Diagnosing Well in Northallerton – Assessment and Diagnosis in One Day

The Hambleton and Richmondshire memory service is based at the Friarage Hospital in Northallerton. Their service has developed from a clinic set up mainly for mild cognitive impairment, before which dementia diagnoses were made in community mental health teams. Post diagnostic support was added and the service evolved. Having joined MSNAP the service continues to value membership, preparing for its fourth re-certification. The service is already thinking of the future and how new medications for dementia may rely on even earlier diagnosis.

The Pathway

- GPs arrange blood work and scans as part of the referral requirements.
- The service aims to see people within 4 weeks of them having a scan.
- A doctor and nurse team work to assess with the patient and carer seen separately.
- The patient & carer reunite for refreshments while the doctor & nurse come to a consensus diagnosis
- They plan what information needs to be shared and barring the need for additional tests, they then feedback the assessment results and agree a plan so that the assessment and diagnosis is all complete in one visit.
- A second appointment may be needed for more complex cases.

Assessment clinics usually take place on Monday and Thursday each week and last four hours. Two doctor/nurse teams work concurrently to deliver an appointment each between 9am and 11am, then another between 11am and 1pm. This means that the service delivers 8 assessments per week plus 2-3 additional ones which are completed in patients' homes. Occasionally, when the doctor nurse team dynamic is disrupted by staff sickness or annual leave the team will have to improvise the best skill mix available. In this case second appointments might be needed if a consultant opinion is essential for the diagnosis.

Involving service users and carers

The service has good community networks, reflected in patients who are happy to pop into the service to ask a question. The service has an extensive information pack for patients and carers. Onward referrals are also made to additional services such as the Alzheimer's Society or the Sporting Memories Foundation. Post diagnosis there is a 'Living Well with Dementia' group that takes place once a month and an 8 week Cognitive Stimulation Therapy (CST) course. The first week of this course takes place with the carer present so that they gain an understanding of what happens in CST. Subsequently the nurses, health care assistants and occupational therapists treat the patients without the carers being present. The course is carried out in the same place each week to ensure the patients become familiar and comfortable in the environment. The sessions are based on clustering together patients with a similar level of need so that the activity they can do is as suitable as possible.

Capacity and Demand

Currently the service receives around 45 referrals per month. This outstrips the number of assessment appointments available, so as a result waiting lists are gradually increasing. To combat this, the service is increasing capacity by working with GPs to transfer responsibility for medication monitoring to primary care. This will reduce the need for medication monitoring clinics within the memory service, which will release facilities and staff time for additional assessment appointments.

Referral and Scanning

Most referrals come from GPs or elsewhere within the secondary care system, for example liaison teams. Criteria for those seen by the memory service is wide, including those with alcohol related conditions. The arrangement of the pathway, frontloading scans for all, means less waiting between assessment and diagnosis. To gain this advantage takes careful consideration of the resource implications for the scanning provider, which would be important for other areas looking to adopt this approach to consider.

Efficiency (Did Not Attend)

The number of patients not attending an appointment is relatively low, around one per week. Health Care Assistants make the appointments using their knowledge and understanding of people with memory problems to try and ensure that the appointment is appropriate. The nurses then phone patients in advance of their appointments to remind them that they are due to attend.

Communications, Education and Innovation

The service subscribes to the trust led protocols on communicating with GPs. In this pathway of care the IT system (Paris) automatically draws together a letter including ICD10 codes. Patients are given copies of the GP letters on request, rather than a care plan. All staff members need to complete mandatory training provided by the trust. Also where operational constraints allow, there are monthly education sessions on different dementia related subjects like the Herbert Protocol or advances in telecare. The service is continuing to innovate by looking at ways to attract funding for an admiral nurse. Currently all of the nurses in the service are mental health trained and some are also trained in non-medical prescribing.

More Information: david.newman7@nhs.net