

Direct Secondary Care Referrals to a Tertiary Memory Clinic: Patient Characteristics and Service Planning Implications

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• KEY TAKEAWAY: More than one-third of memory clinic referrals originated directly from secondary care, highlighting the need for increased memory service capacity to support frail, multimorbid patients identified through hospital cognitive screening.

INTRODUCTION	METHODS	RESULTS	CONCLUSIONS	REFERENCES
- National guidance mandates delirium/cognitive screening for all older hospital patients (aged ≥65 years) with onward referral to memory services for suspected dementia.^{1,2} - Barriers between hospital and community services may impact this pathway. - The Oxford University Hospitals NHS Foundation Trust (OUHFT) physician/geriatrician-led memory clinic takes “internal” referrals directly from local secondary care services as well as from general practitioners (GPs). - We determined the characteristics of the OUHFT memory clinic population including referral route, diagnoses, frailty and multimorbidity. We also analysed brain imaging findings.	In a retrospective study of consecutive patients attending the Memory Clinic for the first time between April 2021 and March 2022, internally and externally (GP) referred patients were compared for: - Diagnosis (dementia, mild cognitive impairment [MCI]) - Montreal Cognitive Assessment (30-point MoCA) score - Clinical Frailty Scale (CFS) - Number of medications as a proxy for multimorbidity. Presence of small vessel disease (SVD) and disproportionate medial temporal lobe atrophy (dMTLA) on computed tomography (CT) brain imaging was extracted from radiology reports.	Figure 1. Referral sources into memory clinic and proportion of diagnoses made. Of those with dementia diagnosis (n=60, 56.6%) who had CT head imaging (n=57, 95%), small vessel disease (SVD) was noted in 38 (66.7%). Disproportionate medial temporal lobe atrophy was reported in 20 (35%). Figure 2. Diagnoses made in clinic across all referral types. Top: 56.6% received a dementia diagnosis, 34.9% MCI, 8.5% other. Bottom: Of the dementia diagnoses, 41.7% were Alzheimer's Disease, 11.7% vascular and 46.7% other dementias. Figure 3. Comparison of MoCA scores between referral sources. There was a trend towards worse cognition in the internal vs GP referrals group (mean/SD MoCA = 16/6.4 vs 18/5.9 respectively; p=0.08). Figure 4. Comparison of number of regular medications between referral sources. Patients referred internally took a significantly higher number of medications than those referred via GP (mean/SD = 6.8/3.6 vs 5.1/3.0 respectively; p=0.01), suggesting greater multimorbidity. There was an additional non-significant trend towards increased CFS score in the internal vs GP referrals group (mean/SD = 5.0/1.3 vs 4.5/1.5 respectively; p=0.1 [data not shown]).	- Over 90% patients seen in the clinic had dementia or MCI at first visit, indicating appropriate systems of referral and triage. - Notably, over one third of patients were referred internally following detection of suspected dementia in secondary care services. These patients were more multimorbid than GP referrals. - Embedding of front-door delirium and frailty screening in hospitals has implications for memory clinic services. - Greater capacity and capability will be required to manage increasing numbers of multimorbid, complex patients.	1. National Institute for Health and Care Excellence (NICE) 2023. Delirium: prevention, diagnosis and management in hospital and long-term care. CG103. Available at: https://www.nice.org.uk/guidance/cg103 (accessed June 2026). 2. National Institute for Health and Care Excellence (NICE) 2018. Dementia: assessment, management and support for people living with dementia and their carers. NG97. Available at: https://www.nice.org.uk/guidance/ng97 (accessed June 2026). CONTACT www.ndcn.ox.ac.uk/research/orchard-study jill.betts@ndcn.ox.ac.uk CPSD@ouh.nhs.uk