

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

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.

We thank the 20 practices that took part in the study and Sue Read for her help with data analysis.

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(Accepted 2 July 1992)

## 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 as important require further training to fit them to do home visits confidently. Patients who were assessed found it worth while. The case for developing a 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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*BMJ* 1992;305:621-4

the assessments, and where; and to document the needs identified and subsequent referrals. In addition the views of doctors, nurses, and elderly people on assessment were investigated.

### Subjects and methods

Wiltshire Family Health Services Authority data show that on 1 April 1990, 39 516 patients aged 75 or over were registered with 281 family doctors based in 83 practices. I collected data from 77 practices, 73 of which (88%) provided complete information.

#### IMPLEMENTATION OF THE ASSESSMENT SCHEME

Data were collected by the practices on prepared sheets which showed how many patients had been offered an assessment, how many had accepted, and who had undertaken the assessment and where. A separate sheet recorded referral numbers and the agency of referral. These sheets together with standard patient assessment cards were given personally to every practice in April and March. The sheets were simple to complete and acted as a means of collecting information that the practice themselves required. Each practice was visited quarterly to collate information from the sheets. The only validation in the study was by regular checking with professionals responsible for carrying out assessments and collating practice data.

#### VIEWS OF FAMILY DOCTORS AND PRACTICE NURSES

Questionnaires were sent to every general practitioner (281) and to practice nurses (54) conducting assessments. Questionnaires were sent through the practice managers with a covering letter; the letters were followed up in most cases by a telephone call. There was an 83% (232) response rate from doctors and 89% (48) response rate from nurses.

#### VIEWS OF PATIENTS

A small sample of 360 (2%) elderly patients was selected from six practices, two from each of the three health districts in the family health services authority.

TABLE IV—Referrals of elderly patients to different services after assessment

Sector	No of referrals
Health services	1454
General practitioner	549
Social services	752
Voluntary services	236
Other	273
Total	3264

Practice staff selected 30 patients who had refused and 30 who had accepted the invitation. Questionnaires were sent to patients from the family health services authority and returned to the practice, from where they were collected. The questionnaire was returned by 156 of 180 (87%) patients who accepted assessment and by 103 of 180 (57%) who refused it.

#### ANALYSIS OF RESULTS

The results of questionnaires were coded and entered into a computer for analysis with the statistical package SPSS. Practices were divided into five groups for analysis: those in which general practitioners did all assessments, general practitioners did over 80%, general practitioners and practice nurses did similar proportions, practice nurses did over 80%, and practice nurses did all. Nurses with specialist qualifications (health visitor, district nurse, English National Board 941 care of the elderly certificate) were also analysed separately.

### Results

The 73 practices which supplied full data sets had offered assessment to 31 963 patients aged over 75. A total of 20 192 (63%) accepted the offer and of these, 19 565 (97%) had been assessed by April 1991. Practices reported that many patients did not reply to the invitation rather than refusing outright.

The way practices managed the assessment scheme varied widely (table I). In some virtually all assessments were carried out by general practitioners while in others all were done by practice nurses. The highest uptake of invitations was among the 18 practices in which general practitioners did most assessments (76%). In the 27 practices where practice nurses did all or most of the assessments uptake was 57%. Doctors carried out the lowest proportion of assessments in patients' homes, while practice nurses with specialist qualifications did 85% of their assessments in the home (table II).

Substantial differences in referral patterns by professional background and training were also found. In all 3264 referrals resulted from the 19 565 assessments, an overall rate of 167/1000. However, the referral rate from practice nurses with specialist qualifications was over twice this: 400/1000 visits. Analysis by practice organisation of assessments showed that the referral rate was lowest in practices in which 80-100% of assessments were carried out by general practitioners and highest in practices in which all assessments were done by practice nurses (table III).

Table IV shows where patients were referred after assessment. Referrals to health services were most common, most of these were for hearing (29% of referrals to health services and 18% of all referrals) or to chiropody services (30% of health service referrals and 18% of all referrals).

#### ATTITUDES TOWARDS ASSESSMENTS

Attitudes of general practitioners and practice nurses to the assessment differed greatly. Table V shows two thirds of general practitioners regarded assessments as unnecessary, usually because they

TABLE I—Uptake of assessments by elderly patients according to practice organisation

Staff assessing patients	No of practices	No of patients invited	No of acceptances	Acceptance rate (%)
General practitioner 100%	13	4663	3359	72
General practitioner >80-99%	5	3022	2478	82
General practitioner and practice nurse	28	10612	6557	62
Practice nurse >80-99%	14	6003	3260	54
Practice nurse 100%	13	7663	4538	59
Total	73	31 963	20 192	63

TABLE II—Numbers of home assessments conducted by professional group

	Total No of assessments	No of home assessments	Proportion of home assessments (%)
General practitioners	8786	4761	54
Practice nurses	5754	2850	50
Practice nurses with specialist qualifications*	5025	4272	85
Total	19 565	11 883	61

\*Including 379 home assessments by district nurses and health visitors attached to practices.

TABLE III—Number of referrals according to practice organisation

Practice staff assessing patients	No of practices	Total No of referrals	No of referrals/100 assessments
General practitioner 100%	13	164	5
General practitioner >80-99%	5	28	1
General practitioner and practice nurse ~50%	28	739	11
Practice nurse >80-99%	14	612	19
Practice nurse 100%	13	1721	38
Total	73	3264	74
Practice nurses with qualifications	16	1858	57

TABLE V—General practitioners' and practice nurses' views on elderly assessments

	No (%) responding				Total
	Unnecessary	Necessary	Important	Vital	
General practitioners	155 (68)	57 (25)	15 (7)	1 (0.4)	228
Practice nurses	3 (6)	20 (42)	21 (44)	4 (8)	48

considered their patients were already well known to them. By contrast over half the nurses rated assessments as important or vital, a view held by only 16 (7%) general practitioners. Differences in attitudes to health promotion were also substantial: 43 (90%) nurses compared with 132 (58%) general practitioners said they saw health promotion as a key part of the assessment.

Only four respondents who had been assessed did not find the assessment helpful. Of those who welcomed the assessment, three quarters said this because it was good to know the doctor or nurse cared. Not surprisingly, the response rate from those who had refused the assessment was low. Those who responded largely comprised those who reported that their health was as good as they could expect for their age (38 patients) and those who visited the doctor regularly anyway (38 patients). The remainder gave other reasons for refusing an assessment.

### Discussion

Since 1964, when Williamson first identified the extent of unreported disease among elderly people, there has been considerable discussion concerning the appropriateness, benefits, and logistics of anticipatory care.<sup>1</sup> During the past 30 years the focus of preventive care has shifted from uncovering disease to detecting unreported or poorly reported conditions. This approach has now widened to include functional, social, and environmental factors affecting the health of elderly people.<sup>2</sup> One of the main influences on the development of case finding programmes has been the assumption that elderly people underconsult. Several studies have found that although elderly people undoubtedly have greater morbidity,<sup>3</sup> they consult their doctor more frequently than younger adults.<sup>4</sup> Indeed, those that do not consult regularly have been found to be healthy.<sup>5,6</sup> However, elderly people and their relatives still tend to accept many minor symptoms as being a natural part of aging.<sup>7</sup>

### VALUE OF SCREENING

Substantial evidence exists to show that case finding assessment uncovers unreported needs,<sup>7,11</sup> but it is difficult to measure the effect of such a programme on the health of elderly people. Most studies so far have used the traditional measures of mortality and morbidity—incidence of hospital admissions and length of hospital stay.<sup>7,9,11</sup> A randomised controlled trial in Newcastle recently showed that a screening programme had significantly improved the morale of elderly people but had not reduced physical problems, or increased ability to carry out activities of daily living.<sup>12</sup> I also found evidence to support the view that patients value somebody caring about them. Illife *et al* showed that an annual assessment would uncover new cases of depression and dementia. In their study one in five elderly people (22%) had evidence of depression; nevertheless, new information leading to effective medical and social intervention was limited.<sup>13</sup> The non-comparability of these studies make it difficult to draw any firm conclusion.

In Wiltshire the overall uptake of assessment (64%) was considerably lower than the 75% predicted.<sup>14</sup> This relatively low acceptance rate clearly limits the usefulness of the data for population based health care

planning. Although those who were assessed welcomed it, blanket screening of elderly people annually may be both crude in structure and expensive in time and resources. Sophisticated measures have been devised over the past decade to identify those elderly people most at risk<sup>8,15</sup> and a more efficient form of surveillance could concentrate effectively on vulnerable elderly people.

### OPPORTUNISTIC SCREENING

Although 76% of patients accepted general practitioners' invitations for assessment, almost half were done in the surgery rather than in the house, as Wallace had recommended. The value of social and environmental assessments done in the surgery is doubtful.

Most doctors considered that assessment was unnecessary as their patients were already well known to them. The low level of referrals from doctors for social care suggests either that doctors do indeed know all their patients and that their functional as well as their clinical needs are being met, or that the social and functional assessment is only cursory.

Williamson suggested that most doctors are not good at case finding because their professional expectations are rarely satisfied by the apparently mundane nature of the work.<sup>16</sup> Moreover, they may not recognise the extent to which their latent fears about growing old and boredom with repetitive complaints impair their therapeutic attitudes and behaviour.<sup>17</sup>

Most doctors consider opportunistic assessment to be the most appropriate form of proactive care.<sup>18</sup> At least three quarters of elderly patients see their general practitioner once a year or more, and assessments were probably carried out during those consultations.

The way in which nurses' work is organised gives them little occasion for opportunistic assessments. Invitations are therefore issued in a more formal way and this possibly explains the lower uptake (57%). The wording of the invitation and the style in which it is offered may also affect the number of acceptances. Examination of practice invitations suggests no correlation between encouraging letters and high uptake, but there seems to be a connection between negative invitations and low uptake. This should be investigated further.

### TRAINED ASSESSORS

Although health visitors seem the most appropriately trained to undertake case finding, most are reluctant to relinquish their traditional work with preschool children and their families.<sup>19,20</sup> Over the past decade support has increased for qualified specialist nurses for elderly people.<sup>21,22</sup> Wells and Freer suggested that with additional training in diagnostic skills and prescribing specialist nurses would fulfil an important role in the primary health care team.<sup>23</sup> My results showed clear differences between practice nurses with and without specialist qualifications.

Wallace argued that there are insufficient staff in primary health care teams to carry out assessments adequately. He proposes employing trained link workers from various professional backgrounds to specialise in this work. Though he considers the demands of the contract and the importance of data collection, Wallace does not mention health education, a key element in anticipatory care.

### SUMMARY

This study represents an overview of the elderly assessment scheme in its first year, from which inevitably new questions have emerged. Care of elderly people is a multidisciplinary exercise. With such disparity of views emanating from general practitioners and practice nurses a means of providing a consistent service needs to be explored. Educational

needs of doctors and nurses should be addressed and the development of specialist community nurses for elderly people further investigated.

This paper is based on a dissertation as part of an MSc in gerontology at the Age Concern Institute of Gerontology, King's College London. The support of my supervisor, Dr Emily Grundy, is gratefully acknowledged.

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(Accepted 30 July 1992)

## Partners in Practice

### The developing primary care partnership

Mike Pringle

*This is the last of a series of articles focusing on the current tasks and functions of the primary health care team*

This series of articles has looked at a number of key issues in teamwork in primary care. It is clear that if a clean start could be made, primary health care teams would probably look substantially different from the ones we encounter today. The historical development of primary care has resulted from three concurrent pressures—political, organisational, and clinical.

#### Development of primary care

The existence of primary care teams can be largely attributed to the 1966 charter, which also limited the range of skills available within the team. The rules for reimbursing 70 per cent of staff costs defined eligible job descriptions; if that list had included physiotherapists, social workers, or counsellors the nature of primary care itself over the past 25 years would have been radically altered. The recent relaxations have given practices much more discretion but have also introduced the possibility of a lower reimbursement.

The second pressure has been organisational. The moves towards group practices, practice reports, audit, and computerisation have all emphasised the need for administration and management. The increasing sophistication of practice information systems for managing both clinical care and the resources of the practice has reached its apotheosis in fundholding. Practices joining this scheme require a level of internal organisation that would have seemed unachievable and unbelievable a decade ago.

Perversely the increasing management role in primary care has resulted in less involvement in management by some doctors. The arrival of practice managers with high level skills has freed general practitioners from administration and often from direct management responsibility. The increase in clerical staff has given the practitioners support with

#### Key points

- The primary health care team as we know it has developed largely in response to political, organisational, and clinical pressures
- Education is required for team members deficient in necessary skills
- The personal responsibility of each member within the team framework must be identified and accepted
- Patients should encounter the teams, not unconnected coworkers
- Every member of the practice should participate in quality assurance
- The result of effective teamwork should be, primarily, an increased quality of care

paperwork that their colleagues of 1966 could only envy.

The third major pressure derives from clinical evolution. In recent years there has been an accelerating transition of medical care into general practice. Child immunisation, developmental assessment, and family planning have been shared with agencies in district health authorities, but the 1990 contract has often led to their transfer to primary health care teams. The national surveillance of the "healthy" population through well person clinics, visits to the over 75s, and new services such as foreign travel clinics has augmented the workload and responsibility of primary care.

Through the 1980s there has been a shift in the care of patients with chronic disease from secondary care into general practice. The closure of many psychiatric

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*BMJ* 1992;305:624-6