NHS
Oxfordshire
Clinical Commissioning Group

OCCG SERVICE SPECIFICATION (2020/21)
Primary Care Memory Assessment Service

1. Background

The Primary Care Memory Assessment Service (PCMAS) started as a pilot in 2013 and is now available to all practices in Oxfordshire. The PCMAS aims to achieve a user-friendly dementia pathway for easier access to appropriate support services and a timelier diagnosis. 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 service 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"

The scheme sets out a three 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.

The 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

The first assessment would be carried out even if a patient is to be referred to a specialist memory clinic, therefore the payments for the PCMAS are for the second (a 20 minute Practice Nurse or HCA appointment) and third assessment, which is completed a week or so later (a 20-30 minute GP appointment). Payment 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 third assessment appointment (i.e. 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.

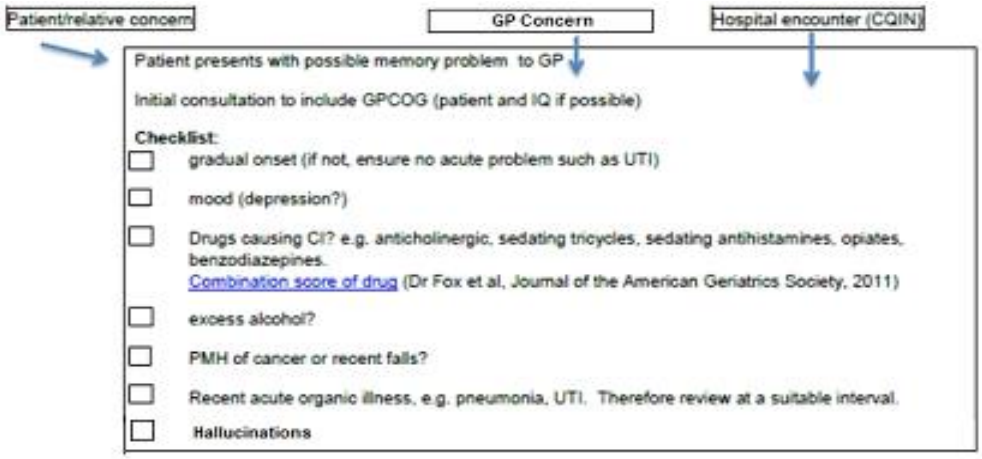
No part of this specification by commission, omission or implication defines or redefines essential or additional services.

2. Service outline

The PCMAS is designed to allow those with suspected dementia to be diagnosed and managed in primary care when appropriate, as an alternative 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 three stage-assessment process should be recorded using the computer template (see Appendix 1), which can be downloaded and imported to EMIS web.

Assessment One:



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 Two as long as informant attends with patient)
   - Offer the PCMAS with Assessments Two and Three and provide patient with Patient Information letter regarding memory appointments (reception staff to provide packs of required questionnaires when patient makes appointment and also provide the urine bottle required for the second assessment)

http://www.oxfordshireccg.nhs.uk/professional-resources/clinical-guidelines/gp-memory-assessment-service-letter-to-patients/63407

Scope:

Offer the PCMAS to patients where there is evidence of cognitive decline by inviting them to make further appointments to undergo further assessment.

It is 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. 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.

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

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 / in place.

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

When to consider specialist referral:

1. Patients under the age of 65 should be referred to a neurologist, noting 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 (i.e. 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 with cognitive impairment in the above categories should be referred to the appropriate specialist memory clinic service using the e-Referral system:

- Older Adult's 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 be advised of the choices available to them and their wishes should be considered.

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 Two (second consultation, which could be undertaken by a practice nurse or health care assistant if suitably trained)

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

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

- 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 (see link below) is more useful in the diagnosis of Mild Cognitive Impairment although the actual score is only part of the picture

http://www.mocatest.org/wp-content/uploads/2015/tests-instructions/MoCA-Test-English_7_1.pdf

Link to guidance for administration and scoring of MoCA test

1. Ask about (and record) any problems with hearing / eyesight / continence
2. Ask about (and record) any falls / mobility problems
3. Dementia screening blood tests (as per QOF requirements, available as a “clinical group” on ICE)
4. Urinalysis to screen for UTI
5. BMI (weight loss?), pulse (AF?) and BP
6. Ensure patient / carer has made appropriate follow up appointment with GP to discuss results of assessment

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

1. With patient and relative / carer
2. Review results from previous assessment
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
   (Note 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:

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 mild cognitive impairment will never develop dementia but a proportion will progress in time so annual review should be offered.

If dementia is 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 patient / carer to dementia advisor / support services by completing a referral form https://www.oxfordshireccg.nhs.uk/professional-resources/clinical-guidelines/referral-pro-formas.htm and sending it to dementia.oxfordshire@nhs.net. Provide leaflet downloaded from http://www.oxfordshireccg.nhs.uk/clinical-guidelines/dementia-oxfordshire-leaflet/60532

3. If patient is 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, notify them that they must alert the DVLA and complete a CG1 form (also available online)

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 constitutes a dementia 'Care Plan' and once done, the PCMAS template should be completed.

If mild cognitive impairment is 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 e.g. puzzles, quizzes, Sudoku, jigsaws, conversation, reading / listening to the news, attending social or public events
2. Offer lifestyle advice including keeping active (physical, social and intellectual if appropriate)
3. Advise to 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

- Patient / family / GP wants a second opinion
- Behavioural or psychiatric difficulties that do not respond to antidepressants
- Uncertainty, e.g. if significant discrepancy between GPCOG patient and informant questionnaire (IQ) scores
- 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 2020 until 31st March 2021 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 One: 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

- PowerPoint training presentation
- Patient Information Letter (to be given to patients after offering PCMAS which outlines GP memory clinic appointments)
- Dementia diagnostic pathway recording template (available also as an EMIS web customised template ready to import direct into EMIS web systems)
- Prescribing protocol for the initiation of Acetylcholinesterase inhibitors
- other useful forms

(b) Component 2 (Assessments Two & Three): Leading to a diagnosis of mild cognitive impairment or dementia using the required codes

£127.50 per patient fully assessed and diagnosed in the PCMAS 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 be based on the quarterly data.

8. Contact

Contact for queries: sharon.hopkins3@nhs.net
Clinical lead: davidchapman@nhs.net

Appendix 1

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	Y/N	1PA	Ability to perform

of everyday life			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	Y/N	8Hla	Referral to

advisor (only if dementia diagnosed)			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	Dementia in Alzheimer's dis, atypical or mixed type
Eu01	Vascular dementia
E2A10	Mild memory disturbance
Eu025	Lewy body dementia

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

SNOMED Codes

Please note SNOMED Codes are currently indicative, subject to data quality checks

The search includes all patients i.e. dieds and lefts except temporary patients to ensure comprehensive reporting of activity.
Data are extracted per quarter only (i.e. not cumulative for the financial year).

	Item	**Read Code and Description**	**SNOMED Codes**
Search population	Practice population aged 65+		
Audit population - *latest codes*	Patients in search population with a referral to GP assessment unit and a GPCOG -.**The search is from January preceding the fiscal year to end of the Quarter to ensure patients with a Referral are captured**	38Dv%GPCOG - general practitioner assessment of cognition 8Hkx. Referral to general practitioner assessment unit	504121000000102 GPCOG - general practitioner assessment of cognition 754221000000103 GPCOG (general practitioner assessment of cognition) patient examination 754241000000105 General practitioner assessment of cognition informant interview 794471000000105 Referral to GP (general practitioner) assessment unit

	Item	Read Code and Description	SNOMED Codes
For payment: Completed pathway	Numbers who have completed the care pathway i.e. who have been • Given a GPCOG • Referred • Seen in memory clinic and Diagnosed **The search is cumulative to the end of the Quarter.**	9Nk1. Seen in memory clinic in the quarter AND one of the following diagnoses (latest record) Latest records of: E2A10 Mild memory disturbance F110 Alzheimer's disease Eu002 [X]Dementia in Alzheimer's dis, atypical or mixed type Eu01 [X]Vascular dementia 28E0 Mild cognitive *impairment. Not all patients seen in memory clinic will meet the pathway because they may be coded with a different diagnosis e.g. anxiety* Eu025 Lewy body dementia	432806004 Seen in memory clinic AND one of the following diagnoses after they have been seen. 192071009 Mild memory disturbance 26929004 Alzheimer's disease 79341000119107 Mixed dementia 419261000000107 [X] Dementia in Alzheimer's dis, atypical of mixed type . 429998004 Vascular dementia 386805003 Mild cognitive impairment 132893017 Diffuse Lewy Body Disease

	Item	Read Code and Description	SNOMED Codes
For information and return – patients who have completed pathway	Dementia care plan recorded during the fiscal year	8CMZ. Dementia care plan	736371006 Dementia care plan
	Referred to dementia care advisor during the fiscal year	8Hla. Referral to dementia care advisor	798381000000109 Referral to dementia care advisor
	Patients with a carer (any date - latest code)	918F Has a carer	184156005 Has a carer
	Prescribed Donepezil/Galantamine/Rivastigmine (Latest record during the fiscal year	dy1% DONEPEZIL HYDROCHLORIDE dy3% GALANTAMINE dy2% RIVASTIGMINE	386856007 Donepezil Hydrochloride 129482002 Galantamine Hydrobromide 395868008 Rivastigmine 126131008 Rivastigmine Hydrogen Tartrate

Children (2)

- General practitioner assessment of cognition informant interview (assessment scale)
- General practitioner assessment of cognition patient examination (assessment scale)