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National Audit of Dementia
Spotlight Audit in Memory Assessment Services
2023/2024

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Standards and Patient/Carer Reflections

Access and Wait Times

"Increase the number of people being diagnosed with dementia, and starting treatment, within six weeks from referral."

The Dementia Care Pathway, The National Collaborating Centre for Mental Health (2018)[1]

Patient/Carer Reflections

People using Memory Assessment Services have a right to a timely, accurate and reliable diagnosis. Variation in waiting times, differential diagnosis and provision will also have an impact on the ability to access any new treatments, if/when they become available.

Physical Health Assessments

"The assessment includes a physical health review, which [includes]:

• A check of vision, hearing, mobility, and falls.

• Lifestyle factors e.g. … alcohol use."

MSNAP Quality Standards for Memory Services RCPsych (2022)[2]

Patient/Carer Reflections

Short, structured assessments of vision/hearing as well as history of falls and alcohol are important to an accurate diagnosis and ongoing support.

Neuroimaging

"Offer structural imaging to rule out reversible causes of cognitive decline and to assist with subtype diagnosis, unless dementia is well established, and the subtype is clear."

NICE Guideline [NG97 (2018)][3]

Patient/Carer Reflections

People using Memory Assessment Services should have scans carried out if there is a clinical need identified and not otherwise; this should not be reliant on local resources/commissioning.

Cognitive Stimulation Therapy (CST)

"Offer group cognitive stimulation therapy to people living with mild to moderate dementia."

NICE Guideline [NG97 (2018)][3]

Patient/Carer Reflections

In addition to the offer, the take up and quality/content of CST should be monitored.

Key Findings

Access Times

2021	66 DAYS
2023	88 DAYS

Time from referral to initial assessment increased
22 days from 2021

Large variation
between services in the average access time, ranging from
13 – 268 days

Overall Wait Times

2021	124 DAYS
2023	151 DAYS

Overall wait time from referral to diagnosis increased
27 days from 2021

Large variation
between services in the average overall wait time, ranging from
44 – 347 days
with **10**% patients receiving a diagnosis 6 weeks after their referral.

Key Findings

Wait Times in Deprived Areas

Wait times from initial assessment to diagnosis for people in deprived areas were

significantly longer

than for people in the least deprived area by 15 days.

Physical Health Assessments

48% patients received four key physical health checks, which includes an assessment on falls, vision, hearing and alcohol intake.

Up from **43%** in 2021

Large variation

between services, ranging from

0% – 100%

patients receiving all assessments checked.

Neuroimaging

Large variation

between services in brain scans performed, ranging from

0% – 90%

patients receiving a scan.

Cognitive Stimulation Therapy

31% patients with a dementia diagnosis received an offer of Cognitive Stimulation Therapy.

Large variation

between services, ranging from

0% – 100%

patients offered CST.

Key Findings Summary

Variation across services

The key findings show increases in waiting times overall, from referral to assessment and to diagnosis, but also very wide variation between services for most of the results in the audit, including waiting times, elements of assessment, diagnosis of dementia and subtypes, and post diagnostic intervention.

Causes of such variation are not captured by the audit data, but could include how individual services are set up (e.g. staffing, specialist input and variations in local commissioning) as well as factors such as the local referral rate, and how services record details (such as referral) in patient notes, and the consistency of data entry/quality.

Next steps

This suggests that future audit in memory services should include gathering information such as service configuration, local patient pathways to diagnosis, diagnostic criteria, and record management. This will help to contextualise results, provide more sensitive benchmarking between services, and help to understand how different configurations may impact on national ambitions such as the dementia diagnosis rate.

Recommendations

1 Memory Assessment Services should ensure provision and consistent recording of high-quality memory assessment, including brief assessment of: eyesight and hearing, alcohol consumption and falls. They should offer post-diagnostic follow up and support through provision or facilitated access to a dementia advisor, Cognitive Stimulation Therapy, carer psychoeducation courses, and medication review as required.

See Key Findings **section and data relating to** Access and Wait Times, Physical Health Assessments, Diagnosis and Treatment **&** Post Diagnostic Support

2 Trusts should ensure monitoring at an appropriate senior level of the recommendations set out in the Dementia Care Pathway Implementation Guidance[1] and work together within regions, involving people with lived experience and their carers, to identify barriers to access, including demographic factors and deprivation.

See Key Findings **section and data relating to** Access and Wait Times **&** Demographics and Deprivation Analysis

3 Integrated Care Boards should review results of their services with reference to responsibilities to meet the recommendations set out in the Dementia Care Pathway Implementation Guidance[1] , including:

- Commissioning to meet current and anticipated need (see Guidance Key Commissioning and Service Development Considerations).
- Recommended waiting times in line with the Guidance (see Benchmark 2: Increase the number of people being diagnosed with dementia, and starting treatment, within 6 weeks of referral).
- Criteria to ensure equitable access to services (see section 2.3, Joint Strategic Needs Assessment and local Dementia Needs Assessment).
- Diagnostic criteria and components of routine in-clinic assessment, as set out in the Guidance (see Principles of Assessment).
- Equitable access to post diagnostic support, including standard provision of Cognitive Stimulation Therapy to people diagnosed as living with mild to moderate dementia (see Cognitive Stimulation Therapy (CST): summary of evidence on cost-effectiveness) NHS England[4]/ Dementia Evidence Toolkit[5].

See Key Findings **section and data relating to** Access and Wait Times, Physical Health Assessments, Neuroimaging, Diagnosis and Treatment, Post Diagnostic Support **&** Demographics and Deprivation Analysis

4 NHS England, at national and regional levels, should support Integrated Care Boards and Trusts to work jointly to address variations highlighted by the audit data in access to and provision within memory assessment services, with the expectation that in all parts of the country people using services receive equitable provision, including:

- appropriate referral and assessment, including appropriate use of neuroimaging,
- timely diagnosis within recommended timeframes,
- access to evidence-based treatment (e.g. Cognitive Stimulation Therapy),
- post-diagnostic support and follow up,

as recommended in the NICE guideline[3]. This work should be informed by the Dementia Care Pathway Implementation Guidance[1] and the Memory Services National Accreditation Programme Standards for Accreditation[2].

See Key Findings **section and data relating to** Access and Wait Times, Physical Health Assessments, Neuroimaging, Diagnosis and Treatment, Post Diagnostic Support **&** Demographics and Deprivation Analysis

Change Over Time

Key Results	2019	2021	2023
Access Time (mean) (referral to initial assessment)	5 Weeks	9 Weeks	13 Weeks
Overall Wait Time (mean) (referral to diagnosis)	13 Weeks	18 Weeks	22 Weeks
% Receiving Physical Health Assessment (Discussion of eyesight)	61%	61%	65%
% Receiving Physical Health Assessment (Discussion of hearing)	57%	58%	63%
% Receiving Physical Health Assessment (Alcohol intake)	73%	78%	80%
% Receiving Physical Health Assessment (Falls history)	71%	76%	79%
% Brain Scans Performed	(N/A)	41%	44%

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Foreword

Dementia is a complex and progressive condition impacting memory, language, judgment, and personality. Globally, it is one of the leading causes of disability and dependency amongst older people.[6] In the UK over 900, 000 people are estimated to be living with dementia.[7] Within this context, dementia care and treatment remains a critically important issue for patients and families, as well as for communities and society. This report provides a timely spotlight on the performance of Memory Assessment Services across England and Wales.

Research shows that accessing early diagnosis is important to patients and families concerned about their memory.[7] Referral to memory services is therefore an important early step in accessing care, treatment and support. This report shows that the overall wait time to first appointment has increased from 66 to 88 days, and that the mean wait time from referral to diagnosis has increased from 124 to 151 days. This is a concerning trend, which is amplified in the most deprived areas, exacerbating existing health inequalities. Understanding the reasons behind these data will be important to improve equitable access to memory assessment services, and this is likely to need a whole systems approach to improvement.

We are very grateful for the support of memory services in gathering our data. It demonstrates the scope and scale of work that is undertaken and highlights many areas of positive care to support people with suspected dementia. Improvements seen since 2021 in performance of physical health checks and brain scans requested are to be welcomed. This data is crucial in our shared desire to improve services, and to learn more about regional variation in practice. This report shows that areas for development should be: wait times, physical health checks and cognitive stimulation therapy. Addressing these issues will significantly improve care for patients.

The report findings should be understood within the UK national context. As our population ages, dementia will become more prevalent[8], there will be increased demand for memory assessment, and for post-diagnostic support. Currently, in England 64.5% of those estimated to have dementia have a recorded diagnosis, and rates are lower in the devolved nations.[7] We need to act now to address problems in access to memory assessment services, as demand will continue to grow in coming years.

As a clinician, I recognise the challenges faced by rising demand, complexity, and stretched resources in this field. I hope this report is received as a call to action for Integrated Care Boards, Trusts and individual clinicians to build equitable access to memory assessment, using high-quality, evidence-based investigations and interventions. This will help to improve health for all, particularly those who are living with dementia, and for their families.

Charlotte Deasy, Consultant Old Age Psychiatrist, Royal College of Psychiatrists Old Age Faculty Executive representative to National Audit of Dementia

Overview

Results presented in this report are from data collection carried out in Memory Assessment Services at the end of 2023, relating to patients who had appointments for assessment from the beginning of that year, plus information about how the service is provided.

Information collected is based on the work of the London Dementia Clinical Network, who audited memory services in London and then across England in 2016 and 2019, collecting data from patient records and at an organisational level.[9] In 2021 the National Audit of Dementia invited Memory Assessment Services across England and Wales to repeat this data collection, reporting in 2022.[10]

This round of audit has shown that the waiting time, from the point of referral to appointment, and then to diagnosis, has increased significantly. However, NHS Digital figures show that at the same time, the rate at which people are being diagnosed has increased.[7] Factors affecting waiting times include increased numbers of admissions to services, which the Memory Services National Assessment Programme has found have increased by 130% per week since 2009[11], while average staffing levels have not increased in accordance.

Results also show that there is still a great deal of variation between services in key results such as the average waiting time for patients, the proportion of patients diagnosed with dementia, and the provision of post diagnostic support and therapy. This degree of variation suggests that services are commissioned and resourced differently, which means that the experience of people using the services will be different depending on their locality.

In this round of audit, we also compared some key outcomes using the Index of Multiple Deprivation, and found different results for patients in the most deprived areas.

Recommendations and frameworks for Memory Assessment Services were set out in the Dementia Care Pathway Implementation Guide (2018)[1], covering priorities for commissioners and highlighting consistency of provision and equality in access to services. Recommendations in this report are aimed at actions to address variation, and to highlight the need for provision of high-quality services on a basis of equitable access.

Methods and Participation

Participation

Regions/Nation	Participating Trusts/Health Board	Total Participation
East of England	4 (out of 6)	67%
London	8 (out of 10)	80%
Midlands	10 (out of 14)	71%
North East and Yorkshire	9 (out of 12)	75%
North West	4 (out of 8)	50%
South East	7 (out of 10)	70%
South West	6 (out of 8)	75%
Wales*	0 (0 out of 8)	0%
Total	48	63%

*2 services from Wales registered for the audit but withdrew due to clinical pressures.

Methods

Casenote Audit

6148 casenotes submitted by **125** services across England. The number of casenotes submitted per service ranged from **10** to **96** records. 2 services had less than 25 records and have been removed from local analysis (34 records).

Participating services were asked to identify at least 40 patients who had an initial assessment in January 2023, and were permitted to include further months as necessary.

Inter-rater reliability checks were conducted by submission of 5 casenotes from two different professionals within one service. Analysis was carried out by a statistician and key findings found to be reliable.

Organisational Checklist

138 services completed the organisational checklist. This asked about the organisational structure and provisions at each Memory Assessment Service.
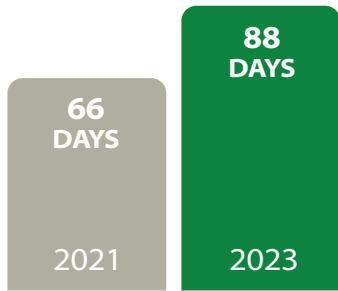
Access and Wait Times

Access Times

Fig 1. National Access Time (Mean Days)

66 DAYS — 2021
88 DAYS — 2023

Access time refers to the time between the referral and the initial assessment appointment. The average time for this has increased significantly to **88 days** on average, up from 66 days in 2021.

There is a large variation between services for the average time patients waited to access their initial assessments, with the maximum average access time for one service being **268 days.** (See Figure B in Appendix II).
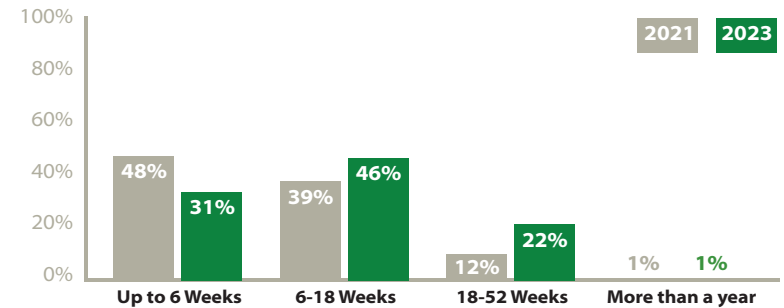
Fig 2. National Access Time by Weeks

	Up to 6 Weeks	6-18 Weeks	18-52 Weeks	More than a year
2021	48%	39%	12%	1%
2023	31%	46%	22%	1%

Diagnosis Wait Time

Diagnosis wait time refers to the time between the initial assessment appointment and the point a patient is diagnosed.

On average, patients waited **63 days** to receive their diagnosis from their initial assessment appointment, up from 58 days in 2021. Diagnosis wait times varies widely between services ranging from **6 days** to **187 days**.

Fig 3. National Diagnosis Wait Time (Mean Days)

58 DAYS — 2021
63 DAYS — 2023

See Demographics and Deprivation Analysis section for comparative analysis on diagnosis wait time.

Overall Wait Time

Overall wait time refers to the time between referral and the point a patient is diagnosed.

The average time for this has increased significantly since 2021, from **124 days** to **151 days** nationally.

2021 — 124 DAYS
2023 — 151 DAYS

Fig 4. National Overall Wait Time (Mean Days)

Refer to Recommendations

Overall Wait Time

Recommended Timeframe for Diagnosis

The national recommended timeframe for diagnosis from the point of referral is 6 weeks. It is recognised that this is not achievable for every patient as requirements for investigations as part of their diagnosis will vary.[1] However, the Dementia Care Pathway implementation benchmark is aimed at increasing the number of people being diagnosed and starting treatment within 6 weeks of referral.

Wait Time from Referral to Diagnosis

The average wait time has increased significantly since the previous audit in 2021. Average wait time was **151 days**, including access time (above), and average time from assessment to diagnosis at **63 days**. For over half of memory services patients, the wait time was over 18 weeks.

Overall Wait Time at Service Level

There is a wide variation between Memory Assessment Services for the average time that patients are receiving diagnosis from the point of referral. Figure 6 shows the range of average wait times from **44 days** up to **347 days** per service, contrasted with the national average of **151 days**. This means that many people using Memory Assessment Services could have a much longer wait for their diagnosis, depending on which service they are referred to.

2021 **2023**

	Up to 6 Weeks	6-18 Weeks	18-52 Weeks	More than a year
2021	18%	43%	38%	2%
2023	10%	38%	49%	4%
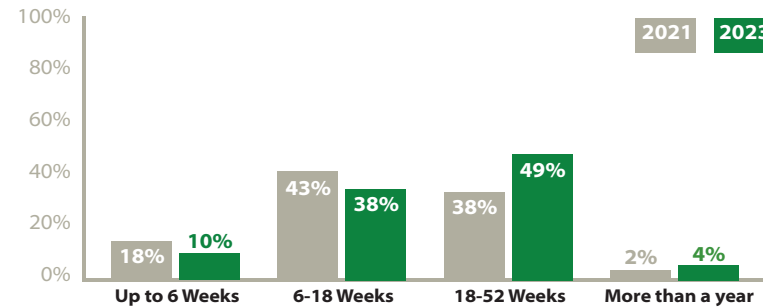
Fig 5. National Overall Wait Time by Weeks

Maximum: **347 Days**

National Average: **151 Days**
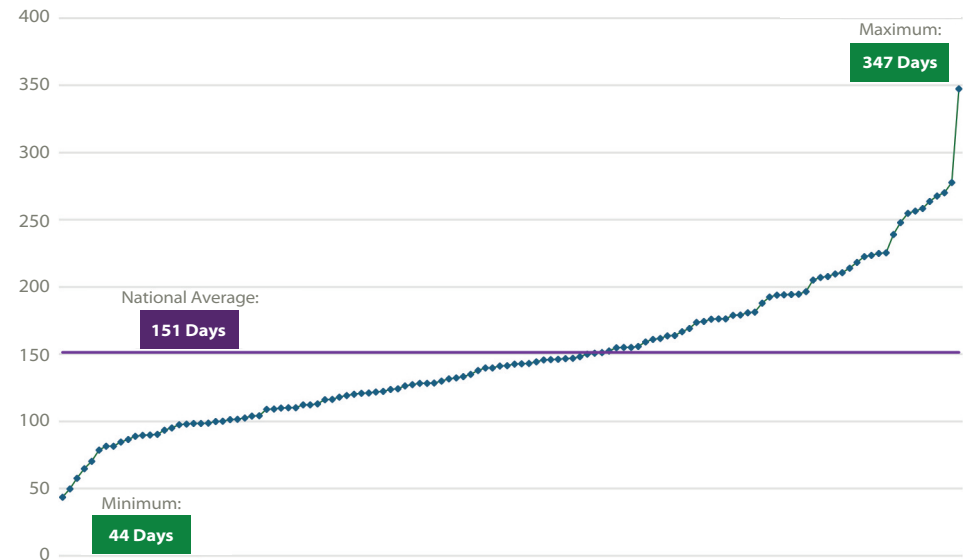
Minimum: **44 Days**

Fig 6. Overall Wait Time by Service (Mean Days)

Access and Wait Times

Wait Times per Service within 6-Week Timeframe

As noted, the ambition is to increase diagnosis and starting treatment within 6 weeks of referral. Figure 7 shows the proportion of patients in each memory service for whom this is achieved, varying between **0-90%** of patients.

32 services had none of their patients receiving their diagnosis within 6 weeks, and there are two services with more than half of their patients meeting the national recommended timeframe.

DiADeM (Diagnosing Advanced Dementia Mandate)[12]

DiADeM is a tool to support GPs in diagnosing dementia for people living with advanced dementia in a care home setting developed by the Yorkshire and Humber Dementia Strategic Clinical Network. In 2022/23 NHS England funded 14 pilots (two Trusts per region) to help enhance dementia diagnosis rates and provision of care.

The initiative has indicated a positive effect on waiting times in a number of the trust sites. In one Trust, the average decreased from 36 weeks to 7 weeks wait time between February and December 2023. NHSE is currently developing a resource to support further implementation of DiADeM, which is due to be released later this year on the Dementia site of the NHS Future Platform.

Maximum: 90%

National Average: 10%

Minimum: 0%
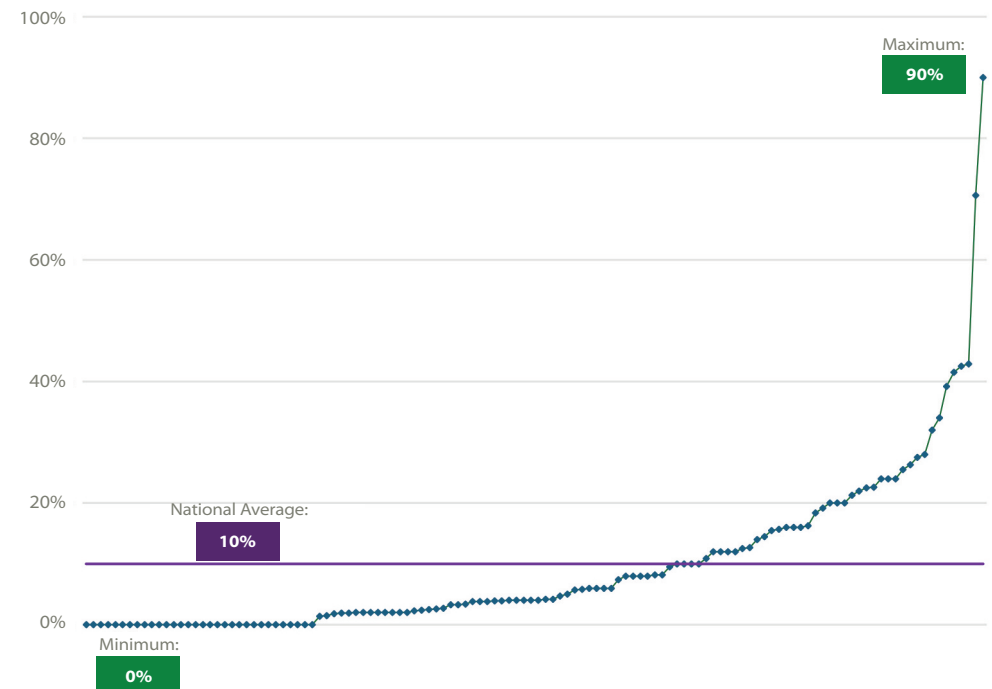
Fig 7. % Patients Diagnosed within 6 Weeks of Referral by Service

Refer to Recommendations

In-Clinic Assessments

A review of physical health is carried out as part of the initial assessment, key to ensuring that any reversible causes of memory problems or cognitive decline have been ruled out, as well as for the person's ongoing care. This should include checks of eyesight and hearing, any history of falls, and lifestyle information such as alcohol consumption.[2]

Results showed a slight increase in these components of the assessment since the 2021 audit, but none were recorded as taking place in all patients, with checks of eyesight and hearing being the lowest results. **Less than 50%** of patients had all 4 checks recorded (2933/6148).

There is a wide variation between services in carrying out these components of assessment, from **0-100%** of patients per service. Only 2 services reported carrying out all 4 components for all their patients. This suggests that services differ in what they ensure has been covered as part of the diagnostic process.

43% 2021

48% 2023
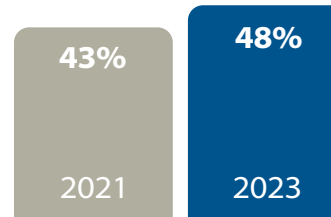
Fig 8. % Patients with All Four Assessments

7% 2021

6% 2023

Fig 9. % Patients with No Physical Health Assessments

Maximum: **100%**

National Average: **48%**

Minimum: **0%**
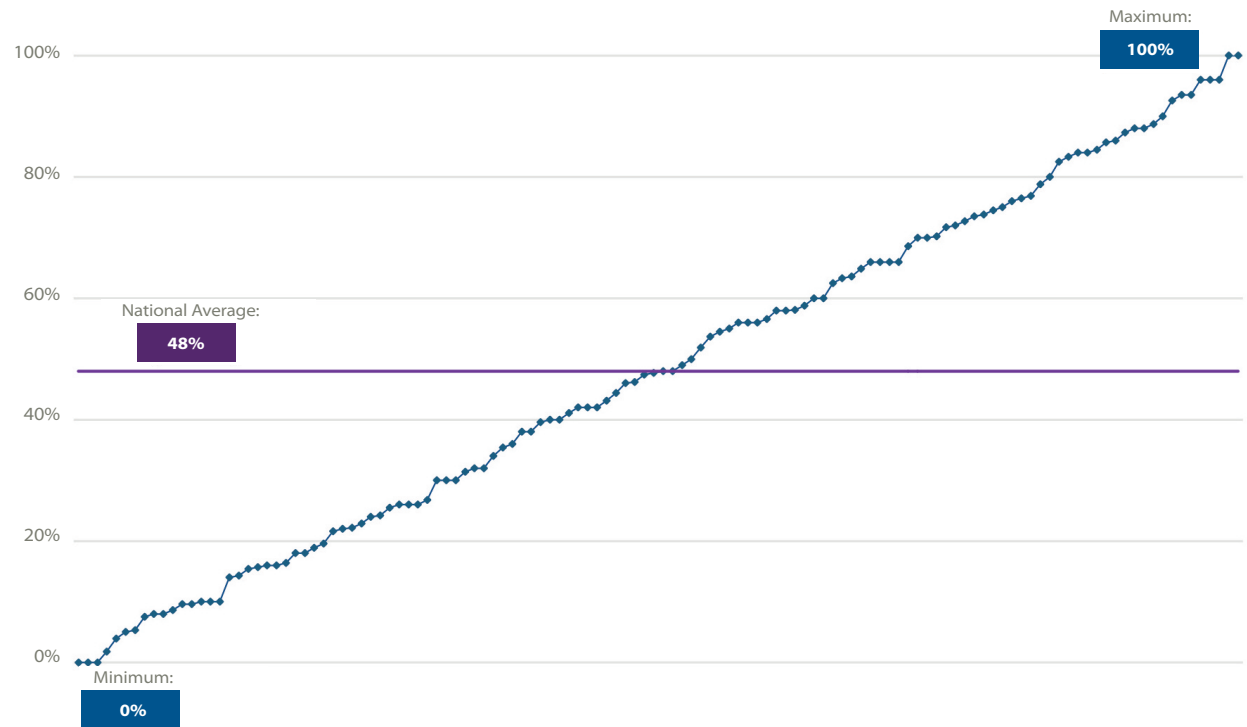
Fig 10. % Patients with Four Physical Health Assessments by Service

Physical Health Assessments

Vision and Hearing

Sensory impairment such as loss of vision or hearing can contribute to cognitive decline.[3]

If these have not been assessed before the referral to the memory service, the service should follow up and ensure these assessments take place. There have been slight increases in assessing both eyesight and hearing since 2021 as part of the diagnosis, but both are recorded for less than two-thirds of patients, with discussion of hearing assessment at **63%** (3871/6148) and eyesight at **65%** (3988/6148).

61% 2021 | **65%** 2023
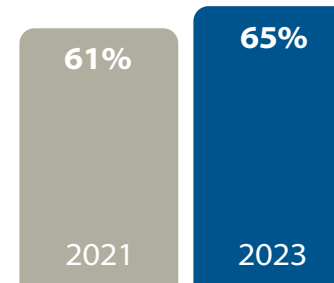
Fig 11. % Patients with Vision Discussion

58% 2021 | **63%** 2023
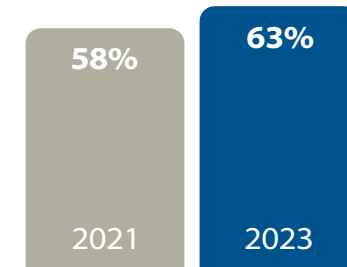
Fig 12. % Patients with Hearing Discussion

Falls History

People with dementia and older adults have an increased risk of falling and injury.[13] NICE recommends routinely asking older people at appointments about falling in the past year.[3] Recording a history of falls has increased slightly since 2021 to **79%** (4881/6148).

76% 2021 | **79%** 2023
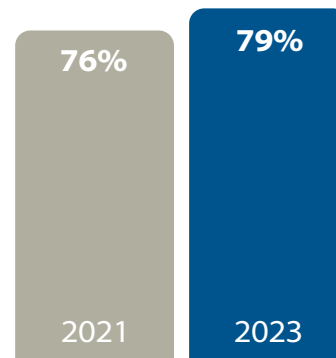
Fig 13. % Patients with Falls History Taken

Alcohol Consumption

Alcohol consumption may contribute to memory problems or cognitive impairment.[14]

Taking details of alcohol consumption during the assessment has increased slightly since 2021 to **80%** (4936/6148). 51% of patients reported drinking 0 units per week, 24% 1-14 units and 5% more than 14 units.

78% 2021 | **80%** 2023
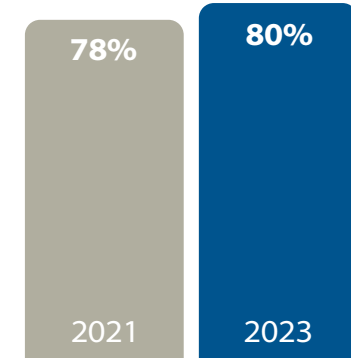
Fig 14. % Patients with Alcohol Consumption Reported

Neuroimaging

Refer to Recommendations

Investigative Brain Scans

As part of the assessment, neuroimaging such as computed tomography (CT) or magnetic resonance imaging (MRI) scans may be offered – these can help to reach a diagnosis and may rule out any cause for cognitive or memory problems which is not dementia.[3]

Overall, there was a slight increase in the proportion of brain scans requested, from **45%** of patients in 2021 to **47%** of patients in 2023 (2910/6148). Nearly all scans requested were then carried out – **94%** (2725/2910), up from **90%** in 2021.

The most common reason given why a scan had not been requested was that a scan had previously been performed. The most common reason scans were not performed was because the patient declined.

41% 2021

44% 2023

Fig 15. % Patients with Brain Scans Performed

Neuroimaging Scans and Wait Times

Average waiting times from request for a brain scan to performing it have increased, from **36** to **42** days. For **61%** of patients, the scan was performed within six weeks of request (1661/2725). **3%** (77/2725) waited longer than 18 weeks for their scan.

Maximum: 132 days

National Average: 42 days

Minimum: 5 days

Fig 16. Wait Time from Brain Scan Requested to Brain Scan Performed by Service (Mean Days)

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Variation of Scans Performed at Service Level

A CT or MRI scan should be carried out if it is needed to rule out a cause in cognitive changes, or to determine a subtype of dementia which may lead to a different medication or treatment. This means that a scan should be requested based on clinical judgement, and guidance highlights that it should not be necessary for all patients to have a scan performed before they are referred to a memory service.[15]
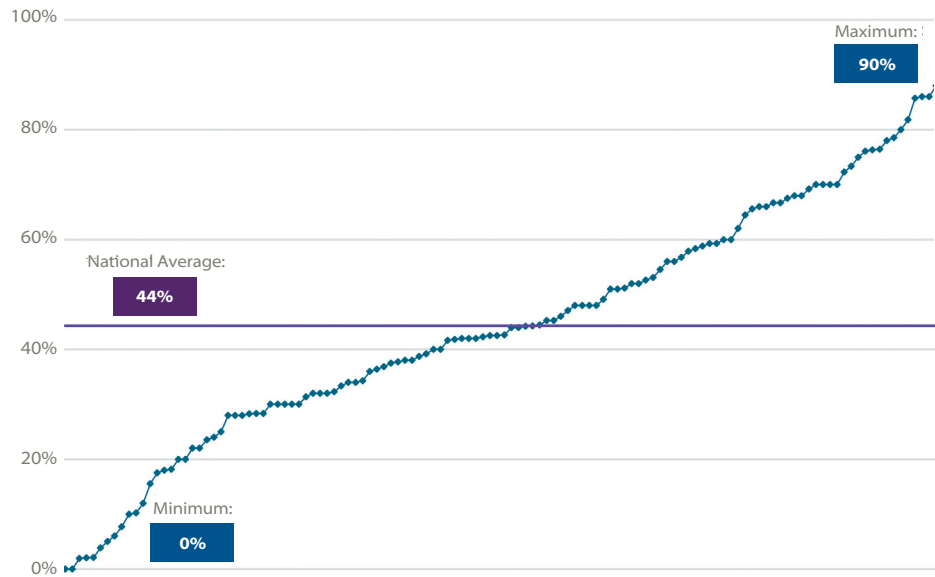
Fig 17. % Patients Brain Scans Performed by Service

Maximum: 90%
National Average: 44%
Minimum: 0%
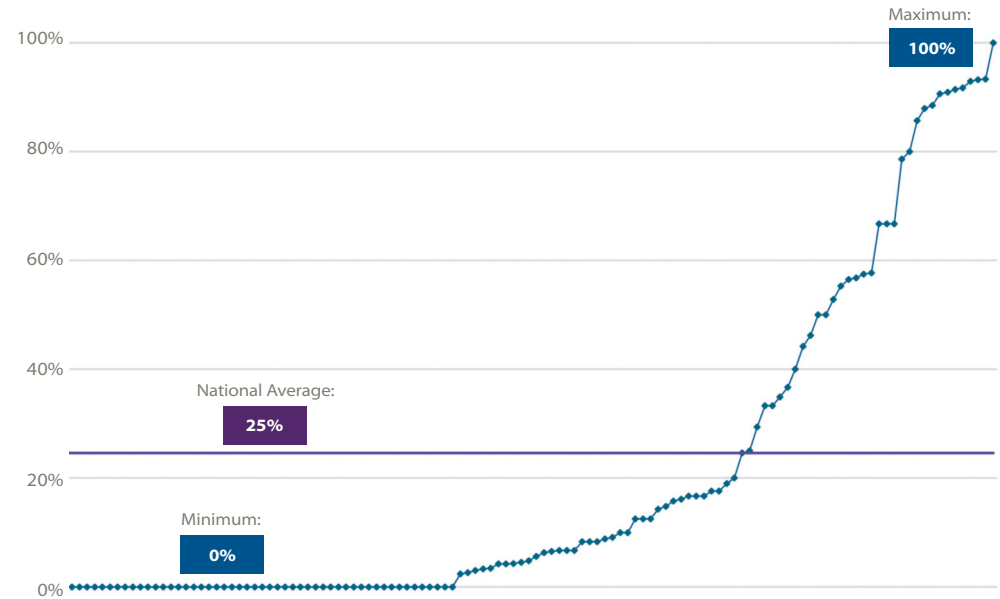
Fig 18. % Patients received Brain Scans before Initial Assessment by Service

Maximum: 100%
National Average: 25%
Minimum: 0%

Variation at Service Level

Service level results vary widely, both for the proportion of their patients who have a scan carried out as part of their assessment (**0-90%** of patients per service), and the proportion of patients who have had a scan carried out before their initial assessment appointment (**0-100%** of patients per service). This suggests that varying operational procedures and resources may affect whether a scan is carried out, rather than consistently basing this decision on clinical judgement.

Refer to Recommendations

Dementia Diagnosis

People diagnosed through a Memory Assessment Service have the right to timely and accurate diagnosis, to ensure that they receive appropriate treatment for their condition. **71%** of patients (4335/6148) received a diagnosis of dementia, highly similar to the 2021 audit. Overall, the breakdown of the subtypes of dementia diagnosed and the proportion of patients with a non-dementia diagnosis were similar between 2021 and 2023 (see Figure Q in Appendix II).

Fig 19. % Patients with Any Dementia Diagnosis

- 70% — 2021
- 71% — 2023

- Maximum: **100%**
- National Average: **71%**
- Minimum: **36%**
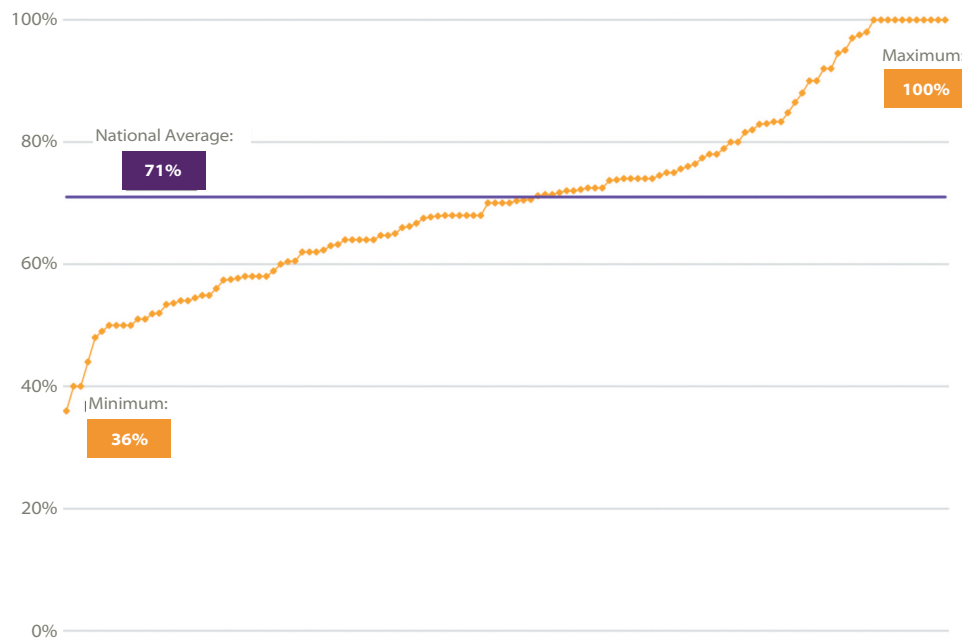
Fig 20. % Patients with Any Dementia Diagnosis by Service
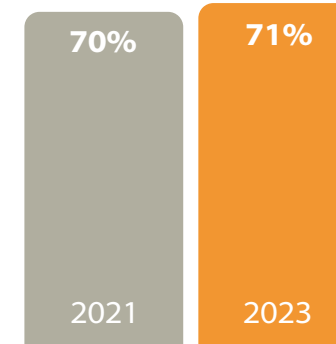
Any Dementia Diagnosis Variation at Service Level

The proportion of patients in each service who received a diagnosis of any type of dementia varies very widely, from **36%** up to **100%** of patients per service. This may mean that there are different referral and diagnostic criteria being used in different areas. There is also variation across services in relation to the proportion of patients receiving a diagnosis of mild cognitive impairment (MCI) or subtypes of dementia. Figure 21 below shows examples of MCI, Alzheimer's disease, and less common subtypes Frontotemporal dementia (FTD) and Lewy body dementia.

Diagnosis and Treatment

Variation of Dementia Subtype at Service Level

Overall, **30%** of patients were diagnosed with Alzheimer's disease (the most common subtype of dementia)[6]. Per service, this ranged from **6%** to **90%**.

Less common subtypes of dementia show variation in diagnosis, with 79 services having no diagnoses of Lewy body dementia (LBD) (range **0%** to **8%**) and 112 services having no diagnoses of Frontotemporal dementia (FTD) (range **0%** to **5%**).

17% of patients were diagnosed with mild cognitive impairment (MCI), ranging from **0%** to **42%** across services. **13 services** had no patients with a diagnosis of MCI.

Data in this audit cannot determine the reasons for variation. Diagnosis patterns could be affected by the time taken to achieve certain diagnoses, or it could be that diagnoses are not made or missed, which could be down to differences in local pathways and/or service commissioning or specialist input. Standards of record keeping regarding diagnosis may also vary between services.
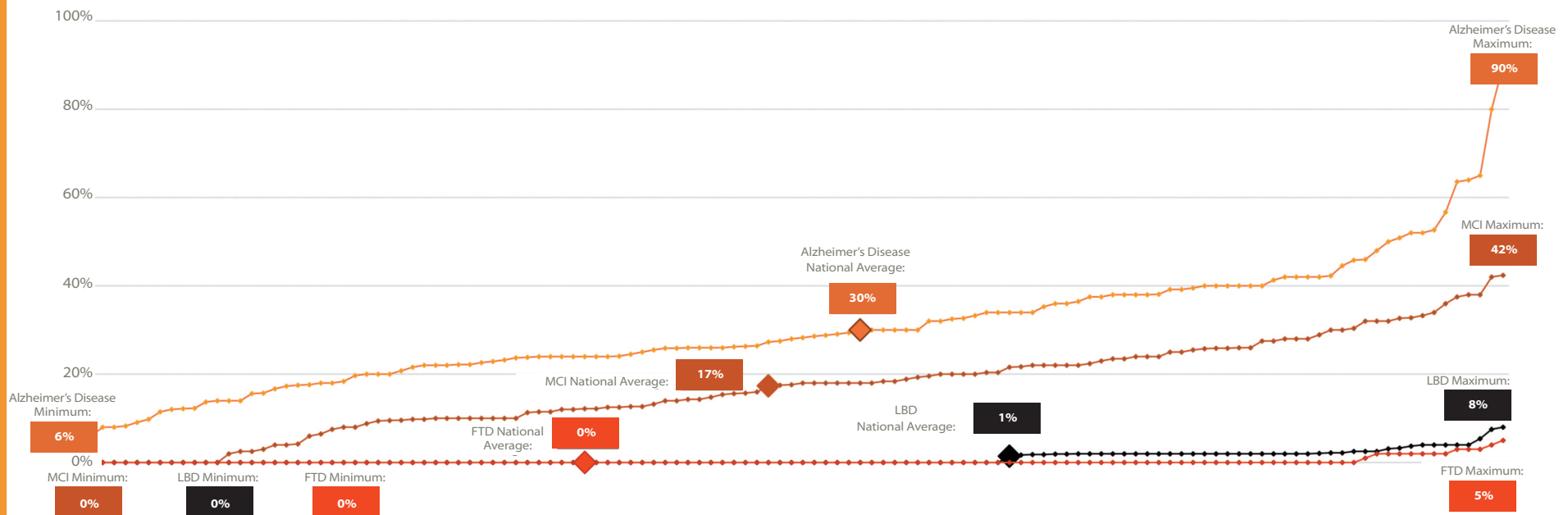
Fig 21. % Diagnoses of Alzheimer's Disease, Mild Cognitive Impairment, and Lewy Body Dementia by Service

Alzheimer's Disease Maximum: **90%**
MCI Maximum: **42%**
Alzheimer's Disease National Average: **30%**
MCI National Average: **17%**
LBD Maximum: **8%**
Alzheimer's Disease Minimum: **6%**
FTD Maximum: **5%**
LBD National Average: **1%**
FTD National Average: **0%**
MCI Minimum: **0%**
LBD Minimum: **0%**
FTD Minimum: **0%**

Refer to Recommendations

Post Diagnostic Support

The NICE guideline[3] recommends a variety of post diagnostic interventions to ensure that people who have been diagnosed with dementia and their carers are supported in their onward treatment journey. This includes:

- ensuring that the patient can attend a memory or dementia service after diagnosis, for monitoring and support;
- referral to a named case worker/dementia advisor responsible for coordinating their care to ensure continuity;
- offering carers a psychoeducation and skills training course;
- provision of group Cognitive Stimulation Therapy (CST) to people living with mild to moderate dementia.

Availability and Provision of CST

CST is a series of 14 structured group activity therapy sessions.[5] **76%** (105/138) of services said that they could offer their patients CST, in house or via an external provider.

31% of patients with a dementia diagnosis were offered CST (1036/3367). This figure excludes those for whom it was noted that CST would not be appropriate. For **41%** of patients (1384/3367) it was recorded that this service was not available.

Variation at Service Level

Although 76% of the services offered CST, this was not reflected in the proportion of people diagnosed with dementia who were offered CST, and this varied widely at a service level. **11 services** who said they could offer CST had not offered it to any of the patients audited.

Maximum: **100%**

National Average: **31%**

Minimum: **0%**
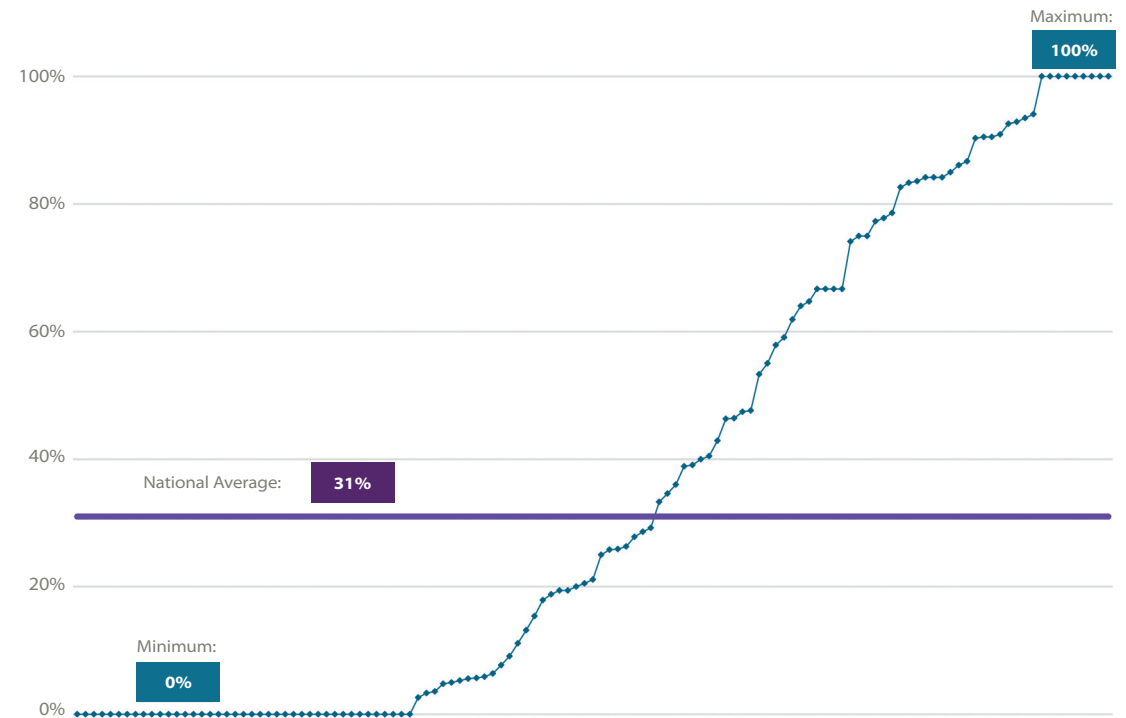
Fig 22. % Patients offered CST by Service

Post Diagnostic Support

Other Post Diagnostic Support

83% of the patients who were diagnosed with dementia (3461/4172) received an offer of referral to a dementia advisor or similar service, and for **4%** of patients it was noted that this service was not available.

Where there was a carer supporting the patient, **32%** (1300/4104) were offered a psychoeducation course (such as START[16,17] or CRISP[18]). For **38%** of patients (1563/4104), it was recorded that this service was not available.

Services Providing Post Diagnostic Support

96% (132/138) of services said that they offered a post diagnostic follow up monitoring service, but only **53%** (73) said that this was for all patients, and 32% said this was just for patients who had been prescribed medication.

Fig 23. % Patients receiving Post Diagnostic Support

Fig 24. % Services providing CST

Fig 25. % Services providing Post Diagnostic Support

Demographics and Deprivation Analysis
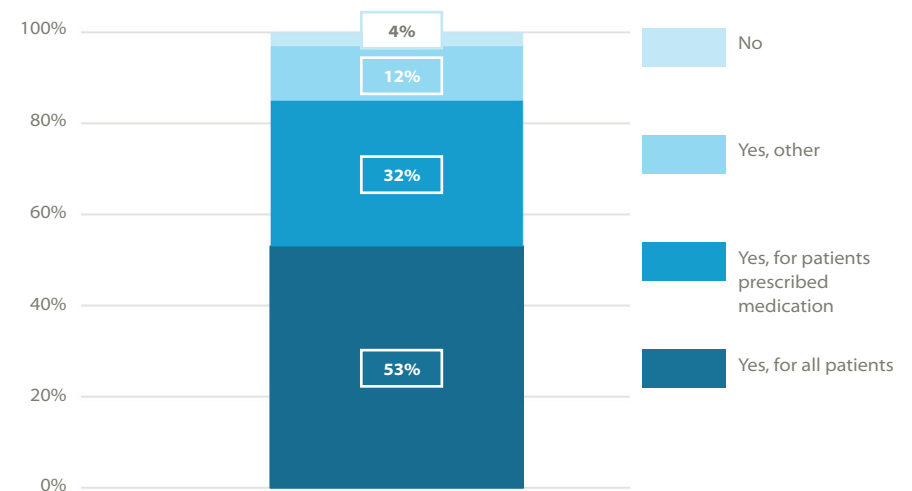
Unrecorded Demographic Data

Demographic information about patients requires accurate recording as it helps to show whether people using services have different experiences related to factors such as age, sex, or ethnicity. The proportion of patients where this information is not recorded has increased slightly for ethnicity, and sexual orientation.

Resources to support the recording of demographic data include the Patient Ethnicity data – Conversational Guidance for Data Collection and Data Quality of Protected Characteristics and Other Vulnerable Groups.
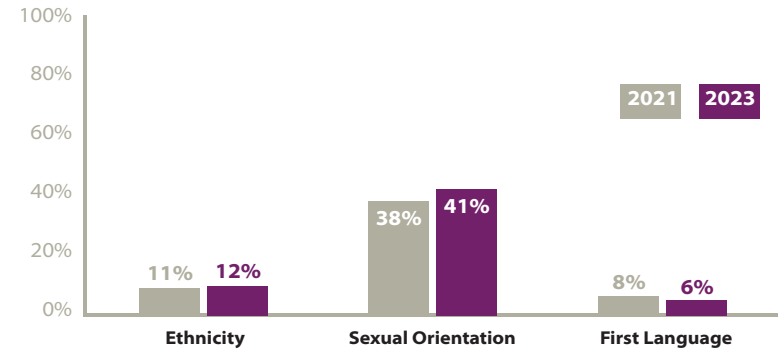
Fig. 26 National Unrecorded Demographic Data

Comparison of Results by Deprivation Index

The Dementia Care Pathway highlights the need for commissioners of services to specifically address inequality risks and identify solutions.[1]

In the casenote audit, we collected information about the areas in which patients live, and used the index of multiple deprivation (IMD) for analysis. The IMD deciles range from 1 being the **most** deprived areas, and 10 being the **least** deprived of areas nationally. (See Table 2 in Appendix II for explanation of IMD analysis).

Diagnosis Wait Time Comparison by Deprivation Index

Average diagnosis wait time was longest in the most deprived area (decile 1). This means people in most deprived areas are waiting longer for their diagnosis, from the point of initial assessment.
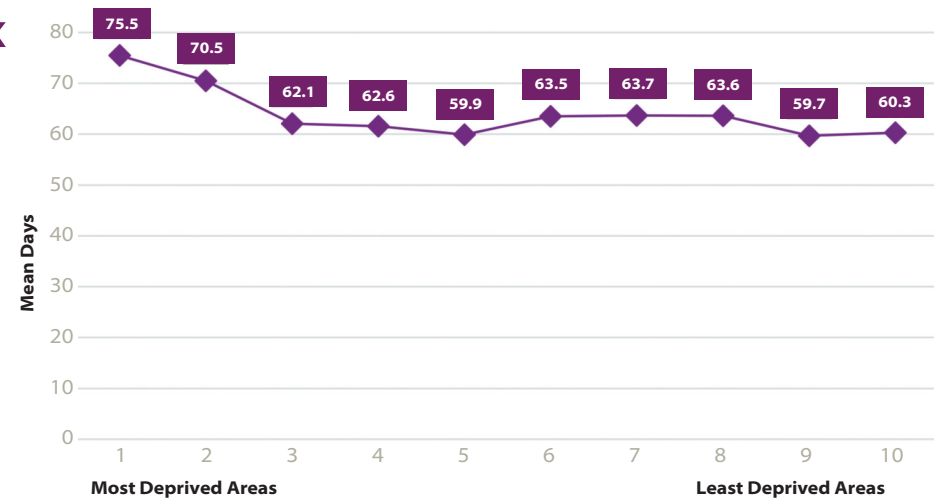
Fig. 27 Diagnosis Wait Times (Mean Days) by IMD Decile

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References

1. National Collaborating Centre for Mental Health. The Dementia Care Pathway Full Implementation Guidance. October 2018 https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/demen-tia/nccmh-dementia-care-pathway-full-implementation-guidance.pdf

2. Royal College of Psychiatrists. Memory Services National Accreditation Programme (MSNAP). Quality Standards for Memory Services. September 2022. https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/memory-clinics-msnap/msnap-standards---8th-edition-(2022).pdf?sfvrsn=d8341549_2

3. National Institute for Health and Care Excellence (NICE). Dementia: assessment, management and support for people living with dementia and their carers. NICE guideline [NG97] June 2018. https://www.nice.org.uk/guidance/ng97

4. NHS England. Cognitive Stimulation Therapy: summary of evidence on cost effectiveness. May 2016. https://www.england.nhs.uk/wp-content/uploads/2018/01/dg-cognitive-stimulation-therapy.pdf

5. MODEM project ESRC and the National Institute for Health Research. Dementia Evidence Toolkit. 2016. https://toolkit.modem-dementia.org.uk/wp-content/up-loads/2016/04/CST-Intervention-Summary.pdf

6. World Health Organisation. Dementia Key Facts. March 2023. https://www.who.int/news-room/fact-sheets/detail/dementia

7. Alzheimer's Research UK. Dementia Statistics Hub. https://dementiastatistics.org/

8. Statista. Prevalence of Dementia in the United Kingdom. November 2023. https://www.statista.com/statistics/1289608/prevalence-of-dementia-in-the-united-kingdom/

9. NHS London. The 2019 national memory service audit. March 2020. https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2020/04/The-2019-national-memory-service-audit.pdf

10. Royal College of Psychiatrists. National Audit of Dementia Memory Services Spotlight Audit 2021. https://www.rcpsych.ac.uk/improving-care/ccqi/national-clini-cal-audits/national-audit-of-dementia/fifth-round-of-audit/memory-services-spotlight-audit-national-report

11. Royal College of Psychiatrists. Memory Services National Accreditation Programme (MSNAP) 6th National Report. November 2023 https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-net-works/memory-clinics-msnap/msnap-national-report-(2023).pdf?sfvrsn=745b86ca_3

12. Yorkshire & Humber Dementia Clinical Network. DiADeM (Diagnosing Advanced Dementia Mandate). https://diadem.apperta.org/

13. NHS. June 2021. https://www.nhs.uk/conditions/falls/

14. Alzheimer's Society. Alcohol-related brain damage (ARBD): what is it and who gets it? https://www.alzheimers.org.uk/about-dementia/types-dementia/alco-hol-related-brain-damage-arbd

15. NHS London Dementia Clinical Network. Neuroimaging for Dementia Guidance from the London Dementia Clinical Network. August 2018. https://www.rcpsych.ac.uk/docs/default-source/members/faculties/old-age/neu-roimaging-for-dementia---guidance-from-london-dementia-clinical-network.pdf?sfvrsn=1d1bcbe5_6

16. University College London. STrAtegies for RelaTives (START). https://www.ucl.ac.uk/psychiatry/research/mental-health-older-people/pro-jects/start/about-start#:~:text=STrAtegies%20for%20RelaTives%20(START)%20is,carers%20of%20people%20with%20dementia

17. MODEM project ESRC and the National Institute for Health Research. Dementia Evidence Toolkit. 2016. https://toolkit.modem-dementia.org.uk/wp-content/up-loads/2016/03/START-Intervention-Summary.pdf

18. Alzheimer's Society. Carer Information and Support Programme (CrISP). https://www.alzheimers.org.uk/about-us/our-dementia-programmes/carer-infor-mation-support-programme

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https://www.rcpsych.ac.uk/improving-care/ccqi/national-clinical-audits/national-audit-of-dementia