DRAFT

South East Memory Assessment Services (MAS) Restore & Recovery

23rd July 2020 - Version 1.0

NHS England and NHS Improvement

Housekeeping

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Aim of Webinar

- It will cover the following topics:
  - Showcasing some of South East MAS services and how they have either adapted or ‘stood down’ during the COVID pandemic and what services have been available for dementia patients especially those in crisis.
  - Outlining their draft Recovery plans going forwards both in the short term and longer term as we slowly ease out of the pandemic. Featuring use of remote consultations (phone & video) and what diagnostic tools have been used, taking history remotely and how to deliver diagnosis including subtypes remotely/ face to face.
- Lessons learnt from ‘new ways of working’ and what can be done differently going forwards?
- Q & A session to allow opportunity for discussion and sharing of best practice

Presenters

- Dementia Clinical leads across South East
- Dr Bikram Raychaudhuri – GP
- Dr Sian Roberts – GP
- Dr Christopher Kipps – Consultant Neurologist
- Jo Gavins & Rachel Chappell - Quality Improvement Managers across South East
- Presentors:

1. Dr Raja Badrakalimuthu – Associate Medical Director for Older Adults CMHT Guildford, Surrey and Borders Partnership Trust
2. Jason Willcox – Service Manager for HERE – MAS in Brighton & Hove
3. Phil Blunden – Clinical Nurse Specialist, Oxford NHS Foundation Trust

Dr Raja Badrakalimuthu

Consultant Psychiatrist – Associate Medical Director for Older Adults in CMHT Guildford, Surrey & Borders Partnership Trust

NHS England and NHS Improvement

MEMORY ASSESSMENT SERVICES RECOVERY PLANNING

Dr RAJA BADRAKALIMUTHU
FRCPSYCH, CLIN CERT PSYCHOPHARM, DHMSA, MSc, MA
ASSOCIATE MEDICAL DIRECTOR – OLDER ADULTS DIVISION
SURREY & BORDERS PARTNERSHIP NHS FOUNDATION TRUST

Assessments in Community

1. Checks
2. TICS-M
3. MOCA BLIND
4. ACE-III REMOTE
5. PILOT STUDY: RESULTS AND CONSCLUSIONS

Assessments in Care Homes

1. Pre-planning
2. Offering virtual assessments
3. Capacity/ confidentiality

DATA on ASSESSMENTS

1. March (post covid)- 112 f2f, 400 virtual
2. April- 283 f2f, 1488 virtual
3. May- 342 f2f, 1825 virtual
4. June- 472 f2f, 1847 virtual
5. Total- 1209 f2f, 5560 virtual

COMMUNITY

REMOTE MEMORY ASSESSMENTS GUIDANCE

Rajesh Abraham, Phil Slack, Damien Dewhurst, Sophie Monaghan & Sarah Agnew

FORGET screening tool for dementia in community and acute

FORGET

History from patient/ carer (specify): ----------

(A score of 3+ will need assessment by liaison mental health team for dementia; less than 3 is indicative of delirium; A score of 1+ will need further assessment in Memory Clinic)

Name:	**D.O.B:**
Name of the carer who provides history	
Item **(Should be present at least 6 months)**	**Present=1** **Absent=0**
• **FORGET**	
• **F**amily/ friends recognition	
• **O**dd beliefs or **O**ut of character behaviours	
• **R**epetitive or reduced speech	
• **G**rooming difficulties	
• **E**vening confusion and sleeplessness	
• **T**oilet awareness	
Total Score © Badrakalimuthu VR May 2014	

© Badrakalimuthu VR May 2014

The **FORGET tool**

A **screening tool** developed to facilitate use by healthcare professionals in hospital and across the community setting will need to focus on duration of functional impairments and common symptoms of **dementia**. The **FORGET screening tool** consists of seven- items, and takes about 5–7 minutes to administer.

27 Jul 2017

https://www.gmjournal.co.uk › forg...

Forget: a screening tool for dementia | GM

Checks whilst organising remote assessments

1. Language and cultural factors.
2. Availability of emotional and social support to process a diagnosis of dementia.
3. Consent to assess and an understanding of the differences in how they will be assessed, the potential outcomes and how they may receive a diagnosis of dementia.
4. Sensory impairments.
5. Presence of a family member or carer.
6. Availability of a calm environment

Telephone Interview for Cognitive

hiatry, Neuropsychology, and Behavioral Neurology
. 2, pp. 103–110
aven Press, Ltd., New York

Detection of Dementia in the Elderly Using Telephone Screening of Cognitive Status

Kathleen A. Welsh, Ph.D., John C. S. Breitner, M.D., M.P.H., and Kathryn M. Magruder-Habib, Ph.D., M.P.H.

The Joseph and Kathleen Bryan Alzheimer's Disease Research Center and Department of Psychia Duke University Medical Center, Durham, North Carolina, U.S.A.

Summary: Detection of dementia in large, geographically dispersed populations is difficult. Conventional in-person neuropsychological assessment techniques, no matter how brief, are too costly to be practical for this purpose. Telephone interviewing is an obvious alternative for cognitive screening, but its practical utility is relatively unexplored. We therefore investigated the performance characteristics of a telephone screen for dementia in elderly residents of congregate housing facilities. We interviewed 209 subjects using the Telephone Interview for Cognitive Status (TICS) and a modified version (TICS-m) that includes items sensitive to early dementia (delayed recall) and eliminates other items difficult to verify in survey work. After the subjects received a brief in-person neuropsychological assessment, TICS and TICS-m scores were compared as predictors of the resulting clinical assignment (normal, mildly impaired, or demented). Although the TICS-m yielded slightly better results, both versions of the instrument were sensitive and specific indicators of dementia in this community sample. In a separate exercise, both instruments also correctly identified 17 clinic patients with carefully diagnosed Probable AD. Telephone interviewing of cognitive function may therefore provide an economical approach to mental status screening in research studies where in-person assessment is impractical. **Key Words:** Telephone interview—Alzheimer's disease—In-person evaluation—Post hoc scores—Cognitive deficits.
NNBN 6:103–110, 1993

TICS

TELEPHONE SCREENING FOR DEMENTIA

TABLE 2. *Items of the TICS and the TICS-m*

TICS	Score (points)	TICS-m	Score (points)
1. State full name	2	1. State full name	2
2. Date	5	2. Date	5
3. **State address**	**5**	3. **State age/phone no.**	**2**
4. Counting backward	2	4. Counting backward	2
5. Word list learning	10	5. Word list learning	10
6. Subtractions	5	6. Subtractions	5
7. Responsive naming	4	7. Responsive naming	4
8. Repetition	2	8. Repetition	2
9. **President's last name**	**1**	9. **President's full name**	**2**
Vice Pres. last name	**1**	**Vice Pres. full name**	**2**
10. Finger tapping	2	10. Finger tapping	2
11. Word opposites	2	11. Word opposites	2
		12. **Delayed recall**	**10**
Total	41 pts	*Total*	50 pts

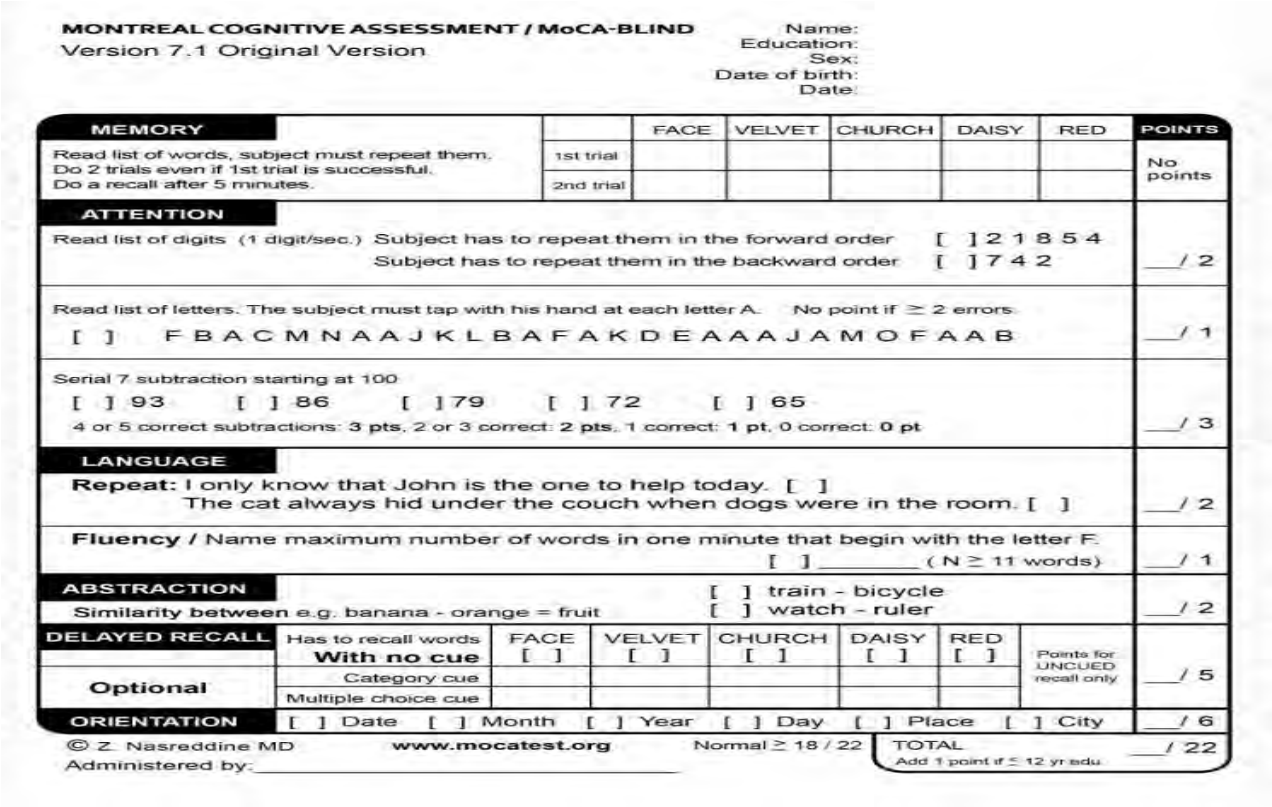
Items unique to either the TICS or TICS-m are in bold type. All other items are identical in the two versions of the telephone interview.

Telephone Interview for Cognitive Status

1. TICS-M outcomes:
2. MCI (score of 28-31*)
3. likely dementia (score below 28*)
4. no evidence of dementia (score above 31*)

David S. Knopman,Rosebud O. RobertsYonas E. Geda,V. Shane Pankratz, Teresa J.H. Christianson,Ronald C. Petersen,and Walter A. Rocca· Validation of the Telephone Interview for Cognitive Status-modified in Subjects with Normal Cognition, Mild Cognitive Impairment, or Dementia 2010 Jan; 34(1): 34–42

MOCA-BLIND



MONTREAL COGNITIVE ASSESSMENT / MoCA-BLIND
Version 7.1 Original Version

Name:
Education:
Sex:
Date of birth:
Date:

MEMORY		FACE	VELVET	CHURCH	DAISY	RED	POINTS
Read list of words, subject must repeat them. Do 2 trials even if 1st trial is successful. Do a recall after 5 minutes.	1st trial						No points
	2nd trial						

ATTENTION

Read list of digits (1 digit/sec.) Subject has to repeat them in the forward order [ ] 2 1 8 5 4 — ___/ 2
Subject has to repeat them in the backward order [ ] 7 4 2

Read list of letters. The subject must tap with his hand at each letter A. No point if ≥ 2 errors — ___/ 1
[ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B

Serial 7 subtraction starting at 100 — ___/ 3
[ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65
4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0 pt**

LANGUAGE

Repeat: I only know that John is the one to help today. [ ] — ___/ 2
The cat always hid under the couch when dogs were in the room. [ ]

Fluency / Name maximum number of words in one minute that begin with the letter F. — ___/ 1
[ ] _____ (N ≥ 11 words)

ABSTRACTION — ___/ 2
Similarity between e.g. banana - orange = fruit
[ ] train - bicycle
[ ] watch - ruler

DELAYED RECALL	Has to recall words	FACE	VELVET	CHURCH	DAISY	RED	Points for UNCUED recall only	
	With no cue	[ ]	[ ]	[ ]	[ ]	[ ]		
Optional	Category cue							___/ 5
	Multiple choice cue							

ORIENTATION [ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City — ___/ 6

© Z. Nasreddine MD **www.mocatest.org** Normal ≥ 18 / 22

TOTAL ___/ 22
Add 1 point if ≤ 12 yr edu.

Administered by: _____

MOCA BLIND Study

Telephone Assessment of Cognition After Transient Ischemic Attack and Stroke

Modified Telephone Interview of Cognitive Status and Telephone Montreal Cognitive Assessment Versus Face-to-Face Montreal Cognitive Assessment and Neuropsychological Battery

Sarah T. Pendlebury, MRCP, DPhil; Sarah J.V. Welch, RGN; Fiona C. Cuthbertson, BSc; Jose Mariz, MD; Ziyah Mehta, DPhil; Peter M. Rothwell, FRCP, FMedSci

Background and Purpose—Face-to-face cognitive testing is not always possible in large studies. Therefore, we assessed the telephone Montreal Cognitive Assessment (T-MoCA: MoCA items not requiring pencil and paper or visual stimulus) and the modified Telephone Interview of Cognitive Status (TICSm) against face-to-face cognitive tests in patients with transient ischemic attack (TIA) or stroke.

Methods—In a population-based study, consecutive community-dwelling patients underwent the MoCA and neuropsychological battery >1 year after TIA or stroke, followed by T-MoCA (22 points) and TICSm (39 points) at least 1 month later. Mild cognitive impairment (MCI) was diagnosed using modified Petersen criteria and the area under the receiver-operating characteristic curve (AUC) determined for T-MoCA and TICSm.

Results—Ninety-one nondemented subjects completed neuropsychological testing (mean±SD age, 72.9±11.6 years; 54 males; stroke 49%) and 73 had telephone follow-up. MoCA subtest scores for repetition, abstraction, and verbal fluency were significantly worse ($P<0.02$) by telephone than during face-to-face testing. Reliability of diagnosis for MCI (AUC) were T-MoCA of 0.75 (95% confidence interval [CI], 0.63–0.87) and TICSm of 0.79 (95% CI, 0.68–0.90) vs face-to-face MoCA of 0.85 (95% CI, 0.76–0.94). Optimal cutoffs were 18 to 19 for T-MoCA and 24 to 25 for TICSm. Reliability of diagnosis for MCI (AUC) was greater when only multi-domain impairment was considered (T-MoCA=0.85; 95% CI, 0.75–0.96 and TICSm=0.83, 95% CI, 0.70–0.96) vs face-to-face MoCA=0.87; 95% CI, 0.76–0.97).

Conclusions—Both T-MoCA and TICSm are feasible and valid telephone tests of cognition after TIA and stroke but perform better in detecting multi-domain vs single-domain impairment. However, T-MoCA is limited in its ability to assess visuoexecutive and complex language tasks compared with face-to-face MoCA. **(*Stroke*. 2013;44:227-229.)**

ACE –III Remote Administration

1. https://www.sydney.edu.au/brain-mind/resources-for-clinicians/dementia-test.html
2. Ensure the carer will be with the participant during the testing/ carer not to provide help or prompts.
3. If the participant requires glasses and/or hearing aids, remind the carer to prepare these. The participant should be seated comfortably at a table with clear view of the screen.
4. Check with the carer before beginning the test where they are.
5. Ensure the carer has the required materials: 1) One pencil 2) 4 blank sheets of paper.
6. *ACE-III has not been validated as an online assessment.*

Criteria for neuropsychological assessment

1. Subjective/informant complaint of memory problems in the absence of identified cognitive impairment on the TICS-M.
2. MCI
3. Denoting dementia subtypes
4. Risk factors such as placement breakdown or challenging behaviour
5. Young onset
6. Potential benefit of psychological intervention to promote memory enhancing strategies/neuro rehabilitation

Prescribing Cognitive Enhancers

1. Checks for pulse rate (ACh I)
2. Renal Function Tests (Memantine)
3. Scan and e-mail prescriptions
4. Piloting e-prescribing in the community

Post-Diagnostic Support

1. Telephone support
2. TEAMS/ Attend Anywhere Meetings

PILOT OF AA (ATTEND ANYWHERE) AND OTHER REMOTE ASSESSMENTS

Rajesh Abraham & Phil Slack, Consultants in Old Age Psychiatry
Surrey & Borders Partnership NHS Foundation Trust

Results of the pilot of AA (Attend Anywhere) and other remote assessments (1)

1. A total of 70 consultations were included in the pilot for Surrey Heath CMHTOP and G&W CMHTOP.
2. All included patients were offered virtual consultations using AA platform.
3. About 62% of the patient agreed for virtual consultation, 14 % declined and 17% did not have access to appropriate technology including smartphone, tablets, laptops etc.
4. Of the 43 patients who agreed to use virtual consultations 40 agreed to use AA.

Results of the pilot of AA (Attend Anywhere) and other remote assessments (2)

1. Out of the 40 AA consultations 26 (65%) were successful and 14(35%) were unsuccessful.
2. 60 (86%) of the patients did not require further face-to-face and 10 (14%) needed further contact to establish working diagnosis and management plans.
3. Remote memory assessments including Remote ACE III and MOCA were successfully completed in 13 (33%) patients using AA.
4. AA platform was down for 5 days during this period and these consultations were converted to telephone consultations.

Conclusions from the pilot of AA (Attend Anywhere) and other remote assessments

1. AA platform works well if there is good connectivity and can be used as a part of hybrid solution to offer remote assessments for both new patients and reviews.

1. Cognitive assessments including remote ACE III are possible over AA if connectivity is good.

1. Contingency plans to fall back on telephone consultation should be in place in case of failure of the platform/ connectivity issues etc.

1. Remote assessments significantly reduced the need for face-to-face consultations especially in review consultations saving travelling time and associated costs

CARE HOMES

GUIDANCE FOR REMOTE ASSESSMENTS IN CARE HOMES

Katy Lee, Gareth O'Leary, Georgia Belam & Cathie Sammon

Pre-planning and information gathering

1. Triage and review notes on referral.
2. Can further collateral history be gathered from carers and family?
3. Consider relevant questionnaires and self/carer assessment, including those which can be completed prior to consultation:

   Cognition (e.g. Tics-M is recommended within the memory assessment protocol but also consider BLIND MoCA, ACE III, mini-ACE etc)

   Behaviour and Function (e.g. ABC charts, BADLs, Neuropsychiatric Inventory, Challenging Behaviour Scale)

   History (e.g. IQCODE)

   Mood (e.g. GDS, Cornell Scale)

4. Remote consultation to be offered as the main intervention (please see later section for the process to be followed if a face-to-face visit is being considered).

Offering virtual assessment and consultation

1. What technology is available? Telephone versus video conference.
2. SABP's preferred virtual assessment tool is Attend Anywhere. For meetings, the preferred platform is Microsoft Teams (with care home staff/external stakeholders dialling into the meeting, rather than being invited via email).

   If Attend Anywhere or Microsoft Teams are unavailable, alternative virtual tools need to be agreed with senior clinicians and Digital before they are used.

1. Maintain principles of information governance and confidentiality.

   NHSX states consent is implied by joining virtual/remote consultation.

   Identify environments for assessment that will maintain confidentiality.

1. Any virtual observations of the person's behaviour in a care home should be first discussed with a senior clinician in the team before they are carried out.
2. For the time-being, virtual observations of personal/intimate care should not be completed.

Identity and safeguarding, consent and capacity, confidentiality

1. Ensure relevant consent and capacity have been considered and recorded in the appropriate care record.
2. Where capacity is lacking, consider the principles of the Mental Capacity Act:
    - Is it in the best interests of the patient to proceed?
    - Have Appointees, Deputies or Attorneys been identified and consent sought?
    - Have next-of-kin or other relevant persons been contacted where it is deemed in the patient's best interest?
1. Ensure that identities of all participants are confirmed at start of consultation (e.g. requesting personal demographic information).
2. Ensure any personal information stored on your device, or obtained through a video or telephone conversation, is safely transferred to the appropriate health and care record as soon as possible.
3. Delete any personal information, including back-up data, from your own device.
4. Apply Caldicott principles and your own relevant professional standards, as you would normally.

Care Home Pathway Support

Understanding distressed behaviour in dementia: https://youtu.be/6bCFA14cMbk
De-escalation skills in dementia care: https://youtu.be/bJAiW52hnGE
Supporting people with dementia in medical isolation: https://youtu.be/ViYrMDmWbTQ
To find out more about the training, contact: Dr Katy Lee, Intensive Support Team Lead and Principal Clinical Psychologist for Older People at: Katy.Lee@sabp.nhs.uk

Jason Willcox

Service Manager, HERE – MAS in Brighton & Hove, Sussex

NHS England and NHS Improvement

Who we are and what do we do?

Brighton and Hove Memory Assessment Service

Who we are?

- Here is a Social Enterprise founded in 2010 delivering NHS services. We believe in working in partnership to deliver meaningful personalised care.

- Here is head contract holder and we work in partnership with SPFT (local mental health trust), The Alzheimer's Society and The Carers C

Here Sussex Partnership NHS Foundation Trust NHS Alzheimer's Society carers centre for brighton and hove

What's our model?

- Integrated Community Service, providing both clinical and support (Pre and Post diagnosis) functions.
- Operate out of primary care sites and deliver home visits.

Support Pathway.

- Pre and Post Diagnostic Support Service delivered by Memory Support Workers (MSW) providing support to all at the point of referral acceptance. MSW have meaningful conversations about needs and deliver upon them. People who receive a diagnosis of dementia receive a year of post diagnostic support with access to care planning and structure support.

Clinical pathway.

- Nurse led with GP and consultant input and support.
- Nurses deliver assessment and diagnosis, medication titration and annual review appointments.
- Routinely scan (CT and MRI) patients. Scans reported on by neuroradiologist. Request re-reports where appropriate.
- Weekly MDT diagnosis formulation
- Doctors and nurse prescriber deliver medication initiation.

Inspected and rated Outstanding Care Quality Commission

UK SOCIAL ENTERPRISE AWARDS 2017 WINNER

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

International Forum on QUALITY & SAFETY in HEALTHCARE

Institute for Healthcare Improvement BMJ

MSNAP MEMORY SERVICES NATIONAL ACCREDITATION PROGRAMME CCQ

hereweare.org.uk

Snapshot of Service Measure Norms

DDR 70.1%
Pre Covid

1114

Number of patient's currently open to MAS

%QOL Improvement or Maintenance

76 %

85 Referrals per month

70 Assessments per month

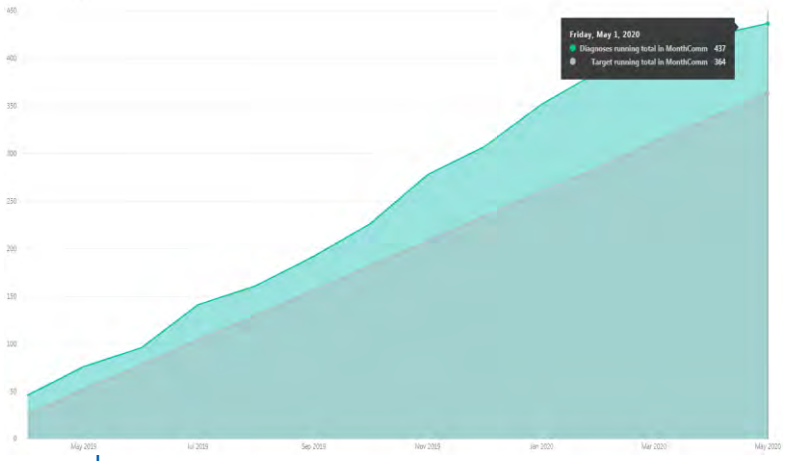
Staffing structure
WTE

Clinical pathway
- 2.2 Nurses,
- 0.1 Psychiatric Consultant
- 0.4 GP

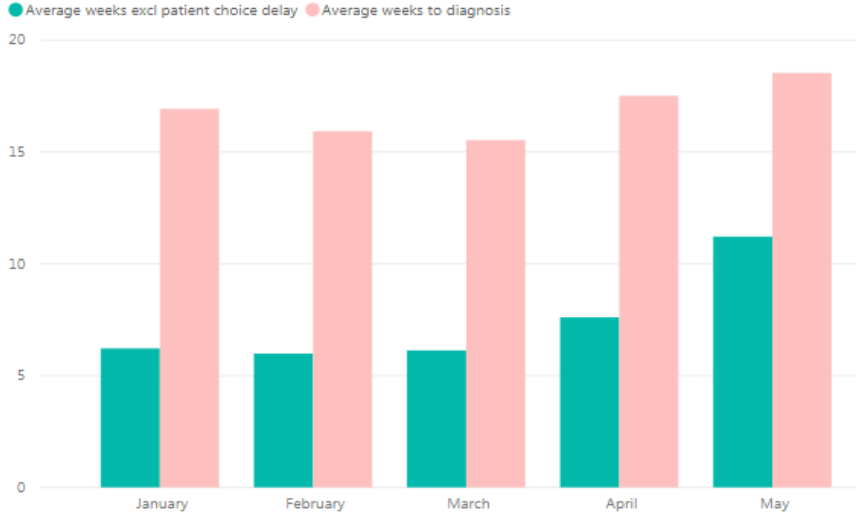
Support pathway
1.8 MSW

Operations
- 3.5 PCA
- 1.0 Manager

6 week target : 437 patients diagnosed within 6 weeks (pt choice included).



Referral to Diagnosis Patient Journey Times



Brighton and Hove Memory Assessment Service

In 2016 the service went through a significant redesign of our service that was shaped by the people we serve. As a result we created a more person centred service that responded to the need they presented and not just our commissioned functions.

As part of the redesign we created a new set of values and a new purpose that has shaped service delivery and innovation to date.

> *Help me and my loved ones to get the support and information we need to live our lives well*

Inspected and rated Outstanding ☆ Care Quality Commission

UK SOCIAL ENTERPRISE AWARDS 2017 WINNER

EMPLOYEE OWNERSHIP ASSOCIATION

BETTER BUSINESS TOGETHER

hereweare.org.uk

What was the impact of Covid?

Impact to Service?

- All Face to Face service delivery stopped across both clinical and support pathways.
- Remote working introduced.
- GP capacity reduced to 0.2 WTE
- Retained nursing team.
- Reallocated resources to priorities critical functions (see slide **40**).
- New support functions introduced (see slide **42**).
- Covid Support Letters created.
- Telephone Assessments introduced.
- Scanning (CT and MRI) pathway stopped – unless need urgent
- Medication Initiation stopped.
- Medication Reviews continued but dose increases paused.
- Annual Review delivery continued.
- Referrals significantly declined.

Impact to Patients and NOK?

- Destabilisation of support networks
- Increase needs
- Increase in isolation
- Increase in carer burden
- Possible pathway to crisis

Impact to the wider system?

- Increase in hospital admissions and pressure on service
- Significant system transformation
- New Community Covid Services mobilised
- Established psychosocial services closed

What was the impact of Covid?

How did we stay open?

- It was helpful that we are not a trust (although have staff seconded into the service) and our contract was specific to delivering a memory service.
- Staff within the service had underlying health conditions that would make redeployment to front lines services questionable.
- We helped the wider system to understand the value our service could deliver and how an operational MAS may help with crisis avoidance.

Guiding Values?

During the pandemic themes emerged from our conversations that have helped with complex decision making and helped us shape what our offer is to our patients and their loved ones. These principles outlined below combined with our service purpose have helped us focus our Covid response.

1. ***Mitigate the risk of Covid infection to our patients and their loved ones.***

2. ***Shared decision making***

3. ***Promote quality of life***

4. ***Respond when we feel we can add value.***

How did we respond?

Safety and BCP Response.

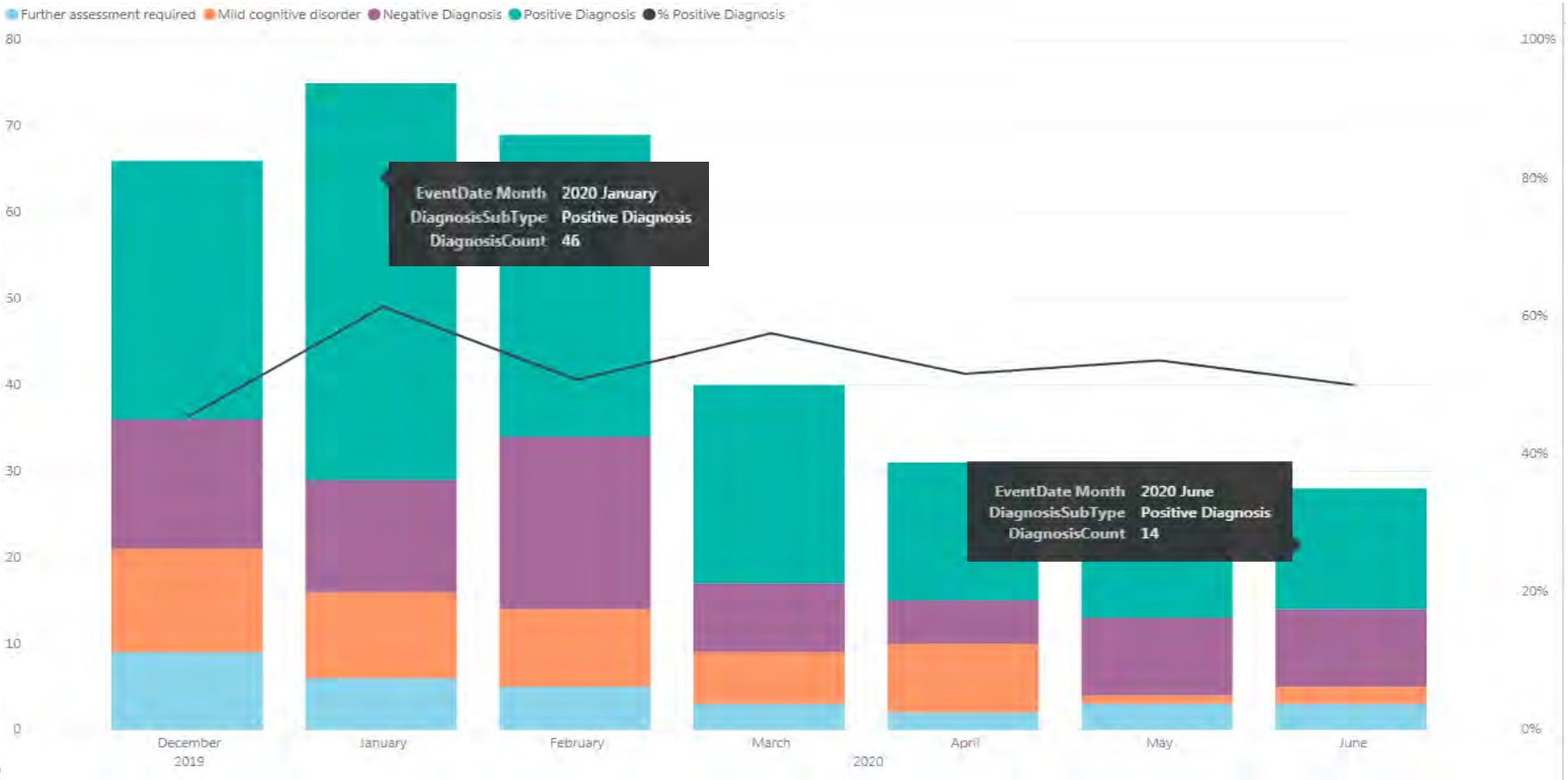
Critical Functions: *Import & Triage, Critical Scan Finding, Medication Management, Risk management, Support planning*
Core Functions: *Assessment and Diagnosis*

Key amendments to the clinical pathway.

- **Telephone Consultation Model:** The service moved to a telephone consultation model and remote working across both the clinical and support pathway.
- **Telephone Assessment**: Focusing on gathering history, presentation and symptoms, collateral history and requesting re-reports of previous scans to by our neuroradiologist.
- **Scanning MRI and CT:** We previously routinely scanned patients as part of the assessment process however our position has shifted to scanning when only requested by the MDT for diagnosis formulation or when clinically indicated.
- **Diagnosis formulation:** Were clinically appropriate the service has been able to complete diagnosis formulation where presentation and collateral strongly suggest a dementia picture without the use of scanning and formal cognitive assessment. Use of the DIADEM tool added assurance.
- **Medication Titration:** Titration pathway amended and to mitigate risk. Patients kept on a treatment dose and not increased due to possibility of destabilisation of physical health.

Diagnosis Formulation Activity

Year, Month	Further assessment required	Mild cognitive disorder	Negative Diagnosis	Positive Diagnosis	% Positive Diagnosis
2019, December	9	12	15	30	45.45 %
2020, January	6	10	13	46	61.33 %
2020, February	5	9	20	35	50.72 %
2020, March	3	6	8	23	57.50 %
2020, April	2	8	5	16	51.61 %
2020, May	3	1	9	15	53.57 %
2020, June	3	2	9	14	50.00 %



New Functions to mitigate the impact of Covid?

We recognised that we serve people who may be significantly impacted by Covid and experience a destabilisation in their support network due to social distancing, shielding and isolating.

Vulnerability and Isolation Reviews

1025 Reviews Completed

- The service created new stratification tool to aide understating of support needs and the potential impact and risk of Covid on their support network.
- The templates leaned into the B&H councils regarding carers risk stratification as well as the Alzheimer's Welfare calls to help shape a MAS Covid specific tool while working to a established local norms.

Welfare and Enhanced Welfare Calls

504 Appointment Delivered

- Welfare Calls introduced to further assessing support needs and risk with a view to connect them to community services such as Community Hub, Befriending, Food Banks and Delivery Services.
- Where appropriate patients registered them on the Government's High Risk Register.
- Where there is urgent need or risk we referred to Secondary Care services such as Enhanced Duty (4 hours responsive service).
- For patient who we were isolated and vulnerable but didn't meet onward referral criteria for secondary care, we also delivered Welfare Calls on a regular basis.
- For patient who we were isolated and vulnerable but didn't meet onward referral criteria for secondary care, we also delivered Welfare Calls on a regular basis.

Covid Support Letters

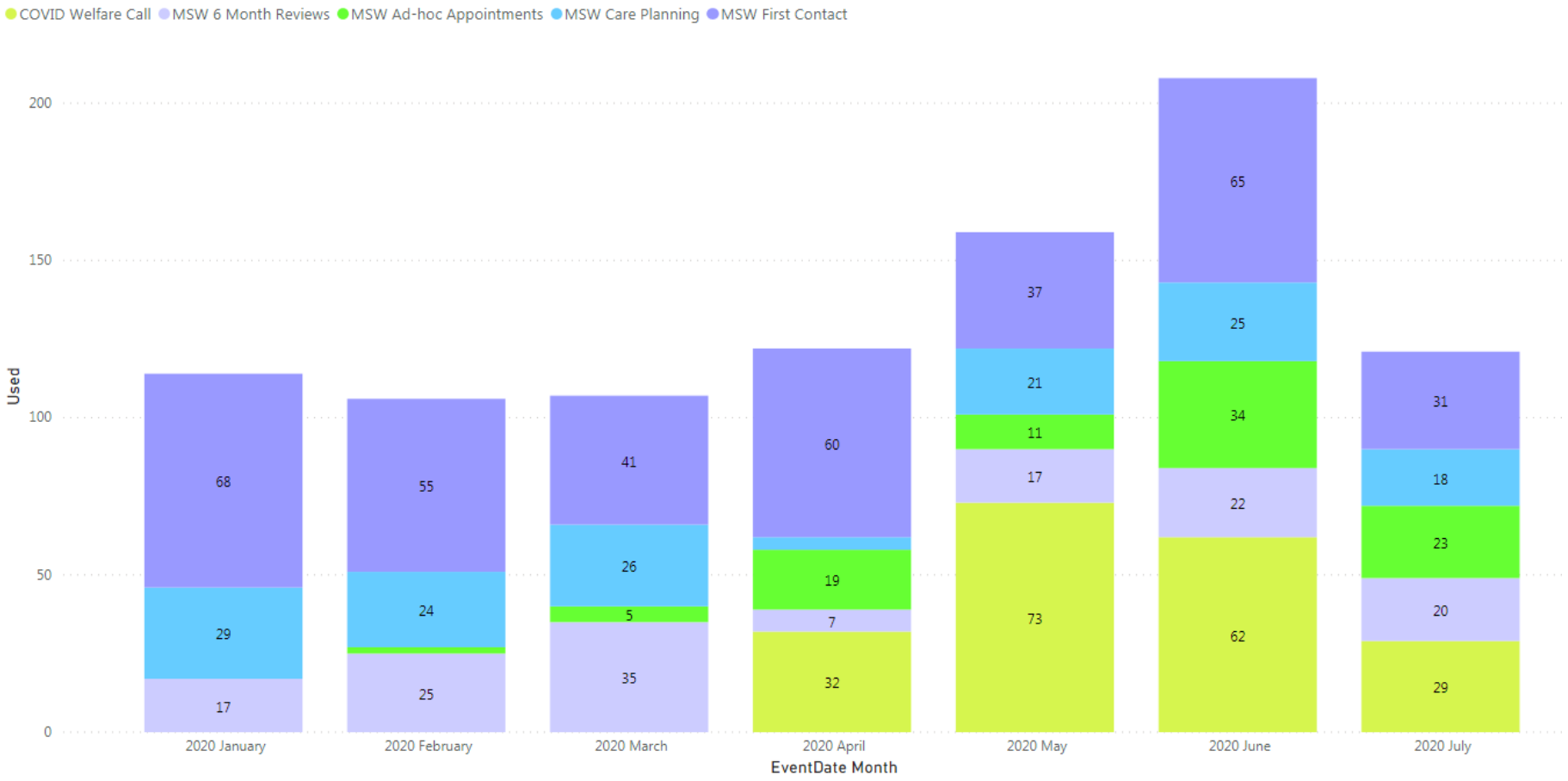
666*letters sent to date

- The service created a Covid Support Letter that signposted patients and cares to services providing practical support to isolated and vulnerable people within the city.
- * reporting functionality introduced after letters were being sent therefore figure stated underreporting.

Support Service Appointment Delivery.

Welfare Calls delivered by MSW to help patients access support and mitigate risk during the pandemic.

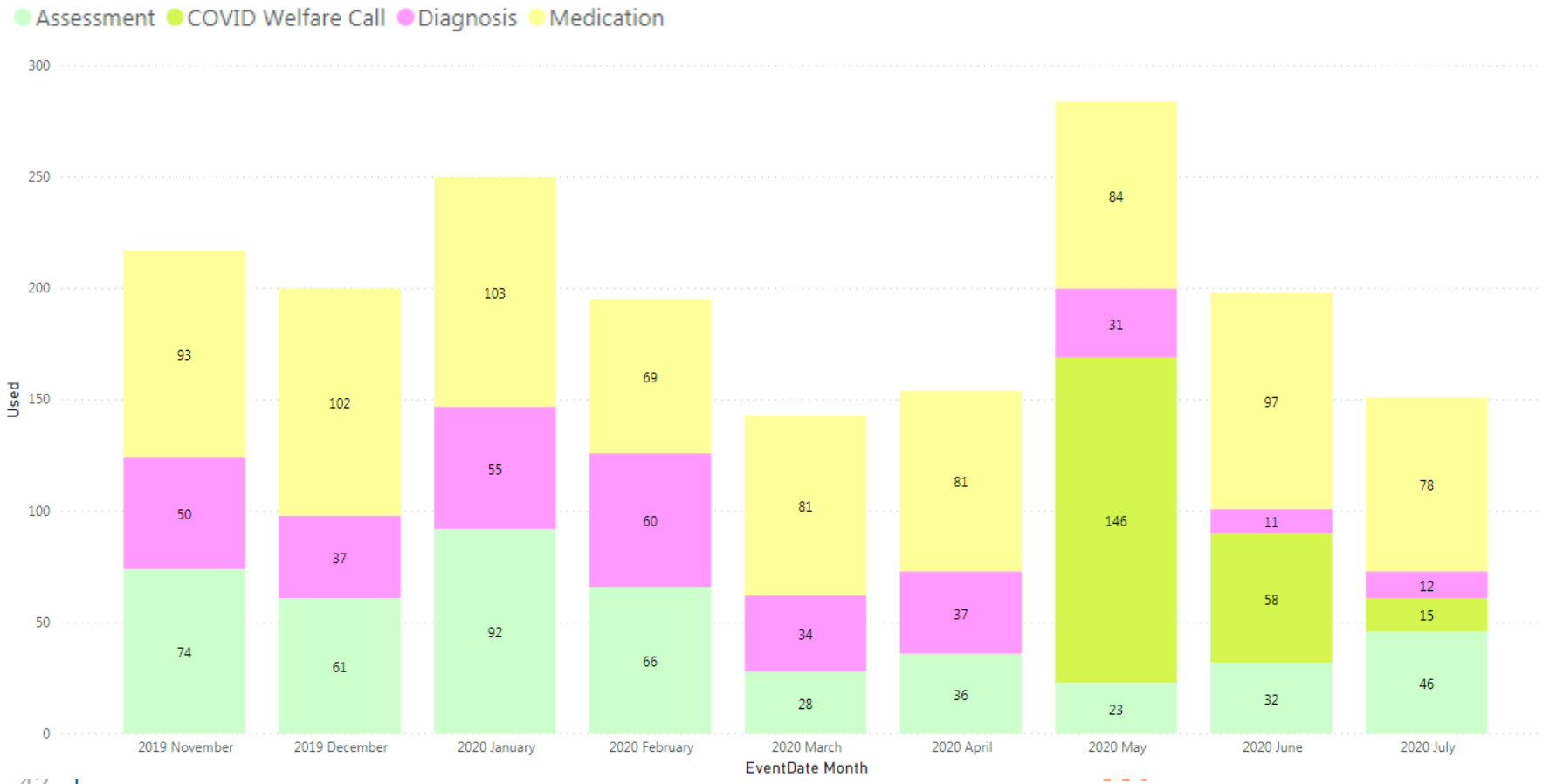
The graph below shows the service appointment delivery grouped into functions within the Support pathway .



Operational reporting summary

The clinical pathway continued to remain operational and introduced new appointments in the form of Covid Welfare Calls delivered by nurses to help patients access support and mitigate risk during the pandemic.

The graph below shows the service appointment delivery grouped into functions within the clinical pathway .



Restoration of closed down functions.

Remote or Face to Face?
Given the uncertainty that we are faced with and that we serve vulnerable people we are focusing our resources on remote service delivery options to ensure that we have a resilient service offer that can remain fully operational during any further waves of infection or local lockdowns.

Remote Prescribing Pilot . – Commencing with Donepezil Remote Prescribing Pilot Aug 2020
While the service has prescribed memantine remotely via telephone / video consultation the majority of people on our waiting list we have yet to initiated donepezil remotely due to a lack of doctor capacity within the service. Now that doctors are returning to the service we have schedule the pilot to commence 4th Aug. Patients who already have access stat machines are being piloted and we have requested funding from B&H CCG to supply stat monitors to our patients to help remote options.

Remote Cognitive Assessment. – Commencing Aug 2020
As of w/c 3rd Aug the service commence with remote cognitive testing use the ACE-III. Update of video consultations has been minimal however with the easing of lockdown it is anticipated that the

Face to Face offer. – Commencing September 2020
The service will offer a limited number of face to face appointments for people who can't engage with remote options. We have create technology champions to help engage people with remote solutions.

Operational reporting summary

What have we learnt?

- The narrative from clinical and support staff was that the majority of people were well connected to and supported by the wider system. What does this mean? Supportive of a service model?
- Our investment in tech allowed us to respond swiftly to the need.
- Our ability to extract data and analyse data from our system was strong and that helped us identify and work with of our most vulnerable and risky patients as a priority.
- Our service was comfortable with remote working as telephone work has been in place since 2016 but at a lower frequency.
- The Systm1 Assessment Template Project of 2018 to created prescriptive, high quality assessments that increased staff confidence in telephone delivery and diagnosis formulation without the need for scans.

Service innovation that will be maintained

- **Telephone Assessment**
- **Video consultation**
- **Remote Cognitive Assessments**
- **Electronic Prescribing Service (EPS)**.
- **Sharing of records electronic records between primary care across EMIS and Systm1** Visibility of **primary care's physical health vulnerability coding** looks to be on the horizon to help services.

What this means to patient?

- A more diverse offer to fit the needs of our patients and a better connected service with primary care.

What challenges and do we face?

- How we will work with primary care.
- User failure for technology.
- Demand and capacity and waiting list reduction work – working with unknowns.
- Workforce / Covid related sickness.
- Ensuring equality of service provision.

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DIGITAL MEMORY CLINICS

Maintaining a Service during COVID-19

Adapting Our Response

1. Telephone Reviews
2. Increasing Waiting Lists for Assessments
3. Escalating Needs
4. Memory Clinic versus CMHT Response

The MACH One-Stop Shop

1. Our usual model – Assessment and Diagnosis in one visit
2. Video Assessment Pilot – attempting to replicate the model
3. MOCA-BLIND

The Learning Curve

1. Largely positive experience for both patient and clinician
2. Obtaining third-party information proved challenging

The Three-Stop Shop

1. Initial Invitation – Discussion and Consent
2. Telephone Conversation with Third Party
3. Video Assessment with both Patient and Relative/Carer

The Video Assessment

1. Microsoft Teams
2. The Complete MoCA – Use of Screen Sharing

Ongoing Challenges

1. The Technology doesn’t always work
2. Obtaining a Pulse
3. Physical Examination
4. Access to neuroimaging and other investigations
5. A less meaningful Human Interaction

A Limited Response

1. Letter to all those on the Waiting List
2. Two Key Messages:
   - Normal Service will not be resuming imminently
   - Connectivity is relatively straightforward
3. Alternative ways of providing Assessments

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