Practice based screening of the over 75 population

Background and Funding

The project aims to detect early signs of medical, social and mental problems so as to allow appropriate interventions and improve quality of life and independence.

GP Practices are in a unique position to identify at risk patients because they have a defined population registered at the Practice, with an accurate database of medical and administrative information, personal knowledge of patients and the goodwill and ability to contact and engage with them.

The project involves the six Practices of Newcastle South Locality Group, member practices of North Staffordshire CCG.

Total Practice Population 37,303
- 3,409 (9.1%) over 75 years
- 785 (2.1%) over 85 years.
Nursing home patients excluded.

Budget £90,000, funded jointly through CCG innovation fund, The Bishop Stamer Foundation (local charity) and Daiichi-Sankyo (NHS Moving Beyond Sponsorship).

The project is supported by Newcastle Social Services, Lions Club International, Knights Solicitors, Citizens Advice Bureau, Red Cross, Age UK, Newcastle Police, Newcastle Fire Services, and local NHS Geriatric and Community services.

Aims and objectives

- Develop an effective screening system with high uptake.
- Develop role of Practice based coordinator of elderly care services.
- Identify local resources for the elderly and extend professional and public knowledge of these.
- Identify carers.
- Maximize inter-agency working.
- Identify the most common problems.
- Reduce unplanned OOH contacts, A&E attendance and hospital admissions.

Success criteria

- 100% at risk patients offered assessment.
- 70% questionnaires returned
- 70% visit uptake
- Next of kin/carer identified, 70% visits.
- New benefit claims exceed project cost.
- Improved clinical data recorded for e.g. 6CIT, alcohol dependency,
- Problems identified and recorded are acted on e.g. risk of falls referred to falls service, and referrals made.

Timescale

24 months, start April 2013.
Project Organisation

A. Patients age 75 to 84 years are sent the Tilburg self-assessment questionnaire and information on local elderly health and social/community services.

The returned questionnaire provides information on health, social, and functional ability. It is scored to determine whether a visit is required.

B. Patients aged over 85 years and over, those with dementia and the housebound, are automatically offered a 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.

A practice coordinator organizes the questionnaires, visits and action plans.

A practice nurse or care worker carries out the home assessments.

Interim findings at nine months:

75 to 84 years

- 428 (19%) of questionnaires sent.
- 80% returned.
- 30% scored as needing visit.
- Visits not identifying problems.

Over 85 years/dementia/housebound

- 372 (35%) of visits completed
- 84% uptake of visits offered
- Four practices achieved 100% for Over 85 visits.
- Significant problems identified:
  - Mobility 22%,
  - New memory problems 5%,
  - Benefits 25%.

Next steps

- Immediately, reassess scoring and use of Tilburg questionnaire.
- Review care pathways for memory loss and mobility problems.
- Develop support to assist benefit claims.
- Complete project. Review continuation in light of success criteria, workload and costs.