

Project Report

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Management Summary

The project creates the Dementia Coordinator role to provide direct liaison between GP and patients who present with symptoms of dementia.

GP's refer directly to the Dementia Coordinator who is tasked with making contact with the patient, assessing needs and making onward referrals to appropriate services.

The aim of the role is to address social care issues for the patient and family at an early stage, thereby reducing the risk of hospital admission and/or inappropriate use of GP time.

Implicit in this is the understanding that family carers often provide the means by which the patient is able to remain at home. Supporting the carer to continue to care, therefore, is seen as an integral part of the role.

The Dementia Coordinator is able to refer directly to Mental Health Services, Social Services and a range of voluntary sector community and home care services that can support the patient and their family. In many cases, the Dementia Coordinator can act as a single point of contact for the patient, meaning that visits from services can be coordinated to ensure minimum impact on patient and/or family.

The project was slow to start, with awareness of the role being the key barrier. The second half of the project has seen a 200% increase in referrals from GPs as awareness of the role has expanded.

The project has benefitted greatly from the continued commitment of the CCG and those involved in commissioning the role. The positive encouragement and practical support received has been instrumental in helping establish and implement the role effectively.

Awareness of the role has been aided through discussion and presentations to approximately 180 individuals including personnel from NHS, Kent Police, voluntary and private sector services, as well as approximately 60+ family carers.

40 patient referrals have been made to date (plus 5 current), with 36 patients agreeing to engage. 85 service referrals have been made of which 11 patients have been referred to Community Mental Health Team (Older People) [CMHT(OP)]s, 11 patients have been referred to Social Services (1 patient requiring an Adult Protection investigation), 5 patients were referred to the Clinical Care Coordinator for clinical review in addition to social care services.

Project overview

GP patients identified as having cognitive issues are referred to the Dementia Coordinator (DC) via the Practice Link (PL) within the surgery. The PL may be a GP or administrator.

The DC will then contact with the patient (or their primary carer) and determine if they would agree to engage with the DC service.

If the patient wishes to engage, the DC will assess the patients' needs either by phone or by meeting, in order to signpost and/or refer to other services as appropriate. The patient is then contacted in 90 days to ensure services are adequate/appropriate.

If the patient does not yet wish to engage, the DC will create a diary entry for 90 days to make further contact to ensure services are still not required.

At each stage, the PL is kept informed of progress for each client ensuring the GP is aware of the services offered to the client.

The additional aspect to the Pilot Role is to create sustainable processes that can be modelled elsewhere. This includes processes for:

- Taking patient referrals
- Ensuring timely responses
- Making referrals to community services
- Ensuring referrals are actioned and/or appropriate
- Ensuring PL's are kept informed of patient status

As this is a pilot project, it is anticipated there will be more barriers than enablers. However, part of the pilot commission is to ensure barriers are identified and, wherever possible, overcome or minimised. This will impact on the initial effectiveness of the DC role, but should ensure future implementations are more effective at an earlier stage.

Dementia Care Coordinator Project

The Referral Process

When a GP identifies a patient or carer who may benefit from DC input, a referral needs to be forwarded to the Practice Link within the surgery.

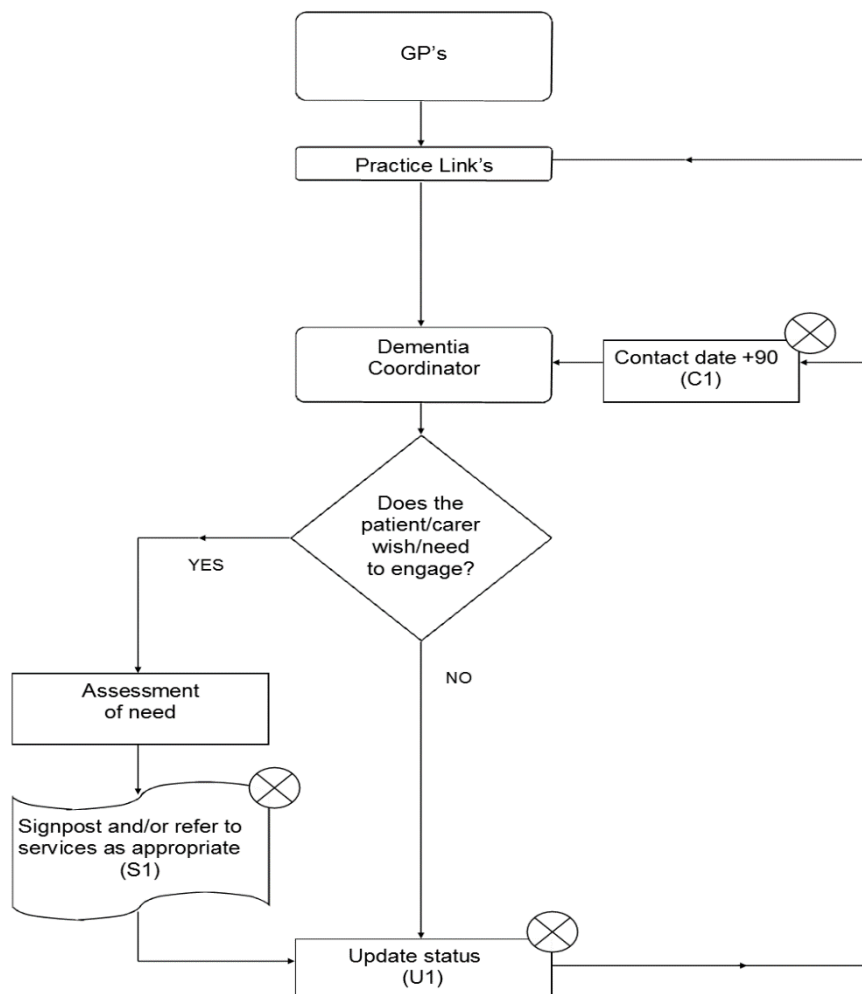
The DC will retrieve the referral the following day and make contact with the patient and determine if they wish to engage.

If the patient does not wish to engage at that time, a letter giving them direct contact details will be sent to them so that they have a single point of contact thereafter. The patient status will be updated and the PL notified of the actions.

If the patient does wish to engage, the DC will arrange a home visit in order to conduct an assessment of need. At this point, the DC will signpost and/or refer to other services as appropriate. The patient status will be updated and the PL notified of the actions (see Page 18).

Dementia Coordinator - Process Flowchart

The Referral Process



The Response/Triage Process

In discussions with the CCG, a need for a very basic triage process was considered. The Response flowchart indicates a dual-track process based on the GP's initial assessment of the patient's needs, by which the GP 'flags' the patient as needing a more urgent response.

On receipt of the referral, the DC will determine whether the patient has been referred before. It is anticipated that some patients may have seen the GP for reasons other than those associated with dementia (for example, a carer seeking help with generalised anxiety or stress) at an earlier time. At that time, the patient may not wish to engage with the DC, but in subsequent visits to the GP may change their mind.

Due to the progressive nature of dementia, it is foreseeable that the home situation may have deteriorated during visits to the GP and therefore it is reasonable to assume that some percentage of patients will require a more urgent assessment of need.

At the earliest stage of the pilot project, with no indication of the numbers of assessments anticipated, the dual-track targets were set thus:

- Patients flagged as urgent by the GP will be contacted by the DC within 24 hours. Having established contact, the Service Assessment (contact visit) by the DC will take place within a further 24 hours. Thus a patient visiting the GP on Monday, will be contacted on Tuesday, with a Service Assessment on Wednesday.
- Patients not flagged, will be contacted within 48 hours, with a Service Assessment within 7 days. Thus a patient visiting the GP on Monday, will be contacted by Wednesday, with a Service Assessment before the following Wednesday.

Clearly, these targets are dependent on a number of factors, which will be recorded:

- The referral being forwarded to the PL on the day of the GP visit.
- Patient availability: is the patient available on the days requested?
- Referral numbers: at the outset, there is no indication of the numbers of patients who may be referred. The targets are ambitious and will certainly need changing if a large number of patients are referred.
- The referral process being understood by GP's and Practice Links so that there are no delays within the referral process.

Project 0-3 months

Enablers

- Commissioners clear about role
The role has been clearly identified in terms of responsibilities, with a Service Level Agreement (SLA) stipulating the desired outcomes and expectations.
- Commissioning support at highest level
The lead commissioners of the project are able to determine, challenge and affect the SLA outcomes in terms of reviewing the scope and style of the DC role. This allows the role to mature and, if required, to change as the demands of the position are identified.
- Communications
Providing feedback to GPs has been made easier since the nhs.net email address has arrived as it satisfies the GPs confidentiality requirements when unencrypted feedback documents are sent.

Barriers

Landscaping

- Service model (responsibilities and reporting)
Once a patient had been referred, assessed and signposted on, it was unclear who needed to be informed. The GP is the key actor and referring agent, but all of the surgeries involved did not want GP's to receive feedback directly, preferring communication to go via the main surgery email. Whilst this is not overly challenging, future implementations of the project might establish a protocol prior to start, confirming link email addresses and preferred layout.
- Service fit (referrals and liaison)
Referrals have been exceedingly slow to arrive. To date (six weeks in) there have been 13 referrals of which 8 have come from one practice. Two practices have made a single referral, both of which have arrived in the past week. Most of the referrals have been appropriate, which is to say the patient has memory or cognition problems, and only two patients have declined to engage. One GP has requested a meeting to discuss the role and to ensure referrals made were appropriate.

Referrals from the Dementia Coordinator (DC) are also problematic. One example is that CMHT(OPS) will only take a referral from the GP as it is the GPs budget that is being used. This means that the GP might refer to the DC who then assesses and then suggests the GP refers on to CMHT. It can be seen that the GP may just dispense with the DC, even though the DC is providing a different service, preferring to make just one referral. Consideration might be given to the DC taking referrals from CMHT, where the GP is based within participating surgeries.

- Service practice (people and contacts)
Prior to start, two surgeries had identified a Practice Link (PL). The practical implementation of the PL role has worked in one of the two surgeries, where the identified person ensures referral paperwork is complete and is the single link for feedback to the GP. The other surgery PL is clearly very busy with other demands on

her time, meaning the 'link' has not been effective. The two remaining surgeries have yet to provide a single point of contact.

Language

- NHS/Social Care
A major barrier to date has been the divide in language and understanding between NHS services and the social care based DC. The NHS uses abbreviations and acronyms that are unfamiliar to anyone outside the NHS. Similarly, understanding of the outside social care systems by those within the NHS, have appeared to be barriers to communication. Future implementations of the DC role might consider a week of induction or shadowing several NHS personnel, such as DN, Clinical Coordinator and hospital social worker, in order to gain familiarity with the remit and language of each.

Similarly, the name of the role has proven to be problematic when engaging with patients, many of whom do not agree (or wish to believe) they have dementia. Whilst the title Dementia Coordinator is easy to place in discussion with other professionals, it creates an identifiable 'them and us' relationship with patients. Care Coordinator is easier for a patient to accept, even if it then needs expanding or explaining subsequently.

Commissioning

- Service links not aware/engaged
Services outside the surgery, in both NHS and social care fields, are not aware of the DC role and requirements. In most cases, it was understood that the DC would be in a position to appraise the service link, but this was dependent on the individual being open to the needs of the patient. One example of this was a patient who needed an urgent reassessment of need by Social Services. In contacting the Case Officer, she agreed to reassess the patient the following day but proviso on a joint visit, seeming to defer authority to (or pass responsibility to) the DC position. Consideration might be given to a commissioning statement being issued to statutory authority managers, voluntary sector providers etc to explain the nature of the DC role.
- Service communications (email, contact No. Etc)
The nhs.net email address has been instrumental in ensuring feedback to GPs has been secure. Future projects might wish to ensure this is in place before the project start.

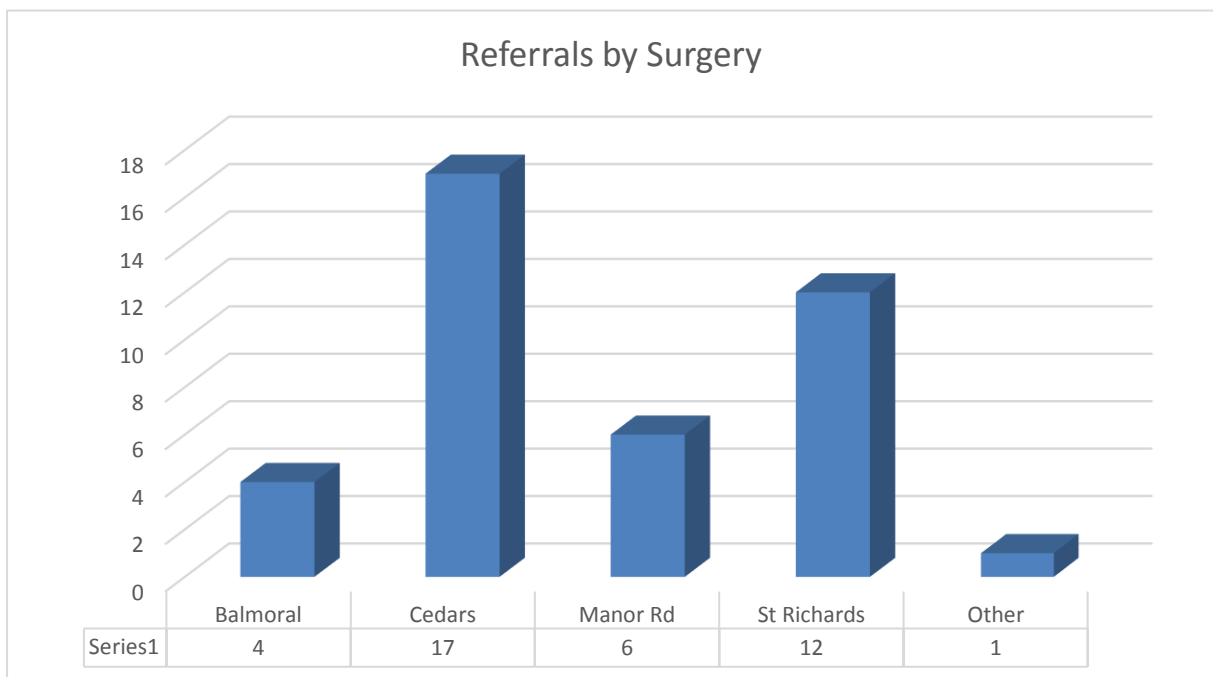
Pathways

- Data for patient uptake of services signposted/referred to by DC is reliant on the services communicating with the DC. Once a referral to a service has been made, the DC will usually not see the patient again for 90 days meaning that should a referral not be processed by the service, the DC will have no knowledge until the follow-up meeting. Consideration might be given to demand agencies funded (or part funded) by KCC, NHS or CCG, provide feedback to the DC.

Project 4-6 months

Notable positives:

- Increased GP awareness of role
Resulting in a 200% increase in referrals in the second half of the project from those made in the first half. A leaflet explaining the role to GPs was distributed (see page 16) and has received positive feedback.
- Direct Memory Clinic referrals
Referrals can now be made directly from the Dementia Coordinator to CMHT(OP). This has saved GP time and has built excellent links between the Dementia Coordinator service and members of the CMHT(OP) team. This has resulted in cooperative exchanges of information that has saved time and improved outcomes for patients.
- Dementia screening
GP's have agreed the Dementia Coordinator can administer the GPCOG dementia screening tool. This saves the GP time and, because it is conducted in the patient's home, is likely to more accurately reflect the true situation due to reduced stress.
- Raised community profile
Approximately 120 NHS staff, 20 personnel from other services (Kent Police, Community Warden Service, voluntary sector and private sector homecare services) and 20 family carers, have all attended presentations regarding the Dementia Coordinator role. Discussions of the role with 40+ individuals from other services and organisations in the Deal area have also taken place.
- Improved referral process
Referral forms and processes have been constantly reviewed and amended with feedback requested from many of the external services, including surgeries and CMHT(OP). This has resulted in a process that meets the needs of the role whilst providing the appropriate information to the referred service.



Future challenges:

- **Increasing GP awareness**
Whilst there has been a clear increase in the number of referrals to the Dementia Coordinator, there are still significant deficits that need to be addressed. Of the four surgeries, one of the largest has made the least amount of referrals meaning awareness of the role has not yet reached those GPs. Two of the largest surgeries (accounting for 29 of 40 patients) show a diversity of GPs making the referrals, suggesting awareness of the role encompasses the whole of the surgery. Consideration needs to be given to determine how to further engage with GP's to ensure the service is utilised fully.
- **Increasing patient/carer awareness**
In many cases, although the GP had sought permission from the patient to refer to the Dementia Coordinator, the family carer was unsure of what the assessment would involve and how it might support them. Although leaflets describing the role have been made available to surgeries, these appear not to have filtered through to the patient. Ensuring leaflets are within the GP reach during patient consultations, might improve this.
- **Streamlining the external referral process**
It is fair to say that early in the role, each patient seen would then require approximately two hours of office-time, creating feedback for GPs, referring to services and logging the data. Given the feedback from external service providers, this has reduced to approximately an hour, but still accounts for a significant amount of time that might otherwise be spent with patients. Reducing this further would benefit the patient and ensure cost-effective use of time.
- **Maintaining skills**
The role works closely with professionals from the statutory sector who require an understanding of their remit and responsibilities. For example, negotiation with CMHT(OP) and GPs regarding direct referrals was dependent on demonstrating an indepth knowledge of dementia, as well as an awareness of Mental Health services. It would benefit the professional standing of the Dementia Coordinator service if future post-holders were experienced in social care and dementia, and were expected (and able) to maintain and update their knowledge regularly via Athens.

Conclusions

The need for the Dementia Coordinator role is evident. The national drive towards social care and NHS integration notwithstanding, the local need for a link between the GP and patient for social care can be clearly seen in the data.

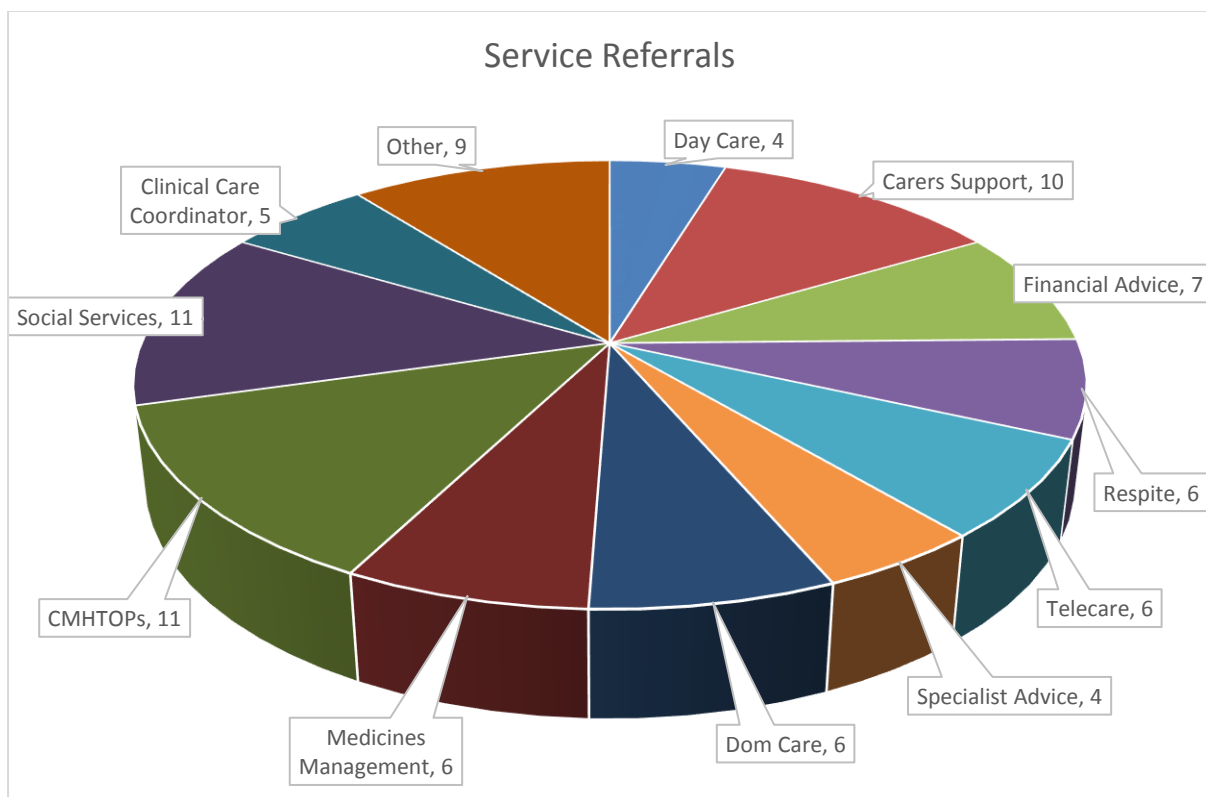
Of the 36 patients that engaged, 85 service referrals have been made:

- 11 of these have required referrals to Social Services
- 11 were referred to CMHT(OP)
- 12 patients required 3 or more services
- 6 patients required 6 or more services
- 1 patient was referred to Adult Protection
- 31 patients have required contact details for community services

Interest in the role has been shown from professionals in other local CCG areas.

Preventing hospital admissions is a clearly defined objective but is difficult to quantify given the admission has not occurred. However, 16 patients received a referral to either Social Services or CMHT(OP) that might otherwise have been delayed. Delay in these circumstances *greatly increases* risk of carer breakdown, GP intervention, or emergency services becoming involved.

Given the included figures, the need for a single point of contact for families is a lot easier to define: 75% of patients or their families, requested more information and a quarter of family carers required help or advice from Carer's Support.



Graph showing services referrals (March 2015)

Patient Case Studies - Mrs B

Mrs B is a 95 year old woman who lives at home with a live-in carer. Her home is a bungalow where she has lived for five years, having moved from Berkshire to be closer to her son who lives locally.

Assessment

Mrs B presents with some short-term memory loss, although she is able to express herself appropriately in most instances when given enough time to do so. Mrs B has chronic mobility difficulties caused by poorly functioning hip replacements exacerbated by dislocations to both shoulders, meaning she is unable to rely on a walking frame for support. Additionally, she has significant hearing loss making communication quite difficult.

Mrs B's live-in carer has a limited understanding of English and was unable to understand most of the queries directed to her. There was clear evidence of poor care and neglect, including loose medication found on different surfaces alongside discarded cups and food. The carer was unable to read English and was therefore not able to understand the medication labels, complete MAR sheets or record new prescriptions.

Mrs B stated clearly that she had no daily stimulation "...I do nothing all day..." and that the carer did not have the ability to escort to (or arrange) trips into town. When questioned about what activities Mrs B might undertake with support, the carer replied that she did not know.

Unhappy with my initial assessment findings, I managed to arrange a meeting with Mrs B's son, Mr B Jnr. He confirmed my assessment of the poor standard of care and added that Mrs B had spent at least one night on a urine-soaked mattress as she was "...too scared to call the carer".

Risks Identified

This patient was at high risk of hospital admission through:

- Clear evidence of neglect and the lack of stimulation, often leading to isolation and depression in older people.
- Poor continence management, placing Mrs B at risk of skin degradation and pressure sores
- Medication maladministration
- Evidence of poor hydration, often leading to UTI
- Evidence of poor nutrition, potentially leading to increase in falls due to weakness

Conclusion

It was agreed that a new live-in care agency would be required as a matter of urgency and Mr B Jnr was able to arrange this for the same week. It is quite likely that the new agency would be able to rectify the problems faced with medication, nutrition/hydration, isolation and raise Mrs B's quality of life.

At the same time an AP1 (Adult Protection) form was completed and submitted to Social Services, who later confirmed the new agency had started and were working with Social Services to improve the situation.

Patient Case Studies - Mrs C

Mrs C is an 85 year old woman who lives with her son-in-law Mr C Jnr in a mid-terrace, two storey, town house. Mrs C's husband died a short while ago and she is described by the GP as 'difficult to engage with'. Mr C Jnr had indicated to the GP and, over the telephone to me, that Mrs C had "...severe memory problems" which had led to several unsafe situations including a small fire. He also spoke of her medication not being self-administered appropriately and a general breakdown in their relationship.

Assessment

I met Mrs C and Mr C Jnr together, at Mrs C's request. Mrs C has COPD and generalised osteoarthritis and receives medication for both conditions.

During the time I spent at the home I saw no evidence of memory loss, sequencing problems or repetitive speech. Whilst her capacity is described as variable by Mr C Jnr, I found her understanding to be good and her recall of recent events to be excellent. The two incidents Mr C points to as evidence of dementia have occurred over the space of 24 months and, whilst clearly of concern, do not necessarily indicate anything other than incidental carelessness. Mrs C struggles to remain standing for periods longer than ten minutes, but is able to walk to the local bus-stop and travel into town unaccompanied. She finds her stairs difficult to manage when she is tired (at the end of the day, for example).

The relationship between Mr C Jnr and Mrs C appears to be the primary presentation. Their relationship could be described as combative and appears to result from resentment regarding the Will of Mr C Snr who gave his son the title to the property, but gave his wife leave to remain for the remainder of her life. Although Mrs C can be strong-willed and forthright in her opinions, Mr C Jnr makes few allowances for her age or declining health; for example, he continues to smoke inside the home despite Mrs C's respiratory difficulties and has refused to accompany her into town for essential visits.

Risks Identified

Mrs C was at risk of increased GP / social care input due to:

- COPD not being managed appropriately/considerately at home
- Poor self-administration of medication
- Family relationship confusing health concerns, leading to increase of calls to GP
- Family contacting Social Services inappropriately

Conclusion

The situation regarding Mrs C and Mr C Jnr's relationship is unlikely to improve. In other circumstances, this might be labelled 'carer breakdown' but for the fact that Mr C Jnr doesn't provide care. Mrs C and Mr C Jnr now have a single point of contact should they continue to struggle. I have referred Mrs C to Medicines Management to review how her self-administration might be improved and have suggested she contact Shepway Lifeline and In Touch for a keysafe. I have also referred to Social Services for an OT assessment for equipment and Blue Badge application. These referrals should enable Mrs C to remain safe for the near future.

Patient Case Studies - Mrs D

Mrs D is an 87 Year old woman living alone in a one-bed bungalow. Mrs D has severe mobility problems and rarely leaves home. She has a large supportive family, most of whom live locally, who visit her at irregular intervals.

Assessment

Mrs D has chronic kidney disease, congestive heart failure, cataracts in both eyes and recurrent depression with anxiety.

Mrs D has contacted her GP surgery on a number of occasions recently and it is felt by the GP that this might be due to loneliness rather than health issues.

Mrs D presents with some memory problems, particularly with time, dates and names. There was some evidence of dysphasic speech and she struggled to express herself at times, which she found frustrating. Mrs D acknowledges her memory has caused her difficulty recently and admitted she wasn't sure how many times she had contacted the GP as she often forgets she has already done so.

Mrs D lives alone but has caregivers 3x /day to help her with personal care and prompt for medication. Mrs D has said that, despite her caregiver's visits, she feels lonely much of the time as she is unable to leave the house.

Risks Identified

Mrs D is at risk of increased demand on NHS services due to:

- Memory deficits causing repeated telephone contacts to GP
- Telephone contacts to out-of-hours service
- Depression due to isolation

Conclusion

Mrs D has agreed to a referral to CMHT(OP) for a memory assessment and further support with her depressive disorder.

Mrs D appears to be 'inside the system' in terms of Social Services input and benefits, however she still feels isolated at times, so I have referred to Age UK to engage a befriending service that might be available to her.

Mrs D's family were also contacted who have agreed to structure their visits more formally between them, ensuring she receives more regular interaction.

Patient Case Studies - Mr E

Mr E is an 84 year old man living with his wife in a geographically isolated area. Mr E does not have a diagnosis of dementia, but the GP has noted memory loss symptoms recently. Mr E is in general good health and is fully ambulant. Mr E's wife has been admitted to hospital for a serious illness and it is not clear when she will return.

Assessment

Mr E presents with substantial short-term memory loss and some mild confusion. He becomes repetitive at times but is time and place aware.

Mrs E's hospital admission means that Mr E is alone for much of the time. Mr E's daughter Ms E Jnr has been able to stay overnight for the past week, but has work and family duties that mean she cannot stay every night. Ms E Jnr is often non-contactable when at work due to the nature of her job.

Ms E Jnr believes Mr E to be safe at night as he has an established routine, but acknowledges that he would not cope if anything out of the ordinary were to occur. This has happened on two previous occasions including once where he had left a tap running and subsequently flooded the kitchen. Mr E sometimes forgets his wife is in hospital.

Mr E walks his dog twice a day, covering approximately a mile each time. Although he feels he knows the route well, he acknowledges he has become lost on occasion.

Ms E Jnr and Mr E both say that respite away from home would not be in his best interest as it would disrupt his existing routines. Mr E is reticent to accept caregivers into his home.

Risks Identified

Mr E is at risk of emergency services contact due to:

- Becoming disoriented whilst walking the dog
- Becoming concerned when his wife fails to return home in the evening
- Inability to cope should an unexpected problem arise

Conclusion

I have requested an urgent assessment from Social Services and have also referred to CMHT(OP)s. Ms E Jnr has agreed to contact Lifeline to arrange for an urgent installation. I have advised her to enquire about geo-fence services, which will help locate Mr E should he fail to return home. I have also created a personal identifier card for Mr E to produce should he need assistance. With Mr E and Ms E Jnr's permission I have also forwarded his details, including likely routes, to Kent Search and Rescue who would be the primary contact for Kent Police in event of him failing to return home.

Patient Case Studies - Mr F

Mr F is an 84 year old man with mixed dementia and chronic kidney disease (s3). He lives with his son Mr F Jnr, Mr F Jnr's fiancée and their two young children.

Assessment

Mr F presents as having severe memory loss and confusion. He is symptomatic of fronto-temporal dementia, becoming anxious and aggressive at Mr F Jnr's with no apparent cause. Mr F appears to not be coping with personal care as he was unshaven and malodorous.

According to Mr F Jnr, Mr F will only attend to his personal care when Mr F Jnr makes a stand, something they both find upsetting. Mr F does not use the WC appropriately, urinating in cupboards, clothes and outside in the garden. He is disoriented in time and will wander around the home at night, calling out when anxious.

Mr F Jnr and his fiancée work full time, meaning that Mr F is on his own for much of the day. Whilst Mr F Jnr is able to 'pop in' during the day, this is ad hoc. Mr F Jnr believes Mr F's confusion has increased in the past few months and is not sure how much longer he will be able to support him without help.

Mr F Jnr is clearly not coping with the changes in his father and presented as emotional throughout our conversation, acknowledging he is 'at the end of his tether'. He has said that he has recently felt like taking his father to the nearest hospital and leaving him there, in order to get a good night's sleep.

Mr F Jnr is clear he wants to continue to provide care for his father and does not want him to go into respite or longer term residential care.

Risks Identified

Mr F is at risk of increased GP input / hospital admission due to:

- Carer breakdown / inability to cope
- Falls when he wanders around at night with no lights on
- Skin degradation leading to infection

Mr F Jnr is at risk of increased GP input due to:

- Inability to cope leading to anxiety, stress and possible depression
- Sleep disruption, exacerbating above symptoms

Conclusion

I have marked referrals to CMHT(OP)s and Social Services as Urgent and have followed up with telephone calls to ensure services are aware of the urgency of the situation. I have also referred to Carer's Support for an assessment and carer's card. Mr F Jnr will make enquiries into using the Dementia Suite at Age UK although he accepts this is likely to be unsuccessful due to Mr F refusing. I have referred to a carers charity for respite and, again, have stressed the high need for this family.

Patient Case Studies - Mrs G

Mrs G is a 79 year old woman with a diagnosis of Alzheimer's disease (2011). She usually lives alone however her son, Mr G Jnr, is currently staying with her. Mrs G's referral was marked 'urgent' by the GP and the assessment took place on the day of the referral.

Assessment

Mrs G presents with considerable short-term memory loss and disorientation in time which is masked by confabulation. This causes considerable difficulties as her presentation is entirely plausible and she will convince herself and others that an action has been taken when, in fact, it has not. Thus asking if she has showered or eaten will result in a positive response every time.

She currently has 1x self-funded 0.5hr care call in the morning, but Mr G Jnr is unhappy with the service provided which he has rated as 'poor'. Mr G Jnr has been the source of many of the details in this assessment.

Mrs G eats and drinks when Mr G Jnr is around, but otherwise will forget to do so. She will sometimes forget to turn taps and electricity supplies off, creating potentially risky situations.

Mr G Jnr's opinion is that his mother has shown a notable deterioration in the past 12 months and he is clearly struggling to cope. I believe that without his continued support, Mrs G would not be able to continue to live at home on her own as she is very vulnerable and would be unsafe for any period of time. Chris is currently signed-off from work and has GP input for anxiety and depression.

Risks Identified

Mrs G is at risk of increased GP input / hospital admission due to:

- Potential dehydration leading to UTI
- Carer breakdown / inability to cope
- Environmental risks caused by forgetting taps and power supplies

Mr G Jnr is at risk of increased GP input due to:

- Inability to cope and feelings of inadequacy in role leading to anxiety, stress and depression

Conclusion

Mr G Jnr needs support urgently. I made referrals to Social Services and CMHT(OP)s for Mrs G on the day I met her and received confirmation of receipt the following day. I also referred Mrs G to a domiciliary care company based at Age UK, for meal preparation and companionship, hopefully taking some of the pressure from Mr G Jnr prior to Social Services providing a service. Similarly a respite request has been sent which should also provide additional hours, including overnight stays when required. I have provided Mr G Jnr with details of an NHS funded service that provides talking therapies (for him) as well as a referral to Carer's Support for a carer's assessment.

Example letter and FAQ to GP's

Dear GP,

My name is Paul Watts and I am the **Dementia Care Coordinator** for your surgery.

My role is to 'plug the gap' between health and social care for people with dementia. In most cases, I can arrange to see the patient the same week which means support services can be put in place quickly.

You can refer anyone to me that presents as confused, with memory loss or with other signs of cognitive impairment. The patient does not need to have a diagnosis of dementia to be referred.

To make a referral, all I need is a patient summary printout and an indication whether the referral is urgent (24hr response and 48hr assessment) or non-urgent (48hr response and 7day response). Your Practice Coordinator Links all have a referrals folder which I collect every day. Should you wish to provide additional information please do so.

I am able to make direct referrals to the Mental Health team (including the Home Treatment Service and Admiral Nurses) and Social Services if necessary. I am also able to refer to a range of community services including day-care, respite care, meals-on-wheels and dementia specialist services.

Many thanks. I have attached a copy of a leaflet for patients but, if you have any questions, please contact me: firstname.surname10@nhs.net or 07000 123456

Do I need to make a referral to the Dementia Coordinator as well as Mental Health services? No. I am happy to assess the client and will make the referral on your behalf if required. The Mental Health team are aware of me and are willing to take referrals directly from me on your behalf. The same is true of Social Services.

Is there yet another form for me to complete? No. All I need is the summary patient printout and to know whether the assessment is urgent or not. I will complete the referral form on your behalf.

What experience do you have to assess patients? I am a qualified social worker and have 24yrs of experience in working in the community with adults with cognitive issues. I have trained approximately 400 professionals in dementia care awareness, including Kent Police, Community Wardens, Shepway Lifeline, British Red Cross and Age UK amongst others. I am an Independent Critical Incident Advisor for Kent Police for dementia and work on their strategic committee for dementia in Kent. I am also an Associate Researcher for Canterbury Christ Church University currently researching the experiences of family carer's of people with dementia.

Example letter for patients

Care Coordinator Service

Hello, my name is Paul Watts and I am one of the Care Coordinators for your surgery. I have worked in community care for about 24 years and know many of the local services, providers and organisations that support people to live at home.

What does a Care Coordinator do?

With my knowledge of local services, I am able to make suggestions as to what services might help support you. These might be agencies that provide (for example) meals, financial assessments, and advocacy or day services. I am also able to make direct referrals to Social Services or the Mental Health team if necessary.

Why has the GP referred me?

Your GP has identified you as someone who might benefit from additional information and/or support. My role is to let you know what is available and help you access it, if you wish.

What should I expect?

A chat. I will visit you (when convenient to you) and spend about an hour in which I will try to understand your circumstance. If you have any specific concerns, please bring them up at this time.

What will happen afterwards?

In agreement with you, I am able to make a direct referral to any of the local services, or provide the information so that you are able to contact them yourself. There is no obligation to take up any service at any time.

Dementia Coordinator – GP Feedback Sheet

Client ID: 1234

Signposted / Referred to:

Patient Needs:

Day Care	<input type="checkbox"/>	
Domiciliary Care	<input type="checkbox"/>	
Live-In Care	<input type="checkbox"/>	
Respite	<input type="checkbox"/>	
Specialist Advice	<input type="checkbox"/>	
Financial Advice	<input checked="" type="checkbox"/>	Age UK for benefits advice
Medicines Advice	<input type="checkbox"/>	
CMHT(OP)	<input checked="" type="checkbox"/>	Mrs G known to Psychiatrist—review due soon
Social Services	<input type="checkbox"/>	
Carer’s Support	<input checked="" type="checkbox"/>	Referral to Carer’s Support for Mr G
Other:	<input checked="" type="checkbox"/>	Psicon for Mr G

Mrs F NHS ID: 123 456 7890 Visited: 23/02/15

Mr G Jnr and Mrs G present. Mrs G presents with significant short-term memory loss. She confirms her very recent memory is reasonable but acknowledges her memory has caused her and Mr G Jnr difficulties at times. She states she hears music at loud volume throughout the day which disrupts her concentration. She mobilises poorly and has fallen recently, despite ICT installing hand-holds in the property. She is at high risk of future falls.

The greatest barrier to Mrs G achieving a higher quality of life is her inability to rise from bed at any particular time. She will frequently remain in bed until late afternoon (3pm is common) meaning that appointments or trips out are often unplannable. Mr G Jnr says that this remains the same even when they visit their holiday home in France, indicating that even with a change of environment the problem persists.

Mrs G is particularly concerned for her husband as he is visibly stressed by the ongoing situation and has experienced serious stress-related health concerns in the past. They appear to be very supportive towards one another, however the health issues are placing considerable strain on their relationship. Enabling Mr G Jnr to continue his role is of prime importance.