

OCCG SERVICE SPECIFICATION (2019/20)
Primary Care Memory Assessment Service (PCMAS)

1. 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.

[Dementia diagnosis and management: "A brief pragmatic resource for general practitioners First published: 14/01/2015"](#)

This scheme sets out a 3 stage assessment process so that the diagnosis and management of mild cognitive impairment and dementia can be made safely and appropriately in primary care. 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 GP consultation in which a patient presents with a memory concern, or through other presentations, for example:

- hospital discharge summary indicates a concern
- evident new difficulties complying with medication/appointments in older adults
- case finding in higher risk patients, including 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 £127.50 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.

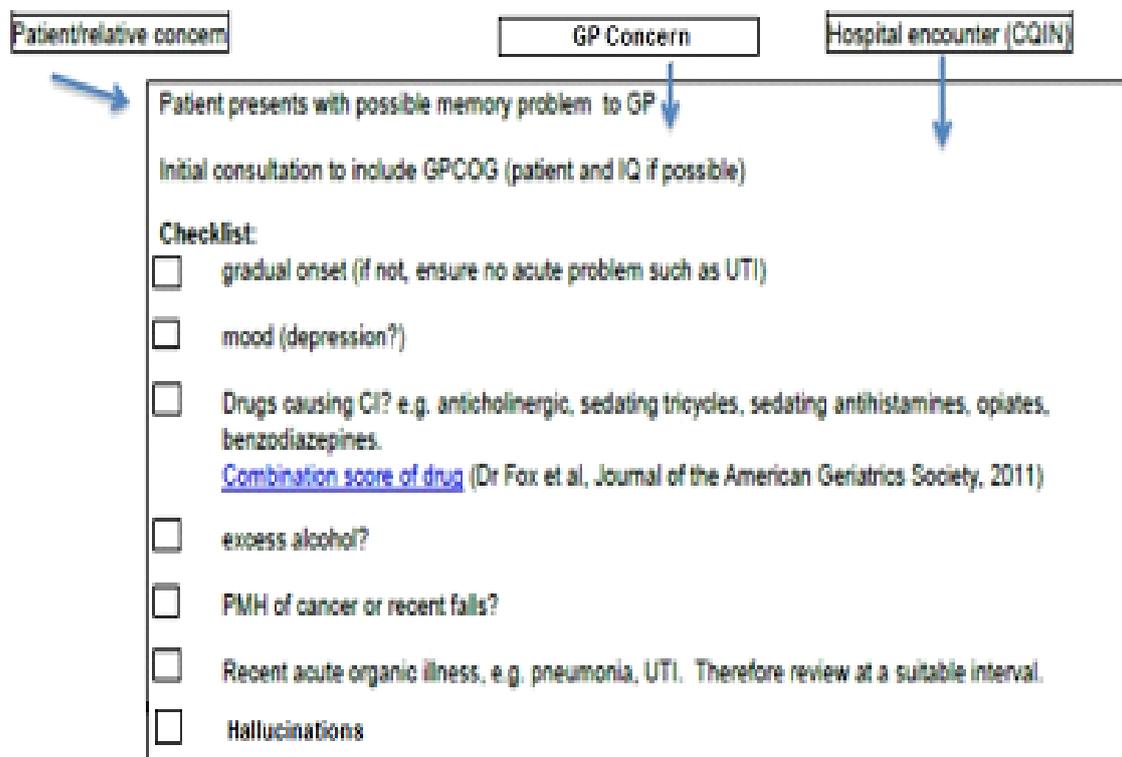
No part of this specification by commission, omission or implication defines or redefined essential or additional services.

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. Primary care and specialist memory services 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 information:

<http://www.oxfordshireccg.nhs.uk/professional-resources/clinical-guidelines/gp-memory-assessment-service-letter-to-patients/63407> to ensure appointments are made correctly and as a reminder. Reception staff should provide the necessary forms and urine bottle required for the second assessment, at the time the appointments are booked.

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:

1. Patients under the age of 65 should be referred to a neurologist as there is a greater chance of an underlying neurological condition
2. Memory problems having an atypical time course, or with associated focal neurological symptoms/signs
3. Associated significant psychiatric comorbidity/history
4. Prominent behavioural or psychological symptoms (e.g. aggression, wandering)

5. Other factors that make assessment in primary care unreliable or challenging, such as communication difficulties
6. Those with pre-existing learning disability should be referred to the Learning Disability service
7. Suspected alcohol-related dementia
8. Suspected Lewy Body Dementia (LBD) or dementia in Parkinson's Disease (If an individual has an established diagnosis of Parkinson's Disease but is no longer under the care of a neurologist, the PCMAS could still be an option for gradual cognitive decline).

Those in the above categories should be referred to the appropriate specialist memory clinic service using the e-Referral system:

- Older adults psychiatry memory clinic: patients with psychiatric comorbidities or prominent behavioural symptoms, or those for whom specialist follow up in the community is likely to be appropriate.
- Geratology memory clinic: patients with parkinsonism, or those for whom physical rather than psychiatric comorbidities (e.g. frailty, complex vascular disease, polypharmacy) are central to management of cognitive impairment.
- Neurology memory clinic: patients younger than 65
- Learning disability team: patients with pre-existing learning disability

Patients should also be advised of the choices available to them and their wishes should be taken into account.

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

<http://www.oxfordshireccg.nhs.uk/professional-resources/documents/clinical-guidelines/mental-health/dementia/older-adult-mental-health-contacts.pdf>

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 should also be 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 Bristol Activities of Daily Living (BADLS) form

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.

[Link to guidance for administration and scoring](#)

4. Ask about (and record) any problems with hearing / eyesight / continence
5. Ask about (and record) any falls / mobility problems
6. Dementia screening blood tests (as per QOF requirements, available as a “clinical group” on ICE)
7. Urinalysis to screen for UTI
8. BMI (weight loss?), pulse (AF?) and BP
9. 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 dementia diagnosis (as the diagnosis is made on the basis of clinical assessment) but to exclude other possible causes for cognitive impairment
 - To exclude a space-occupying lesion, especially if
 - focal neurological signs/symptoms
 - history of malignancy.
 - Symptoms/signs otherwise atypical or progressing more rapidly
 - To exclude chronic subdural (especially if history of falls, on anticoagulants etc.)

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.

When is a CT scan indicated? Summary of recommendations:

| <u>Age 65 or less</u> | <u>Age 65-79</u> | <u>Age 80+</u> |
|--|--|--|
| 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: <ul style="list-style-type: none"> • 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 by completing a referral form <http://www.oxfordshireccg.nhs.uk/professional-resources/clinical-guidelines/primary-care-memory-assessment-service-emis-template/61779> and sending it to dementia.oxfordshire@nhs.net and provide leaflet downloaded from <http://www.oxfordshireccg.nhs.uk/clinical-guidelines/dementia-oxfordshire-leaflet/60532>
3. If a candidate for AChE inhibitor, offer information for relatives/carers to consider ([Link to patient information](#))
4. See separate [prescribing protocol](#) for initiation of AChE inhibitor prescribing in primary care:
5. If the patient drives, they must notify the DVLA (they will usually need to complete and submit form CG1, which is available online [here](#))

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/guidance)
7. Recommend 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. 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. Recommend interval for follow up (6-12 months)

When to consider specialist referral after Assessment

1. Patient/family/GP wants a second opinion
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. prominent hallucinations or movement disorder in mild-moderate 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/Termination

This service will run from 1st April 2019 until 31st March 2020 with the expectation it will continue to be offered on an annual basis. For termination ahead of this 3 months written notice must be given.

4. Payment**(a) Component 1. Set-up costs**

This will be provided at a cost of **£255 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 via the PCMAS Information Suite document:



180329 PCMAS
Information Suite.doc

- a PowerPoint training presentation (prepared in 2013 so awaiting some updating) or Dr Jonathan Crawshaw 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)

£127.50 per patient fully assessed and diagnosed in the primary care memory assessment service alone – see Appendix 1.

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.
- Data will be extracted from the practice system by SCWCSU around the 15th of the month following the end of each quarter to monitor activity (deadline to be confirmed each quarter by SCWCSU).

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 paid based on the quarterly data.

8. Contact

Contact for queries: sharon.hopkins3@nhs.net

Clinical lead: jonathan.crawshaw@nhs.net

Appendix 1

Oxfordshire Clinical Commissioning Group

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 Psychogeriatrician Private referral to Psychogeriatrician Referral to memory clinic declined |
| Referral to Specialist Memory Clinic | 8H4D | | |
| Private referral to Psychogeriatrician | 8HVS | | |
| Referral to memory clinic declined | 8IEen | | |
| Second assessment: PN consultation | | | |
| GPCOG patient (2 nd 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 | 0-15 | 38Dv | GPCOG general |

| | | | |
|--|-----------------------|---|---|
| (today's score + IQ score) | | | 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 | 8H1a | 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 |

Please note: To qualify for payment:

Elements of the PCMAS for payment are that the patient has completed the care pathway =

Referral to GP Assessment Service (8Hkx)

+GP COG (38Dv0)

+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 |
| E2A10 | Mild memory disturbance |

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

SNOMED codes (to be introduced in 2019) to be confirmed.