1.0 Background

1.1 A specialist service has been established within the Practice since June 2006. It was the vision of Dr Ian Greaves that patients with memory problems and possible dementia or related conditions should be assessed, investigated and treated without delay, discouragement or the complications sometimes associated with referral to hospital-based services. This was one component of a wider initiative whereby specialists in a number of disciplines would contribute clinics within the Health Centre.

1.2 The arguments for a specialist memory clinic within Primary Care are strong:

1.2.1 It is a common experience that dementia and similar conditions are under-recognised within Primary Care and it is believed that this means that individuals and families receive less than optimal care and treatment.

1.2.2 Dementia is concentrated amongst people over 75 years and is often associated with other pathologies. It also occurs, though less commonly, among younger people (50 years and over – very rarely amongst even younger people) when it can easily be mistaken for other conditions.

1.2.3 Patients and families are sometimes reluctant to be referred to Mental Health Services for fear of stigma.

2.0 Practical considerations

2.1 The Gnosall Clinic provides one half day clinic per month, with the availability of support and telephone expertise from a specialist between times.

2.2 A consultation room is available within the Practice. This is equipped with computer access and facilities for interview and routine physical examination if needed.

2.3 The clinic is organised by the Practice-based Eldercare Facilitator (ECF) who devotes two sessions per week to this work. This role was originally provided by a Health Visitor.

2.4 Specialist expertise is provided by a consultant psychiatrist with experience of work with older people and with particular interest in dementia.

2.5 People appropriate to the clinic are identified by clinicians within the Practice. This may be as a consequence of observations during routine clinical contact or attendance at screening or monitoring clinics for ‘at risk’
groups. The Clock Drawing Test and BASDEC schedule are used as initial screens for problems of cognition and mood respectively.

2.6 The clinician identifying problems, and seeking advice and help, is responsible for preparing case material for presentation to the consultant in association with the ECF.

2.7 The materials prepared for this consultation provide a basis of core information from which future actions, investigatory and therapeutic, can follow. It is important, therefore, that this is thorough but concise. The materials will be shared with the patient and, in most cases, with main carers.

2.8 The essential ‘inclusion criteria’ are interpreted flexibly: age 65 years or older, or multiple pathology, circumstances and demeanour such as are usually associated with later life. People with memory problems at any age are referred and accepted.

3.0 Identifiers and outline circumstances

Names
DOB
NHS number
Hospital numbers if available
Address, including Post Code
Marital Status
Living arrangements: alone, with spouse or equivalent, wider family (specify) other
Household type: private dwelling, sheltered housing, residential home, nursing home
Current additional support arrangements

4.0 Current concerns and the background to them

4.1 Presenting problems:

4.2 History of presenting problems:

4.3 Personal Previous illnesses: physical and mental

4.4 Family history of illnesses: Physical and mental

4.5 Personal history: including origins, schooling, work history, retirement, marital history, children, grandchildren etc

4.6 Additional factors known to be significant: These may include carer’s problems or illnesses, use of alcohol or other substances

5.0 Recent interventions
5.1 Recent hospital attendances and summary of their outcomes
5.2 Recent investigations
5.3 Recent and current prescriptions of medication
5.4 Any other relevant material

6.0 Current status

6.1.1 Height
6.1.2 Weight (and weight history)
6.1.3 Mobility
6.1.4 Liability to falls
6.1.5 Continence

6.2 Date of most recent physical review and summary of findings
6.3 Date of most recent review of mental state and summary of findings
6.3.1 Measures of cognition undertaken – with findings
6.3.2 Measures of mood undertaken – with findings
6.3.3 Any other materials relevant to the assessment and description of mental state.

This material is collated by the ECF It is drawn from the Practice’s knowledge of the individual, their family and circumstances and these sources are supplemented by additional understandings gleaned by the ECF via a home visit and assessment.

Any gaps in knowledge can be checked on the day of the clinic via the computer records and by interview with the patient and their carer(s).

7.0 Operational details

7.1 On an average day we will see 6-9 individuals at a clinic with their carers: most are seen at the Health Centre but two or more may be seen at home or in a care home
New referrals are allocated an hour: follow ups 20 -30 minutes

7.2 The clinical assessment depends upon interview with review of the history and examination of the current mental state. More sophisticated neuropsychological testing can be requested if indicated (less than once per annum) as can brain scans (less than one patient in four). Dementia is
diagnosed in three patients out of four. There have been a number of unusual and unexpected findings including two intracranial tumours, one malignant and one benign).

7.3 Findings and interpretations are explained to individuals and their carers on the day.
A letter confirming the findings and the plan of actions to follow is dictated at the clinic and is typed and distributed by the Practice – there is a copy for the Practice, the specialist, the patient and their carer(s) and for other relevant agencies with the patient’s agreement.

7.4 Referral to appropriate agencies is made by letter or telephone.

7.5 Advice and support in obtaining relevant benefits is provided as is advice and help with legal matters and issues relating to driving.

7.6 Patients are followed up within the Practice. They do not receive a Mental Health Trust identifier unless they are referred for additional help to that organisation. (That has not happened in five years though it remains a possibility if needed.)

7.7 Individuals with dementia are identified as such and their progress monitored by the ECF in association with colleagues within the Practice.

7.8 A specialist support group ‘MASE’ operates monthly in a neighbouring village and is very popular
www.staffordshirecares.info/HomeCommunityCare/Dementiasupportgroups.aspx
In addition individuals, families and friends make innovative arrangements within the spectrum of local resources.

8.0 Some outcomes

8.1 The ‘hit rate’ of the clinic at 18 per 1000 age 65+ per annum is three times that recorded by equivalent clinics publishing from secondary care and means that the full predicted prevalence of dementia within the Practice population is known.

8.2 There is high satisfaction with the clinic amongst patients and carers.

8.3 Use of Mental Health services has been reduced to a minimum and use of General Hospital facilities has also reduced. This is associated with reduced expenditure on secondary care.

8.4 Our experience is that 90% of patients can be managed within Primary Care given this sort of specialist involvement. This means that secondary care facilities can be used to optimum effect in both investigation and care modes rather than being overwhelmed.

8.5 The work of the clinic has been described in a number of articles:


8.6 The work has been presented at a number of conferences and congresses.

8.7 Dr Greaves received an Enterprise Award for this work from the Royal College of General Practitioners 2010: http://nhslocal.nhs.uk/story/gps-win-prize-dementia-care

8.8 A number of centres are beginning to provide services to a similar model and report that they find similar benefits to those we have described. We hope that the model pioneered at Gnosall will be adopted a standard practice within a three tiered service such as described in our Journal of Dementia article in 2010.

Update April 2013

Clinical activities

The original posting to describe the clinic was made in February 2012.

In that original posting the term Dementia Advisor was used to describe the person coordinating the clinic, linking with other services and people, carrying out initial assessments and following clinic attenders up (among other activities). This term has been replaced here by Eldercare Facilitator (ECF) to avoid confusion with other Dementia Advisors and in order to highlight the broad and important new role undertaken by this person.
The essential features of the clinic and related service have remained the same in the interim.

Professor Susan Mary Benbow has joined the team and now shares the role of visiting consultant with David Jolley.

Professor Benbow brings to the role wide clinical and academic experience which is summarised on her website www.oldermindmatters.com/default.aspx

She used her blog in August 2012 to comment on her early experiences with the Gnosall project.

Professor Benbow will provide a great deal of help in the project which plans to replicate the Gnosall Memory Service in other South Staffordshire Primary Care centres. Her expertise in administration, teaching, training and evaluative research will be invaluable.

She also brings with her expertise in Family Therapy and this may be something to add to the spectrum of services from Gnosall.

The special needs of patients who are resident at Gingercroft have led us to develop a regular four monthly additional clinic to meet and review them there with the staff and their families.

The work of the Practice in care of people with dementia and people with multiple frailty has been recognised with two awards.

**Awards**

In September 2012 Gnosall was honoured with the first ever ‘Best Practice in Staffordshire’ award from the Staffordshire Neurological Alliance:

www.staffsneurologicalalliance.org.uk/information-day-for-people-affected-by-a-neurological-condition-best-of-staffordshire-presentations/

In addition Dr Greaves and the team were Highly Commended as Finalists in the Health Service Journal Acute and Primary Care Innovation awards:

www.hsj.co.uk/Journals/2012/11/20/r/k/h/HSJAWARDS_121122.pdf

**Publications**

The Gnosall Memory service has been visited and studied by the National Institute for Clinical Excellence (NICE) and is mentioned as an example of good practice in the guide to commissioning dementia care published by NICE in April 2013
The press release is worthy of attention, see: Advice from NICE aims to improve commissioning of care for people with dementia

http://www.nice.org.uk/newsroom/pressreleases/DementiaCareSupportForCommissioning.jsp

Additional information and perspectives are provided in the most recent peer reviewed publication:


Updated 25/4/2013