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
(focusing primarily on the diagnostic assessment and treatment of people with dementia)

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 criteria would result in a significant threat to patient safety, rights or dignity and/or would breach the law;

Type 2: criteria that an accredited service would be expected to meet;

Type 3: criteria that an excellent service should meet or criteria 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 first of the four objectives of the National Dementia Strategy is to achieve "good-quality early diagnosis and intervention for all"[1]. To help achieve this, the National Audit Office has recommended that "Primary Care Trusts commission sufficient memory services, which are based on best practice and accredited by the Memory Services National Accreditation Programme"[2].

If dementia is diagnosed early, more can be done to delay progression of the disease[2] 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[3]. The National Audit Office[4] concluded that "early diagnosis and intervention in dementia is cost-effective, yet there is a significant diagnosis gap and only a third to a half of people ever receive a formal diagnosis… the average reported time to diagnose the disease in the UK is… up to twice as long as in some countries". Good quality memory services should be able to address some of this inequality.

The MSNAP Standards for Memory Services and associated criteria, drawn from key documents, will help services demonstrate compliance with key policy and guidance available on the assessment and diagnosis of dementia. The standards also support implementation of NICE guidelines, the NICE Quality Standard for Dementia, and many of the objectives outlined in the National Dementia Strategy, such as Objective 2: Good-quality early diagnosis and intervention for all; Objective 3: Good quality information for those with diagnosed dementia and their carers; and Objective 15: Improved assessment and regulation of health and care services and of how systems are working for people with dementia and their carers.

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 older 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, the amnesic syndrome, and cognitive complications of neurological and psychiatric disorders). Similarly, rare forms of dementia may require specialist assessment services. (see Appendix page 30).

[1] Department of Health (2009). Living well with dementia: A National Dementia Strategy. London: Department of Health.

[2] National Audit Office (2010). Improving dementia services in England: An interim report. London: The Stationary Office.

[3] 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.

[4] National Audit Office (2007) Improving Services and Support for People with Dementia. London: National Audit Office.

The Development of the 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 with other participating services.

The key principles of the memory assessment network are the same as those that underpin the 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 two-stage process involving a period of self review followed by peer review. Local memory service teams are being supported to systematically review a variety of aspects of the services that they provide.

An overview of MSNAP

The 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 memory problems/dementia and carers. The standards have been piloted by 13 memory services in the north-west of England and have been revised in line with feedback from the pilot sites. The standards will be subject to an annual 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. At this stage, the **core** standards and criteria are mainly focused on the functions of 'assessment' and 'diagnosis'. In this third edition of the MSNAP standards, a number of standards on pharmacological treatment have been added to the core set. There is also a **new optional module** on psychosocial interventions that MSNAP members can opt-in to being reviewed against.

Overarching principles

People with memory problems/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 memory problems/dementia and their carers receive a service that is person-centred and takes into account their unique and changing personal, psychosocial and physical needs.

The standards and criteria cover the following topics:

- management systems for the service;
- resources available to support assessment and diagnosis;
- assessment and diagnosis;
- pharmacological interventions;
- signposting to ongoing care management and follow up.

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 criteria would result in a significant threat to patient safety, rights or dignity and/or would breach the law;

Type 2: criteria that an accredited service would be expected to meet;

Type 3: criteria that an excellent service should meet or criteria that are not the direct responsibility of the service.

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

The 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: a series of questions about the experiences of people with memory problems/dementia of different aspects of the services provided by the memory service, e.g. the assessment process, the environment, the provision of information and choice.

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

Staff questionnaire: a series of questions about memory service staff's experiences of different aspects of the services provided by the memory service, e.g. staff support, supervision and training, etc.

Referrer questionnaire: a brief series of 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.

Checklist: a checklist of policies, protocols and procedures that govern service provision.

The 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 memory problems/dementia or a carer.

Stage 3: **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 4: **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 the Royal College of Psychiatrists Centre for Quality Improvement and their peers through the programme's email discussion group. Email 'JOIN' to memory-chat@cru.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.

Acknowledgements

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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	Health and Social Care Commissioners, Practice Based Commissioners and Primary Care Trusts have formally commissioned memory services	**2** *Ref 28*
1.1.2	Health and Social Care Commissioners and Practice Based Commissioners have in place a detailed analysis of the demographic and ethnic profile of their population, to assess needs and plan for current and future provision of services for the assessment and diagnosis of memory problems	**2** *Ref 28*
1.1.3	Health and Social Care Commissioners have undertaken a joint needs assessment and a review of the current service provision of services for the assessment and diagnosis of memory problems	**2** *Ref 28*
1.1.4	Primary Care Trusts and Practice Based Commissioners, in consultation with local partners, people with memory problems/dementia and carers, have a local integrated care pathway based on best practice, which includes referral to national or regional specialist centres and exit from the service, where appropriate	**2** *Ref 14*
1.1.5	People with memory problems/dementia and their carers are involved in service planning, developing and monitoring the service **Guidance:** *i.e. ongoing face-to-face involvement with several service users/carers, in a range of settings*	**2** *Ref 5, 17, 22*

Quality Assurance, Research and Service Development		
1.2	**The memory service demonstrates that there is a commitment to ongoing quality improvement and research**	
1.2.1	The memory service conducts audit and/or service evaluation on compliance with relevant guidelines, at least once every two years **Guidance:** *e.g. compliance with NICE, SIGN, etc*	**2** *Ref 17*
1.2.2	The memory service conducts audit and/or service evaluation on referrals to the memory service, at least once every two years **Guidance:** *e.g. including demographic cultural issues, waiting times, etc, as appropriate*	**2** *Ref 17*
1.2.3	The memory service conducts audit and/or service evaluation on adherence to guidelines around consent and assessing capacity, at least once every two years	**2** *Ref 17*
1.2.4	Local GPs and referrers are surveyed about their experiences of using the service, at least once every two years	**2** *Ref 2, 3*
1.2.5	People with memory problems/dementia and their carers are asked about their experiences of using the service at least once a year, and their feedback has been used to improve the service **Guidance:** *this might include customer surveys, focus groups or suggestion boxes*	**2** *Ref 5, 17*
1.2.6 N	The service provides people with dementia 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	**2** *Ref 28, 29, 30*
1.2.7 N	The service ensures that all people with dementia and their carers are offered the opportunity to register their interest in participating in research	**2** *Ref 28, 29, 30*

Complaints and Untoward Incidents		
1.3	**All complaints and untoward incidents are dealt with in accordance with appropriate Trust rules and guidelines**	
1.3.1	There are policies and procedures for managing complaints	**2** *Ref 8, 9, 27*
1.3.2	Information is provided for people with memory problems/dementia and their carers about how to make a complaint about any aspect of the service **Guidance:** *this should include information on how to report abuse or inappropriate care and might include giving out information leaflets or displaying a poster in the waiting area*	**2** *Ref 8, 9, 27*
1.3.3	There is evidence of audit, action and feedback from complaints and suggestions	**2** *Ref 8, 9, 27*

Supporting Vulnerable People		
1.4	**The memory service has systems and procedures to ensure the safety of vulnerable adults, in accordance with appropriate Trust rules and guidelines and relevant statutory guidance** **• Ref 8 (England), Ref 9 (Northern Ireland), Ref 23 & 24 (Scotland), Ref 26 (Wales)**	
1.4.1	The service is compliant with statutory guidance on the safeguarding of vulnerable adults and children • **Ref 15** – *Pg 15, Recommendation 1.1.6.1*	**1** *Ref 15*

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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 people with memory problems and their carers**	
2.1.1	Where the service is provided in (a) clinic setting(s), the location of the clinic is accessible to the local population **Guidance:** *e.g. accessible by public transport, car parking available, etc*	**2** *Ref 17*
2.1.2	Where the service is provided in (a) clinic setting(s), free transport to and from the memory service is available	**3** *Ref 13*
2.1.3	The assessment takes place at a time and in an environment that is acceptable to all parties	**2** *Ref 13*
2.1.4	The service has the capacity to make home assessments if necessary	**2** *Ref 5, 22*
2.1.5	The service has access to translators and interpreters to meet the needs of the people using the service **Guidance:** *consider needs associated with language, learning disability, sensory impairment, etc*	**2** *Ref 15*
2.1.6	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*	**2** *Ref 15*

Staffing for the memory service		
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 memory problems/dementia:		
2.2.1	A medical practitioner and a multidisciplinary team consisting of at least two other professions	**1** *Ref 13*
2.2.2	A mental health nurse	**2** *Ref 6, 13*
2.2.3	A clinical psychologist or neuropsychologist	**2** *Ref 6, 13*
2.2.4	An occupational therapist	**2** *Ref 6, 13*
2.3	The service has access to adequate administrative support **Guidance:** *ascertain whether the level of available support meets current demand*	**2** *Ref 13*

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 memory problems/dementia:** **Guidance:** *access to can include the speciality of the medical lead*	
2.4.1	A speech and language therapist	**2** *Ref 6*
2.4.2	A dietician	**2** *Ref 6*
2.4.3	A physiotherapist	**2** *Ref 6*
2.4.4	A social worker	**2** *Ref 6*

2.4.5	A geriatrician	**2** *Ref 6, 13*
2.4.6	A neurologist	**2** *Ref 6, 13*
2.4.7	An old age psychiatrist	**2** *Ref 6, 13*
2.4.8 M	An Admiral Nursing Service	**3** *Ref 6*

Functioning of the memory service team		
2.5	**Memory service staff work effectively as a multidisciplinary team**	
2.5.1	There is a named designated service lead who has adequate dedicated sessional time to carry out the tasks associated with the role **Guidance:** *ascertain whether the number of sessions meets current demand*	**1** *Ref 13*
2.5.2	There are opportunities for the multidisciplinary team to meet at least once a week to discuss clinical matters	**2** *Ref 5*
2.5.3	There are opportunities for the multidisciplinary team to meet at least once a month to discuss business/governance/administrative matters	**2** *Ref 5*
2.5.4	There are systems in place that support the staff involved in assessment and diagnosis to work efficiently and effectively as a multidisciplinary team **Guidance:** *this might include IT systems, communication books, bulletin boards, email, up-to-date contact numbers, formal systems for relaying messages*	**2** *Ref 2, 3, 22*
2.5.5	There is clear leadership and an up-to-date line management structure, with clear lines of accountability within the service	**2** *Ref 5*

2.5.6	The roles and responsibilities of the team members are defined **Guidance:** *e.g. in up-to-date job descriptions, including the appropriate grade for the position*	**2** *Ref 19*
2.5.7 M	The memory service prioritises continuity of care **Guidance:** *Ensure that a core and consistent team work in the service every week and by providing access to a care co-ordinator (e.g. lead professional, key worker, dementia advisor, care navigator, case manager)*	**2** *Ref 19*
2.5.8	Feedback from staff is routinely monitored to influence service provision **Guidance:** *e.g. plans from meetings, away days, evaluation of service*	**3** *Ref 17*

Staff Supervision and Support Mechanisms

2.6	**Staff receive regular appraisal and supervision and know how to gain additional advice and support when they need it**	
2.6.1	There is a strategy and policy for staff annual appraisal, personal development planning and supervision	**1** *Ref 17*
2.6.2	Staff know how to obtain additional advice and support when they need it	**2** *Ref 20*
2.6.3	Staff receive adequate professional and clinical supervision **Guidance:** *consider whether the frequency of supervision is sufficient and whether it is carried out by a person with appropriate experience and qualifications*	**1** *Ref 5*

2.6.4	Staff receive adequate management supervision **Guidance:** *consider whether the frequency of supervision is sufficient and whether it is carried out by a person with appropriate experience and qualifications*	**2** *Ref 5*

Staff Training and Development

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 have access to study facilities and study time	**2** *Ref 28*
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	**2** *Ref 18*
2.7.3	There are arrangements for staff cover to allow staff to attend training	**2** *Ref 18*

2.8	**Staff have completed training and development opportunities commensurate with their role within the service. This includes:** **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.*	
2.8.1	Dementia knowledge and awareness Guidance: *e.g. the natural history of the different types of dementia, the main signs and symptoms, the progression and prognosis, and the consequences for the person with dementia and his or her carer and family* • **Ref 15 –** *Pg 17, Recommendation 1.1.9.2*	**1** *Ref 15*

2.8.1.1 N	Dementia awareness training for administrative staff	**2** Ref 28
2.8.2	Safeguarding of vulnerable adults policy and procedures **Guidance:** *e.g. how to report concerns or malpractice, who to contact* • **Ref 15 –** *Pg 17, Recommendation 1.1.9.2*	**1** *Ref 15*
2.8.3	Applying the principles of person-centred care • **Ref 15** *– Pg 17, Recommendation 1.1.9.2*	**1** *Ref 15*
2.8.4 M	Communication skills relevant to the role **Guidance:** *This applies to all staff, including admin staff, but the content is likely to differ depending on role.* *Examples may include: the importance of and use of communication skills. For clinical staff it may include: counselling skills; the use of different communication methods and visual aids.*	**2** *Ref 5, 15*
2.8.5	Awareness of local demographic factors, including ethnic/cultural diversity and use of culturally appropriate measures	**2** *Ref 15*
2.8.6	The assessment and pharmacological treatment of dementia **Guidance:** *this would include the administration of medication and monitoring of side effects*	**2** *Ref 15*
2.8.7 M	Non-pharmacological interventions **Guidance:** *e.g. evidence-based psychological therapies such as Cognitive Stimulation Therapy, Cognitive Behaviour Therapy, functional and behaviour analysis based interventions.*	**2** *Ref 15*

2.8.8	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 15*
2.8.9	The Mental Capacity Act or the Adults with Incapacity (Scotland) Act	**2** *Ref 21*
2.8.10	Undertaking nutritional screening using a validated nutritional risk assessment tool	**3** *Ref 15*

Joint Working		
2.9	**The memory service works closely with other professionals, agencies and providers to support the processes of assessment and diagnosis**	
2.9.1	The service has agreed protocols with the General Practitioners/ Primary Care Trust in relation to the basic dementia screen and blood tests required at the time of presentation	**2** *Ref 13*
2.9.2	There is a policy in place regarding the sharing of information between identified personnel and agencies in accordance with the Data Protection Act and Mental Capacity Act or Adults with Incapacity (Scotland) Act (or equivalent) and their codes of practice **Guidance:** • **Ref 12** - *You should make sure that patients are aware that personal information about them will be shared within the health care team, unless they object, and of the reasons for this. It is particularly important to check that patients understand what will be disclosed if you need to share identifiable information with anyone employed by another organisation or agency who is contributing to their care* • **Ref 15** - *Pg 14, recommendation 1.1.4.3*	**1** *Ref 12, 15*
2.9.3	Systems allow staff to access and share patient information, such as hospital records and investigative results, without undue delay	**1** *Ref 17*

Liaison		
2.10	**The memory service offers a range of supports to promote early identification and referral into the service**	
2.10.1	Written information about the memory service is distributed to GP surgeries and other public places in languages and formats that can be understood by local people	**2** *Ref 2, 3*
2.10.2	The service provides advice to other professionals and staff whose responsibilities include providing care and treatment of people with memory problems/dementia **Guidance:** *e.g. GPs; residential care, nursing homes and sheltered housing; domiciliary care; day care; hospital care, including inpatient services*	**2** *Ref 6*
2.10.3	The service provides training to other professionals and staff whose responsibilities include providing care and treatment of people with memory problems/dementia **Guidance:** *e.g. GPs; residential care, nursing homes and sheltered housing; domiciliary care; day care; hospital care, including inpatient services*	**2** *Ref 6*
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 memory problems/dementia **Guidance:** *e.g. GPs; residential care, nursing homes and sheltered housing; domiciliary care; day care; hospital care, including inpatient services*	**2** *Ref 6*
2.10.5 N	The memory service has links with local home care and social care services	**2** *Ref 28*

The Clinic Environment (where applicable)		
2.11	**Any clinic run by the memory service is accommodated in an environment that is appropriate to the needs of people with memory problems/dementia**	
2.11.1	The clinic is clean and comfortable and has a welcoming atmosphere	**2** *Ref 17*
2.11.2	The environment is suitable for people with memory problems/ dementia and their carers **Guidance:** *e.g. firm seating at the right height, handrails, good lighting, large signs, accessible for people with physical disabilities, etc*	**2** *Ref 13*
2.11.3	There is easy access to suitable toilet facilities	**1** *Ref 13*
2.11.4	Assessment rooms are quiet, comfortable and private	**2** *Ref 13*
2.11.5	Conversations cannot be heard outside of meeting rooms	**1** *Ref 19*

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 13*
2.12.2	The memory service has the facility to store and access records and other key materials when required	**2** *Ref 13*

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Section 3

Assessment and Diagnosis

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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	There are policies and protocols for referring into the service	**1** *Ref 15*
3.1.2	Initial contact is made with all people who are newly referred within two to three weeks of referral	**2** *Ref 28*
3.1.3	The assessment process begins no later than four to six weeks of referral	**2** *Ref 28*
3.1.4 N	The service follows up people who do not attend appointments and identifies the reason for non-attendance	**2** *Ref 28*
3.1.5 N	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 28*

Dignity, Consent and Capacity, and Confidentiality		
3.2	**The memory service is designed and managed so that the respect and dignity of people with memory problems/dementia and their carers is preserved**	
3.2.1	Staff are courteous and treat people and their carers with dignity and respect at all times • **Ref 15** – *Pg 12, Recommendation 1.1.1.2*	**1** *Ref 15*
3.2.2	Staff ensure that people and their carers understand what is being done in the assessment process, and why	**1** *Ref 13*

3.3	**Staff follow clear procedures for gaining consent and ensure that people with memory problems/dementia 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*	
3.3.1	The service provides access to an advocacy service that includes Independent Mental Capacity Advocates	**2** *Ref 18*
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	There are policies/guidelines around assessing capacity	**1** *Ref 7*
3.3.4	Staff check whether or not people have understood information that they have been given	**1** *Ref 15*
3.3.5	Staff ensure people have been involved in decision making processes and that there is no coercion	**2** *Ref 15*
3.3.7	There are systems in place to ensure that the service takes account of any advance directive/decision that the person has made	**3** *Ref 7*

3.4	**Personal information is kept confidential unless this is detrimental to the person's care**	
3.4.1	People who are assessed for the possibility of dementia are asked if they wish to know the diagnosis • **Ref 15** – *Pg 23, Recommendation 1.4.1.2*	**1** *Ref 15*
3.4.2	People who are assessed for the possibility of dementia are asked with whom the outcome should be shared • **Ref 15** – *Pg 23, Recommendation 1.4.1.2*	**1** *Ref 15*
3.4.3	People are informed of the process of how and when they may access their current records if they wish to do so	**2** *Ref 28*

The Processes of Assessment and Diagnosis

3.5	**The memory service ensures that a diagnosis of dementia is made only after a comprehensive and holistic assessment of the person's needs by appropriate professionals, either within the service or elsewhere. This includes:**	
3.5.1	Basic dementia screen and blood tests **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*	**1** *Ref 6, 15, 22*
3.5.2	History taking	**1** *Ref 15*

3.5.3	A physical examination and other appropriate investigations	**1** *Ref 15*
3.5.4	A review of medication in order to identify and minimise the use of drugs, including over-the-counter products, that may adversely affect cognitive functioning	**1** *Ref 15*
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, e.g. the Mini Mental State Examination (MMSE)*	**1** *Ref 6, 13, 15, 22*
3.5.6	A subjective and objective assessment of a person's life, social, family and carer history, circumstance and preferences, as well as their physical and mental health needs, and current level of functioning and abilities, including an interview with an informant • **Ref 15** – *Pg 16, recommendation 1.1.7.2*	**1** *Ref 15*
3.5.7	A check of vision, hearing and mobility • **Ref 6** – *Pg 31, recommendation 2.32*	**1** *Ref 6*
3.5.8	An assessment for medical co-morbidities	**1** *Ref 15*
3.5.9	An assessment for key psychiatric features, including depression and psychosis	**1** *Ref 15*
3.5.10	A risk assessment covering areas appropriate to the individual **Guidance:** *e.g. falls, risk to self*	**1** *Ref 22*
3.5.10.1 N	An evaluation of the person's living situation and any associated risks	**2** *Ref 28*

3.5.11 M	Internationally recognised standards and criteria (i.e. ICD-10, DSM-IV or NINCDS-ADRDA) are used for the diagnosis of Alzheimer's disease and other types of dementia	**1** *Ref 15*
3.5.12	Interpretation of the scores from cognitive tests (such as the MMSE) should take full account of other factors known to affect performance **Guidance:** *this should include educational level, skills, prior level of functioning and attainment, language, and any sensory impairments, psychiatric illness or physical/neurological problems*	**2** *Ref 15*
3.5.13 N	The service has access to in-depth neuropsychological assessment as required (e.g. for early onset dementia, complex or abnormal presentations)	**1** *Ref 28*

3.6	**The outcome of the assessment is communicated to all relevant parties in a timely manner**	
3.6.1 M	The letter/information sent to the referrer contains the following components: • diagnosis • conclusions concerning the care needs of the person with memory problems/dementia and their carer • any need for GP review of the person's physical risk factors (e.g. risk of stroke, high blood pressure, diabetes, smoking, medication)	**1** *Ref 10*
3.6.2	People are asked if they would like to receive a copy of the letter sent to the referrer	**2** *Ref 23*
3.6.3	People are asked if they would like their carer to receive a copy of the letter sent to the referrer	**2** *Ref 15*
3.6.4 M	People are asked if they would like to receive a personalised letter/document containing information about their diagnosis and care needs for them and their carer	**3** *Ref 23*

3.6.5	Where diagnosis is not disclosed, a clear record of the reasons is made	**2** *Ref 26*
3.6.6	People who drive are informed of the necessity to report the diagnosis to the DVLA (or equivalent)	**1** *Ref 22*
3.6.7 M	A local 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)*	**3** *Ref 28*

The Processes of Assessment and Diagnosis: Specific Conditions

3.7	**Additional tests and investigations are carried out in accordance with individual and clinical need, including:**	
3.7.1 M	The service has timely access to structural imaging in the assessment of people with suspected dementia to evaluate cerebral pathologies and to help establish the subtype diagnosis • **Ref 15** - *Pg 25, Recommendation 1.4.3.2*	**1** *Ref 15*
3.7.2	Electrocardiogram	**2** *Ref 15*
3.7.3	Chest x-ray	**2** *Ref 15*
3.7.4	Testing for syphilis serology or HIV **Guidance:** *this must be with the person's consent and with appropriate counselling services made available*	**2** *Ref 15*
3.7.5	Specialist advice is taken when interpreting investigations/ assessments/scans in people with learning disabilities	**2** *Ref 15*

Support for People and their Carers		
3.8	**The memory service is able to offer appropriate support, advice and information to people with memory problems/dementia and their carers at the time of assessment and diagnosis, as needed**	
3.8.1	People and their carers are given the opportunity to discuss what might come out of the assessment before it is carried out	**2** *Ref 15*
3.8.2	Information is communicated sensitively	**1** *Ref 22*
3.8.3	Information is communicated without unnecessary delay	**2** *Ref 22*
3.8.4	When communicating important information to people, staff are able to dedicate adequate time	**2** *Ref 5, 6, 14*
3.8.5	People are given adequate opportunities to talk through the implications of their diagnosis with members of the team, immediately after and/or during the days after receiving a diagnosis **Guidance:** *ascertain whether the supports offered were sufficient to meet the needs*	**2** *Ref 15*
3.8.6	People and their carers are able to access post-diagnostic support groups **Guidance:** *i.e. groups run by the service or other local providers*	**2** *Ref 15*
3.8.6.1 N	The memory service helps people with dementia, carers and the voluntary sector to develop peer support networks and/or signposts people into available networks	**3**

3.8.7 M	The service routinely provides people and their carers with a variety of written information appropriate to their needs, about the following: • **Ref 15** – *Pg 27-28, recommendation 1.4.6.2*	
3.8.7.1	• the signs and symptoms of dementia	**2** *Ref 15*
3.8.7.2	• the course and prognosis of the condition	**2** *Ref 15*
3.8.7.3	• options for care and treatment, including coping methods and strategies	**2** *Ref 15*
3.8.7.4	• local care and support services/support groups	**2** *Ref 15*
3.8.7.5	• sources of financial and legal advice, and advocacy	**2** *Ref 15*
3.8.7.6	• medico-legal issues, including driving	**2** *Ref 15*
3.8.7.7	• local and national information sources, including libraries, voluntary organisations and websites.	**2** *Ref 15*
3.8.7.8 M	• 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 and social engagement*	**2** *Ref 15*
3.8.7.9 N	• any pharmacological, non-pharmacological or psychosocial interventions that the person and/or their carer has been offered	**2** *Ref 28*
3.8.8	Information can be made available as appropriate in a range of formats, including languages other than English, and in forms which people with cognitive, specific language, sight, learning and other disabilities can use • **Ref 15** – *Pg 13, recommendation 1.1.1.7*	**2** *Ref 15*

3.8.9	The service has access to specialist post-diagnostic counselling provided by an appropriately qualified professional for people with specific needs **Guidance:** *e.g. genetic and rarer disorders, and abnormal adjustment reactions to the diagnosis*	**3** *Ref 5, 14*
3.8.10	Any advice given is recorded in the notes • **Ref 15** – *Pg 28, recommendation 1.4.6.2*	**1** *Ref 15*

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Section 4

Pharmacological Interventions

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Pharmacological Interventions		
NUMBER	**STANDARD/CRITERION**	**TYPE**
5.1 N	**The memory service provides equal and timely access to anti-dementia medication in accordance with individual needs**	
5.1.1 N	The service has a locally agreed protocol, based on NICE/SCIE guidance, which ensures that people with dementia have access to anti-dementia medication in accordance with their needs	**2** *Ref 91, 92*
5.1.2 N	The service audits the profile of people prescribed pharmacological treatment for dementia, to ensure equality of access for people from different ethnic groups, in particular those from different cultural backgrounds	**2** *Ref 91, 92*

5.2 N	**Antipsychotics are only prescribed as a last resort, after a thorough assessment of risk factors, and their use is reviewed regularly**	
5.2.1 N	People with dementia 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	**2** *Ref 91, 92*
5.2.2 N	Where antipsychotic medication is given, this prescription is recorded and a single, named individual is responsible for undertaking a review **Guidance:** *when stabilised on medication, review should take place at least every three months*	**2** *Ref 88*
5.2.3 N	A local audit surrounding the prescription of antipsychotic drugs for people with dementia has been carried out in the last year	**3** *Ref 88, 91*

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Section 5

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**	
4.1.1	The service supports personalised care planning that incorporates appropriate agencies/services if necessary • **Ref 6** – *Pg 34, recommendation 2.40*	**1** *Ref 6*

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 people who develop non-cognitive symptoms **Guidance:** *e.g. mood disorders, psychotic symptoms and behaviour that challenges* • **Ref 15** – *Pg 33, Recommendation 1.7.1.1*	**1** *Ref 15*
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 • **Ref 15** – *Pg 30, Recommendation 1.6.2*	**1** *Ref 15*
4.2.3	The service can signpost/refer on to voluntary organisations and support groups such as Age UK, Dementia UK and the Alzheimer's Society, for follow up support and information	**2** *Ref 6*

4.2.4	The service provides or can signpost/refer on to services that will offer information, advice and support with communication problems • **Ref 15** – *Pg 12, Recommendation 1.1.1.4*	**2** *Ref 15*
4.2.5	The service provides or can signpost/refer on to services that will offer information, advice and support on modifiable risk factors for dementia **Guidance:** *e.g. smoking, excessive alcohol consumption, obesity, diabetes, hypertension and raised cholesterol*	**2** *Ref 5, 13, 22*
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 • **Ref 15** – *Pg 42, Recommendation 1.10.1.4*	**2** *Ref 15*
4.2.7	The service provides or can signpost/refer on to services that provide a range of psychological and social interventions **Guidance:** *e.g. cognitive stimulation therapy and reminiscence groups*	**2** *Ref 5, 6, 15*
4.2.8	The service provides or can signpost/refer on to services that provide individual or group psychoeducation • **Ref 15** – *Pg 44, Recommendation 1.11.2.2*	**2** *Ref 15*
4.2.9	The service provides or can signpost/refer on to services that can advise on welfare benefits	**2** *Ref 14*
4.2.10	The service provides or can signpost/refer on to peer support/self-help groups	**2** *Ref 4*

4.2.11 M	The service provides or can signpost/refer on to dementia advisor services (includes Admiral Nurses, dementia navigators or other specialist nurses)	**3** *Ref 4*
4.2.12	The service provides or can signpost/refer on to a range of respite/short break services • **Ref 15** – *Pg 45, Recommendation 1.11.3.1*	**2** *Ref 15*
4.2.13	The service provides or can signpost/refer carers on for a full assessment of their needs • **Ref 15** – *Pg 44, Recommendation 1.11.1.1*	**1** *Ref 15*
4.2.14	The service provides or can signpost/refer on to services that offer information, advice and support on a range of legal matters associated with the loss of capacity, including: power of attorney, managing finances, advance directives etc • **Ref 15** – *Pg 14, Recommendation 1.1.4.4*	**2** *Ref 15*
4.2.15	The service is able to refer to genetic counselling for people and their unaffected relatives (where there is likely to be a genetic cause for their dementia) • **Ref 15** – *Pg 21, Recommendation 1.3.1.3*	**3** *Ref 15*

Follow Up		
4.3	**The memory service ensures that each person with memory problems/dementia is followed up**	
4.3.1 M	The service provides follow up based on clinical need (or refers people on to appropriate agencies/services for follow up) taking into account local protocols and the preferences of people and their carers	**1** *Ref 5*

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Section 6

Psychosocial Interventions

(Optional module)

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Psychosocial Interventions *(Optional Module)*		
NUMBER	**STANDARD/CRITERION**	**TYPE**
6.1 N	**Access to psychosocial interventions is based on the needs and preferences of the person with dementia and, where appropriate, their carer**	
6.1.1 N	The service has access to a range of evidenced-based psychosocial interventions	**2** *Ref 38, 42, 53, 55, 80, 66*
6.1.2 N	Psychosocial interventions and post-diagnostic support are available regardless of dementia subtype **Guidance:** An audit should be carried out of the diagnoses of people offered/participating in psychosocial interventions and support groups	**1** *Ref* 67, 68

6.2 N	**The service provides access to psychosocial interventions for cognitive aspects of dementia**	
6.2.1 N	People with dementia have access to a local programme of group Cognitive Stimulation Therapy (CST)	**2** *Ref* 14, 25, 38, 42, 45, 46, 51, 68
6.2.2 N	People who have participated in group cognitive stimulation therapy have access to a maintenance CST programme	**2** 1, 41
6.2.3 N	People with dementia have access to cognitive rehabilitation	**3** *Ref* 10, 11, 17, 56, 59
6.2.4 N	People with dementia and their carers have access to a group reminiscence programme	**3** *Ref* 6, 50, 77

6.3 N	**The service provides access to psychosocial interventions for emotional aspects of dementia**	
6.3.1 N	People with dementia have access to interventions to address emotional aspects of their diagnosis, in line with their individual needs **Guidance:** *e.g.* • *Life story work* • *Cognitive behaviour therapy* • *Reminiscence therapy*	**2** *Ref* 6, 9, 13, 14, 43, 68, 78, 81, 82, 83

6.4 N	**The service provides access to psychosocial interventions for occupational and functional aspects of dementia**	
6.4.1 N	People have access to personally tailored occupational therapy to assist them with their occupational and functional needs and to help maintain their health and wellbeing, independence and community living	**2** *Ref* 19, 20, 38, 65, 75
6.4.2 N	The memory service has access to advice and support on assistive technology and telecare solutions	**2** *Ref* 14, 60, 75

6.5 N	**The service provides or can signpost / refer people and their carers on to interventions for more complex needs, if required**	
6.5.1 N	Where clinically applicable, people with dementia and their carers have access to tailored psychosocial interventions for behaviour that challenges	**2** *Ref* *1, 28, 38, 43, 44, 53, 68, 75, 79*
6.5.2 N	The service has prompt access to specialist services for rare and/or complex care needs (e.g. regional/tertiary neurology/neuropsychiatry services)	**2** *Ref* 38

6.6 N	**The service provides access to psychosocial interventions for carers of people with dementia**	
6.6.1 N	Carers of people with dementia are offered an assessment, and intervention/s if appropriate, for their emotional, psychological and social needs. **Guidance:** *e.g.* • *Family interventions* • *Cognitive behaviour therapy* • *Counselling* • *Support programmes* • *Psychoeducation* • *Peer support groups* • *Befriending schemes* • *Memory cafés*	**2** *Ref 39, 58, 68*

6.7 N	**People with dementia and their carers are made aware of other non-pharmacological interventions that they may wish to consider**	
6.7.1 N	The service provides information about other possible non-pharmacological interventions that the person with dementia and their carer may wish to consider **Guidance:** *e.g.* • *Music and/or dance therapy* • *Animal-assisted therapy* • *Art therapy* • *Social engagement groups* • *Walking groups* • *Creative activities*	**3** Ref 15, 24, 28, 38, 44, 48, 53, 63, 65, 76

6.8 N	**Staff delivering psychosocial interventions are appropriately trained and supervised**	
6.8.1 N	Staff involved in delivering psychosocial interventions receive appropriate training	**2** *Ref 38, 42, 53*
6.8.2 N	Staff involved in delivering psychosocial interventions receive appropriate supervision	**2** Ref 38, 42, 53

6.9 N	**The service monitors people's responses to psychosocial interventions**	
6.9.1 N	The service has a strategy for monitoring each person's response to an psychosocial intervention and adapts the person's care plan accordingly **Guidance:** *This could include use of standardised outcome measures, quality indicators, quality of life assessments, carer questionnaires, or other appropriate measures and monitoring of adverse reactions such as excessive distress*	**2** *Ref* 5, 38, 42, 61

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Quality Indicators

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Quality Indicators		
Indicator	**Numerator**	**Denominator**
The percentage of people diagnosed in the early stages of dementia over the past year	*The number of people diagnosed in the early stages of dementia over the past year (using a standardised scale)*	*All people diagnosed by the service within the past year*
The percentage of people with dementia who have registered their interest in participating in research over the past year	*The number of people with dementia registering their interest in participating in research over the past year*	*All people with dementia who have had an appointment with the service in the past year*
The percentage of new people with memory problems/dementia in the past year whose initial assessment process began within six weeks of referral	*The number of people with memory problems/dementia in the past year whose initial assessment process began within six weeks of referral*	*All people with memory problems/dementia who have received an initial assessment within the past year*
The percentage of people with dementia who have accessed psychosocial interventions in the past year	*The number of people with dementia who have accessed psychosocial interventions in the past year (see glossary for list of psychosocial interventions)*	*All people with dementia who have been on the memory service's caseload at any point over the past year*
The proportion of people with dementia in the service's catchment area who have received a diagnosis	*The number of people diagnosed with dementia in the service's catchment area*	*The expected number of new cases of dementia in the total catchment population*

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.

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Glossary

MSNAP
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ACE-R	Addenbrookes Cognitive Examination (Revised) - a brief cognitive test battery for dementia screening
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
Anti-dementia drugs	Drugs used to treat some types of dementia
Away days	Team building events to help build staff morale, which can be used to discuss organisational issues and devising an action plan with solutions
Care coordinator	A named individual who is designated as the main point of contact and support for a person who has a need for ongoing care
Care navigator/dementia navigator	Assess an individual's circumstances, explain the options available including treatment, and help 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
Commissioner	Individuals (or groups of individuals) whose role it is to buy services for their local population
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 adviser	A service primarily for people with dementia to provide information, advice and to help people access support that meets their needs
DeNDRon	DeNDRoN supports the development and delivery of clinical research in the NHS in the dementias, Parkinson's disease, Huntington's disease, motor neurone disease, and other neurodegenerative diseases
Domiciliary care	Health care or supportive care provided in the patient's home by healthcare professionals
DSM-IV	Psychiatric Diagnoses are categorised by the Diagnostic and Statistical Manual of Mental Disorders, 4th. 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
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
Independent Mental Capacity Advocates (IMCA)	Help particularly vulnerable people who lack the capacity to make important decisions about serious medical treatment and changes of accommodation, and who have no family or friends that it would be appropriate to consult about those decisions
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
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
MMSE	Mini-Mental State Examination - a brief 30-point questionnaire test that is used to screen for cognitive impairment
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
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
Primary Care Trust	Provide funding for GPs and medical prescriptions; they also commission hospital and mental health services from appropriate NHS trusts or from the private sector
Psychosocial interventions	Interventions or 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

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

Psychosocial interventions

Assistive technology	Devices that promote greater independence by enabling people to perform tasks that they were formerly unable to/or found difficult to accomplish
Befriending schemes	Provides friendship and learning opportunities for adults from vulnerable groups
Cognitive Behaviour Therapy	A psychological therapy that addresses unhelpful emotions, behaviours and thoughts
Cognitive rehabilitation	Is an individualised program to help a person's cognitive functioning by using specific skills training and practice
Cognitive Stimulation Therapy	An evidence-based psychosocial intervention that involves a series of themed, group activity sessions to help people strengthen their cognitive capacity
Functional and behaviour analysis based interventions	A behavioural intervention that involves exploring the meaning or purpose of an individual's behaviour
Life story work	An activity which involves reviewing and evaluating an individual's past life events, in developing an individual biography of that person.
Maintenance CST	Additional "top-up" sessions of Cognitive Stimulation Therapy
Memory cafés	Somewhere where people with dementia and their carers can visit to support each other and share information.
Non-pharmacological interventions	Treatment that does not use medication, e.g. animal-assisted therapy, music/art therapy etc.
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
Psychoeducation	Educating a person and their family about their condition and ways to help them cope.
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.
Tele-care	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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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 (eg Korsakoff syndrome, B12 deficiency), head injury, cerebrovascular disease (eg 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 (eg 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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