SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	01
Service	Memory Support Service
Commissioner Lead	Jane Barnes, Commissioning and Redesign Manager, North Staffordshire and Stoke on Trent CCGs
Provider Lead	Kumbi Mandinyenya, Area Manager, Alzheimer's Society
Period	1st April 2019 – 31st March 2022
Date of Review	April 2021

1. Population Needs

1.1 National/local context and evidence base

Dementia is a term used to describe a syndrome that may be caused by a number of illnesses in which there is progressive decline in multiple areas of function, including decline in memory, reasoning, communications skills and the ability to carry out daily activities. Alzheimer's disease is the most common type of dementia, with other types of dementia including vascular dementia, dementia with Lewy bodies and frontotemporal dementia. Although dementia is predominately a disorder of later life, there are at least 15,000 people in the UK under the age of 65 who have the disease.

The National Dementia Strategy (DH 2009) highlights the scale of the challenge that dementia presents to society. This was further built on in the Prime Minister's challenge 2020 which was building on the progress from the first Challenge issued in 2012. This document aims to make England the best country in the world for dementia care, support, research and awareness.

It is estimated that there are around 670,000 people in England with dementia. However, because of longer life expectancy this number is expected to double by 2035. It is estimated that dementia costs the English economy approximately £26 billion every year and is set to increase.

NHS England's Transformational Framework – the Well Pathway for Dementia follows a patient's pathway through dementia and discusses diagnosing patients well supporting patients well, living well and dying well with dementia. Both CCG's are diagnosing well but there is further work to do on the rest of the pathway.

By 2020 there are National plans to establish an evidence based treatment pathway for dementia. The pathway will have two strands, the first of which is a standard that recommends that by 2020, 85% of people with suspected dementia who are referred to a memory assessment service receive a diagnosis and start treatment within 6 weeks of referral (starting treatment means that the person has met with a named service provider and that an initial care plan of NICE-recommended treatment for dementia has been agreed).

The second pathway standard recommends that a person living with dementia receives NICE-recommended support for a minimum of a year (support means that the initial care plan, agreed in the first pathway, has been reviewed by the named service provider as the person's needs dictate, but at least once within 12 months of it first being agreed. Revisions should be jointly developed and agreed with the person living with dementia, and, if applicable, their

carer). This is clarified in the Implementation guide and resource pack for dementia care which details the care co-ordinators role and also the NHS England Dementia: Good Care Planning guide.

The CCG Improvement and Assessment Framework (IAF) for 2017/18 contains the following indicators that the CCG's are assessed again.

- Estimated diagnosis rate for people with dementia
- Dementia care planning and post-diagnostic support
- Age standardised rate of emergency inpatient hospital admissions of people (65+) with a mention of dementia per 100,000 resident population *
- Percentage of emergency inpatient admission for people (65+) with dementia that are short stays (1 night or less) *
- Percentage of deaths of people aged 65+ with a recorded mention of dementia occurring in a hospital *
- Emergency readmissions to hospital within 30 days of discharge for people (aged 65+) with dementia *
- People aged 65 and over receiving prescriptions for antipsychotic medicines *

Local context

The local Joint Stoke-on-Trent Dementia Strategy – "Living well with Dementia: Stoke-on-Trent Joint Dementia Strategy 2015-2019 was written by the CCG and Stoke-on-Trent City Council. The Council facilitated a large consultation exercise with the residents of Stoke-on-Trent and it outlines the priorities that came out of the consultation.

- Priority 1 – Spread the message of living well – improve professional and public awareness of dementia
- Priority 2 – Timely diagnosis and support – for people to receive a diagnosis in the right way, at the right time, with access to the right support
- Priority 3 – Enable people to live well with dementia – access to high quality, personalised support for both the person with dementia and their carers'.

Dementia prevalence is rising locally; subsequently the number of people requiring post diagnosis support is increasing. The table details how the dementia prevalence rates are changing across Northern Staffordshire.

	North Staffordshire	**Stoke-on-Trent**	**Total**
2016/17	2920	2718	5638
2017/18	2897	3007	5904
2018/19	2970	3062	6032

The numbers of patients diagnosed with mild cognitive impairment (MCI) are increasing. At the end of March 2018 there were 444 patients registered with GP's in North Staffordshire and 448 in Stoke-on-Trent.

Improvements to support patients and carers were made in 2015/16 through the introduction of the Dementia Primary Care Liaison Team providing support in the community for stable patients. However, in light of the complex needs of carers, and the additional IAF indicators,

there is a need to strengthen the support currently provided through the Dementia Advisory Service and going forward the service will be known as the Memory Support Service as detailed in this specification.

Current diagnosis rates at the end of May 2018 for North Staffordshire are 73.3% (2166 patients) and Stoke-on-Trent 82.4% (2500 patients). NHS Digital estimate that there should be 5988 patients diagnosed across the patch. The National target is 66.7% of patients diagnosed over 65.

It is felt across Northern Staffordshire that there should never be a "dementia crisis" if patients and carers are supported well.

The North Staffordshire Carers Association were funded in 2015-17 to carry out a pilot amongst dementia carers. The evaluation of the project highlights gaps in service especially around being able to provide individual support to carers when it is required either:-

- Following diagnosis to enable carers to receive the support they require with finances, coping with caring, signposting to support that is available, etc
- During times of escalation of symptoms when the support for carers needs to be revised.

From the pilot, it was agreed that separate patient and carer pathways were required to identify the support available and identify gaps.

Through this pilot and consultation carried out during the formulation of the joint local Dementia Strategy 2015-19 and the formulation of this service specification. It is clear that the focus of this service needs to move to supporting carers in this way the patient is empowered to live well with dementia and remains supported and able to live in the least restrictive environment.

There is also a need to promote awareness and information to the public.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	✓
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	

2.2 Local defined outcomes

It is anticipated that the Memory Support Service will support both dementia patients, carers and their families along the dementia wellness pathway ensuring that they are living well with dementia. Supporting professionals to minimise dementia "crisis" including avoidable admissions to hospital and supporting with early discharge when a patient is admitted. Early access to support services is essential.

3. Scope

3.1 Aims and objectives of service

The aim of the Memory Support Service is to be the main point of contact (through a named service provider) and provide appropriate emotional support, practical guidance and information to meet the needs of those with dementia as well as facilitating access to well-being interventions which promote independence and quality of life. The transformational well pathway for dementia from NHS England sets out a framework on which to base the aims and objectives of this service.

Preventing Well

- Organising and co-ordinating awareness raising events across Northern Staffordshire.
- Hosting an up to date website with links to relevant organisations and information for the public and professionals.
- Links into health checks around the dementia element.
- Strong links with primary care to facilitate support to patients and carers.
- Service to help to assist avoidable admissions to hospital.

Diagnosing Well

- Allocated named co-ordinator for each patient diagnosed with dementia and their carer.
- Information available in all memory clinics where a diagnosis of dementia is made and availability of staff at the majority of post diagnostic clinics.
- Newly diagnosed patients will be referred to the memory support service unless the patient refuses. Contact can be made with the service at follow up clinics (both within secondary and primary care) to book an appointment or drop in if more support is required.
- Role in facilitating the completion of a care plan in line with NHS England Dementia – Good care planning and the dementia passport.

Supporting Well

- Appropriate levels of training for carers dependent on the severity of dementia to support understanding of the progression of the disease.
- Facilitate drop in clinics where no appointment is necessary.
- Refer carer to Carers Hub for assessment and provide 1:1 support initially to ensure all issues are resolved satisfactorily.
- Encourage and support carers to maintain their current hobbies and support network outside of their dementia carer role.
- Signpost and refer accordingly with support to access services if required.
- Support patients and carers to discuss and complete end of life wishes in dementia passport.
- Where appropriate assist with facilitating safe discharge from hospital.

Living Well

- Support both patients and carer to access community and existing networks – using buddies or providing support to facilitate this.

- Facilitate identifying issues leading to deterioration and work with agencies to ensure a timely and pro-active response.

Dying Well

- Supporting patient to die in preferred place.

- Supporting carer through later stages working with the Dementia Admiral Nurse and Dementia Primary Care service.

- Support carer following death to move on from the careering role by building network and interests outside of dementia – links with the carers hub.

The successful provider will be expected to take part in quarterly meetings with all service providers from the dementia pathway and commissioners to further develop the service to provide seamless support to patients and carers.

3.2 Service description/care pathway

The service is required to be proactive in nature, reaching out to people who are diagnosed with dementia and reassuring them that they are "not alone" on the dementia journey. Each patient and carer will receive a named co-ordinator of their care.

The service will provide continuity of practical and emotional support, and information to people with dementia and their family carers, in a timely and responsive way, which meets their individual needs and preferences.

The service will continue to develop in line with any future dementia guidance issued

The service will:

- Work closely with the memory clinic at the point of diagnosis to help the person with dementia and their family to understand the diagnosis and its implications.

- The named service provider should contact the patient and/or appropriate carer within 1 – 2 weeks of being informed of their diagnosis of dementia and/or review.

- Arrange the first contact within 10 working days of initial referral in order to start to develop relationships with the family and work as part of a multi-agency approach to dementia care facilitating co-ordinated care and support of the person with dementia, their carer and family. To utilise the dementia passport to stimulate conversations with the patient diagnosed and their carers. This should include conversations around end of life support.

- Develop and maintain a website which contains information (such as useful tips for carers etc) and links to relevant information.

- Refer carers to the carers hub for assessment and carry out a financial health check for the patient.

- Provide a drop in service (one stop shop) at set times for carers to provide 1-1 support.

- Act as a Dementia Champion to initiate and sustain the involvement of other agencies with the patient's/carers consent to ensure the best support is in place and service capacity is maximised.

- Act as a facilitator to help the family identify appropriate interventions available in the area where meaningful activities would meet the needs of the individual.

- Raise awareness and network with groups and services in order to provide holistic care and support the family promoting independence and quality of life.

- Be with the person with dementia and the family along their pathway, proactively contacting them on a regular basis dependent on their need but at least annually.

- Attend and provide information as required at MCP meetings as they develop through the CCG areas.

- The service provider will have the technical capacity and necessary data sharing protocols, permissions and security arrangements to fully participate in information sharing with statutory and non-statutory bodies as required throughout the duration of the contract.

- Fulfil the care co-ordinator role as described in the Implementation guide.

Service Location and Delivery

It is expected that the service will be delivered from a number of locations to serve the population of Northern Staffordshire. It is also expected that there will be a local presence within Northern Staffordshire that people can associate this as a local service. **Days/hours of operation**

The memory support service will ensure appropriate and flexible access according to the needs of the individuals, which will mainly be available Monday to Friday 9 – 5 but a degree of flexibility will be required to provide service out of normal working hours on a weekend and evenings as required.

Referrals

The Memory Support Service will be an opt out service and all patients already diagnosed and newly diagnosed will expect to be contacted by the service unless otherwise indicated.

Referral Source

Referrals for diagnosed patients will be from the memory clinic through electronic referral. Existing patients and carers will be from the database of patients already receiving support from the current provider of the service.

Referrals will be accepted from all sources including GPs primary care staff, care home staff, hospital therapy and discharge teams, CCG care home pharmacist and other community health ,social care professionals and self referrals. The introduction of a prescription style tear off pad describing the service with contact details will be put into place by the service provider for all referrers to the service.

Service Response Times

In order to minimise “dementia crisis” it is important that the service responds to patients and carers in a timely manner.

Follow Up

The Memory Support Service will:

- Provide a brief summary/letter to the patients GP surgery/practice outlining assessment, intervention and arrangements for on-going support. .

- Contact the patient/carer at least annually if there has been no contact throughout the year.

Care Pathways

To support the needs of people with dementia and their carers, pathways will be developed that are supportive of best practice, deliver care that is person-centered, tailored to individual needs and considerate of the wider social context in which the individual lives.

Workforce

It is expected that potential providers will indicate the number of staff to be deployed to deliver the service across the two CCG's. This should be at a level that assures service quality and meets contract performance indicators. It is expected that all staff are culturally competent and the service provider can demonstrate how this is achieved and maintained.

It is expected that potential providers will indicate the number of volunteers to be deployed during the contract.

It is expected that the workforce will be suitably trained according to the levels described in the West Midlands Dementia Skills Framework.

Clinical and General Supervision

The service provider will ensure that appropriate arrangements are in place to provide sufficient levels of supervision and support to staff. These arrangements will need to be consistent with identified best practice across the range of specialties within the team.

3.3 Population covered

The Memory Support Service will be provided to people of any age who are residents of Northern Staffordshire and are registered with a North Staffordshire or Stoke-on-Trent GP.

3.4 Any acceptance and exclusion criteria and thresholds

The Service will provide support to people pre and post dementia diagnosis.

3.5 Interdependence with other services/providers

The key relationship for the Service is with General Practitioners, MCP's, Dementia Primary Care Liaison Team, Memory Clinic, Dementia Admiral Nurse and other voluntary sector services.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

The Service shall ensure that it adheres to relevant national standards of best practice in dementia care, to the most recent NICE guidance and other reliable sources of evidence, for example:

- DOH 2006, NICE Clinical Guideline 42 Supporting People with Dementia and their Carers in Health and Social Care
- National Institute for Clinical Excellence (2001) Guidance on the use of Donepezil, Rivastigmine and Galantamine for the Treatment of Alzheimer's Disease. No 19. London: NICE
- NICE Quality Standard 30 on supporting people to live well with dementia (QS30).
- NICE Dementia Pathway
- NHS Implementation guide and resource pack for dementia care
- NHS England Dementia: Good Care and Planning.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

Royal College of Nursing https://www.rcn.org.uk/clinical-topics/dementia/professional-resources

Joint Commissioning Panel for Mental Health http://www.jcpmh.info/good-services/dementia-services/

4.3 Applicable local standards

Stoke on Trent Best practice in the clinical management of Dementia in general practice, 2011

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-C)

5.2 Applicable CQUIN goals (See Schedule 4D)

6. Location of Provider Premises

The Provider's Premises are located at:

Alzheimer's Society
The Coach House
Main Road
Ombersley
WR9 0EW

7. Individual Service User Placement

N/A