City and Hackney Dementia Care Pathway v6.1 - March 2020

**Mild Cognitive Impairment (MCI)**
- NOT dementia
- Advice and support by a Nurse/Psychologist.
- Discharge and recall to MCI Clinic 6-12 months.
- Psychologist/Nurse led clinics

**Pre-diagnostic Support**
- Dementia Navigators – information/advice, community engagement. Support GP with vulnerable/challenging/advanced/socially isolated patients in the process of getting diagnosis

**Not MCI or Dementia**
- Discharge to GP and or make appropriate referral

**Occupational Therapist**
- Functional Assessments

**Psychologists**
- Neuro assessments for complex cases, Cognitive Stimulation Therapy (CST) and MCI groups; high intensity post-diagnostic Psychotherapy; Carers intervention etc

**Post Diagnostic referrals and support**
- Weekly Team Meeting (Nurses/Dementia Navigators/Team Managers/Psychologist)
- New referrals allocation, case discussion, step up/step down cases

**Dementia Nurses**
- One DemNav per 2 Neighbourhoods. Hold a caseload; Review medication efficacy; run MCI clinics, CST/MCI groups; monitor deterioration-risk tool; Advance Care Planning; Lasting Power of Attorney; Palliative Care Approach, discharge follow up and review; carers support pathway

**Community Mental Health Team (CMHT)**
- Care coordinate patients with very complex multiple needs and Behavioural & Psychological Symptoms of Dementia (BPSD). Step down

**Out of Hours (OOH)/Primary Care Referrals**
- ParaDoc/ IIT/GP OOH; GPs/Community Teams
- HUH Admitting Medical Team; HUH Psychological Medicine; Integrated Independent Team (IIT)
- All referrals via SPE. Referrer to advise need for follow up. Named Nurse or Dementia Navigator to review patient within 3 working days

**Single Point of Entry Referrals (SPE) Clinician Screening (triage)**
- Assessment & Diagnosis (within 6 weeks of referral) Consultant led assessment

**Not MCI or Dementia**
- Discharge to GP and or make appropriate referral

**Specialist clinics e.g Parkinson’s Clinic**

**GP**
- FBC, B12, folate, calcium, U&Es, LFT’s, TFT’s, glucose, GPCOG test.
- Consider referring to Dementia Navigator if patient declining referral to Dementia Service or socially isolated/vulnerable

**Homerton University Hospital (HUH)**
- Specialist clinics e.g Parkinson’s Clinic

**Single Point of Entry Referrals (SPE)**
- Clinician Screening (triage)

**Dementia**
- Weekly Multi-Disciplinary Team (MDT)

**Post Diagnostic referrals and support**
- Weekly Team Meeting (Nurses/Dementia Navigators/Team Managers/Psychologist)
- New referrals allocation, case discussion, step up/step down cases

**Dementia Navigators (DemNav)**
- One DemNav per 2 Neighbourhoods. Hold patients for life; Actively signpost; monitor risks-risk tool; information and education; support engagement with services/activities, discharge follow up and review, carers support pathway

**Neighbourhood Multi-Disciplinary Team (MDT) meeting**

**Neighbourhood Multi-Disciplinary Team (MDT)**

**Palliative Care Approach and Advanced Care Planning**
- Referral of all non-CPA (Care Program Approach) patients to ASC for social care and social care reviews

**Escalate to MDT cases of concern**
- Step Up if patient deteriorating/declining
- Step Down if patient stable

**Primary Care: Maintenance of primary care Dementia Register, 12 month Primary care physical and mental health review of people on the register**

**Palliative Care Approach and Advanced Care Planning**
- Referral of all non-CPA (Care Program Approach) patients to ASC for social care and social care reviews

**Adult Social Care (ASC) Integration**
- Four Senior Practitioners; one each per 2 Neighbourhoods. Liaison with linked Dementia Nurse/DemNav within the same Neighbourhoods
- Apart from CMHT patients, all non-CPA patients will have social care provided by ASC including social care reviews for discharged CMHT patients
### DEMENTIA CARE REFERRAL PATHWAY

### 1. Pre-Diagnostic Referral and Support to GPs

#### 1.1 GP Referrals to Dementia Navigators
- Each GP practice has a named Dementia Navigator ([see appendix 1](#) for details) to work with and refer patients directly to for support and engagement
- Use the Dementia Navigators Support Referral form ([see appendix 2](#))
- GPs to refer patients for whom there is a concern of memory problems but who
  - are challenging and not engaging with the GP
  - have declined referral to the Dementia Service (formerly Diagnostic Memory Clinic) or have reservations
- Dementia Navigators to work with the patients and their carers/relatives where possible to fact find
  - listen to patients/carers/relatives’ concerns to understand the main issues/challenges necessitating non-engagement
  - explain the process of screening/diagnosis and answer any questions where possible
  - give advice and information about dementia
  - jointly work up an intervention plan
  - if patient declines to engage, leave contact details and let them and their carers/families know the support is always available whenever they are ready to make contact.
  - if findings are more system related and beyond the remit of dementia navigator to intervene, refer findings to the Dementia Alliance
- Dementia Navigators to feedback outcome to the GP

### 2. Single Point of Entry (SPE) Referral to the Dementia Service

#### 2.1 New Referrals for suspected Dementia
- Referrals accepted from:
  - GPs or community matrons (GP completes dementia blood screening and GPCOG Test)
  - Homerton University Hospital (e.g. patient has been inpatient or has been seen in a specialist clinic)
  - Other specialist clinics e.g Parkinson Clinic
- Referral to include:
  - Medical history and medication
  - Description of symptoms/functional impairment
  - Whether an interpreter is needed,
  - Details of a carer or Next of Kin if there is one,
  - copy of results of blood tests
- GPs can now refer via e-referral.
- All referrals received triaged by Duty
- GPs can email Consultant ([emma.teper@nhs.net](mailto:emma.teper@nhs.net)) for advice to discuss, especially for <65 patients where, unsure if memory assessment indicated

#### 2.2 Referrals of Patients with a diagnosis of dementia
- Referral can be from any service or professional
- Referrals from ParaDoc, IIT, GP OOH, HUH Admitting Medical Team, Homerton Psychological Medicine,
- When referring, please advise if follow up is required. If urgent or where follow up is required, patient's named care professional (nurse or Dementia Navigator) will make contact and arrange F2F with patient within 3 working days of receiving the referral

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**SPE contacts:**
- Email: elt-tr.mhcop.duty@nhs.net
- Telephone: 0203 222 8500
### 3. Assessment and Diagnosis

**CH Dementia Service Diagnostic Team**
- Consultant led assessments
- Assessment and diagnosis within 6 weeks of referrals
- Doctors complete initial assessments and MCI feedback if dementia is suspected
- MDT
  - initial assessments and MCI
  - more complex cases and refer for neuropsychological assessment
  - cases of concern etc.

### 4. Post Diagnostic Referral and support

**CH Dementia Service Review Team**
- Nurse led working alongside Dementia Navigators
- Weekly team meeting chaired by Team Leader
- Allocation of new referrals by neighbourhood
- Case discussions including step up /step down cases
- Post diagnostic follow up by nurses and dementia navigators
  - Telephone contact within 2 weeks of referrals
  - Face to face contact within 6 weeks
  - Risk stratification tool
  - Nurses to initiate conversion on ACP and LPA
  - Nurses -MCI recalls-run MCI Clinics
- Each patient has a named Dementia Nurse or Dementia Navigator depending on complexity
- The named nurse and dementia navigator are also the named practitioners for each of the GP practices within the neighbourhood
- Attend respective Neighbourhoods MDT
- The nurse is the lead practitioner for the neighbourhood
- Nurses hold patients starting on medication and who are complex for a minimum of 3 months and when stable step down to dementia navigators or step up to CMCHT if becoming high risk and meet the criteria
- Dementia navigators hold patients for life and review the majority of patients - stable and non-complex. Step up to neighbourhood nurse if patient is declining

### 5. Specialist Support

**Consultant Psychiatrist**
- Assessment & Diagnosis
- Initial Prescribing
- Clinical Lead and advice to GPs
- Medical input into team

**Psychologist**
- Cognitive Stimulation Therapy
- Memory and Wellbeing Group (for MCI)
- MCI recall-run MCI clinic
- Neuropsychological assessment
- Carers intervention
- Training, education and consultation to the team

**Occupational Therapist**
- Functional assessments to support diagnosis
- Assessment & Support for dementia-related challenges in activities of daily living
6. **LBH Adult Social Care Contacts Details**
Information and Assessment Duty (the Front Door): 0208 356 6262
access@hackney.gov.uk
Long Term Team (Community case management team): 0208 356 2227 duty@hackney.gov.uk
Safeguarding Direct Line 0208 356 6262
adultprotection@hackney.gov.uk
Occupational Therapy Duty 0208 356 5533 / ot@hackney.gov.uk
CHAMRAS - Mental Health Team 0203 222 8000
MHCOP - Mental Health Older people: 0203 222 8500
Adults Social Work Out of Hours 0208 356 2300

Nurse/dementia navigator close working with linked senior practitioner within their respective neighbourhoods
- Refer to ASC all patients for social care including social care reviews of stepped down CMHT patients
- For urgent cases call to discuss first with Duty
- For carers where there is a breakdown refer to ASC for carers assessment. All other cases follow referral pathway to Carers First (Tel: 0300 303 1555 and email: info@carersfirst.org.uk)

7. **Appendix 1: CH Dementia Service- Linked Neighbourhoods Practitioners**

<table>
<thead>
<tr>
<th>Neighbourhood</th>
<th>Neighbourhoods Dementia Nurse (Lead Practitioner)</th>
<th>Neighbourhoods Dementia Navigator</th>
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<tbody>
<tr>
<td>Springfield Park</td>
<td>Diana Okoukoni [<a href="mailto:Diana.Okoukoni@nhs.net">Diana.Okoukoni@nhs.net</a>]</td>
<td>Siobhan Cronin [<a href="mailto:Siobhan.Cronin1@nhs.net">Siobhan.Cronin1@nhs.net</a>]</td>
</tr>
<tr>
<td>Hackney Downs</td>
<td>Vaccum; Interim cover: Mahmood Dilloo [<a href="mailto:Mahmood.Dilloo@nhs.net">Mahmood.Dilloo@nhs.net</a>]</td>
<td>Abigail Igokwe [<a href="mailto:Abigail.Igokwe1@nhs.net">Abigail.Igokwe1@nhs.net</a>]</td>
</tr>
<tr>
<td>Woodberry Wetlands</td>
<td></td>
<td>Cilla Weekes [<a href="mailto:Cilla.Weekes1@nhs.net">Cilla.Weekes1@nhs.net</a>]</td>
</tr>
<tr>
<td>Clissold Park</td>
<td>Jenny-Louise Petchey [<a href="mailto:Jenny-Louise.Petchey@nhs.net">Jenny-Louise.Petchey@nhs.net</a>]</td>
<td>Claire Wheeler [<a href="mailto:Claire.wheeler@nhs.net">Claire.wheeler@nhs.net</a>]</td>
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<tr>
<td>Hackney Marshes</td>
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<td>Wells Commons</td>
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<td>London Fields</td>
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<td>Shoreditch Park and City</td>
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Note: the 8 Neighbourhoods have been paired. Each pair has a link Dementia Nurse (Lead Practitioner) and Dementia Navigator (s) who are the named care professionals for patients and GP practices within the neighbourhoods.

**Telephone contacts**
1. Nurses (For Dementia related clinical issues and support): 020 3222 8500
2. Dementia Navigators (for Community Support, advice, and information): 020 8533 0091
3. Dementia Service Team Leader and Specialist Nurse: Mahmood Dilloo (Mahmood.Dilloo@nhs.net)
8. Appendix 2: Alzheimer’s Society Dementia Navigators Support Referral Form

New Dementia Navigators Support