

Issue 22, August 2022

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WELCOME

Welcome to the Summer 2022 edition of the MSNAP newsletter! We are delighted to be able to share a variety of articles with you in this edition. We have an update on the Alzheimer's Society on their new My Appointments book, designed to help people with dementia and their carers maintain independence in their care. We also have articles on topics of post diagnostic support, challenges in young onset dementia, dementia and driving and a service user's personal account of accepting a diagnosis of dementia and developing coping strategies.

July marks the end of the 2021-22 peer-review cycle; huge thanks are due to member services who have undergone a review in this challenging period. We are also very grateful to everyone who has attended a peer-review as part of the review team, particularly our six MSNAP carer representatives – one of whom attends every review.

From September 2022, MSNAP reviews will start to return to face-to-face for the first time since 2022. Services undergoing a review between September and December 2022 have been offered a choice between an in-person or virtual review; from January 2023, we hope to be able to return to full in-person reviews. Developmental reviews will continue to be held virtually. Please consider signing up for a review if you are able to – details of upcoming reviews will be emailed to our list of trained peer-reviewers periodically.

We look forward to seeing you at MSNAP events over the next few months, including several webinars, MSNAP annual forum and peer reviewer training— for full details, see page 10.

We appreciate that memory services continue to experience significant challenges posed by the Covid-19 pandemic, and we would like to commend all our members on the phenomenal person-centred care you continue to provide to patients with dementia. Have a fantastic summer, and we look forward to seeing lots of you when we are back on the road for reviews!

Miranda Fern, Deputy Programme Manager

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Alzheimer's Society: Order our new diagnosis booklet for your memory clinics

Katrina Pookraj, Publishing Coordinator,
Alzheimer's Society

*'It's easier to manage once you know for
sure what you're dealing with.'*

- Person living with dementia.

We are excited to announce the launch of our
brand new diagnosis booklet **Diagnosing
dementia: A practical guide to assessment**
(code 78DD).

Who is it for?

Diagnosing dementia is for anyone worried
about possible signs of dementia including
memory problems for themselves or
someone else.

What's covered?

- The booklet **compares dementia symptoms with common signs of getting older** – and why it's important to see the GP about any concerns.
- It also **sets out how to prepare and describes what can happen at the GP appointment** including the tests and checks often carried out. A [symptoms checklist](#) to record any difficulties is included, along with tips for speaking with the GP.
- It **describes what is involved at a memory assessment** – and how and where this might be held. It explains what happens if the person is referred to a specialist and who this can be. If the

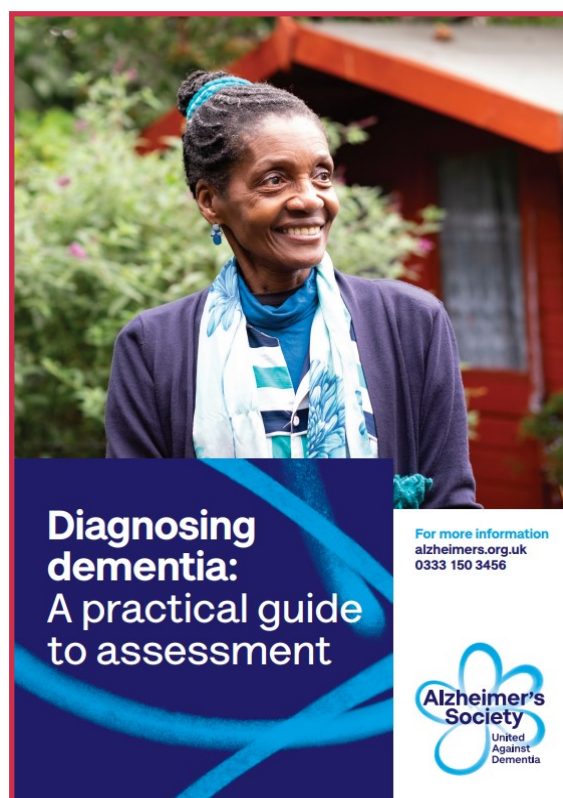
process is drawn out, there is advice on how to cope while waiting for the next stage. The different types of scans are explained along with questions and tests the specialist might carry out.

- With **advice on how to get the most from a consultation**, this booklet provides practical tips for dealing with difficult situations. It also gives guidance on dealing with a diagnosis of dementia – the importance of staying positive and what further information and support is available.

How do I order copies?

Diagnosing dementia is free of charge. Memory services can order copies in bulk to distribute to service users by emailing orders@alzheimers.org.uk quoting code 78DD.

Members of the public can use our [online form](#) to order individual copies. They can also call 0300 593 5933 or email orders@alzheimers.org.uk quoting code 78DD.



A Collaboration of Psychology, Placement Students and People with Dementia in Post-diagnostic Support

Reinhard Guss, *Consultant Clinical Psychologist, Oxleas NHS Foundation Trust*

For many clinicians in current day NHS Memory Assessment and Treatment Services, a prevailing frustration is our inability to provide high quality support for our clients in the lead-up to a dementia diagnosis, throughout the sometimes lengthy diagnostic process, and afterwards when coming to terms with the diagnosis, adjusting, developing strategies and a positive framework for living with the condition would be important. Due to most services having to meet targets on maintaining the diagnosis rate and referral-to-diagnosis times, many services have become front-loaded towards the provision of diagnoses, while the resources to achieve this have been taken out of the post-diagnosis programmes, which have consequently become ever more depleted.

This situation is all the more lamentable, as recent years have seen a massive development in the availability of evidence based approaches to assist people with early to moderate stage dementia with adjustment to diagnosis, with emotional difficulties and with strategies to support independence, engagement and active living. I have found that offering placements to undergraduate psychology students in memory services is one way of adding a little extra resource to our hard-pressed teams, allowing to pick up some of the most recent innovations and to offer these with the degree of specialist input and supervision that is needed, while providing experience to aspiring psychologists, who will hopefully become the much needed workforce of tomorrow. Below are the descriptions of one such collaboration from the student's and a client's point of view.



Daisy Chambers, *Placement Student on year-out from Psychology degree, Sussex Partnership Foundation Trust and Nottingham Trent University*

My role as an undergraduate psychology student within a memory service involved working closely with colleagues within the multi-disciplinary team to provide person centred support to those with mental health difficulties and/or dementia. A key aspect of my role included supporting the development and running of an expert by experience/peer support group of people with a dementia diagnosis. I organised meetings, compile written materials and provide one-to-one support to members. In the wider service I also worked alongside team members to support a selected clients under the supervision of the psychologist and wider team. Specifically, I worked alongside a clinical psychologist to provide extra support to a client outside of their therapy sessions. They were engaging in therapy for depression when they were first referred, but it became clear that the underlying difficulty was with memory, which later led to a dementia diagnosis. My role included calling the client twice a week to check on how they were managing at home and to assist them in becoming more active and less isolated. Much of the calls was spent working on coping strategies to help with memory difficulties, to build confidence in continuing to live independently at home and to support with coming to terms with the dementia diagnosis. Together we used trial and error to figure out what strategies worked well and created a tailored spreadsheet of all useful strategies. This served as a reminder that helped the client manage their memory difficulties. It has also proved to be a useful tool to share with others who have a dementia diagnosis, who have found it helpful in managing their own memory difficulties. Working alongside the clinical psychologist, we were able to provide more intensive support for the client and the combined work helped them to overcome depression, to adjust to the diagnosis, to develop and practice coping strategies, and to continue to live independently and positively with dementia.

Challenges in Young Onset Dementia Diagnosis

Dr Faria Zafar, Consultant Old Age Psychiatrist, Macclesfield Service

Although the incidence and prevalence of young onset dementia is continuously increasing, the diagnostic dilemma still exists. One of the major challenges is delay in diagnosis but diagnostic ambiguity, after 'a diagnosis' is also seen.

Ill-defined referral pathways, scarcity of specialist Young Onset Dementia services, lack of provision of neuropsychology assessments, difficulty in accessing Brain Perfusion Scans i.e. single photon emission computed tomography (SPECT) or a positron emission scan (PET) that can potentially aid towards diagnosis are a few identified factors leading to these challenges.

Through this platform I want to briefly share my experience of two cases highlighting the ongoing challenges leading to delayed and ambiguous diagnosis.

I assessed a 57 years old patient in my clinic with symptoms clearly suggestive of cognitive decline in March 2020. Addenbrookes cognitive examination score was 68/100 with a score of 13/18 on attention, 12/26 on memory, 6/14 on fluency, 24/26 on language and 13/16 on visuospatial abilities. Partner provided a 5-6 years history of gradual decline in cognitive abilities, starting as 'general scantiness'. The patient presented with deficits in both short-term and long-term memory. Expressive dysphasia symptoms were clear. There was decline in personal care, finance management and driving ability. Clinical picture was suggestive

of the possibility of Dementia in Alzheimer's disease with early onset. MRI brain scan was requested, and it was normal. The patient was then referred to neurology service for further specialist input. Neuropsychology assessment was completed in October 2020. It was identified in the neuropsychology assessment that the patient had considerable difficulty across a range of tasks, however the basis for this was not clear. The impression was that the patient's performance would indicate a very severe cognitive disorder with dense retrograde and anterograde amnesia together with problems in spelling, calculation and perceptuospatial function. It was commented that complete loss of retrograde memory would be highly unusual in an organic memory disorder. Further comment was made that the performance on neuropsychological assessment was greatly impaired, but the picture was not typical for a neuro degenerative disorder and there were indications that the performance was affected by sub optimal effort. The case was considered as 'diagnostically difficult' as a firm conclusion could not be reached following detailed neuropsychology assessment. 14 months after the neuropsychology assessment repeat MRI brain scan was requested which did not show any variation from the previous scan. The patient is currently waiting for a SPECT scan and more than two years following the initial assessment still waiting for a diagnosis!

One of my 61 years old patient was diagnosed with Young Onset Alzheimer's in 2020. The patient was referred to our service from a neurology service with the young onset dementia diagnosis and recommendation of commencement of acetylcholinesterase inhibitors. The patient was diagnosed with autoimmune encephalitis in 2014. The patient had reduced spatial awareness and was having seizures. The patient has been on immunosuppressive treatment and steroids since.

Over years the patient's condition deteriorated and a pattern of cortical cognitive impairment typical of Alzheimer's Disease was suggested to be present.

MRI brain scan showed progressive atrophy, and cerebrospinal fluid (CSF) amyloid and Tau biomarkers were in an Alzheimer's disease pattern. Genetic testing for Alzheimer's Disease was negative. Case was discussed in dementia radiology MDT and diagnosis of Young Onset Dementia was made. Although the dementia diagnosis was confirmed in 2020 and the patient is on dementia medication, there are still disagreements amongst healthcare professionals involved in his care if it's encephalitis or dementia. With this confusion, the patient continues to receive treatment for both.

We all agree that there is a compelling need to work towards an early diagnosis but how

to achieve this? Raising public awareness of signs and symptoms of dementia is paramount. Clear referral pathways could potentially help. There is a suggestion that any patient with the possibility of young onset dementia be directly referred to a specialist neurology service who have access to neuropsychology assessments and specialised brain scans. It will probably work in certain diagnostic services but not all. Variety of pathways in diagnosis should be investigated. We must also be flexible in review of diagnosis, where clinically indicated.

An earlier, confirmed, and clear diagnosis is certainly needed to enable prompt access to appropriate care and support services. Whilst trying to combat these challenges let's continue to offer the best possible support to the patient and the family members

UK Dementia and Driving Decision Aid: a tool for people living with dementia

Alessandra Merizzi, *Clinical Psychologist, Pennine Care NHS Foundation Trust*

The Dementia and Driving Decision Aid (DDDA) is a person-centred resource that enables drivers living with dementia to be central in the decision about driving, driving retirement and planning for alternative mobility options. The booklet is divided in four sections and guides the reader through information and reflective points.

The DDDA was first developed in Australia and then adapted for the UK through rigorous research methods by involving individuals living with a dementia, their family carers and practitioners.

The interest for the topic of dementia and driving came from people with dementia who were members of Let's Be Heard, part of the DEEP network. They shared their experience of driving cessation as this felt unclear and unfair. Let's Be Heard members, supported by psychologists from the Oldham Memory Service, contacted Dementia Alliance International and found that they had raised the same topic: they suggested contacting Professor Victoria Traynor. Let's Be Heard members viewed the DDDA booklet and asked to adapt it for UK drivers, and Professor Traynor responded with a research idea.

The study for developing the DDDA UK version included 3 stages:

Stage 1 – Development of an initial draft:
A. Review of the UK literature
B. A sub-group from the Oldham Memory Assessment and Treatment Service team identified basic information to review (N=4)
C. Draft of UK DDDA developed
Stage 2 – Data collection for the review of the draft and the development of a final version by:
A. Online consultation activity to which professionals, people with dementia and caregivers participated (N=102)
B. Online and face-to-face interviews for participants living with dementia (N=11)
Stage 3 – Development of the final UK version (in collaboration with Dorset Healthcare University NHS Foundation Trust)
C. Sequential review and team discussion of the findings
D. Consensus of the team for the findings to incorporate into UK DDDA
E. Final UK DDDA developed

The results showed that 91% of the survey respondents expressed positive views on the booklet and 48% of them wanted to make changes to the booklet. Participants living with dementia greatly appreciated the resource. They would use the UK DDDA in various ways/format, together with a family member, a close friend, their memory nurse, their GP, within their dementia support group or by themselves. They would prefer receiving the booklet from their Memory Service or GP.

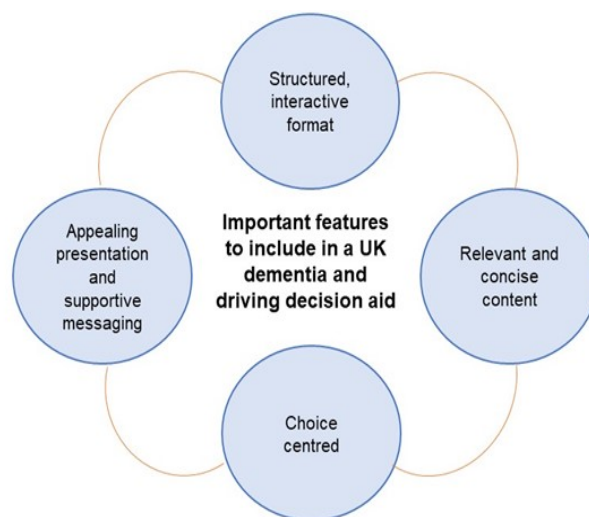
Participants with dementia appreciated the resource being person-centred and empowering in the decision process:

"They have tried to not make the decision for you or influenced that. They have just given you the information and saying (sic) you know this is what it is. I didn't think you could improve on that" (Female, retired driver living with dementia, 82 years).

Professionals viewed the issue of dementia and driving as important, sensitive, and complex. The UK DDDA may help lighten the conversation when there is concern for the driver and when the licence is likely to be removed:

"It is the area I find most difficult when talking to my patients and I would definitely want to use this leaflet to help them to make a decision. It is often a contentious subject and due to the rural nature of my case load (and the lack of public transport) patients are often very defensive about their right to continue driving. There have been times when I have had to report patients directly to the DVLA due to my concerns and their refusal to take advice. This leaflet would be an excellent tool for addressing this". (Nurse, female)

Overall, the most relevant features to include in the UK adapted version were:



The published version of the Dementia and Driving Decision Aid UK (DDDA UK) is now available for free on the ADHERE webpage: <https://www.adhere.org.au/drivingdementia/>

For further information on the booklet and on the research project, please email claire.bradbury1@nhs.net or a.merizzi@inrca.it

My journey towards accepting my diagnosis and developing coping strategies to live with dementia

David Barry, Patient, member of DEEP affiliated Dementia Peer Support group

My first reaction was one of complete denial. I refused to accept that I was in the early stages of dementia. When I accepted it, I went into a state of despair, feeling I no longer had a role in society. I then moved on to realise that I couldn't bury my head in the sand and had to accept my condition. I soon realised that dementia wasn't as life restricting as I at first anticipated. It's just another stage in life's journey. A former colleague said it's a matter of rethinking the way I do things and I now accept that I have to consolidate what I can do and find strategies for what I struggle with. I liken it to being able to run half marathons when I was young but accept I rely on a walking stick to get around now and I cannot walk far. I have always had a good memory and now I no longer have and I need strategies to get by on a day to day basis.

Initially, I told nobody about my diagnosis because of feeling embarrassed. I then started to tell a few selected people but soon realised this placed an unrealistic burden on them so decided to tell all those I interact with. My biggest problem is my memory and I now tell people that they cannot rely on me remembering something they have told me at an earlier time; I also struggle with most people's names. I've been surprised at how understanding and helpful everyone is when I tell them!

It's the hardest problem I've had to face in life and the biggest lifestyle change I've ever dealt with. I'm beginning to adjust to the enforced different changes of lifestyle but I have days when it's overwhelming and I just

have to roll with it and accept that listening to radio or music or watching television is all I'm going to achieve for that particular day. It's rather like planning a day playing golf, cricket, whatever and then finding it's raining heavily. I remind myself that I have to have bad days to appreciate the good days. Coping strategies are a way of life now and I'm constantly looking for ways to improve my lifestyle. Talking to others with a diagnosis of dementia and still coping independently is both encouraging and helpful.

I've always felt my *raison d'être* in this world is helping people and accepting help from others has been a real struggle. I still dread having to ask for help but have realised most people want to help. One friend put it bluntly saying that as I enjoy helping others I'm being selfish by not allowing others to enjoy helping me. I've listed below some of the strategies I use to live independently and meaningfully and hope by sharing them, others might find some of them helpful.

STRATEGIES TO HELP WHEN ATTENDING MEETINGS

1. At one time when wanting to speak I found myself third to speak; by the time the chairperson got to me I'd completely forgotten what I wanted to say. Now I make a note on my hand; usually a couple of bullet points will suffice. I've adapted this from a ploy I used a few years back when public speaking. When others read from a script, with heads bobbing up and down, it made engaging with my audience easier if I only had a few reminder words written on my hand to work with.

2. For regular Zoom discussions a friend offered to ring me the day before with a reminder; I explained that I'm likely to forget the next morning. She now rings me 30 minutes before the meeting which allows me to print out the agenda, minutes of the previous meeting and any other relevant documents and move seamlessly into the meeting with no likelihood of forgetting about it.

STRATEGIES FOR LIVING INDEPENDENTLY

3. Since retirement, a few years back, my lifestyle has tended to be spontaneous: following my diagnosis, I've realised my life needs more structure now. I have trained myself to having a cup of tea and taking my medication the minute I get up; now I also check my diary immediately. Checking the diary the night before just didn't work for me. It's all a matter of trial and error and what works for me may not work for others.

4. Having spoken with someone else who's been living alone for 8 years after a diagnosis, I realise keeping a tidy flat is vital, although unfortunately that's not my forté. It's a work in progress and I keep a list of household chores to ensure they don't get overlooked. I avoid running out of clean clothes by moving my dirty washing basket into the living room when it's nearly full so I can't miss seeing it. It's a great reminder when I get up in the morning! I still cook my own meals but occasionally forget frozen peas I put in the microwave. At least I haven't yet left anything on the hob to burn. I've got a few frozen ready meals that only need microwaving for brain fog days or when I feel lazy. These may eventually become the norm.

5. One of my problems was, when going out, leaving my flat and having to return sometimes several times for items I'd forgotten. Now I have a checklist pinned up inside my front door for keys, cash, bank cards, hearing aids (because I don't always wear them when I'm alone), etc. This saves me getting angry with myself about my forgetfulness.

6. I also stick to one supermarket for most of my groceries. This means I know exactly where to find regular purchases with the added bonus that I don't waste money on impulse buys that invariably I regret buying.

7. I have a clock close to my armchair that shows day of the week, morning/afternoon/evening, date, month and year. A friend found it in a charity shop and I wouldn't be without it now. It's also available on the

Alzheimer's Society's website shop and eBay.

BRAIN FOG DAYS

8. I have occasional days when I just cannot think straight. A friend suffering from dementia advised just rolling with it and accepting that for one day I won't achieve much. I listen to the radio or music or watch TV. I mentioned this to one friend who opined that it sounded defeatist, but it's finite and no different to cancelling a sporting event if it rains on the day. I just hope my neighbours are Led Zeppelin fans!

FORGETTING PEOPLE'S NAMES

9. My biggest problem is being unable to remember names of people, often when they clearly know me well. I recently met someone while out walking. I knew before she spoke that she was American and worked as a secondary school teacher. I plucked up courage to tell her I couldn't remember her name and, having told me, I realised I've known her for over a decade but had completely forgotten how our lives had crossed. She wasn't fazed by my not remembering her name which has left me determined to tell others in future when I can't place them. I find in discussion groups calling people by their names constantly helps to keep their names in my mind. One person at a recent conference took to addressing each person by name whenever she spoke to them. She subsequently confirmed she had done this to help me and agreed to continue it in future as it had served as a memory aid for me.

10. I find it frustrating when, on occasions, I get part way through saying something and lose my train of thought. It's rather like finding myself in a dark tunnel. It sometimes helps, when having told people, they go over what led up to our conversation but others seem surprisingly unfazed by this failing of mine and we just move on.

I'm always looking out for new coping strategies to make my lifestyle more enriching. I am and always will be, a work in progress.

Research Champion; Promoting Research Participation in the Barnet Memory Service

Maija Morton, Assistant Psychologist
and **Dr Navreen Singh**, Clinical
Psychologist, Barnet Memory Service

The Research Champion role was established in the Barnet Memory Service (BMS) in 2020, with the aim of promoting participation in research within Barnet Older People's Mental Health service (BMS and Barnet Older People's Community Mental Health Team (OPCMHT)). While there were projects relevant to service users, there was low engagement, partly due to clinicians having limited awareness of the available research opportunities and subsequently little promotion of these. The BMS standardised protocol reflected the importance of discussion of research opportunities following assessment, but this did not always occur in practice. Hence, the role of Research Champion was developed, with support from Research and Development (R&D) Delivery Team; a team within Barnet, Enfield and Haringey Mental Health Trust (BEHMHT) who support and facilitate research projects. The aim was to promote communication of research studies and opportunities to service users and to generate referrals. It was hoped it would also shift the team culture towards increased consideration of research. This position was voluntarily accepted by an Assistant Psychologist within BMS at the time who had a keen interest in research, to have in addition to their usual role. No extra funding was commissioned for this role.

In order to promote participation in research, the Research Champion attends regular meetings with the R&D team to gain updates on new and current projects being run within BEHMHT. The Research Champion then updates clinicians in the regular Multidisciplinary Team (MDT) meetings held within the BMS and OPCMHT on these projects and provides guidance on how to make referrals. One-to-one meetings with other potential referrers such as Admiral Nurses and Barnet Age UK Dementia Advisors are also arranged. Additionally, the Research Champion has supported the R&D team to perform caseload

screening to identify potentially suitable participants for studies and has liaised with clinicians and service users about the projects. Research projects are also promoted through flyers and leaflets in the Barnet Older People's Mental Health Service, as well as regular emails being circulated to the team. The current Research Champion has also been given the opportunity to be trained to facilitate a psychological intervention as part of a Randomised Controlled Trial for which Barnet is one of the research sites.

Thus far, the role of Research champion has been effective in increasing the number of participants being referred to studies. Subjectively, there appears to be more awareness within the team about the importance of promoting research and the opportunities on offer. In recent months, there has been a rapid increase in the number of referrals to the BMS, which in turn should result in increased participation in research projects. Nonetheless, it is evident that some clinicians find it challenging to find the time to discuss research opportunities and refer people to studies, when service demands are high, and clinicians are working at full capacity.

There have been several points of consideration when developing and undertaking the role of Research Champion. Firstly, finding the right balance between promoting research effectively, whilst considering the team's capacity has been essential. Regular feedback of the team's experience of the research champion role should be obtained. It has also been important to consider when the best time is to promote research to people with dementia and their family carers. We have reflected that it may be more appropriate to discuss research once someone has had time to process their diagnosis, at a follow up review, rather than during an initial memory assessment. It is also important to note the limitations of the role. At present, the role does not include following up participants throughout their research journey to after a study is complete. For this to occur, funding for a more substantial research champion role would need to be sought. This would enable us to explore what the experience of participating in research is like for the service user, as well as any benefits they may have encountered.

MSNAP Special Interest Day - Equity of Access to Memory Services

Menti Meter findings

What are the main barriers to accessing memory services?

- Knowledge about dementia, what services are available and the importance of a diagnosis
- Stigma around dementia
- Delay in GP surgery referrals
- Referrer knowledge of when to refer
- Fear of the outcome
- Language/lack of understanding within cultures
- Lengthy waiting times
- Pressure on primary care
- Lack of resources and staff from minority groups and marginalized communities to understand and empathise with service user needs
- Lack of knowledge/understanding LGBTQ community
- Access to IT for virtual consultations
- Staff shortages across services

How does your memory service collect and use demographic data to determine equality of access?

- Reporting services through the Trust
- Routine returns on Trust performance indicators
- Asking demographic data at the initial assessment/from GP at point of referral
- Patient outcome measures
- Audits and quality improvement projects
- Through CCG commissioners

How can your memory service improve its accessibility?

- Clear pathways
- Collaborative working with other organisation
- Better links between memory services and primary care
- Educate those who refer in/team education
- Promotion of services to patients and GP's information
- Asking the underrepresented group what they want to see and reasons why they are not accessing/ service user involvement
- More vacancies for multicultural staff
- Have better working relationships with referrers

MSNAP Webinars in 2022 so far...

Young Onset Dementia Webinar

Dr Janet Carter (UCL) and Professor Jacqueline Parkes (University of Northampton) speak on recent research and developments in Young Onset Dementia.

The recording is now available; you can watch it [here](#).

The UCL APPLE-Tree Study on Dementia Prevention Webinar

A webinar on the APPLE-Tree study (Active Prevention in People at risk of dementia through Lifestyle, behaviour change and Technology to build REsiliEnce) at UCL, led by Professor Claudia Cooper.

The recording is now available; you can watch it [here](#).

Have you signed up to Knowledge Hub?

MSNAP has launched an online discussion platform for it's members, in place of the current Memory Chat.

Knowledge Hub allows members to:

- Ask questions, have conversations, discuss solutions to problems and share experiences
- Network with one another independently
- Upload, share and comment on documents
- Promote forthcoming events and access MSNAP events and booking forms

Knowledgehub



If you would like to sign up, please [email us](#) so we can send you an invitation.

Upcoming MSNAP Initiatives

We have some exciting initiatives coming up on the Memory Services National Accreditation Programme! Please see below for details.

◆ MSNAP Webinar: Emergency Care Plans



Tuesday 17 August 2022



13:00—14:00



Online (Zoom)

Please join us for an MSNAP webinar on Emergency Care Plans for people with dementia and their carers, given by two of our Carer Representatives Dominic Tye and Douglas Pattison.

MSNAP webinars are free to MSNAP members and are worth 1 hour of CPD time. We look forward to seeing you there

Book your place:

Complete [this form](#) to register for this event.

◆ MSNAP Webinar: Lewy Body Dementia



Thursday 1 September 2022



10:00—11:00



Online (Zoom)

Please join us for a webinar by staff and researchers from the Lewy Body Society, shining light on this challenging dementia subtype.

MSNAP webinars are free to staff working in MSNAP member clinics, and are valid for one hour of CPD time.

Book your place:

Complete [this form](#) to register for this event.

◆ MSNAP Webinar: Rare Dementia Subtypes



Thursday 22 September 2022



12:00—1:00



Online (Zoom)

A webinar by Dr Charles Marshall (Barts & The London) on supporting patients diagnosed with rare dementia subtypes. Members can book their free spaces by going to the MSNAP Knowledge Hub.

Staff working in non-member clinics can book a space for £15.00 by contacting the MSNAP team at MSNAP@rcpsych.ac.uk.

◆ MSNAP Annual Forum



Tuesday 4 October 2022

◆ Peer Reviewer Training



Wednesday 2 November 2022



9:30—11:30



Online (Zoom)

This session is free of charge to members of staff working in MSNAP member services, and must be completed before you attend any peer-reviews. Bookings will open in September.

◆ MSNAP Webinar: Frontotemporal Dementia



Tuesday 22 November 2022



11:00—12:00



Online (Zoom)

A webinar by Professor Jason Warren (UCL) on supporting patients diagnosed with Frontotemporal Dementia. Members can book their free spaces by going to the MSNAP Knowledge Hub.

Staff working in non-member clinics can book a space for £15.00 by contacting the MSNAP team at MSNAP@rcpsych.ac.uk.

For more information about any of the MSNAP events, please contact the team at MSNAP@rcpsych.ac.uk.

Useful links

Discussion group:

Memory-CHAT@rcpsych.ac.uk

General queries:

MSNAP@rcpsych.ac.uk

The Royal College of Psychiatrists:

www.rcpsych.ac.uk

MSNAP page:

www.rcpsych.ac.uk/msnap

MSNAP standards—7th edition

[Access the standards here](#)

Resources for people with dementia and carers

[Access information here](#)

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And use [#MSNAP](https://twitter.com/hashtag/MSNAP) for up-to-date information

Royal College of Psychiatrists' Centre for Quality for Improvement

21 Prescot Street, London, E1 8BB



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www.rcpsych.co.uk/MSNAP