Evaluation of an 18 week Referral to treatment pathway in London Memory Services

NHS England 2026

Authors

Helen Souris – Senior Clinical Project Manager
Charles Marshall – Clinical Director
Dementia Clinical Network, NHS England (London Region)
March 2026

Acknowledgements

The Dementia Clinical Network NHS England London region would like to thank the leads and clinicians from the seven London memory services who participated in this pilot.

Contents

Executive Summary

The London Dementia Clinical Network aligned London memory services with the national 18-week Referral to Treatment (RTT) pathway, replacing the previous 6-week standard, with the aim to improve diagnostic quality, reduce pressure for rapid decisions, and bring parity with physical health services.

An evaluation of the change in target was performed across seven London memory services representing a broad range of geography and waiting time performance. Case notes from 2024 and 2025 were reviewed to extract diagnostic pathway data for comparison, and were supplemented by semi-structured clinician feedback.

Performance against an 18-week target remained stable overall, with a similar proportion of patients receiving a formulation and care plan within 18 weeks. As anticipated, diagnoses and care plans were on average given slightly later within the 18-week window during the 2025 audit period.

Clinicians reported that they felt they had more time and were giving more accurate and specific diagnoses. This was reflected in the proportion of specific dementia diagnoses recorded, with more Alzheimer’s disease and vascular dementia diagnoses and fewer non-specific or MCI diagnoses after the change in waiting time.

Investigations and referrals, such as imaging, biomarkers, Neuropsychology, and Occupational Therapy were all used in a minority of patients and rates did not change, likely reflecting wider resource and capacity constraints, although some clinicians reported that they were more likely to request investigations to support diagnostic thinking.

Clinicians reported reduced performance pressure, greater confidence in diagnosis, a better ability to reflect clinical complexity, and increased incentive to initiate quality improvement work to improve performance against a more realistic target.

Overall, adopting the 18-week RTT standard is feasible, clinically beneficial, and supports higher diagnostic quality. It also creates opportunity within the diagnostic pathway to improve the use of investigations such as imaging, biomarkers and neuropsychology, all of which are currently under-utilised in London memory services. Continued action is needed to strengthen pathways dependent on limited specialist workforce capacity.

Background

All physical health conditions use the RTT pathway, and this is the case for dementia when patients are referred to neurology or geriatric services in acute trusts. Since 2017, evaluation of performance of psychiatry-led memory services has been against a 6-week referral to diagnosis target.

The London Dementia Clinical Network (DCN) proposed to move all London memory services onto the 18-week RTT pathway.

The anticipated benefits of this included:
1. Give dementia parity with other physical health conditions
2. Improve data collection and reporting by using existing RTT infrastructure
3. Provide waiting times for those receiving diagnoses other than dementia in memory services, for example, depression, who are currently overlooked in performance reporting.
4. Improve diagnostic quality by reducing the incentive for rapid application of unspecified dementia diagnoses and the widespread use of “holding diagnoses” that frequently need to be revised
5. Allow services to develop pathways that make better use of investigations, Multidisciplinary Team (MDT) discussions and repeat assessments to enhance diagnostic accuracy and support improved diagnosis of specific pathologies causing dementia syndromes
6. Encourage more quality improvement work around waiting times by providing a more achievable target
7. Permit the use of an “active monitoring” outcome when the most clinically appropriate decision is to monitor for change over time before giving a diagnostic label
8. Shift the emphasis onto providing comprehensive management plans rather than just a diagnostic label

It was proposed that initial assessments be completed within 6 weeks ensuring that a duty of care begins within this timeframe and that social care and safeguarding needs are identified and addressed on this existing timescale. Social care leadership in the capital confirmed feasibility of this. The recommendation was then that the diagnosis and care management plan be formulated and discussed with the patient within 18 weeks of referral.

The DCN shared this proposal with the National Dementia Policy team, London Medical Director, London Mental Health team and the London Mental Health Delivery Group and London Mental Health Board and this proposal was endorsed and approved. It was also presented at a quarterly London Memory Service network meeting and well received.

Following this, the DCN requested that the change in the waiting times standard across all London memory services commence on 1st May 2025, but allowed for flexibility as any change in service pathways and processes may take time to implement. Waiting time data continued to be collected by the NHS England Mental Health Performance team, but the template was adapted to reflect the dates of initial assessment, and 18 week clock stop due to formulation of a care and treatment plan or initiation of a period of active monitoring.

Memory Service Waiting Time Evaluation

Aims and Objectives

Running in parallel with the implementation of change in London memory service waiting times, the DCN evaluated this change in several memory services to assess the impact and ensure service quality and patient outcomes were maintained.

Methodology

In early 2025 the DCN led a discussion with the Dementia Clinical Leadership Group(CLG) on the implementation of a change in memory service waiting times and the means of evaluating the impact of this change. The initial plan was to conduct the evaluation to include a memory service from the five Integrated Care Bodies (ICBs) across London; however, 7 memory services across the 5 ICBs came forward and all 7 were included. These services reflected the waiting time performance across the capital, in that only one service was meeting the 6 week target, 3 had waiting times between 6-18 weeks and the remaining 3 had waiting times over 18 weeks.

Memory services were asked to extract data for 20 case notes referred in July 2024 and a further 20 case notes referred in July 2025. The calendar months for the review coincided to reflect seasonal variations which affect referral rates and staffing.

The dataset consisted of 12 questions documenting the memory service pathway from referral to the care management or feedback appointment and included initial assessment, referrals for imaging and other investigations, receipt of diagnosis and/or care management plans, and referrals to post diagnostic interventions.

The information was captured using a Microsoft survey form. The forms were set so that clinicians were able to access and edit them for the duration of the pilot; this meant that the whole survey did not need to be completed in one sitting. A guidance document was created by the DCN with instructions and screenshots of the process. On completion of the pilot, all the participating clinicians were asked to complete a survey asking them of their experience and the impact that the change in waiting times had on their practice.

Services were sent the guidance document and instructions for the audit in early June with a starting date of 1st July 2025. They were given until 9th January 2026 to complete the audit allowing all those referred in July 2025 over 18 weeks between referral to the service and the care management or feedback appointment.

Results

Seven memory services participated in the audit across the 5 London Integrated Care Boards (ICBs):

- North Central London ICB - Camden and Enfield
- North West London ICB - Hounslow
- North East London ICB - Waltham Forest and Tower Hamlets
- South West London ICB - Wandsworth
- South East London ICB - Croydon

All participating memory services were part of a Mental Health Trust.

Data from 140 case notes were extracted and submitted using the Microsoft survey for July 2024, i.e. 20 from each service. Data from 145 case notes were extracted and submitted using the Microsoft survey for 2025; 3 services submitted one or two additional patients. No submissions were excluded from the audit.

At the time of submission, in the 2024 audit, 1 patient had not been seen for an initial assessment, and a further two had not had a follow up appointment as one emigrated and the other was discharged to a mental health inpatient unit. In the 2025 audit, 9 patients had not had an initial assessment and a further 27 had not had a follow up feedback appointment.

A post pilot evaluation survey was circulated in the final week of case note submission. There were 25 survey responses from clinicians received across the 7 participating memory service pilot sites.

Patient demographics

The peak **age** at referral is 80-89 years in both 2024 and 2025 audit

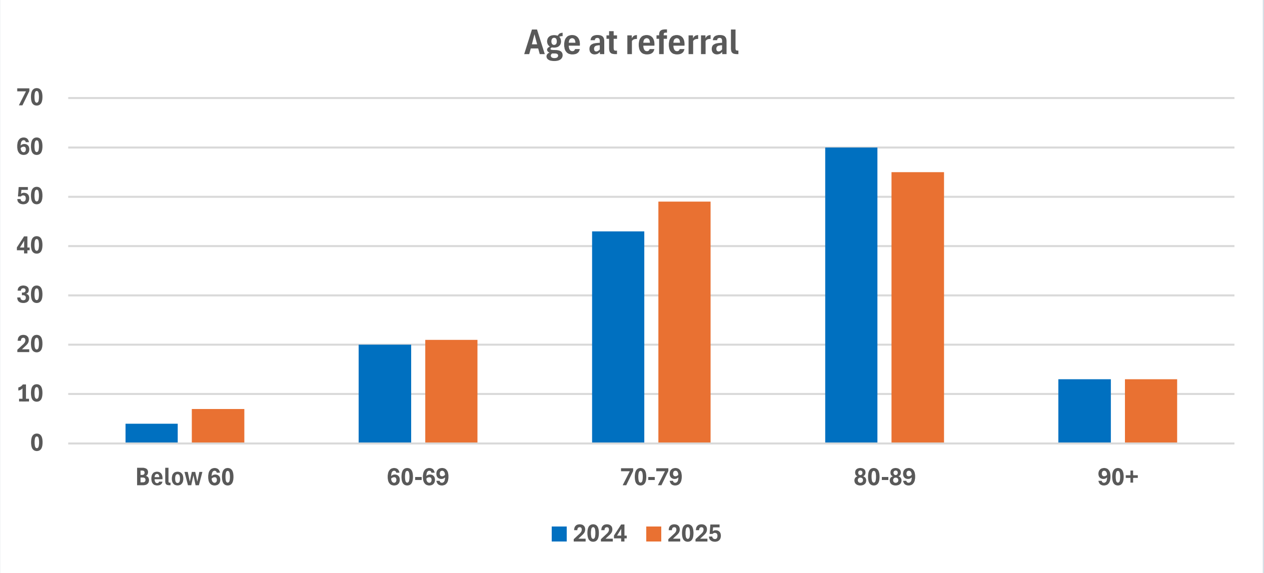


Figure 1 Age of patients at referral in 2024 and 2025

The self-reported **ethnicity** of patients was representative of the London population. See Figure 2 for a breakdown of the ethnicity groups in 2024 and 2025

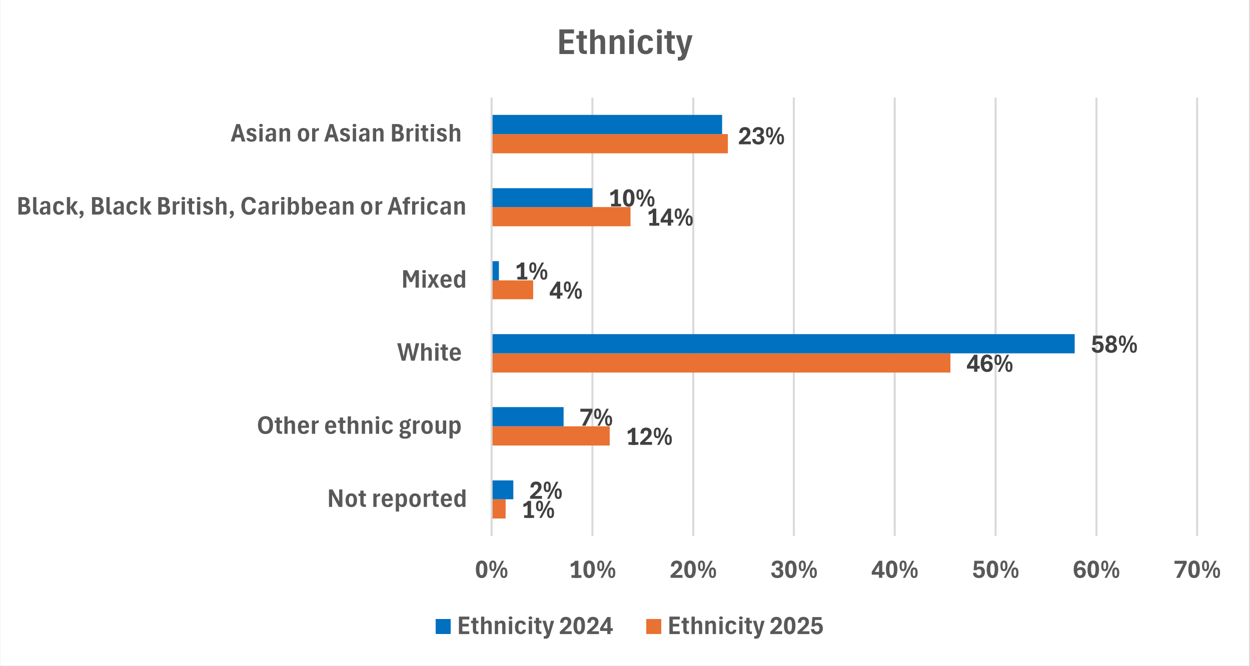


Figure 2 Ethnicity of patients at referral in 2024 and 2025

Waiting times from referral to initial assessment

In 2024, the average waiting time from referral to the initial assessment was 8.7 weeks with 60% of patients receiving a diagnosis at the initial assessment (Figure 3 and 4). At the first appointment, a diagnosis of dementia accounted for 32% of those receiving a diagnosis.

At the time of the 2025 survey closure, 9 patients had not had an initial assessment. Of those assessed, the average waiting time from referral to the initial diagnosis was 8.8 weeks, with 38% of patients receiving a diagnosis at the initial assessment (Figure 3 and 5). At the first appointment, a diagnosis of dementia accounted for 23% of those receiving a diagnosis.

This decrease in dementia diagnosis at the initial assessment may indicate that clinicians were starting to use the additional waiting time allowance for more investigations and clinical review for a more accurate subtype.

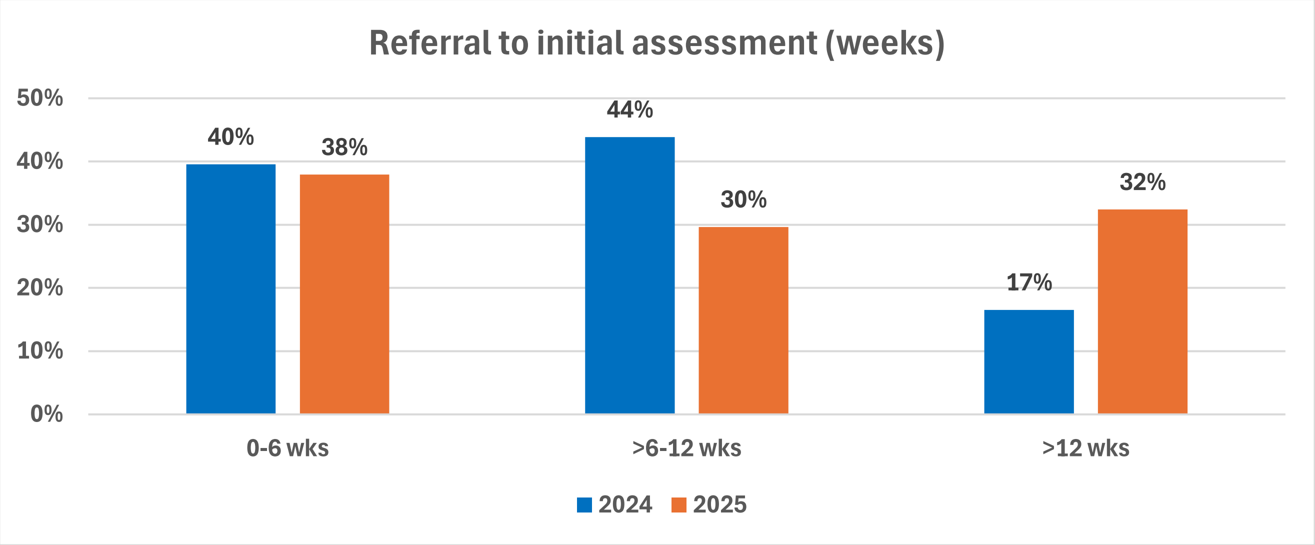


Figure 3 Referral to initial assessment in weeks

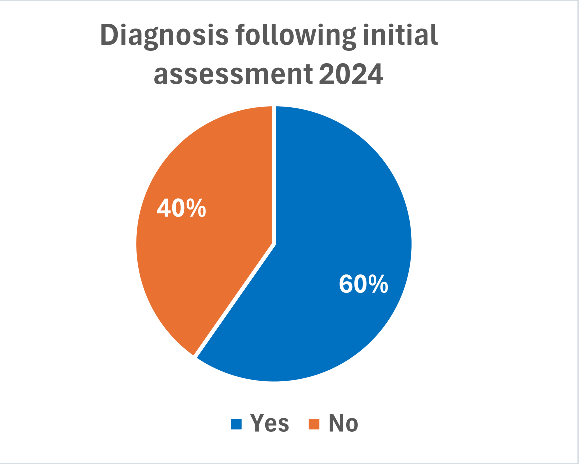


Figure 4 Diagnosis following initial assessment 2024

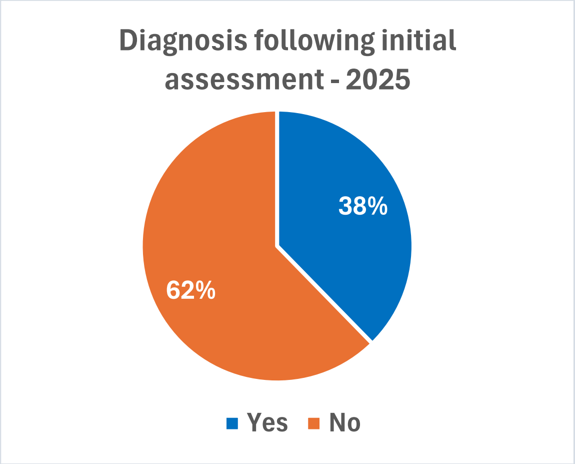


Figure 5 Diagnosis following initial assessment 2025

Referrals following initial assessment

There was no substantial change in the use of investigations following the change in waiting times (Figure 6).

Referral rates for imaging remained below 50% and biomarker testing was rare. Referral rates to Neuropsychology and Occupational Therapy were also low. Anecdotally this may be linked to staff shortages and long waiting lists. Additionally, clinicians might not have a clear understanding of the appropriate criteria or timing for making these referrals.

'Other' indicates referrals to Audiology, Physiotherapy, Neurology, IAPT or 3rd sector.

'No referrals' may indicate that there is an existing scan which allowed for the dementia diagnosis to be confirmed at the initial assessment, or the clinician didn't feel that a scan was needed for diagnosis. It may also indicate that another diagnosis was given e.g. mental health diagnosis not requiring further investigations.

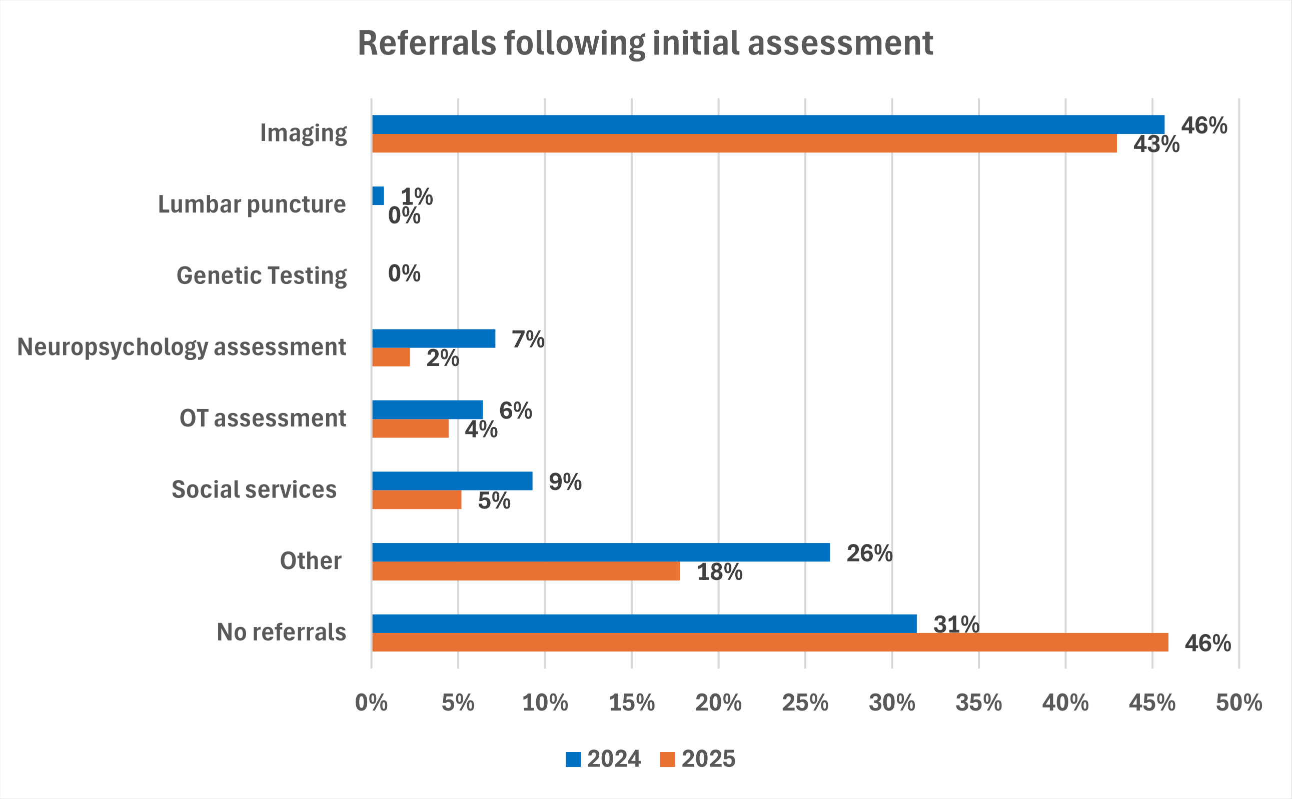


Figure 6 Referrals following initial assessment

Imaging Type

Between 2024 and 2025 there was no major variation in the types of scan requested (Figure 7).

The percentage of patients deemed not to require a scan for a diagnosis was 52% and 57% respectively.

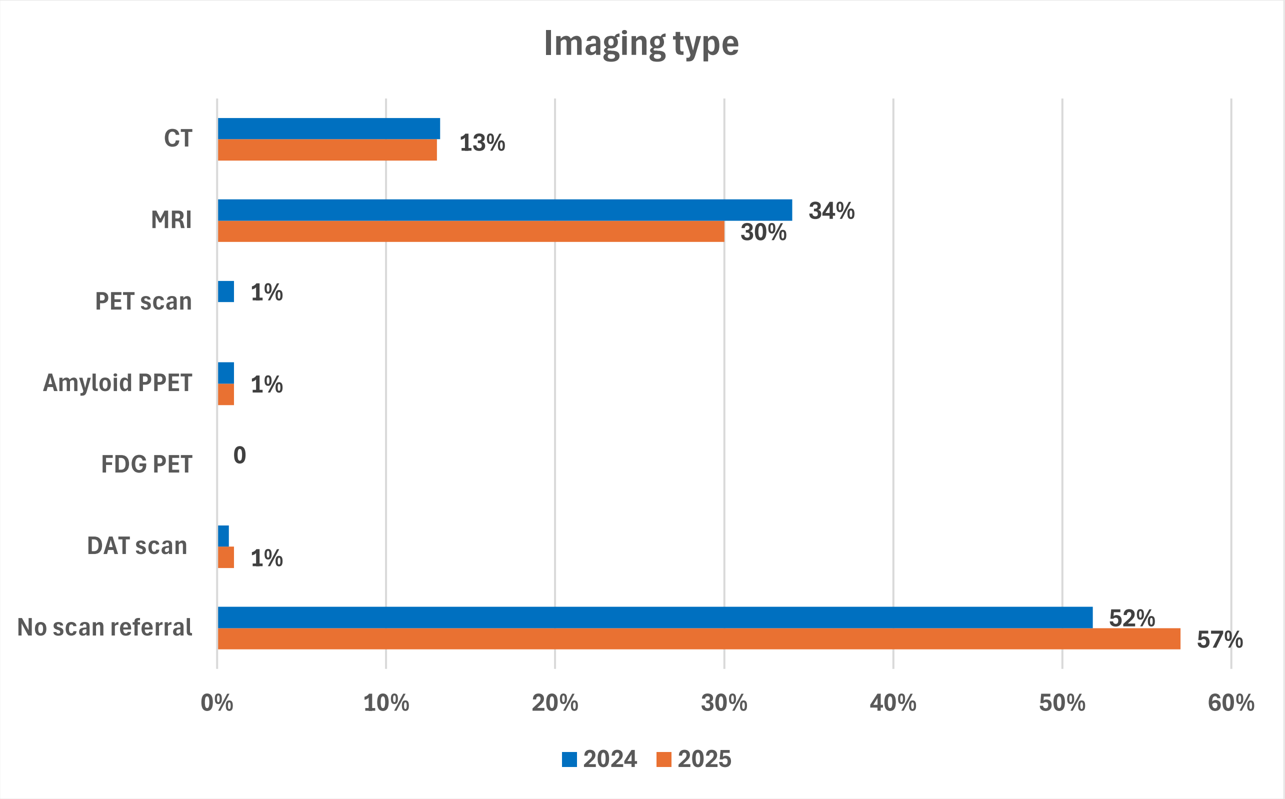


Figure 7 Imaging type

Referral to Care Management Plan

In 2024 and 2025 the proportion of patients receiving feedback and a management plan within 18 weeks remained stable (Figure 8).

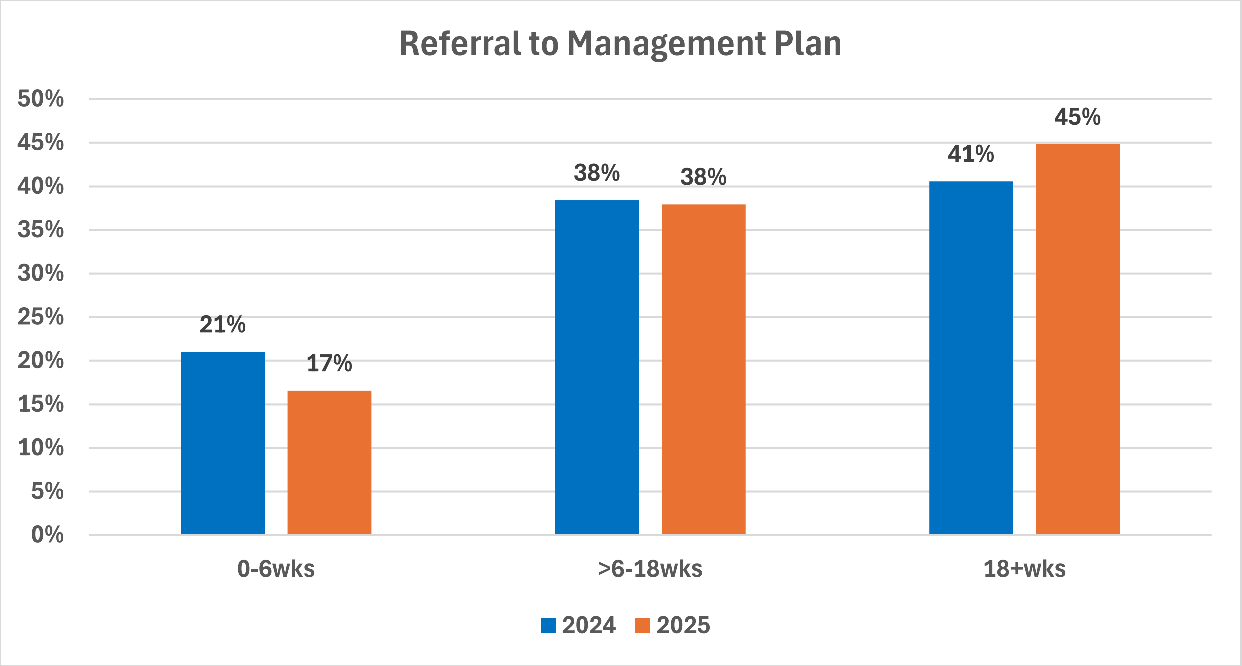


Figure 8 Referral to care management plan

Care Management feedback or Clock stop event

In the 2024 Audit there were 3 patients who were not included in the clock stop event as they were discharged before getting feedback. One appears to have been lost to follow up and did not have an initial assessment, one was admitted to a mental health unit and one moved out of area. Figure 9 shows the outcome of the remaining 137 patients.

In the 2025 Audit there were 36 patients that were excluded as they were still going through the pathway at the time the pilot evaluation was closed. There were 9 patients that were awaiting initial assessments and 27 awaiting scans or follow up appointments for feedback. Figure 9 reflects only those that have had their feedback appointment and excludes those that are still in the pathway, that is, 109 of the 145 patients referred to the respective services in July 2025.

Figure 9 indicates the actions that were agreed at the Care Management feedback appointment, also referred to as the clock stop event.

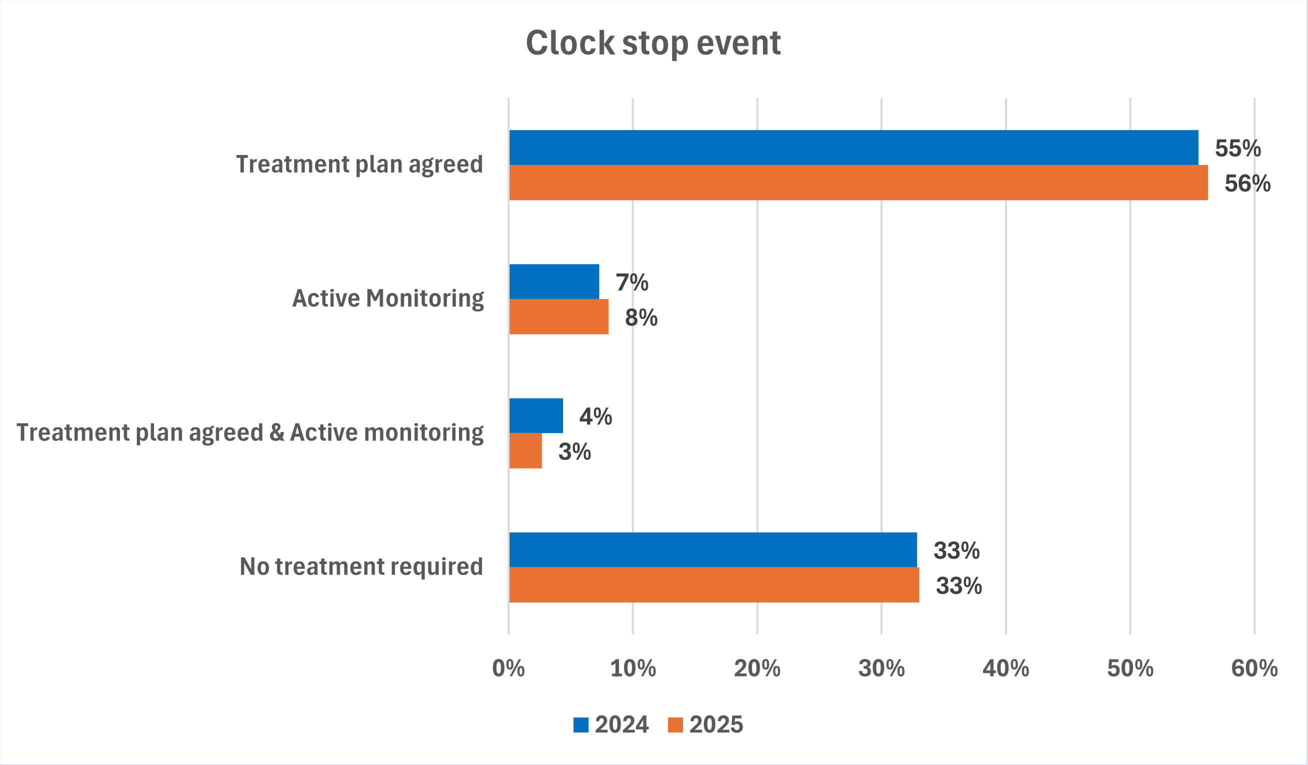


Figure 9 Actions agreed at the Care Management appointment and Clock stop event

Diagnosis

The data indicates that there has been a statistically significant increase in the proportion of people receiving specific diagnoses of Alzheimer’s and Vascular dementia and a reduction in the proportion of people with unspecified dementia, mixed dementia and Mild Cognitive Impairment (MCI) between July 2024 and July 2025 (chi-squared p=0.04) (Figure 10).

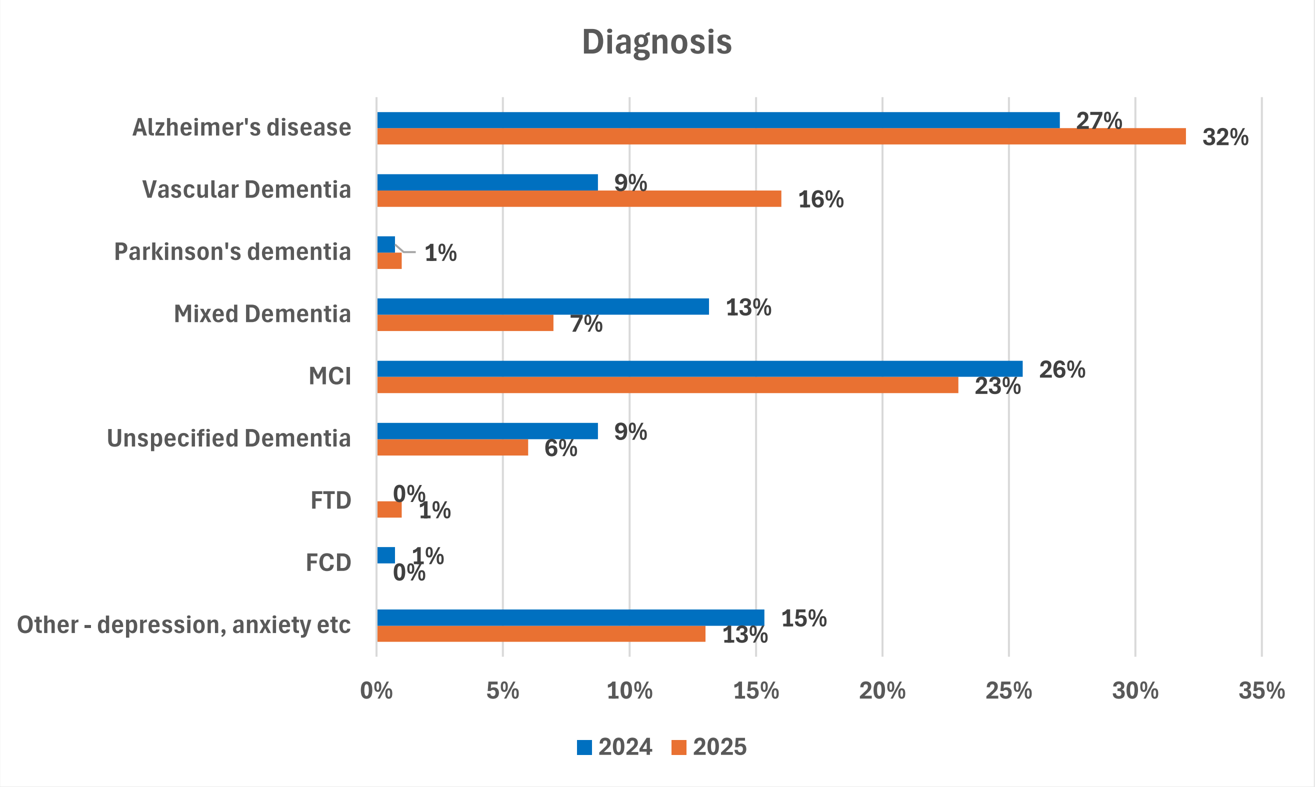


Figure 10 Dementia diagnosis subtypes and other diagnosis

Interventions post feedback appointment

2024: at the time of the survey submission, 3 patients were excluded as they had not completed the pathway either because they had been lost to follow up or discharged prior to their follow up appointment.

2025: at the time of survey submission, 9 patients were awaiting an assessment and a further 27 were awaiting their feedback appointment.

Figure 11 below indicates that of the 137 patients originally assessed and completing the pathway in 2024 and the 109 in 2025 who had received feedback and a care management plan, the following referrals were made:

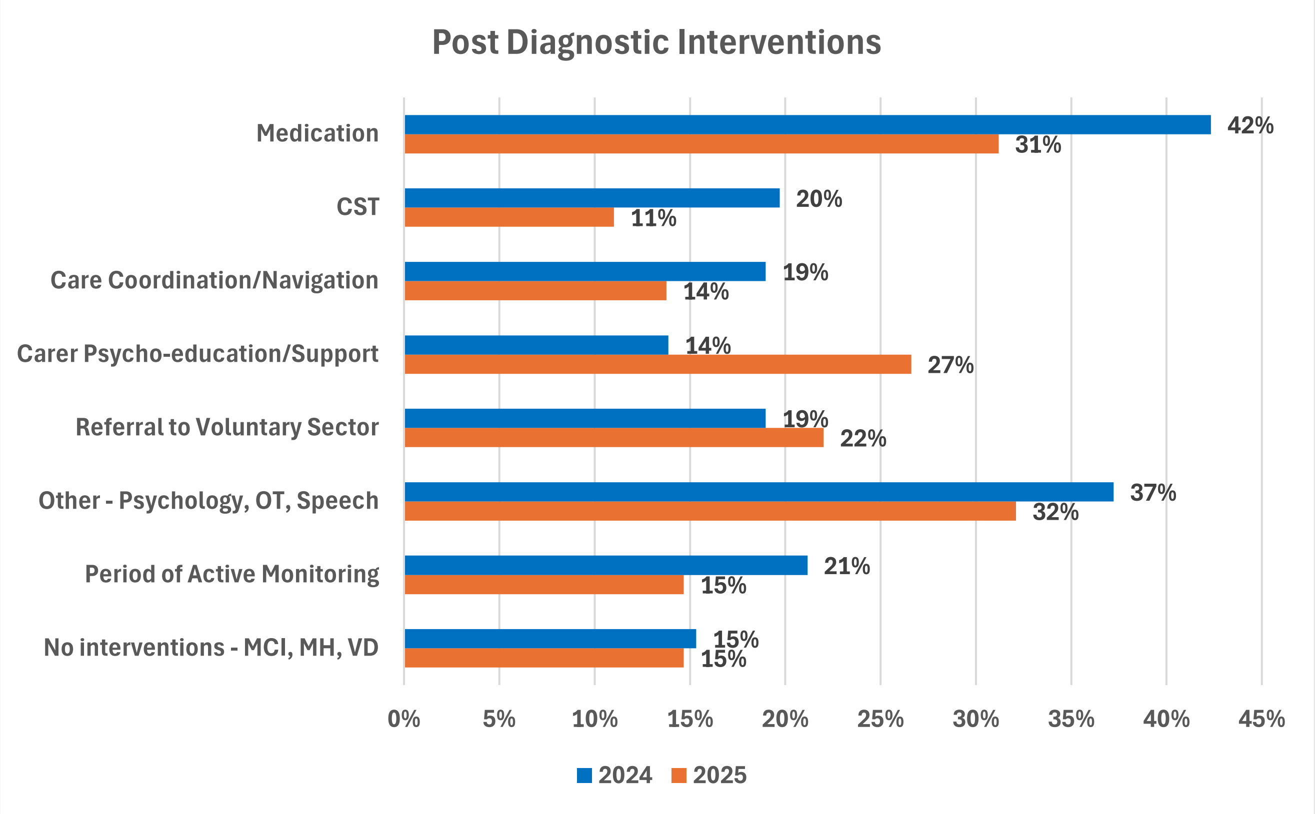


Figure 11 Referral for post diagnostic interventions

The data indicates that proportionately there were more referrals made for post diagnostic interventions in 2024 than 2025.

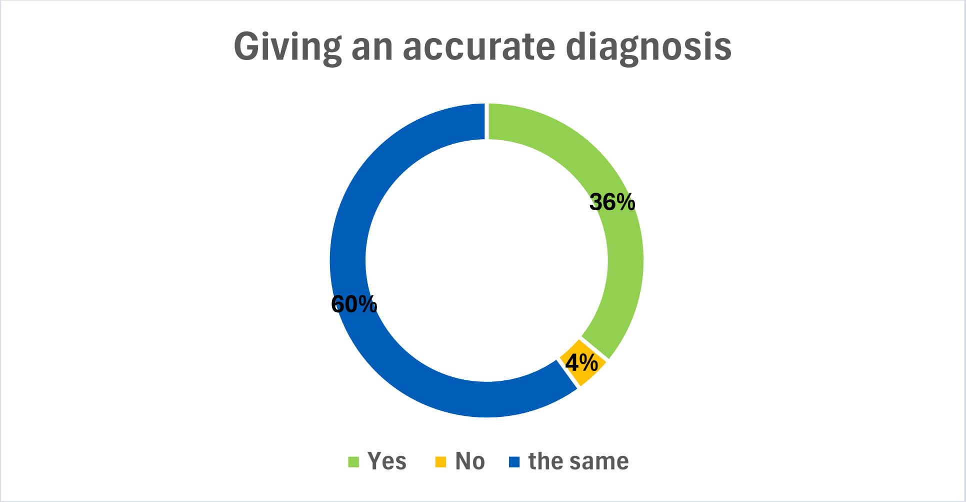
Following the care management or feedback appointment, patients are frequently followed up by other clinicians and dementia advisors who may also make additional referrals depending on their assessment and findings. This may account for the increased number of referrals in those patients who had been through the pathway in 2024 and therefore, had more time for these subsequent referrals to be made.

Clinician survey

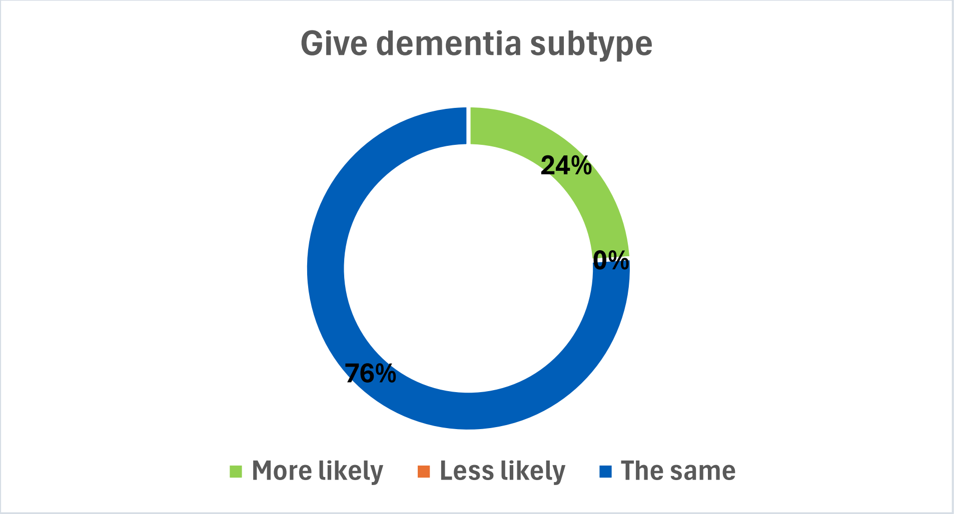
Following submission of the patient data, the clinicians were asked to complete a Microsoft survey giving them an opportunity to express their experience and insights on the change in waiting times. Surveys were submitted by 25 clinicians representing all 7 pilot sites.

The following figures reflect the responses to the questions below:

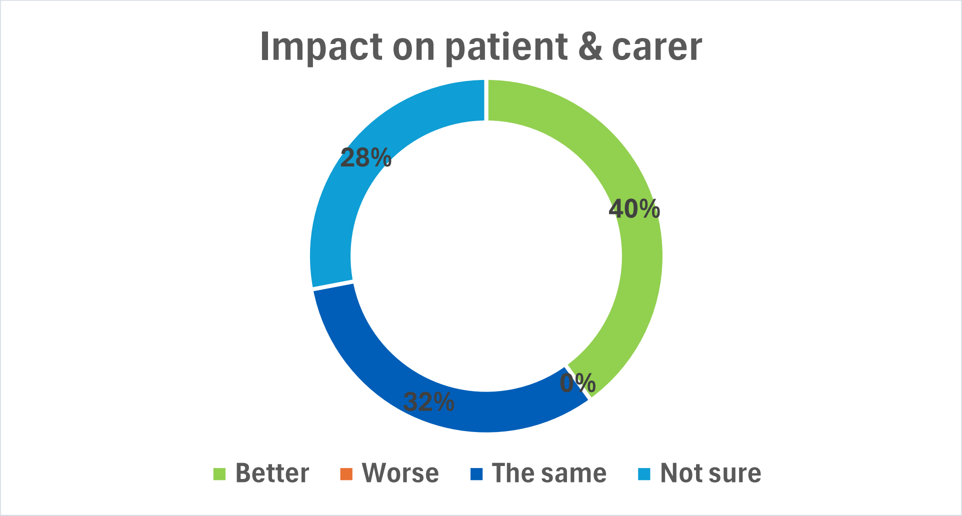
Since the change in the waiting time metric, please state if you feel you are giving a more accurate diagnosis



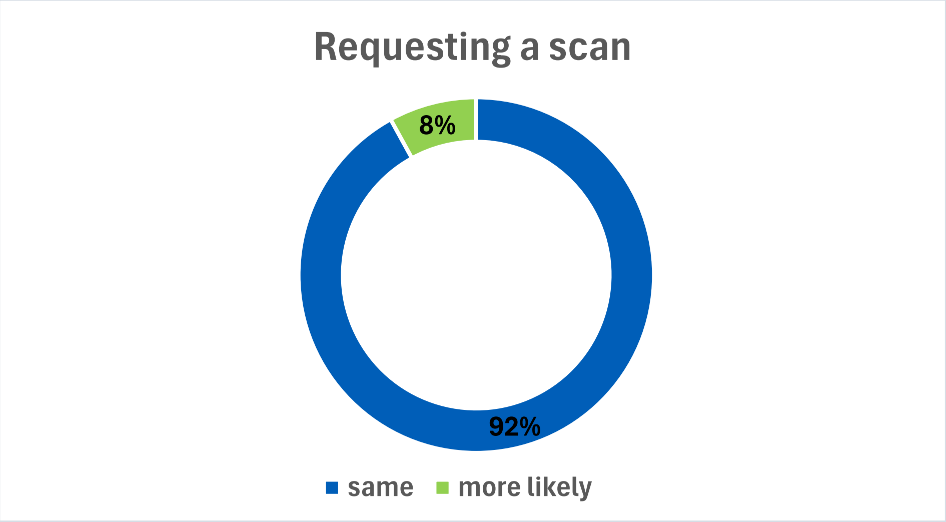
Since the change in the waiting time metric, please state whether you are more likely to diagnose a dementia subtype



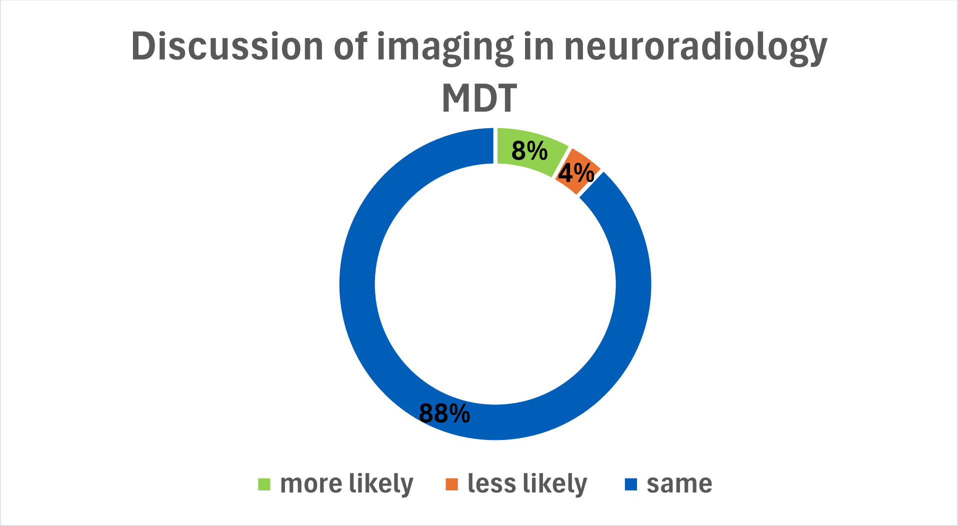
Since the change in the waiting time metric, please state the effect on patient and carers



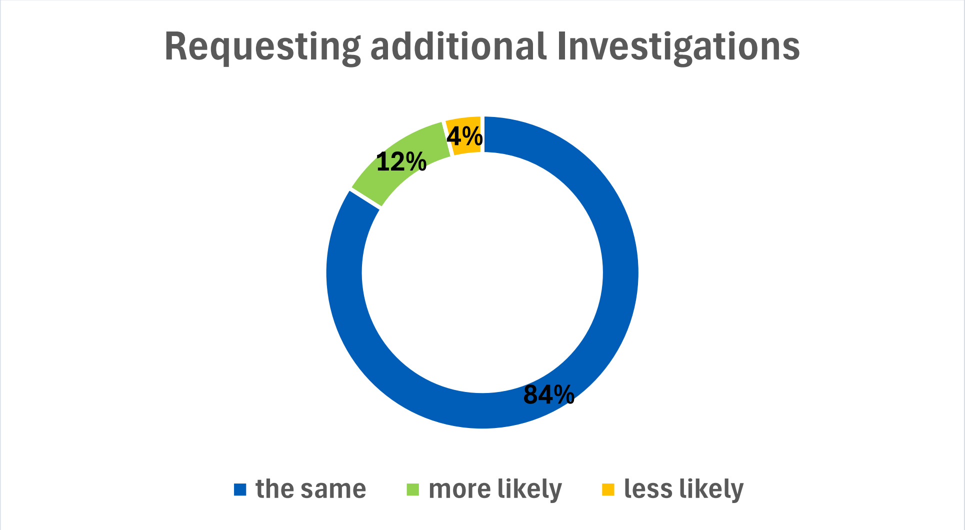
Since the change in the waiting time metric, please state degree of change in requesting a scan:



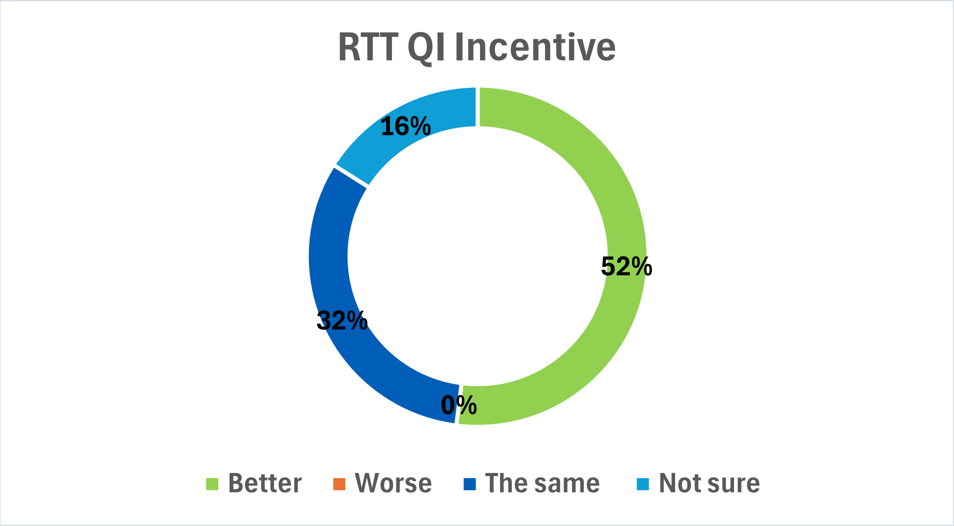
Since the change in the waiting time metric, please state degree of change in discussion of imaging in neuroradiology multidisciplinary team (MDT) meeting before giving a diagnosis:



Since the change in the waiting time metric, please state the degree of change in requesting additional investigations and assessments



Since the change in the waiting time metric, please state if the incentive for Quality Improvement work (QI) around waiting times is:



Clinicians were also given the opportunity to add their comments regarding their experience and thoughts about the change in waiting times and the impact that had on their practice.

> *“I didn’t let the KPI get in the way of good clinical care, but I now feel under less pressure making decisions that would slow down the diagnosis”*
>
> *“Having 6 weeks was not enough time to provide an accurate diagnosis or consider a biomarker diagnosis”*
>
> *“My actual practice has not changed hugely, but over time, the accuracy of diagnosis will improve as clinicians have more time to ‘wait and see’ how a multifactorial situation evolves”*
>
> *“There is no change in clinical practice cause by a change in waiting time metric. We will hopefully get moaned at less by Performance Managers and feel less pressure”.*
>
> *“My practice has not changed significantly as I have always practiced with my focus on my patients best interests; but I can request investigations without thinking about the impact on our statistics….”*

Summary

The London Dementia Clinical Network (DCN) proposed moving all London memory services from a 6-week standard to the nationally recognised 18-week Referral to Treatment (RTT) pathway, bringing dementia into alignment with other physical health conditions. This shift aimed to improve data quality, support more accurate and specific diagnoses, reduce pressure for premature diagnostic decisions, and encourage more sustainable quality improvement activity around waiting times.

Seven memory services across the five London Integrated Care Bodies (ICBs) participated in the evaluation, contributing data from referrals made in July 2024 (n=140) and July 2025 (n=145). The evaluation examined end-to-end pathways from referral through to care management or feedback appointments, including use of investigations, MDT involvement, diagnostic outcomes and post-diagnostic referrals. Clinician feedback was also collected to understand perceived impacts on practice.

Demographic patterns in both audit years were consistent, with referrals peaking in the 80 - 89 age range and ethnicity broadly representative of the London population.

Waiting times to initial assessment remained stable, with averages of 8.7 weeks in 2024 and 8.8 weeks in 2025. The proportion of patients receiving a diagnosis at the initial assessment fell from 60% to 38%, and the proportion receiving a dementia diagnosis at that first appointment also decreased. This suggests clinicians were beginning to use the extended timeframe to gather further information before confirming a diagnosis.

Use of investigations, including imaging, biomarker testing, Neuropsychology and Occupational Therapy, remained broadly unchanged. Imaging rates remained below 50%, and biomarker testing was rare. Lower referral rates to Neuropsychology and Occupational Therapy appear to be influenced by staff shortages, long waiting lists and variable understanding of referral criteria.

Time to care management or feedback appointments remained similar within the 18-week standard in both years, though a shift from the 6-12 week band to the 12-18 week band was observed in 2025. Diagnostic patterns shifted favourably, with increases in the proportion of Alzheimer’s disease and vascular dementia diagnoses and reductions in unspecified dementia, mixed dementia and Mild Cognitive Impairment, indicating improved diagnostic specificity.

Post-diagnostic referral rates were proportionally higher in 2024 than 2025, likely because patients referred earlier were more likely to receive additional interventions after the initial care plan was made. These referrals often occurred outside the immediate feedback appointment through subsequent clinician or dementia advisor contact.

Clinician survey results demonstrated broad support for the new waiting time metric, with many reporting reduced pressure to make rapid diagnoses and greater capacity to “wait and see” where clinically appropriate. Clinicians indicated increased confidence in producing

accurate diagnoses, greater willingness to subtype dementia, and improved opportunities for MDT discussion. Several reported that while their personal practice had not fundamentally changed, the new metric removed performance-driven pressure, supporting more clinically sound decision-making and improving incentives to undertake quality improvement work around waiting times.

Conclusions

The transition to the 18-week RTT pathway across London memory services appears to be both feasible and beneficial, with no evidence of negative impact on service quality or patient outcomes in the first year of implementation. The stability in waiting times, despite a more generous overall target, suggests that services maintained timely access while gaining flexibility to enhance diagnostic processes.

The reduction in initial diagnoses, alongside increased specificity in the types of dementia diagnosed, indicates that clinicians may be using the extended timeframe to incorporate more investigations, MDT input and clinical observation before confirming a diagnosis. This supports the original rationale that the 18-week standard would improve diagnostic accuracy and reduce reliance on unspecified dementia labels.

Although referral patterns for investigations did not substantially change, persistent low referral rates for imaging, biomarkers, Neuropsychology and Occupational Therapy highlight ongoing system-level barriers, such as workforce shortages and unclear referral pathways. Addressing these constraints could further strengthen diagnostic quality and post-diagnostic support, and additional time in the diagnostic pathway will ensure that it is feasible to do so.

Clinician feedback demonstrates strong endorsement of the change, particularly in relation to reduced performance pressure and improved ability to make patient-centred clinical decisions. The new metric also appears to be encouraging more meaningful quality improvement activity, as intended.

Overall, the evaluation shows that the shift to the 18-week RTT standard is a positive development for London memory services. It supports parity with physical health pathways, enhances diagnostic practice, and promotes a more holistic and clinically driven approach to dementia assessment and management. Continued monitoring and targeted support for referral-dependent specialties will be important to maximise the benefits of this system-wide change.

Findings from the pilot evaluation support the continued implementation of the 18-week RTT standard across all London memory services. These insights will also inform the development of the forthcoming Modern Service Framework for Dementia and Frailty, due to be published later this year.