MSNAP
MEMORY SERVICES NATIONAL ACCREDITATION PROGRAMME

CCQI

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Memory Services National Accreditation Programme

Standards for Memory Services - Seventh Edition

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Artwork displayed on the front cover of the report by Mrs Carol Smith, Service User, Surrey & Borders Partnership NHS Foundation Trust

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Introduction

The Memory Services National Accreditation Programme (MSNAP) was established in 2009 to support local service improvement of memory services in the UK and is one of over 20 networks within the College Centre for Quality Improvement (CCQI) within the Royal College of Psychiatrists.

These standards have been developed from key documents and expert consensus and have been subject to extensive consultation with professional groups involved in the provision of memory services, and with people who have used these services and their families/carers.

The standards have been developed for the purposes of review and accreditation as part of the Memory Services National Accreditation Programme. However, they can also be used as a guide for new or developing services. Memory services differ widely in their organisation, funding, staffing and levels of service, even within the same Trust. The standards are therefore focused on 'function', rather than any model of service delivery.

Terms

In this document, the memory service team is referred to as 'the team'.

People under the care of memory services are referred to as 'patients'. Their family, friends or carers are referred to as 'carers'.

Categorisation of standards

To support their use in the accreditation process, each standard has been categorised as follows:

- **Type 1:** failure to meet these standards would result in a significant threat to patient safety, rights or dignity and/or would breach the law. These standards also include the fundamentals of care, including the provision of evidence-based care and treatment;
- **Type 2:** standards that an accredited team would be expected to meet;
- **Type 3:** standards that are aspirational, or standards that are not the direct responsibility of the team.

The full set of standards is aspirational, and it is unlikely that any team would meet them all. To achieve accreditation, a team must meet 100% of type 1 standards, 80% of type 2 standards and 60% of type 3 standards.

Key

* Standard **modified** since last edition

† **New** standard since last edition

Sustainability Principles

The MSNAP standards have been mapped against sustainability principles developed by the Royal College of Psychiatrists Sustainability Committee (**www.rcpsych.ac.uk/workinpsychiatry/sustainability.aspx**).

The Royal College of Psychiatrists is striving to improve the sustainability of mental health care, by designing and delivering services with the sustainability principles at the core. The aim of this process is to raise awareness around sustainability in mental health services and to work towards making psychiatric services sustainable in the long run. In recent years the mounting economic, social and environmental constraints have put mental healthcare system under enormous pressure and it is vital to ensure that high-value services continue despite these constraints. Developing a sustainable approach to our clinical practice is a crucial step in ensuring that mental health services will continue to provide high-quality care in the 21st century in the face of these constraints.

Sustainability in health services involves improving quality, cost and best practice, with a particular focus on reducing the impact on the environment and the resources used in delivering health interventions. A sustainable mental health service is patient-centred, focused on recovery, self-monitoring and independent living, and actively reduces the need for intervention.

Sustainability is written into the NHS constitution (Department of Health, 2013). In Principle 6, it states that the 'NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources' [20].

It is vital for professionals involved in designing mental health services to have a good understanding of sustainability i.e. the resources needed for each intervention, and to have an awareness of the effects of these interventions across economic, environmental and social domains. Adoption of these principles across mental healthcare would lead to a less resource-intensive and more sustainable service.

The five Sustainability Principles are listed below:

1. Prioritise prevention – preventing poor mental health can reduce mental health need and therefore ultimately reduce the burden on health services (prevention involves tackling the social and environmental determinants alongside the biological determinants of health).

2. Empower individuals and communities – this involves improving awareness of mental health problems, promoting opportunities for self-management and independent living, and ensuring patients and carers are at the centre of decision-making. It also requires supporting community projects that improve social networks, build new skills, support employment (where appropriate) and ensure appropriate housing.

3. Improve value – this involves delivering interventions that provide the maximum patient benefit for the least cost by getting the right intervention at the right time, to the right person, while minimising waste.

4. Consider carbon – this requires working with providers to reduce the carbon impacts of interventions and models of care (e.g. emails instead of letters, tele-health clinics instead of face-to-face contact). Reducing over-medication, adopting a recovery approach, exploiting the therapeutic value of natural settings and nurturing support networks are examples that can improve patient care while reducing economic and environmental costs.

5. Staff sustainability – this requires actively supporting employees to maintain their health and well-being. Contributions to the service should be recognised and effective teamworking facilitated. Employees should be encouraged to develop their skills and supported to access training, mentorship and supervision.

Services that meet 90% or more of the standards relevant to Sustainability Principles (marked with the logo, left) will be awarded a Sustainable Service Accreditation certification in recognition of provision of a sustainable mental health service.

Sustainability will automatically be examined alongside the usual review process and services will not have to submit extra evidence for this. Whether a service is awarded the sustainability certification or not will not affect the accreditation status of the service.

A range of guidance reports and papers has already been developed by the College to help improve the sustainability of mental health care. Please see below for further information:

Guidance for commissioners of financially, environmentally, and socially sustainable mental health services
https://www.jcpmh.info/good-services/sustainable-services/

Choosing Wisely – shared decision making
http://www.rcpsych.ac.uk/healthadvice/choosingwisely.aspx

Centre for Sustainable Healthcare
https://sustainablehealthcare.org.uk/

Psych Susnet
https://networks.sustainablehealthcare.org.uk/network/psych-susnet

Sustainability in Psychiatry
https://www.rcpsych.ac.uk/improving-care/working-sustainably

Our Aims

The purpose of MSNAP is to:

- help memory services to evaluate themselves against agreed standards;
- award accreditation to services that meet the required level of performance;
- support local clinical and service improvement in line with the standards;
- produce a local report that highlights achievements and areas for improvement;
- produce a national report which allows a local service to compare its performance against other participating services.

Overarching principles:

- People living with dementia/suspected dementia have fair access to assessment, care and treatment on the basis of need, irrespective of age, gender, social or cultural background, and are not excluded from services because of their diagnosis, age or co-existing disabilities/medical problems.
- People living with dementia/suspected dementia and their carers receive a service that is person-centred and takes into account their unique and changing personal, psychosocial and physical needs.

Section 1: Management

Service planning and commissioning

No.	Type	Standard	Ref
1.	2	The service is explicitly commissioned or contracted against agreed standards *Guidance: This is detailed in the Service Level Agreement, operational policy, or similar and has been agreed by funders*	1
2.	2	The service reviews data at least annually about the people who use it. Data are compared with local population statistics and action is taken to address any inequalities of access where identified *Guidance: These data are used to understand who is accessing the service, identify under-represented groups, promote the service to these groups and improve the accessibility of the service*	1
3.*	2	Health and Social Care funders, in consultation with local partners, people with memory problems/ dementia/ suspected dementia and carers, have a local integrated care pathway based on best practice, which includes referral to national or regional specialist centres and exit from the service, where appropriate *Guidance: This includes specifically a pathway for young onset dementia, people with learning disabilities and people with rarer types of dementia where diagnosis is more complex and likely to be delayed*	3, 4, 5, 6
4.	2	The diagnosis rate in the area covered by the memory service is at least 66%	17

Quality assurance, research and service development

No.	Type	Standard	Ref
5.	2	A range of local and multi-centre clinical audits is conducted which include the use of evidence-based treatments, as a minimum	8
6.	2	Local GPs and referrers are asked to provide feedback about their experiences of using the service at least once every two years, and their feedback is used to improve the service	9

No.	Type	Standard	Ref
7.* 	1	The service asks patients and carers for their feedback about their experiences of using the service and this is used to improve the service *Guidance: Feedback is independently sought (i.e. not by the clinical team). Their feedback is reviewed alongside other feedback to make it as accurate as possible. Staff members are informed of feedback from patients and carers*	7
8. 	2	The service provides patients and their carers with information about opportunities to participate in local, national and international research, such as National Institute for Health Research (NIHR), Health and Care Research Wales, the Medical Research Council, or equivalent local bodies.	10, 11
9.	2	The service ensures that all people living with dementia and their carers are asked if they would like to add their details to a research participation register, e.g. Join Dementia Research	10, 11
10.	2	There are systems in place to monitor waiting times and ensure adherence to local and national waiting times standards *Guidance: There is accurate and accessible information for everyone on waiting times from referral to assessment and from assessment to treatment*	7
11.* 	2	Staff are involved in key decisions about the service provided *Guidance: Involvement could include business meetings for example*	2
12. 	2	Services are developed in partnership with patients and carers who have experience of memory services and have an active role in decision making *Guidance: This might involve patient and carer representatives attending and contributing to local and service level meetings and committees*	7
13. 	2	There has been a review of the staff members and skill mix of the team within the past 12 months. This is to identify any gaps in the team and to develop a balanced workforce which meets the needs of the service	2
14.*	2	The service's clinical outcome data are reviewed at least every six months. The data are shared with commissioners/funders, the team, patients and carers, and used to make improvements to the service	7
15.†	2	The team use quality improvement methods to implement service improvements	7

No.	Type	Standard	Ref
16.†	2	The team actively encourage patients and carers to be involved in QI initiatives	7

Complaints and serious incidents

No.	Type	Standard	Ref
17.	1	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this	7
18.*	1	Lessons learned from untoward incidents and complaints are shared with the team and the wider organisation. There is evidence that changes have been made as a result of sharing the lessons	7
19.*	1	When mistakes are made in care this is discussed with the patient themselves and their carer	7
20. 	1	Staff members, patients and carers who are affected by a serious incident are offered post-incident support	7
21.* 	1	Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns or 'whistleblowing'	7

Section 2: Resources to support assessment and diagnosis

Accessibility of the service

No.	Type	Standard	Ref
22.* 	3	The service is accessible by public transport or transport provided by the service	7
23.	2	The assessment takes place at a time and in an environment that is acceptable to all parties	2
24.	2	The service has the capacity to make home visits if necessary	10
25.*	2	The service uses interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation and/or communication support. The patient's relatives are not used in this role unless there are exceptional circumstances *Guidance: Exceptional circumstances might include crisis situations where it is not possible to get an interpreter at short notice. Consider needs associated with language including learning disability, sensory impairment etc*	7
26.	2	The service has access to a variety of assessment tools to meet the needs of the people using the service *Guidance: Consider needs associated with language, learning disability, sensory impairment, etc*	3

Staffing for the memory service

No.	Type	Standard	Ref
The following professionals have dedicated sessional time to contribute to the processes of assessment and diagnosis of dementia:			
27.	1	A medical practitioner and a multidisciplinary team consisting of at least two other professions	12
28.	2	A registered mental health nurse	12, 13
29.	2	A clinical psychologist or neuropsychologist	12, 13
30.	2	An occupational therapist	12, 13
The memory service has access to or can refer to the following professionals for advice/support during the processes of assessing and diagnosing people living with dementia:			

No.	Type	Standard	Ref
Guidance: access to can include the speciality of the medical lead			
31.	3	A peer support worker	2
32.	2	A speech and language therapist	13
33.	2	A dietician	13
34.	2	A physiotherapist	13
35.	2	A social worker	13
36.	2	A geriatrician	12, 13
37.	2	A neurologist	12, 13
38.	2	An old age psychiatrist	12, 13
39.*	2	There is a named lead within the service for people with young onset dementia	2
40.	2	The service has access to a sufficient level of administrative support to meet current demand	12
41.*	2	Patient or carers with experience of memory services are involved in the interview process for recruiting staff members *Guidance: This could include co-producing interview questions or sitting on the interview panel*	7
42.* 	1	When there are concerns about low staffing levels, for example in relation to annual leave, vacancies or other absence, the team puts a plan in place to provide adequate cover for the patients who are allocated to that staff member	7

Functioning of the memory service team

No.	Type	Standard	Ref
43.	1	There is a named service lead who has a sufficient level of dedicated sessional time to carry out the tasks associated with the role *Guidance: ascertain whether the number of sessions meets current demand*	12

No.	Type	Standard	Ref
44.	1	The team has a timetabled meeting at least once a week to discuss allocation of referrals, current assessments and reviews *Guidance: Referrals that are urgent or that the team feel do not require discussion can be allocated before the meeting*	7
45.	2	There are robust systems of communication in place that support staff to work efficiently and effectively as a multidisciplinary team *Guidance: This might include IT systems, communication books, bulletin boards, email, up-to-date contact numbers, formal systems for relaying messages*	2
46.	2	The memory service prioritises continuity of care *Guidance: By ensuring that a core and consistent team work in the service every week and by providing access to a named worker (e.g. lead professional, key worker, dementia advisor, care navigator, case manager)*	2
47.	2	The team has protected time for team building and discussing service development at least once a year	7
48.*	3	Staff members are able to access reflective practice groups at least every 6 weeks where teams can meet to think about team dynamics and develop their clinical practice	7
49.	1	The service actively supports staff health and well-being *Guidance: For example; providing access to support services, providing access to physical activity programmes, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed*	7
50.	1	Staff members are able to take breaks during their shift that comply with the European Working Time Directive *Guidance: They have the right to one uninterrupted 20-minute rest break during their working day, if they work more than 6 hours a day. Adequate cover is provided to ensure staff members can take their breaks*	7
51.	2	Staff know how to obtain additional advice and support when they need it	2

No.	Type	Standard	Ref
52. 	1	All clinical staff members receive clinical supervision at least monthly, or as otherwise specified by their professional body *Guidance: Supervision should be profession-specific as per professional guidelines and be provided by someone with appropriate clinical experience and qualifications*	7
53.	2	All staff members receive line management supervision at least monthly	7
54.	2	There are systems in place to monitor and manage caseload size for each member of staff	2

Staff training and development

No.	Type	Standard	Ref
55. 	2	Staff members have access to study facilities (including books and journals on site or online) and time to support relevant research and academic activity	2
56. 	2	The training and development budgets enable all staff to meet requirements for their continuing professional development and the Knowledge and Skills Framework, or equivalent local personal development/educational standards programme	2
57.	2	There are arrangements for staff cover to allow staff to attend training	2
58.*	2	Staff members can access leadership and management training appropriate to their profession, role and speciality	7
59.* 	1	New staff members, including bank staff, receive an induction based on an agreed list of core competencies *Guidance: This should include arrangements for shadowing colleagues on the team; jointly working with a more experienced colleague; being observed and receiving enhanced supervision until core competencies have been assessed as met*	7
60. 	2	Patients, carers and staff members are involved in devising and delivering training face-to-face	7
61.	3	Shared in-house multi-disciplinary team training, education and practice development activities occur in the service at least every 3 months	7

No.	Type	Standard	Ref
62. 	1	Clinical staff fulfil the competencies of Tier 2 or above in the Health Education England (HEE) Dementia Core Skills or Wales Good Work Framework, Education and Training Framework or equivalent that includes the following topics: - Dementia awareness; - Dementia identification, assessment and diagnosis; - Dementia risk reduction and prevention; - Person-centred care; - Communication, interaction and behaviour in dementia care; - Health and well-being in dementia care; - Pharmacological interventions in dementia care; - Living well with dementia and promoting independence; - Families and carers as partners in dementia care; - Equality, diversity and inclusion in dementia care; - Law, ethics and safeguarding in dementia care; - End of life dementia care; - Research and evidence-based practice in dementia care	15
63.*	2	Administrative staff have received training in dementia and fulfil competencies according to national guidelines, such as Tier 1 or above in the Health Education England (HEE) Dementia Core Skills, or Wales Good Work Framework Education and Training Framework *Guidance: Tier 1 includes training in dementia awareness*	15
64.*	1	All staff complete statutory and mandatory training consistent with their roles *Guidance: Includes equality and diversity, information governance, basic life support, safeguarding, risk assessment and risk management*	7
65.	2	The team receives training, consistent with their roles, on the roles of the different health and social care professionals, staff and agencies involved in the delivery of care to people living with dementia	3
66.	1	The team receives training, consistent with their roles, on the use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent)	7
67.	2	The team receives training, consistent with their roles, on undertaking nutritional screening using a validated nutritional risk assessment tool	3
68.	1	The team receives training, consistent with their roles, on physical health assessment *Guidance: This could include training in understanding physical health problems, physical observations and when to refer the patient for specialist input*	7

No.	Type	Standard	Ref
69.	2	The team receives training, consistent with their roles, on the use of cognitive assessments, with focus on consistency and the application of national guidance *Guidance: This training is refreshed annually*	2
70.	2	The team receives training from other professionals involved in the work of the memory service, e.g. neuro-radiologists, social workers	2

Joint working and liaison

No.	Type	Standard	Ref
71.	1	The patient's consent to the sharing of clinical information outside the team is recorded. If this is not obtained the reasons for this are recorded	3, 16
72.	2	There are systems in place to monitor referrals made to other services/centres	2
73.	2	The service provides **advice** to other professionals and staff whose responsibilities include providing care and treatment of older people living with dementia/ suspected dementia *Guidance: e.g. GPs; residential care, nursing homes and sheltered housing; domiciliary care; day care; hospital care, including inpatient services*	13
74.	2	The service provides **training** to other professionals and staff whose responsibilities include providing care and treatment of people living with dementia/ suspected dementia *Guidance: E.g. GPs; residential care, nursing homes and sheltered housing; domiciliary care; day care; hospital care, including inpatient services*	13
75.	2	The service provides **outreach**, e.g. by way of joint visits/reviews, to other professionals and staff whose responsibilities include providing care and treatment of people living with dementia/ suspected dementia *Guidance: E.g. GPs; residential care, nursing homes and sheltered housing; domiciliary care; day care; hospital care, including inpatient services*	13
76.	2	The memory service has links with local home care and social care services	2

No.	Type	Standard	Ref
77. 	1	The team understands and follows an agreed protocol for the management of an acute physical health emergency *Guidance: This includes guidance about when to call 999 and when to contact the duty doctor*	7
78. 	1	Staff members follow inter-agency safeguarding protocols. This includes escalating concerns if an inadequate response is received to a safeguarding referral	7
79. 	3	The memory service provides education on the prevention of dementia within the local community *Guidance: This could be disseminated through events, local newspapers/ radio stations or posters etc., and could be done jointly with partner organisations*	2

The clinic environment

No.	Type	Standard	Ref
80.*	2	The environment is clean, comfortable and welcoming	7
81.	2	The environment is suitable for people with different types of dementia and their carers *Guidance: E.g. firm seating at the right height, handrails, good lighting, large signs, accessible for people with physical disabilities, high colour contrasts, etc*	12
82.	1	There is easy access to suitable toilet facilities	12
83.	1	Clinical rooms are private and conversations cannot be over-heard	7
84.	2	The service entrance and key clinical areas are clearly signposted	7
85.	1	The environment complies with current legislation on disabled access (Equality Act 2010, or equivalent) *Guidance: Relevant assistive technology equipment, such as hoists and handrails, are provided to meet individual needs and to maximise independence*	7
86.	1	There is an alarm system in place (e.g. panic buttons) and this is easily accessible for patients, carers and staff members	7
87.	2	A spacious room is available for the memory service team to meet to discuss findings and make plans	12

No.	Type	Standard	Ref
88.	1	All patient information is kept in accordance with current legislation *Guidance: This includes transfer of patient identifiable information by electronic means. Staff members ensure that no confidential data is visible beyond the team by locking cabinets and offices, using swipe cards and having password protected computer access*	7
89. 	1	Staff members follow a lone working policy and feel safe when conducting home visits	7
90.	2	There are sufficient IT resources (e.g. computer terminals) to provide all practitioners with easy access to key information, e.g. information about services/ conditions/ treatment, patient records, clinical outcome and service performance measurements	2

Section 3: Assessment and diagnosis

Referral and access to the memory service

No.	Type	Standard	Ref
91.*	1	The service provides information about how to make a referral and waiting times for assessment and treatment	7
92.	1	A clinical member of staff is available to discuss emergency referrals during working hours	7
93.	2	Where referrals are made through a single point of access, these are passed on to the memory service within one working day	7
94. 	2	Initial contact is made with all people who are newly referred within two weeks of referral	2
95.	1	For planned assessments the team sends letters in advance to patients that include: - The name and designation of the professional they will see; - An explanation of the assessment process; - Information on who can accompany them; - How to contact the team if they have any queries, require support (e.g. an interpreter), need to change the appointment or have difficulty in getting there	7
96.	2	The diagnosis is given with the locally specified target timeframe, unless any further specialist assessments or investigations are required, or other circumstances cause delay. Reasons for delay are recorded and monitored *Guidance: In England, the requirement is within 6 weeks of referral. In Wales, the requirement is within 12 weeks of referral. Investigations such as blood tests and brain scans would be considered routine rather than specialist*.	17, 48
97.	1	The team follows up patients who have not attended an appointment/ assessment or who are difficult to engage, as per local policy *Guidance: This could include making a phone call, sending a letter, visiting people at home or another suitable venue, using text alerts, or engaging with their carers to make it more proactive. If people continue to not engage, a decision is made by the assessor/team, based on need and risk, as to how long to continue to follow them up*	7

No.	Type	Standard	Ref
98. 	1	If a patient does not attend for assessment, the team contacts the referrer *Guidance: If the patient is likely to be considered a risk to themselves or others, the team should contact the referrer immediately to discuss a risk action plan*	7
99. 	2	Data on missed appointments are reviewed at least annually. This is done at a service level to identify where engagement difficulties may exist *Guidance: This should include monitoring a patient's failure to attend the initial appointment after referral and early disengagement from the service*	2
100.	3	There is a website for the memory service *Guidance: This could contain information about what to expect during appointments, relevant health advice and factsheets, contact numbers and a map etc*	2

Dignity, consent and capacity and confidentiality

No.	Type	Standard	Ref
101.	1	Staff members treat patients and carers with compassion, dignity and respect *Guidance: This includes respect of a person's race, age, sex and sexual orientation, gender reassignment, marriage and civil partnership, pregnancy and maternity, disability, religion and belief*	7
102. 	1	Staff ensure that patients and their carers understand what is being done in the assessment process, and why	12
103.* 	2	Patients feel listened to and understood by staff members	7
104.	1	Patients feel welcomed by staff members when attending the team base for their appointments *Guidance: Staff members introduce themselves to patients and address them using the name and title they prefer*	7
105.	1	There are policies/ guidelines around gaining consent	7

No.	Type	Standard	Ref
106.	1	Assessments of patients' capacity to consent to care and treatment are performed in accordance with current legislation and documented in the patient's notes. When patients don't have capacity, best interests processes involving professionals and family (where appropriate) are followed. These assessments should be undertaken: - At the initial assessment; - At regular intervals as required by the relevant legal requirement; - If the patient's capacity changes; - If the treatment plan changes; - If the patient, family or professionals request it	7
107.	1	When talking to patients and carers, health professionals communicate clearly, avoiding the use of jargon	7
108. 	1	There are systems in place to ensure that the service takes account of any advance care plans (e.g. advance directives, advance statements, Lasting Powers of Attorney) that the patient has made *Guidance: These are accessible and staff know where to find them*	7
109.	1	Confidentiality and its limits are explained to the patient and carer at the first assessment, both verbally and in writing *Guidance: For carers this includes confidentiality in relation to third party information*	7
110.	1	People who are assessed for the possibility of dementia are asked if they wish to know the diagnosis	3
111. 	1	People who are assessed for the possibility of dementia are asked with whom the outcome should be shared	3
112. 	1	The team follows a protocol for responding to carers when the patient does not consent to their involvement	7

The prcoesses of assessment and diagnosis

No.	Type	Standard	Ref
113.	1	The assessment includes a basic dementia screen and blood tests in accordance with clinical need *Guidance: this might include:* *- erythrocyte sedimentation rate (ESR) or C-reactive protein* *- routine haematology, full blood count* *- biochemistry tests (including urea and electrolytes, calcium, glucose, and renal and liver function)* *- thyroid function tests* *- serum vitamin B12 and folate levels* *- simple urinalysis (available on referral)* *- lipid profile/ cholesterol* *- syphilis serology and HIV*	3, 13
114.	1	The assessment includes a history taking	3, 12
115.	1	The assessment includes a health review, which takes place as part of the initial assessment or as soon as is practically possible. The review includes but is not limited to: - Details of past medical history; - Current physical health medication, including side effects and compliance with medication regime; - Lifestyle factors e.g. sleeping patterns, diet, smoking, exercise, sexual activity, drug and alcohol use	7
116.	1	The assessment includes arrangement for patients to access screening, monitoring and treatment for physical health problems through primary/secondary care services. This is documented in the patient's care plan or care and treatment plan.	7
117.	1	Patients receive a comprehensive, evidence-based assessment which includes their: - Mental health and medication; - Psychosocial and psychological needs; - Strengths and areas for development. - Suicide risk	7
118.	1	Patients receive a cognitive assessment and mental state examination *Guidance: this might include:* *- examination of attention and concentration, orientation, short- and long-term memory, praxis, language and executive function* *- formal cognitive testing using a standardised instrument*	3, 12, 13
119.	1	The assessment includes an interview with someone who knows the patient well, where available	3

No.	Type	Standard	Ref
120.*	1	The assessment includes a check of vision, hearing, mobility and falls	13
121.* 	1	Patients have a documented risk assessment and management plan which is co-produced and shared where necessary with relevant agencies (with consideration of confidentiality). The assessment considers: - Risk to self; - Risk to others; - Risk from others	7
122.*	2	The assessment includes consideration of the patient's social support	2
123.	1	The service has access to in-depth assessment of occupational functioning and neuropsychological assessment as required (e.g. for young onset dementia, complex or abnormal presentations)	2, 7
124. 	2	Carers are offered individual time with staff members to discuss concerns, family history and their own needs	7
125.*	2	The team sends correspondence detailing the outcomes of the assessment to the referrer, the GP and other relevant services within a week of the assessment *Guidance: The letter includes a summary of advice given to the person, driving status and the need to inform the DVLA if necessary and any need for GP review of the person's physical risk factors (e.g. risk of stroke, high blood pressure, diabetes, smoking, medication)*	7
126.*	1	Patients are asked if they and their carers wish to have copies of correspondence about their health and treatment	7
127.	2	Where diagnosis is not disclosed, a clear record of the reasons is made	2
128.	1	People who drive are informed of the necessity to report the diagnosis to the DVLA (or equivalent vehicle licensing authority)	18
129.	2	A local written protocol is available to assist memory service staff in informing patients about managing issues around driving *Guidance: A protocol could include identification of driving status, giving information about informing the DVLA (or equivalent) and insurance companies, and what staff responsibilities are when a patient is non-compliant or continues to drive without informing the DVLA*	2

No.	Type	Standard	Ref
Additional tests and investigations are carried out in accordance with NICE guidance, individual and clinical need, including:			
130. 	1	Timely access to brain imaging in the assessment of people with suspected dementia to exclude cerebral pathologies and to help establish the subtype diagnosis	3
131.	2	Electrocardiogram	3
132.	2	Specialist advice is taken when interpreting investigations/ assessments/ scans in people with learning disabilities and those with young onset or rare dementias	3
133.†	3	In the assessment process, services should review the potential anticholinergic cognitive burden (ACB) e.g. with the aid of a suitable online tool	2

Support for patients and their carers

No.	Type	Standard	Ref
134.*	1	Patients are given accessible written information which staff members talk through with them as soon as is practically possible. This information includes; 1) Their rights regarding consent to treatment, 2) How to access advocacy services, 3) How to access a second opinion, 4) Interpreting services, 5) How to view their records, 6)How to raise concerns, complaints and give compliments	7
135.	2	People living with dementia/ suspected dementia and their carers are given pre-diagnostic counselling *Guidance: This includes a discussion about the possibility of a diagnosis of dementia*	3
136.	1	Information is communicated sensitively	18
137.	2	Information is communicated without unnecessary delay	18
138.	2	When communicating important information to people, staff are able to dedicate a sufficient amount of time	19
139.	1	People living with dementia are offered a face to face post-diagnostic meeting	3, 20

No.	Type	Standard	Ref
140.	1	Patients and their carers are able to access post-diagnostic support, individually or in a group. *Guidance: This might include education, treatment, support groups or one-to-one support*	3, 17
141.*	2	The team provides information and encouragement to patients to access local organisations for peer support and social engagement This is documented in the patient's care plan and includes access to: - Voluntary organisations; - Community centres; - Local religious/ cultural groups; - Peer support networks	7
142.*	2	The service actively encourages carers to attend carer support networks or groups. There is a designated staff member to support carers	7
143.	1	Patients (and carers, with the patient's consent) are offered written and verbal information about dementia and treatment, and this is recorded in their notes *Guidance: Verbal information could be provided in a one-to-one meeting with a staff member or in a psycho-education group. Written information could include leaflets or websites*	7
144.	2	Where appropriate to their needs, patients and carers are given written information about options for care and treatment, including coping methods and strategies	3
145.	2	Where appropriate to their needs, patients and carers are given written information about, and signposted to, sources of financial and legal advice, and advocacy	3, 17
146.	2	Where appropriate to their needs, people living with dementia and carers are given written information about medico-legal issues, including driving	3
147.	2	Where appropriate to their needs, patients and carers are given written information about local and national information sources, including libraries, voluntary organisations and websites	3

No.	Type	Standard	Ref
148. 	2	Where appropriate to their needs, patients and carers are given accessible written information about improving general health, living positively and maximising quality of life after diagnosis *Guidance: This could include using mental exercise, physical activity, dietary advice alongside drug therapy, maintaining activities, lifestyle management, social engagement, religious and spiritual needs*	3
149.	2	Where appropriate to their needs, people living with dementia and carers are given written information about any pharmacological or psychosocial interventions that the person and/ or their carer has been offered	2
150.* 	2	The team provides each carer with accessible carers' information *Guidance: Information is provided verbally and in writing (e.g. a carers' pack). This includes; the names and contact details of key staff members in the team and who to contact in an emergency and local sources of advice and support such as local carers' groups, carers' workshops and relevant charities*	7
151. 	3	Where appropriate to their needs, patients and carers are given written information on how to create a document about their own preferences and habits	2
152. 	2	The service has access to specialist post-diagnostic counselling provided by a psychologist or other appropriately qualified professional for people with specific needs *Guidance: E.g. genetic and rarer disorders, and severe adjustment reactions to the diagnosis*	19

Section 4: Ongoing care management and follow-up

Care Management

No.	Type	Standard	Ref
153.*	1	People who are diagnosed with dementia are allocated a named worker to co-ordinate their care	17
154.* 	1	Every patient has a written care plan or care and treatment plan, reflecting their individual needs and preferences. Staff members collaborate with patients and their carers (with patient consent) when developing the care plan *Guidance: The care plan clearly outlines:* *- Agreed intervention strategies for physical and mental health;* *- Measurable goals and outcomes;* *- Strategies for self-management;* *- Any advance directives or statements that the patient has made;* *- Carer needs;* *- Crisis and contingency plans;* *- Review dates and discharge framework*	7, 17
155. 	1	Carers (with patient consent) are involved in discussions and decisions about the patient's care, treatment and discharge planning	7
156. 	1	The service provides or can signpost/ refer on to services that will offer assessment and intervention for patients who develop non-cognitive symptoms *Guidance: E.g. mood disorders, psychotic symptoms and behaviour that challenges*	3
157. 	1	The service provides or can signpost/ refer on to services that will offer information, advice and support to assess and manage pharmacological treatment	3
158. 	2	The service provides or can signpost/ refer on to services that will offer information, advice and support with communication problems	3
159. 	1	Patients are offered personalised healthy lifestyle advice such as advice on healthy eating, physical activity, reducing alcohol intake and access to smoking cessation services. This is documented in the care plan	7
160. 	2	The service provides or can signpost/refer on to services that will offer information, advice and support on dietary interventions to help the person adapt dietary intake to help achieve full nutritional requirements	3

No.	Type	Standard	Ref
161. 	1	The team supports patients to access organisations, with whom they have joint working protocols, which offer: - Housing support; - Support with finances, benefits and debt management; - Social services	7
162. 	2	The service provides or can signpost/ refer on to Dementia Advisor and support services for patients and carers (including Admiral Nurses, dementia navigators, or other specialist practitioners)	10
163. 	2	The service provides or can signpost/ refer on to a range of respite/short break services	3
164.	1	Carers are advised on how to access a statutory carers' assessment, provided by an appropriate agency *Guidance: This advice is offered at the time of the patient's initial assessment, or at the first opportunity*	7, 17
165.	3	The service is able to refer to genetic counselling for patients and their unaffected relatives (where there is likely to be a genetic cause for their dementia)	3
166.	2	The service can refer on to specialist services for rare or young onset dementia and/ or complex care needs (e.g. regional/ tertiary neurology/ neuropsychiatry services, learning disability services)	2
167.	1	The service provides follow-up based on clinical need (or refers people on to age appropriate agencies/ services for follow-up) taking into account local protocols and the preferences of patients and their carers. This may include ongoing support as appropriate	2

Discharge planning

168.	2	Discharge or onward care planning is discussed at the first and every subsequent care plan review	7
169. 	1	Patients and their carers (with patient consent) are involved in decisions about discharge plans *Guidance: This could be through a formal discharge meeting*	7
170. 	3	When patients are transferred between community services there is a meeting in which members of the two teams meet with the patient and carer to discuss transfer of care	7

Section 5: Pharmacological interventions

No.	Type	Standard	Ref
171.*	1	Patients and carers are involved in medication reviews and are included in discussions about purpose, expected outcomes, interactions, limitations and side effects of their medications, to enable them to make informed choice and to self-manage as far as possible	7, 17
172.*	1	Patients have their medications reviewed at a frequency according to the evidence base and clinical need. Medication reviews include an assessment of therapeutic response, safety, side effects and adherence to medication regime *Guidance: Side effect monitoring tools can be used to support reviews*	7
173.	3	People living with dementia, carers and prescribers are able to contact a specialised pharmacist and/or pharmacy technician to discuss medications	7
174.	1	Patients who develop psychotic symptoms or behaviour that challenges are only offered antipsychotic medication when the severity and associated risks are high and when other options have been considered and excluded	22, 23, 24, 25
175.*	1	Where antipsychotic medication is given, this prescription is recorded and a single, named individual is responsible for undertaking a review, which may include a physical assessment every 3 months unless a physical health abnormality arises	26
176.	1	Patients prescribed psychotropic medication, e.g. anti-depressants, benzodiazepines, have this reviewed in accordance with NICE guidelines	2
177.	1	For people living with dementia who are taking antipsychotic medication, the team maintains responsibility for monitoring their physical health and the effects of antipsychotic medication for at least the first 12 months or until the person's condition has stabilised, whichever is longer. Thereafter, the responsibility for this monitoring may be transferred to primary care under shared care arrangements	7

Section 6: Psychosocial Interventions

No.	Type	Standard	Ref
178. 	1	Patients are offered evidence based pharmacological and psychological interventions and any exceptions are documented in the case notes *Guidance: The number, type and frequency of psychological interventions offered are informed by the evidence base*	7
179.*	2	Input from psychologists and occupational therapists is sufficient to provide evidence-based interventions *Guidance: The number, type and frequency of psychological interventions offered are informed by the evidence base*	2, 7
180.	2	Psychosocial interventions and post-diagnostic support are available regardless of dementia subtype and age *Guidance: An audit should be carried out of the diagnoses of people offered/ participating in psychosocial interventions and support groups*	27, 28
181.	3	An audit of the capacity to provide psychosocial interventions, and the uptake of psychosocial interventions offered is carried out every 2 years	2
182.*	1	People living with dementia have access to a local programme of appropriate group Cognitive Stimulation Therapy (CST)	29, 30, 31, 32
183.	3	People living with dementia have access to individual Cognitive Stimulation Therapy (iCST)	14, 33
184.	2	People who have participated in group Cognitive Stimulation Therapy (CST) have access to an age appropriate maintenance CST programme	32, 34
185.	3	Patients have access to cognitive rehabilitation according to their clinical needs *Guidance: Cognitive rehabilitation constitutes an individualised approach where personally relevant goals are identified and the therapist works with the patient and his/ her family to devise strategies to address these. The emphasis is on improving performance in everyday life rather than on cognitive tests, building on the patient's strengths and developing ways of compensating for impairments*	21, 35, 36, 37, 38
186.	3	People living with dementia and their carers have access to a group reminiscence programme	3, 39

No.	Type	Standard	Ref
187.	2	Patients have access to interventions delivered by appropriately trained professionals, to address their emotional needs *Guidance: Please see interventions included in the British Psychological Society: A guide to psychosocial interventions in the early stages of dementia*	17, 40, 41
188.	2	The memory service has access to advice and support on assistive technology and telecare solutions designed to assist people with activities of daily living	3
189. 	1	Patients and their carers have access to tailored psychosocial interventions for behaviour that challenges *Guidance: e.g. Functional Analysis-based intervention as part of a multi-component psychosocial intervention, delivered by appropriately trained staff*	42
190.	2	Carers are offered an assessment, and intervention/s if appropriate, for their emotional, psychological and social needs, provided by appropriately qualified professionals *Guidance: Please see interventions included in the British Psychological Society: A guide to psychosocial interventions in the early stages of dementia*	17, 40
191.	3	People living with dementia have access to art/ creative therapies	7, 43, 44
192.	2	The team signposts younger people living with dementia to structured activities such as work, education and volunteering	7, 45
193. 	1	All staff members who deliver therapies and activities are appropriately trained and supervised	7, 47
194.* 	2	Patients have two or more outcome measures (including at least one patient experience measure) recorded at least twice (assessment and one other time point)	7, 46
195. 	2	Staff members review progress against patient-defined goals in collaboration with them at the start of treatment, during clinical review meetings and at discharge	7

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Glossary

Admiral nurses/ Admiral nursing service	Specialist registered mental health nurses who work in the field of dementia, with particular emphasis on supporting family carers
Advance directive/decision	A set of written instructions that a person gives that specify what actions should be taken for their health if they are no longer able to make decisions due to illness or incapacity
Assistive technology	Devices that promote greater independence by enabling people to perform tasks that they were formerly unable to/or found difficult to accomplish
Care navigator/ dementia navigator	An individual who assesses a patient's circumstances, explains the options available including treatment, and helps patients gain appropriate professional help
Care plan	An agreement between an individual and their health professional (and/or social services) to help them manage their health day-to-day. It can be a written document or something recorded in the patient notes
Case manager	Allocating a professional to be responsible for the assessment of need and implementation of care plans
Clinical/ professional supervision	A professional relationship between a staff member and their supervisor. A clinical supervisor's key duties are: • monitoring employees' work with patients; • maintaining ethical and professional standards in clinical practice
Cognitive Rehabilitation	An individualised approach - personally relevant goals are identified and a therapist works with the patient and his/her family to devise strategies to address these. Emphasis is on improving performance in everyday life rather than on cognitive tests, building on the patient's strengths and developing ways of compensating for impairments
Cognitive Stimulation Therapy	Engagement in a range of activities and discussions (usually in a group) aimed at general enhancement of cognitive and social functioning
Commissioner	Individuals (or groups of individuals) whose role it is to buy services for their local population
Dementia advisor	A service primarily for people living with dementia to provide information, advice and to help people access support that meets their needs
Domiciliary care	Health care or supportive care provided in the patient's home by healthcare professionals
DVLA	The Driver and Vehicle Licensing Agency - aims to facilitate road safety and enforcement by maintaining registers of drivers and vehicles and collecting vehicle excise duty
Key worker	A named individual who is designated as the main point of contact and support for a person who has a need for ongoing care
Knowledge and Skills Framework	A competence framework to support personal development and career progression within the NHS in the United Kingdom
Maintenance CST	Additional "top-up" sessions of Cognitive Stimulation Therapy

Management supervision	Supervision involving issues relating to the job description or the workplace. A managerial supervisor's key duties are: • prioritising workloads; • monitoring work and work performance; • sharing information relevant to work; • clarifying task boundaries; • identifying training and development needs
Mental Capacity Act	Legislation that provides protection and support for people who lack capacity to make their own decisions
NICE	National Institute for Clinical Excellence. Publishes guidance for health services in England and Wales
NIHR	National Institute for Health Research. NHS body that supports healthcare-related research
People with suspected dementia	People who have been referred to the memory clinic for an assessment because they may have an undiagnosed dementia
Person-centred care	This approach aims to see the person with dementia as an individual, with particular qualities, abilities, interests, preferences and needs, rather than focusing on their illness or on abilities they may have lost. Person-centred care also means treating people living with dementia with dignity and respect
Pharmacological treatment	Treatment using medication
Psychosocial interventions	Non-drug therapies that focus on improving the individual, social and environmental aspects of a person's life. They should be individualised and tailored to the person's needs, personality, biography, goals, strengths, and preferences. The aim of psychosocial approaches is to enhance the person's sense of self, the relationship between the person with dementia and their family/carer, and improve quality of life
Reflective Practice	The ability for people to be able to reflect on their own actions and the actions of others
Safeguarding	Protecting vulnerable people from abuse or neglect and making sure their rights and needs are met
Sheltered housing	Most commonly refers to grouped housing for older and/or vulnerable people, such as a block or "scheme" of flats or bungalows
Telecare	Devices that enable people to remain independent in their own homes by providing person-centred technologies to support the individual or their carers

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