



Royal College of
General Practitioners

PREPARING THE FUTURE GP: THE EVIDENCE FOR ENHANCING GENERALIST SKILLS





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Lead Writers: Dr Ben Riley & Dr Chantal Simon

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2.1: WHY INCREASED UNDERSTANDING OF THE RELATIONSHIP BETWEEN WORK AND HEALTH, AND OF THE HEALTH NEEDS OF THE LOCAL COMMUNITY, IS A TRAINING PRIORITY

General practitioners (GPs) have an important and wide-ranging role to play in promoting health and preventing disease. The practice list offers a framework to provide appropriate diagnostic, therapeutic and preventative services to individuals and to the registered population.

Complementary to this is the GP's role in supporting the patient to self-care, for both minor ailments and for long-term conditions, and in supporting the health of carers. During the consultation there are excellent opportunities to discuss healthy living with the patients and for the early detection of illness. To put patients at the centre of their care, GPs need to possess the appropriate skills to support people to self-care, taking them through a range of approaches, in partnership, recognising that the individual should make the choices, decisions and take the actions themselves.

High-quality care of multiple and compounding health problems, against a background of deprivation, depends on the ability of the GP to deliver personal and continuing care over time and to work effectively in multidisciplinary teams.

However, there is insufficient time in existing training programmes for trainees to gain a full understanding of these issues and gain experience and confidence in managing multiple health problems to achieve optimal outcomes for individual patients with different socio-economic backgrounds. Gaining a better understanding of inequalities in health and strategies to address them are important aspects of training to be a GP.

CHALLENGE 1: GAINING AN ENHANCED UNDERSTANDING OF THE HEALTH NEEDS AND PRIORITIES OF THE LOCAL COMMUNITY

'The UK Faculty of Public Health (FPH) strongly supports the extended training for GPs. With prevention and population health so high on the agenda, extended training would allow GPs to fulfil the outcomes laid down in the 'Healthy People' curriculum statement co-produced with the FPH. It would also allow some to spend time working alongside public health specialists to help prepare them for advocacy, service development and leadership roles in their local community.'

Prof Alan Maryon-Davis, President, UK Faculty of Public Health, 2009¹

In order to play an effective role in improving the health of their patients and their wider community GPs will require a greater understanding of public health knowledge and skills. Extended training will allow trainees to be more involved in prevention, rather than just concentrating on developing their diagnostic and treatment skills. We also propose that some trainees will have placements in public health departments to gain better understanding of population medicine, with the hope that some will wish to become more involved in management and commissioning, which are key priorities for the health service.

However, community appraisal and diagnosis, in-depth understanding of the needs of the local population, the social determinants of health and the evidence base for tackling health inequalities are new areas for most GPs and are currently not covered in training programmes.

GPs will increasingly be held accountable within their practice populations for tackling the serious public health challenges faced across the UK². The aetiology of important 21st century health problems such as obesity, child health, mental health and co-morbidity, are highly complex and a broader range of abilities will be required to tackle them. These abilities will need to be delivered through enhanced GP training and include:

- Recognising the impact of social aspects of health, such as demography and unemployment on health³
- Understanding the particular health needs of a range of vulnerable groups – both developing general principles of care and specific aspects raised by different groups, and also recognising where most effort should be expended in general practice to address inequalities^{4,5}
- Identifying the ways in which a practice should adapt its services to meet the needs of local populations, including a change in clinical focus that is responsive to changes in demographic requirements⁶
- Understanding when an admission to hospital is not the best option for the patient and a greater awareness of the alternative options

1 Maryon-Davis A. Personal Communication to Royal College of General Practitioners, December 2009.

2 The King's Fund. *Tackling Inequalities in General Practice*. London: The King's Fund, 2010.

3 Hart JT. The inverse care law. *Lancet* (1971);297:405-412.

4 Cabinet Office. *Improving the Way we Meet the Primary Health Care Needs of the Socially Excluded*. London: Cabinet Office, 2010.

5 Marmot M (Chairman) / Strategic Review of Health Inequalities in England post 2010. *Fair Society, Healthy Lives – The Marmot Review*. London: The Marmot Review, 2010.

6 Gill PS, Kai J, Bhopal RS, Wild S. Health Care Needs Assessment: Black and Minority Ethnic Groups. In: Raftery J, Stevens A, Mant J (eds). *Health Care Needs Assessment. The epidemiologically based needs assessment reviews*. Third Series. Abingdon: Radcliffe Publishing Ltd, 2007. Accessed via: www.hcna.bham.ac.uk/pdfs/04_HCNA3_D4.pdf.

- Considering the impact of truly integrated care along key patient pathways such as COPD, cancer and diabetes. This requires knowledge and understanding of care beyond the consulting room⁷
- Using population data to help individuals and to recognise and appreciate the link between individual clinical care and working with communities – and the associated benefits and tensions⁸
- Understanding the key points in a patient pathway where general practitioners acting as advocates for individual patients can be most effective, including the ability to establish the links between clinical care and patient empowerment⁹
- Leading and facilitating the shift in the focus of services onto delivering care closer to home
- Developing an awareness of the changing health landscape and the key drivers that enable clinicians to make longer term, structured decisions about service outcomes and design.

CHALLENGE 2: EVALUATING AND INTERPRETING LOCAL HEALTH DATA AND SERVICE PERFORMANCE

To be effective, local health services must be designed around an understanding of local health needs, service utilisation and performance and patient outcomes. This will require GPs to learn new skills in using epidemiological data, trends analysis, indicators of variation, and analysis of safety, quality and the patient experience.

GPs in England will be heavily involved in commissioning decisions and will need additional training for this new role, building on the clinical and leadership skills acquired through enhanced GP training. For example, GPs will need to build experience in using data from multiple sources, including public consultation, to build collaborative, evidence-based prioritisation processes and to evaluate the outcomes of services¹⁰.

GPs will also need to develop a perspective of health which is broader than the medicine within the consulting room; they will have a duty to protect the needs of the vulnerable, the overlooked and the ignored, and to promote health and wellbeing in partnership with the community, local authorities and health service colleagues¹¹. They will require the skills to create partnerships with a range of teams and organisations, both statutory and charitable, involved with vulnerable and marginalised adults and children, and to take a proactive approach to identify and prepare for future developments in patient need.

7 Dahlgren G, Whitehead M. *Policies and Strategies to Promote Social Equity in Health*. Stockholm: Institute for Futures Studies, 1991.

8 Dixon A, Khachatryan A, Wallace A, Peckham S, Boyce T, Gillam S. *The Quality and Outcomes Framework: Does it reduce health inequalities?* London: National Institute for Health Research, 2011.

9 Royal College of Physicians. *How Doctors Can Close the Gap. Tackling the social determinants of health through culture change, advocacy and education*. London: The Royal College of Physicians, 2010.

10 RCGP Centre for Commissioning. *Essential Skills for All Clinicians*. London: RCGP, 2011. Accessed via: www.rcgp.org.uk.

11 RCGP Scotland /Short Life Working Group Report. *Health Inequalities Time to care: Health inequalities, deprivation and general practice in Scotland*. Edinburgh: RCGP Scotland, 2010.

CHALLENGE 3: UNDERSTANDING AND SUPPORTING THE POSITIVE RELATIONSHIP BETWEEN WORK AND HEALTH

'Recent evidence suggests that work can be good for health, reversing the harmful effects of long term unemployment and prolonged sickness absence. Yet much of the current approach to the treatment of people of working age, including the sickness certification process, reflects an assumption that illness is incompatible with being in work.'

Dame Carol Black, National Clinical Director for Work and Health, 2008¹²

Approximately 175 million working days were lost to illness in 2006. This represents a significant cost, not only economically, but also in terms of social exclusion. The economic costs of sickness absence and unemployment associated with working age ill-health are over £100 billion a year¹³.

Work is generally good for health, reversing the harmful effects of long-term unemployment and prolonged sickness absence. Yet much of the current approach to the treatment of people of working age, including the sickness certification process, reflects an assumption that illness is incompatible with being in work.

Families without a working member are more likely to suffer persistent low income and poverty. There is also evidence of a correlation between lower parental income and poor health in children. Improving the health of the working age population is critically important for everyone, in order to secure both higher economic growth and increased social justice.

Dame Carol Black's review of the health of the working age population of Britain in 2008 sought to establish the foundations for a broad consensus around a new vision for health and work in Britain. It proposed that GPs had a key role to play. At the heart of her vision were three principal objectives:

- Prevention of illness and promotion of health and well-being
- Early intervention for those who develop a health condition
- An improvement in the health of those out of work – so that everyone with the potential to work has the support they need to do so¹⁴.

Dame Carol described the strong evidence demonstrating that enabling people to return to work has a range of benefits for their long-term health and that unemployment can cause poor health and health inequality. However, many patients require active support to be able to return to work or to continue working with a medical condition and, for the majority, GPs are the trusted first point of contact and guidance for those with such health problems. Doctors have a duty of care to act in the best interests of their patient, but there is evidence that GPs find this area particularly challenging and may be unsure of what they and the general practice team should do. This can result in ethical and clinical dilemmas which put a strain on the doctor–patient relationship.

¹² Black C. *Working for a Healthier Tomorrow – A comprehensive review of work and health*. London: Department for Work and Pensions, 2008.

¹³ *Ibid.*

¹⁴ Waddell G, Burton AK, Bartys S. *Concepts of Rehabilitation For the Management of Common Health Problems*. London: Department of Work and Pensions, 2004. Accessed via: <http://www.dwp.gov.uk/docs/rehab-appendices.pdf>.

CHALLENGE 4: INTERVENING EFFECTIVELY TO SUPPORT PATIENTS IN RETURNING TO WORK AND IN REDUCING LONG-TERM UNEMPLOYMENT

GPs also act as the gate-keepers to illness-related benefits through the issuing of medical certificates. People who are not working are more likely to use healthcare services, more likely to attend hospital and more likely to die than people in work. This is reversed if the individual returns to work. People who have been off work for more than one year are likely to remain off work for a further seven years, whilst those who have been off work for two years are more likely to die, or retire than ever return to work.

Evidence suggests that early intervention, within 6–8 weeks of the start of absence from work, has the best outcome for sustained return to employment¹⁵. However, only a small proportion of GPs have received formal training in this intervention. Enhanced training will enable all GP training programmes to incorporate this training and to provide GP trainees with opportunities to develop and practise these important and challenging consultation skills¹⁶.

Following the publication of the Black report, the RCGP was commissioned by the UK Government's Department for Work and Pensions to run workshops across the UK for established GPs building on the *Health and Work Handbook*, a document produced by the RCGP, the Faculty of Occupational Medicine, and the Society of Occupational Medicine.

The RCGP believes that all trainees should have this training incorporated into their training programmes and that they should be supported by their trainer during their GP training placements. This requires the development of a professional culture in which GPs do everything they can to keep people in work, in the belief that it will improve the health and wellbeing of the individual patient and the population as a whole. If successfully implemented, this innovation alone should save the UK economy billions of pounds by keeping people in active work through the support of their GP.

The RCGP will further develop and update the curriculum statement '*Healthy People: Promoting health and preventing disease*' in line with the enhanced skills set out in this document.

15 Campbell J et al. *Avoiding Long-term Incapacity for Work: Developing an early intervention in primary care*. A report of scoping work carried out by the Peninsula Medical School, Primary Care Research Group, on behalf of the Department for Work and Pensions (Health Work and Wellbeing). London: Department for Work and Pensions, 2007. Accessed via: <http://www.dwp.gov.uk/docs/hwwb-developing-an-early-intervention-in-primary-care.pdf>.

16 Faculty of Occupational Medicine/Royal College of General Practitioners/Society of Occupational Medicine. *The Health and Work Handbook* (2005). Accessed via: <http://www.dwp.gov.uk/docs/health-and-work-handbook.pdf>.

2.2: WHY IMPROVED PREVENTION OF ACUTE AND CHRONIC ILLNESS THROUGH HEALTH PROMOTION AND RISK FACTOR MANAGEMENT IS A TRAINING PRIORITY

'The NHS in the twenty-first century increasingly faces a disease burden determined by the choices that people make: to smoke, drink excessively, eat poorly, and not take enough exercise. Today, countless years of healthy life are lost as the result of these known behavioural or lifestyle factors.'

Department of Health, 2008¹⁷

- In England, 21% of adults smoke; every year there are 1.5 million hospital admissions with a primary diagnosis of a disease that can be caused by smoking and 35% of all deaths due to respiratory diseases and 29% of all cancer deaths are directly attributable to smoking¹⁸.
- In England, 33% of men and 16% of women (24% of adults) are classified as hazardous drinkers. In 2007, the estimated cost of alcohol-related harm to the NHS alone in England was £2.7 billion. Every year in England there are over 6,500 deaths directly related to alcohol and this figure is rising¹⁹.
- Obesity is increasing in the UK; in England 24% of adult men and 25% of adult women are obese. Obesity causes 7% of deaths in the UK, and is associated with many diseases including diabetes (relative risk 12.7 for women and 5.3 for men), cardiovascular disease including hypertension, myocardial infarction and stroke, colonic and ovarian cancer, and osteoarthritis²⁰.

¹⁷ Department of Health. *High Quality Care for All: NHS next stage review*. London: TSO, 2008.

¹⁸ NHS Information Centre for Health and Social Care. *Statistics on Smoking: England, 2010*.

¹⁹ NHS Information Centre for Health and Social Care. *Statistics on Alcohol: England, 2009*.

²⁰ NHS Information Centre for Health and Social Care. *Statistics on Obesity, Physical Activity and Diet: England, 2010*.

- In England, the number of new diagnoses of gonorrhoea, chlamydia and genital herpes has increased by around 3–7% every year since 2008²¹. In 2009, the number of people living with HIV in the UK reached an estimated 86,500; it is estimated that a quarter of people living with HIV are unaware of their infection, but treatment of HIV infection can dramatically improve quality of life and reduce mortality²².
- As blood pressure increases so does the risk of stroke, coronary heart disease, and heart failure; elevated blood pressure is also associated with an accelerated rate of decline of cognitive and renal function. A reduction in blood pressure by an average of 12/6 mm Hg would reduce stroke by 40% and coronary heart disease by 20%, and blood pressure lowering significantly reduces the odds ratio (OR) by approximately 25% for both fatal and non-fatal stroke recurrence²³.
- A recent comparison of cancer survival rates from 1995–2007 in six developed Western countries across the world (Australia, Canada, Sweden, Norway, Denmark and the UK) showed that cancer survival in UK was poor in relation to other countries²⁴; one of the major reasons for this is late diagnosis²⁵.

Rather than focussing on individuals, health promotion involves whole populations of people. It supports personal and social development through providing information, education for health and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health²⁶.

Disease prevention may be primary, secondary or tertiary²⁷:

- **Primary prevention** comprises activities designed to reduce the instances of an illness in a population and thus to reduce (as far as possible) the risk of new cases appearing. Good examples are safe sex education for teenagers, or childhood vaccination programmes
- **Secondary prevention** comprises activities aimed at detecting and treating pre-symptomatic disease or to prevent recurrence of disease. The NHS screening programmes for cervical cancer, breast cancer and bowel cancer are all examples of secondary prevention activities as is minimisation of risk factors following myocardial infarction or stroke
- **Tertiary prevention** aims to reduce morbidity from existing conditions or prevent recurrence, and thus encompasses activities such as long-term asthma and chronic obstructive pulmonary disease management.

21 Health Protection Agency. Table 1: Total number of STI diagnoses in genitourinary medicine clinics & community settings in England 2008 – 2010.

22 Health Protection Agency. *HIV in the United Kingdom: 2010 report*. London: HPA, 2010.

23 Joint British Societies. JBS2: Joint British Societies' Guidelines on prevention of cardiovascular disease in clinical practice. *Heart* (2005);91:v1-v52. doi: 10.1136/hrt2005.079988.

24 Coleman P et al. Cancer survival in Australia, Canada, Denmark, Norway, Sweden, and the UK, 1995–2007 (the International Cancer Benchmarking Partnership): an analysis of population-based cancer registry data. *Lancet* (2010);377:127-138.

25 National Patient Safety Agency. *Delayed Diagnosis of Cancer: Thematic review*. London: National Patient Safety Agency, 2010.

26 Ottawa Charter for Health Promotion (1986).

27 Boyce T, Peckham S, Hann A, Trenholm S. *A Pro-active Approach: Health promotion and ill-health prevention*. London: The King's Fund, 2010.

The importance of health promotion and disease prevention has been enshrined in UK Health Policy for at least the past decade. In 2004, the Wanless Report called for a greater focus on health promotion and disease prevention²⁸. The Darzi Report in 2008 blamed the growth in prevalence of diabetes, depression and chronic obstructive pulmonary disease in part on missed prevention opportunities, and again recommended more resources being directed towards health promotion initiatives and prevention of disease²⁹.

The General Medical Council (GMC) views health promotion as part of every doctor's role. Its guidance for doctors on *Good Medical Practice* states that doctors should: '*encourage patients to take an interest in their health and to take action to improve and maintain it. This includes advising patients on the effects of their life choices on their health and wellbeing*'³⁰.

The King's Fund in its overview of general practice regarded health promotion as one of the main tasks of general practice³¹. The GP service is the most accessed part of the UK healthcare system. In 2008/9, just over 300 million GP consultations took place in England alone³². General practices are regarded as 'key agents' that have the best and most frequent opportunities to improve public health³³. The Royal College of General Practitioners (RCGP) agrees that GPs should be proactive in carrying out public health activities and interventions and has devoted an entire curriculum statement to promoting health and preventing disease³⁴.

'GPs see each of their patients, on average, five times per year. Many of these contacts are for minor, self-limiting problems. GPs, therefore, have many excellent opportunities each year to discuss healthy living with their patients and for the early detection of illness.'

Royal College of General Practitioners, 2007

Health promotion is also an integral part of the GP contract and regarded as an 'essential service'. GPs are required to provide advice in connection with the patient's health including relevant health promotion advice³⁵. Furthermore, GPs are rewarded for reaching pre-set standards in primary, secondary and tertiary prevention via the Quality and Outcomes Framework (QOF)³⁶, and for additional health promotion services provided as Directed Enhanced Services, such as the Alcohol Risk Reduction Service in England³⁷.

Examples of the many and varied health promotion and disease prevention activities that are commonly carried out in primary care are listed in Table 2.2.1.

28 Wanless D. *Securing Good Health for the Whole Population*. London: The Stationery Office, 2004.

29 Department of Health. *High Quality Care for All: NHS next stage review*. London: Department of Health, 2008.

30 GMC. *Good Medical Practice*. London: General Medical Council, 1995 with update 2009.

31 The King's Fund. *General Practice in England: An overview*. London: The King's Fund, 2009.

32 NHS Information Centre for Health and Social Care. Trends in Consultation Rates in General Practice 1995 to 2008: Analysis of the QResearch® database.

33 Wirrmann EJ, Carlson CL. Public health leadership in primary care practice in England: Everybody's business? *Critical Public Health* (2005);2(3):205-207.

34 RCGP. Curriculum Statement 5: *Healthy People: Promoting health and preventing disease*. London: Royal College of General Practitioners, 2007.

35 Department of Health. *Standard General Medical Services Contract* (2010 amendment).

36 NHS Employers/BMA. *Quality and Outcomes Framework Guidance for GMS Contract 2011/12*. London: NHS Employers, 2001..

37 NHS Employers/BMA. *Clinical Directed Enhances Services (DES) for GMS Contract*. London: NHS Employers, 2011.

Table 2.2.1: Examples of health promotion and disease prevention activities routinely carried out in primary care

Type of activity	Examples
Health promotion	<ul style="list-style-type: none"> • Information about healthy lifestyle on waiting room and reception area notice boards, and in practice leaflets and practice newsletters • Opportunistic health promotion advice during consultations • Outreach work in local schools or youth groups • Support for local health promotion initiatives
Primary prevention	<ul style="list-style-type: none"> • Childhood vaccination programmes • Travel advice, malaria prophylaxis and travel vaccination • Influenza and pneumococcal vaccination for high-risk groups • Encouragement of breastfeeding • Smoking cessation and weight management programmes • Contraceptive services and safe sex advice • Identification and management of hypertension • Prophylactic prescription of bisphosphonates for people on long-term steroid treatment • Referral of carers for a social services carer assessment • Annual health checks for people with learning disability or severe mental illness
Secondary prevention	<ul style="list-style-type: none"> • Breast, bowel and cervical cancer screening programmes • Routine antenatal screening and checks • Neonatal blood spot screening • Routine child health surveillance • Screening for depression amongst carers and people with chronic disease • Blood pressure and cholesterol management, smoking cessation and prescription of an anti-platelet agents for people with established cardiovascular disease • Retinal screening, foot checks, smoking cessation, hypertension and lipid management for people with diabetes • Falls assessment
Tertiary prevention	<ul style="list-style-type: none"> • Glucose regulation for people with diabetes • Smoking cessation for people with established asthma or chronic obstructive pulmonary disease • Annual epilepsy checks • Annual learning disability checks • Annual severe mental illness checks • Bone densitometry (if under 75 years) and prescription of a bisphosphonate for people who have sustained a low impact fracture • Stroke, cardiac and pulmonary rehabilitation programmes.

Many factors influence the health choices that people make, including other health problems that they might have, and social and economic factors. Health promotion and disease prevention have a vital role in tackling health inequalities.

There is also a great deal of evidence for the effectiveness and value-for-money of health promotion and disease prevention activities. For example:

- Screening in primary care can identify those consuming harmful or hazardous amounts of alcohol; brief interventions from GPs and practice nurses can reduce alcohol-related harm and are cost-effective³⁸
- Providing brief opportunistic advice for smoking cessation in the GP surgery significantly increases smoking cessation compared to no intervention (OR 1.74); this is cost-effective in all age groups³⁹
- Lipid modification for primary prevention of cardiovascular disease with low intensity statins in those with a cardiovascular risk of greater than 20% p.a. effectively reduces cardiovascular events and saves treatment costs; efficacy and cost savings are even greater for those with established cardiovascular disease⁴⁰
- Approximately 3.5 million women are screened each year in England as part of the NHS cervical screening programme; the vast majority of these women have their smear tests done in the GP surgery. Since the introduction of the call/recall programme in 1988, it is estimated that the programme has prevented 1100–3900 cases of invasive cervical cancer every year in the UK⁴¹.

However, there is some evidence that opportunities for promoting health and preventing disease are missed in primary care in the UK: 54% of patients say that their GP has not provided advice on diet and exercise, whilst 72% say that their GP has not asked about emotional issues affecting their health in the last 2 years⁴². In England in 2008/9, it was calculated that the prevalence rate for obesity based on GP obesity registers was 9.9%⁴³; much lower than the 24.5% for adults reported by the Health Survey for England in the same year⁴⁴, suggesting significant under-detection of obesity in primary care. Lack of training has been identified by the World Health Organization (WHO) as one of the four major barriers to preventive medicine⁴⁵.

CHALLENGE 1: ENGAGEMENT WITH STRATEGIES TO PROMOTE BETTER POPULATION HEALTH

The ultimate aim of all public health initiatives is to improve population health. Traditionally in primary care a 'high-risk' strategy⁴⁶ for preventing disease has been employed in which those at highest risk are identified and measures are taken to reduce their negative health outcomes. A good example is the cervical screening programme. Women with abnormal

38 Jackson R, Johnson M, Campbell F, Messina J, Guillaume L, Meier P, Goyder E, Chilcott J, Payne N. *Screening and Brief Interventions for Prevention and Early Identification of Alcohol Use Disorders in Adults and Young People*. School of Health and Related Research (SchHARR), University of Sheffield, 2010.

39 Parrott S, Godfrey C, Kind P. Cost-effectiveness of brief intervention and referral for smoking cessation. Centre for Health Economics. University of York, 2006.

40 NICE. *Lipid Modification* (2008 with 2010 revision).

41 Sasieni PD, Cuzick J, Lynch-Farmery E, and the National Co-ordinating Network for Cervical Screening Working Group. Estimating the efficacy of screening by auditing smear histories of women with and without cervical cancer. *British Journal of Cancer* (1996);73:1001-5.

42 Department of Health. *High Quality Care for all: NHS next stage review* (2008) *ibid*.

43 NHS Information Centre for Health and Social Care. *Statistics on Obesity, Physical Activity and Diet: England, 2010*. *ibid*. 44 Health Survey for England – 2008 trend tables.

45 WHO Collaborative Group. WHO Phase III Collaborative study on implementing and supporting early intervention strategies in primary health care. Report on Strand I: *General Practitioners' Current Practices and Perceptions of Preventive Medicine and Early Intervention for Hazardous Alcohol Use. A 16 country study*. Copenhagen: WHO, 1998.

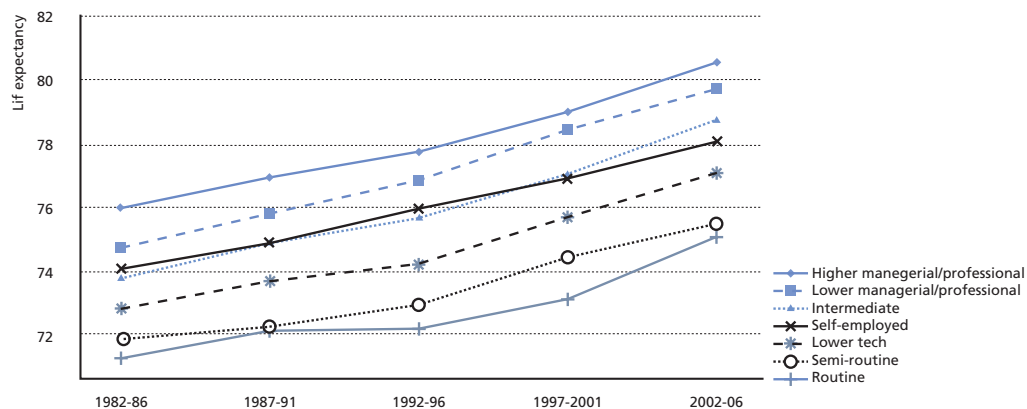
46 Rose G. *Rose's Strategy of Preventive Medicine*. 2nd revised edition. Oxford: Oxford University Press, 2008.

smear tests are at higher risk of developing cervical cancer in the future and treatment reduces that risk.

Health promotion places importance on reducing risk in the population as a whole on the basis that reducing the risk of a small number of people at high risk averts less disease than reducing the risk of a larger number of people at lower risk. The aim of this 'population approach'⁴⁷ is to shift the distribution of risk in the entire population towards a more favourable risk profile. Examples of recent large-scale population health promotion strategies are the smoking ban introduced to work and public places in the UK in 2007 and hard-hitting drink-driving advertising campaigns.

Health inequality is closely linked to population health improvement. Julian Tudor Hart's *inverse care law* states that 'the availability of good medical care tends to vary inversely with the need of the population served'⁴⁸. This paradox has proved to be true across different diseases and healthcare systems.

Figure 2.2.1: Life expectancy for male infants at birth by social class, England and Wales, 1982–2006



Reproduced from *Trends in Life Expectancy by National Statistics Socio-economic Classification 1982–2006*, Office for National Statistics (2011)⁴⁹ under the terms of the Open Government Licence.

It is estimated that 60% of health improvement in the past century is not attributable to advances in medical care, but instead to changes in social factors such as better housing⁵⁰. Dietary choices of people living on low incomes are largely influenced by value-for-money resulting in them eating fewer portions of wholemeal bread, fruit and vegetables than the general population, and more processed and full-fat foods⁵¹. In addition, people with lower levels of education are more likely to follow a less healthy diet⁵². Another example is tobacco consumption. Smoking is less prevalent amongst those who work in management or a

47 Rose G. *Rose's Strategy of Preventive Medicine*. 2nd revised edition. *ibid*

48 Hart JT. The inverse care law. *Lancet* (1971);297:405-412.

49 Office for National Statistics. *Trends in Life Expectancy by National Statistics Socio-economic Classification 1982–2006*. Newport: Office for National Statistics, 2011.

50 Swann C, Carmona C, Ryan M, Raynor M, Baris E, Dunsdon S. *Health Systems and Health-related Behaviour Change: A review of primary and secondary evidence*. London: NICE, 2010.

51 The Food Standards Agency. *The Low Income Diet and Nutrition Survey* (2007).

52 *Ibid*.

profession⁵³, and people with mental health problems smoke 42% of all the tobacco used in England; smoking accounts for most of the excess mortality in this group⁵⁴.

'Health inequalities are not inevitable and can be significantly reduced. They stem from avoidable inequalities in society: of income, education, employment and neighbourhood circumstances. Inequalities present before birth set the scene for poorer health and other outcomes accumulating throughout the life course.'

Marmot Review, 2010⁵⁵

Differences in health outcomes, apart from those that are constitutional or random, are not inevitable. Health promotion targeted towards those who are disadvantaged could significantly reduce health inequalities. Sir Michael Marmot's recent review of health inequalities in England recommended whole population strategies to 'improve the health of the poorest fastest'⁵⁶.

If everyone in England had the same death rates as the most socially advantaged:

- People dying prematurely would enjoy 1.3–2.5 million extra years of life^{57,58}
- People dying prematurely would be more likely to be living disability-free by retirement age, having 2.8 million additional years free of limiting illness and disability⁵⁹
- Every year, the economy would save £31–33 billion in productivity losses⁶⁰, £20–32 billion in lost taxes and welfare payments⁶¹, and in excess of £5.5 billion per year in healthcare costs⁶².

GPs can engage with a wide range of activities to promote better health both within their practices and also more widely. GPs already often display health promotion information in the public areas of their practices through posters in waiting room and reception areas⁶³; they often include health promotion information in practice leaflets and newsletters, and offer health promotion leaflets for patients and those bringing them to the surgery to browse whilst waiting and also to take home⁶⁴. GPs may opportunistically provide health and lifestyle information to patients when seeing them about something else and some GPs may even go into local schools, youth clubs, residential homes or sheltered housing to give talks about healthy living.

53 NHS Information Centre for Health and Social Care. *Statistics on Smoking: England, 2010*. *ibid*.

54 McManus S, Meltzer H, Campion J. Cigarette Smoking and Mental Health in England. Data from the Adult Psychiatric Morbidity Survey (2010). *ibid*.

55 Marmot M (Chairman) / Strategic Review of Health Inequalities in England Post 2010. *Fair Society, Healthy Lives – The Marmot Review*. London: The Marmot Review, 2010.

56 *Ibid*.

57 Frontier Economics. Overall costs of health inequalities. Submission to the Marmot Review (2009).

58 Suhrcke M. The economic benefits of reducing health inequalities in England. Submission to the Marmot Review (2009). Accessed via: www.ucl.ac.uk/gheg/marmotreview/Documents.

59 Frontier Economics. Overall costs of health inequalities. Submission to the Marmot Review (2009). *ibid*.

60 *Ibid*.

61 *Ibid*.

62 Marmot M (Chairman) / Strategic Review of Health Inequalities in England post 2010. *Fair Society, Healthy Lives – The Marmot Review* (2010) *ibid*.

63 The Scottish Government. *Provision of Health Promotion Advice and Information by GP Practices* (2011). Accessed via: [http://www.sehd.scot.nhs.uk/cmo/CMO\(2011\)02.pdf](http://www.sehd.scot.nhs.uk/cmo/CMO(2011)02.pdf).

64 *Ibid*.

However, Marmot's vision is for cross-sector co-operation with GPs working with other authorities such as housing departments, social services or third sector organisations to improve health⁶⁵. The increased role of GPs in commissioning of care throughout the UK, and particularly the introduction of clinically-led commissioning in England, provides an opportunity for integrating health and social care and the potential to address the social determinants of health. However, in order to do this, GPs will need to develop through enhanced training a greater understanding of public health issues, including the prevalence and risk factors for disease, and a better appreciation of the role and expertise of other people working towards the same goals.

The evidence for the role of the GP in mental health promotion is summarised in Supporting Evidence document 1, Outcome 1.2 and the evidence for the role of the GP in health promotion for older people is summarised in Supporting Evidence document 1, Outcome 1.6.

CHALLENGE 2: COMMUNICATION SKILLS TO EFFECT BEHAVIOUR CHANGE

The prompts generated by the QOF and Directed Enhanced Services to identify those at high risk of disease, such as the alcohol-related risk reduction programme in England⁶⁶, have been very effective at identifying more individuals who might benefit from preventive interventions.

For many of these individuals, reducing risk entails a change in behaviour, for example by reducing alcohol consumption, stopping smoking, or changing diet and exercise habits. However, currently most GPs do not feel that they have the necessary skills to help patients to make the necessary alterations to their lifestyle^{67, 68}. Studies asking GPs about their ability to help obese patients to lose weight, and their ability to help their patients stop smoking or reduce alcohol consumption have found that whilst most are confident to identify people with these lifestyle problems, only about one fifth (21–22%) felt that they had the expertise and resources to help patients to actually change their behaviour^{69, 70, 71}.

'Public health is a sensitive subject. It's not easy to strike the right balance between 'protecting' people's sensibilities and telling them hard facts about their personal behaviours that are ultimately shortening their lives.'

Professor Steve Field, Chair of NHS Future Forum, 2010⁷²

65 Marmot M (Chairman) / Strategic Review of Health Inequalities in England post 2010. *Fair Society, Healthy Lives – The Marmot Review* (2010). *ibid*.

66 BMA/NHS Employers. *Clinical Directed Enhanced Services (DEs) for GMS contract. Guidance and Audit Requirements for 2011/12*

67 Laws R, Kirby S, Powell Davies G, Williams AM, Jayasinghe UW, Amoroso CL, Harris MF. 'Should I and can I?': a mixed methods study of clinician beliefs and attitudes in the management of lifestyle risk factors in primary health care. *BMC Health Services Research* (2008);8: 44.

68 Thompson K, Casson K, Fleming P, Dobbs F, Parahoo K, Armstrong J. Sexual health promotion in primary care – activities and views of general practitioners and practice nurses. *Primary Health Care Research and Development* (2008);9:319-30.

69 McAvoy BR, Kaner EFS, Lock CA, Heather N, Gilvarry E. Our Healthier Nation: Are general practitioners willing and able to deliver? A survey of attitudes to and involvement in health promotion and lifestyle counselling. *British Journal of General Practice* (1999);49(440):187-190.

70 Ogden J, Flanagan Z. Beliefs about the causes and solutions to obesity: a comparison of GPs to lay people. *Patient Education and Counselling* (2008);71:72-78.

71 Vogt F, Hall S, Marteau TM. General practitioners' and family physicians' negative beliefs and attitudes towards discussing smoking cessation with patients: a systematic review. *Addiction* (2005);100(10):1423-1431.

72 Field S. Don't take offence if we lecture you on how to stay alive and healthy. *Observer*, 8 August 2010.

GPs also believe that discussing lifestyle issues with patients who do not wish to change their behaviour can have adverse effects on the doctor–patient relationship^{73, 74, 75, 76, 77, 78}. Additionally, time is a barrier to preventive activities in the GP consultation. One study set in the United States estimated that ‘providing all the recommended high-quality preventive care tasks for patients would add approximately 7.4 hours to the day’⁷⁹ and a UK review of the relationship between the GP consultation length, process and outcomes concluded that GPs with longer than average consultation lengths prescribed less and were more likely to include lifestyle advice and preventive activities in the consultation⁸⁰.

But lifestyle interventions in primary care from GPs are effective. For people drinking harmful or hazardous amounts of alcohol, brief interventions from GPs and practice nurses can reduce alcohol-related harm and are cost-effective.⁸¹ Providing brief opportunistic advice for smoking cessation in the GP surgery also significantly increases smoking cessation compared to no intervention (OR 1.74); this is cost-effective in all age groups⁸².

GPs have a crucial role to play in health education and helping patients alter their behaviour in order to improve their health and quality of life and reduce or modify their risk of disease. Enhanced GP training will ensure that:

- GPs are aware that GP interventions are effective in bringing about behaviour change
- GPs will be trained in communication techniques such as motivational interviewing that may help them to broach lifestyle issues with their patients more easily and achieve lifestyle changes
- GPs improve their skills in team working and learn to actively delegate lifestyle intervention to other team members when appropriate so that optimum use can be made of GP time.

CHALLENGE 3: IMPROVEMENT IN ESTABLISHED DISEASE PREVENTION PROGRAMMES

Primary prevention comprises activities designed to reduce the instances of an illness in a population and thus to reduce (as far as possible) the risk of new cases appearing⁸³. Good examples of existing primary prevention programmes are: safe sex education for teenagers presenting to the GP surgery for contraceptive advice, public health notification of infectious illnesses such as food poisoning to ensure that measures are taken so that other

73 Guassora AD, Gannik D. Developing and maintaining patients’ trust during general practice consultations: the case of smoking cessation advice. *Patient Education and Counselling* (2009);78:46-52.

74 McEwen A, West R, McRobbie H. Effectiveness of specialist group treatment for smoking cessation vs. one-to-one treatment in primary care. *Addictive Behaviors* (2006);31:1650-1660.

75 McEwen A, West R, Preston A. Triggering anti-smoking advice by GPs: mode of action of an intervention stimulating smoking cessation advice by GPs. *Patient Education and Counselling* (2006);62:89-94.

76 Michie S. Talking to primary care patients about weight: a study of GPs and practice nurses in the UK. *Psychology, Health and Medicine* 2007;12(5):521-525.

77 Cleland J, Thomas M, Pinnock H. The views and attitudes of general practitioners and smokers toward provision of smoking cessation advice: a qualitative study. *Primary Care Respiratory Journal* (2004);13:144-148.

78 Epstein L, Ogden J. A qualitative study of GPs views of treating obesity. *British Journal of General Practice* (2005);55:750-54.

79 Yarnall KS, Pollak KI, Ostbye T, Krause KM, Michener JL. Primary care: is there enough time for prevention? *American Journal of Public Health* (2005);93:635-641.

80 Wilson A, Childs S. The relationship between consultation length, process and outcomes in general practice: a systematic review. *British Journal of General Practice* (2002);52:1012-1020.

81 Jackson R, Johnson M, Campbell F, Messina J, Guillaume L, Meier P, Goyder E, Chilcott J, Payne N. *Screening and Brief Interventions for Prevention and Early Identification of Alcohol Use Disorders in Adults and Young People*. SCHARR, 2010.

82 Parrott S, Godfrey C, Kind P. *Cost-effectiveness of Brief Intervention and Referral for Smoking Cessation*. Centre for Health Economics. University of York, 2008. A

83 Boyce T, Peckham S, Hann A, Trenholm S. *A Pro-active Approach: Health promotion and ill-health prevention*. London: The

people do not develop disease, hypertension management in people without established cardiovascular disease, or childhood vaccination programmes.

Secondary prevention comprises activities aimed at detecting and treating pre-symptomatic disease or preventing recurrence. Examples of secondary prevention activities undertaken within the GP surgery are the NHS screening programme for cervical cancer⁸⁴, routine screening for human immunodeficiency virus (HIV) for all new GP registrations in high prevalence areas⁸⁵, minimisation of risk factors following myocardial infarction or stroke, and the learning disabilities health check scheme and alcohol-related risk reduction programme Directed Enhanced Services in England⁸⁶.

Tertiary prevention aims to reduce morbidity from existing conditions or prevent recurrence, and thus encompasses activities such as long-term diabetes, epilepsy, learning disability, asthma and chronic obstructive pulmonary disease management.

GPs have a very important role in ensuring the success of established disease prevention programmes. For example, for childhood immunisations, although the GP delegates administration of vaccinations to practice nurses, parents may depend on information from GPs to decide whether their children are vaccinated. There is some evidence that GPs do not currently frame this information in terms that parents can understand; instead of information on absolute or relative risk, parents would prefer personal anecdotes to illustrate information⁸⁷. This might affect vaccination uptake, especially in more deprived areas. Similarly, endorsement of cancer screening from primary care can improve uptake⁸⁸. The evidence for the role of the GP in improvement of care for people with long-term conditions, including secondary and tertiary prevention activities, is summarised in Supporting Evidence document 2, Outcome 2.3.

Enhanced GP training will provide GPs with the expertise to run efficient and patient-centred chronic disease management clinics in primary care and the communication skills to educate patients about the benefits of other disease prevention activities both within and outside the practice in terms that they can understand.

CHALLENGE 4: DEVELOPMENT OF NEW CARE PATHWAYS TO PROMOTE HEALTH AND PREVENT DISEASE

'The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries.'

World Health Organization⁸⁹

84 NHS cervical screening.

85 BASHH. *UK National Guidelines for HIV testing* (2008).

86 BMA/NHS Employers. *Clinical Directed Enhanced Services (DESs) for GMS contract. Guidance and audit requirements for 2011/12. ibid.*

87 Boyce T, Peckham S, Hann A, Trenholm S. *A Pro-active Approach: Health promotion and ill-health prevention* (2010). *ibid.*

88 Weller DP, Campbell C. Uptake in cancer screening programmes: a priority in cancer control. *British Journal of Cancer* (2009);101:S55-S59. 89 WHO. Social determinants of health webpage.

Health promotion interventions require cross-sector co-operation with GPs working with other authorities such as housing departments, social services or third sector organisations to improve health⁹⁰. The increased role of GPs in commissioning of care throughout the UK, and particularly the introduction of clinically-led commissioning in England, provides an opportunity for integrating health and social care and the potential to address the social determinants of health.

For people with identified risk factors for disease, personalised support is required to minimise that risk. In some cases, this is provided through chronic disease management clinics within general practice, but for others, such as those who are misusing drugs or have HIV, outside agencies must be involved. Generating seamless care pathways for people with risk factors for disease is important so that those people do not disengage from care. The introduction of clinically-led commissioning in England provides an opportunity for providing integrated cross-sector services, for example weight loss pathways for obese patients that include dietary advice, motivational counselling and supervised exercise.

However, although ill-health prevention is often described as a means of saving funds for the NHS⁹¹, it can also be costly. A recent review of 1500 health promotion and disease prevention interventions found that although 20% lowered costs, the remaining 80% added more costs than they saved^{92,93}.

To develop better health promotion and disease prevention pathways, enhanced GP training will give GPs a greater understanding of:

- public health issues, including the prevalence and risk factors for disease
- the principles of efficacy and cost-effectiveness of ill-health prevention interventions
- the role and expertise of other people who work in fields relevant to health promotion and disease prevention in its widest context and the skills to work effectively with them in shared team leadership roles.

90 Marmot M (Chairman) / Strategic Review of Health Inequalities in England post 2010. *Fair Society, Healthy Lives – The Marmot Review* (2010). *ibid*.

91 Wanless D. *Securing Good Health for the Whole Population* (2004). *ibid*.

92 Starfield B, Hyde J, Gervas J, Heath I. The concept of prevention: a good idea gone astray? *Journal of Epidemiology and Community Health* (2008);62:580-83.

93 Russell LB. Preventing chronic disease: an important investment, but don't count on cost savings. *Health Affairs* (2009);28(1):42-45.

2.3: WHY IMPROVED CARE FOR PEOPLE WITH MULTIPLE CO-MORBIDITIES AND LONG-TERM CONDITIONS IS A TRAINING PRIORITY

'The biggest single change facing the profession [medicine] is the shift from a routine dominated by making interventions to treat patients' episodic illness to one dominated by working in partnership with the growing numbers of patients living with long-term conditions.'

Royal College of Physicians, 2010⁹⁴

IN THE UK:

- 41% of adult men and 43% of adult women report a long-term illness and this figure is increasing as our population ages; 16% of men and 19% of women have more than one long-term illness⁹⁵
- 22% of men and 23% of women report an illness that limits their activity in some way⁹⁶
- Non-communicable diseases account for 88% of all deaths; most result from chronic disease such as cardiovascular disease (34%); cancer (27%); respiratory diseases (18%); and diabetes (1%)⁹⁷
- Since 1981, life expectancy has outstripped increases in healthy – or disability-free – life expectancy, meaning that we can now expect to live longer in poor health⁹⁸; up to three-quarters of those over the age of 75 are living with chronic disease⁹⁹

94 Royal College of Physicians. *Future Physician: Changing Doctors in Changing Times*. London: Royal College of Physicians, 2010.

95 NHS Information Centre. *Health Survey for England 2009*. Leeds: NHS Information Centre, 2010.

96 NHS Information Centre. *Health Survey for England 2009*. *ibid*.

97 World Health Organization. *Non-communicable Diseases Country Profiles 2011: United Kingdom*.

98 Office for National Statistics. *Health Expectancies at birth and at age 65 in the United Kingdom, 2007–2009*. Newport: Office for National Statistics, 2011.

99 Department of Health. *Improving Chronic Disease Management*. London: Department of Health, 2004.

- 12% of adults living in the UK look after someone else with a chronic disease who could not manage without them¹⁰⁰; the 1.2 million unpaid carers who provide care for more than 50 hours each week equate to a full-time workforce larger than the entire NHS and are estimated to save the UK economy at least £119 billion a year in care costs¹⁰¹
- Around 2% of patients on a GP's list have an intellectual (previously known as 'learning') disability; yet in England in 2010–11, only 49% of eligible adults with intellectual disability received the advised annual GP health check¹⁰²
- 52% of GP consultations relate to chronic disease; people with chronic disease use 64% of out-patient appointments and 77% of hospital bed days¹⁰³
- 70–80% of medications issued in primary care are prescribed on repeat prescription for chronic and ongoing health problems¹⁰⁴; as many as 50% of people taking drugs for chronic disease management follow treatment recommendations¹⁰⁵
- In 2009–10, an estimated £70 billion of total health and social care expenditure was on people with long-term conditions¹⁰⁶; for people with more than one chronic condition, health costs are six times higher than for those with only one chronic condition¹⁰⁷.

The UK scores well in international comparisons for chronic disease management. In 2011, the Commonwealth Fund surveyed over a thousand sicker adults in each of 11 developed countries in Europe, North America and Australasia¹⁰⁸. For chronic disease management, out of all the countries surveyed, the UK performed best. Specific areas in which the UK excelled included:

- Good or very good quality of care
- Engagement in care management for chronic disease
- Ease of obtaining advice
- Patient safety
- Communication with and between teams
- Communication with patients in terms that they can understand
- Discussion of goals and priorities of care with patients
- Provision of an agreed treatment plan to carry out in everyday life
- Clear instructions on symptoms and when to seek care
- Making shared decisions about care.

100 NHS Information Centre for Health and Social Care. *Survey of Carers in Households 2009/2010*. Leeds: NHS Information Centre, 2010.

101 University of Leeds/Carers UK. *Valuing Carers 2011: Calculating the value of carers' support*. London: Carers UK, 2011.

102 Emerson E, Copeland A, Glover G. *The Uptake of Health Checks for Adults with Learning Disabilities: 2008/9 to 2010/11*.

Improving Health and Lives: Learning Disabilities Observatory, 2011.

103 Department of Health Press Release. Innovative care could help over 15 million people with long-term conditions (2011).

104 Duerden M, Millson D, Avery A, Smart S. *The Quality of GP Prescribing*. London: The King's Fund, 2011.

105 World Health Organization. *Adherence to Long-term Therapies: Evidence for action*. WHO, 2003. A

106 Department of Health Press Release. Innovative care could help over 15 million people with long-term conditions (2011). *ibid*

107 Department of Health. Improving chronic disease management (2004). *ibid*.

108 Schoen C, Osborn R. *The Commonwealth Fund 2011 International Health Policy Survey of Sicker Adults in Eleven Countries*.

However, this is not a reason for complacency. With an ageing population and consequently increasing burden of chronic disease¹⁰⁹, new models of care will be needed to maintain these standards and keep care costs within economic constraints¹¹⁰.

Since the late 1990s when the Government policy turned its focus on chronic disease management for people with long-term conditions, GPs have managed selected chronic diseases largely through nurse-led clinics.

Integrated care is a newer development that is seen as a way to improve care for people with long-term conditions whilst simultaneously making substantial savings on care costs^{111, 112, 113}. To achieve this, new care pathways across traditional primary and secondary healthcare boundaries, and between the health, social and the third or voluntary sector agencies are needed. Development of effective pathways requires close co-operation with other disciplines both within and outside health plus innovative ways of working.

For more people to be cared for entirely within the community, and to reduce unplanned admissions and hospital bed days, it is important for GPs to have effective chronic disease management strategies that they can apply to any patient with a long-term condition.

These strategies include:

- Identification of long-term conditions
- Accurate assessment of needs
- Evidence-based, high-quality treatment in line with current best practice guidance
- Patient-centred care plans including emergency planning
- Provision of information and signposting to other relevant resources
- Effective multidisciplinary working; and
- Accurate practice registers with call and recall systems to ensure regular follow up with review of goals.

Crucial to the success of any chronic disease management programme is involvement and support of carers¹¹⁴. People with long-term conditions on average spend around 0.03% of their time with a healthcare professional. They and their carers manage their condition(s) the rest of the time. Skilled negotiation of self-management plans that patients and carers feel are appropriate and feasible, and which they are motivated to follow once at home, is vital¹¹⁵.

Medicines management is also important for management of people with long-term conditions; 70–80% of medications issued in primary care are prescribed on repeat prescription for chronic and ongoing health problems¹¹⁶. Good medicines management

109 Department of Health. *Ten Things You Need to Know About Long-term Conditions* (2008).

110 The King's Fund. *Improving the Quality of Care in General Practice* (2010). *ibid.*

111 Department of Health. *National Framework for Long-term Conditions*. London: Department of Health, 2007.

112 HM Government. *Our Health, Our Care, Our Say: A new direction for community services*. London: The Stationery Office, 2006.

113 Department of Health Press Release. Innovative care could help over 15 million people with long-term conditions (2011). *ibid.*

114 RCGP/The Princess Royal Trust For Carers. *Supporting Carers Action Guide* (2011).

115 Department of Health. *Self-care: A real choice* (2005).

116 Duerden M, Millson D, Avery A, Smart S. *The Quality of GP Prescribing* (2011). *ibid.*

improves health outcomes, diminishes the likelihood of adverse events and reduces drug costs^{117, 118}.

Groups that are particularly high users of resources include those with multiple morbidities^{119, 120} and those with medically unexplained symptoms¹²¹. These highly complex patients are difficult to manage but warrant special attention to optimise their care, maximise their functioning and minimise care costs. Best practice involves a holistic, patient-centred and problem-oriented care model that depends heavily on a multidisciplinary approach and is most easily provided through general practice^{122, 123, 124}.

Therefore, GPs of the future need high-quality training in leading, co-ordinating and delivering care for people with long-term conditions in the community.

CHALLENGE 1: DEVELOPING NEW SKILLS TO SUPPORT INCREASING NUMBERS OF PEOPLE WITH LONG-TERM CONDITIONS

At present 41% of adult men and 43% of adult women report a long-term illness and this figure is increasing as our population ages¹²⁵. Due to our ageing population, the number of people with a long-term condition is set to rise by 23% over the next 25 years¹²⁶. People with long-term conditions are also very intensive users of services; they account for 52% of GP appointments¹²⁷, 65% of outpatient appointments¹²⁸ and 77% of hospital bed days¹²⁹.

Long-term conditions have been at the centre of UK health policy since the mid-1990s. Managing increasing numbers of people with increasingly complex long-term conditions within a limited healthcare budget has been highlighted by the King's Fund as one of the major challenges currently facing the NHS, and in particular general practice¹³⁰.

The Quality and Outcomes Framework (QOF) was introduced in 2004 with the new General Medical Services Contract for GP practices. It is a voluntary incentive scheme for GP practices in the UK that rewards doctors based on the quality of care delivered to patients. The 'clinical domain' of the QOF contains indicators that relate to chronic disease management¹³¹. It is estimated that, based on 2004 QOF targets, improved performance

117 National Audit Office. *Prescribing Costs in Primary Care* (2007). *ibid*.

118 Pirmohamed M, James S, Meakin S et al. Adverse drug reactions as cause of admission to hospital: prospective analysis of 18,820 patients. *British Medical Journal* (2004);329:15-19.

119 Report of an Independent Commission for the Royal College of General Practitioners and The Health Foundation. *Guiding Patients through Complexity: Modern medical generalism* (2011).

120 Salisbury C, Johnson L, Purdy S, Valderas JM, Montgomery AA. Epidemiology and impact of multimorbidity in primary care: a retrospective cohort study. *British Journal of General Practice* (2011);61:18-24.

121 RCGP/Royal College of Psychiatrists/Traillblazers/National Mental Health Development Unit. *Guidance for Health Professionals on Medically Unexplained Symptoms (MUS)* (2011).

122 Wright N, Smeeth L, Heath I. Moving beyond single and dual diagnosis in general practice. *British Medical Journal* (2003);326:512. doi: 10.1136/bmj.326.7388.512.

123 RCGP/Royal College of Psychiatrists/Traillblazers/National Mental Health Development Unit. *Guidance for Health Professionals on Medically Unexplained Symptoms (MUS)* (2011). *ibid*.

124 Katon WJ, Lin EHB, Von Korff M et al. Collaborative care for patients with depression and chronic illnesses. *New England Journal of Medicine* (2010);363:2611-2620.

125 NHS Information Centre. *Health Survey for England 2009*.

126 Department of Health. *Ten Things You Need to Know About Long-term conditions* (2008). *ibid*.

127 *Ibid*.

128 *Ibid*.

129 Department of Health Press Release. Innovative care could help over 15 million people with long-term conditions (2011). *ibid*.

130 The King's Fund. *Improving the Quality of Care in General Practice* (2010). *ibid*.

131 NHS Employers/BMA. *Quality and Outcomes Framework Guidance for GMS Contract 2011/12*. p.26. *ibid*.

across the chronic disease management indicators from baseline to full incentive payment potentially reduced mortality by 11 lives per 100,000 per year¹³².

However, although the QOF has improved health measures for people with the chronic diseases that it covers, there has been considerable debate about whether it has actually improved quality of care¹³³. There are worries that the QOF creates a 'tick-box' medicine culture¹³⁴ and ignores wider aspects of holistic care that are necessary to provide real quality of care¹³⁵. The QOF may result in polypharmacy and increased drug side effects and interactions for those with multiple diseases¹³⁶. Furthermore, the QOF has created 'Cinderella' conditions: patients suffering from diseases not currently covered by the QOF are relatively ignored and thus receive poorer care¹³⁷.

The *National Framework for Long-term Conditions*¹³⁸ advocates patient-centred care for every patient with an ongoing health condition. Care should be planned around individual needs and with all agencies involved working together. The 2006 White Paper *Our Health, Our Care, Our Say*¹³⁹ went further, advocating integrated care across traditional health, social and voluntary sector boundaries.

As well as providing better care to patients with long-term conditions, there is some evidence that integrated care models can maintain people with long-term conditions better in the community, thus reducing emergency admissions and shortening hospital stays. The Department of Health has suggested that this type of approach could save up to £2.2 billion every year in the UK¹⁴⁰.

'People with long-term conditions have some of the most complex health needs in the country and we need to personalise services to suit their needs, not fit them around how the NHS is organised. We want clinicians to take the lead locally in developing health services so that they can support patients to take decisions about their care and help them take charge of their health and the care they receive. With this approach, they will find new ways to tackle this problem for both the NHS and patients.'

Andrew Lansley, Secretary of State for Health, 2011¹⁴¹

As more care for long-term conditions is provided in the community, enhanced GP training is needed to equip GPs of the future with:

- Improved clinical skills to manage long-term conditions more traditionally managed in secondary care
- Innovative working practices to redesign chronic disease management programmes within their own practices so that patients with complex multidisciplinary care needs are provided with sufficiently long consultations to adequately assess and plan their care

132 Fleetcroft R, Parekh-Bhurke S, Howe A, Cookson R, Swift L, Steel N. The UK pay-for-performance programme in primary care: estimation of population mortality reduction. *British Journal of General Practice* 2010; 60(578):e345-e352.

133 Gillam S, Sidiwardena N. *The Quality and Outcomes Framework*, p148. Oxford: Radcliffe Publishing, 2011.

134 Ashworth M, Kordowicz M. Quality and Outcomes Framework: smoke and mirrors? *Quality in Primary Care* (2010);18(2):127-131.

135 Heath I, Hippisley-Cox J, Smeeth L. Measuring performance and missing the point? *British Medical Journal* (2007);335(7629):1075-1076.

136 Oliver D. Care and quality indicators: QOF and public health priorities don't improve care in ageing. *British Medical Journal* (2008). *ibid*.

137 Misselbrook D. Jephcott Symposium: *The Quality Outcome Framework – A critical assessment*. London: Royal Society of Medicine, 2011. Accessed via: <http://rsmvideos.com/videoPlayer/?vid=176>.

138 Department of Health. *National Framework for Long-term Conditions* (2007). *ibid*.

139 HM Government. *Our Health, Our Care, Our Say: A new direction for community services* (2006). *ibid*.

140 Department of Health Press Release. Innovative care could help over 15 million people with long-term conditions (2011). *ibid*.

141 *Ibid*.

- Better knowledge of the roles of other health, social and third sector providers so that it is possible to co-ordinate care effectively across boundaries
- Technical skills to embrace new technology such as telemedicine or risk assessment software in order to use resources in the most efficient way possible, reduce care costs and improve patient experiences and outcomes; and
- New commissioning skills to design and implement integrated care pathways within the community that are flexible enough to enable personalisation to individual patient needs.

Evidence regarding the skills required to manage people with long-term conditions who live in care homes or are from socially isolated populations is summarised in Supporting Evidence document 3, Outcome 3.1.

CHALLENGE 2: ENABLING PEOPLE WITH LONG-TERM CONDITIONS TO SELF-CARE

Self-care is defined as the actions individuals ‘take to lead a healthy lifestyle; to meet their social, emotional and psychological needs; to care for their long-term condition; and to prevent further illness or accidents’¹⁴².

A man with hypertension spends on average three hours with a health professional each year; for the remaining 8,757 hours he must manage his condition himself. Supporting people to self-manage their is a key component of successful outcomes for long-term disease management¹⁴³. This might include:

- Provision of information
- Lifestyle measures
- Access to support groups
- Signposting to other support services
- Information about taking medication, including dose regimes; rationale behind prescribing and side effects; and
- Information about when to step up treatment or seek further medical help.

The Wanless report into NHS resource requirements identified effective self-care as an essential part of the ‘fully engaged’ scenario, which it predicted would bring about the greatest gains in public health¹⁴⁴. More recently the King’s Fund used supported self-care as a quality indicator for long-term disease management in its 2010 report on *Improving the Quality of Care in General Practice*¹⁴⁵.

The extensive evidence for the effectiveness of self-care approaches in chronic disease management has been summarised by the Department of Health in its document *Research Evidence on the Effectiveness of Self-care Support* (2007)¹⁴⁶. Although much of the research focuses on single long-term conditions, the breadth of conditions covered suggests that similar interventions are effective across conditions. For example, self-care skills training

142 Barlow J, Wright C, Sheasby J, Turner A, Hainsworth J. Self-management approaches for people with chronic conditions: a review. *Patient Education and Counselling* (2002);48:177-87.

143 Department of Health. *Self-care: A real choice* (2005). *ibid*.

144 Wanless D. *Securing Good Health for the Whole Population* (2004). *ibid*.

145 The King’s Fund. *Improving the Quality of Care in General Practice* (2010). *ibid*.

146 Department of Health. *Research Evidence on the Effectiveness of Self-care Support*. London: Department of Health, 2007.

courses were initially shown to be effective for people with arthritis in the early 1990s¹⁴⁷. They have subsequently been shown to be effective for many different conditions¹⁴⁸.

However, a recent evaluation of the Expert Patient Programme that provides self-care courses for people with long-term conditions in the UK found that such courses produce modest psychological improvements, but the effect on health outcomes and use of health services is small¹⁴⁹. This may be because these are one-off interventions. A sustained approach supporting self-care on an ongoing basis, for example through self-management plans reinforced at each visit to a chronic disease management clinic, seems to be more effective. The 2009 Health Survey for England found that personal care plans do have a positive impact on investigating options and taking self-care initiatives; 65% of men and 59% of women with a longstanding illness who did not have a personal care plan did not actively participate in the self-care options examined, compared with just 32% of men and 28% of women with a personal care plan¹⁵⁰. However, currently only 54% of patients with long-term conditions receive such support¹⁵¹.

There is evidence to suggest that many healthcare professionals currently lack the skills required to facilitate their patients to self-care¹⁵². Enhanced GP training will equip GPs with the strategies to promote self-care and support their patients to do this by negotiating self-care plans with patients (and their carers) that they are motivated to follow, that are realistic and sustainable, and that can be reinforced and modified at each review. This will require good clinical knowledge about best practice over a wide range of long-term conditions, improved knowledge of the roles and responsibilities of other care providers and excellent communication, including skills in motivational interviewing and cognitive behavioural techniques.

CHALLENGE 3: MANAGING MULTIPLE CO-MORBIDITIES IN THE SAME INDIVIDUAL

'In order to learn how to deal with far greater degrees of complexity and uncertainty than their predecessors would have faced, trainee doctors will need to dwell much less on narrow disease silos and to focus much more on the breadth of possible permutations of co-morbidity.'

Independent Commission on Generalism, 2011¹⁵³

Around 16% of men and 19% of women in the UK have more than one long-term illness¹⁵⁴. Prevalence of co-morbidity and multi-morbidity increases with age and deprivation¹⁵⁵.

147 Lorig KR, Mazonson PD, Holman HR. Evidence suggesting that health education for self-management in patients with chronic arthritis has sustained health benefits while reducing health care costs. *Arthritis and Rheumatism* (1993);36:439-46.

148 Kennedy AP, Bower P, Reeves D, Richardson G, Rogers AE. The effectiveness and cost effectiveness of a national lay-led self-care support programme for patients with long-term conditions: a pragmatic randomised controlled trial. *Journal of Epidemiology and Community Health* (2007);61:254-261.

149 Griffiths C, Foster G, Ramsay J, Eldridge S, Taylor S. How effective are expert patient (lay led) education programmes for chronic disease? *British Medical Journal* (2007);334:1254.

150 NHS Information Centre. *Health Survey for England 2009*. *ibid*.

151 The King's Fund. *Improving the Quality of Care in General Practice* (2010). *ibid*.

152 Kennedy A, Rogers A, Bowers P. Support for Self-care for Patients with Chronic Disease. *British Medical Journal* (2007);335:968.

153 Report of an Independent Commission for the Royal College of General Practitioners and The Health Foundation. *Guiding Patients through Complexity: Modern medical generalism* (2011).

154 NHS Information Centre. *Health Survey for England 2009*. *ibid*.

155 Salisbury C, Johnson L, Purdy S, Valderas JM, Montgomery AA. Epidemiology and Impact of Multimorbidity in Primary Care: A retrospective cohort study. *British Journal of General Practice* (2011);61:18-24.

People with more than one long-term condition have:

- Higher GP consultation rates¹⁵⁶
- Less continuity of care¹⁵⁷
- A markedly poorer quality of life¹⁵⁸
- Poorer clinical outcomes¹⁵⁹
- Longer hospital stays (the 15% of people with three or more conditions account for almost 30% of hospital in-patient days¹⁶⁰), and
- Are the most costly group of patients that the NHS has to look after (health costs for people with more than one condition are six-times higher than for those with only one long-term condition¹⁶¹).

In the UK, hospital-based medicine has become increasingly specialised¹⁶². This trend towards more secondary care specialisation tends to disadvantage people with multiple morbidities. The effective management of such patients requires holistic, patient-centred and problem-oriented care that depends heavily on a multidisciplinary approach best provided through general practice^{163, 164}.

Patients with multiple morbidities often have¹⁶⁵:

- Multiple healthcare specialists involved with their care
- Frequent appointments with healthcare services
- Multiple symptoms
- Multiple drugs with consequent interactions and side effects, and
- Increased total morbidity when considered against the morbidity of each contributing condition alone.

Patients with co-morbidities or multiple morbidities are difficult for GPs to manage as they are complex, and the situation is further complicated because clinical research often excludes patients with multiple morbidities. Thus research evidence may not apply to patients with more than one ongoing chronic condition. Furthermore, clinical guidelines based on research evidence are usually condition specific and it is not uncommon for guidance to conflict regarding management of a single patient.

'To date, the number and diversity of articles on multimorbidity are both insufficient to provide scientific background or strong evidence based care of patients affected by multiple concurrent chronic conditions. Research is needed to increase knowledge and understanding of this important clinical topic.'

Fortin et al., 2005¹⁶⁶

¹⁵⁶ *Ibid.*

¹⁵⁷ *Ibid.*

¹⁵⁸ The King's Fund. *Improving the Quality of Care in General Practice* (2010). *ibid.*

¹⁵⁹ *Ibid.*

¹⁶⁰ Department of Health. *Improving Chronic Disease Management* (2004). *ibid.*

¹⁶¹ *Ibid.*

¹⁶² Report of an Independent Commission for the Royal College of General Practitioners and The Health Foundation. *Guiding Patients through Complexity: Modern medical generalism* (2011).

¹⁶³ Wright N, Smeeth L, Heath I. Moving beyond single and dual diagnosis in general practice. *British Medical Journal* (2003);326:512: doi: 10.1136/bmj.326.7388.512.

¹⁶⁴ Katon WJ, Lin EHB, Von Korff M et al. Collaborative Care for Patients with Depression and Chronic Illnesses. *New England Journal of Medicine* (2010);363:2611-2620.

¹⁶⁵ Centre for Policy on Ageing /Department of Health. *Ageism and Age Discrimination in Primary and Community Health Care in the United Kingdom*. Centre for Policy on Ageing, 2009.

¹⁶⁶ Fortin M, Lapointe L, Hudon C and Vanasse A. Multimorbidity is common to family practice: is it commonly researched? *Canadian Family Physician* (2005) 51(2): 245-245.

As well as providing high-quality of care for these patients within their own surgeries, GPs must work collaboratively with other care providers, sharing information across different teams and settings, and ensuring that care is co-ordinated. As well as being care providers, they are 'navigators' of the system, taking responsibility for the pathway that their patients follow and for the care they receive from a variety of agencies¹⁶⁷. In this sense, general practice becomes a hub of a much wider system of care and support, including input from social care agencies, pharmacies, therapists and nurses working independently or to protocols where appropriate.

GPs need training in critical appraisal of research evidence and clinical guidelines, as well as enhanced clinical skills to manage patients with co-morbidities and multiple morbidities successfully in the future. New models of care providing more time for management of complex multifaceted problems and involving carers as equal partners in care may need to be developed. GPs will also need to act as the hub for co-ordination of care and advocacy for such patients both within and beyond healthcare.

CHALLENGE 4: COST-EFFECTIVE AND SAFE PRESCRIBING

GPs write 98% of primary care prescriptions¹⁶⁸. Although GPs issue a prescription in over 50% of consultations, 70–80% of medications issued in primary care are prescribed on repeat prescription for chronic and ongoing health problems¹⁶⁹.

In 2006, the primary care drugs bill in England accounted for 10% of the entire NHS budget, amounting to a total of £8.2 billion or £22 million per day¹⁷⁰. Between 1997 and 2007 prescribing costs in general practice rose by 60%¹⁷¹ and prescribing costs are still increasing.

Ideally, prescribing decisions by GPs should maximise effectiveness, minimise risks, minimise costs and respect the patient's choices¹⁷². The Quality and Outcomes Framework¹⁷³ for primary care does contain financial incentives for GPs to implement good prescribing and most practices achieve these standards:

- Medicines 10 – meeting a prescribing adviser annually, agreeing up to three actions related to prescribing and subsequently providing evidence of change (94.1% of practices achieved this target in 2009/10)
- Medicines 11 – demonstrating that medication reviews have been recorded in the notes of over 80% of all patients being prescribed four or more repeat medications within the past 15 months (97.6% of practices achieved this in 2009/10)
- Medicines 12 – demonstrating that a medication review is recorded in the notes in the preceding 15 months for at least 80% of all patients being prescribed any repeat medications (95.8% of practices achieved this target in 2009/10).

However, there is still considerable room for improvement. In terms of effectiveness there is marked variation in prescribing between practices that does not match disease prevalence. This suggests that, in some cases, practices are under-prescribing for their patients¹⁷⁴. There is also some evidence that GPs do not follow guidelines for prescribing for certain patient

167 The King's Fund. *Improving the Quality of Care in General Practice* (2010). *ibid.*

168 Duerden M, Millson D, Avery A, Smart S. *The Quality of GP Prescribing* (2011). *ibid.*

169 *Ibid.*

170 National Audit Office. *Prescribing Costs in Primary Care* (2007). *ibid.*

171 *Ibid.*

172 Barber N. What Constitutes Good Prescribing? *British Medical Journal* (1995);310:923-925.

173 NHS Employers/BMA. *Quality and Outcomes Framework Guidance for GMS Contract 2011/12*. *ibid.*

174 National Audit Office. *Prescribing Costs in Primary Care* (2007). *ibid.*

groups. For example, older people who are at high risk of cardiovascular disease are less likely to be prescribed statins to lower their risk than younger people¹⁷⁵.

Cost-effectiveness is also an area in which improvements could be made. Although UK GPs have one of the highest rates of generic prescribing in the world¹⁷⁶, they have multiple competing influences on their prescribing choices and do not always prescribe the most cost-effective drug for purpose¹⁷⁷. In 2007, the National Audit Office looked at potential savings that could be made by standardising the use of just four commonly used drugs that together account for 19% of total primary care prescribing¹⁷⁸. They concluded that overall, without decreasing clinical efficacy, in excess of £200 million could be saved in England alone¹⁷⁹ as follows:

- The proportion of statins prescribed as low cost generic pravastatin or simvastatin ranges from 28% to 86%; if all practices were to change their prescribing to be comparable to the top quartile of cost-efficient practices, with in excess of 69% of statins prescribed as low cost generic pravastatin or simvastatin, £85 million would be saved in the first year
- A similar calculation for drugs affecting the renin-angiotensin system and proton pump inhibitors, would save £67 million and £24 million per year respectively
- If patients taking clopidogrel for a year were changed, as recommended by current national guidance, to aspirin after that time (with or without gastric protection with a proton pump inhibitor), a further £39 million could be saved.

Another problem is adherence to treatment regimens and drug wastage. It has been suggested that between a third and a half of all medication prescribed for long-term conditions is not taken as recommended¹⁸⁰. As well as the effect that this has on patient health, it is estimated that the cost of drug wastage to the NHS in 2009 was in excess of £300 million out of a total drugs budget of £8 billion¹⁸¹. This included:

- £90 million of unused drugs in patients' homes
- £110 million returned to community pharmacies unused
- £50 million in drugs disposed of by care homes every year.

Safety is also an important issue to consider when prescribing. Medication errors in general practice occur in up to 11% of prescriptions, mainly as a result of errors in dosage¹⁸². This is both harmful to patients and costly; 6.5% of all hospital admissions are related to adverse drug reactions and two-thirds of these are potentially preventable¹⁸³.

Despite the importance of good prescribing to improve patient health, to reduce adverse events relating to prescribing and to make best use of scarce NHS resources, GPs receive very little formal training about prescribing in the community either before or during their

175 DT Ko, Mamdani M, Alter DA. Lipid-lowering therapy with statins in high-risk elderly patients. *Journal of the American Medical Association* (2004);291:1864-1870.

176 Duerden M, Millson D, Avery A, Smart S. *The Quality of GP Prescribing* (2011). *ibid*.

177 National Audit Office. *Prescribing Costs in Primary Care* (2007). *ibid*.

178 *ibid*.

179 *ibid*.

180 Nunes V, Neilson J, O'Flynn N, Calvert N, Kuntze S, Smithson H, Benson J, Blair J, Bowser A, Clyne W, Crome P, Haddad P, Hemingway S, Horne R, Johnson S, Kelly S, Packham B, Patel M, Steel J. *Medicines Adherence: Involving patients in decisions about prescribed medicines and supporting adherence*. London: National Collaborating Centre for Primary Care and Royal College of General Practitioners, 2009.

181 York Health Economics Consortium & University of London School of Pharmacy. *Evaluation of the Scale, Causes and Costs of Waste Medicines*. YHEC/School of Pharmacy, University of London, 2010.

182 Sandars J, Esmail A. The frequency and nature of medical error in primary care: understanding the diversity across studies. *Family Practice* (2003);20(2):231-6.

183 Pirmohamed M, James S, Meakin S et al. Adverse drug reactions as cause of admission to hospital: prospective analysis of 18,820 patients. *British Medical Journal* (2004). *ibid*.

GP training¹⁸⁴. They do pick up the practicalities of doing this in their GP placements, but significant wastage and harm could be avoided with better and more comprehensive training in medicines management for GPs. This might include education from PCT/ commissioning body prescribing leads, audit of prescribing practices, supervised medication reviews and/or analysis of significant events involving medication problems.

Evidence relating to the challenge associated with prescribing for the elderly is discussed in Supporting Evidence document 1, Outcome 1.6.

CHALLENGE 5: MANAGING MEDICALLY UNEXPLAINED SYMPTOMS

A medically unexplained symptom (MUS) can be described as a physical symptom for which no organic cause can be demonstrated. A large number of symptom-clusters have been described for which no organic cause can be found including syndromes such as irritable bowel syndrome (IBS), chronic fatigue syndrome (CFS) and fibromyalgia. There are also common overlaps of symptoms: for example, those with irritable bowel syndrome often meet the criteria for chronic pelvic pain and vice versa, and many individuals have more than one MUS¹⁸⁵. Symptoms may persist for years.

Estimates of prevalence of MUS vary due to diagnostic difficulties and labelling, but it is thought that up to a quarter of primary care consultations and up to a half of secondary care consultations are for MUS¹⁸⁶. Once employment and social costs are taken into consideration, the total cost to the economy of MUS is around £18 billion every year¹⁸⁷.

People with MUS often have a pre-occupation with fears of having a serious illness, based on the misinterpretation and misattribution of bodily symptoms, despite investigation and reassurance¹⁸⁸. Many also have an enhanced sense of bodily awareness. This is the tendency to notice and amplify benign physical sensations, such as the heartbeat. Over-awareness increases anxiety and, in a vicious cycle, makes the sensation more likely¹⁸⁹. Around 30% of people with MUS also have a co-morbid common mental disorder such as anxiety or depression¹⁹⁰.

GPs find MUS difficult to manage because over-investigation risks fuelling health anxieties and wastes health resources, but on the other hand people with MUS can develop serious health problems and under-investigation may result in missed diagnoses; 4–10% of patients with MUS have a hidden organic explanation for their symptoms¹⁹¹. For many people MUS is associated with long-term disability and dissatisfaction with healthcare¹⁹².

Recent guidance suggests that the majority of patients with MUS can be managed within primary care. Successful management hinges on the quality and ongoing nature of the doctor–patient relationship and involves a patient-centred approach and good communication so that a shared management plan with realistic goals to improve

184 Aronson J, Henderson G, Webb D, Rawlins M. A prescription for better prescribing. *British Medical Journal* (2006);333:459-60.

185 Rolfe A. Medically unexplained symptoms. *InnovAiT* (2011);4(5):250-256.

186 RCGP/Royal College of Psychiatrists/Traillblazers/National Mental Health Development Unit. *Guidance for Health Professionals on Medically Unexplained Symptoms (MUS)* (2011). *ibid*.

187 *Ibid*.

188 Burton C. Beyond somatisation: a review of the understanding and treatment of medically unexplained physical symptoms (MUPS). *British Journal of General Practice* (2003);53(488):231.

189 Rolfe A. Medically unexplained symptoms. *InnovAiT* (2011). *ibid*.

190 RCGP/Royal College of Psychiatrists/Traillblazers/National Mental Health Development Unit. *Guidance for Health Professionals on Medically Unexplained Symptoms (MUS)* (2011). *ibid*.

191 *Ibid*.

192 HM Government. *New Horizons: A shared vision for mental health* (2009).

functioning and provide reassurance about long-term outcome can be developed¹⁹³. Depending on the symptoms that the person has, this may include self-management strategies (such as increasing physical activity levels), antidepressant medication and/or psychological therapies.

Despite the high prevalence of MUS in primary care, very few GPs receive any formal training in their management. There is evidence that GPs lack the appropriate communication skills to explore patients' ideas and concerns and provide explanations for symptoms that link physical and psychological mechanisms¹⁹⁴.

Enhanced GP training will provide improved communication skills for GPs, together with better knowledge about the underlying mechanisms of MUS and effective treatment strategies. This will enable improved services for patients with MUS with the aim of avoiding distress, improving functioning within the community and reducing excess usage of health and social care resources and thus healthcare costs¹⁹⁵.

CHALLENGE 6: CARING FOR PEOPLE WITH INTELLECTUAL DISABILITY

Around 2% of patients on a GP's registered patient list have an intellectual (formerly known as 'learning') disability. As central co-ordinators of care, GPs are well placed to take on the care of this patient group¹⁹⁶. With closure of large institutions for people with intellectual disability resulting in a shift to community-based care, increasing longevity, and increasing complexity of modern interventions, the responsibility for healthcare for people with intellectual disability has shifted increasingly to GPs. A full-time GP will be caring for about eight patients with clinically significant intellectual disabilities, who often have complex co-morbidities; for example, 50% of patients with profound intellectual disabilities also have epilepsy¹⁹⁷.

Consultations with people with an intellectual disability are often made challenging by communication and sensory difficulties, and can be both assisted and complicated simultaneously by the attendance of family or carers. The presence and attitudes of doctors, carers and family members may make it difficult to address a range of important healthcare issues (e.g. sexual health or other sensitive matters), the solutions of which are often relatively simple and of significant benefit to the patient¹⁹⁸.

As a result, many commonly associated conditions currently tend to be diagnosed late or not at all; these include dementia, depression, diabetes and many gynaecological and gastroenterological conditions¹⁹⁹. This is often because patients cannot articulate or describe their symptoms and doctors and carers may inaccurately attribute them to another condition or to the intellectual disability itself. In 2010/11 in England and Wales, annual learning disability health checks were introduced as a Directed Enhanced Service to address

193 RCGP/Royal College of Psychiatrists/Trailblazers/National Mental Health Development Unit. *Guidance for Health Professionals on Medically Unexplained Symptoms (MUS)* (2011). *ibid*.

194 Dowrick CJ et al. Normalisation of functional symptoms by general practitioners: a functional typology. *British Journal of General Practice* (2004);54(500):164-70.

195 HM Government. *New Horizons: A shared vision for mental health* (2009). *ibid*.

196 Michael J. *Healthcare for All: Report of the independent inquiry into access to healthcare for people with learning disabilities*. London: Independent Inquiry into Access to Healthcare for People with Learning Disabilities, 2008.

197 Robertson J, Roberts H, Emerson E. *Health Checks for People with Learning Disabilities: Systematic review of impact*. Durham: Learning Disability Observatory, 2010.

198 Mencap. *Death by Indifference*. London: Mencap, 2007.

199 Emerson E, Baines S, Allerton L, Welch V. *Health Inequalities and People with Learning Disabilities in the UK: 2011*. Durham: Learning Disabilities Observatory, 2011.

these issues. However, in England in the year 2010–11, only 49% of eligible adults with intellectual disabilities received the advised annual GP health check²⁰⁰.

Currently many adults with significant intellectual disability receive fragmented care, delivered by consultant psychiatrists, hospital specialists and specialist nursing colleagues – often working in different organisations and with minimal primary care involvement; enhanced GP training will enable these colleagues to become confident that, once stable, the responsibility of providing care for many patients could be safely handed back to the GP, who could then co-ordinate this in a more comprehensive manner. This would improve continuity and allow patients and their carers to become more familiar with their GP – who in turn would become more familiar with the patient's individual needs and circumstances.

Despite the challenges, there is much that can be achieved through enhanced training – for example, GP registrars could learn much by performing structured annual health checks, to reflect on and evaluate their performance (e.g. via case-based discussion) and to receive feedback from patients and carers.

During primary care placements, trainees will have an opportunity to lead on projects to improve the organisational aspects of care for patients with intellectual disability in their own practice. A Quality Improvement Project (QIP) undertaken in ST4 will provide an opportunity for trainees to identify health needs for this vulnerable group based in their local community; to consult with patients and the public; to work with colleagues on service redesign and improvement; and to develop the skills to effect meaningful change.

Enhancing GP training in this area will also assist NHS compliance with disability equality regulations, in line with the Mental Capacity and Equality Acts and other relevant legislation.

CHALLENGE 7: INCLUDING AND SUPPORTING CARERS

Carers are unpaid friends or relatives who provide help and support for people who could not manage without them because of ongoing health problems. In the UK, it is estimated that 12% of the adult population are carers²⁰¹ and there are around one million young carers (i.e. carers under the age of 18)²⁰². Carers form a substantial and growing proportion of each practice list.

It is estimated that carers currently save the UK economy £119 billion a year in care costs. This is equivalent to £18,473 per year for every carer in the UK²⁰³. Our society could not afford to provide the current level of community care without this willing army of unpaid support. Carers are therefore vital to both our society and our economy.

Carers also know the people that they care for better than anyone else. This knowledge can be extremely useful in identification of problems that may require intervention, planning and implementing care (see Supporting Evidence document 1, Outcome 1.6). Therefore, engagement and co-operation with carers is an essential part of good patient care.

However, carers suffer health, social and financial consequences as a result of their role (see Supporting Evidence document 1, Outcome 1.6). Although involving and supporting carers requires multidisciplinary input from the health and social services and the voluntary sector,

200 Emerson E, Copeland A, Glover G. *The Uptake of Health Checks for Adults with Learning Disabilities: 2008/9 to 2010/11*. Learning Disabilities Observatory, 2011. *ibid*

201 NHS Information Centre for Health and Social Care. *Survey of Carers in Households 2009/2010* (2010). *ibid*.

202 Simon C, Slatcher C. *Young Carers. InnovAiT* (2011);4(8):458-463.

203 University of Leeds/Carers UK. *Valuing Carers 2011: Calculating the value of carers' support (2011)*

primary care is often the initial point of access for carers. Therefore it is important that GPs and primary care teams are aware of the problems that carers face and GP practices are organised to identify carers, involve them in patient care where appropriate, and support them to maintain the care giving situation.

A 2010 survey of GPs attending workshops about carers' issues²⁰⁴ found that:

- Nine out of ten GPs (89%) felt that they had insufficient training to support carers in their roles
- Approximately half of these GPs (47%) felt that they lacked confidence that they are meeting carers' needs; and
- Confidence in identifying carers was also low (45%).

Appropriate education can provide GPs with knowledge about carers' issues and how to identify and help carers and improve their confidence in working with carers²⁰⁵. Enhanced GP training will teach GPs in training about the problems that carers face and ways in which they can be identified and supported both within primary care and through signposting to other resources and services.

204 Greenwood N, Mackenzie A, Habbibi R, Atkins C, Jones RL. General practitioners and carers: a questionnaire survey of attitudes, awareness of issues, barriers and enablers to provision of services. *BMC Family Practice* (2010);11:100.

205 Jones R, Mackenzie A, Greenwood N, Atkins C, Habbibi R. General practitioners, primary care and support for carers

in England: can training make a difference? *Health and Social Care in the Community* (2011); doi: 10.1111/j.1365-2524.2011.01018.

2.4: WHY MORE COST-EFFECTIVE AND TIMELY USE OF RESOURCES, INCLUDING INVESTIGATIONS, REFERRALS AND TREATMENTS, IS A TRAINING PRIORITY

There is much international evidence on the efficiency and effectiveness of managing patients in primary care²⁰⁶. Patients have better clinical outcomes and there is improved health inequality and lower cost if the following four features of primary care are provided²⁰⁷:

- First contact access for each new need
- Long-term person-centred care (i.e. not disease-centred)
- Comprehensive care for most health needs
- Co-ordinated care when treatment must be sought elsewhere.

For common conditions, chronic disease management is most effective if provided by primary care rather than specialists²⁰⁸. This is because, for the majority of patients, the benefits to the patient of co-ordination and management of co-morbidities provided by general practice generally outweigh the harms of receiving less specialised care for individual conditions. However, for certain patients, referral to secondary care for a period of time is required in order for the patient to access specialist assessment, management or treatment.

The average patient has 5.5 consultations with their GP every year²⁰⁹, and only one out of every 20 consultations (5%) results in secondary care referral²¹⁰; everything else is dealt with in primary care. But given the large numbers of primary care contacts, however, GPs make more than 9 million referrals to hospitals for elective care each year²¹¹ and there is often a lack of shared understanding of the purpose of the referral between the GP, the patient and the consultant²¹². Improving the quality of referrals is therefore a priority for a sustainable NHS. Even a small reduction in inappropriate investigation and treatment will result in large cost savings.

206 Starfield B, Shi I Macinko J. Contribution of primary care to health systems and health. *The Milbank Quarterly* (2005);83:357-502.

207 Starfield B. *Primary Care: Balancing health needs, services, and technology*. New York: Oxford University Press, 1998.

208 Franks P and Fiscella K. Primary care physicians and specialists as personal physicians. Health care expenditures and mortality experience. *Journal of Family Practice* (1998);47:105-9.

209 NHS Information Centre. Trends in Consultation Rates in General Practice 1995 to 2008: Analysis of the QResearch® database. *ibid*

210 The King's Fund. Improving the quality of care in general practice (2011). *ibid*.

211 Hospital Episode Statistics (various years). Accessed via: www.dh.gov.uk/en/Publicationsandstatistics/Statistics/HospitalEpisodeStatistics/index.htm.

212 Imison C, Naylor C. *Referral Management: Lessons for success*. London: The King's Fund, 2010.

CHALLENGE 1: IMPROVING THE COST-EFFECTIVE USE OF PRIMARY CARE INVESTIGATIONS AND TREATMENTS

The use of inappropriate investigations and ineffective treatments incurs extra cost, inconvenience and may result in over-investigation and over-treatment, which in some instances causes preventable harm to patients.²¹³ Traditionally a doctor could get into in difficulty for under-investigating, which led to an attitude of 'playing safe'. But over-using resources inappropriately reduces the amount of resource available to others, which also leads to harm for some patients.²¹⁴

The decision on whether to investigate or how to treat a patient must be informed by evidence-based clinical guidelines. However, there are considerable challenges to this approach^{215, 216}. Research evidence is often gathered from selected populations with high disease prevalence and there are many patients in general practice with multiple problems that don't clearly fall under just one disease-specific guideline (and many patients that fall under no guidelines at all). Some 'recommended' investigations and treatments aren't suitable for patients with multiple illnesses or those with busy jobs or other responsibilities (e.g. carers).

Further training focusing on identified examples of inappropriate testing might reduce costs while simultaneously improving quality of care²¹⁷.

For more detailed evidence on how enhanced GP training will help to address the challenges of cost-effective prescribing, see Outcome 2.3, Challenge 4.

CHALLENGE 2: REDUCING INAPPROPRIATE REFERRAL DECISIONS

Primary care delivers approximately 90% of patient care in the UK. Referral is the method by which the GP enables the patient to move from this generalist first-contact service to the more specialised secondary care service.

A successful referral now requires the GP to facilitate a shared decision (between the GP, the patient and the specialist) on the reason for the patient moving into the secondary care service²¹⁸. It also involves successfully managing the practical referral process – this includes a decision on when and where to refer, an assessment of urgency, and a method of making the referral happen. This process is affected by a range of complex factors, including the perceived clinical benefit, patient factors and the referrer's own workload.

Usually, the referrer and the patient should have a shared expectation of the outcome of a referral. This outcome might be a diagnosis, a test or a specialised treatment. Once this

213 Fisher ES, Wennberg DE, Stukel TA, Gottlieb DJ, Lucas FL, Pinder EL. The implications of regional variations in Medicare spending, part 1: the content, quality, and accessibility of care. *Annals of Internal Medicine* (2003);138(4):273-287.

214 Winkens and Dinent. Rational cost-effective use of investigations in clinical practice. *British Medical Journal* (2002). Accessed via: <http://www.bmj.com/content/324/7340/783.full>.

215 Jiwa M, Skinner P, Coker AO, Shaw L, Campbell MJ, Thompson J. Implementing referral guidelines: lessons from a negative outcome cluster randomised factorial trial in general practice. *BMC Family Practice* (2006);7:65. Accessed via: www.biomedcentral.com/content/pdf/1471-2296-7-65.pdf.

216 Foot C, Naylor C and Imison C. *The Quality of GP Diagnosis and Referral*. The King's Fund, 2010.

217 Winkens and Dinent. Rational cost-effective use of investigations in clinical practice. *British Medical Journal* (2002); *ibid*. 218 Department of Health. Executive summary - White Paper: *Equity and Excellence: Liberating the NHS*. London: Department

of Health, 2010.

outcome has occurred, the GP must support the 'discharged' patient and enable them to safely return to the primary care service.

A range of resources now provide information to support referral decisions (e.g. Map of Medicine and NICE pathways). Some present the information in a form that is useable in a consultation, whereas others are more suited for educational activity outside the consultation. GPs must learn to use these tools in a way that supports, rather than hinders, a patient-centred consultation.

Developing and utilising cost-effective alternatives to secondary care referral

Evidence suggests that routine long-term review of patients with common conditions by specialists is often not in the best interests of most of these patients as this approach does not readily enable comprehensive and co-ordinated care²¹⁹. Explaining these benefits and risks to frail and elderly patients promotes their dignity and improves decision-making capacity. This requires both a high level of understanding of a broad base of medical issues and communication skills. A longer training is needed to develop and hone these skills. Enhanced GP training is required if young GPs are to learn all aspects of care needed to deliver modern, community-based healthcare. An incidence of less than 1–2 per 1,000 for a condition has been suggested as the level at which long-term care by a specialist becomes appropriate. For commoner conditions GP care may be more cost-effective²²⁰.

Patients can be cared for at home in more cases if community services are available that can respond rapidly, such as:

- Hospital at home
- Intermediate care
- Community physiotherapy
- Community (district) nursing services for blood tests, supplies, a commode or other resources
- Social services
- Out-of-hours GP services
- Voluntary services, British Red Cross, Citizens Advice Bureau, patient groups and societies.

As the current period of GP-based training is currently quite limited, it can be particularly difficult for trainees to find out information about local non-NHS services (e.g. provided by patient groups or social services) or to gain experience and trust in using these services for their patients. Collecting and managing such information within the practice is challenging, not least because it needs frequent updating and organisation. Sources include:

- Networking and personal libraries or databases
- Written materials (e.g. PCT newsletters, fliers)
- Published guides to NHS services (electronic and paper)
- Websites of individual organisations
- Patients who have benefited from services.

219 Starfield B, Shi I Macinko J. Contribution of primary care to health systems and health. *The Milbank Quarterly* (2005); *ibid*.

220 Starfield B. Primary and specialty care interfaces; the imperative of disease continuity. William Pickles Lecture, 2003. *British Journal of General Practice* (2003);53:723-729.

CHALLENGE 3: IMPROVING THE QUALITY OF THE REFERRALS PROCESS

Referrals reach the secondary care service via a range of different technologies, including paper correspondence, phone, fax and electronic communications (e.g. Choose and Book). GPs may learn how to refer locally from experience, but local practice varies considerably and locums and new doctors need induction and training. Whichever mechanism is used to make a referral, the decision and process must be robust and reliable.

Reaching a shared understanding with patients

The consultation skills required to achieve a shared understanding with a patient are central to the cost-effective and high-quality use of investigations, treatments and referrals.

Evidence shows that on achieving a shared understanding, the following things happen²²¹:

- patient satisfaction with the consultation increases
- full discussion of the likely benefits/harms of referral and what may take place in secondary care prepares patients for what is likely to happen. As a result, patient satisfaction with secondary care increases. It can also change the patient's mind about the need for referral ; and
- patients are more likely to choose less harmful or invasive treatments and investigations (e.g. topical vs. oral NSAIDs for osteoarthritis of the knee).

Enhanced GP training will support this process by enabling GPs to develop a greater knowledge of the subject area, improved communication skills to impart that knowledge, the skills to elicit patient needs and wants, and the ability to facilitate appropriate decision making.

Maintaining effective relationships between primary and secondary care

Co-morbidity is not randomly distributed; patients with one illness are likely to have other illnesses. There is evidence that the health outcomes of patients with common long-term conditions are better if their care is organised in a patient-centred practice that considers all of their health conditions, rather than in a series of independent specialist clinics. Most patients who have been referred will consult their primary care team for advice on their condition more frequently than they will consult their specialist service. Effective communication and co-ordination of care skills are therefore essential for GPs.

Maintaining the effectiveness of communication links between the practice and other community-based teams requires team-working, mutual respect and trust for colleagues. Effective use of services depends on maintaining effective relationships.

GPs and specialists need to develop systems to find, review and remove patients (with the patient's agreement) from inappropriate specialist review in the interests of improved patient care and better health outcomes.

221 Edwards A & Elwyn G (Eds.). *Evidence-based Shared Decision Making in Healthcare: Achieving evidence based patient choice*. 2nd ed. Oxford: Oxford University Press, 2009.

CHALLENGE 4: EVALUATING AND ACTING ON INDIVIDUAL AND PRACTICE ACTIVITY DATA

For many years, the NHS has been encouraging GPs to reflect on their referrals to secondary care, generally with a view to reducing the absolute numbers of referrals. Various ways of trying to 'manage' GP referrals have been tried, but have proven largely ineffective²²².

With the advent of commissioning, GPs will be even further encouraged to make the most appropriate use of secondary care resources. In addition to identifying potentially avoidable referrals, this includes identifying patients who should be referred but are not. However, deciding in individual cases in a timely way can be difficult and subjective – the ability to engage in, reflect on and respond to peer review is important, as is the ability to build in system change within practice teams and organisational structures.

GPs can be educated to improve referrals quality²²³. This includes training doctors in a range of practical referral competences. This might include ensuring that the reason for referral is clarified with the patient and stated on referral letters and the use of decision-management tools. Finding and storing information on local alternatives to referral can be facilitated through the design and maintenance of a good practice information system.

Table 2.4.1: Questions GP trainees might consider when evaluating their referral behaviour

Is the reason for the referral clear in the referral letter?
Has the patient requested or agreed to the referral?
Have psychosocial and other holistic factors been considered?
Is the patient willing to accept the risks of investigation or treatment?
Have recognised guidelines (e.g. NICE) been followed?
Has the correct pathway been followed (e.g. two-week wait pathway for suspected cancer)?
Does the secondary care provider have the required skills/resources to service the referral?
Would any of the following be an appropriate alternatives to referral? <ul style="list-style-type: none"> • Management within primary care (e.g. another GP, podiatrist, community nurse or other service) • Non-NHS care (e.g. charitable organisations and patient groups) • Telephone or email service for specialist advice.

A range of referrals and prescribing data is now routinely collected and can be a useful starting point for discussion and learning. However, simple data on individual clinician prescribing and referral rates does not correspond to the appropriateness or quality of that clinician's management decisions²²⁴. Further analysis is needed before making decisions or altering activity.

222 BMA. *Factors Capable of Influencing an Increase in GP Referral Rates to Secondary Care* (England only). London: British Medical Association, 2009.

223 Akbari A, Mayhew A, Al-Alawi MA, Grimshaw J, Winkens R, Glidewell E, Pritchard C, Thomas R, Fraser C. Interventions to improve outpatient referrals from primary care to secondary care. *Cochrane Database of Systematic Reviews* (2008);4:CD005471.

224 British Medical Association. *GP Referral Incentive Schemes*. London: BMA, 2009.

GP trainees could audit referrals to ensure patients are not being referred to specialist clinics inappropriately. Coding all referrals with the reason for referral and stating whether long-term review is intended will assist the audit and subsequent reviews and team discussions. Any knowledge or confidence issues resulting in inappropriate referrals can then be addressed through education and mentoring.

Trainees can also contribute to audits of the number of patients attending specialist clinics for routine reviews (who may not all have been referred by the GP). Creating a return route for patients in this situation is an appropriate and useful learning point.

2.5: WHY IMPROVED END-OF-LIFE CARE, ESPECIALLY FOR THOSE WHO CHOOSE TO DIE AT HOME, IS A TRAINING PRIORITY

'Patients who are approaching the end of their life need high-quality treatment and care that support them to live as well as possible until they die, and to die with dignity.'

General Medical Council, 2010²²⁵

IN THE UK:

- 480,000 people die each year in England; it is predicted that this figure will increase to 586,000 by 2030²²⁶
- Currently, 1% of each GP's practice list will die with in any year²²⁷
- 67% of deaths occur in people aged 75 or over²²⁸
- 75% of deaths are 'predictable' and follow a period of chronic illness where end-of-life care would be appropriate²²⁹
- 60–67% of people would prefer to die at home; at the moment 53% die in hospital and just 39% die in their usual place of residence²³⁰
- In the year before death, each person who is dying is admitted to hospital 3.5 times; 20% of hospital beds are occupied by someone who is dying²³¹

225 General Medical Council. *Treatment and Care towards the End of Life: Good practice in decision making* (2010). Accessed via: http://www.gmc-uk.org/static/documents/content/End_of_life.pdf.

226 Gomes B, Higginson, I. Where people die (1974–2030): past trends, future projections and implications for care. *Palliative Medicine* (2008);22:33–41.

227 Dying Matters Coalition. Find your 1% Campaign. Accessed via: http://www.dyingmatters.org/gp_page/providing-good-death.

228 National End-of-life Care Intelligence Network. *Death in Older Adults in England* (2010).

229 National Audit Office. *End-of-Life Care* (2008). Accessed via: http://www.nao.org.uk/publications/0708/end_of_life_care.aspx.

230 Gomes B, Calanzani N, Higginson IJ. *Local Preferences and Place of Death in Regions within England 2010*. Cicely Saunders International, 2011. Accessed via: <http://www.endoflifecare-intelligence.org.uk/resources/publications/default.aspx>

231 NHS QIPP EOL workstream 2010.

- 40% of people who die in hospital have no medical reason to be in hospital²³²
- Each unplanned hospital admission costs around £3,000; if each person had one less crisis admission the NHS would save £1,350,000,000²³³
- People are more likely to talk about end-of-life issues with their GP than any other professional²³⁴.

The General Medical Council (GMC) defines end-of-life-care as care provided for people likely to die in the next 12 months. This includes people whose death is imminent (within a few hours or days) and also those with:

- Advanced, progressive, incurable conditions
- General frailty and co-existing conditions that mean they are expected to die within 12 months
- Existing conditions if they are at risk of dying from a sudden acute crisis in their condition
- Life-threatening acute conditions caused by sudden catastrophic events²³⁵.

Over the past 10 years there have been a number of initiatives to improve end-of-life-care in the UK. The *End-of-Life Care Programme* ran from 2004–2007. It raised the profile of end-of-life care in the UK and encouraged usage of end-of-life care models such as the Gold Standards Framework (GSF), Liverpool Care Pathway for the Dying Patient (LCP) and Preferred Priorities of Care (PPC) to improve care. In 2008, the *End of Life Care Strategy* was published²³⁶. This highlighted the progress that had been made in improving end-of-life care and set out a programme of work aiming to enable access to high-quality, end-of-life care for all. This pledge to improve end-of-life care was reinforced with the Government's 2010 White Paper, *Equity and Excellence: Liberating the NHS*²³⁷. It states:

'In end-of-life care, we will move towards a national choice offer to support people's preferences about how to have a good death, and we will work with providers, including hospices, to ensure that people have the support they need.'

End-of-life care is also one of the 12 national workstreams identified in England for the Quality, Innovation, Productivity and Prevention Programme (QIPP)²³⁸. This programme aims to improve quality of care whilst making substantial cost savings that can then be reinvested into front-line care. It highlights the need to improve end-of-life care in the community and particularly care for people in nursing and rest homes.

In Scotland, *Living and Dying Well: A national action plan for palliative and end of life care in Scotland* places great emphasis on the role of primary care in providing palliative care, regardless of diagnosis²³⁹. The action plan uses the concepts of planning and delivery of

232 National Audit Office. *End-of-Life Care* (2008). *ibid*.

233 NHS QIPP EOL workstream 2010.

234 Dying Matters Coalition/NatCen. Public attitudes to death, dying and bereavement (2009). *ibid*.

235 General Medical Council. Treatment and care towards the end of life: good practice in decision making (2010). *ibid*.

236 Department of Health. *End of Life Care Strategy* (2008).

237 HM Government. *Equity and Excellence: Liberating the NHS* (2010). *ibid*.

238 Department of Health. *End of Life Care* (2011).

239 *Living and Dying Well: A national action plan for palliative and end of life care in Scotland* (2008). <http://www.scotland.gov>.

care, and of communication and information sharing as a framework to support a person-centred approach to delivering consistent palliative and end-of-life care in Scotland.

Although there is evidence that the proportion of people dying at home or in their usual place of residence is increasing slowly, less than half of those who wish to die at home are able to do so²⁴⁰. For those who wish to die at home, hospital admissions often result from crisis intervention; having an appropriate care plan in place can avoid inappropriate admissions. As well as being distressing for patients and relatives, saving just one admission for each patient receiving end-of-life care could save as much as £1,350,000,000 every year in the England alone²⁴¹.

The general management of people who are approaching the end of life forms part of the core essential services expected of GPs within their General Medical Services Contract, and the QOF rewards practices for maintaining a palliative care register and regular, multidisciplinary review of people on that register²⁴². In Scotland there is also a Palliative Care Directed Enhanced Service that practices may opt to participate in.

Most GPs have one or two patients needing end of life care at any time and on average 47 weeks of the final year of life are spent at home²⁴³. GPs and the primary care team have always been, and will continue to be, the main providers of palliative care for most patients. Even when specialist palliative care services are involved, GPs of patients receiving end-of-life care in the community are always team members, and often the key to quality co-ordinated care²⁴⁴. Therefore good end-of-life care from GPs is essential to meet the aims of the *End of Life Care Strategy*²⁴⁵.

However, GPs often find palliative care difficult²⁴⁶. This is for many reasons including:

- difficulties identifying when end-of-life care should begin – particularly for patients with non-cancer disease
- difficulties communicating with patients about issues surrounding the end of life
- lack of initial training and ongoing education in end-of-life care
- difficulties of integrating end-of-life care within a generalist caseload where there are many other competing priorities; and
- difficulties liaising with other agencies (such as out-of-hours services or social care providers).

The Royal College of Physicians recommended in 2007 that ‘generic palliative care should be a core part of training and a subject for the continuing professional development of all’²⁴⁷. Enhanced training for all doctors in provision of end-of-life care was also recommended by the National Audit Office in 2008²⁴⁸. However, although all GPs in training will encounter people receiving end-of-life care during their primary and secondary care placements, only a limited number gain any experience working with specialist palliative care services during their training.

240 Gomes B, Calanzani N, Higginson IJ. Local preferences and place of death in regions within England 2010 (2011). *ibid*.

241 NHS QIPP EOL workstream 2010.

242 NHS Employers/BMA. *Quality and Outcomes Framework Guidance for GMS Contract 2011/12*. *ibid*.

243 Watson M, Simon C. Principles of Palliative Care. *InnovAiT* (2008);1(4):250-256.

244 Shipman C, Gysels M, White P, Worth A, Murray SA et al. Improving generalist end of life care: national consultation with practitioners, commissioners, academics, and service user groups. *British Medical Journal* (2008);337: doi: 10.1136/bmj.a1720. Accessed via: <http://www.bmj.com/content/337/bmj.a1720>.

245 Department of Health. *End of Life Care Strategy*. London: Department of Health, 2008. *ibid*.

246 Shipman C, Gysels M, White P, Worth A, Murray SA et al. Improving generalist end of life care: national consultation with practitioners, commissioners, academics, and service user groups (2008). *ibid*.

247 Royal College of Physicians Working Party. *Palliative Care Services: Meeting the needs of patients*. London: Royal College of Physicians, 2007.

248 National Audit Office. *End-of-Life Care* (2008). *ibid*.

In order for GPs to initiate and provide effective end-of-life care tailored to the individual – that enables people to die at home should they wish to, supports their families and carers, and avoids unnecessary, expensive and distressing hospital admissions – it is important that GPs receive enhanced training in end-of-life care.

'How people die remains in the memory of those who live on.'

Dame Cicely Saunders (1918–2005)

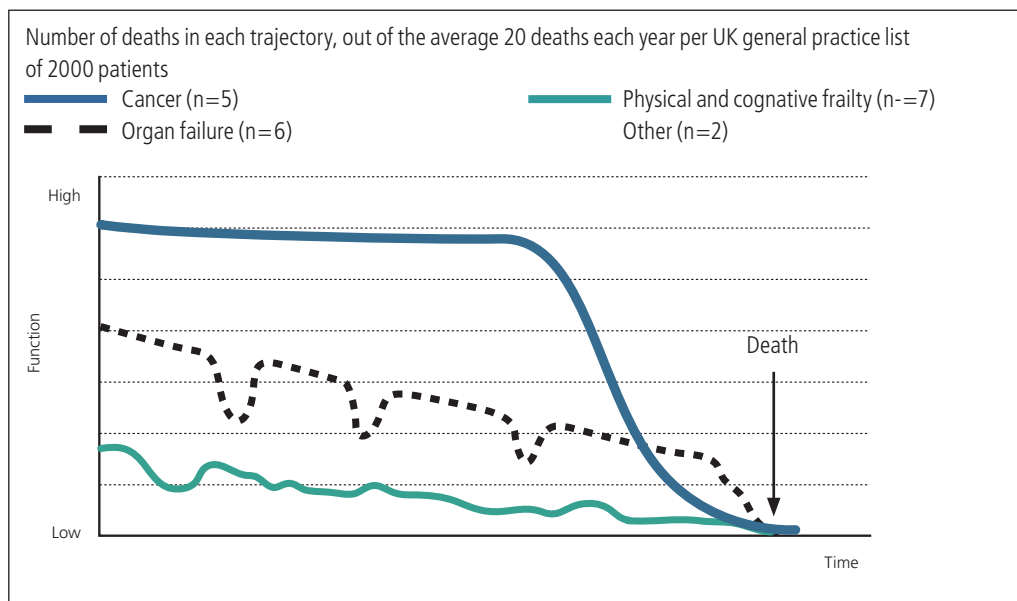
CHALLENGE 1: IDENTIFICATION OF PEOPLE APPROACHING THE END OF LIFE

The *End of Life Care Strategy* highlights the importance of identification of people approaching the end of life as stage 1 of its end-of-life care pathway. It also acknowledges that more training is needed:

'... Many health and social care staff have had insufficient training in identifying those who are approaching the end of life. ... To address this, a major workforce development initiative is now needed, with particular emphasis on staff for whom end of life care is only one aspect of their work'²⁴⁹.

In primary care, if people approaching the end of life are recognised early and included on practice palliative care registers they receive better co-ordinated, proactive care that is more in line with their preferences²⁵⁰. However, it is not easy to identify people approaching the end of life. For some the start may be at the time of diagnosis of a condition that carries a poor prognosis, such as metastatic cancer or motor neurone disease. For others with organ failure, such as those with chronic obstructive pulmonary disease or heart failure, exacerbations cause a rapid deterioration with recovery afterwards on the background of a gradual decline until the terminal event from which the person does not recover. Others may simply become increasingly frail as a result of old age (Figure 2.5.1).

Figure 2.5.1: The three main trajectories of decline at the end of life



Murray, S A et al. *BMJ* 2008; 336 958-959

249 Department of Health. *End of Life Care Strategy* (2008). *ibid*.

250 OMEGA. *End of Life Care in Primary Care: 2009 National Snapshot*. Accessed via: <http://omega.uk.net/admin/uploads/file/National%20snapshot%20of%20end%20of%20life%20care%20-%20key%20findings.pdf>.

Because of lack of familiarity with specific disease trajectories, GPs may have difficulties in identifying when patients would be regarded as nearing the end of life. This can lead to access to end-of-life care services not being offered at all, or being offered quite late in the patient journey²⁵¹.

In the 2009 National Primary Care Snapshot Audit, a quarter of patients on the palliative care register were added to the register less than a month prior to death²⁵². In the same audit, analysis of practice palliative care registers found that only 29% of people who died were included on practice palliative care registers²⁵³. The National Audit Office estimates that 75% of deaths are 'predictable' and follow a period of chronic illness where end-of-life care would be appropriate²⁵⁴. Therefore people approaching the end of life are currently added to the practice palliative care register late in their disease course, and there is a substantial shortfall in the number of people being identified as needing end-of-life care in the community. Further analysis of the 2009 National Primary Care Snapshot Audit also shows inequity between people who have cancer-related disease and those with other conditions: 71% of people on practice palliative care registers have cancer, yet just 28% of deaths in practices result from cancer²⁵⁵.

This suggests that GPs need enhanced training in identification of people approaching the end of life, and particularly for those with non-malignant diagnoses.

CHALLENGE 2: DEVELOPING SKILLS TO COMMUNICATE EFFECTIVELY WITH PEOPLE APPROACHING THE END OF THEIR LIVES AND THEIR FAMILIES

'Death and dying remain one of the last taboos. ...Too many people are not receiving the care they want and need at the end of their lives – part of that has to do with our collective failure to discuss these matters openly beforehand, when the pressure on everyone is much less.'

Niall Dickson, Chief Executive of the King's Fund²⁵⁶

As a nation, the UK finds it difficult to talk about death and dying and GPs are no exception. They may refrain from initiating these sorts of conversations with their patients as they are 'simply difficult conversations to have' or because they are anxious that they will not be able to support patients in meeting their preferences because of resource limitations²⁵⁷.

The 2010 Government White Paper *Equity and Excellence: Liberating the NHS* urges increased choice for patients²⁵⁸. Unless GPs do talk about death and dying with patients and their families/carers, it is impossible to determine individual choices and preferences. A number of studies demonstrate the importance of communication with patients nearing

251 Addicott R, Ashton R. *Delivering Better Care at End of Life: The next steps*. London: The King's Fund, 2010.

252 OMEGA. *End of Life Care in Primary Care* (2009). *ibid*.

253 *Ibid*.

254 National Audit Office. *End-of-Life Care* (2008). *ibid*.

255 OMEGA. *End of Life Care in Primary Care* (2009). *ibid*.

256 King's Fund Press Release. Doctors are no better than patients at facing up to personal end-of-life care decisions (2009). Accessed via: http://www.kingsfund.org.uk/press/press_releases/doctors_and_eol.html.

257 Addicott R, Ashton R. *Delivering Better Care at End of Life: The next steps* (2010). *ibid*.

258 HM Government. *Equity and Excellence: Liberating the NHS* (2010). *ibid*.

the end of life and their carers^{259, 260, 261}. Open discussions about end-of-life care also help carers to manage their bereavement²⁶².

People are more likely to talk about end-of-life issues with their GP than any other professional²⁶³. However, the Dying Matters GP pilot project examined confidence of GPs about talking about death and dying and explored whether this could be improved with appropriate education²⁶⁴. It found that only 33% of GPs were confident about initiating a discussion with a patient about end-of-life issues. These findings are supported by a 2010 King's Fund study that found that less experienced GPs felt ill-prepared by their training to communicate with and manage people approaching the end-of-life²⁶⁵. In the Dying Matters GP pilot project, a training workshop significantly increased GP confidence to 79%²⁶⁶.

This shows that enhanced GP training including communication skills training for end-of-life care could significantly improve patient care and choice. Furthermore, as 18% of complaints referred to the Health Service Ombudsman in England in 2009/10 concerned communication and staff attitude²⁶⁷, and the average cost of each complaint was around £2,500, better communication has the potential to save time and resources through a reduction in complaints, as well as improving patient choice and reducing patient/carer distress.

CHALLENGE 3: ASSESSMENT AND CARE PLANNING FOR PEOPLE APPROACHING THE END OF LIFE

Although people may differ in their precise wishes about death, most would like to be treated as an individual, with dignity and respect; be without pain or other symptoms; be in familiar surroundings and in the company of close family and/or friends²⁶⁸.

The second component of the end-of-life care pathway described in the National End-of-life Care Strategy is assessment of people identified as approaching the end of life and agreement with them about how to meet their preferences using advanced care planning with regular review (Figure 2.5.2)²⁶⁹. This may include:

- Symptom control
- Discussion about preferences for care including 'do not attempt to resuscitate' directives
- Advance directives to withhold treatment
- Discussion about preferred place of death.

259 Wright AA, Zhang B, Ray A, Mack JW, Trice E, Balboni T, Mitchell SL, Jackson VA, Block SD, Maciejewski PK, Prigerson HG. Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment. *Journal of the American Medical Association* (2008);300(14):1665-73.

260 Murray SA, Boyd K, Campbell C, Cormie P, Thomas K, Weller D and Kendall M. Implementing a service users' framework for cancer care in primary care: an action research study. *Family Practice* (2008); 25:78-85.

261 Kendall M, Boyd K, Campbell C, Cormie P, Fife S, Thomas K, Weller D and Murray SA. How do people with cancer wish to be cared for in primary care? Serial discussion groups of patients and carers. *Family Practice* (2006);23:644-50.

262 Wright AA, Zhang B, Ray A, Mack JW, Trice E, Balboni T, Mitchell SL, Jackson VA, Block SD, Maciejewski PK, Prigerson HG. Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment (2008). *ibid*.

263 Dying Matters Coalition/NatCen. *Public Attitudes to Death, Dying and Bereavement* (2009). *ibid*.

264 Dying Matters. *Evaluation of the Dying Matters GP Pilot Project* (2010). Accessed via: http://www.dyingmatters.org/sites/default/files/user/documents/Resources/Dying_Matters_GP_Pilot_Evaluation_-_final.pdf.

265 Addicott R. *End-of-life care*. London: The King's Fund, 2010.

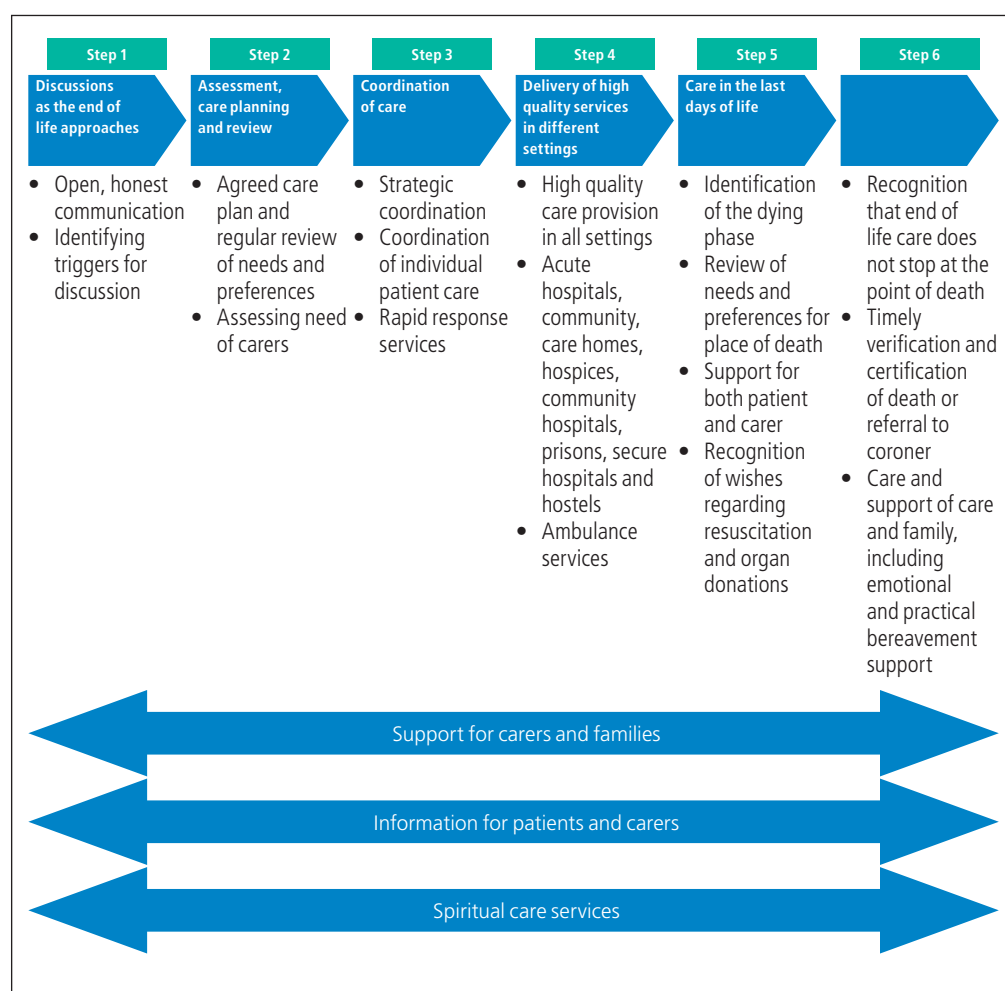
266 Dying Matters. *Evaluation of the Dying Matters GP Pilot Project* (2010). *ibid*.

267 Parliamentary and Health Service Ombudsman. *Listening and Learning: The Ombudsman's review of complaint handling by the NHS in England 2009-10* London: Parliamentary and Health Service Ombudsman, 2010.

268 Department of Health. *End of Life Care Strategy* (2008). *ibid*.

269 *Ibid*.

Figure 2.5.2: End-of-life care pathway



Source: Department of Health. *End of Life Care Strategy* (2008).

60–67% of people express a preference to die at home, but at present 53% die in hospital and just 39% die in their usual place of residence²⁷⁰. Place of death also varies by condition, with cancer patients being more likely than others to die at home or in a hospice. The majority of deaths from dementia occur in care homes and the vast majority of deaths from heart disease and pulmonary disease occur in hospital²⁷¹. However, the National Audit Office found from a detailed review of clinical records that 40% of people who die in hospital have no medical reason to be there²⁷².

For those who wish to die at home, hospital admissions often result from crisis intervention; having an appropriate care plan in place that all those caring for the patient have access to and including anticipatory drugs can avoid inappropriate admissions. This is particularly true of care home residents. The National Audit Office highlighted the wide variation between care homes in the number of patients dying in hospital, ranging from none to all residents.

270 Gomes B, Calanzani N, Higginson IJ. Local preferences and place of death in regions within England 2010 (2011). *ibid*.

271 National Audit Office. *End-of-Life Care* (2008). *ibid*.

272 *Ibid*.

They estimated that the proportion of care home residents who die in hospital could be reduced from 39% to 20% if greater support in the community were to be provided²⁷³.

In primary care, the QOF affords rewards to practices for end-of-life care through two indicators²⁷⁴:

- PC3 – the practice has a complete register available of all patients in need of palliative care/support irrespective of age (3 points)
- PC2 – the practice has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (3 points).

Although over 90% of practices maintain a palliative care register²⁷⁵, and over 60% of practices in the UK now use the Gold Standards Framework to some extent²⁷⁶, the 2009 National Primary Care Snapshot Audit found that of those identified as nearing the end of life (i.e. that were on a palliative care register), only 58% were offered a discussion about their preferences for care and just 42% had an advance care plan documenting their wishes²⁷⁷. Lack of access to palliative care drugs, breakdown of the home situation and inability to manage complex problems in the community are cited as the major reasons why people are unable to die in their usual place of residence²⁷⁸.

Enhanced GP training to provide GPs with the clinical skills to better manage end-of-life care problems, together with improved care planning, could avert a substantial proportion of these admissions. As well as reducing distress of both patients and carers, the National Audit Office estimates that £104 million could be saved every year in England alone by reducing emergency hospital admissions for cancer patients approaching the end of their lives by 10%, and the average length of stay following admission by 3 days²⁷⁹. If these figures are applicable to other end-of-life situations, the savings that enhanced GP-led end-of-life care in the community could deliver are potentially even greater.

CHALLENGE 4: DELIVERY OF HIGH-QUALITY, CO-ORDINATED SERVICES IN ALL LOCATIONS

There are currently a number of problems with end-of-life care provision in the UK. First, the amount spent on end-of-life care varies considerably between primary care organisations. The average amount spent on specialist palliative care services for individuals approaching the end of their life varies from £154 to £1,684 per death²⁸⁰. There is also variation in the availability of palliative care beds, and in the number of staff within hospital and community specialist palliative care teams²⁸¹. Provision of end-of-life care by primary care organisations is not proportional to need²⁸².

Within the community, there is inequity of care provision, with people suffering from non-malignant disease having reduced access to end-of-life care (see Challenge 1). Furthermore, the lack of continuity between in-hours and out-of-hours GP services and failure to share important information such as *Do not attempt to resuscitate* orders between different agencies delivering care can lead to inappropriate treatment or hospital admission²⁸³.

273 *Ibid.*

274 NHS Employers/BMA. *Quality and Outcomes Framework Guidance for GMS Contract 2011/12.* *ibid.*

275 *Ibid.*

276 *Ibid.*

277 OMEGA. *End of Life Care in Primary Care: 2009 National Snapshot.* *ibid.*

278 *Ibid.*

279 National Audit Office. *End-of-Life Care (2008).* *ibid.*

280 *Ibid.*

281 *Ibid.*

282 *Ibid.*

283 Addicott R, Hiley J. *Issues Facing Commissioners of End-of-life Care.* London: The King's Fund, 2011. Accessed via: http://www.kingsfund.org.uk/publications/endoflife_care.html.

Variability in co-ordination between services can result in end-of-life care being disjointed and ineffective, which is often a cause of distress²⁸⁴.

The King's Fund recently published its 10 priorities for commissioners in the changing healthcare system²⁸⁵. Among them was the need to focus on the delivery of high-quality, end-of-life care, central to which should be the integration and co-ordination of provision across the care pathway.

The introduction of clinically-led commissioning in England provides an opportunity for integrating the wide range of services, spanning multiple sectors and settings that are needed in order to meet the diverse needs of individuals and their families/carers at the end of life. However, in order to do this and develop local care pathways for end-of-life care, GPs will need to develop a greater understanding of the role and expertise of other professionals, and also voluntary sector organisations, involved in end-of-life care and the skills to work effectively with them in shared team leadership roles.

CHALLENGE 5: SUPPORT FOR FAMILY AND CARERS, BOTH DURING A PERSON'S ILLNESS AND AFTER DEATH

Evidence for the physical, emotional, social and financial consequences of being a carer and support needed are summarised in Supporting Evidence document 1, Outcome 1.5.

Support for carers of people approaching the end of life leads to fewer unplanned admissions, thus reducing health costs, and more people dying in their preferred place of care²⁸⁶. However, the 2009 National Primary Care Snapshot Audit showed that there had been an assessment of carer's needs for only half of those on the practice palliative care register²⁸⁷. As less than a third of those approaching a 'predictable' death are on the practice palliative care registers²⁸⁸, this suggests that there is significant room for improvement of carer support in general practice for end-of-life care.

Bereaved carers are at increased risk of health problems and even death²⁸⁹. The *End of Life Care Strategy* states that GP support for carers after bereavement is a vital part of good quality end-of-life care²⁹⁰. But the National Primary Care Snapshot Audit showed that overall only 32% of families are offered bereavement support²⁹¹ and research reveals dissatisfaction among bereaved carers with the support they received from their GP^{292, 293}. Enhanced training to improve bereavement support for carers will improve carer satisfaction and is likely to reduce health consequences.

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If you would like more information about enhanced GP training, or to share your ideas and feedback, please contact us at: reviewofspecialtytraining@rcgp.org.uk.

ROYAL COLLEGE OF GENERAL PRACTITIONERS

1 Bow Churchyard, London EC4M 9DQ

Telephone: 020 3188 7400

Fax: 020 3188 7401

Email: admin@rcgp.org.uk

Web: www.rcgp.org.uk

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