# SCHEDULE 2 – THE SERVICES

1. **Service Specifications**

*This is a non-mandatory model template for local population. Commissioners may retain the structure below, or may determine their own in accordance with the Contract Technical Guidance.*

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| **Service Specification No.** |  |
| **Service** | Dementia Post Diagnostic Support and Outreach |
| **Commissioner Lead** | Janice Richards |
| **Provider Lead** |  |
| **Period** | January 2022 – December 2027 |
| **Date of Review** | August 2021 |

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| **1. Population Needs** |
| * 1. **National/local context and evidence base**   Dementia is a syndrome (a group of related symptoms) associated with an ongoing decline of brain functioning. Research shows that there are more than 850,000 people in the UK who have Dementia with 1 in 14 being over the age of 65 and 1 in 6 over the age of 80. The number of people living with Dementia is increasing because people are living longer. It is estimated that by 2025 there will be 1 million people living with Dementia.  Dementia is one of the main causes of disability in later life. Characterised by progressive memory loss, behavioural and personality changes, impaired reasoning and ability to care for oneself, it progresses over time, and in the later stages of the disease people become increasingly frail, may have difficulty eating and swallowing, experience incontinence and lose communication skills such as speech and become increasingly dependent on others.  Following diagnosis, all people with dementia should have access to a dementia adviser who can act as a point of contact for information and signposting to other services. The focus of work would be to help people with dementia to navigate the health and social care system.  There is **clear evidence** that **high quality post diagnostic support, provided over an extended period,** is essential in order to equip people living with dementia, their families and carers with the tools, connections, resources and plans they need to live as well as possible with dementia and prepare for the future.  As at June 2021 there are estimated to be 1,890 people living with dementia with 1,219 diagnosed. People living with Dementia are likely to be overrepresented in emergency admissions to hospital for UTIs, Falls, Sepsis and Pneumonia. Post diagnostic support can ensure that people living with Dementia and their carers are aware of the early signs of deterioration and correct pathways to avoid these hospital admissions.  It is recommended that the person living with dementia and their carer is allocated a named care coordinator who is a central point of contact for the person living with dementia and their carer for the rest of their lives. The care coordinator should also coordinate other necessary services. *(Living well with Dementia working Group London Strategic Clinical Network 2015*.)  Post diagnostic support (PDS) covers a range of services and information available to help those diagnosed with dementia and their carers, both immediately after diagnosis and onwards.  It must be on-going and flexible to adapt to the changing needs of the person, carer and family as the disease progresses.  For many carers, and for those with Young Onset Dementia, this can also include employer awareness and support. (NHS England 2021) |
| **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**   * + - To support people with dementia (post diagnosis) particulary those who do not meet the criteria for clinical or social care intervention     - To risk assess people living with Dementia and tailor follow up care with them accordingly.     - To navigate health and social care pathways for people living with Dementia and their carers.     - To assist people living with Dementia and their carers to prepare for a life with dementia     - To enhance the quality of life for people with dementia and sustain their independence     - To provide access, following diagnosis, to information, support and advice for people living with Dementia particularly around UTI’s, Falls, Sepsis and Pneumonia     - To enable people with dementia and their carers to remain active and connected within the community     - To support and build resilience of people from underrepresented communities by encouraging and facilitating their engagement with mainstream dementia services |
| **3. Scope** |
| **3.1 Aims and objectives of service**   * To provide a consistent approach in post diagnostic support for each person who receives a diagnosis of dementia in Waltham Forest at a time appropriate to them and their carers, friends and family. * To act as a network of support and information within the local health and social care, voluntary and community sector organisations. The service is responsible for collecting and collating knowledge and information to facilitate access to and understanding of local health and social care support available to people diagnosed with dementia and their carers where this relates to the person living with Dementia. * To support people diagnosed with dementia and their carers through the care pathway. This is to ensure that there is a continuity of personalised contact, information, sign posting and liaison support. The roles actively promote self-help, access to information, and peer support.   **3.2 Service description/care pathway**  The provider will offer all residents of Waltham Forest who have a diagnosis of Dementia support following their diagnosis. The support will be person centred but will include the following:  The service will work in close partnership with local care providers and referral partners and this shall carry out the following functions:   1. To coordinate the support for a people living with dementia and their carers on an on-going basis; dependent on the need of the person 2. To provide tailored accessible, accurate information about dementia from diagnosis onwards and support people to make use of this information; 3. To assess the needs of people with dementia and produce a plan to support them and their carer post-diagnosis; 4. To share the support plan of the person living with dementia with the relevant health and social care services including their GP and assigned Care Coordinator to enable integrated support where applicable 5. To maintain up-to-date records on engagement with the service user and/or their carers, and their development; 6. Signpost and facilitate access to services and support to ensure people living with dementia have the help and care they need; 7. Visits to the home of people living with Dementia to observe their general wellbeing and physical health as appropriate 8. Ensure follow up of all aspects of the support plan prior to discharge from service with onward referrals where appropriate 9. Ensure the service is assessible to all people with dementia and their carers in the borough, with a special focus on people from under represented communities 10. To identify and respond to unmet information needs. 11. To actively identify other appropriate community engagement resources such as Day Centers, cafes, and encourage and facilitate service user participation. 12. The service will also undertake the development of peer support networks such as support groups and dementia cafes for people with dementia and their carers. The intention is to provide practical and emotional support, reduce social isolation and promote self-help.   **Financial and legal advice**  **Lasting Powers of Attorney (LPA)**  A person with dementia can appoint someone on their behalf who can make decisions for them if they lose capacity. This formal process requires filling out forms and then registering them with the office of the public guardian. It can take some time to register so this needs to be completed proactively rather than at crisis point.  Someone can be appointed to be an LPA for two types of decisions:  • Property and affairs  • Health and welfare - this allows them to make decisions about medical treatments including refusing treatment but it does not allow them to insist upon treatment).  An LPA needs to be completed when people are still able to express their wishes. It is a legal requirement that the person with dementia has mental capacity on several specific points when applying for this. It gives the appointed person the right to be included in medical decisions where they represent the views of the person with dementia. In the absence of an LPA, family will still be invited to be involved in discussions and decisions but they do not have a legal right to decision making.  **Advance care planning (planning ahead) and end of life care**  People respond to a diagnosis of dementia in different ways. Some people may want to think and plan for the future. Others may want to focus on taking each day as it comes. Everyone should be offered the opportunity to talk about their future and their wishes and preferences if they would like to. This may be at any stage of their illness. These types of conversations about the future are often referred to as advance care planning (ACP). ACP can cover a range of issues such as financial issues, medical choices or place of care. ACP means people thinking about, discussing and recording their wishes and decisions for future care. It is about planning for a time when they may not be able to make some decisions themselves. This is why it is very important to people with dementia.  People may need support to make advance care plans. This support could come from family, friends, care staff or doctors.  ACP discussions with a person with dementia will take time. It is unlikely a one-off conversation or meeting will cover everything. People in the early stages of dementia should be supported to make as many decisions as possible to ensure their future care and support best matches what they want.  **3.3 Population covered**  Residents of London Borough of Waltham Forest or those registered with a Waltham Forest GP who have been diagnosed with Dementia. Referrals will predominantly come from the Memory Clinic as people receive their diagnosis. Carers of people diagnosed with dementia may well refer themselves directly to the service as well as the person diagnosed. GPs and WXH may also refer on discharge people living with Dementia or where further support is identified.   * + The service will be responsive to age, gender, disability and lesbian, gay, bisexual and transgender (LGBT) issues, dealing with them in sensitively and inclusively.   + The service will have processes to ensure that specific cultural and religious needs are respected.   + The service should have access to external advocacy and interpretation/translation services appropriate to need.   + The service will be accessible to people with physical and sensory impairments.   + The service will be accessible to people with learning disabilities.   **3.4 Any acceptance and exclusion criteria and thresholds**  Residents of Waltham Forest or registered with a Waltham Forest GP who have not had a formal diagnosis of a form of Dementia.  **3.5 Interdependence with other services/providers**   * **North East London Foundation Trust ( NELFT ) – Memory Clinic** * **Whipps Cross Hospital** to ensure the referral route into the service is clear and acute clinicians are referring relevant patients into the memory service. * The evolving GP networks * **Clinical Commissioning Groups** to ensure commissioners have adequate information about the service in terms of cost and activity throughout the year. * **Local Authorities -** London Borough of Waltham Forest * **Police and probation services -** Community Safety, Multi Agency Public Protection Arrangements – monitoring high risk offenders (MAPPA), Multi Agency Risk Assessment Conference – Domestic Violence (MARAC). * **General Practitioners -** This will include other non-mental health specific primary care services where appropriate. * **Integrated Community Equipment Services (ICES) and Telecare Services –** * **Voluntary Services** – especially those associated with older people, carers and dementia. |
| **4. Applicable Service Standards** |
| **4.1 Applicable national standards (eg NICE)**  [Overview | Dementia: assessment, management and support for people living with dementia and their carers | Guidance | NICE](https://www.nice.org.uk/guidance/ng97)  [Overview | Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset | Guidance | NICE](https://www.nice.org.uk/guidance/ng16)  [Dementia – discussing and planning support after diagnosis | Quick guides to social care topics | Social care | NICE Communities | About | NICE](https://www.nice.org.uk/about/nice-communities/social-care/quick-guides/dementia-discussing-and-planning-support-after-diagnosis)  **4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)**  **4.3 Applicable local standards**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Indicator** | **Frequency** | **Threshold** | **Frequency** | **Outcome** | | Percentage of people newly diagnosed with Dementia offered support |  | 95% | Monthly | There will be an increase in the number of people living with Dementia offered appropriate support. | | Number of people diagnosed with dementia provided with a risk assessment. |  | 70% | Monthly | There will be an increase in the support provided to people living with Dementia in relation to their risks identified. | | Number of people diagnosed with dementia prevented from hospital admission |  | 20% | Monthly | There will be an in improvement in the quality of life for people living with Dementia and a reduction in unnecessary hospital admissions. | | Number of people diagnosed with dementia with an advanced care plan in place. |  | 30% | Monthly | There will be support for people living with Dementia from diagnosis to death. | | Number of dementia friend’s sessions delivered. |  |  | Monthly | There will be an increase in awareness of dementia across providers, and organisations in Waltham Forest | | Number of dementia clinics facilitated |  | 12 | Monthly | There will be an improvement in the support to people living with Dementia in primary care. | | Report on quality of life improvements offered by support. |  |  | Monthly |  | | Patient and carer satisfaction survey |  | 70% | Annual |  | |
| **5. Applicable quality requirements and CQUIN goals** |
| * 1. **Applicable Quality Requirements (See Schedule 4A-C)**   2. **Applicable CQUIN goals (See Schedule 3E)** |
| **6. Location of Provider Premises** |
| **6.1** **The Provider’s Premises are located at:** |
| **7. Individual Service User Placement** |
| Not applicable. |
| **8. Applicable Personalised Care Requirements** |
| **8.1 Applicable requirements, by reference to Schedule 2M where appropriate** |