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Can Memory Assessment Services (MAS) in England be categorized? A national survey

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ABSTRACT

Background The effectiveness and efficiency of memory assessment services (MASs) is unknown. Our aim was to determine if a typology can be constructed, based on shared structural and process characteristics, as a basis for a non-randomized evaluation of their effectiveness and cost-effectiveness.

Methods Survey of random sample of 73 MASs in 2015; comparison of characteristics and investigation of inter-correlation.

Results It was not possible to group characteristics to form the basis of a typology of MASs. However, there was considerable variation in staff numbers (20-fold), new patients per whole-time equivalent (WTE) staff (20-fold), skill mix and the nurse:doctor ratio (1–10).

The operational performance also varied: first appointments (50–120 minutes); time for first follow-up (2–12 weeks); frequency of follow-up in first year (1–5). These differences were not associated with the number of new patients per WTE staff or the accreditation status of the MAS.

Post diagnosis, all MASs provided pharmacological treatment but the availability of non-pharmacological support varied, with half providing none or only one intervention while others providing four or more.

Conclusions In the absence of any clear typology, evaluation of MASs will need to focus on the impact of individual structural and process characteristics on outcomes.

Keywords Memory assessment services, memory clinics, staffing, workload

Introduction

In England, the 2009 National Dementia Strategy¹ advocated an increase in dementia diagnostic rates, a policy reinforced by the Prime Minister's Challenge on Dementia in 2012.² This was to be achieved by increasing the number of referrals to a Memory Assessment Service (MAS), ambulatory clinics that provide an integrated multi-professional approach and frequently referred to as memory clinics.³ First established in the early 1980s in England, their number increased in the 1990s with the availability of new drugs for Alzheimer's disease and by 2013 there were 214.⁴ Their activities include diagnostic assessment of new referrals, provision of post-diagnosis support (both pharmacological and non-pharmacological) and follow-up.^{1,4–7}

Although attempts have been made to standardize the services provided,^{8–12} there is known to be variation in aspects of the structure (staffing levels, skill mix) and the processes of care (waiting times, length of consultations, diagnostic tests,

treatments and post-diagnosis support [PDS]).^{4,13} An attempt to standardize through accreditation was initiated in 2009 but this scheme does not provide information on individual MAS to permit comparisons of structure or processes.¹⁴ Considerable resources are allocated to MASs (around £125 m in 2014) but little is known about their effectiveness and cost-utility. As it is not feasible to delay referral of people with memory problems, a comparison of MAS with no intervention is not possible. However, it would be possible to compare different types of MAS to establish their relative cost-effectiveness. The best way to do this would be to create a typology of MASs based on shared structural and process characteristics.

Using a large, randomly selected sample of MASs, our aims were: to describe the variation in structural and process

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characteristics of MAS, to explore any associations between the characteristics, and to determine if a typology of MASs based on shared characteristics can be identified.

Methods

Sample

In February 2014, 80 MASs were randomly selected (using a random number generator) from those identified from a Memory Services Register, the Memory Services National Accreditation Programme,¹⁴ a web search and Community Mental Health Teams. Two subsequently dropped out and five were later excluded from the analysis (as in the subsequent prospective cohort study they each recruited fewer than six patients), leaving a final sample of 73 (about a third of all MASs). Ethical approval was not required.

Questionnaire development and survey method

A questionnaire to be completed by each MAS was developed based on existing questionnaires,^{4,5,9,15} the accreditation programme,¹⁴ discussion with MAS staff and the involvement of five experienced doctors. It covered four aspects: structural characteristics (year established, governance, organizational context (speciality setting, stand-alone, one-stop service and single point of access), catchment population, number of staff and whole-time equivalent (WTE), number by profession, allocation of time to different activities, clinic frequency, research and audit activities); first appointments (waiting time, location, length of appointment, clinical assessments, existing diagnosis and provision of diagnosis); PDS (pharmacological and non-pharmacological interventions, assistive technology provision and referral to other providers) and follow-up appointments (time of first follow-up, frequency, length of consultation and clinical assessments). The draft questionnaire was piloted in three MASs which resulted in some minor changes to improve face validity. The questionnaire also collected cost data to enable a comparison of the costs of different types of MAS (based on organizational characteristics) to be made. This will enable the relative cost-effectiveness of different types of MAS to be determined. Given that, it would be inappropriate to include the cost of a MAS in determining the typology as cost would appear on both sides of the comparison.

The questionnaire was sent by e-mail in March 2015 to each MAS. Contact with the sites enabled queries to be answered and reminders were sent to non-respondents. Respondents were asked to report on their actual rather than their intended performance. Missing data (particularly on governance and organizational context) were sought by telephone.

Data management

Extreme values were identified and the originating site contacted for clarification. Attempts were made to obtain missing items and clarify invalid responses. Several variables were recoded in the following ways.

Six continuous variables (year of establishment, number of new patients, waiting times, length of consultations, frequency of follow-up and number of staff) were recoded as categorical variables, dividing ranges of data into tertiles or quartiles.

Respondents used a diverse range of terms to describe the occupations of staff employed. In collaboration with a specialist dementia nurse, all terms were assigned to one of six categories: doctors, nurses, psychologists, allied health professionals (AHPs) (occupational therapists, speech therapists and pharmacists), administrators and advisory and support staff (Appendix A).

Types of non-pharmacological PDS were assigned to one of the six categories: assistance with adjustment to diagnosis; help with stress, anxiety and depression; help for families and carers; help improving and maintaining cognitive function; assistance maintaining quality of life; and help for couples' and families' relationships and communication¹⁶ (Appendix B). In addition, we created a seventh category—help with physical health.

Three derived continuous variables were created: staff workload (number of new patients per WTE staff per month), WTE nurse:doctor ratio and length of initial consultation regardless of location.

Analysis

Simple descriptive analyses identified variables that showed variation across MASs. Prior to any potential grouping of variables, associations between variables were investigated. Pearson correlation coefficients of 0.10–0.35 were deemed weak, 0.35–0.60 moderate and above 0.60 strong.¹⁷ If clear patterns of an underlying typology were apparent, multi-variate analysis (such as cluster analysis) would be used.

Results

Survey response

All 73 MAS responded with over 93% completeness for most variables. Information on a few variables was either not available (respondents were not able to assign staff time to different activities; catchment populations could not be defined), or was not reported consistently because of differences in interpretation (frequency of clinics, single point of access and stand-alone). These were, therefore, not considered in the analysis.

Only 65 MASs supplied data on number of staff of which 42 (59%) supplied accurate data on the WTE number of staff. The latter sites had a mean of 12.80 staff and a mean WTE of 9.02. Given that their mean number was similar to that of the other 23 MASs for which such information were not available, the WTE number was estimated for the latter based on 70.5% (9.02/12.80) of their staff number.

Structural characteristics

MASs were similar in several respects. The medical specialty location of all but one MAS was psychiatry. All employed doctors (predominantly psychiatrists but some geriatricians and a few neurologists), nurses and administrators. While 27% provided a 'one-stop service' in which all diagnostic and treatment activities were provided during a single appointment, the majority needed to refer patients to other services (usually within the same hospitals) for certain assessments. Most MASs provided education and training for their staff (78%) and their staff had contributed to research (85%) and audit (79%) during the preceding year.

In contrast, MASs varied considerably in several characteristics (Table 1). First, while over a third had recently been established (within past 5 years), 19% had been in existence for at least 15 years. Second, only a quarter had been accredited. Third, the overall WTE number of staff ranged from 1.2 to 26.7 (Fig. 1A). This partly reflected variation in the numbers of doctors, nurses and administrators, but was also due to whether they employed psychologists, AHPs and advisory and support staff.

The mean WTE number of staff was 9.9 (SD 6.0) made up of 1.7 doctors, 3.6 nurses, 1.9 administrators, 0.8 psychologists, 0.9 AHPs and 1.0 advisory and support staff. The staff mix varied—while the mean nurse:doctor ratio was 3.4 (SD 3.8), it varied from <1.0 to 20.0 (Fig. 1B).

The variation in staffing levels was not necessarily reflected in differences in the number of first appointments which ranged from 1 to 20 (Fig. 1C) per WTE staff member per month (mean 6.4; SD 3.6).

New patients

All MASs accepted new patients of all ages. Most (75%) operated a 'single point of access' for referrals (i.e. Trusts that managed more than one MAS allocated referrals to each constituent service). The source of referrals was general practitioners (for 73% of MASs), acute hospitals (62%) and mental health teams (56%). The mean number of new patients per month was 48.2 (SD 26.5) with most MASs (85%) seeing fewer than 75 (Table 1; Fig. 1D).

Table 1 Structural characteristics, referrals and first appointments at MASs (n = 73)

Characteristic	Number (%)
Year established	
Before 2000	13 (19)
2000–04	15 (22)
2005–09	16 (23)
2010–15	25 (36)
Missing	4
Accreditation	
No	49 (67)
In progress	5 (7)
Yes	19 (26)
Staff (WTE)	
1–10	40 (61)
11–20	20 (31)
>20	5 (8)
Missing	8
Skill mix ^a	
Psychologist	48 (66)
AHP	51 (70)
Advisory and support staff	38 (52)
Nurse:doctor ratio	
<1.6	24 (37)
1.7–3.3	18 (28)
3.4–5.0	12 (19)
5 or more	10 (16)
Missing	9
New patients per month	
<25	15 (21)
25–49	22 (31)
50–74	24 (33)
75 or more	11 (15)
Missing	1
Workload (new patients per WTE staff per month)	
1–5	21 (39)
6–10	36 (49)
>10	16 (22)
Waiting time for first appointment (weeks)	
6 or less	53 (73)
7–12	15 (20)
>12	5 (7)
Length of first appointment (minutes)	
<60	21 (29)
60–89	37 (51)
90 or more	15 (20)
Clinical assessments performed ^b	
Electro-cardiogram	45 (62)
Neurological examination	31 (42)

^aProportions of MASs with category of staff present.

^bProportions of MASs in which assessment performed.

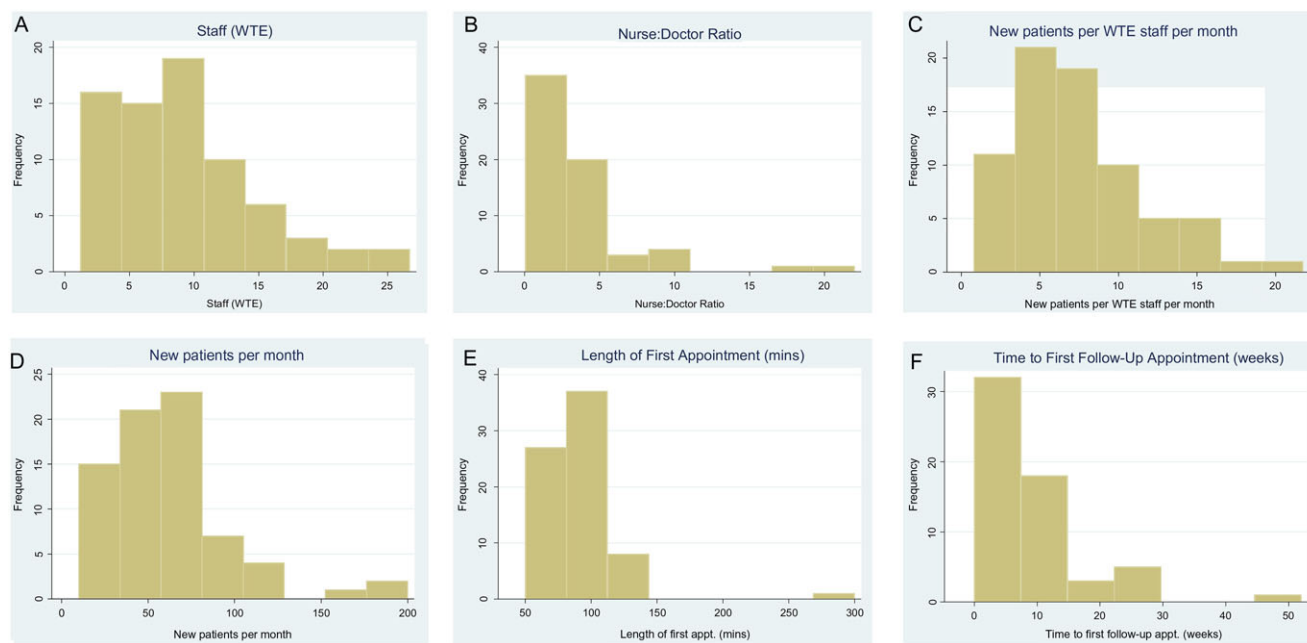


Fig. 1 Histograms showing variation in MASs for (A) WTE number of staff, (B) ratio of number of nurses to doctors, (C) number of new patients per WTE staff, (D) mean number of new patients per month, (E) mean length of first appointment and (F) mean time to follow-up appointment.

In most aspects, initial assessments at the first appointment do not vary between MASs. Most services (87%) offer patients the option of the first appointment being held either in the clinic or in the patient's home. Initial assessments almost always include history taking and review, cognitive function tests, physical examination (88%), blood and urine tests (85%), assessment of vision, hearing and mobility (80%), CT scans (67%), risk assessment (97%) and social needs assessment (84%).

Variation between MASs does occur in the timing and length of first appointments and the type of examination provided (Table 1). While the majority of services (73%) manage to see all referrals within 6 weeks, the waiting time for a few (7%) is over 12 weeks. The mean length of the first appointment was 86.5 minutes (SD 32.0) but varied between MASs from 50 to 120 minutes (plus one MAS in which visits lasted 300 minutes as it included conducting a brain scan) (Fig. 1E). Most services conduct a physical examination but only 42% include a neurological examination (usually conducted by a psychiatrist rather than a neurologist) and 62% an electrocardiogram (ECG).

PDS

Most MASs provide pharmacological treatments (anti-dementia drugs 99%; other drugs 76%), signposting to other services (96%) and education and support for patients and carers (86%). Most also provide advice as to where else

relevant services are provided. In contrast, financial and legal advice is not so widely provided by MASs (63%).

MASs vary in the number of non-pharmacological interventions provided (Table 2) with 21% providing none while 20% provided four or more. The types of interventions most frequently provided aim to help families and carers (57% of MASs). Improving cognitive function (e.g. cognitive stimulation therapy, memory groups and mindfulness) was available in 36% of MASs but the five other categories were provided by only 16–26% MASs.

The provision of a post-diagnosis disclosure programme (60%) and the provision of assistive technologies (e.g. digital devices) (52%) was also not universally available.

Follow-up

The ways patients are assessed at follow-up appointments did not vary much between MASs as regard cognitive function tests (78%), history taking and review (81%), risk assessment (85%) and social needs assessment (74%). Physical examination and clinical investigations were not routinely conducted.

However, MASs varied considerably in the schedule of appointments (Table 2). While 36% of services saw patients within 4 weeks, 36% left it for over 8 weeks (Fig. 1F). When they were seen, the length of the appointment ranged from 20 to 90 minutes: 34% of services provided less than half an

Table 2 Provision of post-diagnosis non-pharmacological support and follow-up ($n = 73$)

Characteristic	Number (%)
Number of categories of interventions provided	
0	15 (21)
1	18 (26)
2	13 (19)
3	10 (14)
4–7	14 (20)
Missing	3
Categories of interventions available	
Assistance with adjustment to diagnosis	18 (26)
Help with stress, anxiety and depression	18 (26)
Help for families and carers	40 (57)
Help improving cognitive function	25 (36)
Assistance maintaining quality of life	12 (17)
Helping couples' and families' relationships and communication	11 (16)
Support for physical health	11 (16)
Missing	3
Post-diagnosis disclosure programme provided	43 (60)
Missing	1
Assistive technology provided	36 (52)
Missing	4
Time to first follow-up appointment (weeks)	
4 or less	24 (36)
5–8	10 (16)
9 or more	24 (36)
No follow-up provided	8 (12)
Missing	7
Length of first follow-up appointment (minutes)	
<30	22 (34)
30–44	21 (33)
45–59	12 (19)
60–89	9 (14)
Missing or not applicable	9
Number of follow-up appointments per year	
None	8 (11)
1	8 (11)
2	23 (31)
3 or more	19 (26)
Variable	14 (19)
Missing	1
Clinical assessments performed	
Physical examination	37 (51)
Vision, hearing, mobility assessment	26 (36)
Missing	1

hour while 33% provided over 45 minutes. MASs also varied in the number of times they saw a patient after their initial visit in the first year—11% provided no follow-up appointment,

11% saw them only once, while 26% saw them at least three times.

Associations between structural characteristics and processes

The associations between all variables that showed considerable variation between MASs (shown in Tables 1 and 2) were investigated to see if there were any groupings that could form the basis of a typology. Eight variables (year established, psychologists employed, nurse:doctor ratio, waiting time for first appointment, post-diagnosis disclosure programme, number of types of PDS, provision of assistive technology and number of follow-up appointments in first year) had no or only a weak association with all other variables and were not considered further. The correlation coefficients (r) for the remaining 12 variables are shown in Table 3. There was one strong association and 11 moderate associations observed. The four main areas of association are described below.

MAS size (number WTE staff)

Larger services (higher WTE numbers of staff) were associated with a higher likelihood of including AHPs ($r = 0.433$) and advisory and support staff ($r = 0.485$). The only association with processes was that larger MAS provided longer first appointments ($r = 0.394$) and the latter was associated with longer follow-up appointments ($r = 0.459$).

New patients per WTE staff

Although larger MASs were associated with higher numbers of new patients ($r = 0.433$), the number of new patients per WTE staff were lower ($r = -0.436$). Despite this, lower workloads were not associated with patients having shorter waiting times or longer first appointments. It is partly explained by fewer new patients per WTE staff being associated with more AHPs ($r = 0.416$) and advisory and support staff ($r = 0.656$) who may be less involved in managing initial appointments and focus more on follow-up attendances.

Staffing and clinic activities

While the overall staffing level and workload did not appear to have any impact on the way patients were assessed or managed (including PDS), the skill mix of the team was associated with some differences. Services with AHPs are less likely to undertake an ECG ($r = -0.355$) which in turn was associated with a lower likelihood of a neurological assessment at the first appointment ($r = 0.481$). This may indicate that some MASs are less medical in their orientation and culture.

Table 3 Associations between the 12 MAS variables which had at least one moderate correlation (>0.35), highlighted

	Staff (WTE)	AHPs	Advice and support staff	New patients per WTE staff	Length of first appointment	Neuro exam at first appointment	ECG at first appointment	Time of first follow-up appointment	Length of follow-up appointment	Physical exam at follow-up	Disability assess at follow-up
Staff (WTE)	1.000										
AHPs	0.433	1.000									
Advice and support staff	0.485	0.517	1.000								
New patients per WTE staff	-0.436	-0.416	-0.656	1.000							
Length of first appointment	0.394	0.294	0.316	-0.247	1.000						
Neuro exam at first appointment	-0.064	-0.170	-0.291	0.070	-0.049	1.000					
ECG at first appointment	0.036	-0.355	-0.223	0.139	0.011	0.481	1.000				
Time of first follow-up appointment	-0.036	0.147	-0.119	0.138	-0.063	-0.212	-0.134	1.000			
Length of follow-up appointment	0.203	-0.042	0.063	-0.265	0.459	0.082	0.268	-0.008	1.000		
Physical exam at follow-up appointment	0.128	0.058	-0.069	0.039	-0.025	0.097	-0.032	0.189	-0.189	1.000	
Disability assess at follow-up appointment	0.089	0.019	-0.134	0.213	0.153	0.177	0.273	0.120	0.047	0.506	1.000
Accredited	0.218	0.206	0.073	0.043	-0.014	0.080	0.032	0.353	-0.222	0.154	0.311

Accreditation

Services that had been accredited did not differ significantly regarding their number of staff, workload, waiting times, lengths and frequency of appointments, and clinical activities. The only way that accredited MASs differed was that they did not follow-up patients as soon after the first appointment ($r = 0.353$).

Discussion

Main finding of this study

Although MASs differ in many structural and process characteristics, no distinct groupings of shared characteristics exists that could form the basis of a typology. Thus evaluations of the effectiveness and cost-effectiveness of these services need to focus on single characteristics that show considerable variation (plus the possibility of deriving some composite variables based on combinations of two or more). Our analysis indicated that a wide range of characteristics deserve consideration.

Staffing levels vary 20-fold which is only partly reflected in the number of first appointments. Thus the workload (as measured by new patients per WTE staff) also varies 20-fold. Some of the variation in staffing levels arise because some MASs are more likely to include AHPs, psychologists or advisory and support staff.

Although all MASs provide post-diagnosis pharmacological treatment, there is variation in the provision of non-pharmacological support, with half providing none or only one type of intervention while others provide four or more. The latter are more likely to employ AHPs, suggesting a greater emphasis on the psycho-social component of their work.

While three-quarters of MASs see new patients within 6 weeks, others have average waits of over 12 weeks. And once seen, the mean length of initial appointments vary 2-fold (50–120 minutes). Variation is also seen in follow-up care: some provide none and, of those that do, the average time to the first follow-up appointment varies from 2 to 30 weeks; the frequency of appointments in the first year varies from one to five and the length of follow-up appointments varies 5-fold (20–100 minutes). Such differences between MASs are not explained by variation in staff workload.

MASs that had been accredited (26%) did not stand out as being different as regard structural or process characteristics from those that had not been accredited. The only difference was unexpected—accredited MAS did not see their patients for follow-up so soon after the first appointment.

What is already known on this topic

Previous research studies have usually been limited to describing a single MAS, not providing any insight into the extent of variation in structures and processes.^{18–21} However, the two national audits conducted in 2012 and 2014^{4,13} provided some evidence of variation but did not investigate associations between characteristics. While the lack of an agreed operational definition of the role and function of MASs was recognized early on by many clinicians in this field and has sparked the development of the national accreditation programme,¹⁴ no attempt has previously been made to quantify the way MASs vary in practice.

What this study adds

Although no typology has been revealed to underpin evaluative studies, this study has identified a wide range of characteristics that vary sufficiently to form the basis of comparative analyses (i.e. natural experiments). This will allow the comparison of ways of assessing patients and different post-diagnosis interventions to establish which ones result in the greatest benefit. This will permit clearer evidence-based guidance for MASs to be drawn up. Equally, if there are no discernible differences in outcomes between different MASs, then the most efficient patient-centred approach needs to be adopted to maximize the benefits to the public.

The characteristics that could be investigated are: workload (new patients per WTE staff); nurse:doctor ratio; waiting time for first appointment; length of first appointment; number and types of post-diagnosis support (PDS) interventions provided; follow-up (frequency of appointments or time to first follow-up appointment). To evaluate these characteristics, their impact on patients' and carers' health-related quality of life needs to be assessed. These are currently being studied in a cohort of patients attending the MASs included in this study.²² In addition, the cost of MASs and the cost implications for patients is being determined so that the cost-benefit of these services can be evaluated.

We have also developed and provided a glossary of terms for staff posts that allow classification into six categories (Appendix A) and, similarly, for the plethora of terms used to describe psycho-social interventions (Appendix B). These should be of help in introducing some standardization of terminology in this field of research.

Limitations of this study

There were five potential limitations. The first concerned data collection. Attempts to collect accurate data on aspects of the governance and the organizational context of services were unsuccessful. This was because of the lack of an established

and widely agreed terminology among MAS staff as regard types of services defined in terms of 'single point of access' and 'stand-alone service'. The development of clear definitions and a meaningful classification is needed.²³ The other limitation of data collection was the lack of data on the allocation of staff time to different activities as this is not routinely collected and varies according to workload and staff availability.

The second limitation was that the grade or experience of staff could not be taken into account in the analyses of workload. Third, we limited the study to distinct MASs so did not consider the assessment of people that takes place within primary care as part of routine services.^{19–21,24,25}

Fourth, inevitably our search for a typology was limited to the variables we collected. Their selection was based on expert clinical advice and on practical considerations as to feasibility given the use of a mailed questionnaire (rather than site visits and interviews). It is possible that consideration of other variables might reveal a typology.

Finally, as with any study that relies on self-reporting, there is some uncertainty about the validity of the data. Phone discussions with all MAS sought to detect any inaccuracies but we cannot be sure all such errors were detected.

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Appendix

Appendix A: Categorization of staff

Administration

Administration Assistant
 Administration Coordinator
 Administration Manager
 Administrator
 Administration Support
 Appointments Clerk
 Assistant Team Manager
 Clinical Team Leader
 Deputy Team Manager
 Information and Advice Administrator
 Manager
 Medical Secretary
 Receptionist
 Secretary
 Senior Administrator
 SPA Administrator
 Team Administrator
 Team Coordinator
 Team Leader
 Team Manager
 Team Secretary
 Temporary Typist

Psychology

Assistant Psychologist
 Clinical Neuropsychologist
 Clinical Psychologist
 Neuropsychologist
 Lead Psychologist
 Psychologist
 Psychology Assistant
 Trainee Psychologist
 Consultant Psychologist

Allied Health Profession

Clinical Team Manager (OT)
 Clinician OT
 Mental Health Practitioner (OT)
 Occupational Therapist (OT)
 OT Technical Assistant
 Pharmacist
 Physiotherapist
 Senior OT
 Speech and Language Therapist

Continued

Appendix A: Continued*Advisory and Support*

Associate Practitioner (Support Worker)
Associate Mental Health Worker
Carer Support
Clinical Support Worker
Community Support Worker
Dementia Advisor
Dementia Care Advisor
Dementia Care Navigator
Dementia Lead
Dementia Navigator
Dementia Support Worker
Healthcare Support Worker
Housing Support Worker
Mental Health Team Worker
Mental Health Worker
Peer Worker
Service User Engagement Lead
Social Support Worker
Social Worker
STR Worker
Support Worker

Nursing

Admiral Nurse
Admiral Nurse (YPWD)
Advanced Practitioner (Nurse)
Assistant Practitioner
Associate Nursing Assistant
Associate Practitioner
Carer Liaison Worker (Nurse)
Charge Nurse
Clinic Nurse
Clinical Nurse Specialist
Clinician Nurse
CMHN (Team Leader)
CMHN Medication Support
CMHN Memory Assessor
Community Mental Health Nurse (CMHN)
Community Psychiatric Nurse
Dementia Lead (Nurse)
Deputy Service Manager (Nurse)
Independent Nurse Prescriber
Lead Nurse
Memory Nurse
Mental Health Nurse
Mental Health Practitioner
Nurse (Project Lead)

Continued

Appendix A: Continued

Nurse (RMN)
Nurse Consultant
Nurse Practitioner
Nurse Prescriber
Nurse RMN (RGN)
Nurse/Manager
Nursing Assistant
Senior Nurse Practitioner
Senior Practitioner
Senior Practitioner (CPN)
Specialist Dementia Nurse
Specialist Nurse
Staff Nurse
Staff RGN
Team Leader (Nurse)
Team Manager (Nurse)
Trainee Advanced Practitioner

Doctor

Associate Specialist
Consultant
Consultant Old Age Psychiatrist
Consultant Psychiatrist
Core Trainee Doctor
Doctor
Doctor (Psychiatry)
Geriatrician
GP Attachment
GP Trainee
Junior Doctor
Medic
Old Age Psychiatrist
Professor
Psychiatrist
SHO
Specialist
Specialist Doctor
Specialist Psychiatrist
Specialist Registrar
Specialty Doctor
Specialty Medic
SpR
Staff Grade Doctor
Staff Grade Psychiatrist
Trainee Doc

Appendix B: Categorization of PDS interventions*Adjustment to Diagnosis:*

Adjusting to Memory Difficulties Group
Education and Support
Education for Younger people with dementia
Post Diagnostic Adjustment Group
Post Diagnostic Counselling Group/Individual
Post Diagnostic Information Sessions
Post Diagnostic Psychological Intervention
Post Diagnostic Support Group
Post Diagnostic Therapy
Training and Education

Stress Anxiety or Depression:

Anxiety Management Group
Cognitive Behavioural Therapy
Cognitive Behavioural Therapy for Distressed Carers
Coping with Forgetting
Individual Psychology Intervention/Counselling
Individual Therapy
Life Story Work
Lifestyle Matters
Mood Management
Worried About Memory Sessions

Help for Families and Caregivers:

Carer Education
Carer Information
Carer Support Group
Carers Day Program
Carers Group
Carers Therapy
Caring and Coping with loss in dementia (For carers)
Creative Writing for Carers
Information Support Programme

Improving and Maintaining Cognitive Function:

Cognitive Stimulation Therapy
MCI Group
Memory Group
Memory Matters
Memory Strategy Group
Mindfulness

Maintaining Quality of Life:

Art Group
Living Well With Dementia

Continued

Appendix B: Continued

Music Group/Therapy
Reading Group
Recovery College
Reminiscence Group

Physical Health Support:

Falls Group
Individual OT programmes
Occupational Therapy
Physiotherapy group
Understanding the Importance of Physical Health

Couples/Families/Relationships/Communication:

Dementia Awareness
Dementia Discovery/Recovery Course
Dementia Workshops
Drop in Sessions
Living at Home with Dementia
Making Memories Trips
Memory Support Group
Men's Group
PALS
Peer Support Group
Psycho-Ed Group
Support Groups for Early Stage Dementia