Annual assessment of patients aged 75 years and over: general practitioners' and practice nurses' views and experiences

CAROLYN A CHEW

DAVID WILKIN

CAROLINE GLENDENNING

SUMMARY

Background. *The new contract for general practitioners, introduced in 1990, required them to offer an annual assessment, or 'health check', to patients aged 75 years or more.*

Aim. *A study was undertaken to collect details of practice organization of these assessments, general practitioners' and practice nurses' experience of assessments, and their views of the value of such assessments.*

Method. *A nationwide postal survey of 1000 general practitioners and interview surveys with general practitioners and practices nurses from 150 practices were carried out in 1992.*

Results. *The postal survey yielded a response rate of 69% and the interview survey a practice response rate of 76%. Organization of assessments varied enormously between, and often within, practices with a variety of methods of invitation and assessment instruments being used. Of general practitioners 13% did not use a letter of any sort to invite patients to attend, and many doctors excluded certain patients from assessment, particularly those who were seen regularly or had been seen recently. However, 70% of general practitioners estimated that they had assessed over 60% of their elderly patients in the first year (1990–91). A substantial proportion of assessments were estimated to have been conducted on an opportunistic basis and few practices were doing all the assessments of those aged 75 years and over in the patients' homes. In the majority of practices, the general practitioners and practice nurses were the only personnel carrying out assessments. Only 9% of the doctors and 34% of the nurses interviewed had been specially trained to carry out the assessment; 54% of nurses said they would like more training in this area. Both doctors and nurses reported that the assessments did detect previously unknown problems, although over half of doctors reported that they rarely picked up new mental health problems. Increased referrals to social services as a direct result of the assessments were reported by 63% of doctors. The majority of doctors and nurses reported that routine assessments were useful in providing advice and reassurance to elderly people. Two thirds of doctors said they would continue to offer at least selected groups of their elderly patients routine assessments, even if not contractually obliged to do so.*

Conclusion. *The findings suggest that the experiences of the first two years of this activity had convinced some general practitioners that routine assessment of elderly patients is worthwhile. However the increased demand for other services must obviously be met by an increase in resources if the effectiveness of these assessments is not to be undermined.*

Keywords: geriatric assessment; doctors' attitude; nurses' attitude; over 75s.

C A Chew, BSc, MRCGP, lecturer, Department of General Practice, University of Manchester. D Wilkin, BSc, MSc, PhD, professor of health services research, Centre for Primary Care Research, University of Manchester. C Glendenning, BA, MPhil, senior research fellow, Department of Social Policy and Social Work, University of Manchester.

Submitted: 11 June 1993; accepted: 7 October 1993.

© *British Journal of General Practice*, 1994, **44**, 263-267.

Introduction

EVIDENCE of the existence of substantial levels of unreported illness and disability among elderly people living in the community in the United Kingdom became available in the 1950s and 1960s.[1,2] Later research suggested that screening elderly populations revealed unmet need, and that intervention led to a reduction in problems detected at future screening.[3] Other studies failed to demonstrate an improvement in morbidity subsequent to screening, although there were reported improvements in quality of life,[4] and a reduction in institutional care among screened groups.[5] More recent work[6-8] suggested that elderly people may benefit from a functional assessment, and that this could be carried out using an opportunistic, case-finding approach, although it still remains unclear to what extent identification of problems will lead to improvements in outcome for patients or their carers.[7,9]

It was into this confusion that the requirement was introduced for general practitioners to offer all patients aged 75 years and over an annual assessment.[10] The terms of service state that the invitation should be in writing, and that the patient should be offered the health check at home. The contract specified that areas to be covered by the assessment (sensory function, mobility, mental condition, physical condition, social environment and medication), but not how it should be performed, who should do it, or what should be done with the results.

This study is the first nationwide survey investigating how general practitioners in England and Wales have organized this aspect of their work, the experiences of general practitioners and practice nurses in the first two years of the contract, and their perceptions of the value of routine assessment for those aged 75 years and over.

Method

The study consisted of interviews with family health services authority managers, a postal survey of general practitioners, interview surveys of general practitioners and practice nurses, and interviews with patients aged 75 years and over. This paper reports the results of the postal survey and interviews with general practitioners and practice nurses.

A stratified, random sample (stratified by geographical region and metropolitan/non-metropolitan status) of 20 family health

services authorities was drawn from the 98 in England and Wales. All practices in these 20 authorities were listed according to the number of partners, and a systematic sample (that is, every *n*th case, with a random starting point) of 1000 practices was drawn for the postal survey. For the interview survey of doctors and practice nurses, a stratified random sample of 10 district health authorities (stratified by the proportion of those aged 75 years and over in the population) was drawn from the 49 included in the 20 family health services authorities. A systematic sample of 150 practices was then drawn from the lists of practices in each district, grouped by partnership size.

The postal questionnaire covered basic details about the practice, organization and experience of assessments of elderly people and general practitioners' views on these assessments. The interview survey of general practitioners and practice nurses covered the same topics in greater detail, with additional information on procedures for follow up of non-respondents, the assessment procedure and the use of results from assessments. Interviews with practice nurses also included questions on training, the use of guidelines, and referral of patients to general practitioners and other agencies.

The fieldwork was carried out by Social and Community Planning Research. After a pilot survey, the postal survey was carried out in March 1992. The questionnaires were sent to the first-named general practitioner in the sampled practices with a request that the questionnaire be completed or, if appropriate, passed to the doctor responsible for the assessment of elderly people in the practice. There were two postal reminders and one telephone reminder. The interview survey was completed by April 1992. Participants were interviewed separately. In analyses, the chi square test of association was used, and P values <0.05 are considered statistically significant.

Results

A total of 693 practices (69.3%) returned completed postal questionnaires. Five out of 150 sampled practices were found to no longer be in existence. Of 145 practices 110 agreed to participate in the interview survey, giving a practice response rate of 75.9%. In 65 of the 110 practices (59.1%) interviews were obtained with both general practitioner and practice nurse, in a further 28 (25.5%) interviews were obtained with the general practitioner only, and in 17 practices (15.5%) the nurse alone was interviewed.

Responding practices to the postal survey were broadly representative of practices in England and Wales in terms of partnership size and mean list size per principal (health and social services statistics, 1991). Of 693 practices, 19.3% had one or more general practitioner trainees (compared with a national average of 18%), and 91.5% employed at least one practice nurse. Most practices (94.4% of 693) had an age–sex register, computerized in 75.3% of practices.

In most respects, interview practices were similar to the postal respondents: 17.2% of 93 were training practices, 88.2% employed practice nurses and 96.8% had age–sex registers (71.0% were computerized). Of the general practitioners interviewed 61.3% had been with their practice for more than 10 years, reflecting the study's approach to the first named doctor, who was commonly the senior partner. The 82 practice nurses interviewed were all women and were, on average, considerably younger than the doctors. More than one third (36.6%) had joined the practice within the last two years, since the revision of the general practitioner contract.

Organization of assessments for 75+ year olds

A variety of methods were used to invite elderly people for assessment, many practices using more than one method. Of 687 general practitioners responding to the question, 82.2% indicated that a letter was sent by post, 65.4% that patients were invited face-to-face by either the doctor or nurse, 32.0% that patients were given a letter at the surgery, 31.9% that patients were telephoned by the general practitioner or nurse, 22.4% that patients were telephoned by the receptionist, 16.4% that patients were given a letter during a home visit, and 1.6% that patients were invited by a different method. Of the 93 general practitioners interviewed 58.1% said that posted letters were the most frequently used method of inviting people for assessment. The standard of letters varied greatly, from a slip of paper (2 cm x 15 cm) attached to a repeat prescription reading: 'From Dr Z: When your next prescription is due for renewal would you please make an appointment to see me for a health check-up' through more inviting letters, to letters with detailed patient health questionnaires attached. Thirteen per cent of practices (89 of 687) did not use a letter of any sort, most of these practices invited people face-to-face instead, often on an opportunistic basis.

Practices with computerized age–sex registers were more likely than those with manual records only to send written invitations (265, 61.6% versus 82, 49.7%; $\chi^2 = 6.5$, 1 df, $P<0.01$). Similarly, those employing a practice nurse were significantly more likely to send written invitations than those not employing a nurse (329, 59.5% versus 18, 36.0%; $\chi^2 = 9.4$, 1 df, $P<0.01$).

Three quarters of 506 practices in the postal survey (76.1%) reported that some patients were deliberately not invited to have an assessment: patients who had a terminal illness, and those who were seen regularly or who had been seen recently were commonly excluded. Eighteen of 93 doctors interviewed estimated that over 40% of their elderly patients were excluded for these reasons.

Of the 93 doctors interviewed 63.4% reported that they followed up patients who failed to respond to an invitation, usually by a further letter or a telephone call. Eighty three per cent of 687 practices usually offered patients a choice of where the assessment would be carried out, but only 33.2% offered a choice of who would carry out the assessment.

Of 687 general practitioners in the postal survey 64.6% reported that few patients had not responded or had actively refused the offer of assessment; 70.3% estimated that their practices had assessed over 60% of their elderly patients in the first year. The proportion of elderly people in the practice population and the mean list size per principal were not related to the proportion estimated to have been assessed.

Of 687 general practitioners 26.2% reported that more than half of their assessments were done opportunistically (in the course of a consultation for another reason), and only 16.2% reported that they did not do any assessments opportunistically. Of 30 practices not employing a practice nurse 53.3% conducted more than 60% of their assessments opportunistically compared with only 23.8% of 147 practices employing a nurse ($\chi^2 = 31.94$, 5 df, $P<0.001$).

Assessment process

The vast majority of assessments were done by general practitioners and practice nurses with only limited input from other members of the primary health care team (Table 1). The other professionals involved in assessments included district nurses, health visitors and, in one area, specially employed link workers.

Of 656 practices 7.5% were doing all their assessments and a further 42.0% did at least half of their assessments in patients' homes. In 46.6% of 101 practices where it was reported that nurses did all of the assessments, more than 60% of assessments were done at home, compared with 24.4% of 164 practices where

Table 1. Proportion of assessments carried out by general practitioners, practice nurses and other professionals, as estimated by doctors.

	% of 656 GPs estimating involvement of		
Proportion of assessments (%)	GPs	Practice nurses	Others
100	*20.7*	*15.4*	*1.8*
>60	*20.1*	*27.1*	*2.9*
40–60	*12.7*	*14.2*	*1.5*
<40	*28.8*	*18.3*	*9.1*
0	*17.7*	*25.0*	*84.6*

nurses were not doing any assessments (χ^2 = 66.3, 16 df, *P*<0.001). The proportion of assessments carried out in the patient's home was not related to size of practice, mean list size or percentage of elderly people on the practice list.

A variety of assessment schedules was used. Of 682 respondents, 52.2% reported that the assessment schedule used had been devised by the practice, 38.0% reported the schedule came from a drugs company, 16.3% that it came from the family health services authority, 8.7% that the schedule was unstructured and 6.9% that it was the Royal College of General Practitioners schedule (other responses 3.4%).

The schedules used varied from simple 'tick box' cards allowing for little commentary, to more detailed functional assessments with attached protocols for the assessor to follow. The drug company and family health services authority devised schedules tended towards the former, while the practice-devised schedules tended to be more detailed. One quarter of practices (164) used more than one type of schedule.

Of 89 general practitioners 56.2% estimated that the assessments took less than 15 minutes at the surgery. Only 14.6% of 82 practice nurses reported that surgery assessments took less than 15 minutes. Eighteen nurses (22.0%) reported that assessments done in the patient's home took more than 30 minutes (compared with only 3.4% of general practitioners).

Training and supervision

Only 8.6% of 93 general practitioners said they had undertaken any special training. Of 82 nurses 34.1% reported having been offered training and 53.7% of nurses interviewed felt they would have liked more training.

Half of the practice nurses said they possessed written guidelines relating to assessments, usually from the practice or the family health services authority, but these often seemed to be limited in scope (covering invitations and recall rather than content). Three quarters of nurses (62) only reported the results of assessments to the doctor if they had 'cause for concern', and only 17.1% always reported back to the doctor. In contrast, one third of doctors interviewed (30/93) said their nurses always reported results to them.

Assessment findings

General practitioners and practice nurses were asked how frequently the assessments detected previously unknown problems in the areas specified in the general practitioner contract (Table 2).

Although few general practitioners considered that referral to hospital-based services had increased as a direct result of the assessments, much larger proportions of general practitioners and practice nurses felt they were referring more patients to community based health services and social services (Table 3).

The majority of the 93 general practitioners said they would be willing to provide aggregated data on assessment results for the total population aged 75 years and over (as opposed to data on individual patients) to various agencies: 73.1% to their family health services authority, 68.8% to community nurses, and 54.8% to the district health authority.

Table 2. Frequency of new problems detected at assessment of those aged 75 years and over, as reported by general practitioners and practice nurses.

	% of 693 GPs (82 nurses) reporting frequency of problem detection at assessment			
Problem	Often	Sometimes	Rarely	Never
Sensory function	*8.8 (14.6)*	*40.1 (42.7)*	*41.3 (31.7)*	*9.7(11.0)*
Mobility	*13.6 (24.4)*	*38.4 (42.6)*	*37.5 (25.6)*	*10.4 (7.3)*
Mental condition	*6.1 (1.2)*	*31.4 (42.6)*	*51.9 (47.6)*	*10.7 (8.5)*
Physical condition	*12.7 (18.3)*	*37.4 (43.9)*	*41.6 (32.9)*	*8.4 (4.9)*
Social environment	*12.0 (22.0)*	*40.1 (43.9)*	*38.7 (25.6)*	*9.2 (8.5)*
Medication	*9.8 (12.2)*	*42.1 (48.8)*	*39.8 (32.9)*	*8.2 (6.1)*

Views on assessments

Doctors were asked whether they considered assessments to be useful. Two thirds (67.1% of 654) felt that assessments were of use in providing reassurance and advice to elderly people, but fewer than a third (29.5%) felt they were useful as a means of uncovering unrecognized medical problems, and only 25.1% in detecting psychological problems. However, 96.3% of 82 practice nurses interviewed said that assessments were useful for giving advice and reassurance, 76.8% for uncovering unmet social problems, 63.4% for detecting unmet medical problems and 52.4% for unmet psychological problems.

Fewer than half of 671 general practitioners (45.0%) felt that routine assessment of those aged 75 years and over improved the overall health of elderly people, and only 7.4% said it was of great value. More nurses than doctors felt assessments to be of great value (19.5% of 82), and a further 56.1% that they were of some value in improving the overall health of elderly people.

The higher the proportion of assessments done opportunistically, the less useful general practitioners felt them to be. Of the 175 doctors whose practices carried out more than 60% of assessments opportunistically, 71.4% said they were of little or no use compared with 50.4% of 387 doctors whse practices carried out less than 40% opportunistically (χ^2 = 59.80, 15 df, *P*<0.001). Similarly, the lower the proportion of assessments carried out in patients' homes the less useful general practitioners

Table 3. General practitioners and practice nurses reporting increase in referrals to services as a result of the 75+ year old assessments.

	% reporting increase	
Referral	GPs (*n* = 671)	Nurses (*n* = 78)
Geriatric day hospital	*15.6*	*12.8*
Outpatient clinic	*16.8*	–
Physiotherapy	*14.2*	*11.5*
Optician	*31.6*	*43.6*
District nurse	*35.8*	*33.3*
Chiropodist	*59.6*	*65.4*
Social services	*63.3*	*62.8*

n = number of respondents in group.

felt them to be. Of the 185 practices carrying out more than 60% of assessments in patients' homes, 43.7% of doctors said they were of little of no value compared with 63.2% of the 329 doctors whose practices carried out less than 40% in patients' homes ($\chi^2 = 44.23$, 15 df, $P<0.001$).

More than two thirds of 676 general practitioners said they would continue to offer routine assessments (28.1% to all elderly patients and 42.3% to selected groups of patients), even if they requirement to do so was removed from their terms of service. Forty six per cent of 81 nurses said they would wish to continue to offer assessment to all elderly patients and 43.2% to selected groups of high risk elderly patients, even if the general practitioners' terms of service were modified.

Discussion

These surveys, conducted almost two years after the introduction of the contractual requirement to offer assessments to all patients aged 75 years and over, provide a national picture of assessments from the perspective of general practitioners and practice nurses, who are undertaking most of the assessments.

The terms of service state that the general practitioner must issue a written invitation for a health check to all patients aged 75 years or more: 13% of responding practices did not use a letter of any sort to invite patients, and three quarters were not inviting all eligible patients for assessment. No doctors reported that their practices were not doing any assessments, in contrast to the 15% reported by Brown and colleagues in their survey of Nottinghamshire general practitioners.[11]

The methods of invitation used varied within and between practices, as did the type of assessment schedule used. Perhaps in the interests of maintaining professional independence and encouraging innovation and development, the general practitioner contract left it to the doctor to decide how to word invitations and how the assessment should be conducted. This approach seems to have produced many examples of good practice, but it has also allowed some poorly worded invitations and poorly designed assessment schedules to develop. While one would not wish to see complete uniformity at the expense of innovation, there is now sufficient experience for family health services authorities to encourage standard setting and the adoption of good practice.

Although over three quarters of practices reported offering patients a choice of whether the assessment would be carried out at surgery or in the home, it is hard to see how this could be done when assessments were done opportunistically. Opportunistic assessments were more common in practices which did not employ practice nurses, and patients registered with these practice may be getting no choice in either who carries out the assessment or where it is done.

It is surprising that so few practices reported that health visitors were involved in these assessments, as anecdotally they are reported to be carrying out assessments, and may be well qualified for such a role.[12]

Assessments were more likely to have been done in the patients' homes if the assessment was carried out by the practice nurse. Nurses took longer over the assessment than general practitioners and more felt they uncovered problems. There is thus a case for suggesting that nurses may be conducting assessments more thoroughly than general practitioners. Certainly nurses were more positive than general practitioners in their views on the value of assessments of those aged 75 years or more. This supports the recent work of Tremellen who similarly found that nurses detected more unmet need than did general practitioners, and were more likely to feel that routine assessment was valuable.[13] It is of concern, however, that fewer than one third of nurses interviewed had been offered any special training in these assessments, and that only half had guidelines to help them carry out the assessments. The training needs of all personnel involved in this type of screening or assessment work should be assessed and appropriate training provided. That only 8% of doctors had undergone special training suggests there is a training need for doctors as well as for nurses.

The introduction of routine assessments for those aged 75 years and over was based on the assumption that there is unmet need which can be detected by assessment, and that problems identified can be treated and outcome improved. It was evident that most doctors and nurses believed that the assessments were identifying some new problems, although few reported they often identified new problems. It is worrying that over half the doctors reported rarely detecting mental problems, as it is known that there is a high incidence of undiagnosed depression among elderly people.[9,14] This may be a reflection of either the lack of training, or of the insensitivity of the schedules used. The provision of more guidance and advice by family health services authorities concerning appropriate assessment schedules and more training in assessment methods, particularly for practice nurses, might considerably enhance the ability of assessments to detect unmet needs.

A substantial proportion of doctors and nurses felt they were making more referrals, particularly to community based health services and social services, as a direct result of the assessments. However, as Brown and colleagues state, the increased demand must be matched by an increase in resources.[11] Without such an increase, the effectiveness of assessments will be compromised, and the perceived usefulness by doctors, nurses and patients will remain in question. One way in which the case for increases in the provision of particular services might be effectively made is by making good use of the data on needs which is potentially available from the assessments. The majority of doctors were willing to share aggregated data from assessments. If practices used a common assessment schedule, the aggregated data from assessments would be of considerable value, and we know (from interviews with family health services authority managers) of some authorities who are using the data in this way.

Most general practitioner respondents felt that annual assessments of people aged 75 years or more were of some value, particularly in providing advice and reassurance to patients. Practice nurses were more positive than doctors about the value of assessments, perhaps reflecting differences in the nursing and medical perspectives on the purpose of assessments. Nevertheless, whatever reservations the doctors had at the outset, the fact that two thirds said they would continue to offer assessments, at least to selected groups of elderly patients, even if not contractually obliged to do so, suggests the experience of the first two years may have convinced many of them that it is worthwhile. Whether it is a cost effective use of professional time remains to be seen. In the meantime, effort should be devoted to ensuring that the potential benefit is maximized.

References

1. Anderson WF, Cowan NR. A consultative health centre for older people. *Lancet* 1955; **2:** 239-240.
2. Williamson J, Stokoe IH, Gray S, *et al.* Old people at home: their unreported needs. *Lancet* 1964; **1:** 1117-1120.
3. Barber JH, Wallis JB. The effect of geriatric screening and assessment on general practice workload. *Health Bull (Edinb)* 1982; **40:** 125-132.

4. Tulloch AJ, Moore V. A randomized controlled trail of geriatric screening and surveillance in general practice. *J R Coll Gen Pract* 1979; **29:** 733-742.
5. Hendrikson C, Lund E, Stromgard E. Consequences of assessment and intervention among elderly people: a three year randomised controlled trial. *BMJ* 1984; **289:** 1522-1524.
6. Freer CB. Geriatric screening: a reappraisal of preventive strategies in the care of the elderly. *J R Coll Gen Pract* 1985; **35:** 288-290.
7. Iliffe S, Haines A, Gallivan S, *et al.* Assessment of elderly people in general practice. 2. Functional abilities and medical problems. *Br J Gen Pract* 1991; **41:** 13-15.
8. Pathy MSJ, Bayer A, Harding K, Dibble A. Randomised control trial of case finding and surveillance of elderly people at home. *Lancet* 1992; **340:** 890-893.
9. Iliffe S, Haines A, Gallivan S, *et al.* Assessment of elderly people in general practice. 1. Social circumstances and mental state. *Br J Gen Pract* 1991; **41:** 9-12.
10. Department of Health. *Terms of service for doctors in general practice.* London: HMSO, 1989.
11. Brown K, Williams EI, Groom L. Health checks on patients 75 years and over in Nottinghamshire after the new contract. *BMJ* 1992; **305:** 619-621.
12. Tulloch A. Screening elderly people. *Practitioner* 1992; **236:** 1022-1026.
13. Tremellen J. Assessment of patients aged over 75 years in general practice. *BMJ* 1992; **305:** 621-624.
14. Baldwin R. Later life depression: undertreated? [editorial] *BMJ* 1988; **296:** 519.

Address for correspondence

Dr C A Chew, Department of General Practice, University of Manchester, Rusholme Health Centre, Walmer Street, Rusholme, Manchester M14 5NP.

RCGP

Research Network

Royal College of General Practitioners

Research Training Fellowships in General Practice

The RCGP is pleased to offer two research training fellowships for general practitioners the aim of which is to provide an opportunity to receive training in research methods whilst undertaking research work in general practice. The fellowships enable general practitioners to develop their research skills and interests by securing them protected time and by working within the environment of an academic unit.

Funding is available for four sessions per week for up to two years. Applicants should be members of the College and priority will be given to applicants prepared to work for a research thesis from general practice. Applicants will be expected to have a formal link with a local university department, an RCGP research unit or a department of postgraduate medicine. Financial support up to a maximum of 10% of the value of the Fellowship awarded is available to meet the costs incurred by the supervising department. Applicants should include a summary of the proposed research and confirmation from the head of the academic unit concerned.

Further details and the application form can be obtained from Professor Denis Pereira Gray, Chairman of the Research Network, Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU, to whom applications and curriculum vitae should be submitted by 1st August 1994.

THE MRCGP EXAMINATION

a guide for candidates and teachers

by Richard Moore FRCGP

Published by

RCGP ROYAL COLLEGE OF GENERAL PRACTITIONERS

THE MRCGP EXAMINATION
A Guide for Candidates and Teachers

BY RICHARD MOORE

The MRCGP examination is the only British examination recognized by the General Medical Council, the governing body of the medical profession, in relation to general practice itself. Taken by up to 2000 candidates a year and now possessed by the majority of general practitioners in several parts of the country, this has become the single most important professional qualification for medical generalists.

How to approach this important hurdle is a subject of great thought for many doctors, and this book offers practical guidelines not only on how to prepare for it but also how to tackle the papers and orals. This is a workbook for candidates and will be of value to course organizers and vocational training schemes.

As an experienced MRCGP examiner Richard Moore is well placed to write this first book on the MRCGP examination to be published by the College.

Price: £15.00 members
£16.50 non-members

ISBN: 0 85084 193 3

The MRCGP examination book is available from:

RCGP Sales, 14 Princes Gate, Hyde Park,
London SW7 1PU.
Tel: 071 823 9698 (or 071 225 3048, 24 hours,
Access and Visa orders only).