

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Mandatory headings 1 – 4: mandatory but detail for local determination and agreement

Optional headings 5-7: optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

Service Specification No.	
Service	Dementia/cognitive impairment service
Commissioner Lead	
Provider Lead	
Period	
Date of Review	

1. Population Needs

Research conducted for Dementia UK: second edition¹ shows that, in 2013, there were 815,827 people with dementia in the UK. 773,502 of these people with dementia were aged 65 years or over. This represents one in every 79 (1.3%) of the entire UK population and 1 in every 14 of the population aged 65 years and over. In 2015, there will be 856,700 people with dementia in the UK in 2015 at the current rate of prevalence.

If current trends continue and no action is taken, the number of people with dementia in the UK is forecast to increase to 1,142,677 by 2025 and 2,092,945 by 2051, an increase of 40% over the next 12 years and of 156% over the next 38 years.

The total cost of dementia in the UK is £26.3 billion.

The NHS picks up £4.3 billion of the costs and social care £10.3.

Of the £10.3 billion in social care costs, £4.5 billion is attributed to Local Authority social services for state funded care. The remaining £5.8 billion is what people with dementia and their families pay out annually for help with everyday tasks that are provided by professional care workers, such as washing, dressing and eating.

Two thirds of the cost of dementia (£17.4 billion) is paid by people with dementia and their families, either in unpaid care (11.6 billion) or in paying for private social care.

Dementia is a syndrome caused by a number of illnesses in which there is a progressive functional decline in memory, reasoning, communication skills and the ability to carry out daily activities. Alongside this decline, individuals may also develop behavioural and psychological symptoms such as depression, psychosis, aggression and wandering. These cause problems in themselves, complicate care, and can occur at any stage of the illness.

¹ Dementia UK: second edition. Alzheimer's Society (2014)

Although the risks of developing dementia increase with age, it is not an inevitable part of ageing.²

There are different types of dementia, these include:

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

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

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

In 2009, the Government published 'Living Well with Dementia: A National Dementia Strategy (DH, 2009).³

The national strategy set out 17 recommendations that the government wants the NHS, Local Authorities and others to take to improve dementia care services. The recommendations are focused on three key themes of:

- Raising awareness and understanding
- Early diagnosis and support
- Living well with dementia

In addition this specification takes account of the following national policy and guidance:

- Prime Minister's Challenge (March, 2012⁴): including focus on improving diagnosis rates by 2015, and developing dementia friendly communities.
- Dementia: A state of the nation report on dementia care and support in England (DH November 2014)
- Improving diagnosis was further highlighted as a key DH priority with all Clinical Commissioning Groups (CCG's) set an aspirational target was set to achieve 67% diagnosis rates by 31/3/15.
- The Care Act 2014 (DH, October 2014)
- The Prime Ministers Challenge, 2020 (DH, 21st February, 2015)

1.1 Local Context

According to the Primary Care Web Tool ⁵(data as at March 2015) the current diagnosis

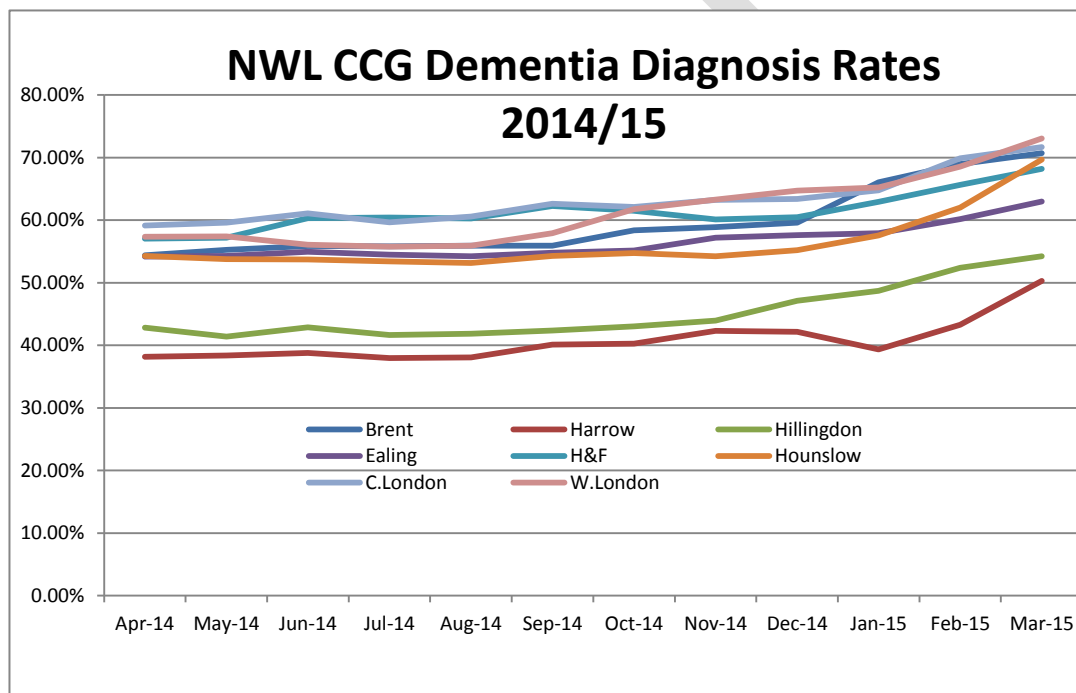
² Joint Commissioning Panel for Mental Health (2012). Guidance for commissioners of dementia services Volume Two: Practical mental health commission. London: JCP-MH www.jcpmh.info NICE (2010). *Dementia Quality Standards*. NICE Implementation. Directorate Quality Standards Programme. London: Department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

³ Living Well with Dementia; A National Strategy (DH 2009)

⁴ Prime Minister's challenge on dementia :Delivering major improvements in dementia care and research by 2015 (DH 2012)

rate for the NWL CCG's is shown below together with the trend (APRIL 14 – March 15)

CCG	Diagnosis rate at 30.03.15
Brent	70.70%
Harrow	50.30%
Hillingdon	54.23%
Ealing	62.98%
H&F	68.18%
Hounslow	69.68%
C.London	71.68%
W.London	73.06%
Source: Primary Care Web Tool accessed 20.4.15	



Note : In terms of local need at a CCG level this section is for completion by the individual CCG.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	
Domain 2	Enhancing quality of life for people with long-term conditions	√

⁵ https://www.primarycare.nhs.uk/private/dpc/dpc_main.aspx

Domain 3	Helping people to recover from episodes of ill-health or following injury	
Domain 4	Ensuring people have a positive experience of care	√
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	√

2.2 Local defined outcomes for people with dementia

In developing locally defined outcomes for people with dementia, these have been linked to the dementia 'I' statements with clear objectives, outcomes and proposed outcome measures. The 'I' statements have been cross referenced with the relevant national quality standards which are set out in section 4.1 of this schedule. There are two sets of outcomes:

- One for people with dementia
- One for carers of people with dementia

Vision Statement	Objective	Outcome	Measure
I was diagnosed in a timely way	Improve the local diagnosis rate	Increased number of individuals will receive a timely diagnosis	<p>Increase in referrals to memory assessment services.</p> <p>Increased number of people on dementia registers</p> <p>Data from electronic patient information systems /ICD 10 codes</p> <p>Increased number of people with a Learning Disability on dementia registers</p>
I understand so I make good decisions and provide for future decision making	Living well with dementia	<p>People with dementia, their families and carers receive high quality and meaningful information, advice and support.</p> <p>The patient and carer will be supported by a care navigator, dementia advisor or care co-ordinator from diagnosis and at all stages of the care pathway</p> <p>Information should be presented clearly and in different formats as required</p>	Individuals and carers report that they are appropriately supported e.g use of patient and carer surveys.
I get the treatment and support which	Living well with dementia	Clear pathway for individuals.	Reduction in the number of people prescribed

are best for my dementia and my life		<p>Increase in number of referrals to psychological therapies if required (e.g.IAPT services)</p> <p>For people with dementia this may be to manage problems such as fear, anxiety, practical and financial issues, using non-pharmacological management as a first port of call.</p> <p>Raised awareness and access to information and advice</p> <p>Support along the patient and carer journey from a named care navigator, dementia advisor or care co-ordinator</p>	<p>antipsychotic medication.</p> <p>Cross reference to IAPT provider and relevant contract data</p> <p>Individuals and carers report that they are provided with relevant and timely information e.g use of patient and carer surveys.</p> <p>Patient and carer feedback</p>
I am treated with dignity and respect	Living well with dementia	<p>All staff have access to appropriate training in dementia.</p> <p>Range of opportunities to engage and listen to people with dementia and their carers are identified and acted upon.</p>	Individuals and their carers report they are treated with dignity and respect
I know what I can do to help myself and who else can help me	Living well with dementia	There is a clear person centered plan in place for every individual known to the service.	<p>Number of people with a copy of own care plan.</p> <p>The care plan will be updated at every review stage so the patient and carer are fully informed.</p>
I can enjoy life	Living well with dementia	People with dementia have access to a choice of activities and services	Individuals and their carers report that they have access to a range of activities and services to meet their needs.
I feel part of a	Living well	People with dementia are	All CCG's in

community and I am inspired to give something back	with dementia	empowered to have high aspirations and feel confident that people in the local community treat them with dignity and respect The service ensures that all people with dementia and their carers are offered the opportunity to register their interest in participating in research	partnership with local authorities, providers and communities achieve dementia friendly status
I am confident my end of life wishes will be respected	End of Life Care	The dementia pathway from late stage dementia to EOL is clear and well communicated	Number of people with dementia with advance directives in place

2.3 Local defined outcomes for carers of people with dementia : with **acknowledgement and grateful thanks to Barbara Benedek**

Vision Statement	Objective	Outcome	Measure
I was listened to by the GP when I said that my relative had some memory/behavioral problems	Improve the local diagnosis rate and reduce stress on family carer who knows there is a problem but no one listens	Increased number of individuals will receive a timely diagnosis Increased number of people referred early to dementia support groups	Increase in referrals to memory assessment services. Increased number of people on dementia registers Increased number of patients and carers getting timely support at the early stages of dementia in order to put in place POA and address other legal and financial issues

<p>I understand so I make good decisions and provide for future decision making in my caring role</p>	<p>Reducing stress and its consequences for family carers</p>	<p>Family carers receive high quality and meaningful information, advice and support.</p> <p>The patient and carer will be supported by a care navigator, dementia advisor or care co-ordinator from diagnosis and at all stages of the care pathway</p> <p>Information should be presented clearly and in different formats as required – carer training programmes</p>	<p>Individuals and carers report that they are appropriately supported</p>
<p>I get the support and ongoing guidance to help me care for my relative</p>	<p>Helping me to continue to care for my relative and allowing me to lead my own life to some extent</p>	<p>Clear support and guidance for individual carers for the entirety of the journey</p> <p>Guidance and advice on all the practical issues of caring for someone with dementia</p> <p>Referral to psychological therapies if required (IAPT services)</p> <p>Raised awareness and access to information and advice</p> <p>Support along the patient and carer journey from a named care navigator, dementia advisor or care co-ordinator</p>	<p>Reduction in carers no longer being able to care- Method and measures to be agreed with commissioner, carer rep and provider</p> <p>Robust information sharing systems in place</p> <p>Reduction in carer illness and psychological problems</p> <p>Patient and carer feedback</p>
<p>I am treated with dignity and respect and my views are listened to by clinicians, social workers and other support workers</p>	<p>Reducing the stress of my caring role and providing me with support and help in making decisions</p>	<p>All staff have access to appropriate training in dementia.</p> <p>Range of opportunities to engage and listen to family carers. Issue raised are identified and acted upon.</p>	<p>Individuals are treated with dignity and respect (based on consistent method of gathering feedback)</p>
<p>I know what I can do to help myself and who else can</p>	<p>Reducing stress and helping me lead a fulfilling</p>	<p>There is a clear person centred plan in place for every carer known to the</p>	<p>Number of people with named carer support worker</p>

help me	life	service.	
I can enjoy life and am helped to have the necessary respite from caring	Reducing stress and helping me lead a fulfilling life	Carers for people with dementia have access to a choice of appropriate activities and services which provide stimulation for the person with dementia and respite for carers	Choice of access is evidenced from consistent method if gathering feedback
I have enough support and respite in my caring role that I have time and energy to participate in engagement activities as well and life enhancing ones (theatre, friends etc)	Provide invaluable input from family carers who have knowledge from years of experience caring for people with dementia	Clinical and social service support becomes more person centred and is able to respond more appropriately to the needs of the person with dementia and their carers	Good practice evidenced from consistent method if gathering feedback
I don't have sole responsibility for end of life conversations with the person I care for. Clinical services are able to engage the person with dementia in this conversation – as it is very hard for close relative to do this	End of Life Care plans made with the person with dementia – reducing the stress and anxiety of the carer who may not know what the person they care for really wants	The dementia pathway from late stage dementia to EOL is clear and well communicated to family carer and clinicians	Number of people with dementia with advance directives in place

3. Scope

3.1 Aims and objectives of service

Aim1: To provide commissioners with confidence that service specifications and operational standards are consistently met. The Provider demonstrates the Service is underpinned by the following values and principles:

For people with dementia and their family/carers to:

- Feel valued and respected
- Be fully informed and engaged in all aspects of their care, via care co-ordination/care management

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

Be supported with services that:

- Are flexible, holistic and responsive to individual levels of need
- Adopt the principle of 'one person, one plan'
- Are built around the needs and wishes of each individual and their family/carers
- Look after people who live alone and offer community support.
- Promote and enable wellbeing
- Take into account people's safety

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

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

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

- Following the NICE/SCIE guidance on Supporting people with dementia and their family/carers in health and social care (CG42), specifically section 1.7, Interventions for Non-Cognitive Symptoms and Challenging Behaviour in People with Dementia,
- Ensuring that people who are prescribed anti-psychotic medication have been fully assessed and are subject to regular and agreed medication reviews
- Ensuring family/carers are fully involved in the decisions about medication
- Ensuring there are therapeutic alternatives for people with behaviours that are considered to be 'challenging'

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

- Care orientated to the individuality, life experiences, strengths and abilities while attending to difficulties and disabilities to support people with dementia and family/carers
- Providing access and/or support into purposeful, stimulating and appropriate engagement, activities and connections
- Promoting people's continued connections with their families, friendships, communities and local neighbourhoods
- Identifying and supporting the cultural and faith groups/spiritual needs of each

person.

- Having access to translators and interpreters to meet the needs of the people using the service (: consider needs associated with language, learning disability, sensory impairment, etc.)
- Identifying any reasonable adjustments necessary at the point of referral and taking appropriate steps to meet individual needs
- Providing 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
- Proactively addressing the stigma of dementia and other mental health issues and proactively identifying issues of social isolation
- Developing a form of expert carer programme for family/carers of people with dementia and uptake that is in line with predicted need, based on the NWL demographics

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

- The provider develops and promotes a culture of continuing learning and improvement throughout the whole Service and across providers
- Staff receive the training and supervision they need in relation to both current good practices and customer service approaches paying particular attention to the needs of the person with dementia and their family/carers
- Workforce capacity and capability are sufficient to deliver the expected outcomes
- The Provider involves people with dementia and family /carers in the dementia training of staff and volunteers, taking a co-production approach
- There is a good quality evidence based programme of training for volunteers to promote a sense of empathy with people with dementia and family/carers
- Staff are familiar with and alert to the benefits of assistive technology and Telecare for people with dementia.
- Dementia care training should include, “the importance and use of communication skills for working with people with dementia’ (Francis report 2013)

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

- Integrated care pathway services and integration across other Providers where all the component parts are clear and well-co-ordinated and used as required through the person’s lifetime, including the development of person-centred holistic care plans
- in collaboration/formal partnership arrangements with other Providers
- Ensuring the service is delivered in a considered and co-ordinated manner
- Effective systems and processes in place to enable people with dementia and family/carers to have the opportunity to take part in high quality research studies
- Putting in place procedures, protocols, governance and audit arrangements to support the delivery of good health care

- Effective communication systems between front-line staff and managers and between members of the staff team and across organisations providing support to an individual
- Management and supervision appropriate to the delivery of good quality care
- Enabling a peer support model of care to be put in place, recognising that the experience of dementia (particularly in the early phases) may mean that the person can actively and valuably contribute to post-diagnostic support (in a paid sessional or voluntary capacity)

Aim 7: To promote a positive experience of services to people with dementia and family/carers through:

- Integrated care pathway services and integration across other Providers, where all the component parts are clear and well-co-ordinated by a named care co-ordinator/care navigator, and used as required through the person's lifetime, including the development of person-centred holistic care plans
- Collaboration/formal partnership arrangements with other Providers
- Ensuring the service is delivered in a considered and co-ordinated manner
- Effective systems and processes in place to enable people with dementia and family/carers to have the opportunity to take part in high quality research studies
- Putting in place procedures, protocols, governance and audit arrangements to support the delivery of good health care
- Effective communication systems between front-line staff and managers and between members of the staff team and across organisations providing support to an individual
- Management and supervision appropriate to the delivery of good quality care
- Enabling a peer support model of care to be put in place, recognising that the experience of dementia (particularly in the early phases) may mean that the person can actively and valuably contribute to post-diagnostic support (in a paid sessional or voluntary capacity)

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

For people with dementia and their family/carers to:

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

Be supported with services that:

- Are built around the needs of each individual and their family/carers
- Look after people who live alone and offer community support.

- Promote and enable wellbeing
- Take into account people's safety

3.2 Service description/care pathway

3.2.1 Key Service Principles

The provider will ensure that people with memory problem/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 will receive a service that is person centred and takes into account their unique and changing personal, psychosocial and physical needs.

3.2.2 Service Model

The service model may vary by CCG with some CCG's commissioning a primary care based model, such as Gnosall, or a secondary care assessment and treatment service. Whatever model is adopted, the service should be part of an integrated pathway for the assessment, diagnosis and management of patients with dementia and cognitive impairment.

The remit of the service is to assess, diagnose and treat with appropriate interventions, including carer support and initiation of medication, until the patient is eligible for discharge into any shared care arrangements that may be agreed with primary care.

As people with dementia progress through the care pathway the need for specialist input is likely to increase. Therefore for patients who are at middle or late stage of the care pathway the management of the patient is likely to sit with specialist care.

The service must be NICE compliant and either have, or work towards, MSNAP accreditation.

The Memory Assessment Service (MAS) is supported by the following key principles,

- The person with dementia and family/carers are at the centre of the model and key to making decisions about care.
- For people with dementia who live alone and have no immediate carer support the service will identify these patients at assessment and work with local partners to ensure the patient is supported throughout the pathway.
- To provide a co-ordinated and integrated approach between health, social care, voluntary and community sectors to provide a person-centred holistic pathway.
- A service that recognises that each person is an individual.
- A service which delivers an integrated response that can meet the needs of people's other co-morbid mental health conditions
- A flexible and sustainable service that delivers the proposed model by co-ordinating the integration of care across all agencies involved and supporting General Practitioners - from diagnosis, active support for self-management through to end of life care.
- To develop shared care arrangements between primary and secondary care providers to ensure that people with significant impairment and challenging needs can be 'Fast tracked' to specialist services when required and GP's supported to manage this cohort of patients in the community for as long as possible.
- Seeing dementia as everybody's business, not just as "health or "social care" issues. Mainstream services and facilities that work towards becoming more inclusive of

and accessible to people with dementia and their families, in line with the “Dementia Friendly Communities” national work stream.

- Care that is actively delivered in collaboration or formal partnership arrangements with other Providers and ensures that agencies communicate and work together effectively along the care pathway
- A service that affords people a high level of dignity and respect, which is sensitive to their social and cultural background, and which maintains the highest standards of quality practice
- A service where people with dementia are understood as part of wider systems (families, carers, neighbourhoods, communities, friendship groups) and must always be worked with in relation to this key understanding

3.2.3 Dementia Framework

As part of the engagement and co-production process with key stakeholders including people with dementia and carers a dementia framework has been developed which underpins the clinical care pathway and outcome measures. The framework began as a high level dementia pathway and was discussed and debated at various forums including themed workshops and most importantly seen through the eyes of people with dementia and carers. The message was clear from people with dementia and carers in that the original format was ‘busy and confusing’ and there was a need for a simplified framework that would support and underpin the clinical care pathway.

The following dementia framework (diagram 1) is therefore a visual framework which contains all the key stages of living well with dementia from pre referral to end of life stage.

Diagram 1



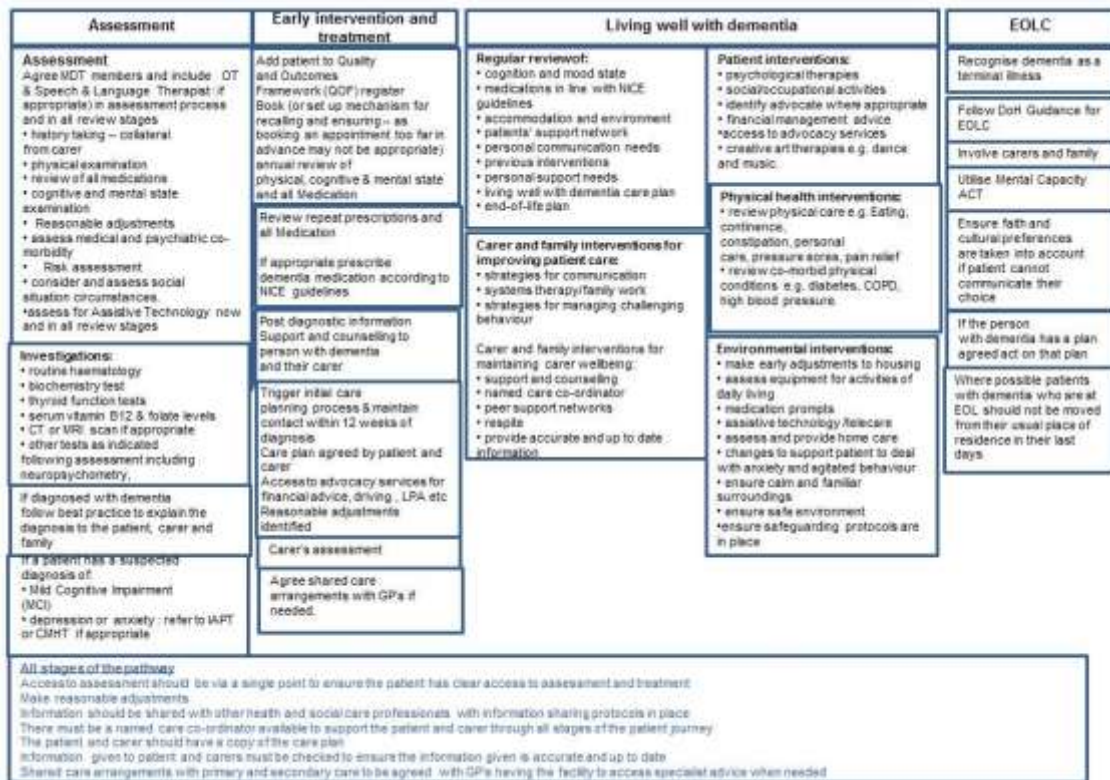
3.2.4

High Level Clinical Care Pathway

The clinical care pathway will be specific to the appropriate model of care. There are however, some elements of the pathway that will be constant regardless of the service model.

The following high level pathway (diagram 2) has also been developed from the dementia framework which underpins the the model of care. The pathway has been produced via a process of collaboration and co-production via the themed workshops and virtual discussion by the clinical leads and is aimed to be used and adapted as appropriate as the role of the clinician will be defined depending on agreed individual CCG model service model.

Diagram 2



Assessment

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

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

If the person lacks the capacity to make a decision, the provisions of the Mental Capacity

Act 2005 must be followed.

The assessment process should include input from other health professionals e.g OT and Speech and Language Therapist if appropriate.

Particular consideration and flexibility needs to be exercised for people who live alone and may need support to attend for an assessment.

Diagnosis

If a primary care model of care is in place it is expected that an increasing number of straightforward cases of Alzheimer's Disease or Vascular Dementia will be diagnosed in primary care without needing to be referred to specialist services.

In some cases, General Practitioners will be supported to make a diagnosis of dementia themselves. In other cases, the General Practitioner will refer a person for the diagnosis to a secondary care service for a diagnosis to be made.

The provider will have an important role in supporting General Practitioners to make a diagnosis, providing timely access to advice and guidance and providing training as appropriate. The Service will put in place a shared care protocol that has been agreed jointly by Providers and Commissioners to ensure that this is delivered in a clinically safe and appropriate way.

The Provider will allocate a named appropriately skilled worker to each practice to facilitate this. The Provider should ensure that there is a shared care protocol in place, (written by the commissioning clinical leads, GPs and the Provider,) for the prescription of cholinesterase inhibitors, as recommended in NICE technology appraisal 217.

Access

The Service will aim to operate a Single Point of Access (SPA), that will be integrated within the existing SPA system and process.

A SPA will eliminate duplication, streamline the referral process and reduce the number of times the patient or carer will need to relate their story.

The SPA will be able to initiate first assessment by the service (following GP referral), provide advice and support for people who have a diagnosis and family/carers and/or professionals who require information, and fast track people back in to the Service who have not been actively using it.

It is important that this component of the service has a signposting role to help people access other services that will be able to provide support, information and advice.

Advice, Education and Training

Professionals can access telephone and e-mail advice from the Service; this will include advice/support for Primary Care to make a diagnosis of dementia and to manage clinical issues.

The Department of Health's Mandate to Health Education England (HEE), published in April 2013, set out the work programme for HEE to develop in partnership with the relevant stakeholders, a national roll-out plan for foundation level dementia training for all NHS staff.

The agreed definition of Foundation level dementia training is familiarising staff with

recognising and understanding dementia, interacting with those with dementia, and training them to be able to signpost patients and carers to appropriate support. By doing this:

- Staff will have greater awareness and confidence to support patients affected by dementia.
- There will be better diagnosis, treatment and care of those with dementia
- NHS staff will be able to identify the early symptoms of dementia
- NHS staff will be more aware of the needs of patients affected by dementia and their families and carers, to enable them to provide safe, dignified and compassionate care
- GPs will be able to identify and work with patients affected by dementia
- The training will signpost staff to the most appropriate care
- The training will raise awareness of the increased likelihood of mental health problems presenting in those with Long Term Conditions

A Tier 2 intermediary dementia training and Tier 3 advanced dementia training is being developed and will be rolled out in 2014/15

3.3 Referral Route

The Provider shall respond to all requests relating to adults who meet the eligibility criteria for assessment and diagnosis.

- The Provider shall respond to referrals/referrers and ensure Initial contact is made with all people who are newly referred within three weeks of referral, as per MSNAP guidance⁶
- The assessment process should begin no later than six weeks from referral
- The provider will have a policy to follow up people who do not attend appointments

Where a face-to face assessment with a person suspected or diagnosed with dementia is required, the Provider will undertake the assessment in the place that is most appropriate for the person, which might be in a clinic, at home or in a care home. The Provider shall respond to requests for advice by telephone.

The Provider shall respond to requests for assessment or general advice by telephone from Primary Care within an agreed response time for urgent and non urgent requests non-urgent requests. (Individual CCG to agree with service providers)

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

3.4 Population covered

- All adults), who are registered with a CCG within NWL at the time of referral and who may be in the early stages of dementia.
- This will include people with mild Learning Disability

3.5 Any acceptance and exclusion criteria and thresholds

- Those who do not meet the referral criteria

⁶ Memory Services National Accreditation Programme (MSNAP) Standards for Memory Services (2014) 4th edition

3.6 Interdependence with other services/providers

In addition, the service will support whole system relationships and develop agreed protocols and interfaces with:

- NWL CCG'S and Member Practices
- Local Departments of Adult Social Services
- Care and Residential Homes
- Alzheimer's Society and other voluntary sector organisations
- Acute Hospital Trusts
- Community Health professionals
- Community Geriatricians

Manage interdependencies with:

- GPs
- CMHTs
- Primary Care Mental Health Services
- Social Services Departments
- Local Authorities
- Allied Health Professionals
- District Nursing and Community Matrons
- Carer groups
- Patient and Public Forums
- Acute Trusts
- Community Hospitals
- Care Homes
- Young/Early Onset Dementia Service including ARBD
- Assistive Technology
- Learning Disability Services
- Domiciliary Care Providers
- Housing Providers
- Advocacy Services

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

- NICE Technology Appraisal TA217 Alzheimer's disease - donepezil, galantamine, rivastigmine and memantine (2012)
- NICE Clinical Guideline CG42 Supporting people with dementia and their carers in health and social care (2011)
- NICE Quality Standard for Dementia (2010)
- Quality Outcomes for people with Dementia: building on the work of the National Dementia Strategy. (DH, 2010)
- Public Health Outcomes Framework (s 4.16)
- NHS Outcomes Framework (s.1.5. 2.1, 2.4)
- Adult Social Care Outcomes Framework (s.1b,1d & 3d)

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

- Royal College of Psychiatrists Memory Services National Accreditation Programme Standards for Memory Services Assessment and Diagnosis

4.3 Applicable local standards

- Initial contact is made with all people who are newly referred within three weeks of referral as per MSNAP⁷
- The assessment process should begin no later than six weeks of referral

4.4 Safeguarding

The service is compliant with statutory guidance on the safeguarding of vulnerable adults and children.

4.5 Information Sharing

There will be 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 and their codes of practice/Guidance.

The provider will ensure 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 essential and important that the provider checks that patients understand what will be disclosed in the event that identifiable information is shared with anyone employed by another organisation or agency who is contributing to their care.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4 Parts [A-D])

5.2 Applicable CQUIN goals (See Schedule 4 Part [E])

6. Location of Provider Premises

The Provider's Premises are located at:

7. Individual Service User Placement

⁷ Memory Services National Accreditation Programme (MSNAP) Standards for Memory Services (2014) 4th edition