SCHEDULE 2 – THE SERVICES

A. Service Specifications (B1)

Mandatory headings 1-4. Mandatory but detail for local determination and agreement
Optional heading 5-7.Optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

Service Specification No.	05_MHDL_0039
Service	Memory Support & Advisory Service- part of the Memory Gateway
Commissioner Lead	MHLD
Provider Lead	*TBA*
Period	1 September 2014 to 31 August 2017, with possible extension for further 2 years
Date of Review	*Initial review after six months*

1. Population Needs

National/local context and evidence base

"Living Well with Dementia" : The National Dementia Strategy aims to ensure that significant improvements are made to dementia services across key areas to:

- improve awareness in the community and across health and social care services get an early diagnosis, followed by evidence based treatment and intervention;
- deliver higher quality of care to enable people to live well with dementia
- ensuring improved awareness through effective advice and support around dementia;
- removing the stigma that still surrounds it;
- consistently improving the delivery of education and training for professionals at all levels and in all settings;
- to develop and commission a range of services for people with dementia and their carers which fully meet their changing needs over time, within an agreed funding package.

Pan Dorset Context

The improvement of services for people in Bournemouth, Poole and Dorset to "Live Well with Dementia" is a top priority for NHS Dorset Clinical Commissioning Group. The table overleaf details the demographics for the local population.

Authority	Total Population	Aged 65+	% Aged 65+
Bournemouth Unitary Authority	186,700	33,233	18%
Poole Unitary Authority	148,600	31,503	21%
Dorset County Council	414,900	109,119	26%
Total Dorset	750,200	173,855	23%
Source: Office for National Statistics (ONS) 2012 Mid-Year Estimates			

The recently published quality and outcomes framework (QOF) data from GP practices for 2012/13 provided an update for the number of people with a formal diagnosis. As at 31 March 2013, the diagnosis rate across the county was 45% but there are variances within the three major localities.

- Bournemouth had the highest diagnosis rate with 55% of those estimated to have dementia receiving a formal diagnosis.
- The rate in Poole was slightly lower at 46%.
- Dorset's rate was the lowest at 40% although this was up from 32% which was reported nationally in 2012 by Alzheimer's UK. Dorset remains the area that requires most input across the Dorset Clinical Commissioning Group (CCG).

The local target for the dementia diagnosis rate for 31 March 2014 is 50%. The CCG has to meet the national target of 67% by 31 March 2015. This will drive the number of people with a diagnosis of dementia who requires support and advice and their carers.

The CCG estimate that they will reach between 52-54% diagnosis rate by end March 2014 and there is a strong indication that the 50% target was met as at end November 2013, although this has not been substantiated.

The following table sets out the increases by District / Local Authority Area from the last substantiated diagnosis figure which was end March 2013:

Estimating increases in local diagnosis rates for dementia.

Crude estimates based on recent QOF data for Dorset; Dementia Prevalence Calculator, 2013; and ONS population projections. Rate refers to the proportion of people with a diagnosis as a percentage of all those estimated to have dementia based on Dementia UK Report (2007)

	Current Picture - QOF 12/13		Future rates based on local targets. March 2015	
	Diagnosis	Rate	Diagnosis	Rate
Dorset CCG	6,187	45%	9,572	67%
Bournemouth	1,852	55%	2,348	67%
Poole	1,247	46%	1,684	67%
Dorset	3,088	40%	5,343	67%
- Christchurch	499	42%	741	67%
- East Dorset	590	37%	1,006	67%
- North Dorset	498	42%	733	67%
- Purbeck	264	43%	385	67%
- West Dorset	728	38%	1,211	67%
- Weymouth & Portland	509	45%	709	67%

Source: Dementia Prevalence Calculator, 2013. QOF data 2012/13. www.poppi.org.uk.

A more detailed table with estimated projections running until 2020 with a 3% annual increase in rates is included in Appendix A. It should be noted that the rates in the table above include both people living in the community and in residential or nursing care homes. Based on the dementia prevalence calculator, around two thirds of people with dementia are living in the community and it would be expected that it is this client group that may have a greater demand/ need for this service.

The diagnosis rate for England in 2012 was 44% and in the South West the rate was 41%.The prevalence rate of dementia based on crude rates per 1,000 list size from the Quality and Outcomes Framework (QOF) shows that the rate of dementia in Dorset (7.5 per 1,000) is higher than the national rate of 5 cases per 1,000.

The new provider will be required to outline how they will provide a service to this clientele (market) and the market penetration that they project they will achieve using various relevant communications channels to maximise this.

This service will support people diagnosis with dementia. It will also be expected to support people diagnosed with Mild Cognitive Impairment (MCI) - where this is identified, offering these clients the option of an annual review/screening as it is estimated that 50% of people with MCI are diagnosed at a later time with Dementia and they need to be supported through this pathway, as necessary.

There will be a need for increased methods of signposting and advice been offered to both people newly diagnosed and their carers.

The projections do not account for the increased numbers of carers who will be identified if the person they care for receives a formal diagnosis for dementia and in

turn the additional support they may need; supporting carers a key role of this service.

NHS Dorset CCG and the three local authorities; Bournemouth Borough Council, Borough of Poole and Dorset County Council commission a range of services for people with memory loss. The memory support and advisory service will dovetail into these services. These services are predominately self-funding through subscription. See Appendix B for details which are subject to change and will require up dating.

The Alzheimer's Society, in a recent review, has identified that there are some excellent examples of raising awareness and understanding of dementia across the county of Dorset.

It is recognised that nationally and locally there is no clear indication of the costs for delivering memory support and advisory services, however, information from the National Institute of Health and Clinical Excellence (NICE) indicates that the annual costs per person with dementia show a wide variation depending on the stage of dementia and the care setting. One of the aims of the dementia strategy, inclusive of the Local Delivery Action Plan of Dorset is to identify and support more people with dementia in the community at an earlier stage, to ensure that early support and services are provided. It is recognised that through this support in the community delays admissions where appropriate into long term Care Homes is likely to benefit individuals, their families/carers and commissioners of health and social care.

Memory Gateway Pilots
Pilot sites are testing the effectiveness of the GP, Memory Support and Advisory Services and the Memory Assessment Services working in partnership.

The aims of creating a Memory Gateway Service are to reduce confusion for referring parties, reduce duplication for clients developing and implementing a single assessment between the Memory Support and Advisory Services and Memory Assessment Services to improve joint working between health, social care and voluntary sector organisations.

It has been shown that there is a need to expand this model to ensure more people with dementia and/or mild cognitive impairment are identified at an early stage in the pathway and are able to access timely and effective information, advice and support across each phase of their condition to enable them to "Live Well with Dementia". See Appendix C.

Dorset CCG believes that an effective memory support and advisory service will support early identification of people who are experiencing problems with their memory, working with primary care. A screening/initial assessment tool is being used to support early identification.

Pilots are being undertaken in the following areas linked to general practices;

Bridport Medical Practice, Christchurch, North Poole, Weymouth and Portland localities with Purbeck and Poole Central being planned for early 2014. The Memory Gateway Pilots to date have shown that there is a need to expand on this model to ensure more people with dementia and/or mild cognitive impairment/ are identified at an early stage in the pathway.

2. Outcomes

2.1 All service providers are required to work to the following outcome frameworks.

NHS Outcomes Framework Domains & Indicators

The NHS Outcomes Framework document sets out the framework for 2013/14 and contains measures to help the health and care system to focus on measuring outcomes.

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 Adult Social Care Outcomes Framework 2013/14

This service would be required to focus on the domains of the framework.

Domain 1	**Enhancing Quality of Life for people with care and support needs**	*
Domain 2	**Delaying and reducing the need for care and support**	*
Domain 3	**Ensuring that people have a positive experience of care and support**	*
Domain 4	**Safeguarding adults whose circumstances make then vulnerable and protecting from avoidable harm**	*

2.3 Public Health England Outcomes Framework 2013 - 2016

The document sets out desired outcomes for public health and how they will be measured.

Outcome 1	**Increased health expectancy- taking account of health quality as well as length of life**		
Outcome 2	**Reduced differences in life expectancy and healthy life expectancy between communities**		
Domain 1	**Domain 2**	**Domain 3**	**Domain 4 ***
Improving the wider determinant of health	**Health Improvement**	**Health Protection**	**Healthcare public health and preventing premature mortality**
Objective: Improvement against wider factors that affect health & wellbeing, and health inequalities	**Objective: People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities**	**Objective: The population's health is protected from major incidents and other threats, while reducing health inequalities**	**Objective: Reduced number of people living with preventable ill health and people dying prematurely, while reducing the gap between communities**

2.4 Local defined outcomes

This service should be fully aware of the seventeen objectives outlined in the National Dementia Strategy DH 2009. It is important that the service adopts a pro-active approach with a philosophy of holding conversations with clients and carers when providing information and signposting.

The goal is for people with dementia and their family carers to be helped to live well with dementia, no matter what the stage of their illness or where they are in the health and social care system, with recognition that dementia is a progressive condition which requires contingency planning as the disease develops. The three

steps to the vision are:

- Encourage help-seeking and help-offering (referral for diagnosis) by changing public and professional attitudes, understanding and behaviour;
- Make early diagnosis and treatment the rule rather than the exception;
- Enable people with dementia and their carers to live well with dementia by the provision of good – quality care for all with dementia from diagnosis to the end of life, in the community, in hospitals and in care homes.

There is a commitment to adopt a pan Dorset approach to supporting people with dementia and/or mild cognitive impairment from diagnosis to end of life. The Local Delivery Action Plan 2012/2013 outlines the outcomes to achieve good quality early diagnosis and intervention for all.

The Dorset Dementia Pathway (Appendix D) highlights 5 key steps around which care and services should be based:

1. Worried about your memory;
2. Diagnosis and treatment;
3. Living well with dementia;
4. Crises and challenging times; and
5. Approaching the end of life;

It is the expectation that all people with dementia will be able to say:

- I was diagnosed early;
- I understand, so I make a good choices and provide for future decision making;
- I get the treatment and support which are best for my dementia and my life;
- I know those around me and looking after me are well supported;
- I am treated with dignity and respect;
- I know what I can do to help myself and who else can help me;
- I can enjoy life;
- I feel part of the community and I'm inspired to give something back; and
- I am confident my end of life wishes will be respected and I can expect a good death.

Through each of these phases of the Dorset Dementia Pathway, those who care for individuals, the carer, should also be supported, both physically and psychologically to maintain their own health and wellbeing. The dignity of the client and their carers should be maintained throughout all communications and contacts with the service.

The service, when coordinating activities and services on behalf of the client, will work with partner organisations to deliver the most appropriate support whilst the person living with dementia or mild cognitive impairment resides in the community.

The service will work closely with primary care and the relevant community / specialist teams and services, to support those with long term conditions who are at an increased risk of developing dementia as part of the implementation of the Dementia Directly Enhanced Services (DES) arrangements. The DES *Facilitating Timely Diagnosis and Support for People with Dementia* requires participating GP practices to undertake and make an opportunistic offer of an assessment for dementia to "at risk" patients and where agreed with the patient to provide that assessment.

For the purposes of this enhanced service, "at risk" patients include:

- patients aged 60 and over with Cardio-vascular disease (CVD), a stroke, peripheral vascular disease or diabetes;
- patients aged 40 and over with Down's syndrome;
- other patients with Learning disabilities aged 50 and over;
- patients with long-term Neurological conditions which have a known neuro-degenerative element, for example, Parkinson's disease.

2.4 Benefits to people with dementia and/or mild cognitive impairment

The local service should provide the following benefits:

- an accessible service with direct contact with a named memory support and advice worker – dementia navigator;
- high quality, relevant and updated information appropriate to the individual's / carer's needs given at the correct stage of their dementia and / or mild cognitive impairment;
- signposting to appropriate services at the right time, with the memory support and advice workers acting as a link with primary care and other services, such as pharmacists, community health and social care services , community and acute in patient health services;
- maintaining dignity and respect of the individual and their carer;
- signposting to the relevant GP for physical health screening and bloods if a GP did not refer the individual to the service;
- support people with dementia or mild cognitive impairment to remain safely in their homes for as long as possible;
- provide signposting information and support to clients and their carers when a decision has been made for the client to move to a care home;
- provision of community groups/clinics including development of memory cafes and/or carers groups if the need is identified by this service. This will include working with other providers to review and develop new services in response to changing demands;
- development of volunteers to enhance the practical support available in this service, utilising people with early dementia and their carers.

2.5 Community Benefits

The community benefits of this service would include:

- local communities would have a raised awareness and be better informed about dementia and / or mild cognitive impairment and memory loss programmes in the local area;
- memory support and advice workers working with Dementia Action Alliance in Dementia Friendly Communities;
- an increased social awareness with increasing numbers of Dementia Champions locally;
- people with dementia and / or mild cognitive impairment would be supported to access social/leisure/exercise groups and cafes.

3. Scope

Aims and objectives of service

Aims:

The Memory Support and Advisory Service will provide local community facing / based point of contact for people with dementia and/or mild cognitive impairment and their families / carers at all stages of their journey through the management of their long term condition – dementia, as part of their individualised support plan. The service will be accessible for people who have concerns about their memory.

The Memory Support and Advisory Service will contribute to the national and local priorities to improve early detection and diagnosis of dementia.

The Memory Support and Advisory Service will provide support and signposting for people with dementia and/or mild cognitive impairment, their families and carers.

This service will contribute to raising awareness about dementia and / or mild cognitive impairment and deliver training and education in local communities and amongst professional groups.

The Memory Support and Advisory Service will organise and facilitate a range of appropriate community groups for people with dementia as identified in co-ordination with established groups. The support choices should be in line with client and carers' need and be accessible.

Objectives:

This service will:

- contribute to the improvement in the quality of care for people with dementia and / or mild cognitive impairment, their carers and families who are referred to the service;
- provide dementia navigators who will be available to support people with dementia and / or mild cognitive impairment in the management of their condition;
- work to the "Memory Gateway" model, working with GPs and the memory assessment service before, during and following diagnosis;
- offer an appointment to people with a diagnosis of dementia, to discuss the implications of their diagnosis, linking with their GP;
- provide an initial appointment for screening/assessment , agreed plan and follow up as required throughout the person's journey of dementia in the community;
- co-develop a joint individualised plan with the person who has dementia / mild cognitive impairment and their family/carers (neighbours/employers where appropriate) ;
- facilitate independence and appropriate coping strategies for people with dementia and / or mild cognitive impairment, their carers and families;
- offer the client the opportunity to receive support via the Safe And Independent Living (SAIL) referral process. This programme is facilitated by Age UK Dorchester and can generate a number of referrals out to a range of agencies, through one single refer form been completed, with the consent of the client/carer, Appendix E/F;
- identify and develop new contact points/services in response to identified unmet need in agreement with commissioners;
- refer the person and/or their carer with dementia and / or mild cognitive impairment to local advocacy services, if appropriate;
- support individuals entering hospital or a Care Home, this will include completing the "This is Me" document;
- actively engage individuals and their carers, in the development and promotion of the memory support and advisory services inclusive of the development of

volunteers;

- seek and record client feedback/survey to understand whether their needs are being met and plan any necessary adjustments to their support;

- provide up to date, good quality information, advice and signposting through a range of media i.e. websites/pages, social media sites, leaflets, posters etc.;

- participate in an education and support programme related to dementia/dying matters to health and social care locality teams in community and intermediate care services, across each of the 13 localities in Dorset CCG.

3.1 Service description/care pathway

This specification sets out how the provider will deliver the service to help achieve delivery of the National and Local Dementia Strategies as follows:

This service will:

- contribute to the improvement in the quality of care for people with dementia, mild cognitive impairment, their families and carers of those referred to this service;

- operate an 'open referral' policy enabling any individual to refer for support and advice regarding dementia and / or mild cognitive impairment;

- work as a key partner within the memory gateway model for those people with dementia and / or mild cognitive impairment and their carers;

- offer and carry out screening/initial assessment for dementia using the agreed tools and where appropriate refer to the memory assessment service;

- gather additional information from the individuals and carers;

- share screening tool results and other information gathered to the individual's GP and Memory Assessment Service;

- offer GAD-7 and PHQ-9 to individuals and carers;

- signpost onto other appropriate services as necessary such as:
  - Primary Care;
  - Steps to well-being service;
  - Community support groups;
  - Community Mental Health Teams (CMHTs) for complex presentations;

- offer an appointment to people with a new diagnosis of dementia provided by the memory assessment service or GP to discuss the implications of their diagnosis, allowing for adjustments as needed;

- provide on-going support through an agreed plan with the individual and their family/carer, dependent on their needs;

- To provide individualised person centred interventions, including follow-up contact, face to face and non-face to face communication;

- provide a named dementia navigator who will support the individual with dementia and / or mild cognitive impairment, families / carers, at all stages of their journey throughout their long term condition, as part of an integrated service delivery;

- provide group sessions/activities and where needed memory cafes in localities as identified at different stages of dementia in co-ordination with the commissioners, primary/community, social care and other providers;

Advice and signposting

This service will act as a signposting service and where appropriate provide advice, guidance and information for those with a diagnosis of dementia and/or mild cognitive impairment to include:

- Legal (Wills) and financial ;
- Housing, employment and benefits advice;
- Carers education and support, development of groups as needed;
- Healthy living groups - nutritional and exercise information (Nutritional Care Strategy for adults, Dorset);
- Mental Capacity Act:
  - Driving regulations;
  - Lasting Power of Attorney;
  - Advance decisions.

Ensure that information given by the service is in an appropriate format for the individual and their carer, working in partnership with other organisations as required in a planned way.

Promote the use of technology i.e. social media such as Facebook, Skype and seek opportunities to use Telehealth /Tele-care; supporting service users in using electronic memory support IPad/ tablet (or similar), using other computer applications / games to assist memory maintenance and /or management of independence.

Training, Education and Promotion of Service

This service will provide training and education activities about dementia and mild cognitive impairment to:

- professionals working within primary and community health services;
- social care teams;
- local community groups;
- dementia action alliance forums.

This service should actively promote itself in primary, community health and social care settings, as well as the wider community, to ensure people with dementia and/or mild cognitive impairment are signposted to the most appropriate service at the earliest opportunity.

Continually promote dementia-friendly communities to encourage individuals, organisations, businesses and the wider community to be better informed to support those living with dementia and / or mild cognitive impairment.

Liaison

The service will provide a named point of contact (dementia navigator) in each locality within the CCG.

This service will liaise with a range of organisations and individuals in order to support the person with dementia and / or mild cognitive impairment, to include:

- local community centres;
- professional groups in primary and community;
- link with hospitals and health and social care teams.

This service will identify and develop networks with key organisations, both statutory and non-statutory working in the field of dementia, mental health, learning and physical disabilities, carers support, benefits and income advice to support individuals to make informed choices.

Design a section for inclusion in the local Dorset Dementia webpage (CCG and local authorities) on these services.

Incorporate web links to other appropriate web based information services to avoid duplication.

Add new services to the Bournemouth, Poole and Dorset SOURCE directory.

Develop and maintain strong working relationships with those supporting carers, such as Carer's Caseworkers, GP Practice Carer's leads and be familiar with carer's resources across all CCG localities, inclusive of primary care.

Develop effective working relationships with the local acute and community hospital staff.

Establish clear pathways of care with the Mental Health Liaison Services from Dorset HealthCare NHS Foundation Trust who work in the three acute hospitals.

Work with the domiciliary care, re-ablement service for people with dementia and mild cognitive memory impairment as needed.

Organisation across localities

This service will be available to all patients registered with a Bournemouth, Poole or Dorset GP, who may suffer from dementia or mild cognitive impairment living in the community. The allocation of memory support and advisors in the service will be determined by the changing/fluctuating needs in each of the thirteen CCG localities.

There is greater need for increasing the diagnosis in the seven localities in the Dorset County Council area, whilst maintaining support across the whole Dorset CCG area for those individuals already diagnosed.

Location
The service will have a staff presence in each Dorset CCG locality; bases are to be agreed by the commissioner.

Referral to service
Referrals to the service can be made by telephone, letter or email, securely.

Referrals to the service can be made by anyone including self-referral, primary care/locality teams, memory assessment services, intermediate care, re-ablement and community teams.

Other health and social care professionals working in both acute and community settings / hospitals can also refer.

Hours of operation
Working hours of the service will be flexible, but mainly Monday – Friday between 9.00 – 17.00 hours, with evening and weekend appointments / group sessions offered for individuals/carers in employment. The service will work across all 13 Dorset CCG localities and will be determined by the needs identified in each locality.

Service Specification Review

It is recognised that the proposed services may be subject to change due to on-going national and local initiatives that will impact on needs over the next 3 years.

The service specification and relevant reporting arrangements will initially be reviewed after six months and then annually and updated to reflect changes in legislation and service requirements. It is recognised that this service will be a major informer of change for people diagnosed with dementia and / or mild cognitive impairment and their carers.

3.3 Any acceptance and exclusion criteria and thresholds

This service will be available to people with dementia and / or mild cognitive impairment and their carers / families.

This service will provide time limited support to those people with mild cognitive impairment and / or memory loss who have not yet been formally diagnosed with either dementia.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

Quality Standard 1 NICE Dementia Pathway - issued June 2010
This quality standard covers the care provided by health and social care staff in direct contact with people with dementia in hospital, community, home-based, group care, residential or specialist care settings. It should be considered in conjunction with Quality Standard 30. Standards and statements 1 - 10 should be met by the service provider

Quality Standard 30 NICE Supporting People to Live Well with Dementia issued April 2013
This quality standard covers the care and support of people with dementia and should be considered in conjunction with Quality Standard 1. It applies to all social care settings and services working with and caring for people with dementia. Standards and statements 1 – 10 should be met by the service provider.

Additional legislation and guidance
The service is required to work to legislation and guidance as set out in:

- Mental Health Act (1983) revised 2007;
- Mental Capacity Act (2005);
- Multi Agency Safeguarding Adults Policy (pan Dorset) 2013;

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

Not applicable

4.3 Applicable local standards

Refer to the Memory Gateway Model for referral timeframes and responses.

5. Applicable quality requirements and CQUIN goals

Not mandatory at this stage

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

6. Location of Provider Premises

Not mandatory at this stage

The Provider's Premises are located at:

7. Individual Service User Placement

Not applicable