NHS
London
Clinical Networks

Virtual multi-disciplinary team meetings: Parkinson's Clinic and Memory Service

Purpose:

Parkinson's disease dementia is a complex multi-system illness that may require highly specialised input from a number of services including a Parkinson's service, Memory and Mental Health services as well as community therapy, nursing and social care services. The care that people with Parkinson's receive is often 'fragmented' resulting in delays and a suboptimal experience for patients and carers.

This paper highlights the benefits of integrated working between Parkinson's clinics and Memory and Mental Health services through a 'virtual' multidisciplinary team meeting (MDT). It includes an example of an MDT that works in this way as a good practice model and a case study highlighting the benefits.

The purpose of this paper is to make services aware of the benefits of integrated working between these services and the positive outcomes for patients and carers.

Background:

In July 2018 the National Neuro Advisory Group (NNAG) published a report highlighting a number of issues in relation to Parkinson's Disease Dementia (PDD) NNAG-Parkinsons-Dementia-and-Psychiatry-event-write-up-v.1.0.pdf

Historically, there has been a significant divide between neurology, dementia and psychiatry services in the treatment of Parkinson's disease. This has been to the detriment of patients and carers, as Parkinson's is a complex illness which requires a joined-up approach to care. Although progress has been made, care provision for people with PDD remains fragmented.

Patients and carers may be uncertain which team to contact in times of crisis. In addition to physical symptoms and cognitive deficits, the illness can also cause mood disturbance, such as depression or anxiety as well as psychotic phenomena e.g. hallucinations and delusions. It may also be unclear who takes responsibility for the provision of carers' support and education. The divide between cognitive, mental and physical health services may lead to uncertainty about which service should lead on the management of cognitive and behavioural symptoms. Furthermore, there may be different approaches between specialties to use of psychotropic medication.

The NHS Long Term Plan states that 'we will go further in improving the care we provide to people with dementia' and has highlighted the need for coordinated care and inter-Trust collaboration. In order to minimise the challenges arising from disjoined care, the Homerton Parkinson's Clinic, the City & Hackney memory service and the Adult Community Rehabilitation team, decided to hold joint multidisciplinary team meetings (MDT). With the emergence of the COVID-19 pandemic, these meetings continued using a secure virtual conferencing platform, (Microsoft Teams).

Virtual MDT:

The Homerton – City of Hackney MDT meeting is held monthly for one hour on Microsoft Teams. The team members who attend are: clinicians from the Parkinson's service

(Consultant Neurologist, Consultant Geriatrician, Parkinson's Specialist Practitioner who is a Physiotherapist by background, the Lead Community Clinical Psychologist from the Adult Rehabilitation Team and a Consultant Psychiatrist from the Memory Service. Clinician time for attending the meeting is not currently funded. Ownership of this meeting is shared.

The Parkinson's Specialist Practitioner liaises between the three teams between meetings and creates a list of patients to be discussed. These patients may have been recently assessed in either service and present with complex symptoms, or they may be patients that have been previously discussed and there is a need for a review. To date, the team has not used the screen sharing function to view scans etc, however, there is the capacity to do so, should the need arise. The doctors record the outcome of the discussion in their own respective recording systems and any action plans are recorded by the Parkinson's Specialist Practitioner and distributed as minutes to facilitate review at the following meeting if appropriate.

Common themes:

A review of some of the patients discussed at this meeting highlighted some common themes:

- Patients with longstanding Parkinson's in whom the onset of dementia is suspected, but not clear, due to confounding disease or medication-related low mood, anxiety and/or psychosis.
- Patients with Parkinson's dementia with motor impairment and psychotic symptoms who need careful joint balancing of anti-psychotic and anti-parkinsonism medications
- Patients with cognitive impairment who subsequently develop movement disorders where a Lewy Body Disease and/or medication-induced movement disorders are suspected
- Patients with advanced Parkinson's dementia who are frail, typically not able to attend hospital appointments and need holistic care planning (joint medication rationalisation, social services support, palliative care)
- Complex patients that 'fall through the gaps' Typically those that have significant motor, mood and cognitive fluctuation interacting with idiosyncratic social circumstances.

The MDT is a useful forum to consider the different symptoms and provides an opportunity for practitioners with expertise in their specific fields to consider what the issues might be and the most effective treatment approach. It is also a useful platform to learn from each other.

The following case study illustrates the benefits of an integrated multidisciplinary approach. Some details have been changed to preserve anonymity.

Case Study

Diagnosis: Idiopathic Parkinson's with marked motor and cognitive fluctuations

Betty was diagnosed with Parkinson's Disease (PD) in 2007 and probable PD dementia in 2013. She first became known to the Homerton PD service in 2019 due to increasing attendances to Accident & Emergency and admissions to the wards, following repeated falls due to sudden and unpredictable "off episodes" (failures of anti-Parkinson's medication) in the context of safeguarding issues relating to her inability to manage her condition as well as possible financial abuse by her husband.

At the time of her initial Parkinson's disease dementia diagnosis, Betty was in her 50's and was living with her husband and daughter. She was retired, having worked as a Teaching

Assistant for most of her life. She appeared to get confused with her medication and her husband was unable to assist in administering these. Her daughter, a teenager at the time, was not involved in her care. Their flat displayed signs of inadequate cleaning. As a result of not being able to manage her care or her social circumstances, Betty was allocated a flat in supported housing, i.e. 'housing with care accommodation'.

Presentation:

Betty presents with sudden "offs"; these are episodes when Parkinson's symptoms, motor and sometimes non-motor, suddenly return, often because medications are not working optimally. She experiences marked motor and cognitive fluctuations. For example, she can suddenly freeze and fall, being too stiff to reach in her pocket for emergency medications and too impaired to communicate her needs to emergency medical services. In addition, she presents with low mood and visual hallucinations, which, as well as causing suffering, limit the anti-Parkinson's medications she can take. In the past, these have become frightening to the point of her considering suicide.

As a result, she has had recurrent admissions to a mental health ward. When unwell, it is reported she has made poor decisions relating to her finances including giving away or losing her money and credit card. When she was in a good "on" phase, she was deemed to have capacity in relation to her risk of accessing the community independently, and of deciding to provide her family with her money.

A discussion of these issues in an integrated Parkinson's clinic and Memory Service MDT meeting involved clinicians from both services and joint home visits commenced in 2019 with Psychiatry, a Mental Health Social Worker and PD Practitioner. Actions were jointly agreed in the MDT meeting, and at the time, included reducing dopamine agonist medication, reviewing support for depression and reviewing capacity and care needs. Betty's medication regime consists of medication for her Parkinson's, mental health and cognitive symptoms. There is a complex interaction between her brittle response to anti-parkinsonism medication, psychiatric and motor symptoms and these symptoms, along with the social issues, all needed to be balanced.

Betty was also assigned a care coordinator to ensure concordance and progress with medication, as well as to monitor her Parkinson's disease, mental health and cognition. She continues to have worsening "off" episodes', which include significant motor symptoms and cognitive impairment. She requires another capacity assessment in relation to managing her finances as she recently lost large amounts of money and had no food in the house and no money to buy food.

Betty continues to be reviewed by the mental health social worker and PD Practitioner. She is currently awaiting a support package to allow her to be escorted to her husbands' house and to enable her to receive care at both locations. Accident and emergency admissions have dramatically reduced. Her progress will continue to be reviewed in the virtual Parkinson's and Memory service MDT as her presentation and needs change.

Benefits of integrated MDT working

- Clinicians from different teams and with multiple perspectives give input relating to their area of expertise
- Allows for a clearer diagnosis and treatment pathway
- Provides an opportunity to discuss a holistic treatment strategy and an opportunity to develop and regularly review a bespoke package of care to meet the particular needs of the patient

- Likely to be cost effective as there is a combined approach to decisions relating to medication and subsequent referrals
- Reduced number of appointments for the patient
- Reduced attendances to Accident and Emergency and hospital admissions
- Improved experience and journey for patients with Parkinson's Disease Dementia and their carers.

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