SCHEDULE 2 – THE SERVICES

A. Service Specifications (Full Length Contract)

Service Specification No.	**11J/0260**
Service	*Dementia Services*
Commissioner Lead	*Primary and Community Care Directorate*
Provider Lead	*Dorset Healthcare*
Period	*01 April 2021 – 31/03/2024*
Date of Review	*March 2023*

1. Population Needs

1.1 National/local context and evidence base

There have been a range of national documents since the 2009 'Living Well with Dementia: National Dementia Strategy'. Currently there is 'Prime Minister's Challenge on Dementia 2020'and the 'Implementation plan'[1] which includes:

- improving diagnosis, assessment and care for people living with dementia;
- ensuing that all people living with dementia have equal access to diagnosis;
- providing all NHS staff with training on dementia appropriate to their role;
- ensuring that every person diagnosed with dementia receives meaningful care.

Dementia remains a national priority with delivery of '*Challenge on Dementia 2020 Implementation plan*' by 2020[2]. NHS England 2018/19 mandates for dementia are:

- maintain a minimum of two thirds diagnosis rates for people with dementia;
- implement and embed the dementia pathway, set out in the Implementation Guide for dementia care, and improve the quality of post-diagnosis treatment and support.

Prevalence of dementia is unclear. It has been estimated nationally at 13,637 (2020) and local analysis suggests around 10,362 people. However, incidence has been at a plateau since around 2015 and more recently slowed due to covid-19 and services being paused. In July 2020 NHS Digital recorded Dorset as reaching 58.5% against the national prevalence estimations. This was 7971 people diagnosed with dementia aged over 65 years. It is also estimated there are around 200 people under 65 years diagnosed with dementia.

Dorset Dementia Services Review Full Business Case was approved by the NHS Dorset CCG Governing Body in November 2019. The model was coproduced with a wide range of stakeholders. This service specification gives the overarching dementia services model detailing the overall outcomes required with the individual service specifications included as appendices.

[1] https://www.gov.uk/government/publications/challenge-on-dementia-2020-implementation-plan
[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/507981/PM_Dementia-main_acc.pdf

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

2.2 Local defined outcomes

Patient outcomes
The agreed outcomes are for each person diagnosed with dementia across Dorset to be able to agree with the following statements;

- I have personal choice and control over the decisions that affect me;
- I know that services are designed around me, my needs and my carer's needs;
- I have support that helps me live my life;
- I have the knowledge to get what I need;
- I live in an enabling and supportive environment where I feel valued and understood;
- I have a sense of belonging & of being a valued part of family, community and civic life;
- I am confident my end of life wishes will be respected.
- I can expect a good death.

Service outcomes

- Design and deliver consistent and high quality, compassionate care and support to meet the needs of people living with dementia and their carers from diagnosis to end of life;
- Ensure equity of outcomes for people living with dementia and their carers across Dorset;
- Improve access to services for people experiencing memory loss through early assessment and diagnosis of dementia to increase the quality of their life
- Support the ambition of a diagnosis rate of two thirds of prevalent population;
- Improve the quality of post diagnosis treatment and support.
- Maintain social functioning and quality of life of patients across all ages
- Improved psychological wellbeing for patients and informal carers
- Prevention of unnecessary admissions to specialist dementia inpatient services
- Reduction in inappropriate admissions to acute hospitals
- Reduction in the number of delayed discharges

3. Scope

3.1 Aims and objectives of service

The aim of the Dementia Care Pathway is to ensure people living with dementia, and their carers/families have timely access to memory assessment, diagnosis, advice and support and to meet the needs of those with a higher level of need due to their dementia and possibly other health or psychological issues.

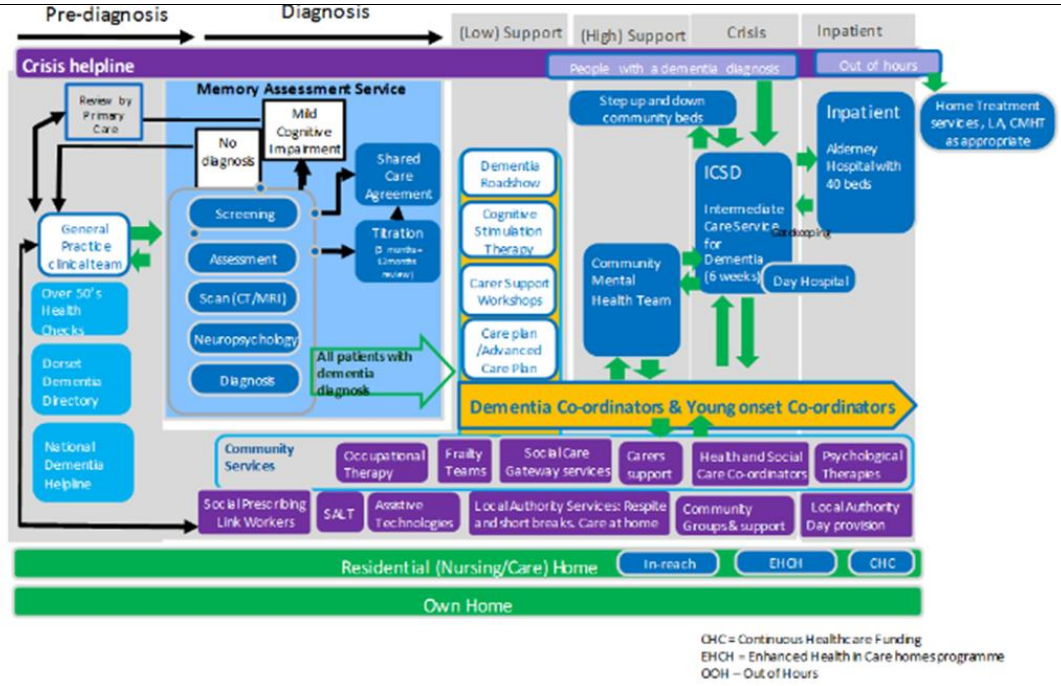
3.2 Service description/care pathway

The scope of the service specification covers the new model of care for Dementia that was developed as part of the Dementia Services Review. These include
services for diagnosing well, supporting well and supporting well in crisis.

- Memory Assessment Service
- Neuropsychology
- Dementia Co-ordinators
- Memory Roadshows
- Cognitive Stimulation Therapy
- Carer Emotional Wellbeing workshops
- Dementia Specialist team/Community Mental Health Team
- Crisis helpline
- Intensive Care Service for Dementia
- In-reach service- EHCH programme * The In-Reach Services were suspended at the start of the COVID19 Pandemic and are under review.

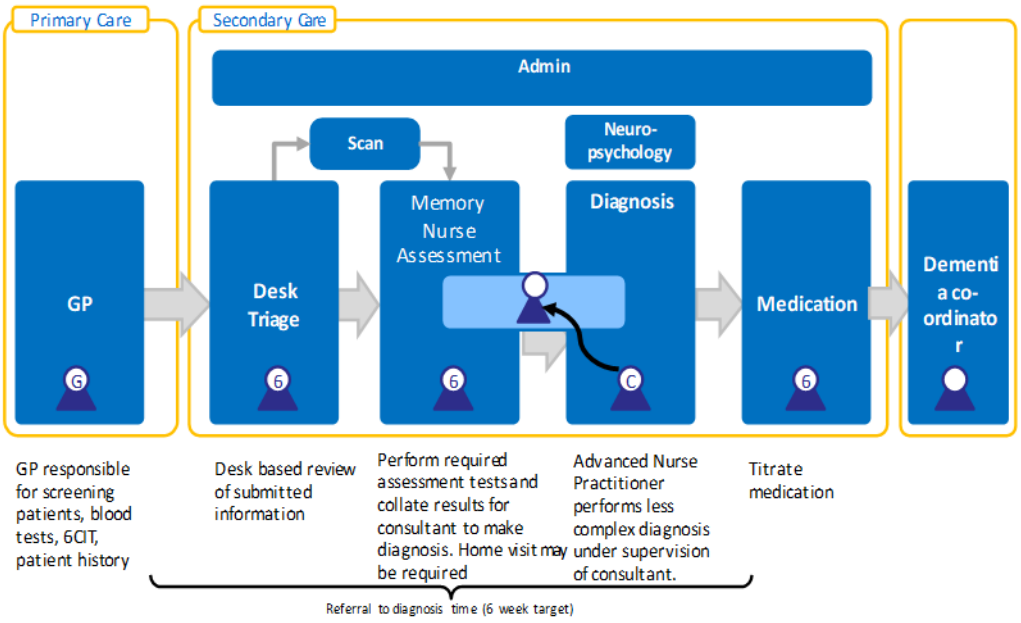
- Day Provision
- Specialist Dementia Inpatient Provision

Dorset Dementia Care Pathway * ICSD- Intensive Community Support for Dementia (diagram A)



Diagnosing well

Diagnosis service (diagram B)



- **Memory Assessment service (MAS)**

The Memory Assessment service will provide a quick and smooth diagnosis process. Referrals will be received directly from GP practices via a triage function operated by registered staff.

This supports the ambition to ensure people receive a diagnosis within six weeks of their referral though it is recognised this in some cases is dependent on access times for neuroimaging which sit outside of this specification.

Patients with a suspected dementia will be referred for a Memory Nurse assessment. If appropriate, a diagnosis will be made through an appointment and further tests and scans by medical and nurse specialists. Those diagnosed clients requiring medication with an initial medication session will receive on average 4 follow up appointments dependent on need (recognising that some clients choose to stop medication early and some may require additional appointments in order to change and titrate an alternative medication).

The Service will use Advanced Nurse Practitioners supervised by consultants to assist with the diagnosis of less complex dementia cases. Consultants will focus on more complex cases.

The service will work in partnership with the Dementia Coordinators, provide supervision, share expertise and knowledge to deliver a seamless service to clients.

The service will offer advice and guidance to Primary Care Networks in the early identification and assessment of people with a possible diagnosis of dementia/MCI especially 'at risk' groups.

The service will provide pharmacological treatments and also refer all clients to the Dementia Coordinators for post diagnosis support and Cognitive Stimulation Therapy service.

The service will ensure any individuals referred who require more specialist ongoing support are referred to the Older Adult Community Mental Health Team

The service will provide Carer Emotional Wellbeing courses to carers to enable them to develop more resilience and greater understanding of the emotional impact on them as a carer.

The service will be available from 09.00 – 17.00 Monday- Friday.

The service will be offered from a range of venues across Dorset including GP practices (where available), Dorset HealthCare clinic settings, the patient's own home and care homes**.**

The expected outcomes from the Memory Assessment Service are:

- Increased dementia diagnosis rates across Dorset
- Prompt triage of referrals
- Prompt access to full assessment meeting 6 week (85%) target from referral.
- Access to neuro-imaging where indicated
- Medication reviews for patients prescribed Acetyl Cholinesterase Inhibitors in line with the shared care protocol.
- Improved patient and carer satisfaction
- Improved waiting times for diagnosis
- Improved patient satisfaction
- Improved cost effectiveness
- Improved quality of diagnosis

- **Neuropsychology Service**

The Neuropsychology Service will be integrated into the Memory Assessment service and provide neuropsychological assessment to assist with diagnosis and differential diagnosis, particularly in complex cases and young on-set. Approximately 10% of clients will require neuropsychology input with 15 hours needed for each diagnosis.

The Memory Assessment staff will be supervised and trained in selecting/administering and interpreting cognitive screening tests/assessments and aspects of pre and post diagnostic counselling. Staff/neuropsychologists will identify a person's cognitive strengths in relation to helping with developing coping strategies.

The service will be accessed via referrals from the Memory Assessment Service team to diagnose more complex cases.

Supporting well

- **Dementia Co-ordinators**

The Dementia Co-ordinators will help people living with dementia to live well in their community and ensure they have the right support and care to meet their needs. This will include making sure people with a dementia diagnosis are aware of and signposted to the various community services provided by organisations and groups which help people feel less isolated and supported.

Dementia Co-ordinators will ensure a care plan is in place and depending on the complexity and level of needs this will be completed by Dementia Co-ordinators and/or Memory Nurses. Memory Assessment nurses and clinicians will provide reflective supervision for the Dementia Coordinators.

Dementia Co-ordinators will ensure co-ordination of care is provided and whilst they may hand the 'baton' of responsibility over to another health and social care professions at certain stages of the dementia journey crucially each patient will still remain under the Dementia Co-ordinator service from diagnosis to end of life.

The Dementia Co-ordinator service will operate within the 18 Primary Care Networks across Dorset. Each Dementia Coordinator will have a case load of approximately 200 people.

- Support people along their journey: 'walk with them' offering information and 'low level' support, being integrated with Memory Assessment Service teams and other community teams based
- Offer advice, guidance, signposting, continuity of care and provides a coordination role linked with multidisciplinary teams including primary care, frailty teams, acute hospitals liaison services and dementia teams across Dorset;
- Monitoring of needs and Advance Care planning;
- Ensuring care plan is in place and reviewed annually as a minimum (a copy shared to GP Practices for their registers) with reviews completed by appropriate service;
- Support and advice to maintain independence – finance, benefits, local resources, assistive technologies and equipment, practical assistance;
- Ensure that people are aware of local advocacy services;
- Offering advice and guidance for Carers and signposting to relevant services. Including advice on how to access to technology, information, respite, advice, carer assessments;

- Working with a range of health and social care services including social prescribing and linking with Dementia Friendly Communities.

Young onset Dementia Co-ordinator role

One WTE Young onset coordinator will hold a caseload of approximately 200 people under the age of 65.

This bespoke role is recognising that those with a dementia diagnosis under the age of 65 may have significantly different needs to those of much older patients. For example, they may hold family responsibilities or be in employment. The function of a co-ordinator would include:

- Provide age appropriate groups across the county for people under 65 years;
- Developing and encouraging peer support groups;
- Offering relevant guidance & signposting. Eg employment support, financial information;
- Providing similar functions to above co-ordinator role including linkages to the voluntary sector, social prescribing and Dementia Friendly Communities.

The Service User will have their first contact from a Dementia Coordinator within 10 working days
All patients with diagnosis of Dementia will have an up to date care plan which will be reviewed at least every 12 months

The Dementia coordinator service will integrate with the wider dementia care pathway and other wider health and social care services delivering patient care.

The services will be based or aligned to Primary Care Networks and therefore strong robust relationships will need to be developed with each of the network arrangements

The Dementia Co-ordinator will also form part of the local Primary Care Multi-disciplinary team and work closely with the Social Prescribing Link Workers.

Outcome measures

- DEMQOL Health related quality of life for people with dementia tool (mild to moderate)
- QUALIDEM (moderate to severe)
- Carers checklist and ReQOL
- Patient and carer feedback on 'I' statements
- Staff feedback & survey

- **Memory Roadshows**

Memory Roadshows will be open to anyone concerned about their memory alongside those newly diagnosed and will be accessible to interested professionals and services.

The function of the Roadshows hosted through the Memory Assessment Service and Dementia Co-ordinator service (coordinated by the latter) will be to:

- Offer a workshop type session open to anyone interested on a regular basis in local areas and ensure all people newly diagnosed with dementia and their carers are invited;

- Offer a short educational talk and information on dementia and available services;
- Bring together all key services in one place for people to meet and have opportunity to talk to services;
- Enable peer support and meeting others.

24 Dementia Roadshows will be held annually across Dorset at various locations.

The Dementia Roadshows will be open to anyone concerned about their memory alongside encouraging those newly diagnosed to attend and is accessible to interested professionals/services.

The delivery of the roadshows will be tailored to meet the restrictions of covid including on-line virtual options and other solutions.

- **Cognitive Stimulation Therapy (CST)**

Cognitive Stimulation Therapy (CST) is an evidence-based group treatment for people with mild to moderate dementia. It will be delivered by appropriately trained skilled staff in CST who specialise in dementia. CST courses will consist of 14 sessions of themed activities, spread over 8 weeks.

The aim of the service is to support those living well with dementia by offering brief, closed, structured groups that follow a programme of themed activities designed to actively stimulate and engage people with dementia, promote cognition (e.g. memory, language and executive function) and quality of life. This is particularly beneficial for those with mild to moderate dementia and would enable a treatment offer to be given to all people with a diagnosis as well as people whom currently do not benefit from the various dementia medications such as vascular dementia

A typical session will involve an informal introduction, a chat about current news stories and a programme of activities arranged around a particular theme. Brief, closed, structured therapy groups for up to 10 clients in each group.

CST aims to engage and stimulate people in a friendly and enjoyable group setting. Research into CST shows that it improves thinking abilities, as well as general wellbeing.

A minimum of 71 courses will be delivered each year in a way that ensures ease of access and equity across all 18 Primary Care Networks in Dorset.

- **Carer Emotional Wellbeing Workshops**

The objectives of the workshops are to:

- Understand the different dementia's and the different ways people are impacted;
- Enable the carer to understand the process of change both physically and emotionally;
- Enable carers to gain knowledge on coping mechanisms for stress management;
- Gain skills to manage behaviours that challenge others, depression and anxiety;
- Encourage ongoing peer support at the end of the sessions.

The carers will be provided with a safe environment for them to learn more around their life changes as a result of caring for someone with dementia and the emotional impact of unrecognised grieving and loss they may be experiencing.

24 workshops will be delivered over one year. Each workshop will be held for 4 hours and run for a 6 week period. Travel and planning time will give a total time of 40 hours per 6 week course. The courses will be held across Dorset within different PCN areas led by a Dementia Nurse Specialist within the Memory Assessment Service with support from a Healthcare assistant.

- **Dementia Specialist team/Community Mental Health Team**

The specialist Community Mental Health Teams for Older People will provide a range of services including assessments, treatments and home visits for older people, including people living with dementia, to enable them to live safely at home.

Community Mental Health Teams for Older People will consist of multidisciplinary teams of mental health workers which may include the following; nurses, social workers, occupational therapists, support workers and psychiatrists.

The teams will work closely with Dementia Co-ordinators to ensure greater responsiveness when patients need more specialist assistance. Community Mental Health Teams, working with the In-Reach team and ICSD, will provide higher intensity support and can refer to relevant services to assess for access to Community beds for short term rehabilitation, reablement or end of life care where available across the County within community hubs with beds or in locality care homes where the service is commissioned (outside of this specification).

Community Mental Health Teams (CMHTs) for older people, based in locations across Dorset to ensure equitable access for the population, will operate, Monday – Friday, 9am-5pm.

Referrals received from GPs, social services and other Dorset HealthCare mental health services.

The following agencies directly or indirectly influence the work of the Older People's CMHTs:

- GPs and Primary Care Networks
- Local authorities/social services
- Voluntary sector
- Steps to Wellbeing services (IAPT)
- Psychiatric liaison service
- Memory Assessment Service
- Dementia Coordinators
- Intensive Care Service for Dementia
- Specialist Inpatient service
- Care homes
- Deprivation of Liberty Safeguards and Safeguarding Adults Services

Supporting well in crisis

- **Crisis helpline**

A Crisis Helpline will be provided through the Connection service. The Connection service is a 24/7 Crisis Help Line that is accessible through 111 and a freephone bespoke number that people are able to use if they prefer not to use 111. The service provides Mental Health Advice and support to people of any age who is heading towards or experiencing a mental health crisis.

The Connection will provide both support and guidance for people with dementia and their carers as well as organising appropriate services when needed; and will also be able to signpost to other services across the county.

- **Intensive Community Support for Dementia**

The Intensive Care Service for Dementia will provide intensive support and treatment to people with a diagnosis of dementia and their families for up to six weeks in a person's own home. The aim of the service will be to support people to remain in their own homes, reduce stress and cognitive decline, and prevent the need for admission to the specialist dementia inpatient beds where appropriate. This service will prevent inappropriate hospital admission to specialist dementia inpatient beds and act in a 'Gatekeeping' role and bed management capacity.

The Intensive Care Service for Dementia (ICSD) is a crucial service within the crisis section of the new dementia model of care (diagram A). The ICSD will support people with a diagnosis of dementia as well as their family carers who are experiencing a crisis situation, or where family members are struggling to care for a family member due to presenting complex needs associated with dementia such as challenging behaviour and/or other psychological distress. The service will operate in peoples own homes as well as providing support in to day care settings.

Access to the ICSD service will be via

- Dementia Specialist team /Community Mental Health Team
- Crisis Home Treatment Teams
- Psychiatric Liaison Teams
- (Physical Health) Intermediate Care Services
- MAS
- In-Reach

The service will work closely with;

- the relevant local authority, specifically in relation to mental health act assessments, and social care provision;
- the third sector in order to signpost patients to appropriate supportive services from which they might gain benefit.
- palliative care teams, hospices.
- Deprivation of Liberty Safeguards and Safeguarding teams
- care homes

The Intensive Care Service for Dementia East will be based at Alderney Hospital, Poole and West at Forston Clinic, Dorchester. The services will operate with core hours from 7.30 am to 7.30pm 7 days a week and 52 weeks per year but will be able to mobilise additional social care outside these hours when necessary. If emergency support, assessment or admission is required outside these hours the current crisis pathway will continue to apply utilising Connections and the social care duty system.

The team will be multi-disciplinary and will include consultant psychiatrists, community psychiatric nurses, occupational therapists, and support workers. The team will also work closely with Social Workers, domiciliary care workers, Older Age Psychologists, physiotherapists and dieticians.
There will be an appropriate mix of staff at any one time during the operational hours. This will include staff who will work closely with the wards regarding admissions and discharges as well as staff who will support people in the community.

Function

- Rapid response within 4 hours
- Assessment of health needs and liaison with social care workers to ensure social care needs are reassessed when required
- Crisis treatment and support to prevent hospital admission;
- Comprehensive risk assessment and management to enable ongoing care in patients normal place of residence. Operating under principles of positive risk taking
- Provision of a clear care plan for service user and family carer
- Discharge planning to start on referral
- Interventions such as assessment, medicines management, therapy, support and education for carers;
- Ensuring intermediate social care is available for those who require it – either through using domiciliary care staff employed on a bank basis or through referral to social care agencies.
- Supporting discharge from an inpatient bed when intensive support is required.
- Direct people to useful resources such as the provision of telehealth and respite
- Links with existing services to ensure continuity of care and ensure people are aware of what is available to them and appropriate steps are taken to support them.
- Supportive discharge to lower intensity services
- Withdrawal from case management within six weeks
- The service will work with CMHT's, the AMHP service and crisis service to facilitate mental health act assessments and ensure DOLS assessments, safeguarding alerts, Best Interest assessments and so on are undertaken as and when necessary
- Liaising with End of Life services

Measured outcomes

- Reduction in the number of delayed discharges from mental health inpatient services
- Reduced dependency on inpatient beds thus maintaining functional skills of patients in own place of residence

- **In-reach service to care homes** *The In-Reach Services were suspended at the start of the COVID19 Pandemic and are under review.

The Dementia In-Reach service will be provided across all of Dorset. The service will provide formal training with advice and support to care homes, crisis care day provision settings and community hospitals, to enable staff to manage crisis situations, particularly behaviours and psychological issues that challenge them.
The In Reach team will provide support through education to care homes in partnership with the Enhanced Health in Care Homes Programme
The In-reach team will work closely with the ICSD Team.

Referrals will be received from

- Dementia coordinators
- Dementia Specialist team /Community Mental Health Team
- Crisis Home Treatment Teams
- Psychiatric Liaison Teams
- (Physical Health) Intermediate Care Services
- MAS

- **Day provision for crisis care**

Day provision for crisis care will provide a joined-up service ensuring equity across Dorset by aligning provision.

Day provision for crisis care will provide a safe environment for those experiencing crisis and align with the 'Intensive Care Service for Dementia'.

The service will provide people in a crisis with a safe environment to receive assessment and treatment.

- **Specialist Dementia Inpatient Provision**

The 40 specialist inpatient beds giving 24 hourly care at Alderney Hospital Poole will provide short-term support to dementia patients with complex needs residing in Dorset and who cannot be supported elsewhere in the community.

The specialist beds are for patients with a very high level of acuity including Young Onset Dementia patients and are usually detained under the Mental Health Act.

Beds are used for people with a primary diagnosis of dementia who are currently known to the Intensive Care Service for Dementia, Community Mental Health service, In-Reach team or Crisis Team.

Operational model

- Continuity of care is an essential ingredient of quality care for older people with mental illness no matter where or for what reason specialist services are involved. Continuity of care should be provided and include the involvement of as few different staff (consistent with the person's needs) as possible.
- There will be a multi-disciplinary team including/with access to Consultant Psychiatrists, Registered Mental Health Nurses, Mental Health Support Workers, Occupational Therapy, Physiotherapy, Dietetics and other specialised practitioners.

- The multi-disciplinary team will assess every patient to identify cognitive problems and implement treatment/management programmes which will be recorded and managed via an individual care/treatment plan
- Carers should be made aware of their right to a separate assessment of their needs and given information on how to access this, but if this is declined their views and wishes should be recorded on the patient's assessment.
- Each patient will have regular reviews and re-assessments of their needs, involving the patient (where possible), their carer and/or advocate.
- Inpatient care will be provided as part of a care pathway and will be provided on the basis of the least restrictive option to meet an individual's needs.
- Where discharge to another setting is assessed as being in the patient's best interests then a clear discharge / care plan should be in place outlining the needs above, how they should be met and any management plans to accompany the patient to their next placement. If at all possible contact should be made with the new placement to enable continuity of care through effective communication with the new carers.
- Advanced decisions under the Mental Capacity Act will be employed to implement end of life care plans where appropriate.
- The reconfigured service will comprise of one female assessment and treatment ward and one male assessment and treatment ward.

The service will work closely with;

- Intensive Care Service for Dementia and Older People Community Mental Health Service to ensure timely and appropriate discharge and to prevent inappropriate admissions.
- the relevant local authority, specifically in relation to application of mental health act assessments, and social care provision;
- the third sector in order to signpost patients to appropriate supportive services from which they might gain benefit.
- palliative care teams, hospices.
- Deprivation of Liberty Safeguards and Safeguarding teams
- care homes
- Dementia Specialist team /Community Mental Health Team
- Crisis Home Treatment Teams
- Psychiatric Liaison Teams
- (Physical Health) Intermediate Care Services
- Memory Assessment Service
- In-Reach team
- Dementia Co-ordinators

Outcome measures

- Reduced use of dementia specialist inpatient beds
- Reduced inpatient costs
- Reduction in delayed transfers of care

3.3 Population Covered

These services are for those people with a suspected dementia and people given a formal diagnosis of dementia and their informal carers. The service will be available to people registered with a GP practice within the 18 Dorset Primary Care Networks.

- **Any acceptance and exclusion criteria.**

Acceptance criteria

- The individual is registered with a GP within the Dorset CCG area;
- the individual is 18 or over;
- the individual is referred from their GP due to memory issues and requires screening and if appropriate assessment
- the individual has received a diagnosis of dementia from an appropriate acute care clinician but needs assessment for treatment;
- Individuals with an existing diagnosis of dementia can be re-referred for review by a GP if it is felt their condition has deteriorated or significantly changed, in particular if they were previously diagnosed with MCI and it is now suspected the person may have dementia;

Exclusion criteria

- Individuals reporting memory problems following a traumatic head injury. These individuals should be referred to neurology services in the first instance
- The services will not include support for those diagnosed with 'Mild Cognitive Impairment'. Patients with this diagnosis remain under the support of their GP.

- **Interdependence with other services/providers**

Services in scope of this specification are provided as an integrated whole care pathway to meet the needs of service users in a seamless fashion. Other key interdependencies with the pathway include:

- Primary Care Networks- GP practices
- Local authorities
- Community Frailty Services
- Psychiatric liaison Service
- Care Home Provider Market
- VCSE and 3rd sector organisations

4. Applicable service standards

4.1 Applicable national standards (eg NICE)

NICE guideline [NG97] Published date: 20 June 2018
Dementia: assessment, management and support for people living with dementia and their carers

Dementia, disability and frailty in later life – mid -life approaches to delay or prevent onset (ND16) 2015

Dementia resource for carers and care providers 2017

Dementia NICE Quality standard [QS184] Published date: 28 June 2019

Technology appraisal guidance [TA217] Published date: 23 March 2011 Last updated: 20 June 2018
Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease

NICE Key therapeutic topic [KTT7] Published date: 15 January 2015 Last updated: 01 September 2019 Antipsychotics in people living with dementia

NICE Advice ESUOM40 Management of aggression, agitation and behavioural disturbances in dementia: carbamazepine (2015)

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

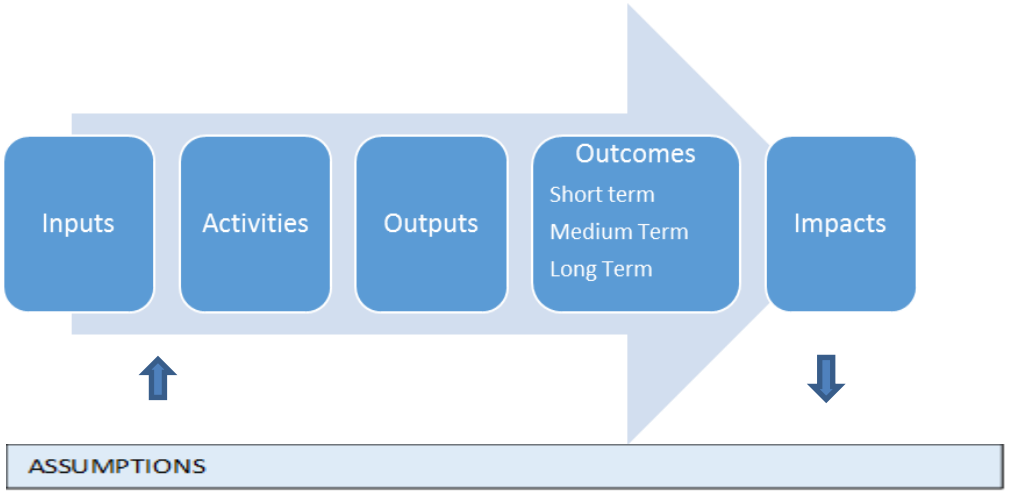
Staff working within the service should adhere to the relevant professional guidance and codes of practice e.g. Royal College of Psychiatrists, Nursing and Midwifery Council, British Psychological Council, British Association of Occupational Therapists and College of Occupational Therapy and other bodies pertinent to the service

5. Location of Provider Premises

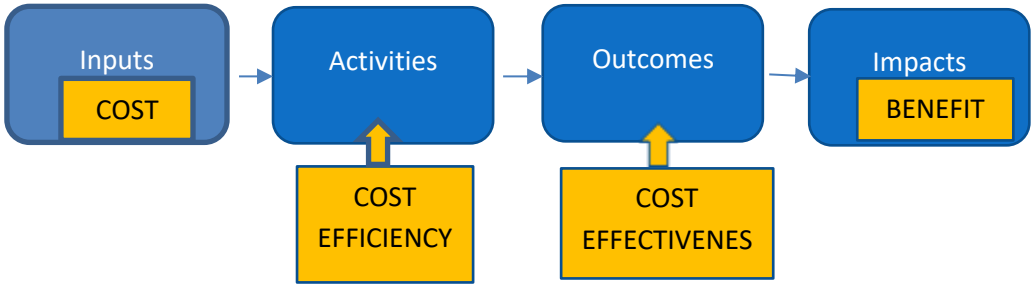
The Provider's Premises are located at:

Services will be offered from a range of venues across Dorset including GP practices, Dorset HealthCare clinic settings, the patient's own home and care homes, taking into account risk, infection control due to covid, timeliness and wherever is most appropriate for the individual, based on need and choice.

Logic Model evaluation framework- Dementia Services (appendix 1)



The key strength of a logic model is it identifies both the inputs and outcomes but also what otherwise is in the 'Black box' with regards the processes and activities that turn inputs into outputs. Furthermore, this approach assists with economic analysis for cost benefits.



	INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES
Diagnosing Well Measurements	Numbers of staff recruited including: Advanced Nurse Practitioners Registered nurses for triage Neuropsychologists recruited	Memory Service activity Advanced Nurse Practitioners diagnose less complex cases New triage process delivered in Memory Services Neuropsychologists assist in diagnostic process Neuropsychologists train and supervise other clinical staff	Waiting times for diagnosis Numbers diagnosed Numbers of patients utilising neuropsychology service 50% more clinics available 90% patients wait a maximum of 6 weeks for diagnosis (excluding scan) Complex diagnostic cases have detailed formulations Clinical staff trained	NHSE targets improved: diagnosis rates and waiting times Staff feedback Improved patient satisfaction Improved cost effectiveness Improved quality of diagnosis
Living Well **Measurements**	Numbers of staff recruited including: Dementia Co-ordinators Trainers for carer workshops	Numbers of roadshows held Dementia Co-ordinator Service activity Numbers of Cognitive Stimulation Therapy (CST) groups held and locations Numbers of Emotional Wellbeing groups held and locations	Attendance at roadshows Numbers of admissions to acute hospitals with primary diagnosis of dementia Numbers of people supported Numbers of people with young onset supported Numbers of people attending CST groups	Patient and carer questionnaire* DEMQOL Health related quality of life for people with dementia tool* DEM QOL (mild to moderate) Quality of life for people with dementia* QUALIDEM (moderate to severe) Quality of life for people with dementia*

	INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES
			Numbers of carers attending workshops	Carers Checklist and ReQOL* Alzheimer's Disease Knowledge Scale – ADKS staff feedback & survey
Supporting Well Measurement	Community Mental Health Teams in place Numbers of staff	Community Mental Health teams offer support, treatment and interventions CMHT activity	All patients with dementia with a higher level of need are supported Family carers of those with higher needs are supported and offered advice and guidance Reduced crisis interventions Reduction in inappropriate admissions Numbers of and cost of admissions to acute hospitals with primary diagnosis of dementia Numbers of referrals to ICSD	Patients feel they have more personal choice and control Patients and family carers feel they have an enabling and supportive environment and feel valued and understood throughout Improved health and psychological wellbeing for patients and carers Improved quality of life
Supporting Well in Crisis Measurement	Staff numbers	Numbers of dementia related calls to crisis line Activity of ICSD Activity of day crisis provision	Numbers using the crisis helpline Numbers and cost of admissions to acute hospitals with primary diagnosis of dementia	Improved equity of outcomes across Dorset Improved quality of life and reduced stress for people with dementia and families

	INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES
		Activity of Dementia Specialist inpatient units	Numbers and cost of admissions to specialist dementia inpatient Numbers of MHA assessments	Reduced use of dementia specialist inpatient beds Reduction in numbers of patients being admitted to dementia specialist inpatient beds Reduced inpatient costs Staff retention Reduction in numbers of patients with a primary diagnosis of dementia being admitted to acute hospitals inappropriately Reduction in Mental Health Act assessments and detentions