Kent and Medway
NHS and Social Care Partnership Trust

MEMORY ASSESSMENT SERVICE: STANDARD OPERATING PROCEEDURE

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DOCUMENT TRACKING SHEET

Standard Operating Procedure/ Local Procedure Title

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Draft 1.5	Draft			

REFERENCES

RELATED POLICIES/PROCEDURES/protocols/forms/leaflets

MAS Operational Policy.	
MHT/+ Operational Policy	
MHT/+ Standard Operating Procedures	
KMPT Risk Assessment Policy	
KMPT Care Planning Policy	

SUMMARY OF CHANGES

Date	Author	Page	Changes (brief summary)

CONTENTS

1 INTRODUCTION

1.1 The Memory Assessment Service (MAS) was created to meet the demands of the NHS Mandate with regards to Dementia assessment and diagnosis across Kent and Medway.

1.2 The NHS Mandate commits us to increasing the number of people receiving a diagnosis within 6 weeks of a GP referral. As part of Kent & Medway Partnership Trust's 2023- 2026 strategy the Trust is committed to delivering a Memory Assessment & Diagnosis Service within 6 weeks of GP referral for 95% of people referred.

1.3 A timely diagnosis of dementia is an important step in receiving the tailored support and treatment that enables people to lead full lives, engaged with their families and communities, for as long as possible. Early diagnosis gives people the best opportunity to plan for the future, and can help prevent crises.

1.4 To improve the efficiency of diagnosing people referred to us, we have introduced the Standalone Memory Assessment Service (MAS). As part of the broader transformation of the Community Mental Health Framework, to ring-fence resources for memory assessments to best support people with dementia and their carers. Post-diagnostic treatment and support for people with dementia and their carers is provided by the Mental Health Together Plus (MHT+) service.

1.5 This SOP should be read in conjunction with the Memory Assessment and Diagnosis Service Operational Policy, and any other applicable local policies available on Staffroom. All links to documents within this SOP are hosted on Staff Room (unless otherwise specified) and a KMPT system login is required to access. Partners supporting the delivery of services will be provided copies of all relevant policy, procedural and standard work instructions via email.

2 PURPOSE

2.1 To meet the statutory requirements of GDPR, MAS needs to have in place robust information governance and management arrangements for the protection of all patient health records retained on Rio. Clear procedures need to be in place to reduce the risk of mistakes which could compromise patient data and confidentiality.

2.2 This document provides guidance and direction for operational staff to establish a consistent approach to managing data appropriately within Rio. It draws on existing policies and guidelines to support users to deliver safe, accountable care. It defines how Rio will be used in a standardised manner across all services within the Memory Assessment Service.

2.3 This document will be reviewed by the MAS Oversight Group every three months as the service continues to embed, once it has been ratified by the KMPT Clinical Effectiveness and Outcomes Group.

3 SCOPE

3.1 The Memory Assessment Service (MAS) takes all GP referrals for a memory assessment if there is:

- History of cognitive decline occurring over six months, with a pattern of symptoms and signs that are typical for dementia.
- The GP has ruled out other potential causes and the clinician believes dementia is the most likely diagnosis.

3.2 **Outside of Scope**:

- when it is clear from the GP referral, and or triage that dementia is not suspected. For example, a younger person is referred where it is clear there are other reasons for cognitive difficulty.
  In this instance: Transfer to the most appropriate Mental Health Together service.
- Where substance and alcohol misuse is still current.
  In this instance: Efforts should be made to ascertain if the individual can be supported to safely reduce substance misuse before being referred. If this has been tried and has not been successful they can still be referred into the service. A decision will be made in triage around appropriateness for assessment.
- If a GP referral requests a diagnostic appointment for people in care homes and for those with suspected advanced dementia.
  In this instance: you should request for them to carry out DiADeM where it is in place in primary care.
- Any internal referral from a KMPT service that has the capability to assess and diagnose. E.g. Inpatient services.
  In this instance: Assessment and diagnosis to be provided by that service.
- If the patient is in crisis
  In this instance: Patient passed to MHT+ Duty Clinician (with older adult speciality).

4 DEFINITIONS

Abbreviation/Term	Definition
Administrator	Administrative staff of any band (internal or external to KMPT) who work on the administration of patient records
ACP	Advanced Clinical Practitioners
Clinician	Any clinically qualified member of staff involved in the care of patients (excluding Medics and unqualified clinical staff)
CMHF	Community Mental Health Framework
CPL	Clinical Pathway Lead
CPN	Community Psychiatric Nurse
DiADeM	Diagnosing Advanced Dementia Mandate: a tool to support GPs in diagnosing dementia for people living with advanced dementia in a care home setting.
Diagnosing Clinician	Members of staff who are able to give a formal diagnosis which currently includes Consultant Psychiatrists, Advanced Clinical Practitioners and Speciality Doctors.
KMPT	Kent and Medway NHS and Social Care Partnership Trust
MAS	Memory Assessment Service
Medic	Umbrella term for the medically qualified workforce (includes junior doctors of all grades and consultants)
MDT	Multi-Disciplinary Team
MHSW	Mental Health Support Worker
MHT	Mental Health Together
MHT+	Mental Health Together Plus
MSNAP	Memory Service National Accreditation Programme - a quality improvement and accreditation network for services that assess, diagnose and treat dementia in the UK.
NFA	No Fixed Abode
NMP	Non-Medical Prescriber
NHS111 Option 2	Urgent Mental Health Helpline
OTM	Operational Team Manager

Practitioner	Umbrella term for any clinically trained workers supporting the delivery of care within MAS.
RTT	Referral to Treatment
SOP	Standard Operating Procedure - detailing the policy and processes to be followed for a particular area of work
Staffroom/Blink	KMPT intranet site requiring a windows login to access
TA/CA	Trusted Assessment or Core Assessment

5 RESPONSIBILITIES

5.1 It is the responsibility of all colleagues involved in the planning and delivery of care under the heading of MAS to ensure that the procedures stated within this document are understood and followed. Furthermore, all staff working within MAS have a responsibility to highlight any emerging risks or issues associated with the procedures within this SOP. Any issues raised will be fully investigated, reviewed and where necessary, updated guidance will be issued.

6 MAS INBOXES

6.1 Referral to the front door of community mental health service for people with an SMI will go through the MHT Generic Inbox – [LOCALITY].MHT@nhs.net. This is managed by the administration Team.

6.2 All MAS teams have a generic inbox for referrals that have been triaged by the CPL from MHT – [LOCALITY]MAS@nhs.net. This is managed by the administration team.

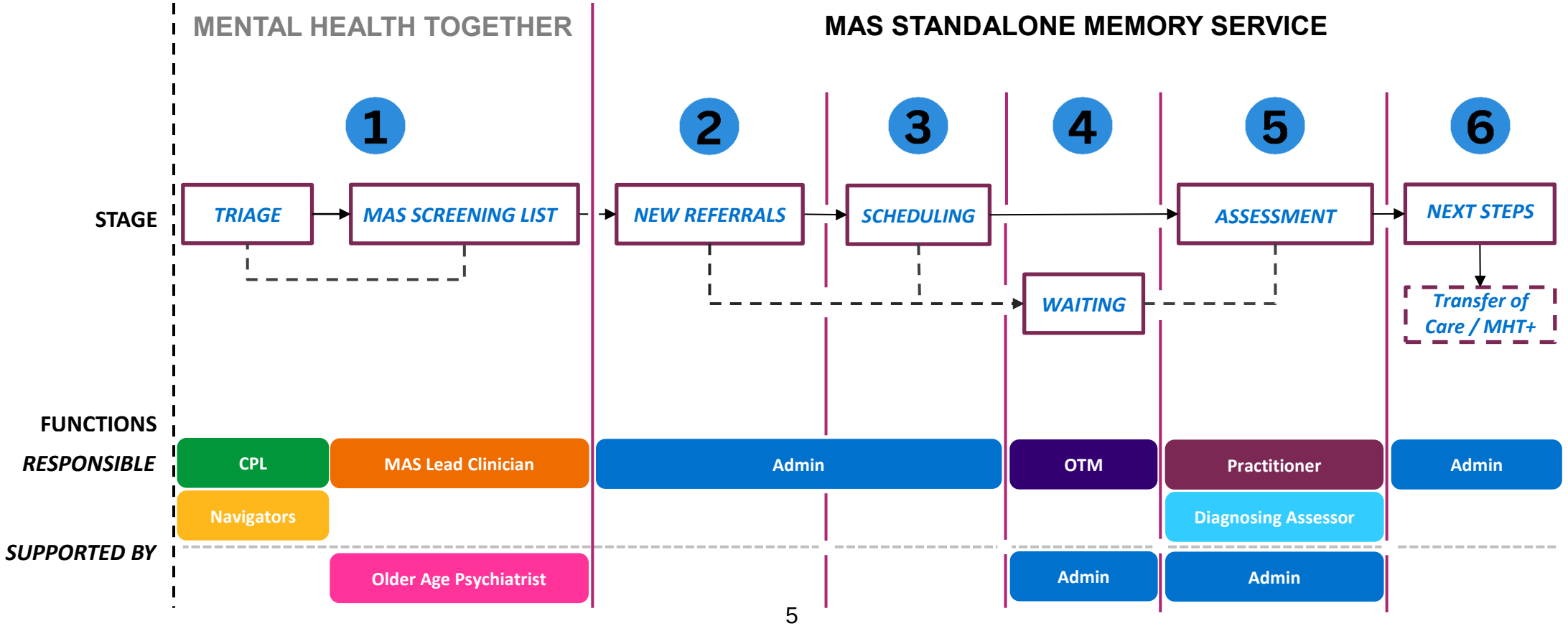
7 MEETING STRUCTURES

Team	Name of Meeting	Description	Frequency
MAS	Complex Case Referrals	Discussion when referrals received which contain complexities between the Lead Clinician and Consultant/Nurse Consultant.	Minimum Weekly
MAS	MDT	Multi-disciplinary forum post-assessment to discuss patient complexities and issues relating to establishing a diagnosis.	Weekly
MAS	Monthly Business Meeting	Monthly governance meeting to discuss quality and performance with admin support.	Monthly
MAS	MAS Leadership Meeting	Forum for MAS clinical and operational leaders to discuss relevant business and functioning of the service. Senior staff with admin coordinators.	Monthly
MAS	Flow Meeting	The Flow Meeting makes clinical decisions on the patient care and where it is best placed to receive treatment within MHT, MHT+ or MAS. The clinicians decide the pathways and intervention allocation. The OTM is responsible for organising the meeting and a patient proforma is submitted ahead of the meeting to aid conversation and decision-making. A nominated clinician will add progress notes to the patients Rio record and email the progress note to the agreed pathway.	Minimum Weekly

		Admin will take notes of the meeting and store on the shared drive. Dependant on local capacity, admin will close referral and open new referral in the meeting or after the meeting takes place. If agreement on the best pathway for the patient cannot be agreed in this meeting, this should be escalated to the consultant psychiatrists for these teams and if this remains unresolved, to the lead consultants and onwards to the head of psychiatry for the directorate.	

8 WORKFLOW OVERVIEW

Key:	
Button	**Function**
	Clicking on the numbered buttons in the Workflow Overview will take the user to more information regarding that stage within the SOP.
	Clicking on this button will return user back to the Workflow Overview.
	Clicking this button will open Staffroom where the relevant Rio 'one-page' guide(s) and associated video(s) are located.
	Clicking on the **Stage** in the Workflow Overview will take the user to more information regarding that stage within the SOP.
	Clicking on the **Responsible/Supported By** in the Workflow Overview will take the user to more information regarding that stage within the SOP.



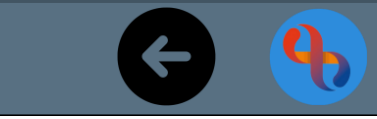
MAS Lead Clinician

Older Age Psychiatrist

- **MAS Lead** checks blood results – if abnormal, discuss with an **Older Age Psychiatrist**; non-availability does not prevent moving to the next stage
- **MAS Lead** reviews client, determining and actioning any gaps/missing information.
  - Refer to "Triage and Scanning Guidance" to determine imaging actions and request as indicated.
- **MAS Lead** to discuss clinical complexities with OA Psychiatrist and decide on what happens next.
- If referral is suitable for MAS, **MAS Lead** opens new referral to MAS Team ensuring this is back dated to match the start date of the MHT referral and closes the MHT referral ensuring a progress note containing next steps for admin is added to the client record.
- If referral is not suitable for MAS, **MAS Lead** reallocates client to MHT Triage caseload ensuring a progress note is added detailing why the referral is not suitable for MAS.

Admin

- **Admin** to check progress note and if Assessment requires booking, move client to Scheduling caseload.
- If assessment is not indicated (pending investigation) move to Waiting caseload and send waiting list letter.



3 SCHEDULING

Admin

- **Admin** to book client appointment(s) in Rio clinics; where possible these should take the format of a combined clinic:
    - **Assessment:** 90 minutes
    - **Handover:** 15 minutes
    - **Diagnosis:** 45 minutes
- **Admin** move the client to the Assessment caseload once appointment(s) are booked.
- If the client cannot be booked for assessment due to lack of room availability, move client to the Waiting caseload and no “Waiting for” intervention is required to be added for this scenario.

4 WAITING

OTM

Admin

- Waiting caseload is used when the next step CAN’T be booked due to the appointment or assessment being unavailable
- **Admin** to open relevant Waiting for interventions.
- **OTM** manages this list with the support of **Admin**.
- Once the appointment type is available, Waiting for interventions to be closed and client moved back to Scheduling caseload for appointment to be booked

5 ASSESSMENT

Practitioner

Diagnosing Assessor

Admin

- Caseload for ALL memory assessment / diagnostic appointments
- It is the **Diagnosing Assessor/Practitioner's** responsibility to ensure that all clinical information is recorded accurately, diagnosis is coded, appointments outcomed within 24 hours and that next steps are clearly detailed for **Admin** in the progress notes.
- In the case of combined clinics, once the appointments are complete, move the client to the Next Steps caseload.
- In the case where a singular assessment has taken place, each client to be looked at on a case-by-case basis for next actions.
- **Admin** to support with caseload management should this be required.

6 NEXT STEPS → Transfer of Care / MHT+

Admin

- **Admin** to check progress notes for Next Steps.
- If indicated, transition client by opening a referral to MHT+ for Post Diagnostic Support (PDS) and close the MAS referral.
- Alternatively, if indicated, transfer care of the client to the GP by closing the MAS referral.

9 INDIVIDUAL ROLES AND RESPONSIBILITIES

9.1 This SOP applies to all staff that are part of the memory assessment and diagnostic service. It applies to all permanent and temporary colleagues across all involved organisations who contribute towards the creation and maintenance of electronic patient records on Rio.

9.2 **Roles:**

9.3 **Clinical Pathway Lead (Mental Health Together)**

- All MAS referrals will be triaged by a CPL and after triage, CPLs will pass only those referrals to MAS who require Assessment and Diagnosis of Dementia and do not have diagnosis.

9.4 **Lead Clinician (MAS)**

- Will screen referrals to ensure suitability for standalone MAS. In line with MHT/+, inappropriate referrals will not be declined but rather referred to the more appropriate service.
- Will also determine whether there is any missing information and request as required.
- Check blood results and discuss with the Psychiatrist any abnormalities found. A discussion will also be had regarding any complexities identified during the triaging stage.

9.5 **Operational Team Manager (MAS)**

- Responsible for managing the 'waiting' caseload. This caseload is primarily used when an appointment or assessment type cannot be booked and will therefore require ongoing monitoring with the assistance of admin.
- The OTM will also assist the Lead Clinician in triaging new referrals as required.
- While the OTM's main focus is the 'waiting' caseload, they will have complete oversight of each stage and will hold overall responsibility for identifying barriers or delays to patient's reaching the point of being diagnosed and will escalate accordingly.

9.6 **GPwER (GPs With Extended Roles) and ACP**

- Assessment and treatment of patients with cognitive impairment for routine patients as triaged by the MAS Lead Clinician.
- Referrals and investigations, if necessary.
- In partnership with the patient develop a care plan including strengths and management of any risks identified.
- Outcome the appointment on RiO, add a progress note and send Letters to GPs after assessments.

9.7 **Consultant Psychiatrist, Speciality Doctor and Higher Speciality Trainee**

- Advising lead clinicians regarding complex referrals.
- Assessment and treatment of patients with cognitive impairment.
- MDT discussions.
- Referrals and investigations, if necessary.
- In partnership with the patient develop a care plan including strengths and management of any risks identified.
- Outcome the appointment on RiO, add a progress note and send Letters to GPs after assessments.
- Discuss in MDT if there is any complexity (for example young onset), risks, safeguarding issues or high scoring in cognitive assessment.

9.8 **Administrators**

- Move referrals through the caseload.
- Take information from progress notes and determine pathway.
- Move through scheduling.
- Book patient appointments and set up text message reminders if consent given.
- Assign to next steps, either transfer care to GP or open to MHT+ pathway.
- Support OTMs in management of waiting list.
- Booking Scanning assessments.
- Booking rooms.
- Answering calls.
- Supporting patients e.g., appointment reminders, sending out patient pack with parking permits and IQ code, demographics and map.
- Asking for patient and carer experience measures.

9.9 Clinician

- Pre-diagnostic discussion and obtaining informed consent.
- Update information sharing/consent on RiO including any LPA or advanced decisions.
- Record any protected characteristics and update client demographics on RiO.
- Add any Allergies to RiO.
- Complete memory assessment and record this on RiO Progress Notes and Uploaded Documents.
- Complete RiO risk assessment if risks identified require a response from the team at the initial assessment.
- Administer ACE III or other appropriate cognitive assessment.
- Ensure IQCODE is completed.
- Obtain completed life story and upload this or gain from the patient and add to RiO Progress Notes.
- Document any physical health findings including BP and pulse.
- Ask the patient/carer to complete PREM/CREM/Feedback.
- In partnership with the patient, develop a care plan including strengths and management of any risks identified.
- Outcome the appointment on RiO within 24 hours of the appointment and add a progress note.
- Discuss in MDT if there is any complexity (for example young onset), risks, safeguarding issues or high scoring in cognitive assessment.
- Caseload transfer to next steps MAS or MHT+ dementia pathway.

9.10 Occupational Therapist

In addition to the above role of 'Clinician', the Occupational Therapist will also:

- Conduct assessments around Activities of Daily Living (ADL).
- OT's are involved in assessing to support a diagnosis of dementia if the presentation is atypical. Utilising OT specialist assessments.
- Social functioning – adaptations that may be helpful, where to link in to get additional support.
- Specific assessments (in addition to ACE III): M-ACE, MMSE.
- Advising and supporting colleagues – discuss signposting in the MDT to other services or assessments.

9.11 Clinical Psychologist

- Advise colleagues on when a neuropsychological assessment is likely to be useful in helping to reach the point of diagnosis or understanding the patient's difficulties.
- Assess informed consent for further assessment including neuropsychological tests.
- Provide psychological and neuropsychological assessment, including the use of neuropsychological tests, write a report containing the assessment results, their interpretation, and whether they help answer the referral questions.
- Give a psychological and neuropsychological formulation of the patients difficulties, recommendations for the patient, and advise whether repeat assessment is recommended.

- feedback the results of their assessment to the patient (and standalone MAS colleagues), answer questions, and suggest care plan/interventions/ recommendations.
- Clinical psychologists can provide a specialist feedback / post diagnostic session in situations of emotional or relational complexity including but not only families with young onset dementia where this is needed before moving to the MHT+ offer.
- Sometimes some of the above work is carried out by Assistant Psychologists or Clinical Associate Psychologists under supervision of the Clinical Psychologist.
- In addition to the direct clinical roles, Clinical Psychologists can provide advice, support and training to standalone MAS staff on administering and interpreting ACE111 (for new staff and team annual refresher), other screening measures for different populations.

9.12 **Dementia Coordinator**

- Dementia coordinators sit outside of KMPT and will support people both pre and post diagnosis. The role will remain and be the point of contact throughout the journey of a person living with dementia - from diagnosis until end of life.

10 COGNITIVE SCREENING

10.1 ACE-III and Mini ACE-III have been identified as the standard cognitive screening tools for MAS assessments. However, there is need to think about the training requirements for these tools (initial and refresher), and also to recognise when the ACE-III might not be appropriate (e.g. when there are barriers such as literacy, people with learning disabilities, sensory difficulties [visual and hearing], speakers of others languages, those educated outside of UK/not acculturated to UK culture), and to identify alternative cognitive screens that might be used within MAS.

Tool	When to use	Training required	Notes
ACE-III	Standard	ACE-III part one (E-learning) and part two training. Details for both are on I-Learn. It is an essential MSNAP standard for MAS staff to have annual refresher training in the use of cognitive assessment tools. Annual refresher training can be arranged in local teams. Part two ACEIII training can also be re-completed as a refresher.	• There are 3 versions: A, B and C. Use version A as standard. Ideally have a minimum interval of 12 months before re-testing (Murphy et al, 2023 – no practice effects were observed on reassessment after 12 months). Consider alternative versions, such as Version B and Version C, to minimise practice effects if testing <12 months. • Other language versions available (for use with interpreters)

			https://www.sydney.edu.au/brain-mind/resources-for-clinicians/dementia-test.html • If using a translated version of the ACEIII, it is important to interpret cautiously, due to a range of factors that can impact upon validity and reliability.
Mini ACE-III (MACE)	If difficulties completing lengthy ACE	As per ACE-III training, plus familiarity with altered scoring and interpretation of score.	 mini-ace.pdf
MoCA Blind	If visual difficulties are present/barrier to using the standard ACE-III	Training online (need KMPT's organisational code to access the training for free). Training takes around one-hour to complete. Here are the instructions to share with each of your full-time employees along with your access code: KMPT-UK2024#3800-1232 •Please visit mocacognition.com and click on "SIGN-IN/REGISTER" on our home page. You will need to create an individual account first using your work email ending with @kmpt.nhs.uk or @nhs.net •Activate your account. •Go to the "Training & Certification" page. •Click on the "Get Certified" button. •Enter your code and click on SUBMIT. Please use Google Chrome or Firefox or Edge to access the website.	
ACE-III Hearing-impaired version  HI ACE Adaptation VC Final PowerPoint.p	If auditory difficulties are present/barrier to using the standard ACE-III	As per ACE-III training, plus ensuring familiarity with the altered administration	• Use the standard ACE-III scoring and norms and interpret cautiously, as the norms are based upon standard administration, not this hearing-impaired version.
RUDAS	If there are cultural or	Should be administered by relevant health care workers after approximately 40 minutes	• Intended to be less biased by cultural factors than

 RUDAS_scale (1).pdf	educational barriers to using the standard ACE-III	of training using videotape (https://www.swslhd.health.nsw.gov.au/acrs/RUDASvideo.html)	traditional cognitive screens. • Easy to interpret into other languages • Assesses multiple cognitive domains including memory, praxis, language, judgement, drawing and body orientation. • Not affected by years of education or preferred language. • At a cut-point of 23, sensitivity and specificity were 89% and 98%, respectively. Inter-rater (0.99) and test-retest (0.98) reliabilities were very high. • Population specific norms might not be available and utility in detecting change over time has not yet been evidenced. • This tool is likely to be most helpful when seen as a baseline to then re-test at a later date, rather than utilising a cut-off.
DSQIID *(especially if this has already been completed in the past for the patient, so a baseline to current presentation comparison can be made)*	People with Learning Difficulties	No formal training. Need to ensure familiarity with the tool, seek opportunity to shadow others, discuss in supervision.	• Administration has been agreed with MHLD colleagues. • Cut-off score for the DSQIID of 20 is based on norms for DS LD population. • This tool is likely to be most helpful when seen as a baseline to then re-complete at a later date, rather than utilising a cut-off. • In keeping with the above point,

Or **NTG-EDSD** *(updated version of DSQIID)*			the updated NTG-EDSD no longer provides a cut-off score. DSQIID.pdf NTG-EDSD-Electronic Form-9'1'16-pdf (1).p
DiADeM	Diagnosing advanced dementia. Often in care home settings.	No formal training. Need to ensure familiarity with the tool, seek opportunity to shadow others, discuss in supervision.	Diagnosing-mental-health-in-care-hom

11 RISK SCREENING

11.1 There are three identified patient cohorts from a risk perspective. The steps for each cohort are detailed in the table below:

Cohort	Descriptor	Action	Responsibility
1	Referral identifies risk	Immediate risk assessment to be completed with the patient	**CPL or MH Clinicians support CPLs**
2	Referral omits risk but is ambiguous	May undertake risk assessment during triage prior to assessment	**CPL or MH Clinicians support CPLs**
3	No risk identified in referral	Move to screening	**CPL or MH Clinicians support CPLs**

11.2 Patients whose presentation and / or concerns regarding escalating risk that require prioritisation, should be discussed with the CPL, OTM or Lead Clinician. Clinical judgment should inform next steps, which may include joint working with MHT + to manage identified risks that cannot be contained within MAS such as onward referral to dementia crisis services where they exist.

11.3 Please refer to the KMPT Service User's Clinical RA Formulation and Management Policy for more information.

12 PATIENTS WHO DO NOT ATTEND (DNA)

12.1 The Do Not Attend (DNA) process for a MAS requires balancing practical logistics with a compassionate approach, particularly since people with potential memory difficulties might miss appointments for a variety of reasons beyond their control.

12.2 The goal should be to reduce the potential for further distress while also improving engagement and attendance. The expectation is that a person will attend and every effort is made to support the person to attend MAS. It is expected that people referred to the MAS are able to engage and choose an appointment appropriate to them.

12.3 Every effort will be made by administrative colleagues to contact an individual to schedule their initial memory assessment. In the event of non-contact, a total of three attempts should be made across a 5 working day period to reach the person referred by telephone, reviewing the contact information with the referrer as necessary.

12.4 The persons dementia coordinator, if they have one, should also be contacted by telephone during that time, to supporting scheduling the assessment.

12.5 If no contact is made, please refer to the Trust DNA Policy, (Appendix L on DNA policy).

13 CARE PLANNING

13.1 Every patient will have a written care plan letter provided after the diagnostic appointment, reflecting their individual needs. If a two-stage appointment is offered, a 2*nd* stage appointment letter is sent after the initial assessment. Staff members collaborate with patients and their carers (with patient consent) when developing the care plan, and they are offered a copy.

13.2 A formal risk assessment would be carried out if risks are identified such as concerns regarding safeguarding and driving and a care plan put in place to manage the risks.

13.3 A template letter can be found on Rio and can also be found on Staffroom.

14 OUTCOME MEASURES

Action/Function	Supporting Documents	Responsibility	Timeframe
Diagnosis in 6 weeks	National Audit of Dementia  nad-mas-2023-national-report-05082024	Service	Ongoing

15 SUPPORTING INFORMATION

15.1 The table below provides details of the supporting documents that should be read in conjunction with this Standard Operating Procedure. These documents are stored on the KMPT Staff Room Site. Access is via log in. Partner organisations will be able to access these documents via access to a shared drive or when sent as an email with attachments.

15.2 Please note, the list of documents below is not an exhaustive list and may be subject to change.

No.	Document Title
1	My Choice: The Information You Need to Help You Live Well With Dementia
2	Brief Read Cognitive Impairment Help
3	DNA Policy
4	Risk Assessment Policy
5	Care Planning Policy
6	Memory Service National Accreditation Programme Information