

# **Gnosall Memory Clinic: A guide to the basics**

This is our brief guide to the memory clinic which runs at Gnosall Health Centre we hope you find it interesting and informative.

## **Background**

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

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

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.

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

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

## How is the clinic organised?

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

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

The clinic is organised by the Practice-based Dementia Advisor who devotes two sessions per week to this work. This role was originally provide by a Health Visitor

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

Potential referrals 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

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

The materials prepared for this consultation provide a basis of core materials 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.

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.

## **Patient information collected prior to the clinic appointment**

***These details incorporate social circumstances to create a fuller picture of the patient***

Name

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

***In addition information about current concerns and the background to them will be gathered***

Presenting problems:

History of presenting problems:

Personal Previous illnesses: physical and mental

Family history of illnesses: Physical and mental

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

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

***Any recent interventions such as.....***

Recent hospital attendances and summary of their outcomes

Recent investigations

Recent and current prescriptions of medication

Any other relevant material

Current status:

Height

Weight (and weight history)

Mobility

Liability to falls

Continence

Date of most recent physical review and summary of findings

Date of most recent review of mental state and summary of findings

Measures of cognition undertaken – with findings

Measures of mood undertaken – with findings

Any other materials relevant to the assessment and description of mental state

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

*This material is collated by the Dementia Advisor. 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 Dementia Advisor via a home visit and assessment*

## Operational matters

On an average clinic 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

The clinical assessment depends upon interview with review of the history and examination of the current mental state. More sophisticated neuro-psychological 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)

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

Referral to appropriate agencies is made by letter or telephone

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

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)

Individuals with dementia are identified as such and their progress monitored by the Dementia Advisor in association with colleagues within the Practice

A specialist support group 'MASE' operates monthly in a neighbouring village and is very popular [www.staffordshirecares.info/HomeCommunityCare/Dementiasupportgroups.aspx](http://www.staffordshirecares.info/HomeCommunityCare/Dementiasupportgroups.aspx)  
In addition individuals, families and friends make innovative arrangements within the spectrum of local resources.

## Key outcomes

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

## **Publishes Articles**

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

Ian Greaves, Nicola Greaves, Lesley Greening, David Jolley (2008) Reaching and keeping people with dementia in Primary Care. The Journal of Dementia Care July/Aug p 18-19

Greening L, Greaves I, Greaves N and Jolley D (2009) Positive thinking on dementia in primary care: Gnosall Memory Clinic. Community Practitioner 82(5) 20-23

Jolley D, Greaves I, Greaves N and Greening L (2010) Three tiers for a comprehensive regional memory service. Journal of Dementia Care 18 (1) 26-29

Greaves I and Jolley D (2010) National Dementia Strategy: well intentioned, but how well founded and how well directed? British Journal of General Practice 60: 193-198

Greaves N and Greaves I (2011) The Gnosall project: setting new benchmarks in dementia care. Journal of Care Services Management 5 (1) 1-5

## **Sharing experiences.....**

The work has been presented at a many conferences and congresses

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>

Quality & Excellence Awards Patients Choice South Staffordshire Primary care Trust 2009

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 2010