Kent and Medway
NHS and Social Care Partnership Trust

Memory Assessment & Diagnosis Service Operational Policy

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DOCUMENT TRACKING SHEET

MAS Ops Policy

Version	Status	Date	Issued to/approved by	Comments
0.8	Draft	28/03/25		

REFERENCES

MSNAP
NICE Guidelines
Dementia Care Pathway

RELATED POLICIES/PROCEDURES/protocols/forms/leaflets

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.

DNA Policy	Lone working policy
Risk Assessment	statutory and mandatory training policy
Care Plan	Concerns and Complaints Policy
Safeguarding Policy	Patient Safety Incidents Response Framework (PSIRF) Policy
Mental Capacity Act Policy	

SUMMARY OF CHANGES

Date	Author	Page	Changes (brief summary)

CONTENTS

1 INTRODUCTION

1.1 The Dementia Care Pathway: full implementation guidance, shaped by the NHS Mandate requires that we increase the number of people being diagnosed with dementia and starting treatment within 6 weeks from referral. As part of Kent & Medway Partnership Trusts (KMPT) 2023- 2026 strategy the Trust is committed to delivering a Memory Assessment & Diagnosis Service (MAS) which, for 95% of people referred, assesses and diagnoses within 6 weeks from referral.

1.2 There are long waits for dementia diagnosis across Kent and Medway with an increase in demand for services and over reliance, within the Trust, on a limited number of professions who offer memory assessment & diagnosis.

1.3 KMPT plays a key role in driving a system wide response to support the assessment and treatment memory needs of the local communities. It is recognised that the system wide response is a developing picture as is the KMPTs assessment & diagnosis model and, as a result, this policy will be reviewed at regular intervals.

2 SERVICE DESCRIPTION

2.1 The service provides assessment and diagnosis (and/or sub-typing of dementia), for adults experiencing memory problems, irrespective of age. The service will offer an assessment for a patient that has cognitive impairment, where the suspected cause is dementia.

2.2 Initial treatment and advice will take place within the standalone MAS.

2.3 The Dementia Pathway within Mental Health Together + will provide further clinical interventions for those who have both a newly diagnosed dementia and those who present to the service who already have a dementia diagnosis but need advice or crisis management.

3 SCOPE

The Memory Assessment Service (MAS) takes all GP referrals for a memory assessment 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.

4 OUTSIDE OF SCOPE

Referrals should not be passed to MAS:

- 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 referring into the service. 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).

5 WHO DOES THIS POLICY APPLY TO?

5.1 This policy directly applies to staff working within the standalone MAS.

5.2 It also provides a clear reference guide for Trust teams which are working alongside standalone MAS colleagues, and whose patients might require memory assessment and/or diagnosis.

5.3 The policy also applies to patients and carers who might access the standalone MAS and support with shaping standalone MAS in developing future co-production of services

5.4 The policy applies to General Practitioners with Extended Roles (GPwERs) who will support the standalone MAS

6 PURPOSE OF THE DOCUMENT

6.1 The purpose of this document is to provide guiding principles for the delivery of the Memory Assessment Service (MAS). The Operating Policy includes best practice guidance, risk management, statutory requirements, legislation and national/local guidance. It is not a standalone policy and should be read in conjunction with all partner organisation policies and the MAS Standard Operating Procedure (MAS SOP).

7 TRIAGE

7.1 Where referrals are made through a single point of access, these are passed on to the MAS within one working day.

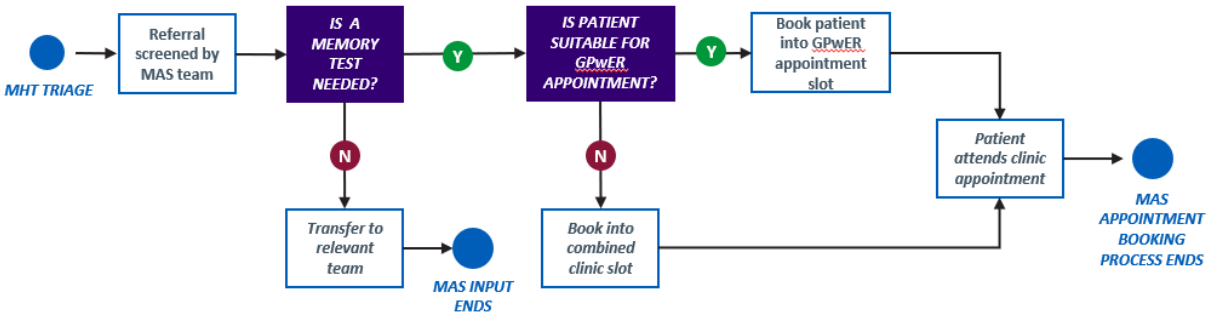
7.2 Initial contact is made with all people who are newly referred within two weeks

7.3 All new referrals will come through to Mental Health Together (MHT) where they will be screened by the MHT Clinical Pathway Lead (CPL). The referral is passed to MAS for the MAS Clinical Lead to triage.

7.4 If the referral is inappropriate for the service, it will be signposted to the more appropriate service, it will not be declined.

7.5 For scanning, not all patients will require additional scanning. The OTM should discuss the need with the appropriate diagnoser. Guidance on when a scan is or is not required can be found in the Triage Guidance document (see Appendix A).

Figure 1



8 ASSESSMENT AND DIAGNOSIS

The following will occur once the individual referred has entered the standalone MAS and a combined clinic appointment becomes available. The option of a home visit is available based on clinical need.

See also figure 2 overleaf;

8.1 Timings for the combined clinic are as follows, 90 minutes for initial assessment, 15 minutes handover between assessor and diagnoser, 45 minutes diagnostic appointment.

8.2 The individual referred is offered and attends a combined clinic consisting of a suitably qualified practitioner and diagnosing clinician, in which they are assessed against the standard memory assessment proforma. See appendix A.

8.3 It is recognised that not all people referred will be suitable to attend a combined clinic. These individuals may also require adaptation to the standard proforma. Please refer to the SOP for further detail. Adaptations will need to be arranged before the individual attends an appointment.

8.4 Following the assessment and appointment with a clinician within the service who can diagnose the question of 'can a diagnosis of Dementia be made?' will be determined.

8.4.1 If NO – Further investigations and specialist referrals may be required; i.e. for neuro-psychological assessments, occupational therapy specialist assessment within the standalone MAS services to aid in the Dementia diagnosis. Once completed either a diagnosis of dementia is made and for further follow up moved to MHT+. If the diagnosis of MCI or no diagnosis of dementia is made, the person should be moved back to the care of their GP with suitable advice and signposting.

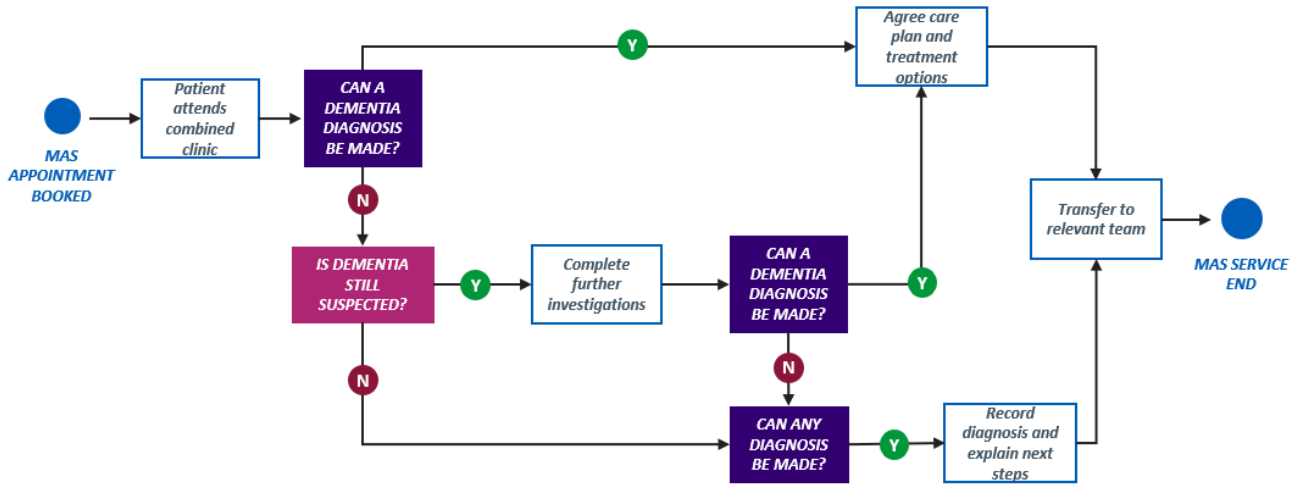
8.4.2 The standalone MAS service will have a short weekly standalone MAS MDT meeting where further investigations can be discussed, as well as complex triage discussions where additional views and discussions are indicated.

8.4.3 If referral is made external to the MAS e.g. Neurologist, Neuropsychiatry is required for further assessment the person should be discharged from standalone MAS service to be followed up by respective teams

8.4.4 If YES – initial support, advice and treatment. For ongoing care planning and treatment, the individual is moved into the Dementia Pathway in MHT+ for post-diagnostic support.

8.4.5 Support for carers can be accessed through the Admiral Nurse service and local carer organisations. Referrals can be made through MAS or MHT+ to these resources.

Figure 2



9 CARE PLAN

9.1 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 2nd 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.

10 PHYSICAL HEALTH MONITORING

10.1 A physical health review is part of the initial assessment

10.2 Any physical health issues that are picked up are referred to their GP

11 RISK ASSESSMENTS

11.1 Risk screening is part of the initial assessment as part of the Proforma (See Appendix B).

11.2 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

11.3 Joint working with MHT + will be required to manage identified risks, that cannot be contained within MAS.

12 SAFEGUARDING

12.1 Safeguarding Adults at Risk

12.1.1 An adult at risk also referred to as a vulnerable adult is defined under the Care Act 2014, as someone aged18 years old or older who: has care and support needs, whether or not the local authority is meeting those needs. Is experiencing, or is at risk of, abuse or neglect including self-neglect. And as a result of their care and support needs is unable to protect themselves against the abuse or neglect or the risk of it.

12.1.2 The lead agency for safeguarding adults at risk or exposed to abuse under Section 42 of the Care Act is the residing local authority, i.e. Kent or Medway.

12.1.3 Where a safeguarding adult concern is identified, however the threshold or consent to refer to the local authority is not met, the safeguarding policy must be utilised. Actions may include referral to the local authority safeguarding team in a person's best interests due to level of risk, or utilisation of the multi-agency policies and protocols.

12.1.4 It is important to note, that the patient may pose the risk to others, therefore a referral to the local authority or other police, MARAC may be needed

12.2 Safeguarding Children and Young People

12.2.1 The welfare of children is paramount, all agencies have a legal duty to safeguarding children and young people. If a patient has a child/ren, access to children, or cares for children, the risk around the presenting mental ill health and behaviour must be considered.

12.2.2 Children are not to be considered as protective factors however exposed to potential or actual risk. Therefore, a child safeguarding referral or early help referral may be required and it must be clearly documented who is taking this responsibility. Please see the safeguarding children and young people policy.

12.2.3 Child Protection Conferences. A statutory and contractual requirement is engagement with Child Protection Conferences; whether this is via a report (when a referral is received, and or no future intervention or contact is needed); or attendance when the patient is open to the service. This is not negotiable.

12.2.4 A named MAS Professional must be identified to ensure this duty is met. The Service Lead and Head of Nursing & Quality for the area must be contacted if there is any challenge to delivering this expectation, with a view for the senior manager to allocate out. Non-engagement is not permitted.

12.3 Mental Capacity Act 2005. The Mental Capacity Act (MCA) 2005 applies to everyone involved in the care, treatment and support of people aged 16 and over living in England and Wales.

12.4 The MCA is designed to protect and restore power to those vulnerable people who lack capacity. The MCA also supports those who have capacity and choose to plan for their future – this is everyone in the general population who is over the age of 18.

12.5 All professionals have a duty to comply with the MCA Code of Practice.

12.6 The primary purpose of the MCA is to promote and safeguard decision-making within a legal framework. It does this in two ways:

- By empowering people to make decisions for themselves wherever possible, and by protecting people who lack capacity by providing a flexible framework that places individuals at the heart of the decision-making process
- By allowing people to plan ahead for a time in the future when they might lack the capacity.

12.7 Deprivation of Liberty Safeguards ensures people who cannot consent to their care arrangements in a care home or hospital are protected if those arrangements deprive them of their liberty. Arrangements are assessed to check they are necessary and, in the person's, best interests.

12.8 A safeguarding referral must be made should there be concern that a person's liberty is restricted without the necessary legal frame work in place.

12.9 The Mental Health Act Code of Practice provides detailed guidance on the Mental Health Act and consent to treatment.

12.10 Please refer to the Mental Capacity Act Policy

12.11 Carers' Assessments. The Care Act 2014 states that where an individual provides or intends to provide care for another adult and it appears that the carer may have any level of needs for support, local authorities must carry out a carer's assessment. The

duty for MHT and MHT+ is to support to identify and refer or sign post carers to the local authority for a care needs assessment.

12.12 What happens when a concern for adult and/or child safeguarding has been indicated? All staff within MAS are responsible for completing the electronic safeguarding alert as appropriate.

12.13 Partner agencies will follow their own organisations safeguarding concern policies and add a note onto the patient's care record, with the expectation that documentation clearly identifies who is responsible for follow up or escalation.

12.14 Patients in MAS should have their safeguarding alert recorded on In-Phase.

12.15 MAS will follow the Patient Safety Incidents Response Framework (PSIRF) Policy

13 DNA POLICY

13.1 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.

13.2 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.

13.3 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.

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

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

14 STAFF OR FAMILY OF STAFF WHO NEED CARE

14.1 In order to maintain service user's confidentiality and dignity, staff or close family of staff members (who become service users of MAS), will have services provided for them based on their individual preference on a case by case basis.

15 REMOTE, HOME AND LONE WORKING

Remote Working:

15.1 The need to deliver services locally will continue to be an essential part of community services.

15.2 In order to enable this to happen across wide locality areas, remote systems will be available for practitioners to access KMPT applications and RIO information and enable the clinicians to access data securely from remote locations. Mobile devices and confidential information, whether manual or electronic, must be protected by adequate security, for example, they must be:

- Kept out of sight, for example, in the locked boot of the car, when transported
- Not left unattended, for example, not left in the car boot overnight
- Locked away when not being used
- Kept secure and guarded from theft, unauthorised access and adverse environmental events particularly when taken home.
- Encrypted

15.3 The Trust is committed to providing an appropriate working environment to facilitate its staff whether they are at their main base, one of the other Trust sites or working from any other remote site. Trust agreed bases will be available for remote working. Within these premises there must be access to appropriate workspace that is fit for purpose and meets Health and Safety requirement. Health and Safety Assessments must be completed for all remote bases and filed within the locality Health and Safety folder.

15.4 There is a need for all community workers to feel supported in their day to day work and ensure that team functioning is not jeopardised by remote working. Team Managers must ensure that team meetings are regularly scheduled and that there is a commitment for all members of the multi-disciplinary team to attend. In addition to

this, regular supervision (both peer and individual) and arrangements for ad-hoc telephone support must be put in place.

Home working:

15.5 Periodic home working is allowed at the discretion of the team/locality manager. It is not anticipated that there will be a regular commitment to home working although occasionally, taking into account individual circumstances or the nature of the work to be undertaken, home working can be considered.

15.6 In determining whether or not periodic home working is appropriate, the Line Manager must ensure that appropriate cover is available within the team and that the appropriate resources and equipment are available to support working from home.

15.7 The Hybrid Working Policy will be adhered to.

Lone Working:

15.8 The Trust recognises that staff may have to work alone in the delivery of clinical and non-clinical services. As with any potential risk to Health and Safety and welfare of staff, the risks associated with lone working need to be identified, assessed and managed. Local protocols must be in place and form part of all local induction for all new staff. Lone working policy must be followed at all times; it is the employee's responsibility to ensure they have read, understood and work to the policy.

Staff supervision:

15.9 Supervision is an important part of managing, motivating, supporting and training staff. Supervision will be carried out in line with their organisation Supervision policy.

- All staff in MAS should expect to receive managerial supervision in line with your organisation policy.
- Clinical supervision is a separate requirement for the Practitioners which should supplement managerial supervision.

16 RECORD KEEPING

16.1 A service user's record is a basic clinical tool used to give a clear and accurate picture of their care and treatment, and competent use is essential in ensuring that an

individual's assessed needs are met comprehensively and in good time (as specified by relevant professional bodies). All NHS Trusts are required to keep full, accurate and secure records (Data Protection Act 1998) demonstrate public value for money (Auditors Local Evaluation) and manage risks (NHS Litigation Authority, Information Governance Toolkit, Essential Standards). Compliance with this Policy and these legal and best practice requirements will be evidenced through information input into the electronic record, RiO. For full details of the specific information needed to ensure compliance with this policy see the RiO training guides and the Directorate's Standard Operating Procedures.

17 IMPLEMENTATION INCLUDING TRAINING AND AWARENESS

17.1 Training will be sourced and delivered both via KMPT Organisation Development department, in accordance with professional role and duties required within standalone MAS and within Trusts statutory and mandatory training policy, and through bespoke training session facilitated by professionals within the standalone MAS.

17.2 Examples of bespoke training might include; annual ACE111 training for all staff using the tool, ACE111 training for new staff, pre-diagnostic counselling and training on adapted assessments. Each standalone MAS service will consider training needs as part of business as usual team forums and individual appraisals, dependent on individual staff member and service needs.

17.3 An example of service needs include all clinical staff working in the standalone MAS to meet the competencies of the Tier 2 HEE dementia core skills framework, to meet MSNAP requirements

17.4 External or specialised training, as appropriate to those working in the standalone MAS, will be managed in accordance with individuals training needs as defined within their annual appraisal or job description and should be applied for via external training policy routes.

18 STAKEHOLDER, CARER AND USER INVOLVEMENT

18.1 Stakeholders, individuals and groups that could be affected (positively or negatively) by this policy.

18.2 Could include: Key individuals, Groups, Disciplines, and associated groups

18.3 Carers/Service users

18.4 Children of service users or Children visiting the Trust

18.5 Young men or young women

18.6 People with physical impairments

18.7 Older people's groups (Dementia/Alzheimer sufferers)

18.8 People with learning difficulties

18.9 Deaf groups/People with hearing impairments

18.10 People with visual impairments

18.11 People with hidden impairments (e.g. cancer, HIV, diabetes etc.)

19 EQUALITY IMPACT ASSESSMENT SUMMARY

19.1 The Equality Act 2010 places a statutory duty on public bodies to have due regard in the exercise of their functions. The duty also requires public bodies to consider how the decisions they make, and the services they deliver, affect people who share equality protected characteristics and those who do not. In KMPT the culture of Equality Impact Assessment will be pursued in order to provide assurance that the Trust has carefully considered any potential negative outcomes that can occur before implementation. The Trust will monitor the implementation of the various functions/policies and refresh them in a timely manner in order to incorporate any positive changes.

Please note: A separate Equality Impact Assessment Screening Form must be completed for this document. It can be downloaded from this link.

20 HUMAN RIGHTS

20.1 The Human Rights Act 1998 sets out fundamental provisions with respect to the protection of individual human rights. These include maintaining dignity, ensuring confidentiality and protecting individuals from abuse of various kinds. Employees and volunteers of the Trust must ensure that the trust does not breach the human rights of any individual the trust comes into contact with.

21 MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THIS DOCUMENT

21.1 Review of this document will initially be 3 monthly, monitored through the MAS oversight group

22 COMPLAINTS, COMPLIMENTS AND FEEDBACK

22.1 Staff should follow their organisation Policy and Procedures for listening and Responding to Concerns and Complaints, and Compliments.

22.2 Any staff member, who should attempt to resolve the complaint wherever possible. The complainant should be informed of the complaints process and a complaint leaflet provided.

22.3 Staff who feel unable to respond appropriately to a complaint should forward it to their line manager and the PALS and Complaints team within their organisation, who will ensure that it is recorded and manage in accordance with process.

22.4 Agreement will be reached between agencies as to the lead agency and correspondence will be shared as appropriate.

22.5 The Service will seek feedback through using variety of tools including the Trust's Friends and Family Test / Patient Reported Experience Measure /Carer Reported Experience Measure

23 PERFORMANCE MEASURE

23.1 The Service will be measured against the national 6 week to diagnosis target.

24 CLUSTERING

24.1 Health of the Nation Outcome Score and Clustering are not required in the MAS.

APPENDIX A: TRIAGE GUIDANCE (including scanning guidance)

Triage Guidance.pdf

APPENDIX B Memory Assessment Proforma

Memory Assessment Proforma.pdf