Berkshire Dementia Care Pathway

[Prescribing Oversight Committee ClinDoc XXX]

For the latest information on interactions and adverse effects, always consult the latest version of the Summary of Product Characteristics (SPC), which can be found at: http://www.medicines.org.uk/

Approval and Authorisation

Approved by	Job Title	Date
Prescribing Oversight Committee	POC Chair	XX/XX/XXXX
BHFT Drug and Therapeutics Committee	Chair: Dr Minoo Irani	09/01/2020

Change History

Version	Date	Author	Reason
Version 1	09/01/2020	Ryan Dunstan, Mental Health Commissioning Support Manager.	Replaces 'Cholinesterase Inhibitors / Memantine Prescribing Arrangement' Version 2.2.

This prescribing guideline remains open to review considering any new evidence

This guideline should only be viewed online and will no longer be valid if printed off or saved locally

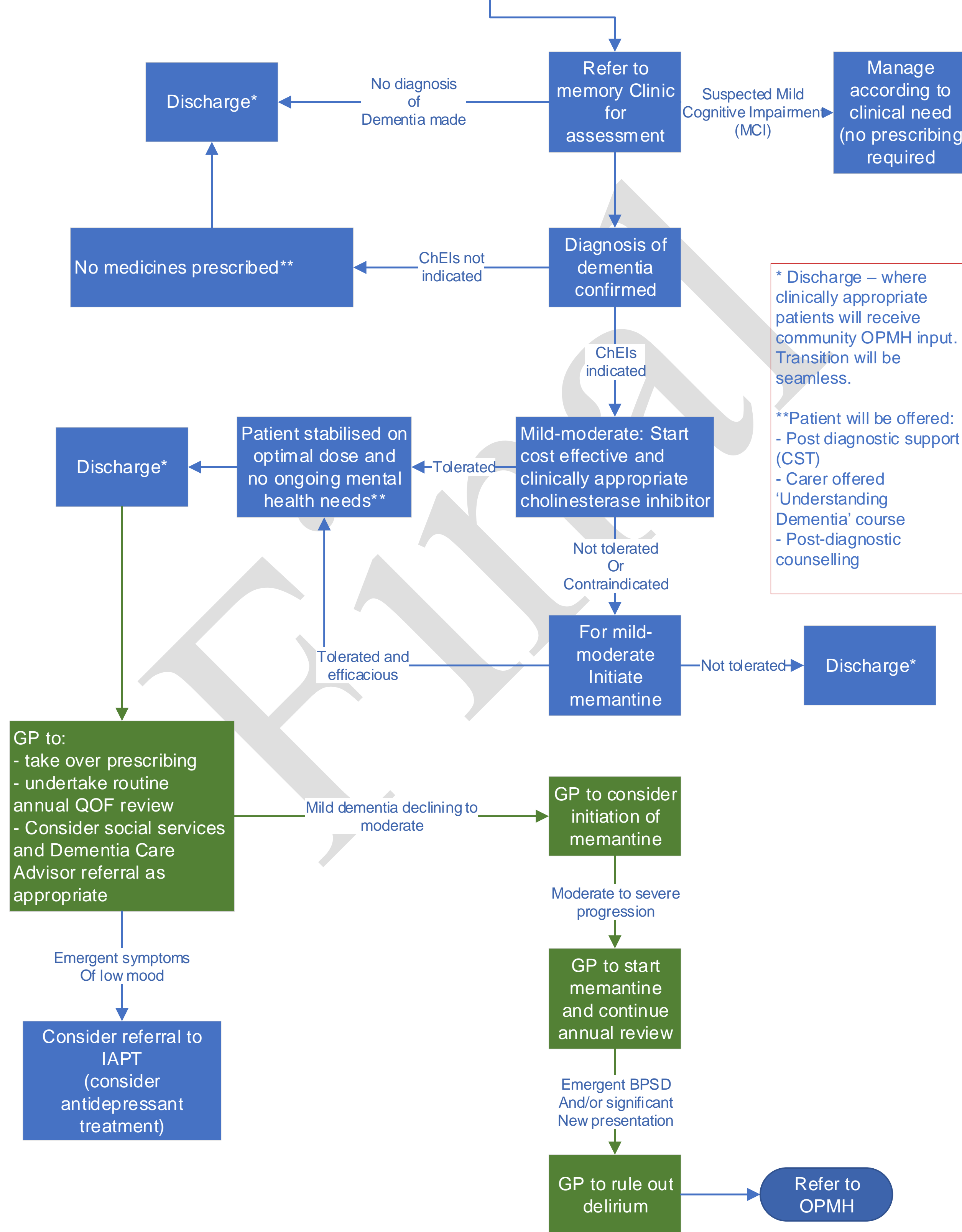
Changes to the Berkshire Dementia Care Pathway and prescribing of cholinesterase inhibitors (ChEIs) and memantine (East Berkshire CCG, West Berkshire CCG, BHFT)

The shared care prescribing arrangements for ChEIs / memantine are coming to an end. This document describes the new process to be followed from 01/04/2020.

To date, clinically stable people with dementia who are prescribed ChEIs (donepezil, galantamine and rivastigmine) and/or memantine have remained on Memory Clinic caseloads for annual review. Primarily, this has been to continue to assess the severity of cognitive decline, as in the past, ChEIs were discontinued when patients progressed to a severe stage of dementia. However, current NICE Guidelines (updated June 2018) https://www.nice.org.uk/guidance/ng97 recommends continuing ChEIs in the long-term and not to stop them considering disease severity alone.

Berkshire West
Integrated Care System

After extensive discussion with all stakeholders, Berkshire CCGs have developed the following care pathway:



* Discharge – where clinically appropriate patients will receive community OPMH input. Transition will be seamless.

**Patient will be offered:
- Post diagnostic support (CST)
- Carer offered 'Understanding Dementia' course
- Post-diagnostic counselling

Author	Unknown	Date of production:	Unknown
Job Title	Unknown	Review Date	Unknown
Protocol Lead	Unknown	Version	v.X

1. Information for GPs

1.1. GP Responsibilities:

- **For patients with MILD Alzheimer's or Mixed dementia which progresses towards MODERATE severity, GPs can consider initiating memantine.**
- **For patients with SEVERE Alzheimer's or Mixed dementia, GPs can initiate memantine and review annually as per QOF.**
- **For patients with emergent BPSD rule out delirium, then consider Memantine. If no response, refer to OPMH Services.**
- **To prescribe dementia medication (ChEIs and/or memantine) to patients who have had an unintentional treatment interruption.**
- **To prescribe dementia medication (ChEIs and/or memantine) to patients who require a dossette box in the Community (as advised by Memory Clinic).**

1.2. Memantine

When memantine should be considered? When the dementia is significantly impacting on activities of daily living; there are emerging Behavioural and Psychological Symptoms of Dementia (BPSD); or there is increased carer strain due to deterioration of the person's symptoms of dementia.

Memantine Initiation Dosing:

- The recommended starting dose is 5 mg per day which is titrated in steps of 5mg weekly over the first 4 weeks of treatment, until the recommended maintenance dose is achieved (generally 20mg).
- It is preferable to prescribe the dose to be taken in the evening (to limit the effect of and potential drowsiness),
- Full prescribing information is available via www.medicines.org.uk

A titration pack is available containing the appropriate strength tablets for the first 4 weeks of treatment. BHFT have opted to use Ebixa Titration Pack® over the generic brand due to the **clearer packaging and instructions**.

Renal impairment –
In patients with moderate renal impairment (eGFR 30 – 49 mL/min) the daily dose should be titrated to 10 mg per day. Then, if tolerated well after at least 7 days of treatment, the dose could be increased up to 20 mg/day according to the standard titration scheme.
In patients with severe renal impairment (eGFR 5 – 29 mL/min) the maximum daily dose should be 10 mg per day.
If the eGFR is less than 5ml/min memantine should be avoided.
In patients with renal impairment, dose adjustments should be considered if the renal impairment further deteriorates.

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Hepatic impairment –
No adjustment is required for mild or moderate hepatic impairment. Seek specialist advice for prescribing for people with severe impairment.

Information sources –
The manufacturer's information leaflet is available via www.medicines.org.uk
Additional information for people taking memantine is available via the Choice and medication website. This website offers information in different formats and languages. (https://www.choiceandmedication.org/sabp/medication/memantine/)

Formulations of memantine other than standard tablets
These formulations are significantly more expensive than the standard tablets.
There is a licensed liquid memantine product available. This is presented either as a pump mechanism; each pumped dose contains 5mg, or an oral solution to be measured in mls.
Orodispersible and soluble tablets are also licensed in 10mg and 20mg strengths.
Alternatively it is acceptable to crush the tablets well and disperse in water for administration. This would however be "off-label" administration.

1.3. Memantine prescribing guidance for GPs when adding memantine for a patient already taking an acetylcholinesterase inhibitor.

Treatment with memantine, in conjunction with a ChEI such as Donepezil, Rivastigmine or Galantamine, should be considered for people with moderate Alzheimer's disease, and offered to people who have Severe Alzheimer's disease.

1.4. Stopping AChE Inhibitors / Memantine in Primary Care

Current best evidence suggests that cognitive enhancers continue to offer benefit in severe dementias and protect against the emergence of BPSD. Accepted good clinical practice is for patients to remain on cognitive enhancers throughout the course of the illness. However, when a patient reaches end-of-life it is sometimes prudent to reduce the medication burden. These decisions should be made on a case-by-case basis in conjunction with family & carers as part of the wider clinical discussion at this time. Advice can always be sought from the OPMHS if needed.

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2. Changes to Pathway

2.1. What are the advantages of the new care pathway?

- Improve early diagnosis for people with dementia because resources can be moved to deal with initial assessments. This will reduce the waiting time for Memory Clinics.
- Improve patients and carers experience of living with dementia and improve access to help to prevent and manage crises
- Access to a named Dementia Care Advisor for each patient with dementia who does not already have a named social worker or mental health practitioner Integrated services with effective joint working

2.2. Why is there a change in ChEIs and memantine prescribing?

The evidence base, clinical experience, familiarity associated with frequent use, and cost of the anti-dementia medication have all changed significantly

Current best evidence suggests that cognitive enhancers continue to offer benefit in severe dementias and protect against the emergence of Behavioural and Psychological Symptoms of Dementia (BPSD).

The latest NICE guideline NG97 https://www.nice.org.uk/guidance/ng97 recommends that treatment with a ChEI and/or memantine can be initiated in primary care on the advice of a secondary care specialist or other healthcare professional with specialist expertise in diagnosing and treating dementia.

There is now a wealth of experience of these drugs in primary care and they do not require any enhanced ongoing monitoring. If patients have side-effects these generally occur soon after commencement or dose titration. Current good clinical practice is for patients to remain on ChEIs and/or memantine throughout the course of the illness. Therefore, we should no longer routinely look to discontinue these medications. Clinicians find that in their experience, even short periods of discontinuation can lead to rapid cognitive decline.

Consequently, unless there is an additional active mental health need requiring specialist input there is no need for regular Memory Clinic appointments simply to review cognitive function. In addition GPs, or any other health care professionals, do not need to routinely perform tests of cognitive functioning at follow up or annual reviews.

2.3. What happens when a patient is referred for a memory assessment using this NEW PATHWAY?

Patients seen in Memory Clinics typically have an assessment appointment, following which any necessary further investigations would be completed including CT head scan and a neuropsychological assessment if required. A diagnostic feedback appointment is then arranged, and any appropriate medications commenced.

The Memory Clinic offers post-diagnostic support to all patients diagnosed with dementia irrespective of the sub-type of dementia (including vascular dementias) - this includes:

- Provision of information about dementia and about local support services
- An offer to participate in medical research
- Signposting to a named Dementia Care Advisor Participation in Cognitive Stimulation Therapy (CST) if applicable.
- Access to Carers Course: Understanding Dementia

The Memory Clinic will continue to initiate either ChEIs or memantine. The Memory Clinic may ask a GP to initiate ChEIs and/or Memantine for example; within a Nursing Home or when existing medication is provided in a monitored dosage system. There may also be circumstances when a retrial of a previously tolerated anti-dementia medication is indicated following a period of non-compliance Or restarting after unintentional treatment interruption and it would usually be more appropriate for a GP to reintroduce this medication.

The Memory Clinics will ask GPs to take over prescribing only after the patient has been stabilised on ChEIs and optimal dose has been reached. Once patients are tolerating a stable dose of medication and do not require further specialist support, they will be discharged. However, they will

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have open access to the support of Dementia Care Advisors who will continue to provide information and support.

NICE guidance suggests the introduction of memantine for moderate to severe Alzheimer's disease or mixed dementia and this should take place in primary care.

2.4. What should be looked for in the annual Primary Care (QOF) review of people with dementia?

- The main focus should be the patient's physical health – pulse (risk of bradycardia) and BP check together with a review of medication
- Reduce anticholinergic burden (see list at the end of the document) The following website is a useful reference: https://www.medichec.com/
- Any unusual or complex symptoms.
- There is no need to do a formal test of cognitive function.
- If the patient presents with mood changes (important to exclude physical causes e.g. Urinary Tract Infections, pain, constipation etc.) the GP may wish to consider whether any environmental or relationship changes are contributing to the presentation. If not thought to be the case current evidence supports Talking Therapies as the best first approach to manage depression and anxiety in mild to moderate dementia If this is not successful, then an antidepressant could be considered.
- If there are significant behavioural or psychological problems then a re-referral to the Older People's CMHT can be made.
- Anti-psychotic medications are not routinely recommended for BPSD and if prescribed should be regularly reviewed.
- Vascular risk factors should be considered
- Check that every patient and their carer has the contact number of their Dementia Care Advisor
- An assessment of carer's needs should be considered with onward referral to social services as appropriate.
- Consider advanced care planning

2.5. Which patients will the Older Peoples Mental Health Service (OPMHS) continue to follow-up?

If patients have ongoing clinical needs or require an extended assessment, they will remain under the care of the OPMHS and allocated a Mental Health Practitioner (MHP).

2.6. When to re-refer to OPMHS?

If a GP thinks a patient with any sub-type of dementia would benefit from a mental health review they can be re-referred back to the OPMHS through CPE. The process for this will mirror the

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current referral process, with referrals being picked up on a routine but timely or urgent basis as dictated by clinical needs.

Emergence of any of the following symptoms could precipitate a re-referral

- psychotic symptoms
- behavioural problems such as significant agitation and aggression
- severe depression

If the patient has suddenly become more confused or there is an acute deterioration in cognitive function, a full delirium work up should be done and reviewed in primary care where possible prior to referral back to OPMHS.

If there is significant carer stress then a discussion with the Dementia Care Advisor or social services may be more appropriate than a referral back to the memory service.

During the first six months after discharge any patient or carer can contact the OPMHS directly if they run into difficulties.

Duty Line: If urgent, GPs can discuss any patients on the day with the Duty Worker, irrespective of whether the patient is currently open to the OPMHS.

Bracknell: BracknellCMHTOAAdmin@berkshire.nhs.uk / 01344 823220

Slough: bhft-opmhslough@berkshire.nhs.uk / 01753 635210

Windsor, Ascot & Maidenhead: OPMH.WAM-Duty@berkshire.nhs.uk / 01628 640200

Newbury: BeechcroftDuty@berkshire.nhs.uk/01635 292070

Reading: BHFT-OPMHReading@berkshire.nhs.uk/01189 605959

Wokingham: BHFT-OPMHWokingham@berkshire.nhs.uk/01189 495101

Mild Cognitive Impairment

Mild Cognitive Impairment: Brief guidance

1/3 improve, 1/3 stay same, 1/3 develop dementia

All pts with MCI should have their cognitive symptoms reviewed annually by Primary are: Ask 2 simple questions e.g.

1. Do you remember being referred to a specialist clinic last year to investigate how well you remember things? How are things now – better, the same or are you concerned?

2. How are you coping with every day things e.g. bills, remembering family events, driving.

If there are concerns about memory: Repeat memory screening bloods and refer back to memory clinic.

If no concerns: Review annually.

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3. Further Information:

Dementia Revealed What Primary Care Needs to Know A Primer for General Practice Prepared in partnership by NHS England and Hardwick CCG with the support of the Department of Health and
the Royal College of General Practitioners
www.england.nhs.uk/wp-content/uploads/2014/09/dementia-revealed-toolkit.pdf

Dementia diagnosis and management A brief pragmatic resource for general practitioners
http://www.nhsiq.nhs.uk/media/2607508/dementia_diagnosis_and_management.pdf

NICE guideline NG97 Dementia: assessment, management and support for people living with dementia and their carers
https://www.nice.org.uk/guidance/ng97

Medicines Management sheets; Changes to the prescribing of the acetylcholinesterase inhibitors and Memantine in all stages of dementia April 2019

NICE 2018.pdf

Pharmacological management for people with dementia:

Neuroimaging for dementia diagnosis (Guidance from the London Dementia Clinical Network):

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thebmj Visual summary

Pharmacological management for people with dementia

This infographic summarises NICE guidance on drugs that can be offered as a part of treatment for people with the most common forms of dementia. An individualised approach is necessary owing to the wide variety of symptoms faced by each person with dementia.

KEY

 AChE INHIBITORS
- DON — Donepezil
- GAL — Galantamine
- RIV — Rivastigmine

MEM — Memantine

ALZHEIMER'S

	Mild	Moderate	Severe
NEWLY DIAGNOSED PATIENTS	Monotherapy is recommended as an option: DON, GAL, RIV	Monotherapy is recommended as an option: DON, GAL, RIV	Monotherapy is recommended as an option: MEM
PEOPLE INTOLERANT OF, OR WITH A CONTRAINDICATION TO, AChE INHIBITORS		Monotherapy is recommended as an option: MEM	
PEOPLE ALREADY TAKING AN AChE INHIBITOR		Consider in addition: MEM	Offer in addition: MEM

Do not stop AChE inhibitors because of disease severity alone

WHO CAN PRESCRIBE ALZHEIMER'S DRUGS?

FOR PEOPLE NOT ALREADY TAKING: RIV, DON, GAL, MEM

Only start treatment on the advice of a clinician who has the necessary knowledge and skills, such as:

- Secondary care medical specialists: Psychiatrists, Geriatricians, Neurologists
- Other healthcare professionals, if they have expertise diagnosing and treating alzheimer's disease: GP, Nurse consultant, Advanced nurse practitioner

Once the decision has been made to start drug therapy, the first prescription can be made in primary care

FOR PEOPLE ALREADY TAKING: RIV, DON, GAL

Primary care prescribers may start treatment with MEM without specialist advice

NON-ALZHEIMER'S

People with DEMENTIA WITH LEWY BODIES

	Mild	Moderate	Severe
No contraindications	Offer DON, RIV	Offer DON, RIV	Consider DON, RIV
DON and RIV not tolerated	Consider GAL	Consider GAL	
AChE inhibitors contraindicated	Consider MEM	Consider MEM	Consider MEM

People with VASCULAR DEMENTIA

Only consider: RIV, GAL, DON, MEM

if they have suspeced comorbid:
- Alzheimer's disease
- Parkinson's disease
- Dementia with Lewy bodies

People with FRONTOTEMPORAL DEMENTIA or COGNITIVE IMPAIRMENT CAUSED BY MULTIPLE SCLEROSIS

DO NOT OFFER: RIV, GAL, DON, MEM

People with PARKINSON'S DISEASE DEMENTIA

For guidance on pharmacological management, see *Parkinson's disease dementia* in the NICE guideline on Parkinson's disease

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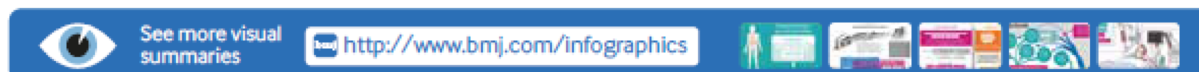

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