Over 75 Frail Elderly Project

Elderly Care Facilitators

North Staffordshire CCG
Newcastle under-Lyme South Locality Group
Elderly Care Facilitator

New

Your foundation – for anything
Overview

1. A proactive approach

2. The Elderly Care Facilitator (ECF) offers improved care and support to older people

3. A GP Practice is in a unique position to contact and engage patients

4. Practice based, but the work is not GP based

- Support healthy ageing
- Early intervention in older people
- Assess needs
- Raise awareness of existing local services
- Help access these services
- A defined population, an accurate database of medical and social information and high levels of patient goodwill.
- Accessible to local services, other health professionals, social support and voluntary groups
- GPs do not have the time.
Where it started

- Pilot Project, single Surgery, 2012
- 24 months, April 2013 to April 2015
- Budget £90,000, cost £70,000
- Our sponsors:

  Daiichi-Sankyo
  Passion for Innovation. Compassion for Patients.

  Staffordshire Community Foundation
  Bishop Stamer Fund

  NHS North Staffordshire Clinical Commissioning Group

Total population of 6 Practices: 37,303

- 85+ years + dementia + housebound
  Total number: **785** (2%)

- 75-84 years
  Total number: **2,624** (7%)

- < 75 years
  Total Number: **33,894** (91%)

Nursing home residents excluded because part of a separate local scheme
Aims of the project

**Proactive assessment and intervention**

- Develop an effective screening system with high uptake.
- Identify most common problems.
- Identify carers and offer them support.

**New ways of working**

- Develop role of Practice based coordinator of elderly care services.
- Maximize inter-agency working.

**Positive outcomes**

- Reduce unplanned OOH contacts, A&E attendance and hospital admissions.
- Increase benefit claims.
- Access local support.

**Learn lessons for future roll-out**

- Identify local resources for the elderly and extend professional and public knowledge of these.
- Assess medical and social benefits, referrals and workload involved.
- Clarify the workload and costs involved.
Approach to the two cohorts

Cohorts

A. Patients aged over 85 years old, those with dementia and the housebound

B. Patients age 75 to 84 years

Approach

• All offered a pre-arranged home visit.
  – An assessment of health and social issues, plus advice on benefits and legal issues.
  – Where possible a carer or next of kin is present.
  – Action points are agreed at the visit.
  – Letter sent to patient post-visit

• Post a Tilburg self-assessment questionnaire and information on local elderly health and social/community services.
• Returned questionnaire provides information on individual health, social, and functional ability.
• Scored – is a visit is required?
• If visit required, then same process as 85+ cohort
IDENTIFY PATIENTS using EMIS Web search OVER 85, HOUSEBOUND and DEMENTIA

CONTACT PATIENT and CARER / Next of Kin on the telephone to arrange “ELDERLY HEALTH ASSESSMENT”

Carry out assessment using “ASSESSMENT CHECK LIST” and visit pack to identify patient’s PROBLEMS and RISKS

Feedback to GP

Do the necessary REFERRALS

Follow up with a LETTER to confirm appointment

WRITE A LETTER TO THE PATIENT CLARIFYING ACTION POINTS
Project approach

1. Practice coordinator, Practice nurse or care worker organises questionnaires, visits, assessments and action plans.

2. Promote multi-professional and inter-agency working, with a wide range of partners.

3. No requirement for direct **GP** involvement unless follow up actions required.

3. Person and carers at the centre of the team, in control and make decisions.
Central role of Elderly Care Facilitators

Assess, communicate, educate.

Support self-care.

- Accessible bridge between patients, carers, health professionals, social support, and voluntary groups.
- A diversification in the Primary Care workforce, informally working together.
Activity: Over 85 years visits

Range: 88%, 100%, 99%, 93%, 35%, 100%

Why not 100%?
The results: Over 85 years referrals

<table>
<thead>
<tr>
<th>Service</th>
<th>Count</th>
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<tbody>
<tr>
<td>Mobility Issues</td>
<td>215</td>
</tr>
<tr>
<td>Physiotherapy / Occupational Therapy</td>
<td>162</td>
</tr>
<tr>
<td>Falls Service</td>
<td>53</td>
</tr>
<tr>
<td>Other Therapy Services</td>
<td>49</td>
</tr>
<tr>
<td>Memory Clinic</td>
<td>39</td>
</tr>
<tr>
<td>Social Services</td>
<td>14</td>
</tr>
<tr>
<td>Medical Referrals</td>
<td>2</td>
</tr>
<tr>
<td>Police &amp; Fire Service</td>
<td>65</td>
</tr>
</tbody>
</table>
The results: Over 85 years claims

- Council Tax Rebate, 26
- Blue Badge, 145
- Pension Saving Credit, 4
- Attendance Allowance, 170

100 confirmed at Year One, worth £275,000 p.a.
170 claims are worth £487,968
The results: Over 75 years emergency secondary care growth 2012-2013 to 2014-2015

<table>
<thead>
<tr>
<th></th>
<th>Practice</th>
<th>Locality</th>
<th>Rest of North Staffs</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E Attendances</td>
<td>1%</td>
<td>7%</td>
<td>15%</td>
</tr>
<tr>
<td>Emergency Discharges</td>
<td>-4%</td>
<td>8%</td>
<td>12%</td>
</tr>
</tbody>
</table>
The Results: 75-84 Years learning as we went...

- Poor correlation between those scoring >5, and those at risk.
- Large numbers and able to access surgery.
- Led to cessation of plan to visit these patients early on in the project.
The results: patient feedback

Most helpful:

- Sign-posting/guide to what's available

- Showing concern/interest in me

- Supply of equipment or other specific action

- Discussing care, gaining advice and suggestions

"helpful to know where to go for help and what is available."

"Was made aware of things available to us"

"The concern shown with health problems and welfare in general"

"I found the fact that the doctors were interested in my health and welfare uplifting"

"Able to discuss my father's care"

"Difficult to improve near perfection"
In summary - the results

✓ Simple, flexible, low cost.

✓ Over 85s - very high uptake. Positive feedback. Significant actions.

✓ Patients always in charge.

✓ Excellent patient and carer feedback.

✓ Key results are mobility issues, attendance allowance claims reduced A&E attendance and reduced acute medical admissions.

? 75 – 84 - good returns of questionnaires. But Tilburg gave a large percentage conversion to visits and the visits were not needed.

? They should be regarded as a different group. Still very independent and frailty is not yet a significant problem. A re-think is needed.
In summary - the approach

✧ Practice contact and engagement worked well.

✧ Although practice based, work is not GP based.

✧ Practice elderly care facilitator role worked well. ECF may be a non-clinician

✧ Flexible - responds to what there is locally in terms of services and needs. A loose multi-disciplinary group, held together by the practice based ECF at the centre. Allows for innovation, new resources, changing systems, IT developments, and patient preferences.

✧ Individual Practices may have separate links - community transport schemes, pharmacy dosette boxes.

✧ Referrals provide viability and justification for some services. e.g. falls service, police security advice
Progress since project

Keep delivering & improving

✓ Continuing over 85 annual reviews

✓ Age UK attendance allowance claims project

✓ The Old Dental Surgery - Improving dental care in the elderly

✓ Dementia Friends

✓ Biographies year 10 and 11

✓ Beat the cold project

Review & evaluate

? 75 to 84 year old stopped Tilburg - review

? Prescribing audit with CCG pharmacy advisor

? Keele research physio - Falls prevention 75 to 84 year olds mobility/balance pathway

? Research - list iPOPP/notepad/Healthfabric/HT/Candid
The Elderly Care Facilitator (ECF):

Although all practices started with separate secretarial & nursing roles, due to circumstances one Practice combined both roles and employed a non-clinical person.

This has been more effective. Less emphasis on clinical issues. It could also pave the way for a new professional post.

The ECF acts as an accessible bridge between patients, carers, health professionals, social support and voluntary groups.

See an interview with an Elderly Care Facilitator:

http://www.frailtytoolkit.org/beas-story/
Full report on the Madeley Practice website:

http://www.madeleypractice.co.uk/elderly-care.html

Plus the ECF video interview

Plus resources used

Dr Chris Oleshko
chrisoleshko@me.com