SCHEDULE 2 – THE SERVICES

Service Specification No.	05/MHLD/0029
Service	Memory Assessment Service (MAS), Part of Memory Gateway
Commissioner Lead	Mental Health and Learning Disability CDG
Provider Lead	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST
Period	1st April 2015 – 31st March 2017
Date of Review	December 2016

1. Population Needs

1.1 National context

Dementia is a growing, global challenge. As the population ages, it has become one of the most important health and care issues facing the world. The number of people living with dementia worldwide today is estimated at 44 million people, set to almost double by 2030. In England, it is estimated that around 676, 000 people have dementia.

Dementia has, and will continue to have, a huge impact on people living with the condition, their carers, families and society. Dementia is now one of the top five underlying causes of death and one in three people who die after the age of 65 have dementia. Nearly two thirds of people with dementia are women, and dementia is a leading cause of death among women – higher than heart attack or stroke.

Dementia mainly affects older people, and after the age of 65, the likelihood of developing dementia roughly doubles every five years. However Dementia can start before the age of 65, presenting different issues for the person affected, their carer and their family.

Estimating the prevalence of dementia across England is not an exact science and has used different methodologies to estimate. Previously data was based on the Delphi approach which is a consensus statement based on experts reviewing a series of international studies. Since April 2015 the Cognitive Function and Ageing II Study (CFAS II) is the national method being applied. This uses real data from three populations in England, allowing for more granular estimates of prevalence, for example at Clinical Commissioning Group level, and indicates that there are ranges. This will be adopted by NHS Dorset CCG in terms of estimating prevalence for national targets however it is hoped more accurate prevalence rates will be reached in future.

Living Well with Dementia: The National Dementia Strategy (2009) set out key areas to:

- Improve awareness in the community and across health and social care services to support early diagnosis, followed by evidence based treatment and intervention;
- Deliver higher quality of care to enable people to live well with dementia;
- Ensuring improved awareness through effective advice and support around dementia;
- Removing the stigma that still surrounds it;
- Consistently improving the delivery of education and training for professionals at all levels and in all settings;

- To develop and commission a range of services for people with dementia and their carers which fully meet their changing needs over time, within an agreed funding package.

This has been followed by key national documents including:

- Prime Minister's Challenge on Dementia 2020 (DH 2015)
- Dementia: a State of the Nation Report (DH 2013)
- Prime Minister's Challenge on dementia – delivering major improvements in dementia care by 2015 (DH 2013)
- Quality Outcomes for People with Dementia (2010)

1.2 Local context

NHS Dorset Clinical Commissioning Group has a top priority to improve services across Bournemouth, Poole and Dorset for people to 'live well with dementia' at whatever stage they are with the disease.

Dorset has a higher than national average of older population and has a large number of care homes which impact on the prevalence rates. Considerable work has been done across Dorset to improve diagnosis rates which had been noted nationally to be very poor in previous years.

A new dementia denominator had been published on 19th February 2015 in the Technical Definitions for Commissioners. The denominator is the prevalence for the CCG calculated from the ONS population estimates multiplied by dementia prevalence rates from the second cohort Cognitive Function and Ageing Study (CFAS II). NHS England will use CFAS II as the as the basis of 15/16 dementia planning assumptions and for monitoring progress toward the national ambition.

As shown in Table 1 below NHS Dorset CCG has an estimated prevalence of 12,857 of age 65+ years. Alzheimer's Society estimate of age 30 – 64 years is 548. So total prevalence is estimated to be 13,405 across NHS Dorset CCG.

Based on previous 2014 methodology to estimate prevalence the national estimated number of people with a dementia diagnosis in March 2015 was 61.6%. NHS Dorset CCG diagnosis rate was 60.8% (based on practices submitting data to the Health and Social Care Information System).

NHS Dorset has agreed to meet the national target of 67% during 2015/16 and has a stretch target of 70%.

Table 1 Comparisons of Dorset prevalence and diagnosis rates within NHS England – South (Wessex)CCG's

Analysis of impact of new CFAS II methodology (65+) for calculating dementia diagnosis rates						
	HSCIC data					Calculated Diagnosis Rate using CFAS II denominator and estimated number of 65+ on register as numerator
CCG	Mar 2015 Reported Diagnosis Rate	Mar 2015 reported number on register	65+ prevalence %s supplied by AH	Mar 2015 Estimated number on register 65+	15/16 CAFS II Denominator	Mar-15
Dorset	60.8%	8096	95.9%	7765	12857	60.4%
Fareham and Gosport	58.2%	1811	95.2%	1724	2745	62.8%
Isle of Wight	66.9%	1958	95.7%	1873	2454	76.3%
North East Hampshire and Farnham	60.7%	1544	94.7%	1462	2295	63.7%
North Hampshire	60.8%	1573	94.1%	1480	2342	63.2%
Portsmouth	66.3%	1528	94.8%	1449	2005	72.2%
South Eastern Hampshire	59.9%	2085	95.4%	1988	3160	62.9%
Southampton	65.0%	1702	94.8%	1613	2256	71.5%
West Hampshire	56.3%	5089	95.4%	4856	8426	57.6%

2.

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	

2.2 Local defined outcomes

It is the expectation that all people with dementia will be able to say:

- I was diagnosed early;
- I understand, so I make good choices and provide for future decision-making;
- I get the treatment and support which are best for my dementia and my life;
- I know 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 can enjoy life;
- I feel part of the community and I'm inspired to give something back;
- I am confident my end of life wishes will be respected and I can expect a good death

The expected outcomes from the Memory Assessment Service are:

- Increased dementia diagnosis rates across Dorset
- Prompt access to full assessment meeting the 4 week (75%) and 6 week (95%) target from referral.
- Access to neuro-imaging where indicated
- Medication reviews for patients prescribed Acetyl Cholinesterase Inhibitors in line with the shared care protocol.
- Increased diagnosis of people from hard to reach groups
- Increased assessment and diagnosis of patients in 'at risk' groups
- Improved patient and carer satisfaction
- Increased public awareness

Improved identification and diagnosis of dementia of 'At Risk' groups:

- Patients aged 60 and over with cardio-vascular disease (CVD), a stroke, peripheral vascular disease or diabetes;
- Patients aged 40 and over with Down's Syndrome (this client group would be referred to the Dorset HealthCare Learning Disability Service)
- Other patients with learning disabilities aged 50 and over (this client group would be referred to the Dorset HealthCare Learning Disability Service) and patients with long term neurological conditions with a known neuro-degenerative element, for example Parkinson's disease.

3. Scope

3.1 Aims of service

People with dementia and their family and carers need to be helped to live well with dementia, no matter what the stage of their illness or where they are in the health and social care system, with recognition that dementia is a progressive condition which requires contingency planning as the disease develops. There is a commitment to adopt a pan Dorset approach to supporting people with dementia and /or Mild Cognitive Impairment from diagnosis to end of life.

The Memory Gateway model has been developed to ensure more people with memory impairment and dementia are identified at an early stage in the pathway and are able to access timely and effective information, advice, assessment, treatment and care to enable them to live well with dementia. It also aims to ensure friends and family whom informally care for an individual with dementia are supported both physically and psychologically to maintain their own health and wellbeing.

The Memory Assessment Service (MAS) forms part of the Dorset Memory Gateway and will work in partnership with the Memory Support and Advisory Service (MSAS).

The aim of the MAS is to:

- Improve access to services for people experiencing memory loss through early assessment and diagnosis of dementia/Mild Cognitive Impairment (MCI) to increase the quality of their life so they can live well with dementia/MCI;
- Assess people referred to the service with memory loss and diagnose dementia as appropriate in a speedy manner;
- Contribute to the national and local priorities to improve early detection and diagnosis of dementia reaching the NHS Dorset CCG stretch target of 70% or as a minimum reaching the national 67% diagnosis rate target by 31.3.2016
- To provide treatment in a timely manner as required for clients and carers;
- Provide specialist dementia advice to clinicians if requested/required.

3.2 Objectives of service

The Memory Assessment Service (MAS) will:

- Work in partnership with the Memory Support and Advisory Service (MSAS) as part of the Dorset Memory Gateway, sharing expertise and knowledge and working jointly to deliver a seamless service to patients removing all duplication between services;
- Agree to a joint operational policy between the MSAS and MAS to form the Dorset Memory Gateway;
- Signpost newly diagnosed patients and their carers to MSAS where not already in touch with the service;
- Offer advice and guidance to primary care in the early identification and assessment of people with a possible diagnosis of dementia/MCI especially 'at risk' groups;
- Assist primary care in diagnosing patients in Care Homes where requested by the GP following identification through the Enhanced Service – Dementia Service Specification;
- Develop a high-quality service for dementia assessment, diagnosis and treatment;
- Provide pharmacological treatments. Refer clients not eligible for pharmacological treatments to the MSAS for post diagnosis support and access to services such memory café and appropriate community services.
- Ensure any clients referred who require more specialist ongoing support are referred to the Community Mental health Team e.g. for treatment of challenging behaviours.
- Access to neuro-imaging where indicated;
- Support commissioners and clinicians from relevant services to ensure the development of a clear pathway, appropriate shared care protocols and prescribing for neurology services (for more complex or rarer dementias), for people with additional neurological conditions e.g. Parkinson's Disease and younger people with early onset dementias;
- Engage with Learning Disabilities (LD) Services diagnostic pathway of people with LD and dementia.
- Report all diagnosis of dementia/MCI within DHC including LD via this service acknowledging that the diagnosis of MCI / Dementia in LD is undertaken by the Learning Disabilities Services in DHC;
- Refer patients or carers to the 'Steps to Wellbeing Services' (DHC) (where not already done by the MSAS /if presentation indicates offer of referral is appropriate);
- Jointly provide education to GPs, primary care, community and hospital services on the Dorset Memory Gateway with Alzheimer's Society;

- Prescribe ACIs according to NICE TA217 monitoring their clinical efficacy where applicable;
- Make ACI prescribing adjustments, according to shared care prescribing protocols and undertake the first annual medication review; liaising with GP and MSAS on the outcomes before discharging to primary care;
- Provide dementia diagnosis data to MSAS and primary care for practices to update their dementia/MCI registers using data from the RIO system as required;
- Work with MSAS service to update the 'This is Me' document adding to them as clinical change is required and sharing with services as agreed by the patient and carer ;
- Provide advice to GP's who wish to undertake diagnosis. This may be via telephone advice to discuss a patient under the care of the GP;
- Maintain the dignity of the patient and their carers throughout all communications and contact with the service;
- Ensure Carers Assessment under the Carers Act is completed or arranged as necessary.

3.3 Service description/care pathway

This service will provide an equitable and consistent service delivery model including waiting times and accessibility across all of Dorset for the diagnosis and treatment where appropriate for people with dementia/Mild Cognitive Impairment.

The service will work alongside other long term conditions, co-working with community services – integrated health teams (Better Together) as appropriate.

Referral sources to the Dorset Memory Gateway

Referrals to this service will come through the Dorset Memory Gateway via the Memory Support and Advisory Service for initial screening. Patients can self- refer to the Memory Gateway and other referrals are anticipated to come from GPs, Mental Health Liaison Nurses, Primary Care Talking Therapies (Steps to Wellbeing), Community and Acute Hospitals.

Pre diagnosis referrals to the Memory Gateway will need to be supported by appropriate blood tests and patient history from the patients GP.

Within implementation of the Dorset Dementia Diagnostic Pathway, GPs can diagnose dementia where the condition is established.

GPs should refer directly onto the Mental Health Older Person's CMHT in more complex cases or where there is evidence of severe psychological and behavioural issues, risk of social or carer breakdown.

Under the current shared care agreement, should the GP identify a patient who may benefit from a trial of ACIs, they will refer their patient to the Memory Gateway for MAS to initiate treatment (ACI's) and monitoring in compliance with the current shared care guidance.

Memory Gateway – Memory Support and Advisory Service

On contact with the Memory Gateway the patient will be contacted within 2 days by MSAS Memory Advisor and will be offered an initial appointment with a Memory Advisor within 2 weeks (10 working days).

MSAS will offer initial screening for cognitive impairment with 6CIT, functional ability with Functional Assessment Questionnaire (FAQ) and depression and anxiety screening.

The 6 CIT test is the cognitive screening tool which identifies a score of below 8 as normal. FAQ Scores below 10 are considered normal. Patients with a 6 CIT score of 8 or above will be referred to the MAS. Patients with a score 7 will not be routinely referred to the MAS unless their combined 6CIT and FAQ score is above 17.

Scoring system	**Total score of 6CIT & FAQ**
Not appropriate currently for MAS	6CIT 7 or below Combined score 14 and below
Discuss with MAS	15/16
Referral to MAS	6CIT of 8 and above Combined 6CIT and FAQ of 17 or above

For patients scoring 15 and 16 there will need to be a discussion between MSAS and MAS to decide the most appropriate course of action for each patient.

Referrals not appropriated to the MAS will be discussed with GP and referrer informed.

All patients will be offered advice, support and guidance and it is recognised some patients may decline an appointment with MAS for further assessment and possible diagnosis.

Patients will remain as an active case with MSAS until a post diagnosis appointment has either been accepted or offered and rejected. Patients will then become classed as 'dormant cases' with life time access for further advice and support as required.

Memory Assessment Service referrals

Following triage by MSAS, if appropriate and in agreement with the patient, patients will be offered an initial assessment appointment within four weeks (75%) or 6 weeks (95%) of receipt of a referral with MAS.

Referrals are triaged within one working day of receipt (service available Monday – Friday).

Referrals will be confirmed with an appointment letter and information leaflet within 5 working days.

Diagnosis will occur within two-four months (subject to any scan required being undertaken within 6 weeks of the request) with a written confirmation letter of diagnosis to be copied to the patient, GP and referrer and MSAS. This will be sent within 5 working days of diagnosis.

The Memory Assessment Service will inform the CCG if they are advised that scan waiting times exceed six weeks by the acute hospitals.

Individuals receiving a new diagnosis of dementia by the MAS will be signposted back to MSAS. MAS will share their diagnosis to enable appropriate ongoing support.

Individuals diagnosed with dementia who would benefit from dementia medications will undergo a trial of ACIs in accordance with NICE Technology Appraisals (TA 217), under supervision of MAS and will also receive support from MSAS.

If the patient is prescribed a trial of ACIs their follow up review of ACI prescribing trials will be provided by the MAS for the twelve months. The patient and their carer will also receive support from MSAS and primary care. A twelve monthly (yearly) review will be carried out by the MAS in line with shared care prescribing guidelines and the NICE Technical Appraisal 217 after the first year. If the patient is stable on the medication, then will be discharged to primary care who will undertake future annual reviews in line with the shared care protocol.

There will be time limited contact with patients to establish and stabilise the patient on a trial of ACIs.

Carers Assessment under the Carers Act is completed or arranged as necessary.

As part of the Dorset Memory Gateway both GPs and MAS can refer patients with complex needs, severe behavioural and psychological symptoms or risk of social or carer breakdown to the relevant locality Older People's Community Mental Health teams.

The MAS service currently operates Monday to Friday 09.00 – 17.00. There is acknowledgement of wider health and social care developments, including the Better Together Programme and Clinical Services Review, the Memory Assessment Service will work with other services to consider the development of seven day week working in future years / specifications.

Confidentiality and information governance principles are required when sharing information with MSAS to provide joint care plans. DHC (MAS) service will share information if appropriate with MSAS in a confidential manner adhering to DHC information governance policy. MSAS will also share information with MAS in a confidential manner adhering to confidentiality policies. Each service will be respectively individually responsible for adhering to data protection and confidentiality policies and procedures in respect of the data they receive and store.

Following diagnostic appointment

Following the diagnostic appointment the patient will receive written confirmation within five working days

The GP and/or referrer including the MSAS will be provided with written confirmation of consultation and any outcomes or recommendations within five working days

Following assessment with no diagnosis of dementia/MCI

Patients who have been diagnosed with Mild Cognitive Impairment (MCI) will be offered the option of an annual review/screening by MSAS as it is estimated that 50% of people with MCI are diagnosed with dementia at a later time.

If indicated, MSAS will then refer the patient directly back to the MAS for further assessment, in agreement with the GP. If more than 12 months have elapsed since the last MAS assessment, the GP will be required to recomplete the dementia blood screen at the point of referral to MAS.

For patients with no diagnosis they are discharged back to the GP and sign posted to other appropriate services other than MSAS. MSAS is informed to ensure the patient is removed from caseload.

Discharge Criteria and Planning

Interventions by the MAS are time limited.

Transfer back to MSAS as part of the post diagnosis Memory Gateway will occur following:

- diagnosis or
- trial(s) of ACIs

3.4 Population Covered

This service will be delivered in community clinics across the thirteen CCG localities (as below). There is greater need for increasing the diagnosis in the seven localities in the Dorset County Council area, whilst maintaining diagnosis across the whole Dorset CCG area.

The east Dorset Localities are:

Poole North	East Bournemouth	East Dorset
Poole Central	Central Bournemouth	Purbeck
Poole Bay	North Bournemouth	Christchurch

The west Dorset Localities are:

Dorset West	Mid Dorset	North Dorset
Weymouth and Portland		

3.5 Any acceptance criteria

- the patient is registered with a GP within the Dorset CCG area;
- the patient has received initial screening by the MSAS (part of the Dorset Memory Gateway) and meets agreed scoring criteria for MAS referral;
- The patient is 18 or over;
- the patient does not already have a diagnosis of dementia/MCI;
- the patient has received a diagnosis of dementia from an appropriate acute care clinician but needs assessment for treatment;
- the patient is physically stable;
- Patients with an existing diagnosis of dementia can be re-referred for review by MSAS (or GP) if it is felt their condition has deteriorated or significantly changed, in particular if they were previously diagnosed with MCI and it is now suspected the person may have dementia;
- The patient requires a review of their ACI prescribing;
- The patient has moved into the area on an existing prescription of ACI medication

that they have been in receipt of for less than 12 months requires ongoing monitoring. After the first 12 months of the prescription the client will receive an annual review from MAS and then if stable be discharged to primary care for ongoing annual reviews.

3.6 Exclusion criteria

Patients reporting memory problems following a traumatic head injury. These patients should in first instance be referred to neurology services

Patients with dementia and severe complex needs such as behavioural and psychological symptoms in dementia. These patients should be referred to the Older Person's Community Mental Health Team.

3.7 Interdependence with other services/providers

It will be essential to ensure that systems are in place to provide good communication and smooth transfer for patients and carers between and particularly across the:

- Memory Gateway with Memory Support and Advisory Services
- Older People Community Mental Health Teams
- Other Community and Mental Health Services
- Learning disability services
- Acute Hospital Service Providers
- GPs

3.8 Service Specification Review

It is recognised that these services may be subject to change due to ongoing national and local initiatives around dementia and dementia diagnosis.

Recognising this service is a major informer of achieving the national/local early diagnosis dementia rates for NHS Dorset CCG and three Local Authorities this service specification will be reviewed by December 2016 to reflect changes in service requirements and agree annual activity and finance.

4.

4.1 Applicable national standards

The service should adhere to national standards and guidance.

- **National Dementia Strategy (2009)** outlines three key steps and seventeen objectives to improve the quality of life for people with dementia and their carers.

- **NICE Technology Appraisal Guidance TA216** Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease

- **NICE Quality Standard 1 Dementia Pathway – issued June 2010.** This quality standard covers the care provided by health and social care staff in direct contact with people with dementia in hospital, community, home-based, group care, residential or specialist care settings. This quality standard should be considered in conjunction with NICE

Quality Standard 30 on supporting people to live well with dementia (QS30).

- **NICE Quality Standard 30 (2013)** - This quality standard covers the care and support of people with dementia. It applies to all social care settings and services working with and caring for people with dementia.

- **NICE Guideline CG42 (2006) -** This guideline makes specific recommendations on Alzheimer's disease, dementia with Lewy bodies (DLB), fronto-temporal dementia, vascular dementia and mixed dementias, as well as recommendations that apply to all types of dementia.

- **NICE Advice KTT7** Low-dose antipsychotics in people with dementia (2015)

- **NICE Advice ESUOM40** Management of aggression, agitation and behavioural disturbances in dementia: carbamazepine (2015)

- **NICE Advice ESUOM41** Management of aggression, agitation and behavioural disturbances in dementia: valproate preparations (2015)

- **Commissioning for quality and innovation (CQUIN) 2015/16 guidance on dementia.**

Additional legislation and guidance

The service is required to work to legislation and guidance as set out in:

- Mental Health Act (1983) revised 2007;
- Mental Capacity Act (2005)
- Multi Agency Safeguarding Adults Policy (pan Dorset) 2013;

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

Staff working within the service should adhere to the relevant professional guidance and codes of practice e.g. Royal College of Psychiatrists, Nursing and Midwifery Council, British Psychological Council, British Association of Occupational Therapists and College of Occupational Therapy and other bodies pertinent to the service

4.3 Applicable local standards

Refer to the Memory Gateway pathway (appendix A)

4.4 Continual Service Improvement

The provider will monitor referrals and ensure this service is responsive to reaching 67% diagnosis of dementia, which is both a local and national target

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)

The reference numbers for quality requirements and CQUIN goals which apply to the service can be listed here. This allows clarity about the requirements relating to specific services.

6. Location of Provider Premises

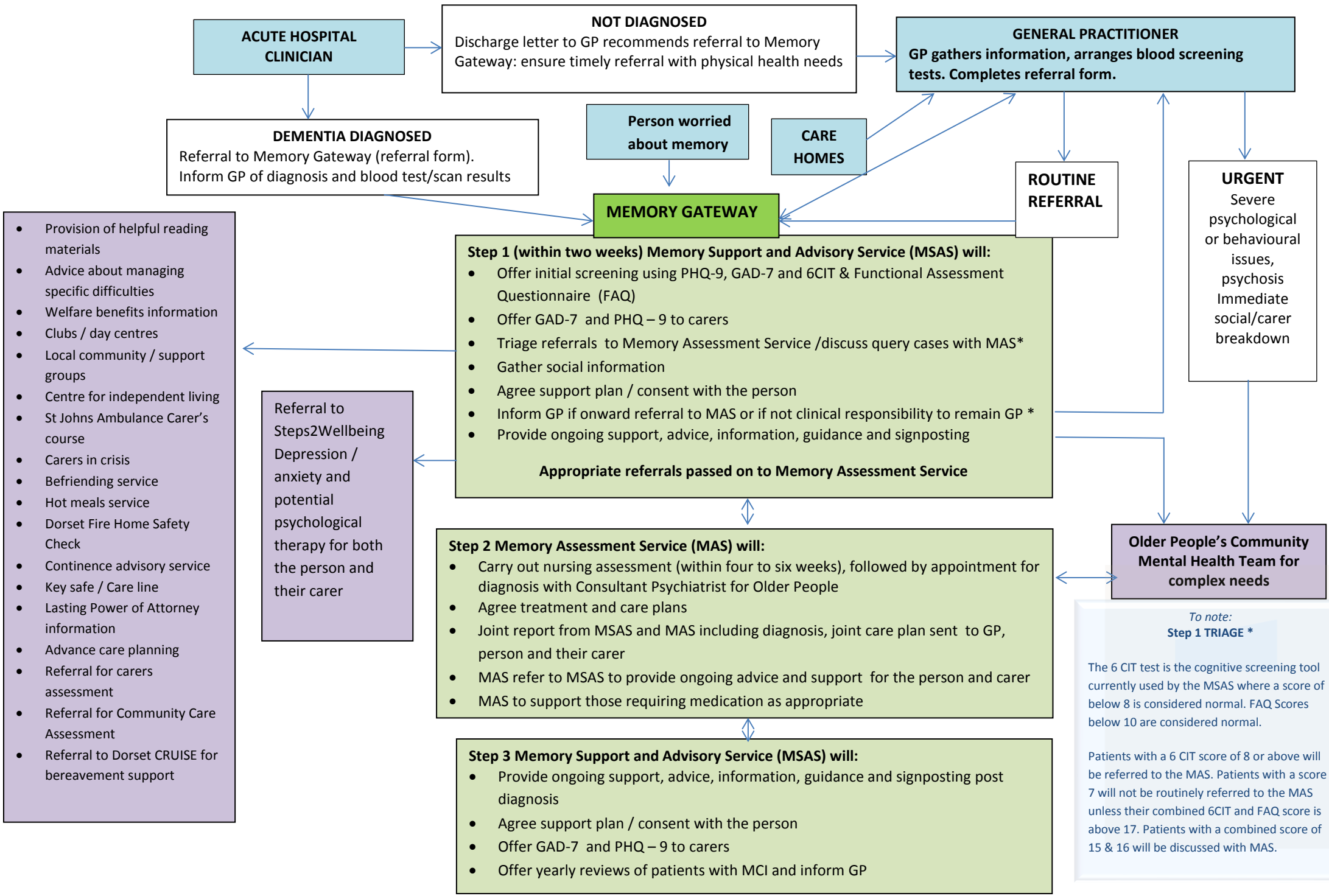
The Provider's Premises are located at:

Services will be offered from a range of venues across Dorset, including the patient's own home, taking into account risk, timeliness and wherever is most appropriate for the individual, based on need and choice.

7. Individual Service User Placement

This section may be used to include details of any individual service user placements (e.g. for care homes). This is likely to be relevant where the service provides tailored specialist placements. It may also be used to record any specialist equipment that is provided as part of an individual care pathway.

APPENDIX A


ACUTE HOSPITAL CLINICIAN
NOT DIAGNOSED
Discharge letter to GP recommends referral to Memory Gateway: ensure timely referral with physical health needs
GENERAL PRACTITIONER
GP gathers information, arranges blood screening tests. Completes referral form.
DEMENTIA DIAGNOSED
Referral to Memory Gateway (referral form).
Inform GP of diagnosis and blood test/scan results
Person worried about memory
CARE HOMES
ROUTINE REFERRAL
URGENT
Severe psychological or behavioural issues, psychosis
Immediate social/carer breakdown
MEMORY GATEWAY
Step 1 (within two weeks) Memory Support and Advisory Service (MSAS) will:
Offer initial screening using PHQ-9, GAD-7 and 6CIT & Functional Assessment Questionnaire (FAQ)
Offer GAD-7 and PHQ – 9 to carers
Triage referrals to Memory Assessment Service /discuss query cases with MAS*
Gather social information
Agree support plan / consent with the person
Inform GP if onward referral to MAS or if not clinical responsibility to remain GP *
Provide ongoing support, advice, information, guidance and signposting
Appropriate referrals passed on to Memory Assessment Service
Provision of helpful reading materials
Advice about managing specific difficulties
Welfare benefits information
Clubs / day centres
Local community / support groups
Centre for independent living
St Johns Ambulance Carer's course
Carers in crisis
Befriending service
Hot meals service
Dorset Fire Home Safety Check
Continence advisory service
Key safe / Care line
Lasting Power of Attorney information
Advance care planning
Referral for carers assessment
Referral for Community Care Assessment
Referral to Dorset CRUISE for bereavement support
Referral to Steps2Wellbeing Depression / anxiety and potential psychological therapy for both the person and their carer
Step 2 Memory Assessment Service (MAS) will:
Carry out nursing assessment (within four to six weeks), followed by appointment for diagnosis with Consultant Psychiatrist for Older People
Agree treatment and care plans
Joint report from MSAS and MAS including diagnosis, joint care plan sent to GP, person and their carer
MAS refer to MSAS to provide ongoing advice and support for the person and carer
MAS to support those requiring medication as appropriate
Older People's Community Mental Health Team for complex needs
Step 3 Memory Support and Advisory Service (MSAS) will:
Provide ongoing support, advice, information, guidance and signposting post diagnosis
Agree support plan / consent with the person
Offer GAD-7 and PHQ – 9 to carers
Offer yearly reviews of patients with MCI and inform GP
To note:
Step 1 TRIAGE *
The 6 CIT test is the cognitive screening tool currently used by the MSAS where a score of below 8 is considered normal. FAQ Scores below 10 are considered normal.
Patients with a 6 CIT score of 8 or above will be referred to the MAS. Patients with a score 7 will not be routinely referred to the MAS unless their combined 6CIT and FAQ score is above 17. Patients with a combined score of 15 & 16 will be discussed with MAS.