DESCRIPTION OF THE PRACTICE	
1. Title of the practice	
- 'HEALTH CHECKS FOR OLDER PEOPLE IN THE AGE RANGE 65+' -	
2. Organisation responsible for the practice	
Regional Government of Andalucía, Spain	
3. Contact person(s)	
E-mail	policy@esn-eu.org
4. Summary of the practice	
The 'Health check for 65+' is provided throughout the region of Andalusia by the Andalusian health service's primary care centres. The purpose of the initiative is to facilitate early detection and prevention of frailty in older people by implementing care plans and interventions, which are selected on the basis of tests, questionnaires and functional performance assessments, to help improve and maintain older people's independence and quality of life. The initiative was proposed jointly by the Andalusian health service and two scientific societies that have provided an evidence base for the programme. These scientific societies focus on family medicine and family and community nursing with a multidisciplinary approach, including nurses and social workers. Successful elements of the initiative have been the introduction of new standardised tests that decrease variability, the periodical assessments following pathway design, the detection of early warning signs and the overall satisfaction of the population.	
5. National/regional/local context of the practice	
Regional policy: The White Book on Active Ageing was published by the Regional Government of Andalusia in 2010. It states that policies should address the following domains: • security • healthy life • participation • life-long learning The White Book also covers other issues, such as older people's media image and their financial situation.	
6. Staff involved	
The health checks are conducted by professionals in the primary care teams, including general practitioners, nurses, nursing assistants and social workers whose main aim is to support older persons' social integration, assess social needs and combat loneliness.	

7. Target group

People living in Andalusia aged 65 years or older have had limited or no contact with their local primary care centre for the past 12 months.

8. Aims of the practice

The overall aims are to detect early warning signs for health problems amongst people aged 65 years or older and to implement evidence-based health promotion and prevention of fragility measures to improve older people's independence, health and quality of life.

Specific objectives include:

- Identification and registration of people aged 65 years or older who are resident in Andalusia;
- classification of people's level of independence;
- identification of health problems and care needs;
- improved co-ordination mechanisms between care professionals and primary care centres;
- improved access to primary care for the target population.

9. Issues for social services

Service Integration/ Cooperation across services	**x**	**Service Planning**		**Contracting**	
Technology		**Skills development (of the workforce)**		**Quality of services**	**x**
Prevention and rehabilitation	**x**	**Participation of service users**		**Volunteering**	

ANALYSIS OF THE PRACTICE

10. Status

Pilot project (ongoing)		Project (ongoing)		Implemented practice (restricted areas)	
Pilot project (terminated)		Project (terminated)		Widely spread practice/rolled out	x

11. Scope of the practice

Describe the setting of the practice, considering the following criteria:

- *Micro-level practice: a* practice that involves individuals at the local level
- *Meso-level practice: a* practice that involves organisations or communities
- *Macro level practice: a* practice that involves large population groups

Macro: the initiative is aimed at all residents of Andalusia who are aged 65 years and older.

12. Leadership and management of the practice

Description of the leadership of the practice, considering the following criteria:

- *Collaborative management*: shared between large partnerships, often of central, regional, and local representation
- *Organisational management*: by one organisation
- *Professional management*: managed by a single person
- *Shared management*: shared with no defined leadership

Organisational management: The general healthcare directorate of the Andalusian health service has the executive responsibility for the management and quality of care, including improving patient outcomes, improving and coordinating social and healthcare programmes, and coordinating resources.

13. Engaging stakeholders in the practice

Description of the engagement of stakeholders, considering the following criteria:

- *Individual practice*: individuals have sought practice change
- *Network approach*: one or more organisations develop a network
- *Collaborative approach*: large collaboration with relevant stakeholders

Collaborative approach: The initiative takes place in the context of the public health system in which the stakeholders operate. Communication and dissemination activities have targeted healthcare professionals to inform them of and get them involved in the initiative. Scientific societies were also contacted and supported the development of the programme through the provision of evidence of best practices.

14. Involvement of service users and their families

Description of the involvement of service users, considering the following criteria:

- *Team involvement: service users and carers were part of the practice team*
- *Consultative: a consultative body of users was set up for an ongoing dialogue and feedback* • *Involvement in care: person-centred approaches to care/support*

Involvement in care: Informative brochures targeting people aged 65 and older have been distributed across the region.

Individuals aged 65 or over are identified using data from the Single Health Database (see below) and are grouped based on what are perceived as required interventions and on where they live. Professionals at the primary care centres then receive information about individuals living in their area who could be targeted. Following this, the professionals then group them into (a) those who did not require healthcare in the last 12 months, (b) those who did require healthcare, (c) those who already follow a specific care pathway, and (d) occasional service users. Lastly, prospective service users are given an initial appointment and are offered routine check-ups.

Based on information from the first appointment, service users may then be grouped further according to their degree of independence and frailty.

15. Costs and resources needed for implementation

Description of how the practice is financed, considering the following criteria:

- *Within existing resources:* staff time and other resources are provided 'in-house'
- *Staffing costs:* costs for staff investment
- *Joint/Pooled budgets:* two or more agencies pool budgets to fund services • *Funded project:* external investment

Within existing resources: The health checks are part of the health professionals' regular work.

Staffing costs: Several training sessions have been held, focusing especially on comprehensive geriatric assessments, activities in health promotion and disease prevention for older people. This has been based on evidence provided by scientific societies.

16. Evaluation approaches

Description of the evaluation method of the practice, considering the following criteria:

- *Multi-method:* use of both a qualitative and a quantitative approach
- *Single method: a* qualitative or quantitative approach
- *Audit:* looks at data sources such as existing medical records and/or other routinely collected service data.
- *Informal:* refers to in-house service evaluation using locally designed tools and/or collecting opportunistic feedback
- *No evaluation*
- *An evaluation is planned*

Single method: quantitative approach:

- The target population is identified through the Single Health Database (BDU). This database contains individual electronic health records as well as an organisational information system and is updated yearly.
- All interventions are recorded on service users' individual electronic health records.
- Service users are then classified according to their level of independence and fragility.
- Classification indicators include ○ percentage of people ascribed to the segments,
    - percentage of people considered independent after the health checks,
    - ○ percentage of people considered fragile or at risk,
    - ○ percentage of people considered dependent.
- Indicators to highlight outcomes after the intervention: ○ percentage of independent people aged 65 and over who follow the activities set out in their care plan
    - percentage of frail or at-risk people whose assessment has been completed (with a target of 90 per cent)
    - flu vaccination for people over the age of 65 (with a target of 75 per cent)
    - ○ pneumonia vaccination for people over the age of 65 (with a target of 75 per cent for those in in-patient care)

17. Measurable effects of the practice and what it has achieved for…

Service users	Perceptual/measurable: • Early detection has had a direct impact on the prevention of disease and health risks.
Formal care givers	Perceptual/measurable: • Becoming more aware of the clinical, functional, emotional, and social situation of the older person and establishing an effective and personalised prevention programme has been beneficial. • Receiving training in interventions to support older persons that are known to be effective has been helpful, avoiding those with little evidence of showing improved wellbeing and autonomy, especially in the field of self-care.
Informal carers	n. a.
Organisations	Perceptual: • The initiative has led to health and care organisations adopting a more holistic view of older people.
Other	n. a.

18. Anticipated or 'aspirational' effects of the practice and what it has achieved for…

This category can include outcomes which are not documented, quantified, or properly evaluated. They can include such elements as improved knowledge, quality, workforce, etc.

Service users	n. a.
Formal care	n. a.
givers	
Informal carers	n. a.
Organisations	n. a.
Other	n. a.

19. How the practice has changed the way the service is provided (lessons learned)

Lessons learnt:

- The concept of frailty needs to be explained to professionals.
- Comprehensive assessments are key to improving older people's quality of life.
- The multidisciplinary care team has to focus on individual wellbeing.

20. Sustainability of the practice *Description of whether the practice is sustainable, considering the following criteria:* • *Potential for sustainability:* practice was newly started or is ongoing/not yet mainstreamed. How could the practice be sustained (in terms of resources)? • *Organic sustainability:* service users have been empowered to take the practice forward • *Established:* the project has been operational for several years
Established: the initiative has become a mainstream service.
21. Transferability of the practice *Description of whether the practice has been transferred, considering the following criteria:* • *Transferred:* transfer to other regions, countries, service user groups, etc. • *Potential for transferability:* there is interest from the outside; elements of the practice have been taken up and used elsewhere; material for transferability (for ex. training material) has been developed
It is unclear whether the initiative has been transferred elsewhere. Potential for transferability: The initiative has the potential for transferability, provided the same indices, questionnaires and protocols are used and a systematic qualitative evaluation, especially with regards to quality of life, is made.