Norfolk Admiral Nurse Pilot Evaluation Report

July 2014
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Partnership working has been key to the success so far in securing Norfolk’s first Admiral Nurses. Numerous organisations have been involved at various levels of the process, from both the third and statutory sectors. It has been important to balance the interests and needs of these stakeholders while keeping the project on course to achieve its overall goal, which is the establishment of a full and effective Admiral Nurse service for the carers in Norfolk who provide so much for people with dementia.

There was initially, as ever, an issue regarding the start-up funding and despite pressure from various organisations, meetings and good intentions, it was not until Dementia UK approached Norfolk and Suffolk NHS Foundation Trust (NSFT), that there was the necessary seed funding to commence the project. A Project Group was quickly established and tasked itself with establishing the best way to implement the Admiral Nurse role into the Norfolk dementia services. Members of the Group contributed their knowledge, experience and resources as well as their vision for Admiral Nurses, to the process. This resulted in a pilot project being located in the Mid Norfolk area. The charitable funding was enhanced by a contribution from NSFT in order to increase the number of Admiral Nurses to three. The Admiral Nurse Team was then structured with a lead Admiral Nurse role (employed by Age UK Norfolk) and two team Admiral Nurses (employed by NSFT).

The work then turned to more detailed operational issues to ensure the working relationship between the 3 main implementation stakeholders was as effective as possible, at this stage an Operational Group was established to include Dementia UK, Age UK Norfolk and NSFT Operational Managers. A Memorandum of Understanding, Information Governance Agreements and Operational Policy were developed and agreed. This group continues to meet regularly to ensure operational matters are addressed and importantly the evaluation of the Admiral Nurse Project is undertaken appropriately.

**Gary Hazelden**  
Partnership Lead  
*Norfolk and Suffolk NHS Foundation Trust*
We would like to thank all of the carers and professionals that took part in this evaluation by giving their time to participate in interviews and completing questionnaires.

Thank you to those who contributed information to enable analysis of the data that was gathered.

We are grateful to the partnership that has been developed between Age UK Norfolk, Dementia UK, Norfolk and Suffolk Foundation Trust and The Peoples Health Trust without whom the Admiral Nurse Pilot would not have been possible.

Special thanks to Nicola Findlay, who has carried out this evaluation in a voluntary capacity, and without whom it would not have been possible to achieve such an in depth analysis of the pilot to date.

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### 1.1 Overview of the Evaluation
The evaluation report has been compiled by Zena Aldridge, Admiral Nurse Lead and Nicola Findlay, Occupational Therapist, MA and edited by Kate Rudkin, Head of Development and Operations, Age UK Norfolk.

A Pilot Project to trial the esteemed Admiral Nurse Service format commenced on April 2013 in the mid Norfolk area serving seven GP surgeries.

The evaluation study has investigated the effectiveness of the Admiral Nurse Service against agreed outcomes with both quantitative and qualitative data used to produce relevant data for analysis.

### 1.2 Aim of the Evaluation
The aim of the evaluation is to ascertain what, if any, impact the Admiral Nurse Service has had within the pilot area of Mid Norfolk. The following key questions have been identified to explore:

<table>
<thead>
<tr>
<th>Q1</th>
<th>Have Admiral Nurses improved the physical, emotional and mental well-being, of carers of people with dementia?</th>
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<tbody>
<tr>
<td>Q2</td>
<td>Has the presence of Admiral Nurses impacted on diagnosis rates of dementia?</td>
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<td>Q3</td>
<td>Has the presence of Admiral Nurses had a positive impact on other professional’s caseloads, and improved their ability to manage the care of people with dementia and their carers more effectively?</td>
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<td>Q4</td>
<td>Have the interventions offered by Admiral Nurses reduced admissions to Acute or Mental Health hospital beds?</td>
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<td>Q5</td>
<td>Have the interventions offered by Admiral Nurses reduced/delayed admissions to Residential and Nursing care for people with dementia?</td>
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<td>Q6</td>
<td>Have the interventions offered by Admiral Nurses improved outcomes at End of Life for people with dementia and their carers?</td>
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<td>Q7</td>
<td>Do Admiral Nurses offer value for money in achieving Health and Social Care targets and legislative requirements?</td>
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1.3 Overview of an Admiral Nurse
Admiral Nurses are registered nurses specialising in dementia. Admiral Nurses work with family carers and people with dementia, in the community and other settings. Working collaboratively with other professionals, Admiral Nurses seek to improve the quality of life for people with dementia and their carers. They use a range of interventions that help people live positively with the condition and develop skills to improve communication and maintain relationships.

Admiral Nurses work holistically with families, addressing the needs of the family carer(s) as well as the Person with Dementia (PWD). Their aim is to empower family carers and encourage problem solving approaches. All Admiral Nurses hold a nursing qualification, are trained to meet the mental health needs of family carers and are able to provide psychological support to avoid crisis and breakdown.

1.3.1 The role has two main functions:
- Clinical casework with carers of people with dementia (PWD). This may be long or short term depending upon need.
- Consultancy work with other professionals.

Nursing interventions are based on a research based stress management model, encompassing carers’ needs which cause or are likely to cause stress. These can be broadly summarised as information needs, emotional support needs and skill needs (coping with problem solving). Admiral Nurses assist, support and empower carers by providing:
- Assessment of physical and mental health of the carer and the PWD and subsequent meeting of those needs identified.
- Enhancing the level of carer understanding in relation to diagnosis, symptoms, behaviours, treatments and approaches to care.
- Facilitating access to professional care and resources available to the carer and PWD.

Admiral Nurses also offer a consultancy role to other professionals by providing:
- Education and training on any aspect of dementia for voluntary groups and professionals.
- Acting as a resource for written and verbal information covering all aspects of dementia care.

1.3.2 The philosophy of the service is:
Carers and family members will cope better if they have a full understanding of the condition of the person with dementia. The Admiral Nurse will therefore provide education, information, advice and support to carers on all issues surrounding dementia care.

The Admiral Nurse:
- believes that there is a need to raise awareness of the needs of people with dementia and their carers’ in order to promote equality and respect for the personhood of those who have dementia and those who care for them.
• will use opportunities to promote these issues within care settings and at a wider level within society.
• will offer education and support within their catchment area and will provide a consultancy service as a nurse specialist.
• believes in the benefit of multi-disciplinary and multi-agency working in the complex field of dementia care.
• will work collaboratively with other disciplines to improve the quality of care for the carer and the person with dementia.
• believes that carers and people with dementia must be respected as individuals. They have a right to confidentiality, dignity and privacy. They also have legal and civil rights under the NHS Constitution (2013) and Human Rights Act (1998) to be treated in a fair, open, honest and flexible manner.
• believes in equality of service provision and acknowledges the diversity of carers. We welcome all carers regardless of age, ethnicity, disability, religion and sexual orientation.

1.4 The National Picture – Dementia and Carers

There are around 800,000 people in the UK with dementia and an estimated 670,000 family and friends acting as primary caregivers to a person with dementia. The current cost to the NHS, local authorities and families is £23bn per year: this is expected to grow to £27 billion by 2018 (Alzheimer’s Society 2012). The Alzheimer’s Society (2012) estimates that carers for people with dementia save the UK over £8 billion per year.


‘The majority of people with dementia are cared for at home by a relative or friend. The average age of (unpaid) family carers is between 60 and 65 years, and many are much older. Caring for a person with dementia can be very different from caring for people affected by other types of illness or disability, because of the complex, unpredictable and progressive nature of the illness. Carers of people with dementia are likely to have higher than normal levels of stress, and report higher levels of depression than carers of other people.’

Further evidence of the need to support carers can be seen within the findings of a report by the Princess Royal Trust for Carers (2011) which found that:

• Two thirds (66%) of older carers have long term health problems or a disability themselves
• One third (33%) of older carers reported having cancelled treatment or an operation they needed due to their caring responsibilities
• Half (50%) of all older carers reported that their physical health had got worse in the last year.
• More than 4 out of 10 (>40%) older carers said that their mental health had deteriorated over the last year.

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It should not be forgotten that some carers of people with dementia are much younger. They could be in a caring role for a parent or grandparent, or caring for a partner who has an early onset dementia prior to the age of 65. This can cause differing issues for the carers that need support in addressing e.g. employment, caring for younger children or accessing education.

1.5 The Norfolk Picture
Data published in Norfolk Dementia Needs Assessment 2010 identified that:

‘Current data predicts increases in the numbers of people being identified with dementia in the future. Due to the ageing population, this will be pronounced in districts with older populations and will also depend on changing ethnic mix of successive ageing cohorts and local and personal socioeconomic circumstances for residents. NHS Norfolk (2010) is estimated to have 11,789 dementia sufferers, rising to 15,590 by 2020. In NHS Great Yarmouth and Waveney, 3,470 current sufferers will rise to 4,603 by 2020 according to the projections used.

Norfolk continues to have a relatively elderly age profile, with around a fifth of the population aged 65 and over (20.8%) and one in ten aged 75 and over (10.1%) (Mid-2008 population estimates, ONS).

People of pensionable age now exceed the under 16s nationally for the first time, though in Norfolk there are currently 1.4 pensioners for every child under 16.

The latest Government (Office of National Statistics, ONS), projections for Norfolk indicate that, based on recent trends, the population would increase from 832,400 in mid-2006 to 1,058,000 in 2031, an increase of over 225,000 (more than a quarter) over the next 25 years.

People aged 65-74 and aged 75 and over would increase by 56.0% and 94.0% respectively by 2031.

Norfolk has a different population age structure compared to England. It has a higher than average proportion of older people in its population compared to the England average. There is also longer life expectancy in Norfolk compared to England. Age is an indicator of the likelihood of developing dementia therefore Norfolk is likely to have a higher incidence of the disease than England as a whole.’

This is demonstrated in the chart overleaf:
A further Norfolk Dementia Health Needs Assessment is currently being undertaken by Public Health which is due for publication in August 2014 and will offer updated demographic data that was unavailable for the purpose of this evaluation.

1.6 National and Local Drivers

1.6.1 The National Dementia Strategy 2009 (NDS): was a response to the challenge that dementia presents to the Health and Social care system and to the widespread recognition that existing services are already inadequate, let alone sufficient to meet that challenge. The strategy identified 17 key objectives to be implemented in all localities.

1.6.2 The Operating Framework for the NHS in England for 2012-13 (2011): clearly reiterates Government’s commitment to implementation of the NDS.

1.6.3 Norfolk Dementia Strategy: ‘Transforming the quality and experience of dementia care for the people of Norfolk. A joint commissioning strategy 2009–2014’ was a response to the NDS; a collaborative local document was produced by Norfolk County Council, NHS Norfolk and NHS Great Yarmouth and Waveney, the Primary Care Trusts (PCT’s) at the time. This focussed on 12 of the objectives from the NDS that related directly to provision of services locally for people with dementia and two that underpinned local action on workforce development and joint commissioning between public sector organisations in order to ensure that dementia services for the future are more ‘person-centred.’
**1.6.4 End of Life Care Strategy (DOH 2008):** identifies the need for the support of family carers. Three key principles that should apply to carers of people approaching the end of life were identified as:

- Carers are central to the team that cares for somebody at the end of life and they should be treated as ‘co-workers’ with the health and social care team;
- Carers have their own needs. Those providing a substantial amount of care on a regular basis are entitled to a community care assessment by their local authority; and
- The condition of the person who is cared for should not affect how the carer is treated, or the services the carer may be able to access.

It went on to identify that:

> ‘It should be recognised that not all carers are family members and that not all family members are carers. Family members may have needs for psychological and social support that are separate from those of the carer or the person who is being cared for. It should also be recognised that the carer’s needs and wishes may conflict with those of the dying person and perhaps the rest of the family and will need to be managed carefully.’

**1.6.5 The Carers Strategy (DOH 2008) envisaged that by 2018:**

- Carers will be respected as expert care partners and will have access to the integrated and personalised services they need to support them in their caring role;
- Carers will be able to have a life of their own alongside their caring role;
- Carers will be supported so that they are not forced into financial hardship by their caring role; Carers will be supported to stay mentally and physically well and treated with dignity.

**1.6.6 The Prime Minister’s Challenge (DOH 2012) identified that:**

> ‘Dementia is one of the biggest challenges we face today – and it is one that we as a society simply cannot afford to ignore any longer. We have made some good progress over the last few years, but there’s still a long way to go.’ As a result NHS England has now set the first ever ‘national goal’ for diagnosis rates, calling for two-thirds (67%) of people with dementia to have a formal diagnosis by March 2015. (Currently the average diagnosis rate in Norfolk is 42% based on figures from 2012-2013 with significant variance within both CCG’s and GP practices).’

**1.6.7 Norfolk’s Health and Wellbeing Board** has identified Dementia as one of the three priorities for the County during 2014-15.
1.6.8 The Care Act 2014
This recently enacted Bill requires fundamental reform of 60 years of care legislation. It sets out the general responsibilities of local authorities towards all people: the well-being principle underpins the entire legal framework with Universal obligations towards all local people:

1. arranging services, facilities or taking other steps to prevent, reduce or delay needs for care and support.

2. information and advice to help people understand the care and support system, access services and plan for the future.

3. promoting diversity and quality in the market of providers so that there are high quality services to meet people’s choices.

There is a requirement to work collaboratively and cooperate with other public authorities, including duty to promote integration with NHS and other services (including housing).

Importantly it includes the first right to support for carers – on the equivalent basis to the people they care for, and with clarity around how meeting those needs may include care directly for the person cared for.
THE ADMIRAL NURSE PILOT

2.1 Scope of Current Service
The service covers the following 7 surgeries in South Norfolk for casework which are:

- Mattishall Surgery (incorporating Lenwade surgery)
- North Elmham Surgery (incorporating Swanton Morley Surgery)
- Orchard Surgery (Dereham)
- Shipdham Surgery
- Theatre Royal Surgery (Dereham)
- Walker- Gregory Practice (Toftwood)
- Watton Medical Practice

There are currently 3 Admiral Nurses working in a defined area within South Norfolk Clinical Commissioning Group (SNCCG).

2.2 Resources
Initially, a Band 7 Admiral Nurse Lead post was created with funding from the Peoples Health Trust and hosted by Age UK Norfolk. This was supported through the partnership that was developed between Age UK Norfolk, Dementia UK and NSFT. The Lead post commenced in April 2013.

Subsequently, NSFT supported the pilot further by providing 1.65 WTE Band 6 nurses in June 2013 which has enabled a casework model to be piloted and they have been committed to the pilot until it comes to an end in April 2015.

2.2.1 Admiral Nurse Lead (Band 7)
The Band 7 role is one of professional navigation acting as Locality Lead responsible for managing and coordinating an inter-agency approach to the management of clients through the cognitive impairment pathway. The Lead has a comprehensive knowledge and understanding of the Norfolk Dementia Strategy, and associated pathways and has formed effective working relationships with all pathway service providers and stakeholders.
The Lead has a strategic overview of dementia services and has clinical input into developing services relating to the provision of support for people with dementia and their carers.

The Lead also acts as clinical lead for the current Admiral Nurse Service and carries out all triage assessments to ensure that clients are accessing the appropriate resource within the dementia pathway.

2.2.2 Admiral Nurses (Band 6)
The Band 6 Admiral Nurses work directly with carers of those with dementia to enable them to navigate through the dementia pathway.

2.3 Access to the Service
The Admiral Nurse Service operates an open referral system. Referrals are welcome from professionals, voluntary organisations and self-referral.

Referrals are triaged by the Admiral Nurse Lead. The following criteria must be met:

- The person cared for has a diagnosis or suspected diagnosis of dementia
- The carer or PWD must live in the pilot area.
- The carer has consented to the referral being made.

2.3.1 Examples of appropriate referral are:
- When there is conflict between the needs and desires of the carer and PWD.
- When the carer has difficulty understanding or coming to terms with the diagnosis.
- When there is emotional support or practical strategies required by the carer.
- When the carer needs practical skill training, information and advice.
- When the carer finds it difficult to make choices or decisions such as: consideration of long term care or acceptance of help.
- When other workers need advice training or support.
- To help the carer make decisions about end of life care.
- When the carer needs help to express choices and needs.
- When there is conflict within the family about the care of the PWD.
- To offer support and guidance at the point of diagnosis.
- To act as an advocate for the carer in liaison with other organisations and services.

2.3.2 Examples of inappropriate referrals:
- Crisis management for PWD—Referrals will be redirected to appropriate resources- e.g. Community Mental Health Teams, Dementia Intensive Support Team, Social Services.
- When the primary need is for the PWD and not the needs of the carer.
- Continuing Healthcare (CHC) Assessments for the PWD.
3.1 Research Design
This evaluation utilised a mixed methods (Tashakkori & Teddlie, 2003) design, which is a procedure for collecting, analysing and ‘mixing’ both quantitative and qualitative data, to understand a research problem more completely (Creswell, 2002). The rationale for mixing is that neither quantitative nor qualitative methods are sufficient by themselves to capture the trends and details of the situation, such as the complex coping mechanisms employed by the carer of someone with dementia and the implication that this has on services. When used in combination, quantitative and qualitative methods complement each other and allow for more complete analysis (Green, Caracelli, & Graham, 1989, Tashakkori & Teddlie, 1998). (For further information regarding methodology see Appendix).

This evaluation utilised a convergent design, where both qualitative and quantitative strands are conducted separately, yet concurrently and merged at the point of interpretation. Equal priority is given to each strand and it ensures a more complete understanding of the impact that the Admiral Nurse Service has had on the families that access support and on the wider medical community.

Whilst this evaluation aims to establish and comment on benefits to both the carers of someone with dementia and the professionals who work with them, it is important to reveal if the benefits are purely therapeutic or if there is a financial or other benefit.

3.2 Research Permission and Ethical Considerations
Ethical issues were addressed during each strand of evaluation. Whilst no formal ethical approval was necessary (i.e. from COREC), the ethical guidelines established by this governing body were followed. Participants were given detailed information on the nature of the evaluation by their Admiral Nurse and the nature of their involvement with the study. They were then given the opportunity not to participate. The nature of the evaluation was re-explained to the carers over the phone prior to completing the semi structured interview. They were given another opportunity to opt out of the investigation. It was made clear to the carers that the support they received from the Admiral Nurses would not alter based on the information they gave, or if they chose not to take part in the questionnaire. In order to increase the evaluation’s objectivity, the information given to the carers was read from a script.
The Researcher was independent from the Clinical Commissioning Groups, Norfolk and Suffolk Foundation Trust and Age UK Norfolk. The Researcher was given an honorary contract with Dementia UK, allowing access to relevant data in order to contact Admiral Nurse service users. This ensured that the evaluation was carried out whilst adhering to the Data Protection Act (1998).

Participants were assigned fictitious names for use in their description and reporting the results. The anonymity of professionals who completed the peer review questionnaire was protected by numerically coding each returned questionnaire and keeping the responses confidential unless they had agreed to be identified. All study data, including the survey electronic files, interview tapes, and transcripts, is stored in locked metal filing cabinets in the Researcher’s office and will be destroyed after a reasonable period of time. Participants will be told that summary data will be disseminated to the professional community, but in no way it will be possible to trace responses to individuals.

3.3 The Role of the Researcher
The Researcher’s involvement with data collection in the two phases of this evaluation is different.

In the qualitative phase, the Researcher conducted the questionnaires by telephone and analysed the data. There is no connection between the Admiral Nurses and the Researcher, and the Carers involved in the study and the Researcher. This ensures that there is a limited potential for bias (Locke, Spirduso & Silverman, 2000).

In the quantitative phase, questionnaires, designed by the Admiral Nurse Lead in collaboration with Norfolk and Suffolk Foundation Trust’s Research and Development Team, were issued to partner agencies including General Practitioners and Social Workers. They were completed anonymously and the role of the Researcher was to analyse the data using rigorous statistical analysis techniques. The results were interpreted based on the established values for the statistical significance of the functions.

3.4 Qualitative Strand
It is important to note that throughout this evaluation, there has been no reference to how advanced in the trajectory the dementia is. This has been a deliberate omission because the Admiral Nurses work with the carers directly and the patient indirectly. Therefore the stage of dementia is academic and almost irrelevant, as it is the carer’s ability to cope with the person with dementia’s condition that fundamentally underpins the type of, and frequency of support that is required and received from the Admiral Nurse. However, when interviewing carers, they would often make reference to their perception of the severity of their loved one’s illness, saying things like:

‘Oh, he’s not that bad at the minute’ (Mrs Smith)

‘She’s gone downhill very quickly over the past few months’ (Mr Jones)
Carer’s seemed to define their role as carer with such statements and often commented on how well or unwell their family member is, followed by a statement about their ability to manage. For example; Mrs Smith went on to say:

‘So we’re doing alright and we’re only seeing her [Admiral Nurse] monthly, which is fine.’

Mr Jones reported;

‘I need and value my time with my worker more than ever.’

As the carers’ ability to cope was seemingly defined by their perception of whether their loved one was at the more advanced stage of dementia or being in the early stages of the illness, these two categories will be used as a method of describing the results of the qualitative strand of this evaluation.

It is essential to highlight that the definition of ‘advanced’ and ‘early’ are by no means medical definitions and each carer, through the course of the interview, naturally allocated themselves to one of these two groups.

3.4.1 Carers of those with more advanced dementia

It was possible to identify a small subgroup of those carers who identified themselves as supporting someone with advanced dementia, and those individuals whose family member had died. This was a small group, consisting of three individuals. Others, whose relative was no longer living in the family home and were instead residing in a care/nursing home, teetered on the edge of this sub group, not as a consequence of their relatives health, but because their caring duties no longer included practical and personal care.

Mr Avery talked about the transition from the marital home to a care home for is wife as:

‘Being traumatic and emotional.’

He described himself as feeling:

‘Very fragile and helpless as he can no longer care for his wife as a husband should do. She [wife] is in a no-man’s land, emotionally and physically. I’m just waiting for her to pass on.’
3.5 Participants
In the qualitative phase of the evaluation, thirty seven carers were asked to participate in a telephone interview. Of these only one chose not to participate and one was not contactable due to an invalid phone number. This was broken down into:

- Twenty three spouses
- Eleven offspring of the patient
- One grandchild of the patient

Thirty three of the people asked were still in a caring role.

In the quantitative phase of the evaluation, twenty-eight percent of the one hundred (100) questionnaires issued were returned; two had to be discarded due to insufficient data. This was broken down into:

- General Practitioners
- Social Workers
- Nurses

The peer review questionnaires were issued to the professionals who use the Admiral Nurse service.

*Chart 1* demonstrates the professional disciplines of those individuals who returned the questionnaires.
The inclusion and exclusion criteria for each strand of the evaluation can be seen in table A.

Table A

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<thead>
<tr>
<th></th>
<th>Inclusion Criteria</th>
<th>Exclusion Criteria</th>
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</thead>
<tbody>
<tr>
<td><strong>Qualitative</strong></td>
<td>1) Clinical assessment completed and an Admiral Nurse allocated to the carer.</td>
<td>1) Clinical assessment completed and no allocation of Admiral Nurse.</td>
</tr>
<tr>
<td></td>
<td>2) Open to the Admiral Nurse service for at least one visit by the Admiral Nurse.</td>
<td>2) Family has not received support from an Admiral Nurse for at least six months prior to data collection.</td>
</tr>
<tr>
<td></td>
<td>3) Meets the criteria for the Admiral Nurse Service (as in section 2.3)</td>
<td></td>
</tr>
<tr>
<td><strong>Quantitative</strong></td>
<td>1) Professionals asked to complete the peer review had to be within the correct geographical area.</td>
<td>1) Those professionals who are not in the geographical area that is entitled to an Admiral Nurse service.</td>
</tr>
<tr>
<td></td>
<td>2) Professionals had to have a good working knowledge of/ had used the Admiral Nurse service.</td>
<td>2) Those professionals who do not work with individuals experiencing dementia or their families were not asked to take part.</td>
</tr>
</tbody>
</table>
4.1 Referrals to the Norfolk service (June 2013–April 2014)

At the time of writing, in excess of 230 referrals have been received by the service since commencement of casework in June 2013.

Dementia Advisors (DA) are employed locally by the Alzheimer’s Society but primarily support the person with dementia. The Alzheimer’s Society has a role of Dementia Support Worker (DSW) to support carers and PWD. Currently, in Norfolk, they are commissioned through a Norfolk County Council contract to deliver Information, Advice and Advocacy and therefore their primary role is not to offer, or have the capacity to offer a 1-1 service for all of those seeking support.

It is arguable that some of the referrals that were received could have been managed by a support worker with good knowledge of dementia care and did not require the input of a specialist nurse, however the current commissioned provision in Norfolk does not offer this service.

Therefore, short term intervention was offered to these cases in order to ensure that there was equity within service provision locally.

Those cases that did meet the criteria for the Alzheimer’s Society services were referred appropriately.

Graph 1 below shows the number of referrals per month from June 2013–April 2014.
There is an ongoing demand for the service and despite being in its infancy, awareness of the service has been raised by promoting the service successfully engaging both professionals and service users.

4.2 Evaluation of Outcomes

4.2.1 Q1: Have Admiral Nurses improved the physical, emotional and mental well-being, of carers for people with dementia?

4.2.1.1 Relationship with the Admiral Nurses
The themes that emerged were different for those carers who considered their family members to be displaying signs of advanced and early dementia, indicating the different needs of the two discreet groups. There was one theme that was consistent in nearly all the participants and this concerned the Admiral Nurses ability to create an empathetic and supportive relationship very quickly.

Phrases such as ‘she [Admiral Nurse] is like a family friend’ and ‘I can tell her [Admiral Nurse] things that I can't tell anyone else’ were used repeatedly, even in examples where contact was monthly and had only occurred a few times.

The service that the Nurses have provided has been a very personal and client-centred service, and this has allowed the carers to feel that they have been listened to and are getting their own needs met. As Mrs Warner stated:

‘They are the only service that is for me. All the other professionals help my husband.’
The very fact is that there are no other services that solely support the carers of dementia patients, and also facilitates a therapeutic relationship between nurse and carer.

### 4.2.1.2 Referral into the service and accessibility

Those carers who categorised themselves as supporting a relative with advanced dementia were often unclear on how they entered services, reporting that “things were a blur” or that they simply ‘weren’t sure: I was at my wits end.’

Consistently, carers reported that their first contact with the Admiral Nurse Service was at a point where they were feeling very stressed and ‘needed extra support.’ For two carers, they described being referred to the Admiral Nurse Service at ‘crisis point.’

Mrs Harris described how her step father is experiencing dementia but her mother is also physically very unwell. Mrs Harris reports how relationships with her siblings are difficult because each sibling has different opinions on how best to support their mother and step-father. Mrs Harris described feeling ‘pulled apart’ and said that ‘juggling appointments is, in itself murder....they [Admiral Nurse] come to my house; it’s a real blessing knowing that I don’t have to go anywhere.’

Mr Jones described being referred by the Community Mental Health Team after his wife made repeated suicide attempts, which he said that he was not coping with. This differs from the responses that were given by the self-defined, early stages group, who could recall how and why they were referred, with all referrals being made by professionals and the majority of these made by GPs ‘just to give a bit of extra support.’

### 4.2.1.3 Improved mental health and empowerment

For those carers in the advanced group, greatest importance seemed to be placed on the counselling role that the Admiral Nurses undertake, closely followed by their wealth of knowledge and experience. The combination of these two key elements seemed to have profound effects on the carers, creating a sense of empowerment and increasing their ability to carry on caring. This finding echoes the results of the cost benefit analysis, which highlights a decrease in services accessed by dementia patients and their carers.

All of the carers in the advanced category talked about valuing their time with their Admiral Nurse:

- **Mr Duffy** reported - ‘I save up all my worries and dump them on [Admiral Nurse] when she comes. She has an impossible job really.’

- **Mrs Crowe** stated that her Admiral Nurse - ‘made life easier. I rely on her quite a bit. I confide in her: personal things. She gives sound advice. She’s saved my mental health.’
• Mrs Livings spoke about the practical help that she receives from her Admiral Nurse, saying that - ‘Before [Admiral Nurse], it felt like it was us against the world, as well as the Government. I am always put on hold or transferred to different departments on the phone. When I phone [Admiral Nurse] she answers straight away. I wonder if she has a special professional’s phone number... I’d tried to get attendance allowance and failed, but she [Admiral Nurse] helped me with the form and got us carer’s allowance too. I didn’t even know that existed.’

• Mrs Livings also talked about the role of the Admiral Nurse in arranging respite - ‘she [Admiral Nurse] liaises with the home and sorts everything out so I don’t have to.’

• Mr Jones, when talking about his wife being detained under the Mental Health Act 1988, said ‘They [psychiatrists] were talking about sectioning her. I didn’t know what that was. Come to think of it, I didn’t know most of what they were saying. Thankfully [Admiral Nurse Lead] explained it. I don’t know what I’d have done without her.’

All the carers were asked what they thought would have happened if they were not supported by the Admiral Nurses, as expected the answers were more emotive for those carers in the advanced group. The initial response to this question was ‘Oh good God. I can’t think about that!’ People felt that they ‘would not be able to cope’ and that ‘things would be done a lot slower and probably the wrong way without her.’

• Mr Oakley said ‘You don’t know how deep the despair goes when caring for someone with dementia. I would not have known what to do. I would have gone to the GP more, with despair and been bloody miserable.’

4.2.1.4 Carer’s description of Admiral Nurses

The qualities that were ascribed to the Admiral Nurses by the carers they worked with were plentiful and all positive. Words like “wonderful” and “amazing” were used repeatedly throughout ninety eight percent of the interviews and a bar chart of the attributes that carers assigned to their Admiral Nurses can be seen below:
Carers were not only asked to tell their stories as part of this evaluation, they were also asked to complete five point Likert scales for the following questions:

1. What has been your overall experience of the Admiral Nurse Service?
2. Do you feel that the Admiral Nurse Service has been useful to you and the person you care for?
3. What impact (if any) do you feel that the Admiral Nurse Service has had for you?

The results of these questions can be seen on the charts below:
4.2.1.5 Negative feedback analysis
Generally the feedback was extremely positive with carers giving ratings of 5 or greater in eighty six percent of cases when describing their overall experience. However, Mrs Henderson described a different experience of the Admiral Nurse Service, which she attributed to her expectations. She reported that she ‘was very grateful that someone came to see me but I was disappointed. I expected more. Having said that, I’m not sure what I did expect.’

Mrs Henderson described the Admiral Nurse that she saw as ‘helpful and understanding and she did her best, but what was she; a support worker, or a nurse? Maybe it would have been better if she’d seen a nurse who specialises in dementia.’

Mrs Henderson went on to say that she ‘was given some leaflets and a phone number but the lady [Admiral Nurse], just said how nice her home was.’ Mrs Henderson had also been seen by a Dementia Advisor and it appeared unclear whether she was indeed referring to the Admiral Nurse.

This highlights the need for a more cohesive approach to supporting people with dementia and their carers to avoid confusion and ensure that they are accessing the correct support at the right time.

Mrs Henderson also said that she had turned down support from a charity, saying that; ‘She and her husband weren’t ready for that yet.’ She did seem to have some regard for the Admiral Nurse Service as she said that she ‘would contact them when things became harder’ and that she hoped ‘my negativity doesn’t mean that the service won’t exist anymore. I wouldn’t want that to happen.’

4.2.2 Q2: Has the presence of Admiral Nurses impacted on diagnosis rates of dementia?

It was identified that from the 112 cases there were 12 cases supported to seek a diagnosis:

• 6 were as a result of carers seeking support due to the issues they were experiencing in caring for a person with a suspected dementia.

• 6 cases were identified as the carer having a dementia which had been undiagnosed.

4.2.2.1 It is also highly likely that the professional liaison role has also led to identifying an increased number of patients that would have otherwise not received a timely diagnosis.

4.2.2.2 Anecdotally it can be stated that many cases have been identified through discussion at GP meetings and through consultation with social workers and primary care workers which have led to referrals being made to mental health services for assessment.
There has been a significant increase in referrals to secondary mental health services from the surgeries covered but due to many variables not all of these can be attributed to the presence of Admiral Nurses and this area could be explored further in the future.

**Q3: Has the presence of Admiral Nurses had a positive impact on other professional’s caseloads, and improved their ability to manage the care of people with dementia and their carers more effectively?**

30% of carers asked, reported that they would not have known how to access support and in order to seek help, they would have made more routine GP appointments for minor ailments.

**Peer review findings**

88% of professionals who returned the peer review questionnaires stated that they had used the service.

- 100% stated that the service was easy to access.
- 94% of professionals said that the contact that they had with Admiral Nurse Service, had improved the confidence in dealing with dementia patients and their carers.
- 92% of professionals reported that they were not aware of a similar provision.
- The 8% who disagreed with this statement reported that they felt that other similar provisions were not to the same professional standard with regards to level of knowledge, expertise and professionalism.

**Reduced contact time**

- 46% respondents stated that the Admiral Nurse Service has reduced contact to their service.
- 34% respondents stated that it had made no difference
- 19% respondents stated that this question was not applicable to their job role.

**HAS USE OF THE AN SERVICE REDUCED THE CONTACT TIME TO YOUR SERVICE BY CARERS AND SERVICE USERS WITH DEMENTIA?**

- % Yes: 46%
- % No: 35%
- % N/A: 19%
Where professionals did consider that a reduction in the service had occurred, data can be analysed further to demonstrate that:

- 60% reduction in contact time with GPs/ Psychiatrists.
- 100% of social workers reported a reduction in contact time
- 16% of nurses reported a reduction in contact time

Dr Neil Ashford Consultant Old Age Psychiatrist, who has given permission for his name and his comments to be used as part of this evaluation, states that:

‘Part of my patch is covered by the Admiral Nurse Service and part is not. I very much miss the availability of the Admiral Nurse Service in that part of my patch that is not covered by the pilot.’

The Manager of the Dementia Intensive Support Team has noted a positive impact on their caseload with fewer community referrals in the Pilot area since the Service commenced. This may well be attributable to the work of the Admiral Nurse Service.

Comments written by professionals were all extremely positive, for example:

‘The Admiral Nurse Service is the most valuable, helpful and reliable service that I and the carers I see have been able to access.’

Dr Ashford commented:

‘One of my roles has been to provide ANs with senior clinical expert advice. As such, I have made few referrals to the AN service, however, it has been clear with my discussions with ANs that they have managed a large number of cases that would undoubtedly led to referral to specialist mental health services were it not for their input and intervention.’

Dr Ashford added:

‘The Admiral Nurse Service has provided rapid and easy access to specialist, highly skilled support for carers of people with dementia.’ He goes on to say, ‘It is absolutely clear that the Admiral Nurse Service should be routinely available as a standard provision to all carers of people with dementia.’

4.2.4 Q4: Have the interventions offered by Admiral Nurses reduced admissions to Acute/Mental Health hospital beds?

4.2.4.1 In many cases there was no other alternative to admission other than Admiral Nurse support. It was identified, using previous risk indicators and client history that 8 admissions to Mental Health inpatient beds have been potentially negated as a result of Admiral Nurse input. Six of these were directly attributable to the support and expertise offered by the Admiral Nurse service, supporting the carer to cope with the PWD increased needs and identifying and minimising potential risk factors that may lead to a mental health crisis.
These interventions therefore, prevented deterioration of the situation and negated the need for a potential admission. Two admissions were negated by engaging the support of the Dementia Intensive Support Team before the situation became untenable.

4.2.4.2 The indirect admission avoidance work that has been carried out as a result of the liaison/advisory role that the Admiral Nurses also perform has not been quantified in this evaluation.

4.2.5 Q5: Have the interventions offered by Admiral Nurses reduced/delayed admissions to Residential and Nursing care for people with dementia?

The Admiral Nurse Lead provided statistics gathered from ongoing service delivery demonstrating that interventions from the team has reduced and delayed admissions. This includes supporting carers to care at home for longer through psychological strategies, practical strategies and supporting end of life at home.

4.2.5.1 Nine cases that required admission to care or nursing placements were planned and therefore enabled to access support in their preferred place of care in a timely manner, not as an immediate or crisis admission.

4.2.5.2 Research demonstrates that there is an increased likelihood of admission to full time care for people with dementia following an acute hospital admission; therefore by preventing the admission there is the potential to delay the need for full time care.

4.2.6 Q6: Have the interventions offered by Admiral Nurses improved outcomes at End of Life for people with dementia and their carers?

Three people with dementia were supported to receive End of Life care at home.

In those instances where the carer's loved one has passed away, the Admiral Nurse can still offer support to the carer. This has been described as ‘a lifesaver... I can't praise her [Admiral Nurse] enough. I can't discuss grieving with my family and she [Admiral Nurse] provides space and time just for me and my thoughts.'

Mrs Thomas gave an amazing and emotional account of her husband's death, which deserves to be told in its entirety:

‘If it wasn’t for the Admiral Nurses, Steve would not have had the perfect death. They knew what to do for him, me and the whole family. We wanted Steve to die at home, not in a hospital where he didn’t belong. She [Admiral Nurse] helped get him home from hospital and talked me through it. The death that is, she told me what it was going to be like and I didn't feel as scared. She showed me how to look after him. All the other nurses would come in do what they had to do and go. She [Admiral Nurse] had time for me and talked to me in a nice way. She treated Steve as if he was part of her family.'
‘When it happened we were all there, all the family sitting round his bed. She [Admiral Nurse] left about half an hour before he passed. My daughter was playing cards and Steve had sleep apnoea, so we had to keep waking him up. My son said, “Mum, dad’s stopped breathing again” and I called his name a few times and touched his shoulder. I was holding his hand with my other hand and I said, “That’s it, he’s passed.” My daughter said “what’s it?” I replied “he’s drifted away.” It was exactly as we’d planned it. I wouldn’t have coped so well afterwards if it hadn’t been such a perfect death’

4.2.7 Q7: Do Admiral Nurses offer value for money in achieving Health and Social Care targets and legislative requirements?

As part of this evaluation, a cost/benefit analysis has been completed of particular factors during the Pilot. Further details of this can be found in Section 5 of the report.

Question seven of the peer review survey also focused on the future development of the service, asking professionals:

- would they use the Admiral Nurse Service again;
- should it be made a permanent service; and
- should the Admiral Nurse Service form part of a standard service for families where one member is experiencing dementia.

The results of this question are conclusive, demonstrating that professionals consider the Admiral Nurse Service as valuable as carers expressed that they do.

This can be seen in the table below:

<table>
<thead>
<tr>
<th>If you have used the AN service do you think you would use it again in the future?</th>
<th>As the AN service is being piloted in Norfolk, is there merit in the service being made permanent?</th>
<th>Do you feel the AN service should form part of standard provision for the future in terms of supporting carers of those with dementia?</th>
</tr>
</thead>
<tbody>
<tr>
<td>92% (8% replied not applicable)</td>
<td>96% (4% replied not applicable)</td>
<td>100%</td>
</tr>
</tbody>
</table>
5.1 Overview
The Cost/Benefit Analysis was carried out in order to determine if the Admiral Nurse Service had a positive financial impact for the health and social care economy.

This was based on the clinical information of one hundred and twelve service users (approx. 50%) of the total cases and considered the following factors:

A. Delay/avoidance of admission to a care home;
B. Delay/avoidance of admission to a nursing home;
C. Delay/avoidance of admission to a general medical ward;
D. Delay/avoidance of admission to an acute mental health ward;
E. Increase in well-being for the person with dementia.
F. Increase in diagnosis of dementia;
G. Delay/avoidance of a referral to Improving Access to Psychological Therapies (IAPT) /Counselling for the carer;

The Cost/Benefit Analysis has been calculated based on the numerical evidence collected by the Admiral Nurse team. It does not consider any indirect savings that were highlighted by carers in the qualitative strand of this evaluation.

The anonymised information was shared with South Norfolk Clinical Commissioning Group to enable tariffs and therefore costs to be attached to the outcomes that were identified.

5.2 A-C. Delay/avoidance of admission to a care home, nursing home and general medical ward

This section captures financial information for categories A-C where intervention(s) by the Admiral Nurse Team prevented or delayed admission to a care home, nursing home or acute hospital.

5.2.1 Excluded data
The data in the following table does not include the indirect admission avoidance work that has been carried out as a result of the liaison/advisory role that the Admiral Nurses also perform.
The costs do not reflect further savings that may have been incurred if the person with dementia was admitted to hospital.

Many of these savings are ongoing as the people with dementia continue to be cared for in their own home with the support of family carers and community based services and have not been included.

**5.2.2 Savings - Delayed Admission/Admission Avoidance**

The following table demonstrates the direct savings of £426,601 that were identified as a result of admission avoidance/delayed admissions to residential /nursing care homes and acute hospital admissions between June 2013 and April 2014.

**Admission Avoidance – Acute**

Total savings of £63,074 due to early identification of chest infections, urinary infections, management of non-specific conditions, falls and end of life without the need for admission to hospital.

**Delayed/Avoided Admission – Care Home**

Total savings of £303,207 due to delayed admission and admission avoidance.

**Delayed/Avoided Admission – Nursing Home**

Total savings of £39,560 due to delayed admission to nursing home.

**Continuing Health Care**

Total savings of £20,760 where alternative support was implemented to meet the needs of the patient and carer.

**Savings between June 2013 - April 2014**

<table>
<thead>
<tr>
<th>Category of Prevented/Delayed Admission</th>
<th>Gross Saving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Avoidance</td>
<td></td>
</tr>
<tr>
<td>3x End of Life (EOL)</td>
<td>£9,948</td>
</tr>
<tr>
<td>Urinary Tract Infection (UTI)</td>
<td>£3,066</td>
</tr>
<tr>
<td>2x General Acute</td>
<td>£4,822</td>
</tr>
<tr>
<td>10x Collapse</td>
<td>£11,550</td>
</tr>
<tr>
<td>Falls</td>
<td>£2,518</td>
</tr>
<tr>
<td>2x General Acute</td>
<td>£4,822</td>
</tr>
<tr>
<td>2x UTI</td>
<td>£5,750</td>
</tr>
<tr>
<td>2x Delirium</td>
<td>£6,132</td>
</tr>
<tr>
<td>2x General Acute</td>
<td>£4,822</td>
</tr>
<tr>
<td>2x General Acute</td>
<td>£4,822</td>
</tr>
<tr>
<td>2x General Acute</td>
<td>£4,822</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>£63,074</strong></td>
</tr>
</tbody>
</table>

Table continues over page
<table>
<thead>
<tr>
<th><strong>Delayed Admission – Care Home</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Home (1 week)</td>
<td>£633</td>
</tr>
<tr>
<td>Care Home (2 weeks)</td>
<td>£1,266</td>
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<tr>
<td>Care Home (2 weeks)</td>
<td>£1,266</td>
</tr>
<tr>
<td>Care Home (8 weeks +)</td>
<td>£5,064</td>
</tr>
<tr>
<td>Care Home (8 weeks +) acute admission x 2</td>
<td>£5,064</td>
</tr>
<tr>
<td>UTI – calculated in Admission Avoidance Section</td>
<td></td>
</tr>
<tr>
<td>Care Home (9 weeks)</td>
<td>£5,697</td>
</tr>
<tr>
<td>Care Home (13 weeks +)</td>
<td>£8,229</td>
</tr>
<tr>
<td>Care Home (13 weeks)</td>
<td>£8,229</td>
</tr>
<tr>
<td>Care Home (13 weeks) + acute admission x 2 – as above</td>
<td>£8,229</td>
</tr>
<tr>
<td>Care Home (14 weeks +)</td>
<td>£8,862</td>
</tr>
<tr>
<td>Care Home (18 weeks +)</td>
<td>£11,394</td>
</tr>
<tr>
<td>Care Home (16 weeks +)</td>
<td>£10,128</td>
</tr>
<tr>
<td>Care Home (18 weeks +)</td>
<td>£11,394</td>
</tr>
<tr>
<td>Care Home (18 weeks +) acute admission x 2 – as above</td>
<td>£11,394</td>
</tr>
<tr>
<td>Delirium as above</td>
<td></td>
</tr>
<tr>
<td>Care Home (19 weeks)</td>
<td>£12,027</td>
</tr>
<tr>
<td>Care Home (19 weeks +)</td>
<td>£12,027</td>
</tr>
<tr>
<td>Care Home (22 weeks +)</td>
<td>£13,926</td>
</tr>
<tr>
<td>Care Home (24 weeks +)</td>
<td>£15,192</td>
</tr>
<tr>
<td>Care Home (26 weeks) + acute admission x 2 – as above</td>
<td>£16,458</td>
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<tr>
<td>Care Home (25 weeks +)</td>
<td>£15,825</td>
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<tr>
<td>Care Home (28 weeks +)</td>
<td>£17,724</td>
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<td>Care Home (28 weeks +)</td>
<td>£17,724</td>
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<tr>
<td>Care Home (32 weeks +)</td>
<td>£20,256</td>
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<td>Care Home (33 weeks)</td>
<td>£20,889</td>
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<tr>
<td>Care Home (33 weeks +)</td>
<td>£20,889</td>
</tr>
<tr>
<td>Care Home (37 weeks +) acute admission x 2 as above</td>
<td>£23,421</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>£303,207</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Delayed Admission – Nursing Home</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Home (13 weeks) EOL – as above</td>
<td>£11,180</td>
</tr>
<tr>
<td>Nursing Home (16 weeks) EOL – as above</td>
<td>£13,760</td>
</tr>
<tr>
<td>Nursing Home (17 weeks)</td>
<td>£14,620</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>£39,560</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Continuing Health Care</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 1 Care Halted @ £2,590 per week reduced to £860 for 12 weeks</td>
<td>£20,760</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>£20,760</strong></td>
</tr>
</tbody>
</table>

**Grand Total**  
£426,601
Qualifying Statement:

‘I can confirm that I have calculated the average costs using the actual prices paid within South Norfolk for the year 13/14. These average costs may not apply in all circumstances but have been applied using our best understanding of the information available, quantifying a saving for the Admiral Nurse Pilot. The quantified saving does not take into account other costs associated with change in service and does not reflect the net gain to the CCG, but expresses the gross savings on avoided admissions’

Sebastian Foster, Business Intelligence Analyst for South Norfolk CCG

5.3 D. Delay/avoidance to an acute mental health ward

It was identified, using previous risk indicators and client history that 8 admissions to Mental Health inpatient beds have been potentially negated as a result of Admiral Nurse input.

Six of these were directly attributable to the support and expertise offered by the Admiral Nurse Service, supporting the carer to cope with the PWD increased needs and identifying and minimising potential risk factors that may lead to a mental health crisis. These interventions therefore, prevented deterioration of the situation and negated the need for a potential admission.

Two admissions were negated by engaging the support of the Dementia Intensive Support Team before the situation became untenable.

Tariff costs are not currently available to provide details of monetary savings.

5.4 E. Increase in Well-being Person with Dementia

Within at least 45 of the 112 cases there was increased well-being for the person with dementia. It is arguable that management of these areas of patient care are likely to reduce the need for premature admission to care and minimise the risk of crisis and its associated costs.

Influencing factors were:

- Achieving diagnosis and then treatment when appropriate
- Better relationships with their families /carers
- Access to treatment for co-morbidities
- Access to social support
- Ability to remain at home for longer
- Preferred place of care at End of Life

5.5 F. Increased Diagnosis Rates

As described in point 4.2.2 there were 12 cases supported to seek a diagnosis.

Of these, 50% were as a result of carers seeking support due to the issues they were experiencing in caring for a person with a suspected dementia and 50% were identified as the carer having a dementia which had been undiagnosed.
Dr Ashford commented:

‘On occasions they (ANs) have identified people in need of specialist mental health services, people who might otherwise have gone undiagnosed or untreated.

This spin-off impact of the AN Service makes an important contribution to National and Local targets to increase diagnosis rates.’

It is also highly likely that the professional liaison role has also led to the identification of an increased number of patients who would otherwise have not received a timely diagnosis.

The Admiral Nurse Service is assisting in achieving national targets.

5.6 G. Avoidance of referral to Improving Access to Psychological Therapies (IAPT)/Counselling.

Twelve (12) cases were identified that would have resulted in carers being referred to IAPT or Counselling without the intervention of an Admiral Nurse.

Due to the nature of how this service is commissioned, using a block contract, it is difficult to offer exact cost savings. However, a report by NIHR CLAHRC (2011) states that:

‘The average estimated cost for a course of exclusively low intensity treatment was £493 and fluctuated between £313 (Suffolk PCT) and £901 (North & East Hertfordshire PCT). The estimated cost of a single course of high intensity treatment was £1,416 and ranged from £987 (Suffolk PCT) to £1,793 (West Hertfordshire PCT).’

It could be assumed that based on these figures, average savings of between £5,916 and £16,992 would have been achieved.

5.7 Additional benefits and potential savings of the Admiral Nurse Service.

• Eight cases were identified as being likely to escalate to Safeguarding without intervention from Admiral Nurse Service. Savings would be achieved in both Health and Social Care resources, depending on the source of the referral.

• Three people with dementia were supported to receive End of Life care at home.

• Nine cases that required admission to care or nursing placements were planned and therefore enabled to access support in their preferred place of care.
• Due to the presence of Admiral Nurses in Norfolk calls to the national Admiral Nurse DIRECT phone line have increased since implementation of the pilot project. For the Norfolk area, in the three year period 2010 - 2013 there were 28 contacts, on average 9.3 contacts per year. In the 10 month period June 2013 to end April 2014 there were 57 contacts (27 of those coming in January - April 2014 alone.) demonstrating a 760% increase in contacts this year. This demonstrates that awareness of the Service has increased and the National Phone Line is enabling those outside the pilot area to access specialist help and advice.

• All appropriate cases were introduced to the concept of Advanced Care Planning (ACP). This reduces the likelihood of unplanned admissions to acute and nursing care.

• Seventy five percent (75%) of carers made reference to experiencing low mood, depression and anxiety symptoms, as well as an inability to cope with their situation prior to input from the Admiral Nurses. This potentially could have led to these individuals accessing secondary care mental health services.

• Co-facilitation of End Of Life and Dementia Training with Norfolk Community Health and Care (NCH&C) palliative care staff. Cost neutral, additional expertise is offered.

• Specialist signposting for health, social care and voluntary sector employees on all aspects of dementia care and supporting carers.

• Participation in operational and strategic boards to improve outcomes for people with dementia and their carers.

• Integrated working across health, social care and voluntary services to improve outcomes for Organisations, PWD and carers.

• A potential reduction in medication costs as a result of the Admiral Nurse involvement both for the carer and the person with dementia as a result of therapeutic interventions as opposed to medical intervention. This area would require more research to validate the statement.
CONCLUSION

6.1
The evaluation has proved that the Admiral Nurse Service has had a positive impact on the seven key areas that were investigated (section 1.2).

It has demonstrated that the success of the Admiral Nurse Service is multifaceted:

- professionals rate the service as “excellent and vital” (GP),
- it provides much needed appropriate support and is a “life line” to carers,
- it has the potential to create savings for both Health and Social Care.

6.2
The Admiral Nurse Service is highly valued, but it is not currently commissioned, and this was highlighted by a GP who said that:

‘It is sometimes difficult to remember that the Admiral Nurse Service should be an additional service not the only service provision.’

6.3
Carers mirrored the above, by stating that it would have been better if they could have accessed support prior to reaching crisis point. Therefore it would be hoped that if this service is to be commissioned in the future these carers would be able to access support earlier and minimise the risk of a crisis occurring. It was noted that as this is a pilot service provision many of the carers had been caring for some time before they received support.

During the process of this evaluation, many individuals have commented on their experiences of the Admiral Nurse Service, which has been evaluated to be an exceptional service, where professional, expert knowledge, delivered in a sensitive, empathic manner has enabled carers to continue caring through the ‘despair’ and ‘traumatic experiencing of caring’ to help them ‘rebuild emotional reserves’ and allow for ‘a perfect death’.
Those carers who considered that their relative was not suffering from an advanced dementia, talked about using the Admiral Nurses as a “safety net.” How, and if the Admiral Nurse Service is developed, was not the remit for this evaluation however this raised the question of whether it is necessary that this safety net is managed by a Band Six Practitioner. If an unqualified practitioner/support worker was used for this role, then there could be an increase in the volume of carers who needed more intensive level of support, being seen by the qualified members of staff.

6.4
The Admiral Nurse Service does not, however, just benefit service users and front-line professionals, it is also a cost effective service.

It has been clearly identified by professionals that there is a benefit to them both in terms of increased confidence and competence, and by reducing their workloads. At a time when both GP’s and Social Work colleagues are struggling to cope with the increased demands upon them it could be argued that a robust Admiral Nurse Service could reduce caseloads further and enable professionals to work more efficiently when they are managing the care of people with dementia and their carers.

Evidence also suggests that if an Admiral Nurse Service is commissioned that this would increase confidence to diagnose those with a suspected dementia. A survey carried out by the Norfolk and Suffolk Dementia Alliance in 2013 found that one of the key concerns when considering diagnosis was the lack of easily accessible relevant post-diagnostic support for people with dementia and their carers. The evaluation has confirmed that this service is considered accessible and that there is no equivalent service available. The need to increase diagnosis rates as set out by NHS England, will be more achievable with this service in place.

The Admiral Nurse Service Pilot has evidenced savings to the health and social care economy of £426,601 and has effectively demonstrated that gold standard clinical care does not have to create a financial deficit. It must also be recognised that sizeable savings to the system are not attributed in monetary terms.

Total costs to set against savings cannot be fully quantified at the time of this report. Current funding information for Year One is as follows: The Peoples Health Lottery via Dementia UK supplied £60,000 of funding to Age UK Norfolk and NSFT allocated funding for 1.65 WTE Band 6 nurses from current budgets.

6.5
The current service provision is in its infancy and has already demonstrated that significant savings and benefits can be achieved by supporting families/carers of dementia. By implementing the Service to meet policies, (both national and local) alongside assessing the need locally there are key elements that have been identified that should inform future service development.

A revised dementia pathway, and Admiral Nurse resources within this, will require further investigation. One Band Seven and two Band Six nurses (1.65WTE) have achieved outstanding results throughout the Pilot, and if the service is to continue providing excellent care, resourcing needs of the service need to be determined.
**Methodology and procedure**
A mixed methods approach allows the researchers to build knowledge on pragmatic grounds (Creswell, 2003; Maxcy, 2003) asserting truth is ‘what works’ (Howe, 1988). A mixed methods evaluation requires the consideration of three issues: priority, implementation, and integration (Creswell, Plano Clark, Guttman, & Hanson, 2003). Priority refers to which method, either quantitative or qualitative, is given more emphasis in the study. Implementation refers to whether the quantitative and qualitative data collection and analysis comes in sequence or in chronological stages, one following another, or in parallel or concurrently. Integration refers to the phase in the research process where the mixing or connecting of quantitative and qualitative data occurs.

This evaluation utilised a convergent design, where both qualitative and quantitative strands are conducted separately yet concurrently and merged at the point of interpretation. Equal priority is given to each strand and it ensures a more complete understanding of the impact that the Admiral Nurse Service has had on the families that access support and on the wider medical community.

**Data Collection - Qualitative Strand**
The qualitative strand of the evaluation focuses on identifying the value that carers place on the service that they receive from the Admiral Nurses. This was achieved using a cross-sectional survey design, where the data collected at one point in time (McMillan, 2000), was used. The primary technique for collecting the quantitative data was a self-developed questionnaire for use in a semi-structured telephone interview, containing items of different formats: self-assessment items, measured on a 5-point Likert scale, and open-ended questions. A panel of professionals representing different organisations (e.g.: Norfolk and Suffolk Foundation Trust. Age UK) was used to secure the content validity of the survey instrument. The questionnaire consists of nine questions plus Likert scales that asked the participant to consider the level of impact and the nature of the service provided by the Admiral Nurse team. The survey also aimed to establish how the coping mechanisms employed by the carer would differ if they had not received a service from the Admiral Nurse team.
Carers Interview Script
(Information for the interviewer please read before making the call):

Remember not to reword the questions so that they are leading to the interviewee. We need to make sure we obtain as honest opinions as possible.

Before you start interviewing please explain that we are asking questions as part of a Service Evaluation of the Admiral Nurse Service. Remind the interviewee that we will be recording what they say and that information given may be used (as anonymous quotes) as part of our final evaluation. If they would like something not recorded they are able to request that a record is not made of that part of the conversation.

Participant ID __________________________ Date ________________ Time ____________

1) Please tell us how you/why you made contact with the Admiral Nurse Service

2) What has been your overall experience of the Admiral Nurse Service?

3) Do you feel that the Admiral Nurse Service has been useful to you and the person you care for – can you tell us why?

4) What impact (if any) do you feel the Admiral Nurse Service has had for you?

5) Have you had access or made any other contact to other services to support you? If so can you tell us which services and what impact they had for you?

6) Did the Admiral Nurses identify any further services for you to access?

7) Can you tell us how (if at all) the Admiral Nurse was different from other help and support you have received?

8) Do you have any further comments about the Admiral Nurse Service?

Quantitative Strand
The quantitative strand of the evaluation focuses on identifying the usefulness of the Admiral Nurse Service as deemed by professionals. A cross-sectional survey design was again used and consisted of an anonymous questionnaire that used both: dichotomous and open ended questions. There were sixteen questions in total, which were separated into five categories, asking for professional opinions on accessibility of the service, providing information, the patients’ views on the service, the impact of Admiral Nurses and whether or not the professional would use the service again.

Paper Feedback Form
The paper feedback form can be found over the following three pages.
Admiral Nurse – Service Evaluation

Peer Feedback

We would like to invite you to provide feedback on the Admiral Nurse Service. This information will be used as part of an evaluation of the service. Your honest opinion is really valuable to us. All feedback will remain anonymous and we may use quotes as part of our final report.

If you would not like your questionnaire feedback to be directly quoted please tick this box ☐

This questionnaire should take less than five minutes to complete.

1) Service Use

Please state your profession ________________________________

Have you used the Admiral Nurse service?

What did you use the AN service for? Advice, referral etc.

2) Accessibility

Did you find the service easily accessible?

What was the approachability and responsiveness of the service?

3) Dealing with Dementia

Do you feel more capable or confident in accessing support and identifying the needs of people with dementia and their carers?

Did the AN service contribute at all to the answer above and if so how?
4) The AN service and the people that access it

Have you received feedback from patients/service users who have accessed the AN service?

If yes please describe some of the feedback you have received.

What kind of impact (if any) do you feel that the AN service has had for people with dementia and their carers?

5) Service Provision

Do you feel that the services provided by the Admiral Nurses could also be obtained elsewhere?

If Yes please let us know where:

6) The direct impact of AN on your service
7) Looking Ahead

If you have used the AN service do you think you would use it again in the future?

As the AN service is being piloted in Norfolk do you think that there is merit in the service being made permanent?

Do you feel the AN service should form part of standard provision for the future in terms of supporting carers of those with dementia? (Please expand if possible with reasons why you have answered as you have).

8) Anything else?

Please provide any further feedback or thoughts you have about the AN service here.

Thank you for your time.
Data Analysis

The return rate on the peer questionnaires was too low to allow for statistical analysis: twenty eight of one hundred questionnaires were returned and two of these had to be discarded because of insufficient data. If a statistical analysis of the data had been carried out, type 1 or type 11 errors would have occurred. Had the return rate been better, a X2 analysis would have been used to demonstrate trend, or a Mann-Whitney U test (with correction for ties) would have been an appropriate analysis to use. It is the intention of the researcher to re-administer the peer review questionnaires and analyse the data at a later date.

The returned questionnaires were still useful and allowed for a simple break down of the data to create percentage values whilst considering the impact of the Admiral Nurse Service on professionals and the views on whether or not the service should continue.

Validity

In quantitative research, reliability and validity of the instrument are very important for decreasing errors that might arise from measurement problems in the research study. Validity refers to the degree to which a study accurately reflects or assesses the specific concept or construct that the researcher is attempting to measure (Thorndike, 1997). Content, criterion-related, and construct validity of the survey instrument were established. Content validity shows the extent to which the survey items and the scores from these questions are representative of all the possible questions. The questionnaires have been examined by a panel of professionals involved with the commissioning of Admirals Nurses.

Criterion-related validity, also referred to as instrumental or predictive validity, is used to demonstrate the accuracy of a measure or procedure by comparing it with another measure or procedure, which has been demonstrated to be valid (Overview: Reliability and Validity, 2001). For this purpose, the qualitative data derived from the carer and professional questionnaires will be compared.

Construct validity seeks agreement between a theoretical concept and a specific measuring device or procedure. To achieve construct validity, factor analysis of the Likert type survey items was performed. Factor loadings for survey items will show a correlation between the item and the overall factor (Tabachnick & Fidell, 2000). Ideally, the analysis should produce a simple structure, which is characterized by the following: (1) each factor should have several variables with strong loadings, (2) each variable should have a strong loading for only one factor, and (3) each variable should have a large communality, i.e. e. degree of shared variance (Kim & Mueller, 1978).
**Qualitative Data Collection**

The multiple case studies design (Stake, 1995) was used for collecting and analysing the qualitative data. A case study is a type of ethnographic design (Creswell, 2002; LeCompte & Schensul, 1999) and is an exploration of a “bounded system” or a case over time, through detailed, in-depth data collection involving multiple sources of information and rich in context (Merriam, 1988; Creswell & Moittta, 2002). In this investigation, the instrumental multiple cases (Stake, 1995) will serve the purpose of “illuminating a particular issue” (Creswell, 2002, p. 485), such as how Admiral Nurses supported the carers when their loved one was dying.

The primary technique will be conducting in-depth semi-structured telephone interviews with the carers of someone from dementia. Triangulation of different data sources is important in case study analysis (Creswell, 1998). The Likert scales and data from the peer reviews will be used to validate the case studies.

**Data Analysis**

In the qualitative analysis, data collection and analysis proceed simultaneously (Merriam, 1998). In the qualitative phase of the evaluation, the verbal data obtained through semi structured interviews was coded and analysed for themes.

The steps in qualitative analysis included: (1) preliminary exploration of the data by reading through the transcripts and writing memos; (2) coding the data by segmenting and labelling the text; (3) using codes to develop themes by aggregating similar codes together; (4) connecting and interrelating themes; and (5) constructing a narrative (Creswell, 2002).

**Establishing Credibility**

The criteria for judging a qualitative study differ from quantitative research. In qualitative design, the researcher seeks believability, based on coherence, insight, and instrumental utility (Eisner, 1991) and trustworthiness (Lincoln & Guba, 1985) through a process of verification rather than through traditional validity and reliability measures. The uniqueness of the qualitative study within a specific context precludes it’s being exactly replicated in another context. However, statements about the researcher’s positions – the central assumptions, the selection of informants, the biases and values of the researcher – enhance the study’s chances of being replicated in another setting (Creswell, 2003).

To validate the findings, i.e., determine the credibility of the information and whether it matches reality (Merriam, 1988), three primary forms will be used when considering the data obtained from the semi structured interviews: (1) member checking – getting the feedback from the participants on the accuracy of the identified categories and themes; (2) providing rich, thick description to convey the findings; and (3) external audit – asking a person outside the project to conduct a thorough review of the study and report back (Creswell, 2003; Creswell & Miller, 2002).
REFERENCES


Fox, Margaret (2013) DEMSTART Survey Hub: GP Audit to understand the low dementia diagnosis rate in Norfolk and Suffolk. Norfolk and Suffolk Dementia Alliance


Kember, D. (1989b). An illustration, with case-studies, of a linear process model of drop-out from distance education. Distance Education, 10 (2), 196-211.


Princess Royal Trust for Carers (2011) Always on call always concerned a survey of the experiences of older carer’s .Princess Royal Trust for Carers.


