SURREY
COUNTY COUNCIL

NHS
Surrey

# Dementia & Mental Health Services for Older People in Surrey

## Draft Commissioning Strategy 2010–15

Surrey Primary Care Trust
Surrey County Council

# Contents


| Title | Page |
|---|---|
| About this document | 2 |
| Welcome | 3 |
| Why do we need to improve Dementia and Older People's Mental Health services in Surrey? | 4 |
| Why do we need a strategy? | 6 |
| Carers | 8 |
| The Strategy: What we are proposing | 9 |
| Health Promotion | 11 |
| Primary and Community Care | 13 |
| Intermediate Care | 16 |
| Hospital Inpatient Care | 17 |
| Long-Term Care | 18 |
| Where are we now in Surrey? | 19 |
| Delivering the Strategy | 27 |
| Investment Plan | 28 |
| Implementation Timeline | 38 |

# About this document

This draft joint commissioning strategy has been produced for consultation by the Dementia and Older People's Mental Health Strategy Group, led jointly by NHS Surrey and Surrey County Council. Membership includes representation from Surrey and Borders Partnership Foundation Trust, Surrey Community Health, district and borough councils and voluntary organisations.

The purpose of this document is to present draft proposals for the future of dementia and older people's mental health services in Surrey. It will be updated following the consultation period. The document has been formed taking account of peoples views and includes work from the **Dementia & Mental Health Services for Older People in Surrey: Commissioning Strategy Reference Document 2009-14**. This can be found online at **www.fadingmemories.surreyhealth.nhs.uk**

**This document describes:**

- Why we need to improve services in Surrey for older people with dementia, mental health conditions and their carers
- Why we need a strategy for people with dementia, and older people with mental health conditions
- The strategy: the main things we want to happen over the next five years and what that means for those with dementia, older people with mental health conditions and their carers

**While dementia is a key feature of mental health services for older people (those over 65 years of age), this joint commissioning strategy also caters for the full range of mental health needs, including depression and severe mental illness.**

**This strategy includes:**

- Mental health services for older people aged 65 and over
- Services that provide treatment, care and support for mental illnesses sometimes known as 'functional', such as depression and anxiety
- Services that provide treatment, care and support for mental illnesses sometimes known as 'organic', such as dementia – including Alzheimer's, vascular dementia, fronto-temporal dementia, Parkinson's disease dementia and Korsakoff's dementia
- Services for the small number of people who experience early onset dementia, meaning those who develop dementia before the age of 65

**This strategy excludes:**

- Mental health services for people younger than 65 (except people with dementia)
- People with learning disabilities who have developed dementia. Although dementia can have similar symptoms among all people that develop it, the social needs of a person with learning disabilities are likely to be distinctly different from someone who has no recognised learning disability. Therefore we are currently developing a separate strategy to meet these needs.

If you need this document in another format please get in touch with the Surrey County Council Contact Centre by telephone on 08456 009 009 or by email contact.centre@surreycc.gov.uk

# Welcome

Dementia and mental ill health in older people is the cause of much suffering and distress that has wide social and economic consequences. These consequences are predicted to significantly increase as people live longer. Combined with this there is also a common perception amongst the public and a number of professionals that feeling depressed comes with older age and that following a diagnosis of dementia little can be done for the person or their family. This is not the case; advances in treatments, care and support have been shown to have positive benefits in improving symptoms and general well being.

The need to produce this strategy has arisen from talking and consulting with a range of people who have informed us that although there is evidence of lots of good services in Surrey, there is room for improvement and modernisation.

An example of improving practice can be found in the Woking Friends of Dementia Project. This two year, pilot project, is an initiative arising from the Department of Health's National Dementia Strategy Programme. The project aims to provide local support to people with dementia and their carers, paying specific attention to the needs of the local British Asian community. It will involve setting up local internet-based information and social network forums, along with peer support groups. It will also enable people with dementia and their carers to take an active role in the development and prioritisation of local services.

The aim of this strategy is to provide a cohesive five-year vision built around the following themes that emerged from our work with a wide range of people and organisations in Surrey, as well as examining the available evidence. These themes are:

**Reducing stigma and improving well-being by:**

1. Increasing awareness of mental health problems in older people.
2. Providing information on what people can do to help themselves.

**Improving the quality of people's lives by:**

3. Providing early diagnosis, treatment and support in the community
4. Providing intermediate care for older people with mental illness or dementia
5. Improving the quality and effectiveness of inpatient care for older people with mental illness or dementia in general hospitals
6. Improving the quality of long-term care

We view these themes as our key priorities ensuring we deliver the right services, in the right place at the right time.

The purpose of this consultation is to check that these priorities and their related actions have wider support. Feedback on the strategy is by **1 October 2010.**

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# Why do we need to improve dementia and older people's mental health services in Surrey?

As part of the preparation to inform this strategy, a review of older people's mental health services was undertaken. The findings were produced as a report in 2007[1] and a reference document in 2009. The review highlighted the following themes:

**Access to information**: This is variable across Surrey and includes information about what services are available and also mental health promotion, which can aid understanding and help reduce risks of developing mental illnesses.

**Primary care services:** Skills and knowledge of assessment, treatment and care options for dementia and older people's mental health is variable

**Community services:** There are not sufficient community services available for people with dementia or older people with mental illnesses in Surrey.

**Short-term break services for carers:** are patchy across Surrey, with some areas not having a service.

**Dementia advisors and outreach workers:** These are invaluable in Surrey, along with befriending services, though provision of support across Surrey is limited.

**Assessment and treatment services:** Community mental health teams in Surrey provide assessment, treatment and care for mental health conditions. All of the teams currently provide a diagnostic memory service although the model and resources available to those being assessed are not consistent across Surrey.

**Integrated services:** Services for older people with mental illnesses in Surrey often suffer from a lack of fully integrated working between health and social care staff. National models of good practice highlight the effectiveness of fully integrated working between health and social care staff.

**Home-based care:** We have generic home-based care services and although older people with dementia and mental illnesses receive these services, there is no specialist service, or stand-alone support, available with specialist knowledge of dementia or depression.

**Intermediate care teams:** Older people with mental health problems are often excluded from intermediate care, as there is a common assumption that they cannot benefit from reablement[2] services.

**Crisis intervention service:** Is responsive to people's needs at acutely difficult times and often prevent distressing and unnecessary admissions to hospital. Such services in Surrey for those aged over 65 are not currently available.

**Acute general hospitals:** Support for older people with dementia or other mental illnesses receiving care in acute general hospitals is inconsistent across Surrey. Currently, there are no agreed standards of how acute general hospitals should meet the needs of older people with dementia or other mental health problems.

- **Service model:** The current way we deliver older people's mental health services is focused more on inpatient and residential beds and does not have a focus of treatment and care at home

[1] Wilson, K (2007) Older People's Mental Health Services Strategic Review

[2] Services for people with poor physical or mental health: To help them accommodate their illness (or condition) by learning or re- learning the skills necessary for daily living

**What have people told us?**

Whilst developing this strategy, we held a number of co design events to gain an understanding of what older people and their carers want in relation to developing mental health services. We listened to what people in Surrey have told us and have incorporated their views into our strategy. Key themes include:

- People would like to remain in their own homes and live a healthy life for as long as possible
- People would like information on services that is coordinated and accessible
- When feeling unwell, down, or having difficulty remembering things, people need to know where to go for help
- Getting an accurate diagnosis on an illness is important, to be able to plan for the future
- Carers need to be able to talk to the right people about their situation. They want access to someone with the right expertise who can understand and advise them.
- Carers want to be supported in their caring role, and be well informed about the options available should they need a break from caring
- People don't want to repeat their stories to different professionals. They don't want to go between health and social care services not really knowing where their support comes from and what they are entitled to
- If diagnosed with a mental illness or dementia, people want to understand fully how they can manage their condition
- Services on offer should be available across all of Surrey, no matter what area you live in
- Older people and their carers should be able to get emergency help and support, even outside of working hours
- People should not experience unnecessary admissions and/or extended periods of time in hospital
- Avoiding going into a care home unless a person really needs to
- If an older person with a mental health condition or a person with dementia does need to be looked after in a residential setting, care staff should have a comprehensive understanding of mental illnesses, as well as physical impairments.

# Why do we need a strategy?

## National Context

Depression, confusional states and dementia are the main mental health conditions of older age. It is estimated that in the UK 700,000 people have dementia and that one in four people is currently experiencing a common mental health problem. The experience of dementia and mental ill health is a cause of much distress and suffering that has a wide social and economic impact on individuals, carers, families, organisations, the community and society as a whole.

## The Policy Context

**The National Dementia Strategy**[3] was published in 2009 by the Department of Health. This strategy aims to drive forward significant improvements for dementia sufferers and their carers across the following three key areas:

- **Improving awareness:** increased public and professional awareness of dementia and an informed and effective workforce for people working with dementia
- **Early diagnosis and intervention:** good quality early diagnosis, and intervention for all; good quality information for those with dementia and their carers and that enables continuity of support and advice
- **Living well with dementia:** by improving the quality of care for people with dementia in home care; respite care/short breaks; intermediate care; general hospitals; care homes.

**New Horizons**[4] was published in 2009 by the Department of Health. This five year mental health strategy combines service improvement with a new partnership of central and local government, the voluntary sector and the professions with the aim of strengthening the mental health and well-being of the whole population. This is about more than preventing mental illness, important though that is; it is also about helping individuals and communities to bring the best out of themselves, with all the health, social and economic benefits that follow.

## Surrey Context

- The two main mental health problems for older people in Surrey are depression and dementia, although other problems such as confusional states, anxiety and phobias are also common.

- Applying national estimates to the Surrey population would suggest that there are around 280 people with dementia under the age of 65 (early onset dementia).

- The most common mental health problem among people over 65 is depression. There is estimated to be over 24,000 people aged 65 and over with either depression or severe depression in Surrey, and 24,000 older people to have sub threshold depression.

- Women are more likely to suffer from depression than men. An estimated 70% of people suffering from depression in Surrey are women.

- In 2009, just under 14,000 older people were estimated to have dementia in Surrey. This equates to around 1 in 12 older people (over 65). By 2020 this is predicted to rise to over 17,000 older people.

[3] Department of Health (2009) 'Living with Dementia: A National Strategy'
[4] Department of Health (2009) 'New Horizons: A Shared Vision for Mental Health'

- Most people with dementia have at least one other co-morbidity[5]. A National study [6] from 2007 showed that 59% of patients with dementia had 2 or more co-morbidities. When providing care or treatment for someone with dementia, other conditions or illnesses must be taken into account.

- 97.5% of the population in Surrey who are 65 years or over are classified as white[7].

- There are significant pockets of black and minority ethnic groups, for example in Elmbridge and Woking. Access to services for black and minority ethnic older people and their carers may be challenging. Barriers might include language, knowledge of what services are available, attitudes and practices of service providers and cultural factors in perceiving and understanding mental illness.

- The population of people aged 65+ in Surrey is estimated to increase by 23% in the next 10 years.

- The likelihood of developing both dementia and depression increases with age therefore the numbers of people predicted to have dementia and depression in Surrey are expected to rise.

The scale of both the predicted increase and need for people with dementia, older people with mental illness and their carers, highlights that Surrey has to be able to meet a significant increase in demand from an increasing number of people over the coming years. Our strategy, in accordance with national guidance, outlines how we aim to address this challenge.



[5] The presence of two or more illnesses in the same person at the same time
[6] National Audit Office (2007) Improving Services and Support for People with Dementia
[7] NHS Surrey and Surrey County Council (2009) Joint Strategic Needs Assessment

## Carers

A carer is someone who regularly cares, unpaid, for a relative, partner or friend of any age, who due to illness, disability or frailty cannot manage without help. People with dementia and older people with mental health needs may have an increased requirement for care and carers; very often these carers are also older people.

Carers of people with dementia and mental health problems in particular can experience a greater strain and distress than carers caring for those who are frail, or have a physical impairment. Dementia, in particular, can be complex, unpredictable and is progressive in nature. Complex care needs often include intimate personal care as the ability for self-care declines, emotional support, decision-making, behaviour changes, coping with risks to safety, personality changes and changes within the relationship. Although there are rewards associated with caring, it is often an extremely demanding role both physically and emotionally, with often a negative financial impact.

Carers play a vital role in Surrey and have a significant role in influencing and delivering our strategy. Estimates show that there are:

- 100,000 carers across the county, and around 20,500 (20%) are older people (65+). Over a third of these are over 75 years old
- 300 carers over 85 are providing over 50 hours of care a week[8]
- An estimated 60% of carers are in employment[9]
- One-third of carers nationally that have a mental health problem[10]
- 60% of unpaid carers providing more than 20 hours of care a week that are female[11]

Surrey's Joint Strategic Needs Assessment (2009) highlights that more work is required to identify carers within black and minority ethnic communities.

Carers are both partners in providing support and care and are individuals with rights and needs themselves. Carers have a right to an assessment of their own needs. The Carers (Equal Opportunities) Act 2004 requires that carers assessments include consideration of carers needs including leisure, living and work.

To help ensure these rights are made real, the roll out of Self Directed Support[12] across Surrey (full implementation will be achieved by Spring 2011) includes an assessment of carers needs, which is incorporated within the Self Directed Support process.

Health services, social care services and voluntary organisations all play a key role in supporting carers. Given that much caring is given in isolation it is important to offer appropriate and timely easy access to information and services that support carers in their role. This strategy outlines a number of proposals of ways in which this might be achieved.



[8] NHS Surrey and Surrey County Council (2009) Joint Strategic Needs Assessment
[9] NHS Surrey and Surrey County Council (2009) Joint Strategic Needs Assessment
[10] Office for National Statistics (2002) 'Mental Health of Carers'. London: Stationery Office
[11] National Census 2001
[12] Self Directed Support is part of a national programme to make social care services more personalised, so people can have more control over their lives. For more information visit www.surreycc.gov.uk and search for 'Self Directed Support'

## The Strategy: What we are proposing

NHS Surrey and Surrey County Council are proposing a new 'model of care' that aims to meet the needs of older people with dementia and mental health conditions. A model of care describes how a person's care is provided through a journey known as a 'care pathway'. The pathway describes how a person's care is provided from assessment, diagnosis and treatment, through to long-term care and support, if that is what they need.

Every older person's needs and their carers will be different; therefore we have developed a range of pathways within our model and have suggested what key elements might be needed.

Our proposed model is based on five 'tiers', each of which reflects the level of support that might be required, based on needs. Whilst the tiers represent differing levels of need it does not mean a person's journey through the tiers is a linear one. A person with dementia or an older person with a mental illness can effectively move from one tier to the next, or the last, skip a tier out. What service an older person or their carer receives is based on need and choice of care that suits them best.

This new model of care differs from the way services have been provided in the past and takes into account what people have told us and the recommendations from best practice.

In future we want less emphasis on the use of hospital and residential care and more of an emphasis on assessment, treatment and care in people's own homes.. This model would also have greater emphasis, than previously on: those with low and moderate needs and the older population in general; and services working together across sectors in offering more support. However, conditions such as dementia are progressive and the strategy will address ways to improve the quality of care for those with complex needs, such as those who may need long term residential care. We aim to meet people's needs with the right services, in the right place at the right time.

The following pages provide more detailed information on our proposed strategy and model:

- Page 10 provides an illustration of the overview of the proposed five tier model

- Pages 11 to 16 describes the key things we think needs to happen at each of the tiers of care; and what that would mean for people with dementia, mental health conditions and their carers

- Pages 27 to 38 describes a draft approach to delivering the strategy and includes our guiding principles, outcomes, our proposed actions, timescales and who might be taking the lead responsibility

We are also mindful that in the immediate and impending economic climate we may not be able to implement the whole strategy in one go. With this in mind we have developed a schedule of priority implementation over the next five years with an expectation that existing services will meet the strategy objectives as far a possible within this period.

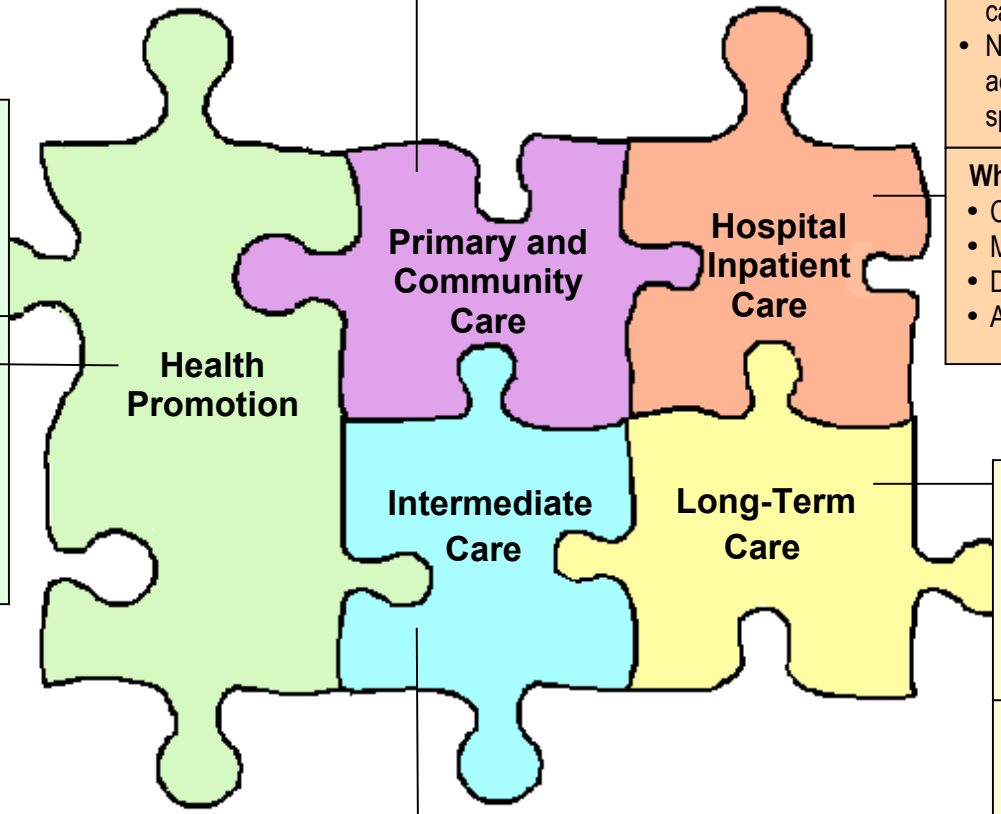
# An Overview of our Model

**Low – Moderate Need**
- Difficulties with memory, mood or anxiety

**What you can expect**
- GP, Social Care and Specialist Home Care
- Mental Health Liaison and Support Service to Primary Care
- Psychological therapies & Memory Assessment

**General Population Needs**
- Aims to promote greater awareness of the importance mental well-being
- Better access to information about mental health and memory concerns in later life

**What you can expect**
- 'What's good for the heart is good for the head' campaign
- Public awareness programme
- Surrey Mental Health Promotion programme
- Agreed standards and training provision




**Substantial Need**
- Limited awareness of symptoms and/or severity of symptoms putting the individual or carer at risk.
- Nature or degree of symptoms requires admission for assessment and treatment to a specialist unit

**What you can expect**
- Clinical lead in acute hospitals
- Mental health liaison in acute hospitals
- Dementia protocols for acute hospitals
- Assessment and Treatment Inpatient Beds

**Enduring Need**
- Cognitive and behavioural difficulties require long-term specialist care in a specialist setting/environment
- Insight is often very limited and many decision-making skills will be impaired

**What you can expect**
- Complex and Enduring Needs service
- Specialist in-reach service into care homes

**Moderate - High Need**
- Problems with memory or mood leading to independent living difficulties
- Behavioural issues leading to difficulties for the individual/carer

**What you can expect**
- Mental health intermediate care service including crisis intervention
- Urgent respite care / unplanned short-term breaks
- Specialist Home Care, Voluntary Organisation support

# The Five Tier Model

## Tier 1: Health Promotion

**What needs to happen?**

- There needs to be improved awareness of the importance of both good physical and mental health and well-being
- Improved awareness of dementia and older people's mental health problems among health, social care and voluntary sector staff - as well as the public
- Improved access to information and advice

**What does this mean?**

A greater awareness and understanding of dementia and mental health problems will:

- Help remove the stigma of dementia and mental health problems
- Improve understanding of the benefits of accurate diagnosis and care
- Encourage prevention of dementia and mental health problems
- Reduce fears and misunderstanding of dementia and mental health problems

**What will this look like?**

We will run an awareness campaign for dementia and depression in old age. The campaign will aim to tackle the public's misunderstandings of older people's mental health and will compliment the recently launched National Dementia Awareness campaign. Educational materials will also include information and advice specific for people with early onset dementia. The campaign will include the following messages:

**Dementia**

- Dementia is not an inevitable consequence of ageing.
- Dementia is a disease – a chronic long-term condition. Its origins are physical. It can affect anyone.
- What's good for your heart is good for your head. Things that you do to keep your heart healthy such as diet and exercise also have the same effect on your mind.
- There are benefits in detecting the disease earlier rather than later. For example accessing treatments that delay symptoms from getting worse, or being able to plan for the future.
- You can still have good quality of life with dementia.
- The actions of family, friends and professionals can improve the quality of life for people with dementia and their carers.
- People diagnosed with dementia can continue to make an important contribution to work, family and their community.

**Depression**

- Depression is a mental illness
- Depression is treatable
- Depression, although common in later life is not an inevitable part of ageing, not "one of those things", not "what you expect at your age"
- There are tell-tale signs of depression that need to be acted upon - discussed with your GP sooner rather than later
- Ignoring the problem is not an option: if not treated, depression can ruin people's quality of life and increases the risk of other illnesses

These kinds of messages will be available through leaflets found in your GP's waiting room, at the library, in day centres and other places that are run by health and social care, borough councils, and voluntary organisations.

You can also find more information online, and you will be able to read further mental health information on the Surrey Mental Health Promotion Service website www.firststeps-surrey.nhs.uk/. These messages and promotional materials will also tell you where you can go for further help.

# Tier 2: Primary and Community Care

**What needs to happen?**

**Improve approaches to diagnosis and early intervention**

- Improve professionals' knowledge and diagnostic skills, as well as other key workers for example care assistants and voluntary sector staff
- Improve pathways of care
- Implement the Single Assessment Process

**Improve quality and capacity of interventions and care**

- Create access to psychological therapies at a primary care level for older people with anxiety and depression
- Deliver services in a fully integrated way (health and social services) to add value and quality to care provision by community mental health services
- Improve community support for older people with mental illness and their carers, building on what works well currently
- Improve community support for people with dementia, taking into account the needs of those experiencing early onset dementia
- Increase peer support for service users and carers
- Increase provision of home care services and develop a specialist home care service
- Provide short breaks for people with dementia
- Ensure carer's needs are addressed

**What does this mean?**

All older people with dementia and mental health problems and their carers will have easy access to care that gives them:

- Staff working with older people can spot telltale signs of dementia and other mental illness and are able to inform health professionals and recommend that the older person sees their GP
- A high quality assessment
- An accurate diagnosis which is explained in a sensitive way to the person and their carers
- Best treatment, care and support as needed after the diagnosis
- Good quality information about their condition and services at diagnosis and during their care
- Get support from local people with experience of dementia
- People with dementia and their carers will be able to see a dementia advisor who will help them throughout their care to find the right: information, care, support and advice. The Department of Health refers to this role and this
- There will be a range of flexible services to support people with dementia and mental health problems living at home and their carers
- Services will consider the needs and wishes of people with dementia and mental health problems and their carers
- Carers will get better support
- Carers will be able to have good –quality short breaks from caring

**What will this look like?**

We will review what services and gaps we currently have in place and how processes currently work in different areas. The aim is to ensure that all workers involved understand the care pathways as a whole and how each older person and their carers will experience it according to their needs.

Services will be coordinated. This means that if the persons needs require more than one service, they will understand how they can move from one type of treatment or support/care to the next, if this is what is needed.

**The GP**

Most people who feel unwell or out of sorts seek advice from their GP. Sometimes situations occur when people are unaware or reluctant to seek help and family or friends may pursue this on their behalf often contacting the GP practice as the first port of call for advice.

The GP will understand symptoms of dementia as well as other common mental health problems like depression or anxiety, as will other Primary Care professionals such as District Nurses and Practice Nurses. The GP may carry out some physical tests; these will be taken to determine any underlying physical conditions that might be causing the problems. GPs may also carry out some simple psychological tests e.g. in gauging how you are feeling or a memory test.

If the assessment and tests carried out by the GP indicate depression, then the GP will most likely make a referral to one of the new talking therapies or Improving Access to Psychological Therapies (IAPT) services currently being rolled out across the county. These new IAPT services also have a number of tiers and can escalate and intensify treatment approaches depending on people's needs. The GP, Practice Nurses and District Nurses also have access to information on voluntary sector services such as counselling services. Alternatively, if the assessment and tests carried out by the GP indicate dementia, then the GP will probably make a referral to a memory service for further assessment, treatment guidance and support.

**The Older Peoples' Community Mental Health Teams**

These teams will be fully integrated health and social care teams that are continually developing to meet local needs. The teams will offer a service for dementia and mental illness and will have three main functions of memory service, complex and enduring service and intermediate care with crisis response.

**Memory Assessment Service**
The general aim of the service will be to detect, diagnose and offer treatment, management and care options according to individual and carer needs The memory services will play a key role in the design of each person's pathway and will involve both health professionals and social services staff working together.

The specialist team will carry out detailed assessment work, to rule out any other reasons for symptoms and also to determine the type of illness. The aim of this work will be to detect, diagnose and offer treatment, management and care options according to individual and carer needs.

**Ongoing Help and Advice**
At the point of diagnosis it is envisaged that people with dementia and their carers will meet with a 'Dementia Navigator'. This is a new role proposed by the National Dementia Strategy. Dementia Navigators, employed by the vountary sector, will act as an ongoing guide or 'navigator' to the individual, carer and family in providing information, guidance and support throughout their 'journey' of treatment and care.

**Support at Home**
Good quality flexible home care services play an important part in maintaining people's independence, and supporting people to care for their loved ones, and often help to prevent admission to hospitals and care homes. We know that many people want to stay in their own homes for as long as possible.

There will be a range of support available such as help with maintaining the home and garden through to support with personal care. There will also be more specialist home services available. By specialist we mean support from staff that have extensive training in caring for people with dementia.

Older people with dementia, and other mental illnesses can now receive 'Direct Payments' to pay for support, enabling services to become more personalised. Individuals must be assessed as needing community care services to receive a Direct Payment, and the payment must be used to purchase the services that the person is assessed as needing.

Support for carers will be available across Surrey, no matter where they live. Should carers need a break then a whole range of options might be considered. The dementia navigator would be a key contact in providing such information.

# Tier 3: Intermediate Care

**What needs to happen?**

- Ensure services can respond rapidly at a time of crisis
- Prevent avoidable admissions to hospitals and care homes by ensuring alignment of mental health and mainstream intermediate care services
- Prevent excessive lengths of stay away from home by facilitating earlier discharge
- Ensure that people with mental health problems have access to reablement services

**What does this mean?**

There will be more care for people with dementia and older people with mental health problems in helping them retain skills and maintain confidence and independence.

**What will this look like?**

The older people's community mental health teams will also have an intermediate care role. A key aim of intermediate care is to avoid unplanned and inappropriate bed based care. If you or the person you care for do receive bed based care, staff from the community mental health teams will help facilitate early discharge where appropriate.

As we get older, we often have more than one illness or impairment. You may, for example, have dementia, but also have a physical impairment for example following a fall, that required treatment in hospital. When hospital staff have decided you are well enough to be discharged but not quite yet able to go back home, there will be rehabilitation facilities available, for your recovery.

**Emergency Help and Support**

There will be a crisis intervention service available. This will be an out of hours service, that will respond quickly to acute crisis situations e.g. if an individual's condition is becoming of great concern. Interventions will be accessible to a person in their own home, in a residential home or elsewhere in the community.

Professionals will be able to provide periods of support until your condition is either stabilised at home, or you need further assessment and treatment in a more specialised environment. The team wherever possible will endeavour to keep people in the best environment, usually this is at home, as it is recognised that this is the least confusing place for people with dementia and other mental illnesses. This said, professionals will be fully aware of the impact of such a decision on caregivers and any support put in place will reflect the need to balance these issues.

# Tier 4: Hospital Inpatient Care

**What needs to happen?**

**Mental Health Assessment & Treatment**

- Ensure that older people with mental health problems are not being admitted to hospital without a clear rationale and after all other options have been positively excluded.
- Ensure that the length of stay in hospital is positively managed to be the minimum required for essential assessment and treatment
- Ensure that robust systems of out-of-hospital care are in place to reduce the need for admission, long lengths of stay and delayed discharge

**General Hospital**

Ensure that a specialist mental health liaison service is available within general hospitals to support clinical management of patients with mental health problems and influence arrangements to optimize the quality of experience in hospital

Ensure that for older people with mental health problems, agreed care pathways are in place within hospitals and community services and robust systems of out of hospital care are in place to reduce the need for admission, long lengths of stay and delayed discharge.

All general hospitals will have a lead clinician responsible for developing protocols and the quality of the hospital experience for people with dementia within their services

**What does this mean?**

If admitted to any hospital it would mean high quality non-stigmatising care and more efficient use of resources.

**What will this look like?**

Mental health service hospital beds will be used efficiently and effectively for assessment and treatment episodes. It will be clear who is responsible for the quality of care for patients with dementia in general hospitals and what their responsibilities are; they will work closely with specialist mental health teams.

In each of the acute general hospitals in Surrey there will be a hospital liaison service that will support and provide the necessary expertise to the general ward staff in caring for people with dementia.

Activity and numbers of beds will be reduced due to more community treatment and care options allowing resources to be saved and redirected to support new services.

# Tier 5: Long-Term Care

**What needs to happen?**

- Improve quality of care for people with dementia and mental health problems in care homes
- Provide specialist in-reach support to care homes
- Keep alternative forms of accommodation and assistive technologies under review
- Ensure that End Of Life care standards are implemented for older people with mental health problems

**What does this mean?**

- Services will work to ensure:
- Better care for people with dementia in care homes
- Clear responsibility for dementia in care homes
- Clear description of how people will be cared for
- Visits from specialist mental health teams
- People with dementia and their carers will be involved in planning end of life care
- Services will consider people with dementia when planning local end of life services

Where it is not possible to meet the needs or manage risk of people with dementia or other mental health problems in a community setting, then long-term care may be provided. This will be the remaining option after trying all other preventative options.

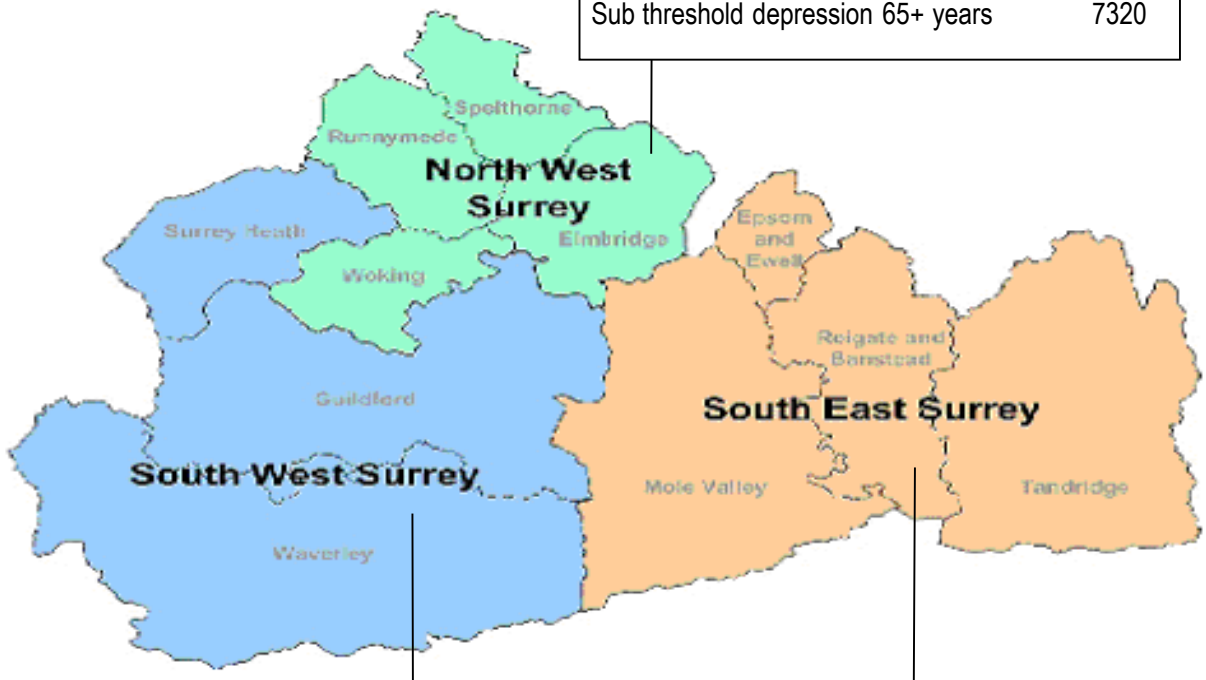
Health and social care staff will provide an in-reach service to residential and nursing homes. The in-reach service will work in conjunction with GPs to provide advice on treatment and care needs, medication and therapies available. Support from these specialist in-reach services will improve confidence within the care home staff to manage more complex and challenging conditions.

## Where are we now in Surrey?

The Surrey population that are registered with a Surrey GP is approximately 1.12 million. The area has three main practice based commissioning localities that are shown on the map below. The map also includes estimates of some prevalence rates for dementia[13] and mental health problems[14].

**Surrey Estimated Prevalence Figures for People with Dementia and Older People with Mental Illness[15]**

| North West | |
|---|---|
| GP registered population all ages | 339,775 |
| GP registered population 65+ yrs | 54,000 |
| Early onset dementia | 85 |
| Dementia 65-84 yrs | 2224 |
| Dementia 85+ yrs | 2067 |
| Severe depression 65+ yrs | 1171 |
| Depression (excluding severe) 65+ years | 6149 |
| Sub threshold depression 65+ years | 7320 |




| South West | |
|---|---|
| GP registered population all ages | 346,153 |
| GP registered population 65+ yrs | 55,000 |
| Early onset dementia | 86 |
| Dementia 65-84 yrs | 2265 |
| Dementia 85+ yrs | 2105 |
| Severe depression 65+ yrs | 1192 |
| Depression (excluding severe) 65+ years | 6261 |
| Sub threshold depression 65+ years | 7454 |

| South East | |
|---|---|
| GP registered population all ages | 441,288 |
| GP registered population 65+ yrs | 70,200 |
| Early onset dementia | 110 |
| Dementia 65-84 yrs | 2889 |
| Dementia 85+ yrs | 2685 |
| Severe depression 65+ yrs | 1521 |
| Depression (excluding severe) 65+ years | 7985 |
| Sub threshold depression 65+ years | 9505 |

[13] Estimates for 2011
[14] Estimates for 2012
[15] Wilson, K (2007) Mental Health Services for Older Adults in Surrey: A Strategic Review'. Commissioned by NHS Surrey

To give us an understanding of the services and support currently available to people with dementia and older people with mental health problems, in Surrey, we have completed an initial mapping that is illustrated in the following table.

The table shows the types of service broken down by area and mapped alongside the strategy's five tiers. The areas that we have used are in accordance with the geographical boundaries of NHS Surrey's practice based commissioning and Local Executive Committee areas. Services include those commissioned by NHS Surrey, Surrey County Council and those provided by borough and district councils, and voluntary organisations. We have also given these services a traffic light rating of red, amber or green as to how we think they are currently performing against our strategy.

We recognise that there are other forms of support available that people with dementia, older people with mental health problems and their carers might access that are not listed here. This mapping focuses largely on the services that are targeted to this group, rather than generic services that are available to all people.

The list of services is not exhaustive, and it is important to note that whilst this gives us an indication of the current state of services available, it is a starting point for a further analysis.

| An initial mapping of Surrey Services for people with dementia and mental health problems | | | |
|---|---|---|---|
| | **North West**<br>(Spelthorne, Runnymede, Woking, Elmbridge) | **South West**<br>(Surrey Heath, Guildford, Waverley) | **South East**<br>(Epsom and Ewell, Mole Valley, Reigate and Banstead, Tandridge) |
| **Tier 1: Health Promotion** | • Limited provision | • Some collaborative working involving Alzheimer's Society | • Mental health information service available in East Surrey, 'First Steps' |
| **Tier 2: Primary and Community Care** | **GPs and Primary Care Health Teams** | **GPs and Primary Care Health Teams** | **GPs and Primary Care Health Teams** |
| | **Community Mental Health Teams for Older People – NHS Provision**<br>• Spelthorne<br>• Woking<br>• Runnymede and West Elmbridge<br>• Mid Surrey and East Elmbridge | **Community Mental Health Teams for Older People – NHS Provision**<br>• Surrey Heath<br>• Guildford<br>• Waverley<br>• Farnham | **Community Mental Health Teams for Older People – NHS Provision**<br>• Mid Surrey and East Elmbridge<br>• East Surrey |
| | **Day Hospital – NHS Provision**<br>No Provision | **Day Hospital – NHS Provision**<br>• Farnham Road Hospital | **Day Hospital – NHS Provision**<br>No Provision |

| | | | |
|---|---|---|---|
| | **Day Centres – Borough/District Council Provision**<br>• Benwell Day Centre in Sunbury, Spelthorne<br>• Elmbridge Relief Carers Scheme provide a day care service | **Day Centres – Borough/District Council Provision**<br>• Ian Goodchild Centre in Camberley may take people with mild mental health problems<br>• Windle Valley Centre in Bagshot may take people with mild mental health problems | **Day Centres – Borough/District Council Provision**<br>• Generic services for older people but not specific to people with dementia or older people with mental health problems |
| **Tier 2: Primary and Community Care** | **Carers Services – Borough/District Council Provision**<br>• Elmbridge Relief Carers Scheme including counselling, advice, phone support and a sitting service<br>• Monthly Alzheimer's Café in Claygate (Elmbridge) | **Carers Services – Borough/District Council Provision**<br><br>Patchy provision | **Carers Services – Borough/District Council Provision**<br><br>Patchy provision |
| | **Day Care – Commissioned Independent Sector Provision**<br>• Places at Kingsley residential home's day care service<br>• Places available at Echelforde residential home in Ashford<br>• Places at Tiltwood residential home in Cobham | **Day Care – Commissioned Independent Sector Provision**<br>• Places at Whitebourne Residential Home<br>• Broadwater residential home in Farncombe | **Day Care – Commissioned Independent Sector Provision**<br>• Day care places available at Appleby House residential home in Epsom<br>• Keswick residential home in Great Bookham<br>• Stanecroft residential home in Dorking<br>• Barnfield residential home in Horley<br>• Orchard Court home in Lingfield |
| | **Day centres – Voluntary Provision**<br>• Runnymede Alzheimer's Society provide day care in Brockhurst<br>• Woking Alzheimer's Society run a day care service in Maybury | **Day centres – Voluntary Provision**<br>• Provided by Haslemere and Waverley Alzheimer's Society | **Day centres – Voluntary Provision**<br>• Day care services available in Redhill and Re provided by East Surrey Alzheimer's Society<br>• Mid Surrey and Dorking Alzheimer's Society provide Day care in Dorking |

| | | | |
|---|---|---|---|
| | **Home Support Service – Voluntary Provision**<br>• Friends of the Elderly offer home support to people with dementia, confusion and depression in Woking | **Home Support Service – Voluntary Provision**<br><br>Patchy provision | **Home Support Service – Voluntary Provision**<br>• Alzheimer's society provide a Home Support Service covering East Surrey |
| **Tier 2: Primary and Community Care** | **Dementia Support Workers (aka Outreach Workers) – Voluntary Provision**<br>• DSWs from Mid Surrey and Dorking Alzheimer's Society cover the East Elmbridge area<br>• Runnymede Alzheimer's Society provide support for the Runnymede borough<br>• Spelthorne and West Elmbridge<br>• Woking Alzheimer's Society | **Dementia Support Workers (aka Outreach Workers) – Voluntary Provision**<br>• Provided by Haslemere and Waverley, and Guildford Alzheimer's Society | **Dementia Support Workers (aka Outreach Workers) – Voluntary Provision**<br>• East Surrey Alzheimer's Society<br>• Mid Surrey and Dorking |
| | **Peer Support – Voluntary Provision**<br>• Runnymede Alzheimer's Society run groups for carers, and older people with dementia and their carers<br>• Spelthorne and West Elmbridge Alzheimer's Society run groups for carers, and older people with dementia and carers<br>• Alzheimer's Society Woking run groups for carers, and older people with dementia and their carers<br>• Alzheimer's Society Woking also run a weekly support group for younger people with dementia | **Peer Support – Voluntary Provision**<br>• Haslemere and Waverley and Guildford facilitate groups for older people, their carers, and for both together<br>• H&W also run a group for younger people with dementia | **Peer Support – Voluntary Provision**<br>• East Surrey Alzheimer's Society provide support for older people, their carers, and for both together<br>• Mid Surrey and Dorking Alzheimer's<br>• Society provide support for older people, their carers, and for both together |

| | | | |
|---|---|---|---|
| | **Non-Specialist Home Care – Surrey County Council Provision**<br>• Elmbridge home care team<br>• Spelthorne and Weybridge home care team<br>• Woking home care team | **Non-Specialist Home Care – Surrey County Council Provision**<br>• South West Home based care team provide support for this area | **Non-Specialist Home Care – Surrey County Council Provision**<br>• Available from Tandridge, Reigate and Banstead, and Epsom and Ewell and Esher home care teams |
| **Tier 3: Intermediate Care** | **Respite - Surrey County Council In-House**<br>• Beds at Brockhurst residential home in Ottershaw | **Respite - Surrey County Council In-House**<br>• Beds at Pinehurst residential home in Camberley<br>• Long field residential home in Cranleigh<br>• Cobgates residential home in Farnham | **Respite - Surrey County Council In-House**<br>• Parkhall residential home in Reigate<br>• Dormers residential home in Caterham |
| | **Mental Health Intermediate Care**<br>• Some coverage in general intermediate care service | **Mental Health Intermediate Care** | **Mental Health Intermediate Care**<br>• Integrated provision in general intermediate care service |
| **Tier 4: In-patient Care** | **In-Patient Assessment – NHS Provision**<br>• Beds for functional mental illness in Spencer Ward, Abraham Cowley Unit at St Peter's Hospital<br>• Dementia beds in Hayworth House at St Peter's Hospital | **In-Patient Assessment – NHS Provision**<br>• Assessment and treatment beds for dementia at Albert Ward in<br>• Farnham Road Hospital<br>• Assessment and treatment beds for functional mental illness at Victoria Ward in Farnham Road Hospital | **In-Patient Assessment – NHS Provision**<br>• Beds for functional mental illness at Primrose, Meadows in West Park, Epsom<br>• Dementia beds at Bluebell, Meadows in West Park, Epsom |
| | **NHS Mental Health Hospital Liaison Service for Older People**<br>• Consultant time and 2 nurses at St Peter's hospital | **NHS Mental Health Hospital Liaison Service for Older People**<br>• Consultant time and a full time nurse at Royal Surrey hospital<br>• Frimley Park has a fully integrated service with working age adults including nurses and doctors | **NHS Mental Health Hospital Liaison Service for Older People**<br>• Consultant time at East Surrey hospital<br>• No dedicated service for older people at Epsom hospital |

| | | | |
|---|---|---|---|
| **Tier 5: Long-Term Care** | **Residential Care – Commissioned Independent Provision**<br>• Beds at Heathside residential home<br>• Kingsley Residential home<br>• Avens Court Pyford<br>• Birchlands residential home in Englefield Green<br>• Meadowside residential home in Staines<br>• Echelforde residential home in Ashford<br>• Linwood residential home in Thames Ditton<br>• Thames side residential home in West Molesey<br>• Glendale residential home in Walton on Thames<br>• Tiltwood residential home in Cobham | **Residential Care – Commissioned Independent Provision**<br>• Beds at Whitebourne residential home<br>• Beds at Limegrove residential home in East Horsely<br>• Beds at Abbeywood residential home in Ash Vale | **Residential Care – Commissioned Independent Provision**<br>• Beds at Appleby house residential home in Epsom<br>• The Beeches residential home Leatherhead<br>• Keswick residential home in Great Bookham<br>• Stanecroft residential home in Dorking<br>• Eastlake residential home, specifically allocated for both organic and functional mental illness<br>• Broadwater residential home in Farncombe<br>• Greenacres in Banstead, where a proportion are dedicated dementia beds<br>• Ridgemount residential home in Banstead, where a proportion are dedicated dementia beds<br>• Barnfield residential home in Horley<br>• Chalkmead residential home in Merstham<br>• Broome Park home, Betchworth<br>• Oakleigh residential home in Godstone Orchard Court home in Lingfield |
| | **Continuing Care Beds – NHS Provision**<br>• No Continuing Care beds in Hayworth House in St Peter's Hospital<br>• No Continuing care beds at Westminster in Ashford House<br>• There are continuing care beds at The Willows,Woking Community Hospital | **Continuing Care Beds – NHS Provision**<br>• Beds at Hale Ward in Farnham Road Hospital<br>• Continuing care beds at Jubilee House in Godalming | **Continuing Care Beds – NHS Provision**<br>• Beds at Meadows in West Park, Epsom |
| | **Surrey County Council In-House**<br>• Beds at Brockhurst residential home in Ottershaw | **Surrey County Council In-House**<br>• Pinehurst residential home beds | **Surrey County Council In-House**<br>• Residential beds for both organic and functional mental illness at Parkhall in Reigate<br>• Beds for both organic and functional mental illness at Dormers in Caterham |

## Delivering the Strategy

NHS Surrey and Surrey County Council are committed to delivering excellent services to older people in Surrey. When planning and delivering these services, we are committed to the following:

| Our Principles of Care | How they will be delivered |
|---|---|
| Opportunities for people to live in their own home | Through home-based care services and personalised care |
| Full commitment to working with carers | Treated as expert care partners by all health and social care professionals |
| Full commitment to working with Borough and District Councils and Voluntary organisations | Work with partners at each of the planning and implementation stages |
| Older people and their carers should have fair access to services and support of the same standard wherever they live and without discrimination | Agreed standards between community mental health teams will be specified and performance monitored |
| Services are available as and when older people with mental health needs and their carers need them | Older People will know where to go for help through dementia navigators, multi-agency teams, hospital liaison and care home in-reach |
| Services are culturally sensitive and based on shared values that place service users and carers at the centre | Services will have full equality impact assessments and be designed by consulting with older people and their carers |
| Decisions around what services to provide are based on substantial evidence | Commissioning will be based on 'Analyse, plan and review' through ongoing review and consultation. Model of care is kept in line with the National Dementia strategy |

## Investment Plan

The thrust of the strategy is to achieve a step change from hospital and residential based care to health promotion, primary, community and intermediate care. A significant investment in home care services will be required to enable us to increase the range, capacity and performance of community mental health services, reduce hospital admissions and the length of inpatient stays in hospitals. We are proposing that this come from a gradual reduction in the number of dedicated mental health and general hospital beds and believe it is right and safe to do so. Where it is not possible to meet the needs or manage risk of people with dementia or other mental health problems in a community setting, then long-term care may be provided. This can only be achieved by full involvement from all stakeholders, including people that use our services, carers, borough and district councils and the third sector as well as Surrey County Council and the NHS system.

New NHS Surrey investment is planned early in the strategy to create more robust community services. Over the lifetime of the strategy a reduction in care home places and in-patient activity and beds is intended.

Surrey County Council plans to reinvest the savings made from reducing the unnecessary reliance on inappropriate placements in residential care into community based and preventative services.

We have seven priority areas that we want to improve on and we will do this through investment, reconfiguring services and stop commissioning what we no longer require. The following list gives an indication of our priority areas for investment and disinvestment over the next five years. These are:

Reducing stigma and improving well-being by:

1. Increasing awareness of mental health problems in older people.
2. Providing information on what people can do to help themselves.

Improving the quality of people's lives by:

3. Providing early diagnosis, treatment and support in the community
4. Providing intermediate care for older people with mental illness or dementia
5. Improving the quality and effectiveness of inpatient care for older people with mental illness or dementia in general hospitals
6. Improving the quality of long-term care

This is not intended to be a list of everything we wish to do, other opportunities and issues will inevitably arise. We are also conscious that in the current economic climate we may not be able to carry out the whole strategy in one go. A draft priority implementation plan for the next five years to meet the objectives as far a possible is illustrated in the following pages

## Tier 1: Health Promotion

| Ref no. | Title | Action required | Timescale Year 1 | 2 | 3 | 4 | 5 | Organisation | Outcomes |
|---|---|---|---|---|---|---|---|---|---|
| 1.a | **Public awareness campaign** | • Work with Communications teams to develop a Communications plan – to include how we can use various media to promote awareness<br>• Engage with a range of voluntary organisations<br>• Engage with a range of user led organisations<br>• Engage with a range of carers organisations<br>• Work with district and borough councils to reach people who use their services<br>• Work with partners and Local Authority Areas to ensure mainstream services take full account of needs of local older people with mental illness<br>• Ensure the campaign is in an accessible format, can be understood by people where English is not their first language, and older people are involved in its' development | | | | | | NHS Surrey<br>Surrey County Council<br>Voluntary Sector<br>Borough Councils | • Improved understanding of mental illness in older people<br>• Reduced stigma of mental illness and in older people<br>• Older people across the county know how to access services available<br>• Cost effective services and whole systems approach to care are implemented<br>• Carers know how to access the information they need |
| 1.b | **Ensure all health promotion activity relating to heart and stroke includes risk factors for dementia** | • Review existing healthy heart promotion material and consider benefits of implementing 'What's good for the heart, is good for the head' campaign<br>• Work with Public Health to incorporate into their work | | | | | | NHS Surrey | • Public and professionals will understand ways to reduce risk of developing mental illness in older people |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1.c | **Developing the commissioning infrastructure** | • Resource the development of a dementia network, to include other mental illness among older people and technical support such as reporting, dementia matrix and analysis | | | | | | NHS Surrey | • Increased engagement and ownership by clinicians and practitioners in development of dementia services across health and social care systems<br>• Improved specifications and standards for dementia services<br>• Increased knowledge and understanding of improvement and outcomes (by using the dementia data and matrix) |
| 1.d | **Develop the mental health promotion service** | • Work with Public Health colleagues to refocus the First Steps programme to include greater mental health promotion<br>• Make this service available to the whole county<br>• Ensure it is accessible to older people | | | | | | NHS Surrey | • Older people and carers feel better able to find appropriate services<br>• Increase in the number of people accessing the service |

## Tier 2: Primary and Community Care

| Ref no. | Title | Action required | Timescale Year 1 | 2 | 3 | 4 | 5 | Organisation | Outcomes |
|---|---|---|---|---|---|---|---|---|---|
| 2.a | **Review and redesign existing care pathways to fit the new service design** | • Review existing design models and service provision within Surrey and Borders Partnership Foundation Trust<br>• Scope service delivery models and complete needs analyses with each district and borough council (in accordance with the priorities in this table)<br>• Examine best practice of different models of service design | | | | | | NHS Surrey, Surrey County Council | • Give a clear indication of current services and the challenges that need addressing to implement new strategy<br>• Our service delivery model are evidence based |
| 2.b | **Support primary care in early diagnosis** | • Establish a Primary Care Best Practice Unit<br>• Work with practice based commissioning clusters to support and inform GPs<br>• Provide access to psychological therapies for older people via the Improving Access to Psychological Therapies (IAPTs) programme | | | | | | NHS Surrey | • Increased numbers of older people diagnosed with dementia and other mental illnesses are identified<br>• GPs can confidently diagnose and recommend suitable treatment options early on<br>• Older people will have NICE[16] compliant treatments for common mental health problems |



[16] National Institute for Clinical Excellence

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 2.c | **Establish integrated Health and Social Care Community Mental Health teams for older people (OPCMHTs)** | • Review existing community mental health teams for older people and develop recommendations for how teams can be reconfigured e.g. staffing, shared protocols etc.<br>• Explore opportunities for co-location<br>• Specify and provide primary care liaison function from OPCMHTs, in each locality<br>• Specify and provide a memory service function, ensuring it is equitable, and the support is consistent across Surrey<br><br>• Work with the voluntary sector to commission Dementia Navigator posts | | | | | | NHS Surrey, Surrey County Council, Surrey and Borders Partnership Trust, Voluntary Organisations | • Older people and their carers can access a multi-disciplinary team who can assess, diagnose, treat, monitor, support advise and liase with other organisations<br>• Older people and their carers receive a consistent approach to treatment and care<br>• Older people with mental health problems and their carers are able to access emergency interventions out of hours<br>• People with dementia and older people with mental illness are increasingly able to maintain their skills and enhance their confidence and independence |
| 2.d | **Ensure there are appropriate services in place to support people with young onset dementia and their carers** | • Revise staffing levels to ensure there is sufficient capacity and skill set to work with younger adults with dementia in the appropriate OPCMHT and memory services<br>• Commission specialist staff element to develop care pathways for younger people with early onset dementia | | | | | | NHS Surrey, Surrey County Council, Surrey and Borders Partnership Trust, Voluntary Organisations | • There is a positive uptake of this service<br>• People with younger onset dementia and their carers feel they have access to the right support |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 2.e | **Ensure staff and carers have the training to address the needs of people with dementia and mental illness – to include staff from voluntary sector, primary care and residential sector** | • Clarify existing knowledge and skills of staff in OPCMHTs<br>• Review existing training and the take up of it<br>• Propose training options<br>• Address gaps via supervision and training, including identification of appropriate assessment skills and instruments | | | | | NHS Surrey, Surrey County Council, Surrey and Borders Partnership Trust, Voluntary Organisations | • Health and social care staff have the confidence and are more capable to work with older people with mental illness and people with dementia<br>• Staff have the knowledge to provide more appropriate treatment and care |
| 2.f | **Improve the quality and capacity of interventions and care in the community** | • Specify and provide a specialist homecare service<br><br>• Raise awareness and increase development of Telecare via voluntary organisations and media and ensure that the Surrey Telecare Strategy caters for people with dementia and other mental health problems<br><br>• Measure the uptake from the Quality Outcome Framework (QOF) | | | | | Surrey County Council, Independent Providers, District and Borough Councils | • Increased numbers of older people with mental health problems and people with dementia are helped to live independently in the community<br>• A decrease in referrals to residential placements<br>• Improved uptake of Telecare<br>• Older people, families and carers feel improved peace of mind |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.g | **Increase access to support advice for carers of people with dementia or older people with mental health problems** | • Set up dementia cafes across Surrey<br>• Work with voluntary organisations to develop peer support networks, building on lessons learned from the Demonstrator site in Woking<br>• Work with the Surrey Carers Strategy to ensure web based information and advice is relevant to those caring for people with dementia or other mental illnesses<br>• Ensure there are accessible short-term break services available, informed by the local needs analyses<br>• Develop a crisis service to meet the needs of carers of people with dementia and mental health problems in times of acute distress (see 3.a) | | | | | | Surrey County Council, Voluntary Organisations NHS Surrey | • Carers feel they can access appropriate support both for the person they are caring for and themselves<br>• Positive take up of services<br>• Carers are better supported, and are less likely to require emergency breaks – anticipated decrease in carers of people with dementia accessing emergency respite care |



**Tier 3: Intermediate Care**

| Ref no. | Title | Action required | Timescale Year 1 | 2 | 3 | 4 | 5 | Organisation | Outcomes |
|---|---|---|---|---|---|---|---|---|---|
| 3.a | **Mental Health Intermediate Care service, as part of the Community Mental Health teams** | • Confirm the intended model mental health intermediate care service with a crisis intervention function, clarify additional investment in staffing and extended working hours of OPCMHTs<br>• Ensure there are agreed care pathways and formal protocols in place between the newly redesigned CMHTs for older people, and the 'mainstream' or physical intermediate care teams | | | | | | | |
| 3.b | **Telecare** | • Please refer to 2.f | | | | | | | |
| 3.c | **Homecare** | • Please refer to 2.f | | | | | | | |
| 3.d | **Urgent Respite Care** | • Review the current level of service that provides respite beds for older people with dementia and mental illnesses<br>• Ensure respite beds are available in care homes to older people with mental illnesses in times of crisis – when hospital admission is unnecessary and remaining at home is not an option<br>• Engage with Surrey Carers Strategy to ensure this is incorporated into commissioning intentions, and that work efforts are not duplicated | | | | | | Surrey County Council, Voluntary Organisations | • Carers are supported in times of crisis, and feel improved peace of mind<br>• Reduction in avoidable hospital admissions |

## Tier 4: Hospital Inpatient Care

| Ref | Title | Action required | Timescale | Organisation | Outcomes |
|---|---|---|---|---|---|

| no. | | | Year | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 | 5 | | |
| 4.a | **Hospital liaison service** | • Pilot the development of a hospital liaison service in one area in the 1st year. Share the learning with other acute hospitals in the 2nd year<br>• Acute trusts to specify and commission directly on appropriate service model | | | | | | NHS Surrey, Acute hospital trusts | • Ensuring appropriate support and /or admission to hospital<br>• Lengths of stays are reduced, and older people can get home from hospital quicker |
| 4.b | **Ensure there is a clinician in acute general hospitals that will lead on improving quality of care for older people with mental health problems** | • Specify the responsibilities of the role, securing an understanding that the post holders will need to work closely with OPCMHTs<br>• Draw up a contractual requirement for all acute general hospitals<br>• Appoint senior clinicians | | | | | | NHS Surrey, Surrey and Borders Partnership Trust | • Acute hospital staff will be more skilled and better placed at meeting the care needs of older people with mental health problems |
| 4.c | **Manage the beds differently** | • Measurement and scoping exercise in 1st year<br>• A reduction of 15 beds from mental health trust in 2nd year<br>• A reduction in 20 mental health trust beds in 4th year<br>• Modelling in the reduction on general hospital activity / beds and implementation through the strategy life time | | | | | | NHS Surrey | • Keep delayed transfer of care below 7.5%<br>• Bring the level of admissions down by 14%<br>• Reduction in people's length of stay in hospital by 8%<br>• Achieve an average occupancy of 90% |

## Tier 5: Long-Term Care

| Ref no. | Title | Action required | Timescale Year 1 | 2 | 3 | 4 | 5 | Organisation | Outcomes |
|---|---|---|---|---|---|---|---|---|---|
| 5.a | **Avoidable admissions to care homes** | • Review current residential placements for dementia | | | | | | Surrey County Council | • Decrease in care home admissions |
| 5.b | **Improve the service in care homes for older people with dementia and other mental illnesses** | • Review existing knowledge, skills and experience of care home staff<br>• Scope a training programme for care home staff<br>• Scope and facilitate a provider forum for residential homes<br>• Design and deliver an In-Reach function within the OPCMHTs that provides support and training into care homes<br>• Specify standards of assessment and admission, as well as periodic review | | | | | | Surrey County Council, Independent providers | • There is improved quality of care provided in care homes<br>• There is improved knowledge among care home staff about managing dementia and complex mental health problems |
| 5.c | **End of life care** | • Ensure dementia is incorporated into the End of Life Care strategy | | | | | | NHS Surrey | • People with dementia are not excluded from end of life services and experience equity of access in the care and support they receive |

## Implementing the Strategy: A Timeline