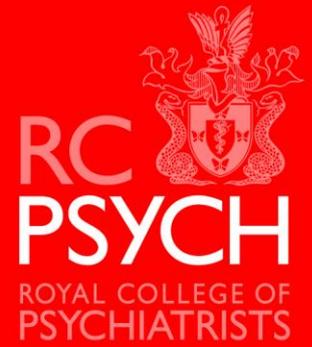


MSNAP
MEMORY SERVICES NATIONAL
ACCREDITATION PROGRAMME



MSNAP Fourth National Report

2015-16

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Of interest to: Memory service staff, people with dementia, carers of people with dementia, commissioners, policy makers and researchers

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www.rcpsych.ac.uk/memory-network

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Foreword

We are delighted to enthusiastically support the new 4th MSNAP national report.

The network continues to grow and there are now over 100 members across the UK. Some services have completed 4 cycles of MSNAP, and the data reflects clear improvements over time, showing that the process is focused on continuous quality improvement rather than a once only snapshot.

With the increased pressure on higher diagnosis rates there have been concerns that psychosocial interventions would be cut so it has been particularly nice to see an increase in the percentage of patients accessing psychosocial interventions (last report was 23.6%, this report 34%). Services have placed much more focus on providing psychosocial interventions (PSI) over the last few years, and now some PSI standards are mandatory in order to achieve accreditation.

The pioneering Join Dementia Research initiative is making a widespread impact and this has been reflected by a strong increase in the percentage of patients registering their interest to participate in research (up from 6.1% in the last report to 9.5% in this one).

The annual National Memory Services Forum has continued to draw a great number of enthusiastic attendees, allowing members to discuss and exchange ideas to improve services and get updates on the latest national developments. In addition to this we are now able to run educational special interest days 2-3 times a year, providing more CPD opportunities for staff working in memory services.

We congratulate the Memory Services National Accreditation Programme on another fantastic report and hope you find it useful and informative.



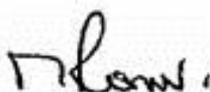
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Summary of key findings

This report looks at data collected from the self-review element of the MSNAP accreditation process. Between August 2014 and July 2016, MSNAP collected data from 88 memory services. These data have been amalgamated and key themes picked out. The data have also been compared with the last MSNAP national report published in January 2015, which looked at data collected between 2013-14, and the performance of members who have completed differing numbers of cycles of accreditation have been compared.

Key findings:

There continues to be a rise in the number of patients being seen by memory clinics. Average caseload has increased from 683 patients in 2013-14, to 819 patients in 2015-16.

The average number of staff working in a memory service has increased from 15 in 2013-14 to 18 in 2015-16.

The average waiting time from referral to assessment is 35 days.

Dementia diagnosis rates ranged from 26.2% - 83.3%.

100% of patients and carers said that memory service staff treated them with dignity and respect at all times.

91% of carers felt they had been given enough written information from the memory service.

76% of referrers have been given advice from memory services; 34% have been provided with training, and 42% outreach.

An average of 34% of patients had accessed psychosocial interventions in the past year.

90% of services are able to offer Cognitive Stimulation Therapy.

55% of carers said they had been offered an assessment of their needs.

An average of 9.5% of patients had registered their interest to participate in research.

Services who have completed more than 1 cycle of MSNAP are more likely than those only having completed 1 cycle to: have a written driving protocol in place; have conducted an audit on the prescription of antipsychotic medication within the last year, and have access to maintenance CST and cognitive rehabilitation.

National Recommendations

1. Ensure carers are offered an assessment of their needs

The data received regarding carers' assessments show that many staff agree they are offering these, but just over half of carers reported having been offered an assessment of their needs. This suggests that carers may not fully understand what a carers' assessment is, or what it would involve. A [letter that can be sent to carers](#) explaining this is available on the resource section of the MSNAP website.

2. Provide access to Cognitive Stimulation Therapy (CST)

While it is great to see that 90% of services are now able to offer CST to people with dementia, all services will need to offer this in future in order to achieve accreditation. The CST programme should follow the full manualised approach.

3. Ensure patients and carers are asked for feedback about the memory service

The data in this report suggests that fewer patients and carers are being asked for feedback about their experiences of the memory service than in previous years. Services could use questionnaires or run focus groups to collect feedback. This standard has been upgraded from a type 2 standard to a type 1 standard, so services will need to evidence that they give patients and carers the opportunity to give feedback, and that their feedback has been utilised, in order to achieve accreditation.

Why are good quality memory services important?

If dementia is diagnosed early, more can be done to delay progression of the disease¹. Additionally, knowledge of the diagnosis can reduce the number and length of acute hospital admissions, delay the need for long-term residential care and allow families to plan future medical care and finances².

The National Audit Office² concluded that “early diagnosis and intervention in dementia is cost-effective”, however only 48% of people with dementia in England have had a formal diagnosis, and area by area it ranges from 39% to 75%³. Good quality memory services should be able to address some of this inequality.

The Prime Minister’s Challenge on Dementia⁴ published in 2015 states that by 2020 the government aims to increase public awareness of dementia; ensure equal access to dementia diagnosis in all parts of the country; provide meaningful care following diagnosis; and show an increase in the number of people with dementia registered to participate in research. Memory clinics have a crucial role to play in order for these targets to be accomplished.

The English National Memory Clinic Audits conducted in 2013⁵ and 2014⁶ demonstrate that the provision of memory services in England varies widely from place to place, with large variance in waiting times, capacity, involvement in research and provision of post-diagnostic interventions. People being assessed for dementia therefore receive a very variable service depending on where they live in the UK.

The Memory Services National Accreditation Programme works with services to assure and improve the quality of memory services for people with memory problems/dementia and their carers. It aims to ensure that all memory services in the UK are of a high quality, by supporting services that are not performing as well to reach a standard of which they can achieve accreditation. This national report summarises the findings from memory service reviews conducted over the last two years of the programme.

¹National Institute for Health and Clinical Excellence and Social Care Institute for Excellence (2006). Dementia: Supporting People with Dementia and their Carers. London: the British Psychological Society and Gaskell.

²National Audit Office (2007) Improving Services and Support for People with Dementia. London: National Audit Office.

³ Department of Health (2013) Dementia – A state of the nation report on dementia care and support in England. London: Department of Health

⁴Department of Health (2015) Prime Minister’s challenge on dementia 2020. London: Department of Health

⁵Royal College of Psychiatrists (2013) English National Memory Clinics Audit. London: Royal College of Psychiatrists

⁶ Royal College of Psychiatrists (2015) Second English National Memory Clinics Audit. London: Royal College of Psychiatrists

Section 1: Introduction to MSNAP

The Memory Services National Accreditation Programme (MSNAP) was launched in 2009 by the Royal College of Psychiatrists' Centre for Quality Improvement. It helps memory services to improve the quality of their service and supports them to achieve accreditation. People with dementia and carers are involved in the programme alongside professionals to ensure that the focus remains on high quality care for people with dementia and those that care for them.

Services are reviewed against a set of standards which are created from published documents, guidelines and expert opinion and are revised regularly. The MSNAP standards cover assessment, diagnosis, drug treatment and psychological and social interventions for people with dementia.

MSNAP is managed by the Royal College of Psychiatrists' Centre for Quality Improvement in partnership with the British Psychological Society, Royal College of Nursing, Alzheimer's Society and the College of Occupational Therapists.

Aims

The ultimate aim of the programme is to work with services to assure and improve the quality of assessment, diagnosis and care of people with dementia and their carers, ensuring that all receive a similarly high quality service and the information they need. It aims to engage staff and people with direct experience of using memory services in a comprehensive process of review, through which good practice and high quality care are recognised. MSNAP aims to support staff in identifying and addressing areas for improvement.

Section 2: The Accreditation Process

Accreditation involves assessing services against a set of evidence-based standards through the process of self review and peer review.

Standards

The relative importance of standards are rated using the following system:

Type 1 standards are essential to safety, rights, dignity and the law. These standards also include the fundamentals of care, including the provision of evidence based care and treatment.

Type 2 standards are those that an accredited service would be expected to meet.

Type 3 standards are those that are aspirational, or standards that are not the direct responsibility of the service.

Self review

Services undergo a self review period of three months in duration, which requires the service to gather data using a range of audit tools: case note audit; organisational checklist; staff questionnaires; referrer questionnaires; patient questionnaires and carer/next of kin questionnaires.

Peer review

Following self review, services receive a peer review; a one-day visit delivered by a multidisciplinary team of reviewers, including peers who work in other member services, a person with dementia and/or carer and often, a member of the MSNAP team. The peer review team's role is to validate the self review findings, identify areas of achievement as well as areas for improvement, and suggest ideas for addressing the latter.

Accreditation decision

On the basis of the self review and peer review data, the MSNAP Accreditation Committee (AC) suggests an accreditation status for the service. The AC acts as part of the Combined Committee for Accreditation – this Committee has an overall chair who assures governance and consistency across those projects measuring the quality of services which are managed by the College.

Affiliate membership

Services that wish to be part of the network and work towards accreditation, but are not yet ready to undergo review, can join as affiliate members. This is a two-year subscription and allows services access to some benefits of membership. Affiliate members are expected to upgrade to full membership within two years.

There are three categories of accreditation status:

- **Category 1: "accredited"**.

The service would *at the point of review by the Accreditation Committee*:

- meet all Type 1 standards;
- meet at least 80% of Type 2 standards;
- meet at least 60% Type 3 standards.

- **Category 2: "accreditation deferred"**.

The service would *at the point of review by the Accreditation Committee*:

- fail to meet one or more Type 1 standards but demonstrate the capacity to meet these within a short time;
- fail to meet a substantial number of Type 2 or 3 standards but demonstrate the capacity to meet the majority within a short time.

- **Category 3: "not accredited"**.

The service would *at the point of review by the Accreditation Committee*:

- fail to meet one or more Type 1 standard and not demonstrate the capacity to meet these within a short time;
- fail to meet a substantial number of Type 2 or 3 standards and not demonstrate the capacity to meet these within a short time.

Services that submit insufficient self review data may also be considered for category 3.

Ongoing quality improvement

As shown in figure 1, the MSNAP process is a cycle, and does not end at the point of accreditation. Members are encouraged to continue thinking about how they can improve the quality of their service by submitting action plans after being awarded accreditation. These action plans will incorporate the areas for improvement identified by the peer review team, and progress against the action plan will be taken into account as part of the brief interim review, which takes place one year after initial accreditation. MSNAP accreditation lasts for two years, after which time services undergo the full review cycle again. The areas for improvement from the last cycle are discussed at the service's next peer review visit.

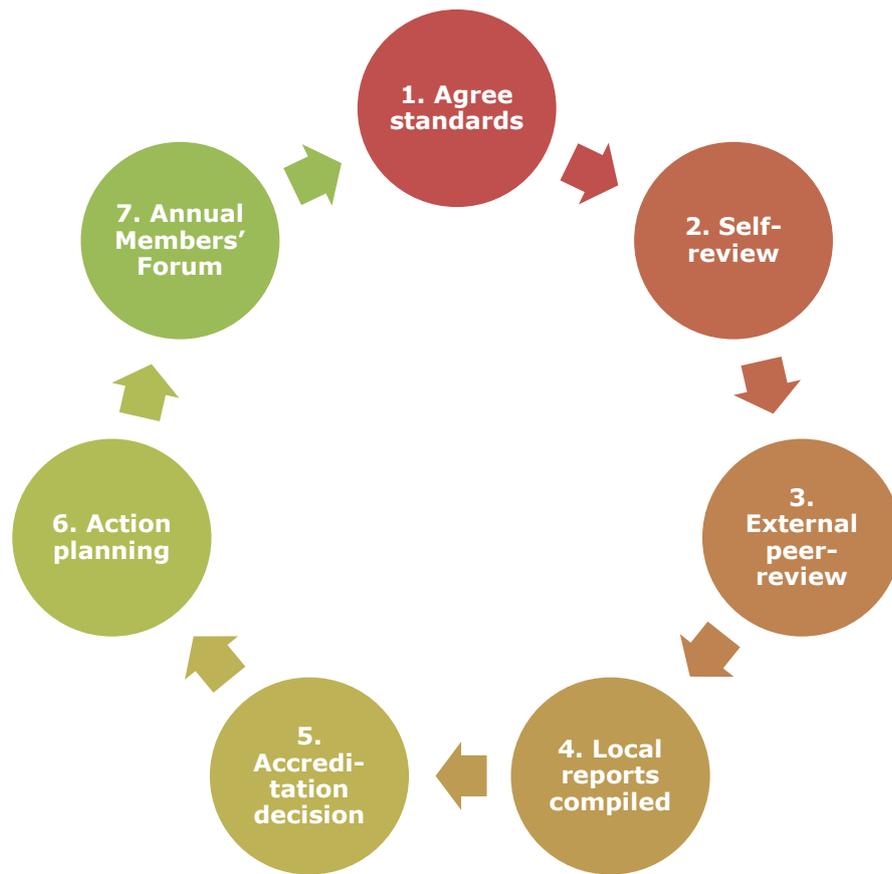


Figure 1. MSNAP Accreditation Cycle

Standards revision

To take into account new developments and publications, the MSNAP standards are revised regularly to ensure that they still represent current best practice for memory services. This is undertaken by the MSNAP Standards Development Group, a multidisciplinary panel consisting of clinicians from memory services participating in MSNAP, representatives from our partner organisations, people with dementia and carers. All MSNAP members have the opportunity during a consultation period to provide feedback and suggest standards for discussion.

Section 3: Opportunities for MSNAP members

Attending peer review visits

Staff from MSNAP member teams have the opportunity to attend peer review visits to other services, which is an excellent learning opportunity. Peer reviewers are able to observe how other teams function, talk to staff, share knowledge and good practice, and create useful contacts. Staff that wish to become peer reviewers attend a one-day training event run by MSNAP which is free for members to attend. Trained peer reviewers are then asked to volunteer for peer review visits, which happen around the UK throughout the year.

Eighty-two peer review visits took place between November 2014 and July 2016, which would not have been possible without trained MSNAP peer reviewer volunteers. The MSNAP team would like to thank all the professionals, people with dementia and carers whose enthusiasm has made the peer review process possible.

MSNAP Forum

The MSNAP National Memory Services Forum is a conference held annually for staff that work in memory services, people with dementia and carers. Members are entitled to free or discounted places, whilst non-members pay a small fee to attend. Each year there are keynote speakers as well as presentations and workshops by members on topical innovations and research.

Over 140 delegates attended our 7th National Memory Services Forum which took place on 3 October 2016 in London. Professor Alistair Burns gave a keynote address, followed by an update on Join Dementia Research from Professor Martin Rossor; an update on the new dementia commissioning guide from NHS England, and a very open and honest account of receiving a diagnosis of dementia from Tom Coppins. In the afternoon there were workshops covering a variety of topics, including psychosocial interventions for younger people with dementia, managing antipsychotic symptoms in care homes, and transgender issues for people with dementia. Many thanks to all the speakers, delegates and exhibitors who helped to make this a successful event.

“This conference has been an eye-opener – it has been interesting, informative and educational. Already looking forward to the next one”

Memory-Chat email discussion group

MSNAP members can join the email discussion group, which is a forum where memory service staff can receive advice from their peers in other memory services around the country. Queries are sent to a central email address, and are then distributed to the group which currently has 260 members. Members of the group can respond to these queries and replies are distributed to the group as a whole, so that others can benefit from the information.

Recent topics include the use of research registers, driving and dementia and discharge criteria.

To join Memory-Chat, email 'JOIN' to MemoryChat@rcpsych.ac.uk

Section 4: What's new in MSNAP?

Fifth edition standards

The 5th edition of the MSNAP standards was published in March 2016. The standards have now incorporated the CCQI core standards for community based mental health services⁷. These standards cover the core principles of high quality care which are relevant to all services. As with the MSNAP standards, the CCQI core standards will also be revised on a regular basis to ensure they stay current.

The new MSNAP standards also include more of a focus on people with young onset dementia, and the standard on access to Cognitive Stimulation Therapy (CST) has been upgraded from a type 2 standard to a type 1 standard.

Special interest days

One of the goals in the previous MSNAP national report was to start offering special interest days. We have held 4 of these so far: Two on waiting times in March and April 2015, one focusing on engaging with patients from Black and Minority Ethnic groups in July 2015, and another on psychosocial interventions in July 2016. These events are free for both members, and non-members to attend.

Our next special interest day will be held on 12 December 2016 in London, and will focus on medico-legal issues in dementia.

Information management system

MSNAP has moved onto a new information management system called the College Accreditation and Review System (CARS). New members can use this system to sign up to MSNAP. MSNAP will register existing members on the system as they come up for their next cycle of review. The new system enables services to submit data, log in and check how many questionnaires have been returned, and access their reports online. Peer reviewers will also be able to log onto the system to download booklets prior to any visits they attend.

Online resources

MSNAP has added a new 'examples of best practice' section to the [resources](#) page on our website. This includes examples of letters, templates and information which have been identified as good practice on peer review visits. Thank you to the services who have given us permission to use and share these examples.

⁷ Royal College of Psychiatrists (2015). Core standards for community-based Mental Health Services

Section 5: Status of MSNAP members

As of August 2016, 108 memory services were participating in MSNAP. The accreditation status of these services is displayed in table 1, and the location in figure 2.

Table 1. Accreditation status of MSNAP members, August 2016

Accreditation Status	Number of services
Accredited as excellent*	51
Accredited	36
Accreditation deferred	1
Not accredited	1
In review (active)	12
Affiliate	7

*From January 2016, MSNAP stopped accrediting services as 'excellent'. Services reviewed in 2016 can be awarded one of 3 outcomes: accredited, accreditation deferred or not accredited.

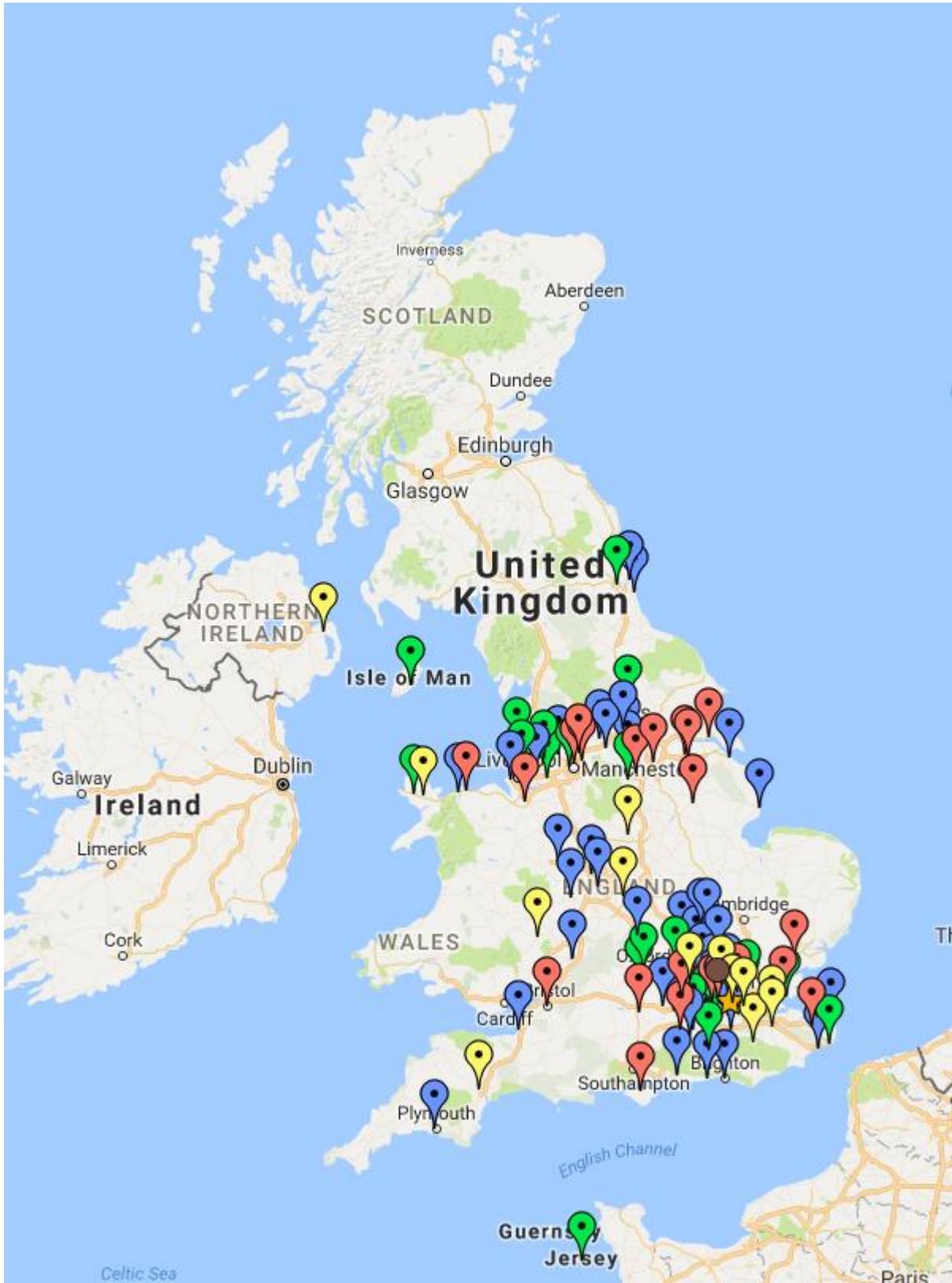


Figure 2. Map showing location of MSNAP members

Accredited as Excellent
 Accredited
 In review
 Affiliate member
Not Accredited

Section 6: Contextual data

Services participating in MSNAP are asked to submit a contextual data questionnaire prior to their peer review. This information is included in the service's report as context, but does not contribute towards their accreditation rating.

Table 2. Contextual data responses received in 2015-2016

Contextual data (number of responses)	Mean	Range	Median
Current caseload (n=85)	819	90-3299	635
Number of new patients seen within the last 4 weeks (n=84)	64	9-381	51
Average time between referral and first assessment (n=84)	35 days	3-84 days	28 days
Number of staff working for the memory service (n=86)	18	5-68	15

As with previous MSNAP national reports, table 2 demonstrates that the size of caseload varies widely from service to service. A range of factors are likely to contribute to this, such as population size, and whether patients remain on the service's caseload or get discharged back to their GP once a diagnosis has been made and treatment options considered.

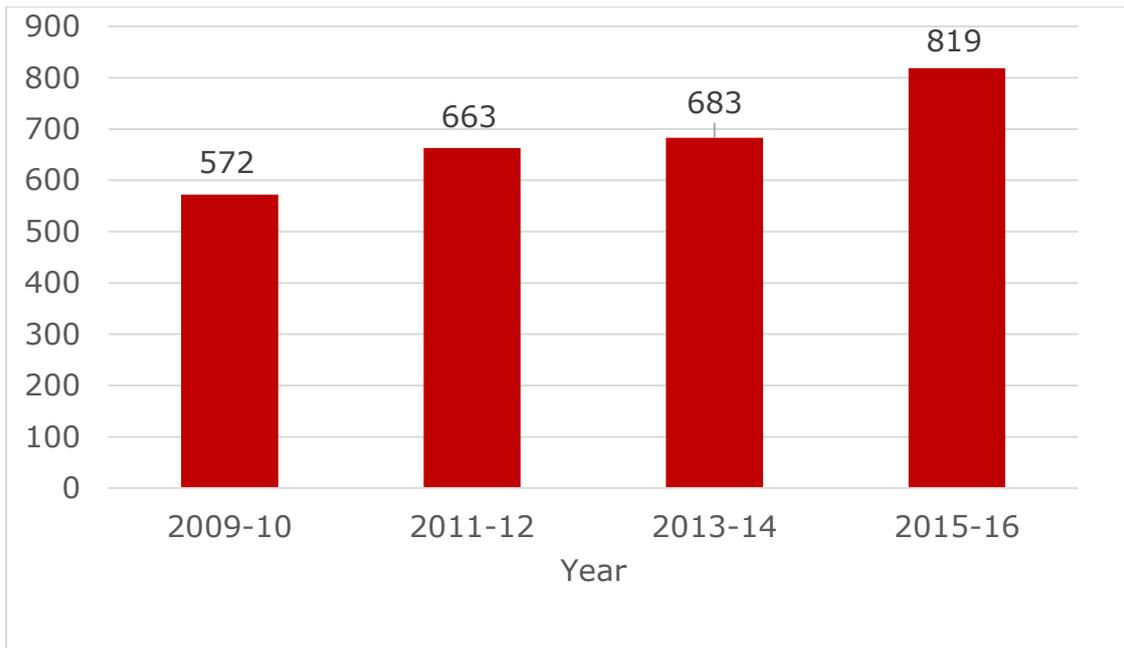


Figure 3. Average caseload of MSNAP member services 2009-2016

Figure 3 demonstrates that there continues to be a rise in the number of patients seen by memory clinics. Whilst we have seen a steady increase in the average caseload between 2009-2014 (572 to 683), there has been a large increase in average caseload size between 2013/14 and 2015/16. This could be because of the current political focus on dementia diagnosis rates, with the Prime Minister’s Challenge on Dementia setting a target for diagnosis rates to reach 66% by 2015.

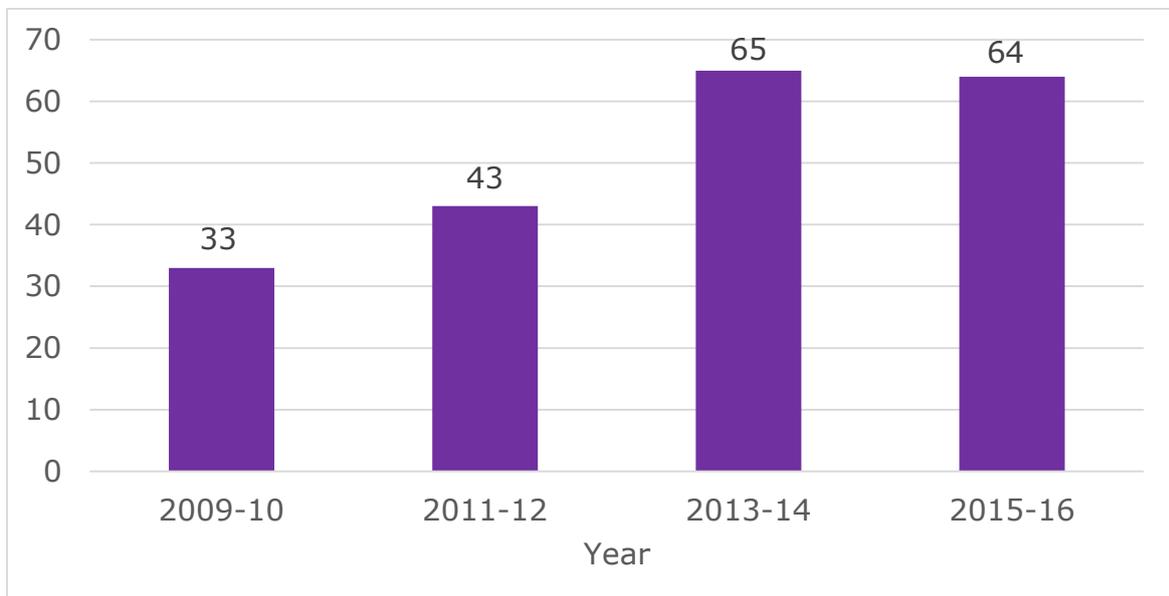


Figure 4. Average number of new patients seen by MSNAP member services within a 4-week period, 2009-2016

Figure 4 above shows that the average number of patients seen over a 4-week period remains very similar to the average number of patients seen by member services 2 years ago.

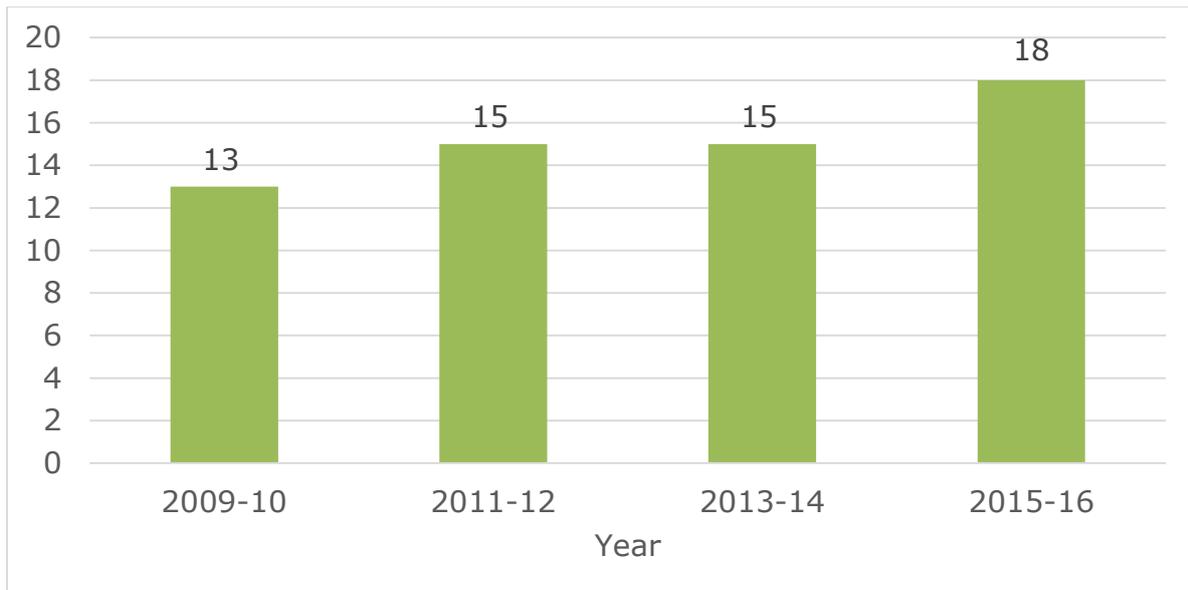


Figure 5: Average number of staff working in MSNAP member services 2009-16

Figure 5 shows that the average number of staff working in MSNAP member services has increased from 15 in 2013/14 to 18 in 2015/16. Given the increase in the average caseload size as demonstrated in Figure 3, it is not surprising that the memory service workforce has had to grow to keep up with this demand. As shown in Table 2, the number of staff working in memory services varies hugely, from 5-68. This is likely to be linked to the different service models of memory clinics, with some stand-alone clinics consisting of fairly small teams, and other services which are part of wider community teams, having a much larger workforce. It is unlikely that all staff working in these larger teams are dedicated solely to the memory service function of the team. Table 3 below shows a breakdown of staff working in memory services by occupation, and the number of sessions provided per week.

Table 3. Average number of weekly sessions for professionals working in MSNAP member services 2015/16

Profession	Percentage of services with dedicated sessional time	Mean number of sessions provided	Range – number of sessions provided	Median – number of sessions provided
Nurse (n=83)	100%	48	4-208	35
Consultant Psychiatrist (n=82)	98.8%	9	0-48	8
Team Manager (n=85)	98.8%	7	0-38	6
Administrator (n=85)	98.8%	1	0-86	15
Psychologist (n=81)	90.1%	8	0-38	6
Occupational Therapist (n=82)	89%	11	0-45	8
Social Worker (n=68)	39.7%	5	0-103	0
Admiral Nurse (n=65)	27.7%	4	0-68	0
Speech and Language Therapist (n=62)	19.4%	1	0-18	0
Physiotherapist (n=58)	8.6%	0	0-20	0
Geriatrician (n=59)	6.8%	0	0-4	0
Dietician (n=56)	3.6%	0	0-4	0
Neurologist (n=56)	3.6%	0	0-1	0

One service had no dedicated sessional time from a consultant psychiatrist, 9 had no dedicated time from an occupational therapist, and 8 had no dedicated time from a psychologist. Whilst few services have dedicated sessional time from speech and language therapists, dieticians, physiotherapists, social workers, geriatricians and neurologists, it is likely that they would be able to access these professionals should specialist input be required.

In addition to the professions listed above, many services also have other professionals such as dementia advisors or support workers, working with them.

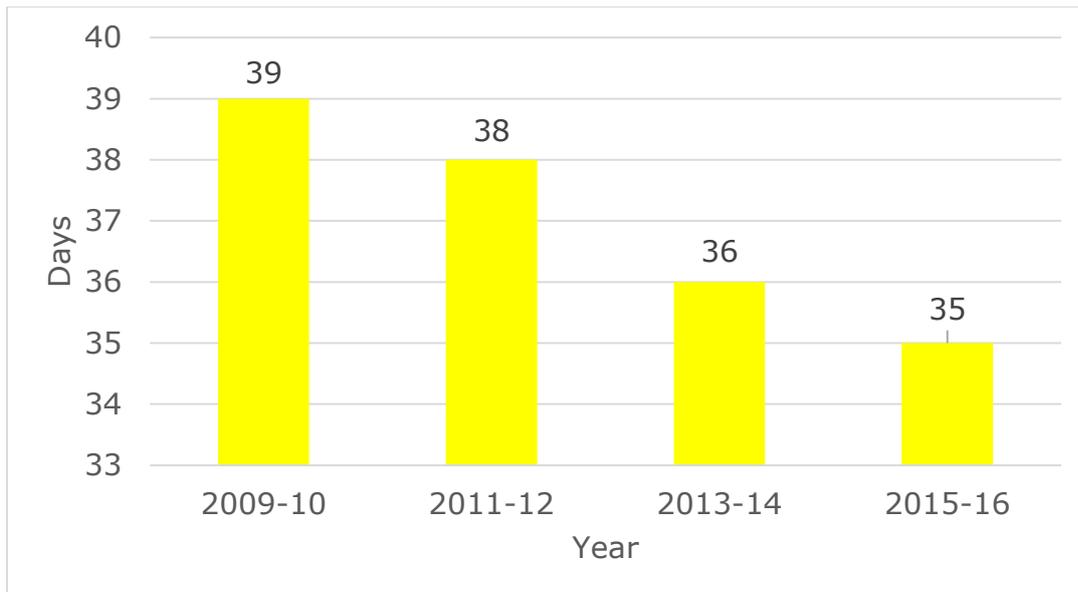


Figure 6. Average waiting time between referral and assessment in MSNAP member services 2009-16

Figure 6 shows that the average waiting time for MSNAP member services has slowly decreased since 2009, with the average waiting time between referral and assessment being 35 days in 2015-16. MSNAP recommends that patients are seen within 6 weeks of referral. Table 4 below shows that an average of 68.8% of patients referred to MSNAP member services were seen within 6 weeks of referral. Some services were unable to see any patients within 6 weeks, while others were able to see all patients within the recommended timeframe.

Table 4. Percentage of patients seen within 6 weeks of referral

	Mean	Range	Median
2015/16: The percentage of new people with memory problems/dementia in the past year whose initial assessment began within 6 weeks of referral (n=83)	68.8%	0-100%	82.3%

Diagnosing patients in the early stages of dementia

Table 5. The percentage of people diagnosed in the early stages of dementia in 2013/14 and 2015/16

	Mean	Range	Median
2015/16: The percentage of people diagnosed with mild dementia over the past year (n=72)	51%	2.3-100%	51%
2013/14: The percentage of people diagnosed with dementia, who are in the early stages of the condition (n=32)	58.5%	10-100%	62%

NB: The question was changed in order to provide clarification between 2013-14 and 2015-16.

Table 5 shows that on average, around half of patients assessed by memory clinics in 2015-16 are diagnosed as being in the early stages of dementia, according to the thresholds defined by the standardised scale used within their clinic. The data shows that on average, clinics are diagnosing fewer patients in the earlier stages of the condition than they were 2 years ago. Some clinics, however, are still diagnosing all of their patients in the earlier stages of dementia. Earlier diagnosis means that people are able to access any available pharmacological and psychosocial interventions sooner, as well as plan for their future.

Diagnosis rates

The data from MSNAP members presented in Table 6 shows that there has been an average increase of 8% in dementia diagnosis rates over the last 2 years. The lowest rate has increased to 26.2%, compared with 2.8% reported in 2013/14.

Table 6. Diagnostic rates in MSNAP member services from 2013/14 and 2015/16

	Mean	Range	Median
2015/16: The proportion of people with dementia in the service's catchment area who have received a diagnosis (n=73)	57%	26.2-83.3%	56%
2013/14: The percentage of people expected to have dementia in the area, who have received a formal diagnosis (n=35)	49%	2.8-93.1%	50%

NB: The question was changed in order to provide clarification between 2013-14 and 2015-16.

Section 7: Key themes in 2013-14 data: Organisational themes

Waiting times

As part of the MSNAP self review process services are asked to complete an audit of at least 20 case notes of patients who have had an assessment and diagnosis at the service during the 6 months prior to self review. Within this case note audit there are two questions that are used to assess waiting times at the service. The first question regards the waiting time for initial contact made (the MSNAP target for this is 3 weeks) and the second question regards the waiting time from referral to the assessment beginning (the MSNAP target for this is 6 weeks).

Table 7. Comparison of waiting times data of that in 2015-14 with 2013-14 and 2011-12 data

Question	2011 -12	2013-14	2015-16
Initial contact was made within 3 weeks of referral	81%	91%	90%
The assessment process began within 6 weeks of referral	79%	80%	77%

Examining the data in Table 7 we can see that although there was a significant increase in patients being contacted within 3 weeks of referral between the 2011-12 and 2013-14 data, there is hardly any difference in the figures between 2013-14 and 2015-16. Although there is still a push to decrease waiting times there is also a continued increase in people being referred to memory services, which may be a reason for these data being fairly static.

There has been a modest reduction in the numbers of patients whose assessment process began within 6 weeks of referral in 2015-16 when compared to 2013-14.

Support for staff

Table 8. Training undertaken by staff in 2015-16

Training	Percentage of staff that have received training
An introduction to local safeguarding vulnerable adults policy and procedures	98.9%
The Mental Capacity Act or the Adults with Incapacity (Scotland) Act, or other local equivalent legislation	96.8%
Applying the principles of person-centred care	92.5%
The assessment and pharmacological treatment of dementia	91.7%
Dementia knowledge and awareness	91.4%
The roles of the different health and social care professionals	91.2%
Awareness of local demographic factors, including ethnic/cultural diversity and use of culturally appropriate measures	90.9%
Non-pharmacological interventions	89%
Communication skills relevant to the role	88.6%
Dementia awareness training for administrative staff	73.7%
Undertaking nutritional screening using a validated nutritional risk assessment tool	61.6%

Table 8 shows the percentage of staff in services that have received specific training related to memory service care. These training domains can either be a standalone course or included in wider training modules. The training that most staff have received is on the Mental Capacity Act and safeguarding, which is to be expected as these are normally mandatory training courses. Ninety-one percent of clinicians have received dementia knowledge and awareness training, compared with 73% of administrative staff working in memory services. Although over a quarter of administrative staff in memory services are still not receiving dementia awareness training, there has been an increase since 2013-14 when only 45% of administrative staff were receiving this training. The training that has been least attended is training on undertaking nutritional screening using a validated nutritional risk assessment tool, although again this has increased from 2013-14, when only 51% of staff had undertaken this training.

Out of all staff who completed the survey (n = 1327), 7% have been refused training and development opportunities due to a lack of staff cover and 8% have been refused training and development opportunities due to a lack of funding. Ninety-nine percent of services reported that training and development budgets enable all staff to meet requirements for their continuing professional development and the Knowledge and Skills Framework.

“High standard and quality of training. My managers are very encouraging with regards to ensuring that I have opportunities to attend training and pursue areas of interest and relevant skills as part of Continuing Professional Development”

“I feel that I am supported to access training relevant to my role and profession and I feel that the service is interested in my development”

Comparisons with 2013/2014 data

Table 9. Comparison of standards met in 2013/14 with 2015/16 data

Standard	2013-14	2015-16
% of services with a website (Type 2)	69%	75%
% of services with systems in place to ensure that the service takes account of any advance directive/decision that the person has made (Type 3)	90%	99%
% of services that have free transport available (Type 3)	72%	65%
% of patients for which other options had been explored before they were prescribed antipsychotic medication (Type 2)	71%	59%
% of services that have access to specialist post-diagnostic counselling (Type 3)	98%	88%
% of services that offer personalised letters to patients and carers (Type 3)	56%	65%
% of patients who were asked if they would like to receive a copy of the letter sent to the referrer (Type 2)	78%	82%
% of patients who were asked if they would like their carer to receive a copy of the letter sent to the referrer (Type 2)	71%	85%

Table 9 shows some interesting trends when comparing the data from 2013-14 to 2015-16. This table shows a mixed report; whilst memory services have improved in certain areas, in other areas they show less compliance. The figures highlighted in green show an increase in compliance, whilst those highlighted red show a decrease.

As shown in Table 9, more services now have a website with specific information about the service, e.g. what to expect at an appointment, contact details, a map etc. There has also been a significant increase in services taking account of advance decisions. Correspondence being offered to patients has also improved which indicates more of an emphasis on person centred care, patient choice and involvement in care. Almost two thirds of patients (65%) are offered a personalised letter, compared with 56% in 2013-14 and 85% of patients are asked if they would like their carer to receive a copy of the letter sent to the referrer.

Eighty-eight percent of services have access to specialist post-diagnostic counselling compared to 98% in 2013/14, which is a significant decrease, however this figure may not be representative as there is sometimes confusion and misinterpretation of what post diagnostic counselling means. Similarly, the decline in services reporting that if the person was offered antipsychotic medication, other options had been considered and excluded first is surprising, but could be due to a misunderstanding of the question as it is suspected that many services answer 'no' to this question when the more appropriate answer is 'not applicable' because no antipsychotics were prescribed. The peer review visit is an opportunity to clarify this and change the data accordingly.

The decline in services offering free transport is no surprise with services like this usually being the first to decrease when budgets are tight. Although less free transport is available, 97% of services have the capacity to make home visits which indicates that those who are unable to get to a clinic can still be seen at home.

Section 8: Key themes in 2015/16 Data: Patient and carer responses

As part of the MSNAP self review process, services are asked to hand out questionnaires to people with dementia and their carers. The questionnaires are then posted directly back to the MSNAP project team who collate the responses. Between August 2014 and July 2016 MSNAP received 1239 completed patient questionnaires and 1443 completed carer questionnaires from 87 memory services around the UK.

When interpreting the data from the self review period it is important to bear in mind that many services will have used this data to make improvements to their service either before or shortly after their peer review visit.

The way they were treated

Reassuringly, like in the 2013-14 report 100% of both patients and carers agreed that staff working in the memory services they had attended were courteous and treated them with respect and dignity at all times.

“ I am very happy to be seen by [name], he is patient, kind, very knowledgeable and has all the time in the world for me”

Environment

Ninety-nine percent of patients and carers thought the clinics they visited were clean and comfortable. Similarly, 97% of patients and 96% of carers thought the clinic had a welcoming atmosphere, which is positive.

“Very high standard, clean and comfortable”

Complaints and feedback

Fifty-nine percent of carers and 55% of patients had been made aware of how to make a complaint if they were unhappy with the service they received. Two percent of patients (n= 27) and carers (n =38) had made a complaint about the memory service. However, when it comes to the handling of complaints patients and carers were less satisfied with the service they received, with only 48% of patients and 65% of carers reporting that their complaint was taken seriously and acted upon.

Aside from being asked for feedback as part of the MSNAP process, 26% of patients and 25% of carers had been asked for their feedback on the memory

service. This number has decreased since the 2013-14 report, where 29% of patients and carers had been asked for their feedback on their service.

Written information for carers

Table 10. Comparison of written information given to carers in 2013-14 with that of 2015-16

The carer was offered written information on:	2013-14	2015-16
the signs and symptoms of dementia;	83%	88%
the course and prognosis of the condition;	81%	83%
options for care and treatment, including coping strategies;	80%	83%
local care and support services/support groups;	89%	90%
sources of financial and legal advice, and advocacy;	75%	77%
medico-legal issues, including driving;	77%	78%
local and national information sources, including libraries, voluntary organisations and websites;	78%	83%
improving general health, living positively and maximising quality of life after diagnosis, e.g. using mental exercise, physical activity, dietary advice alongside drug therapy, maintaining activities, lifestyle management and social engagement;	82%	82%
Do you feel that you have been given enough information?	88%	91%

Both patients and carers are asked about what information the memory service provides to them. Although the amount of information reported being received by patients remained the same in 2013-14 and 2015-16, there has been an increase in all of the written information domains for carers. Most notably, 88% of carers received information on the signs and symptoms of dementia compared with 83% in 2013-14 and 83% of carers received information on local and national information sources, including libraries, voluntary organisations and websites

compared with 78% in 2013-14. Overall, carers seem more satisfied with the written information being given to them with 91% of carers feeling like they have been given enough information compared with 88% in 2013-14.

“It is difficult to assimilate all the 'info' whilst adapting to life as a carer, so I have stored it and keep revising it”

“I have more than enough literature on all aspects both on understanding [my relative] and my options for help and guidance”

“We left with a full folder of very useful information”

What information carers felt they could have benefited from

MSNAP do not only ask what information carers have received but also what information they would have benefited from receiving. Although table 11 indicates an improvement in the provision of information for carers, there are still several carers who have identified specific areas where they could have benefited from more information on.

Table 11. Information carers felt they would have benefited from

Carers reported they would like more information on:	Number
Course and outcome of condition	11
Benefits	11
Coping strategies	9
Groups/local support	7
Respite	5
What to do in a crisis	4
Home care	3
Treatment	3
Power of Attorney	3
How different services link up/communicate	2
Research	1
Improving general health/living positively after diagnosis	1
Incontinence	1
Correlations between mental and physical health	1

Table 11 shows that the most common topics that carers would have liked more information on is the course and outcome of the condition, information on benefits and coping strategies. These data were examined qualitatively

and grouped into themes. These different topics illustrate that the provision of information should try and be as personalised as possible, as people have different needs at different times.

Section 9: Update on 2013-14 recommendations

The previous MSNAP national report published in 2015 contained some national recommendations based on the data submitted by MSNAP members in 2013-14. The recommendations were for memory clinics to improve relationships with referrers; focus on psychosocial interventions; ensure carers are offered a carer's assessment; and to create links with research organisations and actively promote these to people with dementia and carers. An update on each of these recommendations from the 2015-16 data is provided below.

Improving relationships with referrers

Positive relationships with referrers can lead to an increase in good quality, timely referrals to the memory clinic, as well as educating referrers about dementia and the interventions available should patients receive a dementia diagnosis. Feedback from referrers is collected as part of the MSNAP self review process, and the data received in 2015-16 show that services are now offering more support to referrers in terms of advice, training, outreach, and providing written information about the memory service, as seen in table 12 below.

Table 12: Comparison of referrer data collected in 2013-14 with that collected in 2015-16

Referrer Questionnaire	2013-14 data	2015-16 data
Have you been provided with policies and protocols on how to refer people into the memory service?	70%	71%
Has the memory service provided you with written information about the service?	70%	73%
Has the memory service provided you with the following:		
Advice?	72%	76%
Training?	32%	34%
Outreach?	36%	42%

Although slight, it is great to see there has been an increase in referrer engagement over the last 2 years.

The percentage of referrers surveyed about their experience of referring people to the memory service remained largely the same – 16% in 2013-14 compared to 15% in 2015-16.

Access to psychosocial interventions

Data received via the case note audit suggests that there was a 4% increase in the number of patients offered psychosocial interventions between 2013-14 (85%) and 2015-16 (89%). The MSNAP quality indicator data displayed in table 13 show that an average of 34% of patients from each clinic accessed psychosocial interventions, an increase of over 10% on the 2013/14 data. Again this varied widely, however.

Table 13. The percentage of people with dementia accessing psychosocial interventions in 2013/14 and 2015/16

	Mean	Range	Median
2015/16: The percentage of people with dementia under the care of the service who have accessed psychosocial interventions in the past year (n=73)	34%	0.2-100%	23.1%
2013/14: Percentage of people on the memory clinic caseload who have accessed psychosocial interventions in the past year (n=38)	23.6%	0-80%	16.7%

NB: The question was changed in order to provide clarification between 2013-14 and 2015-16.

There has also been an increase in the percentage of services auditing the diagnoses of patients offered psychosocial interventions to ensure equality of access for those with different subtypes of dementia. Sixty-nine percent of services audited this in 2015-16, compared with 53% of services in 2013-14. Data relating to the specific interventions available are displayed in Table 14.

Table 14. The percentage of services able to provide access to psychosocial interventions in 2013-14 compared with 2015-16

Intervention	2013-14 data	2015-16 data
Cognitive Stimulation Therapy (CST)	88%	90%
Maintenance CST	59%	57%
Cognitive rehabilitation	69%	82%
Group reminiscence therapy	69%	72%

It is encouraging to see that there has been an increase in access to most interventions. Access to Cognitive Stimulation Therapy has now been upgraded to a Type 1 standard; therefore going forward services will need to have access to this in order to achieve accreditation.

In addition to the above, there was also an increase in the percentage of patients and carers who said they had been given written information about any non-drug interventions they had been offered. Sixty-six percent of patients in 2015-16 had been given written information, compared to 63% in 2013-14; and 71% of carers

had been offered written information, compared with 60% in 2013-14. Providing people with written information about interventions is vital, as this ensures they have something to refer back to at a later date if necessary.

Carers' assessments

Changes to the Care Act in 2015 meant that carers have a clear right to an assessment of their needs. Despite this, there has been no increase in the percentage of carers being offered an assessment of their needs by the memory service – this remains at 55% (n=933), the same percentage as 2013-14. Despite this, 96% (n=1302) of staff say that carers' assessments are offered. This suggests that there is more work to be done around discussing carers' assessments with carers – making it clear to them what an assessment involves, and what the potential benefits may be.

Promoting research opportunities

The Prime Minister's Challenge on Dementia created a huge focus on dementia research. The data received in 2015/16 suggest that memory clinics have done a lot of work to encourage patients to participate in research, with 50% of patients now being asked whether they would like to register their interest to participate in research, compared with 29% in 2013-14. There has also been an increase in the percentage of patients and carers reporting being given written information about research, with 41% of patients being given information, compared with 36% in 2013-14, and 42% of carers having received information, compared with 32% in the previous dataset.

As shown in Table 15, an average of 9.5% of patients have registered their interest to participate in research, an increase of 3.4% on the previous report data. There are still some clinics who have not had any patients register their interest, however.

Table 15. Percentage of patients registering their interest to participate in research in 2013/14 and 2015/16

	Mean	Range	Median
2015/16: The percentage of people with dementia under the care of the service who have registered their interest in participating in research over the past year (n=57)	9.5%	0-55.6%	6%
2013/14: Percentage of people with dementia who have registered their interest in participating in research over the past year (n=39)	6.1%	0-45.1%	1.8%

While there is still work to be done, it is very clear that research has become a strong focus for memory clinics over the last few years. [Join Dementia Research](#) holds an online register where clinicians, patients or carers can register their interest in research taking place locally or nationally, and is an easy way for services to encourage patients and carers to get involved in research, and to meet this MSNAP standard.

Section 10: Comparisons between Cycle 1, 2, 3 and 4

MSNAP accreditation lasts for 2 years, after which services repeat the accreditation process. The below section looks at and compares trends in the accumulative data across cycles (1-4) between August 2014 and July 2016. Thirty-six services completed their first cycle, 26 their 2nd, 22 their 3rd and 4 services their 4th.

Case note audit

When comparing data across the four cycles for the case note audit, a clear pattern has emerged. The percentage of the standards 'met' increases the more cycles a service undergoes. A selection of standards from the case note audit questionnaire have been chosen which demonstrate an improvement across cycles.

Table 16. The percentage of services meeting each standard across cycles 1-4

Items recorded in the case notes	Cycle number			
	1	2	3	4
Basic dementia screen and blood tests	94%	95%	99%	100%
A physical examination and other appropriate investigations	81%	93%	99%	100%
A review of medication	94%	98%	100%	100%
A check of vision, hearing and mobility	82%	93%	93%	100%
Electrocardiogram (ECG) carried out in accordance to clinical need	87%	92%	95%	97%
If the patient drives, he or she was informed about the necessity to report the diagnosis to the DVLA	76%	93%	89%	100%
The patient (and/or their carer) has been asked if they wish to register their interest in participating in research	38%	60%	53%	69%
The patient asked if they want to know their diagnosis	73%	90%	88%	93%
The patient was asked with whom the outcome of the assessment should be shared	78%	90%	94%	95%
The patient was asked if they would like to receive a copy of the letter sent to the referrer	72%	85%	92%	99%
The patient was asked if they would like their carer to receive a copy of the letter sent to the referrer	61%	83%	86%	97%
The patient was asked if they would like to receive a personalised letter/document containing information about their diagnosis and care needs for them and their carer	52%	65%	80%	100%

The data show that 38% of cycle 1 services documented whether the patient or carer has been asked if they would like to register their interest to participate in research, compared with 60% of cycle 2 services, 53% of cycle 3 services and 69% of cycle 4 services. Similarly, 52% of cycle 1 services offered patients a personalised letter compared to 65% of cycle 2 services, 80% cycle 3 services and 100% cycle 4 services. It is likely that as services progress through the cycles, they improve upon their assessment checklist, ensuring that it covers all of the MSNAP standards.

Checklist data

A selection of standards from the Checklist questionnaire have been chosen which demonstrate an improvement across cycles.

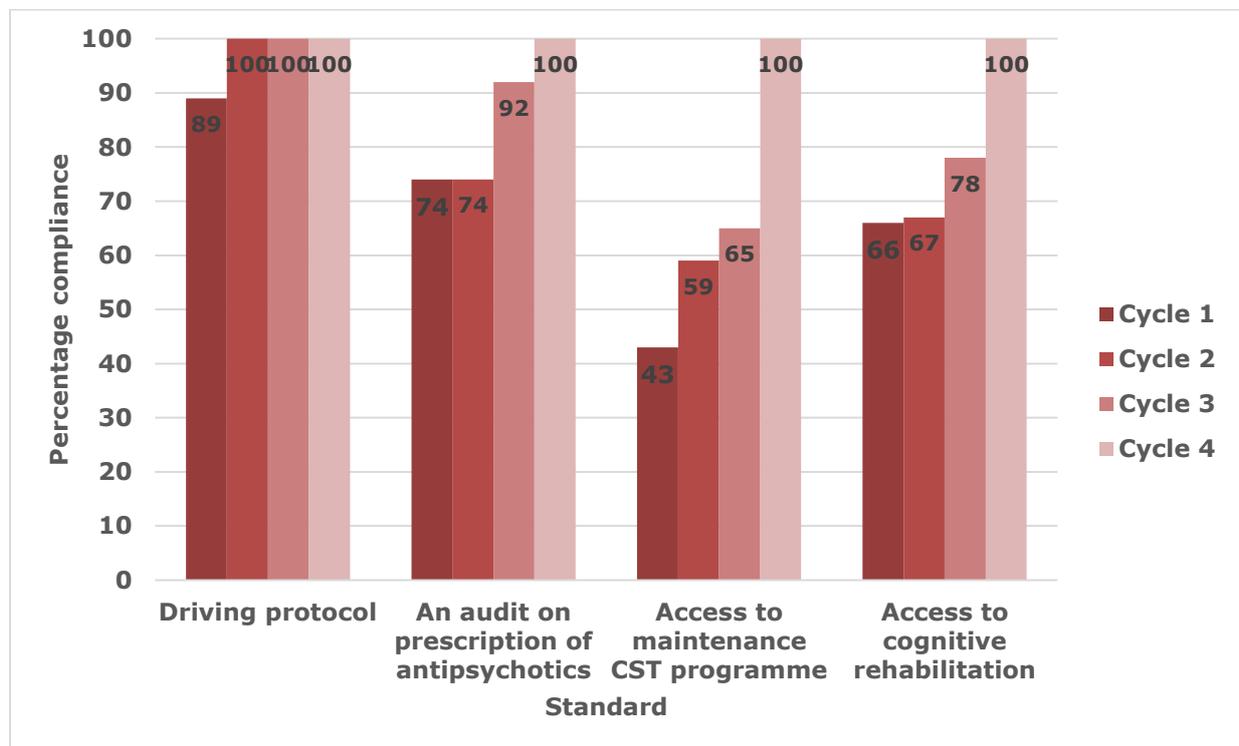


Figure 7. Comparison of services' compliance with checklist standards across cycles 1-4

Driving protocol

The data show that 89% of cycle 1 services had access to a local written protocol for staff on informing patients about managing issues around driving; whereas 100% of services cycle 2- 4 had a protocol in place. This is an indication that this was identified as lacking for services completing their first cycle, explaining the improvement of scores for the consecutive cycles.

Conducting audit on prescription of antipsychotics

Figure 7 shows that cycle 1 and 2 teams (74%) are less likely to have completed a local audit surrounding the prescription of antipsychotic drugs for people with dementia (within the last year), compared to cycle 3 (92%) and cycle 4 (100%) teams. This was a type 3 standard when these data were collected, so it is likely that it is not something teams were addressing until they had worked through any unmet type 1 or 2 standards. However, the standards have recently been updated and this is now a type 1 standard. Therefore all services will need to complete this audit in order to achieve accreditation.

Access to maintenance Cognitive Stimulation Therapy (CST) and cognitive rehabilitation

Ninety-one percent of cycle 1 services have access to CST, however only 43% of cycle 1 services have access to maintenance CST. This improves as services progress through the cycles with 59% of cycle 2 services, 65% of cycle 3 services and 100% of cycle 4 services now offering maintenance CST.

The data show a similar pattern for access to cognitive rehabilitation, with 66% of cycle 1 services and 67% of cycle 2 services having access to this, compared to 78% in cycle 3 and 100% of cycle 4 services. It is great to see such a significant improvement in access to these psychosocial interventions.

Staff offering psychosocial interventions to carers of people with dementia

The responses from the staff questionnaire show that staff working in cycle 4 services were more likely to offer carers of people with dementia interventions for their emotional, psychological and social needs compared to previous cycle services (cycle 1= 93%, cycle 2= 94%, cycle 3= 95%, cycle 4= 99%).

Links with referrers

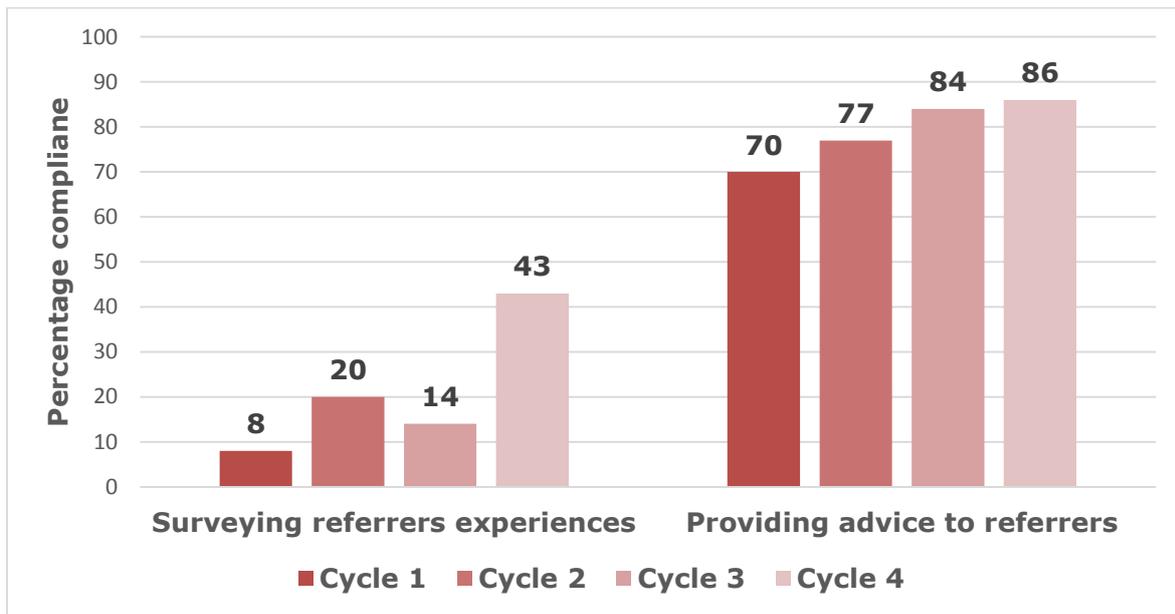


Figure 8. Comparison of data from referrer questionnaires across cycles 1-4

Data from the referrer questionnaires show that cycle 4 services are more likely to have surveyed referrers about their experiences. Figure 8 illustrates this result (cycle 1= 8%, cycle 2= 20%, cycle 3= 14%, cycle 4= 43%). Referrers from services who are undergoing their 3rd or 4th cycles are more likely to have sought and received advice from the memory service compared to cycle 1 and 2 teams (cycle 1= 70%, cycle 2= 77%, cycle 3 = 84%, cycle 4= 86%). Improving contact with referrers is often flagged up as an action point on the peer review day, so it is positive to see that services are acting and improving upon this in later cycles.

Section 11: MSNAP's goals for 2017/18

Goal 1: Offer developmental membership

MSNAP plans to develop another membership option for teams who would like to complete the self review and receive a peer review visit, but who do not yet feel ready to be considered for accreditation. A large part of the peer review day will focus around discussing topics which are pertinent to the team and suggesting ideas for improvement. Developmental members will also gain access to all the other membership benefits, including peer reviewer training and free/discounted places at our annual forum.

Goal 2: 8th National Memory Services Forum

Our 8th National Memory Services Forum will take place in October 2017. The exact date and location will be announced early 2017. We hope to see you there!

Goal 3: Hold more educational special interest days

Following the success of our psychosocial interventions special interest day in July 2016, we will be holding more special interest days over the coming year. Our next event is taking place in London on 12 December 2016 and will focus on medico-legal issues, including driving matters, mental capacity, and Power of Attorney. We will also be holding a learning disabilities special interest day in April 2017.

Appendix 1: Benchmarking – Services which have completed accreditation listed in order compliance with type 2 standards and overall compliance

Please note: Most up to date figures as of July 2016 used

Rank	Service number	% Overall standards met
1	36	100.0%
1	42	100.0%
1	74	100.0%
1	61	100.0%
1	66	100.0%
1	79	100.0%
1	81	100.0%
8	1	99.4%
8	2	99.4%
8	40	99.4%
8	67	99.4%
8	69	99.4%
8	103	99.4%
14	34	98.8%
14	45	98.8%
14	65	98.8%
14	60	98.8%
14	52	98.8%
14	57	98.8%
14	80	98.8%
14	3	98.8%
14	56	98.8%
23	31	98.2%
23	93	98.2%
23	95	98.2%
26	5	97.7%
26	10	97.7%
26	23	97.7%
26	29	97.7%

Rank	Service number	% of type 2s met
1	81	100.0%
1	79	100.0%
1	74	100.0%
1	66	100.0%
1	65	100.0%
1	61	100.0%
1	60	100.0%
1	57	100.0%
1	45	100.0%
1	42	100.0%
1	36	100.0%
1	69	100.0%
13	103	99.1%
13	67	99.1%
13	52	99.1%
13	40	99.1%
13	3	99.1%
13	2	99.1%
19	56	99.0%
19	5	99.0%
19	1	99.0%
22	95	98.2%
22	80	98.2%
22	54	98.2%
22	51	98.2%
22	46	98.2%
22	34	98.2%
22	31	98.2%
22	73	98.2%

26	27	97.7%
26	39	97.7%
26	54	97.7%
26	51	97.7%
26	53	97.7%
26	78	97.7%
26	82	97.7%
26	77	97.7%
38	22	97.0%
38	55	97.0%
38	76	97.0%
38	96	97.0%
42	32	96.5%
43	98	96.4%
44	15	95.9%
44	62	95.9%
44	64	95.9%
47	17	95.3%
47	16	95.3%
47	46	95.3%
47	49	95.3%
47	63	95.3%
47	102	95.3%
47	14	95.3%
54	35	94.9%
55	70	94.8%
56	33	94.7%
56	86	94.7%
56	47	94.7%
59	68	94.2%
60	41	94.1%
60	58	94.1%
60	100	94.1%
60	37	94.1%

22	71	98.2%
22	29	98.2%
22	27	98.2%
33	10	97.9%
34	93	97.3%
34	82	97.3%
34	53	97.3%
34	22	97.3%
34	39	97.3%
39	78	96.5%
39	23	96.5%
39	96	96.5%
39	15	96.5%
39	77	96.5%
39	76	96.5%
45	32	96.1%
46	55	95.6%
47	63	95.3%
48	50	95.2%
49	70	95.1%
50	68	95.0%
51	102	94.7%
51	100	94.7%
51	58	94.7%
51	98	94.7%
51	62	94.7%
56	14	94.5%
57	35	94.1%
58	16	93.8%
58	64	93.8%
60	47	93.7%
60	33	93.7%
60	17	93.7%
60	86	93.7%

60	83	94.1%
65	6	93.6%
66	24	93.5%
67	99	92.9%
67	94	92.9%
67	38	92.9%
67	72	92.5%
71	84	92.3%
72	59	91.8%
72	75	91.8%
72	97	91.8%
75	9	91.3%
76	73	90.8%
77	92	90.6%
78	71	90.2%
79	48	90.0%
79	101	90.0%
81	91	89.4%
81	88	89.4%
83	50	89.0%
83	7	89.0%
85	87	88.8%
85	85	88.8%
87	89	84.6%

64	72	93.2%
64	6	93.2%
66	41	92.9%
66	99	92.9%
66	94	92.9%
66	84	92.9%
66	49	92.9%
66	37	92.9%
72	83	92.7%
72	24	92.7%
74	38	91.9%
75	92	90.3%
76	59	90.2%
77	9	90.1%
78	97	88.5%
79	85	88.2%
80	75	87.6%
80	48	87.6%
82	7	87.3%
83	101	87.0%
84	91	86.7%
85	87	86.6%
86	88	85.6%
87	89	81.1%

Appendix 3: Governance

Accreditation Committee

Member	Professional Body / Role	Status
Martin Orrell	Royal College of Psychiatrists	Chair
Sunita Sahu	Royal College of Psychiatrists	Current
Pradeep Arya	Royal College of Psychiatrists	Current
Emma Barton	College of Occupational Therapists	Current
Alice Moody	College of Occupational Therapists	Current
Emma Ouldred	Royal College of Nursing	Current
Dawne Garrett	Royal College of Nursing	Current
Jill Rasmussen	Royal College of GPs	Current
Reinhard Guss	British Psychological Society, Faculty for Old Age	Deputy Chair
Tamsin Fryer	British Psychological Society, Faculty for Old Age	Current
Felicity Freeman	Carer advisor	Current
Roger Le Duc-Barnett	Carer advisor	Current
Tim Beanland	Alzheimer's Society	Current

Advisory Group

Member	Profession / Role
Stephen Curran (Chair)	Old Age Psychiatrist
Paula Lonsdale	Nurse
Emma Dickinson	Occupational Therapist
John Mulinga	Consultant Psychiatrist
Sharon Stephenson	Team Lead
Sue Parker	Service User Forum Representative
Beth Britton	Carer representative
Mary Rodgers	Carer representative
Dominic Tye	Carer representative

Appendix 4: Publications and conference presentations

Publications

Hodge, S., Hailey, E., Colwill, A., Walker, L & Orrell, M (eds) (2016). *Memory Services National Accreditation Programme - Standards for Memory Services (5th Edition)*. London: Royal College of Psychiatrists.

Hailey, E., Hodge, S., Burns, A & Orrell, M. Patients' and carer's experiences of UK memory services. *International Journal of Geriatric Psychiatry*.

Oral Presentations and Workshops

MSNAP and NHSIQ Special Interest Day: Waiting times, Leeds, 10 March 2015 & London, 7 April 2015

Waiting times: managing demand and capacity

6th National Memory Services Forum, Liverpool, 29 September 2015

MSNAP: An update

Meeting of the regional dementia leads, Pontefract, 28 June 2016

Memory Services National Accreditation Programme

MSNAP Special Interest Day: Psychosocial Interventions, London, 8 July 2016

Psychosocial Interventions

Accreditation for Inpatient Mental Health Services – Older People Annual Forum, 6 September 2016

Memory Services National Accreditation Programme

London Memory Assessment Network Meeting, 7 September 2016

Memory Services National Accreditation Programme

Poster Presentations

Hailey, E. & Walker, L. (2015, November), *Memory Services National Accreditation Programme (MSNAP): Improvements over Cycles*. Poster presented at the 10th UK Dementia Congress. Telford, 3-5 November 2015.

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