Bristol Clinical Commissioning Group

Local Enhanced Service Agreement 1 July 2013 – 31 March 2016

Recognition and Management of People with Dementia and their Family/Carers in General Practices in Bristol

Agreement between NHS Bristol Clinical Commissioning Group and insert Practice name

1. Background

Around 4300 people in Bristol are estimated to have dementia, however currently only around 50% of them have a diagnosis. GPs have a crucial role in ensuring that early concerns about memory problems are detected and responded to.

Following national and local awareness raising campaigns, people are encouraged to express concerns about their memory at an earlier stage to ensure people get the right support as early as possible. It is envisaged that this will increase the demand on GP practice time. It is also recognised that assessing people and making a dementia diagnosis at an earlier stage could be more challenging.

The GP practice does not only have a key role in the diagnostic process, it also has an important role in following the person with dementia and their family/carers through the different stages of their condition to ensure all the support is available for the person's ongoing management of health and well-being.

Dementia is a medical disorder and should be managed like any other serious long-term illness, including prompt diagnosis, regular monitoring, conducting health checks (for the person with dementia and their family/carers), ensuring people with dementia attend screening programs, advising on preventive actions, advanced decision making and contingency planning, and signposting people to local information, advice & support services as well as end of life care.

With respect to dementia care a specific shared care pathway has been developed and piloted in 11 GP practices, to describe partnership working between GPs and Secondary Mental Health Care (Avon and Wiltshire Mental Health Partnership Trust). One key aspect of this pathway is the guidance regarding the initiation and maintenance of dementia drugs and decision making around discontinuation of medication. The tasks and responsibilities

for both care providers have been captured in a shared care protocol (see appendix 5). This LES is meant to support all GP practices in Bristol to implement the shared care pathway and to ensure every person with dementia receives the same level of support regarding assessment, diagnoses and follow up care regardless which GP practice they are registered.

2. Parties to the agreement

The 'Provider' is the GP Practice providing the service to patients

The 'Commissioner' is NHS Bristol Clinical Commissioning Group

3. Terms of the agreement

This Enhanced Service Agreement will run from 1st July 2013 until 31st March 2016.

Practices wishing to withdraw from this enhanced service will need to do so in writing and provide NHS Bristol CCG with 3 month's notice of their intention to do so.

NHS Bristol CCG may terminate this agreement by giving 3 month's written notice to the Provider.

In the event of disagreement or dispute NHS Bristol CCG and the practice will use best endeavours to resolve the dispute without recourse to formal arbitration. If unsuccessful, the matter will be determined in accordance with the normal contractual dispute resolution procedure.

The LES will be reviewed on an annual basis and funding will increase in-line with standard CCG inflationary uplift.

4. Aims

This GP Local Enhanced Service for Dementia Care aims to:

- Ensure people with dementia and their carers receive the same level of care among all GP practices in Bristol
- Ensure each practice has a lead GP and lead practice nurse/health practitioner for dementia
- Increase the early recognition and diagnosis of dementia in every GP practice in Bristol
- Enable secondary care to support primary care to make a diagnosis of dementia. To do this there will be a named memory nurse for each locality.

- Provide a recall and comprehensive review system for people who are transferred back into Primary Care after being initiated and stabilised on Cholinesterase Inhibitors and/or memantine in the Memory Service, according to the appropriate local shared care protocols and pathway, using the EMISweb template (paper version will be available)

- Provide a comprehensive review process for people with dementia who are on anti-psychotic medication

- Contribute towards the reduction of the waiting time for a memory assessment in Secondary Care, by implementing the shared care pathway in the GP practice. This will enable Secondary Care resources to focus on the most complex cases

- Provide a holistic package of care to enable more people with dementia and their carers to be managed in primary care where appropriate

- Enhance physical care and health promotion advice for all people and carers for people with dementia, especially regarding vascular dementia.

5. Expected Outcomes

It is expected that by delivering the LES practices will be able to deliver the following outcomes:

- There is a culture in primary care of dementia being viewed and managed as a long term condition

- People with dementia and their family/carers are highly satisfied that their GP practice understands their dementia and that they gain relevant information about their dementia.

- An increased number of people with dementia receive a timely diagnosis.

- There is a sustained level of diagnosis of dementia and on-going management in primary care, with appropriate signposting to post diagnostic services

- Carers of people with dementia receive appropriate information and are signposted to support, to enable them to take a break

- Bristol has an appropriately trained workforce of health professionals who are highly competent in supporting people with dementia

6. Service criteria

To participate in the LES, practices are required to carry out the following.

Basic
£500 one off payment for signing up to the LES. Evidence must be collected during the year, to fulfil the basic requirement of the monitoring form (appendix 6). If this is not completed, the practice will be required to return the funding to the commissioner at the end of the year. Requirements are:

1. Having a named lead GP and a named practice nurse/health care practitioner for dementia
2. Named lead GP and named practice nurse/health care practitioner participate in yearly dementia training, provided or endorsed by Bristol Clinical Leads for Dementia (training completed in 2012 will count towards this), this could be in person or online and will be a maximum of half a day.
3. The named lead GP for dementia to provide a structured update session on dementia for all the other GPs and practice staff at least once a year
4. Upload the practice QoF data on dementia to QMAS on a monthly basis, as per usual practice
5. Actively participate in evaluation of the service, this may include sending out surveys to patients/families and practice staff being interviewed
6. Record carers on the carers register and signpost carers for short breaks, evidenced by at least 6 monthly meetings with the Primary Care Carers Support Workers – contact details:

   Dale Cranshaw (Inner City and East)– 07557440931 or dalec@carerssupportcentre.org.uk

   Ann Tolaini (North & West and South) – 07786195889 or annt@carerssupportcentre.org.uk

Enhanced
£164 per diagnosis
£40 per enhanced review

To participate in the enhanced section of the LES, practices must evidence their participation in the basic section, via the monitoring form (see appendix 6). Practices should use the supplied EMISweb template to carry out the diagnosis and enhanced review (a paper copy will be supplied for practices not on EMISweb.)

- Undertake a diagnosis of uncomplicated dementia (Alzheimer's Disease or Vascular Dementia) within a Primary Care setting (using the agreed template) and provide appropriate post diagnostic support and signposting information
- Carry out enhanced reviews of people with dementia and their family/carer (using the agreed template) that delivers review of all medication including cholinesterase inhibitors, memantine and anti-psychotic medication.

Practices will need to consider how best to manage the reviews. Practices may wish to work together and appoint a practice nurse to carry out all the reviews across a cluster of practices.

Detailed Description of the Enhanced Requirement

- Adopting the shared care pathway including management of people stable on dementia medication.
- To undertake investigations as indicated in Appendices 1-5 and investigate any abnormalities to exclude potentially treatable causes
- To undertake a diagnosis of dementia and initiate medication in line with guidance provided in appendices 2 and 3
- To complete a plan for the patient that includes relevant information including where to go for further support and signposting
- To note the diagnosis of dementia, if made in secondary care and record accordingly with relevant read code.
- To review stable cases of people with dementia, currently seen in secondary care (payment £40 per review)
- To review every person diagnosed with dementia at least once a year (6 monthly if on dementia related medication, 3 monthly if on anti-psychotic medication), following the review template provided in EMISweb form
- To continue the prescribing of Cholinesterase Inhibitor or memantine
- To notify the Memory Nurse of any adverse drug reactions, deterioration in condition or any other clinical concerns regarding the person's health that can not be managed in Primary Care.

In order to qualify for payment the practice must complete the work detailed above. The memory nurse for the locality will be able to provide support, advice and guidance. The memory nurse will be able to carry out joint home

visits with the GP/nurse. **If the memory nurse carries out a home visit on their own, the practice will not be eligible to claim payment.**

Bonus Payment
£200

Practices will receive a bonus payment if they achieve a 5% increase in the number of people on the practice register with a diagnosis of dementia, in year, or if they achieve 65% of expected diagnosis against expected prevalence.

7. Monitoring and evaluation

The contractor must provide NHS Bristol CCG with such information as may be reasonably required to demonstrate that it has robust systems in place to deliver the Local Enhanced Service.

Practices will be required to submit quarterly monitoring forms in respect of this Local Enhanced Service. See appendix 6.

Practices will be required to provide evidence of the basic requirements and the specific numbers of people supported under the enhanced part of the agreement. Practices will be supplied with an EMIS web template (paper version will be available) that will guide them through the review process. A random sample of review templates will be scrutinised annually. Submission of reporting data will trigger the payment for this Local Enhanced Service.

Practice registers will be monitored in order to triangulate the payment process and to ensure appropriate payment of the bonus part.

Practices will be required to send out a number of evaluation forms (template will be provided) as part of the evaluation of the patient and family/carer experience of the service. Some members of the practice team may also be asked for their own experiences through answering questionnaires, or participating in interviews.

8. Read codes

Suggested read codes for the identification of people with dementia are the following:

"Uncomplicated Senile Dementia"	E000
"Alzheimer's disease unspecified"	Eu00z
"Multi-infarct dem'"	Eu011
"Alzheim' disease“	F110
"Lewy body dementia”	F116

9. Fees payable

Evidence must be collected during the year, to fulfil the basic requirement of the monitoring form (appendix 6). If this is not completed, the practice will be required to return the funding to the commissioner at the end of the year
The practice will receive £164 per diagnosis of dementia made in primary care.

The practice will receive £40 per person per yearly enhanced review.

The practice will be paid £200 for improving diagnosis rate by 5% on the previous year, or by achieving 65% diagnosis rate against expected prevalence

Practices should submit the monitoring form to the CCG no later than:

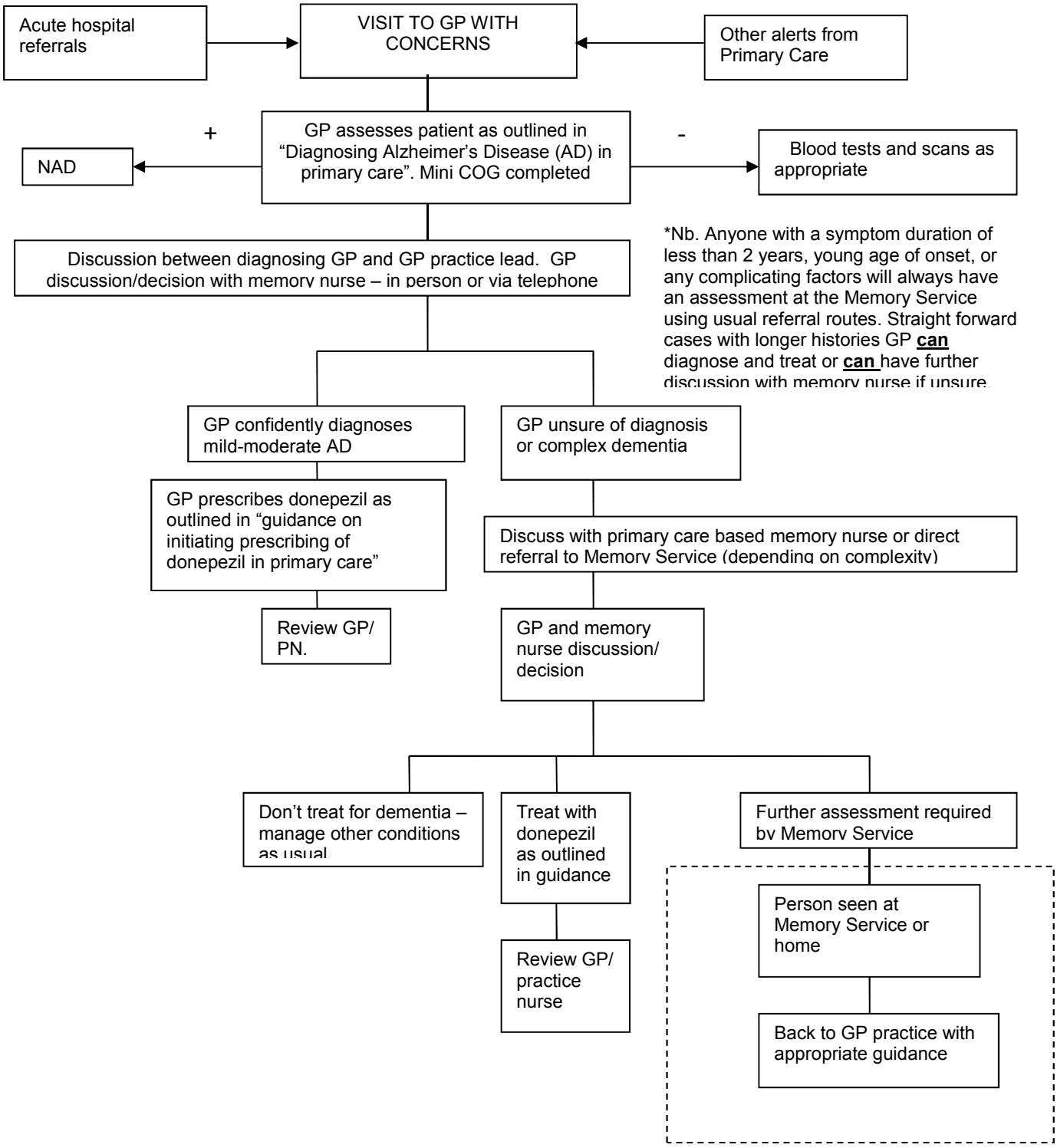
2013-14
Q1 July – September by 30th October
Q2 October- December by 31st January
Q3 January – March by 30th April

2014-15 and 2015-16
Q1 April – June by 31st July
Q2 July – September by 30th October
Q3 October- December by 31st January
Q4 January – March by 30th April

In addition to this, practices will also be entitled to receive payment if they participate in the QoF, Dementia DES and Health Check LES, of which there is now a dementia section.

Appendix 1

Pathway for Diagnosis of dementia in Primary Care



Appendix 2

Guidelines for diagnosing Alzheimer's Disease in Primary Care

3. Diagnosing AD in Primary Care.pdf

Appendix 3

Guidelines for Prescribing and Reviewing Donepezil and Reviewing Memantine (*Please note GPs are **NOT** being asked to initiate memantine)*

Guidelines_on_Prescr ibing_Donepezil_in_Pr

Reviewing Memantine Prescribin

Appendix 4

Guideline for Managing Behavioural and Psychiatric Disorder in People with Dementia

Managing BPSD guidelines_3.6.13_Bri

Appendix 5

Shared Care Protocol

This is put in place to outline the agreement between the GP Practice and the Primary Care Memory Nurses, who are employed by Avon and Wiltshire Mental Health NHS Trust (AWP).

Locally Enhanced Service Shared Care Protocol for Diagnosis of Dementia in Primary Care

Background - GP LES 13/14 Dementia Care

It is increasingly recognised that Primary Care should be at the centre of patient care for people with dementia, in the same way as they are for other long term conditions. GPs feel that with the right training and specialist support they would be confident to make a diagnosis and coordinate on-going

management in the majority of cases. The Dementia Locally Enhanced Service will support practices to provide this extended level of care. One of the aims of the new approach to dementia diagnosis and management is that General Practices are equipped with the skills, resources and support to provide a timely diagnosis and holistic care throughout the patient journey.

Crucial to the success of this approach is for Practices to have access to a Service to obtain prompt advice or an assessment of the patient when necessary. This is currently provided by the AWP Memory Service. In order to ensure that the staff are able to provide an efficient response to the needs of Practices with minimal waiting times, it is very important that the service is used for the people with the most complex needs.

Aim

To outline the process of diagnosing dementia in primary care and to describe the respective responsibilities of General Practices and the AWP Memory Services.

The Pathway for diagnosing dementia in primary care

The Pathway is described in appendix 1 consists of the following steps.

1. The GP responds to a patient's concern or those raised by other members of the primary health care team or secondary care, by taking a history, a collateral history, doing a cognitive test such as the MiniCog and appropriate bloods and imaging (see Appendix 2)

2. GP discusses all cases of possible dementia with the practice GP dementia lead.
    a. If the patient has had symptoms for more than 2 years with no other complicating factors and it is agreed that the diagnosis is Alzheimer's Disease (AD) or Mixed AD and vascular dementia, then the GP offers to prescribe Donepezil and reviewed as appropriate (Appendix 3).
    b. If the patient has a more recent history, a young age of onset, has particular complex needs, or remains uncertain for any other reason, the GP can either refer directly to the Memory Service using the existing referral route, or discusses the case with a memory nurse based in primary care. This can then result in: i) the GP treating the patient with Donepezil, ii) investigating and treating other conditions such as depression or iii) can result in the GP being advised to make a formal referral to the Memory Service for further assessment.

3. Following assessment at the Memory Service, the patient is referred back to the GP with clear advice regarding on-going care. The GP practice has responsibility for on-going follow-up and care of the patient and their carer, apart from in exceptional cases when the need for some extended follow up is agreed between the GP and Memory

Service. The on-going reviews do not always need to be done by GPs themselves, if there are other appropriately trained clinical staff at the practice or locality. Practices are encouraged to build appropriate dementia-related skills in their nursing and HCA team, similar to that of other chronic diseases such as COPD, diabetes or vascular conditions.

4. If the GP or practice nurse needs advice at any time during the patient's follow, then they should telephone the memory nurse based in primary care.

Responsibilities of the Memory Nurse in Primary Care

- To support the practice in making an appropriate and timely diagnosis through providing responsive advice to GPs either face to face or by telephone
- To work with the GP Practice to provide further assessment for people with dementia and liaise with the GP once a diagnosis and management plan is in place
- To support and advise the practice regarding the on-going management of patients with dementia of all subtypes, including ad hoc telephone advice, performing the reviews in housebound patients (jointly with GP practice staff if required) or in patients for whom attending the surgery is inappropriate.
- In exceptional cases and with agreement with the GP, to provide on-going management in some patients

Responsibilities of the Practice

- To undertake a full assessment of patients presenting with possible dementia. This should include, wherever possible, input from appropriate carers and relatives.
- To ensure that input from the practice dementia lead is included before a diagnosis is made or before the case is referred to the Memory Service.
- Where appropriate, to make a diagnosis in cases of routine Alzheimer's Disease, vascular or mixed dementia, provide immediate and on-going post diagnosis information, support and sign posting
- To code all diagnoses made on the dementia register
- Where appropriate, to prescribe and monitor donepezil (in line with prescribing guidelines)
- To perform on-going follow-up and reviews including patients on acetylcholine esterase inhibitors and memantine (using the agreed template)

Appendix 6

Monitoring and reporting template

Bristol Clinical Commissioning Group

General Practice Dementia Care Local Enhanced Service 2013-14

Monitoring Form

To be completed quarterly

1. **Basic information**

Practice name	
Practice code	L8

2. **Basic**

Name of Lead Dementia GP	
Name of Lead Dementia Practice Nurse/HealthCare Practitioner	
Date of Training Session attended/completed	GP: Nurse/HCP:
Date of structured training/update to practice and who attended	
QoF data uploaded monthly	Yes/No
Date of meeting with Carers Support Worker	1st meeting: 2nd meeting:

£500 payable annually, upon completion of part 1.

3. Enhanced

Month	Number of people diagnosed with dementia in primary care, by the GP. Please include NHS Number	Number of people reviewed in primary care using the enhanced review template. Please include NHS number	Number of Carers on the Carers Register
July			
August			
September			
October			
November			
December			
January			
February			
March			
Total			

Payment of £164 per diagnosis and £40 per review. Paid on a quarterly basis. **Please note if the memory nurse undertakes a home visit on their own, this can not count towards payment, joint visits are able to be counted.**

4. Bonus

Month	Number of people diagnosed with dementia on the QoF register
July	
August	
September	
October	
November	
December	

January	
February	
March	
Total	

Payment of £200 for improving diagnosis rate by 5% over year, or for reaching 65% of expected diagnosis rate for practice, based on DH Dementia prevalence Calculator figures.

5. Medicines management

Antipsychotics:

How many patients with dementia in your practice were prescribed the following antipsychotics during this quarter?

Aripiprazole	
Chlorpromazine	
Haloperidol	
Olanzapine	
Quetiapine	
Risperidone	
Trifluoperazine	
Other	

How many of these patients have had their antipsychotics reviewed during this quarter?	

Benzodiazepines:

How many patients with dementia at your practice were prescribed the following benzodiazepines during this quarter?

Chlordiazepoxide		Lormetazepam	
Diazepam		Nitrazepam	
Loprazolam		Oxazepam	
Lorazepam		Temazepam	

'Z' drugs:

How many patients with dementia at your practice were prescribed the following 'Z' drugs during this quarter?

Zaleplon	
Zolpidem	
Zopiclone	

6. Feedback/Evaluation

In your opinion what benefits have been experienced by your patients and their family/carers as an outcome of this LES
Please state:

What additional training requirements do you or your team need to effectively deliver this LES?
Please state:

What have been the challenges this quarter of the delivery of the LES
Please state:

Do you, as the lead dementia GP for your practice, feel that you have a greater understanding of dementia since starting this LES. If not why not? **Score:** **1 = not at all** **10 = significantly greater understanding**
Score: Comment:

Do you, as the lead dementia nurse/health care practitioner for your practice, feel that you have a greater understanding of dementia since starting this LES. If not, why not? **1 = not at all** **10 = significantly greater understanding**
Score: Comment:

Do you feel that patients are getting a quicker and more effective service since the introduction of the LES If not, why not?
Strongly agree Agree No change Disagree

Strong disagree Comment:

Do you see dementia as a long term condition If no/uncertain, why not?
Yes No Uncertain Comment:

Comments *Please include any comments or concerns that you would like raised with the commissioner and clinical lead for dementia*

Declaration:	
I confirm that the above activity is a true record of that undertaken by the practice for this monitoring period with respect to the General Practice Dementia 2013-14 Local Enhanced Service agreement.	
Name	
Position	
Date	

Monitoring and payment instructions
Please return an electronic completed copy of this monitoring form to sarah.nicholson@bristolccg.nhs.uk
Payment is made quarterly upon receipt of the monitoring form. Payment is also dependent upon practice's returning their sign-up form to the dementia LES

Queries
If you have any queries about this monitoring form please email emma.moody@bristolccg.nhs.uk

Appendix 7
Sign up Form

Bristol Clinical Commissioning Group

Local Enhanced Service Agreement Sign Up Form
1 July 2013 – 31 March 2016

Recognition and Management of People with Dementia and their Family/Carers in General Practices in Bristol

Name of Practice:
Practice Code: L8

We agree to participate in the GP Dementia Local Enhanced Service

We plan to participate in the following parts of the GP LES

	Yes/No	Value
Basic		£500
Enhanced - Diagnosis		£164 per diagnosis
Enhanced - Reviews		£40 per enhanced review (cases will be returned from secondary care)
Bonus		£200

Print Name:

Signature:

Date:

Practice Contact Details:	Name	E-mail Address	Telephone Number
Practice Manager			
Lead GP for Dementia			
Lead Nurse/Health Care Prof for Dementia			