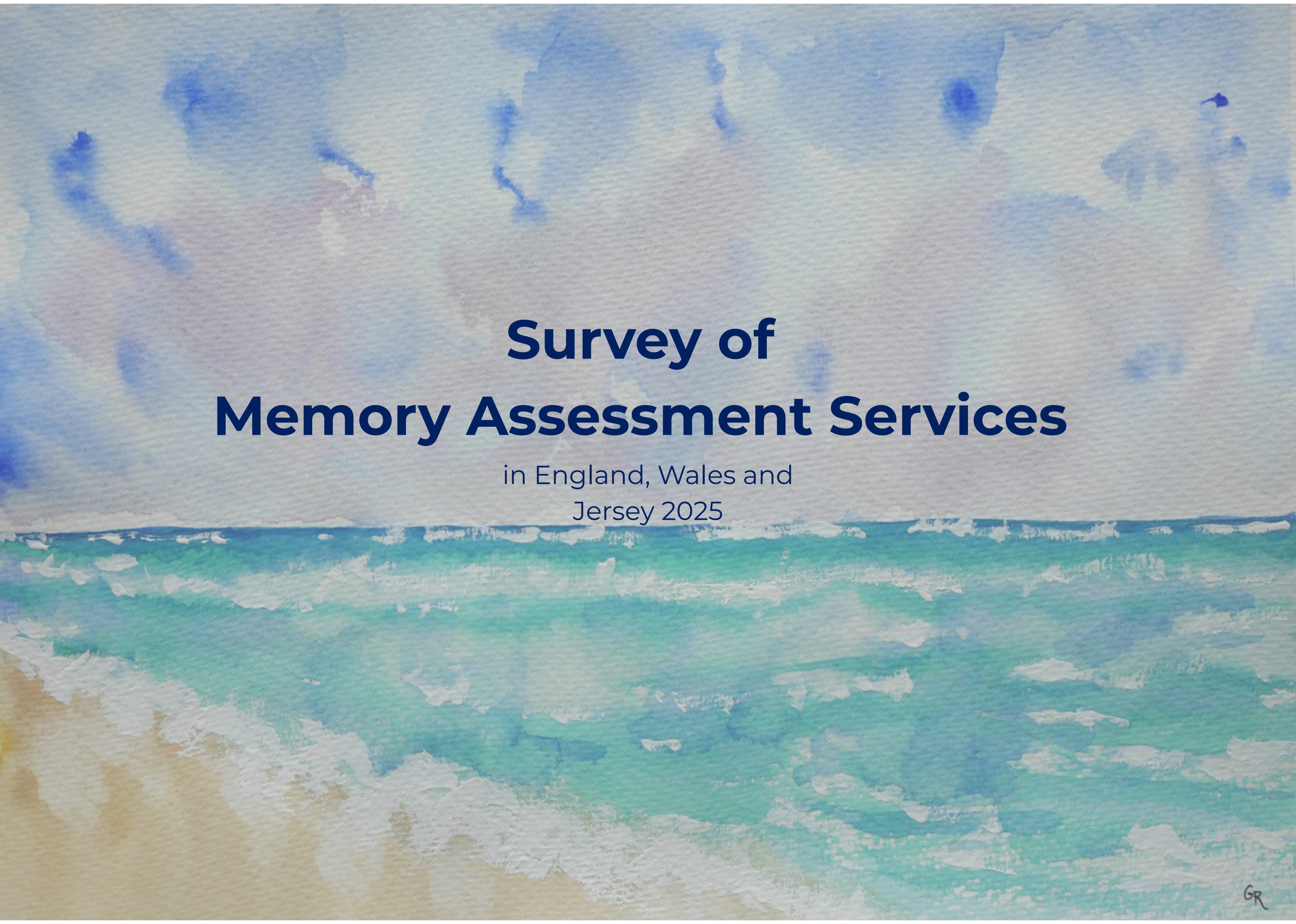

Survey of Memory Assessment Services

in England, Wales and
Jersey 2025

June 2026

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National Audit of Dementia is commissioned by the Healthcare Quality Improvement Partnership (HQIP) and funded by NHS England and the Governments of Wales and Jersey as part of the National Clinical Audit and Patient Outcomes Programme.

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Survey of Memory Assessment Service in England, Wales, and Jersey

Key Findings

Service demand rises proportionally with population (an increase in investigations size) - approximately **2 additional referrals** for every **1,000 people** covered

137

The median **overall wait time** in days from referral to dementia diagnosis across services

(Increase of 5 days from 2023 MAS Spotlight audit)

Low Staff Vacancies

50% of services reported **no vacancies**

42% of services reported **0-10% vacancies**

95% of services offer **post-diagnostic medication review** at 3 months

77% of services **can provide cognitive stimulation therapy** either in-house or by referral to an external provider

23% of services **do not provide CST**

Incomplete Data Issues

Many services could not return all requested data, in particular **diagnostic data**

Background

Introduction

The National Audit of Dementia (NAD) is a clinical audit programme examining the quality of care received by people living with dementia in different healthcare settings. In 2025, NAD surveyed Memory Assessment Services (MAS) in England, Wales, and Jersey, with questions relating to their waiting times and lists, the assessment and support they provide, staffing, and service organisation.

Participation

The survey was open to all services with a primary remit to diagnose dementia. Key findings and data presented in this report focus on data compiled from **151** responses from Mental Health Trusts (MHT) and Health Boards (HB) in England, Wales and Jersey. Data analysed comprises **131** service-level responses and **20** MHT / HB-level responses. Participation by MHT / HB is shown below. In addition, 14 responses were received from neurology-led diagnostic clinics in acute Trusts in England, and these are presented separately.

Please refer to the Diagnostic Services: Participation and Survey of Neurology-led Diagnostic Services: Key Findings documents for further information.

Missing data

Many memory assessment services were unable to submit data for some key results. Dementia type and total dementia diagnoses were among the most affected. There was also considerable variation in reported totals, suggesting inconsistencies in how data is recorded and reported.

Percentage of services with missing data:

Waiting times	
Referral to initial assessment	15%
Initial assessment to diagnosis	21%
Diagnoses	
Dementia	25%
Mild Cognitive Impairment (MCI)	29%
Diagnoses by dementia type	
Lewy body dementia (LBD)	44%
Other types	33%
Alzheimer's disease	30%
Mixed dementia	30%
Vascular dementia	28%

Results reporting

Missing data means that for some results the denominator is less than 151 (all participating services and Trusts), which is then stated. These results (e.g. for diagnosis) are indicative as they do not contain the full data set. A breakdown is available in Appendix I: Data Tables.

Reasons for Missing Data and Variation Across Services

Services provided details on factors contributing to missing data and variation in reported figures. These included:

Inaccurate coding: Several services cited inconsistent or missing ICD-10, SNOMED, or Read codes, creating diagnosis data gaps.

IT Systems Update: Multiple services reported major software updates that disrupted data retrieval.

Local reporting: Services noted local data capture issues: figures held at team level, estimates, and incomplete logging.

Resources supporting coding accuracy are available from NHS England and the National Collaborating Centre for Mental Health (References and Resources).

Why this matters

"...if the coding is inconsistent and not being done properly, that will have a massive impact on researchers doing dementia research. ... The equity of data recording is vital." - *Carer*

Referrals and Waiting list

Referral to a memory service, usually by a GP, is the starting point for most people in their diagnosis journey. Services now accept more new patients per week: the Memory Services National Accreditation Programme (2023) found this increased by 130% 2009-2023, but much smaller increase in average staffing levels. Demographic changes, including a steadily aging population (Office for National Statistics, 2018), will increase not only demand, but also complexity of patient presentations, further impinging on diagnostic capacity.

Waiting list

As of 1 April 2025, the median number of people per service on the waiting list for an initial assessment for dementia was **134** (n = 125 service-level responses). Table 1 shows the total number of referrals by service and Trust.

Table 1: Total annual referrals split by service and Trust level

Level	Total responses	% Missing data	Mean	Median	Min.	Max.
Service	128	2% (3/131)	1131	989	109	5021
Trust	19	5% (1/20)	2242	2322	424	3904

Sources of referral

A person experiencing memory problems is mostly likely to be referred to a memory assessment service by their general practitioner (GP) (Figure 1).

Figure 1: Sources of referral

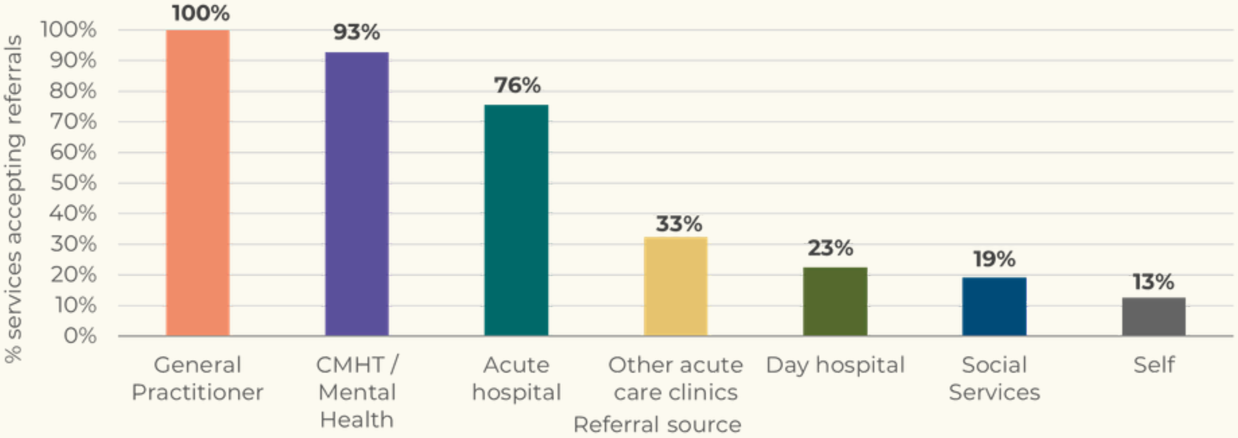


Table 2: Services with age eligibility for assessment

All patients (no cut off)	72%
Patients 45+	2%
Patients 55+	7%
Patients 60+	4%
Patients 65+	13%
Other age group	2%

Why this matters

> "… Any delay in referral potentially means the families are continuing without any support, without any access to benefits, without any education. It's absolutely life changing."
>
> *- Carer*

More than two-thirds of services reported they could accept patients of all ages (Table 2).

Recommended timeframe

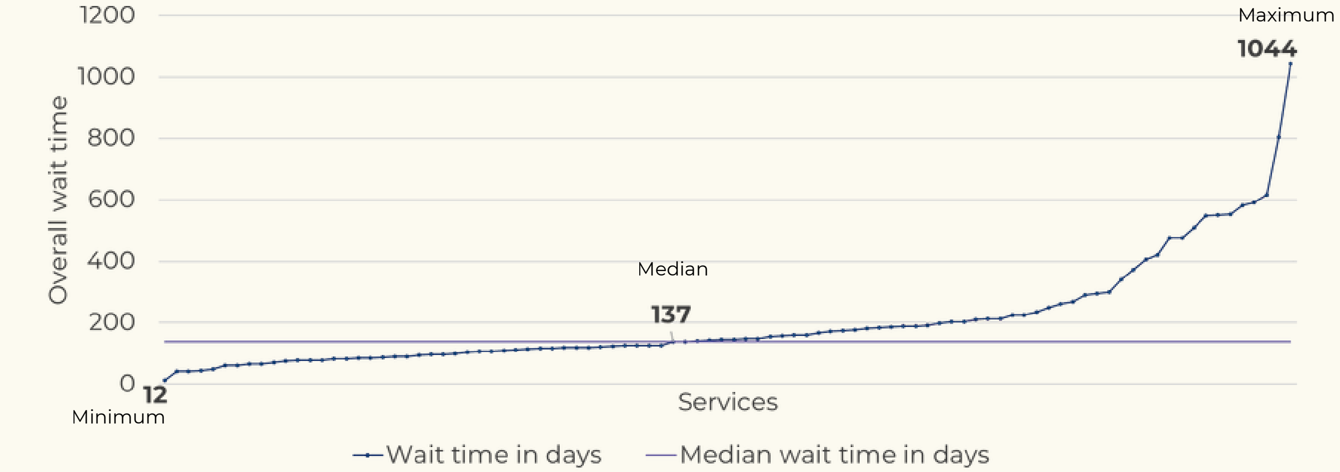
The Dementia Care Pathway: Full implementation guidance (NCCMH, 2018) proposes that most patients should receive a diagnosis within **6 weeks** from referral. The NHS target for consultant-led, non-urgent treatments is **18 weeks**. It has been suggested that this is also an appropriate target for the period from referral to dementia diagnosis. This reflects the growing number of people being referred at an earlier stage (an increase in investigations), the development of more targeted treatment options and other supportive interventions.

Overall wait time

Actual timeframe

The median overall wait time from referral to diagnosis has increased to **137 days** (19.6 weeks) compared to **132 days** reported in the *Spotlight Audit in Memory Assessment Services* (NAD, 2023/2024) (Figure 2). Figure 3 shows that **48%** of services had an average wait time of **18 weeks** or less. The increased volume of referrals noted above is likely to have contributed to this.

Figure 2: Overall wait time in days by service (N=111)

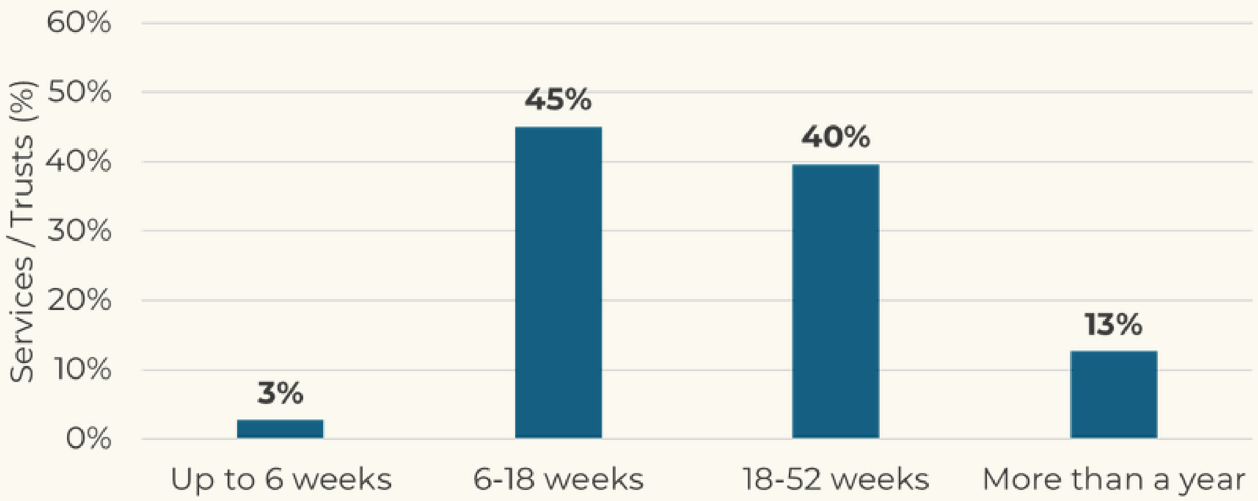


Waiting time in days (median)

Referral to initial assessment (access time)	**57** (1 - 455)
Initial assessment to diagnosis (diagnosis wait time)	**69** (0 - 999)
Overall waiting time*	**137** (12 - 1,044)

*Not all services were able to provide both access and diagnosis wait times

Figure 3: Services and average overall wait time in weeks (N=111)



Why this matters

"... (waiting times) make an enormous difference. If someone has summoned up the courage... to get their GP to refer them, then surely to wait for a year for quite a lot of people – **over a year for some** - well, they could deteriorate hugely without getting the limited amount of treatment that might be available to them."

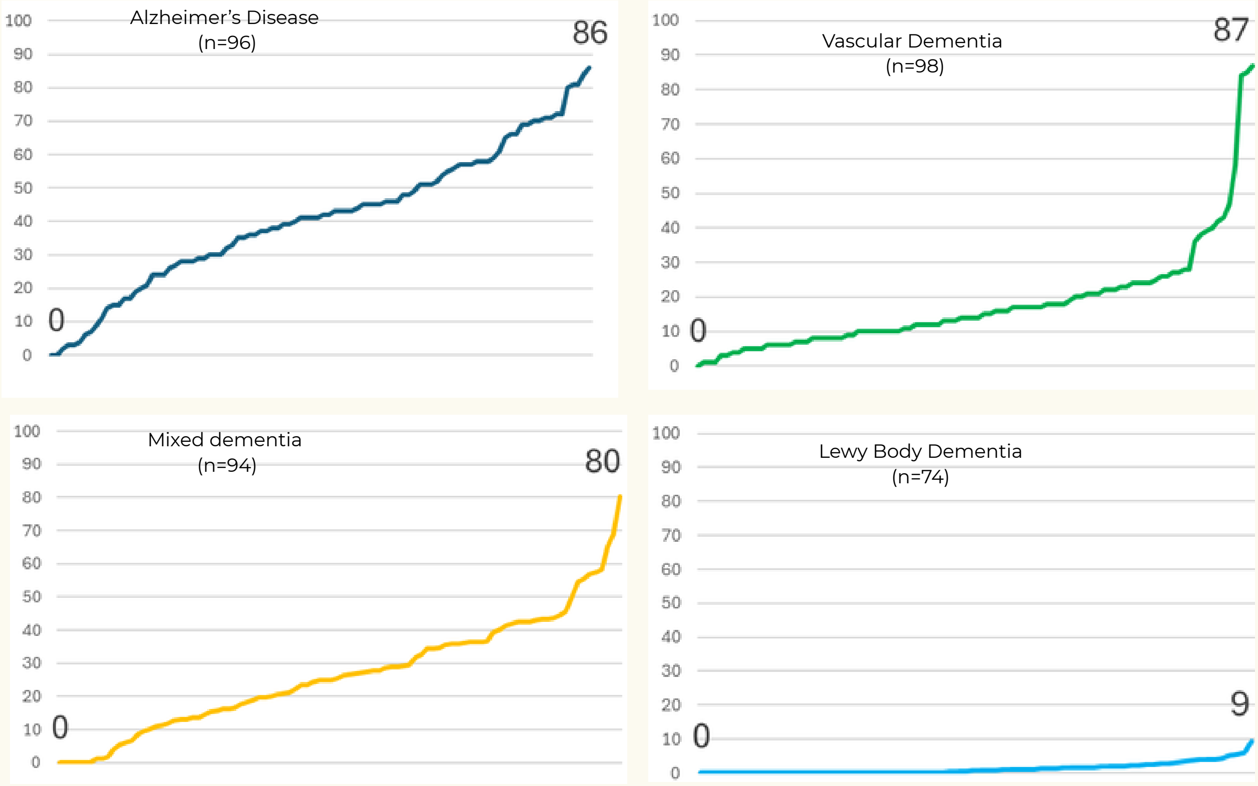
- Person living with dementia

Diagnosing dementia

Diagnosis of dementia types

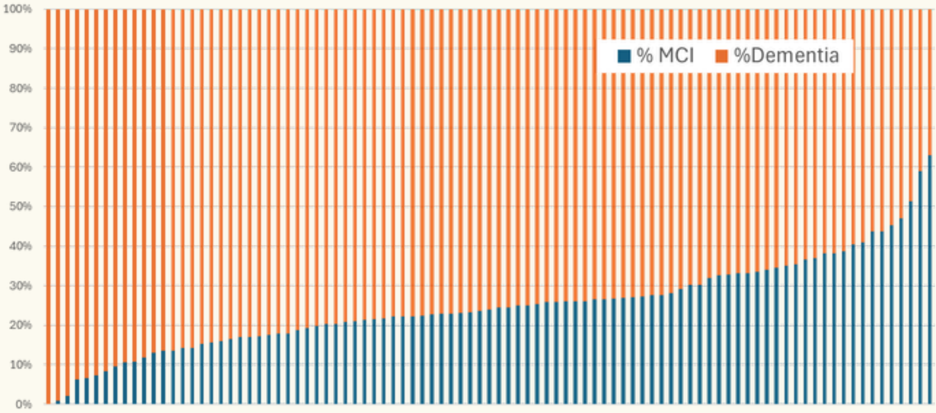
Accurate diagnosis is important in ensuring that the person diagnosed is given appropriate treatment or support. *The Spotlight Audit in Memory Assessment Services* (NAD, 2023/2024) found that there was wide variation in the proportion of different diagnoses made by each service. Variation was again found in the collated data on diagnoses provided by participating services, shown below.

Figure 4: Service-level variation in percentage of diagnosis type out of dementia diagnoses



Wide service level variation is also apparent when comparing the ratio of diagnoses of dementia with diagnoses of mild cognitive impairment (MCI). MCI diagnoses range from 0-63% of the total (sum of MCI and dementia diagnoses):

Figure 5: Proportion of MCI and total dementia diagnoses per service (N=94)*



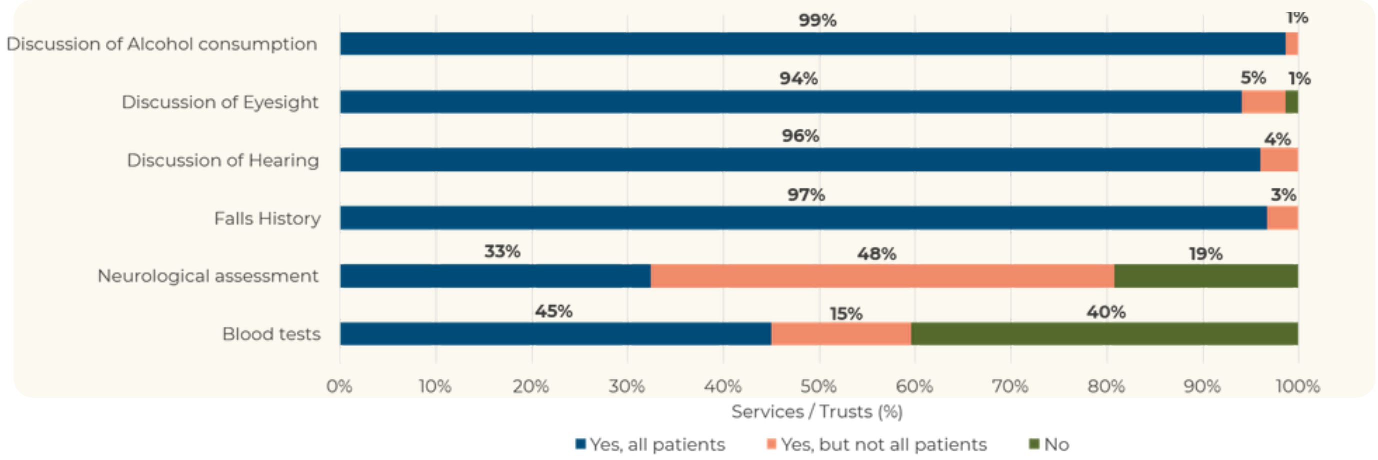
The variation between services in diagnosis of dementia type may indicate differences in diagnostic practice. However, it could relate to different practices in coding the diagnosis across the systems in use, which is likely to introduce error into the data that we have at a local and national level. System difficulties, upgrades, and a lack of ability to extract data at team-level were some of the difficulties fed back by participants, leading to a degree of **missing data**, especially affecting diagnosis reporting (see page 4). Missing data and potential coding problems should be considered when reviewing these results.

Assessment

Components of assessment

The importance of physical checks is highlighted by NICE (2018) as an essential part of the diagnostic process to help exclude other possible causes of cognitive decline. Figure 6 shows that almost all services reported routinely including discussions of alcohol consumption, falls history, hearing, and eyesight for all patients.

Figure 6: Physical health assessment as part of initial assessment



Forty percent of services said they did not routinely take blood for testing, and a further 15% only tested blood for some patients. However, many services commented that this component of assessment was almost always carried out by the GP at the point of referral.

Dealing with delirium

Services were asked about their approach to ongoing delirium, which complicates diagnosis.

- **67%** of services refer patients back to primary care for re-referral
- **12%** deal with delirium on a case-by-case basis
- **8%** continue with the assessment
- **8%** conduct the assessment after the delirium has been resolved
- **5%** use another approach

Neuroimaging and other tests

As part of an initial assessment, structural imaging can be used to rule out reversible causes of cognitive decline and to help with diagnosing the type of dementia. Guidance highlights that requesting a scan should be based on the patient's presentation, as not all patients will require one.

Requests for MRI[4]/CT[1] scans:

Services reported requesting scans at varying stages of the diagnostic process:

- **44%** depends on their pre-assessment triage (before or at initial assessment)
- **31%** at the initial assessment
- **23%** prior to the initial assessment for all patients
- **2%** other

Referral for additional tests:

Most services were able to refer patients for additional tests:

- **93%** for PET[5] scans
- **93%** for DAT[2] scans
- **76%** for SPECT[6] scans
- **65%** for EEG[3] testing

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[1] CT - Computed Tomography

[2] DAT - Dopamine Transporter Scan

[3] EEG - Electroencephalogram

[4] MRI - Magnetic Resonance Imaging

[5] PET - Positron Emission Tomography

[6] SPECT - Single-Photon Emission Computed Tomography

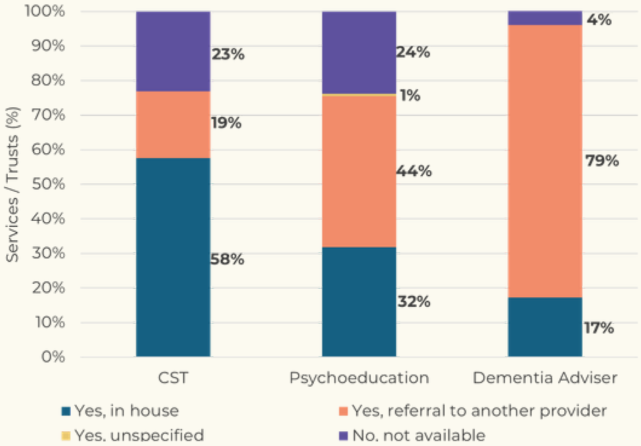
Post-diagnostic support

Post-diagnostic support

Figure 7 shows NICE (2018)-recommended components of post-diagnostic support provided by services:

- People living with mild to moderate dementia should be offered group **cognitive stimulation therapy (CST)** to promote cognition, independence and wellbeing
- Carers of people living with dementia should be offered **psychoeducation** to help them provide care, including information on the symptoms of dementia, changes to expect as the condition progresses, and skills training, particularly on how to understand and respond to changes in behaviour
- **Dementia Care Advisors** can provide specialist guidance and coordination, bridging clinical services, social care, and community resources to help families navigate the complex care system.

Figure 7: Provision of post-diagnostic support



Why this matters

"... not having post-diagnostic support available... puts higher stress and earlier burnout on carers... the patient has a reduced quality of life, there's no continuity of care, and that leads to more crisis-driven cases and poor long-term outcomes..." - *Carer*

Medication review

Medication reviews help to ensure safe, effective, and optimised prescribing.

95% of services offer a medication review within the first three months of initiating treatment and **81%** of those include an assessment of anti-cholinergic burden[7]

Care plans

Every person diagnosed with dementia should have a care plan that provides a detailed post-diagnostic support strategy.

- **85%** of people living with dementia received a care plan
- **74%** of services produce care plans for all patients
- **11%** produce care plans only for patients with dementia
- **15%** do not produce care plans

Referral to neurology

Referral to neurology is often required when a person presents with symptoms that are atypical, complex, or not fully explained by common forms of dementia.

93% of services could refer to neurology when clinically required

Referral to occupational therapy

Occupational therapists play a key role in assessing and supporting daily functioning, safety, and overall quality of life.

92% of services refer individuals to occupational therapy when required

Why this matters

"...the **care plan needs to be defined**... the care plans that memory services always talk about are actually the GP instructions for what they want them to do... not what patients call a care or support plan." - *Person living with dementia*

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[7] Anti-cholinergic burden is the cumulative negative effects of taking some medications prescribed for symptoms of dementia, and many other common conditions e.g. allergies, depression, and urinary incontinence.

Staffing

Service composition

Services provided details of their staffing in whole-time equivalent days per job role (Figure 8).

Figure 8: Average Staffing in whole-time equivalent (n = 131)

*N represents number of **services** with this job role. Average is across services which have the role

Staffing and service model

Figure 8 shows the average staffing per job role, for those services that include the role in their establishment. This is not uniform across all services. Staffing input varies a great deal (see below). This can be due to factors such as how the service is commissioned, whether it is a stand-alone service or incorporated into a wider Community Mental Health Team, and whether services such as post diagnostic support are provided by other organisations. There is currently no Standard Service Specification for Memory Assessment Services. Memory Services National Accreditation Programme Standards (2025) set out expectations for appropriate and adequate staffing. This includes input from an old age psychiatrist, geriatrician, neurologist, mental health nurse, psychologist, physio-, occupational and speech and language therapists, dietician, peer support worker and social worker. Appendix I has a further breakdown of staffing.

Staff WTE (service-level)	Range	Mean	Median	N Services
• All staff	2.6 - 79.4	17.8	15.0	131/131
• Doctors	0.1 - 10.6	2.3	1.8	129/131
• Nurses	0.8 - 36.5	7.3	6.0	131/131

Low staff vacancies

Low vacancy rates (Table 3) suggest a relatively stable workforce, which may support continuity of care and service delivery. However, vacancy levels alone do not capture workload intensity, staff wellbeing, or the adequacy of staffing establishments relative to demand.

The median wait time from referral to diagnosis of **137 days** - an increase of 5 days from NAD's *Spotlight Audit in Memory Assessment Services* (NAD, 2023/2024) - could suggest that, despite most services being close to full establishment, current staffing levels may be insufficient to meet high and increasing demand.

Table 3: Proportion of vacant posts

0	50%
1 - 10%	42%
11 - 20%	3%
21 - 30%	1%
Over 30%	1%
Unknown	2%

Why this matters

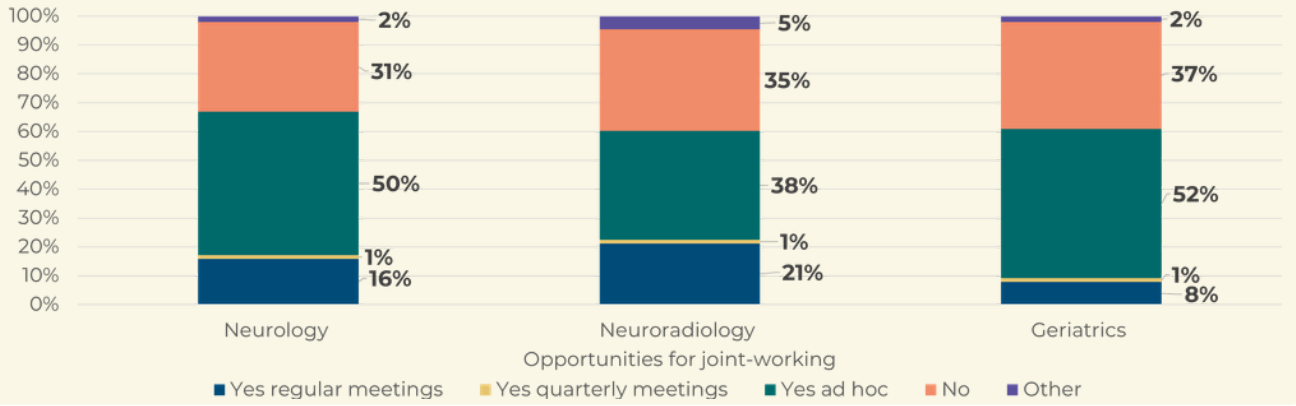
> “... it's a mish mash...the services I've been to, some them have a really good, big team, including OTs, social workers, support workers, physiotherapists. Other services... are very small and they pass any requirements for AHP (Allied Healthcare Professionals) - type stuff - they pass it back to the Mental Health Trust, for their people to do, which is not great for someone with dementia. There is no set requirement for staff..."
>
> *- Person living with dementia*

Service Organisation

Joint working opportunities

The ability to work jointly on a regular basis with other specialties enables services and staff to share expertise and coordinate care, in order to deliver more effective, person-centred support.

Figure 10: Opportunities for joint working with other specialities



Lead for Young Onset Dementia (YOD)

People who are younger when diagnosed with dementia have specific needs, and require ongoing help and support.

- **72%** have no age cut-off for referral
- **54%** have a lead for YOD

Interpreter support availability

- **66%** both face-to-face & virtual
- **24%** face-to-face
- **5%** only for phone & video calls
- **4%** only sometimes have one available
- **1%** had no availability

Research

Services reported involvement in research activities:

- **21%** held Participant Identification Centre (PIC) site status, enabling them to inform patients about opportunities to participate in research
- **60%** were actively engaged in ongoing research studies or trials

Access to brain scan images

The ability to view scans can be helpful to the diagnosing service and can speed up the process.

- **48%** of services did **not** have access to a Picture Archiving and Communications System (PACS)

Assessment and outreach

Enabling assessment to take place in a patient's home, or familiar setting such as a community or day care centre, or using new technology, helps services to provide supportive and inclusive care most suited to the individual (Table 4).

Table 4: Alternative assessment locations

(n=151)	Responses (%)
Patient's usual place of residence	97%
Outreach sessions – care home	72%
Virtual – video call	70%
Virtual – phone call	60%
Outreach sessions – community	53%
Other	3%

Coding in Correspondence

SNOMED CT is the international clinical coding system used in primary care for electronic health records. Services reported using:

- **19%** SNOMED directly
- **70%** ICD10 coding
- **13%** READ codes

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NAD Lived Experience Advisory Group

The Lived Experience Advisory Group is comprised of people who have a lived experience of healthcare services, either as a person living with dementia or person caring for someone with dementia. The group is coordinated and facilitated by our partnering charity, Innovations in Dementia.

The Lived Experience Advisory Group works alongside the Steering Group and collaborates with our Patient and Carer Advisors to provide collective feedback on key audit decisions, ensuring they reflect issues that matter most to people living with dementia and their carers.

Acknowledgements

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