

Memory assessment service for  
the early identification and care  
of people with dementia

**Commissioning guide**  
Implementing NICE guidance

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## Memory assessment service for the early identification and care of people with dementia

This commissioning guide provides support for the local implementation of NICE clinical guidelines through commissioning, and is a resource to help health professionals in England to commission an effective memory assessment service for the early identification and care of people with dementia.

This commissioning guide should be read in conjunction with the following NICE guidance:

- [NICE–SCIE clinical guideline CG42 ‘Dementia: supporting people with dementia and their carers in health and social care’](#)
- [NICE technology appraisal TA111 ‘Donepezil, galantamine, rivastigmine \(review\) and memantine for the treatment of Alzheimer’s disease’](#).

The clinical guideline covers clinical and cost effectiveness in detail and underpins the content of this guide.

The NICE guideline should also be read with the Department of Health National Dementia Strategy.

The guide:

- [makes the case for commissioning a memory assessment service](#)
- [specifies service requirements](#)
- [helps you determine local service levels](#)
- [helps you ensure corporate and quality assurance.](#)

The full text of this commissioning guide is accessed from the navigation menu on the right hand side of the screen. The associated [commissioning tool](#) is available until 25 June 2010 to primary care organisations in England who are already registered to use the tool. New registrations for the existing commissioning tool will not be possible after 31 March 2010.

From 1 April 2010 the new freely available [commissioning and benchmarking tool can be downloaded here](#). There is no need to register.

We are keen to improve the commissioning guides in order to better meet the needs of commissioners. Please [send us your ideas for future topic-specific guides or other comments](#).

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**[Topic-specific Advisory Group: memory assessment service](#)**

# Commissioning a memory assessment service for the early identification and care of people with dementia

Memory assessment services offer a responsive service to aid the early identification of dementia, and include a full range of assessment, diagnostic, therapeutic and rehabilitation services. Memory assessment services ensure an integrated approach to the care of people with dementia and the support of their carers, in partnership with local healthcare, social care and voluntary organisations<sup>[1]</sup>, and have been shown to significantly improve the quality of life of carers and people with dementia<sup>[2]</sup>.

Dementia refers to a syndrome characterised by a deterioration of cognitive functions that is usually progressive and eventually severe. There are many types of dementia, of which Alzheimer's disease is the most prevalent accounting for over 50% cases<sup>[3]</sup>.

Dementia is one of the most pressing challenges facing health and social care in the UK. The direct costs of Alzheimer's disease alone exceed the total costs of stroke, cancer and heart disease combined, and the overall economic burden has been estimated to be over £14 billion per year in the UK<sup>[4]</sup>.

Dementia affects one person in twenty over the age of 65 years, and one in five of those over the age of 80. It is estimated that the number of people with dementia in England will have risen from the current 574,000 to 793,000 by 2021, substantially increasing the already considerable financial and social burdens of this disorder<sup>[5]</sup>.

In current practice, the diagnosis of dementia is often delayed for several years after the initial onset of symptoms. Experts and the Department of Health agree that early diagnosis and intervention in dementia is cost-effective, yet there is a significant diagnosis gap, and only between a third and a half of people with dementia ever receive a formal diagnosis<sup>[6]</sup>. The early recognition and detection of dementia enables people with dementia, their families and clinicians to plan more effectively for the future<sup>[7]</sup> and can improve quality of life for both the person with dementia and their carer(s)<sup>[8]</sup>.

Primary care is often the point of first medical contact for people with suspected dementia and hence is the cornerstone of ensuring early detection and intervention, as well as effective ongoing management<sup>[9]</sup>. Early detection and intervention enables more timely access to treatments<sup>[10]</sup> and ultimately reduces total care expenditure by delaying the need for long-term care and other costly outcomes<sup>[8]</sup>.

## **Benefits**

The potential benefits of robustly commissioning an effective memory assessment service for the early identification and care of people with dementia include:

- **providing a cost-effective way of significantly increasing the number of people seen for early diagnosis and intervention**
- **reducing total care expenditure** by delaying the time to nursing home admissions and other costly outcomes<sup>[8]</sup>
- **breaking down the stigma of dementia and potential barriers to recognition/diagnosis, and reducing refused referrals**
- **improving the quality of life of people with dementia and their carers** by promoting and maintaining the independence, including mobility, of people with dementia for as long as possible
- **improving performance and patient-centred clinical care** through implementing the recommendations outlined in [NICE–SCIE clinical guideline CG42 on dementia](#)
- **reducing inequalities** and improving access to appropriate treatment and support
- **increasing patient choice**, and improving partnership working, patient experience and engagement
- **better value for money**, through helping commissioners to manage their commissioning budgets more effectively – this may include opportunities for commissioners to undertake local service redesign to meet local requirements in novel ways.

### ***Key clinical issues***

Key clinical issues in providing an effective memory assessment service for the early identification and care of people with dementia are:

- **accurately identifying and referring** all people who present with signs and symptoms of possible early dementia
- **ensuring that appropriate referral pathways are in place**
- **providing comprehensive assessment and diagnosis** of dementia, including subtype diagnosis
- **providing an integrated approach** to care coordination and implementation across all agencies involved in the treatment and care of people with dementia and support of their carers
- **[providing a quality assured service](#)**.

### ***National priorities***

National priorities and initiatives relevant to commissioning a memory assessment service for the early identification and care of people with dementia include:

- [Living well with dementia: a National Dementia Strategy](#)
- [‘World class commissioning’](#).

- [‘The NHS in England: The operating framework for 2009/10’](#).
- [‘National service framework for mental health: modern standards and service models’](#).
- [‘National service framework for older people’](#).
- [‘Everybody’s business. Integrated mental health services for older adults: a service development guide’](#).
- [‘Commissioning framework for health and well-being’](#).
- National Audit Office report [‘Improving services and support for people with dementia’](#).
- [‘Delivering the 18 week patient pathway’](#).
- The [‘Single assessment process’](#).
- The [‘Care closer to home’](#) initiative outlined in chapter 6 of the white paper ‘Our health, our care, our say’.
- Considering the impact of [patient choice](#).
- [‘A stronger local voice: a framework for creating a stronger local voice in the development of health and social care services’](#).
- Implementation of NICE clinical and public health guidelines. These are core standards, and performance against these standards will be assessed by the [Care Quality Commission](#) in line with [‘Standards for better health’](#).

Although many or all of these priorities may be relevant to the services nationally, your local service redesign may address only one or two of them.

## **References**

1. National Institute for Health and Clinical Excellence (2006) [Dementia: supporting people with dementia and their carers in health and social care. NICE–SCIE clinical guideline 42](#). London: National Institute for Health and Clinical Excellence.
2. Wanless D (2006) [Securing good care for older people: taking a long-term view](#). Wanless Social Care Review. London: Kings Fund.
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4. Lowin A, McCrone P, Knapp MRJ (2001) [Alzheimer’s disease in the UK. Comparative evidence on costs illness and volume of health services research funding](#). International Journal of Geriatric Psychiatry 16: 1143–8.
5. Kings College London and London School of Economics (2007) [Dementia UK. A report to the Alzheimer’s society on the prevalence and economic costs of dementia in the UK](#). London: Alzheimer’s Society.

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9. Department of Health (2001) [National service framework for older people: modern standards and service models](#). London: Stationery Office.
10. Audit Commission (2000) [Forget me not: mental health services for older people](#). London: Audit Commission.

# Specifying a memory assessment service for the early identification and care of people with dementia

## *Service components*

The key components of a memory assessment service for the early identification and care of people with dementia are:

- early identification and referral of people with a possible diagnosis of dementia
- [developing a high-quality service for dementia assessment, diagnosis and management.](#)

## **Early identification and referral of people with a possible diagnosis of dementia**

Early diagnosis and intervention in dementia is cost-effective yet only between a third and a half of people with dementia ever receive a formal diagnosis<sup>[1]</sup>.

People with symptoms associated with the possible onset of dementia often do not present to their GP because of fear and the stigma associated with a diagnosis of dementia. The attitudes of GPs to the disease can also hamper diagnosis, with many holding the view that little can be done<sup>[2]</sup>.

The National Audit Office report on improving services and support for people with dementia<sup>[1]</sup> suggests that memory assessment services can help to break down barriers and reduce stigma by:

- being called 'memory' services rather than 'mental health' or 'old age psychiatry' services
- improving communication
- moving away from intimidating psychiatric or other hospital settings to a primary care environment.

Currently, people with suspected dementia can be referred to a variety of places for confirmation of the diagnosis, including memory clinics, community mental health teams, and neurologists or old age psychiatrists in secondary care. Commissioners should consider reviewing local practice and referral processes and protocols if these are not in line with the recommendations of the [NICE–SCIE clinical guideline on dementia](#).

The [NICE–SCIE clinical guideline on dementia](#) contains the following recommendations.

- 'Memory assessment services (which may be provided by a memory assessment clinic or by community mental health teams)

should be the single point of referral for all people with a possible diagnosis of dementia.’

- ‘Primary healthcare staff should consider referring people who show signs of mild cognitive impairment (MCI) for an assessment by memory assessment services to aid early identification of dementia, because more than 50% of people with MCI later develop dementia.’
- ‘Those undertaking health checks as part of health facilitation for people with learning disabilities should be aware of the increased risk of dementia in this group. Those undertaking health checks for other high-risk groups, for example those who have had a stroke and those with neurological conditions such as Parkinson’s disease, should also be aware of the possibility of dementia.’

### **Developing a high-quality service for dementia assessment, diagnosis and management**

The diagnosis and general management of dementia is described in detail in [NICE–SCIE clinical guideline CG42 on dementia](#), which recommends that memory assessment services should:

- offer a responsive service to aid early identification and include a full range of assessment, diagnostic, therapeutic and rehabilitation services to accommodate the needs of people with different types and all severities of dementia, and the needs of their carers and family (see the [clinical guideline](#) for further detail on the recommendations made for each service component)
- ensure an integrated approach to the care of people with dementia and the support of their carers, in partnership with local healthcare, social care and voluntary organisations
- offer follow-up to people identified with MCI (including those with memory impairment, which may be absent in the earlier stages of non-Alzheimer’s dementias) to monitor cognitive decline and other signs of possible dementia in order to plan care at an early stage.

Memory assessment services are typically provided in psychiatric hospitals, by community mental health teams and in general hospitals. Commissioners may wish to consider the potential for locating such services (or aspects of such services) in primary care, where they may be provided by practitioners with a special interest in dementia.

Commissioners may wish to consider delivering a memory assessment service in a number of different ways, and mixed models of provision may be appropriate across a local health economy.

Local stakeholders, including [service users](#), their carers and the voluntary sector should be involved in determining what is needed from a memory

assessment service in order to meet local needs. The service should be patient-centred and integrated with other elements of care for people with cognitive impairment/dementia. Commissioners should consider joint local planning, together with the use of pooled budgets or joint funding of services where appropriate, in order to achieve a whole-systems approach to the consultation, planning, commissioning, delivery and monitoring of such services.

The NICE–SCIE clinical guideline on dementia recommends that the publication '[Everybody's business. Integrated mental health services for older adults: a service development guide](#)' is used as a framework for the planning, implementation and delivery of specialist mental health services for older adults, including memory assessment services. When developing integrated mental health services, commissioners should be aware that younger adults can also be diagnosed with dementia and that their needs will also have to be met.

The service specification needs to consider:

- the required competencies of, and training for, staff responsible for providing the service
- the expected number of patients (this should take into account how quickly any changes in service provision are likely to take place)
- ease of access and service location; commissioners should engage with service users and other relevant individuals and organisations locally
- care and referral pathways
- information and audit requirements, including IT support and infrastructure
- planned service improvement, including redesign, quality, equitable access, and referral-to-treatment times according to the [18 week patient pathway](#), or equitable waiting times locally for those services currently outside 18 weeks
- [service monitoring criteria](#).

Useful sources of information may include:

- National Audit Office report '[Improving services and support for people with dementia](#)'.
- '[Everybody's business. Integrated mental health services for older adults: a service development guide](#)'.
- The '[NHS networks: learning from practice](#)' database offers examples of innovative commissioning across the NHS and its partners.
- The '[Map of medicine](#)' provides an information resource that visually organises the latest evidence and best practice guidelines.

- The [NICE 'shared learning' database](#) offers examples of how organisations have implemented NICE guidance locally.
- [Implementation advice for NICE–SCIE clinical guideline CG42 on dementia](#).

## ***References***

1. National Audit Office (2007) [Improving services and support for people with dementia](#). London: The Stationery Office.
2. Audit Commission (2002) [Forget me not 2002: developing mental health services for older people in England](#). London: Audit Commission.

# Determining local service levels for a memory assessment service for the early identification and care of people with dementia

## ***Benchmarks for a standard population***

Available data suggest that the indicative benchmark rate for new referrals into a memory assessment service is **0.19%**, or 190 per 100,000 population, per year.

For a **standard primary care trust** population of 250,000, the average number of people requiring referral to a memory assessment service would be **475** per year.

For an **average practice** with a list size of 10,000, the average number of people requiring referral to a memory assessment service would be **19** per year.

This represents a minimum expected rate of referral, because a large proportion of people who develop dementia are currently likely to remain undiagnosed, or will not have their condition diagnosed until the disease has progressed<sup>[1]</sup>. Therefore commissioners need to consider planning for increased activity to reflect current unmet needs of their population.

This service is likely to fall under [programme budgeting](#) category 205B (mental health disorders – organic mental disorders).

Examine the [assumptions used in estimating these figures](#).

Use the memory assessment service [commissioning and benchmarking tool](#) to determine the level of service that might be needed locally and to calculate the cost of commissioning the service using the indicative benchmark and/or your own local data.

## ***Further information***

Sources of further information to help you in assessing local health needs and reducing health inequalities include:

- Annex A of the '[Commissioning framework for health and well-being](#)' outlines the process and data needed to undertake a joint strategic needs assessment.
- Department of Health '[Delivering quality and value – focus on benchmarking](#)'.
- NICE '[Health equity audit – learning from practice briefing](#)'.

- The '[No delays achiever](#)' provides access to service improvement tools aimed at reducing time between referral and treatment.
- The '[Practice-based commissioning comparators reporting service](#)' provides access to a range of indicators and activity data at practice level, enabling a better understanding of local commissioning activity, referral patterns and outcomes.
- The '[Disease management information toolkit \(DMIT\)](#)' is a good-practice tool for decision-makers, commissioners and deliverers of care for people with long-term conditions, which presents data on conditions that contribute to high numbers of emergency bed days. It models the effects of possible interventions that may be commissioned at a local level and helps users to consider the likely impact of commissioning options.
- [PRIMIS+](#) provides support to general practices on information management, recording for, and analysis of, data quality, plus a comparative analysis service focused on key clinical topics.

## **References**

1. Wilkinson D, Sganga A, Stave C et al. (2005) [Implications of the Facing Dementia Survey for health care professionals across Europe](#). International Journal of Clinical Practice 59: 27–31.

## Assumptions used in estimating a population benchmark

The assumptions used in estimating a population benchmark rate for new referrals into a memory assessment service of 0.19%, or 190 per 100,000 population, per year are based on the following sources of information:

- [epidemiological data](#) on the prevalence/incidence of dementia
- [current practice](#) to establish the number of existing patients in contact with GP services
- [published research](#) and local audits on the diagnostic profile of people referred to a memory assessment service
- [expert clinical opinion](#) of the topic-specific advisory group, based on experience in clinical practice and literature review.

### *Epidemiological data*

#### **Incidence of dementia**

The Medical Research Council Cognitive Function and Ageing Study<sup>[1]</sup> used identical methodology in five diverse sites across England and Wales to assess the annual incidence of dementia by age and sex. The study found that rates rise with age, particularly above the age of 75, and that the rate of increase was marked in both sexes.

Application of the age- and sex-specific rates from the Medical Research Council Cognitive Function and Ageing Study to estimates for the population of England in mid-2005 suggests that the annual incidence of dementia in the population is 0.31%. This represents the proportion of the population that is likely to develop dementia within 1 year.

Currently, a large proportion of these people with dementia are likely to remain undiagnosed or will not have their condition diagnosed until the disease has progressed<sup>[2]</sup>.

#### **Prevalence of dementia**

A report to the Alzheimer's Society by the London School of Economics and Kings College London suggests that there are around 684,000 people with dementia in the UK, around 574,000 (84%) of whom are resident in England. This corresponds to a population prevalence for England of 1.1%. Currently a large proportion of these people are likely to be undiagnosed<sup>[3]</sup>.

#### **Mild cognitive impairment**

Some people are identified with symptoms of cognitive decline but do not meet clinical criteria for the diagnosis of dementia. These people are said to have mild cognitive impairment (MCI)<sup>[4]</sup>.

The definition of MCI used within the [NICE–SCIE clinical guideline CG42](#) on dementia is a syndrome defined as cognitive decline greater than expected for an individual's age and level of education but which does not interfere notably with activities of daily life<sup>[4]</sup>. MCI is heterogeneous in clinical presentation, and there is no clear strategy for diagnosing people with suspected MCI<sup>[4]</sup>.

A proportion of people with MCI have been shown to develop some form of dementia over time. The rate of conversion from MCI to dementia depends on the diagnostic criteria used, the type of cohort studied and the length of observation time from diagnosis of MCI<sup>[4]</sup>.

In people with MCI who are referred to memory assessment services and other specialist centres, the rate of conversion to dementia (generally Alzheimer's disease) has been estimated to be around 18% per year<sup>[5]</sup>.

Several different types of MCI have been proposed<sup>[6,7]</sup>, to include a range of cognitive impairments and deficits, including deficits in the non-memory domain. Studies that have been conducted using these definitions have estimated a population prevalence of MCI of between 5% and 25%<sup>[8–10]</sup> in older people. The value depends on the specific diagnostic criteria used and the type of cohort studied<sup>[6]</sup>.

However, most people with MCI or subjective memory impairment – the perception of memory problems by people themselves or their carers – do not report any symptoms to their general practitioner (GP) or may present with symptoms other than cognitive impairment<sup>[4]</sup>.

### ***Current practice***

The General Practice Research Database (GPRD) holds data for over 3.4 million currently registered patients from a sample of general practices (GPs) in England, Wales, Scotland and Northern Ireland, and is a representative UK sample by age and sex.

Data on the incidence of dementia in people aged 60 years and over were extracted from the GPRD to determine age- and sex-specific rates, which were then applied to the population of England in mid-2005. The results of the analysis suggest that the annual incidence of diagnosed dementia is 0.10% in the population as a whole, and 0.49% in the population aged 60 and over.

The estimated prevalence of diagnosed dementia based on GPRD data is 0.40% in the population as a whole, and 1.89% in the population aged 60 and over.

Although the analysis using GPRD data is based on people with dementia who are aged 60 and over, the use of these data is unlikely to significantly underestimate the prevalence or incidence figures. This is because onset of dementia in older people (over 65) accounts for around 98% of all dementia cases, and in the population with early onset of dementia, people aged 60–65 account for around one-third of cases in this group<sup>[3]</sup>.

It is not possible to analyse GPRD data to estimate the number of people who may have MCI, subjective memory impairment or a related condition that would be suitable for referral to a memory assessment service. This is because many people with MCI do not report symptoms to their GP<sup>[4]</sup>.

The quality of data from general practice databases depends on the coding of conditions used by GPs. This means that there may be a discrepancy between data from GP practices and the actual incidence and prevalence of diagnosed dementia in primary care. The numbers of people diagnosed with dementia and the percentage of those reviewed by their GP are being recorded in primary care as part of the [Quality and Outcomes Framework \(QOF\)](#). For guidance relating to the technical requirements for correctly recording QOF information, see the [QOF business ruleset](#).

## ***Published research and local audits***

### **Diagnostic profile of people referred to memory assessment services**

Not all people attending a memory assessment service will have dementia. Some may have cognitive impairment that does not meet the criteria for dementia or conditions associated with cognitive symptoms, whereas others may have no objective cognitive impairment<sup>[11]</sup>.

Luce and coworkers (2001)<sup>[12]</sup> examined the diagnostic profile of 100 consecutive referrals to a memory assessment service. They found that around 57% of the people attending had probable or possible dementia, with the remainder having other conditions or cognitive deficits that did not meet the criteria for dementia.

Banerjee and coworkers (2006)<sup>[13]</sup> examined the diagnostic profile of people referred to a memory assessment service during an 18-month period. They found that 63% of people referred to the service had some form of dementia, with the remainder having either other conditions or no illness.

Other published research<sup>[11]</sup> suggests that the proportion of people attending memory assessment services who have some form of dementia is 43%.

The diagnostic profile of people referred to a memory assessment service based on two service audits is given in the table below.

	People with condition (%)	
	South Manchester memory clinic	Croydon memory service
Dementia	43%	65%
Mild cognitive impairment	37%	17%
Depression	14%	4%
No illness	3%	10%
Other	3%	4%

The figures from published research and service audits depend on the nature of local referral patterns and of the memory assessment service itself.

Taking the average of estimates from published research and audits suggests that around 54% of people attending memory assessment services are likely to have dementia, and 46% are likely to have either other conditions such as MCI or no illness.

### ***Expert clinical opinion***

The consensus opinion of the topic-specific advisory group was that where memory assessment services are available there is likely to be an increase in the referral of people with suspected dementia for assessment.

A benchmark determined by current activity (based on areas with and without memory assessment services) should be considered as a minimum expected rate of referral. Therefore commissioners should consider planning for increased activity to reflect current unmet need.

### ***Conclusions***

Based on the epidemiological data and other information outlined above, it is concluded that the proportion of the population suitable and identified for referral to a memory assessment service is 0.19% of the population as a whole and 0.91% of the population aged 60 years and over. This is based on the following assumptions:

- the annual incidence of diagnosed dementia for the whole population is 0.1%
- the proportion of people attending a memory assessment service who have conditions other than dementia is around 46%.

Increasing the estimate of 0.1% to take into account referrals of people without dementia gives a whole-population estimate of 0.19%, and an estimate of 0.91% of the population aged 60 years and over.

Hence a population benchmark for referral to a memory assessment service of 0.19% is considered appropriate. This represents a minimum expected rate of referral because a large proportion of people who develop dementia are currently likely to remain undiagnosed or will not have their condition diagnosed until the disease has progressed<sup>[2]</sup>. Therefore commissioners may wish to consider planning for increased activity to reflect current unmet needs of their population.

Sensitivity analysis based on the differing age and sex structures within primary care organisations suggests that in around 90% of primary care organisations variation around this population benchmark of 0.19% will be within  $\pm 0.07\%$ , giving a range of 0.12–0.26%.

Use the memory assessment service [commissioning and benchmarking tool](#) to determine the level of service that might be needed locally and to calculate

the cost of commissioning the service using the indicative benchmark and/or your own local data.

## **References**

1. Matthews FC, Brayne C (2005) [The incidence of dementia in England and Wales: findings from the five identical sites of the MRC CFA study](#). PLOS Medicine 2: 753–63.
2. Wilkinson D, Sganga A, Stave C et al. (2005) [Implications of the Facing Dementia Survey for health care professionals across Europe](#). International Journal of Clinical Practice 59: 27–31.
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6. Portet F, Ousset PJ, Visser PJ et al. (2006) [Mild cognitive impairment \(MCI\) in medical practice: a critical review of the concept and new diagnostic procedure](#). Report of the MCI working group of the European Consortium on Alzheimer's disease. Journal of Neurology, Neurosurgery and Psychiatry 77: 714–8.
7. Winbald B, Palmer K, Kivipelto M et al. (2004) [Mild cognitive impairment - beyond controversies, towards a consensus](#). Journal of Internal Medicine 256: 240–6.
8. Kumar R, Dear KBG, Christensen H et al. (2005) [Prevalence of mild cognitive impairment in 60- to 64-year-old community-dwelling individuals](#). Dementia and Geriatric Cognitive Disorders 19: 67–74.
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10. Purser JL, Fillenbaum GG, Pieper CF et al. (2005) [Mild cognitive impairment and 10-year trajectories of disability in the Iowa established populations for epidemiological studies of the elderly cohort](#). Journal of the American Geriatrics Society 53: 1966–72.
11. Hejl A, Høgh P, Waldemar G (2002) [Potentially reversible conditions in 1000 consecutive memory clinic patients](#). Journal of Neurology, Neurosurgery and Psychiatry 73: 390–4.

12. Luce A, McKeith I, Swann A et al. (2001) [How do memory clinics compare with traditional old age psychiatry services?](#) International Journal of Geriatric Psychiatry 16: 837–45.

13. Banerjee S, Willis R, Matthews D et al. (2007) [Improving the quality of care for mild to moderate dementia: an evaluation of the Croydon memory service model.](#) International Journal of Geriatric Psychiatry 22: 782–88

## The commissioning and benchmarking tool

[Download the memory assessment services commissioning and benchmarking tool.](#)

Use the memory assessment services commissioning and benchmarking tool to determine the level of service that might be needed locally and to calculate the cost of commissioning the service, as described below.

### ***Identify indicative local service requirements***

The indicative benchmark based on the national average for the population suitable and identified for referral to a memory assessment service is **0.19%**.

The commissioning and benchmarking tool helps you to assess local service requirements using the indicative benchmark as a starting point. With knowledge of your local population and its demographic, you can amend the benchmark to better reflect your local circumstances. For example, if your population is significantly younger or older than the average population, you may need to provide services for relatively fewer or more people.

### ***Review current commissioned activity***

You may already commission a memory assessment service for your population. You can download your own up-to-date secondary care activity data into the tool and data specifications and user notes are provided to help. You can review and amend the downloaded data for your population to calculate the service levels and cost of the service you currently commission. When commissioning outpatient appointments or activity outside of secondary care the tool provides you with tables that you can populate to help you calculate your total current commissioned activity and costs.

### ***Identify future change in capacity required***

Using the indicative benchmark provided, or your own local benchmark, you can use the commissioning and benchmarking tool to compare the activity that you might need to commission against your current commissioned activity. This will help you to identify the future change in capacity required. Depending on your assessment, your future provision may need to be increased or decreased.

When identifying future change in capacity required, commissioners should be aware that the indicative benchmark represents a minimum expected rate of referral, and they may wish to consider planning for increased activity to reflect current unmet need.

## ***Model future commissioning intentions and associated costs***

You can use the commissioning and benchmarking tool to calculate the capacity and resources needed to move towards the benchmark level, and to model the required changes over a period of 4 years.

Use the tool to calculate the level and cost of activity you intend to commission and to consider the settings in which the memory assessment services may be provided, comparing the costs of commissioning the service across the various settings. The tool is pre-populated with data on the potential recurrent and non-recurrent cost elements that may need to be considered in future service planning, which can be reviewed and amended to better reflect your local circumstances.

Commissioning decisions should consider both the clinical and economic viability of the service, and [take into account the views of local people](#). Commissioning plans should also take into account the costs of monitoring the quality of the services commissioned.

## Ensuring corporate and quality assurance

(Using guidance> Commissioning guides> Memory assessment service for the early identification and care of people with dementia)

Commissioners should ensure that the services they commission represent value for money and offer the best possible outcomes for patients. Commissioners need to [set clear specifications](#) for monitoring and assuring quality in the service contract.

Commissioners should ensure that they consider both the clinical and economic viability of the service, and any related services, and take into account [patients' and carers' views](#) and those of other stakeholders when making commissioning decisions.

A memory assessment service needs to:

- **be effective and efficient**
- **be responsive to the needs of patients and carers**
- **provide treatment and care based on best practice**, as defined in [NICE–SCIE clinical guideline CG42 on dementia](#)
- **deliver the required capacity**
- **be integrated** with other elements of care for people requiring memory assessment services; see '[Everybody's business. Integrated mental health services for older people: a service development guide](#)'
- **define agreed criteria for referral**, local [protocols](#) and the care pathway for people requiring memory assessment services
- **be patient-centred and provide equitable access**, ensuring that patients are treated with dignity and respect, are fully informed about their care and are able to make decisions about their care in partnership with healthcare professionals
- **demonstrate how it meets requirements under equalities legislation**
- **demonstrate value for money.**

### ***Local quality assurance***

Any mechanisms for quality assurance at a local level are likely to refer to the following:

- **Service and performance targets**, including estimated activity levels and case mix, waiting and referral-to-treatment times (ensuring that patients and carers do not experience unnecessary delays), and complaints procedures. When

estimated levels of activity have been determined for the local population requirements, commissioners may wish to monitor actual against planned activity levels and develop local strategies for the early identification and appropriate referral of people with suspected dementia.

- **Clinical quality criteria:** appropriateness of referral, consenting procedures, clinical protocols, length of time from assessment to treatment.
- **Audit arrangements:** frequency of reporting, reporting route and format, and dissemination mechanisms. This should include auditing the proportion of eligible people requiring a memory assessment service who are provided with care, and monitoring of patient outcomes and complications. Patient outcomes may include quality of life, independence including mobility, and number of people with integrated care. See [audit criteria for NICE–SCIE clinical guideline CG42 on dementia](#) for further information.
- **Health, safety and security:** infection control, waste management, confidentiality procedures, legislative requirements.
- **Equipment:** testing and calibration.
- **Patient satisfaction:** patient and carer perspective and perception of service provision, including access to written information (see audit arrangements above) and to counselling; complaints.
- **Staff competencies:** individual and team baseline requirements, monitoring and performance. The [NICE–SCIE clinical guideline CG42 on dementia](#) recommends that staff involved in the care of older people in the healthcare, social care and voluntary sectors have access to dementia-care training (skill development) that is consistent with their roles and responsibilities. The [implementation advice for NICE clinical guideline CG42 on dementia](#) suggests that a sustained programme of training, education and awareness raising for all staff, including GPs, would help to improve the recognition, detection and diagnosis of dementia.
- **Information requirements,** including both patient-specific information (NHS number, referring GP, provision of high-quality information to patients/carers) and service-specific information (referral-to-treatment times, workload trends, number of complaints).
- **The process for reviewing the service with stakeholders,** including decisions on changes necessary to improve or to decommission the service.
- **Achieving targets associated with equalities legislation.**

## ***Further information***

**General information** on quality and corporate assurance can be obtained from the following sources:

- The [National Patient Safety Agency](#) (NPSA) oversees the implementation of a system to report and learn from adverse events and near misses occurring in the NHS. The publication ‘Seven steps to patient safety’ provides an overview of patient safety and gives updates on the tools that the NPSA is developing to support patient safety across the health service.
- [NHS Alliance online resources](#). NHS Alliance is the representational organisation of primary care and primary care trusts, and provides them with an opportunity to network and exchange best practice. The alliance supports its members with an open-access helpline, in-house and joint publications and briefings, internal newsletters and a website.
- The [DH commissioning framework](#) provides guidance on the commissioning process in the context of the NHS reform agenda.
- [Implementation advice for NICE–SCIE clinical guideline CG42 on dementia](#)
- ‘[Delivering the 18 week patient pathway](#)’ provides a range of resources to support the key NHS objective to deliver an 18 week patient pathway from GP referral to the start of treatment by the end of 2008.
- NHS Institute for Innovation and Improvement support for commissioners, includes [Commissioning for Health Improvement](#) products to accelerate the achievement of world class commissioning; [The Productive Leader](#) programme to enable leadership teams to reduce waste and variation in personal work processes, and [Better care, better value indicators](#) to help inform planning, to inform views on the scale of potential efficiency savings in different aspects of care, and to generate ideas on how to achieve these savings.
- ‘[10 Steps to your SES: a guide to developing a single equality scheme](#)’. This guidance has been developed to assist NHS organisations that have a duty, as public authorities, to comply with the race, disability and gender public sector duties; and in anticipation of new duties in relation to age, religion and belief, and sexual orientation.

**Specific information** on quality and corporate assurance for a memory assessment service can be obtained from the following sources:

- [Better metrics](#) is a pragmatic project that provides clinically relevant measures of performance to support the development of

measurable local targets and indicators for local quality improvement projects. See mental health metric 9.16 'Responding to the needs of carers', mental health metric 9.18 'Appropriateness of treatment for people with dementia', and older age metric 10.07 'Population health and well-being'

- The '[Quality and outcomes framework \(QOF\)](#)' was designed to deliver substantial financial rewards for high-quality care. The framework sets out a range of national standards based on the best available research evidence. See '[QOF Business Ruleset](#)' for guidance relating to the technical requirements for correctly recording QOF information.
- '[Skills for health](#)' works with employers and other stakeholders to ensure that those working in the sector are equipped with the right skills to support the development and delivery of healthcare services.
- '[Skills for care](#)' supports employers in improving standards of care provision through training and development, workforce planning and workforce intelligence.

## **Topic-specific Advisory Group: memory assessment service**

A topic-specific advisory group was established to review and advise on the content of the commissioning guide. This group met once, with additional interaction taking place via email.

### **Professor Sube Banerjee**

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### **Mr David Norman**

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