Dementia Diagnosis & Disease Management in Primary Care

Service Level Agreement (SLA) 1st April 2016 to 31st March 2019

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1. Financial Details

The agreement is to cover the 36 months commencing April 2016.

Each practice contracted to provide this service will receive a monthly payment in line with prior year activity. Payment adjustments will be made quarterly based on actual activity levels for those diagnosed and prescribed within year.

£108 Payment per patient that is newly diagnosed, medication prescribed within attached guidelines and the disease managed in the patient’s GP practice. Evidenced by practice register of specified measures and audit.

£40 Payment for each dementia patient on the caseload, per annum, commencing the year after initial prescribing has taken place.

Patients included and being claimed as part of this service should be read coded appropriately; for TPP practices this is: X002w (dementia). A search of Donepezil prescribing will also be used.

Practices will be requested to complete quarterly activity returns in 2016/17 which the CCG will reconcile against activity reports run centrally from TPP SystmOne and equivalent clinical systems. Through discussion with practices differences will be identified and agreed in order to eliminate future differences throughout 2016/17. Quarterly payment adjustments will be made based on agreed actual activity levels.

From 2017/18 onwards it is envisaged that the CCG will run central searches in order to make quarterly payment adjustments based on actual activity, following the alignment of activity reporting within 2016/17.
In signing up to this service the practice agrees to recording patient activity using the read codes above, and agrees for the CCG to reconcile quarterly activity returns to central reports run based on these read codes, for payment and audit purposes.

The CCG reserves the right to make changes to, add, amend or cancel this service with three months given notice.

### 2. Service Aims

**Introduction**

As part of the Older People’s Mental Health Services redesign for Wiltshire, the Dementia Delivery Board conceived a pilot to trial prescribing Donepezil in primary care and for initiating diagnosis and treatment of late onset Alzheimer's disease in primary care settings.

This was considered appropriate as it would:

- Free up specialist time for complex cases and thereby reduce waiting list times in secondary care;
- Provide care nearer to home with known staff for people whose memories were failing; and
- Return GPs and their teams to a position of involvement and knowledge about this condition in advance of the expected increase in prevalence.

The pilot was a joint enterprise between Avon & Wiltshire Partnership Mental Health Trust (AWP), Wiltshire Council, NHS Wiltshire, the emerging Wiltshire Clinical Commissioning Group and the Alzheimer’s Society. The partners agreed a pathway of care which has been presented widely to all Stakeholders. The purpose of the pilot was to try out the pathway in practice with the above as aims.

The pilot practices were supported by:

- Teaching for all staff members, including GPs. This was provided by Avon & Wiltshire Partnership (AWP) staff;
- Memory Service nurse easy access and support; and
- Alzheimer’s society staff for advising those who were newly diagnosed

All participants, patients, carers and health care professionals liked the new service. GPs have shown themselves more than capable of prescribing safely for this group of patients with late onset Alzheimer’s who make up approximately 50% of all cases of dementia.

Dementia is currently under-diagnosed nationally because the lack of available treatment until recently and the negative connotations for families and sufferers. With the support, as needed, of the memory service nurse from AWP, treatments are now available and, as dementia becomes better understood, all agree that early diagnosis is important to:

- Rule out other causes or conditions;
- Give access to information, advice and support services;
- Enable persons with dementia to plan for future; and
• Give the best possible quality to remaining life by treating early where appropriate.

As part of the local dementia strategy, a local dementia care pathway has been developed to describe partnership working between GPs and secondary care providers. The tasks and responsibilities for both primary and secondary care providers have been captured in a care pathway and through medication guidelines.

Some of the GP pilot practices already deliver care according to this protocol, others not yet. This LES is meant to support all GP practices in Wiltshire to implement the care protocol and to ensure every dementia patient in Wiltshire will receive the same level of care regarding diagnosis, medication management and disease management from their GP practice or memory clinic as appropriate.

The CCG reserve the right to audit practices on key criteria and or service outcomes

### 3. Criteria

As part of this service the practice agrees:

• to follow the Wiltshire dementia care pathway regarding diagnosis, disease management & medication monitoring;

• to provide, if changed, a named lead GP and practice nurse who will be responsible for the implementation of the LES and who will cascade dementia related information to other colleagues in the practice;

• to conduct dementia patient monitoring according to the patient’s condition;

• to submit an action plan by 1st June 2016 on how the practice is going to improve early detection of dementia, establish the Practice’s ‘diagnosis gap’, and local trajectory for improvement and to keep the practice’s dementia and carers registers up to date. A brief report on achievements will be submitted by 31 March 2017;

• to undertake a diagnosis of dementia where possible. Complex and unstable patients may be referred to specialist memory nurses or to the memory clinic;

• to prescribe dementia drugs within attached guidelines, add patient/carer to QOF registers, give post diagnostic information, advice and emotional support;

• to refer to secondary care, Mental Health Services or Community Learning Disabilities Teams where specialist assessment is appropriate and in line with the care pathway;

• to repatriate non-complex & stable patients in a managed and agreed way with the Memory Service. These will be previously diagnosed patients who have been stabilised on the medication in secondary care. The primary care team will take responsibility for the on-going prescribing of the acetyl-cholinesterase inhibitor, Donepezil;

• to make effective use of Memory Nurses to support Practice skill development and prescribing; and
• to signpost patients and work closely with the Dementia Advisors for the benefit of patients, carers and families.

4. High Level Quality Indicators

An integrated approach to provision of services is fundamental to the delivery of high quality Care to people with dementia. The following table represents the high level quality indicators as developed by the National institute for Clinical Excellence, NICE –SCIE Clinical Guidelines 42 (CG42)

<table>
<thead>
<tr>
<th>Number</th>
<th>Quality Statements</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>People with dementia receive care from staff appropriately trained in dementia care.</td>
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<tr>
<td>2</td>
<td>People with complexities are referred, where appropriate, to a memory assessment service specialising in the diagnosis and initial management of dementia.</td>
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<tr>
<td>3</td>
<td>People newly diagnosed with dementia and/or their carers receive written and verbal information about their condition, treatment and the support options in their local area.</td>
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<tr>
<td>4</td>
<td>People with dementia who have been assessed will have an ongoing personalised care plan agreed across health and social care which identifies a named care coordinator and addresses their individual needs.</td>
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</table>
| 5      | People with dementia, while they have capacity, have the opportunity to discuss and make decisions, together with their carer(s), about the use of:  
  • advance statements;  
  • advance decisions to refuse treatment;  
  • Lasting Power of Attorney; and  
  • Preferred Priorities of Care. |
| 6      | Carers of people with dementia are offered an assessment of emotional, psychological and social needs and, if accepted, receive tailored interventions identified by a care plan to address those needs. |
| 7      | People with suspected or known dementia using acute and general hospital inpatient services or emergency departments have access to a liaison service that specialises in the diagnosis and management of dementia and older people’s mental health. |
| 8      | People in the later stages of dementia are assessed by primary care teams to identify and plan their palliative care needs. |
| 9      | Carers of people with dementia have access to a comprehensive range of respite/short-break services that meet the needs of both the carer and the person with dementia. |
# Donepezil Prescribing Information

## Introduction
This provides prescribing information for practices participating in the Dementia LES. **The LES is for Donepezil 5mg and 10mg tablets ONLY and not for any other formulation (orodispersible tablets) or any other acetylcholinesterase inhibitors.** If a product other than donepezil tablets is required please refer the patient to the Memory Service.

## Indication
Diagnosis of mild to moderate Alzheimer’s Dementia.

## Dose & Administration
Prescribe as generic to ensure that drug of lowest acquisition cost is used Donepezil tablets. Initially 5mg each evening, just before going to bed. This can be increased after four weeks to the maximum daily dose of 10mg.

## Monitoring Required in Primary Care
No specific monitoring is required. If routine consultations give rise to concerns about tolerability or the appropriateness of on-going treatment then this would prompt a secondary care review.

## Adverse Effects
- **Most Common (Incidence > 10%)**
  - Diarrhoea, muscle cramps, fatigue, nausea, vomiting, insomnia
- **Common (Incidence 1 - 10%)**
  - Headache, pain, common cold, dizziness, anorexia, syncope, rash, pruritis, urinary incontinence, fatigue
- **Uncommon (Incidence 0.1 – 1%)**
  - Seizures, bradycardia, gastrointestinal haemorrhage, gastric and duodenal ulcers.
- **Rare (Incidence 0.01 - 0.1%)**
  - Sinoatrial and atrioventricular block, Extrapyramidal symptoms Liver Dysfunction including hepatitis
  - There have also been reports of psychiatric disturbances, including hallucinations, agitation and aggressive behaviour, which resolved on dose reduction or discontinuation of treatment.
  - No notable abnormalities in laboratory values were observed, except for minor increases in serum concentrations of muscle creatinine kinase.

## Drug Interactions
- Should not be prescribed with other acetylcholinesterase inhibitors, anticholinergics or cholinergic agonists.
- NSAID’s- Monitor for symptoms of ulcerative disease. In clinical trials, however, there was no increase compared with placebo in the incidence of either peptic ulcer disease or gastrointestinal bleeding
- Inhibitors of Cytochrome P450 3A4 and 2D6 may increase plasma levels.
  - Examples include erythromycin, ketoconazole, itraconazole, fluoxetine, quinidine.
- Enzyme inducers may decrease plasma levels. Examples include rifampicin, phenytoin, carbamazepine and alcohol
- Potential to interfere with drugs having anticholinergic activity
- Potential for additive effects with beta- blockers
- Additive effects with succinylcholine and other neuromuscular blockers
  - Please refer to the BNF and SPC for full list.

## Contraindications
Hypersensitivity to the active ingredients or excipients used in the formulation

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This guidance does not replace the SPC, which should be read in conjunction with this guidance.
1. Identification - GP / Carer / Hospital / Other health & social care staff
- People who worry about their memory/relatives raising concerns
- People (including younger people) who are forgetful in last 12 months/confused/present with mood changes or changes in communication skills / having lost confidence
- Pro-active screening of people from underrepresented or at-risk groups: people with learning disability/BME groups/people with HIV/patients who do not attend planned health appointments/ people with Parkinson’s/people with vascular conditions/people with alcohol & substance misuse problems/those who regularly present with falls or delirium

2. Assessment Primary Care - GP (primarily covered by the National Enhanced Service)
- History taking (including relative’s impression)
- Physical assessment; Assess medical and psychiatric co-morbidity
- Medication review
- Basic dementia screen: routine haematology, biochemistry tests, thyroid function tests, serum vitamin B12 and folate levels, midstream urine test if delirium is possibility, chest X-ray / ECG as determined by clinical presentation
- Cognitive and mental state examination (attention, concentration, short- and long term memory, praxis, language, executive function, conduct test e.g. 6-CIT, GPCOG
- Consider and assess social situation circumstances – carer’s assessment

3. Referral for further assessment & diagnosis in Secondary care
- Memory Service/Specialist Learning Disability Services
- Diagnosis including diagnosis of subtype
- Post diagnostic information, advice and counselling information
- Health & wellbeing advice; referral to peer support and training

4. & 5. Initiating dementia drugs - Dementia Treatment
(for patients diagnosed with Alzheimer’s / some mixed dementias)
- Initiating dementia medication
- Monitoring till patient is stable on medication

5. Disease management in secondary care until stable

6. Disease management in Primary Care
- Add patient to QOF dementia register and carer to QOF carer register
- Give post-diagnostic information, advice and emotional support
- Signpost person with dementia and carer services
- Prescribing dementia drugs
- Give healthy life style & wellbeing advice
- Set review date for person with dementia and their main carer
- Regular review / Anti-psychotic review (3 monthly)
- Global, mood, cognition, behaviour, function, medication, quality of Life, healthy life style, use of support services, advanced decision making, carers’ assessment

6. Diagnosis confirmed: disease management in Primary Care
- Add patient to QOF dementia register and carer to QOF carer register
- Give post-diagnostic information, advice and emotional support
- Signpost person with dementia and carer services
- Prescribing dementia drugs
- Give healthy life style & wellbeing advice
- Set review date for person with dementia and their main carer
- Regular review / Anti-psychotic review (3 monthly)
- Global, mood, cognition, behaviour, function, medication, quality of Life, healthy life style, use of support services, advanced decision making, carers’ assessment
The assessment and diagnosis of individuals with Down’s syndrome, if complex, is not covered by the SLA and the following care pathway (shown below) should be used.

Key points:

• People with learning disabilities have a higher risk of developing dementia compared to the general population, with a significantly increased risk for people with Down’s syndrome and at a much earlier age;

• Undertaking prospective screening for dementia for adults with Down’s syndrome conducted at intervals from the age of 30 and then at intervals of 40 or 50 onwards;

• Life expectancy of people with Down’s syndrome has increased significantly; and

• Early detection of dementia relies on a good baseline. Prompt diagnosis ensures that attention can be paid in a timely way to necessary changes to a care package, medication, preparing family carers and support staff for the inevitable changes and challenges that dementia will bring. This may help the person to access cognitive enhancers in line with NICE eligibility guidelines.
Referral received by Community Team for People with Learning Disabilities

1. Triage completed by;
   a) If unknown to team by Community Learning Disability Nursing
   b) If professional already working with client, then professional completes Triage.
   The Triage assessor checks that the GP has ruled out other diagnosis and that the following have been done:
   - A Health Action Plan;
   - Blood screens completed;
   - Annual Health Check undertaken;
   - Risks identified and management plan developed;
   - Referral to other professionals if required; and
   - Differential diagnosis ruled out.

2. Discussed at Dementia Group
   Core members: Psychiatry, community Nursing & Psychology. Meets bi-monthly/ six weekly.

3. Psychiatric Assessment
   Mental health assessment to rule out mental illness.

4. Cognitive and Adaptive Assessment
   Baseline cognitive and adaptive functioning assessments completed. Psychology led, with support from Community Nursing if required. Follow-up assessment 6 – 12 months later. Feedback to referral team, carers and GP following baseline and follow-up assessments.

5. Dementia Group
   If Dementia identified; Provisional diagnosis & formulation. Monitor situation and develop MDT intervention plan. Follow Care Pathway Stage 2.
   If unclear – no formal diagnosis, continue to monitor through the Dementia Group.