NHS
Bristol, North Somerset
and South Gloucestershire
Integrated Care Board

Reference: FOI.ICB-2324/379

Subject: Neurology and Dementia Services

I can confirm that the ICB ***does hold the information requested****; please see responses below:*

QUESTION	RESPONSE
Neurology Service Please provide a list of all providers the ICB holds contracts with for this service. For each contracted provider, please provide the Service Specification that describes the service (whether standalone or integrated in a broader Service Specification)	North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW). All pathways are published online at: https://remedy.bnssg.icb.nhs.uk/adults/neurology/ https://remedy.bnssg.icb.nhs.uk/children-young-people/neurology/
Dementia Service Please provide a list of all providers the ICB holds contracts with for this service. For each contracted provider, please provide the Service Specification that describes the service (whether standalone or integrated in a broader Service Specification)	The ICB holds a contract with Devon Partnership Trust for the Bristol Dementia Wellbeing Service which provides Dementia services for the population of Bristol. The ICB holds a contract with Avon and Wiltshire Mental Health Partnership Trust (AWP). One of the services commissioned within the contract are the provision of Dementia services to the population of North Somerset and South Gloucestershire. Please find service specifications enclosed.

The information provided in this response is accurate as of 24 January 2024 and has been approved for release by Sarah Truelove, Deputy Chief Executive and Chief Finance Officer for NHS Bristol, North Somerset and South Gloucestershire ICB.

SECTION B PART 1 - SERVICE SPECIFICATIONS

Service Specification No.	**2A11**
Service	**Memory Service**
Commissioner Lead	**Bristol CCG**
Provider Lead	**AWP**

1. Population Needs

1.1 National/local context and evidence base

Memory Services are a significant aspect of the National Dementia Strategy (NDS), which emphasises early diagnosis of dementia. Memory services see people with dementia early on in their disease pathway and will also assess and offer advice to people with cognitive impairments for other reasons. The main emphasis of the work is to provide a service that enables the diagnosis of dementia; which is made well and delivered well; supported by pre- and post-diagnostic psychological interventions (individual and group) and training for both patients and carers. The aim of the service is to promote understanding and ownership of the disease and its implications and promote independence and meaningful occupation at a time when both patient and carer can fully utilise the skills of the clinical staff.

Other significant policy

- NSF for Older People – DH (2000)
- Everybody’s Business (2005)
- NICE Guidelines (2006)
- NSF for Long Term Conditions – DH (2005)
- National Dementia Strategy – DH (2009)

Local strategic context

Across AWP, memory clinics have developed at differential rates, depending on local priority and skills. Rationalisation of the clinics around a hub and spoke organisation began and central management was established. Services are now set up to ‘mirror’ the community mental health service & to work to the same geography as the commissioners. Although based with the community services within the same buildings, the memory service out-reaches to provide services / clinics locally to meet the needs of the service users & carers.

The services have been configured to work alongside the community mental health services and will be managed as part of the overall community service to provide assessment, diagnosis & access to psychological therapy as required

2. Scope

2.1 Aims and objectives of service

- To transform current memory services by developing a new model of care, informed by joint commissioning to meet the needs of known and hidden people with dementia and the predicted future demand, and to work in close partnership with other agencies to provide a full comprehensive service (including voluntary & other statutory services)
- The service to be available to all people with Dementia regardless of age
- To develop a memory service that can assess, diagnose, and provide interventions, advice and support to people with dementia and their carers.
- To provide memory services that can offer pre and post diagnostic counselling where required in conjunction with our partners
- To develop a single point of referral.
- To increase access to memory services and reduce waiting times for assessment.
- To provide advice and support to all agencies involved in dementia care.
- To reduce inequalities in health provision by offering care to people who are currently hidden and marginalised groups.
- To improve early detection, assessment, diagnosis and treatment.
- To allow people more informed choice about care alternatives.
- To promote independence and increase social inclusion.
- To promote dignity in care.
- To ensure a positive impact on the health of carers
- To reduce or delay admissions to residential care.

2.2 Service description/care pathway

2.3 Population covered

The population of people over 65 in the AWP catchment area is approx 282.000
This is broken down by area as such

- B&NES 34.000
- Bristol 60.000
- S Glos 40.000
- Swindon 27.000
- Wilts 83.000

2.4 Any acceptance and exclusion criteria

Exclusion criteria

All referrals will be triaged

In order to promote early access to dementia services, and in keeping with the National Dementia Strategy objectives, the memory service is intended to be a wide-ranging and inclusive service. The Team leaders will triage all referrals and will advise GP’s if a referral is considered to be inappropriate giving reasons for this decision.

Individuals who are currently significantly abusing alcohol or drugs or those with a non-progressive acquired or traumatic brain injury would not be considered as suitable for a memory service.

Referrals for individuals with complex mental health needs and challenging behaviour would be passed on to the local community mental health service and the GP informed.

2.5 Interdependencies with other services

- Works closely with the community mental health service
- Works closely with voluntary organisations providing memory support
- Works closely with Primary Care liaison services
- Works closely with other primary health care providers
- Works closely with local authority service providers

3. Applicable Service Standards

3.1 Applicable national standards eg NICE, Royal College

- **Works to NICE guidelines**

SCHEDULE 2 – THE SERVICES

A. 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.

Service Specification No.	**BMH 03**
Service	**Bristol Dementia Wellbeing Service**
Commissioner Lead	**BNSSG ICB**
Provider Lead	**Devon Partnership NHS Trust**
Period	**April 2023 – March 2024**

Key Messages:

The Bristol Dementia Wellbeing Service (known as “the Service”) will deliver an integrated person-centred primary care-led model for people with dementia and their family/carers.

At the heart of the Service will be relationship-centred care which emphasises the imperative to consider the needs of the family/carers to ensure ongoing wellbeing. This must form the focus for the delivery of the Service, which will be supported by appropriately trained professionals, support staff, as well as volunteers, to ensure the right care is delivered at the right time, in the right place.

The Service will understand that co-morbid health conditions are the normality and will provide an integrated response to support other mental health conditions as well as working with other services that support physical health needs.

To support the delivery of this Service we have commissioned a General Practitioner Local Enhanced Service (LES), to enable a truly holistic primary care-led approach, which enables General Practitioners to make a diagnosis of dementia, with the support of the Service.

1. Population Needs

1.1 Background

The initial specification for the Service was produced as an outcome of the NHS Bristol Modernising Mental Health Project. The overarching outcome of the consultation was for support for people with dementia and their family/carers to be delivered as a separate pathway, taken outside of traditional mental health services and for it to be understood as a long-term condition.

The initial service specification was co-produced by a Steering Group with representation from Clinicians; Local Authority; Carers and Family; Research and Academia.

This service will support the delivery of the Vision of the Joint Bristol Dementia Strategy 2010-2015, and draws upon current thinking and good practice in the field. It aims to:

- improve the quality of existing services for people with dementia
- invest money into new and existing services to meet the demographic need

- ensure resources are appropriately distributed along the care pathway with increased emphasis on prevention and early intervention
- focus on improving the skills and competencies of all staff who work with people with dementia and their family/carers
- address the specific needs of people with dementia and their family/carers in black and minority ethnic communities and other communities
- address the specific needs of people with dementia and a learning difficulty and their family/carers
- consider the need for dementia research when designing services

The Strategy can be found here: Bristol Dementia Strategy

This specification and delivery model was shaped by a three-month formal consultation period. The Bristol Dementia Wellbeing Service encompasses five stages; a high-level service description is given in section 2.2. The stages are:

Foundation Stage:	**Organisational and Service Level Requirements**
Stage 1:	**Assessment**
Stage 2:	**Diagnosis**
Stage 3:	**Supporting Ongoing Wellbeing**
Stage 4:	**Palliative and End of Life Care**

National Institute for Health and Clinical Excellence (NICE) Dementia Quality Standards provides clinicians, managers and service users with a description of what high quality dementia care should look like. The standards describe markers of high quality, cost-effective care that, when delivered collectively should contribute to improving the effectiveness, safety, experience and care for adults with dementia and their family/carers. Each of the 13 recommendations have been reviewed and incorporated into the specification, further information can be found at[1]: https://www.nice.org.uk/guidance/ng97

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[1] NICE (2010). Dementia Quality Standards. NICE Implementation Directorate Quality Standards Programme. London: Department of Health.

1.2 National/Local Context and Evidence Base

Dementia is a syndrome caused by a number of illnesses in which there is a progressive functional decline in memory, reasoning, communication skills and the ability to carry out daily activities. Alongside this decline, individuals may also develop behavioural and psychological symptoms such as depression, psychosis, aggression and wandering. These cause problems in themselves, complicate care, and can occur at any stage of the illness. Although the risks of developing dementia increase with age, it is not an inevitable part of ageing.[2]

There are different types of dementia, these include:

- Alzheimer's disease (60% of all cases in people aged over 65)
- Vascular dementia (15–20% of all cases of people aged over 65)
- Dementia with Lewy bodies (15–20% of all cases of people aged over 65)
- Frontotemporal dementia (more common among younger people)

There are over 940,000 people living with dementia in the UK today, a number forecast to rise rapidly as the population ages with around 550,000 people acting as primary carers for people, and this will increase to more than 1.6 million by 2050. In the UK, 61.8% of patients over 65 who are estimated to have a dementia have a recorded diagnosis. In the UK, dementia affects[12]:

- 1 in 6 people aged over 80
- 1 in 25 people aged 70–79
- 1 in 100 people aged 65–69
- 1 in 1400 people aged 40–64

Many cases of dementia may have mixed pathology (for example, Alzheimer's disease and Vascular dementia or Alzheimer's disease and Dementia with Lewy bodies). Such cases should be managed according to the condition that is thought to be the predominant cause of dementia.[1]

In the UK around 15,000 people aged under 65 years have dementia. This is probably an under-estimate as it is based on referrals to services, and not all people will seek help early in the course of the disease.[2]

An estimated 15,000 people of all ages from black and minority ethnic groups have dementia, and 6% of this group will have young onset dementia, compared with 2% in the wider UK population. People with learning disabilities and Down's syndrome are at higher risk of dementia. People with Down's syndrome have an increased genetic risk. Higher risk of dementia is also associated with stroke and some other neurological conditions. Between 30% and 70% of people with Parkinson's disease develop dementia, depending on duration of the condition and age.[2]

[1] Numbers of people in the UK - Dementia Statistics Hub

[2] Joint Commissioning Panel for Mental Health (2012). Guidance for commissioners of dementia services Volume Two: Practical mental health commission. London: JCP-MH www.jcpmh.info NICE (2010). *Dementia Quality Standards.* NICE Implementation Directorate Quality Standards Programme. London: Department of Health.

[3] Department of Health (2012). *Prime Minister's challenge on dementia: Delivering major improvements in dementia*

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care and research by 2015. London: Department of Health.

People can develop an alcohol-related dementia over a period of time. It is estimated that 80% of people who reduce their alcohol consumption can recover their memory, therefore it is recommended that they are managed by the primary care mental health service. For the 20% who are unlikely to recover despite reducing their alcohol consumption / abstinence the Dementia Wellbeing Service will be best placed to support their needs.

Around two thirds of people with dementia live in their own homes and around one third live in care homes. Of the total number of people in care homes, around two thirds are estimated to have dementia[3]. Between 1998 and 2031, the number of care home places is expected to rise by 63%. Despite the fact that around two thirds of people in care homes are estimated as having dementia, in 2008 only 28% of care home places were registered to provide specialist dementia care.[4]

People with the condition are also core users of NHS care, a quarter of hospital beds are occupied with people with dementia over 65 at any one time.[3]

Dementia is a long-term condition; with some people living with it for 10–12 years. On average people live seven years after developing symptoms. This is because many people are not diagnosed until late in their illness.[2]

There are around 690 000 people with dementia in England, of whom 565 000 receive unpaid care or community care or live in a care home. Total annual cost of dementia in England is estimated to be £24.2 billion in 2015, of which 42% (£10.1 billion) is attributable to unpaid care. Social care costs (£10.2 billion) are three times larger than health care costs (£3.8 billion). £6.2 billion of the total social care costs are met by users themselves and their families, with £4.0 billion (39.4%) funded by government. Total annual costs of mild, moderate, and severe dementia are £3.2 billion, £6.9 billion, and £14.1 billion, respectively. Average costs of mild, moderate, and severe dementia are £24 400, £27 450, and £46 050, respectively, per person per year. [The costs of dementia in England - PMC (nih.gov)]

Dementia is a disease that is strongly associated with age and its prevalence is affected by an ageing population; unchecked, this spending pressure on more expensive services is likely to rise at an increasingly unsustainable pace. Hospital stays for people aged 60-74 have increased by more than 50% between 1999/2000 and 2009/2010, and hospital stays for people aged 75 and over have increased by 66% in the same period.

Identification and diagnosis of dementia often comes late in the illness, when the person needs more expensive care services.

Dementia has been an increasing priority both locally and nationally over the past few years. There is now a wealth of information and evidence to support the delivery of services to enable people to “live well” with dementia.

[4] Dementia Commissioning Pack (2011). *Service Specification for dementia: better care at home, and in care homes Specialist dementia service*. London: Department of Health.

[5] Dementia Commissioning Pack (2011). *Case for Change – community-based services for people living with dementia evidences.* London: Department of Health.

1.3 Current Key Documents Underpinning the Service Specification Include:

Living Well with Dementia: A National Dementia Strategy

Department of Health, 2009:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_094058

This strategy provides a strategic framework within which local services can deliver quality improvements to dementia services and address health inequalities relating to dementia; provide advice and guidance and support for health and social care commissioners and providers in the planning, development and monitoring of services; and provide a guide to the content of high-quality services for dementia.

Quality Outcomes for People with Dementia: Building on the National Dementia Strategy

Department of Health, 2010

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119827

This document presents the Department's revised, outcomes focused implementation plan for 'Living well with dementia: A National Dementia Strategy', which was published in February 2009. It updates the previous implementation plan for the Strategy, which was published in July 2009.

Four priority objectives are defined:

- good-quality early diagnosis and intervention for all;
- improved quality of care in general hospitals;
- living well with dementia in care homes; and
- reduced use of antipsychotic medication

More generally, the improvement of community personal support services is integral to and underpins the four priorities as it supports early intervention, prevents premature admission to care homes and impacts on inappropriate admission to hospital and length of stay.

NICE Dementia Quality Standards

Quality standard [QS184] Published date: June 2019

QS184: https://www.nice.org.uk/guidance/qs184

This NICE quality standard defines a high standard of care within this topic area. It provides specific, concise quality statements, measures and audience descriptors to provide patients and the public, health and social care professionals, commissioners and service providers with definitions of high-quality care.

This quality standard covers the care provided by health and social care staff in direct contact with people with dementia in hospital, community, home-based, group care, residential or specialist care settings.

10 specific quality standard statements are made.

NICE Clinical Guidelines 97. Dementia

NICE guideline [NG97] Published date: June 2018

NG97: https://www.nice.org.uk/guidance/ng97

This guideline makes specific recommendations on Alzheimer's disease, dementia with Lewy bodies (DLB), frontotemporal dementia, vascular dementia and mixed dementias, as well as recommendations that apply to all types of dementia. Dementia in Parkinson's disease shares a number of similarities with DLB. Although the evidence base for dementia in Parkinson's disease was not examined specifically in the context of this guideline, the recommendations for DLB may be useful when considering treatments for dementia in Parkinson's disease. NICE has also produced a clinical guideline on Parkinson's disease (available from https://www.nice.org.uk/guidance/ng71

The guideline makes recommendations for the identification, treatment and care of people with dementia and the support of carers. Settings relevant to these processes include primary and secondary healthcare, and social care. Wherever possible and appropriate, agencies should work in an integrated way to maximise the benefit for people with dementia and their carers.

The dementia guideline incorporates recommendations from NICE's technology appraisal of donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer’s disease.

NICE Clinical Guidelines 120 Psychosis with Co-Existing Substance Misuse

NICE, 2011

https://www.nice.org.uk/guidance/cg120

This guideline has been developed to advise on the assessment and management of adults and young people (aged 14 years and older) with psychosis and coexisting substance misuse.

Primary Care Interventions for Dementia Caregivers: 2-Year Outcomes From the REACH Study (Burns R., Nichols LO. et al., The Gerontologist 43 (4): 547-555, 2003)

The interventions, using targeted educational materials, were patient behaviour management only, and patient behaviour management plus caregiver stress-coping management. They hypothesized that the addition of the stress-coping component would improve caregiver outcomes.

Results: During 24 months, caregivers who received the patient behaviour management component only, compared with those who also received the stress-coping component, had significantly worse outcomes for general well-being and a trend toward increased risk of depression (i.e., a score of >16 on the Centre for Epidemiological Studies Depression scale). There was a study wide improvement for bother associated with care recipient behaviours (according to the Revised Memory and Behaviour Problems Checklist).

Implications: The data suggests that brief primary care interventions may be effective in reducing caregiver distress and burden in the long-term management of the dementia patient. It further suggest that interventions that focus only on care recipient behaviour, without addressing caregiving issues, may not be as adequate for reducing caregiver distress.

Caring for a relative with dementia: family caregiver burden

Papastavrou E., Kalokerino A., et al., Journal of Advanced Nursing Volume 58, Issue 5, pages 446–457, June 2007

This paper is a report of part of a study to investigate the burden experienced by families giving care to a relative with dementia, the consequences of care for the mental health of the primary caregiver and the strategies families use to cope with the care giving stressors.

The results showed that 68% of caregivers were highly burdened and 65% exhibited depressive symptoms. Burden was related to patient psychopathology and caregiver sex, income and level of education. There was no statistically significant difference in level of burden or depression when patients lived in the community or in institutions. High scores in the burden scale were associated with use of emotional-focused coping strategies, while less burdened relatives used more problem-solving approaches to care-giving demands.

Effects of person-centred care on residents and staff in aged-care facilities: a systematic review

Brownie S., Nancarrow S., Clin. Interv. Ageing 8: 1–10, 2013

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3540911/

Several residential aged-care facilities have replaced the institutional model of care to one that accepts person-centred care as the guiding standard of practice. This culture change is impacting the provision of aged-care services around the world. This systematic review evaluates the evidence for an impact of person-centred interventions on aged-care residents and nursing staff.

The studies in this review incorporated a range of different outcome measures (i.e., dependent variables) to evaluate the impact of person-centred interventions on aged-care residents and staff. One person-centred intervention, i.e., the Eden Alternative, was associated with significant improvements in residents’ levels of boredom and helplessness. In contrast, facility-specific person-centred interventions were found to impact nurses’ sense of job satisfaction and their capacity to meet the individual needs of residents in a positive way. Two studies found that person-centred care was actually associated with an increased risk of falls.

Typically, person-centred interventions are multifactorial, comprising: elements of environmental enhancement; opportunities for social stimulation and interaction; leadership and management changes; staffing models focused on staff empowerment; and assigning residents to the same care staff and an individualized philosophy of care. The complexity of the interventions and range of outcomes examined makes it difficult to form accurate conclusions about the impact of person-centred care interventions adopted and implemented in aged-care facilities.

Recommendations for the diagnosis and management of Alzheimer's disease and other disorders associated with dementia: EFNS guideline

Waldemar G., Dubois B. et al., European Journal of Neurology Volume 14, Issue 1, pages e1–e26, January 2007

http://www.ncbi.nlm.nih.gov/pubmed/17222085

The aim of this international guideline on dementia was to present a peer-reviewed evidence-based statement for the guidance of practice for clinical neurologists, geriatricians, psychiatrists, and other specialist physicians responsible for the care of patients with dementia. It covers major aspects of diagnostic evaluation and treatment, with particular emphasis on the type of patient often referred to the specialist physician. New recommendations were added for the treatment of vascular dementia, Parkinson's disease dementia, and dementia with Lewy bodies, for monitoring treatment, for treatment of behavioural and psychological symptoms in dementia, and for legal issues.

Dementia: A Public Health Priority

World Health Organization and Alzheimer’s Disease International, 2012

https://www.who.int/publications/i/item/dementia-a-public-health-priority. The purpose of this report is to raise awareness of dementia as a public health priority, to articulate a public health approach and to advocate for action at international and national levels.

The number of people living with dementia worldwide is currently estimated at 35.6 million. This number will double by 2030 and more than triple by 2050. Dementia is overwhelming not only for the people who have it, but also for their caregivers and families. There is lack of awareness and understanding of dementia in most countries, resulting in stigmatization, barriers to diagnosis and care, and impacting caregivers, families and societies physically, psychologically and economically.

The report is expected to facilitate governments, policy-makers, and other stakeholders to address the impact of dementia as an increasing threat to global health. It is hoped that the report will promote dementia as a public health and social care priority worldwide.

Dementia Commissioning Pack

Department of Health 2012

https://www.gov.uk/government/publications/dementia-commissioning-pack.
Dementia presents a significant and urgent challenge to health and social care both in terms of the number of people affected and the cost of care. It is also a major personal challenge to anyone experiencing symptoms of dementia and to families and carers of people living with dementia.

A response to this challenge is set out in the National Dementia Strategy and outcomes focused implementation plan.

This highlights four aims:

1. Early diagnosis and interventions;
2. Better care at home or care home;
3. Better care in hospital;
4. Appropriate use of antipsychotic medication.

- all underpinned by improved support for carers.

The Dementia Commissioning Pack provides commissioners with a range of service specifications, tools and templates to help deliver these changes. It sets a standard of what good, integrated dementia care should look like for commissioners, providers, people with dementia and carers alike.

Prime Minister's Challenge on Dementia

Department of Health, 2012

https://www.gov.uk/government/publications/prime-ministers-challenge-on-dementia-2020

This document sets out the Prime Minister's challenge on dementia, an ambitious programme of work to push further and faster to deliver major improvements in dementia care and research by 2015, building on the achievements of the existing National Dementia Strategy. The Prime Minister's Challenge on Dementia focuses on three key areas:

- Driving improvements in health and care
- Creating dementia friendly communities that understand how to help
- Better research

It sets out 34 actions to deliver against the three key areas.

Unlocking Diagnosis: All-Party Parliamentary Group (APPG) Report

Alzheimer's Society, 2012

https://www.alzheimers.org.uk/sites/default/files/migrate/downloads/unlocking_diagnosis_all-party_parliamentary_group_report_2012.pdf

It is still common for a person with dementia to live with the condition and never be given a formal diagnosis. The APPG wanted to explore why this was still the case, despite the political priority that has been given to early diagnosis.

The inquiry found there were barriers throughout the process of diagnosis, from people having poor understanding of dementia so not visiting a doctor, through issues faced by GPs and memory specialists, to problems with the quality of support offered immediately following diagnosis. In particular, the inquiry heard a large volume of evidence on problems in the following areas:

- Public education
- Primary Care
- Variability of Memory Services
- Post diagnosis support

The Report makes 9 recommendations for improving diagnosis.

Left to Cope Alone: The unmet support needs after a dementia diagnosis
(Alzheimer's Society 2022)

https://www.alzheimers.org.uk/sites/default/files/2022-07/left-to-cope-alone-after-diagnosis-report.pdf

This report sought the views and experiences of over 2,000 people affected by dementia to understand what support they need after diagnosis. It shows that people's needs are holistic and wide-ranging, encompassing support for medical, emotional and social wellbeing.

This report finds that people are regularly missing out on care that is timely and appropriate. This failure is having a negative impact on the wider system as well as on the quality of life of those living with the condition. For example, Hospital Episode Statistics for 2021-22 show that almost one third of people with dementia admitted to hospital stayed for a day or less.

This suggests that better community support would be able to treat many of these admissions in the community, relieving pressure on NHS acute services.

1.4 Local Demographic Information – Dementia Prevalence in Bristol

NHS England collect and publish data about people with dementia at each GP practice in England, to enable NHS GPs and commissioners to make informed choices about how to plan their dementia services around patients' needs.

The publication includes the rate of dementia diagnosis. As not everyone with dementia has a formal diagnosis, this statistic compares the number of people thought to have dementia with the number of people diagnosed with dementia, aged 65 and over. Where current monthly data for a GP practice is unavailable, the most recent data available are used (up to a maximum of 6 months).

NHS Digital Primary Care Dementia Data from January 2023 estimates a prevalence in Bristol of 4,345 people living with dementia. Of which 2,997 (69%) currently have a diagnosis of dementia.

Also included is local demographic data from JSNA as relevant background: Census 2011 population figures on Older People and older Black & Minority Ethnic (BME) populations.

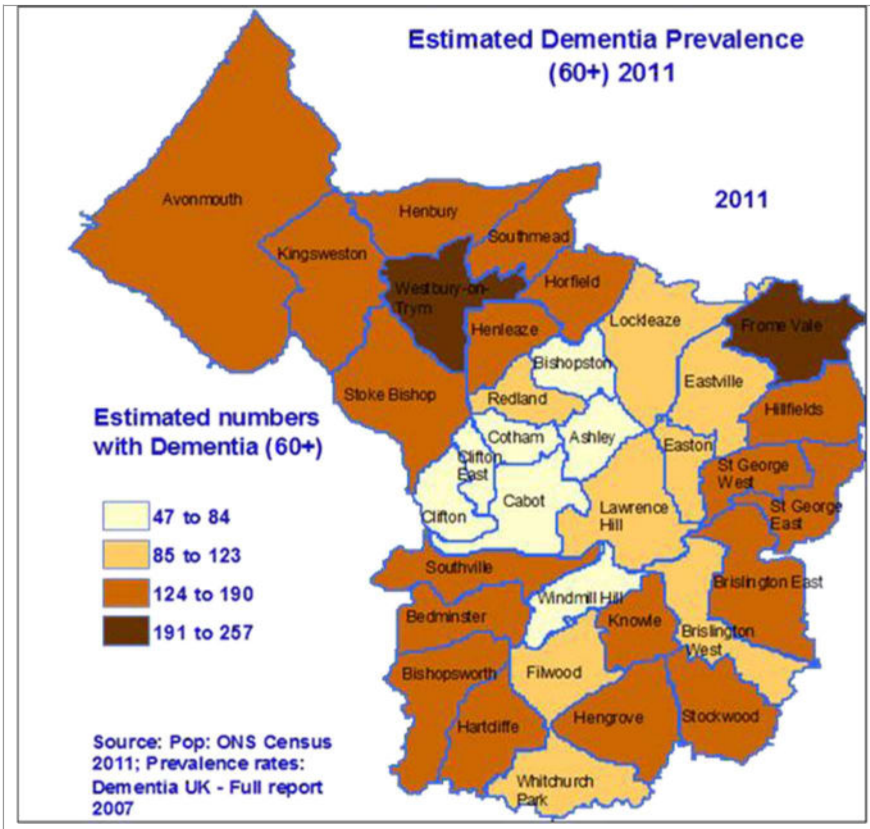
1.4.1 Local Demographic Prevalence (Census 2011 data)

The data below uses the National Dementia Prevalence rates (NDPR) applied to Census 2011 population data for Bristol wards and other regional local authorities. The Bristol estimate is around 4,330 people with Dementia (over 60). The estimate doesn't change significantly for other age ranges: 4,300 people 65+, or 4,400 all ages (including early onset).

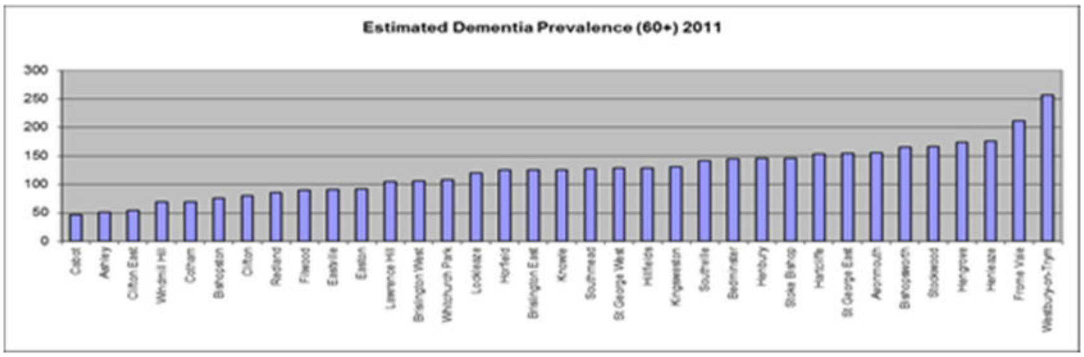
1.4.1.1 Prevalence of Dementia by Ward within Bristol

Estimated Dementia Prevalence in Bristol (2011)				
Ward	Estimated prevalence (All 60+)	% of total population	Males (60+)	Females (60+)
Ashley	51	0.3%	20	31
Avonmouth	155	1.2%	51	104
Bedminster	145	1.2%	49	96
Bishopston	76	0.5%	26	50
Bishopsworth	165	1.4%	58	107
Brislington East	126	1.1%	46	80
Brislington West	106	0.9%	38	68
Cabot	47	0.3%	18	29
Clifton	80	0.7%	27	53
Clifton East	55	0.5%	16	39
Cotham	70	0.6%	19	51
Easton	92	0.7%	31	61
Eastville	91	0.7%	34	58
Filwood	90	0.7%	31	60
Frome Vale	212	1.8%	66	146
Hartcliffe	154	1.3%	54	100
Henbury	146	1.4%	51	95
Hengrove	174	1.5%	58	116
Henleaze	176	1.7%	59	118
Hillfields	129	1.0%	47	81
Horfield	126	1.0%	40	85
Kingsweston	131	1.3%	43	88
Knowle	126	1.1%	41	85
Lawrence Hill	105	0.6%	42	64
Lockleaze	120	1.0%	42	78
Redland	86	0.7%	31	55
St George East	155	1.3%	47	108
St George West	128	1.1%	43	85
Southmead	127	1.1%	45	82
Southville	142	1.1%	41	101
Stockwood	167	1.5%	55	111
Stoke Bishop	146	1.6%	52	94
Westbury-on-Trym	257	2.4%	73	185
Whitchurch Park	109	1.0%	42	66
Windmill Hill	69	0.5%	26	43
Bristol	**4330**	**1.0%**	**1460**	**2870**

Source: 2011 Census & NDPR (via Bristol JSNA)



Source: 2011 Census & NDPR from Dementia UK report (via Bristol JSNA)



Source: 2011 Census & NDPR from Dementia UK report (via Bristol JSNA)

Area	Estimated Prevalence (65+)	Recorded Diagnosis (65+)	Diagnosis % Rate
Bristol	4,345	2,997	69%
North Somerset	3,613	2,498	69.1%
South Gloucs	3,568	2,182	61.6%
BANES	2,494	1,502	60.2%
South West	85,728	49,085	57.3%
England	675,541	417,797	61.8%

1.4.1.1 Dementia Predictions

The Projecting Older People Population Information System (POPPI) is also based on ONS Census population data and NDPR, and uses ONS projections to estimate future numbers of people with dementia. This estimates that numbers increase very slightly in the next 5 years, but after that start to rise more substantially, exceeding 4,600 by 2020.

Data for: Bristol, City of

Table produced on 06/03/23 12:22 from www.poppi.org.uk version 14.2

People aged 65 and over predicted to have dementia, by age and gender, projected to 2040

	2020	2025	2030	2035	2040
People aged 65-69 predicted to have dementia	273	283	310	306	291
People aged 70-74 predicted to have dementia	476	439	460	509	506
People aged 75-79 predicted to have dementia	666	791	738	781	870
People aged 80-84 predicted to have dementia	931	987	1,195	1,119	1,196
People aged 85-89 predicted to have dementia	1,004	1,049	1,140	1,372	1,317
People aged 90 and over predicted to have dementia	1,108	1,108	1,191	1,344	1,615
Total population aged 65 and over predicted to have dementia	4,458	4,657	5,033	5,431	5,795

Source: Projecting Older People Population Information System

1.4.2 Dementia Partnerships South West 2012

The following data is taken from the Dementia Partnerships South West Dementia Prevalence Calculator. It takes into account the number of people on the General Practitioner registers and adjusts NDPR to account for the number of care home beds in the area, to give an expected prevalence of dementia. This method estimates a higher prevalence than the Census population alone, especially in the future.

	2011/12	2012/13	2013/14	2014/15	2015/16
Forecast number of cases	**4,533**	**4,643**	**4,749**	**4,848**	**4,946**
Diagnosis rate	47.7%	47.7%	47.7%	47.7%	47.7%
Resulting Dementia Register	2,162	2,214	2,265	2,312	2,359

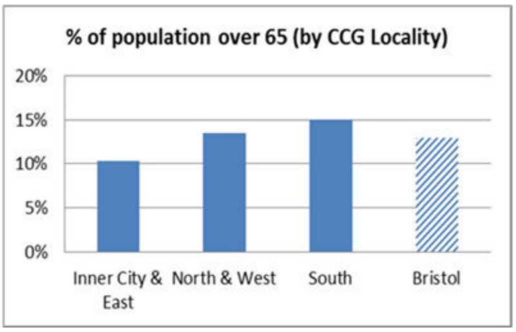
Source: Dementia Partnerships South West

Estimated number of dementia cases in Bristol 2011/12	**Using National Dementia Prevalence Rate (NDPR)**	**Using Adjusted NDPR (adjusted to weight care home beds)**
Living in the community		3,163
Living in residential care		1,370
Total	4,553	4,533
Total Dementia register	2,162	2,162
Diagnosis rate	47.5%	47.7%

1.4.3 Other local demographic data

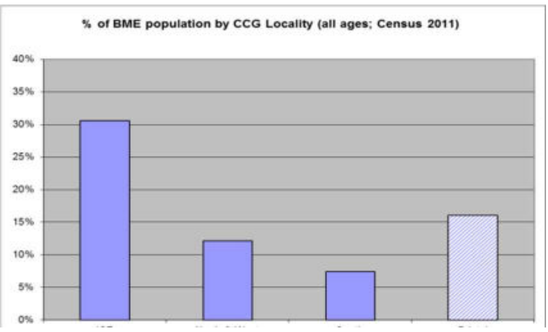
Over 65 Population by CCG Locality		
CCG Locality	Over 65 Population	% over 65 Population
North & West	21660	13.5%
South	21170	15.0%
Inner City & East	13045	10.3%
Bristol	55870	13.0%

BME Population by CCG Locality



	Total Population (All Age)	Over 65 BME	% of BME (all age)
Inner City & East	134821	44312	32.9%
North & West	183617	29167	15.9%
South	154041	15813	10.3%
Bristol	**472479**	**89292**	**18.9%**
England & Wales			18.3%

Source: 2021 Census



Ward-level demographic data (Census 2011)				
Ward	Population over 65	% of population over 65	BME over 65	% of 65+ pop'n who are BME
Ashley	838	5.2%	366	43.7%
Avonmouth	1979	15.9%	51	2.6%
Bedminster	1841	14.8%	17	0.9%
Bishopston	1016	7.3%	69	6.8%
Bishopsworth	2100	18.1%	18	0.9%
Brislington East	1714	14.8%	44	2.6%
Brislington West	1451	12.8%	22	1.5%
Cabot	730	4.6%	45	6.2%
Clifton	1171	10.4%	25	2.1%
Clifton East	691	6.5%	32	4.6%
Cotham	788	6.3%	42	5.3%
Easton	1187	8.8%	326	27.5%
Eastville	1358	10.9%	184	13.5%
Filwood	1451	11.8%	32	2.2%
Frome Vale	2165	18.6%	104	4.8%
Hartcliffe	2036	17.7%	26	1.3%
Henbury	1822	17.0%	29	1.6%
Hengrove	2291	19.5%	25	1.1%
Henleaze	2054	19.7%	55	2.7%
Hillfields	1731	12.8%	75	4.3%

Horfield	1655	12.9%	93	5.6%
Kingsweston	1645	15.9%	42	2.6%
Knowle	1613	14.3%	54	3.3%
Lawrence Hill	1526	8.1%	523	34.3%
Lockleaze	1564	12.9%	165	10.5%
Redland	1034	8.8%	50	4.8%
Southmead	1833	15.3%	69	3.8%
Southville	1469	11.7%	36	2.5%
St George East	1845	15.2%	36	2.0%
St George West	1665	14.0%	62	3.7%
Stockwood	2329	21.6%	32	1.4%
Stoke Bishop	1842	19.9%	44	2.4%
Westbury-on-Trym	2567	23.9%	49	1.9%
Whitchurch Park	1790	16.5%	17	0.9%
Windmill Hill	1081	8.2%	68	6.3%
Bristol	**55,870**	**13.0%**	**2,930**	**5.2%**

Source: Census 2011, ONS Crown Copyright Reserved [Additional data released 2013]

2. Scope

2.1 Bristol Vision

The Vision, as stated in the Local Action Plan for Dementia for Bristol (2011-2015), is:

"*That all people in Bristol with dementia receive a timely diagnosis, in a place appropriate to their needs, with a range of ongoing support available to them. We expect people with dementia to receive excellent care from diagnosis to end of life, by staff expertly trained in dementia, whether the person is at home, in a care home or in hospital. We expect all family/carers to be properly supported and to have access to a break from the stresses that caring can bring. We expect our services to be joined up and enable people to live well with dementia. Our overarching aim is for Bristol to be a dementia friendly City.*"

To support the delivery of the Vision and in line with NICE guidance, to the Service implements a Primary Care-led integrated model for people with dementia and their families/carers in Bristol.

2.1.1 Key Principles of the Service

The Bristol Dementia Wellbeing Service is supported by key principles, based on current thinking and practice which includes:

- ✓ The person with dementia <u>and</u> family/carers are at the centre of the model and key to making decisions about care

- ✓ Providing a co-ordinated and integrated approach between health, social care, voluntary and community sectors[6] to provide a person-centred holistic pathway using a primary care, chronic disease model
- ✓ A service that recognises that each person is an individual
- ✓ A non-discriminatory service which is provided on the basis of need, not chronological age, that meets the needs of all people, including younger people
- ✓ A service which delivers an integrated response that can meet the needs of people's other co-morbid mental health conditions
- ✓ A flexible and sustainable service that delivers the proposed model by co-ordinating the integration of care across all agencies involved and supporting General Practitioners - from diagnosis, active support for self-management through to end of life care
- ✓ Seeing dementia as everybody's business, not just as "health or "social care" issues. Mainstream services and facilities that work towards becoming more inclusive of and accessible to people with dementia and their families, in line with the "Dementia Friendly Communities" national workstream
- ✓ Care that is actively delivered in collaboration or formal partnership arrangements with other Providers and the BNSSG Dementia Health Integration Team (HIT) and ensures that agencies communicate and work together effectively along the care pathway
- ✓ A service that affords people a high level of dignity and respect, which is sensitive to their social and cultural background, and which maintains the highest standards of quality practice
- ✓ A service where people with dementia are understood as part of wider systems (families, carers, neighbourhoods, communities, friendship groups) and must always be worked with in relation to this key understanding
- ✓ A service which enables neighbourhoods and communities to be recognised for the important role they have to play in the lives of people with dementia and their families (for example, relationships/friendships, activities, support networks)

2.1.2 Aims and Objectives

Aim 1: To provide high quality integrated person centred-care for people with dementia (and family/carers) who may also have other co-morbid organic or functional mental health and/or physical health conditions, at home, in care homes or other residential settings through:

- ✓ Advice and the delivery of high quality, timely, accurate diagnosis of dementia and other co-morbid mental health conditions
- ✓ An understanding of and sensitivity to the complex presentations of people who have dementia and family/carers

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[6] Government of South Australia (2009). *South Australia's Dementia Action Plan 2009-2012: facing the challenges together*. Office for the Ageing: Department for Families and Communities.

- ✓ Integrated and co-ordinated care services with high quality, cost effective treatments based on the best available evidence
- ✓ A non-discriminatory service which is safe for everyone
- ✓ Timely interventions appropriate to people’s need, to enable people to remain at home for as long as this is their preferred place of care, aiming to delay or avoid admission to care homes
- ✓ A reduction in the number of unplanned admissions to hospital
- ✓ Equality of access and experience for all people who have symptoms or a diagnosis of dementia and their family/carers
- ✓ Providing timely and appropriate support for people with early onset dementia
- ✓ Ensuring people with dementia and family/carers have a strong sense of being in control of their services
- ✓ A service that is consistent with Social Care Institute for Excellence good practice on caring for people with dementia, in particular good practice around eating well and challenging behaviours

Aim 2: To provide high quality advice and support for other Providers, especially Primary Care, on assessment and management interventions for dementia through:

- ✓ Effective knowledge transfer
- ✓ Development of joint shared care protocols across organisations
- ✓ Education on good clinical care
- ✓ Contribution to training and organisation service development
- ✓ Providing links and sharing of information, that can support independent living and wellbeing
- ✓ Advice and signposting on other available support

Aim 3: To prevent or minimise the inappropriate use of anti-psychotic medication, including advice on alternative strategies for people with dementia living at home, in care homes or in other residential settings, through:

- ✓ Following the NICE/SCIE guidance on Supporting people with dementia and their family/carers in health and social care (NG97), specifically section 1.7, “Managing Non-Cognitive Symptoms”[1]
- ✓ Ensuring that people who are prescribed anti-psychotic medication have been fully assessed and are subject to monthly medication reviews
- ✓ Ensuring family/carers are fully involved in the decisions about medication
- ✓ Ensuring there are therapeutic alternatives for people with behaviours that challenge

Aim 4: To promote support and inclusion for people with dementia and family/carers using the Service through:

- ✓ Care orientated to the individuality, life experiences, strengths and abilities while attending to difficulties and disabilities to support people with dementia and family/carers
- ✓ Providing access and/or support into purposeful, stimulating and appropriate engagement, activities and connections
- ✓ Promoting people's continued connections with their families, friendships, communities and local neighbourhood
- ✓ Identifying and supporting the cultural and faith groups/spiritual needs of each person
- ✓ Proactively addressing the stigma of dementia and other mental health issues and proactively identifying issues of social isolation
- ✓ A form of expert carer programme for family/carers of people with dementia and uptake that is in line with predicted need, based on the Bristol demographics

Aim 5: To support the development of the workforce and volunteers providing the Service with the right attitudes and skill mix by ensuring that:

- ✓ The provider develops and promotes a culture of continuing learning and improvement throughout the whole Service and across providers
- ✓ Staff receive the training and supervision they need in relation to both current good practices and customer service approaches paying particular attention to the needs of the person with dementia and their family/carers
- ✓ Workforce capacity and capability are sufficient to deliver the expected outcomes
- ✓ The Provider involves people with dementia and family / carers in the dementia training of staff and volunteers, taking a co-production approach
- ✓ There is a good quality evidence-based programme of training for volunteers to promote a sense of empathy with people with dementia and family/carers
- ✓ Staff are familiar with and alert to the benefits of assistive technology and telecare for people with dementia

Aim 6: To promote a positive experience of services to people with dementia and family/carers through:

- ✓ Integrated care pathway services and integration across other Providers where all the component parts are clear and well co-ordinated and used as required through the person’s lifetime, including the development of person-centred holistic care plans in collaboration/formal partnership arrangements with other Providers
- ✓ Ensuring the service is delivered in a considered and co-ordinated manner

- ✓ Effective systems and processes in place to enable people with dementia and family/carers to have the opportunity to take part in high quality research studies
- ✓ Putting in place procedures, protocols, governance and audit arrangements to support the delivery of good health care
- ✓ Effective communication systems between front-line staff and managers and between members of the staff team and across organisations providing support to an individual
- ✓ Management and supervision appropriate to the delivery of good quality care
- ✓ Enabling a peer support model of care to be put in place, recognising that the experience of dementia (particularly in the early phases) may mean that the person can actively and valuably contribute to post-diagnostic support (in a paid sessional or voluntary capacity)

Aim 7: To provide a range of agreed consistent, measurable and auditable information, agreed with commissioners, to support the performance management of the Service and give commissioners confidence that the specified service is being provided. As a minimum this performance information will cover:

- ✓ Quality
- ✓ Finance
- ✓ Activity
- ✓ Level of integration with and support of the wider care pathway
- ✓ Person and family/carers reported outcomes

Aim 8: To provide commissioners with confidence that service specifications and operational standards are consistently met. The Provider demonstrates the Service is underpinned by the following values:

For people with dementia and their family/carers to:

- ✓ Feel valued and respected
- ✓ Be fully informed and engaged in all aspects of their care
- ✓ Live a normal life as far as possible, be safe and feel secure
- ✓ Be included in local community and activities
- ✓ Not be stigmatised or discriminated against on any grounds
- ✓ Have easy access to up to date and accurate information
- ✓ Have options in the choice of care available locally

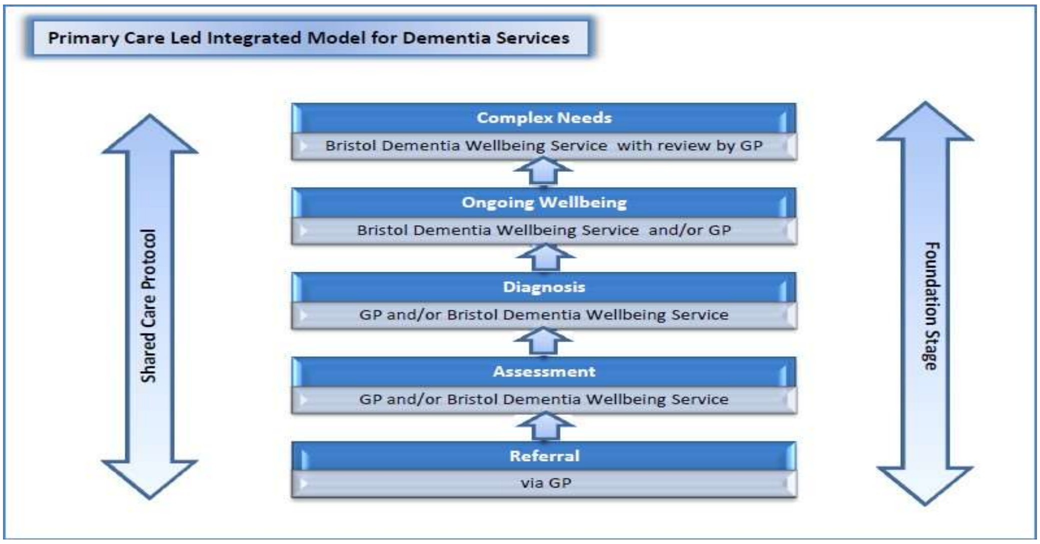
Be supported with services that:

- ✓ Are built around the needs of each individual and their family/carers
- ✓ Promote and enable wellbeing
- ✓ Take into account people’s safety

2.2 Service Model

In Bristol, the General Practitioner is the co-ordinator of care for people with dementia and their family/carers. The Bristol Dementia Wellbeing Service will work alongside, providing a co-ordinated and integrated approach and be responsive to the requirements of the General Practitioner in primary care, providing specialist advice, ongoing support, and specialist interventions. The General Practitioner will be responsible for:

- ✓ Raising awareness of dementia (as per the Health Checks and Local Enhanced Service)
- ✓ Case finding for dementia (in line with the Directed Enhanced Service)
- ✓ Diagnosing Dementia and providing formal review (including medication) at least every 12 months (as per Local Enhanced Service and QoF)



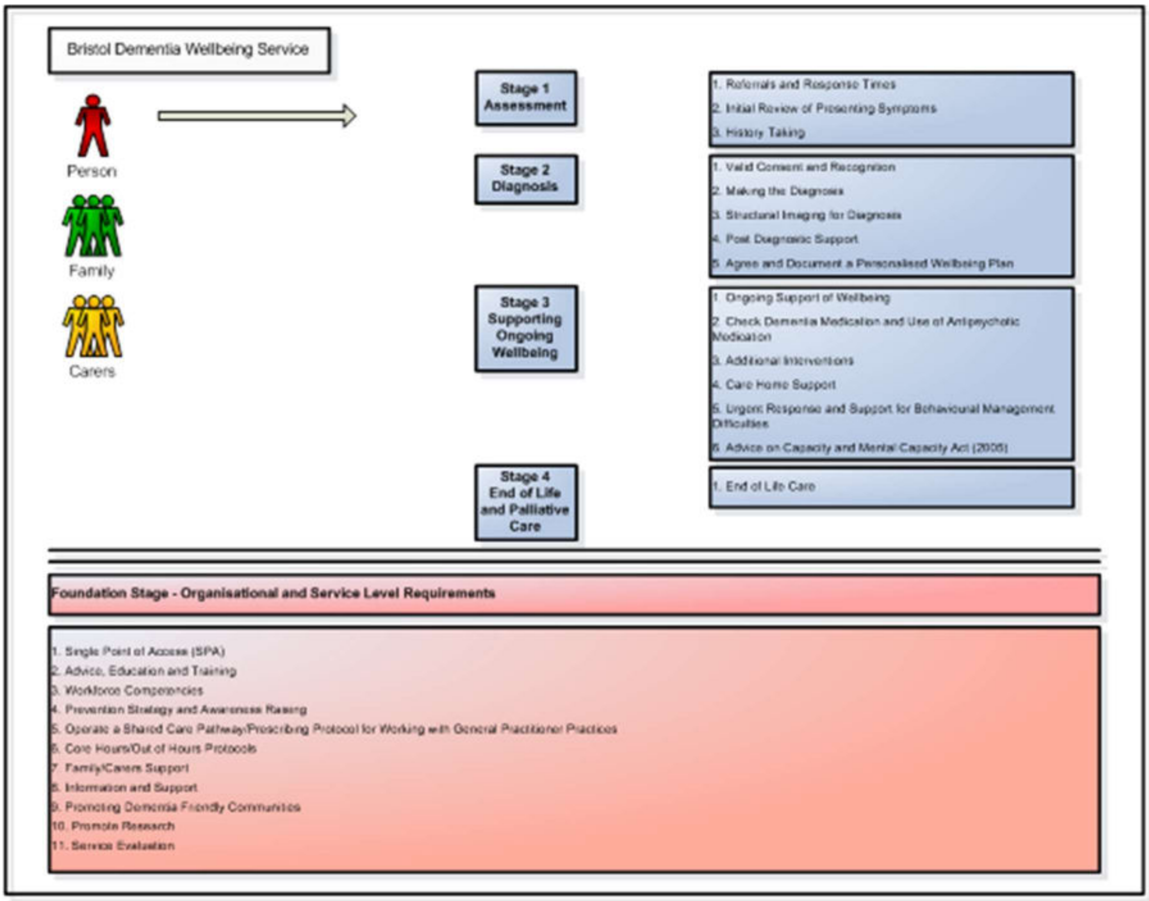
The Bristol Dementia Wellbeing Service will be based on person/relationship centre planning, supporting people with suspected or diagnosed dementia and their family/carers at home, or in a care home, to ensure they maintain independence and a high quality of life where they have chosen to live. The Service will be delivered through a shared care principle between General Practitioners and the Service, integrated and co-ordinated advice, assessment, treatment and on-going wellbeing support to people with dementia, their family/carers as well as advice, training and education to professionals, to understand and proactively manage their dementia and any other co-morbid mental health condition the person presents with.

Community/Primary Care-based services have the potential to prevent crises and reduce unplanned hospital admissions as well as delay or avoid admission to residential care placements. This Service will support the shift of provision from Secondary Care based services, to an integrated Service based in Primary Care.

For the purpose of the specification, the Service is broken down in to five stages, with a number of components for each stage. The following diagram sets out the stages in the Bristol Dementia Wellbeing Service, it should be noted certain components may take place in parallel rather than in series and not every person with dementia and family/carers will require all components of the service. The Foundation Stage underpins the whole spectrum of the service and will be required to underpin the delivery of good quality care; stages 1 to 4 reflect the delivery of the Service.

The Provider shall contribute to establishing procedures, protocols, governance and audit arrangements as well as education and training where needed in order to support a good quality Service and promote the efficient use of existing resources.

A high-level service description is set out below:



2.2.1 FOUNDATION STAGE: Organisational and Service Level Requirements

2.2.1.1 Foundation Stage: Point 1: Single Point of Access (SPA)

The Service will operate a Single Point of Access (SPA). The SPA will be able to initiate first assessment by the service (following GP referral), provide advice and support for people who have a diagnosis and family/carers and/or professionals who require information, and fast track people back in to the Service who have not been actively using it. It is important that this component of the Service has a signposting role to help people access other services that will be able to provide support.

2.2.1.2 Foundation Stage: Point 2: Advice, Education and Training

The following are requirements to fulfil this section of the specification:

- ✓ Professionals can access telephone and e-mail advice from the Service, this will include advice/support for Primary Care to make a diagnosis of dementia and to manage clinical issues
- ✓ A named and consistent member of the Service for each GP practice and each older person's care home in the City (nursing and residential). The member of staff will be able to co-ordinate rapid access to specialist support and advice, they will have a key role in ensuring the Service is embedded within local mainstream services (One named person can support several practices/homes).
- ✓ "On the job" training and support will be available. This will particularly be required for staff within care homes
- ✓ On-going training on dementia will be run for staff in mainstream services, which will be based on a needs analysis of the system (e.g. social care)
- ✓ Staff are able to recognise risk of abuse/neglect, deal with safeguarding issues, in-line with Safeguarding Adults policy

2.2.1.3 Foundation Stage: Point 3: Workforce Competencies

A range of core competencies are required for delivering integrated care of people with dementia and their family/carers at every stage across the pathway. These competencies need to support integrated care including the health and social care of a person with dementia, regardless of the individual or Provider delivering the care. It is acknowledged:

- ✓ Core competencies are required to ensure an integrated and seamless workforce, not a workforce artificially split into 'health' and 'social care'[7]
- ✓ Sustained work is needed to embed competencies in the workforce, including voluntary sector and private sector workforces
- ✓ Training should enable an understanding of the diversity in dementia, including younger people with dementia, those who have dementia and a learning disability, and those with particular needs from minority backgrounds who may require a more tailored approach

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[7] Department of Health (2011) *Common Core Principles for Supporting People with Dementia A guide to training the social care and health workforce*. London: Skills for Care, Skills for Health.

Workforce competencies for every stage of the integrated dementia care pathway, for all staff in health and social care and the third sector should:

- ✓ Think “family” at all times in order to provide holistic support and relationship-centred care
- ✓ Promote an information culture
- ✓ Communicate effectively with individuals
- ✓ Empower family, carers and volunteers to support individuals
- ✓ Involve the person with dementia in their own care planning, adhering to the value base of care (identity, dignity, respect, choice, independence, privacy, rights and culture)

The Service will be staffed by an appropriately trained competent workforce with specialist training and able to deliver evidenced based practice[1] sensitively. This will include, but not limited to, the skills of:

- ✓ Old Age Psychiatry
- ✓ Psychology
- ✓ Nursing
- ✓ Occupational Therapy
- ✓ Social Work
- ✓ Physiotherapy
- ✓ Pharmacy
- ✓ Speech and Language Therapy
- ✓ Equality, Diversity and Inclusion Support
- ✓ Learning Difficulties Support
- ✓ Generic Support
- ✓ Volunteers

2.2.1.4 Foundation Stage: Point 4: Prevention Strategy & Awareness Raising

The Service will take a proactive approach, alongside and in partnership with Public Health, voluntary sector organisations, in public awareness campaigns of dementia and other co-morbid mental health conditions, focusing on prevention and targeted at different audiences across the whole community to:

- ✓ raise the profile of dementia and other co-morbid mental health conditions
- ✓ reduce stigma
- ✓ promote understanding to Public and Professionals on an on-going basis and during Dementia Action Week and World Alzheimer's Day
- ✓ promote strategies for prevention of dementia and lifestyle changes that reduce or delay the onset of dementia
- ✓ deliver culturally appropriate dementia awareness and risk reduction awareness programs

2.2.1.5 Foundation Stage: Point 5: Operate a Shared Care Pathway/Prescribing Protocol for Working with GP Practices

In Bristol, General Practitioners are being supported to undertake a diagnosis of dementia and the initial management in primary care, where this is appropriate. The Provider will allocate a named appropriately skilled worker to each practice to facilitate this. The Provider should ensure that there is a shared care protocol in place, (written by the commissioning clinical leads, GPs and the Provider,) for the prescription of cholinesterase inhibitors, as recommended in NICE technology appraisal.

https://www.nice.org.uk/guidance/ta217

2.2.1.6 Foundation Stage: Point 6: Core Hours/Out of Hours Protocols

The Service will run 8am to 6pm; Monday to Friday. Within these core operating hours the Bristol Dementia Wellbeing Service will operate an effective and timely urgent intervention response.

The Provider will work in collaboration/formal partnership with other services to produce protocols and guidance for crisis responses that occur out of hours, to ensure there is access to appropriate care. The Service will also need to work closely with the Crisis Service (commissioned separately) which will also be able to provide an out of hours response, in accordance with the specification.

2.2.1.7 Foundation Stage: Point 7: Family/Carers Support

NICE Guidance emphasises the imperative in dementia care to consider the needs of carers, whether family and friends or unpaid carers, and to consider ways of supporting and enhancing their input to the person with dementia described as 'relationship-centred care' (NICE Guidance). The Service will be expected to work with family/carers in a variety of ways, including family/carers to be involved:

- ✓ input to an individual's wellbeing plan, where this is acceptable to the person with dementia
- ✓ in the developments of family/carers support groups
- ✓ with organisational service development/improvement activities
- ✓ on interview panels for staff recruitment
- ✓ in staff training

A key element of Carer's legislative documents found in:

- ✓ The Carers (Recognition & Services) Act 1995
- ✓ The Carers and Disabled Children Act 2000
- ✓ The Carers (Equal Opportunities) Act 2004
- ✓ The Care Act (2014) and Health and Care Act (2022)

is that a person identifying themselves as a carer is entitled to a comprehensive assessment of their emotional, psychological and social needs, NICE Dementia Quality Standard (2010), even if the person with dementia does not identify the person as a carer themselves. Therefore, to facilitate the identification, meaningful engagement of and potential support for family/carers, the Service will ensure that:

- ✓ carers are offered a carers assessment
- ✓ people with dementia are invited to bring someone with them to any appointments
- ✓ social networks are discussed in any assessment
- ✓ all family/carers are offered an opportunity to discuss their role in more detail
- ✓ all services will work collaboratively with family/carers providing support advice, on-going assessment and specific family/carers interventions where appropriate (if a family/carer declines an invitation to talk more about their role, then this should be recorded in the appropriate record and a review date set)
- ✓ all family/carers identified will be given an initial care assessment plan containing information and advice as an intervention
- ✓ all family/carers will be signposted to service that can provide support, this will include access to carers breaks

The commissioners expect that there will be a clear understanding between the Service, family/carers and people with dementia in relation to valid consent, confidentiality and sharing of information. Family/carers should always be given the opportunity to present their views and their views must be listened to and recorded even if permission is not gained from the person with dementia to relay information back to the family/carers.

2.2.1.8 Foundation Stage: Point 8: Information and Support

The Provider shall issue and/or signpost to appropriate information, support and follow-up for people with a suspected or confirmed diagnosis of dementia and their family/carers. In sharing information and providing support, the Provider shall ascertain the areas of most interest and relevance to the person with dementia and family/carers and assist them in identifying services and support that are best suited to their needs.

Sharing information shall include, but shall not be limited to:

- ✓ guidance on how people with dementia can improve their general health, live positively and maximise their quality of life after diagnosis e.g. using mental exercise, physical activity, dietary advice alongside drug therapy
- ✓ medico-legal issues, including driving
- ✓ services to support people with dementia and their family/carers from other organisations including peer support services
- ✓ services that can advise on welfare benefits
- ✓ advice and support on planning for the future, including legal matters associated with loss of capacity, including power of attorney, managing finances and benefits, advance statements, advance decisions to refuse treatment and preferred priorities of care
- ✓ services to support people with other health or social care needs
- ✓ opportunities for involvement in research studies

Providing support shall include, but shall not be limited to:

- ✓ advice and support to manage pharmacological treatment
- ✓ support for family/carers of people who have non-cognitive symptoms (e.g. mood disorders, psychotic symptoms and behaviour that challenges)
- ✓ assessment of family/carers needs
- ✓ support on planning for the future, including legal matters associated with loss of capacity, including power of attorney, managing finances and benefits, advance statements, advance decisions to refuse treatment and preferred priorities of care

All staff will need to have a high level of person centred cultural competency and an understanding of the importance of language access and communication.

Printed information and other formats (audio visual) shall be kept up-to-date and shared with General Practices and other relevant Providers and communities in the language of choice and age appropriate for young carers.

2.2.1.9 Foundation Stage: Point 9: Promoting Dementia Friendly Communities

The Provider will have a strong role in supporting the development of Bristol as a Dementia Friendly City. The Provider will work with local communities through their Community Development Coordinators, addressing barriers to accessing services and increasing awareness and education about dementia, including prevention. The Provider will be a member of the Local Dementia Action Alliance.

2.2.1.10 Foundation Stage: Point 10: Promote Research

The Provider will work collaboratively with the Bristol Dementia Health Integration Team as well as other partners, including NICE as requested by the commissioners to ensure:

- ✓ Access to best available evidence to influence service delivery
- ✓ Promotion of participation in research

The Provider is required to have systems and processes in place to ensure that people are given the opportunity to take part in high quality research studies funded by the National Institute of Health Research and others[8]; the need for better research was identified as one of three key areas in the Prime Minister's challenge on Dementia (2012) [3].

Examples of such systems and processes could include:

- ✓ Employ a dedicated Assistant Research Practitioner to support the above systems and processes.
- ✓ Adopt an 'opt-out' policy where people with dementia and family/carers may be contacted about opportunities to join research unless they explicitly request not to be contacted.

AND/OR

- ☐ To maintain a database of people with dementia and family/carers, with relevant demographics, to ensure accurate identification of potential participants for research activity.
- ✓ Have job descriptions and plans that make reference to Provider's commitment to promoting people's recruitment in to research studies and the view that it is a positive intervention
- ✓ Inform existing and new employees at induction of the Provider's commitment to contributing to the evidence base, a culture of innovation and improvement, and how employees can contribute
- ✓ Ensure access to appropriate research-relevant training
- ✓ Facilitate opportunities for people with dementia and family/carers to inform and participate in the research portfolio. For example, research opportunities for people with dementia and family/carers should be clearly presented in clinical areas using posters and leaflets or other media, and in Provider communication strategies

The Provider should understand that research does not only concern medical trials, but can include social and non-pharmacological interventions.

The Provider should make a statement on research activities undertaken in their annual Quality Account and should include a statement of the number of people recruited and the number of studies they host.

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[8] Routine data from the National Institute for Health Research Clinical Research Network can be used to monitor performance.

2.2.1.11 Foundation Stage: Point 11: Service Evaluation

The Provider is required to perform at least one full evaluation of the service within twelve months of operation, and thereafter at least every 18 months, other monitoring and audit activities may be required more frequently in agreement with the Commissioner.

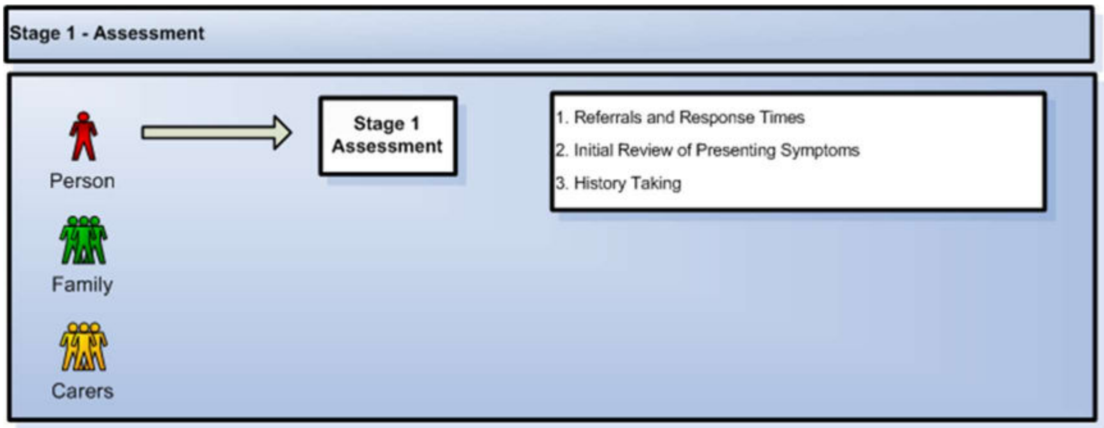
The full evaluation should use appropriate data to assess whether the Bristol Dementia Wellbeing Service is delivering the objectives as set out in the service specification and is providing value for money while also evaluating the processes involved in running the service. An evaluation plan should be developed in conjunction with the Provider's service delivery plan and clearly state the choice of performance measures that will be collected. This plan should then be agreed with the Commissioner and be funded from the overall value of the contract. The evaluation must be delivered in partnership with an external organisation, to ensure transparency. It is expected the plan will collect a mixture of both quantitative, qualitative and process data (where appropriate), and data might include as a minimum:

- ✓ Person with dementia satisfaction interviews (10% of caseload or a minimum of 30), surveys, complaints and compliments
- ✓ Family/Carers views (10% of caseload or a minimum of 30)
- ✓ Staff interviews (10% of caseload or a minimum 30)
- ✓ DemQal or other measures appropriate for assessing clinical and cost effectiveness
- ✓ Surveys, interviews, focus groups and workshops with stakeholders
- ✓ Person reported outcome measures, Quality of Life measures
- ✓ Performance measures such as numbers of people accessing the service, referrals, waiting times, demographics, Did Not Attend

The service evaluation is expected to inform the ongoing development of the Service. As a result of the evaluation parts of the Service may cease, change or increase. The Provider is encouraged to constantly reflect best practice in the Service and has the flexibility to try new interventions and to cease out of date ones.

The Service will work closely with external academic bodies, to influence the current curriculum of training and post registration continued professional development, to ensure that the workforce are able to deliver the requirements of the Service.

2.2.2 STAGE 1: Assessment



2.2.2.1 Stage 1: Point 1: Referrals and Response Times

The Provider shall respond to all requests relating to adults who meet the eligibility criteria as outlined in section 2.6.

The Provider shall respond to requests and confirm acceptance of referral within 10 working days of receipt and confirm a date and time to provide advice or support. Where a face-to-face assessment with a person suspected or diagnosed with dementia is required, the Provider will undertake the assessment in the place that is most appropriate for the person, which might be in a clinic, at home or in a care home.

The Provider shall respond to requests for advice by telephone from Primary Care within 4 hours for urgent requests and within 48 hours for non-urgent requests.

Where an urgent response is required, the Provider shall undertake the assessment within the same working day, if within the operating times of the Service, or if appropriate signpost any urgent referrals to the most appropriate service.

2.2.2.2 Stage 1: Point 2: Initial Review of Presenting Symptoms

The Provider shall provide advice and/or support on the initial review of presenting symptoms appropriate to what is required by the referrer. This advice shall be provided by a suitably qualified and trained professional, who is able to determine whether presenting symptoms or indicators are likely to be those of dementia and/or another mental health problem.

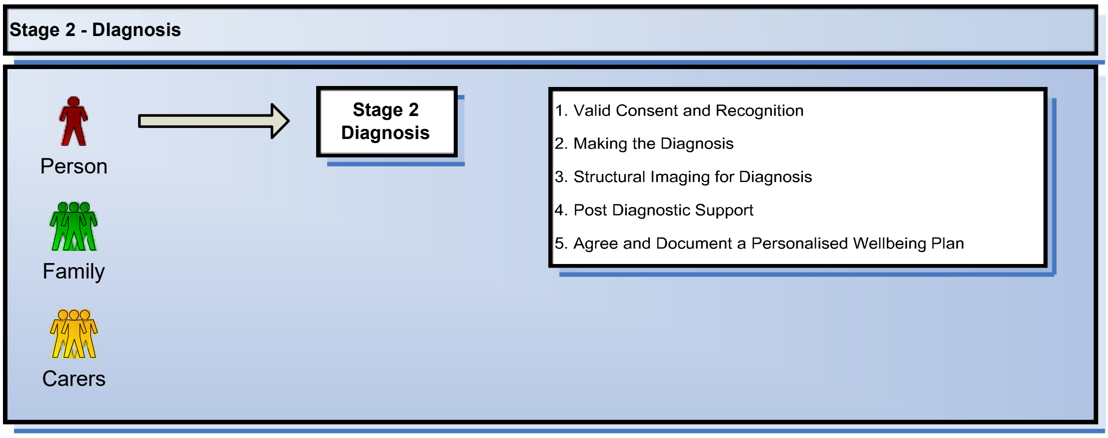
2.2.2.3 Stage 1: Point 3: History Taking

At the date and time agreed with the person who has made the request, the Provider shall advise on or undertake the assessment with the person. History taking shall be undertaken by a suitably qualified and trained professional and shall include, but shall not be limited to:

- ✓ a subjective and objective assessment of person’s life, social, family and carer history, circumstances and preferences, as well as their physical and mental health needs and current level of functioning and abilities
- ✓ assessment of history and impacts of impairments of vision, hearing and mobility
- ✓ assessment of history and impacts of impairments of medical co-morbidities and medication
- ✓ risk assessment covering all areas appropriate to the individual, e.g. falls, risk to self, childcare or family/carer responsibilities, driving, and financial and legal issues
- ✓ family/carer assessment including stress, health and function

From the initial contact date, the Provider shall complete the assessment (non urgent) within 20 working days. Upon completion, the Provider shall contact the person and family/carers, with a copy to the General Practitioner, within 10 working days to organise a time and venue to communicate the outcome; the appointment shall be within 20 working days of the assessment having been completed.

2.2.3 STAGE 2: Diagnosis



2.2.3.1 Stage 2: Point 1: Valid Consent and Recognition

In line with NICE guidelines (2013) valid consent should always be sought from the person being assessed, this should entail informing the person of the options and checking that he or she understands and that there is no coercion and he or she continues to consent through time and the process.

People who are assessed for the possibility of dementia should be asked if they wish to know the diagnosis and with whom this should be shared with and documented accordingly.

If the person lacks the capacity to make a decision, the provisions of the Mental Capacity Act 2005 must be followed.

2.2.3.2 Stage 2: Point 2: Making the Diagnosis

In recognising the primary care led model of dementia care, supported by a Local Enhanced Service, it is expected that an increasing number of straightforward cases of Alzheimer’s Disease or Vascular Dementia will be diagnosed in primary care without needing to be referred to the Service. In some cases, General Practitioners will be supported to make a diagnosis of dementia themselves, by an appropriately trained member of the Bristol Dementia Wellbeing Service giving telephone advice. In other cases the General Practitioner will refer a person for the diagnosis to be made by the Service. The Provider will have an important role in supporting General Practitioners to make a diagnosis, providing timely access to advice and guidance and providing training as appropriate. The Service will put in place a shared care protocol that has been agreed jointly by Providers and Commissioners to ensure that this is delivered in a clinically safe and appropriate way.

A detailed specification for delivering a Memory Service has been written by the Department of Health. The Bristol Dementia Wellbeing Service will encompass aspects of a traditional memory service, and the Provider should work with the Commissioner to ensure that this part of Service meets the appropriate requirements. However, as the Bristol model is moving towards primary care, with General Practitioners taking an active role in diagnosis and management, not all of the standards will be appropriate.

Service specification for dementia: memory service for early diagnosis and intervention (dementiapartnerships.com) At the specific request of the referring General Practitioner the Service will undertake the diagnosis of complex dementias, in a clinic based or if appropriate a home setting. A diagnosis of dementia and its sub-type shall be made by health care professionals with expertise in differential diagnosis of dementia using international standardised criteria in line with NICE/SCIE Clinical Guideline 42.

https://www.nice.org.uk/guidance/ng97 and NICE TA217
https://www.nice.org.uk/guidance/ta217

In some complex presentations (for example in a very young person), the Provider will refer the person to the North Bristol Trust Neurology Service or another appropriate speciality to provide the diagnosis and the Commissioner will be informed.

2.2.3.3 Stage 2: Point 3: Structural Imaging for Diagnosis

Structural imaging should usually be used in the assessment of people with suspected dementia to exclude other cerebral pathologies and to help establish the subtype diagnosis. While magnetic resonance imaging (MRI) may be the preferred modality to assist with timely diagnosis and detect subcortical vascular changes, computed tomography (CT) scanning could be used. The specific choice of imaging will depend upon a regional or local consensus approach and it is expected that the Provider complies with the agreed approach at the time. Specialist advice should be taken when interpreting scans in people with learning disabilities (NICE[1]).

2.2.3.4 Stage 2: Point 4: Post Diagnostic Support

The Provider shall deliver written and verbal information, support and follow-up to people who have had been referred to the Service, with reassurance that empowers the person with dementia and their family/carers to make informed decisions about the management of the condition and their individual wellbeing.

Wherever possible, the Provider shall contact the person or family/carers within 20 working day(s) of the diagnosis having been made in order to organise another time to discuss the diagnosis with the person and the family/carers together.

The Provider shall support people who have received a diagnosis of dementia and their family/carers in simple, direct language avoiding use of medical jargon and shall communicate in a warm, caring and respectful manner.

The Provider shall ensure that the diagnosis is conveyed to the General Practitioner with the explicit information that the person should be added to the General Practitioner dementia register.

The Provider shall offer post diagnostic groups in a variety of formats. Groups can be more formal with specific content and information or could be in an informal setting, with the aim of building confidence and mutual support. These groups should be available to everyone, no matter where the diagnosis of dementia has been made.

Stage 2: Point 5: Agree and Document a Personalised Wellbeing Plan The Provider shall agree and co-ordinate a holistic personalised Wellbeing Plan based on the individual's health and social care needs and talk through timely intervention options to empower the person and their family/carers regarding the condition and its management, within 12 weeks of their assessment. The Wellbeing Plan should reflect the individuality of the person with dementia, their unique personality and life experiences focus on maintaining wellbeing, encouraging optimism and focus on positive achievable outcomes. As a minimum the plan should identify a point of contact for the Service and family member/carers who can advocate on behalf of the person with dementia and provide information on:

- ✓ physical health including the impact on vision, hearing and mobility
- ✓ psychological well-being
- ✓ medication
- ✓ social care needs
- ✓ assistive technology
- ✓ activities/occupation
- ✓ family/carers needs; caring issues; access to careers assessment
- ✓ managing risk and safeguarding
- ✓ follow up wellbeing call
- ✓ who the person and the family/carer should contact if their needs change
- ✓ sources of local information and support
- ✓ access to legal and financial information, including support with claiming benefits, where eligible

The Provider shall share information about options for care and treatment, including coping methods and strategies and addressing immediate care or support needs.

The Provider shall signpost and provide information to the person and family/carers, as appropriate, about:

- ✓ groups run by the Service or other local providers and voluntary organisations
- ✓ local care and support services / support groups
- ✓ local information sources, including libraries and voluntary organisations such as Alzheimer's Society

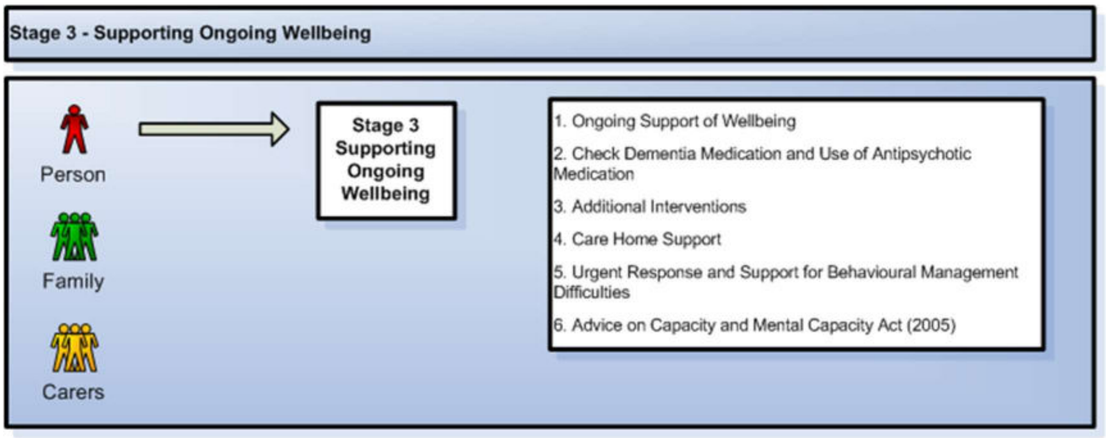
Where cognitive enhancing medication is prescribed all healthcare professionals involved should follow the National Guidance. NICE/SCIE Clinical Guideline 42.

and NICE TA217 https://www.nice.org.uk/guidance/ta217

The content and number of post diagnostic sessions will vary according to the person's needs. The Provider shall ensure there is continuing advice and support and that information is available. The General Practitioner will carry out the standard reviews and may call upon the Service to support this, if the needs have changed significantly.

The Provider should ensure the person with dementia has a copy of "This is Me" from Alzheimer's Society and is encouraged to take this with them if they are ever admitted to hospital or a care home.

2.2.4 STAGE 3: Supporting Ongoing Wellbeing



2.2.4.1 Stage 3: Point 1: Ongoing Support of Wellbeing

The Provider will implement a robust service model to support ongoing wellbeing and to provide optimal care after a referral to the Service has been made. This will be through a continuous, co-ordinated and responsive process of re-evaluation with improved and refined interventions being developed as needs of the person change.

It is expected that the Service will provide some on going low level wellbeing checks, for people who are not in active contact with health services with regards to their dementia. As a minimum this should be via a 6 monthly telephone check. It is expected that this will be provided by non-clinical staff, including volunteers. This should be carefully co-ordinated alongside the General Practitioner and should focus on those people who have not been reviewed by the Service or General Practitioner in the previous 6 months, or if the person does not have close family/carer, in the past 3 months. Staff delivering this element of the service should be closely linked with the General Practitioner practices to avoid duplication and ensure any pertinent issues raised are discussed at the time.

The Provider shall also provide timely support and advice to requesting clinicians to help support the delivery of good quality evidence based care to people with dementia and their family/carers and other mental health needs. This support and advice shall include, but not be limited to:

- ✓ Liaising with others involved in supporting the person with dementia and their family/carer in agreement with them
- ✓ Updating of the Wellbeing Plan in conjunction with the General Practitioner (as a minimum at the 6 monthly telephone wellbeing check)
- ✓ Checking medication and advising on appropriate use of alternatives to prescribing antipsychotic drugs
- ✓ Managing behavioural and psychological symptoms of dementia
- ✓ Therapeutic interventions
- ✓ Urgent response and support for crisis events
- ✓ Advice on capacity decisions and the Mental Capacity Act (2005)
- ✓ Identification of Safeguarding issues, in line with National and Local Guidance

The Provider will be expected to work closely with the Recovery Ward for any people with dementia who are an in-patient. The Provider will need to attend Multi-disciplinary team meetings, to ensure the person with dementia has a smooth, timely transition home, with a well-coordinated wellbeing plan.

2.2.4.2 Stage 3: Point 2: Dementia Medication & Use of Anti-Psychotic Medication

There is a wealth of evidence which states that although there are clinical situations where a time-limited prescription of anti-psychotic medication may be appropriate, anti-psychotic medication is often overprescribed and continued, when alternative approaches may be more beneficial. There is an unambiguous case for a substantial reduction in their use alongside the wider adoption of alternative interventions, which can help to maximise the quality of life for people with dementia and their family/carers.[9]

All people with dementia who are receiving anti-psychotic medication will undergo clinical reviews to ensure that their care is compliant with current best practice and NICE guidelines. The Provider will ensure that alternatives to the person’s prescription have been considered and a shared decision has been agreed regarding their future care.

In cases of poor response, the Provider shall provide recommendations regarding changes to medication prescribed for a mental health need, if safe to do so, and advice on alternative strategies as appropriate.

The Provider shall comply with good practice from available evidence and policy, including:

- ✓ ensuring that people prescribed anti-psychotic medication have been fully assessed and are subject of regular monthly medication reviews or more often if appropriate
- ✓ ensuring family/carers are fully involved in decisions about medications
- ✓ ensuring there are therapeutic alternatives for people with behaviours that challenge

Older people are particularly susceptible to the effects of combinations of medication. The GP alongside the Provider shall check the suitability of medications and their combinations and provide advice on the possible effects, prior to initiation and on an on-going basis as the persons needs dictate. This includes all psychotropic medications (antipsychotic, anti-depressant and mood stabilisers).

2.2.4.3 Stage 3: Point 3: Additional Interventions

The Provider shall provide interventions in line with NICE/SCIE guidelines, which shall include, but not be limited to:

- ✓ post diagnostic sessions
- ✓ family/carers support group
- ✓ therapeutic support including Occupational Therapy, Speech and Language Therapy
- ✓ education sessions in dementia
- ✓ cognitive stimulation therapy
- ✓ psychology support

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[9] Dementia Commissioning Pack (2011). *Reducing inappropriate prescribing of antipsychotic medication.* Department of Health: London.

- ✓ and signpost/refer

on to:

- ✓ memory cafes
- ✓ peer support groups
- ✓ community hubs
- ✓ assistive technology
- ✓ community equipment (accessed via the Integrated Community Equipment Service)
- ✓ volunteering opportunities

2.2.4.4 Stage 3: Point 4: Care Home Support

The Service will include liaison provided on an in-reach basis to care homes, to prevent inappropriate admissions to hospital and/or to provide active intervention at a time of safeguarding in support of safeguarding investigations. In care homes with nursing, If there is an identified low level mental health or dementia need of a resident, the Bristol Dementia Wellbeing Service will provide the support regardless of diagnosis that the resident has.

It should be noted that people in extra care will be treated as if they were in their own home and will come under the umbrella of the assigned General Practitioners Practice.

As well as providing specialist dementia advice the Service should be designed to meet some of the specific challenges that exist in care homes due to the large numbers of people with advanced dementia who reside in this setting.

The service will:

- ✓ provide education, training and coaching to care home staff to enable them to recognise, prevent and manage challenging behaviours more effectively
- ✓ have a particular remit in ensuring that people in care homes are not inappropriately prescribed anti-psychotic medication
- ✓ provide specialist input into decision making concerning the initiation, monthly review and cessation of anti-psychotic medication for people with dementia
- ✓ focus on making dementia an explicitly owned priority in care homes enabling a high level of input into care
- ✓ prevent escalation of problem behaviours by means of timely intervention
- ✓ provide access to specialist advice for problems arising between reviews
- ✓ be a source of expertise to draw on, in order to build and maintain a social and therapeutic environment within the care home, that is positive for people with dementia and tailored to their needs

The Service will have a particular remit to support care homes who are under safeguarding investigation. If a home is under notice, the team will ensure that priority is given to these residents.

2.2.4.5 Stage 3: Point 5: Urgent Response and Support for Behavioural Management Difficulties

The Service should be set up in a way that will enable an “urgent response” during the hours of Service operation, for people with diagnosed/suspected dementia experiencing challenging behaviour. The Service should be able to provide a timely intervention to stabilise a situation and will need to work closely, using an integrated approach, to enable a holistic approach to be taken and to avoid unnecessary admission to hospital.

People with dementia who develop non-cognitive symptoms that cause them significant distress or who develop behaviour that challenges, should be offered an assessment at an early opportunity to establish the likely factors that may generate, aggravate or improve such behaviour. NICE guidance (2013) advices the assessment should be comprehensive and include:

- ✓ the person's physical health
- ✓ depression
- ✓ possible undetected pain or discomfort
- ✓ side effects of medication
- ✓ individual biography, including religious beliefs and spiritual and cultural identity
- ✓ psychosocial factors
- ✓ physical environmental factors
- ✓ behavioural and functional analysis conducted by professionals with specific skills, in conjunction with carers and care workers

Individually tailored wellbeing plans that help family, carers and/or staff address the behaviour that challenges, should be developed, recorded in the notes and reviewed regularly. The frequency of the review should be agreed by the carers and staff involved and written in the notes.

It is anticipated that as the Service develops and the wellbeing plan and wellbeing checks are implemented, the requirement for an urgent response will diminish.

If an urgent response is required out of core hours, a response will be required from the Crisis Response Team. This Service must work closely with the Out of Hours Providers to ensure that there are appropriate plans in place. This will need to include the development of local protocols and guidance.

2.2.4.6 Stage 3: Point 6: Advice on Capacity and Mental Capacity Act (2005)

Treatment and care should take into account person's needs and preferences. People with dementia should have the opportunity to make informed decisions about their care and treatment, in partnership with their care professionals.

Professionals should discuss with the person with dementia while they have capacity and their family/carer the use of:

- ✓ Advance Statements
- ✓ Advance Statements to refuse treatment
- ✓ Lasting Power of Attorney
- ✓ A preferred Place of Care Plan (allows people to record decisions about future care choices and where the person would like to die)

If people do not have the capacity to make decisions, care professionals should follow the Department of Health's advice on consent and the code of practice that accompanies the Mental Capacity Act.

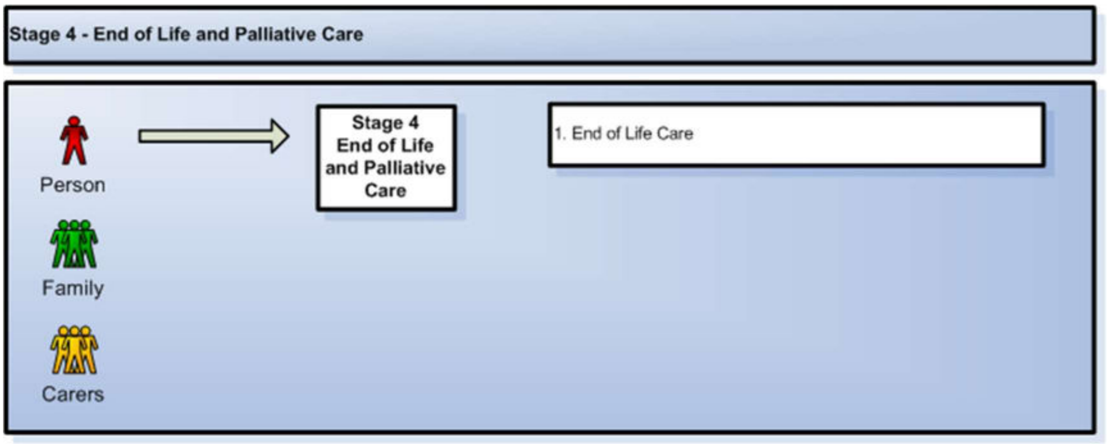
The Provider shall be aware and up to date on advice on capacity decisions and compliance with the Mental Capacity Act (2005) and accessing advocacy services. Where appropriate the Provider shall reinforce the message that a diagnosis of dementia does not mean that a person does not have capacity. The Provider should support decision makers from other non-specialist staff where:

- ✓ the level of capacity is genuinely unclear, or
- ✓ a significant decision is to be made (e.g. a change in relation to the place of residence)

Where the decision is likely to be in relation to a new place of residence, the Provider may have a role in supporting the decision maker to engage with health and social care professionals, the person with dementia and their family/carers in a timely manner to ensure this is delivered in a coordinated way.

2.2.5 STAGE 4: End of Life and Palliative Care

The Service shall have a role in supporting people with dementia and family/carers to make timely end of life care decisions and in the smooth transition to end of life care services.



2.2.5.1 Stage 4: Point 1: End of Life and Palliative Care

People with dementia who are dying should have the same access to end of life care services as those without dementia. However, treatment decisions differ for people with dementia from other people approaching end of life in two ways:

- ✓ The decline in health is less predictable and more variable, making prognosis difficult
- ✓ The deterioration in communication skills prevents people with dementia from expressing their views and wishes later in the disease pathway

The NICE/SCIE Guideline 42 recommends that dementia care should incorporate a palliative care approach from the time of diagnosis until death, aiming to support the quality of life of people with dementia and to enable them to die with dignity and in the place of their choosing, while also supporting family/carers during their bereavement, which may both anticipate and follow death[3].

End of life care is normally defined as the care needed during the last year of life. End of life for dementia differs from other long term conditions because of the slow transition, which makes the identification of the time for a transition to end of life difficult.

This Service does not have a specific remit to deliver end of life care. However, there is a key requirement to ensure that the person with dementia and family/carers are equipped with the information to enable them to make well informed decisions. In dementia, end of life care planning should be incorporated early while someone has sufficient mental capacity and where decisions and preferences can be recorded, consistent with principles set out in the Mental Capacity Act (2005), this should consider physical, psychological, social and spiritual needs to maximise the quality of life of the person with dementia and their family/carers. Some benefits include[3]**:**

- ✓ reducing inequalities and stigma by improving access to information, advice and a range of supportive services
- ✓ improving the psychological, physical and spiritual wellbeing of people with dementia and their family/carers through access to an appropriately trained workforce
- ✓ improving the quality of care through timely interventions in the right place by a knowledgeable and caring workforce
- ✓ increasing choice through advance care planning, advance statements and Advanced Decisions to Refuse Treatment (ADRTs)
- ✓ reducing unnecessary hospital admissions by supporting people with dementia to live in a place of their choice for as long as possible
- ✓ improving cross boundary and partnership working, improving care coordination, minimising unnecessary duplication and reducing costs
- ✓ supporting family/carers and ensuring access to an assessment of need as set out in the Carers and Disabled Children Act 2000 and the Carers (Equal Opportunities) Act 2004

The Service will identify a designated end of life champion who will be the point of liaison between the Service and the end of life care pathway leads. The champion will have the ability to cut across pathways sensitively and understand the steps, supporting people by giving practical guidance, advice and signposting to ensure that the needs of people with dementia are being met within the mainstream services.

The Service will develop a close working relationship with existing palliative care services and end of life care services, to ensure that there is a seamless transfer of care at this stage.

2.3 Referral

New referrals should usually come form the General Practitioner; once the person has been accepted by the Service subsequent follow up referrals can be made to the Service without the need to go via the General Practitioner, however joint discussions should take place on a regular basis and, particularly if the person's symptoms are exacerbating to the extent that the person may need complex interventions.

If the person with dementia has already been seen by the Service, a formal referral will not be required, requests for the Service to actively engage with the person will be accepted from:

- ✓ Self/Family/Carer
- ✓ Crisis Access Points
- ✓ Crisis Service
- ✓ Vita Minds (IAPT)
- ✓ Recovery Service
- ✓ Recovery Ward
- ✓ Primary Care Staff
- ✓ Acute Trusts Discharge Teams
- ✓ Community Services
- ✓ Social Work Teams
- ✓ Other Social Care services
- ✓ Intermediate Care Team
- ✓ Safeguarding Team
- ✓ Community Learning Difficulties Team
- ✓ Care Home Providers
- ✓ Third Sector Organisations
- ✓ Community Pharmacy
- ✓ Police
- ✓ Ambulance
- ✓ Fire Brigade

2.4 Discharge Process

The person with dementia will not be formally "discharged" from the Service, as dementia is a long term condition, people not in current receipt of a service will be classed as 'inactive' therefore they will not contribute to caseloads.

2.5 Population Covered

To access the Service people must be registered with a Bristol General Practitioner. Bristol is divided in to three geographical localities: North and West; Inner City and East, and South.

Providers will actively consider how their service will respond to the needs of Bristol's diverse population. This will include complying with relevant equalities legislation and best practice guidance. We will expect the service to make reasonable adjustments to ensure the service is open and accessible to the whole of the population.

Particular reference will be made to needs of people with disabilities, people from B~~b~~lack, Asian and other ethnic minority communities or those people who currently find it difficult to access current services or are under-represented within those services.

There is a specific expectation that people with a learning disability will not be excluded from the services offered and that reasonable adjustments will be made to ensure an inclusive service delivery model.

The service will be delivered in line with the requirements of the national and local autism strategy to ensure people with autism have access to mainstream public services where ever possible and in doing so will be treated fairly as individuals.

2.6 Any Acceptance and Exclusion Criteria

2.6.1 Inclusion Criteria

The Bristol Dementia Wellbeing Service is designed to meet the needs of people with symptoms or a diagnosis of dementia and will work with them as part of a wider (family) system; it will support their family/carers, whether they are living at home, in care homes or other residential settings. The inclusion criteria include:

- ✓ People presenting with symptoms or a diagnosis of any form of dementia
- ✓ People with suspected or diagnosed dementia, who may/may not have a co-morbid mental health condition
- ✓ People with a learning difficulty and who have suspected dementia or a diagnosis of dementia
- ✓ People who have had a brain injury and previously exhibited symptoms of dementia
- ✓ All people aged 16 and over if they meet the above criteria

The Service is primarily for people with a diagnosis of dementia and their family/carers however this will not preclude anyone with presenting symptoms of dementia, who does not want to receive a formal diagnosis, from accessing the Service.

2.6.2 Exclusion Criteria

The following is not the responsibility of this Service:

- ✓ It is not the role of the Bristol Dementia Wellbeing Service to carry out the functions of mainstream hospital or community staff nor to duplicate existing skill provision

- Whilst it is not the role of the service to directly carry out functions that would normally be understood as those of social care staff, it is recognised that the boundaries are often less than clear and the Service will work closely with Social Care to promote good holistic joint working
- Whilst it is recognised that people should be generally be supported by the Service that is most appropriate to meet their needs; for example, if the presenting co-morbid mental health condition is more dominant than the dementia, it may be appropriate to refer the person to the Primary Care Mental Health Service or the Assertive Engagement Team, this service will actively work against silo working and will promote inter-agency support and mutual learning and develop clear pathways and protocols to enable smooth transition between pathways**.** This should be managed between Providers, however if there is any disagreement, this should be referred to the Lead Provider.

2.7 Interdependencies with Other Services

The Service shall interface with other existing services (listed below) to make and share diagnoses and other relevant services to meet the health and/or social care needs of people with dementia and family/carers. The Service will develop a partnering relationship with:

- GP Practices
- Other Social Care services

The service will develop working relationships with (not exclusively):

- GP Practice Staff
- Recovery Service
- In-patient Service
- Crisis Service
- Crisis Access Points
- Vita Minds (Improving Access to Psychological Therapies)
- The Bristol Dementia Health Integration Team
- Community Nursing Teams
- Social Work Teams
- Intermediate Care Teams
- Acute Trusts Discharge Teams
- Safeguarding Teams
- Community Learning Difficulties Team
- Care Home Providers
- Third Sector Organisations
- Community Pharmacy Services
- Supported Housing
- Drug and Alcohol Services
- Community Pharmacists
- Emergency Services
- South West Dementia Strategic Clinical Network
- The National Institute for Health Research, Clinical, Research Network
- Representation at the Reporting Stakeholder User Group

2.8 Information Management and Technology

Within Bristol Mental Health Services the focus of the IM&T systems will be on continuity of patient care across services and not on organisational boundaries. In order to support the requirement for joined-up care the Commissioner Lead will provide the following:

- ✓ The core clinical information system (RiO via AWP)
- ✓ The system wide reporting solution
- ✓ Configuration and support associated with these core systems

The core systems will be used by

- ✓ Community Mental Health Services including:
    1. Assessment and Recovery Service
    2. Early Interventions in Psychosis Service
    3. Crisis Service Single Point of Access Crisis Assessment and Intensive Home Treatment Service
    4. Complex Psychological Interventions Service
- ✓ Community Rehabilitation Services
- ✓ Bristol Dementia Wellbeing Service
- ✓ Employment Services
- ✓ Assertive Engagement Service
- ✓ Inpatient Services, including 136
- ✓ Bristol Sanctuary
- ✓ Women and Men's Crisis Houses

The provider must work with the provider of the core clinical information system to share and document business processes and to work together to effectively implement the shared clinical record and reporting solution.

The provider must contribute to developing a collaborative, problem solving culture for implementing and maintaining a shared IT approach.

At a high level, the provider is responsible for the provision of:

- ✓ Local hardware and infrastructure
- ✓ Non-clinical business applications such as email, finance, HR and file servers
- ✓ Telephony

- **Electronic Patient Record (EPR) System**

The provider must use the EPR system provided by the Commissioner Lead to ensure there is a single patient record across the whole Bristol mental health system.

To enable the effective collaborative working of all providers and organisations within Bristol's mental health system, all patient information is to be entered into the EPR system in real time, i.e. during the consultation with the patient.

All records are to be kept on the EPR system and all written communication between practitioners and or services is to be kept within the system.

This should ensure that everybody who may come into contact with a particular patient has access to up-to-date, accurate and complete information at all times.

The provider must support the provider of the core clinical information system to put in place a system which captures medication information that can be shared across relevant providers.

The provider must ensure they make staff available to be trained on how to use the core EPR system.

- **Reporting**

The provider will be able to generate their own reports from the core reporting solution that will be made available by the provider of the core clinical information system. The provider must ensure they make staff available to be trained on how to generate reports from the system.

Through the core reporting solution, the provider will be responsible for:

- ✓ Their own minimum data set return to the Department of Health
- ✓ KPI reporting to the Commissioner
- ✓ All other statutory returns
- ✓ Ensuring their own data quality

The provider of the core clinical information system will have specific responsibilities for generating system wide reports which include data from some or all of the providers across the system. This information will be used to help identify problems and produce evidence-based response to performance issues. The provider will work with the Commissioner Lead to improve data quality and consistency across the system.

Information on patient experience shall where possible be collected in real time and provided to clinical teams so that it can be used to improve patient experience of the service during the course of their episode of care, rather than gathered at the end and reflected in future practice.

- **Wider Information Sharing**

Wider information sharing across the patient pathway is at the heart of safe and effective care. Information must be available to staff at the point of care to support clinical decision making.

The Commissioner Lead will be responsible for enabling information sharing between the core EPR solution and other systems agreed with the Commissioner.

Connecting Care is the flagship systems integration/clinical portal project in Bristol, North Somerset and South Gloucestershire and active stakeholders include; CCGs, GPs, social care, acute hospitals, community providers, the ambulance service. It is expected that the provider will be committed to Connecting Care as the method for sharing data between stakeholder organisations.

Where electronic data sharing is not in place, the provider must work with other providers and the Commissioner Lead to ensure information is shared appropriately. This could include:

1 Recording interventions in the GP clinical record

2 Ensuring that Social Services are updated with relevant information such as services being delivered and any change to place of residence as a consequence of health service delivery

- **Hardware and Infrastructure**

The providers must ensure they have appropriate hardware, infrastructure and telephony in place to allow them to access relevant clinical and non-clinical IT systems. This will include the EPR and reporting solutions provided by the Commissioner Lead and any other applications that the provider requires in order to deliver the specified service, for example email, finance systems, HR systems, file-servers.

The Commissioner Lead will provide a warranted environment specification in relation to the core EPR and reporting solutions, which the provider must adhere to.

All hardware and infrastructure should have a high level of resilience to ensure that services can be delivered to the agreed service and quality levels. Disaster recovery processes and business continuity plans must be in place.

- **System Maintenance and Support**

The provider of the core clinical information system will manage the maintenance and support associated with the core EPR and reporting solutions, including the provision of a helpdesk.

The provider must ensure that they have robust and appropriate maintenance and support arrangements (including disaster recovery and business continuity) in place for:

- ✓ The hardware and infrastructure that they will use to access the core systems
- ✓ Any other clinical or non-clinical systems that will be used to deliver the specified services
- ✓ Telephony

- **Information Governance**

The provider must contribute to and sign up to the information sharing protocols developed by the Commissioner Lead.

The provider must comply with all Information Governance (IG) standards, NHS standards for record-keeping, the Data Protection Act, Information Governance toolkit, Caldicott principles and Department of Health standards and the common law duty of confidentiality.[1]

The core IG requirements of Mental Health Service providers when acting as a service provider to the NHS are that the provider shall:

- ✓ Perform an annual information governance compliance assessment via the NHS IG toolkit. In doing so, shall achieve a minimum of level 2 compliance across all requirements. If unable to meet this level the provider shall agree an action plan to achieve this with the commissioning organisation
- ✓ Utilise the ‘Mental Health Trust Version 11 (2013-2014)’ model of the toolkit unless there is a more relevant model that will be agreed with the commissioner.
- ✓ In relation to compliance, the following items are specifically required to assure that the self-assessment is robust: The provider must:
- ✓ Ensure they have identified senior individuals to fulfil the roles of Caldicott Guardian and Senior Information Risk Owner. As a default these roles should be with two separate individuals. If the roles are held by one person information supporting the reasoning for them being held by one individual must be given
- ✓ Ensure all mobile devices (including but not limited to laptops, tablets, smartphones and removable media) are encrypted to current NHS standards
- ✓ Ensure they work with the Commissioner Lead to educate and train staff on the handling of personal data, with a minimum of an annual update and assessment of knowledge
- ✓ Maintain all information storage within the United Kingdom, unless appropriate technical and organisational measures (as defined by principle 8 of the Data Protection Act (1998)) are in place and agreed with the commissioner
- ✓ Have an active risk assessment and management programme to ensure the on-going security of all information assets and information flows
- ✓ State how their systems and processes are compliant with the NHS Care Record Guarantee, including reporting on who, when and where access to a service-user’s information was carried out, both from the perspective of the service-user and the member of staff
- ✓ State how access to personal data is controlled, so that only staff with a legitimate reason to use records for direct care can access them. In addition state how management related ‘secondary uses’ of personal data are effectively anonymised or pseudonymised.
- ✓ Ensure that processes and methods to inform service-users how their information is used, how they can access their records and how they can raise any concerns about the use of their personal data are clearly stated and in place for all users of the system
- ✓ Providers must work with the Commissioner Lead to evidence and assure on how the creation, amendment and removal of user access to their information assets containing personal data is managed, to the effect that staff are set up with access to the assets they need in a swift manner and changes/removal of access are enacted at the time of need or as soon after as possible
- ✓ Describe the controls to prevent disruption to use of information systems from threats such as viruses/malware and other continuity issues (such as power/technical failure)

[1] https://nww.igt.hscic.gov.uk/RequirementsList.aspx?tk=414484859081170&lnv=2&cb=864ffc3e-71ce-4145-a50e-ad05a3ac31a8&sViewOrgType=5&sDesc=Mental%20Health%20Trust

- **Training**

The provider must work with the provider of the core clinical information system to put in place job focussed training i.e. how the system supports provider staff in performing their duties supported by job focussed user guides to underpin use of the system. The provider of the core clinical information system will ensure there is a training environment to facilitate continuous up to date relevant training. The provider must support the Commissioner Lead to put in place relevant and systematic I&MT training including, but not limited to:-

- ✓ Induction
- ✓ IM&T training plans in place for each staff group
- ✓ Up to date Standard Operating Procedures (SOPs) and evidence they are adhered to
- ✓ Processes to ensure staff are achieving and maintaining competency
- ✓ Integration of IM&T training into the staff training programme
- ✓ Provider must contribute staff to work as part of a network of system champions from across the service and run sessions to maintain IT and clinical engagement across the board.

2.9 Transition Plans

The providers must support the Commissioner Lead to put in place transition plans that ensure continuity of services for staff and people with dementia and families/carers from day one of the new

contract and for transfer of relevant data at the end of the contract to a new provider should the contract not be extended or re-awarded. The plan must include, but not limited to:

- ✓ Manage the transfer of all agreed IM&T resources including, patient data, infrastructure, hardware, and additional relevant data so that these are all in place for contract start and so that service moves seamlessly from the existing provider to new provider
- ✓ The provider will support the Commissioner Lead to manage the data migration from other systems and ensure data quality is continually improved.

2.10 Research and Evaluation

2.10.1 Research

The Provider will work collaboratively with the Commissioners to ensure:

- ✓ Access to best available evidence
- ✓ Promotion of participation in research

The Provider is required to have systems and processes in place to ensure that people are given the opportunity to take part in high quality research studies. Examples of such systems and processes could include:

- ✓ Adopt an ‘opt-out’ policy in which people with mental health needs and family/carers are informed that research is a routine part of the philosophy of the Bristol Mental Health Model and that they may be contacted about opportunities to join research unless they explicitly request not to be contacted.
- ✓ Have a system in place such as a ‘consent for approach register’ to keep a record of people who are willing to be offered research opportunities, together with relevant demographic details and their diagnosis
- ✓ Have job descriptions and plans that make reference to Provider’s commitment to promoting people’s recruitment in to research studies and the view that it is a positive intervention
- ✓ Inform existing and new employees at induction of the Provider’s commitment to contributing to the evidence base, a culture of innovation and improvement, and how employees can contribute
- ✓ Ensure access to appropriate research-relevant training
- ✓ Facilitate opportunities for people with mental health needs and family/carers to inform and participate in the research portfolio. For example, research opportunities for people with mental health needs and family/carers should be clearly presented in clinical areas using posters and leaflets or other media, and in Provider communication strategies

The Provider should understand that research does not only concern medical trials, but can include social and non-pharmacological interventions.

The Provider should make a statement on research activities undertaken in their annual Quality Account and should include a statement of the number of people recruited and the number of studies they host.

2.10.2 Evaluation

The Provider will agree with the Commissioner the level of service evaluation required to be undertaken. In most cases the Provider will be required to perform at least one full evaluation of the service within twelve months of operation, and thereafter at least every 18 months, other monitoring and audit activities may be required more frequently in agreement with the Commissioner.

The full evaluation should use appropriate data to assess whether the service is delivering the objectives as set out in the service specification and is providing value for money while also evaluating the processes involved in running the service. An evaluation plan should be developed in conjunction with the Provider's service delivery plan and clearly state the choice of performance measures that will be collected.

This plan should then be agreed with the Commissioner and be funded from the overall value of the contract. The evaluation must be delivered in partnership with an external organisation, to ensure transparency. It is expected the plan will collect a mixture of quantitative, qualitative and process data (where appropriate), and data might include as a minimum:

- ✓ Service User satisfaction interviews (minimum of 30), surveys, complaints and compliments
- ✓ Staff interviews (minimum 20)
- ✓ DemQal or other measures appropriate for assessing clinical and cost effectiveness
- ✓ Surveys, interviews, focus groups and workshops with stakeholders
- ✓ Person reported outcome measures, Quality of Life measures
- ✓ Performance measures such as numbers of people accessing the service, referrals, waiting times, demographics, Did Not Attend

The service evaluation is expected to inform the ongoing development of the service. As a result of the evaluation parts of the service may cease, change or increase. The Provider is encouraged to constantly reflect best practice in the service and has the flexibility to try new interventions and to cease out of date ones.

The service will work closely with external academic bodies, to influence the current curriculum of training and post registration continued professional development, to ensure that the workforce are able to deliver the requirements of the service.

3. Applicable Service Standards

3.1 Applicable National Standards e.g. NICE, Royal College

The Provider shall endeavour to comply to the following National Guidance, unless agreed with the Commissioner in advance.

National Memory Service Specification

http://www.nice.org.uk/media/4F1/D6/Memory_assessment_service_commissioning_guide.pdf

NICE Dementia Quality Standards QS1 (2010) and QS184 (2019)

http://guidance.nice.org.uk/QS1

https://www.nice.org.uk/guidance/qs184

MSNAP Memory Service Accreditation Programme

www.rcpsych.ac.uk

NICE TA217

https://www.nice.org.uk/guidance/ta217

3.2 Service Accommodation/Buildings

The Provider shall endeavor to:

1. ensure that the design of the building is consistent with: **The Dementia Design Checklist, NHS Scotland 2007**
   www.hfs.scot.nhs.uk/publications/dementia-checklist-v1.pdf
2. ensure that care environments are consistent with the principles set out in **Enhancing the Healing Environment, King's Fund, 2007**
   www.kingsfund.org.uk/projects/enhancing-healing-environment/ehe-design-dementia

3.3 Applicable Local Documents

The following are local key documents and should be reflected in the Provider's ethos and service model:

Bristol Joint Strategic Needs Assessment

https://www.bristol.gov.uk/documents/20182/3849453/JSNA+2021+-+10.1+Dementia

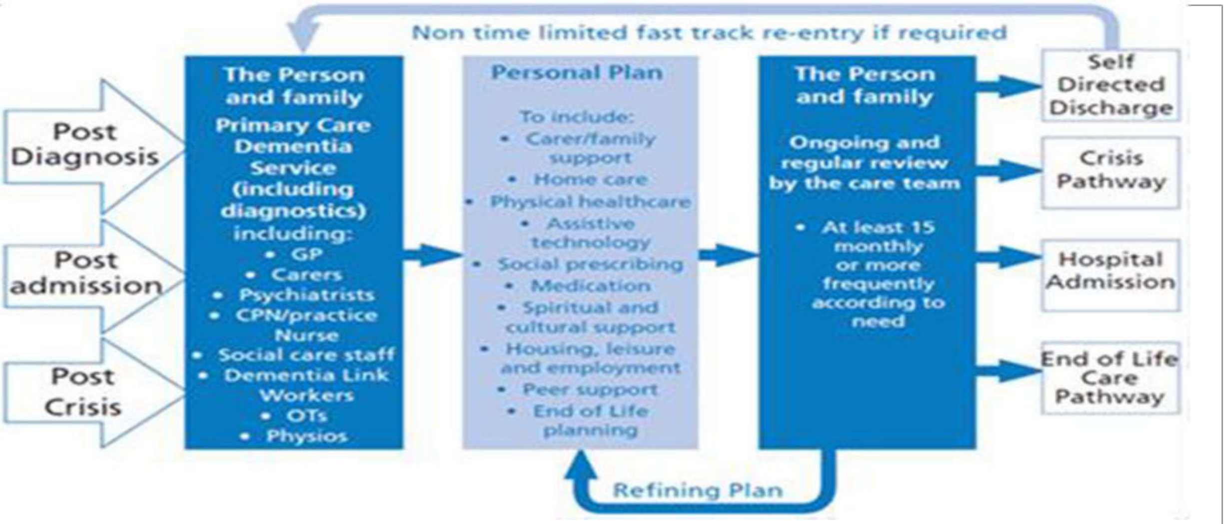
The Joint Bristol Dementia Strategy and the Local Bristol Action Plan (2011-2015)

www.bristol.nhs.uk/your-health/dementia.aspx

The Local Bristol Carers Action Plan

www.bristol.nhs.uk/your-health/carers.aspx

The Bristol Clinical Commissioning Group, Consultation Feedback and Analysis (November 2012) http://www.bristolccg.nhs.uk/ describes the Dementia care pathway as:



4. Key Service Outcomes

4.1 Contract Reporting and Monitoring

The Provider will need to monitor and maintain information on demand and capacity across the Bristol Dementia Wellbeing Service in order to promote effective flow and optimal deployment of resources.
It will also need to establish common requirements across Providers with respect to information sharing to inform whole system governance, collaboration and partnership working.

Contract monitoring meetings for service performance should take place quaterly and more frequently if an exception arises such as complaint or adverse incident. The monitoring meeting will discuss activity and outcomes, performance and the Service quality and clinical governance report, including national and local requirements which should be submitted two weeks before the agreed date.

4.2 Outcomes

The Provider will work with the Commissioner to develop and refine the service outcomes, to include the current quality dementia statements, as outlined by NICE-SCIE clinical guidelines (QS1; 2010 and QS184; 2019) and the key service outcomes as detailed in Schedule 4 Quality Requirements: Part C Local Quality Requirements.
http://publications.nice.org.uk/quality-standard-for-supporting-people-to-live-well-with-dementia-qs30/how-this-quality-standard-fits-into-the-nice-pathway:

The Provider will be expected to deliver the outcomes which include:

1. The service will ensure equity of access to services for the diverse Bristol population
2. Improved outcomes through increased access to diagnosis of dementia in primary care
3. The service will provide an approach which engages with the local population to promote service improvement
4. Increased confidence in managing dementia through improved assessment and care planning
5. The service uses the information from satisfaction data leads to service improvement
6. People with dementia, family/carers feel proactively supported in their care leading to a reduction of crisis interventions
7. Improving dementia services and outcomes through research
8. Adoption of best practice and NICE guidelines for use of antipsychotic medication in dementia
9. GP’s are supported by dementia wellbeing services to effectively manage people with dementia and their family/carers in primary care

10. People receiving care from the Dementia Wellbeing Service are cared for by well trained staff in a psychologically informed way
11. People using dementia wellbeing service and their families/carers are safe and protected
12. Carers are recognised and supported in their wellbeing
13. People with dementia in care homes are supported to live well through improved outcomes

    Staff in care homes are supported to provide a high quality service to people with dementia
14. Staff working with the Service rate their employment highly and feel positive and satisfied about the service they are able to deliver

5. Location of Provider Premises

5.1 Location of Premises

The Provider's Premises will be based in the community close to GP practices, so that a shared care approach can be maximised (space permitting) using a Hub and Spoke Model. It will be provided flexibly in locations which are accessible to people across the community. This should include within people's homes, primary and secondary care settings (including surgeries, health centres) community locations and other suitable settings, which can provide a clinically effective and safe environment.

6. Think family and Safeguarding

Parents' mental health problems are a major factor in impacting on outcomes for children and child safeguarding situations, and a major factor in the development of poor mental health in the next generation.

Adherence to Bristol Clinical Commissioning Group's Safeguarding Children Standards

The provider will adhere to the Bristol CCG's Standards for Safeguarding children (see separate document), including:

- Having an up to date safeguarding policy and procedure, including how to respond to disclosures of historic allegations of abuse and how to supervise and manage visits from celebrities and volunteers.
- An active training plan for staff, as outlined in the Standards, but also particularly ensuring that all clinical and managerial staff receive training in the Bristol Safeguarding Children Board's Protocol for Joint Working across Adult Mental Health and Children's Services
- The service will ensure that staff comply with local policies and procedures relating to safeguarding and they have undertaken training appropriate for their professional role.
- A safe recruitment policy and procedure, and all staff in contact with patients having a full DBS check
- Systems for reporting and dealing with safeguarding concerns about members of staff
- Understanding of and cooperation with the Information Sharing Protocol

- Cooperation in completion of reports for serious case reviews, and implementation of action plans arising from safeguarding reviews
- The service will ensure that staff comply with local policies and procedures relating to safeguarding and they have undertaken training appropriate for their professional role.
- Provision of safeguarding supervision for all staff in line with the current guidance on 'working together to safeguard children' http://media.education.gov.uk/assets/files/pdf/w/working%20together.pdf
- The Provider must have clear guidance for staff on who to contact for advice, support, guidance and supervision around safeguarding children.
- The Provider will be expected to engage in any inspection of safeguarding procedures as required. These inspectors require access to practitioners, case records and tracking outcomes for Parents of children, young adults and looked after children. There is generally only 2 days notice for these types of inspections.

The Commissioner may audit the providers safeguarding practice through documentation and face to face interviews with staff.

Assessment of Caring Responsibilities

The Provider will ensure they undertake a parenting/carers assessment on any client who has a caring responsibility. If safeguarding concerns are identified the Provider must liaise with 'First Response'[10] or a Safeguarding Lead in their service to access further support.

Think Family

A think family approach and the 'think family toolkit' for working with troubled families should be incorporated into training courses, including awareness of the impact of adult mental health difficulties on children.
http://www.scie.org.uk/publications/guides/guide30/summary.asp

Young Carers

In families where a parent has mental health needs, children and young people often take on caring roles. They need information about mental health. The training needs of young carers will be considered in planning training for carers. If the Provider identifies a young carer they must assess their needs to see if 'First Response' or early help is needed and make a referral as appropriate.

Perinatal mental health

In recognition of the detrimental impact of very early poor parent-child relationships, and the desirability of preventing the next generation of mental ill health, the provider will liaise with maternity services and CAMHS to create a coordinated effective approach to perinatal mental health which treats the parent's mental health needs in conjunction with the relationship between parent and child, in line with recent guidance from Royal College Of Psychiatrists. (http://www.rcpsych.ac.uk/pdf/perinatal_web.pdf). The Provider must also assess for any safeguarding concerns and make a referral to First Response' for child protection or early help as appropriate.

5. Vulnerable Adults and Safeguarding

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[10] First Response is one number (0117 903 6444) that anyone in Bristol can telephone if they are worried about a child or young person. First response have information and guidance, they can refer to the Early Help team for support or can do a safeguarding referral to a social work team.

Adherence to Bristol Clinical Commissioning Group's Safeguarding Adult's Standards.

The provider will adhere to the Bristol Policy for Safeguarding Adults (see separate document), including

- ✓ An up to date safeguarding policy and relevant procedures
- ✓ An active training plan for staff, ensuring that all clinical and managerial staff receive training in Adult Safeguarding and the Mental capacity Act
- ✓ A safe recruitment policy and procedure, and all staff in contact with service users having a full DBS check.
- ✓ Systems for reporting and dealing with safeguarding concerns about members of staff
- ✓ Understanding of and cooperation with the Information Sharing Protocol
- ✓ Cooperation in completion of reports for serious case reviews, and implementation of action plans arising from safeguarding reviews
- ✓ If during the course of treatment disclosers of domestic violence /abuse are made, practitioners should follow safeguarding adults and children procedures.
- ✓ Using the Bristol Care Direct number (0117 9222700) as the single point of contact for adults where there are safeguarding concerns

Lead professional for safeguarding issues

The service provider must have a lead professional for safeguarding issues.