What makes a good dementia care memory service?

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Memory services have a central role in the whole process of dementia care. With the new NHS five year plan emphasising integration between services and bridging the primary/secondary care divide, it is essential for memory services to learn from each other. In this review, Dr de Silva examines three memory services of varying size and complexity and assesses their effectiveness, additionally what the future could offer with ‘one stop shop’.

Memory services have been in place in the National Health Service (NHS) over the last 20 years in a variety of forms ranging from a hospital outpatient clinic,¹ to a service entirely based in primary care.² Other potential innovations, such as a clinic attached to a geriatric day hospital or a rotating clinic, have not been described. Furthermore, performance benchmarking between the 300-plus NHS services has not been carried out, with the exception of the 100 services incorporated into the memory services accreditation programme (MSNAP) organised by the Royal College of Psychiatrists.

In this article, three services of varying size and complexity are described with an attempt to identify innovations which have led to effectiveness in terms of waiting times to be seen, patient related outcome measures (PROMs) and the percentage of patients predicted to have dementia who subsequently receive a diagnosis of dementia. The services described are in Whitby, North Shields and Sunderland in the North East of England.

The average diagnostic rate nationally is around 45%,³ and there is some evidence that the areas with a dedicated memory service have higher diagnostic rates.⁴ It is not known if there is an association between shorter waiting times and higher diagnostic rates. In the meantime, financial inducements per patient for primary care to increase diagnosis rates have been considered by NHS England.

Whitby CMHT memory service
This rural service – an extension of the community mental health team (CMHT) – covers Whitby and the surrounding North Yorks Moors National Park (area 40 000 square miles). The overall population is 24 000 with 5000 people over the age of 65 years. The team consists of a half time equivalent (0.5) secretary, 0.5 consultant, three staff nurses, 0.5 occupational therapist (OT) and clinical psychology consultant input if needed. The main third sector provider is the Alzheimer’s Society.

There are two options for neuroimaging – Scarborough and Middlesbrough general hospitals, both involving a 45 minute drive. However, volunteer drivers are available, and GPs can request a computed tomography (CT) or magnetic resonance image (MRI) scan prior to referral, as agreed in the integrated care pathway between primary and secondary care. On average the service receives between 4–6 referrals per week.

The key features promoting accessibility include daily triaging of referrals with open appointment slots used at the time, followed by telephone confirmation. Depending on rurality and frailty a decision is made for a home visit. The daily triage also decides on the skill mix needed for the initial assessment (for example, the need for the OT or consultant to accompany the nurse).

In terms of quality, over the last two years there has been a carer’s clinic run by the Alzheimer’s Society at the CMHT site at the time of the memory follow up clinic. This has helped both services, for example by optimising staff time and encouraging more referrals for local initiatives including ‘singing for the brain’ and the memory café. The local Citizen’s Advice Bureau helps with benefit forms and has good contacts with the memory clinic.

North Shields memory clinic
This service covers a suburban area with a population of 150 000 involving an over 65 year old population of around 25 000. The main general hospital is in North Shields, about a mile from the clinic with MRI and CT scanning facilities. The team consists of two administration staff, 0.4 consultant, a community psychiatric nurse (CPN) covering young-onset cognitive impairment, three staff nurses and a further three healthcare assistants who can carry out
electrocardiograph (ECG) checks. The nurses carry out blood testing (if not done by GPs) and arrange for all results to be made available to the consultant psychiatrist for diagnosis and treatment planning. Nurses lead the follow-up service with access to the consultant for advice. Overall, the service receives 10–20 referrals a week.

In terms of accessibility, there is a daily triaging process of all referrals to the old age psychiatry service with diversion to the memory clinic if appropriate (ie non-urgent, low risk patients). People referred are then allocated appointments by administration staff and offered hospital transport. ECG and blood tests are carried out by nurses during the initial assessment.

Quality features include access to memory strategy and carers groups (run by clinic staff) and access to community OT (provided by the CMHT) for additional risk assessment. Neuropsychology is available if needed. Memory support nurses in the community provide support following discharge, including support to patients diagnosed with mild cognitive impairment (MCI).

Patients and carers are offered refreshments at the clinic by reception staff. There are active links with DeNDRoN (clinical research network, dementias and neurodegeneration) with options to be discussed during the diagnostic session.

**South of Tyne memory protection service**

The memory protection service (MPS) covers the Cities of Sunderland, Gateshead and South Shields, a population of 500 000 with an over-65 population of 50 000. The team consists of 1.5 consultants, three GPs with special interests (three sessions in total), an OT, 1.5 clinical psychologists and six nurse practitioners who undertake most of the initial assessments. The admin team consists of four full-time staff. The team receives around 40 referrals per week. Self-referrals are accepted but a GP is contacted to provide blood results, medication and clinical history. In terms of accessibility, the initial assessments and diagnostic appointments are carried out in four-GP practice, with a prompt medical review of the findings leading to decisions on neuroimaging, medication optimisation (including recommendation of antidepressants) and other assessments (such as OT or neuropsychology).

High quality aspects of the service include initial assessment / triage clinics held at the primary care, where a consultant reviews patients on the same day they are seen by the nurse practitioners. This allows prompt management planning, including arranging imaging, OT or neuropsychology assessment. Furthermore, patients can be discharged if there is no need to continue memory assessment. Another quality aspect is access to a single educational group session, alongside a longer term memory strategy group run by clinical psychology. Prescriptions (similar to the other two services) are provided via the service until a patient is stabilised on a suitable memory enhancer within three months.

There is access to medical support daily to manage any difficulties with treatment. A film club for patients and carers is being planned with the help of the carer’s organisation in the area, the Essence of dementia and neurodegeneration service. This confers a number of benefits including reminiscence, cognitive enhancement, relationship building and opportunities for information provision.

**How services compare on performance**

For the Whitby clinic, the time from referral to initial assessment varies between two to three weeks with a further two to three weeks to receive a diagnosis. Therefore the maximum wait between referral to diagnosis is six weeks. The method used for PROMs is the patient satisfaction survey, which includes the friends and family test. Results (available biannually) over the last three years have been consistently positive.

For North Shields, the time from referral to initial assessment has improved over the last year to between two to three weeks, with a further five to six weeks for diagnostic review, a total of nine weeks. PROMs are measured every month with a questionnaire called ‘2 minutes of your time’ which includes the friends and family test, with evidence of improvement over the last year.

The MPS clinic currently has a wait time to be seen of four to six weeks, with a further 12 weeks for a diagnostic appointment. It is hoped that reductions in this waiting time will be possible with a full staffing complement involving a further 1.5 consultants. PROMs feedback is via the patient satisfaction survey, with information collected every six months, with results (which have bee stable over the last two years) being broadly similar to the Whitby Clinic. North Shields and MPS clinics are part of MSNAP with the latter graded as ‘excellent’.

The overall percentage diagnosis of dementia compared to the expected figure in each area is 45% for Whitby, 49% for North Shields and 67% for MPS. These figures have been stable over the last year. The Whitby clinic has been in existence for 15 years, similar to North Shields. However, the MPS has only been in existence for two years.
Discussion
The striking difference in figures is on the percentage of dementia diagnoses. There does not appear to be a direct association between waiting time to be seen and the diagnostic rate. The most recently established clinic (MPS) had the highest diagnostic rate (77%), despite having the longest waiting times. It is possible that full involvement of the local GP commissioners prior to the clinic being set up and clinics based in primary care, alongside a strategy of regular presentations in the local community and media, have all contributed to a higher diagnostic rate. Alternatively this might reflect a higher rate of diagnoses of dementia by the three general hospitals south of the Tyne.

However, caution needs to be exercised, as it is possible that clinic patients with mild cognitive impairment and general hospital patients with subacute delirium have been incorrectly diagnosed with dementia. Using research based diagnostic criteria could help, and this is currently being applied in the MPS clinic. Ideally, a research project following up patients diagnosed as having MCI after two years to determine diagnostic accuracy should take place.

It is likely that arranging and reporting a scan is the main factor impacting on the time taken to make a diagnosis. The willingness of GPs in Whitby to refer for neuroimaging prior to specialist referral was probably helpful in achieving a short waiting time. In the North Shields clinic, the nurse assessors were responsible for completing the scan referral (mostly for MRI), countersigned by the consultant.

The radiology department in North Shields has made significant improvements by limiting scan reporting time to two weeks, partly as a consequence of data from the memory clinic (which is run by the same acute trust). Nurse practitioners in the MPS clinic had to wait until medical review for an appropriate scan referral to be made. However, the wait for a scan and subsequent report (around four to six weeks) probably accounted for most of the delay. It would be helpful for a ‘walk in’ CT scanning service to be agreed in all three services, including scanning over the weekend.

The third area of variability was the process of triage. Both Whitby and North Shields had a daily triage system with use of open appointment slots for initial assessment. MPS did not have this capability, partly due to the larger number of referrals, and limited space in primary care settings. Limited space was a factor in arranging diagnostic appointments as well. The potential of home visits in Whitby probably helped, as did the relatively large number of rooms in the North Shields clinic, whilst the early onset service was entirely home visit based.

Prospects for a one-stop shop?
It is possible to envisage a one-stop shop (similar to a breast clinic) based in a geriatric day hospital close to the radiology department. The benefits include utilising clinic rooms to maximum efficiency (including Saturday clinics) and having access to blood testing, ECG and brain scanning within the same site, ideally coordinated within a single morning. Furthermore, integration with other day hospital clinics, for example, falls, Parkinson’s and stroke clinics, could improve access to the memory clinic and build up diagnostic rates. It would be easy for old age wards (including orthopaedics) to get an opinion on cognitive decline prior to discharge. Easy access to the memory clinic from hospital wards would also increase the diagnostic accuracy in subacute delirium.

Access to OT, physiotherapy and dietetics could be provided by the day hospital – a further cost saving. The memory clinic could be rotated between a number of day hospitals based on demand and room availability. Triaging and appointment setting could be shared by all clinics at the day hospital saving on administration staff, and using the same computer infrastructure. Clinicians working in the different clinics could learn from each other, and this placement could be an ideal learning environment for both GP trainees, GPs with a special interest and medical students.

The main drawback of a one-stop clinic for memory would be the lack of pre-diagnostic support, as potentially a diagnosis could be given on the same day. However, a later diagnostic appointment could be an option available to patients, with back-up by community memory support nurses or contact with the local branch of the Alzheimer’s Society being arranged in between. Only structural imaging could be incorporated in a one stop-shop. However, functional scanning (single-photon emission computed tomography and dopamine transporter) is typically arranged after structural imaging.

Younger patients with cognitive impairment might not be willing to attend a day hospital for older patients. However, most day hospitals have an outreach facility, which could be offered in these cases. The cultural divide between psychiatry and other medical specialties needs to be kept in mind, but joint planning by clinical leads prior to integrating a memory clinic at the day hospital would reduce the impact of this issue.
Common post-diagnostic support service?
The alternative to a single assessment service is a common post diagnostic pathway agreed by all local assessors (Neurology, Old Age Psychiatry, Geriatrics and Specialist GPs). This pathway (ideally run by old age psychiatry) would include signposting to local resources, carers groups, initiation of prescribing, cognitive enhancement and referral to social services or community mental health teams when needed.

This type of service increases the consistency of post diagnostic provision and hopefully reduces the risk of patients accessing emergency and on-call services and potential admission. It allows multiple assessment sources for GPs to refer to depending on the type of dementia and co-morbid factors. A clinical network of assessors could also assist cross referral of more complex cases and facilitate inter specialty education.

Conclusions
Three memory services in the North East of England have been described, comparing process, quality and outcome. The need for daily triage, open appointment slots and rapid access to imaging has been highlighted. Furthermore, the prospects for a memory clinic based at a day hospital has been considered, with the main benefits and drawbacks discussed.

Memory services have a central role in the whole process of dementia care. With the new NHS Five-Year Forward View emphasising integration between services and bridging the primary secondary divide, it is essential for memory services to learn from each other in order to optimise efficiency and quality. This is best done by joining MSNAP. Furthermore, prompt and accurate diagnosis, coupled with appropriate education and preventive work could increase the amount of quality time in the community and reduce urgent hospital admission.

Dr de Silva is a retired Consultant Old Age Psychiatrist.

Declaration of interests
No conflicts of interest were declared.

References