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ROYAL COLLEGE OF PSYCHIATRISTS

MSNAP
MEMORY SERVICES NATIONAL ACCREDITATION PROGRAMME

Quality Standards for Memory Services

Eighth Edition

Editors: Jemini Jethwa, Miranda Fern, Claudelle Abhayaratne and Kulvinder Wariabharaj

Publication date: 01 October 2022 | Publication no. CCQI419

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Correspondence:
Memory Services National Accreditation Programme
Royal College of Psychiatrists' Centre for Quality Improvement
21 Prescot Street
London E1 8BB

Tel: 0208 618 4018
Email: MSNAP@rcpsych.ac.uk
Web: www.rcpsych.ac.uk/msnap

This publication is available at www.rcpsych.ac.uk/msnap

Any enquiries relating to this publication should be sent to us at:
MSNAP@rcpsych.ac.uk

Artwork displayed on the front cover of this publication is titled '*Tranquility*' and was produced by Sheila Garnham, Memory Assessment Service – Jersey, entrant of the MSNAP Artwork Competition 2021.

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 just under 30 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.

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.

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.

The Standards

Section 1: Assessments and referrals

Std No	Type	Standard	Ref
1	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
2	2	There are systems in place to monitor referrals made to other services/ centres.	2
3	1	The service provides information about how to make a referral and waiting times for assessment and treatment.	7
4	1	A clinical member of staff is available to discuss emergency referrals during working hours.	7
5	2	Where referrals are made through a single point of access, these are passed on to the memory service within one working day unless it is an emergency referral.	7
6	2	Initial contact is made with all people who are newly referred within two weeks of referral.	2
7	1	For planned assessments the team sends letters in advance to patients that include: - The job title and role 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
8	2	The diagnosis is given with the nationally 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
9	1	The team follows up patients who have not attended an appointment/assessment. If patients are unable to be engaged, a decision is made by the assessor/team, based on patient need and risk, as to how long to continue to follow up the patient. *Guidance: Where patients consent, the carer is contacted.*	7

10	1	If a patient does not attend for an assessment/appointment, the assessor contacts the referrer. *Guidance: If the patient is likely to be considered a risk to themself or others, the team contacts the referrer immediately to discuss a risk action plan*	7
11	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
12	1	People who are assessed for the possibility of dementia are asked if they wish to know the diagnosis.	3
13	1	People who are assessed for the possibility of dementia are asked with whom the outcome should be shared.	3
14	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
15	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
16	1	Patients receive a cognitive assessment and mental state examination. *Guidance: this should 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

17	1	The assessment includes an interview with someone who knows the patient well, where available. *Guidance: The patient should not be present during this interview unless requested.*	3
18	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
19	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
20	2	Where diagnosis is not disclosed, a clear record of the reasons why is made.	2
21	1	There is timely access to brain imaging (if clinically required) in the assessment of people with suspected dementia to exclude cerebral pathologies and to help establish the subtype diagnosis.	3
22	2	Additional tests and investigations are carried out in accordance with NICE guidance, individual and clinical need, including an electrocardiogram.	3
23	2	During the assessment process, services should review the potential anticholinergic cognitive burden (ACB) e.g. with the aid of a suitable online tool.	2
24	1	The assessment includes a physical 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 including long COVID; - Current physical health medication, including side effects and compliance with medication regime; - A check of vision, hearing, mobility and falls. - Lifestyle factors e.g. sleeping patterns, diet, smoking, exercise, sexual activity, drug and alcohol use.	7
25	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

Section 2: Patient and carer experience

Std No	Type	Standard	Ref

26	2	Appointment times and locations are flexible, with the patient's needs being taken into consideration. *Guidance: this might include offering home visits if appropriate.*	2, 10
27	1	Staff members treat patients and carers with compassion, dignity and respect.	7
28	1	Patients feel listened to and understood by staff members.	7
29	1	Patients feel welcomed by staff members when attending their appointments. *Guidance: Staff members introduce themselves to patients and address them using their preferred name and correct pronouns.*	7
30	1	Assessments of patients' capacity to consent to care and treatment are performed in accordance with current legislation.	7
31	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
32	1	Confidentiality and its limits are explained to the patient and carer on admission, both verbally and in writing. Patient preferences for sharing information with third parties are respected and reviewed regularly.	7
33	1	The team follows a protocol for responding to carers when the patient does not consent to their involvement.	7
34	2	Carers are offered individual time with staff members to discuss concerns and their own needs. *Guidance: the patient should not attend this meeting.*	7
35	2	People 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
36	1	People with dementia and their carers are offered a post-diagnostic meeting. *Guidance: This might include education, treatment, support groups or one-to-one support.*	3, 20

37	2	The service actively encourages carers to attend carer support networks or groups. There is a designated staff member to support carers.	7
38	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: This includes genetic and rarer disorders, and severe adjustment reactions to the diagnosis.*	19
39	1	People who are diagnosed with dementia are allocated a named worker to co-ordinate their care.	17
40	1	Every patient has a written care plan, reflecting their individual needs. Staff members collaborate with patients and their carers (with patient consent) when developing the care plan, and they are offered a copy. *Guidance: Where possible, the patient writes the care plan themselves or with the support of staff.*	7, 17
41	1	Carers (with patient consent) are involved in discussions and decisions about the patient's care, treatment and discharge planning.	7
42	2	Discharge or onward care planning is discussed with patients and their carers at the first and every subsequent care plan review.	7
43	1	Patients are offered personalised healthy lifestyle interventions, such as advice on healthy eating, physical activity and access to smoking cessation services. This is documented in the patient's care plan. *Guidance: This includes promoting brain health awareness, improving general health, living positively and maximising quality of life after diagnosis.*	7

Section 3 : Information for patients and carers

Std No	Type	Standard	Ref
44	3	There is an accessible 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

45	1	A local written protocol is available to assist memory service staff in informing patients about managing issues around driving. *Guidance: A protocol could 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
46	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
47	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; - Age appropriate peer support networks.	7
48	1	Patients (and carers, with patient consent) are offered written and verbal information about the patient's dementia and treatment. *Guidance: Verbal information could be provided in a 1:1 meeting with a staff member or in a psychoeducation group. Written information could include leaflets or websites.*	7
49	2	Where appropriate to their needs, patients and carers are given written information about, and signposted to, sources of financial and legal advice.	3, 17
50	2	Where appropriate to their needs, people with dementia and carers are given written information about medico-legal issues, including lasting power of attorney.	3
51	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
52	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

53	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
54	1	The service provides patients and their carers with information about adding their details to a research participation register and 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 or national bodies. *Guidance: this could include using the Join Dementia Research Call Back service, where staff from JDR will call the patient and their carer after memory service staff submit a short form to JDR with the patient's details.*	3, 10, 11, 49, 50, 51
55	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 and carers are made aware that they can access this at any point in their subsequent caring.*	7, 17

Section 4: Clinic environment

Std No	Type	Standard	Ref
56	2	The environment is clean, comfortable and welcoming. *Guidance: This includes dementia-friendly facilities, clear and large signs, firm seating at the right height, handrails, good lighting, high colour contrasts etc.*	7
57	1	Clinical rooms are private and conversations cannot be over-heard.	7
58	1	The environment complies with current legislation on accessible environments. *Guidance: Relevant assistive technology and equipment, such as hoists and handrails, are provided to meet individual needs and to maximise independence*	7
59	1	There is an alarm system in place (e.g. panic buttons) and this is easily accessible for patients, carers and staff members.	7

60	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
61	3	Everyone can access the service using public transport or transport provided by the service.	7

Section 5: Staff training and development

Std No	Type	Standard	Ref
62	1	The team is able to identify and manage an acute physical health emergency.	7
63	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
64	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 under the care coordination of that staff member.	7
65	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
66	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
67	2	The team has protected time for team building and discussing service development at least once a year.	7
68	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

69	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
70	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
71	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 and includes discussing caseloads.*	7
72	2	All staff members receive line management supervision at least monthly.	7
73	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
74	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
75	2	Patients, carers and staff members are involved in devising and delivering training.	7
76	3	Shared in-house multi-disciplinary team training, education and practice development activities occur in the service at least every 3 months.	7

77	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
78	2	Administrative and reception 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
79	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
80	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 with dementia.	3
81	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
82	2	The team receives training, consistent with their roles, on undertaking nutritional screening using a validated nutritional risk assessment tool.	3
83	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

84	2	The team receives training, consistent with their roles, on the use of cognitive assessments, with a focus on consistency and the appropriate application of national guidance. *Guidance: This training is refreshed annually.*	2
85	2	The team receives a range of training from other professionals involved in the work of the memory service, e.g. neuro-radiologists, social workers.	2
86	1	Staff members follow inter-agency safeguarding protocols. This includes escalating concerns if an inadequate response is received to a safeguarding referral.	7
87	1	There are measures in place to ensure staff are as safe as possible when conducting home visits. These include: • Having a lone working policy in place; • Conducting a risk assessment; • Identifying control measures that prevent or reduce any risks identified.	7
88	3	Staff are knowledgeable about the Join Dementia Research Database (including the registration procedure) and any local dementia research projects. *Guidance: Staff are aware of local studies and look for opportunities to better support patient and carer uptake of JDR (e.g. by all staff completing the JDR Learn tool, providing tablet computers and/or paper registration forms for registration completion in clinics, follow up letters mention JDR and include JDR materials).*	3, 49, 50, 51

Section 6: Resources and staffing

Std No	Type	Standard	Ref
89	2	The team works with interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation. The patient's relatives are not used in this role unless there are exceptional circumstances. *Guidance: Services support interpreters with advice on dementia awareness and training where practical.*	7
The following professionals have dedicated sessional time to contribute to the processes of assessment and diagnosis of dementia:			
90	1	A medical practitioner and a multidisciplinary team consisting of at least two other professions	12
91	2	A mental health nurse	12, 13
92	2	A clinical psychologist or neuropsychologist	12, 13
93	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: *Guidance: Access to can include the speciality of the medical lead*			
94	2	A peer support worker	2
95	2	A speech and language therapist	13
96	2	A dietician	13
97	2	A physiotherapist	13
98	2	A social worker	13
99	2	A geriatrician	12, 13
100	2	A neurologist	12, 13
101	2	An old age psychiatrist.	12, 13
102	2	There is a named lead within the service for people with young onset dementia.	2
103	2	The service has access to a sufficient level of administrative support to meet current demand.	12

Section 7: Psychosocial interventions

Std No	Type	Standard	Ref
104	1	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
105	3	An audit of the capacity to provide psychosocial interventions, and the uptake of psychosocial interventions offered is carried out every 2 years.	2
106	1	People with dementia have access to a local programme of appropriate group Cognitive Stimulation Therapy (CST).	29, 30, 31, 32
107	2	People who have participated in group Cognitive Stimulation Therapy (CST) have access to an age-appropriate maintenance CST programme.	32, 34
108	2	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

109	3	People with dementia and their carers have access to a group reminiscence or life story programme.	3, 39
110	1	All staff members who deliver therapies and activities are appropriately trained and supervised.	7, 47
111	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
112	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
113	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
114	3	People with dementia have access to art/ creative therapies.	7, 43, 44
115	2	The team signposts younger people with dementia to structured activities such as vocational rehab, employment support and workplace adjustments.	7, 45
116	2	Clinical outcome measurement is collected at two time points (at assessment and discharge). *Guidance: This includes patient-reported outcome measurements where possible.*	7, 46
117	2	Progress against patient-defined goals is reviewed collaboratively between the patient and staff members during clinical review meetings and at discharge.	7

Section 8: Pharmacological interventions

Std No	Type	Standard	Ref
118	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
119	1	When medication is prescribed, specific treatment goals are set with the patient, the risks (including interactions) and benefits are discussed, a timescale for response is set and patient consent is recorded.	7

120	1	Patients have their medications reviewed regularly. Medication reviews include an assessment of therapeutic response, safety, management of side effects and adherence to medication regime. *Guidance: Side-effect monitoring tools can be used to support medication reviews.*	7
121	3	Patients and carers are able to discuss medications with a specialist pharmacist.	7
122	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
123	1	Where antipsychotic medication is given, this prescription is recorded and a single, named individual is responsible for undertaking a review, which should include a physical assessment every 3 months unless a physical health abnormality arises.	26
124	1	Patients prescribed psychotropic medication, e.g. anti-depressants, benzodiazepines, have this reviewed in accordance with NICE guidelines.	2
125	1	For patients who are taking antipsychotic medication, the memory service maintains responsibility for monitoring their physical health and the effects of antipsychotic medication for at least the first 12 months or until the patient's condition has stabilised. Thereafter, the responsibility for this monitoring may be transferred to primary care under shared care arrangements.	7

Section 9: Joint working and liaison

Std No	Type	Standard	Ref
126	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
127	2	The service provides training and outreach to other professionals and staff whose responsibilities include providing care and treatment of older people 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

128	2	The memory service has links with local home care and social care services.	2
129	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
130	3	The service works with other organisations involved in preventative work for those vulnerable to dementia e.g. people who have had a stroke or have Parkinson's Disease.	2
131	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 or other relevant agencies 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
132	2	Specialist advice is taken when interpreting investigations/ assessments/ scans in people with complex needs, such as learning disabilities and those with young onset or rare dementias.	3
133	3	The service works with other agencies concerned with the early identification of Mild Cognitive Impairment (MCI) to provide psychoeducation and advice and interventions as required.	2
134	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
135	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: For example, mood disorders, psychotic symptoms and behaviour that challenges.*	3

136	2	The service provides or can signpost/ refer on to services that will offer information, advice and support with communication problems. *Guidance: For example, speech and language therapy and audiology.*	3
137	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
138	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
139	1	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
140	2	The service provides or can signpost/ refer on to a range of respite/short break services.	3
141	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
142	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
143	1	When patients are transferred between community services, there is a handover which ensures that the new team have an up-to-date care plan and risk assessment.	7

Section 10: Governance

Std No	Type	Standard	Ref
144	1	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
145	2	The diagnosis rate in the area covered by the memory service is at least 66%.	17

146 	2	The service is developed in partnership with appropriately experienced patient and carers who have an active role in decision making.	7
147	2	The service's clinical outcome data are reviewed at least every six months. The data is shared with commissioners/funders, the team, patients and carers, and used to make improvements to the service.	7
148	2	The team is actively involved in quality improvement activity.	7
149	2	The team actively encourages patients and carers to be involved in quality improvement initiatives.	7
150	1	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.	7
151	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
152	1	When mistakes are made in care this is discussed with the patient themselves and their carer.	7
153 	1	Staff members, patients and carers who are affected by a serious incident are offered post-incident support.	7
154 	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

References

1. Joint Commissioning Panel for Mental Health (2013). Guidance for commissioners of Dementia Services. Volume 2: Practical Mental Health Commissioning. Retrieved from: http://www.jcpmh.info/good-services/dementia-services/

2. Good practice principle developed on the basis of expert consensus through the 2022 standards revision. See acknowledgements.

3. NICE and SCIE (June 2018). Dementia: assessment, management and support for people living with dementia and their carers. NICE Guideline 97. Available at www.nice.org.uk/ng97

4. Rodda J and Carter JE. A UK survey of services for YPD. Accepted Nov 2015. International Journal of Geriatric Psychiatry.

5. van Vliet D, de Vugt ME, Bakker C et al (2013) Time to diagnosis in young-onset dementia as compared with late onset dementia. Psychological Medicine 43, 423–432

6. Harris, P. Braudy and Keady, J. (2004) Living with Early onset dementia: Exploring the experience and developing evidence-based guidelines for practice, Alzheimer's Care Quarterly, 5, 2, 111-122

7. Royal College of Psychiatrists (2022). Core standards for community-based Mental Health Services. Available at: https://www.rcpsych.ac.uk/improving-care/ccqi/resources/core-standards-project

8. Phipps, A. and O'Brien, J. (2002). Memory clinics and clinical governance - A UK perspective. International Journal of Geriatric Psychiatry, 17, 1128-1132.

9. Audit Commission (2000). Forget me not: Mental health services for older people.

10. Department of Health (2015). Prime Minister's challenge on dementia 2020. Retrieved from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414344/pm-dementia2020.pdf

11. See Join Dementia Research for information and advice on research: https://www.joindementiaresearch.nihr.ac.uk

12. Jolley, D., Benbow, S. and Grizzell, M. (2006). Memory clinics. Postgraduate Medical Journal, 82,199-206.

13. Department of Health (2001). National service framework for older people. Retrieved from http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003066

14. Orrell, M., Spector, A. & Woods, B. (2012). Should we use individual cognitive stimulation therapy to improve cognitive function in people living with dementia? British Journal of Psychiatry, 344(7844),46–47. doi: 10.1136/bmj.e633

15. Skills for Health, Health Education England and Skills for Care (2015). Dementia Core Skills Education and Training Framework. Retrieved from: http://www.skillsforhealth.org.uk/images/projects/dementia/Dementia%20Core%20Skills%20Education%20and%20Training%20Framework.pdf?s=cw1

16. General Medical Council (2017): Confidentiality: Good practice in handling patient information. Retrieved from: https://www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp

17. NHS England (2017): Implementation guide and resource pack for dementia care. Retrieved from: https://www.england.nhs.uk/wp-content/uploads/2018/01/implementation-guide-and-resource-pack-dementia-guide.pdf

18. Royal College of Psychiatrists (2005). Forgetful but not forgotten: Assessment and aspects of treatment of people living with dementia by a specialist old age psychiatry service.

19. National Audit Office (2007). Improving services and support for people living with dementia. Retrieved from http://www.nao.org.uk/publications/0607/support_for_people_with_dement.aspx

20. Department of Health (2016). Policy paper: Joint declaration on post-diagnostic dementia care and support. Retrieved from https://www.gov.uk/government/publications/dementia-post-diagnostic-care-and-support/dementia-post-diagnostic-care-and-support

21. De Vreese, L., Neri, M., Fioravanti, M., Belloi, L. and Zanetti, O. (2001). Memory rehabilitation in Alzheimer's disease: A review of progress. International Journal of Geriatric Psychiatry, 16, 794-809.

22. Committee on Safety of Medicines (2004). Atypical Antipsychotic Drugs and Stroke. Available at: http://webarchive.nationalarchives.gov.uk/20141205212951/http://www.mhra.gov.uk/Safetyinformation/Safetywarningsalertsandrecalls/Safetywarningsandmessagesformedicines/CON1004298

23. Department of Health (2009). Report on the prescribing of anti-psychotic drugs to people with dementia. Available at: http://webarchive.nationalarchives.gov.uk/20130104165557/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108303

24. National Institute for Clinical Excellence (2011). NICE technology appraisal guidance 217:Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease(review of NICE technology appraisal guidance 111). Retrieved from http://www.nice.org.uk/guidance/TA217/Guidance/pdf

25. Royal College of Psychiatrists Faculty for the Psychiatry of Old Age (2004). Atypical antipsychotics and behavioural and psychiatric symptoms of dementia: Prescribing update for old age psychiatrists. Retrieved from http://www.rcpsych.ac.uk/PDF/BPSD.pdf

26. All-Party Parliamentary Group on Dementia (2008). Always a Last Resort: Inquiry into the Prescription of Antipsychotic Drugs to People living with dementia Living in Care Homes.

27. Draskovic, I., Vernooij-Dassen, M., Verhey, F., Scheltens, P. and Olde Rikkert, M. (2008).Development of quality indicators for memory clinics. International Journal of Geriatric Psychiatry,23, 119-128.

28. Olazarin, J., Reisberg, B., Clare, L., Cruz, I., Pena-Casanova, J., del Ser, T., Woods, B and Muniz, R. (2010). Non-pharmacological therapies in Alzheimer's disease: A systematic review of efficacy. Dementia and Geriatric Cognitive Disorders, 30, 161-178.

29. Spector, A., Gardner, C. & Orrell, M. (2011). The impact of Cognitive Stimulation Therapy groups on people living with dementia: Views from participants, their carers and group facilitators. Ageing &Mental Health, 15(8), 945–949.

30. Spector, A., Orrell, M. & Woods, B. (2010). Cognitive Stimulation Therapy (CST): Effects on different areas of cognitive function for people living with dementia. International Journal of Geriatric Psychiatry, 25(12), 1253–1258.

31. Spector, A., Thorgrimsen, L., Woods, B., Royan, L., Davies, S., Butterworth, M. & Orrell, M.(2003). Efficacy of an evidence-based cognitive stimulation therapy programme for people with dementia: Randomised controlled trial. British Journal of Psychiatry, 183, 248–254.

32. Knapp, M., Thorgrimsen, L., Patel, A., Spector, A., Hallam, A., Woods, B. and Orrell, M. (2005).Cognitive Stimulation Therapy for people living with dementia: Cost effectiveness analysis. British Journal of Psychiatry, 188, 574 - 580.

33. Yates, L., Leung, P., Orgeta, V., Spector, A and Orrell, M. The development of individual cognitive stimulation therapy (iCST) for dementia. Clinical Interventions in Aging (2015). 10:95-104.

34. Orrell M., Aguirre E., Spector A., Hoare Z., Streater A., Woods B. et al (2014). Maintenance Cognitive Stimulation Therapy (MCST) for dementia: A single-blind, multi-centre, randomised controlled trial of Maintenance CST vs. CST for dementia. British Journal of Psychiatry, 204(6),454–461.

35. Clare, L., Wilson, B., Carter, G. and Hodges, J. (2003). Cognitive rehabilitation as a component of early intervention in Alzheimer's disease: A single case study. Aging and Mental Health, 7, 15-21.

36. Clare, L. (2009). Working with memory problems: Cognitive rehabilitation in early dementia. In Moniz-Cook, E. and Manthorpe, J. (eds) Early psychosocial interventions in dementia: evidence-based practice. Jessica Kingsley: London.

37. Carr, I., Jarvis, K. and Moniz-Cook, M. (2009). A host of golden memories: Individual and couples group reminiscence. In Moniz-Cook, E. and Manthorpe, J. (eds) Early psychosocial interventions in dementia: evidence-based practice. Jessica Kingsley: London.

38. Clare, L., Linden, D., Woods, R., Whitaker, R., Evans, S., Parkinson, C., van Paasschen, J., Nelis,S., Hoare, Z., Yuen, K. and Rugg, M. (2010). Goal-oriented cognitive rehabilitation for people with early-stage Alzheimer disease: a single-blind randomized controlled trial of clinical efficacy. American Journal of Geriatric Psychiatry, 18, 928-939.

39. Woods R, Bruce E, Edwards R, et al. (2012) REMCARE: reminiscence groups for people with dementia and their family caregivers – effectiveness and cost-effectiveness pragmatic multicentre randomised trial. Health Technology Assessment, 16: v–xv, 1–116.

40. Moniz-Cook, E. (2008). Assessment and psychosocial intervention for older people with suspected dementia: A memory clinic perspective. In Laidlaw, K. and Knight. B. (eds) Handbook of Emotional Disorders in Later Life: Assessment and Treatment. Oxford University Press: Oxford.

41. British Psychological Society (2014). A guide to psychosocial interventions in early stages of dementia. Retrieved from: https://www.bps.org.uk/system/files/user-files/DCP%20Faculty%20for%20the%20Psychology%20of%20Older%20People%20(FPoP)/public/a_guide_to_psychosocial_interventions_in_dementia.pdf

42. Marriott, A., Donaldson, C. and Burns, A. (2000). Effectiveness of cognitive-behavioural family interventions in reducing the burden of care in carers of patients with Alzheimer's disease. British Journal of Psychiatry, 176, 557-562.

43. Beard, R.L. (2012). Art therapies and dementia care: A systematic review. Dementia, 11, 633–656.

44. Urbas, S. (2009). Art therapy: Getting in touch with inner self and outside world. In E. Moniz-Cook & J. Manthorpe (Eds.), Early psychosocial interventions in dementia: Evidence-based practice. London: Jessica Kingsley Publishers.

45. Andrea Mayrhofer, Elspeth Mathie, Jane McKeown, Frances Bunn & Claire Goodman (2017): Age-appropriate services for people diagnosed with young onset dementia (YOD): a systematic review, Aging & Mental Health, DOI: 10.1080/13607863.2017.1334038

46. Moniz-Cook, Esme & Vernooij-Dassen, Myrra & Woods, Bob & Verhey, Frans & Chattat, Rabih & Vugt, Marjolein & Mountain, Gail & O'Connell, M & Harrison, J & Vasse, Emmelyne & Dröes, Rose-Marie & Orrell, M. (2008). A European consensus on outcome measures for psychosocial intervention research in dementia care. Aging & mental health. 12. 14-29.10.1080/13607860801919850.

47. Rapaport P, Livingston G, Murray J, et al. Systematic review of the effective components of psychosocial interventions delivered by care home staff to people living with dementia. BMJ Open2017;7:e014177. doi:10.1136/bmjopen-2016-014177

48. NHS England and NHS Improvement (2021). NHS Operational Planning and Contracting Guidance 2022 – 2023. Available at: https://www.england.nhs.uk/publication/2022-23-priorities-and-operational-planning-guidance/

49. Department of Health (2015). Prime Minister's challenge on dementia 2020. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414344/pm-dementia2020.pdf

50. Join Dementia Research for information and advice on promoting research and the Join Dementia Research registry to patients and carers, including the JDR Learn tool and links to order free materials: https://nhs.joindementiaresearch.nihr.ac.uk/

51. NHS England (2017 – updated 2020). Dementia: Good Personalised Care and Support Planning. https://www.england.nhs.uk/wp-content/uploads/2020/02/FINAL-_Update_Dementia-Good-Care-Planning-.pdf

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

Acknowledgements

The Memory Services National Accreditation Programme is extremely grateful to the following people for their time and expert advice in the development and revision of these standards.

MSNAP would like to thank the following people for their input and support in reviewing and compiling these standards:

- Professor Martin Orrell, Consultant Psychiatrist, Nottingham University Hospital Trust and MSNAP Accreditation Committee Chair
- Dr Sarah Ghani, Consultant Clinical Psychologist and former MSNAP Advisory Group Chair
- MSNAP Carer Representatives
- Members of the MSNAP Advisory Group
- Members of the MSNAP Accreditation Committee
- Individuals who contributed to the standards e-consultation and standards revision workshop.

Project contact details and information

Jemini Jethwa, Programme Manager
Jemini.Jethwa@rcpsych.ac.uk
0208 618 4061

Miranda Fern, Deputy Programme Manager
Miranda.Fern@rcpsych.ac.uk
0208 618 4018

Claudelle Abhayaratne, Project Officer
Claudelle.Abhayaratne@rcpsych.ac.uk

Kulvinder Wariabharaj, Project Officer
Kulvinder.Wariabhara@rcpsych.ac.uk

Address

Memory Services National Accreditation Programme
Royal College of Psychiatrists
21 Prescot Street
London
E1 8BB

Mailing list

MSNAP@rcpsych.ac.uk

Knowledge Hub
Home - Memory Services National Accreditation Programme (MSNAP) - Knowledge Hub (khub.net)

Website

www.rcpsych.ac.uk/msnap

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E1 8BB

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