Practice based screening of the over 75 population

Newcastle South Locality

Evidence to support the development of the Elderly Care Facilitator profession

19th August 2015

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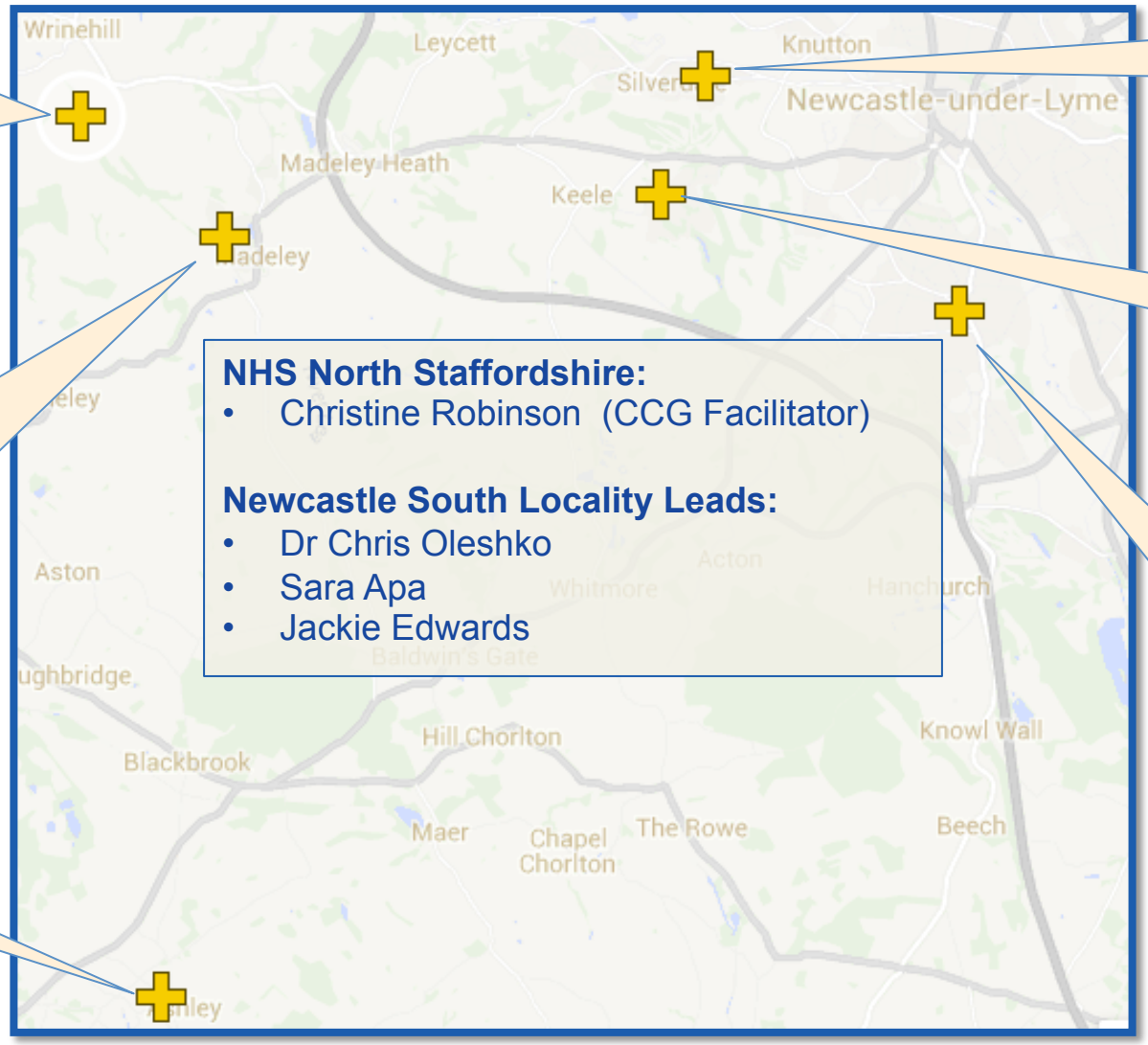

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With thanks to our project sponsors:

Daiichi-Sankyo
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North Staffordshire Clinical Commissioning Group

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Context for the project

Rapidly aging populations are resulting in increased demand for health and social care.

- 15% >65 rising to 22% by 2030 (OECD2009).
- Older age with multiple chronic conditions and a growing number of functional and cognitive impairments. US data indicates those aged >85 are 6x more likely to have multiple functional impairment than 65 – 69 age band (Anderson 2001).
- Number of people living alone is increasing (Coyote et al 2008).
- NHS costs rise disproportionately with age. Hospital stays in England for patients aged 75 and over rose by two thirds in the last decade and now comprise almost one in four hospital admissions. The Department of Health estimates that the average cost of providing hospital and community health services for a person aged 85 years or more is around three times greater than for a person aged 65 to 74 years.

Patient Safety in Care of Older People

- Safety in older people is being protected against physical, social, financial, and emotional harm. The control of hazards to achieve an acceptable level of risk.
- Safety is relative. Eliminating all risk, if even possible, would be extremely difficult and very expensive. A safe situation is one where risks are low and manageable.

Integrated care for older people with complex needs

- The problems experienced by patients are a combination of multiple medical, social and mental issues. Problems may be chronic. Action on identified problems will involve collaborative working between support services – medical, social, voluntary council, other and knowledge of age related services within the community.
- No single model or approach but some “design principles”:
  - Primary Care based – bolt on to the existing GP practice;
  - Single point of entry;
  - Holistic care assessments and care planning;
  - Care co-ordination through personal contact with a named co-ordinator (Elderly Care Facilitator (ECF));
  - Support self-management;
  - Collaborative working between services.
- Implies designated care manager (Elderly Care Facilitator, ECF) within General Practice at centre of a team based approach to help with assessing needs sharing information and coordinating care delivery by multiple caregivers – formal and informal.
- Success more likely where a focus on working with individuals, their families and other informal carers to support self-management. Personal contact with a named co-ordinator more effective than remote monitoring or phone based support.
- Improve communication between professionals and organisations - professionals working loosely together – provider networks in health and social care.
- Remove barriers to access such as differences in financing and eligibility.
- Prioritise visits: Aged 85 plus, dementia, and housebound.

Overview of project

- 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:
  - Defined population registered at the Practice;
  - Accurate database of medical and administrative information;
  - Personal knowledge of patients;
  - The goodwill and ability to contact and engage with them.

- The project involves the six Practices of Newcastle South Locality Group, part of North Staffordshire CCG covering population of 37,303:
  - 3,409 (9.1%) over 75 years;
  - 785 (2.1%) over 85 years;
  - Nursing home patients excluded.

- Timescale: 24 months (Apr 13 – Mar 15).

- Budget £90,000 (£70,000 actual spend) from The Bishop Stamer Foundation (local charity), CCG Innovation Fund, and Daiichi-Sankyo (NHS Moving Beyond Sponsorship). Paid for staff clerical and visit time and expenses.

- NHS North Staffordshire CCG, Newcastle Social Services & Newcastle Council, Lions Club International, Knights Solicitors, Citizens Advice Bureau, Red Cross, Age UK, Newcastle Police, Newcastle Fire Services, Stoke-on-Trent council, and local NHS Geriatric and Community services (Physiotherapy and Occupational Therapy) supported the work.

- Thanks to Fusion48 for donating their time to help produce this report www.fusion48.net.

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.

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 age 75 to 84 years

Approach:

- 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.
- If visit required, then same process as 85+ cohort.

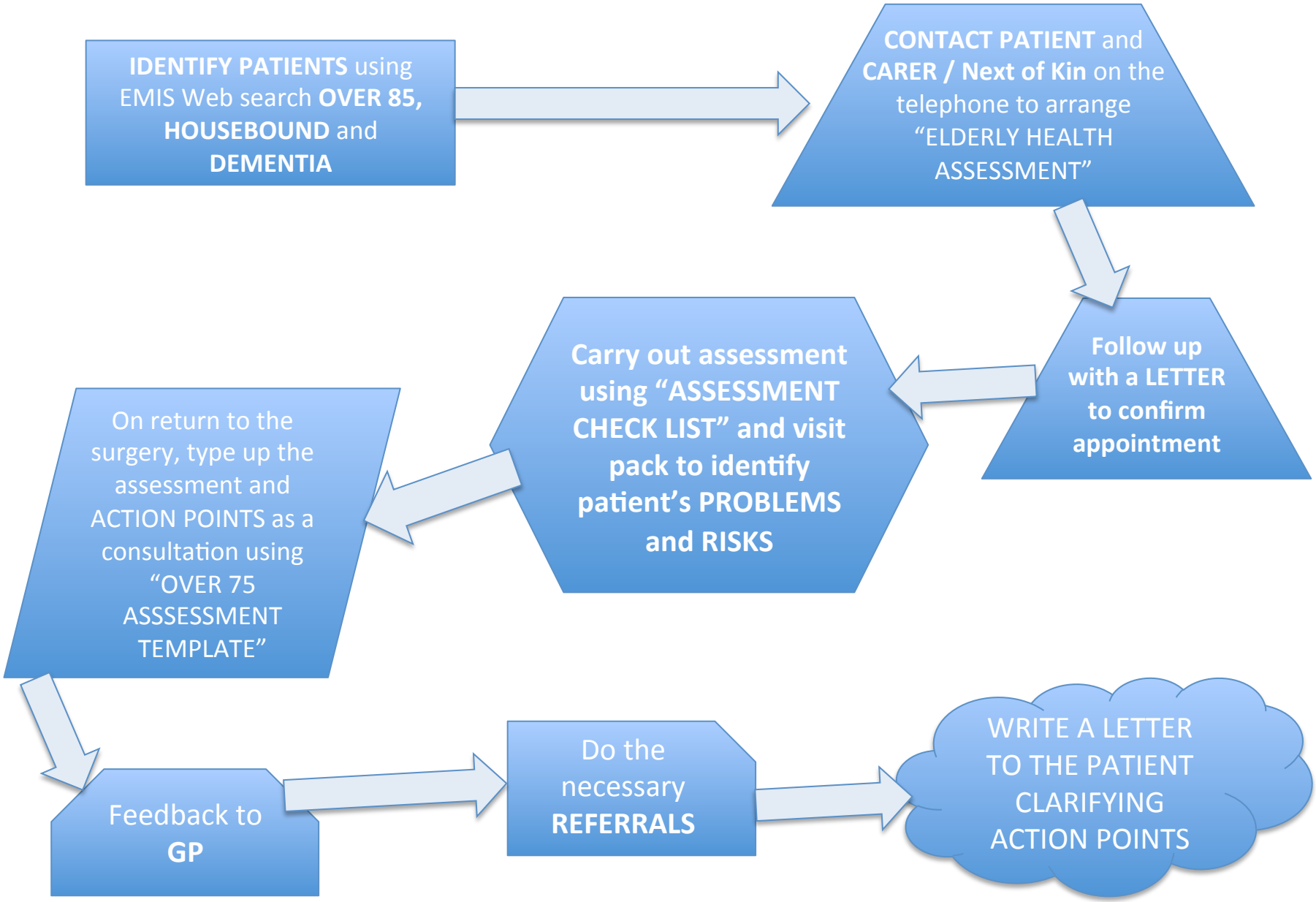
B. Patients aged over 85 years old, those with dementia and the housebound

- Automatically 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.

Flexible approach to resource deployment:

- Any combination of Practice coordinator, Practice nurse or care worker organizes the questionnaires, visits and action plans and carries out the home assessments.
- No requirement for direct GP (or even clinical) involvement in co-ordination and visit, only in subsequent follow up actions (where required).

From case finding to action



Success criteria and summary results

Cohorts:	Success criteria:	Results (based on latest practice data):
A. Patients age 75 to 84 years	• Questionnaires returned 70%. • Visit uptake 70%.	• 1,546 (69%) of questionnaires sent. • 78% returned. • 27% score as needing visit. • 156 visits completed (51% of those needing visit). • 27 / 41 visits undertaken by Moss Lane could have been completed in the surgery.
B. Patients aged over 85 years old, those with dementia and the housebound	• At risk patients offered assessment 100%. • Visit uptake 70%. • Next of kin/carer identified, 70% visits. • New benefit claims exceed project cost. • Improve 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.	• 83% of those needing visit offered. • 707 visits completed (73% of cohort). • 88% uptake - 4 practices achieved over 90% for Over 85 visits. • NOK recorded 90% of visits (Moss Lane). • Annual Attendance Allowance claims estimated to be in excess of £275,000*. • 600 new clinical assessments captured (0.6 per visit). • Significant problems identified: – Benefits 36%, – Mobility 23%, – New memory problems 4%. • 384 referrals made (0.4 per visit).

* 170 individuals identified as potentially eligible for attendance allowance. Madeley audit indicates 57% take up rate (97 claims) and value of attendance allowance £2,865 p.a. based on £55.10 per week.

Source: Monthly monitoring returns and practice updates

Key features

- Starting point was an intention **to improve patient care and well being** with patients and their carers having a major say.
- The work **builds on the experience of one of the practices** with residents of a large complex of private sheltered flats.
- Bottom up - **full integration of organization not the goal**, not possible as very disparate, and that is a major strength.
- Flexible **– responds to what there is locally in terms of services and needs**. Sometimes professional working together, but strength is operating as a very loose network with GP **practice based ECF at centre**. It allows for innovation, new resources, changing systems, IT, and patient preferences.
- No single organizational approach. **Individual Practices may have separate links**, e.g. community transport scheme, pharmacy weekly dosette home deliveries to housebound. Each practice identified a co-ordinator and a nurse or other to participate in the project.
- **Gently led, managed and nurtured over time** with a local lead co-ordinator and a lead nurse practitioner based at Madeley Practice provided initial training, supervision and support to the practices.
- **Care co-ordinator a non-clinician**. Focus on close personal contact face to face.
- **High touch vs. high tech.** Does not rely on IT with little use made of existing IT. Deliberate choice as allowed personal contacts to develop, but could be a role in patient held records, and shared data between health and social services to support medical admissions avoidance and early discharge.
- **Referrals provide viability and justification for some services** e.g. falls service.
- Simple, acceptable, **extremely high patient uptake, excellent patient feedback.**
- **Patients in charge** – one or two delightful ladies who said ‘no thank you’.
- **Effective interventions highlighted areas for improvement.**

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Summary data for period Apr 13 to Mar 15 (including updates from practices)

	Silverdale	Kingsbridge	Moss Lane (Madeley)	Ashley	Betley	Keele	Total
75-84 with exclusion cohort	**854**	**631**	**382**	**234**	**110**	**37**	**2,248**
Questionnaires sent (% of cohort)	433	390	326	202	162	33	**1,546**
	51%	62%	85%	86%	147%	89%	69%
Questionnaires returned (% of sent)	381	263	290	103	142	30	**1,209**
	88%	67%	89%	51%	88%	91%	78%
% needing visit	118	110	32	16	35	12	**323**
	31%	42%	11%	16%	25%	40%	27%
% needing visit offered	45	43	32	10	21	15	**166**
	38%	39%	100%	63%	60%	125%	51%
% uptake (of those offered)	45	43	31	2	21	14	**156**
	100%	100%	97%	20%	100%	93%	94%
Action Points sent (of those visited)	45	43	31	2	13	12	**146**
	100%	100%	100%	100%	62%	86%	94%
>85, Housebound and Dementia (with exclusions)	**327**	**312**	**167**	**92**	**53**	**11**	**962**
% needing visit offered	266	223	160	69	69	12	**799**
	81%	71%	96%	75%	130%	109%	83%
% uptake (of those offered)	235	223	149	64	24	12	**707**
	88%	100%	93%	93%	35%	100%	88%
Action Points sent (of those visited)	235	223	149	64	24	4	**699**
	100%	100%	100%	100%	100%	33%	99%
Last data	***Mar-15***	***Mar-15***	***Jan-15***	***Jan-15***	***Mar-14***	***Oct-14***	

- Betley finished project early due to small numbers; Ashley had completed all visits except those that declined.
- Silverdale & Kingsbridge lower level of questionnaires sent for 75-84; Ashley low on returned rate (although small #s) Overall high rates of offering visits to >85 plus cohort.
- Overall uptake very high (c. 90%), except for Betley (35%).
- Very high rate of follow up in terms of action points sent.

Source: Monthly Monitoring Database Over 75s risk assessment - whole project to Mar 15 plus updates from Practices during preparation of report

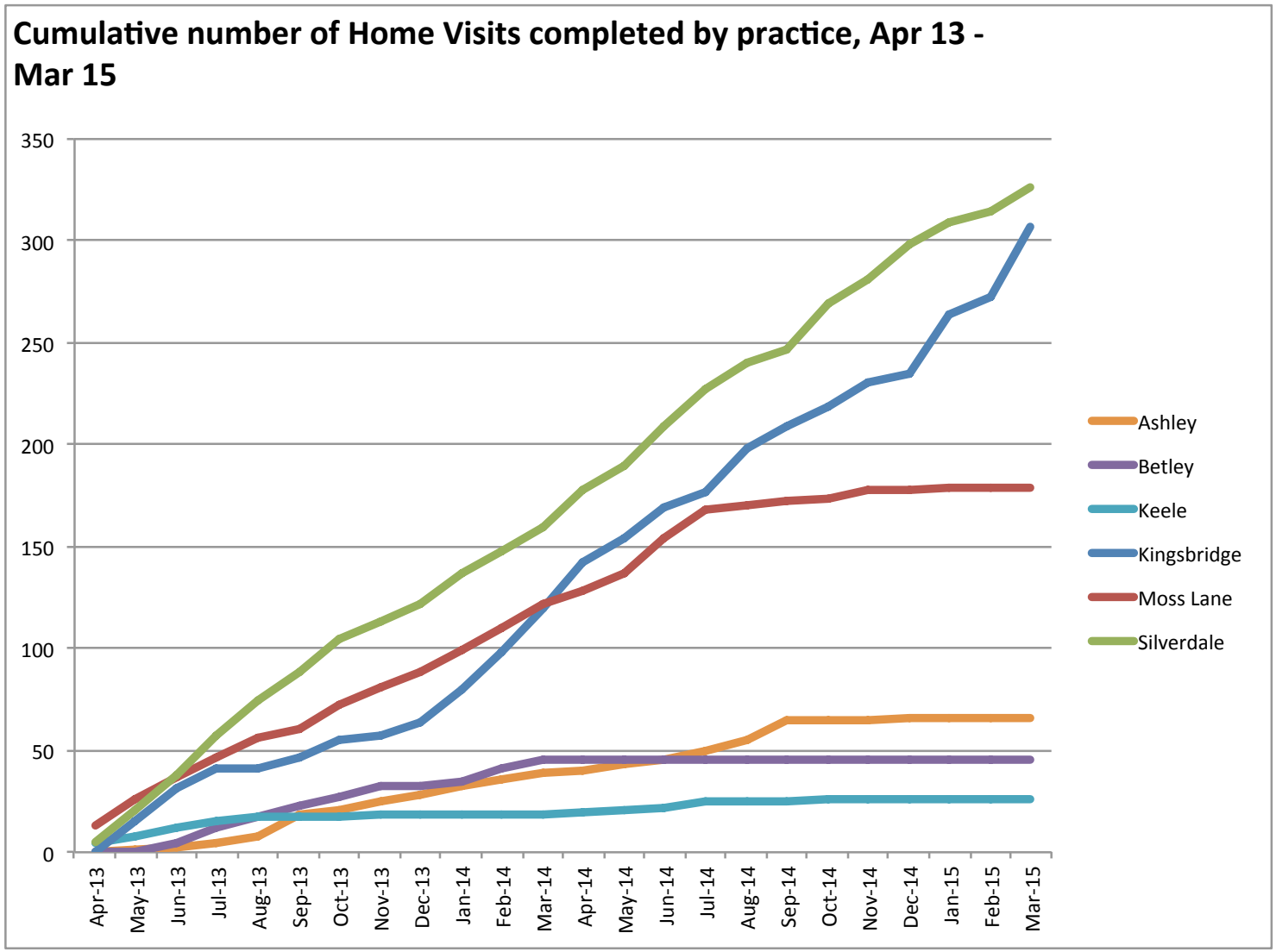
Overview of comparative data

	Silverdale	Kingsbridge	Moss Lane	Ashley	Betley	Keele	Locality Total	Remainder of North Staffs CCG
List size, HSCIC data	**12191**	**8388**	**6888**	**3965**	**1847**	**6660**	**39,939**	**175,523**
% 75+, HSCIC data	11%	10%	11%	10%	13%	1%	9%	9%
% 75+ / Housebound / Dementia with exclusions (from project data as % of HSCIC list size)	10%	11%	8%	8%	9%	1%	8%	N/A
IDAOPI (Income Deprivation Affecting Older People), 2012	20	12	11	10	8	14		
Disability allowance claimants (per 1000), Nov 11	69	46	38	42	31	21		
Deprivation Score (IMD), 2012	25	13	11	11	10	10		
% with caring responsibility, 2012-13	16	24	25	20	25	9		
Growth in A&E attends for 75+ (2012-13 to 2014-15)	5%	19%	1%	-1%	7%	14%	7%	15%
2014-15 Age Standardised A&E attends ratio 75+ (based on national rates)	94	87	86	54	79	61	85	86
Growth in emergency admissions for 75+ (2012-13 to 2014-15)	4%	24%	-4%	3%	15%	46%	8%	12%
2014-15 Age standardised admission ratio for 75+ (based on Northern Staffordshire CCGs rates)	98	96	97	62	79	82	92	96

- Silverdale by far the largest practice, although all except Keele (University) have similar proportions of list aged 75+ and this is broadly comparable with project data for cohorts.
- Silverdale covers most deprived area, Betley the least deprived.
- Betley, Kingsbridge and Moss Lane have highest % of list with caring responsibility at 25%.
- Kingsbridge and Keele (small numbers) have seen largest % growth in both A&E and emergency admissions; Silverdale, Moss Lane and Ashley the lowest. **Locality growth markedly less than rest of CCG.**
- Ashley, Betley and Keele all have lowest age-standardised ratios of attends and admissions.

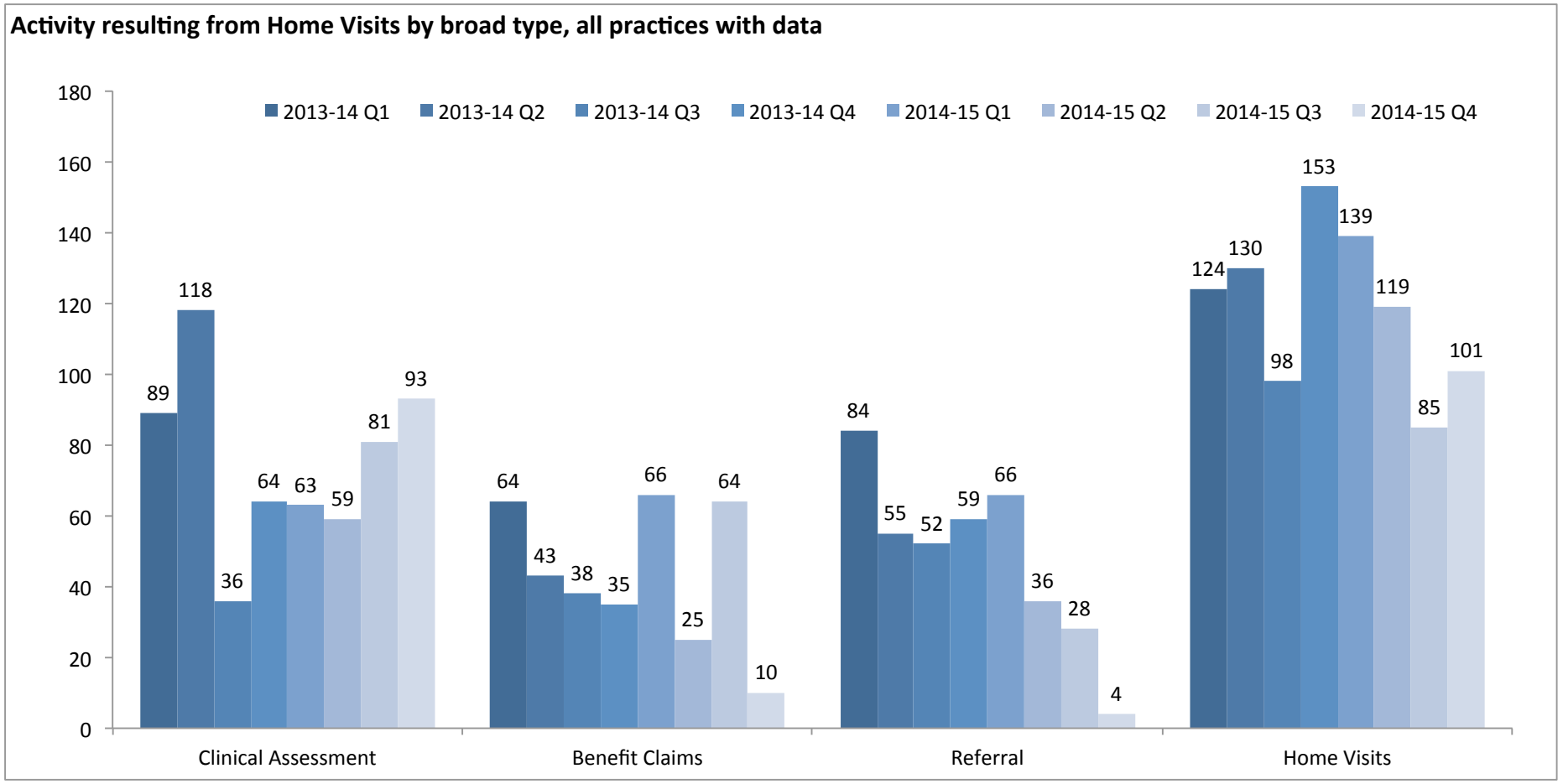
Source: HSCIC GP list size; GP Practice profiles; Midlands and Lancashire CSU activity data for A&E attends and Emergency admissions 2012-13 to 2014-15

Cumulative number of Home Visits completed by practice over time



Source: Monthly Monitoring Database Over 75s risk assessment - whole project to date

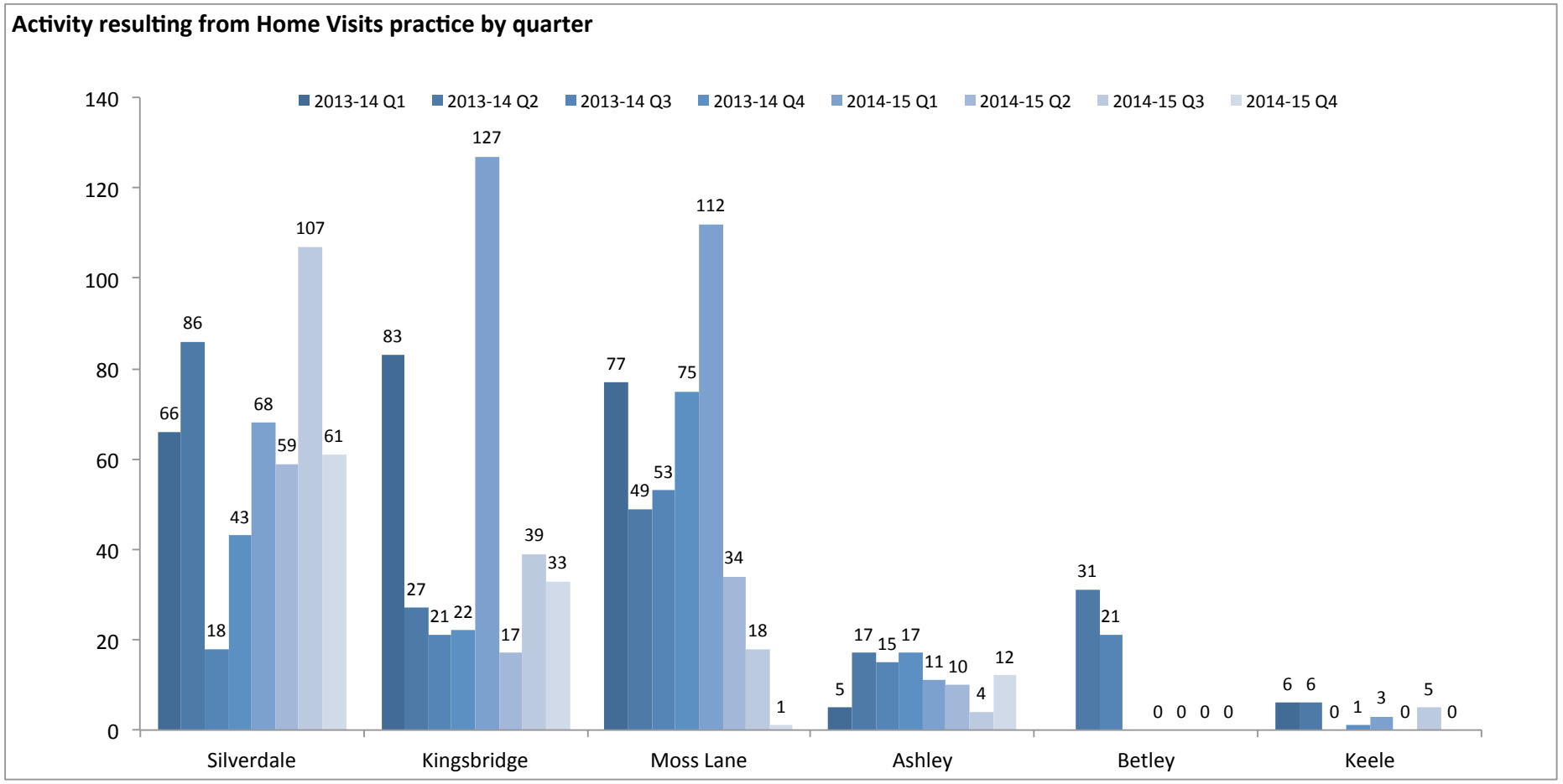
Quarterly activity monitoring by broad activity type



- Home Visits peaked at end of 2013-14 and start of 2014-15, with Q3 lowest volume in both years
- Number of referrals shows greatest decrease across the quarters, particularly in 2014-15
- Clinical Assessments have almost opposite profile to number of Home Visits

Source: Quarterly Monitoring Database Over 75s risk assessment – 2013-14 and 2014-15, excludes vaccination checks

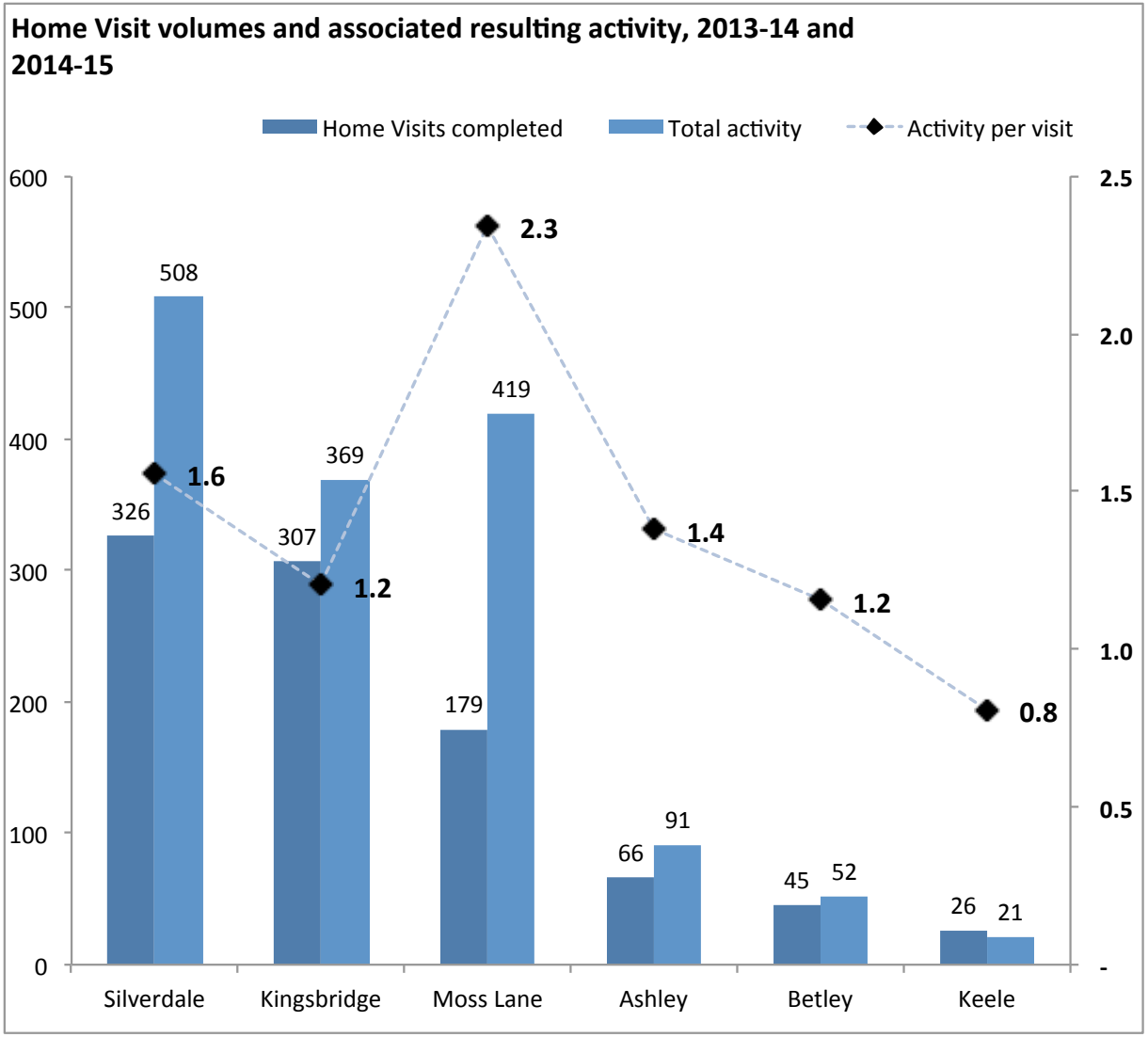
Quarterly activity monitoring by broad activity type



- Three largest practices make up almost 90% of overall activity resulting from Home Visit
- Keele and Betley very low volumes, Ashley also finished by start of Q4 2014-15 and Moss Lane (Madeley) levels of activity have reduced sharply during 2014-15 (started earlier)
- Silverdale and Kingsbridge both recorded more post-visit activity in 2014-15 (both around 40% higher)

Source: Quarterly Monitoring Database Over 75s risk assessment – 2013-14 and 2014-15, excludes vaccination checks

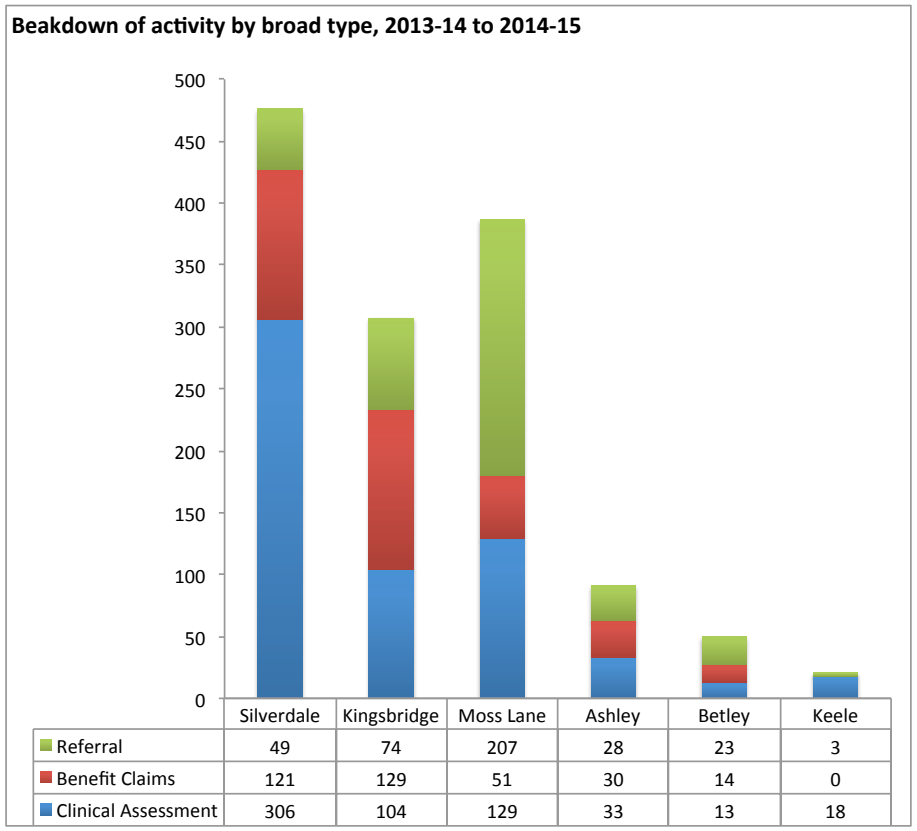
Average activity resulting from each Home Visit, 2013-14 and 2014-15



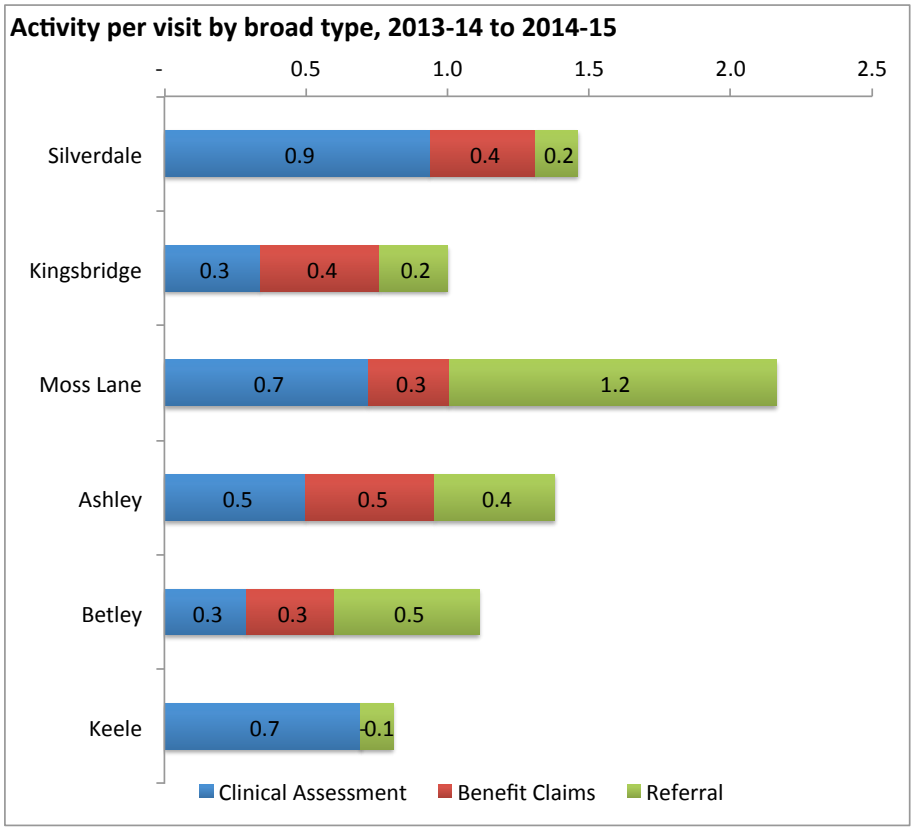
- Combining monthly monitoring data with quarterly activity data allows analysis of activity per visit
- Moss Lane has highest amount of activity resulting from a visit (2.3 activities) compared to 1.6 or lower for other practices)
- All other practices in range 1.2 to 1.6 except Keele (v. small numbers)
- In addition, Moss Lane (Madeley) reports:
  - LIONS pots for 146/154 (95%) patients
  - Life line call care alarm and a key safe fitting 75/154 (49%) Stoke City Council, whilst many of the others will already have a device

Source: Quarterly and Monthly Monitoring Database Over 75s risk assessment – 2014-15, excludes vaccination checks

Total activity by practice and broad activity type, 2013-14 to 2014-15



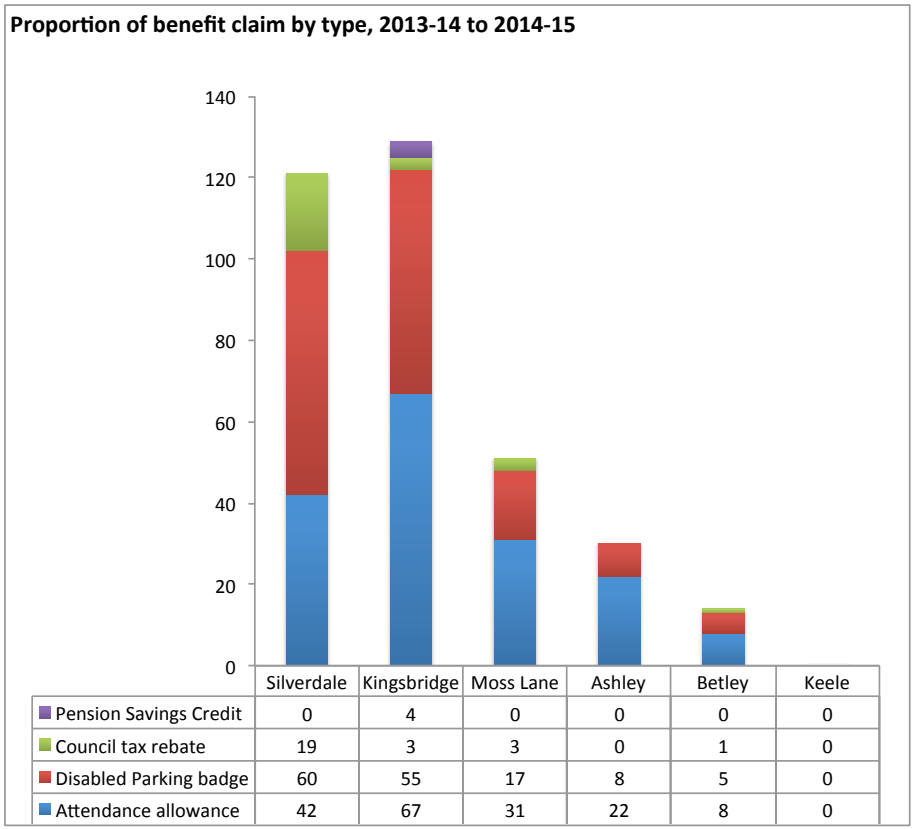
	Silverdale	Kingsbridge	Moss Lane	Ashley	Betley	Keele
Referral	49	74	207	28	23	3
Benefit Claims	121	129	51	30	14	0
Clinical Assessment	306	104	129	33	13	18

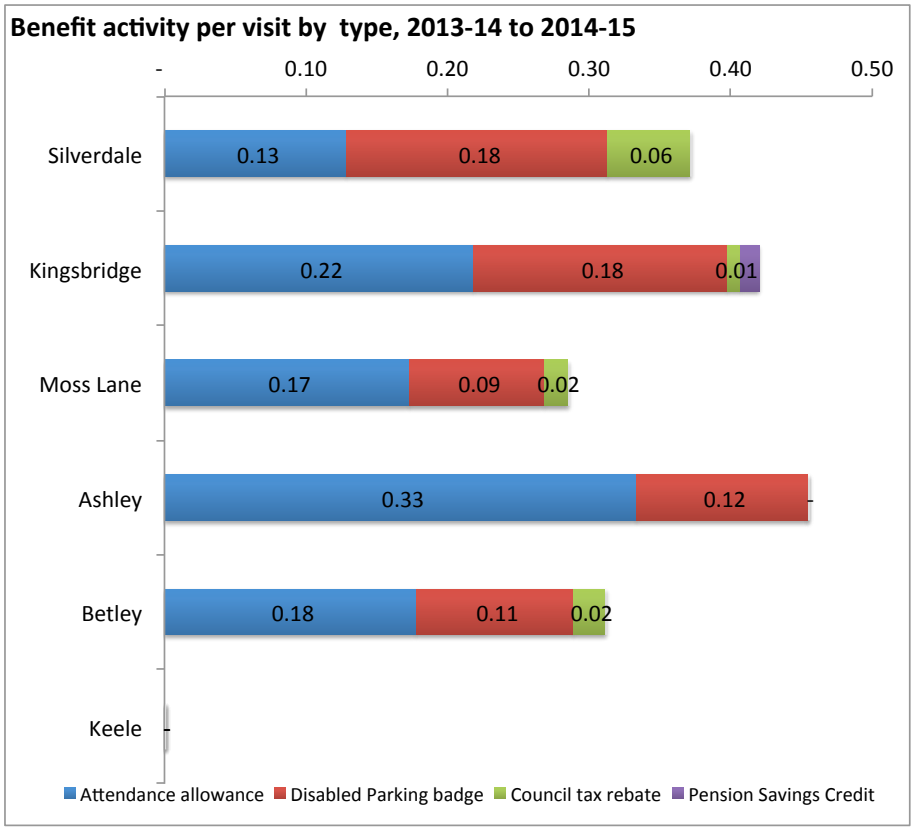


- Moss Lane (Madeley) has highest number and overall proportion of referrals (which is main difference between practices), followed by Ashley and Betley
- Silverdale has highest per visit rate of clinical assessments
- Similar levels of benefits claims per visit across all practices.

Source: Quarterly Monitoring Database Over 75s risk assessment – 2013-14 and 2014-15, excludes vaccination checks

Benefit claims by practice and type, 2013-14 and 2014-15





- Mix of benefits claims is similar across the practices with main difference being between attendance allowance and council tax rebate. Only Kingsbridge had any Pension Savings Credit
- Silverdale has lower proportion of attendance allowance but highest proportion of council tax rebate
- Blue badge parking actions ranges from around 1 in every 10 visits (Moss Lane) to almost 1 in every 5 visits (Silverdale and Kingsbridge)

Source: Quarterly Monitoring Database Over 75s risk assessment – 2013-14 and 2014-15

AUDIT OF ATTENDANCE ALLOWANCE CLAIMS AT 12 MONTHS - Madeley (Moss Lane) practice (1/2)

Madeley (Moss Lane) practice only

Background:

- Attendance allowance provides help with personal care if you are over 65 years old and have physical or mental disability. Two rates and the lower rate is now worth £55.10 per week
- The benefit is not means tested or taxed and can be used for whatever purposes the claimant wishes: cleaning, ironing, shopping, gardening etc.
- Direct payments and personal health budgets have been proposed as the way forward for patients to organize their own social care and may yet be widely introduced, but this financial benefit although small exists now.
- For many of our older patients the social problems that they experience are often greater than the medical problems. This is one way in which they can be helped.

Results

- **Population:** Over 85 years old, housebound and dementia
- **Criteria:**
  - Identify possible new claimants
  - Achieve successful new claims for this group
- **Target:** Successful new claims 50%
- **Results:**
  - Number of visits 96
  - Not claiming attendance allowance, and advised to claim 37
    - Successful claims 21 (57%)
    - Declined to claim 9 (24%)
    - Rejected 2 (5%)
    - Other - not recorded 5 (14%)
- Value of new successful claims per annum **£60,169**

- Approx. 60 visits for Madeley (Moss Lane) practice had been carried out before start of project during a separately funded 'pre-pilot'. Data from these **are** included in the audit figures and is the reason for the difference with the quarterly monitoring data for project on earlier slides

Source: AUDIT OF ATTENDANCE ALLOWANCE CLAIMS Newcastle south locality Over 75 Project – Madeley Practice

AUDIT OF ATTENDANCE ALLOWANCE CLAIMS AT 12 MONTHS - Madeley (Moss Lane) practice (2/2)

Madeley (Moss Lane) practice only

Discussion

- Should GPs be involved? May be not, but we do have access to all of our patients and usually have their trust to be able to ask questions and advise on such matters.
- Outcomes suggest worth putting in the work: 21 new claims worth over £60,000 per year. Money that for many will make an immediate, though small, positive impact on their daily life. The money will also go into the lower end of the local economy, and costs the local NHS and social services nothing.
- We will continue this work. Other Practices within the locality Group have been supported by our staff to carry out the same work. It should be carried out across the CCG on way or another.
- Need to address the issue of patients who claimed and were unsuccessful, and those who were deterred from claiming by the length and complexity of the application for.

By the end of the £70,000 project, practices reported 170 new attendance allowance claims worth potentially £500,000 per annum (assuming 100% success rate) - new money that stays in the local economy.

Source: AUDIT OF ATTENDANCE ALLOWANCE CLAIMS Newcastle south locality Over 75 Project – Madeley Practice

AUDIT OF COUNCIL TAX REBATE CLAIMS BY PATIENTS WITH DEMENTIA - Madeley (Moss Lane) practice (1/2)

Madeley (Moss Lane) practice only

Background:

- A financial benefit that is very quick and simple to claim. Few people are aware of it, and many don't want the hassle of claiming.

- **Criteria:**
  - On home assessments ask patients with a diagnosis of dementia and their relatives whether they receive a council tax rebate.
  - If they do not, then provide the claim form and advice on how to claim
  - Record how many claimants are successful

- **Target:**
  - New claimant application (%age of the group that claim): 50%
  - Success rate for such applications: 100%

Results

- Number of patients coded with dementia who have had an assessment 22

- Number of patients already claiming Council tax rebate: 14 (64% of eligible group)

- Number of patients advised to claim Council Tax rebate: 4 (50% of group not already claiming)

- Of this number how many have successfully claimed: 2 (50% of group that applied)

- Approx. 60 visits for Madeley (Moss Lane) practice had been carried out before start of project during a separately funded 'pre-pilot'. Data from these **are** included in the audit figures and is the reason for the difference with the quarterly monitoring data for project on earlier slides

Source: AUDIT OF ATTENDANCE ALLOWANCE CLAIMS Newcastle south locality Over 75 Project – Madeley Practice

AUDIT OF COUNCIL TAX REBATE CLAIMS BY PATIENTS WITH DEMENTIA - Madeley (Moss Lane) practice (2/2)

Madeley (Moss Lane) practice only

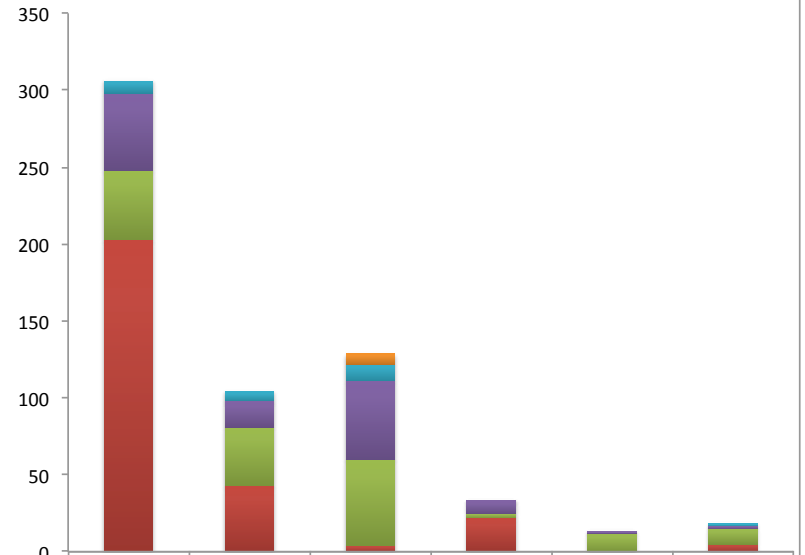
Discussion

- As a practice we have pushed for people to claim this benefit for many years so the figures don't appear too bad, Silverdale practice over the whole 24 months achieved 19 new claims - we need to review what they have done differently to achieve such a high number.
- Clearly, as with attendance allowance, and despite the claim form being so simple there is a need to help people with the application.
- Another issue has also arisen that staff at the other practices report that patients who have applied have been refused the allowance because of other finances – i.e. the council is means testing the application. **This is incorrect.**
- Three action points:
    - Analyse Silverdale approach and work
    - Add to the Innovation Project proposal with AGE UK as a referral option
    - Liaise with the council with regard to advice and actions being taken by their staff.

Source: AUDIT OF ATTENDANCE ALLOWANCE CLAIMS Newcastle south locality Over 75 Project – Madeley Practice

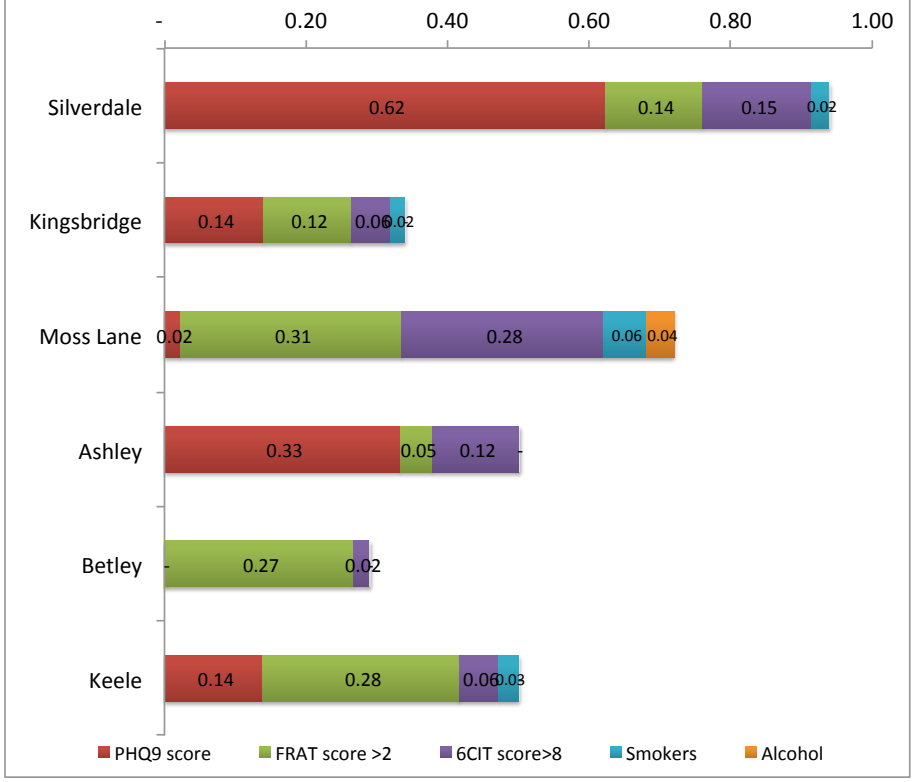
Clinical assessments by practice and type, 2013-14 and 2014-15

Number of clinical assessments by type, 2013-14 to 2014-15



	Silverdale	Kingsbridge	Moss Lane	Ashley	Betley	Keele
Alcohol	0	0	7	0	0	0
Smokers	8	6	11	0	0	1
6CIT score>8	50	17	51	8	1	2
FRAT score >2	45	38	56	3	12	10
PHQ9 score	203	43	4	22	0	5

Clinical Assessment activity per visit by type, 2013-14 to 2014-15

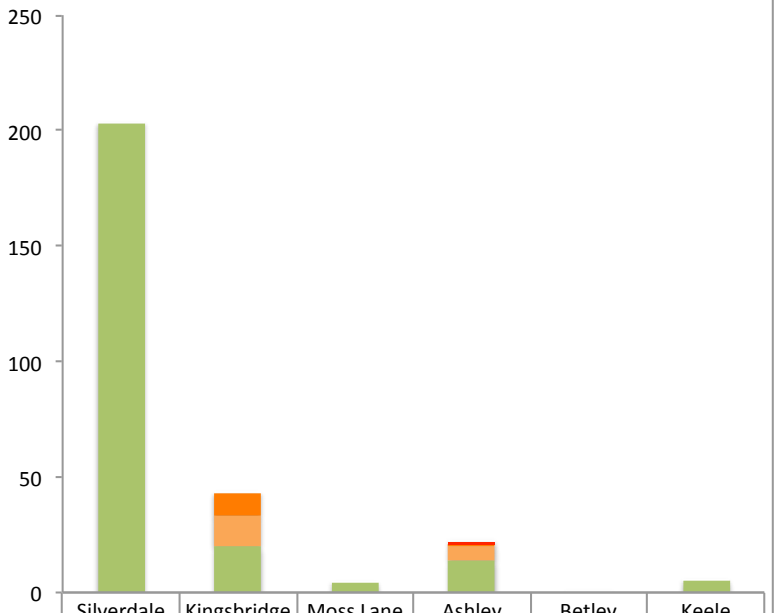


- Silverdale has logged largest number and proportion of PHQ9 scores for larger practices (0.6 per visit) but Ashley also high, albeit on low total numbers (a third of visits)
- Moss Lane (Madeley) has highest proportion (0.28 per visit) and absolute number of 6CIT scores > 8 and only practice to log alcohol issues.
- Relatively small number of smokers across all practices (0.03 per visit)

Source: Quarterly Monitoring Database Over 75s risk assessment – 2013-14 and 2014-15, excludes vaccination checks

Comparison of recorded PHQ9 assessments

Breakdown of PHQ9 scores by practice, number of patients with recorded assessment



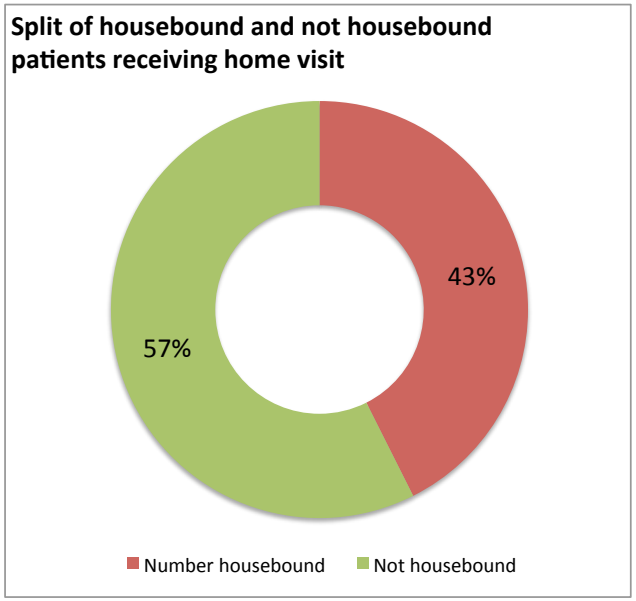
	Silverdale	Kingsbridge	Moss Lane	Ashley	Betley	Keele
Patients with PHQ9 score 20-27	0	0	0	0	0	0
Patients with PHQ9 score 15-19	0	0	0	1	0	0
Patients with PHQ9 score 10-14	0	10	0	1	0	0
Patients with PHQ9 score 5-9	0	13	0	6	0	0
Patients with PHQ9 score 0-4	203	20	4	14	0	5

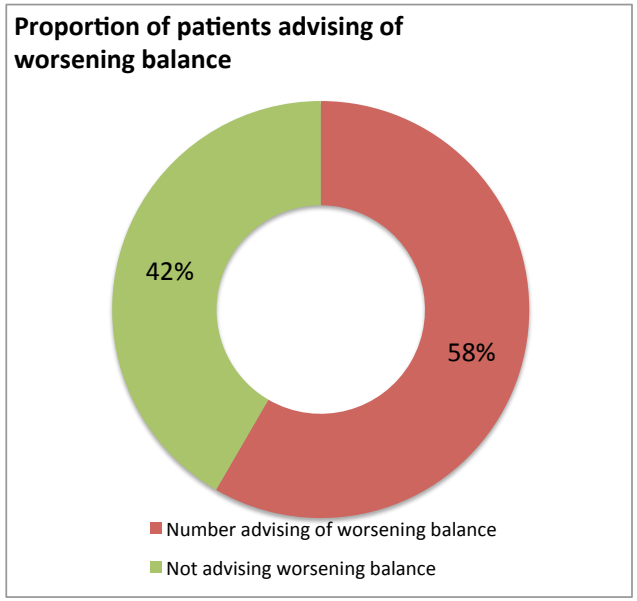
- One of the areas where practices took a different approach was PHQ9 assessments (Patient Health Questionnaire)
- Basic screening questions for Depression were used:
- During the past month, have often been bothered by:
  - Little interest or pleasure in doing things?
  - Feeling down or hopeless?
- If a patient answers yes to either of these questions, then complete PHQ9.
- Silverdale completed the most but all had recorded score 0-4
- Kingsbridge and Ashley had similar profile of higher scores
- Moss Lane, Betley and Keele did not undertake many, if any, PHQ9 assessments

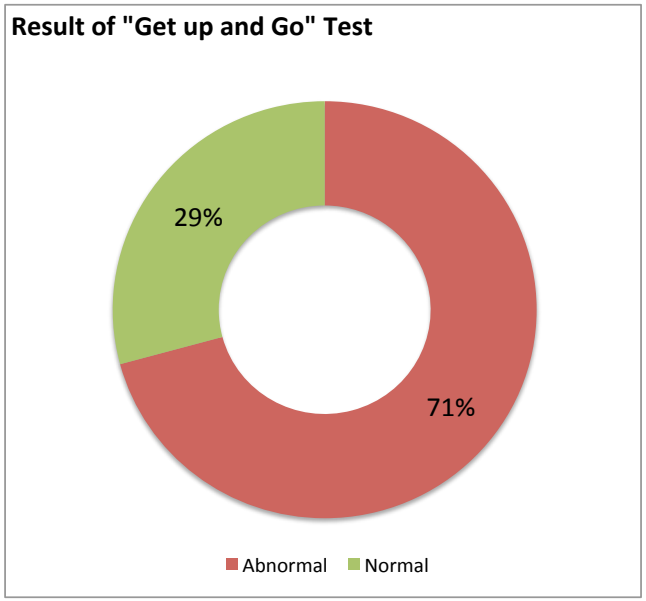
Source: Quarterly Monitoring Database Over 75s risk assessment – 2013-14 and 2014-15

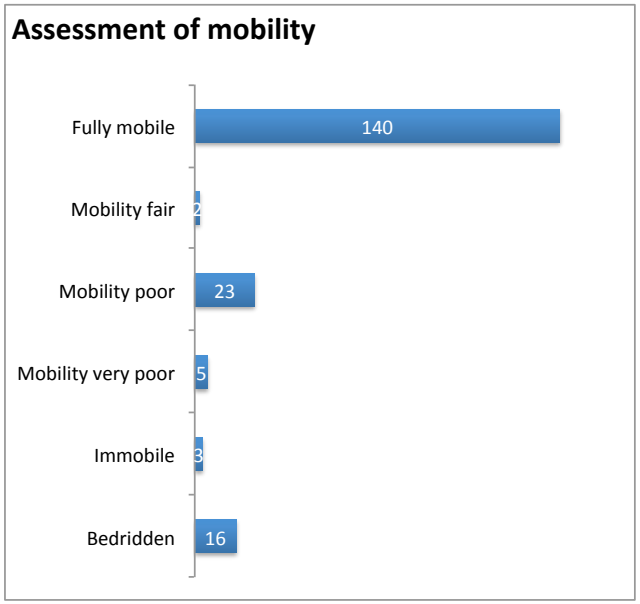
Mobility data from Madeley (Moss Lane) Practice

Madeley (Moss Lane) practice only







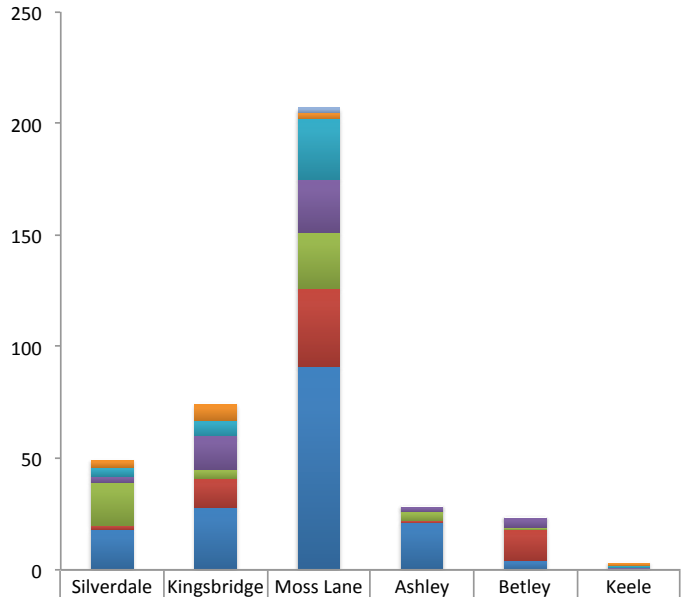


- Analysis of Madeley (Moss Lane) surgery detailed mobility assessments shows:
- 43% of 85+s visited were housebound
- 58% advised of worsening balance
- 71% were abnormal on “Get up and “Go Test

Source: Madeley (Moss Lane) surgery Over 85 assessments data

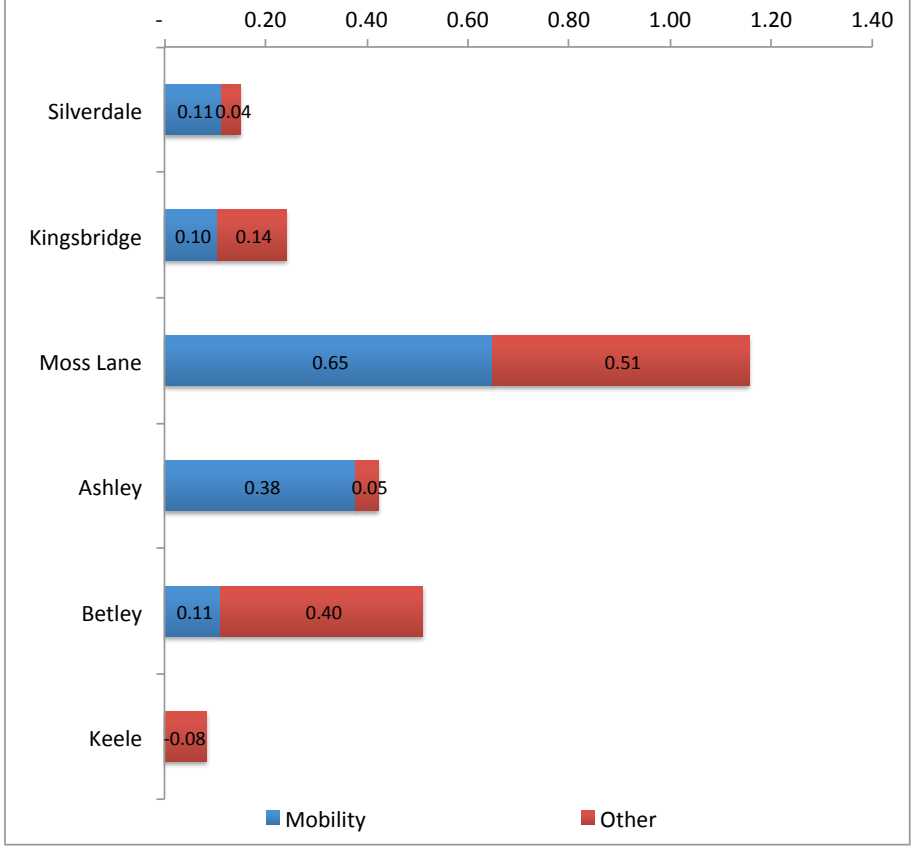
Referrals by practice and type, 2013-14 and 2014-15

Breakdown of referrals by type, 2013-14 to 2014-15



	Silverdale	Kingsbridge	Moss Lane	Ashley	Betley	Keele
Medical	0	0	2	0	0	0
Social services	3	7	3	0	0	1
Memory	4	7	27	0	0	1
Other therapy	3	15	24	2	4	1
Falls	19	4	25	4	1	0
Other advice or checks	2	13	35	1	14	0
Physio / OT	18	28	91	21	4	0

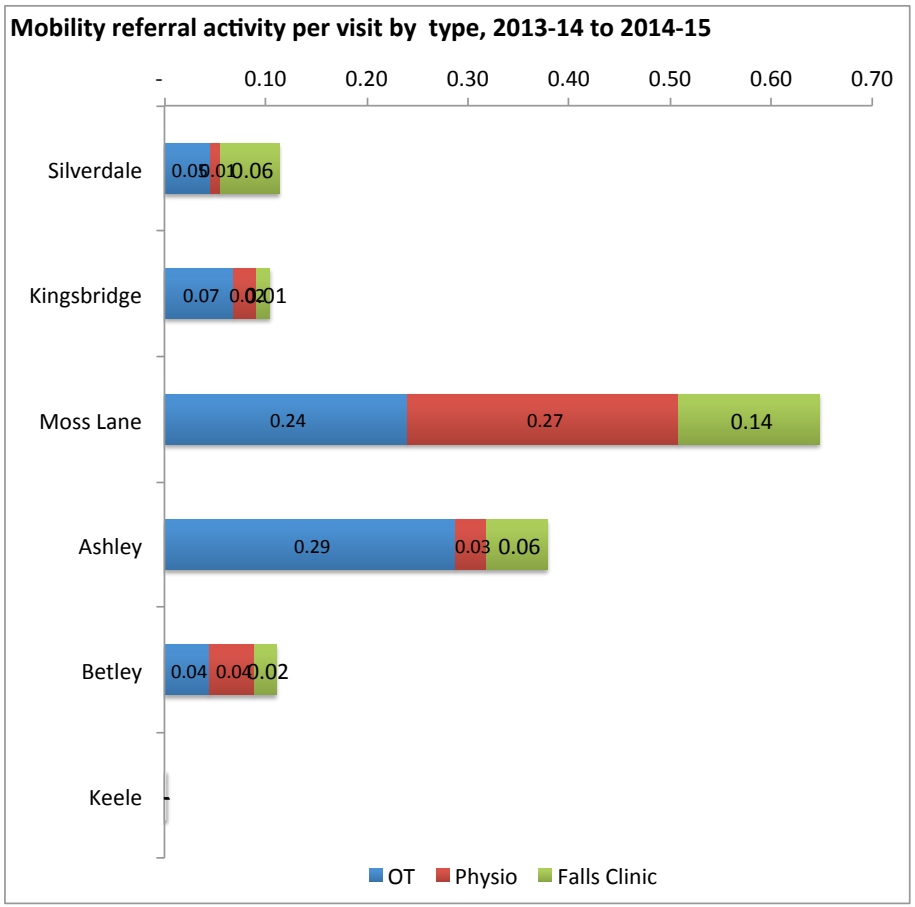
Referral activity per visit by type, 2013-14 to 2014-15

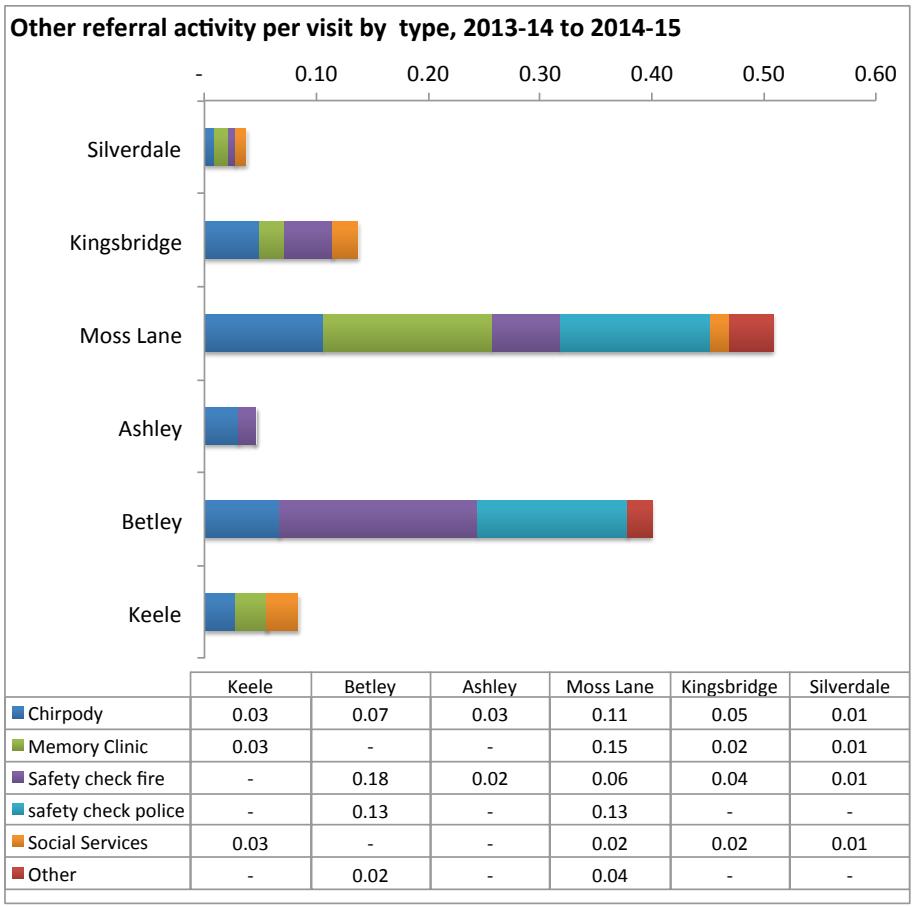


- Wide variation in referrals with Moss Lane clear outlier in terms of volume of referral activity – over 5 times more than Silverdale and Kingsbridge
- Higher levels of both “mobility” referrals (Falls, OT/Physio) and “Other” referrals
- Other therapy referrals cover Chiropody, Dietetics and Speech Therapy

Source: Quarterly Monitoring Database Over 75s risk assessment – 2013-14 and 2014-15

Referrals by practice and type, 2013-14 and 2014-15





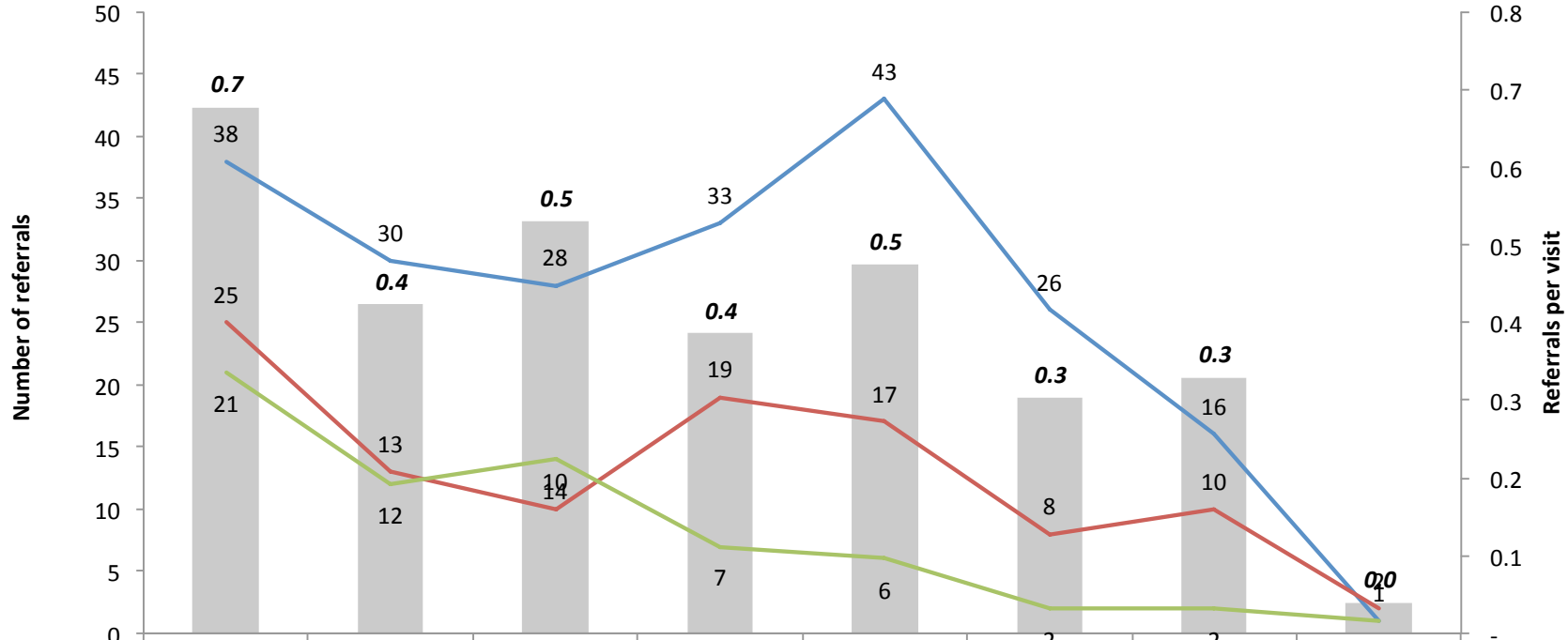
	Keele	Betley	Ashley	Moss Lane	Kingsbridge	Silverdale
Chirpody	0.03	0.07	0.03	0.11	0.05	0.01
Memory Clinic	0.03	-	-	0.15	0.02	0.01
Safety check fire	-	0.18	0.02	0.06	0.04	0.01
safety check police	-	0.13	-	0.13	-	-
Social Services	0.03	-	-	0.02	0.02	0.01
Other	-	0.02	-	0.04	-	-

- Moss Lane and Ashley made greatest use of OT referrals post-visit (1 in 4 visits) and Moss Lane had similar level of Physio referrals which was around 10x higher than other practices
- For “Other” referrals, Moss Lane had similarly higher levels per visit for almost all categories
- Only Betley and Moss Lane accessed Police safety checks, whilst all practices apart from Keele accessed fire safety checks, albeit to differing levels
- Only around 1 in every 70 visits led to a social services referral

Source: Quarterly Monitoring Database Over 75s risk assessment – 2013-14 and 2014-15

Change in referrals by type, 2013-14 Q1 to 2014-15 Q4

Total Referrals and referrals per visit by type and by quarter, Q1 2013-14 to Q4 2014-15

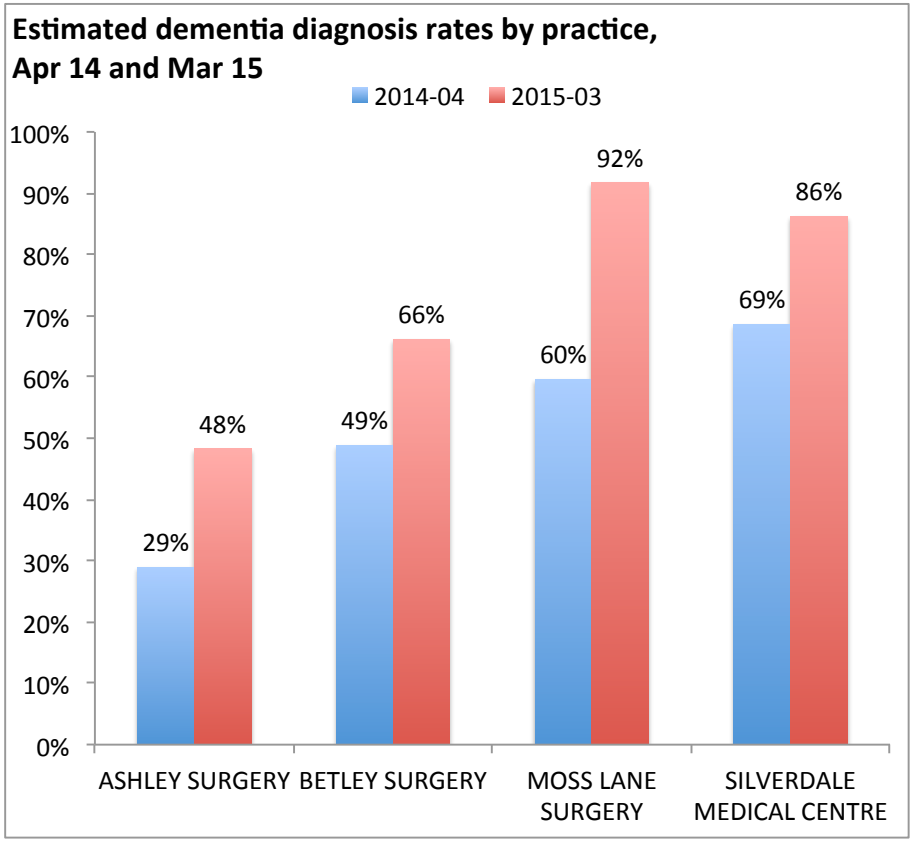


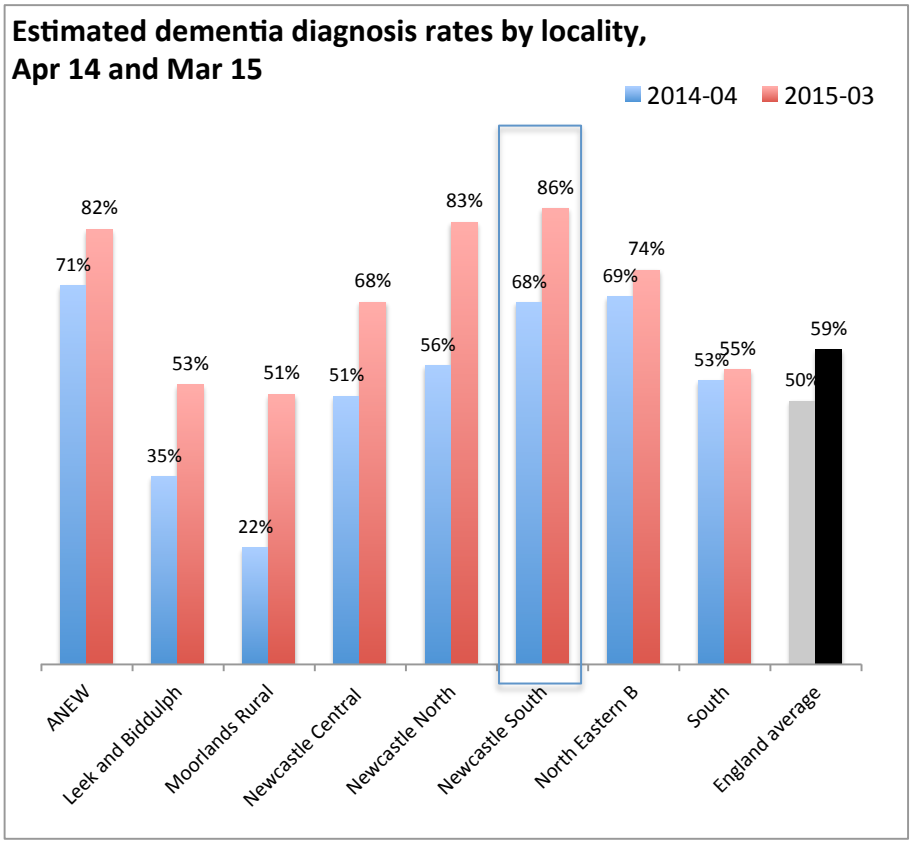
	2013-14 Q1	2013-14 Q2	2013-14 Q3	2013-14 Q4	2014-15 Q1	2014-15 Q2	2014-15 Q3	2014-15 Q4
Referrals	0.7	0.4	0.5	0.4	0.5	0.3	0.3	0.0
Mobility	38	30	28	33	43	26	16	1
Other Health & Care	25	13	10	19	17	8	10	2
Police & Fire	21	12	14	7	6	2	2	1

- All referral types have seen large reductions with referrals per visit dropping from 0.7 in Q1 of project to 0.04
- Mobility referrals dropped from a peak in Q1 2014-15, whilst Other health and care and Police / Fire referrals peaked in first quarter of project

Source: Quarterly Monitoring Database Over 75s risk assessment – 2013-14 and 2014-15

Estimated dementia diagnosis rates by practice and locality - based on publicly available HSCIC data only





- Diagnosis rates are estimated based on dementia register numbers compared to 'expected' prevalence which have been calculated based on age profile of practice as at October 2014. It is **not** adjusted for proportion of nursing home patients or deprivation.
- England average is around 59%, Northern Staffordshire Localities is 67% with Newcastle South now the highest
- University Medical Centre excluded from chart due to very low numbers leading to over 100% diagnosis rate
- No HSCIC publicly available data for Kingsbridge (Commissioning Support / Practice data estimate 56%)

Source: Quality Outcomes Framework (QOF) Recorded Dementia Diagnoses Copyright © 2015, Health and Social Care Information Centre. All rights reserved.

AUDIT OF DEMENTIA DATA (1/2)

Background:

- Dementia is under diagnosed by all Practices. It places major demands not just on the patient but also on family and carers. Unlike some health problems patients do not often present to their GP because of the lack of insight, the known lack of effective treatment, or the stigma that is attached to the diagnosis.
- The publication by NHS England of Estimated Dementia Prevalence Data at last gives us a benchmark against which to measure our work. This audit was completed part way through the project and is therefore an interim report.
- However, diagnosis is just the start. Unfortunately, the local hospital service is poor but by a group of Practices identifying a large number of previously undiagnosed patients may have the evidence for providing an effective community based service.
- More immediately we would offer patients and families social and mental health support and closer Practice supervision.

Population: All patients age over 85 years on 1.1.2013, excluding nursing home residents.

Criteria: To detect undiagnosed dementia

Standard: To achieve 70% of the estimated dementia prevalence rate as published by NHS England

Process: Data was collected as part of the Locality Over 75 project.

- Patients age over 85 years were offered a home visit home.
- 6CIT test was performed and result recorded.
- Patients scoring 8 or more were offered a referral to the memory clinic.
- If a patient declined referral but clearly had memory loss they could still be diagnosed with dementia.
- For patients referred to the clinic we awaited their opinion on diagnosis.
-

AUDIT OF DEMENTIA DATA (2/2)

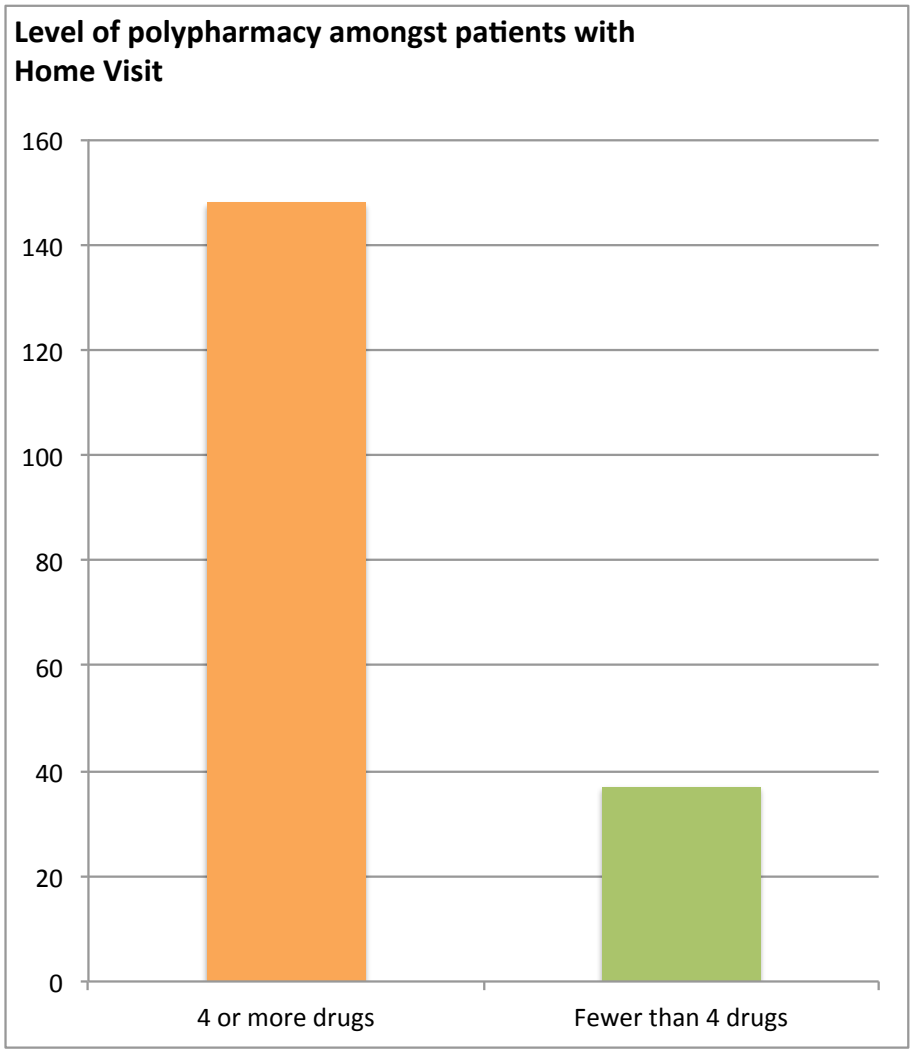
	Practice						
	A	B	C	D	E	F	ALL
Visits	96	136	98	45	32	1	408
6CIT 8+	22	41	11	9	13	1	97
6CIT 8+ as % of visits	*23%*	*30%*	*11%*	*20%*	*41%*	*100%*	*24%*
NET memory loss	21	38	9	9	13	1	91
Referred	14	2	0	4	1	0	21
Referred as % of NET memory loss	*67%*	*5%*	*0%*	*44%*	*8%*	*0%*	*23%*
Refused	4	31	4	6	0	0	45
Refused as % of NET memory loss	*19%*	*82%*	*44%*	*67%*	*0%*	*0%*	*49%*
Seen	8	2	0	3	1	0	14
Seen as % of referred	*57%*	*100%*		*75%*	*100%*		*67%*
Diagnosed dementia	2	1	0	3	0	0	6
Diagnosed as % of seen	*25%*	*50%*		*100%*	*0%*		*43%*

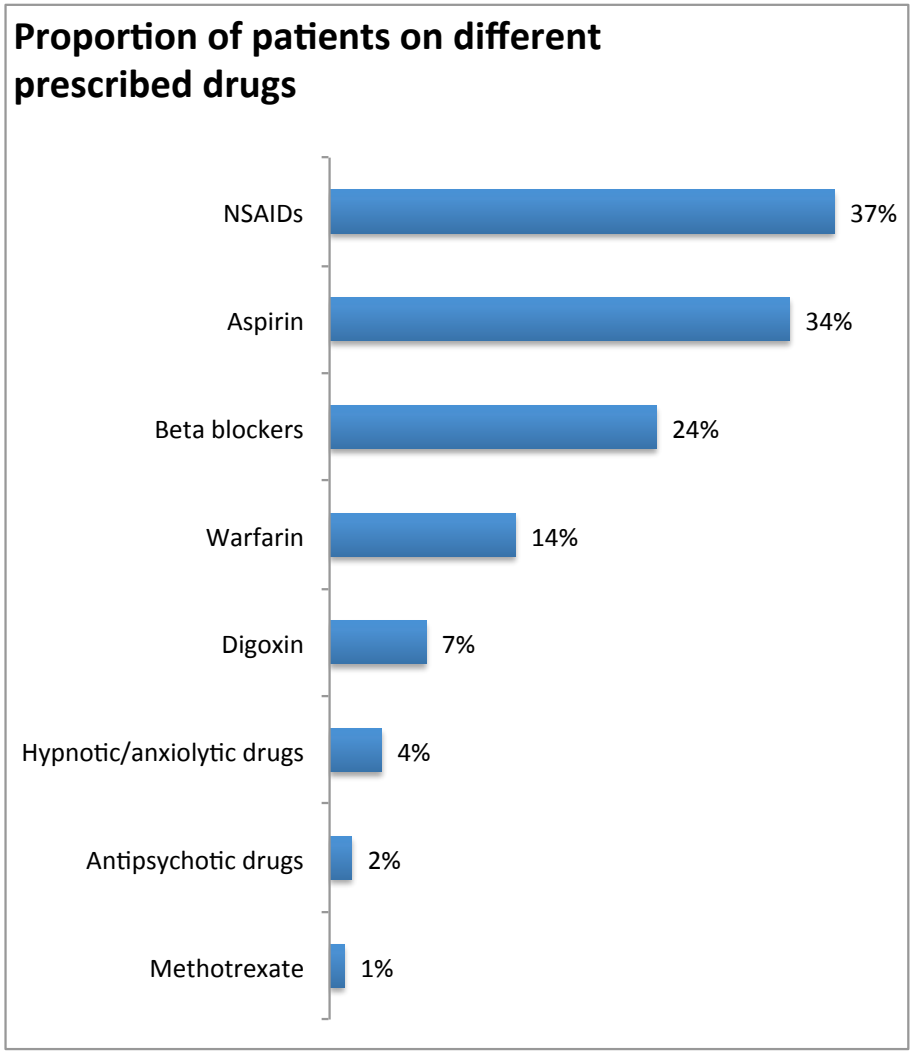
Discussion

- Whilst there are caveats around the numbers, they provide a feel for what is going on.
- The reviews and questionnaire were acceptable to patients and easy to reliably ask and record by the practice staff member.
- A significant number of patients scored poorly on the 6CIT test – an average of 24%.
- Only a small proportion of patients were referred (23%), and then not all were seen (67% of referred)
- A significant number of patients were recorded as refusing - 82% in practice B, 49% overall with a further 28% 'missing' numbers which will be patient refusals or GP advice.
- Over three quarters of our patients with memory problems do not wish to engage with the hospital service. But they will engage with GPs and community workers.
- A Locality application for Innovation funding to develop a community based dementia diagnosis and support service has been submitted to the CCG.

Source: AUDIT OF DEMENTIA DATA Newcastle south locality Over 75 Project – Madeley Practice

Prevalence of polypharmacy and proportion of patients on different drugs - Moss Lane (Madeley) practice only





- 80% had polypharmacy
- Non-steroidal anti-inflammatory drugs (NSAIDs) were mostly widely prescribed group of drugs (37%)
- 1 in 3 were taking Aspirin, and 1 in 7 were prescribed Warfarin

Source: Madeley Practice - based on data for 185 patients who had received a home visit as part of the project on 1 Apr 15

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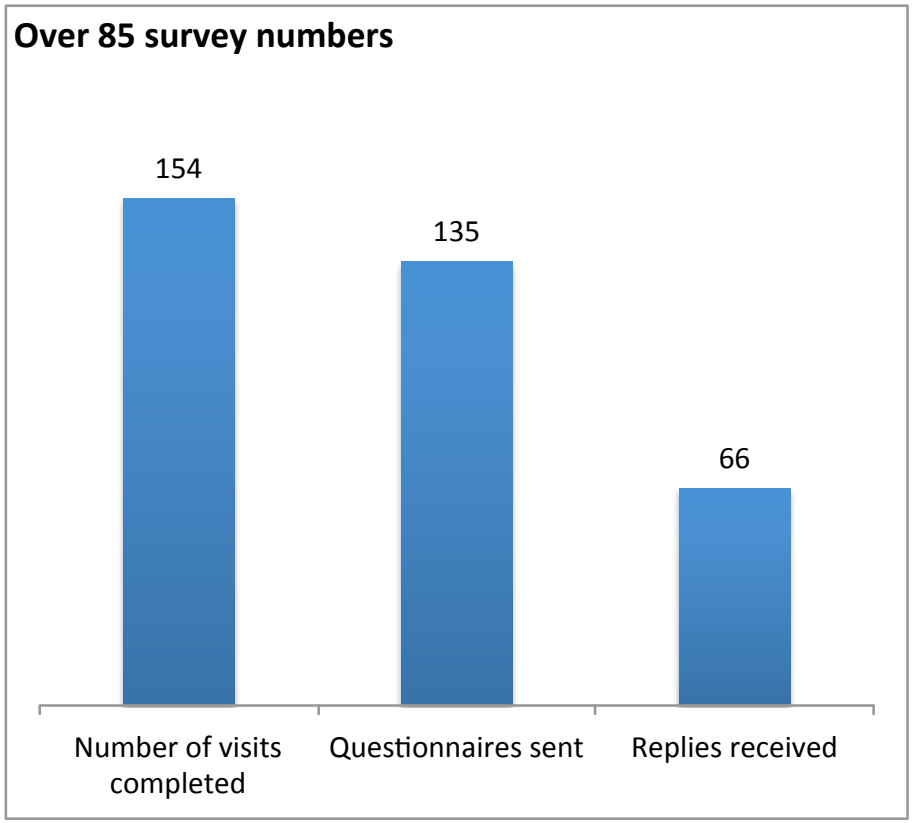
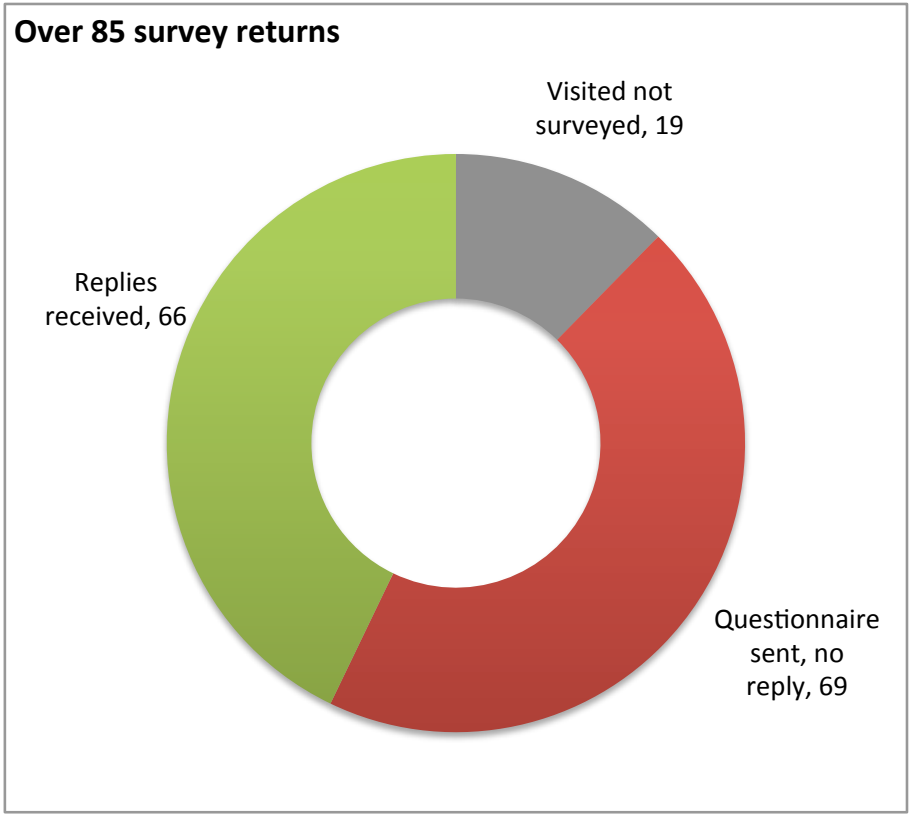
Survey of individuals who received a home visit assessment (1/4)

Madeley (Moss Lane) practice only



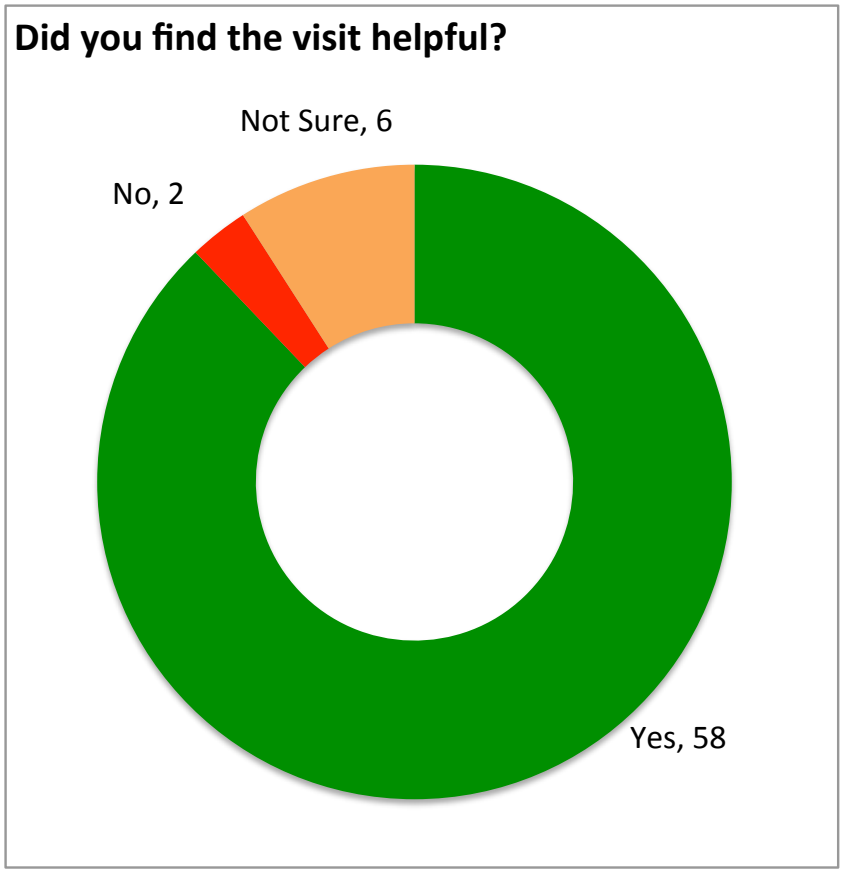


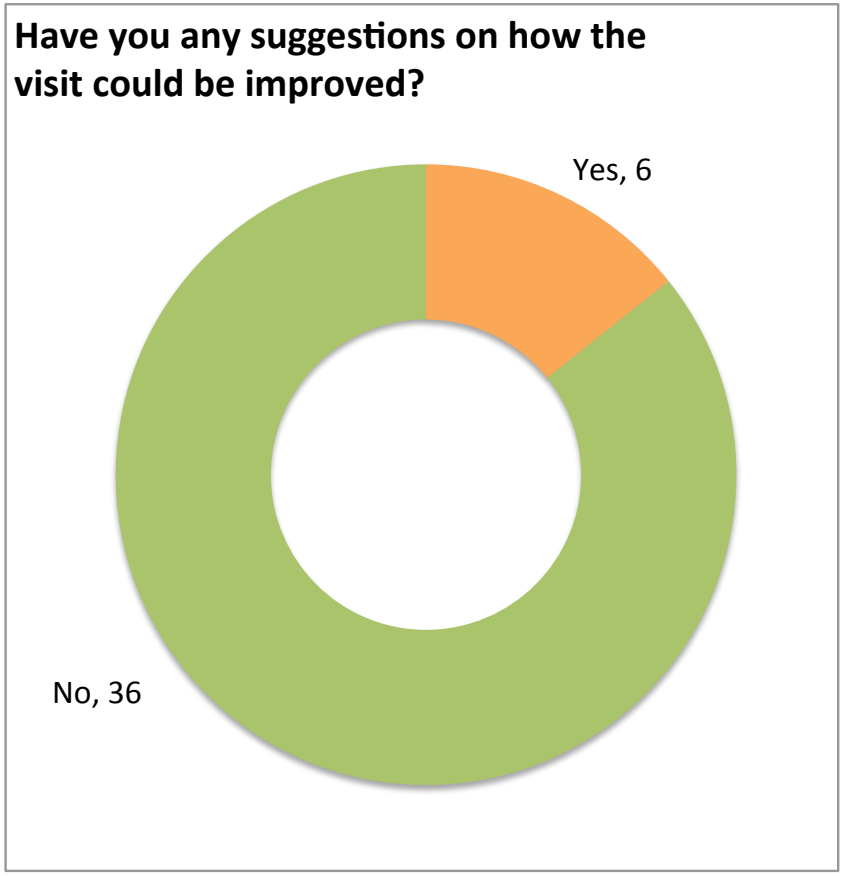
- At the time the survey was carried out, 154 visits had been completed.
- 12% (19) were not sent a questionnaire because they had been deregistered (RIP or moved away)
- Of those that were sent a questionnaire, return rate was around 50% which equates to feedback from around 43% of those visited (or their carers)

Source: Over 85s Home Visit survey, Madeley (Moss Lane) Practice only

Survey of individuals who received a home visit assessment (2/4)

Madeley (Moss Lane) practice only



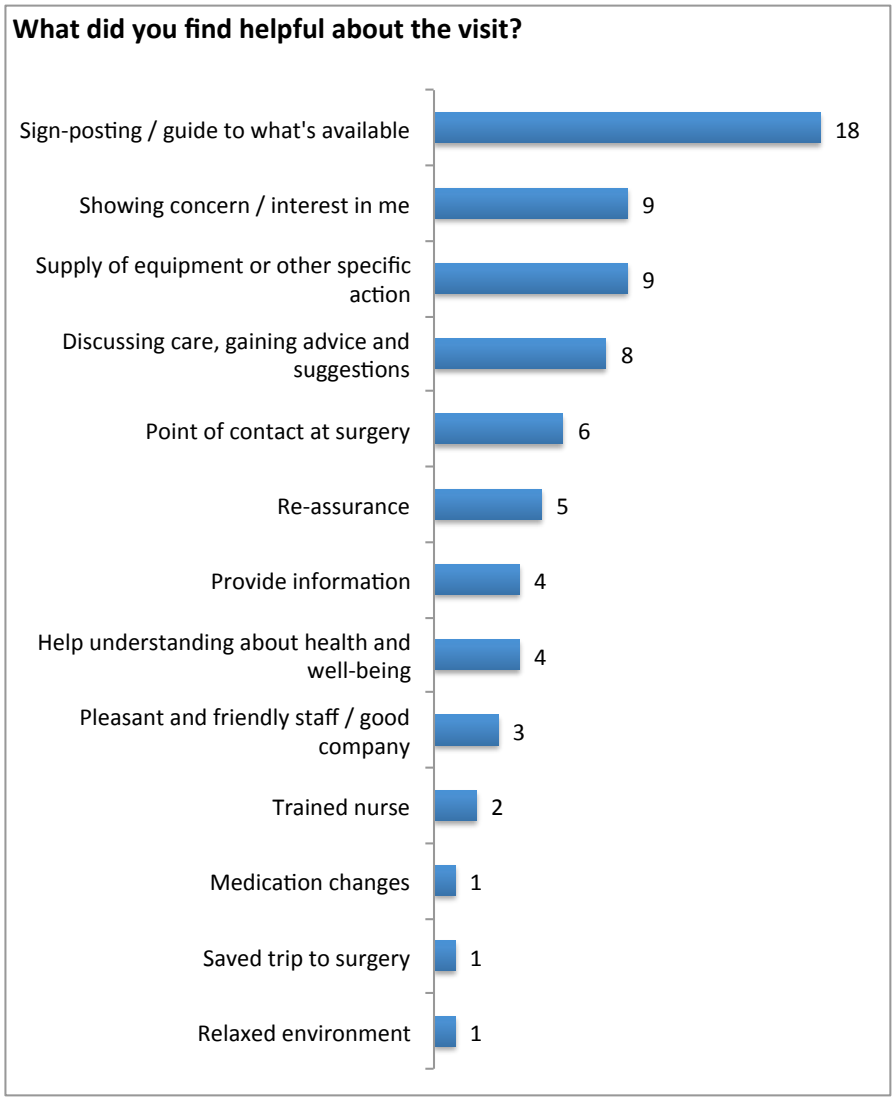


- 88% (n=58) found the visit helpful with only 2 (3%) who did not find the visit helpful and 6 (9%) who were "not sure"
- 42 respondents added a free text comment to the question "Have you any suggestions on how the visit could be improved?" of which the majority (36 or 86%) said "No" directly or indirectly (e.g., "*None, difficult to improve near perfection")*
- Of the six respondents who made a suggestion for change, 3 referred to more regular / frequent visits, 2 implied the visit may not have been necessary and 1 requested information in advance

Source: Over 85s Home Visit survey, Madeley (Moss Lane) Practice only

Survey of individuals who received a home visit assessment (3/4)

Madeley (Moss Lane) practice only



All respondents provided some comment to the question "what did you find helpful about the visit" and these have been categorised as shown on left.

Examples of sign-posting comments include:

- *"helpful to know where to go for help and what is available"*
- *"Was made aware of things available to us…"*
- *Was informed of all the services that are available to elderly people"*

Examples of showing concern include:

- *"The concern shown with health problems and welfare in general"*
- *"I found the fact that the doctors were interested in my health and welfare very uplifting"*

Examples of equipment and actions include:

- *Blue Badge; installation of care box; raising of bed and toilet; appointment at hearing clinic*

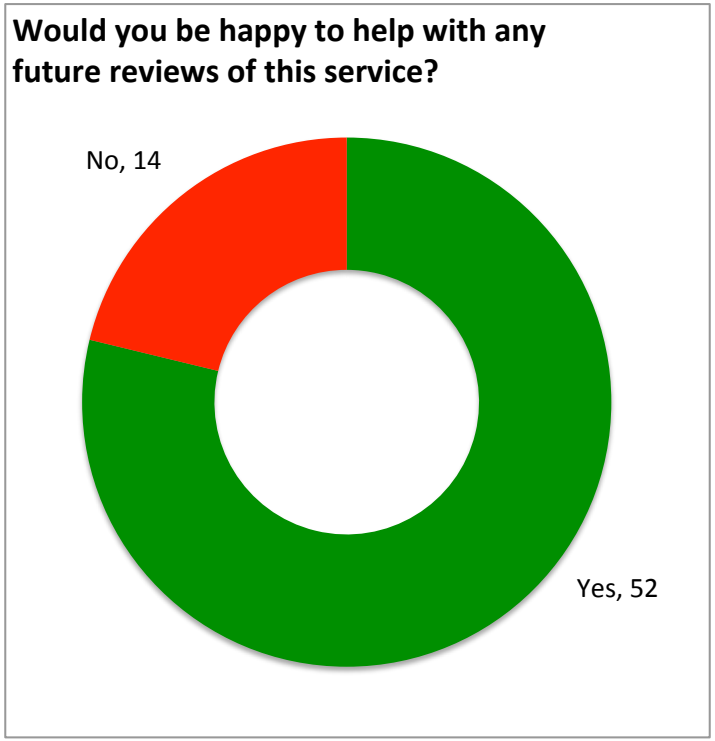
Examples of discussing care include:

- *"Able to discuss my father's care"*
- *"I found the visit to the house most useful as they were able to make suggestions for your own particular problems"*

Source: Over 85s Home Visit survey, Madeley (Moss Lane) Practice only

Survey of individuals who received a home visit assessment (4/4)

Madeley (Moss Lane) practice only



Around 80% of respondents would be happy to help with future reviews of the service.

Respondents were also asked for any additional comments which largely took the form of thanks either specific to visit or to the practice in general e.g.,

- *"Just to thank you all for the help and kindness and courtesy…"*
- *"No further comments necessary, thank you"*

Some comments referred to their situation e.g.,

- *"For my age I feel quite good"*
- *"Although I see in my patient information I am diagnosed with Alzheimer's Disease I am still very independent also helping to care two days a week for my sister who is [90+]"*

Some mentioned future needs e.g.,

- *"If my walker needed replacement would I be able to get a replacement?"*
- *"At the moment – no [further comments] – in the future we may need more help…"*

Some provided additional suggestions:

- *"It would be better if check ups could be done in your own home when you have a visit instead of coming to surgery"*
- *"A visit – maybe after they have been discharged from hospital after a difficult health problem just for advice"*

Source: Over 85s Home Visit survey, Madeley (Moss Lane) Practice only

Practice staff survey (all practices) - Reviewing the project and the work undertaken so far:

What has gone well?

- Good uptake of the project, patients have welcomed the idea of the service & purpose of the visit. Feedback has been positive.
- Patients appreciated the service and those who were positive of the service reported their wellbeing has improved even if no intervention was needed, as reassures them that the patient was looking out for them.
- Patients appreciate being offered the service without having to ask, they don't feel like they are bothering the GP.
- Home visits have worked well to be able to identify care needs previously not identified / that wouldn't be identified from patient coming into surgery for GP/ Nurse appointment.
- Raises awareness of services available for the elderly.

What difficulties have you experienced carrying out the project and how have these been overcome/resolved?

- Some patients are difficult to contact & require additional admin resources to make contact.
- Some patients need their next of kin / carer to be present, this can make arranging appointments more difficult – overcome by being more flexible with the visits i.e. including late starts some days to provide visits after 5.30pm.
- Difficulties when patients ask for the visits to be repeated – this may be picked up with the LiS Scheme.
- Some patients guarded / untrusting as to objectives of the project, overcome by encouragement and reassurance.
- The amount of information required for Audit purposes.

Practice staff survey (all practices) - changes to the project (1/2)

From a practice perspective, have there been any changes made to the process during the project? e.g. change in staff, change in format of visits

- Practice needed to adopt a more structured approach to fit visits in the allocated time allowed.
- As the process progressed there was a change in the patient selection criteria.
- Visits were initially undertaken by practice nurses, this changed to highly trained member of clerical staff, which proved highly successful.
- Review of Tilburg questionnaire scoring was changed, originally 5+ received a home visit, now it is reviewed by a GP and acted on appropriately i.e., appointment, home visit or referral.

Are there any changes you would like to make to the project to improve the current process

- Better communication /publicity/awareness of the aims of the project to the public and present as a service rather than project.
- The Tilburg questionnaire had mixed reviews. Common trends were that it does not select the most at risk population or scoring needed to be adapted. Some practices changed this, others suggested redesign the Tilburg Questionnaire and/or an alternative method of selecting the at risk population would be better.
- Increased time for administration is required.
- Reduction in paperwork / amount of audit information required was a common theme however one practice thought more robust auditing was required.
- Patient evaluation forms to be more timely i.e. shortly after the visit.

Practice staff survey (all practices) - changes to the project (2/2)

If the project continues long term, are there changes that would make the process more effective?

- Whilst a Health Care Assistant (HCA) can do the visits, a prescribing Nurse Practitioner (NP) would enable a more seamless process to include clinical aspects into the visits, a benefit for both patient & practices. Some services will not accept referrals from an HCA, a nurse practitioner with specialist interest in the elderly would be able to provide an improved service.
- Better sharing of information encouraged between carers / wardens where they are supporting patients.
- Tilburg questionnaire – comments as above section.
- Following initial review, all patients would have an annual review, already requested by several patients.

What advice would you give to anyone new taking on this or a similar project?

- A comprehensive introduction to the requirements of the service and what is expected is required
- Do not underestimate the time required for visits, including travel time & to be flexible in the approach especially with time.
- The administrative element can be time consuming with onward referrals, chasing up information etc.
- To have a care co-ordinator as well as someone to undertake the visits to ensure smooth running of the project.

Practice staff survey (all practices) - looking to the future

Looking at future planning – how would this project support the Avoiding Unplanned Admissions Enhanced Service?

- Anticipating demand and identification of potential problems before they reach crisis point.
- Intervention Regarding Falls Prevention.
- Provides the opportunity for patients to discuss ongoing health matters and concerns.
- The project flags up undetected health problems before they result in an hospital admission.
- The project is a starting point for putting together care plans for the Avoiding Unplanned Admissions scheme (AUA), many will be on the 2% register and therefore this project gives a good baseline for those patients and will help to avoid admissions.

Outcomes for patients and other comments

- Patients & relatives have been extremely grateful for the support, the project allows both parties to talk with a member of the practice team in the comfort of their own home enabling problems to come to light that would not have in a 10 minute practice based appointment.
- Patients feel they are respected and thought about.
- Patients state they no longer felt alone and in need of help.
- Patient example provided of patient saying “The system and its application is a winner”.
- A recent satisfaction survey highlighted the benefits of the service, many patients appreciative of equipment supplied following OT referrals, many new claims for Blue Badges and attendance allowance (confirmed by follow up calls to patient).
- Several patients have found the provision of a key safe extremely valuable.

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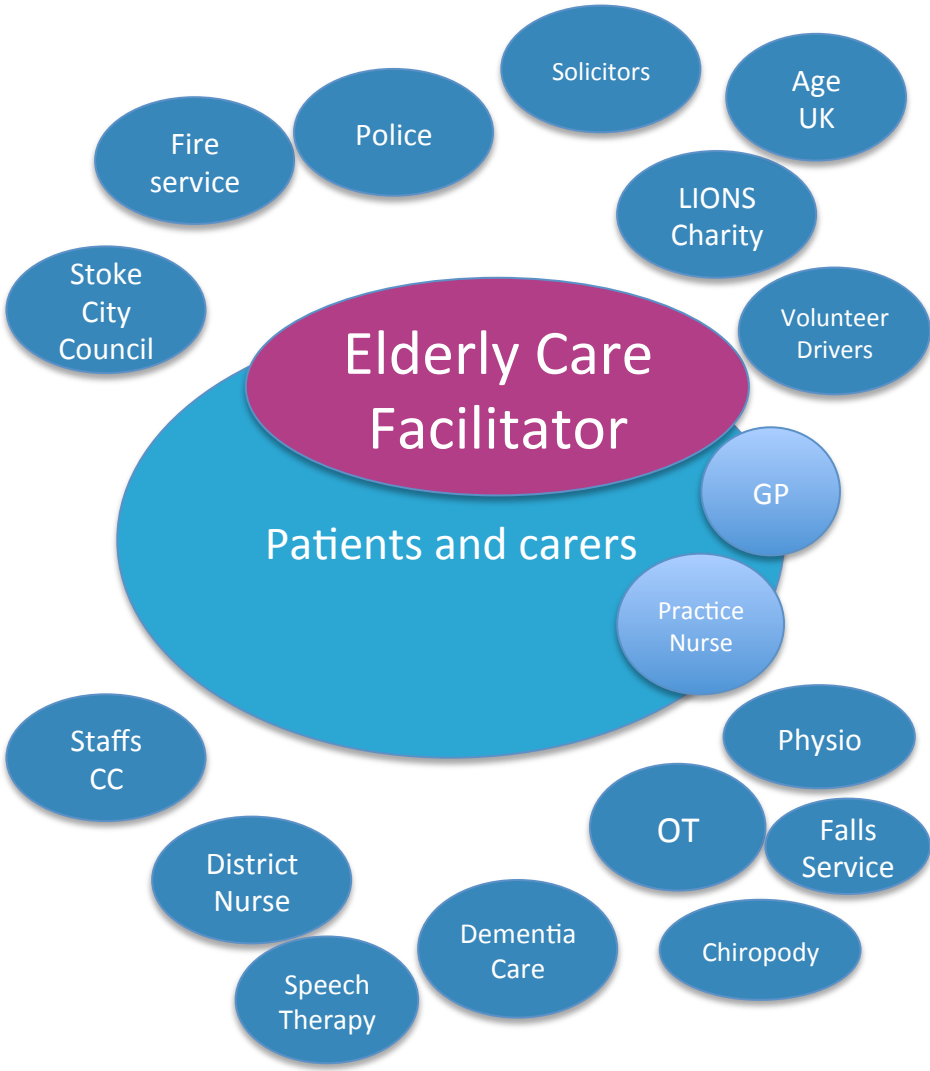
Cost is modest, it works, there is much to learn from and…

- **Cost is modest.** Simple and easy to set up, though process rigor is essential. Practice based, but not GP based.
- **It works.** Very high uptake. 90% over 85s visited, 75% 75 to 84 questionnaires returned. Patients and their carers stay in charge and make the decisions. Enjoyable, rewarding, and excellent feedback.
- **Mobility assessment** – one in four patients over 85 have problems. Extensive involvement of community physio and O.T.
- **Benefit claims** – in the first 12 months over £250,000 per annum in new attendance allowance claims.
- **Dementia screening works** – two practices the best achieving in diagnosis rates for Staffordshire. Gnosall Practice have already demonstrated how a community based service works well.
- **Work with others** – e.g. Stoke Council provided key safes and call care alarms. In a different way support and teaching provided by local solicitors.
- **Prescribing** – comprehensive data, though not effectively used.
- **Tilburg questionnaire for 75 to 84 year olds worked**. 75% returned, quick and easy to assess. Few significant problems identified. Are we using it effectively?
- **Emergency Admissions.** An incidental finding; in most Practices, though not all, there was little or no increase in A&E attendances and in Emergency admissions for the over 75s, over a three year period, compared with a 14% increase in both categories across the whole CCG.
- **IT issues** – can we further reduce theses admissions by sharing information with secondary care and sometimes involving the ECFs? Patient uptake of the LIONS pots implies that they are willing to do this.
- **Practices should continue the work – together, and help others:**
  - This is happening in all six practices, five of who are using the £5 per head funding from the CCG.
  - They need to be prepared to support other Practices who may wish to start such schemes.
  - Practice staff need to meet regularly to share ideas, discuss problems, and maintain consistency and high standards to their work.
  - Continuing to collect this high level of data will give a picture over time.

…it gives rise to a new profession: Elderly Care Facilitators

Establish role of Elderly Care Facilitator (ECF)

- The ECF assesses needs. Communicates and educates.
- The ECF is a matchmaker and facilitator. Practice based. They are the accessible bridge between patients, carers, health professionals, social support, and voluntary groups.
- You can 'Bolt on' whatever the local resources are and address local needs. It allows other projects to work and work well, which might otherwise struggle to get to their target group.
- All practices started with a secretary supporting a nurse. Another model, which arose, was to have a non-clinical person combine both roles.
- Combining the roles works:
  - It was as effective;
  - It reduced the emphasis on clinical issues by ECF, patient and carers;
  - It cost less.
- This gives rise to a new professional post. Training needs? Professional qualification?



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Overview of potential referrals and actions

Area	Problem	Refer to:	Action/notes
Medication	Five high risk issues e.g. NSAID	GP	?Change medication
	Side effects	GP	?Change medication
	Compliance	GP/Pharmacist	?Change medication Weekly Dosette box Home delivery
Lifestyle	Smoker	Practice nurse	Cessation support offered
	Alcohol > guidelines	GP	Reduction support offered
Benefits	Attendance allowance	CAB, AGE UK 2 practices in-house CAB	Claim form given CAB and AGE UK support
	Blue badge	Local Council	Claim form given
	Council tax rebate	Local council	Claim form given
Legal	Will	Private solicitor	AGE UK
	Power of attorney	Private solicitor Knights	Written info. given
	End of life planning	GP	GP consultation/visit
	DNAR	GP	GP consultation/visit
Security	Personal	Lifeline/Local council	Call care alarm – free 6 months
		Lifeline/Local council	Key safe fitting - free
	Home	Fire service	Home visit
		Police PCSO	Home visit
	Personal data	LIONS charity	Message in a bottle scheme
Mobility	Poor	Physio OT and Falls clinic	Referral as appropriate
	Falls/Fracture	GP	?DEXA Ca/vit D
	Foot care	Chiropody	Service provision
Warnings	Admissions	GP	Review records
	Weight loss	GP	GP consultation/visit
Prevention	Annual flu jab	Practice nurse	Offer
	Pneumovax	Practice nurse	Offer
Mental health	Poor memory	GP	Refer memory clinic
	depression	GP	GP consultation/visit

Source: Overview of Services listings

Falls related services

Service	Approach:
Falls Responder Service	• Set up by the charity Lifeline, (based at Stoke City Council) • Receive referrals from the GP Surgery then try to contact the patient within a week to: – Set up a call care alarm (a pendant worn by the patient that connects to the house landline) – A key safe (to lock a key safely in outside the home) • If pendant is pressed by patient, Lifeline dial-in to see if patient responds. If no response then responder is sent to house immediately and gains access via key safe.
Occupational Therapy (OT)	• Community OT based at Bradwell Hospital, although their HUB (where all referrals are sent) is Shelton Primary Care Centre. • Patients referred to OT with Falls Risk Assessment Tool (FRAT) score >=2 because they have suffered falls within the last twelve months, and/or their balance and mobility have deteriorated. • OT would usually be asked to assess the patient in their home to determine whether there are any aids or adaptations that can be put in place to prevent falls and help with the patient's day-to-day living.
Physiotherapy	• Physiotherapy works well alongside OT (HUB also Shelton Primary Care Centre). • Refer to physiotherapy if the patient scores two or more on FRAT due to falls within the last twelve months and/or deteriorating balance and mobility. • Physio assess the patient's potential for rehabilitation. • Physio provide exercises to increase/maintain muscle strength and also provide appropriate walking aids if needed.

Source: Overview of Services listings

Security related services

Service	Approach:
Police Security Checks	• Local police (PCSOs) provide home security checks in the local area for elderly patients who are concerned about the security of their property. • GP Surgery telephones the Police Airwave and leaves an answerphone message with the patient's details asking them to contact the patient directly. • Checks include: locks on windows and doors, garden fencing, burglar alarms, etc. • They do not have the funding to provide anything free of charge, they are happy to advise of anything that can be done to increase security.
Fire Safety Checks	• Newcastle-under-Lyme Borough Council Fire Service provides free home fire risk checks. • A "voucher" is left with the patient so that they can telephone to arrange a convenient time to suit them. • Fire Service assess potential fire risks within the home, and make sure that everything is in place in the case of a fire. • They will provide smoke alarms free of charge when they are required.
LIONS Pots	• LIONS International has set up a local club in Newcastle-under-Lyme who provide the "message in a bottle" scheme free of charge. • It encourages patients to keep their basic personal and medical information in the bottle, and then store it in the fridge where it can be found in an emergency. • Emergency Services will know if a patient has the bottle by two stickers; one is stuck to the inside of the main entrance to the home, the other to the fridge door.

Source: Overview of Services listings

Memory, legal and local services

Service	Approach:
Memory Clinic	• Based at Bradwell Hospital and run by Dr Udeze, Consultant Psychogeriatrician. • Patients are referred to the memory clinic, with their consent, if Six-item Cognitive Impairment Test (6CIT) score >=8. • Dr Udeze and the nurses at the clinic assess any potential memory issues by talking to the patient and performing further memory tests. • Require GP to do standard blood tests and an ECG before the referral is made. • Clinic would usually arrange a head CT and any other tests that may be required. • If patient is deemed to not have memory problems, or is diagnosed with vascular dementia, they are discharged from the service (nothing further they can do). • Any other “memory” diagnosis, including Alzheimer’s, the patient will be reviewed by the clinic on a 3-6 month basis.
Knights Solicitors	• A local company of solicitors with offices in Newcastle-under-Lyme and Chester. • Provided teaching for all of the Practices about Wills and lasting power of Attorney and written information for patients which is given to patients at the home assessment.
Madeley & District Community Association	• M&DCA is a registered charity which relies on donations and grants to keep its services going. • A band of dedicated volunteers are able to offer lifts to people who are unable to get to their medical related (Hospital, Doctors etc.) appointments. • A community Café runs on weekly on a Wednesday at the Madeley Methodist Church is going really well , people come along for a light lunch and a chat.

Source: Overview of Services listings

Local council and small local Practice specific services

Key safes

- Occupational Therapy are able to provide you with a key safe, alternatively simple digital key safes are available from most large DIY stores and from specialist security services.

Call Care Alarms

- Stoke Lifeline provide the alarm and responder service which is free for the first 6 months.
- Age UK provide a similar service.

- Transport - Volunteer drivers
- Befriending - Weekly café
- Rural Isolation - Weekly home delivery of medicines

Source: Overview of Services listings

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Elderly Health - patient information (1/8)

Topic	Approach:
Consent for carers to talk to Madeley doctors and nurses	• For reasons of confidentiality we may only discuss a patient's problems and treatment with the patient. • We do, however, have a simple consent form, that if you wish to sign would allow us to speak to a nominated carer or next of kin regarding your medical and social care, e.g. giving them blood test results, discussing your health, discussing medication and giving the medicines. • Forms are available at reception.
General day-to-day living	• If you are experiencing problems with day to day activities such as washing, dressing, taking medicines we can ask a social worker to visit you and carry out an assessment of your needs with a view to providing additional home care. • Any care services that are provided do have to be paid for. • You may contact the Practice based Social Worker, Steve Thomson, via Madeley Surgery reception without the need to see a doctor. • If you are experiencing problems with your walking or have suffered falls then we can ask a physiotherapist to help you, and an occupational therapist to visit your home, e.g. to provide ramps to your front door or rails within the house. • Referral to the local Falls Clinic service is available where appropriate. • Hip protectors can be bought privately. Stair lifts also have to be purchased privately. • Anyone over 75 years old should consider taking a daily calcium and vitamin D supplement which is available on prescription. • Where appropriate we may request a DEXA bone scan to be carried out to exclude osteoporosis. If osteoporosis is diagnosed additional treatment can be offered.

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

Elderly Health - patient information (2/8)

Topic	Approach:
Mood and memory	• As we get older we may become dependent on others and more restricted in our day-to-day abilities and it is quite easy to feel low. If this is an issue do talk to us. • There are a variety of informal befriending and more formal counseling services available. Sometimes treatment with anti-depressants medicines is helpful. • Deteriorating memory can be another problem. There are simple assessment test that we can use and where appropriate we can refer you on to a specialist Memory Clinic at the hospital. Medication may sometimes be offered to attempt to slow down changes.
Other social support	• Where appropriate Day Care and holiday relief admissions can be arranged. There are also activities and support groups available at the new Madeley Village Centre. Ask for detailed information. • Alan Wilson runs a Community Café Project with volunteer drivers and holds a weekly Wednesday morning café to which transport can be arranged at the Methodist Chapel. Telephone number 751164.
Driving	• We all regard access to our own car as essential but as we get older it is important that you are fit to drive because of safety for yourself and others on the road. • If you drive when you are not considered to be fit to drive you may also invalidate your car insurance and make yourself liable for substantial financial costs. • If you have any concerns regarding if you are fit to drive, then either contact one of the Doctors or the DVLA. • For help with transport phone Alan Wilson 751164.

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

Elderly Health - patient information (3/8)

Topic	Approach:
Other health services	• The district nurses are based at Madeley Surgery and can be contacted on 752087. • They provide a community nursing service and can arrange for blood tests to be taken at home. • Physiotherapy referrals and occupational therapy referrals can be made by a GP. • For some specific problems, such as incontinence, we can refer you to one of the local incontinence advisors for further assessment and provision of pads where appropriate. • Chiropody services are available at the Surgery and under special circumstances by a visiting chiropodist. The need for treatment is, however, assessed independently of the Surgery and you must be considered to be in a high risk group to be eligible for treatment.
Key safes	• Occupational Therapy are able to provide you with a key safe, alternatively simple digital key safes are available from most large DIY stores and from specialist security services. • They can be hard fixed to the outside of your house in a hidden area. Access to the box is by a four digit code. A spare front door key for your own use or for access by carers can be left inside. • If you do fit one it is helpful for us to know the code at the Surgery in case we need to visit.

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

Elderly Health - patient information (4/8)

Topic	Approach:
Care call alarms	• These can be worn as a pendant or put on the wrist and are worth considering. A local contact is essential for the alarm company to contact if the alarm is activated. • Stoke Lifeline provides the alarm and responder service free for the first 6 months. • Age UK provide a similar service.
Hearing problems	• Initial referrals have to be made by a GP but if you already have an NHS hearing aid you can contact the Endon Audiology Clinic direct on 504109.
Eye checks	• We recommend that you have your eyes and your vision checked at least annually by a qualified optician who can form a more comprehensive assessment than ourselves and can make appropriate recommendations regarding glasses. • They will also screen for conditions such as cataracts and glaucoma and can either refer directly to the eye specialist or back to ourselves. • If you are housebound and require a home visit for a general eye examination this can be arranged by contacting Heron House on 0800 389 8832.

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

Elderly Health - patient information (5/8)

Topic	Approach:
Dental care	• We recommend that you see a dentist on a regular basis.
Attendance Allowance	• Forms are available by phoning the Department of Work and Pensions on 08457123456. The form will be sent out with a stamp addressed envelope. • Someone can qualify if they need attention or supervision from another person: – Attention means active help from another person; – The help must take place in the physical presence of the disabled person; – It can include hands on care such as help getting in and out of the bath; – It doesn't have to involve physical contact so long as it is some form of personal contact, e.g. prompting someone to carry out activities such as prompting someone to eat regularly will fulfill the criteria. • Supervision means keeping an eye on someone to assure that they don't put themselves or others in substantial danger. It includes being ready to intervene if something goes wrong, e.g. if someone with dementia is prone to wandering off. • Further details regarding Attendance Allowance is available at www.nhs.uk/carersdirect.
Disabled driver badge report (Blue Badge)	• This is available for both as a driver and as a passenger if you have a permanent problem with walking and are no longer able to walk more than 50 metres without stopping using an aid. • Forms are available from the Surgery or from Newcastle Borough Council now based at the Madeley Village Centre.

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

Elderly Health - patient information (6/8)

Topic	Approach:
Council Tax Exemption	• Anyone with a severe mental impairment including dementia, living on their own and receiving the appropriate Disability Benefit such as Attendance Allowance is exempt from paying Council Tax. • Contact Newcastle Borough Council directly on 01782 715500 or the Madeley Village Centre Office and speak to one of the officers who will arrange an assessment. The doctors will be happy to sign the necessary paperwork. • Individuals or couples may also qualify for main Council Tax benefit if they have a low income and no more than £16,000 in savings.
Legal aspects	• Make sure that you have an up-do-date Will. • Wills can be quite tricky to draw up and we do recommend that you seek legal advice. • Some patients would like to draw End of Life Advanced Care Plans to explain what their wishes are with regard to hospital provisions and treatments. Do talk to a doctor or nurse for further information if you do wish to do this. • Similarly you may wish to sign a Do Not Resuscitate Form which does not mean that medical treatment is withdrawn if you fall ill but it is a way of saying that you would not wish a team or Paramedics arrive in a blue light ambulance to defibrillate you and carry you off to Casualty if you collapsed. • If your memory is not as good as it was and you were experiencing difficulty managing your affairs, you may wish to draw up a legal Power of Attorney. This is a complex legal document and again we advise that you seek specialist legal help.

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

Elderly Health - patient information (7/8)

Topic	Approach:
Medicines	• Sometimes it is difficult to collect your medicines from the chemist or from the Surgery. Sometimes it is difficult to remember to take them. • You may ask your pharmacy or if we dispense to you ask our dispensary whether they would deliver your medicines to you and whether they would put them in a dosette box. These services should be available free of charge.
Flu jab and pneumococcal jab	• We advise that you receive an annual 'flu jab. These are normally available late September through to December and you should receive a written invitation each year. If you are not able to attend the Surgery we can visit. • Pneumococcal vaccination is a one-off vaccination that gives excellent protection against the pneumococcal bacteria which is the main cause of chest infections and it is recommended that everybody over the age of 65 receives this vaccination. You can contact the Surgery at anytime during the year and make an appointment with the nurse for this to be given.
Other useful resources:	• **Citizens Advice Bureau -** We are fortunate that the Citizens Advice Bureau hold a clinic with pre-bookable appointment times every second Wednesday morning at Madeley Surgery. You can book an appointment through Madeley reception. • **Fire Brigade -** The local Fire Brigade are able to provide Home Fire Risk checks free of charge. Contact them on 0800 024 1999. • **Keeping Warm** - For advice on keeping warm and saving money on your heating bills, contact Beat The Cold on 0800 389 2258. • **PALS** - For help with any medical hospital related matters or GP surgery matters, contact PALS on 0800 030 4563.

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

Elderly Health - patient information (8/8)

Topic

Other useful resources:

Approach:

- **Madeley Police** - For advice on home security please contact PCSO John Cartwright 8870 either by ringing 101 – Staffordshire Police non emergency telephone number or visit him at The Madeley Centre, New Road, Madeley.
- **Newcastle Lions -** Newcastle Lions offer a 'Message in a bottle' Service, this is where medical information can be written down and kept in a bottle which is kept in your fridge at home in case of a medical emergency, we do have a supply of these bottles at the Surgery with details on their use.
- **Social Services -** A social worker attends Madeley Surgery every Wednesday between 11.00am and 12.30pm, appointments can be booked via the Surgery.
- **www.staffordshirecares.info** A good website for local information.

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

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Visit Pack Content Checklist

- Print out of Patient Summary
- Print out of Questionnaire (completed by patients aged 75-84 years old)
- Assessment checklist
- Action Points
- FRAT Assessment Tool (falls) – Staying Steady Leaflet
- Six Item Cognitive Impairment Test (6CIT)
- Screening questions for depression and Patient Health Questionnaire – PHQ9
- FAST – Fast alcohol screening test and Audit Questionnaire – Alcohol
- Useful Telephone Numbers List
- Groups, Clubs and Societies List
- Elderly Health – patient information leaflet
- Next of Kin/Care consent form
- Council Tax Exemption Form – patients suffering from severe mental impairment
- Attendance Allowance Form
- Blue Badge Application Form
- DNAR form
- Lasting Power of attorney

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

Assessment check form

Assessment Check List

EMIS No .....

Next of kin: Name:..... Relationship: .....Contact: .....Consent: .....

Main carer: Name: ..... Relationship: .....Contact: .....Madeley Patient? .....

Co-morbidity	CVA/TIA Epilepsy	IHD Dementia	BP CCF	Diabetes Cancer	COPD CKD
Drugs	BDZ/Z	Antipsychotic	NSAID	Diuretic/ACEi	4+
Lifestyle	Never smoked	Ex-smoker	Current smoker	Alcohol > guidelines	Alcohol <guidelines
Dispensing issues	Understanding	Compliance	Side effects	Under usage check	Nomads
Social benefits	Att Allowance	Blue Badge	Council tax rebate	Call Care	Key safe
Legal	Will	Power of Attorney	End life planning	DNAR	
PHCT etc Either has or required	District nurses Social worker Volunteers	Physiotherapy Geriatrician Meals on Wheels	Occ Therapy Psychogeriatrics Day Care	Chiropody Dietician Respite	CPN Speech Falls Clinic
Warnings check	Admissions <12 months Mini mental/6CIT	A&E<12months PHQ9	OOH<12months Continence	Weight Loss	
Falls	FRAT Questionnaire	DEXA	Cal/Vit D		
Other	flu	Pneumovax	Lions message in a bottle	Police security check	Fire Check
Action Points	What	Who	Give Elderly Health Patient Information Sheet - in pack	Give Useful Telephone Numbers and Groups, Clubs and Societies List	

Time taken: .....

Letter sent: .....

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

Carer form

Name: .....

Date of Birth: .....

Address:

.....

NAME	RELATIONSHIP	ADDRESS	TELEPHONE NO	TICK AS APPROPRIATE			
				CARER	NEXT OF KIN	CONSENT TO ORDER & COLLECT PRESCRIPTIONS	CONSENT TO DISCLOSE MEDICAL INFORMATION TO

Signed ..... Date.....

6CIT

Six Item Cognitive Impairment Test (6CIT)

Name: ..... **DOB:** .....

Date: .....

1.	What year is it	Correct 0 pts Incorrect 4 pts
2.	What Month is it	Correct 0 pts Incorrect 3 pts
3.	Give the patient an address phrase to remember with 5 components eg John, Smith, 42, High Street, Bedford	
4.	About what time is it (within 1 hour)	Correct 0 pts Incorrect 3 pts
5.	Count backwards from 20 - 1	Correct 0 pts 1 error 2 pts More than One error 4 pts
6	Say the months of the year in reverse	Correct 0 pts 1 error 2 pts More than One error 4 pts
7	Repeat address phrase	Correct 0 pts 1 error 2 pts 2 errors 4 pts 3 errors 6 pts 4 errors 8 pts All wrong 10 pts

6CIT score = /28

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

Patient Health Questionnaire – PHQ-9

Screening Questions for Depression

- During the past month, have often been bothered by:
  - Little interest or pleasure in doing things?
  - Feeling down or hopeless?
- If a patient answers yes to either of these questions, then complete PHQ9.

PATIENT HEALTH QUESTIONNAIRE – PHQ-9[15]
Nine Symptom Depression Checklist

Patient Name: ..... Date: .....

1. Over the *last 2 weeks* how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

2. If you checked off any problem on this questionnaire so far how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat Difficult	Very Difficult	Extremely Difficult
☐	☐	☐	☐

Total Number of Symptoms: ..... Total Score: .....

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

Falls Risk assessment tool (1/2)

Falls Risk Assessment Tool

Service User Details:	NHS No:	Name:	DOB:	Date of Assessment:	No. of Falls in past 12 months:

FALLS QUESTION	ACTIONS – Circle the appropriate number response for each question; give falls advice to all patients/clients and refer all appropriate patients/clients following the guidance on page 2			
1. Is there a history of falls in the last twelve months?	**No Falls:** Give general falls prevention and healthy lifestyle advice 1	**Single fall known cause:** • Give Falls advice • Suggest environmental modifications if appropriate • Refer to specialist falls service if necessary 3	**More than one fall/fear of falling:** • Give falls advice • If significant effect on quality of life refer to rehab team 3	**Unexplained fall/loss of consciousness:** • Advise patient to see GP • Give falls advice • Refer to specialist falls service 3
2. Are you on more than four medications?	**No:** Give general falls prevention and healthy lifestyle advice 1	**Yes, but medication review completed in last 12 months:** Give general falls prevention and healthy lifestyle advice 1	**Yes, with no recent medication review:** • Advise patient to contact GP for medication review • Give falls advice 1	**Yes, with history of falls** • Refer to specialist falls service • Give falls advice 3
3. Have you been diagnosed with a Stroke or Parkinson's disease?	**No:** Give general falls prevention and healthy lifestyle advice 1	**Yes**, & receiving specialist services • Give falls advice • Liaise with specialist service if patient has a h/o falls 2	**Yes,** not receiving specialist service • Give falls advice • Refer to specialist and/or rehab/OT team as necessary 2	
4. Do you have any problems with your balance?	**No:** Give general falls prevention and healthy lifestyle advice 1	**Yes,** known cause and managed appropriately • Give falls advice 1	**Yes,** known cause but needs review of management • Refer to physiotherapy (2) or if patient has h/o falling refer to specialist falls service (3) 2 or 3	**Yes**, cause unknown • Advise to see GP • Refer to physiotherapy (2) or if patient has h/o falling refer to falls service (3) 2 or 3
5. Are you able to rise from a chair of knee height without using your arms?	**Unable due to physical disability –** If patient is bed bound/hoisted referral may not be appropriate 0	**Independent:** Give general falls prevention and healthy lifestyle advice 1	**Difficulty rising:** Refer to Rehab/OT team 2	

Name of person completing form:	Signature:	Date:

Please note that the numbers are not scores – they are a guide for referral. See page 2 for referral guidelines.

Outcome (please tick):	NO RISK ☐	REFERRED TO LEVEL 2 OR 3 SERVICE & CARE PLAN COMPLETED ☐

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

Falls Risk assessment tool (2/2)

Falls Risk Assessment Tool Referral

Service User Details:	NHS No:		Name:	DOB:
Details of person completing this form:	Name:	Job Title:	Base:	Tel:

Referral Procedure:

If the patients highest individual score is 1:

General Falls Prevention Advice - Offer falls advice/prevention leaflet to all patients/clients. Offer 'STAYING STEADY' leaflet to all patients/clients (available from www.ageuk.org.uk/healthandwellbeing). Provide information for voluntary sector falls prevention / exercise groups e.g. Age UK.

If the patients highest individual score is 2 or 3:

Refer for additional assessment - Fax a copy of this form **AND completed SAP contact form** to: **0300 123 0996**

PATIENT CONSENT:
Please note, this referral will be declined if this section is not completed.

I agree to a referral being made to the Rehab Team; Occupational Therapist; Physiotherapist and/or the Specialist Falls Service (delete as appropriate).
I have been provided with information about falls prevention.

Service User Name: _____ Signature: _____ Date: _____

Unable to obtain written consent, verbal consent given to: _____(staff member name). Signed: _____ Date: _____

Other factors to consider:

Is footwear / foot care appropriate?	Yes = No further action	No = give footwear advice and consider Podiatry appointment
Are you able to summon help if needed?	Yes = No further action	No = give advice on assistive equipment e.g. lifestyle; careline; aspire
Is mobility impaired?	No = No further action	Yes = consider referral to rehab team

Page **2** of **2**

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

Fast Alcohol Screening Test & Audit questionnaire

Audit Questionnaire
(Saunders et al Addiction 1993: 88 . 791-803)

Please circle the answer that is correct for you

How often do you have a drink containing alcohol?

0	Never
1	Monthly or less
2	2-4 times a month
3	2-3 times a week
4	4 or more times a week

How many standard drinks containing alcohol do you have on a typical day when drinking?

0	1 or 2
1	3 or 4
2	5 or 6
3	7 or 9
4	10 or more

How often do you have six or more drinks on one occasion?

0	Never
1	Less than monthly
2	Monthly
3	Weekly
4	Daily or almost daily

During the past year, how often have you found that you were not able to stop drinking once you had started?

0	Never
1	Less than monthly
2	Monthly
3	Weekly
4	Daily or almost daily

During the past year, how often have you failed to do what was normally expected of you because of drinking?

0	Never
1	Less than monthly
2	Monthly
3	Weekly
4	Daily or almost daily

During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?

0	Never
1	Less than monthly
2	Monthly
3	Weekly
4	Daily or almost daily

During the past year, how often have you had a feeling of guilt or remorse after drinking?

0	Never
1	Less than monthly
2	Monthly
3	Weekly
4	Daily or almost daily

During the past year, have you been unable to remember what happened the night before because you had been drinking?

0	Never
1	Less than monthly
2	Monthly
3	Weekly
4	Daily or almost daily

Have you or someone else been injured as a result of your drinking?

0	No
2	Yes, but not during the past year
4	Yes, during the past year

Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?

0	No
2	Yes, but not during the past year
4	Yes, during the past year

8 or more = harmful/hazardous drinking
13 or more (women) 15 or more (men) = likely to indicate alcohol dependence

Patient Name: .....

Date of Birth: .....

FAST
Fast Alcohol Screening Test

1 drink =
½ pint beer OR
1 glass of wine OR
1 single of spirits

1) MEN: How often do you have EIGHT or more drinks on one occasion?
WOMEN: How often do you have SIX or more drinks on one occasion?

0	Never
1	Less than monthly
2	Monthly
3	Weekly
4	Daily or almost daily

2) How often during the last year have you been unable to remember what happened the night before because of drinking?

0	Never
1	Less than monthly
2	Monthly
3	Weekly
4	Daily or almost daily

3) How often during the last year have you failed to do what was normally expected of you because of drinking?

0	Never
1	Less than monthly
2	Monthly
3	Weekly
4	Daily or almost daily

4) In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

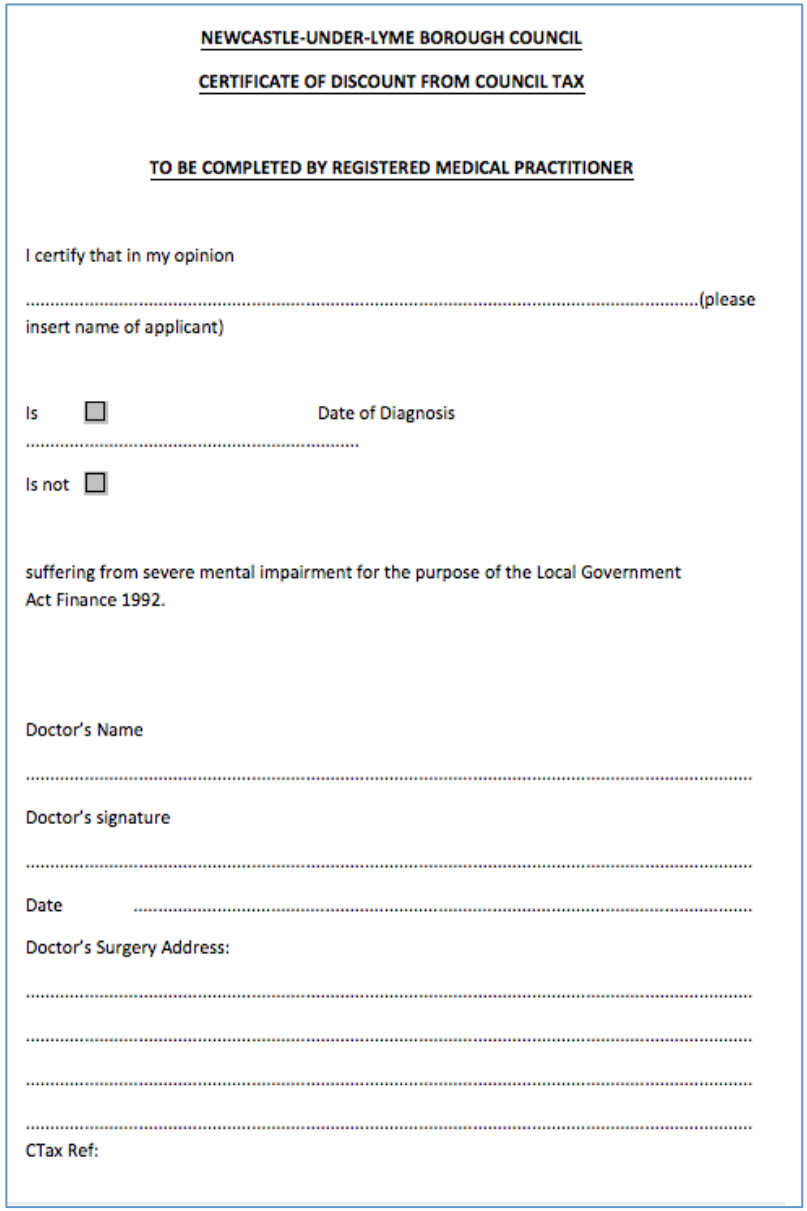
0	No
2	Yes on one occasion
4	Yes on more than one occasion

The minimum score is 0, the maximum score is 16
A positive response to any of the questions is predictive of an alcohol problem.
The score for hazardous drinking is 3 or more

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

Claiming allowance, benefits and discounts

- **Attendance allowance claim form:**
- https://www.gov.uk/government/publications/attendance-allowance-claim-form
- Applying for a Blue Badge
- https://bluebadge.direct.gov.uk/directgovapply.html



NEWCASTLE-UNDER-LYME BOROUGH COUNCIL

CERTIFICATE OF DISCOUNT FROM COUNCIL TAX

TO BE COMPLETED BY REGISTERED MEDICAL PRACTITIONER

I certify that in my opinion

.....(please insert name of applicant)

Is ☐ Date of Diagnosis .....

Is not ☐

suffering from severe mental impairment for the purpose of the Local Government Act Finance 1992.

Doctor's Name

.....

Doctor's signature

.....

Date .....

Doctor's Surgery Address:

.....

.....

.....

.....

CTax Ref:

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

Do Not Attempt Resuscitation (DNAR) proforma (1/2)

NORTH STAFFORDSHIRE HOSPITALS AND PRIMARY CARE TRUSTS

DO NOT ATTEMPT RESUCITATION (DNAR) PROFORMA

Name .....

Address .....

.....

DOB .....

Unit No .....

ATTACH PATIENT LABEL (if available)

THIS FORM DOES NOT CONSTITUTE PART OF THE MEDICAL RECORD

This proforma is to be completed by the Consultant/Staff Grade/Registrar/General Practitioner. The proforma should be kept inside the patient's medical notes within the hospital setting and in nursing/patient held records within Primary Care

THE DNAR ORDER AND REVIEWS MUST BE WRITTEN PROMINENTLY IN THE MEDICAL NOTES BY THE DOCTOR MAKING THE DECISION.

Please read notes on reverse of this form.

Date	Doctors Name (PRINT)	Doctors Signature	Grade	Ward/ Setting	Documented in notes (tick)	Nurses Name (PRINT)	Nurses Signature	Review Date

Has the decision not to resuscitate been discussed with the patient? YES/NO

N.B. THIS PROFORMA SHOULD BE DESTROYED WHEN THE PATIENT IS IDENTIFIED FOR RESUSCITATION.

Any change in a patient's condition that results in change of resuscitation status must be recorded in the patient's notes and documented that the DNAR proforma was destroyed.

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

Do Not Attempt Resuscitation (DNAR) proforma (2/2)

Guidelines for physician regarding Resuscitation Status

- There must be a multidisciplinary discussion about the patients' condition before any decision not to attempt resuscitation is made.
- The wishes of the patient and relatives should be considered where appropriate; in the decision making process and it is the consultants' responsibility to ensure that this is the case.
- The DNAR order and reviews must be written prominently in the medical records by the doctor making the decision 'Not for cardiopulmonary resuscitation' or words to that effect MUST BE WRITTEN IN FULL with the date, time, clinical justification, and those consulted with their views and the patients documented consent if applicable. The notes must then be signed and the name and job title must be printed.
- The proforma should be completed to alert clinical staff involved in the care of that patient that a DNAR decision has been made.
- A DNAR order applies solely to Cardiopulmonary resuscitation and does not affect any other aspect of treatment.
- A DNAR order is acceptable only if it is deemed in the 'best interest of the patient.' Circumstances that warrant a DNAR order include.
  - If the patients life expectancy is very short
  - Resuscitation presents an unacceptable probability of brain damage or death even if successful.
  - The resulting length and quality of life would not be acceptable to the patient.
  - If the resuscitation is against a mentally competent patients sustained and documented wishes including Advanced Directives.
- Regular review of resuscitation status must be undertaken to allow for changes in the patient's condition and wishes. The frequency of the review should be determined by the health professional in charge and will be influenced by the clinical circumstances of the patient. It is important to note that patient's abilities to participate in decision making may vary over time.
- The senior nurse present who is responsible for informing the health care team records the DNAR order and reviews in the nursing notes.

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

Groups, clubs and societies

GROUPS, CLUBS AND SOCIETIES

Madeley

The Madeley Centre, New Road Madeley. 01782 751808

Activity	Venue	Details	Contact
Yoga	The Madeley Centre	Monday 7.00pm to 8.30pm	Yvonne Bradley 01782 750178
Indoor Bowling	The Madeley Centre	Monday (winter) 1.00pm to 3.30pm	Kath Elms 01782 751132
Zumba Fitness	The Madeley Centre	Tuesday 7.00pm to 8.00pm	Sarah
Bokwa	The Madeley Centre	Wednesday7.30pm to 8.30pm	Sarah
Madeley and District First Responders	The Madeley Centre	Monthly	Anthea Bourne 01782 750051
Adult Karate	The Madeley Centre	Thursday 7.30pm – 8.30pm	Dave Blower
Darby and Joan	The Madeley Centre	Every other Wednesday 2..00pm to 4.00pm	Sheila Lines
Bingo	The Madeley Centre	Tuesday 7.30pm to 9.30pm	Glynys Lightfoot 01782 750459
Craft Group	The Madeley Centre	Every other Wednesday 2.00pm to 4.00pm	Pastor Doris Owen
USA	Various in Area	Please contact for details	Steve Hurd 01782 750338
Martial Arts/Shukokai	The Madeley Centre	Saturday 9.30am to 10.30am	Dave Blower
Academy of Performing Arts	The Madeley Centre	Monday 4.00pm to 7.30pm Thursday 4.30pm to 6.15pm Friday 4.00pm to 7.00pm	Amy Fryer 07738098062 Gemma Pender tafpa@hotmail.co.uk
Jill Clewes Performing Arts	The Madeley Centre	Monday 4.00pm to 6.45pm Friday 11am to 12.20pm and 4.15pm to 6.30pm Saturday 9.30am to 12.30pm	631895
Beavers Cubs Scouts	The Madeley Centre	Term time Wednesday 5.15pm onwards	Tony Polwart 01782 750041
Mother and Child Groups	Childrens Centre @ The Madeley Centre	Daily activities for Mother's and Yound Childrens Activities please contact the centre for full programme	
Pilates	The Madeley Centre	Wednesday 6.30pm to 7.30pm Friday 9.10am to 10.30am	
Little Karate Warriors	The Madeley Centre	Thursday 4.00pm to 5.00pm	Dave Blower
Tea Dance Ballroom and Sequence	The Madeley Centre	Sunday 2.00pm to 4.00pm	The Madeley Centre
CAR BOOT SALE	The Madeley Centre	2nd Sunday in the month 1.00pm to 3.00pm indoor tables supplied	Indoor £7.00 Outdoor £5.00 June Dale 01782 751194 Pre booking required

Whitmore/Baldwins Gate

Whitmore Village Hall Information and Bookings:- Krys Holbrook 01782 680481

Yoga Club	Whitmore Village Hall	Monday (term time) 9.45am	
Tai Chi	Whitmore Village Hall	Monday 6.00pm	
Slimming World	Whitmore Village Hall	Tuesday 7.00pm	
Indoor Bowling	Whitmore Village Hall	Wednesday 2.00pm (Autumn and Winter only)	
Maer WI	Whitmore Village Hall	Wednseday 7.30pm Second week of each month autumn and winter only	Paddy Clark 01782 650472
IT Training	Whitmore Village Hall	Thursday 9.00am to 1.00pm	Wendy Wood
Art Group	Whitmore Village Hall	Thursday 9.30am	Betty Deville
Indoor Bowling	Whitmore Village Hall	Friday 2.00pm autumn and winter only	Margaret Grocott 01782 680185
Dance Club	Whitmore Village Hall	Friday 8.30pm	
Tai Chi	Whitmore Village Hall	Sunday 6.00pm	
Zumba	Whitmore Village Hall	Tuesday 10.00am	
Pilates	Whitmore Village Hall	Tuesday 11.30am	
CAR BOOT SALE	Whitmore Village Hall	Last Sunday in the month 8am to 12 noon, indoor and outdoor, indoor tables supplied	No booking required £6.00 per pitch

Other Clubs, Societies and Support Groups

Baldwins Gate Methodist Church			Rev'd Robert Fisher 01782 638805
Parish Council Meeting	The Madeley Centre	Second Thursday in each month 7.30pm	Clerk
Parish Council Meeting	Whitmore Village Hall	First Wednesday in each month 7.15pm	Clerk Wendy Kinson 01782 680613
Newcastle Under Lyme 50+ Forum	www.nul50plusforum.org.uk	4 Forums per year	Margaret Coley 01782 562659
Rotary	Ramada Hotel	Call for details	01782 613093
Newcastle Bridge Club		Monday to Friday	01782 717231
Bowling	Slaters. Baldwins Gate	Wednesday	David Hunter 01630 673524
Probus (retirement club)	Slaters. Baldwins Gate	1st Wednesday of each month	Roger Garland 01630 672714
GOLF CLUBS			
Onneley			01782 750577
Barlaston Old Rd			01782 658109
Newcastle Road			01782 617006
Keele Muncipal			01782 627596
Trentham Park			01782 658800
Wolstanton			01782 622718

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

STOPP (Screening Tool of Older People's potentially inappropriate Prescriptions)

Appendix 1: STOPP (Screening Tool of Older People's potentially inappropriate Prescriptions).

The following prescriptions are potentially inappropriate in persons aged ≥ 65 years of age

A. Cardiovascular System

1. Digoxin at a long-term dose > 125µg/day with impaired renal function *(increased risk of toxicity).*
2. Loop diuretic for dependent ankle oedema only i.e. no clinical signs of heart failure *(no evidence of efficacy, compression hosiery usually more appropriate).*
3. Loop diuretic as first-line monotherapy for hypertension *(safer, more effective alternatives available).*
4. Thiazide diuretic with a history of gout *(may exacerbate gout).*
5. Non-cardioselective beta-blocker with Chronic Obstructive Pulmonary Disease (COPD) *(risk of bronchospasm).*
6. Beta-blocker in combination with verapamil *(risk of symptomatic heart block).*
7. Use of diltiazem or verapamil with NYHA Class III or IV heart failure *(may worsen heart failure).*
8. Calcium channel blockers with chronic constipation *(may exacerbate constipation).*
9. Use of aspirin and warfarin in combination without histamine H2 receptor antagonist (except cimetidine because of interaction with warfarin) or proton pump inhibitor *(high risk of gastrointestinal bleeding).*
10. Dipyridamole as monotherapy for cardiovascular secondary prevention *(no evidence for efficacy).*
11. Aspirin with a past history of peptic ulcer disease without histamine H2 receptor antagonist or Proton Pump Inhibitor *(risk of bleeding).*
12. Aspirin at dose > 150mg day *(increased bleeding risk, no evidence for increased efficacy).*
13. Aspirin with no history of coronary, cerebral or peripheral arterial symptoms or occlusive arterial event *(not indicated).*
14. Aspirin to treat dizziness not clearly attributable to cerebrovascular disease *(not indicated).*
15. Warfarin for first, uncomplicated deep venous thrombosis for longer than 6 months duration *(no proven added benefit).*
16. Warfarin for first uncomplicated pulmonary embolus for longer than 12 months duration *(no proven benefit).*
17. Aspirin, clopidogrel, dipyridamole or warfarin with concurrent bleeding disorder *(high risk of bleeding).*

* estimated GFR <50ml/min.

B. Central Nervous System and Psychotropic Drugs

1. Tricyclic antidepressants (TCA's) with dementia *(risk of worsening cognitive impairment).*
2. TCA's with glaucoma *(likely to exacerbate glaucoma).*
3. TCA's with cardiac conductive abnormalities *(pro-arrhythmic effects).*
4. TCA's with constipation *(likely to worsen constipation).*
5. TCA's with an opiate or calcium channel blocker *(risk of severe constipation).*
6. TCA's with prostatism or prior history of urinary retention *(risk of urinary retention).*
7. Long-term (i.e. > 1 month), long-acting benzodiazepines e.g. chlordiazepoxide, fluazepam, nitrazepam, chlorazepate and benzodiazepines with long-acting metabolites e.g. diazepam *(risk of prolonged sedation, confusion, impaired balance, falls).*
8. Long-term (i.e. > 1 month) neuroleptics as long-term hypnotics *(risk of confusion, hypotension, extra-pyramidal side effects, falls).*
9. Long-term neuroleptics (> 1 month) in those with parkinsonism *(likely to worsen extra-pyramidal symptoms)*
10. Phenothiazines in patients with epilepsy *(may lower seizure threshold).*
11. Anticholinergics to treat extra-pyramidal side-effects of neuroleptic medications *(risk of anticholinergic toxicity).*
12. Selective serotonin re-uptake inhibitors (SSRI's) with a history of clinically significant hyponatraemia *(non-iatrogenic hyponatraemia <130mmol/l within the previous 2 months).*
13. Prolonged use (> 1 week) of first generation antihistamines i.e. diphenydramine, chlorpheniramine, cyclizine, promethazine *(risk of sedation and anti-cholinergic side effects).*

C. Gastrointestinal System

1. Diphenoxylate, loperamide or codeine phosphate for treatment of diarrhoea of unknown cause *(risk of delayed diagnosis, may exacerbate constipation with overflow diarrhoea, may precipitate toxic megacolon in inflammatory bowel disease, may delay recovery in unrecognised gastroenteritis).*

Appendix 1 *continued*

2. Diphenoxylate, loperamide or codeine phosphate for treatment of severe infective gastroenteritis i.e. bloody diarrhoea, high fever or severe systemic toxicity *(risk of exacerbation or protraction of infection)*
3. Prochlorperazine (Stemetil) or metoclopramide with Parkinsonism *(risk of exacerbating Parkinsonism).*
4. PPI for peptic ulcer disease at full therapeutic dosage for > 8 weeks *(earlier discontinuation or dose reduction for maintenance/prophylactic treatment of peptic ulcer disease, oesophagitis or GORD indicated).*
5. Anticholinergic antispasmodic drugs with chronic constipation *(risk of exacerbation of constipation).*

D. Respiratory System

1. Theophylline as monotherapy for COPD. *(safer, more effective alternative; risk of adverse effects due to narrow therapeutic index)*
2. Systemic corticosteroids instead of inhaled corticosteroids for maintenance therapy in moderate-severe COPD *(unnecessary exposure to long-term side-effects of systemic steroids).*
3. Nebulised ipratropium with glaucoma *(may exacerbate glaucoma).*

E. Musculoskeletal System

1. Non-steroidal anti-inflammatory drug (NSAID) with history of peptic ulcer disease or gastrointestinal bleeding, unless with concurrent histamine H2 receptor antagonist, PPI or misoprostol *(risk of peptic ulcer relapse).*
2. NSAID with moderate-severe hypertension (moderate: 160/100mmHg – 179/109mmHg; severe: ≥180/110mmHg) *(risk of exacerbation of hypertension).*
3. NSAID with heart failure *(risk of exacerbation of heart failure).*
4. Long-term use of NSAID (>3 months) for relief of mild joint pain in osteoarthritis *(simple analgesics preferable and usually as effective for pain relief)*
5. Warfarin and NSAID together *(risk of gastrointestinal bleeding).*
6. NSAID with chronic renal failure *(risk of deterioration in renal function).* * estimated GFR 20-50ml/min.
7. Long-term corticosteroids (>3 months) as monotherapy for rheumatoid arthritis or osteroarthritis *(risk of major systemic corticosteroid side-effects).*
8. Long-term NSAID or colchicine for chronic treatment of gout where there is no contraindication to allopurinol *(allopurinol first choice prophylactic drug in gout)*

F. Urogenital System

1. Bladder antimuscarinic drugs with dementia *(risk of increased confusion, agitation).*
2. Bladder antimuscarinic drugs with chronic glaucoma *(risk of acute exacerbation of glaucoma).*
3. Bladder antimuscarinic drugs with chronic constipation *(risk of exacerbation of constipation).*
4. Bladder antimuscarinic drugs with chronic prostatism *(risk of urinary retention).*
5. Alpha-blockers in males with frequent incontinence i.e. one or more episodes of incontinence daily *(risk of urinary frequency and worsening of incontinence).*
6. Alpha-blockers with long-term urinary catheter *in situ* i.e. more than 2 months *(drug not indicated).*

G. Endocrine System

1. Glibenclamide or chlorpropamide with type 2 diabetes mellitus *(risk of prolonged hypoglycaemia).*
2. Beta-blockers in those with diabetes mellitus and frequent hypoglycaemic episodes i.e. ≥ 1 episode per month *(risk of masking hypoglycaemic symptoms).*
3. Oestrogens with a history of breast cancer or venous thromboembolism *(increased risk of recurrence)*
4. Oestrogens without progestogen in patients with intact uterus *(risk of endometrial cancer).*

H. Drugs that adversely affect those prone to falls (≥ 1 fall in past three months)

1. Benzodiazepines *(sedative, may cause reduced sensorium, impair balance).*
2. Neuroleptic drugs *(may cause gait dyspraxia, Parkinsonism).*
3. First generation antihistamines *(sedative, may impair sensorium).*
4. Vasodilator drugs known to cause hypotension in those with persistent postural hypotension i.e. recurrent > 20mmHg drop in systolic blood pressure *(risk of syncope, falls).*
5. Long-term opiates in those with recurrent falls *(risk of drowsiness, postural hypotension, vertigo).*

Appendix 1 *continued*

I. Analgesic Drugs

1. Use of long-term powerful opiates e.g. morphine or fentanyl as first line therapy for mild-moderate pain *(WHO analgesic ladder not observed).*
2. Regular opiates for more than 2 weeks in those with chronic constipation without concurrent use of laxatives *(risk of severe constipation).*
3. Long-term opiates in those with dementia unless indicted for palliative care or management of moderate/severe chronic pain syndrome *(risk of exacerbation of cognitive impairment).*

J. Duplicate Drug Classes

Any regular duplicate drug class prescription e.g. two concurrent opiates, NSAID's, SSRI's, loop diuretics, ACE inhibitors *(optimisation of monotherapy within a single drug class should be observed prior to considering a new class of drug).* This excludes duplicate prescribing of drugs that may be required on a prn basis e.g. inhaled beta2 agonists (long and short acting) for asthma or COPD, and opiates for management of breakthrough pain.

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

Screening Tool to Alert Doctors to the Right Treatment for Older People (START)

Cardiovascular System

(i) Warfarin in the presence of chronic atrial fibrillation, where there is no contraindication to warfarin.

(ii) Aspirin in the presence of chronic atrial fibrillation, where warfarin is contraindicated, but not aspirin.

(iii) Aspirin or Clopidigrel with a documented history of coronary, cerebral or peripheral vascular disease in patients in sinus rhythm, where therapy is not contraindicated.

(iv) Antihypertensive therapy where systolic BP consistently >160 mmHg, where antihypertensive therapy is not contraindicated.

(v) Statin therapy in patients with documented history of coronary, cerebral or peripheral vascular disease, where the patients' functional status remains independent for activities of daily living and life expectancy id more than 5 years

(vi) ACE inhibitor in chronic heart failure, where no contraindication exists.

(vii) ACE inhibitor following acute myocardial infection.

(viii) Beta blocker in chronic stable angina, where no contraindication exists.

Respiratory System

(i) Regular inhaled $\beta 2$-agonist or anti-cholinergic agent for mild to moderate asthma or COPD

(ii) Inhaled steroid in moderate-severe asthma or COPD, where reversibility of airflow obstruction has been shown.

(iii) Home continuous oxygen where chronic type 1 respiratory failure ($pO_2 < 8.0$kPa, $pCO_2 < 6.5$kPa) or type 2 respiratory failure ($pO_2 < 8.0$kPa, $pCO_2 > 6.5$kPa) has been well documented and where there is no contraindication to continuous oxygen therapy.

Central Nervous System

(i) L-DOPA in idiopathic Parkinson's disease with definite functional impairment and resultant disability.

(ii) Antidepressant in the presence of clear-cut depressive symptoms, lasting at least 3 months.

Gastrointestinal System

(i) Proton pump inhibitor in the presence of chronic severe gastro-oesophageal acid reflux or peptic stricture requiring dilatation.

(ii) Fibre supplement for chronic, symptomatic diverticular disease with constipation.

Locomotor System

(i) Disease-modifying anti-rheumatic drug (DMARD) with known, moderate–severe rheumatoid disease lasting more than 12 weeks.

(ii) Bisphosphonate in patients taking glucocorticoids for more than 1 month (i.e. chronic corticosteroid therapy).

(iii) Calcium and vitamin D supplement in patients with known osteoporosis (previous fragility fracture, acquired dorsal kyphosis).

Endocrine System

(i) Metformin with type 2 diabetes +/– Metabolic Syndrome (in the absence of renal impairment present i.e. blood urea >12.0 mmol/l, ± serum creatinine >200 mmol/l).

(ii) ACE inhibitor or Angiotension Receptor Blocker in diabetes with nephropathy i.e. overt dipstick proteinuria or microalbuminuria (>30 mg/24 h) ± serum biochemical renal impairment (blood urea > 8.0 mmol/l or serum creatinine >130 μmol/l).

(iii) Aspirin therapy in diabetes mellitus with well controlled blood pressure.

(iv) Statin therapy in diabetes mellitus if fasting serum cholesterol >5.0 mmol/l or additional cardiovascular risk factor(s) present.

Figure 1. Screening tool to alert doctors to the right (i.e. indicated, but not prescribed) treatment for older people (START).

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the START criteria, one or more appropriate medicines were omitted in 347 (57.8%), where no contra-indication existed. The probability of omission of an appropriate medicine increased with advancing age (detailed below). The medications omitted are detailed here. These were in order of frequency: statins for atherosclerotic cardiovascular disease, warfarin thrombo-embolic prophylaxis in chronic atrial fibrillation, angiotensin coverting enzyme (ACE) inhibitor therapy for congestive cardiac failure, aspirin for symptomatic stenotic arterial disease and calcium supplementation for established symptomatic osteoporosis (i.e. prior history of fragility fractures). See Table 1.

The top five 30-day prescription costs (rounded off to the nearest Euro) associated with these indicated but omitted medicines for all 600 patients were as follows in order of decreasing cost:

(i) Statins in symptomatic cardiovascular disease .. €3926
(ii) Bisphosphonates with long term corticosteroid treatment €1056
(iii) ACE inhibitors in congestive cardiac failure €738
(iv) Statins in diabetes mellitus with hypercholestero laemia €604
(v) ACE inhibitors with a prior history of myocardial infection €446

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

The Tilburg Frailty Indicator

Name:..... Date of Birth: .....

1. Do you feel healthy?	Yes ☐ (0)	No ☐ (1)	
2. Have you lost a lot of weight recently without wishing to do so? ('A lot' is 12lbs or more during the last six months or 6.5lbs or more during the last month.)	No ☐ (0)	Yes ☐ (1)	
Do you experience problems in your daily life due to:			
3. Difficulty in walking?	No ☐ (0)	Yes ☐ (1)	
4. Difficulty with maintaining your balance?	No ☐ (0)	Yes ☐ (1)	
5. Poor hearing?	No ☐ (0)	Yes ☐ (1)	
6. Poor vision?	No ☐ (0)	Yes ☐ (1)	
7. Lack of strength in your hands?	No ☐ (0)	Yes ☐ (1)	
8. Physical tiredness?	No ☐ (0)	Yes ☐ (1)	
9. Do you have problems with your memory?	No ☐ (0)	Yes ☐ (1)	Sometimes ☐ (0)
10. Have you felt down during the last month?	No ☐ (0)	Yes ☐ (1)	Sometimes ☐ (1)
11. Have you felt nervous or anxious during the last month?	No ☐ (0)	Yes ☐ (1)	Sometimes ☐ (1)
12. Are you able to cope with problems well?	No ☐ (1)	Yes ☐ (0)	
13. Do you live alone?	No ☐ (0)	Yes ☐ (1)	
14. Do you sometimes wish you had more people around you?	No ☐ (0)	Yes ☐ (1)	Sometimes ☐ (1)
15. Do you receive enough support from other people?	Yes ☐ (0)	No ☐ (1)	

Please complete the name and contact number of your next of kin or carer who can be contacted in case of an emergency.

Name ..... Telephone Number .....

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

Lasting Powers of Attorney

LASTING POWERS OF ATTORNEY

A Lasting Power of Attorney (LPA) is a deed by which you can give someone authority over your property and financial and/or health and welfare affairs. LPA's replaced Enduring Powers of Attorney (EPA's) from 01.10.2007, under the provisions of the Mental Capacity Act 2005 (although EPA's made prior to this date are valid and capable of registration). There are two types of LPA and you can set up one or both types:-

- the property and affairs LPA
- the welfare LPA

1. Property and Affairs LPA

This particular type of LPA is similar to the EPA and enables your attorney to make decisions about your property and affairs, which may include day to day management such as paying your bills, or major decisions such as selling your house. It is up to you as the donor to decide the extent of your attorney's powers, and any restrictions you wish to impose should be specified in your LPA.

Provided you have registered your LPA, it can operate whilst you still have capacity, allowing you to give instructions as to how you wish your affairs to be dealt with. However, you can specify that the attorney can only start managing your financial affairs in the event of your mental incapacity, but failure to do so will mean that your attorney(s) can start using their powers granted by the LPA as soon as it is registered.

2. Personal Welfare LPA

This LPA gives your attorneys the power to make various decisions about your health and welfare. Again, the gravity of the decisions they can make will vary according to the provisions you choose to put in your LPA. They may have to make day to day decisions about your diet, dress or daily routine. Alternatively, they may need to use their discretion in more serious matters, such as

- giving or refusing consent to particular types of healthcare, including medical treatment decisions e.g. an operation, or a course of treatment such as antibiotics
- you staying in your own home, perhaps with help and support from social services
- you moving into residential housing and choosing the right care home for you.
- consenting to life sustaining treatment, e.g.: heart bypass, chemotherapy, organ transplant, artificial nutrition or hydration, (**only** if you expressly give them the power to make such decisions)
- Stop particular treatments if they are burdensome or ineffective, (**only** If such express power is given)

Your attorneys can only act within the powers you have given them, and some acts are prohibited regardless of the powers you grant them (e.g. consenting to marriage or divorce).You need to consider what powers you want your attorneys to have very carefully, and if you choose to grant them the power to consent to or reject life sustaining treatment, you should advise them of your preferences in those matters whilst you have capacity. You may even wish to limit the less serious powers, such as placing an obligation on your attorneys to discuss your place of residence with a particular family member.

The Attorney(s)

The attorney(s) hold a hugely responsible position. They must always act in your best interests and are under a duty to help you to make as many decisions as possible for yourself. There are safeguards to protect the LPA from abuse, and ultimately Attorney's are answerable to the Office of the Public Guardian, who can impose sanctions on those who abuse their powers. Nevertheless, it is imperative that you consider your choice of attorney(s) very carefully, and only appoint people you have the utmost confidence and trust in. It is also important that the person(s) you appoint knows you well, and will not only

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listen to your requests and suggestions, but will also be capable of acting consistently with your wishes when you do not have the capacity to give them guidance.

You can have as many attorneys as you like, but if you choose more than one you need to decide whether you want them to act:-

- together in every matter (decisions must be unanimous) or
- together and independently or (so they act alone or work together as they see fit) or
- together in some matters and independently others (for example all big decisions such as sale of house must be made together)

If you do not specify how you wish your attorneys to act, they will have to act together on all decisions, which may not be practical, especially due to geographical restrictions etc.

You can, if you so chose appoint replacement attorneys to act if your first choices are unable to act.

Certificate Providers

The LPA is a much longer, more complicated form than the EPA. In addition to the LPA form itself, you must provide a signed certificate to prove that you understand the form, and ensure that the LPA is not fraudulent or made under undue pressure. The person who signs this certificate is known as a certificate provider and can be someone with relevant skills, such as registered healthcare professional, Solicitor, barrister or advocate, registered social worker, Independent mental capacity advocate, or alternatively it can be signed by someone who has known you personally for at least two years, provided they do not fall into one of the following categories:-

- any member of your or your attorney's family,
- business partner or paid employee of you or your attorney,
- an attorney listed in your LPA or any LPA or EPA you have made previously,
- the owner director or employee of a care home in which you currently live or their family members or
- a director or employee of a trust corporation appointed as attorney in your LPA.

Named Persons

Ideally, you should also give details of up to five people you wish to be notified of the registration of the LPA. The people you name should know you well enough to be able to raise any concerns they may have about the application to register because once notified, they will be provided with details of how to object to the registration. It is wise to let these people know you have named them before making your LPA so that you have an opportunity to explain to them what it means, so that if they do not wish to be named you can consider an alternative contact. Once the LPA is made, it is essential that you keep the contact details of these people up to date, by keeping a note or letter with the original LPA.

NB: It is advisable to try and include people to notify, because if you are unable to do so you must have two certificate providers instead.

This fact sheet is intended to give only a brief summary of Lasting Powers of Attorney and is, of necessity, broad in its scope. It is not intended to cover individual circumstances or specific considerations which may apply and is for general guidance only.

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

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  - Visit pack documentation
  - **Guidance for staff**
  - EMIS Template Read Codes

Over 75 Health Assessment Visits – Guidance for staff (1/5)

- **First of all enjoy yourself.** It is not often that you have the opportunity to spend an hour with somebody and go through medical and social issues carefully. The person who you are visiting is usually delighted to see you, you may already know them. Hopefully a next of kin or carer will also be present because this will help with both the questions you ask, the issues that you discuss and the guidance that you give, such as making a claim for attendance allowance.
- Do make sure that you have **read the patient information sheet**. This has been posted out to patients aged 74 to 84 and contains useful information for yourself. For those patient's aged 85 and over or with dementia or housebound, they will not have received a questionnaire and you will need to give them this information sheet, which is enclosed in the resource pack.
- **You do not need to be a trained nurse to carry out these home assessments**. We have carried them out very well using clerical staff. In Cheshire firemen do the visits. There will be support provided as you require.
- As is usual**, introduce yourself briefly, explain what you are doing**. You should have with you – provided by your Practice Co-ordinator – the resource pack and a patient's summary printout to give you medical information on significant medical problems and current medication. Where appropriate you will also be given a copy of the Tilburg questionnaire that the patient completed – patients aged 75-84 only. This is so you can see how the patient sees their problems.
- **Don't be daunted by the bulk of the pack that you take with you, the only sheet which you actually use to work with is the Assessment Checklist.** The other sheets are information for the patient if required, e.g. useful local phone numbers, forms for patients if required, e.g. Attendance Allowance, and tools for you to use if you feel it is appropriate such at the PHQ9 and the Six Item Cognitive Impairment (tool) questionnaires.

Over 75 Health Assessment Visits – Guidance for staff (2/5)

- **Carers.** Check names and contact details for next of kin and main carer. These may or may not be the same person. They may already be recorded in the patient notes. Remember also, if the carer is a patient at your Practice, to also record this person as a carer.
- **Consent.** The form is an in-house one, ask if the patient is willing to sign it, the carer/next of kin does not need to sign the form, it simply gives permission for the Practice GP/Nurse to speak to the named relative or carer about the older person. They may wish to sign it there and then, in which case you can take it back to the Surgery, or they may prefer you to leave it so that they can have a think about it. If you do leave it, we do not chase the patient up to return it, it is their decision whether to or not. When you return to Surgery, pass the form to the Co-ordinator who will check that the name of the persons are recorded on the patient's record and the form will be scanned on to the patient's record. There is a question on the template to confirm whether or not it has been completed.
- **Chronic Diseases.** The listing of some of the chronic diseases is merely meant for you to use in the context of the assessment. I suggest that before the visit you simply circle the relevant problems that the patient has using the summary print out that has been provided by your Co-ordinator.
- **Medicines.** Listed are some of the medicines which may cause particular problems in the elderly and which might lead to unnecessary hospital admissions. You will need to have simple basic knowledge of the drugs within each group, for example Ibuprofen is an NSAID, that Temazepam is a Benzodiazapine. Again this can be completed using the clinic summary sheet provided by the Co-ordinator. Before the visit simply circle those drugs that you have identified. You will also need to see if someone is on a calcium or vitamin D supplement and count whether they are on 4 or more medications on repeat (exclude dressings and appliances). You will need to record this information on the computer template. You will need to check with the GP when you have your discussion after the visit about whether it is appropriate for these medications to be continued or not. Some of these medicines e.g. the sleeping tablets may have been used for 40 or 50 years and the patient may decline to stop them, sometimes it may be the only drug that works but this is an opportunity to just double check. If you are interested in more information then within the pack there are two information sheets called START and STOP giving detailed information about what medicines should be actively considered in the elderly and which medicines should be considered to be stopped. Further information on medicines which may contribute to falls in the elderly is in the 'Falls' section of information on the website.
- **Daily Living.** There are several entries on the template relating to simple daily living activities e.g. dressing, washing. These are not included on the nurse assessment tool sheet, often it is simple observation, sometimes you will need to ask.
- **Legal Issues.** These are to be discussed as appropriate. It may be that on some visits you do not feel comfortable to bring up an issue such as the 'do not resuscitate form' but you should broach issues such as Wills and Lasting Power of Attorney. Information within the information pack can be left with the patient.

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

Over 75 Health Assessment Visits – Guidance for staff (3/5)

- **Dispensing Issues.** Quickly check for understanding, compliance and side effects. Does the patient need a metered dose system or home delivery from a chemist? Some practices may dispense to their patients. Discuss any issues identified with the GP.
- **Primary Health Care Team (PHCT).** This is a listing of other professionals in the Primary Health Care team who the patient may have seen, or who you feel may need referral to. You will need to devise your own system to distinguish between where a review has already taken place and those where you feel a review needs to be made, for example you could tick if the patient has already been seen by the dietician and you could circle it if you feel they need a referral to the dietician.
- **Social Benefits.** Discuss and advise as appropriate. Do give application forms there and then if required. Brief guidance is in the patient information sheet.
- **Attendance Allowance.** Lower rate Attendance Allowance is worth £51.85* per week and the higher rate is worth £77.45* per week. These benefits are not means tested. They are not taxed and there is no check up on what they are spent on. You may need to do a hard sales pitch, most patients do not wish to apply for extra state benefits even though they and their children have paid/are paying taxes. Reassure them about this - it is cheaper for the Government to pay for them to stay at home than, they end up in hospital or in a nursing home. Usually I find that if a son or daughter is there the task is much easier. You actually have the form in your pack so give it to them there and then. This is one of the problems with claims being made that it is difficult to get the application forms themselves. The next problem is that the form itself is awkward to fill in and takes a lot of time. I would advise people that it would probably take two to four hours to complete and occasionally it might take longer. If they want help filling it in then put them in touch with the Citizens Advice Bureau (information in pack). For some patients who are fairly elderly or have dementia and without family support there may not be anyone available to fill it in for them. In these instances refer them to Social Services or if they can get out of the house, get them to go to the CAB.
- This extra money is significant and can make a big difference to the person's quality of life. Often the GP cannot improve their COPD or cure their dementia but the ability to have someone to do the garden or do their shopping makes a huge difference. Remember as well that this money is often being re-circulated to local people such as the granddaughter who has two young children and can't get a job but is able to help with the care of grandmother.
- If the patient wants to apply by phone or online this means that if the application is successful it will automatically be backdated to the date they registered even if it takes them a month or two to complete and send off, if they post it without preregistering it will be backdated to the date of receipt. Initially applications take about 3 months to process unless they fall under the special rules for patients (DS1500) who are terminally ill. So what this means is that the patient may well receive a few months later a tax free lump sum of £600.00 plus the start of £55.00 per week extra benefit.
- Remember if it is appropriate both husband and wife can apply individually, and can both be given attendance allowance.

*correct as of 17.1.2013 **Source: http://www.madeleypractice.co.uk/elderly-care.html**

Over 75 Health Assessment Visits – Guidance for staff (4/5)

- **Council Tax Rebate.** The one that we are interested in here is for patients with memory loss. There is a form in the pack, the form is very quick and easy to complete and should be sent to the local council office. The GP will subsequently receive a letter from the Council asking them to confirm the memory impairment. For a couple living together if the rebate application is for one person there will be a 25% reduction. This could be worth £1000 to £2000 a year for a full rebate).
- **Disabled Driver (blue badge).** Forms are available from the local council or on line, the form is very quick and easy to complete and you usually get an answer within a month. The important issues here are that the person has to have a permanent problem when they are walking and is not able to walk for more than 50 meters at normal pace without stopping or assistance. The GP no longer has to fill the form in.
- **Lifestyle.**
  - Asking about smoking is easy. Even in older patients there is major benefit in quitting. Most Practices have their own smoking cessation scheme and referral to this can be offered where appropriate.
  - Do ask about alcohol. Make sure that you are able to calculate alcohol consumption and that you know what the recommended weekly limits are for men and women. Bear in mind that these are Government advised limits and many Specialists suggest that 1 unit a day, and days without alcohol are more appropriate. Give appropriate intervention advice and offer referral where appropriate. The FAST tool is included as an extra quick check if you feel there is an alcohol problem and if they score high on this you could carry out the AUDIT tool.
- **Mental Health and Depression.** Ask the two screening questions. If a patient answers yes to either then complete PHQ9, if you have time. Report any positive answers to the screening questions to the GP.
- **Falls.** Complete the FRAT form. Score it and report the result to the GP.
- **Safety Issues.** Offer and explain the Newcastle Lions Pots scheme. For home safety advice or fire safety advice, contact the relevant service on behalf of the patient. Information on call care and key safe is given in the patient information sheet, with prices and contact numbers (a full rebate is given if a person lives alone).
- **Immunisations.** Flu jabs are obviously seasonal, but it does provide an education point even if you are carrying out the visit in the Spring. Pneumovax can be given at any time of year. You may wish to take it with you, discuss this with the Practice GPs.

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

Over 75 Health Assessment Visits – Guidance for staff (5/5)

On Your Return to Surgery.

- **Fill in the template.** You'll probably be tired. The assessments are mentally hard work. You will need to fill in the template, it doesn't have to be that day, but try to do it as soon as possible otherwise you may forget some of the detail. The template is long and in some ways cumbersome but is actually quite quick for you to go through. Fill it in where appropriate, for example if they are not receiving any help from the CPN, dietician, physio etc. and you do not want to refer them to these people then you just need to leave these questions blank. Do put in items such as the Six Item Cognitive Impairment Test score and the PHQ9 score as free text because we will audit these.
- **Action Points.** You will probably be identifying 'action points' as you go along. Write them down so that you don't forget them, they should be quick bullet points. Before you leave the patient, go through them together and check that they are agreed, this allow you to draw the meeting to a conclusion. Remember also that some points may be conditional upon talking to the GP who may wish to manage a problem in a different way. Discuss these action points with the GP.
- **Letter to patients.** If these action points are agreed you need to write a letter back to the patient, which can be very brief, which confirms what needs you have identified and what is being done about it. This letter must not be omitted. The letter can be written by the GP, yourself or by the Co-ordinator.
- **Tracking applications.** The only additional work after this is if a patient needs to apply for Attendance Allowance, the Blue Badge or the Council Tax rebate, the Co-ordinator needs to make a note of this and ensure that the application has been made and that it has been successful. Otherwise all of your hard work may be lost.

Support for You

- Once you have done two or three visits, you will realise that they are very straight forward and they give you a good feeling that you are making a difference to someone's life.
- For your first two or three visits we can offer support from a Nurse Practitioner who has already done many such visits.
- We will be setting up a private internet forum that we can all use, to share knowledge and problems, so that although we will be separated by working at difference Practices we can maintain a regular conversation.
- Don't hesitate to contact me on 01782 750274, leave a message for myself or Sara Apa, or email to chrisoleshko@me.com – just don't expect an immediate reply!
- If you identify problems either with local services on the project please share the issues. Part of the remit of the project is to clarify where there are most needs or where care could be provided better or differently. The work you are doing is important.

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

Contents

- Context and overview of project
- Analysis of activity
- Analysis of survey results
- Summary of findings
- **Appendix - resources**
  - Referrals
  - Patient Information
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  - Guidance for staff
  - **EMIS Template Read Codes**

EMIS Template Read codes (1/5)

Type of Elderly Assessment
- ☐ 9N1U - Seen in elderly assessment clinic
- ☐ 9NFB - Home visit elderly assessment

Ethnic Group
- ☐ 9i0 - British or mixed British - ethnic category 2001 census
- ☐ 9i1 - Irish - ethnic category 2001 census
- ☐ 9i2 - Other White background - ethnic category 2001 census
- ☐ 9i3 - White and Black Caribbean - ethnic category 2001 census

... and 13 more
- ☐ _____

Main Spoken Language
- ☐ 13I4 - Main spoken language English
- ☐ 13IC - Main spoken language Polish
- ☐ 13I5 - Main spoken language French
- ☐ 13IH - Main spoken language Spanish

... and 4 more
- ☐ _____

☐ Key Holder (9189 - Key Holder)

☐ Patient's next of kin (9182 - Patient's next of kin)

☐ Has a carer (918F - Has a carer)

☐ Carer - home telephone number (918J - Carer - home telephone number)

☐ Carer - work telephone number (918K - Carer - work telephone number)

☐ Carer - mobile telephone number (918L - Carer - mobile telephone number)

☐ Housebound (13CA - Housebound)

Housing
- ☐ 13F2 - Lives alone - help available
- ☐ 13F3 - Lives alone -no help available
- ☐ 13F40 - Resident in sheltered accommodation
- ☐ 13F61 - Lives in a nursing home

... and 1 more
- ☐ _____

☐ Admission to hospital (8Hd - Admission to hospital)

☐ Admission to accident and emergency department (8Hu - Admission to accident and emergency department)

☐ Out of hours patient call detail received (9e3 - Out of hours patient call detail received)

Mobility
- ☐ 13C1 - Fully mobile
- ☐ 13C2 - Mobile outside with aid
- ☐ 13C4 - Needs walking aid in home
- ☐ 13C5 - Confined to chair

... and 1 more
- ☐ _____

Walking Aid Use
- ☐ 39B0 - No aid for walking
- ☐ 39B1 - Stick only for walking
- ☐ 39B2 - Tripod/quadrupod: walking
- ☐ 39B3 - Uses zimmer frame

... and 1 more
- ☐ _____

EMIS Template Read codes (2/5)

Walking Aid Use
- ☐ 39B0 - No aid for walking
- ☐ 39B1 - Stick only for walking
- ☐ 39B2 - Tripod/quadrupod: walking
- ☐ 39B3 - Uses zimmer frame

... and 1 more
- ☐ _____

☐ Number of falls in last year (16D2 - Number of falls in last year)

☐ Worsening balance (29LF - Worsening balance)

Get up and go test
- ☐ 3984 - Get up and go test - normal
- ☐ 3985 - Get up and go test - abnormal

☐ Falls risk assessment tool (38GK - Falls risk assessment tool)

Transport
- ☐ 13C7 - Car owner
- ☐ 13C8 - Has access to a car
- ☐ 13CA - Housebound
- ☐ 13CB - Depends on public transport

Fitness to drive
- ☐ 692A - Fit to drive
- ☐ 692B - Unfit to drive

Dressing Ability
- ☐ 3950 - Dependent for dressing
- ☐ 3951 - Needs help with dressing
- ☐ 3952 - Independent with dressing
- ☐ 3953 - Difficulty tying shoe laces

Chair/Bed transfer
- ☐ 3960 - Dependent: chair/bed transfer
- ☐ 3961 - Able to sit: chair/bed trans.
- ☐ 3962 - Minimal help: chair/bed trans.
- ☐ 3963 - Independent: chair/bed transf.

... and 1 more
- ☐ _____

Stairs Ability
- ☐ 3990 - Unable to climb stairs
- ☐ 3991 - Needs help on stairs
- ☐ 3992 - Independent on stairs
- ☐ 3993 - Difficulty walking up stairs

Bathing Ability
- ☐ 39A0 - Independent bathing
- ☐ 39A1 - Dependent for bathing

Grooming Ability
- ☐ 3921 - Independent for grooming
- ☐ 3920 - Dependent for grooming

Toilet Dependency
- ☐ 3972 - Independent in toilet
- ☐ 3971 - Needs help in toilet
- ☐ 3970 - Dependent in toilet
- ☐ 3973 - Difficulty performing toileting activities

Feeding Ability
- ☐ 3910 - Dependent for feeding
- ☐ 3911 - Needs help with feeding
- ☐ 3912 - Independent feeding

Diet
- ☐ 1FA - Diet good
- ☐ 1FB - Diet poor

EMIS Template Read codes (3/5)

Bladder Assessment
- ☐ 3940 - Bladder: incontinent
- ☐ 3941 - Bladder: occasional accident
- ☐ 3942 - Bladder: fully continent

Bowels Assessment
- ☐ 3930 - Bowels: incontinent
- ☐ 3931 - Bowels: occasional accident
- ☐ 3932 - Bowels: fully continent

Mood
- ☐ 1BS - Normal mood symptoms
- ☐ 1BT - Depressed mood

☐ Patient health questionnaire (PHQ-9) declined (8IA1 - Patient health questionnaire (PHQ-9) declined)

☐ Patient health questionnaire (PHQ-9) score (388f - Patient health questionnaire (PHQ-9) score)

☐ Six item cognitive impairment test (3AD3 - Six item cognitive impairment test)

Hearing Assessment
- ☐ 1C11 - Hearing normal
- ☐ 1C12 - Hearing difficulty
- ☐ 1C13 - Deafness
- ☐ 1C14 - "Blocked ear"

... and 6 more
- ☐ _____

☐ Hearing aid worn (2DG - Hearing aid worn)

☐ Wears glasses (22EG - Wears glasses)

Under Care of?
- ☐ 9N2U - Seen by optician
- ☐ 9N2C - Seen by dentist
- ☐ 9N0B - Seen in psychogeriatric clinic
- ☐ 9NNM - Under care of community psychiatric nurse

... and 7 more
- ☐ _____

Referral done
- ☐ 8H4D - Referral to psychogeriatrician
- ☐ 8H7B - Refer to community psych.nurse
- ☐ 8H75 - Refer to social worker
- ☐ 8H72 - Refer to district nurse

... and 6 more
- ☐ _____

☐ Voluntary worker (13G5 - Voluntary worker)

☐ Home help (13G6 - Home help)

☐ Meals on wheels (13G7 - Meals on wheels)

☐ Provision of telecare community alarm service (8O9 - Provision of telecare community alarm service)

☐ Home safety advice (67IB - Home safety advice)

☐ Referral to home safety service (8Hk9 - Referral to home safety service)

☐ Receipt of Attendance Allowance (13O50 - Receipt of Attendance Allowance)

☐ Referral to affordable warmth programme (8HkN - Referral to affordable warmth programme)

EMIS Template Read codes (4/5)

Community Charge Exemption
- ☐ 9DE4 - Community charge exempt
- ☐ 9DE5 - Community charge not exempt

☐ Respite care (8GE9 - Respite care)

☐ Holiday relief admission (8GE5 - Holiday relief admission)

Resuscitation
- ☐ 1R0 - For resuscitation
- ☐ 1R1 - Not for resuscitation

☐ Has made a living will (13VH - Has made a living will)

☐ Has end of life advanced care plan (8CME - Has end of life advance care plan)

☐ Lasting power of attorney property and affairs (9W4 - Lasting power of attorney property and affairs)

☐ Lasting power of attorney personal welfare (9W5 - Lasting power of attorney personal welfare)

☐ At risk of osteoporosis (14O9 - At risk of osteoporosis)

DEXA Scan
- ☐ 58ET - Femoral neck DEXA scan result normal
- ☐ 58EV - Femoral neck DEXA scan result osteoporotic
- ☐ 58EW - Femoral neck DEXA scan result osteopenic
- ☐ 8I6X - DXA scan not indicated

☐ Vitamin D supplements (8B73 - Vitamin D supplements)

☐ Height (229 - O/E - height)

☐ Weight (22A - O/E - weight)

Body Mass Index
- H - Height (m):
- W - Weight (kg):
- Body Mass Index:

☐ Mini mental state score (388V - Mini mental state score)

Smoking Status
- ☐ 1371 - Never smoked tobacco
- ☐ 137R - Current smoker
- ☐ 137S - Ex smoker

☐ Smoking cessation advice (8CAL - Smoking cessation advice)

☐ Alcohol consumption (136 - Alcohol consumption)

☐ Patient advised about alcohol (8CAM - Patient advised about alcohol)

Understanding of Meds
- ☐ 8BIg - Patient understands why taking all medication
- ☐ 8BIh - Patient does not understand why taking all medication

Drug Compliance
- ☐ 8B3E - Drug compliance good
- ☐ 8B3i - Drug compliance poor
- ☐ 8BIA - Uses monitored dosage system

Medication Side Effects
- ☐ 8BIE - Has shown side effects from medication
- ☐ 8BIJ - Has shown no side effects from medication

Drug under usage
- ☐ 8BIk - Patient forgets to take medication
- ☐ 8BIn - Drug under usage checked

EMIS Template Read codes (5/5)

- ☐ On four or more medications (8B3w - On four or more medications)

- ☐ Hypnotic or anxiolytic dependence (E241 - Hypnotic or anxiolytic dependence)

- ☐ Antipsychotic medication review (8BM01 - Antipsychotic medication review)

- ☐ Non-steroidal anti-inflammatory drug risk assessment completed (9OhB - Non-steroidal anti-inflammatory drug risk assessment completed)

- ☐ Seasonal influenza vaccination (65ED - Seasonal influenza vaccination)

- ☐ Pneumococcal vaccination given (65720 - Pneumococcal vaccination given)

O/E - blood pressure reading: / mmHg

Urine Glucose Test

- ☐ 4661 - Urine glucose test not done
- ☐ 4662 - Urine glucose test negative
- ☐ 4663 - Urine glucose test = trace
- ☐ 4664 - Urine glucose test = +

... and 7 more

- ☐ _____

Urine Protein Test

- ☐ 4671 - Urine protein test not done
- ☐ 4672 - Urine protein test negative
- ☐ 4673 - Urine protein test = trace
- ☐ 4674 - Urine protein test = +

... and 14 more

- ☐ _____

- ☐ Gold standards framework surprise question (38De - Gold standards framework surprise question)