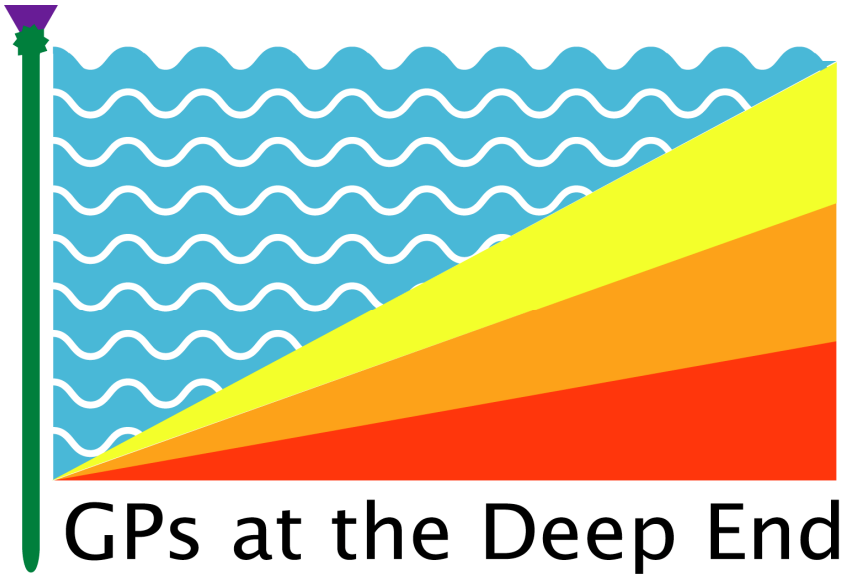


Deep End Report 10

Care of elderly patients

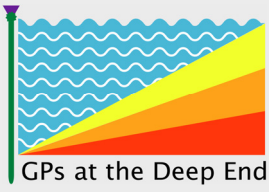
The tenth meeting of "General Practitioners at the Deep End"

26 August 2010

Five Glasgow GPs met on Thursday 26 August 2010 at the Section of General Practice & Primary Care at the University of Glasgow for a discussion about policies and practices for elderly patients, drawing on their experience, commenting on a policy review by researchers at Stirling University, and considering what types of intervention would be feasible and acceptable in maintaining independent living at home.

SUMMARY

- Most national policies and top down initiatives, including SPARRA and HEAT targets, have little profile and impact in general practices addressing the practical needs of patients on a day to day basis.
- Care has become increasingly fragmented, with acute hospitals becoming less helpful in providing comprehensive care, often addressing only some of a patient's problems, with early discharge and inadequate communication to the practice.
- Joint working between professions and services in the community is patchy, but can work well, especially when colleagues know each other by name and have developed mutual respect and trust.
- District nurses and heath visitors are an invaluable source of cumulative knowledge about elderly patients, their problems, preferences and circumstances. If shared effectively, such knowledge protects against impersonal, fragmented care.
- Patient expectations and family resources are lower in deprived areas, providing different types of challenge for primary care teams.
- GPs are hesitant to adopt a proactive approach, because of pressure of work, lack of resources and patients' reluctance to see themselves as vulnerable and needing care.
- Screening of elderly patients is only justified if it provides new information and if needs can be met; practitioners prefer a case-finding approach, making use of routine contacts to provide individual advice.
- Additional services could be made known to patients in this way, if primary care staff were better informed about what is available locally.
- In severely deprived areas, "elderly people" are younger, in terms of having less healthy life expectancy at a younger age.
- The Keep Well target age range of 45–64 is appropriate, therefore, for measures to promote healthy living and maintain independence in elderly people in deprived areas.
- Keep Well has worked best in deprived areas when delivered in close collaboration with practices.
- An expanded service is possible, but only if core services are secure.



"General Practitioners at the Deep End" *work in 100 general practices, serving the most socio-economically deprived populations in Scotland. The activities of the group are supported by the Royal College of General Practitioners (Scotland), the Scottish Government Health Department, the Glasgow Centre for Population Health, and the Section of General Practice & Primary Care at the University of Glasgow.*

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CONTENTS

PARTICIPANTS

Name	Location	CHCP	Deprivation ranking	List size
Robert Jamieson	Bridgeton HC	GLA (E)	16	2646
William Lam	Gilbertfield	GLA (E)	33	4988
Clare McCorkindale	Kelso Street	GLA (W)	67	3238
Lindsey Morley	Pollok HC	GLA (SW)	53	4180
Nick Treadgold	Pollok HC	GLA (SW)	53	4180

Clare Dow	Research Fellow, University of Stirling
Kirstein Rummery	Professor of Social Policy, University of Stirling
Bhautesh Jani	GP Academic Fellow, University of Glasgow
Graham Watt	Professor of General Practice, University of Glasgow

CONTENT OF MEETING

Presentations

- *The Deep End Project so far*
  Graham Watt, Professor of General Practice, University of Glasgow
- *Mapping policies to reduce disability and maintain independent living in the elderly* (See Annex A)
  Clare Dow, Research Fellow, University of Stirling

Discussion and comment

The presentations were followed by two periods of discussion, firstly reviewing policy and practice and then considering whether and how additional steps could be taken to prolong independent living in elderly people.

DISCUSSION

Session 1
Review of policy and practice

Most of the policies described in the presentation (See Appendix) were considered remote from the ground level experience of general practitioners, dealing with patients' practical problems on a day to day basis.

Although HEAT targets had little impact on general practice, being of more concern to health boards, hospitals and community health partnerships, it was acknowledged that HEAT targets had improved things for patients by reducing waiting times for outpatient appointments.

The SPARRA initiative also had a low profile, with some practitioners struggling to recall their involvement. Most recalled receiving and reviewing a list of patients at higher risk of hospital admission, but this had not become a regular task, and it was felt that the list provided practices with little information that they did not already know, and was similar in that respect to the results in the 1990s of screening 75 year old patients.

GPs reported that most patients are very reluctant to be admitted to hospital, partly because of the bad reputation of several named Glasgow hospitals concerning current standards of care.

GPs were also dissatisfied with discharge arrangements following hospital admission, which often occurs quickly when patients' problems had been only partially addressed and communication is confined to a list of medications with no information on investigations or diagnosis. It could be weeks before details emerge.

This poor communication and collaboration was contrasted with the situation 10-15 years ago when a hospital admission was more likely to result in a comprehensive assessment and plan. Nowadays it was felt that attendance at the elderly day clinic is much more likely to provide such an approach than an acute admission.

While links between primary and secondary care were considered poor, the group was more complimentary about joint working within primary care. The Community Old People's Team (COPT) and the Falls Team (now merging) were considered to be excellent. Although access is sometimes a problem, these services have become well known and are being used a lot. It was felt that the Falls Team had provided a clear referral pathway and response for problems that were dealt with previously in a much less consistent and organised way.

One GP described the prompt response of the Falls Team to a referred patient, with initial assessment by an occupational therapist, but there was then a longer delay in being seen by the medical team at the hospital, which was the part of the service that the GP most wanted.

COPT was considered to provide a good example of multidisciplinary joint working, not only within the COPT but also with the primary care team within general practices, although experience can be patchy. If professionals do not know each other, with good experience of joint working and reliable forms of communication, care is likely to be fragmented. Although the structure of care may be identical in two places, the way that it is delivered can vary substantially.

GPs described uncertainty in knowing which part of the system to approach in order to get the best help for patients with multiple problems. The best arrangement is when the system can re-route a patient, if the first point of contact is not appropriate, but sometimes patients are simply referred back to the GP, who is then back to square one.

The practice district nurse tends to have more involvement with frail, elderly housebound patients, than GPs who tend to see healthier elderly patients as they attend the practice for blood pressure and diabetic checks. District nurses are usually the member of the practice team with regular contact with the COPT. Having lost his practice-attached health visitor, one GP said that his biggest fear is losing his practice attached district nurse. The arrival of a practice-attached pharmacist had been poor compensation for the loss of a health visitor. This GP felt that inappropriate local policies were much more frustrating than inappropriate demands by patients.

Social work is another point of referral, especially for home care. Initial contact is now more reliable, with referrals being taken by the duty social worker and passed on for assessment and follow up. There tends to be little communication from social work to practices concerning the process and outcome of referrals.

Patient anxiety arises due to uncertainty, fear of being admitted to hospital and concern that they will lose control of their lives, as carers gain access to their home and make decisions about meal times and when they have to go to bed. Reluctance to accept help, and the perceived intrusiveness of carers, can make early intervention difficult. Patients tend to be more accepting when their situation has become desperate. Early intervention is not only about resources; it also needs time for discussion, so that pros and cons can be considered.

In general, the pressure for additional help comes from relatives and professionals rather than elderly people themselves. Of course, when a carer starts to visit

regularly, they notice changes in a person's condition and can call for help sooner than might have happened otherwise.

The group did not feel under pressure to take a more pro-active approach: patients' instincts are to wait until problems arise; professionals are busy already, especially in Deep End practices; and politicians are having their minds concentrated by other things.

Although it was said that initiatives such as SPARRA and screening of the over 75s tended to provide practices with information they already knew, several commented on current threats to the knowledge that practices accrue. Previously, health visitors had worked through their elderly case loads, building up a knowledge base over time that helped to identify problems at an early stage and to establish relationships and trust with patients that made the discussion of options easier. The redeployment of health visitors to child protection issues had weakened this aspect of practice. Although GPs see most patients over a period of time, the ten minute consulting slot, with a focus on medication review, tends not to provide such rich information about how people are actually coping.

Asked how care of elderly patients differed between deprived and affluent areas, GPs commented on the prevalence of alcohol problems in deprived areas, the lower expectations of patients and their greater tolerance of a poor quality of life. Patients in deprived areas feel much more vulnerable and anxious about losing control over the lives, in a way that does not concern patients in more affluent areas. Patients in deprived areas are also less likely to have "pushy" relatives. For professionals there may be much less to work with in terms of family resources.

There is also a big difference between chronological age and biological age. Patients in deprived areas can be 10-15 years older biologically than patients of the same chronological age in affluent areas. In order to focus on health risks in the last two decades of life, it is necessary in deprived areas to start with people in their 50s.

Although there are sprightly people in their 80s and 90s in deprived areas, they are much fewer in number than in affluent areas. Many of these patients had had extraordinary lives, surviving World War 2 and other adversity. Some GPs felt that younger generations might not be as resilient.

The group was asked whether, aside from the very frail elderly, and the robustly well elderly, there is a middle group in which a preventive approach could make a difference. Several examples were given, such as referral to Tai Chi and exercise classes. One practice had had a very positive experience of the Keep Well programme, with over 90% of the target group having participated. In deprived areas it was felt necessary for initiatives such as Keep Well to be based as much in the practice as possible, to achieve such high response rates and to link patients with available resources.

Although Keep Well does not target elderly patients, confining its screening to people aged 45-64, this age range can be considered "elderly" in deprived practices. Keep Well interventions can be more difficult to deliver in deprived areas, however, as patients tend to have more pressing concerns than primary prevention, such as housing and welfare benefits.

It was said that the new GMS contract, with its emphasis on chronic disease management, and regular assessment of blood pressure, cholesterol and smoking, may be changing expectations, so that a focus on primary prevention may be becoming more acceptable. Computer literacy is also increasing, especially in younger age groups.

Asked if there are “red lights” or triggers which might alert professionals to impending health problems in elderly people (“not waiting for a fall to happen first”), GPs replied with several examples, such as longstanding alcohol problems, unkempt living arrangements and dizziness. Relatives and regular carers can also notice significant changes in a person’s functional ability. Early detection requires knowledge which is best built up over time, on the basis of long term relationships.

Session 2
Prolonging independence in elderly people

This session focused on whether and how steps could be taken in Deep End general practices to prevent disability and prolong independence in elderly people.

The first question was who such efforts should be targeted at and how they could be identified. Risk scores for emergency hospital admission, such as SPARRA, include previous hospital admission, which obviously excludes people who have not yet been admitted.

Public awareness would have to change. At present, many of the vulnerable elderly and probably all of the “pre-vulnerable” do not consider themselves in these categories.

However, if the approach was not based on screening (calling patients for a special appointment) but on taking advantage of contact through routine consultations, it would be easier to make suggestions that would be appropriate to individual patients.

GPs would be enabled in this respect by a list of available services and opportunities. An example was mentioned of men taking part in exercise programmes on the pitch of their favourite football club. In Lothian, a guide Get Up and Go is updated annually, with information on times and venues for a range of activities suitable for different age groups.

It was felt that the list of possible activities could be vast, which GPs found daunting. There would need to be flexibility and discretion in choosing what to recommend, when and how. However, the heterogeneity of this approach could be difficult to audit and review.

Four types of activity for which there is good evidence of effectiveness, in promoting independence in the elderly are:

- Physical activity
- Medication review
- Specific adaptations, for communication and/or mobility
- Social interaction

A booklet would be helpful for practitioners but it was felt that many patients would not use a booklet and that other types of communication would be necessary, emphasising local and familiar locations. Much of this information is available but is not provided in a way that is meaningful or usable in particular general practices. It would be a big step forward if the information could be bespoke and customised at practice level. The information would have to be kept up to date, as schemes come and go.

Before getting carried away with this idea, it is important to recognise the prior concerns of practices on basic issues, such as the retention of key staff, including district nurses. Extension of practice activity cannot develop if core services are at risk.

It was recognised that although some patients might need specific encouragement and help, others would only need access to the information and would then pursue possibilities themselves.

All of the GPs felt that the health visitor role for the elderly had helped to assess changing individual needs and to provide encouragement and support for individual patients, but all recognised the small possibility of this happening, given the declining number of health visitors and their redeployment to child health issues. The management of heath visitors by social work had removed any flexibility they might have in addressing elderly issues at practice level.

Although the task of knowing what services area available and how to access them would not required someone as highly trained as a health visitor, it was felt that assessing need and knowing what might suit an individual patient was a major strength of the type of relationships and knowledge that health visitors had been able to establish.

Patients might not think that a particular activity (e.g. Tai Chi or an art class) would benefit their health, but would take the suggestion seriously if made by a professional they know and trust.

Although such staffing is in short supply, it was felt that there are large numbers of people in the NHS and, in particular, the local authority who could be deployed more effectively and helpfully.

Having a dog was considered a valuable asset for older people, providing regular exercise, social exchange with other dog owners, company in the home and a very strong motivation to avoid going into hospital, leaving no one to look after the pet. Cats provided similar but lesser advantages.

It was pointed that in some areas, gang violence can restrict the extent to which people can walk about in local communities, especially at night.

Some new referral pathways, requiring patients to travel across the city, to remote destinations such as Stobhill Hospital or the Victoria Infirmary, were considered unrealistic, in terms of patients' willingness and ability to travel.

GPs did not see giving advice about social activities as being very different from the advice they already give about smoking cessation and weight control. It takes a long time for individuals and communities to adopt such advice but gradually progress is being made. The recent banning of smoking in public places had strengthened the advice that GPs give to individual patients.

There is a need to change public perceptions so that a fit and active elderly person is considered the norm, rather than something idiosyncratic and unusual. But this will need a wider range of options to be available as not everyone wants to attend a gym, and some find gyms intimidating.

The idea of a "well people clinic" was suggested, and remembered as something that had been tried before, making contact with the "hard to reach" and linking them to available resources. GPs involved in Keep Well said that this is now happening, and involving the "elderly" populations of practices in deprived areas, in their 50s

and 60s. It was noted that only 25 of the 85 Deep End practices in Glasgow had been involved in Keep Well.

Keep Well had achieved high coverage rates in some practices. The challenge is to build on this, keeping consistent messages concerning smoking, alcohol and exercise, and integrating these messages with more fundamental issues such as literacy and employability. It was felt that this could be done much more effectively if services are available “in house” and do not involve a journey elsewhere.

The Quality and Outcomes Framework (QOF) of the new GP contract had been of limited value in supporting audit of preventive activities in the elderly, who were considered less likely to attend for check ups. In some parts of Glasgow, elderly housebound patients had been excluded from the QOF because GPs had not been able to get the co-operation of district nurses to do this work.

A GP described how general practice staff in an affluent suburb of Glasgow go out of their way to see all patients over 75, including home visits, despite the fact that this work is not incentivised or rewarded by the new contract. Practices in deprived areas did not have the time to do this. A 20-fold variation in the number of child protection cases per health visitor was cited as an example of the different circumstances under which practices work in socially contrasting areas. Sectioning patients under mental health legislation is another hugely contrasting activity.

What would GPs in deprived areas do without such constraints? With additional resource, at health visitor or district nurse level, practices would start by checking their core services, to ensure that these are working well. Then they could be more proactive, with selective home visits, checking welfare entitlement, encouraging eye tests etc. It was felt that such work should eventually include all patients, as any one of them could fall and be admitted at great expense to an acute hospital bed.

A part-time health visitor or district nurse was considered the most attractive additional resource. Premises are another important issue as many practices lack space to accommodate additional activity.

In summary, GPs felt that an intervention to support independent living by elderly people is “do-able”, but would need to be carefully imagined and supported, and couldn’t jump the queue of things that practices need to do.

All agreed that 65 was too late to start and that the target age group should be younger. The main difference between elderly patient groups in affluent and deprived areas, apart from social problems, complexity and family resources, is that older people in deprived areas are younger. Fifty was considered a good age to start.

Flexibility would be important, in dealing with a great mixture of abilities, attitudes and morbidity. Despite this heterogeneity, however, there is only one denominator, comprising all elderly people in a practice with whatever problems they have, and this denominator provides a comprehensive and continuing basis for practices to measure what they do and what they achieve.

The concept of “red flags”, to help identify patients at greatest risk and with most need for additional support, is attractive but difficult to put into effect, when many judgments are based on personal knowledge, experience and instinct rather than formal risk assessment.

Practices are aware that many other activities and services are present within local communities, but lack detailed knowledge and experience of how to engage with them. Developing these interfaces needs work, not wholly by the practice, in order to

develop a more integrated approach and increase the resources available to practices.

Keep Well, or at last some practice examples of Keep Well, had shown the added value of bringing additional resources into the practice, so that practitioners and patients can make use of them. The challenge is to bring other resources into the practice in the same way. The initiative needed is not so much new resources, as better ways of accessing the resources that exist.

Leadership is important at a local level. One GP described himself as a “terrific volunteer but a lousy conscript”. Fund holding had been popular with some GPs because of the local leadership opportunities it provided. It was felt that the proposed changes to the English NHS, involving GP consortia, are too large for the type of local leadership that practices require. The ban on smoking in public places was mentioned again as a type of national initiative which supported practitioners on the ground.

In considering measures to promote independent living by elderly people, it is important to evaluate initiatives in terms that are meaningful to patients.

The challenge is to normalise preventive activity, so that it is something that everybody does. “Whatever you think is normal; this is what we all do”. Change doesn’t come in big jumps; it comes from chipping away at the same, familiar problems.

ANNEX A

Presentation

Preventing or delaying disablement amongst older adults

Preventing or delaying disablement amongst older adults

Mapping the Scottish landscape of policies and programmes

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Research Questions

Aim 1

Which Scottish policies and programmes are aimed at either preventing disablement or sustaining independence amongst older adults?

- To which problems are the programmes seen as a solution?
- How are programmes targeted and to which populations?
- How do programmes operate?
- What is defined as success and what evidence then exists of that success?
- How are such programmes embedded and normalised in routine practice
- How are general practitioners working in the most deprived areas of Scotland involved in preventing or delaying disablement?

Aim 2

- What gaps exist in current programmes that are relevant to primary and community care based developments?
- What primary care community care based developments are considered desirable, useful and feasible to develop and evaluate in Scotland?

Proposed methods

- Documentary analysis
- Interviews
- Health Board case studies (three programmes in each)
- Focus groups with GPs
- Knowledge exchange event

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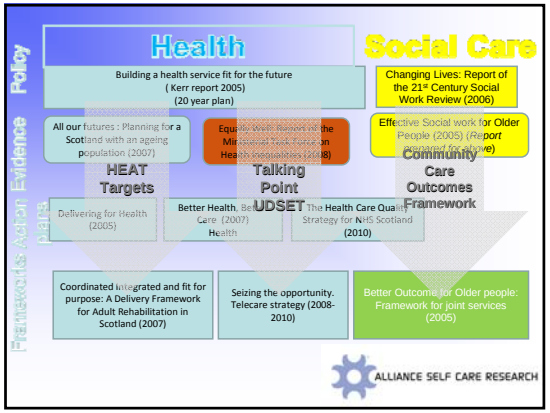
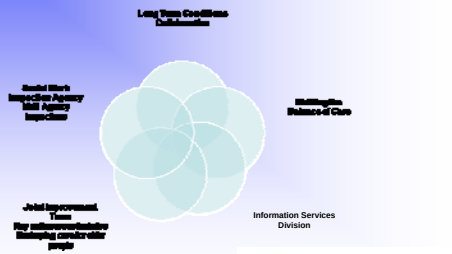
Policy, action plans and frameworks???



Organisations implementing policy & facilitating and evaluating practice



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What are the levers for change?

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HEAT Targets

Treatment Targets for 2010/11

- To achieve agreed reductions in the rates of hospital admissions and bed days of patients with primary diagnosis of COPD, Asthma, Diabetes or CHD, from 2006/07 to 2010/11.
- Increase the level of older people with complex care needs receiving care at home.
- Each NHS Board will achieve agreed improvements in the early diagnosis and management of patients with a dementia by March 2011.
- By 2010/11, NHS Boards will reduce the emergency inpatient bed days for people aged 65 and over, by 10% compared with 2004/05.

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Community Care Outcomes Framework

There are 16 measures which fall into 6 themes

- **Satisfaction -** amongst people using services or support, and carers
- **Access -** getting the right service or support at the right time
- **Support for carers** to continue their caring role
- **Quality of assessment, care planning and review**
- Identifying and supporting those at **risk of admission to hospital**
- **Shifting the balance of care** to support more people at home for longer, promoting self-care rather than reliance on professionals, and providing necessary services and support closer to people's own homes.

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SPARRA

- SPARRA Scottish Patients at Risk of Readmission and Admission
  - Used since 2006 at point of hospital admission
  - Plans to enhance use for people with long-term conditions by 2010 to help prevent unscheduled admission

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What is out there?

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Mapping of programmes

- Intermediate care
- Case management
- Anticipatory Care
- Telehealth/Telecare
- Exercise and Activity
- Falls prevention
- Medication review
- Nutrition diet
- Mental health and wellbeing
- Witten information

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Promising Evidence base

- Exercise to improve physical function
  - Consistent evidence for preventing risk and rate of falls
- Interventions that reduce social isolation

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