Older patients’ community care – GP workload and social care views

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Abstract

In the United Kingdom the number of people aged 75 and older is rising and predicted to increase by 80% in the next 20 years. Against this backdrop it seemed timely to look at workload and staff opinion on the adequacy of care provided by General Practices to patients aged 75 and over. Four General Practices in Dundee, Scotland were the setting for this study. Workload was measured by number of home visits, consultations and telephone calls over the previous year. Increasing patient age correlated to increase in measured workload, with no gender difference. Subdivision using the Scottish Index of Multiple Deprivation demonstrated that those with highest deprivation had significantly fewer encounters.

A questionnaire on adequacy of service was distributed to all general practice staff and the local social work team – around 75% of health and social care respondents felt their service would not cope with larger numbers of elderly patients. Most deprived quintile (as defined by Scottish Index of Multiple Deprivation) of patients aged 75 and over had significantly less contacts with primary care during normal office hours than all other quintiles. Currently the majority of healthcare and social workers feel needs of older people are not adequately met and they feel with increasing numbers of older people their services will not cope. Coding issues are a hidden difficulty in attempting to assess GP workload.

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Background

In the United Kingdom the number of people aged 75 and older is predicted to increase by approximately 80% in the next 20 years (Office for National Statistics, 2012). This has profound implications for health and social care services planning, with integration of health and social care services being recognised as a key government priority. The over 75s are the highest users of the NHS service and over the next 20 years demography alone could increase expenditure on health and social care by over 70% (Scottish Government, 2011a). A Consultation of Proposals titled “Integration of Adult Health and Social Care in Scotland” published in May 2012 by the Scottish Government highlights that reform is required now to improve care particularly for older people and that this hopes to be achieved by improving integration of care of health and social care (Scottish Government, 2012).

In response to changing demographics and severe financial pressures that Scotland faces, the programme titled ‘Reshaping Care for Older People: A Programme for Change 2011 – 2021’ was published. This stated that people aged over 65 provide more care than they receive and suggested we need to push back
the concept of older age with a focus on those over 75 (Scottish Government, 2011b).

In 2010, the Christie Commission (Christie, 2011) noted that radical change in design and delivery of health and care was required to ensure the future of public services. It proposed four pillars of reform (Person Centred, Performance and effectiveness, Partnership working and Prevention). These themes were used by the Scottish Government to help develop the 2020 Vision, which stated that, “by 2020 everyone is able to live longer healthier lives at home, or in a homely setting. We will have a healthcare system, where we have integrated health and social care” (Scottish Government, 2011a). A Consultation of Proposals titled “Integration of Adult Health and Social Care in Scotland” published in May 2012 also suggested reform is required to improve care particularly for older people and would be best achieved by improving integration of care of health and social care (Scottish Government, 2012).

Subsequently the Public Bodies (Joint Working) (Scotland) Bill has been introduced (Public Bodies Act, 2014). This received Royal Assent on 1 April 2014 and puts in place the proposed framework for integrating health and social care in Scotland. This aims to approach integration via being outcome focused, and there is scope for flexibility allowing a bespoke model to be put in place unique to that particular area of Scotland.

For this vision of integration to succeed, localities, the natural communities or units of health and social care, will need to have an understanding of the service pressures that each face and be able to work collaboratively with patients, communities and the third sector to meet needs and aspirations. A concern within primary health care is that workload could significantly increase based on changing demographics even before any new integrated system is enacted.

In a previous study of patient initiated workload relating to home visits it was suggested that “present work patterns of general practitioners in locations popular with retired people may represent the future of home visiting” (Beale, 1991). A different publication evaluating general practice home visit rates revealed that home visiting rates were twice as high in the most deprived social class compared with the most affluent social class (Aylin, Majeed and Cook, 1996).

Against this backdrop it seemed timely to look at the workload and staff opinion on the adequacy of care provided by Scottish General Practices for their populations aged 75 and over. This study set out to assess if any trends are apparent relating to gender, age and deprivation as well as capturing views from front-line staff about caring for older members of society.

**Methods**

Four General Practices in Dundee, Scotland were the setting for this study. Three of these practices had reported to the Health Board that they were struggling with workload related to caring for higher numbers of older patients in the community. Information Service Division figures show the percentage of these practice populations aged 75 and over was 12%, 13% and 14%, and that 4% of their registered patients were aged 85 and over. These three practices were above the Scottish average which typically have 8% of its patients aged 75 and over and 2% of it patients aged 85 and over. A further practice was included in the study which had typical demographics of Scotland (Information Services Division, 2013). All of the practices had patients living at home, and in residential and nursing homes; no community hospitals were included in this study.

Workload was measured at each practice by running a reproducible Vision (software used for general practice consultations) search to obtain the number of home visits, practice based consultations and telephone calls over the previous year relating to patients aged 75 and over during normal office hours. In addition, demographic data were obtained which included the date of birth, gender and postcode of the patient’s registered address. A further search was run in each practice to obtain the number of registered patients aged 75 and over in the same period.

A questionnaire survey was designed following discussions with a lead general practitioner from each practice, the authors and two community healthcare partnership
managers, which aimed to assess the adequacy of service relating to the 75 and over age group. This voluntary anonymous survey was distributed electronically in March 2013 to all general practice staff (via practice managers) and 10 flyers were left in each practice to raise awareness of the survey. The questionnaire survey was also sent to all social work staff in Dundee City via email invitation. The questionnaire survey included free text boxes for responses to explore their views and was non-identifiable.

The questionnaire explored healthcare and social work staff perceptions of how their service is currently meeting the needs of older people and how they feel it would manage with an increased number of older people.

**Results**

Across all four practices, there were 3,684 registered patients aged 75 and over. Of these patients 3,493 had one or more encounter over the previous year. This equates to 94.8% of registered patients having one or more encounter with general practice over the year studied.

There was a mean average of nine encounters per registered patient with primary care over the year studied. There was no significant difference in the mean average number of encounters between all practices.

Gender did not have significant impact on number of encounters – of the patients that attended, both sexes had a similar number of encounters (females 10.07, males 9.78), however as expected there were significantly more females than males aged 75 or over (2,199 females and 1,294 males).

**Figure 1: Frequency of Encounters for Attended Patients against Age**

When subdividing the population into quintiles using the Scottish Index of Multiple Deprivation, those over 75 living in postcodes associated with highest deprivation had significantly fewer encounters with their general practice compared with all other quintiles.

Coding issues were prevalent in every practice - particularly home visits were incorrectly coded as face-to-face consultations. A manual count of the number of home visits was performed in two practices and this revealed a greater number of home visits than was obtained from the search (manual counts 1,563 and 3,713 - vision search 720 and 1,409). One has to bear in mind the primary purpose of general practice records is for patient care to aid the continuity of care rather than a research tool. Therefore the number of the home visits, practice-based consultations and telephone calls have been grouped together and collectively known as encounters which were usually performed by a doctor, however sometimes by a nurse or practice pharmacist – due to the limitations of coding.

This study attempts to measure GP workload and has highlighted some of the difficulties in doing this - the particular search only captured information on actively registered patients. Therefore this underestimates that workload as it did not capture patients who have died in the previous year – many of whom will have had a significant number of encounters with primary care or patients who have de-registered and moved to a different area.
Figure 3: Recorded Home Visits

Figure 3 shows 4,916 home visits that had been picked up on the vision search for patients aged 75 and over against age, the number of registered patients for each age is also included. This demonstrates that, with an increasing age a significant increase in the number of home visits occurs. General practitioners were more likely to report that the standard of the current service did not fully meet the needs of older people than other health and social care workers (other than the one support worker who responded). Social work staff appeared to be extremely concerned about the increasing numbers of elderly people and over 80% of the respondents feel their service would not cope with increasing numbers of older people being cared for in the community.

Survey responses may be found in Table 1 in the Appendix. Themes from the survey suggested a perceived lack of resource, increasing complex problems due to multiple pathologies, lack of effective service integration, crisis management (acute issues dealt with - impossible to do preventative work due to demand) and communication between professionals was difficult.

Healthcare staff repeatedly voiced concerns about the sustainability of home visits and a perceived inequality due to relatively less funding compared to practices with a more deprived population. All staff groups described a number of challenges regarding the complexity of managing physical frailty and multi-morbidity in the community and the consensus was one that service redesign was required as well as additional staffing.

It was clear that there is considerable interest from both healthcare professionals and social work staff about caring for the ageing population. Below is a selection of the responses from different individuals to reveal the types of responses:

“We have a high elderly population on our list. Demand often exceeds availability for appointments. High proportion of Nursing and Residential Homes in our practice area, which is reflected in the high volume of Home visit requests” (Administration/Receptionist, 02).

“Sometimes we cannot fully meet an older person's needs due to lack of resources. In particular there is a lack of support for people in the community during the night. Also the social needs of older people are often not met by carers as the focus is on the personal care and there are time restrictions on how long carers can visit” (Care Manager, 11).

“Lack of time to spend with service users; lack of resources to offer; sometimes services available but are chargeable” (Social Care Co-ordinator, 01).

“Lack of resources to meet the needs of individuals: obtaining services to meet the need of the individual example due the complex needs of someone with periods of severe mental illness they are not going to be enabled within the community (although they may experience good mental wellbeing through their journey) due to a lack of service most are placed on the enablement team, which means that they are assessed for six weeks then have to transfer service to another provider when this does not work out. Again this has the potential not to work and they are still placed on waiting lists for the community health team carers which due to this being a smaller team the waiting list can be very long and things may come to a crisis before being allocated the appropriate workers” (Support Worker, 01).

“Ten minute consultations are not sufficient for a complex elderly patient. Consideration needs to be given to multiple medical issues, multiple medications (all with their own interactions). Also the consultations tend to be slower, and trying to do all this
in 10 minutes is not fair or safe for the patient or the doctor. The number of frail elderly living alone is increasing and therefore the number of home visits is high. The resources to allow a sufficient number of home visits to be done is not present....in these times of trying to keep people out of hospital, early and quick access to a visit is essential. Elderly patients can phone the practice three or four times a day to ask about their medication, their test results or about any other medical query. The demand on practice admin and clinical time can therefore be very stretched if many elderly patients are phoning on a regular basis” (GP, 05).

“The increased demand for services, based around the age demographic/long-term conditions, makes it increasingly difficult to meet all expected commitments. There is a finite number of front-line staff available and we are now faced with a week-to-week situation where demand clearly outstrips supply” (Team Manager, 01).

Discussion

Of the patients who attended, it was clear with an increasing age there was an increase in measured workload. This study revealed an apparent decrease in demand from the most deprived quintile of patient aged 75 and over (as shown in Figure 2). This was an unexpected finding, particularly as a previous study revealed more home visits tend to occur when looking after the most deprived patients compared with the most affluent (Aylin, Majeed and Cook, 1996). The reason for the apparent decrease in demand is out with the scope of the study and would require further investigation – it may relate simply to the particular locations of nursing and residential homes in this area. However, it may be that the most deprived patients expect to be unwell and live with a certain amount of morbidity, therefore do not seek help as frequently as others. It is also possible that the most deprived quintile chooses to seek medical attention elsewhere and may have a higher rate of out of hours and A&E attendances than the more affluent quintiles. This would fit with a previous study based on council tax banding revealing that more out of hours home visits occur in areas with cheaper council tax (Beale et al, 2006).

There is potentially a response bias with the survey - as with all optional surveys - however it cannot be ignored that the 76% of the 55 multidisciplinary responders felt that with an increasing number of older people their service would not meet the needs of older people. A further issue highlighted in the surveys is the lack of social care provision at night.

A previous systematic review assessing the quality of morbidity coding in general practice (Jordan, Porcheret and Croft, 2004) demonstrated that the accuracy of coding in general practice notes is varied. This particular study search relied upon the accuracy of input of the location of clinical care not the clinical information entered. There was no particular incentive to code the location of clinical care with accuracy and is up to the individual clinician - this study suggests that if coding of location of clinical care is done accurately it can be useful as a measure to assess general practice workload.

Conclusion

This study suggests that at present primary care and social work perceive they are working to maximum capacity – further inevitable increases in the number of elderly population will cause significant strain on these services.

Recommendations

A large demand on primary care and social work in caring for older people in the community was revealed by this study – at times, patient care is being managed with a resource-led rather than need-led assessment with crisis intervention the priority rather than preventative work. General consensus is one calling for the need to re-design services and funding with improved integration of care. These findings have been presented locally to senior management in social and health care, key older people stakeholders and have been useful for planning and distribution of resources.

References


### Appendix

#### Table 1: Survey Responses

<table>
<thead>
<tr>
<th>Occupation, Number Invited</th>
<th>Number Responded (Response rate in brackets)</th>
<th>Does your practice (or service) adequately meet the needs of your older patients? (Percentage of respondents in brackets)</th>
<th>Do you think your service would cope with increasing numbers of older patients being cared for in the community? (Percentage in brackets)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration/Receptionist (Medical), 36</td>
<td>8 (22%)</td>
<td>4 (50%)</td>
<td>4 (50%)</td>
</tr>
<tr>
<td>District Nurse, 11</td>
<td>3 (27%)</td>
<td>2 (67%)</td>
<td>1 (33%)</td>
</tr>
<tr>
<td>General Practitioner, 29</td>
<td>14 (48%)</td>
<td>2 (14%)</td>
<td>12 (86%)</td>
</tr>
<tr>
<td>Health Care Assistant, 6</td>
<td>1 (17%)</td>
<td>1 (100%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Practice Nurse, 11</td>
<td>2 (18%)</td>
<td>2 (100%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Care Manager *</td>
<td>12</td>
<td>4 (33%)</td>
<td>8 (67%)</td>
</tr>
<tr>
<td>Job Type</td>
<td>Invited</td>
<td>Acceptance</td>
<td>Rejected</td>
</tr>
<tr>
<td>------------------------------</td>
<td>---------</td>
<td>------------</td>
<td>----------</td>
</tr>
<tr>
<td>Senior Social Worker *</td>
<td>1</td>
<td>1 (100%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Social Care Coordinator *</td>
<td>4</td>
<td>3 (75%)</td>
<td>1 (25%)</td>
</tr>
<tr>
<td>Social Worker *</td>
<td>6</td>
<td>3 (50%)</td>
<td>3 (50%)</td>
</tr>
<tr>
<td>Support Worker *</td>
<td>1</td>
<td>0 (0%)</td>
<td>1 (100%)</td>
</tr>
<tr>
<td>Team Manager *</td>
<td>3</td>
<td>2 (67%)</td>
<td>1 (33%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health care</td>
<td>28</td>
<td>11 (39%)</td>
<td>17 (61%)</td>
</tr>
<tr>
<td>Social Work</td>
<td>27</td>
<td>13 (48%)</td>
<td>14 (52%)</td>
</tr>
<tr>
<td><strong>All</strong></td>
<td>55</td>
<td>24 (44%)</td>
<td>31 (56%)</td>
</tr>
</tbody>
</table>

*Social work total number invited approximately 80. Further breakdown of job types invited was not possible.