NHS
London Clinical Networks

Streamlining Memory Service Pathways

Guidance from the London Dementia Clinical Network

London Dementia Clinical Network July 2017

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Streamlining Memory Service Pathways: guidance from the London Dementia Clinical Network

Purpose

This guidance has been developed by the London Dementia Clinical Network to aid memory services in reviewing their care pathway. It offers suggestions for streamlining memory service pathways, whilst maintaining or improving quality of care. All recommendations made have been taken from current memory service practice.

Introduction

The Prime Minister's Challenge on Dementia 2020 set a key aspiration to decrease waiting times for dementia diagnosis. Following on from this, the NHS England Implementation guide for dementia care 2017 highlights a requirement to increase the number of people receiving a diagnosis of dementia and starting treatment within six weeks of referral.

The London Memory Service Pathway Project was undertaken to explore the different pathways being used across London in order to produce practical guidance for services to reduce waiting times to diagnosis, and improve the experience of diagnosis for people with dementia and their relatives/carers.

The Pathway Project

In November 2016 all London memory service managers and clinical leads were contacted via letter requesting a visit to discuss their pathway. In February 2017 a follow-up letter was sent to services that had not responded.

From December 2016 to June 2017 meetings were held with 21 London memory services (72%), including at least one service from each of the Mental Health Trusts that provide memory services. This covered 24 (75%) Clinical Commissioning Groups.

Meetings were conducted using a semi-structured interview schedule. Information was obtained on patient pathways, initiatives to decrease waiting times and barriers preventing improvement. Meetings lasted approximately one hour.

Memory service pathways were split into four sections:

- Triage
- Initial Assessment
- Investigations
- The Second Appointment

Each section of the pathway is explored with recommendations taken from current practice.

Triage

The Triage process starts when a referral is received and concludes when an initial appointment is booked. We found that the triage process varied and could take up to three weeks. There is potential for the triage process in most memory services to be streamlined significantly, with no reduction in quality of care.

Recommendations

1. The triage process should consist of the smallest possible number of steps and take no more than two working days.

2. Services should aim to triage referrals on a daily basis (Monday-Friday).

3. A degree of flexibility on referral criteria is suggested; for example booking the initial appointment whilst awaiting blood test results.

4. The triage process can be used to gain valuable information for example:
    a. Does the patient require a home visit; e.g. housebound and frail patients?
    b. What days/time would best suit the patient and relative/informant to attend clinic (to avoid DNAs)?
    c. Has the patient had a brain scan within the lifetime of the cognitive symptoms? If so can this be reviewed/re-reported to avoid unnecessary neuroimaging?

5. Service managers should ensure that all clinicians involved in the triage process have the appropriate skills to process a referral and allocate a practitioner to see the patient without the need for an allocation meeting.

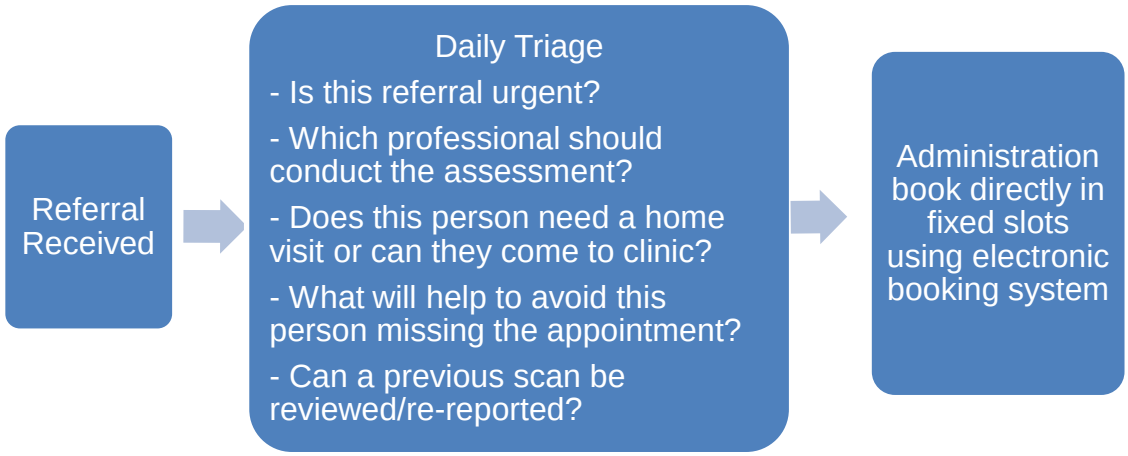
6. Service managers should ensure that clinicians carrying out the triage process have quick access to advice from consultants/service managers to enable allocation to take place.

7. Clinicians involved in the triage process should discuss potentially "inappropriate" referrals with the GP. This is particularly important in patients under 60 years of age. Most people under 60 with memory symptoms do not have dementia; many will have an underlying mood disorder. It may be more appropriate for younger patients with memory symptoms in the context of depression or anxiety to receive treatment (e.g. IAPT or antidepressant therapy) before a memory service referral. Referral to the memory service can then be made if cognitive symptoms persist despite treatment.

8. If a Single Point of Access (SPA) is used, memory service referrals should be quickly passed on to the memory service or SPA clinicians should have the appropriate skills to fully triage memory service referrals including points 1-7 above.

9. Clinic or assessment slots with pre-set times should be agreed for each practitioner, so that the administration team can book patients directly (without discussion with the practitioner) into these slots, preferably using an electronic diary or appointments system.

Suggested triage pathway:



Examples of good practice

Computerised diaries -Tower Hamlets Memory Service
"In Tower Hamlets Diagnostic Memory Clinic we use Rio Electronic Patient Record. We have clinics set up on the system for every day of the week. The clinics are divided into different slots *Initial Assessment*, *Feedback* and *Medication Review*. Every practitioner has regular slots for initial assessments and the administrator has a timetable of these slots. Once referrals have been accepted for the Memory Clinic, the administrator will allocate them into the first available slots. This will automatically put the appointments into each practitioner's Rio diary." Jana Mikova Nurse Practitioner

Triage process -Greenwich Memory Service
"Following this initial admin screening, a clinician looks at the referrals on a daily basis (we have a rota), and decides what other investigations we need to request…. The clinician during the screening process will also decide who should see the patient, the memory nurse, nurse prescriber, or doctor" Dr Anna Saiz Consultant Psychiatrist.

Initial Assessment

Location of Assessment

Memory service initial assessments can take place at the person's home or in the clinic setting. Assessing patients in clinic is more efficient in that more patients can be seen in a given time period; however steps need to be taken to avoid DNAs. Interestingly, many services that complete initial assessments in the patient's home offer clinic appointments for follow up.

As more people are being diagnosed in the early stages of dementia or with mild cognitive impairment, it is usually reasonable for patients to attend a clinic. It can be argued that further information can be gained from home assessment and that the person being assessed will perform better in a familiar environment; however assessing how someone manages out of their usual environment can also be informative.

Recommendations for clinic appointments:

1. Ensure steps are taken to avoid DNAs, aiming for less than 10%; for example;
    - Checking with the patient and relative/informants what their preferred days/times to attend are.
    - A phone call reminder the day before the appointment to both the patient and relative/informant.
    - Automated text messaging to both the patient and relative/informant.
2. Identify patients who require a home visit at the triage process. Reasons include:
    - Immobility.
    - Lack of insight.
    - Significant risks in the home environment e.g. not managing hygiene, unsafe living conditions.

3. Ensure there is a pathway in place for performing a home visit if concerns are raised in clinic, for example occupational therapy home assessment.

Professional conducting the assessment

A variety of professionals were noted to complete initial assessments including band 5-7 nurses, psychologists, occupational therapists, social workers, consultant psychiatrists, specialty registrars and other junior doctors. The degree of diagnostic autonomy of the practitioner can have a significant impact on the time taken from referral to diagnosis. Multiple multi-disciplinary team meetings can increase the time someone has to wait for a diagnosis by up to three weeks, therefore, efficient models of assessment and supervision need to be considered.

Recommendations:

1. Where possible, the professional conducting the initial assessment should have the skills to make a diagnosis in the person they are seeing. Services should define appropriate competencies for staff roles and offer training as required. Some services have specialist nurses who have the necessary skills and competencies to diagnose non-complex cases.

2. If appropriate a diagnosis (or most likely diagnosis) should be given at the first appointment with an initial treatment plan initiated.

3. When supervision is required to make a diagnosis, this should be provided in a time efficient manner and occur as soon as possible after the assessment, for example;
    - 1:1 supervision to discuss new patients instead of reviewing all new patients in an MDT meeting. This avoids staff who are not involved in the care of the patient attending unnecessary meetings. MDT meetings are most effective for discussing complex patients where the opinion of more than two professionals is needed.

- Informal discussion to aid diagnostic decisions via phone, email or face to face
- Clinical supervision during clinics with the use of 'floating consultants'; *see good practice example below*.

Example of good practice

'Floating Consultant'- Enfield Memory Service
"In one clinic session 5-6 clients are booked in staggered appointments. They are initially assessed by memory service staff (nurses, OT, junior doctors). Each assessor in turn presents to the "floating consultant" who will then review the client with that member of staff. The consultant will deliver the diagnosis and a care plan initiated. If necessary they can perform more complex cognitive testing, physical examination and medical assessment. This is a cost effective use of consultant time and resources. It is popular with the team, who are supported with instant clinical supervision and the opportunity to upskill through real time peer learning."
Anna Sobel Consultant in Old Age Psychiatry
Barnet, Enfield and Haringey Mental Health NHS Trust

Investigations (Neuroimaging and Clinical Neuropsychology)

Diagnostic Clinical Neuropsychology

Services vary in the access they have to neuropsychology assessments and the extent to which clinical psychologists are embedded within the team.

Recommendations:

1. In order to make the diagnostic process more efficient, clinical neuropsychologists should work closely and flexibly with the team, for example, providing verbal feedback to the clinician prior to the diagnostic appointment if a full report is not ready.

2. Services should carefully consider which patients definitely require a diagnostic neuropsychological assessment.

3. Requests for assessment should be informally discussed with neuropsychologists to determine if a shorter assessment for a specific diagnostic question is appropriate.

Neuroimaging Contracts

Waiting for neuroimaging investigations can be a key factor in the time it takes to receive a dementia diagnosis. We found a lack of awareness of local contracting arrangements and a lack of access to PACS (picture archiving and communication system) software to view images and electronic scan reports.

Recommendations:

1. Discuss neuroimaging contracts with commissioners and the neuroimaging provider, considering whether renegotiation of contract or sourcing another provider may be required. Quality indicators to consider include:
   - Waiting times for the scan and the report
   - Flexible access to MRI and CT based on patient need
   - Whether the scan is reported by general or neuro-radiologists
   - That those reporting scans have the necessary competencies and experience in diagnostic neuroimaging to provide an accurate report
   - How the memory service can view the images and receive reports electronically
   - The opportunity to meet on a regular basis with radiologists (and potentially other relevant specialists e.g. neurology) to discuss neuroimaging findings and encourage more joint working

Who needs a scan and when to request?

The 2016 London memory service audit revealed significant variation in the proportion of people who receive a scan as part of their assessment. Services need to ensure that they have protocols in place to avoid unnecessary neuroimaging.

Recommendations:

1. The decision to refer a patient for neuroimaging should be a clinical decision and take into account patient preference. The reasons, benefits and negative aspects of having a brain scan should be discussed.

2. Having a CT or MRI scan in primary care must **not** be a requirement of referral to a memory service. This does not improve the overall time taken for someone to receive a diagnosis and leads to unnecessary neuroimaging.

3. During triage, check if the patient has had a brain scan within the lifetime of the cognitive symptoms. If so, source the scan and ask for it to be re-reported if there is insufficient information on the report to aid a dementia diagnosis. Bear in mind that the optimal time for re-reporting might be following the initial assessment as relevant clinical information will then be available.

4. Services may choose to refer patients for neuroimaging at the point of triage, as long the triage process is sufficiently robust to identify for whom a scan is appropriate.

5. Consider which patients might not need neuroimaging. For example, people over the age of 80 with a clear history of gradual and significant cognitive decline given by a reliable informant, with evidence of impairment in memory and at least one other cognitive domain on testing, and no atypical features (such as predominant language impairments or unexpected neurological signs) and who are already in the moderate to severe stage of dementia are likely to have Alzheimer's disease and a scan is unlikely to assist with a diagnosis or alter management.

Examples of good practice

Requesting Imaging - Greenwich Memory Service
"We tend not to request CT scans on patients for whom it's unlikely that the CT scan will give us much more information, for example those who evidently already appear to have dementia from the referral letter, those who have had a CT in the past two years or those patients under 65 for whom, the decision to request other investigations will be taken after they are seen in clinic."
Dr Anna Saiz Consultant Psychiatrist

Discussing neuroimaging with patients - Barnet Memory Service

"As part of the diagnostic assessment, consistent with NICE Guidance, referral for a brain scan would be considered and discussed for all patients. This may be either MRI or CT scan. We explain that a diagnosis is made on clinical grounds, based on a careful and thorough history and examination and the main purpose of the scan is to aid in diagnosis, by excluding other causes of cognitive impairment and although not essential, it can often be helpful for this process. If people are reluctant to have a scan, if they have had one recently, if there are major logistical problems e.g. because of mobility, transport problems etc., we would consider the likelihood of the scan result altering our management. If it is unlikely to do so then we do not insist. For example, in the case of a frail 95 year old with a history and clinical findings consistent with severe dementia, who has never previously had a scan but the scan result would be extremely unlikely to alter the management plan, clinical judgement and common sense would be applied and a decision taken not to scan."

Neuroimaging appointment DNAs

Patients not attending their appointment for a brain scan is a common occurrence, and many services have put in place initiatives to reduce this.

Recommendations:

1. Put in place steps to avoid neuroimaging DNAs, for example;
    a. Sending patients and relatives/informants a letter explaining that the memory service has requested a scan.
    b. The memory service administrator being responsible for reminding patients of their scan appointment.
    c. A named co-ordinator within the memory service keeping a clear record of scan appointments and reports, and facilitating patients to attend if required.
    d. Neuroimaging departments contacting patients if they have not confirmed their appointment.
    e. Agreeing with the neuroimaging provider a 'family protocol' where the memory service indicates on the request form if the neuroimaging department will need to contact a relative.
    f. A recovery support worker in the community mental health team or memory service accompanying patients to and from their scan. Patients who require this support are identified at the initial assessment.

Examples of good practice

Family Protocol - Havering Memory Service
"We ask on our memory clinic referral form whether appointments need to be organised via a relative. If the answer is yes, we have a form that we fill in and fax over together with the scan request, explaining that the person being referred needs help with appointments and providing the contact details of the relative or carer to be contacted directly. This makes it easier for the relative or carer and also means that the person being referred does not get sent correspondence that might be confusing or distressing and might get thrown out or ignored."
Dr Joanna Rodda Consultant Psychiatrist

Facilitating attendance to neuroimaging department - Islington Memory Service

“If the patient requires assistance to get to the appointment, then the clinical support worker will ensure her availability to accompany the patient. Having heard the presentation in the team meeting, she will also be able to gauge whether the patient has difficulties engaging and may arrange a home visit to meet the patient prior to the visit and alleviate their anxieties about the scan process.

The clinical support worker has access to the system allowing her to track the details of the appointment as well as the results. Once the results appear on the system, the clinical support worker alerts the team administrator to send the patient a letter inviting them to attend clinic for their diagnostic feedback appointment.

A face to face meeting has also been arranged with the Manager of the scan department. It has been very useful to establish these links and this has facilitated effective working between the teams.”

Helen Souris Clinical Team Manager

The Second Appointment

In some services, the second appointment will be used to deliver a diagnosis. When a diagnosis can be given in the first appointment there is consensus that a second appointment is still important to finalise treatment plans.

The booking system needs to be effective, particularly if a scan is required prior to making a diagnosis.

Recommendations:

1. Services should consider offering clinic appointments rather than home visits unless the patient is unable to attend; for example, frail elderly and housebound patients.

2. Clinicians need to ensure that the second appointment results in the initiation of a treatment plan (as well as a diagnosis) in order to reduce the referral to treatment time. For example, a medication prescription (where clinically appropriate), or referral to a dementia advisor.

Summary

Memory services across London vary greatly in their care pathways. In order for services to reduce wait times and improve patient experience it is imperative that they review their pathways and put in steps to improve efficiency.

Key factors in ensuring an efficient pathway are;

- 'Lean' triage.
- Diagnosis by autonomous practitioners or efficient supervision.
- "Fit for purpose" neuroimaging contracts.
- Moving to a clinic-based model where possible.

A project is currently taking place with patients and relatives to inform pathway recommendations and will be added to this report in early 2018.

Acknowledgements

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