STANDARD OPERATING PROCEDURE

MEMORY ASSESSMENT SERVICE

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VALIDITY – All local SOPS should be accessed via the v:drive:

CHANGE RECORD

Version	Date	Change details
1.0	*19.05.2022*	*First version of the SOP – Approved May-22 Practice Network meeting and Clinical Network*

CONTENTS

1. INTRODUCTION

1.1 Overall Purpose

The team's purpose is to provide a dementia diagnosis service in a caring, supportive and holistic manner to improve the lives of patients who are experiencing problems with cognition whilst supporting their families/supporters. We aim to provide comprehensive assessment of health and social care needs allowing shared interventions and treatment that are agreed collaboratively with our patients, in their best interest and in the least restrictive manner.

We aim to promote independence and care in the community wherever possible taking into account the needs, wishes and advanced statements of our patients and carers. We aim to support those diagnosed with Dementia to live well with this diagnosis. We aim to provide an individualised care plan to support the person living with Dementia and their supporters on transfer from the team.

1.2 Team Vision

The Hull & East Riding Memory Clinic collectively shares a commitment and passion in caring for patients, their families and carers (formal and informal).

We are clear about the values that we share which are in line with our various codes of practice and conduct for all professional bodies:

- Prioritise people
- Practice effectively
- Preserve safety
- Promote professionalism and trust

1.3 Team Aims

To improve the lives of people with declining cognition by:

- Providing comprehensive assessment of cognition and the resulting needs. This is for the individual with cognitive decline and their supporters.
- Education and advice to care providers formally and informally.
- Promote a "Living Well with Dementia" focused approach and utilise the least restrictive option.
- Consideration of pharmacological / non-pharmacological interventions, recovery-focused approach and psychosocial interventions relative to patient need.
- Working collaboratively in partnership with other health and social care professionals and carers.
- Recognition of the needs of the carer, as well as the person they care for.
- Enabling carers to develop their skills and expertise as care givers.

Facilitating a seamless transition between services when needed

1.4 Context

Our Team is part of a multi-speciality provider Trust working toward providing excellence in primary, community care and secondary mental health services through both integration and joint working. Our Older People's Mental Health Services are a sub-speciality group of clinical, managerial and support staff working specifically with older people (to include providing advice or expert clinical input into younger people with dementia or associated frailty) within the wider mental health service.

1.5 Commissioning Arrangements

The service is commissioned by the Hull Clinical Commissioning Group (Hull CCG) and the East Riding Clinical Commissioning Group (ER CCG).

1.6 Partnership Working

The team covers a wide area and provides services for people living within the boundaries of several NHS Trusts.

1.6.1 Key Partners

The Carers Information and Support Service (Hull), East Riding Carers Support Service (ERCSS), the Alzheimer's Society and Integrated Care Centre (ICC – Hull GP Only and ER care homes) are key partners to the Memory Assessment Service and integral to the service offered. Supporting both the person living with Dementia and their supporters throughout their journey living with a diagnosis. These services are offered as part of the memory assessment and diagnosis service and are included in the Care Plan offered on transfer from the Memory Assessment Service to onward care. These services sit alongside the diagnostic team within clinics and are part of the Multi-Disciplinary Team.

Frailty Services – the recognition that the aging population are those who account for the majority of dementia diagnoses and that this patient group can experience multiple comorbidities that impact on each other and on the quality of life supports the partnership with local frailty services. Patients who are identified as frail during assessment are referred to the Integrated Care Centre(ICC) at the earliest opportunity. Work is ongoing to ensure that those who meet a frailty score of 0.25 (Elderly Frailty Index) are referred to the ICC (Hull CCG patients only and ER care homes). The service works in partnership by attending MDT team meetings.

Innovations in Dementia – This is a service commissioned by ER CCG, Humber Teaching NHS Foundation Trust and East Riding of Yorkshire Council and offered to those whose care is commissioned by the ER CCG. This is a partnership that offers training for those working with people living with dementia and their supporters. They have trained staff to deliver interventions on "Getting Along" – this recognises the effect dementia and receiving a diagnosis can have on relationships and offers interventions to support these relationships. "A Good Life" is a course offered to those who have recently received a diagnosis of dementia. The aim of the group is for delegates to find out more about dementia, look to overcome some of the barriers they face, look at the changing relationships with those closest to them and to find out what and who is there to support them in the East Riding. On completion of the "A Good Life" course, attendees are encouraged to continue to support each other.

Butterflies Memory Loss Support Group – Offer workshops around Hull for people with memory loss. These groups are open to carers and those they care for. There is a partnership between Humber Teaching NHS Foundation Trust and this organisation for them to offer a Voice and Influence Forum for those living with Dementia and their supporters. They will discuss any issues around care and services to be implemented and offer their ideas and opinion on services offered.

Research – There is a strong partnership with this department within Humber Teaching NHS Foundation Trust. All those who receive a dementia diagnosis are offered the opportunity to become involved with research. Those who take up this offer feedback that they find this involvement beneficial – gaining contact with others and also supporting research that may lead to an improvement in care/reduction of cases.

Venue partnerships- in order to offer a local service to patients the service has formed partnerships across Hull and East Riding with GP surgeries, local hospitals, the ICC and also services within Humber Teaching NHS Foundation Trust to provide venues for clinics.

1.6.2 Additional Partners

Voluntary sector; residential care homes; nursing homes; Red Cross; Humberside Fire and Rescue Service; Social Prescribing; Humberside Police, Regional Driving Assessment Centre and many other local and other service.

2. SCOPE

This SOP will be used across the Memory Assessment Service within Humber NHS Foundation Trust. It includes both registered and unregistered nursing and therapy staff who are permanent, temporary, bank and agency staff. It will cover all patients referred to the service.

3. DUTIES AND RESPONSIBILITIES

3.1. Profession Role

Consultant Psychiatrists

The Consultant Psychiatrist role within the Memory Assessment Service is one of offering specialist input into the service. From receipt of the referral and supporting screening for appropriateness, identifying areas for further differentials to support diagnosis, to multidisciplinary formulation – in the first instance with the assessing clinician and then where necessary considering the outcomes of further assessments in order to come to a diagnostic decision. The Consultant Psychiatrist may offer feedback of complex diagnoses and follow up to patients. They also offer treatment by prescription of medication.

The Consultant Psychiatrist offers supervision to members of the nursing team who are Independent Prescribers (IP). They also offer supervision to team members on all aspects of the patient journey. They are part of the weekly Multi-Disciplinary Team Meeting.

Team Leader
The Team Leader is responsible for the day to day operations of the Memory Assessment Service.

Band 7 Clinical Lead
An experienced Senior Nurse with specialist knowledge of dementia, dementia diagnosis and treatments. This nurse is also an Independent Prescriber able to prescribe medications to the patient group in keeping with HERPC guidelines for dementia medications. This is under the supervision of the Consultant Psychiatrist. The Clinical Lead offers clinical leadership to the team and supports with clinical supervision. They take a lead in clinical governance for the team. They take a lead role in the Multi-Disciplinary Team Meeting, and provide case management.

Band 6 Specialist Nurse/NMP
The Band 6 Specialist nurse is an experienced nurse with specialist knowledge of dementia and dementia assessment and treatment. The nurse is part of the referral screening – identifying those people for who dementia diagnosis is appropriate – having a thorough knowledge of co-morbidities, both physical and mental health, that can impact on cognition and making onward referrals to support the patient to receive the right care. The Specialist nurse offers assessment, presents cases for formulation, feeds back diagnosis and supports the treatment pathway to transfer out of the Memory Assessment Service, collaborating with the patient and their carer/supporter in future care planning. They provide case management. The Band 6 Specialist nurse offers supervision to Band 5 nurses.

Band 5 Nurse
The Band 5 nurse is a nurse who has an interest in dementia. They are part of the referral screening process, supporting the identification of the best care pathway for those referred along with a Band 6 nurse, Clinical Lead or Consultant Psychiatrist. They offer assessment to those referred for memory assessment and present their findings at formulation. They offer feedback of diagnosis following formulation. Work in a multi-disciplinary manner – attending the MDT meeting and involving partners where appropriate.

Highly Specialist Clinical Psychologist
The Highly Specialist Clinical Psychologist provides specialist neuropsychological testing to support diagnosis. This intervention is essential when a patient presents with atypical symptomology. The Highly Specialist Clinical Psychologist offers support to the team in diagnosis.

Occupational Therapist
The Occupational Therapist has two roles within the Memory Assessment Service. They are part of the diagnostic testing, providing specialist assessment of function to support diagnosis. They are also part of the treatment offered. Where it is identified that a person will benefit from the skills of Occupational Therapy, this may be support to continue in current roles or to establish new activity, a treatment programme is drawn up with the patient and their carer/supporters. OTs work in partnership with a wide variety of professionals and third sector partners including GP's the local authority, care homes, wheelchair services, NRS, Alzheimer's society, MIND, Age UK, Recycling Unlimited, leisure services, Men in Sheds to name but a few. This is then transferred to the care plan at the point of transfer out of services. Occupational Therapists can assess for aids and

adaptations to enhance independence, they will order equipment and ensure patients are able to use this (see reference 1.3).

Psychology Assistants
The Psychology Assistant carry out the initial memory assessment and present at formulation following supervision by the Clinical Psychologist.

Support Time and Recovery Workers(STR)
The STR workers within the memory service support the team to offer further assessment of functioning, observation within the home, support with socialisation, etc. They work from treatment plans drawn up with the qualified clinicians. The STRs are involved in the reviews of those diagnosed with dementia at 12 weeks post diagnosis. They support the implementation of the care plan for care following transfer.

Healthcare Assistant
The HCA carries out 4 and 12 week medication reviews, 12 week care plan reviews and Friends and Family Tests.

Administrators
Band 3 administrators have responsibility for stages within the care pathway using access plans to navigate the patient through the pathway.
Band 2 administrators have responsibility for reception, telephones and team email inbox.

3.2. Staffing And Resources

Discipline	Grade	WTE
Consultant Psychiatrist		2.1
Highly Specialist Clinical Psychologist	B8b	0.4
Team Leader	B7	0.6
Clinical Lead NMP	B7	0.85
Specialist Nurse	B6	3.6
Qualified Nurse	B5	1.7
Occupational Therapy	B6	1.0
Psychology Assistant	B4	1.5
Support Staff	B3	3.2
Administrators	B3	2.8
Administrators	B2	2.0

The team also includes other professionals to ensure we can meet the holistic needs of our patient group. This includes physiotherapy, and administrative staff to include medical secretaries and domestics. The team also are actively involved and supported by local authority staff.

4. HOURS OF OPERATION

The team offers memory assessment across Hull and the East Riding.

Hull - patients have a choice of three venues:

- The Memory Clinic, Coltman Street, Central Hull
- West Hull hub
- ICC

East Riding - clinics are held in Driffield, Hornsea, Hedon, Market Weighton, Beverley, Bridlington and Goole for those patients who reside in the East Riding CCG area.

The service operates Monday to Friday between the hours of 09:00 to 17:00 (excluding Bank Holidays).

5. REFERRAL PROCEDURES

The Hull & East Riding Memory Assessment Service accepts referrals primarily from GP's but it also accepts referrals from other agencies. All referrals from outside of HTFT are made directly via the electronic referral system. For those referrals that are made from within HTFT (Mental Health Liaison Service, OPMH Team, MHRT) an internal referral on Lorenzo is acceptable.

Referrals from external sources should be made on the appropriate Referral Form (see Appendix A, 1.1 and 1.2) with all information requested included (recent bloods test results – any abnormalities investigated and corrected, Elderly Frailty Index (EFI), consent to assessment). Basic physical screening to exclude medical/reversible causes underlying the person's presenting cognitive impairment needs to be undertaken (usually by the GP) before a formal assessment can be offered and undertaken by the Hull and East Riding Memory Clinic. There are some differences in the information requested on the referral forms dependant on the CCG due to Service Level Agreements. Hull CCG ask that a CT scan is carried out prior to referral.

A basic dementia screening assessment should involve:

- History taking.
- A brief cognitive assessment using a standardised tool.
- Physical examination.
- A review of medication in order to identify and minimise the use of drugs including over the counter products that may adversely affect cognitive functioning.
- Blood results (FBC, TSH, UE, LFT, Cholesterol, Hba1C (where the patient is not already diagnosed with diabetes2), folate, B12. These requirements differ in the CCG areas – these differences are acknowledged at the point of acceptance.
- An ECG result or Chest X-Ray if these have been done for any indication in the work up.
- Any recent imaging of head (e.g. CT/MRI) in the last 5 years and report if possible
- Where red flags have been identified a CT head should be requested by the referrer, concurrent with the referral.
- Co-morbidities, allergies (populated from EMR).
- Result of GPCog or DemTect if done, also GAD7 if anxiety is suspected or PHQ9 if depression is suspected.
- A midstream urine test should always be carried out if delirium is a possibility.

All external referrals are made direct to the MAS. Referrals are accepted from GPs, Hospital Mental Health Liaison Service, CMHTs, ICC, Prison Service, Acute Hospitals and other health care professionals on the appropriate referral form.

Referrals from teams internal to HTFT should be made via Lorenzo:

5.1. Hospital Mental Health Liaison Team

HMHLT should contact MAS to discuss the referral with the MAS duty worker and complete the internal referral form on Lorenzo. Recent blood screening results and information on the reason for hospital admission should be available to MAS at time of the referral. Evidence that all reversible causes for a decline in cognition have been ruled out should be included in the notes.

5.2. Mental Health Triage And Assessment Team

Where a working age person is referred to MHTAT for memory assessment, MHTAT will triage to ensure all reversible causation for cognitive decline, either physical or functional mental health, are eliminated. The referral from the GP will be on the correct referral form and include all physical screening i.e. bloods and CT (Hull).

5.3. Older People's Mental Health Teams

Referral for memory assessment for a patient open to OPMH
Cognitive assessment and diagnosis should be carried out by the OPMH team. Support will be offered by the Memory Assessment Service if requested however the patient will remain within the OPMH Team.

5.4. Working Age Community Mental Health Teams/Inpatient Units (this service is currently under review)

Full mental health assessment should be carried out by MHRS/CMHT/Inpatient Unit to ensure all reversible causes for cognitive decline are corrected. The patient should be diagnosed by the working age service. Support is available from the Memory Assessment Service, however the patient should remain with Working Age services. The responsibility for prescribing will remain with the working age service.
It is recognised that early onset dementia can bring many complexities – loss of income, effect on children, vulnerability of children, loss of employment, etc. It is for this reason that the service is currently under review. It is likely that the diagnosed person will require ongoing support and care co-ordination. Each case will need individual consideration for ongoing care.

5.5. Referrals From The Neurology Department

People can be referred from the neurology department if they have received a dementia diagnosis and wish to access post diagnostic services such as care planning, onward referral, etc.

5.6. Referrals From The Prison Service

This pathway is currently under development.

6. REFERRAL SCREENING

Referrals are received to the team via the electronic referral system (ERS). Administrators take the referrals from ERS and place on an electronic patient record on Lorenzo (see reference 2.1).

Each working day referral are screened by a qualified clinician. Patient Information systems (Lorenzo, SCR, HUTH) are checked for further information relevant to the referral.

Referrals are screened to ensure they are:

i. Complete – they contain the minimum amount of data requested in the referral form (see Appendix A, 1.1 and 1.2).

ii. There is no evidence of presence of reversible causation of cognitive decline – any abnormalities within the physical screening process carried out by the GP have been treated, i.e. low B12,

iii. Appropriate for the Dementia Diagnosis Pathway – there are no other unmet needs that deem the pathway unsuitable, examples are that the patient is:

- presenting with Increased levels of risk that could be attributed to mental health issues such as depression, high levels of distress, behaviours that challenge
- Have a complex mental health presentation
- Have complications to their presentation that may require care co-ordination to meet all of their additional care needs
- Open to Learning Disability services, Neurology, Community Mental Health Teams
- Providing evidence of “Red Flags” may indicate an immediate referral onwards to Neurology, Accident and Emergency.

Red flag screening questions
1. Rapid onset not related to confirmed stroke
2. Rapid progression
3. Short duration (less than 6 month history)
4. Marked confusion
5. Early visuospatial symptoms (within 6 months of onset)
6. Neurological symptoms including headaches (esp if worse on leaning forwards, coughing, sneezing), poor coordination, gait disturbance, weakness, seizures
7. History of head injury in the preceding weeks associated with new onset of cognitive symptoms, nausea, vomiting or reduced consciousness
8. Atypical history or features not otherwise listed (clinician experience)

iv. Where an Elderly Frailty Index score is available, if this is 0.25 or above, or the referral clearly indicates a frailty need the GP is advised to consider concurrent referral to the Frailty Service (Hull patients only)
v. An indication of the appropriate assessor is made, for example, band 4, band 5, band 6, dependant on complexity.

When a referral is returned to the referrer or a decision is made to refer onwards the patient is informed of the decision and consent gained for onward referral. Where consent is unable to be gained due to mental capacity a consideration for the use of Best Interests is made by the professional who is screening and other appropriate parties (see Appendix A, 4.0).

Where a referral is returned due to lack of information, for example, there are no valid blood test results, the patient is informed of the return of the referral and the reason why and any action they need to take, for example, they need to attend the surgery for blood tests(admin will inform the patient via a standard letter). A record kept by administrative staff of the patient's name, date of return and the reason why. This is to ensure that prompts and reminders can be sent to the GP should the patient not be re-referred.

Where a referral is returned due to a physical abnormality that could affect the patient's cognition i.e. B12, Thyroid Stimulating Hormone, Diabetes the GP will be requested to treat this abnormality and refer following treatment and 3 months of stability.
Notes of the outcome of the referral screening are added to the appropriate access plan.

The clinician will document within a communication note (using a set proforma) in the patient record, the outcome of the referral screening and will also inform admin of the outcome so the access plan can be updated. .

6.1. Onward Referral To OPMH/Working Age CMHT

Where a referral is to be forwarded to the Older People's Mental Health Team at this point in the pathway (prior to any intervention from MAS with the patient) a telephone call is made by the duty clinician to the appropriate team and an internal referral form is completed.

6.2. Administration Process

Accepted referrals are coded by type by the delegated administrative staff.
The patient is placed on the "waiting assessment" access plan.
The appropriate SNOMED intervention code will also be inputted (see Appendix A, 5.1).
This will be inputted by a delegated clinician
Admin staff will make a Lorenzo internal referral to the receiving team on receipt of a task on Lorenzo from the clinician who has contacted the receiving team.

7. ASSESSMENT PROCEDURES

7.1. Initial Memory Assessment

The aim of this assessment is to conduct cognitive screening, undertake case history.

This appointment is a pre-booked appointment at a venue local to the patient's CCG boundary or patient address. The appointment invitation is sent to the patient and/or where requested to the identified supporter.

Along with the appointment letter a BADLS (Bristol Activities of Daily Living Scale) assessment and a Hospital Anxiety & Depression Scale is sent to the patient for their completion prior to attendance for the assessment. The letter also contains Information leaflets for Carer Services.

Patients are requested to confirm their attendance at the appointment. If no confirmation is made a member of the administrative team will contact the patient to gain confirmation 7 days prior to the appointment.

A telephone call is made to the patient/carer on the day prior to the assessment to remind them of the assessment appointment.

The patient attends the face to face assessment appointment and the appropriate assessment form is completed along with a cognitive assessment. The Addenbrooke's Cognitive Assessment is the assessment of choice, however other, standardised, validated assessment tools are utilised dependent on the needs of the patients – i.e. those with poor sight would be offered, for example, the MoCA(Montreal Cognitive Assessment) Blind this is a clinical decision. The pulse of the patient is taken at this appointment in readiness for prescribing anti-dementia medication where appropriate.

All information is collected and inputted to the assessment documentation.

Where risks are identified that require the input of another service such as OPMH or Social Services consent will be gained from the patient for this. Consent will be gained to inform the patient's supporter of this.

Consent is sought regarding the patient receiving copies of clinical letters as per the Coping Letters to Patients consent form. (see Appendix A, 8.0).

7.2. Formulation

The assessment findings are discussed at a formulation meeting. This meeting is carried out with the assessing clinician and a member of the medical team. In the case of psychology assistant completing the assessment, a senior nurse will also be present.

The purpose of this meeting, for every case assessed is to:

- Explore and if possible, agree diagnosis.
- Identify any general risks or safeguarding issues relating to the patient and/or the family/supporters/carers.
- Peer review Mental Health Care Cluster (MHCT) and update MHCT, if appropriate.
- Identify additional referral pathways such as neurology, Community Geriatrician, Frailty Service, Computerised Tomography (CT) or Magnetic Resonance Imaging (MRI) scans, Occupational Therapy, Support Time and Recovery Workers and Neuro-psychological assessment Identify if dementia medications are appropriate

- Identify if dementia medications are appropriate as these individuals will be given written information regarding potential treatments and receive a follow up appointment with a prescriber.
- Identify any specific needs and risks associated with diagnostic feedback and agree who will undertake the individualised feedback. Routinely it is anticipated that he assessing nurse will give feedback immediately after formulation and provide written information on any potential available treatments.
- If necessary, specify and plan interim monitoring arrangements.
- If a diagnosis of Mild Cognitive Impairment is given, the patient will be transferred to their GP with advice to re-refer in an agreed timescale.
- Appropriate interventions provided by other organisations, such as voluntary organisations, will also be considered and information about these services.
- Identify need for other statutory and/or non-statutory support/services, where appropriate.

7.3. Onward Referral To OPMH

Where a referral is to be forwarded to the Older People's Mental Health Team at this point in the pathway (see Appendix A, 6.0),. A clinician will make a telephone call to inform the team of the referral and this will be documented within the internal referral form. The MAS referral will be closed. All referrals for those patients who are requiring urgent input due to crisis will be referred to the appropriate OPMH team, they will then further triage and make the decision to refer on to Crisis Intervention & Treatment Team (Older People).. A ReQol tool, found on the clinical chart within Lorenzo; will be completed by the assessing clinician on forward referral following face to face assessment.

7.4. Referral To Social Services

If it is apparent that the patient requires a social needs assessment, the assessing clinician will make this referral by telephone to the appropriate department.

- Hull Social Care 01482 300300
- East Riding of Yorkshire 01482 393939

The MAS referral will remain open unless agreed otherwise within formulation.

7.5. Administration Process

Lorenzo inputting will be carried out by the assessing clinician as "Non Face to Face" "Case Conference" and will include others present at formulation.

The SNOMED intervention code and the ICD 10 code will be inputted by the assessing clinician.

If diagnosis is not agreed and further investigation is required, the administration team will be requested to make onward referrals and to place the patient on the "Further Testing" access plan.

The outcome of the Formulation will be recorded on the appropriate paperwork (using set proforma) within Lorenzo. It will be agreed if the Medic will need to authorise this.

7.6. Feedback Of Outcome Of Formulation/Diagnostic Disclosure

Specific needs and risks associated with diagnostic feedback and the most appropriate clinician(s) to undertake individualised feedback will have been agreed within the Formulation Meeting. A feedback appointment is always made with the patient and carer, regardless of whether any further multi-professional assessment is required in order to make sure the patient is aware of any probable diagnosis and to provide information and signposting.

The diagnostic feedback session will have the following purpose:

- To disclose the diagnosis if one has been reached.
- To discuss brain health and lifestyle choices that may help to maximise cognition, provide information on basic memory management strategies. To discuss the potential involvement of other agencies such as Social Services, Alzheimer's Society, Carer Services, Research, Occupational Therapy, Social Prescribing, etc.
- To inform the patient of any further investigations required to be able to provide a diagnosis(if relevant)
- To discuss any potential pharmalogical and non-pharmalogical interventions and provide information where needed. Prescribing decisions will not be discussed at this time (unless the feedback is conducted by an independent prescriber)

The Alzheimer's Society booklet titled "The Dementia Guide: Living Well After Diagnosis" is routinely provided to every patient who receives a diagnosis of dementia during their Memory Clinic feedback appointment. In addition, local information and signposting to other useful services is also provided. All information is provided in both verbal and written form.

If no diagnosis is the outcome of assessment and formulation the patient will be transferred from the service to the care of their GP.

If medication is a potential treatment option, a further appointment with an independent prescriber will be made to consider this. The patient will be provided with relevant Patient Information Leaflets.

The option for involvement in research will also be discussed and information given.

The invitation to a 12 week post diagnostic care plan review meeting will be discussed.

7.7. Administration Process

The clinician who delivers the diagnostic feedback will be responsible for inputting the contact onto Lorenzo. It will be recorded as "Telephone" or "Face to Face" then "Intervention/Treatment." The appropriate SNOMED intervention code will be added.
A communication note will be made in the patient record by the clinician delivering diagnostic feedback, and a 'Diagnostic' / 'plan of care' letter will be sent to the GP and the patient/their significant others (as agreed during the feedback)
The clinician will task the administrative team if the access plan is to be updated including the requirement for a follow-up appointment with an Independent Prescriber if this is indicated.

8. FORMULATION MEETINGS FOLLOWING FURTHER MULTI-PROFESSIONAL ASSESSMENT FOR PATIENTS WHERE ASSESSMENT IS MORE COMPLEX

The outcomes of extended assessment including medical investigations, in-depth neuropsychological assessment and/or Occupational Therapy are discussed in a second Formulation Meeting.

To review outcomes of additional assessment information received.
To reach Diagnosis

- Peer review Care Cluster and update MHCT, if appropriate.
- Identify need for other statutory and/or non-statutory support/services, where appropriate.
- To consider treatment options if appropriate.
- To agreed potential agreed onward referrals
- It is agreed during the reformulation which clinician will be responsible for providing the feedback. Where medication is a potential treatment option this may be carried out by an Independent Prescriber, or an initial feedback may be provided by a non-prescribing clinician, with a subsequent medication initiation appointment with an independent prescriber. The patient and their supporter will be invited to feedback as per 9.4 within 10 working days.

Referral to carer information and support services will be offered along with the opportunities to participate in research.

8.1. Onward Referral To OPMH

Where a referral is to be forwarded to the Older People's Mental Health Team at this point in the pathway (see Appendix A, 6.0), aclinician will make a telephone call to inform the team of the referral and this will be documented within the internal referral form. The MAS referral will be closed. All referrals for those patients who are requiring urgent input due to crisis will be referred to the appropriate OPMH team, they will then further triage and make the decision to refer on to Crisis Intervention & Treatment Team (Older People).. A ReQol tool, found on the clinical chart within Lorenzo; will be completed by the assessing clinician on forward referral following face to face assessment.

8.2. Referral To Social Services

If it is apparent that the patient requires a social needs assessment, the assessing clinician will make this referral by telephone to the appropriate department.

- Hull Social Care 01482 300300
- East Riding of Yorkshire 01482 393939

The MAS referral will remain open unless agreed otherwise within formulation.

8.3. Administration Process

- Lorenzo inputting will be carried out by the assessing clinician as “Non Face to Face” “Case Conference” and will include others present at formulation.
- The SNOMED intervention code and the ICD 10 code will be inputted by the assessing clinician.
- If diagnosis is not agreed and further investigation is required, the administration team will be requested to make onward referrals and for the patient to remain on the “Further Testing” access plan.
- The outcome of the Formulation will be recorded on the appropriate paperwork (using a set proforma) within Lorenzo.
- The admin will be tasked to book in a feedback appointment for the patient with the agreed clinician.
- The GP letter will be completed and distributed by the clinician providing the feedback appointment.

9. TREATMENT BY MEDICATION

Patients where medication is a potential treatment option will be offered a consultation with an Independent Prescriber. The purpose of this appointment is to review and confirm diagnosis, explore treatment options available including risks and benefits and make a shared decision regarding prescribing outcome. Where medication is prescribed this will be in line with the Hull & East Riding Prescribing Guidelines; initial prescription will be issued for the first 28 days using an FP10.

The prescribing clinician will complete a Shared Care Protocol(SCP) in Lorenzo and distribute this to the GP. The communication notes and/or a GP letter detailing the medication and dosage will be completed by the prescriber and distributed to the GP.

See Appendices D - G

Patients who accept medication are invited to review at 4 weeks following initiation of medication and again at 12 weeks following the 4 week review. These reviews will be carried out by a Healthcare Assistant. The Healthcare Assistant will receive supervision daily by an Independent Prescriber. Assessment of risk and of unmet need will take place and onward referrals made as clinically necessary. The GP is updated if there are any prescribing changes made

9.1. Prescribing Appointment

- The IP will offer a medication initiation appointment either by telephone or face-to-face.
- An FP10 will be produced and either given or posted to the patient. A communication note will be written detailing the medication and dosage. This will be distributed to the GP.
- The IP will complete the SCP and distribute this to the GP.
- The IP will input the contact to Lorenzo as “Telephone/Face to Face”, “Intervention/Treatment.”
- The appropriate SNOMED Intervention code will also be inputted.

9.2. Medication Review

- The HCS will complete an entry in the patient record and the IP supervising will complete a GP letter, when this is required
- The HCA will input the contact to Lorenzo as “Telephone/Face to Face”, “Intervention/Treatment.”
- The appropriate SNOMED Intervention code will also be inputted.
- The clinician will input the contact to Lorenzo as “Telephone/Face to Face” “Medication/Monitoring Prescribing Medication.”
- The appropriate SNOMED Intervention code will also be inputted.

10. 12 WEEK CARE PLAN MEETING

This is carried out by a suitable clinician, usually a HCA. All patients receiving a Dementia diagnosis will be offered a 12 week review. This gives the patient the opportunity to discuss any issues they have and ask any questions regarding their diagnosis. The supporter is also able to attend this appointment. Resources that are available to the patient and their carer are discussed and a care plan is drawn up that identifies the person who will be responsible for reviewing their care on an annual basis.

At times this review may be offered in conjunction with a review of a more discreet aspect of their memory interventions such as a medication review or OT review.

The care of the patient will then be transferred to their GP if all memory assessment interventions are complete and there are no unmet mental health needs. Where there are felt to be ongoing, unmet mental health needs or risks, cases will be transferred to CMHT.

10.1. Administration Process

The clinician who carries out the 12 week review will input the contact to Lorenzo as “Telephone/Face to face” “Memory Service Diagnosis 3 month review.” The patient is transferred out of the memory assessment service following this review unless they are continuing to receive medication monitoring. A Mental Health Clustering Tool is completed on transfer.

10.2. Safeguarding Issues Or Concerns

Safeguarding issues or concerns are usually highlighted within the assessment process and Mental Health Clustering Tool (MHCT) and are always reflected within care plans and the patient record. Where there are any concerns following assessment about a patient’s welfare or safety, the Safeguarding Adults Policy and Procedures are followed (see Appendix A, 16.0). The Humber Safeguarding Team are contacted where required in the first instance. Information is also available to the Hull & East Riding Memory Assessment Service practitioners via the appropriate Safeguarding Adults web pages Hull City Council and East Riding of Yorkshire Council. Any referral to the Safeguarding Adults Team is completed as a matter of priority. This information is shared with the relevant agencies or organisations, which have a legitimate relationship with the patient on a “need to know” basis e.g. the patient’s registered General Practitioner. All Safeguarding documentation is filed in the patient’s record. The patient is also discussed at earliest opportunity during the Multi-disciplinary Team (MDT) meeting.

10.3. Death Of Patient While Open To The Service

If a serious life event occurs while the patient is active to the memory assessment service, consideration should be made as to whether treatment with dementia medication has commenced at the point of reporting the event VIA Datix.

11. ROLE OF THE DUTY CLINICIAN

A clinician will be identified each day as the “Duty Clinician.”

The duty clinician will respond to incoming requests for non-scheduled intervention from patients and their supporters.

Incoming requests for intervention for the duty clinician will be received by the admin team. These will be forwarded to the “MAS Duty” inbox. The duty clinician will receive these and prioritise their response to the request based on clinical judgement.

The Duty Clinician will document their intervention on a communication note within the patient record on Lorenzo. They will refer onwards where appropriate in response to identified need and risk.

Enquires related to medication are initially screened by the duty worker but will be contacted byan Independent Prescriber if prescribing / de-prescribing activity is likely required The duty clinician prefixes the enquiry with ‘MEDS DUTY’ in the subject title of the email in the MAS DUTY inbox, for an independent prescriber to respond to in due course. There is time allocated each week for IP’s to undertake this activity.

. However, where the query requires a more immediate response the Duty Clinician will request support from a member of the prescribing team (i.e. Medic and/or NIP).

11.1. Administration Process

The duty clinician will enter the contact for the intervention on to Lorenzo as “Triage, telephone, telephone.”

11.2. Request For Imaging

If it is identified at any point within the patient pathway that further imaging is required for the purpose of diagnosis, a consultant will complete the request which will be forwarded to the appropriate imaging department.

Imaging Results are received via email to the requestor and to the Humber Memory Service Inbox. The identified administrator will move the result from the Humber MAS inbox to the scans inbox. Each day a nominated consultant will review the scans received to identify any code yellow results and take appropriate action.

12. THE MULTI-DISCIPLINARY TEAM MEETING

The Team meet each week on a Tuesday afternoon. The purpose of this meeting is to discuss patients, share information and make decisions regarding care. There is a set agenda. (see Appendix A, 13) A member of the administrative team is present at the meeting to take notes.

The meeting will follow the standards set out in "Standards for Patient Review Meetings Patient Not Present, No Feedback Given [Also known as Community Team MDTs, formulation meetings].

Prior to the meeting the staff member wishing to discuss a patient will complete the MDT Record (see Appendix A, 15) – pre meeting notes in preparation for discussion. The person taking the case for discussion will be responsible for entering the outcome of the discussion on to the MDT record within the patient record.

Partner agencies(CISS, ERCSS, Alzheimer's Society) are included in the meeting to discuss any service issues that affect the service they provide to the Memory Assessment Service and also to discuss patient related issues for patients known to the Memory Assessment Service. Those patients who will be receiving the 12 week review and who are known to partner agencies are also discussed to inform the patients care plan.

The partner agencies leave the meeting once these discussions have taken place to ensure patient confidentiality.

13. CONTACT AND ACCESSIBILITY

Hull & East Riding Memory Assessment Service
39-41 Coltman Street
Hull
HU3 2SG
Tel: 01482 336617
Email: hnf-tr.humbermemoryservice@nhs.net

The service can be contacted on the above number between 09:00 and 16:30 hours Monday to Friday. An answerphone is available for out of hours messages it also gives redirection details for emergencies/crisis.

Appointments are offered in various locations across Hull and East Yorkshire.

Hull - patients have a choice of three venues:

- The Memory Clinic, Coltman Street, Central Hull
- West Hull hub
- ICC

East Riding - clinics are held in Driffield, Hornsea, Hedon, Market Weighton, Beverley, Bridlington and Goole for those patients who reside in the East Riding CCG area.

14. TRANSFER OF CARE

Patients are transferred to the person who is responsible for monitoring their condition following the 12 week review meeting or as described in the pathway. This is usually the GP.

15. INVOLVING PATIENTS, CARERS AND FAMILIES

Patients who have experienced our services at first hand, their families and carer(s) are best placed to help us develop, monitor and improve services. To help us better understand the quality and effectiveness of our services we collect information about the service including; complaints, compliments and contribute to the national Friends & Family Test surveys. The organisation has a Complaints and Feedback service which helps us to listen to patients, their relatives, carers and friends. The Division takes opportunities in its developmental work to assess patient, carer and family feedback through a specific Patient and Carer Experience Group. The Butterflies Organisation facilitates a “Voices and Influence Group” that actively seeks the opinions of the people who use the Memory Assessment Service.

16. TRAINING AND STAFF DEVELOPMENT

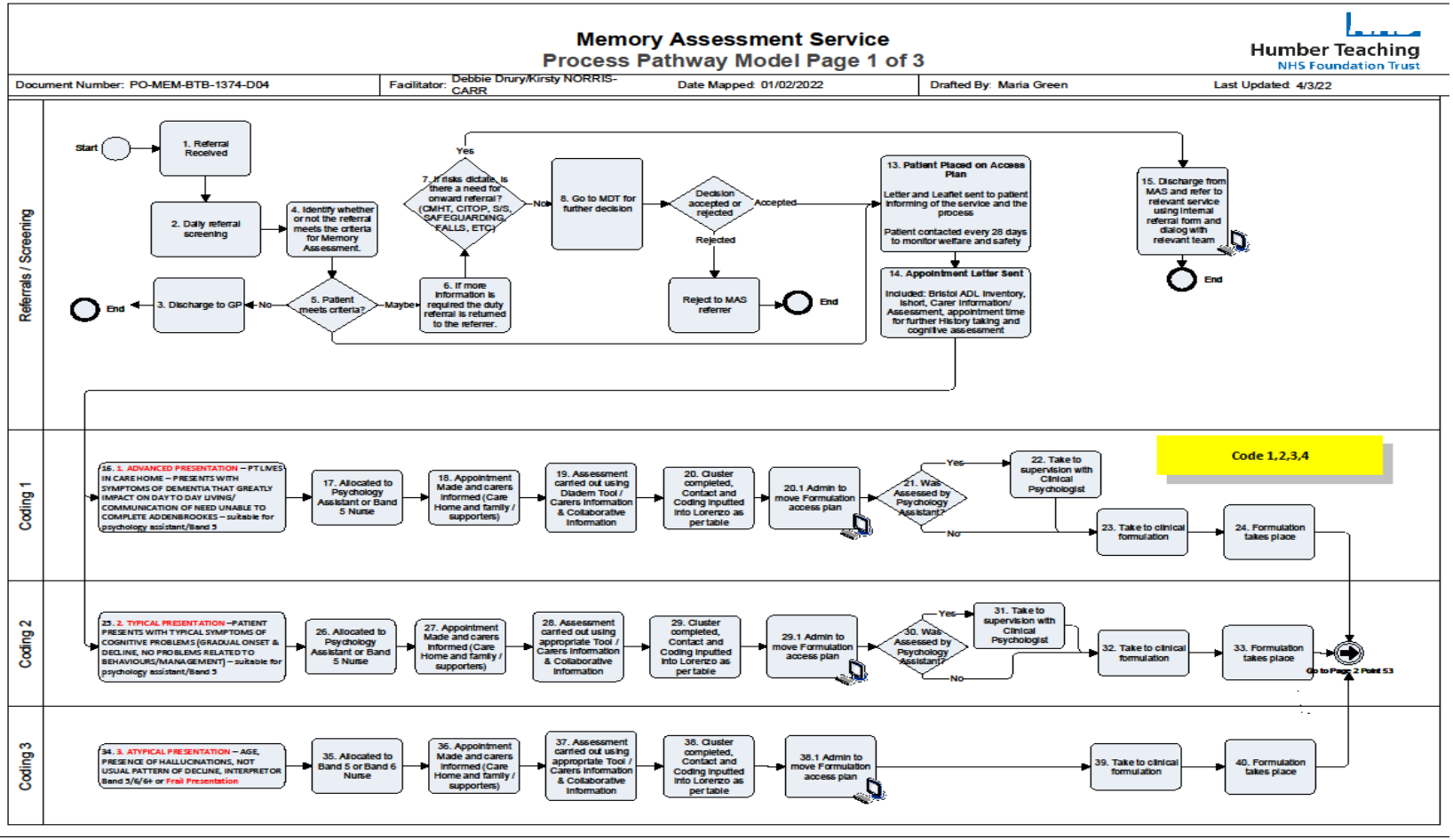
All staff Employed by Humber Teaching NHS Foundation Trust receives regular Clinical Supervision and an annual Appraisal. This incorporates statutory and mandatory training as a means to support continuous professional development. Medical staff in particular has access to regular weekly Continual Professional Development (CPD) and annual job planning meetings.

Our organisation views clinical and professional development as essential and continues to work pro-actively with higher and further education establishments to plan for and review pre-and post-registration requirements for all professionals. Training can also be accessed via a mixture of profession specific update courses, conferences and internal multi-agency developments, workshops and training sessions.

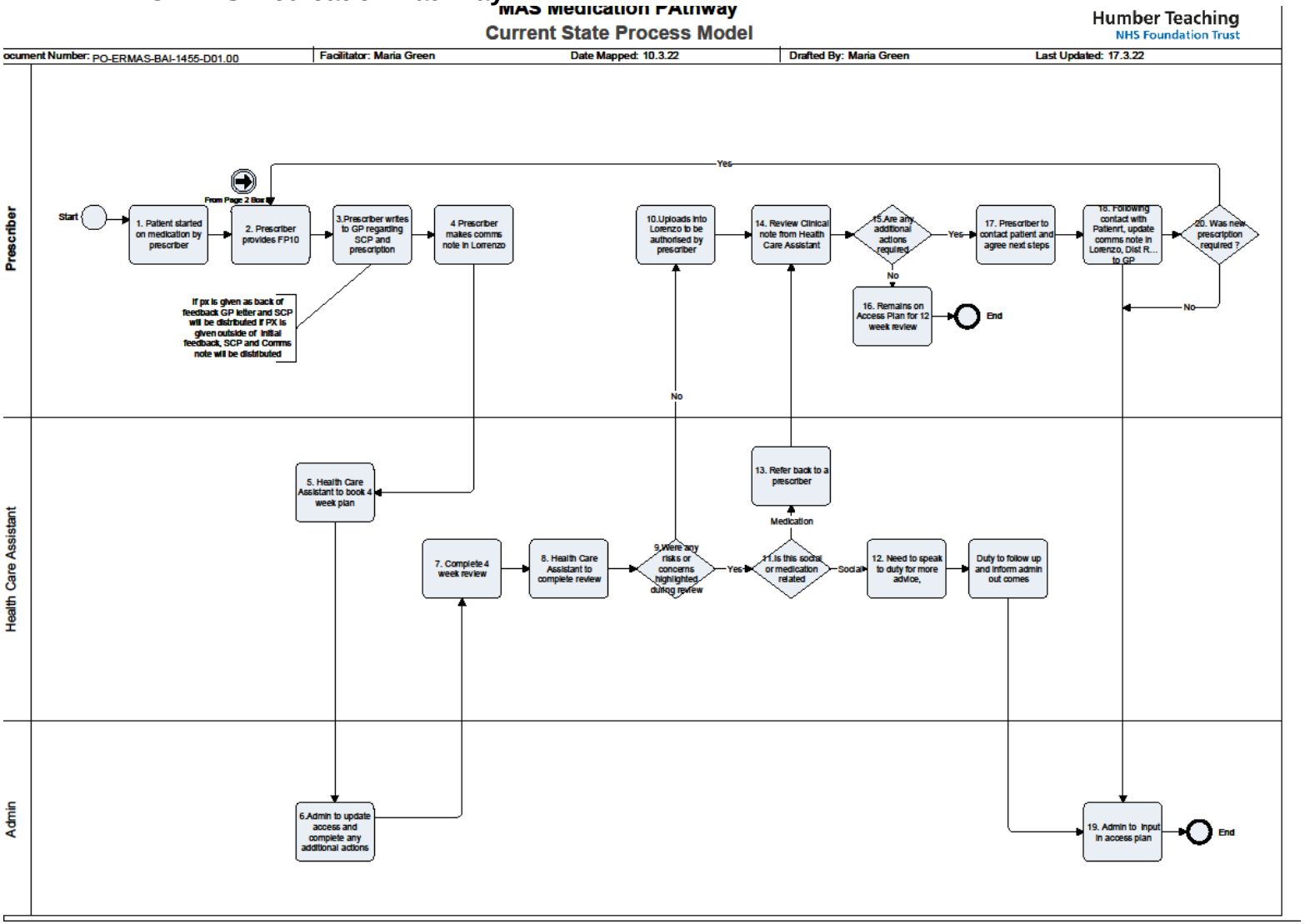
APPENDIX A: Documents referred to in the SOP

1.0: Local Demographic/Needs Assessment Information	Hull Data Observatory – WELCOME TO THE HULL DATA OBSERVATORY About our population and area (eastriding.gov.uk)
1.1: MAS Referral Form East Riding CCG	accessible ARDENs (GP system for referring)
1.2: MAS Referral Form Hull CCG	accessible ARDENs (GP system for referring)
1.3: JCPMH OP Guide	Guidance for commissioners of older people's mental health services | Mental Health Partnerships
2.0**: OPMH** Waiting List Standard Operating Procedure	*currently creating a SOP for and will be linked once approved*
2.1: Process Map of MAS Pathway	*Awaiting updated pathway*
4.0: Mental Capacity Act and Best Interest Decision Making Policy	Clinical Policies, Procedures and SOPs (humber.nhs.uk)
5.0: MAS Coding SOP	*currently creating a SOP for and will be linked once approved*
5.1: SNOMED intervention code	Lorenzo SNOMED code: dementia assessment service 893331000000102
6.0: Referral & Triage Form	Lorenzo/Clinical Charts/Op Team/ Correspondence/Notes/Op Triage and referral form
9.0: Outcome of Memory Assessment and Post Diagnostic	Lorenzo/Clinical Charts/OP Team/Correspondence/documents/GP Report PC Memory Clinic
11.0: Choice and Medication - Patient Information Leaflets via Humber Teaching NHS Trust Intranet	Humber Teaching NHS Foundation Trust Home (choiceandmedication.org)
12.0: Hull & East Riding Prescribing Committee/guidelines	Hull and East Riding Prescribing Committee | Hull University Teaching Hospitals NHS Trust (hey.nhs.uk)
13: The Multi-Disciplinary Team Meeting agenda	See team to access: V:\Mental Health Services\OPMemory Service - Hull\Shared\MAS\BUSINESS & MDT MINUTES\MDT\MDT form
15: MDT Record	Lorenzo/Clinical Charts/OP Team/care plan, care pathways/notes/MDT meeting record
16.0: Safeguarding Adults Policy	Clinical Policies, Procedures and SOPs (humber.nhs.uk)
17.0: Division Structure	Mental Health Services Division (humber.nhs.uk)
18.0: OPMH Inpatient Units Operational Structure	Mental Health Services Division (humber.nhs.uk)

APPENDIX B :MAS Process Pathway Model



APPENDIX C: MAS Medication Pathway



APPENDIX D: How to Guide for Prescribing Within MAS - Medic Telephone Or Upstream Medication Initiation Appointment, F2F, Patient Already Had Feedback Previously

If a patient has an appointment with a medic (F2F) with a view to initiate medication when they have already had their feedback during a previous intervention, and it is agreed that medications will be initiated.

https://intranet.humber.nhs.uk/document-library/Policy related documents/OPMH SOP documents/How to prescribe in MAS Guide - medic - F2F meds initation no feedback.docx

APPENDIX E: How to Guide for Prescribing Within MAS - Medic Telephone Or Upstream Medication Initiation Appointment, remote.

If a patient has an appointment with a medic for their feedback (remote means) and it is agreed that medications will be initiated the following process should occur.

https://intranet.humber.nhs.uk/document-library/Policy related documents/OPMH SOP documents/How to prescribe in MAS Guide - medic - remote feedback.docx

APPENDIX F: How to Guide for Prescribing within MAS - Medic Telephone Or Upstream Medication Initiation Appointment, remote, Patient Already Had Feedback Previously

If a patient has an appointment with a medic (remote means) with a view to initiate medication when they have already had their feedback during a previous intervention, and it is agreed that medications will be initiated, the following process should occur

https://intranet.humber.nhs.uk/document-library/Policy related documents/OPMH SOP documents/How to prescribe in MAS Guide - medic - remote meds initation no feedback.docx

APPENDIX G: How to Guide for Prescribing Within MAS - Medic Telephone Or Upstream Medication Initiation Appointment, F2F

If a patient is seen by a medic during their feedback (F2F) and it is agreed that medications will be initiated the following process should occur

https://intranet.humber.nhs.uk/document-library/Policy related documents/OPMH SOP documents/How to prescribe in MAS Guide - medic - F2F feedback.docx