Right care, right place, right time: How can we improve health and care for vulnerable older people?

1. The RCGP welcomes the opportunity to respond to the Department of Health's consultation on Vulnerable Older People.

2. 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 49,000 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. Through our General Practice Foundation, established by the RCGP in 2009, we maintain close links with other professionals working in General Practice, such as practice managers, nurses and physician assistants.

3. We gratefully acknowledge the contributions of our members in formulating this response.
Our response

Summary

1. We warmly welcome and support the focus of this consultation. The way in which older people are cared for in the NHS is a very important issue, and many of the measures proposed relate directly to GPs who are at the forefront of diagnosing and delivering care to vulnerable older people. Our principle concern is how general practice will be able to deliver the aspirations set out without addressing the funding, workload and workforce crisis within the profession. We are calling for an urgent package of investment to ensure there is sufficient capacity in general practice and a long term plan to shift greater resources into the community. This will enable GPs to deliver safe care and explore new ways of working.

2. In principle we support the idea of having a named accountable clinician for vulnerable older patients, and believe that the clinicians best placed to provide this service are GPs. However, there is a lack of understanding over how the introduction of a named accountable clinician would differ from the current system in operation within GP surgeries. In addition, we have concerns around how GPs will manage to undertake greater responsibility without an urgent package of investment in general practice.

3. We have significant concerns about the emphasis placed in the consultation on the use of rapid walk-in centres as a means of accessing primary care, particularly for vulnerable older people. There is no evidence that rapid walk-in centres lead to a reduction in admissions for A&E and shorter waiting times in general practice. Moreover, there is significant evidence that walk in centres can lead to supply induced demand, the servicing of which does not always represent the best use of limited NHS resources. In the case of older patients with multi-morbidity the best possible way for them to access primary care services is through their GP, therefore any policies aimed at achieving greater access for this group must focus on providing general practice with the necessary resources.

4. We support the principles underpinning many elements of the Government’s approach, in particular the focus on care planning, continuity of care and prevention being more important than cure. In line with this focus, it is our view that embedding care planning will be especially crucial to the implementation of the Government’s proposals. Care planning is an essential part of management of long term conditions, especially in the case of multi-morbidity, as not only does it support patients to understand and manage
their condition confidently, it encourages all components of the health service to work together.

5. In order to implement these proposals significant investment is needed in general practice. GPs currently carry out 90% of patient contacts within the NHS, but receive only 9% of the budget, and there is a serious shortfall in the number of GPs both in current terms and in terms of future projections. In a recent poll four in five GPs said they are concerned that it will become increasingly difficult to deliver continuity of care to vulnerable older people. General practice cannot absorb more responsibility and a greater workload unless this situation is addressed.

6. We feel strongly that geographically defined GP practice areas should be maintained. The abolition of practice boundaries would undermine GP practices (as it would be far more difficult to plan to meet demand), impact adversely on continuity of care and would make it harder for GPs to deliver integrated care alongside local authorities, as these are organised on a geographic basis. Furthermore it is likely that a number of rural practices would become unsustainable, as they would face losing significant numbers of their patients – typically younger, healthier commuters – and would be left caring for a greater proportion of patients lacking mobility and/or living with complex long-term conditions. This imbalance would rarely be viable in the long term and would thus ultimately reduce choice in rural communities, to the detriment of the most ill and vulnerable.

**Detailed response**

Please note that we have responded only to the questions that are relevant to the work of the RCGP.

1) Staying healthy for longer: concentrating on prevention and managing long term conditions

7. It is our view that general practice is best placed to help prevent and manage long term conditions, particularly in the case of vulnerable older people. In the RCGP vision of general practice ‘*The 2022 GP*’ we see GPs of the future working within federations

1 Royal College of General Practitioners (2013) RCGP responds to Health Secretary’s speech on future of primary care


networks, and multidisciplinary teams, collaborating with colleagues across nursing, hospital and community services to deliver more integrated care for the benefit of their patients.

8. An important part of our vision is that GPs and patients living with long term conditions should have more time to plan and discuss care. This is particularly relevant for vulnerable older people who often suffer from a number of complex conditions, which require time and detailed communication to properly manage. However, this again will require greater capacity and investment in general practice than currently exists due to the spiralling workloads most GPs now face.

9. GPs can also have an outreach role, targeting health inequalities by encouraging individuals of low socio-economic status to be involved in their own healthcare.

a. How can we strengthen the incentives, or increase flexibility, for GPs to effectively manage the health of the local population?

10. We agree that we need to move towards a model in which GPs take a proactive population health approach to the way they deliver care to their local communities. GPs in future should look to combine a reactive service model with a more proactively planned anticipatory system of care that will particularly benefit the expanding number of patients with long-term conditions. To achieve this, however, we need to:
   I. Shift more investment into general practice so that GPs have greater capacity – including more time – to develop anticipatory care systems and processes.
   II. Ensure that GPs receive the right training to have a better understanding of the needs of their practice population, which will inform capacity and workforce planning, as well as improve service quality. The RCGP’s proposals for extended and enhanced general practice postgraduate training are very important here. Boosting GP leadership and quality-improvement skills will encourage active participation in service redesign, and enable fundamental change.
   III. NHS England and CCGs must ensure that the right infrastructure and technology is in place to ensure GPs can access data about their population’s health needs.

11. Greater joint working across disciplines is also a vital way in which GPs to address the health needs of their local populations. Our vision of integrated care is ‘Patient-centred, primary care led, delivered by multi-professional teams, where each profession retains their professional autonomy but works across professional and organisational
boundaries to deliver the best possible health outcomes, ideally with a shared electronic GP record.’

b) In your experience, how do you suggest people can be better supported to manage their own care?

12. We strongly support embedding personal care planning within primary care as the best means of supporting patients to manage their own care. The Wagner Care model of care planning shows that the best patients outcomes can be achieved when three components of care are integrated;

I. A prepared proactive practice team,
II. An informed engagement by people in their own care, and
III. Partnership working between health professionals and individuals with long term conditions.

In order to achieve the best outcomes all three of these components need to be present.

c) Can you share any best practice examples of how to strengthen prevention and early diagnosis in primary and community services?

13. In 2008, a group of GPs in Sheffield led on the delivery of proactive, coordinated healthcare to local care home residents funded as a Locally Enhanced Service. This project is an excellent example of how integrated working between GPs and care homes can avoid unnecessary admissions to hospital amongst vulnerable older people. Each care home taking part in the initiative was assigned one practice which accepted all residents who chose to register. A service agreement was set up between the home and the practice, with named GPs providing proactive care. The project involved an annual medical review and care plans, copies of which were kept in the home and flagged on out of hours (OOH) databases to alert anybody on call out. In year one of the scheme, there was a reverse in the trend of rising emergency visits from care homes, with a reduction in emergency admissions by six per 100 care home beds (approximately 9 per cent) compared with the previous year. A&E attendances also fell by three per 100 care home beds (approximately 10 per cent) at a time when A&E attendances were rising in other areas.³

³ Royal College of General Practitioners, Care homes case study

http://www.rcgp.org.uk/policy/rcgp-policy-areas/~-/media/Files/Policy/A-Z-policy/Case-Study-Sheffield-Care-Homes-LES.ashx
2) Named clinician: providing a single, named contact to coordinate an individual’s care

a) How do you identify vulnerable older people or people most at risk in the local area?

14. The development of disease registers and the employment of risk stratification techniques can be important tools to identify those most likely to benefit from proactive intervention at the local level.

b) Who do you feel is best placed to perform the role of a named accountable clinician in a primary care setting?

15. We think that the obvious choice for the named accountable clinician would be a GP with support from the wider practice team. GPs as medical generalists are well placed to direct and track the care of the patient throughout the system, and will currently refer to other parts of the health service and treat patients before and after any instances of hospital or specialist care.

c) Named clinician: providing a single, named contact to coordinate an individual’s care [This isn’t strictly a question, but comments are sought nonetheless]

16. We welcome the Government’s acknowledgement that care for vulnerable elderly people needs to improve, and that GPs will play a vital role in achieving this. We want to support and contribute to the Government’s initiative as it is taken forward.

17. In principle we support the proposal to introduce a named accountable clinician for vulnerable elderly patients, and recognise that GPs would be best placed to act as that named clinician. However, there is a lack of understanding over how the introduction of a named accountable clinician would differ from the current system in operation within GP surgeries. In addition, the way in which the named clinician will be held accountable and for what is not currently clear.

18. Already, when patients register with a practice they are nominally allocated to an individual GP for administrative purposes. Although patients may see a number of different GPs within a particular practice, when booking appointments, most practices will ask patients who their usual or preferred doctor is.

19. While GPs may be the best placed clinician to hold responsibility for vulnerable older patients, their ability to ensure this will need to be underpinned by the practical systems and clinical time required to enable the effective co-ordination of care. It is therefore vital
that this policy is underpinned by the provision of additional resources to enable GPs to deliver care co-ordination for the growing number of patients who need it.

20. In addition, there is a need to distinguish between proactive care planning and responsibility for responding to unscheduled care needs, including out of hours. While a named clinician may be able to take on responsibility for the former, it is unrealistic to expect a single person to be continuously available to deal with the latter, particularly given the growing number of GPs who work on a part-time basis.

21. The 2011 report of the Independent Commission on medical generalism, commissioned by the RCGP and the Health Foundation, concluded that “there is a clear conflict between the importance of access to medical advice and care 24 hours a day, and patients’ preference for continuity of that care and advice”. It stated that “it may be impractical to wish for a return to GPs’ personal patient lists, as opposed to practice or group lists, and to round-the-clock access to ‘your’ doctor. But there is a clear case for taking steps to restore a discipline of continuity of responsibility for registered patients, seven days a week, on the part of a named team.”

22. One possible model for achieving this may is the development of multi-disciplinary micro teams. These provide continuity of care to identified groups of patients such as those at the end of life, and can involve a range of mechanisms such as buddying, job sharing, and organized handover systems.

23. The lack of joined up IT systems and shared patient records is likely to pose a significant barrier to the effective information sharing that would be necessary to truly realise the benefits of the named clinician proposals. In addition, in order to make the concept of a named clinician effective, there will be a need for providers of secondary care to improve the way in which they communicate with surgeries concerning patients. At present, secondary care providers follow a variety of different procedures when selecting which GP to communicate with concerning a patient on a practice’s list. If there is to be a named accountable clinician, it will be important to ensure that in future, they are copied into all correspondence concerning those patients for whom they have responsibility.

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5 Royal College of General Practitioners (2012), General Practice and the Integration of Care http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/medial/Files/Policy/A-Z-policy/General_Practice_and-the_Integration_of_Care%20_An_RCGP_Report.ashx
3) Improving access: making it easier to book appointments and get advice

24. We support the principle of increasing access and ease of appointments for all patients. However we have significant concerns about the mention of rapid walk-in centres in the consultation document. There is no evidence that rapid walk-in centres lead to a reduction in admissions for A&E and shorter waiting times in general practice. In the case of older patients with multiple conditions the best possible way for them to access primary care services is through a GP or GP surgery with whom they have had previous contact. Seeing a clinician who has no awareness of the complexity of an individual’s illness may have a detrimental effect on their overall health.

25. Consideration should be given to the issue of supply induced demand (increased uptake as a result of increased provision of services), as a by-product of the use of rapid walk in centres. Patients should be offered the best value healthcare to address their needs; where patients with self-limiting illnesses are attending rapid walk in centres this is unlikely to be an efficient use of NHS resources.

26. Furthermore GPs have been at the forefront of using technology for some time. Many GPs communicate extensively with their patients via email and telephone as is described in the consultation document.

a) Can you share some examples of introducing new technologies and new ways of providing primary care services?

27. A growing number of practices are using telephone triage systems such as Doctor First for all patients as a way to manage demand for services. Under this scheme if a patient calls their surgery for an appointment they will be put throughout to a doctor to discuss their reason for an appointment. The doctor, with the consent of the patient, will then decide whether they need to see a GP or a nurse, or if their complaint can be dealt with without the need to come into the surgery. In this way practices can prioritise time for those most in need as many issues can be dealt with without the need for an appointment. In rolling such systems out, it is of course important to ensure that procedures are put in place to ensure that patients who may require face to face contact are not deterred from doing so, and that the quality of the care provided is not compromised.

b) What are the barriers to introducing new technologies to improve access?
28. With an elderly population, especially with those suffering from dementia or similar conditions, modern technology may not be the most appropriate form of contact for all patients. A significant proportion of these patients may prefer face to face contact.

29. Delivering new technological solutions in general practice is unlikely to be cost neutral in the short-medium term. For example, the British Medical Journal, in its analysis of the recent Whole Systems Demonstrator programme, has calculated that that adding telehealth to usual care costs £92,000 per quality adjusted life year\(^6\). As outlined above, an urgent package of investment in primary care is clearly needed if we are to keep pace with demand and deliver the kind of innovative technologies needed.

4) Out of hours: ensuring a safe and consistent service

30. There is a lack of recognition of the extensive role that GPs currently play in delivering care 24/7. GPs currently provide extended hours, often work beyond closing time, provide care in urgent care centres, do out of hours shifts, and work in hospital emergency departments. This is consistent with the results of the recent GP patient survey, in which 80% of patients said they were “very” or “fairly satisfied” with their surgery’s opening hours. Just 2% of patients said they are “very dissatisfied” and just 6% said their surgery’s out of hours services were “very poor”. We therefore challenge the idea that there needs to be an increase in out of hours GPs services.

a) How can we best ensure clear accountability for out of hours services?

31. It is our view that to successfully meet the challenges of delivering urgent and emergency care in the 21st century NHS we must redesign services based on a ‘whole system’ approach, more effectively integrating care across different parts of the system, and between in and out of hours care. The key elements of this would include shifting resources into primary care to prevent unnecessary hospital admissions, embedding a multi-disciplinary ‘care planning’ approach within primary care to help anticipate patients’ needs, improving communication between primary, secondary and social care, and encouraging greater integration with ambulance services so they feel able to explore alternative care pathways for their patients. Out of hours non-emergency telephone services also have a very important role to play, if implemented properly. By working together the health service as a whole can react appropriately to the out of hours needs of patients.

\(^6\) BMJ 2013; 346 doi: [http://dx.doi.org/10.1136/bmj.f1035](http://dx.doi.org/10.1136/bmj.f1035) (Published 22 March 2013)
b) What is the role of other primary care services, for example, pharmacists, in providing safe and consistent out of hours care?

32. We view out of hours services as being a coalition of services including A&E, GPs, pharmacists and community services working together. It is certainly the case that there is an important place for pharmacists within that coalition to deal with minor ailments. However, it is vitally important that pharmacists have the skills and knowledge to understand when more specialist help is needed. RCGP and the Royal Pharmaceutical Society have previously advocated collaborative working between general practice and pharmacy in our joint statement on ‘Breaking down the barriers – how community pharmacists and GPs can work together to improve patient care’. ⁷

c) Do you have any examples of good practice and innovation in out of hours provision?

33. EPaCCs (Electronic palliative care co-ordination systems) are a valuable tool in advanced care planning for vulnerable older people who are reaching the end of their lives as these allow for advanced care planning discussions to be widely shared, which results in patient’s wishes being known and respected wherever possible.

5) Choice and control: providing clear and accurate information to help patients make decisions

34. We have significant concerns regarding the proposals around greater choice for patients particularly the reference to building on the findings of the GP choice pilots. The pilots have seen a very poor uptake in their first nine months. We would therefore caution against using evidence from these pilots as the basis of future policy making.

35. RCGP is strongly opposed to the idea of abolishing practice boundaries on the basis that this will put vulnerable patients at risk. The best way to support patients is for them to be seen by a GP who has a good understanding of the needs of the local community and can work with other services in a joined up fashion. Abolishing practice boundaries would work against this.

36. We support in principle the idea of empowering patients to make informed decisions about their care. However, we have significant concerns about the use of the ‘friends and

⁷ Royal College of General Practitioners and Royal Pharmaceutical Society (2011) ‘Breaking down the barriers-how community pharmacists and GPs can work together to improve patient care’

family test’ as a measure of quality in general practice. A single question survey taken from a unstratified sample is neither useful nor reliable, and will not assist patients in making informed choices based on their priorities for their care.

37. The existing GP Patient Survey presents a much more valuable resource for patients. Not only does it contain a number of different elements and aspects that allow patients to make decisions about their healthcare based on what is important to them, the results are available down to the practice level so patients can apply the results directly to their care. We see no need to introduce another test when the GP Patients Survey in is existence. Within this context it is perhaps worth noting that the GP Patient Survey already has a question about whether patients would recommend their GP surgery to someone who has just moved into the local area. 80% said they would definitely (49%) or probably (31%) recommend their local surgery.

a) How do you think patient choice can be supported in out of hospital care, for example more transparency, flexible provision and support for decisions?

38. As discussed above in section one we believe the best way to deliver patient choice in out of hospital care is through care planning and shared decision making. By setting up a dialogue between clinicians and their patients we can help patients set person-centred goals, review outcomes and plan care on an ongoing basis. This can give patients meaningful choice over the type of treatment they undergo.

39. Federations are also an important way to deliver patient choice. By working within federations and groups of federations, individual GP surgeries are able to expand the services they can offer.

b) What do you think are the barriers to enabling choice in out-of-hospital services?

40. One of the major barrier to helping patients, is the lack of adequate time within general practice to address all of the issues surrounding their condition and care. This is particularly true of vulnerable older people who will often be suffering from a number of complex conditions and facing a many different care options. In order to address this issue greater capacity must be created in the workforce.

c) Do you have any examples of patients who have been supported to achieve better outcomes through the use of choice and control?

6) Joining up services: sharing up to date and accurate information and supporting coordination of care
41. RCGP has consistently been a champion of integrated care and has called on the government to make this a priority. As such, we warmly welcome the focus on this in the consultation.

42. As providers of primary care and commissioners GPs are ideally positioned to be champions of integration. In the RCGP’s 2022 vision for general practice we see GPs of the future collaborating together with colleagues in nursing, hospital and community services in order to deliver more integrated care as part of multidisciplinary teams, networks and federations.

**What do you see as the main barriers to achieving integrated out of hospital care and how can these be overcome?**

43. The lack of shared records and the technology required to support them acts as a significant barrier to achieving integrated out of hospital care. It results in a lack of proper communication between clinicians, and the burden of communication often being placed on patients.

44. The payment by results system currently used by NHS England to reimburse secondary providers also acts as a serious barrier to integrated care. Under this system payment is structured around single episodes of care, which discourages the development of integrated services around long term conditions and care pathways. In addition, as income is dependent on the volume of patients treated, the interests of secondary care providers are pitted against those of commissioners which can undermine efforts to provide more services in the community. Furthermore the fact that primary and secondary care have very different forms of funding, with primary care being funded by a combination of capitation payments and money linked to achievement under the Quality and Outcomes Framework, acts as a specific barrier to integrated out of hospital care.

45. The lack of adequate funding for general practice also acts a serious barrier to integrated care. In order to implement the structural and technological changes needed for properly integrated care, general practice will need significant investment. Given that there is currently a crisis in general practice in terms of funding and workforce, taking on more responsibility and work within existing resources will not be possible.

a) Do you have any examples of integrated out of hospital care happening in your local area and having a positive impact on patient outcomes?
46. The ‘gold standard framework’ employed by many GP practices provides an excellent example of how general practice can work in an integrated fashion to help elderly people when they are reaching the end of their lives. Working closely with the care sector, this framework helps GPs to identify when an individual patient is nearing death, assess their the clinical and personal needs and develop a plan of care with input from them and/or family members. In this way GPs can help individuals to die in their home rather than in a hospital, which is in line with the majority of patients’ wishes.

b) What do you think are the main barriers to data sharing between services to support patient care?

47. There is a lack of efficient, effective and compatible systems for the sharing of patient information within the NHS, which acts as one of biggest barriers to overall integration of care. A big gap is seen in the lack of a comprehensive system of shared electronic care records. Indeed, in many parts of the service electronic records are not the main form of record keeping: for example, many hospitals rely on paper based systems. In addition, out of hours services often function without any notes at all. It is extremely difficult to share records without even the same form of record keeping.

48. Many patients have anxieties around the issue of data sharing and feel uncomfortable with organisations being able to access their personal information without their expressed consent. This can act as a barrier to data sharing between services. However, it is very important that any system of data sharing takes into account the concerns of patients regarding the use of their personal information.

c) Can you highlight any examples of where data sharing to support patient care is happening effectively?

49. As mentioned previously in paragraph 32 EPaCCs can have a very positive effect on the care of elderly patients, as they enable care decisions to be widely shared, which results in patient’s wishes being known and respected wherever possible.

50. A number of NHS areas, including Croydon, Wandsworth and Devon, currently run a ‘Virtual Ward’ model. This model provides support to high risk patients by replicating the structure of a hospital ward on a virtual basis within the community, with the aim of providing as much care as possible within the home. A community matron or GP acts as case manager, assessing the patient's needs and drawing up a care plan, and regular virtual ward rounds are held, at which each patient is reviewed by a multidisciplinary
team. A ward clerk provides a central point of contact and facilitates the timely exchange of information.

The RCGP welcomes the opportunity to respond to this consultation and looks forward to further dialogue with the Department of Health on this subject.

Please do not hesitate to contact me if you have any questions about our response.

Yours faithfully,

Professor Amanda Howe MA Med MD FRCGP

Honorary Secretary of Council