

Table 1. Referral numbers, sources and diagnoses, 2009–2013.

Year	n	Referral source		Diagnosis		
		Primary care (%)	Secondary care (%)	Dementia (% of n)	No dementia (% of n)	MCI (% of n; % of no dementia)
2009	249	174 (70)	75 (30)	76 (31)	173 (69)	30 (12; 17)
2010	233	149 (64)	84 (36)	71 (30)	162 (70)	25 (11; 15)
2011	227	177 (78)	50 (22)	53 (23)	174 (77)	39 (17; 22)
2012	245	197 (80)	48 (20)	67 (27)	178 (73)	40 (16; 22)
2013	323	243 (75)	80 (25)	88 (27)	235 (73)	66 (20; 28)
Total	1,277	940 (74)	337 (26)	355 (28)	922 (72)	200 (16; 22)

MCI = mild cognitive impairment.

Impact of the National Dementia Strategy in a neurology-led memory clinic: 5-year data

The National Dementia Strategy (NDS) for England was launched in February 2009 and was anticipated to roll out over a 5-year period. The three key themes proposed to address the issue of dementia were: improved awareness of the condition, early diagnosis and intervention, and improved quality of care, with a pathway for implementation.¹

A progress report on NDS delivery in 2010 did not examine frontline services, since they were not anticipated to have changed as local implementation plans were still being developed.² A study of a neurology-led memory clinic examining referrals in the 12-month periods immediately before and after NDS launch found an increased number of referrals, mostly from primary care, but with no accompanying increase in the number of new diagnoses of dementia, and hence no evidence for closure of the dementia ‘diagnosis gap’.³

As the NDS reaches its proposed date of fruition, data from a neurology-led memory clinic encompassing the 5-year period 2009–2013 were examined (Table 1) to see what impact NDS has had on this service.

Referral numbers were found to have increased, most particularly for those from primary care (Table 1). The null hypothesis that the proportion of patients referred from primary care over this time period did not differ significantly was rejected ($\chi^2=22.1$, degrees of freedom [df]=4, $p<0.001$).

Considering patient diagnoses, the null hypothesis that the proportion of all referred patients who were diagnosed with dementia over this period did not differ significantly was not rejected ($\chi^2=4.03$, df=4, $p>0.1$), and likewise for a diagnosis of any cognitive impairment (dementia + mild cognitive impairment [MCI]; $\chi^2=3.85$, df=4, $p>0.1$).

These data suggest that in the 5 years since the launch of the NDS there has been an increased number of referrals to a neurology-led memory clinic, confirming the previous observations after 1 year.³ The data might therefore be taken as evidence for the efficacy of the NDS in raising awareness of the problem of dementia and the importance of early diagnosis and intervention. Since most referrals came from primary care, they

support the view that GPs are becoming more positive about diagnosing dementia early. The findings incidentally contradict the erosion in such referrals to neurology clinics anticipated on the basis of previous directives (National Institute for Health and Care Excellence [NICE] and Social Care Institute for Excellence [SCIE]) suggesting a ‘single point of referral’ (ie old age psychiatry) for all such cases.

However, the data provide no evidence of increased dementia diagnosis and hence no evidence of closure of the dementia diagnosis gap.⁴ This failure has also been observed with other national directives impinging on the treatment of dementia.⁵ Rather, the increase in referrals has been of individuals with neither dementia nor cognitive impairment, but with subjective memory impairment (the ‘worried well’ in many instances). Hence, a more nuanced policy approach is likely to be needed to access those in our communities with undiagnosed dementia and with potentially unmet care needs. ■

References

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