Sheffield Health and Social Care NHS
NHS Foundation Trust

NHS
South Yorkshire
Integrated Care Board

DEMENTIA PROTOCOL UPDATED October 2023

SHEFFIELD PRIMARY CARE AND ACUTE TRUST GUIDELINES FOR REFERRAL TO OLDER ADULT SECONDARY MENTAL HEALTH SERVICES OF PEOPLE WITH A SUSPECTED DEMENTIA

CONCERN EXPRESSED BY PATIENT AND / OR CARER OR PROFESSIONAL

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Patient seen by GP or Hospital Consultant / Liaison Psychiatry / other Clinicians e.g. Community Nursing Teams

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Has diagnosis of Dementia previously

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Yes

No / Unknown

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Assessment by GP or Hospital Consultant or Liaison Service

Assessment to include:

- Description of onset, length of history and progression and impact of daily life (include cognition, behaviour and psychological symptoms)
- Patient/carers/professional perception of problem
- Contact details of Next of Kin (interpreter needed?)
- Consider housebound – Do they require a home visit
- Past medical history
- Exclude treatable illness - *refer to GP if required*
- Review of medication to identify any *medication that may impair cognitive functioning
- Weight and Height (BMI)
- Recommended dementia blood screen (completed within previous 3 months unless there has been an acute change in presentation then repeat) may include: FBC, B12 & folate, U&Es, glucose, HbA1c, LFTs, TFTs, calcium, MSU (required if acute onset of confusion).
- CT Head Scan and ECGs are to be requested of STH alongside blood test (see dementia set on ICE) *(Only delay referral to SMS if there is a high suspicion of an alternative differential diagnosis, otherwise request and refer).* CTH request to include: *Cognitive impairment? Dementia. Please comment on degree and pattern of any atrophy (especially in medial temporal lobes) and the extent of any vascular damage.* **If referring directly to Memory Service from STH or asking GP to make an onward referral, please ensure baseline tests (bloods, CTH, ECG) have been requested prior to discharge.**
- Complete a brief cognitive screening e.g. 6CIT, AMTS or GPCOG (Requires a carer (family or close friend) to be present).
- Assess for other psychiatric illness e.g. depression (see Older Adult Mental Health protocol)
- Patient aware of, and consented to, referral. See Capacity info and Assessment form.
- Risk to self or others (Safeguarding)

If dementia is suspected

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Types of dementia - See link

Younger People with Dementia - The expectation is that younger people (<65 years old) need to be referred to STH's Neurology to receive a diagnosis of dementia (Referrals via ERS _electronic referral system). People under 65 year old with Korsakoff's should remain in AMH services.

Learning Disabilities - Adults with a diagnosis of Learning Disabilities will be assessed for dementia by Community Learning Disability Team (CLDT) and referred to Neurology (if they are under 65) and to the Memory Service (if they are 65 or over) for scans and first follow up (i.e. feedback scan result / give potential diagnosis/ can start cognitive enhancers if required). Adults >65 where there is no formal diagnosis or evidence of LD or previous contact with a CLDT will be seen by Memory Service to assess for dementia following the Greenlight Policy. See also SHSC's dementia and learning disabilities resources.

Resources to support people to live well with Dementia

- **Dementia Advice Sheffield** - a one-stop shop, first point of contact service to respond to any non-clinical dementia-related query from a person who is living with dementia (or suspected dementia) or their family carer. Call 0114 250 2875 /dementiaadvice@ageuksheffield.org.uk
- **Community dementia support** referral routes (incl. for those with suspected dementia – you can refer to these services alongside a Memory Service referral). Low/medium dementia needs: local PKW dementia groups and wellbeing calls. Higher dementia needs (e.g. you may be concerned about their ability to cope/regularly presenting at GP): Dementia Short Term Intervention Service. Dementia Day Activities.
- Sheffield Directory for local dementia support, groups and services in Sheffield.

Sheffield Carers Centre – Practical, social and emotional support for carers (Refer with consent or if this is not or if this is not possible, carer can register themselves.)

Is patient already known to a Community Mental Health Team or Sheffield Memory Service?

Yes

No

Liaise with Community Mental Health Team Professionals and Sheffield Memory Service about concerns.

Sheffield Memory Service Advice line
0114 2718585
Monday, Thursday, Friday

Between 9am – 12pm; 1pm-5pm. Closed on weekends & Bank Holidays.

Authors – Dr Shonagh Scott, Dr Karen O'Connor, Heidi Taylor (March 2017); 1st Review completed August 2020.
2nd Review October 2023: Dr Shonagh Scott (SHSC), Dr Sarah Jones & Liz Tooke (NHS SY ICB, Sheffield); Esme Blyth & Daniel Blackburn (STH)
3rd Review due: October 2028 – with option to update before this date if required.

*Referral to Older Adults Community Mental Health Services:

All referrals should be made to CMHT (sct-ctr.olderadultcmht@nhs.net), **they will triage referrals to either the Sheffield Memory Service (SMS) or their assessment and care may stay under CMHT. Please ensure referral letter contains sufficient information to support triage (see above). It is recommended (but not mandatory) that GPs use the standard referral letter template available on SystmOne and EMIS Web** (Use of the template will help reduce delays in arranging assessments, however completion of all sections may not be possible – Only delay referral to SMS if there is a high suspicion of an alternative differential diagnosis, otherwise request and refer).

Refer if at least one of the following is present:

- Completed brief cognitive screening - for example; 6CIT (≥8), AMTS (≤8) or GPCOG (pt score ≤4 or pt score 5-8 and informant score ≤3) **and** patient scores above/below cut-off (local cut off recommendations in brackets) on cognitive screening test used **or**
- Patient scores above/below cut off but requires further specialist investigation. Do not rule out dementia, especially prodromal states such as MCI, solely because the person has a normal score on a cognitive screening tool **and**
- Treatable physical and medication causes of cognitive impairment have been excluded/treated
- *Behavioural / psychological symptoms*
- *Complex / multiple problems / dual diagnosis needing specialist assessment*

ALSO TO NOTE:

- Please assess mood if appropriate using PHQ9 and GAD score
- **State clearly if concerns around safety** – e.g. self-neglect, breakdown in care situation, safety concerns either to patient or carer (also consider if referral to social services required).
- If **cognitive enhancing medication** is indicated – See shared care guideline.
- **AUDIOLOGY**– check if there has been a recent test and if not/if further testing required, refer to Audiology Cognition and Hearing service. *See info.*

Whilst referring to specialist memory services is gold standard it is **widely accepted UK practice to make a GP or Geriatrician "pragmatic" dementia diagnosis especially where patient presenting is significantly impaired with a longer history of cognitive issues.** For this group of people, cognitive enhancers are very unlikely to be helpful and the most important intervention is likely to be referring allied dementia support and social services. The Sheffield Dementia Strategy Implementation Group supports GPs and Geriatricians to make these diagnoses (e.g. with a diagnosis coded as "dementia syndrome" / "dementia unspecified"). Tools such as DiaDem can be used to support this and secondary care can be contacted to discuss if needed.

See also guidance to support diagnosis of care home patients.

Urgent referral to Community Mental Health Team Older Adults – Phone Sheffield Care Trust's 24 hour switchboard on (0114) 2716310
Southeast Community Mental Health Team – (0114) 226 3965
Southwest Community Mental Health Team – (0114) 226 3131
North Community Mental Health Team - (0114) 305 0600
West Community Mental Health Team – (0114) 226 3600

*Examples of medication that may impair cognitive functioning

- Anticholinergic medication (See link – consider prescribed and OTC)
- Diuretics – risk of electrolyte disturbance
- Benzodiazepines
- Opioids - consider prescribed / OTC / Substance misuse
- Dopaminergic medication may worsen cognitive impairment – discuss with PD specialist
- Combinations of various sedative medication

Cognitive Enhancers under Shared care & Medication Optimisation

- Primary care will be asked to prescribe under local Shared Care Protocol
- Decline of cognitive function alone should not be a reason to stop cognitive enhancers. Evidence demonstrates potential harm with substantial worsening in cognitive function upon discontinuing cholinesterase inhibitors in people with moderate Alzheimer's disease, See Shared Care Protocol for further considerations around this. Also see NICE TA217 - Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease
- Clinician should consider implication of the dementia diagnosis on other medicines compliance and patient's ability to self-medicate. Dementia diagnosis doesn't demand use of Multicompartmental dosage System (e.g. NOMAD) or liquid preparations.

Behavioural support

- Non-pharmacological support should be first line to manage challenging behaviour- See *link*
- Avoid the use of antipsychotics for Behavioural and Psychological Symptoms of Dementia (BPSD) unless the person is severely distressed or there is an immediate risk of harm to them or others (or if the patient is experiencing psychosis). See *Optimising treatment and care for people with behavioural and psychological symptoms of dementia* for pathway decision tool for antipsychotic prescribing.
- Lowest effective dose of risperidone and haloperidol (**up to 6 weeks**) could be used within its licence.
- Assess routinely and record / refer if need for longer antipsychotic treatment. NICE patient decision aid to support discussions.
- See link for further supporting information.