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NHS
Gloucestershire Health and Care
NHS Foundation Trust

# Operational Policy

## Managing Memory Together

(Memory Assessment Service / Community Dementia Nursing and Advice / Information Service)

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**Service Title**

Managing Memory Together

## 1. Introduction

What is dementia?

Dementia is a syndrome that is caused by damage to the structure and functioning of the brain, as a result of specific disease processes, the most common cause being Alzheimer's disease. Dementia is a diagnosis of exclusion, therefore relying on other reversible causes being ruled out before a diagnosis can be made. For a diagnosis to be given, there must be clear evidence of a progressive decline in cognitive and functional abilities, i.e. a deterioration in the person's ability to complete their usual everyday activities, as a result of their cognitive difficulties.

There are currently estimated to be 982,000 people living with dementia in the UK and this is projected to rise to 1.4 million in 2040.

In the NHS Gloucestershire ICS there are currently:

- 6,539 people over the age of 65 with a recorded diagnosis of dementia.
- 10,064 people over the age of 65 estimated to be living with dementia.

- Data taken from the Alzheimer's Society local dementia statistics, May 2025

Locally, there remains a large gap between the number of people living with dementia and those with a recorded diagnosis. There is an increasing challenge to reduce this gap, to enable people living with dementia to access the health and social care support that they would be entitled to.

## 2. Purpose

The Managing Memory Together Service's main objective is to provide specialist assessment, diagnosis, support and treatment, for people aged 18+ presenting with cognitive difficulties, where there is a suspicion of a possible dementia, or a confirmed diagnosis.

The service will promote early identification of dementia and its risk factors, through public and primary care education and engagement.

People with dementia and their carers will be invited to access dementia information and peer support sessions, following diagnosis. Managing Memory Together will work collaboratively with other agencies to respond to the individual needs of people diagnosed with dementia and their carers and link them with services that can support them in their dementia journey.

## 2.1 Aims

The main aims of the service are to:

- Provide a high quality and comprehensive service for people living in Gloucestershire who are experiencing cognitive difficulties, or who have a confirmed diagnosis of dementia or mild cognitive impairment.

- Provide timely diagnosis of dementia, to enable early access to support services and any treatment that might be appropriate.

- Encourage and enable people living with dementia to give their own views and opinions about their care and to make plans for their future, involving family members and carers as appropriate.

- Provide people living with dementia and their family members or carers (as appropriate) with information that is relevant to their circumstances and the stage of their condition.

- Provide carer education about dementia, its symptoms and the changes to expect as the condition progresses. Support carers in developing personalised strategies and building carer skills.

- Reduce stigma and raise awareness of dementia and its risk factors, amongst the public and other professionals.

- Encourage early identification of dementia signs and symptoms and access to assessment.

- Link with other health, social care and third party agencies to provide holistic and individualised care for people diagnosed with dementia and their carers, to ensure all round support is offered to help support people through the ways that dementia may affect their lives.

## 2.2 Service Principles

The current NICE Guidance on Dementia: assessment, management and support for people living with dementia and their carers (NG97) (2018) provides recommendations for the assessment, management and support of people who are living with dementia, as well as their carers. It emphasises the importance of timely diagnosis and access to appropriate support, both pre and post diagnosis.

At a local level, the Gloucestershire ICS Dementia Strategy 2023-2028 sets out the following key aims:

- *The risk of people developing dementia is minimised*
- *Timely and accurate diagnosis*

- *Access to appropriate health and social care support for people living with dementia and their carers.*
- *Inclusive communities where people with dementia can live well and safely*
- *People with dementia are able to die in dignity in the place of their choosing*

The Managing Memory Together Service sets out to align with the above directives by providing support to people who are worried about their memory, are in the process of assessment, or have received a diagnosis of dementia or mild cognitive impairment. The service also provides support for relatives and carers, to help ensure their own wellbeing as well as building on their understanding and skills in supporting someone with a cognitive impairment. The service delivers dementia public awareness sessions and educational peer group sessions for people diagnosed with dementia and their carers, to support people to understand how dementia may affect their lives and develop skills and resilience for living with the impact of this condition.

### 2.3 Scope

The service will be delivered by four locality teams, countywide. The service supports people pre and post diagnosis of dementia and will consist of the following sub-teams:

Memory Assessment Service (MAS)
MAS will deliver routine, specialist dementia assessment, diagnosis and initiation of dementia medication (where this is indicated). MAS is a diagnostic pathway for people aged 18 and over with cognitive difficulties where there is a suspicion of an underlying neurodegenerative cause. Patients will be discharged from this service once they have received post-diagnostic support, signposting and once any onward referrals have been made for ongoing support.

Information and Education Service (IES)
IES will deliver dementia awareness sessions to the public to help them to recognise the signs of dementia, so that they can seek support in a timely way. The public engagement work will involve collaboration between Managing Memory Together and other agencies, to offer people affected by memory problems or dementia an understanding of the range of support that is available to them and where to seek help if needed. IES will offer peer group information sessions to patients and carers who have been seen through the MAS pathway and are affected by dementia. Others who are not currently under Managing Memory Together, but are living with and/or affected by dementia, will also be eligible to sign up for these sessions. IES will deliver individualised support and signposting via phone and email, to people affected by cognitive difficulties.

Community Dementia Nurse/Practitioner Service (CDN)
The CDN service will provide guidance to GP practices in meeting the needs of people affected by dementia. They will work collaboratively with GPs to support them to make a primary care led diagnosis of dementia, where there is evidence of advanced cognitive symptoms. The CDN service will offer short term interventions for people affected by dementia where there are psychological or behavioural

symptoms, causing distress and other difficulties. Where people living with dementia, and their carers, might need additional short term support to access appropriate health and social care or third sector services, the CDN service can provide short term support to facilitate this.

Care Home Support Team (CHST)

The CHST will provide support to people living with dementia in care homes, where there are behavioural or psychological symptoms that may cause the person distress or challenge essential care delivery provided by care home staff. The CHST will work collaboratively with the person living with dementia, their relatives and carers, to create person-centred care plans to support with these difficulties. The CHST will also support with primary care led diagnosis of dementia, in care homes.

### 2.4 Duties

Responsibility for the development, maintenance, review and ratification of this document lies with the Chief Operating Officer (COO). The COO has board level responsibility for the development of this document and may delegate this responsibility to a subordinate.

The Governance Committee will be notified when this policy has been approved by the Chief Operating Officer (COO) and made aware of any amendments.

All staff who have contact with service users and other care agencies are responsible for using the policy correctly to ensure patient safety.

### 2.5 Ownership & consultation

The Community Service Manager (CSM) and Team Managers for Managing Memory Together, are the owners of this document.

### 2.6 Ratification details

This Policy has been ratified by the Chief Operating Officer (COO) with notification to the Trust Governance Committee.

### 2.7 Release details

This policy will be available on the Trust intranet page in the policy section under ‘Essentials; Policies; Policies – Clinical; A-Z General’. Notification of its review and update will be published in staff briefings.

### 2.8 Review arrangements

This document will be reviewed in April 2027.

### 2.9 Process for monitoring compliance

The policy will be reviewed every two years to ensure that it reflects current guidance and research on dementia assessment, care and treatment.

## 3.0 Demographics and target population

Memory Assessment Service (MAS)
The service will be available to adults aged 18 years and over, who are residing in Gloucestershire and experiencing difficulties with their cognition, where assessment for dementia is required.

Care Home Support Team (CHST)
The service will be aimed at providing advice and guidance to Gloucestershire based care homes. It will support individual residents, who have an established diagnosis of dementia, with their behavioural and psychological symptoms of dementia. This will involve collaborating with care home staff to develop care plans that aim to reduce distressed behaviour or behaviour that challenges the delivery of essential care for the resident.

Community Dementia Nurse/Practitioner Service (CDN)
The CDN service will be aimed at providing brief periods of supportive interventions and education, relating to living with dementia, for those with an established diagnosis of dementia and their carers, of any age. The service will also support GPs to make a primary care led diagnosis for people presenting with symptoms of advanced cognitive and functional difficulties where a dementia diagnosis is considered highly likely, in order to support with timely diagnosis. The CDNs will provide post-diagnostic support for people who have not received this through the MAS pathway (e.g. people referred in to Managing Memory Together following independent diagnosis by GP or through private dementia assessment services).

Information and Education Service (IES)
IES will provide dementia education group sessions for people diagnosed with dementia, and their carers. They will also provide information, signposting to support services and general emotional support to people who are concerned about their memory or someone else's memory, with or without a formal diagnosis of dementia.

## 3.1 Exclusions

- MAS does not accept referrals where physical and/or mental health causes of the cognitive difficulties have not been adequately excluded. This is required in order for a reliable dementia assessment to be carried out, since dementia is considered a diagnosis of exclusion. Where appropriate, referrals will be redirected to other GHC services, or recommendations made to the referrer on any further investigations that may be needed, to ensure the patient receives the most appropriate care pathway.

- MAS does not accept referrals where there is a rapid progression of cognitive and functional symptoms, where an urgent neurology opinion would be more appropriate. Typically, patients presenting with cognitive difficulties of a duration of six months or less, would benefit from neurological opinion.

- MAS does not accept referrals where there are moderate to severe comorbid mental health difficulties and/or risk factors that would make the referral more appropriate for secondary mental health services, where a cognitive assessment can be completed as part of the assessment and intervention, if indicated, with support from MAS where required.

- MAS clinicians will accept referrals for people presenting with problem alcohol use, on a case-by-case basis, with triage support from the Trust's Alcohol and Substance Abuse Lead. This will aim to minimise the risk of people presenting with vulnerability from Alcohol Related Brain Damage falling through the gaps of services, in the absence of a current local or national agreed pathway for this client group.

- CDNs will not accept referrals for supporting primary care led dementia diagnosis where a person's cognitive issues are mild- moderate, the person is under the age of 75, the difficulties have been present for less than one year, other reversible causes haven't been sufficiently excluded, or there is complexity such as comorbid mental health, alcohol or substance misuse. These referrals may be redirected to other services, such as MAS.

- CDNs will not accept referrals to their dementia support/brief intervention caseloads if there is not an established diagnosis of dementia and the person is ineligible for primary care led dementia diagnosis.

- CDNs will accept referrals for dementia support on a case-by-case basis where there is evidence of a delirium as the cause of sudden behavioural changes for a person living with dementia. They may provide advice on managing the underlying causes of delirium and the symptoms of this.

- CHST will not accept referrals for people who are not residing in a care home.

- CHST, MAS and CDN referrals for people in temporary care home Discharge to Assess (D2A) beds will be considered on a case- by-case basis, depending on the nature of the person's physical and mental health condition and likely length of stay in a D2A bed. Referrals may be declined where the person's physical health condition is not stable and it would be appropriate to delay an assessment or intervention from Managing Memory Together, until such a time as the person's condition is more stable and they are considered to be at cognitive baseline. Support may be provided by CHST or CDN for delirium management if this is presenting a risk or challenge to essential care delivery.

- CDN and CHST will not accept referrals where the complexity and risk is deemed to be of a secondary care level nature, where the MDT input of the Community Mental Health Team would be a more appropriate team to support the patient.

## 4.0 Activity assumptions

MAS initial nursing assessments are expected to take on average 1.5-2 hours to undertake and approximately 1.5 hours to complete associated documentation. MAS nurses will be expected to complete post diagnostic appointments for each person allocated to them who receives a diagnosis of dementia. They will complete nurse diagnosis appointments in non-complex cases and support with the triage of referrals. All staff within the Managing Memory Together Services are encouraged to support with post-diagnostic information and education sessions, provided by IES.

CDN and CHST staff will hold caseloads and receive regular caseload supervision to support with managing the size and complexity of these. It is expected that patients will remain on CDN and CHST caseloads for short term support only and no longer than six months. CHST and CDN staff will support with the triage of referrals to their respective teams, via a duty system.

## 5.0 Performance measures

Data pertaining to wait times for different elements of the MAS pathway, including referral to assessment and referral to diagnosis, will be monitored and reported on within the Trust. The NHS England national target for dementia diagnosis rates (66.7%) will be applied when comparing with the local Gloucestershire NHS ICS dementia diagnosis rate data. Friends and Family Test feedback forms will be provided to people who use the Managing Memory Together service, for feedback on their experience of the quality of care provided. Experts by experience will be invited to contribute feedback and ideas relating to service development, where possible.

### 5.1 Quality requirements

- Friends and Family Test
- GHC internal quality audits
- National targets on dementia diagnosis rates and wait times

### 5.2 Minimum data set requirements

The primary care level ‘Core 0 MM2G’ will be used when recording data on rio.

## 6.0 Service delivery

MAS will be organised as a multi-disciplinary team, providing assessment, diagnosis, initiation of treatment (where indicated) and post-diagnostic support. The multi-disciplinary team consists of memory assessment nurses, psychiatry doctors, occupational therapists, psychologists and speech and language therapists.

The CDN and CHST service will consist of community dementia nurses and practitioners. Although medical input is not commissioned for these services, some may be provided by the MAS psychiatrists on an as-needed basis, to support clinical decision making and prescribing.

The countywide service consists of 4 locality bases:

- Cheltenham
- Gloucester
- Stroud
- Forest of Dean

## 6.1 Clinical services

- MAS

Triage
Referrals are triaged by the MAS nurses, with the support of the Team Manager and wider MDT as needed. Referrals are triaged within 48 hours of receipt. Where referrals are accepted, a letter will be sent to the patient advising of their acceptance to the MAS wait list and information will be provided about the service and what to expect. Where referrals are not felt to be appropriate for MAS, they will either be redirected to a more appropriate service, or a rationale for declining the referral will be provided to the referrer, with recommendations as appropriate.

Assessment
A MAS nurse will be allocated at the point of assessment and will complete the initial core assessment, including a comprehensive history taking and Addenbrookes III Cognitive Assessment. Assessments take place in clinic as standard unless adjustments are necessary to assess a person at home, if they cannot travel to clinic.

Assessments will be discussed in a weekly MDT meeting and a decision made as to whether there is sufficient information to proceed to a diagnostic appointment, or whether further assessment by occupational therapy/psychology/speech and language therapy, are required.

Where needed, additional brain scans or other physical health investigations may be ordered/recommended, to further explore the cause of the difficulties.

Diagnosis
Diagnosis appointments will be provided by either the allocated MAS nurse or a psychiatry doctor, depending on the level of complexity, with the doctors delivering diagnosis for the more complex patients. Dementia medication may be offered at this point, if appropriate. A dementia 'red folder' will be provided to the patient, containing the team's Dementia Handbook.

Post-diagnostic support
Post-diagnostic support will be provided by the allocated MAS nurse and in collaboration with the Alzheimer's Society Dementia Advisor Service, who are commissioned to provide this support within the MAS pathway. The MAS nurse will complete the post-diagnostic appointment by telephone (unless for some reason contraindicated) and will further discuss the diagnosis and review any treatment initiated. Dementia research opportunities will be discussed and a referral to the Information and Education Service (IES) educational peer group sessions will be offered. A dementia advisor from the Alzheimer's Society will call the patient within 4 weeks of the nurse-led post-diagnostic appointment, to discuss other support services,

benefits the person may be entitled to, advanced care planning and any other individualised support that might be helpful.

Discharge
Patients will be discharged once they have received their post-diagnostic appointment and any dementia medication that has been started is optimised. If further support is required for adjusting to a dementia diagnosis, accessing support services or managing the symptoms of dementia, onward referrals to other services, such as CDN, IES or services external to Managing Memory Together, can be made.

- CHST

CHST clinicians will triage referrals received in to the CHST email inbox. They will offer assessment in person, followed by a care plan developed in collaboration with care home staff, patients and carers, as appropriate. They may offer a period of intervention to monitor and review the care plan.

- CDN

The CDN service will triage referrals received in to the CDN email inbox. Referrals will be allocated to the CDN/P allocated to the patient's GP practice. Referrals will be allocated to one of three caseloads:

1) CDN Memory Assessment- for patients allocated for dementia assessment as part of primary care co-diagnosis with the GP, or for post-diagnostic support.

2) CDN Support and Review- for patients and/or carers requiring support with living with dementia, coping with changes and accessing support services they may be entitled to, where there are no behavioural and psychological symptoms of dementia present.

3) CDN Brief Intervention- for patients and their carers needing support to manage behavioural and psychological symptoms of dementia, where the symptoms cause the person with dementia distress and/or put themselves or others at risk.

The CDN service will offer assessment in person, followed by a care plan for support over a defined period of time, in collaboration with the person with a dementia diagnosis and where appropriate, their carer(s).

## 6.2 Referral Process

The service provides email/telephone advice and guidance to potential referrers, giving information about the principles and activities of the service, including referral criteria and care pathways/management guidelines.

- MAS

Referrals will be made by GPs and other health professionals, using the MAS referral form (see appendix), which will be emailed to the MAS email inbox, for processing by MAS administrative staff.

Once processed, referrals will be triaged by the MAS nurses, on a rota basis. If further information is required to decide on the appropriate of a dementia assessment, the MAS nurse completing the screening will contact the referrer/patient/carer/relative for more information, as appropriate (taking in to account consent to share information).

Complex referrals will be discussed with the Team Manager or another senior member of the team.

Any referrals for people with problem alcohol use or alcohol dependence will be discussed with the Trust's Alcohol and Substance Abuse Lead, to agree on the appropriate pathway for assessment/support.

- CDN

Referrals for support can be made by healthcare professionals, people with a diagnosis of dementia, or their carers, via the Managing Memory Together HQ number, or the CDN email inbox.

Referrals for primary care led memory assessment, supported by the CDN service, can be made by GPs, through the Managing Memory Together HQ number or the CDN email inbox.

- CHST

Referrals can be made by healthcare professionals, to the CHST email inbox or by calling the Managing Memory Together HQ number.

### 6.3 <u>Urgent Referrals</u>

The Managing Memory Together Service will offer routine, elective assessments for patients. If urgent support is required due to risk concerns, the patient will need to be redirected to the Community Mental Health Team and/or other service that will be able to respond to this on an urgent basis.

### 6.4 <u>Management of cancelled/missed appointments</u>

The Memory Assessment Service will work proactively to minimise the risk of missed appointments, by calling patients up to 3 days in advance of their assessment appointment, to check they are aware of the details of the appointment and that they plan to attend. Where assessments are cancelled in advance of the appointment, every effort will be made to contact those next on the wait list to offer them a last minute cancellation slot.

The CDNs and CHST will, in most cases, contact their patients, carers/relatives by telephone to arrange appointments. This will help to minimise the risk of missed appointments.

Due to the nature of the patient group and the memory difficulties they may have, we will work flexibly with patients to offer a further appointment where someone does not attend, if the patient wishes to engage with the service. We may consider whether

adjustments are needed to support engagement, for instance a home visit or an appointment at an alternative clinic site.

Since the service is elective for patients, they will be discharged back to the GP if they do not wish to engage.

## 6.5 Clinical responsibility & Care Programme Approach (CPA)

As the Managing Memory Together Service is an assessment service (MAS) and a primary care level service (CDN and CHST), the CPA process is not applicable. The Managing Memory Together Service is a primary care service for the purposes of the assessment and care management policy.

## 6.6 Risk assessment and management

Risk will be assessed as part of the initial assessment; a risk screening or full assessment will only be completed if clinically indicated, as per Trust Policy.

## 6.7 Links to other agencies/services

### 6.7.1 Internal

The service aims to provide a consultation response to those internally and externally who may be involved in the care and treatment of a person with cognitive difficulties, where there is a concern about possible underlying dementia.

### 6.7.2 External

As part of post-diagnostic support provided, patients and carers are signposted to other agencies, where appropriate.

- The service will refer/signpost to the Local Authority for social care needs assessment and carers' assessment, where appropriate.
- The Alzheimer's Society Dementia Advisor Service will provide post-diagnostic support to enable people diagnosed with dementia to access benefits they may be entitled to, such as Attendance Allowance. They will give advice around aspects of planning ahead, such as Lasting Power of Attorney and Advanced Care Plans. They will provide personalised information around local support services and activities that may be of benefit to the person with dementia and, where appropriate, their carers. The dementia advisors will be able to provide ongoing support to people after diagnosis, as needed.
- With consent, the GHC Research Team will provide information to people diagnosed with dementia, and their carers, on research that they may be able to participate in.

- The Gloucestershire Carer's Hub will be a primary source of advice and support for carers of people with a diagnosis of dementia.

## 6.8 Discharge arrangements

- MAS
  Once patients have completed the memory assessment pathway and are stable on any anti-dementia medication that may have been started, they are discharged back to the care of GP and to the Alzheimer's Society Dementia Advisor Service, where consent has been given for this. If additional dementia nursing support is indicated, an onward referral may be made to the CDN service for a period of brief intervention or support.

  Where patients have been assessed through MAS but not given a diagnosis of dementia, they may be referred back to MAS in future, if further deterioration in cognition occurs.

- CDN/CHST
  Patients are discharged back to GP once their short term period of support has been completed. Referrals can be made back to these services should further support be required.

## 7.0 Service times

The service operates Monday-Friday, 9am-5pm.

## 8.0 Patient/ carer involvement

Patients and carers (where appropriate consent/best interest decisions are in place) will be fully engaged and involved in care and treatment decisions. Approaches to assessment and care can be adapted to suit the needs of the patient and carers and support people to feel as reassured and comfortable as possible throughout the process, which is often a distressing one for people. Carers/relatives are an important source of information about cognitive and functional changes, which aids dementia assessment. Their needs will be assessed in their own right and information provided to them to support them in their caring role and maintaining their own wellbeing.

## 9.0 Staff support

Staff employed within the service are subject to regular supervision and monthly peer support. Where necessary, there are additional sources of clinical and personal support available, for instance through the Trust's Wellbeing Line and Occupational Health services.

## 9.1 Clinical/management supervision

GHC NHS Foundation Trust is committed to delivering the key policies that support staff to carry out their roles effectively and support staff wellbeing. Supervision will be completed every 4-5 weeks and will include managerial and clinical elements, including caseload review, to ensure effective throughflow in the service. Peer group supervision will take place on a monthly basis and encourage discussion around team issues as well as the opportunity for CPD.

## 9.2 Team meetings

Multi disciplinary team meetings will be held weekly within each locality.

## 9.3 Day to day management

The Managing Memory Together service sits within the Specialist Services Directorate.

## 9.4 Staff appraisal

Staff appraisal will be consistent with GHC policy. Full details of these policies can be found within the relevant sections in the GHC NHS Foundation Trust policy regarding appraisal.

## 9.5 Training/Continuing Professional Development

- Training and development will reflect the needs of GHC and of the individual.
- Team members will comply with mandatory/statutory training and this will be monitored at supervision.
- Team members will be encouraged to consider continuing professional development (CPD) opportunities and will be supported with protected time to attend appropriate training.
- Monthly peer group supervision provides the opportunity for case discussions and CPD, which the team manager and the wider team will help to organise.

## 9.6 Staff induction

- Staff induction will be undertaken in a planned way, to take in to account the team and local induction frameworks and Trust Induction Policy and Procedure. Protected time will be allocated for training related to induction to the team.

## 9.7 Clinical Governance Issues

Clinical governance is the framework through which we are accountable for improving the quality of our services and safeguarding high standards of care. This includes how we reflect on adverse incidents and areas of good practice and will reflect the required standards outlined in the Service Specification.

## 9.8 Staff Safety/Lone Working

All staff will carry out their clinical work within the following safety parameters:

- Whenever possible all sessions will take place at a clinical base, at a time where other staff are available. Home visits will be completed only where absolutely necessary.
- All activity will be carried out in accordance with the GHC NHS Foundation Trust and local lone working policies.

## 9.9 Business Continuity

The service will have an up to date business continuity plan in place that will identify actions required in the event of an emergency or other incident that affects service delivery.