Interface between Primary and Secondary Medical Care in the new NHS: The care of frail elderly people by GPs and Consultant Geriatricians

1. Background

“Delivering for Health” \(^1\) was the Scottish Executive’s response to “Building a Health Service Fit for the Future" (the Kerr Report) and despite the recent change in administration remains the main policy document setting out the direction of service planning across the Scottish Health Boards. Amongst the key proposals, health policy was seen as moving towards a model where care is delivered in community settings as opposed to hospitals - on the basis that this might be more cost effective or preferable to users. Within England this policy developed from the NSF-OP [National Service Framework – Older People] which stimulated the growth of intermediate care and related policy initiatives e.g. community matrons. However, some of these changes have not been adopted in other parts of the UK, though the key principles seem to have wide acceptance. This paper relates primarily to the Scottish context, though reflects the consensus agreed within England.

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The health and social care landscape has been changing towards greater community provision of health care. The good news is that there is a real opportunity for the care of frail elderly people in the community to improve. Difficulties remain however. For example, community services are often fragmented, with insufficient evidence of joint working between health [primary and secondary] and community/social care provision. In some areas there are questionable standards of clinical governance. Lessons from good practice need to become routine practice.

One of the many necessary conditions for effective services for frail older people is adequate medical input. This may appear self evident, because the health problems in older people arise from acute illnesses occurring in the presence of chronic illnesses. It follows that it is vital that these conditions are diagnosed, their prognosis established and appropriate treatment given. However, there are no accepted standards for the medical requirements in services for frail older people in the community.

The purpose of this document is to give guidance upon effective ways of joint working of primary and secondary care doctors and their respective teams. The provision of care to the elderly is a very important part of General Practice, the demands on service created by the transfer of the frail elderly into community settings is recognized by all GPs and the delivery of this care to an appropriately high standard is challenging. These changes in activity represent to some extent a transfer of provision of care from secondary to primary care settings, and have stimulated growth in the development of community geriatrics. At the same time greater sub-specialisation of primary care doctors has led to the development of GPs with Special Interests in older people and GPs with “extended knowledge”.

GPs and community geriatricians historically would interface either through referral to out-patient clinics, day hospitals or through requesting domiciliary visits. The new interfaces include supporting the work of Health and Community Care Teams, providing services to care homes, and supporting assessment in intermediate care settings, including local community hospitals.
We are currently witnessing the development of Community Geriatrics services in these areas. Many different models have developed, largely dependent upon the views and experiences of the enthusiasts (whether from Primary or Secondary Care) who have taken leadership roles in project development and their associated resources. Some have deliberately chosen to develop demonstration projects so as to illustrate what high quality care can achieve, aiming to model good practice to encourage improvements in other neighbouring services, leading by example. Others, particularly those arising in primary care, have taken a population based approach based upon the needs and resources of a CHP (Community Health Partnership) or primary care practice.

2 Challenges faced

Several potential challenges are faced. These include:

2.1 Problem-based as opposed to diagnosis-based services.

Many new community services for frail older people led by staff other than doctors have developed using a “problem-based” model of care, with the risk that underlying diagnoses are not sought or treated. Such models have many advantages in stable patients with medically untreatable conditions where person-centred problem-based interventions are likely to be highly acceptable to users. Such models are potentially dangerous when medically treatable conditions are the principal cause of the problems (e.g. Parkinsonism or anaemia) and if they fail to facilitate relevant secondary prevention (e.g. bone mineralisation, statins, etc). This is a strong justification for robust medical care

2.2 Potential tensions related to professionalism.

GPs, GPs with extended knowledge, GPs with Special Interest (GPwSIs), Community Geriatricians and Health and Community Care Teams may be seen as competing over the same professional territory. Conversely if no-one takes clear responsibility, management can be inefficient or ineffective

2.3 Communication failures.

This includes the adequacy, sharing, and using of particularly medical information, such as relevant diagnoses. Its absence leads to anxiety in patients and families and uncertainties in those who are treating or supporting their care.

3 Responses to the challenges

3.1 Teamwork

Of prime importance is proper teamwork focused on the clinical care of frail older people in the community.

Teams are needed that can:

- Respond rapidly
- Make diagnoses
- Make comprehensive assessments
- Deliver comprehensive care
• And can do this at home, in care homes, and in assessment or intermediate care facilities.

Features of good teams are that they:
• Meet regularly
• Understand each other’s competences
• Are clear about responsibility and its delegation (in those who delegate it and to whom it is delegated)
• Take pains to communicate effectively
• Plan together
• Contribute to teaching and training each other

These elements of teamwork clearly apply if GPs and Geriatricians are to provide shared care.

3.2 Time

One of the features of the geriatrician, the GPwSI or those with expertise within Health and Community Care teams is that he or she can provide the time to assess complex patients - time that is not ordinarily available in primary care. The need for adequate medical time to assess, determine the need for investigation, and monitor progress is important to achieve the best outcomes and efficient use of resources. This is of particular importance in some intermediate care settings – e.g. within community hospitals and care homes, including crisis respite care provision.

3.3 Available specialist expertise with older people

Practitioners in these settings indicate that they sometimes need specialist advice, at times with a minimum of delay. Both GPs and Geriatricians need to be easily available to the teams they support.

The areas of specialist knowledge and skills that define the training curriculum for trainees in Geriatric Medicine apply in principle to the GP with an extended role. By virtue of their dedicated training and workload, Geriatricians may have deeper and more up-to-date knowledge, giving them the ability to manage more complex situations outside the acute hospital, and identifying those who would benefit from further investigation or treatment. Geriatricians have the training and authority to access the resources of secondary care, whereas the GP can martial the primary care resources, emphasising the benefit of shared care.

Describing the roles of the various medical and clinical practitioners is not straightforward. This is partly because their roles adapt as the role of those they work with change. More can be delegated to highly trained community staff than to less trained staff.

3.4 Accepting responsibility

As GPs and Geriatricians and new clinical colleagues interact, some of the etiquette and practice of the past bears re-examination. In the past GPs were
ultimately responsible for patients at home and consultants were responsible in hospital, and GPs requested consultants to “consult”. In the new interfaces there are other responsible people, and the consultant might be asked to consult by someone other than the GP. Legal and ethical considerations reflected in good clinical practice will need to be accepted by all parties. These issues can be overcome by the following:

- Prior agreement between GP, Consultant and members of Health and Community Care Teams with regard to referral practices
- Meticulous attention to communication between all members of such arrangements, not just between any two people
- Full acceptance of the responsibility of the referral process if delegated to non-medical personnel.

4 Establishing a Community Specialist Elderly Care Service

4.1 Elements of the service

Meeting the requirement to respond rapidly, and to cover the range of help needed, requires a community geriatric team. Many localities rely on reactive Primary Care, with a divorced specialist elderly care service dealing with emergency admissions. Community elderly care is core, high volume work, and its delivery is suitable for “commissioning” by Community Health Partnerships, or practice clusters. Its delivery requires a combination of specialist and generalist care.

It makes sense to identify (and establish if absent) the elements of specialist elderly care services for each locality:

- Community Geriatrician sessions and linked OP/Day Hospital resources
- Primary Care practitioners
  - GPs with Special Interest or training in elderly care
  - Other community specialists (e.g. continence, falls specialists)
- A social work/care manager team
- Members of the Health and Community Care team (nurses, pharmacy and therapy services)
- Old Age Psychiatry services

We recommend that these elements be developed into an integrated service. This service should adhere to the principles outlined in the previous section by concentrating upon teamwork, ensuring that staff have adequate time and access to appropriate specialist input. Shared information systems may be useful, but at the very least ensuring good flow of communication between practitioners is vital, with acceptance of roles and responsibilities.

In parts of the UK there has been investment to develop an integrated community specialist elderly care service along these lines, but at present this remains the exception. In some parts of the country the necessary elements do not exist. Some areas do not have community geriatricians, and most others do
not yet have GPs identified with special interest or extended knowledge. Both are required, but the exact ratio of one to another, and which of them should take on the leadership role may vary according to local circumstance.

4.2 Organisation and roles of services

The community elderly care service should be facilitated through the CHP working alongside local specialist services for older people. It is likely to operate at two levels, although these might be merged.

4.2.1 Practice-based, or practice-cluster level

This team could meet weekly, to discuss new cases and review problems. It may comprise:

- District/practice nurses;
- a GP taking special responsibility for managing vulnerable older people;
- a social worker/care manager;
- a community psychiatric nurse;
- clear links to the locality-based team, e.g. the community geriatrician.

4.2.2 Locality-based team

This team has three principal responsibilities:

- Supporting frontline staff in delivering community elderly assessment and care [at practice/cluster level].
- Contributing to intermediate care services within its locality – with involvement in the community hospital, “step down/up” services, supported discharge schemes and respite care.
- Involvement with the local care homes, including pre-admission assessment and review

The locality team is likely to run specialist assessment services, ideally as integrated “one-stop” services. The team will be responsible for clinical governance within elderly care community services. It will also contribute to strategy, review effectiveness and identify service gaps.

Sessional medical time, split between specialist and generalist should be identified to support institutional facilities, as well as community teams. This is effective, evidence-based, and cost-effective. These units may also provide rapid out-patients and comprehensive multidisciplinary assessment which can often prevent hospital admission.

Care Homes are in clear need of access to higher standards of care, with equivalent opportunity to receive community support. Applying principles of palliative care, and optimising managing of late-stage long-term conditions can improve quality of life and will also avoid unnecessary hospital admission. The support needs to embrace training as well as delivery of care. In a typical locality of 100,000, with 1,000 older people in care, at least one specialist nurse, 0.5 community pharmacist, and 0.5 WTE of specialist medical time (either a GP with elderly care training or community geriatrician) is recommended. A
comprehensive collaborative statement was issued by the Royal College of Physicians (London) in 2000 on this subject remains apposite4.

4.3 GPwSI

A number of GPs have developed specific skills in the care of the elderly. The RCGP has developed an accreditation process to quality assure their training. Such clinicians should also have links with local Departments of elderly medicine and associated educational programmes.

5 Summary of Recommendations

The emergence of these teams at practice and locality levels would provide a structure which can be built into routine practice, reducing fragmentation, encouraging integration and easily understood lines of communication. This is already happening in several parts of the country, but has not yet become standard practice. This integration of care offers the promise of professional holistic care for our growing frail older people, the major consumers of health care today.

We recommend:

5.1 As CHPs are taking more of a role in the development and delivery of community based geriatric care, CHPs must be involved at an early stage. Planning of integrated community specialist elderly care services, led by CHPs, but in a vertically integrated manner involving acute Trusts if they employ community geriatricians and other staff working in the community

5.2 Investment in specialist medical care for older people in the community, with responsibilities for supporting frontline clinicians in their day-to-day work, and providing the medical care within intermediate care services, supporting care homes, and running local training and clinical governance structures.

5.3 Identification within each locality the services that can be delivered through General Practice or cluster-based services and those which will be delivered by a team at Primary Care/ locality level

5.4 Development of practice-based community teams for specialist services for frail elderly people.

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References


3. J O'Reilly, K Lowson, J Young et al A cost effectiveness analysis within a randomised controlled trial of post-acute care of older people in a community hospital. BMJ 2006;333:228