SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	
Service	Primary Care Memory Assessment and Management Service (MAMS)
Commissioner Lead	Lincolnshire West CCG, Annette Lumb
Provider Lead	Lincolnshire Partnership Foundation Trust
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 may be caused by a number of illnesses in which there is progressive decline in multiple areas of function, including decline in memory, reasoning, communication skills and the ability to carry out daily activities. Alzheimer's disease is the most common type of dementia, with other types of dementia including vascular dementia, dementia with Lewy bodies and frontotemporal dementia. Although dementia is predominantly a disorder of later life, there are at least 15,000 people in the UK under the age of 65 who have the disease.

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.[1] Over the next 40 years the number of people with dementia in the UK will more than double to 1.7 million.4

The current GP registered population of Lincolnshire is 730,275 (April 2013). This is projected to rise to 902,000 by 2033.

This specification supports best practice, in line with NICE guidance as indicated within Section 4.1 of this service specification, in the delivery of Dementia services. It sets out the requirements for service delivery and development for the needs of service users requiring assessment, diagnosis and treatment of service users with Dementia.

1.2 Local Context

- The CCG has 37 practices within 5 localities
- The total registered population in January 2013 is 226,845
- The CCG's registered patients live in 3 different upper tier Local Authorities.
- The CCG's main Local Authority is Lincolnshire County Council and this

[1] King's Fund (2008), Paying the Price: The cost of mental health in England to 2026. London: King's Fund.

CCG accounts for 219,800 (30%) of its population.

- This CCG's main provider is United Lincolnshire Hospitals NHS Trust and accounts for 60,822 (83%) of its admissions. These represent 33% of that provider's total admissions.
- For Lincolnshire West CCG. 16.2% of the CCG's registered population are under age 15 (England average 17.1%) and 8.4% are age 75 or over (England average 7.5%). 50.8% are female (England average 50.2%).
- The CCG currently has 1,577 patients with a diagnosis of dementia and has a predicted prevelance of 3,203 (2013/14)
- In line with the Governments strategy for dementia the CCG is required to formally diagnose a minimum of 67% of its dementia prevelance (3,335 patients) by 2016/17 which equates to 2,235 patients.
- This service is designed to help address this need.

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

2.2 Local defined outcomes

- Early Diagnosis in line with the DH Dementia Outcomes September 2010 “I statements”:
  - I was diagnosed early
  - I understand, so I can make good decisions and provide for future decision making
  - I get the treatment and support which are best for my dementia, and my life
  - Those around me and looking after me are well supported
  - I am treated with dignity and respect
  - I know what I can do to help myself and who else can help me
  - I feel part of a community and I’m inspired to give something back
  - I can enjoy life
  - I am confident my end of life wishes will be respected. I can expect a good death
- Providing a diagnosis to help service users and their families make good decisions
- Help people live well with Dementia
- Improve diagnosis rates especially early diagnosis (mild stages of the illness)
- Increase in the proportion of people with dementia having a formal diagnosis compared with the local estimated prevalence.

The service should enable the delivery of:

- Responsive and patient centred care
- High quality and safe care
- A service within the principles of no delays

3. Scope

3.1 Aims and objectives of service

- Support the CCG and its practices to increase diagnosis rates
- Reduce waiting times for dementia diagnosis
- Provide the dementia diagnosis and care closer to the service users home
- Increase primary care and secondary care collaboration
- to provide the dementia 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 engage people with dementia and their carers in decisions about the care options available to them, including the
- development of personal care plans including supporting individuals with Advanced Decisions e.g. Power of Attorney
- 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

3.2 Service description/care pathway

Primary Care Memory Assessment and Management Service (MAMS)

This service will establish Community Psychiatric Nurse (CPN) led memory assessment and management service in a primary care setting. The service will provide quick, convenient access for service users with suspected dementia. The service will provide assessment, diagnosis, early intervention and commence treatment, where possible, of service users with dementia.

Service users will be referred for an initial dementia assessment usually by their GP or other appropriately qualified clinician e.g. CPN to the local Primary Care Memory Assessment and Management Service clinic.

The Provider will undertake an assessment of the service user within the Primary Care MAMS. The assessment shall include, where appropriate:

- history taking which will include but not be limited to:
    - a subjective and objective assessment of the service user's life, social, family and carer history, circumstances and preferences, as well as their physical and mental health needs and current level of functioning and abilities, including an interview with an informant (usually carer/family) to generate a collateral history
    - assessment of history and impacts of impairments of vision, hearing and mobility
    - assessment of history and impacts of impairments of medical co-morbidities
    - assessment of key psychiatric and behavioural features, including

depression, wandering and psychosis
    - risk assessment covering all areas appropriate to the individual, e.g. falls, risk to self, childcare or carer responsibilities, driving and financial and legal issues
    - carer assessment and/or signposting including burden, health and function.
- cognitive and mental state examination
- a review of medication

Once the assessment has been completed, the service user's assessment will be reviewed by the Provider's Old Age Mental Health consultant led Multi-Disciplinary Team (MDT) to include the CPN conducting the assessment, an Old Age Consultant Psychiatrist, Occupational Therapist and social worker as a minimum to confirm the diagnosis.

If the MDT conclude the service user needs to be seen by consultant and/or further tests e.g. functional tests are required, the Provider will provide the appropriate specialist assessment or appointment within 10 weeks of the original assessment

For cases where the clinical presentation and history is not in doubt and there are no other complex comorbidities the Provider shall complete the assessment and communicate the diagnosis within 4 weeks (unless a service user chooses to receive the diagnosis at a later date in a more convenient location) and where other functional tests are required within 10 weeks of the assessment.

If the MDT agree the case is Dementia and can be appropriately managed in Primary Care then the case is returned to the clinician working within the Primary Care MAMS. The Provider shall develop a draft care plan in consultation with other relevant disciplines, to discuss with the service user and their carer.

The Provider will communicate the diagnosis with the service user and carer at their next appointment with appropriate documentation on support. The communication of the diagnosis shall take place face-to-face in a quiet, private and comfortable setting. It shall be in simple, direct language avoiding use of medical jargon, in a warm, caring and respectful manner.

The service provides a timely and local / individualised assessment service, with discharge occurring once the assessment has been completed and the outcome of this is communicated to all required parties. The Provider will discharge the service user back to the care of the GP where it is clinically appropriate to do so ensuring all necessary shared care protocols are in place.

Once diagnosis has been delivered, the Provider shall refer the service user and carer(s) onto local dementia support services or networks and any other appropriate service.

Follow Ups

Where appropriate, the Provider is responsible for organising the necessary follow ups within the Primary Care MAMS for the purposes of but not limited to:

- providing a diagnosis
- starting and stabilising drug therapies in line with NICE Guidance
- providing further support for the service user and their carer(s).

It is expected that a service user will require on average 3/4 follow up appointments.

Care Plans

The Provider shall complete a written personal care plan, in consultation with other relevant disciplines where appropriate, for the service user and their carer and this shall be agreed with the service user and the carer. The service user shall receive a copy of the care plan; the carer shall receive a copy of the personal care plan where the service user's permission has been given.

Rapid Access

Where a service user has been discharged (Section 3.2.3) and their needs have change a GP may request further support and information prior to referring back into the Primary Care MAMS by contacting the Provider's local CPN or Old Age Consultant Psychiatrist. The Provider will reply to all requests for further support and information on the same day.

Following a change in need and where the GP believes the service user would benefit from reassessment, the GP will refer back into the Primary Care MAMS so long as the service user is still appropriate for the service. The Provider will see the service user within 5 working days and re-assess their needs. Where the service user needs have changed the Provider will work with other organisations to put relevant support in place.

Neighbourhood Teams (Physical & Mental Health and Social Care)

Where the Provider feels a service user would benefit from an MDT assessment for any other health and social care needs then they shall refer the service user onto the local Neighbourhood Team for discussion. The Provider will need to ensure consent is gained from the service user or their carer, where appropriate, prior to the referral being made. The referral should be made by the CPN for the team who can request the service user be added to the next MDT agenda.

3.2.1 Review and Booking of Referrals

All referrals to the service shall by via the LPfT Single Point of Access (SPA).

The Provider shall contact service users and carers in person or by telephone within 3 working days of receipt of referral. The service user shall be offered a memory assessment (initial offer).

The Provider shall send service users who cannot successfully be contacted after 2 attempts and within 8 working days, an offer of an assessment date in writing. If the offer is not accepted, or the service user cannot be contacted within 3 attempts, the service user shall be referred on to GP-supported management.

The Provider shall record the date of successful contact and the proposed assessment date.

Do Not Attend (DNA and Cancellation)
Service users who do not attend their outpatient appointments will be contacted and a new appointment arranged/offered. Where appropriate, and in line with mental capacity legislation and guidance, this appointment can be arranged with the service user's carer.

Avoiding Empty Slots
The Provider must have a system for avoiding empty slots which may include a reminder call service to contact service users a few days before an appointment to ensure all slots are used. The Provider should fill empty slots from cancellations by offering service users earlier appointments where this doesn't compromise patient experience.

Re-offer assessment date
The Provider shall make a second offer of an assessment date to service users who are not ready and/or not willing within a mutually agreed timeframe of the initial offer.

Where a service user accepts a second date for assessment, the Provider shall record the date when the service user confirms that acceptance.

Where a service user is not willing to accept a second date for assessment, the Provider shall record the date when the service user confirms that s/he is not willing to accept the second assessment date. If the service user is not willing to accept the second assessment date s/he shall be referred to GP-supported management and the GP shall be asked to discuss reasons for non-attendance with the service user and undertake a review for a possible re-referral in 6 months.

Where a service user is willing but not yet ready to accept a second date for assessment, the Provider shall record the date when the service user confirms that he/she is willing but still not ready. The service user shall be offered a third date for assessment within a mutually agreed timeframe of the previous offer.

The Provider shall record the onward referral of unwilling service users to GP-supported management and the date the onward referral is made.

3.2.2 Onward Referral
Where a service user has received a diagnosis other than dementia, the Provider will refer the service user onto the appropriate service and inform the service user's GP of the transfer of care.

3.2.3 Discharge
Where clinically appropriate the Provider will discharge the service user back into the care of their GP. The Provider will send a discharge letter summarising the main points of the agreed personal care plan within 48

hours. This shall include confirmation of the diagnosis and a recommendation that the service user is entered on to the Quality and Outcomes Framework (QOF) dementia register. A fuller report is to be sent within 10 working days.

GP-supported management shall include the monitoring and management of elements in the personal care plan relating to activities to promote health and wellbeing, for both the service user and the carer, and review at agreed intervals.

3.2.4 Referral Sources

Referrals into the Primary Care Memory Clinic will primarily be from GP practices directly. Referrals may also come from other professionals.

3.3 Population covered

The Service will cover all patients who are registered permanently or temporarily with a practice within Lincolnshire West CCG.

3.4 Any acceptance and exclusion criteria and thresholds

Acceptance Criteria

- people with memory problems, where dementia is suspected;
- Physical causes for the change in behaviour or psychological well-being have been eliminated.

Exclusion Criteria

- Physical causation not excluded prior to referral (i.e. via physical health screening and review)
- Social need only (no health related needs)

3.5 Interdependence with other services/providers

The provider is expected to work within the Lincolnshire Health Economy. Partners within this pathway include (not limited to):

- Other Secondary Care Providers e.g. United Lincolnshire Hospital Trust (ULHT), North Lincs and Goole (NLAG) etc
- Community Health Trusts e.g. Lincolnshire Community Health Services
- Adult Social Care
- GPs
- Integrated Community Teams (Physical & Mental Health and Social Care)
- Other services as required e.g. physiotherapy, Occupational Therapy

To help the service user experience a seamless pathway of care the provider shall work collaboratively with the commissioner, primary care and other secondary care providers to deliver services in an organised and cohesive manner, and to reduce sequential waits between services within the pathway within their authority.

Providers are expected to cooperate and share information with others involved in a service user's care, treatment and support while having regard to the service user's rights to confidentiality and Information Governance legislation.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

- NICE Clinical Guideline 42 (CG42) – Dementia
- NICE Quality Standard 1 (QS1) – Dementia Quality Standard
- NICE Quality Standard 30 (QS30) - supporting people to live well with dementia
- NICE Technology Appraisal 217 (TA217) - Alzheimer's disease

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

4.3 Applicable local standards

The provider will respond to referrals within 3 working days and complete the assessment where indicated within a further 4 weeks. Where a service user chooses to wait longer this must be recorded.

4.4. Reporting metrics

Impact	*Outcome*	*Purpose*	*Metric specifics*	*Reporting type and frequency*	*Source of Data*
Patient receives a timely diagnosis of dementia	How many new diagnosis of dementia are made by the MAMS service	To ensure the service is efficient in its patient flow	First referral to MAMS and the Follow-up referral for Memory re-assessment Data To be differentiated by : *GP practice *Source of referral profession – will be coming on line Q3 2016	Number of referrals by first referral or follow-up by specified narrative Quarterly reporting by month	LPFT Data Silverlink
Referrers are utilising the service appropriately	Service is utilised effectively	To ensure the service is being used appropriately by referrers	The number of referrals accepted and declined together with the reason	Number Monthly reporting	LPFT Data Silverlink
Patients are accessing the service	Service is utilised effectively	To ensure the service is being utilised efficiently by patients	The Number of DNA's by: *GP Practice	Number and narrative Monthly reporting	LPFT Data Silverlink
Waiting times for the service are kept to a minimum	Ensuring the patient flow is efficient	The service can be monitored for external impacts on	Waiting time from referral received to assessment	Number Monthly	LPFT Data Silverlink

and monitored accordingly		patient flows		reporting	
Waiting times for the service are kept to a minimum and information used to assist QOF register directly	Ensuring the patient flow is efficient	The service can be monitored for external impacts on patient flows	Waiting time from referral received to *working diagnosis. **(10 week target)***by GP practice *by PbR Cluster	Number by GP practice and PbR Cluster Monthly reporting	LPFT Data Silverlink
Patients are accessing the service appropriately	Service is utilised effectively by referrers	To ensure the service is being utilised efficiently by patients	Outcome of assessment outcomes by *diagnosis of dementia *ICD code *Not diagnosed as dementia (alternative diagnose listed if possible?)	Number by diagnosis by GP practice? Monthly reporting	LPFT Data Silverlink
Quality Metric Assessment Outcome information is shared with GP and referrer	Communication is shared promptly and in a useful manner	Notice of referral outcome is shared with the GP and the referrer (if not the same)	All Outcome communication is sent to GP and referrer within 10 working days of the *End Care Option outcome* being known	*Team Coordinator to* sample 10 random patients each month for Communication being sent, to be reported quarterly. Expectation of the end of year report to be 95% attainment across the service	LPFT Data Silverlink to generate the random samples

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

Please see quality requirement Q1 of the Quality Schedule.

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

None

6. Location of Provider Premises

The Provider's will operate at Premises located at:

Nettleham Medical Practice, Lodge Lane, Nettleham
Welton Family Health Centre, Cliff Road, Welton
The Glebe Practice, Saxilby
Plus other GP Practices requested within the West CCG area.
Operation at these premises is in line with a patient focussed and GP supporting service. It is a change in operational activity with no financial change.