RCGP Written Evidence
Health Select Committee Inquiry on Management of Long-Term Conditions

The Royal College of General Practitioners (RCGP) is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 46,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient-centred generalist clinical care.

Executive Summary

We welcome the opportunity to contribute to this Inquiry. Caring for patients with long term conditions is at the core of day-to-day practice for GPs, with such patients representing over 50% of GP appointments\(^1\). GPs have a vital role to play in supporting those living with long term conditions because:

- Whilst many health professionals may be involved in providing support to patients with long term conditions, general practice can serve as a natural ‘home’ ensuring that continuity of care is maintained over time.
- GPs’ holistic approach means they are best placed to provide ‘whole person’ care that takes into account patients’ social, mental, and physical wellbeing in the round. As expert generalists, GPs breadth of knowledge also means they are able to support the increasing number of patients living with multiple long term conditions.

The increasing prevalence of long term conditions is one of the biggest challenges currently facing our health and social care systems. We need a shared vision for how we adapt to meet this challenge at a time when the UK’s population is ageing and funding is predicted to remain flat. The following will be vital to delivering a successful strategy on long term conditions:

- **Moving to a ‘whole system’ approach:** We must explore new ways of providing joined up care and support to those with long term conditions, redesigning the way care is provided in the community. Integrated models of care – with GPs working in multi-disciplinary teams alongside secondary care, social care and others – have the potential to deliver better patients outcomes.

- **Making care planning the norm:** We must move away from reactively treating individual episodes of illness – often in secondary care settings – to better anticipating patients’ needs by planning and managing long term care in the community. Care planning should become the norm for all patients with long term conditions, and general practice is already taking the lead in terms of implementing this in practice. Key to this approach is patient empowerment through the promotion of shared decision making and self care, putting patients in control.

- **Focusing in on multiple morbidities:** Health and social care services must shift their focus away from treating individual long term conditions towards a ‘whole person’ approach to better meet the needs of the growing number of people with multiple long term conditions. Multiple morbidity is rapidly becoming the norm amongst those with long term disease. Whilst the total number of people with one long term condition is expected to remain relatively stable over the next ten years at around 15.4m, the number with two or more long term conditions is projected to increase from 5m today to 6.5m.\(^2\)
• **Shifting resources into primary care:** The primary care team will be vital to any successful future model of support for patients with long term conditions. However, the system of funding for NHS services remains skewed towards hospitals care. Over 2010/11 and 2011/12 spending on general practice fell in real terms (compared to real terms increases for hospital care, mental health and community health services). If we are serious about anticipating the care needs of those with long term conditions and putting them in control of their care, we must look at how we can provide primary care – where 90% of patient contact with the NHS takes place – with better resources.

**Response to specific issues highlighted by the Select Committee**

1. **Defining 'long-term conditions'**

   Given the Committee's stated aim to review the definition of long-term conditions, RCGP offers the following proposed wording:

   
   A long term condition is any medical condition that cannot currently be cured but can be managed with the use of medication and/or other therapies. This is in contrast to acute conditions which typically have a finite duration such as a respiratory infection, an inguinal hernia or a mild episode of depression.

   As with many concepts in healthcare, there are likely to be many different interpretations of what constitutes a long term condition. Ultimately, the best means of defining what is and isn't a long term condition, and making decisions about care requirements, is as part of a conversation between an individual and their doctor (usually a GP).

2. **Moving care out of hospitals and into the community – are we ready?**

   It is vital that in the coming years we see a major shift towards managing and planning 'whole person' patient care in the community, moving away from the focus on treating individual episodes of illness in secondary care. The increasing prevalence of long term conditions and multiple morbidity mean that the 'status quo' is not an option.

   However, we absolutely must avoid moving care out of hospitals without first establishing a clear plan for how services in the community should to be organised and resourced to accommodate this change. In RCGP's view we need to effect change in three key areas:

   (i) **Service redesign, care planning and ‘communities of practice’**

   We need to establish new models of generalist-led care in the community in order to meet the changing needs of patients with long term conditions. Currently it is still the norm that different professionals work within their own organisational silos, funding systems and cultures. We need to redesign services in a way that encourages shared ownership and responsibility for ensuring that those with long term conditions are supported to manage and plan their own care.

   One potential model is to create multi-disciplinary teams based within primary care. This consists of different health care professionals, drawn from the wider primary care team, working together to deliver routine care, health advice and case management to high-risk patients. The model ensures such patients have access to longer appointment times, and health
professionals are trained in skills such as chronic disease management, shared decision making and prevention.

Another powerful tool is care planning, an approach pioneered by the diabetes ‘Year of Care’ initiative (see section 5 below). This involves agreeing a plan to improve an individual’s health and well-being, and co-ordinating across a range of health, social care and other professionals to ensure the provision of support and services to address the patient’s needs. There is strong evidence that care planning can improve outcomes for patients, reduced unnecessary hospital admissions and save money. We now need to embed care planning into the ‘core business’ of general practice and other parts of the system. RCGP is hosting a consortium of charities and primary care organisations to develop a set of ‘communities of practice’ in a number of pilot locations in the UK. These will work together to break down barriers to change, agreeing the redesign of services, developing shared risk stratification metrics, determining how to share resources and agreeing use of IT to support the process.

Finally, Under the right circumstances, pooled budgets can help to drive integration between health and social care, potentially leading to better outcomes for patients and reduced hospital admissions. However, safeguards are needed to prevent cost shifting between service areas, by using means such as tying the use of funds to the delivery of jointly agreed outcomes based on shared needs analysis, and the application of open book accounting procedures. Personal health budgets potentially offer the opportunity to meet individuals’ health and social care needs in a more integrated way, but pose various practical challenges and risks.

(ii) Investment in primary care

Delivering on the aspiration of moving more care out of hospitals, and at the same time integrating care more effectively around patients with long term conditions, will require a change in the balance of resources within the NHS. At the moment, the systems through which NHS care is funded continue to encourage activity in hospitals. In contrast there has been marked underinvestment in general practice, as indicated in the following chart from the Nuffield Trust.

Balancing resources towards primary care would enable general practice to:

- Focus time and funding on redesigning services in the community to better meet the
needs of patients with long term conditions.

- Offer patients with complex needs – particularly those with multiple morbidities – more time with their GP. The standard 10 minute consultation is no longer enough to deliver a shift towards more anticipatory care. In the future greater flexibility will be needed, but with GP workload currently under severe strain most practices are unable to offer this.
- Focus time and funding on risk profiling GP practice populations, and engage more with patients in GPs’ local community to assess need.

In addition, an urgent review of Payment by Results is needed. It acts as a barrier to integrated care, because:

- Payment is structured around single episodes of care, discouraging the development of integrated services around long term conditions and care pathways.
- Reimbursement is based on activity (and to a certain extent quality), rather than health outcomes.
- By making the income of secondary care providers dependent on the volume of patients they treat, it pits their interests against those of commissioners and undermines efforts to provide more services in the community.

(iii) Workforce planning and training

Continuing to move care out of hospitals and into the community has significant implications for the primary care workforce. The Centre for Workforce Intelligence has highlighted that the GP workforce is not growing quickly enough to meet predicted increases in demand. The CfWI has recommended a 17% increase in recruitment into GP specialty training, which will necessitate a reduction in recruitment into training in hospital-based specialties. We need a robust long term approach to workforce planning, led by Health Education England, to ensure that patients with long term conditions are supported by an adequate GP workforce.

As the needs of patients change – and as the rise of multiple morbidities continues to lead to increases in the complexity of care – we also need to ensure that GP training reflects this. The RCGP’s proposals for extending the length of GP training from 3 (currently the shortest of any medical specialty) to 4 years are in the process of being considered by the Government, with a decision by health Ministers across all four nations of the UK expected in late 2013. Extending and enhancing GP training will mean that GPs of the future are better equipped to provide care and support to those with long term conditions.

3. Can we deliver 'whole person' care for people with long term conditions?

Personalisation is strongly associated with better patient outcomes and experience and is rooted in the same values of holism and patient centredness as general practice. The NHS and social care still focus too much on individual disease areas, and a shift in focus is needed towards supporting patients with two or more multiple morbidities. Potential solutions include:

- Embedding a stronger core element of medical generalism in all medical training, including providing all junior doctors with greater opportunities to spend time working in the community.
- Reviewing the incentives and standards embedded throughout the NHS and considering how they need to change to tackle multiple morbidities. For example, NICE could develop clinical guidance focusing on multiple conditions rather than single disease
areas.

- We need to redefine the primary care consultation, supporting GPs to spend more time face to face with patients who have complex needs.
- Joining up community mental health services with general practice to ensure that the needs of people with long term physical and mental health needs are addressed. This could involve co-locating mental health professionals into practice based multi-disciplinary teams.

5. Current examples of effective integration of services across health, social care and other services which treat and manage long-term conditions

We would point to two examples that the Committee could consider in this context:

**The diabetes ‘Year of care’ and care planning**

The ‘Year of Care’ programme demonstrated the potential for care planning to deliver improved health outcomes for people living with long term conditions, using diabetes as an exemplar. Pilots were undertaken in three diverse pilot sites (Calderdale & Kirklees, North of Tyne and Tower Hamlets). Key outcomes include:

- People with diabetes reported improved experience of care and real changes in self care behaviour.
- Professionals reported improved knowledge and skills, and greater job satisfaction.
- Care planning was found to be cost neutral at practice level, with some making savings.
- The programme found that care planning takes time to embed and requires whole system change.

**Joint working between GPs and care homes in Sheffield**

Patients living with long term conditions who live in care homes may suffer from poorer access to support tools such as care planning. In some areas, GPs are working collaboratively with local care homes to better meet the needs of their residents. In Sheffield, local GPs have been leading on the delivery of proactive, coordinated healthcare to care home residents through a Locally Enhanced Service (LES) first set up by NHS Sheffield in 2008. The initiative focuses on developing clear lines of communication between care homes and GPs and establishing effective access to community health services. The scheme has contributed to a reduction in hospital admissions in the area and has been popular with both residents and GPs, with 94% of surveyed residents saying the service provides for their needs.

6. How can the new commissioning system deliver more integrated care for people with long term conditions?

The introduction of clinically-led commissioning is an opportunity to deliver new ways of working that benefit people with long term conditions, but there are both risks and opportunities associated with the new NHS structure as it comes into force. Key factors include:

- Whether GPs feel 'ownership' of the process. GPs need to be able to lead the redevelopment of services along lines that they judge will benefit their patients, and CCGs will need to engage effectively with all GPs in their areas, as well as with patients and other professional groups.
• CCGs must be given the freedom and responsibility to explore the development of new models of care, and shouldn’t be held back by concerns about having their decisions overruled (e.g. in the courts) due to competition law. The Government has given assurances that the 'Section 75' procurement, patient choice and competition regulations recently passed by Parliament won't restrict CCG freedom and will encourage integrated commissioning; however, some uncertainty remains around the legal implications of the regulations.

7. As a contributory factor to conditions including diabetes, heart failure and coronary heart disease, how can we address obesity?

Obesity is well known to be a fundamental risk factor for a series of conditions, such as diabetes, heart failure and coronary heart disease. Its impact on psychological problems, low self esteem and even suicide risk should also not be forgotten. The impact on health budgets, workload and service development is immense. Potential solutions include:

• A multi-disciplinary approach is needed involving the whole health and social care system with coordinated services at all levels.
• GPs can and do have a role to play in supporting patients to live healthily. However, evidence suggests that GP practices should not be running first line weight management clinics themselves, but rather should signpost patients to an appropriate source of support, such as a weight management group.
• To achieve real traction on obesity, however, major public health interventions are needed to such as tackling the food industry, legislation around sale of high calorie sweets and drinks and improving access to exercise.

1 Department of Health, Improving the health and well-being of people with long term conditions: World class services for people with long term conditions - Information tool for commissioners, January 2010.
5 The concept of ‘communities of practice’ builds on the development of GP federations – through which practices can pool resources and expertise to redesign services in a way that better meets the needs of patients with complex care needs, an approach that has been successful in Redbridge and Cumbria.
6 The College has published a position statement on Personal Health Budgets: http://www.rcgp.org.uk/policy/rcgp-policy-areas/~media/Files/Policy/A-Z%20policy/RCGP-Personal-Health-Budgets-position-statement-June12.ashx