NHS London Clinical Networks

Review of dementia medication shared care protocols across London

Background

The NICE dementia guideline was updated in 2018. There were changes from the previous guideline in relation to prescribing acetylcholinesterase (AChE) inhibitors and memantine. It was therefore decided to review the current shared care protocols for dementia medication in London to identify if they are aligned to the updated NICE guideline.

The 2018 NICE guideline states that:

- The three acetylcholinesterase (AChE) inhibitors donepezil, galantamine and rivastigmine as monotherapies are recommended as options for managing mild to moderate Alzheimer's disease or severe Alzheimer's Disease

- Memantine monotherapy is recommended as an option for managing Alzheimer's disease for people with: moderate Alzheimer's disease who are intolerant of or have a contraindication to AChE inhibitors

- Once a decision has been made to start an AChE inhibitor or memantine, the first prescription may be made in primary care.
- For people with an established diagnosis of Alzheimer's disease who are already taking an AChE inhibitor:
    - consider memantine in addition to an AChE inhibitor if they have moderate disease
    - offer memantine in addition to an AChE inhibitor if they have severe disease.
- For people with an established diagnosis of Alzheimer's disease who are already taking an AChE inhibitor, primary care prescribers may start treatment with memantine

For dementia with Lewy bodies the NICE guideline states:

- Offer donepezil or rivastigmine to people with mild to moderate dementia with Lewy bodies.
- Only consider galantamine for people with mild to moderate dementia with Lewy bodies if donepezil and rivastigmine are not tolerated.
- Consider donepezil or rivastigmine for people with severe dementia with Lewy bodies
- Consider memantine for people with dementia with Lewy bodies if AChE inhibitors are not tolerated or are contraindicated.

Protocols reviewed and coverage

Five protocols were reviewed covering 19 of the 32 London CCGs. Five CCGs are not currently using a shared care protocols and two Mental Health Trusts are already in the process of updating theirs.

Protocols varied in review dates, some appeared to be overdue a review, others are due to be reviewed this year or next year.

Only two of the shared care protocols also included acute Trusts

Findings – Prescribing and monitoring

In all the shared care protocols the memory assessment service (MAS) or other specialist determined the suitability of prescribing. In one of the shared care protocols the MAS/specialist could request initiation from the GP, in all others the MAS/specialist initiated medication.

In all protocols the MAS/specialist titrated medication and initially monitored the patient. Initial monitoring timeframes varied from 4-12 weeks to at least 6 months.

Ongoing monitoring varied; in two of the protocols the MAS/specialist continued to monitor at least 6 monthly or yearly, in the other protocols the GP continued prescribing with a minimum of yearly review. In two of the protocols GP agreement to take over prescribing was required in each individual case.

Findings – Dementia subtypes included

Three of the five shared care protocols only covered Alzheimer's Disease (AD). Two protocols also covered Parkinson's Disease dementia (PDD) and Dementia with Lewy bodies (DLB); however, some the prescribing guidance for PDD and DLB was not aligned to current NICE guidance.

Findings – Memantine

All the shared care protocols only covered memantine as a single agent, usually stating that it could be used only if AChE inhibitors were contra-indicated or not tolerated. Most of the protocols explicitly stated that dual prescribing of Memantine with an AChE inhibitor was not recommended.

Other findings

- One STP footprint had two shared care protocols covering overlapping CCGs with slightly different information included
- One protocol stated that only a consultant or SpR under supervision could initiate AChE inhibitors.

- In some protocols re-referrals to MAS were recommended if a patient/carer wanted to stop medication and one protocol recommended referral back to MAS if the patient deteriorated.
- Three protocols recommended undertaking ECGs if there were cardiac concerns. One protocol mentioned pulse checks, but not ECGs

Summary

The shared care protocols reviewed were not currently aligned with NICE guidance particularly regarding provision of the initial prescription, monitoring requirements and dual prescribing of memantine. We would recommend that CCGs and providers work together to revise their prescribing protocols for dementia medication. In particular we suggest moving away from a 'shared care' protocol to a model in which the recommendation to initiate treatment at the point of diagnosis is given by a specialist and all aspects of prescribing are then handled in primary care.

The Dementia Clinical Network will produce a dementia pathway medication guidance document for CCGs to use as a template for local prescribing guidelines.