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WELCOME

In this final MSNAP newsletter of 2022, we would like to thank everyone who has participated in a network review or event this year. Over the course of the last twelve months, we have seen a huge surge in activity as we start to move forward living alongside Covid-19, and would like to commend every member service for their continued hard work.

Highlights from the year include:

- The development and publication of the 8th edition of MSNAP standards
- 23 peer-reviews, including the first ever Developmental review and a gradual return to in-person peer-reviews
- 51 new peer-reviewers trained across three sessions
- An exceptional Annual Forum in October including speakers from across the sector.

Looking ahead to 2023, we're planning a Special Interest Day on Rare Dementia Subtypes on 21 March, three further peer-reviewer training sessions in March, July and November, and the 14th MSNAP Annual Forum, along with more peer-reviews across the country. We look forward to seeing many of our members at these events.

On behalf of the whole MSNAP team here at the College, we would like to wish all our members a very happy Christmas and New Year.

Miranda Fern, Deputy Programme Manager

MSNAP HIGHLIGHTS




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Australia launches its first national service guidelines and quality improvement program for Memory and Cognition Clinics

Gemma Jahn, WA State Coordinator,
Australian Dementia Network

In November 2021, the Australian Dementia Network's Memory Clinics Initiative launched the country's first *Memory and Cognition Clinic Guidelines*. These *Guidelines* were developed in collaboration with Australian health professionals, leading academics and researchers, and people with a lived experience of dementia and their care partners.

The *Guidelines* seek to harmonise the clinical practices and procedures of Memory and Cognition Clinics that assess Australians who present with the symptoms of a cognitive disorder. The *Guidelines* include best-practice Standards across 14 areas, including the pre-assessment process, clinical interview and diagnostic work-up, and post-diagnostic care. They offer an overarching view to supporting continuity of care, enhancing patient outcomes, and improving quality of life for those diagnosed with dementia and their care partners.

Accompanying the *Guidelines* is a Client Guide that outlines the functions of a Memory and Cognition Clinic. It also summarises important points from the *Guidelines*, such as how to access a clinic, recommended waiting times, what to expect before the assessment and when receiving a diagnosis, and what post-diagnostic care may include.

The Memory Clinics Initiative is currently preparing the second iteration of the *Guidelines* that will include service delivery recommendations for Australians with an intellectual disability, as well as those from a Culturally and Linguistically Diverse background. To inform this content, focus groups with

representatives from these diverse-needs groups are being conducted.

In mid-2022, the Memory Clinics Initiative commenced its *Monitoring and Quality Improvement Pilot Program* (MQIPP). A sample of Memory and Cognition Clinics from across the country are completing an online self-assessment framework and non-identifiable client case note audit to provide feedback on the extent to which the *Guidelines* are being implemented, the level of achievement of each Standard, barriers and enablers to achievement, and additional resource needs to enable greater achievement of the Standards.

Site-specific reports will be provided to each Clinic and an overarching report will be released by the Memory Clinics Initiative in early 2023. There is a view to extending this program to all Memory and Cognition Clinics, with a formal accreditation component included.

The MQIPP has been based on the MSNAP. The Australian Dementia Network acknowledges the support of MSNAP staff, particularly Professor Martin Orrell and Jemini Jethwa, for kindly assisting in the planning phase of the MQIPP and generously sharing their program resources.

For more information:

- To view the *Memory and Cognition Clinic Guidelines* and *Client Guide*, please visit [our website](#).
- For further information about the Australian Dementia Network or its Memory Clinics Initiative, please email sharon.naismith@sydney.edu.au or visit www.australiandementianetwork.org.au



Australian
Dementia Network
REGISTRY. CLINICS. TRIALS.

Strategy During Covid-19 Pandemic

Sophie Boateng-Manu, Team Leader,
Haringey Memory Service

Haringey Memory Service is based in Haringey, a borough in London. The borough is diverse, and this is reflected in the service clientele group.

As part of the post-diagnostic support, the service has a full time Admiral Nurse Dementia Navigator who works 4 days. Apart from working with carers they also run the Post-Diagnostic Intervention Groups such as the Carer and Patient Information Sessions and Tom's Club. The service also offers Cognitive Stimulation Therapy (CST) sessions and the Service User Forum.

The service recognised that patients from Greek, Cypriot and Turkish backgrounds were missing out on accessing Cognitive Stimulation Therapy after being given a diagnosis of Dementia due to language barrier. Therefore, in May and October 2021, our Admiral Nurse, Margaret Carroll and our Speech and Language Therapist, Susu Lawrence, met with Christina Kalou, the manager of the Haringey Cypriot Centre and some of her staff to provide training in running CST groups at the Centre.

The aim was to equip staff with the skills, knowledge and confidence to run CST groups for their Cypriot Centre clients who have a diagnosis of Dementia, where they can provide culturally relevant sessions, using appropriate language, music and resources that will engage their clients and be meaningful for them.

As an outcome of this training, the Cypriot Centre started running groups in October 2021, twice a week on Tuesday and Friday mornings, for a range of their clients with Dementia and cognitive impairment. Ongoing CST support and trouble-shooting advice from Haringey Memory Service was made available to the Centre. A joint working agreement is in development, with the aim of the Memory Service referring patients directly to the Cypriot Centre for CST. The service also found that during the lockdown periods, due to the COVID-19 pandemic, carers were quite isolated and there was limited scope for memory service staff to provide support due to

significant redeployment of memory service staff, both medical and non-medical to the inpatient wards. Therefore, there was limited post-diagnostic support for the carers although there were leaflets and flyers sent to help them access telephone support and attempts made to contact some on the telephone. However, the service realised more support was needed to be provided for the carers. To alleviate this, a WhatsApp group was set up for the carers where they would keep in touch with one another and often shared Zoom links for different activities, for example mindfulness and quizzes. The carers were reminded not to share any personal information. In addition, we introduced a weekly virtual carers' session via Zoom. Speakers like doctors, occupational therapists and psychologists hosted sessions and spoke about topics related to Dementia and carers' wellbeing.

After the pandemic situation improved, the service continued with virtual sessions as most carers were unable to attend sessions in person due to personal commitments. Also, many carers complained of difficulties attending in person as they were unable to find someone to look after their family member whilst they attend. This is still ongoing alongside face to face groups which allows all carers to have a choice whether to participate in person or virtually.

Dementia Active - A sustainable pro-active service-user led intervention

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Justine Harris, Occupational Therapist
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Warwickshire Memory Assessment and
Community Dementia Team

'Sky Blues in the Community' (Sky Blues) is the official charity arm of Coventry City Football Club. The aim of the organization is to:

'Increase opportunities for people to take part in a range of sports and physical activities... to improve health and wellbeing... (and) support inclusion amongst disadvantaged and underrepresented communities.'

Sky Blues collaborated with Coventry and Warwickshire Partnership Trust (CWPT) to explore how they could support individuals living with or affected by dementia in Coventry and Warwickshire. They worked with Occupational Therapists in the Trust's Memory Assessment and Community Dementia Services and asked service users and families what they would like to see in their community. Most of the feedback identified the wish to participate in an activity that would increase and improve their physical health and wellbeing.

Funding was granted through the National Lottery to help develop the programme, with staff from CWPT and Sky Blues sourcing suitable venues, developing appropriate protocols for the group and ensuring joint charity and health service staff involvement to support each session.

After just a few months the first session was held at a large city leisure centre in Coventry in May 2021 and has now expanded to areas in Nuneaton and Warwick. The groups run weekly and participants (those with dementia and their partners or carers) can self-refer directly to Sky Blues. Sessions are usually two hours and involve activities laid out in the main hall of the centre and, where possible, a side room used for refreshments, socialising and seated activities such as cards or dominoes. The groups are facilitated by Sky Blue employees and supported by Occupational Therapy CWPT staff. Sessions are loosely structured and participants choose how they wish to spend their time. Activities include, football, badminton, table tennis, archery, basketball and darts. Fundamentally the groups' focus and direction is led by the participants themselves. Whilst the Sky Blues staff provide equipment and guidance on the activities themselves, the role of the Occupational Therapy staff is to support new members, respond to any queries from carers or service users, signpost to appropriate services and provide resource materials or advise on the adaptation of an activity. They will also fetch the ball, keep score, make up the numbers on the court or serve the tea.

We asked participants what they thought about the groups and what motivated them to come. Here are their voices:

"I absolutely love it; I've been coming since it started. I enjoy the activities, making friends and socializing. It helps to bring you out of yourself... I come home buzzing from it."

"It takes the stress out of my dementia - your brain is working when you're doing something."

"The social aspect is as important as the activities - you can come and go as you please."

"I come to talk to the carers - you can't talk to your family very much, it's nice to talk to someone who understands what you are dealing with."

"All the supporting staff are amazing, I feel I can approach them about any concerns or problems, sometimes I have just needed to be pointed in the right direction and they have been there to help me."

"It's my lifeline for my week ahead, I can be myself and chat with others who are in the same situation as me caring for their loved ones with dementia."

Dementia Active it is an ever-evolving programme that is continuing to grow and develop, helping benefit many residents throughout Coventry and Warwickshire and improving many lives through participation in physical activity. It is a demonstration of the effectiveness of joint working in the community for sustainable service user-led services that focus on activity, friendship and for many in the group, the love of the beautiful game.

The neuropsychological impact of vitamin B12 deficiency and its relevance to assessment of suspected dementia

Claire Rowley, Assistant Psychologist and **Dr Julia Cook**, Consultant Clinical Neuropsychologist, Early Intervention in Dementia Service, Worcestershire

B12 deficiency is common in older people, affecting 10-15% of people over the age of 60 (Baik & Russell, 1999), primarily due to malabsorption in addition to increasing prevalence of pernicious

anemia with advancing age (Wong, 2015). B12 deficiency is well known to cause cognitive impairment, with gradual course and progression. Cognitive domains affected include language, verbal fluency (Eastley et al., 2000), praxis (McCracken et al., 2006), visuospatial skills (Riggs et al., 1996) and elements of episodic memory (Silva et al., 2013), mimicking Alzheimer's disease. In addition, mood disturbance and neurological symptoms can arise (e.g. Goebels and Soyka, 2000). These changes may occur over a course of 6 months or more and are sufficient to affect activities of daily living; therefore mimicking the trajectory of dementia. Whilst b12 deficiency and its treatment are not specifically mentioned in NICE (2018) guidance for dementia, people with suspected early dementia are routinely screened for b12 deficiency as a reversible cause of cognitive impairment in primary care, prior to referral to dementia assessment services.

NICE (2022) guidance on anaemia define a cut-off for b12 deficiency as 148 pmol/L, noting that this is "sensitive enough to diagnose 96% of people with vitamin b12 deficiency". However, due to recent issues with laboratory testing accuracy of b12, some areas of the country are accepting 83-132 pmol/L as an acceptable 'indeterminant' range, classing <83 pmol/L as the range for deficiency. This functions to reduce the risk of false positive identification of b12 deficiency (i.e., falsely identifying b12 deficiency in someone who doesn't have it). However, this is likely to significantly increase the risk of false negatives (i.e., not identifying someone who does have b12 deficiency). This change is potentially problematic for dementia assessment services.

B12 is particularly important in the synthesis of myelin in the central nervous system. B12 deficiency contributes to elevated concentrations of homocysteine. When elevated, this amino acid has a toxic effect on cells, targeting NMDA receptors in neuronal tissue (e.g., Boldyrev, 2009) and increasing the risk of adverse cardiovascular outcomes (Perla-Kajan, 2007). In addition, raised plasma homocysteine is associated with the rate of medial temporal lobe atrophy in people with Alzheimer's Disease (AD; Clarke et al., 1998) and is associated with increased CSF phosphorylated tau (a protein involved in the development of neurofibrillary tangles in AD; Obeid et al., 2007). An international consensus statement concluded that elevated homocysteine (of which b12 deficiency is a significant contributory factor) is a modifiable risk factor for development of cognitive decline and dementia (including

Alzheimer's disease) in older people (e.g., Smith et al., 2018; Douaud et al., 2013).

Changes to the reference range have significant implications for dementia assessment services. Lowered acceptability thresholds therefore have potential to increase diagnostic uncertainty (i.e., giving the appearance of a cognitive condition which is more severe than it is) and therefore may increase time to diagnosis and/or result in false positive identification of dementia.

Early identification of b12 deficiency is therefore not only critical to reducing diagnostic uncertainty in dementia assessment services and the risk of false positive dementia diagnoses; it is also pivotal to reducing dementia risk at a public health level. We are currently undertaking a literature review and prospective audit to support our dementia assessment pathways to identify appropriate biochemical thresholds for acceptance for assessment of suspected dementia and look forward to disseminating this widely.

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Reflections of upskilling a community service in Cognitive Stimulation Therapy

Megan Thomas, Assistant Psychologist,
Harrow Memory Service

Spector et al (2018) suggested that research was needed into ways of teaching care staff to deliver Cognitive Stimulation Therapy (CST). I will discuss and reflect upon my experience of upskilling staff in a community outreach service in CST informed group work. The aim of the collaborative work was to increase accessibility of post diagnostic psychosocial input for individuals with a diagnosis of dementia in the London Borough of Harrow, consistent with MSNAP's sustainability principals. We sought to provide this by supporting third sector organisations to build their knowledge and skills in person centred care and in offering CST. Harrow Carers, a highly valued local charity, was awarded short term commissioning to fund a CST informed treatment course for people with dementia and a concurrent carer support group. We worked in partnership with them to support their skills development, and to evaluate their course with a view to enable continued funding for this much needed resource.

CST comprises of 14 weekly sessions surrounding different topics or themes. However, the group in question was provided in collaboration with Harrow Carers for 7 weeks, alongside their carers' group. Feedback was assessed through the use of a questionnaire addressed to group attendees and carers at the end of the 7 weeks.

The purpose of CST is to encourage fresh ideas and associations, stimulate thinking and increase confidence in people diagnosed with dementia. CST principals are in line with suggestions made by Kitwood (1997) of person-centred care in Dementia. These principals helped shape our practice and approach to facilitating the group over the 7 sessions. This included gathering biographical information in order to tailor sessions to those attending, using reminiscence through stimuli (pictures, sounds), consistency, valuing each person in the group, and an

emphasis on opinion over facts.

Firstly, we arranged screening telephone appointments, in order to gather autobiographical information regarding the service users. We used this autobiographical information to shape our sessions, and add a person-centred approach which was inclusive of people's culture, interests and background. This encouraged discussion within the group, and helped participants to get to know each other. We also gained an understanding of each person's presentation relating to their disability, this was to ensure inclusivity and accessibility of tasks. We decided to develop a more functional/ activity-based session in order to include and meet the needs of a group attendee who presented with expressive aphasia. It was important for us to develop a session which could involve a discussion around art to inspire some new ideas, as well as create a piece of art- and therefore remove any anxieties regarding producing words and discussion.

This is an important aspect of CST, and upon reflection it is important that (with consent of the service user), referrals include additional information relating to biographical details, or that staff at Harrow carers use a similar screening approach before commencing their group work. However, I'm aware that limited resources may impact upon a service's ability to gather this information and tailor groups with enough time in advance.

We used varied stimuli including pictures, sounds and music during sessions. This was a useful way of encouraging conversation and provoking new ideas. Our first group was related to orientation, and included pictures of the local area and landmarks, as well as pictures of countries that service users were born in. Service users were able to discuss the names and locations and knowledge they held of certain buildings and landmarks. During the faces of the world session, we decided to use pictures of some familiar faces (famous singers, politicians, actors), as well as unfamiliar faces (National Geographic- faces of the world). Service users were able to discuss how they recognised the familiar faces, how they knew of the person, and were able to discuss some things they found interesting regarding the unfamiliar faces. We also used this as an opportunity to discuss any similarities and differences between the familiar and unfamiliar faces.

Ongoing feedback was provided to Harrow Carers staff to scaffold development of skills and this was formalised in feedback to all staff once the sessions were concluded.

A common reflection throughout the process was that there was a need to reemphasise the CST principal of 'opinions over facts' and to promote the use of open ended, rather than closed questions (i.e. "who is this in the picture?" compared to "what do you think of this person?"). We normalised this for those developing CST skills, as there can be natural tendency to offer others assistance and prompts during conversation, and to guide service users to correct answers to avoid any embarrassment. However, there was opportunity to reflect with facilitators about the value of expanding on ideas by eliciting opinion, so that they can support their service users to engage in novel thought, provide creative responses, and expand in further exploration in conversation. Service users themselves remarked on the inhibitory impact of closed questions, and described how they valued a more exploratory approach. Interestingly, carers also highlighted the importance of more open-ended questions, and in doing so demonstrated acquisition of CST ideas. Upon feedback to staff, it was advised that they think of more open-ended questions, for example similarities and differences, preferences and comparisons to encourage discussion.

Feedback provided by the service users and carers indicated that attendees enjoyed the groups, as it provided them with the opportunity of meaningful company and to talk and learn about other people with difficulties similar to their own. Attendees also appreciated the 1:1 support that was offered to those who needed it in the group setting, and carers reported to value the support received and the increased specialist CST knowledge they acquired. Carers fed back that their loved ones would be more likely to attend a similar group in future based on their positive experiences. Also, Harrow Carers fed back how they valued the support and reported to feel more skilled in the delivery of CST.

Upon beginning the group, I was quite apprehensive of how things would turn out throughout the weekly sessions. I had anxieties that group attendees wouldn't enjoy themselves, or find activities dull. However, upon reflection I realised that pleasing every single person, every single week would be a difficult task, and I came to accept that some people would enjoy some

tasks, and others would enjoy other types of tasks. I came to understand that the priority was to be inclusive in terms of organising weekly sessions, and consider service users' needs from a neuropsychological perspective. Observing service users' becoming more confident, conversing more openly and expressing their personality and humour throughout the weeks, was a particular highlight I had at the end of the group. It was very heart-warming to watch attendees' bond and build friendships with each other. I also found the group very beneficial in terms of building my own confidence with leading in group work, and collaborative working with a third sector organisation.

This experience demonstrates that third sector services are able to offer effective and meaningful CST-informed activities that can bolster local psychosocial intervention. Memory Services hold a wealth of expertise to understand an individual's unique neuro/biopsychosocial formulation so as to promote selfhood, and clearly have a role in upskilling community groups to increase access to psychosocial intervention by modelling and offering consultation. The experience also suggests that Memory Services should advocate for commissioning to ensure retention of core evidence based psychosocial intervention including CST, to ensure quality, to prevent dilution of standardised practice and to uphold key principals of person-centred care.

Acknowledgements – Service users, carers, Sara Martins, Brigit Bergin and colleagues at Harrow Carers

Young Onset Dementia in the Early Intervention Dementia Service: a service review of referral and outcome data

Emma Bick, Assistant Psychologist and **Dr Joanne Martin**, Clinical Psychologist, Early Intervention in Dementia Service, Worcestershire

A project reviewed referral and dementia diagnosis data for the Worcestershire Early Intervention Dementia Service (EIDS). The

aim was to compare the referral and diagnostic data for people with Young Onset Dementia (YOD) with that for people aged 65 and over. YOD is a term used when people develop dementia before the age of 65, as such we will refer to people aged 64 and under as younger people in this article.

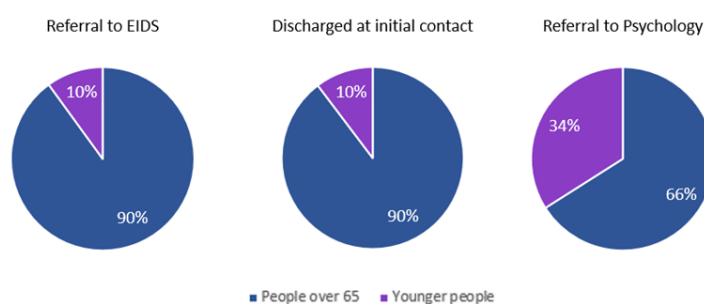
EIDS is one of the dementia pathways in a community NHS Trust. EIDS focusses on assessment for possible early stages of dementia in people of any age who have insight and are wanting to know for themselves whether they may have dementia. People who present later to services with more moderate presentations of cognitive changes or who have significantly reduced insight are seen for assessment by another Worcestershire dementia pathway. EIDS data was collected from a combination of paper records from 2012 to 2016 and an electronic record system, Carenotes, from 2016 onwards. One of the largest limitations of this project has been inconsistencies in data storage and reporting. The EIDS referral data reported is based on the full data set of everyone referred to the team (excluding the financial years 2018 to 2020 when there was a significant change in service criteria, and when referrals were impacted by the COVID-19 pandemic). The diagnostic outcome analysis is based on a sub-set of service users where we were able to accurately align age and outcome data, and comparison years of 2017 and 2021 were chosen.

The proportion of referrals to EIDS for younger people was fairly static over time with an average referral rate of 10% between years 2012 and 2022 (excluding the years affected by the service criteria change and Covid-19). This is consistent with the estimate that 7.5% of individuals diagnosed with dementia in the UK are living with YOD (Dementia UK, 2022a).

After referral to EIDS, the first team contact with people is initially focused on pre-assessment counselling (PAC). After PAC some people choose not to continue with the

assessment process. As can be seen in Figure 1, the proportion of younger people out of those who were discharged after their initial contact with the team was very similar to the proportion of younger people being referred to the team. This indicates similar proportions of younger people to those over 65 choosing to continue with assessment after PAC.

Figure 1



Looking at the reasons why people did not continue with the assessment after PAC (see Table 1) there were differences between younger people and those over 65. The primary reason for younger people to be discharged after PAC was that there was no evidence of dementia detected. In contrast, for individuals over 65 the most common reason for discharge after PAC was that they were not consenting to further assessment. For individuals over 65 other reasons for discharge after PAC were mostly related to physical health issues, with other physical health issues being more of a priority at that time or there being possible reversible causes of cognitive changes linked to physical health to be addressed prior to an assessment for dementia. For younger people the other reasons for discharge after PAC were more related to mental health issues being a priority at that time, with more referrals onto other services to help people receive the support they need to optimise their mental health. This would align with the most common alternative explanations for cognitive change found in younger people, such as stress and mental health problems (O'Malley et al., 2021).

Table 1

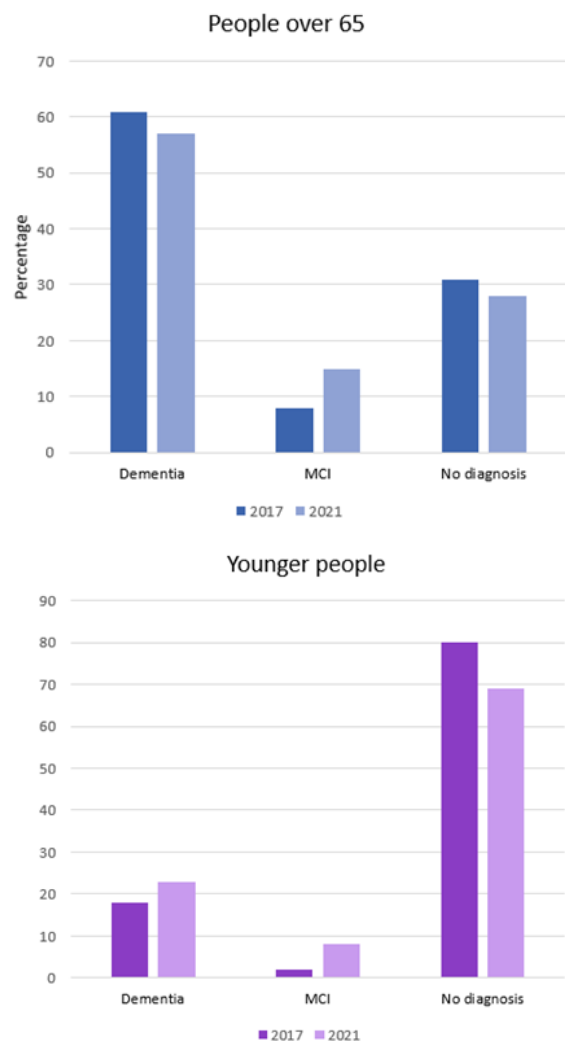
Reason for discharge after initial contact	Younger people (n=68)	People Over 65 (594)
Concerned about implications of diagnosis	0.0%	0.8%
Deceased	0.0%	0.5%
Did not meet service criteria	1.5%	2.2%
Hospitalised	0.0%	2.9%
Moved out of area	1.5%	1.0%
No evidence of dementia detected	48.5%	22.1%
Not consenting to further assessment	25.0%	59.8%
Transferred to another team	1.5%	0.3%
Other	22.1%	10.4%

For those who continue with the EIDS assessment process this involves a detailed clinical history, gathering of collateral information where possible with consent, followed by cognitive testing usually with the Addenbrookes Cognitive Examination (ACE-III). When indicated there may be additional investigations, such as structural brain scans, Occupational Therapy (OT) functional assessments and more detailed neuropsychological assessment. Across the data 34% of the referrals to EIDS Psychology for neuropsychological assessment are for younger people (see Figure 1). This demonstrates that a much higher proportion of younger people are referred for more detailed assessments, which infers increased complexity reflecting the multiple factors and differentials to consider for younger adults (Rosser et al., 2010; O'Malley et al., 2021).

The diagnostic outcome data for people completing the EIDS assessment is shown in Figure 2, comparing the years 2017 to 2021. For younger people there was an increase in the percentage who received a diagnosis of dementia, and an increase in the percentage

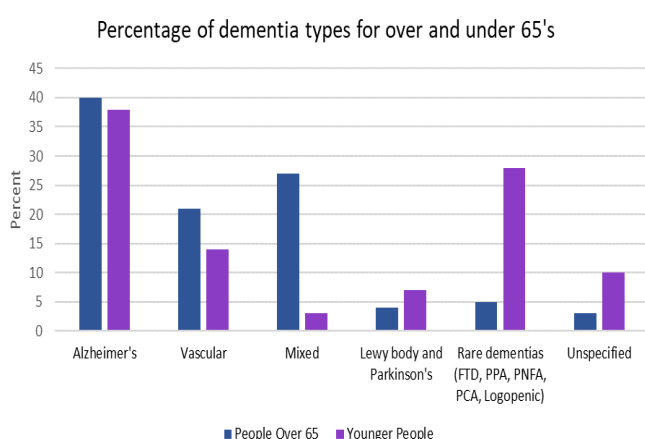
receiving MCI outcomes from 2017 to 2021. The association between assessment outcome and year for younger people was statistically significant with a small effect size (using Fishers exact due to the small sample size not meeting the assumptions for Chi-square). The increase in dementia diagnoses for younger people between 2017 and 2022, suggests as a team we are now making more YOD diagnoses than before. There have been many service developments between these timeframes that are likely to have influenced the higher diagnostic rate for younger people including: upskilling of the team; more OT functional assessments; more neuropsychological assessments; increased access to functional brain imaging particularly CT-PET scans; and in a small number of cases where indicated conducting repeat assessments a year later.

Figure 2



centage of different dementia subtype diagnoses in our EIDS dataset (see Figure 3) is consistent with national figures for dementia subtypes (Prince et al., 2014). For people over 65 the most common dementia subtypes diagnosed by EIDS are Alzheimer’s disease (AD), vascular dementia and mixed dementia (usually AD and vascular dementia). For younger people the most common dementia subtype is AD but more often the frontoparietal variant of AD. Also consistent with national figures (Dementia UK, 2022b), rarer dementias were diagnosed more often for younger people in our data set.

Figure 3



Overall, this project has demonstrated that we are seeing relatively consistent levels of referrals for suspected dementia for younger people but an increase in dementia diagnoses and MCI outcomes for younger people assessed by EIDS over time. This increase is likely to be due to service developments including upskilling the team and greater use of a range of more specialist assessments. We plan to investigate this further by auditing the range of specialist assessments completed in EIDS with younger people, and continuing to monitor referral rates and YOD diagnostic outcomes over time.

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Expanding our Dementia Advisory Service - what this means for people diagnosed with dementia and their carers

Karen White, *Dementia Services Development Coordinator/Young Onset Dementia Adviser, Bracknell Memory Clinic*

Recently our NHS Trust changed the Memory Services pathway. People are now discharged, once stable on medication, to the care of their GP. We knew this could be a difficult time for people. The pandemic also brought further challenges. We therefore looked at ways people could continue to have the support they needed.



Our Memory Service is part of a wider Community Mental Health Team for Older Adults (CMHTOA). As a multi-disciplinary team, which includes the Dementia Advisory (D/A) Service, we are able to offer ongoing support to people who have a diagnosis of dementia, even after discharge from the

Memory Service. Knowing that after discharge, people would continue to be supported was reassuring, however we were aware this would increase workload on other teams. Being aware that the D/A service would have an increase in demand, temporary funding was granted for a part-time Dementia Adviser Assistant to join the full-time Dementia Adviser and part-time young-onset Dementia Adviser. This has meant that a more proactive, responsive and empowering service is delivered. Regular support is provided to over 300 people which has enabled a seamless transition from Memory Service discharge to Dementia Adviser support. As the D/A service offers regular reviews there is early identification of any issues/concerns. Timely advice is offered and ongoing referrals for increased level of support can be implemented promptly. The D/A service is able to access advice from our Memory Service as well as the wider CMHTOA. This not only reduces any potential crisis situations, it reduces wait



times for support and also reduces inappropriate referrals within CMHTOA. Having additional resources through the D/A Service has meant further initiatives can be implemented. For example, it was identified through a Carers Focus Group, that there was a shortage of social groups for people to attend. Therefore the D/A Service, in conjunction with people with dementia and their carers, set up a weekly peer support group. This group has gone from strength to strength. People who attend have provided excellent feedback on the sessions. They have mentioned how valuable they have found meeting up face to face with others and hearing from, other organisations who are invited along to the group. There are regular new attendees and lots of friendships have developed. For example two men with dementia met up at the group for the first time since they left school. They instantly recognised each other and rekindled their friendship.



By working together with our partner teams and organisations, people with dementia and their carers continue to have a good quality service. Joined-up working makes more things possible and keeps people we support at the heart of everything we do.

Have you signed up to Knowledge Hub?

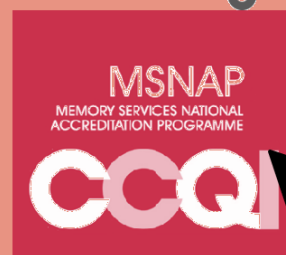
MSNAP has launched an online discussion platform for it's members, in place of the current Memory Chat.

Knowledge Hub allows members to:

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

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

Knowledgehub



MSNAP You Said, We Did!

We collect feedback from our members on a regular basis through feedback surveys. This page highlights some of the suggestions and what we've done to address these!

You said...

MSNAP full-day events could be reduced into more bitesize sessions to enable more staff to attend, if it's difficult to take out a whole day.

We did...

MSNAP decided to have a series of 1 hour webinars throughout 2022. The series included talks on:

- Memory Services & Social Care
- Young Onset Dementia
- APPLE-Tree Study
- Emergency Care Plans
- Lewy Body Dementia
- Frontotemporal Dementia

Recordings are also available on demand on Knowledge Hub!

You said...

MSNAP peer reviews should return to face-to-face rather than only being virtual.

We did...

MSNAP have transitioned back to offering face-to-face reviews. However, we have enabled members to make a choice of whether they would prefer to opt for a virtual review, which we will accommodate.

You said...

MSNAP peer reviews can be quite stressful due to the number of standards that need to be covered on the day, which leaves less time for discussion of the aspirational standards.

We did...

MSNAP went through a standards revision process. This has reduced the number of standards significantly, which will reduce the pressure on review days.

MSNAP is always seeking feedback to make further improvements. If you have any suggestions, please email us at MSNAP@rcpsych.ac.uk

MSNAP Highlights from 2022!

MSNAP 13th National Forum for Memory Service



Tuesday 11 October 2022



10:00—16:00



Online (Zoom)

In October, we hosted our 13th MSNAP Forum and we were so pleased to see so many of you there.

It was a fantastic day of speakers and presentations covering topics such as the ADAPT study, MSNAP Member Service Case Studies and Using GPS Trackers in Dementia patients to improve quality of life. You can access a recording of the event on [Knowledge Hub!](#)

MSNAP Webinar Series 2022

This year we hosted a number of webinars focusing on a range of topics that would be of most interest and benefit to our members.

Our webinars covered:



Emergency Care Plans



Lewy Body Dementia



Rare Dementia Subtypes



Frontotemporal Dementia

The recordings of each webinar are available on [Knowledge Hub](#).

Upcoming MSNAP Initiatives in 2023

MSNAP Peer Reviewer Training



Wednesday 15 March 2023



09:30—11:30



Online (MS Teams)

Peer-reviewer training is a free event for staff that are from an MSNAP member service. The training is a great learning experience for those who are interested in participating in peer-reviews.

We strongly encourage individuals organising and reviewing other services to attend this training.

To register your place, or to find out about future peer reviewer training dates, please [email us](#).

Save the date! MSNAP Special Interest Day



Tuesday 21 March 2023



10:00—16:00



Online (MS Teams)

More information about this event,

MSNAP Webinar Series 2023



Introducing the new MSNAP standards, 28 February 2023.

We are currently working on a schedule of webinars for 2023 and will share information about the upcoming topics soon!

If you would like to present a webinar, please get in touch with us!

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](#)

Twitter

Follow us: **@rcpsych**

@rcpsychCCQI

And use **#MSNAP** for up-to-date information

Royal College of Psychiatrists' Centre for Quality for Improvement

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