

# SERVICE SPECIFICATION

## Nottinghamshire, Nottingham City & Bassetlaw

<b>Service / Care pathway / Cluster</b>	<b>Working Age Dementia Service -</b>
<b>Commissioner Lead</b>	
<b>Provider Lead</b>	
<b>Period</b>	
<b>Date of Review</b>	

### 1. Purpose

#### 1.1 Policy context

Dementia is a clinical syndrome characterised by a widespread loss of mental function, including memory loss, language impairment, disorientation, change in personality, self-neglect and behaviour which is out of character. (Department of Health, 2001).

Although most prevalent in the over 65 age group dementia is not restricted to older adults, there are 15,000 people under the age of 65 with dementia in the UK, although this figure is likely to be an underestimate.

#### 1.2 Local strategic context

Prevalence rates estimate that 247 people in Nottinghamshire will have dementia below the age of 65 in 2008 rising to 260 by 2017. This is based on a study of known referrals and is likely to be an underestimate (Knapp, 2007).

#### Relevant Policies

- Nottinghamshire Guidelines on identification and management of dementia in clinical care.
- The National Dementia Strategy '[Living Well with Dementia](#)' 2009 and its associated delivery mechanisms provide a range of exemplar projects as well as a large number of pilot projects.
- The [Joint Commissioning Framework](#) for Dementia (DH June 2009)
- CSED Dept of Health care networks website – particularly learning from the 2009 Wirral older persons project
- ExtraCare Housing and People with dementia Scoping Review 2009 Housing & Dementia Research Consortium (Joseph Rowntree).
- NICE guidance clinical guidelines Dementia June 2009
- NICE/SCIE (2006) Dementia: Supporting people with dementia and their carers in health and social care, (NICE Clinical Guideline 42) December 2006
- NICE, Health Technology Appraisal, Donepezil, galantamine, rivastigmine (review) and memantine for the treatment of Alzheimer's disease (TA111) (NICE, 2006, revised 2007)

#### 1.3 Aims and objectives of the service

This service is commissioned to ensure that younger people with dementia have access to an age-appropriate service in accordance with the East Midlands Next Stage Review *A Picture of Health*, 2008 and the National Dementia Strategy 2008.

This is a community-based service; where inpatient admission is required admission will be based on individual needs and vulnerability and could be within NUH, MHSOP or AMHS.

## 2. Service Scope

### 2.1 Service user groups covered (including care clusters, where relevant)

This service is available to people below the age of 65 with dementia registered with a Nottingham City, Nottinghamshire County or Bassetlaw General Practice.

This service complements the existing dementia service for people aged 65 and over and the provider will accept referrals irrespective of gender, race, religion, ethnicity, and physical or mental ability.

### 2.2 Exclusion criteria

- Individuals not registered with a Nottingham City, Nottinghamshire County or Bassetlaw GP
- Patients without either an established or suspected diagnosis primarily of dementia, which is progressive in nature.

### 2.3 Geographical population served

This service will cover the geographical area of Nottinghamshire consisting of the 3 local PCTs: NHS Nottingham City, NHS Nottinghamshire County and NHS Bassetlaw.

### 2.4 Service description/ care package- overview i.e. what is provided

#### Assessment

Diagnosis will be determined by the specialist team for younger people with dementia. There will be a single point of access via the OT consultant (lead for the service), and diagnosis will be through the dementia diagnostic clinic and, where appropriate, in community settings familiar to the patient.

In more complex cases, the team will be supported by a specialist neurology service including MRI scans and spectroscopy.

It will be essential to assess patient's level of functioning and risk, at home, in the community and potentially at work. The person and their family will immediately be given information and support.

#### Care planning

Each patient will be managed by a care coordinator within their local CMHT, who will: -

- Manage and care coordinate all referrals to their team, of people below the age of 65 years with actual or suspected dementia ensuring all individuals and carers have a named person to reduce fragmentation.
- Provide input into the memory assessment service for their area when a younger person with dementia is attending to provide specialist knowledge and information from the outset.
- Complete a functional assessment (assessment of activities of daily living) for every younger person with dementia referred to their team, who wishes to. Providing advice and the implementation of strategies to maintain skills, roles, ability, and reduce risks from the outset, (this may also include assessment for assistive technology).
- Devise care plans with the individuals to ensure activities chosen are graded at the right level for individuals to succeed and maintain health and well being.
- Where appropriate work with the allocated worker from Nottingham City Adult Social Care Services, or Nottinghamshire County Adult Social Care and Health Departments.
- Outreach to inpatient/day services/residential care to provide advice, information and continuity of care.
- Work with palliative care specialists to provide quality end of life care for younger people with dementia

#### Interventions

Care and treatment interventions – this will consist of: -

- Treatment: including pharmacological and psychological interventions in accordance with NICE guidance
- Information and advice
- Practical support - communications, skill maintenance and access to community facilities.
- Patients and their families/carers will also be signposted to other forms of support provided by partners in Adult Social Care & Health and the voluntary sector.

## Health Promotion

The provider will be expected to improve links with primary care and other referral routes to increase awareness and promote services available for people below the age of 65 with dementia so people are referred and diagnosed earlier.

## Consultation & Liaison

The team will offer consultation to clinicians from other services: mental health, learning disabilities, alcohol and substance misuse, where dementia is a secondary diagnosis

## 3. Service Delivery

### 3.1 Location of service

Workers will be allocated to locality based CMHTs for older people.

The OT consultant will be based in Kirkby-in-Ashfield.

The specialist neurology clinic will be at the Queen's Medical Centre campus of Nottingham University Hospitals.

### 3.2 Days/ hours of operation

Hours of work will be Monday to Friday 9 am to 5 pm.

### 3.3 Referral processes

Referrals will be accepted from GPs, hospital acute specialists and other mental health services and will be assessed by a senior clinician.

### 3.4 Response times

All referrals will be seen within 8 weeks from the date of the referral.

### 3.5 Care pathways (where applicable to meet each care cluster)

**Identify: partnerships  
transitions and interfaces between services and agencies  
subcontractors**

Staff will comprise a medical consultant, an occupational therapy consultant, CPNs, OTs, therapy technical instructors, administrative staff and a support worker from the Alzheimer's Society, this will be based on a sub-contracting arrangement between NHT and the Alzheimer's Society. A Consultant Neurologist will also be part of the team via a sub contracting arrangement between NHT and NUH.

Other key relationships will include: -

- Primary care
- Palliative care
- Nottingham City Adult Services, Housing and Health and Nottinghamshire County Adult Social Care and Health Departments
- Voluntary services
- NUH Neurology services - the service will work with the neurology service at NUH to develop a higher-level memory assessment clinic which is capable of dealing with people with more complex or unclear presentations. This will be based on a sub-contracting arrangement between NHT and NUH.

### 3.6 Discharge process

Clients and their families will remain known to the team whilst their needs remain specialist.

Individuals will be discharged back to the referrer when intervention is complete with care packages tailored to the individual's needs if required. Information on how to re-refer if needs change will be given before discharge.

When clients reach 65 years their needs will be discussed following multi-disciplinary assessment and discussion with clients and carers/families and if they no longer require specialist care they will be transferred to their local CMHT for older people.

### 3.7 Training / Education / Research Activities

#### Training & Development

Essential and other training will be provided by NHT. Highly specialist training provided by external agencies will be commissioned and funded by NHT as part of the service level agreement.

The Team will provide high-level training to GPs, Specialist Workers and other services; and will contribute to training for carers.

#### Clinical & Managerial supervision

Management supervision will be provided to the OT consultant through NHT management structures and clinical supervision will be provided by NHT's Associate Director for Allied Health professionals. Clinical supervision will be provided to workers by the OT consultant with line management from the CMHT team leaders.

#### Research and Audit

The Team will participate in research studies into dementia as appropriate. Undertaking research and audit as appropriate e.g. to identify measurable outcomes, ensure service is meeting demand, efficient and cost effective. The Team will ensure an accessible and quality service is provided, based on evidence-based practice.

### 4. Quality Indicators

<i>Quality Indicator(s)</i>	<i>Method of Measurement/ information requirement</i>	<i>Incentive or sanction</i>
100 % of referrals will have a visit within 8 weeks.	Case load review Report to commissioners with reason for delay	Raised as a performance issue in Quarterly or 6-month review
A service user and/or carer/relatives experience survey is offered to a random sample of patients.	Audit by service head Report to commissioners	Raised as a performance issue in Quarterly or 6-month review
Patients will be successful in achieving personal goals (outcome measures to be developed)	Monitoring	Raised as a performance issue in Quarterly or 6-month review

### 5. Activity Plan

### Activity Plan

The directorate will establish a database to record referrals to the service. This will help to confirm that the expected numbers of new cases are being identified at Primary Care Level and referred for confirmation of diagnosis and initial advice on treatment.

Activity requirements:

By PCT/cluster/practice

1. Referrals no/source/equality data - age ,gender, ethnic origin, employment status
2. Discharges/reason
3. No. on caseload
4. Contacts

Activity for 2010 /11 is set out below:

	Nottinghamshire County tPCT	Nottingham City PCT	Bassetlaw PCT
SLA Team contacts			
LDP Caseload size			

### 6. Prices

Basis of Contract	Unit of Measurement	Price	Thresholds	Expected Annual Contract Value
Block Arrangement Price _____*		£		
<b>Total</b> (Included in consultant 1 <sup>st</sup> and follow up and community lines in the activity plan)		£		

\*delete as appropriate