RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

THE OLD AGE PSYCHIATRIST

Issue 87

September 2023

Memory Assessment Services Special Issue

HELLO

Welcome to Issue 87, September 2023 Memory Assessment Service Special edition of the RCPsych Old Age Faculty Newsletter

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Cover

Memory Corner at Geriatric Memory Clinic on World Alzheimer's Day - Doha, Qatar. Commemorating four years Of Qatar's National Dementia Plan, The First National Dementia plan in any Arab Country. Read the intresting article on the development of Qatar memory services and an inspiring poem on the psychiatric history pages, 26 and 30 respectively.

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Update from the editorial team

Hello again from the Editorial Team. Hope you are all keeping safe and well.
The September 2023 edition has our usual updates. The Chair's report highlights all the current relevant issues.
The update by Dr Amanda Thompsell, the National Specialty Advisor (NSA) for Older People's Mental Health (OPMH) at NHS England/NHS Improvement and Prof Alistair Burns as always provides food for thought. Their update has always been interesting to read and kept many of us updated on what's going on across the country. We are very sad to know that we may not have articles from them going forward.

This edition is specially dedicated to Memory Services and what a variety of articles we have received which highlight the excellent work we do… of course there are things we can improve significantly and Dr Allan's article highlights recommendations we can take forward.

This edition has articles from international colleagues on how memory services work in other countries such as Qatar and Australia – both these articles make interesting reads. Locally we have articles on how joint working is essential for assessing memory in those with learning difficulty.

We also have an article on a Social enterprise and their innovative services in Brighton and Hove. Of course new treatments are all in the news and several webinars are advertised in this article. Finally but very importantly the ARUK article on patient and carer perspectives is something worth reading and thinking about.

In other Newsletter news, this is the last newsletter Anne, our current trainee editor will be involved in. Anne has been instrumental in developing the new look for the newsletter, which has been greatly applauded. Thank you Anne for all your hard work.

We welcome two new trainee Editors Dr Parker and Dr Curtis from September 2023.

The next newsletter is January 2024 so please feel free to send dedicated articles on the email below. The last date for submission is 30th November 2023.

As always let us know what you think of the newsletter, and feel free to email me c/o Kitti.Kottasz@rcpsych.ac.uk with ideas, suggestions and of course articles for the future newsletter.

Dr Sharmi Bhattacharyya
Lead Editor

View from the Chair

Dr M S Krishnan (Krish)
Chair of the Faculty of Old Age Psychiatry

@deliriumkrish

Dear colleague,

It was also lovely to see many of our faculty members at the international congress in Liverpool.

Our PsychStar Dominic presented his poster. Well done, Dominic. We look forward to supporting our next PsychStar.

This newsletter has a specific focus on memory services.

I am sure you have all received the email from me regarding our faculty initiatives on learning about new treatment that has been approved in USA.

We are trying to have view that is impartial at the same time making sure we are included in all the key decisions when in comes to regulatory reviews (NICE & MHRA) The series of workshops Bob Barber and colleagues are facilitating is to help our faculty members with updates.

We are running a webinar on 15 September on behalf of the college as a CPD session on Dementia for colleagues outside of our faculty. Please share the info to your wider network (advert on page 5).

Our trainee conference is being organized by our trainee reps as a face to face conference towards the end of this year.

As always we get excellent overview from Prof Alistair Burns and Dr Amanda Thompsell from NHS England. We note that Alistair is hoping to stand down in October we will miss his leadership and support to Old Age Psychiatry in his role and we wish him well. Amanda continues to champion older people's mental health summarized recent work including info on Outcomes.

Welcome to our trainee editors and good luck to Anne our outgoing trainee editor who has been instrumental in the design of the current format.

Newsletter Update

Professor Alistair Burns - alistair.burns@manchester.ac.uk
Dr Amanda Thompsell - amanda.thompsell@nhs.net

As Heraclitus noted some eight centuries ago, "There is nothing permanent except change!" This aphorism is particularly apt when applied to health and care strategy as the Government and the NHS struggles to deal with increasing demand and finite resources.

By the time that this goes out the DHSC's latest major consultation, relating to its "Major Conditions Strategy" launched at the end of May 2023 will have closed and we will be awaiting the outcome.

This important consultation has provided another opportunity to keep the focus on both dementia and mental health and the teams dealing with dementia and with older people's mental health has been active in responding to this consultation and rallying support for the recognition of the growing importance of these aspects of healthcare as our population ages. Thank you to everyone who has helped us with thoughts and information to feed in.

Dementia

The consultation paper on the Major Conditions Strategy recognises that the number of people in England estimated to have dementia is set to rise to almost 900,000 in 2025 and to more than 1.3 million by 2040. It seems that rather than taking a broad approach and improving all aspects of dementia care DHSC anticipates prioritising some aspects as it asks respondents to the consultation to choose three priorities from five suggested priorities relating to prevention; delaying the progression of dementia; quicker diagnosis; improving emergency care; and improving non-urgent and long-term treatment.

In other news, we are optimistic that funding will be agreed for the National Dementia Hospital Audit next year. The latest data report from this national audit is likely to have been published by the time this newsletter is read and is well worth a read.

On the question of audit, NHSE has been aware of concerns raised by clinicians concerning the auditing of Memory Assessment Services (MASs) and has fed back those concerns to be taken into account in the next such exercise..

The QOF payments for GPs around care planning for a person with dementia has been under scrutiny. The dementia team at NHSE has provided evidence of its value and hopefully the CQUIN will remain in place.

Update for the Newsletter

As part of marking this year's Dementia Action Week 2023 NHSE released a set of resources to help narrow the health inequalities gap for people living with dementia from an ethnic minority background.. These included a new NHSE and RCPsych e-learning module for health and care professionals - "Improving access, experience and outcomes for people living with dementia from ethnic minority communities" and a new NHSE and Alzheimer Europe "Intercultural dementia care guide" - for health and care professional and also a new leaflet designed for ethnic minority communities – for VCSE and faith organisations.

Dementia remains a prime focus for medical research. Three drugs, lecanemab, donanemab and remternetug show particular promise and NHSE continue to work of what would be needed to be in place to be prepared for them.

Older Adult's Mental Health

It is encouraging that the consultation paper on the Major Conditions Strategy recognises mental health as one of the "major conditions" upon which it is focused, but of some concern that it does not specifically address older people's mental health. This is something on which we at NHSE have responded to in the consultation.

It has continued to be a busy time in relation to older adults' mental health. We divide our time between contributing to the development of policy – attempting to keep it evidence-based and ensuring that the needs of older patients are taken into account – and developing and disseminating best practice guidance.

As regards policy, we have been active in ensuring that team developing guidance for implementing the outcome measures (DIALOG, ReQoL10 and GBO) for community mental health implementation guidance will include, and take account of, contributions from old age psychiatrists and older people.

Similarly, relating to the development of the so-called "Currencies" that are being developed for key conditions psychosis, neurodegenerative conditions, depression and anxiety as well as complex emotional needs, we have been instrumental in ensuring that complexity is being acknowledged and that thanks to support from Colleagues we have an Old Age Psychiatrist in each currency group.

We have also been active in increasing awareness of the need to consider older adults and people with dementia in a range of policy developments, from NHS111 services to physical health rehabilitation and intermediate care models

Update for the Newsletter

As regards best practice guidance, following on from the two webinars in the first part of this year (on peer support with older adults and on engaging and supporting older adult experts by experience with serious mental illness) there has been a webinar on how best to involve people with dementia in developing services.

These webinars, and many other resources are available on what we think is the most exciting resource development in the last few months - a slide deck bringing together useful dashboards and links to guidance /case studies /recording of webinars for both older adults mental health and dementia Core slide pack good practice for Older Adults in wider Mental Health. This information should be of use when you are thinking about your services. It covers community, complex emotional needs, eating disorders, crisis and inpatient services for older adults' mental health. With dementia the slide deck provides links to the dashboards relating to MASs and also antipsychotic prescribing .

The development of training by means of e-learning on tier 1 and tier 2 depression in older adults is progressing and is on course to be available at the end of 2023.

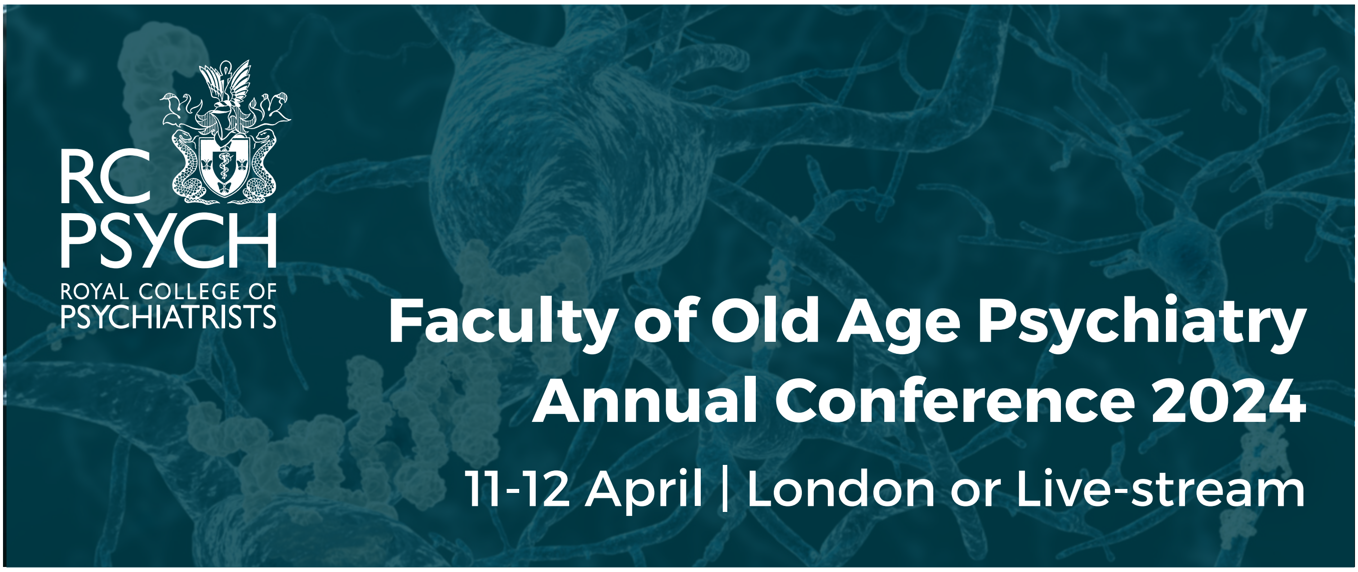
Finally I (Amanda) wanted to update you (in case you did not know already) that NHSE is undergoing a massive restructuring involving 30% loss of staff. At the time of writing it is uncertain whether there will remain any provision for a national speciality adviser on older people's mental health (my, Amanda's, current role) and this may be my last summary. I do however want to thank you all for being so supportive and also for doing the polls at the Faculty Conference as they really made a difference.

I (Alistair) will aim to stand down from my position as National Clinical director at the end of October 2023.As far as we know, advertising for a replacement will take place.

Whilst change is stressful it also presents unique opportunities, and it is important that services seize any that come along. We are optimistic that there is an increasing realisation that older people have specific needs that services need to be able to meet as evidenced for example, in the Chief Medical Officer's Annual Report being focused on our ageing population.

We also firmly believe that the more we can support older adults themselves to speak up the more likely we will be to get the change we wish for for older adults.

As always, we would be happy to hear your views and thoughts on national developments so please do not hesitate to contact us.



How can we develop UK Memory services?

Charlotte L. Allan MRCPsych, MD (Res)
Consultant Old Age Psychiatrist
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Current challenges for memory clinics

Memory Services in the UK were set up to identify, diagnose and treat dementia, and to support integration with research (Passmore & Craig, 2004; Mehrani & Sachdev, 2022; Luce et al, 2001). Service models have evolved over the past two decades, but continue to centre on: individualised, holistic assessments; a multi-disciplinary approach; close links with community mental health and third sector services; and a commitment to education and training.

The **purpose** of memory clinics is to provide:

- consistent high standards of assessment and diagnosis for patients with suspected dementia
- specialist assessment and advice for patients with mild cognitive symptoms who are at risk of dementia i.e. diagnose early
- initial management and signposting to long-term support
- opportunity to participate in dementia research.

Referral rates to memory services are rising, with time to first assessment over 17 weeks in England and Wales (Royal College of Psychiatrists, 2022). This trend has occurred due to multiple factors. First, population ageing has caused an increasing proportion of adults in at-risk age categories for dementia. Second, increased awareness of dementia and the treatment options available, means that more people are seeking a diagnosis. Third, the impact of the Covid-19 pandemic and its aftermath, coupled with increased patient complexity, has slowed flow through services (Royal College of Psychiatrists, 2022).

The **key challenges** now facing memory clinics are:

- longer waiting times for assessment and diagnosis
- delays in neuroimaging acquisition and reporting
- pressures resulting from clinical documentation requirements
- staff shortages
- lack of availability of specialist investigations (e.g. genetic testing or lumbar puncture).

These elements have exacerbated variations in practice (Cook et al, 2019), and have caused clinicians to review the model of service provision.

Future challenges for memory clinics

If memory clinics are to continue providing safe, high-quality and timely services, they need to ensure they can meet the demands of rising referral rates and increased complexity, build capability to deliver new treatments for dementia, and retain a competitive advantage, in the face of competition from artificial intelligence technology or private investment.

To achieve this will require implementation of efficient, evidence-based pathways, that are not hampered by bureaucracy (NICE, 2018). Investigations need to make use of neuroimaging, neuropsychology and biomarker assessment to manage the increasing complexity of patients who may present at an earlier stage where dementia symptoms are not fully established (Cooke, 2019; Griffanti et al, 2022). Staffing shortages across professional groups will continue to threaten productivity. Thus, ensuring recruitment and retention is vital, and appraising the long-term impact of hybrid working on individuals and teams needs to be considered. This can be promoted through considering autonomy, belonging and competence, at both individual and team levels (West & Coia, 2019).

Approaches to improvement

There will never be one single approach to memory service provision, but there are many models of good practice that can be considered.

1.. Increasing service capacity to meet increased referral rates and complexity

Memory services should consider streamlining pathways for straightforward or complex patients, and monitoring appropriateness of neuroimaging (Cook et al, 2019). Some clinics continue to utilise remote assessment using digital technology to increase capacity for clinical assessment and care (Owens et al, 2020).

At Newcastle Memory Assessment and Management Service we have increased service capacity through:

- Developing more efficient models of care with a fast-track pathway for patients suitable for same day assessment and diagnosis, and a complex care pathway for patients who require more detailed assessment to aid accurate diagnosis.
- Increasing service capacity by training non-medical prescribers to deliver a dementia diagnosis, leading to 30% increase in diagnostic appointments offered.
- Reducing clinical documentation requirements and encouraging clinicians to document in accordance with professional record keeping standards (GMC, n.d.; NMC, 2021). Digital enablers have further increased administration efficiencies.
- Judicious use of neuroimaging; access to viewing images via PACS; collaborations with radiology

2. Build capability to deliver new treatments for dementia

'Brain Health Clinic' models have been proposed which closely integrate research and clinical practice. These support clinical pathways to enable earlier diagnosis, whilst undertaking high-quality assessments that align with the UK Biobank (Griffanti et al, 2022). These approaches integrate clinical and research approaches, enhancing patient care and research participation. A further advantage is that they develop systems, and staff skills to enhance memory clinic readiness to deliver new treatments alongside detailed investigation and monitoring requirements.

3. Retain a competitive advantage

For memory services across the country to retain a competitive advantage, it is not sufficient to deliver 'more of the same'. Innovation and development needs to be embedded within memory clinic structures. This may include digital approaches to assessment and diagnosis, collaborations with geriatricians and neurologists, building relationships with GPs, pivotal roles in research studies, education and training or activity to enhance staff wellbeing, dependent on local priorities.

Conclusion and recommendations

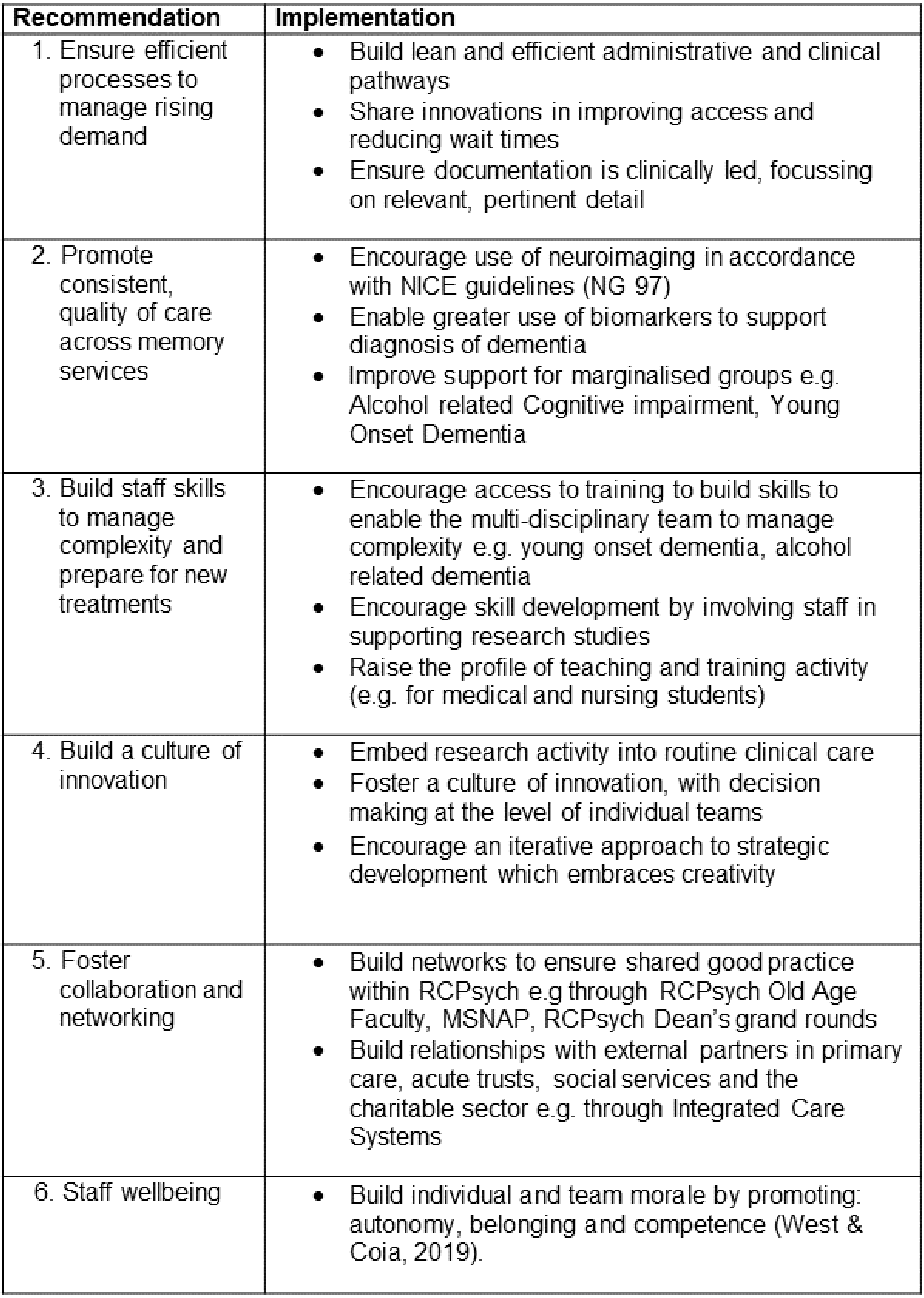
The main driver for modernising memory clinics should be through considering which model offers the best value for patients. Value for patients equates to the level of quality and service offered, in relation to cost.

To provide value for patients, UK memory clinics should strive to:

- Diagnose accurately to consistent high standards
- Offer early diagnosis and intervention
- Address inequalities in access to diagnosis and treatment
- Embed research in clinical practice
- Encourage innovation e.g. digital approaches and being ready for new treatments

Implementing this approach will require a detailed assessment based on evidence-based guidelines, use of supporting investigations, a menu of treatment options, and an approach underpinned by kindness and compassion (Jethwa et al., 2022; NICE, 2018). Services will be enhanced by offering access to research and novel treatments, and by considering the recommendations in Table 1. These recommendations seek to involve patients and carers in service innovation, build expertise in managing complexity by collaboration, and to increase access to research participation.

References are available on request



Recommendation	Implementation
1. Ensure efficient processes to manage rising demand	• Build lean and efficient administrative and clinical pathways • Share innovations in improving access and reducing wait times • Ensure documentation is clinically led, focussing on relevant, pertinent detail
2. Promote consistent, quality of care across memory services	• Encourage use of neuroimaging in accordance with NICE guidelines (NG 97) • Enable greater use of biomarkers to support diagnosis of dementia • Improve support for marginalised groups e.g. Alcohol related Cognitive impairment, Young Onset Dementia
3. Build staff skills to manage complexity and prepare for new treatments	• Encourage access to training to build skills to enable the multi-disciplinary team to manage complexity e.g. young onset dementia, alcohol related dementia • Encourage skill development by involving staff in supporting research studies • Raise the profile of teaching and training activity (e.g. for medical and nursing students)
4. Build a culture of innovation	• Embed research activity into routine clinical care • Foster a culture of innovation, with decision making at the level of individual teams • Encourage an iterative approach to strategic development which embraces creativity
5. Foster collaboration and networking	• Build networks to ensure shared good practice within RCPsych e.g through RCPsych Old Age Faculty, MSNAP, RCPsych Dean's grand rounds • Build relationships with external partners in primary care, acute trusts, social services and the charitable sector e.g. through Integrated Care Systems
6. Staff wellbeing	• Build individual and team morale by promoting: autonomy, belonging and competence (West & Coia, 2019).

Table 1. Recommendations for development of UK Memory Services

Memory Services National Accreditation Programme (MSNAP)

Jemini Jethwa, MSNAP Programme Manager
Sujoy Mukherjee, Chair of MSNAP Accreditation Committee and Old Age Consultant Psychiatrist

Who we are and what we do

In 2009, The Royal College of Psychiatrist's College Centre for Quality Improvement (CCQI) launched the Memory Services National Accreditation Programme (MSNAP) and is now one of just under 30 networks within the CCQI. This is a not-for-profit accreditation programme aiming to improve assessment, diagnosis and care for people with dementia and their carers. This includes timely and equal access to services, provision of evidence-based treatments, monitoring and follow-up.

On MSNAP, our key objectives are to help memory services to evaluate themselves against agreed standards, award accreditation to services that meet the required level of performance, support local clinical and service improvement in line with the standards and to enable sharing good practice across services. To our knowledge, we are not aware of any other national accreditation programme of this magnitude anywhere else in the world. This provides MSNAP with a unique stance in it's ability to support international memory clinics in their quality of care and treatment to patients and carers.

Services that are awarded accreditation can assure patients, carers, frontline staff, commissioners, managers and regulators that their memory service is of a good quality and that staff are committed to improving care. Accreditation also rewards hardworking memory service staff for their efforts, raises morale and the profile of the team within the wider organisation.

Our standards

The MSNAP standards have been produced to underwrite the self and peer review processes. These standards have been developed from a literature review and in consultation with stakeholder groups. Care has been taken to include information from a wide range of sources and to take into account the views of memory service staff, people with dementia and carers. The standards are subject to regular review to account for new developments. Memory services differ widely in their organisation, funding, staffing and levels of service, even within the same Trust. The standards are therefore focused on 'function', rather than any particular model of service delivery. The standards cover the processes of assessment, diagnosis, pharmacological treatment and psychosocial interventions.

Types of MSNAP membership

Accreditation: Designed for services which are already meeting the majority of MSNAP standards and can demonstrate that they are meeting the required thresholds for accreditation.

Developmental: A starting point membership for all services that are new to MSNAP, or for services that are still working towards meeting the sufficient thresholds for accreditation. This membership option is also open to international memory services.

Affiliate: For memory services that are not ready to undergo the MSNPA peer review process but have plans to in the near future. Services will gain access to all membership benefits including events, publications, networking opportunities and support from peers.

The peer review assessment process

The peer review process starts with a self-review assessment over a period of 12 weeks. This is an opportunity for memory services to rate themselves against the MSNAP standards, stating whether they think they meet the standard or not. This assessment also includes a brief audit of case notes and online questionnaires to be completed by staff, referrers, patients and their carers.

A review team made up of at least two memory service professionals from other MSNAP member services, a patient or carer representative and a member of the central MSNAP team will then visit a service to discuss and validate their self-review data. The data collected from both the self- and peer review will then be used to write a comprehensive local report. The report will highlight the service's achievements and outline any changes that need to be made in order to meet any unmet standards.

For teams that wish to be awarded accreditation, their report and further evidence will be presented to the MSNAP Accreditation Committee, who will review the evidence and make decisions relating to accreditation. If awarded accreditation, this award will last for a period of three years. Teams are given time, guidance and support to reach accreditation by both the Accreditation Committee and MSNAP team.

Working with patients and carers

The CCQI strongly advocate for the involvement and engagement of people with lived experience in all Quality Networks or Accreditation Programmes. MSNAP is lucky enough to have six representatives with lived experiences that feed into the work of the programme. This includes two patient representatives and four carer representatives. All MSNAP peer review visits aim to have a lived experience representative attending, as well as Accreditation Committee and Advisory Group meetings. Our standards are developed in close collaboration with our representatives as well as our data collection tools, such as our patient and carer questionnaires.

The national picture

Since it's inception, MSNAP has been collecting and reviewing data on average waiting times between referral and assessment. Since 2009, on average there were 39 days between referral and assessment. This dropped significantly in 2017 to 33 days on average, however our most recent data from 2023 demonstrates that this is on the rise again to 40 days on average, which is the highest it has been thus far. In addition, we are also seeing a significant rise in new admissions received per week, which has been rising since 2009 from 33 new admissions, to 76 new admissions as of this year. Finally, we have seen a small increase in the average number of staff within memory service teams, which began at an average of 13 members in 2009 and is now on average, 20 members of staff. Given the increasing number of new admissions, the increase in staff does not appear to appropriately match the needs of these teams and therefore this is creating a stressful situation for many services.

Summary

MSNAP is designed to support services to improve the quality of care provided to patients and their carers. Membership to our programme is not just open to UK providers, but also internationally. We have been supporting Australia who is developing their own national programme and we have recently presented our work at the International Psychogeriatric Association congress. We would welcome the opportunity to learn about services in other nations and how we may be able to work together to improve the standards of care within memory services globally.

In addition, MSNAP is keen to review evolving new treatment scenarios, considering the impact of this and ensuring our standards and processes are up-to-date in line with best practice, key literature and guidance.

How can you get involved?

We would welcome any service that is interested in becoming a member of MSNAP to get in touch with us. In addition, we hold several training sessions a year which is free for all staff within our member services to attend. We would encourage any old age psychiatrists that have not yet completed the training, to attend and qualify as a peer reviewer to gain insight into how other memory services are operating. Information about our upcoming events and training are on our website.

For more information about the programme, please access our **website** or contact us on **MSNAP@rcpsych.ac.uk.**

Dementia Diagnosis in Intellectual Disability – an innovative service development pilot project

Dr Rachel Gorny, Speciality Doctor
Ash Green Learning Disability Centre

Dr Madaline Cosmulescu, Consultant Psychiatrist
Older Adult Services

Dr Karol Borzecki, Consultant in Intellectual Disability Psychiatry
Ash Green Learning Disability Centre

Derbyshire Healthcare NHS Foundation Trust

Introduction

There have been significant improvements in life expectancy for those with intellectual disabilities in recent decades, and it is estimated a third of those with intellectual disabilities are now over 66 years old. Men with intellectual disability currently have a life expectancy of 66, and women with an intellectual disability a life expectancy of 67 (1). Subsequently we have seen the numbers of patients with dementia symptoms increasing year on year in our clinical practice. Diagnosis of dementia in this population is often complex and requires specialist input, with many of our patients with moderate or more severe intellectual disabilities unable to access mainstream services. As a result, the rate of dementia diagnosis is low for this population. For these reasons we have established links in North Derbyshire with the Memory Assessment Service (MAS thereafter) and are piloting a monthly MDM between the Intellectual Disability Service (IDS thereafter) and MAS. The purpose of the MDM is to review the existing specialist dementia assessment for those with an intellectual disability, confirm the diagnosis and subtype of dementia where applicable and share knowledge and advice on specific neuroimaging and cognitive enhancers where indicated.

Background

The health inequalities often experienced by people with Intellectual Disability have been known of for many years. Poorer outcomes are often associated with late diagnosis, misdiagnosis, variations in access to appropriate investigations and treatment and lack of robust implementation of reasonable adjustments. Many factors can influence cognitive decline in the intellectual disability population including environmental factors, psychiatric disorders and age related physical ill health. We are also treating increasing numbers of patients with cognitive and functional decline following Covid-19 infection. This suggests the possibility of a long covid syndrome which can be challenging to identify in the intellectual disability population. We have also seen an increase in functional decline and pervasive mood disorders in patients due to the environmental restrictions introduced during the pandemic.

The most common type of dementia in those with intellectual disabilities is Alzheimer's dementia. In those with Down's syndrome, Alzheimer's dementia can present in patients in their 30s and the prevalence increases with age It is estimated that 40-60% of people with Down's syndrome will develop dementia in the fifth to sixth decade of life (2) and studies have shown the prevalence of Alzheimer's dementia in Down's syndrome patients aged 70 is 70% (3). The gene coding for amyloid precursor protein (APP) is located on gene 21 which is thought to account for the higher rates of prevalence in those with Down's syndrome (3.)

Due to the variability in baseline cognitive ability and functioning in those with Intellectual Disability, screening and assessment can be challenging. In addition, those with Intellectual Disability have often lived in multiple care settings during their lives with a lack of consistent support therefore it can be problematic obtaining a clear collateral history when establishing baseline functioning.

The Derbyshire IDS Dementia pathway

The Derbyshire dementia screening and assessment pathway (see Figure 1) involves input from the multidisciplinary team including clinical psychologists, ID specialist nurses, speech and language therapists, occupational therapists and psychiatrists. The Derbyshire IDS carries out a dementia assessment in those with Down's syndrome from age 30 and those with an Intellectual Disability from the age of 50 to establish baseline cognition and functioning. Screening is carried out proactively in patients with Down's syndrome from age 30, again at 40 and annually thereafter. In patients who do not have a diagnosis of Down's syndrome, screening and baseline assessment is carried out age 50 or following referral to the dementia pathway. The assessment consists of obtaining a detailed collateral history and screening for treatable conditions which may mimic dementia symptoms. This screening includes taking into consideration physical and mental health conditions, visual acuity, hearing, sleep, nutrition and hydration status, pain, environmental changes and delirium. Patients are advised to have a physical examination and blood tests to rule out reversible causes of cognitive decline and neuroimaging is considered if applicable as per NICE guidelines (4).

In terms of cognitive assessment, the Dementia Questionnaire for People with Learning Disabilities (DLD) is used. This tool is comprised of 50 questions covering a range of cognitive domains and social skills. The cognitive scores include short term memory, long term memory and spatial and temporal orientation. The social score includes speech, practical skills, mood, activity and interest and behavioural disturbances. Unlike cognitive testing for the general population, the scores are compared to the individual's baseline score rather than standardised cut-off points. Neuropsychological testing is carried out using the Neuropsychological Assessment (of dementia) in Intellectual Disabilities (N.A.I.D). Again, this tool is designed to be used for baseline testing and then compared with repeated measures to assess for longitudinal change.

Once the report and any neuroimaging or physical investigations are collated and discussed at the IDS dementia MDM, a provisional diagnosis of dementia is made. Patients are then reviewed by the Intellectual Disability Psychiatrists and discussed at the IDS-MAS MDM. We have been able to confirm diagnosis for the majority of patients and provide treatment options in terms of cognitive enhancers where indicated. Anecdotal evidence from patients and their carers has been overwhelmingly positive, and we are in the process of developing a quality improvement project to measure the outcomes.

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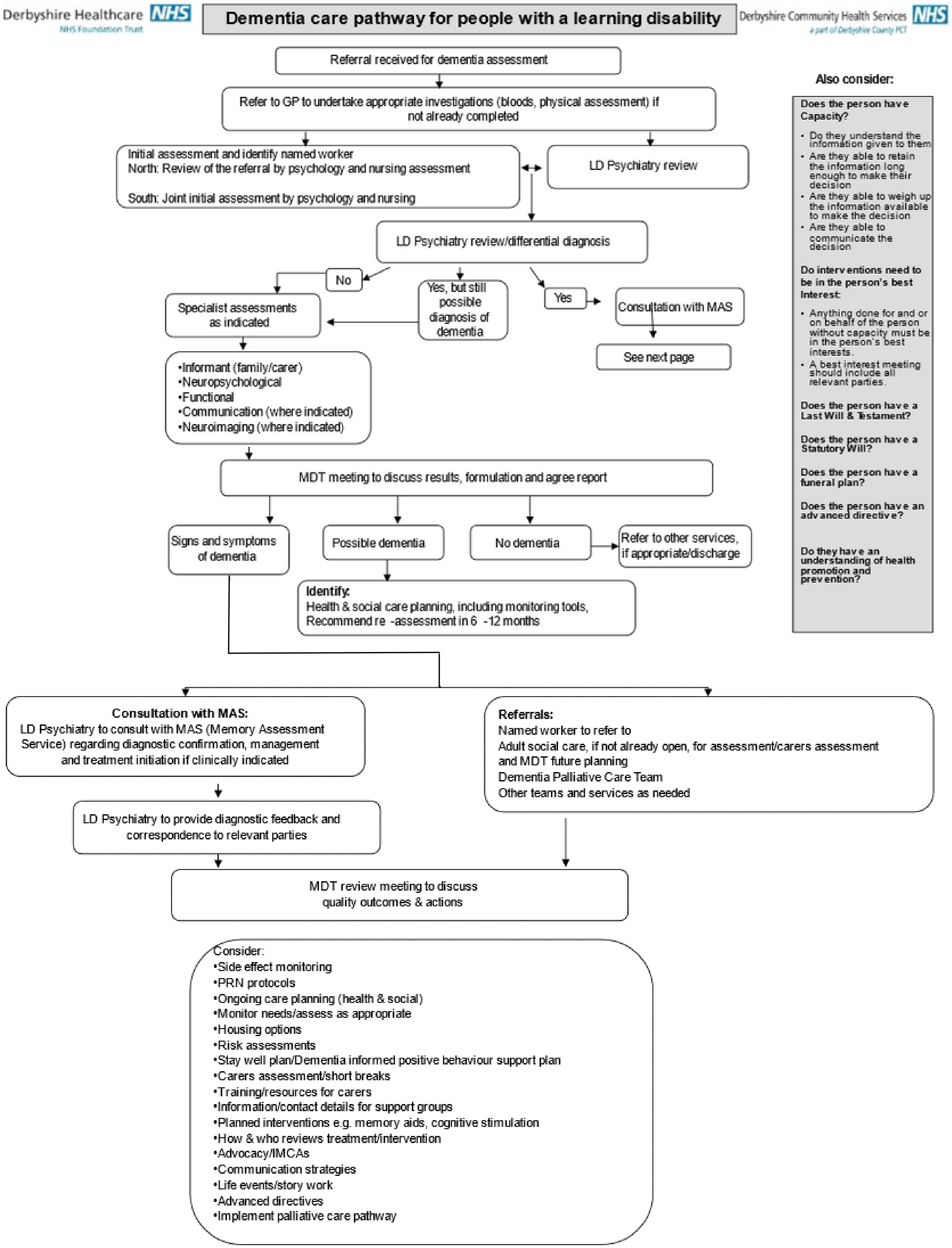

Also consider:

Does the person have Capacity?

- Do they understand the information given to them
- Are they able to retain the information long enough to make their decision
- Are they able to weigh up the information available to make the decision
- Are they able to communicate the decision

Do interventions need to be in the person's best Interest:

- Anything done for and or on behalf of the person without capacity must be in the person's best interests.
- A best interest meeting should include all relevant parties.

Does the person have a Last Will & Testament?

Does the person have a Statutory Will?

Does the person have a funeral plan?

Does the person have an advanced directive?

Do they have an understanding of health promotion and prevention?

Consider:
- Side effect monitoring
- PRN protocols
- Ongoing care planning (health & social)
- Monitor needs/assess as appropriate
- Housing options
- Risk assessments
- Stay well plan/Dementia informed positive behaviour support plan
- Carers assessment/short breaks
- Training/resources for carers
- Information/contact details for support groups
- Planned interventions e.g. memory aids, cognitive stimulation
- How & who reviews treatment/intervention
- Advocacy/IMCAs
- Communication strategies
- Life events/story work
- Advanced directives
- Implement palliative care pathway

Figure 1: Dementia Pathway for Derbyshire

Thinking outside the box. What is the role of old age psychiatry in a memory service?

Dr Jennifer Parker, ST5 in Old Age and General Adult Psychiatry
Avon and Wiltshire Mental Health Partnership Trust

Ahead of a service-wide development day for our team, our group of eight doctors was tasked with creating a 'Team Banner' which would demonstrate the core role and values of our medical team within a wider Dementia service. We were advised the banner would be judged against other teams and professional groups within the service, and there was even mention of a banner parade. We all work with the Bristol Dementia Wellbeing Service, which works as a unique model for long term support of dementia as a chronic illness, from diagnosis to the end of life. We support primary care with assessment, diagnosis and long-term management of dementia. We predominantly see people in the community, and also provide a Care Home Liaison Service. The service is enriched by broad multidisciplinary input, and as doctors we operate as cogs in a much larger, brilliantly functioning machine. Like most NHS professionals, we are all busy, and regular opportunities to all come together for reflective practice are limited.

Certainly, regular afternoons of team banner making are seldom on the cards. This crafty task seemed less of a priority than any number of other responsibilities. However, not wishing to show up to our development day empty-handed, we arranged a 'medical crafternoon'- the first of its kind within our service. Once together, we found that our trepidation melted away to reveal unreserved enthusiasm for the task and our perceived lack of creativity was demonstrated to be clearly unfounded. Over the course of a couple of hours, our banner came to be. Rather controversially, we took inspiration from the 3D cube so often found in structured cognitive assessments which neatly overcame the problem of our not having a big enough piece of paper for a banner, as well as demonstrating our ability to think outside of the box, if you will. Whilst we approached the task in a fun-spirited way with plenty of light-heartedness, we were able to agree that the task had provided a valuable opportunity for team reflection and bonding.

Image description: Our banner/ cube from afar

The six roles of the old age psychiatrist in a memory service

1. Accessibility: Being available to support patients through our welcoming approach, integration with the team and our availability to all of our multidisciplinary colleagues within and beyond the service is an important core value for us.

Image descriptions: This shows a door to the 'medic resource room', which opens up to show the smiling faces of the team in an Oscars-style selfie.

2. Expertise and Knowledge: To provide expert advice and information about dementia, from pathophysiology, through diagnosis to treatment.

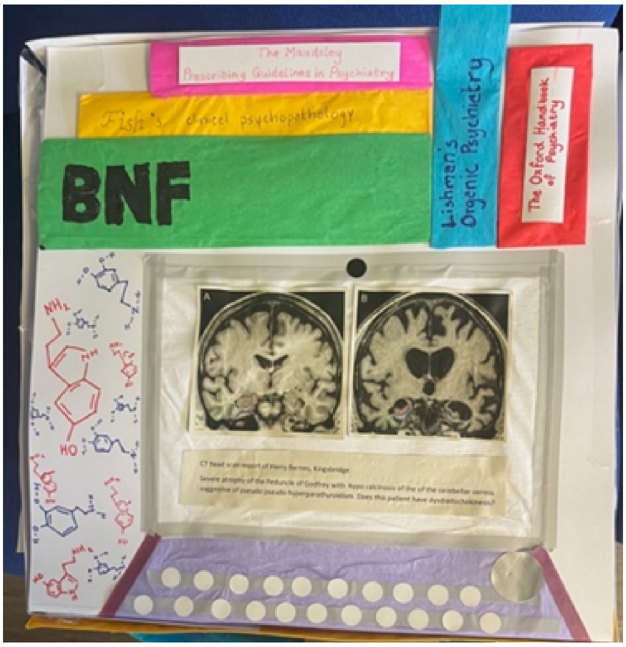

Image description: a laptop screen showing a CT head, various popular psychiatry textbooks and some dopamine and serotonin chemical symbols.

3. Psychopharmacology: To provide expert advice on treatment of dementia, with particular respect to prescribing medication which we have unique expertise in.

Image description: A prescription pad, a medication chart and some medication boxes and tablets

4. Physical Health: To provide advice and input about physical health conditions and their relationship to people with dementia.

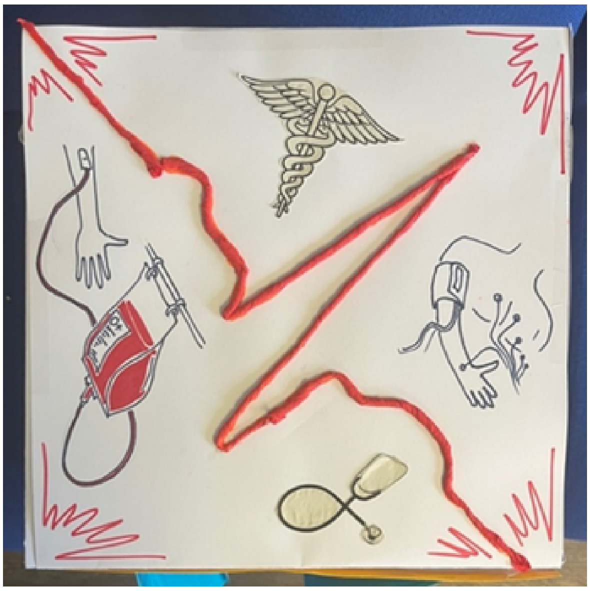

Image description: This picture depicts some classic physical health investigations and equipment, including a stethoscope and an ECG trace.

5. Wider geographical overview: Whilst our service is subdivided into geographical teams (North, South and Central/East Bristol) alongside a care home liaison team, we provide a wider geographical overview of all patients and other teams by providing city-wide medical cover. We also liaise with all primary providers, and colleagues within the acute trusts.

Image description A map of Bristol with stickers demonstrating different hubs and geographical teams, linked together by a Rod of Asclepius

6. Snack Providers: We have found our colleagues appreciate our commitment to providing snacks at meetings and in our doctor's office

Image description: A collage of various delicious snacks and beverages. In the centre is a large 3D samosa made with crepe paper, which represents the samosas available from one of the brilliant shops, Sonni's, in the multicultural area of the city where our team's office is located.

With credit to the doctors of the Bristol Dementia Wellbeing Service, part of Devon Partnership Trust (in alphabetical order):
Dr Chloe Harrison, core trainee (CT1) in psychiatry
Dr Rachel Holland, associate specialist
Dr Jenny Humphries, consultant old age psychiatrist
Dr Martha Fawcett, GP specialty trainee (GPST2)
Dr James Main, consultant old age and general adult psychiatrist
Dr Jennifer Parker, specialty trainee (ST5) in old age and general adult psychiatry
Dr Ruth Purkiss, specialty doctor
Dr James Selwood, specialty doctor

Gateshead specialist memory hub. A post-diagnostic service for people with dementia with a slight difference

Dr Anitha Howard, Consultant Psychiatrist
Bensham Hospital, Gateshead Health NHS Foundation Trust

Background

The Gateshead Specialist Memory Hub (Hub) has a different approach in managing people with dementia compared to the more traditional memory clinic to help with the person with dementia journey through diagnosis and treatment.

Gateshead is a large borough comprising of rural, urban areas with socioeconomic deprivation alongside affluent areas. There are approximately 39,000 people over the age of 65 and old age psychiatry services are provided through Gateshead NHS Foundation Trust which is an acute trust. The Gateshead Memory Hub was funded through the closure of our day hospital in 2015 and the service pathway was designed based on NICE guidance on the management of dementia at the time Nursing staff were redeployed to the memory hub but already had experience in managing people with dementia and supporting carers. The service caters for people with dementia over 65 who have a Gateshead GP with under 65s managed by our dedicated young onset dementia service. The Hub was reaccredited with Memory Services National Accreditation programme in 2023.

Service provision

The Memory Hub differs from the usual memory clinic by not providing diagnostic assessments for people with cognitive impairment. The initial assessments are carried out by the Community Mental health teams and referred to the Memory Hub for medication and /or post diagnostic support after a diagnostic review is completed by a Consultant. People with Young Onset Dementia and complex needs can transition to the MHUB for further management after the age of 65.

The Hub accepts people with mild, moderate and severe dementia of all sub-types with mild functional or psychotic symptoms If at the time of diagnosis, the person with dementia needs extra support due to complexity, they are managed by the CMHT. This accounts for a minority of patients and most people diagnosed with dementia are referred to the memory hub. The Hub accepts and manages patients with dementia in twenty- four care settings.

The Hub makes contact with the person with dementia or their carers within two weeks to discuss the referral, signpost and arrange an appointment. After initial titration, a follow up appointment is made for 6 months or earlier if needed. If the person with dementia and their carers feel supported and services are in place, they are discharged back to primary care, if not they remain under the memory hub. The hub provides follow-up after 6 months for our patients with more complex presentation such as patients with depression, anxiety, psychosis and other non-cognitive symptoms that challenge.

The nursing staff undergo training to use our locally developed Patient Group Directive (PGD) in order to be able to deliver and monitor response to Donepezil. A PGD for memantine was later added. The PGDs enables the nurses to start Donepezil and Meantime and continue this independently of a doctor. All other dementia medication are prescribed by the medical staff via the hub. The MHUB is supported by a Consultant Psychiatrist with a weekly MDT

The Hub provides structured post-diagnostic support for people with dementia who are not prescribed treatment such as those who decline medication or dementias other than Alzheimer's, Parkinson's disease dementia and Lewy Body dementia. The Hub delivers group cognitive stimulation therapy (CST) with maintenance CST provided by Age UK in the community.

Links with local services

Age UK and the Citizens advice bureau run drop in clinics providing advice on benefits, assistance with filling in forms for financial assistance and LPAs or accessing support in the community. The Hub have strong links with local Parkinson's Team, and Care of the Elderly service as we are part of the same

trust. Patients are able to access the latest local and national trails as their research nurses based on the Hub. The Hub has access to Admiral Nurses to provide more intensive support for carers.

Advantages of our service.

The main advantage is that there is no artficial split of patients with memory difficulties due to functional disorders or organic disorders at the point of assessment. So if at the point of initial assessment, a person was found to have a functional disorder rather than a cognitive one, they would remain under the community team. Primary care can refer people with all degrees of cognitive impairment without having to decide if they meet they meet certain criteria unlike other local memory services. If the person with dementia develops additional functional difficulties including psychosis or non-cognitive symptoms that challenge while under their care, they continue to be managed by the hub. Patients are transferred to the community teams if the patients need more intensive support and management

Challenges

The Hub like all other memory clinics, face a huge demand for services and a shortage of trained staff to deliver care and treatment.

Future plans

The GMHUB'S long term plans includes supporting people with pre-diagnostic and peri-diagnostic support as well as providing more tailored education to carers and patients. The Hub will also need to adapt and change the service to look at delivering disease modifying drugs and new treatments that maybe developed in the future.

Sharing what works: 4 ingredients of our memory assessment service success

Jason Willcox, Head of Dementia Provision - jason.willcox@nhs.net
Here, Care Unbound Ltd.

Can you ever really take learning from one place to another? Many triumphs in one setting have been tried somewhere else only to meet disaster. We're incredibly proud of what we - Here, a social enterprise with a mission to deliver exceptional care, for everyone - have achieved with our memory assessment service in Sussex. But if what we've learnt in Brighton and Hove can't carry to Basingstoke and Bury, why should I even write this article?

A clue might be in a great paper by Mar Dixon-Woods and team) about efforts to reproduce successful patient safety initiatives. "Without understanding the ingredients of success" the Health Foundation funded paper writes, "efforts to reproduce an improvement programme risk mimicking its superficial outer appearance, but not replicating the essential processes that actually make it work."

So in an attempt at getting to those ingredients of success, here are four key learnings from our journey.

1. It's more than a service

The B&H MAS is more than an assessment service. It is a community service delivered in partnership (Sussex Partnership Foundation Trust & The Carer's Centre), providing clinical and support pathways that are fully integrated in one service. We are a lean team that is nurse lead assessment service supported by consultant psychiatrists and GPwER. All clinician work with our non-healthcare professional (support workers) and have a symbiotic relationship that supports personalised and holistic care.

It's also a prime example of our organisational values and purpose and our commitment to both high performance and quality provision. Here delivers NHS services, across large and small geographical areas in Sussex while also providing business intelligence and transformation services across the NHS national system.

There is no one best model for memory assessment services but this model has delivered exceptional performance, outcomes and experience for patients, with results we are proud to share that have led to us achieving:

- DDR compliance both pre and post covid, significantly exceeding both the national target (66.7%) and the national and ICS average
- Rated CQC Outstanding
- MSNAP Accreditation Level 3
- Letter of Commendation from MSNAP Board
- Received MSNAP Sustainability Award
- Exceptional Patient Satisfaction results >90% over last 5 years
- 76% of patients reported maintaining or improving their quality of life (via the QOL-AD) within first year of receiving a dementia diagnosis

Our success is all the more impressive given that the sustained transformation was delivered within the existing financial envelope, without additional investment by commissioners during 2017 to 2020.

2. We thought we were good, but not good enough

In 2012 Here designed and mobilised an integrated service - highly innovative for its time and perhaps even more so today. Between 2013 to 2016 the service delivered improvements in DDR of around 30% and improved patient journey times for Referral to Diagnosis with commissioner set targets of 10 weeks.

As the service continued to surge forward, attaining commissioned journey time targets, there was an increasing narrative that speed was not what all our patients wanted and needed.

We identified there was a gap between commissioned provision and what people required. This learning was painful as despite our best efforts and integrated model, we were not delivering what mattered most to our patients. Diagnosis had been our priority and it was clear that our patients wanted a service that was designed around their priorities and needs, whilst giving them time and support to adjust to the possibility of receiving a diagnosis of a life limiting degenerative disease.

Putting aside our service specification, KPI and system rules we started a process putting our citizens at the heart of our enquiry. We asked our patients key questions: what was important to them and what mattered most.

Over a 4-month period we conducted a System Thinking enquiry to better understand the needs and experience of the people who used our service. System Thinking analysis requires taking a step back, to investigate whilst looking at the wider picture through a more holistic lens to gain further understanding. Services do not operate in isolation, our healthcare system and the people we serve are complex and multifaceted and our investigation had to acknowledge this.

We also undertook case studies, direct observations, hosted patient and carer focus groups and reviewed the patient journey from referral to discharge. This accounted for approximately 15% of our caseload.

Our key learning was: Of the patients reviewed 70% that were requesting support, diagnosis was not their priority.

In 2017 with the consent of our commissioners, we redesigned our service around patient voice and needs and anchored ourselves to a new purpose created out of the learning from our patients and their loved ones: 'To help me and my loved ones to get the care we need to live our lives well.'

Our aim was to become a more compassionate and personalised service. Reallocating support from our post diagnostic pathway, we offered support at the point of referral to all, working proactively to meet patients' needs. Our Dementia Advisors were renamed Memory Support Workers (MSW) and each patient was provided a named worker that held patient care. Our team built relationships with patients and their support network, ensuring everyone had 'what mattered' conversations at the start of their journey, whilst supporting people to navigate and integrate across the system.

3. It's always about the patient journey

Adding another step to the pathway may seem counterintuitive as it could have extended or delayed patient journey times. However, this addition improved patient journeys and therefore ensured we understood our patients needs and support any barriers they might encounter whilst travelling through the service.

Our MSW counselled people, listening to their concerns and explained how they would be supported if a diagnosis was made. Understandably for many the fear of a diagnosis was a barrier and the thought of clinical assessment and its outcome was something to fear and avoid. Having support throughout the process from one person aided engagement and flow while also improving patient experience and outcomes.

4. We're excited about the future and the potential of biomarkers

The redesign also taught us that there was significant unmet need in people who receive an MCI diagnosis. Given the inequity of biomarker via CSF, Here in 2022 expanded and delivered a pathway enhancement with our local trust UHSx, to create a dedicated biomarker pathway funded by Roche Pharmaceuticals. During 2022-23 we also attained our long-term goal of being commissioned as a lifelong service that aligned with commissioner intentions providing annual care planning and access to our established post diagnostic service.

So did I manage to convey some of the ingredients of our success? We'd love to know what resonated with you, and we're always keen to learn from others.

To learn more about the B&H MAS visit **our website** or contact me via email

Jason Willcox is Head of Dementia Provision with Here, Care Unbound Ltd. Jason is a Subject Matter Expert and has supported NHSE Improvement workstreams. He recently presented at NHSE national webinar sharing his learning from the B&H MAS as an example of high performing, high quality, holistic and personalised service.

Telemedicine for Memory Service Assessments- A Literature review

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Hull York Medical School, Faculty of Old Age Psychiatry Psych Star

With thanks to Dr Josie Jenkinson and Dr Mani Krishnan – PsychStar Mentors from Faculty
Poster Presented at International Congress July 2023

Aim

Memory clinic waiting times are at a record high, increasing from 13 weeks in 2019 to 17.7 weeks in 2022. This backlog is partially due to COVID-19 disruption, linked to the redeployment of staff and the surge in referrals following the first wave. Staff are concerned that waiting times are resulting in missed diagnoses, particularly with early-onset memory loss, and that relatives of patients with challenging behaviours are not receiving adequate support. At the start of the pandemic, many Memory Service Assessments (MSAs) were done via teleconsultation to ensure patients could access services despite lockdowns. Telemedicine has continued to be used for MSAs and is a strategy proposed to tackle waiting times. This literature review explores whether using telemedicine for MSAs is evidence-based.

Methods

A search using the MEDLINE database was conducted, using the terms 'dementia', plus 'telemedicine', 'video calls', and 'telephone calls'. This identified one relevant systematic review and one clinical trial. The identified evidence was insufficient for a systematic review. A google search, carried out with the same terms, identified a variety of non-academic papers. These were NHS Audits, Quality Improvement Projects, Clinical Network publications, and one governmental publication.

Results

Telemedicine was reported to reduce waiting lists. Appointments could be organised quickly, without infection risk, and without requiring transportation. At-home telemedicine consultations were relaxing for some patients and reduced demand for home visits. However, clinicians reported that some environments were cluttered and noisy, impacting the MSA. Patients struggled with the complex telemedicine technology; carers were required to facilitate the calls, which increased the risk of an inaccurate assessment. Patients with sensory impairments disliked telemedicine, and clinicians struggled to distinguish between cognitive impairment and poor hearing. Financial inequalities at times prevented telemedicine. Some relatives felt that patients would mask their memory symptoms in teleconsultations, and not speak openly about their concerns. Clinicians felt adequate safeguarding assessments were not possible over teleconsultation. There was no inclusion of the long-term impact of these assessments. No distinction was made between dementia subtypes.

Conclusion

The National Audit of Dementia- 2021 encourages the future use of telemedicine for MSAs. However, there is limited evidence to support its use. Telemedicine was essential during COVID-19 and may help reduce waiting times but may also produce worse outcomes than face-to-face consultations. Only pilot studies without randomisation exist on the topic and none of these are UK based. Further research is required to produce NHS-specific data on the impact telemedicine has on: the quality of MSAs, the patients', carers', and clinicians' experiences, and memory service waiting times.

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Memory Services in Qatar The Caring Futuristic Model

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Dementia - The Impact - The Need

There can be no doubt that Dementia is one of the greatest 21st century challenges faced by health and social care systems. With someone in the world developing dementia every 3 seconds, with no cure yet in sight with numbers projected to reach 139 million over the coming three decades with its impact be it the person, be it the family, be it the society, be it the country and be it the world at large, its wider psychosocial impact and the societal-economic impact inevitably, it is called the biggest health and social care crisis in 21st century. There has been no time ever before, it has become ever important to have a robust effective memory service that should be there in every country, every state, every city, every district to ensure that the best in the care for Persons living with dementia and support for their families is provided.

Dementia is the condition that requires multi-agency, multi-disciplinary collaborative approach. It does not respect the boundaries that have been created between the primary and secondary care, between the health and social care and between what is done by the services and families. It requires us not just to do more but to do things differently (1). The memory services model should be a specialist led multidisciplinary model that is looking at prompt effective high-quality diagnosis at the very early stage. A model that provides support system of care and treatment for the person with dementia and the family members from the time of diagnosis through the entire journey of dementia supporting each stage. A service model that is easily accessible and has all the essential elements of care all times. Qatar Model exemplifies all these essentials.

On one side, it is providing the high-quality diagnosis, treatment care and support, equally it takes on the education training approach not only for the health care professionals but equal to the community and to the family care givers. A model that also incorporates the elements of research into its wings. Having a holistic model which keeps carer support group with its Multispeciality led National Alzheimer's and Memory services Helpline " RAHA" at its centre a model which cuts across the primary care, the secondary care, a model which brings together the multiple disciplines including the Geriatric medicine, Specialist Nurses, Geriatric Psychiatry, Neurology, Neuroradiology and the allied health disciplines including Psychology, Neuro psychology, Occupational therapy, Physiotherapy, Speech therapy, Pharmacists, Dietician , Dentistry and Social services. A model that runs across the service areas of Geriatric Home Health, Acute Geriatric Inpatient Units, urgent medical day care and long-term residential care.

Qatar - The context of Uniqueness

Qatar - The Country.

Situated in the peninsula of the Persian Gulf with a total land area of 11,610 square kilometre. Placed as one of the smallest countries in Asia and with its unique health care system with the electronic medical record's CERNER where health care information can be accessed across all areas in the country within its Government health care services. With this uniqueness it enables to have a service model which can be implemented uniformly across the country.

Qatar Healthcare - The visionary leadership

With its innovative healthcare system, Principle Healthcare is Provided by the Hamad Medical Corporation (HMC) the Secondary and Tertiary care Provider , the elderly care in the state of the Qatar is run by department of Geriatrics and Long-Term care from HMC . At the very outset as the department was within its formative growth, the visionary leadership recognized the impact of the growing elderly population, the impact of dementia presenting to healthcare at its late stages of the disease highlighting the societal stigma (2) and the reluctance to seek help in the early stages of the disease reinforced the need for the department of Geriatrics to take the lead for the dementia care in the State of Qatar enabling in mitigating the societal stigma from the mental health context and this led to the Department of Geriatrics initiating the first Memory clinic approximately a decade ago. And from then on further Consolidating on the model of care of Specialist led Multidisciplinary team. With its innovative skill mix that Every Memory Clinic service is Jointly led by Skilled Geriatrician along with Geriatric Psychiatrist.

Qatar Geriatric Memory Services

A Memory Services Model

With Clinical care at its Heart, at the same time Takes lead on Nations Dementia Education and Training , Research and Drives on Implementation on Country's National Dementia Plan which Includes works on Key 7 Action Areas Including:

1) Dementia A Public Health Priority
2) Dementia Risk Reduction
3) Dementia Awareness and Friendliness
4) Dementia Carer Support
5) Dementia Diagnosis Treatment Care and Support
6) Dementia Information system
7) Dementia Research and Innovation

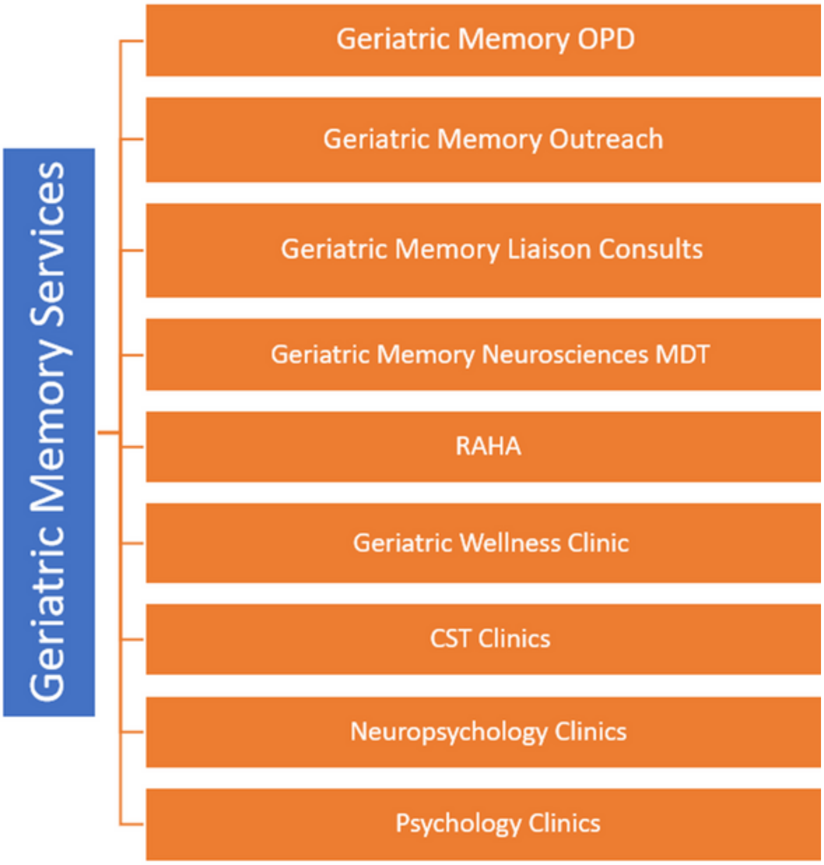
Clinical services

Teaching and Training

Research

Qatar National Dementia Plan works

Qatar Memory Services Model



Clinical Services Essentials

With 12 Clinics spread through the Week Each Jointly led by Geriatrician, Geriatric Psychiatrist, Specialist Nurses, ensuring Comprehensive Physical Health and Mental Health Evaluation same time, this includes.

- 3 Integrated Clinic Led by the Specialist team going to the Primary Care Health Centres and 2 Memory Outreach Clinical sessions and 1 Dedicated Triage Clinic (3)
- RAHA the National Alzheimer's and Memory Services Helpline enhances the service access where anyone/ (Including Family member), over the age of 60 can call and self-referrals accepted apart from system Referrals from Primary and Secondary care services.
- Integral to our Memory Services Model Includes Fortnightly Dedicated Geriatric Neurosciences Multidisciplinary Team Meetings and assessments which Includes Clinical Neurologists, Neuropsychologists, Geriatricians, Geriatric Psychiatrists, Psychologists, Neuroradiologists attending together and Evaluating Complex Cognitive syndromes and Drawing Joint action plans.
- Geriatric Wellness Clinics offers state of the art Multidisciplinary Input for Persons with Mild Cognitive Impairment, Focussing on Dementia Risk Reduction Measures
- CST Clinics - Specialist Occupational Therapy Led Cognitive Stimulation Therapy Clinics, added with Weekly Each Neuropsychology Clinic and Psychology Clinics.
- Persons with Dementia having Severe or challenging behavioural Symptoms are Referred and taken care by Older Adult Mental Health services which is separate service under Department of Psychiatry .

With " RAHA" Carer Support at its centre, With 12 Jointly Led Geriatrician, Geriatric Psychiatrists , Specialist Nurses Clinics through the Week , With Multidisciplinary Teams Joining Hands , With Neurologists Neuropsychologists and Neuroradiologists working Together with Geriatrician and Geriatric Psychiatrists Unravelling Complex Cognitive Syndromes and Young Onset Dementia's With service access, with a Telephone call, with service overseeing Implementation of National Dementia Plan. Truly This Model Epitomises - A Caring Futuristic Memory Services Model

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This issue's front cover photo. Memory Corner at Geriatric Memory Clinic on World Alzheimer's Day - Doha, Qatar. Commemorating four years Of Qatar's National Dementia Plan.

HISTORY TAKING IN PSYCHIATRY IT'S TIME TO EXHUME AND REVIVE

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History Taking in Psychiatry -It's time to Exhume and Revive
The Rusts of human inertia from the invasion of modern-day Information systems
The loss of time from the modern-day fast-paced life
The apathy of human communications from the invasion of modern-day systems communication
The chase for an instant from a cherished hard day works
It all takes it away ...the richness of History taking in Psychiatry
History Taking in Psychiatry -It's Time to Exhume and Revive

History Taking in Psychiatry -It's Time to Exhume and Revive
Amidst the tides of policy's and protocols of modern-day Healthcare
Amidst the artificially created care-less boundaries of risk aversive environments
Amidst the noises and voices of all but me and my husband
Amidst the hazed memories from the eroded neurons
"Lay hidden the 60 Years of Love -until the lights from History taking in Psychiatry unraveled it for all "
History taking in Psychiatry - took me away from the clutches of care homes to the arms that ever cared for me
History Taking in Psychiatry -It's time to Exhume and Revive

History Taking in Psychiatry -It's Time to Exhume and Revive
From the times of "listen to the patient -he will tell you the diagnosis "
To the times of "Death of Long Case in Psychiatry "(1)
History taking in Psychiatry has gone through the tides of Trials and Triumphs
As the onset of assessments in Medical Sciences became piecemeal
Became the onset of History Taking in Psychiatry becoming a history by Itself
Art and science of History Taking started its slow death
And Psychiatry started the journey of lifelessness
History Taking in Psychiatry – It's Time to Exhume and Revive

History Taking in Psychiatry -It's Time to Exhume and Revive
When every time the blue lights with its sirens takes me away to Hospital's narrow corridors
Every time I see the tears looking blue through the lights, of my daughter's,
Each Time within hours I am sent back home
Each Time within hours blue lights take me back
Each time I see the tears blue again and again
Until the day History taking in Psychiatry unraveled the medical jigsaw
History Taking in Psychiatry – It's Time to Exhume and Revive

History Taking in Psychiatry – It's Time to Exhume and Revive
Whilst I lay in the bed
Whilst all around felt my neurons had erased all memories it had
Whilst all around felt my mind had lost all its thoughts
Whilst all around felt no longer my body could hold me
Whilst all around felt I could no longer sense the tastes
Whilst all around felt my heart could no longer feel emotions
Whilst all around felt it was time for all tubes and trolleys all times
Whilst all around felt it was time for them to write my Wishes and they started writing my wishes
Whilst all around were away from me
History Taking in Psychiatry -stood by me
History taking in Psychiatry -gave me my life back
I could talk, I could smile, I could taste my sweets, I could run and hug my Daughter
History Taking in Psychiatry -It's Time to Exhume and Revive

History Taking in Psychiatry -It's Time to Exhume and Revive
It's time for Resurrection of History Taking (2)
It's Time for Renaissance of History Taking
It's time for giving time in care
It's time for Humane Communications
It's time for feeling the time, holding the time not rushing the time
It's time to -getting back to the ages of "Listen to your patient -He will tell you the diagnosis "
History Taking in Psychiatry -It's Time to Exhume and Revive

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Memory clinics in Australia: working towards greater harmonisation.

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Dementia in Australia

Dementia is the leading cause of disease burden in Australians over 65 and the leading cause of death for women. An estimated 401,300 people across the total Australian population of about 26 million have been diagnosed with dementia with about 1.5million people involved in their care (1). One third of Australians with dementia reside in regional and remote areas with limited access to specialists and dementia specific care. Diagnostic settings vary largely across the country. While reliable national data are not available, a small-scale study from Melbourne, Victoria, suggested that most patients are diagnosed in a hospital setting (as in-patients) and single specialty practices (e.g., geriatrician, neurologist, or old age psychiatrist). A smaller proportion is diagnosed in general practice or memory clinics (2). Many Australians currently experience long diagnostic delays with an average of around 3 years between first noticing symptoms and a firm diagnosis. This delay in diagnosis increases for people with non-Alzheimer type dementia or young onset dementia.

Memory Clinics in Australia

Memory clinics have been established as highly specialised and multi-disciplinary assessment services in Australia since the early 1980s. Since then, they have steadily increased in numbers and different service models have evolved. It is estimated that about 90 memory clinics are operating across Australia, including over 50 public services.

Funding systems vary greatly. In the early 2000s, the state of Victoria introduced a state-wide and subsidised network of around 30 memory clinics called 'Cognitive, Dementia and Memory Assessment Services (CDAMS)'. In other states, memory clinics are supported through local health districts and heavily rely on reimbursements through the Australian Medical Benefits Scheme (MBS). Many allied health services, like Neuropsychology, are not covered under the current MBS. Hence, many dementia-specific allied health services incur out-of-pocket costs for the patient.

Australian memory clinics also vary largely in their staffing, clinic frequency (5x week to 1x year) and waiting times for an appointment (1 week to over 1 year, average 10 weeks) (3).

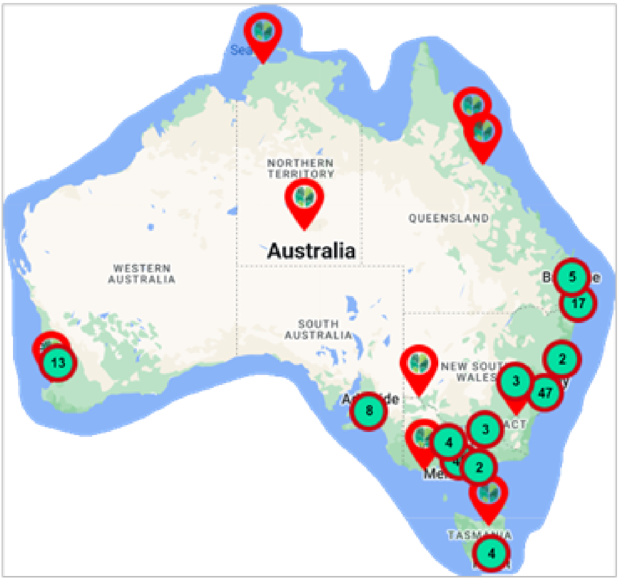

Figure 1: Map of dementia assessment services registered with the Australian Dementia Network

Waiting times are particularly long in regional areas with limited access to local specialists, allied health, or brain imaging. These areas commonly rely on visiting specialists to staff their memory clinics. In contrast to the UK, old age psychiatrists are less frequently involved in the assessment of dementia and cognitive decline and often only consulted when patients present with psychiatric symptoms. Most memory clinics are run by geriatricians, with a smaller number of services led by a neurologist or old age psychiatrists.

While all memory clinics provide a medication review and prescribe dementia-specific medication if required, post-diagnostic support in form of evidence-based cognitive interventions is only offered by around 20% of memory clinics (4). Uniquely funded as assessment services, most memory clinics do not have resources or capacity to provide ongoing support. Hence, care is mostly provided through primary care and local allied health services. The considerable differences in memory clinic service models across Australia make it difficult to obtain national benchmarking information and compare services nationally. In 2018, the Australian Dementia Network – Memory Clinic initiative was established to address this issue and work towards greater harmonisation across Australian memory clinics.

The Australian Dementia Network

The Australian Dementia Network (ADNeT) was funded by the Australian National Health and Medical Research Council Boosting Dementia Research Fund. Under ADNeT the first national Clinical Quality Registry for patients newly diagnosed with dementia and mild cognitive impairment (MCI) was established (ADNeT-Registry), recruitment into clinical trials was facilitated and dementia research infrastructure improved (ADNeT-Screening and Trials) and a national collaborative network of Memory Clinics introduced (ADNeT – Memory Clinics).. Further information about ADNeT can be accessed at **www.australiandementianetwork.org.au/**

National Memory and Cognition Clinic Guidelines

Led by the ADNeT-Memory Clinics team, a modified Delphi process was conducted to develop the first national Guidelines for memory clinics. The research team consulted with 125 health professionals and 89 people with lived experience of dementia via surveys, focus group meetings and email consultations. In November 2021, the final Guidelines document including 151 Standards over 14 sections was published. A copy of the Guidelines can be accessed at **www.australiandementianetwork.org.au/initiatives/memory-clinics-network/adnet-memory-and-cognition-clinic-guidelines**

A client guide, summarising Standards that were deemed most important by people with the lived experience of dementia and care partners accompanied the Guidelines document. Here, the recommended waiting times for a first appointment of maximally 90 days for routine patients and 30 days for high-priority referrals and the importance of receiving written information prior to (e.g., what to expect, what to bring) and after the assessment (e.g., diagnosis, care plan, next steps) were highlighted.

Following the example of the UKs Memory Service National Accreditation Programme – Standards for Memory Services three different levels of recommendation were introduced. Strong recommendations highlight essential Standards for a high-quality memory clinic service, while less essential Standards are classified as recommendations, and mostly aspirational issues are categorised as practice points. All Standards that were brought forward and particularly endorsed by people with the lived experience of dementia were classified as strong recommendations.

Implementing the Guidelines – Pilot

Following the launch of the national Guidelines, a monitoring and quality improvement pilot program was conducted, to encourage implementation and evaluate the extent to which the Guidelines can support service quality improvements and facilitate the collection of national benchmarking data. Seven clinics from five different jurisdictions (including 1 private clinic and 1 single specialty clinic) participated in a 3-month pilot phase. All clinics provided site-specific information (e.g., #patients, frequency, staffing) and completed a self-assessment and case-note audit of their 10 most recent patients (8x newly diagnosed, 2x review), from which the clinic's current practices were evaluated against each Standard. The ADNeT research team prepared an evaluation report and highlighted achievements and opportunities for further improvement. In a virtual meeting, the clinic's outcomes were discussed in details, and clinic staff were asked to provide feedback on their experience of the process.

The clinic's adherence to the Guidelines ranged from 18 and 87%. Lowest results were achieved by the single specialty clinic, underlining the Guideline's specific purpose for multi-disciplinary memory clinics. Most clinics identified opportunities for immediate improvement and viewed the evaluation as a useful quality assurance exercise. All clinics commented that the data entry process was too time-consuming. Participating sites also noted some imbalances in the weighting of the current achievement ratings, which made the overall results more reflective of the resources available to the clinic than the quality of service they were providing. Learnings from the pilot phase will inform the establishment of a nation-wide memory clinic accreditation programme.

Future Directions

With new pharmacological therapies for early dementia and MCI on the horizon, highly accurate and specialised memory clinic assessments will gain importance. The ADNeT- memory clinic initiative has recently received funding to evaluate the current training and health infrastructure needs (e.g., access to specific imaging and blood tests) across Australian memory clinics to enable a national roll-out of novel pharmacological therapies when available. Additionally, 1-year funding from the federal Department of Health was received to continue the establishment of a formal Australian memory clinic accreditation program, explore opportunities to offer evidence-based cognitive interventions for people with dementia and MCI through memory clinics, trial a virtual memory clinic model supporting regional and remote areas, and strengthen the Australian memory clinics network to meet future demand.

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New dementia treatments: what matters to people

Dr Isolde Radford, Policy Manager
Alzheimer's Research UK

Almost one million people are living with dementia today. If nothing changes, one in two of us will be directly affected by the condition in our lifetime – either by developing it ourselves, caring for someone who has it, or both (ARUK 2023) As the UK's leading dementia research charity, Alzheimer's Research UK are striving for a cure, and there is hope on the horizon: the first new disease-modifying treatments for Alzheimer's disease could be available in the UK as early as next year.

Progress in research means we need to be clearer than ever about what outcomes we are seeking from new therapies. And it will mean different conversations between clinicians and patients about benefits and risks of treatment. Do we know what people who might take these new treatments really want from them? If interventions are increasingly aimed at the earlier stages of disease progression and a younger population, do we know what outcomes are most meaningful and relevant to them? What side-effects might they be willing to risk for the right outcome? And is this understood by the people developing, assessing, and one day prescribing these new treatments? (ARUK, 2023)

To answer some of these questions, we commissioned two pieces of research with leading universities, together representing the views of nearly 9,500 people across the UK from all walks of life. In both studies, a small number of people had mild cognitive impairment (MCI) or dementia:

The University of Edinburgh collected and analysed free text responses from over 5,800 people on what is important to them about their brain health and the outcomes that would matter most from a new dementia treatment. 3% of respondents had a diagnosis of MCI or dementia. (Saunders et al 2018, Watson et al 2019, Saunders et al 2021, Saunders et al 2022)

University Medical Centre Groningen surveyed over 3,600 people to determine the highest level of risk they would accept in exchange for delaying the progression of Alzheimer's disease to a more severe stage by two years. 15% of respondents reported living with memory problems. (Summings et al 2023)

Key Findings

Patient report Outcome Measures

The five most important patient-reported outcome measures identified were family connections, driving, socialising, reading and friendships. Most clinicians want to understand what will give their patients the best possible quality of life, yet the use of patient outcomes and preferences models is in its infancy, particularly for dementia. For example, the priority outcomes identified in this study are not included in the Clinical Dementia Rating scale (CDR) commonly used to assess the severity of dementia.

> *"Living rurally, driving is a major issue, my parents were three miles from the nearest town and 45 minutes from the nearest hospital. Both of my parents had to stop driving, my father due to Parkinson's dementia and then my mother who went on to display symptoms of Alzheimer's disease. Suddenly they were completely isolated. They were really reluctant to let go of the car as it signifies independence",*

- **Shelle Luscombe** cared for both her parents with dementia and is a member of the ARUK Policy Insights and Experience Panel.

> *"I love my reading, I couldn't do without my reading. I've always read...I would really miss my reading if I couldn't do it", -*

- **Martin Robertson** lives with posterior cortical atrophy and is a member of the ARUK Policy Insights and Experience Panel.

Acceptance of Risk

People are willing to accept a higher Maximum Acceptable Risk (MAR) than seen for other chronic diseases, perhaps due to the irreversible consequences of the progression of Alzheimer's disease. More than half of the respondents in the Groningen research were willing to accept very high risks for severe side effects. Whether or not someone was living with memory problems or had experience as a caregiver had no effect on the MAR for either mild, moderate or severe side effects.

Demographic differences

What matters most to people about their brain health and the side-effects they are willing to tolerate can depend on their individual characteristics and health. Many of the disease-modifying treatments in development now are aimed at the earlier stages of disease progression and a younger population, so it is important outcomes are meaningful and relevant to them.

- Priorities change as people progress from mild cognitive impairment through to diagnosed dementia, and between Alzheimer's and other forms of dementia. This underscores the need for tailored approaches to support individuals at different stages of the condition.
- Attitudes to risk were also influenced by whether people lived alone and their beliefs about the benefits and potential overuse of medicines. For example, being younger, male, more highly education, living alone, or having positive views about the general benefit of medicines were all associated with higher levels of risk acceptance.

Background

Research breakthroughs over the past few years have culminated in a new generation of treatments. For the first time, we have the prospect of drugs that act on the disease processes that cause dementia, rather than helping with symptoms alone. Two disease-modifying treatments for Alzheimer's disease – the most common cause of dementia – have already been approved in the US and one of these, lecanemab, is under consideration by European and UK regulators. A third, donanemab, is expected to be put forward to regulators later this year.

These first disease-modifying treatments will be followed by others. Indeed, there are over 140 further treatments currently in clinical trials (Cummings et al 2023) This wave of innovation means its more important than ever to include more sensitive measures such as patient-recorded outcomes in how we assess the benefits of new treatments.

To ensure these drugs are safe, they will need to be assessed by the Medicines and Healthcare products Regulatory Agency (MHRA). Then, to ensure they are an effective use of NHS resources they will need to be assessed by health technology assessors like the National Institute for Health and Care Excellence (NICE) and the Scottish Medicines Consortium (SMC).

Conclusion

As we strive to develop effective treatments for dementia, it is crucial to prioritise the perspectives and preferences of individuals living with the condition.

These perspectives need to be embedded through all parts of the medicines development pathway, from clinical trial design, through to regulation, health technology assessment and into clinical practice. The results of these research studies can help inform conversations between people with dementia and healthcare professionals, enabling clinicians to make more informed recommendations and support individuals in making decisions that align with their values and priorities.

We urge collaboration among stakeholders to agree how the outcomes that matter most to people with dementia and their attitudes to risk are appropriately measured and incorporated throughout the research and healthcare process. Clinicians have a vital role to play in this collaboration, listening to their patients and ensuring their voices are heard.

Working together, we can make significant strides in improving the lives of people with dementia and their families.

References are available on request

Monoclonal antibody therapy in Alzheimer disease

Arguably we find ourselves in a complex and uncertain therapy landscape as we await the outcome of regulatory appraisal in UK regarding lecanemab and potentially donanemab.

Both these intravenously administered monoclonal antibodies target the removal of amyloid and there is clearly lots to debate as we grapple with their potential role and relevance in the future treatment of Alzheimer's disease.

By spring 2024 we are anticipating we will know whether the Medicines and Healthcare products Regulatory Agency has approved lecanemab and if so, it is possible the National Institute for Health and Clinical Excellence and Scottish Medicines Consortium will have published their evaluation of lecanemab by September 2024.

We know from the survey of colleagues, delivering such treatments if approved for use within the NHS will raise challenges and opportunities for patients, professionals and the wider NHS.

To help explore these issues and think through the implications of delivering monoclonal antibodies, we have set up a series of CPD (remotely accessed and free) workshops to run in November. You should have received an invite to attend these workshops. If not, please contact Kitti Kottasz at the College via Kitti.Kottasz@rcpsych.ac.uk

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Faculty of Old Age Psychiatry

"Getting Ready for Disease Modifying Treatments"

CPD Workshops for Faculty members via Teams - November 2023

The workshops will run between 4-5pm with time for questions and discussion. These will be free and delivered remotely via Teams. For the full programme click here.

To register: The 4 webinars are set up as individual events so you can select each event you wish to attend. You will need to register separately for each webinar you choose.

Please click on the relevant session and it will take you to the registration page. Press the register button and fill in the relevant details. You will then be sent a confirmation email and an invitation to join the Teams webinar.

If you have any questions, please email Kitti Kottasz: kitti.kottasz@rcpsych.ac.uk

Please note – it will not be possible to issue certificates of attendance - so if you need to record your attendance, please do this independently.

Are we ready to deliver disease modifying treatments?

Old Age Psychiatrists' views on diagnosing and treating Alzheimer's disease before dementia.

May 2021

Brain Health Infographic

Dr Andrew Tait, FY2 Doctor
Dr Thomas McCabe, Consultant Psychiatrist, Supervisor
Royal Alexandra Hospital
NHS Greater Glasgow and Clyde

Background

Attendance at older adult psychiatric outpatient clinics can be a daunting experience for patients and loved ones. Furthermore, processing information offered in the face of cognitive deficits can be challenging for many. To simplify advice given as well as giving patients practical interventions based on evidence-based medicine, we reviewed our practices within our old age psychiatry service.

Many large, multi-centre studies have found that multiple domains of intervention can be utilised to prevent cognitive decline in the elderly.[i] Translating this data into our patient's management plans can be difficult for clinicians as such interventions can be viewed of as part of the wider multidisciplinary team role and not necessarily within the core skill set of an average old age psychiatrist. Cognitive training and exercise have a long-established history of improvements in global cognition, executive function, memory, and verbal fluency – which is only enhanced when completed together. Improvement this also seen with optimisation of nutrition too, which can boost serotonin production and improve sleep quality, reduced depression, and even help pain.[ii] Socialisation also plays a key role, with multiple studies showing that social isolation and withdrawal can significantly worsen cognitive function.[iii]

Given that the impact from these factors is well proven, and there are various strategies employed to intervene for each single domain, we extrapolated the common themes and reviewed under the headings; Nutrition, Exercise, Cognitive Stimulation and Socialisation. [iv][v][vi]

From there it was possible to create some 'tips for better brain health,' finding a practical way that patients can try to improve the health of their brain. To keep these patient/older adult friendly, whilst also practical, the below list was compiled:

Nutrition

1 – Increase dietary fruits, vegetables, fish, nuts, unsaturated oils and plant proteins

2 – Reduce alcohol consumption

3 – Reduced high sugary/fatty foods

Exercise

1 – Dance/walk a little every day

2 – Get off the bus early / park slightly further away

3 – Take the stairs

Cognitive Stimulation

1 – Challenge yourself with puzzles

2 – Learn a new skill

3 – Pick up a new hobby

Socialisation

1 – Call up friends you can't call in on or catch up with a neighbour

2 – Avoid social isolation, make new friends

3 – Get your hearing checked

Creating the poster

The aim of creating this poster was to ensure information could be conveyed in a way which was beneficial for patients. As such, it was important to make sure that the information was appropriate and displayed in a way which was easily visible and understandable.

Guidance for the presentation of the poster was taken from the Alzheimer's Society website. Here they have studied the best was to present information to people with Alzheimer's disease, a disease known to have a large impact on brain health. This highlighted some key aspects for the design of the poster, including:

- **Keep font large for printed documents – minimum size 14 Ariel**
- **Clump together information with space in between splitting**
- **Use contrasting colours**
- **Avoid thin columns**
- **Print on coloured paper**
- **Use of photographs on limited basis (cartoons not always helpful)**

Click or Scan the code above to view a video of tips for keeping brain healthy created by Trinity College of Dublin

Result

The results of the project can be seen on the next page. This utilised the advice from the Alzhemiers Society whilst also ensure accuracy and scientific basis for each step.

Summary

The positive impact of this poster was clear soon after implementation. Patients in waiting areas were found to be reading the information and discussing with those attending with them. This promoted a multi-factor approach to treating early cognitive decline and better improved options within the bio-psycho-social model of treatment. The general feedback is that the posters have had a positive impact and have proved to be a useful exercise. The evidence-based information provides clear and, although challenging for some, achievable options for patients to improve their brain health.

It is possible to speculate that this will impact patient management going forward. Potentially reducing the pharmacological burden on patients by providing alternative/adjuvant approaches to treatment. Furthermore, this empowers loved ones with a factor to focus on and contribute to outside of the classic interventions. As such, the older adult psychiatry community should aim to up-skill on less conventional interventions and improve resources to deliver such opportunities, given the ease and impact this project has had. Navigating some barriers to implementation of these interventions such as osteoarthritis, social isolation and reduced oral intake, will be our next challenge.

References are available on request

Wondering how to keep your brain healthy?

Try some of these simple steps to help your brain as healthy as can be.

Small changes can go a long way.

Nutrition

- Increase dietary fruits, vegetables, fish and nuts
- Reduce alcohol consumption
- Reduce foods high in sugar/fat

Exercise

- Dance a little every day
- Join an exercise class
- Take the stairs

Cognition

- Challenge yourself with a puzzle a day
- Learn a new skill e.g. language, instrument
- Pick up a new hobby e.g. chess or dominos

Socialise

- Call up an old friend or meet up for coffee
- Make new friends
- Don't limit yourself - Get your hearing checked!

Use your phone camera to view this short video --->

References: 1. Alzheimersresearchuk.org 2. Harvard Health - 12 ways to keep your brain young 3. Brainfoundation.org – Brain health
Created by Dr Andrew Tait (FY2). Supervisor Dr Thomas McCabe (Consultant)

Trainee Focus

Hi, Welcome to September and your new posts, especially those trainees who have just commenced their training programmes. We hope you're starting to get to grips with your new role and responsibilities. We thought now would be a great time in the year to zoom in on the curriculum and portfolio and so we asked someone who knows about these things. Many thanks to Dr Rosemary Gordon (ST6 GAP SE Scotland, Ex-Officio Psychiatric Trainees' Committee 2022-2023, Vice-Chair RCPsych Scottish Career & Workforce Committee) for her insights.

All the best, Lizzie and Becky (OA HT Reprasentatives)

Our new core and higher trainees are around a month into their first posts. What would be your advice for getting settled into their programmes?

There is so much to get used to when you start a new job including getting used to the day to day job, the on call rota, the portfolio, and thinking about exams or career progression. It can feel incredibly overwhelming at times.My advice is to work smart rather than only working hard. Try to be organised as early in your post as you can, work out what you need to do and when you need to do it and make a plan. Make the most of supervision, you don't need to navigate the intricacies of training on your own, there is tonnes of support available. If you aren't sure, ask someone.

You've been very involved in the development and roll out of the 2022 RCPsych curricula, could you give an elevator pitch run down of why the changes were made and the vibe of where we have moved to?

Changing the curricula wasn't something RCPscyh just decided to do. The GMC want the curricula of all medical royal colleges to follow the same generic professional capabilities (GPC) framework. If you look at the new curricula you will notice that the Higher Learning Outcomes (HLO) mirror the GPCs. The hope is that trainees and supervisors will be familiar with the new curricula so that it is easier to meet training needs and see where there might be gaps in learning.
The silver guide is my go-to for any practical questions I have.

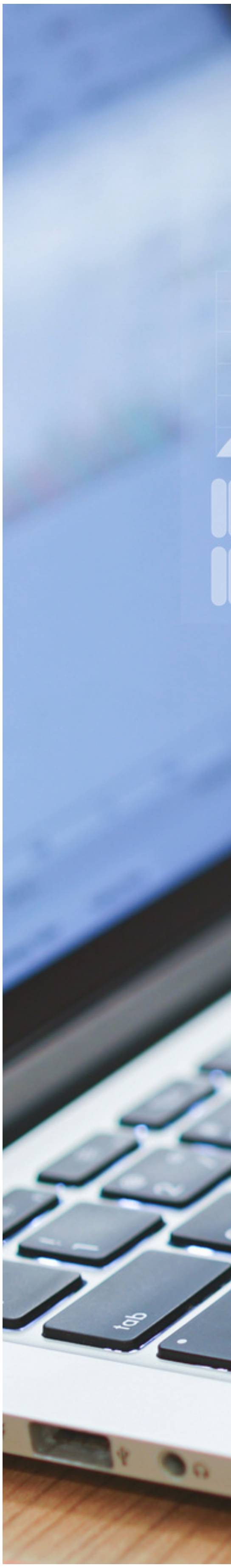
The e-portfolio is our platform for recording our experience, learning, and evidencing we are meeting curriculum requirements, how would you recommend the new trainees familiarise themselves with the portfolio and get started?

RCPsych have made a helpful e-learning about the new curricula and portfolio which I would advise everyone has a look at

https://rise.articulate.com/share/weJt9HEN_GHcvTqGD2e_1dx2nPUM4LQ7#

I would recommend having a look at your portfolio in the first couple of weeks and have a play around. Start your PSPDP early, you can add to this as you go through your post, but you don't want to be trying to do it all just before your ARCP. For example, if I was an ST4 I might write a PSPDP for HLO 3 (Knowledge of legal and organisational frameworks in your UK jurisdiction), then write a reflection on completing additional training for the relevant MHA for your jurisdiction and link it to my PSPDP. The PSPDP is the part that has changed the most and takes some getting used to, there are some example ones on the RCPsych website that will help.

https://www.rcpsych.ac.uk/training/curricula-and-guidance/curricula-implementation/curricula-documents-and-resources



What are the main differences, if any between how we use the portfolio to evidence our coverage of the curriculum in core training and higher training?

The fundamentals of how to evidence curricula coverage is the same in core training and higher training. However, the actual evidence may differ. With regards to workplace based assessments (WPBAs) the higher training requirements are focussed more towards teaching, leadership and clinical decision making compared to core training where there are more assessments of clinical expertise. It may feel like there is less opportunity in higher training to get WPBAs due to having a more autonomous role and more of your evidence might be reflections on cases, courses or other learning experiences.

How does the curriculum work for trainees doing endorsements such as liaison?

When you start your endorsement post you can add a subspecialty to your new (or not new if out of sync) training level folder. This will attach both your main specialty curricula but also the curricula for your endorsement to the folder.When you do your PSPDP you then link this to the curricula for your endorsement. You only need to link to your endorsement curricula (although you might do something that fits the wider specialty curricula better so you can still link to it, but there is no requirement to)

What are your top tips for efficient portfolio management?

1. Be organised – start early and discuss in supervision what parts of the curricula you want to cover and how you will do this

2. Preparation is key – have a look at the silver guide to confirm what WBPAs you need during the job and look for opportunities to get these done.

3. Little and often – try to keep up with your portfolio, link activities as you go along (a massive linking session a week before ARCP is not fun)

4. Change the narrative – the portfolio is often seen as hoops to jump through. Rather than seeing it as hoops try to think of it as a tool to ensure that you have the skills needed for when you finish training.

Faculty of Old Age Psychiatry Trainees Conference 2023

November 6th 2023
in-person at RCPsych, London

Call for posters deadline
Monday 18th September at 5pm

Please find the registration form on the RCPsych events page
For more information contact: charles.hale@rcpsych.ac.uk

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