"Ageing presents a wide variety of issues and from the whole cohort of 'Older People'. Navigating the route to a fully supported set of needs is truly challenging."

– Older Person lived experience volunteer

The provision of services

Surrey's residents tend to live longer and healthy lives, exceeding the national average for both Men (81.4 compared to 79.5) and Women (84.6 compared to 83.1).
Increasing levels of complex medical and health needs.There are approximately 22,000 frail residents in Surrey, many with complex medical conditions. The figure is expected to increase by 30% over the next decade. Additionally, 17,700 Surrey residents suffer with dementia (a range of disorders which affect the brain). This figure is predicted to rise to 22,672 by 2030.
There are also changes in the structure of our society which mean that increasingly older people are living alone with less family support.

The Joint Strategic Needs Analysis (JSNA), which looks at the health needs of Surrey's population, confirms that the county has an increasingly ageing population with a life expectancy above the national average.

Our plan and approach to commissioning Older People's services sits alongside our broader Adult Social Care Commissioning Intentions. We have highlighted a number of key areas of focus for 2021-22 and beyond. Key elements are as follows:

In January 2020, SCC re-introduced strategic county wide commissioning teams to ensure that through a more strategic commissioning approach it could deliver better outcomes for Surrey residents.

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

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

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

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

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

Prevention includes:

- Technology enabled care
- Day opportunities
- Information, advice and guidance
- Community support services

Living Independently includes:

- Accommodation with Care and Support (Extra Care)
- Home based care and live in
- Collaborative reablement
- Discharge to recover and assess (D2A

Care Homes includes:

- Residential
- Residential Dementia
- Nursing care
- Dementia nursing care
- End of life care

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

Through focussing on enabling people to live well and as independently as possible for a long as possible we will en

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

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

Emphasis on the importance of mental health through community services that support people to remain independent within their local community. These services are mainly provided by local district and borough councils and community providers.
It was important for residents and unpaid carers to feel connected within their own local community, to be offered a range of services to choose from and for those services to be affordable to everyone that has a need.
Services need to be accessible in all areas of the county and importantly need to offer support for people, families and unpaid carers living with dementia.
Services need to be improved when residents and unpaid carers are discharged from hospital and there needs to be better communication and information available. Residents want to return home and need support to do so.
An improvement to the overall information and advice services within Surrey was also a key theme. These services need to provide better pathways for people accessing information on services both locally and countywide to prevent the need for formalised care. They need to map pathways for residents moving from local community services to statutory services at the right times.
There is a need to recognise that people accessing day services have much higher and complex needs now, therefore the day centres and the staff need to be better equipped and trained to support this.

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

"As you get older it's harder to learn new technology and skills may wane, which will see more older people become excluded."

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

the needs of the person being assessed impacts on other family members, or anyone in

Use technology to complement the face-to-face care people receive, provide greater opportunities to monitor risks, deterioration in needs and access to care and support and we will ensure technology is considered as part of an individual’s care needs both at home and when receiving social care funded services

There was feedback given that the process of accessing the NHS and ASC system is confusing and that people had experienced paperwork, communication and equipment issues when being discharged from hospital back into the community. Communication [ ] could be greatly improved to support people at often difficult and confusing times of their lives.
Improvement suggestions were made for our services. Surrey needs to ensure consistency of schedules [ ], that better trained staff are available especially for specific needs such as people with dementia and continuity of staff delivering care and support. Some individuals with lived experience felt that often an increase in availability of hours needs to be reviewed in order to keep some safe at home for longer.

*Definitions of the services highlighted in are below

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

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

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

- Home Based Care – domiciliary care
- Live In Care – where someone lives in an individual's home
-

demonstrated a “postcode lottery” and that they would like to better understand how decisions were made about placements.

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

See the latest version of our action plan at www.surreycc.gov.uk/livingwellinlaterlife