Health checks on patients 75 years and over in Nottinghamshire after the new GP contract

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Abstract

Objective—To investigate annual health checks for patients of 75 years and over required by the 1990 contract for general practitioners.

Design—Visits to practices to collect information on how assessments were organised and carried out; completion of questionnaires for every patient who had been assessed in a sample month, using information provided by the practice records.

Setting—20 general practices in one family health services authority.

Subjects—Patients of 75 years and over in 20 general practices.

Results—Three practices (15%) had not performed checks. Thirteen practices sent a letter to invite patients to undergo a check. Of these practices, seven followed up non-responders. Two practices visited patients' homes unannounced, and two did checks on an opportunistic basis only. Sixteen practices used a checklist. Sixteen practices involved their practice nurses; at eight of these, doctors also performed checks; in six practices the nurses undertaking the checks had no training in assessing old people. Ten practices assessed more than 75% of their old people in the first year of the new contract. Practices that did not follow up patients who had not responded to the invitation for assessment completed significantly fewer checks. During the sample month, 331 patients were assessed in the 17 practices. 204 new problems were discovered in 143 patients. Significantly more problems per patient were found in inner city areas.

Conclusions—The way health checks were performed varied greatly, both in their organisation and the practices' attitudes. Many old people did not respond to letters asking if they wanted an assessment but very few refused one if followed up. Forty three per cent of those assessed had some unmet need. The number of new problems found per patient may reduce over the next few years if the assessments are successful. The need for annual assessment should be kept under review and adequate resources made available for the needs uncovered. Improved training for practice nurses in assessment is needed. Effectiveness of the checks must be monitored. If most unmet need falls in particular high risk groups it would seem sensible to modify the annual check to target these groups.

Introduction

Earlier work which showed that a substantial number of old people had unmet health needs has been confirmed by more recent studies.¹⁻³ Since the new contract for general practitioners was introduced on 1 April 1990, general practitioners have been obliged to offer an annual check to all their patients aged 75 years and over. The new contract recommended that this

check should be based on functional assessment but included little detail of how it should be performed, who should do it, or what actions should be taken. General practitioners therefore had few guidelines on how to implement this new service. Assessing old people was clearly going to be expensive both in time and money, and some general practitioners may not have considered it to be as important as fulfilling other demands of the new contract. We expected, therefore, that practices would have taken up the assessments with varying enthusiasm.

At the time of writing there have been no reports of how general practice as a whole has tackled the checks although some general practitioners have reported the results from their own practices.^{4,5} The aim of the present study was to gain a broader view by establishing how Nottinghamshire general practitioners have carried out the checks and what results they have found. It examined how checks were organised, who did them, where they were done, and how many had been completed by the end of the first year of the new contract. The results of a sample of the assessments and the actions that followed from them were obtained from practices' records.

Method

A list of all the practices in Nottinghamshire was obtained from the local family health services authority and showed which ones undertook dispensing and the numbers of partners. The list was then divided into practices with main surgeries in inner city, suburban, semirural, and rural areas. A representative sample of 20 practices (table I) was selected to take part in the study. The sample was chosen so that it had the same proportions of practices with the above characteristics and the same proportion of teaching to non-teaching practices as the county as a whole. Six practices that declined to take part were replaced with another six with the same characteristics.

One of the authors visited each practice between February and August 1991 and interviewed a doctor or nurse involved with the checks on old people. Information was collected using a standard questionnaire. This asked about practice characteristics, how many patients were over 75 years old, how many of them had been assessed in the first year of the contract, how the assessments were organised and carried out, and the involvement and training of nurses.

A second questionnaire was completed using information from practice records for all old people assessed in the calendar month preceeding the researcher's visit or, if no checks had been done in that time, the last month when checks had been carried out. This questionnaire recorded problems that were already known to the practice, those discovered at the health check, and the actions taken as a result. Problems were recorded in 11 categories (table II), including all those

TABLE I—Practice characteristics

	No of practices
No of GP principals:	
Singlehanded	6
2	3
3	6
≥4	5
Teaching practices	5
Dispensing practices	2
Area served:	
Inner city	5
Suburban	9
Semirural	4
Rural	2
Total	20

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TABLE II—New problems discovered by the health check during one month

	No (%) of problems (n=204)
Medical	57 (28)
Activities of daily living	37 (18)
Mobility	36 (18)
Hearing	23 (11)
Mental state	17 (8)
Social support	12 (6)
Vision	10 (5)
Use of medicines	6 (3)
Falls	3 (1)
Finance	2 (1)
Other	1 (<1)

TABLE III—Actions taken as a result of health check during one month

	No (%) of actions (n=227)
Advice	32 (14)
Note of "at risk" situation	26 (11)
Appliances	21 (9)
Treatment drugs	17 (7)
Occupational therapy	17 (7)
Further tests	16 (7)
Chiropody	15 (7)
Nurse surveillance	13 (6)
Care assistant	12 (5)
Nursing services	11 (5)
Ear syringing	7 (3)
Social services	6 (3)
Outpatients	6 (3)
Housing	5 (2)
Meals on wheels	5 (2)
Optician	5 (2)
Hearing aid	4 (2)
Day centre	4 (2)
Lunch club	2 (1)
Other	2 (1)
Social casework	1 (<1)

specified in the contract. Most were concerned with function. The category "medical problems" indicated symptoms of physical illness, and "use of medicines" showed when patients had difficulties with compliance or when there were side effects from drugs. Actions were grouped into 21 categories (table III). Sometimes the records included comments made by the assessor about problems with no immediate solution but which put the old person "at risk." Comments of this kind alert staff to the likelihood that there will be more problems which may need priority attention, and so they were included as a distinct category.

Data from the patients' questionnaires were analysed using the statistical package for the social sciences (SPSS X).

Results

Seventeen practices (85%) had organised health checks for patients over 75 years of age. The three not doing so shared no common characteristics except that none took part in postgraduate or undergraduate training.

HOW HEALTH CHECKS WERE ORGANISED

Six practices had devised and issued a standard letter asking patients to contact the surgery if they wanted a health check; non-responders were assumed not to want one. Seven issued a standard letter and followed up non-responders by telephone or by visiting. Two did not issue a letter but visited the patient's home unannounced. The remaining two did health checks on an opportunistic basis only. Nine practices used the opportunistic approach as well as their main method. No one method identified significantly more new problems per patient.

Sixteen practices used a checklist. Seven designed their own, and nine used one of the commercially available checklists. All checklists involved assessment of mobility, continence, hearing, vision, social support, medical problems, and medication as specified in the contract. The content was fairly consistent.

Practices' estimates of the length of their average check varied widely. The lowest estimate was less than 15 minutes per patient. In seven practices the checks took between 15 and 30 minutes, and in nine between 30 and 45 minutes, all not including travelling time. There was no significant association between any of the variables examined and how long the check took.

Three practices did not assess patients who lived in residential or nursing homes.

WHO DID THE CHECKS

In one practice that had no nurse the doctor did all the checks. In seven, practice nurses performed all the checks. In nine practices doctors performed some checks; in one of these the district nurses also helped. All the single handed doctors did at least some of the checks themselves; no other practice characteristics were associated with who did the checks.

Five practices used nurses who had had no training in assessing old people or previous experience in working with them. One used a nurse with no formal training in assessment but who had worked with old people at one time. Another six practices used "in house" training, including three who had also sent their nurses on a course on assessing old people. Four practices had nurses with previous experience with old people, including one who was a qualified community nurse, and these nurses had also attended a course.

The time given to nurses to do the checks varied between less than one to more than three hours per week per 100 registered patients of 75 years and over. There were no associations between any of the practice characteristics and the time given to nurses for this task.

WHERE CHECKS WERE CARRIED OUT

All practices undertaking checks offered to do them at patients' homes if necessary. Five did them mainly at the surgery; seven did them mainly, and five exclusively, in the patients' homes. There was no association between any practice characteristics and where the checks were done. The seven practices doing checks mainly at home found significantly more new problems ($p < 0.05$, $\chi^2 = 6.72$, $df = 2$).

HOW MANY CHECKS WERE BEING CARRIED OUT

Out of the 8279 old people registered in the 16 practices, 4524 (55%) were assessed during the first year of the contract. Ten practices had assessed more than 75% of their old patients by 1 April 1991; three had seen 50-75%; two, 25-50%; two, less than 25%; and three had not performed any checks at all. Where checks were organised by standard letter without follow up of non-responders, significantly fewer were completed by the end of the first year than when other methods were used ($p < 0.025$, Fisher's exact test). Of the six practices using this method, three had non-responder rates of greater than 50%. Very few patients (175, 2% of the total) responded to the invitation for a health check by actively refusing it. In two practices more than 10% actively refused a check; in another two practices the refusal rate was 5%-10% and in the remaining 13 it was less than 5%. Refusal rate was not related to any practice or health check characteristics.

RESULTS OF THE CHECKS

A total of 331 patients were assessed in the sample month and 184 (56%) of them had at least one problem recorded. A total of 484 problems were recorded (mean 2.6 per person with a problem). Of these problems, 204 were newly discovered at the health checks; 183 patients (43% of those assessed) had a new problem discovered.

Significantly more new problems were found in inner city areas than elsewhere ($p < 0.005$, $\chi^2 = 15.1$, $df = 3$). The total list size, the number of old people registered, who performed the checks, how the checks were organised, and nurse training were not related to the number of problems newly discovered.

Table II gives details of problems newly discovered at the health checks. The commonest actions were giving advice and noting "at risk" situations (table II). The most common referrals were for chiropody and for occupational therapy. In total, 227 actions were taken to deal with the 204 new problems.

Discussion

The sample size was small, and so significant differences between types of practice were difficult to establish. This study is therefore mainly descriptive. The results reflect a great variation in the way health checks of old people were carried out. Fifteen per cent of practices in the sample were not attempting to do health checks. The fact that six practices declined to take part in the study may have biased results towards those who felt that assessment of old people was of value.

From comments made by health workers it was evident enthusiasm for the service varied. In some practices there was a feeling that it was of little value, that routine checks found little new, and that most problems discovered were minor or insoluble. This attitude may have contributed to some low rates of response to standard letters. Even where these letters complied with the contractual obligation to offer a health check, the wording may have discouraged some patients from accepting it. Some practices felt that patients in residential care were not at risk and so did not include them; this also reduced the proportion of

old people screened. This attitude may be mistaken: old people in residential and nursing homes may still have unmet need.⁶

Some health workers were enthusiastic about the checks. They felt they were a valuable new method of discovering unmet need and were popular with patients. Others had a positive attitude but felt the changes required by the new contract were a great burden and so had not been able to organise checks on old people effectively in their first year.

In most practices the nurse was involved in organising and carrying out the checks but the amount of protected time allowed for doing them varied. The previous training of the nurses often included experience with old people but not their assessment in the community. This may reflect a lack of suitably trained nurses, the expense of employing them, or the amount of training available locally. The study was small and it was not surprising that we were not able to show any effect of nurse training on the results of the checks. However, functional assessment is a task which requires particular skills and assessors need to know what resources are available if they are to make best use of the results of the assessment. We were concerned that over a third of the practice nurses doing checks had had no training in assessment of old people at all.

Where checks were being offered, patients always had the option of being assessed at home, though some practices still did most checks in the surgery. This used less of the doctors' and nurses' time but may have detracted from the value of the procedure. It is unclear why more new problems were found when checks were done mainly, but not exclusively, at the patient's home. It may be that these practices selected high risk patients for further assessment in their homes.

MEETING UNMET NEED

The commonest referrals were for chiropody and occupational therapy; 5% of the old people assessed in the sample month needed a new referral for chiropody and 5% for occupational therapy. Locally these services

have long waiting lists. The increased demand for these services needs to be matched by an increase in resources. The higher number of problems found in inner city areas probably reflects greater unmet need in deprived areas. This also needs to be addressed by appropriate allocation of resources.

In total, 43% of patients assessed had a new problem that needed action. This pick up rate seems to be substantial though the actions taken suggest that most unmet need can be handled at a primary care level. Only 3% of new problems required referral to hospital. The present study was unable to find out the proportion of problems that were insoluble or trivial since this would have required asking practices to record information in a suitable form. This would have changed the way they carried out the checks. However, the finding that no problems were recorded for nearly half the old people in the sample is enough to suggest that the obligation to assess all old people annually needs to be questioned. For some patients, less frequent assessments may be sufficient after an initial check. Also, the number of new problems found per patient may diminish over the next few years if the checks are successful in helping to meet previously unmet need. For these reasons, it is essential that the effectiveness of the checks on old patients is carefully monitored.

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Assessment of patients aged over 75 in general practice

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Abstract

Objectives—To evaluate the assessment scheme for people aged 75, to establish doctors' and nurses' views on the value of the assessment scheme, and to seek patients' opinions on elderly assessments.

Design—Data on the assessment process were collected from individual practices. Questionnaires were sent to doctors and practice nurses undertaking assessments and to a sample of elderly patients.

Subjects—31 565 patients aged 75 and over and all doctors registered with Wiltshire Family Health Services Authority, as well as practice nurses assessing elderly patients. A 2% random sample of elderly patients was selected to answer questions on patient satisfaction.

Main outcome measures—Numbers of patients accepting the invitation for assessment, who carried out the assessments and where, what unmet needs were identified, and by whom.

Results—20 192 patients (64%) accepted the assessment offer. Doctors carried out 8786 assessments and nurses 10 779. Although 12 317 (61%) were carried out in the home, nurses did most domiciliary assessments (7122/11 883). Nurses with extra quali-

fications identified the highest number of unmet needs (400/1000 visits). 155 of 228 (68%) doctors thought assessments unnecessary whereas 25 of 48 (52%) of nurses thought them important. 93% of patients found assessment useful.

Conclusions—Doctors see no merit in the scheme, most undertake assessments opportunistically and pick up few new problems. Nurses who see it important require further training to fit them to do home visits confidently. Patients who were assessed found it worth while. The case for developing specialist community nurse for elderly people should be investigated.

Introduction

The 1990 general practitioner contract requires general practitioners to offer all patients aged 75 and over an annual home visit and assessment. The areas of assessment are specific: general function, to include continence, mobility, and mental state; sensory assessment; social assessment; and review of treatment.

This study was undertaken to measure the uptake of invitations for assessment; to examine who carried out

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