CITY AND HACKNEY DEMENTIA SERVICE (CHDS)

OPERATIONAL PROTOCOL (IMPLEMENTATION FRAMEWORK)

© OCTOBER 2023

Document Information & Version Control

Document Name	**CHDS Operational Protocol**		
Document Status	**Revised**		
Document Version	**v6.3.4**		
Lead Authors **Contributors**	**Martina Agho -** Programme Manager, Strategy & Transformation, CH Dementia Alliance **Dr Emma Teper** -Consultant Psychiatrist and Lead Clinician, CHDS **Adenike Saidu** - Operational Healthcare Lead **Olasheni Shorunke-Samuel**- Operational Social Care Lead **Mahmood Dilloo** - Specialist Nurse and Team Leader, CHDS **Dr Michelle Hamill -** Consultant Clinical Psychologist Lead Psychologist for Older Adult Mental Health, East London Boroughs **Dr Darshi Kumareswaran -** Clinical Psychologist **Steve Reading -** Service Manager, Alzheimer's Society, City and Hackney, Tower Hamlets and Newham **Claire Wheeler -** Dementia navigator **Carol Feldon -** Dementia navigator **Andrew Whipp -** UCP Coordinator and KPIs Monitoring Officer, CHDS **Avis Lewallen -** Lead Admin **Tasneem Mukith** Service Manager, Alzheimer's Society, Barking & Dagenham, City & Hackney, Redbridge		
Approval	**Approving Body**		**Date**
	1. CMHT Management Team 2. Alzheimer's Society Management Team		**October 2019**
Dates	**Effective**	**28th October 2019**	**Next Review Date**
	Yearly Review	October 2023	October 2024
Monitoring Group/Review Committee	CHDS Working Group		

Table of Content

1. Introduction

This operational protocol has been written in collaboration with staff and managers of the CH Dementia Service and key stakeholders. This document provides a framework for the delivery of the City and Hackney (CH) Dementia Service and provides a step by step approach to all areas of delivery.

The City and Hackney Dementia Service (also known as the Dementia Service) went live on the 7th October 2019 replacing the Diagnostic Memory Clinic. It sits in the City and Hackney Community Mental Health Team for Older People. The new City and Hackney dementia care pathway is a NICE recommended model, which also aligns with the ethos of the National Dementia goals for 2020.

The new service model was launched on the 28th October 2019 and formally adopted the name: CH Dementia Service.

1.1 The name "Dementia Service" reflects the extended functions and ambition of the new service as one that:

- provides timely assessment and diagnosis in addition to post diagnostic support and treatment
- holds everyone diagnosed with dementia from the point of diagnosis to death
- ensures, everyone diagnosed with dementia has a named professional to support them and their family/carer throughout their journey with dementia until death.
- will work with all key stakeholders to provide a well-coordinated person-centred care for people living with dementia, their carers and family members

1.2 The new service is delivered jointly as a collaboration between East London NHS FT (ELFT) and Alzheimer's Society with ELFT being the lead provider

1.3 The new service is funded by the City and Hackney Clinical Commissioning Group (CCG) as a Consultant Led Service

1.4 The service operates a Single Point of Entry (SPE) system for all referrals

1.5 The service is open to all residents who are registered with a GP in City and Hackney.

1.6 The service shall also treat residents who are registered with an Islington GP

1.7 The service does not provide care management. This is provided by Adult Social Care

1.8 The service does not provide carers assessment but will provide brief support to carers and refer appropriately to either Carers First or Adult Social Care

1.9 The service is open 9:00-17:00, Monday to Friday. All out of hours (OOH) referrals are picked up the next working day

2. The CH Dementia Service Operational Protocol

Domain	Subdomain	Summary Description/procedure
1. Team Meetings	**1.1 Dementia Service Team meeting**	1.1.1 Weekly DS Team meeting, every Tuesday (12:30 -13:30): 1.1.1.1 New referrals allocation to NURSEs by neighbourhoods 1.1.1.2 Case discussion/breaches- (if need be, escalate to MDT) 1.1.1.3 Step up /step down cases (handover step down list to Dementia navigators) 1.1.1.4 RiO/UCP issues/updates; KPIs monitoring/updates (UCP & Data Quality Coordinator-UCP&DQC) 1.1.2 Psychology input (fortnightly for first 6 months, and then monthly)-training, education and consultation to the team; discussion of MCI pathway with the team 1.1.3 **Membership:** Nurses/Dementia navigators, UCP & DQC, Team Lead (chair), Team Admin, Psychologists as in 1.1.2 above
	1.2 Dementia Service MDT	1.2.1 Weekly DS MDT every Tuesday, 10:00-12:00am: 1.2.1.1 Doctors to discuss complex cases 1.2.1.2 Brief discussions of initial assessments, cases of concern including complex medication 1.2.1.3 Post initial assessments -Psychologists-max 4 active assessments per week (includes neuro assessments, MCI, and on-going neuro assessments/ feedbacks) 1.2.2 Target wait time for neuro assessments-6 weeks from point of referral to neuro psychological assessment 1.2.3 **Membership:** Consultants, Doctors, Nurses, Navigators, UCP & DQC, Team Lead, Admin, Asleen, Psychologists, Operational leads, OT (Functional Assessment)-attends once a month - email the other weeks ahead of the MDT
	1.3 Neighbourhood MDT	1.3.1 Nurses and Dementia Navigators to attend respective neighbourhoods MDT 1.3.2 Present and discuss cases of concerns, provide specialist input to MDT cases, work collaboratively with practitioners involve in patient's care e.g. senior social care practitioners, District Nurses etc. to seamlessly coordinate care.

2. Single Point of Entry (SPE) Referrals	**2.1 SPE Pathway**	2.1.1 All referrals via SPE: 2.1.1.1 Referrals for suspected dementia accepted from GPs or Community Matrons, Homerton University Hospital or Specialist Clinics e.g. Parkinson Clinic 2.1.1.2 Referrals to include all relevant information 2.1.2 SPE weekly meeting on Tuesday morning: 2.1.2.1 Discuss new referrals and triage to: - CMHT or DS or if further information required from GP- or bounce back to GP. 2.1.2.2 New referrals where patients already diagnosed e.g. moving into area - no BPSD triage to DS, BPSD to CMHT 2.1.3 **When a service user calls:** 2.1.3.1 If not known goes through normal referral pathway as in 2.1.1 above 2.1.3.2 If known to the DS, pass on to the DS Duty 2.1.3.3 DS Duty to triage to the relevant nurse, or dementia navigator (if known to them or to the Navigator Duty if the named dementia navigator is not available). 2.1.4 **If patient has a diagnosis of dementia** 2.1.4.1 All emails/fax referrals, including concerns, discharge from hospital, merlin notification triage to DS Duty who will triage accordingly to the respective neighbourhood nurses or dementia navigator, if patient is known to them 2.1.4.2 Based on level of risk and presenting needs, named nurse and or dementia navigator to make contact and arrange F2F (where applicable) within 3 working days of receiving referral 2.1.4.3 If the named nurse is not available, nurses to agree among themselves who to pick it up. The nurse stepping in should discuss the case with the neighbourhood dementia navigator for actioning or Navigator Duty if named dementia navigator not available 2.1.4.4 Duty emails checked and managed daily (M-F, 9-5pm) by 2 qualified staff and 1 senior practitioner.

		2.1.5 **Referrals to Dementia Navigator from GP/Professionals/Community** 2.1.5.1 Patients has a diagnosis of dementia: ○ Referrals can come from anyone ○ If urgent flag immediately with neighbourhood nurse who will arrange a follow up in line with recall process as in sec 7.1.5 below ○ Where possible, nurse and dementia navigator to do a joint visit ○ If non-urgent, discuss at weekly team meeting. If no further nursing input required at this stage, dementia navigator to take over patient and follow up within 7 working days and in line with review process as in secs 4.2.7.2 to 4.2.7.4 below 2.1.5.2 Patients without a diagnosis ○ If a professional or family member or neighbour calls about memory concerns, advise them of the referral process as in 2.1.1 above and encourage them to support the person to consult with their GP ○ Input relevant RiO Code including supporting client with Planning for the future form ○ If anyone rings up worrying about their memory, duty / neighbourhood dementia navigator to explain the process of diagnosis; provide advice and encourage them to book an appointment with their GP. ○ If they would rather prefer you do the referral, seek consent, and then refer to GP ○ Keep records of all referrals and follow ups 2.1.5.3 Pre-Diagnostic Support to GPs with non-engaging/vulnerable patients ○ GPs to refer (using dementia navigator Support Referral form) patients for whom there is a concern of memory problems but who: - are challenging and not engaging with the GP - have declined referral to the dementia service or have reservations ○ Dementia Navigators to work with patients (by neighbourhoods) and their carers/relatives where possible to fact find: - listen to patients/carers/relatives' concerns to understand the main issues/challenges necessitating non-engagement - explain the process of screening/diagnosis and answer any questions where possible - give advice and information about dementia

		- jointly work up an intervention plan - if patient refuses to engage, leave contact details, and let them and their carers/families know the support is always available whenever they are ready to make contact. - if findings are more system related and beyond the remit of Dementia navigator to intervene, refer findings to the Dementia Alliance ○ Dementia navigators to feedback outcome to the GP ○ Keep records of all referrals and follow ups
3. Assessment & Diagnosis	**3.1 Assessment and Diagnosis**	3.1.1 Consultant led assessments 3.1.2 Doctors to complete initial assessments and MCI feedback if dementia suspected: 3.1.2.1 Initial assessment within 6 weeks of referrals 3.1.2.2 Diagnosis and treatment **within 18 weeks of referrals** 3.1.3 Doctors to discuss: 3.1.3.1 UCP at feedback 3.1.3.2 More complex cases discussed at MDT and referred for neuropsychological assessment after initial assessment 3.1.4 Doctors to review complex cases if needed once discussed at MDT

4. Post Diagnostic Support and follow up	**4.1 Caseloads**	**Nurses** 4.1.1 Caseload (about 50) of high risk and complex patients with no BPSD. 4.1.2 Responsible for patients starting on medication within assigned neighbourhoods (2 neighbourhoods for each nurse) 4.1.3 Responsible for medication review in line with NICE recommended guidelines 4.1.4 Lead named Practitioner for each Neighbourhood **Dementia Navigators** 4.1.5 Caseload (about 150) each of low risk patients across 2 neighbourhoods 4.1.6 Responsible for majority of reviews - patients who are stable, low risk and non-complex (non-complex patients include patients who are stable, have no clinical complications/issues of concerns or are deteriorating) 4.1.7 Each Neighbourhood to have a named Lead Dementia Navigator (while there maybe more than one dementia navigator supporting a neighbourhood, the lead dementia navigator remains the responsible person for patients within that neighbourhood)

	4.2 New referrals - Initial contacts and follow up	**Nurses and New Referrals** 4.2.1 Nurses to lead on all new referrals, initial contacts and follow up as below. 4.2.2 Dementia navigators may be required to carry out telephone or virtual follow up, sign posting etc. 4.2.3 Initial contact with patient by telephone within 2-weeks of receiving post diagnostic referrals from Doctors: 4.2.3.1 Check summary care records on RiO/HIE prior and also ask patient when contact is made, if GP has prescribed medication 4.2.4 Face-to-Face (F2F) contact within 6 weeks of receiving post diagnostic referrals: 4.2.4.1 Complete DS Risk Stratification Tool (RST) and take appropriate actions. Appendix See appendix 2 4.2.4.2 If patient is low risk and stable step down to Dementia navigator 4.2.4.3 If high risk and complex but with no BPSD, hold in caseload for a minimum of 3 months or until stable and then step down to dementia navigator (see 6.1.2 below) 4.2.4.4 Upload completed RST on RiO 4.2.4.5 Provide information/intervention on how to reduce personal risks including maintain good physical health 4.2.4.6 Initiate ACP conversation at first visit ○ Maintain ongoing ACP discussion ○ Give information based on patient's wishes and follow ACP pathway ○ Input relevant RiO Code including supporting client with Planning for the future form ○ When ACP form completed, send copy to GP and update UCP with details 4.2.4.7 Seek UCP consent if not given at diagnosis ○ Explain information sharing and give UCP patients information leaflets ○ Record and date UCP consent outcome ○ Inform UCP Coordinator of consent outcome 4.2.4.8 Lasting Power of Attorney (LPA) ○ Enquire if one is in place ○ If not give information and discuss

		○ Update RiO and UCP 4.2.4.9 Advanced Decision to Refuse Treatment (formerly Advanced Directive) ○ Check if one is in place and ○ Update UCP 4.2.4.10 Ceiling of Treatment ○ Explain what it means ○ Check if already discussed with GP and the outcome ○ Inform UCP Coordinator who will follow up with GP for any missing information 4.2.4.11 Preferred place of care and death ○ Enquire if already discussed with GP and the outcome ○ If not, discuss with patient ○ Update UCP 4.2.4.12 Involve carers/family in support and decision making 4.2.4.13 Enter all appointments (2 weeks telephone; 6 weeks F2F and 3 months as minimum) in RiO diary 4.2.4.14 Upload RST and care plan on RiO whenever one is done and or revised 4.2.4.15 Update RiO progress notes whenever contact is made **Patients in caseload** 4.2.5 From January 2020 to use RST for all reviews-see appendix 2 4.2.6 Regular review of patients who are stable and non-complex 3 months by telephone and at least once every 6 months F2F or as guided by RST. 4.2.7 If a client is uncontactable, please follow the process in appendix 3 4.2.8 Identify changes using RST: 4.2.8.1 This should be completed F2F however virtual or telephone review can take place in some circumstances. Flag any clinical concerns to named nurse immediately at this stage. 4.2.8.2 Face to Face visit should be considered:

		○ where client lives alone/has no family or other support and is unable to engage in a telephone or virtual assessment due to advance dementia, other health conditions or impairment ○ there are concerns that client is not effectively communicating or disclosing the true picture of their current situation 4.2.9 Develop a support plan to include activities that promote social inclusion including virtual activities. 4.2.10 At each care review, continue with ACP discussion (if unsure discuss with nurse or at Team Meeting), complete RST and review support plan 4.2.11 Actively signpost to the most appropriate source of help. Support patients to access a range of services (health and social care, day service, 3rd sector support), and community resources of choice including benefits check, taxi-cards, wellbeing and housing, will writing services etc.) 4.2.12 Enter all appointments (6 weeks F2F, 3/6 months reviews) in RiO diary 4.2.13 Upload RST/support plan on RiO whenever one is completed and or revised 4.2.14 Update RiO progress notes within 72 working hours of engaging with patient (either F2F or via the phone) **Care Homes Patients** 4.2.15 Each care home (Acorn Lodge, Beis Pinchos, Queen Elizabeth II Infirmary and St Anne's) to have a named nurse/dementia navigator duo 4.2.16 Named nurse to do/review medication, ACP discussion, RST and UCP documentation 4.2.17 Nurse to hold patients for a min of 3 months and once stable on medication and less complex, step down to dementia navigator as in 6.1.2 below 4.2.18 Dementia Navigator to hold patients and support them and their carer/families till death or out of borough placement 4.2.19 Dementia Navigator to review patients at least once every six months. 4.2.20 The nurses/dementia navigators to participate in their respective care homes MDTs to provide specialist input and support as and when invited 4.2.21 Dementia Navigators to also provide pre-diagnostic support to care homes Linked GPs with non-engaging residents as in 2.1.5.3 above

		4.2.22 Dementia liaison nurse to support care homes and social care providers trainers in running training sessions for their workforce

Post Diagnostic Support and follow up-*continues*	**Initial contacts and follow up-New referrals**	**<u>Psychological Interventions</u>** 4.2.23 Cognitive Stimulation Therapy (CST) Groups 4.2.23.1 Currently running for 14 weeks. 4.2.23.2 Support workers to facilitate groups under Psychologist supervision. 4.2.24 Memory and Well-being group for those with MCI 4.2.24.1 8-weekly sessions (based on cognitive techniques and anxiety/ mood management/ emotional distress). 4.2.24.2 Co-facilitated by at least one psychologist and another discipline due to complexity of presentations, mental health, high levels of distress about the diagnosis, determining who need to be reassessed with urgency, managing carer distress, etc. 4.2.25 High intensity post diagnostics psychotherapy - individual/carer/couples therapies facilitated by clinical psychology; length of time dependent on clinical need. 4.2.26 Carer's group psychotherapy - 8-fortnightly sessions. Must be run by two qualified clinical psychologists. 4.2.27 NEW PROVISION: PATH research trial (UCL). Open to all eligible patients with depression in dementia and their carers. Open to recruitment since Sep, offered by home visit or remotely as carer must be involved.

5. Hospital Admissions and Post Hospital Discharge Follow Up	**5.1 72 hours Follow Up**	5.1.1 All referrals via SPE for triage to the DS duty 5.1.2 For patients admitted into hospital, where possible, the Homerton Team (IIT, HUH Admitting Medical Team, Homerton Psychological Medicine) will notify the DS of admissions via SPE 5.1.3 When a patient is being discharged from hospital, if follow up/review at home is required, the Homerton Team will inform the DS team via SPE. 5.1.4 Where a referral is received but it is not clear if a follow up/review is required, the DS Duty nurse to check with the referrer. 5.1.5 Duty to triage to the relevant nurse who will discuss with their linked dementia navigator and agree the best follow up plan. If the linked dementia navigator is not available, the nurse to discuss with Dementia Navigator duty. 5.1.6 Patient to be contacted and reviewed within 3 working days of receiving referral either via telephone, virtually or face to face as agreed 5.1.7 If patient is in DS caseload and on admission, where possible and if known, the named nurse to liaise with the ward to formulate a discharge plan and facilitate 72 hours follow up 5.1.8 If a post hospital discharge referral is sent directly to a dementia navigator duty, discuss with the named nurse or at DS Team meeting 5.1.9 It is important for all 72 hours referrals to be discussed between the neighbourhood nurse and their linked dementia navigator to avoid any duplication, ensure a consistent approach and the best plan of action.

6. Stepped Model	**6.1 Step down**	6.1.1 **<u>Step Down from CMHT to DS</u>** 6.1.1.1 When patient is stable, CMHT to step down to DS 6.1.1.2 All stepped-down referrals to DS <u>via</u> SPE pathway 6.1.1.3 A patient can only be stepped down to the DS when ASC has taken over any social care/care reviews on mosaic 6.1.1.4 If transfers to ASC are not sorted with the CMHT before the new service starts, CMHT to hold unto the cases 6.1.2 **<u>Step Down from Nurses to Dementia Navigators</u>** 6.1.2.1 Patient who are low risk, stable and non-complex (non-complex patients include patients who are stable, have no clinical complications/issues of concerns/are deteriorating) 6.1.2.2 Ensure all urgent referrals for assessment have been made before stepping patient down. 6.1.2.3 Compiled list of all stepped down cases for handover to Dementia Navigator including copy of RST, ACP form at the weekly Team meeting. 6.1.2.4 Do joint stepdown visit where possible and complete RST
	6.2 Step Up	6.2.1 **<u>Step up from DS to CMHT</u>** 6.2.1.1 Patients becoming more complex with BPSD nurses to step up to CMHT 6.2.1.2 Discuss all stepped up referrals to CMHT in weekly Team meeting and at MDT 6.2.2 **<u>Step up from Dementia Navigators to Nurses</u>** 6.2.2.1 Patients with increased risks and complexity (i.e. patients with clinical complications/issues of concerns/are deteriorating) • Medication issues • Side effects or review of current medication • BPSD (behavioural and psychological symptoms of dementia) • Covers behavioural issues, hallucination /delusion and paranoia • Delirium • Low in mood – Harm to self • Safeguarding in place

		• Repeated wandering • Aggressive /violent 6.2.2.1 Before stepping up -essential actions to complete: • Face to face visit completed. • Risk Stratification completed and shows increase level of Risk. • Case (s) for step up discussed with Alzheimer's Society Manager and/or Dementia nurse in neighbourhood • Liaised with all agencies involved in patient care including family. This will be helpful to complete before step-up but not essential for a step-up • RIO entry completed with regards to current concern.

7. Recall of Existing Patients	**7.1 Recall of patients to reassess needs and allocate to appropriate named professional**	7.1.1 All recalls (estimated 850 patients) to be completed by nurses. 7.1.2 Recall of patients to start from 4th November 19 and end by the 31st Oct 2020 7.1.3 Reconcile GPs, Homerton and Carers First lists with ELFT list (UCP and Data Quality Coordinator to lead) 7.1.3.1 Open all existing patients on RiO under the CHDS Review Team 7.1.4 Recall patients by discharge date in descending order from earliest discharged to present date 7.1.4.1 Starting with community patients then nursing homes (St Anne's, Acorn and Beis Pinchos and Queen Elizabeth II Infirmary -City of London) 7.1.4.2 Mary Seacole patients-no need for recall as under the care of Dr Cianan O'Sullivan 7.1.5 Urgent referrals from GP/Community Services, add to recall list and arrange a F2F review within 3 working days or sooner depending on level of urgency 7.1.6 Send out recall letters and follow up with a telephone call 7.1.6.1 Admin to send out recall letters on a month by month basis 7.1.6.2 Nurses to follow up with telephone calls to book a face to face appointment for patients in their neighbourhoods. 7.1.6.3 Maximum of 4 recalled patients/week per nurse (Team Leader to help with Recalls) 7.1.7 Face to face appointment (Always refer to guidelines and local risk assessment protocols 7.1.7.1 Complete CH Recall Checklist (RCL_v1_ 10.10.19) 7.1.7.2 ACP discussions and UCP 7.1.7.3 Update RiO and UCP accordingly 7.1.7.4 Upload copy of RCL on RiO 7.1.8 All low risk and non-complex patients step down to Dementia navigator (include copy of Recall Checklist and follow the process in 6.1.2 above) 7.1.9 Recalled patients to be reassessed in addition to new post diagnostic assessments according to neighbourhoods

8. MCI Clinics	**8.1 MCI Recalls including VCI**	8.1.1 Keep an MCI/VCI register from July 2019. Include new MCI referrals from GPs previously diagnosed 8.1.2 All MCI/VCI patients are referred here as MCI 8.1.3 Recall MCI patients within 6-12 months based on need and clinical judgement 8.1.4 MCI list to be discussed at weekly MDT and allocate 4 weeks in advance. 8.1.5 Initially, Clinical Psychologist (Dr Kumareswaran as agreed with M Dilloo-Team Leader) to carry out two months' worth of all MCI assessments from Jan to support the new team as they settle in 8.1.6 Possibility of joint MCI assessment with nurses shadowing 8.1.7 After the initial 2 months as in 8.1.5: 8.1.7.1 Straight forward MCI cases – nurses 8.1.7.2 Complex cases-Psychologists-or Doctors 8.1.8 MCI cases once assessed to be discussed at weekly MDT 8.1.9 Psychologists to provide group training/education/consultation to the team for MCI pathway. See 1.1.2 above for details

9. RiO Re-Configuration	**9.1 Team Set up**	9.1.1 Work with RiO/Performance Teams to: 9.1.1.1 Change team name from DMC to CHDS 9.1.1.2 Reconfigure RiO with the new KPIs (such as 6 weeks initial assessment, **18 weeks referrals to diagnosis and treatment**, 2 weeks post diagnostic initial telephone contact, 6 weeks post diagnostic face to face contact etc). 9.1.2 Two teams set up on Rio: 9.1.2.1 CH Dementia Service Diagnostic Team-Doctors/Psychologists (for initial and complex assessments) 9.1.2.2 Lead Consultant- Dr E Teper 9.1.2.3 CH Dementia Service Review Team - nurses/dementia navigators (recall and post diagnostic patients) 9.1.2.4 Lead Health Care Practitioner (HCP) – Ingrid Sharishnakumar 9.1.3 RiO<>UCP Link 9.1.3.1 UCP flag in RiO. Go live date in September 2019.
	9.2 RIO Access-Dementia navigators	9.2.1 Dementia navigator set up on RiO **(ISA signed off, RiO documentation, staff trained)** 9.2.1.1 Input RiO diary contacts 9.2.1.2 Input RiO progress notes within 72 hrs (3 working days) of engaging (F2F or via telephone) with a patient. 9.2.1.3 Upload RST each time one is completed or revised 9.2.2 Two (2) terminals to install for Dementia navigators' use 9.2.3 Set up nhs.net email addresses for Dementia navigators to use (each Dementia navigator to have individual nhs.net email address)

10. CMC care plans	**10.10 UCP Access Right**	10.10.1 Consultants/Doctors/Nurses/Dementia Navigators to seek UCP consent and give out patients UCP information leaflet 10.10.2 UCP care plans created and published for all newly diagnosed and all recalled patients 10.10.3 UCP care plans created/updated with dementia diagnosis by UCP and Data Quality Coordinator and approved/publish by DS Team Leader 10.10.4 Both CMHT and DS band 6 nurses and above only: 10.10.4.1 Can amend/update UCP care plan with LPA details, ACP, Contingency and Crisis Prevention plans, risks, alerts, social information and contact details 10.10.4.2 Can approve/publish updated care plans (Please publish the care plan you update so that it is live) 10.10.5 Dementia navigators/Social Workers/OT/Admins/Support Workers/Band 5 nurses: 10.10.5.1 can update and publish/approve only social and personal information on a UCP care plan. If you update any of these please publish 10.10.5.2 Can update risks and or alerts and any other relevant clinical information but cannot publish. Once updated they must be sent to a band 6 nurse or above to publish/approve 10.10.6 Please do not upload /attach any document on UCP. 10.10.7 Remember UCP care plan is an urgent care tool for crisis management and to help prevent unnecessary hospital admissions. It does **not replace** patients standard care plan
11. Complaints Management	**11.10 Complaints response procedure**	**ELFT** 11.10.1 Manage all complaints regarding Dementia navigators in line with their policy 11.10.2 Manage all complaints in line with Trust policy 11.10.3 All complaints regarding clinical/administrative teams
Interfaces with Key Services		

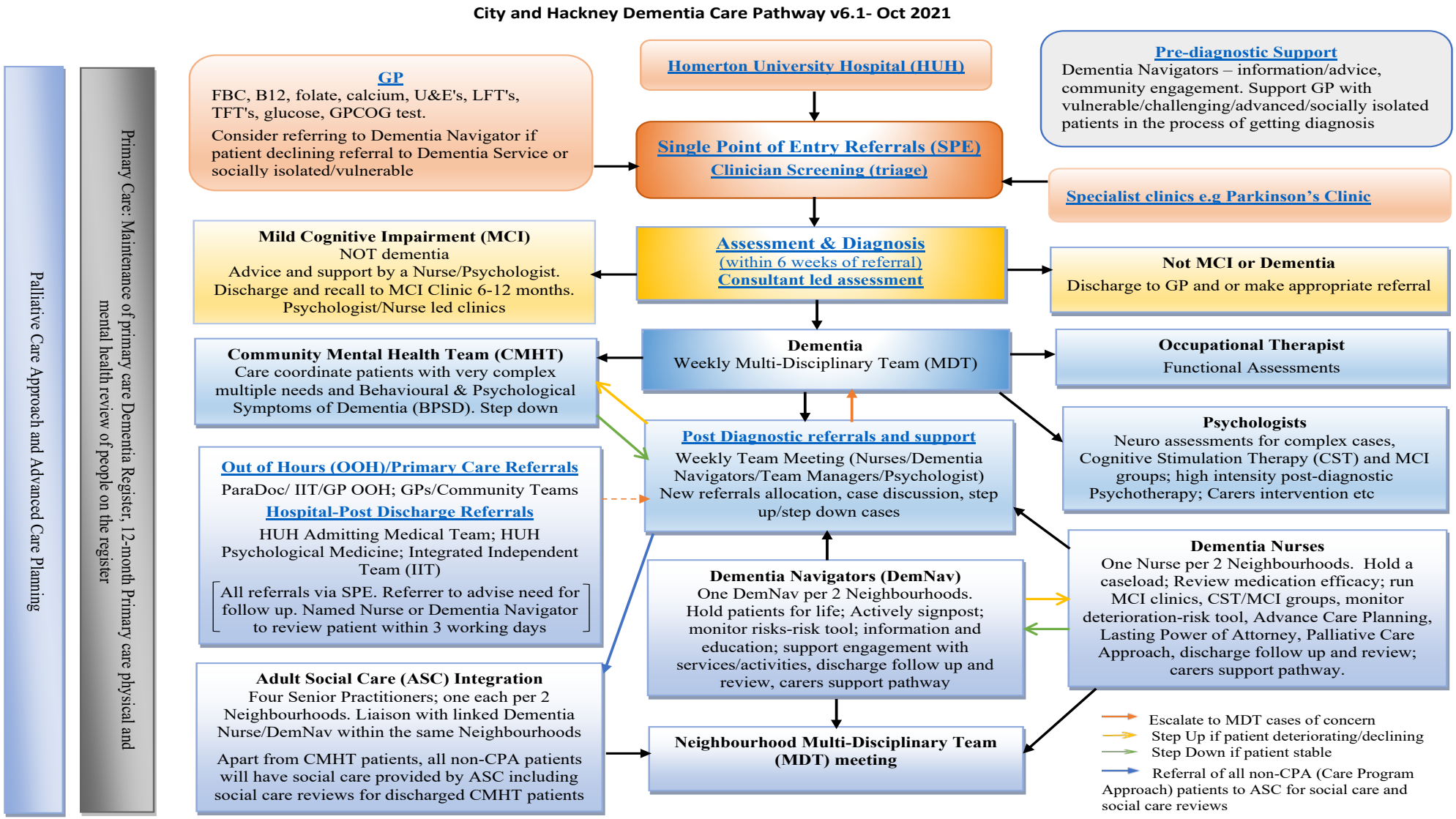
12. GP Pathway	**12.10 Referrals - patients with suspected dementia**	12.10.1 GP does bloods and GP COG Test 12.10.1.1 Sends referral via SPE 12.10.1.2 Referral to include: ○ Medical history and medication ○ Description of symptoms/functional impairment ○ Whether an interpreter is needed ○ Details of a carer or Next of Kin if there is one ○ Copy of results of blood tests 12.10.2 All referrals triaged by Duty 12.10.3 Referrals of challenging and non-engaging patients 12.10.3.1 Dementia navigators to actively engage with patients and their carer/relatives where appropriate to support them in having a memory assessment 12.10.3.2 Dementia navigators to feedback outcome to the GP 12.10.3.3 Refer to 2.1.5 in sec 2 above for the full pathway
	12.11 Referrals - patients with a diagnosis of dementia	12.11.1 Referrals can be from anyone including self-referral 12.11.2 Referrals can be either by phone or via email 12.11.2.1 All email referrals - duty to triage in line with the process in 2.1.4 above 12.11.2.2 All phone referrals - admin to follow process in 2.1.3 above 12.11.3 If referrals to Dementia Navigators - relevant neighbourhood Dementia navigator Duty to follow process in 2.1.5.1 above
13. Parkinson Pathway	**13.10 Parkinson-Dementia Pathway**	13.10.1 Bi-monthly case-based MDT by Consultant (Dr Teper) 13.10.2 GP to refer Parkinson patients to DS with suspected dementia and who have no diagnosis of dementia (see GP pathway in 12 above)

14. ASC Pathway	**14.10 Care Management**	14.10.1 DS does not provide care management; this will be provided by ASC including social care reviews for discharged CMHT patients. 14.10.2 Nurse/Dementia Navigator linking in with Senior Practitioner within their respective neighbourhoods to discuss cases of concerns/high priority 14.10.3 For patients who meet the criteria for CMHT (Complex with BPSD), CMHT will provide care coordination. 14.10.4 Refer all patients for social care including social care reviews of stepped down CMHT patients to ASC 14.10.5 When referring include information on LPA/ACP if one is in place and attach copies where documented 14.10.6 For urgent cases call duty in the first instance to discuss–see append 4 14.10.7 Refer to append 4 below for referral process to ASC 14.10.8 For safeguarding referrals, please complete safeguarding referral form (see appendix 5 below) and send to adultprotection@hackney.gov.uk 14.10.9 For carers where there is a breakdown refer directly to ASC for carers assessment. All other cases follow normal referral pathway via Carers First 14.10.10 Quarterly pathway meeting with ASC starting from March 2020 14.10.10.1 Membership: • CHDS: Healthcare Manager (ELFT), Team Leader (ELFT) • ASC: Principle Head of Adult Social Care, Dep Head of Service, Service Manager, (Information & Assessment Team), Service Manager (Long Term Team) 14.10.10.2 Discuss demands of new dementia service on ASC 14.10.10.3 Discuss and resolve any challenges presenting.

15. Homerton University Hospital FT (HUH) /Urgent Care Pathway	**15.10 Referral pathway**	15.10.1 Referrals can be from ParaDoc, IIT, GP OOH, HUH Admitting Medical Team, Homerton Psychological Medicine 15.10.2 All referrals via SPE 15.10.3 Out of Hours referrals to be picked up the next working day 15.10.4 New Referrals for suspected Dementia – follow referral pathway in 2.1.1 above 15.10.5 Referrals of Patients with a diagnosis of dementia including post discharge referrals - Referrer to advise if follow up/review of patient is required. 15.10.6 For hospital discharges patient's named care professional (Nurse or Dementia navigator) to make contact and review patient within 3 working days of receiving referral. 15.10.7 For all other post diagnostic referrals, named nurse and or dementia navigator to contact the patient accordingly depending on the urgency
16. LAS Pathway	**16.10 Referral pathway**	16.10.1 **Under discussion**
17. St Joseph's EoL Pathway	**17.10 Referral pathway**	Emergency admissions prevention If patient deteriorating flag with GP for EoL care Where medical needs seem to be escalated, discuss at MDT-and refer to STJH based on clinical decision STJH to provide training to DS Team on palliative care, prognostics and diagnostics Possibility of nurses to do joint visit with STJH team

18. OOH Pathway	**18.10 Pathway for OOH provisions**	18.10.1	DS team to ensure up to date contingency and crisis prevention plans on UCP, LPA details, ACP, Social and personal information
		18.10.2	Refer to IIT for OOH provisions
		18.10.3	If patient is at risks of crisis and or acute hospital admissions without an urgent package of care
		18.10.4	If patient cannot manage and need urgent Multi-disciplinary assessments
		18.10.5	If patients seen OOH and likely to require follow up in the community, OOH services to refer to DS via SPE to be picked up in the morning

19. Appendix 1: New CH Dementia Care Pathway



20. Appendix 1a: Linked Neighbourhoods (PCNs) Dementia Practitioners-Oct 2021

Neighbourhoods	Neighbourhoods Dementia Nurse (Lead Practitioner)	Neighbourhoods Dementia Navigator	PCN Aligned Care Homes
Clissold Park	Alain Michel Nana alain.michelnana@nhs.net	Cilla Weekes Cilla.Weekes1@nhs.net Erin Bradford (erin.bradford@nhs.net) part time	St Annes
Woodberry Wetlands			Beis Pinchos
Hackney Downs	Ivan Dushime (agency nurse) ivan.dushime3@nhs.net	Adi Zeira Adi.zeira@nhs.net Amy Claringbold (part time) Amy.claringbold@nhs.net	
Springfield Park			
Hackney Marshes	Helen Onwualu Helen.onwualu@nhs.net	Oktawian Janicki Oktawian.janicki@nhs.net	Acorn Lodge
Well Street Common			
London Fields	Gemma French Gemma.french2@nhs.net	Carol Feldon (Lead Navigator) Carol.feldon@nhs.net Joyce Tomlinson Joyce.Tomlinson1@nhs.net	
Shoreditch Park and City			Queen Elizabeth II Infirmary (The Charterhouse)

21. Appendix 2: Risk Stratification Tool (RST) & Risk Status

CHDS Risks Stratification Tool _\

22. Appendix 3: Processes to follow where a client cannot be reached

Clients not responding to telephone, email or letters. Follow all five steps below to try and ascertain whereabout of client.

- ❖ Contact next of Kin/Carer (if one is registered)
- ❖ Contact ASC/Care agency (if involved)
- ❖ Contact GP to find out and advise of next step.
- ❖ Carryout an unannounced visit, check with neighbours/friends.
- ❖ If still concern, notify the Police and seek feedback

If client found and does not want to be reviewed or is out of area/country, inform Andrew Whipp (CMC and Data Quality Coordinator) to update register

Update RiO with outcome at each stage

23. Appendix 4: LBH Adult Social Care Referral guide

Referrals to ASC

Information and Assessment Team (the Front door)

Long Term Team (Community case management team)

Contact Numbers

Information and Assessment Duty (I &A)	0208 356 6262	access@hackney.gov.uk
Long Term Team Duty (LTT)	0208 356 2227	duty@hackney.gov.uk
Occupational Therapy Duty	0208 356 5533	ot@hackney.gov.uk
Safeguarding Direct Line	0208 356 6262	adultprotection@hackney.gov.uk
CHAMRAS - Mental Health Team	0203 222 8000	
MHCOP - Mental Health for Older people	0203 222 8500	
Adults Social Work Out of Hours Contact	0208 356 2300	

Appropriate for I & A

- To check if they are known to Adult Social care
- To create records on electronic database
- If known see LTT workflow
- General request for Care Act Assessment for Individuals in the Community
- Request for individual Carers Assessment
- Management of the adult protection in box (safeguarding concerns)

What will happen

We will collate all demographics - contact numbers - all professionals details that are involved, health conditions, family and friend support networks - outcome from social prescribing (ie who and where they are linked into).

How soon will it happen?

- Cases will be triaged and allocated for assessment based on a risk assessment of presenting needs.
- We will endeavour to see individuals and complete an initial assessment within 28 days.
- In crisis, we are able to commission care services within 24 hours.

What counts as Crisis?

As adopted by the ASC, it is:

'One off disruption to normal routines or coping strategies having a significant impact on the individual/family where support cannot be resolved with a conversation one'

Appropriate for LTT

All individuals who are in receipt of council funded care, domiciliary care, day care, direct payment, Housing with care, supported living, Residential and Nursing Care in Borough who are requesting adjustments and or further assessments in the following areas:

- Carers Assessment
- Safeguarding investigations on known cases.
- Re assessment/reviews of current care and support plans
- Complex case management
- Referrals for Court of Protection for management of Financial matters and welfare
- Individuals Change of accommodation i.e. to Housing with care schemes, residential or nursing care homes.

24. Appendix 5: Safeguarding Adults Alert/Referral Form - Adult Safeguarding Team

Safeguarding Adults Alert-Referral

25. Appendix 6: Managing Reviews Backlog

Where there are backlogs, discuss cases with line manager and bring to Tuesday Team meeting if any concerns. Using own judgement, clients could be prioritised in order of vulnerability as follows:

- ❖ Clients who live alone or do not have supportive family or have a carer who is also vulnerable, a f2f review.
- ❖ Clients with supportive family – a video call, however if client/family turns down video calling, then a phone call or f2f to be offered, but where there are concerns a f2f visit before stepping up. Always ensure client is part of the review conversation.
- ❖ Clients in care homes – these clients are already receiving ongoing support, a phone call review with care home staff and client may suffice but where there are concerns a f2f visit before stepping up.
- ❖ Lastly reviews could also be spread out, as some months turn to have more than others

26. Appendix 7: Training for staff

UCP Training (By UCP Team). Update Training by Andrew	All
EoL and ACP (By St Joseph's Debbie Pegram-Matron)	Nurses, but open to all
Bi-monthly workshop 'Talking about Death and Dying' facilitated by MHCOP psychology and Bart's Psychology to increase staff confidence in having such conversations with patients and their families.	Nurses, but open to all
Delirium, Depression, Dementia (By Homerton Lead Dementia Nurse)	Nurses, but open to all
Cognitive Stimulation Therapy	Nurses/support workers
Smoking Cessation (Very Brief Advice) training Various. Book online: www.smokefreehackney.org	Navigators/nurses
ASC Care assessment process (ASC Team)	Dementia navigator/nurses
Namaste training (St Joseph's)	Dementia navigator/nurses (optional)
Cognitive screening (inhouse by Clinical Psychologist)	Nurses
RiO Training (Various. Book with RiO Training Lead)	All
E-Referral	All
Train the Trainer Course in Dementia and Delirium (training subject to ICB funding)	Nurses