

**Dementia**  
**Early diagnosis Local Enhanced Service (LES)**  
**Torbay Care Trust 2010-11 and 2011-12**

**Early identification of people with dementia and their carers and development of new pathways to support through primary health care teams. Offering 'enhanced' health and wellbeing checks to patients and their carers and appropriate social care support.**

This proposal is to extend a pilot carried out in 2010 – 11, at St Luke's Medical Centre Brixham and Chelston Hall Torquay, to 6 - 8 other practices in Torbay and evaluate the impact on the early identification of cases of dementia, carers of people with dementia and the effectiveness of early intervention through 'integrated' health and social care support in primary care. The target group will be patients (and their carers) who may be at early stage of the illness where intervention would make a significant difference to the patient and the wellbeing of their carer.

**1 Key Activity for each practice:**

- Identification of people with dementia or memory problems on practice registers.
- Identification of carers of people with dementia
- Offering the patient and their carer an enhanced health and wellbeing check carried out at home by a Practice Nurse (using a standard template)
- Follow up of underlying medical conditions by practice team
- Linking carer to experienced Carers Support Worker for support and signposting to support services.
- Referral of patient to appropriate services including EDI clinic
- Evaluation of impact of interventions on carer's health and the cost effectiveness of the approach.

**2 Profile of Pilot project 2010 - 11**

- 2.1 Each practice produced a baseline data set:
- Number of patients on practice register with diagnosis of dementia
  - Number of carers of people with dementia known to practice
  - Number of patients on register with confusion / memory problems
- 2.2 Over 6 months those patients identified were offered a comprehensive home based 'health and wellbeing check' which included mini mental test, falls screening and fracture risk plus healthy lifestyle, benefits check etc.
- 2.3 Carers identified were offered the same check but additionally completed the General Health Questionnaire (GHQ12) as a measure of carer strain.

- 2.4 Liaison between the Practice Nurse and Carers Support Worker ensured practical and emotional support were offered to the carer and they were linked in to local support networks.
- 2.5 Following the health check, referral to GP or specialist dementia services as appropriate
- 2.6 Promotion activity and awareness raising with staff and patients was carried out at the Practice and in the local community
- 2.7 Evaluation of the impact of the project . Full evaluation of St Lukes and Chelston will be completed by end of July 2011 as part of the findings of the DH Carers Breaks Demonstrator Site.

### **3 Background - Key Findings from initial evaluation**

- 3.1 The programme has helped practices to use examination of their patient register to identify patients with confusion or memory problems who might be in the early stages of dementia and/or whose condition may have deteriorated. Without the pilot these patients could have been 'missed' until a crisis occurred.
- 3.2 Significant numbers of carers of people with dementia or memory problems not previously 'known' to the practice were identified and offered support –  
St Luke's 13/30 cases, Chelston Hall 10/20 cases
- 3.3 Many carers of people who already had a diagnosis of dementia were not getting regular support and were struggling to cope on their own. The intervention via Practice Nurse enabled social care support to be put in place immediately.
- 3.4 In St Luke's 29% of checks led to a referral for an underlying physical health problem and of those referred 66% were carers. Problems included Tachycardia, Bradycardia, depression, incontinence, high risk of falls, postural drop, UTI.
- 3.5 In St Luke's 4 (of 30) new referrals were made to specialist services for a diagnosis of dementia, including for one carer. Two other cases were referred to the GP because of low MMSE scores.
- 3.6 The partnership between a dedicated Practice Nurse and Carers Support Worker was viewed as a highly effective approach, enabling carers to get easy access to a range of community based services for people with

dementia plus referral to the Zone Team where appropriate. A number of patients and carers would otherwise not have accepted services.

#### **4 Proposed development for 2011 – 12**

To run this project in a number of selected practices across Torbay during 2011 – 12, starting from August 2011. The project will take approximately 6 months per practice but be a rolling programme over 12 months.

##### **Resources that will be funded or provided to practices by TCT**

Staffing funded (per practice):

Practice Nurse (Band 6) 0.2 for 6/12

Dedicated Carers Support Worker (Band 4) 0.1 for 6/12

(These posts could be from existing practice staff or via a secondment)

Staff training programme in dementia and needs of carers for Practice Nurses  
(but also available to other members of team)

Coordination and Evaluation by Carers Services Team TCT

Project Coordinator 0.2 for 12 months (based on 6-8 practices)

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