

Community care of vulnerable older people:

cause for concern

A CHALLENGE TO PRIMARY CARE

The projected doubling of the >75-year-old population in the next 20 years presents a major challenge.¹ While standards of care in general practice have risen steadily over the past 30 years, for vulnerable older people the picture is different. The term 'vulnerable' covers multimorbidity, functional incapacity, and socioeconomic and psychological problems severe enough to put the patients at significantly increased risk of hospital and institutional admission. Routine GP surgery sessions alone are inadequate to assess complex comorbidity, polypharmacy, and adherence, in addition to reviewing disabilities and carer pressure. At the age of 75 years, patients will have, on average, three medical disorders. At least one-quarter will have a significant level of functional disability, rising exponentially with increasing age, and they will often have socioeconomic and psychological problems which loom larger in advanced old age. It is vital that all these problems are addressed if the patient's needs are to be adequately met.

We challenge primary care to develop cost-effective ways to integrate population scanning of the older population, most logically for those over the age of 75 years, leading to risk stratification and a coordinated primary care and community response. Community programmes, working with primary care, are also needed to reduce behavioural risks such as smoking cessation as well as encourage exercise and give dietary advice. In our own practices we valued cooperative work with trained volunteers.² De Maeseener, argued that 'practices integrate individual and population-based care, blending the clinical skills of practitioners with epidemiology, preventive medicine and health promotion'.³

THE NEED FOR A CHANGE IN PRIMARY CARE

The first requirement may be to change the mindset, from student level into practice, of some GPs in their management of vulnerable older people; recognising that they require a different programme of care geared to their particular needs.

The present system, usually relying on demand-led care, and used successfully for younger people, is not appropriate to the needs of vulnerable older patients. The key to success is to define the objectives very clearly. These are as follows:

- minimising suffering;
- promoting and maintaining health, function, integration in society, and independence;
- enabling them to lead the best life possible and to remain fit and active for longer;
- reducing the time they spend in hospital and institutional care; and
- dying with as much dignity and as little suffering as possible.

RISK ASSESSMENT

The first requirement is a register of all patients aged 75 years, where most of the multimorbidity lies. Annual postal birthday questionnaires place patients in four risk categories according to the severity of their chronic diseases, disabilities, and socioeconomic problems. The Cardiff Newport Questionnaire is used for this purpose in Cirencester's Stay Well 75+ program⁴ and by Age UK in Waltham Forest. The categories are:

1. *Relatively low risk*: patients in fairly good health for their age, with medical disorders which are neither serious nor progressive: disability is limited and they can cope with their non-medical problems.
2. *Medium risk*: patients have chronic disease and/or disability which affect their day-to-day life to some degree while their non-medical problems need identification. Careful management and prevention of falls is vital.
3. *High risk*: more serious disease, disability and non-medical problems which together have a significant effect on day-to-day life and put patients at greater risk of institutional admission.
4. *Very high risk*: very frail or severely disabled subjects, often with significant or high levels of medical or non-medical problems, at imminent risk of need for institutional care.

COMPREHENSIVE GERIATRIC ASSESSMENT

We suggest careful data collection preferably using questionnaires of health, disability and relevant socioeconomic problems leading to assessment of risk. A community nurse-led comprehensive review with protected time follows for the 25% identified as entering frailty (categories 3 and 4) and a full comprehensive geriatric assessment (CGA) at a clinic for those with clinical and complex needs (category 4) when time is not at a premium.

Stuck *et al*⁵ concluded that 'CGA programmes linking geriatric evaluation with strong long-term management are effective for improving survival and function in older people'. Huss *et al* in 2009, with another meta-analysis of randomised controlled trials, reported that:

*'...preventative home visits have the potential to reduce disability burden among older adults when based on multidimensional assessment with clinical examination.'*⁶

We think it is important for one doctor with a special interest in elderly care to take the lead in coordinating and directing such a programme in a group practice, and lead the organisational audit of elderly care services. This doctor may also assess those with complex problems in a clinic for comprehensive geriatric review. Coordinated practice-based risk stratification approaches work well with a healthy ageing strategy, in combination with voluntary organisations such as Age UK and the Expert Patients Programme.

WORKLOAD

In a notional 'list' of 2000 patients, 7.9% will be >75 years of age, totalling 158. Higher risk patients in risk categories 3 and 4 represent about 40 patients for comprehensive review at home by community nurses or in a practice clinic. Doctor-led CGA for category 4 patients leads to a clinic of 4 patients per 2000 once a month. Each practice will

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decide how many patients they can fit into their normal workload, adding the small number of longer appointments, depending on their demography and working with departments of geriatric medicine.

VOLUNTEER SUPPORT

From an early stage we both recognised the need to recruit volunteer visitors. In Bicester, trained volunteers visited the over 75s at home to give health education and to brief them about benefits and entitlements, as well as helping them to complete the health and social questionnaire.⁷ In Cirencester trained volunteers were introduced after the community health visitor and nurse had assessed the patient as disabled and vulnerable.⁸ They follow-up these patients with a 3-monthly assessment using the Winchester Questionnaire, which stratified disability into low, medium, and high. A change of score band led to an earlier complete comprehensive geriatric review.

UNMET NEED

In 1956 the Rutherglen Experiment⁹ in Glasgow drew attention to a significant level of undiagnosed disease among older people, who tended to assume that their health problems were simply the price of ageing. The conditions most likely to be overlooked were sensory impairment, depression, dementia, urinary tract disorders, anaemia, foot, and locomotor disorders. Steel *et al*¹⁰ in 2008 reported unacceptably low levels of investigation and treatment in many clinical areas in patients aged ≥ 50 years.

REDUCED INSTITUTIONAL CARE

The first randomised controlled trial of geriatric screening and surveillance by Tulloch and Moore⁷ produced two important findings. Study group patients spent significantly less time in institutional care, that is, they were kept more active for longer in the community. Health was not significantly improved. The MRC study,¹¹ reporting in 2004, did not use time spent in institutional care as an indicator of outcome. Instead it used hospital admissions, and not bed days, as an outcome measure and these were reduced but not significantly. The number of bed days of institutional

care was also explored but the data were inconclusive. In a large systematic review Beswick *et al* in 2008¹² concluded that:

'... complex interventions can help elderly people living at home, largely through prevention of the need for nursing home care, and can help to reduce the rate of falls — evidence suggested that all elderly people may benefit from assessment and appropriate health and social interventions'.

BENEFITS FROM ACHIEVABLE PROGRAMMES

Patients are kept active for longer and spend less time in institutional care. The reduction in institutional care represents a considerable saving when on average, 50% of those in nursing and residential care are paid for by the state. Hospital bed days are reduced.

However, we can only trace four doctors or practices who have attempted to develop a programme of anticipatory care in the past 40 years.² We believe that the reason for this is that doctors are not taught, at student or postgraduate level, to organise and deliver care to older people in a manner fundamentally different from that in the young and middle-aged. Beswick¹² pointed out in 2008 that programmes of this sort were under way in Germany, Italy, France, the Netherlands, and Denmark. What is needed is a requirement by the NHS Commissioning Board for an organisation audit of community care of older people with recommended standards and inclusion within the Quality Outcomes Framework.

Commissioners, aware that 10% of the population consume 70% of NHS and social care costs, will need to include protected clinical time for anticipatory care planning and assessment for those at risk. The management of complexity and comorbidity become an essential part of core primary care. Commissioners need to create the right multidisciplinary teams to support primary care.

David L Beales,

Medical Advisor, Centre for Nutrition and Lifestyle Management, Wokingham.

Alistair J Tulloch,

Retired GP, Bicester.

ADDRESS FOR CORRESPONDENCE

David Beales

Hampshire Hunt Cottage, Ropley, SO24 0EG, UK.
E-mail: dbeales@heartsandminds.fsnet.co.uk

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