Assessment and Diagnosis
Example Pathways
East of England Strategic Clinical Network
Why Dementia: 2015 and beyond
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What is a Memory Assessment Service?

• 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 (NICE Guidance -CG42)
NICE Guidance

Offer a responsive service to aid early identification and include a full range of assessment, diagnostic, therapeutic and rehabilitation services.

Ensure an integrated approach to the care of people with dementia and the support of their carers, in partnership with local health, social care and voluntary organisations.

Offer follow-up to people with mild cognitive impairment to monitor cognitive decline and other signs of possible dementia.
Typical dementia diagnosis pathway

**GP Primary Care**
Case finding, Identifying a problem

**GP investigation of suspected dementia & referral**
Screening, blood tests, may need more information, may refer to MH if complex.

**MAS Initial appointment**
Usually initial assessment with specialist team member (home/clinic), cognitive & functional tests

**Scan and other tests ordered**
Waiting time, may be additional assessment

**Diagnosis and beyond**
Appointment with specialist, post diagnostic info, support or refer on, discharge to GP/shared, may involve carers
but ...... people with dementia and their families rarely experience a linear progression

They have different needs at different times and changing circumstances

- Maybe their carer is ill or the spouse dies
- Financial problems
- Major and minor physical health problems or changes in drugs
- Small changes in behaviour can cause the situation to fail
Issues – patients perspective

Seeking help
- Stigma
- Fear
- Lack of knowledge

Experiences in primary care
- Multiple appointments
- Lack of ownership

Diagnosis and beyond
- Long waiting times
- Poor integration secondary/primary care
- Poor post diagnostic support / information
Alternative Models

- Specialist led
- GP based with specialist outreach
- GP led
Model 1 – Specialist led

- Specialist led memory assessment (home/clinic)
- Specialist led diagnosis
- Specialist/nurse led follow up
- Care planning and PDS care coordination

Primary Care

- GP screening investigations
- GP led follow up from 6m (MCI, non complex)
Examples

Salford
- City wide dementia alliance
- MAS recently tendered – 4 options considered for cost and quality
- GP training and education, MDT factors
- Follow up by MAS (inc. MCI) - vascular dementia by GPs
- Navigator support – from diagnosis to end of life
- Key indicators inc. waiting times, antipsychotics

Isle of Wight
- Single pathway for island
- All referrals to IoW Trust
- MAS led Individual/group education sessions after diagnosis
- MAS led Cognitive Stimulation Therapy (16 sessions x 2hrs then 24x 1hr)
- MAS led care planning and handover to primary care – 3 monthly reviews
- Strong 3rd sector and community based support services
Model 2 – GP based with specialist outreach

- Mental Health Trust (complex)

GP screening Investigations
- Specialist led assessment
- Specialist led diagnosis
- Specialist/GP led follow up
- Care planning and PDS care coordination
Example – Gnosall

‘GP First’ consortium – 41 practices (162 GPs) across Cannock and Stafford

Each patient assigned an ‘eldercare facilitator’ (employed by hospices) – 2 teams.

GP practice based memory clinics led by Consultant Psychiatrist/Advanced Nurse Practitioner

Care planning and ongoing support via eldercare facilitator

Patient held record system with smartphone apps to help patient and carer monitor care.
Key Features

- **2° care expertise plus 1° care expertise**
- Community based eldercare facilitator
- Access to primary care resources (incl. IT)
- Less daunting for patient/family, less stigma
- Evaluated positively by patients and carers
- Improved continuity of care
- Open access follow up
- Improved quality & decreased costs
South Manchester

- GP based with specialist outreach
- One clinic per month
- Nurse led assessment
- Specialist led diagnosis
- GP/Specialist led follow up
- GP/Nurse led care planning and PDS
Model 3 – Primary Care led

**Specialist**

- Specialist led diagnosis (complex)
- Specialist follow up (complex)

**Primary Care**

- GP Investigations
- GP led memory assessment
- GP led diagnosis (non complex)
- GP/nurse led follow up (non complex)
- Care planning and PDS
Examples

Dudley

- Three ‘dementia gateways’ - referrals from GPs and acute providers
- 7 dementia advisors plus specialist dementia nurses
- Specialist nurse led assessment (home/gateway day care centre)
- Specialist nurse led diagnosis and care planning (patient and carer)
- Care coordination - Dementia Advisor
- Education and information support – patient and carer
- Adult community enablement team for access to support services

Wiltshire

- Redesign triggered by long waits for MAS
- GP led diagnosis– non complex (50%)
- Majority followed up in primary care
- Secondary care access and support if needed
- Dementia Advisor support
- GP based care coordinator provided to patients
Examples

Bexhill on Sea

- 12 GPs (6 practices) and 12 nurses (10 practices) trained (Bradford School of Dementia Studies)
- Supervision and mentorship from local provider during training
- Referral to primary care led MAS
- Specialist GPwSI and practice nurse perform assessment, refer scans
- Diagnosis at first appointment, if appropriate
- Information and care plan with rapid review
- Seen by dementia advisor within days of diagnosis
- Skilling up the whole team – receptionists, secretaries, HCAs
Things to consider

- Service user views
- Geography and access
- Collaborative options
- Demand by practice
- Workforce - capacity and capability
- Quality v costs benefits
- Agreed Dementia pathway
- Post diagnostic support
- Joint protocols / screening tools
- Clinical Leadership
- Access to specialist advice / support incl psychologist, OT, SALT
- Care co-ordination – diagnosis to EoL
Essential requirements of a memory service

- Excellent clinical relationships between local commissioners and providers
- Joint clinical development of pathways of care for primary care, intermediate care hospitals & the acute trust
- Pathways that cross organisations (mental health, community and acute sectors) & reduce the ‘noise in the system’