OCCG SERVICE SPECIFICATION (2017/18)
Primary Care Memory Assessment Service (PCMAS)

1. **Summary of new changes:**

- Funding increased from £100 to £125 per completed assessment with diagnosis
- Introduction of MOCA(Montreal Cognitive Assessment http://www.mocatest.org) as alternative to repeat GPCOG in selected individuals
- Replacement of term Mild memory Disturbance with Mild Cognitive Impairment

Searches for monitoring and payment purposes will still include Mild Memory Disturbance but a new EMIS recording template will be issued to replace the term Mild Memory Disturbance with Mild Cognitive Impairment for new diagnoses.

These changes are in response to feedback and a review of the PCMAS following its pilot phase

They also align to Dementia diagnosis and management: "A brief pragmatic resource for general practitioners First published: 14/01/2015"

http://occg.oxnet.nhs.uk/GeneralPractice/ClinicalGuidelines/Mental%20Health/Dementia/20150114%20Dementia%20diagnosis%20and%20management%20AB-PT.pdf

2. **Background**

The PCMAS started as a pilot in 2013 and is now available to all practices in Oxfordshire. The Primary Care Memory Assessment Service (PCMAS) aims to achieve a user-friendly dementia pathway for easier access to a more timely diagnosis and support services. Primary care is well placed to play a bigger role in the treatment and care of patients with dementia and improve the rate of diagnosis. This supports national strategy to increase timely diagnosis of dementia and recognises that GPs play an active role in the diagnosis and management of patients with dementia.
This scheme sets out a 3 stage assessment process so that the diagnosis and management of mild cognitive impairment and dementia can be made in primary care in most cases safely and appropriately. This is an alternative to the usual referral to a specialist memory clinic. Access to CT scans if indicated is available and GPs can initiate a trial of Acetylcholinesterase inhibitors if appropriate.

There are payments set out below to cover this additional work. This first stage of the assessment is the initial GP consultation in which a patient comes with a memory concern or through other presentations including case finding in those at risk.
E.g. hospital discharge summary indicates a concern; evident new difficulties complying with medication/appointments in older adults; or older adults especially those over 80 or over 60 with multiple cardiovascular risk factors.

This first assessment would be carried out even if a patient is to be referred to a specialist memory clinic so the payments for the PCMAS are for the 2nd assessment (a 20 minute Practice Nurse or HCA appointment) and the 3rd assessment a week or so

later (a 20-30 minute GP appointment). This is set at £125 per patient completing a full assessment and diagnosed with Mild Cognitive Impairment or dementia. It is not expected that all patients will need a 30-minute 3rd assessment appointment eg in the case of those with very clear new presentations of dementia but it is recognized that in some, the process to reach a diagnosis may take a little longer.

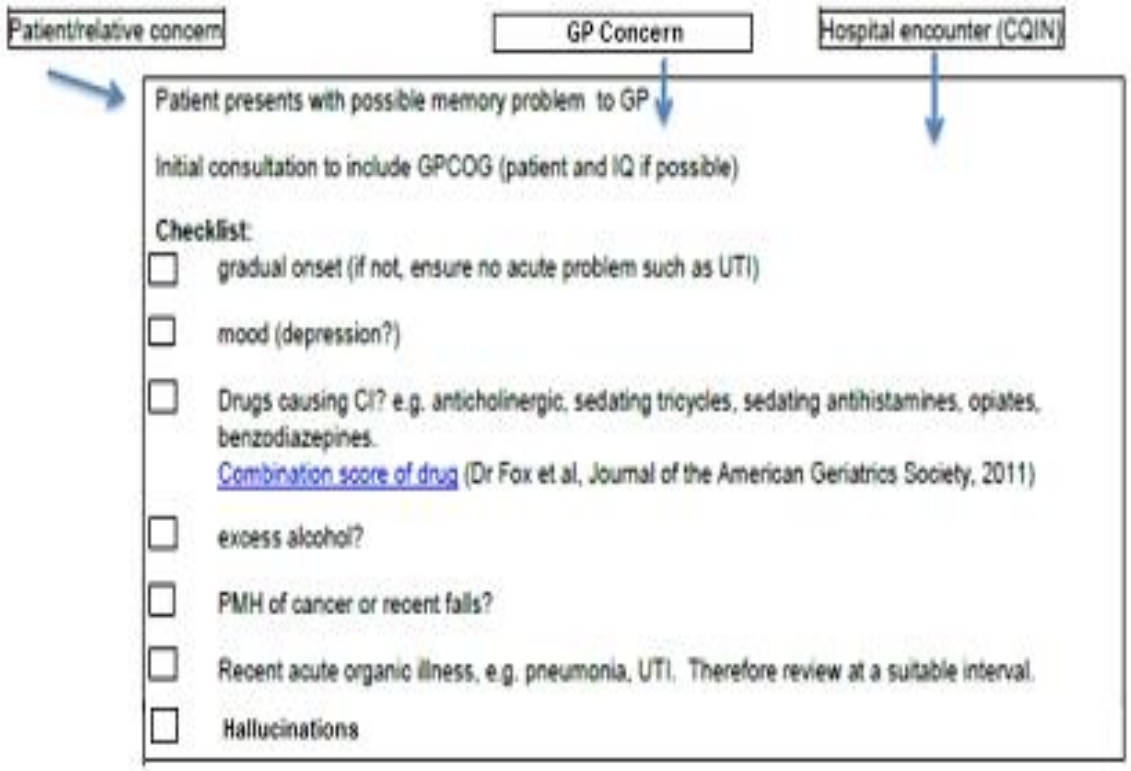
Not all patients will be suitable for initiation of Acetylcholinesterase inhibitors so the payment for the diagnostic pathway includes any subsequent appointments for the initiation and review of these drugs.

2. Service outline

The Primary Care Memory Assessment Service (PCMAS) is designed to allow those with suspected dementia to be diagnosed and managed in primary care as an alternative, when appropriate, to referral on to a specialist-led memory clinic service. The two services, forming the wider community memory service, are intended to complement and support each other in the interests of optimum patient care.

The 3 stage-assessment process should be recorded using the computer template at the end of this document (Appendix 1) – this can be downloaded and imported to Emis web.

Assessment 1



Outcome of GPCOG

1. **GPCOG (patient score) 9 (or 8 with a minor slip such as getting day of month wrong)**
    - Informant Questionnaire (IQ) optional.
    - Reassure
    - Address any concerns from checklist above
    - Offer review as appropriate

2. **GPCOG 8 or less**
    - Proceed with Informant Questionnaire (IQ) (can be deferred to assessment 2 as long as informant attends with patient)
    - Offer PCMAS with Assessments 2 and 3 (print patient information letter about memory appointments for patient to show reception who should have packs of the required questionnaires to give out when they make the appointments-see appendix 1)

Scope: The PCMAS may be offered to those with memory problems over the age of 65 except in the circumstances listed below.

For those suitable for the PCMAS, offer this to patients where there is evidence of cognitive decline by inviting them to make further appointments to undergo further assessment.

It is strongly recommended practices supply patients/carers with the following leaflet to ensure appointments are made correctly and as a reminder. The forms and urine bottle required for the second assessment can be provided if reception staff are trained to provided packs of these to supply at the time the appointments are made.

http://occg.oxnet.nhs.uk/OCCG%20Document%20Library/Primary%20Care%20Memory%20Assessment%20Service/2014%2010%2023%20GP%20Memory%20Assessment%20Service%20Appointment%20Card.pdf

The PCMAS is particularly suitable for those who have frailty, multi-morbidity or advanced dementia at presentation.

It is also useful for those who present with anxiety about developing dementia but only very mild cognitive impairment as this group can best be managed with reassurance and “watchful waiting” as only a proportion will go on to develop dementia. In particular, at present there are no tests or investigations that can predict who is in the early stages of dementia but the progressive nature of dementia will manifest itself after 1-3 years.

Please note, the PCMAS may also be used for clarifying the diagnosis of those in care homes. Many of these will prefer not to be disturbed from their usual surroundings and many will have advanced dementia in whom the diagnosis will be very straightforward. It is important to communicate the diagnosis sensitively to the relevant family member (if they had not realised it), ensure care home staff are aware and Proactive Care Plans are completed.

Behavioural and psychological disturbance in those already diagnosed with dementia would best be managed via Care Home Support Service which has an attached Older Adult Mental Health consultant.

When to consider specialist referral:

Those with cognitive impairment in the following categories:

3. Patients under the age of 65 should be referred to a neurologist as there is a greater chance of an underlying neurological condition
4. Patient with a co-existing serious psychiatric disorder
5. Those in whom there is considerable behavioural disturbance
6. Other factors that make assessment in primary care unreliable or challenging, such as communication difficulties
7. Those with pre-existing learning difficulties should be referred to the Learning Disability service
8. Where there is a history of hallucinations, Suspected Lewy Body Dementia (LBD) or dementia in Parkinson's Disease (If an individual has been diagnosed with Parkinson's Disease but is no longer under the care of a neurologist, the PCMAS would still be an option for straightforward cognitive decline but if any complexities, including common psychiatric complications, specialist memory clinic referral would be advised).

Note, those with urgent behavioural problems or safeguarding issues (abuse, high risk situations) should be referred urgently to the CMHT:

http://occg.oxnet.nhs.uk/GeneralPractice/Docs/Dementia/OLDER%20ADULT%20MENTAL%20HEALTH%20contact%20for%20duty%20desks_GP.docx

Those in the above categories should be referred to the specialist memory clinic service using Choose and Book and those aged under 65 should be referred to neurology also via CAB.
Patients should also be advised of the choices available to them and their wishes should be taken into account.

Assessment 2 (second consultation, could be undertaken by practice nurse or health care assistant if suitably trained)

Note that 1,2 and 3 below could be done in advance by supplying forms for completion at home and bringing completed to this second assessment. The urine sample could also be done at home and brought in to this second assessment.

1. Arrange GPCOG (IQ) if not already done
2. Arrange depression screen (e.g. PHQ 9) if not already done
3. Assessment of any functional impairment by asking carer / close relative to complete form, Bristol Activities of Daily Living Scale (BADLS). Available on the OCCG intranet.
4. Repeat GPCOG or Montreal Cognitive Assessment (MOCA) http://www.mocatest.org/wp-content/uploads/2015/tests-instructions/MoCA-Test-English_7_1.pdf
    - If history and initial GPCOG (especially inability to draw a clock correctly) support a likely diagnosis of dementia, repeating the GPCOG is likely to be sufficient.

- The value of repeating the GPCOG is to ensure the patient demonstrates the same impairment as before, especially as the initial test may have been done in limited time during a routine GP consultation.
- The MOCA is more useful in the diagnosis of Mild Cognitive Impairment although the actual score is only part of the picture. http://occg.oxnet.nhs.uk/GeneralPractice/Docs/Dementia/MoCA_Administration%20and%20Scoring%20Instructions.pdf

5. Ask if any problems with hearing / eyesight / continence
6. Ask if any falls / mobility problems
7. Dementia screening blood tests (as on ICE)
8. Urine dip to exclude UTI
9. BMI (weight loss?), pulse (AF?) and BP
10. Ensure patient/carer has made appropriate follow up appoint with GP to discuss results of assessment.

Assessment 3 (third consultation, GP, 20-30 mins)

1. With patient and relative/carer
2. Review above results
3. Obtain more detailed history about the pattern of cognitive decline if required including length of history, fluctuations, changes in personality, altered behaviour, other symptoms such as hallucinations
4. Treat/address any possible factors that could be causing cognitive impairment such as depression, alcohol excess, anticholinergic drugs
5. Consider need for CT scan
   This is not needed for diagnosis (as the diagnosis is made on basis of history and the PCMAS) but to exclude other possible causes for cognitive impairment
   - To exclude any possible Space-occupying lesion (SOL) especially if evidence of neurosigns/neurosymptoms of carcinoma
   - To exclude chronic subdural (especially if history of falls, on anticoagulants etc.)
   - If there is atypical history or progression of dementia.(Limited value in >75.)

If mild cognitive impairment or dementia manifests itself following a CVA with no prior memory concern, a diagnosis of vascular dementia is likely and, as it is assumed most will have had a scan at the time of the CVA, a repeat scan will not normally be indicated.

Summary Of Recommendation of When CT Scan Indicated

Age 65 or less	Age 65-79	Age 80+
Not suitable for primary care management- refer secondary care service	Arrange scan unless history of gradual memory decline over 1 yr and no atypical features	Only scan if: • Recent head injury • History of malignancy • Rapid unexplained deterioration • Unexplained focal neurological symptoms and signs including early urinary incontinence or gait disturbance

Make diagnosis of Mild Cognitive Impairment or dementia (codes to be added to patient record)

Remember dementia is a combination of multi-domain cognitive decline and significant impairment in functional abilities (in the absence of a physical reason to cause such impairment). Do not make diagnosis on basis of GPCOG or MOCA alone.

Mild Cognitive Impairment is where there is objective cognitive decline on testing (more than is to be expected from age alone) but not associated with any significant functional impairment. It is not possible to predict with certainty whether this is the early stages of dementia. Many with MCI will never develop dementia but a proportion will progress in time so annual review should be offered

If dementia diagnosed:

1. Communicate diagnosis sensitively but clearly and provide written information about diagnosis
   e.g. http://www.patient.co.uk/health/memory-loss-and-dementia

2. Refer to dementia Advisor/ support services at dementia.oxfordshire@nhs.net and provide leaflet downloaded from http://occg.oxnet.nhs.uk/GeneralPractice/Docs/Dementia/Dementia-Oxfordshire-leaflet-PDF.pdf

3. If a candidate for AChE inhibitor, supply information for relatives/carers to consider (do not start at this consultation if arranging a CT scan)

4. See separate prescribing protocol for initiation of AChE inhibitor prescribing in primary care
   http://occg.oxnet.nhs.uk/GeneralPractice/Pages/PCMASInformationSuite.aspx

5. Advise patient / carer they should notify DVLA –some with mild dementia may still be able to drive for a while.

6. Advise patient / carer to consider arranging Lasting Power of Attorney to help manage finances etc (and/or welfare) while patient still has the capacity to make their own decisions
   (Dementia Advisor will be able to provide more details)

7. Arrange interval for follow up

Providing written information about the diagnosis, referring to a dementia Advisor and arranging a suitable follow up appointment constitute a dementia "care plan" and once done, this prompt on the computer PCMAS template should be completed.

If mild cognitive impairment diagnosed:
Reassure not necessarily progressive or dementia but offer annual reviews to detect progression. However, explain that at 5 years, up to 50% have not progressed to dementia.

1. Advise cognitive stimulation to keep the brain active eg puzzles, quizzes, Sudoku, jigsaws, conversation, reading/listening to the news, attending social or public events.
2. Lifestyle advice including keeping active (physical, social and intellectual if appropriate)
3. Keep to safe alcohol limits
4. Address all modifiable vascular risk factors if not already done so.
5. Supply invitation to participate in research with leaflet http://occg.oxnet.nhs.uk/GeneralPractice/Docs/Dementia/JDR_Leaflet.pdf
6. Arrange interval for follow up (6-12 months)

When to consider specialist referral after Assessment
1. Patient/family/carer wish for second opinion
2. GP concern
3. Behavioural or psychiatric difficulties that do not respond to antidepressants
4. Uncertainty, e.g. if significant discrepancy between GPCOG patient and informant questionnaire (IQ) scores
5. Evidence of atypical dementia features e g. hallucination for dementia with Lewy Body, dementia in Parkinson's Disease, frontotemporal dementia

Note that although those with a diagnosis of Mild Cognitive Impairment can be referred to a specialist memory service, there are currently no reliable means to predict which individuals will go on to progress to dementia. Watchful waiting is therefore an appropriate option unless there are other reasons to seek another opinion.

3. Service Duration

This service will run from 1st April 2017 until 31st March 2018 with the expectation it will continue to be offered on an annual basis.

4. Payment

(a) Component 1. Set-up costs

This will be provided at a cost of £250 per practice and includes time for practice staff for training and familiarisation with the process. To support practices with this, the following are available on the OCCG intranet:
http://occg.oxnet.nhs.uk/GeneralPractice/Pages/PCMASInformationSuite.aspx

- a PowerPoint training presentation (prepared in 2013 so awaiting some updating) or Dr Julie Anderson is available to provide practice-based training sessions in person on request
- Letter to give patients/carers after offering PCMAS about GP memory clinic appointments
- a dementia diagnostic pathway recording template (available also as an EMIS web customised template ready to import direct into Emis web systems)
- a prescribing protocol for the initiation of Acetylcholinesterase inhibitors
- other useful forms

(b) Component 2 (Assessments 2 & 3 leading to a diagnosis of Mild Cognitive Impairment or Dementia using the required codes)

£125 per patient fully assessed and diagnosed in the primary care memory assessment service alone

5. Audit & Monitoring

Payments are subject to the following conditions:

- Return of signed agreement from a participating practice.
- Practices will need to e-mail notification (see below) of the completion of setting-up administrative systems to support the PCMAS.
- The CCG have arranged for an enquiry programme (for the READ codes outlined within Appendix 1, on a quarterly basis. This programme is sent to the practice to run and report.

6. Data reporting

The measurement periods run quarterly.

All practices will need to ensure they are using the PCMAS computer recording template and all staff understand how to use it.

Payment depends on the recording of:

- Referral into PCMAS (to distinguish this from specialist memory clinic referrals)
- GPCOG (to ensure cognitive deficit has been tested and therefore appropriate referral)
- Seen in (GP) memory clinic (this represents the 3rd assessment and implies the PCMAS process has been completed)
- Diagnosis of one of the following:
  - Mild Cognitive Impairment

- Alzheimer's Disease
- Vascular dementia
- Mixed (Alzheimer's and vascular) dementia

This does not have to be completed in one quarter but data on those referred into the service + GPCOG is only collected for 6 months prior to the current quarter.

Quality assurance of the PCMAS depends on:
- The payment indicators above
- Referral to Dementia Advisor
- Dementia Care Plan
- Numbers undergoing CT scan (there is no target)
- Numbers prescribed an acetylcholinesterase inhibitor (there is no target)

The specific codes are listed in the template below and are embedded in the Emis web PCMAS template available to download and import.

7. Evidence of Achievement

Quarterly reporting data collected from each practice will be collated and summarised to provide evidence from each practice of achievement. Practices will then be sent an invitation to submit and invoice bases on the quarterly data.

Appendix 1

Oxfordshire Clinical Commissioning Group

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PCMAS recording template: Read Codes
This template is designed to incorporate the components of the Primary Care Diagnostic and Management Protocol for GPs and their teams to complete the 3 stages of assessment that would form the pathway.
The purpose of the template, which would be incorporated into the practice computer system to sit alongside other practice templates, is to serve as an aide-memoire for GPs/PNs and to capture the relevant coded information as specified in the protocol.

First assessment :GP consultation			
Prompt	**Data to be entered**	**Clinical Code**	**Classification Term**
GPCOG patient	0-9	38Dv0	GPCOG(GP assessment of cognition) patient examination (38Dv0)
GPCOG informant*	0-6	38Dv1	GPCOG (GP assessment of cognition)informant interview
GPCOG (total)	0-15	38Dv	GPCOG general practitioner assessment of cognition
Medication possibly affecting medicine	Y/N	9N73	Repeat medication check
For further memory assessment?	Y/N Choose from pick list if yes	8HTY	Referral to memory clinic
Referral to GP memory service	8Hkx		Referral to general practitioner assessment unit
Referral to Specialist Memory Clinic	8H4D		Referral to Psychogeriatrician
Private referral to Psychogeriatrician	8HVS		Private referral to Psychogeriatrician
Referral to memory clinic declined	8IEn		Referral to memory clinic declined
Second assessment: PN consultation			
GPCOG patient (2nd test)	0-9	38Dv0	GPCOG(GP assessment of cognition) patient examination (38Dv0)
GPCOG (informant) if 5-8 and not already done	0-6	38Dv1	GPCOG (GP assessment of cognition)informant interview

Total GPCOG score (today's score + IQ score)	0-15	38Dv	GPCOG general practitioner assessment of cognition
Ability to perform activities of everyday life	Y/N	1PA	Ability to perform activities of everyday life
Ability to carry out everyday activities	Choose from pick list	Free text to indicate whether the patient has no, mild, moderate or severe impairment	No impairment, mild impairment(needs a little help) Moderate impairment (needs quite a lot of help) Severe impairment (needs help with nearly everything)
Ability to perform personal care activity	Y/N	1P8	Ability to perform personal care activity
Ability to perform personal care	Choose from pick list	Free text to indicate whether the patient has no, mild, moderate or severe impairment	Independent, mild impairment (needs some help), moderate impairment (need quite a lot of help), severe impairment (needs help with most things)
Depression score PHQ9	0-27	388f	Patient health questionnaire (PHQ9) score
Dementia screening blood test done?	Y/N	ZV7Az	[v] Screening for unspec. Neurological, eye or ear disorder
Urine dip?	Y/N	461	Urine exam-general
Hearing Ok?	Choose from pick list	1C11 1C12 2DG 1C17	Hearing normal Hearing difficult Hearing aid worn Hearing aid problem
Vision OK?	Y/N	668A 668B	Normal vision Poor visual acuity
Has a carer	918F	Has a carer	
3rd assessment		**GP consultation**	
GP memory clinic	Y/N	9Nk1	Seen in memory clinic
CAT scan brain requested?	Y/N	5675	CAT scan-brain

Result of assessment	Choose from pick list	28E0 F110 Eu002 Eu01	Mild Cognitive Impairment Alzheimer's disease [X]Dementia in Alzheimer's dis, atypical or mixed type [X]Vascular dementia
Dementia Care Plan Made?	Y/N	8CMZ	Dementia Care Plan
Referral to dementia care advisor (only if dementia diagnosed)	Y/N	8Hla	Referral to dementia care advisor
Patient advised to inform DVLA (if dementia)	Y/N	8CA9	Patient advised to inform DVLA
Dementia annual review	Next review (diary date)	6AB	Dementia annual review

Note
Elements of the PCMAS for payment are:
GP COG (38Dv0) + Referral to GP Memory Service (8Hkx) +Seen in GP memory Clinic (9Nk1) + Diagnosis of one of the following:

28EO	Mild Cognitive Impairment
F110	Alzheimer's disease
Eu002	[X]Dementia in Alzheimer's dis, atypical or mixed type
Eu01	[X]Vascular dementia

The pathway needs to be completed within 6 months in order for payment.