MSNAP
MEMORY SERVICES NATIONAL ACCREDITATION PROGRAMME

CCQI

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Memory Services National Accreditation Programme (MSNAP)

Standards for Memory Services

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A manual of standards written primarily for:
Memory services

Also of interest to:
People with dementia
Carers of people with dementia
Commissioners
Policy makers
Researchers

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A full copy of this document is available on our website at:
www.rcpsych.ac.uk/memory-network

The criteria associated with the standards have been classified 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: criteria that a service would be expected to meet;

Type 3: standards that are aspirational or standards that are not the direct responsibility of the service.

Key

M	Standard **modified** since last edition
N	**New** standard since last edition

Contents

Introduction

The aim of the Memory Services National Accreditation Programme (MSNAP) is to improve assessment, diagnosis and care for people with dementia and their carers. This includes timely and equal access to services, provision of evidence-based treatments, monitoring and follow-up.

If dementia is diagnosed early, more can be done to delay progression of the disease[1]. Additionally, knowledge of the diagnosis can reduce the number and length of acute hospital admissions, delay the need for long-term residential care and allow families to plan future medical care and finances[2]. Professor Alistair Burns, National Clinical Director for Dementia, stated, "We know there is variation in service provision across the country, in particular in waiting times, and MSNAP has been instrumental in bringing this issue to the fore and facilitating individual services to improve the care they provide for people, their families and carers."[4]

The *Implementation guide and resource pack for dementia care* (2017)[3] suggests a waiting time of no more than 6 weeks from referral to diagnosis. In the 2014 *Second English National Memory Clinics Audit*[4], the average wait was 14 weeks and only 11% clinics were able to give diagnosis within 6 weeks or less.

Access to evidence-based treatments and support, as recommended by the National Institute for Health and Care Excellence (NICE)[5], the *Implementation guide and resource pack for dementia care*[3], and available research, is crucial to quality care for people with dementia. A timely diagnosis must be followed by quality, timely psychological and pharmacological treatment. Post-diagnostic care must not be compromised in the quest for shorter waiting times.

The *MSNAP Standards for Memory Services* and associated criteria, drawn from key documents, will help services demonstrate compliance with key policy and guidance. The standards also support adherence to the *Implementation guide and resource pack for dementia care*[3], NICE guidelines including *CG42*[5], the *NICE Quality Standard for Dementia*[6], and the *Prime Minister's Challenge on Dementia 2020*[7].

Non-dementia memory disorders

The memory services described in these standards usually serve a specified local catchment area and generally focus on the assessment, diagnosis and care for people with dementia and their carers. However, it is important to note that there are many other types of memory disorders which require assessment by experienced clinicians working within specialist (and often tertiary) neurological, neuropsychiatric, and neuropsychological services (e.g. transient memory disorders, amnesic syndrome, and cognitive complications of neurological and psychiatric disorders). Rare forms of dementia may also require specialist assessment services. For more information on non-dementia memory disorders, see Appendix page 60.

1 National Audit Office (2010) Improving dementia services in England: An interim report. London: The Stationary Office.
2 National Institute for Health and Clinical Excellence and Social Care Institute for Excellence (2006) Dementia: Supporting People with Dementia and their Carers. London: the British Psychological Society and Gaskell.
3 National Collaborating Centre for Mental Health (2017) Implementation guide and resource pack for dementia care. Leeds: Older People's Mental Health and Dementia, NHS England
4 Royal College of Psychiatrists (2015) Second English National Memory Clinics Audit Report London: Royal College of Psychiatrists.
5 National Institute for Health and Clinical Excellence & Social Care Institute for Excellence (2006) NICE clinical guideline 42. Dementia: supporting people with dementia and their carers in health and social care. London: National Institute for Health and Clinical Excellence.
6 NICE (2010) QS1: Dementia Quality Standard. London: National Institute for Health and Clinical Excellence.
7 Department of Health (2015) Prime Minister's challenge on dementia 2020. London: Department of Health

Memory Services National Accreditation Programme (MSNAP)

The Royal College of Psychiatrists' Centre for Quality Improvement (CCQI) has developed an approach to supporting local service improvement that has proved successful in a range of settings (see www.rcpsych.ac.uk/ccqi). MSNAP applies this approach to memory services. 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.

The key principles of the memory assessment network are the same as those that underpin other quality networks managed by the CCQI:

- **local ownership and trust:** the process is led by front-line staff and incorporates true peer-review. It also engages senior service managers, patients and carers;
- **credibility:** the standards on which the work is based are explicit and the process of applying them is transparent;
- **responsiveness:** feedback to participating services is prompt and includes advice and support on how to meet standards;
- **a focus on development:** although the process of review is rigorous, and the feedback honest, the purpose of the programme is to support and help services to improve in line with the standards.

The programme involves a broad range of people who access, work in, or come into regular contact with the participating memory services, and will take them through a three-stage process involving a period of self review, followed by peer review, and finally review by an Accreditation Committee. Local memory service teams are supported to systematically review a variety of aspects of the services that they provide.

An overview of MSNAP

Standards

This manual of standards and associated criteria has been produced to underwrite the self and peer review processes. These standards have been developed from a literature review and in consultation with stakeholder groups. Care has been taken to include information from a wide range of sources and to take into account the views of memory service staff, people with dementia and carers. The standards are subject to regular review to account for new developments.

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 particular model of service delivery.
The standards cover the processes of **assessment**, **diagnosis**, **pharmacological treatment** and **psychosocial interventions.**

Changes to MSNAP Standards - Sixth Edition

The sixth edition of the MSNAP standards has been updated with the 2nd edition of the CCQI core standards for community based mental health services[8]. **M** next to the standard number indicates that a standard has been **modified**; **N** indicates a **new standard** added since the last edition.

Overarching principles

People 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 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 full set of standards and criteria is aspirational and it is unlikely that any service would meet all of them. To support their use in the accreditation process, the criteria associated with each standard have 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: criteria that a service would be expected to meet;

Type 3: standards that are aspirational, or standards that are not the direct responsibility of the service.

To achieve accreditation services are required to meet 100% type 1 standards, 80% type 2 standards and 60% type 3 standards.

A copy of these standards and associated criteria will be sent to every service that becomes a member of the Memory Services National Accreditation Programme.

This document is also available on our website: www.rcpsych.ac.uk/memory-network

[8] Royal College of Psychiatrists (2017). Standards for Community-Based Mental Health Services. London: Royal College of Psychiatrists

Audit tools

A series of audit tools have been developed to support the measurement of adherence to the criteria associated with each standard. These include:

Patient questionnaire: questions about the experiences of people with dementia/suspected dementia on different aspects of the service, e.g. assessment process, environment, provision of information and choice.

Carer questionnaire: questions about carers' experiences of different aspects of the service, e.g. assessment process, environment, provision of information and choice.

Staff questionnaire: questions about memory service staff experiences of working for the service, e.g. ways of working, staff support, supervision and training.

Referrer questionnaire: brief questions for referrers about different aspects of the referral process and service provision.

Case note audit: an audit of a sample of case notes against a checklist of standards.

CARS online workbook: an online tool for services to self-rate against each of the MSNAP standards.

Review process

Stage 1: **Service undertakes a self review** using a range of audit tools (as above);

Stage 2: **Service hosts a peer review visit** by a multi-professional team that includes a person with dementia and/or a carer; **Service receives a written local report**, which includes a statement about performance against the standards and associated criteria, highlights issues that need attention and includes advice and comments from the review team;

Stage 3: **Local report is presented to the Accreditation Committee**, which awards accreditation or deferral of accreditation based on content of the report;

Ongoing: **Service begins action planning** and implementation of improvements based on findings.

Email discussion group and website

Memory service staff have access to advice and support from their peers through the programme's email discussion group. Email 'JOIN' to memorychat@rcpsych.ac.uk to become a member of the Memory Services National Accreditation Programme email discussion group.

Further information can also be found at www.rcpsych.ac.uk/memory-network

Sustainability Principles

The sixth edition of the MSNAP standards has 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-centered, 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'[9]

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

[9] Department of Health and Social Care (2015) NHS Constitution for England. London: Department of Health.

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 contacts). 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 team working 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
  http://www.rcpsych.ac.uk/files/pdfversion/OP97.pdf

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Section 1

Management

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Service planning and commissioning		
NUMBER	**STANDARD/CRITERION**	**TYPE**
1.1	**Health and Social Care Commissioners take an evidence-based approach to commissioning.**	
1.1.1	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*	**2** Ref 1
1.1.2	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*	**2** Ref 1
1.1.4	Health and Social Care Commissioners, in consultation with local partners, patients 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 a specific 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*	**2** Ref 3, 4, 5, 6
1.1.5 M 	Services are developed in partnership with patient and carer representatives. *Guidance: This might involve patient and carer representatives attending and contributing to local and service level meetings and committees* Sustainability Principle: empower individuals and communities.	**2** Ref 7
1.1.6 N	The diagnosis rate in the area covered by the memory service is at least 66%.	**2** Ref 17

Quality assurance, research and service development		
NUMBER	**STANDARD/CRITERION**	**TYPE**
1.2	**The memory service demonstrates that there is a commitment to ongoing quality improvement and research.**	
1.2.1	A range of local and multi-centre clinical audits is conducted which includes the use of evidence based treatments, as a minimum.	**2** Ref 8
1.2.4 M	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.	**2** Ref 9
1.2.5 M 	Patients and their carers are encouraged to feed back confidentially about their experiences of using the service, and their feedback 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* Sustainability Principle: empower individuals and communities.	**1** Ref 7
1.2.6 	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) portfolio studies or equivalent local bodies. Sustainability Principle: empower individuals and communities.	**2** Ref 10,11
1.2.7	The service ensures that all patients and their carers are asked if they would like to add their details to a research participation register, e.g. Join Dementia Research.	**2** Ref 10,11
1.2.8	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*	**2** Ref 7
1.2.10 	Front-line staff members are involved in key decisions about the service provided. Sustainability Principle: staff sustainability.	**2** Ref 2
1.2.14 	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. Sustainability Principle: staff sustainability.	**2** Ref 2

Complaints and untoward incidents		
NUMBER	**STANDARD/CRITERION**	**TYPE**
1.3	**All complaints and untoward incidents are dealt with in accordance with appropriate Trust rules and guidelines.**	
1.3.1	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.	**1** Ref 7
1.3.2 M	Patients are given verbal and written information on:	
1.3.2.1 M	• Their rights regarding consent to care and treatment;	**1** Ref 7
1.3.2.2 M	• How to access independent advocacy services;	
1.3.2.3 M	• How to access a second opinion;	
1.3.2.4 M	• How to access interpreting services;	
1.3.2.5 M	• How to raise concerns, complaints and compliments;	
1.3.2.6 M	• How to access their own health records.	
1.3.3 M	Lessons learned from incidents are shared with the team and the wider organisation. There is evidence that changes have been made as a result of the lessons learnt.	**1** Ref 7
1.3.4	Staff members share information about any serious untoward incidents involving a patient with the patient and their carer, in line with the Statutory Duty of Candour.	**1** Ref 7
1.3.5 M 	Staff members, patients and carers who are affected by a serious incident are offered post-incident support. Sustainability Principle: empower individuals and communities.	**1** Ref 7

Supporting vulnerable people		
NUMBER	**STANDARD/CRITERION**	**TYPE**
1.4	**The memory service has safeguarding systems and procedures, in accordance with appropriate Trust rules and guidelines and relevant statutory guidance.**	
1.4.1 M 	Staff members follow inter-agency safeguarding protocols. This includes escalating concerns if an inadequate response is received to a safeguarding referral. Sustainability Principle: prioritise prevention.	**1** Ref 7
1.4.2 M 	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. Sustainability Principle: empower individuals and communities.	**1** Ref 7

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Section 2

Resources available to support assessment and diagnosis

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Accessibility of the service		
NUMBER	**STANDARD/CRITERION**	**TYPE**
2.1	**The memory service is accessible to patients and their carers.**	
2.1.1 	Everyone is able to access the service using public transport or transport provided by the service. Sustainability Principle: consider carbon.	**3** Ref 7
2.1.3	The assessment takes place at a time and in an environment that is acceptable to all parties.	**2** Ref 2
2.1.4	The service has the capacity to make home assessments if necessary.	**2** Ref 10
2.1.5 M	The service uses interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation. The relatives of the person with dementia 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*	**2** Ref 7
2.1.6 M	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.*	**1** Ref 3
2.1.7 N	The service provider has a local strategy in place to promote and monitor equality and diversity, prevent discrimination and to address any barriers to access.	**1** Ref 7

Staffing for the memory service		
NUMBER	**STANDARD/CRITERION**	**TYPE**
2.2	**There are sufficient numbers of appropriately skilled and qualified staff.**	
The following professionals have dedicated sessional time to contribute to the processes of assessment and diagnosis of dementia:		
2.2.1	A medical practitioner and a multidisciplinary team consisting of at least two other professions	**1** Ref 12
2.2.2	A mental health nurse	**2** Ref 12, 13
2.2.3	A clinical psychologist or neuropsychologist	**2** Ref 12, 13
2.2.4	An occupational therapist	**2** Ref 12, 13
2.3	The service has access to a sufficient level of administrative support to meet current demand. *Guidance: ascertain whether the level of available support meets current demand*	**2** Ref 12

Staffing for the memory service		
NUMBER	**STANDARD/CRITERION**	**TYPE**
2.3.2 M	Patient or carer representatives are involved in the interview process for recruiting staff members. *Guidance: This could include co-producing interview questions or sitting on the interview panel*	**2** Ref 7
2.3.4 M 	The service has a mechanism for responding to low/unsafe staffing levels, when they fall below minimum agreed levels, including: • A method for the team to report concerns about staffing levels; • Access to additional staff members; • An agreed contingency plan, such as the minor and temporary reduction of non-essential services. Sustainability Principle: staff sustainability.	**1** Ref 7
2.3.4.1 N 	When a staff member is on annual leave or off sick, the team puts a plan in place to provide adequate cover for the patients who are allocated to that staff member. Sustainability Principle: improve value.	**1** Ref 7
2.3.5	There is a named lead within the team for people with young onset dementia.	**2** Ref 2
2.4	**The memory service has access to or can refer to the following professionals for advice/support during the processes of assessing and diagnosing people with dementia:** *Guidance: access to can include the speciality of the medical lead*	
2.3.6 N	A peer support worker;	**3** Ref 2
2.4.1	A speech and language therapist;	**2** Ref 13
2.4.2	A dietician;	**2** Ref 13
2.4.3	A physiotherapist;	**2** Ref 13
2.4.4	A social worker;	**2** Ref 13
2.4.5	A geriatrician;	**2** Ref 12, 13
2.4.6	A neurologist;	**2** Ref 12, 13
2.4.7	An old age psychiatrist.	**2** Ref 12, 13

Functioning of the memory service team		
NUMBER	**STANDARD/CRITERION**	**TYPE**
2.5	**Memory service staff work effectively as a multidisciplinary team.**	
2.5.1	There is a named designated 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*	**1** Ref 12
2.5.2 M	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*	**1** Ref 7
2.5.4 M 	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* Sustainability Principle: improve value.	**2** Ref 2
2.5.4.1 	Staff members work well together, acknowledging and appreciating each other's efforts, contributions and compromises. Sustainability Principle: staff sustainability.	**3** Ref 7
2.5.7 	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)* Sustainability Principle: improve value.	**2** Ref 2
2.5.8 	The team has protected time for team-building and discussing service development at least once a year. Sustainability Principle: staff sustainability.	**2** Ref 7
2.5.9 M 	Staff members are able to access reflective practice groups at least every 6 weeks where teams can meet together to think about team dynamics and develop their clinical practice. Sustainability Principle: staff sustainability.	**2** Ref 7
2.5.10 M 	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* Sustainability Principle: staff sustainability.	**1** Ref 7

Functioning of the memory service team		
NUMBER	**STANDARD/CRITERION**	**TYPE**
2.5.10.1 M 	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* Sustainability Principle: staff sustainability.	**1** Ref 7

Staff supervision and support mechanisms		
NUMBER	**STANDARD/CRITERION**	**TYPE**
2.6	**Staff receive regular appraisal and supervision and know how to gain additional advice and support when they need it.**	
2.6.2 	Staff know how to obtain additional advice and support when they need it. Sustainability Principle: staff sustainability.	**2** Ref 2
2.6.3 	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* Sustainability Principle: staff sustainability.	**1** Ref 7
2.6.4 M	All staff members receive line management supervision at least monthly.	**2** Ref 7
2.6.5 M 	Staff members in training and newly qualified staff members receive weekly line management supervision. Sustainability Principle: staff sustainability.	**2** Ref 7
2.6.8 M	The service's clinical outcome data are reviewed at least 6 monthly. The data are used to make improvements to the service.	**2** Ref 7
2.6.9	There are systems in place to monitor and manage caseload size for each member of staff.	**2** Ref 2

Staff training and development		
NUMBER	**STANDARD/CRITERION**	**TYPE**
2.7	**Staff working within the memory service are well-trained for their jobs, and their continuing professional development is facilitated.**	
2.7.1 	Staff members have access to study facilities (including books and journals on site or online) and time to support relevant research and academic activity. Sustainability Principle: staff sustainability.	**2** Ref 2
2.7.2 	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. Sustainability Principle: staff sustainability.	**2** Ref 2
2.7.3	There are arrangements for staff cover to allow staff to attend training.	**2** Ref 2
2.7.4	Staff members can access leadership and management training appropriate to their role and speciality.	**2** Ref 7
2.7.5 **M** 	New staff members, including agency staff, receive an induction based on an agreed list of core competencies. This covers: • The purpose of the service; • The team's clinical approach; • The roles and responsibilities of staff members; • The importance of family and carers; • Care pathways with other services. *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* Sustainability Principle: staff sustainability.	**1** Ref 7
2.7.7 	All new staff members are allocated a mentor to oversee their transition into the service. Sustainability Principle: staff sustainability.	**2** Ref 7
2.7.9 	Patients, carers and staff members are involved in devising and delivering training face-to-face. Sustainability Principle: empower individuals and communities.	**2** Ref 7
2.7.10	Shared in-house multi-disciplinary team training, education and practice development activities occur in the service at least every 3 months.	**3** Ref 7
2.7.13 **N** 	Staff members are knowledgeable about, and sensitive to, the mental health needs of people from minority or hard-to-reach groups. This may include: Black, Asian and minority ethnic groups; Asylum seekers or refugees; Lesbian, gay, bisexual or transgender people; Travellers. Sustainability Principle: empower individuals and communities.	**1** Ref 7

Staff training and development		
NUMBER	**STANDARD/CRITERION**	**TYPE**
2.8	**Staff members receive training consistent with their role, which is recorded in their personal development plan and is refreshed in accordance with local guidelines.** *Guidance: Training/learning and development may include structured training courses, in-house training, "on-the-job" training, e-learning, conferences, university or college courses etc.*	
2.8.0 N 	Clinical staff fulfil the competencies of Tier 2 or above in the Health Education England (HEE) Dementia Core Skills, Education and Training Framework. This 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. Sustainability Principle: improve value.	**1** Ref 15
2.8.1.1 M	Administrative staff have received training in dementia and fulfil the competencies of Tier 1 or above in the Health Education England (HEE) Dementia Core Skills, Education and Training Framework. *Guidance: Tier 1 includes training in dementia awareness*	**2** Ref 15
2.8.2 M 	The team receives training, consistent with their roles, on risk assessment and risk management. *Guidance: This could include:* • *Safeguarding vulnerable adults and children;* • *Assessing and managing suicide risk and self-harm;* • *Prevention and management of aggression and violence;* • *Prevent training;* • *Recognising and responding to the signs of abuse, exploitation or neglect.* Sustainability Principle: prioritise prevention.	**1** Ref 7
2.8.5 M	All staff complete statutory and mandatory training. *Guidance: Includes equality and diversity, information governance, basic life support*	**1** Ref 7
2.8.8 M	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.	**2** Ref 3

Staff training and development		
NUMBER	**STANDARD/CRITERION**	**TYPE**
2.8.9 M	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).	**1** Ref 7
2.8.10 M	The team receives training, consistent with their roles, on undertaking nutritional screening using a validated nutritional risk assessment tool.	**2** Ref 3
2.8.11 M	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*	**1** Ref 7
2.8.14 M	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** Ref 2
2.8.15 M	The team receives training from other professionals involved in the work of the memory service, e.g. neuro-radiologists, social workers.	**2** Ref 2

Joint working		
NUMBER	**STANDARD/CRITERION**	**TYPE**
2.9	**The memory service works closely with other professionals, agencies and providers to support the processes of assessment and diagnosis.**	
2.9.1 M 	The team follows a joint working protocol/care pathway with primary health care teams. *Guidance: This includes shared prescribing protocols with the GP, the team informing the patient's GP of any significant changes in the patient's mental health or medication, or of their referral to other teams* Sustainability Principle: improve value.	**1** Ref 3, 16
2.9.2	The patient's consent to the sharing of clinical information outside the team is recorded. If consent is not obtained the reasons for this are recorded.	**1** Ref 3, 16
2.9.5 M 	Patients can access help, from mental health services, 24 hours a day, 7 days a week. *Guidance: Out of hours, this may involve crisis/home treatment teams, psychiatric liaison teams and telephone helplines* Sustainability Principle: improve value.	**1** Ref 7
2.9.6 M	Where the service has access to a crisis resolution/home treatment team (CRHTT), the memory service ensures that crisis resolution is offered via the CRHTT as a first-line service, to support people with dementia who are in crisis if the severity of the episode, or the level of risk to self or others, exceeds the capacity of the memory service to effectively manage it.	**1** Ref 7
2.9.8	There are systems in place to monitor referrals made to other services/centres.	**2** Ref 2

Liaison		
NUMBER	**STANDARD/CRITERION**	**TYPE**
2.10	**The memory service offers a range of supports to promote early identification and referral into the service.**	
2.10.2	The service provides advice to other professionals and staff whose responsibilities include providing care and treatment of 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*	**2** Ref 13
2.10.3 	The service provides training to other professionals and staff whose responsibilities include providing care and treatment of 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* Sustainability Principle: improve value.	**2** Ref 13
2.10.4 	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 with dementia/suspected dementia. *Guidance: E.g. GPs; residential care, nursing homes and sheltered housing; domiciliary care; day care; hospital care, including inpatient services* Sustainability Principle: improve value.	**2** Ref 13
2.10.5 	The memory service has links with local home care and social care services. Sustainability Principle: improve value.	**2** Ref 2
2.10.6 	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* Sustainability Principle: prioritise prevention.	**1** Ref 7
2.10.8 N 	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* Sustainability Principle: prioritise prevention.	**3** Ref 2

The clinic environment *(where applicable)*		
NUMBER	**STANDARD/CRITERION**	**TYPE**
2.11	**Any clinic run by the memory service is accommodated in an environment that is appropriate to the needs of people with dementia/suspected dementia.**	
2.11.1	All rooms are kept clean. *Guidance: All staff members are encouraged to help with this*	**1** Ref 7
2.11.2 M	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.*	**2** Ref 12
2.11.3	There is easy access to suitable toilet facilities.	**1** Ref 12
2.11.4 M	Clinical rooms are private and conversations cannot be over-heard.	**1** Ref 7
2.11.6	The service entrance and key clinical areas are clearly signposted.	**2** Ref 7
2.11.8 M	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*	**1** Ref 7
2.11.9	An audit of environmental risk is conducted annually and a risk management strategy is agreed.	**1** Ref 7
2.11.10	Furniture is arranged so that doors, in rooms where consultations take place, are not obstructed.	**1** Ref 7
2.11.12 M	There is an alarm system in place (e.g. panic buttons) and this is easily accessible for patients, carers and staff members.	**1** Ref 7
2.11.13 N	Staff members follow an agreed response to alarm calls.	**1** Ref 7
2.12	**Any clinic run by the memory service provides the necessary facilities and resources for staff to effectively carry out their duties.**	
2.12.1	A spacious room is available for the memory service team to meet to discuss findings and make plans.	**2** Ref 12
2.12.2 M	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*	**1** Ref 7
2.12.3 	Staff members follow a lone working policy and feel safe when conducting home visits. Sustainability Principle: staff sustainability.	**1** Ref 7

The clinic environment *(where applicable)*		
NUMBER	**STANDARD/CRITERION**	**TYPE**
2.12.4 	Staff members have access to a dedicated staff room. Sustainability Principle: staff sustainability.	**2** Ref 7
2.12.5	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** Ref 2
2.12.6 M	Emergency medical resuscitation equipment, as required by Trust/organisation guidelines, is available immediately (available for use within the first minutes of a cardiorespiratory arrest) and is maintained and checked weekly, and after each use.	**1** Ref 7

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Section 3

Assessment and diagnosis

MSNAP
MEMORY SERVICES NATIONAL ACCREDITATION PROGRAMME
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Referral and access to the memory service		
NUMBER	**STANDARD/CRITERION**	**TYPE**
3.1	**The memory service provides timely access to assessment and diagnosis.**	
3.1.1 M	Clear information is made available, in paper and/or electronic format, to people with dementia, carers and healthcare practitioners on: • A simple description of the service and its purpose; • Clear referral criteria; • How to make a referral, including self-referral if the service allows; • Clear clinical pathways describing access and discharge; • Main interventions and treatments available; • Contact details for the service, including emergency and out of hours details. *Guidance: The information is co-produced with patients*	**1** Ref 7
3.1.1.1	A clinical member of staff is available to discuss emergency referrals during working hours.	**1** Ref 7
3.1.1.2 M	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.	**2** Ref 7
3.1.1.3 M	Outcomes of referrals are fed back to the referrer, patient and carer (with the patient's consent) in writing. If a referral is not accepted, the team advises the referrer, patient and carer on alternative options.	**1** Ref 7
3.1.2 M 	Initial contact is made with all people who are newly referred within two weeks of referral. Sustainability Principle: improve value.	**2** Ref 2
3.1.2.1 M	The team provides patients and carers with information about expected waiting times for assessment and treatment.	**2** Ref 7
3.1.2.2 M	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.	**1** Ref 7
3.1.3.1 M	Within 6 weeks of referral, patients receive a diagnosis, meet with their care coordinator and set an initial NICE-recommended care plan, unless any further specialist assessments or investigations are required, or other circumstances cause delay. Reasons for delay are recorded and monitored. *Guidance: Investigations such as blood tests and brain scans would be considered routine rather than specialist*	**2** Ref 17, 48

Referral and access to the memory service		
NUMBER	**STANDARD/CRITERION**	**TYPE**
3.1.4 M	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*	**1** Ref 7
3.1.4.1 	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* Sustainability Principle: prioritise prevention.	**1** Ref 7
3.1.4.2 	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* Sustainability Principle: improve value.	**2** Ref 2
3.1.5	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.*	**3** Ref 2

Dignity, consent and capacity, and confidentiality		
NUMBER	**STANDARD/CRITERION**	**TYPE**
3.2	**The memory service is designed and managed so that the respect and dignity of patients and their carers is preserved.**	
3.2.1 M	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*	**1** Ref 7
3.2.2 	Staff ensure that patients and their carers understand what is being done in the assessment process, and why. Sustainability Principle: empower individuals and communities.	**1** Ref 12
3.2.2.1 	Patients feel listened to and understood in consultations with staff members. Sustainability Principle: empower individuals and communities.	**2** Ref 7
3.2.3 M	Staff members wear their Trust ID at work and this is easily visible.	**1** Ref 7

Dignity, consent and capacity, and confidentiality		
NUMBER	**STANDARD/CRITERION**	**TYPE**
3.2.4 M	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*	**1** Ref 7
3.3	**Staff follow clear procedures for gaining consent and ensure that patients are well-informed of their rights regarding consent.** Guidance: *This must include adhering to guidance outlined in the Mental Capacity Act 2005, the Adults with Incapacity (Scotland) Act 2000, or equivalent*	
3.3.2	There are policies/guidelines around gaining consent. *Guidance: This should include a list of topics for which written consent is required*	**1** Ref 7
3.3.3 M	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.	**1** Ref 7
3.3.4 M	When talking to patients and carers, health professionals communicate clearly, avoiding the use of jargon.	**1** Ref 7
3.3.7 M 	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* Sustainability Principle: empower individuals and communities.	**1** Ref 7
3.4	**Personal information is kept confidential unless this is detrimental to the person's care.**	
3.4.0.1 M	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*	**1** Ref 7
3.4.1	People who are assessed for the possibility of dementia are asked if they wish to know the diagnosis.	**1** Ref 3
3.4.2 	People who are assessed for the possibility of dementia are asked with whom the outcome should be shared. Sustainability Principle: empower individuals and communities.	**1** Ref 3

Dignity, consent and capacity, and confidentiality		
NUMBER	**STANDARD/CRITERION**	**TYPE**
3.4.4 	The team follows a protocol for responding to carers when the patient does not consent to their involvement. Sustainability Principle: empower individuals and communities.	**1** Ref 7

The processes of assessment and diagnosis		
NUMBER	**STANDARD/CRITERION**	**TYPE**
3.5	**The memory service ensures that a diagnosis of dementia is made only after a comprehensive and holistic assessment of the patient's needs by appropriate professionals, either within the service or elsewhere.** **This includes:**	
3.5.1	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*	**1** Ref 3, 13
3.5.2	History taking.	**1** Ref 3, 12
3.5.3 **M**	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; • 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	**1** Ref 7
3.5.3.1 **M** 	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. Sustainability Principle: improve value.	**1** Ref 7

The processes of assessment and diagnosis		
NUMBER	**STANDARD/CRITERION**	**TYPE**
3.5.4 M 	A comprehensive, evidence-based assessment which includes their: • Mental health and medication; • Psychosocial and psychological needs; • Strengths and areas for development. Sustainability Principle: improve value.	**1** Ref 7
3.5.5	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*	**1** Ref 3, 12, 13
3.5.6 	An interview with someone who knows the patient well, where available. Sustainability Principle: empower individuals and communities.	**1** Ref 3
3.5.7	A check of vision, hearing and mobility.	**1** Ref 13
3.5.10 M 	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. Sustainability Principle: prioritise prevention.	**1** Ref 7
3.5.16	An assessment of the person's social support.	**2** Ref 2
3.5.10.3 N 	Risk assessments and management plans are updated according to clinical need or at a minimum frequency that complies with national standards, e.g. College Centre for Quality Improvement specialist standards or those of other professional bodies. Sustainability Principle: prioritise prevention.	**1** Ref 7
3.5.11	All patients have a documented diagnosis made using internationally recognised standards and criteria (i.e. DSM-5, ICD-10 or NINCDS-ADRDA).	**1** Ref 3

The processes of assessment and diagnosis		
NUMBER	**STANDARD/CRITERION**	**TYPE**
3.5.13	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).	**1** Ref 2, 7
3.5.15	The patient and the team can obtain a second opinion if there is doubt, uncertainty or disagreement about the diagnosis or treatment.	**1** Ref 7
3.5.17 	Carers are offered individual time with staff members to discuss concerns, family history and their own needs. Sustainability Principle: empower individuals and communities.	**2** Ref 7
3.6	**The outcome of the assessment is communicated to all relevant parties in a timely manner.**	
3.6.1	The team sends a letter 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)*	**2** Ref 7
3.6.2	Patients are asked if they and their carers wish to have copies of letters about their health and treatment.	**1** Ref 7
3.6.4 	The patient and their carer (with patient consent) are offered a copy of the care plan and the opportunity to review this. Sustainability Principle: empower individuals and communities.	**1** Ref 7
3.6.5	Where diagnosis is not disclosed, a clear record of the reason is made.	**2** Ref 2
3.6.6	People who drive are informed of the necessity to report the diagnosis to the DVLA (or equivalent vehicle licensing authority).	**1** Ref 18
3.6.7	A local written protocol is available to assist memory service staff in informing people 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 person is non-compliant or continues to drive without informing the DVLA (or equivalent)*	**2** Ref 2

The processes of assessment and diagnosis: specific conditions		
NUMBER	**STANDARD/CRITERION**	**TYPE**
3.7	**Additional tests and investigations are carried out in accordance with NICE guidance, individual and clinical need, including:**	
3.7.1 	Timely access to brain imaging in the assessment of people with suspected dementia to exclude cerebral pathologies and to help establish the subtype diagnosis. Sustainability Principle: improve value.	**1** Ref 3
3.7.2	Electrocardiogram.	**2** Ref 3
3.7.5	Specialist advice is taken when interpreting investigations/ assessments/scans in people with learning disabilities.	**2** Ref 3

Support for patients and their carers		
NUMBER	**STANDARD/CRITERION**	**TYPE**
3.8	**The memory service is able to offer appropriate support, advice and information to patients and their carers at the time of assessment and diagnosis, as needed**	
3.8.1	Patients and their carers are given pre-diagnostic counselling. *Guidance: This includes a discussion about the possibility of a diagnosis of dementia and does not have to be a formal counselling session*	**2** Ref 3
3.8.2	Information is communicated sensitively.	**1** Ref 18
3.8.3	Information is communicated without unnecessary delay.	**2** Ref 18
3.8.4	When communicating important information to patients, staff are able to dedicate a sufficient amount of time.	**2** Ref 19
3.8.5	Patients are offered a face to face post-diagnostic meeting.	**1** Ref 3, 20
3.8.6 	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* Sustainability Principle: empower individuals and communities.	**1** Ref 3, 17

Support for patients and their carers		
NUMBER	**STANDARD/CRITERION**	**TYPE**
3.8.6.1 M 	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; • Recovery colleges. Sustainability Principle: empower individuals and communities.	**2** Ref 7
3.8.6.2 	Carers have access to a carer support network or group. This could be provided by the service or the team could signpost carers to an existing network. *Guidance: This could be a group/network which meets face-to-face or communicates electronically* Sustainability Principle: empower individuals and communities.	**2** Ref 7
3.8.7	**The service routinely provides patients and their carers with a variety of written information appropriate to their needs.**	
3.8.7.1 M	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*	**1** Ref 7
3.8.7.3 	Where appropriate to their needs, patients and carers are given written information about options for care and treatment, including coping methods and strategies. Sustainability Principle: empower individuals and communities.	**2** Ref 3
3.8.7.5 	Where appropriate to their needs, patients and carers are given written information about, and signposted to, sources of financial and legal advice, and advocacy. Sustainability Principle: empower individuals and communities.	**2** Ref 3, 17
3.8.7.6 	Where appropriate to their needs, patients and carers are given written information about medico-legal issues, including driving. Sustainability Principle: empower individuals and communities.	**2** Ref 3
3.8.7.7 	Where appropriate to their needs, patients and carers are given written information about local and national information sources, including libraries, voluntary organisations and websites. Sustainability Principle: empower individuals and communities.	**2** Ref 3

Support for patients and their carers		
NUMBER	**STANDARD/CRITERION**	**TYPE**
3.8.7.8 	Where appropriate to their needs, patients and carers are given 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* Sustainability Principle: empower individuals and communities.	**2** Ref 3
3.8.7.9	Where appropriate to their needs, patients and carers are given written information about any pharmacological, non-pharmacological or psychosocial interventions that the patient and/or their carer has been offered.	**2** Ref 2
3.8.7.11 M 	The team provides each carer with 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. It also includes other local sources of advice and support such as local carers' groups, carers' workshops and relevant charities* Sustainability Principle: empower individuals and communities.	**2** Ref 7
3.8.7.12 	Where appropriate to their needs, patients and carers are given written information on how to create a document about their own preferences and habits. Sustainability Principle: empower individuals and communities.	**3** Ref 2
3.8.8 M 	Information for patients and carers is written simply and clearly, and can be provided in languages other than English (ensuring cultural relevance if necessary). It is available in easy-to-use/easy-read formats for people with sight/hearing/cognitive difficulties or learning disabilities. Audio, video, symbolic and pictorial materials, communication passports and signers are used as necessary. Sustainability Principle: empower individuals and communities.	**1** Ref 7
3.8.9 	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* Sustainability Principle: empower individuals and communities.	**2** Ref 19

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Section 4

Ongoing care management and follow-up

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Care management		
NUMBER	**STANDARD/CRITERION**	**TYPE**
4.1	**The memory service ensures that each person with memory problems/dementia has a care plan.**	
4.1.0 M	People who are diagnosed with dementia are allocated a named co-ordinator of care. This person should be allocated based on personal need, and may come from various settings, for example primary care, the voluntary sector or memory assessment services.	**1** Ref 17
4.1.1 M 	Every patient has a written care plan, reflecting their individual needs and preferences. Staff members actively seek to 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* Sustainability Principle: empower individuals and communities.	**1** Ref 7, 17
4.1.3 M	The team reviews and updates care plans at least annually.	**1** Ref 7, 17
4.1.5 M 	Carers (with patient consent) are involved in discussions and decisions about the patient's care, treatment and discharge planning. Sustainability Principle: empower individuals and communities.	**1** Ref 7
4.2	**Professionals working within the memory service ensure that the person (and their carer, where appropriate) is able to access a range of post-diagnostic supports and interventions.**	
4.2.1 	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* Sustainability Principle: improve value.	**1** Ref 3
4.2.2 	The service provides or can signpost/refer on to services that will offer information, advice and support to assess and manage pharmacological treatment. Sustainability Principle: improve value.	**1** Ref 3
4.2.4 	The service provides or can signpost/refer on to services that will offer information, advice and support with communication problems. Sustainability Principle: improve value.	**2** Ref 3

Care management		
NUMBER	**STANDARD/CRITERION**	**TYPE**
4.2.5 M 	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. Sustainability Principle: prioritise prevention.	**1** Ref 7
4.2.6 	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. Sustainability Principle: empower individuals and communities.	**2** Ref 3
4.2.9 M 	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. Sustainability Principle: empower individuals and communities.	**1** Ref 7
4.2.11 M 	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). Sustainability Principle: empower individuals and communities.	**2** Ref 10
4.2.12 	The service provides or can signpost/refer on to a range of respite/short break services. Sustainability Principle: empower individuals and communities.	**2** Ref 3
4.2.13 M	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*	**1** Ref 7, 17
4.2.14	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** Ref 3
4.2.17	Patients and their carers are given a point of contact for future enquiries.	**2** Ref 2
4.2.18 N	Patients know who is co-ordinating their care and how to contact them if they have any questions.	**1** Ref 7
6.5.2 M	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** Ref 21

Follow-up		
NUMBER	**STANDARD/CRITERION**	**TYPE**
4.3	**The memory service ensures that each patient is followed up.**	
4.3.1 M	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.	**1** Ref 2

Discharge planning and transfer of care		
NUMBER	**STANDARD/CRITERION**	**TYPE**
4.4	**The memory service ensures that patients and their carers are involved in planning their discharge from the service, and transfer of care.**	
4.4.1	Discharge or onward care planning is discussed at the first and every subsequent care plan review.	**2** Ref 7
4.4.2	Patients and their carers (with patient consent) are involved in decisions about discharge plans. *Guidance: This could be through a formal discharge meeting* Sustainability Principle: empower individuals and communities.	**1** Ref 7
4.4.3 M	A discharge letter is sent to the patient and all relevant parties within 10 days of discharge. The letter includes the plan for: • On-going care in the community/aftercare arrangements; • Crisis and contingency arrangements including details of who to contact; • Medication, including monitoring arrangements; • Details of when, where and who will follow-up with the patient as appropriate.	**1** Ref 7
4.4.4	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. Sustainability Principle: improve value.	**1** Ref 7
4.4.5	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. Sustainability Principle: improve value.	**3** Ref 7

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Section 5

Pharmacological interventions

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NUMBER	**STANDARD/CRITERION**	**TYPE**
5.1	**The memory service provides equal and timely access to antidementia medication in accordance with individual needs.**	
5.1.3 M 	When medication is prescribed, specific treatment goals are set for the patient, the risks (including interactions) and benefits are reviewed, a timescale for response is set and patient consent is recorded. Sustainability Principle: improve value/ consider carbon.	**1** Ref 7
5.1.4 M 	Patients (and their carers, with patient consent) are helped to understand the 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. Sustainability Principle: empower individuals and communities.	**1** Ref 7, 17
5.1.5 M 	Medication reviews take place at a frequency according to the evidence base and clinical need. *Guidance: This includes an assessment of therapeutic response, safety and side effects. Long-term medication is reviewed according to the local shared care protocol* Sustainability Principle: improve value/ consider carbon.	**1** Ref 7
5.1.6 M 	When patients experience side effects from their medication, there is a care plan in place for managing this, which has been developed with the patient. Sustainability Principle: empower individuals and communities.	**1** Ref 7
5.1.7 N 	People with dementia, carers and prescribers are able to contact a specialised pharmacist and/or pharmacy technician to discuss medications. Sustainability Principle: improve value.	**3** Ref 7
5.2	**Antipsychotics are only prescribed as a last resort, after a thorough assessment of risk factors, and their use is reviewed regularly.**	
5.2.1 M 	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. Sustainability Principle: improve value/ consider carbon.	**1** Ref 22, 23, 24, 25
5.2.2 M	Where antipsychotic medication is given, this prescription is recorded and a single, named individual is responsible for undertaking a review.	**1** Ref 26
5.2.2.1 M 	Patients who are prescribed antipsychotics have the appropriate physical health assessments at the start of treatment (baseline), and then every 3 months unless a physical health abnormality arises. Sustainability Principle: prioritise prevention	**1** Ref 7, 23, 24, 25

Pharmacological interventions		
NUMBER	**STANDARD/CRITERION**	**TYPE**
5.2.2.2 N 	Patients prescribed psychotropic medication, e.g. anti-depressants, benzodiazepines, have this reviewed in accordance with NICE guidelines. Sustainability Principle: consider carbon.	**1** Ref 2
5.2.3 M 	The service collects data on the safe prescription of high risk medications such as: lithium, high dose antipsychotic drugs, antipsychotics in combination, benzodiazepines. The service uses this data to make improvements and continues to monitor the safe prescription of these medications on an ongoing basis. Sustainability Principle: prioritise prevention	**1** Ref 7
5.2.4 N	For people 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.	**1** Ref 7

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Section 6

Psychosocial interventions

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Psychosocial interventions		
NUMBER	**STANDARD/CRITERION**	**TYPE**
6.1	**The service provides timely access to psychosocial interventions, based on the needs and preferences of the patient and, where appropriate, their carer.**	
6.1.1 	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* Sustainability Principle: improve value.	**1** Ref 7
6.1.1.1 N	Input from psychologists and occupational therapists is sufficient to provide evidence-based interventions.	**1** Ref 2, 7
6.1.2	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*	**2** Ref 27, 28
6.1.3	An audit of the capacity to provide psychosocial interventions, and the uptake of psychosocial interventions offered is carried out every 2 years.	**3** Ref 2
6.2	**The service provides timely access to psychosocial interventions for cognitive aspects of dementia.**	
6.2.1	Patients have access to a local programme of age appropriate group cognitive stimulation therapy (CST). *Guidance: CST constitutes engagement in a range of activities and discussions aimed at general enhancement of cognitive and social functioning*	**1** Ref 29, 30, 31, 32
6.2.1.1	Patients have access to individual Cognitive Stimulation Therapy (iCST).	**3** Ref 14, 33
6.2.2	People who have participated in group cognitive stimulation therapy have access to an age appropriate maintenance CST programme.	**2** Ref 32, 34
6.2.3	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*	**3** Ref 21, 35, 36, 37, 38
6.2.4	Patients and their carers have access to a group reminiscence programme.	**3** Ref 3, 39
6.3	**The service provides timely access to psychosocial interventions for emotional aspects of dementia.**	
6.3.1 M	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*	**2** Ref 17, 40, 41

Psychosocial interventions		
NUMBER	**STANDARD/CRITERION**	**TYPE**
6.4	**The service provides timely access to psychosocial interventions for occupational and functional aspects of dementia.**	
6.4.2	The memory service has access to advice and support on assistive technology and telecare solutions designed to assist people with activities of daily living.	**2** Ref 3
6.5	**The service provides or can signpost/refer patients and their carers on to interventions for more complex needs, if required.**	
6.5.1 	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* Sustainability Principle: improve value.	**1** Ref 42
6.6	**The service provides timely access to psychosocial interventions for carers.**	
6.6.1 M	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*	**2** Ref 17, 40
6.7	**Patients and their carers are made aware of other non-pharmacological interventions that they may wish to consider.**	
6.7.1	Patients have access to art/creative therapies.	**3** Ref 7, 43, 44
6.7.2	The team signposts younger people with dementia to structured activities such as work, education and volunteering.	**2** Ref 7, 45
6.8	**Staff delivering psychosocial interventions are appropriately trained and supervised.**	
6.8.1 	All staff members who deliver therapies and activities are appropriately trained and supervised. Sustainability Principle: improve value/ staff sustainability.	**1** Ref 7, 47
6.9	**The service monitors people's responses to interventions.**	
6.9.1 M 	Patients have two or more outcome measures (including at least one patient experience measure) recorded at least twice (assessment and one other time point). Sustainability Principle: improve value.	**1** Ref 7, 46
6.9.2 M 	Staff members review progress against patient-defined goals in collaboration with them at the start of treatment, during clinical review meetings and at discharge. Sustainability Principle: empower individuals and communities.	**2** Ref 7

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Quality Indicators

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Quality Indicators

These quality indicators have been introduced to allow MSNAP member services to benchmark themselves on these criteria against other participating memory services. Indicator data collected will be published in the MSNAP National Report. We hope that this will be interesting and useful data for services to collect.

Please note: At this point, the indicator data will not be used to determine the accreditation decision for participating memory services, but will be included in services' reports as contextual data.

Indicator 1	
The percentage of people diagnosed with mild dementia over the past year	
Numerator	**Suggested Data Sources**
The number of people diagnosed with mild dementia by the service in the past year	1. Electronic Patient Information System with standardised scale data. 2. Develop stand-alone diagnosis database with standardised scale data. **Standardised scales suggestions:** a) MMSE/SMMSE score >20. b) Clinical Dementia Rating scale (CDR) score 0.5 or 1. c) Mental Health Clustering Tool (MHCT) Cluster 18: Cognitive impairment (low need). This will include Mild Cognitive Disorder (MCD) diagnosis. To exclude MCD cross reference with ICD code data.
Denominator	**Suggested Data Sources**
The number of people diagnosed with dementia by the service in the past year	1. Electronic Patient Information System ICD 10 codes. 2. Mental Health Clustering Tool (MHCT) Cluster 18,19 & 20. This will include Mild Cognitive Disorder (MCD) diagnosis. To exclude MCD cross reference with ICD code data. 3. Develop stand-alone Diagnosis database.

Indicator 2	
The percentage of people with dementia under the care of the service who have registered their interest in participating in research over the past year	
Numerator	**Suggested Data Sources**
The number of people with dementia under the care of the service registering their interest in participating in research over the past year	1. Request annual data from research organisations/groups your service refers to, e.g. DeNDRoN, other local or national NHS or Commercial research groups. 2. Develop stand-alone database.
Denominator	**Suggested Data Sources**
The number of people with dementia who have had an appointment with the service in the past year	1. Electronic Patient Information System - if available. 2. Estimate from: Current service caseload - assuming all patients on follow up caseload will have at least 1 appointment each year. This may include Mild Cognitive Disorder as well as Dementia dependant on service model. 3. Develop stand-alone database.

Indicator 3	
The percentage of new people with memory problems/dementia in the past year whose initial assessment process began within six weeks of referral	
Numerator	**Suggested Data Sources**
The number of people with dementia/suspected dementia in the past year whose initial assessment process began within six weeks of referral	1. Electronic Patient Information System. 2. Develop stand-alone database.
Denominator	**Suggested Data Sources**
The number of people with dementia/suspected dementia who have had an assessment in the past year	1. Electronic Patient Information System. 2. Develop stand-alone database.

Indicator 4	
The percentage of people with dementia under the care of the service who have accessed psychosocial interventions in the past year	
Numerator	**Suggested Data Sources**
The number of people with dementia under the care of the service who have accessed psychosocial interventions in the past year	1. Registers of people attending service-delivered interventions - individual and group. 2. Registers of people attending psychosocial interventions delivered by other organisations: a) Collate data on referrals made by the service b) Request annual referral data from provider organisations.
Denominator	**Suggested Data Sources**
The number of people with dementia who have had an appointment with the service in the past year (same figure as the denominator for Indicator 2)	1. Electronic Patient Information System. 2. Estimate from: Current service caseload (this may include Mild Cognitive Disorder as well as dementia dependent on service model) + people with dementia discharged from service/transferred to other services in the past year.

Indicator 5	
The proportion of people with dementia in the service's catchment area who have received a diagnosis	
Numerator	**Suggested Data Sources**
The number of people diagnosed with dementia in the service's catchment area	1. Electronic Patient Information System ICD 10 codes. 2. Mental Health Clustering Tool (MHCT) Cluster 18, 19 & 20. This will include Mild Cognitive Disorder (MCD) diagnosis. To exclude MCD cross reference with ICD code data. 3. Develop stand-alone Diagnosis Database.
Denominator	**Suggested Data Sources**
The expected number of people with dementia in the total catchment population	1. Identify from local incidence data. 2. Request information through the Care Commissioning Group.

Indicator 6	
The percentage of people with dementia/suspected dementia who have accessed neuropsychological assessment within the past year	
Numerator	**Suggested Data Sources**
The number of people with dementia/suspected dementia who have accessed neuropsychological assessment within the past year	1. Electronic patient information system. 2. Develop stand-alone database.
Denominator	**Suggested Data Sources**
The number of people with dementia/suspected dementia who have had an assessment in the past year (same figure as the denominator for Indicator 3)	1. Electronic patient information system. 2. Develop stand-alone database.

Indicator 7	
The percentage of people with dementia/suspected dementia under the care of the service who have been offered psychosocial interventions within the past year	
Numerator	**Suggested Data Sources**
The number of people with dementia under the care of the service who have been offered psychosocial interventions within the past year	1. Electronic Patient Information System. 2. Develop stand-alone database.
Denominator	**Suggested Data Sources**
The number of people with dementia who have had an appointment with the service in the past year (same figure as the denominator for Indicators 2 and 4)	1. Electronic Patient Information System. 2. Develop stand-alone database.

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Glossary of terms and abbreviations

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Glossary of terms and abbreviations

Admiral nurses/ Admiral nursing service	Specialist mental health nurses who work in the field of dementia, with particular emphasis on supporting family carers
Adults with Incapacity (Scotland) Act	The Adults with Incapacity (Scotland) Act 2000 provides ways to help safeguard the welfare and finances of people who lack capacity
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
Antidementia drugs	Drugs used to treat some types of dementia
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 Behaviour Therapy	A psychological therapy that addresses unhelpful emotions, behaviours and thoughts
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
Co-ordinator of care	A named individual who is designated as the main point of contact and support for a person who has a need for ongoing care
Data Protection Act	Legislation that governs the protection of personal data in the UK
Day care	Day Care provides care for a person during the day, away from the person's home
Dementia advisor	A service primarily for people 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

DSM-5	Psychiatric Diagnoses are categorised by the Diagnostic and Statistical Manual of Mental Disorders, 5th. Edition
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
E-learning	Electronically supported learning and teaching, e.g. computer-based, via the internet etc.
Functional and behaviour analysis based interventions	A behavioural intervention that involves exploring the meaning or purpose of an individual's behaviour
GP	General Practitioner or 'family doctor'
HIV	Human immunodeficiency virus
ICD-10	The International Statistical Classification of Diseases and Related Health Problems is a medical classification list for the coding of diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases
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
NINCDS-ADRDA	Criteria used for the diagnosis of Alzheimer's Disease. Proposed by the National Institute of Neurological and Communicative Disorders and Stroke and the Alzheimer's Disease and Related Disorders Association
Peer support groups	Groups where other people in a similar situation can meet up to talk, ask for advice and offer support to each other
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 with dementia with dignity and respect
Personal development planning	A plan that includes short term and long-term goals relating to current role, future career and to personal development

Pharmacological treatment	Treatment using medication
Power of Attorney	A Lasting Power of Attorney is a legal document that lets you appoint someone to make decisions about your welfare, money or property
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
Reminiscence Therapy	Reminiscence therapy is a biographical intervention that involves either group reminiscence work, where the past is discussed generally, or the use of stimuli such as music or pictures
Safeguarding	Protecting vulnerable people from abuse or neglect and making sure their rights and needs are met
SCIE	Social Care Institute for Excellence
Sheltered housing	Most commonly refers to grouped housing for older and/or vulnerable people, such as a block or "scheme" of flats or bungalows
SIGN	Scottish Intercollegiate Guidelines Network. Publishes guidance for health services in Scotland
Signposting	Linking people up with different services or organisations that could help them
Structural imaging	The use of various techniques to image the structure of the brain to help with diagnosis
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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Appendices

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Appendix 1: Non-dementia memory disorders

These memory disorders require specialist investigation and management which is usually beyond the scope of local memory services.

Transient disorders of memory

These include: toxic confusional states, head injury, epilepsy, alcoholic blackout, transient global amnesia, and transient epileptic amnesia.

Persistent neurological memory and cognitive disorders

These include: amnesic syndrome; and memory/cognitive disorders due to viral encephalitis, limbic encephalopathies, cerebral hypoxia, deficiency syndromes (e.g. Korsakoff syndrome, B12 deficiency), head injury, cerebrovascular disease (e.g. stroke, subarachnoid haemorrhage), cerebral tumours, epilepsy, or meningitis.

Memory and cognitive problems complicating other neurological conditions

These can occur in: Parkinson's disease, Multiple Sclerosis, sleep disorders, HIV disease, and may relate to pharmacological or other treatments (e.g. radiotherapy, chemotherapy).

Memory and cognitive problems related to psychiatric conditions

These can occur in schizophrenia or depressive pseudodementia. They can also arise from psychological causation particularly in younger adults for example in Post-Traumatic Stress Disorder, psychogenic fugue or other dissociative states.

Early onset and unusual dementias

There are also specific forms of dementia, particularly those occurring in younger adult populations, where the dominant presenting problems are not in memory (they may be in behaviour, language or vision for example). These disorders include Creutzfeldt-Jakob disease, Huntington's disease, frontotemporal dementias, posterior cerebral atrophy, or unusual presentations of Lewy body dementia. These require referral direct to a neurological or appropriate specialist service. This will vary according to availability but may be the local memory services provided that they include appropriate expertise from neurology and neuropsychology.

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