

**BEST PRACTICE IN  
MEMORY SERVICES:  
Learning from across England**



# **Best practice in Memory Services: Learning from across England**

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## Executive Summary

The diagnosis of dementia is the key first step in the dementia pathway. Several things can help increase the number of people receiving a diagnosis, enabling them and their carers to access vital post diagnostic support. These include raising public and professional awareness, enhancing the skills of colleagues in primary care, in particular General Practitioners (GPs), and shared protocols with specialist providers. With the increase in the interest in dementia and the need for high quality services, memory services have an important role to play in the assessment, diagnosis and management of people with suspected dementia.

Waiting times from referral to assessment and diagnosis vary and the 2013 English National Memory Clinics Audit <sup>1,2</sup> demonstrated that although three-quarters of clinics were seeing patients within 6 weeks of referral, waiting times sometimes extended to months.

This report summarises the findings from a series of visits carried out by NHS England's National Clinical Director for Dementia, Alistair Burns supported by the team of NHS Improving Quality (Anne Wilkinson, and Susie Peachey) and the Memory Services National Accreditation Programme (MSNAP). The visits were to a number of memory services which were experiencing longer waiting times from referral to assessment. The audit found that there had been significant successes in a number of clinics in improving access times over the past year, often in challenging circumstances.

Common features of the services which were reducing waiting times were:

:

- **Reviewing the assessment pathway** and reconfiguring workforce to match demand. Some achieved this through upskilling existing staff, using vacancy funding creatively or investing in new staff
- **Developing joint clinical protocols** for referral and diagnosis, follow-up care, access to and reporting of scans and care home management
- **Supporting memory services in primary care** <sup>3,4</sup>.

Based on the findings the top ten tips to service improvement are:

### TEN TIPS for Service Improvement

- 1** Involve service users and carers at every step
- 2** Understand current and future demand and map against available capacity
- 3** Review referral protocols
- 4** Review brain scan (CT/MRI) protocols
- 5** Examine DNA rates
- 6** Ensure correspondence clearly states diagnosis and accompanying 'Read Codes'
- 7** Identify education and training opportunities
- 8** Consider protocol for diagnosis in primary care including care homes
- 9** Review with commissioners the role of specialist nurses
- 10** Become MSNAP accredited and share best practice examples (on MSNAP or NHSIQ websites).

It was clear from these site visits that many of those who reported long waiting times in the 2013 Memory Clinics Audit had since made significant improvements to reduce waiting times. There is clearly genuine enthusiasm and drive in many localities to work in collaboration with primary care and acute care providers to develop joint pathways, protocols and operational processes to improve the experience and care for people at this critical point in their dementia pathway.

Special thanks to all those sites visited for their hospitality and willingness to share information and to Martin Orrell and Sophie Hodge from MSNAP for inspiration and support.

## Background

It is estimated that there are currently approximately 850,000 people in the UK with dementia, and this number is expected to double over the next thirty years.

Memory clinics were set up in the UK in the early 1980s, based on models from the USA. The original purpose of memory clinics were to see patients who would not normally be seen by generic psychiatry services, as their symptoms were relatively mild and potentially responsive to interventions. Many of these pioneering clinics were based in specialist centres and concentrated on recruiting patients with early Alzheimer's disease into clinical drug trials. Their numbers increased steadily from around 20 in the early 1990's to a 100 by 2000, a figure which has now doubled.

Memory clinics today are less specialised and are the cornerstone of the diagnosis of people with suspected dementia. The NHS Information Centre's 2011 report *Establishment of Memory Services*<sup>5</sup> showed the reach of these clinics with then the majority of Primary Care Trusts (PCTs) commissioning what were described as memory clinic "services", reflecting the broader role of the offer given to people with memory difficulties.

NHS England has set an ambition that two-thirds of the estimated number of people with dementia should have a diagnosis and access to high quality post-diagnostic support by March of 2015,<sup>6,7</sup> From GP dementia registers in September 2014 we know that there are around 53 percent of people who have had their diagnosis confirmed and can access post-diagnostic information and support services.

The majority of people with symptoms of dementia are assessed and diagnosed through a memory service usually provided within secondary care, though increasingly GPs are taking an active role in the assessment and diagnosis process, without referral to secondary care.

Although no specific waiting time targets are set in NICE Guideline CG042<sup>8</sup>, the service specification for memory services published by the Department of Health in 2011<sup>9</sup> suggests that commissioners should set specific waiting times for each stage of the referral and assessment process.

The 2013 English National Memory Clinics Audit<sup>1</sup> received responses from 178 out of 214 memory services and found that whilst the average waiting time from receipt

of referral to assessment was 5.2 weeks (range 1-25 weeks), there were 43 services (24.3%) of memory services where waiting times exceeded the MSNAP recommended six week standard. Longer waiting times for assessment are perceived by many as the reason why diagnosis rates in some areas remain low.

The Care Quality Commission (CQC) 'Cracks in the Pathway' report<sup>10</sup> cited inadequate sharing of information across organisational boundaries, variations in staffing, and confusion over responsibility for care planning and care pathways as major causes of variable or poor care; all of which were observed to some extent across the memory services visited.

The guidance on changes to Quality and Outcomes Framework (QOF) has now been published with the strengthened emphasis on dementia. From April 2015, QOF has been further developed to ensure a greater emphasis on post-diagnostic support and care planning for people with dementia<sup>11</sup>.

## Approach

In May 2014 it was agreed that Alistair Burns, National Clinical Director for Dementia, NHS England (assisted by NHS Improving Quality, and advised by Martin Orrell Chair of MSNAP) undertake a selection of visits (or teleconferences where a face-to-face meeting was not feasible) to memory service providers where self-reported referral to assessment waiting times in the 2013 English National Memory Clinics Audit exceeded 12 weeks.

Of the 12 memory services approached 11 accepted the offer of the visit. The purpose of the visits was to offer support and advice and identify whether there were any common factors affecting waiting times. The visits provided an opportunity to listen and learn, and highlight actions that could be taken to achieve the ambition set out in the Dementia Strategy<sup>12</sup>.

Visits took place between July and August 2014. Great care was taken to ensure the emphasis was on mutual learning and supportive review, rather than the process being misinterpreted as having a performance management approach.

In addition to the 11 services with longer waiting times, further two visits were arranged to services where waiting times were reported as less than two weeks. These visits were also supported by an MSNAP team member and a Delivery Support Manager from NHS IQ (see appendix 2).

The aim of the approach was to:

- gain an understanding of issues and challenges faced by memory services
- develop a picture of the pathways for memory services
- identify and spread examples of good practice for service improvement that could be offered to all services across England
- stimulate discussion and encourage action to help achieve shorter waiting times.

The visits were generally well attended and attracted a range of people, including medical staff, clinic nurses/nurse specialists, service managers, psychologists, operational staff and in some cases, mental health commissioners and medical directors. Without exception, the teams welcomed the opportunity for an in-depth discussion about waits for assessments and related issues.

*"It is a great privilege to see the enthusiasm and excitement around the country to commit to provide the highest quality services to people with dementia and support for their carers".*  
**Alistair Burns- National Clinical Director for Dementia, NHS England**

### Analysis and Findings

The following reflects findings from the site visits. Where the two sites with short waiting times have been excluded they have been referred to as 'comparator sites'. Memory services are referred to as 'sites'.

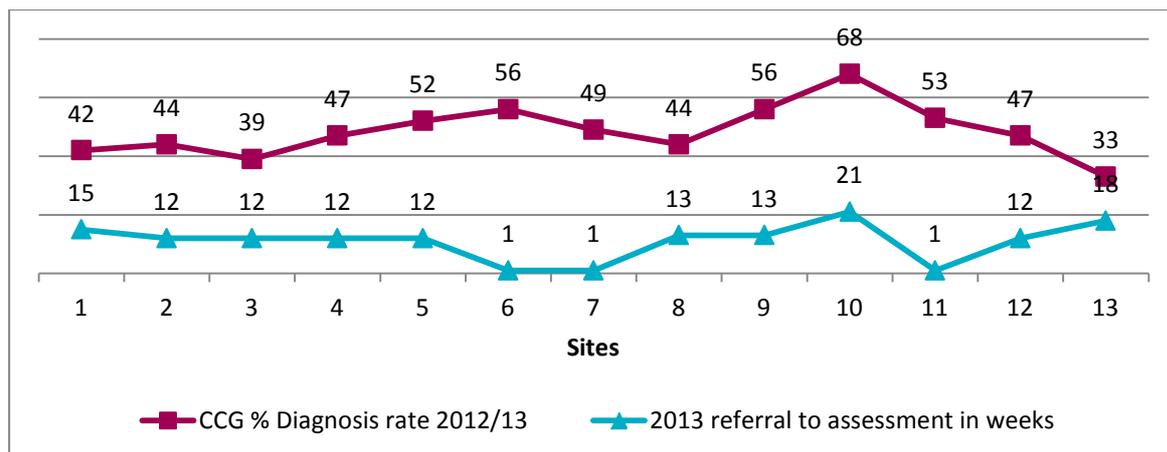
*"This project was hugely important in sharing good practice, allowing memory services the opportunity to have a voice about their difficulties, and recognising innovative ideas to share with other teams."* **Sophie Hodge, Deputy Programme Manager, MSNAP**

### Accreditation

Three sites visited were accredited with MSNAP and all three had reported waiting times over 12 weeks. One further site was an affiliated member and four sites were planning to become accredited.

### Diagnosis rates

There was no significant correlation between waiting times and diagnosis rates. Indeed some of the sites with the longest waits also had the best local CCG diagnosis rate. One site (thirteen) had long waiting times and low diagnosis rates.



*'It was refreshing to see Memory Services who were willing to share good practice but were also prepared to reflect on what they could do to improve things'* **Professor Martin Orrell, Chair of the MSNAP Accreditation Committee**

### Waiting times from referral to assessment.

- In seven sites, waiting times had dropped since the audit was undertaken
- In four sites the waiting time had increased from 1 to 28 weeks, but this site was expected to improve following launch of new pathway in August 2014
- In both the comparator sites waiting times had increased but were still within the six week standard.

### Referral process

- All sites reported significant increases to referrals over recent years
  - Three sites demonstrated rises between 40 to 50 percent over the past three years

This increase in demand had been met in some areas through:

- increased investment in staff
  - service redesign
  - staff training
  - greater involvement of primary care.
- 
- Five sites noted poor quality and inadequate completeness of referral
    - e.g. next of kin information or screening blood tests had not been completed.
  - Two sites accept self and carer referrals
  - Three sites accept referrals from social care
  - Five sites reported having a single point of access for all referrals
  - Two sites had introduced choose and book systems and these had both had a positive impact on waiting times
  - DNA rates were a problem in two sites
    - one site recording rates of 40 percent for follow up visits
  - All sites accept referrals for Mild Cognitive Impairment (MCI) with most discharging back to GPs after six months.

### Assessment

- Some sites had reviewed their assessment processes and introduced more clinic based assessment to meet increases in demand and staff capacity issues.
- All sites offered home based assessments
  - Some sites offered this for almost all referrals
  - Some sites offered home-based assessment to a minority of referrals only in certain circumstances (e.g. inability to travel)
- Assessments were nurse led in most sites, with two sites using Occupational Therapists (OT) to undertake assessments
- Where specialist outreach services had been established in primary care the consultant performed the first assessment  
Two sites had extended their working week to provide a Saturday assessment service.

### Tests and brain scans

- In most sites the referral for scans were requested following the assessment stage
  - nurses generally complete the scan request with sign off from a consultant
  - in two sites the scan request was initiated by the GP at the time of referral
- There was mixed practice around the percentage of people referred for scans with some referring virtually all and others only 40 percent
- There was considerable variation in waiting times for scans (on the day to 8 weeks) with the average of four weeks
- There was mixed practice regarding access to the picture archiving and communication system (PACS) and reports.

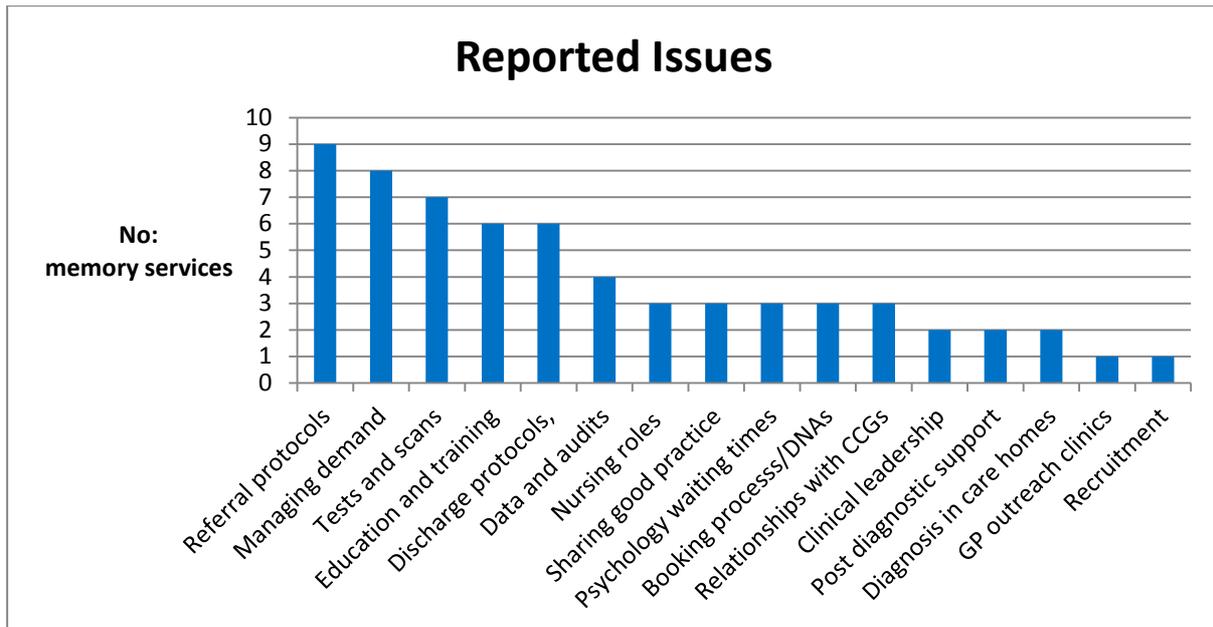
### Follow up

- Appointments are nurse-led in many sites
  - Five sites reported the benefits of having nurse prescribers undertaking the role of user follow-up
- One nurse led follow up clinic was run in primary care and in this instance no patients were referred to the GP for follow up
- Protocols for follow up with the primary care providers were either agreed or under development in all sites
- For the majority of services, patients were referred back to primary care 6 to 12 months after diagnosis although many reported significant reluctance from GPs to accept this
- This reluctance from GPs to pick up responsibility for follow-up had been addressed in a number of ways including:
  - fast-track re-access systems (four sites),
  - appointment of General Practitioner with a Special Interest (GPwSI) posts to which 'fast track patients could be referred.

### Workforce

- Occupational therapists and psychologists were core members of most teams
  - Psychologist capacity was noted as a particular issue for many services
  - One site had a speech and language therapist and physiotherapist as part of their team
- There were some excellent examples of cross-organisational working and strong voluntary input into the memory services
- There appears to be an expanded role developing for specialist or community dementia nurses within primary care that, in some places, encompasses the Admiral Nurse service.

Fluctuations in staffing levels (either through Waiting List Initiative (WLI) investment to reduce waiting times or through inability or delays to recruitment) were experienced by most sites.



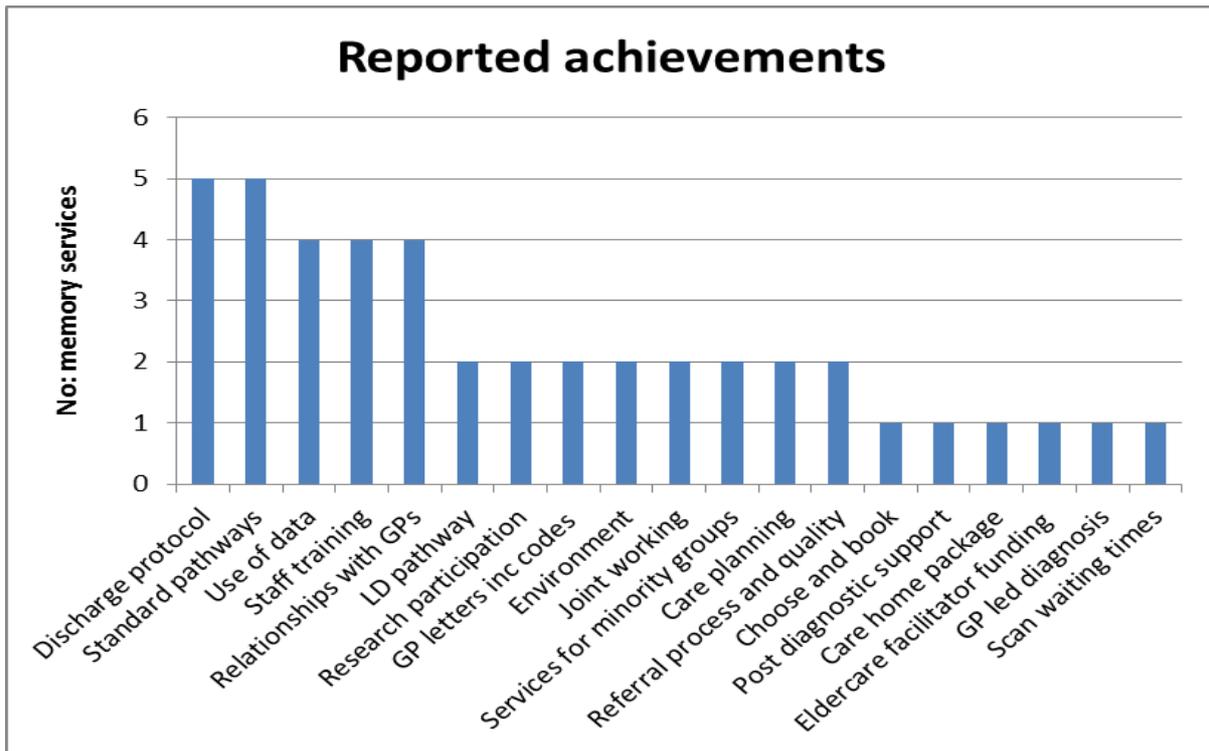
*'Those memory services with longer waiting lists which they were finding hard to manage, were keen to look at alternative ways of working. This included trying to reduce the number of appointments needed for diagnosis; and considering whether appointments for brain scans should be arranged for everyone as a routine, or whether they should primarily be for patients who had a clinical need for a scan.'* **Professor Martin Orrell, Chair of the MSNAP Accreditation Committee**

### Common Features of Services Making Progress

The visit team were able to determine a number of important factors associated with sites that had made progress over the past year.

These include:

- Good clinical and managerial working relationships within teams and across organisational boundaries
- Use of quality, reliable, regular data presented to CCG, GP and Trust management groups
- Using the MSNAP standards as a guide to service development
- Redesign of pathways and reconfiguration of workforce - matching people to pathway, competencies/training, increased role of nurses, dementia advisors, Admiral Nurses, specialty doctors
- Joint protocols for shared care – follow-up appointments in primary care, scans, diagnosis, referral criteria to improve quality, care home management
- Pro-active approach to clinics in primary care
- Learning from others



*'The memory clinic run in our practice in South Manchester in collaboration with Alistair Burns has greatly improved our access to specialist memory advice and I know the patients love it.'* **Dr Doug Jeffrey, Managing Partner, Barlow Medical Centre, Didsbury, Manchester**

### Current challenges to low waiting times and examples of improvement

The following identifies the main issues identified during site visits and some specific examples of change where there has been an impact on waiting times. There were many other examples of good practice such as for post- diagnostic support and whole system working, however these have not been included in this report.

Sites identified several current challenges associated with reducing waiting times for assessment.

*"Meeting and speaking to memory clinic teams allowed us to get an honest insight into their ways of working: to hear about the aspects of work they are proud of, and also the issues they struggle with."* **Sophie Hodge, Deputy Programme Manager, MSNAP**

### Referrals

Nine sites reported issues around referrals and in particular the completeness of referral information provision of next of kin information, outcome of tests, etc.

### Case study example

To reduce waits from referral to assessment and improve the quality of referrals, the **Chiltern Memory Service** introduced a Choose and Book (C&B) service in January 2014 as a trial in the memory clinic. Users can choose from clinic slots across the whole of Oxford and Bucks. Although there are some issues with acceptance by GPs, referral quality has improved due to the specific referral criteria and required mandatory information built into the C&B system. Memory clinic clinicians are currently visiting GP surgeries to promote the use of the C&B system which has reduced waits to less than two weeks.

### Demand and Capacity

Eight sites reported capacity and demand issues. Most sites reported demand increases of 40 to 50 percent over the past three years. Several reported long waiting times for a psychologist review.

### Case study example

**Lancaster Memory Service** has introduced a one-stop-visit for assessment and diagnosis for selected patients. On receipt of the referral, service users are contacted by telephone within 24 hours to start the assessment process using a set of standard questions and protocols. Where appropriate, scan requests and other pre-diagnostic tests are arranged and information is sent to the user in advance of their appointment. Users suitable for a one-stop single assessment with a nurse, including diagnosis and treatment, has enabled 50 percent of users to leave clinic with a diagnosis. This release of clinic capacity has helped improve waiting times for assessment.



### Case study example

**North Somerset Memory Service** found that merging of local services, coupled with rising demand had led to their waiting times exceeding six months. Under the leadership of a new team manager, the care pathway and workforce skills were reviewed. Revised criteria for home based assessments were agreed and implemented to enable more assessments to be undertaken in the out-patient clinic setting. This revised criteria has led to an increase in nurse led clinic capacity for the initial assessments and helped reduce waiting times to between four and six weeks

### Case study example

To meet increasing demand, **the Chiltern Memory Service** has worked in partnership with primary care to introduce four outreach clinics in GP surgeries using one extra consultant PA (non-recurring funding). The service has received good feedback from users as they were seen quickly, in a familiar setting. Users now receive their first appointment and diagnosis within two weeks, instead of 12 weeks previously.

This led to a demand from other GPs in the area wanting to offer the same service in their practices, and a possibility of moving some existing clinics from secondary care to GP practices.

### Tests and Brain Scans

Seven sites reported waits for and management of scans. This included agreement of scan protocols and request criteria, long waiting times for appointments, difficulties accessing picture archiving and communication (PACS) and reporting systems.

### Case study example



**Hartlepool Memory Service** have explored several options to reduce waiting times for scans. They now offer shorter waiting times at another nearby Trust for those who are prepared to travel. Interestingly they have found that most people prefer to have their scan locally and wait longer rather than attend another hospital and reduce their waiting time between assessment and diagnosis. This has prompted the team to explore other ways to meet the demand, including capacity and demand analysis and service reviews.

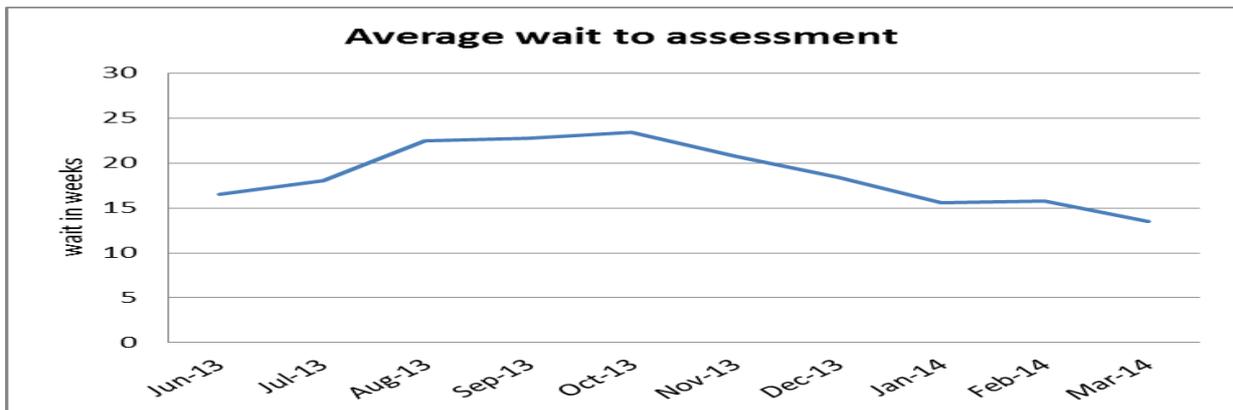
*“It is so impressive to see at first hand the local solutions being brought to bear on challenges in the provision of memory services to reduce waiting times and improve care”* **Alistair Burns, National Clinical Director for Dementia, NHS England**

## Workforce Capacity and Capability

Six sites reported challenges around education and training, though some have identified good opportunities for training and education in primary care. Some sites referred to the variance in nursing roles and responsibilities between Admiral Nurses, dementia advisors, practice nurses and others

### Case study example

**Southwark & Lambeth Memory Service** used their data to demonstrate increasing demand and the capacity to meet that demand. The service modelled the impact on waiting times if further staff resources were identified and as a result secured increased funding for three additional Band 6 practitioners one of who is based in primary care. The waiting list from referral to assessment has reduced from 23 weeks in October 2013 to 13 weeks in March 2014



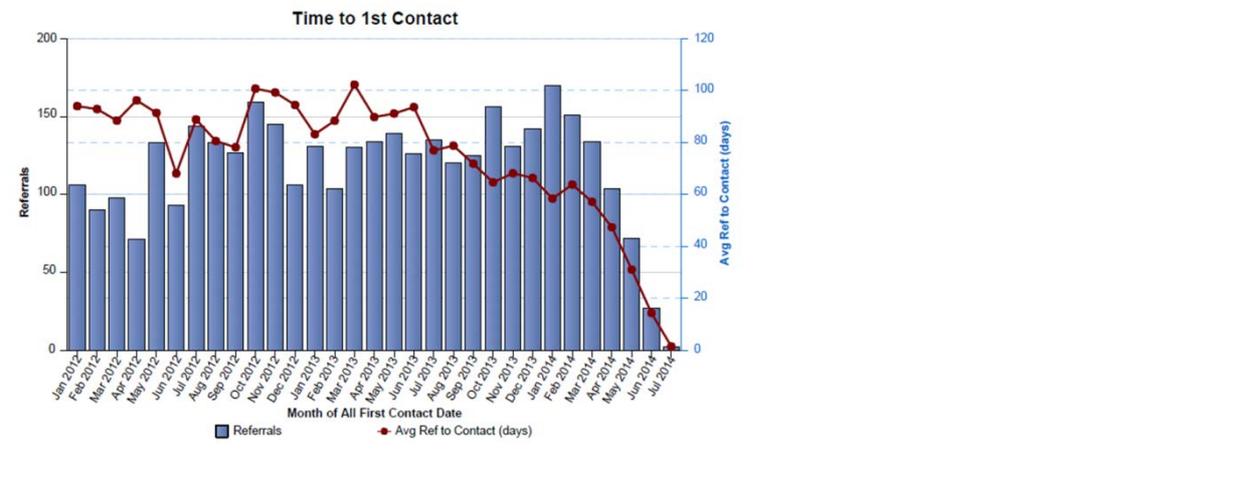
### Case study example

**Enfield Memory Service** extended their working week to provide a Saturday assessment service. The trust operates a 13 week breach policy across Mental Health services, and an exception report is generated to identify each breach case. In 2013 reports to the Management Group noted that there were too many breaches in the Memory Service. An action plan was developed to reduce the waiting list including Saturday clinics with variable appointments dependant on staff availability (using vacancies within establishment). The service started in June 2014 and ended in mid-Aug 2014 and successfully reduced the waits from 13 to 6 weeks. Maintenance of more flexible working hours longer term (Saturday working, seven-day services) to help maintain and further reduce waiting times may require additional investment.

*"Where services have organisational or resource problems, then looking at the management structure and leadership could be helpful"* **Professor Martin Orrell, Chair of the MSNAP Accreditation Committee**

## Case study example

**Leeds Memory Service** based at St Mary's Hospital reviewed their workforce needs in the light of high demand and long waiting times and secured funding to appoint a specialty doctor solely for the Memory Service. Since this appointment in October 2013 the waiting time from receipt of referral to first appointment has reduced dramatically.



### Other challenges included:

- Building relationships with GPs, CCGs and negotiations around sufficiency of resources
- Reaching agreement on protocols for outreach services, referrals and follow up care
- Improving discharge letters - introduction of correspondence to improve patient and GP understanding of diagnosis and to support improvement to coding in primary care
- Enhancing data collection - what to collect, analysis, and audits
- Retaining post-diagnostic support/ activity groups whilst reducing diagnosis waiting times
- Supporting care home assessment and diagnosis

### Conclusions

The factors that had an impact on waiting times were:

- increased referrals in the absence of a review of capacity needs
- workforce capability
- effectiveness of referral and discharge protocols

It was apparent from these site visits that many of those who reported longer waiting times in the 2013 Memory Clinics Audit had since made significant improvements to reduce these. There is clearly real enthusiasm and drive in many localities to work in collaboration with primary care and acute care providers to develop joint pathways, protocols and operational processes to improve the experience of people at this critical point in their dementia pathway.

*“The visits demonstrated how differently memory clinics around England work, and also opened our eyes to the innovations and creativity of individual teams to meet the challenges of daily work.”*  
**Sophie Hodge, Deputy Programme Manager, MSNAP**

Ongoing challenges for the memory services visited are focussed around building relationships with colleagues in primary care. This shift to primary care, supported by appropriate funding and incentives will help release capacity and thus help to further reduce waiting times.

We would encourage all memory services to aspire to, if not achieve MSNAP accreditation.

Memory services that are not prepared for full review can register with MSNAP as affiliate members. This will allow memory services to begin the process of service review and improvement prior to full accreditation.

### Next steps

1. NHS England has appointed seven ambassadors to support local NHS England area and regional teams to work with their CCGs to improve their services.
2. NHS IQ will offer a series regional workshops in conjunction with MSNAP to support Memory Service teams achieve and maintain 6 weeks from referral to assessment by using service improvement techniques.
3. NHS IQ will develop and publish a demand and capacity tool to enable Trusts to identify and map demand, capacity and activity over time. This will be free to all users.
4. Sharing good practice and case study examples will be facilitated through the setting up of a case study resource on the NHS IQ website. Sites are encouraged to submit their work demonstrating improvement in quality, outcomes and experience of care.
5. NHS England will publish findings from an economic review of alternative models of assessment and diagnostic care. The report, which is aimed at commissioners, will help improve their understanding of each type of model and the cost and quality implications of each - due to be published by the end of December 2014

### Acknowledgements

Thanks to Professor Martin Orrell, Chair of the MSNAP Accreditation Committee and Sophie Hodge Deputy Programme Manager MSNAP, Royal College of Psychiatrists for their time and advice during the course of the visits.

Thank you to all those memory services who responded so positively to the visits, offered their valuable time and who were so open and honest about their services.

Memory services visited:

Southwark and Lambeth Memory Service	South London and Maudsley NHS Foundation Trust
Enfield Memory Service	Barnet Enfield and Haringey Mental Health Trust
Wolverhampton Memory Service	Black Country Partnership NHS Foundation Trust
Chiltern Memory Clinic	Oxford Health NHS Foundation Trust

Harrow Memory Clinic	Central and Northwest London NHS Foundation Trust
Basildon Memory Service	South Essex Partnership University NHS Foundation Trust
Lancaster Memory Service	Lancashire Care NHS Foundation Trust
Slough Memory Clinic	Berkshire Healthcare NHS Foundation Trust
North Somerset Memory Service	Avon and Wiltshire NHS Partnership Trust
Sheffield Memory Service	Sheffield Health & Social Care NHS Trust
Leeds Memory Service	Leeds and York Partnerships NHS Foundation Trust
Coventry Memory Clinic	Coventry and Warwickshire Partnership NHS Trust
Hartlepool CMHT	Tees, Esk & Wear Valleys NHS Foundation Trust

## Useful resources

**MSNAP- Memory Services National Accreditation Programme** <http://www.rcpsych.ac.uk/memory-network>

**NHS Improving Quality- Mental Health and Dementia pages and Dementia Toolkit** <http://www.nhs.uk/qualityimprovement/mental-health-and-dementia-toolkit>

**NHS Change Model-** uses evidence based critical success factors and includes support around:

- Relationships
- Leadership
- Structures and processes
- Culture of learning
- Standards
- Outcomes focus(supported by data)

[www.changemodel.nhs.uk](http://www.changemodel.nhs.uk)

**NHS Operating Framework 2009-**

**10** [http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_091446.pdf](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_091446.pdf) page19

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**Care Quality Commission-** Cracks in the Pathway- October 2014  
<http://www.cqc.org.uk/search/site/cracks%20in%20the%20dementia%20care%20pathway?location=&sort=default&distance=15&mode=html>

**Royal College of Nursing-** <http://www.rcn.org.uk/>

**British Association of Occupational Therapists and College of Occupational Therapists -** <http://www.cot.co.uk/Homepage/>

**NICE Guidance 42- Guidance on brain scans – page 22** <http://www.nice.org.uk/guidance/cg42/resources/guidance-dementia-pdf>

## Glossary of Terms

'sites'	Memory services with waiting times of >6weeks in MSNAP audit Nov 2013
'comparator sites'	Exemplar sites with short waiting times
MCI	Mild cognitive impairment
PACS	Picture archiving and communication system
MDT	Multi-disciplinary team
CST	Cognitive stimulation therapy
MSNAP	The Memory Services National Accreditation Programme

Classification: Official

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OT	Occupational therapist
GP	General practitioner
GPwSI	General practitioner with special interest
DNA	Did not attend
C&B	Choose and book

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## Appendix 1

Our ref AB/sf



MEDICAL DIRECTORATE (5W33)  
Quarry House  
Quarry Hill  
LEEDS  
West Yorkshire  
LS2 7UE

Dear Colleague

We are writing to ask for your help in building a picture across England of some of the opportunities and challenges associated with long waiting times for people referred to memory services.

As you know, the recent audit of memory services <http://www.rcpsych.ac.uk/pdf/English%20National%20Memory%20Clinics%20Audit%20Report%202013.pdf> showed that a majority of clinics were seeing people for assessment in around an average of six weeks, but within this there was wide variation (1 week to almost 6 months) with almost 25% over 6 weeks. It looks from the audit that your waiting time was longer than 6 weeks. One of the aspirations of the Secretary of State and NHS England is that in future audits, fewer clinics will report waiting times for a diagnostic assessment exceeding six weeks.

We are planning to visit a number of sites and the proposal would be that we arrange a time, at your convenience, to come and meet you and your colleagues, say for an hour and half, to try and understand some of the reasons for the longer waiting times in your service. It may be that we can be of some help, by sharing and learning across the system, to help you in this regard. Our experiences from a piece of work with CCGs and from sharing good practice across the Memory Service National Accreditation Programme (MSNAP) indicate that this kind of approach is often very helpful and well received. *Services do not need to be members of MSNAP to be involved in this.* It will also be valuable for us to understand a broader picture of memory clinics in England.

This is collaboration between the Memory Services National Accreditation Programme and NHS England.

We look forward to hearing from you.

Yours sincerely

A handwritten signature in black ink that reads 'Alistair Burns'.

Alistair Burns  
**National Clinical Director for Dementia**  
NHS England

A handwritten signature in black ink that reads 'Martin Orrell'.

Martin Orrell  
**Director**  
Memory Services National Accreditation Programme

Our ref AB/sf

MEDICAL DIRECTORATE (5W33)  
Quarry House  
Quarry Hill  
LEEDS  
West Yorkshire  
LS2 7UE

Dear Colleague

We are writing to ask for your help in building a picture across England of some of the opportunities and challenges associated with improving waiting times for people referred to memory services.

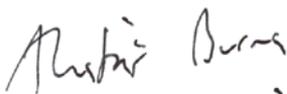
As you know, the recent audit of memory services (<http://www.rcpsych.ac.uk/pdf/English%20National%20Memory%20Clinics%20Audit%20Report%202013.pdf>) showed that a majority of clinics were seeing people for assessment in around an average of six weeks, but within this there was wide variation (1 week to almost 6 months) with almost 25% over 6 weeks. It looks from the audit that your waiting times are very low which is excellent. One of the aspirations of the Secretary of State and NHS England is that in future audits, fewer clinics will report waiting times for a diagnostic assessment exceeding six weeks.

We are planning to visit a cross section of memory services including those with both long waiting times and those, like yours, with very short waits. We would like to arrange a time, at your convenience, to come and meet you and your colleagues, say for an hour and half, to learn about your service, its key features and any learning from changes you have introduced. Our experiences from a piece of work with CCGs and from sharing good practice across the Memory Service National Accreditation Programme (MSNAP) indicate that this kind of approach is often very helpful and well received. *Services do not need to be members of MSNAP to be involved in this.* It will also be valuable for us to understand a broader picture of memory clinics in England.

This is collaboration between the Memory Services National Accreditation Programme and NHS England.

We look forward to hearing from you.

Yours sincerely



Alistair Burns  
**National Clinical Director for Dementia**  
NHS England



Martin Orrell  
**Director**  
Memory Services National Accreditation Programme

## Appendix 2

### Memory Services National Accreditation Programme

The Royal College of Psychiatrists Memory Services National Accreditation Programme<sup>2</sup> (MSNAP) works with services to assure and improve the quality of memory services for people with memory problems / dementia and their carers by engaging staff in a comprehensive process of review, through which good practice and high quality care are recognised, and services are supported to identify and address areas for improvement. Their Standards for Memory Services<sup>1,2</sup> states that people should wait no more than six weeks between the receipt of referral and their first appointment.

Accreditation assures staff, service users and carers, commissioners and regulators of the quality of the service being provided. The All Party Parliamentary Group on Dementia report *Unlocking Diagnosis*<sup>14</sup> (2012) recommends "*accreditation for memory services should be mandatory.*"

The Prime Minister's Challenge on Dementia (2012) includes an action to, "work with the Royal College of Psychiatrists to drive up the proportion of memory services that are accredited...so that individual organisations can benchmark and report their own performance to drive improvement."

Additional benefits of the accreditation process include;

- Involvement of a wide range of stakeholders, service users and their carers in identifying service improvements
- Sharing of best practice through a regular newsletter, email discussion group, annual conference and publication of resources on their website
- Sharing good practice: services are engaged with a network of peers, enabling sharing of good practice and providing a forum for advice and information sharing
- Peer review process
- Benchmarking and trend analysis via regular national reports.

*"All services should aim for the first assessment and diagnosis to take place within six weeks of referral"* **Professor Martin Orrell, Chair of the MSNAP Accreditation Committee**

### NHS Improving Quality (NHS IQ)

Established on 1 April 2013 and hosted by NHS England, NHS IQ is the driving force for enhancing value and excellence across the NHS in England, providing improvement and change expertise to produce better health outcomes. NHS IQ also supports the key transformation priority areas set out by NHS England to help deliver the NHS Outcomes Framework. As well as continually looking at best practice from both across the NHS and around the world, NHS IQ draws on the experience of previous successful improvement programmes established by legacy organisations.

As part of the long term conditions and integrated care work-stream, NHS IQ is helping to drive improvements in care for people with dementia, mental health needs and learning disabilities.