

Internationally and locally, the impact of dementia is increasing within primary care. GPs must now become actively involved in addressing the growing challenges presented to us on a regular basis by dementia. Internationally, dementia contributes more years lived with disability than stroke, musculoskeletal disorders, or heart disease. Nationally, dementia costs state health and social care systems more than stroke, heart disease, and cancer combined.¹ Regionally, many areas are experiencing the challenge of providing locally-responsive services which can cater for the rising prevalence of dementia, within the objectives of the National Dementia Strategy.² And, at a primary care level, it is well established that GPs still have many barriers to pursuing a diagnosis for their patients and, possibly more importantly, feel that they lack the skills and knowledge to be able to manage the problems these patients present to them on a day to day basis.³ This perceived shortcoming in management is apparently supported by measurement of our performance at dementia annual reviews.⁴

Furthermore, many GPs are realising that specialist and social care services are often over-stretched and voluntary or community sector services may not cater for all of the needs of our patients.⁵ This realisation only serves to reinforce the therapeutic nihilism many of us cite as the main reason for delaying or avoiding pursuing a diagnosis in the first place. However, 'head-burying' has now become a much less satisfactory response for several reasons:⁶ first, in the UK GPs are now expected to become actively involved with commissioning services; and second, dementia now features in the Quality and Outcomes Framework which is firmly embedded in primary care.

Further uncertainty among GPs lies in the mystique of the diagnosis itself. Who makes it and where are the subjects of much debate as commissioners look for greater cost-effectiveness and accountability. There is no single test and many GPs feel uneasy about 'labelling' their patient without confirmation by specialist services, and sometimes even that confirmation is uncertain. This debate is beyond the scope of this editorial, but the diagnosis ought to be a means to an end rather than an end

itself, and even without it we should still be able to support our patients.

INCREASING GP EXPERTISE IN DEMENTIA CARE

Despite our lack of confidence there remains hope for dementia care within general practice. Moving dementia away from mental health and into primary care is logical, both to reduce any perceived stigma and also to place it alongside other chronic, progressive conditions which we manage on a regular basis already. Most of the support that people with dementia and their carers and family need is not difficult to provide even if we cannot simply prescribe. Primary care dementia education strategies, designed to inform management and promote more timely diagnosis, are helping to generate a sea change of attitudes towards dementia which is a step in the right direction.

However, it is not sufficient for us to be simply handed dementia and expected to get on with it. Increasingly in primary care we are being asked to become more expert in managing many areas of medicine in an attempt to reduce secondary care costs. If we are also to take on dementia we should feel adequately supported and invested in, which is likely to require a change of commissioning strategy.

NEW APPROACHES: ADDRESSING THE CARE VACUUM

Considering all these factors there is one solution which offers a lynch-pin to hold together dementia care: the state provision of a locally-designed and genuinely proactive community support service for people with dementia and their carers and families. The role, or roles, underpinning this service may be that of dementia adviser or admiral nurse, or may adapt an existing role, such as practice healthcare auxiliary or local community mental health nurse.

From the perspective of patients with dementia, or patients who care for someone with dementia, this solution offers a significant improvement in support during the period between diagnosis and first or subsequent crisis — which a person with dementia succinctly described to me as a 'care vacuum' — and can facilitate the forward planning which is so important in the early stages of the dementia journey.

For commissioners this role offers a locally adaptable opportunity to improve dementia services which, importantly, offers cost-effectiveness. Working relationships between primary and secondary care services can be strengthened and coordinated more effectively. From a primary care perspective the provision of such a service directly challenges that therapeutic nihilism, and benefits us through opportunistic education, attendance at primary care meetings, and even the potential for assistance with the pre-diagnosis work up.⁷

COSTING THE BENEFIT

When we take this opportunity we must be careful not to waste it. In many parts of the UK dementia support services already exist and are welcomed by health and social care staff as much as people with dementia and their carers and families. While there is plenty of emerging qualitative evidence, what is often lacking is robust quantitative data which is so crucially important in ensuring the longevity of a new service. The evidence for potential financial savings elsewhere in the system is growing, both in the UK⁸⁻¹⁰ and internationally,¹¹ but we must make sure that any such service is commissioned for a sensible period of time, and that any patient events that might have a price attached to them are rigorously measured. For example, the UK Department of Health estimated in 2008 that if a new service led to a 10% reduction in care home placements for people with

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dementia then it would take that service 4 years to be cost-neutral,¹² not the 1 or 2 years that most pilots currently run for.

Reduced carer stress through support, and better management of behavioural problems, may maintain people in their own homes for longer but there are other potential fiscal benefits which should not be missed, such as lower acute hospital admission rates, shorter hospital bed occupancies, reduced need to refer to specialist services, and reduced or safer anti-psychotic prescribing. If community dementia support is commissioned, and

these benefits can be adequately demonstrated, then the future of better dementia care in the primary care setting is secure.

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Provenance

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REFERENCES

1. Knapp M, Prince M. *Dementia UK*. London: Alzheimer's Society, 2007.
2. Greaves I, Jolley D. National Dementia Strategy: well intentioned — but how well founded and how well directed? *Br J Gen Pract* 2010; **60(572)**: 193–198.
3. Ahmad S, Orrell M, Iliffe S, Gracie A. GPs' attitudes, awareness, and practice regarding early diagnosis of dementia. *Br J Gen Pract* 2010; **60(578)**: 360–365.
4. Connolly A, Iliffe S, Gaeht E, *et al*. Quality of care provided to people with dementia: utilisation and quality of the annual dementia review in general practice. *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X625148.
5. Cartmell N. *NHS Devon: report on the GP education programme*. Exeter: NHS Devon, 2011.
6. Iliffe S, Manthorpe J. Dementia: still muddling along? *Br J Gen Pract* 2007; **57(541)**: 606–607.
7. Cartmell N, Bardsley D. *An evaluation of dementia support worker roles*. Taunton: South West Dementia Partnership, 2011.
8. Clifford J, Theobald C, Mason S. *The Princess Royal Trust for Carers: social impact evaluation using social return on investment*. London: The Princess Royal Trust for Carers, 2011.
9. Alzheimer's Society. *Support, stay, save*. London: Alzheimer's Society, 2011.
10. All Party Parliamentary Group on Dementia. *The £20 billion question — an inquiry into improving lives through cost-effective dementia services*. London: Alzheimer's Society, 2011.
11. Weimer D, Sager M. *Early identification and treatment of Alzheimer's disease: social and fiscal outcomes*. *Alzheimers Dement* 2009; **5(3)**: 215–266.
12. Department of Health. *Transforming the quality of dementia care: consultation on a National Dementia Strategy*. http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Consultations/Closedconsultations/DH_085570 (accessed 16 Jan 2012).