. We plan to work with our colleagues in the boroughs and districts to further develop this local

[18] Projecting Older People Population Information System (POPPI – www.poppi.org.uk), as retrieved on 31 August 2011.

focus by developing centres for social inclusion in all boroughs and districts.

The gaps identified

92. There is an inconsistent provision of day care borough by borough. The number of centres, level of care needs, and the level of funding provided by the Adult Social Care vary significantly.

93. Older people and their carers are looking for flexible hours including weekend, evenings and informal attendance. This is not often available through block purchased agreements. The planned way ahead is for a full review of contracts to provide the types of services that older people and their carers want.

94. It is anticipated that for older people the greatest impact of personalisation will be in this area, as people use self-directed support to allow them to do things that help them meet need in the way they choose and lead more fulfilling lives.

95. The Public Value Review consultation with older people and consultation through the Dementia Strategy regarding current care provision has shown that people do still value day care, but in some cases the services do not always reflect expectations of what people want. There is some excellent provision in the county and we want to build on that excellence.

96. Older People said they preferred the notion of a “club” or “resource” centre where their contribution is valued and they are engaged in meaningful and personalised activity.

97. A flexible personalised approach includes flexible informal attendance patterns as well as weekend and evening provision. These expectations are reflective of what carers expect too. These flexible options are not widely available through our current block purchased agreements.

98. Due to the increasing need for dementia specialist day-care, we are looking for more flexibility in opening times and increased sessions every week.

99. It is difficult to say at this stage what impact the increased trends for self directed support will have on day care provision, however our service users and carers are telling us that they want improvements in what we currently provide.

What we will do:

- Renegotiate existing contracts to deliver the "resource centres " and flexibility of hours that people want including where possible weekend access.
- Elderly frail day care contracts with Anchor will be decommissioned. Negotiations will take place and a review of the existing arrangements to minimise impact to people who currently attend. We will aim to agree a unit cost specification in order that people with individual budgets can make appropriate choices to attend.
- We will redesign processes with current block contract arrangements to help people book attendance direct with providers, at short notice and without the need for cumbersome processes.
- Ensure transport services are available to help people get to these centres
- Ensure that each borough has within it a day resource, which has the skills and competence to effectively engage and support people with dementia.
- Reduce contracts for elderly frail day care in block contract residential care settings to reflect demand.
- Realign the grant allocation for dementia to reflect local priorities of investment in day-care in each of the 11 districts/boroughs.
- Work with the 11 district/boroughs in 2011/12 to increase the number of dementia placements in day care.

Community transport

100. The Public Value Review highlighted the use of funding to provide transport to meet our statutory requirements under the Disabled Persons Act 1970. Older people tell us that their most prominent need is for transport that can assist them from their front door; it is pointless developing services in the community if older people cannot reach them.

The gaps identified

101. The majority of Districts and Boroughs have reported a decrease in demand in the last 4-5 years; there are a number of reasons for this, e.g. reluctance to leave home if mobility is very poor. There is an appreciation that the marketing of the service and improving the image by updating the transport, and having smaller vehicles would make it more attractive.

102. As the proportion of people living in the community with dementia increase, there is a need for transport with escorts who cannot only support people in transport, but can help people prepare to get onto transport.

103. The only non-generic transport that will continue to receive funding is in Mole Valley; as it is “out of hours” it is highly valued, and fully utilised with a waiting list.

What we will do

- Renegotiate existing contracts to deliver the “resource centres“ and flexibility of hours that people want including where possible weekend access.
- Our major initiative for Transport in the coming year will be to develop a “Placed Based Budget“ approach to increase the choice of transport options. This will involve our colleagues across the County Council, Boroughs and Districts, and Health, with the focus on Ageing Well. The initial focus will be Tandridge, and its deliver will inform wider transport initiatives, especially for rural locations
- We will "unbundle” existing contractual arrangements that build in transport costs.
- Further funding arrangements are required in respect of the transport arrangements developed around specific services e.g. Alzheimer’s day care. This will ensure real costs are transparent and can align with Self Directed Support.
- Transport contracts commissioned from Guildford, Surrey Health and Epsom & Ewell Borough Councils to transport people to day centres will be modified. They will offer flexible contracts that make best use of the available resources, by being reflective of demand and the actual use of day centres.
- The commissioning intention will be to review and change the specification and in some instances decommission services that cannot be fully utilised.
- There is a need for further investments/developments in transport arrangements with escorts to support the dementia strategy.

Residential care

104. Nationally the UK Elderly care home market is estimated to be worth £14bn. The demand for elderly care beds is expected to increase over the next ten years with the number of people in the UK aged 85+ forecast to double to 2.9 million by 2031

105. The market in Surrey is fragmented and consists of operators of varying sizes, ranging from smaller privately owned businesses to large national organizations. Market analyses indicate that the more profitable elderly care homes tend to operate 50-80 beds, providing sufficient economies of scale and retaining personalised levels of care.

106. There are several important data sources to understand before reading this section (see Appendices 4, 5, 6 and 9):
    - Analysis of overall commissioned capacity at a borough and district basis
    - Analysis of demand versus capacity taking into account the impact of increased demography minus the impact of the reablement and dementia strategy (a 10% reduction based on predictive modeling).

107. The total number of older people supported by Surrey County Council in Residential and Nursing Care Homes has been reducing over the last five years. The main reduction is in Residential services (Frail & EMI) where the number of people in care has reduced from 1,770 at the end of 2005-06 to 1,565 at the end of 2008-09. However, the number of people in nursing care has fluctuated during this period, with a low of 1,275 (2005-06) and a high of 1,345 (2008-09).

108. The overall volume of Older People's placements purchased by Adult Social Care in the financial year 2010/2011 is outlined in the table below.

Volume of Older People's residential and nursing care purchased by Surrey County Council, 2010/2011[19]

Care type	Expenditure 2010/2011 £000s
Nursing (spot – dementia)	5,375
Nursing (spot – general)	26,455
Nursing (block/contracts – dementia)	0
Nursing (block/contracts – general)	1,475
Total nursing	**33,305**
Residential (spot – EMI)	5,825
Residential (spot – general)	7,623
Residential (block/contracts – EMI)	6,455
Residential (block/contracts – general)	16,684
In-house residential	7,004
Total residential	**43,591**
Total residential and nursing	**76,896**

109. There was a significant decrease over last year of over 277 places or approx 9.7%. This is a testament to the success of the strategy and an indicator of the choices older people are making. This reduction in placement activity will support the shift to more preventative and home-based care.

110. We have updated the Public Value Review Care Journey which shows a reduced spend (based on actuals) on residential and nursing care. This overall reduction in the number of people in care is in line with the council's objective to help more people to live at home.

[19] Data excludes section 256 (ie NHS funded) budgets.

111. According to the DoH report “Use of resources in adult social care” (2009), an excellent local authority will "*have a balance of services available, with no more than 40% of its overall adult social care budget being spent on residential care (or a plan to reach this target)*".[20] In the OP PVR our care journey model showed that Surrey was allocating over 50% of its budget to residential care.

Length of stay

112. The average length of stay for people in permanent care beds funded by Surrey County Council as at 2009/10 was 3.2 years for frail residential care, 2.4 years for EMI residential care and 2 years for nursing care. The average length of stay in all residential and nursing care settings was 2.5 years in the same period.

113. In a report commissioned by Bupa, the national average lengths of stay were calculated to be approximately 2.3 years, with shorter stays for people in nursing care.[21]

114. The admissions to residential care needs to be monitored more closely and reviewed. It is assumed that as people will be entering long term care at a later stage in their care journey, their length of stay will reduce. This delay is a key factor in predicting the cost of care for the future.

115. The Council currently purchases older people residential and nursing home services from 465 providers. Of this figure, 212 (45%) are out of county placements. This means that a significant percentage of people are choosing homes outside the Surrey area. It is believed that this high proportion is because of emotional, psychological needs and and older

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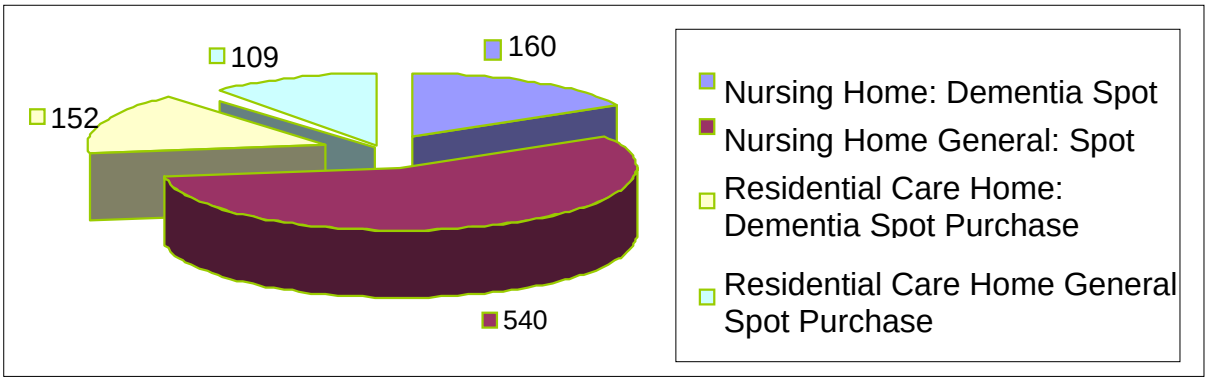
20 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107596

21 J Forder & J-L Fernandez, Length of stay in care homes (Bupa, January 2011): www.pssru.ac.uk/pdf/dp2769.pdf

people's rights to family life, rather than dissatisfaction with the quality of care available within the county.

116. In 2010/11 Adult Social Care made 961 new placements with independent sector homes (see below). The vast majority are nursing homes. Care homes registered to provide nursing have a registered nurse present at all times.



Adult Social Care placements in the independent sector, 2010/2011

117. Nursing care assessments are not carried out in care homes registered to provide personal care only, because people in these homes should have their nursing needs met by the NHS through a visiting district or community nurse and GP service.

118. We need to consider that the demand for elderly frail beds will reduce disproportionately to the demand for dementia beds due to increased support, virtual ward models and whole systems approach in the community. This could lead to a position where the entry point for an older person with physical disabilities requiring 24/7 care would be at nursing care level rather than residential care.

119. The Society of Geriatricians has estimated that:

- 50% of care home residents have urinary incontinence
- 40% have depression.

- Over half of people living in nursing homes (66.9%) and residential care homes (52.2%) have dementia. This is broadly reflected in Surrey.
- Up to 4% of people in care homes may be in pain as a result of their condition or disability. More than one in five people who report daily pain find it prevents their activities of daily living.
- 20% of people aged over 75 have sight loss and this rises to 50% for people aged 90.

120. The table below shows the top ten local authority areas outside Surrey for older people accessing residential and nursing care, as at 30 September 2009:

Local Authority	**No. of providers**	**No. of older people accessing residential/ nursing care**
Hampshire	31	85
London Borough of Sutton	7	52
West Sussex	32	41
London Borough of Richmond	2	16
London Borough of Hounslow	5	15
Cornwall	7	7
Kent	7	7
East Sussex	5	5
Norfolk	5	5

121. Current or previous home addresses are not accurate indicators of where people may choose to live when accessing residential or nursing care. In a snapshot survey of twelve homes in Surrey, the numbers of local people in a local home varied from 54% to 79%.

Independent Sector Block Contract Arrangements

122. Block contract beds have been agreed with the Private & Voluntary Sector through negotiations and formal contracts, with a set number of beds and unit cost.

123. There are currently countywide and local area contracts in place, providing residential care for the frail elderly, residential care for elderly mentally infirm (EMI, including dementia) and nursing care.

124. The contractual arrangements for this investment rely on the ability of providers to market the remainder of beds within the home to the private sector at significantly greater charges to individuals.

Anchor Homes

125. For Anchor the contract commenced in 1998, with 17 care homes transferred to Anchor Trust under a 20-year leasehold Private Finance Initiative (PFI) agreement. Whilst the freehold remains with Surrey County Council, the properties are leased to Anchor on a fully maintained basis. Of the 17, 8 homes were refurbished and 9 rebuilt, with PFI credits received annually from Central Government in relation to the capital investment in the buildings. The homes primarily cater for frail elderly although each home has some capacity for dementia care.

126. The 17 homes currently have **949** beds - SCC currently purchases **664** of these beds, with Anchor marketing the remaining beds privately. The number and mix of local authority and privately funded beds varies between homes.

Care UK - contract for residential care (dementia)

127. The block contract with Care UK commenced in 2002, where 6 homes were transferred to Care UK Community Partnerships under a 25 year

agreement. As with the Anchor contract, the freehold remains with Surrey County Council, whilst the properties are leased to Care UK on a fully maintained basis). Six homes were refurbished and 1 home was rebuilt, although no PFI exists in relation to this agreement

128. The 7 homes involved in the contract have a total capacity of 422 beds. Of these, Surrey County Council currently purchases **280** beds and Care UK markets the remaining beds privately.

Shaw Healthcare

129. Shaw Healthcare was awarded a contract in August 2011 to operate Redwood Care Centre, which was originally part of the Care UK agreement. The home provides 50 beds, of which Surrey County Council purchases 20 permanent Nursing care beds, and 10 assessment and reablement beds.

Locally agreed block contracts

130. Surrey also has three small contracts with independent sector providers to meet local demand:
    - Springkell House - budgeted cost for financial year 2009/10: £63,876.
    - Sydenhurst - budgeted cost for financial year 2009/10: £212,807.

Average costs for residential and nursing care

135. The analysis of average costs to Surrey for residential and nursing homes shows some surprising results. In the main the average costs for:
    - **Residential care** range from **£350 to £600 per week**. This includes older people with the most complex physical needs requiring two or more carers.
    - **Dementia residential care** range from **£335 to £507 per week.**
    - **Nursing care** range from **£460 to £504 per week.**

- **Dementia nursing care** range from **£455 to £518 per week.**

136. Current unit costs for contracted residential care are within a scale of £350 to £600, irrespective of the type of care purchased. It is our commissioning intention therefore to be explicit about contracting for dementia care at no more than a scale of £350 to £550, not including inflation assumptions year on year. This includes in-house provision and we will work to manage costs with all providers to ensure public value for money.

Occupancy Rates

137. The average occupancy rate of both nursing homes and care homes across Great Britain remained at around 91% for the second half of 2010. This average figure was generally stable regardless of care home size, with occupancy rates only moving slightly higher (92%) in larger establishments with more than sixty beds and for nursing homes. Care homes in Scotland and the West Midlands registered the highest average levels of occupancy at 94%, whereas care homes in Greater London registered the lowest average levels of occupancy at 88% in 2010.

138. The occupancy rates for Surrey contracted care are:
    - Care UK – 92%
    - Anchor – 89.5%

139. There are specific issues with Local Authority run residential care (see the below table for a table of this). Capacity can be affected by the volume of respite beds, the patterns of demand, and the number of people who are in short term beds for assessment.

In-house residential care occupancy, as at 31 December 2009

		Occupancy		Age Breakdown		
In House Residential Home	Permanent bed capacity	Occupancy end Dec 2009	% Occupied	65-74	75-84	85+
Brockhurst	40	28	70%	5	4	19
Cobgates	37	36	97%	2	11	23
Dormers	26	19	73%	2	7	10
Longfield	33	31	94%	3	13	15
Park Hall	39	23	59%	2	5	17
Pinehurst	30	29	97%	0	13	16
Total	**205**	**166**	**81%**	**14**	**53**	**100**

140. In the main, Local Authority operated homes tend to be much less efficient than their peers in the private sector. Laing and Buisson estimate that the average weekly fee per resident is £400 more in a Local Authority home (Colliers research 2011). Some other local authorities had been making care home closure announcements. There has been a very sharp increase in such announcements since the turn of 2011, with 153 homes (16.6%) across 29 Local Authorities being earmarked for closure. In this time only one Local Authority has announced plans to build three new homes, and another has stated that it will invest heavily in the modernisation of two homes. In all of the cases announcing closure, the intention was to transfer residents to alternative operational arrangements.

Modelling Future Demand and Securing Supply

141. It is the responsibility of the Council to secure adequate supply of residential care, of the right type and that provides good public value, for the future.

142. What we know is that demographic pressures mean demand will rise and that demand will increasingly be from people with dementia. What we have are contractual arrangements and obligations, along with in-house capacity, that are at the forefront of our supply chain. We also know that

current activity does not always secure best value as there are differential occupancy levels, varying unit costs for similar services and no standard of excellence in dementia care provision.

143. If we assume that through the introduction of more consistent and comprehensive reablement and prevention services, and targeted joint investment, that demand can be affected by 10% (consistent with dementia strategy assumptions) an opportunity emerges.

144. The key messages from the data in Appendices 4, 5, 6 and 9 are that, as at 31 March 2011:
    - 64% of residential placements were provided by block or in-house care homes, with the remainder in spot placements.
    - If we changed purchasing behaviours, we may be able to reduce the spot purchase proportion from its current 36% to approximately 17%.
    - In order to manage the future increase in demand we need to secure investment in prevention
    - There is no differential in cost between dementia bed prices and elderly frail prices currently within the contracted base, so a targeted shift towards meeting our priority needs for dementia care may have a minimal impact on cost.
    - There are differentials in the volumes of beds contracted in different areas in relation to demand. This needs adjustment subject to contract negotiations.
    - The implications of the Dilnot report have not been factored into the supply / demand activity. There is the potential for a significant increase in the numbers of people who are approaching the County Council for support.

145. It is difficult at this stage to anticipate the impact of the global financial crisis as well as the impact of the Dilnot report. With future increases in the number of people with dementia we know that there will be a requirement for excellent quality dementia care provision.

The identified gaps

146. Through forum meetings, older people and their carers living in Surrey have told us that when they need to move to they would like continuity of care. For residential and nursing care, this means that homes should be competent in meeting people's needs in a flexible way, so that further movements to other homes can be avoided.

147. Our sourcing teams and managers in personal care and support have indicated difficulties in finding suitable placements for couples, dual diagnosis, and homes with suitable skills and knowledge to meet the needs of the growing population of people who have specific needs related to a learning disability and dementia.

148. It is acknowledged that health needs can become more complex, and there may be a time when people in residential care will require more intensive nursing. As residents age, their health needs inevitably increase, leading to a considerable overlap in nursing and social care needs. Whilst residential homes have traditionally catered for less dependent clients than nursing homes, there is no clear accountability, liability and competency framework nationally to clearly articulate when people must move to a nursing home.

149. If nursing home places do not expand sufficiently, it follows that residential homes will need to provide enhanced care to their clients. This means social care staff will need to develop basic clinical skills. As the distinction between residential and nursing home clients blurs, a continuum of care provision may be required in residential homes.
150. Providers are reporting that when people enquire about homes they are now asking for improved facilities, such as ensuite toilet and shower facilities. Many homes are now building these facilities into existing rooms to fulfill residents' requests for dignity in care.

151. The Joint Accommodation Strategy has identified that there are a number of boroughs and districts where there is no access to Extra Care housing as a positive alternative to residential care

What we will do

- Surrey will develop a commissioning framework to support care homes to maintain continuity of care where appropriate.
- We will commission residential and nursing care that demonstrates a commitment to the principles of personalisation and quality assurance.
- We will commission residential care placements that can meet complex needs provide a continuum of care, particularly if someone develops dementia.
- Our commissioning aim is to adjust our contracts to achieve an average standard occupancy all permanent beds to a best in class level of a minimum of 94%.
- To maintain the current capacity of commissioned beds and to secure a high quality provision of dementia care for the county. This means a gradual reduction in the volumes of elderly frail beds commissioned through block contracts across the county
- Work with our contracted and in house providers on a model of excellence for dementia care
- In order to sustain a capacity of beds in the community we need to seek the most cost effective options. We will seek to contract for beds that can provide value for money, benchmarked against current market conditions and block contract rates.
- To maintain the current level of efficiency in bed capacity and cost, we must reshape the way in which respite care beds are managed, including the option of seeking more cost effective options in the wider independent market.
- To work with the PVR for Learning Disabilities to commission beds that will meet the specific needs of a growing population of older people with learning disabilities.

- Focus the priority for block purchasing residential beds to meet the needs of people with dementia
- We are commissioning training through the Surrey Care Association to address dignity in care and attitudes to an increasingly diverse older population
- It is important that we put in place advice on where people can access independent support to and appropriate guidance to help people make informed choices about financial planning for care. It is our intention to work with providers to address issues and implications associated with the future funding of care and support and reduce risk. We await the final recommendations of the Dilnot report at this time.

End of Life (EOL) Care

152. We are committed to ensuring people approaching the End of Life and their families and carers receive high quality, personalised care that supports them to achieve the best possible outcomes and be cared for and die in the place of their choice.

153. Our priorities for achieving this include:

- Promoting the use of a Provider End of Life Action Plan
- Identifying EOL care leads
- Promoting the use of EOL care tools, eg Gold standards framework, preferred priorities of care, Liverpool care pathway, DNAR.
- A Holistic and Personalised Assessment of Need and Preferences – advance care planning for individuals, their carers and families towards the end of life.
- Training and development. In the coming year we will undertake a training needs analysis for social care staff involved in the planning and delivery of services for those approaching the end of life, and use the Multi-Agency Partnership to roll out a programme of blended learning
- Carer support. Our plans for the coming year include commissioning support for carers of people approaching the end of life the Crossroads Carers Scheme for End of Life.

5. Commissioning safe services

Adult Social Care Area Quality Assurance Team

Led by the Quality Assurance Manager for Adult Social Care, this is a team of four QA Managers, one for each geographical area. The role of the team is to take the lead in developing and managing area wide review arrangements working with local teams to support local quality outcomes and contract monitoring of providers in the independent sector.

The team will undertake the following functions:

- To develop tools and processes to ensure that Quality Assurance information informs service commissioning
- Support the development of appropriate information systems and databases to assist in the coordination of quality assurance information
- To monitor and progress actions agreed by QA Team to improve services by working with providers to address concerns identified.
- Maintain and manage the database of QA information about independent sector providers.
- Maintain and manage the *poor performing* providers
- Bring together local and other evidence of quality or concern around independent providers
- Report to Area Quality Assurance Focus Groups
- Support local teams to implement quality assurance framework for care management and assessment
- Hold quarterly meetings with providers or more frequently if necessary
- Receive and act upon monitoring reports including CQC, monitoring reports.

6. Summary of current position

The opportunities	The risks
• The emerging work with older people and co-designing the services they want • Our work in partnership with districts and boroughs across Surrey that sets a local planning framework to assess and address supply and demand • The joint investment plan with NHS Surrey on key areas of prevention that will pump prime whole system change • The contracting arrangements for home-based care and current work underway to support the delivery of more personalised services • Secured long term investment in the supply of residential care and opportunities to manage the increasing demand for dementia care across the county • Our understanding of unit costs across key areas of business and setting benchmarks for providers	• Hearing from and involving older people from excluded groups or hard to reach groups and getting a better understanding of their needs • That the strategic management of a provider base and economies of scale are achieved within a more locality-based planning framework • Developing an exit strategy from time-limited partnership monies that ensures sustainability of proven value for money and outcome focussed services • Negotiating with and influencing providers to deliver more personalised and flexible services within set costs • Developing a standard of excellence in dementia care across different statutory and independent providers • Understanding what personalisation may mean for people who lack capacity or ability to fully engage with

• Creating an environment for direct individual purchasing of traditional services, community services and new emerging bespoke care services through establishing unit costs and variety in the systems of holding personal budgets • The evidenced shift in activity and resources to prevention and services, which promote independent living and remaining in own home.	processes and benefit from self-directed support; • Changing service patterns in the context of public organisations facing an uncertain future base of financial resources and increased demands. • Assessing risks in terms of demand and resources from implications of the Dilnot enquiry.

7. The design of future provision

	Prevention	Customer Access	Reablement	Direct Payments, Self Assessment & RAS	Home Based Services	Residential & Nursing Care	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
2010/11 Actual Expenditure	12,121	226	9,586	9,285	27,148	76,896	135,263
2011/12 Budgets	11,338	147	10,170	11,144	29,699	73,172	135,671

This profile shows how the Adult Service Directorate is beginning to implement its key commissioning intentions and reducing the percentage of the budget spent on residential / nursing home care, while investing more in reablement and personalised home based support.

The additional whole system partnership monies of £10.6m and £10.2m over 3 years provide a greater opportunity to make more of an impact and include diversion from and earlier discharge from NHS hospital care and long term care.

8. Action Plan

Actions Required	Financial resource implications	Timescale
Access + Information and Advice **1.** We will commission Wellbeing Centres in each of our borough council areas, having a wide range of accessible information and advice specifically aimed at older people, people with dementia and their family and carers. This will be an investment of £300,000 to our information and prevention agenda.	£450,000	July 2012
2. A full map of information and advice will be completed and broad consultation and co-design to recommission advice and information services.	Within current resources	October 2013
3. Working with hospital Transformation Boards to commission the management of information systems and ensure we provide the right quantity and quality of information in the correct settings.		December 2012
4. We are commissioning support workers to help people to plan and organise their own support and monitor their own conditions: • Stroke support workers – 5 support workers who help people manage the impact of stroke in the East Surrey Hospital Cluster area • Dementia Navigators – 19 full time employees across Surrey who help "navigate" people with dementia through the care system, signposting them to the various care services in their local areas.	£115,600 Surrey County Council commitment of £147,872 against total spend of £371,371	Current contract ends May 2012 December 2011 onwards

5. Through our commission agreements we will ensure that promotion of benefits take up is central to any agreements with the specific aim to improve the geographical variance in Attendance Allowance uptake up in Surrey and improve economic wellbeing, choice and control of older people in need.	Initiative to be taken through Ageing Well agenda	June 2012
6. We are consulting on an advocacy strategy and we will continue to commission services sensitive to the specific issues related to ageing and older people.	£415,000 total per year for 3 years, with c.£61,700 from Older People's budget	April 2012 for commencement of new model of advocacy
7. We are in discussion with innovators through Future Gov to identify creative solutions to the problems older people face with access and interfaces with technology in particular for people who are in residential and nursing homes.	To explore sponsorship and funding resources	December 2012
8. Through our Ageing Well strategy we will continue to work with older people to agree the best local solutions, and the right place to access information for local people	None	Commenced 2011
<u>Prevention</u> **1.** Warm Homes, Healthy People Project Fund. Running from January to the end of March 2012, this joint fund is focused on keeping vulnerable people safe and well over the winter. The fund will be used to: • Run Home Energy Audits • Run a loft clearance scheme • Distribute thermometers • Repair boilers and heating systems • Run a door knocking scheme to check that people are coping with the winter • Produce promotional materials	£267,000 (used by Surrey County Council, Action Surrey, the local borough and district councils, the PCT, GPs and community and voluntary groups)	End March 2012

2. Working with our district and borough colleagues to expand existing Meals on Wheels delivery services and extend service to residents in Mole Valley and Reigate & Banstead.	Part of the Warm Homes, Healthy People Project Fund (£21,400)	April 2012
3. Working with other providers such as care homes, support workers and personal assistants, as well as volunteer groups in communities to continue to expand the range of service and develop community lunch clubs where gaps exist.	Working models through Supporting People, voluntary groups and existing contracts	April 2012
4. We are exploring some innovative ideas connecting volunteers and mobile phone text message technology to respond to older people who may need a meal at short notice	Future Gov initiative within existing resources	April 2012
5. Promote good hydration and nutrition in older people through working with partners and providers in: - Developing Hydration and Nutrition Action Plans - Delivering training and development programmes - Producing promotional Materials - Increasing the use of Personal Hydration/Nutrition Plans	Built into new tenders: Meals on Wheels and Home Based Care	Ongoing
6. Commissioning services with nutrition and hydration factors built into specifications.		

Telecare / Telehealth **1.** Develop equality of access to Telecare services across the county, so that people are supported to use telecare for reablement (preparing people to live independently at home again, after a period of hospitalisation or crisis). We will also install telecare equipment in our older people's reablement beds to support discharge planning. Through our Whole Systems Partnership Plan we will make significant investments in the telecare/ telehealth infrastructure to demonstrably increase the effectiveness of support in the community for those living with chronic and long-term conditions.	£2m investment through Whole Systems Partnership	April 2012
2. We will commission a local service in each Borough and District to respond to individual older people who would otherwise have no family support or other community networks.		Tendering April 2012
3. We will commission a project manager to develop the Telecare/ Telehealth agenda, convince people of the benefits of telecare to the whole community and health and social care system, and to ensure that we invest in the right technology, in the right place at the right time		December 2011
4. We will install telecare and telehealth information and demonstration points through our older people's Wellbeing Centres across Surrey to allow people to familiarise themselves with equipment and promote uptake.		Commenced December 2011, with openings over 2012.

Respite **1.** To improve the current level of efficiency in bed capacity and cost, we must reshape the way in which respite care beds are managed, including the option of seeking more cost effective options in the wider independent market.	Within existing financial resources	Negotiation on current arrangements commencing January 2012
2. Establish an infrastructure of day care provision and respite service in each of the 11 boroughs for people with Dementia.		
3.Examine the respite services in the 11 district/boroughs to ensure equity of access in each borough/district in 2011/12 and reallocate spend to match need.	Within existing financial resources	Negotiation on current arrangements commencing January 2012
4. Invest a proportion of the saving on residential care on increased day care and equitable respite services across the county based on population need.		
Reablement **1.** Achieve a rapid and efficient throughput from our reablement service and monitoring of activity and outcomes needs to be robust and continuous improvement made.	Forms part of the Surrey County Council Working Together Differently Strategy and Whole Systems Partnership Fund planning 2011-2014.	Funding in place Nov 2011
2. We need to commission providers who can offer a short “stop gap” service, pending the completion of a support plan. This will require a change to the notice period for cessation of a service.		
3. We will require all care providers to demonstrate that they promote the values and philosophy of reablement.		

4. We should commission reablement capacity within the independent sector to cope with surges in demand and Winter Pressures.	Forms part of the Surrey County Council Working Together Differently Strategy & Whole Systems Partnership Fund planning 2011-2014	Funding in place Nov 2011
5. Our current reablement service will need to grow commensurate with demand arising from demography and changes underway in practice avoiding long term care.		
6. In order to achieve sustainability of reablement services then unit cost reductions must be applied to the current delivery models. We need to aim for top quartile performance of hourly rate (£25 per hour for domiciliary settings)		
7. We will commission up to 6 weeks multi-disciplinary therapeutic and health support to ensure people get early access to skills gain and can return home as speedily as possible where their physical and mental health needs have changed and dependency has increased.		
Community Budgets **1.** We recognise that older people and people with complex needs may need greater time and support to help them get the most from individual budget schemes.	Within existing financial resources	Launch of Ageing Well Community Budgets Programme commenced Oct 2011.
2. We will be working with providers to set unit costs where it is economically sensible.		
3. We are currently working with providers to develop direct book and pay systems to reduce bureaucracy.		

4. Brokerage services are developed and available to support people through self-directed support, should they choose it	£125,000 per year for external brokerage to end March 2014.	Implemented. Review to take place March 2014.
5. Individual service funds pilots are being developed this will allow providers to host and manage, and call off services against a set budget. They will do this on behalf of the older person.	Within available resources	Pilot of ISF commenced 2011
Home based care **1.** It is intended that the zones, in future, will be aligned as far as possible to the 11 Districts and Boroughs.	Within available resources	New home based care tender published. New contract in place April 2012.
2. A home based care tender process is underway with an overt reference to moving to outcome based personalised services over the next 3 years.		
3. Contract for Home Based care will include overt references to the quality expectations outlined in the gaps analysis above.		
4. We will work with providers to implement individual service funds and promote the advantages of personalisation and self directed support for older people.		
Day Care **1.** Renegotiate existing contracts to deliver the “resource centres “ and flexibility of hours that people want including where possible weekend access.	As outlined in the Dementia & OPMH strategy	Negotiations to be concluded April 2013

2. Elderly frail day care contracts with Anchor will be decommissioned. Negotiations will take place and existing arrangements reviewed to minimise impact to people who currently attend. We will aim to agree unit cost specifications so that people with individual budgets can make appropriate choices to attend.	As outlined in the Dementia & OPMH strategy	Negotiations to be concluded April 2013
3. We will redesign processes with current block contract arrangements to help people booking attendance direct with providers, at short notice and without the need for cumbersome processes.		
4. Ensure transport services are available to help people get to centres		
5. Ensure that each borough has within it a day resource, which has the skills and competence to engage and support people effectively with dementia.		
6. Reduce contracts for elderly frail day care in block contract residential care settings to reflect demand.		
7. Realign the grant allocation for dementia to reflect local priorities of investment in day-care in each of the 11 districts/boroughs.		
8. Work with the 11 district/boroughs in 2011/12 to increase the number of dementia placements in day-care		

Residential / Nursing Home Care **1.** Surrey will develop a commissioning framework to support care homes to maintain continuity of care where appropriate.	No additional resource identified for 2011- 2016.	Links to review of Surrey County Council in house homes with paper going to Cabinet early 2012
2. We will commission homes that demonstrate a commitment to the principles of personalisation and quality assurance.		
3. We will commission residential care placements that can meet complex needs provide a continuum of care, particularly if someone develops dementia.		
4. Focus the priority for block purchasing of residential beds to meet the needs of people with dementia		
5. The commissioning aim is to adjust our contracts to achieve an average standard occupancy all permanent beds to a best in class level of a minimum of 94%		
6. To maintain the current capacity of commissioned beds and to secure a high quality provision of dementia care for the county.		
7. Work with our contracted and in house providers on the model of excellence for dementia care.		
8. In order to sustain a capacity of beds in the community we need to seek the most cost effective options, and seek to contract for beds that can provide value for money benchmarked against current market conditions and block contract rates.		

9. To maintain the current level of efficiency in bed capacity and cost, we must reshape the way in which respite care beds are managed, including the option of seeking more cost effective options in the wider independent market.	No additional resource identified for 2011- 2016.	Links to review of Surrey County Council in house homes with paper going to Cabinet early 2012
10. To work with the PVR for Learning Disability to commission beds that will meet the specific needs of a growing population of older people		
11. We are commissioning training through the Surrey Care Association to address dignity in care and attitudes to an increasingly diverse older population		
12. It is important that we put in place advice on where people can access independent support to and appropriate guidance to help people make informed choices about financial planning for care. It is our intention to work with providers to address issues and implications associated with the future funding of care and support and reduce risk. We await the final recommendations of the Dilnot report at this time.		