Early Identification of People with Dementia and their Carers in Torbay

A Report on a Project to Develop New Pathways to Support for Carers through Primary Health Care Teams

September 2012

“There is good evidence that early diagnosis improves the sufferers and carers quality of life, is cost effective and can release substantial funds back into the local health and social care economy by delaying or preventing unnecessary admissions to hospital and care settings. Informal carers exert a twenty-fold reduction on care home placements improving the quality of life for the sufferer and helping them to stay where they would wish to be, at home. Informal carers make an often hidden but essential contribution to the care of tens of thousands of people with dementia across the UK. Identifying them and offering considered support at an early stage will help them build the support networks and knowledge they will need during the course of their loved-ones illness and to help them to protect their own wellbeing.

Carers of people with dementia are a national asset which we have a responsibility to support, develop and nurture”.

DrDavidSomerfield
Co-Medical Director, Clinical Director Older Peoples Mental Health & Consultant Psychiatrist

“Carers support is worth investing in. As a GP I need to put myself constantly in the place of the people I deal with daily: ‘What are they experiencing, what are they needing?’ Carers often feel isolated and helpless; they may believe help is available but are unfamiliar with getting hold of it. I have found that supporting carers to care is the best solution for them and the patient they care for.”

Dr Richard Montgomery GP Brixham / Lead for Dementia

1 Policy Background to the Project

1.1 Less than 30% of people with dementia receive a formal diagnosis at any time in their illness, all too often too late to benefit from effective and evidence-based interventions, to build support networks and make personal, practical, legal and financial plans for themselves and their families. For those who do receive a diagnosis, the delay is on average 30 months from the time symptoms were first recognised. The UK significantly trails most European countries in the time to diagnosis.

1.2 In 2009, the **National Dementia Strategy** set out to transform services for people with dementia and specifically to address this issue with three clear aims;

- To encourage help-seeking and help-offering by changing public and professionals attitudes, understanding and behaviour
- To make early diagnosis and treatment the rule rather than the exception
- To enable people with dementia and their carers to live well with dementia by the provision of good quality care for all with dementia from diagnosis to the end of life, in the community, in hospitals and in care homes.

1.3 In **'Recognised, Valued and Supported: Next steps for the Carers Strategy' (2010)**, the government identified four priority areas for its Carers strategy. Two of these specifically related to this project:

- supporting those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset, both in designing local care provision and in planning individual care packages.

- supporting carers to remain mentally and physically well.

1.4 **The NHS Operating Framework 2012 – 13**

The NHS Operating Framework identified Dementia and Carers as two priorities that require particular attention during 2012/13 to "provide the bedrock for a health service driven by patients and clinicians" Recognition of the significance of support to carers was explicit - "Carers play a vital role in our system and must receive help and support from local organisations".

2 Introduction and Recommendations from the Project

2.1 Project Outline

2.1.1 The target group were patients with a diagnosis of dementia, or those who may be at early stage of dementia, where early intervention could make a significant difference to the patient and the wellbeing of their carers.

2.1.2 This project extended a pilot scheme, carried out in 2010 - 11 at St Luke's Medical Centre Brixham and Chelston Hall Torquay, to a further 6 practices in Torbay (August 2011 – July 2012) The practices involved were Barton, Chilcote, Croft Hall, Old Farm, Parkhill, and Southover,

The selected practices were asked to offer 'enhanced' health and wellbeing checks, carried out at home, to both patients and their carers, using a standard template; to follow up any identified medical conditions; and to offer appropriate social care support to the carer, from a Carers Support Worker based in the practice. Reviews of the patients and carers were carried out after 6 months.

2.1.3 The primary aim of the project was to evaluate the impact of this joint approach on identification of carers of dementia, and to evaluate the effectiveness of early intervention using an 'integrated' health and social care support programme.

2.1.4 Each practice was funded for a Practice Nurse (7.5 hours p.w.) to carry out the Health Checks and a Carers Support Worker (3.5 hours pw). Training and induction was provided for these staff prior to implementing the preogramme

2.1.5 The project was coordinated by the Lead Officer Integrated Carers Services, who had been responsible for the original pilot.

2.2 Patients and Carers involved in the Project

2.2.1 Across the 6 practices, 116 patients had Health Checks and 116 carers received Health Checks and were also offered support from the Carers Support Worker. (NB For the analysis of Carers health and well-being, we have included 49 carers from St Lukes giving a total cohort of 165 carers for analysis)

2.2.2 The majority of the carers were female, on average older people themselves, white, and looking after the home or retired. The average hours of care per week provided in looking after the primary cared for person was 111 hours and most carers had been caring for a considerable amount of time. Over half of carers provided care to their spouse or partner. Most described their own health as 'fairly good' or 'good' although there were 5 (5%) people in this sample who described their health as 'poor'. A good proportion were retired or not in work themselves but with 5 (5%) stating that there were engaged in work, whether full or part time or self-employed.

2.3 Project Activity September 2011 – July 2012

2.3.1 Induction / Staff training. Dementia Awareness training, was provided by Steve Milton from Innovations in Dementia covering What is dementia?; effects on the individual; the diagnostic process and issues around diagnosis - for and against. Practice staff were also

encouraged to access The Open Dementia e-Learning Programme from SCIE. This is aimed at anyone who comes into contact with someone with dementia and provides a general introduction to the disease and the experience of living with dementia. A session with Practice Nurses and CSWs to explore the project aims, the paperwork and evaluation methods. Input was provided by Heather Montgomery who was the Practice Nurse from one of the two pilot practices

2.3.2 In each practice, the patients identified with a diagnosis of dementia, or confusion / memory problems, were offered a comprehensive home based 'Health and Wellbeing check' which included mini mental test, falls screening and fracture risk assessment plus healthy lifestyle, etc. (See Appendix 1 for Health Check format)

2.3.3 Carers identified were offered the same check but additionally completed a General Health Questionnaire (GHQ12) as a measure of carer strain. (See Appendix 2 for details)

Health and social care needs - liaison between the Practice Nurse and a Carers Support Worker to ensure that practical and emotional support was offered to the carer and they were linked in to local support networks.

2.3.4 For patients and carers, referral to GP or specialist dementia services as appropriate - follow up of underlying medical conditions by the practice team; referral of patient or carer to appropriate services including Early Diagnosis and Intervention Clinic (EDI)

2.3.5 All Health checks were reviewed at approximately 6 months, with the carer repeating the GHQ12 for comparison

2.3.6 Promotion activity and awareness raising with staff and patients was carried out in practices, health and social care teams and in the local community in order to increase identification . This used publicity material (leaflets and posters) from a recent publicity campaign based on a local carer of someone with dementia - 'I needed help and I got it …just in time' - plus talks to staff groups to encourage referrals.

2.3.7 The Project Coordinator held regular review meetings with Practice Managers and the project staff to monitor progress, identify issues and share learning. A number of briefing papers were produced and distributed to all participating practices to address frequently raised questions

2.3.8 Evaluation. Standard recording templates were used to summarise the activity in each practice. For all carers, an individual carer record was completed (with permission) and these together with GHQ 12 self- assessments were analysed by Dr Paul Clarkson of Manchesteter University PSSRU.

A questionnaire for carers was devised and interviews with a sample of 17 carers were carried out by Carer Evaluators, who are carers trained in interview and evaluation technique. (See Appendix 3 for copy of questionnaire)

2.4 Summary of Recommendations

1. All practices should examine their practice registers to identify people who may be caring for someone with dementia or confusion / memory problems.

2. There should be agreed and consistent Read coding for memory problems for patients. This would include those who have been assessed for dementia but not diagnosed. Communication between EDI/Memory Clinic and GPs following assessment should include a recommended Read code for the practice register.

3. All carers of newly diagnosed patients with dementia should be offered an enhanced health check at the time of diagnosis. This should also be offered where patients with an existing diagnosis join a practice. This offer should include carers who do not live with the person who has dementia.

4. Poor health among carers is a major predictor of psychological distress, particularly in older people. There should therefore be targeting of ongoing support for carers of people with dementia who are in poor health themselves. This group of carers should be proactively supported and regularly reviewed, particularly because of experience of their reluctance to seek help or lack of knowledge as to how to access it.

5. The MH Commissioners should consider commissioning the extension of this identification project to the remaining practices in Torbay

6. Ongoing awareness training is needed for all staff in practice teams with an emphasis on early identification of people with memory problems/confusion. Receptionists should be particularly targeted for this training.

7 Torbay should implement an integrated statutory Carers' Assessment based on the model from this project. This Carers Assessment will include the enhanced Health Check. This would involve delegation of the responsibility for Carers Assessments to the practices. A further pilot in 2013 – 14 should be funded to test out the model with other groups of carers, in addition to carers of people with dementia.

8. Any future pilot should explore the cost effectiveness of alternative delivery models including the use of Health Care Assistants to carry out the Health Checks.

3 Key Results from project

The results are set out under the following headings to summarise the learning from the project:

Identification of Carers
Read Coding of Carers
Carers Health
Carers in early stages of dementia – low MMSE scores
Carers Strain - Results of General Health Questionnaire
Cared for person's health
Medication reviews
Carers accessing social care support services
Delivering integrated Health Checks and Social Care support to carers
Other benefits and issues

Case studies are used throughout the text to illustrate the issues identified. Appendices with full details are attached to the report.

3.1 Identification of Carers

3.1.1 The project aimed to target two groups of patients and their carers equally - practices were asked to recruit 50% from patients who already had a diagnosis of dementia and 50% from people with memory problems / confusion. The reasoning for this was an assumption that patients with a diagnosis would already be known to services and therefore that it was more likely that their carer would also be known. We wanted to identify patients who might be in the early stages of dementia but had not yet had a diagnosis, as early identification would be a route to support.

In practice, only one surgery (Old Farm) had a 50/50 split of cases and this was from a small cohort. Across all 6 of the practices 77% (89/116) of the cases involved a patient with an existing diagnosis of dementia and 23% (27/116) of patients identified with memory problems. Therefore a very high proportion of the cases seen through the project were ones where we would have expected the patient and their carer to be known to services and be receiving support. However, this did not turn out to be the case.

3.1.2 The majority of the carers of patients with dementia or memory problems had not previously been identified by the practices - 98/165 or 59% of the total carers seen were not known /coded as carers by practices. Furthermore, in 3 practices, the number not previously known was much higher - 73% (Chilcote), 78% (Croft Hall), and 78% (Parkhill). Given the historically good performance of Torbay practices in identifying carers, this represents a significant issue for this group of carers. It suggests that carers of people with dementia or memory problems are less likely to be known to their practice than other groups of carers. This is further emphasised by the fact that 77% of the patients involved already had a diagnosis of dementia, so one could have expected their carers to already have been identified.

Recommendation1: All practices should examine their practice registers to identify people who may be caring for someone with dementia or confusion.

3.2 Read Coding carers on Practice Registers

3.2.1 In order to identify individuals who might be in the early stages of the condition, patient registers were searched for Read codes that were considered to be potential early dementia indicators, including forgetfulness, confusion, memory loss or mild cognitive impairment.

3.2.2 Several practices identified issues of coding patients with memory loss, mild cognitive impairment or confusion etc. which could affect the effectiveness of identification of people with early stage dementia and their carers:

a There is not a consistent pattern of Read Coding across the practices - some practices only Read Code for dementia, when there is a confirmed diagnosis, and do not code for memory problems etc. Other practices code for forgetfulness/MCI / confusion etc, but these practices vary as to which Read codes they use.

b When GPs refer patients to the local Memory Clinic (EDI) and there isn't a diagnosis of dementia, but the patient is deemed to have Mild Cognitive Impairment, the practices were not always being informed and advised to Read code the patient. EDI have confirmed that this has been an administrative problem. This lack of coding could mean that the patient may not be followed up later and there may not be prompts about their memory problems for practice staff. As an example of the impact of this, a check on patients seen at EDI for 3 of the practices resulted in 8 patients with MCI who were not coded at the practice, and who had therefore not shown up when the practices had run the check of their Registers for the project. The proportion of these cases may be small but a simple administrative change could avoid some patients 'slipping through the net'.

We suggest that these 'blocks' in the system could, if resolved, increase the identification of people with dementia as well and get support to carers at an earlier stage

Recommendation 2: There should be agreed and consistent Read coding for memory problems for patients. This would include those who have been assessed for dementia but not diagnosed. Communication between EDI/Memory Clinic and GPs following assessment should include a recommended Read code for the practice register.

3.3 Carers Health

3.3.1 In 32% of cases (53/165) carers had health problems identified as a result of the health check, which required active intervention. This figure from the Health Checks compares to carers self-rating of their health where only 5% rated their health as Poor and 79% rated it as either Fairly Good or Good.

3.3.2 Although all practices used a standard format for the check and were issued with a template for recording any health problems identified and the subsequent interventions, it was left to the individual Practice Nurse to determine what was 'significant'. Therefore there has been some variation across practices in what was recorded and the totals given here may be underreporting the number of identified health problems.

3.3.3 The health problems identified are summarised below. (NB some carers had more than one problem)

High Falls Risk	**3**
High Fracture Risk	**6**
Medium Fracture Risk	**20 (this figure refers to 3 practices only)**
Blood Pressure problems	**19**
Postural Drop	**3**
Palpitations	**1**
Sensory Problems	**3**
Incontinence	**2**
Alcohol problems	**2**
Depression/Anxiety	**2**
Stress Related Issues	**11**
Low MMSE	**6**
Anaemia	**1**
Medication Reviews	**3**

3.4 Carers in early stages of dementia – low MMSE scores

3.4.1 The findings from this cohort confirm the experience from the first pilot practices, that there are a small but significant number of carers of people with dementia who themselves are experiencing confusion and memory problems and who needed to be referred for further assessment.

Low MMSE - Case study Mr and Mrs S.

The couple had been known to the practice Carers Support Worker before the project started. Mrs S was caring for her husband who has mobility issues. Whilst doing a search for patients for the project, Mrs S's name showed up in a search under a 'Forgetful' code. Mrs S was then included in the project and had a subsequent assessment of her memory by her GP. Mrs S was referred by the GP to the memory team and diagnosed with probable Alzheimer's in February 2012. Now the couple are carers for each other. It is probable Mrs S would not have been identified as having a form of Dementia if the project had not taken place, as she has other behaviours that may have masked dementia. All the GPs and the nurses are now aware of the difficulties that may face this couple over time and the impact this has on support that may be required.

Recommendation 3: All carers of newly diagnosed patients with dementia should be offered an enhanced health check. This should also be offered where new patients with an existing diagnosis join a practice. This offer should include carers who do not live with the person who has dementia.

3.5 Carers Strain - Results of General Health Questionnaire - Independent Evaluation of service by Manchester University PSSRU (See Appendix 4 for full report)

3.5.1 The service was evaluated using the GHQ-12 over two time points to assess the effects that continued use of the services had on carer well being. The GHQ is a well-validated measure of psychological well being (in effect, a measure of distress or psychiatric symptomatology with higher scores indicating increased distress) is sensitive to change and

has been used in surveys of the public and extensively with carers. The GHQ makes it possible to evaluate changes in carer well being on two levels; changes in the overall level of distress and changes in specific symptoms of distress such as anxiety or sleeplessness.

3.5.2 The size of this sample is very good in terms of the statistical 'power' to detect true differences in the outcome of interest (carer well being) if they are present. For support to people with dementia in particular, very often we are interested in detecting quite small to moderate changes where these exist. This sample was robust in terms of numbers; any changes detected being reliable in terms of adequacy to detect true change. These numbers also make it possible to look at whether certain characteristics of carers influence their changes in well being over time, with the analysis reported then being a good 'fit' to the data.

3.5.3 Overall GHQ scores were, on average, towards the lower range of possible scores (a range of 0 to 12) at the commencement of the service indicating the presence of mild degrees of what could be considered psychiatric symptoms. In terms of a traditionally used cut-off score on the GHQ (1/2) which would identify cases of psychiatric disorder, **51% of the carers could be identified as psychiatric 'cases' at commencement of the service**, this proportion remaining appreciably the same after receipt of the service.

3.5.4 In terms of specific symptoms identified by individual questions on the GHQ, there were mixed changes with certain symptoms showing significant improvement whilst others showed decline. Sleeplessness improved significantly over the period whilst problems with concentration increased. All other changes in symptoms were not statistically significant.

3.5.5 Carers who rated their own health as 'poor' at commencement of the service was significantly associated with an increase in distress (on average, nearly a 4 point increase in the GHQ score over time, all other factors remaining constant). This finding was highly significant. Poor self-rated health is a major predictor of psychological distress, especially in older people.

3.5.6 The other grouping of note was carers who cared for their spouse as opposed to other relationships; this factor being associated with just over a one point decrease in the GHQ score over time. The importance of the spouse relationship is that carers often approach the burden of caring for husbands or wives as largely inevitable and so are more sanguine about the demands this brings compared with other relationships.

3.5.7 These findings point to the importance of the service perhaps proactively targeting these groups, particularly those in poor health where the opportunity for gain might be greatest.

Recommendation 4: Poor health among carers is a major predictor of psychological distress, particularly in older people. There should therefore be targeting of support for carers of people with dementia who are in poor health themselves. This group of carers should be proactively supported and regularly reviewed, particularly because of their reluctance to seek help or lack of knowledge as to how to access it.

3.6 Cared for persons health

3.6.1 The project, although primarily aimed at carers, also provided a Health Check for the cared for person. The findings from this are relevant in two respects – the identification of physical health problems requiring intervention and the impact that poor health of the cared for can have on the carer.

Case study - Mr and Mrs M
The husband was stressed with regard to his wife's dementia and her non compliance with medication as she lacked awareness of her difficulties. Through the health check, his wife scored Medium on the Fracture Risk Assessment and was consequently prescribed supplements.
On the first visit, we discussed them considering dementia medication again and, by the second visit, they had attended Chadwell, the wife was now prescribed medication, and the carer was attending an 8week carers training course at Chadwell. Additionally all benefits were in place, the carer had joined the Carers Register and Mrs M had been given a Safely Home bracelet as she goes out on her own.

3.6.2 Summary of significant health problems of cared for person:

High Falls risk	**2**
High Fracture Risk	**11**
Blood Pressure problems	**12**
Postural Drop	**2**
Sensory Problems	**2**
Incontinence	**6**
Alcohol problems	**1**

3.7 Medication reviews

3.7.1 The number of cases requiring reviews of medication varied across practices and this may be in part because there was variability as to whether they were recorded as a 'health problem'. However, as an illustration of the need for reviews which may have been a direct result of the project, in one practice alone 17/39 (44%) of Health Checks resulted in a referral for a medication review. Additionally 8 of the cared for were referred back to Chadwell for review of their dementia medication.

A view from one of the GPs involved in the project summarises the benefit of the Health Check approach for both carers and cared for: "This is an 'at risk' group both medically and from the point of view of personal care and the extra input and assessment of these patients has yielded a useful amount of information and medical need, for which relatively simple interventions may help prevent a major breakdown in care needs. I would guess that if this was studied as a full research project the 2 areas which would yield the most cost-effective benefit would be falls and general/nutritional neglect. The extra work falling into the GP's lap is not great – perhaps a review of medication and referral to physio/intermediate care team for falls, and nutritional supplements for the latter."

Recommendation 5: The MH Commissioners should consider commissioning the extension of this short term dementia project to the remaining practices in Torbay

3.8 Carers accessing social care support services

3.8.1 A significant proportion of carers seen were struggling to manage their caring responsibilities and, although eligible for community care services, were not accessing the available support. The needs identified ranged from information about the condition, advice on benefits, continence management and support with personal care for the cared for person. The high levels of psychological distress amongst this group – 11/53 with stress related health problems 2/53 with depression - may be a reflection of many carers struggling on without support. Given the high percentage of people with an existing diagnosis of dementia in the cohort, it is possible that they would have been offered support in the past, and may have turned it down, but subsequently have not been followed up.

Case study Mr B

The carer was living and caring for his wife and also his father who lived in the flat above with both cared for having dementia. High levels of carer stress were evident on the visit as he supported both cared for full-time with no services in place. The carer was referred for a Carers Assessment, was helped to join the Carers Register and applied for a Safely Home Bracelet with other options discussed on how to support the carer On the second visit, the carer informed that the Carers Assessment had been completed and services were in place for his father, having support 3 days per week and a weekly day out. His wife was currently having some day care. Carer was pleased with all the support given.

3.8.2 Carers Support Worker interventions through the project, enabled a large proportion of carers to access social care support. The project work needs to be seen in the context of the existing availability of Carers Support Workers in GP surgeries in Torbay and the relatively easy access to support services. The fact that so many of the carers accessed support as a result of the project suggests that they are a 'hard to reach' group who benefitted from the very proactive approach in the project and the use of the Health Check as a route to social care input as well as medical intervention.

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Accessing social care services:

> 20/165 (12%) of the cared for were referred for an OT or Community Care Assessment
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> 20/165 (12%) of cases were referred for benefits advice
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> 53/165 (32%) of the Carers were assisted to join Torbay Carers Register, an independent database providing free access to information, regular newsletters, access to carers education, Carers Emergency Card, Safely Home Bracelet for people with dementia found wandering in a public place, Carers Discount Scheme etc

Case Study Mr and Mrs W

As a result of the Health Check, the husband was referred to Chadwell for assessment. After a meeting with his wife/ carer a number of problems at home were highlighted. The carer is very deaf and relied on her husband to be her ears for telephone calls etc. As they slept in separate rooms the carer was not aware if her husband was up and wandering.

As a result of referral to the Memory Clinic they now have an alarm system in the Carers bedroom to alert her at night. The Carer is now aware that her husband cannot be relied upon solely to remember dates and times when made on the telephone so they keep a notebook by the telephone. Ongoing support and care are in progress, making any possible crisis manageable and as minor as possible. The Carer and family 'feel empowered and prepared for the future'.

Case study Mr and Mrs G

The husband cares for his wife and was struggling with his caring role with regard to her mobility, but was unsure of the services available. Through the Health Checks, his wife scored Medium on the Fracture Risk Assessment, GP informed, supplements prescribed Husbands blood test showed low B12, advice given and now having regular blood tests.

Following the first, visit, the CSW helped the carer to apply for increased Attendance Allowance, as he was up in night with his wife, and she was referred for an Environmental Assessment re stair lift and shower adaptation. On second visit, the stair lift was in place and shower adaptation in process.

3.9 Delivering integrated Health Checks and carer support

3.9.1 Past experience with this group of carers indicates that they are often reluctant to accept outside help, often don't see themselves as carers and can be under pressure from the person with dementia or memory problems to continue sole caring, without outside intervention. The results of this project confirm this experience and emphasise the importance of proactive follow up of this group of carers.

3.9.2 Health staff often had a significant role in mediating or persuading carers and patients to accept social care support. This role was very useful in a number of specific cases. Viewing health and social care as a seamless response or integrated solution, promoted by the GP team may make it easier for some carers and patients to cooperate. The partnership between the Practice Nurse and Carers Support Worker was viewed by many carers as a positive response to their needs.

3.9.3 Carers response to the integrated approach was generally very favourable. 17 randomly selected carers were interviewed by independent Carer Evaluators (Appendix 3 for interview questions):

- 13/17 considered that they were more aware of their own health as a result of the interventions
- 12/17 felt having the memory check was helpful (7/17 felt reassured to have 'passed it')
- 8/17 felt they were more aware of the support available and 12/17 felt that the support from CSW was important
- 8/17 felt the service helped them in their caring role

3.9.4 Carers Assessments are a statutory responsibility of the Local Authority and a route to social care services. In Torbay this responsibility for adults is delegated to the Care Trust. Although the current guidance for a statutory Carers Assessments includes a requirement to consider the carer's health and well being, in practice the focus in the past has not been on the physical and mental health of the carer, particularly as assessments have been carried

out by social care staff. This is a significant limitation on their effectiveness in addressing carers 'health and well being'. The project approach has highlighted the impact of carers physical and mental health on their capacity to care and in the risk of breakdown in the caring relationship. The evidence suggests that a truly holistic Carers Assessment should incorporate a Health Check, particularly as it would ensure that those carers in poor health were identified.

To achieve this, the responsibility for the statutory Carers Assessment would have to be delegated to GP practices.

Recommendation 7: Torbay should implement an integrated statutory Carers' Assessment based on the model from this project. This Carers Assessment will include the enhanced Health Check. This would involve delegation of the responsibility for Carers Assessments to the practices. A further pilot in 2013 – 14 should be funded to test out the model with other groups of carers, in addition to carers of people with dementia.

3.10 Other benefits and issues

3.10.1 Awareness raising of dementia .The specific focus on the project raised awareness of dementia in the practice teams, but also led to more emphasis on a 'team' approach. It was recognised that Reception staff could be more aware of changes in a patient's 'personality', appearance and general demeanour at Reception or on the phone. Where issues of memory problems were identified, this was fed back to the GP's by way of a practice note on the patient's record.

The Practice nurses involved in the project welcomed the training on dementia provided, particularly as some had no previous experience of working with this group of patients.

Recommendation 6: Ongoing awareness training is needed for all staff in practice teams with an emphasis on early identification of people with memory problems/confusion. Receptionists should be particularly targeted for this training

3.10.2 A publicity campaign and awareness raising with staff and patients, was carried out in practices, health and social care teams and in the local community in order to increase identification. This used publicity material (leaflets and posters) from a recent publicity campaign based on a local carer of someone with dementia 'I needed help and I got it …just in time' plus talks to staff groups to increase identification.

3.10.3 Sustainability of the approach. Delivery of the Health Checks was extended over 9 months to allow for 6 monthly reviews to happen for as many patients as possible, and for the GHQ data to be collected over two time periods. Nevertheless the project had a relatively short timescale and the availability of practice Nurses was crucial. We found that those practices that had available Practice Nurse time found it easier to deliver the Health Checks project. This was not simply about available capacity but also familiarity with practice procedures.

Three practices (Croft Hall, Parkhill and Southover) jointly recruited a specific Practice Nurse and Carers Support Worker to deliver the project. This had some advantages in dedicated time, flexibility across the practices and joint induction. In these three practices, the CSW

who was recruited also worked part time in older peoples mental health services, which had real advantages.

It was harder for several practices to get started as they were using existing staff who due to illness or other responsibilities could not focus on the project until much later. This delay affected the number of checks they could do and consequently the unit cost of the Check was higher in those practices.

Recommendation 8: Any future pilot should explore alternative delivery models including the use of Health Care Assistants to carry out the Health Check element.