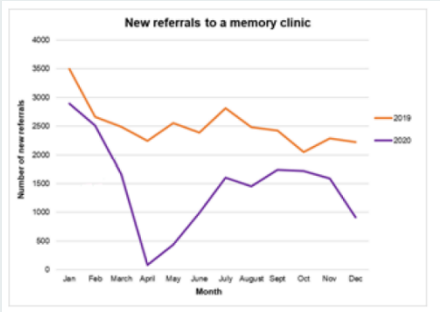
Dementia Co-diagnosis in Gloucestershire

An effective model for rapidly diagnosing people with dementia and getting them (and loved ones and/or carers) access to treatment and post diagnostic support.

Background

Covid had a catastrophic effect on people with dementia (36% Gloucestershire deaths). During the pandemic, our Memory Assessment Service (MAS) was closed to referrals with staff re-deployed. People referred to the service could not get assessed or receive treatment.



Many of these people were frail and already known to our Primary Care Network (PCN) frailty teams. Using population health management (PHM) principles and adopting a QI approach with rapid PDSA cycles we set up virtual MDTs with frailty nurses, a dementia specialist nurse, and a GP to diagnose & start treatment.

Aims

1. To encourage a culture of innovation and improvement between PCN frailty nurses, the community dementia nurses and the hospital-led Memory Assessment Service (MAS)

2. To demonstrate that using a population health management approach together to assign our frailty team to work with a specific patient segment and then apply quality improvement techniques to continuously improve we can effectively free up clinical time, deliver value to our system and improve care.

4. To demonstrate that by working differently we can create MAS capacity to see other patients more quickly.

Measurement

Before Covid, Gloucestershire had a 67% dementia diagnosis rate. We have been struggling to get it back up to this level. In April 2024 the rate was 63.5%; it has now increased to 65.1% (May 2024).

The model has been piloted in South Cotswold (2020/21), and the Forest of Dean (April 22), and is now in Stroud and Berkley Vale, with services starting in January 2024 in Tewkesbury and planed in future for North Cotswold.

Performance metrics were 'time to diagnosis' and the outcome measure was the 'number of patients diagnosed'.

Method/Design

The MDT runs fortnightly via MS Teams and reviews findings of person presenting with cognitive impairment and enables early diagnosis of dementia

Core clinical staff group attend to support diagnosis including Managing Memory Together, Integrated Care team, Complex Care at Home, Forest of Dean PCN & Community Dementia Nurse

Forest of Dean data:

- **57** people were referred for diagnosis in the Co-diagnosis project
- **70%** (40/57 people) were diagnosed by the Co-diagnosis project
- **70%** (28/40 people) were diagnosed at the first multi-disciplinary meeting

Referral to diagnosis time

- Average time from referral to diagnosis – **30** days
- Quickest referral to diagnosis **4** hours
- Longest time from referral to diagnosis was **60** days but this was due to the person being admitted to hospital

Dementia diagnosis rate

- DDR in the Forest of Dean locality has increased from 59.9% to **67.4%,** therefore exceeding Gloucestershire's overall dementia diagnosis rate (64.1%) and the national target of 66.7%

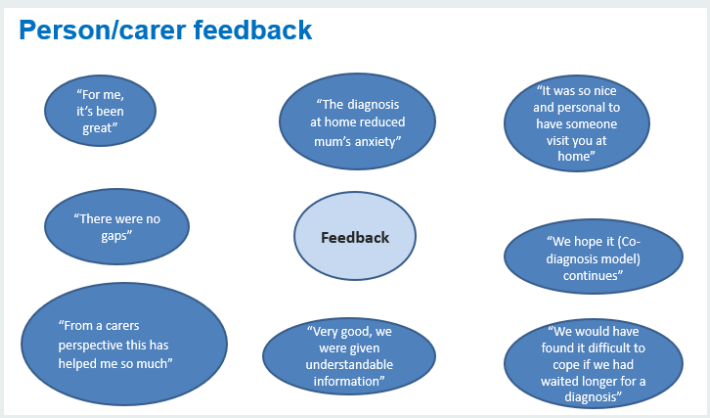
Impact on the system

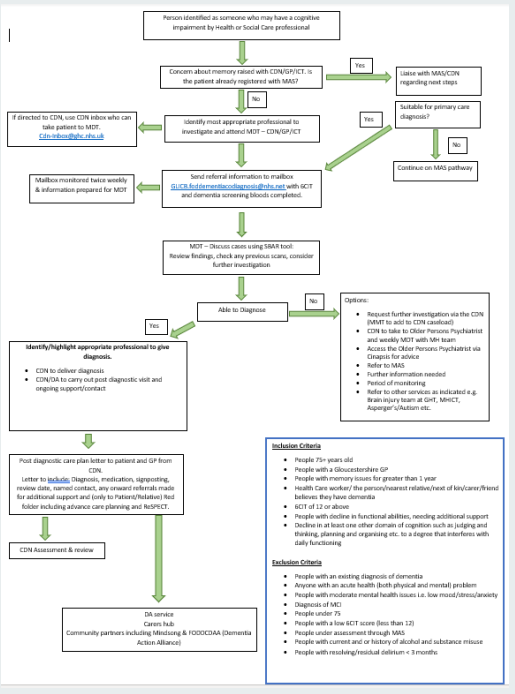
- MAS waiting list in FOD locality has stabilised

Learning

By adopting PHM principles (stratification / segmenting / targeting) to define our target patient group we took a practical QI approach to developing and refining our model via our primary care frailty nurses that were aligned to PCNs.

Using the Model for Improvement and rapid PDSA cycles we worked through patient examples to understand what history and investigations were required. The nurses learned to present in a SBAR format to make this time efficient and clinical suspicion of dementia was the main point of entry.





Conclusion

Post-diagnosis support provided:

- Check understanding of Diagnosis and meds efficacy check
- Referral to Alzheimer's Society Dementia Advisor Service
- Dementia Information and Education Service
- Further Onward referrals (if indicated)
- Advance Care Planning
- Earlier completion of red folders

Next steps

- Continue co-diagnosis meetings
- Roll the model out to other localities across the county: North Cotswolds

Tools and/or Models Applied

- PHM stratification to support identification of the cohort
- PDSA
- SBAR
- Service design in collaboration with patient and staff

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