Hampshire Primary Care Trust
and
Hampshire County Council

Joint Hampshire Commissioning Strategy for
Older People’s Mental Health
2008 - 2013

Working in partnership with:

Hampshire Partnership NHS Trust
Surrey and Borders Partnership NHS Trust
Alzheimer’s Society
# Final Joint Hampshire Commissioning Strategy for Older People’s Mental Health

**Joint Hampshire Commissioning Strategy for Older People’s Mental Health**  
2008 - 2013

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Chapter 1
Background and the Case for Change

Hampshire County Council Adult Services and Hampshire Primary Care Trust, working with Hampshire Partnership NHS Trust, Surrey and Borders Partnership NHS Trust and the Alzheimer’s Society, are developing a joint commissioning strategy that aims to improve the range and quality of services for older people with mental health problems in Hampshire, in line with the national policy guidance: “Everybody’s Business - Integrated mental health services for older adults: a service development guide”¹ and the National Institute for Health and Clinical Excellence and the Social Care Institute for Excellence “Guideline on supporting people with dementia and their carers in health and social care”².

This strategy also draws on the report produced by Sinead Brophy Consulting, on behalf of Hampshire County Council and Hampshire Partnership NHS Trust, “Towards an Integrated Hampshire Health and Social Care Strategy for Older People with Mental Health Needs’ (2004).

1.1 Why do we need a strategy?
Currently there is a high level of need related to services for older people with mental health problems and a large increase in demand for services is anticipated over the coming years due to significant demographic changes and growth in the local population of older people. This must be addressed in planning and developing services.

We need to respond to developments in good practice published by the Department of Health, the National Institute for Health and Clinical Excellence and the Social Care Institute for Excellence.

We are also in a time of considerable change. NHS and social care services are being modernised and re-designed to meet the challenges of the coming years. Services need to be aligned and coordinated across health and social care organisations in order to support the needs of this client group.

In light of the current demand for services and the levels of mental health need in generic service settings, it is clear that a co-ordinated response is needed from all agencies and that older people’s mental health is indeed “everybody’s business” - not just the domain of specialist mental health services.

1.2 Current Issues
1.2.1 Demography and need
See Appendix 1 for an overview of older people’s mental health needs in Hampshire.

In 2007 there are 220,753 people in Hampshire over 65 years of age. By 2013 it is estimated that this number will rise by 16% to 256,618, in excess of 35,865 additional people. For those aged 80 years and over, the predicted increase is 17%, around 11,118 additional people.
During the same period, the number of people aged between 18 – 65 years in Hampshire is predicted to rise by 2%.

Depression and dementia are the two most common conditions resulting in mental health problems for older people.

Within the general community:
- Depression is present in about 15% of older people.
- Overall, one in 20 people over 65 years has a form of dementia. The prevalence increases with age, doubling with every 5 year increase across the age range\(^3\).

In Hampshire this translates to:
- 33,113 older people with depression, with an anticipated increase of 16% or 5,380 additional people by 2013.
- 19,318 older people with dementia, anticipated to increase by 15%, or 2,928 additional people by 2013.

The recent Dementia UK report from the Alzheimer’s Society shows that Hampshire is the local authority with the highest number of older people with dementia in the South Central Strategic Health Authority area\(^3\).

Currently, conservative estimates tell us that older people with a mental health need account for:
- 40% of people attending their GP
- 50% of all general hospital inpatients
- 60% of care home residents\(^1\).

In cost of illness studies, the direct costs of Alzheimer’s Disease alone exceed the total costs of stroke, cancer and heart disease\(^1\).

Older people with mental health needs often not only have a long-term condition in their mental illness, but also are also more likely to have other long-term conditions. People with long-term conditions are more likely to suffer mental illness, which worsens their prognosis. For people with more than one long term condition, costs are six times higher than for those with only one\(^1\).

In the general hospital setting, the presence of mental health needs is an independent predictor of poor outcome in terms of increased mortality and length of stay, loss of independent function and increased likelihood of transfer to long-term institutional care. It is also associated with increases in hospital acquired complications, increased likelihood of readmission and use of health and social care services\(^4\).

The presence of mental health needs for people resident in their own homes in the community, particularly dementia, is associated with significantly higher risk of entry to long-term institutional care\(^3\).

Evidence from information gathered to date as part of the monitoring of the Community Innovations Service in Hampshire, has shown that experiencing anxiety,
low mood and lack of motivation are important risk factors in accessing statutory services for help, particularly from General Practitioners.

1.2.2 Carers’ needs
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.

Carers play a vital role in Hampshire providing unpaid care to older people with mental health needs in the community. They provide a substantial range of care including emotional, physical, medical and practical support. Many carers need help and support to continue in their caring role.

Older people with mental health needs may have an increased requirement for care. This is often provided by family carers, the majority of whom are old themselves. Although there are rewards associated with caring, it can be very demanding on people physically and emotionally, and can have a negative impact on them financially. An Office of National Statistics study showed that one-third of carers have mental health problems, while two-thirds of carers who provide more than 50 hours of care a week report that their health has been affected by caring.

Estimates in Hampshire show that we have 113,835 carers, with 19,859 carers providing 50 or more hours of care a week. This could translate to an anticipated 37,945 carers with mental health problems, or 13,239 carers whose health has been affected by caring.

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. Health services, social care services and voluntary organisations should all play a key role in supporting carers. This might include mainstream health promotion activities, providing appropriate and timely information, carers’ support groups and a range of respite care.

1.2.3 Population diversity and developing culturally appropriate services
In the 2001 census, 99.4% of the population in Hampshire who were 65 years or over were classified as white. But significant pockets of black and minority ethnic groups were identified, particularly in Rushmoor and Basingstoke, and also in East Hampshire, Eastleigh, Gosport and Hart. The number of older people from black and minority ethnic groups is predicted to rise over coming years.

It is widely reported that people with mental health problems, black and minority ethnic communities and older people experience social exclusion. It follows, then, that black and minority ethnic older people with mental health problems are particularly vulnerable.

Access to services for black and minority ethnic older people and their carers remains problematic. Barriers include issues of language, knowledge of what services are available, and the attitudes and practices of service providers, as well as cultural factors in the perception and understanding of mental illness. Black and
minority ethnic older people with mental health problems and their carers need to have access to appropriate and responsive services.

Within Hampshire there are pockets of deprivation, which can lead to health inequalities. Health improvement programmes and services will aim to reduce these. This may mean providing services in different ways to ensure ease of access.

1.3 Other key drivers for change

1.3.1 Promoting independence and autonomy
Increasingly, service users expect to have their needs met in a person centred way, retaining autonomy and independence and choosing how services will be provided to meet their needs. Patterns of provision are already changing in Hampshire, driven by service users’ aspirations. Different responses will be required in the future and services need to change to reflect this. There is a need:

- To give people more control over their own care and support arrangements
- To provide services that respect dignity and privacy
- To provide services which are convenient and closer to home, wherever possible, enabling people to remain in their own home
- For a wider range of providers and provision that is more innovative, offering services better tailored to people’s need
- To focus, wherever possible, on enabling people to do things for themselves
- To focus on developing local communities
- To enable commissioning of services not only at local authority and Primary Care Trust level, but also at individual (direct payments, individual budgets) and general practice level (practice based commissioning).

1.3.2 Outcome focussed services and achieving value for money
The priority for both Hampshire Primary Care Trust and Hampshire County Council is to be in a position to respond to demographic pressures. Social care services in Hampshire are currently managing financial recovery programmes in response to ongoing demographic and performance pressures. Therefore it will be a major financial challenge to meet the significant increases in demand outlined above and both organisations recognise that there will be a significant financial burden in the future if they do nothing to address these issues now.

There is increasing evidence about the clinical and cost effectiveness of some interventions and care pathways, such as National Institute for Health and Clinical Excellence guidance on drugs in Alzheimer’s disease and guidance on effective care for people with dementia. It will be crucial to ensure that services are effective in achieving optimal outcomes for service users and that they represent value for money.

1.3.4 Promotion of health and well-being
Currently, statutory services focus heavily on illness services and crisis situations. If we are to improve the effectiveness of provision and tackle the predicted increase in demand due to demographic pressures, it is essential to focus on promotion of health, well-being and independence and the development of preventative and early intervention services and support for self care and for carers, alongside services to meet more critical needs.
Age Concern and The Mental Health Foundation Inquiry into Mental Health and Well-being in Later Life highlighted five themes of particular relevance for mental health and well-being in later life:

- Public attitudes
- Staying active
- Social networks
- Standards of living
- Physical health

Certain transition points may challenge older people’s resilience and coping mechanisms, for example, retirement, moving home and going into hospital, and life events involving change and loss, such as bereavement and illness. The cumulative effects of day-to-day problems can also challenge the mental health of older people. Low-level preventative services, such as help with housework, gardening, laundry, and home maintenance and repairs, can help improve people’s quality of life and keep them independent.

Staying mentally and physically active gives a sense of purpose and personal worth to people, as well as enabling people to make an effective contribution to their communities. Participating in valued activities can also provide an opportunity for social contact. Older people may suffer from isolation from a variety of causes such as bereavement, dispersed family, lack of occupation, insufficient financial resources, poor transport services and the impact of poor health.

1.3.5 Mental Capacity Act 2005
This Act, fully implemented from Oct 2007, provides a statutory framework to empower and protect vulnerable people who may not be able to make their own decisions.

Guiding principles include:

- A presumption of capacity – every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise;
- Individuals being supported to make their own decisions – a person must be given all practicable help before anyone treats them as not being able to make their own decisions;
- Unwise decisions – just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision;
- Best interests – an act done or decision made under the Act for or on behalf of a person who lacks capacity must be done in their best interests; and
- Least restrictive option – anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms.

Implementation of the Act is well underway in Hampshire and is being monitored by individual organisations and the multi-agency Local Implementation Network.

The Act is to be amended further to take account of new procedural safeguards regarding deprivation of liberty and those who lack the capacity to consent. The
amendments will be implemented from 2008 and planning has started locally to ensure compliance.

1.3.6 Meeting national targets and standards
Taking account of the mental health needs of older people should be an integral part of any strategy aimed at improving the overall performance of health and social care services.

Working together to improve the care and treatment of older people with mental health problems should:

- Improve the mental health and quality of life for service users and their carers
- Improve the effectiveness and efficiency of health and social care services, enabling resources to be freed up for reinvestment.
- Deliver on national priorities to:
  - Reduce the number of avoidable hospital admissions
  - Enable safe and timely discharge from hospital
  - Increase the number of people supported in their own homes for longer
  - Increase the number of people entering sheltered accommodation, as an alternative to residential and nursing home placements
  - Increased range and availability of services closer to people’s own homes
  - Reduce death from suicide
  - Provide integrated services.

1.3.7 Other national drivers
This strategy is being developed in the context of national legislation and guidance, including:

- The White Paper, “Our Health, Our Care, Our Say”, which gives a clear direction for planners of NHS services to ensure health services are based in community settings, linked to primary care and with pathways into specialist hospital settings.
- Commissioning a Patient led NHS: which supports the commissioner led development of local services.
- National Service Frameworks, particularly those for Older People, Mental Health and Long Term Conditions, which support the development of more accessible, community based services and including A New Ambition for Old Age, The Next Steps in Implementing the National Service Framework for Older People.
- Everybody’s Business - integrated mental health services for older adults: a service development guide, which describes the foundations and key elements of a comprehensive older adult mental health service.
- Supporting people with dementia and their carers in health and social care, clinical practice guidelines from the National Institute for Health and Clinical Excellence and the Social Care Institute for Excellence.
- National Institute for Health and Clinical Excellence guidelines on depression, anxiety and schizophrenia.
- “Strong and Prosperous Communities” - the Local Government White Paper, which aims to give local people and local communities more influence and power to improve their lives.
- The planned first ever national strategy for dementia, announced by the Care Services Minister in August 2007, which will cover the themes of: improved awareness, early diagnosis and intervention and improving the quality of care.
Extension of the national Dignity in Care campaign to cover mental health services.

Themes of recent policy include:
- Promoting social inclusion and well-being
- Embedding service user and carer involvement into the planning and delivery of services
- Empowering citizens to have greater influence over services through a stronger “voice” and greater choice and control
- Developing community resources
- Responding to people on the basis of need, not age
- Delivering holistic, person-centred health and care services, which address mental as well as physical health needs
- Developing sustainable preventative services
- Marshalling of resources across local authorities, NHS and other agencies, including the voluntary sector and independent providers of services
- Developing local leadership
- Enabling cooperation across statutory agencies, improving coordination and communication at all levels.
Chapter 2
Vision and Principles

This strategy is underpinned by the issues and themes outlined in chapter 1 and outlines a vision for services that will enable agencies and communities to move forward together to address the challenges of delivering effective, person-centred services for older people with mental health needs and their carers, within available resources.

This strategy will guide decision making by commissioners about resource allocation over the longer term and will clearly demonstrate how the fundamental principle that older people’s mental health is everybody’s business will be delivered.

This strategy will provide:
- A commissioning framework for Hampshire County Council and Hampshire Primary Care Trust for older people’s mental health services that will deliver:
  - a modernisation programme for health, social care, and voluntary sector providers
  - priorities that make a real difference in the short term to medium term
  - clear statements of commissioning intentions.
- A robust analysis of the mental health needs of older people in Hampshire to inform commissioning.
- A whole health and social care system focus for improvement that spans all aspects of the dementia and functional mental health needs based pathways for older people.
- Cohesion with other related health and social care commissioning strategies, e.g. primary care mental health, day opportunities, extra care sheltered housing.

The overarching commissioning aims of this strategy to be achieved within available resources are:
- To secure services and support that deliver holistic, person-centred health and care, which address mental, as well as physical health, needs and which provide dignity and respect.
- To secure services that are flexible and able to change in line with people’s unique circumstances, enabling independence and choice.
- To secure a comprehensive specialist older people’s mental health service as part of a fully integrated pathway of care.
- To promote equity of access to services and support based on individual and population needs.
- To ensure that treatment and care is based on the best available evidence of effectiveness.

The principles underpinning the strategy are:
- Service users and carers are involved in all stages of the care pathways.
- Person-centred assessment and care planning are at the heart of everything we do.
- Service users and carers feel they are in control of the services and support they receive.
• Services and support are provided as near to home as possible.
• Access to services is simple and timely.

Process for developing the strategy

A steering group of the main agencies involved has been overseeing development of the strategy: Hampshire Primary Care Trust, Hampshire County Council Adult Services, Hampshire Partnership NHS Trust, Surrey and Borders Partnership NHS Trust and the Alzheimer’s Society. There is engagement with the wider voluntary sector through a voluntary sector reference group and Community Action Hampshire.

The work programme to support production of this strategy has included:
• An assessment of current levels of provision using the commissioning checklist in “Everybody’s Business” and using a Red, Amber or Green scoring system. This was undertaken across all areas within Hampshire and validated through Older People’s Local Implementation Teams and/or Older People’s Mental Health Local Implementation Teams (or similar where they operate) - see Appendix 3.

• Two stakeholder workshops, supported by the Care Services Improvement Partnership, were held to secure wide engagement and to consider how this strategy linked with other programmes of work, such as the Hampshire Carers’ Strategy and the Older Persons Well-being Strategy. Reports from these workshops are available.

• A consultation and communication exercise with service users and their families/carers was undertaken by the Alzheimer’s Society - see Appendix 2. This involved visits to 17 different groups across Hampshire, for example lunch clubs and day services, for people with varied needs. It included meeting service users and their families/carers from gay, black, minority and ethnic groups. Case studies and questions were used to find out what mattered to people.

• Multi-agency and multi-professional work groups have been looking at:
  o Development of the needs based care pathways for dementia and functional mental illness (i.e. depression)
  o The acute and community hospital experience
  o Needs analysis and performance measures.
Chapter 3
Model of Care and Needs Based Pathways

Older people’s mental health is often divided into functional mental health (i.e. depression, anxiety and psychotic disorders) and organic mental health (i.e. dementia). The following sections outline separate needs based care pathways for people with dementia and for people with functional mental health needs. The development of these pathways has been informed by:

- National best practice guidance
- The service user and carer consultation and communication exercise undertaken by the Alzheimer’s Society
- A series of multidisciplinary and multi-agency workshops and work groups that involved carers and service user representatives.

Both the dementia and functional mental illness needs led care pathways share the same initial focus on well-being and health promotion, which will be delivered through the development of the Hampshire Older Persons Well-being Strategy.

General principles of care

Assessment:
- Good person centred care depends on holistic assessment of psychological, social and physical characteristics, including the living conditions, economic and social situation and the quality of interpersonal relationships.

Consent and choice:
- The person with mental health problems should be supported to make decisions both in the present and for the future according to the principles of the Mental Capacity Act, and the use of advance directives encouraged.
- Fully informed decisions depend on good information on the nature, course and treatment of the mental health condition, including self-help and support groups.

Organisation of care:
- Care should be delivered across agencies in the most appropriate manner for the individual. This will require clear agreement between all professionals about the responsibility for monitoring and treatment, which is shared with the individual and family where appropriate. When referral to a specialist service is required, age should not be a restriction to access – see Appendix 5 for a broad description of specialist services.

3.1 Functional Mental Illness Care Pathway

This pathway for older people with functional mental health problems (including depression, anxiety, schizophrenia and other psychoses) is presented within a stepped care framework that is comparable to that developed locally for mental health services for adults of working age.
The model aims to match the needs of the individual to the most appropriate services, depending on the characteristics of their illness and their personal and social circumstances. Each step represents increased complexity of intervention, with higher steps assuming interventions in previous steps remain relevant.

People would enter the clinical pathway at different steps, depending on severity and previous history. Within steps, there are choices for people about the type of treatment. It is a needs led process; people may move directly to the appropriate level and move between levels, to suit their needs.

**Summary of functional mental illness care pathway**

Level 1: Prevention, promotion and well-being  
Level 2: Recognition and management of mild mental health problems in primary care and mainstream services  
Level 3: Treatment of moderate to severe mental health problems in primary care and mainstream services  
Level 4: Treatment of severe mental health problems by mental health specialists  
Level 5: Inpatient and crisis team interventions

**Level 1: Prevention, promotion and well-being**

Prevention of ill health and the promotion of health and well-being is being addressed through the Older People’s Well-being Strategy for Hampshire, led by Hampshire County Council. Older people with mental health problems should have access to the full range of health promotion and prevention services available for all adults.

Of particular relevance for prevention of developing mental health need are:
- Isolation and lack of social networks
- Difficulties accessing services
- Insufficient information about possible sources of help, available in the right format, in the right places
- Difficulties with language and communication
- Poor transport options
- Problems with mobility
- Loss of physical health
- Hospital admission
- Bereavement
- Change of accommodation
- Stress from caring
- Poor standard of living
- Fear of crime
- Anxiety regarding potential accidents in the home, illness or regarding ability to cope with everyday tasks
- Cumulative effects of day to day problems like housework, laundry, house maintenance, etc.
<table>
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<th>Level</th>
<th>Care needs</th>
<th>Service involvement</th>
<th>Core functions</th>
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<td>Level 1</td>
<td>Prevention, promotion and well-being</td>
<td>Primary care team</td>
<td>Healthy living style</td>
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<tr>
<td>Level 2</td>
<td>Recognition, assessment and interventions for people with mild mental health problems</td>
<td>All statutory care workers: primary care team, primary care mental health worker, social care staff, general hospital staff</td>
<td>Screening, assessment, watchful waiting, guided self-help, computerised cognitive behavioral therapy, exercise, brief psychological interventions, social support (especially meaningful activities, assistance with activities of daily living, housing), linking with long term conditions</td>
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<td>Level 3</td>
<td>Joint working between primary and secondary care</td>
<td>Primary care team, primary care mental health worker, social care staff, general hospital staff</td>
<td>Medication, psychological and social interventions, in-reach by specialist teams for training / supervision</td>
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<td>Level 4</td>
<td>Treatment-resistant, recurrent, atypical and psychotic depression, unstable psychosis and those at significant risk</td>
<td>Mental health specialists, including crisis teams, assertive outreach function</td>
<td>Medication, complex psychological interventions, combined treatments, training and supervision of mainstream services</td>
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<tr>
<td>Level 5</td>
<td>Risk to life, severe self-neglect</td>
<td>Inpatient care, crisis teams, forensic placements</td>
<td>Medication, combined treatments, electroconvulsive therapy</td>
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Level 2: Recognition, assessment and interventions for people with mild mental health problems

Staff in all settings need to recognise signs of mental health needs and encourage people to seek additional assessment or help as appropriate. Depression is common in all care settings and simple screening should be available. Protocols for the care and management for older people were developed to meet the requirements of the National Service Framework for Older People and the primary care Quality and Outcomes Framework also includes screening for depression in diabetes and coronary heart disease. Further work is required to bring these approaches together, and to organise training for the relevant health and social care workforces.

Interventions considered (dependent on the individual’s choice) should include:

- **Signposting to services and information**
- **Discussion with the individual patient about diagnosis and treatment options**, with a view to gaining agreement about the treatment plan. This will involve:
  - Consideration of the person’s capacity to consent
  - Feedback on the outcome of the assessment
  - Provision of information leaflets and other sources of information, for example NHS Direct website, Patient Advice and Liaison Service, National Institute for Health and Clinical Excellence Patient Information Leaflet.
  - Discussion of treatment options
  - Giving the individual information about who to contact if they have questions or concerns
  - Consideration and encouragement of advance directives/statements or other expression of individual choice
  - Provision of information on recovery statistics.
- **Watchful waiting** for patients who either:
  - do not wish to have an intervention
  - or, for whom the health professional thinks will recover without an intervention.
- **Sleep and anxiety management**
- **Supervised exercise** as part of good general health
- **Guided self help** based on cognitive behavioral therapy principles, or computerized cognitive behavioral therapy may be beneficial.
- **Psychological interventions** (including bereavement counseling)
- **Group psycho-education** (including Expert Patient, Expert Carer Programmes)
- **Social Interventions:**
  - assistance with daily living, domiciliary support, focussed on regaining motivation and promoting independence
  - support to access meaningful things to do in the day, mainstream or specialist services
  - advice on housing.
- **Support for carers** – respite, education, information and advice.
- **Incorporation into long term conditions healthcare programmes** where appropriate.
Level 3: Moderate or severe mental health problem
As a general principle, in order to deliver optimal care and respond appropriately to risk, if psychosis is found alongside depression or anxiety, the psychosis and then the depression should be treated as priorities. Many people with mental health problems are at an increased risk of suicide, and so should be directly asked about suicidal ideas and intent. Guidance should be given on how to access services if things deteriorate, and specialist services contacted if there is felt to be considerable immediate risk to self or others.

Interventions considered for all people with moderate or severe mental health problems (dependent on the individual’s choice) should include:

- Antipsychotic and / or antidepressant medication
- Combination of antidepressants and individual cognitive behavioral therapy
- Depression focused brief psychological therapies
- Couple focused therapy
- Regular assistance with daily living, domiciliary support, focussed on regaining motivation and promoting independence
- Support to access meaningful things to do in the day, possibly universal services, possibly specialist services
- Ongoing assessment and review
- Care planning for the future
- Support for carers: respite and information.

The service should work towards information being available electronically, in line with the aspirations of the single assessment process.

Consideration should be given to referral and joint working with specialist mental health services if there is:

- High risk of suicide or self harm, or risk to others
- Significant degree of functional impairment or neglect
- Presence of significant multiple physical or psychiatric illnesses
- The person’s medical history suggests referral to secondary specialist care as the most appropriate step
- Psychotic symptoms present, such as delusions, hallucinations
- Inadequate response to first two initial treatment recommendations
- Complex symptoms, for example multiple physical problems in addition to psychological.

Level 4 : Treatment-resistant, recurrent, atypical and psychotic depression, unstable psychosis and those at significant risk

Specialist mental health teams should generally be involved at this level of complexity and risk. Staff from partner organisations should discuss with specialist services if there is doubt.

For treatment resistant, atypical and psychotic depression, as well as severe anxiety states, medication and psychological therapies should be considered. For people with recurrent relapses of mental health problems, there should be a focus on relapse prevention.
Care coordination should be carried out according to the provisions of the Care Programme Approach and the single assessment process. Unless assessment dictates otherwise, the person should be considered for enhanced level care coordination. Social factors should be taken into consideration as well as the needs of any carers.

Specialist services should be able to provide for crises in and out of hours, to allow people to remain in their own home wherever possible if that is the wish of the person being supported. Those people who are difficult to support may benefit from a more assertive approach, and working age adult assertive outreach teams provide one model for how this could be organized. Drug and alcohol teams are currently available for all adults, irrespective of age.

Given the prevalence of functional mental health problems in all mainstream services, specialist teams have an important role in providing training, advice and supervision to staff in these settings.

**Level 5 : Risk to life, severe self-neglect**

If there is severe mental illness and / or at high risk of self-harm / suicide or harm to others, there should be access to appropriate community based intensive and crisis support services, alongside inpatient care, when available. Inpatient and forensic setting care should be used when the levels of complexity and risk mean that someone cannot be adequately managed in the community.

The care of people with high level of suicide risk despite no severe mental illness should be closely coordinated and include the person’s GP.

Forensic services should be accessed as for working age adults, although care should be tailored to people’s individual needs.
3.2 Dementia Needs Pathway
This framework provides a needs based model that aims to match the needs of people with dementia and their carers to appropriate services and support. Each phase represents different levels of support, with an assumption that people with higher phase needs may also require interventions described for preceding phases. Within phases there are choices for people about the type of care that suits them best, the setting of that care and who provides the care.

Even though each individual’s experience of dementia will be different, it is a progressive disease and it is likely that, over varying amounts of time, the level of support a person needs will increase. This does not, however, mean that those who support people with dementia need increasingly high levels of specialist skill and knowledge as people become more and more disabled by the disease.

There are certain points within a person’s journey through dementia when more highly skilled assistance may become necessary, but these points may happen at different stages in the journey for different people, and are not necessarily inevitable for all (for example, complex diagnosis, changes in behaviour that are not readily understood or managed).

All those who provide care and support for people with dementia need a sound level of skills and knowledge related to communication, understanding needs and providing care appropriately. Specialist older people’s mental health services need to be well integrated with more generic services used by older people to support mainstream delivery of care. It is at times of critical need when the most highly skilled assistance may be required. A description of the role of specialist older people’s mental health services can be found in Appendix 5.

The steps in the model are:
Phase 1 : Promoting health and well-being and minimising the risk of mental health problems.
Phase 2 : Memory difficulties begin to become apparent
Phase 3 : Living independently becomes more difficult
Phase 4 : 24 hour supervision and support are required
Phase 5 : Critical level of need
Phase 6 : Total inability to initiate movement; end of life care

There is potential for crisis situations to develop at any point along the pathway. Consideration of potential crises and levels of risk should form part of all assessment and care planning activities and contingency plans should always be developed to identify what interventions and/or support may be required under which foreseeable circumstances. There is always the potential for unforeseen crises. The response to these situations will be dependent on the nature of the crisis, but good contingency planning should provide clues for response.

The diagram on page 26 summarises the model above and the care pathway described here sets out the types of needs experienced at each phase, the responses to those needs and who could provide the required support.
Phase 1: Promoting health and well-being

Need
This section is not only about promoting health and well-being but also about minimising the risks of developing dementia.

The factors important in promoting all-round good health and well-being, as identified in the pathway for functional mental illness, are also important here.

The Older People’s Well-being Strategy for Hampshire, led by Hampshire County Council, is the major vehicle for securing change at this point in the pathway. Links have been made between the two strategies and specific issues related to well-being and older people’s mental health have been fed into the development of the Well-being Strategy.

Response
Provision of the following is felt to be most important:

- A range of health promotion and leisure activities
- Low level support services such as housework, gardening, home maintenance and repair, transport
- Telecare and other assistive technology
- Opportunities to volunteer and make a useful contribution to the community.
- Safeguarding individuals from abuse within the context of the multi agency Hampshire-wide Protection of Vulnerable Adults Policy
- Access to services to maximise physical health and functioning that minimise the effects of cognitive decline, for example: optician, dentist, chiropodist, hearing therapist
- Information in different formats, languages and appropriate locations, about all the above.

Advice is available on pension planning, benefits and other financial issues.

Advice is available on alternative accommodation options, for example:

- Sheltered housing
- Extra Care Sheltered housing

or aids/adaptations that might assist in maintaining independence and well-being.

People are supported in accessing the above activities and services and in making healthy lifestyle choices. This includes older people with mental health needs, without discrimination or bars to access.

Potential service/support provider
Voluntary organisations
County Council
District/Borough Councils
Primary Care Trust
GPs
Private providers
Faith groups
Parish groups
**Phase 2 : Difficulties with memory, reasoning or perception**

**Need**
Regularly having difficulties with recalling events, mislaying and losing things, learning and retaining new information. Staff in all settings need to recognise signs of mental health problems and encourage and signpost people to seek additional help, as appropriate.

Early detection and diagnosis of dementia allows:
- Early intervention to maximise quality of life and independent functioning
- Assessment and management of risk to prevent future harm
- Sound assessment and diagnosis also ensures identification of treatable causes of cognitive impairment.

Symptoms of dementia are exacerbated by the presence of other mental health conditions, such as anxiety and depression. People with dementia will often experience these other conditions and it is important to minimise the risks of these developing. Again, the health and well-being promotion stage of the functional mental health pathway is also highly relevant here.

**Response**
This is the optimum phase in which to carry out assessment and differential diagnosis, however, there is often a significant delay in diagnosis and perhaps only a third to a half of people currently receive a formal diagnosis. When diagnosis is confirmed, in addition to the above, the following other interventions are recommended.

- Education and information provision to:
  - gain insight into the condition
  - suggest simple coping mechanisms to lessen the adverse effects of the condition
  - inform about when and where to seek further help and support (for carer and cared for)
- Empathetic assistance to aid in coming to terms with a diagnosis
- Ongoing support for cared for and carer
- Structured cognitive stimulation programmes
- Access to meaningful and appropriate things to do in the day; access to universal services should not be barred due to mental health needs
- Provision of appropriate drug therapy to ameliorate symptoms, plus ongoing monitoring of medication and assistance with medication management
- Advocacy to support people in making decisions and securing the assistance they choose
- Advice and assessment re driving
- Legal and financial advice
- Care planning for the future
- Memory aids and prompts.
**Potential service/support provider**
GP/primary care
Community health services
Memory/outpatient clinic
Community mental health services
Voluntary organisations
Private providers
Solicitors
Hampshire County Council older drivers’ assessment service
Unpaid carers

**Phase 3 : Independent living difficulties**

**Need**
Significant difficulties with:
- Memory
- Word finding and comprehension
- Many stepped or complex operations.

Confused and frequently disorientated, possibly with behavioural issues such as:
- Passivity
- Suspiciousness
- Exaggerated social behaviour
- Lack of appropriateness
- Low level agitation
- Low level aggression.

The individual and/or carer’s life is significantly disrupted by their symptoms. Carers need to feel supported and motivated to continue to care.

**Response**
In addition to the above, the following interventions are recommended:
- Environments adjusted to limit risk, aid orientation and memory and maximise independence and relieve carer stress. This includes provision of technological solutions (Telecare)
- Advice and support in accessing alternative accommodation, as appropriate
- Alternative accommodation choices available, such as sheltered housing
- Meaningful things to do in the day; accessing universal services, as appropriate, but requiring support to do this
- Structured cognitive stimulation programmes to maximise functioning and maintain skills for as long as possible, built from individual interests and preferences
- Services to maximise physical health and functioning, to minimise any disabling effects of cognitive difficulties
- Variety of opportunities for breaks for carers (respite) should be available, both within the home, away from home and sometimes together as a couple
- Assistance with understanding behaviour and developing coping strategies
- Some assistance with some personal care tasks and maintaining continence
- Advice about care planning for the future.
People with early onset dementia may need a slightly different approach, for example to enable the main carer to continue working.

**Potential service/support provider**
Providers as for phase 2 plus Hampshire County Council Adult Services – see note about eligibility criteria\(^\text{12}\).

**Phase 4: 24hr supervision and support required**

**Need**
High level of risk and difficulties due to:

- Lack of awareness of symptoms
- Extreme difficulties with communication
- Inability to think ahead and foresee danger
- Inability to provide for own basic needs such as food, warmth, personal hygiene, etc
- Possible danger of exploitation or abuse
- Possible danger of carer breakdown due to mental, emotional, physical and financial strain
- Possible high levels of agitation
- Possible high levels of aggression.

**Response**
In addition to the above responses, the following interventions are recommended:

- Multidisciplinary assessment and care planning to maximise well-being of both the person with dementia and any carer; this will include assessment and management of risk to person with dementia and any carer in the context of the Mental Capacity Act 2005 and an understanding of rights and the individual's best interests; also care plans to include contingency plans for possible foreseeable crises/changes/difficulties
- Availability of Independent Mental Capacity Advocacy service
- Coordination of assessment and provision of services and support, to simplify and ease access for service users and carers.
- Assistance with personal care tasks such as:
  - Meals
  - Dressing
  - Washing
  Focus on therapeutic interactions and maintaining well-being. Avoid deskilling, identify abilities and maintain these for as long as possible. Available 24/7.
- Assistance with managing continence
- Assistance with taking medication
- Assistance for carers (paid and unpaid) with communication, understanding behaviour and care needs, and developing coping strategies
- Meaningful and appropriate things to do in the day. May still be able to access universal services with support, but likely to need some kind of specialist provision, including structured cognitive stimulation programmes to maximise functioning and maintain remaining skills for as long as possible; also focus on
well-being and interests/life history. This could be provided in or outside own home and could be linked with personal care service above

- Advice and support in accessing alternative accommodation, as appropriate
- Alternative accommodation choices available, such as sheltered and extra care housing and care home provision. Where a move is being considered, decisions should be made within the clear framework provided by the Mental Capacity Act, accessing the Independent Mental Capacity Advocacy service, using Mental Health Act 1983 provisions, such as Guardianship, and taking account of interim guidance on the Bournewood case (and ultimately the Bournewood Safeguards, once enacted), as appropriate
- Flexible provision of breaks for carers, based on need and provided within or outside the home (links with activities and personal care points made above, covering both the person with dementia and their carer’s needs).

**Potential service/support provider**
Providers, as for phase 3

**Phase 5: Critical level of need**

**Need**
- Crisis situation threatening life
- Extreme behaviours that are highly unpredictable and require intervention from highly skilled staff
- Incidence of abuse adding to need for place of safety or removal of abuser
- Medical emergency.

**Response**
For extreme behaviours, services as outlined above will generally need to be delivered by highly skilled staff (or highly skilled unpaid carers with the support of professionals).

For response in a situation of known or suspected abuse, see Hampshire Safeguarding Vulnerable Adults Policy (multi-agency).

For crisis situations and medical emergencies see below.

**Potential service/support provider**
Statutory providers
Highly skilled unpaid carers
Unpaid carers

**Phase 6: End of Life Care**

**Need**
- Very limited ability to engage with the environment or other people in any way
- May be a total inability to initiate any movement.

**Response**
All support for carers as outlined above will still apply and, in addition to above, the following interventions are recommended:
- Total care will be needed
- Palliative care focused on symptom control and, as far as is possible, maintaining well-being
- Assessment, care-planning, coordination and continuity of care are as essential as in above stages, as is advanced planning for any likely crises to reduce inappropriate admissions to hospital from other settings
- Care homes, primary care and in-patient facilities should consider the Liverpool Care Pathway and Gold Standards Framework and how improvements in end of life care for people with dementia can be taken forward in line with the Care at End of Life Hampshire Health Overview and Scrutiny Committee Review Project.

**Potential service/support provider**
Statutory providers
Hospices
Private sector
Unpaid carers

**Crisis situations**
Crises can occur in any phase of dementia and appropriate support needs to be simple to access and timely. Some crises are due to a change in the person with dementia and some from issues affecting the carer’s ability to carry on coping (such as illness in the carer).

**Need**
- Carer no longer able to care
- Acute illness of service user or carer
- Accident in the home, for example a fall (cared for or carer)
- Step change in service user’s condition.

**Response**
The way in which emergency teams respond is paramount. Times of crisis are particularly stressful for people with dementia and their carers, as their usual routines and ways of coping are disrupted. Services need to be timely and sensitive to the particular needs of the individuals concerned.

The following interventions are recommended:
- Responsive emergency services (police and ambulance)
- Specialist community teams that promote independence
- Generalist services, including NHS Direct, community nursing and primary care and all out of hours services, that understand and are able to support the person with dementia and their carer
- Access to services such as crisis resolution and home treatment teams and Adult Services
- Access to emergency respite if required
- Access to skilled generalist and specialist mental health services in acute and community hospitals
- ‘Message in a Bottle’ or similar communication techniques for use in emergency situations
Communications are particularly important in crises situations, for example:
- Informing the carer if they are not present at time of crisis
- Appropriate routing of telephone calls in general hospitals
- Informing general practice
- Informing specialist mental health and social care services.

**Potential service/support provider**
All providers
SUPPORT NEEDS OF PEOPLE WITH DEMENTIA AND THEIR CARERS

- Memory difficulties
- Independent living difficulties
- 24 hr supervision and support required
- Critical level of need
- Total inability to initiate movement
- End of life care

- Person with dementia
- Carer
- Person with dementia and their carer

- Information
- Advocacy
- Safeguarding from abuse
- Leisure activities
- Low level preventative services
- Assessment and diagnostics
- Psychotherapeutic interventions
- Structured cognitive skills programmes
- Drug therapy
- Continence services
- Assistance with personal care
- Staff with appropriate skills and knowledge
- Assessment and management of risk to user and carer
- Assistance with communication, understanding, behaviour and care planning to maximise well being
- Variety of opportunities for breaks for carers
- Meaningful relationships and therapeutic interactions
- Maximising physical health and functioning including health promotion
- Appropriate accommodation
- Telecare
Chapter 3.3
Acute and Community Hospital Experience

The report “Who Cares Wins” states that two-thirds of NHS beds are occupied by people aged 65 years or older\(^4\). Up to 60% of general hospital admissions in this age group will have or will develop a mental disorder during their admission. A typical district general hospital with 500 beds will admit 5,000 older people each year and 3,000 will suffer a mental disorder. On average, older people will occupy 330 of these beds at any time and 220 of these will have a mental disorder.

This means that the acute hospital will have at least four times as many older people with mental disorder on its wards as the older people’s mental health service has on theirs. Three disorders; depression, dementia and delirium, will account for 80% of this mental disorder co-morbidity, such that, 96 patients will have depression, 102 dementia and 66 delirium.

In Community Hospitals the proportion of service users who are over 65 years and who might potentially have mental health problems would potentially be higher.

The presence of mental health problems increases the risk of admission and is an independent predictor of:

- Poor experience for both services users and their relatives
- Higher and earlier rates of death
- Increased length of stay
- Loss of independent function
- Increased likelihood of transfer to long-term institutional care\(^4\).

A recent audit within Portsmouth Hospitals NHS Trust demonstrated that older people with mental health issues stay in hospital between 2 - 7 days longer than was necessary.

The National Audit Office report “Improving Services and Support for People with Dementia”\(^6\) found in one study that effective identification of dementia in patients admitted with fractured neck of femur and more proactive, coordinated management of their care and discharge (provided a suitable discharge destination was available) could release between £64million and £102 million a year in England. If this calculation was applied to Hampshire, this would equate to between £1.7million – £2.8million (note: with caveats about broad comparisons between different health and social care systems).

The same report looked at the impact of dementia on people who fall and fracture their hip. Hip fracture can have devastating consequences, with subsequent increased mortality and loss of independence. For people with dementia the outcomes are generally worse, and the costs to health and social care system are greater. Better integration of psychiatric and general hospital services has the potential to improve outcomes and reduce costs.

Consultations that have taken place in Hampshire as part of the development of this strategy tell us that, although there are some notable examples of good practice around the county, there is significant room for improvement in managing an older
person’s journey through hospital systems when they have mental health problems alongside physical health problems.

Key issues identified for attention are:

- Limited understanding and commitment to the mental health agenda at Board, professional, ward and individual practitioner level in hospitals
- Hospitals’ reactive approach to access and capacity issues can detract from person centred approaches to care and discharge
- Access to opportunities for community-based resources is variable across the county; thus diversion from unnecessary admission and speeding up appropriate discharge is often problematic
- Multiple moves within hospital are shown to extend length of stay, as well as causing undue distress
- Lack of attention and attribution of importance to personal and family knowledge, needs, opinions and perspectives
- Mental health problems are under recognised and under communicated:
  - in discussion with patients and their relatives and carers
  - within hospital
  - to and from primary care.
- Lack of knowledge and confidence of hospital staff in caring for people with mental health problems
- Lack of knowledge by hospital staff of the available community options
- Difficulty in identifying if a person is already known to specialist mental health services
- Limited engagement of specialist mental health clinicians in admission avoidance interventions in Accident and Emergency departments, assessment processes in medical assessment units and wards and discharge planning processes
- Limited understanding of, and engagement with, the specialist mental health services available to hospital staff, patients and relatives
- Variable provision of liaison service from specialist older people’s mental health services across the county and time taken for the specialist service to respond.

A work group has been established to support implementation of this strategy and to take some of these issues forward. It has cross county, cross agency and multidisciplinary representation, including voluntary sector and carer representatives. This work group has identified some early priorities around training for staff and development of admission pathway guidelines.
Chapter 4
Analysis of Current Position

This chapter provides a high level assessment of current levels of provision of older people’s mental health services across Hampshire. It draws on several sources of work undertaken to date.

There are many providers of health and social care for older people with mental health needs in Hampshire:

- Specialist mental health trusts: Hampshire Partnership NHS Trust and Surrey and Borders Partnership NHS Trust, which covers the populations of north east Hampshire
- District and Borough Councils
- Third sector organisations: charities such as the Alzheimer’s Society, Age Concern and MIND
- Private sector providers, such as care homes and domiciliary care agencies
- Hampshire County Council Adult Services
- Hampshire Primary Care Trust – providing primary care and community based care
- General hospitals: Portsmouth Hospitals NHS Trust, Southampton University Hospitals NHS Trust, Winchester and Eastleigh Healthcare NHS Trust, Basingstoke and North Hampshire NHS Foundation Trust, Frimley Park Hospital NHS Foundation Trust.
- Family, friends and other unpaid carers.

In 2006, a mapping exercise of current provision was undertaken with the involvement of Older People’s Local Implementation Teams and/or Older People’s Mental Health Local Implementation Teams (groups of service providers, users and carers, commissioners, voluntary organisations and other interested parties) – where they were in operation – using the requirements for an integrated mental health services for older people as set out in “Everybody’s Business”. This involved assessing services as Red (none or minimal services), Amber (some provision) and Green (sufficient services to meet current demand) across all geographical areas within Hampshire – see Appendix 3 for the full aggregated Hampshire position.

This analysis provides some broad headlines to indicate where services need strengthening and where we need to inquire further, at both a Hampshire and at a local level. However, the limitations of this exercise need to be noted, as it did not assess either the quality of provision or the outcomes for older people with mental health problems.

Some consistently sufficient levels of provision across Hampshire were identified, for example:

- Acute specialist mental health bed provision
- Day hospitals (except in Basingstoke)
- Locally based community teams
- Primary care disease registers.

This process also identified areas where services were limited, including:
• Crisis response services
• Training and education for providers of general health services and housing staff
• Access to intermediate care services
• A&E diversion schemes
• Provision of talking therapies
• Expert patient programmes
• Dedicated provision for black, minority and ethnic groups
• Services for young onset dementia
• General Hospitals had minimal training and development related to mental health and, where they existed, liaison services were stretched.

Also, users and carers have told us that they find it valuable to gain information in a timely way to help them self-manage their condition or to understand, cope and provide support. The mapping showed inconsistent provision.

The service user and carer engagement work undertaken by the Alzheimer’s Society and the input of carers involved with the strategy has provided the following important feedback:

• Some carers reported a loss in service provision, such as day opportunities, or had seen a reduction in services over a number of years
• Individuals with a functional mental illness had noticed a difference in the services available when transferring from working age adult services to older people’s services.
• Flexible day opportunities were crucial in providing meaningful activity for the service user and to support the carer, particularly through services provided away from the home
• Support to stay involved with everyday community activities and live as normal a life for as long as possible
• Access by telephone 24 hours a day to help in a crisis situation from people trained in older people’s mental health problems
• The importance of adequate access to respite services
• Staff in acute hospitals and home care in particular were seen as lacking in understanding and skills to deal with mental health problems
• The experience of poor communication between all parts of the health and social care system, a lack of timely communication and consultation with the carer and service user and failing continuity of care and follow up
• A lack of information and training for carers, particularly in early intervention
• Concern that a policy to keep people at home and out of hospital needs to be better supported with adequate community based services.

The final report on consultation with older people and their carers is at Appendix 2.

An overall assessment of the strengths in provision of older people’s mental health services across the health and social care system and a parallel identification of areas for attention has been drawn from:
• Service user and carer consultation feedback
• Feedback gained from the stakeholder workshops
• Input to the work groups from health and social care staff, voluntary organisations, service users and carers
• The service mapping exercise across Hampshire
• Discussions with health and social care staff as part of the development of this strategy.

Strengths and opportunities within the current system:
• Specialist services are generally well thought of locally, once they are accessed
• There is motivation and willingness across agencies and sectors to work together on tackling older people’s mental health issues
• Joint planning is underway
• Users, carers and the voluntary sector are involved in strategic planning
• Other key pieces of work are already under development in Hampshire, for example:
  • Older People’s Well-being Strategy
  • Carers’ Strategy
  • Extra Care Sheltered Housing strategy
  • Primary Care Mental Health Strategy
  • End of Life Strategy
  • Day Opportunities Strategy
• Telecare services are being developed
• User and carer integrated care standards are being implemented
• Access to some services is available 24/7
• Locally based community teams are in place
• We have some excellent individual services demonstrating innovative practice, for example: Dementia Advice and Support Service in Winchester, Memory Matters courses, the Alzheimer’s café in Farnborough, young onset service in Fareham and Gosport, support to care homes in Fareham and Gosport, Rowan Court extra care housing in Eastleigh.

Areas for our attention:
• There is considerable variation of service provision and access across the county in relation to many aspects of care for older people with mental health problems, for example:
  • different guidelines and tools are used for initial assessment and referral in primary care and people are receiving variable support in the early stages of their mental health problems
  • service user and carer information and ongoing support is patchy and not coordinated, for example: assistance with managing continence and support for carers, both paid and unpaid, about understanding and coping with behaviour that challenges are not always provided
  • difficulties in accessing stimulating and meaningful things to do
  • crisis services and support is variable; and access to some provision is on the basis of age, rather than need
  • older people’s psychiatric liaison capacity in general and community hospitals is variable
• Statutory services are tightly targeted and focus on illness and crisis
• Users and carers feel that access to services and choice is reducing
• Joint assessment and care planning is not always well coordinated and information is not always appropriately shared
• Carers highlight difficulties in accessing respite care and say the quality of respite care is not always good
• Psychological therapies are currently provided mainly in secondary specialist mental health inpatient care
• There is under utilisation of acute specialist mental health inpatient beds
• There is limited dedicated provision for young onset dementia
• There is clear evidence that training, development and support for staff caring for older people with mental health needs in all settings is vital and that there is currently no mechanism for strategic planning and co-ordination of training for staff in the needs of older people with mental health problems
• Hampshire Partnerships NHS Trust has found a wide variation in day hospital provision; it is currently not fully utilised, is very geographically based and has the potential to be more therapeutically focused
• There are issues about decisions about an individual’s long-term care being taken early in the hospital discharge process and exclusion from some mainstream services which prevent unnecessary admission to hospital and / or facilitate discharge
• Provision for black, minority and ethnic groups is variable and services have been designed historically without significant consideration of BME provision
• There is significant scope to use new technology in increase the independence of people with dementia; current levels of provision are minimal
• There is a general lack of knowledge about what services are available across all settings
• Organisational boundaries can limit the ability to work together.
Chapter 5
Commissioning Intentions: What We Are Trying To Achieve

This is a five-year plan that enables health and social care commissioners to respond to local demographic challenges and the information gathered as part of this exercise and that will deliver improvements to services over the period 2008 to 2013.

5.1 Hampshire Primary Care Trust and Hampshire County Council Adult Services’ commissioning intentions

We will work towards commissioning within available resources:

- Needs led care pathways for dementia and functional mental illness (developed as part of this strategy), which will:
  - describe clear outcomes for older people with mental health needs
  - inform Hampshire Primary Care Trust’s Local Delivery Plan for 2008/2009 (and subsequent years) and budget setting for Adult Services.

- An integrated service between working age and older people’s mental health services for older people with functional mental health needs that is responsive and enables choice for individuals – see Appendix 5 for broad service specification for specialist services.

- A map of the total resources (Hampshire Primary Care Trust and Hampshire County Council Adult Services) currently spend on older people’s mental health and social care services in Hampshire, including for example: specialist mental health services, continuing care, voluntary sector services, social care. This will identify the total envelope of funds to support a modernisation programme, showing where there is any duplication or gaps and enabling maximisation of available resources. As part of this work, Hampshire Primary Care Trust and Hampshire County Council Adult Services will undertake a review of grants to voluntary organisations.

- A “Balance of Care” project across Hampshire to identify the costs of unnecessary bed usage in acute and community hospitals, specialist mental health inpatient services, residential and nursing homes and to identify appropriate alternatives to hospital for people with dementia; this will provide a platform for planning services across the whole health and social care system.

- Providers to undertake modernisation programmes to deliver services that implement the needs led care pathways that deliver the commissioning aims set out on page 10 within existing resources. This will involve review and redesign of:
  - specialist and generic provision
  - working age and older people’s functional mental illness health provision
  - the balance between inpatient capacity and access to community based and universal well-being services - in particular a focus on prevention and early diagnosis.

- Improvements to services to be delivered over the short, medium and longer term period of the strategy.
How we will commission:

- We will focus on preventative and community based services that promote independence in the early years of this strategy. All investment plans will be balanced with a disinvestment plan to demonstrate affordability within the available resources and the links between business cases will be demonstrated.
- Where significant redesign of services is required, this will be subject to the usual scrutiny and public consultation processes.
- Service level agreements will be agreed with NHS trusts and any future Foundation Trusts and with health and social care providers that set out the modernisation programme and describe service specifications based on the needs led care pathways, with identified outcomes and standards – see Appendix 4 for proposed performance indicators.
- Hampshire Primary Care Trust and Hampshire County Council will review the funding position, should it be indicated that additional resource is required in the future.
- We would wish to work alongside practice based commissioning groups.
- We will proactively pursue opportunities for attracting further grants/resources to support older people’s mental health services, such as any future Partnerships for Older People’s Projects or similar funding and access to funding for the voluntary sector.
- We will consider the implications of this strategy for market management and will proactively engage with the voluntary sector as a key player within the market.

5.2 Resources:
The comprehensive spending review in October 2007 announced:

- For the NHS - growth of 3% above inflation per year for the next 3 years and 3% efficiency savings per year
- For Local Authorities - growth of 1% above inflation for the next 3 years and 3% efficiency savings per year.

We assess that this growth in funds would be consumed by the increase in demand for older people’s mental health and social care in Hampshire if we do nothing. The challenge for Hampshire Primary Care Trust and Hampshire County Council Adult Services is to manage our current investment and resources to maximise opportunities for older people’s mental health.

We have assessed the current level of resources spent on older people’s mental health services by Hampshire Primary Care Trust and Hampshire County Council Adult Services – see table below. This is an under-estimate and does not reflect all the associated costs linked to the care needs of older people with mental health problems, particularly in hospital where an individual may be treated for another illness.
Table: Expenditure on older people’s mental health services:

<table>
<thead>
<tr>
<th></th>
<th>£000</th>
<th>Assumesions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hampshire PCT</td>
<td>28,851</td>
<td>Includes only specialist mental health providers, continuing NHS healthcare and joint finance budgets for 2007/08. Excludes acute and community/primary care spend.</td>
</tr>
<tr>
<td>HCC Adult Services</td>
<td>51,747</td>
<td>Based on 2006/07 budgets, net of income and excluding management and support overheads and assumption that 50% of the older people’s budget is spent on clients with mental health needs.</td>
</tr>
</tbody>
</table>

Further information about resources is provided in Appendix 1 - Needs Analysis and Data Set.

5.3 Early commissioning priorities for Hampshire Primary Care Trust and Hampshire County Council

These are described in relation to the needs led care pathways for dementia and functional mental illness and they respond to the identified gaps in current provision. The aim is to provide a modern, evidenced based, integrated service that will meet current and future need within available resources. Delivery will be based on national policy and services will implement the agreed needs led care pathways for dementia and functional mental health needs, promoting person-centred care and choice and enabling independence.

Four key strategic priorities underpin these early commissioning intentions:

1. Supporting carers – so that they are enabled to provide care and support and are actively involved in planning care for the older person with mental health problems.
2. Prevention and access to universal well-being services – so that individuals can maintain their independence and live as “normal” a life as possible for as long as possible.
3. Balancing specialist and generic services – through skilling up mainstream staff, removing barriers to services and gaining clarity on the respective roles and functions of specialist mental health and mainstream services, so that the majority of mild and moderate severity mental health needs can be managed in mainstream settings.
4. Pathways in and out of hospital - so unnecessary admissions are avoided and the older person with mental health problems receives timely and appropriate care in response to their individual needs while in hospital and the focus is on maintaining independence on discharge.

To help prevent escalating levels of need in the early parts of the care pathways, early developments will focus on:

- Working alongside partners to support older people with mental health needs and their carers in the community
• Promoting awareness amongst the general public, particularly about dementia and depression in old age and messages about maintaining good health, to assist in developing a more inclusive approach
• Making sure we enable people to live in their own homes and limiting the impact of crises that result in emergency admissions to hospital.

We will monitor our progress and reassess these early priorities as the strategy develops over the period 2008 – 2013.

The following overview of proposed early commissioning intentions are described in relation to the needs led care pathways for dementia and functional mental illness.

5.3.1 Phase/Level 1 - Promoting health and well-being

Well-being
The Hampshire County Council corporate Older People’s Well-being Strategy will support delivery of the care pathways for dementia and functional mental illness around the strategy’s seven domains of independence:

- housing and the home
- neighbourhood
- social activities/networks
- getting out and about
- income
- information
- health and healthy living,

all of which are aimed at reducing isolation.

The Hampshire County Council Adult Services and Trading Standards joint initiative – Protecting Older People – will continue, which is aimed at preventing doorstep crime for older people and the potential for subsequent mental health decline.

The Hampshire Well-being Strategy is being produced and local well-being plans developed in a number of areas around the county. Specific programmes such as the older person’s area link worker project and the gardening strategy are underway.

The well-being programmes will continue to expand from 2008/09 to support older people’s mental health.

Public awareness
We will seek to promote awareness amongst the general public and professionals in all settings about dementia and depression in old age. The intention of the national dementia strategy, due to be published in summer 2008, is to:
- develop better understanding
- ensure information is provided
- tackle stigma and misunderstanding.

We will build on the higher profile gained through consultation on this strategy to assess current activities, information campaigns, training and education available and develop a local plan.
Falls prevention
Older people with mental health needs will be targeted within falls prevention work.

We will be reviewing falls services across Hampshire and will include older people’s mental health within the scope of this work.

5.3.2 Phase/Level 2 – difficulties with memory, reasoning or perception
Primary Care. Recognition, assessment and management of early memory difficulties and mild mental health problems

Primary care and community health services
GPs will be supported to:
- recognise and refer for a timely, early diagnosis of dementia using referral guidelines and access to specialist mental health advice
- diagnose and manage mild mental health problems.

The current guidelines and pathways for referral and initial assessment will be reviewed jointly between mainstream and specialist mental health clinicians, so that trigger symptoms can be consistently recognised and community-based support resources can be more easily accessed.

We will assess practice registers and protocols for dementia and depression against known prevalence and defined good practice guidelines.

We will work towards developing clinical reference groups across primary and community care, acute and specialist mental health services to facilitate learning and implementation.

Information and support
We will develop consistent support and information about dementia and functional mental health problems and services for service users, carers, primary care teams and community mental health teams. Currently there are different service models around the county and the aim is to learn from what works well and maintain locally appropriate services. This will link with the Hampshire Carers’ Strategy, which will enable further work on information resources, and support for carers will be progressed.

With the support of the Care Services Improvement Partnership and the Carers’ Stakeholder Group we will work closely with carers, users and the voluntary sector to develop specific information resources about available community based support.

The Carer’s Strategy will continue to be taken forward to develop and provide a range of accessible information for carers, including the development of local directories, using the national service mapping information and other identified priorities.

The contact centre for all social care referrals will be established, which will provide a one-stop shop for advice and information.
Day opportunities
For this part of the pathway, people will be encouraged and enabled to continue accessing and pursuing universal services for their usual activities and hobbies, for example: the local choir, gardening clubs, the Women’s Institute.

Primary care mental health strategy
Primary care plays an important part in the delivery of mental health care and is where the majority of mental health problems are managed. 90% of people with a mental health problem are cared for entirely by the primary care team and 40% of people who see their GP have a mental health problem\textsuperscript{13}.

A joint Hampshire Primary Care Trust and Hampshire County Council primary care mental health strategy is being developed with support from the Care Services Improvement Partnership. The strategy aims to enable the primary and community care team to provide improved support for those with mild to moderate mental illness, providing assessment and therapeutic interventions to individuals in a primary care setting through:

- Information and advice
- Assessment
- Care planning
- Evidence based psychological interventions
- Onward referral to specialist mental health services
- Liaison work with other providers.

Expert Patient Programme
We will explore extension of the Expert Patient Programme to cover older people with mental health problems and linked to Memory Matters courses.

Training
There will be a partnership approach to prioritising and developing training programmes that provide a basic understanding of mental illness, both functional and dementia. This will support individuals to remain in their chosen environment as long as possible, achieve an optimum quality of life and reduce the need for high levels of specialist secondary support. Opportunities to link training programmes with access to and provision of formal courses, such as relevant NVQs, will be explored.

We will work towards developing a broad training strategy for health, social care, voluntary and independent sectors to support all phases of dementia and functional mental illness pathways, linking with the Sector Skills Councils.

For those over the age of 65 years, the skill set of staff may be significantly different from those working with adults of working age. This is likely to include skills around working with people exhibiting a mixed pathology of depression and dementia, physical illness and physical frailty. Careful and creative thinking about the best match of staff skills, service user compatibility and physical environment is of the utmost importance\textsuperscript{14}.

We will look to establish the necessary leadership and processes to develop a broad training strategy for health, social care, voluntary and independent sectors and initial priorities for action.
We will explore opportunities for partnership development in training, for example with Housing.

**Telecare**

Telecare can be defined as a range of detectors and monitors, which are usually connected to a community alarm response centre. The most well known is the pendant alarm but there are many others, including falls detectors and bed sensors.

Telecare can be used in a variety of ways to help improve confidence and minimise risk. It can also provide peace of mind to carers and family members.

Telecare can help older people with mental health difficulties to remain living independently in their own home. For instance, gas detectors and flood sensors can help if the older person is becoming forgetful. The “Just Checking” portable sensor system can help build up a picture of the patterns of daily life of an older person with dementia living alone. Door sensors can let a carer know when a person with dementia has left the house. Other sensors can reduce the sense of isolation that may contribute to an older person feeling depressed.

Hampshire County Council currently contracts with organisations on a district council area basis to provide Telecare equipment.

We will jointly look at ways that Telecare can help keep people in the community. In 2007/08 the service is working to achieve the target of 750 new users. In 2008/09 there is a target for 1500 new Telecare users.

**Memory services**

We will work towards developing a specification for memory services to provide: early diagnosis, specialist assessment, information and support, memory matters that will be available in all areas.

**Equality impact assessments**

Equality impact assessments will be undertaken on existing and any new services to ensure that there is an appropriate assessment of black, minority and ethnic groups’ requirements. We will work with the focused implementation site project in Hampshire and the introduction of Community Development Workers across the county. Where indicated, facilities for dedicated provision will be put in place.

We will review the role of the Community Development Workers being appointed across Hampshire to include older people with mental health problems from black, minority and ethnic groups.

5.3.3. Phase/Level 3 - Supporting people with independent living difficulties; moderate or severe mental health problems

**Reducing barriers to access to specialist mental health services and generic older people’s services**

We will seek to promote equity of access, based on individual and population needs and based on the best available evidence of effectiveness, to the whole range of
mental health services across working age and older people’s services for people with a functional mental illness. This is also an integral element of the strategies for working age mental health services and primary care mental health that are both being developed.

Our aim is that all current generic older people’s community support services will be accessible for individuals with mental health problems (includes short-term crisis prevention, intermediate care, reablement and rehabilitation services), based on individual and population needs and based on the best available evidence of effectiveness. This work will be informed by the findings of the “Balance of Care” project.

**Crisis services and emergency responses**
We will seek to develop a service specification and plan with providers that works towards enabling access to current working age adult specialist mental health and social care crisis response services for older people with functional mental illness and access to primary care and social care crisis response services for older people with dementia.

We will work with our partners (out of hours services, NHS Direct and ambulance services) to develop an emergency care pathway for older people with mental health problems.

**Medicines Management**
We would wish to support older people with mental health problems and their carers in understanding and taking their medication through:
- Pharmacist input to discharge planning and in-depth medication review where indicated
- Community pharmacists’ medicines use reviews.

We would wish to promote good prescribing practice for dementia and depression in old age in all settings, looking at care pathways and shared care agreements between primary care and specialist mental health services.

We will explore opportunities for community pharmacists’ medicines use reviews to identify and support older people with mental health needs and their carers.

We will review implementation of National Institute for Health and Clinical Excellence guidance (both technology appraisals and clinical guidelines for depression, anxiety and dementia) across Hampshire and develop methods to monitor and audit their implementation.

**Community Innovations Teams**
The Community Innovations Teams model will be further developed providing:
- early identification of the vulnerable population in the community
- assessment and sign-posting to supporting community and voluntary interventions
- help to link with these interventions
- integrated working between health and social care
- Community capacity building using an Invest-to-Save Grant received from the Treasury.

The Innovations Team work is to be thoroughly evaluated, looking at:
- Improvements in well-being (using a measure developed by the New Economics Foundation)
- Reductions in use of emergency and other services.

Existing teams will be expanded from 2008 to include Community Development Workers, who will be employed by local Councils for Voluntary Services using the Invest-to-Save grant. Any future roll-out of the approach will depend on the findings from the development phase.

**Psychiatric liaison services in acute and community hospitals**

There is evidence supporting the value of liaison services.

We will aim to develop a service specification for delivering psychiatric liaison in both acute and community hospitals (in Accident and Emergency, medical assessment units and on the wards), working on:

- Appropriate admissions
- Assessment
- Discharge planning processes
- Staff training.

We will further develop the existing acute and community hospital work group that informed the development of this commissioning strategy and establish a Hampshire wide network that supports shared learning, delivery of good practice and implementation of service improvements.

**Discharge from hospital**

Hampshire County Council and Hampshire Primary Care Trust are currently reviewing hospital discharge pathways in light of developments in the health service that facilitate shorter lengths of stay, as it is thought that this has resulted in decisions about an individual’s long-term care being taken earlier in the patient pathway, which has led to an unnecessary rise in the number of patients being admitted to long-term care directly from hospital.

Hampshire Adult Services and Hampshire Primary Care Trust will work with their NHS partners to review the discharge pathway for older people with mental health problems, including options for longer periods of assessment, recovery and rehabilitation that allow the individual and their family and carers to make timely and informed decisions about future long-term care.

**Care in nursing and residential homes**

We will maximise opportunities in the current training programme for staff in private and voluntary sector domiciliary, residential and nursing homes to learn about the care of older people with mental health problems.

From the mapping work and pilot work that has been undertaken across Hampshire, we will need to review what additional support nursing and care homes may need.
5.3.4 Phase/level 4 - 24hr supervision and support for dementia; treatment-resistant, recurrent, atypical and psychotic depression, unstable psychosis and those at significant risk

Day opportunities
As part of the Hampshire strategy for day opportunities, we will develop a specification for day opportunities specifically targeted at specialist dementia care.

Day hospitals
Day hospital provision within Hampshire Partnership NHS Trust will be remodelled to maximise linkages with memory assessment and treatment services and improve the therapeutic basis with clear outcome based programmes. The aim is to provide services close to the individual’s home, enable access to other social care services where needed and be responsive to an individual’s changing needs. Work with the voluntary sector will provide part of the support systems that people will need and information and teaching will be core elements of future provision.

Respite services
We are committed to the provision of a range of quality, flexible and locally based respite services that offer real support to individuals in the community. We will continue to listen to user views and build an appropriate range of support to meet needs. This may include a range of support including residential respite, day opportunities and also respite in the individual’s own home.

We will develop a flexible specification for new emergency respite services linked to the Hampshire Carers’ Strategy work, which also includes the review of current respite availability and service models and will identify options for the future. Funds made available under the New Deal for Carers for emergency respite will be overseen by the Hampshire Carers’ Strategy. The early thinking is to focus on out of hours respite services.

Health and social care working in primary care
Integration of specialist mental health care services with primary care and social care services will be key to early detection and treatment to prevent rapid deterioration and maintain independence.

We will develop a service specification to define the social care team deliverables for older people with mental health problems through:
1. a generic social care rapid response function via a single point of access; this will include access to specialist expertise as required at the earliest point of contact
2. community social care support teams working with generic primary care teams and health care specialists who support long term conditions, including older people’s specialist mental health teams.

We will commission integrated working between specialist mental health and community social care teams for:
- functional mental illness
- dementia.
All areas will meet the agreed standards for integrated working between social care and specialist mental health services – see Appendix 4. We will further develop integrated specialist and social care working by developing joint assessment processes. The pilot sites for integrated social care and specialist mental health working will continue to be introduced through a staged approach, initially in two sites: New Forest and Andover.

A job specification for a Consultant Social Worker role has been developed and we will further consider the development of this role in older people’s mental health services.

**Extra Care Sheltered housing**

We will commission a service specification for Extra Care Sheltered housing that will provide affordable social housing for older people, including those with mental health needs. The Extra Care Sheltered housing strategy aims to deliver 400 new apartments over the next 5 years.

Generic criteria for Extra Care Sheltered housing:
- the building is fully accessible
- 24 hour care is available.

In partnership with colleagues in district councils and the Housing Corporation, we will commission a new generation of housing care and support services for older people that will be appropriate for older people with mental health needs. The first four new build Extra care schemes will be in Gosport, Basingstoke, Calmore and Test Valley and the apartments will open from 2009/10 onwards.

**Self directed support**

Hampshire County Council has, along with nine other local authorities in the country, been chosen as an “In Control” site. In Control’s vision is that Self Directed Support will change the organisation of social care in England, so that people who need support can take more control of their own lives and fulfill their role as full citizens: the complete transformation of social care into a system of Self-Directed Support.

We are currently developing a project plan which will detail how Self Directed Support will be implemented across Hampshire. We are consulting with a wide range of service user groups and service providers on how we take account of stakeholders’ views when implementing Self Directed Support in Hampshire.

Self Directed Support will mean more varied and flexible responses to meet an individual’s care and support needs. This will increasingly be the case for older people with mental health needs and their carers, as we look to implement Self Directed Support across Hampshire.
5.3.5 Phase 5/level 5 critical level of need; risk to life/severe self neglect

Care at end of life
We will make sure that older people with mental health problems are included in the work of the Care at End of Life Hampshire Health Overview and Scrutiny Committee Review Project. Care plans for older people with mental health problems at the end of life will be available to out of hours services to avoid unnecessary hospital admissions.

A national strategy on end of life care is due shortly and is expected to include specific reference to end of life care for people with dementia.

5.3.6 Further areas for development
There are several key areas that we will look to work on as the strategy develops, including:
- Generic advocacy services (i.e. not only the Independent Mental Capacity Advocacy service)
- Review of the Hampshire Care Homes Strategy for People with Dementia
- Workforce issues
Chapter 7
Governance Arrangements

Hampshire County Council Adult Services and Hampshire Primary Care Trust are committed to working together to commission older people’s mental health services.

Further discussions will be necessary regarding the governance arrangements to support implementation of this strategy, to ensure that they are robust and aligned with other whole system planning and emerging joint governance processes. In the meantime, the multi-agency Steering Group will continue to oversee development of this strategy and will progress these commissioning intentions.

The Steering Group has representation from Hampshire County Council Adult Services, Hampshire Primary Care Trust, Hampshire Partnerships NHS Trust, Surrey and Borders NHS Partnership Trust and the Alzheimer’s Society. The Steering group will meet regularly and report to the Management Board of Hampshire Primary Care Trust and Adult Services Departmental Management Team.

As partners to this strategy, both Hampshire Primary Care Trust and Hampshire Adult Services will be responsible for implementation and delivery of this strategy. We will jointly monitor outcomes and standards for services using agreed measures of performance. Performance indicators that reflect the phases and levels of the care pathways for dementia and functional mental illness are proposed – see Appendix 4 – and these will be reviewed in light of any changes in the national performance management framework.

Acute Trusts/Foundation Trusts and Primary Care Trust Care Services are invited to join the Acute and Community Hospital Experience Work Group, which will support implementation of this strategy and which reports to the Steering Group.
## Chapter 8
### Summary Table of Proposed Early Priorities

<table>
<thead>
<tr>
<th>Strategic Priority</th>
<th>Proposed Actions</th>
<th>Responsible organisation</th>
<th>Work to commence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Supporting carers - so that so that they themselves are enabled to provide care and support and are actively involved in planning care for the older person with mental health problems.</td>
<td>With the support of the Carers’ Stakeholder Group and the Care Services Improvement Partnership, we will work closely with carers, users and the voluntary sector to develop specific information resources about available community based support.</td>
<td>HCCAS and HPCT</td>
<td>2008/09</td>
</tr>
<tr>
<td></td>
<td>The contact centre for all social care referrals will be established, which will provide a one-stop shop for advice and information.</td>
<td>HCCAS</td>
<td>2008/09</td>
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<td>We will develop a flexible specification for new emergency respite services linked to the Hampshire Carers’ Strategy work, which also includes the review of current respite availability and service models and will identify options for the future.</td>
<td>HCCAS</td>
<td>2008/09</td>
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<tr>
<td></td>
<td>We will aim to support older people with mental health problems and their carers to understand and take their medication.</td>
<td>HPCT</td>
<td>2008/09</td>
</tr>
</tbody>
</table>

Key: HCCAS - Hampshire County Council Adult Services, HPCT - Hampshire Primary Care Trust
2. Prevention and access to universal well-being services - so that individuals can maintain their independence and live as “normal” a life as possible for as long as possible.

<table>
<thead>
<tr>
<th>Description</th>
<th>Responsible Body</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Hampshire Older People’s Well-being Strategy is being produced and local well-being plans developed in a number of areas around the county. Specific programmes such as the older person’s area link worker project and the gardening strategy are underway. The well-being programmes will continue to expand to support older people’s mental health.</td>
<td>Hampshire County Council</td>
<td>2007/08</td>
</tr>
<tr>
<td>People will be encouraged and enabled to continue accessing and pursuing universal services for their usual activities and hobbies, for example, the local choir, gardening clubs, the Women's Institute.</td>
<td>HCCAS</td>
<td>2008/09</td>
</tr>
<tr>
<td>The Community Innovations Teams will be expanded to include Community Development Workers, who will be employed by local Councils for Voluntary Services using the Invest-to-Save grant.</td>
<td>HCCAS</td>
<td>2008/09</td>
</tr>
<tr>
<td>In partnership with colleagues in district councils and the Housing Corporation, Hampshire County Council will commission a new generation of housing care and support services for older people that will be appropriate for older people with mental health needs. The first four schemes are already being planned.</td>
<td>HCCAS</td>
<td>2008/09</td>
</tr>
<tr>
<td>We will seek to promote awareness amongst the general public and professionals in all settings about dementia and depression in old age and messages about maintaining good health. We will build on the higher profile gained through consultation on this strategy to assess current activities, information campaigns, training and education available and develop a local plan.</td>
<td>HCCAS and HPCT</td>
<td>2008/09</td>
</tr>
</tbody>
</table>

Key: HCCAS - Hampshire County Council Adult Services, HPCT - Hampshire Primary Care Trust
### 3. Balancing specialist and generic services – through skilling up mainstream staff, removing barriers to services and gaining clarity on the respective roles and functions of specialist mental health and mainstream services, so that the majority of mild and moderate severity mental health needs can be managed in mainstream settings.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Responsible Bodies</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>A joint Hampshire Primary Care Trust and Hampshire County Council primary care mental health strategy is being developed, which aims to enable the primary and community care team to provide improved support for those with mild to moderate mental illness.</td>
<td>HPCT and HCCAS</td>
<td>2007/08</td>
</tr>
<tr>
<td>The current guidelines and pathways for referral and initial assessment will be reviewed jointly between GPs and specialist mental health clinicians, so that trigger symptoms can be consistently recognised and community-based support resources can be more easily accessed via primary care.</td>
<td>HPCT</td>
<td>2008/09</td>
</tr>
<tr>
<td>We will work towards developing a specification for memory services to provide: early diagnosis, specialist assessment, information and support, memory matters that will be available in all areas. Day hospital provision within Hampshire Partnership NHS Trust will be remodelled to maximise linkages with memory assessment and treatment services and improve the therapeutic basis with clear outcome based programmes.</td>
<td>HPCT</td>
<td>2007/08 - Day Hospitals</td>
</tr>
<tr>
<td>As part of the Hampshire strategy for day opportunities, we will develop a specification for day opportunities specifically targeted at specialist dementia care.</td>
<td>HCCAS</td>
<td>2008/09</td>
</tr>
<tr>
<td>We will work towards developing a broad training strategy for health, social care, voluntary and independent sectors to support all phases of dementia and functional mental illness pathways, linking with the Sector Skills Councils.</td>
<td>HCCAS and HPCT</td>
<td>2008/09</td>
</tr>
</tbody>
</table>
| We will develop a service specification to define the social care team deliverables for older people with mental health problems through:  
  - a generic social care rapid response function via a single point of access  
  - community social care support teams working with generic primary care teams and specialists who support long term conditions, including specialist older people’s mental health teams.  
The pilot sites for integrated social care and specialist mental health working will continue to be introduced, initially through a staged approach in two sites: New Forest and Andover. | HCC                | 2008/09     |
| We will seek to promote equity of access based on individual and population needs and based on the best available evidence of effectiveness to:  
  - the whole range of mental health services across working age and older people’s services for people with a functional mental illness  
  - all current generic older people’s community support services. | HPCT and HCCAS     | 2008/09     |
### 4. Pathways in and out of hospital - so unnecessary admissions are avoided and the older person with mental health problems receives timely and appropriate care in response to their individual needs while in hospital and the focus is on maintaining independence on discharge.

<table>
<thead>
<tr>
<th>Description</th>
<th>Responsible Bodies</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working with our NHS partners, we will review the discharge pathway for older people with mental health problems, including options for longer periods of assessment, recovery and rehabilitation that allow the individual and their family and carers to make timely and informed decisions about future long-term care. The aim will be to reduce the length of stay in hospital and strengthen links between primary care and acute and community hospitals.</td>
<td>HCCAS and HPCT</td>
<td>2007/08</td>
</tr>
<tr>
<td>We will aim to develop a service specification for psychiatric liaison working in acute and community hospitals, based on good practice, which will reflect the needs led care pathways and address the identified key areas for attention.</td>
<td>HPCT</td>
<td>2008/09</td>
</tr>
<tr>
<td>We will undertake a “Balance of Care” project approach across Hampshire to identify the costs of unnecessary bed usage in acute and community hospitals, residential and nursing homes and to identify appropriate alternatives to hospital for people with dementia.</td>
<td>HCCAS and HPCT</td>
<td>2008/09</td>
</tr>
<tr>
<td>Telecare can help older people with mental health difficulties to remain living independently in their own home and can be used in a variety of ways to help improve confidence and minimise risk. It can also provide peace of mind to carers and family members. We will jointly look at ways that Telecare can help keep people in the community.</td>
<td>HCCAS and HPCT</td>
<td>2007/08</td>
</tr>
</tbody>
</table>
| We will seek to develop a specification and plan for crisis response with providers that works towards enabling:  
  - access to current working age adult health and social care crisis services for older people with functional mental illness  
  - access to primary care and social care crisis response services for people with dementia.  
We will work with our partners (out of hours services, NHS Direct and ambulance services) to develop an emergency care pathway for older people with mental health problems. | HCCAS and HPCT           | 2008/09|
| We will be reviewing falls services across Hampshire and will include older people’s mental health within the scope of this work. | HPCT and HCCAS           | 2008/09|

Key: HCCAS - Hampshire County Council Adult Services, HPCT - Hampshire Primary Care Trust
5. Mechanisms to enable organisations and individuals to work together towards shared goals – so that shared governance arrangements support delivery of the joint strategy

<table>
<thead>
<tr>
<th>Description</th>
<th>HCCAS and HPCT</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>We will establish a joint implementation group to oversee and take forward our commissioning intentions.</td>
<td>HCCAS and HPCT</td>
<td>2007/08</td>
</tr>
<tr>
<td>We will map the total joint resources for older people’s mental health to identify the envelope of funds and enable maximisation of available resources through identification of gaps and areas of duplication or inefficiency.</td>
<td>HCCAS and HPCT</td>
<td>2007/08</td>
</tr>
<tr>
<td>Jointly monitor outcomes and standards for services using agreed measures of performance, which reflect the phases and levels of the care pathways and which will be kept under review.</td>
<td>HCCAS and HPCT</td>
<td>2008/09</td>
</tr>
</tbody>
</table>

Key: HCCAS - Hampshire County Council Adult Services, HPCT - Hampshire Primary Care Trust
1. Everybody’s Business: Integrated mental health services for older people Department of Health and Care Services Improvement Partnership (2005)
3. Dementia UK - A report to the Alzheimer’s Society on the prevalence and economic cost of dementia in the UK produced by King’s College London and London School of Economics (2007)
6. Improving services and support for older people with mental health problems Second report from UK Inquiry into Mental Health and Well-Being in later Life (2007)
7. Our Health, Our Care, Our Say: a new direction for community services Department of Health (2006)
11. Improving services and support for people with dementia National Audit Office (2007)
12. In Hampshire we can only offer community care support to meet needs that are defined as “critical or substantial”, as derived from the Government’s Fair Access to Care Services guidance. Most of Adult Services resources are therefore likely to be targeted at Phase 4 level needs. For more information on eligibility criteria for Adult Services please see the leaflet “Who Can Get Help from Adult Services” available at http://www3.hants.gov.uk/who-can-get-help-from-adult-services-2.pdf