CITY AND HACKNEY DEMENTIA SERVICE (CHDS)

OPERATIONAL PROTOCOL (IMPLEMENTATION FRAMEWORK)

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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. UCP 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 <u>(Please publish the care plan you update so that it is live)</u> 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 <u>but cannot publish</u>. Once updated they must be sent to a band 6 nurse or above to publish/approve 10.10.6 Please <u>do not upload /attach any document</u> on UCP. 10.10.7 Remember UCP care plan is <u>an urgent care tool</u> for crisis management and to help prevent unnecessary hospital admissions. It does **<u>not replace</u>** patients standard care plan
11. Complaints Management	**11.10 Complaints response procedure**	**<u>ELFT</u>** 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		

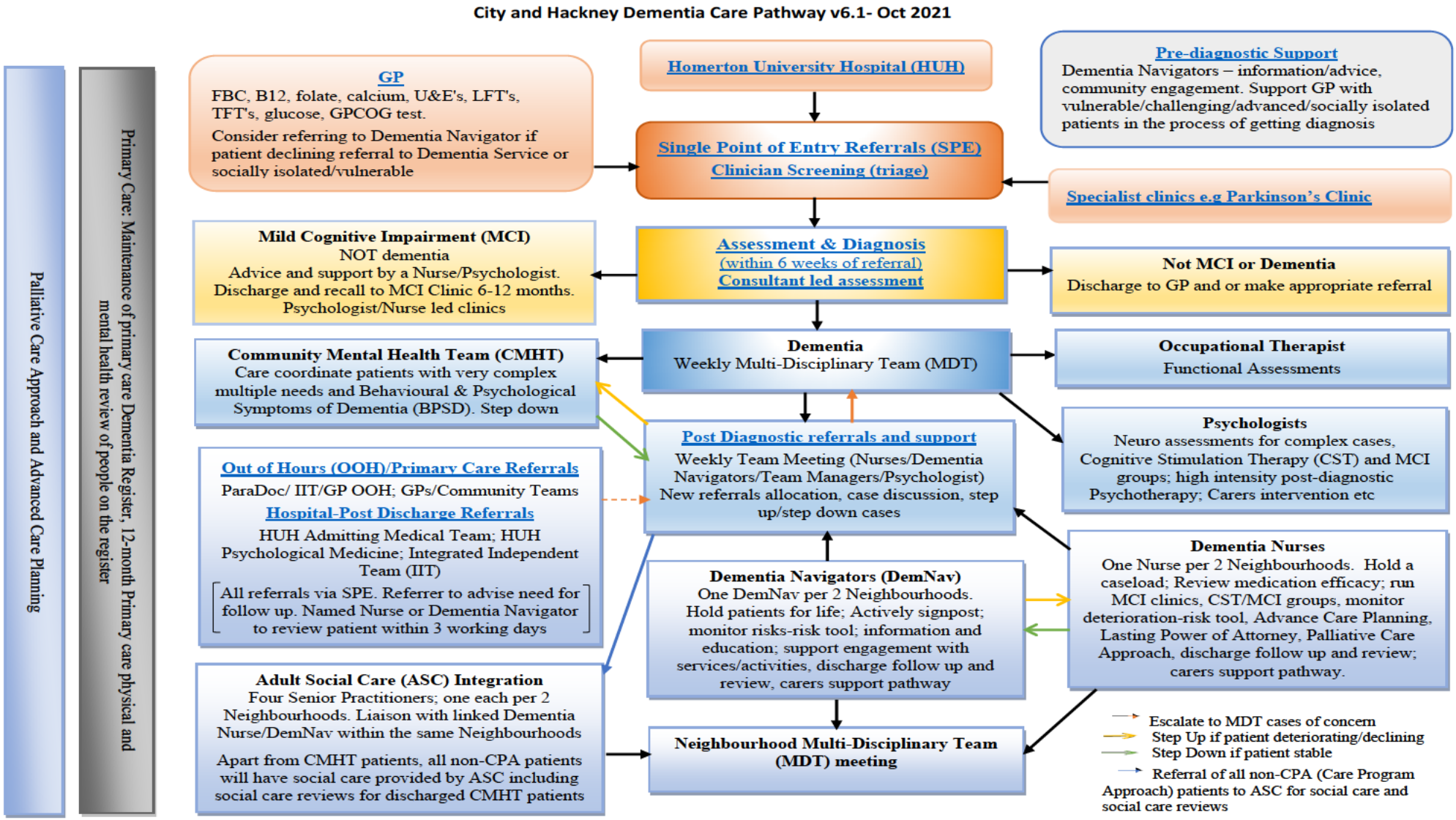
12. GP Pathway	**12.10 Referrals - patients with suspected dementia**	12.10.1 GP does bloods and GP COG Test 12.10.1.1 Sends referral via SPE 12.10.1.2 Referral to include: ○ Medical history and medication ○ Description of symptoms/functional impairment ○ Whether an interpreter is needed ○ Details of 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	[redacted]	[redacted] Vacant full time	St Annes
Woodberry Wetlands			Beis Pinchos
Hackney Downs	[redacted]	[redacted]	
Springfield Park			
Hackney Marshes	[redacted]	[redacted]	Acorn Lodge
Well Street Common			
London Fields	[redacted]	[redacted]	
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

BEDFORDSHIRE AND LUTON MEMORY ASSESSMENT PATHWAY OPERATIONAL POLICY

POLICY NUMBER:	
LEAD AUTHOR:	[redacted]
IMPLEMENTATION DATE:	1 December 2012
Local HCG REVIEW DATE:	March 2024 (Policy reviewed and no changes made, retained original DMT approval date).
DMT Approval Date:	July 2021
Next Review Date:	December 2025 12.01.25 - Extended till 31/03/2026 14.04.6 – Extended till 31/05/2026

EAST LONDON NHS FOUNDATION TRUST

BEDFORDSHIRE AND LUTON MEMORY ASSESSMENT PATHWAY OPERATIONAL POLICY

CONTENTS

Assurance Statement

This policy and the associated procedures set out clear guidance for the management of service users in the Memory Assessment Services.

The policy and associated procedures provide a framework for referral, assessment, risk management, care planning, care reviews, discharge and transfer from ELFT. This policy also ensures that the Dementia Services are provided in line with Memory Services National Accreditation Programme (MSNAP) Standards, NICE guidelines and NHSE

1.0 INTRODUCTION

In response to key objectives in the National Dementia Strategy (DOH 2009)- as well as the Prime Ministers Challenge on Dementia 2020 and Commissioning guidelines for Dementia Services, a Memory Assessment Pathway has been developed in order to provide a clearly defined pathway for anyone with a suspected diagnosis of Dementia in Bedfordshire and Luton.

Luton and Bedfordshire Memory Assessment Service Vision Statement –
For the memory assessment service to deliver a person-centred, compassionate service in a supportive way, promoting safety and wellbeing at the forefront. provide and support effective, responsive and caring multi-agency care pathways in partnership with primary and secondary mental health care which are safe and well-led, while working to the principles of early intervention and prevention, trusted assessments, recovery, and breaking stigma at every stage of the pathways.

2.0 AIMS

2.1 The aim of the Memory Assessment Service (MAS) is to provide a full assessment of memory concerns, which will include a range of physical, neurological, medical and psychosocial assessments in order to formulate a diagnosis.

2.2 The aim of the clinic is to provide good quality, early diagnosis and intervention for patients with dementia.
The clinic service will include:

- making the diagnosis well (i.e. high diagnostic accuracy including sub-typing – see Appendix 1 Diagnostic criteria) and making it early in a timely manner

- communicating the diagnosis well to the person with dementia and their family

- advising on appropriate treatment, information, care and support after diagnosis

3.0 OBJECTIVES

3.1 The Memory Assessment Service will be the single point of referral to ELFT for all people with a suspected diagnosis of Dementia.

3.2 The Memory Assessment Service will be responsive to aid early dementia identification.

3.3 The Memory Assessment Service will provide access to a full range of assessment and diagnostic service needs of people with different types and all severities of dementia and their carers and family.

3.4 The Memory Assessment Service will facilitate integrated care, supporting the person, their carers and families in partnership with local health, social care and voluntary organisations.

4.0 INCLUSION CRITERIA

4.1 The Memory Assessment Service will be for anyone registered with a GP with available access to clinics across Bedfordshire and Luton.

4.2 **Specific Target Groups**

- People with symptoms of mild to moderate dementia whose dementia has not been diagnosed.
- People with memory problems, where a diagnosis of dementia is suspected, rather than a physical or functional mental illness
- People with dementia, whose confirmation of the sub type are required; these people will be seen routinely by the Community Mental Health Team.

5.0 CONSENT

All Referrers will obtain consent prior to referral to the MAS in line with the Trust Consent to Treatment Policy.

The patient's consent will be sought and recorded. This will include providing information about options, checking, and understanding, ensuring coercion is not occurring and that consent continues over time.

If the person lacks capacity for decision making the Trust policy on Mental Capacity will be followed.

The Memory service is a confidential service that will discuss with the person any need for information sharing with colleagues and/or other agencies in line with the Trust's Information Sharing Policy.

6.0 CLINIC STRUCTURE

There will be 4 locality-based Memory Assessment clinics, each working across Bedford, Central Bedfordshire and Luton. Patients will be able to be seen in any of the clinics across Bedfordshire and Luton in order to provide convenience and effecticeny. We are also piloting a project where a clinic is run from a local GP surgery, if successful this will be rolled out in various GP surgeries across Luton and Bedfordshire.

Bedford
The clinics are currently held in Florence Ball House. The clinic takes place Monday to Friday. Home assessments and feedback discussions may take place based on individuals' needs.

Mid Beds
The clinics are currently held in The Lawns. The clinic takes place Monday to Friday. Home assessments and feedback discussions may take place based on individual needs.

Luton
The clinics are currently held at Calnwood Court. The clinic takes place Monday to Friday. Home assessments and feedback discussions may take place based on individual need.

South Beds
The clinics are currently held in Townsend Court. The clinic takes place Monday to Friday. Home assessments and feedback discussions may take place based on individual need.

Memory Assessment clinic will consist of input from:

- Consultant Psychiatrist
- Trainee doctors in Psychiatry
- Clinical Psychologist
- Assistant Psychologist
- Dementia Nurse Specialist
- Occupational Therapist
- Experienced Community Support Worker
- Alzheimer's Society Representative or equivalent service (as Tibbs is in Bedford)

- Speech and Language Therapist – on request
- Dietician – on request
- Physiotherapist – on request
- Geriatrician – on request
- Neurologist – on request

7.0 ROLES AND RESPONSIBILITIES

- **Consultant Psychiatrist**

  The Consultant Psychiatrist provides assessment, diagnosis and initiates treatment with anti-dementia medication when indicated in line with NICE recommendations.

- **Trainee doctors in Psychiatry**

  The trainee doctors under supervision of the Consultant Psychiatrist provide assessment, diagnosis and initiate treatment.

- **Clinical Psychologist**

  The Clinical Psychologist provides specialist neuropsychological assessment for more complex cases, and supervision of assessments undertaken by Assistant and Trainee Psychology staff.

- **Assistant Psychologist**

  The Assistant Psychologist carries out neuropsychological assessment under the supervision of the Clinical Psychologist.

- **Dementia Nurse Specialist**

  The Dementia Nurse Specialist provides a coordination function for the memory assessment pathway and provides post diagnosis support, advice, planning and education to patients referred to the clinic and their families. They also carrying out Initial assessments, diagnosis and initiate treatment for the less complex patients.

- **Occupational Therapist**

  The Occupational Therapist provides specialist Occupational therapy assessments, such as the Assessment of Motor and Process skills to assist in the diagnostic process. The Occupational Therapist assesses the client's performance of activities of daily living and provides support, advice and education to patients and their families.

- **Community Support Worker**

The support worker undertakes carers' assessments and. They also provide input into the triage process supporting the Dementia Nurse Specialist.

- **Alzheimer's Society Representative**

  The Alzheimer's Society provides support, signposting and access to community resources to support the patient and their family during and after the assessment.

- **Administrator**

  The Administrator is responsible for booking all appointments, ensuring that the appropriate tests are requested, and the results returned, tracking people's progress throughout the process and liaising with patients and their carers.

8.0 SERVICE PROVISION

The Memory Assessment Service will.

- Provide supportive contact to the patient with memory impairment and their supporters/family from the point of first contact until handover to another Team/agency or discharge.

- Allow time for the person and subject to consent, their family members, to discuss the outcome of the assessment.

- Signpost to and provide appropriate information regarding any other relevant services including advocacy and voluntary support.

- Provide appropriate information to the person and family/carer in an appropriate format.

- Provide information about the information prescription scheme - www.nhs.uk/ips (Recommended in National Dementia strategy, 2008)-

- Refer the person and their relatives for genetic counselling where a genetic cause for their dementia, e.g. Huntington's disease is considered likely.

- Offer specialist support for the initiation of acetyl cholinesterase inhibitors for people with Alzheimer's disease.

- Complete six-monthly follow-up reviews for people treated with acetyl cholinesterase inhibitors including; as part of the Shared Care Protocol.

    - MOCA/MMSE score/relevant cognitive tests
    - Global functional & behavioural assessment

- Carers views

- Memory service clinicians will provide consultation and advice about dementia to other agencies and to colleagues within the Trust and external partners.

9.0 ACCESS TO PATHWAY

9.1 Referral

Referral to the memory clinic will be a clinical decision based on the possibility that the individual presenting has symptoms of Dementia. Referrals will be received primarily from GP's. Other services, as agreed with commissioners, i.e. Community Matrons and Acute hospitals may directly refer to the memory clinic and will be required to provide the same referral information as GPs. The following points are relevant for referrers;

- The referrer is responsible for informing the GP of the referral for memory assessment and diagnosis.

- The referrer will confirm that the patient has consented to the referral or provide a copy of a capacity assessment where the patient lacks capacity.

- They will also provide contact details for a carer or appropriate person to provide collateral information.

- The GP/ referrer will undertake initial dementia screening prior to referral, consistent with NICE CG 42 (June 2019).

- The following detail is necessary from referrers;

    - presenting symptoms
    - review of past history
    - collateral history from an informant
    - exclusion of other acute medical reasons such as delirium by physical examination and investigations
    - Brief, objective measure of cognition.
    - FBC, ESR, U&E, LFT, eGFR measurement, calcium profile, blood glucose, TFT, B12 and red cell folate blood results

9.2 Eligibility

- 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.

- Possible other medical reasons and psychological have been excluded

- Referrer provides contact information for the patient and carer (where appropriate)

9.3 **Initial Contact**

The patient will be contacted by phone upon receipt of referral to the MAS Service once eligibility has been confirmed. They will be informed that a referral has been received and the memory assessment process explained.

The MAS triage worker will seek to identify:

- Who (other than the patient) is able to provide collateral information
- Current level of support being received
- Patient and carer consent
- Ability to attend appointment in clinic
- Interpreter requirements if English is not first language
- Immediate risks and needs; this is in order to ensure immediate risks and needs are managed appropriately and to prepare the patients for attending for assessment.

NB a CT/MRI scan may be requested by the Consultant if not already available from the referrer.

9.4 **Memory Clinic unable to make contact**

Patients who cannot successfully be contacted by telephone after 2 attempts (and within 5 operational days), will be offered an assessment date in writing.
If the offer is not accepted, or the patient cannot be contacted within 3 attempts, the memory clinic will speak to the GP/Referrer to agree a strategy for engagement with the patient and who will be responsible for this.
Patients who are assessed to have capacity but who do not wish to engage with the process will be discharged back to their GP following discussion with the referrer.

9.5 **Assessment**

The memory assessment clinic will primarily be run in a clinic setting in order to:

- Use resources most effectively - clinician travel time may be considerably reduced/ eliminated

- Enable swift discussion between MDT members at every stage of the assessment
- Provide the opportunity to engage with other clinicians earlier in the process if required i.e. medical review due to observation in clinic
- Enhance communication between team members, as the full clinical record is available

Where assessment cannot be undertaken in clinic, assessment will be completed in the most appropriate environment i.e. patients home / GP surgery.

9.5.1 History taking and Cognitive assessment:

a) A subjective and objective assessment of the patient'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
b) Assessment of history and impacts of impairments of vision, hearing and mobility
c) Assessment of history and impacts of impairments of medical co-morbidities
d) Assessment of key psychiatric and behavioural features, including depression, wandering and psychosis
e) 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
f) Carer assessment including burden, health and function.
g) Cognitive and mental state examination including attention and concentration, orientation, short and long-term memory, praxis, language and executive function

9.5.2 Further investigations may be necessary to exclude other causes, inform diagnosis or sub-typing and identify suitable treatment options. These may include:

a) At the time of diagnosis and at regular intervals, subsequently assessment will be made for medical comorbidities and key psychiatric features associated with dementia, including depression and psychosis, to ensure optimal management of coexisting conditions.
b) Testing for syphilis serology or HIV will not be routinely undertaken. This will only be considered when the history suggests risk or if the clinical picture indicates this.

c) A Confusion Assessment Method (CAM) test may be carried out if delirium is a possibility. If delirium is identified the client will be immediately referred back to the GP.
d) Clinical presentation will determine whether investigations such as chest x-ray or electrocardiogram are needed.
e) Cerebrospinal fluid examination will not be performed as a routine investigation
f) Review of medication in order to identify and minimise the use of drugs that may adversely affect cognitive functioning
g) ECG – may be carried out by the GP as per NICE CG42
h) Structural imaging may be used in the assessment of people with suspected dementia to exclude other cerebral pathologies and to help establish the subtype diagnosis. Magnetic resonance imaging (MRI) is the preferred modality to assist with early diagnosis and detect subcortical vascular changes. Computed tomography (CT) may also be used depending on the specialist's assessment.
i) Specialist advice should be taken when interpreting scans in people with learning disabilities.
j) Formal neuropsychological testing will form part of the assessment in cases of mild or questionable dementia and unusual/complex presentations
k) Other investigations as appropriate e.g. Observational assessment of Activities of daily living (ADL), Assessment of Motor and Process Skills (AMPS).

9.5.3 **Communicating the Diagnosis**

At the start of the assessment process the patient will be asked if they wish to know the outcome of the diagnosis and with whom the diagnosis should be shared and documented within notes

Diagnosis will be made following the collation of assessment evidence. This could take place at the initial assessment, but may require further contact from memory assessment clinic staff.

A meeting will be held with the patient and carer/s (with patient's permission) to discuss the outcome of the assessment, the diagnosis, prognosis and immediate recommendations.

A report containing the assessment information and diagnosis will be shared and given to the patient if they have agreed to hear their diagnosis. A copy will be sent to the GP and others as requested and consented by the patient.

9.5.4 **Personalised Care Plan**

Throughout the assessment the care plan will be developed. Initially the care plan will focus on the assessment process in order to meet individual need.

Following diagnosis a care plan will be jointly developed which will identify the individual need, interventions to address need, who will undertake the interventions and how this will be reviewed.

9.6 **Post Diagnosis Interventions**

9.6.1 Following a diagnosis of Dementia, unless the person with dementia clearly indicates to the contrary, written information will be given to them and their families. These interventions include a vast range. The following list is not exhaustive but may include the following: (some may have taken place during the assessment if required).

- Signs and symptoms, course and prognosis, treatments
- Referral to Alzheimer's Society and other organisations as agreed by the individual for support and signposting to specific groups
- CMHT/ Older Persons' Team for care package, day centre, etc
- Cognitive stimulation therapy
- Out Patient appointment/ prescription clinic
- Referral for assistive technology
- Carers in Bedfordshire / Advocacy Services
- DVLA/ driving assessment
- Lifestyle advice
- Local information services, including libraries and voluntary organisations
- Participating in research

9.6.2 A post diagnosis meeting will be held with the Dementia Nurse Specialist in partnership with other professionals and voluntary organisations such as the Alzheimer's Society. This will allow the patient / carers the opportunity for further discussion, education and understanding of the diagnosis and its implications.

10.0 FOLLOW UP CARE PLANNING

10.1 The Dementia Nurse Specialist will co-ordinate the post diagnostic support and provide signposting/information to patients and families as part of the Dementia Assessment Pathway for a period of up to six weeks.

10.2 If the person requires longer term input they will be allocated a care co-ordinator from the CMHT and care will be co-ordinated in line with the CPA process.

10.3 The assessment process and subsequent reviews will incorporate;

- Need for on-going support for the service users family members
- The persons and carers specific needs arising from diversity, including gender, ethnicity, age, religion and personal care.
- The persons and carers specific needs arising from ill-health, physical disability, sensory impairment, communication difficulties, problems with nutrition, poor oral health and learning disabilities.
- The benefits of advocacy services and voluntary support. Including considering if these should be available to the person or carers independently

10.4 Care plans will;

- Clearly identify whom to contact during the assessment pathway.
- Be signed by the person and/or carers
- Have dates agreed between professionals, the person and carers for the next formal review
- Promote and maintain independence, including mobility
- Address activities of daily living to maximise independent activity, enhance function, adapt and develop skills

10.5 Where other agencies already act as a care co-ordinator/case manager the memory service will liaise with them to share information appropriately in line with Trust Policy and patient/ carer consent.

11.0 DISCHARGE OR TRANSFER FROM THE MEMORY ASSESSMENT SERVICE

11.1 The decision on when the person should be transferred or discharged from the Memory Service will be made as a joint decision by the multi-disciplinary team and include discussion with the patient and their family/supporters. It is expected that this transfer or discharge would take place if;

- The person develops complex needs which require support from a CMHT under Care Programme Approach (CPA)
- The person and their family have needs which could more appropriately be met in primary care or other agencies – in this case, future re-referral into the Memory service will be fast-tracked.

- The person has completed the assessment pathway and diagnostic support and has no identified current needs.

12.0 CARERS

12.1 Carers will be offered an assessment in line with the requirements of the 'Carers (Recognition and Services) Act' Available here; http://www.legislation.gov.uk/ukpga/1995/12/introduction and Care Act 2014

12.2 Carers of people with dementia who experience psychological distress and negative psychological impact will be offered information on access to psychological therapy, including cognitive behavioural therapy, conducted by a specialist practitioner.

12.3 Care plans for carers of people with dementia are to be individualised and may include the following elements, some of which may be provided by voluntary or third sector partners;

- Individual and/ or group psycho-education/psychosocial interventions
- Peer-support groups with other carers, tailored to the needs of individuals depending on the stage of dementia of the person being cared for and other characteristics.
- Support and information by telephone and through accessing the internet

Training courses to;

- highlight relevant dementia services and available benefits
- facilitate communication and problem solving to enhance the care of people with dementia
- involvement of other family members as well as the primary carer in family meetings.

12.4 Clinic staff should explain to people with dementia and their carers that they have the right to receive direct payments and individual budgets (where available). If necessary, people with dementia and their carers should be offered additional support to obtain and manage these through the CMHT or local social services.

13.0 RESEARCH AND CLINICAL TRIALS

Patients may also be offered the opportunity to be involved in some of the clinical trials or research programmes aimed at pushing the frontiers of new treatments and knowledge of conditions associated with memory problems.

These trials and research programmes are under the strict ethical oversight of the Ethics Committee and patients are reassured they are in no way obliged to be part of these trials nor will it affect access to the Memory Clinic service in any way.

14.0 REVIEW AND MONITORING

14.1 How did we do? NHS Friends and Family Test Feedback

Questionnaires will be available following each appointment. Action Plans to implement findings will be developed and monitored through the Trust Governance structure.

15.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURES

- Diagnostic criteria for dementia (Appendix 1)
- Templates for Referral, etc
- Shared Care Protocol
- Care Plan
- Carer's Assessment
- Consent Policy
- Policy for assessing Mental Capacity
- Information Sharing Agreement
- Information Sharing Policy
- Complaints Policy
- CPA / Risk Assessment
- Memory Assessment Pathway
- Business Information Flow
- Memory Assessment Pathway Tracking Form
- Diagnosis, Prevention and Management of Delirium
- CAM (Confusion Assessment Method)

  http://www.ohsu.edu/sgimhartford/toolbox/Card2bCAM.pdf

  http://www.nice.org.uk/nicemedia/live/13060/49913/49913.pdf

http://www.bgs.org.uk/Publications/deliriumtk/contents/pdfs_word_files/cam.doc

http://www.guysandstthomas.nhs.uk/resources/our-services/acute-medicine-gi-surgery/elderly-care/cam-diagnostic-algorithm.pdf

16.0 RELATED GUIDANCE

- NICE CG42 –Dementia
- NICE TA217 – Donepezil, galantamine, rivastigmine (review) and memantine for the treatment of Alzheimer's disease.
- Department of Health Service Specification for Dementia: memory service for early diagnosis and intervention
- Nice Clinical Guidance 103 – Delirium
- Supporting People to live well with dementia – QS30
- Dementia Quality Standard – QS1

Appendix 1: Diagnostic criteria for dementia

Type of dementia	Diagnostic criteria
Alzheimer's disease	Preferred criteria: NINCDS/ADRDA. Alternatives include ICD-10 and DSM-IV
Vascular dementia	Preferred criteria: NINDS-AIREN. Alternatives include ICD-10 and DSM-IV
Dementia with Lewy bodies	International Consensus criteria for dementia with Lewy bodies
Front temporal dementia	Lund-Manchester criteria, NINDS criteria for front temporal dementia

DSM-IV, Diagnostic and statistical Manual of Mental Disorders, fourth edition; ICD-10, International Classification of diseases, 10th revision NINCDS/ADRDA, National Institute of Neurological and communicative Diseases and Stroke/Alzheimer's Disease and related Disorders Association; NINDS-AIREN, Neuroepidemiology Branch of the National Institute of Neurological Disorders and Stroke-Association Internationale pour la Recherché et l'Enseignement en Neurosciences.