SUPPORTING EVIDENCE: DOCUMENT 3

RCGP Royal College of General Practitioners

PREPARING THE FUTURE GP: THE EVIDENCE FOR ENHANCING LEADERSHIP SKILLS

PREPARING THE FUTURE GP
THE EVIDENCE FOR ENHANCING LEADERSHIP SKILLS

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3.1: WHY IMPROVED DELIVERY OF IN- AND OUT-OF-HOURS PRIMARY CARE SERVICES IS A TRAINING PRIORITY

'General practice is primarily responsible for the provision of comprehensive and continuing care to every individual seeking medical care irrespective of age, sex and illness.'

WONCA, 2002[1]

FACTS AND FIGURES ABOUT UK PRIMARY CARE:

- The consultation rate is rising: primary care consultations in England rose from 217.3 million in 1995 (3.9 consultations per patient per year) to 300.4 million in 2008 (5.5 consultations per patient per year)[2]
- The average length of surgery consultations with GPs has increased from 8.4 minutes in 1992/3 to 11.7 minutes in 2006/7[3]
- There 8.6 million contacts with out-of-hours services every year in England alone,[4] but in 2009/10 13% of patients rated their out-of-hours service as poor or very poor[5]
- In England alone there are 220,000 people in residential or nursing care[6]; people in residential care have complex needs yet receive relatively poor medical care[7]
- People with an intellectual (formally know as 'learning') disability are 58 times more likely to die prematurely than the general population[8]

1 WONCA (Wold Organisation of National Colleges/Academies) Europe. The European Definition of General Practice/ Family Medicine (2005).

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

3 NHS Information Centre. *2006/7 UK General Practice Workload Survey*.

4 Healthcare Commission. *Not Just a Matter of Time: A review of urgent and emergency care services in England* (2010).

5 The Patients' Association. *Postcode Lottery in Patient Care: Interim findings factsheet* (2010).

6 NHS Information Centre. *Community Care Statistics: Social services activity, England 2010/11*.

7 Joseph Rowntree Foundation. *Improving Care in Residential Care Homes: A literature review* (2008).

8 Department of Health. *Inclusion Health: Improving primary care for socially excluded people* (2010).

- People with serious mental illness have higher rates of obesity (1.5–2 times), diabetes (2 times), dyslipidaemia (5 times), and smoking (2–3 times); they die on average 25 years earlier than might be expected, mainly as a result of physical health problems[9]
- People from other socially excluded populations have increased morbidity and mortality: just 30% of Irish travellers live beyond their 60th birthday[10]; 85% of street sex workers report using heroin and 87% crack cocaine[11]; two-thirds of refugees and asylum seekers have experienced anxiety or depression[12]; and the average age of death for homeless people in the UK is between 40 and 44 years[13].

The UK has a worldwide reputation for high-quality primary care services. However, the NHS is going through a time of rapid organisational change putting GPs at the forefront of commissioning of patient services (in England), in an era of an expanding and ageing population and under severe economic constraints. GPs must adapt and modernise their services to meet the challenges of the future whilst maintaining the excellent quality of services that they have provided to date.

Over the past 15 years there has been a 40% increase in the number of consultations per patient[14]. The reasons for this are:

- Changing population demographics – consultation rate increases with age and so an older population demands more consultations
- A deliberate shift of work from secondary to primary care[15,16] – GP services are good value for money[17] and patients prefer services in the community and closer to home
- Better access to GP appointments – financial incentives for reaching practice access targets has resulted in a reduction in the barriers to getting GP appointments
- Media information about health – headlines about health matters are common in the popular press and television programmes that highlight health conditions encourage patients to take action to visit their GPs
- Loss of the family structure – people are less able to ask other family members for advice about management of minor illness.

Case mix has also altered with GPs now seeing more complex patients and patients with severe disease. Consultation length has consequently increased by 40% too, although at 11.7 minutes per patient[18] people in the UK still have some of the shortest consultations in the

9 National Mental Health Development Unit. *Factfile 5: Equalities in mental health* (2011).
10 Department of Health. *Inclusion Health: Improving primary care for socially excluded people* (2010). *ibid*.
11 *Ibid*.
12 Cabinet Office/Department of Health. *Inclusion Health: Evidence pack* (2010).
13 Department of Health. *Healthcare for Single Homeless People* (2010).
14 NHS Information Centre. *Trends in Consultation Rates in General Practice 1995 to 2008. ibid*.
15 HM Government. *Our Health, Our Care, Our Say: A new direction for community services* (2006).
16 Department of Health. Transforming community services website.
17 The King's Fund. *Improving the Quality of Care in General Practice: A report of an independent inquiry commissioned by The King's Fund*. London: The King's Fund, 2011.
18 NHS Information Centre. *2006/7 UK General Practice Workload Survey*.

developed world[19,20]. Add to this the competing demands for GP time from other roles such as clinical governance and leadership and it is clear that GP time has never been so stretched.

Care for people in care homes can be particularly demanding. People residing in care homes are often elderly and have complex health problems. Home visiting can mean that GPs are seeing these patients with very limited information about that person available to them.

There is a considerable body of evidence to suggest that care home residents receive a poorer standard of care than people living in the community[21]. They are less likely to have their long-term health problems treated in accordance with national guidance[22], more likely to be admitted inappropriately to hospital[23] and end-of life care is often substandard[24]. Problems with medications are also common, affecting over 60% of residents in one recent study[25].

GPs could provide better primary care services to care residents and more support for care home staff[26]. As a result, new models of care have been proposed. These include having dedicated GPs responsible for care homes and their residents[27].

Socially excluded groups such as the homeless, refugees and asylum seekers, those with learning difficulties, substance abuse or severe mental illness, are often also difficult to care for. GPs often feel ill-prepared by their training to manage care and reduce the barriers that result in health inequalities for these groups[28].

Out-of-hours care

Primary medical care is provided by out-of-hours services from 18.30 to 08.00 on weekdays and for weekends and public holidays; a total of at least 70% of every week. However, since the takeover of out-of-hours care by primary care organisations in 2004, complaints about out-of-hours GPs have soared[29,30].

At present it is often new GPs that deliver the out-of-hours service as more experienced GPs are established in daytime practice. Working out of hours demands special skills. Out-of-hours GPs see a higher proportion of very ill patients; they are usually dealing with patients of whom they have no prior knowledge nor information, apart from the information that the patient or carer gives; they may not know the colleagues that they are working with and may be working in unfamiliar surroundings or alone; and access to mediciation and services may be limited. Telephone skills are particularly important as most initial contacts are made

19 Bindman AB, Forrest CB, Britt H, Crampton P, Majeed A. Diagnostic scope of and exposure to primary care physicians in Australia, New Zealand, and the United States: cross sectional analysis of results from three national surveys. *British Medical Journal* (2007);334: doi: 10.1136/bmj.39203.658970.55.
20 Deveugele M, Derese A, van den Brink-Muinen A, Bensing J, De Maeseneer J. Consultation length in general practice: cross sectional study in six European countries. *British Medical Journal* (2002);325: doi: 10.1136/bmj.325.7362.472.
21 Joseph Rowntree Foundation *ibid.*
22 Shah SM, Carey IM, Harris T, DeWilde S, Cook DG. Quality of chronic disease care for older people in care homes and the community in a primary are pay for performance system: retrospective study. *British Medical Journal* (2011);342:d912.
23 Bowman CE, Elford J, Dovey J. Acute hospital admissions from nursing homes: some may be avoidable. *Postgraduate Medical Journal* (2001);77(903):40-2.
24 Seymour JE, Kumar A, Froggatt K. Do nursing homes for older people have the support they need to provide end-of-life care? A mixed methods enquiry in England. *Palliative Medicine* (2011); 25(2):125-138.
25 Barber ND, Alldred DP, Raynor DK, Dickinson R, Garfield S, Jesson B et al. Care homes' use of medicines study: prevalence, causes and potential harm of medication errors in care homes for older people. *Quality and Safety in Healthcare* (2009);18(5):341-346.
26 Joseph Rowntree Foundation. *ibid.*
27 Jacobs S. Addressing the problems associated with general practitioners' workload in nursing and residential homes: findings from a qualitative study. *British Journal of General Practice* (2003);53(487):113-119.
28 Department of Health. Inclusion health: improving primary care for socially excluded people (2010). *ibid.*
29 Personal communication with the Medical Defence Union.
30 Medical Protection Society. *Case Book: Out of hours* (2008).

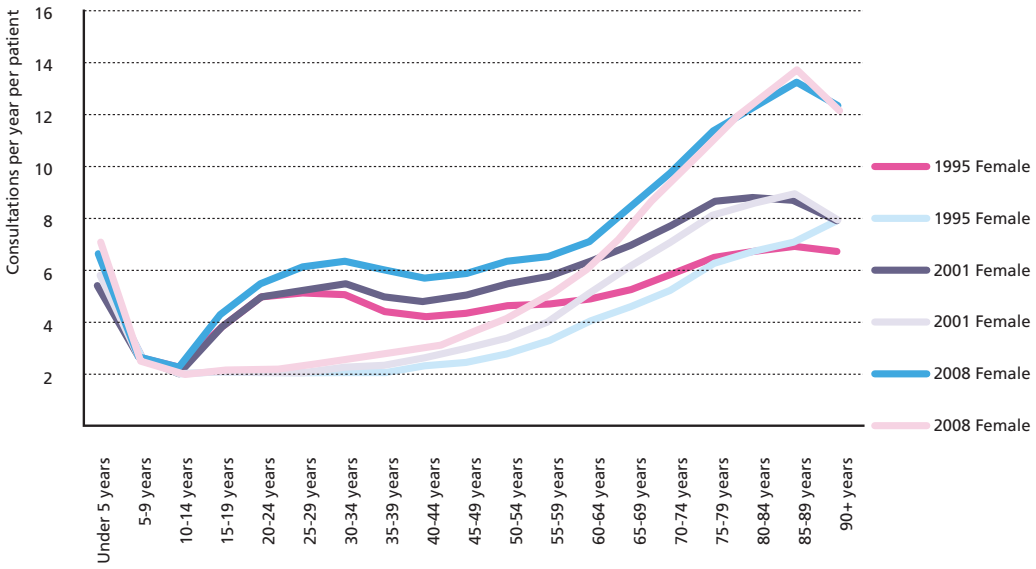
by telephone. Up to 60% of complaints about out-of-hours care involve errors made during telephone consultations[31].

GPs are not prepared on completion of training to manage workload, or to care for minority sectors of the population who have special healthcare needs. Preparation for out-of-hours work is inadequate for entry into higher level training.

CHALLENGE 1: MANAGING INCREASING DEMAND FOR AND COMPLEXITY OF GP CONSULTATIONS

Over the past 15 years there has been a progressive increase in demand for general practice appointments. Data from the NHS Information Centre for Health and Social Care shows that there was in excess of a 40% increase in the number of consultations per patient from 1995 to 2008, with an average 5.5 consultations per patient per year in 2008[32]. This increase in consultation rates has occurred in all age groups over the age of 14 years (Figure 3.1.1). The increase in consultation rates is particularly pronounced for people over the age of 80, who have on average 13.5 consultations every year[33].

Figure 3.1.1: Historical changes in consultations by age group for 1995, 2001 and 2008



Based on QResearch data and reproduced from the Centre for Workforce Intelligence General Practice Factsheet (2011)[34].

31 Medical Protection Society. *Analysis of Patient Safety Data Following Out of Hours Conference* (2010).
32 NHS Information Centre. Trends in Consultation Rates in General Practice 1995 to 2008: Analysis of the Q Research® database.
33 NHS Information Centre. Trends in Consultation Rates in General Practice 1995 to 2008. *ibid*.
34 Centre for Workforce Intelligence. *Medical Specialty Workforce Factsheet: General Practice* (2011).

There are several reasons for this increase in demand for GP consultations. Our ageing population means that there are greater numbers of people who are elderly or very elderly and this trend is set to continue into the future. Consultation rate increases with age and so an older population demands more consultations.

Another factor that has driven the need for increased primary care appointments is the shift of work that is continuing to occur from the secondary care to the primary care sector. The 2006 White Paper '*Our Health, Our Care, Our Say'* [35] proposed a major reshaping of the NHS in which appropriate care was moved out of acute hospitals and into the community, and particularly into primary care. It proposed to transfer 5% of the acute sector budget into the community. The Transforming Community Services Programme, which completed its work in 2011, aimed to support this through extending best practice on improving discharge from acute hospital and increasing access to care and treatment in the community[36].

This trend is set to continue as GP services have been shown to provide better value for money than other parts of the healthcare system[37]:

- GP care for a whole year costs less than a single day's hospital admission
- GP consultations cost less than outpatient consultations, accident and emergency and ambulance calls
- A face-to-face consultation with a GP costs the NHS about the same as a telephone consultation with a nurse through NHS Direct.

Although undoubtedly patients prefer care in the community that is tailored to their needs and closer to home, and care provided in the community represents better value for money than care provided in hospital settings, this change in care setting has resulted in increased demand for primary care consultations.

Finally, there has been a change in the way that people use the GP service which fuels demand for primary care appointments. Factors that have contributed to this include:

- Better access to GP appointments
- Patient-centred consultation techniques that make GPs more approachable
- Media information about health, and
- Loss of the family structure, resulting in reduced advice from family members about management of minor illness.

To cope with increasing demand for GP appointments and also the changing pattern of disease from management of acute illness to management of long-term conditions, there has been considerable adaptation to the way that primary care services are delivered. There has been an increase in the proportion of telephone consultations and a decrease in the proportion of home visits provided by GPs (Table 3.1.1)[38]. Furthermore, in 2008, 62% of consultations were undertaken by GPs, 34% by nurses and 4% by other clinicians (Figure 3.1.2). The consultation rate with practice nurses more than doubled between 1995 and 2008[39].

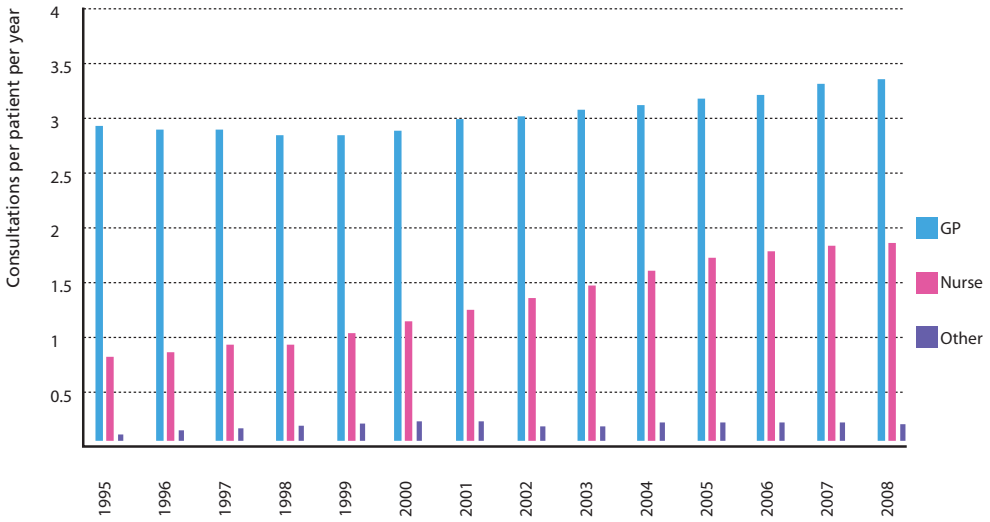
35 HM Government. *Our Health, Our Care, Our Say: A new direction for community services* (2006). *ibid.*
36 Department of Health. Transforming community services website. *ibid.*
37 The King's Fund. *Improving the Quality of Care in General Practice* (2010). *ibid.*
38 NHS Information Centre. *Trends in Consultation Rates in General Practice* 1995 to 2008. *ibid.*
39 *Ibid.*

Table 3.1.1: Changing consultation patterns in primary care 1995–2008

Consultation type	% consultations		
	1995/6	2001/2	2008/9
GP surgery appointment	86.6	86.4	81.8
Telephone consultation	3.0	6.2	11.8
Home visit	9.0	5.1	3.5
Other location	1.4	2.3	2.9

Based on QResearch data obtained from the 'Trends in consultation rates for general practice 1995 to 2009' tables[40]

Figure 3.1.2: Primary care consultations by clinician type 1995–2008



Based on QResearch data and reproduced from the Centre for Workforce Intelligence General Practice Factsheet (2011)[41].

Over the past decade, practice nurses have increasingly been employed to manage minor ailments that present to the GP surgery and provide routine ongoing care for people with chronic diseases. This has changed the case mix of GPs, who now see those patients with more serious illness or more complex care needs who cannot be managed by practice nurses.

40 The Information Centre, NHS. *Trends in Consultation Rates in General Practice 1995 to 2009* (tables) (2009).
41 Centre for Workforce Intelligence. *Medical Specialty Workforce Factsheet: General practice* (2011).

Complexity of consultations is also increased by:

- Improved patient-centred care with patients involved with their own care[42]
- Rising prevalence of people with more than one long-term condition (see Supporting Evidence document 2, Outcome 2.3)
- Greater focus on opportunistic health promotion and disease prevention activity during GP consultations made for other reasons (see Supporting Evidence document 2, Outcome 2.2)
- Management of people traditionally managed within secondary care in the primary care setting[43]; GPs manage 95% of problems that present to them without onward referral[44].

Increased complexity of consultations has resulted in an increase in consultation length in the UK from an average of 8.4 minutes in 1992/3 to 11.7 minutes in 2006/7[45]. However this compares unfavourably with other developed countries, such as the United States (average consultation length 16.5 minutes)[46], Switzerland (15.6 minutes)[47], New Zealand (15 minutes)[48], Belgium (15 minutes)[49], and Australia (14.9 minutes)[50].

On the other hand, as most GP surgeries in the UK book appointments at 10-minute intervals (the minimum appointment interval required by the Quality and Outcomes Framework), an average consultation length of 11.7 minutes means that for every patient seen, the GP will run a further 2 minutes behind time. Based on an average morning's work of 20 appointments, this means that the average GP is already running over half an hour behind schedule by the end of each session worked.

When considering workload, competing demands for GP time must also be considered. GPs have a wide variety of roles (Box 3.1.1). There is increasing demand for them to be involved in clinical governance and leadership roles as well as patient care. For example, as GPs in England spend increasing amounts of time in commissioning roles, time spent as healthcare providers will diminish[51]. Irrespective of the need for enhanced training, it is clear that we need more GPs, spending longer with their patients and their communities.

42 Lakhani M, Baker M, Field S. *The Future Direction of General Practice: A roadmap*. London: RCGP, 2007.
43 HM Government. *Our Health, Our Care, Our Say: A new direction for community services* (2006). *ibid*.
44 The King's Fund. *Improving the Quality of Care in General Practice* (2010). *ibid*.
45 NHS Information Centre. *2006/7 UK General Practice Workload survey*.
46 Bindman AB, Forrest CB, Britt H, Crampton P, Majeed A. *ibid*.
47 Deveugele M, Derese A, van den Brink-Muinen A, Bensing J, De Maeseneer J. *ibid*.
48 Bindman AB, Forrest CB, Britt H, Crampton P, Majeed A. *ibid*.
49 Deveugele M, Derese A, van den Brink-Muinen A, Bensing J, De Maeseneer J. *ibid*.
50 Bindman AB, Forrest CB, Britt H, Crampton P, Majeed A. *ibid*.
51 Centre for Workforce Intelligence. *Medical Specialty Workforce Factsheet: General practice* (2011). *ibid*.

BOX 3.1.1: THE FUNCTIONS OF A GP

- Holistic care – relationship-based care
- Enablement and patient centredness
- Reaching a diagnosis
- Navigating the patient to the right section of health care where appropriate
- Co-ordination of care
- Managing co-morbidity
- Prescribing and complex medicines management
- Protecting patient safety and managing uncertainty
- Improvement – clinical and quality improvement, narrowing the gap between research and practice, healthcare governance; exceptional potential of the consultation
- Clinical leadership.

Source: Adapted from Lakhani M, Baker M, Field S. *The Future Direction of General Practice: A roadmap*. London: RCGP, 2007.

The GPs of tomorrow will need to embrace new ways of working in order to manage increasing primary care workload and other demands on their professional time whilst ensuring continued high-quality patient care. Enhanced GP training will equip them with:

- Improved clinical skills to manage conditions more traditionally managed in secondary care
- Better knowledge of the roles of other health, social and third sector providers and excellent inter-professional communication skills so that it is possible to co-ordinate care effectively across boundaries
- Technical and managerial 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
- Innovative working practices to redesign, commission and implement new care pathways and ways of consulting that can be tailored to individual patient needs both within their own practices and the wider health and social care service
- New sites of working – for example, many GPs now work exclusively in out-of-hours services, walk-in clinics, front-ends of accident and emergency. Others work in supermarkets, caring via on-line web based services or via call-centres. All of these places where GPs take their generalist skills pose new training challenges.

CHALLENGE 2: IMPROVING THE PROVISION OF PRIMARY CARE SERVICES FOR PEOPLE IN RESIDENTIAL CARE HOMES

Each year around 64,000 people move into residential care[52]. The most recent figures suggest that there are 220,000 people living in long-term residential care in England[53]. The majority (77%) are over the age of 65 years[54]. Of younger adult residents living in long-term residential care, 61% have learning disabilities; 21% have mental illness; 17% have an ongoing physical disability and the remaining 2% have substance misuse problems or are vulnerable because of other problems[55].

52 NHS Information Centre. *Community Care Statistics: Social services activity*, England 2010/11. *ibid.*
53 *Ibid.*
54 *Ibid.*
55 *Ibid.*

There is a substantial body of evidence to suggest that medical care in nursing homes is sub-standard[56]. Although some of the deficiencies in care relate to nursing care, there is evidence that GPs could provide better primary care services to residents and more support for nursing home staff[57].

Nursing homes are common places for people to die; however, residents receive very variable end-of-life care. A recent qualitative study highlighted that variable support from GPs, reluctance of GPs to prescribe appropriate medication and lack of out-of-hours support were all factors that contributed to this[58].

When GPs visit nursing homes they may be limited by the information they have access to about residents, which can be compounded 'out of hours' if the GP does not know the patient. Acute hospital admissions for nursing home residents may be avoided if better information is available during response to emergency calls[59]. Care home residents are more than twice as likely to be admitted to hospital compared with matched community-dwelling controls (0.62 as compared to 0.26 admissions per person per year)[60]. In-hospital mortality rate is 16% and 30-day mortality after discharge is 30%[61].

Another recent UK study looked at the quality of chronic disease management in care home residents and found that there was considerable room for improvement[62]. The authors examined 16 quality indicators included in the UK Quality and Outcomes Framework (QOF). They found that even after adjustment for other factors such as age and dementia, attainment of quality indicators was significantly lower for residents of care homes than for those in the community for the majority (14 out of 16) of the indicators. The largest differences were for:

- prescribing for heart disease
- monitoring of diabetes
- monitoring of hypothyroidism
- blood pressure for those with a history of stroke and
- measuring serum electrolytes for those taking loop diuretics.

Residents of care homes were also more likely to be identified by their doctor as unsuitable or non-consenting for QOF indicators, allowing their exclusion from targets. Over one-third of residents were excluded from stroke and diabetes quality targets in this way[63].

56 Joseph Rowntree Foundation. *ibid.*
57 *Ibid.*
58 Seymour JE, Kumar A, Froggatt K. Do nursing homes for older people have the support they need to provide end-of-life care? A mixed methods enquiry in England. *Palliative Medicine* (2011);25(2):125-138.
59 Bowman CE, Elford J, Dovey J. *ibid.*
60 Graverholt B, Riise T, Jamtvedt G, Ranhoff AH, Krüger K, Nortvedt M. Acute hospital admissions among nursing home residents: a population-based observational study. *BMC Health Services Research* (2011);11:126.
61 *Ibid.*
62 Shah SM, Carey IM, Harris T, DeWilde S, Cook DG. Quality of chronic disease care for older people in care homes and the community in a primary are pay for performance system: retrospective study. *British Medical Journal* (2011);342:d912.
63 Shah SM, Carey IM, Harris T, DeWilde S, Cook DG. *ibid.*

Problems with medications are also common. Care home residents take an average of eight medications each[64]. Medication errors are common with errors being identified for in excess of 60% of residents in one recent study[65]. Reasons for this included:

- GPs who were not accessible to care home staff to provide advice
- GPs who did not know the residents and lacked information in homes when prescribing
- Lack of team working between the home, pharmacy and GP surgery
- Inaccurate medicine records and prevalence of verbal communication between care home staff and GPs.

Recent controversies surrounding prescription of psychotropic drugs for people with a diagnosis of dementia have heightened concerns about inappropriate prescribing for residents of care homes. In 2009, the Department of Health published a report into the use of neuroleptic medication for non-cognitive symptoms in patients with dementia[66]. It found that, at that time, despite NICE guidance to prescribe only if essential[67], atypical anti-psychotics were the most common pharmacological treatment of non-cognitive symptoms in the UK. A large number of people with dementia were being treated with anti-psychotic medication, when only a proportion derived any benefit and older people with dementia were more at risk of side effects from these drugs, including excess cerebrovascular events and death.

Although this report concluded antipsychotic agents were being used too readily as first-line agents for the treatment of non-cognitive symptoms of dementia, subsequent reductions in prescribing have been disappointing[68]. This may be partly because GPs are not trained in appropriate alternative strategies for management.

People living in residential care place high demand on GP services. They have a much higher prevalence of home visiting and also consultations take much longer when travel time is factored in. By the very nature of residential care populations, people living in residential care tend to be elderly and have long-term health conditions. Many have multiple morbidities. Furthermore, most GPs do not have access to practice computer systems when home visiting, which limits the information available to the GP when seeing the patient and also means that automatic health prompts that remind GPs to perform routine health checks when seeing patients in the GP surgery are absent.

Investigation into provision of GP services to care homes has shown that most care homes allow residents to choose a GP. This can result in many different GPs visiting a single care home to see different residents. This is an inefficient use of GP time and resources, but can also cause problems with communication as nursing homes have to deal simultaneously with several different systems for visits, chronic disease management and prescription requests that different GP surgeries operate. Many homes would prefer their residents to be registered with just one GP surgery and have a weekly 'clinic' to deal with minor problems and chronic illness[69].

64 Barber ND, Alldred DP, Raynor DK, Dickinson R, Garfield S, Jesson B et al. *ibid*.
65 *Ibid*.
66 Bannerjee S. *Report on the Prescribing of Anti-psychotic Drugs to People with Dementia*. Department of Health, 2009.
67 NICE. *Dementia: Supporting people with dementia in health and social care* (2011 update).
68 Burstow P. Speech at the National Dementia Congress 2nd November 2011.
69 Jacobs S. Addressing the problems associated with general practitioners' workload in nursing and residential homes: findings from a qualitative study. *British Journal of General Practice* (2003); 53 (487):113-119.

This position has been backed by the Independent Commission on Generalism, in their 2011 report '*Guiding Patients through Complexity: Modern medical generalism*'[70]. This report advocates that care homes should have dedicated GPs responsible for provision of medical services to their residents and that a national expertise in this particular aspect of generalism should be fostered.

At present GPs receive no specific training in care of people who live in residential care. Enhanced GP training will provide GPs with:

- increased understanding of the difficulties associated with providing primary healthcare to care home residents
- better clinical knowledge to manage the healthcare problems, such as dementia and long-term neurological disease that are particularly prevalent in care home residents
- improved communication skills to promote team working with nursing home staff and reduce medication errors
- better organisational skills to ensure that medication review and chronic disease management occurs for people living in residential care; and
- flexibility to explore and assist with commissioning new working practices that could improve medical services for care home residents.

CHALLENGE 3: IMPROVING PRIMARY CARE FOR SOCIALLY EXCLUDED POPULATIONS

There are a number of distinct socially excluded populations in the UK. Often health services do not meet their needs and this can result in increased prevalence of preventable disease and excess use of unscheduled and hospital services. These populations include:

- people with severe mental health problems
- people who abuse drugs or alcohol
- people with learning difficulty or autistic spectrum disorders
- the homeless; and
- refugees and asylum seekers.

Addressing the problems that these populations have in accessing primary health care is an important step towards reducing the health inequalities that they experience.

The evidence for the need for improved management of the health impacts of severe mental illness and drug and alcohol misuse are summarised elsewhere (Outcomes 1.2 and 1.3 respectively). Those that have dual diagnosis of substance abuse and mental ill-health are a particular challenge to manage and successful management requires co-ordination of a broad range of services[71]. Although many of those who have mental health problems or abuse alcohol or drugs do use general practice services very effectively, their consulting patterns may be erratic with frequent missed appointments and poor compliance with medication. Their behaviour may also be challenging with practice staff and other patients. These factors can make provision of high-quality care with continuity of provider very difficult.

For those with learning difficulty, recent health statistics[72] reveal that obesity is more prevalent (22%) than in the general population (15%); women with learning difficulty are

70 Report of an Independent Commission for the Royal College of General Practitioners and The Health Foundation. *Guiding Patients through Complexity: Modern medical generalism* (2011).
71 HM Government. *New Horizons: A shared vision for mental health* (2009).
72 NHS Information Centre. *Access to Healthcare for People with Learning Difficulties* (2010).

less likely to have received contraceptive advice (OR=0.6) or smear tests (OR=0.3) than their matched controls of similar age; those with epilepsy and learning difficulty are considerably less likely to have been seizure-free for a year compared to matched controls with epilepsy but no learning difficulty (OR=0.6); and antibiotics are less likely to be prescribed the same day for urinary tract infection than for matched controls (OR=0.7).

A 2010 survey of healthcare professionals found that almost half of doctors think that people with learning disability receive a poorer standard of healthcare than the rest of the population[73]. The Department of Health's '*Inclusion Health: Evidence pack*'[74] concurs and offers several explanations which include:

- Institutional problems – literacy problems and/or communication barriers can make form filling and/or calling to make appointments a major obstacle; language and accents of staff can also be difficult for people with learning difficulties; feelings of anxiety can grow if waiting for long periods of time in waiting rooms
- Lifestyle and behaviour problems – people with learning difficulty may not seek help; advocacy can improve access but can also hinder access on occasions; communication problems and diagnostic overshadowing may make diagnosis more difficult
- Service provision problems – healthcare staff may have limited experience and lack specific training in dealing with people with learning disability; new health problems may be dismissed as part of the underlying condition; false assumptions may be made, such as an assumption that people with learning disability are not sexually active and thus do not need contraceptive advice or cervical smears.

For autism, a 2009 National Audit Office survey of GPs found that 80% of those who responded felt that they required additional guidance and training to identify and manage patients with autism more effectively[75]. *The Strategy for Adults with Autism in England* (2010)[76] recommends that autism awareness training should be part of the core training curriculum for GPs.

It is difficult to estimate the number of homeless people in the UK as many are unknown to authorities. However, official figures recognise at least 60,000 individuals across the UK. This is acknowledged to be a significant underestimate. Many homeless people will suffer from a triad of poor physical health, mental health and substance misuse. Being homeless is associated with a significant increase in levels of poor health and premature death. The average age of death for homeless people in the UK is 40–44 years[77]. A recent study of homeless patients admitted to hospital with drug-related problems in Glasgow found that they were seven times more likely to die over the next five years than housed patients with the same reason for admission[78].

A chaotic lifestyle may then mean that significant health needs are exacerbated by difficulties accessing health care, particularly primary care. A survey by the *Big Issue* found

73 Health and Social Care Bill: Memorandum submitted by MENCAP (2010).
74 Cabinet Office/Department of Health. *Inclusion health: Evidence pack* (2010). *ibid*.
75 National Audit Office. *Supporting People with Autism through Adulthood* (2009).
76 HM Government. *Fulfilling and Rewarding Lives. The strategy for adults with autism in England* (2010).
77 Cabinet Office/Department of Health. *Inclusion health: Evidence pack* (2010). *ibid*.
78 Morrison DS. Homelessness as an independent risk factor for mortality: results from a retrospective cohort study. *International Journal of Epidemiology* (2009);38:877–83.

that only 71% of vendors were registered with a GP compared with 98% of the general population.

Homeless people's use of acute and secondary care appears to be disproportionately high, perhaps because of these difficulties. For instance, homeless people used an estimated eight times more hospital inpatient services than an average person of similar age[79]. Comparison of data from a GP practice for homeless patients in Leicester with neighbouring practices shows a six times higher Accident and Emergency Department attendance rate, with homeless patients being four times as likely to be admitted[80]. National hospital data looking at patients who gave their address as 'No Fixed Abode' demonstrates an average length of stay almost triple that of the general population of the same age[81]. Analysis by the Office of the Chief Analyst found that these differences are largely accounted for by the difference in case mix and so not due to discharge difficulties: the homeless patients stay longer because they are more unwell[82].

Over-utilisation of acute and emergency care is costly for the health service and disadvantageous for homeless people. Such services are not well placed to provide long-term holistic care for the health needs of such patients nor to offer continuity in the patient–practitioner relationship. Therefore, there are strong arguments to strive to ensure better access to primary care for homeless people.

Refugees and asylum seekers are another group that find healthcare difficult to access. Whilst refugees and asylum seekers are entitled to be registered with a GP and receive prescriptions free of charge, entitlement is not always synonymous with use and many find it difficult, if not impossible, to access health services when needed[83].

Refugees and asylum seekers often have complex physical, psychological and social needs. Whilst most arrive in the UK in good health, a significant minority do not. They may suffer from physical illnesses such as tuberculosis and HIV, have physical injuries as a result of war, torture or cultural practices (such as female circumcision), and mental health problems. Once in the UK they suffer the consequences of low income, unemployment and social isolation and deprivation[84].

GPs find care for asylum seekers difficult for many reasons including language and cultural barriers, complex healthcare needs that require considerable time and resources to manage, and lack of information about entitlement to general services and access to local services specifically for asylum seekers and refugees[85]. The use of interpreters is imperative and new communication skills are needed for GPs to work effectively through interpreter services. The British Medical Association recommends that GPs should receive better training and support to develop a greater understanding of cultural, social and other issues relating to refugees and asylum seekers[86].

There are many other examples of socially excluded groups that suffer health inequalities. However, these examples show that improved GP training in management of the barriers to healthcare that these groups face, and flexibility of service provision to develop and

79 Department of Health. *Healthcare for Single Homeless People* (2010).
80 Leicester Homeless Primary Health Care Service. *Annual report 2007/8*. Leicester City NHS Community Health Service, 2008.
81 Department of Health. *Healthcare for Single Homeless People* (2010). *ibid*.
82 *Ibid*.
83 British Medical Association. *Meeting the Healthcare Needs of Refugees and Asylum Seekers – A survey of general practitioners* (2007).
84 *Ibid*.
85 *Ibid*.
86 *Ibid*.

commission novel models of care in collaboration with other service providers to cater for these populations can improve health for socially excluded groups and save healthcare costs.

CHALLENGE 4: IMPROVING THE PROVISION OF OUT-OF-HOURS CARE

Definitions of emergency, unscheduled and urgent care are provided in Box 3.1.2. GPs provide emergency and unscheduled care during usual office hours in the GP surgery. However, since April 2004, and the advent of the 'new' GP Contract, GP practices have been able to 'opt out' of providing out-of-hours care with responsibility for this service falling to local Primary Care Organisations (PCOs).

Box 3.1.2: Definitions of emergency, unscheduled and urgent care[87]

Emergency care: Immediate response to time-critical healthcare need

Unscheduled care: Services that are available for the public to access without prior arrangement where there is an urgent actual or perceived need for intervention by a health or social care professional

Urgent care: A response before the next in-hours routine (primary care) service is available.

Primary medical care is provided by out-of-hours services from 18.30 to 08.00 on weekdays and for weekends and public holidays; a total of at least 70% of every week. In England alone in 2007/8[88], primary care out-of-hours services:

- Received 8.6 million calls and
- Completed 6.8 million assessments – 3 million in out-of-hours primary care centres (44%), 2.9 million by telephone (43%); and 0.9 million through home visits (13%).

About 1.5% of the calls dealt with were considered 'life-threatening' emergencies and 15% were classified as 'urgent'[89].

However, there have been problems over recent years with out-of-hours services in the UK. High profile cases such as the death of Mr David Gray after an opioid overdose administered by a locum GP working for out-of-hours have hit the headlines[90] and prompted official reviews[91,92]. The out-of-hours service has been criticised for variability in coverage and care

87 Department of Health. *Telephone Access to Out-of-hours Care: Practical guidance* (2004).
88 Healthcare Commission. *Not Just a Matter of Time: A review of urgent and emergency care services in England* (2010).
89 *Ibid*.
90 BBC. Locum doctor inquest hears of patient's last moments (14.1.2010).
91 Care Quality Commission. *Investigation into the Out of Hours Services Provided by Take Care Now* (2010).
92 Colin-Thomé D, Field S. *General Practice Out of Hours Services: Project to consider and assess current arrangements* (2010).

provided[93], for access difficulties because of the variety of different out-of-hours providers operating across the UK[94], and for being poor value for money[95].

Analysis of complaints paints an equally worrying picture. Medical defence organisations report a rapid increase in complaints against GPs working in the out-of-hours setting since 2004. In 2004/5, the Medical Defence Union (MDU) handled 155 complaints against out-of-hours GPs; by 2007/8 this had risen to 517 complaints[96]. The Medical Protection Society (MPS) recently stated that 14% of all complaints that it handles, and 26% of claims involving children, involve out-of-hours GPs[97].

In 2010, the White Paper '*Equity and Excellence: Liberating the NHS*' was published[98]. It included a commitment to develop a coherent 24-hour urgent care service. The King's Fund has also set provision of improved out-of-hours care as one its ten key priorities for commissioners[99]. As well as improving health outcomes and the experience of care for patients, improvements in out-of-hours care provision could substantially reduce Accident and Emergency Department attendance and emergency admissions to hospital and thus result in considerable savings in healthcare costs.

'Out of hours care is usually accessed at a time when patients can be at their most frightened and vulnerable.'

Dr Clare Gerada, Chair RCGP, 2011[100]

GPs in training currently receive limited exposure to provision of out-of-hours care during their GP training. In most areas this amounts to 36 hours for every 6 months of full time experience in general practice. Out-of-hours competences include[101]:

- Ability to manage common medical, surgical and psychiatric emergencies in the out of hours setting
- Understanding of the organisational aspects of NHS out of hours care
- Individual personal time and stress management
- Ability to make appropriate referrals to hospitals and other professionals in the out-of-hours setting, and
- Demonstration of communication skills required for out-of-hours care.

But is this enough? Although there is considerable overlap between the work of within hours GPs and out-of-hours GPs, some specialised and very different skills are needed when working out of hours. The challenges of out-of-hours care provision are summarised in Box 3.1.3.

93 *Daily Telegraph*. One out of hours GP for 650,000 people (1.2.2010).
94 Lattimer V, Burgess A, Knapp F, Dalton S, Brailsford S, Moore M, Baverstock J, Heaney D. *The Impact of Changing Workforce Patterns in Emergency and Urgent Out-of-hours Care on Patient Experience, Staff Practice and Health System Performance*. Final report for the National Institute for Health Research Service Delivery and Organisation Programme (2010).
95 National Audit Office. *The Provision of Out of Hours Care in England* (2006).
97 Medical Protection Society. *Case Book: Out of hours* (2008).
98 HM Government. *Equity and Excellence: Liberating the NHS* (2010).
99 Imison C, Naylor C, Goodwin N, Buck D, Curry N, Addicott R, Zollinger-Read P. *Transforming our Healthcare System: Ten priorities for commissioners* (2011). The King's Fund.
100 RCGP/RCPCH/The College of Emergency Medicine. *Urgent and Emergency Care Clinical Audit Toolkit* (2011).
101 COGPED. *Out of Hours (OOH) Training for GP Specialty Registrars* (2007).

Box 3.1.3: The challenges of working as an out-of-hours GP

Out-of-hours GPs see a higher proportion of very ill patients than daytime GPs and may need to commence resuscitation or critical illness management protocols more frequently

In out-of-hours practice, GPs are usually dealing with patients that they have no information about apart from the information that the patient or carer provides

GPs work within a much bigger team out of hours and often do not know other team members and may be unfamiliar with their working environment; at the same time they may work alone for a high proportion of their time doing home visits or manning an out-of-hours clinic

Access to medication and some services may be limited out of hours

First contact is almost always over the telephone and good communication skills are needed to provide accurate assessment, triage to appropriate care and safety netting. An analysis of 250 cases handled by the MPS found that 60% involved errors made during telephone conversations[102].

At present it is often new GPs that man the out-of-hours service as more experienced GPs are established in daytime practice. Enhanced GP training will provide increased emergency care training and out-of-hours experience so that new GPs are competent and safe to work in out-of-hours primary care settings on completion of GP training.

102 Medical Protection Society. *Analysis of Patient Safety Data Following Out of Hours Conference* (2010). *ibid.*

3.2: WHY INCREASED CO-ORDINATION AND LEADERSHIP OF MULTIDISCIPLINARY TEAMS IS A TRAINING PRIORITY

'GPs are the anchor of the healthcare system, who should have knowledge both of individuals and populations, who sit at the intersection of medicine, public health and social care, and who are expected by government to make the best, and most efficient, use of resources available in a health economy.'

Richard Giordano, Senior Lecturer in Leadership and Management in Health and Social Care, University of Southampton[103]

CHALLENGE 1: ENGAGE GPS IN THE LEADERSHIP OF QUALITY IMPROVEMENT

The White Paper *Equity and Excellence: Liberating the NHS* sets out a vision for a high-quality National Health Service that places the GP at the heart of a web of relationships in the healthcare system.[104] This vision of the GP's leadership role is mirrored in the RCGP's document *The Future Direction of General Practice: A roadmap*[105] and complements the broader framework for medical leadership set out by Tooke in 2008:

'The doctor's frequent role as head of the healthcare team and commander of considerable clinical resource requires that greater attention is paid to management and leadership skills regardless of specialism. An acknowledgement of the leadership role of medicine is increasingly evident.'

Professor John Tooke in *Aspiring to Excellence*, 2008[106]

This shared vision will require GPs to develop and maintain rich and influential relationships between:

- the GP and the patient
- the GP and members of multi- and interdisciplinary healthcare teams, spanning both primary and secondary care
- the GP and local management professionals
- the GP and healthcare systems and the community (including local authorities and social care)
- the GP and national, regional and local policy professionals.

103 Giordano R. *The Leadership Challenge for General Practice in England*. The Kings Fund, 2011.
104 *Ibid*.
105 Royal College of General Practitioners. *The Future Direction of General Practice: A roadmap*. London: RCGP, 2007. 106 Tooke J. *Aspiring to Excellence: Findings and recommendations of the independent inquiry into modernising medical careers*, 2007.

Relationships that extend beyond the consulting room are not unfamiliar to many GPs, especially those who have developed local or national leadership roles, but few will have experience of utilising these relationships in their everyday clinical work. To do so effectively will require GPs to gain a deep understanding of their professional and personal values and identity[107] and to engage in 'a complex responsive process of relating' to colleagues in a variety of roles[108].

The need for GPs to provide greater leadership raises considerable challenges for GP training (in England). The recommendation of the Tooke Inquiry[109] and the evidence from Higher Professional Education (HPE)[110] indicates that an extension to the GP training period is essential to deliver a GP who can work within the general practice environment as a sound, competent and confident doctor and who has been empowered with leadership skills, gained and demonstrated in the context of real-life practice.

To a significant degree, this need for increased focus on leadership training exists because general practice training is unlike that of any other specialty. During the first two years of the training programme, GP trainees move between teams every few months and so continually find themselves as the most junior member of the team; anecdotally, they report being frequently likened to their less experienced colleagues in Foundation Year 2 and, in many Trusts, are treated as being at the same level of training. They are therefore rarely afforded the opportunity to demonstrate leadership in the workplace. Even if they find opportunities to work on quality improvement projects, they attain this role from a junior rather than a senior position with little opportunity to effect change.

It has been reported in the literature for some time that GPs completing the current three-year specialty training programme do not have the experience or confidence required to take on clinical leadership roles and have required further training and support.[111] In a recent survey of GP trainees in London, 74% either disagreed or strongly disagreed that they had or were developing the skills needed to get involved with commissioning, compared with just 9% who felt prepared. Nearly half (48%) did not believe that they would be able to get involved with their clinical commissioning groups.[112]

CHALLENGE 2: TAKE RESPONSIBILITY FOR CONTINUITY OF CARE ACROSS MANY DISEASE EPISODES OVER TIME AND CO-ORDINATE CARE ACROSS HEALTH ORGANISATIONS

Continuing care for the whole person over time, informed by the person's values, beliefs and community context, is a core value of general practice[113] and requires the doctor

107 Tresolini CP, the Pew-Fetzer Task Force. *Health Professions Education and Relationship-Centered Care*. San Francisco: Pew Health Professions Commission, 1994.
108 Suchman A (2006). A new theoretical foundation for relationship-centered care. *Journal of General Internal Medicine* (2006);21:540-44.
109 Tooke J. *Aspiring to Excellence: Final report of the independent inquiry into modernising medical careers*. MMC, 2007.
110 Jackson N and Abouharb T. *Higher Professional Education for new GPs In Postgraduate Medical Education: A guide for primary and secondary care*. Oxford: Radcliffe Publishing, 2005.
111 Griffin A, Abouharb T. Transition to independent practice: a national enquiry into the educational support for newly qualified GPs. *Education for Primary Care* (2010);21(5):299-307.
112 *BMJ Careers*. GP trainees feel unprepared for commissioning. BMJ Careers (06 May 2011).
113 Royal College of General Practitioners. *Being a General Practitioner*. The core curriculum statement. London: RCGP, 2011 (update).

to reach an understanding of the patient's biological, psychological and sociological contexts[114].

To co-ordinate care effectively, GPs need the skills and experience to operate effectively across the many boundaries that exist within the health and social care system. This gives them a unique responsibility for promoting continuity and integration of care and support for people in need, and for achieving optimal cost-effective use of services.[115]

There is much evidence in the literature that the leadership attitudes and skills of clinicians are critical promoters (or barriers, if they are lacking) to the development of functioning and effective multidisciplinary healthcare teams.[116] There is also evidence that the key participants of the team require a 'degree of maturity and flexibility with regard to their knowledge base'.[117] To develop these attitudes and skills, GP trainees need sufficient time and opportunity to take responsibility for their patients' care through an extended period of specialty training in general practice. There should be increased focus during this time on the development of the skills required to communicate freely and clearly with professionals from a range of disciplines across health and social care boundaries.

CHALLENGE 3: DEVELOP THE SKILLS REQUIRED FOR LEADING AND MANAGING COMPLEX HEALTH ORGANISATIONS

NHS care is increasingly delivered in ways that span systems and require teams to work across organisations, sites and interdisciplinary boundaries. In addition, patients expect more care to be delivered 'closer to home'. GPs must learn to work in these complex new systems of care, while managing the influences of increased competition, patient choice and consumer-led healthcare provision.

The Academy of Medical Royal Colleges' Medical Leadership Competency Framework (MLCF)[118] defines the domains, the generic competences and the levels of performance required at three stages of NHS leadership:

- **Stage 1** – up to the end of undergraduate training: 'Understanding and describing'
- **Stage 2** – up to the end of specialty training (CCT): 'Demonstration of performance by doing'
- **Stage 3** – continuing practice: 'Integrated as part of everyday practice'.

The Stage 2 competences described in the MCLF have been written into the current GP curriculum. However, they are only currently assessed as learning outcomes at the level of Stage 1 (i.e. describing) rather than Stage 2 (demonstrating). This is consistent with the expected standard that can be achieved within a three-year specialty training programme. To deliver the competences to the level of demonstration required of Stage 2 performance, which is necessary to be fit for practise in the modern NHS, GP trainees will need an extended period of time in environments where their leadership competences can be developed and adequately demonstrated and assessed.

114 Engel GL. The need for a new medical model: a challenge for biomedicine. *Science* (1997);196:219-22.
115 Mullins C. Leadership in general practice: Part 1. *BMJ Careers* (2006).
116 Wilson and Pirrie. *Multidisciplinary Teamworking Beyond the Barriers? A review of the issues* (2000).
117 Wilmot S. Professional values and Interprofessional dialogue. *Journal of Interprofessional Care* (1995);9:257-65.
118 Academy of Medical Royal Colleges. *Medical Leadership Competency Framework*. 3rd edition. Coventry: NHS Institute for Innovation and Improvement, 2010.

In addition to developing their personal leadership capacity, GPs will need the ability to engender leadership capacities in the local healthcare organisations within they work. Such organisational capacities have been identified by Giordano in a recent King's Fund report as including:[119]

- the ability to self-organise quickly
- the ability to learn and adapt
- a willingness to engender leadership behaviours in everyone at all levels of the organisation
- a culture of innovation
- the ability, among all parties, to understand the local context – from a unit as small as the office visit to the big picture (national policy – and their place in it).

Pilot studies have demonstrated how the development and assessment of medical leadership can be done effectively in conjunction with consolidating learning in the delivery of evidenced-based care, and developing reflective practice, clinical maturity and confidence across the proposed extended GP training timeframe[120, 121, 122].

Increased opportunities for team working, systems awareness and organisational literacy will lead to increased quality and safety of healthcare. GP trainees need the time and opportunities to develop the skills required to turn good ideas and team commitment into successful, sustained organisational change as efficiently as possible. To do this, they must be given opportunities to engage in quality improvement projects, to generate new ideas, set appropriate objectives, test and refine the proposed solutions, measure changes and ensure improvements are sustained over time.

CHALLENGE 4: CONTRIBUTE TO THE DEVELOPMENT OF POPULATION-BASED INTERVENTIONS TO PREVENT ILL HEALTH AND ENHANCE WELLBEING

There is growing focus on improving the health of populations rather than just individuals. GPs have a duty to protect the needs of the vulnerable, the overlooked and the ignored and to promote health and wellbeing. This will require GPs to think more broadly than the patient in front of them and to develop a new range of skills to ensure that data about population needs and service utilisation covers all relevant population groups and maintain effective working relationships with colleagues in a wide range of organisations[123].

Through enhanced training, GP trainees will gain opportunities to develop a perspective of health that is broader than their immediate practice. Working in partnership with the community, specialist teams, local authorities and other bodies, GP trainees will have opportunities to understand how these organisations are shaped and organised, the levers to activate change, and how they utilise health informatics to shape services to meet the needs of local patients, ensuring that they take account of the needs of marginalised members of society.

119 Giordano R. The Leadership Challenge for General Practice in England. The Kings Fund, 2011. *ibid.*
120 Bowler I, Swanwick T. Extended training in general practice: senior registrars in general practice in the London Deanery. *Education for Primary Care* (2005);16:34-140.
121 Peters M, Jones R. *The London Academic ST4 Programme 2008-2009: Evaluation*. London GP Deanery and London Medical School, 2010.
122 Sibbett C, Thompson W, Crawford M, McKnight A. Evaluation of extended training for general practice in Northern Ireland: qualitative study. *British Medical Journal* (2003);327:971-3.
123 Department of Health. *National Framework for Long-term Conditions* (2007).

Examples of such training opportunities might include defining and developing a healthcare service within the locality in which a trainee is training, as part of a Quality Improvement Project in ST4. Such a service might be in areas related to deprivation or special need. This would provide experience of working alongside other professionals, such as healthcare managers, public health consultants and practitioners, interface working with local government and social care and being involved in public and patient consultation processes. Whilst some elements of leadership can be delivered in the early years of training, the higher level performance must be based upon the foundation of the core clinical, humanistic and scientific competences of general practice.

For high-performing trainees, extending the period of training into ST5 would potentially enable the inclusion of a major project-based component that spans organisational boundaries. It would also allow flexibility for further 'sub-specialist' training with accreditation of additional leadership skills that might aid the transfer of healthcare interventions and the integration of services between secondary and primary care.

3.3: WHY MORE EFFECTIVE ENGAGEMENT IN THE DEVELOPMENT OF LOCAL SERVICES, WORKING COLLABORATIVELY WITH SPECIALISTS AND PATIENTS, IS A TRAINING PRIORITY

'The ageing population and increased prevalence of chronic diseases require a strong re-orientation away from the current emphasis on acute care towards prevention, self-care, more consistent standards of primary care, and care that is well co-ordinated and integrated.'

The King's Fund: *Integrated Care for Patients and Populations*, 2011[124]

High-quality primary care services improve health outcomes for people, families and communities and can greatly reduce costs of health care.[125, 126]. The importance of enhancing the understanding and engagement of GPs in the development of such services has been identified by the Department of Health (England) as a critical factor in delivering the Quality Innovation Productivity and Prevention (QIPP) programme[127] and for realising substantial health, cost and efficiency benefits to the UK[128].

Current training programmes for general practice have rightly focused on individual patient care but will need to expand to recognise wider community and population needs. Working with local communities requires GP training to provide opportunities to develop a different skill set to that needed to work solely with individual patients and their families.

Designing and improving services for patients is a collaborative, multidisciplinary process which brings managers and clinicians together to evaluate local health needs and opportunities, create vision and priorities with the public, and specify and manage services with providers[129]. The aim must be to ensure that patients receive appropriate, safe, effective and efficient care which improves their health outcomes and contains costs. The leaders in local commissioning organisations must ensure that commissioning plans are

124 The King's Fund. *Integrated Care for Patients and Populations: A report to the Department of Health and the NHS Future Forum*. The King's Fund, 2011. 125 Rohde J et al. 30 years after Alma-Ata: has primary health care worked in countries? *Lancet* (2008);372:950-961.
126 World Health Organization. *Primary Health Care (Now more than ever)*. WHO, 2008.
127 Department of Health. *The Operating Framework for the NHS in England 2012/13*. London: The Stationery Office, 2011.
128 Wanless D. *Securing Our Future Health: Taking a long-term view*; final report. London: Department of Health, 2002. 129 NLIAH. *Getting Collaboration to Work in Wales: Lessons from the NHS and partners*.Cardiff: NLIAH, 2009.

developed with all relevant partners, serve the locally agreed vision and priorities, and deliver the right outcomes for patients and the public.

The RCGP has published a competence framework for clinically-led commissioning which sets out in detail the competence required by all clinicians participating in local service re-design, commissioning and quality improvement[130]. This framework can be used as a template on which to base this area of enhanced GP training.

CHALLENGE 1: ENGAGING WITH PROFESSIONAL COLLEAGUES

Integrated services cannot be designed or delivered effectively without the full participation of all the healthcare professionals involved[131]. This requires GPs to engage with the full range of healthcare professionals in local GP practices, community teams, specialist teams and hospitals to identify opportunities for improvement and to design cohesive systems of care and evaluate data on patient experience and outcomes[132] . Yet differences between disciplines in professional culture, employment arrangements, funding, and approaches to service provision build allegiances that can make it difficult for multidisciplinary teamwork to happen [133].

There is a need for both general practice and specialty care to adapt so that health and social care specialist support and advice can be rapidly and easily accessed by primary care teams, so that they can ensure that people receive well co-ordinated and personalised care[134]. This might involve thinking beyond the traditional 'outpatients' model and incorporating new technologies such as online communication tools and telemedicine.

Enhanced GP training is necessary to provide GP trainees with opportunities to learn the importance of engaging all relevant healthcare professionals in the evaluation and design of local, integrated systems of care, to understand the factors which promote professional engagement and to employ appropriate strategies and behaviours to engage with professional colleagues.

CHALLENGE 2: ENGAGING WITH PATIENTS AND THE PUBLIC

The NHS Act 2006 places a statutory duty on all NHS organisations to involve patients and their representatives in decisions about services. GPs' new responsibility for commissioning in England means they will have to consider issues on a broader scale, planning for whole communities and not just their individual practice populations.

To support the development of effective local services, GPs need to build sustainable partnerships with patients and the public that relate not only to patients as passive recipients, but as active participants in creating the local community's health vision, priorities and plans[135]. To do this, GPs need the skills to share knowledge and decision-making power

130 RCGP Centre for Commissioning. *Essential Skills for All Clinicians*. London: RCGP, 2011. Accessed via: www.rcgp.org.uk.
131 Wilson and Pirrie. *Multidisciplinary Teamworking Beyond the Barriers? A Review of the issues* (2000).
132 National Audit Office. *Tackling Inequalities in Life Expectancy in Areas with the Worst Health and Deprivation*. NAO, 2010. 133 The King's Fund. *Integrated Care for Patients and Populations: A report to the Department of Health and the NHS Future Forum*. *ibid*.
134 The King's Fund. I*mproving the Quality of Care in English General Practice* (2010). *ibid*.
135 Crawford M, Rutter D, Manley C, et al. Systematic review of involving patients in the planning and development of health care. *British Medical Journal* (2002);325:1263-1266.

proactively with the public, making it easy and attractive for lay members to get involved. GPs will need to actively seek the voice of the vulnerable and disenfranchised [136].

GPs must be provided with increased opportunities to practise proactively the sharing of information, decisions and power with patients and carers and to build care decisions around the needs, experience and views of patients and carers. For example, this could be achieved through working with patient participation groups in practices and with local third sector and community-based patient organisations. Training programmes will also develop new informatics skills in translating data into useful intelligence that can be acted upon.

GP trainees also need educational opportunities where they can develop the ability to manage the tension between population needs and individual health needs.

CHALLENGE 3: PARTICIPATING ACTIVELY IN SERVICE RE-DESIGN

'Achieving integrated care would be the biggest contribution that health and social care services could make to improving quality and safety.'

National Voices, 2011[137]

GPs have a key role in designing services to meet local strategic priorities, in partnership with service providers, and in ensuring that robust processes are used to co-design services. These should be informed by high-quality evidence and experience of innovative approaches to service delivery. GPs require a deep understanding of local health data, patient safety, quality improvement, efficiency and patient experience to design safe and cost-effective services.

A more integrated approach to services would help improve the care of over 15 million people living with long-term conditions and reduce the number of unnecessary visits to hospital – the Department of Health (England) has estimated potential savings of £2.2 billion if recent innovative pilot schemes to reduce ambulance call-outs and hospital bed-days were rolled out nationwide[138].

Enhanced training will provide GP trainees with the opportunity to learn about the impact of well designed systems on patient outcomes. For example, trainees could contribute to local efforts to redesign systems or processes of care, including the collection and auditing of feedback and other health data. They could also contribute to the local interpretation and application of evidence-based policies, guidelines, protocols and procedures in order to deliver high-quality community-based services. They could also work to identify, analyse and communicate threats, risks and opportunities relating to the improvement of service quality in their local area and help to co-ordinate the collection of patients' data and views.

Medicine traditionally operates in a 'reactive' culture but future primary care needs to start working 'proactively'. It is no longer sufficient for a GP to understand the best management for a clinical condition on an individual level alone – a competent GP needs to be able to contribute their expertise to the improvement of the entire patient pathway. Trainees will be

136 Stout D. Why public and patient engagement must work in the new commissioning system. *Health Service Journal* (2011).
137 National Voices. *Principles for Integrated Care*. National Voices, 2011.
138 Department of Health. Innovative care could help over 15 million people with long-term conditions. Press Release. Department of Health, 2011.

able to understand, collate and interpret feedback from patients about the whole pathway of care, potentially involving several teams and services.

CHALLENGE 4: WORKING COLLABORATIVELY WITH A RANGE OF NON-CLINICAL COLLEAGUES AND ORGANISATIONS

Current exposure to working with non-clinical colleagues in the three-year GP training programme is limited and operational. To enable the development of integrated care, it needs to expand to enable a wider awareness of roles and to reflect the wide range of business and procurement models now present in the NHS, including the increasing use of a mix of public, private and third sector organisations to deliver health and social care services.

To develop integrated services and to address the social determinants of ill health, GPs will increasingly need to work effectively with colleagues from a range of non-clinical backgrounds and organisations, such as local authorities and third sector organisations[139]. They will need the ability to work flexibly with wider, looser teams and collaborative organisations and appreciate the contributions of these colleagues to local healthcare services and the factors that influence effective joint working[140].

To deliver these key skills, enhanced GP training could include experience with relevant organisations – this could include commissioning groups (in England) and other commissioning organisations, public health organisations and other relevant community projects that are engaged in tackling local health needs. Trainees could undertake rapid/participatory appraisal, health needs assessment and health promotion projects within their practice populations as part of this training. Working with local authorities (perhaps via the Health and Wellbeing Boards) and the voluntary sector would also be possible.

139 The King's Fund. *Tackling Inequalities in General Practice*. The King's Fund, 2010.
140 Cameron A and Lart R. Factors promoting and obstacles hindering joint working: a systematic review of the research evidence. *Journal of Integrated Care* 2003;11(2): 9-17.

3.4: WHY IMPROVED ACADEMIC SKILLS FOR EVIDENCE-BASED PRACTICE, INNOVATION, QUALITY IMPROVEMENT, EDUCATION AND RESEARCH ARE TRAINING PRIORITIES

Over the past decade, there have been numerous high-profile and well evidenced reports calling for greater development of academic and leadership skills in general practice in order to bring about necessary improvements in healthcare service redesign, innovation, quality and research. For example, the 2011 King's Fund report *Improving the Quality of Care in General Practice*[141], Darzi's *Next stage Review of the NHS*[142] and Tooke's *Independent Inquiry into Modernising Medical Careers*[143] have all recommended enhancement of GP training to meet these key challenges.

A fundamental reason for this recurrent and growing need is the limited provision for the acquisition of these skills in the current GP specialty training programmes. With just 18 months of specialty training spent in general practice, with a necessary focus on core clinical and generalist skills, GP trainees have insufficient time to acquire and put into practise the academic, leadership and change management skills that are critical for cost-effective population healthcare, business management, innovation, service re-design, education and quality improvement. As a result, only those GPs who are sufficiently motivated and have opportunities to acquire these skills after specialty training are able to do so, often in an *ad hoc* manner and with variable degrees of support.

While trainees may be able to absorb the core knowledge and skills required in the GP curriculum to a level required to perform competently at assessment during training, they lack sufficient time and opportunity during training to apply these skills in practice. There is much educational research evidence to show that competent performance in the highly variable real world of independent general practice requires higher levels of application than the minimum-level requirements of an exit exam. This is a key argument for extended training: to ensure the modern general practitioner is able to perform these higher level academic and leadership roles when practising independently in the real NHS.

141 The King's Fund. *Improving the Quality of Care in General Practice* (2010). *ibid*.
142 Department of Health. *High Quality Care for All: NHS next stage review final report* (2008).
143 Tooke J. *Aspiring to Excellence: Findings and recommendations of the independent inquiry into modernising medical careers*. MMC Inquiry, 2008.

Box 3.4.1: Some of the academic contributions of general practice to medicine

Withering (1785) – a GP in Birmingham who first identified of the beneficial effects of digitalis in treating congestive cardiac failure, from which digoxin treatment is derived today

Jenner (1796) – a GP in Gloucestershire who performed the first inoculation for smallpox, laying the foundation for vaccination programmes that have saved millions of lives

MacKenzie (1879) – a GP in Burnley who became a leading authority on cardiology and first described the signs of cardiac arrhythmia, angina and other heart conditions

Pickles (1939) – a GP in Wensleydale who described the epidemiology of viral hepatitis and Bornholm's disease

Hope-Simpson (1954) – a GP who identified reactivated varicella virus as the cause of shingles, while working in the Shetlands

Tudor Hart (1971) – a GP in South Wales who formulated the Inverse Care Law, from careful observation of the health of his mining community.

Recent examples of GP-led research which has had a wide-ranging impact on practice and patient care includes:

- Sullivan F M, Swan I R, Donnan P T et al. Early treatment with prednisolone or aciclovir in Bell's palsy. *New England Journal of Medicine* (2007);357(16):1598-607
- Mant J, Hobbs FDR, Fletcher K et al. Warfarin versus aspirin for stroke prevention in an elderly community population with atrial fibrillation (the Birmingham Atrial Fibrillation Treatment of the Aged study BAFTA) a randomised controlled trial. *Lancet* (200);370(9586): 493-503.

CHALLENGE 1: DEVELOPING A ROBUST ACADEMIC SKILL SET FOR GENERAL PRACTICE

Over an extended training period all GP trainees will have the opportunity to achieve competence in core academic skills, including core critical appraisal and applied research skills (e.g. finding, understanding and utilising research evidence), research process and governance, and education and training.

The RCGP has identified a set of academic skills that all GPs should develop, including[144]:

- Reflective practice and self-directed learning
- Basic statistics and critical appraisal
- Problem framing
- Accessing evidence
- Prioritising and interpreting relevant information
- Implementing change in clinical practice
- Evaluating ethical issues and understanding the role of research governance committees.

144 RCGP curriculum. Accessed via: www.rcgp.org.uk.

The NHS will greatly benefit by having a new workforce with this robust skill set for facilitating educational and research utilisation in practice. These skills are important to evidence-based service improvement, redesign and commissioning, the development of integrated care, establishing a positive learning climate in primary care teams, and in data management and informatics[145].

A three systems approach is crucial to modern, high-quality healthcare – i.e. 'Education and Training' and 'Research and Development' both support 'Service Design and Delivery'.

CHALLENGE 2: DEVELOPING ACADEMIC SKILLS IN THE CRITICAL APPRAISAL AND IMPLEMENTATION OF EVIDENCE-BASED PRACTICE IMPROVEMENTS

General practice requires effective use of the relevant evidence base in order to guide prevention, screening diagnosis and management. Despite the advent of rapid online access to guidelines, there are numerous examples in the literature of the failure of healthcare professionals to successfully implement guidelines in their everyday practice[146]. There is a need for all GPs in training to acquire the necessary skills to understand how evidence is generated and to be able to interpret and implement research findings appropriately, thus achieving evidence-based practice.

Over the past 60 years general practice has evolved into a broad and highly complex discipline, and future GPs will be required to demonstrate the highest levels of expertise in exercising their profession. Like all medical sciences, the evidence base informing general practice is growing exponentially. However, much of the existing evidence base has been generated by academics from specialty-based disciplines and may not apply to the primary care context. Given the scale and impact of primary care within the NHS, the benefits to patients and the economy of more academically trained GPs are potentially huge and include greater patient safety, improved health outcomes, increased holistic care, safer and more cost-effective prescribing and referrals, and an evidence-based approach to practice, plus a more integrated, multi-professional workforce.

CHALLENGE 3: DEVELOPING ACADEMIC SKILLS TO FACILITATE INNOVATION AND QUALITY IMPROVEMENT

There is compelling evidence that the strength of the primary care system in a region or country predicts the health status of the population[147]. There is also a rightfully growing expectation among patients and carers that the NHS should deliver a high-quality service with access to the latest innovations. This is set against a background of growing complexity, with increasing multi-morbidity as the population ages and survival improves, and greater polypharmacy as more drugs are developed and incorporated into guidelines.

Primary care has a track record for innovation and quality improvement, but in many instances this may be more a manifestation of the ability of practices to quickly and

145 Beasley, Starfield et al. Global health and primary care research. *Journal of the American Board of Family Medicine* (2007);20(6):518-526.
146 Livesey E, Noon JM. Implementing guidelines: what works. *Archives of Disease in Childhood Education Practice* (2007);92:ep129-ep134: doi:10.1136/adc.2005.093328.
147 Beasley, Starfield et al. Global health and primary care research. *Journal of the American Board of Family Medicine* (2007);20(6):518-526.*ibid*.

effectively respond to a steady stream of external imperatives rather than the ability to analyse data and set direction internally.

During the next decade general practice will have an unprecedented opportunity to shape healthcare delivery to greater or lesser degrees in the four home nations. The changes required in service delivery will *de facto* require changes in the nature of generalism; the first challenge is that these large-scale possibilities and influences will require GPs to buy into in the concept and mechanism of change.

There are well documented specific competences (and clusters of competences) that are needed to effect and sustain change[148]. Although trainees may be provided with motivation to learn these through the need for MRCGP examination success, we must also support their colleagues and educators in this task. If trainees do not see motivation within this key group, they will fail to learn through role modelling (a technique that is particularly important in this complex area) and may fail to utilise their new skills in independent practice. Furthermore, trainees must themselves learn the skills to model and transmit good practice to others.

In relation to QIPP and quality improvement more generally, we can anticipate that primary care will, through increasing regulation and societal expectation, have to report more robustly in future. At present GPs are used to reporting outcomes, but in future they will have to provide and monitor evidence that processes and procedures are sound. Beyond this, we may anticipate that general practice service units will demonstrate for external scrutiny the qualities of 'learning organisations' by showing how they systematically monitor quality and promulgate learning. These attributes may later lead to a requirement to demonstrate innovation at local level.

CHALLENGE 4: INCREASING THE IMPACT OF RESEARCH IN AND ON PRIMARY CARE

Although approximately 90% of patient contact occurs in primary care, only a minority of research is conducted there. More research in primary care would greatly facilitate quality improvement. For example, how does a practice identify what level of continuity with a named doctor or nurse should be exercised – and how does the team evaluate whether they are meeting the goals set?

The research assessment exercise (RAE) conducted in 2008 by the UK university funding bodies assessed the quality of research activity by higher education institutions in the UK. The ratings of the primary care unit of assessment (RAE Unit of Assessment 8) found that the research outputs of general practice compared very favourably with those of other clinical specialities[149]. The contribution of research to the understanding of general practice comes increasingly from a combination of multidisciplinary working, a range of research methods and collaborative practice networks[150].

Despite this evidence of quality, general practice is not regarded as an 'academic' discipline by many doctors and patients. Many patients with co-morbidities request to see a 'specialist' in one condition when an expert generalist would be more appropriate, and more cost-effective, for their needs. Enhanced training will help to foster an academic

148 Iles V, Cranfield S. *Managing Change in the NHS: Developing Change Management Skills*. National Co-ordinating Centre for NHS Service Delivery and Organisation, 2004.
149 UK Universities. *Research Assessment Exercise, 2008.*
150 Wallace P. Research in general practice and primary care. *InnovAiT* (2010);3(5):298-301.

culture with the expectation that every GP has a duty to facilitate research, and some should be encouraged to pursue this as a career. GP training schemes need to attract the best medical school graduates to what will be an increasingly demanding role. Training should stretch the most talented and able doctors, as well as help out those requiring extra support. An academic approach can greatly help to reinforce a culture of excellence.

The lack of primary care research has contributed to a siloed approach to evidence-based healthcare, with most of the evidence base originating from selected populations which do not reflect the growing levels of complex co-morbidity seen in many individuals. Research skills will encourage doctors to question the work they routinely do. This is a significant benefit for primary care, where the research base that GPs use is often not generated within a community context but translated from secondary care. A better evidence base should lead to better patient outcomes, both in terms of patient health and patient satisfaction. Research may help us to think afresh about where, with what and by whom patients are best treated.

There is a rich history of research network development in general practice in the UK on which enhanced GP training can build (see Box 3.4.2). In the 1970s, the Medical Research Council General Practice Research Framework (MRC GPRF) was set up to answer key questions about the effectiveness of treatment of mild hypertension in general practice. In 2006 the NIHR Primary Care Research Network was established, and since that time it has supported more than 4,000 general practices throughout England in recruiting patients to an extensive national portfolio of clinical trials and other research studies.

Box 3.4.2: Development of primary care research networks in UK

1967 Weekly returns service – RCGP

1969 UK GP Research Club

1973 MRC GPRF

1984 Midlands Research Network

1993 Northern Primary Care Research Network and Wessex Research Network

1996 NHS research and development (R & D) funds for primary care

1998 UK Confederation of Primary Care Research Networks (PCRNs)

2006 National Institute for Health Research (NIHR) PCRN for England

From Wallace P (2010). Research in general practice and primary care. *InnovAiT* (2010);3(5):298-301.

There is also a need to improve the effectiveness of getting existing evidence into practice. To address this, trainees need more experience in systems change, service redesign and improvement methodology, ensuring that the outcomes of research have an impact on patient care. There should also be wider exposure to the range of primary care organisations during training, so trainees can better understand service redesign and quality improvement in the context of new ways of delivering primary care (e.g. walk-in centres, unscheduled care providers, polyclinics, etc). Exposure to public health and comparative or contrasting global healthcare systems elsewhere would also stimulate the development of critical enquiry into quality improvement.

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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.

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