



Health and Wellbeing Checks for Carers Programme

2009 - 2011



Final Programme Report
July 2011

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Carers' Health and Wellbeing Checks.

Foreword

The important role that carers play in Devon, supporting the health and wellbeing of the people they care for cannot be underestimated; neither should the fact that this is often at the expense of thinking about their own health and wellbeing.

1 in 9 of Devon's population reported caring responsibilities in the 2001 census, and the recent Carers UK survey shows that this is more likely to be 1 in 8. It is a fact that carers are at higher risk of experiencing health inequalities; this report demonstrates the positive impact that partnership working between GP Practices, pharmacies and the voluntary sector, health and social care professionals, can make to reducing this inequality by identifying hidden carers and providing support for them to continue their caring role through a holistic health and wellbeing check.

Being part of the Devon Health and Wellbeing Checks for carers Department of Health demonstrator site programme has had a huge impact on my own practice as a GP in terms of my understanding of carers' needs and the benefits that can be reaped when primary care, the voluntary sector and health and social care teams work together to ensure that carers are supported to sustain their caring role.

I would particularly recommend it to GP Commissioning Groups and Social Care Commissioners for its contribution to our understanding of Carers needs, in the context of our objectives to reduce inequalities, to increase choice and control and to deliver the Quality, Innovation, Productivity and Prevention agenda.

Dr. Simon Kerr

Clinical Lead – Carers, NHS Devon

Preface

This report is based on the management information collected during the course of the Devon demonstrator site programme. It will show the extent to which the programme has been successful in reducing inequalities for carers through:

- Increased support to carers by GP practices generally and specifically in rural areas and areas of deprivation
- Targeted support for carers in BME communities and other minority groups of carers, e.g. carers of people with learning disabilities or mental health needs
- Opportunities for working carers to think about the impact of their caring role on their work / life balance
- Providing focused events for young carers to think about aspects of their own health and wellbeing that they hadn't considered before
- Ensuring carers who meet the eligibility criteria established by NHS Devon and in keeping with NICE guidelines for a vascular check received this check
- Providing a holistic carers' assessment, early identification of need and interventions that enable carers to maintain their own health and wellbeing and sustain their caring role.

The national demonstrator site programme was designed by the Department of Health to test new approaches to carer support, and our interest locally was to maximise this opportunity. Carers have been involved at every stage of Devon's programme; we have worked with a wide range of partners to invest this additional resource to provide a quality health and wellbeing check to carers in a variety of settings.

The following recommendations should be read alongside the local research evaluation (Donnellan H 2011). The focus of the research is the lived experience of carers receiving a check and the difference it made to their lives in terms of their health and wellbeing and ability to sustain their caring role.

It is noteworthy that the learning from the programme has already been used to shape joint plans to invest an additional £1million for carers in 2011/12 including replacing the current carers' assessment with a holistic carers' health and wellbeing check and rolling out provision across all GP practices; tendering for an enhanced Carer support service from October 1st 2011; increasing the number of carers receiving a short break and plans to reduce inequalities for rural carers, working carers and carers aged 18-24.

We will continue to study and apply the learning from this programme, working with Devon carers, to improve services and lives.

Clare Cotter

Joint Planning and Strategic Commissioning Manager - Carers
August 2011.

Executive Summary

Introduction

In spring 2009, Devon was successful in a bid to the Department of Health (DH) to become a Carers Demonstrator Site, to provide health and wellbeing checks (HWBC) for carers; £1million of additional funding was secured (£800,000 from DH, £200,000 from Devon County Council) to set up an ambitious project that would test a new way of collaborative working between GP practices, pharmacies, and the community and voluntary sector for the benefit of carers. The heart of Devon's ambition was to raise general awareness of carers' needs in primary care and to improve the health and wellbeing of carers in Devon.

A total of 2,924 adult carers in Devon received a carers' health and wellbeing check, 105 of whom had an annual recheck. 105 young carers attended one of two young carer health and wellbeing events. The check provided an hour of time for a carer to consider with a health professional various aspects of health and wellbeing including:

- Safety and warmth at home
- Living and caring safely at home
- Their own health and health care needs
- Check-ups, vaccinations and screening
- Work, education and leisure
- Caring roles and tasks

The aims of the Devon programme were to:

- ***maximise the physical and mental health and wellbeing of carers***
- ***identify more carers***
- ***give carers a structured consultation to consider their own health***
- ***increase recognition of and support to carers in GP practices***
- ***improve carers' choice and control***
- ***promote Devon Carers Link membership (preventive/early intervention services)***
- ***narrow the inequalities experienced by carers***
- ***test the alignment of the checks with NHS vascular check and Carers' Assessment for quality, effectiveness, carer acceptability and cost effectiveness.***

Achievements, key findings and recommendations

Achievements

Demonstrator sites were required to identify the key benefits that their programme would produce for carers. The following list constitutes the benefits identified in Devon and the achievements for Devon carers by the end of the programme:

- More carers accessing specific carer support services, through Devon Carers Link and other services; 2,459 referrals were made to this type of service
- More carers supported to stay mentally and physically well; 1,644 NHS referrals were made
- Black and Minority Ethnic carers to be identified and supported to have a Carers' Health and Wellbeing Check (CHWBC) and unmet need would be responded to; services have been redesigned, e.g. St John Ambulance bespoke Carer Support Programme for BME carers; new specification for carer support integrating support for BME carers in Devon – service to commence Oct 1st 2011
- Increase in the number of READ¹ coded carers by GP practices; the number of carers READ coded was increased by 75%
- Contribution to the number of carers' assessments provided in Devon; 2,510 checks counted as carers' assessments in 2010/11; 25% of the total carer assessments offered
- Contribution to the number of people receiving a vascular check; 58% of carers who were aged 40-74 received a vascular checks as part of their health and wellbeing check; 8% of the total number of people receiving a vascular check in 2010/11

Progress was also achieved in relation to:

- Equality of access to services by BME carers
- Integrating the carer assessment into the health and wellbeing check and enabling some carers to access community care services without further assessment
- Reducing inequalities for carers of people with learning disabilities and carers living in areas of social deprivation

¹ READ coding is a systematic method of recording used by GP practices to identify the health needs of individual patients; READ codes can be aggregated to produce information about the health needs of populations

Key findings and recommendations

Key finding 1

Investment in GP practices and pharmacies is productive in identifying carers, providing an early assessment of need through a Carers' Health and Wellbeing Check (CHWBC) and enabling carers who would otherwise not come forward to be supported in primary care and the voluntary sector.

Collaboration with Devon libraries, memory clinics and Parent Carers was successful in providing appropriate settings for working carers, some carers of people with dementia and parent carers; in these instances having two experienced nurses who were able to work peripatetically to deliver these checks was critical to success.

Complex care teams were able to provide some domiciliary provision, but this is an area that needs further development.

Recommendation 1

The programme is rolled out to all GP practices in Devon, and pharmacies in locations where GP practices are not offering checks to carers; also that GP Commissioning Groups consider using a Peripatetic Nurse as a way forward for small practices to increase capacity to support carers and to collaborate to address specific needs. Further consideration is given to the provision of domiciliary checks, where the carer is unable to access other provision due to their own health restrictions or caring responsibilities.

Key finding 2

The appointment of a lead GP for the programme was effective and practices where a lead GP was identified and a team approach was adopted to identifying carers were the most successful in achieving their targets.

Recommendation 2

That GP Commissioning Groups consider having a Lead Clinician for carers to support the development of the carers' agenda locally and that individual GP practices identify a 'Carer Champion' to lead a whole team working approach to supporting carers; GP practices consider the advice produced by participant practices in section 4 - Partners learning from their own involvement.

Key finding 3

READ coding of carers consistently is an effective method of identifying carers and ensuring that all practice staff are aware that a patient has caring responsibilities, enabling them to be responsive to the patient as a carer. Only one practice which reached less than 1.9% READ coded carers (target 2%) reached their delivery target, and only one that exceeded the READ coding

target failed to get close to their delivery target. Cross-sector cooperation increased identification.

Recommendation 3

Any future commissioning of CHWBCs should include the requirement for practices to maintain an accurate carers' register through READ coding and progress should be monitored through an annual data return.

Key finding 4

58% of carers were eligible to receive a vascular risk assessment as part of the check, which contributed 8% of NHS Devon's performance on delivering this aspect of the NHS Constitution; significant levels of onward referrals for further investigations and treatment have been recorded, and this element was valued by carers.

Recommendation 4

The vascular check should continue to be integral to any future check design for carers, and carers between the age of 40-74 should be targeted by GP practices to receive a carers' health and wellbeing check; opportunities should be taken to identify carers by other providers and clinics established to provide vascular checks to the general population, in order to do a comparative evaluation in the future of the number of carers benefiting from this initiative.

Key finding 5

The programme has offered a development opportunity for Health Care Assistants (HCAs) in GP practices which although well received, has in some cases challenged their self confidence and self reported competence to undertake the checks; instigating further training in managing a consultation and clinical supervision helped in some measure to support their development and to mitigate any risks to the HCAs and Carers (this relates not to the technical aspects of the vascular check, but in managing time and emotions where carers were often given the first opportunity ever of talking to someone meaningfully about their own health and wellbeing).

Recommendation 5

Further work is done on the development of competency based training and assessment, care pathways and delivery protocols; future provision should be coupled with a competency based programme for staff delivering checks, and GP practices should facilitate appropriate clinical supervision for HCAs to support their development.

Key finding 6

Health and wellbeing checks were preferred by carers to the traditional form of Carer Assessment; the check gave effective access to health and social care services and was regarded by some carers as a support in its own right. The Devon holistic design was implemented successfully in general practice, pharmacies, and clinics and in carers' own homes; time to follow up the carer's progress was identified as a gap in provision. Referrals to Care Direct Plus resulted in some carers feeling they had been heard, and some receiving care packages which would not have been accessed without the check.

Recommendation 6

That the traditional format of the Carers' Assessment is replaced by a revised Carer Health and Wellbeing Check, and that it be carried out in Primary Care, Social Care Teams and commissioned Carer Support Services to the optimum benefit of carers; this should include a half hour follow-up at 6 months.

Key finding 7

Cross-sector collaboration, particularly between Devon Carers Link and GP practices, has been found to be beneficial in supporting practices to identify new carers.

Recommendation 7

GP practices continue to work with Devon Carers Link to support the identification of hidden carers and enable access to the range of carer support services available

Key finding 8

An intensive and bespoke approach in terms of time and resources is required to engage with young carers, working carers and carers in BME, traveller and drug and alcohol communities in order to identify and meet needs appropriately. Without the specialised BME work stream BME carers would have been significantly disadvantaged. Achieving equality for these groups will remain a challenge in the short and medium term, including fulfilling the basic need of GP registration for some BME carers. The building of trust and provision of services in an appropriate environment is required to ensure these particularly hidden groups of carers feel able to respond to the offer of a check.

Recommendation 8

Activity is continued with young carers, BME and the traveller communities to ensure that momentum is not lost and checks for working carers, with backfill costs if necessary, are continued and rolled out further. Resources directed to achieve equality should be spread across the county and should not remain

focussed on the same BME or geographic group or groups. Further work is needed to understand the extent to which non-white groups need help to access Primary Care and other health and social services.

Key finding 9

Young carers welcomed the opportunity to explore aspects of their own health and wellbeing at two structured but fun health and wellbeing days, with access to GP and pharmacy support; this was most successful in a young people's venue, where a 'young person first' approach was adopted. Young carers between the ages of 16-25 did not access health and wellbeing checks during the course of this programme.

Recommendation 9

This approach should be built on for future events provided by Devon Carers Link, young carers' work stream and further understanding should be sought with regards to the appropriate format of a health and wellbeing check for young carers / young adults aged 16-25.

Next steps

In 2011/12 NHS Devon has agreed an additional £1m investment in carer services and is working with Devon County Council to agree spending plans based on the views of Devon Carers and other key stakeholders; these will be published in September.

Devon County Council also agreed a £54k carry forward of funding from 2010/11 to enable carers health and wellbeing checks to be continued for working carers, BME and travelling carers, carers living in more rural areas; this funding will also support a young carers event for 16-25yr olds in September

The learning from participation in the DH programme has influenced the joint plans and some work has already begun to implement these from existing resources:

- A new carer support specification to improve assistance to Practices to identify carers and engage with carer support services has been embedded in an enhanced specification for Carer Support Services, this contract is due to commence 1st October 2011
- Devon Carers Link has commenced a programme offering short term support to non-participating practices to identify carers and prepare for the start of the new contract, which will continue to offer support. This has already had good take up

Section 1 – The Devon demonstrator site programme

1.0 Introduction

In spring 2009, Devon was successful in a bid to the Department of Health (DH) to become a Carers Demonstrator Site, to provide health and wellbeing checks (HWBC) for carers; £1m of additional funding was secured (£800,000 from DH £200,000 from Devon County Council) to set up an ambitious project that would test a new way of collaborative working between GP practices, pharmacies, and the community and voluntary sector for the benefit of carers. The heart of Devon's ambition was to raise general awareness of carers needs in primary care and to improve the health and wellbeing of carers in Devon.

This report is one of two local evaluations prepared for the Department of Health, NHS Devon, Devon County Council, partners in the Devon Demonstrator Site, and carers in Devon. Our research partner the University of Plymouth RE:search Southwest, will address the individual and aggregated experience of carers and effectiveness from their perspective.

The basis of this report is management Information collected during the course of the programme; feedback from the programme team, Carers, delivery partners and front line staff. It also outlines the delivery of the checks to carers, addresses issues of equality, and the broad impact for carers.

It reflects on the lessons learned from designing the programme, and from the partnerships which delivered it, and makes recommendations for the future.

1.2 The Devon Programme Outlined.

The following account formed the basis of our bid to the DH:

Aims:

- ***to maximise the physical and mental health and wellbeing of carers:***
- ***to identify more carers***
- ***to give carers a structured consultation to consider their own health***
- ***to increase recognition of and support to carers in GP Practices***
- ***to improve carers choice and control***
- ***to promote Devon Carers Link membership (preventive/early intervention services)***
- ***to narrow the inequalities experienced by carers.***

Objectives:

To deliver a minimum of three cohesive pilot sites covering areas of rural, social or economic deprivation.

Within each there would be:

- **GP practices: central coordination point**
- **Project support worker: initially set up relevant systems and processes and increasingly provide carer support within GP practices**
- **identifiers: health and social care professionals, Carers Link and other voluntary sector staff,**
- **schools and other children's projects,**
- **pharmacists to assure targeting of hidden carers and carers of people with complex needs**
- **providers of checks: Health Care Assistants working in or with GP practices, school nurses, pharmacists, St John Ambulance, health and social care teams**
- **Carers Link, specialist carers services, appropriate health services including health trainers and other sources of local support.**

In addition:

- **Individual GP practices not located in pilot sites**
- **centre-based choices for BME carers in Exeter and North Devon.**
- **workplace-based checks for DCC and DPCT staff (priority area in Devon Carers Strategy)**

We will deliver:

- **a minimum of 3,000 health/health and wellbeing checks**
- **raised general awareness of carers**
- **improved systems and processes**
- **a template for health and wellbeing checks**

Each aspect of the programme will test the alignment of the checks with NHS vascular check and Carers Assessment for quality, effectiveness, carer acceptability and cost effectiveness.

1.3 Summary of approach

The Office of Government Commerce-approved methodology "Managing Successful Programmes"² was adopted to ensure the programme stayed on target.

² Key MSP documents for the Programme are contained in the separate reference file at Appendix 2.

Three target cohesive pilot sites were identified at the level of NHS/SSD Clusters – Barnstaple in North Devon, Teignmouth/Dawlish in South Devon, and Budleigh/Exmouth on the basis of deprivation factors, known interest and likely success. Later the Moorlands area (Ashburton, Buckfastleigh and Bovey Tracy) were added where, the GP Practices wished to work to a different model without other check providers.

All GP Practices in the County were invited to express an interest in the Programme and recruited Practices who were willing to participate.

Pharmacies were invited from the cohesive site areas

Contracts were awarded to:

- St John Ambulance for the services of a nurse, Emma Healey, to offer checks for Black and Minority Ethnic Carers and for workplace checks
- The Sahara outreach service to make links with Black and Minority Ethnic communities (mainly of Asian and Chinese backgrounds), and prepare and support BME carers to take the checks, with Emma Healey, or if possible at their own surgery or a local Pharmacy. This was to operate mainly in the Exeter and North Devon areas;
- Westbank, the host organisation of Devon Carers Link, to provide development, training and support services to the programme as a whole and in particular the local providers;
- The University of Plymouth for a local evaluation of the checks;
- Devon Young Carers Consortium and Young Devon to provide two young carers health and wellbeing events;
- Participating GP Practices and Pharmacies

A Partnership Agreement for all partners to sign up to was established; this set out how programme partners intended to work together, and partners' responsibilities. Delivery Partners signed up with the host organisation for Devon Carers Link for this, and with NHS Devon for the service agreement which contained the two key measures – target checks for all delivery partners, and the increase in carers registers for Practices.

Carers, GP Practice staff and other health and social care staff were involved in designing the programme, and the Health and Wellbeing Check itself.

All check materials, protocols and pathways, designed and printed forms were developed locally and piloted in the first couple of months of operation; delivery partners were consulted early on the experience of their use and products were revised in the light of their input.

The Carer Assessment and the Vascular Risk Assessment were incorporated into the Check.

Negotiations with delivery partners took place regarding the use of the Vascular Risk Assessment Protocol and Near Patient Testing Equipment, including offering part of the remuneration for checks up front to help cash flow.

Delivery of the initial training for Practices and for Check Providers was designed locally and contracted for.

Initial targets were agreed with all delivery partners.

Westbank provided a financial resource to the Practices to enable them to make ready for the checks and undertake preliminary administration.

A three phase approach was designed so that the programme team could support Practices as they became operational.

Agreements were established with DCC and NHS Devon for a workplace check pilot; other employers were also sought.

When it appeared that delivery by the original delivery partners would fall short of our commitments, a further phase of delivery partners was recruited - Phase 4, commencing June 2010.

Additionally a publicity campaign undertaken to assist with carer identification and check take up (see below); before this could commence a Peripatetic Nurse was required to avoid the campaign simply generating dissatisfaction from carers who could not have a check (see below).

A bespoke check format for Young Carers was developed based on a fun day of thinking and working together about their health; this was delivered twice.

Monthly meetings of the implementation and sustainability team were held to monitor progress, problem solve and manage risks.

Quarterly reports were returned to the DH and the National Evaluation Team to fulfil the requirements of the Demonstrator Site national programme design.

1.4 Day Clinics and the Exeter Library.

Not all Carers in the County were either registered with a participant Practice or within reach of a participant Pharmacy. For this reason an alternative route for carers to get a check was needed to prevent generating frustration and dissatisfaction for some carers through the publicity campaign.

A peripatetic nurse was employed by Coleridge Medical Practice to undertake both general carer checks and workplace checks.

Devon County Council offered facilities in Exeter Central Library, a venue ideally placed close to public transport links near Exeter City High Street. Other DCC venues were also used plus Newton Abbot and Bideford Hospitals. Some of these clinics catered jointly for workplace and general checks to maximise efficiency.

Clinics were also undertaken at some surgeries that had demand over their capacity, or which had been interested but unable to take part at the time.

The specialised venues of the Memory Café and the Parent Carer Conference suited some carers very well, and there were no voids at these events. It is the Programme's recommendation that such venues continue to be used for checks if carers wish it.

1.5 Communications

Communications with operational colleagues and with strategic stakeholders were maintained throughout the programme using separate monthly bulletins (and where necessary "news flash" bulletins) with key messages determined by the Implementation and Sustainability Team.

Routine operational contacts were maintained using tailored emails from the Delivery Manager.

Part way through the programme formal feedback on progress was individually issued to practices by letter to the senior partner.

The local researcher maintained direct links with all delivery partners to assist them with the demands of the local evaluation.

Initially it was not intended to hold regular briefings with providers as we understood they saw this as unnecessary. However, when it was necessary to bring providers together for a briefing on the integration of the National Evaluation into the programme, regular quarterly briefings were requested, which were supplied in Exeter and in North Devon on each occasion.

1.6 Summary of what worked and what did not

Objective	Overview of achievement and comment (detailed evidence of success available in Section 3)
<p>To deliver a minimum of three cohesive pilot sites covering areas of rural, social or economic deprivation.</p>	<p>This objective was designed to explore carer choices, with multiple sources of checks being available.</p> <p>This did not work as planned due to the following reasons:</p> <p>It was not possible to recruit all the GP Practices in three areas; this was achieved this in two areas, the Moorlands area (Ashburton/ Buckfastleigh/ Bovey Tracy) and Barnstaple.</p> <p>In Exmouth/ Budleigh 3 out of 6 Practices were recruited.</p> <p>In Teignmouth/Dawlish there was initially comprehensive interest but finally only one Practice signed up.</p> <p>It was realised that in no case would the original vision of a “cohesive site” be deliverable, but that Barnstaple, Moorlands, Exmouth/Budleigh and Teignmouth (Teignmouth had one Pharmacy) all had features of the original idea. In practical terms first three were regarded as “enhanced sites”.</p>
<p>Within each cohesive site there will be:</p> <ol style="list-style-type: none"> 1. GP practices: central coordination point 2. A Project support worker: initially to set up relevant systems and processes and increasingly provide carer support within GP practices 	<ol style="list-style-type: none"> 1. GP Practices were pivotal to carer benefit but did not act to refer to other providers based on carer choice as envisaged. 2. In Moorlands the Practices worked together to achieve this. In Barnstaple a team worker was appointed, based with Barnstaple Poverty Action Group which already had good relations with the GP Practices. <p>In all other areas Practices preferred to use the resource in-house and individually.</p>

<p>3. Identifiers: health and social care professionals, Carers Link and other voluntary sector staff,</p> <p>4. schools and other children’s projects,</p> <p>5. pharmacists to assure targeting of hidden carers and carers of people with complex needs</p> <p>6. providers of checks: Health Care Assistants working in or with GP practices, school nurses, pharmacists, St John Ambulance, health and social care teams</p>	<p>To ensure the available resources were shared fairly between participant Practices, according to the length of time delivering checks Phase 1 Practices received 9 months initial funding to support start up; all other Practices received a minimum of six months start up funding.</p> <p>The Project coordinator model, working across Practices rather than wholly within one Practice, was a successful approach; after the initial period further investment was made in this model to support Practices more effectively.</p> <p>3. There is some evidence that this did work. See Section 3 of the report and tables in Appendix 7 on which carers had checks.</p> <p>4. Schools were not involved as hoped; Young Carers Projects were involved but the plan to have them as part of the “cohesive site” approach changed as a different model was adopted for young carers.</p> <p>5. Pharmacies were involved but their experience was mixed, as evidenced in the delivery section of this report.</p> <p>6. Deliverers of checks were Health Care Assistants and Practices Nurses in GP Practices. In the “cohesive” sites. Health and Social Care teams were represented as check providers only by Complex Care Teams operating in Barnstaple and in the original enhanced site of Exmouth/Budleigh. Pharmacy staff undertook checks in participating Pharmacies.</p> <p>School nurses were not available to provide checks.</p> <p>Other Health and Social Care teams for Learning Disability and Mental Health elected to remain in the identifying role only.</p> <p>It had originally been hoped that St John Ambulance would be able to provide checks alongside its training programme in the cohesive sites but for practical reasons this was not possible.</p>
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<p>7. Devon Carers Link, specialist carers services, appropriate health services including health trainers and other sources of local support</p>	<p>All services were available as planned.</p>
<p>In addition to the cohesive sites there would be:</p> <ol style="list-style-type: none"> 1. Individual GP practices not located in “enhanced” sites 2. centre-based choices for BME carers in Exeter and North Devon. 3. workplace-based checks for DCC and DPCT (NHS Devon) staff (priority area in Devon Carers Strategy) 	<ol style="list-style-type: none"> 1. 23 of the 33 Practices that took part were outside the Moorlands, Exmouth/Budleigh and Barnstaple areas. 2. This worked well; 61 checks for BME carers were delivered in the centres. 3. This worked well although the full ambition for delivery was not achieved; 29 (target 40) workplace checks were undertaken in the programme, between 29/10/10 and 25/3/11. (5 males and 24 females).³ Slow take up was thought to be attributed to staff feeling vulnerable about exposing their caring responsibilities at work. In addition other checks programmes were running at the same time. However, a payslip publicity campaign in DCC worked well to encourage staff to come forward.
<p>We will deliver:</p> <ol style="list-style-type: none"> 1. a minimum of 3,000 health/health and wellbeing checks 2. raised general awareness of carers 3. improved systems and processes 	<ol style="list-style-type: none"> 1. A total of 3029 health and wellbeing checks, including 105 annual re-checks were delivered. 2. Feedback from participant Practices indicates that carer awareness is much higher than previously. Although the original target of 2% of participant Practices’ registered patients READ coded as carers as not reached in all Practices, 2,234 new carers were READ coded in participant Practices, a 75% increase. 3. Participants are now much more aware of processes for referral for services carers need and have been using them; the system is therefore working better for carers. Specific

³ Action was taken to attract the University of Exeter and the Royal Devon and Exeter NHS Foundation Trust Hospital but this was unsuccessful. The University of Plymouth agreed to encourage Devon staff to come forward for a check but there was no take-up from this.

<p>4. a template for health and wellbeing checks</p>	<p>Practice improvements in systems and processes for recording were also targeted, which can be demonstrated in the improved coding and register increases.</p> <p>4. The template was completed and well-tested; it is being revised in the light of experience though currently it is thought the revision will not be substantial. Some other Check sites used some or all of Devon's check design</p>
<p>Each of the three sites will test different ways of aligning the checks with NHS vascular check and Carers Assessment for quality, effectiveness, carer acceptability and cost effectiveness.</p>	<p>It was determined early in the planning process that a single way of aligning the vascular check and carer assessment was required for operational reasons.</p> <p>The local research evaluation will report on quality and carer acceptability.</p> <p>47% of carers having a check received a Vascular risk assessment</p> <p>In 2010/ 2011 in Devon 9,936 people were offered a carers assessment / advice or information. Of this, 25% (2,510) were Carers Health and Wellbeing Checks. Without the checks, DCC would not have met its 10/11 target of 38%.</p> <p>It is considered that the alignment was successful.</p>

Section 2 Delivery of the Programme

1. Introduction

The Carers Health and Wellbeing check programme operated from August 2009-March 2011. This section of the report outlines the overall achievements of the Carers Health and Wellbeing Check programme, the activity of delivery partners, the actions taken by the Programme Team to achieve the Programme's targets and the range of outturns achieved.

2.1 Delivery Overall

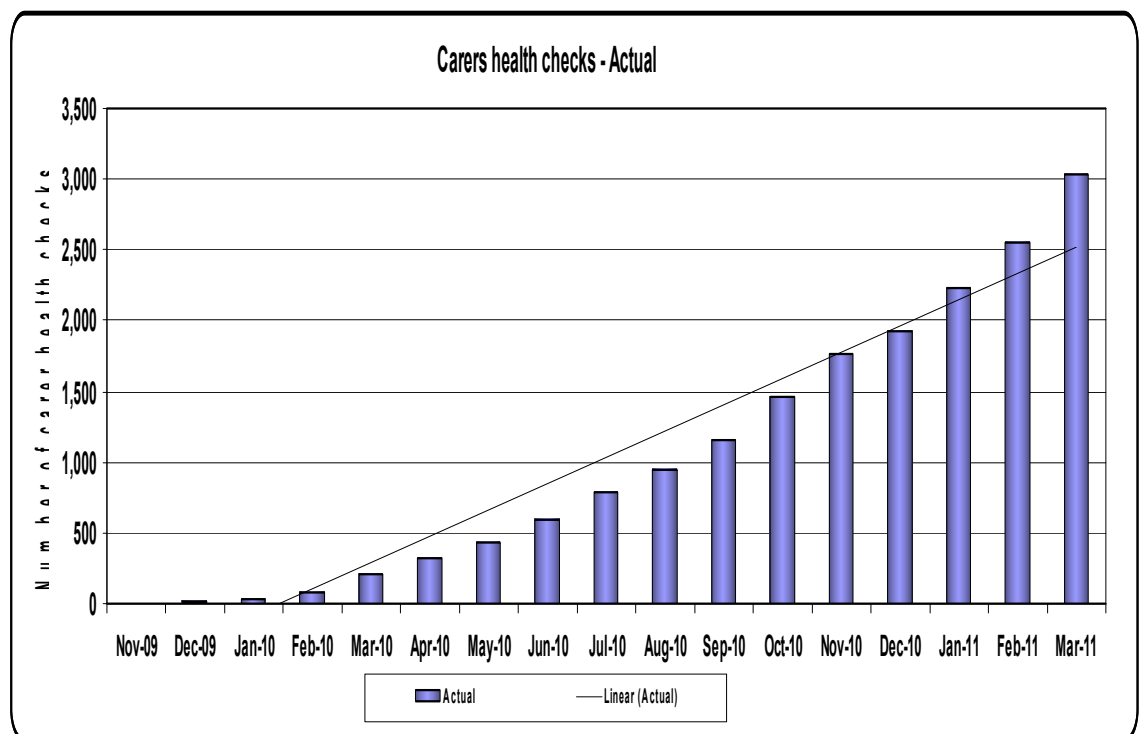


Chart1: Overall delivery of Health and Wellbeing Checks in the Devon Demonstrator Site.

Chart 1 shows cumulative delivery (bars) compared with a straight-line projection of overall delivery illustrating the momentum which developed over time in the Programme and the stronger delivery in the final quarter.

The overall commitment made to the Department of Health was to deliver a minimum of 3,000 Health and Wellbeing Checks to carers in Devon.

In total 11,863 carers were offered checks, 3029 checks were carried out and 2,234 new carers coded (75% increase).

2924 of these checks were initial checks and 105 were follow up annual reviews.

Of the carers for whom data is available⁴:

- 2833 were adults, of which,
 - 72 were recorded as BME carers and a further 10 were recorded as white backgrounds or mixed British but required an interpreter, totalling 82⁵
 - 29 were working carers and
- 105 were young carers

Of all adult Carers in Devon – estimated 74,000 (baseline) – the programme provided checks for 3.7% of the baseline.

2.2 Key delivery partners - GP Practices.

The major delivery partners were GP Practices. 33 participant GP Practices between them delivered 2562 checks, and READ coded 2,234 new carers.

The average length of time Practices were active was just over 12 months.

Due to the fact that GP Practices vary significantly in size; the information about check delivery is therefore standardised as a % of registered population, which is the way initial targets were also calculated.

Initial targets were set to ensure delivery of the commitment in the Devon bid to deliver a minimum of 3,000 checks. Phase 1 Practices, which started first, were given a target of 1.2% of their registered population. Others, starting later, reduced Phase by Phase to 1%.

These targets proved challenging, but in most cases delivery increased substantially in the latter half of the programme.

Managing the Carers Health and Wellbeing Check Programme to achieve the DH commitment within budget was complex. Initially a “cap” was set for Practices at their target level. Later, when it seemed most likely that overall delivery would fall below 2,000 checks, and some practices wished to reduce their targets, additional GP Practices were recruited (Phase 4, June 2010). Towards the end of the Programme, to boost delivery, it was agreed with high-performing

⁴ Data was missing in some fields, particularly ethnicity, for some carers, therefore analysis in any section of this report analyses only the data available.

⁵ This excludes carers recorded as Irish ethnicity of which there were 4. Details can be found in Section 3 and Appendix 7.

Practices that wished to do so that they could exceed their “cap” as part of a managed process

10% of Practices significantly over-delivered on their targets as part of this managed process.

- Three Practices, two small and one large, achieved 1.4%. Two of these were from Phase 1 and one from Phase 2.

One third of practices involved exceeded, reached or almost reached their target.

- Ten practices in total achieved 1% or better, and a further three achieved 0.9%.
- Of those Practices achieving 0.9% (90%) or above, there were Practices from all four phases:
 - 7 (of 12) from Phase 1,⁶
 - 1 (of 4) from Phase 2,
 - 3 (of 6) from Phase 3 and
 - 3 (of 11) from Phase 4.

The overall average for check delivery was 0.8% of Practice population.

All but 6 Practices achieved 50% or more of their original target

There is no simple association between length of operation in the Programme, and delivery. Of the three Practices achieving 1.4%, two did not commence until February 2010 and one not until June 2010. The latest entrant to achieve 1% started delivering checks in August 2010 – they achieved this and the 2% targets for READ coding of carers in just eight months.

Practices that did not get so close to their target still made a valuable contribution to the overall success of the programme. The evidence suggests that many initially encountered problems which they later overcame; had the programme been longer this would have resulted in improved delivery.

Where numbers of checks delivered was relatively low, this was usually related to some particular local problem such as staff turnover or illness and their achievement still forms the basis for future support for carers.

Good performance was reported by Practices to be related to good Practice Team working and GP’s driving the local programme.

⁶ Phase 1 included Practices which had recently taken part in a similar pilot.

Appendix 4 illustrates in six charts the variation in Practice performance related to baseline registered population and date of first delivered check.

Chart 1: Checks delivered as % of baseline population

Chart 2: Checks delivered ordered by start date

Chart 3: Delivery against targets - note that some Practices agreed revised targets

Chart 4: READ coding of carers

Chart 5: Change in Devon Carers Link Membership by Practice

Chart 6: Outcomes (checks delivered, READ coding and DCL membership) as % of baseline population

2.3 READ coding

READ coding⁷ is a way of GP practices consistently recording on an individual patient record when a registered patient has caring responsibilities.

The target of READ coding 2% of GP practice registered population as carers (one in five carers) was agreed with each participating practice unless they had already reached this; in these cases a 1% improvement target was agreed.

The target was set in this way to ensure that GP practices could identify sufficient carers to provide a health and wellbeing check to and to inform any relevant decisions about their future care. As a measure of success only one Practice that reached less than 1.9% READ coded carers reached their delivery target, and only one that exceeded the READ coding target failed to get close to their delivery target.

The top achievement on this measure was 6%. Nine Practices reached or exceeded the target; a further 2 reached 1.9%. The average by Practice was 1.7%.

2.4 Specialist Workstreams

Black and Minority Ethnic carers: Delivery partners St John Ambulance and Sahara (the outreach arm of Hikmat) collaborated to deliver 65 checks (target 75 – a further 10 checks were incomplete or abandoned at the carers' request – factors as below) to carers identified and supported through the process by Sahara. The workstream was successful in attracting hidden carers, but the project was considerably more difficult than originally envisaged. There were significant features which were unforeseen (or their impact had been originally underestimated):

⁷ READ coding is a systematic method of recording used by GP practices to identify the health needs of individual patients; READ codes can be aggregated to produce information about the health needs of populations

- carers were not engaged with services to a very significant degree - some carers were not registered with GP's
- carers were fearful of taking the check as they were afraid of authority and state intervention believing it could affect their immigration status or benefits (the voluntary nature of St John Ambulance was helpful here)
- carers were unwilling to be supported to receive checks in their GP Practice, thus diverting some of the resource from St John Ambulance which had been intended for workplace checks (see below); (conversely receiving checks at a familiar centre and in a supportive environment was valued)
- additional time was needed with some South Asian groups to persuade men of the value of the project (and with one Imam who was worried the project was anti-Islamic) and that women's modesty would not be compromised by it before work could start with the women who were the carers
- additional preparation time was required with isolated women carers whose experiences outside the home were extremely limited
- the concepts of "care" and "carer" took more time to convey and understand, cultural issues of family honour and shame became involved for some groups who felt these would be compromised by admitting difficulties or receiving support

Working Carers: a small pilot was conducted in DCC and NHS organisations in Exeter and the Newton Abbot area to test demand. 29 (target 40) working carers had checks via this route. This workstream started relatively late and was further delayed by a capacity issue with delivery partner St John Ambulance, whose time was diverted to the BME workstream (see above), and it took time to identify the additional resource of the Peripatetic Nurse to allow it to go ahead.

Young carers: checks for young carers were carried out at two health days, one at a sporting venue in Exeter and the other in a youth venue in Newton Abbot. Young carers were supported by the young carers' projects and Young Devon. A total of 105 young carers benefited. The young carers' work stream is being evaluated by the University of Plymouth using specially designed methodology and no Management Information is held on the young carers individually.

Complex Care Teams in North Devon and Exmouth reported that carers in families they are working with were often in crisis during their short period of work with them and were not ready to take up a check. However, they undertook 36 checks (target 60), with performance ramping up significantly since November 2010, suggesting that this will be an important route for some carers in the longer term.

Pharmacies had mixed experiences. Checks delivered in individual Pharmacies ranged in number from 5-55 (original target 60). Pharmacies did best where GP Practices were referring carers to them because they were not themselves undertaking checks.

The Peripatetic Nurse: in addition to workplace checks the Peripatetic Nurse undertook checks for carers coming forward as a result of general publicity to boost carer identification and check take up. The St John Ambulance Nurse also did such checks. In total 76 such checks were undertaken (no target). Checks were undertaken at non-participating Surgeries, in the Exeter Library and other DCC venues, and at Memory Cafes and a Parent Carer conference. The Memory Cafes and the Conference were fully subscribed and produced no “did not attends”.

Section 3 Impact of the Carers Health and Wellbeing Checks Programme

3.0 Introduction

In this section the impact of the programme will be described in terms of:

- overall impact using proxy measures of access to Devon Carers Link and READ coding, and delivery of NHS Life Checks
- the pattern of referrals from health and wellbeing checks
- the social care impact for carers and their cared-for
- equalities impacts – gender, rurality, age, rural isolation and race
- the overall achievement in terms of what we set out to do

3.1 Overall impact

As three proxy measures for overall impact on carers lives, it is possible to analyse:

i. **Differential take up of membership of Devon Carers Link (DCL).⁸**

At the end of the Programme DCL reported improved take up for 2010/11 as follows:

- Practices not providing HWBC's: 17.5%
- All Practices providing HWBC's: 27.9%

Participating Practices accounted for 58.4% of the membership increase of DCL in 2010/11. The registered populations of participant practices were approximately 45% of the total in Devon.

It is a recommendation of the programme that work continues to strengthen the links between GP Practices and Devon Carers Link to support the identification of hidden carers and enable access to the range of Carer support services available

ii. **Number of READ coded carers**

There was a 75% increase overall in the number of READ coded carers; this is a way in which a patients GP record records that they have caring responsibilities. This is taken to be a proxy

⁸ DCL membership is included alongside Check delivery and READ coding in the charts in Appendix 4.

measure for improved relationships between carers and GP practice staff. This includes:

- An increased awareness of where the impact of their caring role may: restrict the time at which the carer can attend an appointment; require them to cancel appointments at short notice; prevent the carer from attending for routine screening
- Ability to take account of where the carers health condition has deteriorated due to their caring responsibilities e.g. back pain, depression
- Working in partnership with the carer due to their expert knowledge on the condition of the person they care for if they are registered with the same practice.

iii. Receipt of Vascular check component

The programme adhered to the Devon protocol for the provision of a vascular risk assessment (known as the NHS Life Check) for carers who were between the ages of 40-74, who had not otherwise received an assessment.

In Devon 67% of carers, the highest proportion of carers, are in this age band.

Within the Programme, the proportion of carers who were within this age range was almost 69%, of these 58% received a vascular check (1937 and 1128 respectively)

The programme contributed 8% of the number of people generally in Devon who received a vascular assessment in 2010/11

The Peripatetic Nurse said:

“The carers health and wellbeing checks have allowed me to use all of my nursing / professional skills and experience to holistically help carers find the own solutions or indeed seek urgent help to prevent long term disability and, I believe, in two case early death.

The information and evidence that I gained enabled me to gain a significant understanding of the bigger picture of caring and confirmed that carers are generally spending little investment in their own health due to their wider responsibilities. Some carers (some of whom were well below midlife in age) demonstrated potential for life limiting illnesses if clinical help and advice was not sought. Several of these required earlier help as opposed to later.

Undiagnosed conditions such as diabetic risk, cardiac (hypotension / hypertension), raised cholesterol, low level fractures indicating underlying osteoporosis, obesity and lack of knowledge of good diet post menopause were common. “

Mr H. a carer from Ottery St Mary said:

"They have come up trumps; they have found a problem with my heart that I had no idea I had. Now I am booked for an ECG and have been put on tablets for high blood pressure"

Mr B. of Exmouth said:

"I found the health check very reassuring that there was nothing wrong, which also reassured my wife."

And Mrs C. a carer from Honiton said:

"It was very thorough, the nurse talked to me about all sorts of things that we could have to help us if we needed them. At the moment we are managing OK but its comforting to know that help is available. Although I am only a couple of pounds overweight, the test picked up that I have high cholesterol so I have been booked in to have a 'fasting test' next week to confirm the result. Just think, I would never have known".

3.2 Young Carers

105 young carers attended young carers' health and well being events either at Sandy Park (Rugby Club) or The Change Academy, Newton Abbot (Youth Centre).

The impact of these events will be reported on in the research evaluation; but it is the recommendation of this programme that best practice is followed in relation to enabling young carers to be young people first and be facilitated to access activities in a youth focused environment.

3.3 Working Carers

This was a small pilot element of the programme and that the management information and research evaluation is unlikely to distinguish any distinctive impact for this group of carers.

This report therefore includes the experience of working carers through the testimonials that they have provided on the benefit to their health and work / life / caring balance and feedback from the peripatetic nurse:

"I found it really useful to have someone to talk too who was really listening and understanding the challenges as a carer I deal with everyday. Emma was really easy to talk too and gave me lots of very useful contacts. Although I thought my own health was really good, following my check this was found actually not to be the case, though nothing to worry about, but I will be following this up with my GP

I would recommend any working carers to have a health and wellbeing check. It would be nice if these were available once a year."

Working Carer

I've been a carer for years: so many years that it took me a while to actually realise that what I was doing was caring: running around after an increasingly fuzzy-brained mother, disabled husband, and a daughter whose health problems were written off as 'stropky teenager' and went undiagnosed for 5 years... but that's another story. So burning out, not taking time to look after me, putting everyone else's needs first and trying to continue to hold down a fulltime job (being the sole bread-winner) was my 'normal'. When the carer health and well-being checks came around, I was pretty scared: what if they find something wrong? What will happen? Who'll look after the tribe...? But then there's 'if they do find something, I can get it fixed or helped', and 'if they don't find anything, then what a relief!' All things considered, I went for the check.

I had an hour with a non-judgemental, truly empathic (not wishy-washy) and down-to-Earth nurse who could see into my soul and acknowledged my fears and human failings. I'm overweight – so what? Could be worse; no preaching – just solid advice on how I might manage to avoid the 'bad' fats (have you ANY idea just how many there are and where they hide????). A small prick of the finger, a few more minutes' helpful talk and – hey presto! Cholesterol check done. Blood pressure done; height, weight done and all without my feeling that I was being 'monitored'; all I felt was that I was being enormously helped and understood. My health hasn't changed, but my underlying anxiety about it has! I hadn't realised my anxiety until faced with the choice of having this check – and there it was; scared – just in case. But what if the just in case isn't found out, and just in case becomes 'if only I had...?'

Crucially, something changed for me as a result of this check: in taking that short amount of time for me, with someone who was there entirely for my benefit, allowed me time to reconsider my approach to being a carer; the burden and what I can do to relieve that. I'm a mad keen photographer – not very good, but it is my time and I'd let it slip of late. The check helped me to see that taking this time – even to take monumentally bad photographs – is vital recharging time. It breaks my cycle: fatigue, resentment, anxiety, anger; by injecting 'me time' and what a difference that makes.

Working carer

"The working carers I encountered were among the most stressed I met in doing 67 checks"

Peripatetic Nurse

3.4 Pattern of Referrals

5503 referrals were made by check providers recorded in table 1⁹

Table 1

NHS Services	Number of referrals	Sector level %
• GP appointment	509	
• Practice nurse clinic	372	
• Phlebotomy	245	
• Stop Smoking Service	47	
• Screening programme	79	
• Health Trainers	113	
• Community Nursing	24	
• Check ups (Audiology, Optician , Dentistry)	146	
• NHS Other	109	
Total NHS Services	1644	30%
Community and Voluntary Sector Services		
• Carers link	1038	
• Community Mentoring	221	
• Addaction (substance misuse treatment)	4	
• St John Ambulance	532	
• Looking after me programme	348	
• Citizens advice Bureau	87	
• Community and Voluntary Sector other	229	
Total Community and Voluntary Sector	2459	45%
Devon County Council		
• Care Direct	520	
• Care Direct plus	106	
Total Devon County Council	626	12%
Voucher for Care and Repair – home safety and handyman	774	14%
Total including Care and Repair	5503	100%¹⁰

The level of referral suggests that significant levels of need for investigations, treatments and support services were found among the group of carers who had checks and that needs were identified and spread across sectors.

⁹ Note that this information was collected by monthly returns and is likely to understate actual referral levels as evidenced by comparison with the section on social care referrals which follows.

¹⁰ Note totals do not add due to rounding

Nearly 36% were referred for the training programmes offered by St John Ambulance and “Looking after Me”, which are designed to practically and emotionally support carers to sustain their caring role.

Nearly 25% of referrals to health were for screening, check ups, health trainers and stop smoking services; these outcomes would be unlikely from the traditional carer assessment.

The preventive effect of following up on screening programmes where appointments have been missed, or regular check ups, should also be noted.

Referral information was collected on a monthly return as aggregated data, rather than at individual carer level, this has reduced the potential to undertake any further analysis on referrals. It is recommended that future management information collection includes in the individual carer record an account of referrals that are made by:

- Actual referral by the check provider
- Agreed action that the carer will take to access other support required

3.5 Social Care Impact

Referrals to social care were managed through Care Direct Plus in the Northern Locality, which has enabled the collection of data on all referrals and analysis of impact.

209 Carer records and the records of 220 people cared for were available to analyse; a further 17 records were not available at the time of analysis. Of the people referred:

- 26 Carers were FACS¹¹ eligible
- 75 people cared for were FACs eligible.

106 Carers were not previously known to ACS, and of these, 66 had cared-fors who were known.

A total of 37 care packages were provided, ranging from very simple grabrails or other equipment (the majority) to complex packages. Of these the number provided by Direct Payments or Personal Budgets was 2.

- 18% of carer referrals resulted in a service package being provided or improved to assist them or relieve the care required in some way.
- 4 carers had an additional period of respite booked

¹¹ Fair Access to Care Services

- 10% were referred or sign posted for things not directly provided by DCC or for Benefits Checks
- 20% were referred on for Benefits checks.
- 7.6% were assisted with information and advice.

However:

- 48 carers declined assessment or did not respond to attempts to contact;
- In 5 cases a carer assessment form was sent out, but not returned

Overall, less than 25% of people that were referred met FACs eligibility for a service to be provided.

The programme has provided an opportunity to test a new care pathway between GP Practices (specifically referrals from HCAs and some Practice Nurses) and Care Direct Plus for the provision of support for carers. The above analysis demonstrates that whilst over 75% of referrals may be considered misdirected (appropriate to Care Direct rather than Care Direct Plus), in a significant proportion of those properly referred to Care Direct Plus eligible needs were identified and packages were supplied without the need for further carer assessment. For cases where neither the carer or cared for was previously known to Social Care packages were provided in 39% of cases.

When undertaking the collation of the health and well being checks it became apparent that the carers were very happy to have undertaken them and felt more supported because of them. In fact we had several comments that made it clear that the mere fact that their needs had been recognised was a support in itself; carers who were previously struggling to cope, feeling overwhelmed by their situation and had felt so 'unheard' responded so positively that we found that after assessment they felt that they often were not in need of a service. They had been heard and that had made such an impact that they felt stronger and able to carry on in their role. It is very apparent that the Carers Health and Wellbeing checks hold great importance within the realm of health and social care and how we support our carers and the carers checks have been indicative in myself and my team learning that a service is not always the answer; the assessment and expertise that the carers experienced by us contacting them, because of the health and wellbeing checks, helped us understand that 'an ear' is an important tool that is often ignored or rather the value of it is not always recognised. Health and Wellbeing Checks for carers are a vital part of the changes that health and social care need to undertake to provide the correct support that carers need. We listen, we then hear what they need and then we have a service shaped more by them and this improves the situation for them and DCC. It is supporting the "Putting People First"¹² agenda fully.

Manager – Care Direct Plus

¹² "Putting People First" is the name of the agenda to "personalise" social care services, making them more personally designed by and useful to the people who use them.

3.6 Reducing Inequalities

The following inequalities were identified in the Equality Impact Assessment for Carers 2008 and included as part of our bid. The categories identified in bold are the ones that were actually addressed in the programme.

- **Gender**
- Disability (sensory)
- **Age – young people, parent carers, working age carers and people aged 65 plus**
- Sexual orientation
- **Access to support – rural isolation**
- Carers of people with drug and alcohol problems, aggressive or unsociable behaviour
- **Carers of people with dementia**
- Carers of people with HIV/AIDS
- Bereaved.
- **Race/Ethnic origin** and religion or belief

In addition to these analysis is available in the benefits chart in the Appendices with regards to:

- Deprivation
- Learning Disabilities

3.6.1 Gender

Male carers generally access service at a lower rate than female carers.

In the programme it was hoped to attract more male carers by using publicity material showing a male carer having a check and using male carers' quotes in publicity material where possible.

<p>In 2009/10 the gender breakdown of Devon Carers Link (DCL) Members was as follows: Female 72%; Male 28%.</p>	<p>In 2010/11 DCL reports carers joining who say they heard about DCL through having a check as follows: Female 68%; Male 31%.</p>
<p>The estimated breakdown of carers in the Devon population is: Females 59%; Males 41%¹³</p>	<p>Carers accessing health and wellbeing checks as follows: Female 70%; Male 30%</p>

¹³ Source figures from 2001 census; see appendices

Although equality for male carers in accessing checks has not been achieved their representation in the membership of Devon Carers Link has improved slightly.

3.6.2 Age

Who are older carers caring for?

Of the older carers who had a health and wellbeing check:

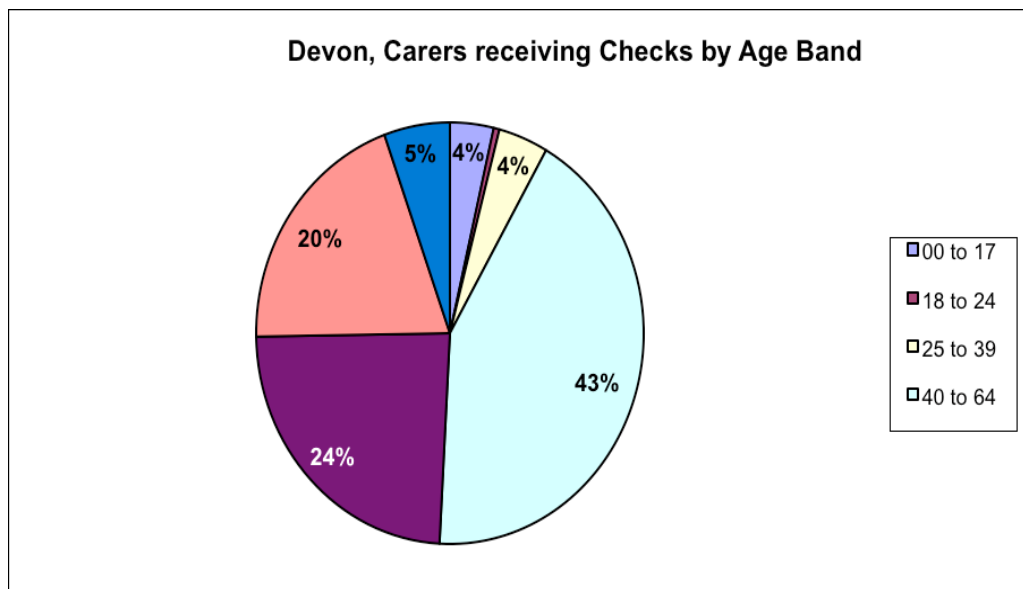
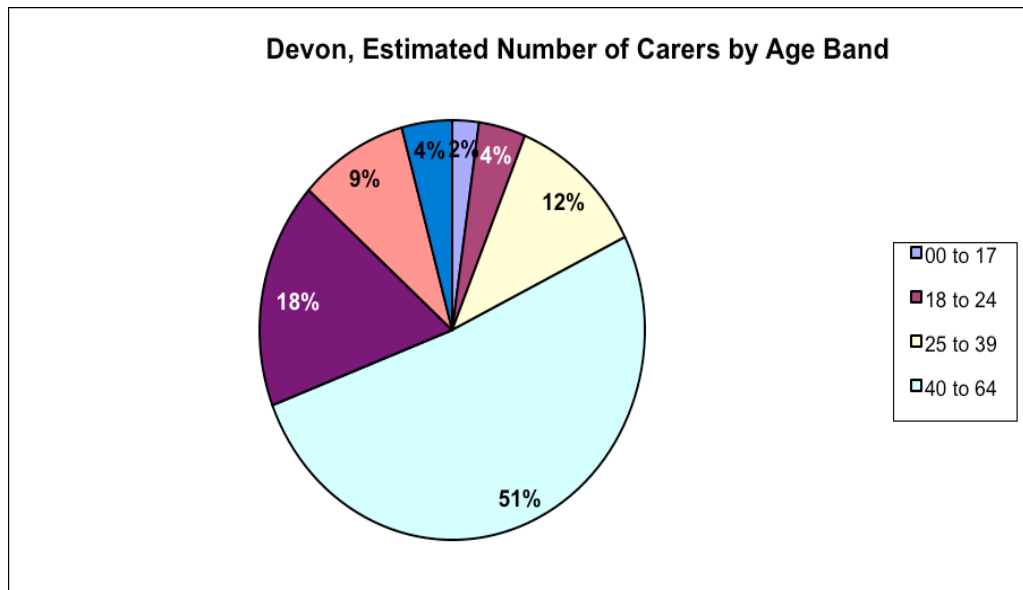
- The largest group looked after by carers aged over 65 are spouses/partners – 70% of carers looking after a spouse/partner are aged over 65.
- Older people provide most of the care provided to friends – over 65's are 55% of carers providing care to a friend
- Of carers looking after a parent, 14% are 65-74 and 1% are 75-84
- Of carers looking after a child: 15% are aged 65-74; 6% are 75-84; 2% are aged 85 plus
- Older carers provide most of the care for people with Mental Health Problems - 58% of those caring for someone with a mental health problem are over 65 (8% are over 85)
- They also provide most of the care for people with physical and sensory disabilities – 52%

The following charts demonstrate the demographic breakdown of carers in the Devon population followed by the demographic breakdown of carers that received a health and wellbeing check.

These show clearly that the largest proportion of carers in both the total population of carers and the population of carers receiving a health check are between the ages of 40 and 74 (the eligible age for a vascular check and the majority of the working population).

This means that we achieved our objective of advantaging older age groups of carers;

The most under-represented group of carers receiving a health and wellbeing check are the 18-24 year olds who represent 4% of the total carer population. Funding has been secured from DCC to provide a health and wellbeing checks event, targeting this group of young adults in September.



3.6.3 Rural Isolation

An analyses of the distribution of the urban/rural classification groups in the general population in 2011 with the % of carers receiving checks by urban / rural classification where known suggests that the greatest access to the checks is from the 'town and fringes' locations (Devon market and coastal towns with populations of under 10,000).

However, this conclusion must be treated with caution. Given the age profile of carers, their distribution in the population may not match the general population distribution used here for purposes of comparison.

Setting	Devon Population % Resident in settings	Carers receiving health and wellbeing checks
Urban 10k+	47.4%	43.9%
Town and Fringe	22.8%	29.5%
Village	17.5%	17.1%
Hamlet and isolated dwelling	12.4%	9.5%

Further analysis is contained in the Appendices.

3.6.4 Carers of people with drug and alcohol problems

Only data on carers of people with drug and alcohol problems was collected (aggressive and unsociable behaviour are not care categories and it was considered too difficult to ask carers to categorise their cared-fors this way)

Thirteen carers of people with substance misuse problems were coded as such; the number reached may be more as there are groups for which no primary need is identified, which could represent reticence.

Of the 2833 adult carers in the Programme there were: 0.45% caring for someone with a substance misuse problem. Further analysis is contained in the Benefits Table.

3.6.5 Carers of people with Dementia/Mental Health Problems

508 carers of people with mental health needs received a check; these represent 17% of the total number of carers receiving a check. This is comparable with the proportion of MH service users known to Adult and Community services as shown in the table below.

DCC Care Categories		ACS service users	Carers having HWBCs
Older people, physical and sensory disability	Proportion	74%	65%
Learning Disabilities	Proportion	6.9%	6%
Mental Health	Proportion	19%	17%

The Devon Carers Health Needs Assessment 2009 estimated that 6% of carers were looking after someone with a MH need (including dementia), and 18% were caring for someone with a dual diagnosis, which would include more people with mental health problems.

Appointments were made available at Memory Clinics in the latter part of the programme and delivered by the peripatetic nurse. In some places it was found that Memory Clinic attendees had already accessed checks; however in Tavistock where there were no GP practices' participating this venue was popular- three day clinics were held, fifteen carers received checks and there were no voids.

Within the limits of the data available it would seem that the programme has achieved reasonably for carers of people with mental health problems.

Check providers reported that people caring for someone with dementia were experiencing difficulties with appointments. It had originally been planned that some appointments would be available in people's own homes, which would have assisted this group, but this did not prove feasible for practices.

The programme recommends continuing to make checks available at Memory Cafes and that a domiciliary option should be available where a cared for person cannot be left with a sitter for the appointment.

3.6.7 Race/Ethnic origin

Ethnicity is only one dimension of equality but an important one which the CHWB Checks programme set out to address with a dedicated work programme (workstream)

This report compares data for BME carers having a check with the BME population of Devon. The table below shows the data with which the CHWBC sample was compared

	All groups	Persons white	Persons mixed	Persons Asian	Persons Black	Persons Chinese or other ethnic group
Devon County Council Area	740,800	718,300	5,900	6,500	3,800	5,700

This table contains the experimental Population Estimates by Ethnic Group. The estimates are consistent with the Mid-Year Population Estimates. Source: Office for National Statistics

In the pilot final return 72 people are recorded with a non-white ethnicity. A total of 72 BME carers are recorded out of a total of 2820 returns (excludes young carers).

On this basis 2.5% of the checks done were for BME carers.

Persons of all non-white groups constitute 2.9% of the total Devon population.

The ratio of the representation of BME carers in the “population” of the Programme to the representation of BME people in the Devon population is the key indicator of whether equality has been achieved.

The ratio of 2.5% (programme population) to 2.9% (Devon population) is 0.86, where 1 is equality.

Equality was not achieved for non-white BME carers within the Programme; however, there are further considerations.

The BME workstream, provided checks for 65 individuals out of the 72 recorded, with only 7 otherwise recorded as provided. On this basis, without the workstream there would have been a proportion of 0.25% BME carers in the programme “population” and an equality ratio of 0.08.

There were also 12 carers recorded in “mixed British”, “other White Background”¹⁴ and “ethnic group not stated” where an interpreter was needed.

Practices recorded 13 non-white BME checks, (of which 2 were facilitated by Hikmat). There appears to be some discrepancy in recording (likely non-recording of ethnicity) If these additional 11 checks are taken into account, the figure for checks for BME carers rises to 76¹⁵, and if this is the case then the proportion of BME carers receiving checks is 2.7% and the equality ratio rises to 0.93. Without the workstream but including these 11 (and the 7 where ethnicity was recorded) checks the ratio is 0.2.

Caution must be exercised around these calculation for the following reasons.

- Hikmat, the local specialist provider works broadly with (though not exclusively) Asian and Chinese groups in particular areas of the County
- The BME population may not have the same health or age profile as the white population, and the Programme does not have data on the prevalence of caring in the BME groups served. Additionally, no direct work was undertaken with groups such as Eastern Europeans, although the data is suggestive that

¹⁴ 8 of these were “other white” and are presumed to be most likely East European.

¹⁵ 65 checks facilitated by Hikmat plus 11 checks in GP practices not so facilitated

they may have accessed checks independently with Practices or other providers.

Impact on BME membership of Devon Carers Link:

- in 2009/10 DCL reported BME membership (excluding white minority groups) as 0.48% of the total
- in 2010/11 DCL reported that new members who said they had heard about DCL through a CHWBC, and were BME, were 4.4% of the total new members who said that.

Since little previous work had been done with BME carers this may be regarded as a good start.

Sahara reported that 12 BME carers withdrew from appointments. The project coordinator commented:

At least 12 people cancelled appointments, and one of the most common reasons was that they had no GP and were worried about this. The one who had no GP and agreed to the Check was not well, and was persuaded by Emma that it would be OK and they could go straight to hospital, which they did.

It is the recommendation of the programme that the specialist workstream is maintained and further attention is given to the access of non-white groups to Primary Care.

Impact of the main programme on BME population

The contribution of the main programme (outside the dedicated workstream) to the wellbeing of BME carers is much more marginal than anticipated (from comparison with a programme which also included Sahara in Community Mentoring).

Either or all of the following factors may contribute to this:

- BME carers identifying as carers to a much lesser extent than in the white population
- BME people in Devon less in touch with primary care than other people
- Services, including carers services, seen as “white” and “not for us”
- Suspicion of direct approaches and fear that service take up will jeopardise their position, benefits or immigration status.

(source – feedback on carers responses from Sahara)

- Language barriers at surgeries, lack of leaflets in community languages and low awareness among staff of language line.

(source – St John Ambulance Nurse, from direct carer comments)

Conclusion on Race

Without the specialised BME work stream BME carers would have been significantly disadvantaged. Achieving equality for these groups will remain a challenge in the short and medium term.

In the future resources directed to achieving equality spread across the County should not remain focussed on the same BME or geographic group or groups.

However the Programme was able to make a significant difference for BME carers in a short space of time.

3.7 Overall Achievement of Benefits

A programme is managed to achieve the benefits agreed at its inception. These are set out with more detail in the Benefits Map in the Appendices; achievement is recorded in the Benefits Table.

In brief,

- More carers accessing specific carer support services, through Devon Carers Link and other services; 2,459 referrals were made to this type of service
- More carers supported to stay mentally and physically well; 1,644 NHS referrals were made
- Black and Minority Ethnic carers to be identified and supported to have a Carers Health and Wellbeing Check (CHWBC) and unmet need would be responded to; services have been redesigned e.g. St John Ambulance bespoke Carer Support Programme for BME carers; new specification for carer support integrating support for BME carers in Devon – service to commence Oct 1st 2011
- Increase in the number of READ coded Carers by GP practices; the number of carers READ coded was increased by 75%
- Contribution to the number of carers assessments provided in Devon; 2,510 checks counted as carers assessments in 2010/11; 25% of the total carer assessments offered

- Contribution to the number of people receiving a vascular check; 58% of carers who were aged 40-74 received a vascular checks as part of their health and wellbeing check; 8% of the total number of people receiving a vascular check in 2010/11

Progress was also achieved in relation to:

- Equality of access to services by BME carers
- Integrating the carer assessment into the health and wellbeing check and enabling some carers to access community care services without further assessment
- Reducing inequalities for carers of people with learning disabilities and carers living in areas of social deprivation

Overall the programme partners were in touch with over 12,000 carers, a quarter of whom took up the offer of a carers health and wellbeing check. The following section demonstrates the learning that has been achieved, through participation in the DH programme, which will continue to impact on the lives of carers in Devon as joint plans are developed to sustain the provision of these checks.

Section 4: Key findings and recommendations

4.0 Key Finding 1

Investment in GP Practices and Pharmacies is productive in identifying Carers, providing an early assessment of need through a Carer's Health and Wellbeing Check (CHWBC) and enabling carers that would otherwise not come forward to be supported in primary care and the voluntary sector.

Providing choice is not successful in a competitive market environment, without collaborative partnerships being created e.g. GP practices are unlikely to refer to another provider, if this results in a loss of income for the practice; however, where GP practices were not providing checks, they welcomed the delivery of checks by a local pharmacy who then referred the carer to the GP as appropriate for follow up health care. Choice is also not successful where carers perceive one provider as a 'lesser' choice than receiving a check from their GP practice.

Collaboration with Devon Libraries, memory clinics and Parent Carers was successful in providing appropriate settings for working carers, some carers of people with dementia and parent carers; in these instances having two experienced nurses that were able to work peripatetically to deliver these checks was critical to success.

Complex care teams were able to provide some domiciliary provision, but in most instances found that offering a check to a carer when they are dealing with a crisis situation was not appropriate; this is an area that needs further development.

Recommendation 1

The programme is rolled out to all GP practices in Devon, and pharmacies in locations where GP practices are not offering checks to carers; also that GP Commissioning Groups consider utilising a Peripatetic Nurse as a way forward for small practices to increase capacity to support carers and to collaborate to address specific needs. Further consideration is given to the provision of domiciliary checks, where the carer is unable to access other provision due to their own health restrictions or caring responsibilities.

Key finding 2

The appointment of a Lead GP for the Programme was effective and Practices where a lead GP was identified and a team approach was adopted to identifying carers were the most successful in achieving their targets.

Recommendation 2

That GP Commissioning Groups consider having a Lead Clinician for carers to support the development of the carers agenda locally and that individual GP practices identify a 'Carer Champion' to lead a whole team working approach to supporting carers; GP practices consider the advice produced by participant Practices in section 4 - Partners learning from their own involvement

Key finding 3

READ coding of carers consistently is an effective method of identifying carers and ensuring that all practice staff are aware that a patient has caring responsibilities, enabling them to be responsive to the patient as a carer. Only one Practice that reached less than 1.9% READ coded carers (target 2%) reached their delivery target, and only one that exceeded the READ coding target failed to get close to their delivery target. Cross-sector cooperation increased identification.

Recommendation 3

Any future commissioning of CHWBCs should include the requirement for practices to maintain an accurate carers' register through READ coding and progress should be monitored through an annual data return.

Key finding 4

58% of carers were eligible to receive a vascular risk assessment as part of the check, which contributed 8% of NHS Devon's performance on delivering this aspect of the NHS Constitution; significant levels of onward referrals for further investigations and treatment have been recorded, and this element was valued by carers.

Initially the programme was challenged by some GP practices over the NICE guidelines for delivery of the vascular check as some GPs disagreed with the protocol and resisted the purchase of the Near Patient Testing Kit. Working with the Cardiac GP Clinical Lead was critical to being able to resolve these issues and move forward.

As the programme progressed there were additional issues that arose from implementing rigid guidelines re: vascular risk assessment. For example, carers who wanted their blood pressure checked, or just to know their cholesterol level were frustrated if this was not offered.

Recommendation 4

The vascular check should continue to be integral to any future check design for carers and carers between the age of 40-74 should be targeted by GP practices to receive a carers health and wellbeing

check; opportunities should be taken to identify carers by other providers and clinics established to provide vascular checks to the general population, in order to do a comparative evaluation in the future of the number of carers benefiting from this initiative.

Key finding 5

The programme has offered a development opportunity for Health Care Assistants (HCA's) in GP practices which although well received, has in some cases challenged their self confidence and self reported competence to undertake the checks; instigating further training in managing a consultation and clinical supervision helped in some measure to support their development and to mitigate any risks to the HCAs and Carers (this relates not to the technical aspects of the vascular check, but in managing time and emotions where carers were often given the first opportunity ever of talking to someone meaningfully about their own health and wellbeing). With the appropriate competency based training HCAs have been able to attain the skills set required to deliver the checks to carers and the training programme offered through the programme was generally viewed as a good opportunity for structured learning and development,

Recommendation 5

Further work is done on the development of competency based training and assessment, care pathways and delivery protocols; future provision should be coupled with a competency based programme for staff delivering checks, and GP practices should facilitate appropriate clinical supervision for HCAs to support their development.

Key finding 6

Health and wellbeing checks were preferred by carers to the traditional form of Carer Assessment; the check gave effective access to health and social care services and was regarded by some carers as a support in its own right. The Devon holistic design was implemented successfully in General Practice, Pharmacies, and Clinics and in Carers' own homes; time to follow up the carer's progress was identified as a gap in provision. Referrals to Care Direct Plus resulted in some Carers' feeling they had been heard, and some receiving Care packages which would not have been accessed without the check.

Recommendation 6

That the traditional format of the Carers' Assessment is replaced by a revised Carer Health and Wellbeing Check, and that it be carried out in Primary Care, by Social Care Teams and commissioned Carer Support Services to the optimum benefit of carers; this should include a half hour follow-up at 6 months

Key finding 7

Cross-sector collaboration, particularly between Devon Carers Link and GP Practices, has been found to be beneficial in supporting Practices to identify new carers. Partnerships with and between voluntary agencies worked well, and without them would have been very difficult to maintain the flexibility which was essential to respond to risks and issues as they emerged

Recommendation 7

GP practices continue to work with Devon Carers Link to support the identification of hidden carers and enable access to the range of Carer support services available

Key finding 8

An intensive and bespoke approach in terms of time and resources is required to engage with young carers, working carers and carers in BME, traveller and drug and alcohol communities in order to identify and meet needs appropriately. Without the specialised BME work stream BME carers would have been significantly disadvantaged. Achieving equality for these groups will remain a challenge in the short and medium term, including fulfilling the basic need of GP registration for some BME carers. The building of trust and provision of services in an appropriate environment is required to ensure these particularly hidden groups of carers feel able to respond to the offer of a check

Recommendation 8

Activity is continued with young carers, BME and the traveller communities to ensure that momentum is not lost and checks for working carers, with backfill costs if necessary, are continued and rolled out further. Resources should be directed to achieve equality spread across the County should not remain focussed on the same BME or geographic group or groups. Further work is needed to understand the extent to which non-white groups need help to access Primary Care and other health and social services.

Key finding 9

Young carers welcomed the opportunity to explore aspects of their own health and wellbeing at two structured but fun health and wellbeing days, with access to GP and pharmacy support; this was most successful in a young peoples' venue, where a 'young person first' approach was adopted. Young carers between the ages of 18-25 did not access health and wellbeing checks during the course of this programme

Recommendation 9

This approach should be built on for future events provided by Devon Carers Link, young carers' work - stream and further understanding should be sought with regards to the an appropriate health and wellbeing check for young carers / young adults aged 18-25.

Key finding 10

Practices responded differently to the discipline of programme management (Managing Successful Programmes methodology), which of necessity imposed external demands and scrutiny.

Some Practices commented on the value of the programme for the development of their staff and indicated the longer term benefits of this; others felt that meeting the requirements of a wider programme restricted their own autonomy.

The Programme provided regular communications to staff and separately tailored ones for strategic stakeholders which were important in maintaining impetus; also additional, time limited resources to support the internal change management required was critical to success.

Generally speaking, carers, the programme team and providers felt that the administrative burden was too onerous; the combination of the check itself and the Local and National evaluation requirements were substantial, compounded by the fact that ethical approval for research requires the separation of data for service provision and research, and this impacted on carers and on staff.

The disciplines necessary for the delivery of this project were significantly different to those in use everyday in Practices and Practices are extremely diverse in culture, infrastructure and management capacity, but many of the issues expressed by Providers sprang from a) an external discipline; b) the requirements for research and evaluation.

Recommendation 10

That GP practices who sign up for any future Local Enhanced Scheme and have not participated in the DH programme, receive short term support for the change management required. All GP practices develop partnerships with Devon Carers Link to enable carers to access the wider carer support services available. Electronic solutions are sought to streamline data collection and where appropriate (with consent), the sharing of information for the purpose of enabling carers to access support services.

Partners learning from their own involvement

Some delivery partners comment that they have learned from participating and will be mainstreaming some activity regardless of funding. This learning includes the role of an HCA in being the Practice lead for carers.

Providers also say they learned: there is a need for this kind of check; the direct personal approach worked best in inviting carers to have a check; telephoning in advance of the check reduced voids; a GP lead made an important difference; a local team approach worked well where Practices grouped together and shared development; being proactive in using the Practice computer system to identify carers; being flexible in offering appointments on different days and at different times.

Practices said:

- A committed lead GP and Manager, with everyone working as a team, is critical to success
- Co-working with other local Practices is helpful
- A dedicated lead internally and support from an external project coordinator helped Practices
- Scheduling and missed appointments were a big problem for the surgery to manage because of the lengthy appointment time needed. Phoning the day before reduced this.
- Practical tips – using the Practice computer system, multimedia screens, telephoning to confirm appointments the day before reduced “did not attend”, resource packs for carers to take away – all helped
- Continuing support from a dedicated carer expert would be helpful
- The expertise needed to effectively assist carers in the check is outside the comfort zone of some staff. While some HCA’s found the experience useful in personal development some others felt it was beyond their skills.

Pharmacies

Pharmacies had very mixed experiences in the Programme. They had similar concerns to Practices concerning administration, appointments times etc.

They felt that promoting the Pharmacy as a service in its own right, being able to follow up with a Medicines Use Review and offer Saturday appointments were valuable.

- The local Pharmaceutical Committee raised the question of a Carers’ Specialist Pharmacy; further understanding of this is required.

The last word....

In a letter to a Practice Manager, following a health and wellbeing check, a carer wrote:

'I have been affected physically and, more significantly, mentally by my caring responsibilities. When I came in for my flu vaccination I filled in the form to say I was a Carer and last December was offered an appointment with Tina. Mine is not a situation where the problems can be solved. However, the advice Tina gave me has made all the difference. It has enabled me to stand back from some of the worst pressures on me.

In the past few months I have passed on Tina's advice to four friends who have varying degrees of caring responsibilities. This is information on the organisations that can assist and also the strategies for coping mentally.

I would like you to be aware that not only have I been helped, but also there is a positive ripple effect.

Please continue to provide this service. I am concerned that in the current economic climate it is vulnerable as it will never get dramatic results that can be shown statistically. My experience has shown that such an advisory service is vital for those in my situation'

Acknowledgements and Thanks

The personal as well as professional contribution of many people has been necessary to make this demanding programme a reality.

Particular thanks go to:

- All Members of the Implementation and Sustainability Team who individually and corporately contributed significantly to the success of the Programme
- The Carers who attended Team meetings faithfully and voluntarily to help shape the Programme to meet Carers' needs

Without our partners and their staff this programme could not have been delivered:

- Devon Carers Link
- St John Ambulance,
- Sahara (Hikmat)
- Health Promotion Devon staff who developed and delivered a comprehensive training package; University of Plymouth for providing later training on managing consultations
- The GP's, managers, clinical and administrative staff of participant GP Practices
- The 101 staff who carried out the checks and administered the research
- The Pharmacists and staff of participant pharmacies
- The managers and staff of the two participant complex care teams
- Young Devon and the Young Carers Consortium

Finally, we thank the Carers who came forward to have a Check, and who participated in the National and Local Evaluations generously.

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1. CHWBC Carers Registered with Participant Practices by Areas of Deprivation and Rurality
2. Estimated numbers of carers and receipt of CHWBC by age
3. Devon Carers by age and gender

Appendix 8 Competencies for delivering Carers Health and Wellbeing Checks

Appendix 9 Carer-held Health and Wellbeing Check Booklet

Appendix 1

Programme Team

Implementation & Sustainability Team Membership

Members:

Ruth Baker	Devon Partnership Trust representative
Clare Cotter	Senior responsible Officer: Joint Planning and Strategic Commissioning Manager - Carers
Dr Simon Kerr	GP Clinical Lead, Carers
Nory Menneer	Learning Disability Partnership representative
Tim Morgan	Carers Lead, Drug & Alcohol Team
Julia Page	Head of Health Improvement, NHS Devon
Beryl Perrin	Physical Sensory and Learning Disability, Devon Children's Trust
Denise Rendell	Programme Delivery Manager, Westbank
Solveig Sansom	Service Development Manager, NHS Devon
Pauline Shields	Communications Lead, Devon County Council
Keri Storey	Assistant Director Health & Social Care Northern Devon, Devon County Council
Sue Taylor	Chief Officer, Devon Pharmaceutical Committee
Sue Younger-Ross	Programme Manager (Chair)

Carer Members

Sonia Barton	Chair, Carers UK
Carol Brown	Devon County Carer Chair
Joan Edgecombe	Joint Chair, East Devon Carers Forum
Gill Whitfield	Joint Chair, East Devon Carers Forum

Others in attendance

Matthew Byrne	Development Manager, Devon Carer's Link
Helen Donnellan	University of Plymouth
Karen Helliwell	Senior Information Analyst, NHS Devon
Brenda Laker	Hikmat/Sahara
Tina Teague	Vascular Check Lead, NHS Devon

Programme Support

Simon Chant	Public Health Analyst
Stephanie Cheesman	Graphic Designer, Devon County Council
Karen Helliwell	Senior Information Analyst, NHS Devon
Graeme Stirk	NHS Finance

Appendix 2

Key Programme Management Documents

1. Programme Initiation Document
2. Benefits Map
3. Completed Milestones

Appendix 2.1

Devon Primary Care Trust Devon County Council

Carer Health and Wellbeing Checks Programme

Programme Initiation Document

Prepared by: Sue Younger-Ross
Version: 1
Issue Date: 24th August 09

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1. Document Revision History

1.1 Revision History

Revision Date	Author	Version	Change Reference & Summary
		0.1	Initial Draft
11 th August		1a	Draft for Programme Board
24 th August		Issue 1	Records approval from Programme Board.

1.2 Reviewers and Approvals

This document requires the following reviews and approvals. Signed approved forms are kept in the Programme file.

Name	Position	Signature on approval	Date	Version
Clare Cotter	SRO	C Cotter	18 th August	1
Sue Younger-Ross	Programme Manager	S Younger-Ross	18 th August	1
-----	Programme Board (Steering Group)	-----	18 th August	1

1.3 Distribution

This document has been distributed to:

Name	Date of issue	Version
Steering Group, IST, Programme Office	24 th August 2009	Issue 1

1.4 Document Version Numbering

Document versions numbered "1a, 1b", are draft status and therefore can be changed without formal change control. Once a document has been formally approved and issued it is version numbered "Issue 1" and subsequent releases will be consecutively numbered, following formal change control. The version number appears in the footer of every page.

2. Purpose

The purpose of the Programme is to deliver and evaluate health and wellbeing checks for Carers in Devon in order to benefit carers and develop the evidence base for annual health and wellbeing checks for carers.

3. Programme Background and Context

The Department of Health identified the need for this programme as part of its national strategy for carers.

Carers in Devon identified the need for this programme during a POPPS Carers pilot project.

Carers in Devon have identified health and wellbeing checks as a priority in our Joint Strategic Needs Assessment. The Devon POPPS programme demonstrated that GP Practices are convinced of the value of carer focus through supported change management. We want to build on this, extend the scope, and the extent of the checks to a much larger group of practices.

Objectives

- . identify more carers
- . give 3,000 carers a structured consultation to consider their own health
- . Increase recognition of and support to carers in GP Practices
- . improve carers choice and control
- . promote Devon Carers Link membership (preventive/early intervention services)
- . narrow inequalities
- . improve the evidence base around interventions for carers

3. Scope

In scope:

- . All carers in 40% of the total population of Devon
- . Health checks – mental & physical health; wellbeing, including carers assessment

We have agreements/commitments in place to cover :

- . all relevant health and social care commissioning and delivery interests: ACS, LD, MH, CYPS,
- . DAAT (Drugs and Alcohol Action Team),
- . St John's Ambulance and local Pharmacies to provide choice
- . domiciliary options, workplace checks and dedicated BME centres
- . involvement of GP's practices as the key coordinating role.
- . Community mentoring programme:
 - to facilitate checks for BME carers
 - to help overcome loneliness and isolation.
- . Local Health Trainers: provide support to making life style changes.
- . Standing arrangements with housing staff of our 8 District Councils to promote the programme.
- . Workplace checks: to local public sector staff, to evaluate this route, and to promote awareness
- . among front line staff to encourage carer identification.
- . RelativeCare: provide, where appropriate, a self help DVD.

3) – Delivery:

Three cohesive pilot sites covering the cluster areas of Dawlish/Teignmouth, Exmouth/Budleigh, Barnstaple (subject to local agreement).

Within each there will be:

- GP practices: central coordination point
- Project support worker: initially set up relevant systems and processes and increasingly provide
- carer support within GP practices
- identifiers: health and social care professionals, Carers Link and other voluntary sector staff,
- schools and other children's projects, pharmacists to assure targeting of hidden carers and carers of people with complex needs
- providers of checks: Health Care Assistants working in or with GP practices, school nurses,
- pharmacists, St John Ambulance, health and social care teams
- links – Carers Link, specialist carers services, appropriate health services including health trainers
- and other sources of local support.

In addition:

- Individual GP practices not located in pilot sites
- centre-based choices for BME carers in Exeter and North Devon.
- workplace-based checks for DCC and DPCT staff (priority area in Devon Carers Strategy)

We will deliver:

- a minimum of 3,000 health/health and wellbeing checks
- raised general awareness of carers
- improved systems and processes
- a template for health and wellbeing checks
- a local research report, in collaboration with carers
- an account of the experience of the programme from the perspectives of those involved.

Each of the three sites will test different ways of aligning the checks with NHS vascular check and Carers Assessment for quality, effectiveness, carer acceptability and cost effectiveness.

4. Interfaces

Principle identified interfaces are:

- Primary Care delivery systems
- DCC services for carers
- Third sector organisations including Carers Link
- Pharmacies
- Devon Adult and Community Services and Joint DCC/Devon PCT Delivery Teams and Trusts: Care Direct, Care Direct Plus, CCT's, LD, Devon Partnership Trust, the DAAT.
- Devon Childrens' Trust, schools and youth projects.

- Vascular Checks and NHS Lifechecks
- Carer Assessment
- Other programmes:
 - Transforming Community Services
 - Rapid Improvement process for carer assessment
 - Practice Based Commissioning
 - NHS health checks initiatives
 - ACS Putting People First

5. Exclusions

No carers are excluded.

GP Practices which had not registered an interest by the due date are excluded unless capacity becomes available through extra finance or a failure to convert expressions to interest to signed up partnership.

We will commit to trial the incorporation of the carer assessment on one site only because of the anticipated systems issues.

6. Constraints

The principle constraints are:

Finance and Time – the initial budget matches the DH grant of #800,000 with #200,000 from the Carers Grant over a period from 1 August 2009 to 31st March 2011.

Any issues arising from systems or governance that are not aligned between partners are outwith the programme.

Other constraints addressed in planning are:

- capacity within health and social care teams to provide checks
- availability of mentors with appropriate languages
- system change capacity

7. Assumptions

Principle Assumptions:

- Pandemic and Seasonal Flu and other illnesses will not derail the programme or significantly alter its findings.
- Solutions can be found to information management issues between Primary Care and other parts of the health and social care system.
- Any demand increases can be managed within existing resources.

8. Outline Programme Deliverables (Final Product):

Templates for Health and Wellbeing Checks:

- For children and young people who are carers;
- For adults aged 18-39 (not incorporating vascular check, incorporating carer assessment)

- For adults aged 40-74, incorporating vascular check where appropriate, incorporating carer assessment
- For adults aged 75 plus, not incorporating vascular check where appropriate, incorporating carer assessment.

Research Report.

Programme Report

9. Initial Programme Plan

Preparation: 1 August to 30 September

Phase 1:

Initial Delivery: 1 October.

Health and wellbeing checks for carers aged 40-74 within GP practices (including domiciliary options) only:

- a) in the three enhanced sites
- b) in any of the previous POPPS pilots wishing to commence.

Extended delivery: 1 January. 2010.

As above, but to include additional GP practices which

- a) are willing to start at this time, and
- b) which the pilot is able to support.

Delivery of initial evaluation report: end February.

Analysis of report, adjustment of template, preparation for Phase 2: March 2010.

Phase 2.

1st April 2010.

Commencement of delivery:

By other providers on the three enhanced sites

With a revised template for checks for carers aged 40-74

Of health and wellbeing checks for children/young people, adults aged 18-39 and aged 75 plus

For BME carers (specialist workstream)

Centre and workplace checks

Incorporating carer assessment on one site.

31st March 2011: end of Programme

Delivery of research report.

10. Business Benefits/Benefits Summary/Costs

10.1 Initial Business Case/Benefits Summary

The underlying business case is the development of an evidence base for policy development for carers health and wellbeing checks.

The vascular checks have their own benefits assessment “owned” by DH with a 10 year horizon for benefits realisation.

In the period to end December 2009 benefits mapping and their financial assessment for this programme will be further developed.

The initial statement of benefits for this programme from which the benefits mapping work is proceeding is as follows:

Key outcomes/benefits	Means	Measure
<p>For all carers:</p> <ul style="list-style-type: none"> • improved <ul style="list-style-type: none"> ○ partnership working with GP's, statutory and voluntary services ○ self care, ○ school attendance – young carers ○ health status including mental health, drugs and alcohol use • timely information and support • perceived benefit of service 	Qualitative	Research
<p>Increased access to wider support networks by carers generally but by carers identified in equalities impact assessment specifically (see section 2.4)</p>	Quantitative Qualitative	<p>Carers on Carers Link Devon Carers Involvement Census Uptake of:</p> <ul style="list-style-type: none"> • flexible breaks grant • sitting services • practical skills training
<p>Improved personalisation and control for carers</p>	Quantitative Qualitative	<p>Research Uptake of direct payments Research</p>
<p>Increased access to health and social care services for people in areas of social and economic deprivation</p>	Quantitative Qualitative	<p>Carers Assessments (NI135) Respite Care (NI135) Research</p>
<p>Appropriate service usage – carer visits to GP for own health More effective risk management through increased no of:</p> <ul style="list-style-type: none"> • carer assessments • contingency plans & emergency cards • emergency response <p>Health checks as case finding for carers Early detection and treatment of emerging conditions reducing long term costs.</p>	Qualitative Qualitative Quantitative Quantitative	<p>Research</p> <p>Carer assessments Carers with a contingency plan & emergency card Carers using rapid response service to prevent hospital admission</p> <p>Carers READ coded Carers receiving checks Carers referred on as a consequence of health check Carers READ coded with LTCs</p>
<p>Contribution to analysis of unmet need</p>	Quantitative	<p>Needs identified where no service is available to meet</p>

We would like to include the following targets and test in terms of measurability by building criteria that can be applied on a case by case basis

Reduce the number of permanent admission to residential or nursing care for older people	Quantitative, criteria to be established
Reduce the number of emergency admissions	

10.2 Savings and Benefits

The draft benefits mapping development report is attached as appendix 1.

A conservative approach is being taken to the question of savings arising from benefits in the lifetime of the programme.

10.3 Resources

Stage 2 Carers Demonstrator Site Budget estimate Devon

	Estimate areas	Budget as at 29 July 2009	
Staff estimates (pay etc)	Salaries, including on-costs		
	Programme Manager	£	72,269.31
	Delivery Manager	£	69,609.96
	Local Project Staff	£	235,067.76
	Support Staff	£	50,263.12
	Total staff estimates	£	427,210.15
Related staff estimates	Training	£	19,346.00
	Travel & subsistence	£	30,905.40
	IT for home-based workers	£	4,167.60
	Overheads for local project staff	£	47,013.55
	Total staff related estimates	£	118,632.55
Carer Involvement estimates	Access costs/expenses/replacement care	£	29,640.60
	Carers' meeting expenses	£	6,680.00
	Carers' awareness training	£	9,400.00
	Publicity/information costs	£	6,000.00
	Total Involvement estimates	£	51,720.60
Equipment and Consumables estimates	Medical equipment	£	1,400.00
	Information / communication costs	£	28,000.00
	Total Equipment estimates	£	29,400.00
Other estimates	BME project	£	25,000.00
	Centre / work-based checks	£	20,000.00
	Health-check payments to GPs, etc.	£	227,812.50

Carer assessment reports	£	10,844.00
Meeting Expenses	£	8,700.00
Research contract, Plymouth University	£	80,640.00
Match-funding contributions (carers grant)	-£	200,000.00
Total Other estimates	£	172,996.50
Total estimates	£	799,959.80

11. Initial Risk Log

The initial risk register is attached as Appendix 2

12. Programme Organisation Structure

The Programme structure and roles paper is attached as Appendix 3

13. Programme Quality Plan

NB quarterly activity to be aligned with Programme Board reporting cycle.

Priority processes and deliverables for quality assurance	Standards	When	By whom
Partnership working (Programme Board, PIST, operational levels)	Programme documentation, including this PID Partnership Agreements Contracts Statutory/voluntary sector compact	Quarterly	Programme Sponsor
Programme alignment with strategic objectives	Contained in PCT and DCC strategic plans	Quarterly	SRO
Health and wellbeing checks delivery	Template and standards as specified	Training/ Assessment of competence to deliver. Continued competence within clinical supervision	Locally by Nurse Clinical Lead. Process/compliance quality check initiated by Delivery Manager on random basis or on carer representation – quarterly cycle.
Practice systems and processes for identifying and READ coding carers	Specification and standards in Local Enhanced Service (LES) Agreement	Quarterly review (based on monthly reporting of progress)	Delivery Manager
Data recording and reporting from clinical sites	Monthly reporting schedule to be incorporated in LES	Quarterly	Strategic Performance Lead
Budget management	PCT financial management standards,	Quarterly	Strategic Finance Lead

	(except where LA standards apply)		
Training	Training and Human Resource development plan	Quarterly	Human resource lead

14. Programme Controls

Major controls will be:

The Steering Group (Programme Board):

Endorsement of and commitment to the programme demonstrated through active cooperation for example making appropriate resources available to assist the programme including with the design, development and assurance of project outputs.

Escalates risks to PCT SMT and ACS SMG and the Children's Trust Board.

Senior Responsible Owner (SRO – Clare Cotter):

- Maintaining the interface with the Steering Group and other key stakeholders
- Providing advice to the Programme Manager and Delivery Manager including risks or issues escalated
- Managing and monitoring strategic risks
- Ensuring other roles needed are appointed as required.
- Leading and monitoring review activities
- Escalates risks to Steering Group

Programme Implementation and Sustainability Team

- Support the SRO and assist with stakeholder engagement
- Ensure changes are implemented
- Ensure local health care systems are not adversely affected by healthcheck implementation
- Ensure adequate and appropriate resources are provided to the programme to ensure outputs are designed, developed and assured to give them the best chance of success
- Escalates risks to Steering Group

Programme Manager

- Designs the Project Dossier (list and specifications of projects), Programme Plan, Resource Management Strategy, required monitoring and control activities.
- Works with the Delivery Manager to ensure that plans are able to deliver the required outcomes.
- Establishes and maintains appropriate governance arrangements for the programme
- Updates key programme documentation.
- Risk and issue management activities
- Coordinates the projects to manage their interdependencies
- Manages stakeholder expectations, coordinating and approving all communications.
- Escalates risks to SRO.

Delivery Manager

- Works closely with the Programme Manager to ensure all parts of the programme support the realisation of the required benefits.
- Prepares local partners for participation
- Ensures project outputs can be readily implemented locally.
- Escalates risks to Programme Manager.

Project Teams

- Deliver the required project outputs to the programme.
- Escalates risks to Programme Manager

Programme Office

The coordination function and configuration management for the programme office will be undertaken within the ACS Putting People First Programme Office.

However:

- finance and performance functions will reside with the PCT;
- communications will be managed within the ACS communications team by agreement;
- most local liaison will be coordinated via Westbank as the provider of the Delivery Manager
- Contract Management will be conducted by the Programme Manager on behalf of the SRO to the standards and requirements of the PCT/DCC as appropriate.

15. Stakeholder Engagement (to date)

Principle stakeholders have been identified and their interests mapped in preparation for the communications plan.

Involvement outline:

Pre-bid (bid submitted 6th June 2009):

- A steering group consisting of key stakeholders met to prepare the bid;
- The outline bid was subjected to a challenge day with a wider group of stakeholders
- GP Practices were invited to register their interest in taking part.

Post bid:

- A stakeholder planning event was held on 16th July; this gave shape to Benefits and Process Mapping, the evaluation, the development of the checks themselves and the communications plan.
- Discussions have been held with the Carer Chairs
- A Programme Implementation and Sustainability Team has met to prepare the papers for this meeting including benefits profiling.
- It has been determined that the integration of the programme management arrangements into the Carer Involvement Framework gives the best opportunity for carer involvement.

16. Communication Plan

The communication plan is attached as appendix 4.

17. Equality & Diversity

The EINA for this programme was completed as part of the original planning and included in the bid.

Equalities Area:	Positive Action for carers:	Case finding through:
Gender	Male	Targeted communications
Race / Ethnic Origin, and Religion or belief	BME	Hikmat
Disability	with sensory disabilities	sensory teams
	with long term health conditions	Complex Care Teams (CCT's)
Age	Young	Schools, Childrens' Centres, Young People's project
	Parent carers	GP's, Carers Link, Schools, Childrens' Centres, Young People's project, parent carer forum
	Working	Workplace publicity
	65+	Senior Council, CCT's, communications
Sexual Orientation	Fact finding	TBC
Other factors:		
Access to support	rural isolation	Local communications, Parish Councils, Churches, BME networks.
	of people with alcohol and drug addiction	GP's, Pharmacists, targeted specialist leaflet and event sponsored by DAAT
	of people with aggressive or unsociable behaviour	Carer support workers
	Of people with dementia	Memory Cafes, CCT's, Casefinding
	Of people with HIV / Aids	Specialist services
	bereaved	Hospice, GP Practices

18. Environmental Impact

The principal adverse environmental impact is likely to be the disposal of clinical waste mitigated by use of NHS protocols.

Travel has been minimised by the planned location of development staff in local GP Practices.

19. Quality Checklist

Quality Checklist (This checklist should be completed by the PID Author/Programme Manager before submitting the PID to the Programme Board for Sign Off / Approval)	Author/PM Check		Board Check	
	Y	N	Y	N
Does the PID correctly represent the Programme?	x		x	
Does the PID show a viable, achievable Programme?	x		x	

Is the Programme Organisation Structure complete, with names and titles? ¹⁶	x		x	
Have all roles been considered?	x		x	
Does the PID clearly show a control, reporting and direction regime which is workable and appropriate to the scale, business risk and business importance to the Programme?	x		x	
Are the relationships and lines of authority clear?	x		x	
Does the Programme organisation structure indicate to whom the Programme Board reports?	x		x	
Do the controls cover the needs of the Programme Board, Programme Manager Delivery Manager and Project Leaders?	x		x	
Does the PID contain a Benefits Summary? ¹⁷	x		x	
Does the PID evidence sufficient levels of Stakeholder Engagement in both the development of the PID and the definition of Benefits/Benefits Profiling?	x		x	

20. Sign-Off

Programme Manager's Signature: Sue Younger-Ross

Date: 11th August 2009

Programme Board Sign-Off:

Date: 18th August 2009

¹⁶ Note: some roles still to be appointed to at project and workstream level.

¹⁷ Subject to finalisation in consultation with strategic commissioners by end December 09.

Carer Health and Wellbeing Check Programme

Benefits Map

Version Control

20.1 Reviewers and Approvals

This document requires the following reviews and approvals.

Name	Position	Signature on approval	Date	Version
Clare Cotter	SRO			1
Sue Younger-Ross	Programme Manager	Sue Younger-Ross	25/5/10	1

20.2 Distribution

This document has been distributed to:

Name	Date of issue	Version
IST	25/5/10	1

2.1 The Map

The benefits map shows:

- when expected benefits are considered likely to be first observed;
- in outline how they will be measured – unless otherwise stated this will be through the management information being collected from individual providers;
- text in blue is from the bid document (amended for practicality) and text in green relates to later additions, mainly the vascular check programme.

2.2 Comments on the Benefits

In the main, the type of benefits identified are strategic in nature rather than economic.

As this is a pilot programme, they are also anticipated rather than expected. These benefits may not be realised, and if they are not the learning from this is important. Although further consideration will be given to whether health improvements can be allocated cash values this is not considered very likely at this stage.

3. Benefits Map

1. June 2010	2. Sept 2010	3. Dec 2010	4. May 2011
1.1 Increased numbers of Carer Assessments	2.1 Needs identified where no service available to meet them (interim research report)	3.1 Young carers benefiting from improved service: gross number up to and including 17 years of age participating.	4.1 Evidence to support development of policy on health checks for carers (delivery of reports, compliance of providers with research)
1.2. Increased number of carers in Devon accessing specific carer support services (through checks): numbers who have had a check where any one of the following results: <ul style="list-style-type: none"> • Membership of Devon Carers • Link • Voucher for care and repair • Looking after me • St John Ambulance Training • Community Mentoring 	2.2 Increased service access for carers in areas of Social and Economic deprivation (as rural, cohort of practices in areas of social and economic deprivation)	3.2 Greater proportion of male carers benefiting from services than previously (proportion of male/female carers accessing checks/proportion of male/female carers accessing Devon Carers Link 2009/10)	4.2 Reduced: <ul style="list-style-type: none"> Stroke Heart disease Diabetes Among carers (vascular checks undertaken –proxy measure – vascular check evidence base)
1.3 Increased number of carers in Devon supported to stay mentally and physically well - numbers who have had a check where any one of the following results: <ul style="list-style-type: none"> • GP appointment • Phlebotomy • Practice Nurse appointment • Medicines Review • Health trainers • Addaction • Smoking Cessation 	2.3 Improved relationships between carers and GP's (increased number of carers READ coded – proxy measure)	3.3 Equal access for BME carers (proportion of BME carers receiving check is equal to proportion of BME people in Devon community)	4.3 NI135 performance Improved service access (contribution of programme to ACS performance improvement)
1.4 Increased access for disadvantaged groups of carers: <ul style="list-style-type: none"> • Carers of people with alcohol/drug problems; • Carers of people with mental health problems • Carers of people with learning disability • {Carers of people with dementia • Carers of people with HIV/AIDS (not collected); } 	2.4 % Carers receiving the health and wellbeing checks believe it is a benefit to them (interim research)	3.4 Parent carers (% of parent carers joining Devon Carers Link; number of parent carers having a HWBC)	4.4 Carers READ coded with LTC's (data survey of GP practices)
1.5 Vascular checks delivered (number – electronic record)	2.5 Integration of Carers assessment <ul style="list-style-type: none"> - benefit for carers (reduced effort) - improved efficiency for ACS/NHS Devon Demonstrated by: number of referrals to ACS which allow care plan to be developed without further carer assessment	3.5 Improved personalisation and control (take up of flexible breaks and take a break grants)	
1.6. More carers access services who have issues concerned with rural isolation: (as 2 and 3 above for practices in rural areas)			

Appendix 2.3 Completed Milestones

Devon HC 31 Milestones at Completion of Programme Progress against common milestones

<u>Common Milestones</u>	<u>Completion Date (plan)</u>	<u>Completion Date (actual)</u>	<u>Reasons for variance</u>
<u>Project team in place</u>	<u>1.8.09</u>	<u>1.8.09</u>	-
<u>Local evaluation set up</u> <u>1. Local evaluation officer in post</u> <u>2. Local evaluation processes agreed</u> <u>3. Baseline metrics agreed with NET and baseline report sent to NET</u>	<u>1. 1.8.09</u> <u>2. 2.9.09</u> <u>3. 30.12.09</u>	<u>1. 1.8.09</u> <u>2. 2.9.09</u> <u>3. Not completed</u>	<u>3. NET delay in ethics approval – document now sent (July).</u>
<u>Carers start receiving services which will be evaluated</u>	<u>Phase 1</u> <u>16.11.09</u>	<u>Phase 1</u> <u>16.11.09</u>	-
	<u>Phase 2</u> <u>1.2.10</u>	<u>Phase 2</u> <u>10.2.10</u>	<u>Minor delay due to operational pressures.</u>
	<u>Phase 3</u> <u>30.5.10</u>	<u>Phase 3</u> <u>commenced</u>	
	<u>New Phase 4</u> <u>30.6.10</u>	<u>Providers</u> <u>commenced</u>	
<u>Systems or Website ready</u>	<u>30.10.09</u>	<u>30.10.09</u>	-
<u>Mid evaluation report</u>	<u>30.9.10</u>	<u>30.9.10</u>	-
<u>End evaluation report</u>	<u>30.5.11</u>	<u>Now re-scheduled for 30/7/11</u>	Reason is that data from a very late surge in delivery, evidenced below, could not be included without further time for data returns and analysis. It was decided collaboratively with the SRO that a delay was preferable to the loss of the value the additional data would provide.

<u>Common Milestone 7</u>	<u>Original target</u>	<u>Actual achieved</u>	<u>Reason for variance</u>
<u>Number of interventions/services delivered etc - target for this quarter</u>	1083	1107	<i>This achievement represents a huge effort by the providers and the programme team to reach the original target of 3,000 checks.</i>

Appendix 2.3 Completed Milestones

Revised CM7 (numbers of carers receiving services) figures

Please use this section to provide figures of the number of carers receiving services. Please also include figures for previous quarters.

Q0 1/10/09 -31/12/09	Q1 1/1/10-31/3/10	Q2 1/4/10-30/6/10
17 <u>(30)</u>	188 (revised) <u>(160)</u>	383 (revised) <u>(900)</u>
Q3 1/7/10-30/9/10	Q4 1/10/10-31/12/10	Q5 1/1/11-31/3/11
568 (revised) <u>(760)</u>	766 (revised) <u>(900)</u>	1107 <u>1083 (revised; previously 1,005)</u>

Note: the targets (in blue and underlined)) shown in this table relate to provider commitments in excess of the original commitment by the programme to DH to deliver 3,000 checks.

This reflects additional capacity generated with new providers when it became clear that the original providers would be unable to meet the overall commitment.

The target for Q5 was revised to meet the original commitment of 3,000 checks (the objective of generating the additional capacity)

The figures achieved (black, not underlined) have been revised in all quarters except the first (and last) in this quarter as data has been verified by the programme team and providers have completed their returns.

Progress against project milestones

No	Local Milestone	Completion date (plan)	Completion date (actual)	Reason for missed milestone
D1	Programme Initiation Document (PID) completed (to “Defining a Programme” stage in MSP)	30/8/09	30/8/09	
D2	PID signed off by Steering Group	30/9/09	30/9/09	
D3	Programme Implementation and Sustainability Team in place.	30/8/09	30/8/09	
D4	Steering Group (Programme Board) in place.	30/8/09	30/8/09	
D5	Agree main contract for development and evaluation (Westbank)	15/9/09	15/9/09	
D6	Define Roles of Project team and local delivery support staff and check	30/9/09	30/9/09	

Appendix 2.3 Completed Milestones

No	Local Milestone	Completion date (plan)	Completion date (actual)	Reason for missed milestone
	providers. Agree Job description of local delivery support staff.			
D7	Agree Evaluation Plan	30/9/09	30/9/09	
D8	Duplicated - withdrawn			
D9	Sign off clinical governance with Director of Patient Safety and Quality.	30/9/09	30/9/09	
D10	Agree arrangements for payment processing to check delivery partners (GP Practices and Pharmacists)	30/9/09	30/9/09	
D11	Agree delivery schedule with Westbank	30/9/09	30/9/09	
D12	Align Programme with PCT self care strategy	30/9/09	30/9/09	
D13	Sign off partnership agreement (Westbank/check delivery partners) (executed by signature of Westbank and Practice/Pharmacy managers)	30/9/09	30/9/09	
D14	Sign off contract for check delivery for GP Practices and Pharmacies (executed by signature of Westbank and Practice/Pharmacy managers)	30/9/09	30/9/09	
D15	Sign off communications plan	30/9/09	30/9/09	
D16	Clinical Lead in place	30/10/09	30/10/09	
D17	Agree financial arrangements to be made (PCT/DCC)	30/10/09	30/10/09	
D18	Agree reporting arrangements for GP Practices	30/11/09	30/11/09	
D19	Agree reporting arrangements for	30/12/09	30/12/09	

Appendix 2.3 Completed Milestones

No	Local Milestone	Completion date (plan)	Completion date (actual)	Reason for missed milestone
	Pharmacies			
D20	Agree Reporting arrangements for other providers and contracting partners.	30/1/10	30/1/10	
D21	Agree contract for Checks conducted alongside training for carers (St John's)	15/3/10	15/3/10	
D22	Agree contract for BME carer facilitation project (Sahara)	15/3/10	15/3/10	
D23	Agree Complex Care Team input (check delivery)	15/3/10	15/3/10	
D24	Agree Devon Partnership Trust input (check delivery)	15/3/10	15/3/10	
D25	Agree Learning Disability Teams input (check delivery)	15/3/10	15/3/10	
D26	Agree DAAT activity	15/3/10	15/3/10	
D27	Agree Children's Trust activity (check development, check delivery)	15/3/10		Capacity issues have led to delay; see risks. Resolution now achieved.
D28	Agree approach to use of Relative care DVD	15/3/10	15/3/10	No longer part of programme due to clinical governance issues.
D29	Develop adult check template	2/10/09	2/10/09	
D30	Develop Care Pathway and associated Guidance	2/10/09	2/10/09	
D31	Resource initial training (identify and contract appropriate training writers and trainers)	2/10/09	2/10/09	
D32	Confirm PCT finance lead.	30/9/09	30/9/09	
D33	Write training package	15/10/09	15/10/09	
D34	Commence routine communications to	30/10/09	30/10/09	

Appendix 2.3 Completed Milestones

No	Local Milestone	Completion date (plan)	Completion date (actual)	Reason for missed milestone
	potential and actual programme partners, also to ACS and PCT staff, and to carers			
D35	Complete collection of information for carers pre-and post- check.	30/10/09	30/10/09	
D36	Complete identification of GP practices wishing to take part in Phase 1	30/10/09	30/10/09	
D37	Complete identification of Pharmacies wishing to take part in Phase 1.	30/10/09	30/10/09	
D38	Identify local delivery support resource allocation pattern	30/10/09	30/10/09	
D39	Invite practices to nominate themselves for phases 2 and 3.	30/10/09	30/10/09	
D40	Complete delivery of initial training to first phase check delivery partners (GP's and Pharmacies only)	13/11/09	13/11/09	
D41	First phase delivery commences	16/11/09	16/11/09	
D42	First review and update of Plan (including risk, issues) and Budget	17/11/09	6 th January	Sickness of PM (to 17/12) and uncertainty caused by NET plans
D43	Review training	30/11/09	30/11/09	
D44	Confirm PCT Performance Lead	1/12/09	1/12/09	
D45	Practice first returns are due (then monthly)	7/12/09	7/12/09	
D46	Complete identification of phase 2 practices	30/12/09	30/12/09	
D47	Confirm Benefits profile	30/12/09	Delayed	Completed 30/5 as re-planned
D48	Complete training for second phase check delivery partners	30/1/10	30/1/10	
D49	Commence monitoring of Benefits	30/1/10		Commenced

Appendix 2.3 Completed Milestones

No	Local Milestone	Completion date (plan)	Completion date (actual)	Reason for missed milestone
D50	First review of communications and of information for carers	30/1/10	30/1/10	
D51	Revised information materials available for second phase	30/1/10	30/1/10	
D52	Second phase check delivery commences	1/2/10	10/2/10	Minor delay due to operational pressures
D53	Second review and update of Plan (including risk, issues) and Budget	28/2/10	28/2/10	
D54a	First Phase practice implementation plans approved	28/2/10	28/2/10	
D54b	Second Phase practice implementation plans approved	28/2/10	28/2/10	
D55	Identify requirements for carer assessments	3/3/10	3/3/10	
D56	BME carer identification and facilitation project commences	5/4/10	5.4.10	
D57	Third review and update of Plan (including risks issues etc and budget)	30/5/10	30/5/10	
D58	Review training	7/4/10	7/4/10	
D59	Duplicate of D67 – deleted.			
D60	Other delivery partners plans signed off and resourcing agreed			
	a) CCT	7/4/10	7/4/10	
	b) LD	7/4/10	7/4/10	
	c) DPT	7/4/10	7/4/10	
	D) Childrens' Trust ¹⁸	7/4/10	Resourcing plan agreed June 2010.	
D61	Review Check format and associated forms	7/4/10	7/4/10	
D62	Review information for carers	7/4/10	7/4/10	

¹⁸ However, full delivery still anticipated.

Appendix 2.3 Completed Milestones

No	Local Milestone	Completion date (plan)	Completion date (actual)	Reason for missed milestone
D63	Check format and associated forms, and information for carers available for third phase delivery.	30/4/10	30/4/10	
D64	Other partners commence implementation	30/4/10		Not delivering checks
	LD			
	CCT		Check delivery commenced May	
	DPT			Not delivering checks
	Children's Trust		Implementation plan commenced June. Capacity issues in Children's Trust previously reported; programme directly supporting development.	Check delivery re-planned for event 23/10
D65	Third phase check delivery commences	30/5/10	30/5/10	
D66	Complete training for third phase check delivery partners, top-up training for first and second phase partners, and additional enhanced sites partners	30/5/10	30/5/10	
D67	Third phase practice plans approved	3/6/10		1/10/10. In view of experience with Phases 1 and 2 it was decided to give more time for negotiation and coaching of providers in the process of approval. This became integrated with performance management during the quarter.
D68	Review training	30/6/10	30/6/10	
D69	Fourth review and update of Plan (including risks issues etc and budget)	30/7/10	30/7/10	

Appendix 2.3 Completed Milestones

No	Local Milestone	Completion date (plan)	Completion date (actual)	Reason for missed milestone
<i>DNew A</i>	Complete identification of phase 4 practices	4/5/10	4/5/10	
<i>DNew B</i>	Complete training for fourth phase check delivery partners	31/5/10	31/5/10	
<i>DNew C</i>	Fourth phase check delivery commences	1/6/10	1/6/10	
<i>DNew D</i>	Fourth phase practice implementation plans approved	30/6/10	30/10/10	See D67
<i>D70</i>	Any additional training required for integration of carer assessment completed	30/7/10	30/7/10	
<i>D71</i>	Second review of communications and information	30/8/10	30/8/10	
<i>D72</i>	Fifth review and update of Plan (including risks issues etc and budget)	30/10/10	30/10/10	
<i>D73</i>	Follow up checks commence	17/11/10	17/11/10	
<i>D74</i>	Initial systems and processes for conducting checks in place	30/10/09	30/10/09	
<i>D75</i>	Revised systems and processes for conducting checks in place	30/4/10	Was delayed by NET requirements; was in place for implementation of NET requirements prior to clearance being received on 15/6.	
<i>D76</i>	Complete any system agreed changes required for carer assessment integration	30/4/10	30/4/10	

Appendix 3: Benefits Table

Benefits for Carers.

Please note that this chart documents the realisation of Benefits set out in the Benefits Map and realisation plan.

It contains some information, on achievements for carers of people with Learning Disability, and related to deprivation, which were identified in Benefits Mapping but not in the original bid. The text in Section 3 Impact relates to the original Bid.

Please note all figures relate to the whole Programme period

1. June 2010	Achievements	Comments																
1.1 Increased numbers of Carer Assessments	2,510 Carer Health and Wellbeing Checks were counted as Carer Assessments in 2010/11	In 2010/11 9,936 people were offered a carers assessment in Devon. Of this, 25% were Carers Health and Wellbeing Checks. Without the checks, the end of year outturn would have been 35.80% rather than 47.91% and the target of 38% would not have been reached.																
1.2. Increased number of carers in Devon accessing specific carer support services (through checks (indicator) numbers who have had a check where any one of the following results: <ul style="list-style-type: none"> • Membership of Devon Carers Link • Voucher for care and repair • Looking after me • St John Ambulance Training • Community Mentoring 	The following numbers of referrals (including signposting) are recorded: <table border="1" style="margin-left: 20px;"> <tr> <td>Carers link</td> <td style="text-align: right;">1038</td> </tr> <tr> <td>Community Mentoring</td> <td style="text-align: right;">221</td> </tr> <tr> <td>Addaction</td> <td style="text-align: right;">4</td> </tr> <tr> <td>St John Ambulance</td> <td style="text-align: right;">532</td> </tr> <tr> <td>Looking after me programme</td> <td style="text-align: right;">348</td> </tr> <tr> <td>Citizens advice Bureau</td> <td style="text-align: right;">87</td> </tr> <tr> <td>VS_other</td> <td style="text-align: right;">229</td> </tr> <tr> <td colspan="2" style="text-align: center;">Total Voluntary Sector 2459</td> </tr> </table> A total of 774 vouchers for Home Safety Assessments (Devon Care and Repair) were issued.	Carers link	1038	Community Mentoring	221	Addaction	4	St John Ambulance	532	Looking after me programme	348	Citizens advice Bureau	87	VS_other	229	Total Voluntary Sector 2459		Addaction, CAB and VS other have been retained in this section although it could be argued they should be elsewhere.
Carers link	1038																	
Community Mentoring	221																	
Addaction	4																	
St John Ambulance	532																	
Looking after me programme	348																	
Citizens advice Bureau	87																	
VS_other	229																	
Total Voluntary Sector 2459																		
1.3 Increased number of carers in Devon supported to stay mentally and physically well - numbers who have had a check	The following appointment referrals are recorded: <table border="1" style="margin-left: 20px;"> <tr> <td>GP appointment</td> <td style="text-align: right;">509</td> </tr> </table>	GP appointment	509	See Section 3 Impact for further analysis														
GP appointment	509																	

Appendix 3: Benefits Table

1. June 2010	Achievements		Comments																		
<p>where any one of the following results:</p> <ul style="list-style-type: none"> • GP appointment • Phlebotomy • Practice Nurse appointment • Medicines Review • Health trainers • Addaction • Smoking Cessation 	<table border="1"> <tr><td>Practice nurse clinic</td><td>372</td></tr> <tr><td>Phlebotomy</td><td>245</td></tr> <tr><td>Stop Smoking Service</td><td>47</td></tr> <tr><td>Screening programme</td><td>79</td></tr> <tr><td>Health Trainers</td><td>113</td></tr> <tr><td>Community Nursing</td><td>24</td></tr> <tr><td>Check ups (Audiology, Optician Dentistry)</td><td>146</td></tr> <tr><td>NHS Other</td><td>109</td></tr> <tr><td colspan="2" style="text-align: center;">Total NHS 1644</td></tr> </table>	Practice nurse clinic	372	Phlebotomy	245	Stop Smoking Service	47	Screening programme	79	Health Trainers	113	Community Nursing	24	Check ups (Audiology, Optician Dentistry)	146	NHS Other	109	Total NHS 1644			
Practice nurse clinic	372																				
Phlebotomy	245																				
Stop Smoking Service	47																				
Screening programme	79																				
Health Trainers	113																				
Community Nursing	24																				
Check ups (Audiology, Optician Dentistry)	146																				
NHS Other	109																				
Total NHS 1644																					
<p>1.4 Increased access for disadvantaged groups of carers:</p> <ol style="list-style-type: none"> 1. Carers of people with alcohol/drug problems; 2. Carers of people with mental health problems 3. Carers of people with learning disability 4. {Carers of people with dementia} data not collected (see mental 	<p>In addition there were 4 referrals to Addaction (see above)</p> <ol style="list-style-type: none"> 1. 13 carers of people with alcohol/substance misuse received a check 2 508 carers of people with mental health problems received a check. 3. 183 carers of people with a learning disability received a check. 	<p>1 Numbers currently in treatment – 1307 drug users, and 737 alcohol users. No data is available on numbers of carers, and it is identification of such carers which provides the major barrier to their support. If all of those in treatment have a carer then the Programme reached 0.6%. However, at commencement of the Programme the DAAT had identified 1 carer willing to be regarded as such who they were encouraging to have a check. While there is still significant progress to be made this may be regarded as a start.</p> <p>Performance on carer assessments in 2010/11 varied significantly across the client group teams, with Older People and Physical/Sensory Disability 45.33%, Learning Disability failing to meet target at 18.4% and Mental Health significantly lower at 2.01%.</p> <p>Access for carers of people with Mental Health problems was identified as a priority in the bid and is comments on in</p>																			

Appendix 3: Benefits Table

1. June 2010	Achievements	Comments
health)		<p>Section 3 Impact.</p> <p>In terms of service users (whether cared-for or not), DCC's client base has 7% people with learning disabilities and 19% with Mental Health problems.</p> <p>Of the 2833 adult carers in the Programme there were:</p> <ul style="list-style-type: none"> • 0.45% caring for someone with a substance misuse problem • 18% caring for someone with a mental health problem • 6.4% caring for someone with a learning disability, (1.7% of the LD population 18-64 (10,752)) <p>180 Carers of people with a learning disability received a check. Based on available demographic data, these carers represent:</p> <ul style="list-style-type: none"> • 1.7% of the Devon population of people with a learning disability aged 18-64; • 5.7% of the Devon population of people with a learning disability READ coded on GP practice systems (please note that GP practices tend to identify people 18+ with a severe learning disability; • 35% improved performance in the provision of LD carer assessments based on: <ul style="list-style-type: none"> • Number of ACS clients with LD 1,576 • Number of carer assessments needed 566 2010/11 Actual number delivered by ACS = 502 <p>Contribution of carers HWBC to LD performance =</p>

Appendix 3: Benefits Table

1. June 2010	Achievements	Comments															
		<p>+180</p> <p>Increased performance in LD as a result of HWBC = 35%</p>															
1.5 Vascular checks delivered (number – electronic record)	47% of carers having a health and wellbeing check had a vascular risk assessment	Devon's overall performance was 35% of the total target for vascular checks needed; HWBC contributed 3% of total eligible people which amounts to 8% of actual performance.															
1.6. More carers access services who have issues concerned with rural isolation: (as above for practices in rural areas)	<p>Analysis not currently available on rural service access.</p> <p>Access to checks was achieved as follows</p> <table border="1" data-bbox="723 624 1270 1169"> <thead> <tr> <th data-bbox="723 624 907 810">Environment type</th> <th data-bbox="907 624 1086 810">% Devon Population living in that type</th> <th data-bbox="1086 624 1270 810">% carers receiving a health and wellbeing check living in that type</th> </tr> </thead> <tbody> <tr> <td data-bbox="723 810 907 911">Urban 10k+</td> <td data-bbox="907 810 1086 911">47.4%</td> <td data-bbox="1086 810 1270 911">(43.9%)</td> </tr> <tr> <td data-bbox="723 911 907 975">Town and Fringes</td> <td data-bbox="907 911 1086 975">22.8%</td> <td data-bbox="1086 911 1270 975">(29.5%)</td> </tr> <tr> <td data-bbox="723 975 907 1075">Village</td> <td data-bbox="907 975 1086 1075">17.5%</td> <td data-bbox="1086 975 1270 1075">(17.1%)</td> </tr> <tr> <td data-bbox="723 1075 907 1169">Hamlet and Isolated dwelling</td> <td data-bbox="907 1075 1086 1169">12.4%</td> <td data-bbox="1086 1075 1270 1169">(9.5%)</td> </tr> </tbody> </table>	Environment type	% Devon Population living in that type	% carers receiving a health and wellbeing check living in that type	Urban 10k+	47.4%	(43.9%)	Town and Fringes	22.8%	(29.5%)	Village	17.5%	(17.1%)	Hamlet and Isolated dwelling	12.4%	(9.5%)	<p>More details are contained in the appendices on the percentage of the population by deprivation group and urban / rural classification who were registered with a participating practice.</p> <p>There are also summaries based on the total practice population, and the estimated number of carers, and a matrix which shows percentages registered with a participating practice by both deprivation and urban / rural classification. These reveal slightly higher percentages with access to a participating GP in the most deprived areas, and also in town/fringe locations.</p> <p>Please note that the above are about access rather than actual usage. In the final table this is presented as a percentage of the estimated numbers of carers in the participating practices populations. This highlights that use of health checks was slightly higher in town/fringe and village locations.</p> <p>The total numbers of carers shown are slightly lower than in other analyses because this series of charts are based on the GP registered population for Devon, which is 10,000 or so less than the resident population mainly due to registration with Plymouth and Torbay practices, and the analysis was restricted also to only those resident in Devon</p>
Environment type	% Devon Population living in that type	% carers receiving a health and wellbeing check living in that type															
Urban 10k+	47.4%	(43.9%)															
Town and Fringes	22.8%	(29.5%)															
Village	17.5%	(17.1%)															
Hamlet and Isolated dwelling	12.4%	(9.5%)															

Appendix 3: Benefits Table

1. June 2010	Achievements	Comments
		in order to do an accurate deprivation / rurality analysis. It is also based on the population in 2010 rather than the 2011 projections used for other analyses.

2. Sept 2010	Achievements	Comments																														
2.1 Needs identified where no service available to meet them (interim research report)	Need and demand for carer courses tailored to BME carers identified and met. Need for market development to provide for Asian sitters (take a break) identified. Need for carer support services in GP surgeries identified and incorporated in new service specification																															
2.2 Increased service access for carers in areas of Social and Economic deprivation (as rural, cohort of practices in areas of social and economic deprivation)	<p>The table shows population in deprived and rural areas served by Practices participating in the Programme. This means that for example 27.7% of the Devon population, living in a village in an area of above average deprivation were registered with a GP Practice participating in the Programme. There was 100% coverage in the most deprived Town and Fringe areas. Information on actual take up of checks in these areas – via the Peripatetic Nurse, for example, or at Pharmacies, is not available.</p> <table border="1"> <thead> <tr> <th>Deprivation</th> <th>Urban</th> <th>Town and Fringe</th> <th>Village</th> <th>Hamlet and Isolated dwelling</th> <th>Devon</th> </tr> </thead> <tbody> <tr> <td>Most</td> <td>48.9%</td> <td>100%</td> <td>No villages in this quintile</td> <td>No hamlets etc in this quintile</td> <td>50.5%</td> </tr> <tr> <td>Above average</td> <td>48.1%</td> <td>52%</td> <td>27.7%</td> <td>21.5%</td> <td>44.2%</td> </tr> <tr> <td>Average</td> <td>45.9%</td> <td>56.1%</td> <td>39.3%</td> <td>38.6%</td> <td>44.9%</td> </tr> <tr> <td>Below average</td> <td>47.4%</td> <td>49%</td> <td>50.9%</td> <td>51.9%</td> <td>49%</td> </tr> </tbody> </table>	Deprivation	Urban	Town and Fringe	Village	Hamlet and Isolated dwelling	Devon	Most	48.9%	100%	No villages in this quintile	No hamlets etc in this quintile	50.5%	Above average	48.1%	52%	27.7%	21.5%	44.2%	Average	45.9%	56.1%	39.3%	38.6%	44.9%	Below average	47.4%	49%	50.9%	51.9%	49%	<p>The Programme was designed to operate primarily through Primary Care Practices, whose participation was voluntary. This Benefit was identified by the Implementation and Sustainability Team after set up of the Programme.</p> <p>Further work on addressing identifying carers in rural areas and providing them with checks is underway funded by DCC. The deprivation issues identified will be taken into account.</p>
Deprivation	Urban	Town and Fringe	Village	Hamlet and Isolated dwelling	Devon																											
Most	48.9%	100%	No villages in this quintile	No hamlets etc in this quintile	50.5%																											
Above average	48.1%	52%	27.7%	21.5%	44.2%																											
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Below average	47.4%	49%	50.9%	51.9%	49%																											

Appendix 3: Benefits Table

2. Sept 2010	Achievements						Comments
	Least	41.3%	56%	38%	50.4%	46.4%	
	Devon	46.6%	53.2%	42%	39.9%	46.4%	
2.3 Improved relationships between carers and GPs (increased number of carers READ coded – proxy measure)	Further analysis is contained in the Appendices. Increase in carers registered in participant GP Practices has increased by 75%						
2.4 % Carers receiving the health and wellbeing checks believe it is a benefit to them (interim research)	Interim research revealed a very high proportion (80%) of carers agreed or strongly agreed with all 8 satisfaction statements <ul style="list-style-type: none"> • 78%felt the check met expectations • 84%satisfied with their check • 85%felt staff were well trained and competent • 88%would like the check to be an annual event • 91%would recommend to others 						
2.5 Integration of Carers assessment - benefit for carers (reduced effort) - improved efficiency for ACS/NHS Devon Demonstrated by: number of referrals to ACS which allow care plan to be developed without further carer	There is evidence that integration is not yet complete; see Section 3 Impact.						(a) Data quality on referrals may indicate incomplete development of understanding among new referrers to ACS of requirements – this is likely to be improving and will be improved further by basing carers support workers for part of the time with Practices (b) an exercise undertaken by Care Direct Plus indicated 5 “carer

Appendix 3: Benefits Table

2. Sept 2010	Achievements	Comments
assessment		assessment forms” sent out. However, of 209 (106 not previously known) carers recorded by CDP as referred from the programme only 16 carer assessments are referred to, whereas for their 220 cared-fors for whom there were records 75 assessments were needed. This resulted in 37 care packages being provided or increased. See Section 3 Impact
3. Dec 2010	Achievements	Comments
3.1 Young carers benefiting from improved service: gross number up to and including 17 years of age participating.	105 young carers attended targeted events ¹⁹	See Section 3 Impact
3.2 Greater proportion of male carers benefiting from services than previously (proportion of male/female carers accessing checks/proportion of male/female carers accessing Devon Carers Link 2009/10)	<p>In 2009/10 the DCL gender breakdown was as follows: Female 72% Male 28% In 2010/11 DCL reports carers joining who say they heard about DCL through having a check as follows: Female 68% Male 31%.</p> <p>The population of carers accessing health and wellbeing checks broke down as follows: Female 70% Male 30%</p> <p>This compares with an estimated breakdown of carers in the Devon population of Females 59%; Males 41%²⁰</p>	<p>The programme has had a small impact in gender equality in carers joining DCL The programme has not achieved full equity for male carers and this requires further attention.</p>
3.3 Equal access for BME carers (proportion of BME	<p>See Section 3 Impact for analysis. An equality ratio of 0.93 was achieved, where 1 is equality.</p>	Significant learning was derived from this exercise. The specialist

¹⁹ One further 17 year old male received a check at his GP Practice; the reason is not known and no further data is available; he is therefore generally categorised as an adult for the purposes of this paper.

²⁰ Source figures from 2001 census; see appendices

Appendix 3: Benefits Table

3. Dec 2010	Achievements	Comments
carers receiving check is equal to proportion of BME people in Devon community)		workstream contributed almost all the benefits for BME carers.
3.4 Parent carers (% of parent carers joining Devon Carers Link; number of parent carers having a HWBC)	% of parent carers joining DCL not yet available. Management Information identifies 272 carers aged between 25 and 64 who were caring for their child (parent carer).	See Appendices
3.5 Improved personalisation and control (take up of flexible breaks and take a break grants)	Information on take up of flexible break and take a break grants by carers who joined DCL having heard about it by having a health and wellbeing check is not available.	

4. May 2011	Achievements	Comments
4.1 Evidence to support development of policy on health checks for carers (delivery of reports, compliance of providers with research)	The local researcher reports excellent compliance with reporting requirements from Providers despite the weight of requirements. Carers have also responded at a high level to the local research: <ul style="list-style-type: none"> • 31% agreed to the initial enquiry; • 46% to the Time 1 satisfaction survey • 50% to the Time 2 follow up. 	
4.2 NI135 performance Improved service access (contribution of programme to ACS performance improvement)	Without the checks, the end of year outturn would have been 35.80% rather than 47.91% and the target of 38% would not have been reached. (see first section)	
4.4 Carers READ coded with Long Term Conditions (data survey of GP practices)	Data survey not yet available.	

Appendix 4: GP Practice delivery Charts

GP Practice Delivery Charts

This Appendix contains detail relating to Section 2 of this report

In the following charts Practices have been anonymised. The code used is based simply on the date of their first delivered check so that the length of time Practices were delivering checks can be considered against the pattern and range of achievement.

As Practices vary in size, information has been standardised in relation to an agreed baseline of the Practice registered population. In one case later representations from a Practice that a substantial student population should be discounted was agreed.

There are six charts.

Chart 1: Checks delivered as % of baseline population

Chart 2: Checks delivered ordered by start date

Chart 3: Delivery against targets - note that some Practices agreed revised targets

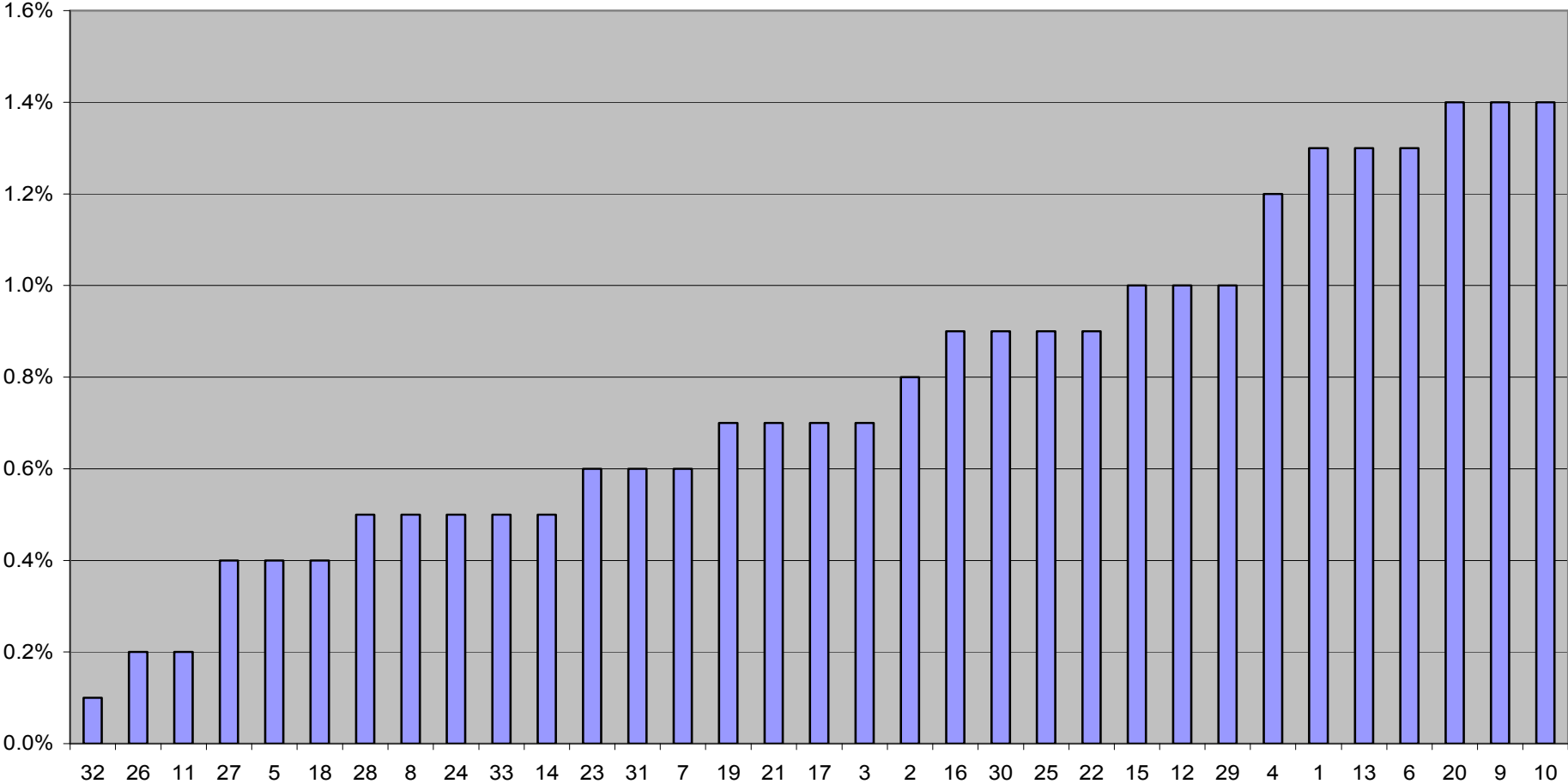
Chart 4: READ coding of carers

Chart 5: Change in Devon Carers Link Membership by Practice

Chart 6 Outcomes (checks delivered, READ coding and DCL membership) as % of baseline population

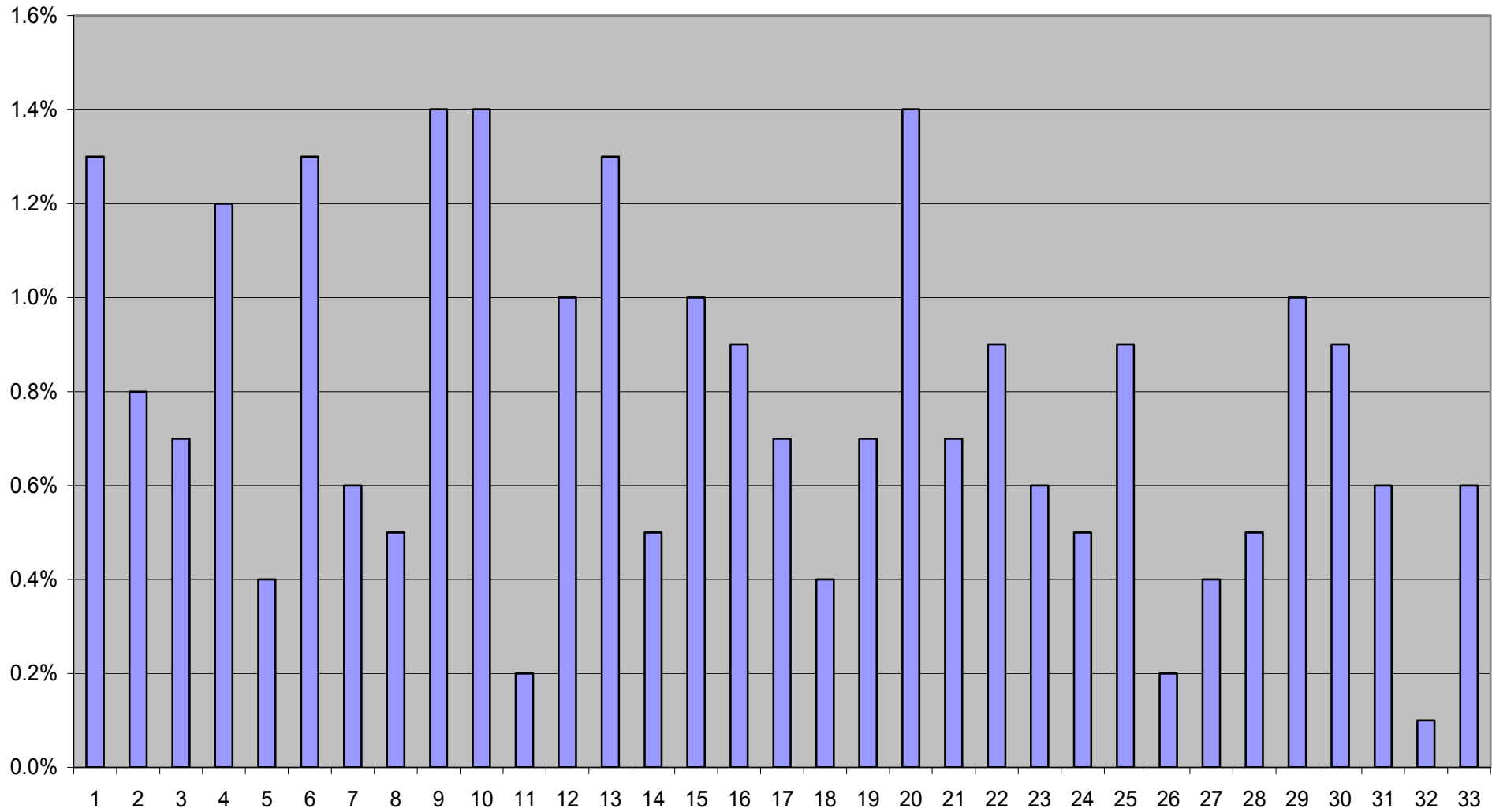
Appendix 4: GP Practice delivery Charts

Carer Health and Wellbeing Check Project - Chart 1 Checks Delivered as % of Baseline Practice Population



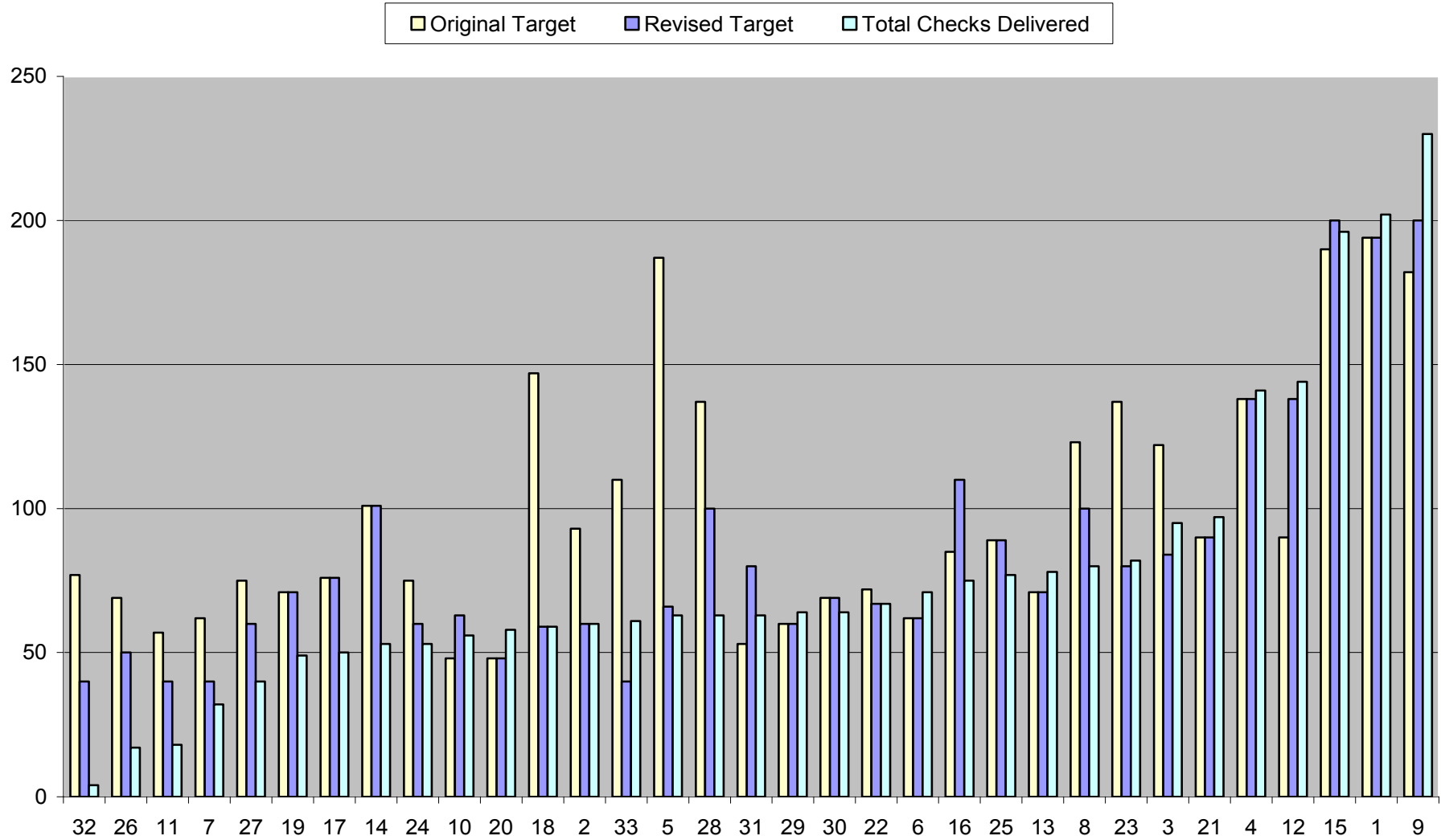
Appendix 4: GP Practice delivery Charts

Carer Health and Wellbeing Check Project
Chart 2 - Checks delivered ordered by start date



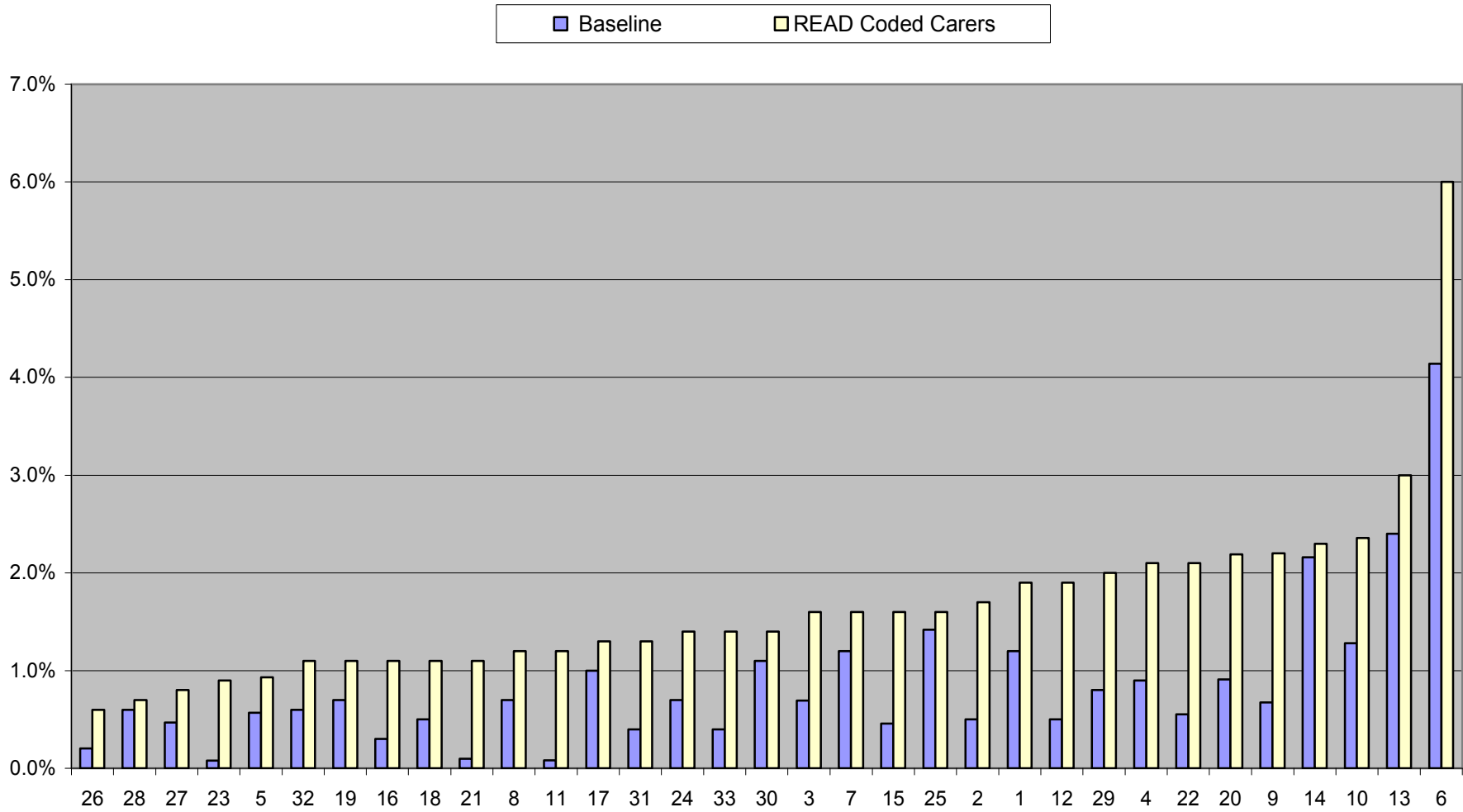
Appendix 4: GP Practice delivery Charts

Carer Health and Wellbeing Check Project - Chart 3 - Delivery v Target



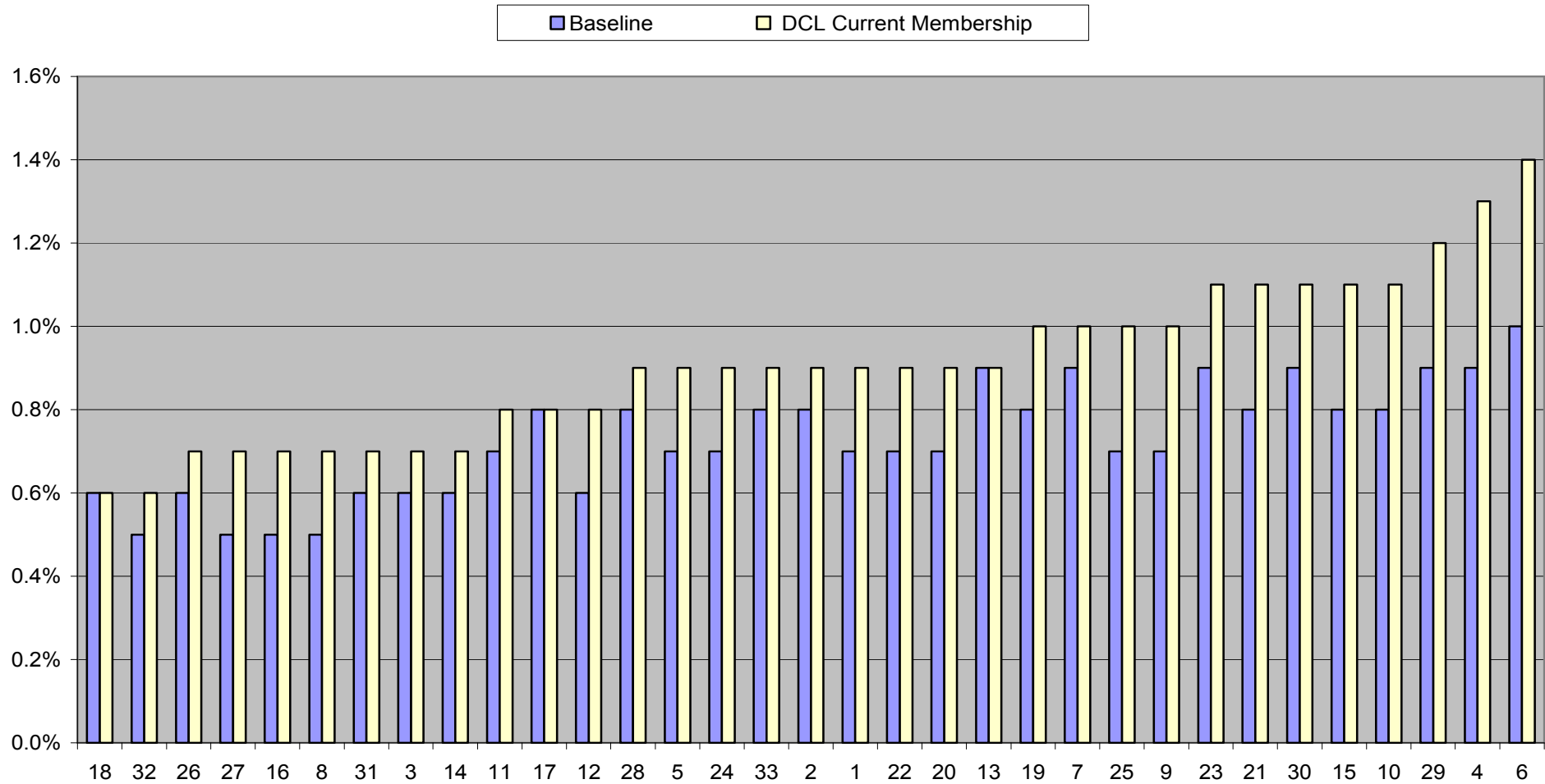
Appendix 4: GP Practice delivery Charts

Carer Health and Wellbeing Check Project - Chart 4
READ Coding of Carers

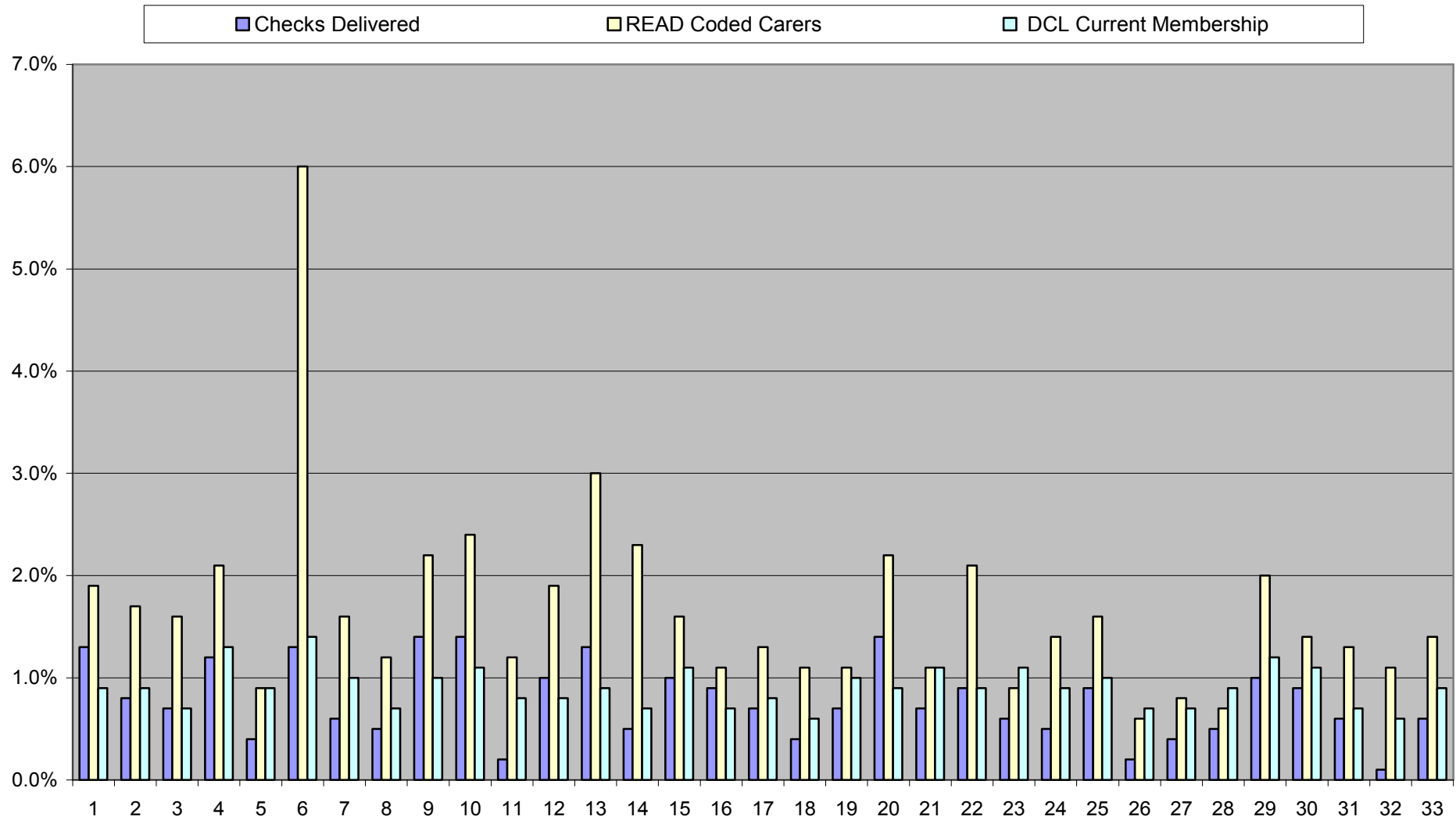


Appendix 4: GP Practice delivery Charts

Carer Health and Wellbeing Check Project
Chart 5 - Devon Carers' Link Membership

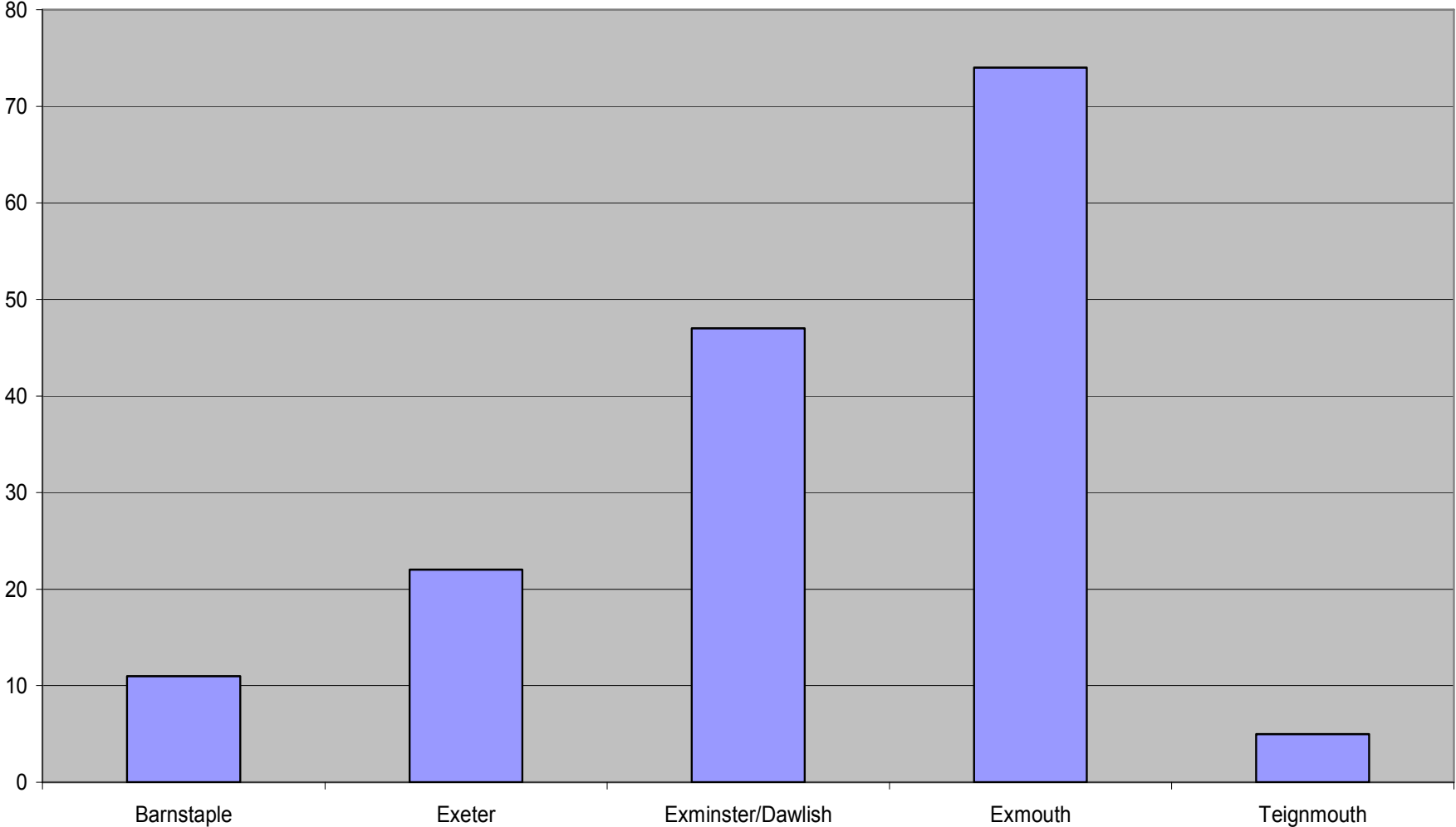


Carer Health and Wellbeing Check Project - Chart 6 - Outcomes as % of Baseline Practice Population



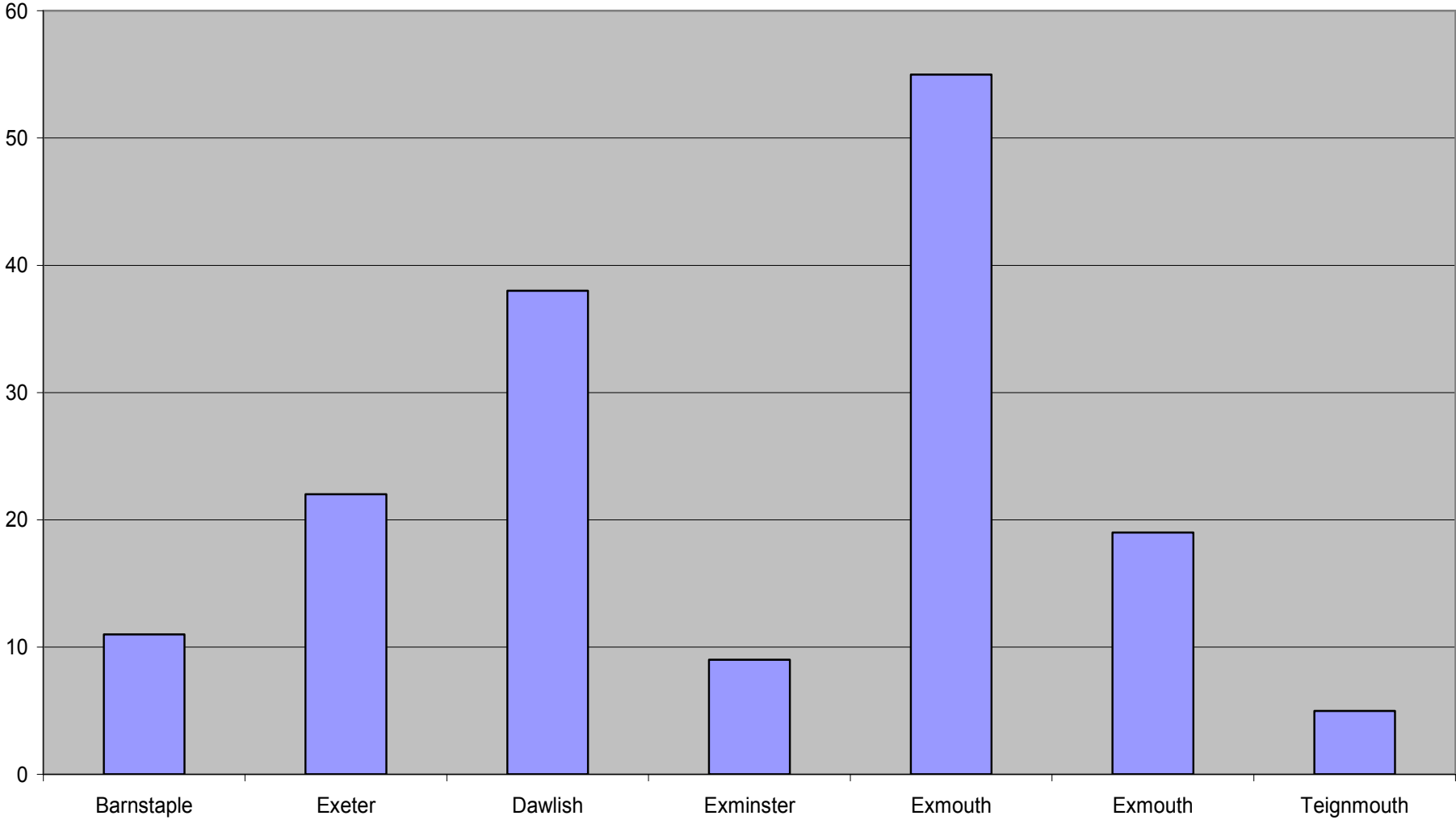
Appendix 5: Pharmacy Delivery Charts

Carer Health and Wellbeing Checks
Pharmacy Checks by Area



Appendix 5: Pharmacy Delivery Charts

Carer Health and Wellbeing Check Project
Pharmacy Checks



Appendix 6: List of Check Delivery Partners

Devon Health and Wellbeing Checks for Carers



Check Delivery Partners

North Devon

Queens Medical Centre	Barnstaple
Litchdon Medical Centre	Barnstaple
Boutport Medical Centre	Barnstaple
Brannams Medical Centre	Barnstaple
Boots Pharmacy	Barnstaple
Fremington Medical Centre	Barnstaple
Warwick Medical Practice	Ilfracombe
Waterside Medical Practice	Ilfracombe
Bideford Medical Centre	Bideford
Holsworthy Medical Centre	Holsworthy

South Devon

Buckfastleigh Medical Centre	Buckfastleigh
Ashburton Surgery	Ashburton
Bovey Tracey, Riverside Surgery	Bovey Tracey
Chudleigh Tower House Surgery	Chudleigh
Dartmouth Medical Practice	Dartmouth
Teign Estuary Medical Group	Teignmouth & Shaldon
Cricketfield Surgery	Newton Abbot
Kingskerswell & Ipplepen	Kingskerswell
Leatside Surgery	Totnes
Lloyds Pharmacy	Dawlish
Exminster Pharmacy Dawlish Warren Pharmacy	Exminster & Dawlish Warren

Exeter, East & Mid Devon

Barnfield Surgery	Exeter
Mount Pleasant Health Centre	Exeter
St Leonard's Medical Practice	Exeter
St Thomas Health Centre	Exeter
The Blackdown Practice	Cullompton
College Surgery Partnership	Cullompton
Chiddenbrook Surgery	Crediton
Seaton & Colyton	Seaton
Coleridge Medical Centre	Ottery St Mary
Axminster Medical Practice	Axminster
Townsend House Medical Centre	Seaton
Sid Valley Practice	Sidmouth
Honiton Surgery	Honiton
Budleigh Medical Practice	Budleigh Salterton
Claremont Medical Practice	Exmouth
Imperial Surgery	Exmouth
Pines Pharmacy	Exmouth
Lewis Pharmacy	Exmouth
Pinhoe Pharmacy	Exeter

St John Ambulance	
Complex Care Team,	Barnstaple
Complex Care Team,	Exmouth
Peripatetic Nurse	

Appendix 7: Evidence Charts

1. Key data charts
2. CHWBC Carers Registered with Participant Practices by Areas of Deprivation and Rurality
3. Estimated numbers of carers and receipt of CHWBC by age
4. Devon Carers by age and gender

Appendix 7.1: Key Data Charts

Please note these charts are taken from direct data inputting by delivery partners (except in the cases of Pharmacies, the Peripatetic Nurse, and St John Ambulance where the data was entered centrally by the project).

Percentages may not always add due to rounding.

(NB Data is missing on some items for some individuals.)

1. Age and Gender of individual carers having a HWBC

1a Numbers

Age	Male	Female	Unknown	Total
0-17	1			1
18-24	7	7		14
25-39	31	90		121
40-64	264	974	3	1241
65-74	205	485	6	696
75-84	228	344	4	576
85+	97	62	1	160
Unknown	2	7	2	11
Total	835	1969	16	2820

1b. Percentages

Age group	Male	Female
0-17	0%	0%
18-24	1%	0%
25-39	4%	5%
40-64	32%	49%
65-74	25%	25%
75-84	27%	17%
85+	12%	3%
Unknown	0%	0%
Total	30%	70%

2a. Age of carer and type of cared-for – main categories and totals

Age	Child		Partner / Spouse		Other Family Member		Friend		Total
0-17		0%		0%		0%		0%	1
18-24		0%		0%	2	2%		0%	14
25-39	31	9%	32	2%	9	9%	2	4%	121
40-64	241	68%	477	28%	50	51%	22	41%	1241
65-74	52	15%	518	30%	25	25%	16	30%	696
75-84	23	6%	520	31%	13	13%	10	19%	576
85+	7	2%	145	9%		0%	3	6%	160
Unknown	1	0%	7	0%		0%	1	2%	11
Total	355	13%	1699	60%	99	4%	54	2%	2820

2b. Age of carer and type of cared-for - other data and totals

Age	Other		Unknown		Total
0-17		0%		0%	1
18-24		0%		0%	14
25-39	2	8%		0%	121
40-64	16	67%	8	47%	1241
65-74	2	8%	3	18%	696
75-84	3	13%	2	12%	576
85+	1	4%	2	12%	160
Unknown		0%	2	12%	11
Total	24	1%	17	1%	2820

3a. Age of carer and main care category of cared-for – main categories and totals

Age group	Learning Disability		Mental Health		Physical disability, frailty and sensory impairment		Substance Misuse		Total
0-17		0%	1	0%		0%		0%	1
18-24	1	1%		0%	9	0%	2	15%	14
25-39	12	7%	22	4%	74	4%	1	8%	121
40-64	119	66%	190	38%	811	43%	8	62%	1241
65-74	30	17%	111	22%	480	26%	1	8%	696
75-84	13	7%	140	28%	383	20%	1	8%	576
85+	4	2%	39	8%	108	6%		0%	160
Unknown	1	1%	1	0%	7	0%		0%	11
Total	180	6%	504	18%	1872	66%	13	0%	2820

3b. Age of carer and main care category of cared-for – additional data and totals

Age group	Vulnerable People		Unknown		Total
0-17		0%		0%	1
18-24		0%	2	1%	14
25-39	2	6%	10	5%	121
40-64	18	56%	95	43%	1241
65-74	7	22%	67	31%	696
75-84	4	13%	35	16%	576
85+	1	3%	8	4%	160
Unknown		0%	2	1%	11
Total	32	1%	219	8%	2820

4. Age, ethnicity and gender, carers who had an annual follow-up check

Age group	Male		Female		White (British, Irish and other white background)		BME		Unknown Ethnicity		Total
0-17	0	0%	0	0%	0	0%	0	0%	0	0%	0
18-24	0	0%	0	0%	0	0%	0	0%	0	0%	0
25-39	0	0%	0	0%	0	0%	0	0%	0	0%	0
40-64	9	33%	34	44%	40	40%	1	100%	2	50%	86
65-74	4	15%	29	37%	32	32%	0	0%	1	25%	66
75-84	10	37%	13	17%	22	22%	0	0%	1	25%	46
85+	4	15%	2	3%	6	6%	0	0%	0	0%	12
Unknown	0	0%	0	0%	0	0%	0	0%	0	0%	0
Total	27	26%	78	74%	100	95%	1	1%	4	4%	105

5. Ethnicity of Carers who had a HWBC

Ethnic group	Total number	% ethnic group	interpreter req	% Interpreter req
9i0 - British or mixed British	2618	93%	8	0.3%
9i1 - Irish - Ethnic category	4	0%		0.0%
9i2 - Other White Background	18	1%	2	11.1%
9i4 - White and Black African	1	0%		0.0%
9i5 - White and Asian	2	0%		0.0%
9i6 - Other Mixed Background	1	0%		0.0%
9i7 - Indian or British Indian	5	0%		0.0%
9i8 - Pakistani or British Pakistani	1	0%		0.0%
9i9 - Bangladeshi or British Bangladeshi	25	1%	4	16.0%
9iA - Other Asian Background	6	0%		0.0%
9iC - African - Ethnic Category	4	0%		0.0%
9iD - Other Black Background	1	0%		0.0%
9iE - Chinese - Ethnic Category	20	1%	7	35.0%
9iF - Other - Ethnic Category	6	0%	1	16.7%
9iG - Ethnic Category not Stated	108	4%	2	1.9%
Total	2820		24	0.9%

6a. Ethnicity by provider type – GP Practices and totals

Ethnicity	Total	%	In practices	
9i0 - British or mixed British	2618	92.8%	2349	95.5%
9i1 - Irish - Ethnic category	4	0.1%	3	0.1%
9i2 - Other White Background	18	0.6%	15	0.6%
9i4 - White and Black African	1	0.0%	1	0.0%
9i5 - White and Asian	2	0.1%		0.0%
9i6 - Other Mixed Background	1	0.0%		0.0%
9i7 - Indian or British Indian	5	0.2%	1	0.0%
9i8 - Pakistani or British Pakistani	1	0.0%		0.0%
9i9 - Bangladeshi or British Bangladeshi	25	0.9%	3	0.1%
9iA - Other Asian Background	6	0.2%	2	0.1%
9iC - African - Ethnic Category	4	0.1%		0.0%
9iD - Other Black Background	1	0.0%	1	0.0%
9iE - Chinese - Ethnic Category	20	0.7%	2	0.1%
9iF - Other - Ethnic Category	6	0.2%	3	0.1%
9iG - Ethnic Category not Stated	108	3.8%	79	3.2%
Total	2820		2459	87%

6b. Ethnicity by provider type – Other Providers and totals

Ethnicity	Total	%	In Pharmacies		By CCTs		Peripatetic Nurse		St Johns Ambulance	
9i0 - British or mixed British	2618	92.8%	136	86.1%	31	86.1%	62	92.5%	40	40.0%
9i1 - Irish - Ethnic category	4	0.1%	1	0.6%		0.0%		0.0%		0.0%
9i2 - Other White Background	18	0.6%	3	1.9%		0.0%		0.0%		0.0%
9i4 - White and Black African	1	0.0%		0.0%		0.0%		0.0%		0.0%
9i5 - White and Asian	2	0.1%		0.0%		0.0%		0.0%	2	2.0%
9i6 - Other Mixed Background	1	0.0%		0.0%		0.0%		0.0%	1	1.0%
9i7 - Indian or British Indian	5	0.2%		0.0%		0.0%		0.0%	4	4.0%
9i8 - Pakistani or British Pakistani	1	0.0%		0.0%		0.0%		0.0%	1	1.0%
9i9 - Bangladeshi or British Bangladeshi	25	0.9%		0.0%		0.0%		0.0%	22	22.0%
9iA - Other Asian Background	6	0.2%		0.0%		0.0%		0.0%	4	4.0%
9iC - African - Ethnic Category	4	0.1%		0.0%		0.0%		0.0%	4	4.0%
9iD - Other Black Background	1	0.0%		0.0%		0.0%		0.0%		0.0%
9iE - Chinese - Ethnic Category	20	0.7%		0.0%		0.0%		0.0%	18	18.0%
9iF - Other - Ethnic Category	6	0.2%		0.0%		0.0%	1	1.5%	2	2.0%
9iG - Ethnic Category not Stated	108	3.8%	18	11.4%	5	13.9%	4	6.0%	2	2.0%
Total	2820		158	6%	36	1%	67	2%	100	4%

7. Analysis by provider type for gender and ethnicity

Provider type	Male	Female	Unknown Gender	White (British, Irish and other white background)	BME	Unknown Ethnicity	Total
Practices	30.5%	69.0%	0.6%	96.3%	0.5%	3.2%	2459
Pharmacy	22.2%	77.8%	0.0%	88.6%	0.0%	11.4%	158
CCT	30.6%	69.4%	0.0%	86.1%	0.0%	13.9%	36
Peripatetic Nurse	13.4%	83.6%	3.0%	92.5%	1.5%	6.0%	67
St Johns	31.0%	69.0%	0.0%	40.0%	58.0%	2.0%	100
Total	835	1969	16	2640	72	108	2820

8a. Analysis by provider type for age – to age 64 and total

Provider type	0-17		18-24		25-39		40-64		Total
Practices	1	100%	7	50.0%	89	73.6%	1076	43.8%	2562
Pharmacy	0	0%	1	7.1%	4	3.3%	67	42.4%	160
CCT	0	0%	0	0.0%	3	2.5%	6	16.7%	36
Peripatetic Nurse	0	0%	0	0.0%	6	5.0%	32	47.8%	67
St Johns	0	0%	6	42.9%	19	15.7%	60	60.0%	100
Total	1	0.04%	14	0.5%	121	4.3%	1241	1241	2820

8b. Analysis by provider type for age – age 65 plus and total

Provider type	65-74		75-84		85+		Unknown		Total
Practices	620	89.1%	510	88.5%	150	93.8%	6	54.5%	2562
Pharmacy	45	6.5%	31	5.4%	6	3.8%	4	36.4%	160
CCT	7	1.0%	16	2.8%	4	2.5%	0	0.0%	36
Peripatetic Nurse	16	2.3%	13	2.3%	0	0.0%	0	0.0%	67
St Johns	8	1.1%	6	1.0%	0	0.0%	1	9.1%	100
Total	696	25%	576	20%	160	6%	11	0.4%	2820

9. Analysis by provider type for primary need of cared-for

Provider type	Learning Disability		Mental Health		Physical disability, frailty and sensory impairment		Substance Misuse		Vulnerable People		Unknown		Total
Practices	156	6.3%	398	16.2%	1678	68.2%	7	0.3%	32	1.3%	188	7.6%	2459
Pharmacy	7	4.4%	50	31.6%	82	51.9%	3	1.9%	0	0.0%	16	10.1%	158
CCT	0	0.0%	5	13.9%	29	80.6%	0	0.0%	0	0.0%	2	5.6%	36
Peripatetic Nurse	4	6.0%	27	40.3%	36	53.7%	0	0.0%	0	0.0%	0	0.0%	67
St Johns	13	13.0%	24	24.0%	47	47.0%	3	3.0%	0	0.0%	13	13.0%	100
Total	180	6.4%	504	17.9%	1872	66.4%	13	0.5%	32	1.1%	219	7.8%	2820

10a. Was an interpreter required? GP Practices and totals

Interpreter required	Total	%	Carried out by practices	
Yes	24	0.85%	8	0.3%
No	2771	98.26%	2433	98.9%
Unknown	25	1%	18	0.7%
Total	2820	87%	2459	87%

10b. Was an interpreter required? Other providers and totals

Interpreter required?	Total	%	Carried out by Pharmacies		Carried out by CCT		Carried out by Peripatetic Nurse		Carried out by St Johns	
Yes	24	0.85%	2	1%		0%		0%	14	14%
No	2771	98.26%	150	95%	35	97%	67	100%	86	86%
Not known	25	1%	6	4%	1	3%		0%		0%
Total	2820	87%	158	6%	36	1%	67	2%	100	4%

11. Average number of visits to GP for own health carers report for last 12 months

Age group	Male	Female	Unknown Gender	White (British, Irish and other white background)	BME	Unknown Ethnicity	Total
0-17	2.0			2.0			2.0
18-24	1.4	5.14		5.3	0.7		3.3
25-39	3.2	5.89		5.8	3.2	1.0	5.2
40-64	3.1	3.82	0.7	3.7	3.9	2.8	3.7
65-74	3.6	3.74	5.3	3.7	3.3	4.7	3.7
75-84	4.8	4.83	2.8	4.8	3.7	4.2	4.8
85+	4.9	5.06	4.0	5.0	9.0	2.0	4.9
Unknown	11.0	4.29	1.0	6.0	10.0	0.7	4.9
Total	3.9	4.12	3.2	4.1	3.6	3.3	4.0

12. Average number of visits to Practice Nurse for own health carers report for last 12 months

Age group	Male	Female	Unknown Gender	White (British, Irish and other white background)	BME	Unknown Ethnicity	Total
0-17	2.0			2.0			2.0
18-24	0.4	1.1		1.1	0.3		0.8
25-39	0.8	2.5		2.4	1.0	0.0	2.1
40-64	2.2	1.9	0.3	2.0	1.9	1.0	2.0
65-74	3.4	2.5	1.0	2.8	0.7	2.9	2.8
75-84	4.5	3.4	2.0	3.8	1.3	5.3	3.8
85+	4.2	4.5	2.0	4.4	4.0	1.2	4.3
Unknown	3.0	0.9	1.0	1.7	0.0	0.7	1.3
Total	3.3	2.4	1.2	2.7	1.4	2.3	2.7

13. Average number of emergency admissions to hospital for own health carers report for last 12 months							
Age group	Male	Female	Unknown Gender	White (British, Irish and other white background)	BME	Unknown Ethnicity	Total
0-17	0.0			0.0			0.0
18-24	0.1	0.1		0.1	0.2		0.1
25-39	0.0	0.1		0.1	0.2	0.0	0.1
40-64	0.0	0.1	0.0	0.1	0.1	0.0	0.1
65-74	0.1	0.0	0.0	0.1	0.7	0.0	0.1
75-84	0.1	0.1	0.0	0.1	0.0	0.2	0.1
85+	0.1	0.0	0.0	0.1	0.0	0.0	0.1
Unknown	0.0	0.1	1.0	0.0	1.0	0.7	0.3
Total	0.1	0.1	0.1	0.1	0.2	0.1	0.1

7.2 CHWBC Carers Registered with Participant Practices by Areas of Deprivation and Rurality

Rurality	Registered with participant	Registered with non-participant	Total	% registered with participant
Urban > 10k	17,110	19,620	36,730	46.6%
Town and Fringe	9,740	8,560	18,300	53.2%
Village	5,989	8,282	14,270	42.0%
Hamlet and Isolated Dwelling	4,129	6,228	10,357	39.9%
Devon	36,968	42,689	79,657	46.4%

Carers Health Checks, Matrix - % registered with participating practice by deprivation and urban/rural classification

	Urban > 10k	Town and Fringe	Village	Hamlet and Isolated Dwelling	Devon
Most Deprived	48.9%	100.0%	-	-	50.5%
Above Average	48.1%	52.0%	27.7%	21.5%	44.2%
Average	45.9%	56.1%	39.3%	38.6%	44.9%
Below Average	47.4%	49.0%	50.9%	51.9%	49.0%
Least Deprived	41.3%	56.0%	38.0%	50.4%	46.4%
Devon	46.6%	53.2%	42.0%	39.9%	46.4%

Carers Health Checks, Persons receiving health checks in participating practices as a percentage of estimated carers in practice populations

Rurality	Participants	Practice Population (Carers)	Percentage
Urban > 10k	985	17,110	5.76%
Town and Fringe	662	9,740	6.80%
Village	384	5,989	6.41%
Hamlet and Isolated Dwelling	214	4,129	5.18%
Unknown	463	-	-
Grand Total	2708	-	-
Grand Total excluding unknown	2245	36,968	6.07%

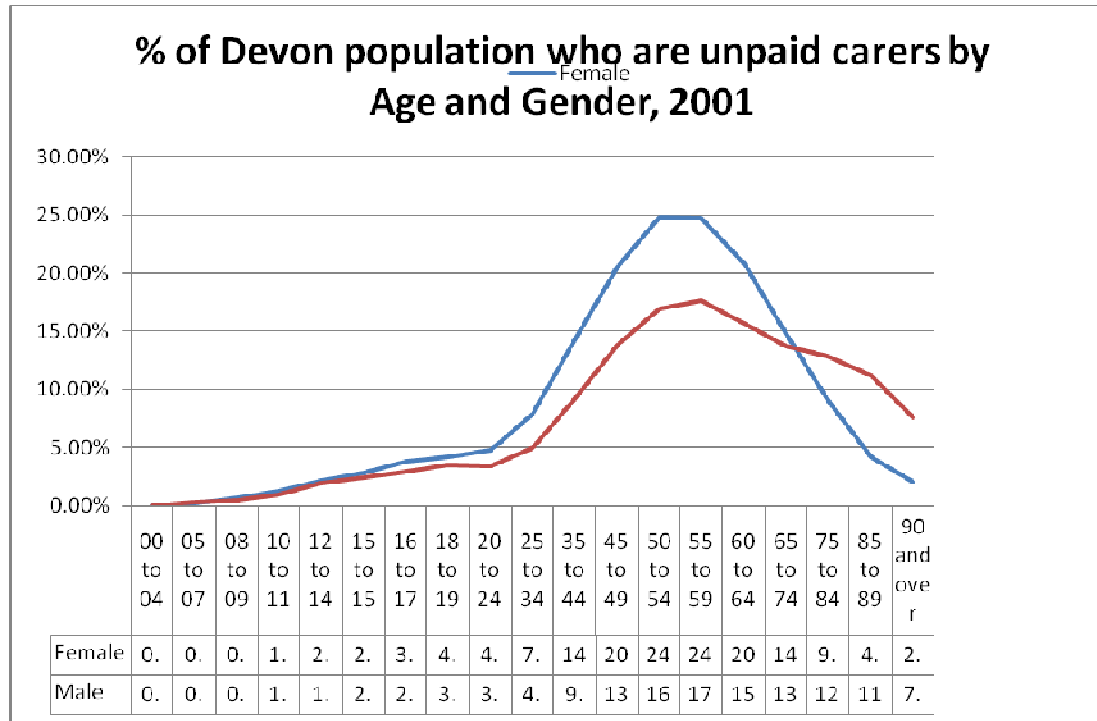
7.3 Estimated numbers of carers and receipt of CHWBC by age

Estimated number of carers and receipt of Health and Wellbeing Checks, Devon, 2010-11

Age	Population	Carers (Estimated)*	Health and Wellbeing Checks		As % of initial checks
			Number	As % of all carers	
00 to 17	145360	1809	106	5.8%	3.60%
18 to 24	61440	3202	14	0.4%	0.47%
25 to 39	116200	9391	121	1.3%	4.13%
40 to 64	268000	41936	1241	2.9%	42.42%
65 to 74	89100	14256	696	4.8%	23.79%
75 to 84	57300	7449	576	7.7%	19.60%
85 and over	26400	3432	160	4.6%	5.47%
Unknown	-		11		
Total	763900	81475	2925	3.6%	

* Estimated using NHS Information Centre Survey of Carers 2009-10 (adults) and 2001 Census (children) age-specific rates against 2011 Devon population

7.4 Devon Carers by Age and Gender



Appendix 8

Devon Carer Health and Wellbeing Check Competencies.

Three levels of competence have been identified in the Devon Pilot: The first two are appropriate in an environment where help is on call if needed e.g. GP surgery.

1. Entry level – the level at which an HCA or equivalent level worker is competent to give a check when support is close by and can be called on readily, e.g. if carer discloses an issue requiring immediate intervention or outside the parameters of what is on offer.
2. Full competence – the level which an experienced HCA or equivalent has reached when – as examples: s/he has
 - good knowledge of carers lives and issues
 - knows local services for carers and availability
 - is therefore able to make good and appropriate referrals that do not result in further hand-ons being required
3. Extended competence – likely to be very experienced in delivering checks or to have broad experience of carers' issues and services, good technical skills and confidence with the public health message delivery in an individual environment. This is the level of competence most likely to be needed in environments such as memory clinics, and carers are likely to be encountered who are facing the biggest challenges or have undiagnosed health conditions. As examples s/he:
 - has deeper knowledge of one or more areas as a speciality and is fully confident in all areas of knowledge
 - has gained full competence in managing a carer-consultation within time boundaries
 - recognises and deals effectively with more complex reactions carers may have to their situations

Further work to develop these competences to fully identify the levels and develop training packages based on them is underway.

Knowledge

- Carers lives and issues
- Health knowledge sufficient to identify requirement for referral to GP for routine, urgent or emergency assessment
- Nature of vascular risk
- Background to cardiovascular disease
- Protocol for recall and making appointments (where check is in the carers' surgery)
- Protocols relating to technical skills, including health and safety issues
- Local services:
 - Direct carer support provided by voluntary sector organisations
 - How (and when) to access community services
 - Safeguarding children and adults procedures and when to activate them

- Local health services and voluntary sector condition specific support available
- 5 key health messages
- Health improvement methodology
- Carers Equal Opportunities Act
- Local policies and procedures on patient consent and data protection
- Local policies and procedures on control of infection
- appropriate NICE guidelines / condition pathways
- Protocol for clinical supervision/support
- Personal Protective Equipment/PPE
- Lone working principles

Skills

Counselling skills

- Listening
- Questioning
- Summarising
- Reflecting
- Empathising
- Giving feedback
- Dealing with angry and/or distressed people
- Identifying and dealing with suicide risks

Consultation skills

- Inter-personal communication
- Assessment against protocols/standards/criteria
- Time management
- Prioritising
- Presenting options and choices
- Decision making
- Signposting and referral

Coaching skills

- Planning and review
- Goal setting
- Motivating and empowering others

Technical skills

- Use, care, and calibration of Near Patient Testing Kit
- Taking blood pressure
- Weighing, measuring height and waist, and BMI calculation
- Near-patient blood testing
- Interpretation of test results
- Calculation of vascular risk
- Giving of results and advice when follow up is indicated
- Disposal of sharps and dealing with likely spillages
- Recording and updating patient records (in surgeries)

Appendix 9

Devon Carers' Health and Wellbeing Check Carer-held Booklet

To see the Devon Carers' Health and Wellbeing Checks Carers' handheld booklet please visit:

www.devon.gov.uk/carers_health_booklet_apr10_issue2.pdf