**Parkinson’s New Patient Pathway**

**Desired Outcomes**

1. Newly diagnosed patients will feel well informed and supported at the time of diagnosis.
2. Patients will feel they are actively involved in treatment decisions.
3. All patients will have been offered clinical research opportunity.
4. All patients will be comprehensively assessed and managed prior to handover to the community nurse team.

**Outcomes will be assessed by patient survey and notes review to be conducted in Q1 2017.**

**Key Pathway Features**

1. Patients will be seen twice within the first year by the consultant – at baseline and at month 12.
2. Patients will have individually tailored contact with the hospital nurse team, depending on requirement:
   1. All newly diagnosed patients will be seen at month 1 and month 4.
   2. Cornwall patients will be discharged to Community PNS team at month 4.
   3. All other patients will be offered a PKG appointment at month 6 to allow medication adjustment, facilitated by telephone follow-up (if required).
   4. All non-Cornwall patients will be offered a further appointment at month 9.

**Key Impacts compared with Current Practice**

1. The pathway will meet the requirements for Best Practice Tarff.
2. Reduced pressure on consultant clinic as patients not being seen at 3- or 4-monthly intervals during initiation of medication phase.
3. Reduced pressure on community PNS team, as patients will not be handed over to team until after the 1st year, when required nurse input is likely to be less.
4. Less variability in standard of care, as all patients will have the same level of nurse input, which is currently variable geographically.

Referred with possible Parkinson’s

**Neurology appointment**

**(within 6 weeks; 2 weeks for complex cases)**

**Consultant appointment(s)**

* Consultant review
* Investigation
* Diagnosed with Parkinson’s

Refer to Parkinson’s Nurse Specialist via – Copy of Clinic letter

Invite to the PNS new patient clinic

**1st Nurse Clinic – within 4 weeks of Consultant appt**

Invite partner/carer/spouse – and forewarn it will be an hour long appt

* Medication review
* Confirmation of patient’s understanding of their condition, discuss diagnosis
* Explore their thoughts & concerns
* Conduct the Nurse Assessment
* Explain the various groups & activities available to conserve present condition/ prevent rapid deterioration
* Discuss the therapies required to maintain positive outcome –physiotherapy, occupational therapy, speech & language therapy, exercise classes etc., offer referrals
* Identify their particular problems
* Ask carers to voice their concerns
* Discuss driving – the need to inform DVLA and their insurance company
* Discuss the need for base line scores and assessment tools to monitor their condition – supply some of the questionnaires to be completed and brought to the next appt
* Ask if interested in research opportunities; refer to research team and PRO-DeNDRoN
* Discuss PKG monitoring and refer to PKG clinic
* Make a 2nd appointment to conduct the validated assessment tools in 12 weeks’ time

**2nd Nurse Clinic appointment**

**4 months post Consultant appointment**

* Assessments
  + MOCA – Montreal cognitive assessment
  + PDQ39 – quality of life scale sensitive to Parkinson’s
  + NMS Quest – non motor symptoms
  + Disease Stratification
* **If indicated**
  + Beck’s /geriatric depression scale
  + Must – malnutrition score
  + Continence
  + PDSS II – Parkinson’s sleep scale
* Medication review

\*Refer Cornwall patients to Community PNS

\*Reappoint all other postcodes to 3rd clinic for review at 9 mths.

**Refer on to Community PNS – for follow up in six months unless there are indications for earlier appointment.**

Refer on if indicated \*

**PD MDT Review**

* Review stratification and assessments
* Review medication
* Arrange further consultant review if required

**PKG Clinic** (Parkinson’s kinetigraph)

**6 months post Consultant appointment**

* Reiterate the use, procedure and need for wearing the device
* Explain with use of the patient leaflet how to use
* Obtain written consent for sharing data
* Supply return envelope
* Discharge from PKG clinic
* Follow up with telephone appointment (within 4 weeks) to feedback outcome to patient and make medication adjustments if needed.
* Consultant review of PKG

**PD MDT Review**

* **Allocate appropriate follow-up pathway (with referrals as appropriate)**
  + **(Remote monitoring)**
  + **Current standard practice**
  + **Hospital nurse-led care – with triggered consultant review**
  + **Community nurse-led care – with triggered consultant review**

**2nd Consultant Clinic appointment**

**12 months post diagnosis**

* Review of diagnosis
* Review medication and medication response
* Review motor and non-motor symptoms
* Review medication-related complications
* Assess need for AHP referral
* Copy letter to community PNS team

**3rd Nurse Clinic appointment**

**9 months post Consultant appointment**

* Greet and address any patient concerns
* Review medication
* Review all initial assessment criteria
* Make necessary referrals
* Raise End of Life considerations – Power of attorney, Wills, Options for care if needed