SECTION B PART 1 - SERVICE SPECIFICATIONS

Mandatory headings 1 – 5. Mandatory but detail for local determination and agreement.
Optional heading 6. Optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement.

Service Specification No.	
Service	**Memory Assessment Service**
Commissioner Lead	**Blackburn with Darwen CCG on behalf of;** • **East Lancashire CCG** • **Blackburn with Darwen CCG** • **Blackpool CCG** • **North Lancashire CCG** • **Fylde and Wyre CCG** • **West Lancashire CCG** • **Greater Preston CCG** • **Chorley and South Ribble CCG**
Provider Lead	
Period	
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Dementia is a term used to describe a syndrome that carries a massive personal, family, social and economic cost. There are currently 750,000 people in the UK living with dementia and the cost to the UK economy as a whole is more than £20 billion annually. Over the next 40 years the numbers of people with dementia in the UK will more than double to 1.7 million. Within the UK there is a 24-fold variation between highest and lowest activity by commissioning organisation.

Historically, fewer than half the people with dementia receive a formal diagnosis. Figures in Lancashire in 2011 are similar to the nationwide picture with only 43% of people actually diagnosed with dementia against the estimated prevalence of the disease. It is clear that there are significantly more people in Lancashire living with dementia that we do not know about, than those that are known to health and social care.

When a diagnosis is made, it is often late in the disease trajectory, when it may be too late for those suffering to make decisions and choices. Diagnosis is often made at a point of crisis that could potentially have been avoided had the diagnosis been made earlier. The National Dementia Strategy suggests diagnosis of people with severe dementia should take place in primary care, with or without the support of specialist dementia services.

Evidence points to the value of early diagnosis and intervention to improve quality of life and to delay unnecessary admissions into hospitals and care homes.

Memory services are anticipated to include positive impacts on:

- identification and early assessment of those undiagnosed
- better understanding of the cognitive difficulties by clients - an understanding of remaining strengths, current difficulties, and preliminary strategies in place to assist
- improvement in the quality of life of people with dementia following early diagnosis and intervention
- positive effects on the quality of life of family carers following early diagnosis and intervention.
- reductions in care home placement by providing carer support, education and counselling at

diagnosis

The provision of a Lancashire wide Memory Assessment Services (MAS) is key to supporting the Lancashire wide strategic intention of meeting the requirements of the National Dementia Strategy and contributes to the Lancashire Dementia QIPP ‘Case for Change’.

Lancashire has around 17,600 people with dementia aged 65 years and over. These numbers are expected to rise to more than 25,600 by 2025. This is because of the projected increase in the ageing population and the increased prevalence of dementia as people age.

There are also at least 317 people aged 64 and under who have dementia. Though the numbers are small and projected increases are marginal (as they are based on the demographic projection and the age-related prevalence rate), this remains an issue for MAS services to consider.

The table below sets out the projected increase across Lancashire with an estimate that increases over the next 15 years range between 30% (Blackpool) and nearly 70% (Chorley) (Source: Mental Health Observatory).

	2010	2015	2020	2025	% difference 2010-2025
England	607,249	671,656	755,951	866,297	42.7%
Lancashire 14	17,607	19,504	22,045	25,611	45.5%
Lancashire 12	14,379	16,095	18,279	21,385	48.7%
Blackburn w Darwen	1260	1332	1477	1657	31.4%
Blackpool	1968	2077	2289	2569	30.6%
Burnley	985	1,061	1,173	1,380	40.1%
Chorley	1,124	1,270	1,560	1,899	68.9%
Fylde	1,402	1,567	1,794	2,104	50.1%
Hyndburn	872	974	1,058	1,254	43.7%
Lancaster	1,823	2,009	2,269	2,594	42.3%
Pendle	1,016	1,115	1,211	1,399	37.6%
Preston	1,281	1,374	1,525	1,711	33.6%
Ribble Valley	741	854	1,002	1,213	63.8%
Rossendale	704	759	821	962	36.6%
South Ribble	1,262	1,446	1,675	1,939	53.6%
West Lancashire	1,298	1,493	1,732	2,050	57.9%
Wyre	1,868	2,174	2,458	2,879	54.1%

MAS is commissioned in Lancashire for good quality early diagnosis and intervention for all patients without a diagnosis of dementia whatever point they are on the dementia journey. The future ambition is to reach the position where the majority of patients requiring assessment have mild to moderate symptoms.

In summary the service will include:

- making the diagnosis well (i.e. high diagnostic accuracy including sub-typing)
- making a diagnosis early in a timely manner
- initiation of the most appropriate medication and titration
- communicating the diagnosis well to the person with dementia and their family
- either advising on appropriate treatment, information, care and support after diagnosis or the development of a care plan
- the delivery of an on-going consultation to primary care in relation to shared care for medicines management
- formal discharge communication to primary care outlining the need to place diagnosed patients on the QoF register
- transition into on-going support services where available for both on-going support for dementia and memory maintenance

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**	
Domain 3	**Helping people to recover from episodes of ill-health 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

Expected high-level outcomes of the service:

I. Increase in the proportion of people with dementia having a formal diagnosis compared with the local estimated prevalence

II. Increase in the number of patients and carers who have a positive service experience

III. Increase in the numbers of patients who are accessing Acetylcholinesterase Inhibitors)

IV. Increase in the numbers of patients who receive advice and on-going support post diagnosis.

V. Increase in the proportion of people with dementia receiving a diagnosis while they are in the mild stages of the illness – unlikely initially

3. Scope

3.1 Aims and objectives of service

The aim of MAS is to deliver quicker and timely diagnostic outcome to people with symptoms that would suggest the potential of having dementia. It will provide all patients who fulfil the referral criteria with a person-centred service, which empowers people with dementia and their carers to make informed decisions about care and which helps maximise quality of life. The service should help reduce the risk of crises later in the illness and enable the patient to be cared for at home for as long as possible while this is the preferred place of care.

The objectives of the service are:

- to promote and facilitate early identification and referral and encourage eligible patients to attend assessment
- to provide a high-quality accurate diagnosis of dementia that is communicated in a person-centred way to both the person with dementia and their carers and which meets the individual needs of the person with dementia and their carers
- to provide diagnosis early in the disease
- to ensure that the service is readily accessible and meets the range of needs of the local population, including minority groups
- to ensure that people with dementia and their carers have appropriate information that allows them to manage their care more effectively along the pathway and to ensure that both those referred and their carers understand how to access other assistance- including initial post diagnostic counselling.
- to engage people with dementia and their carers in decisions about the care options available to them, including the development of personal care plans. • to ensure continuity of care across the pathway and integration with other care providers
- to ensure that the service is delivered in a considered, timely and co-ordinated manner
- to provide opportunities for people with dementia to be included in research studies.

3.2 Service description/care pathway

Days/Hours of operation

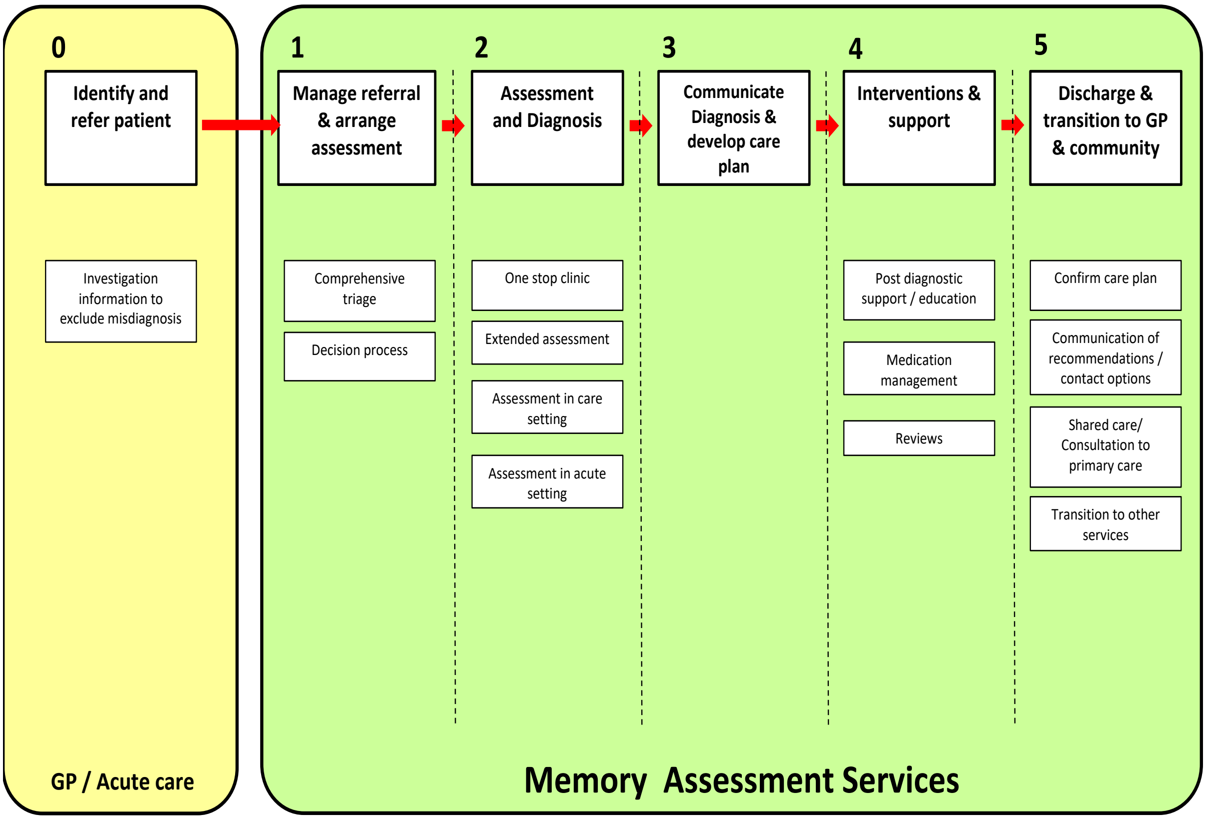
The MAS in all localities will provide a responsive service that will include Saturdays or evenings. This will offer a range of options to facilitate access. Precise hours of work for each service will be determined by need and ultimate size of the team, in keeping with the transition plan.

Memory Service pathway

The following diagram sets out the pathway for a memory service for early diagnosis and intervention. It illustrates six stages in the pathway, though it is anticipated certain elements may take place in parallel rather than in succession.

Stages 1 to 5 reflect the delivery of the commissioned memory service. Stage 0 is included in the service specification to confirm the obligations and relationships with primary care, since Stage 0 reflects prerequisites that should be in place for Stages 1 to 5 to be most effective.

Lancashire MAS Pathway



Pre- Assessment

Diagnosis of a dementia syndrome can often be made in primary care, though if diagnosis is in doubt, referral to a specialist in MAS should be undertaken with prerequisite investigations complete.

The main reason for undertaking investigations in a person with suspected dementia is to exclude a potentially reversible or modifying cause for the dementia and to help exclude common misdiagnoses including delirium. Whilst there is no universal consensus on the appropriate diagnostic battery that should be undertaken in those with suspected dementia, MAS follow the NICE guidance suggesting the information that is necessary to support the patients referral to MAS is;

- Blood Tests results - B12, Folate, FBC, U&E, LFT, TFT, Random Glucose, Non fasting lipids, bone profile
- Current Medication List
- Past Medical History
- Next of Kin details (if known)

(An ECG is no longer required when referring - if a patient requires an ECG following assessment then MAS staff will facilitate this).

Management of the referral & Triage

MAS will collate transferred patient information within 3 operational days of receiving the referral and will send an acknowledgment of receipt to referrer. Where the pre-assessment information is incomplete they may reject the referral requesting standard investigations, in line with referral procedures. Reasons for rejection will be recorded.

MAS will liaise with all relevant staff and providers regarding the referred patients within 3 operational days in order to stimulate all the information required for that referred patient.

MAS will contact the patients and carers in person or by telephone within 3 operational days of receipt of referral. The patient shall be offered a memory assessment (initial offer).

In consultation with the patient, and where appropriate the carer, MAS will determine whether the patient is willing and/or ready to attend an assessment. Where the patient is ready and willing, they shall be offered an assessment offer based on the triage within 10 operational days.

MAS will send patients who cannot successfully be contacted after 2 attempts and within 8 operational days, an offer of assessment date in writing. If the offer is not accepted, or the patient cannot be contacted within 3 attempts, the GP will receive communication to that effect and suggest their GP discuss reasons for non-attendance with the patient – it may also be appropriate to propose that a joint assessment in collaboration with primary care may be appropriate.

Triage
Lancashire will implement the whole service approach to the triage process in the MAS pathway. The comprehensive triage duration with an identified MAS qualified clinician on average would be under 30 minutes. All patients referred to MAS will be triaged by the service.

Assessment is required prior to the diagnosis of dementia, consisting of history, cognitive and mental state examination, physical examination and examination of investigations.

The triage will in most cases be conducted by telephone and be integral to determining the individual offer of the assessment approach to the patient. The triage will involve an appraisal of the supporting information and circumstances to establish the appropriate assessment approach. – effective in determining patient’s assessment pathway

Patients will be encouraged to have accompaniment by a carer at initial assessment. Where the carer is unable to be present, conversations with the carer may take place separately.

Decision process for managing referral

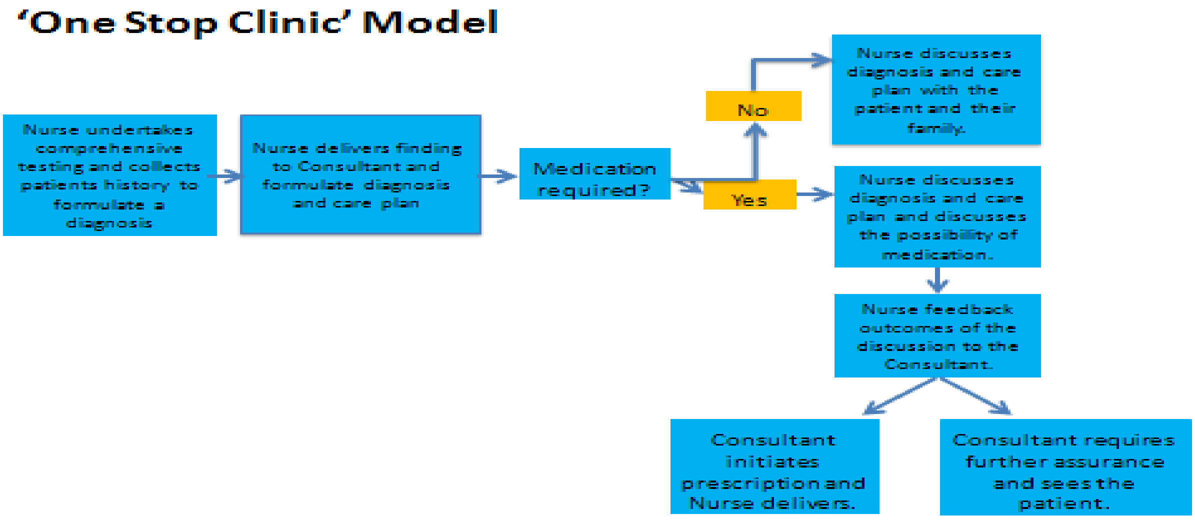
Patient	Offer 1	Offer 2	Offer 3	Refer to GP
Not willing	Within 3 operational days from receipt of referral	Within 8 operational days of referral unless firm refusal at offer 1	→	GP to consider management of patient within their service & discuss reasons for non-attendance. Possible collaborative process between MAS and primary care to progress diagnosis.
Not ready	Within 3 operational days from receipt of referral	On date agreed with patient	On date agreed with patient	
Not contactable	3 week period			
	Contact 1	Contact 2	Contact 3	
	Within 3 operational days from receipt of referral	Within 8 operational days of referral receipt	Within 15 operational days of referral receipt If no response (written letter offers assessment date)	

Confirm memory assessment booking
Once the patient and carer have accepted a proposed assessment date, MAS will send confirmation of the date, time and all information relevant to the patient and carer regarding the memory assessment. A reminder by phone or text will be made between 36 & 24 hours before the scheduled appointment.

Memory Assessment Approaches
Following an evaluation of pilot initiatives to undertake effective assessments, the ‘one stop clinic’ method will be implemented across Lancashire. In most cases, subtype-specific diagnosis of the type of dementia will be required and MAS triage and assessment staff will possess expertise in the differential diagnosis of the condition.

To facilitate a diagnosis of dementia, a comprehensive assessment including, where appropriate (NICE/SCIE CG 42): history taking, cognitive and mental state examination, physical examination as needed, a review of medication and diagnosis formulated.

One Stop clinic
It is estimated that 70% of referred patients in Lancashire will be suitable for the 'one stop clinic' approach. The clinics will be provided locally to deliver the assessment service to a cluster of GP practices. This provides the opportunity to deliver the nurse led provision of an efficient assessment process for patients. The 'one stop clinic' enables a further MDT discussion. The model is illustrated below.


'One Stop Clinic' Model

Extended Assessment
Also available following triage will be the provision of an extended assessment. Identifying patients requiring extended assessment at an early stage (triage) will allow for immediate referral for scans and further investigations to prevent hold ups in the diagnostic process, together with clearer expectations for patients and referrers around the likely process and waiting times.

This approach to assessment is offered for those patients determined during triage as

- Complex and 'unusual' cases
- Where home visits are clinically necessary
- Requiring further clinical assessments beyond those automatically available at the 'one stop clinic' (OT, neuropsychology, scanning etc.)

The term 'complex' which may influence the assessment approach may include:

- 65 years or under at onset of symptoms
- Memory is not the primary cognitive symptom
- Other current co-morbid neurological signs, condition or history
- Rapid decline from onset
- Known Learning Disability or poor literacy
- Very mild symptoms, especially in the context of high pre-morbid functioning

MAS in limited circumstances need to undertake further investigations to inform diagnosis or sub-typing and these shall include, but not be limited to:

- review of medication in order to identify and minimise the use of drugs that may adversely affect cognitive functioning
- ECG/EEG
- structural imaging (magnetic resonance imaging, MRI, or computer tomography, CT)
- formal neuropsychological testing where appropriate

Care Home Diagnosis
The MAS team will liaise with the local care and nursing home liaison team to ensure there is a

rounded offer to provide assessment and diagnosis for those identified as requiring a confirmed diagnosis of dementia. Since a key objective of the care and nursing home liaison team is to close the dementia diagnosis gap, some part of their service will mirror that of MAS offer, but in the distinct locations of care homes.

Acute Hospital referrals
The SQuID (single question) within the national CQUIN is likely to identify significant numbers of people requiring on-going assessment.

Acute care can refer directly into MAS (but it may be appropriate for the MAS service to delay assessment to ensure that any complicating symptoms of delirium do not share diagnostic decision. In these cases, review within 12 weeks would be appropriate.

Consultation
The experience of this assessment process may influence the way in which the person with dementia and his or her family or other carers deal with the diagnosis. MAS staff involved in assessment and diagnosis of dementia must be sensitive to the potential impact of the experience of the assessment process. This will be in the way they respond to questions, offer and share information and provide support.

Making the Diagnosis
A diagnosis of dementia and its sub-type shall be made by healthcare professionals with expertise in differential diagnosis of dementia using international standardised criteria as set out in NICE/SCIE Clinical Guideline 42.
Where the patient has a diagnosis of dementia, MAS will develop a draft care plan in consultation with other relevant disciplines, to discuss with the patient and their carer. The development of a good quality care plan for people with dementia and their carers requires the involvement of a number of different disciplines and the Provider will need to demonstrate how this will be achieved.

From the assessment date, MAS will complete the diagnosis and formulate the care plan within 2 weeks and where a brain scan is required within 4 weeks. Timeframes may be adjusted to take account of local provision (e.g. of scanning) but there will be no more than 8 weeks between assessment and diagnosis.

Once the diagnosis has been made MAS will contact the patient to organise a meeting to communicate the outcome of the diagnosis. This shall be within 14 days of the diagnosis having been made.

MAS staff will communicate the diagnosis in a manner that minimises unwarranted anxiety and shall provide information and reassurance that empowers the patient and carer to make informed decisions about the management of the condition and their individual well-being.
Outcomes and actions should fall in to the following five categories

Outcome	Action
1. No illness	Advise outcome of assessment to GP including any recommendations Discuss fully with the patient (and carer, where applicable)
2. Other illness (including depression)	Initiate urgent treatment or referral for physical or mental disorder if required or discharge to GP with advice on treatment or referral management
3. Dementia (no medication)	Talk through timely interventions; signpost and refer to resources/ support available. Advise GP of outcome and recommended next steps
4. Dementia (medication)	Talk through timely interventions, including medication. Signpost and refer to resources/ support available. Advise GP of outcome and recommended next steps
5. Possible dementia (MCI)	Advise GP to re-refer if symptoms persist or increase - sign-post to services that support maintenance of cognitive skills

	where these are available

MAS will agree and document a personal care plan and talk through timely intervention options, empowering the patient and their carer/family regarding the condition and its management.

Care planning

Having informed the patient and carer of the available support options open to them, and having discussed the patient's needs and preferences, MAS staff will talk through the contents of the draft personalised care plan, in line with NICE guidance.

Health and social care staff should aim to promote and maintain the independence, including mobility, of people with dementia. When writing care plans, the varying needs of people with different types of dementia should be addressed. The personal care plan shall cover both patient and carer needs and preferences. As a minimum, the care plan should address the following factors:

- prevention
- physical health
- psychological well-being
- medication
- social care and support
- activities
- carer's needs and issues
- risk and safeguarding.

Care plans should also include consideration on :

- consistent and stable staff available as a resource to the patient/carer, including relevant support available from other agencies
- retaining a familiar environment
- minimising relocations
- flexibility to accommodate fluctuating abilities
- assessment and care-planning advice regarding ADLs
- assessment and care-planning advice about independent livingskills; all possible causes should be assessed and relevant treatments tried
- environmental modifications to aid independent functioning, including assistive technology, with advice from an OT and/or clinical psychologist
- physical exercise, with assessment and referral for advice from a physiotherapist when needed
- support for people to go at their own pace and participate in activities they enjoy.

When developing a care plan for a person with a learning disability newly diagnosed with dementia, an assessment using the AMPS should be considered. Collaboration and joint working with colleagues in the learning disability service should be considered

Where a diagnosis of dementia is made, MAS staff will provide a 'serious illness notification' to the patient's GP within 2 working days of the diagnosis being shared with the patient. The serious illness notification may take a format similar to that used for a diagnosis of cancer and shall be transmitted via fax or secure email. Advice to enter the patient on the diagnostic register at the practice should be given within this notification.

Sharing the diagnosis

The majority of people with mild dementia wish to know of their diagnosis and all practitioners should assume that the diagnosis will be discussed with the person with dementia, unless there are clear reasons not to do so. Clinicians will discuss disclosure carefully with people with suspected dementia and their families, to establish the best approach and what the person wishes to be told. During the assessment and diagnostic process, people will routinely be asked if they wish to know the diagnosis and with whom this should be shared.

There should be no automatic assumption that diagnosis should not be conveyed to the individual simply because of the perceived severity of dementia. Similarly, people with learning disabilities should be told their diagnosis of dementia; those supporting them should have access to specialist clinical advice and support.

Support and information
For people with newly diagnosed dementia and members of their family, accurate details of local support should be available which refer to primary and secondary care, social care, voluntary and community services.

When working with people from minority communities where terms like dementia may not be widely known, MAS staff will develop or draw on specialist support and publications.

Post diagnostic Interventions
MAS will offer timely advice and support for patients (and their carers) who have received a diagnosis of dementia. This support shall, as a minimum, include information sharing, support and local services to receive follow-up. The patient and carer shall be informed about:

- education sessions in dementia
- therapeutic activities for dementia
- peer support/self-help groups
- support for carers
- medication, where appropriate.

The content and the number of the information sharing and support suggestions and offer will vary according to individual patient and carer needs.
However, as a minimum, all patients and carers shall have one subsequent meeting post diagnosis to share information and finalise a personal or discharge care plan.

MAS will provide to all PWD and carers information and linkage to the post diagnostic system of resources. MAS will pass on relevant information and ensure every diagnosed patient knows where to access further support. This will be promptly on receiving the diagnosis.

Information and support shall include, but shall not be limited to:

- support for carers of patients who have non-cognitive symptoms (e.g. mood disorders, psychotic symptoms and behaviour that challenges)
- advice and support to assess and manage pharmacological treatment
- medico-legal issues, including driving
- guidance on how people with dementia can improve their general health, live positively and maximise their quality of life after diagnosis, e.g. using mental exercise, physical activity, dietary advice alongside drug therapy
- services to support people with dementia and their carers that may be available from other organisations
- services that can offer information, advice and support with communication problems
- services that can advise on welfare benefits
- local dementia support services, including dementia adviser services and useful websites for patients and carers
- peer support services
- assessment of carer needs
- advice and support on planning for the future, including legal matters associated with loss of capacity, including power of attorney, managing finances and benefits, and advance directives
- services to support people with other health or care needs

Printed information materials will be kept up-to-date and shared with general practices.

MAS staff will notify the patient and Carer/ family of their local dementia adviser service. MAS members will routinely attend local dementia cafes and link with dementia advisors.
Where available, MAS will signpost/refer on to services that will provide interventions in line with

NICE/SCIE guidelines, which shall include, but not be limited to:

- education sessions in dementia
- therapeutic activities for dementia (e.g. cognitive stimulation therapy, reminiscence groups)
- peer support/self-help groups
- carer support.

The expected period of contact and support from the MAS shall be [*12*] weeks from acceptance of assessment date

Review & Medication Management
Where anti-dementia medication is prescribed, the local shared care protocol will be followed. Ordinarily an annual medication review takes place within MAS until agreement is reached with CCGs as part of discussion on the shared care protocol.

Pharmacological interventions
Specialists in the care of patients with dementia (that is, psychiatrists including those specialising in learning disability, neurologists, specialist nurse prescribers and physicians specialising in the care of older people) should initiate treatment.

Titration of medication will usually take place at 4 weekly intervals, the majority being complete within 3 months. Where side effects may occur a small number may require 3-6 months and discussion on this would take place with primary care colleagues.

Patients who continue on treatment should be reviewed annually using cognitive, global, functional and behavioural assessment as appropriate Treatment and wellbeing reviews should be reviewed by shared care within the annual QOF assessment following the initiation and titration of medication by MAS.

Carers' views on the patient's condition at follow-up should be sought.

Discharge & transition to GP care
MAS will manage the arrangements for a successful transition to GP care or other services. This will follow the confirmed care plan.

A final support session will be provided to the patient / carer to communicate the transition, expectations, support available and points of contact.

Within 5 operational days of the final meeting, MAS will distribute the care plan with all relevant details as outlined above.

Discharge / shared care
Following the completion and agreement of the personal care plan, a copy will be given routinely to the patient (or carer) unless there are specific issues which make this inappropriate (e.g. their dementia is advanced and they would struggle to manage written material). The care plan shall also be copied to the patient's GP, alongside a discharge letter summarising the main points of the care plan and discharge arrangements.

The discharge letter will
- confirm the diagnosis
- recommend the patient is entered on to the Quality and Outcomes Framework (QoF) dementia register
- the monitoring and management considerations relating to health and wellbeing, for both the patient and the carer
- an estimate on any review intervals based on the assessment outcomes

A GP may consider a review following any initiation of antipsychotics, but a wellbeing review will take place annually as part of the QoF requirements. This needs to be in line with antipsychotic protocols in dementia

Where patients are discharged following input from MAS, GPs will have a contact point for direct access to MAS clinicians for consultative advice. This should be in relation to medicines management issues or issues related to the diagnosis of dementia. This support should be available for up to 3 months post discharge from MAS and where re-accessing MAS, MAS will judge what other services, such as CMHT, might be required after triage.

3.3 Population covered

The MAS teams will be delivered across Lancashire area. Eligible Lancashire GP practices will be key referring agents.

3.4 Any acceptance and exclusion criteria

The memory service is designed to meet the needs of adults of all ages with symptoms of dementia who have not already received a diagnosis. Referrers shall refer patients who they suspect may have mild to moderate dementia that is beginning to impact on the person's day-to-day living.

Target groups

- ✓ people with memory problems, or showing signs of mild cognitive impairment where a diagnosis of dementia is suspected;
- ✓ people with dementia, where confirmation of the sub type and/or specialist advice is required.
- ✓ people showing symptoms of unexplained personality change or behavioural changes that would lead to a suspicion of rarer forms of dementia

Equity of access to services

MAS will be accessible to all, regardless of age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex or sexual orientation, and deal sensitively with all service users and potential service users and their family/friends and advocates. It should design systems and processes for assessment that are sensitive to the needs of different user groups (for example Learning disability or where English is not the first language).

Eligibility

The complexity and heterogeneity of symptoms for dementia makes it difficult to provide a list of referral criteria; instead referral to the MAS will be a clinical decision based on the possibility that the individual has dementia. This will be on the basis of presenting symptoms, a review of past history, collateral history from an informant and exclusion of other acute medical reasons such as delirium by physical examination and investigations. Together with a brief, objective measure of cognition, eligibility and referral will be consistent with NICE Clinical Guideline 42. The MAS teams will support primary care for people living at home and in care homes, setting out arrangements for the assessment of people where referral to a clinic setting is not appropriate.

Principal Inclusion criteria would be

Adults should be referred to the memory service if they meet the following criteria:

- ✓ The person is presenting with symptoms consistent with suspected dementia rather than a physical or functional mental illness.
- ✓ The person does not have an existing clinical diagnosis of dementia or the sub-type dementia is unknown.

Referral criteria:

- ✓ working-age adults and older adults
- ✓ subjective memory problems
- ✓ change in everyday function over a period
- ✓ a rapid cognitive deterioration, not explained by the person's physical health condition/s
- ✓ carer's report of change in client no previous or definitive diagnosis of dementia.

MAS will not see any cases where urgent treatment is needed. MAS may signpost the referrer to other secondary services, for example:

- more complex behavioural and psychological problems
- suicidal ideation

- psychotic behaviour
- crisis situation from carer's perspective
- occasions where a very rapid cognitive deterioration, not explained by the person's physical health condition/s

3.5 Interdependencies with other services

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

4.2 Applicable standards set out in Guidance and/or issued by a competent body

4.3 Applicable local standards

This service should adhere to all relevant standards, guidelines and local formulary. The service should notify commissioners should any benchmarking against these standards identify gaps in commissioned services.

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:
The MAS will shall ensure that services are arranged to suit the person's needs. The majority of appointments will be offered in local clinics to ensure best use of MAS resources. Venues for delivery such as 'One stop clinic' models will be delivered in certain GP surgeries, intending to be easily accessible by public transport.

7. Individual Service User Placement

[Insert details including price where appropriate of Individual Service User Placement]