Using DiADeM to support timely Dementia Diagnosis in primary care

Friday 7th November 2025

Managing Frailty in Primary Care Conference – Vitality Stadium, Bournemouth

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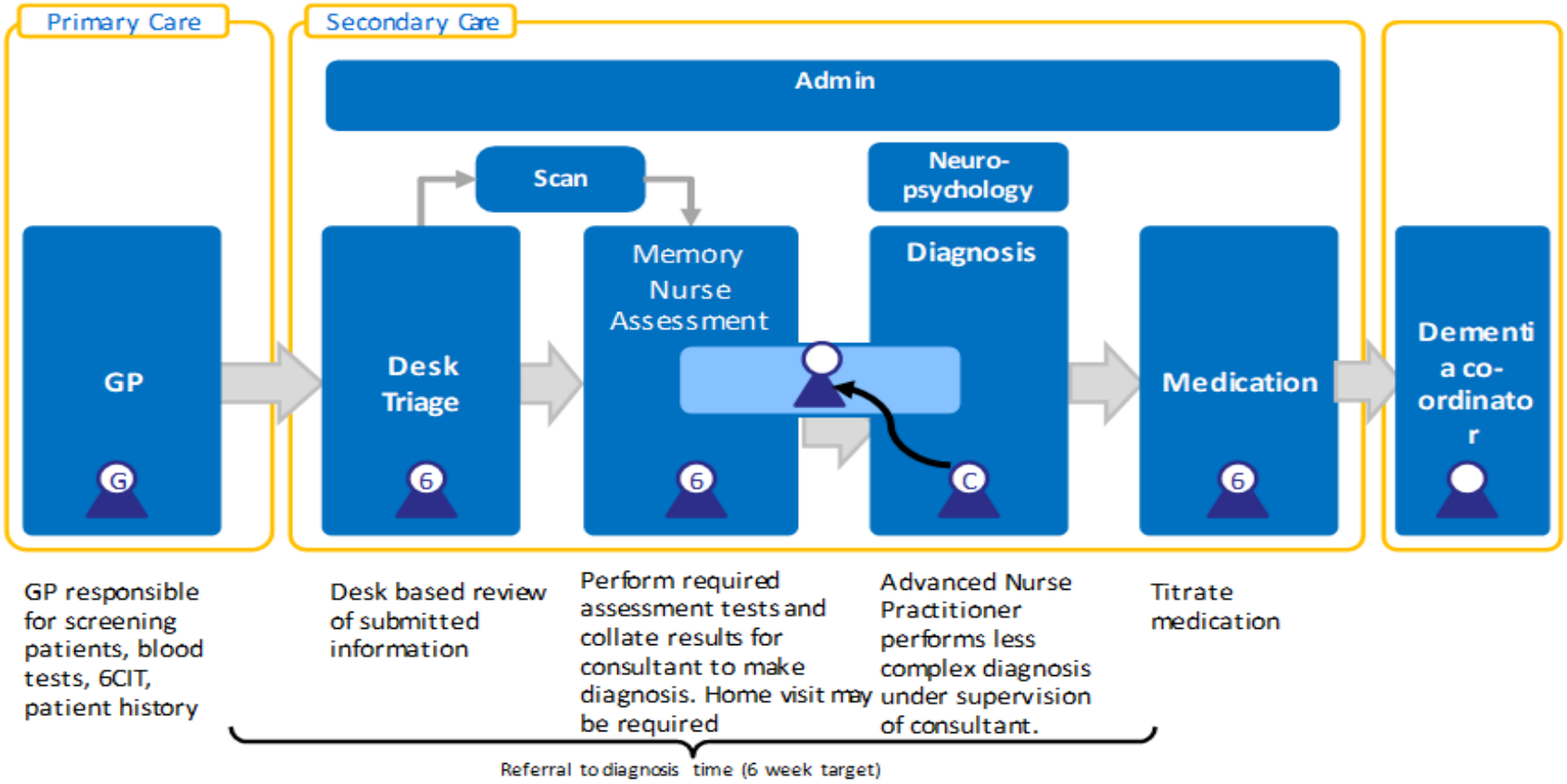
Dementia in Dorset: Context

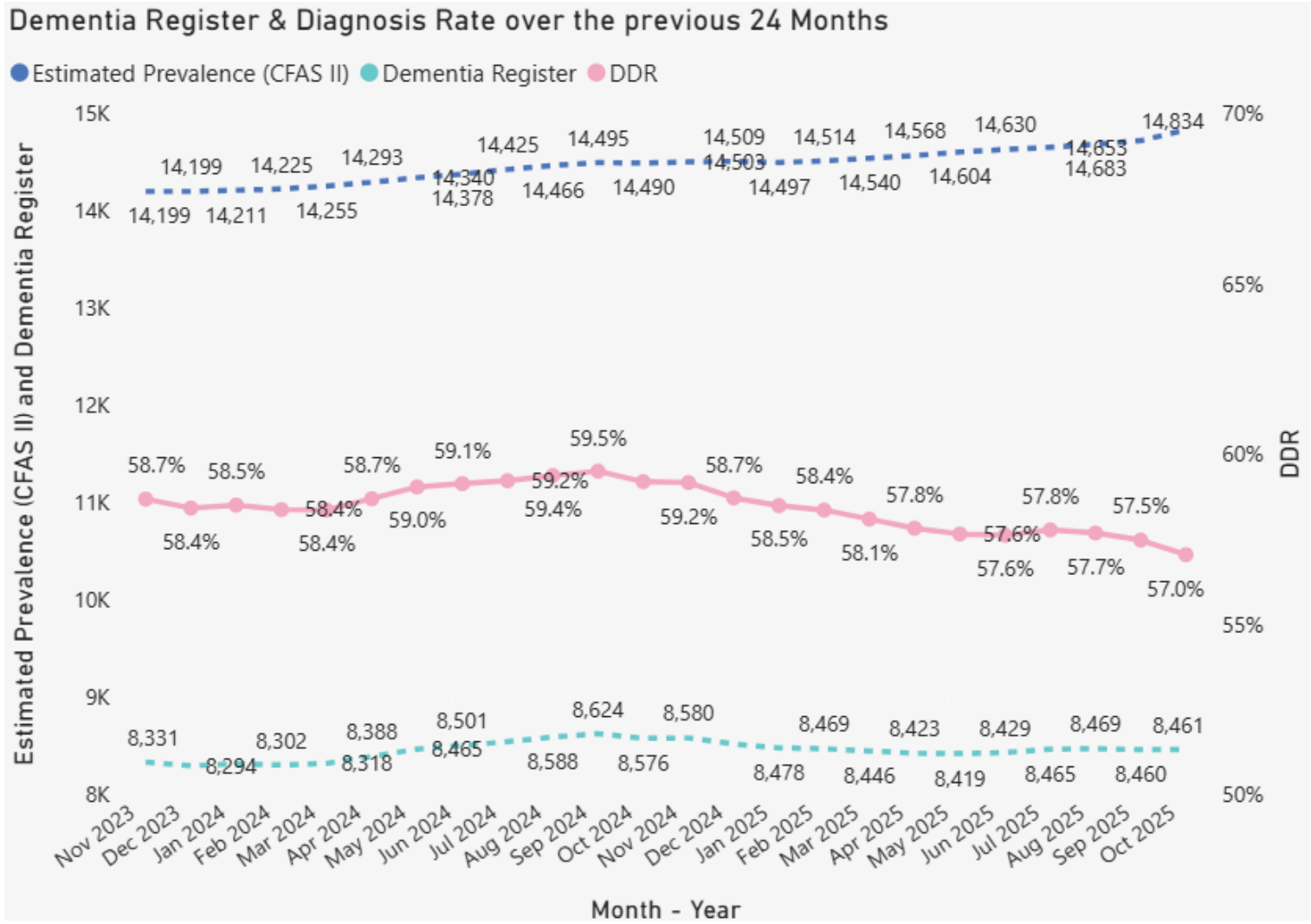
Dementia Service Model: New model implemented on 1 April 2021 following a 2 year review **(DSR)**

- New diagnostic pathway -**Memory Assessment Service**
- Dementia Coordinators Service
- Cognitive Stimulation Therapy
- Memory Roadshows
- Carers Emotional Support Workshops
- Intensive Care Service for Dementia - east and west of the county
- Crisis Helpline- Connection

Dorset Memory Assessment Service (MAS) Model



Dementia Diagnosis Rates



Dementia Diagnosis: Challenges

- Post Covid pandemic **Dementia diagnosis rates** (DDR) in Dorset declined from around 62% to 57%
- **Variation** across PCNs
- Number of **referrals** to MAS approx. 25% above the estimated
- **Long waiting time** from referral to diagnosis averaging **7 months** (Source: Memory Assessment Service, June 2025) This has improved from 12 months in May 2024.
- Limited reach into **care home population** – local intelligence suggest DDR in care homes are below national average

Why diagnose Advanced Dementia in Care Homes ?

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It has been estimated that in excess of 70% of care home residents have dementia symptoms either on admission or develop symptoms post admission this equates to in excess of 311,000 people

One third of people living with dementia reside in care homes, many of whom do not receive a diagnosis

Older people who are admitted to care homes are often frail, have multiple comorbid conditions and have complex health and social care needs

Dementia is caused by neurodegenerative diseases which are non-curative and are life-limiting

The majority of people with advanced dementia die in care homes or hospital, a diagnosis can inform goals of care at end of life and support families understanding of the dying process

Why DiADeM?

- Increasing waiting lists in memory assessment services
- Acknowledgement of need to improve outcomes for people in care homes and improve access to an appropriate diagnosis which can inform care and treatment
- Existing MAS service approach can be burdensome for people with advanced dementia
- Acknowledgement that there is a gap in skills, knowledge, confidence and resource in primary care to universally adopt the DiADeM approach
- Positive experience of using DiADeM in other places in the country
- Consideration of dementia diagnosis in all frail and elderly patients

Aims of the introducing DiADeM

- To **improve the identification and diagnosis** of dementia and differential diagnoses in care homes
- To convey the importance and **value of a diagnosis** of dementia for people living in care homes
- Create an **opportunity** to test an abbreviated MAS offer appropriate to the needs of people with advanced dementia in care homes
- **Increase awareness** of the prevalence and impact of dementia in care homes
- **Improve relationships** between care homes, primary care and memory assessment services
- **Improve the quality of life** and decision-making for people with dementia living in care
- **Test alternative models** of memory assessment for non-complex dementia diagnosis
- Offer timely **advice and guidance** to care home staff

What is DiADem?

- DiADeM is a tool that was developed by Yorkshire and Humber Dementia Strategic Clinical Network in 2015 and was originally designed to support GPs in diagnosing dementia for **people living with advanced dementia in a care home setting** (Alzheimer's Society 2022).
- This was in recognition that referral to memory assessment services could be **distressing and burdensome** for someone living with advanced dementia.
- Recognised that there was an **unmet need** of diagnosing dementia for people residing in care homes.
- The **tool** prompts the assessing clinician to consider any functional impairment, cognitive impairment by means of administering the GPCOG (Brodatyet al, 2002) or 6CIT (Katzman et al, 1983) brief screening tools, corroborating history confirmed by care staff, relatives and medical records, investigations where clinically appropriate and excluding other acute or treatable causes such as delirium or depression.

DiADeM Tool

Diagnosing Advanced Dementia Mandate (for care home setting)

NHS

A diagnosis of dementia is usually made within memory services. Some care home residents with advanced dementia have never had a formal diagnosis. In these cases a referral to memory services is rarely desirable. It is likely to be distressing for the individual and is usually unnecessary[1].

People with advanced dementia, their families and staff caring for them, still benefit from a formal diagnosis. It enables access to appropriate care to meet individual needs and prompts staff to consider MCA and DOLs issues where appropriate. A diagnosis of dementia can be made with a high degree of certainty if all five criteria listed below are met:

1 Functional impairment

The person is no longer fully independent in relation to basic activities of daily living, washing, dressing, feeding and attending to own continence needs. The requirement of prompting or supervision of staff constitutes a loss of full independence. ☐

2 Cognitive impairment – 6 CIT assessment ☐

Question	Scoring	Score achieved
1.What year is it?	Correct – 0 points, incorrect – 4 points	
2.What month is it?	Correct – 0 points; Incorrect – 3 points	
3.Give an address phase to remember with 5 components e.g. John, Smith, 42, High St, Wakefield		
4.About what time is it (within 1 hour)	Correct – 0 points; Incorrect – 3 points	
5.Count backwards from 20-1	No errors – 0 points; 1 error – 2 points; more than 1 error – 4 points	
6.Say the months of the year in reverse	No errors – 0 points; 1 error – 2 points; more than 1 error – 4 points	
7.Repeat address phase	No errors – 0 points; score 2 points for every component wrong e.g. 3 errors, 6 points	
TOTAL SCORE:		

6 CIT scores: 7 and below normal; ***8 and above indicate impairment.***

Assessment tools other than 6CIT can be used. If used does score indicate impairment Y/N? Y / N

NB. Scores obtained in this patient group would be expected to be at the severe end of scale and for some patients their cognitive impairment will be of such severity that they cannot undertake the assessment.

3 Corroborating History

History of gradual cognitive decline (typically for the last few years) is confirmed by care staff, relatives and medical records. Staff/relatives confirm that in their opinion the patient consistently demonstrates both functional and cognitive impairment. ☐

4 Investigations

Dementia screening ***bloods are normal*** (where clinically appropriate and patient consents to bloods). If patient lacks capacity to consent to bloods, a best interest decision must be made and documented accordingly. NB. If intracranial pathology (e.g. subdural haematoma, cerebral tumour) is suspected, referral for a brain scan may be appropriate. Otherwise where dementia is advanced, differential diagnosis is unlikely to affect patient management & a brain scan is unnecessary. ☐

5 Exclusion Criteria

There is ***no acute underlying cause to explain*** confusion i.e. delirium (acute confusional state) has been excluded. Mood disorder or psychosis is also excluded. ☐

A diagnosis of dementia can be made with a high degree of certainty if ***all five*** criteria listed above are met. If dementia is confirmed, please add this patient to your GP practice dementia register using the recommended codes. Consent should be sought for this from the person themselves or a family carer where the individual lacks capacity.

[1] "Guidance for Commissioners of Dementia Services", published by The Joint Commissioning Panel for Mental Health states patients who present with advanced symptoms of dementia can be diagnosed and managed by primary care with or without CMHT help. www.jcpmh.info.

where a diagnosis of dementia is confirmed, a copy of the completed DiADeM tool should be saved into the patient's clinical record as evidence for the diagnosis

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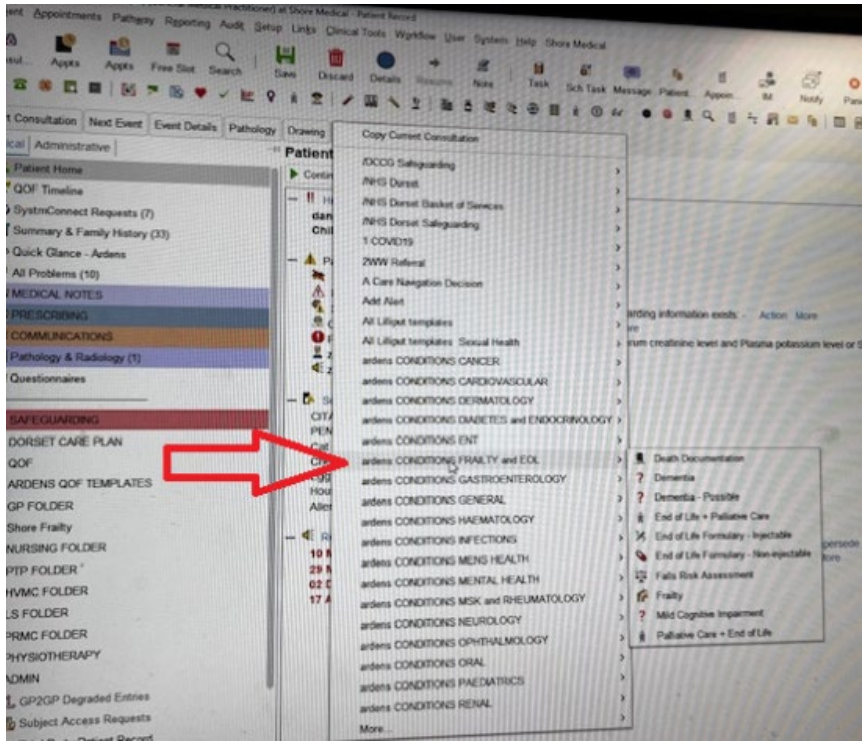
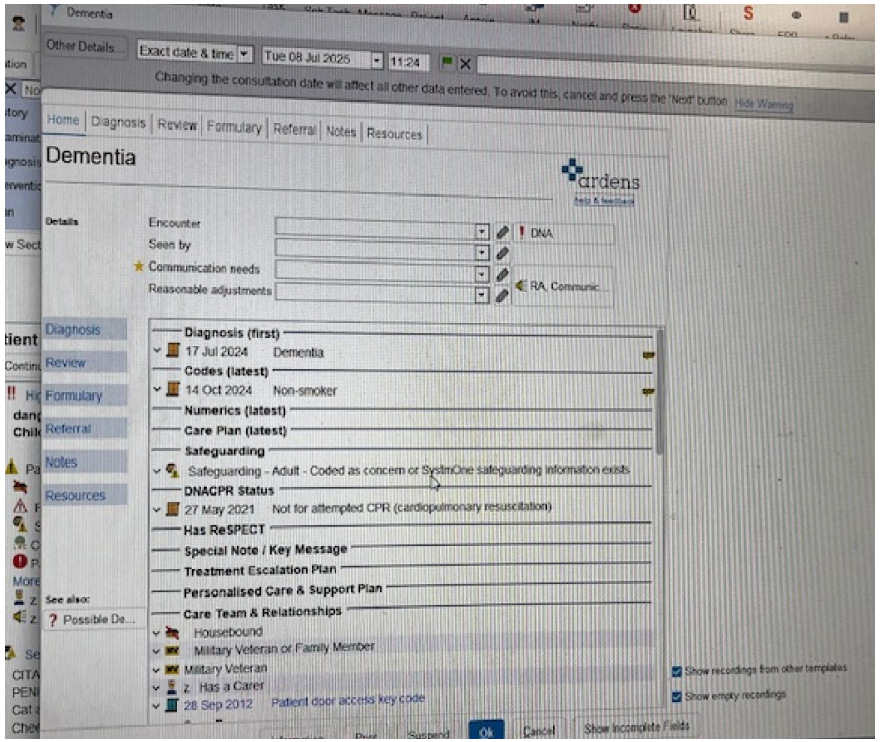
How do you access the DiADem?

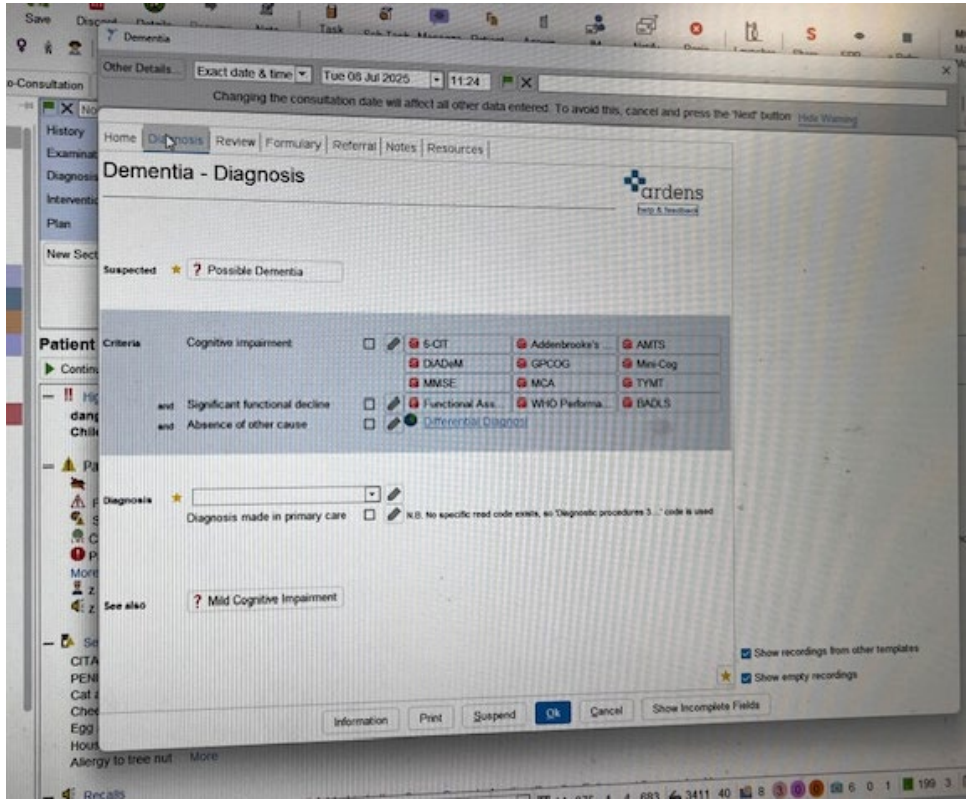
- **SystmOne - Via Ardens - Frailty and EOL**

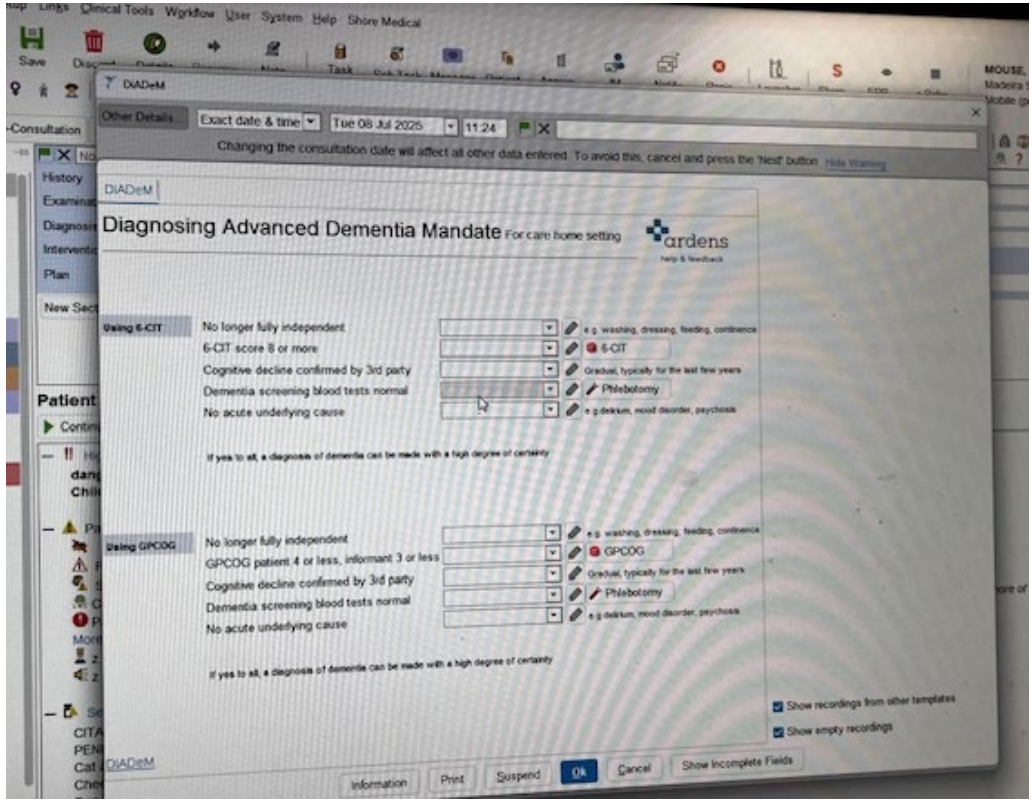




How do you access the DiADem?

- **Use this template here – click on diagnosis tab – go to DiADeM page**





1.Functional Impairment

- If the person is no longer fully independent in relation to basic activities of daily living such as, washing, dressing, feeding and attending to their own continence needs.
- The requirement of prompting or supervision of staff constitutes a loss of full independence

2.Cognitive Screening Tool

- Administer brief cognitive screening tool e.g.
  - 6CIT
  - GPCOG

3. Corroborating History

- Is there a history of cognitive decline (typically over past few years) confirmed by care home staff, relatives or significant others and medical records
- Do care home staff relatives and significant others confirm that in their opinion the person has consistently demonstrated both functional and cognitive impairment

4.Investigations

- Dementia screening bloods are normal (where clinically appropriate and patient consents)
- If the person lacks mental capacity to consent a best interest decision should be made and documented accordingly
- N.B If intracranial pathology (e.g. subdural haematoma, cerebral tumour) is suspected, referral for brain scan may be appropriate. Otherwise where dementia is advanced, differential diagnosis is unlikely to affect management and a brain scan is likely to be unnecessary

5.Exclusion Criteria•

- There is no evidence of acute underlying cause to explain confusion or reduced cognition e.g. delirium
- Mood disorder or psychosis has been excluded

Confirming the Diagnosis

- A diagnosis of dementia can be made with a high degree of certainty if **all five criteria** are met
- If dementia is confirmed, this should be coded in notes and the patients should be added to the **dementia register**
- Best practice would suggest that **consent** should be sought for this from the person themselves or a family carer where the individual lacks capacity.
- Signposting families to **support** from Help and Care Dementia co-ordinators if appropriate.

Support from MAS

- **MAS Single Point of Access** - 0300 303 5342 – ask for the duty/screening team – Andrew Mon – Fri, Tracey Tue – Fri

- **Help and Care** – Dementia Co-ordinators, email memory@helpandcare.org.uk

- **Shadowing Opportunities**

If you would like to shadow anyone in MAS please can you contact Jood Gibbins directly jood.gibbins@nhs.net

Future Training Courses

- Free!
- Morning Session approx. 2 hours
- East - Wednesday 21st January, Bournemouth
- West – Monday 19th January 2026, Bridport

- How to sign up -
  - contact Cath Woodman, Cath.woodman@nhsdorset.nhs.uk
  - use the sign up sheet here today

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Thank you for listening.

Any Questions?