

Dementia management

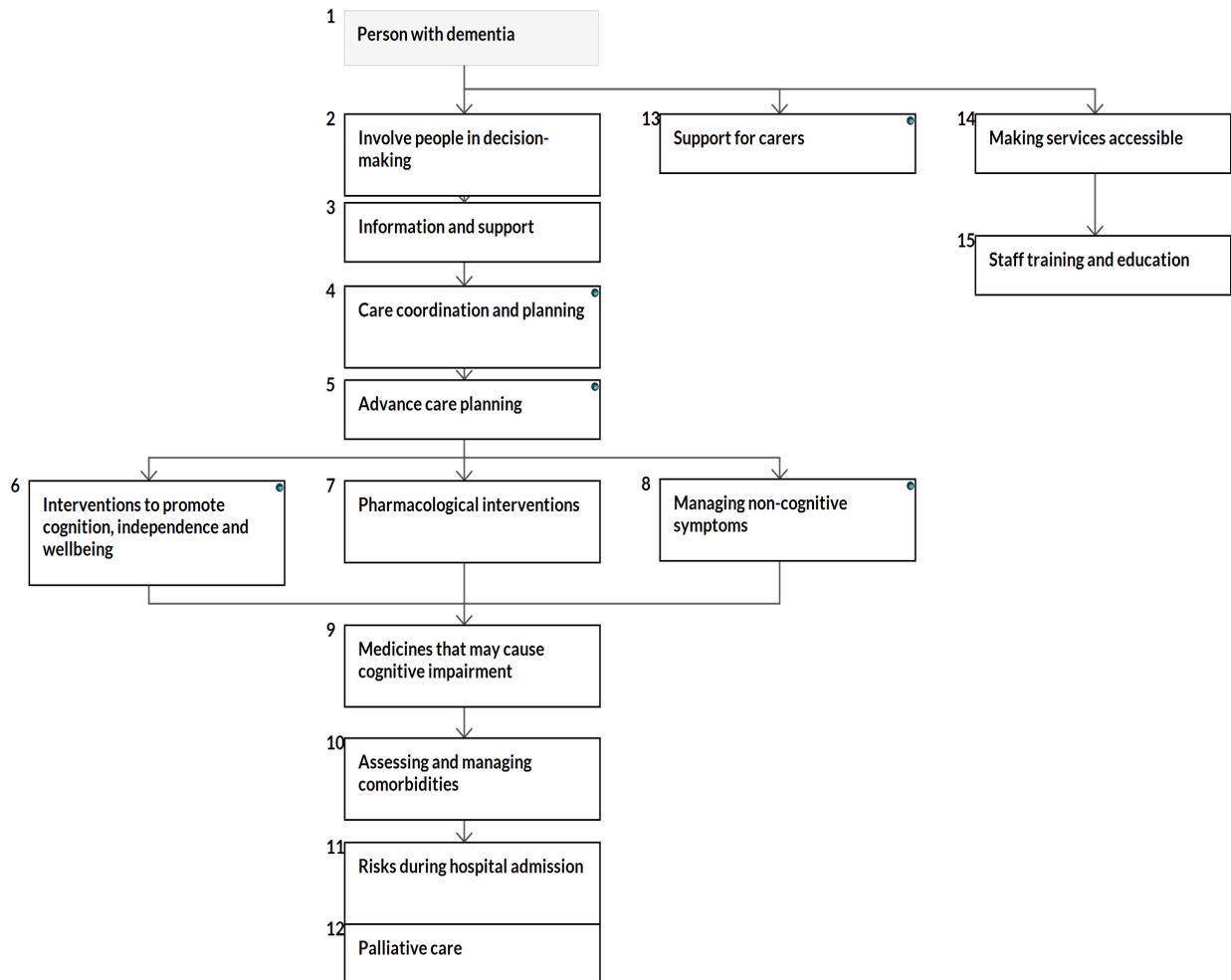
NICE Pathways bring together everything NICE says on a topic in an interactive flowchart. NICE Pathways are interactive and designed to be used online.

They are updated regularly as new NICE guidance is published. To view the latest version of this NICE Pathway see:

<http://pathways.nice.org.uk/pathways/dementia>

NICE Pathway last updated: 02 November 2020

This document contains a single flowchart and uses numbering to link the boxes to the associated recommendations.



1 Person with dementia

No additional information

2 Involve people in decision-making

Encourage and enable people living with dementia to give their own views and opinions about their care.

If needed, use additional or modified ways of communicating (for example visual aids or simplified text).

Consider using a structured tool to assess the likes and dislikes, routines and personal history of a person living with dementia.

3 Information and support

Provide people living with dementia and their family members or carers (as appropriate) with information that is relevant to their circumstances and the stage of their condition.

Be aware of the obligation to provide accessible information as detailed in the NHS [Accessible Information Standard](#). For more guidance on providing information and discussing people's preferences with them, see NICE's recommendations on [patient experience in adult NHS services](#) and [people's experience in adult social care services](#).

At diagnosis, offer the person and their family members or carers (as appropriate) oral and written information that explains:

- what their dementia subtype is and the changes to expect as the condition progresses
- which healthcare professionals and social care teams will be involved in their care and how to contact them
- if appropriate, how dementia affects driving, and that they need to tell the [Driver and Vehicle Licensing Agency](#) and their car insurer about their dementia diagnosis
- their legal rights and responsibilities
- their right to reasonable adjustments (in line with the [Equality Act 2010](#)) if they are working or looking for work
- how the following groups can help and how to contact them:

- - local support groups, online forums and national charities
 - financial and legal advice services
 - advocacy services.

After diagnosis, direct people and their family members or carers (as appropriate) to relevant services for information and support (see [care coordination and planning \[See page 4\]](#)).

For people who do not want follow-up appointments and who are not using other services, ask if they would like to be contacted again at a specified future date.

Ensure that people living with dementia and their carers know how to get more information and who from if their needs change.

Tell people living with dementia (at all stages of the condition) about research studies they could participate in.

Sharing information with others

If it has not been documented earlier, ask the person at diagnosis:

- for their consent for services to share information
- which people they would like services to share information with (for example family members or carers)
- what information they would like services to share.

Document these decisions in the person's records.

NICE has written information for the public on [dementia](#).

4 Care coordination and planning

Provide people living with dementia with a single named health or social care professional who is responsible for coordinating their care.

Named professionals should:

- arrange an initial assessment of the person's needs, which should be face to face if possible
- provide information about available services and how to access them
- involve the person's family members or carers (as appropriate) in support and decision-

- making
- give special consideration to the views of people who do not have capacity to make decisions about their care, in line with the principles of the [Mental Capacity Act 2005](#)
- ensure that people are aware of their rights to and the availability of local advocacy services, and if appropriate to the immediate situation an independent mental capacity advocate
- develop a care and support plan, and:
 - agree and review it with the involvement of the person, their family members or carers (as appropriate) and relevant professionals
 - specify in the plan when and how often it will be reviewed
 - evaluate and record progress towards the objectives at each review
 - ensure it covers the management of any comorbidities
 - provide a copy of the plan to the person and their family members or carers (as appropriate).

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

Dementia quality standard

4. Coordinating care

5 Advance care planning

Offer early and ongoing opportunities for people living with dementia and people involved in their care (see [information and support \[See page 3\]](#)) to discuss:

- the benefits of planning ahead
- lasting power of attorney (for health and welfare decisions and property and financial affairs decisions)
- an advance statement about their wishes, preferences, beliefs and values regarding their future care
- advance decisions to refuse treatment
- their preferences for place of care and place of death.

Explain that they will be given chances to review and change any advance statements and decisions they have made.

At each care review, offer people the chance to review and change any advance statements and decisions they have made.

NICE is developing a guideline on [decision-making and mental capacity](#) (publication expected July 2018).

Quality standards

The following quality statements are relevant to this part of the interactive flowchart.

Dementia quality standard

3. Advance care planning

6 Interventions to promote cognition, independence and wellbeing

Offer a range of activities to promote wellbeing that are tailored to the person's preferences.

Offer group cognitive stimulation therapy to people living with mild to moderate dementia.

Consider group reminiscence therapy for people living with mild to moderate dementia.

Consider [cognitive rehabilitation](#) [See page 22] or occupational therapy to support functional ability in people living with mild to moderate dementia.

Do not offer acupuncture to treat dementia.

Do not offer ginseng, vitamin E supplements, or herbal formulations to treat dementia.

Do not offer cognitive training to treat mild to moderate Alzheimer's disease.

Do not offer [interpersonal therapy](#) [See page 22] to treat the cognitive symptoms of mild to moderate Alzheimer's disease.

Do not offer non-invasive brain stimulation (including transcranial magnetic stimulation) to treat mild to moderate Alzheimer's disease, except as part of a randomised controlled trial.

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

Dementia quality standard

5. Activities to promote wellbeing

7 Pharmacological interventions

Managing medicines in the community

For guidance on managing medicines (including covert administration), see NICE's recommendations on [managing medicines for people receiving social care in the community](#) and [managing medicines in care homes](#).

Alzheimer's disease

Donepezil, galantamine, rivastigmine and memantine

1. The three AChE inhibitors donepezil, galantamine and rivastigmine as monotherapies are recommended as options for managing mild to moderate Alzheimer's disease under all of the conditions specified in recommendations 4 and 5 below.
2. Memantine monotherapy is recommended as an option for managing Alzheimer's disease for people with:
 - moderate Alzheimer's disease who are intolerant of or have a contraindication to AChE inhibitors **or**
 - severe Alzheimer's disease.

Treatment should be under the conditions specified in recommendation 4 below.

3. For people with an established diagnosis of Alzheimer's disease who are already taking an AChE inhibitor:
 - consider memantine in addition to an AChE inhibitor if they have moderate disease
 - offer memantine in addition to an AChE inhibitor if they have severe disease.
4. Treatment should be under the following conditions:
 - For people who are not taking an AChE inhibitor or memantine, prescribers should only start treatment with these on the advice of a clinician who has the necessary knowledge and skills. This could include:
 - secondary care medical specialists such as psychiatrists, geriatricians and

- - neurologists
 - other healthcare professionals (such as GPs, nurse consultants and advanced nurse practitioners), if they have specialist expertise in diagnosing and treating Alzheimer's disease.
- Once a decision has been made to start an AChE inhibitor or memantine, the first prescription may be made in primary care.
- For people with an established diagnosis of Alzheimer's disease who are already taking an AChE inhibitor, primary care prescribers may start treatment with memantine (see recommendation 3) without taking advice from a specialist clinician.
- Ensure that local arrangements for prescribing, supply and treatment review follow NICE guidance on [medicines optimisation](#).
- Do not stop AChE inhibitors in people with Alzheimer's disease because of disease severity alone.

5. If prescribing an AChE inhibitor (donepezil, galantamine or rivastigmine), treatment should normally be started with the drug with the lowest acquisition cost (taking into account required daily dose and the price per dose once shared care has started). However, an alternative AChE inhibitor could be prescribed if it is considered appropriate when taking into account adverse event profile, expectations about adherence, medical comorbidity, possibility of drug interactions and dosing profiles.

6. When using assessment scales to determine the severity of Alzheimer's disease, healthcare professionals should take into account any physical, sensory or learning disabilities, or communication difficulties that could affect the results and make any adjustments they consider appropriate. Healthcare professionals should also be mindful of the need to secure equality of access to treatment for patients from different ethnic groups, in particular those from different cultural backgrounds.

7. When assessing the severity of Alzheimer's disease and the need for treatment, healthcare professionals should not rely solely on cognition scores in circumstances in which it would be inappropriate to do so. These include:

- if the cognition score is not, or is not by itself, a clinically appropriate tool for assessing the severity of that patient's dementia because of the patient's learning difficulties or other disabilities (for example, sensory impairments), linguistic or other communication difficulties or level of education **or**
- if it is not possible to apply the tool in a language in which the patient is sufficiently fluent for it to be appropriate for assessing the severity of dementia **or**
- if there are other similar reasons why using a cognition score, or the score alone, would be inappropriate for assessing the severity of dementia.

In such cases healthcare professionals should determine the need for initiation or continuation of treatment by using another appropriate method of assessment.

Recommendations 1, 2, 5, 6 and 7 above are from NICE technology appraisal guidance on [donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease](#).

NICE has written information for the public on [donepezil, galantamine, rivastigmine and memantine](#).

Slowing the progression of Alzheimer's disease

Do not offer the following specifically to slow the progress of Alzheimer's disease, except as part of a randomised controlled trial:

- diabetes medicines
- hypertension medicines
- statins
- non-steroidal anti-inflammatory drugs, including aspirin.

Non-Alzheimer's dementia

Offer donepezil or rivastigmine to people with mild to moderate dementia with Lewy bodies¹.

Only consider galantamine² for people with mild to moderate dementia with Lewy bodies if donepezil and rivastigmine are not tolerated.

Consider donepezil or rivastigmine for people with severe dementia with Lewy bodies.

Consider memantine³ for people with dementia with Lewy bodies if AChE inhibitors⁴ are not tolerated or are contraindicated.

Only consider AChE inhibitors or memantine for people with vascular dementia if they have suspected comorbid Alzheimer's disease, Parkinson's disease dementia or dementia with Lewy bodies.

Do not offer AChE inhibitors or memantine to people with frontotemporal dementia⁵.

Do not offer AChE inhibitors or memantine to people with cognitive impairment caused by multiple sclerosis.

¹ At the time of publication (June 2018), donepezil and rivastigmine did not have a UK marketing authorisation for

this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Prescribing guidance: prescribing unlicensed medicines](#) for further information.

² At the time of publication (June 2018), galantamine did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Prescribing guidance: prescribing unlicensed medicines](#) for further information.

³ At the time of publication (June 2018), memantine did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Prescribing guidance: prescribing unlicensed medicines](#) for further information.

⁴ At the time of publication (June 2018), the AChE inhibitors donepezil, rivastigmine and galantamine did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Prescribing guidance: prescribing unlicensed medicines](#) for further information.

⁵ Note that logopenic aphasia, which has previously been included in some diagnostic guidelines for frontotemporal dementia, has now been shown to most commonly be caused by Alzheimer's disease.

For guidance on pharmacological management of Parkinson's disease dementia, see [Parkinson's disease dementia](#) in NICE's recommendations on Parkinson's disease.

8 Managing non-cognitive symptoms

Agitation, aggression, distress and psychosis

Before starting non-pharmacological or pharmacological treatment for distress in people living with dementia, conduct a structured assessment to:

- explore possible reasons for their distress **and**
- check for and address clinical or environmental causes (for example pain, delirium or inappropriate care).

As initial and ongoing management, offer psychosocial and environmental interventions to reduce distress in people living with dementia.

Only offer antipsychotics^{1, 2} for people living with dementia who are either:

- at risk of harming themselves or others **or**
- experiencing agitation, hallucinations or delusions that are causing them severe distress.

Be aware that for people with dementia with Lewy bodies or Parkinson's disease dementia, antipsychotics can worsen the motor features of the condition, and in some cases cause severe antipsychotic sensitivity reactions. For more information, see [psychotic symptoms \(hallucinations and delusions\)](#) in NICE's guidance on Parkinson's disease. Be aware that interventions may need to be modified for people living with dementia.

Before starting antipsychotics, discuss the benefits and harms with the person and their family members or carers (as appropriate). Consider using a decision aid to support this discussion. NICE has produced a patient decision aid on [antipsychotic medicines for treating agitation, aggression and distress in people living with dementia](#).

When using antipsychotics:

- use the lowest effective dose and use them for the shortest possible time
- reassess the person at least every 6 weeks, to check whether they still need medication.

Stop treatment with antipsychotics:

- if the person is not getting a clear ongoing benefit from taking them **and**

¹ The MHRA (2012) has given [advice for health and social care professionals on prescribing antipsychotics to people living with dementia](#) to treat the behavioural and psychological symptoms of dementia.

² At the time of publication (June 2018), the only antipsychotics with a UK marketing authorisation for this indication were risperidone and haloperidol. The marketing authorisation for risperidone only covers short-term treatment (up to 6 weeks) of persistent aggression in people with moderate to severe Alzheimer's disease unresponsive to non-pharmacological approaches and when there is a risk of harm to self or others. The marketing authorisation for haloperidol only covers treatment of persistent aggression and psychotic symptoms in people with moderate to severe Alzheimer's dementia and vascular dementia when non-pharmacological treatments have failed and when there is a risk of harm to self or others. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Prescribing guidance: prescribing unlicensed medicines](#) for further information.

- after discussion with the person taking them and their family members or carers (as appropriate).

Ensure that people living with dementia can continue to access psychosocial and environmental interventions for distress while they are taking antipsychotics and after they have stopped taking them.

For people living with dementia who experience agitation or aggression, offer personalised activities to promote engagement, pleasure and interest.

Do not offer valproate to manage agitation or aggression in people living with dementia, unless it is indicated for another condition¹.

NICE has published an evidence summary on [management of aggression, agitation and behavioural disturbances in dementia: carbamazepine](#).

Depression and anxiety

For people living with mild to moderate dementia who have mild to moderate depression and/or anxiety, consider psychological treatments.

Do not routinely offer antidepressants to manage mild to moderate depression in people living with mild to moderate dementia, unless they are indicated for a pre-existing severe mental health problem.

Sleep problems

Do not offer melatonin to manage insomnia in people living with Alzheimer's disease.

For people living with dementia who have sleep problems, consider a personalised multicomponent sleep management approach that includes sleep hygiene education, exposure to daylight, exercise and personalised activities.

Parkinson's disease

For guidance on managing Parkinson's disease symptoms in people with Parkinson's disease dementia or dementia with Lewy bodies, see [Parkinson's disease dementia](#) in NICE's recommendations on Parkinson's disease. Be aware that interventions may need to be modified for people living with dementia.

¹ If relevant, follow MHRA advice that [valproate medicines are contraindicated in women and girls of childbearing](#)

potential unless a Pregnancy Prevention Programme is in place.

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

Dementia quality standard

6. Managing distress

9 Medicines that may cause cognitive impairment

Be aware that some commonly prescribed medicines are associated with increased anticholinergic burden, and therefore cognitive impairment.

Consider minimising the use of medicines associated with increased anticholinergic burden, and if possible look for alternatives:

- when assessing whether to refer a person with suspected dementia for diagnosis
- during medication reviews with people living with dementia.

Be aware that there are validated tools for assessing anticholinergic burden (for example, the Anticholinergic Cognitive Burden Scale), but there is insufficient evidence to recommend one over the others.

For guidance on carrying out medication reviews, see [medication review](#) in NICE's guidance on medicines optimisation.

10 Assessing and managing comorbidities

Ensure equivalent access to care

Ensure that people living with dementia have equivalent access to diagnosis, treatment and care services for comorbidities to people who do not have dementia. For more guidance on assessing and managing multimorbidity, see NICE's recommendations on [multimorbidity and social care for older people with multiple long-term conditions](#).

For more guidance on providing support for older adults with learning disabilities, see NICE's recommendations on [care and support of people growing older with learning disabilities](#).

Pain

Consider using a structured observational pain assessment tool:

- alongside self-reported pain and standard clinical assessment for people living with moderate to severe dementia
- alongside standard clinical assessment for people living with dementia who are unable to self-report pain.

For people living with dementia who are in pain, consider using a stepwise treatment protocol that balances pain management and potential adverse events.

Repeat pain assessments for people living with dementia:

- who seem to be in pain
- who show signs of behavioural changes that may be caused by pain
- after any pain management intervention.

Falls

For guidance on managing the risk of falling for people living with dementia (in community and inpatient settings), see NICE's recommendations on [preventing falls in older people](#). When using this guidance:

- take account of the additional support people living with dementia may need to participate effectively
- be aware that multifactorial falls interventions may not be suitable for a person living with severe dementia.

Diabetes

For guidance on setting HbA1c targets for people living with severe dementia who have type 2 diabetes, see information on when to relax target levels in NICE's recommendations on [HbA1c targets](#) for managing blood glucose in adults with type 2 diabetes.

Incontinence

For guidance on pharmacological treatment of overactive bladder, see NICE technology appraisal guidance on [mirabegron for treating symptoms of overactive bladder](#).

For guidance on treating faecal incontinence, see NICE's recommendations on [managing faecal incontinence in specific groups](#).

Sensory impairment

For guidance on hearing assessments for people with suspected or diagnosed dementia, see [assessment and referral](#) in NICE's guidance on hearing loss.

Encourage people living with dementia to have eye tests every 2 years. Consider referring people who cannot organise appointments themselves.

11 Risks during hospital admission

Be aware of the increased risk of delirium in people living with dementia who are admitted to hospital. See NICE's recommendations on [delirium](#) for interventions to prevent and treat delirium.

When thinking about admission to hospital for a person living with severe dementia, carry out an assessment that balances their current medical needs with the additional harms they may face in hospital, for example:

- disorientation
- a longer length of stay
- increased mortality
- increased morbidity on discharge
- delirium
- the effects of being in an impersonal or institutional environment.

When thinking about admission to hospital for a person living with dementia, take into account:

- any advance care and support plans
- the value of keeping them in a familiar environment.

12 Palliative care

From diagnosis, offer people living with dementia flexible, needs-based palliative care that takes into account how unpredictable dementia progression can be.

For people living with dementia who are approaching the end of life, use an anticipatory healthcare planning process (see [advance care planning \[See page 5\]](#)). Involve the person and their family members or carers (as appropriate) as far as possible, and use the principles of

best-interest decision-making if the person does not have capacity to make decisions about their care.

For guidance on care for people in the last days of life, including quality standards and measures on palliative care, see what NICE says on [caring for an adult at the end of life](#).

For guidance on best interests decision-making, see what NICE says on [decision-making and mental capacity](#).

Encourage and support people living with dementia to eat and drink, taking into account their nutritional needs.

Consider involving a speech and language therapist if there are concerns about a person's safety when eating and drinking.

Do not routinely use enteral feeding in people living with severe dementia, unless indicated for a potentially reversible comorbidity. NICE has produced a patient decision aid on [enteral feeding for people living with severe dementia](#).

13 Support for carers

Offer carers of people living with dementia a psychoeducation and skills training intervention that includes:

- education about dementia, its symptoms and the changes to expect as the condition progresses
- developing personalised strategies and building carer skills
- training to help them provide care, including how to understand and respond to changes in behaviour
- training to help them adapt their communication styles to improve interactions with the person living with dementia
- advice on how to look after their own physical and mental health, and their emotional and spiritual wellbeing
- advice on planning enjoyable and meaningful activities to do with the person they care for
- information about relevant services (including support services and psychological therapies for carers) and how to access them
- advice on planning for the future.

Ensure that the support provided to carers is:

- tailored to their needs and preferences and to what they want it to achieve (for example, providing information on carer's employment rights for carers who work or want to work)
- designed to help them support people living with dementia
- available at a location they can get to easily
- provided in a format suitable for them (for example individual or group sessions, or online training and support)
- available from diagnosis and as needed after this.

Be aware that carer interventions are likely to be most effective when provided as group sessions.

Advise carers about their right to the following and how to get them:

- a formal assessment of their own needs (known as a 'Carer's Assessment'), including their physical and mental health
- an assessment of their need for short breaks and other respite care.

Be aware that carers of people living with dementia are at an increased risk of depression. For guidance on identifying and managing depression, see NICE's recommendations on [depression](#) in adults.

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

Dementia quality standard

7. Supporting carers

14 Making services accessible

Service providers should design services to be accessible to as many people living with dementia as possible, including:

- people who do not have a carer or whose carer cannot support them on their own
- people who do not have access to affordable transport, or find transport difficult to use
- people who have other responsibilities (such as work, children or being a carer themselves)
- people with learning disabilities, sensory impairment (such as sight or hearing loss) or physical disabilities

- people who may be less likely to access health and social care services, such as people from black, Asian and minority ethnic groups.

15 Staff training and education

Care and support providers should provide all staff with training in person-centred and outcome-focused care for people living with dementia, which should include:

- understanding the signs and symptoms of dementia, and the changes to expect as the condition progresses
- understanding the person as an individual, and their life story
- respecting the person's individual identity, sexuality and culture
- understanding the needs of the person and their family members or carers
- the principles of the [Mental Capacity Act 2005](#) and the [Care Act 2014](#).

Care providers should provide additional face-to-face training and mentoring to staff who deliver care and support to people living with dementia. This should include:

- understanding the organisation's model of dementia care and how it provides care
- how to monitor and respond to the lived experience of people living with dementia, including adapting communication styles
- initial training on understanding, reacting to and helping people living with dementia who experience agitation, aggression or pain, or other behaviours indicating distress
- follow-up sessions where staff can receive additional feedback and discuss particular situations
- advice on interventions that reduce the need for antipsychotics and allow doses to be safely reduced
- promoting freedom of movement and minimising the use of restraint
- if relevant to staff, the specific needs of younger people living with dementia and people who are working or looking for work.

Consider giving carers and/or family members the opportunity to attend and take part in staff dementia training sessions.

Consider training staff to provide multi-sensory stimulation for people with moderate to severe dementia and communication difficulties.

Ensure that all health and social care staff are aware of:

- the extent of their responsibility to protect confidentiality under data protection legislation

- **and**
- any rights that family members, carers and others have to information about the person's care (see guidance on information sharing between different care settings in [care coordination and planning \[See page 4\]](#)).

Health and social care professionals advising people living with dementia (including professionals involved in diagnosis) should be trained in starting and holding difficult and emotionally challenging conversations.

Brief structured attachment-focused therapies for people with mild to moderate depression. These therapies are based on the idea that difficulties interacting with other people can cause psychological symptoms such as depressed mood, which then make the difficulties with interaction worse, causing a cycle. Interpersonal therapies aim to help people interact more effectively with others, and through this improve the psychological symptoms. Therapy typically focuses on relationship issues such as conflict, difficulty starting or maintaining relationships, grief and loss, and life changes.

Identifying functional goals that are relevant to the person living with dementia, and working with them and their family members or carers to achieve these. The emphasis is on improving or maintaining functioning in everyday life, building on the person's strengths and finding ways to compensate for impairments, and supporting independence. Cognitive rehabilitation does not aim to improve cognition, but it addresses the disability resulting from the impact of cognitive impairment on everyday functioning and activity. Rehabilitation is sometimes referred to as 'reablement'.

Glossary

AChE

acetylcholinesterase

cognitive stimulation

engaging in a range of activities and discussions (usually in a group) that are aimed at general improvement of cognitive and social functioning

cognitive training

guided practice on a set of standard tasks that are designed to reflect particular cognitive functions; there may be a range of difficulty levels, to fit the tasks to each person's level of ability

specialist clinician

(for the purpose of starting and monitoring treatment with cholinesterase inhibitors and memantine) those with appropriate knowledge and skills and include secondary care medical specialists (for example psychiatrists, geriatricians and neurologists) and other healthcare professionals (for example GPs, nurse consultants and advanced nurse practitioners) with specialist expertise in diagnosing and treating Alzheimer's disease

Sources

Dementia: assessment, management and support for people living with dementia and their carers (2018) NICE guideline NG97

Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease (2011 updated 2018) NICE technology appraisal guidance 217

Your responsibility

Guidelines

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Technology appraisals

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, health

professionals are expected to take these recommendations fully into account, alongside the individual needs, preferences and values of their patients. The application of the recommendations in this interactive flowchart is at the discretion of health professionals and their individual patients and do not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Commissioners and/or providers have a responsibility to provide the funding required to enable the recommendations to be applied when individual health professionals and their patients wish to use it, in accordance with the NHS Constitution. They should do so in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Medical technologies guidance, diagnostics guidance and interventional procedures guidance

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, healthcare professionals are expected to take these recommendations fully into account. However, the interactive flowchart does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Commissioners and/or providers have a responsibility to implement the recommendations, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this interactive flowchart should be interpreted in a way that would be inconsistent with compliance with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.