Surrey Heartlands and East Surrey Dementia Strategy

Local Priorities and Action Plan for
Surrey Downs Clinical Commissioning Group

Our Surrey Heartlands and East Surrey Dementia strategy proposes a whole-system pathway with 5 inter-dependent component parts that together describe the journey that individuals and their carers may experience, together with the overarching concept of LIVING WELL within dementia friendly communities. The table below demonstrates how Surrey Downs CCG and Adult Social Care in conjunction with partners plan to deliver these components in the context of the strategy.				
Key Component	**Objectives**	**High Level Actions (current/proposed)**	**Timescale to be implemented**	**Required outcome**
1. Living well in dementia friendly communities	• **People with dementia and their carers to have greater choice and access to personalised services by building range of high-quality, responsive support services.** • **Dementia (diagnosis and post diagnostic support) is an important part of the STP Mental Health Workstream so that it is part of the transformation process.**	• **Working towards a more joined up IT system and piloting the Mental Health Practitioners based in Community HUBs accessing EMIS (GP Case Management System) to improve information and increase rate of dementia diagnosis.** • **Promoting a Dementia Friendly Surrey in future planning of other services, for example, district nursing via partnership boards and led by the voluntary sector (i.e. third sector).** • **Inclusion of dementia services in STP work programme and local actions are included in future changes in services.**	**2017/18**	**A wrap around service for people with dementia and their carers so that their needs are met is a seamless manner.**
2. Preventing well	• **Improve awareness and understanding of dementia by the public and professionals, reduce stigma and improve recognition of dementia and ways to seek help.** • **Reduce risk of developing dementia by promotion of healthy living and reduction of associated risk factors.** • **Empower people with dementia and their carers to have an active role in developing support and services that enable them to live well.**	• **Develop a preventative approach – develop a local preventative action plan in partnership with Public health.** • **Reduce prevalence of long term conditions through action on leading causes (e.g. focus on weight & physical activity, alcohol control/high risk drinking & smoking, diabetes and hypertension)** • **Promotion of NHS Health Checks.** • **Continued provision of awareness and lifestyle intervention programmes.**	**2017/2018**	**More joined up working with Public Health Colleagues and more seamless pathways of care for people with dementia and carers.** **Local people are supported to live healthier lifestyles. People will maintain independence and a good quality of life for longer post dementia diagnosis.**
3. Diagnosing well	• **The process of referral to diagnosis will not be longer than 8 weeks duration.** • **Services users will receive good information about what to do next when they receive a diagnosis and understand**	• **Working with Service Providers to improve data collection regarding time to diagnosis and how many patients they have diagnosed year to date. More detailed data has been requested in the contract for 2017/2019. Agree a target with providers for time to diagnosis.**	**2017/2018**	**Time taken to diagnose dementia is reduced so that correct treatment and care planning can be provided as soon as possible.**

	what services are available to them and their family. • **Increase the diagnosis rate and reach the national target of 67.6%. Surrey Downs CCG rate of dementia diagnosis is 64.5% in March 2017.** • **The patient journey will be more efficient when further tests are required to complete a dementia diagnosis, i.e. ECGs**	• **Dementia Navigator Service – extended Dementia navigator contract (with Alzheimer's society)** • **Screening of patients for dementia in Community Hubs by Psychiatric Nurses (Mental Health Professionals) based in the Hubs.** • **Surrey and Borders Partnership NHS Trust (SABP) will have direct access to Epsom Hospital for Surrey Downs patients who require an ECG.**		**Accessible information for service users and families.** **Screening for dementia is increased in the community and the national target (67.6%) is reached.** **More efficient use of resources and easier for patients to receive an ECG and SABP to order the investigation.**
4. Supporting well	• **Local commissioning intentions (e.g. grant allocation) will request providers to evidence more joined up working for the welfare of people with dementia before funding is granted.** • **Access to information for people with dementia and families/carers is of good quality and easy to obtain.** • **Facilitate market development to increase availability of services that offer flexible day care opportunities for people with dementia and their carers.** • **Carers/families and people with dementia will have access for free counselling services to manage their mental health.** • **Carers will be supported in their role and the risk of carer breakdown will be reduced.** • **Maximise use of technology to support people with dementia and their carers.** • **People have access to home based care appropriate to their needs when required.**	• **Future commissioning decisions are based on evidence of joined up working by providers when bidding for grant payments from the CCG** • **Dementia Navigator Service – extended Dementia navigator contract (with Alzheimer's society).** • **Create a joint framework (Health & Social Care) for dementia care in the community to ensure that the spot purchase of services is of good quality and provided by a group of qualified providers.** • **IAPT (Free Counselling Services) providers and services for people with dementia will work more closely together to support service users. Providers will attend local providers meetings and evidence how they are working more effectively together. The number of carers accessing IAPT will increase.** • **Carer's assessments are included in the pathways for dementia care. Recruit a carers representative to inform providers and commissioners on future service design and strategy.** • **Make best use of Technology Enabled Care Services (TECS) and maximise opportunities to include them in local commissioning activities.** • **This is aligned with/part of the work on digital roadmaps and strategy with the NHS and STP.** • **Use the information from the Local Authority Domiciliary Care review to align with future CCG commissioning plans and have a collective focus of maintaining independence in the home of people with dementia.**	**2017/2018**	**The Local Health Economy reflects the needs of people with dementia as well as their carers.** **Access to information to improve times to interventions.** **Increase the range and quality of services available in the community.** **Increase in access and recovery for people using IAPT who are caring for someone with dementia.** **Co design of future services by stakeholders will facilitate the creation of services that meet the needs of services users and carers.** **Increasing the use of technology to improve patient care.** **People can live independently in their own homes instead of admission to a Care Home if they wish to do so.**

5. Dying well	• **People with dementia and their families will have a real choice where to receive end of life care. Where appropriate all new strategies, frameworks and models of care will include EOLC considerations**	• **Update pathway and highlight ways to reduce unnecessary admissions to hospital for people with dementia using the Rightcare packs. Ensure Surrey Downs CCG integrated EOLC strategy includes dementia.**	**Aug 2017**	**People with dementia have end of life care plans that reflect their wishes and feeling. Unnecessary Hospital admissions are avoided.**