Derby City Dementia Support Service – draft Specification for Soft Market Testing

**CONTENTS**

|  |  |
| --- | --- |
| 1. BACKGROUND
 |  |
| 1. Aim of Service
 |  |
| 1. Approach
 |  |
| 1. Service Objectives
 |  |
| 1. Scope of Service
 |  |
| 1. Range of Services
 |  |
| 1. Promotion
 |  |
| 1. Management
 |  |
| 1. Monitoring
 |  |
| 1. Accommodation
 |  |
| 1. PERSONNEL/STAFFING
 |  |
| 1. Service Values, Principles and Ethos
 |  |
| 1. RETENDERING AND HANDOVER
 |  |
|  |  |

**List of Appendices:**

Appendix A The Well Pathway for Dementia

Appendix B Summary Report for Derbyshire and Derby City Dementia Support Consultation

Appendix C The Living Well Programme and Cognitive Stimulation Therapy

Appendix D Recommended split between providing information and improving social inclusion for the different types of groups

**SERVICE SPECIFICATION**

**Dementia Support Services for Derby City.**

**1 Background**

**1.1 Derby City Council**

1.1.1 Derby City Council is a unitary authority with responsibility for all local authority functions including social care (Adult Care, Children and Younger Adults) serving 17 wards within the City area.

1.1.2 The population of Derby City, (March 2011 census) was 248,752, there is a considerable variation in population density between wards, the most densely populated wards such as Normanton (75.4 people per hectare), Abbey (58.9 people per hectare) and the least densely populated Spondon (15.5 people per hectare) and Allestree (21.0 people per hectare). The proportion of males (49.5%) and females (50.5%) is similar, and the City has significant variation in the age profile of the wards, with the highest numbers of people in 60-64 age bands in Allestree and Mickleover. Within the City 10 wards had more than 1000 people aged 75 plus in 2011.

1.1.3 The percentage of City population that identify themselves as belonging to a BME (Black and Minority Ethnic) community group is 24.7% an increase from the 15.1% recorded in 2001. The largest BME group recorded was Asian/Asian British representing 12.6% of total population. Within this group the Pakistani community represented 5.9% of the total population and the Indian community made up 4.4% of the total population. The 'Other White' ethnic group, which includes Eastern Europe, made up 3.9% of the total population – the third largest BME group in the City. In addition, 13.9% of the City's population recorded that they were born outside of the United Kingdom – indicating the rapid change in the City's population profile.

1.1.4 There are an estimated 37,669 people over the age of 65 in Derby City, and the prevalence of people with Dementia in this group is 2,980 and it is predicted that this may rise to 3,358 by 2020.

**1.2 NHS Derby and Derbyshire Clinical Commissioning Group** brings together the combined expertise of 112 local GP practices to commission health services on behalf of over 1,065,000 patients in Derbyshire. Their vision is to continuously improve the health and wellbeing of the people of Derbyshire, using all resources as fairly as possible.

**1.3 Relevant National Government Legislation, Policies and Guidance**

Current national legislation and relevant policies and guidance affecting this service include:

* Department of Health (2009) Living Well with Dementia: a National Dementia Strategy
* Derbyshire Dementia Equity Audit (2010)
* National Dementia Declaration for England (2011)
* Think Local Act Personal: Making Progress towards personalised, community-based support (2011)
* NICE (2014) Dementia Care Pathway
* The Dementia Toolkit (2014)
* Direction of Travel: Carers’ Strategy (2015-18)
* Care Act (2014) – Regulations and Statutory Guidance
* NHS England (2015) The Well Pathway for Dementia (please see Appendix A)
* Prime Minister’s Challenge on Dementia for 2020 – Implementation Plan (2016)
* Community Mental Health Framework – CMHF (2019)
* Integrated Health and Social Care Systems - ICS (2021)

**1.4 Relevant Local Policies and Guidance and Services**

**1.4.1** The original Derbyshire Joint Commissioning Strategy for Dementia was produced in 2014 and ran to 2019. The Strategy was reviewed and updated in 2020 to run to 2025 by Joined Up Care Derbyshire (JUCD) commissioning partners from Derby City and Derbyshire County Councils and the NHS to reflect the current challenges faced by people living with dementia and developments in local services. The emphasis of the Strategy is on the Derbyshire Well Pathway for Dementia (see appendix A).

**1.4.2 Memory Assessment Services (MAS)**

The Memory Assessment Service has been developed across Derbyshire and Derby City and is provided by Derbyshire Healthcare Foundation Trust. The purpose of MAS is to provide specialist assessment, diagnose Dementia, initiate treatment and provide a care plan.

It is expected that the Dementia Support Services will be present at the diagnostic appointments to offer immediate support and contact information following diagnosis. The Provider will be expected to liaise with the MAS service to identify the times and venues of the MAS clinics that the services will attend.

The Providers of the Dementia Support Services will need to be flexible in their approach to supporting MAS Clinics, as venues and localities may be subject to change through developments of Memory Assessment services.

**1.4.3 Living Well Programme**

The programme has been developed by Registered Clinicians to impart information, provide Clients with strategies and education to support them to live well with Dementia. This programme is provided by both Derbyshire Healthcare Foundation Trust and Derbyshire Community Health Services.

**Appendix C** gives detail of the Living Well programme content and provision.

**2. Aim of Service**

2.1 The aim of this service is to enable easy access to appropriate information and advice for individuals with Dementia and their carer(s), to develop a range of activity-based groups and to facilitate peer support networks for people with Dementia and their carers in all areas of Derby City.

**3 Approach**

3.1 The Provider will:

* Seek continuous improvement to best utilise the resources available and by finding more efficient ways of developing the service.
* The Provider will work in partnership with relevant statutory, voluntary and independent sector agencies.
* Work to a contract which is flexible enough to reflect changing needs, priorities and lessons learnt, and which encourages client participation.
* Form strong links with key partners in the wider health and social care network.
* Utilise public health resources to understand the fluctuating needs of the local populations in order to adapt provision to meet these needs
* Work closely with the Memory Assessment Services to provide information and advice following diagnosis including the provision of face to face information.
* The Provider will involve Clients and their families in planning and evaluating the services provided.
* The Provider will support the Commissioners in working with Clients and other stakeholders to develop services for people with Dementia and their carers.

**4 Service Objectives**

4.1 To provide easily accessible information for people who are experiencing memory loss and people who are living with Dementia and their carer(s).

4.2 To enable people to live well with Dementia and remain living in their own homes and communities for as long as possible.

4.3 To reduce social isolation for people with Dementia and their carers by providing opportunities to access peer and carer support in their local area.

4.4 To advise and signpost people with Dementia and their carer(s) to access support options at diagnosis and throughout the Dementia pathway.

4.5 To increase access for currently under-represented groups including different ethnic communities, young onset Dementia, people with sensory impairments and those with a learning disability.

4.6 To provide advice and practical support for people with Dementia and their carer(s) to support their independence e.g. welfare benefits support.

4.7 To increase the knowledge of carers by providing specific information to develop their confidence and resilience.

4.8 To actively promote partnership working and co-ordination between services for people with Dementia and their carer(s).

4.9 To work flexibility and innovatively to ensure on-going support as required throughout the duration of the Dementia pathway.

4.10 To ensure an open-door policy is maintained so Clients can access the service at any time for further support when they need it most.

**5 Scope of Service**

**5.1** **Clients**

5.1.1 Clients are defined as those who meet one of the following criteria:

* has Dementia or
* has concerns about their memory
* is a carer / family member of the above
	+ 1. Clients must be a resident of Derby City and/or registered with a GP belonging to Derby and Derbyshire Clinical Commissioning Group (CCGs or is a carer of someone registered to a GP belonging to the CCG).

5.1.3 The service will be accessible to and suitable for all sections of the community including people:

* who are physically frail or disabled
* of all ages, including people with young onset Dementia
* who have other mental or physical health problems
* who have a Learning Disability and/or with Downs Syndrome
* of all ethnicities and should be sensitive to cultural needs of the different groups
* from other sections of the community who are identified as having difficulty accessing local services

5.1.4 The Commissioners reserve the right to alter these components in light of future requirements. In addition the Commissioners will consider alternative proposals from the Provider during the life of the contact where they can evidence that these could better meet the outcomes.

* 1. **Operational Hours**

5.2.1 The service will be delivered at a time which meets the needs of people with Dementia and carers (see also section 8). Consideration should be given to timing of services so that it provides ease of access for working people with Dementia and carers. The Provider will be required to demonstrate that the service is flexible to meet the needs of working Clients. This may include evening and weekend working.

5.2.2 The Provider must work in partnership with Memory Assessment Services (MAS) to ensure that post diagnostic advice and information is provided by a Dementia Adviser at Memory Assessment clinics.

5.2.3 The Provider will need to ensure continuity of service provision including during holiday periods.

* 1. **Referrals**

5.3.1 At the point of diagnosis, people with Dementia will be offered referral to the Dementia Support Service by the Memory Assessment Service.

5.3.2 Referrals will also be accepted from a range of statutory or voluntary organisations, primary or secondary care or by self-referral for people who are worried about their memory, before or after diagnosis.

5.3.3 The Provider will develop a referral form which records appropriate information to help identify more complex cases.

* + 1. The Provider should respond to all referrals within 72 hours.

5.3.5 The Provider will see Clients within 10 Business Days from the time of the referral. It is expected that the Provider will operate a triage system whereby referrals are prioritised according to need. The Provider will agree details of triage arrangements and follow up arrangements with the Commissioners prior to the Service commencing.

5.3.6 The Provider will only refuse a referral if it clearly does not meet the criteria set out in section 7.1. The Provider must respond to the referrer in writing explaining their reasons and offer signposting to more appropriate services.

5.3.7 If the client declines the service, they will be offered the opportunity to receive local periodic updates about the service so they can keep in touch.

* 1. **Sharing of Information**

5.4.1 The Provider and its Personnel shall comply with Data Protection legislation and article 8 of the Human Rights Act (the right to privacy) and any subsequent legislation that is applicable during the course of the Agreement.

5.4.2 As a minimum this means:

* Clients are informed of how their personal data will be processed;
* Personnel will not share information about Clients outside of the workplace;
* Records will be accurate and kept up to date;
* Clients will have a right to access to information held about them;
* Personal data will be kept secure at all times;
* Any disclosure of personal information must be done securely;
* Personal data will not be collected that is not required for the provision of the Service.

5.4.3 The Provider shall have a Data Protection Policy that governs conduct of Personnel and Volunteers to ensure personal data is kept secure.

5.4.4 The Provider will ensure that the Personnel who provide this service are aware of their responsibilities under Data Protection legislation. The Provider will ensure that new Personnel receive training on this as part of their induction and receive refresher training on their responsibilities under the Data Protection legislation at least every two years.

5.4.5 The Provider will ensure appropriate security procedures are followed to protect the personally identifiable information belonging to Clients when making referrals or communicating on their behalf.

5.4.6 The Provider will provide the required information for the Council to complete a Data Privacy Impact Assessment. The Provider should note that this may change the draft Information Processing/Sharing Agreement in Schedule XX **- TBC**

*Location of Personal Data Storage/Back-up*

5.4.7 The Service Provider is to ensure that any personal data processed under this contract shall not be processed outside of the UK. If requested the Council may consider alternatives to this as long as significant security requirements are met, which may mean a change of terms and conditions the Service Provider has with any third-party storage solution provider. The Council is under no obligation to consider a request to store this personal data outside of the UK. Any additional costs the Service Provider incurs to meet these requirements shall be entirely met by the Service Provider.

5.4.8 The Service Provider is required to understand where the personal data is 'stored' especially if using 'cloud services'.

5.4.9 The Service Provider will engage and respond to any request from the Council concerning the location of stored personal data, with proof if requested, at no extra cost to the Council.

5.4.10 With the consent of the client, the Provider is responsible for sharing appropriate information with the referrer, client’s GP and other organisations the client is involved with.

**6 Range of Services**

6.1 The following service functions will be provided across all areas of Derby City.

* Dementia Information and Advice – 60% of provision.
* Community Support Groups – 40% of provision.

6.2 This percentage split is offered as a guide of how the services should prioritise resources and the details are to be agreed and developed in consultation with the Commissioners.

6.3 This range of services is based on the results of the consultation undertaken regarding Dementia Support in Derbyshire and Derby City – please refer to Appendix B for further detail.

**6.3 Dementia Information and Advice (60%)**

The Provider will:

6.3.1 Provide a single non-premium landline telephone number that is operated by staff who are suitably trained to be the first point of contact. As a minimum this will be available Monday – Friday, 10:00am – 6:00pm (timings to be reviewed periodically with the commissioners). The Provider will have arrangements in place to ensure continuity of service, during annual leave and staff sickness. An answerphone service will be provided out of hours which will signpost to alternative sources of information/helplines.

6.3.2 Provide an easily accessible website providing local information and a local email contact for the service which will be checked each working day.

6.3.3 Provide written contact details of a Dementia Adviser for all Clients.

6.3.4 Prioritise referrals and calls according to need and allocate Dementia Adviser’s time accordingly.

6.3.5 Provide high quality information in a range of formats including for those who speak different languages and easy read information for people with learning disabilities.

6.3.6 Provide information packs containing relevant and up to date information and contact details that will benefit people who have Dementia and their carer(s).

6.3.7 Ensure an open door policy is maintained so Clients can access the service for further support when they need it most.

6.3.8 People who contact or decline the service are given the opportunity to receive local periodic updates about the service so they can keep in touch.

6.3.9Provide suitably trained Dementia Advisers who will:

* Operate within the community and undertake home visits where required, in addition to face to face and telephone support to ensure equitable access to the service across all localities in Derbyshire or Derby city. This element of the service may need to be available outside of usual office hours to meet the needs of clients.
* Signpost people with Dementia and their carer(s) to the most appropriate services throughout any stage of Dementia including early intervention / preventative services through to end of life.
* Enable people with Dementia and their carer(s) to navigate the health and social care systems and access relevant information and services.
* Attend Memory Assessment Service clinics to offer information and advice immediately following diagnosis providing a contact for ongoing support.
* Provide continued support as required for carer(s) when the cared for is admitted to hospital or any other health or care setting.
* Work closely with acute and community hospital teams to:
	+ accept new referrals for this service
	+ to support carers through the discharge process
	+ support with adjustments at home following discharge
* Ensure carers are offered on-going support and appropriate signposting to services following bereavement.
* Work closely with Derbyshire and Derby City approved local partners who provide telecare / assistive technology that may be of benefit to Clients.
* Provide opportunities for people with Dementia and their carer(s) to maximise their receipt of welfare benefits and to obtain impartial financial and legal advice by signposting to alternative services or providing direct support.
* Provide advice on the need for contingency planning including emergency care plans and end of life care planning.
* Provide on-going support as required throughout the duration of the Dementia pathway; frequency and type of contact will vary according to need.

**6.4 Community Groups (40%)**

6.4.1 The Provider will deliver and support a range of groups which both increase knowledge (by providing information) and increase social inclusion. The focus of each group will vary; the Diagram in Appendix D recommends the split between providing information and improving social inclusion for the different types of groups.

6.4.2 The Provider will be expected to develop a range of peer support and activity groups for people with Dementia and their carers based on the interests and needs of people in the area

6.4.3 The Provider will be expected to support and develop a range of regular and accessible groups for people with Dementia and carers in all localities of Derby City.

6.4.4 Provision should be made for the person with Dementia to be cared for and engaged in meaningful activity whilst the carers attend any community groups and therefore staffing levels will be appropriate.

6.4.5 The Provider should ensure that the community groups are available in local community-based venues which are easily accessible by public transport and have parking available.

6.4.6 The distribution of groups should be arranged, taking into account other services available to the client group and other existing provision to ensure there are no gaps or duplication.

6.4.7 The same provision may not suit every community and therefore the Provider is encouraged to deliver innovative solutions whilst also recognising areas of change and improvement.

6.4.8 The Provider will continually evaluate local need in each area, adapt provision accordingly and actively seek opportunities to utilise the support available from other services.

6.4.9 The Provider will regularly evaluate all community groups through participant feedback to ensure the content is appropriate and that service objectives are achieved.

6.4.10 People who use groups and activities may be asked to make a small contribution towards the activity or refreshment cost. The Provider must ensure that any charge:

* is affordable and does not act as a barrier to accessing support activities
* is appropriate to the activity and discussed with Clients as part of developing activity programmes
* The Provider ensures necessary financial systems are in place

6.4.11 Community Groups will provide support which reflects local needs, including but not limited to:

* A range of themed sessions whereby people with Dementia and their carers have the opportunity to engage in activities including musical sessions.
* Other activities/themes which could include speakers, group discussions, social activities, practical advice, art sessions and exercises.
* Activities that promote physical and mental wellbeing that are appropriate and engaging for the client group.
* Opportunities for people with Dementia and carers to develop their social support networks.
* Opportunities for sharing and joint problem solving.
* A local hub for people with Dementia and their carers to meet regularly.
* Appropriate staffing levels will be provided to accommodate those who attend.

6.4.12 Information for Carers Groups

The Provider will need to ensure that information for carers groups complement the education sessions provided by the Living Well programme (see Appendix C for details of provision) or alternative education programmes provided by health professionals.

The Provider will work closely with key partners to ensure that information groups for carers are available in each locality in Derby city. These may run alongside community groups for people with Dementia or run as separate groups.

The Provider will deliver information for carer(s) groups which will:

* Provide carers with realistic information about topics that cover the whole Dementia Well Pathway in an easily accessible and relevant format.
* Be tailored to cover different stages and severities of Dementia.
* Increase carers’ awareness of their rights and local services, support and community opportunities.
* Focus on increasing the confidence and resilience of carers.
* Help carers to recognise their status as carers and recognise their own personal limitations.

6.4.13 Self-sustaining Groups and Activities

* Alongside the directly managed groups described above, the Provider will identify opportunities to create and support local self-sustaining community groups that meet independently of the service.
* Supporting self-sustaining groups includes:
* - starting new groups for people with Dementia and their carers and supporting them to become independent groups.
* - supporting existing independent Dementia specific groups to grow and continue.
* The Provider needs to allow self-sustaining groups to flourish by stepping back and stepping in to support or facilitate as required.
* The Provider will have an ongoing role in growing the membership of the self-sustaining groups.
* Supporting the development of self-sustaining groups will allow the Dementia Support Services to provide additional support options for a greater number of Clients.

**7 Promotion**

7.1 The Service will be known and promoted as the Derby City Dementia Support service.

7.2 Any promotional or information resources will be developed in conjunction with the Commissioners in order to ensure consistency and local branding on all documentation produced by the service

7.3 The Provider will need to deliver an up to date and easily accessible webpage that is clearly branded as a local Dementia Support Service.

7.4 The Provider will be responsible for promoting the service through local media, community events, local businesses and other appropriate means to encourage referrals.

7.5 Extensive marketing and promotion of the Dementia Support Service will be undertaken by the Provider through a wide range of means, including newsletters, leaflets and advertising.

7.6 The Provider should build a network within the local community including community leaders, local GP practices, hospitals, pharmacies, community groups, voluntary groups and local businesses where appropriate.

7.7 The Provider will create strong links with other organisations (statutory and non- statutory) to ensure referrals are received from a wide variety of sources.

**8. Management**

8.1 The Derby service will be commissioned and monitored by Derby City Council working with NHS Derby and Derbyshire CCG.

8.2 The Manager of the service will join health and social care Commissioning representatives in quarterly monitoring meetings to discuss the following:

* Compliance with the funding agreement and delivery of the service
* Reviewing the service provision and agreeing future plans
* Service monitoring and evaluation
* Implementing quality assurance.

8.3 Additional meetings can be held at the request of either the Commissioner or the Provider should it be considered necessary.

8.4 The Provider is required to provide quarterly and annual performance reports based on the service outcomes and activity monitoring requirements below.

8.5 If the Provider is unable to respond to referrals within the agreed timeframe, any change to the triage arrangements and prioritisation for services will be agreed with the Commissioners.

**9. Monitoring**

9.1 The full details regarding the Monitoring Information requirements are included in **Schedule 2**.

**10. Accommodation**

10.1 Providers will meet the costs required to cover accommodation as well as associated accommodation costs such as office hardware, telephones and business support costs within the overall budget.

10.2 It is not an expectation that office accommodation should be public facing but should be located to facilitate a convenient base for staff working within the service and to ensure the appropriate administration of the information and advice service provision.

**11. PERSONNEL/STAFF**

11.1 The Provider will supply sufficient and suitably experienced and qualified staff and volunteers (i.e. staff that have undertaken or are willing to undertake specialist training) to effectively provide and manage the service as described in this Specification.

11.2 Once fully trained, staff should demonstrate the following competencies:

* Excellent customer service skills including the ability to deal with difficult and challenging situations
* Facilitation skills to ensure groups operate effectively
* Good understanding of the common causes of Dementia
* High level of understanding of the impact Dementia has on the lives of people with Dementia and their carers
* High level of understanding of how to support people to live with Dementia independently in the community
* Knowledge of The Dementia Well Pathway including the services which are available to people locally

11.3 The Provider will ensure that all staff are subject to enhanced DBS checks where required and meet the necessary requirements before appointed.

11.4 The Provider will have a policy in place regarding meeting clients in the community, which includes protocols for lone working.

11.5 The Service Provider will ensure that all Staff have a right to work in the UK and have a robust recruitment process to ensure all pre-employment checks are made as appropriate for requirements of delivering this Service, including any new requirements due to the UK leaving the EU

**11.6 Volunteers**

11.6.1 The Provider is required to recruit volunteers to enhance the service offer.

11.6.2 The Provider must ensure that advanced Disclosure and Barring Service (DBS) checks are carried out and appropriate levels of training and supervision are provided in accordance with paragraph 17 of the main agreement.

11.7 Within the budget, Providers should ensure the costs required to enable this Service Specification to be met.

11.8 Staff supervision, appraisal and training and development.

 The Provider will be required to have the following systems in place:

* Regular supervision of all staff, including volunteers, by the line manager
* Annual staff appraisals for all staff
* Development and learning portfolios for all staff
* Induction and equal opportunities training for all staff
* Adult protection training for all operational staff
* Management development programme for first line managers and above
* Access to service related training programmes.

11.9 Derby City Council’s Staff Education training courses are available to the Provider’s staff, as a partner agency working with the Council. These can be found at:

 <http://www.derby.gov.uk/health-and-social-care/your-life-your-choice/support-from-adult-social-care/training-courses/>

These courses involve a charge in Derby City.

**12. Service Values, Principles and Ethos**

**12.1 Safeguarding**

12.1.1 The Service Provider will be fully compliant with the protocols for Safeguarding Adults and Safeguarding Children set out by the Council on our website;

* <http://www.derby.gov.uk/health-and-social-care/safeguarding-adults-at-risk/safeguarding-vulnerable-adults>
* <https://www.derbysab.org.uk/>
* <https://www.derby.gov.uk/health-and-social-care/safeguarding-children/>

12.1.2 The Service Provider will have a named officer will act as the lead safeguarding officer who will be responsible for reporting to the Council all concerns raised in connection with the protection of vulnerable adults at Stage One of the Safeguarding Adult Protection Policy and Procedures and inform the Council in writing who that person is. The Service Provider will notify the Council of any changes to this member of Personnel.

12.1.3 The Service Provider will ensure all its Personnel are aware that they are individually responsible for compliance with the Safeguarding Adult Protection Policy and that they know all the internal and external processes for reporting all concerns in connection with the protection of vulnerable adults and children where appropriate.

12.1.4 Personnel should be told in writing that they can report concerns through the nominated member of Personnel, or if they would prefer to, through the Council as set out in the Council’s Safeguarding Adult Protection Policy and Procedures.

12.1.5 Staff training needs in relation to safeguarding will be continually evaluated with all staff receiving appropriate training, The Service Provider will be able to access the Council’s training relating to appropriate Safeguarding courses.

12.1.6 The Service Provider is expected to have a clear statement outlining the service’s responsibilities towards Client available for all staff,

12.1.7 The Service Provider will demonstrate senior management commitment to the importance of safeguarding and promoting the Clients' welfare,

**12.2 Improper Conduct**

12.2.1 The Service Provider shall ensure that neither it or its Staff shall not take any actions that result in the detriment of a Client’s welfare or to the delivery of the Service, either by positive action or by omission. Such action shall include but is not limited to:

* abuse
* fraud and theft from Clients
* sexual misconduct or sexual exploitation
* improper inducements, including inducements offered to employees of the Council
* conspiracy with officer or officers of the Council or any Staff to defraud or disadvantage Customers
* financial malpractice

**12.3 Equalities**

12.3.1 The Council is committed to advancing equality of opportunity and providing fair access and treatment in employment and when delivering services. We will work to deliver our commitments by tackling inequality arising out of age; disability; gender re-assignment; marital status and civil partnership; pregnancy and maternity; race; religion and belief including non-belief; sex or gender; sexual orientation; and other forms of disadvantage such as rural deprivation and isolation. Our policy applies to every Councillor, manager and employee of the Council and any other person or organisation employed by the Council to work or to deliver services on its behalf, including those employed through contractual, commissioning or grant-aided arrangements.

12.3.2 It is the responsibility of the Service Provider to actively meet the requirements of the Equality Act 2010 and the Council’s responsibilities under the Public Sector Equality Duty (the Duty) by paying due regard to:

* eliminating discrimination, harassment, and victimisation and any other conduct that is prohibited by the Equality Act
* advance equality of opportunity
* foster good relations between people who share a relevant protected characteristic and those who don’t.

12.3.3 Having due regard means the Service Provider needs to:

* remove or minimise disadvantages suffered by people due to their protected characteristics:
* take steps to meet the needs of people with certain protected characteristics where these are different to the needs of other people
* encourage people with certain characteristics to participate in public life or in other activities where the participation is disproportionately low.

12.3.4 The Duty and this specification requires the Service Provider take into account disabled people’s impairments, when making decisions about policies and services, as the law recognises that disabled’s people’s needs may be different from the needs of non-disabled people. This might mean making reasonable adjustments or treating disabled people better than non-disabled people to meet their needs or providing positive discrimination to enable disadvantaged groups access to the Service.

12.3.5 All Personnel employed by the Service Provider will recognise and respect the religious, cultural and social backgrounds of Customers in accordance with legislation and local and national good practice.

12.3.6 It is expected that the Provider will work in line with the values and principles underpinning the **social model** of person-centred Dementia care.

**13 RETENDERING AND HANDOVER**

13.1 Towards the end of the Agreement or a new agreement is let with another organisation the Provider will assist as appropriate and in a reasonable, positive and timely manner that offers maximum support and positive outcomes for Clients using the Service.

13.2 Where, TUPE is likely to apply on the termination or expiration of the framework (and therefore individual contracts), the information to be provided by the Provider on request from the Council, to the Council, shall include, as applicable, accurate information relating to the Staff/Employees who would be transferred under the same terms of employment under TUPE, including in particular (but not limited to):

* The number of Staff/Employees who would be transferred,
* In respect of each of those Staff/Employees, their dates of birth, sex, salary, pensions, length of service, hours of work and rates, and any other factors affecting redundancy entitlement, any specific terms applicable to those Staff/Employees individually and any outstanding claims arising from their employment; and
* The general terms and conditions applicable to those Staff/Employees, including provisions, probationary periods, periods of notice, current pay agreements and structures, special pay allowances, working hours, entitlement to annual leave, sick leave, maternity, paternity and special leave, injury benefit, redundancy rights, terms of mobility, any loan or leasing agreements and any other collective agreements, facility time arrangements and additional employment benefits.

13.3 If another replacement Provider is successful winning the contract in the future with the Council that replaces this Agreement, the Service Provider will provide the new Provider with the details of Clients to ensure a smooth transfer of the Service. The Provider shall ensure that when collecting the personal data of Clients for' they inform the data subjects that the transfer of information may happen.

**Appendix A – NHS England Transformation Framework – The Well Pathway for Dementia**

Services for people with Dementia and their carers in Derbyshire are currently mapped against the NHS England Transformation Framework – The Well Pathway for Dementia (shown below).

|  |
| --- |
| **Information and Advice** |
| **The Dementia Advisers should give signposting and practical support. They need to:*** Explain options of what support is available and signpost to other services (explain to families as well as immediate carer)
* Help navigate the health and social care system and interpret health and social care language/jargon – use plain language
* Give guidance and support for self-funders
* Provide information to help cope with diagnosis
* Support younger people with Dementia to stay at work
* Empower carers to make informed decisions
* Form partnerships with other organisations to improve capacity of wider community to support people
* Signpost to other health services such as podiatry, dietician, dentist
* Provide practical support and advice: help with benefits/disabled badges/form filling/power of attorney/finance advice/Social service information/legal support/council tax/pension/heating tariffs/equipment/telecare/assistive technology/housing
 |
| **Dementia Advisers should be skilled and knowledgeable. They need to:** * Be knowledgeable and give clear advice – need knowledge about all types and stages of Dementia
* Be proactive – Emergency Care plans/ contact card/contingency plans
* Give tailored information – knowledge of individual needs and what is available in the local area. Adapt this as needs vary over time.
* Support people with Dementia/carers to make their home Dementia Friendly
 |
| **The information and advice must be accessible. The service needs to:*** Promote the service in a wide variety of ways
* Be accessible and easily available (e.g. hub) and give practical advice
* Provide a follow up call and leave an open door if people don’t want to engage initially.
* Provide a phone call monthly to check that people are coping
* Provide a pack of information/contact details/resources
* Provide information at MAS clinics.
* One phone number/helpline – single point of access (24/7)
* Each person needs one named worker.
* Reach into hospitals and care homes - having a familiar face is important for people with Dementia
* Use a variety of communication methods as not everyone is computer literate – including written/postal. Face to face is the best method
* Provide more information/signposting at GP surgeries and hospitals
* Engage with volunteers who speak different languages
* Work with other groups – temples, mosques, community venues
* Ensure information and advice varies over time and age so younger people don’t miss out.
 |

| **People with Dementia and/or Carers Groups** | **Education** | **Activities** |
| --- | --- | --- |
| **Benefits/advantages*** Problem solving – shared learning and networking
* Meet other carers/ people with Dementia face to face
* Prevents isolation
* A lot of carers would prefer to receive information from DSS instead of professionals
* Beneficial to have Dementia specific carers groups
* Support in bereavement
* Being able to express and validate frustrations
* Opportunity to meet others, get out and do social activities

**Community Groups need to:*** Be accessible geographically and regular– on bus route
* Be promoted well
* Consider where the people with Dementia will go when carer has support
* Have a range of options – not one size fits all.
* Support end of life as well.
* Give carers the opportunity to meet people in local area
* Give simple information
* Support carers to come to terms with the diagnosis

**The DSS should:*** Support people to set up their own groups to run independently
* Continue to offer support to carers even when the cared for is in hospital
* Help carers challenge professionals if they have concerns
* Advertise groups in hospital
* Offer online support for carers who can’t go out
* Provide more groups & provide groups for protected characteristic groups e.g. BME
 | **The following were highlighted as valuable:*** Information sessions
* Training for carers
* Information sessions can link and lead on to other less formal support groups
* Unless the carer can understand Dementia, they can’t give support.

**The following was highlighted as a need:*** Carers need information after diagnosis and then further sessions later on as disease progresses (e.g. managing behaviour) – different phases
* Greater information about the specific behaviours that will come from specific types of Dementia
* All sessions should give a file of information that you can refer back to later.
* BME information courses
* Information sessions should include telecare
* Information sessions need to be well promoted.
 | **Benefits of Activities:**Give break from routineCognitive stimulation/ Help maintain skills Raises mood/Promotes peer support/inclusion**Highlighted as a need:*** More regular activities – one a month not enough
* Should consider physical health as well as mental
* Mixed times day/evening
* Transport is difficult – this needs considering
* More groups in local areas – need to be more regular and not stop for long periods over xmas
* Need intellectual challenge and not just arts, singing, crafts etc.
* Need central venues

**Suggested Activities / Activities with positive feedback:*** Community based sessions e.g. swimming
* More intergenerational learning needed
* Gardening, music, relaxation,
* Life History work
* Fitness/sport/seated exercise/ group walks
* Cinema/library/theatre
* Courses e.g. computers, photography
* Lunch clubs
* Life History Café
* Singing for the brain/Musical Sessions
* Old Derby’ at the library
* Hardy Group
* Trips Out/Coach Trips
* Beckside Care Farm
 |

**Appendix C: Living Well Programme and Cognitive Stimulation Therapy**

**Living Well Programme**

The Living Well Programme is delivered by Occupational Therapists and Nurses. The Living Well Programme has been designed to educate patients and their carers following the Dementia diagnosis and to offer health based information to enable people to better understand their condition and sign posting into other support services as appropriate. This is aligned with the National Dementia Strategy (2009) and supports the Memory Assessment Service which provides diagnosis.

Throughout the programme, Clients are continuously assessed and referrals can be made, as appropriate, to other services such as Improving Access to Psychological Therapies (IAPT), Community Mental Health Team (CMHT), Dietician, Physiotherapy, Psychology etc. as appropriate.

**The programme has been developed by Registered Clinicians to impart information, provide Clients with strategies and education to support them to live well with Dementia. This includes:**

* **Medical information about treatment options - current and future**
* **The impact of mood and sleep hygiene on mental health**
* **General lifestyle factors.**
* **Specific evidence based information about physical health and delirium including increased risk factors**
* **Mental Capacity and advanced care planning, including the rationale and discussions around Lasting Power of Attorney and Advanced Directives.**

Dementia Support Services and third sector community support are invited in towards the end of the sessional programme to discuss how they can provide on-going support, education on finances, benefits and entitlements and local community initiatives/groups currently available.

Other voluntary agencies / support services are also signposted to during the programme to allow patients and carers to develop strategies and self-care within their local communities.

**Cognitive Stimulation Therapy (CST)**

Cognitive Stimulation Therapy involves activities including cognitive processing; in a social context and group-based, with an emphasis on enjoyment of activities. CST is also delivered once a week over a period of 8 weeks by trained health professionals. The CST programme has a strong evidence base within the NICE Guidelines. Cognitive stimulation is the only non-drug intervention to be recommended for cognitive symptoms and maintenance of function.

* **Appendix D: Recommended split between providing information and improving social inclusion for the different types of groups**

Information and Knowledge

Social Inclusion

**Living Well Programme**

**Specialist education provided by DHCFT (see Appendix D)**

**Information for**

**Carers sessions**

**Peer Support/Carers Groups**

**Activity Groups**

**Dementia Support Service (Community Groups Provision)**

**SCHEDULE 2**

**MONITORING INFORMATION AND OUTCOMES**

All Monitoring information and data will be provided quarterly in time for contract monitoring meetings as well as in an Annual Report and for any ad-hoc requests by the Commissioner. Additional meetings can be held at the request of the Commissioner or the Provider, if necessary.

**1 Outcomes:**

1.1 The Provider will demonstrate achievement of outcomes and this will include:

* an individual plan that includes client details and individual goals
* a mechanism for monitoring progress of individual client goals
* a service review and an annual survey process to track achievement of outcomes and outputs set out below.

1.2 **Service Outcomes:**

1. People with Dementia and their carer(s) are supported to continue to live well in their own home as long as possible.
2. People with Dementia and their carer(s) feel informed and have access to support immediately following diagnosis.
3. People with Dementia and their carer(s) are educated and equipped to plan for their future care and support.
4. People with Dementia and their carer(s) have a good understanding of the local services and support options available and can access them easily.
5. Carers have increased confidence and resilience to continue in their caring role.
6. People with Dementia and their carer(s) have stronger social support networks.
7. People with Dementia and their carer(s) feel included in their local community and their risk of social isolation is reduced.
8. People with Dementia and their carer(s) are able to access all appropriate welfare, financial and legal benefits.

1.3 The Provider will need to carry out a survey following service intervention and utilise the data to demonstrate the service outcomes.

* 1.4 The Provider will use an agreed framework to demonstrate achievement of service outcomes.

1.5 The Provider will report on client’s identified individual goals and outcomes that have been achieved and explain any differences.

* 1.6 The Provider will use an agreed framework to demonstrate achievement of individual outcomes.

1.7 The Provider will link individual client’s outcomes with service level outcomes.

**2.** **Activity Monitoring (Outputs)**

The Provider will report to the Commissioners quarterly on the following activity data and how this data was recorded to demonstrate the performance of the service:

|  |  |
| --- | --- |
| **Service** | **Measure** |
| All Services | Referrals responded to within 72 hours |
| Percentage of Clients seen within 10 Business Days of referral date |
| Number of new referrals accepted this quarter by source e.g. Carer, GP, etc. |
| Number of new referrals by client type e.g. person with Dementia / carer |
| Number of refusals / people who have declined the service |
| Number of carers receiving support whilst the cared for is in hospital or other care setting |
| Staff contracted hours and actual hours |
| Number of completed surveys following intervention and results |
| Numbers of Clients receiving the different elements of the service:* Information and Advice only
* Community Groups only
* Both information and Advice and Community Groups
 |
| Number of compliments / complaints received and how they were resolved |
| Breakdown of main achievements and barriers to developing stronger partnership working |
| Evidence of how the service has been widely promoted |
| Number of volunteers supporting the service provision |
| Number of people receiving local periodic updates about the service |
| Evidence of how the Provider has formed new links with key partners in the wider Health and Social Care network. |
| Number of Clients by age, gender, district / ward and all protected characteristics groups |
| Staff, management, volunteer training and other quality developments |
| **Dementia Information and Advice** | Total number of Clients provided with information and advice, this needs to be broken down into:* Telephone contacts
* Face to face contacts and where they took place
* Internet i.e. email, online forums, website hits
 |
| Number of referrals to other support services – summary of support services used |
| Practical support provided with income maximisation |
| Number of MAS sessions attended by the service broken down by clinic |
| Number of follow-up contacts |
| Number of contacts:* People with Dementia or concerned with memory loss
* Carers
 |
| Average contact time per client broken down by face to face and telephone |
| Number of Clients by age, gender, locality/ward and ethnicity |
| 3 case studies provided quarterly (1 per month) to evidence the quality of work being undertaken by the service. |
| **All Community Groups**  | Number of groups and localities and whether directly run or self -sustaining |
| Numbers of people with Dementia and carers attending each group |
| Summary of activities delivered at groups |
| Summary of any costs or charges for group activities. |
| Summary of support provided to self-sustaining groups / activities |
| Number of Clients by age, gender, locality/ward and ethnicity. |
| Summary of information to carers groups content |
| Summary of any charges for group activities.  |
| **Annually** | Summary of all the above |
| Annual review of the service, including cost breakdown for delivery and action plan to improve service (to be agreed with commissioners) |

**\*** The Commissioners may request additional information to support the overall monitoring process. The Provider will be given sufficient notice to allow this to be collected.

**3.** **Social Value (not from the services’ financial envelope)**

3.1 As part of the quarterly monitoring process, the Provider will set out details of any added social value activities that are undertaken in addition to the service. This may include:

* Dementia Friends information and awareness sessions
* Supporting the Derbyshire Dementia Action Alliance
* Attendance at any community events
* Radio appearances to promote the service
* Information stands to promote the service
* Working with partner services to increase the number of Clients supported

3.2 The Provider will seek to raise public awareness of Dementia with a positive message about the benefits of early intervention and reduce any stigma through advice and information.

**4. Governance**

 The Provider will share information about any safeguarding issues and policy breaches with the Commissioners as soon as feasibly possible.

**5. Quality assurance**

 The Provider will share all complaints and compliments, engagement work undertaken with people who use the Service and how information has been used to improve the Service.

**6. Finance**

The Provider will prepare a finance report showing actual spend against the budget.