RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

MSNAP
MEMORY SERVICES NATIONAL ACCREDITATION PROGRAMME

MSNAP Commonly Unmet Standards **2021 – 2022**

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Introduction

This report looks at a number of MSNAP standards which are commonly unmet by memory services undergoing a peer review. The report will detail the reasons why these areas are commonly unmet and provide some suggested recommendations for how to evidence these.

For an overview of the MSNAP peer review process and further information on our data collection process, please visit our website.

Contained within this report

We have aggregated data from 26 memory services that took part in the MSNAP peer review process from January 2021 to July 2022.

These services have been reviewed against the 7th edition of MSNAP standards[1] for memory services.

The data within this report has been compiled from services at the peer review stage. This is prior to any standards being changed to 'met' following a review process by the MSNAP Accreditation Committee.

How memory clinics can use this report

We hope that this report can be used to address any standards that are currently unmet in other services, with some suggestions for improvements or recommendations based on good practice examples.

The report is laid out into several sections in relation to the standard being referred to. Within each section, we have defined what the standard is asking for and why it is important that the standard is met by services. The information gathered for this section draws on references from the standards publication[1]. We have also summarised common reasons why the standards are not met to add some contextual information to the data. There are recommendations following this, which are drawn from suggestions provided by the MSNAP accreditation committee and peer review teams.

JARGON BUSTER

MSNAP: The Memory Services National Accreditation Programme is a quality improvement and accreditation network for services that assess, diagnose and treat dementia in the UK.

RCPsych: The Royal College of Psychiatrists is a professional body that is responsible for setting and improving standards in psychiatry.

CST: Cognitive Stimulation Therapy is a form of treatment for people with mild to moderate dementia.

iCST: Individual Cognitive Stimulation Therapy is similar to CST and is used for people with mild to moderate dementia that may not wish to partake in group settings.

NICE Guidelines: National Institute for Health and Care Excellence guidelines are evidence-based recommendations for health and care in England.

Executive Summary

No.	Type	Section	Standard	% Met
184	2	Section 6: Psychosocial Interventions	People who have participated in group Cognitive Stimulation Therapy (CST) have access to an age-appropriate maintenance CST programme.	38%
185	3	Section 6: Psychosocial Interventions	Patients have access to cognitive rehabilitation according to their clinical needs. Guidance: Cognitive rehabilitation constitutes an individualised approach where personally relevant goals are identified and the therapist works with the patient and his/ her family to devise strategies to address these. The emphasis is on improving performance in everyday life rather than on cognitive tests, building on the patient's strengths and developing ways of compensating for impairments.	58%
183	3	Section 6: Psychosocial Interventions	People with dementia have access to individual Cognitive Stimulation Therapy (iCST).	62%
181	3	Section 6: Psychosocial Interventions	An audit of the capacity to provide psychosocial interventions, and the uptake of psychosocial interventions offered is carried out every 2 years.	69%
191	3	Section 6: Psychosocial Interventions	People with dementia have access to art/ creative therapies.	69%
7	1	Section 1: Management	The service asks patients and carers for their feedback about their experiences of using the service and this is used to improve the service. Guidance: Feedback is independently sought (i.e. not by the clinical team). Their feedback is reviewed alongside other feedback to make it as accurate as possible. Staff members are informed of feedback from patients and carers.	73%
48	3	Section 2: Resources to support assessment and diagnosis	Staff members are able to access reflective practice groups at least every 6 weeks where teams can meet to think about team dynamics and develop their clinical practice.	77%
67	2	Section 2: Resources to support assessment and diagnosis	The team receives training, consistent with their roles, on undertaking nutritional screening using a validated nutritional risk assessment tool.	77%

Commonly Unmet Standards:

Cognitive Stimulation Therapy

Standard 184: People who have participated in group Cognitive Stimulation Therapy (CST) have access to an age-appropriate maintenance CST programme

Of the 26 memory services that were assessed against this standard, **62%** did not meet the standard at the point of their peer review visit.

Why is it important?

Cognitive Stimulation Therapy (CST) is an evidence-based treatment for people with mild to moderate dementia and involves patients engaging in a range of activities and discussions which are aimed at general improvement of their cognitive and social functioning. CST often takes place within a group setting[2].

CST is important as a way of treating people with dementia, particularly as an alternative to pharmacological interventions[3]. The provision of CST has been a recommendation within the MSNAP standards for the last 13 years.

Reasons for this standard frequently being unmet:

- Some services are not commissioned to provide maintenance CST, they are looking into developing this in the future; however, it would be something to approach the commissioners with.
- The team suggested that it may be about signposting and supporting other teams to provide CST so that patients and carers have access to it.
- Occupational therapists have previously run maintenance CST groups but do not currently do so.
- This would be looked into once the pilot has been done and groups are routinely in place.
- Some teams have their own CST programme but not maintenance CST due to their lack of capacity to do this.
- There is no capacity to provide maintenance CST within the service, but the Alzheimer's Society are looking at running a maintenance CST group with appropriately trained staff.
- Funding finished pre-pandemic for maintenance CST from a third-party charity, which will be rebranded as a general cognitive rehabilitation group; however, it is not currently in place.

Recommendations:

- To meet this standard, we recommend ensuring those that have participated in group CST have access to an age-appropriate maintenance CST programme.
- Accreditation reports should be used to aid potential agreements with commissioners to support the roll out of CST for services that are not commissioned to provide this.
- Services can pilot a maintenance CST programme which will give them a better idea of what will be required for a full programme.

Commonly Unmet Standards:

Cognitive Stimulation Therapy

Standard 183: People with dementia have access to individual Cognitive Stimulation Therapy (iCST)

Of the 26 memory services that were assessed against this standard, **38%** did not meet the standard at the point of their peer review visit.

Why is it important?

Individual Cognitive Stimulation Therapy (iCST) is likely to increase access to this treatment, as there can be barriers for people with dementia in accessing groups including personal preferences, for example, they do not like attending group settings or they have health and mobility issues, such as being unable to walk[4].

iCST is delivered in a one-to-one setting, making it person-centred, and if it is delivered by a familiar carer it is particularly beneficial as they have an understanding of the patient[5].

The provision of iCST has been a recommendation for services within the MSNAP standards for the last six years.

Reasons for this standard frequently being unmet:

- Many services had to pause iCST due to the pandemic. Some services developed activity packs to send to patients and carers which occupational therapists were heavily involved in.
- Some services do not offer iCST or are in the planning stage of providing iCST.
- In some instances, CST is only offered as a group not individually; however, the service gives patients and carers information on how to continue to implement CST principles in the home through an information pack and by involving them at the end of the CST course.

Recommendations:

- To ensure the effective roll-out and implementation of iCST, it is recommended that services run a pilot group to start with, to get a sense of how it is working before full-roll out, and to identify the resources and staffing required.
- Services that have paused their iCST programme should ensure a clear timeframe is established as to when this will be initiated again. This should be provided as reassurance to patients.
- For services that do not provide iCST, it is recommended that individual information is offered to patients and their carers on how to implement the principles underpinning CST within their own environments and home settings where appropriate.

Commonly Unmet Standards:

Cognitive Rehabilitation

Standard 185: Patients have access to cognitive rehabilitation according to their clinical needs.

Of the 26 memory services that were assessed against this standard, **42%** did not meet the standard at the point of their peer review visit.

Why is it important?

Cognitive rehabilitation is a personalised approach which is aimed at enabling people with dementia to maintain as much of their independence and manage everyday activities. It is based on a problem-solving framework[6].

A number of clinical professions can be cognitive rehabilitation practitioners, such as clinical psychology, occupational therapy or nursing. The goal is to improve functioning in areas that the person with dementia identifies as relevant and important to them[7].

This approach was adapted for people with dementia, and is consistent with the values of person-centred dementia care[8].

This is usually offered as an individual intervention instead of a group session[9].

Reasons for this standard frequently being unmet:

- The team is planning for the new occupational therapist in the team to do work around cognitive rehabilitation.
- The memory service is currently engaged in an ongoing project identifying what interventions they can offer in the future, including cognitive rehabilitation if possible.
- Aspects of cognitive rehabilitation are involved in the service's post-diagnostic support and influence a lot of what the service does, but the team do not offer specific sessions.
- The service does not provide access to cognitive rehabilitation. There are discussions around individual approaches, particularly when patients are entering the palliative stage.
- Services do not currently have any members of staff trained in offering cognitive rehabilitation.

Recommendations:

- Services should ensure there is access to cognitive rehabilitation training for staff, which would allow patients and carers to have access to sessions in-house.
- Services should look at other organisations who can provide access to sessions and establish a joint working agreement with them to enable patients and carers to access cognitive rehabilitation as needed.

Commonly Unmet Standards:

Psychosocial interventions

Standard 181: An audit of the capacity to provide psychosocial interventions, and the uptake of psychosocial interventions offered is carried out every two years

Of the 26 memory services that were assessed against this standard, **31%** did not meet the standard at the point of their peer review visit.

Why is it important?

Psychosocial interventions are good for understanding the needs of individuals and improve cognitive abilities, enhance emotional well-being, reduce behavioural symptoms and promote daily functioning[10].

These interventions are beneficial for carers too through support programmes[10].

These interventions for dementia are vast and include lots of different therapies such as creative, sensory, and activity-based interventions[11].

Reasons for this standard frequently being unmet:

- The team does a general audit on uptake but there is not yet a robust system in place to do this; the team is considering working more closely with psychology team to develop this. There is a county-wide capacity audit that takes place, but this is not focused on psychosocial interventions.
- As the service does not currently provide ongoing interventions, audits of the psychosocial provision available are not possible at this time.
- Services do not have an audit of the capacity to provide and uptake psychosocial interventions every two years; however, they do collate data on the uptake of psychosocial interventions.

Recommendations:

- For services that do not currently provide ongoing interventions, they should consider auditing interventions currently provided by the Alzheimer's Society.
- Services that are collecting data on the uptake of psychosocial interventions should complete an audit to determine uptake and use the findings to address any gaps in access.

Commonly Unmet Standards:

Creative and art therapies

Standard 191: People living with dementia have access to art/creative therapies

Of the 26 memory services that were assessed against this standard, **27%** did not meet the standard at the point of their peer review visit

Why is it important?

Access to creative and art therapies has several benefits for patients with a diagnosis of dementia. In addition to general intellectual stimulation, creative arts also enable patients to communicate in a different way: they provide a means for self-expression and a catharsis of negative emotions[13].

Improving communication and social skills, creative arts may help caregivers understand and clarify the mood and inner world of the patient at that a particular point in time. Patients are able to express their feelings with other patients through group activities and form positive relationships[14].

The provision of a non-verbal channel of communication means that patients are able to overcome inadequacies of self-expression and release negative emotions. This is said to improve attention, reduce behavioural and psychological symptoms and improve patient quality of life and social skills[12].

The MSNAP standards have included this area to enable people living with dementia to access creative therapies for the past nine years.

Reasons for this standard frequently being unmet:

- Creative art therapy is not available in the local community. There are no organisations in the area that offer this.
- The service provides access to art classes rather than art therapy. The principal ways in which art therapy differs from art classes is that it is facilitated by a trained art therapist, involves a therapeutic relationship, has self-expression as the main goal and focuses on the creative process as opposed to the final art product.

Recommendations:

- Services could think more broadly about how interventions can be tailored to support patients to access a form of art/creative therapies, which encompasses any type of non-verbal expression including music.
- Services can look into therapy groups such as Singing for the Brain. The therapy does not have to be provided in-house; services should local third sector organisations for available options.

Commonly Unmet Standards:

Patient and carer feedback

Standard 7: The service asks patients and carers for their feedback about their experiences of using the service and this is used to improve the service

Of the 26 memory services that were assessed against this standard, **27%** did not meet the standard at the point of their peer review visit.

Why is it important?

This is a core Royal College of Psychiatrists standard for mental health services and is also in accordance with the NICE guidelines.

It is important that people using mental health services are asked about their direct experiences and that their feedback is used to improve services. Services users will have a unique insight into the service through their individual experiences and capturing this feedback is essential in the reviewing, planning and, ultimately, improvement of mental health services[15][16].

This standard on seeking feedback from patients and carers on their experiences of the memory service has been included within the MSNAP standards since the first edition, which was published in 2009.

Reasons for this standard frequently being unmet:

- The majority of patients and carers surveyed and spoken to on the review day recall being asked for feedback, but the service was not able to demonstrate how the feedback is used in making improvements.
- Services may ask for feedback in an informal and inconsistent way, for example verbally asking patients and carers about their experiences and not recording the feedback or not asking all patients and carers routinely.
- Feedback surveys such as Friends and Family Test alone are often too generic and do not relate to the work of the memory service in a meaningful way.
- Sample sizes are often too small and not representative of the number of patients and carers that the service sees.

Recommendations:

- It is recommended that services improve documentation of all feedback collected by patients and carers, which can be used to make service improvements.
- Services could demonstrate compliance through anonymised copies of questionnaires sent out to service users and consider incorporating a “you said, we did” board to evidence how the feedback is being used to improve the service.
- Consider working with any existing service user focus groups or development/engagement groups to come up with more effective ways to obtain feedback from patients and carers.

Commonly Unmet Standards:

Reflective practice

Standard 48: Staff members are able to access reflective practice groups at least every six weeks where teams can meet to think about team dynamics and develop their clinical practice

Of the 26 memory services that were assessed against this standard, **23%** did not meet the standard at the point of their peer review visit.

Why is it important?

Reflective practice enables staff to continually assess their professional experiences and progress, highlighting their individual strengths as well as identifying where improvements may be needed[17].

Reflection allows teams to address any issues that have occurred in practice and discuss these in an open and honest manner. It also provides the opportunities for shared learning, education and professional development and helps practitioners to make sense of challenging and complicated cases.

Reflective practice provides extra support to staff and their mental and emotional wellbeing. In these sessions, staff are able to take ownership of their thoughts, feelings and behaviours and consider how these might impact on their work and what changes are appropriate to make[18].

Reasons for this standard frequently being unmet:

- The majority of staff agree that that have opportunities for informal reflection in their supervision session and team meetings and some services confused this for reflective practice provision. Although peer support is available, there is no formal reflective practice group with a facilitator.
- Reflective practice was suspended during COVID and has not restarted due to things like backlog and waiting list concerns.

Recommendations:

- Services should schedule formal reflective practice sessions with a facilitator, consider making these sessions virtual for ease of access.
- If an external facilitator is not feasible for the service to access, staff should be offered peer group supervision which encompasses reflective practice themes.
- Ensure that staff have a safe space to raise any issues or concerns that may have come up in practice, with the opportunity to determine ways to overcome these moving forward. This could be in a group setting or one-to-one with line managers.

Commonly Unmet Standards:

Nutritional risk assessments

Standard 67: The team receives training, consistent with their roles, on undertaking nutritional screening using a validated nutritional risk assessment tool

Of the 26 memory services that were assessed against this standard, **23%** did not meet the standard at the point of their peer review visit.

Why is it important?

Malnutrition is a risk factor and it can negatively impact a patient's clinical outcomes, quality of life, body function and autonomy. It is important that any risk of malnutrition is identified in a timely manner in order for the patient to be able to receive adequate nutritional support[19].

A systematic and standardised approach to identifying issues with nutrition is needed and this can be addressed by using a nutritional screening tool and training more staff to use this tool.

Nutritional risk screening tools should be part of a specific clinical protocol that results in a plan of action if nutritional problems are identified.

Reasons for this standard frequently being unmet:

- Malnutrition Universal Screening Tool (MUST) training is available but few staff have completed it as it is not mandatory for all staff.
- Some staff use the MUST tool to conduct nutritional screening, however, have not been formally trained in the use of this tool.
- The memory service does not perform nutritional risk assessments as these are conducted by local GP.

Recommendations:

- Services should arrange for staff to receive training on using a validated nutritional screening tool (e.g. MUST) if it is appropriate for their role. All staff should have an awareness of nutritional screening tools as this is a part of Health Education England Training.
- Services could consider obtaining funding for this training through a business case in line with HEE requirements.

References

[1] MSNAP Standards. (2020). Standards for Memory Services – 7th Edition. Retrieved from msnap-7th-edition-standards-final.pdf (www.rcpsych.ac.uk)

[2] National Institute for Health and Care Excellence. (2018). Dementia: assessment, management and support for people living with dementia and their carers (NICE Guideline No. 97). Retrieved from https://www.nice.org.uk/guidance/ng97

[3] Cognitive Stimulation Therapy. (2022). An Introduction to Cognitive Stimulation Therapy. Retrieved from Cognitive Stimulation Therapy (cstdementia.com)

[4] Orgeta V, Leung P, Yates L, et al. Individual cognitive stimulation therapy for dementia: a clinical effectiveness and cost-effectiveness pragmatic, multicentre, randomised controlled trial. Southampton (UK): NIHR Journals Library; 2015 Aug. (Health Technology Assessment, No. 19.64.) Chapter 1, Introduction to the individual Cognitive Stimulation Therapy trial. Available from: https://www.ncbi.nlm.nih.gov/books/NBK311121/

[5] Yates LA, Leung P, Orgeta V, Spector A, Orrell M. The development of individual cognitive stimulation therapy (iCST) for dementia. Clin Interv Aging. 2014 Dec 30;10:95-104. doi: 10.2147/CIA.S73844. PMID: 25565792; PMCID: PMC4283984.

[6] Kudlicka A, Martyr A, Bahar-Fuchs A, Woods B, Clare L. Cognitive rehabilitation for people with mild to moderate dementia The Cochrane Database of Systematic Reviews. 2019 Jan;2019(8). PMCID: PMC6681837.

[7] Clare L. Working with memory problems: cognitive rehabilitation in early dementia. In: Moniz-Cook E, Manthorpe J editor(s). Early Psychosocial Interventions in Dementia. Evidence-based Practice. London, UK: Jessica Kingsley, 2008:73–80.)

[8] Clare 2017 Clare L. Rehabilitation for people living with dementia: a practical framework of positive support. PLoS Medicine 2017;14(3):e1002245. DOI: 10.1371/ journal.pmed.1002245)

[9] Kudlicka A, Martyr A, Bahar-Fuchs A, Woods B, Clare L. Cognitive rehabilitation for people with mild to moderate dementia The Cochrane Database of Systematic Reviews. 2019 Jul;2019(8). PMCID: PMC6681837.

[10] Kurz A. Psychosoziale Interventionen bei Demenz [Psychosocial interventions in dementia]. Nervenarzt. 2013 Jan;84(1):93-103; quiz 104-5. German. doi: 10.1007/s00115-012-3655-x. PMID: 23306213.

[11] Patel, B., Perera, M., Pendleton, J., Richman, A., & Majumdar, B. (2014). Psychosocial interventions for dementia: From evidence to practice. Advances in Psychiatric Treatment, 20(5), 340-349. doi:10.1192/apt.bp.113.011957

[12] Urbas, S. (2009). Art therapy: Getting in touch with inner self and outside world. In E. Moniz-Cook & J. Manthorpe (Eds.), Early psychosocial interventions in dementia: Evidence-based practice. London: Jessica Kingsley Publishers

[13] Watts, S., Moniz-Cook, E., Guss, R., Middleton, J., Bone, A., & Slade, L. (2016). Early psychosocial interventions in dementia: a compendium 2013.

[14] Qiu-Yue Wang, Dong-Mei Li, Advances in art therapy for patients with dementia, Chinese Nursing Research, Volume 3, Issue 3, 2016, Pages 105-108, ISSN 2095-7718, https://doi.org/10.1016/j.cnre.2016.06.011.

[15] Royal College of Psychiatrists (2019). Core standards for community-based Mental Health Services. Available at: https://www.rcpsych.ac.uk/improving-care/ccqi/resources/core-standards-project

[16] NICE. Service user experience in adult mental health services (QS14). December 2011. https://www.nice.org.uk/guidance/QS14

[17] Business Bliss Consultants FZE. (November 2018). Why is Reflective Practice Important in Healthcare?. Retrieved from https://nursinganswers.net/essays/reflective-practice-plays-a-big-part-in-healthcare-today-nursing-essay.php?vref=1

[18] Knight SÂ (2015) Realising the benefits of reflective practice. Â Nursing Times; 111: 23/24.

[19] Reber E, Gomes F, Vasiloglou MF, Schuetz P, Stanga Z. Nutritional Risk Screening and Assessment. J Clin Med. 2019 Jul 20;8(7):1065. doi: 10.3390/jcm8071065. PMID: 31330781; PMCID: PMC6679209.

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